Improving Safe Transitions Across the Continuum of Care

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Learning Points

- Why focus on Care Transitions?
- What are Best Practices for Improved Transitions?
- What is the MaineHealth Transitions of Care Program?
- What lessons have we learned?

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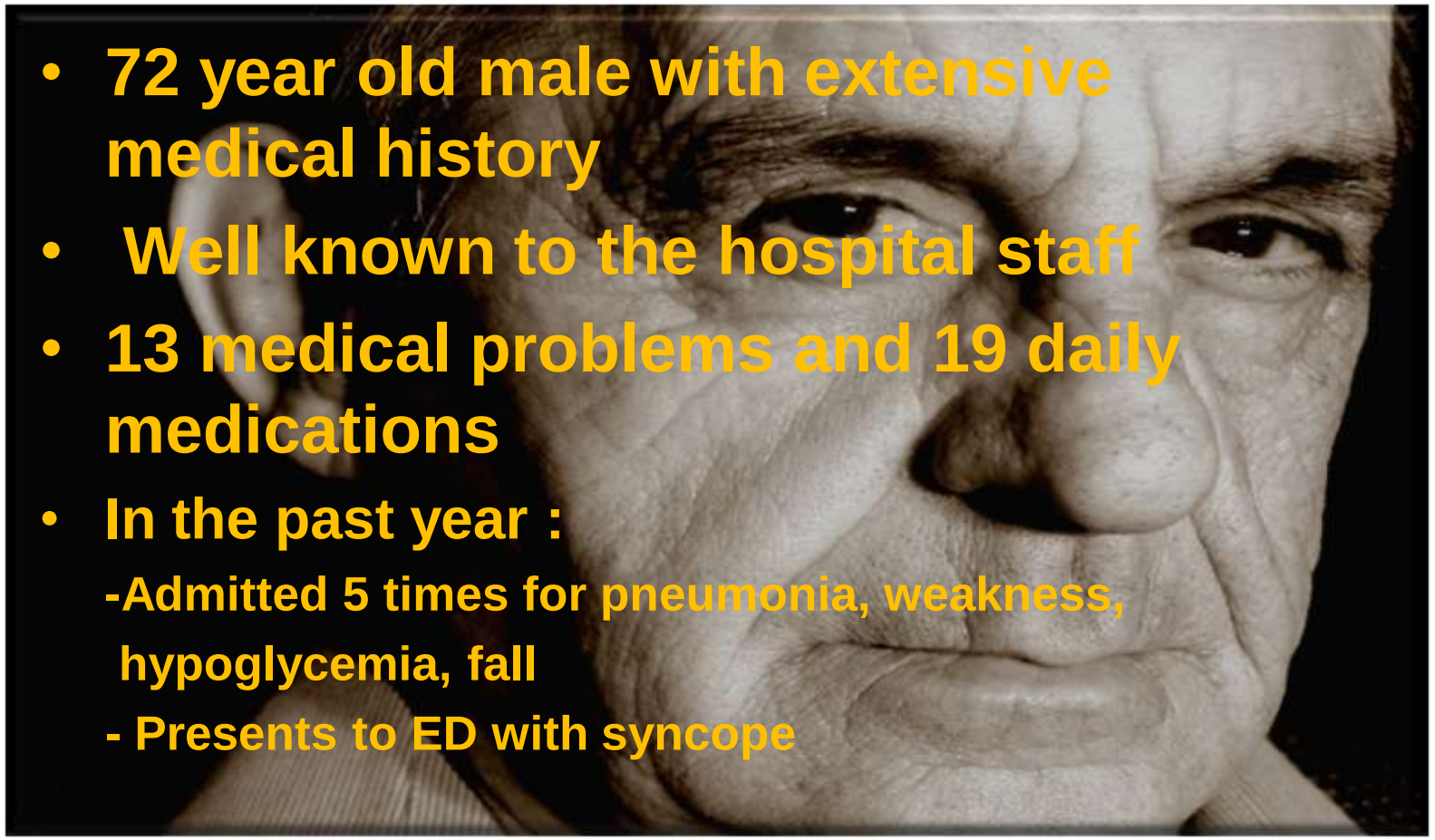
Victor's Story



- 72 year old male with extensive medical history
- Well known to the hospital staff
- 13 medical problems and 19 daily medications
- In the past year :

  -Admitted 5 times for pneumonia, weakness, hypoglycemia, fall

  - Presents to ED with syncope

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Past Medical History

Diagnoses

- **Benign prostatic hyperplasia (**BPH)
- **Hypertension** (HTN)
- **Hyperlipidemia** (HLD)
- **Coronary Artery Disease** (CAD)
- **Gastroesophageal reflux disease** (GERD)
- **Diabetes Type 2**
- **Depression**
- **Insomnia**
- **Chronic back pain**
- **Chronic fatigue**
- **Recent forgetfulness**, not been fully worked up

Victor's Health Goals

- Wishes to stop being so forgetful
- Would like to decrease the amount of daily medications he takes
- Would like to have more energy and motivation to play with his grandchildren during the day,
- Would like to get adequate rest at night

CURRENT:
19 Medications: 3-4 times/day

- Acetaminophen PM 500mg/25mg qhs
- Furosemide 40mg qam
- Acetaminophen 650mg tid
- Glyburide 10mg bid
- Amitriptyline 25mg qhs
- Metformin 500mg bid
- Amlodipine 5mg qam
- Methylphenidate 10mg qam and qnoon
- Aspirin EC 81mg qam
- Omeprazole 20mg qam
- Bupropion SR 300mg qhs
- Pregabalin 50mg tid
- Carvedilol 12.5mg q12h
- Simvastatin 40mg qhs
- Captopril 12.5mg tid
- Terazosin 10mg qam
- Cyclobenzaprine 10mg tid
- Trazodone 50mg qhs
- Digoxin 0.25mg qam

“Doc, if you think I need it, I’ll take it - but it sure does feels like I take handfuls of medications every single day.”

