The Policy Landscape and Transitions of Care

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Health Care Needed A Transformation

The Current Process Is Not Working

The Vision

To provide health care services and support to all consumers including health prevention, care coordination, and appropriate resource utilization. To promote quality of care to improve quality of life for our citizens. A commitment to processes that focus on education, consumer advocacy, clinical optimization of resources, patient safety, and technology to achieve superior clinical and financial outcomes with positive member and provider satisfaction.

Critical Business Issues?

Needs

Optimum Health

Gap

Fragmentation & Silos of Care
Growing Cost of Chronic Care
Access to Care Options (24/7)
Inconsistent Approaches
Collaborative Team Practice
Whole Person Care Approach
Transitions of Care Facilitation
Technology Advancements
Regulatory/Gov’t Imperatives
Healthcare increases, M&Ls and Provider Payment

Five 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
Three Broad Aims of the National Quality Strategy
Better Care, Healthy People/Healthy Communities and Affordable Care
Six Strategies to Advance these Aims include:

1. Prevention and Treatment of Leading Causes of Mortality
2. Supporting Better Health in Communities
3. Making Care More Affordable
4. Making care safer by reducing harm caused in the delivery of care
5. Ensuring that each person and family members are engaged as partners in their care
6. Promoting effective communication and coordination of care

5 Years in - What does the Consumer think?

The differences of opinion have narrowed: 40% in favor & 43% oppose
- Those who view the law favorably like the expansion of coverage, more affordable, as a whole country and people will be better off
- Those opposed cite the health-care law is driving up insurance costs, against the individual mandate, government related issues

What do Providers Think?
Health Care Policy Shaping Our Strategy

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

Health Care Policy Brings Innovation, Creativity, & Opportunity

New Models of Health Care Delivery and Reimbursement for Systems

- Patient-Centered Medical Home (PCMH) Primary Care Practices
- Accountable Care Organizations (ACOs)
- Integrated Health Delivery Systems
- Population Health Management
- Comprehensive Primary Care
- Outcomes-Based Reimbursement With Shared Risk
- Value Based Purchasing of Health Care Services

New Models of Improving Transitions of Care

- Dr. Eric Coleman – Transition Coaching - http://www.caretransitions.org
- Dr. Mary Naylor – Advanced Nurse Practitioners - http://www.nursing.upenn.edu/mediatransitionalcare/Pages/default.aspx
- Guided Care - Dr. Chad South - Guided Care Nurse - http://www.guidedcare.org
- Boston University Medical Center - Project RED – Re-engineering Discharges - http://www.bu.edu/fammed/projectred/
- Society of Hospital Medicine – Project BOOST - http://www.hospitalmedicine.org/pressrelease?design=RR_CareTransitions/CT_Home.sflb
- Transition of Care Clinic - Tallahassee Memorial Hospital – Dr. Dean Watson, Chief Medical Officer
- Rush Enhanced Discharge Planning Program – Rush University Medical Center - Robyn Golden, MA, Director of Older Adult Programs, robyn_golden@rutm.edu
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

To Make It All Work, We Must Build Collaborative Teams

Physician Engagement

- As health care organizations struggle to transform the health care delivery system, the need for strong physician leadership, engagement and innovation are key elements for success.
- Hospital administration and community stakeholders must be willing to hear the concerns of physicians and build trust and respect.
A Different Level of Physician Engagement

- Today's health system transformation calls for a different level of physician engagement
  - Organizing care around the patient
  - Working together in teams
  - Embracing the bigger mission of the organization

"An engaged physician workforce is also linked to enhanced patient care, greater efficiency and lower cost and improved quality and patient safety."

Core Components of Collaborative Care

- Psychiatrist-supervised systematic diagnostic assessment with baseline symptom documentation
- Initial agreed upon clinical and functional goals
- First line evidence-based intervention through primary care clinician
- Care management behavioral activation and follow-up with outcome measurement under psychiatrist review
- Treatment to target—care escalation based on follow-up findings (psychiatrist involvement and treatment change)
- Symptom stabilization and return to primary care follow-up

Value-Added Integrated General Hospital Inpatient Services

- Psychiatrist consultation team
  - Psychiatrist-led BH team assesses all medical admissions for BH comorbidity as a part of hospitalist group teams
  - Evidence-based protocol development and implementation for common BH conditions in medical inpatient settings, e.g., substance withdrawal, delirium prevention and treatment
  - Routine constant observation review
  - Complexity Intervention Unit—medical inpatient unit with full psychiatric safety features and capabilities
  - Psychiatric coverage in the general medical emergency room
Creating the Collaborative Clinical Team

Collaboration among physicians, pharmacist, nurses, case managers, social workers, allied health and supporting staff is critical to achieving the goals of the team, the organization and changing the way we deliver healthcare today.

