Moderator: Hello and welcome to Public Health Live! --The Third Thursday Breakfast Broadcast. I'm Rachel Breidster and I will be your moderator today. Before we get started I would like to ask that you fill out your online evaluation at the end of the webcast. Continuing education credits are available after you take our short post-test. And your feedback is helpful in planning future programs. I also want to let you know that the planners and presenters of Public Health Live! do not have financial arrangements or affiliations with commercial entities whose product, research or services may be discussed. And no commercial funding has been accepted for this activity. As for today’s program we will be taking questions throughout the hour at 1-518-402-0330 or via e-mail at phlive.ny@gmail.com. Today’s program is titled Transitional Care Partnerships: Building Bridges Across the Healthcare Continuum. And our guests are Ms. Sara Butterfield, Senior Director for Healthcare Quality Improvement Program at IPRO and Ms. Patricia LeGasse, a Quality Insurance Coordinator for the Niagara Falls Memorial Medical Center. Thank you for joining us.

Moderator: Good morning, Sara. Thank you so much for being here today. To get us started would you review what the objectives are for today's webcast?

Ms. Butterfield: We will discuss the forces driving re-hospitalization at the national and statewide level and also identify some of the importance of cross-setting collaboration for improved communication, information transfer and patient caregiver activation and involvement in their care and describe strategies for involving caregivers in the discharge planning process.

Moderator: Excellent, thank you. What are factors that are driving the importance of improving patient and caregiver experience at the time of transition between different healthcare settings?

Ms. Butterfield: There is a number of national and statewide driving forces and initiatives that are focusing on readmissions, re-hospitalization and the overall care management and care transition as patients transfer across the continuum of care. Certainly, the Centers for Medicare and Medicaid services. Medicare is focusing on coordination of care, looking at readmissions, medication management for high risk medications, but also emergency department utilization. And within New York State and other states there is also a delivery system program, DSRIP. And that also is focusing on a specific patient population, the Medicaid or duly eligible population. Those focus on exactly the same things, readmission, emergency department and utilization of services. Also on the national and statewide perspective are quality improvement or performance improvement pay for performance initiatives that involve looking at overall care management and outcomes of patients. In some regions, there are report cards or quality report cards that are being put together perhaps for acute care systems or hospitals looking at most cost effective highest quality of care organizations and providers in the community to provide the most efficient care possible to the patient.

Moderator: Let's talk about data and what does the data show about the forces really driving the
Ms. Butterfield: If you look back to when care transitions really became a focus, say back to the end of 2009 when we first began our work we saw a higher re-hospitalization rate for national perspective it was 62.5. And that has trended down, if you look at the first quarter of 2016, to 51%. New York State is always higher than the national rate. New York State started at 70.7 and now it is trending down for the first quarter of 2016 to 56.5. So the trend really started in decreasing around the fourth quarter of 2011 and that really comes together if you see the lowest over the last few quarters. There is definitely a number of initiatives causing the rates to come down and improvement to be seen.

 Moderator: Excellent. Is there data that shows where the 30-day Medicare fee for service readmissions are coming from in the community?

Ms. Butterfield: Yes. When we look at Medicare fee for service data we look at what is driving from the community, where are the patients coming from. Certainly, when you look at all of New York State aggregate data for readmissions the 30-day all cause readmissions rate is 19.5%. The majority of patients are discharged home. Forty-three percent of discharges from all New York State hospitals are discharged home without after care meaning they don't have services in place such as home care. That population they have a readmission rate at 30-days of 17.3%. That is pretty low. Discharges to skilled nursing facility account for 24% of the patient population discharges. Those have a higher readmission rate of 21.5%. Home health care 22% of the discharges are going to that health care setting. They have readmission rate of 22% at 30-days. Certainly, those patients that are going to home health, skilled nursing facilities are a more complex co-morbid patient population. We have seen through our work there is definitely opportunities for cross continuum collaboration and care management to bring those rates down even further.

 Moderator: Are there certain diagnosis that you see that have higher readmission rates that others?

Ms. Butterfield: We do. Looking at Medicare fee for service data the most primary cause coded for readmission is septicemia, which is surprising to some folks when we share that with them. So the second being congestive heart failure and followed by complications of implants or graft, complications with surgical procedures or medical care. The number five is pneumonia. We have a special program dedicated to sepsis and identifying sepsis earlier in the community to help reduce readmission rates.

 Moderator: Excellent. Now, let's talk about why there is such importance being placed on the idea of care transition. Why is it important to have the conversation?

