AMERICAN CASE MANAGEMENT ASSOCIATION

Transitions of Care 2.0

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Transitions of Care 2.0

Introduction and Background of Transitions of Care

In 2017, American Case Management Association (ACMA) convened thought leaders from across the care continuum to recommend Transitions of Care (TOC) Standards that could apply to all care settings. Supported by Pfizer, Inc., this work continued throughout 2018 and resulted in five TOC standards, associated measures and outcomes, consensus measures, assessment guides, and other resources. The TOC standards and TOC website were launched in early 2019 to support all organizations in assessing and improving transitions of care across the continuum.

To further test the standards and outcome measures, a Learning Collaborative was assembled, consisting of six prominent organizations (Advocate Aurora, Duke University, Inova Health System, Memorial Hermann Health System, St. Francis Hospital and Medical Center of Trinity Health, and Tenet Health). The intent of the collaboration was to assess compliance with the standards, test implementation, and collect data regarding performance improvement after implementation. The Learning Collaborative launched in January 2020 just prior to the SARS-COV2 pandemic. To the credit of this team of leaders, the collaborative continued and resulted in publishing the ACMA Transitions of Care Learning Collaborative white paper on the TOC website.

ACMA's Commitment to Transitions of Care

The American Case Management Association is the preeminent association for Transition of Care professionals across the country. With a growing membership of nurse case managers, social workers, and physicians involved with advising and utilization review, ACMA is committed to improving care transitions for patients and families. ACMA offers practice standards, professional education, conferences for networking, and advocacy/policy initiatives to support their members. A national survey is obtained every two years to assess current practices, concerns, staffing, and staffing models. National survey results allow ACMA to report and recommend best practices for national case management practice.

Partnership with Pfizer

ACMA and Pfizer partnered in 2017 to develop the TOC standards, institute the TOC Learning Collaborative, and disseminate information through the website, presentations, and white paper. ACMA acknowledges Pfizer's continued support to advance standardization in transitions of care.

SDOH Terminology

The World Health Organization's definition of Social Determinants of Health includes the political, social, and economic factors that affect health by shaping the conditions in which people live and work (World Health Organization, n.d.).

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Health Related Social Needs (HRSN) is sometimes used interchangeably with SDOH, but an important distinction can be made. HRSN refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being.

In some settings, social drivers of health are replacing the previous SDOH (social determinants of health) for several reasons. Reframing the terminology to social drivers of health suggests that the person can overcome some social factors, especially with the support of education and enhanced community resources. Centers for Medicare & Medicaid Services (CMS) has elevated Health Related Social Needs (HRSN) and Social Drivers of Health (SDH) to a top priority.

CMS released the 2022-2023 Framework for Health Equity which sets the foundation and identifies five priorities to further advance health equity and outcomes for the more than 170 million individuals using CMS programs (CMS Framework for Health Equity, 2022-2032).

In 2024, CMS has mandated submission of Health-Related Social Needs data from CMS-participating acute care facilities. This data will be analyzed as a part of their Priority 1 initiative.

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

"CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and SDOH data, including race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH. By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage" (CMS Framework for Health Equity, 2024).

"As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Dr. LaShawn McIver, Director, CMS Office of Minority Health.
(CMS Framework for Health Equity, 2022-2032)

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Reassessment of TOC Standards

While SDOH factors were layered into the initial TOC Standards and assessment, after a thorough review, ACMA and Pfizer decided a revision was needed to further expand and update the TOC Standards. A gap analysis of SDOH in the current TOC standards was performed. These efforts demonstrated that TOC can be enhanced regarding health-related social needs (HRSN). An Advisory Committee was formed to collaborate with ACMA in the undertaking called TOC 2.0.

Table A. Transitions of Care 2.0 Advisory Committee

Name/Title	Organization
Dr. Michelle Williams Executive Director, Office of Research	Stanford Health Care
Ronda Lehman President	Mercy Health (Lima)
Arianne Dowdell VP, Chief Diversity Equity & Inclusion Officer	Houston Methodist
Helen Zughni VP, Case Management	HCA Healthcare
Karen Vanaskie Chief Clinical Officer	Innovation Care Partners
Tameeka Smith Chief Executive Officer	VA Community Health Plan UnitedHealthcare Community & State
Dr. Sarah Redding Co-Founder of the Pathways Community Hub Institute	Pathways Community Hub Institute
Dr. Isaac Martinez Senior Medical Director, Clinical Performance and Quality	Cigna Healthcare
Dr. Thanh-Nghia Nguyen Director, US Market Access, Customer Solutions	Pfizer
L. Greg Cunningham Chief Executive Officer	ACMA
Kathy Ferket Senior Consultant	ACMA
Marlene Bober Senior Vice President Client Services and Professional Practice	ACMA

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TOC 2.0 Advisory Committee

The TOC 2.0 Advisory Committee selection process began in early 2023. Candidates were selected from the payor, academia, acute care, community, and wide-ranging hospital system entities.

