Enhancing Care Transitions Through Community Partnerships
Innovative Solutions for Community Hospitals

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Objectives

- Review best practices for care transitions that have a positive impact on population health
- Better understand the impact of suboptimal care transitions
- Identify strategies for community partnerships to enhance care transitions
Best Practices for Successful Care Transitions
Three–Pronged Standard for Continuity of Care (Zander, 2010)

- **Safe Discharge**: patient’s needs can be safely met at the selected level of care

- **Smooth Discharge**: seamless transition to next level of care

- **Sustained Discharge**: patient and/or caregiver demonstrates the appropriate knowledge and skill to manage healthcare needs outside of acute care setting
Discharge Planning

- Daily Multidisciplinary Rounding: “plan for today and the stay”
  - Includes attending physician, pharmacist, RN care coordinator, social worker, and nursing
  - Discharge screen
    - All acute care patients screened
    - Completed within 24 hrs of admission
Discharge Planning (Continued)

- **Care Coordinator**
  - Ensures patients receive the “right care at the right time” during hospital stay
  - Schedules discharge appointment with PCP or specialist, as needed
  - Facilitates referrals for post acute care needs
  - Obtains authorization for discharge medications as needed
Care Transitions Program

- Launched September 2013
  - Participation is voluntary
  - Focus on high risk patients for care coordination needs, i.e., polypharmacy, multiple ER visits and hospital admissions, lack of family support, or psychosocial concerns.
  - Current enrollment:
    - 20 patients
    - 6 community volunteer health coaches
Care Transitions Program

- RN Care Transitions Coach
  - Screens high risk patients prior to discharge
  - Assigns volunteer health coach
  - Conducts comprehensive home assessment in program within 3 business days of discharge
  - Develops care plan and goals in collaboration with the patient and PCP
Care Transitions Program

- RN Care Transitions Coach (continued)
  - Completes post discharge call on all patients 65 and older (regardless of enrollment in program) within 2 business days of discharge
  - Coordinates plan of care with PCP, specialists, and other healthcare providers
  - Monitors medication adherence device – Medacheck®
  - Monitors readmissions and coordinates weekly readmission meeting with Care Management team, CMO, and PHS case managers to discuss ways to improve patient outcomes
Care Transitions Program

- RN Care Transitions Coach (continued)
  - Coordinates discharge needs with PHS case managers for patients enrolled in PHS medical home
  - Coordinates medication reconciliation process with PCP and specialist offices
  - Ensures PCP and other healthcare stakeholders receive a copy of hospital discharge summary
Better understand the impact of suboptimal care transitions
The Impact of Suboptimal Care Transitions

- Poor Outcomes
  - Overutilization of services – Emergency Department and Hospital beds
  - Poor medication compliance/medication errors
  - Underutilization of disease management services – primary care access
  - Poor management of co-existing mental health issues
Best Practice Methods to Improve Transitions of Care

- Disease management
- Medication reconciliation
- Address socioeconomic factors
- Primary care access
- Manage coexisting mental health/substance abuse
Disease Management Solutions

- Population health approach
- Swim Lanes for common diagnoses—developed for CHF and Lower Respiratory Infections
- Collaborative rounding of hospitalists, pharmacists, & care management team
- Collaboration with skilled nursing and home health agencies
- Arthroplasty pathways & order sets
Medication Reconciliation Solutions

- Volunteer health coach program

- Home medication monitoring
  - Partnership with Medacheck®.
  - Innovative solution in pilot phase.
  - Tablet device deployed through volunteer home visit.
  - Pilot program with ten devices.
  - Care managers collaborate with PCPs
Avoidable Readmissions Solution

- Readmissions team weekly review
  - CMO, Director Care Management, Care Transitions Coach, Care Managers
  - Identify high utilizers
  - Individual care plans

- Readmissions Committee

- Multiple Tools
Address Socioeconomic Factors

- Free Clinic–
  - Community safety net
  - Facilitate entry into the healthcare delivery system
  - Berger Health Foundation entity

- Federally Qualified Health Center
  - Partnership with Columbus Neighborhood Health Center

- Pickaway Health Services
  - Employed physicians/ Allied Health Professionals– charity care policy