Ms. Butterfield: We have increasing population of very complex patients that in the older days were managed at a greater length of time in the hospital. And now they are moving out into the community. So the care management really has to shift out into the community. The more complex patients we also see that there is more focus on the discharge or the handoff to the next community. For these complex patients they need to be managed as a whole from the hospital out to the community whether that be skilled nursing facility or home health. And they need to be communicating and collaborating on the care management. There needs to be transitions of the outcomes. When you think of some of these patients they are going back and forth to the hospital two and three times a month. When you think about the stress to the patient, to the caregiver and all things that can happen during that transition it's very stressful for the patient and the caregiver.
There is also a great deal of communication gaps that are existing across the health care setting. And then confusion over and perceptions about HIPAA where one care setting is afraid to share with next care setting to be able to coordinate the care. Lastly, one of the issues we see, one of the major driving forces in all the communities is the polypharmacies. We have patients in multiple medications, 15 to 20. And those medications are being managed by about five or six different physicians. As it gets to be very complex on the caregiver and the patient to be able to manage their own care. And then lastly the absence of a medication reconciliation so, there is a source of truth document that transitions across almost care coordination provider setting.

**Moderator:** There is certainly a lot to consider. We are hoping transitions happen well. Let's talk about what is the impact if a care transition is not well coordinated.

**Ms. Butterfield:** Certainly, increased readmissions, utilization of the emergency department. We have patients that are on observation stay and focusing on what happens to those observation stay patients once they leave the hospital. Are they having higher utilizations of emergency department visits? Poor care transitions is also the leading cause for adverse drug events which also lead to readmissions and poor outcomes for the patient. We talked about it being stressful for residents and families, but also expensive both to the health care system and provider settings that are caring for the patients. And it really increases when you think about a readmissions if this is a patient that is in home care or skilled nursing facility. The time and resource allocation that it takes for the staff to coordinate that transfer to the hospital and then taking that patient back out into the community, there are certainly costs associated with that, as well.

**Moderator:** Absolutely. As a Medicare quality improvement organization for New York State, IPRO is involved in a very important national coordination of care tasks funded by CMS, Centers for Medicare and Medicaid services. With your efforts focused on New York State can you tell us more about that initiative and the outcomes that are involved?

**Ms. Butterfield:** Yes. This is a national initiative. New York was one of the first IPRO organizations that pilot tested this coordination of care initiative. All of the quality improvement organizations nationally focus on this with their community focusing on partnering the different provider settings together within a community. Anyone involved in care management of that patient or resident in the community is involved in talking and communicating and doing a better job at care management. Our job is really to help those organizations identify how to engage patients and caregivers, identify what is not working so well within the system and allows focus on the system in process and insuring that it is patient-centered care, so the patient is at the center of what is happening and they are involved and actively engaged in the care management. And then another big piece of this is the medication management coordination, reconciliation of medication.

**Moderator:** What are some approaches that you would recommend to successful care transitions?

**Ms. Butterfield:** The way we found to be most successful in managing this is regional cross-setting community coalition. We involve and invite everyone within the community that is involved in the care management. That includes the hospital, home health, hospice, nursing homes and community service providers together to look at what are driving forces. We help them do a Root Cause Analysis to identify what are the factors within the community driving readmissions and utilization. And then we help them identify evidence-based interventions that would be appropriate to address what the issues are in that community. And then most importantly we help them monitor and measure the impact. Certainly, you don't want to have an intervention in place and
not be looking at progress and seeing if it is make a difference. What we found is the coalitions
develop a collaborative partnership together and that promotes the sustainability for it to continue
on in the community.

**Moderator:** What would you say in looking at this approach, what are key steps you think are
important to discuss?

**Ms. Butterfield:** I think with partnering all of the health care providers together it helps them
identify what their common goals are across the setting. I would venture to say that every health
care organization now no matter what setting is focusing on readmissions and utilization and
medication management. Being able to identify common goals and then also as they do this work
together as a coalition they are able to identify the challenges between one another's settings. So
the hospital gets to understand the nursing home challenges, home health, so that helps them
better identify what the gaps are in the system and to be able to address and improve the process
of care management. Looking at the perspective of the issues that are associated with failed
transitions and also identifying what is the current state and where do we want to be as the desired
state for that transition to happen. And those partnerships together help build those
communication and develop those relationships, so that those areas can be focused on.

**Moderator:** Certainly seems like the idea of collaboration is really key in all of this.

**Ms. Butterfield:** It is. Moving folks out of their silos, which everyone tends to be in. And to be
able to be talking with one another.

**Moderator:** You mentioned earlier of Root Cause Investigation. Can you tell us more about what
you mean by the Root Cause Investigation?

