



Reducing READMISSIONS

A Blueprint
for
Improving
Care
Transitions

Christina Pavetto Bond, MS, FACHE

Eric A. Coleman, MD, MPH

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HCP Pro

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Christy Bond, MS, FACHE, is the founding director of a service line focused on aging and complex care at Crouse Hospital in Syracuse, NY. In this role, she has introduced several best-practice programs, including NICHE (Nurses Improving the Care of Healthsystem Elders), HELP (Hospital Elder Life Program), the Care Transitions InterventionSM, and the Transitional Care Model. In addition, Christy has led her hospital's participation in several grant-funded national collaboratives, including the Medicare Innovations Collaborative, to develop strategies for integrating best-practice geriatric care, and Stop CAUTI, to reduce catheter-associated urinary tract infections. She has also led her hospital's participation in four regional collaboratives to improve care transitions focused on community-dwelling elders, patients in long-term care, and adults with sensory loss and caregivers.

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Dr. Coleman bridges innovation and practice through: (1) enhancing the role of patients and caregivers in improving the quality of their care transitions across acute and postacute settings; (2) measuring quality of care transitions from the perspective of patients and caregivers; (3) implementing system-level practice improvement interventions; and (4) using health information technology to promote safe and effective care transitions.

For more information, please go to www.caretransitions.org or www.practicechangefellows.org.

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Dedication

To my sons, Stephen and Jonathan, and my mother Shirley—you are my inspiration.

Introduction

In reading this book, you and I share a common interest in improving the health and well-being of the patients we serve. My background and, thus, my approach to this undertaking are unique. Approximately 20 years ago, I made the transition from teaching college students about business and leadership to healthcare administration. Whenever possible, I drew from my background in education to enhance what I was doing as a healthcare administrator. This book contains practical information that I found useful in implementing transitions programming to reduce readmissions. But you will also find information on the patient education process that may be different from what you are used to. I urge you to view it with an open mind and think about your experiences with patients when you read it. I am certain you will find that it enhances your perceptions about patients as adult learners in the discharge and transitions processes.

Because I am administrator now, my life is implementing new programs. So, I have included strategic discussions of the benefits of transitions programming and considerations for implementation. I have also tried to provide you with practical tools you can adapt and use right away as you begin to implement these programs. To enhance your experience, I have included tips from some of the greatest minds in business and leadership. They are not all healthcare leaders, but I think a broader base of knowledge helps us think more creatively about solutions to healthcare problems. I know the best ideas often originate with frontline staff and people in informal leadership roles. If you are in that position, I hope you find the case studies helpful in thinking about the practical aspects of functioning in a transitions role.

Inside this book you will find a wide-ranging, yet succinct, review of some of the strongest programming to reduce readmissions that exists today, as well as discussions of many corresponding issues. I hope you find it comprehensive enough to allow you to begin the process of adoption in your facility.



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Time to Reinvent Transitional Care for Older Adults?

LEARNING OBJECTIVES

After reading this chapter, you should be able to:

- Identify the leading components of quality transitional care
- Explain the role healthcare technology should play in enhancing the transition process

by:

Eric A. Coleman, MD, MPH

Director, Care Transitions Program

Professor of Medicine

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The goal of this chapter is to provide a framework for reinventing transitional care that will set the stage for subsequent chapters, which will explore the transition approaches of a distinguished collection of leaders in the field. The chapter will conclude with an overview of promising directions in national health policy that may serve to better align incentives for delivering high-quality transitional care services.

Definition of Transitional Care

The term *transitional care* has evolved to include many connotations in healthcare delivery. For the purpose of this chapter, we will derive the definition of transitional care from the American Geriatrics Society:

“A set of actions designed to ensure the coordination and continuity of healthcare as patients transfer

between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. Transitional care is based on a comprehensive plan of care and the availability of healthcare practitioners who are well trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.”¹

A Need for a Galvanizing Vision

Although transitional care is a critical component of quality care and safety for older adults, it suffers from the lack of a clear and galvanizing vision shared by consumers, family caregivers, health professionals, and policy makers.

Current challenges include controversy over which elements of transitional care coordination are most essential, wide variation in program design and execution, a prevailing provider-centric orientation, and conflicting evidence from existing trials as to whether transitional care improves outcomes and reduces costs. At a more fundamental level, do we conceptualize transitional care as a set of services? A detailed assessment and care plan? A particular healthcare professional that spans different care settings? Given the attention care coordination in general and transitional care in particular is receiving in policy discussions, now would seem to be a critical time to articulate a practice change vision.