Victor

Victor's Hospital Course

- Cardiac monitoring and diagnostic testing
- Developed urinary retention and UTI
  - Urology consultation
  - Urologic procedure performed
- Discharged on coumadin, new antibiotic, with urinary catheter

One week later…

- Developed hematuria, urinary retention
- ED Visit
  - Dramatic hematuria with catheter obstruction
  - INR 9.6 (ideal range 2 –3)
  - More urological intervention
- Readmitted
  - Reversal of anticoagulation
- Transfused 6 units of blood

Questions to Consider

- Was this readmission predictable?
- Was this readmission preventable?
- What went wrong with the transitions of care?
- How can we do better?

Why focus on Care Transitions?

- Frequent & costly
- Issue of quality of care and patient safety
- Source of patient & provider dissatisfaction
- Waste increasingly scarce clinical resources

2007 MedPac Report

- Medicare Payment Advisory Committee
- Readmissions
  - "sometimes indicators of poor care or missed opportunities to better coordinate care"
  - 17.6% of Medicare patients readmitted within 30 days
  - $15 billion in annual spending
  - 76% of readmissions potentially avoidable
- Recommended public reporting, payment reform

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Rehospitalizations 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.

N Engl J Med 2009; 360:1418-1428 | April 2, 2009

Medicare currently pays for all rehospitalizations, except those in which patients are rehospitalized within 24 hours after discharge for the same condition for which they had initially been hospitalized. Recent policy proposals would alter this approach and create payment incentives to reduce the rates of rehospitalization. The Medicare Payment Advisory Commission (MedPAC) recommended to Congress in its report in June 2008 that hospitals receive from the Centers for Medicare and Medicaid Services (CMS) a confidential report of their risk-adjusted rehospitalization rates and that after 2 years, rates should be published. MedPAC also recommended complementary changes in payment rates, so that hospitals with high risk-adjusted rates of rehospitalization receive lower average per case payments. The commission reported that Medicare expenditures for potentially preventable rehospitalizations may be as high as $12 billion a year.[1] In July 2008, the National Quality Forum adopted two measures of hospital performance based on the rate of rehospitalization,[2] and the CMS indicated an interest in making the rehospitalization rate a measure for value-based hospital payment.[3] Reducing rehospitalization is an important element of President Barack Obama's February 2009 proposal for financing health care reform.[4] Such proposals would radically change the accountability of hospitals for patients' outcomes after discharge.

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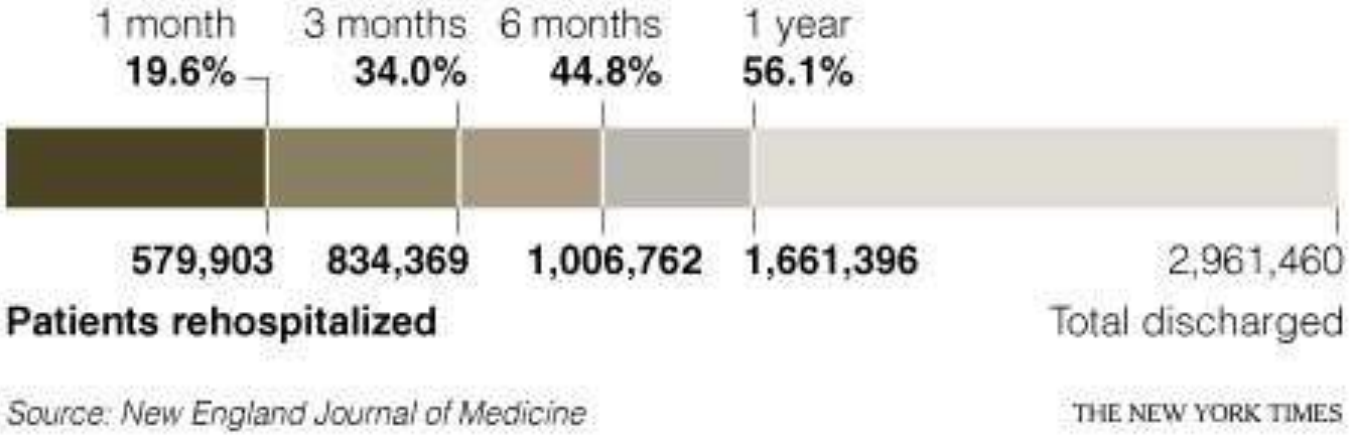
The New York Times
Expect the World®

Back to the Hospital

A study of Medicare patients found that nearly a fifth were back in the hospital within a month of being discharged, and more than half within a year. The study looked at almost three million patients discharged from October through December 2003.

MEDICARE REHOSPITALIZATION RATE

Cumulative percentage of patients rehospitalized after:



