MED Minutes Podcast Transcript – Series 2: Care Transitions
Role of the Community Physician Office

Lynne: Hello, this is Lynne Chase from the New England QIN-QIO. Thank you for joining today's podcast. Our topic for today is care transitions and the role of the community physician office. I'm pleased to have Dr. Rebekah Gardner with me today. She is a senior medical scientist at the New England QIN-QIO and Assistant Professor of Medicine at Alpert Medical School of Brown University.

Rebekah: Thank you Lynne. It's a pleasure to be with you.

Lynne: Care transitions have gotten a lot of attention from policy-makers and researchers in the last few years. Can you start us off by telling us how you define the term "care transitions?"

Rebekah: Sure. A care transition is when a patient moves between clinicians and treatment settings as their condition and health care needs change. Typically, people think about the transition between the hospital and home, but care transitions are much larger than that and include patients transitioning between their home and the emergency department, or a skilled nursing facility to their home.

We tend to focus on the healthcare we provide in our settings, but regardless of whether it's a hospital or office, 99 % of the time, it's the patient and their families directing their own healthcare in their own homes. Often on their own, what pills they should or should not take. Deciding how to manage acute problem, how to interpret a symptom. And often they represent the only thread of continuity between settings.

Lynne: Patients have been getting discharged from the hospital forever. Why is there all this attention to the issue now?

Rebekah: There are several reasons why care transitions are such an important issue right now. Until about ten or fifteen years ago, patients were generally cared for in the hospital by their regular internist or family doctor. So the doctor knew the patient well when they came into the hospital and then would be caring for them right when the patient got out of the hospital. There was not a need to transfer information to another physician either coming or going. Also the doctor could see the patient right away after discharge, would have a pretty good idea of how well this patient was going to be able to manage at home, and could perhaps even check in at their house.

Well over the last decade so, there fewer and fewer family doctors or internists who take care of their own patients in the hospital, for a variety of reasons. So the doctor taking care of the patient in the hospital has never met the patient before and knows nothing about them, and the patient's regular doctor may have no idea that one of their patients is in the hospital.

Lynne: I can see why that could be such a big problem. What other factors are having an impact?

Rebekah: Another big factor is an awareness by Medicare and others of just how often patients are getting readmitted to the hospital after being discharged. And just how much it is costing them.

Lynne: It sounds like a lot of changes were happening all at once in the way healthcare was being delivered in the hospital. I can see why doctors and patients were not quite prepared to manage all those changes. What sorts of signs were there that there was a problem? In other words, how can we tell if a care transition does not go well?

Rebekah: You know a care transition has NOT gone well when patients and their families do not feel prepared to manage the patient's care at home or where ever the patient is going next. It hasn't gone well if the physicians and nurses who will be caring for that patient do not have the information they need to pick up the care of the patient right away and to answer any questions the patient may have. A care transition has not gone well if the patient and their healthcare team don't know what tests are still pending or what work-up still needs to happen, what specialists they might need to see, or what medications might have changed. And it has not gone well if the patient and their family feels that their preferences were not taken into account when the discharge planning was happening.

Lynne: That sounds frightening for the patient and their families.

Rebekah: I agree Lynne. It's not just the delayed diagnoses and delayed onset of appropriate treatment, or the medication errors, or the duplication of testing. Most importantly, it is really burdensome for patients. It's a stressful time for patients and their families. A readmission to the hospital is very discouraging, stalls recovery, and decreases patient satisfaction. It's also really expensive for patients, not just the healthcare system. They see higher medical bills and more missed work for them and their caregivers.

Lynne: Unfortunately, readmissions are common

Rebekah: That's right, really common. And for older adults, about 20% have one or more transitions a year. About half of those are simple—going from the hospital to home, for example, but for the other half, it's a lot more complex, sometimes 6 or more transitions in a year.

Lynne: Dr. Gardner Besides having a patient's own doctor care for them in the hospital or letting them stay longer, what else can be done to help patients transition out of the hospital, or any other healthcare setting, more safely?

Rebekah: First and foremost, it's important to recognize patients and/or their caregivers as critical members of the health care team, and we need to prepare them accordingly. They need to know about their medical conditions, all their medicines, red flags, which might prompt them to seek care earlier than what's already been scheduled, and they also need to understand how important it is to follow up with their doctors.

After that, it's about communication – connecting with the other providers, the PCP is critically important here.

Lynne: The community physician seems like a critical player in transitions; what role do you think they have?