Increasing evidence suggests widespread problems associated with the quality of transitional care. One in five Medicare beneficiaries is rehospitalized within 30 days, costing our nation more than \$17 billion annually.² The lack of incentives and accountability make these transfers particularly susceptible to medical errors, service duplication, and unnecessary utilization.³ Consumers are uniquely positioned to reflect upon the quality of transitional care, acknowledging that they are often the only common thread weaving across an episode of chronic illness exacerbation. Qualitative studies have consistently shown that patients and their caregivers do not know what to expect and are unprepared for their role in the next care setting. They do not understand essential steps in the management of their condition, feel abandoned because they do

not know which healthcare practitioner to contact for guidance, and believe that their input into their care plan is often disregarded. Many patients and caregivers are frustrated with the significant amount of redundancy in assessments and dissatisfied with having to perform tasks that their healthcare practitioners have left undone.⁴

Optimal transitional care begins with consumer engagement as active participants in their care. This vision further encompasses a targeting approach designed to identify those individuals at high risk for poor quality transitional care, a measurement strategy to evaluate the effectiveness of interventions from the standpoint of payers, clinicians, and consumers, and employs interoperable health information technology to foster timely and accurate information exchange. Optimal transitional care requires an alignment of financial incentives and removal of regulatory impediments. Ultimately, transitional care can be characterized as providing the right care in the right place at the right time by consumers, family caregivers, and healthcare professionals with the right skill sets, and at a price that promotes the long-term sustainability of our healthcare financial resources.

Engage consumers

The value of engaging consumers—patients and family caregivers—as active participants in their transitional care has not received adequate national attention. Engagement includes coaching to promote skill transfer and activation to express treatment preferences and ensure that needs are met. Consumers live with their chronic conditions 24 hours per day, seven days per week. In most cases, their illness exacerbations and their attempts to respond to common transitional care challenges occur when no healthcare professionals are present. If this is not reason enough to engage consumers, consider the impending healthcare professional workforce shortage exacerbated by our aging population detailed in the recent Institute of Medicine (IOM) report. In 2010, the first cohort of baby boomers will reach the age of 65.⁵ Thus, engaging consumers is not only the right thing to do, it has become a necessity.

However, we have a long road ahead to achieve this worthy aim of consumer engagement. As an illustration, the results of the Centers for Medicare & Medicaid Services (CMS) Medicare Care Coordination Demonstration were released in 2009.⁶ Among the 15 individual trials conducted in exemplary health delivery systems, 14 did not show improved outcomes or reduced costs. None of the trials explicitly focused on consumer engagement of patients or family caregivers, and none focused on family caregiver training and involvement.

Fortunately, the United Hospital Fund's Next Step in Care (www.nextstepincare.org) provides family caregivers with guides to hospital discharge, medication management, and other navigation tools. Meanwhile, health coaching is gaining greater attention as an effective strategy to engage consumers as more active participants in their care, as well as to impart the skills and confidence they need to ensure they receive what they need. Health coaching has been used in a wide variety of programs and models with goals such as helping patients:

1. Manage a specific condition (such as diabetes);
2. Navigate a process (such as cancer treatment);
3. Be more informed and engaged in their healthcare (communication and information focus); and/or
4. Achieve specific health or wellness goals.⁷⁻¹¹

A more expansive discussion of transitional care coaching follows in Chapter 5.

Targeting

Beginning with the rationale that most interventions designed to improve quality are time- and resource-intensive, our national health budget simply cannot afford to provide these to every patient undergoing transitions. Enter the need for a targeting strategy to identify those individuals who are at the highest risk to then tailor limited resources to those with the greatest need. Within the context of such decision-making, the nature and magnitude of the risk is often implied and therefore not readily apparent. Risk can be defined from different perspectives. For example, health insurers often equate risk in terms of likelihood for future use of high-cost healthcare services such as hospitalization. Alternatively, clinicians may conceptualize risk from the standpoint of likelihood for poor quality care or adverse medical events such as medication errors. From the consumer's perspective, risk could be envisioned as the likelihood of not receiving the necessary services for managing one's condition.

What is often lacking from each of these views of risks and many others is the extent to which this risk can be mitigated. In other words, can the trajectory of the downward spiral be modified with a well-placed intervention? For example, patients who are requiring high-intensity, high-cost services are unlikely to

remain on this course for long—typically, either they improve or they die. Let’s explore a number of approaches commonly undertaken to target high-risk patients for transition-related services.

