Enhancing Care for Patients with Complex & Special Needs by Improving Transitions of Care

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strategic interests
strategic vision + thinking + relationships

Problems Associated with Poor Transitions of Care (TOCs)

1. 80% of serious medical errors involve miscommunication during provider hand-offs
2. Poorly coordinated TOCs from hospital to other settings costs $12-$44 billion per year
3. A large % of Hospital Readmissions can be attributed to ineffective TOCs associated with:
   - **Medications:** Dosages or meds omitted or incorrect
   - **Tests:** Needed tests missed, or unnecessary tests repeated
   - **Diagnoses:** Omitted or incorrect diagnosis from past history
   - **Patient Capability:** Cognitive ability omitted or inaccurate
   - **Care Team:** Family contacts, MDs, care manager, social worker inaccurate
   - **Advance Directives:** Unavailable or conflicting MOLST, Living Will, Health Care Proxy
4. Poor TOCs negatively impact point of care, data for pop health, & patient engagement

Sources:

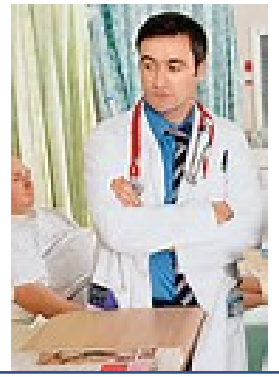
1. Solet DJ, et al: Lost in translation: challenges and opportunities in physician-to-physician communication during patient hand-offs. Academic Medicine, 2005;80:1094-9
2. 1 L.O. Hansen, R.S. Young, K. Hinami, et al. 2011. Interventions to Reduce 30-Day Rehospitalization: A Systematic Review. ***Annals of Internal Medicine*** *155*: 520–8.
3. Diamond Geriatrics - http://www.diamondgeriatrics.com/newsletters/2011-newsletters/transitions-in-care-how-problems-arise-how-you-can-prevent-them/

Causes of Poor TOCs

- **Communication:** Providers do not effectively or completely communicate important information to each other, the patient, or caregivers

Gap in Expectations

Different Style / Culture



No Time for Successful Handoff

Lack Standard ToC Procedure

- **Patient Education:** Patients or caregivers receive conflicting and unclear instructions about follow-up care; patients lack understanding of medical condition or plan

- **Accountability:** No physician or entity assures patient's care is coordinated across settings and providers

Types of TOCs

Change in Location or Provider

- HOSPITAL to HOME
- HOME to HOSPITAL
- HOSPITAL to LTPAC
- LTPAC to HOSPITAL
- HOME to LTPAC
- LTPAC to HOME
- HOME Providers
- HOSPITAL to HOSPITAL

Change in Level of Care

- Hospital
  - ED – Inpatient
  - Hospital Transfer (Rural/Specialty/Snowbird))
- LTPAC
  - SNF – ILF – ALF - Rehab

Non-Clinical Care Needs

- Care Management / Health Home
- Behavioral Health
- CBO Services: Housing, Transportation, Food, IDD, etc.

