Bridging the Gap: Improving Care Transitions from Hospital to Community care

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CCO Summit
Outline

• Why transitions matter
  – Understanding the gaps
  – Incentives to improve

• Improvement efforts
  – National and regional examples
    • Panel: Four Oregon examples of transitions improvements

• Implications for leaders and implementers

• Q&A
Show of hands:
What is your interest in this topic?

• My CCO:
  A. Has no formal efforts to improve transitions of care but we want to start
  B. Is in the beginning stages of transitions improvements and we are looking to improve
  C. Has well established transitional care efforts and we are looking to improve
Background: Why care about hospital readmissions?

- Readmissions are common and costly
- Transitions are increasingly recognized as target for quality improvement
- Expected to be a source of cost savings
Transitions are risky

- Adverse events are common as patients move across health care settings
  - Half of all discharged patients are exposed to medical errors in medication continuity, test follow-up or diagnostic work-up
    
  - One-quarter of discharged patients experience an adverse event
    

- Usually an adverse drug event
Penalties for High Readmission Rates

• Financial Penalties
  – CMS penalty starting in FY 2013
    • if risk-standardized readmission rates for AMI, CHF, or pneumonia are in the worst quartile

• Quality Reporting
Predicting Readmission Risk

- Medical, Behavioral
- Socio-economic
- Hospital
- Post-discharge care

Kansagara, Englander, et al JAMA 2011
Transitions: Key deficiencies

- Communication
- Patient education
- Access to care
- Integration
## Interventions to Reduce 30-Day Rehospitalization: A Systematic Review

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<th>Pre discharge Intervention</th>
<th>Post discharge Intervention</th>
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<td>Patient education</td>
<td>Timely follow-up</td>
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<td>Discharge Planning</td>
<td>Timely PCP communication</td>
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<td>Medication Reconciliation</td>
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<td>Appointment scheduling before discharge</td>
<td>Patient hotline</td>
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<td>Home visit</td>
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### Bridging Intervention

- Transition coach
- Patient-centered discharge instructions
- Provider continuity

- No single intervention was regularly associated with lower readmits; bridging interventions were most promising

Hansen, Annals 2012
Interventions to improve transitions and reduce readmissions
Tiered approach to transitions improvements

- Standard roles and processes across care settings and services
- Target high risk subgroups (i.e., CHF, polypharmacy, low SES)
Large scale quality improvement initiatives

• Set of tools to optimize discharge planning and cross site communication
• Incorporates best practice insights
• Smart about implementation
• Evaluation showed modest improvement though serious method flaws
Coleman

• 4 pillars:
  – Medication Self-Management
  – Personal Health Record
  – Follow-Up
  – Red Flags

• Original study: nurse coach in single integrated setting among geriatric patients with one of 11 chronic conditions; 3.6% ARR
Panel Discussion
Panel

Care Transitions Innovation (C-TraIn): Multnomah, Washington, Clackamas

Linn-Benton-Lincoln County AAA

Lane County Collaborative

AllCare Collaborative: Josephine, Jackson, Curry, southern Douglas
Panel

- Cynthia Ackerman
- Gale Blasquez
- Dan Reece
- Jackie Sharpe, Honora Englander
Post-DC Home Visit & Medication Reconciliation
Implications for CCOs

Importance of:

• Broad stakeholder engagement
  – including mental health/ A&D, social service and healthcare

• Champions across settings

• Standardized processes, roles, and accountability

• Person-centered approach
  – may include home visit, pharmacy intervention, trauma informed care
  – match intervention to need/ resources
Q&A
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Supplemental Slides
"We don’t have a community contract where everybody acknowledges their role... ‘my role as the sender is to do these things’, ‘my role as the recipient is to do these things’...the ‘who will’ and ‘how’ of the handoff. We never get close to that sort of formality, which is really what any smart handoff or transition would require."

-Healthcare administrator

Davis et al, JGIM 2012
Readmission risk prediction models have been developed for hospital comparison and clinical intervention purposes. Most models in both categories perform poorly and have relied on comorbidity and utilization data. Few models examine social determinant variables.
Implication 1:

Match the readmission risk model to intended use

- Models designed for measuring quality are probably not well suited for clinical use and vice versa.
- Think carefully about the local population to which it is being applied.
Implication 2:

• A risk assessment does not necessarily tell you what to do for the patient.
• Consider incorporating clinically informative variables to which specific intervention elements could be tailored and that are not otherwise captured
  • Housing status
  • Access to care
  • Health literacy
  • Substance abuse
Implication 3:

Think about workflow and feasibility of data collection when adapting risk assessment tools

– Avoid overly complex models that impede workflow
– Data must be easily available in real-time
  • ? Incorporate into EMR
  • Simple surveys
Implication 4:

We do not know how many readmissions are preventable. Think about using additional metrics to measure peri-discharge care.
Implication 5:

When selecting transitional care improvements, remember:

• No off-the-shelf fixes
• Gaps differ across systems; first step is to understand local needs and then map interventions to fill in those gaps