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Bridging the Inpatient/Outpatient Divide: Improving Transitions of Care to Reduce Hospital Readmissions
March 19, 2015
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Today's Purpose

• understand issues related to avoidable hospital readmissions and the extent to which they affect health outcomes and health care costs

• recognize inpatient-outpatient care transition models that promote collaboration and reduce avoidable hospital readmissions and use of emergency department resources

• identify the major components of transition programs to determine the potential for implementation.

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Today's Speakers

Jason Martin, LCPC, CPRP, Family Services, Inc.

Harold A. Pincus, MD, Columbia University

Sarah M. Steverman, PhD, MSW, CIHS Consultant

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Poll Question: How do you identify your role in primary care/behavioral health integration?

- Primary Care Provider/Administrator
- Behavioral Health Provider/Administrator
- Inpatient Provider/Administrator
- Policy Maker
- Other Stakeholder

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Poll Question: For those participants who are providers or administrators of clinical programs, are you:

- A Primary Care Organization
- A Mental Health or Addictions Organization
- Part of an Accountable Care Organization
- Part of a hospital-based system
- Other

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Connecting Hospitals and Community Providers

Jason Martin, LCPC, CPRP
Director of Carelink Transitions and OnTrack Maryland, Family Services, Inc.

Over 100 Years of Service
Family Services, Inc.
An affiliate of Shepperd & Enoch Pratt Foundation
Thomas E. Harr, CEO

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Carelink Transitions: The Community We Serve

Family Services is located in Montgomery County and Prince Georges County MD
- Multiple locations in each jurisdiction
- Suburban Washington DC
- Culturally diverse
- Economically diverse

Large Social Service agency
- Part of Sheppard Pratt Health System
- Served over 25,000 people in 2014
- 400+ Staff operating 33 distinct programs

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Carelink Transitions: FSI's Solution

- FSI was approached by Washington Adventist Hospital (WAH) in 2011
  - WAH had a history of a high 30 day readmission rates
  - Wanted community partner to help develop solution
- The hospital's request:
  1. Connect the client to community resources
  2. Implement the discharge plan
  3. Reduce or eliminate avoidable readmissions
- CareLink Solution – 30 day intensive case management

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Community Based Behavioral Health Providers: Our Role

- Expertise in working with behavioral health population
- Experience in providing community based case management
- Ability to make home visits
- Connections to community resources and providers
- Integrated health services

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Carelink Transitions: Implementation

"Home Grown Effort"

- Started very small with one nurse providing support
- Worked with WAH to achieve desired metrics
  - Reduce readmissions and connect clients to community resources

Started initially with complicated Behavioral Health clients, moved to clients of all diagnoses quickly

Finances

- Started at $650 a month paid by WAH, increased over time to current rate at $1200 a month
- Paid one time for 30 days of service with extensions possible on case by case basis

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Carelink Transitions: How It Works

- Hospital identifies a high risk, likely to re-admit patient
- CareLink Transitions meets with patient in the hospital, completing a "warm handoff"
- Nurse Care Manager and Entitlements Care Manager work with the patient for 30 days
- Utilize the Coleman Model for care transitions

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The "Warm Handoff"

- Rapport building and engagement
- Verification of current address
- Provision of "TracFone" to patient if no working number identified
- Needs assessment completion in the hospital
- Collaboration with referring social worker

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Carelink Transitions: Integration At Its Core

A Carelink team consists of:

1. Licensed Practical Nurse
2. Entitlements Coordinator
3. Clinical Manager (.5 FTE)
4. Hospital liaison (.5 FTE)
5. Data manager (.2 FTE)

*We speak English, Spanish, French and Swahili

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What Our Nurses Do In 30 Days

- Transportation for follow up appointments
- Appointment scheduling assistance
- Nursing assessment
- Home visits
- Medication reconciliation
- Patient education:
  - Discharge instructions
  - Proper use of emergency department
  - Self management
- Coordinating community based providers:
  - Primary care
  - Mental health
  - Substance abuse

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What Our Entitlements Coordinator Does In 30 Days