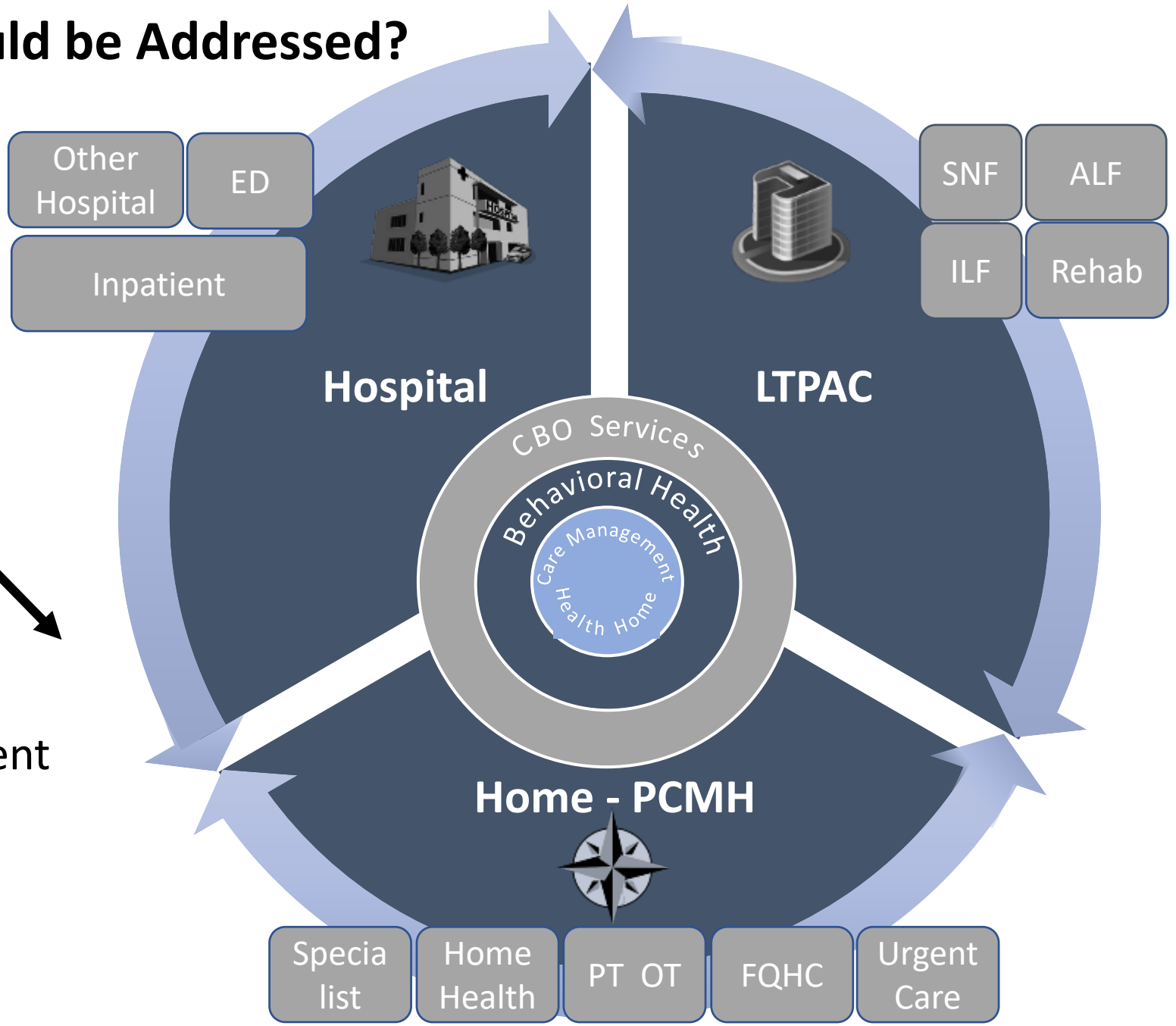
- Dozens of transitions with 100's of non-clinical need combinations possible
- No single organization can effectively manage all variants

Which Care Transitions Should be Addressed?

