CARE TRANSITIONS:

Improving Care for High-Risk Populations in Tompkins County

Health Planning Council of Tompkins County

January 9, 2012

Community-Based Care Transitions

Tompkins County Application to CMS for Community-Based Care Transitions

- Introduction – Lisa Holmes
- Background: Best Practices in Care Transitions and Regional Experiences and Success – Christine Klotz
- Community Based Care Transitions – Lisa Holmes
- Local Analysis for the Application: Root Cause Analysis for Causes of Re-admissions – Susan Nohelty
- Tompkins Planned Intervention and Status of CMS Application – Lisa Holmes

Improving Transitions of Care

A Strategy to Defer Decline

Christine Klotz
Community Health Foundation of Western & Central NY

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

ABSTRACT

1. 1 in 5 Medicare Beneficiaries are readmitted in 30 days
2. National cost of over USD $17 Billion
3. Half of patients readmitted had no physician contact
4. 70% of surgical readmits were for chronic medical conditions

How the Foundation Got Started with Care Transitions

- First Quality Improvement Collaborative 2005-2006
  - Teams chose palliative care or transitions
  - By the end, almost all teams included some aspects of care transitions with uniform transfer forms, medication reconciliation and other system changes.
  - Learned about Dr. Eric Coleman and his recently published Care Transitions Intervention

Collaboratives and Learning Community

- 2007-2008 Collaborative
  - Fourteen teams, implemented Care Transitions Intervention (CTI)
- 2009-2010 Collaborative
  - Fourteen teams implemented (CTI) and the Next Steps in Care, family caregiver bundle
- 2011-2013 Care Transitions Learning Community and Coach Learning Comm.
  - Components of the ACA and evidence-based best practice models

Care Transitions Intervention™

Developed by Dr. Eric Coleman of the University of Colorado

Care Transitions Intervention is designed to encourage older patients and their caregivers to assert a more active role during care transitions

Patients and Families as Care Coordinators

- Most transition plans assume the patient and family will play a significant role
- Patients and families
  - May be willing and able, BUT they. . .
    - Don’t know what to expect
    - Aren’t prepared – lacking tools, knowledge and confidence

Used by permission of Dr Eric Coleman

Voice of the Patient

- Inadequately prepared for next setting
- Conflicting advice for illness management
- Inability to reach the right practitioner
- Frequently needed to complete tasks left undone by health professionals

Used by permission of Dr. Eric Coleman

Care Transitions Intervention (CTI)

- Low cost, low intensity, adaptable to different settings
- Short – 30 days – with one home visit and three phone calls
- *Transitions Coach* is used to build skills, confidence and to provide tools to support self-management
  - *Model behavior for common problems*
  - *Practice or role play for health care encounters*
  - *Create an accurate medication list*

Four Pillars

- Medication self-management
- Follow-up with PCP/Specialist
- Knowledge of “red flags” or warning signs/symptoms and how to respond
- Patient-centered record

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Transition Coach begins CTI before the transition

- Introduced in the hospital or SNF
  - Explain how the coach will support patient and family in transition
  - Focus on patient goal for the next month
  - Arrange home visit with patient and family caregiver
- Home Visit
  - Coach patient on the four pillars using Personal Health Record
  - Role play and prepare for physician visit

Coach Follow-up Phone Calls

- Follow-up on active coaching issues
- Review the Four Pillars
- Estimate progress made in activation
- Ensure that patients needs are being met

Results are tracked with the Care Transitions Measure, Patient Activation Assessment and Medication Discrepancy Tools providing feedback to the sending organization to improve discharge preparation

Model Fidelity- Important for Results

- Dedicated Transition Coach role
- Coach focuses on skill transfer, identification and pursuit of patient self-identified goal and modeling of behavior
- Home visit is essential
- Coach receives training offered by the Care Transitions Program

Care Transitions Intervention Summary of National Key Findings

- Significant reduction in 30-day hospital readmits (time period in which Transition Coach involved)
- Significant reduction in 90-day and 180-day readmits (sustained effect of coaching)
- Net cost savings of $300,000 for 350 pts/12 mo
- Adopted by over 500 leading health care organizations in 34 states nationwide