**Ms. Butterfield:** We identified who the high risk patients are, who are the high risk populations.
Each of the provider settings needs to have a screening mechanism in place to identify the
patients, residents in their organizations that are having frequent hospitalization, frequent
utilization of the emergency department. Each organization, having a screening mechanism to
know what to do different with those patients, what are the interventions? How will they impact
that particular high risk area? We found that most organizations focused on disease specific
initially and certainly what we were able to see was a decrease in readmissions. The
socioeconomic factors, the duly eligible patients with dementia or behavioral health issues,
substance abuse, multiple chronic conditions and then specifically those patients at high risk for
adverse drug events, those patients on opioids or diabetic agents or anticoagulants that are at
high risk for an adverse drug event. All of those are part of the Root Cause Investigation to be
able to drive what interventions are appropriate for that particular community.

**Moderator:** What strategies have you found to be successful in building strong care transition
teams?

**Ms. Butterfield:** Well, we want to be able to promote integration of all of the services within that
community that touch the care of the patient. And each community has initiatives that are in place.
What we see is that most other care coordinators or providers in the community aren’t aware of
initiatives that are going on. Every one of the providers’ organizations has liaisons that work with
hospitals or home health agency or skilled nursing facility. We encourage folks to focus on who
those liaisons are to be able to get to the table, to invite them to be part of the coalition for this
work. You also want to make sure that the front line staff, direct care staff are the folks that are
working on this initiative. They know all of the steps, what’s not working well, and often have
opportunities to share on how to improve that. They also, finding the champions out in the community and champions within each organization and then certainly education of the medical staff within each organization, so that they know what is happening and are involved in the process.

Moderator: Are there also key things to keep in mind in addition to building a successful team? Looking at the other side of it, the data systems. Are there key things to keep in mind reviewing your data systems?

Ms. Butterfield: Certainly, we call getting your data house in order. Each organization needs to know who are their readmissions, where are they driven from? Where are they coming from in the community? Who are high risk providers that are sending patients in for readmissions? Those are certainly folks you want to involve in the coalition process. Looking at who those are and tracking and trending those readmissions and reviewing them with the sending organization. We recommend monthly meetings between home health, hospitals and skilled nursing facilities, to review who was readmitted to see if anything could been done differently. Along with that, it is very important to talk to patients and caregivers themselves. They can tell you why they came back into the hospital and identify what the gaps in communication or information transfer were. And implementing a process to identify those high risk patients out into the community and have a community service plan in place to manage their care.

Moderator: So now in your experience, what would you say are some of the key strategies? We are talking a lot about collaboration and getting folks out of their silos. What strategies have you found to be effective for really building these partnerships and seeing this work?

Ms. Butterfield: Each organization as I mentioned has referral sources that they could be working with. Those are the folks you want at the table to bring them together. Connect with monthly meetings. We recommend initially to identify what are the goals of that team, what are some of the gaps in how to address that? We also recommend that you focus on the system and the process in the patient and caregiver. No blaming. There is not any one system or health care entity that causes this everyone needs to work together. When we do these meetings we focus on the big three. What is working well? What is not working so well and is an opportunity for improvement? We have the coalition identify what are the top areas, goals that they want to work on, so everybody is involved in the process?

Moderator: Are there regulations that require care transition programs or require involvement of the caregiver?

Ms. Butterfield: There actually are. The Centers for Medicare and Medicaid Services has proposed discharge planning regulations that have not gone into effect yet. They have gone through comment period and they will impact hospitals and home health agencies, those rules themselves. There is a large focus on the types of information that is going to be transferred between each care transition. So certainly medication and the whole plan of care for that particular patient as well as what happened during that care time period or the care episode that that provider had the patient so there is a more smoother transition of care. There is also the Medicare long term care regulations that have gone into effect and those impact skilled nursing facilities. Now let's also address information transfer and discharge planning whether it be a short term skilled nursing facility patient or one that is a long term resident of the skilled nursing facility. There is the Caregiver Advise, Record, and Enable Act that has gone into effect New York State and that is part of The AARP National Campaign which requires the hospitals to identify upon admission a caregiver for the patient and the caregiver has to sign and agree to be the caregiver
for that patient during that stay. And they need to provide education information not only to the patient, but also to involve the caregiver so that when that patient transitions home that caregiver can assist them in remaining in the community and managing the home. All of those will have an impact on readmissions and care transitions.

Moderator: Thank you so much for everything you have shared with us this morning.

Ms. Butterfield: You're welcome.

Moderator: We recently spoke with registered pharmacist, Ann Myrka, Director for Drug Safety in Health Care Quality Improvement Program at IPRO in the important role pharmacists play in care transitions.

