Take Accountability for Ambulatory Care Transitions

CHANGE PACKAGE
Overview

Background
An acute care hospitalization represents a major event in the lives of patients, and the 30-day period immediately following discharge is an especially vulnerable time. Not only are patients still clinically vulnerable, but they are often mentally and emotionally compromised. Failure to properly manage their conditions during this period can lead to lack of adherence to the discharge plan, adverse events and missed opportunities to minimize complications. Any one of these issues can cause preventable readmissions, which are a major cost driver and an indication of poor coordination and quality of care.

While a post discharge follow up appointment with a primary care physician is critical, this visit alone is often not enough to prevent readmission. A multidisciplinary care-team approach is needed to address a patient’s medical and social conditions that can lead to readmission.

A retrospective review of Medicare fee-for-service claims conducted by Jencks, et al., found that one-fifth of Medicare beneficiaries discharged from hospitals were readmitted within 30 days, and one-third were readmitted within 90 days. While some of these hospital readmissions are planned and others are related to the follow-up treatment for specific conditions, Medicare beneficiaries are being increasingly readmitted for avoidable conditions indicative of poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. The Medicare Payment Advisory Commission estimated Medicare costs of approximately $15 billion due to readmissions, $12 billion of which is for cases considered preventable.

Mission
The mission of TAACT is to optimize an organization’s capacity to reduce readmissions. Through the TAACT Collaborative, CQC and its faculty work with organizations to develop team-based coordinated care models that reduce readmission rates by improving post-hospital discharge care.

Goals
The overarching goal of the TAACT Collaborative is to reduce an organization's 30-day readmission rate by at least 20%, by developing better systems for addressing complex patient issues including medical, social, physical, and mental in the post-discharge setting. Organizations will:

- Have developed and implemented a clear, tested strategy for improving the post-acute care of patients, and have developed a mechanism for monthly tracking and measurement of readmission rates.
- Have a plan to spread their improvement beyond their pilot population to more widely achieve scale.
Objective

Reduce 30 day preventable readmission rate by 20% compared to baseline

Primary Drivers

Outpatient Care Team Delivers Appropriate Care

Change Concepts

Patient Population

Structure

The Delivery Model: How will your multi-disciplinary post-discharge team function? Examples of different models

The Care Team: Who should be involved, and how? Suggested participants, roles, structure

Readmission Risk Assessment: How are patients assessed for readmission risk? Tools, and stratification ideas

Patient Assessment: How are patients assessed for activation? PAM tool

Coordination Care

Division of Responsibility: Who are you connected to? Clarified roles of hospital, health plan, physician organization and other community services

Discharge Transition: How does the transition from hospital to out patient care occur?

Medication Strategy: Ideas for med. Rec., adherence strategies, and pharmacy involvement

Post Discharge Appointments: Post-discharge team appointment within 2-7 days of discharge.

Home Strategy: Benefits and components of home care for select patients

Patient Self Management

Knowledge of Red Flags: Tools to help patients recognize symptoms that may signal a need for medical attention

Medication Self Management: Communication, processes, and patient support to ensure medication adherence.

Personal Health Record: Appropriate use of health and provider information that is kept by the patient or caregiver.

Community Resources: Helpful materials for patients and caregivers, information for available community resources

The Community

Program Components

Foundation for Success

Root Cause Analysis

Aims / Goals

Leadership Structure

Measurement

Action Periods

Pilots / PDSA

5 Whys

Teach back

Spread

Sustaining Improvement
Resources

**Primary Driver:** Outpatient Care Team Delivers Appropriate Care

### Change Concept: STRUCTURE

The first step in developing an ambulatory care strategy is to determine what is needed, the resources available, and what model makes the most sense for your particular organization, culture, partners, and patients. Many of these considerations are at the foundation of your strategy, with the structure of your program or strategy as a key starting point.

### Program Component: The Delivery Model

Several models have been implemented successfully in different settings. Two of the most common models include a post discharge clinic model where patients see a multi-disciplinary team in a single physical location; or, a virtual model which includes the same team of caregivers who, in collaboration with a PCP, provide their services individually via various modes. Hybrids and other models exist as well, so please use these resources to help determine what model would make the most sense for your organization. Please also use your fellow collaborative participants as well as faculty as resources for developing your model.

