The 'One Cape' Journey to Meet the IHI Triple Aim and Decrease Readmissions through Interdisciplinary Care Coordination

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November 6, 2014

CAPE COD HEALTHCARE

Objectives

- Describe strategies used to build partnerships between the hospital, ACO, VNA, Elder Services and SNF's for coordination/communication of patient care
- Discuss how active physician involvement enhanced the team and pushed us forward in new directions
- Review the 'ups' and 'downs' of keeping the team together for this length of time including lessons learned

Cape Cod Healthcare

- Mission Statement:

"To coordinate and deliver the highest quality, accessible health services, which enhance the health of all Cape Cod residents and visitors."

Cape Cod Healthcare

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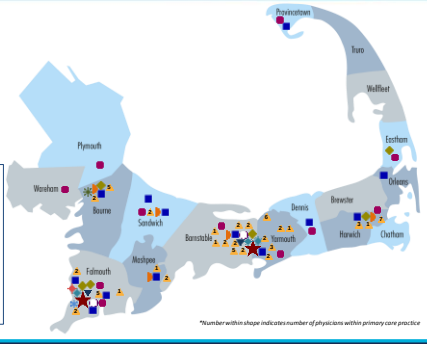
- Leading provider of healthcare services on Cape Cod
- Two Acute Care Hospitals
  - Cape Cod Hospital
    - 269 beds
    - Sole Community Provider
  - Falmouth Hospital
    - 95 beds
- Visiting Nurse Association of Cape Cod including hospice and palliative care
- JML Care Center
- Heritage Assisted Living Facility
- Cape Cod Health Network (PHO)

- Staff
  - 450 Physicians
  - 4,700 Employees
  - 1,100 Volunteers

CCHC Locations

Cancer Centers
Pain Centers
Wound Care Centers
Women's Health Centers
Assisted Living
Transitional Care Centers
Rehab Centers



- ★ Hospitals – 2
- Outpatient Centers – 5
- C-LAB Centers – 13
- VNA Centers – 11
- Primary Care Practices – 26
- Cancer Centers – 3
- Pain Centers – 2
- Wound Care Center – 1
- Women's Health Centers – 2
- Assisted Living – 1
- Transitional Care Center – 1
- Rehab Centers – 6

*Number within shape indicates number of physicians within primary care practice

In the beginning….

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- CCH monitored readmissions
- In 2011, joined 2nd cohort for State Action on Avoidable Rehospitalizations (STAAR)
- First team meeting: January 21, 2011
- Team members
  - CCH representatives
  - Six Skilled Nursing Facilities
  - VNA of Cape Cod
  - Elder Services of Cape and the Islands
  - Physician Practices rep
  - Patient Family Advisory members
  - Physician champions

In the beginning… from 2011 - 2012

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- Goal: "*To ensure a safe and effective discharge process, improve outcomes and address all post discharge needs.*"
- Successes:
  - Nurse to Nurse Communication/warm hand-off (SNF nurse calls hospital nurse)
  - PCP notified of patient discharge and disposition (specific form)
  - Follow-up PCP appointments made prior to discharge
  - Provided statistics to team with provider specific/patient specific readmission
    - Researched readmissions and reported detail
    - Trends and opportunities identified

…2011 -2012

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Successes continued:

- Teach Back Methodology – CCH and SNF nurse education
- VNA/SNF readmissions audits with action plans
- Hospital and SNF Medical Directors meeting – facilitating two way communication
- CCHC 'Helping Hand" program for post-discharge patients
- Heart Failure – standardization of patient teaching materials
- Emergency Center (EC) Case Manager at Cape Cod Hospital
- SNF EC Communication "Orange Envelope"
- SNF Standardized Audit tool

2012 forward…

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- Pilot -daily discharge care planning rounds on hospitalist unit with case manager, clinical leader, PT/OT, Manager, physician
- CCH requested to participate on specific project aimed at SNF readmissions
- A patient education flyer for the Helping Hand program
- Treating patients in the Emergency Center and returning them to their facility or home after treatment – avoiding readmission
- Barnstable County EMS services joined the team
- "Walk in My Shoes' program

EMS involvement

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- Education
  - EMS Scope of Practice and movement toward National EMS SOP
  - Limitations of practice within SOP
- Collaboration
  - Representation from each town on the Cape
  - Description of unique populations and challenges within the towns
  - Case presentations by town of our mutual patients

So, to where do our patients transition?

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Discharge by Disposition Profile	
Disposition	% of Total
Home	44.4%
Home with Home Health	23.0%
Hospice	1.4%
SNF	22.0%
IRF (acute rehab)	2.8%
STAC	1.8%
LTAC	0.1%
Expired	2.0%
AMA	1.2%
Psych	0.6%
Unknown	0.3%
	100%

But, the transitions are dynamic……

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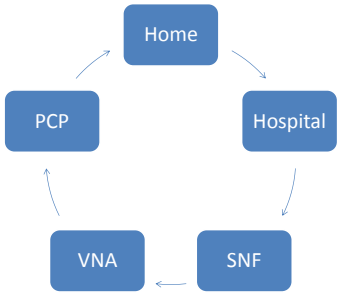

Hospital and Post Acute Engagement

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- Communication Between and Among Care Givers
  - Inclusion of PCPs
    - @ Hospital transition points
    - @ SNF transition points
    - @ Home Health transition points
  - Direct Care Givers
    - Nurse to Nurse Warm Hand-off from Hospital to SNF
    - Discussion of Warm Hand-off from SNF to Emergency Room

Hospital and Post Acute Engagement

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- Cross Continuum Work Groups
  - Focus Group (STAAR)
    - Has consistently met twice per month since 2011
    - Readmission case reviews
      - High Risk Case Identification with Multi-provider Team Meeting/Intervention *
    - Improvement opportunities
    - Educational opportunities
      - Patient educational materials (Heart Failure)
      - Staff Education to provider community (Teach Back)
  - Care Transitions Group
    - Cape Wide Bi-monthly meeting
      - Data sharing
      - Tool sharing
      - Best Practice Sharing

Hospital and Post Acute Engagement

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- Case Study
  - Patient at risk for readmission identified by SNF
    - Had been hospitalized in May and June 2014 with intervening SNF admission and community discharge with VNA and Elder Services
    - Patient frail, elder, multiple co-morbidities with dementia
    - Elder Spouse as Primary Care Giver highly reluctant to accept services in their home – Unable to sufficiently provide care and safe environment – Unable to recognize his limitations – Highly educated – Proud - No other family
  - Team Meeting Held
    - Hospital CM & Nursing, SNF Admin & Nursing, ACO Case Manager, VNA Team Leader, Elder Services representative. Plan: VNA team lead would meet with spouse, working toward a plan that spouse would be able to agree with
  - Outcome
    - Short Term – Spouse accepted a well-developed home care plan for patient
    - Long Term – Spouse accepted Long Term Placement for spouse and accepted home health and community support for himself

CCH PEPPER Report Q2 FY 2014

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Target	Number of Target discharges	Percent	Hospital National Percentile	Hospital Jurisdiction Percentile	Hospital State Percentile
30-day Readmissions to Same Hospital	216	12.1%	43.0	30.1	33.3
30-day Readmissions to Same Hospital or Elsewhere	245	13.7%	19.9	10.5	8.3

Health Care Reform

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The Triple Aim Goals

- **Better Care**
  - Improve/maintain quality and patient outcomes
  - Eliminate avoidable re/admissions
  - Eliminate potentially preventable conditions (e.g., never events)
- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness
- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

PHO/PO involvement

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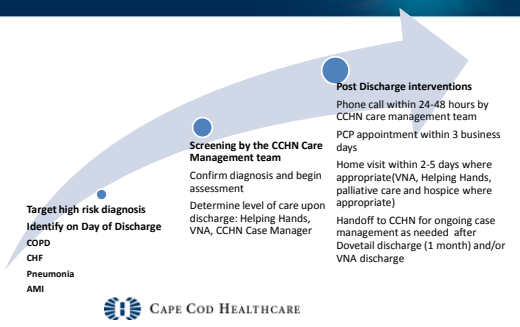
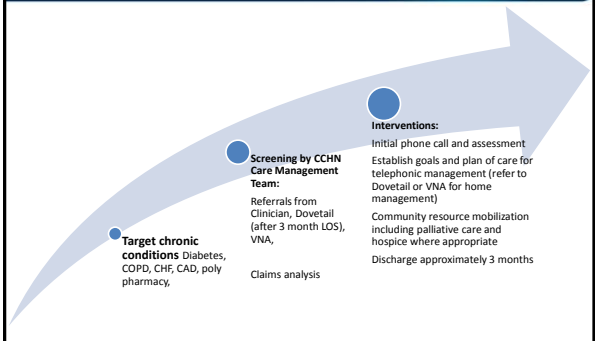
- BCBS Alternative Quality Contract, HPHC, Tufts commercial
  - 25,000 lives
- Medicare MSSP ACO contract
  - 20,000 lives
- Tufts Medicare Preferred Contract
  - 800 lives
- Employees
  - 8,000 lives

Care Transitions: Post Acute



CAPE COD HEALTHCARE

Care Management of High Risk Patients



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Care Transitions

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- 7 Preferred Skilled Nursing Facilities
  - Clinical capabilities assessed
  - Team meetings
  - Discharge Planning
- Cape Cod Helping Hand: Provide post-acute care management programs to highest risk patients after hospitalization – April 2011
  - Transitions – one time home visit/telephonic support by clinical pharmacist
    - Medication education with adherence to compliance and/ or administration issues
  - Complex Care – ongoing in-home support from nurse care manager
    - Home visits where patient does not fit Home Care criteria

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Helping Hand Case Scenario

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- 89 yo hospitalized for CHF and worsening kidney failure followed by short-term rehab
- Home visit by Dovetail pharmacist – no VNA nursing or assessment
- Referred to VNA and Telehealth
- During med reconciliation, still taking previously prescribed NSAID – educated patient and removed from supply
- Identified new med (Imdur) – patient unsure why
- Contacted MD to clarify medication and called pharmacy
- Given med chart and education
- Care plan set up with follow up PCP visit and VNA services
- Follow-up phone call – patient good understanding and no red flags for signs/symptoms for progression of CHF or CKD

Helping Hand Transition Program Patient Profile

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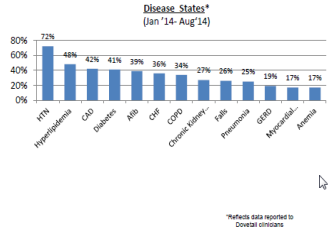

Patient Profile*	
Avg. Age	78.9
Avg. # of Medications per Pt	13.4
Avg. # of Medication Issues per Pt	5.7
% Patients with VNA services	55%
Avg. # days between discharge and home visit	5.1
Avg. # days between discharge and PCP visit	7.4
Avg. # days between discharge and PCP visit for patients who readmitted	6.0
Avg. # of days from discharge to readmission	19.8

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Helping Hand results

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Transition Program Readmission Rates

Program Enrollee Readmission Rates: 30 Days From Hospital Discharge	Readmission Rate 2013	Readmission Rate 2014 *
Falmouth Hospital (all)	12.1% (20/165)	10.7% (11/103)
Cape Cod Hospital (all)	11.4% (20/175)	11.3% (15/133)
Total	11.8%	10.9%

VNA of Cape Cod – Care Transitions

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- Participated on CCH STAAR meeting since inception
- Provide array of services – home health, private services, hospice and palliative care, public health and wellness programs
- VNA Liaison (both home health and hospice) on site
  - Meet patient in hospital when feasible
  - Information in VNA system including hospital referral as attachment
  - Reinforces timely follow up with PCP
- Improved communication since STAAR
  - Patient scheduled to be discharged to a SNF and SNF screening completed
  - Patient prefers to go home
  - VNA liaison documents SNF information in VNA record
  - If patient fails at home, can contact SNF for direct admission
  - Usually works within the first week.

VNA of Cape Cod, continued

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- ACO Interaction
  - Two of ACO case managers worked previously for VNA
  - ACO receives weekly reports on admissions and discharges
  - VNA nurses can identify patients who need further oversight and notify ACO
- SNF interaction
  - VNA liaisons at the SNF's
  - Meet the patient prior to discharge and review plan
  - Attend case conferences prior to discharge to assure safe plans for patients
  - Communication improved between VNA and SNF to discuss patients.