Community Health Foundation of W&C NY Supported Regional Result Examples

- Jones Memorial Hospital in Wellsville
- Crouse Hospital in Syracuse
- Lakeshore Hospital and Community Concern in Irving
- Beechtree and Long-Term Care (Ithaca)
- Hospicare of Tompkins County

Jones Memorial Hospital

- Focused on CHF patients
- 39% decline in CHF admissions for patients who had been coached
- Discovered a 20% medication error rate during coaching with mostly system errors
  - Discharge instructions inaccurate or incomplete
  - Led to hospital QI effort to improve medication reconciliation

Crouse Hospital (Syracuse)

- Reduced 30-day readmission rate for heart failure to 9.7%
- Patient and Physician Satisfaction High (3.5/4.0)
- Functional goals met
- Improvements in discharge process
- Currently expanding number of coaches to cover all older patients with multiple chronic conditions or admissions

Average Days Out – CHF Patients

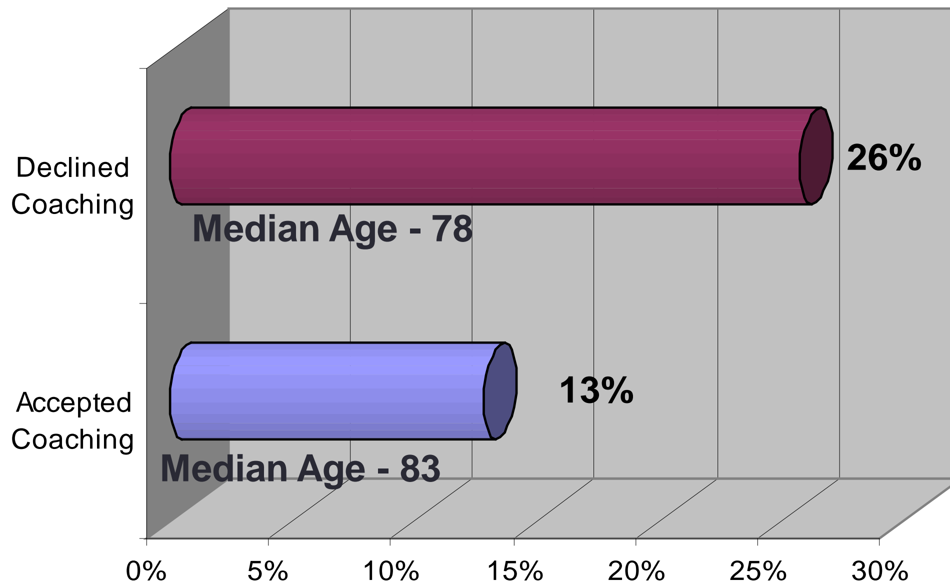
294 Patients Studied 9/2007 – 12/2010		
	# patients	Days Out
Patients with no other admission	122	534
Patients with subsequent admissions	172	Before 105
		After 279

Lakeshore Hospital with a Transition Coach from Community Concern (a CBO)

Faye Contino - Discharge Planner
Beth Nowak - Social Worker

Jerry Bartone MA MBA Executive Director
Jennifer Anselmo - Team Leader
Dawn Abramowski - Transition Coach

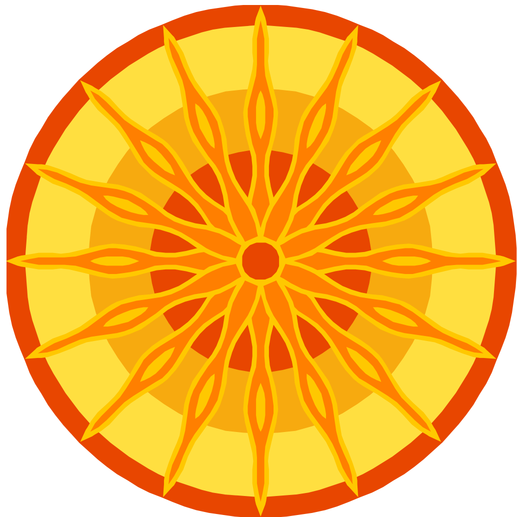
Hospital Readmissions



Transition Coaching reduced hospital readmissions by 50%.

