What’s Good Follow-up?
Transitions from Hospital to Home

Steven Connelly, MD, FACP
Joanne Skaggs, MD

Lloyd Hayes Symposium
August 23, 2014
1. Objectives

Define methods to improve care transitions that translate to practice within hospitals & communities
Discuss how emerging healthcare delivery & payment models may impact delivery of services & outcomes for patients
Analyze barriers to care transitions, including those related to prevention & chronic disease management

2. Transitions of Care: Definition

3. State of the Union

Greenville Health System

4. The Good, The Bad and The Ugly

Hospital Inpatient Care: Dr. Steven Connelly
Outpatient Primary Care: Dr. Joanne Skaggs

5. The Ugly: Point – Counterpoint: Who’s to Blame?

How can we do better?

Dr. Steven Connelly
Dr. Joanne Skaggs

6. Questions/Answers
Transitions of Care: Definition

Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include hospitals, nursing homes, the patient’s home, primary and specialty care offices, and long-term care facilities.

Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient’s goals, preferences, and clinical status.

Transitional of Care includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.

American Geriatrics Society  Position Statement
GHS State of the Union
## Multi-Year Goals

### Total Health Organization
- Right Care, Right Time, Right Place
- Clinical competencies to perform under Health Reform

### Health Care Value Leader
- Business systems and structures to perform under Health Reform
- Partnerships with payers and industry
- Cost efficient, quality focused

### Clinical Integration
- Systems, structures, and processes to improve operating performance
- Network development for FFS business and for population coverage
- Building and linking the healthcare continuum

### Innovation in Academics
- Leverage academics to improve clinical and financial performance
- Create a clinical workforce to lead in a reformed healthcare environment

### Sustainable Financial Model
- Efficiently create and allocate resources to achieve mission
- Strong performance in today’s environment while positioning for Health Reform
Beyond the Medical Home

Healthy Communities
(Nutrition, Prevention, Physical fitness, Healthy living)

Community Resources
(Supportive housing, Social Services, Eligibility programs, etc.)

Medical Neighborhoods
(Specialists, ER, EMS, Fire Department Medical personnel, Employer work sites, MD 360, Pharmacists, Home Health, School nurses)

Patient Centered Medical Home
(Care Managers, Office staff, Family Members, etc.)
Clinical Integration Initiatives

- Duke Innovation Grant
- ER Care Management
- GHS/EMS Partnership
- Community Care Outreach
- GHS Employee Care Management
- Readmission Projects
- Nurse Family Partnership
- Centering Pregnancy
- Business Health
- BlueChoice Medicaid
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Results to-Date:

• In year one, there was a 26% decrease in Emergency Department visits and a 55% decrease in inpatient days.
• For Diabetes, the number of patients with HgA1c High values (>9%) decreased 14%.
• LDL-C Abnormal values decreased 15%.
• For Hypertension, Non-Diabetic, the number of patients with readings within 140/80 parameters improved approximately 13%.
• For Asthmatics, the number of patients appropriately receiving corticosteroid/acceptable alternative therapy improved approximately 11%.
Awarded a $300,000 grant to reduce unnecessary ER and EMS utilization by:

• Creating an innovative nurse triage call center that is currently being used in only two other locations in the US
• Providing care coordination to ER and EMS high utilizers so they receive the right care at the right time and place
• Developing patient-centered medical neighborhoods within the community
BlueChoice Medicaid

- Partnership with BCBSSC
- 14,000 covered lives in Greenville county
- Joint Operating Committee
- Care Management/Coordination by GHS/UMG
- Shared-savings program
BlueChoice Medicaid

- Inpatient utilization/1000 decreased by 11.2%
- Professional utilization/1000 decreased by 4.5%
- Script/member decreased by 12%
- Percent generic utilization increased by 2%
- Total cost PMPM decreased by 12.1% for CY 2013 compared to CY 2012
- Significant shared savings realized at year end
Medical Neighborhoods

- Health System and Safety-net Collaboration
- Providing Access to Care within Communities
- Community Paramedic and Health Worker Models
- Home Health
- Care Management
- Care Coordination
Accountable Communities

- Community-led Innovation
  - Community Volunteer Programs
  - Community Paramedics
  - Community Resources (Faith-Based Organizations, Schools, EMS, Police and Fire Districts)

- Patient Education and Social Determinants
- Population Health Management
- Social Service Providers
The Good, The Bad, & The Ugly