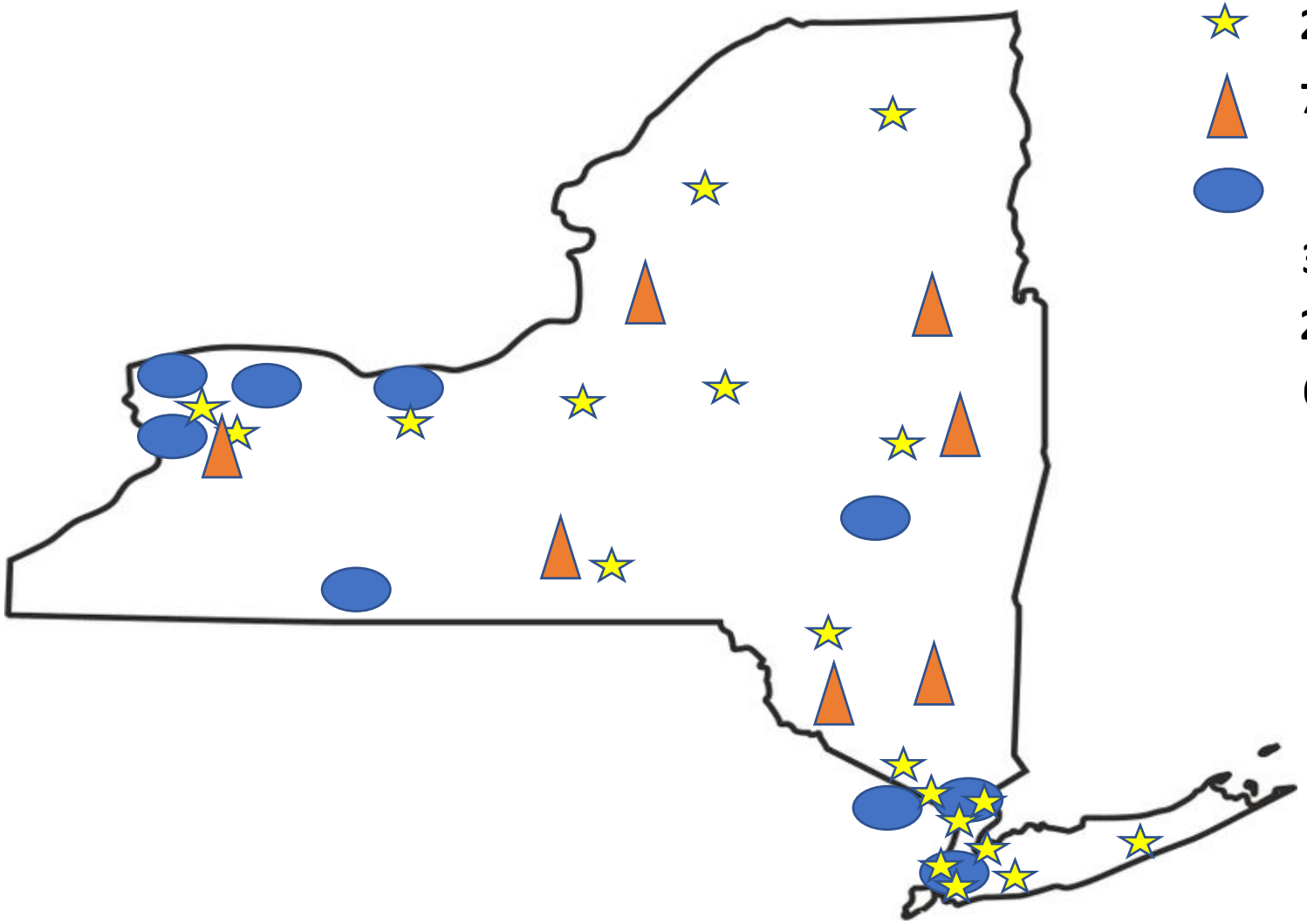
1. Clinical TOCs

2. Non-Clinical Care Needs

- Health Home/Care Management
- Behavioral Health
- CBO Services
  a. Food, Transport, etc.



Connecting NY Medicaid VBP Stakeholders – Special Needs



25 PPSs

7 Care Coordination Orgs (CCOs)

9 PACE Programs

32 Health Homes

21 MCOs

60 MLTC Programs

8(?) RHIOs - QEs

1 SHIN-NY

TOC Challenges: *Hospital to Skilled Nursing Facility & Home*

Overall Statistics*

- 25% of hospitalized Medicare patients hospitalized discharged to SNF
- 23% of them readmitted within 30 days, many unnecessary
- 33% of TOCs to SNFs that result in Readmission fail in first 3 days
- 50% of those are result of medications

Problems & Limited Use of HIE**

- Lack of robust data-sharing between hospitals & SNFs yields poor transitions for patients, from missing, delayed or hard-to-use info, worse outcomes and increased re-hospitalization
- HIE tools are underused to support post-acute care transitions and usage across SNFs