In the summer of 2023, ACMA leaders convened the Advisory committee members for a two-day, in-person meeting. Several pre-calls were held to identify the mission and goals, including prework to be completed prior to the in-person meeting.

The meeting commenced with introductions and a round-robin discussion regarding current "pain points" and how the impact of SDOH contributed to challenges in their health care setting. A review of the literature was presented, including the lessons learned during the COVID-19 pandemic.

Lastly, we reviewed each of the five TOC standards, the assessment tool, and the process/outcome measures related to each standard, with particular focus on strengthening connections to SDOH.

Transitions of Care 2.0 Revision Process

Members of the Advisory Committee were grouped into pairs and assigned one standard to revise. Recommendations were reported back to the group.

ACMA leaders collected the feedback and consolidated the changes. Two cycles of reviews were undertaken through virtual meetings in order to finalize TOC 2.0.

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The following table lists the revised standards with new language underlined.

STANDARDS (REVISIONS)	CRITERIA (REVISIONS)
Standard 1: **Identify patients at risk for <u>ineffective</u> transitions of care**	• Defined social drivers and social determinants of health (SDOH) • Added screening elements related to medication adherence, SDOH
Standard 2: **Complete a comprehensive transition assessment**	• Identify who may become at risk in a new setting due to physical, mental, or social barriers from one setting to another • Additional links added as referenced for individual and Family Self-Management Theory • Link for medication adherence tools provided • Social drivers of health and social determinants of health defined • Advance care planning resources link provided
Standard 3: **<u>Perform, communicate, and implement</u> findings from a Medication Reconciliation**	• Link for medication adherence tools provided • Over the counter medications and supplements review added • Medication discrepancies and non-adherences review added
Standard 4: **Establish a dynamic care plan that addresses all settings across the care continuum**	• Additional technology support i.e., HIE (Health Information Exchange) and referral management systems to communicate plan of care • Advance care planning resources link provided
Standard 5: **Communicate essential care transition information to key stakeholders across the care continuum**	• Payor/Community-Based organizations care coordinators included in Transition of Care handoff • Deploy communications electronically whenever possible • Share information bidirectionally between the hospital and the health plan via Electronic Health Record (EHR). • SDOH assessments in Transitions of Care information • Advance discharge notification to payor • Endorsed appropriate assessment / documentation of Z codes (SDOH criteria)

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TOC Metrics

The initial version of the TOC Standards included consensus measures for each standard; these included a process and outcome measure to consider when using the assessment tools developed for each standard. The 2.0 TOC advisory committee continues to endorse the original consensus measures, so those remain consistent in TOC 2.0. However, a committee recommendation was adopted to eliminate the lengthy metric tables, and instead insert organizational links to the measures. This will allow ACMA the opportunity for regular revisions as resources evolve.

PROCESS MEASURES (HEDIS) **MEASURES PERFORMANCE**	**OUTCOME MEASURES (VARIED PROGRAMS)** **MEASURES IMPACT**
Evidence of inpatient admission documentation to primary care provider	Evidence of completion of a health risk assessment (CMS: IQR/OQR 2624)
Evidence of receipt of discharge information on the day of discharge or the following day	Evidence of high risk medication assessment in elderly (CMS IQR/OQR 0022)
Evidence of patient engagement (office, home, telehealth visits) provided within 30 days after discharge	Evidence of advance care planning documentation (CMS 0326)
Evidence of medication reconciliation on date of discharge	Evidence of bilateral exchange of necessary patient information (CMS IA_CC_13)
	Evidence of longitudinal care management for patients at high risk for adverse health outcomes or risk (CMS IA_PM_14)

TOC 2.0 Pilot

ACMA looked to the 2.0 TOC SDOH Advisory Committee for support in piloting the revised standards and two members volunteered their organizations to participate. These organizations were successful in engaging their members to support the initiative of testing the impact of SDOH factors on Transition of Care. A charter with pilot scope and expectations was endorsed by each organization and ACMA.

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Cigna Healthcare Pilot

Cigna is a global health service company dedicated to helping people improve their health, wellbeing, and peace of mind. Cigna has 74,000 employees who serve more than 100 million customers throughout the world. (Cigna Healthcare, 2024).

Problem: Individual and Family Plan (IFP) segment of Cigna Virginia members indicates emergency utilization per 1000 members is trending higher over the past years.