Video
Transitions of Care
Hospital Inpatient Perspectives
The Bad

- 39.5 million discharges per year:
  - 19% have a post discharge adverse event: 30-50% preventable
  - 20% of Medicare patients are readmitted within 30 days
  - 4.4 million hospital stays are due to potentially preventable readmissions
  - Cost = $31 Billion
  - 33% of patients did not get the follow up care they needed after leaving the hospital
  - One study found that only 49% of patients had a timely follow-up within 30 days. Readmission rate 10x higher

_Misky, Wald, Coleman Journal Hospital Medicine 2010_
The Bad
The Current Problem with Hospital Discharges

- Poorly coordinated care:
  Poor communication: pending labs & tests necessary follow up tests continuity of care

- Unreconciled medications
- Fragmented care
- Poor preparation for discharge
- Poorly communicate discharge instructions

- GHS current readmission rate is 11%
## Transitions of Care
### Hospital Inpatient Perspective
#### The Bad

**Dr. Steven Connelly**

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage</th>
</tr>
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<tr>
<td>When discharging patients, which of the following do you do routinely?</td>
<td></td>
</tr>
<tr>
<td>Send a discharge summary to the PCP</td>
<td>90.9%</td>
</tr>
<tr>
<td>Schedule a follow-up visit</td>
<td>47.0%</td>
</tr>
<tr>
<td>Contact the PCP only for specific circumstances (new diagnosis, death, new anticoagulation)</td>
<td>45.4%</td>
</tr>
<tr>
<td>Use teachback</td>
<td>19.1%</td>
</tr>
<tr>
<td>Contact the PCP</td>
<td>17.2%</td>
</tr>
<tr>
<td>Schedule a follow-up call</td>
<td>10.2%</td>
</tr>
<tr>
<td>See patient in a post-discharge clinic</td>
<td>2.9%</td>
</tr>
<tr>
<td>What strategies does your group use to manage discharges?</td>
<td></td>
</tr>
<tr>
<td>A discharge planner</td>
<td>56.2%</td>
</tr>
<tr>
<td>A dedicated case manager</td>
<td>36.0%</td>
</tr>
<tr>
<td>A post-discharge call center or someone making post-discharge calls</td>
<td>31.0%</td>
</tr>
<tr>
<td>An administrative assistant</td>
<td>23.9%</td>
</tr>
<tr>
<td>How will the time you spend on discharges change in the next five years?</td>
<td></td>
</tr>
<tr>
<td>Increase</td>
<td>61.8%</td>
</tr>
<tr>
<td>Decrease</td>
<td>6.1%</td>
</tr>
<tr>
<td>Stay the same</td>
<td>26.3%</td>
</tr>
<tr>
<td>Not sure</td>
<td>5.8%</td>
</tr>
<tr>
<td>Do you plan to do more discharge care?</td>
<td></td>
</tr>
<tr>
<td>Don’t plan to do more</td>
<td>38.2%</td>
</tr>
<tr>
<td>Dedicate more hospital staff (NPs, etc.) to transitional care</td>
<td>35.7%</td>
</tr>
<tr>
<td>Contact more patients after discharge</td>
<td>25.1%</td>
</tr>
<tr>
<td>Set up or staff a post-discharge clinic</td>
<td>22.2%</td>
</tr>
<tr>
<td>Treat patients in a post-acute setting such as a SNF</td>
<td>11.6%</td>
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Transitions of Care
Hospital Inpatient Perspectives
Dr. Steven Connelly

The Bad

The Patient Protection Accountable Care Act: March 2010

• **Payment Adjustment for Hospital Acquired Conditions:** Section 3008
  Beginning in FY 2015, hospitals scoring in the top quartile for the rate of Hospital Acquired Conditions (HAC) as compared to the national average will have their Medicare payments reduced by 1 percent for all DRGs.

• **Hospital Value Based Purchasing Program:** Section 3001
  The secretary is required to develop a Value Based Purchasing (VBP) Program, which pays hospitals based on their performance for certain quality measures. Incentive payments begin in FY2013 based on discharges occurring on or after October 1, 2012. The incentive payments will be based on both attainment and improvement.