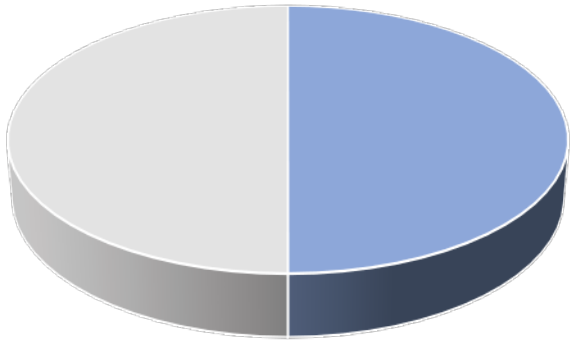
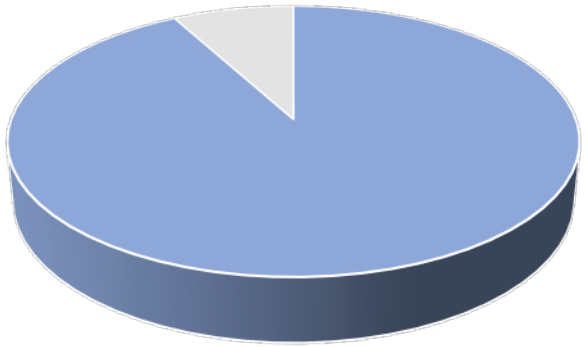
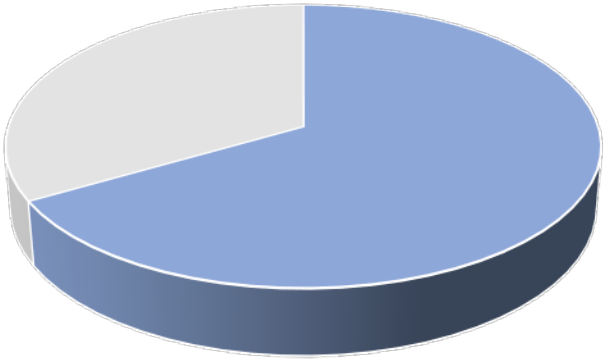
SNF to Home Also a Problem***

- 22% of SNF-home discharges required ED and/or hospital stays within 30 days
- 39 % required ED and/or hospital stays within 90 days

** https://www.jointcommissionjournal.com/article/S1553-7250(17)30048-X/fulltext, PointClickCare.*
*** American Journal of Managed Care (2019;25(1):e7-e13*
**** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4869313/*

TOC Challenges: *Hospital to Home*

- 20% of hospitalized Medicare beneficiaries readmitted within 30 days of discharge
- Those with conditions such as CHF or COPD had even higher rates of readmission
- Estimated cost of more than $17 billion to the federal government
- Post-discharge specialist follow-up rate problematic - not utilizing PCMH model

Up to 50% of Referring Providers Unsure if Patients Saw Specialist	92% of Providers Feel Referral Management Needs Improvement	67% of Patients Complete Specialist Referral Visit
		

***** TOC: Optimizing Handoff from Hospital-Based Teams to PCPs, CHARLES E. COFFEY, JR., MD, MS, Cedars Sinai Medical Center, Los Angeles, California *Am Fam Physician.* 2014 May 1;89(9):706-707
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160594
https://www.beckershospitalreview.com/payer-issues/3-important-statistics-about-provider-referrals.html

TOC Challenges: *Social Determinants Of Health*

- **Assessing and discussing SDOH during clinical encounters**
- **Finding the right providers to address SDOH in the community**
- **Creating and maintaining consistent care plans with goals and interventions**
- **Sharing SDOH, care plans, progress & issues with CBOs and clinicians**
- **Analytics to determine success and challenges for population cohorts**

