APPENDIX F
TRANSITIONS OF CARE SUBCOMMITTEE

INTRODUCTION

Effectively managing patient transitions between settings of care (eg, from hospital to primary care, or from community to nursing home) is one of the most important and most difficult challenges in improving the quality and reducing the cost of health care. The Patient Protection and Affordable Care Act (ACA) includes changes in Medicare payment meant to encourage hospitals to reduce readmissions. However, preventing readmissions and improving the success of transitions between other parts of the health care system will require strategies that bridge the traditional separation of providers across settings.

Under the ACA, hospitals may be subject to Medicare rate reductions for potentially preventable readmissions for three conditions (heart attacks, heart failure, and pneumonia), and the Secretary of Health and Human Services is given the authority to expand the policy to additional conditions in future years. The Secretary is also directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available (effective October 2012).[1] The North Carolina Institute of Medicine (NCIOM) Health Reform Quality workgroup identified several gaps in addressing hospital readmissions, and the need to improve information transfer between providers to facilitate transitions in care. The workgroup also identified potential strategies to reduce preventable readmissions including access to patient-centered medical homes, addressing health literacy, high-risk care and medication management, shared savings models, information technology support, the forging of relationships between providers of care, and the need for new models of care within skilled nursing facilities that would reduce the number of patients transferred from skilled nursing facilities to emergency departments by facilitating assessment and care in place.

The ACA also includes many new provisions aimed at testing models to increase quality (without increasing spending), or reduce spending (without reducing quality). The Secretary is charged with evaluating these demonstrations to identify successful initiatives, and then will disseminate these financing and delivery models more widely throughout the country. One provision, Section 3026, appropriates $500 million for hospitals and community-based entities to furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

NCIOM's Quality and New Models of Care workgroups each recommended that a subcommittee discuss priorities and strategies for North Carolina to improve transitions of care in the context of the requirements and opportunities in the ACA.

The New Models of Care workgroup asked its subcommittee to:

- Explore the Transitional Care Model (Naylor),[2] and explore what DMA is implementing to determine if additional changes are needed to follow this evidence-based model.
- Explore the possibility of creating a multipayer demonstration for transition of care.

The Quality workgroup asked its subcommittee to:

- Discuss strategies for reducing preventable hospital readmissions, specifically in response to Sec. 3025 of the Affordable Care Act, which will start adjusting hospital payments in 2012 based on potentially preventable readmissions.

A joint subcommittee met on January 19, 2011. This document summarizes the subcommittee discussion and its recommendations for priority steps to improve transitions of care.

SUMMARY OF DISCUSSION

As the starting point for discussing existing transitions of care initiatives in North Carolina and exploring gaps, the subcommittee used a framework of evidence-based components of successful transitions of care compiled by Dr. Sam Cykert. See Table 1 for the subcommittee's working document, with notes on existing initiatives and gaps.

The subcommittee also discussed several cross-cutting issues and questions that affect the implementation of strategies to improve transitions of care. The subcommittee identified key elements to excellent care transitions for hospital discharge, high-risk patients, and outpatient settings, as well as across all care settings.

Key elements of hospital discharge transitions that prevent readmissions include:

1) Effective patient (or caregiver) education on medication management (including medications started, changed, or stopped).
2) Effective patient education on self-management including appropriate factors to monitor (eg, daily weights for CHF, fevers s/p pneumonia, etc.) and "red flags" that suggest a need for immediate care.
3) As part of the educational process, a teach-back approach that confirms patient understanding of these educational elements was highly recommended.
4) Effective selection of high-risk patients for intensified care management. It was acknowledged that CCNC care managers and transition methodologies were well developed and evidence-based though in most counties would not be available for patients covered by other payers, suggesting the need for creative solutions based on local resources (eg, the FirstHealth model[3]).
5) Some form of a personal health record should be provided pending the availability of robust HIE.

Key elements of high risk care management include:

1) Outpatient medication reconciliation with hospital discharge medications – preferably on home visit but at least by telephone visit.
2) Reaffirmation of self-management skills and recognition of red flags.
3) Extended telephone contacts, eg, four or more phone visits over the course of one month

Key elements of outpatient care transitions include:

1) An outpatient visit within 3 to 7 days of hospital discharge; therefore, practices must have a scheduling workflow that accommodates this need for access.
2) Components of the hospital follow-up visit should include:
   a. Reiteration of medication reconciliation and management.
   b. Reinforcement of self-management skills and "red flags."

c. Appropriate disease specific evaluation.
d. Review and incorporation of the personal health record into ambulatory records.
e. Whenever appropriate, discussions concerning palliative care are best initiated with patients in the environs of the medical home.
f. Systems of shared, after-hours, primary care access should be strongly considered.
g. Use of non-physician staff to manage care plans for some patients.