• **Hospital Readmissions Reduction Program:** Section 3025:
  To account for “excess readmissions,” effective October 1, 2012, DRG payment rates will be reduced based on a hospital’s ratio of actual to expected readmissions. The reduction applies to the base DRG payment. In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond. Current focus: CHF, Acute MI, Pneumonia, COPD.
Transitions of Care
Hospital Inpatient Perspective
Dr. Steven Connelly

The Good
Hospital Initiatives to Improve Care Transitions

1. Project BOOST: Better Outcomes by Optimizing Safe Transitions
Dr. Mark Williams, Dr. Eric Coleman
Evidence based principles of quality improvement

8 P’s: Problem medications & Polypharmacy
Psychological problems: Depression or Anxiety
Principal diagnosis: Cancer, Stroke, COPD, CHF, DM complications
Physical Limitations: Poor functional status, limited ADL’s
Poor Health Literacy
Poor Social Support
Prior Hospitalization in last 6 months
Palliative Care: Progressive disease
2. The Care Transitions Program: Dr. Eric Coleman, University of Colorado Denver, School of Medicine

During a 4-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home.

Value Proposition
Reducing rehospitalization helps contain costs for complex patients and improves hospital bed capacity for patients admitted with more favorable DRGs.

The program is self-sustaining.

The program is consistent with both Medicare Advantage and Medicare fee-for-service financial incentives.

The program promotes better performance on new JCAHO initiatives aimed at post-hospital care.

Key Findings
Patients who received this program were:
Significantly less likely to be readmitted.
More likely to achieve self-identified personal goals around symptom management and functional recovery.

Findings were sustained for as long as six months after the program ended.

Four Pillars: * Medication Self-Management
* Dynamic Patient Centered Record: Personal Health Record (PHR)
* Follow-up
* Red Flags
The Good
GHS Hospital Initiatives to Improve Care Transitions

3. Project **RED: Re-Engineered Discharge**

*Dr. Brian Jack, Boston University  Annals of Internal Medicine 2009*

- An evidence based, patient-centered, standardized approach to discharge planning and discharge education
- Initially developed through research funded by the Agency for Healthcare Research and Quality. AHRQ funded JCR to assist hospitals with the implementation.
- GHS became one of the first 50 hospitals to be accepted to participate
The Good

GHS Initiatives: Project RED

Goals

• **Improve patient safety** by improving patient’s preparedness for self care after discharge.
• **Reduce overall cost of health care utilization** by reducing readmissions and post discharge emergency department visits
• **Improve patient outcomes and satisfaction**
• **Improve transitions of care across the continuum of healthcare providers and locations**

Hospital Components & Principles of Project RED

• **Discharge Advocate:** Dedicated nurse with specialty training in transitions of care
• **Education** of patient and family about diagnoses and self care
• **Arrange** follow up appointments
• **Communication** regarding pending tests across the continuum of care
• **Medication reconciliation**
• **Discharge plan:** Well designed and easy to understand
• **Information Transfer:** Hospital to primary care providers and community doctors including timely discharge summary
• **Assessment:** Patient’s understanding of diagnosis/disease process and after hospital care utilizing the “Teach Back” technique
Project **RED**

- Randomized trial of 750 patients at Boston University to study problems with hospital discharges
- GHS Pilot 5C & 3B

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<th>Project Red</th>
<th>GHS Pilot</th>
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<tr>
<td>Readmissions</td>
<td></td>
<td>↓30%</td>
<td></td>
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<tr>
<td>Follow up appointment</td>
<td>79%</td>
<td>87%</td>
<td>No change</td>
</tr>
<tr>
<td>92%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Education</td>
<td>51%</td>
<td>67%</td>
<td>100%</td>
</tr>
<tr>
<td>Med reconciliation</td>
<td>83%</td>
<td>89%</td>
<td>95%</td>
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The Good
GHS Hospital Initiatives to Improve Transitions of Care

**Multidisciplinary Team Rounds: Daily Inpatient Team Rounds**

With multidisciplinary rounds, disciplines come together, informed by their clinical expertise, to coordinate patient care, determine care priorities, establish daily goals, and plan for potential transfer or discharge.

This patient-centered model of care has proven to be a valuable tool in improving the quality, safety, and patient experience of care. Many hospitals have demonstrated reduced patient days, reduced central line days, and increased coordination of care through the use of multidisciplinary rounds.