Ms. Myrka: Medication reconciliation is a struggle for many institutions because they fail to see it as a larger part of a medication management system but instead often see it as a check list of things that need to be done instead of thinking about it in a way where there are clearly delineated roles, responsibilities, and accountability and of course quality improvement builds into the entire system. Some of the keys to successful medication reconciliation is to first of all establish almost a department of Medrec or a system of Medrec. So, number one you want to create executive leadership. You want somebody at the top who can help identify resources to bring to bear to the program. And then you want to identify clinical champions and apply evidence-based best practice such as the marquis Medrec tool kit that was developed by the Society of Hospital Medicine in conjunction with an AHRQ grant. The other key issues are identifying roles, responsibilities and accountability. Often times facilities will say we all do Medrec. If everybody does Medrec then nobody is really doing it. You need accountability. You need a system to measure outcomes using quality improvement techniques and be able to move forward in a way that is constantly improving and you can't do that in an isolated system. Everybody needs to be trained who is responsible from Medrec on obtaining the best possible medication history, discharge counseling and also identifying with patients who are the most important to capture for Medrec and for discharge counseling. Those high risk patients will be the elderly, patients who are being transferred into nursing homes, patients on high risk medications like anticoagulants, opioids, and antihyperglycemics, and antibiotics. So those are just a few of your high risk drug area that you could focus on for those particular patients. Often, times there have been a lot of studies that go on that utilize pharmacists for improving Medrec and certain studies have shown that when a pharmacist applies a pharmacotherapeutic intervention to patients' medication reconciliation and in conjunction with Medrec and that is identifying and resolving medication related problems. Then they can avoid having inappropriate medications remain on the medication list beyond that index admission. In fact, the Society of Hospital Medicine's marquis tool kit will provide return on investment tool where you can actually plug in your numbers and understand what your return on investment would be for hiring pharmacists and instituting a Medrec program. Communication is a huge overarching issue with medication management and Medrec. In several ways, there is communication between providers within an institution, understanding that they have to communicate in a standardized way so that they understand each other whether a nurse talking to a doctor, doctor talking to pharmacist or social worker. And then you have the issue of providers talking across care settings, maybe nurse to nurse talking about a patient's medication management or their Medrec across care settings somebody being transferred from hospital to nursing home or a clinician speaking to a patient, family or caregiver. So in a system that is creating an evidence-based medication management program you will define your roles, responsibilities, and accountabilities. People will be trained in getting the best possible medical history, people will be trained in discharge counseling. They will be trained in how to do medication reconciliation, but ultimately the pharmacy has to be a lead on this. This is how we were trained.
This is what we were meant to do as pharmacists and we need executive commitment to bring resources forward. You need clinical champions and you need intensive pharmacy involvement in order to identify not just discrepancies of medications but the pharmaco-therapeutic problems, medication related problems that need resolving so that patients do not remain on inappropriate medication.

**Moderator:** So welcome, Patty. Thank you so much for joining us this morning.

**Ms. LeGasse:** Thank you for having me.

**Moderator:** Let’s start off by talking about some of the key factors that you find that might contribute to somebody being readmitted.

**Ms. LeGasse:** We find the poor outcomes result in patient’s limited knowledge of their healthcare needs. Limited support, possibly mental and emotional issues resulting in needing hospitalization and limited understanding of access to the community support. The discharge planners and social workers need to assess patients both strengths and weaknesses in a short period of time and develop a comprehensive discharge plan. Patients with language barriers. As a result of those issues we have dramatic challenges to patients coming back in for readmissions.

**Moderator:** Absolutely. What are some of the other factors that might drive hospital readmissions?

**Ms. LeGasse:** Well, again, education of the patients and caregivers, language barriers, cultural differences, depression and really having the patients understand what is available out there in the community, being able to communicate their needs to their primary care physicians and really recognizing that there are health care needs to be paid attention to.

**Moderator:** So given all of these different potential readmissions risk factors can you give an example of interventions that might really help to reduce the risk of readmission?

**Ms. LeGasse:** What you really want to try to do is divide your discharge plan into phases. The first phase is to incorporate the demographics, understanding what the patient’s contact information, what are caregiver supports, incorporate your pharmacist throughout the discharge process.

**Moderator:** And in your experience, what do you consider a caregiver? We talked a lot about caregivers throughout the show. What do you consider a caregiver?

**Ms. LeGasse:** A caregiver can be a relative or a friend, a neighbor. You really want to try to have the patient define who that person is. A lot of times people will assume it is their emergency contact on their information, but really it’s who the patient really relies on to provide them transportation, support, a ride to groceries to needing a few dollars to get through the week. Really having that patient define who that support person for them in the community.

**Moderator:** That really might look different from patient to patient.

**Ms. LeGasse:** Absolutely.

**Moderator:** What would you say or why is it important, why do we need to engage a caregiver in the discharge planning process?
Ms. LeGasse: Really because again the patient has been through a traumatic event, they are here in the hospital. And you really want to have patient understand that they do have supports in the community and then having that caregiver understand what is going on with that patient.

