Do You Know Where Your Patient Is? Improving Care Transitions

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Disclosures
- Nothing to disclose

Objectives
- To understand the need for transitions of care
- To demonstrate examples of transition programs that have made a clinical impact
- To suggest some opportunities that dialysis care-givers can have in their patients' transitions of care
Why Implement Changes?

- >75% of Medicare spending occurs in patients with 4 or more chronic diseases. (CBO)
- 25% of Medicare beneficiaries consume 85% of the Medicare expenditures. (CBO)
- ESRD population (0.7% of the Medicare population) consumes 7% of Medicare spending. (USRDS)

Why Implement Changes?

- 70% of American adults believe there is a need for major reform (CMWF 2011)
  - Inadequate access to care
  - Poorly coordinated care
  - Excessive cost
  - Administrative burdens

Why Implement Changes?

- Many of the defects in the current health care system stem from its disorganization (Millbank Q.)
- Poorly coordinated, fragmented care tends to be:
  - Inefficient
  - Ineffective
  - Error-ridden
  - Costly
- An entity charged with coordinating care clearly could have a major impact on the quality of health care
Why Implement Changes?

- Focus of CMS
- Berwick’s Triple Aim
  - To improve the patients experience of care
  - To improve the health of the population
  - To reduce the per capita cost of health care

Examples of Transitions of Care That Have Made a Clinical Difference

Geisinger Medical Center
Danville Campus
What is Geisinger?

- Largest Rural Health Care System in the U.S.
- Approximately 3 million people in service area
  - > 48,000 inpatient admissions/year
  - > 2.0 million outpatient encounters/year
- 900+ Physicians, 450+ Advanced Practitioners
- 60+ Community Practice sites
- 5 Hospitals
- 270,000+ member health plan
- Healthcare IT and Informatics
  - EPIC in Ambulatory Clinics since 1996
  - EPIC in Inpatient Arena since 2007

Geisinger’s Model has Five Core Components

- Patient-centered primary care
  - Patient and family engagement & education
  - Enhanced access and scope of services
  - Physician led team delivered care
  - Chronic disease and preventive care optimized via HIT

- Integrated population management
  - Population segmentation and risk stratification
  - Office based case management
  - Disease management

- Medical Neighborhood
  - Micro-delivery referral systems
  - 360° care systems – SNF, ED, hospitals, H1, etc

- Quality
  - Patient satisfaction
  - Comprehensive chronic disease bundled metrics
  - Preventive Care metrics

- Value-based reimbursement
  - Fee-for-service with P4P payments for quality outcomes
  - Physician and practice transformation stipends
  - Value-based incentive payments
  - Payments distributed on Quality Performance

Embedded Case Management

- Personal Care Link
  - Comprehensive Care Review – medical, social support
  - TOC follow-up – acute care, SNF, ED
  - Direct phone access – questions, exacerbation protocols
  - Patient, family support contact

- Embedded Case Manager
  - High risk patient case load
    - 15 - 20% Medicare
    - 5% commercial
    - 125 - 150 pts per CM
  - 1 CM per 800 Medicare lives
  - 1 CM per 5000 commercial lives

- Recognized Team
  - Regular follow-up of high risk patients
  - Facilitates access – P4P, specialist, ancillary
  - Facilitate special arrangements – home care, hospice, AAA
  - Links health care team to payer

- Not disease management focused
- Focus on those at most risk
- Focus on driving issue within the case
### Results for Nursing Home

<table>
<thead>
<tr>
<th>Nursing Home</th>
<th>Baseline Readmissions 2008</th>
<th>PY 1 Readmissions 2009</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>34%</td>
<td>18.5%</td>
<td>-45.5%</td>
</tr>
<tr>
<td>B</td>
<td>18.5%</td>
<td>14.5%</td>
<td>-21.6%</td>
</tr>
<tr>
<td>C</td>
<td>27%</td>
<td>9%</td>
<td>-66.6%</td>
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<tr>
<td>D</td>
<td>44%</td>
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<tr>
<td>E</td>
<td>42.5%</td>
<td>31%</td>
<td>-27%</td>
</tr>
<tr>
<td>F</td>
<td>27.5%</td>
<td>24%</td>
<td>-12.7%</td>
</tr>
</tbody>
</table>

### Medicare Readmissions

[Graph showing risk-adjusted readmissions per 1,000 population across different years and sites, with comparison between PHN and non-PHN sites.]

### ER stays flat in PHN while un-managed increases

[Graph showing Medicare ER visits per 1,000 population across different years and sites, with comparison between PHN and non-PHN sites.]
Commercial experience to date

Acute admissions also show impact

Cumulative percent difference in spending attributable to PHN

Cumulative percent difference in spending (Pre-Rx Allowed PMPM $) attributable to PHN in the first 21 PHN clinics for calendar years 2005-2009. Dotted lines represent 95% confidence interval. P = < 0.003
Clinical Results
Claims Data 2005-2009

<table>
<thead>
<tr>
<th>Condition</th>
<th>Odds Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation</td>
<td>0.178</td>
<td>0.04-0.66</td>
</tr>
<tr>
<td>ESRD</td>
<td>0.688</td>
<td>0.51-0.91</td>
</tr>
<tr>
<td>MI</td>
<td>1.067</td>
<td>0.99-1.14</td>
</tr>
<tr>
<td>CVA</td>
<td>0.966</td>
<td>0.94-1.02</td>
</tr>
</tbody>
</table>

