Objectives

-Know key definitions related to care transitions

-Recognize the most common care transitions interventions/programs

-Discuss ways to connect with community partners and why it is important

-Familiarize yourself with pertinent data & know sources of data
Key Definitions

► Care coordination
► Transition
► Interventions*
► Medicare Readmission Penalty*
► Index Admission/Readmission
► Patient Activation Measure*
► Social Determinants of Health
► Disparities/ Health Equity
► Certification in Transitional Care Nursing*
**Interventions**

- **Project RED**
- **Project BOOST**
- **INTERACT**
- **Advanced Care Planning**
- **Coaching Models**
- **Other Models**
- **SNF**: Identify problems early, act on quickly and evaluate processes
- **Project ReEngineered Discharge**: 13 key pieces that pts should get at d/c
- **Project BOOST**: During IP stay changes that are MD driven. Team work.
- **CT Intervention**: Non-licensed coach, 4 pillars, PHR
- **Transitional Care model**: NP led care wherever the pt is
- **Most**: Clarify expectations and plans for all
- **Bridge Model**: SW led model, hospital to home
- **MOST**: Clarify expectations and plans for all
Re-Engineered Discharge

https://www.bu.edu/fammed/projectred

- Newest part: Part 7
- targets family caregivers as a critical element in the success of the discharge plan
- systematically reviews the challenges they face and the support and training they need from staff in the hospital and beyond
Project Better Outcomes for Older Adults through Safe Transitions

http://www.hospitalmedicine.org

- Newly integrated into the Cerner Millennium Medical Record EHR product
  - Automated early identification of specific readmission risk factors and corresponding interventions
  - Help to identify patient concerns about their readiness to leave the hospital
  - Simplified discharge instructions to help safely transition a patient home
  - Teach Back education process and documentation
Interventions to Reduce Acute Care Transfers

www.INTERACT2.net

- Now with versions for Skilled Nursing (v. 4.0)
- Assisted Living
- Home Health
- ACO and Health Systems models are under development
Coaching Models

- Transitional Care Model. Key component- advanced practice care nurses
  http://www-transitionalcare.info/index.html

- Care Transitions Program. Key component-Personal health records and increasing activation
  http://www.caretransitions.org

- The Bridge Model. Originated and studied at the Univ. of Illinois. Key component- Social Workers
  http://www-transitionalcare.org/the-bridge-model
Medical Orders for Scope of Treatment Form

www.ncdhhs.gov/dhsr/EMS/dnrmost.html

- Name varies by state
- Legislation promotes self determination at the end of life
- Provides a summary of treatment preferences in a clear medical order for care in emergency situations
- Program housed at the NC Medical Society
Other Proven Interventions

- Community Based
  - Cross Setting Meetings
  - EMS home visits
  - Primary care provider f/u

- Provider-Based
  - BPIPS (Home Health)

- Problem/Gap Based
  - Enhanced Med Rec
# Readmission Penalty

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Penalty Date</th>
<th>Diagnosis Groups</th>
<th>Dates Included</th>
<th>Max Penalty</th>
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<tbody>
<tr>
<td>2015</td>
<td>10/15</td>
<td>AMI, PN, CHF COPD, elective hip/knee replacement</td>
<td>7/10-6/13</td>
<td>3%</td>
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<tr>
<td>2016</td>
<td>10/16</td>
<td>AMI, PN, CHF COPD, elective hip/knee replacement</td>
<td>7/11-6/14</td>
<td>3%</td>
</tr>
<tr>
<td>2017</td>
<td>10/17</td>
<td>AMI, PN, CHF COPD, elective hip/knee replacement CABG</td>
<td>7/12-6/15</td>
<td>3%</td>
</tr>
</tbody>
</table>
How does the Hospital Readmission Penalty affect NC hospitals?

- Penalties for FY 2016 range from 0.02% to 2.35%
- Average penalty is 0.47%
  - Great source of information is Kaiser Health News
- ~65% of NC hospitals being penalized
Note to Self:
Supporting individuals in their communities as they age will take more effort than any single entity can provide.
Community Based Cross Setting Meetings

www.AlliantQuality.org/ Communities
Where readmissions are happening
How is NC doing compared to others?

North Carolina
State Ranking: 30-Day Readmissions per 1,000 Beneficiaries (CY 2014)

This material was prepared by Telligen, the Quality Innovation Network National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. [1150W-QINNCC-00362-07/31/15]
NC Performance 2009-2015

North Carolina
State
Quarterly 30-Day Readmissions per 1,000 Beneficiaries

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Ways to connect with others

► Community meetings- best way to find people in your community

► Payer groups

► National groups

► Calls sponsored by interested parties: IHI, NTOCC, HHQI, HENs, NCACT
Starting the Conversation

► What is your facility doing to actively reduce readmissions?

► Is nursing report adequate? Does your staff get it from mine?

► Is the written information you get from us on discharge complete/contain what you need to care for the resident?

► How can we help you with families/resident introduction?

► How can we meet regularly to go over problems and to strategize working together?
The Patient Activation Measure

► Allocation of resources is a major issue for all of us-efficiency and cost effectiveness

► Proven to be predictive of utilization and performance
  – ER visits
  – Medication adherence
  – Hospitalization and rehospitalization
  – HbA1C score
The Patient Activation Measure

**Level 1**
Disengaged and overwhelmed
Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: “My doctor is in charge of my health.”

**Level 2**
Becoming aware, but still struggling
Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: “I could be doing more.”

**Level 3**
Taking action
Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: “I’m part of my health care team.”

**Level 4**
Maintaining behaviors and pushing further
Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: “I’m my own advocate.”

Increasing Level of Activation

©2016 Insignia Health. Patient Activation Measure® (PAM®) Survey Levels. All rights reserved.
Social Determinants of Health

► As percent of pts with SSI increases, the greater likelihood that your hospital will be have a penalty.
  – Not currently a good risk adjustment in the penalty program
  – Teaching hospitals and safety net hospitals at greatest risk

► Socioeconomic factors at the community and individual levels are shown to influence the problem of readmissions
## Data Sources

<table>
<thead>
<tr>
<th>LTC/SNF</th>
<th>Hospital</th>
<th>HHA</th>
<th>Physician Office</th>
<th>Dialysis</th>
<th>AAA</th>
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<tbody>
<tr>
<td>INTERACT QI tool</td>
<td>QIO Report</td>
<td>OASIS-C</td>
<td>Hospital partner reports</td>
<td>Hospital partner reports</td>
<td>Hospital partner reports</td>
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<tr>
<td>Hospital partner</td>
<td>PEPPER Report</td>
<td>Community Data</td>
<td>Community Data</td>
<td>ESRD Network</td>
<td>Community Data</td>
</tr>
</tbody>
</table>
New Nursing Certification
CCCTM=Certified in Care Coordination and Transition Management (CCCTM)

- Hold an unencumbered and current license as a registered nurse (RN) in the United States or territories
  AND
- Have a minimum of two calendar years’ experience as a registered nurse (RN) in a care coordination and transition management role
  AND
- Have practiced a minimum of 2,000 hours in care coordination and transition management practice within the last three years as a registered nurse (RN). Practice may be clinical, management, or education. May practice in an acute, ambulatory, community, sub-acute, school health, or home health care setting.

http://www.msncb.org/ccctm-exam
Making Health Care Better

This material was prepared by Alliant GMCF, the Medicare Quality Improvement Organization for Georgia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-NC-C3-16-01