Building the Community
Strategies to Strengthen Transitions of Care

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Objectives

- Understand the “quality” concern of avoidable hospital returns
- Identify proven interventions that enhance the transition of care
- Strengthen community relationships

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Across the Continuum

Older patients with chronic illness often require care from varied practitioners in multiple settings. CMS reports, “This situation can be changed by approaching health care quality from a community-wide perspective and focusing on how all the members of the area health care team can better work together in the best interest of the shared patient population.”

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The ‘Quality’ Connection

- 1 in every 20 have an infection related to their hospital care
- 1 in 7 harmed in the course of their care
- 1 in 5 Medicare beneficiaries discharged from the hospital are readmitted within 30 days

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Drivers of Hospital Returns

- The five most common medical conditions for which hospital readmissions occur are:
  - heart failure
  - pneumonia
  - chronic obstructive pulmonary disease
  - psychoses
  - gastrointestinal problems.

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CMS Triple Aim

- Care
  - Improve the individual experience of care
- Health
  - Improve the health of the population
- Cost
  - Lower the Medicare cost curve

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Partnership for Patients

- Public/Private partnership
- Improve quality
- Improve safety
- Improve affordability of health care

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Partnership for Patients

- Hospital leadership
- Employers
- Physicians
- Nurses
- Patient advocates
- State and federal governments

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Partnership for Patients

Two goals:

1. Keep patients from getting injured or sicker
2. Help patients heal without complications

Potential savings:

•$35 billion across the health care system

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Hospital Engagement Networks

- Learning collaboratives for hospitals
- Initiatives to improve patient safety
- Technical assistance to establish systems to monitor and track progress toward goals

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Hospital Value-Based Purchasing

- Measure:
  - Patient experience of care
- Explanation:
  - How well….
    - …caregivers explained the steps patients and families need to take to care for themselves outside of the hospital (i.e. discharge instructions)

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Proven Interventions

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Proven Interventions

- Project RED
- Transitional Care Model
- Project BOOST
- Hospital to Home (H2H)

Proven Interventions

- **Care Transition Coaching ™ (Dr. Eric Coleman, MD, MPH)** is a model designed to:

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Proven Interventions

- **Care Transition Coaching ™ (Dr. Eric Coleman, MD, MPH)** is a model designed to:
  - Transfer skills
  - Build patient/caregiver confidence
  - Provide tools to support self-management

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Proven Interventions

- **The primary role of the Care Transition Coach SM** is to empower the patient/caregiver to:
  - Assert a more active role during care transitions and
  - Develop lasting self-management skills

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Coleman Model: The Four Pillars

- Medication management
- Patient-centered record (PHR)
- Follow-up with PCP/Specialist
- Knowledge of "Red Flags" or warning signs /symptoms and how to respond

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Paradigm Shift

Doing	Teaching & Advising	Coaching & MI
Clinician "owns" the agenda Clinician "does to" the patient Patient receives skilled care	Educator still controls agenda Patient is receiving information and advice on specific issues, medications, diseases	•Patient is telling the coach what their goals are •Patient is telling the coach what they know about their health and meds •Patient is telling the coach what prevents them from reaching their goal •Patient outlines their plan to meet goals •Patient creates action items, agrees to tasks

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Community Action

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CMS Triple Aim

- Care
  - Improve the individual experience of care
- Health
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Community Care Transitions Program (CCTP)

- Section 3026 of Affordable Care Act
- Community-based organizations tailor their program to unique needs of the community
- $500 million in funding

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- 654 acute care beds providing the full spectrum of primary and tertiary care services
- Over 30,000 Emergency Department visits in FY 2011
- 550 Physicians
- 5,000+ Employees who are dedicated to "*improving the health and well-being of every life we touch".*

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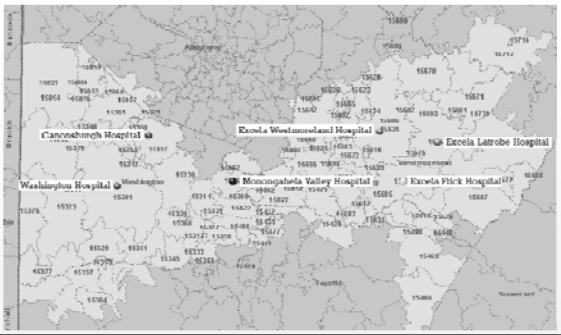
WPA Community Map



WPA CCTP Aims

The mission of the Western PA Community Care Transitions Coalition is to improve the experience of care and the health of the community while lowering costs with a model that supports a variety of care transitions.

