Improving Transitions Across the Continuum of Care

Presented By: Cheri A. Lattimer, RN, BSN - Executive Director, NTOCC

NTOCC is a 501(c)(4) nonprofit coalition.
The Statistics Were Staggering In 2006 and Not Much Better Today!

Non-adherence statistics:
- 45% of hospital NRxes or Rx changes are never documented in out-patient medical records
- 12% of NRxes are never filled
- 29% don't complete LOT
- 22% take < than prescribed
- Average hospital LOS due to medication non-compliance is 4.2 days

Despite wide distribution, evidence based clinical practice guidelines have not changed physician behaviors

Convene experts and apply evidence based clinical practice guidelines

Medication Reconciliation across care settings is a Joint Commission National Patient Safety Goal

National Quality Forum (NQF) endorsed 3-Item Care Coordination Measures to expand voluntary hospital consensus standards in care transitions

Mobilize resources to optimize appropriate coordination across all channels & health care states

Poor Transitions of Care Contribute to Hospital Readmissions

COALITION LAUNCH

October 18, 2006 - National Transitions of Care Coalition – Chicago

Sanofi in Collaboration with CMSA to lead multidisciplinary coalition of experts

Diverse Organizations and Professionals

These groups represent over 200,000 health care professionals, 11,000 employers and 30,000,000 consumers throughout the United States.
NTOCC’s Mission & Community

Mission Statement
Improve Transitions of Care in the healthcare industry

The Coalition Consists of:
Advisory & Partners Council – 35 members
Subscribers – >3,500 members
Associate Members – 536 members, 450 companies
83 Countries Use the NTOCC website globally

WWW.NTOCC.org
NTOCC’s Considerations for Change

- Improve communication during transitions with providers, patients and caregivers
- Support the implementation of electronic medical records that include standardized data elements
- Establish points of accountability for sending & receiving
- Increase the use of case management and professional care coordination
- Expand the role of the pharmacist in transitions of care
- Implement a payment system that align incentives
- Development performance measures to encourage better transitions of care

www.ntocc.org
Transition Issues Dramatically Impact Patients & Their Caregivers
Transition Issues Dramatically Impact Patients & Their Caregivers & Providers

- Patient & Caregiver
- ER
- ICU
- In-Patient
- Patient & Caregiver
- OUTPATIENT:
  - Home
  - Home Care
  - PCP
  - Specialty
  - Pharmacy
  - Case Mgr.
  - Caregiver
  - Hospice
- NO Discharge Care Plan
- NO Medication Reconciliation
- NO Personal Medicine List
- NO Coordinated Care Plan
- SNF
- ALF
- NO Care Plan
- NO Medication Reconciliation
- NO Personal Medicine List
- Discharge Care Plan
- Personal Medicine List
- Coordinated Care Plan
- Transition Issues Dramatically Impact Patients & Their Caregivers & Providers
To Date We Have Not Had Consistent and Accepted Transition Tools

- Medication Reconciliation Elements
- Comprehensive Care Plan
- Health or Clinical Status
- Transition Summary
- Patient & Caregiver Tools & Resources
- Consistent Performance Measures That Apply to All Health Care Settings
- Accountability for Sending & Receiving Information
Our healthcare system operates in “silos” and information queues – incapable of reciprocal operation with other related management systems & different departments of organizations
Rehospitalization – Medicare Fee-For-Service

• Analysis of Medicare Claims data from 2003-2004
• 11,855,702 Medicare beneficiaries DC from the hospital
  – 19.6% nearly 1/5 were rehospitalized within 30 days
  – 34% were rehospitalized within 90 days
  – 50.2% of those rehospitalized within 30 days after a medical discharge there was no bill for a visit to a physician office

Rehospitalization 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.
Figure 1. Rates of Rehospitalization within 30 Days after Hospital Discharge.
The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.

Continuum of Care & Spectrum of Services

How will you coordinate care beyond your service?
The Care Transitions Intervention

• Does encouraging older patients and their caregivers to assert a more active role in their care transition reduce rates of rehospitalization?

