In the Trenches: Managing Care Transitions Successfully

2014 Geriatric Update
Meharry Consortium Geriatric Education Center
In the Trenches:
Managing Care Transitions Successfully

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Objectives

- Recall two model programs for effective care transitions
- Identify key components of interdisciplinary collaborations to promote successful care transitions
- Discuss the challenges of care transitions for underserved, low literacy populations
- Describe strategies for managing care transitions in partnership with older adults and family caregivers
No Disclosures

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Care Transitions Models

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Why Collaborate?
Interdisciplinary Teams

• Coordination of Services
• Strategic Planning around common goals
• Access to Benefits Coordinated
• Create new partnerships
Mrs. Staley
Agenda

• Shifting the Paradigm
  – National Initiatives
• What is driving the change?
• CMS penalties
• What are the community needs?
Shifting the Paradigm

• Not about discharging patients
• It is about coordinating care and having frequent contact with patients.
National Initiatives

• Project BOOST
• Eric Coleman: The Care Transitions Program
• Mary Naylor: Transitional Care Model
• IHI: STAAR Initiative
• The Memphis Model: Congregational Health Network
• Project RED
• Qsource Care Transitions model - TN
Memphis Model

- Congregational Health Network
  - Established in 2006
  - Covenant relationship between Methodist Le Bonheur Healthcare and over 500 faith congregations in Memphis
  - Model of “Blended Intelligence” which refers to the integration of community wisdom, hospital data streams, academic research and best practices from local and international partners
Memphis Model, cont’d

• Navigators are hospital employees
• Liaisons are volunteers from congregations
• Clergy actively involved as advocates of the program
• Navigator + Liaison + Clergy + Education = Faith and Health
• Education provided to all participants
Memphis Focus Areas

• Elderly and Advanced Disease
• Mental Health
• Chronic Disease
• Infants and Mothers

Mostly low-income, urban, minority population
Person-Centered Journey of Health

• Aftercare plans and trained lay leaders
• Pre-register congregants
• Arrange for supports at time of transition (transportation, prescriptions, pet care, food)
• Provide support to clergy as lead “healthy congregation” initiatives
Liaison Training Courses

- Care and Visitation
- Care for the Dying
- Mental Health First Aid
- Aftercare
- Transplant Services
- Pastoral Care
- Living with Disease
- Navigating Healthcare System
Readmission

Regardless of diagnosis or conditions, all patients in the Congregational Health Network had significantly longer time-to-readmission than matched patients out of the network (CHN=426 vs. Non-CHN =306 days) from 2008 through 2011, first quartile.
LOS, Readmission, Mortality

CROSS-SECTIONAL SNAPSHOT AT 25 MONTHS INTO THE WORK OF CHN

LOS Total
- CHN: 6.21
- Non-CHN: 6.43

Readmits
- CHN: 41
- Non-CHN: 33

Mortality Rate
- CHN: 2.63%
- Non-CHN: 1.32%

LOS - No difference between cohorts
Readmits and Mortality Rates – Significant difference in favor of CHN
Mortality Rate

LONGITUDINAL DATABASE (2005 -2011)

- Significantly lower mortality rates, on average, for CHN vs. the general population.
  - [Odds ratio=.78, p=0.04]

- 97 CHN patients died (1.42%) and 249 non-CHN patients died (3.64%) during the 2008-2011 time period for analysis.
CHN members are more likely than the general population to be discharged from the hospital to home health services \([F(1,9)=65.113; \ p<.001]\)
Referrals to Hospice

LONGITUDINAL DATABASE (2005 - 2011)

CHN members are more likely than the general population to be discharged to hospice services [F(1,9) = 121.721; p < .001].
Qsource Model

- Community Based
- Nine Communities in TN
- Goals:
  - Each readmission represents a potential breakdown in care, a patient safety concern, and an opportunity to eliminate wasteful spending.
  - Measures designed for hospital reporting do not easily translate to the community level.
  - A community’s rate of readmissions is a better indicator of whether a healthcare delivery system is functioning properly.
  - STAT’s goal is to help set a priority for the community to focus energy as a unit and break down silos.
  - Communities can target scarce resources for patients for whom the current delivery system is not working.
A Regional View

- **West Tennessee**
- Two communities
- Multiple hospitals, SNFs, home health providers, and other community providers collaborating on ongoing projects
- ESRD network involvement
- Very engaged, willing to remove silos and work across all disciplines to improve outcomes
- Continuing to develop projects to improve transitions and healthcare quality!
A Regional View

- **Middle Tennessee**
- **Four communities**
  Vanderbilt community awarded Innovations Challenge Grant
  Multiple hospital systems and providers involved
  Strong partnerships formed with home health providers
- **Communities working across rural and urban settings to improve care**
A Regional View

- East Tennessee
- Three communities  
  Chattanooga awarded 3026 funding
- Diverse communities across region with strong AAA leadership for all communities
- Multiple hospital systems collaborating to improve care
- All communities involved in multiple projects and forming committees to carry out plans
Savings: HRRs

- Money saved by preventing readmissions in Tennessee
  - Chattanooga $3,639,115.66
  - Jackson $3,301,559.59
  - Johnson City $3,109,869.31
  - Kingsport $2,156,009.22
  - Knoxville $6,908,776.67
  - Memphis $1,584,692.27
  - Nashville $5,907,686.62

- Savings from October 2010 through June 2013 using total Medicare readmission data
Savings: HRRs (cont.)