<u>The goals of the coalition are to:</u>

1. Improve quality of care
2. Reduce 30-day readmissions by 20%
3. Test sustainable funding streams for care transitions
4. Demonstrate measurable savings to Medicare

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Area Agency on Aging Partners

Southwestern Pennsylvania Area Agency on Aging

- CCTP Community Based Organization
- Serves over older adults and caregivers in Washington, Fayette, & Greene Counties
- Core competencies include *Assessment; Information, Referral, & Assistance*; *Care Management*; and a broad range of *Home & Community Based Services*
- Excellence in Action awardee for QIO 9th SOW Care Transitions Intervention™ pilot
- WPA CCTP CTI coach - Monongahela Valley Hospital, The Washington Hospital, and West Penn Allegheny Health System Canonsburg General Hospital

Westmoreland County Area Agency on Aging

- CCTP Community Based Partner
- Serves older adults and caregivers in Westmoreland County
- Core competencies include *Assessment; Information, Referral, & Assistance*; *Care Management*; and a broad range of *Home & Community Based Services*
- Excellence in Action awardee for QIO 9th SOW Care Transitions Intervention™ pilot
- WPA CCTP CTI coach - Excela Health Latrobe Hospital, Excela Health Westmoreland Hospital, and Excela Health Frick Hospital

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Frick, Latrobe, & Westmoreland Hospitals
Participating Downstream Provider Partners

Skilled Nursing Facilities

- Baldock Health Care Center
- Greensburg Care Center
- Harmon House Care Center
- Hempfield Manor
- Loyalhanna Care Center
- Mountainview Specialty Care Center
- Oak Hill Nursing & Rehab Center
- Rehab & Nursing Center of Pittsburgh (RNC)

Home Care & Hospice

- Excela Home Health Care & Hospice
- Amedisys Home Care of PA
- Amedisys Hospice of PA
- Home Health Services: The Thorne Group
- Medi Home Health & Hospice

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WPA CCTP Target Population:
CTI™ Intervention

Zip code Service Area

- Serving 129 zip codes
  - ❖ Westmoreland County 64
  - ❖ Washington County 51
  - ❖ Fayette County 9
  - ❖ Greene County 3
  - ❖ Indiana County 2

High-Risk Medicare FFS Beneficiaries

- 3,500 annually having the following diagnosis or patient characteristics
  - ❖ AMI
  - ❖ CHF
  - ❖ COPD
  - ❖ PNEU
  - ❖ Multiple chronic disease

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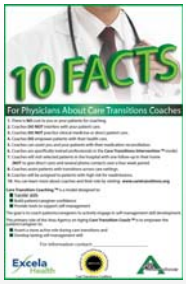
Education Tools



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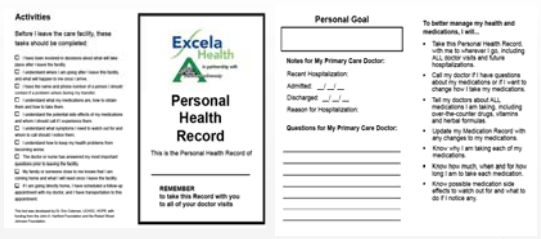
Personal Health Record


Activities

Before I leave the care facility, these tasks should be completed:

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Personal Health Record

This is the Personal Health Record of

REMEMBER to take this Record with you to all of your doctor visits

Personal Goal

Notes for My Primary Care Doctor:

Recent Hospitalization:

Admitted: __/__/__

Discharged: __/__/__

Reason for Hospitalization:

Questions for My Primary Care Doctor:

To better manage my health and medications, I will...