Transition of Care Episode: Emergency Department discharge to home/community

Hypothesis: Virginia Individual and Family Plan (IFP) member ED utilization receiving care coordination outreach and community referrals will decrease.

Supporting literature: Frequent ED utilization may be related to underlying SDOH factors.

In the 2023 IPPS final ruling, CMS mandated those hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program report on two new measures, the Screening for Social Drivers of Health Measure, and the Screen Positive Rate for Social Drivers of Health. These new quality measures fall under the Advancing Health Equity initiative and include screening and identification of patient level, health related social needs. This data will be collected utilizing a screening tool derived from the CMS' AHC HRSN tool. The measures will assess whether a hospital implements screening for all patients that are 18 years or older at time of admission. Hospitals will report on two SDOH quality measures: (1) the percent of adult inpatients who are screened, on their date of admission, for at least one of the health-related social needs and (2) the percent of screened adults who screen positive for each of the five-health related social needs. Patients are excluded if they opt out of the screening or if they or a caregiver is unable to complete the screening during the inpatient stay (U.S. Department of Health and Human Services, 2024).

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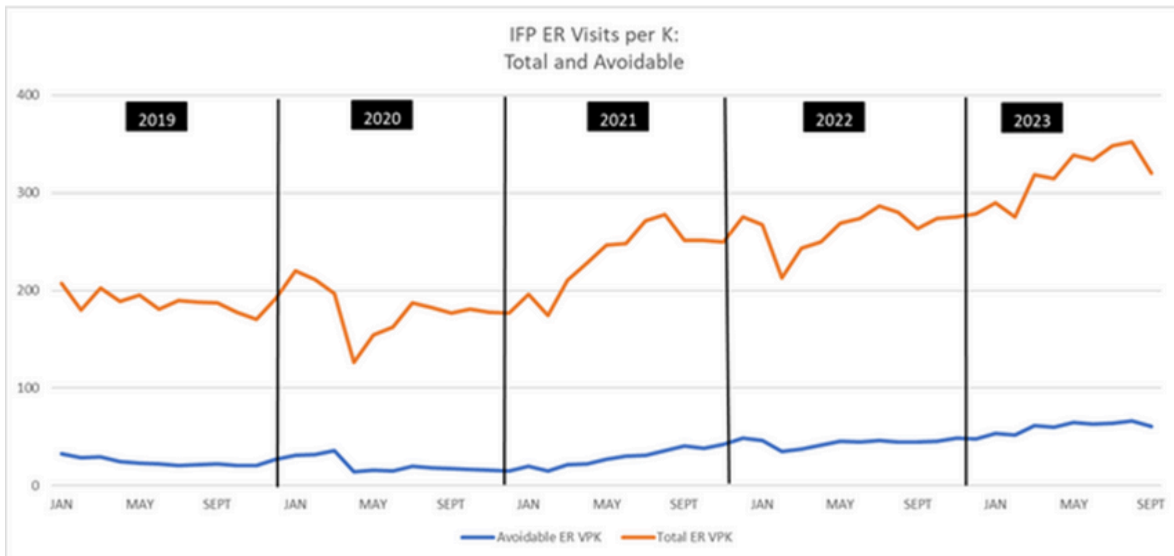

Pilot Interventions:

- Utilize Virginia HIE IFP Member ED visit data
- Utilize 5 IFP care coordinators to provide outreach calls to members within one (1) business day to address any potential Health Related Social Needs (HRSN). (TOC Standard 1)
- Complete a Cigna enterprise SDOH assessment on any contacted member (TOC Standard 2)
- Care coordination services and/or community resources (FindHelp™) offered to contacted members (TOC Standard 4 and 5)
- Document and communicate referral (TOC Standard 5)

Anticipated Benefits:

- Improved ability to assess member social determinants of health
- Lower cost of care to IFP members demonstrated by reduced ED utilization
- Collaboration and communication within internal CM teams
- Increase in Find Help™ referrals.
- Increased community-based services referrals

Process Outcomes: January - May 2024

- Member reach rate -36%
- Care coordination services- 22%
- Community resource information -3.5%

Next Steps and Lessons Learned:

- Expand IFP pilot program
- Monitor data analytics: ED utilization, inpatient admission and readmission rates among population receiving care coordination and community referrals.

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HCA Pilot

Sunrise Hospital and Medical Center Pilot

Sunrise Hospital and Medical Center, located in Las Vegas, Nevada, is dedicated to giving people a healthier tomorrow. As a part of HCA Healthcare, the nation's leading provider of healthcare services, Sunrise Hospital has been committed to delivering top-notch medical services to a diverse population for over six decades. Being the largest acute care facility in the state, the hospital stands on its mission to provide compassionate and quality care, while continually evolving to meet the ever-changing needs of its community.
HCA chose Sunrise Hospital to participate due to their high population of Health-Related Social Needs (HRSN).