**RESOURCES & TOOLS:**

#### Models:
- A centrally located coordinated team,
- A virtual team,
- Better coordination of multiple existing care management programs, or
- A longer term strategy of developing a medical home for complex patients

#### Examples:
- Greater Newport Physicians schedules high-risk patients for visits to a special care clinic staffed by a hospitalist, care manager, pharmacist and social worker for post discharge care before patients return to their PCP.
- Monarch HealthCare started with a post discharge clinic but found high no-show rates which drove development of their Senior Touch program of home care by a Geriatric Nurse Practitioner and Social Worker.
- Sutter Health has an established team to manage home-based care for complex patients and is simultaneously piloting a Medical Home office based approach.
- Brown & Toland blends a variety of programs based on patient needs including a physician –led team for home based care of complex patients.

*Scaling Up: Bringing the Transition Care Model Into the Main Stream* - Naylor, M., Sochalski, J.

*The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses* – Brown, R.
Program Component: The Care Team

The heart of the transitional care approach involves creating a multi-disciplinary team of care givers to address the variety of needs that high-risk patients often have. The following is a list of recommended participants on this team and a brief description of their role.

- **Physician** – In a medical home model, the patient’s PCP is the lead physician on the care team. In the case of a special care clinic, a single provider might lead the special care team before transferring care back to the patient’s PCP. This role might be filled by a hospitalist from an area hospital who has knowledge of the inpatient system and patient population. It may also be a physician dedicated to the post-discharge clinic.

- **Nurse Practitioner / Physician Assistant**: An NP or PA can be an enhancement or an alternative to staffing a physician in a special care clinic. These clinicians can manage much of care needed by your patient population; however, access to a physician is ideal.

- **RN Case Manager/Transitional Care Manager** – The Case Manager is responsible for facilitating patient transitions from the inpatient setting, through their coordinated outpatient care, and to home.

- **Pharmacist** – In addition to performing medication reconciliation, the pharmacist can assist the physician in managing medications related to chronic disease management. In existing models it is becoming more and more apparent that a pharmacist is vital to the transitional care team.

- **Social worker** – Coping with the “social determinants of health” may be even more important than clinical issues in preventing readmissions. A social worker can work with patients to jointly plan how to mitigate these barriers and to facilitate the connection with community resources.

- **Behavioral Health** – Collaborative management of depression with various models for integrating behavioral health providers with primary care has proven effective (Katon, “Collaborative Management of Late Life Depression in a Primary Care Setting”, *JAMA*, 2002.)

- **Community and Patient/Consumer Partners** – Patient input and participation in developing and guiding implementation of the program can be critical in ensuring processes and outcomes satisfy the most important constituent of the program.

- **Hospital discharge planner** – A presence by the medical group in the hospital might be necessary to ensure that relevant bi-directional information flows between the inpatient unit and the outpatient provider not only at discharge but also on admission and throughout the hospital stay, that qualifying patients are successfully identified, and that appropriate follow up visits are scheduled before they are discharged.

**RESOURCES & TOOLS:**

Greater Newport Physicians employs a team of hospitalists which also rotates into the special care clinic to better promote care continuity and ensure effective communication between settings. Dignity Health put in place collaborative practice agreements including standing orders so that pharmacists can adjust medication for long-acting insulin and cholesterol management.

- Assessing physician champion’s potential for success (Appendix F)
- CHCF reports on building teams in primary care

**Change Concept: PATIENT POPULATION**

In order to start trialing a new process or concept, you must identify your target population and build a registry containing relevant information about the individuals in that target group. This section describes
what you need to first assess which patients you should include, and second, various tools to provide 
you information on patient status, activation, and risk once you target population is identified.

**Program Component: Readmission Risk Assessment**
Coordinate with hospital and community partners on selecting or developing a risk stratification tool 
(based on age, diagnosis, history of acute care utilization, transitioning into palliative/hospice care, 
homebound, polypharmacy, Patient Activation Measure) to identify hospitalized patients at high risk for 
readmission.

- Starting on Admission, establish bi-directional information exchange between ambulatory and 
hospital staff.
- Establish protocols for identifying target patients while still hospitalized and connecting them to 
your initiative.
- Develop a tracking mechanism to maintain pertinent patient information from admission 
through the 30 day period following discharge

**Minimum requirements are:**
1) Notification of admission and discharge
2) Transmission of discharge summary and plan to ambulatory team at time of discharge.

**RESOURCES & TOOLS:**
There are a number of medical conditions which are used to define preventable 
readmissions:

- [2012 LTQA White Paper](#)
- LACE is one of the most common tools used 
  CQC tips for the identification of high risk patients.
- Assessment and stratification tool (Humboldt)
- The Patient Activation Measure (PAM) gauges knowledge and confidence in self-
  management. The PAM has many uses including stratification: chance of readmission is 
  12% for more activated and 28% for less activated patients.