Patients who agreed to coaching (n=47) had hospital readmission rate pf 13% vs. 26% for patients (n=70) who declined transition coaching

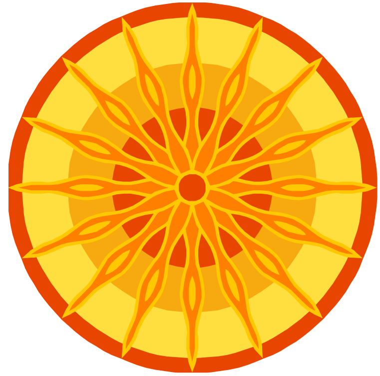
Beechtree Care Center and Long Term Care Services



Medication Discrepancy Tool

- Medication Reconciliation completed with 17 former Beechtree residents after they returned to their home

- Out of the 17 residents who received assistance with medication reconciliation six were found to have medication errors



Lessons Learned

- All nursing and discharge planning staff involved in the project became more focused on the needs of the clients returning home
- This resulted in improved CTM3 scores and fewer medication discrepancies

Hospicare and Palliative Care Services of Tompkins County

Creative and effective uses for
Next Step in Care tools

Admission to discharge

- Focused on the Medication Management form, the Caregiver Self Assessment and the Personal Health Record.
- Next Step in Care tools are provided to all our patients/caregivers via our Hospicare guide on admission
- Changes in setting, needs and medications all trigger a review of the NSIC documents
- NSIC tools are reinforced at discharge as well

Impact of these results

- CTI effective in promoting proactive symptom management and reducing the number of visits made by the nurse on call
- Sustainability proven by significant savings to the agency
- Reduction in unmanaged/unplanned ER visits reduces the risk for unknown cost to the agency and reduces unwanted hospitalizations at the end of life

Unanticipated benefits

- Total phones calls, both those made by patients to the on call nurse and calls made by the on call nurse to the patients, increased by 32%

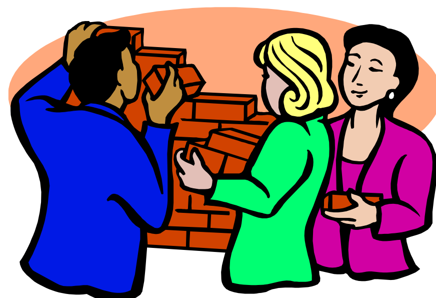
- The positive results on the Family Satisfaction Survey was not adversely impacted by reduced nurse home visits

Benefits of Collaborating Together for this Effort

"Care transitions is a team sport, and yet all too often we don't know who our teammates are, or how they can help."
~ Eric A. Coleman, MD, MPH

"One person alone cannot bring best practices into the real world. Success is emblematic of teamwork."
~ Mary Naylor, PhD, RN, FAAN

"Teamwork divides the task and multiplies the success."
~ *Author Unknown*



Tompkins County's Community Based Care Transitions Application

Lisa Holmes
Tompkins County Office for the Aging

Community-Based Care Transitions

- The Affordable Care Act (Section 3026) provided $500 million of funding to test models to improve care transitions with a focus on the high-risk Medicare population
  - Reduce Re-hospitalizations
  - Improved quality and continuity of care
- Applications began being accepted in April 2011
- Eligible applicants – Led by either
  - A high readmission hospitals OR
  - A Community Based Organization (CBO)
  - Interest in rural areas
- Partnership between a hospital and a CBO

Key points re Intervention

- The CBO will
  - use effective care transition services
  - report process and outcome measures on their results
- Applicants will not be compensated for services already required through the discharge planning process
- This is not a grant but payment for a new service
- The intervention must show savings with reduced readmissions

Proposal Preference

Given to proposals that:

- Include participation in a program administered by the Area on Aging to provide concurrent care transition interventions
- Provide services to medically-underserved populations, small communities and rural areas
- Include communities/providers currently providing care transitions services
- Hospitals whose 30-day readmission rate on at least two of the three hospital compare measures falls in the fourth quartile for its state

Tompkins Application

- Tompkins County submitted an application at the final 2011 deadline October 28th.
- On December 19th, we heard from CMS – Our application was *approved with conditions.*
- On January 4th we spoke with CMS about those conditions– more details later

