Designing & Delivering Whole-Person Transitional Care

Coordinating care across settings and over time to drive outcomes

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CNYCC Annual Meeting

November 6, 2017

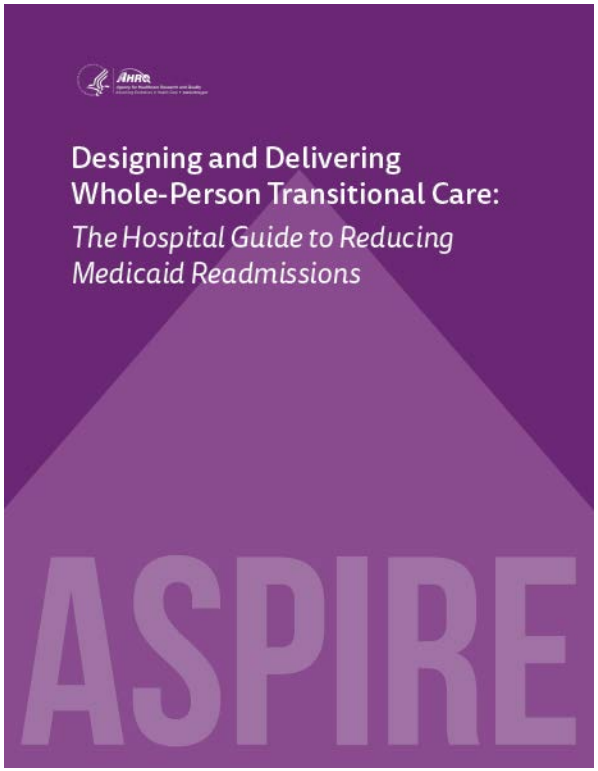
Agenda

- 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*