The use of administrative data represents an attractive approach to risk identification. Health plans and governmental agencies often gravitate toward this strategy. Once collected, these data sets offer a wealth of valuable information on demographics, diagnoses, medication use, and prior healthcare utilization to construct risk indexes. Although many of these risk tools have been developed for routine use¹² (www.acmq.org/natlconf/pdfs/goldfield.pdf), this approach is constrained by a number of limitations. The first was alluded to earlier; these risk indexes do not tell us much about modifiable risk. A potential exception is the strategy to target based on admission for an ambulatory sensitive condition.¹³ These are conditions for which it is hypothesized that earlier treatment-seeking behavior to a primary care source could have led to intervention to avert the hospital admission. The second is that there are patient characteristics that are of potential great importance to determining risk that are not routinely available in administrative databases, including presence of a willing and able family caregiver, financial or transportation barriers to obtaining one’s medications, and whether the individual has a reliable source of primary care.

In 2009, CMS began publicly reporting hospitals’ 30-day readmission rates for Medicare beneficiaries discharged for congestive heart failure, acute myocardial infarction, and pneumonia (www.hospitalcompare.hhs.gov). Given that hospitals now have greater incentive to improve their performance for these three conditions, it follows that this initiative may drive their approach to targeting.

Beyond using diagnostic criteria, targeting could also be directed toward those patients at greatest risk for poor comprehension or execution of their discharge instructions. With support from the Aetna Foundation, our Care Transitions ProgramSM led an effort to guide healthcare leaders in this manner.¹⁴ Developed through a comprehensive review of the literature, individual conversations with leaders in the field, and the convening of an expert panel, we articulated a multi-tiered prototypical approach that could be tailored to the resources of a given provider or health plan. Within the first tier, we recommend the use of the teach-back method and the clock-drawing test for detecting low health literacy and impaired cognitive function respectively. At the second level, we recommend the use of simulation of specific actions included in discharge instructions to allow more in-depth assessment as to whether the patient is likely to be able to carry out the discharge instructions.

The Society of Hospital Medicine provides leadership for project BOOST (Better Outcomes for Older adults through Safe Transitions) (www.hospitalmedicine.org/boost). This project provides a framework for ensuring safe transitions for hospitalized Medicare beneficiaries, and its developers have proposed an approach to targeting based on the “7 Ps,” which are:

- Problem medications
- Punk (i.e., depression)
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Prior hospitalization

The 7 Ps approach is based upon empirical research as well as clinical experience (www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm). Under ideal circumstances, the hospital care team is already assessing each of these items individually as part of the intake assessment. Aggregating across the seven factors then provides a more complete picture of a patient’s overall risk.

Some healthcare organizations may choose to target based on the professional opinion of hospitalists, hospital nurses, discharge planners, or case managers to determine which patients are at high risk for poor quality care transitions. Although neither rigorous nor evidence-based, this type of approach may have a role in supplementing the other targeting approaches described.

The mentioned approaches attempt to identify risk but do not provide a clear path for how healthcare professionals may tailor information and services to reduce risk of subsequent preventable use of high-cost healthcare services. In contrast, the Patient Activation Measure (PAM) not only facilitates the ascertainment of risk, it further directs healthcare professionals on how to mitigate the risk.¹⁵ The

PAM characterizes patient level of activation into four discrete categories. Once the category has been determined, the developers of the PAM provide guidance for how to measure both the amount and the approach for how to optimize the provision of patient instructions. The authors of the PAM have demonstrated that knowledge of patient activation combined with a directed intervention can both improve clinical indicators and reduce subsequent utilization.¹⁶

Measurement

The lack of quality measurement of transitional care represents a significant barrier to improving quality and safety. With few exceptions, quality is not routinely measured, and when it is, the focus is often on those elements of care provision that can be routinely ascertained and with minimal effort. Resistance often stems from the fact that no single healthcare setting “owns” transitional care, and therefore our setting-specific approach to quality measurement seems misapplied. The assignment of accountability often follows performance measurement and in the case of transitional care, this has heretofore been unclear. In 2009, a consensus statement on behalf of six leading physician professional societies released a set of standards that addressed this critical gap, articulating the nature and duration of accountability.¹⁷ Although a detailed analysis of this topic is beyond the scope of this chapter, a comprehensive review can be found in a report from the IOM.¹⁸ Since the release of the IOM report, a number of esteemed quality improvement efforts have revisited this important topic that will serve as the primary focus for this discussion.

