Bridging the Gap: Improving Care Transitions from Hospital to Community care

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CCO Summit

health share

OHSU

Outline

- Why transitions matter
  - Understanding the gaps
  - Incentives to improve
- Improvement efforts
  - National and regional examples
    - Panel: Four Oregon examples of transitions improvements
- Implications for leaders and implementers
- Q&A

Show of hands:
What is your interest in this topic?

- My CCO:
  A. Has no formal efforts to improve transitions of care but we want to start
  B. Is in the beginning stages of transitions improvements and we are looking to improve
  C. Has well established transitional care efforts and we are looking to improve

Background: Why care about hospital readmissions?

- Readmissions are common and costly
- Transitions are increasingly recognized as target for quality improvement
- Expected to be a source of cost savings

Transitions are risky

- Adverse events are common as patients move across health care settings
  - Half of all discharged patients are exposed to medical errors in medication continuity, test follow-up or diagnostic work-up

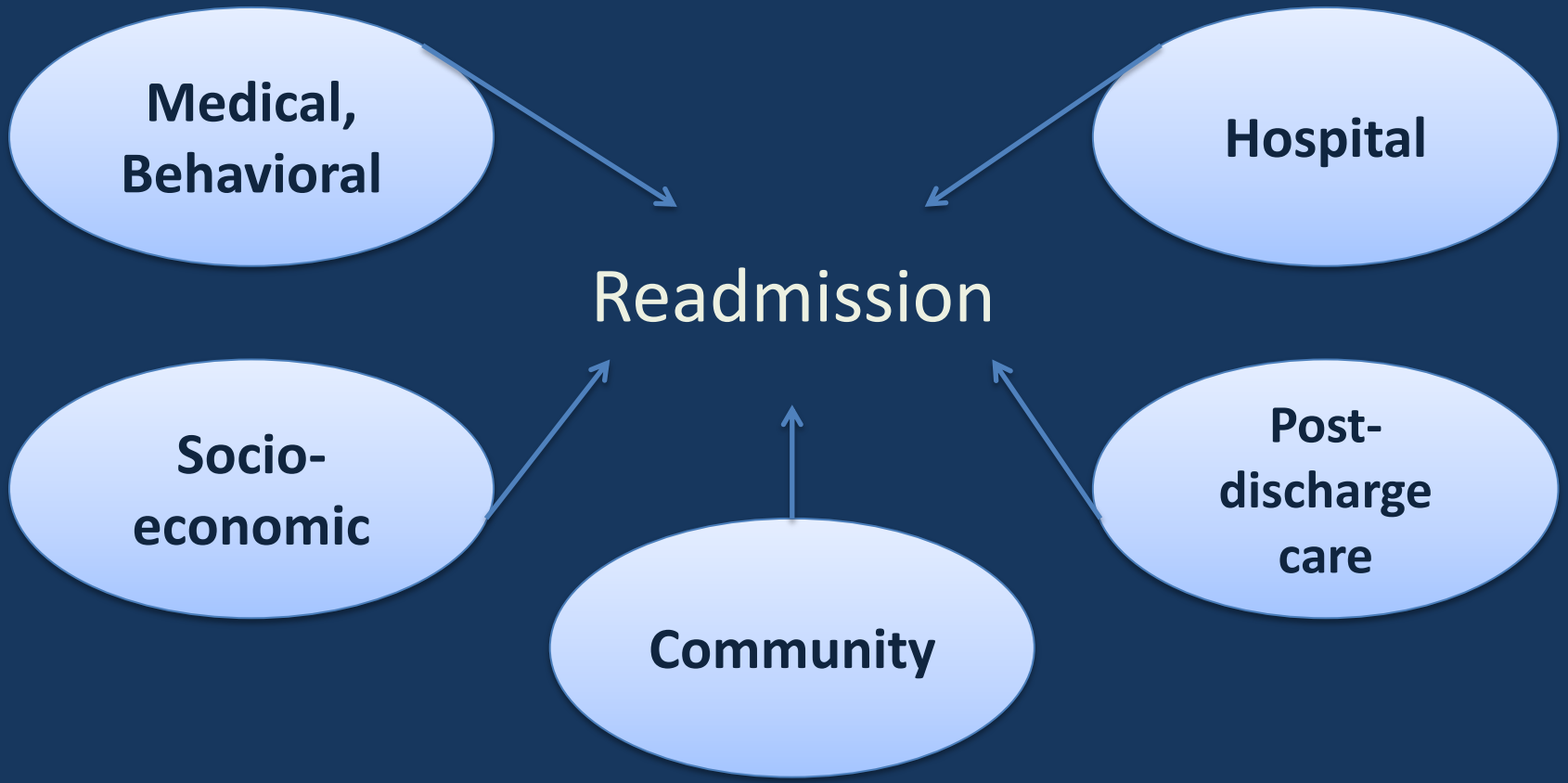
    Kripalani S, J Hosp Med, 2007
  - One-quarter of discharged patients experience an adverse event
    - Usually an adverse drug event

    Forster AJ, Ann Intern Med, 2003

Penalties for High Readmission Rates

- Financial Penalties
  - CMS penalty starting in FY 2013
    - if risk-standardized readmission rates for AMI, CHF, or pneumonia are in the worst quartile
- Quality Reporting