VNA of Cape Cod

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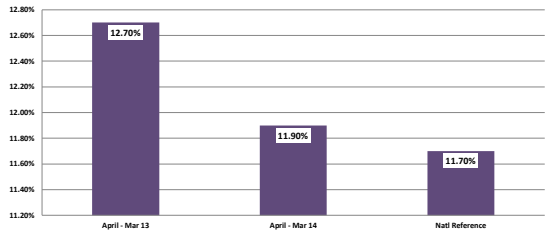
- VNA Specific STAAR committee meets monthly
- Staff Education on:
  - Teach back
  - SBAR
- 1st and 2nd visit are critical – front loading, med rec
- Reinforce MD appts within 7 days
- Patient Education materials
- Revising risk assessment in computer
- All readmissions are reviewed by the Team Leader

VNA OF CAPE COD
Readmission during 30 days of Home Health
(LOWER IS BETTER)



VNA Results Sept 2013 -2014

Rehospitalizations Within 30 Days

		You	SHP State (MA)	SHP National	Your % Rank
Within 30 Days of SOC (Hospital DC in the five days prior to M0030)	Count:	331	11.02%	12.24%	12.49%	67%
	Cases:	3,004			

Rehospitalizations within 30 Days by Current Revenue Impact DX Groups

		You	SHP State (MA)	SHP National	Your % Rank
AMI (Inpatient DX)	Count:	7	12.28%	17.21%	16.83%	59%
	Cases:	57			
Heart Failure (Inpatient DX)	Count:	44	13.71%	18.05%	18.93%	72%
	Cases:	321			
Pneumonia (Inpatient DX)	Count:	36	15.51%	14.96%	15.74%	48%
	Cases:	245			
Total Rehospitalizations with Current Revenue Impact	Count:	76	13.98%	16.54%	17.50%	69%
	Cases:	558			

		You	SHP State (MA)	SHP National	Your % Rank
Joint Replacement (Aftercare DX)	Count:	9	1.59%	2.73%	3.09%	57%
	Cases:	502			
COPD (Inpatient DX)	Count:	25	12.50%	16.17%	18.37%	72%
	Cases:	200			
Total Rehospitalizations with Future Revenue Impact (Includes Current Total from previous table)	Count:	90	8.53%	11.89%	11.77%	73%
	Cases:	1,100			

Delta Study to Reduce Unplanned Hospitalizations

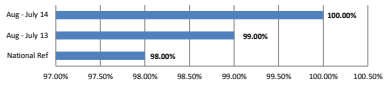
Top 5 Strategies

- Falls Prevention
- Home Adaptation
- Emergency Plan
- Medication Reconciliation
- 24/7 Coverage

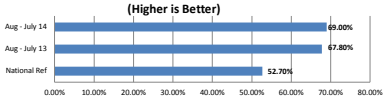
Visiting Nurse Association
Member Cape Cod Healthcare

Percent of Agencies Using Strategy	Strategy
94.9%	Fall Reduction Program
92.5%	Agency Awareness and Support
89.0%	Front Loading
78.8%	Medication Management
78.5%	Twenty-four Hour Availability/Response System
77.2%	Staff Education
76.6%	Care Management
73.3%	One Person in Charge
70.6%	Patient/Caregiver Education
69.4%	Risk Assessment and Management
69.4%	Formal Hospitalization Avoidance Program
69.2%	Audit Practice
63.5%	Point of Care*
62.1%	Data Driven
61.0%	Disease Management
52.8%	Non-Medical Community Agency Support Services
51.0%	Telephonic Practices
41.7%	Physician/Home Care Hospitalization Avoidance Protocol
41.7%	Care Transitions
38.9%	Hospital/Home Care Hospitalization Avoidance Protocol
32.5%	Telehealth*
13.5%	Emergency Room/Home Care Hospitalization Avoidance Protocol

Fall Risk Assessment
(Higher is Better)



Improvement in Management of Oral Meds
(Higher is Better)



Telehealth Program

- Remote Monitoring- portable tablet technology
  - Prevent Re-hospitalizations
  - Ensure Patient Self-management of Chronic Diseases
  - Visit Patient when Indicated
  - Use for Patients with Diagnosis of Heart Failure, Hypertension, COPD, Diabetes, Post Cardiac Interventions
  - Wireless Peripherals: Weight, Pulse Ox, Blood Pressure, Glucometer
  - Parameters set based on American Heart Association (AHA) and American College of Cardiology (ACC) Guidelines
  - RN Coverage 7 days/week
  - Changed vendor one year ago

Patient-Centered…

Service Selection (check the box(es) that apply)	☐	☐	☐	☐
Patient Service	**Enrollment**	**Tier I**	**Tier II**	**Tier III**
Patient Outreach	Medical Assistant	Medical Assistant	Nurse	Nurse
Monitoring and Identification				
Alert Verification		X	X	X
Health Coaching and Education			X	X
Provider Coordination:				
Electronic Alert Summary		X		
Care Need Communication			X	X
Family Communication			X	X
Scheduled Outreach			X	X
Advocacy and Navigation				X
Complex Illness Care Coordination				X

PASS: Patient Advocacy and Support Services

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CARDIOCOM'S TELEHEALTH NURSE EXPERTS CAN HELP YOU ACHIEVE YOUR PROGRAM OUTCOME AND ROI GOALS.

Whether you're starting a new telehealth program, increasing the scope of your current program, or simply want an effective, low-cost telemonitoring alternative, our Integrated Nurse Services provide targeted, compassionate care that decreases hospitalizations and improves your patient's quality of life. Cardiocom provides turn-key, expert telehealth nurses that operate as a natural extension of your coordinated care program. We serve as an integrated care team and combine the strengths of your local field team with Cardiocom's centralized call center expertise. The result is a highly effective, efficient, and scalable telehealth program. Cardiocom can serve as your back-office, integrate your care management protocols in our sophisticated call center software, and even warm transfer patients with specialized service needs to your team.

CLINICAL MANAGEMENT

Our Integrated Nurse Services team intervenes at the "teachable moment" to effectively communicate patient physiological, behavioral and adherence information to managing healthcare providers. We provide essential vital sign and symptom data to the patient's physician that is used to make important care plan adjustments. We work as an extension of your team to communicate the recommended plan of care and ensure that interventions occur in a timely manner.

Telehealth results

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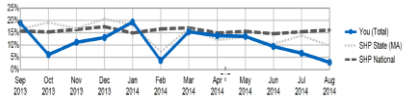
Rehospitalizations Within 30 Days

		You	SHP State (MA)	SHP National	Your % Rank
Within 30 Days of SOC (Hospital DC in the five days prior to M0030)	Count:	42			
	Cases:	375	14.51%	15.79%	71%
		11.20%			



Elder Services/Community involvement

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- Health Living Cape Cod Coalition
  - Community-based group began in 2013
  - Bring evidenced based and health aging programs
  - Some funding from Cape Cod Healthcare
  - Membership includes:
    - VNA of Cape Cod
    - Elder Services of Cape Cod
    - Gosnold
    - COAST (Council on Aging Serving Together)
    - New England Wellness Foundation

Health Living Cape Cod Coalition

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- Evidenced Based Programs
  - My Life, My Health (Chronic Disease Self Management)
  - Matter of Balance
  - Diabetes Self-Management Program
  - Healthy Eating for Successful Living for Older Adults
  - Powerful Tools for Caregivers
- Healthy Living Programs
  - Tia Chi
  - Osteo Exercise

Website fall 2014: Healthylivingcapecod.org

CMS Readmission Reduction Program Penalty

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- CCH received penalty in AMI in FY13 and FY 14
- In FY 15, had same number of eligible discharges however, 29 fewer

Cape Cod Hospital		Number of Eligible Discharges	Number of Readmissions	Predicted Readmission Rate	Expected Readmission rate	Excess Readmission Ratio	National Crude Rate
AMI	FY 2015	716	110	15.70%	16.30%	0.9609	17.40%
	FY 2014	721	134	18.20%	17.20%	1.0581	17.90%
	FY 2013	712	139	19.20%	18.70%	1.0352	19.20%
COPD	FY 2015	734	146	19.7%	19.2%	1.0225	20.70%

CMS Readmission Reduction ProgramPenalty

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- FH received penalty in PN in FY14 and FY 15

Falmouth Hospital		Number of Eligible Discharges	Number of Readmissions	Predicted Readmission Rate	Expected Readmission rate	Excess Readmission Ratio	National Crude Rate
PN	FY 2015	353	64	17.7%	17.2%	1.0260	17.4%
	FY 2014	306	60	19.1%	18.6%	1.0266	17.6%
	FY 2013	300	56	18.7%	18.8%	0.9974	18.5%
COPD	FY 2015	492	106	21.4%	21.2%	1.0084	20.7%

CMS Readmission Penalty

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	Cape Cod Hospital	Falmouth Hospital	Total for both hospitals	State Average
FY 2013	0.17% ($154,000)	0.00%	$154,000	
FY2014	0.24%($196,050)	0.06% ($19,610)	$ 215,660	
FY2015	0.05%	0.10%		0.78%

MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT and tied with NJ

MA is #7 highest average magnitude of penalty - behind KY, WVA, VA, NJ, AK, AR and we are tied with IL

Physician involvement

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- Fundamental difference in the approach and conclusion of case review
  - Pre physician case review: Conclusions/opportunities were process focused
  - Post physician case review: Conclusions/opportunities are treatment/assessment focused
- Physician Dimension propelling discussions regarding potential for care paths across transition points

Physician involvement

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- Refocus efforts to pre-discharge management
- Look for clinical trends
- Chart review

Physician Involvement

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- What could we have changed?

- Was the patient ready?
- Did we risk-assess?
- Was the follow-up appropriate for the clinical condition
- Were the medications appropriate

Physician Involvement

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- Results to date
  - Aspiration
  - End of Life Care

Lessons learned

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- Don't give up!
- Don't be afraid to change course!
- Can implement new processes but needs constant monitoring
  - For example, orange envelope
- Sustainability requires constant oversight
- Be open to additional members as needed…EMS as new members
- Began in 2011and still has much work to do
- Enhance communication and understanding of challenges in each setting involved in team

Major Accomplishment

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- Cohesive multi-disciplinary team across the continuum of care where all working together for common goal
  - Continued Attendance
  - Active Participation

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Questions?

Thank you!

The Office of the National Coordinator for Health Information Technology

IMPACT - Building Care Coordination Tools for the Healthcare System of the Future

Massachusetts Readmissions Summit
November 6th, 2014

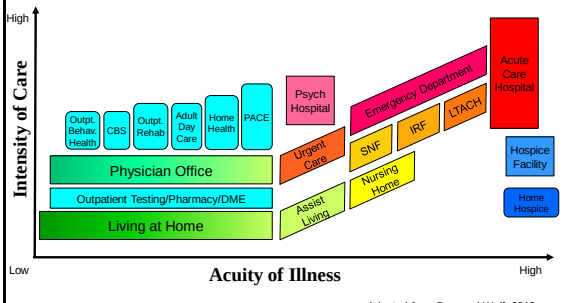
Larry Garber, MD
Terrence A. O'Malley, MD
Jaimie Kelley

Putting the I in HealthIT
www.HealthIT.gov

Agenda

- National standards for transitions of care
- Overview of MA IMPACT Project
- Creating new national standards to better support care coordination
- Technology to extend electronic health information exchange (HIE) to the Long Term and Post-Acute Care providers
- Avoiding Readmissions by Wiring Up the System
- The view from the front lines – Nursing Facilities

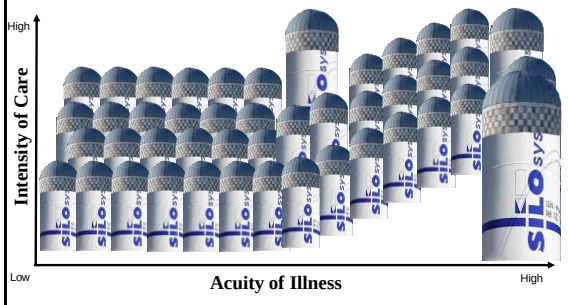
The Spectrum of Care is Vast…



Adapted from Derr and Wolf, 2012

...as are the Barriers to Care Coordination

Putting the I in HealthIT



Adapted from Derr and Wolf, 2012

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Putting the I in HealthIT

National Policies & Standards to Support Coordination of Care

5

Meaningful Use and the C-CDA

Putting the I in HealthIT

- Electronic Health Record (EHR) "Meaningful Use" program consists of standards for EHR functionality, and incentives for hospitals and physicians to meaningfully use those EHRs
- Meaningful Use Stage 2 defined the 2014 Edition EHR standards which require support the "Consolidated CDA" (C-CDA) R1.1 standard to communicate clinical information between healthcare providers
- C-CDA includes 8 standard document types

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Consolidated CDA Release 1.1 Documents

Putting the I in HealthIT

- History and Physical Note
- Progress Note
- Consultation Note
- Diagnostic Imaging Report
- Operative Note
- Procedure Note
- Discharge Summary
- Continuity of Care Document (CCD)

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What is a CDA document?