Moderator: And what else would you say is important to focus on during this process? How do we integrate caregivers into the planning?

Ms. LeGasse: Again, once you make contact with that caregiver you have to begin to assess that caregiver. What role is that caregiver providing to that patient? What are some of the issues that the patient is really not providing to you with regard to their own health care needs and emotional needs? And again what are some of the limits and expectations that that caregiver may have for that patient? Maybe that caregiver themselves need linkages to support services. You really want to try to have a full understanding of that caregiver and what they're capable of providing to that patient.

Moderator: Sounds like it is important to not make assumptions about what the patient needs but really having a comprehensive conversation.

Ms. LeGasse: Really understanding the caregiver, what are the roles playing with that patient. You may need to have multiple caregivers so may need somebody providing transportation, somebody who will be assisting that patient with wound care or medication management. Maybe that person is going to be able to be a different person providing emotional support. It is important to have a true understanding of what is going on with that patient and who is providing what to that patient back into the community.

Moderator: Now, what are some barriers that might crop up during the process even if you have one or two different cooperative caregivers? I imagine there might be barriers that might pop up. What would that look like?

Ms. LeGasse: I think some of the barriers that we have are really the stresses that caregiver may have and understanding the medical needs or emotional needs of the patient and really what are the extent of those patient needs? And is that caregiver going to be able to manage those fears and those anxieties. A lot of times the caregivers themselves have issues and may have gone without recognizing some supports that are available to them in the community. So you want to make sure that you have a very comprehensive view of that patient and what supports they are going to need back in the community and who is providing them and what supports that individual is going to need, as well.

Moderator: So once you have made an assessment of the caregiver and what the needs might be. What is the next phase?

Ms. LeGasse: How are you going to integrate that caregiver to the discharge plan? Once you recognize what that patient needs upon their discharge back into the community, who is going to be playing what role? And then making sure that caregiver provided that education, that teaching and access to each part of the interdisciplinary team whether pharmacist for answering questions in regard to medications, maybe the physical therapist and how to assist the patient with their ambulation from standing to sitting and then walking. Whether or not they need assistance with bathing, toileting, or dressing and what are some of the avenues or equipment they are going to need for that. What are the appointments who are specialists? What is the contact information? It is a full gamut, not only for the patient to understand what is going on and what the diagnosis
and their testing was, but also for the caregiver. It is essential that the caregiver understands what is exactly going on for that patient to be able to assist that patient back into the community and be able to have those providers’ information and knowledge. Who are the community supports and if there is something going on how are they going to be able to access that community provider.

Moderator: Excellent. Now, what are some key things that really need to be shared with the caregiver during this process to make sure they are fully informed and can be a partner in giving care to the primary patient?

Ms. LeGasse: Again, it's important that the discharge planners and entire team know exactly what role that caregiver is going to be doing. So, for example, if that patient has a wound that they are viewing that wound while they are in the hospital. If there is a certified home care agency that will provide services in the home the net liaison is talking with the caregiver and patient while in the hospital so they are able to assess how to address it and what are the steps to that and if they have any concerns or questions who are they going to be able to contact. And making sure that that caregiver is comfortable and confident with what they going to need to provide for that patient. If they have issues or concerns who they are going to be able to follow up with.

Moderator: And what is important to address when informing the caregiver of the entire discharge plan?

Ms. LeGasse: It is important that you develop a relationship with your caregiver as well as your patient, to teach them. You are going to instruct them, guide them and provide you with that information back. What is the health care status of that patient? What is their diagnosis? What does that mean? What are medications and what is the reason for the medications? What are the follow up appointments that that patient has and dates and times of those? Are there community providers to assist that patient once they return home? If there are problems or questions who is going to be able to answer them not only for the patient, but for the caregiver because you are wanting a second pair of eyes on the patient once they return home.

Moderator: That makes sense. Who is capable of gathering the caregiver information?

Ms. LeGasse: Everybody is capable of gathering that information from the moment they come into the emergency room until transferred to the unit it is imperative that each member of the team communicate with one another. You want to make sure that you have the accurate contact information. You want to make sure that you understand what the role of that caregiver is going to be. You want to make sure that your team is aware of the anxiety or limitations of that caregiver as well as that patient. You want to make sure that you're anticipating any of the issues that may arise when that patient returns home so that caregiver is anticipating questions that that caregiver will have and maybe provide them with reassurance to what is going to happen in that transition.

Moderator: So do interventions stop once the patient is discharged? Is that the end of the road or what happens?

