



“There’s No Place Like Home”

Reducing Hospital Admissions and Readmissions Through Transitional Care and Technology

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Disclosures

We, Helen Portalatin and Betty Jessup, have no actual or potential conflict of interest in relation to this presentation



Learning Objectives

- Discuss the complexity of Care Transitions
- Review Care Management activities that improve care transitions
- Highlight our organization's transitional care home visit model and follow a patient from hospital to home
- Share our strategies to reduce avoidable admissions and readmissions from Skilled Nursing Facilities, and strategies to reduce CHF readmissions.
- Discuss how telehealth technology is used in our practice, it's benefits and challenges



Crystal Run Healthcare Highlights



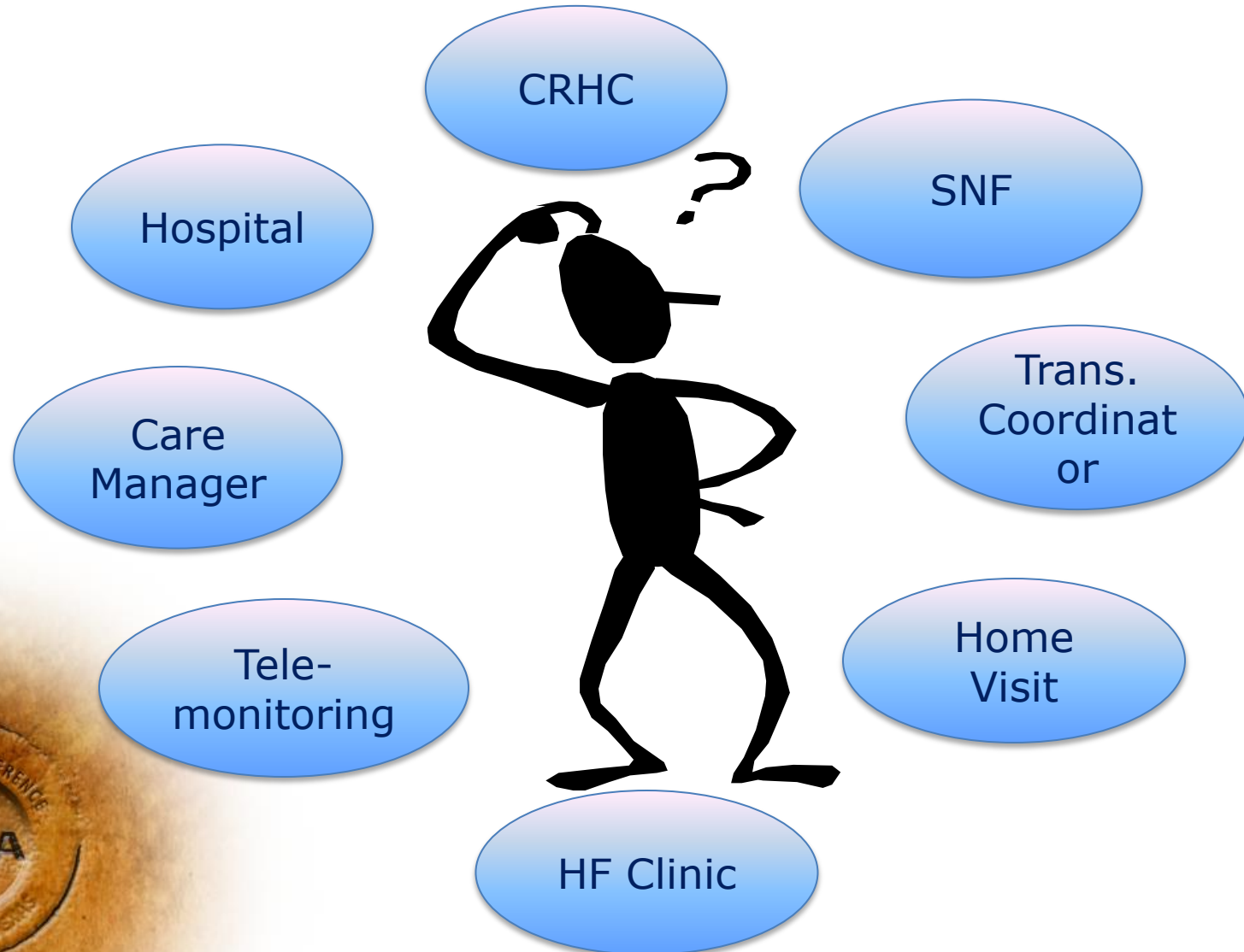
- Crystal Run Healthcare was established in 1984
- 15 sites
- 300 plus Providers
- 35 specialties
- 868,533 outpatient visits
- NextGen EHR.
- Joint Commission Accreditation since 2006
- Patient Centered Medical Home Level III Recognitions since 2009
- CMS – First group of ACO's MSSP participant
- NCQA ACO accreditation 2012



Almost one of five hospitalized Medicare beneficiaries are readmitted within 30 days; more than one-third are readmitted within 90 days. Research suggests that a substantial proportion of readmissions can be prevented with evidence-based care in the hospital combined with comprehensive discharge planning, supportive transitions in care, and timely primary care. With reduced readmissions, experts estimate the nation can save \$12 billion annually in the Medicare program alone. Medicare Payment Advisory Commission, "Payment Policy for Inpatient Readmissions," in *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, D.C.: MedPAC, June 2007).