Tompkins: Rural Community Based Care Transitions

- CBO led – Tompkins County Office for the Aging
- Partner Hospital – Cayuga Medical Center
- Other key partners:
    - The Health Planning Council
    - Visiting Nurse Services of Tompkins County
    - Hospicare of Tompkins County
    - Ithaca Health Alliance
    - Tompkins County Emergency Medical Services
    - TC Health Department – Certified Home Health Care
    - Tompkins County Department of Social Services
    - Excellus Blue Cross Blue Shield
    - Community Health Foundation of Western and Central New York
    - IPRO (NYS Regional QIO)

Building on Previous Experience

- Care Transitions Intervention pilots (Supported by CHFWCNY)
- One of two NYS counties Community Supports Navigator
- NY Connects to long term care services
  - Designated as an Aging and Disability Resource Center
- Sharing Your Wishes for older adults to receive care according to their wishes
- Support of family caregivers
- Cayuga Medical Center's work on reducing readmissions
  - Hospitalists arranging post hospital MD appointments
  - Clinical Integration focused on long term coordination of chronic disease management (Presented to HPC in 2011)

Application

- Goal: To reduce hospital re-admissions among Medicare FFS beneficiaries by 20%
- Strategy: Implement intervention through collaboration of multiple community agencies facilitated and led by the OFA

Tompkins County's Root Cause Analysis

Susan Nohelty
Cayuga Medical Center

What is a Root Cause Analysis

- An objective process to analyze a system/process to determine the main source(s) of a problem:
  - How
  - Where
  - Why
- Look at unexpected events/outcomes to determine *CAUSES that* underlie them
- Use data to determine *HOW* to intervene

Source: http://www.cfmc.org/integratingcare/toolkit_rca.htm

Key Elements

- A historical review of times when the unexpected event/outcome occurred (chart audits)
- Interviews with those involved in the unexpected event/outcome (staff and patients/consumers)
- Creation of a problem statement
- Identification of drivers leading to this problem

Tompkins CCTP Process

- Goal – To analyze the process issues within and across providers and care settings to determine why patients are being readmitted to the hospital within 30 days of hospital discharge

Community Root Cause Analysis

- Organizations Involved:
  - Cayuga Medial Center
  - Beechtree Care Center
  - Cayuga Ridge
  - Visiting Nurse Services of Tompkins County
  - Tompkins County Office for the Aging
  - Tompkins County Health Department
  - Ithaca Free Clinic
- Process:
  - Chart Reviews
  - Admission and Discharge Process Mapping
  - Patient, Caregiver and Staff Interviews
  - Data Review
  - Stakeholder Review and Consensus

Chart Audits: Key Findings

- Patients and family caregivers did not understand what to expect during the discharge/transition process
- Adverse reactions to medications, medication discrepancies or medication mismanagement often led to readmission
- Lack of timely and effective advance care planning
- Patients did not see their primary care provider prior to a hospital readmission
- Falls among community dwelling older adults led to readmission
- Patients mismanaging their own conditions, not following the instructions of health care professionals, leading to condition exacerbation

Chart Audits: Key Findings Cont.

- Hospital readmissions were occurring after typical work hours, during evenings and weekends
- Patients seemed not to follow the instructions of the health care professionals responsible for managing their care
- Lack of timely and accurate communication between providers impacted the discharge/transition process
- All patients who were part of this chart audit had more than one chronic condition

Process Mapping: Key Findings

- Organizations did not identify a point in the process at which the patient's understanding of what to expect at discharge/transition was reviewed
- The assessment of patients and family caregivers occurred very early in the stay but patients were not reassessed as the care routines changed
- There was no point in the process at which the patient was engaged in improving their self management of their condition upon returning to the community

Older Adult Interviews: Key Findings

- Interviewees reported feeling they were being discharged too early/too quickly.
- Interviewees reported the discharge planners successfully setting up the services they needed upon discharge, but that as new needs arose they were unsure what services to access.
- Patients felt the reason for readmission was often related to “similar symptoms” or condition exacerbating over time.
- The patients felt the discharge process was improved when they were able to see their primary care provider quickly upon discharge.

