Using Health IT to Improve Care Transitions

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A Personal Story

What was inside the envelope?

- Face sheet
- Three medication monographs

What was NOT inside the envelope?

- Current medication list (8 medications)
- Any orders
- Discharge summary
- Lab results
- Radiology reports
- Care plan or goals
Transitions are Critical!

Transitions of care where appropriate information is sent to the receiver had (caretransitions.org):

• Significantly less likely to be readmitted
• Saved money ($300,000 for 350 patient panel over 12 months)

Meaningful Use Stage 1: Try something!
Meaningful Use Stage 2: Do something!

Source: http://www.caretransitions.org
Stage 2: **Do Something!**

**Core Requirement 12 Objective:** “The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a **summary care record** for each transition of care or referral.”

Objective is so important, it has three measures!
Transitions of Care: Measure 1

“The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.”

Note: The word “electronic” is not used here...
Transitions of Care: Measure 2

“The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) **electronically transmitted** using CEHRT to a recipient or (b) where the recipient receives the summary of care record **via exchange facilitated by an organization that is a NwHIN Exchange participant** or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.”

**Note:** “Another setting of care or provider of care” includes lots of things...
Transitions of Care: Measure 3

“The eligible hospital or CAH must satisfy one of the two following criteria:

• Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" (for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or

• Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.”

Note: Can’t just exchange within your network if they are all using the same EHR...
Transitions of Care: What is it?

“Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all discharges from the inpatient department and after admissions to the emergency department when follow-up care is ordered by an authorized provider of the hospital.”

Note: Internal transitions will usually not count...
Care Transitions - Where do they go?

Measure 1: > 50% of transitions or referrals to another setting of care get a summary of care record

Measure 2: > 10% of transitions or referrals to another setting of care get a summary of care record transmitted electronically
The summary of care record has now been clearly defined:

- Patient Name
- Referring provider’s name and contact information
- Procedures
- Encounter diagnosis
- Immunizations
- Lab results
- Vitals (height, weight, BP, BMI)
- Smoking Status
- Functional Status
- Demographic Information
- Care plan w/ goals
- Care team
- Discharge Instructions
- Reason for referral
- Current problem list
- Current medication list
- Current allergy list
Challenges

Many are not participating in Meaningful Use
• LTC
• Homecare/Hospice

HIEs are still in their infancy
• Technologically
• Functionally

Has not been a focus, so limited engagement
Networks are the answer!

Shared Services
• HIE’s and PHR’s
• ACO-driven exchange

Community-based approach
• Around PHR with HIE behind it

Work with EHR vendors
• If no centralized approach, portals can be effective
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Care Transition: What is it?

“…the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness” (Coleman, 2007).

“…a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location” (Coleman & Boult, 2003).

“The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another” (CMS, 2010)
Are we in agreement?

The patient is the only constant in care transitions?

It’s true:
6 Potential Areas for Improvement

- Improve communications during transitions between providers, patients, and family caregivers.
- Develop standardized processes for EMR use, including medication reconciliation.
- Establish points of accountability for sending and receiving care.
- Increase use of case management and professional care coordination.
- Expand the role of the pharmacist in transitions of care.
- Implement payment systems that align incentives and include performance measures.
Some Care Transitions Programs

• University of Colorado School of Medicine: Care Transitions Program

• Community-based Care Transitions Program (CCTP)

• National Transitions of Care Coalition (NTOCC)

• The Joint Commission Transitions of Care Portal
# Where are Care Transitions in Stage 1 & Stage 2 MU?

## Stage 1 MU
- Electronic copy of discharge instructions/health information (C12/EPC12)
- Electronic exchange of clinical information (C13/EPC14)
- Medication reconciliation (M6/EPM7)
- Transition Care Summary (M7/EPM8)
- Clinical Summary in 3 days (EPC13)

## Stage 2 MU
- Replaced with: Provide ability for view, download, transmit for patients (C6/EPC7)
- Eliminated for Stage 2
- Medication reconciliation is now CORE (C11/EPC14)
- Now CORE (C12/EPC15)*
- Now only 1 day (EPC8)
Stage 1 to Stage 2 (EPs only)

- Patient electronic access (M5)
- Eliminated for Stage 2
A close “family member”: Patient Centered Medical Home (PCMH)

- **PCMH 1**: Enhance Access and Continuity
- **PCMH 2**: Identify and Manage Patient Populations
- **PCMH 3**: Plan and Manage Care
- **PCMH 4**: Provide Self-Care and Community Support
- **PCMH 5**: Track and Coordinate Care
- **PCMH 6**: Measure and Improve Performance
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Stratis Health Projects

• HITPAC (Health IT for Post Acute Care)
  – 1-year project
  – Purpose: Assist nursing homes in HER adoption and optimization
  – Focused on transitions of care and medication management processes
  – Goal: accomplish HIE between nursing homes and hospitals
The **RARE** Campaign (Reducing Avoidable Readmissions Effectively)

A campaign across the continuum of care to reduce avoidable hospital readmissions across Minnesota

- Led by: Institute for Clinical Systems Improvement (ICSI), Minnesota Hospital Association (MHA), and Stratis Health

5 Key Areas Known to Reduce Avoidable Readmissions:

- Comprehensive discharge planning
- Medication management
- Patient and family engagement
- Transition care support
- Transition communications
RARE Results to Date

- 82 hospitals
- 75 Community Partners across the care continuum
- 3,128 readmissions prevented (13% reduction)
- 10,000 more nights of sleep in their own beds

Each person represents 250 prevented readmissions, and 1,000 more nights of sleep in their own beds for Minnesotans
Improving Transitions of Care

- RARE addresses hospital side
- Community-based approach
- Goal: To engage providers across the continuum of care to build an effective community coalition that will improve care transitions and reduce hospital readmissions
- Lasts through 2014
Thanks for your time & attention!
References


References, cont.

Key Health Alliance—Stratis Health, Rural Health Resource Center, and The College of St. Scholastica.

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