Reducing admissions and readmissions



High-Risk Patient Management

High-risk patient characteristics

- Post hospital discharges
- Predictive modeling (Commercial payers and Medicare)
- Frequent fliers (2+ hospitalizations in last 6 months)
- 30-day hospital readmission pattern
- Noncompliance with prescribed treatment options and medications
- Complex comorbidities, heart failure, COPD

Population management

- Prioritizes chronic conditions
- Identifies comorbidities
- Uses disease registries

Practice guidelines

- Supported by Best Practice Council
- Improves care effectiveness
- Reduces unwanted variation
- Establishes goals and determines effectiveness

Patient-centered medical home – level 3

- Integrates population management with care managers
- Utilizes population data to conduct profiling and predictive modeling
- Embedded care managers on site
- Conducts remote monitoring and pharm management
- Conducts pharm management and remote monitoring

Advanced care management

Patient and system impact

- Better care coordination
- Increases communication between internal and external providers
- Enhances collaboration between PCPs and specialists
- Improves interaction among team members
- Facilitates seamless transitions
- Tele-monitoring
- Improves outcomes
- Hospital based Transitions Increases satisfaction and patient experience



Improving Transitions

- 1 Structured documentation of targeted high-risk patients and populations
- 2 Standardized assessments, treatment plans, goals and outcomes
- 3 Real-time patient tracking and provider communication
- 4 Embedded care managers at medical homes sites, Ortho, transition coordinator at hospital, home visits
- 5 Hand off communication

Care manager-to-patient ratio: 1:100-125



Improving Transitions

1 Ensure safe transitions to home post discharge

2 Patient contacted within 24 hours of discharge

3 Medication reconciliation and optimization

4 Appropriate services in place

- Home visit within 24-48 hours
- Tele-monitoring
- Heart Failure Clinic
- DME
- Safe to be home

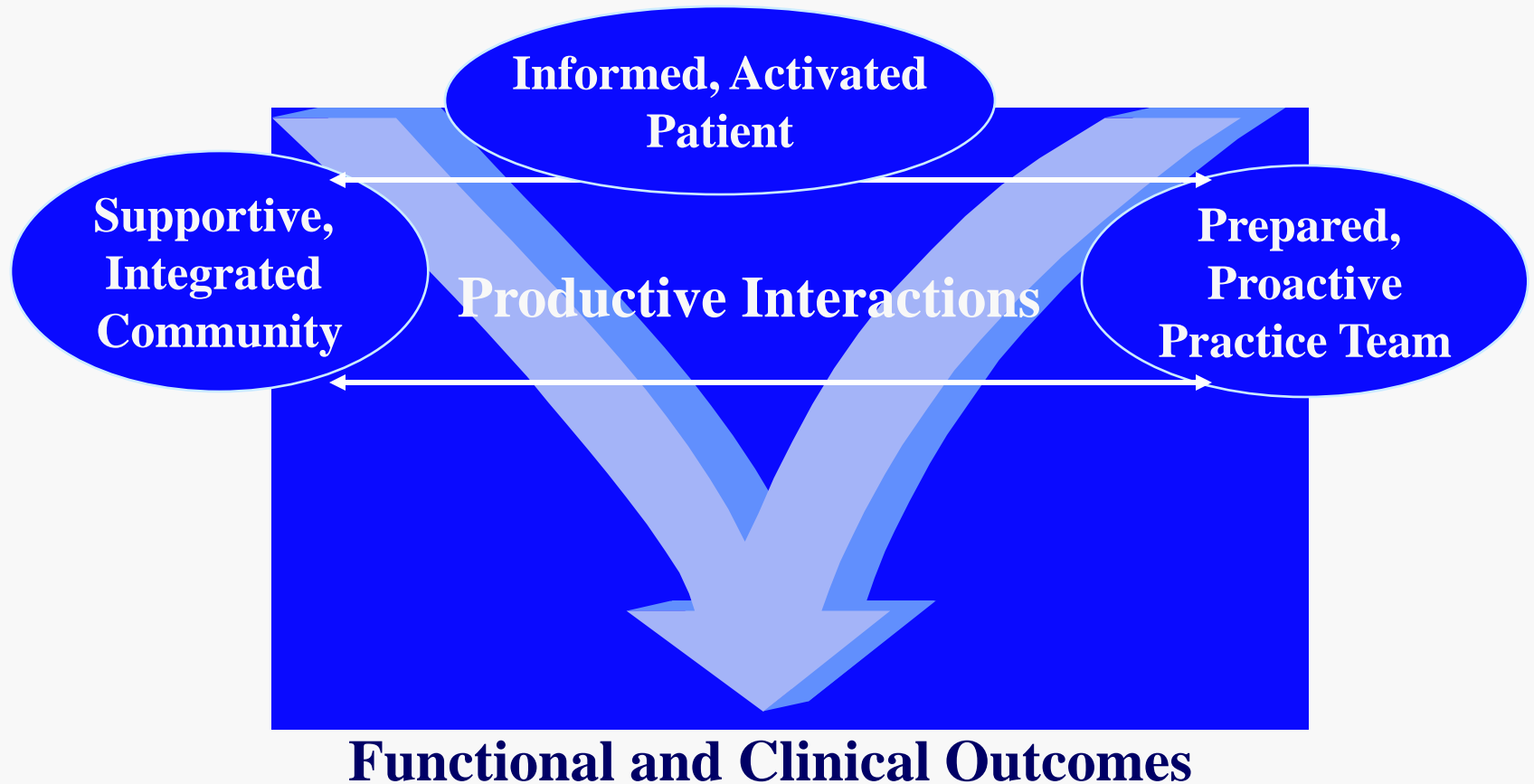


Avoidable admission/readmission

- 1 Exacerbation management
- 2 Self-management
- 3 Telephone and/or device monitoring
- 4 Follow-ups appropriate to meet care needs
- 5 End of life strategies - DNR, living will, non-hospital DNR