Source: New England Journal of Medicine

THE NEW YORK TIMES

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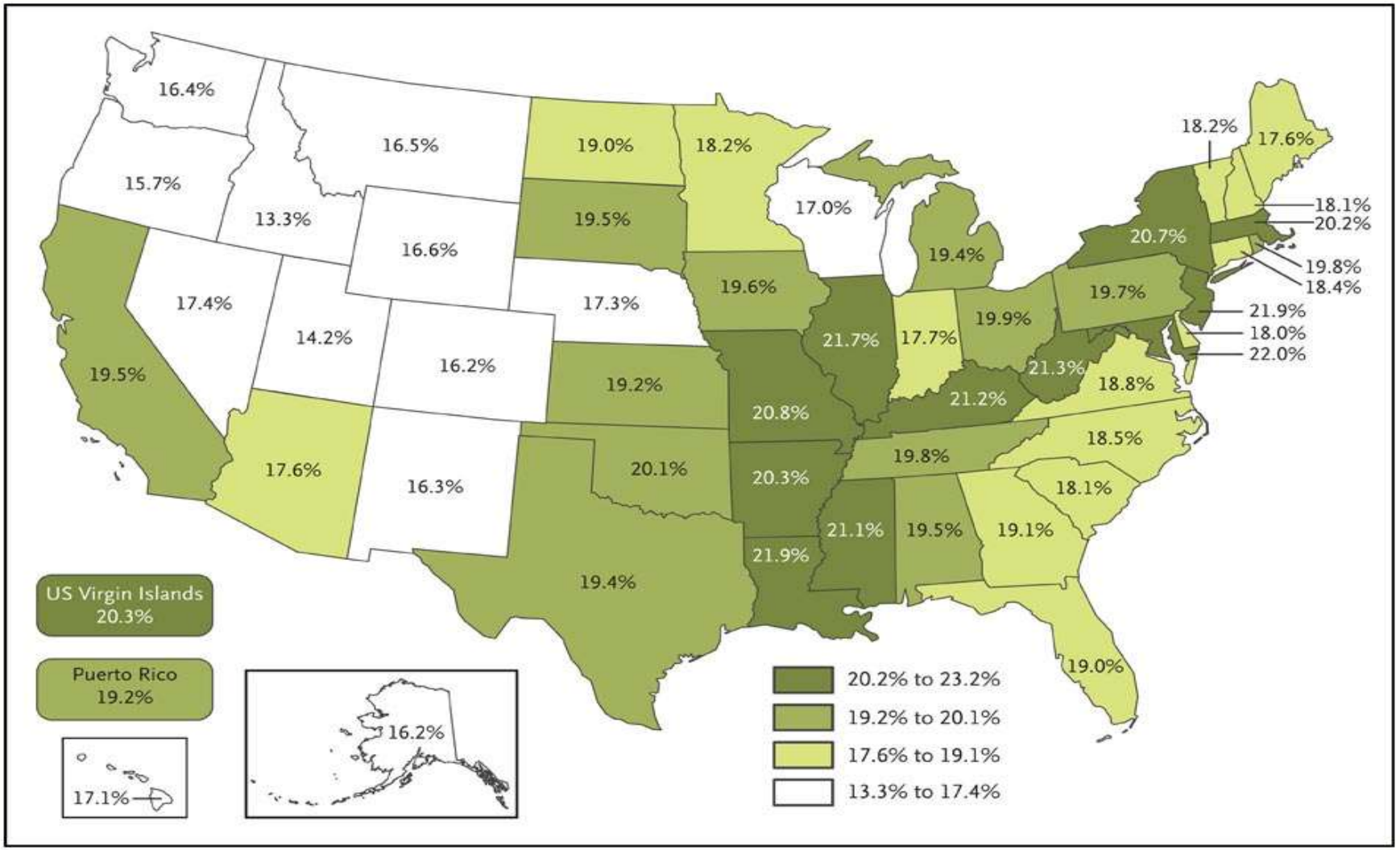
16.4%
15.7%
16.5%
13.3%
16.6%
17.4%
14.2%
19.5%
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17.6%
16.3%
19.0%
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18.2%
17.6%
20.7%
18.1%
20.2%
19.8%
18.4%
21.9%
18.0%
22.0%
US Virgin Islands
20.3%
Puerto Rico
19.2%
17.1%
16.2%
20.2% to 23.2%
19.2% to 20.1%
17.6% to 19.1%
13.3% to 17.4%

Health Care Reform: Hospitals

- Reduce reimbursement for hospitals with high risk-adjusted rates of readmission by 1% a year beginning in 2012 (up to 5% total)
  - 2012 : CHF, pneumonia, AMI
  - 2013: Add COPD, CABG, PTCA, Other vascular procedures, potentially global readmission rate
- Reduce reimbursement to SNF, Home Health when patient under their care readmitted

Health Care Reform: Physicians

- Create new payment code for patient visit within one week of discharge

- Apply payment reductions for physicians who treat a patient during an admission that results in a readmission

Payment Reform: MaineCare

- Reimburse for only one hospitalization when MaineCare patient readmitted to same hospital within 72 hours for the same diagnosis.

Where to start?

Lots of Data, Best Practice, and Tools
at your fingertips

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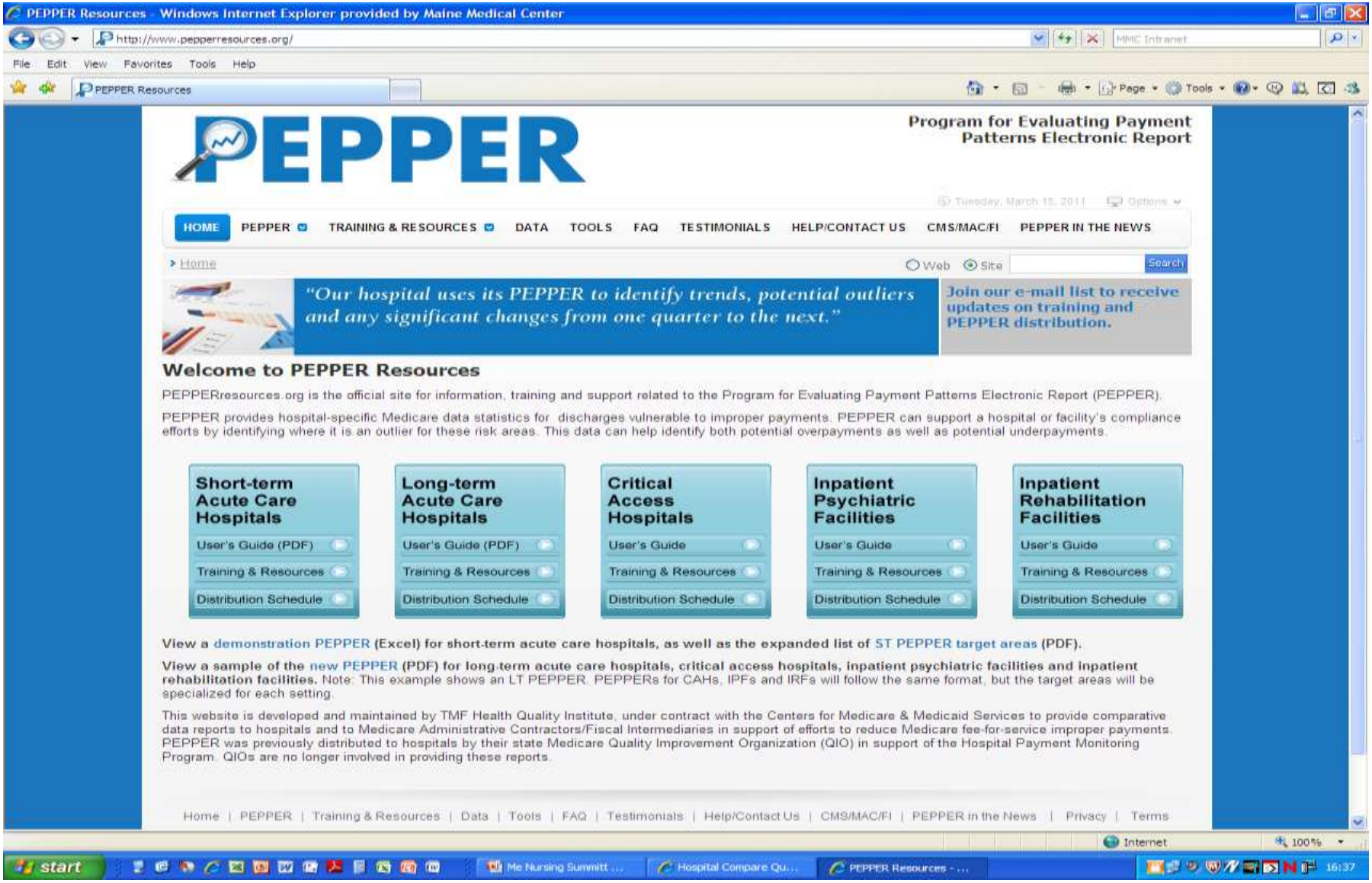

