The ‘One Cape’ Journey to Meet the IHI Triple Aim and Decrease Readmissions through Interdisciplinary Care Coordination

Presented by:
Kevin Mulroy, D.O. Cape Cod Healthcare Chief Quality and Safety Officer and Chief Medical Information Officer
Kathryn Harris, RN, MHA, Cape Cod Health Network Director of Clinical Operations
Mary Brulette, RN, MSN-CPNP, Chief Cape Cod Hospital Director of Case Management
Colleen Dommermuth, MBA, CPPS-AP, Cape Cod Healthcare Director of Corporate Quality and VNA of Cape Cod Chief Executive Officer

November 6, 2014

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Objectives

• Describe strategies used to build partnerships between the hospital, ACO, VNA, Elder Services and SNF’s for coordination/communication of patient care

• Discuss how active physician involvement enhanced the team and pushed us forward in new directions

• Review the ‘ups’ and ‘downs’ of keeping the team together for this length of time including lessons learned

Cape Cod Healthcare

• Mission Statement:

“To coordinate and deliver the highest quality, accessible health services, which enhance the health of all Cape Cod residents and visitors.”
Cape Cod Healthcare

- Leading provider of healthcare services on Cape Cod
- Two Acute Care Hospitals
  - Cape Cod Hospital
    - 269 beds
    - Sole Community Provider
  - Falmouth Hospital
    - 95 beds
- Visiting Nurse Association of Cape Cod including hospice and palliative care
- JML Care Center
- Heritage Assisted Living Facility
- Cape Cod Health Network (PHO)

- Staff
  - 450 Physicians
  - 4,700 Employees
  - 1,100 Volunteers

CCHC Locations

In the beginning….

- CCH monitored readmissions
- In 2011, joined 2nd cohort for State Action on Avoidable Rehospitalizations (STAAR)
- First team meeting: January 21, 2011

- Team members
  - CCH representatives
  - Six Skilled Nursing Facilities
  - VNA of Cape Cod
  - Elder Services of Cape and the Islands
  - Physician Practices rep
  - Patient-Family Advisory members
  - Physician champions
In the beginning… from 2011 - 2012

- Goal: “To ensure a safe and effective discharge process, improve outcomes and address all post discharge needs.”
- Successes:
  - Nurse to Nurse Communication/warm hand-off (SNF nurse calls hospital nurse)
  - PCP notified of patient discharge and disposition (specific form)
  - Follow-up PCP appointments made prior to discharge
  - Provided statistics to team with provider specific/patient specific readmission
    - Researched readmissions and reported detail
    - Trends and opportunities identified

…2011 -2012

Successes continued:
- Teach Back Methodology – CCH and SNF nurse education
- VNA/SNF readmissions audits with action plans
- Hospital and SNF Medical Directors meeting – facilitating two way communication
- CCHC ‘Helping Hand” program for post-discharge patients
- Heart Failure – standardization of patient teaching materials
- Emergency Center (EC) Case Manager at Cape Cod Hospital
- SNF EC Communication “Orange Envelope”
- SNF Standardized Audit tool

2012 forward…

- Pilot -daily discharge care planning rounds on hospitalist unit with case manager, clinical leader, PT/OT, Manager, physician
- CCH requested to participate on specific project aimed at SNF readmissions
- A patient education flyer for the Helping Hand program
- Treating patients in the Emergency Center and returning them to their facility or home after treatment – avoiding readmission
- Barnstable County EMS services joined the team
- "Walk in My Shoes’ program
EMS involvement

- Education
  - EMS Scope of Practice and movement toward National EMS SOP
  - Limitations of practice within SOP

- Collaboration
  - Representation from each town on the Cape
  - Description of unique populations and challenges within the towns
  - Case presentations by town of our mutual patients

So, to where do our patients transition?

<table>
<thead>
<tr>
<th>Discharge by Disposition Profile</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>44.4%</td>
</tr>
<tr>
<td>Home with Home Health</td>
<td>23.0%</td>
</tr>
<tr>
<td>Hospitl</td>
<td>1.4%</td>
</tr>
<tr>
<td>SNF</td>
<td>22.2%</td>
</tr>
<tr>
<td>IRF [acute rehab]</td>
<td>2.8%</td>
</tr>
<tr>
<td>ORC</td>
<td>1.8%</td>
</tr>
<tr>
<td>Expired</td>
<td>0.1%</td>
</tr>
<tr>
<td>Expired</td>
<td>2.6%</td>
</tr>
<tr>
<td>AMIA</td>
<td>1.2%</td>
</tr>
<tr>
<td>Psych</td>
<td>0.6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

But, the transitions are dynamic......
Hospital and Post Acute Engagement

• Communication Between and Among Care Givers
  • Inclusion of PCPs
    • @ Hospital transition points
    • @ SNF transition points
    • @ Home Health transition points
  • Direct Care Givers
    • Nurse to Nurse Warm Hand-off from Hospital to SNF
    • Discussion of Warm Hand-off from SNF to Emergency Room

• Cross Continuum Work Groups
  • Focus Group (STAAR)
    • Has consistently met twice per month since 2011
    • Readmission case reviews
      – High Risk Case Identification with Multi-provider Team Meeting/Intervention *
    • Improvement opportunities
    • Educational opportunities
      – Patient educational materials (Heart Failure)
      – Staff Education to provider community (Teach Back)
  • Care Transitions Group
    • Cape Wide Bi-monthly meeting
      – Data sharing
      – Tool sharing
      – Best Practice Sharing

• Case Study
  • Patient at risk for readmission identified by SNF
    • Had been hospitalized in May and June 2014 with intervening SNF admission and community discharge with VNA and Elder Services
    • Patient frail, elder, multiple co-morbidities with dementia
    • Elder Spouse as Primary Care Giver highly reluctant to accept services in their home
      – Unable to sufficiently provide care and safe environment
      – Unable to recognize his limitations
      – Highly educated – Proud - No other family
  • Team Meeting Held
    • Hospital CM & Nursing, SNF Admin & Nursing, ACO Case Manager, VNA Team Leader, Elder Services representative
      • Plan: VNA team lead would meet with spouse, working toward a plan that spouse would be able to agree with
  • Outcome
    • Short Term – Spouse accepted a well-developed home care plan for patient
    • Long Term – Spouse accepted Long Term Placement for spouse and accepted home health and community support for himself
**CCH PEPPER Report Q2 FY 2014**

<table>
<thead>
<tr>
<th>Target</th>
<th>Number of Target Discharges</th>
<th>Percent</th>
<th>Hospital National Percentile</th>
<th>Hospital Jurisdiction Percentile</th>
<th>Hospital State Percentile</th>
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</thead>
<tbody>
<tr>
<td>30-day Readmissions to Same Hospital</td>
<td>216</td>
<td>12.1%</td>
<td>43.0</td>
<td>30.1</td>
<td>33.3</td>
</tr>
<tr>
<td>30-day Readmissions to Same Hospital or Elsewhere</td>
<td>245</td>
<td>13.7%</td>
<td>19.9</td>
<td>10.5</td>
<td>8.3</td>
</tr>
</tbody>
</table>

**Health Care Reform**

**The Triple Aim Goals**

- **Better Care**
  - Improve/maintain quality and patient outcomes
  - Eliminate avoidable readmissions
  - Eliminate potentially preventable conditions (e.g., never events)

- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness

- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

**PHO/PO involvement**

- BCBS Alternative Quality Contract, HPHC, Tufts commercial
  - 25,000 lives
- Medicare MSSP ACO contract
  - 20,000 lives
- Tufts Medicare Preferred Contract
  - 800 lives
- Employees
  - 8,000 lives

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**Target high risk diagnosis identify on Day of Discharge**
- COPD
- CHF
- Pneumonia
- AMI

Screening by the CCHN Care Management team
- Confirm diagnosis and begin assessment
- Determine level of care upon discharge: Helping Hands, VNA, CCHN Case Manager

**Post Discharge Interventions**
- Phone call within 24-48 hours by CCHN care management team
- PCP appointment within 3 business days
- Home visit within 2-5 days where appropriate (VNA, Helping Hands, palliative care and hospice where appropriate)
- Handoff to CCHN for ongoing case management as needed after Dovetail discharge (3 months) and/or VNA discharge

**Screening by the CCHN Care Management Team:**
- Referrals from Clinician, Dovetail (after 3 month LOS), VNA, Claims analysis

**Interventions:**
- Initial phone call and assessment
- Establish goals and plan of care for telephonic management (refer to Dovetail or VNA for home management)
- Community resource mobilization including palliative care and hospice where appropriate
- Discharge approximately 3 months

**Care Management of High Risk Patients**

**Target chronic conditions**
- Diabetes
- COPD
- CHF
- CAD
- Polypharmacy

Screening by CCHN Care Management Team:
- Referrals from Clinician, Dovetail (after 3 month LOS), VNA, Claims analysis

**Interventions:**
- Initial phone call and assessment
- Establish goals and plan of care for telephonic management (refer to Dovetail or VNA for home management)
- Community resource mobilization including palliative care and hospice where appropriate
- Discharge approximately 3 months

**Care Transitions**

- 7 Preferred Skilled Nursing Facilities
  - Clinical capabilities assessed
  - Team meetings
  - Discharge Planning

- Cape Cod Helping Hand: Provide post-acute care management programs to highest risk patients after hospitalization — April 2011
  - Transitions — one time home visit/telephonic support by clinical pharmacist
    - Medication education with adherence to compliance and/or administration issues
  - Complex Care — ongoing in-home support from nurse care manager
    - Home visits where patient does not fit Home Care criteria