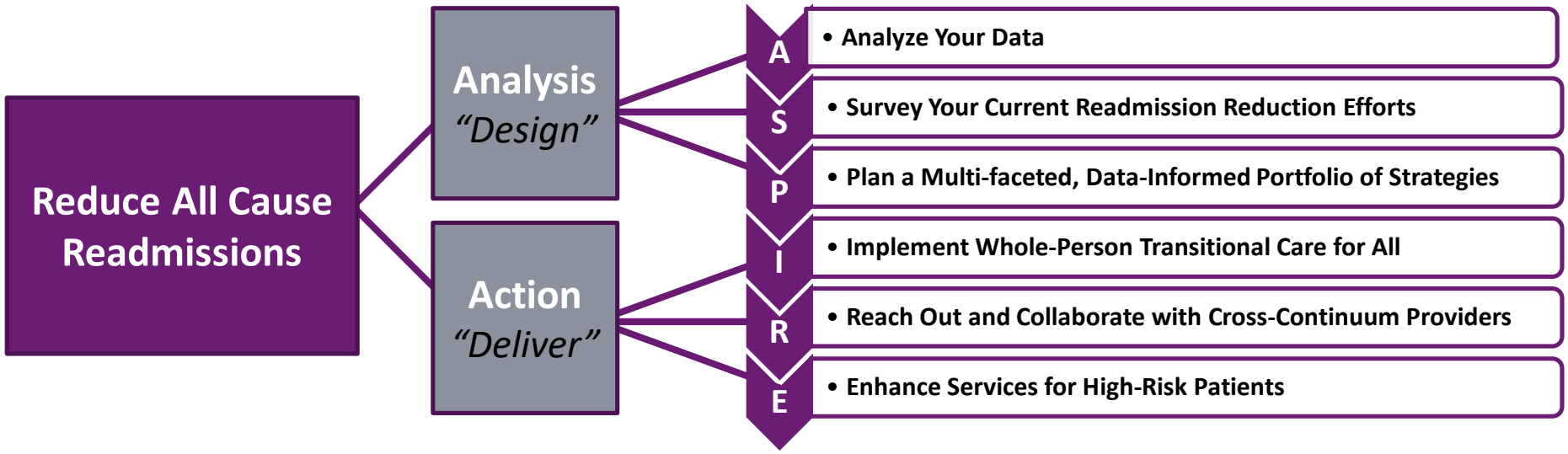


13 customizable tools

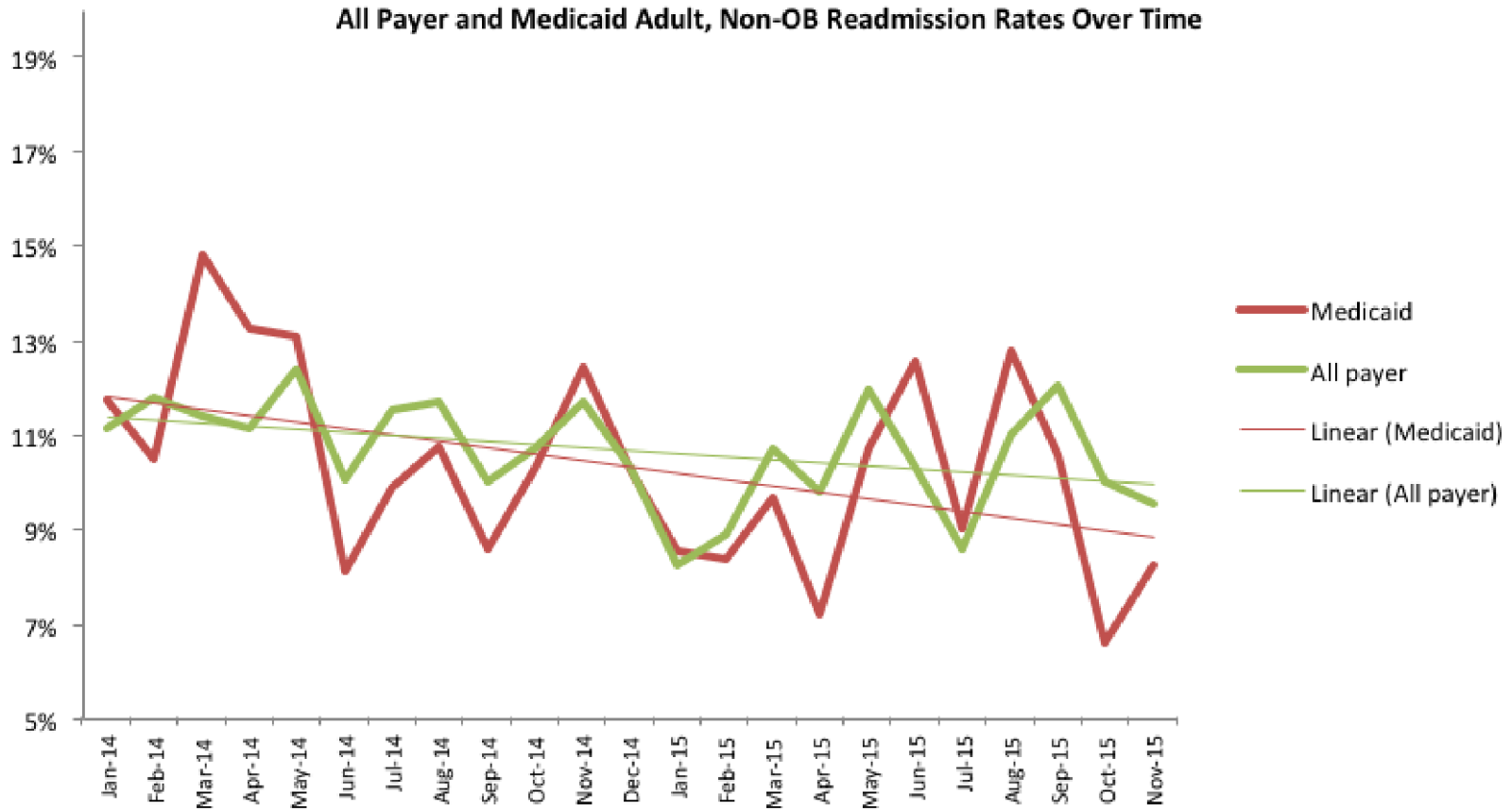
6-part webinar series

https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

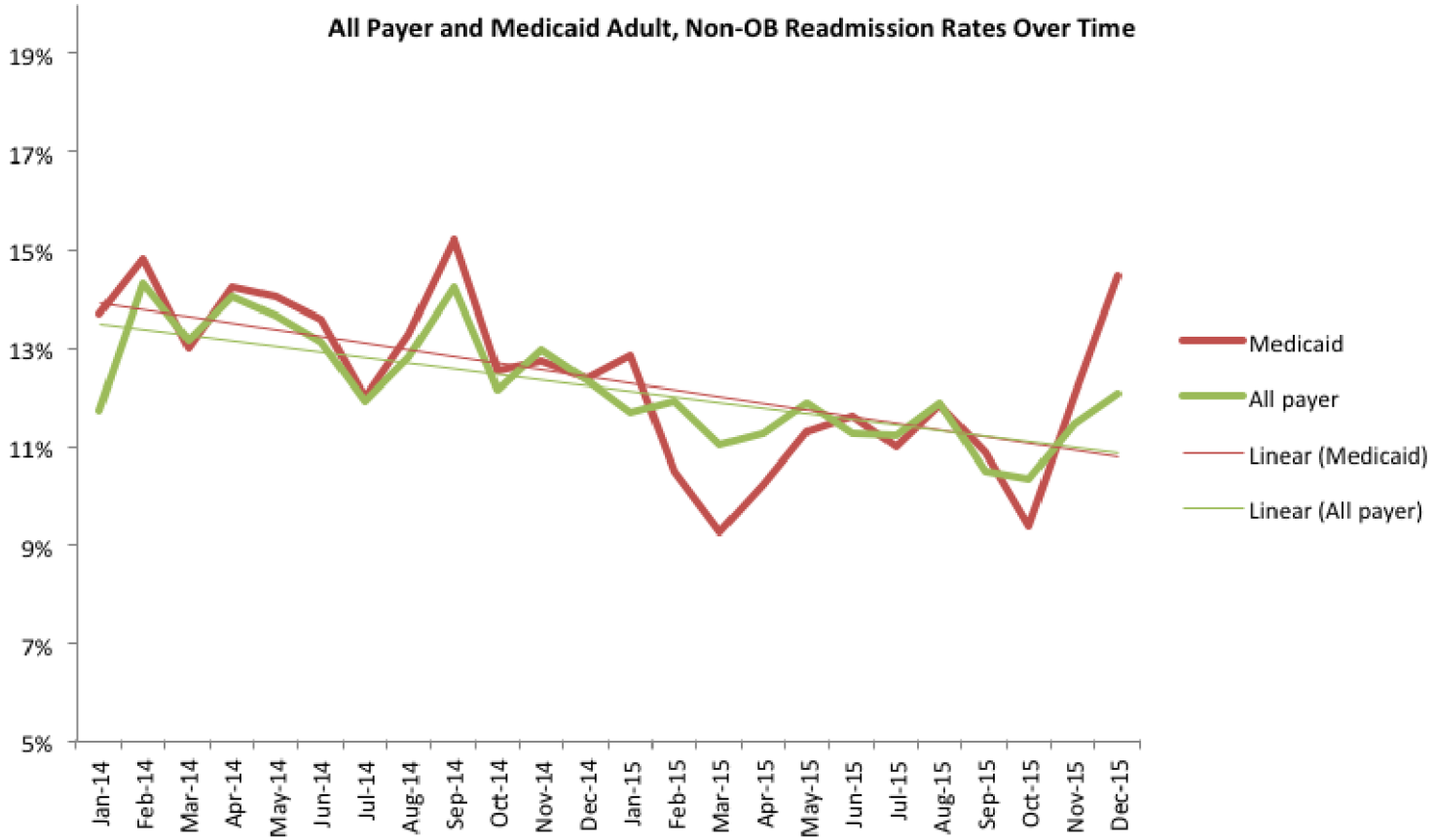
The ASPIRE Framework



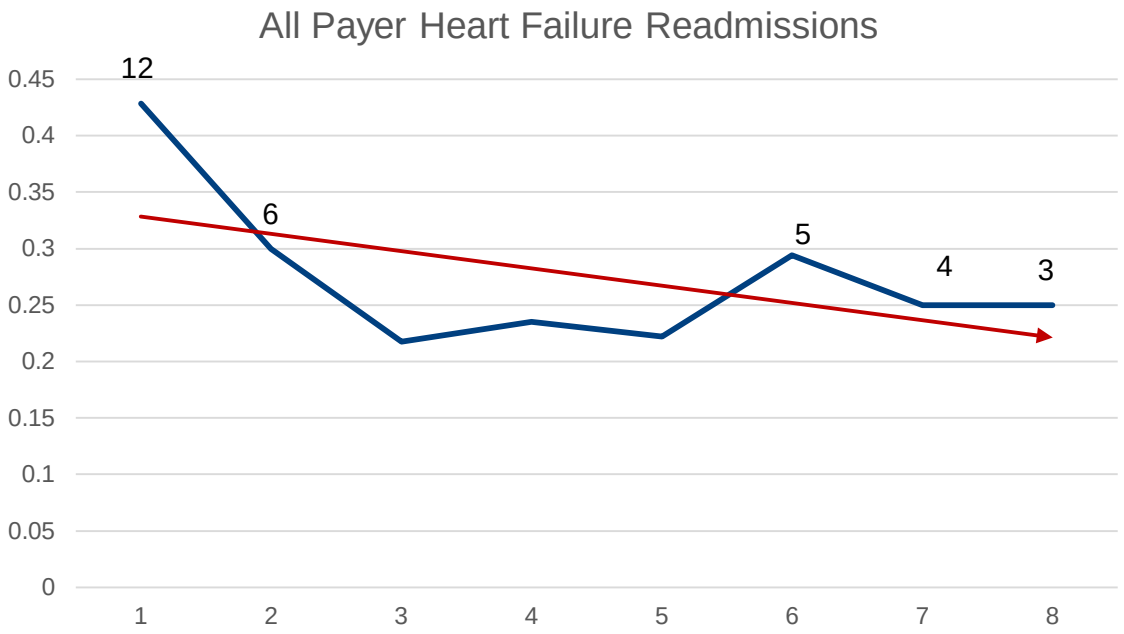
All Cause All Payer 30-day Readmissions Community Hospital in Maryland



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

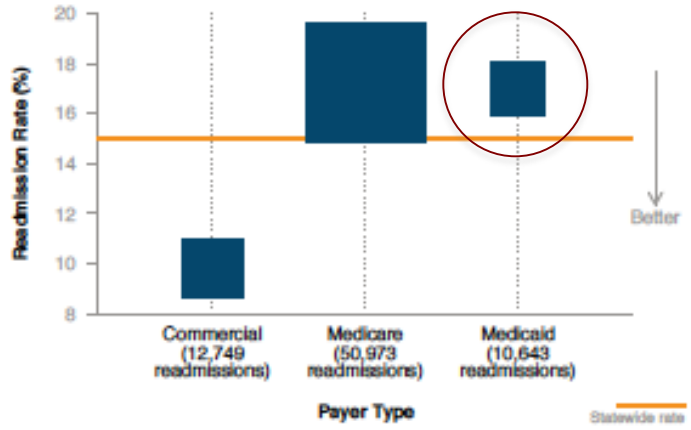
1. What is our aim?
2. What does our data show?
3. Who should we focus on?
4. What services will address the root causes of utilization?

