

The Policy Landscape and Transitions of Care

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Health Care Needed A Transformation

The Current Process Is Not Working

The Vision

Critical Business Issues ?

Needs

Optimum Health

Gaps

"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"

Fragmentation & Silo's of Care
Growing Cost of Chronic Care
Access to Care Options (24x7)
Inconsistent Approaches
Collaborative Team Practice
Whole Person Care Approach
Transitions of Care Facilitation
Technology Advancements
Regulatory/Gov't Imperatives
Premium Increases, MLRs 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

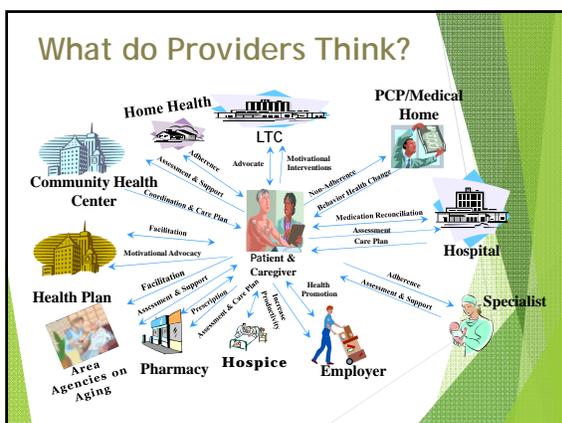
5 Years in - What does the Consumer think?

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

www.blogs.wsi/washwire2015/03/19
www.kff.org/health-reform/poll-finding/



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

<http://www.ntocc.org/Toolbox/ncsse/>

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

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.ca - 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



Development of Care Coordination Measures



- ▶ 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	National Average \$231.11
<ul style="list-style-type: none">• 99495: Transitional Care Management Services with the following required elements:<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 99496: Transitional Care Management Services with the following required elements:<ul style="list-style-type: none">• 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

<http://www.cms.gov/Regaffairs/PDF/2014/11/c14-11-ccm-fact-sheet.pdf>
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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

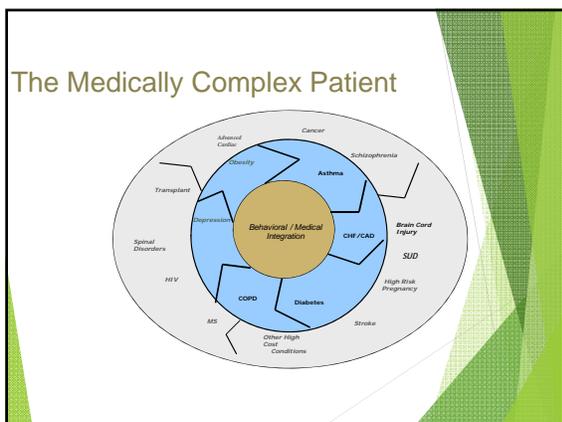
What Can We Do?

- 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 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 - Toolkits www.patientsafety.org
- ▶ NTOCC - National Transitions of Care Coalition - Provider & Consumer Tools www.ntocc.org
- ▶ CMSA - Case Management Society of America - CM Medication Adherence Guidelines & Disease Specific Adherence Guidelines, CMSA Standards of Practice - www.cmsa.org
- ▶ ICM - Integrated Case Management - <http://www.cmsa.org/Individual/NewsEvents/IntegratedHealthManagementTraining/tabid/380/Default.aspx>
- ▶ 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/TOCCPG/index.html>
- ▶ ACC and IHI - Hospital to Home - Reducing Readmissions, Improving Transitions - <http://www.h2hquality.org/>
- ▶ AHRQ - Agency for Healthcare Research and Quality - Questions Are The Answers - www.ahrq.org
- ▶ NASW - National Association for Social Workers - <http://www.socialworkers.org/Resources>
- ▶ VNAA Blue Print for Excellence - www.vnaablueprint.org

Resources for Development Measures

- ▶ The Joint Commission (TJC)- http://www.jointcommission.org/assets/1/18/TJC_Annual_Report_2014_FINAL.pdf
- ▶ Agency for Healthcare Research and Quality (AHRQ)- http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/cmm_atlas.pdf
- ▶ National Quality Forum (NQF) - http://www.qualityforum.org/measures_reports_tools.aspx
- ▶ URAC - <https://www.urac.org/wp-content/uploads/CaseMgmt-Standards-At-A-Glance-10-9-2013.pdf>
- ▶ National Committee for Quality Assurance (NCQA) http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015_93x
- ▶ American Medical Association (AMA) - <http://www.ama-assn.org/apps/listserv/c-check/qmeasure.cgi/submit-PCPI>
- ▶ American Nurses Association (ANA)- <http://www.nursingworld.org/Framework-for-Measuring-Nurses-Contributions-to-Care-coordination>

Questions

Thank You

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