3-Item Care Transitions Measure (CTM-3™)

The 3-Item Care Transitions Measure (CTM-3), developed by our Care Transitions ProgramSM, was re-endorsed by the National Quality Forum for use in public reporting (www.caretransitions.org/ctm_main.asp). The measure has been translated into seven languages, and more than 3,000 organizations in 15 countries have requested permission for its use. Developed with direct input from consumers, the CTM-3 measures the extent to which patients are prepared for subsequent self-management of their health conditions. In this respect, the CTM-3 represents patient self-reported assessment of the quality of their care experience. This characteristic of the measure often attracts resistance on the part of healthcare providers who argue that patients are not able to judge the quality of their care experience. To counter these arguments, we have demonstrated that low CTM-3 scores strongly predict subsequent utilization.¹⁹ Based on this finding, some of the CTM-3 adopters have employed this tool as a risk-screen at the time of hospital discharge.

HCAHPS

All hospitals are mandated by CMS to report their scores on the standardized Hospital Consumer Assessment of Health Plans (HCAHPS). Two of the HCAHPS survey items address hospital discharge. Like the CTM-3, HCAHPS is consumer-reported and has also been endorsed by the National Quality Forum. In contrast to the CTM-3 that measures the extent to which patients' sense of preparation for self-care, HCAHPS inquires as to whether patients recall receiving particular key information from their healthcare professionals:

- During your hospital stay, did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- During your hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

The mandatory reporting program for 30-day hospital readmission enacted by CMS was described in the previous section on targeting. To date, this effort represents the ambitious attempt at wide-scale performance measurement reporting. Consumers who have the ability to select their preferred hospital can now make more informed decisions regarding which hospitals perform well on a range of factors, including the likelihood of readmission. Despite the fact that the reported measures have been risk-adjusted based largely on patient comorbidities, many hospitals and quality improvement experts believe there are many additional important factors that need to be taken into account, such as socio-economic status, race and ethnicity, and functional status.²⁰ These hospitals argue that failing to take these factors into account disadvantages those hospitals that disproportionately care for the nation's poor and underserved populations.

The American Medical Association (AMA) developed a series of recommended approaches for transitional care within the physician consortium performance improvement (PCPI) initiative. These approaches largely focus on recommended care processes that if done correctly would be hypothesized to result in improved quality of care. Most if not all of these approaches have not been formally evaluated for their measurement properties and may therefore be best characterized as a series of best practices. Because most practice settings continue to document these care approaches in paper medical records, determining how

to collect information on these care processes remains a challenge (www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement.shtml).

Similarly, the American Medical Directors Association (AMDA) recently produced a comprehensive report on clinical practice guidelines for transitional care that are uniquely directed at the long-term care arena. As with the AMA PCPI approaches, the AMDA guidelines could be translated into processes of care that are relevant to the patients in nursing homes, long-term acute care hospitals, assisted living facilities, and adult day health programs.²¹

The National Transitions of Care Coalition (NTOCC) represents a diverse group of stakeholders, including healthcare professionals, national quality improvement entities, consumer groups, and insurers. NTOCC recently produced a practical step-by-step guide to help health organizations approach quality improvement (www.ntocc.org/Portals/0/ImplementationPlan.pdf).

Finally, although not explicitly designed to assess transitional care quality, the CMS Continuity Assessment and Record and Evaluation (CARE) tool provides an important infrastructure or platform from which quality can be measured (www.pacdemo.rti.org). The CARE tool would ultimately replace the site-specific assessment tools used in hospitals, nursing homes, and home care agencies in favor of a single assessment that would simply be validated and updated as patients move across care settings. The primary advantage of this tool is that for the first time, quality could potentially be evaluated across an entire episode of care.