- Needs assessment
- Medicaid, Medicare applications
- SSI/SSDI
- SNAP (food stamps)
- Transportation (MetroAccess, Call-n-Ride)
- Referrals and applications to:
  - PRP
  - RRP
  - Housing and shelters
  - Food resources
  - Other social services and resources
- Assistance getting necessary documents

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Introduction Of Pathways Model

- October 2014 Carelink adopted Care Coordination Systems (CCS) as its documentation system
  - Pathways and CCS are approved by AHRQ
- CCS documents integration of care
  - Provides for progress reports and outcome assessment
  - Provides a relative risk assessment for triage
  - Supports a braided funding model (Hospital, 3rd party insurers, other stakeholders)—example Ohio

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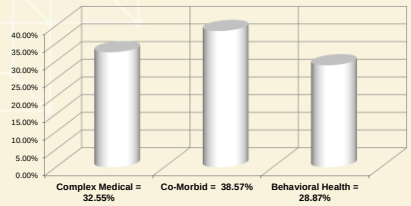
Trends: Complex Medical, Behavioral Health And Co-morbid Conditions (N=552)



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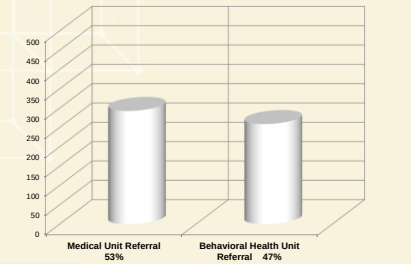
Data: Type Of Referral (N=552)



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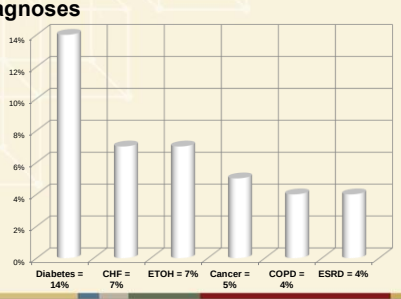
Medical Unit Referrals: Most Common Diagnoses



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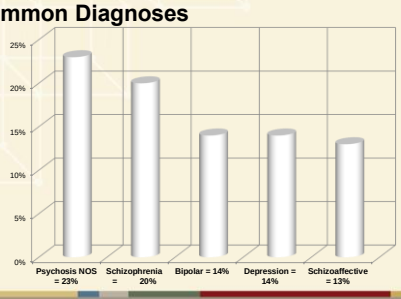
Behavioral Health Referrals: Most Common Diagnoses



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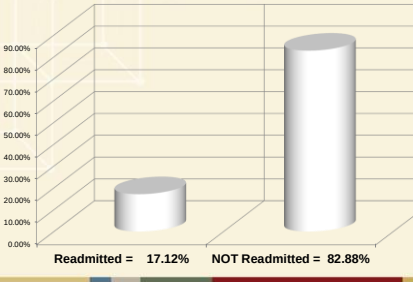
Data: Client Readmission Rate



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Moving Forward

- Expansion to other hospitals
- Changes in staffing
  - Utilizing Community Health Workers (CHW)
  - Continuing to use LPN, more consultative
- Changes in funding

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Poll Question: For those of you in community provider organizations or inpatient settings, do you have a care transitions program?

- **Yes**
- **No**

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Poll Question: For those of you with a care transition program, what model do you use?

- Care Transitions Intervention (CTI – Coleman Model)
- Transitional Care Model (TCM – Naylor Model)
- Reducing Avoidable Readmissions Effectively (RARE)
- Re-engineered Discharge (RED)
- Other

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Care Transitions Interventions in Behavioral Health

Harold Alan Pincus, MD
Professor and Vice Chair, Department of Psychiatry
Co-Director, Irving Institute for Clinical and Translational Research
Columbia University

Director of Quality and Outcomes, Research
New York-Presbyterian Hospital

Senior Scientist RAND C0rporation

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Care Transitions and Readmission