Chronic Care Model



Satisfaction • Clinical Measures • Cost • External Review Measures

Care Management Improving transitions

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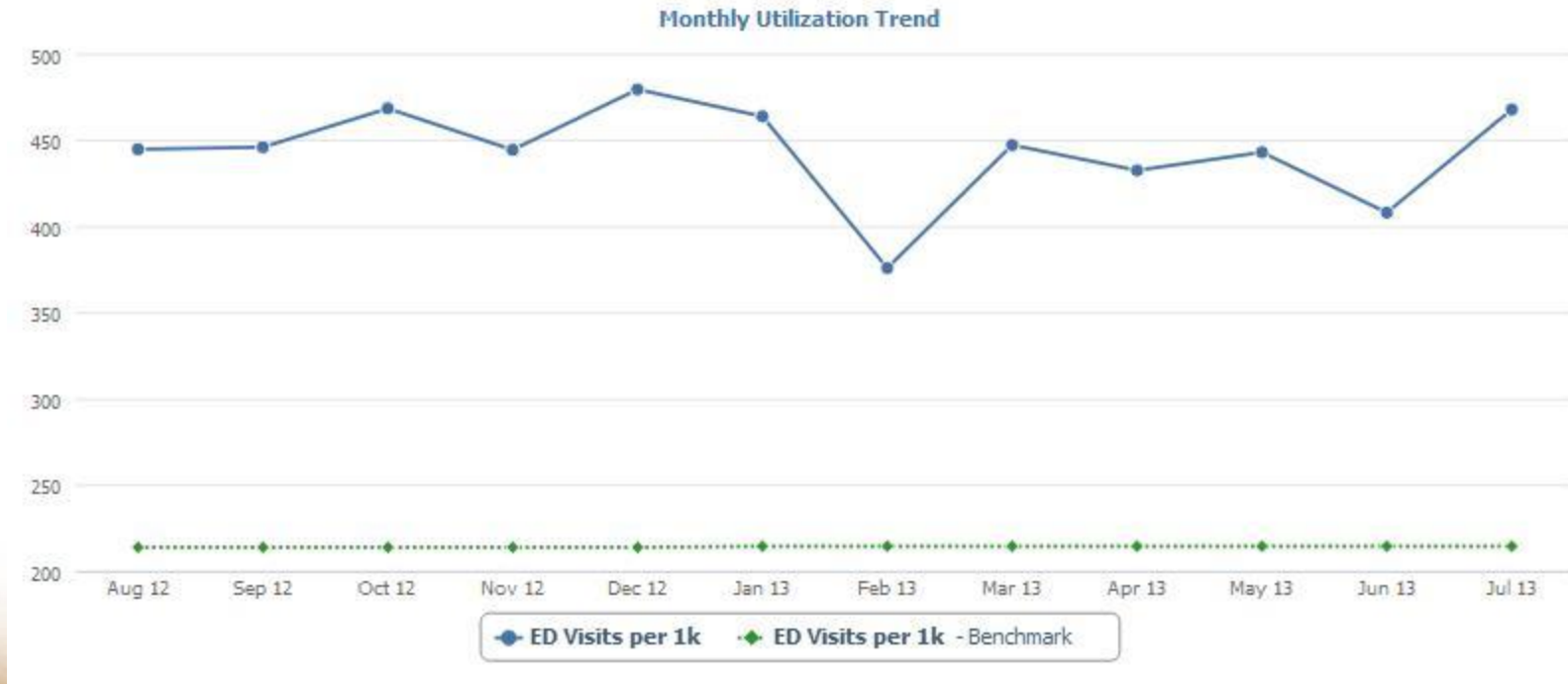
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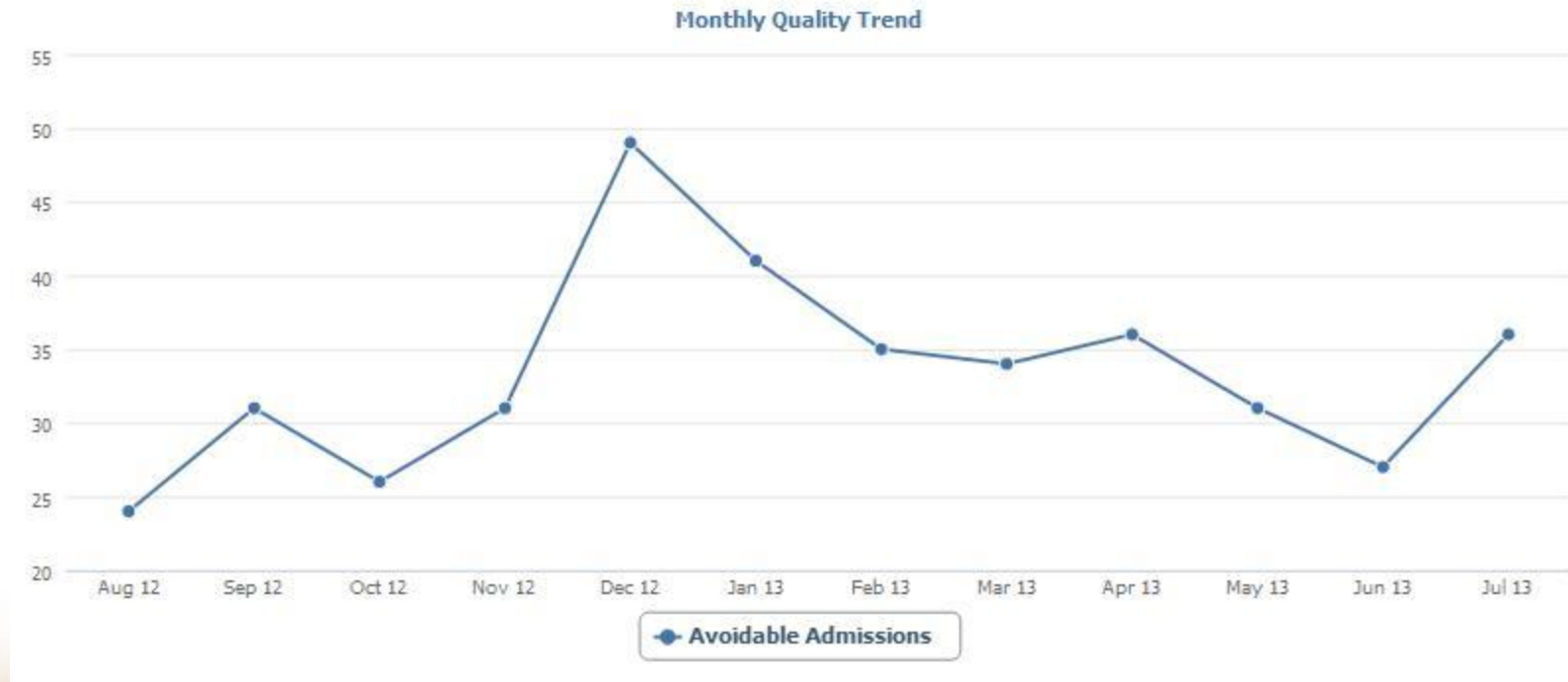
30 Day Readmissions



ED Utilization



Avoidable Admissions



Care Transitions

Evidence Based Models

Home Visit Program Structure

Patient Transition



Transitional Care Evidence Based Models

- Care Transitions Intervention
 - Coleman
- University of Pennsylvania
 - Mary Naylor
- Various Models