Putting the I in HealthIT

- XML **Document** standard based on HL7 V3 and RIM
- **Must** be human-readable using web browser
- Could be a single, large text document
- May contain specific sections (e.g. HPI, meds)
- May contain coded computer-interpretable data within sections
- Numerous standard documents can be defined based on CDA model (e.g. 8 in C-CDA R1.1, QRDA, Questionnaire Form and Response, etc…)

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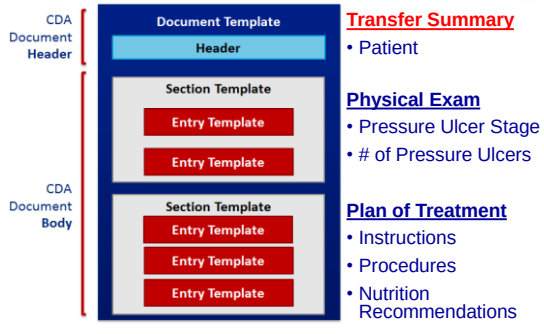
C-CDA built with reusable templates

Putting the I in HealthIT



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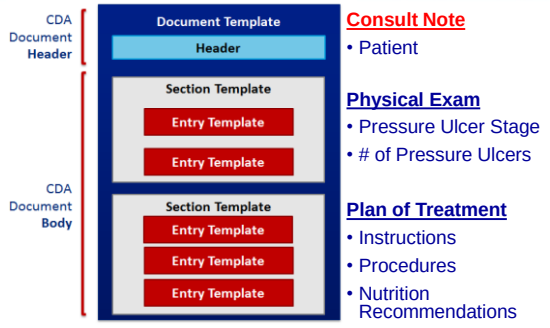
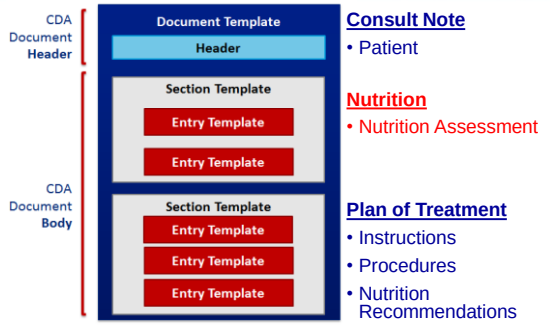
C-CDA built with reusable templates



10

Documents can add templates



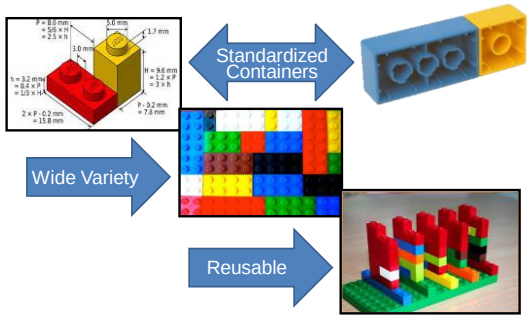
11

C-CDA Release 1.1 Template Reusability

Section	History & Physical	Continuity of Care Document (CCD)
Allergies	X	X
Medications	X	X
Immunizations	X	X
Problem List	X	X
Family History	X	X
Procedures	X	X
Results	X	X
Plan of Care	X	X
Chief Complaint/ Reason for Visit	X	
Hx of Present & Past Illness & Social	X	
Review of Systems	X	
Physical Exam/Status/Vitals	X	
Assessment & Plan	X	
Advance Directives		X
Encounters		X
Functional Status		X
Medical Equipment		X
Insurance		X

Just like Legos®

Putting the I in HealthIT



13

C-CDA Release 1.1 Documents

Putting the I in HealthIT

- Billions of CDA documents are generated by dozens of countries around the world each year
- US hospitals and physician practices are required to send Consolidate CDA R1.1 documents electronically during care transitions in order to receive Meaningful Use incentive $$$
- **So does the Consolidated CDA R1.1 meet the needs of its users?**

14

IMPACT Grant

February 2011 – HHS/ONC awarded $1.7M HIE Challenge Grant to state of Massachusetts (MTC/MeHI):

Improving **M**assachusetts

Post-**A**cute **C**are **T**ransfers (**IMPACT**)

15

Datasets for Care Transitions

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- **Traditionally** – What the **sender** thinks is important to the receiver
- **Future** – Also take into account what the **receiver** says they need

16

"Receiver" Data Needs Survey

Putting the I in HealthIT www.HealthIT.gov

- 46 Organizations completing evaluation
- 11 Types of organizations
- 12 User roles
- 1135 Transition surveys completed
- Largest survey of Receivers' needs

6		From Acute Care Hospital	From Emergency Department	From Skilled Nursing Facility
72	Chief Complaint	Required	Required	Required
73	Reason Patient is being referred	Required	Required	Required
74	Reason for Transfer	Not needed/No	Not needed/No	Not needed/No
75	Sequence of events proceeding patient's disease/condition	Optional	Optional	Required
76	History of Present Illness	Required	Required	Required

Contact Information | HomeHealth Nurse

Findings from Survey

Putting the I in HealthIT www.HealthIT.gov

- Identified for each transition which data elements are required, optional, or not needed
- Each of the data elements is valuable to at least one type of Receiver
- Many data elements are not valuable in certain care transitions

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Five Transition Datasets

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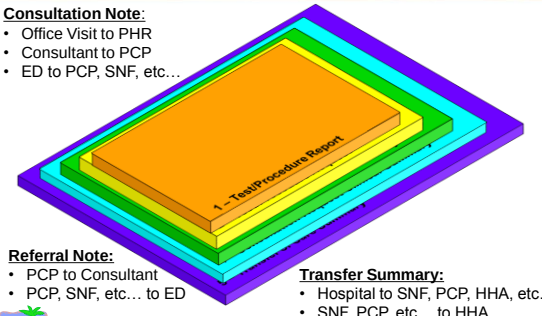
1. **Report from Outpatient testing**, treatment, or procedure
2. **Referral to Outpatient testing**, treatment, or procedure (including for transport)
3. **Consultation Note** (Office Visit, Consultation Summary, Return from the ED to the referring facility)
4. **Referral Note** Clinical Summary (Referral to a consultant or the ED)
5. Permanent or long-term **Transfer Summary** to a different facility or care team or Home Health Agency

19

Five Transition Datasets

Putting the I in HealthIT

Consultation Note:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc…



Referral Note:
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP

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Additional Contributor Input

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State (Massachusetts)
- MA Universal Transfer Form workgroup
- Boston's Hebrew Senior Life eTransfer Form
- IMPACT learning collaborative participants
- MA Coalition for Prevention of Medical Errors
- MA Wound Care Committee
- Home Care Alliance of MA (HCA)

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Additional Contributor Input

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National

- American College of Physicians
- NY's eMOLST
- Multi-State/Multi-Vendor EHR/HIE Interoperability Workgroup
- Substance Abuse, Mental Health Services Agency (SAMHSA)
- Administration for Community Living (ACL)
- Aging Disability Resource Centers (ADRC)
- National Council for Community Behavioral Healthcare
- National Association for Homecare and Hospice (NAHC)
- Longitudinal Coordination of Care Work Group (ONC S&I Framework)
- Transfer of Care & CCD/CDA Consolidation Initiatives (ONC's S&I)
- Electronic Submission of Medical Documentation (esMD) (ONC S&I)
- ONC Beacon Communities and LTPAC Workgroups
- Assistant Secretary for Planning and Evaluation (ASPE): Standardizing MDS and OASIS, LTPAC Assessment Summary, and Care Plans, including home health plan of care
- Geisinger: LTPAC Assessment Summary Documents and CCD
- Centers for Medicare & Medicaid Services (CMS)(MDS/OASIS/CARE)
- DoD and VA: working to specify Home Health Plan of Care dataset
- AHIMA LTPAC HIT Collaborative
- HIMSS: Continuity of Care Model
- **INTERACT** (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers)
- Transfer Forms from Ohio, Rhode Island, New York, and New Jersey

22

Additional Contributor Input

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International

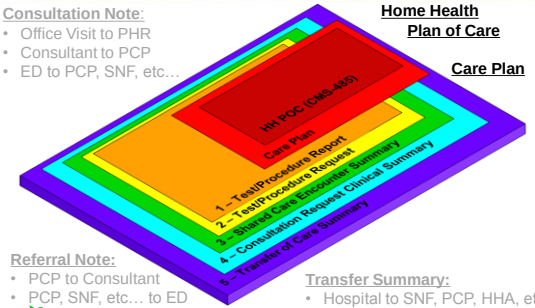
- **HL7** Structured Document, Patient Care, Care Coordination Services, Child Health, and Security Workgroups
- **IHE** Patient Care Coordination Technical Committee

23

Datasets include Care Plan

Putting the I in HealthIT

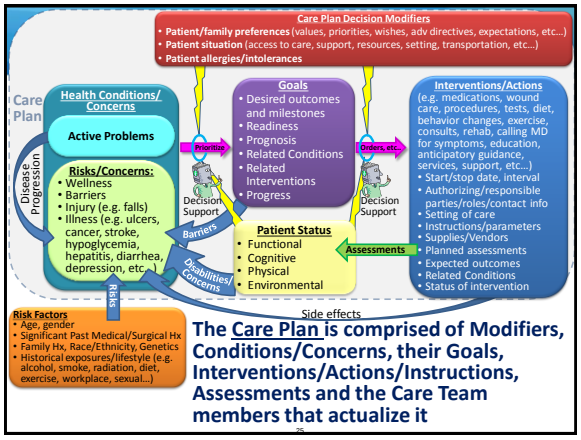
Consultation Note:
- Office Visit to PHR
- Consultant to PCP
- ED to PCP, SNF, etc…



Referral Note:
- PCP to Consultant
- PCP, SNF, etc… to ED

Transfer Summary:
- Hospital to SNF, PCP, HHA, etc…
- SNF, PCP, etc… to HHA
- PCP to new PCP

24



The Care Plan is comprised of Modifiers, Conditions/Concerns, their Goals, Interventions/Actions/Instructions, Assessments and the Care Team members that actualize it

IMPACT Learning Collaborative

Putting the I in HealthIT

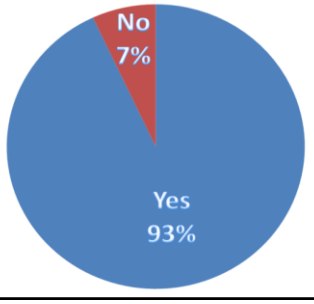
Testing Transfer Summary on Paper

2 Hospitals, 2 large group practices, 8 nursing facilities, 1 IRF, 1 LTACH, 2 home health agencies and several hundred patient transfers…

Senders found the data

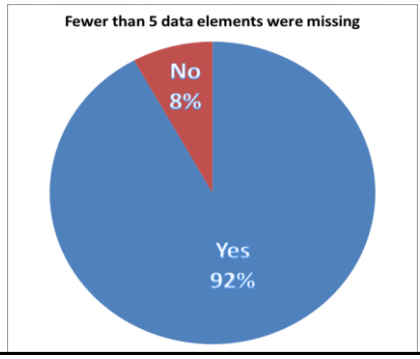
Putting the I in HealthIT

I was able to send all of the requested IMPACT data elements



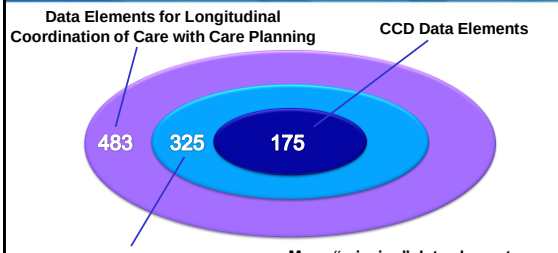
Receivers' needs met

Putting the I in HealthIT



How do datasets compare to CCD?

Putting the I in HealthIT



- Many "missing" data elements can be mapped to CDA templates with applied constraints
- 20% have no appropriate templates

29

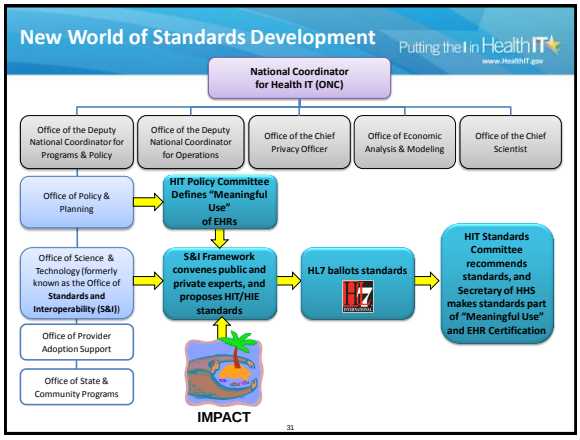
Putting the I in HealthIT

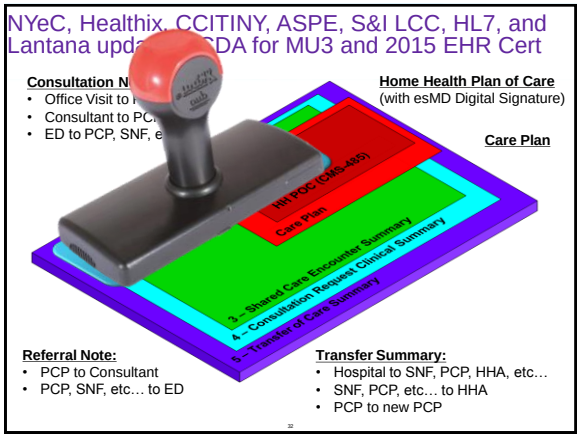
Turning Datasets into National Standards

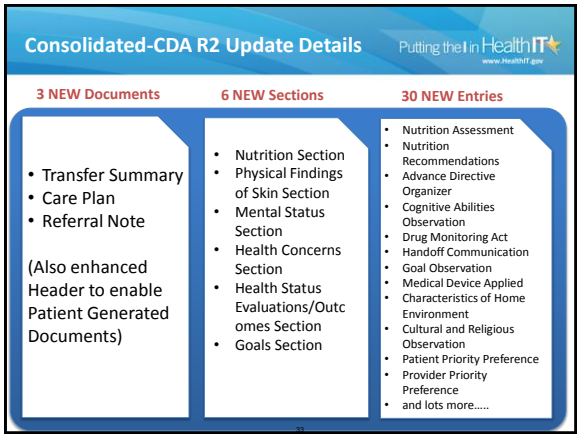
S&I FRAMEWORK

HL7 INTERNATIONAL

30


New World of Standards Development
Putting the I in HealthIT
www.HealthIT.gov
National Coordinator for Health IT (ONC)
Office of the Deputy National Coordinator for Programs & Policy
Office of the Deputy National Coordinator for Operations
Office of the Chief Privacy Officer
Office of Economic Analysis & Modeling
Office of the Chief Scientist
Office of Policy & Planning
HIT Policy Committee Defines "Meaningful Use" of EHRs
Office of Science & Technology (formerly known as the Office of Standards and Interoperability (S&I))
S&I Framework convenes public and private experts, and proposes HIT/HIE standards
HL7 ballots standards
HIT Standards Committee recommends standards, and Secretary of HHS makes standards part of "Meaningful Use" and EHR Certification
Office of Provider Adoption Support
Office of State & Community Programs
IMPACT
31


NYeC, Healthix, CCITINY, ASPE, S&I LCC, HL7, and
Lantana upda DA for MU3 and 2015 EHR Cert
Consultation N
• Office Visit to
• Consultant to PC
• ED to PCP, SNF, e
Home Health Plan of Care
(with esMD Digital Signature)
Care Plan
HH POC (CMS-485)
Care Plan
3 – Shared Care Encounter Summary
4 – Consultation Request Clinical Summary
5 – Transfer of Care Summary
Referral Note:
• PCP to Consultant
• PCP, SNF, etc… to ED
Transfer Summary:
• Hospital to SNF, PCP, HHA, etc…
• SNF, PCP, etc… to HHA
• PCP to new PCP
32


Consolidated-CDA R2 Update Details
Putting the I in HealthIT
www.HealthIT.gov
3 NEW Documents
• Transfer Summary
• Care Plan
• Referral Note
(Also enhanced Header to enable Patient Generated Documents)
6 NEW Sections
• Nutrition Section
• Physical Findings of Skin Section
• Mental Status Section
• Health Concerns Section
• Health Status Evaluations/Outcomes Section
• Goals Section
30 NEW Entries
• Nutrition Assessment
• Nutrition Recommendations
• Advance Directive Organizer
• Cognitive Abilities Observation
• Drug Monitoring Act
• Handoff Communication
• Goal Observation
• Medical Device Applied
• Characteristics of Home Environment
• Cultural and Religious Observation
• Patient Priority Preference
• Provider Priority Preference
• and lots more…..