1. The Problem
   a. Hospitals incentivized to discharge early
   b. Fragmented inpatient/outpatient care systems
   c. Insufficient attention to transition planning
2. The Result
   a. High rates of potentially preventable readmissions
   b. Bad for consumers
   c. Bad for costs

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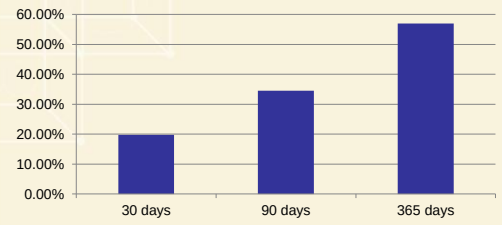
Overall Medicare Readmissions Rates



Source: Jencks, S. F. et al., N Engl J Med 2009; 360: 1418-1428

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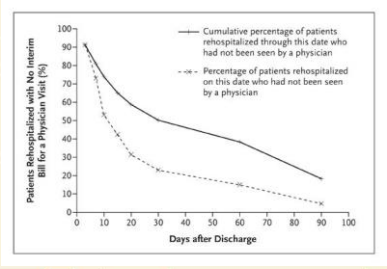
Patients for Whom There Was NO Bill for an Outpatient Physician Visit between Discharge and Rehospitalization



Source: Jencks, S. F. et al., N Engl J Med 2009; 360: 1418-1428

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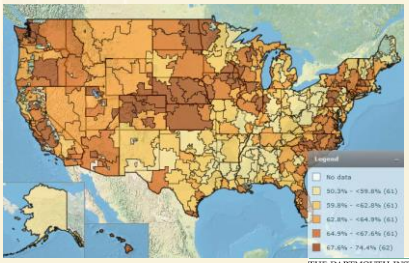
Percent of Patients Having an Ambulatory Visit within 14 Days of Discharge, by Cohort

(Cohort: All Medical Discharges; Year: 2010; Region Level: HRR)



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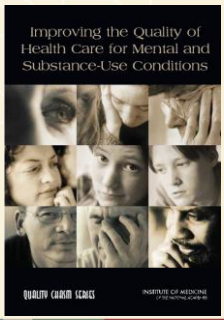

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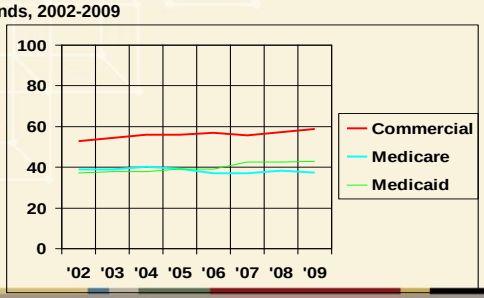
Follow-Up After Hospitalization: Within 7 Days Post-Discharge- HMO Means Trends, 2002-2009



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Top Ten Most Common Medicaid Readmissions

1. Septicemia (except in labor) — $319 million (17,600 total readmissions)
2. Schizophrenia and other psychotic disorders — $302 million (35,800 total readmissions)
3. Mood disorders — $286 million (41,600 total readmissions)
4. Congestive heart failure (nonhypertensive) — $273 million (18,800 total readmissions)
5. Diabetes mellitus with complications — $251 million (23,700 total readmissions)
6. Chronic obstructive pulmonary disease and bronchiectasis — $178 million (16,400 total readmissions)
7. Alcohol-related disorders — $141 million (20,500 total readmissions)
8. Other complications of pregnancy — $122 million (21,500 total readmissions)
9. Substance-related disorders — $103 million (15,200 total readmissions)
10. Early or threatened labor — $86 million (19,000 total readmissions)

* AHRQ Statistical Brief

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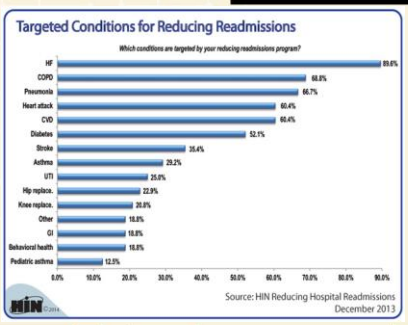

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Three Focal Questions for Review

- What are the components of existing frameworks/interventions to improve care transitions? To what extent have they been evaluated?
- Have care transitions interventions been developed/adapted/evaluated specific to the behavioral health population?
- How can current intervention frameworks be modified to address transitions specifically focused on behavioral health populations who are hospitalized to enhance continuity of care, reduce readmissions and improve outcomes?