Key elements across all care settings include:

1) Emphasis on taking time with patients, maintaining relationships, building trust.

The most effective care model to date for improved transitions, decreased emergency department use, decreased overall hospitalizations, reduced unnecessary utilization, and improved quality of care is an integrated, patient-centered medical home (PCMH) with robust informatic systems, advanced ambulatory access, health literacy level appropriate education, a team-based approach led by primary care, and high intensity care management for well-defined high-risk patients. In these medical homes, the care team is aware of all transitions across the spectrum of care for member patients. These medical homes have core responsibility to ensure that red flag warnings, self-management skills, and the reconciliation of medications and records occur at the level of the medical home. Data regarding successes in cost efficiency and improved outcomes have been published within the last year by Geisenger Health System, Group Health of Seattle, and the VA Midwest Healthcare Network (VISN 23).[4] Community Care of North Carolina (CCNC) functionality is based on a medical home model with evidence-based transition services and includes NCQA PCMH recognition as one of the major pillars of its multi-payer demonstration pilot project in partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC) and the North Carolina State Health Plan. NC Area Health Education Centers (NC AHEC) through its Regional Extension Center (REC) Primary Care Services offers EHR implementation, PCMH Recognition consultation, and workflow redesign tools including a specific "transitions" package.

Given local variation in resources and penetration of enhanced transition programs, members of the subcommittee raised several questions and concerns regarding funding, information, and stakeholders:

Funding

How can money saved by hospital or other providers from improved transitions be shared with the community to help support management and coordination?

Discussion: Hospitals cannot legally pay private practices, although they will be able to share savings if part of a formally constituted Accountable Care Organization. Hospitals may be able to contract with pharmacists in the community to help manage patients and do enhanced medication teaching (that must include medication reconciliation and teach back methodologies).

Information

What information is most important during a transition given current limitations involving exchanging accurate and timely information in the current system?

Discussion: Single, accurate, and complete, medication list; a hierarchy for resolving conflicts between multiple legitimate documents for a single patient; record of what each provider saw as the next step in patient's care; easy ways to navigate through electronic records (eg, single table of contents for record with direct links). Timeliness of information exchange is crucial. Previous attempts to develop standardized transfer forms have collapsed.

Stakeholders

Who should be at the table in communities when developing transitions of care programs?

Discussion: Home health, hospitals, physicians, public health, free clinics, long-term care, hospice care, Department of Aging/Area Organization on Aging (AOA), MH/DD/SA local management entities (LMEs), Critical Access Behavioral Health Access (CABHA) providers, end users (eg, nurses on duty in nursing homes, medical director that cares for patients), patients and families. All possible local resources should be leveraged to ensure safe and effective transitions.

Specific suggestions for patient and family representatives included LME consumer advisors, Department of Insurance consumer network through outreach work, hospital patient advisory councils, LTC facility residents councils, community advocacy organizations active in a particular community, Spanish speakers via ombudsman in governor's office

RECOMMENDATIONS

The subcommittee's review of existing initiatives highlighted the many programs to improve transitions of care that are in place at integrated health systems, such as CarePartners, CCNC, and FirstHealth.

Therefore, the subcommittee's recommendations address strategies that can be used for patients outside of an integrated system, with a particular focus on transitions for patients leaving the hospital, because of ACA incentives and requirements intended to reduce readmissions.

Recommendations:

- **Improve patient education at hospitals, with a focus on the health literacy checklist and teach-back methodology.**
- **Improve education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.**
- **Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions.**
- **Personal health records, in the possession of the patient, should be emphasized pending the availability of more robust HIE.**
- **Align existing initiatives that address care transitions at state and local level.**
- **In each community, stakeholder alliances including provider groups, CCNC, home health representatives, mental health providers, and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with**

pending improvements in telemonitoring and home use of health information technologies.

