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Transitional Care Partnerships: Building Bridges for Improved Communication & Care Coordination Across the Healthcare Continuum

December 15, 2016

Featured Speakers

- Sara Butterfield, RN, BSN, CPHQ, CCM, Senior Director, Health Care Quality Improvement Program, IPRO

- Patricia LeGasse, Quality Assurance Coordinator, Niagara Falls Memorial Medical Center
Objectives

- Discuss forces driving re-hospitalization at the national & statewide level
- Identify the importance of cross-setting collaboration for improved communication, information transfer & patient/caregiver activation and engagement
- Describe strategies for involving caregivers in the discharge planning process

National & NYS Landscape

- Center for Medicare & Medicaid Services (CMS) Triple Aim
- Delivery System Reform Incentive Payment Program (DSRIP)
- Quality Assurance/Performance Improvement (QAPI) Requirements
- Preferred Provider Status
- Quality Report Cards
- Community Based Care Focus
- 30 day Readmission Penalties
- Pay for Performance/Quality Based Payment Initiatives
Medicare Fee for Service (MFFS) Readmission Trends

Source: CMS Medicare FFS Paid Claims Data

NYS MFFS 30-Day All Cause Readmission Trends, CY 2015

Observations Drawn from the #s in the Re-Admission Table

<table>
<thead>
<tr>
<th>Percent Of Discharges With No After Care</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall 14 Day Re-admission Rate</td>
<td>59,424</td>
<td>504,620</td>
</tr>
<tr>
<td>Overall 30 Day Re-admission Rate</td>
<td>98,252</td>
<td>504,620</td>
</tr>
<tr>
<td>14 Day Re-admission Rate For These Patients</td>
<td>220,772</td>
<td>504,620</td>
</tr>
<tr>
<td>30 Day Re-admission Rate For These Patients</td>
<td>23,022</td>
<td>220,772</td>
</tr>
<tr>
<td>Numerator</td>
<td>38,550</td>
<td>220,772</td>
</tr>
<tr>
<td>Denominator</td>
<td>10,4%</td>
<td>17,5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent Of Discharges To SNF</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall 14 Day Re-admission Rate</td>
<td>121,217</td>
<td>504,620</td>
</tr>
<tr>
<td>Overall 30 Day Re-admission Rate</td>
<td>15,400</td>
<td>121,217</td>
</tr>
<tr>
<td>14 Day Re-admission Rate For These Patients</td>
<td>26,065</td>
<td>121,217</td>
</tr>
<tr>
<td>30 Day Re-admission Rate For These Patients</td>
<td>111,007</td>
<td>504,620</td>
</tr>
<tr>
<td>Numerator</td>
<td>24,215</td>
<td>111,007</td>
</tr>
<tr>
<td>Denominator</td>
<td>12.7%</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent Of Discharges To Home Health</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall 14 Day Re-admission Rate</td>
<td>111,007</td>
<td>504,620</td>
</tr>
<tr>
<td>Overall 30 Day Re-admission Rate</td>
<td>14,875</td>
<td>111,007</td>
</tr>
<tr>
<td>14 Day Re-admission Rate For These Patients</td>
<td>24,215</td>
<td>111,007</td>
</tr>
<tr>
<td>30 Day Re-admission Rate For These Patients</td>
<td>13.4%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

Source: CMS Medicare FFS Paid Claims Data
NYS MFFS 30-Day All Cause Readmission Trends, CY 2015

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Septicemia (except in labor)</td>
<td>12,367</td>
</tr>
<tr>
<td>Congestive Heart Failure: Non-Hypertensive</td>
<td>7,012</td>
</tr>
<tr>
<td>Complications of Device: Implant or Graft</td>
<td>3,699</td>
</tr>
<tr>
<td>Complications of Surgical Procedures or Medical Care</td>
<td>3,479</td>
</tr>
<tr>
<td>Pneumonia (except tuberculosis or sexually transmitted cases)</td>
<td>3,396</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease and Bronchiectasis</td>
<td>2,887</td>
</tr>
<tr>
<td>Acute and Unspecified Renal Failure</td>
<td>2,773</td>
</tr>
<tr>
<td>Cardiac Dysrhythmias</td>
<td>2,645</td>
</tr>
<tr>
<td>Respiratory Failure: Adult Insufficiency and Arrest</td>
<td>2,360</td>
</tr>
<tr>
<td>Urinary Tract Infections</td>
<td>2,247</td>
</tr>
</tbody>
</table>