Ms. LeGasse: No, we find that this is really one of the key phases in a lot of institutions reducing their readmissions rate is doing the post discharge contact. I think the first thing is not only are you going to do a follow up phone call to the patient to make sure whatever services we provided have reached that patient, that patient assured what medications they are supposed to be taking. Also, post discharge contact to the caregiver is something going on? Is that patient following the medication regime? Are there other issues going on? Are you noticing a change in their breathing
or a change in their wound? So that you’re making sure that upon that initial few days to that two weeks afterwards that constant communication between the patient and that hospital setting.

**Moderator:** Now, Patty, your hospital, Niagara Falls Memorial Medical Center, successfully launched a program that focused on engaging the caregiver. Can you tell us more about that program?

**Ms. LeGasse:** Yes, we received a grant through the Balancing Initiative Program and the program was targeted for Medicaid patients. So any patient that came into our acute setting, behavioral health setting and a nursing home attached to our hospital, we try to obtain consent from patients to reach out to caregivers and involve them in the discharge plan and have them become part of the team. In addition, we made sure that the caregiver needed themselves some linkages and supports that we were able to provide that to the caregiver prior to that patient being discharged home.

**Moderator:** And are there any additional information that you would like to share about the intervention your hospital launched?

**Ms. LeGasse:** Really it required the entire team, from the administration staff to every insularly department so, everyone knew. We called it the BIP program, “Bridging in Patient Process” from hospital to home and back into the community. Really we wanted to make sure that every individual made contact not only with the patient, but caregiver so the caregiver had a full understanding of that patient health care needs but also became aware of what their community supports were and began to teach them how to speak to their primary care physicians or specialists not only for the patient, but also maybe for themselves, as well.

**Moderator:** Excellent. Have these programs led to positive outcomes or save any state Medicaid dollars?

**Ms. LeGasse:** Yes. Initially, prior to starting the project in September 2014 our readmission rate for acute patients was 13.5%. To date as of September of 2016 our readmissions rates for Medicaid patients is 7.1%. On behavioral health unit we started in 2013 readmissions rates of 20.3. We have seen a reduction in our readmissions to 8.1. And then in our nursing home we were able to have nine long-term care patients return back to the community to either a family like setting or to their home with supports.

**Moderator:** That’s certainly very promising outcomes, certainly something to be excited about.

**Ms. LeGasse:** Absolutely. In addition, we were able to save the state over $1.5 million.

**Moderator:** As much as the program is about providing quality care people like to hear about financial impact of things as well. That’s really terrific.

**Ms. LeGasse:** Absolutely.

**Moderator:** Thank you so much for what you have shared with us so far this morning. We will be back with Sara in just a few moments to answer questions from the audience.

**Moderator:** So welcome back. Thank you both for everything you have shared with us so far this morning. We have quite a few questions coming in from the audience. I want to start with the first one. How or who do we connect with someone from IPRO to be involved in a coalition? We have
a care coordination task force here in Albany and we are reviewing recruitment, pipeline, professional development and information referrals, etc. At the table we have behavioral health, insurance plans, senior services, home health agencies, the 3 P’s, AHEC, United 211, etc. IPRO’s presentation and support can provide insight into other areas of focus.

Ms. Butterfield: First of all that is an excellent start to building your coalition and having that coalition up and running. If you google IPRO, if you go to our website there is a coordination of care section on the website. And the contact information is there for myself. If you e-mail me we will certainly reach out to you and would be happy to send you your data, but also to engage you in the coordination of care project.

Moderator: Excellent. Thank you. Next question for Patty, can you talk more about the culture change in your hospital to incorporate the caregiver and discharge planning. How do you get a buy-in throughout the whole institution?

Ms. LeGasse: First we evaluated the process. From there we began to talk about what the grant was and what the project was. Then we provided education and teaching to all the insularly departments, your nursing, laboratory staff, physical therapists, occupational therapists, pharmacists as well as your program aides and then all of your environmental staff. So everyone knew what was going on and recognize that continues to be a challenge and occasionally a barrier but really when we began to talk about our success stories and gave them feedback to what the success of the project was not only to that patient but to caregiver and community then you began to see a change when they recognized that they had a difference in someone’s life.

Moderator: Yes, I could imagine that there is some resistance with all of the pressure and demands placed on medical professionals that now we incorporate new challenge but when you can show how effective it is that helps to sell the product.

Ms. LeGasse: It is a process, not an automatic change and change is evolving. So you need to recognize and evaluate what is going on, what are barriers the staff have and how do you address those to ensure that ultimately we are meeting the goal of providing care to that patient. That needs to be quality care.

Moderator: Excellent. Is there currently reimbursement for care transition programs?