Family Caregiver Interviews: Key Findings

- Family caregivers felt they were not adequately involved in the discharge process and that the needs of the family were not always taken into account.
- Family caregivers would like guidelines or more information about what to expect not only during the hospitalization, but upon discharge.
- Family caregivers reported needing to go back to the hospital when they did not understand or could not manage a new medication regimen.
- The discharge process felt rushed with little time to have questions answered.

Medicare Fee For Service Data – Discharge Disposition

Reported Disposition	Percent Readmitted within 30 days by discharge location	
	January 1, 2010 – December 31, 2010	January 1, 2011 – March 31, 2011
Home	14%	18%
Skilled Nursing Facility	13%	13%
Home Health Care	20%	10%
Hospice	0%	0%
Rehab	8%	11%
Other	13%	30%

Medicare Fee For Service Data – Diagnosis Category

Diagnosis Category	Percent re-admitted within 30 days by diagnosis category	
	2010	Quarter 1 2011
Heart Attack – Primary DX	22.2%	14.8%
Pneumonia – Primary DX	12..3%	16%
Heart Failure – Primary DX	14.9%	13%
Heart Failure – Secondary DX	18.8%	19.4%
COPD – Primary DX	13.0%	44.4%
COPD – Secondary DX	13.9%	24.4%
ESRD – Primary or Secondary DX	34.4%	20%
Diabetes – Primary or Secondary DX	12.6%	13.2%

Results

Problem Statement:

“Patients and family caregivers are not adequately prepared to manage their long term care conditions during their transition between care settings in the absence of health care professionals leading to symptom exacerbation, an increased likelihood of crisis, inappropriate health care utilization, and readmission to the hospital."