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Getting Connected: LAND & SEE

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LAND & SEE

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- Sites with EHR or electronic assessment tool use these applications to enter data elements
  - **LAND** ("**L**ocal" **A**daptor for **N**etwork **D**istribution) acts as a data courier to gather, transform, and securely transfer data if no support for Direct SMTP/SMIME or IHE XDR
- Non-EHR users complete all of the data fields and routing using a web browser to access their "**S**urrogate **E**HR **E**nvironment" (**SEE**)

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High Level Overview of SEE

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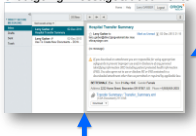
www.HealthIT.gov

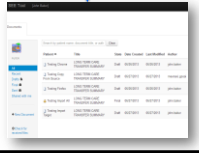
Webmail Mailbox for Facility
Temporary storage for incoming and outgoing messages/documents



Other Facilities

Other Providers

Facility staff and providers with access to a shared Webmail and SEE mailbox



SEE Document Storage for Facility
Permanent storage for:
- Incoming Finalized documents,
- New Draft documents
- Outgoing Finalized documents

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Surrogate EHR Environment (SEE)

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- Acts as destination for routed CDA documents
- Software hosted by MA HIway, accessed via web browser
- SEE is accessed via the HIE's web mailbox
- Non-EHR users able to use SEE to view, edit, send CDA documents via HIE or Direct to next facility
- Can create a new document by copying an entire document and editing it, and/or importing sections from multiple documents
- Can use SEE for other workflows (e.g. completing INTERACT SBAR prior to sending patient to ER)
- Multiple staff can work on the new document at the same time, but not the same section at the same time (will get a warning)
- SEE users can print copies of the document for family or ambulance transport

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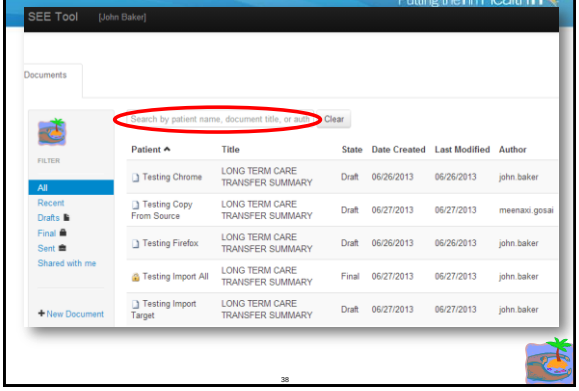
Search by Patient Name

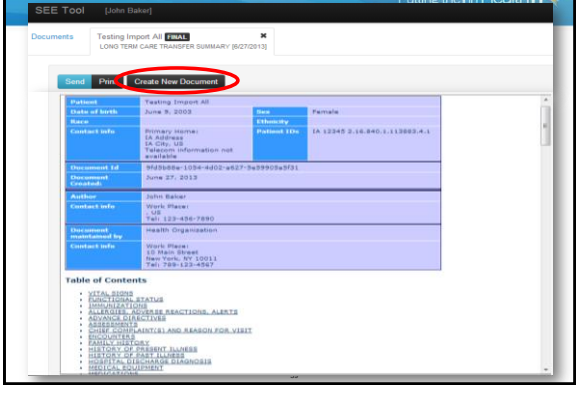
Putting the I in HealthIT



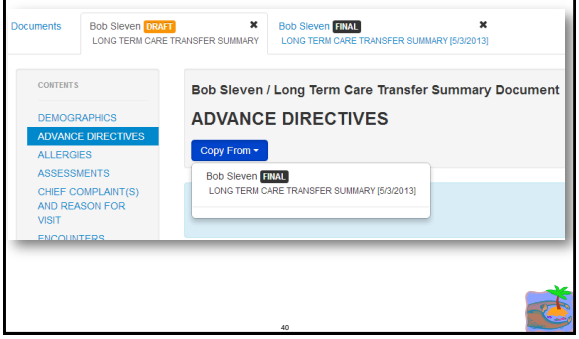
38

Copy All Into New Document

Putting the I in HealthIT



Copy data from existing document



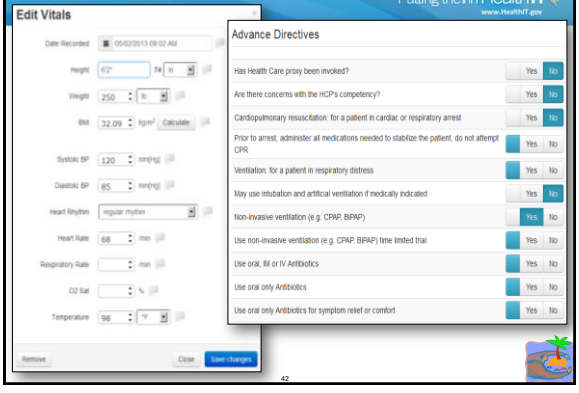
40

Sections of Summary Document

- Demographics
- Advance Directives
- Chief Complaint
- History of Present Illness
- Encounters
- Problems
- History of Past Illness
- Family History
- Social History/Risks
- Allergies
- Medications
- Immunizations
- Medical Equipment
- Vital Signs
- Physical Exam
- Functional Status
- Procedures
- Results
- Assessment
- Discharge Diagnoses
- Care Plan
- Payers

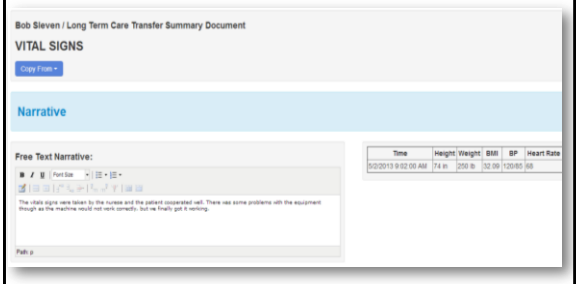
41

Intuitive data entry for each section



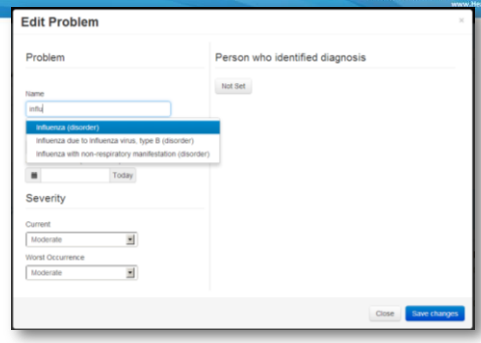
42

Free Text Narrative can be added anywhere



43

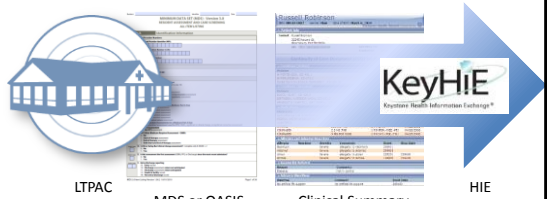
Type-aheads make data entry easy



44

KeyHIE Transform

Developed with AHIMA, ASPE, and S&I (LCC workgroup)
HL7 Balloted. Nationally available Web service.



LTPAC MDS or OASIS Clinical Summary HIE

Transform.KeyHIE.org

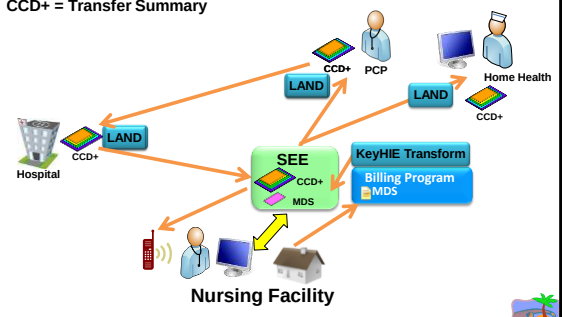
KeyHIE Transform
powered by BridgeGateHealth

45

LTPAC Communication using LAND & SEE

Putting the I in HealthIT

CCD+ = Transfer Summary



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Sharing LAND & SEE

Putting the I in HealthIT

- **LAND**
  - Orion Health's Rhapsody Integration Engine
    http://www.orionhealth.com/solutions/packages/rhapsody
  - Currently Modular EHR certified for MU1 and MU2 (2014)
  - CDA ←→ HL7 2.5.1 MDM Transcription map freely available
- **SEE**
  - Written in JavaScript
  - Baseline functionality software and source code that can connect to Orion's HISP mailbox via API available for free starting ~December 2014 (Apache Version 2.0 vs. MIT open source license)
  - Innovators can develop and charge for enhancements, for example:
    - Integration with other vendors' HISP mailboxes
    - Automated CDA document reconciliation

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C-CDAR2.0 (Draft) Implementations

Putting the I in HealthIT

- MA IMPACT
  - Go-live scheduled for November 2014 using LAND & SEE
  - Implement C-CDA R2.0 **Transfer Summary** and C-CDA R1.1 Continuity of Care Document (CCD)
- NY Downstate Coordination Project
  - Go-live was Nov 2013
  - Implemented **Care Plan**
- GSI Health 'Brooklyn Health Home Consortium'
  - Go-live was March 2014
  - Implemented **Care Plan**
- Veterans Health Administration
  - Demonstration of **Care Plan** September 2014
- Other Vendor Demonstrations of C-CDAR2.0 (draft)
  - CCITI-NY: **Transfer Summary**
  - Datuit: **Care Plan**
  - Healthwise: **Care Plan**
  - Lantana 'SEE' tool: **Care Plan**
  - Care at Hand: **Care Plan**

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Avoiding Readmissions by Wiring Up the System

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Acute Care-PAC-LTSS Communication

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Complex Care Management

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Acute Care-PAC-LTSS Communication Without LAND

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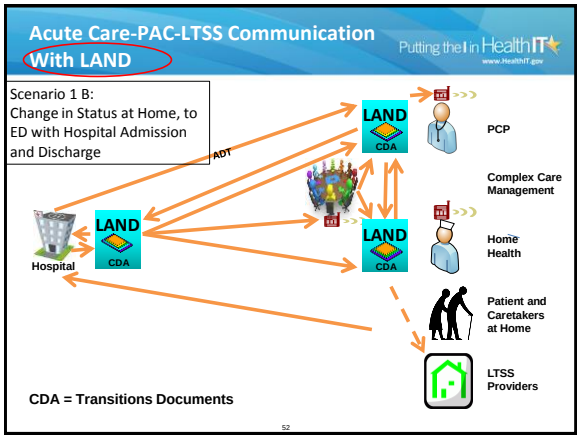
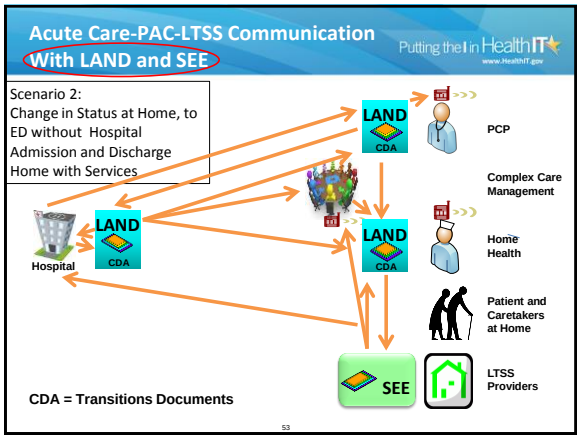
Scenario 1 A:
Change in Status at Home, to ED with Hospital Admission and Discharge

