LeadingAgeNY – DNS Conference 2014

Transitional Care Partnerships: Aligning Forces for Improvement In Care Coordination Across the Continuum

Introduction

Three year innovative community coalition partnership involving the hospital, skilled nursing facility & home health providers within the Albany, New York community, focusing on improvement in communication, care coordination and management of clinically complex, high-risk patients across the health care continuum.

The successful outcomes achieved from this community-based partnership approach across multiple care settings are a result of implementation of cross-setting strategies, tools & resources within the coalition through monthly meetings, ongoing communication and case review.
Call To Action

Improve the quality of care
for patients who transition among the
Albany Care Transition Coalition health care settings
through a comprehensive community effort
to improve cross-setting communication, care coordination and
patient/caregiver activation
and self-management skills.

Albany Care Transitions Coalition

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<th>ALBANY CARE TRANSITIONS COALITION PROVIDERS</th>
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Project Goals & Objectives

- Engage senior leadership within each of the community healthcare organizations for support of cross-setting initiatives to improve transitional care across the continuum
- Identification of the driving forces of readmissions within the Albany community targeting a 5% reduction in Medicare FFS 30-day all cause readmissions by December 2013
- Establish desired goals & outcomes through shared perspectives from the acute care hospital, skilled nursing facility and home health agency care settings, including measureable financial & satisfaction outcomes achieved through the collaborative partnerships
- Adopt & implement cross-setting innovative strategies, tools, resources within the Albany community coalition partnership to improve communication, information transfer and care coordination across the continuum

Why is this really an issue?

- Cost to healthcare
- Acute care crowding and overuse
  - Hospital push-back
- Negative impact to resident
Why is this really an issue?

It’s the right thing to do!

Readmission Drivers

- Lack of Standardized Information Transfer
  - SNF  Emergency Department
  - Emergency Department  SNF
  - Hospital  SNF
  - Hospital  Primary Care Physician

- Lack of Patient/Caregiver Activation & Self Management Skills

- Lack of Standardized Process for Communication to Coordinate Care
Vision & Focus of Initiative

- Three year initiative (January 2012 – January 2015)
- Facilitate cross-setting partnerships
- Shift the paradigm of care coordination away from the existing “siloed” care delivery to patient-centered care that spans the health care continuum
- All community healthcare providers have an active role in collaborating with their community partners to address cross-setting
  - Care Coordination
  - Information Transfer & Exchange
  - Patient Activation and Education for Self-Management
  - Medication Reconciliation
- Commit to investigate internal systems and processes to target opportunities for improvement and implement strategies and interventions to improve care coordination

Local Challenges

- Each care setting functioned as a “silo”
- Lack of effective formal relationships with other settings making 1:1 communication care coordination difficult
- Information systems not interoperable making it difficult to access patient information between settings
- Large merger between several local hospitals and skilled nursing facilities consolidated into one health system within community
- Financial impact of length of stay and readmissions
- Single clinician rarely provides continuous care across patient settings (Hospitalists, SNFists, PCP, Specialists)
Acute Care Perspective

- Financial penalties for readmissions
- “Frequent Flyers”
- Misuse/overuse of ED and inpatient resulting in lack of bed availability
Quality Pool Money

- DAL 7/31/14 - 2014 Nursing Home Quality Initiative (NHQI) Methodology

  - In the Efficiency Component, the points assigned to the Potentially Avoidable Hospitalizations (PAH) measure have been reduced from 20 to 10, while the total points in the Quality Component have increased from 60 to 70.
The PAH measure will be calculated using the primary diagnosis on the hospital discharge record. This is a change from the 2013 NHQI, in which the admitting diagnosis was used. Use of the primary diagnosis aligns with the avoidable hospitalization measures used in the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, the Managed Long Term Care Quality Incentive, and the Delivery System Reform Incentive Payment (DSRIP) Program in New York State.

Quality of Care

- Residents Decompensate
  - Increased confusion, dementia
  - Potential to return de-conditioned
  - Potential to return with skin impairment
  - Potential for change in medication management with short and long term adverse effects
What are the driving forces for transfer from LTC to the ED?

- Staffing
  - Nurse skill mix
    - Licensure and capabilities
  - Staffing numbers
    - Nurse to patient/resident ratio

- Medical staff coverage

What are the driving forces for transfer from LTC to the ED?

- Family influences
  - Fear
  - Lack of trust in NH capabilities
    - Hospital was always the place to go

- Advanced Directives
  - Lack of resident/family education
    - Resident/family not prepared or ready
What are the driving forces for transfer from LTC to the ED?

