Why We Get Off Course and What We Must Do

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Six Years Ago – March 2010 Congress Passed & President Obama Signed the Health Care Reform Bill

- The Patient Protection and Affordable Care Act
- Known as PPACA, ACA and Obamacare
  - Increases access to health coverage
  - Aims to reduce costs via payment reductions and focus on wellness and prevention
  - Seeks to reward “value-based” care delivery
Health Care Policy Shaping Our Strategy

Benefits of the Affordable Care Act for Americans

- **Rx Discounts For Seniors**
- **Protect Against Health Care Fraud**
- **Small Business Tax Credits**
- **Free Preventive Care**
- **Pre-existing Conditions**
- **Health Insurance Marketplace**
- **Consumer Assistance**

**Benefits for Women**
Providing insurance options, covering preventive services, and lowering costs.

**Young Adult Coverage**
Coverage available to children up to age 26.

**Strengthening Medicare**
Yearly wellness visit and many free preventative services for some seniors with Medicare.

**Holding Insurance Companies Accountable**
Insurers must justify any premium increase of 10% or more before the rate takes effect.

Courtesy: www.hhs.gov/healthcare/facts/timeline/index.html
Readmissions Expensive

<table>
<thead>
<tr>
<th>Condition</th>
<th>Readmission $</th>
<th>Initial Admission $</th>
<th>% of Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>$13,000</td>
<td>$11,000</td>
<td>25.1%</td>
</tr>
<tr>
<td>All Cause Readmissions</td>
<td>$11,200</td>
<td></td>
<td>21.2%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>$13,000</td>
<td>$7600-$23,400</td>
<td>17.1%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>$13,000</td>
<td>$9,600</td>
<td>15.3%</td>
</tr>
<tr>
<td>COPD</td>
<td>$8,400</td>
<td>$7,000</td>
<td>17.3%</td>
</tr>
<tr>
<td>Joint Replacement</td>
<td>$12,300</td>
<td>$18,500</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

Most U.S. hospitals will get less money from Medicare in fiscal 2016 because too many patients return within 30 days of discharge.

http://www.beckershospitalreview.com/quality/6-stats-on-the-cost-of-readmission-forcms-tracked-conditions.html
http://www.modernhealthcare.com/article/20150803/NEWS/150809981
Most hospitals face 30-day readmissions penalty in fiscal 2016

Only 799 out of more than 3,400 hospitals subject to the Hospital Readmissions Reduction Program performed well enough on the CMS' 30-day readmission program to face no penalty. Thirty-eight hospitals will be subject to the maximum 3% reduction, according to a Modern Healthcare analysis of newly posted CMS data.

For fiscal 2015 the CMS added treatment for two conditions—chronic obstructive pulmonary disease and total hip and total knee replacements—and the penalty rose to 3%. The majority of hospitals faced fines during that reporting year. The number subject to penalties in fiscal 2016 rose by 55 facilities, to 2,665.

http://www.modernhealthcare.com/article/20150803/NEWS/150809981
What Causes Poor Transitions of Care & Often Hospital Readmissions?
Transition Issues Dramatically Impact Patients & Their Family Caregivers

- **Patient & Caregiver**
- **ER**
- **ICU**
- **In-Patient**
- **SNF**
- **ALF**

**OUTPATIENT:**
- Home
- Home Care
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Caregiver
- Hospice

- **Patient & Caregiver**
Transition Issues Dramatically Impact Patients & Their Family Caregivers & Providers
Barrier to Effective Care Transitions

1. Delivery System-Level Barriers

2. Clinicians-Level Barriers

3. Patient-Level Barriers
# Moving Towards Collaborative Care

## Table 1

<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>

NTOCC’s Seven Essential Interventions Categories

1. Medications Management
2. Transition Planning
3. Patient and Family Engagement / Education
4. Health Care Providers Engagement
5. Follow-Up Care
6. Information Transfer
7. Shared Accountability across Providers and Organizations

http://www.ntocc.org/Toolbox/browse/
Medication Management

- Assessment of patient medication intake
  - Medication review including over the counter medications, herbals, vitamins, allergies and drug interactions
  - Identification medication-related problems

- Patient and family education and counseling about medications
  - Teach-back method to establish understanding of the medication plan
  - Explain what medication to take, discussion of changes in the regime and rationale for changes
  - Review each medication purpose and how to take or administer each medication correctly

- Development and implementation of a plan for medication management as part of the patient’s overall plan of care
  - Provide medication reconciliation and a patient medication list
  - Communicate and distribute medication reconciliation lists to all care team sites
Improving Transition Planning

Transition planning needs to start at admission and setting that expectation with the patient and family/caregiver.