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Helping Hand Case Scenario

- 89 yo hospitalized for CHF and worsening kidney failure followed by short-term rehab
- Home visit by Dovetail pharmacist – no VNA nursing or assessment
- Referred to VNA and Telehealth
- During med reconciliation, still taking previously prescribed NSAID – educated patient and removed from supply
- Identified new med (Imdur) – patient unsure why
- Contacted MD to clarify medication and called pharmacy
- Given med chart and education
- Care plan set up with follow up PCP visit and VNA services
- Follow-up phone call – patient good understanding and no red flags for signs/symptoms for progression of CHF or CKD

Helping Hand Transition Program Patient Profile

Helping Hand results

<table>
<thead>
<tr>
<th>Program Enrollee</th>
<th>Readmission Rate 30 Days From Hospital Discharge: Readmission Rate 2013</th>
<th>Readmission Rate 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth Hospital [all]</td>
<td>12.1% (9/73)</td>
<td>10.7% (11/103)</td>
</tr>
<tr>
<td>Cape Cod Hospital [all]</td>
<td>11.4% (9/78)</td>
<td>11.5% (15/132)</td>
</tr>
<tr>
<td>Total</td>
<td>11.8% (18/151)</td>
<td>10.9% (26/239)</td>
</tr>
</tbody>
</table>
Participated on CCH STAAR meeting since inception
Provide array of services — home health, private services, hospice and palliative care, public health and wellness programs
VNA Liaison (both home health and hospice) on site
Meet patient in hospital when feasible
Information in VNA system including hospital referral as attachment
Reinforces timely follow up with PCP
Improved communication since STAAR
Patient scheduled to be discharged to a SNF and SNF screening completed
Patient prefers to go home
VNA liaison documents SNF information in VNA record
If patient fails at home, can contact SNF for direct admission
Usually works within the first week.

ACO Interaction
Two of ACO case managers worked previously for VNA
ACO receives weekly reports on admissions and discharges
VNA nurses can identify patients who need further oversight and notify ACO

SNF Interaction
VNA liaisons at the SNF’s
Meet the patient prior to discharge and review plan
Attend case conferences prior to discharge to assure safe plans for patients
Communication improved between VNA and SNF to discuss patients.

VNA Specific STAAR committee meets monthly
Staff Education on:
Teach back
SBAR
1st and 2nd visit are critical — front loading, med rec
Reinforce MD appts within 7 days
Patient Education materials
Revising risk assessment in computer
All readmissions are reviewed by the Team Leader

VNA OF CAPE COD
Readmission during 30 days of Home Health
(Lower is Better)

VNA Results Sept 2013 -2014

Delta Study to Reduce Unplanned Hospitalizations

Top 5 Strategies
- Falls Prevention
- Home Adaptation
- Emergency Plan
- Medication Reconciliation
- 24/7 Coverage
Telehealth Program

- Remote Monitoring - portable tablet technology
  - Prevent Re-hospitalizations
  - Ensure Patient Self-management of Chronic Diseases
  - Visit Patient when Indicated
  - Use for Patients with Diagnosis of Heart Failure, Hypertension, COPD, Diabetes, Post Cardiac Interventions
- Wireless Peripherals: Weight, Pulse Ox, Blood Pressure, Glucometer
- Parameters set based on American Heart Association (AHA) and American College of Cardiology (ACC) Guidelines
- RN Coverage 7 days/week
- Changed vendor one year ago

Patient-Centered...
PASS: Patient Advocacy and Support Services

CARDIOCOM’s TELEHEALTH NURSE EXPERTS CAN HELP YOU ACHIEVE YOUR PROGRAM OUTCOME AND ROI GOALS.

WHETHER YOU’RE DEVELOPING A TELLTHATHEAR PROGRAM, REVIEWING THE AWARENESS OF YOUR CURRENT PROGRAM, OR SEEKING NEW OPPORTUNITIES, WE CAN HELP. CONDUCTING A THOROUGH ASSESSMENT ALLOWS US TO IDENTIFY OPPORTUNITIES TO IMPROVE PROGRAM EFFICIENCY AND EFFECTIVENESS. OUR TELEHEALTH NURSES PROVIDE A FAIR, COMPREHENSIVE CARE THAT MIGHT NOT BE AVAILABLE THROUGH CONVENTIONAL METHODS. OUR PROGRAMS ARE DESIGNED TO HELP YOU MEET YOUR PROGRAM GOALS AND DRIVE YOUR PROGRAM TO SUCCESS.

Clinical Management
Cataract management saves lives. From delivery of the “infection management” to the development of the “infection management” and continuation of follow-up. We focus on identifying barriers to uptake and morbidity. By implementing a care plan that includes regular follow-up and education, the patient’s health is greatly improved. Part of this care plan involves the implementation of areally effective care program, which includes regular education and support.

PASS: Patient Advocacy and Support Services

Telehealth results

Rehospitalizations Within 30 Days

Elder Services/Community involvement

- Health Living Cape Cod Coalition
  - Community-based group began in 2013
  - Bring evidenced-based and health aging programs
  - Some funding from Cape Cod Healthcare
  - Membership includes:
    - VNA of Cape Cod
    - Elder Services of Cape Cod
    - Gosnold
    - COAST (Council on Aging Serving Together)
    - New England Wellness Foundation
Health Living Cape Cod Coalition

- Evidenced Based Programs
  - My Life, My Health (Chronic Disease Self Management)
  - Matter of Balance
  - Diabetes Self-Management Program
  - Healthy Eating for Successful Living for Older Adults
  - Powerful Tools for Caregivers

- Healthy Living Programs
  - Tai Chi
  - Osteo Exercise

Website fall 2014: Healthylivingcapecod.org

CMS Readmission Reduction Program Penalty

- CCH received penalty in AMI in FY13 and FY 14
  - In FY 15, had same number of eligible discharges however, 29 fewer

<table>
<thead>
<tr>
<th></th>
<th>Number of Eligible Discharges</th>
<th>Number of Readmissions</th>
<th>Predicted Readmission Rate</th>
<th>Expected Readmission Rate</th>
<th>Excess Readmission Ratio</th>
<th>National Crude Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI FY 2015</td>
<td>756</td>
<td>110</td>
<td>15.70%</td>
<td>16.30%</td>
<td>0.9609</td>
<td>17.03%</td>
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<tr>
<td>FY 2016</td>
<td>721</td>
<td>106</td>
<td>15.80%</td>
<td>17.00%</td>
<td>1.0581</td>
<td>17.30%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>712</td>
<td>107</td>
<td>15.80%</td>
<td>17.00%</td>
<td>1.0527</td>
<td>17.30%</td>
</tr>
<tr>
<td>COPD FY 2015</td>
<td>736</td>
<td>146</td>
<td>19.7%</td>
<td>20.2%</td>
<td>0.9646</td>
<td>20.21%</td>
</tr>
<tr>
<td>FY 2016</td>
<td>721</td>
<td>140</td>
<td>19.1%</td>
<td>20.1%</td>
<td>1.0215</td>
<td>20.40%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>722</td>
<td>140</td>
<td>19.1%</td>
<td>20.1%</td>
<td>1.0215</td>
<td>20.40%</td>
</tr>
</tbody>
</table>

- FH received penalty in PN in FY14 and FY 15

<table>
<thead>
<tr>
<th></th>
<th>Number of Eligible Discharges</th>
<th>Number of Readmissions</th>
<th>Predicted Readmission Rate</th>
<th>Expected Readmission Rate</th>
<th>Excess Readmission Ratio</th>
<th>National Crude Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN FY 2015</td>
<td>500</td>
<td>86</td>
<td>37.7%</td>
<td>37.2%</td>
<td>1.0345</td>
<td>37.4%</td>
</tr>
<tr>
<td>FY 2016</td>
<td>499</td>
<td>80</td>
<td>39.1%</td>
<td>38.6%</td>
<td>1.0205</td>
<td>37.40%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>502</td>
<td>96</td>
<td>39.7%</td>
<td>38.8%</td>
<td>1.0287</td>
<td>38.5%</td>
</tr>
<tr>
<td>COPD FY 2015</td>
<td>500</td>
<td>105</td>
<td>21.4%</td>
<td>21.1%</td>
<td>1.0213</td>
<td>21.30%</td>
</tr>
<tr>
<td>FY 2016</td>
<td>499</td>
<td>101</td>
<td>21.8%</td>
<td>21.4%</td>
<td>1.0187</td>
<td>21.30%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>502</td>
<td>103</td>
<td>21.8%</td>
<td>21.5%</td>
<td>1.0187</td>
<td>21.30%</td>
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</tbody>
</table>
CMS Readmission Penalty

<table>
<thead>
<tr>
<th></th>
<th>Cape Cod Hospital</th>
<th>Falmouth Hospital</th>
<th>Total for both hospitals</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>0.17% ($154,000)</td>
<td>0.00%</td>
<td>$154,000</td>
<td></td>
</tr>
<tr>
<td>FY 2014</td>
<td>0.24% ($196,050)</td>
<td>0.06% ($19,610)</td>
<td>$215,660</td>
<td></td>
</tr>
<tr>
<td>FY 2015</td>
<td>0.05%</td>
<td>0.10%</td>
<td></td>
<td>0.78%</td>
</tr>
</tbody>
</table>

MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT and tied with RI
MA is #7 highest average magnitude of penalty - behind KY, WA, WI, AK, AR and we are tied with IL

Physician involvement

- Fundamental difference in the approach and conclusion of case review
  - Pre physician case review: Conclusions/opportunities were process focused
  - Post physician case review: Conclusions/opportunities are treatment/assessment focused
- Physician Dimension propelling discussions regarding potential for care paths across transition points

Physician involvement

- Refocus efforts to pre-discharge management
- Look for clinical trends
- Chart review
Physician Involvement