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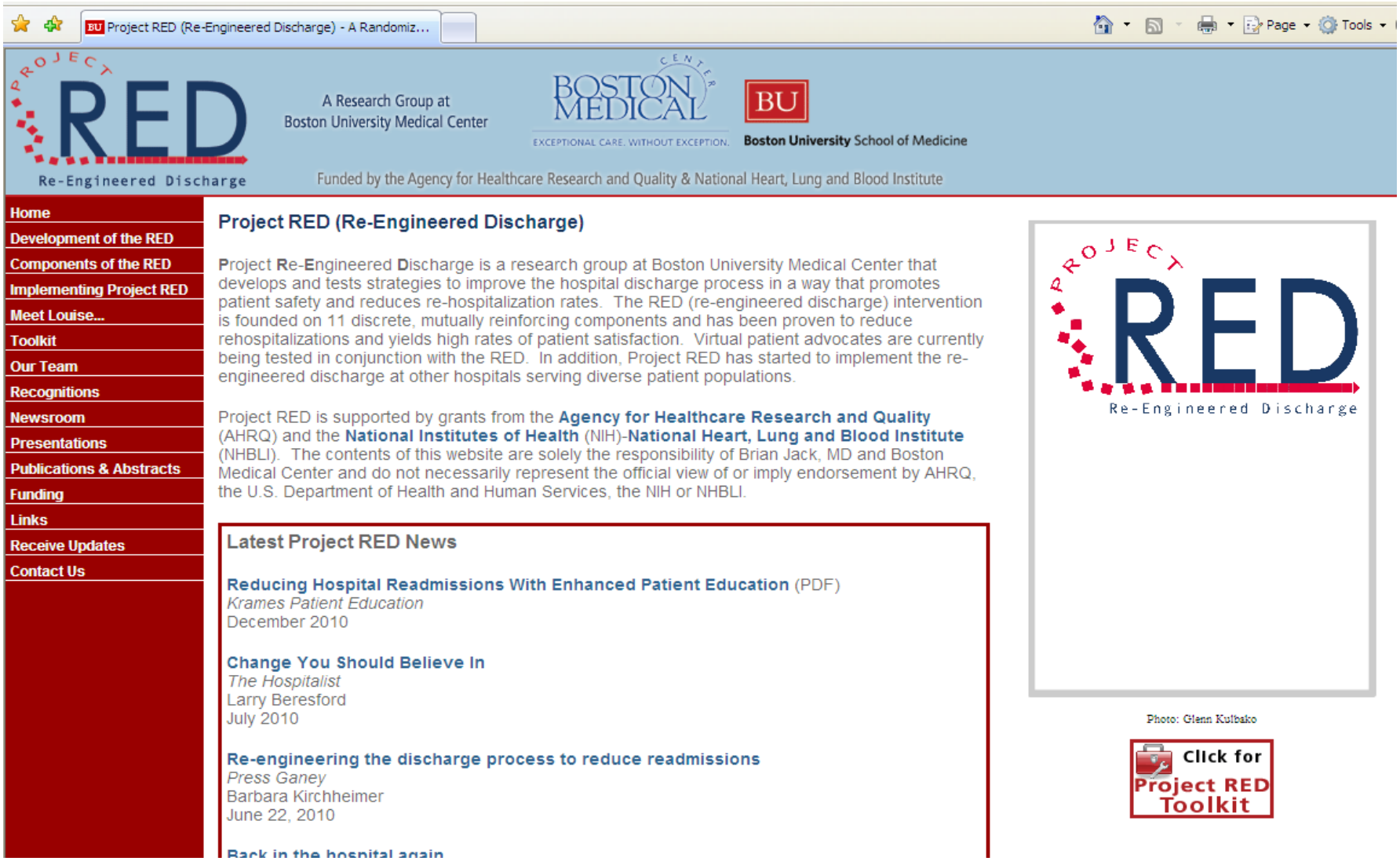