Many teams start in the ***reverse*** order

5. READMISSIONS BY PAYER TYPE

Figure 6: All-Payer Readmission Rates by Payer Type, July 2012 to June 2013

Readmission rates varied by payer type; patients with commercial payers had lower readmission rates than those with public payers.



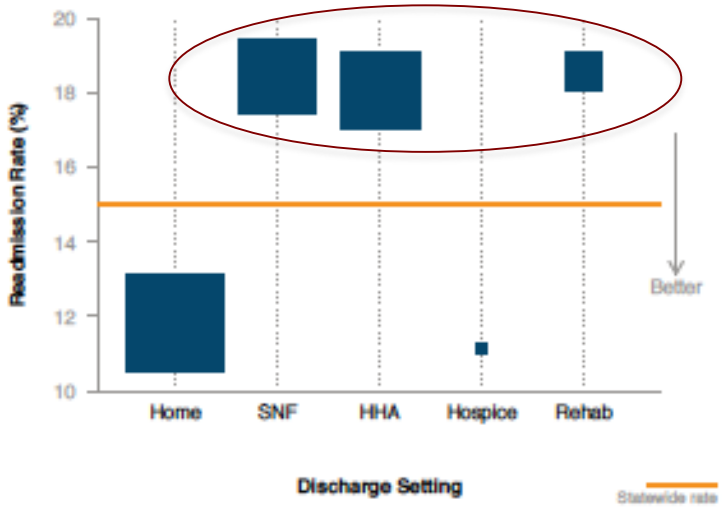
High rates: adult non-OB Medicaid

High rates: discharges to SNF, CHHA

3. READMISSIONS BY DISCHARGE SETTING

Figure 3: All-Payer Readmission Rates by Discharge Setting, July 2012 to June 2013

Patients discharged to home (without home health agency care) and hospice have lower readmission rates than those discharged to post-acute care.



Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Discharge Diagnoses Leading to Most Readmissions

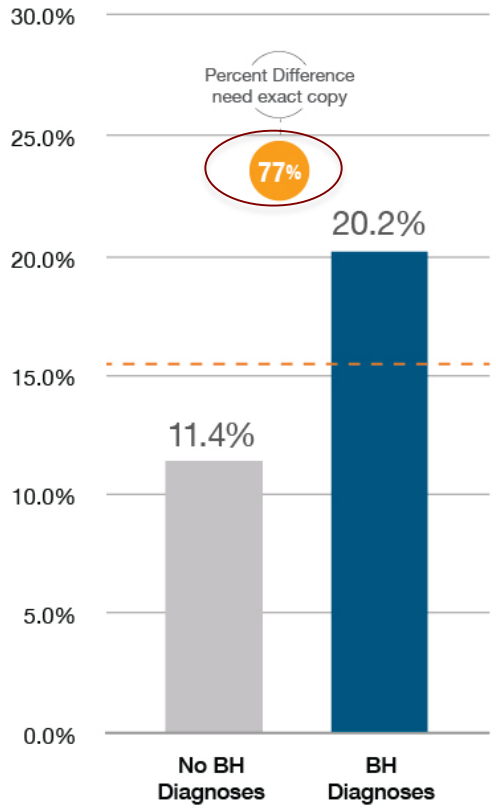
Medicare list differs from Medicaid list

Medicare	Medicaid	Comm.	Unins.	Total
ARF (1384)	Sickle Cell (478)	Chemo (290)	Pancreatitis (187)	Sepsis (1859)
Sepsis (1366)	Sepsis (175)	CVA (276)	Chemo (157)	ARF (1800)
PNA (1336)	Chemo (175)	Arthritis (260)	DKA (136)	PNA (1750)
COPD (1211)	COPD (173)	Sepsis (222)	CVA (125)	CVA (1622)
CVA (1140)	DKA (156)	PNA (188)	COPD (109)	COPD (1608)
UTI (1038)	PNA (145)	ARF (182)	ARF (97)	UTI (1608)
Afib (851)	ARF (137)	CAD (181)	Sepsis (96)	HF (1115)
HF (822)	HF (129)	Pancreatitis (153)	PNA (81)	CAD (1092)
CAD (746)	Pancreatitis (127)	Afib (152)	ETOH w/d (76)	Afib (1092)

