TRANSITIONS OF CARE: SUPPORTING PATIENTS AND PHYSICIAN PARTNERS

This article was written by Desiree Vuocolo Canovic MPA, and Julie Hobson RN, BSN of Highmark Health

Highmark Inc., one of America's leading health insurance organizations and an independent licensee of the Blue Cross Blue Shield Association, and its affiliated health plans is the fourth-largest overall Blue Cross Blue Shield-affiliated organization covering the insurance needs of more than 6 million members in Pennsylvania, Delaware, West Virginia, and New York, is on a journey to transform health. This goal requires a focused partnership with our provider partners, and enhanced coordination with hospitals and post-acute care facilities to improve the care for our members. In an ongoing effort to strengthen this collaboration, we are developing a series of educational modules aimed at continuous improvement and population health management. Transition of Care (TOC) is an important topic for transformation which is even more important due to the pandemic. Many patients are leaving the hospital, rehabilitation facility, and long-term care settings to go to another, often in a vulnerable state with little understanding of what comes next.

TOC is the movement of a patient from one care setting (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another involving a set of proactive actions. The actions to coordinate this care and ensure clear concise handoffs, are what is known as transitional care management. These services should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences, and health or clinical status. They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition.[1]

WHY DO TRANSITIONS IN CARE FALTER?

Ineffective care transition processes lead to adverse events and higher hospital readmission rates and costs. One study estimated that 80% of serious medical errors involve miscommunication during the hand-off between medical providers.[2]

The Joint Commission identified several factors that contribute to ineffective transition of patient care and noted that they often differ from one health organization to another but there are often common root causes, including:

- Communication breakdowns. There is not effective or complete communication among care providers, to the patient or those caring for the patient in a timely fashion. The risk factors found contributing to this were:
    - Expectations differ between sender and receiver of the patient transition
    - Culture does not promote successful hand-off (lack of teamwork, respect, and health literacy).

    - Inadequate amount of time provided for successful hand-off.
    - Lack of standardized procedures in conducting successful hand-off.
- Patient education breakdowns. Patients or family members sometimes receive conflicting recommendations, confusing medical regimens, and unclear instructions about medications and follow-up care.
- Accountability breakdowns. When there are several physicians involved (multiple specialists and a primary care physician), there is often a failure to coordinate care or communicate effectively, which creates confusion for the patient and those responsible for transitioning the care of the patient to the next setting or provider.[4]

EMERGING FOCUS: PROVIDER SUPPORT

Conventional TOC plans rely heavily on the physician to coordinate care between the patient's care team, develop a comprehensive plan throughout a hospital stay, create transition plans, and complete timely follow-ups. Highmark supports our provider partners by promoting the coordination of care for our members and assisting the physician's office in transformation that seeks to involve the patient along with their family and care givers. Involvement from the health plan serves as an extension of their office during and beyond the TOC. We continue to build relationships with our clinician partners leveraging the use of new technologies and best practices to build a better model; at Highmark we are calling this Living Health.

Our team, Living Health Partnerships, works closely with physicians and their staff to develop the tools to help them succeed in our value-based reimbursement programs and provide best practices for general use in their offices.

Highmark's clinical programs were designed with our members in mind while the Living Health Partnerships team is focused on supporting our provider partners. We tailor our strategies and approach based on a providers' capabilities and market-specific needs. This means offering analytical, clinical, and pharmaceutical support as well as developing tools to help office staff manage patient care.

For the purposes of this article, we will focus on transition from the acute care setting. Our model focuses on identification and early intervention for our members transitioning from one care setting to another, to determine what support they need to return home safely or to receive care in an appropriate setting. To achieve this, we focus on the processes needed to support the transfer of members between care settings and ensure they are set up for success to transition home. The Highmark field team of population health performance specialists, population health pharmacists and clinical transformation consultants are committed to supporting practice transformation.

As mentioned previously, communication failures are a major contributor in the breakdown of the TOC process. Early communication with care providers and the daily monitoring of admissions and discharges can prevent communication breakdowns and serve as a guide to help patients and their care givers. Highmark has reporting tools and applications (daily reporting through a shared reporting portal, collaboration with a 3rd party care coordination software application vendor) that can be integrated into daily practice activities to make it easier to track and manage communication.

While TOC programs can be resource intensive, we focus on decreasing unnecessary admissions rates and targeting individuals at risk for readmissions to help with prioritization of patient outreach. Highmark utilizes risk models to identify ambulatory care-sensitive conditions and those members at increased risk for readmissions to support the building of clinical pathways and process transformation to address variances in care. The Highmark team employs various resources and applications in the development of initiatives to address admission and readmission rates.

Early outreach to a patient and/or care giver to assess their understanding of discharge instructions is another element that contributes to the success of TOC. Eric Coleman, MD, MPH, identifies 4 pillars of transition:[3]

- Medication management
- Red flags
- Medical care follow-up
- Personal health record

Keeping these elements in mind, when building or redefining a TOC model can help aid in building a strong, well-defined process that is easy to manage and follow. The Highmark field staff are available to our physician partners to aid in the development of a TOC program with toolkits, patient outreach scripting, and outcomes measurement that leverage Coleman's pillars.

As Coleman's pillars highlight, medication management is an integral part of successful transitions of care. Pharmacists are uniquely qualified and offer a specific medication management skillset to identify and resolve medication related problems and optimize medication regimens. Pharmacists play a vital role in providing clinically significant and timely care to patients recently discharged from the hospital. The challenges patients face during TOC include clarifying and adhering to complex medication regimens. Numerous medication changes can negatively impact patient outcomes. Incorporating pharmacists into the collaborative care team during transitions can be essential to a successful process and has been shown to reduce readmissions, reduce medication related problems, and ultimately improve patient care.[4]

The Highmark Health pharmacy team can help physician and hospital groups realize the variety of clinical services that pharmacists can provide, as well as identify the best way to incorporate pharmacists into their collaborative care team to support the TOC process.