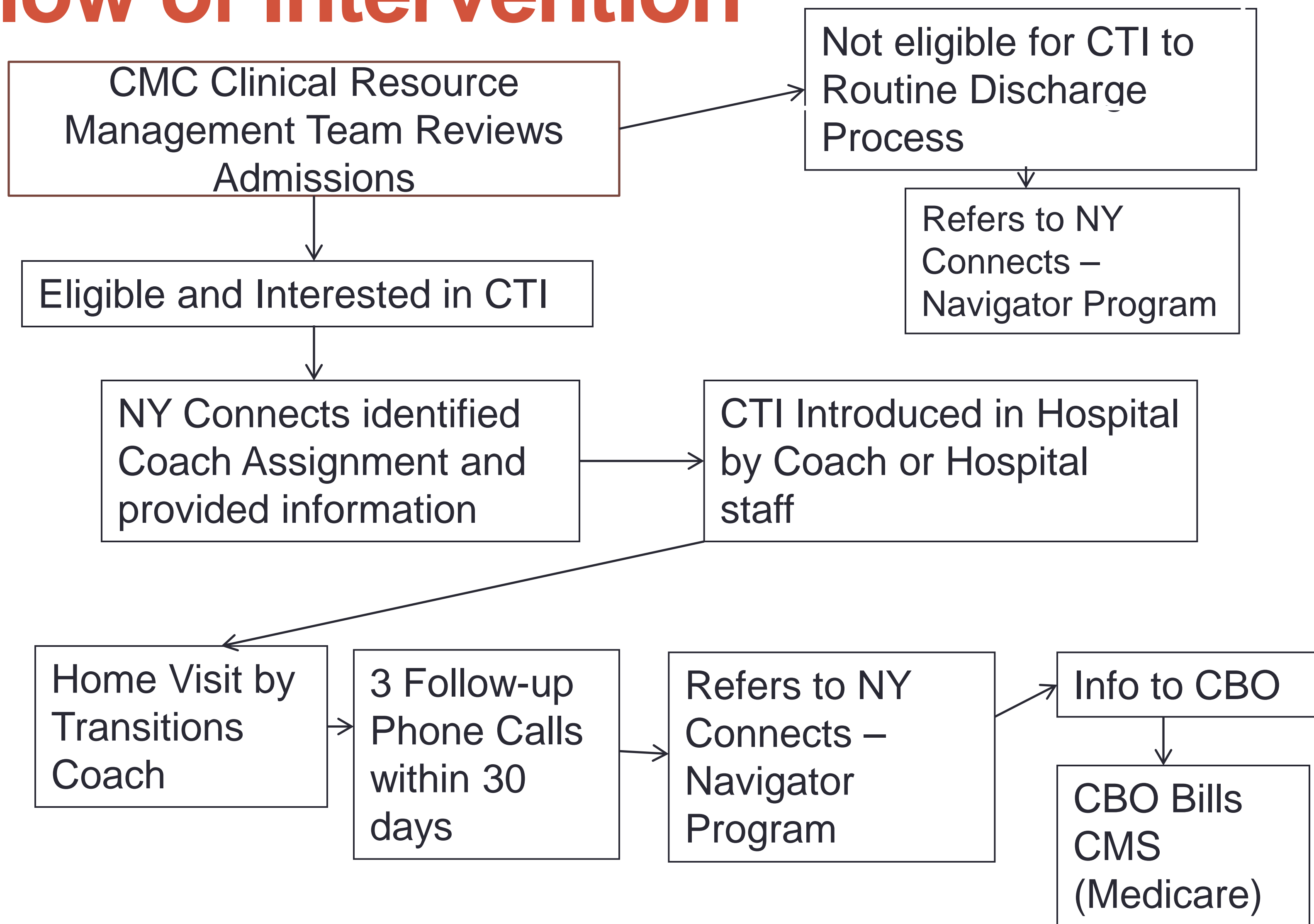
Target Population

"Medicare Fee for Service patients admitted to Cayuga Medical Center who (1) reside in Tompkins County, (2) have a primary or secondary diagnosis of congestive heart failure, pneumonia, chronic obstructive pulmonary disease, urinary tract infection, and or any other patient frequently readmitted to the hospital, (3) have a discharge plan that includes returning to the community and, (4) have consented to receive this intervention"