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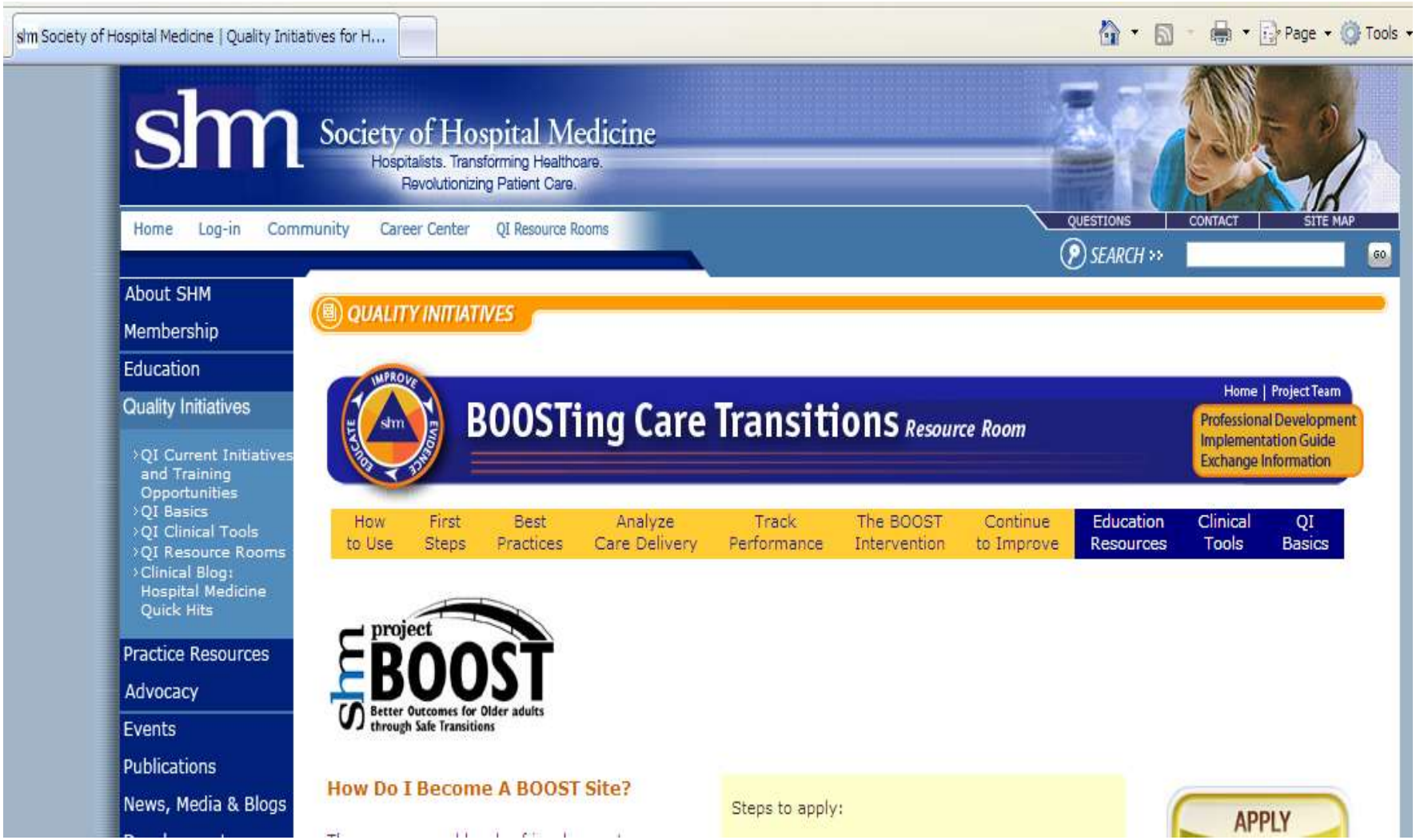

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Reducing Avoidable Readmissions: A Paradigm Shift?

Past Focus	Focus Going Forward
Traditional focus on discharging patients *D/C to home*	Facilitating transitions in care with a shift to handoffs (senders and receivers design the process) *Admission to Home (30-day LOS)*
Hospital problem	Continuum issue
Focus is on what clinicians are teaching	Focus on what the patient is learning
Patient is the focus of the care team	Patient and defined family are essential members of the care team
Immediate focus on clinical needs	Focus on the whole person and their social situation over time
Focus on patient care needs in various settings	Focus on the patient's experience over time

