Care Coordination and Transitions in Care

How do these fit into our ongoing discussions and how can we improve patient care by focusing on them?

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Objectives

- Define some terms that are being used frequently these days in discussions of PCMHs, ACOs, healthcare reform goals, prevention of readmissions, reducing preventable ER visits, shared savings and other payment model changes, etc.
- What is often missed with poor care coordination and during transitions?
- Look at several models of care coordination and improving transitions
- What might this look like in a community?

Spring = Track. So, before we start the race today........
We need some definitions so we are speaking a common language

- Organizing Care
- Care Coordination
- Transitions of Care
- Transitional Care

Organizing Care

Marshalling personnel and other resources to carry out required patient care activities.

Often managed by the exchange of information among participants responsible for aspects of the care

Care Coordination

Deliberate organization of patient care activities among two or more participants (including the patient and/or family) to facilitate the appropriate delivery of health care services.
Transitions of Care

Movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change.

- Within settings
  - primary care to specialty care, ICU to ward
- Between settings
  - hospital to nursing home, tertiary to local hospital
- Across health states
  - curative care to hospice, personal residence to assisted living
- Between providers
  - generalist to specialist

NTOCC Measures Work Group, 2008

Transitional Care

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.

Based on a comprehensive care plan and availability of well-trained practitioners that have current information about the patient’s goals, preferences, and clinical status.

NTOCC Measures Work Group, 2008

Transitional Care

Includes:
- Logistical arrangements
- Education of the patient and family
- Coordination among the health professionals involved in the transition

Transitional Care

- Transitional care—range of time-limited services and environments that compliment primary care and are designed to ensure health care continuity and avoid preventable poor outcomes among at-risk populations as they move from one level of care to another, among multiple providers and across settings.

CMS National Conference on Care Transitions, December 3, 2010

So it’s about creating teams with highly-set, clear goals for improving patient care!

Why are we concerned about Coordination and Transitions?

Healthcare in America is often:
- Fragmented
- Discontinuous
- Difficult to access
- Inefficient
- Unsafe
- Expensive
The dangers of fragmentation (as well as the expense) is greatest for our most complex (often elderly) patients

- 23% of Medicare patients have 5 or greater chronic diseases (83% have one or more)
- 40 million people in the US are > 65 y.o., but this is projected to more than double to 89 million by 2050
- 6 million people are > 85 y.o. today, but their numbers are projected to rise to over 19 million by 2050

The 25% of Beneficiaries Who Have 4+ Chronic Conditions Account for 80% of Medicare Spending

Source: Medicare 5% Sample, 2001

How do we improve the results of the care we provide?
Where does this fit in our previous PCMH discussions? Right in the middle!

Before looking at specific models, let’s examine the importance of good handoffs

What are some of the “missed handoffs” during transitions?

- Lack of Communication between one arena of care and another regarding any or all:
  - Tests performed and results – lab, radiology, procedures
  - Subspecialty consultations – results and recommendations for ongoing care and follow-up
  - Plans discussed regarding short and long-term care
  - Recommendations for f/u tests, procedures, visits
  - Recommendations for f/u with primary healthcare team
What are some of the “missed handoffs” during transitions?

• Medication errors – HUGE!
  – Reconciliation differences – what the patient has in the bottle at home is not what was on home med list or what was prescribed at discharge
  – Patient didn’t fill new rxs from ER or hospital
  – Filled rxs but medications not taken correctly
  – Problem with new medication, so just stops taking without notifying anyone

What are some of the “missed handoffs” during transitions?

• Unknown patient circumstances not recognized during other healthcare interactions
  – Living condition issues
    • safety concerns
    • hygiene issues
    • nutritional needs
  – Spouse/caregiver issues
  – Financial concerns
  – Transportation concerns
  – Unrecognized mental health needs

What are some of the “missed handoffs” during transitions?

• Need for available community resources
  – Meal assistance
  – Home nursing/homemaker services
  – Mental health/counseling services
  – Elderly services
  – Physical surrounding needs
How do we get out of the starting blocks? Let's see some ideas........

Models to explore

- Guided Care – Johns Hopkins School of Public Health
- Transitional Care Model – University of Pennsylvania School of Nursing
- The Care Transitions Program – University of Colorado Division of Healthcare Policy and Research
- Much of this work is based on Ed Wagner's Chronic Care Model:
Nobody on the team can be out to lunch!