**Program Component: Patient Assessment**
Once a patient becomes a part of your trial or program, there will be a number of assessments you need 
to complete in order to address the potential myriad of needs they’ll have; from medical, to physical, to 
social.

**RESOURCES & TOOLS:**

- [Geriatric Depression Scale available for iPhone or Android](#)
- Assessing and addressing health literacy
- Consider use of Patient Activation Measure (PAM) Available through 
  [www.InsigniaHealth.com](#);
- [Depression Screening using PHQ-9](#)
- For patients with complex chronic conditions, consider adverse childhood events. See: 
  [http://acestudy.org/](#)
- The Engagement Behavior Framework describes the critical role of assessing patient ability 
to participate effectively in their care.
Change Concept: COORDINATING CARE

This section provides information on a variety of action oriented interventions you might consider adopting for your model. These interventions have been tried and are viewed as best practices for reducing readmissions in an ambulatory care setting. Ideally some element of each intervention will be implemented into your practice in order to provide the most comprehensive care for your identified patient population. There may be different strategies to implementing these, however, an effort to address each is highly recommended.

Program Component: Community Connection

Developing relationships with community partners is a crucial element of a successful ambulatory care program. From local hospitals to SNFs, home health agencies, pharmacies, health plans, provider groups, social service agencies (meals on wheels, transportation, etc.).

A starting point would be with area hospitals to develop the Discharge Communication Plan and a standardized process for transferring patient discharge summaries in a timely and consistent manner. This might involve designating a team member to initiate daily contact with hospitals to obtain and act on information about newly discharged patients. This will be covered more in section B. Information.

- Engage skilled nursing facilities to better assess when to re-hospitalize patients.
- Coordinate with other transition care programs in the patient’s community including programs run by the hospital or care transition coaching by Area Agencies on Aging and social services such as transportation and Meals on Wheels.
- Partner with care management staff from Health Plans; evaluate whether efforts are duplicative and whether a better division of effort is possible.
- Engage with Primary Care Physicians to educate them on the scope of your transitional care plan. Develop a communication plan for management of shared patients.

Program Component: Discharge Transition

- Coordinate and decide who (Hospital, Physician organization, Community Based Organization or Health Plan) will call patients within 48 hours of discharge to ensure that medications were received and educate patients/caregivers on red flags and managing their condition. (This is an important step – patients may receive several confusing follow-up calls if they are not coordinated carefully between hospital, medical group, and health plan).
- Review patient information and anticipate the needs of the patient prior to post discharge visit including defining “red flags” that would alert the patient and/or caregiver to seek help before planned follow up.
- Remind patients to bring medications to follow-up appointments for reconciliation. Use “Teach Back” process (Tool in “Foundations” section) to close understanding gaps between providers, patients and caregivers.

Program Component: Post Discharge Appointments

- Schedule an outpatient appointment upon discharge, to occur within two to seven days. Using the virtual model, this might be with the PCP, or at the special care clinic if that model is in place.
- Determine which patients will be called, who will do the calls and when the calls will occur.
  - Gather information from these calls to find trends that can inform your readmission team. For example, repeated questions about medications may guide your team to develop different education materials or processes.
• Anticipate high no answer rates for calls. Patients and caregivers tend to answer calls from a clinician they met in the hospital. Determine if patterns occur with unanswered calls, e.g., time of day, location of patient, level of activation.
• Maximize the continuity of post-discharge calls when possible.
• Consider medication reconciliation for low or moderate-risk patients by phone. Pharmacy technicians can also support home medication reconciliation.
  o Determine which patients require a home visit, who will do the visits and when they will occur. Review home health referrals.
  o Review home health readmission patterns to determine opportunities for focused interventions.

**Program Component: Home Strategy**
The mix of office and home care will vary with each patient but many will profit from a home visit to assess the how well the discharge plan matches available resources. Home-confined patients will need special attention. Assessment should include specific accounts from the care team, patient and family caregivers.

- Provide education on medication, red flag symptoms and disease state at appropriate level of health literacy.
- Assess level of patient/caregiver activation
- Coach patients on becoming an active member of the care team.
- Naylor and Sochalski have documented that the critical features that produce significantly lower hospital readmissions included in-person contact with patients and family caregivers and a coordinated interdisciplinary team approach to managing and delivering care which may be best accomplished in the home.

**Program Component: Medication Strategy**
Perform medication reconciliation. Reconcile physical bottles by either instructing patients to bring them in, over the phone or during a home visit. Consider enlisting a pharmacist in the care team to perform this function and establish a standard protocol for communicating with the physician when adjustments are needed.
- Send patients home with a reconciled medication list.