• What could we have changed?
• Was the patient ready?
• Did we risk-assess?
• Was the follow-up appropriate for the clinical condition
• Were the medications appropriate

Physician Involvement

• Results to date
  • Aspiration
  • End of Life Care

Lessons learned

• Don’t give up!
• Don’t be afraid to change course!
• Can implement new processes but needs constant monitoring
  • For example, orange envelope
• Sustainability requires constant oversight
• Be open to additional members as needed…EMS as new members
• Began in 2011 and still has much work to do
• Enhance communication and understanding of challenges in each setting involved in team
Major Accomplishment

- Cohesive multi-disciplinary team across the continuum of care where all working together for common goal
  - Continued Attendance
  - Active Participation

Questions?
Thank you!
IMPACT - Building Care Coordination Tools for the Healthcare System of the Future

Massachusetts Readmissions Summit
November 6th, 2014
Larry Garber, MD
Terrence A. O’Malley, MD
Jaimie Kelley

Agenda

- National standards for transitions of care
- Overview of MA IMPACT Project
- Creating new national standards to better support care coordination
- Technology to extend electronic health information exchange (HIE) to the Long Term and Post-Acute Care providers
- Avoiding Readmissions by Wiring Up the System
- The view from the front lines – Nursing Facilities

The Spectrum of Care is Vast…

Adapted from Derr and Wolf, 2012
National Policies & Standards to Support Coordination of Care

Meaningful Use and the C-CDA

- Electronic Health Record (EHR) “Meaningful Use” program consists of standards for EHR functionality, and incentives for hospitals and physicians to meaningfully use those EHRs.
- Meaningful Use Stage 2 defined the 2014 Edition EHR standards which require support the “Consolidated CDA” (C-CDA) R1.1 standard to communicate clinical information between healthcare providers.
- C-CDA includes 8 standard document types.
Consolidated CDA Release 1.1 Documents

- History and Physical Note
- Progress Note
- Consultation Note
- Diagnostic Imaging Report
- Operative Note
- Procedure Note
- Discharge Summary
- Continuity of Care Document (CCD)

What is a CDA document?

- XML **Document** standard based on HL7 V3 and RIM
- **Must** be human-readable using web browser
- Could be a single, large text document
- May contain specific sections (e.g. HPI, meds)
- May contain coded computer-interpretable data within sections
- Numerous standard documents can be defined based on CDA model (e.g. 8 in C-CDA R1.1, QRDA, Questionnaire Form and Response, etc...)

C-CDA built with reusable templates

**Transfer Summary**
- Patient

**Physical Exam**
- Pressure Ulcer Stage
- # of Pressure Ulcers

**Plan of Treatment**
- Instructions
- Procedures
- Nutrition Recommendations
Billions of CDA documents are generated by dozens of countries around the world each year. US hospitals and physician practices are required to send Consolidate CDA R1.1 documents electronically during care transitions in order to receive Meaningful Use incentive $$$. So does the Consolidated CDA R1.1 meet the needs of its users?

**IMPACT Grant**

February 2011 – HHS/ONC awarded $1.7M HIE Challenge Grant to state of Massachusetts (MTC/MeHI):

**Improving Massachusetts Post-Acute Care Transfers (IMPACT)**
Datasets for Care Transitions

- **Traditionally** – What the **sender** thinks is important to the **receiver**
- **Future** – Also take into account what the **receiver** says they need

“Receiver” Data Needs Survey

- 46 Organizations completing evaluation
- 11 Types of organizations
- 12 User roles
- 1135 Transition surveys completed
- Largest survey of Receivers’ needs

<table>
<thead>
<tr>
<th>Item</th>
<th>From Acute Care Hospital</th>
<th>From Emergency Department</th>
<th>From Skilled Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>Chief Complaint</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>73</td>
<td>Reason Patient is being referred</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>74</td>
<td>Reason for Transfer</td>
<td>Not needed/No</td>
<td>Not needed/No</td>
</tr>
<tr>
<td>75</td>
<td>Sequence of events proceeding patient’s disease/condition</td>
<td>Optional</td>
<td>Optional</td>
</tr>
<tr>
<td>76</td>
<td>History of Present Illness</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

Findings from Survey

- Identified for each transition which data elements are required, optional, or not needed
- Each of the data elements is valuable to at least one type of Receiver
- Many data elements are not valuable in certain care transitions
Five Transition Datasets

1. **Report from Outpatient testing**, treatment, or procedure
2. **Referral to Outpatient testing**, treatment, or procedure (including for transport)
3. **Consultation Note** (Office Visit, Consultation Summary, Return from the ED to the referring facility)
4. **Referral Note** Clinical Summary (Referral to a consultant or the ED)
5. Permanent or long-term **Transfer Summary** to a different facility or care team or Home Health Agency

---

Consultation Note:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc...

Referral Note:
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc...
- SNF, PCP, etc… to HHA
- PCP to new PCP

---

Additional Contributor Input

State (Massachusetts)
- MA Universal Transfer Form workgroup
- Boston’s Hebrew Senior Life eTransfer Form
- IMPACT learning collaborative participants
- MA Coalition for Prevention of Medical Errors
- MA Wound Care Committee
- Home Care Alliance of MA (HCA)
National
- American College of Physicians
- NY’s eMOLST
- Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
- Substance Abuse, Mental Health Services Agency (SAMHSA)
- Administration for Community Living (ACL)
- Aging Disability Resource Centers (ADRC)
- National Council for Community Behavioral Healthcare
- National Association for Homecare and Hospice (NAHC)
- Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
- Substance Abuse, Mental Health Services Agency (SAMHSA)
- Administration for Community Living (ACL)
- Aging Disability Resource Centers (ADRC)
- National Council for Community Behavioral Healthcare
- National Association for Homecare and Hospice (NAHC)
- Longitudinal Coordination of Care Work Group (ONC S&I Framework)
- Transfer of Care & CCD/CDA Consolidation Initiatives (ONC’s S&I)
- Electronic Submission of Medical Documentation (esMD) (ONC S&I)
- ONC Beacon Communities and LTPAC Workgroups
- Assistant Secretary for Planning and Evaluation (ASPE): Standardizing MDS and OASIS, LTPAC Assessment Summary, and Care Plans, including home health plan of care
- Geisinger: LTPAC Assessment Summary Documents and CCD
- Centers for Medicare & Medicaid Services (CMS): (MDS/OASIS/CARE)
- DoD and VA: working to specify Home Health Plan of Care dataset
- AHIMA LTRAC HIT Collaborative
- INTERACT (Interventions to Reduce Acute Care Transfers)
- Transfer Forms from Ohio, Rhode Island, New York, and New Jersey

International
- HL7 Structured Document, Patient Care, Care Coordination Services, Child Health, and Security Workgroups
- IHE Patient Care Coordination Technical Committee

Datasets include Care Plan
- Consultation Note:
  - Office Visit to PHR
  - Consultant to PCP
  - ED to PCP, SNF, etc...
- Referral Note:
  - PCP to Consultant
  - PCP, SNF, etc... to ED
- Transfer Summary:
  - Hospital to SNF, PCP, HHA, etc...
  - SNF, PCP, etc... to HHA
  - PCP to new PCP

Additional Contributor Input
The Care Plan is comprised of Modifiers, Conditions/Concerns, their Goals, Interventions/Actions/Instructions, Assessments and the Care Team members that actualize it.

**IMPACT Learning Collaborative**

**Testing Transfer Summary on Paper**

2 Hospitals, 2 large group practices, 8 nursing facilities, 1 IRF, 1 LTACH, 2 home health agencies and several hundred patient transfers...

Senders found the data

I was able to send all of the requested IMPACT data elements
Receivers’ needs met

- Fewer than 5 data elements were missing
  - No: 8%
  - Yes: 92%

How do datasets compare to CCD?

<table>
<thead>
<tr>
<th>Data Elements for Longitudinal Coordination of Care with Care Planning</th>
<th>CCD Data Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT Data Elements for basic Transition of Care needs</td>
<td></td>
</tr>
<tr>
<td>483</td>
<td>325</td>
</tr>
<tr>
<td>175</td>
<td></td>
</tr>
</tbody>
</table>

- Many “missing” data elements can be mapped to CDA templates with applied constraints
- 20% have no appropriate templates

Turning Datasets into National Standards
New World of Standards Development

- Office of the Deputy National Coordinator for Programs & Policy
- Office of the Deputy National Coordinator for Operations
- Office of the Chief Privacy Officer
- Office of Economic Analysis & Modeling

HIT Policy Committee identifies "Meaningful Use" of EMRs

S&I Framework convenes public and private experts, and proposes HIT/NIE standards

HIT Standards Committee recommends standards, and Secretary of HHS makes standards part of "Meaningful Use" and EHR Certification

IMPACT

NYeC, Healthix, CCITINY, ASPE, S&I LCC, HL7, and Lantana updates CDA for MU3 and 2015 EHR Certification

Consolidated CDA R2 Update Details

- Transfer Summary
- Care Plan
- Referral Note

(Also enhanced Header to enable Patient Generated Documents)

3 NEW Documents
6 NEW Sections
30 NEW Entries

- Nutrition Section
- Physical Findings of Skin Section
- Mental Status Section
- Health Concerns Section
- Health Status Evaluations/Outcomes Section
- Goals Section

- Nutrition Assessment
- Nutrition Recommendations
- Advance Directive Organizer
- Cognitive Abilities Observation
- Drug Monitoring Act
- Handoff Communication
- Goal Observation
- Medical Device Applied
- Characteristics of Home Environment
- Cultural and Religious Observation
- Patient Priority Preference
- Provider Priority Preference
- and lots more....
Getting Connected: LAND & SEE