Peg Bradke, Portland, ME. 2011

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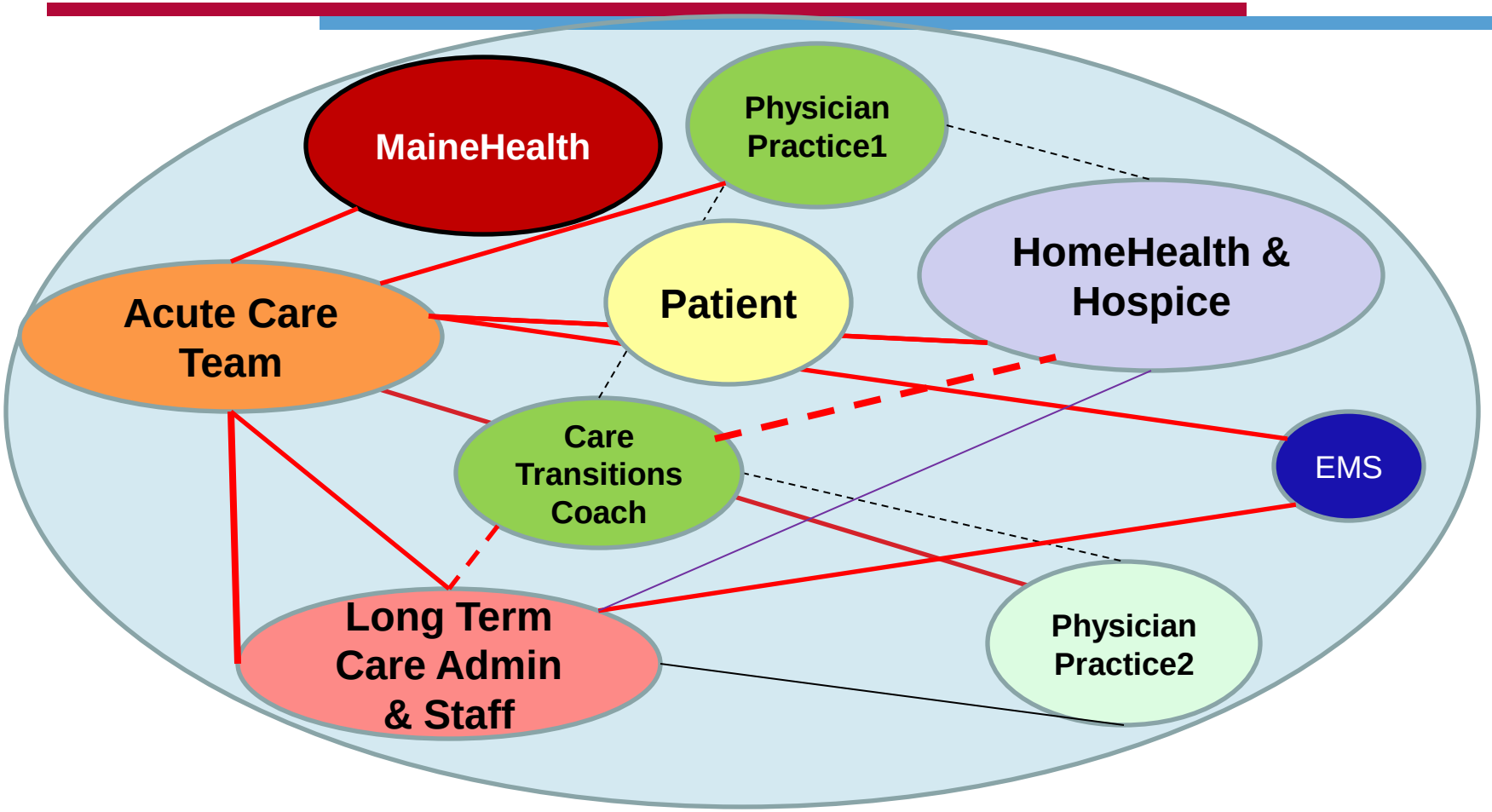
MaineHealth Transitions of Care Program Highlights

1. Care Transitions Pilot - Care Transitions Intervention Training, Eric Coleman – **Sept 2006**
2. Readmission Baseline established **2008**
3. Sr. Leadership support for program **2009**
4. Cardinal Grant funding; Establish pilots **2009-10**
5. Transitions of Care Program established **2010**
6. Development of Transitions of Care Bundle **2010**
7. Cross Continuum teams established at each MH hospital **2011**
8. TOC Workgroup convenes first monthly meeting **2011**
9. Multiple collaborative learning sessions and symposia **2009-present**
10. Achieved FY 2012 target of 15.1% - **March 2012**
11. Focus on patients at highest risk, medication safety: **2012-13**

Cross Continuum Networks



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Transitions of Care Bundle

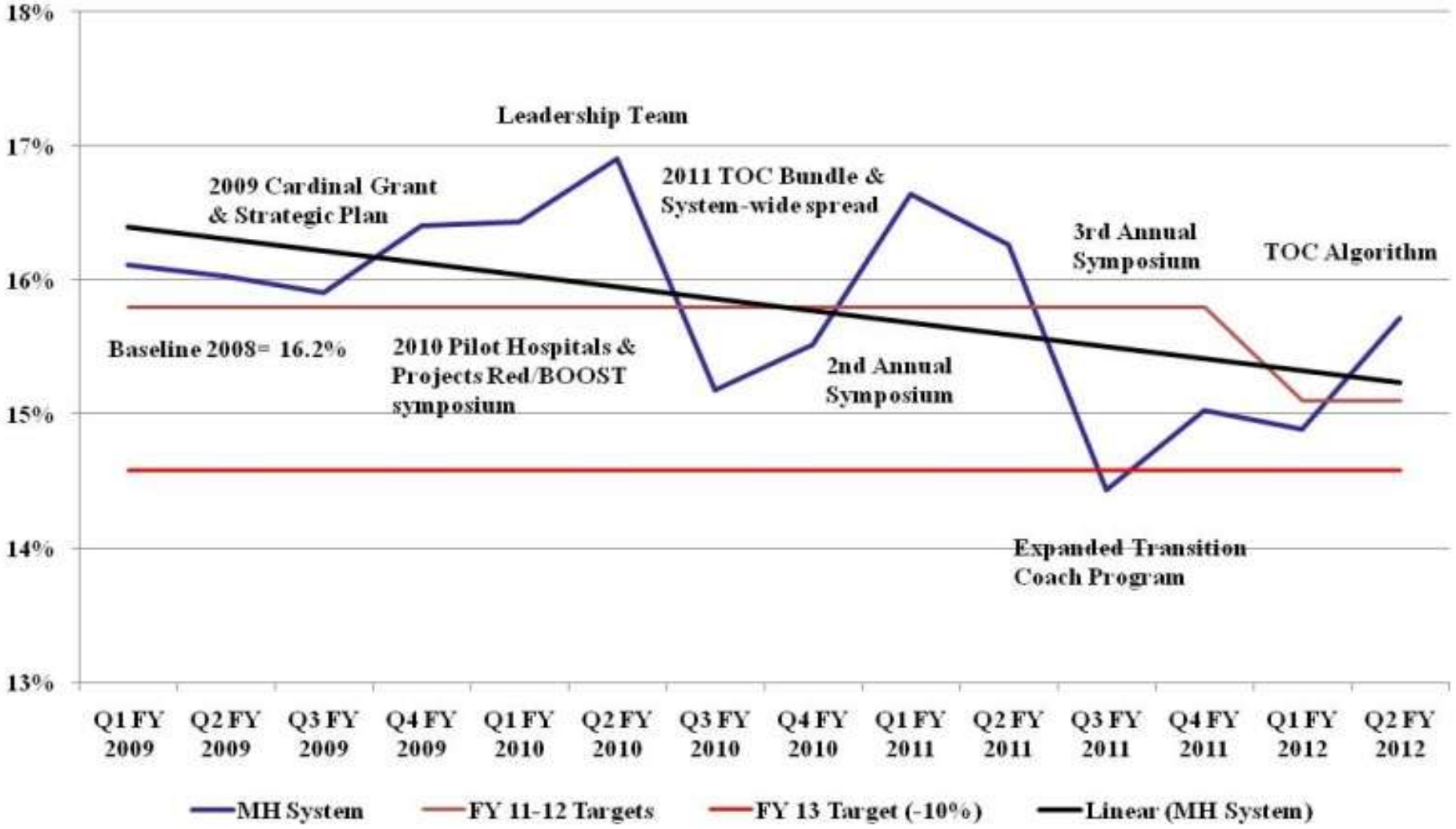
1. Risk stratification for readmission
2. Transition Checklist
3. Medication reconciliation
4. Patient/family health education
5. Timely communication among hospital and post-hospital providers
6. Timely follow-up of patients