Care Transitions

Critical Components

- Patient follow up with PCP and Specialists within 7 days of hospital discharge
 - Includes outpatient labs and diagnostics
- Medication Reconciliation
- Self Management Education
- Effective hand-offs at each stage of transition
- Transition to chronic Care Management



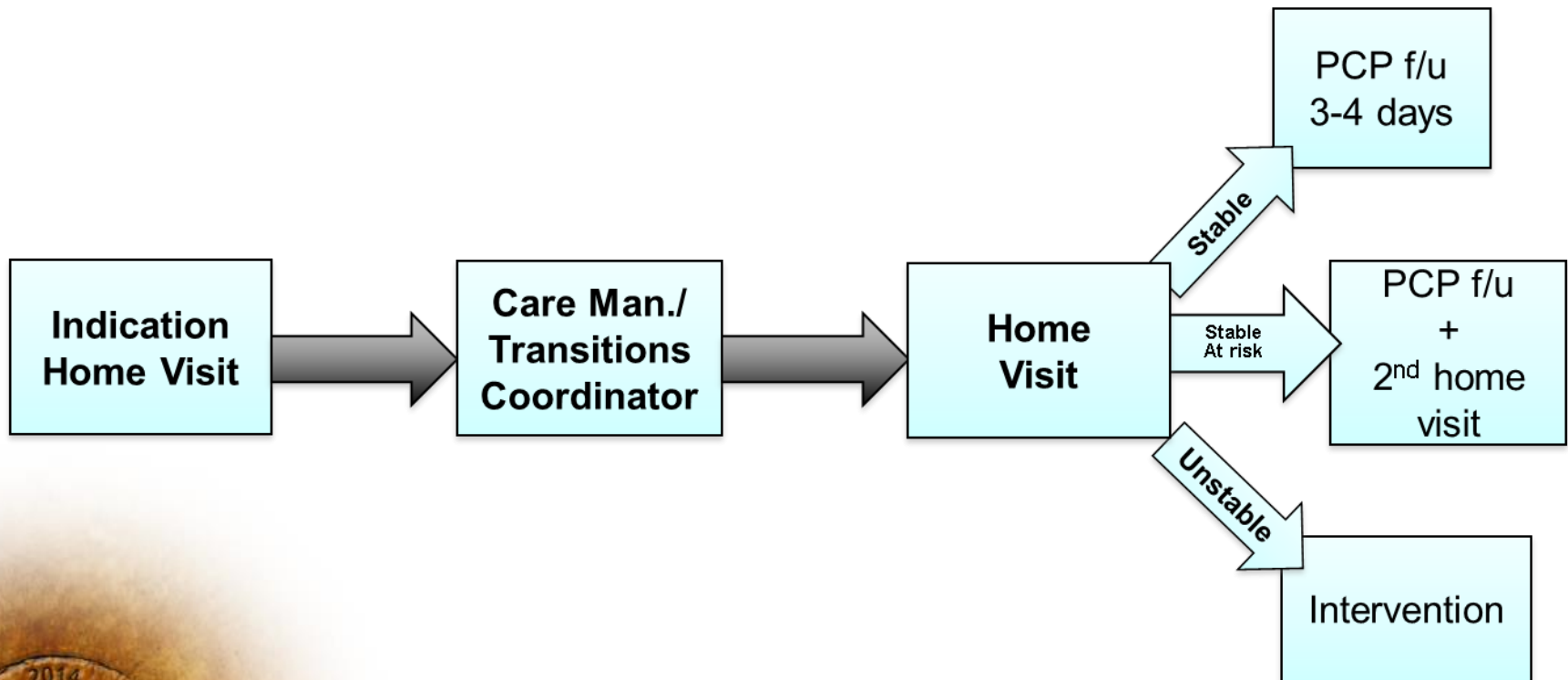
Home Visit

Patient Selection

- MSSP Population
- PCP in our practice
- 65yo and older
- High risk: 2 or more complex comorbidities
 - Primarily CHF and COPD
- Risk factors for poor outcomes:
 - Poor Self Management Skills
 - New Diagnosis
 - No Support/Lives Alone
 - No transportation to PCP appointment
 - Poor Medication Compliance
 - Impaired Cognitive Status
 - Mental Illness



Hospital To Home Transition Process



Transition: Hospital to Home



- Maria is a 70 y.o female h/o CHF EF 30%, afib on ac, COPD, Parkinsons, lives alone in senior housing, has progressive shortness of breath x 5 days, productive cough, weakness. Her daughter brings her to ED after finding her mother sitting in recliner struggling to breathe and confused. She is admitted to the hospital for CHF exacerbation.





- Transition process starts on hospital admission
 - “Transitions Coordinators” embedded in hospital, with access to hospital EHR
 - Review all admissions by our hospitalists
 - Identifies Maria as a high risk patient for readmission
 - **Reconciles hospital meds with outpatient meds**



Medication Reconciliation

- Greater than 50% of medication histories taken upon admission have some form of discrepancy requiring resolution
- Greater than 50% of documented medication errors occur at three times: Admission, Transfer, Discharge

Gleason, et al. Amer J Health Syst Pharm. 2004; 61: 1689-95

- Admission Med errors: hospital staffing, EHR, poor historians
- Transfer and Discharge:
 - Patient don't receive maintenance meds during stay OR receive different doses
 - AVS will not include resumption of PTA meds OR will have incorrect doses
 - Patient doses often changed during hospital stay- may not be accurately reflected in AVS



Maria's Transition

- Hand off from Hospitalist to Transitions Coordinator when patient is being discharged
- Hospital Transitions Coordinator meets with Maria at discharge
 - **2nd Med Reconciliation and review of AVS**
 - PCP, Home Visit, and Specialty Appointments
 - DME, Scripts, Prior Auths
 - Home Care
 - Self Management education
 - Hand off to office based Care Manager (**3rd Med reconciliation**)



Maria's Transition

- Home Visit with Nurse Practitioner 48h
 - She was offered a sub acute rehab stay and refused
 - At home visit Maria is more short of breath than when she left the hospital, little dizzy and weak
 - Has worsening cough but is taking all meds as prescribed
 - Has leg edema and not urinating as much as usual
 - She was going to go to the ED this morning but decided to wait for the NP to “check her out”.



