Designing & Delivering Whole-Person Transitional Care

Coordinating care across settings and over time to drive outcomes

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Agenda

- Design – data, root causes
- Deliver – whole-person, across settings & over time
- Execute – innovate methods, prioritize engagement
During this session, consider:

• Do you know your *data*?

• Do you seek to understand *root causes* of utilization?

• Do you take a *disease-specific* or "*whole-person"* approach?

• Do you *actively collaborate* with staff in other organizations?

• Do you *deliver services* in ways that meet your patients’ needs?
Designing and Delivering Whole-Person Transitional Care: The ASPIRE Guide

13 customizable tools

6-part webinar series

The ASPIRE Framework

Reduce All Cause Readmissions

Analysis “Design”

- Analyze Your Data
- Survey Your Current Readmission Reduction Efforts
- Plan a Multi-faceted, Data-Informed Portfolio of Strategies
- Implement Whole-Person Transitional Care for All
- Reach Out and Collaborate with Cross-Continuum Providers
- Enhance Services for High-Risk Patients

Action “Deliver”
All Cause All Payer 30-day Readmissions
Community Hospital in Maryland

All Payer and Medicaid Adult, Non-OB Readmission Rates Over Time

- Medicaid
- All payer
- Linear (Medicaid)
- Linear (All payer)
All Cause All Payer 30-day Readmissions
Safety Net Hospital in Illinois
All Cause All Payer Heart Failure Readmissions
Rural Hospital in Alabama

- ED CM flags all HF admits
- List to HF ToC RN
- 1-2 new patients / day
- Brief visit in-hospital
- Phone calls x 30 days
- Transportation
- Medication – affordability
- Care seeking patterns

Team:
- ED CM, 1 RN
- Finance/ Quality Analyst
Design

*Know your data; Understand Root Causes*
Take a Data-Informed Approach

1. What is our aim?
2. What does our data show?
3. Who should we focus on?
4. What services will address the root causes of utilization?

Many teams start in the *reverse* order
High rates: adult non-OB Medicaid

High rates: discharges to SNF, CHHA

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016
### Discharge Diagnoses Leading to Most Readmissions

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<th>Medicaid</th>
<th>Comm.</th>
<th>Unins.</th>
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<td>ETOH w/d (76)</td>
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</table>

*Medicare list differs from Medicaid list*

**Method:** DRG, age>18, exclude OB  
**Source:** Boutwell in collaboration with South Carolina Hospital Association
Readmission Rates for People with BH Conditions

- 40% of hospitalized adults had at least 1 behavioral health (BH) condition
- Patients with any BH condition have 77% higher readmission rates

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016
Heart Failure Readmission Rate by Age, Payer

High rates across ages; highest for Medicaid

Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010


-- Indicates too few cases to report.
High Utilizers

Small number of patients account for majority of readmissions

- 4+ hospitalizations/year
- 6 hospitalizations/year v. 1.3
- LOS 6.1 days v. 4.5
- Readmission rate 38% v. 8%

Boutwell with Massachusetts Center for Health Information and Analysis 2016
Jiang et al. AHRQ HCUP Statistical Brief #184 Nov 2014
Understand Root Causes: the “story behind the cc”

• 77F hospitalized to have a dialysis catheter placed returns to the hospital 8 days following discharge with shortness of breath.

• 86M with cancer hospitalized for constipation and abdominal pain returns to the hospital 1 day after discharge with abdominal pain.

• 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with persistent cough.

• 32M with a lifetime of uncontrolled diabetes presents to the ED or hospital every day with chest, flank, abdominal pain.
Interviewed 60 patients who returned to ED <9 days of visit

- Average age 43 (19-75)
- Majority had a PCP,
- Preferred the ED: more tests, quicker answers, ED more likely to treat symptoms
- Most reported no problem filling medications
- 19/60 thought they didn’t get prescribed the medications they needed (pain)
- 24/60 expressed concerns about clinical evaluation and diagnosis

Primary reason: **fear and uncertainty about their condition**

Patients need **more reassurance during and after** episodes of care

Patients need access to **advice between** visits
DELIVER

ADDRESS WHOLE-PERSON NEEDS, OVER TIME & ACROSS SETTINGS
Proposed New Standards for Transitional Care

**IMPROVING TRANSITIONAL CARE FOR ALL PATIENTS**

CMS has recommended that hospitals should do the following to improve discharge planning — now referred to as “transitional care.” These expectations apply to Medicare and Medicaid patients.

