AHRQ National Web Conference on the Role of Health IT to Improve Care Transitions - Questions and Answers

September 26, 2019

"Interactive Patient-Centered Discharge Toolkit (PDTK) to Promote Self-Management During Transitions"
Presented by Anuj K. Dalal, MD, SFHM

QUESTION: On the patient discharge preparation checklist you ask for an answer of Yes/No/Unsure for multiple questions. Why did you not ask for an answer to each question?
ANSWER: To clarify, each question required an answer before the checklist could be submitted.

QUESTION: Can patients provide answers to each individual question, or to just each domain?
ANSWER: They are required to provide an answer to each individual question within all domains.

QUESTION: What was the content of the web-based video in the PDTK intervention?
ANSWER: We developed a script based off the checklist and recorded that in the video. Thus, it was essentially the checklist in video format.

QUESTION: When was the checklist video distributed to the patient? Day 1? Day 2? Day 3 or? Is the video sent after Discharge Order is posted? Who manages the sending of the video? or checklist?
ANSWER: We approached patients approximately 24-48 prior to their current expected discharge date. If the discharge was delayed, as in some cases, we then went back and updated the checklist with the patient.

QUESTION: Who is the vendor for the text? is it HIPAA compliant?
ANSWER: We used Imprivata Cortext, a HIPAA compliant secure messaging vendor.

QUESTION: Who developed the checklist?
ANSWER: The checklist was originally developed by Coleman, and adapted and modified for use at our institution as part of a prior study in addition to the current study.

QUESTION: Did you think about looking at HCAHPS scores for the Care Transitions questions as a metric?
ANSWER: This is a good suggestion. HCAHPS would be good to measure once this is operationalized.

QUESTION: How do you plan to get physicians more involved in the post-discharge follow-up? Perhaps there's a role for RNs in the communication/interaction.
ANSWER: This is the key challenge and it won't be easy. I think much of this resistance is unjustified fear that the patient will inundate them with messages.

QUESTION: Were any attempts made to ensure the patient facing materials considered the readability levels of the patients or to revise written materials in order revise them to address the health literacy needs of all patients?
ANSWER: Indeed. The checklist was originally developed by Coleman, which took this into account. We adapted this locally for our institution and iterated with input from our PFAC who frequently reviews materials at our hospital to ensure readability at appropriate literacy levels.

QUESTION: Of those patients who utilized the secure text messaging, were any readmitted? Alternatively, were any readmissions caught/prevented because of this service?
ANSWER: There were only 3 patients on whom it was used - to my knowledge, none were readmitted. However, there were many more who requested messaging, but this was never initiated by the attending.

QUESTION: I work in home care. All three of you have offered much to contemplate regarding opportunities to positively impact patients and their care. The patients you describe often move through home health care as well. Have you worked with home care or might?
ANSWER: As home hospitals become increasingly prevalent, I imagine there will be opportunities to use checklists to discharge patients from home hospital as well.

"Using Location-Based Smartphone Alerts Within a System of Care Coordination"
Presented by David T. Liss, PhD

QUESTION: Can you please tell when was your app deployed for piloting?
ANSWER: Our initial beta test (first phase of our AHRQ-funded R21) was in 2017, and the feasibility study (phase 2) was in 2018; both tested an Android-only app. A revised version of the app, on both the Android and iOS platforms, was deployed in 2019.

QUESTION: It seemed that the app didn't notify the center for each hospital/ED encounter - was this due to technical issues? or perhaps I misunderstood?
ANSWER: That's correct, it was due to technical issues. We later determined that one of the large manufacturers of Android phones had modified their background app/battery saver settings, causing the app to close unexpectedly. A newer version of the app has since addressed this technical issue.

QUESTION: I really like the app idea. Have you thought about deploying it for patients affected by disasters?
ANSWER: No, we have not [yet], though there are many potential applications beyond our initial approach to coordinating emergency/inpatient visits. For implementation/deployment for any purpose, the challenges lie in 1) recruiting organizations that want to be notified about relevant events, and then; 2) recruiting patients who receive services from those organizations and are at moderate/high risk of relevant events.

QUESTION: Does the DRG cover the transfer of the CCDA?
ANSWER: I'm guessing this question is regarding the CMS Transitional Care Management services referenced during my presentation (CPT 99495, 99496)? To be reimbursed for this service, practices need to complete a few tasks, including contacting the patient within 2 business days of discharge and a face-to-face visit within 7-14 days of discharge. There is also a requirement for non-face-to-face services, such as receipt of a discharge summary or continuity of care (CCD) documents. For further details, visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

QUESTION: How does the rule that CMS release today move discharge planning forward?
ANSWER: Good question, and thanks for notifying me about this new rule - I assume you're referring to 'Revisions to Discharge Planning Requirements [CMS-3317-F]?' From my initial read of the new rule, it seems to move discharge planning forward by codifying the need for hospitals to do things like identify an outpatient provider of post-acute care, identify patient goals, and

promote patients' access to their EHR data. However, time will tell if this new rule moves the needle in improving care processes during and after care transitions, especially in regions (such as metro Chicago) with fragmented delivery structures and no health information exchange.

