



Results and Implications of “Putting the IT in Transitions” Convening (10/14/2011)

Presented by Janhavi Kirtane and Leah Marcotte

November 9, 2011



Agenda

- ▶ Convening Context and Aims: Understanding the Opportunity
- ▶ Meeting Results: Convergence around Key Priorities
- ▶ Implications Moving Forward: Converting Priorities into Action

Context : Understanding the Opportunity

- ▶ **High and growing level of focus on hospital to post hospital transitions**
 - Models and Interventions: CMS 9th scope of work, STAAR Initiative, Project RED, BOOST, CTI, GRACE, Naylor model etc.
 - Payment: Penalty in 2013 (3025), funding opportunity now (3026), growing number of private/state programs, other payment pilot opportunities
 - 2013 Goal: Partnership for Patients 20% reduction in readmissions
- ▶ **Growing interest and understanding of how technology can improve transitions for patients and caregivers**
 - ONC Programs: 14 of 17 Beacons 4 HIE challenge grantees, S&I Transitions of Care workgroup, MU recommendation for Stage 2
 - Innovation community: “Ensuring Safe Transitions from Hospital to Home” mobile app challenge, Health 2.0
 - Other partners: Center for Technology and Aging, CMS, LTPAC Collaborative, etc
- ▶ **Opportunity: Better align on-going work and inform an IT – transitions of care agenda to drive near term improvement and innovation**

The Context: On-going, intractable challenges for patients and care givers that could be addressed by technology

Putting the IT in Transitions: With the Patient at the Center

Washington, D.C. • October 14, 2011



Maria, 83, a widow being discharged, has many chronic conditions: heart failure, dizziness and falls, hearing and vision problems, gum disease, and moderate memory loss. She has trouble living alone; her daughter lives nearby, but works, and her house has too many steps. She doesn't trust quality of food delivered to home, creates a fire hazard by keeping newspapers, and forgets to pay the rent. **How does she get a comprehensive care plan?**



Jesse, 11, a schoolchild with severe asthma, is being discharged to a home with a mother and uncle who smoke; they have no vacuum cleaner. School requires Jesse's medications to be locked up in the nurse's office. Jesse has had dozens of serious exacerbations requiring emergency room use or hospitalization. **How can IT support an asthma action plan?**



Tom, 30, a homeless man with schizophrenia and diabetes is released from the hospital. Sometimes he visits various community health clinics. When in good control and on his medications, he manages fairly well with nightly stays in homeless shelters and occasional jobs, but the living situation provides no effective way to manage diabetes. **How could his records be everywhere he needs them?**

Photos are for
illustration purposes only.
The people portrayed
are models only.



Developed by Altarum Institute Center for Elder Care and Advanced Illness

Meeting Aims

- From the point of view of *patients and caregivers*, identify the most intractable challenges related to care transitions.
- **“Open Space” workgroups:**
 - Harvest the best IT enabled solutions available today—those ready for spread and scale-up now.
 - Recommend high-priority areas for IT-enabled innovation.
- **Identify key drivers for spread and uptake of IT-enabled solutions**
- **Conduct group prioritization activity to define areas of emerging consensus**



Facilitated sessions of 30-40 individuals:

- 1) Information flow and feedback (2 groups)
- 2) Discharge process
- 3) Patient and caregiver activation
- 4) Medication reconciliation

Putting the IT in Transitions

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FOUNDATION



Media Partners: *Health Affairs and Health 2.0*

Washington DC and Online (#ITrans)
October 14, 2011 8am-3pm EST
Kaiser Permanente Center for Total Health