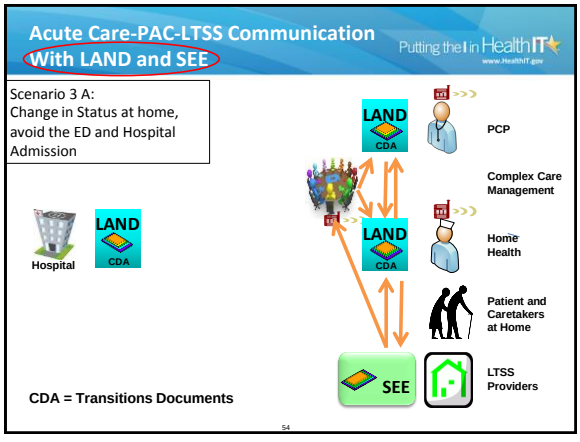
Complex Care Management

Works 80% of the time

51


Acute Care-PAC-LTSS Communication
With LAND
Putting the I in HealthIT
Scenario 1 B:
Change in Status at Home, to ED with Hospital Admission and Discharge
ADT
LAND
CDA
Hospital
PCP
Complex Care Management
Home Health
Patient and Caretakers at Home
LTSS Providers
CDA = Transitions Documents
52

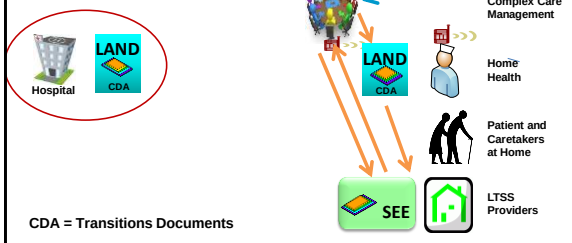

Acute Care-PAC-LTSS Communication
With LAND and SEE
Putting the I in HealthIT
Scenario 2:
Change in Status at Home, to ED without Hospital Admission and Discharge Home with Services
LAND
CDA
Hospital
SEE
PCP
Complex Care Management
Home Health
Patient and Caretakers at Home
LTSS Providers
CDA = Transitions Documents
53


Acute Care-PAC-LTSS Communication
With LAND and SEE
Putting the I in HealthIT
Scenario 3 A:
Change in Status at home, avoid the ED and Hospital Admission
LAND
CDA
Hospital
SEE
PCP
Complex Care Management
Home Health
Patient and Caretakers at Home
LTSS Providers
CDA = Transitions Documents
54

Acute Care-PAC-LTSS Communication With LAND and SEE

Putting the I in HealthIT

Scenario 3 B
Change in Status at home, avoid the ED and Hospital Admission



CDA = Transitions Documents

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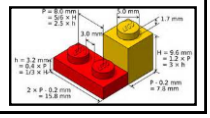
HIT to Link Healthcare and Support Services Providers

Putting the I in HealthIT

- A shared (electronic) highway
- Low cost on-ramps and off ramps
- Similar trucks: C-CDA as exchange standard
- High value cargo
  - Functional assessment
  - Cognitive/behavioral assessment
  - Medication management
  - Transitions
  - Longitudinal Care Plans
- Remember: HIT is just a Tool



What's Missing

Putting the I in HealthIT

- Specifications for information that healthcare providers need that LTSS providers have.
- Info that LTSS providers need and healthcare providers have
- Information that both need that neither have
- A shared vision of who's in charge
  - Whose plan is it
  - Whose priorities matter most
  - Person centered vs Patient centered

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View from the Front Lines – Nursing Facilities

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Millbury
Health Care Center

Jamie Kelley, Clinical Liaison
Millbury Health Care Center

- Heart Failure, Pulmonary and Parkinson's Disease Programs
- Wound Care, Stroke Recovery, Orthopedic Care
- We can divert patients from ED, PCP and Home

BEST NURSING HOMES U.S.News 2014
America's Best Nursing Homes
U.S. News & World Report
2014 Recipient
A 5-Star Rated Facility

Summary

Putting the I in HealthIT
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- IMPACT helped to develop national standards to meet the needs of all providers and patients
- National HL7 standards for Transitions of Care and Care Plans (C-CDA R2.0) will be available in November 2014
- EHRs will likely be required to support these new document types in 2017
- LAND & SEE software will facilitate integrating LTPAC and LTSS organizations into electronic health information exchanges and enable reusing data
- Multiple organizations are starting to pilot these new standards now
- The winners will be our patients and the healthcare system

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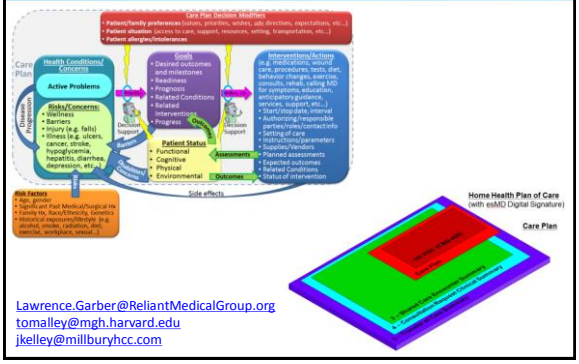
Questions?

Putting the I in HealthIT
www.HealthIT.gov



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PARTNERS
CONTINUING CARE

Collaboration Across the Continuum to Prevent Readmissions after an Acute Care Episode

Partners Continuing Care with Brigham & Women's Hospital
MHA Readmission Summit
November 6, 2014

The Panel

Chuck Pu, MD, CMD
- CMO, Spaulding North Shore
- Chair, PCC Acute Transfer Committee

Mary O'Quinn
- Dir. Quality & Compliance, Spaulding Cambridge
- Dir. Patient Safety & Risk Management, Spaulding Network

Judy Flynn
- VP Patient Care & Quality, Partners Healthcare at Home

Kathryn Britton, MD
- Medical Director of Care Transitions, Brigham & Women's Hospital

20% Readmissions within 30 days After Acute Hospital Discharge

Jenks, NEJM 2009

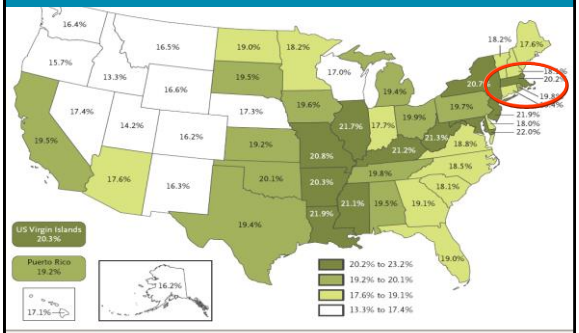


Figure 1. Rates of Rehospitalization within 30 Days after Hospital Discharge.
The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.

"Every system is perfectly designed to get the results it gets."

P. Batalden, MD

- High Mortality
- High Cost
- High Readmissions
- High Degree of Suffering
- High Disability

Pressure to Reduce Readmissions

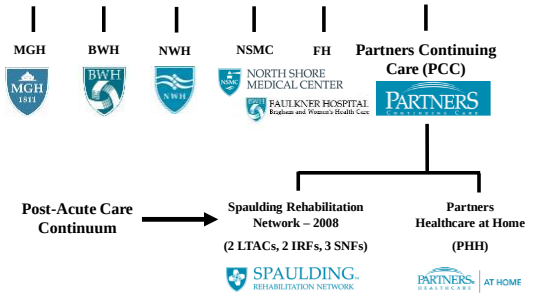
The Changing Healthcare Landscape

- Payment Penalties (Qualifying diagnoses, Value Based Purchasing)
- Public Reporting of Readmission Rates
- Push for migration to ACO Care Delivery Model
- 25/70 Post-Acute Care Predicament

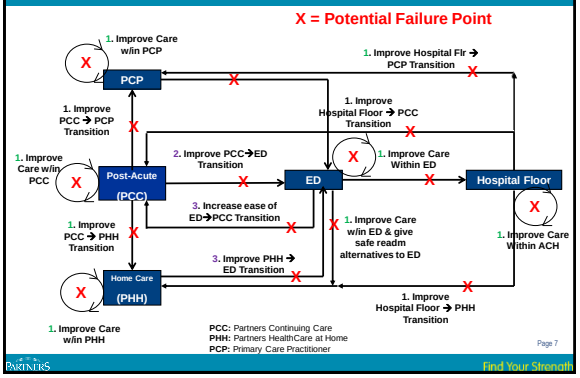
Within Partners Healthcare Systems

- Quality of Care for patients
- Financial penalty of $20 – 35 million over 3 years

Partners Health Care System



Challenges for PCC & PHS – Potential Failure Points



Organize the System

PCC Acute Transfer Committee - Charter

Purpose: To act as the major steering body to optimize readmission rates through the mitigation of causative factors that influence the unanticipated, avoidable return of patients to acute care from PCC

Objectives:
- Prioritize and Set Strategy
- Standardize and Coordinate Activities
- Innovate and Implement Best Practices
- Monitor Compliance and Performance

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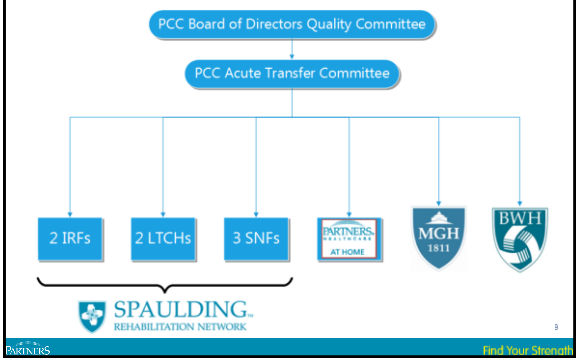
Find Your Strength

Committee Membership



Timeline Summary

2010	2011	2012	2013	2014
• Acute Transfer Committee (ATC) formation • 72 Hour Bounce-back Study	• Fine-tuned ATC • Acute Transfer Database I	• Site PI Projects Developed • Acute Transfer Database II	• P4P I • Site PI Projects executed	• P4P II

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PARTNERS Find Your Strength

Leverage Analytics - Challenges

- Top Performers Unaware of Keys to Success
  - "I guess we're just lucky, I don't know why we're doing better, no one really does."
  - "We've undertaken many initiatives…not sure what the silver bullet is…our LOS is a day higher…"
  - "Our readmission rates have just always been low."
- Readmission Reduction Strategy decisions made in the dark
- Need better Qualitative Data!

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PARTNERS Find Your Strength

The Holy Grails of Readmissions

1.The Preventable Readmission

2. Risk Stratification

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PARTNERS Find Your Strength

Spaulding Network Acute Transfer Database (ATDB)

- PATIENT INFORMATION
- DEMOGRAPHICS
- Review Date
- ACH Info
  - Referring Facility Name
  - Adm date
  - Referring Service
  - Referring MD
- Spaulding Info
  - Adm date/day
  - Adm time
  - Adm MD and type
  - Program
  - Acute Transfer date, day, time
  - ACH (ED) transferred to
  - ACH admitted to
- CLINICAL
  - Primary SRN Adm Dx
  - Main Symptom for Acute Transfer
  - Clinical Etiology for Readm
  - SIRS/Sepsis – Early Goal directed Tx

PREVENTABILITY ASSESSMENT

- Event Category – New (unrelated); New (related); Worsening (related); adverse event
  - Unpreventable;
  - Potentially Preventable;
  - Definitely Preventable
- Contributing Factors:
  - Failure to Dx/Tx
  - Delay in Dx/Tx
  - Medication/Pharmacy event
  - No D/C summary at time of adm
  - Pt Behavioral / non-adherence
  - Family factors
  - Wrong level of care
  - Suboptimal communication with ACH
  - Suboptimal Advanced Care planning
  - Unnecessary Transfer to ED

FINAL ASSESSMENT - Attributability

- SRN preventability?
- Overall Health Care System (including ACH factors) preventability?

FOLLOW-UP Needed

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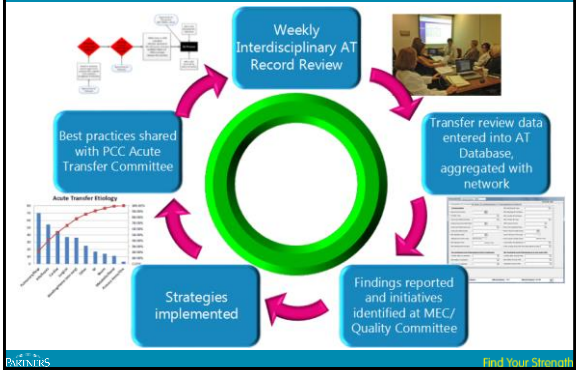
SRN – Local Learning Loops



PARTNERS Find Your Strength

Hospital-Specific Readmission Data

Unplanned bounce-backs between SNS and Acute Facility X	
Patients sent to SRN from Acute Hospital X	36
Acute Hospital X patients readmitted to Acute Care	7
Acute Hospital X / SNS Readmit Rate	20%
SNS Overall Readmit Rate	15%

Why are patients coming to SNS from Facility X more likely to be readmitted?