- **Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation, and emphasis on self-management.**
- **Encourage collaboration and contracts between hospitals, LMEs, CABHAs, and other community providers (eg, pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients.**
- **Solutions utilizing transition principles should be applied to all patients regardless of payer.**
- **Encourage formal development of Medical Home Models that include the use of non-physician extenders to work with some patients (eg, stable diabetics), with physicians focusing on higher need patients**

SELECTED RESOURCES AND MODELS ON TRANSITIONS OF CARE

Guided Care model developed by Chad Boult, MD, MPH, MBA, and colleagues at Johns Hopkins Bloomberg School of Public Health. Also by Boult: *Guided Care: A New Nurse-Physician Partnership in Chronic Care*. http://www.guidedcare.org/

Care Transitions Program developed by Eric Coleman and colleagues at University of Colorado, Denver, School of Medicine. http://www.caretransitions.org/

Nurses Improving Care for Healthsystem Elders program developed by Mary Naylor,PhD, RN, FAAN, and colleagues at the University of Pennsylvania School of Nursing. http://elearningcenter.nicheprogram.org/login/index.php

Hospital Elder Life Program (HELP) developed by Dr. Sharon K. Inouye and colleagues at the Yale University School of Medicine. http://www.hospitalelderlifeprogram.org/public/public-main.php

Center to Advance Palliative Care. http://www.capc.org/

Hospital to Home National Quality Improvement Initiative. www.h2hquality.org

National Transitions of Care Coalition: NTOCC Compendium. http://www.ntocc.org/Toolbox/default.aspx

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge. Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions). http://www.ahrq.gov/qual/impptdis.htm

”Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting” by David E. Weissman and Diane E. Meier. http://www.capc.org/tools-for-palliative-care-programs/national-guidelines/primary-palliative-care-trigger-criteria-capc-consensus.pdf

“The Ironic Business Case For Chronic Care In The Acute Care Setting” by Albert L. Siu and colleagues. *Health Affairs* January 2009.

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge – Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions). http://www.ahrq.gov/qual/impptdis.htm

“The Group Health Medical Home at Year 2: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers” by R. J. Reid and colleagues. *Health Affairs* 2010.

“Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial” by K. L. Rice and colleagues. *American Journal of Respiratory and Critical Care Medicine* 2010.

“Value and the Medical Home: Effects of Transformed Primary Care.” R. J. Gilfillan and colleagues. *American Journal of Managed Care* 2010.

Table 1
Subcommittee Working Document

Feature	**Evidence-Based Components** (compiled from literature)	**Existing Local Initiatives** (from discussion at 1/19/11 meeting and feedback on draft report)	**Committee Brainstorming – Gaps and Recommendations** (from discussion at 1/19/11 meeting and feedback on draft report)
Inpatient-Outpatient Communication	Direct electronic exchange		
	Record access (EHR or paper)	CarePartners uses Western NC HIE to access hospital records; CCNC has access to Datalink (also view only); View only access to hospital records but no ability to download, print, or communicate back; can access records of tertiary care facilities through the local care mger; care mgers can access different systems but means have to juggle multiple systems; University health system has 3rd party view only access for non-affiliated physicians; FirstHealth has access w/in system; will be adding access to home health record by primary care physicians; HC Facilities – receive several conflicting records; tried universal transfer form but couldn't keep ppl at table; discussion w/ UNC of real-time ER record access; electronic prescribing systems allow access to prescription fill history for NC Medicaid, other insurers, sometimes cash customers	
	Personal Health Record	CCNC relies a lot on personal health record – delayed access to claims-based info	
	Secure email system	No real time info exchange for nursing homes other than ad hoc phone calls	

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
Care Coordination	Identify high risk patients	LME Care Coordinators identify high risk/high cost consumers, coordinate and monitor success of services	
	Engaging patients	CCNC uses hospital assessment to determine best post-discharge follow-up	Pts more likely to accept home follow-up if physician recommends How to capture patients who initially decline in hospital (multiple contacts)? Importance of low tech activities to build and maintain trust with patients
	Range of preventable effect		
	Discharge med training	FirstHealth – Starts with bedside nurse as part of self-mgt training; pharmacist flags add'l needs for particular education [heart failure, COPD pilot]	Literature shows med adherence is most important in post-MI care
	Self-management training		Literature shows self-management skills most important in CHF patients
	Health literacy – teachback	FirstHealth – assesses depression and health literacy at baseline; uses teachback	
	Sequence of visits		
	In person vs. phone vs. telehealth	FirstHealth has telehealth grant from HRSA Telehealth has been effective in literature for COPD patients Health center in UHS area has telehealth system – most complex pts; decrease up to 70% in admissions over 18 mos with 6 months of telehealth	