Transition Models

• Dr. Eric Coleman – Transition Coaching - http://www.caretransitions.org

• Dr. Mary Naylor – Advanced Nurse Practitioners- http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.asp

• Dr. Chad Boult – Guided Care Nurse – http://www.guidedcare.org

• Boston University Medical Center - Project RED – Re-engineering Discharges – http://www.bu.edu/fammed/projectred/

• Society of Hospital Medicine – Project BOOST- http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm
Emerging Models

• **Transition of Care Clinic** - Tallahassee Memorial Hospital  
  – Dr. Dean Watson, Chief Medical Officer

http://www.tmh.org/TMHTransitionCenter

• **Rush Enhanced Discharge Planning Program** –  
  Rush University Medical Center - Robyn Golden, MA,  
  Director of Older Adult Programs. robyn_golden@rush.edu.
Waves of Change

• New models of health care delivery and reimbursement are quickly evolving

• Their success is contingent on effective care coordination

• This in turn requires interprofessional and transdisciplinary collaboration
Key Driver: The National Quality Agenda

The Triple Aim:

Better Care
Healthy People
Affordable Care

The National Quality Strategy is available at www.ahrq.gov/workingforquality
Care Coordination Is A National Priority!

National Quality Strategy Priorities

- Making care safer
- Ensuring person- and family-centered care
- Promoting effective communication/coordination of care
- Promoting the most effective prevention and treatment of leading causes of mortality
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable

A full summary of the National Quality Strategy is available at www.ahrq.gov/workingforquality
Goals Of These New Models

- Minimize fragmentation & improve transitions of care
- Focus on patient safety and quality of care
- Improve the patient’s experience with care
- Expand access to care
- Reduce the cost of effective care
- Payment that recognizes value of patient-centered care
What These New Models Require

Processes to promote evidence-based medicine, patient engagement, and care coordination, including:

- Patient-centered philosophy and operations
- Coordinated and integrated care
- Use of evidence-informed medicine
- Use of health information technology for data sharing/reporting capabilities
- Continuous quality improvement processes
## Seven Essential Intervention Categories

<table>
<thead>
<tr>
<th></th>
<th>Intervention Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medications Management</td>
</tr>
<tr>
<td>2</td>
<td>Transition Planning</td>
</tr>
<tr>
<td>3</td>
<td><strong>Patient and Family Engagement / Education</strong></td>
</tr>
<tr>
<td>4</td>
<td>Information Transfer</td>
</tr>
<tr>
<td>5</td>
<td>Follow-Up Care</td>
</tr>
<tr>
<td>6</td>
<td>Healthcare Providers Engagement</td>
</tr>
<tr>
<td>7</td>
<td>Shared Accountability across Providers and Organizations</td>
</tr>
</tbody>
</table>


[http://www.ntocc.org/Toolbox/browse/](http://www.ntocc.org/Toolbox/browse/)
NTOCC Provides Tools & Resource Development for Patient and Family Caregivers

Tool Highlights

- Guidelines for a Hospital Stay with Helpful Definitions For Patient, Family, & Caregiver
- Taking Care of MY Health Care Français & Español
- My Medicine List Français & Español
- Patient TOC Bill of Rights
Additional NTOCC Tools & Resources for Providers
TOC Compendium Functionality

- **TOC Compendium** holds > 308 journal articles, resources and industry links

- The **Compendium** allows users to browse by care strategy (medication management) or care setting (hospital, home care, etc.)

- Users may also search through the **Compendium**: by entering the name Coleman all of the Dr. Eric Coleman’s articles will be brought up

- **Individuals may recommend a new resource to be added to the Compendium**

- The **Compendium** is updated annually – next release of new journal articles is the week of April 22\(^{nd}\) brings the library to >400 resources

- CMS linked to the **Compendium** in March 2011 supporting the application process for the Community Based Transition Program

http://www.ntocc.org/Toolbox/browse/
CMS Selects the Second Round of Sites for the Community Based Care Transitions Program

Posted on 3/14/2012 by NTCC © in Public Policy Updates

Today, the Centers for Medicare and Medicaid Services (CMS) announced the second set of sites selected for the Community-Based Care Transition Program (CCTP). Authorized by the Affordable Care Act, the CCTP provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients’ transitions effectively.