- Total Savings
  - $27,422,932.33
Savings: Beneficiaries

These communities saved at least

2,659

beneficiaries from readmission to hospitals
Community-Based Summary Points

• Removing silos and breaking down barriers between hospital systems and all providers of care is vital.
• Community rate of readmission is a better indicator of whether the healthcare delivery system is functioning; community involvement is key.
• Help set a priority for the community to focus energy as a unit and break down silos.
• Provide opportunity to focus on system-level changes at the individual community level.
Questions?

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Perils of Care Transitions

Poorly managed care transitions result in:

- **↑ Rates of re-hospitalization**
- **↑ Health care costs**
- **↓ Health outcomes**
- **↓ Patient & family satisfaction**
Factors determining Care Transition Outcome

Patient Profile + Service Delivery System = Care Transition Outcome
Identifying Patients at Risk for Poor Care Transitions

Society of Hospital Medicine: Project Boost “8P” Risk Assessment:

- Problem medications
- Psychological factors
- Principal diagnosis
- Physical limitation
- Poor health literacy
- Poor social support
- Prior recent hospitalization
- Palliative care
How do older adults measure up on the “8Ps”?

- Problem medications - Seniors more likely to be prescribed 10+ medications and/or high-risk medications

- Psychological - Depression risk - A special consideration for low-literacy and lower-income seniors
Principal diagnosis - Higher risk when related to cancer, stroke, diabetic complications, COPD or heart failure. Age-related dementia is increasing area of concern.

Physical limitations - Frailty is a factor

Poor health literacy - Issue of particular concern for low literacy seniors
Poor social support - Social isolation increases with loss of cohort

Prior hospitalization in past 6 months

Palliative care - Is this a foreseeable possibility for the patient?
The Service Delivery System Component of the Care Transitions Outcome Equation

- **Challenge:**
  - Ineffective care transitions responsible for large percentage of wasted health care dollars.
  - Government phases in reduced Medicaid/Medicare reimbursement rates for hospitals with high readmission rates.

- **Opportunity:**
  - Additional payments available to outpatient providers for care transition services.
“Care for vulnerable elders falls short of acceptable levels for a wide variety of conditions.”

“Failure to get timely, evidence-based care has negative impacts on physical and mental health and functional status and leads to increased morbidity and mortality and the need for expensive emergency department and hospital care.”

(Counsell, SR., 2007)
Care Transition Models

- Mary Naylor’s Transitional Care Model
- Eric Coleman’s Care Transition Intervention
- Project RED
- Congregational Health Network, Memphis, TN
What are care providers trying to overcome?

“Each transition presents a new risk for miscommunication, duplication of services, medical errors, or provision of care in conflict with the patient’s and family’s goals of care.”

(Callahan, CM; 2012)
Common Components of Effective Care Transition Approaches

- 1) Care coordination through an interdisciplinary team
- 2) Patient Assessment pre- and post-discharge
- 3) Creation of care plan which includes patient in goal setting
- 4) Ongoing patient and family education
Care Coordination

Interdisciplinary teams work with patients and families at set intervals.

Teams often include: primary care physicians, community-based nurses and nurse practitioners, social workers, care managers.

“Effective teams are local, highly skilled and well-trained.” (Burke, R.E. and Coleman, E.A. 2013)
Assessment

► Pre- and post-discharge

► Assess literacy, health needs and social circumstances as factors in success

► Ensure that assessment is comprehensive
  ► 70% of surgical readmissions are for chronic medical conditions (Jencks, et al; 2009)
  ► 25% of all discharged patients require additional outpatient work-ups & 33% of those are never completed (Moore, et al; 2007)
Care Plan

- **Key Components:**
  - Patient-centered goal setting
  - Follow-up with Primary Care Physician arranged pre-discharge
    - 50% of re-hospitalized patients do not see their outpatient MD before re-hospitalization (Jencks, et al. 2009)
Care Plan

Care Plan addresses:

- Medical/Mental Health Needs
- Finances/Insurance
- Social Supports
- Legal Needs - advance care planning, etc.
- Activities of Daily Living
- Home Environment
Patient and Family Education

- Coaching in self-management
- Use of “Teach Back” method
- Behavioral strategies
Care Transitions *Can* and *Must* Succeed

- Assemble an interdisciplinary team with clearly defined roles that follows evidence-based practices.
- Plan early for discharge.
- Encourage and respect goal-setting by the patient and family.
- Consider the whole patient and his/her circumstance, including community supports.
- Follow up promptly with outpatient medical providers.
- Encourage consistent and ongoing communication.
Bibliography


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Questions ?