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PARTNERS Find Your Strength

PCC Process Improvement Pilots 2012-13

Health Care System Alignment

2013 Goal: Reduce Overall 30 Day Unplanned Readmissions to Acute

Pay for Performance: Establish at least one metric to measure impact of work to reduce overall readmissions

- SRN Goal (SRH, SHC, SNS) Reduce readmissions by 10% building on existing foundation of local projects (hospital to ED handoffs; discharge documentation packets; reduce send-outs to ED; STAAR; HEN).
- PHH goal: Reduce readmissions to PHS hospitals by 8% through early risk identification (at referral for medications and all other factors at admission visit), standardized communication of risk and interventions and implementation of visit protocol

Unplanned Transfers to Acute Care within 30 Days of Admission
Percent of all Partners Discharges

Facility	CY 2012	CY 2013	
SRH	11.7%	10.7%	↓
SHC	25.8%	22.0%	↓
SNS LTAC	15.5%	11.7%	↓
TOTAL	17.5%	15.2%	↓ 13.1%

2014 System Alignment

Outcome Measure

- Build on 2013 Success and lessons learned
- Reduce Readmissions by 10% for ALL SRN entities and 8% for PHH

Process Measures

- SRN: standardized ED handoff note, transfer packet
- PHH: identification of risk at time of referral, visit protocol, communication protocol

SRN – PHS ED Transitions

- Standardized communication with ED
- SBAR Handoff Note available in LMR
- SRN Provider Contact Information
- Engagement of ED Chiefs
- Provide ED with alternatives to admission
- Goal – Increase ED Disposition Discussions

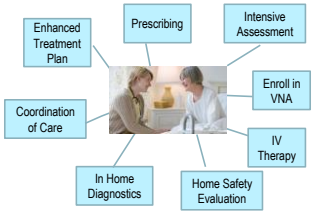
Partners Healthcare at Home - Leveraging IT

- PHH vendor application
  - Sweeps OASIS data to identify readmission risks
  - Allows us to see readmit rate real-time, by referral source
- Communication
  - Internal messaging system internal to PHH EMR
  - Proprietary outpatient system (LMR) used by SRN
- Mobile devices, tele-monitoring, tele-health
- Even without a lot of tech, this is what we were able to do.

PHH – Partners Mobile Observation Unit

PMOU provides same day home visits by an advanced practice clinician for patients with urgent care needs referred from:

- ED/ED OBS Units
- Selected PCP Practices
- Selected Specialty Units



Benefits
- Improved patient experience and outcomes
- Reduced hospitalizations
- Lower healthcare costs
- Improved clinical flow in emergency departments, inpatient observation units and urgent care centers

"Thanks for seeing her and for your note. I think this could be a terrific service and she could be an ideal patient for it. Communicating with her is a real challenge, and having eyes and ears in her home setting could make a huge difference"

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Find Your Strength

PHH 5 Day Readmission Reduction Project

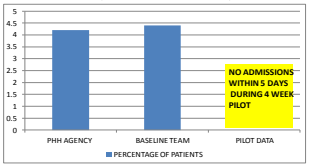
Project Goal: Improve Readmission Rates of Patients Admitted to PHH within the First Five Days of Admission to Homecare

AIM: Reduce PHH re-hospitalization within 5 days from 5% to 3% in 12 months.

TEAM:
Dana Sheer ACNP, MSN
Jennifer Ryan Cluff RN BSN CWON
Denise Anderson- Referral Service Center Manager
Ena Flaherty RN-Weekend Clinical Manager
Merlyne Janvier RN-Liaison
Joyce Rockwell RN
Jill Ouellette RN

INTERVENTIONS
- Communication
- Scheduling Protocol
- Consistent Care Givers

RESULTS: Pilot study showed decrease in re-hospitalizations following new protocol.



CONCLUSIONS:
On track to achieve AIM as stated.

NEXT STEPS:
- 6 Month Study using new protocol
- Clinical Manager of Specialty Programs to over see Pilot.

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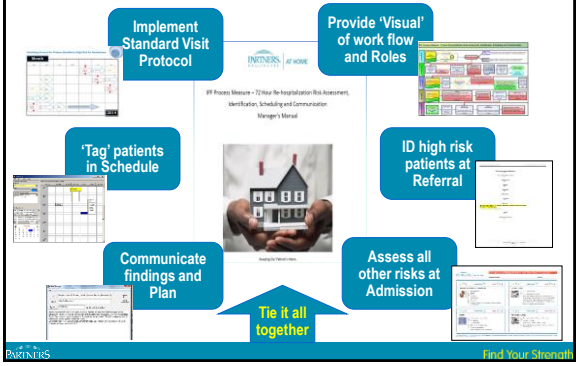
Find Your Strength

PHH Readmission Reduction



Find Your Strength

PHH – Lessons Learned

- Dig in and understand what your data is telling you
  - Different factors at different time points = different interventions
  - Suspend your assumptions
- Communication, communication, communication
- To ensure high reliability in a new or modified process
  - Planning and preparation is the key
  - Use visuals (screenshots, process flow maps) to show process
  - Monitor and report progress on adherence to each of the steps
  - Expect the need for repeated clarification and reminders
- Always remember change is hard

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PARTNERS Find Your Strength

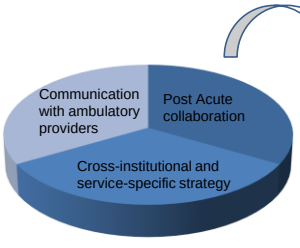
Unplanned Transfers to Acute Care within 30 Days of Admission
Percent of all Partners Discharges

Rate remained stable at 13.2% 2012- 2013

Cumulative Rate	June 2014	July 2014	August 2014	September 2014	
Day 7	5.7%	4.8%	5.2%	4.8%	15%
Day 14	10.3%	8.3%	8.3%	7.8%	24%
Day 21	12.5%	10.6%	10.2%	11.4%	8%
Day 30	14.2%	12.7%	11.7%	N/A	

PARTNERS Find Your Strength

2015 BWH Care Transition Strategies



Why Focus on Post-Acute as part of Care Transition Strategy?

- 68% of readmissions to BWH have been seen by a post acute provider
- Growing opportunities for collaboration with post-acute providers within and outside of Partners

BRIGHAM AND WOMEN'S Center for Clinical Excellence

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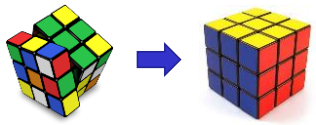
PARTNERS Find Your Strength

Lessons Learned

- Leadership engagement and involvement
- Embrace (competing) priorities
- Expanding definitions of the "team" while not losing local innovation and ownership
- Standardization vs. customization
- Respect the data, but don't be owned by it
- Flexibility



BRIGHAM AND WOMEN'S
Center for Clinical Excellence

Next Steps

- Epic
- Cross-Continuum Data Sharing
  - Centralized Partners-level review of AT data, not just PCC AT Committee or MGH AT Committee
  - Value of case reviews with both acute and post-acute physicians
- Prioritization of High-Risk Populations
  - Work across the continuum to develop procedures and order sets for high-risk patients, e.g. oncology, BCRISP

Q & A

Care Transitions Education Project

Nurses Leading Patient-Centered Care Transitions

November 6, 2014

MASSACHUSETTS SENIOR CARE FOUNDATION

The Western Massachusetts Nursing Collaborative
Advancing Nursing | Addressing Critical Needs

Care Transitions Education Project

2011 Environment

- Cross Continuum Teams
- Care Transitions Forum
- STAAR
- INTERACT
- BOOST
- Care Transitions Coaches

3

Care Transitions Education Project

Emerging Leaders

Care Transitions Education Project

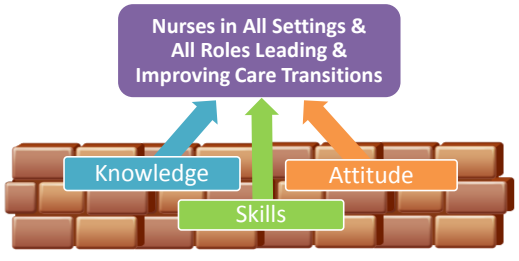
Triple Aim

Different types of Care Transition Initiatives

The workforce is foundation for success

5

Care Transitions Education Project



CTEP is a foundational workforce strategy that complements other care transition initiatives

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Care Transitions Education Project

Nurses From Across the Continuum LEARN TOGETHER!

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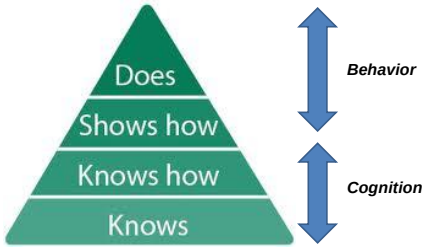
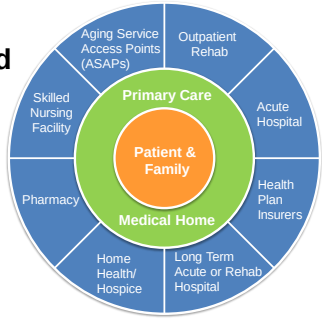
Care Transitions Education Project

Miller's Pyramid of Clinical Competence



Care Transitions Education Project

Focus on Patient and Family



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Care Transitions Education Project

Curriculum Components

1. Four Interactive Learning Modules
2. Patient Tracer Experience
3. Quality Improvement Activity

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Care Transitions Education Project

Piloting the Curriculum

- Eight pilot sites
  - 22 service organizations engaged in cross continuum teams
  - 6 schools of nursing
  - 350 RNs and student nurses
- Training for educators
- Implement curriculum, evaluate content, delivery & outcomes, revise curriculum

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Care Transitions Education Project

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Care Transitions Education Project

Results

1. Increased competency to lead and improve care transitions
2. Increased mutual respect across care settings
3. Improved coordination and collaboration
4. Demonstration of nurse-led quality improvements

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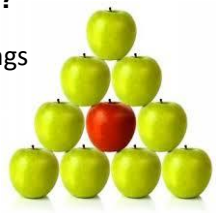
Care Transitions Education Project

How is CTEP Unique?



- All nurses across settings
- Competencies to implement care transitions tools
- Empowered frontline nurses engaged in quality improvement

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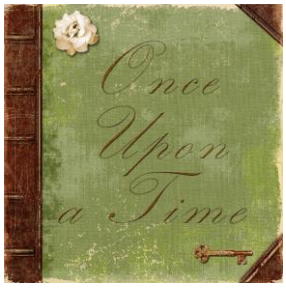
Care Transitions Education Project

CTEP Stories

- It all started because….(tell us what was at stake: What was happening? Why did you start this work?)
- We did a couple of important things…
- We had some heroes….
- The thing that surprised me most was….
- Our biggest win was…..
- We still need to…..

The title of our story is…..



Care Transitions Education Project

Phase 2 Goals

1. Spread CTEP in a way that complements existing care transitions work
2. Build the case for CTEP from a cost savings perspective

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Care Transitions Education Project

Current Environment

- Pioneers
- ACO
- Risk
- Penalties
- Rates
- Preferred Provider

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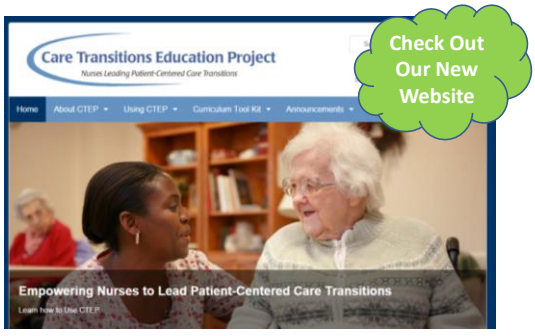

www.CareTransitionsEducation.org

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Care Transitions Education Project

2015 Offerings

- Train the Trainer
- Technical Assistance
- Community of Practice

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Care Transitions Education Project

More Information?

Kelly Aiken
CTEP Project Director
Massachusetts Senior Care Foundation
kaiken@maseniorcare.org

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tenet HEALTH

MetroWest Medical Center
Framingham Union Hospital • Leonard Morse Hospital

Reducing Avoidable Readmissions through Safer Transitions

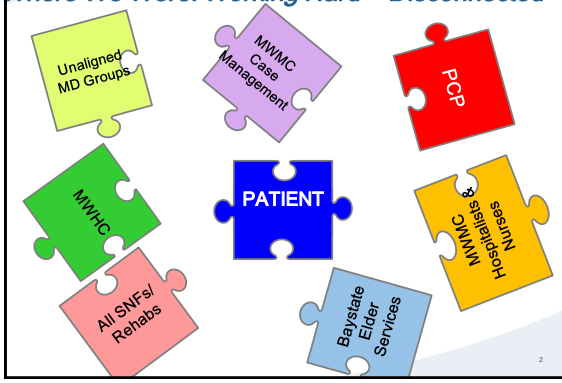
A COMMUNITY PARTNERSHIP APPROACH

Our Team Representatives

- Jaime Long RN MWMC Director of Post Acute Care Services
- Carolyn Gifford MS, RN MWMC Director of Case Management
- Pat Burke RN Director of Transitions in Care & CCTP
- Mary Hatch RN Kathleen Daniels Director of Nursing
- Natalie Kenney RN MWHC Care Transition & Special Projects Manager
- Mary Bottachiari RN- MWHC Transition Care Coach
- Rebecca Sommers-Petersen BayPath Elder Services – Coleman Coach

tenet HEALTH 1

Where We Were: Working Hard > Disconnected



2

Who We Are

- **Two Campuses - 285 Beds**
  - Framingham Union Hospital &
  - Leonard Morse Hospital
- **Two – 24 hour Emergency Departments**
- **Inpatient Services:**
  - Medical / Surgical
  - Intensive Care Units
  - Pediatrics
  - Maternity
  - Level 2 Special Care Nursery
  - Advanced Cardiac Care
- **Inpatient and Outpatient Behavioral Health Services**
- **Ambulatory Clinics**

tenet HEALTH 3

Where We Were

January 2014 Core Readmission rate of 21.8%
Medicare Readmission penalty of 1.0%

- Undefined post acute strategy
- Under-developed preferred provider network
- Inadequate communication to post acute providers
- Insufficient internal workflow processes & systems
- Minimal case management coverage in ED
- Uncoordinated readmission reviews
- Inpatient care team uninformed about impact of readmissions
- Gaps in transition and follow up plans for patients at time of discharge (Follow up PCP appointments)