Method: DRG, age>18, exclude OB

Source: Boutwell in collaboration with South Carolina Hospital Association

Readmission Rates for People with BH Conditions

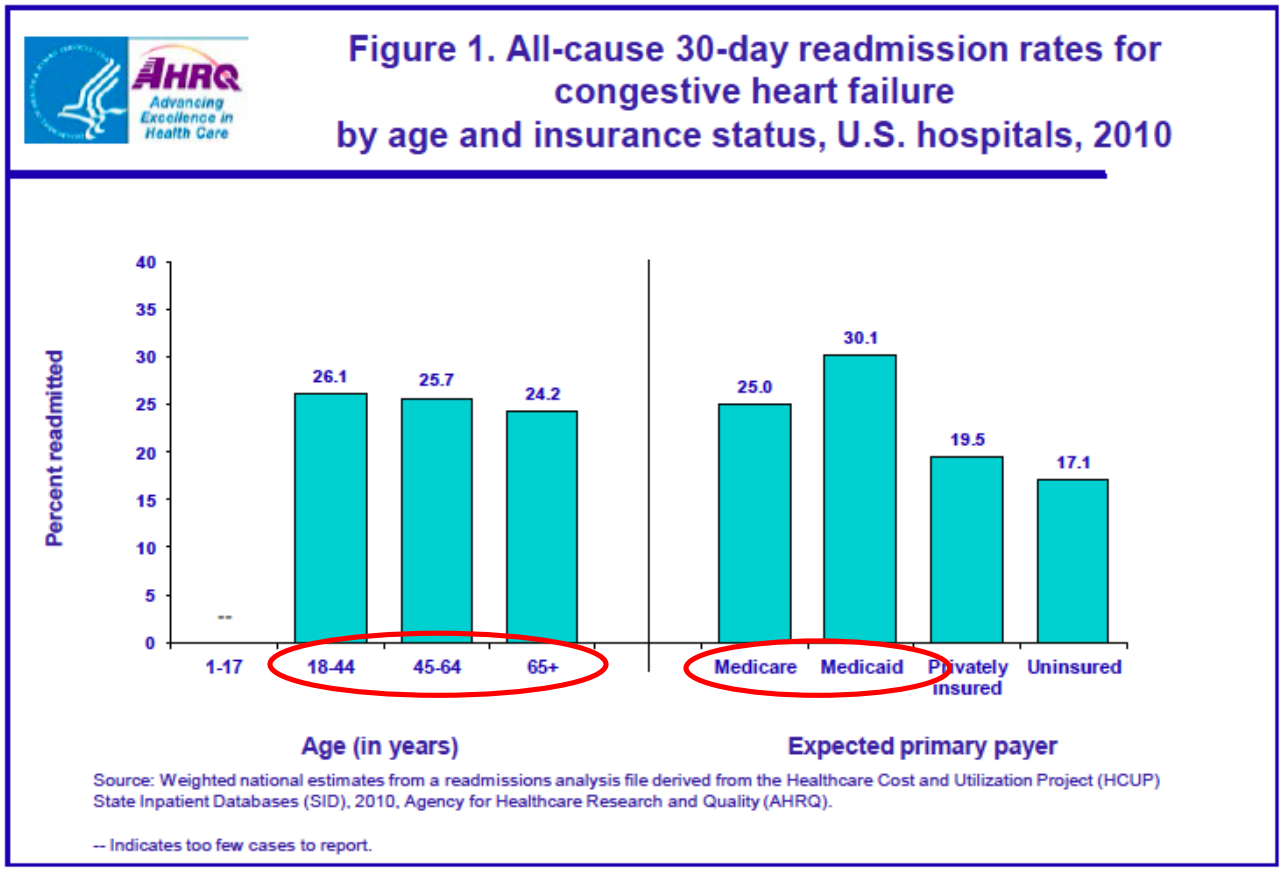


- **40%** of hospitalized adults had at least 1 behavioral health (BH) condition
- Patients with any BH condition have **77%** higher readmission rates