Ms. Butterfield: There is for the different various settings. Certainly for the medical practices, physician practices there are transitional care management codes that they can build to for the physician or nurse practitioner, physician’s assistant, or nurse to work with patient post discharge from the hospital. And there are different initiatives depending on what setting you are in of the cost benefit analysis for some of the interventions certainly through the DSRIP program but from the Medicare side looking at some of the penalties that are put upon the hospital if they had higher readmission rates also coming into effect for skilled nursing facilities. If you look at the overall system that you have in place to see where the most efficient means of improving the process can be, it is going to be a cost reduction for yourself and the staff in allocation of time and resources. But, for some of the interventions, yes, there are reimbursement factors.

Moderator: Thank you. The next question, do you have suggestions for how to grow or develop the champions you need for this in your facility or community?

Ms. LeGasse: I think the first step is that you really want champions in every department. And then from there you want to develop a kind of team approach. You want to involve them in the
meeting and strategies and want to involve them in what the process changes are going to be. I think when you present a project or plan directly to them and they don't have an avenue in order to recognize that they built upon it. Then I think you get resistance when you recognize some of the barriers, issues that they may have with regard to bringing this new change in. Communicating and talking to your patients and your caregivers is going to be added time. Again, a lot of times where health care has gone is there are times when they come into the hospital and you are looking to get them out as soon as possible. Adding a few extra minutes, extending a discharge half a day results in reducing your readmissions when you are insuring yourself to have a clear comprehensive plan. And when the staff recognizes they are an important intricate part and a catalyst to the change.

Ms. Butterfield: I think what you mentioned before, Patty, is the importance of senior leadership support from the beginning and to have them help identify some champions. Also to think about patients and caregivers as champions, as well to involve them in the coalition and process because they have the most excellent feedback and ideas of what did not work well and perhaps how to fix that.

Moderator: That is a great point to make, as well. Thank you to both of you. Question for Patty. Did you have to add additional staff for your initiative at Niagara Falls Memorial Medical?

Ms. LeGasse: Yes, the grant able to provide us with a resource coordinator for behavioral health unit initially and were able to receive additional funds because of the success of the grant. In addition, we hired a full-time pharmacist for our behavioral health unit. We recognize that incorporating the pharmacist both at our emergency room department on each of the units and then providing that contact to both that patient and caregiver we saw reduction in anxiety and concern with regard to the medications and we saw more compliance among our behavioral health patients and willing to take medications because they had a better understanding of what the medications are and what the potential side effects are and symptoms they were haven't were not directly correlated to the medications, psychotropic medications that they were taking.

Moderator: We have two other questions that have come in in the same e-mail. One says on the one side hospital readmissions records is one of the other risk factors the patient's alcohol and other drug use?

Ms. LeGasse: Absolutely. Again, you are seeing a dramatic increase in alcohol and substance abuse admissions and readmissions in hospitals throughout the state. I think that brings upon its own challenges. However, when you recognize with a lot of your substance abuse users, alcoholics, who is one person they may have burnt a bridge with who potentially can have change in their life and bring that person back in or let that person know that you are going to try to re-bridge that relationship you may begin to see a change. We had one particular patient who was a chronic alcoholic and who had a limited contact with his daughter. He had multiple readmissions and then ended up becoming very sick. We asked to be able to contact his daughter and he wasn't sure whether or not his daughter would allow us to speak with her or be involved in his case. She ended up coming in and spending time with her father. They reconnected and she was able to be with him at the end stage of his life. So you may not get that, you know, absolute change but you may be able to rebuild relationships in different ways.

Moderator: Thank you. The second part is on slide summary of NFMC outcomes is the behavior health unit made up of mental health and substance abuse services? And I should preface that this is coming from someone that works for OASAS.
Ms. LeGasse: Unfortunately, a lot of your mental health patients do have substance abuse issues. A lot of patients who are alcoholics or substance abuse are depressed when they have been using for extended periods of time become suicidal. A lot of times we do have duly diagnosed patients in behavioral health units. A lot of times we are looking to send our patients to rehab. The challenges that we are finding now is your rehabs are full because of degree of alcohol and substance abuse in each of our communities.

Moderator: So in the behavioral health unit that you have you provide mental health and substance abuse services?

Ms. LeGasse: We provide mental health services, but it is an adjunct to our mental health. We are not substance abuse treatment facility.

Moderator: Thank you. The next question, excellent outline of caregiver engagement. The question is a majority of discharges and readmissions are nursing homes and home health agencies. Is there a corresponding one-on-one coordination with nursing assistant and home health aide caregivers to cover the same material and assure communication? Should there be?