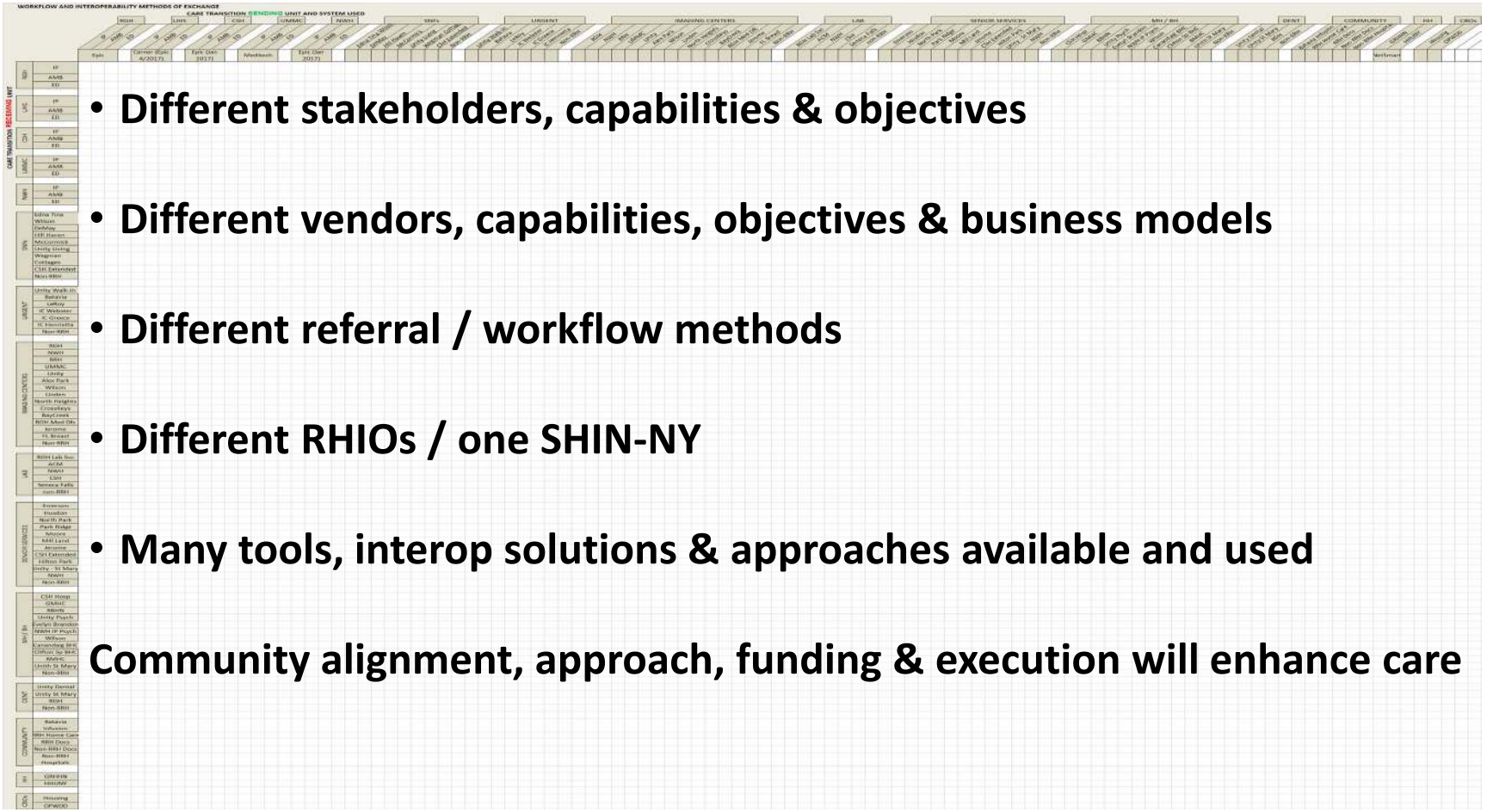
"Organizations are still undervaluing processes within their clinical care to determine these challenges and find support to help improve risk factors for a better, longer-term health outcome for the patient," said Matt Hawkins, chief executive officer, Waystar.*

*https://www.ajmc.com/focus-of-the-week/survey-highlights-high-prevalence-of-social-determinant-challenges-need-to-better-address-them

Enabling Community TOCs - *Common Tools & Alignment for Specific TOCs*

Hosp, ED
PCPs
Specialists
SNFs
Urgent Care
Imaging
Labs
Sr Services
BH / SA
Oral Health
FQHC
Care Mgmt
CBOs

Hospitals, ED
PCPs
Specialists
SNFs
Urgent Care
Imaging Ctrs
Labs
Senior Services
BH / MH / SA
Oral Health
FQHC
Care Management
CBOs