LAND & SEE

• Sites with EHR or electronic assessment tool use these applications to enter data elements
  — LAND (“Local” Adaptor for Network Distribution) acts as a data courier to gather, transform, and securely transfer data if no support for Direct SMTP/SMIME or IHE XDR
  • Non-EHR users complete all of the data fields and routing using a web browser to access their “Surrogate EHR Environment” (SEE)

High Level Overview of SEE

Webmail Mailbox for Facility
Temporary storage for incoming and outgoing messages/documents

SEE Document Storage for Facility
Permanent storage for:
• Incoming Finalized documents
• New Draft documents
• Outgoing Finalized documents
Surrogate EHR Environment (SEE)

- Acts as destination for routed CDA documents
- Software hosted by MA Hiway, accessed via web browser
- SEE is accessed via the HIE's web mailbox
- Non-EHR users able to use SEE to view, edit, and send CDA documents via HIE or Direct to next facility
- Can create a new document by copying an entire document and editing it, and/or importing sections from multiple documents
- Can use SEE for other workflows (e.g. completing INTERACT SBAR prior to sending patient to ER)
- Multiple staff can work on the new document at the same time, but not the same section at the same time (will get a warning)
- SEE users can print copies of the document for family or ambulance transport

Search by Patient Name

Copy All Into New Document
Copy data from existing document

Sections of Summary Document

- Demographics
- Advance Directives
- Chief Complaint
- History of Present Illness
- Encounters
- Problems
- History of Past Illness
- Family History
- Social History/Risks
- Allergies
- Medications
- Immunizations
- Medical Equipment
- Vital Signs
- Physical Exam
- Functional Status
- Procedures
- Results
- Assessment
- Discharge Diagnoses
- Care Plan
- Payers

Intuitive data entry for each section
Sharing LAND & SEE

- **LAND**
  - Orion Health’s Rhapsody Integration Engine
    - Currently Modular EHR certified for MU1 and MU2 (2014)
    - CDA $\leftrightarrow$ HL7 2.5.1 MDM Transcription map freely available

- **SEE**
  - Written in JavaScript
  - Baseline functionality software and source code that can connect to Orion's HISP mailbox via API available for free starting ~December 2014 (Apache Version 2.0 vs. MIT open source license)
  - Innovators can develop and charge for enhancements, for example:
    - Integration with other vendors’ HISP mailboxes
    - Automated CDA document reconciliation

C-CDAR2.0 (Draft) Implementations

- **MA IMPACT**
  - Go-live scheduled for November 2014 using LAND & SEE
  - Implement C-CDA R2.0 Transfer Summary and C-CDA R1.1 Continuity of Care Document (CCD)

- **NY Downstate Coordination Project**
  - Go-live was Nov 2013
  - Implemented Care Plan

- **GSI Health ‘Brooklyn Health Home Consortium’**
  - Go-live was March 2014
  - Implemented Care Plan

- **Veterans Health Administration**
  - Demonstration of Care Plan September 2014

- **Other Vendor Demonstrations of C-CDAR2.0 (draft)**
  - CCHIT-NY: Transfer Summary
  - Datuit: Care Plan
  - Healthwise: Care Plan
  - Lantana SEE tool: Care Plan
  - Care at Hand: Care Plan
Avoiding Readmissions by Wiring Up the System

Acute Care-PAC-LTSS Communication

Scenario 1A: Change in Status at Home, to ED with Hospital Admission and Discharge

Works 80% of the time
Scenario 1 B: Change in Status at Home, to ED with Hospital Admission and Discharge

LAND CDA = Transitions Documents

Scenario 2: Change in Status at Home, to ED without Hospital Admission and Discharge Home with Services

CDA = Transitions Documents

Scenario 3 A: Change in Status at home, avoid the ED and Hospital Admission

CDA = Transitions Documents
Scenario 3 B
Change in Status at home, avoid the ED and Hospital Admission

HIT to Link Healthcare and Support Services Providers

- A shared (electronic) highway
- Low cost on-ramps and off ramps
- Similar trucks: C-CDA as exchange standard
- High value cargo
  - Functional assessment
  - Cognitive/behavioral assessment
  - Medication management
  - Transitions
  - Longitudinal Care Plans
- Remember: HIT is just a Tool

What’s Missing

- Specifications for information that healthcare providers need that LTSS providers have.
- Info that LTSS providers need and healthcare providers have
- Information that both need that neither have
- A shared vision of who’s in charge
  - Whose plan is it
  - Whose priorities matter most
  - Person centered vs Patient centered
View from the Front Lines – Nursing Facilities

Jamie Kelley, Clinical Liaison
Millbury Health Care Center

- Heart Failure, Pulmonary and Parkinson’s Disease Programs
- Wound Care, Stroke Recovery, Orthopedic Care
- We can divert patients from ED, PCP and Home

Summary

- IMPACT helped to develop national standards to meet the needs of all providers and patients
- National HL7 standards for Transitions of Care and Care Plans (C-CDA R2.0) will be available in November 2014
- EHRs will likely be required to support these new document types in 2017
- LAND & SEE software will facilitate integrating LTPAC and LTSS organizations into electronic health information exchanges and enable reusing data
- Multiple organizations are starting to pilot these new standards now
- The winners will be our patients and the healthcare system
Collaboration Across the Continuum to Prevent Readmissions after an Acute Care Episode

Partners Continuing Care with Brigham & Women's Hospital
MHA Readmission Summit
November 6, 2014

The Panel

Chuck Pu, MD, CMD
CMO, Spaulding North Shore
Chair, PCC Acute Transfer Committee

Mary O’Quinn
Dir. Quality & Compliance, Spaulding Cambridge
Dir. Patient Safety & Risk Management, Spaulding Network

Judy Flynn
VP Patient Care & Quality, Partners Healthcare at Home

Kathryn Britton, MD
Medical Director of Care Transitions, Brigham & Women’s Hospital

20% Readmissions within 30 days After Acute Hospital Discharge
Jenks, NEJM 2009
“Every system is perfectly designed to get the results it gets.”

P. Batalden, MD

- High Mortality
- High Cost
- High Readmissions
- High Degree of Suffering
- High Disability

Pressure to Reduce Readmissions

The Changing Healthcare Landscape

- Payment Penalties (Qualifying diagnoses, Value Based Purchasing)
- Public Reporting of Readmission Rates
- Push for migration to ACO Care Delivery Model
- 25/70 Post-Acute Care Predicament

Within Partners Healthcare Systems

- Quality of Care for patients
- Financial penalty of $20 – 35 million over 3 years

Partners Health Care System

MGH  BWH  NWH  NSMC  FH  Partners Continuing Care (PCC)

Post-Acute Care Continuum  Spaulding Rehabilitation Network - 2008 (2 LTACs, 2 IRFs, 3 SNFs)
Partners Healthcare at Home (PHH)
Challenges for PCC & PHS – Potential Failure Points

X = Potential Failure Point

1. Improve Care w/in PCC

PCC: Partners Continuing Care

PHH: Partners HealthCare at Home

PCP: Primary Care Practitioner

Post-Acute
HOME

Hospital Floor

ED

1. Improve Hospital Floor → PCC Transition

1. Improve PCC → PCP Transition

1. Improve PCC → PHH Transition

1. Improve Care w/in PHH

1. Improve Care w/in PCP

1. Improve Care w/in ED & give safe/health alternatives to ED

1. Improve Care w/in ACH

2. Improve PCC → ED Transition

3. Increase ease of ED → PCC Transitions

3. Improve PHH → ED Transition

3. Improve Hospital Floor → PHH Transition

X = Potential Failure Point

Organize the System

PCC Acute Transfer Committee - Charter

Purpose: To act as the major steering body to optimize readmission rates through the mitigation of causative factors that influence the unanticipated, avoidable return of patients to acute care from PCC

Objectives:
• Prioritize and Set Strategy
• Standardize and Coordinate Activities
• Innovate and Implement Best Practices
• Monitor Compliance and Performance

Committee Membership

PCC Board of Directors Quality Committee

PCC Acute Transfer Committee

2 IRFs 2 LTCHs 3 SNFs
Timeline Summary

2010
- Acute Transfer Committee (ATC) formation
- 72 Hour Bounce-back Study

2011
- Fine-tuned ATC
- Acute Transfer Database I

2012
- Site PI Projects Developed
- Acute Transfer Database II

2013
- P4P I
- Site PI Projects executed

2014
- P4P II

Leverage Analytics - Challenges

- Top Performers Unaware of Keys to Success
  - "I guess we’re just lucky, I don’t know why we’re doing better, no one really does."
  - "We’ve undertaken many initiatives…not sure what the silver bullet is…our LOS is a day higher…"
  - "Our readmission rates have just always been low."

- Readmission Reduction Strategy decisions made in the dark

- Need better Qualitative Data!