The Role of Health Information Technology

Care fragmentation remains a significant threat to improving transitional care. The IOM report, *Crossing the Quality Chasm*, summarizes current practice, “Physician groups, hospitals and other healthcare organizations operate as silos, often providing care without the benefit of complete information about the patient’s condition, medical history, services provided in other settings, or medications prescribed by other clinicians.” In an ideal system, a core set of health information would seamlessly follow the patient between sites of care and include medications, allergies, a problem list, baseline function, advance directives, and

family caregiver roles and contact information. The information would be updated across sites as test results become available, or as the healthcare needs of the patient change. The information would be secure, yet transparent to all involved in the care of the patient, whether it is the practitioner, patient, or caregiver. To date, however, we are far from realizing the potential that technology has to offer. To achieve this vision, financial incentives need to be in place to encourage health systems to adopt interoperable electronic health information systems, as hospitals and ambulatory clinics have been more likely to implement electronic medical records than nursing homes and home care agencies.²²

In addition to interoperability, quality improvement in primary care will also be enhanced by mandatory e-prescribing and the implementation of unique patient identifiers. With regard to the former, wide-scale e-prescribing would facilitate the opportunity for each prescribing physician to see the complete list of medications a patient has received. With a more complete medication list, pharmacists would be better equipped to detect dangerous drug-drug interactions. Once all patients have an assigned unique patient identifier and healthcare utilization and testing information is collected into a single repository, healthcare professionals can quickly determine which laboratory and diagnostic imaging tests have been recently performed and thereby avoid costly duplication.²³

Aside from electronic medical records, two other health information facilitators include telehealth and the personal health record (PHR). Telehealth involves the use of technology to remotely engage and evaluate patients, particularly those who live in rural or frontier settings. The Veterans Affairs has been a leader in this regard (www.carecoordination.va.gov/telehealth). PHRs facilitate better cross-setting communication and encourage patients to own and routinely update a core set of health information. PeaceHealth's Shared Care Plan represents an important prototype (www.sharedcareplan.org). Microsoft Health Vault (www.healthvault.com) and Google Health (www.google.com/health) represent two of the nation's leaders in encouraging the use of PHRs by developing readily available, user-friendly platforms.

Finally, there is an important role for health information technology in what could be characterized as the ultimate in anticipatory transitional care: disaster preparation. Hurricane Katrina exposed the many weaknesses of our health information system.²⁴ Persons with multiple chronic conditions and nursing home residents were displaced without any record of their current problems, medications, or family caregivers.

The Policy Landscape

The statement “the only constant is change” embodies the current policy landscape regarding transitional care. Given the rapid state of flux, this section will focus on those areas that are likely to be central to policy efforts for the foreseeable future—namely controlling escalating healthcare costs, aligning financial incentives to improve quality, fostering greater accountability, and expanding the healthcare workforce. Fortunately, transitional care has garnered considerable national attention from leading quality improvement entities. These organizations include:

- The Joint Commission
- CMS and their quality improvement organizations
- The Institute for Healthcare Improvement
- The IOM
- The National Quality Forum
- The Medicare Payment Advisory Committee
- The National Coalition on Care Coordination

The Obama administration and the U.S. Congress have clearly signaled intent to reign in escalating healthcare costs. Among potential targets for cost reduction, none is more attractive than the potential to reduce avoidable hospital readmissions. With an annual price tag estimated at \$17 billion for the Medicare population, there is no other readily identified component of healthcare spending that could produce such a sizable return.²⁵ As previously stated, one in five Medicare beneficiaries is readmitted to the hospital within 30 days, representing an unequivocal failure to appropriately design and execute effective transitional care strategies. The Medicare Payment Advisory Commission that advises the Congress on changes to the Medicare program has proposed financial penalties for those hospitals with high readmission rates.²⁶

Complementing strategies to drastically reduce healthcare spending are those approaches designed to align incentives for improving greater cross-setting coordination and collaboration, particularly for those patients transitioning across different care settings. In the past several years, three promising financing models were designed and are being piloted to better align these financial incentives, including the patient-centered medical home, bundled payment, and accountable care organizations. For a practice to be deemed a patient-centered medical home (and be eligible for additional payment), it must meet requirements developed by the National Committee for Quality Assurance (www.ncqa.org/tabid/631/default.aspx). These requirements include specific language for facilitating cross-setting care coordination. A second strategy involves providing hospitals and physician groups a single “bundled” payment to foster greater collaboration for managing recently discharged patients. CMS recently reported on a pilot study of this bundled payment approach.²⁷ Third, accountable care organizations extend the bundled payment concept across a community of healthcare providers and patients, thereby encouraging a more population-based approach to resource allocation to promote health inclusive of preventive treatment and restorative healthcare service delivery.

Summary

As the topic of transitional care increasingly becomes a central area of focus for both quality improvement and cost containment, your healthcare organization may benefit from the framework identified in this chapter to guide your decision-making. This chapter has provided such a framework for reinventing transitional care to serve this purpose, as well as to set the stage for subsequent chapters.

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