- Anticipated Day of Discharge with daily discharge planning
- Attending physician
- Discharge Advocate
- Nurse Manager, Nurse
- Pharmacist
- Social Worker and Case Manager
- Physical, Occupational, Speech and Respiratory therapists
The Good
GHS Hospital Initiatives to Improve Transitions of Care

Post-Discharge Patient Communication: Patient & Family Services

- Post discharge: Phone call within 24 hours of discharge with standardized questions
- Telephone reinforcement: Discharge care plan and post discharge problem solving
- Confirm follow up appointments
- Pharmacist intervention
Transitions of Care
Hospital Inpatient Perspectives
Dr. Steven Connelly

The Good
GHS Hospital Initiatives to Improve Transitions of Care

Pharmacy Medication Reconciliation Abstract

Abstract: Implementation of a Comprehensive Pharmacy Discharge Service at Greenville Memorial Hospital
ASHP: Ghizzoni PharmD, Sawyer PharmD, BCPS, Connelly, MD, FACP
Transitions of Care
Outpatient Primary Care Perspectives
Transitions of Care
Outpatient Primary Care
Perspective
The Good
• Multi-Disciplinary Employee Health Diabetes Management Study
• Duke Innovation Grant
• Care Management embedded into outpatient practice sites
• Primary Care Medical Home
Multi-Disciplinary Employee Health Diabetes Management Study

• Multidisciplinary diabetes management
  – CDE managed referral diabetes education service
  – New Telecare wireless monitor for population management
Multi-Disciplinary Employee Health Diabetes Management Study

- Telecare Diabetes Meter
  - Wireless Enabled Meter
    - AT&T and Verizon
  - Portal Profile Page
    - Healthcare professional
    - Patient
    - Support person
  - Customized telephonic messaging and alerts
  - $100/meter (three-year life)
Diabetes Pilot Purpose and Objectives

• Provide better control of diabetes
  – Reduce A1c
  – Reduce incidence of hypo and hyperglycemia events

• Improve patient understanding of diabetes and diabetes self management
  – Reduce overall cost of healthcare
  – Increase adherence rates of blood glucose monitoring and medication utilization

• Develop a primary care workflow model that is replicable and self-sustaining
Multi-Disciplinary Employee Health Diabetes Management Study
Enrollment and Collaboration

Primary Care Provider and Certified Diabetes Educator (CDE)
  – Diabetes Self Management Program
  – Patient coaching
    » Telehealth device
    » Weekly contact to address diabetes management
    » Care management coordination
  – Glucose Management Assistance
    » Primary care provider communication
    » Treatment plan adjustments
      • Endocrinology algorithms and support
    » Pharmacy alliance
Transitions of Care
Outpatient Primary Care
Perspective
The Good

• Duke Innovation Grant
Duke Innovation Grant

Overview:

• $2.7 million grant for delivery innovation

Eligibility:

• Initial pilot focused on Medicaid clinic population and subsequently the unfunded population
• Developed a stratification process based on ER and hospital utilization
## Duke Innovation Grant

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Transitions of Care
Outpatient Primary Care
Perspective
The Good

- Care Management embedded into outpatient practice sites
- Chronic disease management
  - In office contact
  - Out of office follow-up
  - Heart failure, Hypertension, Diabetes, Asthma, COPD
Transitions of Care
Outpatient Primary Care
The Good

• Primary Care Medical Home
  – “The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into ‘what patients want it to be.’ Medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care” – NCQA website
Transitions of Care
Outpatient Primary Care
The Good

• Primary Care Medical Home
  – Comprehensive Care
  – Patient-centered
  – Coordinated Care
  – Accessible Services
  – Quality and Safety

Agency for Healthcare Research and Quality
Transitions of Care
Outpatient Primary Care
Perspective
The Bad

• “Following hospital discharge nearly half (49%) of hospitalized patients experience at least 1 medical error in medication continuity, diagnostic workup, or test follow-up.”

• Most errors are due to poor communication between hospital/patient/primary care physician

Transitions of Care
Outpatient Primary Care
Perspective
The Bad

• Patient Issues
  – Medication reconciliation, adherence, compliance, adverse effects
  – Health literacy
  – Patient education regarding their care plan
  – Family education
  – Accessibility of primary care office for appointment/phone calls
    • Ensuring appointment made at discharge
  – Patient compliance
  – Social issues
Transitions of Care
Outpatient Primary Care
The Bad

• Provider Issues:
  – Hospital readmission
  – Coordinating care between hospital discharge and primary care f/u appointment
    • Opportunity: hospital discharge clinic
  – Discharge summary with key information, reaching PCP before appointment
    • Pending tests
    • Communication on day of discharge with email/phone call
  – Accessibility of primary care office for appointment/phone calls
  – Follow-up from hospital discharge
    • Labs, radiology, referrals
Transitions of Care
Outpatient Primary Care
Perspective
The Bad

• System Issues:
  – Population health
    • Opportunity: utilize community resources
  – Payment
  – Performance measures/outcomes/report card
  – Electronic medical record
References


The Ugly: Point- Counterpoint

Dr. Connelly: Inpatient
Dr. Skaggs: Outpatient
Video