Care Transitions Peer Hour – Institutional Transitions

Frequently Asked Questions

Question: Is Multnomah County Area Agency on Aging (AAA) currently doing home visits in your care transitions program? What services do you provide in the program? Do you plan on returning to home visits later or will the model remain via virtual?

Answer: Currently, the care transitions program is operating in a virtual capacity due to the COVID-19 Pandemic. We are currently exploring the integration of virtual options as the Pandemic continues. In a future state, we do anticipate moving back to a home visit model once the COVID-19 risk has subsided.

Question: Who did Multnomah County AAA initially approach in the hospital setting about getting access to the Electronic Health Record (EHR)?

Answer: We were a CCTP participating site. During CCTP, we discovered early on that we could not be as effective in our role in supporting safe transitions, without access to the electronic health record. Based on this experience, we included the requirement for continued access to the EHR in all of our subsequent negotiations. Therefore, when we went into negotiations with the hospital administration for a care transitions contract, we made sure that the contract language included EHR access in the same manner as a contracted specialist provider.

Question: Does Multnomah County AAA get reimbursed for care transitions services regardless if the person is readmitted?

Answer: Yes. We receive full compensation for every eligible person that we provide care transitions services for, regardless of their readmission status. The contract is not a risk-based, performance-only contract model. However, the hospital has an option of terminating the contract due to poor performance. Therefore, the hospital continually reviews our outcomes and performance.

Question: What care transitions model is Multnomah County AAA implementing?

Answer: We implement the Care Transitions Intervention® (CTI) Model, also known as the Coleman Model.

Question: What criteria are used to determine what clients are included in the program?

Answer: The primary exclusion criteria for our program is a primary admitting diagnosis being a substance-use disorder or serious mental illness (SMI). Inclusion criteria includes one or more chronic conditions with an expectation of transitioning from acute inpatient status to a community-based setting.

Question: What services, if any, are provided to individuals post discharge?

Answer: Our care transition program follows the core tenants of the CTI® Model. Under this model, each participant is matched with a care transitions coach. The coach will provide services to coordinate care based on the three pillars of the program model. Since the primary tenant of CTI is health coaching, the care transitions coach does not actively direct the participant to any program or service.

Question: As your hospital partner(s) are under audits, survey, or other governmental/licensure review, is the ADRC also reviewed?

Answer: The ADRC is providing a contracted service to the hospital. We provide the services, as defined by the contractual arrangement with the hospital. The funding for the intervention is paid by the hospital so we do not submit claims to Medicare, Medicaid or other payers. As a result, our services are not directly included as part of any audits or surveys, except for the fact that our services must comply with the standards of care when providing health services, such as HIPAA requirements and the protection of health information.

Question: How do the care transitions coaches have access to EPIC? Are there parts of a patient's chart they cannot access?

Answer: The care transitions coaches have remote access to the EPIC system. The type of access is “read only” access. The coaches only access the electronic health record based on their need for information regarding the patient’s care. This generally includes the patient’s entire inpatient treatment record and medication information. The care transitions coaches are trained to access the EHR on a need-to-know basis and the use of the system is continually monitored. Therefore, if the care transitions coach accesses patients or systems that are not relevant to the person that they are working with, this could be flagged for a violation and repeated infractions could jeopardize continued access.

Question: Are you working with individuals who have a post-acute facility stay prior to going home?

Answer: No. We do not currently accept patients that will transition from the acute hospital to a post-acute care facility. We are only providing care transitions services for persons that will transition to an appropriate community setting.

Question: Are the transition coaches for your program social workers and case managers?

Answer: We have persons of varying skill sets that operate as transition coaches. Our transition coaches include social workers, case managers, and health coaches. Each person must be properly trained on our intervention prior to being deployed.

Question: What are some key ADRC data components you pitch to health care systems?

Answer: The key data evaluation metrics include the following:

Outcome Measure

- 30-day readmission rate

Process Measures

- Number of persons that are offered the program
- Number of persons that accept the program
- Number of people that complete the intervention
- Additional services that were offered to participants

Question: How are the care transitions interventions paid for? What are the typical rates/fees under the contract?

Answer: The primary contract is directly with the hospital. The hospital pays a fixed fee for a 30-day care transition intervention. Each person that receives the 30-day intervention is included in an invoice that is submitted to the hospital monthly. The hospital remits payment for care transitions services based on the invoiced amount.

Question: What has been some of the biggest challenges with continuing or establishing programs and collaborations with hospitals?

Answer: One of the biggest challenges for establishing program and collaborations with hospitals is defining a clear pathway for sustainability. Hospitals are recognizing the value of the care transitions program, but it can be a challenge to define how the program is paid for. Another primary challenge is the development of community-based information technology systems that integrate with health system and physician-based EHRs. The cost of most health IT systems is generally beyond the scope of most community-based organizations so deploying models without the proper IT systems represents a significant challenge.