Ms. LeGasse: Absolutely. You know, you want to have direct contact with your liaison whoever is providing the services whether it is your certified home care agency. That liaison is usually the same coming in on a daily basis. You want the liaison to have as much information as the patient and caregiver as the rest of the team does. And then if you know your patient is high risk for readmissions there should be that communication with those community providers whether your mental health service providers, substance abuse providers or child services. And really following up with that patient.

Ms. Butterfield: And there is a particular intervention that has been successful for home health and skilled nursing facilities and the intervention is to reduce care transfers. And the interventions to interact, that program involves all levels of staff within the home health agency as well as skilled nursing facility with the goal to improve communication and understanding internally within the organization but to improve communication out into the community. That certainly is one intervention that could address that question.

Moderator: Thank you. Another question, Sara, what kinds of care transition programs are there across the state?

Ms. Butterfield: Actual programs? Well what we find is within different regions there are different programs. Some are system wide programs that involve multiple entities or just single hospitals or home health agencies or skilled nursing facilities. What we don't see a lot of is the cross-setting approach to that. There are a number of care transition interventions that folks have up and running. We don't see the connection out to the community. There are probably over 25 different interventions, care transitions programs that are effective. Unfortunately, there is not just one that can address all of the Root Cause Analysis issues that you identified. So depending on the region and depends on what particular segment.

Moderator: The next question we have, what is the best way you have found to educate or inform the caregiver about various community or facility services or medication reconciliation process?

Ms. LeGasse: We provide them with knowing where they live, what is their location? Bringing that patient and the caregiver right into the room and the liaison having contact with that liaison coming into your hospital and speaking directly to the patient and caregiver. So that there is that
beginning to build the relationship with that provider right in the hospital setting.

**Moderator:** Thank you. The next post discharge question for Patty and Sara. Can you talk more about the follow up that the hospital does after the patient is discharged?

**Ms. LeGasse:** We usually have a contact to the patient within 48 hours of the discharge. We also try to have a follow up phone call to the caregiver within 72 hours of discharge. How is everything going? Did the service providers come into the home? Are there any questions or concerns that you have? Have you been able to get ahold of your primary care physician? Do you remember when your appointments are? So providing that reinforcement to what the discharge plan is. And then with the DSRIP initiative we are going to do a follow-up phone call to both the patient and the caregiver within two weeks. We have a transitional care program right now that is a pilot program that we are doing where we are following up with the patient within 48 hours and then you also begin to do another follow-up phone call within 14 days of discharge.

**Moderator:** This is just my own personal follow-up question. We live in an area where everyone has a cell phone. Do you encounter where you go to make the phone call in the 48 hours and the phones have been disconnected or don't work? How do you address that?

**Ms. LeGasse:** With a lot of Medicaid patients they have minutes, so what we have begun to do is text. We will be texting you and our discharge planners or our care coordinators have a cell phone, so they are able to text with the patient.

**Moderator:** That sounds terrific. We have one more question. The same gentleman who e-mailed us from OASAS. In screening, debrief intervention and referral to treatment, SBERT, a service provided at NFMNC -- is screening, debrief intervention and referral to treatment a service that is provided at Niagara Falls Memorial Medical Center? The focus on the screening, SBERT, is to identify and provide a brief intervention service to these using AOD in a risky or harmful manner or not necessarily those with a diagnosis of a substance abuse disorder. It is proven to be evidence-based practice that reduces emergency department visits and hospitalization. I'm not sure if that is something your facility uses or is familiar with.

**Ms. LeGasse:** That is not something our department uses. Again, we are behavioral health unit, we are psychiatric in patient unit so our focus is on mental health although a lot of patients do have a substance abuse issue that we do try to address and provide linkages to those services for that particular patient but we are not a treatment for substance abuse at our facility. So again we are getting into the initial phases. We are having the patient recognize it is part of their disease process and having them begin to become receptive to seeking treatment for that particular issue.

**Moderator:** Thank you both so much for all the information today. We are unfortunately out of time, but I think we have covered quite a bit of information. You both presented a really strong case for why this is such an important conversation to be having.

**Speakers:** Thank you very much.

**Moderator:** And thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available for today’s program. To obtain nurse continuing education hours, CME and CHES and Social Work credits learners must visit [www.phlive.org](http://www.phlive.org) and complete evaluation and the post-test for today’s offering. This webcast will be available on demand on our website within two weeks. Additional information on upcoming webcasts and
relevant topics can be found on our Facebook page. Don't forget to like us on Facebook to stay up to date. Now you can also let us know how you use Public Health Live! by taking a brief survey at www.phlive.org. Please join us for our next webcast on January 19th focused on Clinical and Ethical Indications for Cognitive Impairment Screening in Primary Care. I'm Rachel Breidster. Thanks for joining us on Public Health Live!