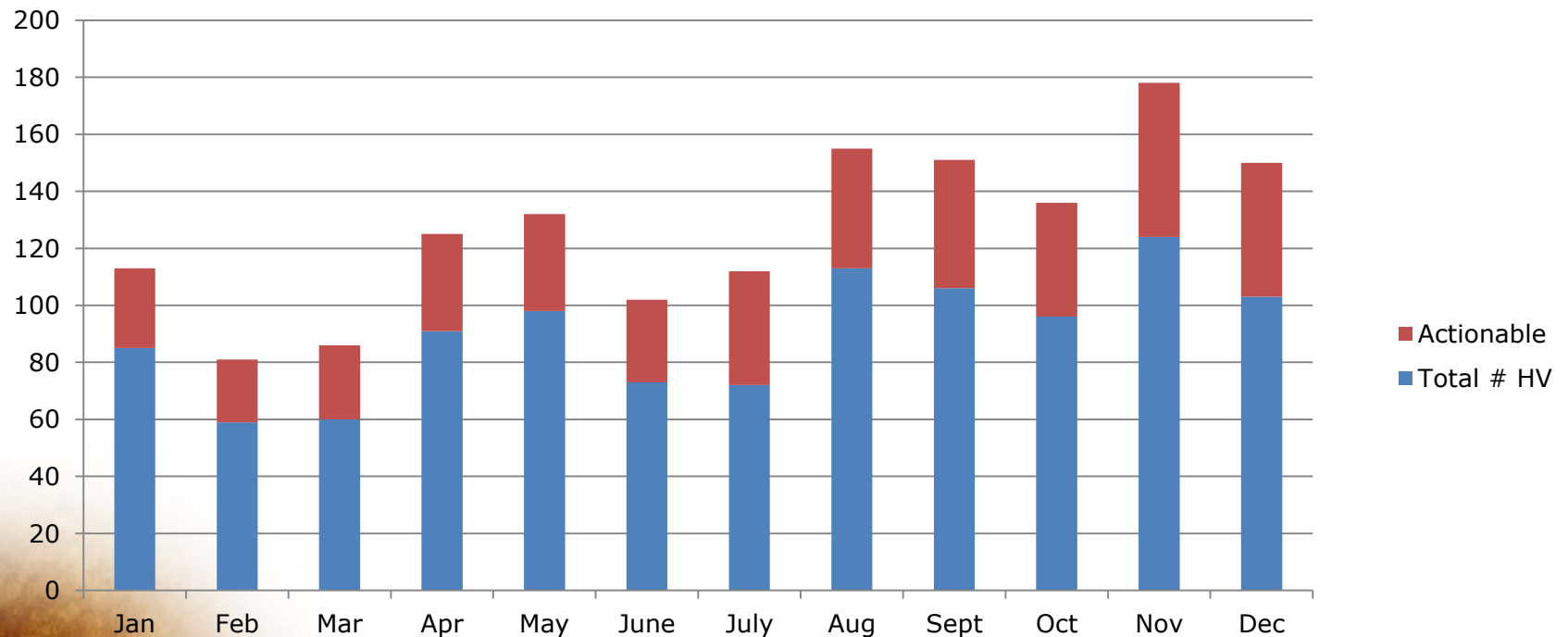
Maria's Transition

- NP reviews all med bottles in home with accurate AVS **(4th med reconciliation)**
- Diagnosed and treated in the home for CHF exacerbation, meds adjusted
- Labs
- Daughter called to assist in getting meds today
- Linked to Care Management for community resources
- PCP alerted to new event and management plan
- Has follow-up office visit with PCP and Cardiologist within 7 days **(5th med reconciliation)**
- Enrolled in CHF telehealth



Home Visit Data

Actionable Home Visits Yr 2013



Yearly Averageg Actionable visits =41%
Yearly Actionable Patients Hospital D/C =25%



Follow-up home visits

- Patients followed in home for 30 days:
 - Medically unstable at time of home visit
 - New problem or exacerbation of chronic condition
 - New meds or adjustment of meds
 - Poor self management skills
 - Lack of support