Predicting Readmission Risk



Kansagara, Englander, et al JAMA 2011

Transitions: Key deficiencies

Communication

Patient education

Access to care

Integration

Interventions to Reduce 30-Day Rehospitalization: A Systematic Review

Pre discharge Intervention	Post discharge Intervention
Patient education	Timely follow-up
Discharge Planning	Timely PCP communication
Medication Reconciliation	Follow-up phone call
Appointment scheduling before discharge	Patient hotline
	Home visit
Bridging Intervention	
Transition coach	
Patient-centered discharge instructions	
Provider continuity	

- No single intervention was regularly associated with lower readmits; bridging interventions were most promising

Hansen, Annals 2012

Interventions to improve transitions and reduce readmissions

Tiered approach to transitions improvements

Target high risk subgroups (ie CHF, polypharmacy, low SES)

Standard roles and processes across care settings and services

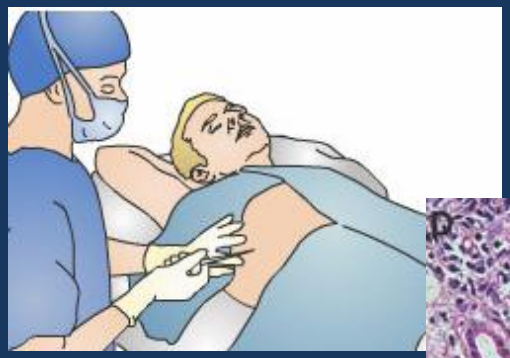
Large scale quality improvement initiatives

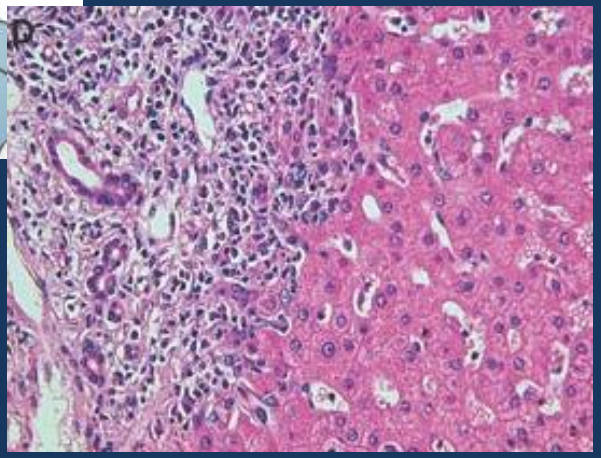
- Set of tools to optimize discharge planning and cross site communication
- Incorporates best practice insights
- Smart about implementation
- Evaluation showed modest improvement though serious method flaws

Coleman

- 4 pillars:
  - Medication Self-Management
  - Personal Health Record
  - Follow-Up
  - Red Flags
- Original study: nurse coach in single integrated setting among geriatric patients w one of 11 chronic conditions; 3.6% ARR

Panel Discussion





Panel

Care Transitions Innovation (C-TraIn): Multnomah, Washington, Clackamas

Linn-Benton-Lincoln County AAA

Lane County Collaborative

AllCare Collaborative: Josephine, Jackson, Curry, southern Douglas

Panel

- Cynthia Ackerman
- Gale Blasquez
- Dan Reece
- Jackie Sharpe, Honora Englander

Post-DC Home Visit & Medication Reconciliation

Implications for CCOs

Importance of:

- Broad stakeholder engagement
  - including mental health/ A&D, social service and healthcare
- Champions across settings
- Standardized processes, roles, and accountability
- Person-centered approach
  - may include home visit, pharmacy intervention, trauma informed care
  - match intervention to need/ resources

Q&A

Contact info

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- Jackie Sharpe, Oregon Health & Science University (Health Share of Oregon), sharpej@ohsu.edu
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Supplemental Slides

"We don't have a community contract where everybody acknowledges their role… 'my role as the sender is to do these things', 'my role as the recipient is to do these things'…the 'who will' and 'how' of the handoff. We never get close to that sort of formality, which is really what any smart handoff or transition would require."

-Healthcare administrator

Davis et al, JGIM 2012

Risk Prediction Models for Hospital Readmission

A Systematic Review

Devan Kansagara, MD, MCR
Honora Englander, MD
Amanda Salanitro, MD, MS, MSPH

Context Predicting hospital readmission risk is of great interest to identify which patients would benefit most from care transition interventions, as well as to risk-adjust readmission rates for the purposes of hospital comparison.

- Readmission risk prediction models have been developed for hospital comparison and clinical intervention purposes
- Most models in both categories perform poorly and have relied on comorbidity and utilization data
- Few models examine social determinant variables

Kansagara, Englander JAMA 2011

Implication 1:

Match the readmission risk model to intended use

- Models designed for measuring quality are probably not well suited for clinical use and vice versa.
- Think carefully about the local population to which it is being applied.

Implication 2:

- A risk assessment does not necessarily tell you what to do for the patient.
- Consider incorporating clinically informative variables to which specific intervention elements could be tailored and that are not otherwise captured
    - Housing status
    - Access to care
    - Health literacy
    - Substance abuse

Implication 3:

Think about workflow and feasibility of data collection when adapting risk assessment tools

- Avoid overly complex models that impede workflow
- Data must be easily available in real-time
  - ? Incorporate into EMR
  - Simple surveys

Implication 4:

We do not know how many readmissions are preventable. Think about using additional metrics to measure peri-discharge care.

Implication 5:

When selecting transitional care improvements, remember:

- No off-the-shelf fixes
- Gaps differ across systems; first step is to understand local needs and then map interventions to fill in those gaps