Source: CMS Medicare FFS Paid Claims

Driving Forces

- Increased population with complex care needs
- Focus is on discharge versus transition (the hand-off)
- No ownership of transition outcome
- Burden of coordination is placed on patient/caregiver
- Lack of advance directives & screening for palliative care
- Communication gaps across health care settings
- HIPAA perceptions
- Polypharmacy
- Absence of cross-setting medication reconciliation
Poorly Executed Care Transitions

- Increase hospital readmissions, Emergency Department visits & observation stays
- Leading cause of medication errors
- Emotionally & physically stressful for residents & caregivers
- Expensive
- Result in adverse events & avoidable complications
- Contribute to increase in time & staffing allocation to manage the transition

Coordination of Care Initiative Goals

- Facilitate a comprehensive, cross-setting community-based effort
- Engage & activate patients/caregivers
- Achieve effective communication, information transfer & care coordination
- Ensure patient-centered care
- Coordinate medication management across care settings
Care Coordination Approach

- Regional cross-setting community coalitions
- Community-based Root Cause Analysis
- Adoption of evidence based interventions
- Assistance in monitoring & measuring impact
- Building collaborative partnerships for sustainability

Care Coordination Approach

- Identify common goals across settings
- Understand cultural & procedural differences
- Discuss perspectives on issues associated with failed transitions
- Focus on the current versus desired state
- Move out of the silo(s)
Root Cause Investigation

- Identify high-risk populations & screening mechanism
- Socio-economic factors
  - Dually-enrolled in Medicare and Medicaid
  - Behavioral health & substance abuse
  - Alzheimer’s & other dementia disorders
  - Social determinants of health
  - Multiple chronic conditions
  - Three or more medications including but not limited to anticoagulants, diabetic agents & opioids

Building Community Care Transition Collaboration & Partnerships

Build a strong care transitions internal team
- Promote integration across all services & disciplines
- Identify current initiatives that support your efforts
- Ensure essential senior leadership buy-in
- Involve front line staff to build enthusiasm
- Find your champions
- Educate your medical staff
Building Community Care Transition Collaboration & Partnerships

Get your Data House in order
- Know your hospitalization & readmission rates for all payors
- Track & trend readmissions
- Review readmissions in real-time to identify those that were potentially avoidable & identify any recurrent conditions for initial focus
- Implement process to identify high-risk patients/residents

Building Community Care Transition Collaboration & Partnerships

- Identify referral sources & community partners with stake in improving care transitions
  - Connect with liaisons, case managers, discharge planners
  - Know and market your data and initiatives
  - Monthly meetings with referral sources to review progress & discuss challenges and barriers
- Focus on the Big 3:
  - What is working well?
  - What is not working well/an opportunity for improvement?
  - What are the priorities to address?
Important to Incorporate

- Proposed Medicare Discharge Planning Regulations for Hospitals & Home Health Agencies
- Medicare Long Term Care Regulations
- Caregiver Advise, Record & Enable (CARE) Act:
  - New York State legislative requirement
  - Part of AARP National Campaign & Federal plan
  - Creates process for hospital patients to formally identify a caregiver to provide after-care assistance
  - Caregivers to be educated to the discharge plan & related tasks

Hospital Readmission Risk Factors

- Poor outcomes
- Low health literacy
- Complex medication regimens
- High risk medications
- Incomplete transfer of information
Hospital Readmission Risk Factors

- Inadequate education of patients & support person/caregivers
- Language barriers
- Cultural differences
- Depression
- Limited understanding of community supports

Reducing 30-Day Readmissions

Pre-discharge interventions
- Confirm demographic information
- Identify a Primary Care Physician and community providers
- Identify a support person/caregiver
- Medication reconciliation
- Discharge planning/social work
**Caregiver Defined**

- Any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance to an older person or an adult with a chronic disabling condition
- Individuals may be primary or secondary caregivers
- May live with, or separately from, the person receiving care

**Integrate Caregivers Into Planning**

Identify
- Who recipient calls for emergencies or questions?
- Who takes patients to appointments & helps with transportation, etc?
- Where the patient & caregiver(s) live?
- The best way to communicate?
- Multiple caregivers?
Integrate Caregivers Into Planning

- Assess: Structured assessment (is there one in your Electronic Health Record)?