The Holy Grails of Readmissions

1. The Preventable Readmission

2. Risk Stratification
Spaulding Network Acute Transfer Database (ATDB)

- PATIENT INFORMATION
- DEMOGRAPHICS
- Review Date
- ACH Info
  - Referring Facility Name
  - Adm date
  - Referring Service
  - Referring MD
- Spaulding Info
  - Adm date
  - Adm time
  - Adm MD and type
  - Program
  - ACH Transfer date, day, time
  - ACH transferred to
- CLINICAL
  - Primary SRN Adm Dx
  - Main Symptom for Acute Transfer
  - Clinical Etiology for Readm
  - SRN Targets – Early Goal directed Tx

PREVENTABILITY ASSESSMENT
- Event Category – New (unrelated); New (related); Worsening (related); adverse event
- Unpreventable;
- Potentially Preventable;
- Definitely Preventable
- Contributing Factors:
  - Failure to Dx/Tx
  - Delay in Dx/Tx
  - Medication/Pharmacy event
  - No D/C summary at time of adm
  - Pt/Behavioral - non-adherence
  - Family factors
  - Wrong level of care
  - Suboptimal Advanced Care planning
  - Suboptimal Advanced Care planning
  - Unnecessary Transfer to ED

FINAL ASSESSMENT - Attributability
- SRN preventability?
- Overall Health Care System (including ACH factors) preventability?
- FOLLOW-UP Needed

SRN – Local Learning Loops

Weekly Interdisciplinary AT
Record Review

Transfer review data entered into AT
Databases aggregated with network

Best practices shared with INC Acute
Transfer Committee

Findings reported and initiatives
identified at INC Quality Committee

Strategies implemented

Hospital-Specific Readmission Data

Unplanned bounce-backs between
SNS and Acute Facility X

| Patients sent to SRN from Acute Hospital X | 36 |
| Acute Hospital X patients readmitted to Acute Care | 7 |
| Acute Hospital X / SNS Readmit Rate | 20% |
| SNS Overall Readmit Rate | 15% |

Why are patients coming to SNS from Facility X more likely to be readmitted?
PCC Process Improvement Pilots 2012-13

- ED-SBAR Communication
- Adm Risk Factors
- Warm Handoffs
- Sepsis PNA
- CHF Telemonitoring
- PCP Communication

Health Care System Alignment

2013 Goal: Reduce Overall 30 Day Unplanned Readmissions to Acute

Pay for Performance: Establish at least one metric to measure impact of work to reduce overall readmissions

- SRN Goal (SRH, SHC, SNS) Reduce readmissions by 10% building on existing foundation of local projects (hospital to ED handoffs; discharge documentation packets; reduce send-outs to ED; STAAR; HEN).
- PHH goal: Reduce readmissions to PHS hospitals by 8% through early risk identification (at referral for medications and all other factors at admission visit), standardized communication of risk and interventions and implementation of visit protocol

Unplanned Transfers to Acute Care within 30 Days of Admission Percent of all Partners Discharges

<table>
<thead>
<tr>
<th>Facility</th>
<th>CY 2012</th>
<th>CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRH</td>
<td>11.7%</td>
<td>10.7%</td>
</tr>
<tr>
<td>SHC</td>
<td>25.8%</td>
<td>22.0%</td>
</tr>
<tr>
<td>SNS LTAC</td>
<td>15.5%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>
| TOTAL        | 17.5%   | 15.2%   | 13.1%
2014 System Alignment

Outcome Measure
- Build on 2013 Success and lessons learned
- Reduce Readmissions by 10% for ALL SRN entities and 8% for PHH

Process Measures
- SRN: standardized ED handoff note, transfer packet
- PHH: identification of risk at time of referral, visit protocol, communication protocol

SRN – PHS ED Transitions

- Standardized communication with ED
- SBAR Handoff Note available in LMR
- SRN Provider Contact Information
- Engagement of ED Chiefs
- Provide ED with alternatives to admission
- Goal – Increase ED Disposition Discussions

Partners Healthcare at Home - Leveraging IT

- PHH vendor application
  - Sweeps OASIS data to identify readmission risks
  - Allows us to see readmit rate real-time, by referral source
- Communication
  - Internal messaging system internal to PHH EMR
  - Proprietary outpatient system (LMR) used by SRN
- Mobile devices, tele-monitoring, tele-health
- Even without a lot of tech, this is what we were able to do.
PHH – Partners Mobile Observation Unit

PMOU provides same day home visits by an advanced practice clinician for patients with urgent care needs referred from:
- ED/OBS Units
- Selected PCP Practices
- Selected Specialty Units

Benefits:
- Improved patient experience and outcomes
- Reduced hospitalizations
- Lower healthcare costs
- Improved clinical flow in emergency departments, inpatient observation units and urgent care centers

* Thanks for seeing her and for your note. I think this could be a terrific service and she could be an ideal patient for it. Communicating with her is a real challenge, and having eyes and ears in her home setting could make a huge difference.

PHH 5 Day Readmission Reduction Project

Project Goal: Improve Readmission Rates of Patients Admitted to PHH within the First Five Days of Admission to Homecare

AIM: Reduce PHH re-hospitalization within 5 days from 5% to 3% in 12 months.

TEAM:
- Dana Sheer ACNP, MSN
- Jennifer Ryan Cluff RN BSN CWON
- Denise Anderson - Referral Service Center Manager
- Ena Flaherty RN - Weekend Clinical Manager
- Merlyne Janvier RN - Liaison
- Joyce Rockwell RN
- Jill Ouellette RN

INTERVENTIONS
- Communication
- Scheduling Protocol
- Consistent Care Givers

RESULTS: Pilot study showed decrease in re-hospitalizations following new protocol.

CONCLUSIONS: On track to achieve AIM as stated.

NEXT STEPS:
- 6 Month Study using new protocol
- Clinical Manager of Specialty Programs to oversee Pilot.

PHH Readmission Reduction

Implement Standard Visit Protocol
Provide "Visual" of work flow and Roles
ID high risk patients at Referral
Communicate findings and Plan
Assess all other risks at Admission
Tie it all together
PHH – Lessons Learned

• Dig in and understand what your data is telling you
  – Different factors at different time points + different interventions
  – Suspend your assumptions
• Communication, communication, communication
• To ensure high reliability in a new or modified process
  – Planning and preparation is the key
  – Use visuals (screenshots, process flow maps) to show process
  – Monitor and report progress on adherence to each of the steps
  – Expect the need for repeated clarification and reminders
• Always remember change is hard

Unplanned Transfers to Acute Care within 30 Days of Admission
Percent of all Partners Discharges

<table>
<thead>
<tr>
<th>Cumulative Rate</th>
<th>June 2014</th>
<th>July 2014</th>
<th>August 2014</th>
<th>September 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 7</td>
<td>5.7%</td>
<td>4.8%</td>
<td>5.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Day 14</td>
<td>10.3%</td>
<td>8.3%</td>
<td>8.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Day 21</td>
<td>12.5%</td>
<td>10.6%</td>
<td>10.2%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Day 30</td>
<td>14.2%</td>
<td>12.7%</td>
<td>11.7%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Why Focus on Post-Acute as part of Care Transition Strategy?

• 68% of readmissions to BWH have been seen by a post acute provider
• Growing opportunities for collaboration with post-acute providers within and outside of Partners
Lessons Learned

• Leadership engagement and involvement
• Embrace (competing) priorities
• Expanding definitions of the “team” while not losing local innovation and ownership
• Standardization vs. customization
• Respect the data, but don’t be owned by it
• Flexibility

Next Steps

• Epic
• Cross-Continuum Data Sharing
  – Centralized Partners-level review of AT data, not just PCC AT Committee or MGH AT Committee
  – Value of case reviews with both acute and post-acute physicians
• Prioritization of High-Risk Populations
  – Work across the continuum to develop procedures and order sets for high-risk patients, e.g. oncology, BCRISP

Q & A
Equipping nurses across all settings and roles to lead effective patient-centered care transitions

2011 Environment

- Cross Continuum Teams
- Care Transitions Forum
- STAAR
- INTERACT
- BOOST
- Care Transitions Coaches
The "Ah Ha" Moment
Care Transitions Education Project
Emerging Leaders

Different types of Care Transition Initiatives
The workforce is foundation for success

Nurses in All Settings & All Roles Leading & Improving Care Transitions
Knowledge
Attitude
Skills

CTEP is a foundational workforce strategy that complements other care transition initiatives
Care Transitions Education Project

Nurses From Across the Continuum
LEARN TOGETHER!

Care Transitions Education Project

Miller’s Pyramid of Clinical Competence

- Does
- Shows how
- Knows how
- Knows

Focus on Patient and Family

Focus on Patient and Family

- Medical Home
- Outpatient Rehab
- Long Term Acute or Rehab Hospital
- Health Plan Insurers
- Pharmacy
- Home Health Services
- Skilled Nursing Facility
- Aging Services Access Points (ASAPs)
- Primary Care

11/4/2014
Care Transitions Education Project

Curriculum Components

1. Four Interactive Learning Modules
2. Patient Tracer Experience
3. Quality Improvement Activity

Care Transitions Education Project

Piloting the Curriculum

- Eight pilot sites
  - 22 service organizations engaged in cross continuum teams
  - 6 schools of nursing
  - 350 RNs and student nurses
- Training for educators
- Implement curriculum, evaluate content, delivery & outcomes, revise curriculum

Care Transitions Education Project

Logos and partners

11/4/2014
Care Transitions Education Project

Results

1. Increased competency to lead and improve care transitions
2. Increased mutual respect across care settings
3. Improved coordination and collaboration
4. Demonstration of nurse-led quality improvements

Care Transitions Education Project

How is CTEP Unique?

• All nurses across settings
• Competencies to implement care transitions tools
• Empowered frontline nurses engaged in quality improvement

Care Transitions Education Project

CTEP Stories

• It all started because....(tell us what was at stake: What was happening? Why did you start this work?)
• We did a couple of important things...
• We had some heroes....
• The thing that surprised me most was....
• Our biggest win was.....
• We still need to.....
The title of our story is.....

Care Transitions Education Project

Phase 2 Goals

1. Spread CTEP in a way that complements existing care transitions work
2. Build the case for CTEP from a cost savings perspective

Current Environment

- Pioneers
- ACO
- Risk
- Penalties
- Rates
- Preferred Provider
Check Out Our New Website

www.CareTransitionsEducation.org

2015 Offerings

- Train the Trainer
- Technical Assistance
- Community of Practice

More Information?