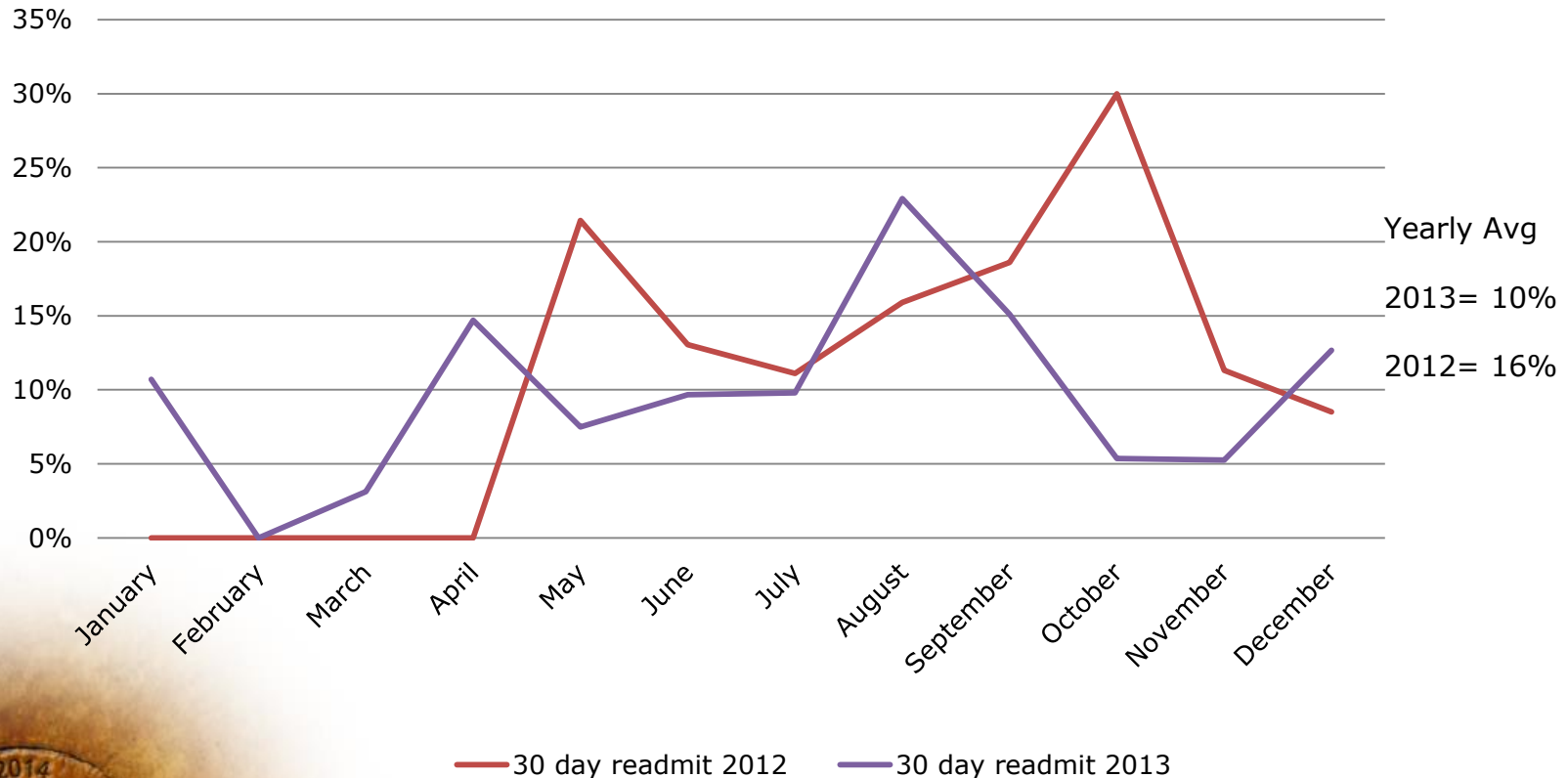
Maria's Transition

- She followed up with PCP and Cardiology in office within 7 days
- Several home visits were made in between office visits to assess response and adherence to treatment, teach self management
- Care Management continues to follow
- She was not readmitted within 30 days
- She continues on CHF telemonitoring



Home Visit Data

Careteam 30 Day Readmissions



Care Transitions

Skilled Nursing Facilities



SNF Summit



SNF Summit

- 3 SNF, Hospitals, multi-disciplinary provider team
- Defined and aligned focus areas: avoidable admissions, readmissions, quality, patient experience
- Charter: reduce avoidable admissions and readmission from the SNF population
- Reviewed baseline data
- Reviewed surveys



SNF Summit

- Identified Processes:
 - Facility level:
 - early warning signs
 - improved communication to on call provider
 - improved familiarity of on call provider
 - Transition:
 - communication to ER
 - awareness of hospital course
 - communication back to SNF on discharge
 - timing of discharge



SNF Summit Outcome

- Standardized communication tool
January 2014
- Ongoing working group meeting
- Metrics



Universal Physician Communication Tool for SNF to Hospital Transfer

RESIDENT: _____ Transferring MD/NP: _____ PCP: _____ Date/Time: _____ Report given to: _____ By: _____			
S <i>Situation</i>	<u>Reason(s) for transfer</u> _____ _____ _____ _____ _____ The primary reason for transfer is for: <input type="checkbox"/> Diagnostic Testing <input type="checkbox"/> Admission Tests needed: _____ _____		
B <i>Background</i>	Patient is in SNF for <input type="checkbox"/> Long Term Care dx: _____ <input type="checkbox"/> Rehab dx: _____ <u>Code Status</u> <input type="checkbox"/> Full Code <input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> DNH <input type="checkbox"/> Comfort Care/Palliative Care <input type="checkbox"/> Hospice <input type="checkbox"/> Uncertain <u>Relevant diagnoses</u> <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> CRF <input type="checkbox"/> DM <input type="checkbox"/> Cancer (active treatment) <input type="checkbox"/> Dementia <input type="checkbox"/> Other _____ <u>Today's Vital Signs</u> Time taken _____ am/pm BP _____ HR _____ RR _____ Temp _____ Rectal/Oral/Axillary O2 Sat _____ E On O2 _____ L/min Blood Glucose: _____ If CHF Weight today _____ weight prior to today _____ date ____/____/____ Most recent pain level ____ (____ N/A) Pain location: _____ Most recent pain med _____ Date given ____/____/____ Time (am/pm) _____ <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <u>Baseline Mental Status:</u> <input type="checkbox"/> Alert, oriented, follows instructions <input type="checkbox"/> Alert, disoriented, follows simple instructions <input type="checkbox"/> Alert, disoriented, cannot follow simple instructions <input type="checkbox"/> Not Alert </td> <td style="width: 50%; vertical-align: top;"> <u>Current Mental Status:</u> <input type="checkbox"/> Alert, oriented, follows instructions <input type="checkbox"/> Alert, disoriented, follows simple instructions <input type="checkbox"/> Alert, disoriented, cannot follow simple instructions <input type="checkbox"/> Not Alert </td> </tr> </table> <u>Diet:</u> _____	<u>Baseline Mental Status:</u> <input type="checkbox"/> Alert, oriented, follows instructions <input type="checkbox"/> Alert, disoriented, follows simple instructions <input type="checkbox"/> Alert, disoriented, cannot follow simple instructions <input type="checkbox"/> Not Alert	<u>Current Mental Status:</u> <input type="checkbox"/> Alert, oriented, follows instructions <input type="checkbox"/> Alert, disoriented, follows simple instructions <input type="checkbox"/> Alert, disoriented, cannot follow simple instructions <input type="checkbox"/> Not Alert
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A <i>Assessment</i>	<u>Meds/Treatments: MAR ATTACHED</u> <input type="checkbox"/> Coumadin (if on Coumadin, last INR was _____ date ____/____/____) <input type="checkbox"/> Oxygen <input type="checkbox"/> Chemo/Radiation <input type="checkbox"/> CPAP/BiPAP <input type="checkbox"/> Foley (date) _____ <input type="checkbox"/> Pacemaker/Defibrillator <input type="checkbox"/> TPN <input type="checkbox"/> Ostomy type _____ <input type="checkbox"/> Diet _____ <u>Labs: LAST RESULTS ATTACHED</u>		
R <i>Recommendation</i>	<u>Special Considerations/Request:</u> _____ _____ <u>SNF Contact Information:</u> Attending MD: _____ Phone: _____ SNF Unit Manager: _____ Phone: _____ Patient's HCP: (name) _____ (ph) _____		