- Take this Personal Health Record with me to wherever I go, including ALL doctor visits and future hospitalizations.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

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The Structure of the Intervention

- 5 visits
  - In hospital prior to discharge
  - Home visit within 24-72 hrs. of discharge
  - 3 follow-up phone calls
- Completed within one month (30 days)

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AAA Opportunities for Collaboration

- AAA mission

"We hereby adopt the mission to be responsible to the maximum degree of our resources, to assist and enable older and/or disabled persons to live their lives as independently as their circumstances will allow and in the best possible and desired manner."

- Services
  - Preventative care
  - Nutritional
  - Transportation
  - Caregiver service
  - Support services

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Downstream Provider Partner Roles

Skilled Nursing Facilities

- Notified when transferred patients are enrolled in CCTP and have a CTI coach
- Coaches will communicate as authorized by CCTP participants consistent with the intent of the Coleman model
- Communication includes
  - confirmation of discharge dates from SNF
  - reminders to engage the CTI Coach upon discharge

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Downstream Provider Partner Roles

Home Health & Hospice

- Notified when transferred patients are enrolled in CCTP and have a CTI coach
- Coaches will communicate as authorized by CCTP participants consistent with the intent of the Coleman model
- CTI Coach and Home Health Agency to coordinate interventions

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Cross-Setting Transfer Tool

Universal Transfer Tool "Discharge/Transfer Nursing Summary" completed <u>within an hour of discharge</u> and faxed to next care provider with:

- Completed medication reconciliation discharge form
- Completed discharge instructions (AHPC)
- Contact information of hospital clinician

For SNF transfers, also include:

- Current MAR
- Dictated Discharge Summary

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Project RED

- Proven to:
  - Improve the care of Heart Failure Patients
    - Focused education
    - Timely follow-up
    - After Hospital Plan of Care
  - Reduce unplanned hospital returns
  - Reproducible methodology for many chronic diseases

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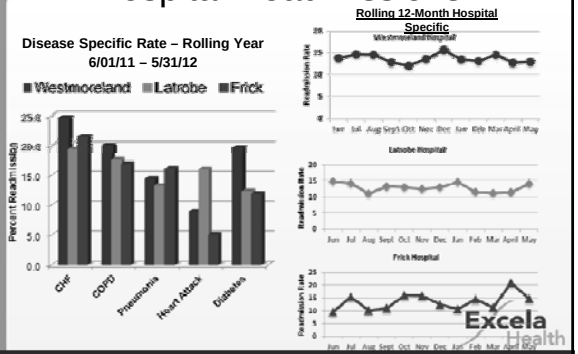
Hospital Readmissions



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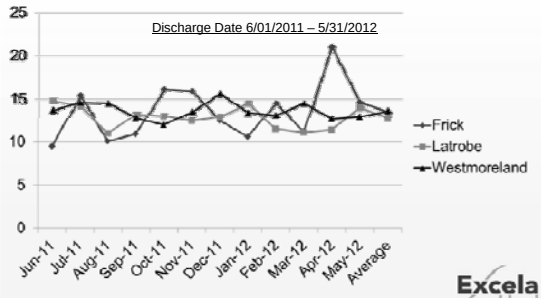
Hospital Readmissions



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Re-Engineered Discharge

- LH – all nursing units for heart failure; pilot COPD
- FH / WH – heart failure patients
- Diabetes

Nursing Facility Interventions

- Partnering to improve care delivery to the patient
  - Project RED
  - Enhanced ED Communication
  - Staff Education
  - Regular meetings with DONs

Electronic Medical Record

- Latrobe
  - February 2012
- Frick
  - March 2012
- Westmoreland
  - Spring 2013

Electronic Medical Record

- More concise medication reconciliation for home medications
- Printed “After Hospital Plan of Care” (AHPC) for every patient
- Follow up appointments made prior to discharge
  - Captured on the AHPC

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Next Steps

- Re-group with post-acute providers
  - Excela Health Community Liaison
- Share 30-day readmission rates
- RCA of “failed” transfers
- Readmission risk tools (hospital)
- Staff education
- Break down barriers

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Resources

- www.qipa.org
  - –Quality Insights of PA Tool Kit
- www.caretransitions.org
- www.CFMC.org
- www.cms.hhs.gov/QualityImprovementOrgs
- www.healthcare.gov/compare/partnership-for-patients

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Questions?

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