Coalition Dedicated to Improving Patient Transitions and Care Attains New Organizational Status

Posted on 3/29/2012 by NTCC © in Press Releases

National Transitions of Care Coalition (NTOCC) Becomes 501(c)(4) Organization

Little Rock, AR- February 15, 2012— The National Transitions of Care Coalition (NTOCC), an organization dedicated to improving patient transitions through the healthcare system, has announced its formal incorporation as 501(c)(4) organization. The Coalition was founded in 2006 as a partnership between the Case Management Society of America (CMSA) and Sanofi U.S. Last year, the two founders, along with the 32 members of NTOCC’s Advisory Task Force, elected to establish NTOCC as an independent, membership-based organization.

National Transitions of Care Coalition (NTOCC) Launces Three New Resources to Assist Practitioners in Addressing Issues Related to Transitions

Posted on 3/28/2011 by NTCC © in Press Releases

Little Rock, AR (PRWeb) February 28, 2011— The National Transitions of Care Coalition (NTOCC) is pleased to announce the launch of three new resources to assist practitioners in addressing the complex issues related to patient transitions through the healthcare system. The newly released publications include a comprehensive toolkit, a patient-centered care model, and a resource guide designed to support providers in improving care transitions for Medicare beneficiaries.
Transition of Care Evaluation Software Tool

Improving Transitions of Care

Start Here

Click 'Create New Project' to begin.

There are no open projects existing to resume at this time. Clicking this button will allow you to create a new project to measure transitions of care.

Introduction

Health care professionals and government leaders increasingly understand that improving care coordination among the various care settings can improve patient safety, quality of care, and health outcomes while avoiding significant costs.

This web evaluation tool is an open resource, available free of charge for any institution or facility undertaking a Transition of Care evaluation and quality improvement project. The tool is designed to allow users to track data and report findings of projects developed using the NTOCC Evaluation Plan process.
To Make It All Work, We Must Learn How to Communicate with Each Other.
“The biggest problem with communication is the illusion that it has been accomplished.”

George Bernard Shaw
Improving Communication

NTOCC Measures Work Group, 2008
Responsibilities of Health Professionals for Seniors in Transition

Sending health care team
- Stable for transfer
- Patient/caregiver understand and are prepared
- Transfer information is complete
- Contact person’s name and number

Receiving health care team
- Review transfer information promptly and clarify
- Incorporate patient’s goals/preferences in care plan
- Document contact information

(c) Eric A. Coleman, MD, MPH
Effective Communication = Effective Engagement

Open and honest conversations are critical to promote interprofessional approach to patient care

Bring active listening skills into everyday conversations

Need to be fully in the moment for meaningful communication to occur

Connect on a personal level to build trusting relationships
Building High-Performance Teams

- Becoming the Change Agent
- Community-Based Transitions Teams
- Networking between the Acute & the Post Acute & The Continuum of care
## Table 1

**Conventional vs. Collaborative Care**

<table>
<thead>
<tr>
<th>Conventional</th>
<th>Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authoritarian</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Autonomous practice culture</td>
<td>Team culture</td>
</tr>
<tr>
<td>Physician driven, with physicians accountable for care outcomes</td>
<td>Patient centered, with team members sharing responsibility for care outcomes</td>
</tr>
<tr>
<td>Episodic, fragmented</td>
<td>Continuous, coordinated</td>
</tr>
<tr>
<td>Primary care delivered in one-size-fits-all, 15-minute visits</td>
<td>Primary care delivered via individualized visits, phone calls, and online communication</td>
</tr>
<tr>
<td>Payment based on quantity (fee for service)</td>
<td>Payment based on value (considers both quality and cost)</td>
</tr>
<tr>
<td>Reactive, focused on illness</td>
<td>Preventive, focused on health</td>
</tr>
<tr>
<td>Communication is inconsistent</td>
<td>Communication is imperative</td>
</tr>
</tbody>
</table>

Core Competencies for Interprofessional Collaborative Practice

Values/Ethics for Interprofessional Practice

• Work with individuals of other professions to maintain a climate of mutual respect and shared values.