EMERGING FOCUS: MEMBER SUPPORT

When additional support is needed for the patient, Highmark offers health coaching, care and disease management, and social services.[5] Effective care coordination supports achieving the Quadruple Aim: enhance the patient experience, improve the work life of health care providers, reduce costs, and improve population health. [6] This coordination of care could involve connecting the member, telephonically or digitally, to a health coach, care or case manager nurse, pharmacists, or social worker, dependent upon their need. Our goal is early intervention to address the barriers that prevent the patient from receiving the best care in the most appropriate setting. We rely on our provider partners to champion these calls and encourage engagement from their patients. This allows Highmark to enroll participants in various programs that may help them through the transition process or with the management of chronic diseases. In addition, this process is set up to address social determinants of health issues that may inhibit adherence in the programs.

Highmark's programs have an added benefit of reducing cost and readmissions: "Post discharge support for members with greatest need resulted in Medical cost savings of $721 per member per month reduction**.** For participating members, reduces all inpatient admissions by 4%, and avoidable inpatient admissions by 25%.**"**[7]

SOCIAL DETERMINANTS OF HEALTH

The World Health Organization defines social determinants of health (SDOH) as "the conditions in which people are born, grow, live, work and age." Poorer social conditions correlate with poorer health. According to PwC's Health Research Institute Report, clinical care accounts for only 20% of a person's health. Health behaviors, physical environment and socioeconomic conditions determine the remaining 80%.[5] Teams across Highmark Health have collaborated to develop a Universal SDOH Assessment to identify member needs in 7 SDOH domains. The domains are assessed through a series of 13 questions designed to identify an individual's social needs. Additionally, Highmark has contracted with Aunt Bertha, an online social care network, which serves as a referral tool for urgent needs such as food, housing, and transportation. Highmark's Community Support platform, powered by Aunt Bertha, allows users to find nearby community-based organizations, making it easier for people to access social services in their neighborhoods, for nonprofits to coordinate their efforts, and for healthcare providers to integrate social care into their work. It is available to all Highmark members across Delaware, Pennsylvania, and West Virginia as well as nationally. The service is free and there are no income restraints. In addition to public access, providers, social workers, and care coordinators across the Highmark Health enterprise can access information and recommend services. This is important because unless we understand and address SDOH, we can never truly improve health when the real issues of importance for the patient might be food insecurity or financial strain.

INTEGRATED CARE TEAM

For those members requiring most intensive level of care, we have developed the Integrated Care Team consisting of clinical and non-clinical staff focused on analytically driven, patient centric care, in close collaboration with providers to:

- Reduce length of stay
- Effectively transition to post-acute settings resulting in reduced readmissions
- Manage post-discharge care, in collaboration with the primary care physician
- Manage specialty drugs

This team advocates for appropriate care of members with the integration of utilization management, care management, medical directors and supporting programs. Using predictive algorithms, the team has re-oriented around the patient for a person-centered approach and achieved outstand results within a 12-month period of time.[8]

- Readmission rates for commercial plans have decreased by a minimum of 14.7%, and for Medicare Advantage plans by a minimum of 31.9%.
- Length of stay for commercial plans decreased by a minimum of 0.7 days and for Medicare Advantage plans decreased by a minimum of 0.4 days.
- Utilization of long-term acute care facilities has been reduced by 70%.
- Inpatient rehabilitation has been reduced by 40%.

NEXT STEPS

We believe the emphasis and focus on TOC will ensure the highest level of care for our members and provide much needed support to our physician partners. Early communication and patient identification, prioritizing patient outreach, incorporating pharmacists into the collaborative team, and addressing SDOH are some key aspects of our approach. Highmark's physician support tools are offered free of charge to all practices in our value base reimbursement programs.

1. The National Association of Clinical Nurse Specialists;2016. Accessed January 3, 2021. https://www.nacns.org/wo-content/uploads/2016/11/TC-definitions.pdf.
2. Joint Commissions:2012. Accessed January 12, 2021. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assests/tjc/system-folders/topics-library/hottopicstransitionsofcarepdf/pdf?db=web&hash+CEFB54DF3C36E4FF30ABB20A5550E0.
3. Geriatric Interdisciplinary Teams in Practice Care Transitions Model. Accessed January 12, 2021. https://www.johnahartford.org/ar2007/pdf/Hart07CARETRANSITIONSMODEL.pdf.
4. Stranges, P. M., Jackevicius, C. A., Anderson, S. L., Bondi, D. S., Danelich, I. P., Emmons, R. P., . . . Smithgall, S. P. Role of clincal pharmacist and pharmacy support personnel in transition of care. *Americal College of Clinical Pharmacy* 2020;3:532-545. doi:10.1002/jac5.1215
5. Bodenheimer, Bodenheimer, T., & Sinsky, C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine* 2014;12(6)573-576. doi:https://doi.org/10.1370/afm.1713
6. The Triple Aim or the Quadruple Aim? Four Points to Help Set Your Strategy. Accessed January 20, 2021. http://www.ihi.org/communities/blogs/the-triple-aim-or-the-quadruple-aim-four-points-to-help-set-your-strategy.
7. Highmark Health. (2020). *TRANSITIONS OF CARE PROGRAM.* Pittsburgh, PA.
8. Holly D'Amico, C.E. (2020). Brand Innovation Award Winning Programs for Improving Members' Health. *BlueCross BlueShield 2020 Summit*, (pp 23, 24, 26, 29 and 30).

HIGHMARK. | HIGHMARK.