8P Risk for Readmission

1. Prior hospitalization
2. Problem medications
3. Polypharmacy
4. Principal diagnosis
5. Psychological
6. Poor health literacy
7. Patient support
8. Palliative care

Outcomes?

MaineHealth Medicare 30 Day Readmission Rates
Q1 FY 2008 - Q1 FY 2012



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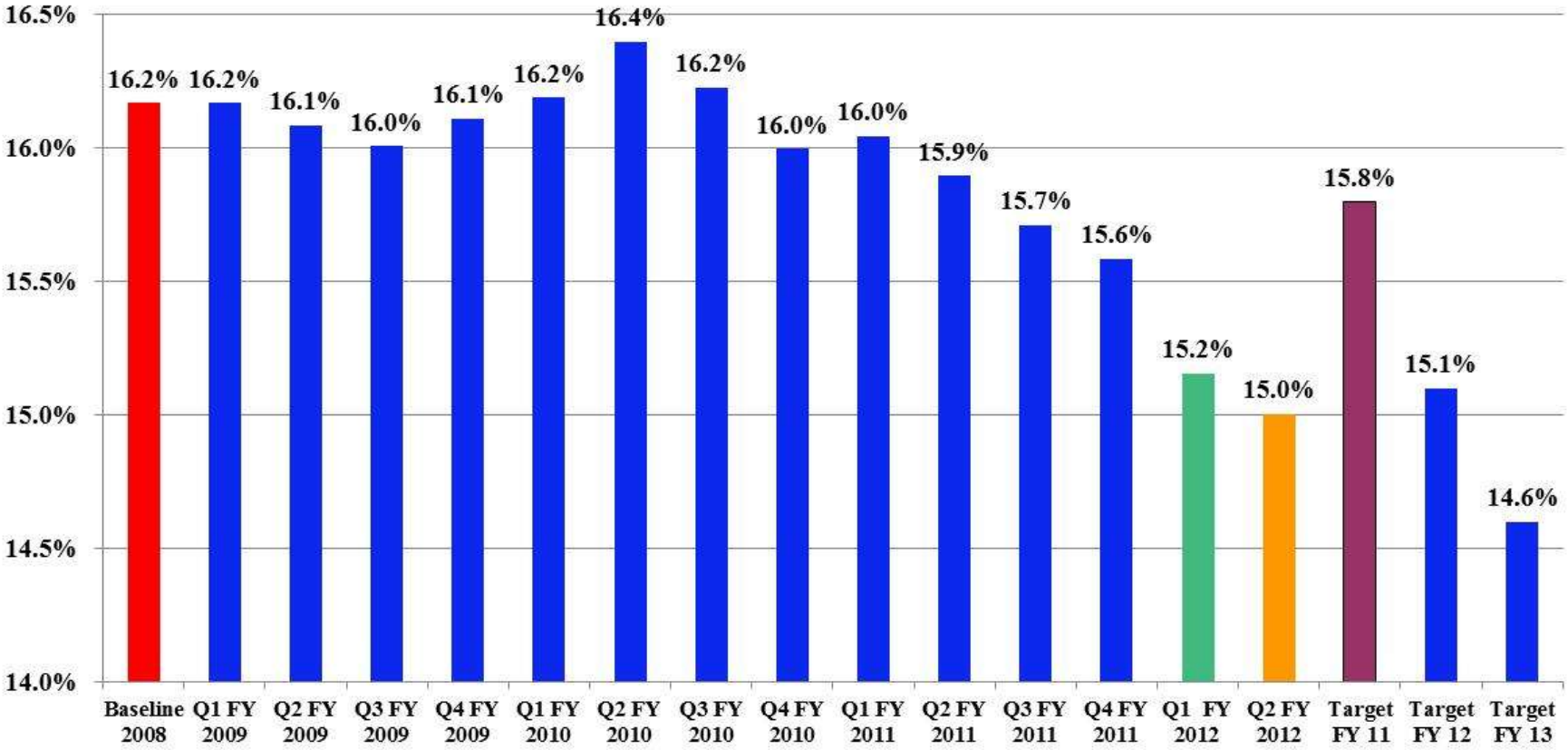
MaineHealth Rolling 4 Quarter Medicare 30 Day Readmission Rate