- LTC acuity
  - Acuity has increased
  - ? Preparation

Culture

- Easier to send to ED than manage on site
  - Lack of staff for monitoring
  - Lack of technical ability
    - Frequent labs
    - IVs, IV push, central lines (PICC, etc)
    - Wound vacs, respiratory therapies, CPM machines, etc
  - Agency staff
Transitional Care Partnerships

- Educate acute care, LTC and home care regarding reality and challenges of health care in the different settings
  - Staffing
  - Medical Support
  - Technical capabilities

Community Approach

- Shared agenda & leadership
- Cross-setting Case Reviews
- Evaluation Summary review
- Concurrent tracking of 30-day all-cause readmissions
- Monthly review of progress
Community Approach

- Monthly face-to-face meetings
  - Hospital
  - Skilled Nursing Facilities
  - Home Health Agencies
  - IPRO

- Multidisciplinary representatives
  - Case Managers
  - SNF Liaisons / Admissions Coordinators
  - SNF Administrators
  - SNF Directors of Nursing
  - Information Systems
  - Hospitalists
  - SNF Medical Directors
  - Emergency Department Physician & Director of Nursing
  - Hospital Associate Medical Director
Transitional Care Partnerships

- Improve Communication
- Face to Face meetings
  - Formal
  - Informal networking
- Relationship building
  - 2 way communication – contact person
  - Trust

Transitional Care Partnerships

- Improvement Communication
  - Written
    - IPRO Transfer Record
    - Negotiate medical records to be sent between facilities to meet information needs in a timely, efficient manner
Interact

- Communication within Nursing Home
  - Stop and watch
  - sBar Communication Tool & Change in Condition Progress Note
  - Medication Reconciliation Worksheet for Post-Hospital Care
- Decision Support Tools
  - Acute Change in Condition File Cards
  - Care Paths
- Communication Between Nursing Home and Hospital
  - Nursing Home Capabilities List
  - NH – Hospital Transfer Form
  - Acute Care Transfer Checklist

Interact

- Quality Improvement
  - Hospitalization Rate Tracking Tool
  - Quality Improvement Tool for Review of Acute Care Transfers
- Advance Care Planning Tools
  - Advance Care Planning Tracking Tool
  - Comfort Care Order Set
  - Educational Information for Residents and Families
LTC responsibilities for process

- NH must initiate contacts in acute care and home care to be successful
- Know and enhance your clinical capabilities

LTC responsibilities

- Market self
- Know your outcomes – enhance your outcomes
  - 30 day returns
  - Infection rate
  - Number of ED transfers
    - Number of ED visits vs number admitted
LTC Responsibilities

- Medical staff development
- Nursing staff development
- Culture change
- Standardized order set for physician population
- Customer focus for external healthcare customers

Culture change for staff

- Manage resident’s healthcare
  - IV therapy for short term hydration
  - Perform frequent VS, FSBS
  - Monitor resident
    - Manage and report early changes
  - Provide more complex services
Home Care Perspective

Patient Centered

Patient transitioned by Home Care Liaisons:
- Hospital
- Nursing Home
- Home
Home Care Perspective

● At the hospital:
  - Hospital CM’s & SW’s identify patients going to SNF who may require home care post - d/c from SNF
  - Patient referred to home care agency at the hospital
  - **Home Care Liaison RN** meets with patient to discuss what they can anticipate with home care, advise that a Home Care Community liaison will meet with them at the SNF
  - Home Care Liaison RN communicates clinical/social issues to home care agency, anticipated SNF and hospital d/c date.

Home Care Perspective

● At the nursing home:
  - Home Care **Community Liaison RN** follows up with patient at SNF
  - Has discussion with SNF Discharge Planner and Clinical Team to gather pertinent information and **communicate** to Home Care Intake Department, clinical leadership, and clinicians
  - Identifies specific needs of patient; assists in facilitating referral
  - **Meets with patient** to answer questions, and prepare family/caregivers for what they can expect with home care
Home Care perspective

- At home:
  - Home care clinicians deliver care based upon information that was shared and communicated throughout the transition from hospital to SNF to home
  - Patient has had interaction with a liaison at both hospital and SNF where services and the transitions are explained
  - 30-day readmission rate for patients in the program: 3%

Home Care Perspective

Patient Centered Communications is Key!

- Hospital Case Management
- Home Care RN Liaisons – Hospital & Community; Clinical Teams
- SNF Discharge Planners and Clinical Teams
Outcomes

- Improved partnerships and communication
  - Nurse to Nurse Report upon transfer

- Real-time communication
  - Notify hospital Access Center prior to transfer
    - Communicate directly with RN regarding patient condition
    - Allows for shared decision making for plan of care
  - Case scenarios reviewed at monthly meetings
  - Discussion related to transfer issues
  - Skilled Nursing Facilities & Home Health Agencies provided access to Sorian EHR to track patient/resident progress

Outcomes

- SNF capabilities for care management incorporated into an automated resource database for Emergency Department staff & Case Manager access

- Standardized transfer of information
  - Standardized information to accompany resident upon transfer back to the SNF
  - Re-designed Medication Reconciliation document
  - Emergency Department Summary and Plan of Care

- Cross-setting assessment of patient outcomes
  - Hospital performs onsite follow-up visit to SNF post discharge

- SNFs utilizing INTERACT Transfer Tool to ED

- SNF implementation of INTERACT QI Tools
Progress To Date: 30-Day All Cause SNF Readmissions

- Average decrease of 7% in the SNF 30-day readmission rate
  - April 2012 and February 2013
- Actual decreases range from 3.3% to 14.2%
  - An increase was noted during the November - December onset of flu season
- 30-day readmission rate has remained substantially below the April 2012 baseline of 32%, prior to the implementation of interventions
- Outcomes were achieved without capital investments & with the financial impact relating only to salary time for meeting participation
- Collaborative partnerships are the foundation for sustaining and building on the improvements and successes achieved to date within the program
Why a partnership?

- To understand each other’s challenges
- Forces compliance
- Forces progress

QUESTIONS