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
		CarePartners has been doing telehealth w/o extra funding; allows them to reduce visits Challenge to engage some patients to allow visits Koeble, in Alaska, used webcams to connect pharmacists with patients in remote communities CCNC care managers conduct home visits with patients after discharge, addressing range of issues including patient education, teaching, coordinating primary care visits, arranging specialist follow-up	
	One coordinator – one patient	A CCNC network pilot was successful with nurse care manager assigned to patient at hospital that followed patient through	
	Practice co-location		
	Timely info to practices		
	Home med reconciliation	FirstHealth does joint home visit with CCNC network CCNC care manager home visits after discharge may include med rec	For smaller communities and pts not under CCNC – could make arrangements with local pharmacies to help with med rec, but pharmacists can't bill Medicare for those services. (Limited option to bill now under NC Check Meds program) Hospitals could contract with pharmacists (Stark issue w/ paying referring physicians) – want to target the higher risk patients
	Use of visiting NPs or home health staff	Home health is already established Medicare benefit for patients who qualify;	How can home health visits be leveraged? (Not all Medicare

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		NPs cost more	patients qualify for home health benefit)
	Proactive, prepared care team		Not all care teams and providers alike, but need to be trained and expected to perform necessary functions
Post – Discharge Ambulatory Access	Early outpatient follow up	FirstHealth – schedules 7 day follow up appt before patient leaves; facilitates transport, etc. if necessary	
	Components of outpatient visit	UHS – no protocols yet for what happens at the outpt visit	Define essential elements for post-discharge. Create protocols for particular diagnoses for outpt visit after discharge; set protocols could also help with home health taking on larger role
	After-hours access	UHS setting up after care clinics Began discussion about how to arrange extra access from private providers Main challenge has been access to appointments – need to pay for add'l providers; UHS has previously looked at partnering w/ Walmart on minute clinics but they are not set up to manage chronically ill Kaiser has set up after care clinics, staffed by hospitalists for first outpt visit	How to arrange after hours access in communities without academic medical system? Hospitals could engage own employees or hospitalists to ensure post-discharge care and follow ups. Legal challenges to having hospitals incentivize drs to provide extra access
	Timely transfer of information		Need for timely information – discharge summaries from hospital may not be available for 30 days – this makes it difficult to synthesize

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
			information for primary care provider. Need for full information – eg, retail pharmacists can be hesitant to share because of HIPAA concerns
Nursing Home & Assisted Living	Med communication		
	Facility employed NP	Patients from nursing homes go to hospital only with dr order, but dr not on site; often default to hospital visit based on telephone conversation with nurse on site	
	Connection to mental health	Nursing home regs don't allow admission of pts with primary need of mental health; no such restrictions for assisted living	
	Management sequence		
	Outpatient/MD connection		
	Clinical pathways (particularly pneumonia)		
Palliative Care	Advanced directives/palliative care discussions	Federal requirement to discuss this at admission to nursing home – but decisions are different than at time of event	Too political to include in regulations? Can still be included in protocols used for patients with chronic disease Needs to be education of providers and patients; currently too linked to hospice care Ctr for Palliative Care working on protocols for outpatient care, already have them for inpatient care Should separate palliative care discussion from hospice image – more emphasis on symptom amelioration; these symptoms bring

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting and feedback on draft report)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting and feedback on draft report)
			them back to hospital
	"Good palliative – Geriatric Practice" algorithm		

Addendum:
North Carolina Department of Health and Human Services received funding in 2009 to develop a model(s) to improve the hospital discharge planning process. This will offer individuals information to make good decisions about their lives and post-hospital discharge, while maximizing their opportunities to live in the communities of their choice. This will build upon other initiatives: Community Resource Connections for Aging and Disabilities (CRCs) and Person-centered training. In conjunction with the grant, a Person-Centered Hospital Discharge Planning (PCHDP) Learning Partnership has been established to provide: 1) an inclusive process to develop parameters for common evidence-based benchmarks, critical data elements, and outcomes; 2) establish protocols; and 3) provide resources for local sites. Through a facilitated community engagement process, three local communities are implementing care transition programs designed to meet their community's needs and address issues related to hospital discharge. These communities are Surry, Forsyth, Chatham, and Orange counties. Key partners in this project are Community Care of North Carolina, the Forsyth, Northwest Piedmont, and Chatham-Orange CRCs, and the hospitals serving those communities.

[1] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3025, 10309.
[2] Transitional Care Model (TCM). TCM Overview. http://www.transitionalcare.info/index.html. Accessed April 16, 2012.
[3] First Health is a mid-sized health system based in Pinehurst, NC that has aggressively sought grant funding for transitions of care pilot programs that include home health and the local CCNC network.
[4] See Selected Resources section at end of document.