Roles/Responsibilities for Collaborative Practice

• Use the knowledge of one’s own role and those of other professions to appropriately assess and address the health care needs of the patients and populations served.

Interprofessional Communication

• Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

Interprofessional Teamwork and Team-Based Care

• Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

“We’ve medicalized so many things, but transitions are not medical events. It’s about the team working together. It’s a person event.”

Jennifer Fels, RN, MS, Director, Southwestern Vermont Medical Center
Development of Care Coordination Measures

• AHRQ – Comparative Effectiveness Research for Case Management
• NQF – Performance Measures for Care Coordination
• CMS – 10th SOW for QIOs supports Care Transitions
• TJC – Patient Safety Standard #8 Medication Reconciliation
• URAC – Incorporated Transition of Care in revised CM Standards
• NCQA – Complex Case Management Standards
• AMA – PCPI Transitions of Care
• ANA – Care Coordination Quality Measures
Beginning January 1 2013 payment for Transitional Care Management post-discharge from acute care facilities:

– *Transitional Care Management Services* (TCM)
– *Complex Chronic Care Coordination* (CCCC)

*These codes are important because we are acknowledging the importance of care coordination and transitions of care at the point of the patient leaving one provider/facility and moving to another.*
Transitional Care Codes - 2012

National Average $142.96
- 99495: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 calendar days of discharge.

National Average $231.11
- 99465: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least high complexity during the service period
  - Face-to-face visit, within 7 calendar days of discharge.
But we need to go further in recognizing that care coordination is a collaborative process supported by a multidisciplinary team and expand the codes in support the delivery of services to the multiple clinicians who provide those services.
Medicare Transitional Care Act

- Legislation Introduced that Seeks to Fill Care Transition Gaps
- *Medicare Transitional Care Act of 2012 designed to improve transitions of care for high risk Medicare beneficiaries*

- **WASHINGTON, D.C.—** Today, Representatives Earl Blumenauer (D-OR), Thomas Petri (R-WI), Allyson Schwartz (D-PA) and Jan Schakowsky (D-IL) introduced the bipartisan *Medicare Transitional Care Act of 2012*, legislation that seeks to improve transitions of care for Medicare beneficiaries at highest risk for readmission as they move from the hospital setting to their home, skilled nursing facility or next point of care. The National Transitions of Care Coalition (NTOCC) believes the bill is an important step forward to improving patient outcomes and reducing unnecessary health-related expenses.
Medicare Transitional Care Act

NTOCC Recommended changes incorporated into bill:

• “Findings” which include multiple care transition models and references NTOCC’s work on care transitions issues

• An expanded definition of “eligible entities and providers” (physician, physician assistant, nurse, case managers, pharmacists, social workers etc. are eligible to provide services)

• Broadens the definition of “Transitional Care Services” to support evidence-based care transition models which align with NTOCC’s seven essential elements.

• Includes language to require the documentation of a family caregiver during the plan-of-care process.

• Requires the development of measures to address and hold accountable both the sending and receiving side of the transition.
Moving Forward in 2013

• Medicare Transitional Care Act – reintroduced late April early May
• Encouraging the expansion of payment codes supporting multidisciplinary care coordination and transitions of care
• Bringing greater awareness to legislators and regulatory bodies on the value of case/care management and the important role we play in care coordination
• Continued focus on aligning the payment incentives with performance outcomes
Waves of Change

• Changing is like Breathing – And we all know what happens when we stop Breathing

Questions

Cheri Lattimer RN, BSN
clattimer@cm-innovators.com