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Background: Efforts to Reduce Rehospitalizations

- Most extensive efforts are in areas of care outside of behavioral health
- Models that aim to improve care in transitions have largely focused on:
  - Elderly
  - Specific illness groups (Diabetes, Cardiovascular)
  - State/system-specific quality initiatives
  - State/system-specific policies directed at reducing readmissions

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Care Transitions and Health Care Reform

1.Policies and structures to reduce readmissions include:

a. Inpatient/Outpatient collaborative care teams
b. ACOs/Medical Homes/Health Homes
c. Overarching financial models (e.g., capitation)
d. Bundling inpatient and outpatient care
e. Quality measures
f. Public reporting
g. Penalties related to readmission rates
h. Value-based purchasing

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Methods

- Systematic literature/web search, snowballing, etc.
  - Including grey literature, education, T/A, implementation material
- Inclusion criteria:
  - Intervention models descriptions
    - General medicine
    - Mental health
  - Trials or evaluation studies
    - General medicine
    - Mental health

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Major Care Transition Models in General Medical Care

- Care Transitions Intervention (CTI); Eric Coleman
- Transitional Care Model (TCM); Mary Naylor

- Adapted Models/Initiatives:
  - Reducing Avoidable Readmissions Effectively (RARE)
  - Better Outcomes for Older Adults through Safe Transitions (BOOST)
  - Transforming Care at the Bedside (TCAB)
  - Re-engineered Discharge (RED)
  - Geriatric Resources for Assessment and Care of Elders (GRACE)
  - Guided Care Model
  - Bridge; Illinois Transitional Care Consortium
  - Centers for Medicaid and Medicare Innovation Center

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Care Transitions Intervention (CTI); Eric Coleman

- Four components:
  - Patient-centered record
  - Pre-discharge checklist/tool of critical activities to empower patients
  - Pre-discharge patient session with a Transition Coach
  - Transition Coach follow-up visits and calls
- Intervention based on "Four Pillars":
  - Medication self-management
  - Use of a dynamic patient-centered record
  - Primary care and specialist follow-up
  - Patient knowledge of red flags

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Transitional Care Model (TCM); Mary Naylor

- Similar in scope to CTI, but differs in approach
- Focuses on chronically ill patients who have been hospitalized for common medical and surgical conditions
- Nurse-led, multi-disciplinary intervention that includes:
  - screening; engaging the elder/caregiver; managing symptoms; educating/promoting self-management; collaborating; assuring continuity; coordinating care; and maintaining relationship

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How CTI and TCM Relate to Other Models

- All adapted models found included the major components of the CTI and TCM:
  - Recognize that healthcare delivery and support are delivered in silos, with a general lack of communication and collaboration
  - Focus on elderly and/or chronically ill population
  - Utilize a "health coach", whether a specially trained coach or an assigned nurse or social worker
  - Include pre-discharge planning with the patient
  - Follow-up visits and/or calls with the patient by the coach
  - Patient/family takes an active and responsible role in his/her care

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Availability, Responsiveness, and Continuity (ARC)

- Only model found that focused specifically on mental and behavioral health; designed to support the improvement of social and mental health services for children
- Uses "change agents" to apply 10 intervention components: personal relationships, network development, team building, information and assessment, feedback, participatory decision-making, conflict resolution, continuous improvement, job redesign, and self-regulation
- 4 phases: problem identification, direction setting, implementation, and stabilization
- All within three levels: community, organization, and individual

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"What, For Whom, By Whom, Where, When, and How"

- *What:* components that constitute the model based upon themes from existing intervention models
- *For Whom:* specific clinical populations that are targeted
- *By Whom:* which professionals (and caregivers/consumers) play which roles

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"What, For Whom, By Whom, Where, When, and How"

- *Where:* setting is vital to understanding type of implementations and type of system the patients and providers are part of
- *When:* key time points of intervention (and for collection of metrics)
- *How:* implementation strategies/models, T/A, training, infrastructure development, and measurement/communication/technology capabilities, etc.