- Medication Assistance Program support
Primary Care Access Solutions

- Patient Centered Medical Home Model
  - Care management
  - Developing registries
  - Population model of disease management

- Primary care access team

- Post-hospital and post-emergency care

- Optimized Care Network
  - Partnership for virtual care
  - Same day, urgent, transitions

- Dedicated CNP model
Manage Coexisting Mental Health/Substance Abuse Issues

- Crisis Counseling in partnership with Scioto Paint valley Mental Health (SPVMH)

- Therapist part-time for inpatient consults

- Integrated care model
  - Psychiatry resident in partnership with SPVMH & Ohio University
  - Psychiatry care at patient centered medical home

- Leverage Optimized Care Network
Strategies for community partnerships to enhance care transitions.
Community Care Transitions Team

- Established September 2011

- Membership:
  - External Agencies:
    - Skilled Nursing Facilities (SNF)
    - Home Health Agencies (HHA)
    - Hospice
  - Health System:
    - Care Management – Hospital and Pickaway Health Services
    - Quality and Nursing Staff
    - CNO
    - CMO
Community Care Transitions Team (Continued)

Focus:
- Readmissions
- Improved transitions of care
- Collaborative projects
- Open communication
- Education
  - IOM – Six Aims (safe, effective, patient-centered, timely, efficient, and equitable)
  - INTERACT (Interventions to Reduce Acute Care Transfers) – website for clinical and educational tools related to avoidable transfers
Community Based Order Sets

- Chief Medical Officer worked directly with SNFs Medical Directors to develop and implement order sets for:
  - CHF
  - COPD

- Director of Care Transitions collaborated with Directors of Nursing from the Home Health Agencies and Skilled Nursing Facilities to develop:
  - Discharge Checklist
  - Agency Transfer Checklist
CNP Daily Rounding at SNF

- The Health System contracted with Pickaway Manor to provide a full-time Medical Director and CNP for daily resident rounding.

- Program Goals:
  - Reduce avoidable transfers/transports to the Emergency Department
  - Improve collaboration, communication, and continuity of care for unavoidable transfers
  - Reduce readmissions
  - Implementation of evidenced-based care paths and order sets
CNP Daily Rounding at SNF

Next Steps:
- Add additional SNFs and CNP Rounding
- Establish Preferred Partnerships for SNF and HHA
- Quarterly rounding at SNFs by Director of Care Transitions and RN Transitions Coach
- Implement additional Care Paths/Order Sets for:
  - Pneumonia
  - Diabetes
  - Urinary Tract Infection
  - Sepsis
340b Drug Program

- HRSA implemented program in 1992 for Medicare Disproportionate Share Hospitals
- Requires manufactures to provide outpatient medications to eligible covered entities at a significantly reduced price thus stretching scarce resources
- Berger partnered with two local independent pharmacies
- Financial impact of the program for Berger:
Discharge pharmacists completes a referral for MTM based on the following patient criteria:

- Multiple medications
- Multiple pharmacies
- Multiple health conditions
- Readmission risk (CHF, COPD, and Pneumonia)
- Medications that require close monitoring (anticoagulants and diabetic medications)
Medication Therapy Management

- MTM – health services provided by a pharmacist with a goal to optimize therapeutic outcomes for individual patients which includes:
  - Medication review
  - Disease management
  - Anticoagulation management
  - Medication safety education
  - Immunization review
  - Health and wellness initiatives
PICC Line Services

- PICC Line Education for HHAs and SNFs
  - Indications for PICC lines
  - Process for scheduling a PICC line placement
  - Maintenance of PICC lines
  - Troubleshooting strategies
  - Infusion Center’s Hours of Operation
Telemedicine program – RN examination and documentation on-site with physician collaboration via audiovisual link

Revolutionary “Care Space” 3D Video Technology with state of the art digital medical devices

Utilizes a cloud based EHR

Enhances PCP access with a plan to add physician specialties (psychiatry, infectious disease, neurology, and others)
Next Steps

- Identifying and selecting preferred partners for Home Health and Skilled Nursing Facility
- Continue to add additional CNPs and Medical Directors at SNFs
- Development and implementation of community care protocols
- Add additional pharmacies to the 340b Drug Program
- Update bi–directional community disaster memorandums of understanding