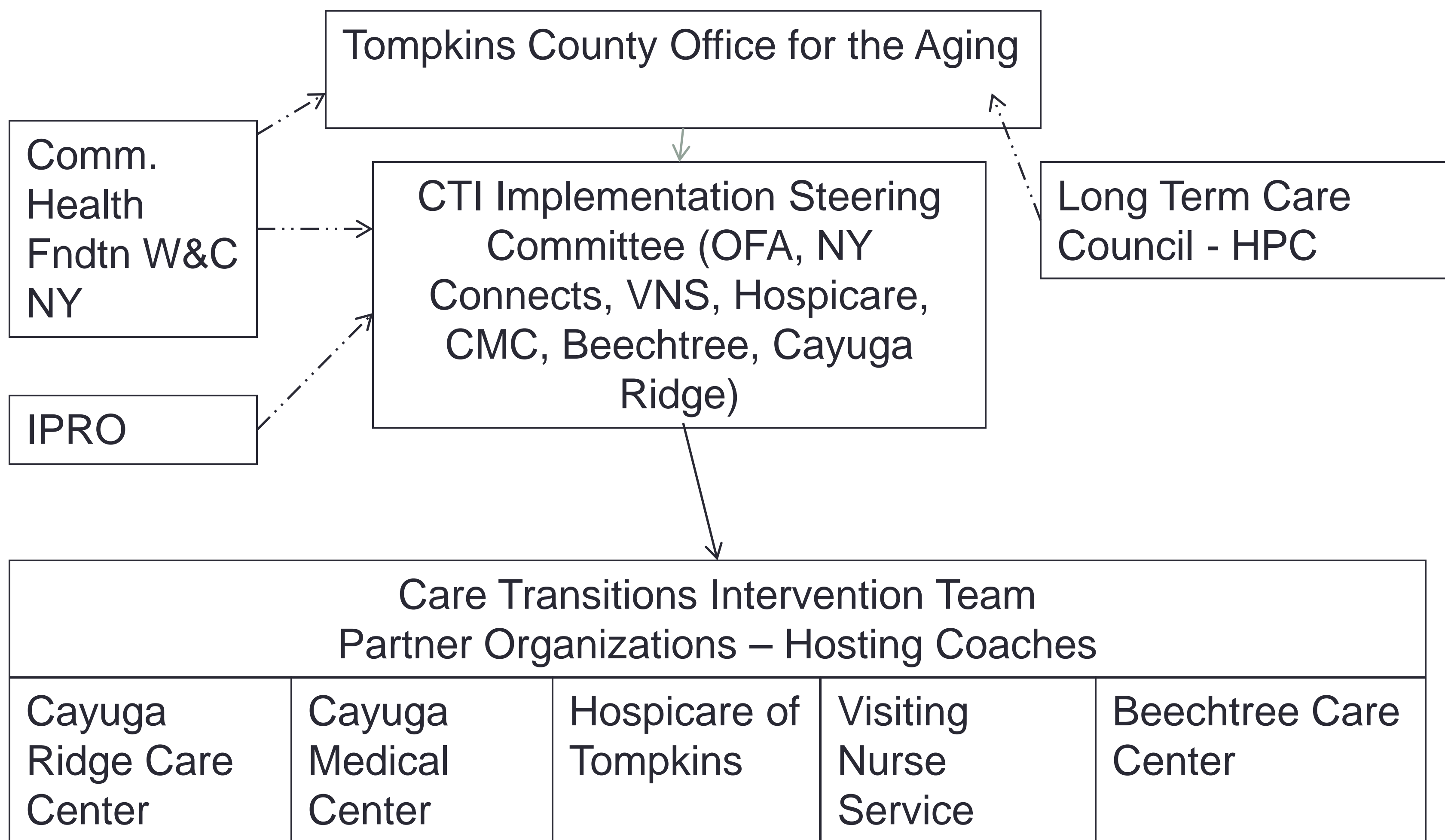
Intervention Plan

- To address the problem identified in the root cause analysis
  - Patients and families are not prepared to manage condition during care transition without support of health professionals
  - Leads to exacerbations of illness
    - Health crisis
    - Inappropriate, unnecessary health care utilization
    - Hospital re-admission
- Care Transitions Intervention is the core approach
- From previous work, thirteen people in Tompkins have been trained in the model as Transitions Coaches

Flow of Intervention



Organization Chart



Expected results

- Savings of $133,741 in Medicare costs through reduction in readmissions
  - After considering costs of intervention, Medicare savings of $64,275 over five years
- CMC has better than average readmission rates now
  - Financial savings is not large
- Improved health care for elders requiring hospitalization
  - By providing transition support
  - By better connections to community-based services

Some other Services to Connect

- Patients who are near end of life – particularly at skilled nursing facilities – will be introduced to Sharing Your Wishes and MOLST and referred to Hospicare
- Patients and family caregivers will be supported for self-management through
  - Family caregiver support including Powerful Tools for Caregivers
  - Better Choices, Better Health (Chronic Disease Self-Management Program)
  - Expanded use of Teachback in patient encounters
  - Expanded use of Next Step in Care™ Caregiver Resources
- Clinical Integration Services to strengthen communication between care settings
- VNS Tele-health support

Support for our efforts

- IPRO (Regional QIO)
  - Technical support and advice
- Community Health Foundation
  - Technical support and advice
  - CTI Learning Community – monthly education for coaches
  - Coach Training and Refresher
  - Resources and Tools as needed

Next Steps

- Respond to CMS conditions for approval:
  - More detail on staffing and coordination of coaches;
  - Items related to discharge process that the Care Transitions Intervention does not address;
  - More detail regarding budget and blended rate
- January 12th Implementation Meeting
  - Care Transitions Team Organizations
  - IPRO and CHFWCNY

Transitions of Care

Transitions of Care refers to the movement of patients from one health care practitioner or setting to another as their condition and care needs change. This includes transitions from hospitals to nursing homes or home care after an acute illness. The locations and care practitioners involved in care transitions are many. As a result, information shared with patients and their caregivers is often confusing, contradictory, or missing critical details. Appropriate transitions of care include understanding the needs of chronically ill patients, understanding health goals and wishes, making appropriate logistical arrangements, educating patients and families about expectations and next steps, and coordinating between health care practitioners at both settings.

Most of the focus on medical error is on patients in institutional settings; however the seriousness of the problems that exist between settings is significant and often overlooked. Most health care practitioners only practice in one setting and understand little about the requirements of other settings.