Problem: Need to ensure Z Code/SDOH factors are captured and documented in the EMR to comply with 2024 CMS IPPS requirements.

Transition of Care Episode: Acute Care to discharge/next care setting

Hypothesis: Utilize modified nursing assessment to capture SDOH factors will increase case management consultations, SDOH interventions, referrals, and collection/reporting of Z codes to CMS.

Pilot Interventions:

- EMR assessment revisions and SDOH education to nursing staff pre pilot
- EMR nursing assessment modified to assess/document for SDOH factors
- Positive nursing assessment triggers an alert to case management for further assessment and consultation (TOC Standard 1)
- Case management assessment determines contributing SDOH factors (TOC Standard 2)
- All acute care patients require mandatory medication review/reconciliation by hospital pharmacist/physician. (TOC Standard 3)
- Case management documentation of SDOH contributing factors (TOC Standard 4)
- Case management collaborates with patient/family on transition of care plan (TOC Standard 4)
- Case management utilizes Find Health™ for community referrals/resources (TOC Standard 5)

Z Code

SDOH-related Z codes (Z55-Z65) are the ICD-10 CM diagnosis codes used to document SDOH data (Centers for Medicare and Medicaid, 2023; Medicaid.gov, n.d.).

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Anticipated Benefits:

- Increase in Z codes captured
- Identify the highest % of Z codes by the five Health-Related Social Needs (HRSN)
- Increase in case management referrals for HRSN patients
- Identify and capture the community resources provided to patients to support HRSN.
- Improved patient transition of care
- Patient knowledge of community resources

Process Outcomes:

SDOH CM Consult Volume				
January 2024	February 2024	March 2024	April 2024	May 2024
23	98	108	109	118

SDOH Category	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
Living Situation	12	39	41	54	50
Food	4	18	15	21	21
Transportation	5	25	27	37	33
Utilities	0	1	2	2	0
Safety	1	24	20	22	23

**Homelessness, transportation, and food insecurity are the primary unmet needs. Safety unmet need required additional education to nursing staff.*

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SDOH Interventions per Category

SDOH Category	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
Living Situation	2	18	15	28	18
Food	1	9	6	15	13
Transportation	1	13	10	23	18
Utilities	0	0	0	3	1
Safety	0	4	4	5	3

**Interventions were largely provided related to homelessness and transportation needs. Many transportation needs were for the Medicaid population who were unaware of transportation program benefits.*

Lessons Learned:

- The term *interpersonal safety* (one of the HRSN criteria) required further discussion
- Education was provided regarding interpersonal safety criteria
- Case management identified Medicaid patients who were often unaware of their transportation benefits in their coverage

Next Steps:

- Monitor data regarding patients who screen positive for at least one of the HRSN
- Monitor data regarding patients who screen positive for each of the HRSN criteria.
- Monitor case management consult alerts for social drivers of health needs
- Develop additional strategies to address high homelessness and transportation needs

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Summary:

ACMA recommends that organizations committed to improving SDOH processes (which include: data collection, early identification, and interventions) should utilize the 2.0 TOC Standards, the organizational assessment tools, and the 2.0 TOC toolkit to develop their organization-specific plan. Early process outcomes indicate the TOC 2.0 Standards show applicability in populations with health-related social needs.

Dissemination of the TOC 2.0 Advisory Committee work, and the results of the pilots were presented at the 2024 ACMA National Case Management conference in Nashville, Tennessee. (April 2024) The Transitions of Care website will be updated and ACMA will continue to share the value of the TOC 2.0 standards nationally.

Listed below are key considerations for organizations intent on improving transitions of care for patients with HRSN factors:

- Health care organizations require an interdisciplinary framework for collecting, submitting, and evaluating SDOH data to develop a comprehensive intervention plan
- EMR Automation/Alerts are key to success
- Organizational SDOH education mandatory
- CMS - Inpatient Z code submission transitioning to mandatory process and organizations should be prepared
- Organizations should consider hardwiring community resources/referral processes

Acknowledgement

ACMA wishes to acknowledge Pfizer for their support to review and revise the TOC 2.0 standards and assessments. Our thanks to the TOC 2.0 advisory committee members, who contributed their insight and experience to bring the important SDOH-related elements to the TOC standards. Our gratitude is immeasurable to Cigna Health and HCA for participating in pilots to test the applicability of the TOC 2.0 standards. In addition, the pilot project leads who implemented the processes and helped gather the data are included below. We could not have met the short timeline without their support!

Participants from Cigna HealthCare include:

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