**RESOURCES & TOOLS:**
- Consider use of Patient Activation Measure (PAM)
- CQC Patient Engagement webinar by Team Up for Health groups
- Medication list for patients
- Advanced care planning tools from Interact II
- Medication Management
- Resources for Improving Medication Adherence in Older Adults

**Primary Driver:** Patients and Care-givers Adhere to Plan

**Change Concept: PATIENT SELF-MANAGEMENT**
Develop standard processes and competencies for engaging patients in their care, checking understanding and ensuring patients have the skills and confidence needed for self-management. This is a combination of education and coaching ensuring that the resulting care plan reflects the patient’s values and preferences as well as accounts for their home circumstances and barriers. Keys to success are: knowledge of medications and early warning signals; knowing what to do if these signals occur and
knowing what to do if they have any questions. In some cases, the patient is neither the primary caregiver nor the primary learner. Identify who provides the care for the patient, including multiple caregivers, and target self-management skill development to them. (HRET)

**Program Component: Knowledge of Red Flags**

Patients should understand when their condition begins to worsen and from whom and how they should obtain assistance. When patients have this level of understanding, they can obtain assistance early and thereby prevent urgent and emergency medical needs. Some patients understand when red flags occur but lack the assertiveness or problem solving skills necessary to navigate the ambulatory process, especially if their doctor is not available. (HRET)

*Options:*
- Develop patient-centered diagnosis and symptom educational tools that use health literacy concepts.
- Consider tools that are easily accessible such as wallet cards, refrigerator magnets, etc.
- Keep red flag messages simple to understand.
- Determine the patient and caregiver’s familiarity with managing red flags and steps to find help to resolve the problems. Script system navigation steps when appropriate.

**Program Component: Medication Self-Management**

Upon discharge, each person needs to know which medications they should take, the purpose for the medications and their clinical condition, and an easy-to-use system for obtaining and taking their medications. Medication management issues are a significant driver of avoidable readmissions. (HRET)

Medication education:
- Educate patient regarding: each medication, need for medication, and method of obtaining and taking medication once discharged. Simplify instructions to the extent possible.
- Provide clearly written medication instructions using health literacy concepts. Pictures of medications that accompany easy to understand text can help some patients.

**Program Component: Personal Health Record**

Make the patient a key source of his/her clinical information. Develop a patient-centered record that is used by the patient to manage their care and used by the patient to communicate with their clinical providers. (HRET) Develop written materials for patients or caregiver to use that documents the discharge plan and provides appropriate provider contact information.

**RESOURCES & TOOLS:**
- **POLST** can better ensure that patient wishes regarding end of life treatment are followed.
- **10 facts physicians need to know about POLST**
- **Sample tests of health literacy** using “teachback” as a tool for improving provider-patient communication.
- **CQC Self-Management Change Package** – includes training resources
- **Resources for Improving Medication Adherence in Older Adults**
- **Online Personal Health Record**
**Change Concept: THE COMMUNITY**

Many, more vulnerable patient populations may benefit from additional resources. In most communities there is a wealth of resources; however, it is often difficult or impossible for our high-risk patients and care-givers to know how to access those resources. Developing a comprehensive list of names and phone numbers, websites, and contacts that you can provide your patients is a step in the right direction. (HRET)

**RESOURCES & TOOLS:**
- No Place Like Home provided by HSAG
- Area Agencies on Aging
- War Era Veterans provides $1-2,000 per month for those spending over 50% of monthly income on health and cost of Senior Living Community counts.
- Alzheimer’s Association
- MedicAlert register for a nationwide emergency response service for individuals with dementia who wander.
- How To Leverage Community Partnerships
- Working With Consumer Representatives (Free registration required)

**Foundation for Success**

For large scale improvement to take place and be successful, it is necessary to have a strong foundation on which to build the model. The foundation should include fundamental understanding of the process and components of change, strong leadership to lead the improvement, goals to guide the improvement, techniques to monitor progress, and the resources to sustain. The following section contains information and tools to help build this foundation, both as it relates to the TAACCT Collaborative and to improvement in general.

**Assess Internal Strengths:**
- Identify providers who recognize the need for change. Usual care will not meet the needs of patients with complex conditions.
- Consider other organizational problems that a readmission initiative can solve. Can provider workload be reduced by centralizing some care coordination duties? Can disease-related education of patients with complex care needs be improved?
- Consider how pre-established services can be utilized. Can home visits be made more accessible for homebound patients at high risk for readmission?
- In order to better manage these patients, provider access must broaden to encompass a team which can coordinate patient care across multiple health care settings.
- **Develop a business case that will work with your payer mix and population need.** Among fully capitated members, there is a strong financial justification to invest in services that reduce acute care utilization. Additionally, some payers will reimburse for care coordination activities or offer pay for performance initiatives on related metrics. Evaluate your patient population for additional reimbursement opportunities and cost savings which will make transitions of care investments financially viable.