Clearly identify the interdisciplinary care team members and coordinate the patient’s transition plan.

Support and management of the patient’s and family’s/caregiver’s transition needs including patient preference (both clinical and non-clinical issues).

Use formal transition planning tools (providers, patients and family’s/caregiver’s).

Timely and complete transition summary with a copy for the patient and family (considering health literacy and knowledge deficit).
Healthcare Provider Engagement

- Clearly identified patient’s primary care team
  - Personal physician
  - Enhanced access to services
  - Communication, communication, communication

- Bi-directional communication with patient’s specialist or care center

- Clearly identified patient’s hospital and care continuum team

- Hub of case management activities
  - Improve documentation around change in patient’s condition
  - Improve the flow of information between the care team and all levels of care
  - Take the role of communication hub
  - Medication reconciliation during transitions of care
Patient & Family/Caregiver Education

Ensure that patients and families/caregivers are knowledgeable about their condition and have a plan of care they can understand and implement:

◦ Patient understands what “red-flags” related to their symptoms worsening and how to respond

◦ We have reviewed both clinical and non-clinical issues

Patient and family-centered transition communication

◦ Multidisciplinary approach to ensure that the care team, patient and family are speaking the same language/information

Development of self-management skills

◦ Assess the patient’s and family’s/caregiver’s ability to manage their medication therapies, medical procedures, infusion, oxygen,

◦ Tools and resources for self-management & care team engagement
Follow Up and Information Transfer

- Patients and families require timely key access to key healthcare providers after an episode of care as required by the patient’s condition and needs
  - Transitional care follow up with care team members, physician, nurses, case managers, social work, home health
  - Review with patient and family the follow-up care plan

- Communication with patients and/or families and other health care providers post-transition from an episode of care:
  - Call to patient 24-48 hours after transition
  - Home visit
  - Re-assessment of care plan and regular contact times with patient and family

- Implementation of clearly defined communication models
- Use of formal communication tools
- Clearly defined providers, care centers, and community resources to facilitate timely transfer of critical information
Role of the Professional Case Manager

- A complete assessment of Medical, Behavioral, Social and Health system issues and concerns
- Patient and family advocacy identifying and supporting patient preference
- Defining and improving educational & knowledge deficits
- Development of a plan of care that supports the patient and family in working with their care team
- Collaboration with the pharmacist in developing the patients medication lists and understanding the medication regime
- Assisting the patient and family in recognizing “red flags” for symptom escalation
- Enhancing care coordination and access to care options
- Communication, motivational support, health coaching and clarification of miscommunication
How Well Do We Know our Patients and their Family Caregivers?

Do they want the same outcomes as their clinical team?

Do we really understand our patient and their family caregiver?

So we know the specifics of their world?

Do we care about those specifics or are we tuned to a check list of what needs to be done to meet performance measures and/or get reimbursed?

Are we focused on how to prevent a readmission?

How do we define success?

◦ Clinical Indicators
◦ Health Status
◦ Adherence
◦ Cost Containment – Length of Stay, Meets Criteria
The Patient Definition of Success?

Let me know you care by what it is in your policies, programs and outreach

Be proactive and teach me to be proactive

When you are developing programs think about what if this were me or my loved one

Provide resources that I need and teach me how to use them

Understand my perspective because we want the same things, those things may just be defined a little differently

Remember you are on my side & team – I am not just a patient or on your team
I am the Patient
Ask Me
Complex Care Planning

Know who is on your care team and their roles & functions – Physician, Advanced Practice Nurse, Pharmacist, Nurse, Social Worker, Case Manager, Allied Health Professionals, Para-Professionals, Patient & Family/Caregiver

Using the strengths of the Pharmacist and Case Manager creates a team supporting medication management/transitions

Building a strong care team includes a PA & CM who work together addressing and building strong communication, improve patient care and meeting organizational goals.

Effective case managers identify barriers or gaps in community resources that affect outcomes, clinical and non-clinical issues and work with the care team to facilitate discharge/transitions and plan for care needs.