Opportunity for Improvement: With grant support from the John A. Hartford Foundation and the Robert Wood Johnson Foundation, Dr. Eric Coleman, of the University of Colorado Health Sciences Center, studied the impact of care transitions and developed the Care Transitions Intervention(CTI). His research found that patients and their caregivers are unprepared for their role in the next care setting, they do not understand essential steps to manage their condition, and they do not know what health care practitioner to contact for additional guidance. Many patients and their caregivers are frustrated with tasks that were left undone by health care practitioners in the transition of care. In another study looking at a representative sample of Medicare patients, Dr. Coleman found that 12-25% of poorly managed care transitions required a return to a higher intensity of care setting.

Efforts to Improve Care Transitions in WNY: Over the past five years the Community Health Foundation of Western and Central New York has invested in four projects aimed at improving care transitions. This work supported implementation of the CTI through health care providers in WNY, including training of 65 coaches. For more information and to see results, see www.chfwcny.org.

Care Transitions Intervention (CTI) Through the use of Transitions Coaches, patients and families are supported for a few weeks to ease transitions from one care setting to the next. The Coach helps patients acquire self management skills to ensure their needs are met and their likelihood of immediate decline is deferred. The CTI focuses on four pillars:

- Medication self-management to that patients know their medications and have a system to manage them.
- A personal health record to facilitate communication with health professionals and ensure continuity of care across settings.
- Timely physician follow-up scheduled by the patient with preparation to be an active participant in medical appointments.
- Knowledge of red flags indicating that the patient's medical condition is worsening and how to respond.

Dr. Coleman demonstrated patient re-hospitalization could be reduced by half through the use of simple tools and coaching. His three-item Care Transitions Measure (CTM) was endorsed for public reporting by National Quality Forum in May 2006 and is considered the national standard for assessing care transition effectiveness.
For more information, see www.caretransitions.org

Summary: CMS Solicitation for Applications – Community-based Care Transitions Program

The Centers for Medicare & Medicaid Services (CMS) has released a solicitation for applications for participation in the Community-based Care Transitions Program (CCTP). The CCTP, mandated by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of care from the inpatient hospital to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measureable savings to the Medicare program. The CCTP is part of Partnership for Patients, a national patient safety initiative with components to reduce harm caused to patients in hospitals and to improve care transitions.

CCTP Eligibility:

- Hospitals with high readmission rates that partner with community-based organizations (CBOs)
- CBOs that provide care transition services.
  CBOs are defined as community-based organizations that provide care transition services across the continuum of care through arrangements with hospitals and whose governing bodies include representation of multiple health care stakeholders, including consumers.

The CBOs will use care transition services to effectively manage transitions and report process and outcome measures on their results. CBOs will be paid on a per eligible discharge basis for Medicare beneficiaries at high risk for readmission, including those with multiple chronic conditions, depression, and cognitive impairments.

In selecting CBOs to participate in the program, CMS will give preference to Administration on Aging (AoA) grantees that provide care transition interventions in conjunction with multiple hospitals and practitioners and/or entities that provide services to **medically- underserved** populations, **small communities**, and **rural** areas. In addition, consideration will be given to organizations that have established similar care transition interventions with State Medicaid programs and organizations that have established relationships with medical homes serving Medicare beneficiaries. Applicants are also encouraged to collaborate with Medicare Advantage plans and to have a comprehensive all-payer approach to readmission reduction. The program will run for 5 years beginning April 12, 2011. Applicants will be awarded 2-year agreements with annual extensions for the remaining 3 years based on performance.

Applicants must complete a root cause analysis of readmissions, define their target population, and strategies for identifying high risk patients. In addition to readmission reduction, client satisfaction with the care transition process is an important CMS goal. Applicants must also specify care transition interventions and strategies for improving provider communications in care transitions and improving patient activation. Applicants will describe how care transition strategies will incorporate culturally appropriate and effective care transition approaches to ethnically diverse beneficiaries, and how other community and social supports and resources will be incorporated to enhance the beneficiaries' post-hospitalization management outcomes. Lastly, applicants will be required to provide a budget, including a per eligible discharge rate for care transition services, provide an implementation plan with milestones, and demonstrate prior experience with effectively managing care transition services and reducing readmissions.
Community Care Transitions Program Website:
http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313