Kelly Aiken
CTEP Project Director
Massachusetts Senior Care Foundation
kaiken@maseniorcare.org
Reducing Avoidable Readmissions through Safer Transitions

A COMMUNITY PARTNERSHIP APPROACH

Our Team Representatives

- Jaime Long RN MWMC Director of Post Acute Care Services
- Carolyn Gifford MS, RN MWMC Director of Case Management
- Pat Burke RN Director of Transitions in Care & CCTP
- Mary Hatch RN Kathleen Daniels Director of Nursing
- Natalie Kenney RN MWHC Care Transition & Special Projects Manager
- Mary Bottachiaro RN MWHC Transition Care Coach
- Rebecca Sommers-Petersen BayPath Elder Services – Coleman Coach

Where We Were: Working Hard >Disconnected
**Who We Are**

- **Two Campuses - 285 Beds**
  - Framingham Union Hospital &
  - Leonard Morse Hospital
- **Two – 24 hour Emergency Departments**
- **Inpatient Services:**
  - Medical / Surgical
  - Intensive Care Units
  - Pediatrics
  - Maternity
  - Level 2 Special Care Nursery
  - Advanced Cardiac Care
- **Inpatient and Outpatient Behavioral Health Services**
  - Ambulatory Clinics

**Where We Were**

January 2014 Core Readmission rate of 21.8%
Medicare Readmission penalty of 1.0%

- Undefined post acute strategy
- Under-developed preferred provider network
- Inadequate communication to post acute providers
- Insufficient internal workflow processes & systems
- Minimal case management coverage in ED
- Uncoordinated readmission reviews
- Inpatient care team uninformed about impact of readmissions
- Gaps in transition and follow up plans for patients at time of discharge (Follow up PCP appointments)

**Where We are Now – 9 Months Later**

- **Formal Post Acute Strategy**
  - Definitions, Goals, Metrics
- **Organized and effective preferred provider network**
  - Coordination with other community resources including CCTP
  - Regularly scheduled meetings with post-acute collaborators
  - Standardized expectations, metrics and reporting
- **Inpatient Team Informed, Engaged and Focused**
  - Case Management – ED
  - Daily Review of all readmissions using format
  - Collaborative care rounds format standardization, with readmission assessments
  - Discharge PCP and other follow-up appointments for patients made prior to discharge
Medicare Readmission Penalties

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hospital</th>
<th>FY2013</th>
<th>FY2014</th>
<th>FY2015</th>
<th>Rank</th>
<th>Hospital</th>
<th>FY2013</th>
<th>FY2014</th>
<th>FY2015</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Adcare Hospital Of Worcester Inc</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>28</td>
<td>Berkshire Medical Center</td>
<td>0.42%</td>
<td>0.94%</td>
<td>1.39%</td>
</tr>
<tr>
<td>2</td>
<td>MetroWest HomeCare &amp; Hospice</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>27</td>
<td>Brown Medical Center</td>
<td>0.42%</td>
<td>0.94%</td>
<td>1.39%</td>
</tr>
<tr>
<td>3</td>
<td>New Bedford Hospital</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>26</td>
<td>Brockton General Hospital</td>
<td>0.42%</td>
<td>0.94%</td>
<td>1.39%</td>
</tr>
<tr>
<td>4</td>
<td>New Bedford Hospital</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>25</td>
<td>Cape Cod Hospital</td>
<td>0.42%</td>
<td>0.94%</td>
<td>1.39%</td>
</tr>
<tr>
<td>5</td>
<td>Cape Cod Hospital</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>24</td>
<td>Carney Hospital</td>
<td>0.42%</td>
<td>0.94%</td>
<td>1.39%</td>
</tr>
<tr>
<td>6</td>
<td>Cape Cod Hospital</td>
<td>0.00%</td>
<td>0.00%</td>
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MWMC Medicare Readmission Penalties:
- 2013 - 1.0%, 2014 - 0.5%, 2015 - 0.1% (13th lowest out of 61 MA hospitals)

MWMC September

Community Based Care Transitions Program
CCTP

Pat Burke
Director of Transitions in Care & CCTP
MetroWest HomeCare & Hospice
CCTP Community-Based Organizations

102 Approved / 83 Active

CCTP Program Components

- Transition Care Coach
- Telephonic Care
- Palliative Care
- Transitions in Care Pharmacy Intervention
- Care Transition Intervention®
- Care Transition Intervention® plus

Results (June 2012 - April 2014)

- Population Size = 7087 patients
- Baseline readmission rate for target high risk population = 31%
- Reduced readmission rates by 50% for patients receiving a Transition Intervention

Re-Admission Rate by Intervention (June 2012 - April 2014)
Success!

CMS recognized our project as one of the top performing projects across the 102 nation-wide approved sites.

Top Performers in:

- Reaching our Enrollment Target
- Reduced Readmission by 50% for patients receiving a CCTP Intervention
- Reduced All-Cause Medicare Readmissions by 7.7%

Where We Were: Working Hard > Disconnected

Where We Are: Engaged and Aligned
Palliative Care: A Collaborative Model to Reduce Hospital Readmission

Jeanne Ryan, MA, OTR, MBA, CHCE
Vice President, Post-Acute Care, Cooley Dickinson Health Care

Maureen Groden, RN, MS, CHPN
Director, Hospice and Palliative Care, Cooley Dickinson Health Care

Objectives for Presentation

- Understand the development of Palliative Care as a response to community demand
- Understand the growing need for home care Palliative Care management of patients with serious illness
- Describe key components of a successful Palliative Home Care Program
- Describe Cross Continuum Collaboration as a model to decrease hospital readmissions

Structure of Cooley Dickinson Health Care

Cooley Dickinson Health Care Corporation, (CDHCC) made up of:
- Cooley Dickinson Hospital
- Cooley Dickinson Practice Associates
- VNA & Hospice of Cooley Dickinson

A Massachusetts General Hospital Affiliate
Our Service Area

Definition of Palliative Care

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.
Definition of Palliative Care

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Existing Palliative Structure CDHC circa 2007-2009

- Small Inpatient and Outpatient Palliative Consultation Service Line – Dr. Jeff Zesiger
- Hospital-based Palliative Care Committee meeting monthly to enhance experience of patients identified with palliative care needs
- Small, not well-developed Palliative Program at the VNAH
- Limited Community Awareness of Palliative Programs at CDHC

Developing the Cross Continuum Team

- 2009-Patient and Family Advisory Council at CDH
- 2010-Patient-Centered Care and Human Mortality Report
- 2011-Center to Advance Palliative Care Public Opinion Research
- 2012-Medical Orders for Life Sustaining Treatment (MOLST) pilot roll-out
- 2013-Faith Outreach Coordinator
- 2014-Post Acute Care Transition Team (PACT)
Department of Public Health requires all Hospitals in the state of Massachusetts to establish a Patient and Family Advisory Council

Patient and Family Advisory Council: 105 CMR 130.1800 and 130.1801
Section 11 of c. 305 adds section 53E to M.G.L. c. 111, which requires each hospital to establish a patient and family advisory council (PFAC). PFACs facilitate patient and family participation in hospital care and decision-making, information sharing, and policy and program development. The PFAC concept is based on the work of the Institute for Family-Centered Care, which is credited with developing the core principles that are the foundation of the patient and family-centered care movement.

- Consistent with section 53E, the proposed amendment provides that the PFAC shall advise the hospital on matters including but not limited to patient and provider relationships, institutional review boards, quality improvement initiatives and patient education on safety and quality matters. The proposed amendment requires hospitals to adopt and implement policies and procedures that govern a PFAC’s goals, membership, training, and roles and responsibilities.

Palliative sub-group of the PFAC

- Palliative Sub-Committee of PFAC formed based on initial members advice
- Three PFAC members join sub-committee
  Here’s why:

“When the opportunity presented itself I think there were several factors that led me to join. Reflecting on the end of life experience of a number of members of my extended family, I realized it did not have to end that way. I also saw it as a way to educate myself. More importantly, the goal of informing members of the community about Palliative Care was a compelling challenge.” Ray

Patient-Centered Care and Human Mortality Report-2010

Patient-Centered Care and Human Mortality
The Urgency of Health System Reforms to Ensure Respect for Patients’ Wishes and Accountability for Excellence in Care
Report and Recommendations of the Massachusetts Expert Panel on End-of-Life Care

Submitted to:
Deval L. Patrick, Governor
October 2010
Objectives of Research

The objectives of this research were to:

• Explore key audiences' awareness and understanding of palliative care; and,

• Test language, terminology, definitions and messaging to be used in discussing palliative care with consumer audiences.
Key Finding

- Although consumers may be content with the quality of health care they receive, they have concerns about the level of care patients with serious illness receive.

- The biggest concerns relate to information sharing between doctor and patient and other doctors, patient control and choice over treatment options, patient understanding about their illness and treatment, and the quality of time doctors spend with patients.

Consumer Awareness About Palliative Care

How knowledgeable, if at all, are you about palliative care?

*Data from a Public Opinion Strategies national survey of 800 adults age 18+ conducted June 5-8, 2011.

Key Finding

- Language makes a difference.

- Palliative care is about improving quality of life, providing an extra layer of support, and having a team focus to patient care.

- Palliative care is about helping both the family as well as the patient with serious illness.

- Serious Illness vs. Advance Illness: Palliative care should be positioned as care for patients with serious illness not advanced illness. Advanced illness is perceived to be more closely aligned with terminal illness.
Key Finding

- After hearing the definition of palliative care, consumers strongly agree that:
  - Patients with serious illness and their families be educated about palliative care.
  - Palliative care is appropriate at any age and any stage in serious illness.
  - Palliative care treatment options should be covered by health insurance and Medicare.