Standards and Interoperability: The Transitions of Care Initiative Update

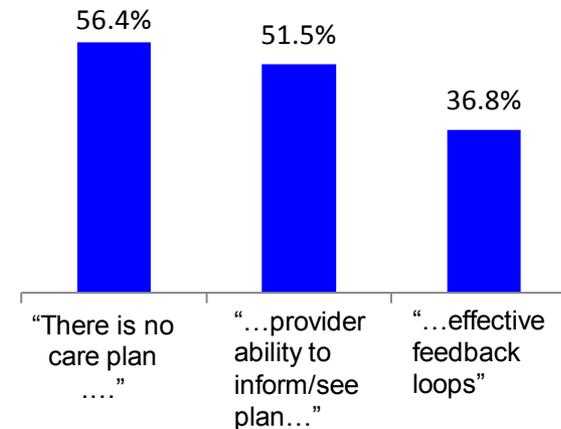
- ▶ **Several announcements were made to socialize and celebrate recent progress made through the S&I Transitions of Care Initiative – targeting a stakeholders who have not been involved to date, but are incredibly excited:**
 - Successfully selected a single standard (the HL7 "Consolidated CDA" standard) to be used for care transitions
 - Created clear clinical (as opposed to technical) definitions for the data to be exchanged for a core set of care transitions scenarios: hospital-discharge-to-primary care, primary care-to-specialist-and-back (better known as "closed loop referrals"), and hospital-to-PHR
 - 10+ vendors had signed up across 4 pilots to demonstrate and improve the new standard (numbers have doubled since then)
- ▶ **Questions and discussion posed by the group:**
 - The need for standards to support other important care transitions scenarios, particularly to long-term and post-acute care
 - The need for a number of disconnected/local standards initiatives across the country to align efforts and push forward on a single set of standards
 - **ACTION TAKEN POST MEETING:** New S&I "Longitudinal Coordination of Care" initiative ("LCC") was launched which is in the early problem definition stage

Results:

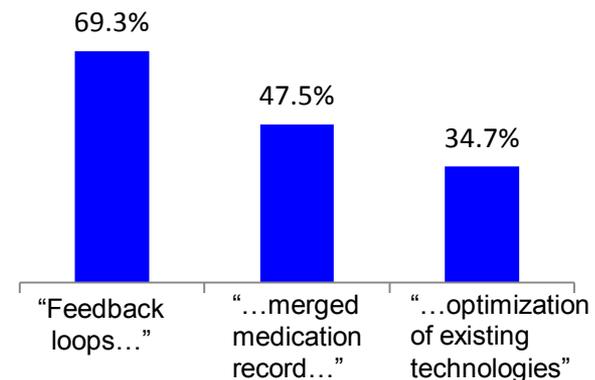
▶ Remarkable convergence from stakeholders around top priorities for an IT-Transitions agenda

- Vision of a **plan of care**, that spans time and setting, incorporates social and medical factors, reflects patient goals and is accessible to all care team members
- Effective and efficient **medication reconciliation** continues to evade even the most sophisticated providers
- **IT-enabled feedback loops** are underdeveloped, and are critical to ensure safe care and self management
- **Shifting from the hospital centric model** is the most important enabler for spread and uptake

*Of the **priority problem statements** that emerged from the break out sessions, the **three most important** are:*



*Of the **innovation opportunities** that would address the most difficult challenges in care transitions discussed in the break out sessions, the **THREE that will likely yield the most impact** are:*



Implications Moving Forward

▶ Key to success and rapid action

- Socializing the priorities identified to different stakeholders
- Translating meeting results into a customized agenda for specific stakeholders – public and private
- Example: Anne Degheest/NPR interview giving advice to Silicon Valley venture capitalists

▶ Implication for HHS

- Align with current activities and inform future policy and programmatic activity
- Create pockets of shared areas of focus across agencies, i.e., ONC-CMS-AoA
 - CMMI payment pilots and learning collaboratives
 - Best practice harvesting from ONC grantees
 - Additional challenges to activate innovation community

▶ Potential roadblocks to spread and uptake

- Information gap for providers on the ground – who is doing something like me?
- Believability around what's truly possible and effective
- “Noise” in the system



Questions and Feedback from Policy Committee

- ▶ What are your reactions to the suggested priorities for an IT-Transitions agenda?
- ▶ How could these priorities inform future policy recommendations related to meaningful use?
- ▶ How could these recommendations inform ONC's agenda?
- ▶ Other feedback?

Contact/Want to Join the Conversation?

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