**RESOURCES & TOOLS:**
- 10 Essential Steps to Effectively Engaging Physicians
- Care Coordination Model
**Establish Aims / Goals**

Consider how a readmission initiative can address quality metrics which are already used to evaluate provider performance in your organization (e.g. patient satisfaction, meaningful use measures, IHA Pay-for-Performance metrics, and disease management targets).

**RESOURCES & TOOLS:**
- SMART Goals
- Aim worksheets & Instructions

**Establish a Measurement Plan**

A formal measurement system is the only way to determine whether or not your changes resulted in improvement. Your measures will reflect your overall success as well as individual changes made during action periods or PDSA cycles. Outcome measures are important because they track outcomes related to your aim. Performance measures are also useful for tracking specific elements of your change and should be used as indicators of success but are not an absolute reflection of success.

- Gather baseline data prior to starting the intervention and chart data over time on run charts
- Consider the following sample measures and refine based on data availability:
  - Percent of patients identified as high risk
  - Percent of readmission cases identified as preventable in root cause analysis
  - Number of hospitalized patients who are discharged with a follow-up appointment
  - Number of post-discharge follow up appointments which have access to hospital discharge summaries
  - Percent of patients who attend their post-discharge appointment within seven days
  - PAM (Patient Activation Measure) score on admission and at 30 days post discharge
  - Patient satisfaction or risk avoidance impact scale
  - Provider satisfaction
  - 30 day readmission rate
    - for selected diagnoses
    - for patients from a given hospital
    - as a population-based rate for the medical group

Successful measurement plans will also include process and balance measures. Process measures are those that focus on the activities that being improved or implemented. The following are examples:

- What proportion of post hospital patients are seen by the transitional care team?
- What proportion of appointments was kept?
- Percent of discharged patients who received a phone call within 48 hours

Balance measures are those that focus on activities that should not show a negative side-effect to the rest of the organization.

- Did any patient file a complaint because they were seeing someone other than their primary care provider?
- Was there any gap in care caused by lack of continuity with usual care?

Monarch HealthCare provides PCPs and readmission reduction team members with monthly dashboards on quality metrics and appropriate acute care utilization.
- PAM can be used to stratify patients on admission and again at 30 days post discharge as an outcome measure.

**RESOURCES & TOOLS:**
- Sample data collection and measurement plan
- Run chart resources
- Resources for measuring the effectiveness of your intervention
- National Quality Forum Specifications for the Three Item Care Transition Measure (CTM 3)
- TAECT Measurement Workbook

**Note:** Both readmission rates as a function of discharges and as a function of member months are calculated by IHA for physician organizations in California for the Commercial Population based on 2011 data. In California HMO populations, these two ways of measuring are highly correlated.

**Develop Pilots & PDSA**
- Developing a project plan that includes testing new processes in test mode
- Pilot intervention with hospitalized patients from a limited number of physician offices to demonstrate proof of concept and build organizational support.
- Identify hospitalized patients from designated physician offices.
- One of the core elements of an effective quality improvement strategy based on the plan/do/study/act cycle, is to pilot every element of the work plan with small tests of change.

**RESOURCES & TOOLS:**
- 10 Essential Steps to Effectively Engaging Physicians
- Sample diagnostic worksheet to identify pilot practices

**Plan for Spread & Sustain Improvement**

Include sustainability planning throughout implementation

- Changes that are effective should be incorporated into everyday work.
- Continue to measure initiative indicators
- Communicate results to all stakeholders – celebrate success!
- Conduct training to address slippage

Build champions and encourage communication through social media. Primary characteristics of physician champions:

- Wide peer and social network and knowledge of how his/her colleagues interact with each other
- Perceived as credible and is respected by peers
- Highly knowledgeable and stays connected to his/her area of expertise through a variety of sources
- Willing to share knowledge with others
- Willing to support and advocate for process changes
- Willing to implement new guidelines and serve as a resource for others
- Easy to interact with, welcomes contact by others, makes time to attend to their issues and shows an interest in their views
- Is flexible and controlled in the face of stress, leading others by example

Is not afraid to speak his/her mind or of trying to influence others, but does so in a way that respects the personal boundaries of others.

RESOURCES & TOOLS:
- Sustaining improved outcomes toolkit
- Spread strategies presentation by Tammy Fisher, MPH
- Assessing physician champion’s potential for success (Appendix F)