Readmission Data: Nation

Quick Facts
- 2,610 hospitals are receiving a readmission penalty this year (October 1 2014-Sept 30 2015)
- Conditions expanded to "5": AMI, PNA, HF, COPD, hip/knee (together)
- Penalty is up to a 3% decrease on all Medicare FFS reimbursements
- Medicare will recoup $428M from payment reductions due to readmission penalties nationally this year

Readmission Data: Massachusetts

- 55 hospitals in MA are receiving a penalty this year, which is 80% of all eligible hospitals
- The average penalty in MA is 0.78% (of a possible 3%)
- MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT and tied with NJ
- MA is #7 highest average magnitude of penalty - behind KY, WVA, VA, NJ, AK, AR and we are tied with IL
Existing Palliative Care Program VNA circa 2007-2009

- Palliative Program within the VNA managed by VNA Clinical Manager
- Lack of clear eligibility guidelines for Palliative Care
- Inconsistent case management and scheduling
- Limited clinician competency on trajectory of illness, advanced directives and symptom management
- Gaps in coordination of care between VNA, hospital, SNF
- Census in low 20s/30s

Why Focus on Palliative Care?

- In the US in 2009, 12.9% of people (39.6 million) were over the age of 65; in 2030, it will be 19% (72.1 million)
- Patients with chronic illness in their last two years of life account for about 32% of total Medicare spending
- Rise in patients with multiple co-morbidities, complex illnesses and treatment plans
- Many patients are in clinical, functional, +/or nutritional decline, but are not ready, eligible or interested in hospice
- Such patients generally experience poorly coordinated care and repeat hospitalizations, often related to pain and symptom management.

What is the Benefit? Quality of Life?

- Need for discussions on benefits and burdens of treatment options due to seriousness of illness - prognosis
- Weighing potential pros and cons of ALL treatments
- PROGNOSIS is crucial – and challenging with multiple illnesses and multiple physicians. People need to know. Not just how long will I live but how well will I live with this treatment?
- Only 20% of predictions were accurate. MDs over-predicted prognosis by 500%, longer length of relationship = worse predictive ability
Disease Trajectories

Quantitative Scales

PALLIATIVE PERFORMANCE SCALE

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<th>R</th>
<th>Ambulation</th>
<th>Life Expectancy / Terminal Illness</th>
<th>Self-Care</th>
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Palliative Care Program Goals

- High Quality Patient and Family Care with a Focus on Helping Them Achieve Their Goals
- Improvement in Symptom Management
- Reduction of Acute Care Hospitalization
- Linkages with Primary Care Providers
- Transition to Hospice
- Patient Satisfaction
- Employee Satisfaction
- Program Growth
Palliative Care Action Plan

Goal – Responsible Person – Due Date - Outcomes

- Education, Competency, Certification
- Quality Outcomes, Case Management, Teamwork, IHHC
- Patient Satisfaction, Consistency, Informed, Focus on Pt Goals
- Employee Satisfaction, Education, Support, Tools
- Structure, Caseloads, Scheduling, IT, Transitions
- Collaboration, PFAC, Readmission Reduction, Cancer Committee
- Marketing – Brochure, Customer Service, Outreach
- Finance, Efficiencies, Care Management, Transition to Hospice

Employee Development and Support

- Agency-wide educational program on Palliative Care
- Hire Palliative Care R.N.s with Hospice / EOL Experience
- Educational Program on PC with Modules & Competencies
  Model: Concensus Project for Quality Palliative Care
  - Disease Management and Case Management Coaching
  - Symptom Management
  - Interdisciplinary Collaboration
  - Ethics
- Palliative Care Staff Support Meeting Monthly
- Certification in Hospice & Palliative Care (CHPN)

Systematic Changes

- Intake
- Liaison
- Scheduling
- I.S.
- Administrative
- Orientation
- Management Development
**Strategies to Achieve our Goals**

- Hire Qualified Palliative Care Staff with End of Life Experience / Certification
- Case Management, Disease Management Coaching
- Education: Goals of Care, Advanced Directives, Trajectories of Illness, Symptom Management
- Collaboration: PCP, Palliative Care - Inpatient, Outpatient, SNF, Home Care, Hospice

**Palliative Care Screening – Recruitment: VNA**

1. Cancer-metastatic / recurrent
2. Serious Organ Disease: low functional status
   - Cardiac, Pulmonary, Neuro, Dementia, Kidney, Liver
     - Multiple ED visits
     - Hospitalized 2 times or > in past 6 months for the same problem
     - Symptoms poorly controlled
     - Family distress

**Additional Screenings**

- OASIS Start of Care Alerts “likely hospice referral”
- OASIS Start of Care Alerts “risk for re-hospitalization”
- CDH Palliative Care Screenings
- Quantitative Scales (PPS, FAST, NYHA)
Palliative Care Team

M.D.  
R.N.  
S.W.  
P.T.  
O.T.  
Home Health Aide

Hospice Team

M.D.  
R.N.  
S.W.  
Spiritual Care  
Complimentary Care  
Volunteers  
Home Health Aide  
Bereavement

Case Example CHF: Dyspnea & Anxiety

Dottie, 84 y/o w/ CHF with EF 30%, COPD, CKD, OA, Hypothyroidism
Widowed, lives alone, daughter and family live next door, another son &
dughter nearby; retired food service, was active with church, now unable to
get out, amb w/ walker; DNR
Admitted hosp x 3, last 3 months for SOB; she won’t complain; hates to
come in the hospital

Goal: Stay out of the hospital, get to church

PPS: 50, NYHA Class III

Rx: Furosemide, captopril, potassium, albuterol and ipratropium,
Ibuprofen, levothyroxine, miralax, O2, oxycodone, lorazepam

PC Plan:
R.N.: CV assessment, CHF teaching, dyspnea/pain, emergency mgmt plan
S.W.: Community resources, PERS, caregiving & homemaking referrals, support
P.T.: Safety, transfers, strengthening
O.T.: Energy conservation, adaptive equipment, ADL assessment, incontinence
HHA: Bathing, skin care, assist with anti-embolism stockings, weights

Interdisciplinary collaboration, PCP & Medical Director

Outcome Measures

Quality: 10% HHC Scores
Pain, Dyspnea, Hospitalization

Patient Satisfaction
Staff Informed, Pain & S/E

Employee Satisfaction
Education, Certification, Support

Finance / Growth
Census, Transition to Hospice, LOS
Growth in Home Care Palliative Care

Quality & Patient Satisfaction Outcomes

Readmission Reduction Committee: Hospital

Literature Review & Best Practice Examples
Data Analysis: BOOST Tool, Pathways Analysis
Findings: * COPD & Pneumonia accounted for 79% of readmissions within 30 days;
* 14 patients accounted for 10% of readmissions in 12 months
* Every patient had a social, financial or transportation concern
Interventions: Medication Reconciliation
Motivational Interviewing Education:
Multi-disciplinary Cross Continuum Team
**Readmission Reduction Committee: VNA**

- Literature Review & Best Practice Examples
- Data Analysis: SHP Data: Transfers, VNA Resumption of Care
- Findings: * COPD & CHF were primary diagnoses in patients readmitted to the hospital
  - COPD 11.3% Palliative Care / 4.8% Clinical
  - CHF 14% Palliative Care / 5.3% Clinical
- Interventions: Focus on Palliative Care patients / family
  - Management of Dyspnea and Anxiety
  - Telehealth and Telecommunications
  - COPD/ACH Staff Education
  - Transfer patients to Hospice

**Reduction of Acute Care Hospitalization**

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<th>Year</th>
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**Transition to Hospice**

- FY2013: PC → HS, 33%
- FY2014: PC → HS, 42%
Hospice LOS: Length of Stay

Hospice Discharge and Hospitalization

2010-2014 What we did to grow Cross Continuum Programs

- Changed CDH Palliative Physician Model to Staff Model
- Adding full-time NP
- Responded to CAPC info by creating Community Education Model
- Utilized PFAC Members as Community Ambassadors
- Led MOLST Roll-Out
- Presented Statewide on Palliative Programs at CDHC/VNAH
2010-2014 What we did to grow Cross Continuum Programs

- Educated Community on Care Choices

- Educated cross-continuum groups on motivational interviewing to decrease readmission

- Trained on motivational interviewing

- Increased Hospice presence in SNFs
2012-2013 Community Presentations

The Conversation Continues: Nuts and Bolts of End of Life Care. Introducing MOLST to the Community

MOLST Roll-Out

- Video made to Train Physicians in MOLST Conversation
- Patients/Community members must be trained to participate in MOLST discussions if they are to receive the care they want
- Video is being used to train community members to be active participants in MOLST conversations
  - Senior Centers
  - ALFs
  - Independent Living Facilities
- Website for video http://www.cooley-dickinson.org/main/media/10.aspx
Community MOLST Presentation

Community Dialogue on End of Life Choices 2014

Taking Control Over Your End of Life

- Community Dialogue with over 150 participants
- MOLST Completion
- VSED
- “Is it ethical to stop feeding my demented mother?”
- Care Choices: Ethical Decision-Making

2014 Community Presentation
The Effect of Hospice on Hospitalizations of Nursing Home Residents

- Journal of the American Medical Directors Association
  Zeng, N.T., Makame, D.B., Friedman, B., Caprio, T., Temken-Greener, H.

- Hospice enrollment is known to reduce risk of hospitalizations for nursing home residents who use it. We examined whether residing in facilities with a higher hospice penetration: (1) reduces hospitalization risk for nonhospice residents; and (2) decreases hospice-enrolled residents' hospitalization risk relative to hospice-enrolled residents in facilities with a lower hospice penetration.
## The Effect of Hospice on Hospitalizations of Nursing Home Residents

### Results
- In the last 30 days of life, 37.63% of non-hospice and 23.18% of hospice residents were hospitalized. Every 10% increase in hospice penetration leads to a reduction in hospitalization risk of 5.1% for non-hospice residents and 4.8% for hospice-enrolled residents.

