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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

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

December 15, 2016
### 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

### 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

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**Medicare Fee for Service (MFFS) Readmission Trends**

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Number of Cases</th>
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<tbody>
<tr>
<td>Septicemia (except in labor)</td>
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<td>7,012</td>
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<tr>
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</tr>
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Source: CMS Medicare FFS Paid Claims Data

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

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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

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

### Hospital Readmission Risk Factors

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

### 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

Integrate Caregivers Into Planning

- 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>Behavioral Health Un.</th>
<th>Acute Units</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible Patients</td>
<td># Patients Enrolled</td>
</tr>
<tr>
<td>TOTALS</td>
<td>883</td>
<td>405</td>
</tr>
<tr>
<td>Behavioral Health % Participating</td>
<td>52%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Behavioral Health % Assessment Completed</td>
<td>78.2%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Acute Unites</td>
<td>596</td>
<td>326</td>
</tr>
<tr>
<td>Acute Unit Percentages</td>
<td>66%</td>
<td>82.9%</td>
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