Learning Topics for Care Transitions
Draft of April 11, 2011
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Framing: In order to make a local care system seamless as patients and clients move around, rather than continuing with dysfunctional silos that fail to coordinate, communicate, or plan, reformers need an array of skills, attitudes, knowledge, and commitment. This list deals with the knowledge – those things that, once known by someone, could be taught to someone else without having to have the direct experience, and which therefore should end up being readily available to new recruits into the work. There are other elements needed – encouragement, story-telling, altered perspectives, expert support, and so on. Here, the list is meant to be reasonably comprehensive but also reasonably manageable, and the aim is to formulate a list for which resources are or could readily be available for "just in time" learning through an on-line search engine that would enable large numbers of people to move along as rapidly as our state of knowledge will allow. We are in the process of developing such a search engine and we hope that such a crossroads of on-line information would keep improving through the contributions of those who gain better insights, more useful tools, or better ways of communicating their understanding.

Major Categories:

A. Understanding current dysfunctions in care transitions
B. Developing and sustaining the commitment to improve
C. Organizing the geographic community
D. Measuring progress
E. Making improvement happen
F. Planning care services across settings
G. Moving information to where it is needed
H. Standardizing the processes
I. Enabling the patient and family to take an active role
J. Enhancing and right-sizing services
K. Fostering professional competencies needed
L. Available support/resources

The Extended Outline

- A. Understanding current dysfunctions in care transitions
  - a. The Gold Standard – negotiated care plans reflecting medical and social situation and patient (and family or caregiver) preferences, carried out across settings and time, with revision and evaluation
    Question is – how far from that are we in this situation, and why?
  - b. Indicators
    - i. Frequency of failed transfers as evidenced by "bouncebacks" – return to ER or hospital within a short time – 3d, 14 d, 30d, etc.
    - ii. Frequency of particular failures in transitions
      1. Medication errors
      2. Pressure ulcers or other injury
      3. Lack or or loss of advance care plan/failure to review and respect plan
      4. Lack of knowledge of "red flags" or what to do when they occur
      5. Lack of planned appropriate follow-up
      6. Inadequate capability or training of caregiver
      7. Inadequate physical setting or skill mix of transition destination
      8. Service duplication and other waste
    - iii. Record reviews
      1. In "sending" setting
      2. In both "receiving" and "sending" setting
    - iv. Patient stories – perhaps building on record reviews and sometimes including interviews of various involved persons as to what really happened.
    - v. Routine reports from "receiving" providers or from patients/family about the adequacy of the transition
- B. Developing and sustaining the commitment to improve – including the business case
  - a. Professional commitment, and chagrin over avoidable suffering/pride in "workmanship"
  - b. Interest in limiting need for new facilities (e.g., as population grows)
  - c. Interest in making the community attractive for new and established businesses
  - d. Interest in reducing low-margin hospital utilization
  - e. Patient and family interest
- C. Organizing the geographic community
  - a. Why geography matters
  - b. The effectiveness of the "trading partners" knowing one another
  - c. The need for social services and often political leaders to be engaged
  - d. The forming of coalitions and the nature of governance
  - e. The challenge of anti-trust
- D. Making improvement happen
  - a. Building on success and leadership
  - b. Testing
  - c. Sustainability

    d. Spread locally
    e. Sharing in regional and national improvement
    f. Finding opportunity for win/win/win between partners and patients/caregivers

E. Measuring progress
    a. Rehospitalization data, measures, challenges, recommendations
    b. Using Medicare (and multi-payer) claims data
    c. Using BRFSS and vital records
    d. Direct measures of transitions – CTM-3 and others
    e. Measures of patient activation
    f. Measures of medication reconciliation
    g. Care plan adequacy
    h. Care plan continuity, evaluation, revision
    i. Monitors of adverse effects – mortality, substitution of services

F. Planning care across settings(and presumably how assessment can serve to drive care planning)
    a. Knowledge of likely course and range of likely alternatives
    b. Constrained by medical and social (patient and community) factors
    c. Patient and family input and awareness
    d. Time limits, evaluations, feed-back, and revisions
    e. Methods for medication reconciliation at transitions

G. Moving information to where it is needed
    a. Uniform patient assessment instruments, meaningful use, CARE (and MDS/OASIS)
    b. Electronic access to patient-specific routine data
    c. Electronic transmission of specially formulated patient-specific data
    d. Non-electronic transmission of patient-specific data
    e. Patient-held electronic or paper records
    f. Just right data, just in time (not too much, not too little, not too early or too late!)

H. Standardizing the processes
    a. The problem of variation in processes
    b. The merits of standard process and the usual resistance to standardizing
    c. The challenge of non-geographic standards – large systems with processes designed and used in many settings
    d. Steps toward standardization in a local area
        i. Discharge/transfer process, including physician responsibility transition and care plan transition
        ii. Standardizing patient/family activation and self-care
        iii. Standardizing elements of disease algorithms

I. Enabling the patient and family to take an active role/ meeting patients at their level with respect to literacy, activation, cognition
    a. Passivity and activation – methods and measures
    b. One-on-one targeted coaching
    c. Activation and self-care as public health and social action
    d. “red flag” training

    e. Strategies to elicit patient preferred learning approach and identify barriers including low health literacy and cognitive impairment

J. Enhancing and right-sizing services
    a. Support in the community, including palliative care
    b. Right-sizing hospitals
    c. Right-sizing specialists
    d. Economics of "slimming down" health care in defined communities
    e. Forging better integration of medical and social services

K. Controversies
    a. Adding people to make the system work (vs redefining roles for existing people) – navigators, care coordinators, guides for care, advance practice nurses in transitional care, etc.
    b. Geographic variation in how costly services are used and paid for (is it forever OK to send more Medicare funds to some areas and less to others?)
    c. Cooperation and competition – community action and anti-trust

L. Available support for reformers
    a. MediCaring website, serving as a connector
    b. Section 3026 funding
    c. Penalties in Section 3025
    d. QIO support to get underway
    e. Integration models – ACOs, PCMH, managed care, PACE, VA,
    f. Meaningful use