- Identify all patients at high-risk of readmission
- Assess clinical, behavioral and social needs
- Communicate with patients simply and effectively
- Link patients to follow-up and post-hospital services
- Provide real-time information to receiving providers
- Ensure timely post-discharge contact
- Have a process
- Track, trend and review readmissions
- Continuously improve the process to meet needs

[Our hospital] is working to meet these expectations — and we need your help! Please contact your manager or supervisor if you have feedback or ideas to improve how we deliver safe and high quality transitional care to all of our patients. For more information, contact [Readmission Champion].

ASPIRE Tool 8: [https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html](https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html)
“Whole-Person” Adaptations to Service Delivery

- Navigating
- Hand-holding
- Arranging for….
- Providing with….
- Harm reduction
- Meet “where they are”
- Patient priorities first
- Relationship-based
Whole-Person Approach

Successful teams state:

- “We look at the whole person, the big picture”
- “We always address goals and ask what the patient wants”
- “We meet the patient where they are”
- “First and foremost it’s about a trusting relationship”
- “You can’t talk to someone about their medications if there is no food in the fridge”
- “Our navigators are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills”
- “We do whatever it takes”
Community Resources

First: identify the community resources that serve the needs of your patients

Then: identify a **point of contact** at those agencies to start working with

Cross Continuum Coordination – Getting Started

✓ Hold regularly scheduled monthly meetings
✓ Start with a “coalition of the willing” – doesn’t need to be perfect
✓ Invite new partners/ agencies as you learn about them
✓ Allow 3-4 months for the group to gel
✓ Start with common agenda items:
  • Readmission data
  • Readmitted patient stories
  • Handoff communication
  • What can we do together to achieve our aims for our shared patients?
In Practice: New Partnership with Behavioral Health Center

A hospital had established a vibrant cross-continuum community coalition. The coalition was comprised primarily of post-acute and aging services providers. Together over the years, the coalition had developed a shared understanding of the opportunity to reduce readmissions, reviewed readmission data together, reviewed readmissions to identify root causes, and developed better processes for handing off patients from the hospital to post-acute providers.

After several successful years and in response to new market incentives, the hospital expanded its focus from Medicare readmissions to all-payer readmissions. In the course of reviewing the composition of the cross-continuum team, the hospital recognized there were no behavioral health providers. The natural first choice was the large community behavioral health center.

The collaboration started with a meeting between the director of programs of behavioral health center and the director of case management at the hospital. They arranged to begin monthly collaborative team meetings with the behavioral health center contact, ED case management, the behavioral health crisis team, and inpatient psychiatry service to reduce inappropriate ED utilization and readmissions by:

- Gaining a better understanding of the behavioral health center’s services;
- Establishing a key contact in each organization to facilitate collaboration;
- Sharing data by using the state health information exchange to notify both the center and ED/hospital providers when a behavioral health center patient enters the ED;
- Training in motivational interviewing for hospital staff who care for patients with behavioral health diagnoses;
- Making health center enrollment packets available at the hospital; and
- Creating individual care plans for high-utilizers.

Warm Handoffs with “Circle Back” Call

Circle Back Questions (“Sender” calls “receiver” <1 day of transition):

✓ Did the patient arrive safely?
✓ Did you find the information complete?
✓ Were the medication orders correct?
✓ Does the patient’s presentation reflect the information you received?
✓ Is patient and/or family satisfied with the transition?
✓ *Have we provided you everything you need to provide excellent care to the patient?*

Key Lessons:

• Transitions are a **process** (forms are useful, but need intent)
• Best done **iteratively with communication**

Source: Emily Skinner, Carolinas Healthcare System
Circle Back: “Ideas that Work”
Implementation Example

https://www.youtube.com/watch?v=SG28aJhs63s

“Anytime I discover an issue, I always follow up. When I started making the calls, I found issues 26% of the time; last month I only had issues 8% of the time”