Rebekah: Yes – the community physician has an essential role and can help guide transitions to make them safer and smoother. As part of our work with the QIO, we develop best practices for physician offices around communications during care transitions. So for example, when a PCP sends a patient to the emergency room department for an evaluation, they should also send summary clinical information to the clinicians in the ED. And if the ED or hospital physician calls the office with questions about the patients, we need to make sure there is a system in place in the office so that they can get answers to the inquiries promptly and get the information they need.

Certainty outreaching to high-risk patients via phone after ED or hospital discharge is very important, and this can pick up a lot of potential problems earlier than they might have been noticed.

And everyone's favorite activity, timely medication reconciliation plays an important role here, both in the initial outreach and again when you see the patient in the office after discharge.

Lynne: The additional outreach sounds great but is it reimbursable?

Rebekah: Not all of it- but Medicare has created CPT codes for Transitional Care Management Services which can be used. These are generally based on the complexity of the medical decision making, required for a particular patient, and they require a face to face visit within a specific time frame, depending on which code you are using.

As all offices know, coding can be very tricky and it might be helpful to review a detailed reference or to seek out assistance from your local QIO.

Lynne: A supplemental communication sounds fantastic, certainly necessary – but is it sufficient?

Rebekah: You're right- communication is a two –way street so the other care settings have reciprocal best practices for communicating during these care transitions. We have established best practices for hospitals, Emergency Departments, Urgent Care Centers, Nursing Homes and Home Health Agencies. These are on the NE QIN-QIO website.

Setting standards is just a first step, but incorporating them in a meaningful way is much more challenging work.

Lynne: There is a lot of great work being done in this area. How are researchers and others measuring if their work is successful?

Rebekah: That's such an interesting question, because you can look at this in so many different ways. You could look at it purely from the patient level—how ask the patient how they

felt about the discharge process through HCAPS questions or other tools. You can call the patient and assess their knowledge about the admission and the need for follow up.

Or you can measure things from the physician perspective—survey your community doctors or your nursing home clinicians and ask if they are getting the information they need to take care of the patients that are coming to you.

The way it's most commonly done, however, is by calculating a readmission rate to measure how well care transitions are going in a particular population of people. Most of the time it's a percentage with the number of readmissions in numerator and total number of admissions in denominator. Another way, and one that's actually better, is the number of readmissions per 1,000 people in a population.

Even better is not just looking at admissions, but including observation stays and ED visits. We can also look at the costs incurred after a hospitalization, and that's a nice way to measure utilization as well.

Lynne: We know that Medicare looks very closely at readmission rates. You can go to their Hospital Compare website and see all the numbers for a particular hospital.

Rebekah: That's right. They started with readmissions that occurred within 30 days of a hospital stay for a heart attack, heart failure, or pneumonia. Then they added COPD and hip and knee replacement surgery, and then stroke and cardiac bypass readmissions. A hospital's overall readmission rate is there too.

Lynne: And they're not just keeping track of readmission rates, are they? Can you tell me more about the payment adjustments that some hospitals are facing, based on those rates?

Rebekah: Absolutely—this is a really important policy change that has had a big financial impact on hospitals. Since October 2012, Medicare has been running its Readmissions Reduction Program, which reduces its payments to hospitals that have what they describe as excess readmissions. At this point, this can mean a reduction in payment of up to 3%. They do risk adjust somewhat, to account for differences in patient characteristics like age, gender, medical history, and other diseases or conditions that might make a readmission more likely. There has been some pressure to also account for socioeconomic factors in the risk adjustment, but so far these have not been included.

Lynne: Unfortunately the financial impact won't be limited to hospitals much longer; physician offices will soon be penalized for high readmission rates. The Value-Based Payment Modifier Program, which evaluates provider performance on the quality and cost of care they provide to their Fee-for-Service Medicare beneficiaries, incorporates a risk adjusted 30-day All-Cause Hospital Readmission measure along with other quality measures.

Knowing this is coming, what would you recommend an office do to prepare.

Rebekah: As we move from fee for service to value based payment- more & more clinicians are focused on improving care transitions. To get started- I recommend reaching out to

other local providers, with whom you share patients, to establish expectations and standards for communication so that clinicians receiving your patients always have the info they need to assume responsibility for the patient's care.

Lynne: Dr. Gardner, thank you for chatting with us today about this important topic. I would also recommend that if our providers don't know where to begin, they can reach out to their local QIO. All QIOs are working with providers across the continuum to improve care coordination and reduce unplanned utilization.