SNF Capabilities list (over)



Universal Physician Communication Tool for SNF to Hospital Transfer

Nursing Home Capabilities List

	Middletown Park Rehab	Valley View	Achieve	Campbell Hall	Montgomery	
Stat Labs	Y	Y				
EKG	Y	Y				
Frequent VS q 2h	Y	Y				
I&O Monitoring	Y	Y				
Daily Weights	Y	Y				
Glucose Fingersick q 8h	Y	Y				
INR	Y	Y				
Urine Culture	Y	Y				
UA or dipstick	Y	Y				
O2 Sat	Y	Y				
Nebulizer Treatments	Y	Y				
IVF	Y	Y				
IV Antibiotics	Y	Y				
IV Lasix	N	N				
PICC Management	Y	Y				
TPN	N	Y				
		24 hour notice				
Isolation	Y	Y				
Surgical Drain Care	Y	Y				
Trach Care	N	Y				
Wound Care	Y	Y				
Analgesic Pump	N	N				



Care Transitions

Heart Failure



HEART FAILURE CLINIC



Crystal Run[®]
Healthcare
We want you healthy.*



Telehealth

Program Highlights



Telehealth

- Insert National Data for CHF, COPD, IVR
- Our Goals
 - Reduce Avoidable Admissions (CHF, COPD)
 - Reduce 30 day readmissions and ER visits
 - Reduce utilization

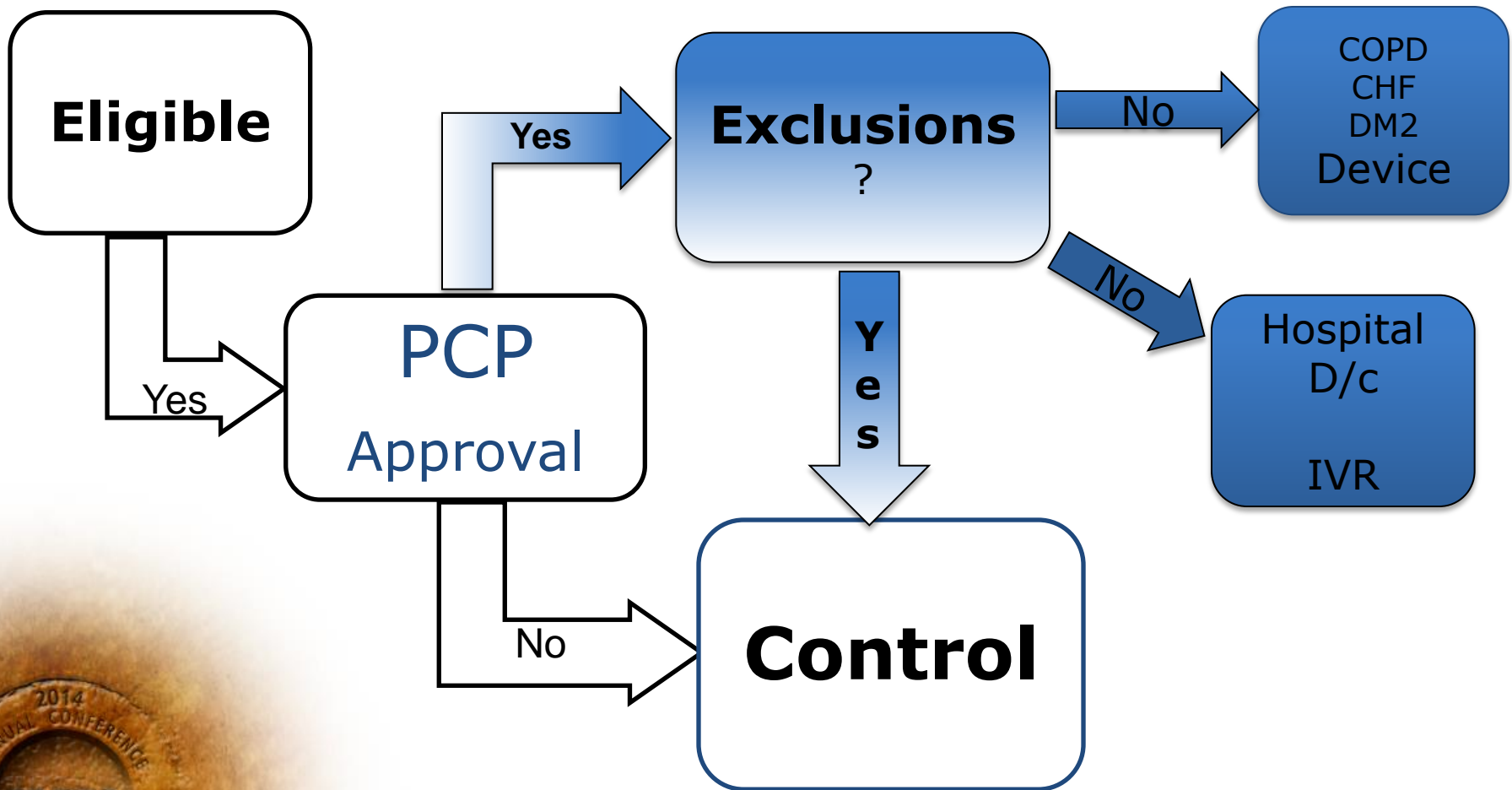


Patient Selection

- Patient Eligibility
 - MSSP, PCP
 - Telehealth Responsive Conditions: COPD, CHF, DM2, hospital discharges
 - Patient Identification:
 - Provider Referral
 - Data Mining: Disease Severity ($FEV1 < 1L$, $EF < 40\%$, $Hgb A1c > 11$), Excess Utilization
- Exclusions: Refusal, Inability to participate (cognitive, mental health), Infectious Reasons