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

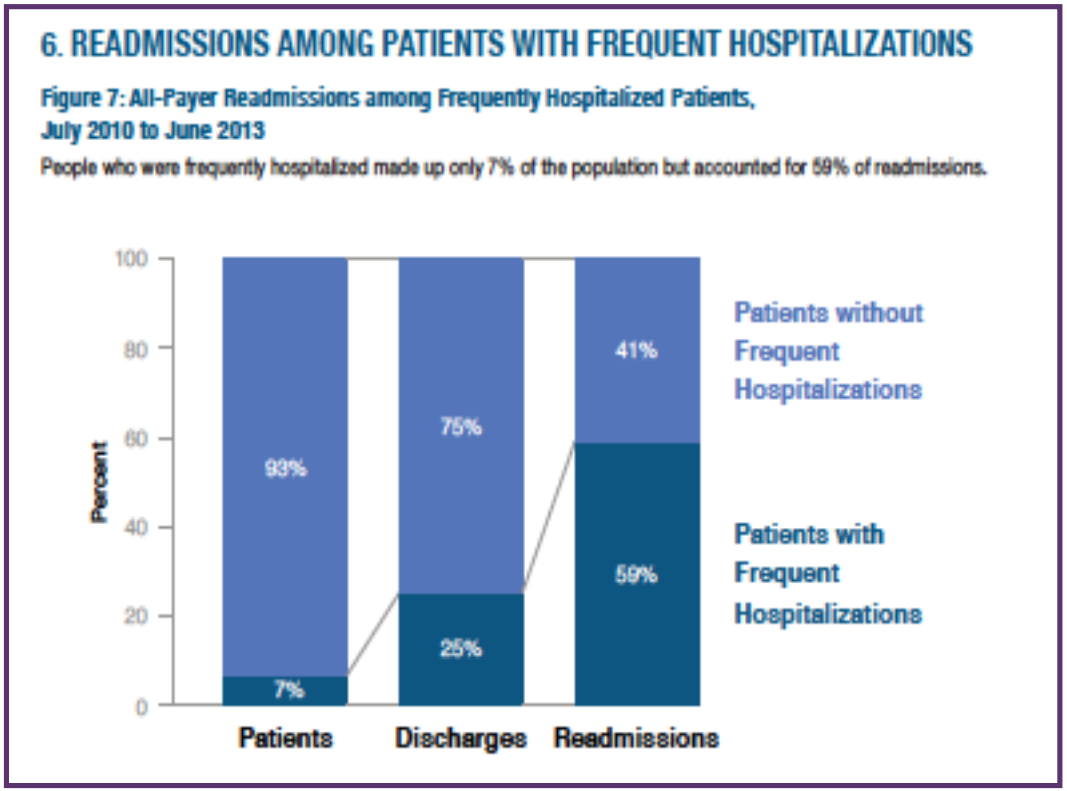
Heart Failure Readmission Rate by Age, Payer

High rates across ages; highest for Medicaid



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.

Return Visits to the Emergency Department: The Patient Perspective

Kristin L. Rising, MD, MS*; Kevin A. Padrez, BA; Meghan O'Brien, MD, MBE; Judd E. Hollander, MD; Brendan G. Carr, MD, MA; Judy A. Shea, PhD

- Interviewed 60 patients who returned to ED <9days 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

Annals of Emergency Medicine

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.

- ✓ Have a documented discharge planning process, approved by the hospital's governing board;
- ✓ Provide discharge planning for all inpatients, observation patients, and certain ED patients;
- ✓ Analyze and track readmission rates;
- ✓ Review readmissions to look for patterns;
- ✓ Conduct root cause analyses on readmissions to assess whether the discharge planning process meets patients' needs;
- ✓ Craft a discharge plan that can be realistically implemented;
- ✓ Actively solicit the input of the patient and family/friends/support persons;
- ✓ Address behavioral health follow up as part of the discharge plan;
- ✓ Provide customized education to patients and their caregivers;
- ✓ Provide verbalized instructions using the teach-back technique;
- ✓ Arrange for (not just refer to) post-hospital services;
- ✓ Know the capabilities of post-acute and community-based providers, including Medicaid home-and community-based services;
- ✓ Provide patients data to help inform their choice of high quality post-acute providers;
- ✓ Know options for Medicaid long-term services and supports, or have a contact at the State Medicaid agency that can assist with these issues; and
- ✓ Follow up with high risk patients after discharge.

[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].

- ***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

AND

- Have a ***process***
- Track, ***trend and review*** readmissions
- ***Continuously improve*** the process to meet needs

ASPIRE Tool 8: 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

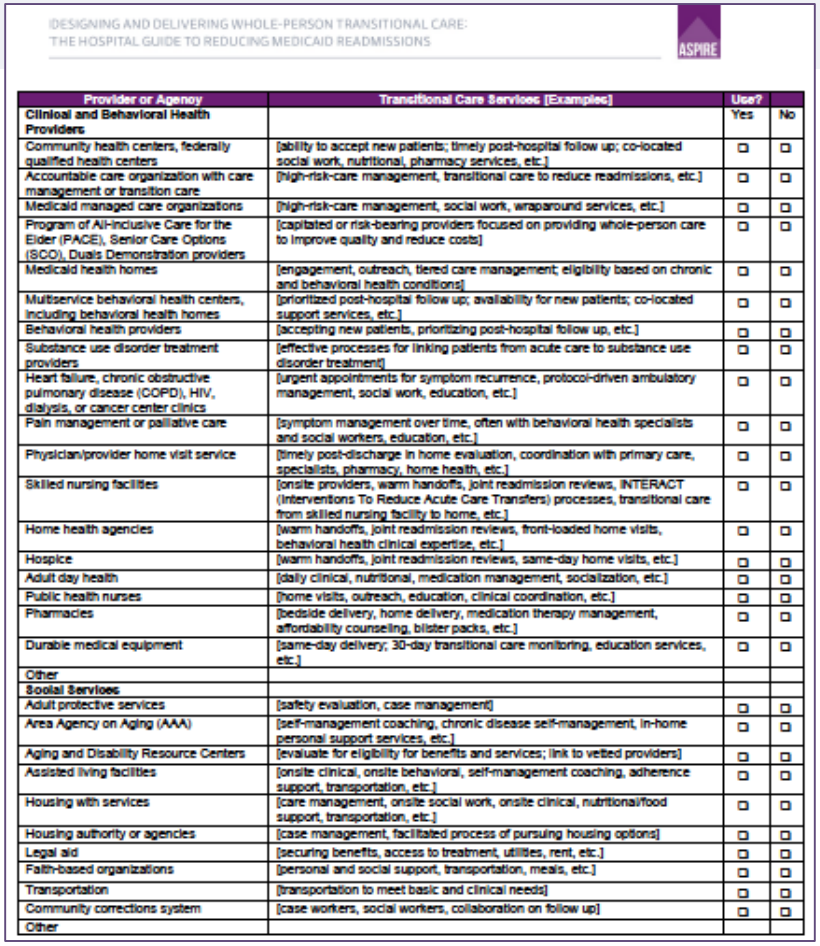
Successful teams state:

- *"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



DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE:
THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS

Provider or Agency	Transitional Care Services [Examples]	Use? Yes	No
Clinical and Behavioral Health Providers			
Community health centers, federally qualified health centers	[ability to accept new patients; timely post-hospital follow up; co-located social work, nutritional, pharmacy services, etc.]	☐	☐
Accountable care organization with care management or transition care	[high-risk-care management, transitional care to reduce readmissions, etc.]	☐	☐
Medicaid managed care organizations	[high-risk-care management, social work, wraparound services, etc.]	☐	☐
Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers	[capitated or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs]	☐	☐
Medicaid health homes	[engagement, outreach, tiered care management; eligibility based on chronic and behavioral health conditions]	☐	☐
Multiservice behavioral health centers, including behavioral health homes	[prioritized post-hospital follow up; availability for new patients; co-located support services, etc.]	☐	☐
Behavioral health providers	[accepting new patients, prioritizing post-hospital follow up, etc.]	☐	☐
Substance use disorder treatment providers	[effective processes for linking patients from acute care to substance use disorder treatment]	☐	☐
Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics	[urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.]	☐	☐
Pain management or palliative care	[symptom management over time, often with behavioral health specialists and social workers, education, etc.]	☐	☐
Physician/provider home visit service	[timely post-discharge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.]	☐	☐
Skilled nursing facilities	[onsite providers, warm handoffs, joint readmission reviews, INTERACT (Interventions To Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.]	☐	☐
Home health agencies	[warm handoffs, joint readmission reviews, front-loaded home visits, behavioral health clinical expertise, etc.]	☐	☐
Hospice	[warm handoffs, joint readmission reviews, same-day home visits, etc.]	☐	☐
Adult day health	[daily clinical, nutritional, medication management, socialization, etc.]	☐	☐
Public health nurses	[home visits, outreach, education, clinical coordination, etc.]	☐	☐
Pharmacies	[bedside delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.]	☐	☐
Durable medical equipment	[same-day delivery; 30-day transitional care monitoring, education services, etc.]	☐	☐
Other			
Social Services			
Adult protective services	[safety evaluation, case management]	☐	☐
Area Agency on Aging (AAA)	[self-management coaching, chronic disease self-management, in-home personal support services, etc.]	☐	☐
Aging and Disability Resource Centers	[evaluate for eligibility for benefits and services; link to vetted providers]	☐	☐
Assisted living facilities	[onsite clinical, onsite behavioral, self-management coaching, adherence support, transportation, etc.]	☐	☐
Housing with services	[care management, onsite social work, onsite clinical, nutritional/food support, transportation, etc.]	☐	☐
Housing authority or agencies	[case management, facilitated process of pursuing housing options]	☐	☐
Legal aid	[securing benefits, access to treatment, utilities, rent, etc.]	☐	☐
Faith-based organizations	[personal and social support, transportation, meals, etc.]	☐	☐
Transportation	[transportation to meet basic and clinical needs]	☐	☐
Community corrections system	[case workers, social workers, collaboration on follow up]	☐	☐
Other			

ASPIRE Tool: https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

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.