When there are concerns i.e. delayed transition, inadequate care plan, medication reconciliation or lack of medical record documentation the PA and CM can assist the team in meeting the patient’s needs

Optimizing the Physician Advisor in Case Management; M. Michelman, MD, MBA, S. Mass, PhD, ACM, Ukanowicz, MS, RN, ACM, 2008
Building A Case Management Team

Build the department to meet the needs of the provider, patient & family caregiver

**An Interprofessional Team**: Physician Advisor, Pharmacist, Nurse, Social Worker, Allied Health, Administrative Assistant

Level the Scope of Practice but Coordinate the Care

- Physician Advisor – Over sight & Grand Rounds
- Pharmacist – Medication reconciliation & management
- Professional Case Manager – Medically Complex Patients
- Utilization Management – LOS, Concurrent Review
- Population Health Manager – Chronic Condition
- Case Management Extender – Administrative, Follow up, Scheduling
- Community Health Workers & Lay Navigators
Connecting the Case/Care Management Community Through Team-Based “Hand-Overs”

ED Case Mgr.

Hospital Case/Care Mgr.

ER

ICU

Patient & Caregiver

Patient Navigators & Community Health Workers

Continuum Case/Care Mgr.

Managed Care/Case Mgr.

Managed Care/Case Mgr.

Managed Care/Case Mgr.

Patient & Caregiver

Patient & Caregiver

Patient & Caregiver

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Outpatient:
- Home
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Caregiver

SNF

ALF

Case/Care Mgr.

Case/Care Mgr.

Case/Care Mgr.

Case/Care Mgr.
Innovative Health Information Technology

Technology Enabled Transitions

Using data analytics and the EHR to shift from event based treatment to continuity of care

Approach to a preventive medicine comprehensive wellness focus

Integrated and interactive transfer of information in a timely and effective manner to providers, patients and family caregivers

Understanding data in forming new interventions or programs

Make it more than a financial business move but a focus of improving the patient-experience and becoming the change agent for a failing healthcare system
What Can We Do?

• Focus on patient-centered care
• Understand both the clinical and non-clinical issues for patients and family/caregivers
• See this as a continuous quality improvement process
• Effective Team practice with financial and performance measure alignment including patient measures
• Team leadership and communication
• Cultural sensitivity and community focus
• Integrating behavioral health care with primary care
• Know the Value You Bring to this Process
The Professional Case Manager & Case Management Team

Licensed Healthcare Professional with an Advanced Practice Case Management Certification

Case managers are the **Patient Advocate** and know the “Value-Add” of their services to patients, family/caregivers & providers

Case managers know they cannot do this alone but are part of a care team consisting of professionals, para-professionals, the patient and family caregiver

Case managers understand the Standards of Practice are a “Best Practice” guideline
Transitions Of Care & Care Coordination Resources

CAN – Caregiver Action Network- Family Caregiving Resources – [www.caregiveraction.org](http://www.caregiveraction.org)
CAPS - Consumers Advancing Patient Safety – Toolkits [www.patientsafety.org](http://www.patientsafety.org)
NTOCC - National Transitions of Care Coalition – Provider & Consumer Tools [www.ntocc.org](http://www.ntocc.org)
AMDA’s (Dedicated to Long Term Care Medicine™) Transitions of Care in the Long Term Care Continuum practice guideline - [http://www.amda.com/tools/clinical/TOCCPG/index.html](http://www.amda.com/tools/clinical/TOCCPG/index.html)
NASW – National Association for Social Workers - [http://www.socialworkers.org/Resources](http://www.socialworkers.org/Resources)
VNAA Blue Print for Excellence – [www.vnaablueprint.org](http://www.vnaablueprint.org)
Resources for Development Measures

The Joint Commission (TJC) -
http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf

Agency for Healthcare Research and Quality (AHRQ) -


URAC -

National Committee for Quality Assurance (NCQA)

American Medical Association (AMA) -

American Nurses Association (ANA) -
http://www.nursingworld.org/Framework-for-Measuring-Nurses-Contributions-to-Care-Coordination
References

1) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

2) http://www.ntocc.org/WhoWeServe/HealthCareProfessionals.aspx

3) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-tcms.pdf

4) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-tcms.pdf

5) http://energycommerce.house.gov/cures

6) http://www.cmsa.org/SOP
Waves of Change

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

Questions

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