NOTE: CAH data excluded in calculations of system performance

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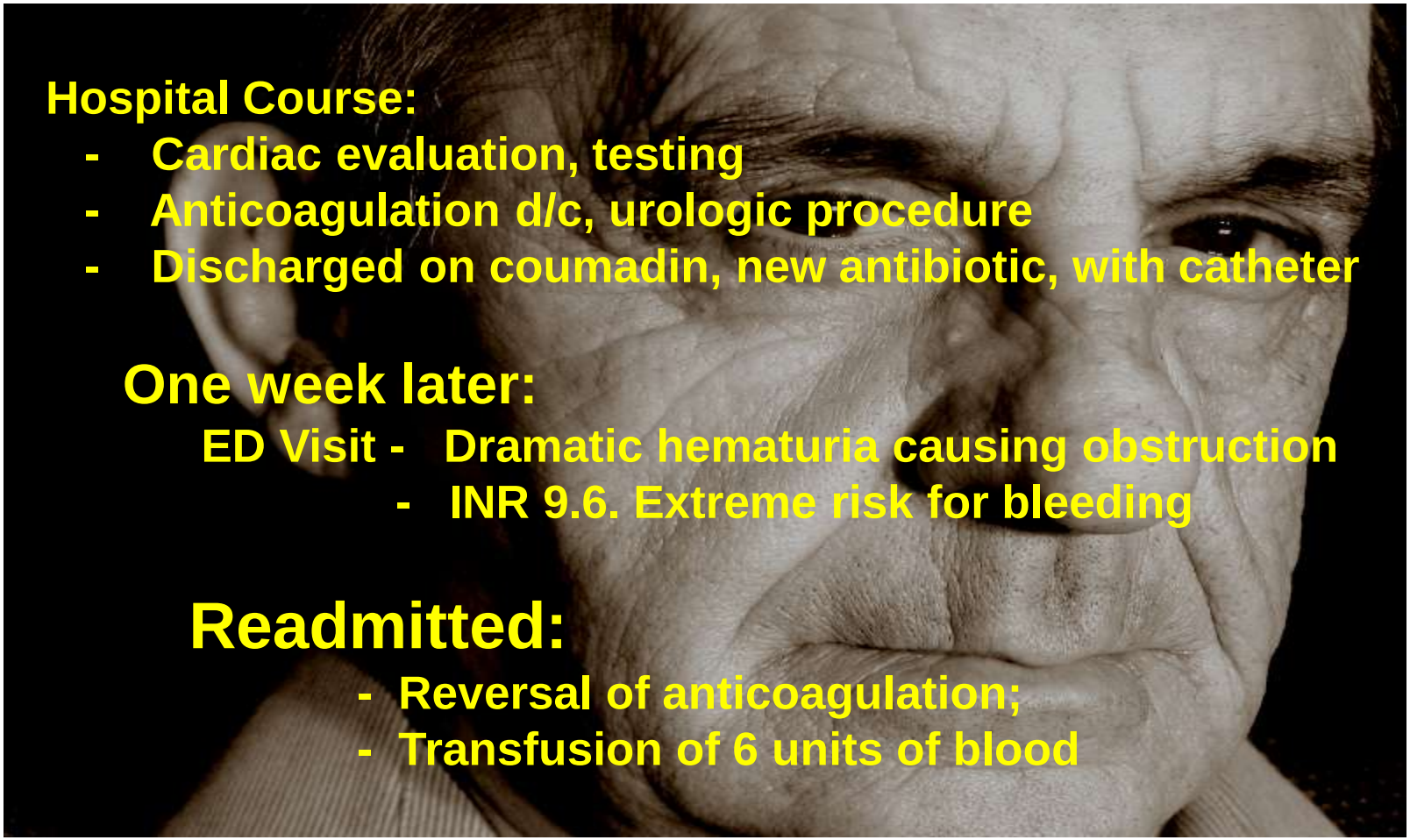
Victor revisited

(admitted for evaluation of syncopal episode)



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Transitions of Care Bundle:

- ✓ 1. Risk stratification for readmission (8P)
- 2. Transition Checklist
- ✓ 3. Medication Reconciliation
- ✓ 4. Patient/family health education
- ✓ 5. Timely communication among hospital and post-hospital providers (including Victor's meds)
- ✓ 6. Timely follow-up of patients

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Victor's Risk for Readmission (**8P**'s)

- ✓ **Prior hospitalization:** in last 6 months
- ✓ **Problem medications:** anticoagulants
- ✓ **Polypharmacy:** ≥ 5 routine medications
- ✓ **Principal diagnosis:** heart failure
- **Psychological:**
- **Poor health literacy:**
- ✓ **Patient support:** absence of caregiver to assist
- **Palliative care:** advanced or progressive illness

Victor's Medication Schedule

	Morning	Noon	Afternoon/ Evening	Bedtime
Acetaminophen PM 500mg/525mg				X
Furosemide 40mg	X			
Acetaminophen 650mg	X	X	X	
Glyburide 10mg	X		X	
Amitriptyline 25mg				X
Metformin 500mg	X		X	
Amlodipine 5mg	X			
Methylphenidate 10mg	X	X		
Aspirin EC 81mg	X			
Omeprazole 20mg	X			
Bupropion SR 300mg				X
Pregabalin 50mg	X	X	X	
Carvedilol 12.5mg	X		X	
Simvastatin 40mg				X
Captopril 12.5mg	X	X	X	
Terazosin 10mg	X			
Cyclobenzaprine 10mg	X	X	X	
Trazodone 50mg				X
Digoxin 0.25mg		X		

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Victor's Medication Schedule – After Pharmacy Review		
	Morning	Evening/Bedtime
furosemide 40mg	X	
acetaminophen 1000mg	X	X
glipizide 15mg	X	
duloxetine 60mg	X	
metformin 500mg	X	X
amlodipine 5mg	X	
aspirin EC 81mg	X	
omeprazole 20mg	X	
carvedilol 12.5mg	X	X
atorvastatin 20mg		X
lisinopril 40mg	X	
tamsulosin 0.8mg		X
trazodone 50mg		X
digoxin 0.25mg	X	

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Case Study:

Victor's New Post Hospital Scenario

- Home support services
  - Monitoring of anticoagulant status
- Follow-up phone call
- Office visit within 5 to 7 days

* No ED visit
* No readmission
* Decreased morbidity
* Decreased cost
* Increased patient satisfaction

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Lessons Learned

- Community partnerships key to improving quality through strengthened communication/collaboration
- System wide collaborative learning sessions accelerated progress
- Leadership support key to gaining buy-in for improvement at the local level.

Learning Points

- Focus on Care Transitions.
- Best Practices for Improved Transitions.
- MaineHealth Transitions of Care Program.
- Lessons learned

Questions?

THANK-YOU

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