- Unique caregiver needs:
  - Not the same as the recipient, different understanding of needs & goals & how to support and provide care
  - The Assessment is a conversation, not an interrogation
  - Integrate results with assessment of recipient’s needs and plan of care

Assess Caregiver Needs

Potential barriers
- Professional discomfort with caregivers
- Caregiver reluctant to participate in an assessment
- Prioritize caregiver needs according to what could have biggest impact on recipient’s post discharge planning and well-being
- Assessment is an opportunity for caregiver to talk (for the first time) about fears, concerns, ambivalence and life circumstances related to caregiving
Integrate Caregivers Into Planning

Integrate
- Discharge options
- Medications
- Post-discharge appointments
- Identify & eliminate gaps in care
- Training
- Identify caregivers needs & link to services

Integrate Caregivers Into Planning

Share
- Communicate caregiver needs & role with post discharge providers
- Create a bridge from hospital or institutional care to home & long term care
- Review training provided to caregiver & make recommendations for further training
Integrate Caregivers Into Planning

- Reinforce
  - Post discharge call to both recipient and identified caregiver(s)
- Review
  - Health status
  - Medicines
  - Appointments
  - Home services
  - Plan for what to do in emergency or if problems arise
  - How caregiver is doing

Professional Staff Competencies

- Communication
  - Use active listening & teaching/coaching skills
  - Translate information across systems/providers & from family/caregivers to providers
- Assessment and Practice
  - Identify, understand and articulate caregiver’s circumstances, needs, strengths & goals
  - Understand and anticipate needs of caregiver & family
  - Develop, implement, evaluate and modify care plans in collaboration with caregiver
Reducing 30-day Readmissions

Post-discharge interventions
- Timely follow-up with providers
- Timely PCP communication
- Follow-up phone call to patient and caregiver
- Patient and caregiver HOTLINE
- Home visit with community provider

Interventions at Niagara Falls Memorial Medical Center

- Administration invested in the PROCESS change
- All departments trained & involved in the discharge planning process of the Patient-Caregiver Centered Approach
- Decision to focus on pre-discharge interventions
- Nursing & ancillary departments involved in patient & caregiver education
- Pharmacists on the units & ED facilitate medication reconciliation & patient/caregiver education
Interventions at Niagara Falls Memorial Medical Center

- Daily multi-disciplinary rounds/huddles to brainstorm & address needs of patients & caregivers
- Patients linked to Health Home Services
- Patients linked to Navigator program in the ER
- Caregiver key player in patient-centered approach

Summary of NFMMC Outcomes

<table>
<thead>
<tr>
<th></th>
<th># Eligible Patients</th>
<th># Patients Enrolled</th>
<th># Caregiver Assess. Completed</th>
<th># Trainings Provided</th>
<th># Rcvd Plan</th>
<th># BIP patient Readmits</th>
<th># all Medicaid Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Un.</td>
<td>883</td>
<td>455</td>
<td>356</td>
<td>365</td>
<td>290</td>
<td>37</td>
<td>65</td>
</tr>
<tr>
<td>Behavioral Health %</td>
<td>52% Participating</td>
<td>78.2% Assessment Completed</td>
<td>80.2% Trainings to Care-givers</td>
<td>63.7% Received Caregiver Plans</td>
<td>8.1% BIP Readmit Rate</td>
<td>8.65% Medicaid Readmit Rate</td>
<td></td>
</tr>
<tr>
<td>Acute Units</td>
<td>596</td>
<td>326</td>
<td>273</td>
<td>273</td>
<td>239</td>
<td>16</td>
<td>46</td>
</tr>
<tr>
<td>Acute Unit Percentages</td>
<td>55% Participating</td>
<td>82.9% Assessment Completed</td>
<td>82.9% Trainings to Care-givers</td>
<td>71.8% Received Caregiver Plans</td>
<td>4.9% BIP Readmit Rate</td>
<td>7.7% Medicaid Readmit Rate</td>
<td></td>
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