### Conclusions
- Higher facility-level hospice penetration reduces hospitalization risk for both non-hospice and hospice-enrolled residents. The findings shed light on nursing home end-of-life care delivery, collaboration among providers, and cost-benefit analysis of hospice care.

## Final Thoughts

“We work cooperatively with staff members of the committee to revise printed material available to the community and present information at forums held at Senior Centers and other locations serving elderly populations. The forums have been very successful and we enjoy interacting with those attending the sessions”

Howard, Ray, Don

## Questions?

### References:
- National Consensus Project for Quality Palliative Care. 2013. [www.nationalconsensusproject.org](http://www.nationalconsensusproject.org)
Leveraging Palliative Care: A Hospital to Home Based Approach

Presented by:
Robin Hynds, Lawrence General Hospital
Diane Martin, Greater Lawrence Family Health Center
Sarah Plante, Lawrence General Hospital

Objectives
• Describe processes to engage high risk patients in care across continuum
• Describe processes for better coordination, decreased readmissions and attainment of Patient Centered Medical Home (PCMH) status
• Define how palliative care was utilized to meet triple aim goals

History Lawrence General & Greater Lawrence Family Health Center
• Disparate organizations but similar goals, mission and values
  • Work cooperatively with the City of Lawrence and Department of Public Health
  • Focused programs on reducing obesity and the incidence of diabetes
• Greater Lawrence Family Health Center (GLFHC)
  • Independent Section 330 federally qualified health center, and NCQA Level 3 Patient Centered Medical Home
  • Has four sites within the City of Lawrence
  • Flagship site adjacent to the hospital campus
  • A fifth site, co-located inside LGH
  • Provides primary care for more than 30,000 residents of the Greater Lawrence community
  • 80% admitted to LGH
  • Operates a 30 resident Lawrence Family Practice Residency jointly with the Hospital
Opportunity to Work Closer Together

• Waiver through Centers Medicare and Medicaid Services (CMS) and Executive Office Health Human Services (EOHHS)
  – Disproportionate Share Hospital & Safety Net Providers
  – Serve patients who otherwise cannot afford or gain access to care
  • Higher proportion of Medicaid patients

• Transformation of health care and triple aim goal
  – Better health
    • Readmission reduction
    • Care coordination enhancements
  – Better experience
    • Increased access to needed services in local community (PCP, Specialists etc.)
    • Seamless transitions
  – Lower cost
    • Utilization of appropriate services

The Journey Begins…

• Root Cause Analysis
  – Interdisciplinary analysis of readmission data (50 charts)
  – Revealed key contributing factors
    • Communication failures
    • Medication compliance failures
    • Post-hospitalization care coordination failures
    • Lack of addressing social determinants of health
    • End of life care challenges
      – 40% could benefit from Palliative Care
      – Diabetes, CHF and COPD large proportion of shared patients
    • Monitor rates of top diagnoses to measure effectiveness of interventions

“Bringing the PCMH to the Bedside”
How did we get there?

- Created a joint team
- Job shadowing
  - observed gaps in patient disconnect during transition of care
- Identified barriers
  - Cultural
  - Language
  - Communication (2 separate EHR)
- Identified roles
  - Clinical Nurse Leaders (CNLs)
  - Clinical Care Nurse Coordinators (CCNCs)
  - Clinical Pharmacist

Created Improvement Plan

- Care Mapping
  - Identify GLFHC patients on admission
  - Share access to both EHR
  - Risk stratify patients
  - Warm handoffs during Transition of Care
  - TOC note developed
  - Documentation in both EHR
  - Chaired by CCNC and Clinical Pharmacist
  - Ensured PCP follow up

Risk Level Criteria TOC Recommendations:

**Level 1**

- DKA (Diabetic Ketoacidosis)
- "Diabetic HHS" or "HHS" (Diabetic Hyperglycemic Hyperosmolar Syndrome)
- Newly diagnosed Type 1DM
- Initiation of Insulin for home; or change in home insulin regimen from once daily insulin injection to multiple daily insulin injections
- Gestational Diabetes: new diagnosis or change in treatment regime
- Recurrent Hypoglycemic events, hypoglycemic unawareness or patient needed glucagon to treat
- Uncontrolled DM with one or more of the following:
  - A1C ≥ 11
  - Complex medical needs requiring close supervision (such as status post surgery, initiation of corticosteroids, and other conditions)

- Newly diagnosed Type 2 DM (NOT on insulin)
- Patient who meets high risk criteria as above but is discharged with VNA services other than HHVN

**Level 2**

- DM w/A1C ≥ 9* but < 11
- DSME Referral in Centricity or No referral in Centricity
- Patient who meets high risk criteria as above but is discharged to Long Term Care Hospital, Skilled Nursing Facility, Rehab, Inpatient Psychiatric or other temporary care facility
- Patients who are d/c'd from HHVNA and who received DSME support at home

**Level 3**

- DM w/A1C < 9*
- DSME Referral in Centricity or No referral in Centricity
- DSME at discretion of PCP at time of f/u for hospitalization
Outcomes of Care Mapping Pilot

## Hospital Specific Measures

<table>
<thead>
<tr>
<th></th>
<th>CMS IQR Definition</th>
<th>Hospital Specific Report</th>
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</thead>
<tbody>
<tr>
<td>30 Day All-Cause 18+ Diabetes Readmission Rate</td>
<td>6/1/13 - 2/28/14</td>
<td>25 140 17.9%</td>
</tr>
<tr>
<td>30 Day All-Cause 18+ Heart Failure Readmission Rate</td>
<td>6/1/13 - 2/28/14</td>
<td>87 346 25.1%</td>
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</tbody>
</table>

Identifying Palliative Appropriate Patients

Interventions for Palliative Care Patients

- Medication Reconciliation
- MOLST
- End-of-life wishes
- Health care proxy
- Follow-up appointments
- Outpatient palliative management

All with the goal of:

- Decreasing frequency of hospital admissions/ED visits
- Improvement in quality of life
- Symptom management
- Education about palliative care options
- Support for psycho-social, spiritual and family issues
- Discuss treatment options
Your patient was seen at Lawrence General Hospital and received a Palliative Care Consult. See Customized Care Plan below:

**Admission Date:** 10/22/13

**Consulting Provider:** Matt Bellanich, NP

**Admitting Diagnosis:** Patient presented to LGH EC with complains of abdominal pain, appeared sleepy for last 2 days per patient's girlfriend. Patient diagnosed with sepsis after positive blood cultures.

**Reason for Consultation:** Discuss goals of care and assist with symptom management.

**History of Present Illness:** 50 y.o. male with end-stage liver disease who was enrolled in Hospice for the past month, admitted to EC with above complaints. PMH includes: Hep C cirrhosis, cocaine use, Methadone maintenance, hepatic encephalopathy, pancytopenia, splenomegaly, portal HTN, COPD, depression, varices, DM, chronic abd pain, nephrolithiasis, atypical chest pain, pulmonary nodule and septic arthritis.

**Psycho/Social:** Lives with his wife who is primary caregiver, no other family members. Patient was enrolled in Hospice and came to the hospital prior to notifying Hospice.

**Medication Changes:** Continue current medications per Hospice orders. Patient's pain appears well controlled at this time unless his abdomen is manipulated.

**Advanced Directives:** Patient listed as **FULL CODE**. NP had conversation with patient and his wife about the reality of his illness. Patient and wife are willing to discuss DNR in the future.

**Recommendations:** Follow-up with patient regarding CODE STATUS, reinforce need to call Hospice for evaluation of symptoms prior to coming to the Emergency Room.

**Disposition:** Patient remains in the hospital at this time. Continue to be enrolled in hospice currently and after discharge. Questions of returning patient to Hospice House or discharge to home to continue his IV ABX therapy.

*For further information please refer to Palliative Consultation Report.*

**Questions please call:** Sarah Plante, Clinical Nurse Leader, Lawrence General Hospital (978) 683-4000 ext. 2267

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Signed by Sarah Plante on October 24, 2013 @10:11 AM.

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Signed by Annamaria Cappucci MD on October 27, 2013 @2:36 PM.

Electronically signed by Annamaria Cappucci MD on 11/07/2013 at 12:42 PM

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Sample Care Coordination Note in EMR

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**Meaningful Care Coordination**

<table>
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<tr>
<th>Admission Month</th>
<th>Total Patients Age 55 and Over Screened for Palliative Consult</th>
<th>Palliative Care Consults Ordered and Coordinated with PCMH</th>
<th>% of Screened Patients with Palliative Care Coordination</th>
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</thead>
<tbody>
<tr>
<td>Jan - 13</td>
<td>150</td>
<td>8</td>
<td>5.3%</td>
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<tr>
<td>Feb - 13</td>
<td>149</td>
<td>7</td>
<td>4.7%</td>
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<tr>
<td>Mar - 13</td>
<td>144</td>
<td>12</td>
<td>8.3%</td>
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<tr>
<td>Apr - 14</td>
<td>159</td>
<td>9</td>
<td>5.7%</td>
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<tr>
<td>May - 14</td>
<td>175</td>
<td>6</td>
<td>3.4%</td>
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<tr>
<td>Jun - 14</td>
<td>130</td>
<td>11</td>
<td>8.5%</td>
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</table>

**June '14 Total (July 1, 2013 - June 30, 2014)** 1359

90

6.6%

*All patients age 55 and over are screened for Palliative Consult using an evidence-based “Trigger Tool”. Attributable consultation at admission allows staff and attending physician to determine if consult would be beneficial on an individual basis. Care Coordination consists of a customized Palliative Care Plan documented in EMR.*
So what did all this work reveal?

Reduction in Potentially Avoidable Readmissions

40% 2013

28% 2014