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Care Transitions Intervention Components

1. Prospective Modeling
2. Consumer and Family Engagement
3. Transition Planning
4. Care Pathways
5. Information Transfer/Personal Health Record (PHR)
6. Transition Coaches/Agents
7. Provider Engagement
8. Quality Metrics and Feedback
9. Shared Accountability

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Components: 1 of 9

Prospective Modeling

- Identify who is at greatest risk
- Ideally use community/population-specific data
- Transition phase/site: Pre-hospital

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Components: 2 of 9

Consumer and Family Engagement

- Authentic inclusion of consumer and family in treatment plan
- Transition phase/site: Pre-Hospital, Hospital, Outpatient, Home

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Components: 3 of 9

Transition Planning

- Collaboratively establish appropriate client-specific plan for transition to next point of care
- Transition phase/site: Hospital

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Components: 4 of 9

Care Pathways

- Specific clinical/procedural guidelines and instructions, i.e., what to do when
- Includes assessment, medications, psycho-social interventions/management, self-care instructions, follow-up, etc.
- Linkage with national guidelines
- Customize to local community/population
- Transition phase/site: Hospital, Outpatient, Home

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Components: 5 of 9

Information Transfer/Personal Health Record (PHR)

- Ensuring that all information is communicated, understood and managed
- Links consumer, caregivers, and providers
- Transition phase/site: Hospital, Outpatient, Home

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Components: 6 of 9

Transition Coaches/Agents

- Roles/tasks, competencies, training and supervision should be specified
- Training includes planning tools, red flags, client engagement/education strategies
- Transition phase/site: Pre-hospital, Hospital, Outpatient, Home

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Components: 7 of 9

Provider Engagement

- Providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions
- Communication and handoff arrangements among providers and organizations should be pre-specified in a formal way
- At a patient-specific level, providers at each level of care should know what the plan is
- Transition phase/site: Pre-hospital, Hospital, Outpatient, Home

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Components: 8 of 9

Quality Metrics and Feedback

- Gather metrics on follow-up post-hospitalization, rehospitalization, and other feedback on process and outcomes and consumer/family perceptions
- Feedback to (and use by) providers for quality improvement and accountability.
- Transition phase/site: Pre-hospital, Hospital, Outpatient, Home

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Measurement Options

1. All-cause readmission
2. Readmission for same specific condition
   - CHF, Pneumonia, AMI
3. Discharge plan with transition elements
4. Care transition record transmitted to OP
5. 7/30 day outpatient follow-up
6. Patient perceptions survey (CTM3)

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3 Item Care Transitions Measure

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

Response Options:
- Strongly Disagree Disagree Agree Strongly Agree Don't Know/Don't Remember

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Components: 9 of 9

Shared Accountability
- All providers share in expectations for quality and results as well as rewards/penalties
- Accountability mechanisms may include financial mechanisms and public reporting with regard to quality and value
- Consumers/families also share in accountability
- Transition phase/site: Hospital, Outpatient

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Care Transitions Intervention Components

1. Prospective Modeling
2. Consumer and Family Engagement
3. Transition Planning
4. Care Pathways
5. Information Transfer/Personal Health Record (PHR)
6. Transition Coaches/Agents
7. Provider Engagement
8. Quality Metrics and Feedback
9. Shared Accountability

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"Crossing the Quality Chasm"

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Resources

Health Affairs Brief – Improving Care Transitions: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76

Minnesota Reducing Avoidable Readmissions Effectively (RARE) Initiative: http://www.rarereadmissions.org/resources/mental_health.html

American Hospital Association Brief – Bringing Behavioral Health into the Care Continuum: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf

National Transitions of Care Coalition: http://www.ntocc.org/

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

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