QUESTION: What was your biggest challenge to conducting this project?
ANSWER: The technical issues we encountered during the feasibility study (second phase of the project) were probably our biggest challenge. In a related project, we also encountered challenges when we asked patients to download and install the app on their own, without help from the research team; in particular, it can be difficult for patients to do things like configure the phone's location settings and complete data entry tasks such as entering their PCP and birth date.

QUESTION: Were the clinics able to use this CPT code to get reimbursed for this service?
ANSWER: To our knowledge, the FQHC we worked with did not use the Medicare CPT codes (99495 and 99496) for reimbursement, since these CPTs were created for the Medicare fee-for-service program. Our study targeted a non-elderly Medicaid population; as such, I do not believe that the FQHC was eligible to receive these Medicare fee-for-service payments.
For further details, visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

QUESTION: Who was the app vendor?
ANSWER: We worked with a vendor here at Northwestern University; the group was in Northwestern's Center for Behavioral Intervention Technologies (CBITs) but has since ceased operations. At present, we work with a commercial vendor, located here in Chicago, who has experience working with many academic teams across the country.

QUESTION: The App sounds very interesting but there will be ED patients that can't respond to their phone. What steps are being considered to record information on behalf of these patients?
ANSWER: This is a good point. The app was designed to have alerts repeatedly 'fire' until the user (or someone in possession of the user's phone) responds. In some instances, such as when the user is unconscious, they obviously would be unable to respond until they regain consciousness. Here we would expect a late response which, though suboptimal, is certainly superior to the primary care team receiving no notification at all about the event in question.

QUESTION: I work in home care. All three of you have offered much to contemplate regarding opportunities to positively impact patients and their care. The patients you describe often move through home health care as well. Have you worked with home care or might?
ANSWER: We haven't yet worked with home health providers but would certainly be interested in doing so if there was an opportunity to collaborate in a way that advanced the app/intervention.

QUESTION: How is patient privacy secured using the app?
ANSWER: Although the app collects data on the phone’s location, the only way an ‘event’ was logged was when the smartphone went inside a defined hospital geofence, i.e. we didn't collect any location data for locations outside hospitals. All data was transmitted securely to study servers, and in newer versions of the app data has been encrypted during transmission. We would be happy to discuss these issues further if you want to get in touch via email or phone.

QUESTION: Did the staff in the ERs have any introduction to the app being used in order to assist patients with use of the app?
ANSWER: No, we did not work with staffs in local emergency departments when implementing this app/intervention. Given that the app was designed to be used by patients, and the large number of geofenced hospitals, we felt the potential benefit of collaborating with local EDs was

insufficient to warrant this undertaking.

"Coordinating Transitions: Health Information Technology's Role in Improving Multiple Chronic Disease Outcomes"
Presented by Sharon Hewner, PhD, RN, FAAN

QUESTION: If physicians are not able to follow up post discharge-for whatever reason, maybe encourage/allow other clinicians such as Doctor of Physical Therapy to complete the follow up?
ANSWER: The coordinating transitions project used registered nurses to complete the post-discharge follow-up.

QUESTION: Do you think the results will be different for Accountable Care Organizations? Here is the UK we are placing greater emphasis on MDT Primary Care Networks, and our own version of ACOs, Integrated Care Systems.
ANSWER: One of the strengths of the coordinating transitions project was the development of co-located care teams who had a long-term relationship with the patient and their caregiver. To the extent that that can be completed in an MDT Primary care network then I would expect similar results. I think inclusion of social determinants of health is especially important in low-income and elderly populations.

QUESTION: I work in home care. All three of you have offered much to contemplate regarding opportunities to positively impact patients and their care. The patients you describe often move through home health care as well. Have you worked with home care or might?
ANSWER: Home care referrals are often made by the acute hospital for a time-limited service. Sharing of electronic data and care plans through regional health information exchange creates an opportunity for home care nurses and other staff to communicate with the primary care team.

QUESTION: Do you believe that the same value realized from this important outreach could be achieved by having a centralized CC team, to include RNs and Social Workers. I agree that co-location is preferred, but our goal is also to standardize.
ANSWER: The question of centralized vs. co-located care teams is an important one especially in rural areas where a practice may not be able to have a dedicated care coordinator (either RN or SW). I think a centralized care coordinator needs to make the extra effort to be part of the team delivering hands-on care.

QUESTION: Can you elaborate on the roles of the agencies in diving into claims for the roster of patients with chronic diseases? Did the HIE lead this process or did the FQHC review their own claims?
ANSWER: This is complicated. The primary care practice provided their billing information (diagnoses) for patients seen in the prior 3-year period to the research team This allowed the Research team to create a cohort table that classified the complete roster of patients based on the presence of chronic conditions. The cohort table was shared with the RHIO using HIPAA compliant identifiers, so that the alerts could be limited to those with pre-existing chronic conditions. In contrast, the analysis of health outcomes was completed using de-identified claims from the NYS Medicaid Data Warehouse using flags for inpatient, emergency, and outpatient utilization and diagnosis codes from the claims. Rosters were created for the study and control practices based on the past 3 years of utilization -- but this was for Medicaid patients only.