ASPIRE Guide: https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

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

"6 simple questions are making a difference in the Richmond community"

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

“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 accurate 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

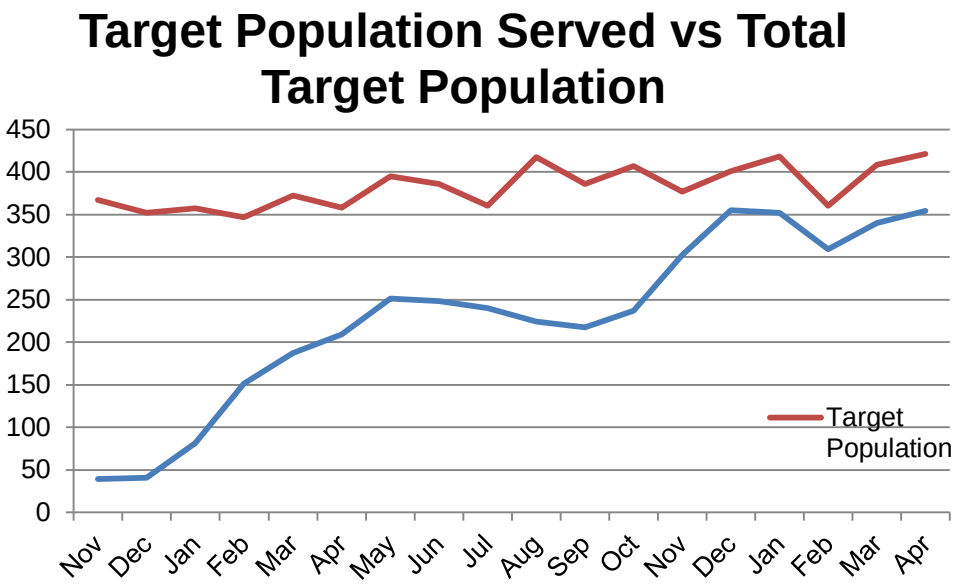
Execute

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

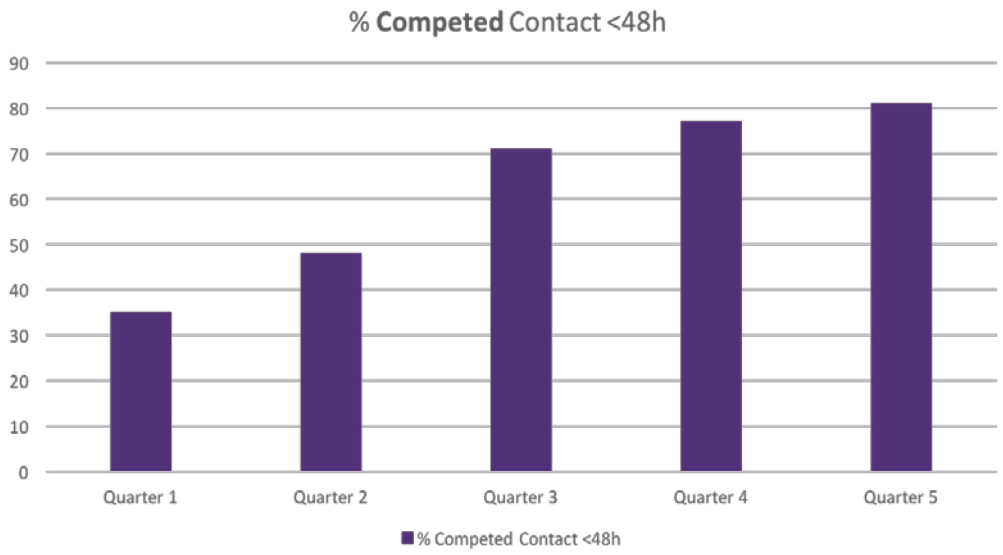
Percent of Target Population Patients Served



Implementation Tips:

- Reliably identify target pop
- Face to face in-hospital
- Opt-out approach
- Continuation of your care
- Avoid “special program”

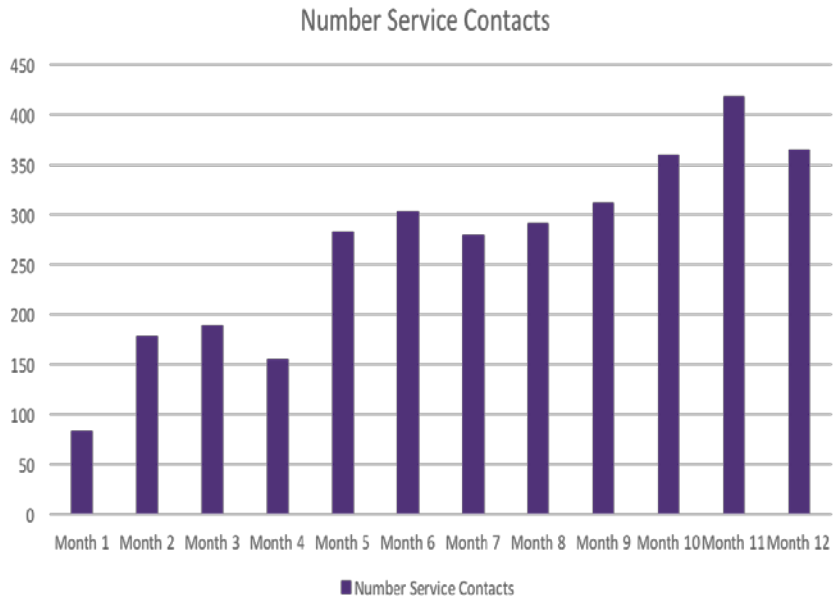
Timely Contact Post-Discharge



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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