4

Where We are Now – 9 Months Later

- **Formal Post Acute Strategy**
  - Definitions, Goals, Metrics
- **Organized and effective preferred provider network**
  - Coordination with other community resources including CCTP
  - Regularly scheduled meetings with post-acute collaborators
  - Standardized expectations, metrics and reporting
- **Inpatient Team Informed, Engaged and Focused**
  - Case Management – ED
  - Daily Review of all readmissions using format
  - Collaborative care rounds format standardization, with readmission assessments
  - Discharge PCP and other follow-up appointments for patients made prior to discharge

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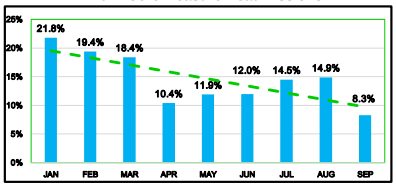
Readmissions: Results

2014 Core Measure Readmissions



MWMC Medicare Readmissions Penalties:

- 2013 - 1.0%, 2014 - .95%, 2015 - .14% (13th lowest out of 61 MA hospitals)

Medicare Readmission Penalties

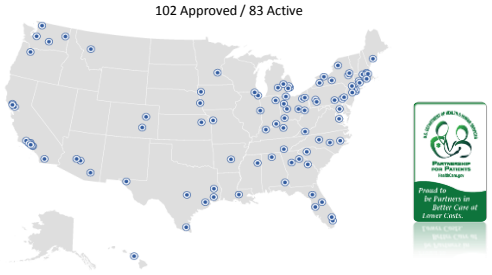
Rank	Hospital	FY2013	FY2014	FY2015	Rank	Hospital	FY2013	FY2014	FY2015
1	Adcare Hospital Of Worc	0.00%	0.00%	0.00%	32	Umass Memorial Medi	0.96%	0.73%	0.57%
2	Baystate Mary Lane Hosp	0.00%	0.00%	0.00%	33	Beth Israel Deaconess	1.00%	0.69%	0.64%
3	Baystate Medical Center	0.00%	0.00%	0.00%	34	Lawrence General Hos	0.24%	0.36%	0.64%
4	Massachusetts Eye And E	0.00%	0.00%	0.00%	35	Beth Israel Deaconess	0.84%	0.05%	0.71%
5	Nantucket Cottage Hospi	0.45%	0.15%	0.00%	36	Carney Hospital	0.11%	0.46%	0.71%
6	New England Baptist Hos	0.02%	0.01%	0.00%	37	Healthalliance Hospita	0.22%	0.43%	0.72%
7	Emerson Hospital	0.00%	0.00%	0.01%	38	Holyoke Medical Cente	0.20%	0.63%	0.77%
8	North Shore Medical Cen	0.00%	0.00%	0.03%	39	Brigham And Women'S	0.81%	0.85%	0.78%
9	Berkshire Medical Center	0.05%	0.04%	0.05%	40	Cambridge Health Allia	0.94%	0.32%	0.86%
10	Cape Cod Hospital	0.17%	0.24%	0.05%	41	Lahey Hospital & Medi	0.88%	0.54%	0.91%
11	Baystate Franklin Medical	0.05%	0.14%	0.09%	42	North Adams Regional	0.36%	0.10%	0.92%
12	Falmouth Hospital	0.00%	0.06%	0.10%	43	Norwood Hospital	0.41%	0.45%	1.08%
13	**Metrowest Medical Cent**	**1.00%**	**0.95%**	**0.14%**	44	Saint Anne'S Hospital	1.00%	0.79%	1.08%
14	Newton-Wellesley Hospit	0.07%	0.23%	0.17%	45	Beverly Hospital Corpo	0.17%	0.09%	1.17%
15	Massachusetts General H	0.51%	0.25%	0.24%	46	Good Samaritan Medic	0.94%	0.73%	1.18%
16	Brigham And Women'S Ho	0.55%	0.30%	0.27%	47	Harrington Memorial H	0.65%	0.64%	1.21%
17	Marlborough Hospital	0.94%	0.86%	0.29%	48	St Elizabeth'S Medical (	1.00%	0.75%	1.22%
18	Mercy Medical Center	0.02%	0.00%	0.31%	49	Hallmark Health Syster	0.06%	0.24%	1.28%
19	Jordan Hospital Inc	1.00%	1.00%	0.32%	50	Tufts Medical Center	1.00%	0.85%	1.28%
20	Merrimack Valley Hospita	0.13%	0.00%	0.35%	51	Clinton Hospital Assoc	0.58%	0.48%	1.29%
21	Noble Hospital	0.02%	0.00%	0.37%	52	Holy Family Hospital	0.85%	0.69%	1.29%
22	Heywood Hospital	0.76%	0.52%	0.40%	53	Southcoast Hospital G	1.00%	0.83%	1.40%
23	Lowell General Hospital	0.19%	0.26%	0.42%	54	Wing Memorial Hospit	0.91%	1.39%	1.43%
24	Signature Healthcare Bro	0.24%	0.27%	0.43%	55	Quincy Medical Center	0.43%	0.63%	1.44%
25	South Shore Hospital	0.43%	0.23%	0.45%	56	Winchester Hospital	0.25%	0.41%	1.49%
26	Sturdy Memorial Hospital	0.01%	0.23%	0.45%	57	Morton Hospital	0.66%	0.95%	1.81%
27	Cooley Dickinson Hospita	0.19%	0.12%	0.46%	58	Saints Medical Center	0.12%	0.21%	1.83%
28	Mount Auburn Hospital	0.60%	0.16%	0.46%	59	Beth Israel Deaconess	0.23%	0.69%	1.91%
29	Nashoba Valley Medical C	0.33%	0.21%	0.46%	60	Anna Jaques Hospital	0.26%	0.34%	1.94%
30	St Vincent Hospital	0.32%	0.30%	0.49%	61	Milford Regional Medi	0.42%	0.88%	1.99%
31	Boston Medical Center Co	1.00%	0.79%	0.56%					

Community Based Care Transitions Program CCTP

Pat Burke
Director of Transitions in Care & CCTP
MetroWest HomeCare & Hospice

CCTP Community-Based Organizations

102 Approved / 83 Active



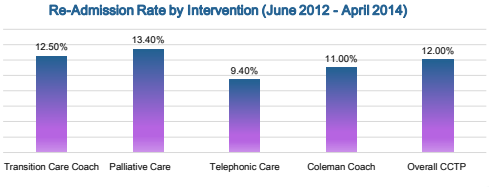
Source: Centers for Medicare & Medicaid Services

CCTP Program Components

- Transition Care Coach
- Telephonic Care
- Palliative Care
- Transitions in Care Pharmacy Intervention
- Care Transition Intervention®
- Care Transition Intervention® *plus*

Results (June 2012- April 2014)

- Population Size = 7087 patients
- Baseline readmission rate for target high risk population = 31%
- Reduced readmission rates by 50% for patients receiving a Transition Intervention



Success!

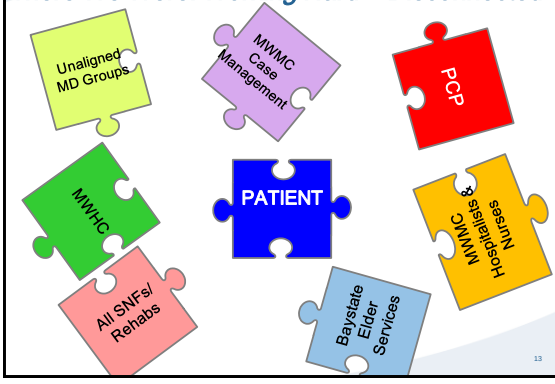
CMS recognized our project as one of the top performing projects across the 102 nation-wide approved sites

Top Performers in:

- Reaching our Enrollment Target
- Reduced Readmission by **50%** for patients receiving a CCTP Intervention
- Reduced All-Cause Medicare Readmissions by **7.7%**

tenet HEALTH

Where We Were: Working Hard > Disconnected



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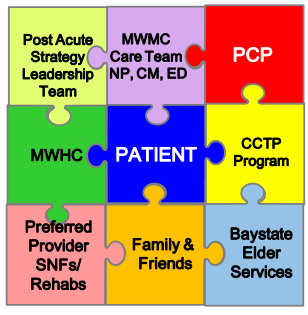
Where We Are: Engaged and Aligned



14

Palliative Care: A Collaborative Model to Reduce Hospital Readmission

Jeanne Ryan, MA, OTR, MBA, CHCE
Vice President, Post-Acute Care,
Cooley Dickinson Health Care

Maureen Groden, RN, MS, CHPN
Director, Hospice and Palliative Care,
Cooley Dickinson Health Care

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MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

Objectives for Presentation

- Understand the development of Palliative Care as a response to community demand
- Understand the growing need for home care Palliative Care management of patients with serious illness
- Describe key components of a successful Palliative Home Care Program
- Describe Cross Continuum Collaboration as a model to decrease hospital readmissions

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Structure of Cooley Dickinson Health Care

Cooley Dickinson Health Care Corporation, (CDHCC) made up of:

- Cooley Dickinson Hospital
- Cooley Dickinson Practice Associates
- VNA & Hospice of Cooley Dickinson

A Massachusetts General Hospital Affiliate

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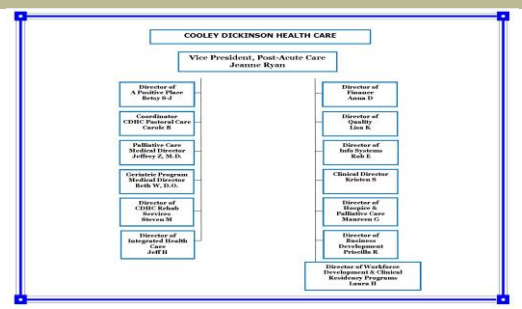
Structure of Continuum



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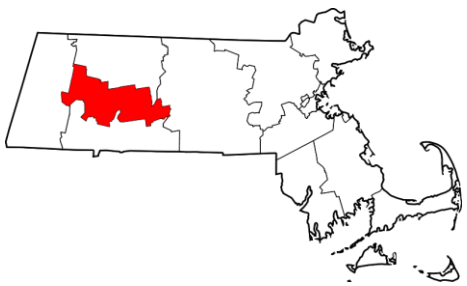
4

Our Service Area



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Definition of Palliative Care

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.

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Definition of Palliative Care

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment

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Existing Palliative Structure CDHC circa 2007-2009

- Small Inpatient and Outpatient Palliative Consultation Service Line – Dr. Jeff Zesiger
- Hospital-based Palliative Care Committee meeting monthly to enhance experience of patients identified with palliative care needs
- Small, not well-developed Palliative Program at the VNAH
- Limited Community Awareness of Palliative Programs at CDHC

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Developing the Cross Continuum Team

- 2009-Patient and Family Advisory Council at CDH
- 2010-Patient-Centered Care and Human Mortality Report
- 2011- Center to Advance Palliative Care Public Opinion Research
- 2012- Medical Orders for Life Sustaining Treatment (MOLST) pilot roll-out
- 2013-Faith Outreach Coordinator
- 2014-Post Acute Care Transition Team (PACT)

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Patient and Family Advisory Council PFAC 2009

Department of Public Health requires all Hospitals in the state of Massachusetts to establish a Patient and Family Advisory Council

Patient and Family Advisory Council: 105 CMR 130.1800 and 130.1801

Section 11 of c. 305 adds section 53E to M.G.L. c. 111, which requires each hospital to establish a patient and family advisory council (PFAC). PFACs facilitate patient and family participation in hospital care and decision-making, information sharing, and policy and program development. The PFAC concept is based on the work of the *Institute for Family-Centered Care*, which is credited with developing the core principles that are the foundation of the patient and family-centered care movement.

- Consistent with section 53E, the proposed amendment provides that the PFAC shall advise the hospital on matters including but not limited to patient and provider relationships, institutional review boards, quality improvement initiatives and patient education on safety and quality matters. The proposed amendment requires hospitals to adopt and implement policies and procedures that govern a PFAC's goals, membership, training, and roles and responsibilities

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Palliative sub-group of the PFAC

- Palliative Sub-Committee of PFAC formed based on initial members advice
- Three PFAC members join sub-committee

Here's why:

"When the opportunity presented itself I think there were several factors that led me to join. Reflecting on the end of life experience of a number of members of my extended family, I realized it did not have to end that way. I also saw it as a way to educate myself. More importantly, the goal of informing members of the community about Palliative Care was a compelling challenge". Ray

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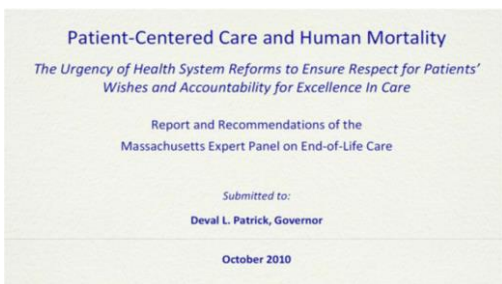
Patient-Centered Care and Human Mortality Report-2010


Patient-Centered Care and Human Mortality

The Urgency of Health System Reforms to Ensure Respect for Patients' Wishes and Accountability for Excellence In Care

Report and Recommendations of the
Massachusetts Expert Panel on End-of-Life Care

Submitted to:

Deval L. Patrick, Governor

October 2010

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Patient-Centered Care and Human Mortality Report-2010

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Public Opinion Research on Palliative Care 2011

A Report Based on Research by Public Opinion Strategies

CENTER TO ADVANCE PALLIATIVE CARE

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MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

Objectives of Research

CENTER TO ADVANCE PALLIATIVE CARE

The objectives of this research were to:

- Explore key audiences' awareness and understanding of palliative care; and,
- Test language, terminology, definitions and messaging to be used in discussing palliative care with consumer audiences.