Telehealth Enrollment



Telehealth Disenrollment

- Patient met their goals
 - No Hospital Admissions or ER visits in 6 months
 - No CHF or COPD Exacerbation 6 months
 - IVR: auto-disenrollment 30 days
- Patient asked to be disenrolled
- Long term SNF placement
- Non compliance with taking daily readings or answering to alert readings
- PCP request



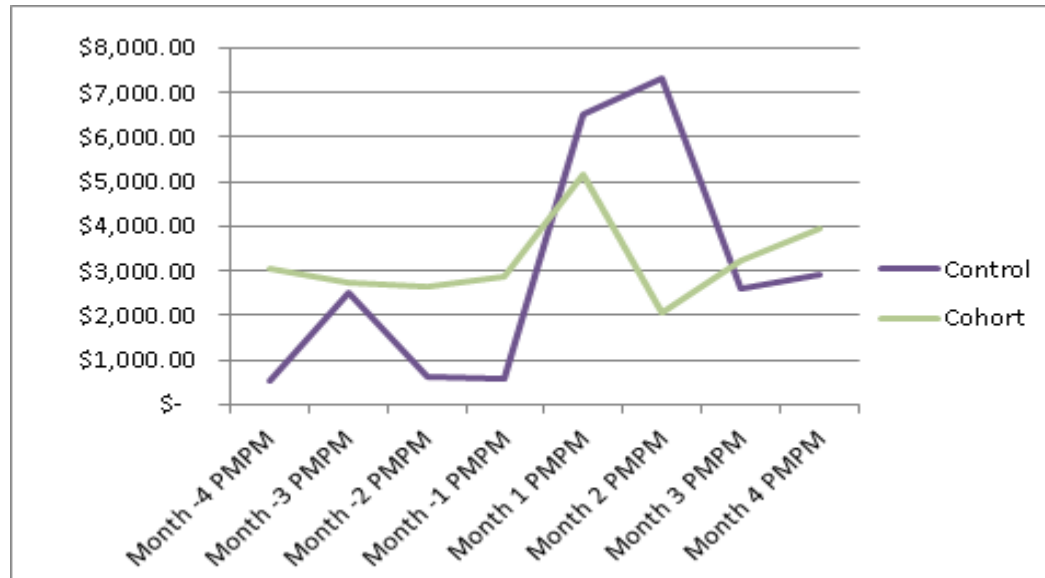
Telehealth Data

30 Day readmissions



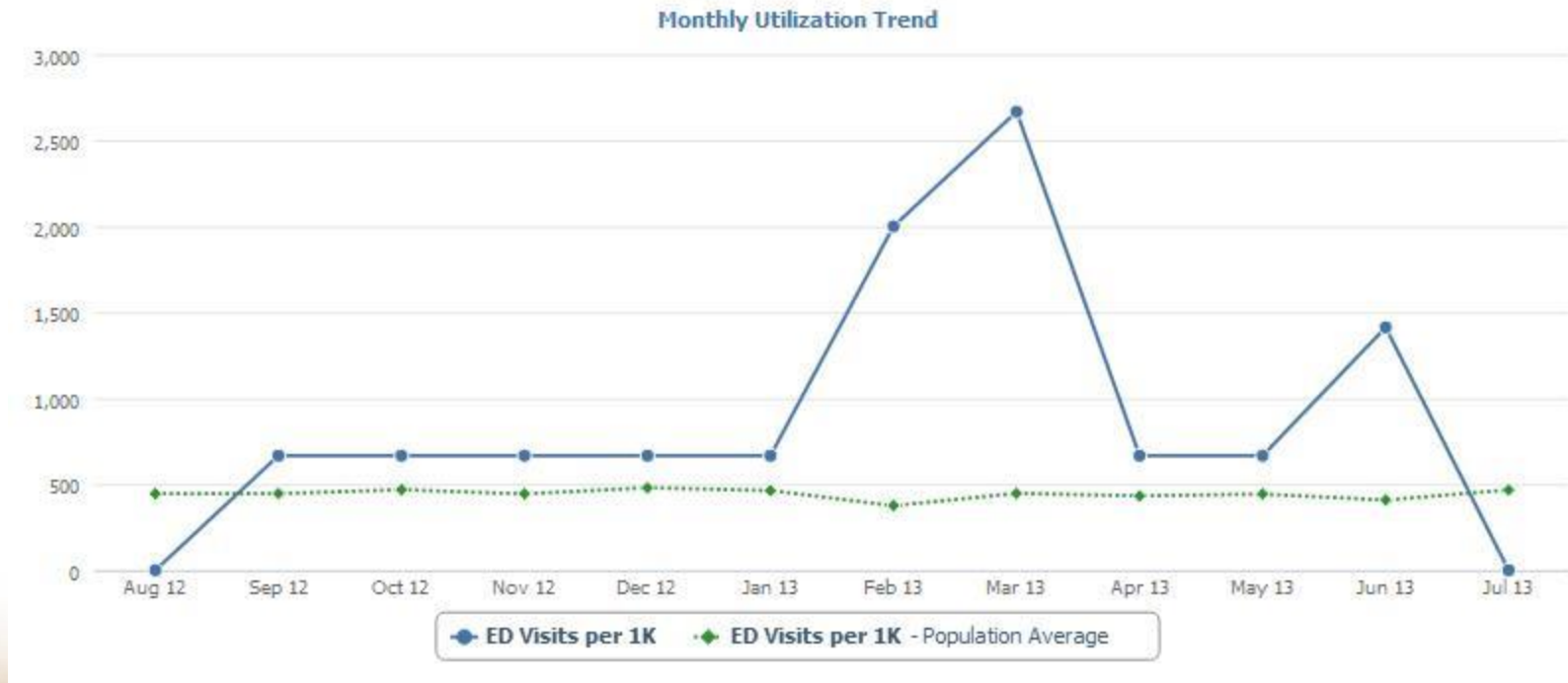
Telehealth Data

Cost PMPM



Telehealth Data

ED Visits



Telehealth

- Benefits
 - Homebound patients
 - ? Utilization
 - Patient satisfaction
- Challenges
 - Wireless equipment
 - False alarms, customize biometrics and equipment



Reflections on Transitions

- What works well
- What needs tweaking
- Future strategies



Questions?

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Thank You