The Pharmacy Opportunity

- Leadership role in interdisciplinary efforts to establish accurate and complete medication lists
  - Hospital admission and discharge
  - Any change in level of care
- Encourage community-based providers and health care systems to collaborate in medication reconciliation efforts
- Educating patients and their caregivers on their role in retaining a current list of medications
- Assisting patients and caregivers through the provision of a personal medication list
- Providing a Comprehensive Medication Review (CMR)

Case/Care Manager Skills Are Required For Success in These New Models!

- Knowledge and experience with care coordination
- Focus on patient-centered processes
- Assessment, planning, facilitation across care continuum
- Knowledge of population-based care management strategies
- Meaningful communication with patient, family, care team

Courtesy: www.CMSA.org – CMSA Standards of Practice 2010
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
- 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

Continued Support for Care Coordination & Transitions of Care

- AHRQ – Care Coordination Measurers Atlas
- NQF – Performance Measures for Care Coordination
- CMS – SOW for QIOs focus on Care Transitions & Care Coordination
- TJC – Core Performance Measures & Patient Safety Standard #8 Medication Reconciliation
- URAC – Incorporated Transition of Care in revised CM Standards – Case Management Measures
- NCQA – Complex Case Management Standards
- AMA – PCPI Transitions of Care
- ANA – Framework for Measuring Nurse’s Contribution to Care Coordination
Transitional Care Codes
Implemented January 2013

National Average $142.96
- 99495: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 calendar days of discharge

National Average $231.11
- 99496: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least high complexity during the service period
  - Face-to-face visit, within 7 calendar days of discharge.

FY2015 Medicare Physician Fee Schedule (PFS) - Effective January 2015 - CPT Code 99490
- Chronic Care Management Codes (CCM)
- Focus on paying for team based care
- Patients with two or more chronic conditions
- Separate fee for managing multiple conditions
- 20 minutes of clinical labor time & may be provided outside of normal business hours
- Billed no more frequently than once a month
- Care management services may be provided by social workers, nurses, case managers, pharmacist
- Services must be available 24X7 to patients and their family caregivers
- Providers using the CCM code must have an electronic health record or other health IT

Health Policy Initiatives 2015
- 21st Century Cures Act
- Better Care Act
- Medicare Transitional Care Act 2015
- Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)
- Meaningful Use Phase 3
- Advanced accountable care organizations (ACO) model
- Primary Care Transformation
- Medicare Access & Reauthorization Act of 2015
What Can We Do?

- Focus on patient-centered care
- Continuous improvement
- Effective Team practice with financial and performance measure alignment
- Team leadership
- Cultural sensitivity and community focus
- Integrating behavioral health care with primary care

Opportunities to Improving Transitions

- Increased resources for team-based training
- Interprofessional education & competencies
- Outdated financial models
- Incomplete patient integration
- Technology gaps and barriers
- Meaningful performance measures
- Innovation for culture change

Don’t Forget The Patient & Their Family Caregiver - They are Part of the Care Team
The Medically Complex Patient

Don Berwick on Partnerships for Patients

"No single entity can improve care for millions of hospital patients alone. Through strong partnerships at national, regional, state and local levels – including the public sector and some of the nation’s largest companies – we are supporting the hospital community to significantly reduce harm to patients" April, 2011

Transitions Of Care & Care Coordination Resources

- CAN - Caregiver Action Network - Family Caregiving Resources - www.caregiveraction.org
- CAPS - Consumers Advancing Patient Safety - Toolkit www.patient-safety.org
- NTCCC - National Transitions of Care Coalition - Provider & Consumer Tools www.ntocc.org
- CMA - Case Management Society of America - CMA Medication Adherence Guidelines & Disease Specific Adherence Guidelines, CMA Standards of Practice - www.cmaj.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/TOCCEPG/index.html
- ACOs and TIH - Hospital to Home - Reducing Readmissions, Improving Transitions - http://www.nhshadow.org/
- NASW - National Association for Social Workers - http://www.socialworkers.org/Resources
- VNAA Blue Print for Excellence - www.vnablueprint.org
Resources for Development Measures

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

Questions

Thank You

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