Putting the Puzzle Pieces Together for Effective Care Transitions—the people, the metrics, the technology, the processes, and the patients

April 2012
Vicki Weber & Beverly Christie
Fairview Health Services
vweber3@fairview.org  bchrist2@fairview.org
Addressing Three Problems

1. There are **inconsistent hand offs** between care settings with variation in information.

2. **Multiple care coordinators** are confusing to the patient and the broader team.

3. Care Transitions is a **complicated process** with increasing probability of error in some care settings due to volume, patient complexity and number of persons on the care team.
Care Transition

Movement of Patient From One Setting to Another

In the space, or transition, between care environments, there is risk.
Our Objectives

• Design an integrated, coordinated, safe, effective care transition process
• Connect to care coordination models in clinics and in the community
• Address our core problems (handoffs, complexity, multiple care coordinators)
• Reduction in preventable events (e.g. admissions, readmissions, ED visits)
Measures of Success

Delivering greater value (Triple Aim) for at risk, attributed population

**Improve Quality:**
- Reduce readmissions
- Reduce preventable admissions
- Reduce complications (e.g. medication errors)
  - Improve experience
  - Decrease Total Cost of Care

**Improved Processes:**
- Completion of the *Risk Stratification and Care Transitions Checklists*
- Up to date Health Care Home Patient Care Plan
- Medication reconciliation at every transition
- Post-event primary care visit with care coordinator intervention
The People—the development team

*Representation from vast areas across the organization*

- Hospital
- Transitional Care Units
- Senior Care
- Home Care
- PATIENT
- Primary Care
- Specialty Care
- Hospice
- Behavioral Services
- Rehab Services
Care Management System Goal
Achievement of self care, or self care with help, at the highest level of willingness and ability

Individual
Determined as high risk based on care needs

Support System
Family, significant others, community connections that support the individual

Medical Home Team
May be Primary care, Specialty Care or Other

Care Coordinator
Health Care Professional skilled in coordination of care that assists high risk patients to achieve self care or self care with help. When there is more than one care coordinator involved in an individuals’ care, one care coordinator is identified as primary contact

Care Transition Specialist
Health care professional skilled in transitioning individuals between care settings safely and accurately

FOUR DRIVERS OF CARE

Patient Care Plan
Medication Self-Management
Thorough and Successful Hand-Offs
Use of Checklist, Risk Stratification
Care Transitions Specialists—RN / SW

• Newly defined role in hospital settings

Position Summary

• Provides comprehensive care transition management of patients

• Assesses the patient’s needs, evaluates progress, facilitates decision-making and collaborates with the health care team during the patient’s episode of care.

• Responsibilities include the identification of resources, facilitation of options for movement along the care continuum, and identification of transition of care needs. The intensity of care transition services is situational and appropriate based on patient need.

• Accountable for the quality of clinical services delivered by both them and others, and identifies/resolves barriers which may hinder effective patient care.
Technology—Care Transitions Checklist

Items on the checklist include:

✓ Triggering event (e.g. hospitalization, home care needed)
✓ Face to face meeting with patient
✓ Complete patient profile
✓ Care plan initiated/updated
✓ Risk assessment completed/updated
✓ Post-event needs identified/initiated (e.g. DME, MTM)
✓ Visit summary initiated/completed
✓ Handoff initiated/communicated to appropriate person(s) (e.g. PCP, care coordinator)
✓ Documentation sent to appropriate person(s)
**At Risk: Definition**

Transitions of Care Risk Stratification Criteria

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Moderate-High Risk</th>
<th>Moderate Risk</th>
<th>LOW RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 3+ hospitalizations within past 6 months OR</td>
<td>• &gt;2 hospitalizations and/or ER visits within the past 12 months OR</td>
<td>• ≤2 hospitalizations and/or ER visits within the past 12 months OR</td>
<td>• ≤1 hospitalizations and/or ER visits within the past 12 months OR</td>
</tr>
<tr>
<td>• 3+ ED visits within past 6 months OR</td>
<td>• PHQ9 &gt;10 OR</td>
<td>• PHQ9 &lt;5 OR</td>
<td>• Negative CAGE-AID SCORE OR</td>
</tr>
<tr>
<td>• 1+ hospitalizations for Suicidal ideation within past 12 months OR</td>
<td>• Positive CAGE-AID SCORE (2+) OR</td>
<td>• ≤1 Positive response to CAGE-AID OR</td>
<td>• SSSI =72-90</td>
</tr>
<tr>
<td>• Newly diagnosed DM, HF, COPD, AMI, Mental Health, Substance Abuse OR</td>
<td>• MOS/ SSSI = 36-53</td>
<td>• SSSI =54-71</td>
<td>• ≤1 hospitalizations and/or ER visits within the past 12 months OR</td>
</tr>
<tr>
<td>• PHQ9 20+ OR</td>
<td></td>
<td></td>
<td>• Negative CAGE-AID SCORE OR</td>
</tr>
<tr>
<td>• Positive CAGE-AID SCORE (2+) OR</td>
<td></td>
<td></td>
<td>• SSSI =72-90</td>
</tr>
<tr>
<td>• MOS/ SSSI = 18-35 OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &gt;3 no shows with care team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Influencing Risk Factors**

**High Risk**
- HCH Tier 3-4
- ≥ 4 medication changes during the transition
- 5+ chronic conditions
- 10+ chronic medications
- Dementia/Alzheimer’s diagnosis
- Using warfarin and/or insulin
- Literacy: non–English speaking

<table>
<thead>
<tr>
<th>Moderate-High Risk</th>
<th>Moderate Risk</th>
<th>LOW RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2+ medication changes during the transition</td>
<td>• ≤2 chronic conditions</td>
<td>• HCH Tier 0</td>
</tr>
<tr>
<td>• 3-5 chronic conditions</td>
<td>• &lt;5 chronic medications</td>
<td>• ≤1 chronic condition</td>
</tr>
<tr>
<td>• 5-10 chronic medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Using oral antplatelet agents, oral hypoglycemic agents, opioid analgesics, digoxin, injectables (non-insulin), and/or inhalers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Literacy: non–English speaking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pilot Implemented – April 16th

**Early Successes and Learnings**

- **Early Successes**
  1) Identification of high risk and moderate-high risk patients needing intervention
  2) Improved communication between all transition points
  3) Better understanding of the Patient’s Story
  4) Improved patient engagement via Health Care Home Patient Care Plan

- **Early Learnings**
  1) Difficult to understand literacy level of patient and/or caregiver
  2) Risk levels can change between transitions
  3) Community transitions can be challenging due to lack of care transition support
  4) Medication reconciliation needs to occur multiple times
Summary—Challenges and Strategies

- Attention to cultural differences
- Socializing concepts takes time
- Competing organizational priorities
- Communication and transparency is key
- Stakeholder input/consensus – final decision
- Forming structures/processes with no increased resources
- Measurement – what, who, how, frequency
- Creating and changing functions can be messy
- Patience and when needed, executive champion involvement
Questions