The ESRD Population and Transitions of Care

Why Transitions of Care is Needed
- ESRD patients are complex
  - ESRD patients at Geisinger
    - Average age 65.9 years
    - 57% male, 43% female
    - See 6.7 different classes of medical providers per year
    - Have 12.7 different prescriptions (not including those given at dialysis)
Readmission Rate – GMC 2010

Reasons for Admission

Top 10 Causes of Hospital Admission for ESRD Demo Patients

- 60% of admissions are in “avoidable” categories

Reasons for Readmission – GMC

- ESRD – 30 days (69 patients; 100 readmissions; 13% of all readmissions)
  - 1. CHF (13%), 2. Sepsis (12%), 3. Access (10%), 4. Arrhythmia (7%), 5. Diabetes (7%) – 49%
- ESRD – 90 days (94 patients; 166 readmissions; 12% of all readmissions)
  - 1. Access (14%), 2. Sepsis (12%), 3. CHF (12%), 4. Electrolyte (8%), 5. General Symptoms (8%) – 54%
Transition Opportunities

- **Vascular access**
  - Patients with CVC for access have approximately a 3 fold increase in annual mortality
  - Patients with CVC for access have an approximately 10 fold increased risk of bacteremia over those with an AVF
  - 3X increased risk in first year of HD
  - Annual cost for patient with CVC is $45-60,000 higher than seen with patients with functioning AVF for access

- **Fluid overload**
  - #1 cause of readmission for ESRD patients at GMC
  - #2 cause of readmission for ESRD patients in LDO-CMS Demonstration Project

- **Medication-related problems**
- Transitions of care/communication
- Dietary-related problems
  - #4 cause of readmission for ESRD at 90 days at GMC
- End-of-Life Care
  - Advanced Care planning
ESRD/CKD Medical Home Documented Results

- LDO/CMS Demonstration Project
- Utilizing a Transition of Care Team
  - 60% reduction in catheters
  - 25% higher medication compliance
  - 35% fewer access related admissions
  - 15% fewer re-admissions
  - 8% lower Non-dialysis costs

Clinical Results

- ESRD Readmission Rates
- GMC Nephrology Group
  - CMI 2.0
  - 30 Day Readmission Rate 12.8%
  - 90 Day Readmission Rate 38.3%
- All Other Providers
  - CMI 2.01
  - 30 Day Readmission Rate 33.0%
  - 90 Day Readmission Rate 49.9%
Transitions of Care

Opportunities for the Dialysis Care-givers

Current Model of Care

Coordination of Care – New Model
Programmatic Design

- A Case Manager(s) would be employed to act as the focal point for transitions of care for ESRD patients.
- The Case Manager will be trained by and provided clinical supervision by the Nephrology practice.
- Case management services will be provided to optimize medical management while hospitalized and to ensure proper care coordination with all appropriate arenas after discharge.

Objectives of Program

- To reduce unnecessary re-admissions and emergency department visits driven by unmanaged and poorly coordinated transitions for patients with ESRD
- Enhance patient and provider satisfaction
- Enhance communication surrounding ESRD patients across the care continuum
- Reduce medical costs by decreasing hospital and emergency department utilization

Coordination of Care – New Model
QIO-Network 4 Collaborative

- Care Transitions Project
  - Between hospitals, nursing homes, and dialysis units
  - Focused on 4 counties in Western Pennsylvania
    - Two hospitals in project
  - Ten dialysis providers in area (2 in project)
  - 430 dialysis patients
    - 51% older than age 65
    - 8.8% older than age 85

QIO-Network 4 Collaborative

- Care Transitions Project
  - To reduce medication and treatment errors
  - To avoid inaccurate or missing rest results
  - To avoid inaccurate or missing physician orders
  - To reduce 30-day readmission rates

- Success dependent on:
  - Breaking down long-established "silos" of care
  - Deepening existing relationships and developing new community partners

QIO-Network 4 Collaborative

- Workgroup identified three major quality care management barriers
  - Cross-setting transition workflow gaps between providers
    - Providers were not completely aware of the cross-setting needs of their patients.
  - Communication disconnects
    - Providers were not aware of the patient specific information required for safe, dignified, efficient care.
  - Lack of standardized, evidence-based documentation across providers
QIO-Network 4 Collaborative

- Cross-setting transition workflow gaps
  - “Hospital staff…had assumed they knew what information was needed by the next care provider to transition care for the ESRD patient. However they learned that their assumptions were short-sighted…”

QIO-Network 4 Collaborative

- Transition Communication Forms were developed specific to the ESRD patient
  - For communication from hospital (or nursing home) to dialysis unit
  - For communication from dialysis unit to hospital (or nursing home)
- Eight week pilot was conducted

QIO-Network 4 Collaborative

- Results of the Pilot
  - Staff adjusted very quickly to the use of the Transition Communication Forms.
  - Staff found the Transition Communication Forms very valuable in the enhancement of care of the ESRD patient.
  - Staff wanted the Transition Communication Forms to be a permanent component of their clinical practice.
- Network 4 Web Site Link –
  - http://www.esrdnetwork4.org/facres
QIO-Network 4 Collaborative

Observations of Pilot

- Cross-setting collaboration is not always easy – but it is possible and extremely important for our ESRD population.
- Cross-setting collaboration takes shared vision, time, flexibility and commitment.
- It is important that all participants have a voice in the development of cross-setting communication tools.
Summary

- The ERSD population is extremely complicated and in need for improved Transitions of Care.
- Successful Transitions of Care Programs have been performed in the ESRD population.
- Opportunities exist for all of us, as dialysis care-givers, to assist in improved Transitions of Care.

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http://www.esrdnetwork4.org/facres

Thank You
Questions?