- Different stakeholders, capabilities & objectives
- Different vendors, capabilities, objectives & business models
- Different referral / workflow methods
- Different RHIOs / one SHIN-NY
- Many tools, interop solutions & approaches available and used

Community alignment, approach, funding & execution will enhance care

Keys for Successful TOCs – More than HIE

- **Right info, right time, right format…without extra noise – clean referral**
- PCMH Model, Care Coordination, Health Coaching
- Meds Reconciliation, Management & Adherence Tracking
- Effective Hand-offs to Providers / Social Workers with Follow-up
- Self-Management Care Plans with Patient Education and Clear Follow-up
- Identify and Provide Resources for Social Determinants of Health (SDOH)
- Build TOC into Quality and Payment Measures (NQF, HEDIS, MIPS, etc.)

Sources:

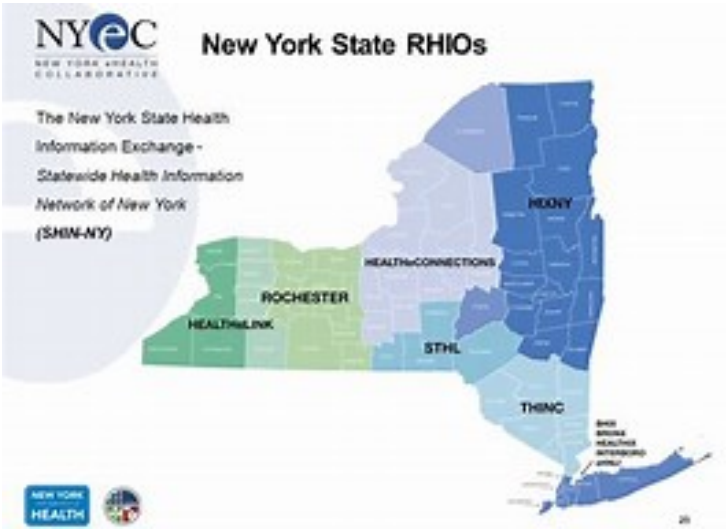
- Project BOOST (Better Outcomes by Optimizing Safe Transitions) – www.hospitalmedicine.org
- Care Transitions Interventions (CTI) –www.caretransitions.org
- CMS Community-Based Care Transitions Program (CCTP) – www.innovations.cms.gov/initiatives/CCTP/
- Guided Care Comprehensive Primary Care for Complex Patients – www.guidedcare.org
- Project RED (Re-Engineered Discharge) – www.bu.edu
- State Action on Avoidable Rehospitalizations (STAAR) – www.ihi.org

Tools to Enable Transitions of Care

Which Should You Use to Help Improve Collaboration with Your Partners?

- Networks of Clinical Information beyond the EMR:
  - **RHIOs/QEs, SHIN-NY: Push, Pull, Alerts, other**
  - EMR Hubs & Networks (i.e. Epic Care Everywhere)
  - Emerging Networks: CareQuality, eHealth Exchange, CommonWell
  - Private HIE: Comprehensive view of data from many EMRs
- APIs – FHIR for Direct Access
- Patient Centric: My Blue Button, Portal, PGHD
- Direct Messaging through HISP
- Referral Management Systems
- Frameworks to Guide TOC (i.e. Interact)

RHIOs – QEs – SHIN-NY



Emerging Networks

Initiatives to Address TOCs

1. Should your community establish initiative(s) to address critical TOCs? If so, who should convene stakeholders? Who are key stakeholders?

2. Which TOCs should be addressed?
   - Which have problems? Which can get alignment w/ key stakeholders? Which have solutions?
     - Hospital to Home (PCP, Home Health, Health Home)
     - Hospital to SNF to Home
     - CBOs (Clinical to Health Home/CBO, Health Home to CBO, CBO to CBO)
     - PCP to Specialist and Back
     - IDD Population
     - Behavioral Health / Substance Abuse
     - Upstate to NYC Specialists
     - Other

3. Which TOCs should be addressed statewide? Can we leverage vendors?