- Hospital RN

“6 simple questions are making a difference in the Richmond community”
“Warm Follow Up”

“Warm follow-up” – check in call with staff after referral / transition

Process:
• **Tracked** which patients were referred to which entities
• Scheduled a weekly call (“**batch processing**”)
• **Touch base** to ensure effective linkage has occurred

Key lessons:
• **Took a while** to develop collaborative rapport v. “in-charge”
• **No substitute** for verbal communication and problem solving
Co-Management Over Time

• **Dedicated Point Person**
  - Care manager, care coordinator

• **Co-Management ("case conference")**
  - Weekly or biweekly meetings
  - Discuss unresolved issues, anticipate needs
  - Clarity on next steps
  - Increase impact, avoid duplication

• **Care plans**
“Reach In – Transition Out”

In practice: High-risk Care Team Averts (Re)admits from ED

“Our patients look bad on their best day”

A highly successful high-risk, high-cost care management demonstration program leveraged the emergency department as an important opportunity to avert an admission or readmission. When a high-risk patient registered in the ED, a notification was sent to the care management team. The expectation was that the team would collaborate with the emergency department staff to identify whether a discharge, rather than (re)admission, was a safe and appropriate option.

In reflecting on their success factors, the program cited the care managers’ and primary care physicians’ longitudinal knowledge of their patients as critical to providing context to admission decisions, stating “our patients look bad on their best day,” reflecting the importance of knowing a patient’s “baseline” in order to accurately determine whether an acute change in clinical status has occurred. In addition, the fact that a high cost complex patient had a “team” willing to provide timely and close follow up allowed care to be delivered in the home or other lower-cost settings.
ED Care Alerts: Emerging Tool in the Field

• High-value, need-to-know information about a patient to support better decision-making at the point of care
  • Instantly accessible in the ED
  • Brief
  • Guidance from a clinician who knows the patient
  • Convey baseline
  • Identify clinician, care team with contact info
  • Intended to inform the decision to admit
Example ED Care Alert

“Mr. F is a gentleman who commonly dials 911 on weekends and holidays, noting shortness of breath. He does have COPD and his baseline, everyday physical exam is notable for wheezes and rhonchi. His CXR will show a LLL ‘infiltrate’ that has been stable for 15 years. Please call his PCP, Dr. C, on her cell phone (#) if you are contemplating invasive testing or admission. Please note patient can be (and often is) seen daily in her office, which is located in his apartment building. Please note he has low literacy skills and will not be able to comprehend written discharge or medication instructions.”

Courtesy Dr Patricia Czapp, Anne Arundel Medical Center
Lessons from Cross-Continuum Collaboration

• *Takes time* to develop a collaborative rapport

• No substitute for verbal communication and *problem solving*

• *Establish a point person* to be the “back door” facilitator

• *Active* co-management and care management gets results
Execute

_Innovate Methods; Prioritize Engagement_
Engagement → Implementation → Outcomes

- Focus on engagement to drive outcomes
- We can’t get outcomes we seek unless we are meeting patient needs
- Low levels of “engagement” signals a need to change our approach
- Breakthroughs: be personable, low-barrier, be helpful, navigate, link
- Effective engagement is a marker for good outcomes; it is a virtuous cycle
Percent of Target Population Patients Served

Implementation Tips:
- Reliably identify target pop
- Face to face in-hospital
- Opt-out approach
- Continuation of your care
- Avoid “special program”
Timely Contact Post-Discharge

Implementation Tips:
• “It’s my job to check on you”
• Use texting
• Any relevant contact
• Call their cell to confirm #
Service Delivery: Work Smarter, not Harder

Implementation Tips:

- Brief in-hospital visit
- Prioritize community visits
- Batch SNF follow up
- Batch home visits
- Batch documentation

Same # FTEs, more patient service by redesigning workflow
Summary

- Know your *data*
- Design efforts targeted at addressing the *root causes*
- *Address* whole-person needs
- *Actively collaborate*: this is a team sport
- Prioritize effective *engagement*
- *Deliver* interventions: innovate what we do until we are effective
THANK YOU FOR YOUR COMMITMENT TO IMPROVING CARE

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