Examples of Models

• Guided Care
  – A well-trained Guided Care nurse, based in a primary care office, works with 2-5 physicians and other members of the care team
  – provides coordinated, patient-centered, cost-effective health care to 50-60 of their chronically ill patients
  – conducts in-home assessments, facilitates care planning, promotes patient self-management, monitors conditions monthly, coordinates the efforts of all health care professionals, smooths transitions between sites of care, educates and supports family caregivers, and facilitates access to community resources.

Looks at the big picture – the whole track, not just one lane.
Examples of Models

• Transitional Care Model
  – provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions.
  – The heart of the model is the Transitional Care Nurse (TCN), who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline.

Examples of Models

• Transitional Care Model
  – While the TCN is crucial, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists and other members of the health care team.
  – Emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management - all accomplished with the active engagement of patients and their family and informal caregivers and in collaboration with the patient’s physicians.

We need talented individuals, but all working together to improve care.
Examples of Models

- Care Transitions Program
  - 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.
  - 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.

Examples of Models

- Care Transitions Program
  - Dr. Coleman and colleagues at the University of Colorado designed a 15-item unidimensional measure, the Care Transitions Measure (CTM™), to assess the quality of care transitions, consistent with the concept of patient-centeredness, and useful for the purpose of performance measurement and subsequent public reporting.
  - Supported by several propriety toolkits including a medication discrepancy tool and a family caregiver tool.

Many different players have a role in extended care teams.
Who are the players in our communities?

- Patients
  - Including family/caregivers
  - Nursing home/Assisted Living staff
  - Group home staff
- Medical Home Care Team
  - Personal physician/provider
  - Clinic nurses
  - Health coach, especially if has 1+ chronic disease
  - Scheduler, phone triage nurse, etc.

It takes many runners to make a successful relay team. If anyone fails to do his/her part, the effort fails.

Who are the other players in our communities?

- ER Care Team
  - ER physician/provider
  - ER nurse
  - Team member responsible for f/u calls or arrangements
- Hospitals
  - Discharge planning, UR nurse, social worker
  - Attending physician(s) – primary care and subspecialists, hospitalist, etc.
- Home Health agencies and providers of home services
Who are the other players in our communities?
- Urgent Care Centers
- Nursing/Assisted Living/Residential Care Facilities
- Substance Abuse Centers
- Pharmacists
- Optometrists
- PT/OT/ST providers
- Imaging facilities
- Insurers
- The potential list goes on... schools, employers, etc.

How do we get to the great results we desire? What stands in our way?

What are the largest barriers in most of our communities?
- Breaking down silos of information, each with their own systems and processes
  - Hospital inpatient/outpatient
    - Local facilities
    - Regional facilities
  - Hospital ERs
  - Home health/Public health
  - Subspecialty physician offices
  - Pharmacies/labs/PT/OT/imaging centers
  - Insurers
  - Outpatient primary care physician clinics (PCMHs)
What are the largest barriers in most of our communities?

• Figuring out payment models to support the needed changes in care
  – Who will take on the added costs – hospitals, medical homes, others?
  – Will insurers step up with real support for changing models of care?
  – In large part, this is how an ACO hopes to save money, by reducing ER visits and readmissions.

  • Medical homes, actively involved in managing a patient’s care coordination and transitions in addition to performing core PCMH functions, should allow ACOs to meet the goals of improving care while lowering costs.

In summary, it’s all about functioning as a high-performing team!

What might this look like in a practice/community?

• Better flow of information, however it can happen
  – HIE holds great promise, but we can’t wait

• Discussions/arrangements/agreements between entities involved in a patient’s care
  – Responsibilities of each party outlined

• Proactive outreach/care from PCMHs
  – Calls to ER/inpatient in first 1-2 days
  – In-home visits by nursing – public/hospital/clinic
  – Improved access
  – Close follow-up of care plans
Every community will have a different set of strengths and weaknesses.

- We all need to be creative as we devise a better system of care for our patients!

We need to work hard to function well as a highly creative care team!

Resources

- National Quality Forum - www.qualityforum.org/Topics/Care_Coordination.aspx
- Institute for Healthcare Improvement (IHI) - www.ihi.org/ihi/
- TransforMED - www.transformed.com/resources/index.cfm
- Guided Care – Johns Hopkins, integrated into practice www.guidedcare.org
- Transitional Care Model – U of Penn Nursing, fills gap www.transitionalcare.info/index.html
- The Care Transitions Program – Transition coach www.caretransitions.org
In the end, it’s not about us at all, but about helping our patients live long, healthy, functional lives!

Thank You for listening (and putting up with my track analogies)!

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