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Key Finding

- Although consumers may be content with the quality of health care they receive, they have concerns about the level of care patients with serious illness receive.
- The biggest concerns relate to information sharing between doctor and patient and other doctors, patient control and choice over treatment options, patient understanding about their illness and treatment, and the quality of time doctors spend with patients.

Consumer Awareness About Palliative Care

How knowledgeable, if at all, are you about palliative care?

[a]Data from a Public Opinion Strategies national survey of 800 adults age 18+ conducted June 5-8, 2011.

Key Finding

- Language makes a difference.
- Palliative care is about improving quality of life, providing an extra layer of support, and having a team focus to patient care.
- Palliative care is about helping both the family as well as the patient with serious illness.
- Serious Illness vs. Advance Illness: Palliative care should be positioned as care for patients with serious illness not advanced illness. Advanced illness is perceived to be more closely aligned with terminal illness.

Key Finding

- After hearing the definition of palliative care, consumers strongly agree that:
  - Patients with serious illness and their families be educated about palliative care.
  - Palliative care is appropriate at any age and any stage in serious illness.
  - Palliative care treatment options should be covered by health insurance and Medicare.

Readmission Data: Nation

Quick Facts

- - 2,610 hospitals are receiving a readmission penalty this year (October 1 2014-Sept 30 2015)
- - conditions expanded to "5": AMI, PNA, HF, COPD, hip/knee (together)
- - penalty is up to a 3% decrease on all Medicare FFS reimbursements
- - Medicare will recoup $428M from payment reductions due to readmission penalties nationally this year

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Readmission Data: Massachusetts

- 55 hospitals in MA are receiving a penalty this year, which is 80% of all eligible hospitals
- - the average penalty in MA is 0.78% (of a possible 3%)
- - MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT and tied with NJ
- - MA is #7 highest average magnitude of penalty - behind KY, WVA, VA, NJ, AK, AR and we are tied with IL

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Existing Palliative Care Program VNA circa 2007-2009

- Palliative Program within the VNA managed by VNA Clinical Manager
- Lack of clear eligibility guidelines for Palliative Care
- Inconsistent case management and scheduling
- Limited clinician competency on trajectory of illness, advanced directives and symptom management
- Gaps in coordination of care between VNA, hospital, SNF
- Census in low 20s/30s

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Why Focus on Palliative Care?

- In the US in 2009, 12.9% of people (39.6 million) were over the age of 65; in 2030, it will be 19% (72.1 million)
- Patients with chronic illness in their last two years of life account for about 32% of total Medicare spending
- Rise in patients with multiple co-morbidities, complex illnesses and treatment plans
- Many patients are in clinical, functional, +/or nutritional decline, but are not ready, eligible or interested in hospice
- Such patients generally experience poorly coordinated care and repeat hospitalizations, often related to pain and symptom management.

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What is the Benefit? Quality of Life?

- Need for discussions on benefits and burdens of treatment options due to seriousness of illness - prognosis
- Weighing potential pros and cons of ALL treatments
- PROGNOSIS is crucial – and challenging with multiple illnesses and multiple physicians. People need to know. Not just how long will I live but how well will I live with this treatment ?
- Only 20% of predictions were accurate. MDs over-predicted prognosis by 500%, longer length of relationship = worse predictive ability

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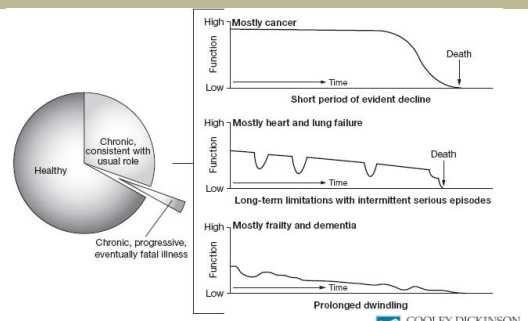
Disease Trajectories



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Quantitative Scales

PALLIATIVE PERFORMANCE SCALE

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal No Disease	Full	Normal	Full
90	Full	Normal Some Disease	Full	Normal	Full
80	Full	Normal with Effort Some Disease	Full	Normal or Reduced	Full
70	Reduced	Can't do normal job or work Some Disease	Full	As above	Full
60	Reduced	Can't do hobbies or housework Significant Disease	Occasional Assistance Needed	As above	Full or Confusion
50	Mainly sit/lie	Can't do any work Extensive Disease	Considerable Assistance Needed	As above	Full or Confusion
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion
30	Bed Bound	As above	Total Care	Reduced	As above
20	Bed Bound	As above	As above	Minimal	As above
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma
0	Death	-	-	-	--

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Palliative Care Program Goals

- High Quality Patient and Family Care with a Focus on Helping Them Achieve Their Goals
- Improvement in Symptom Management
- Reduction of Acute Care Hospitalization
- Linkages with Primary Care Providers
- Transition to Hospice
- Patient Satisfaction
- Employee Satisfaction
- Program Growth

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Palliative Care Action Plan

Goal – Responsible Person – Due Date - Outcomes

- **Education**, Competency, Certification
- **Quality Outcomes**, Case Management, Teamwork, HHC
- **Patient Satisfaction**, Consistency, Informed, Focus on Pt Goals
- **Employee Satisfaction**, Education, Support, Tools
- **Structure**, Caseloads, Scheduling, IT, Transitions
- **Collaboration**, PFAC, Readmission Reduction, Cancer Committee)
- **Marketing** – Brochure, Customer Service, Outreach
- **Finance**, Efficiencies, Care Management, Transition to Hospice

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Employee Development and Support

- Agency-wide educational program on Palliative Care
- Hire Palliative Care R.N.s with Hospice / EOL Experience
- Educational Program on PC with Modules & Competencies

  Model: Concensus Project for Quality Palliative Care
  - Disease Management and Case Management Coaching
  - Symptom Management
  - Interdisciplinary Collaboration
  - Ethics
- Palliative Care Staff Support Meeting Monthly
- Certification in Hospice & Palliative Care (CHPN)

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Systematic Changes

- Intake
- Liaison
- Scheduling
- I.S.
- Administrative
- Orientation
- Management Development

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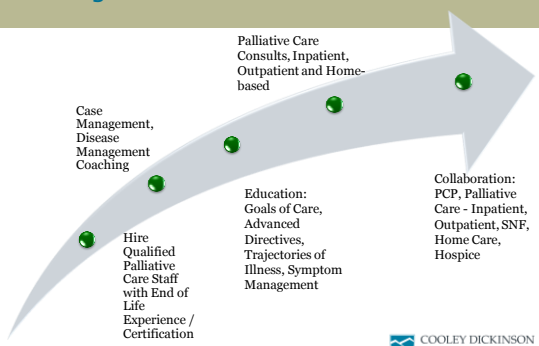
Strategies to Achieve our Goals



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Palliative Care Screening – Recruitment: VNA

1) Cancer-metastatic / recurrent

2) Serious Organ Disease: low functional status
   Cardiac, Pulmonary, Neuro, Dementia, Kidney, Liver

- Multiple ED visits
- Hospitalized 2 times or > in past 6 months for the same problem
- Symptoms poorly controlled
- Family distress

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Additional Screenings

- OASIS Start of Care Alerts "likely hospice referral"
- OASIS Start of Care Alerts "risk for re-hospitalization"
- CDH Palliative Care Screenings
- Quantitative Scales (PPS, FAST, NYHA)

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Palliative Care Team	Hospice Team
M.D.	M.D.
R.N.	R.N.
S.W.	S.W.
P.T.	Spiritual Care
O.T.	Complimentary Care
S.T.	Volunteers
Home Health Aide	Home Health Aide
	Bereavement

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Case Example CHF: Dyspnea & Anxiety

Dottie, 84 y/o w/ CHF with EF 30%, COPD, CKD, OA, Hypothyroidism
Widowed, lives alone, dghter and family live next door, another son & dghter nearby; retired food service, was active with church, now unable to get out, amb w/ walker, DNR
Admitted hosp x 3, last 3 months for SOB; she won't complain; hates to come in the hospital
Goal: Stay out of the hospital, get to church
PPS: 50, NYHA Class III
Rx: Furosemide, captopril, potassium, albuterol and ipratropium, Ibuprofen, levothyroxine, miralax, O2, oxycodone, lorazepam

PC Plan:
R.N.: CV assessment, CHF teaching, dyspnea/pain, **emergency mgmt plan**
S.W.: Community resources, PERS, caregiving & homemaking referrals, support
P.T: Safety, transfers, strengthening
O.T.: Energy conservation, adaptive equipment, ADL assessment, incontinence
HHA: Bathing, skin care, asst with anti-embolism stockings, weights

Interdisciplinary collaboration, PCP & Medical Director

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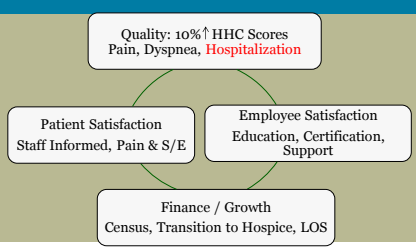
Outcome Measures



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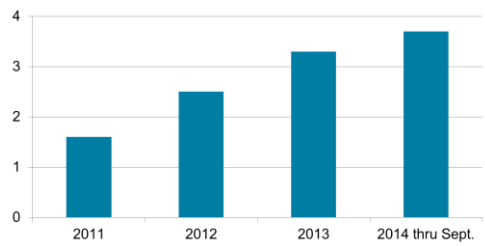
Growth in Home Care Palliative Care



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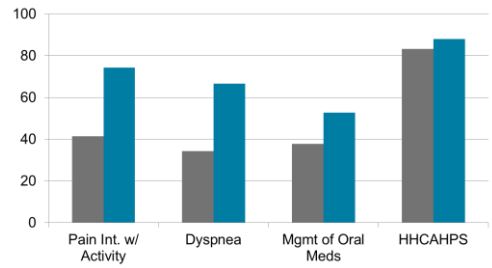
Quality & Patient Satisfaction Outcomes



2014 Quarterly Scores

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Readmission Reduction Committee: Hospital

Literature Review & Best Practice Examples

Data Analysis: BOOST Tool, Pathways Analysis

Findings: * COPD & Pneumonia accounted for 79% of readmissions within 30 days;
* 14 patients accounted for 10% of readmissions in 12 months
* Every patient had a social, financial or transportation concern

Interventions: Medication Reconciliation

Motivational Interviewing Education:
Multi-disciplinary Cross Continuum Team

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Readmission Reduction Committee: VNA

Literature Review & Best Practice Examples

Data Analysis: SHP Data: Transfers, VNA Resumption of Care

Findings: * COPD & CHF were primary diagnoses in patients readmitted to the hospital
* COPD 11.3% Palliative Care / 4.8% Clinical
* CHF 14% Palliative Care / 5.3% Clinical

Interventions: Focus on Palliative Care patients / family
Management of Dyspnea and Anxiety
Telehealth and Telecommunications
COPD/ACH Staff Education
Transfer patients to Hospice

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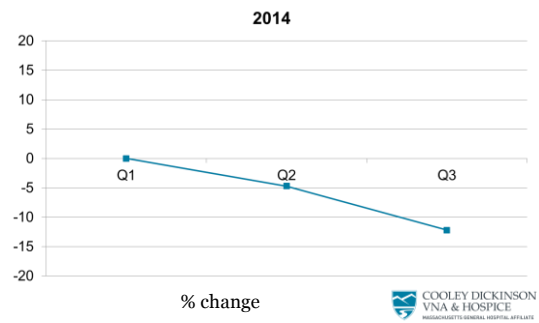
Reduction of Acute Care Hospitalization



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Transition to Hospice

FY2013	PC → HS	33%
FY2014	PC → HS	42%

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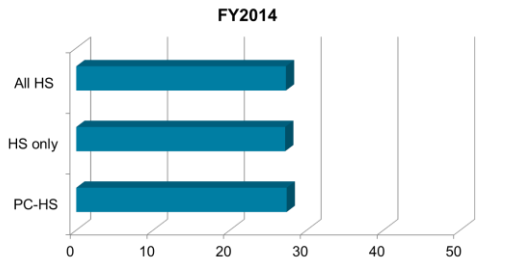
Hospice LOS: Length of Stay



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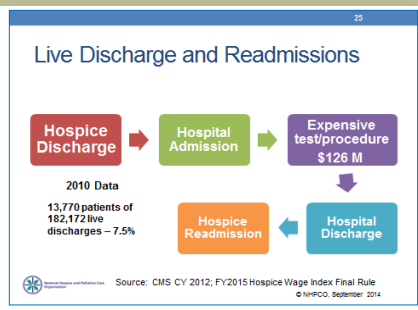
Hospice Discharge and Hospitalization



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2010-2014 What we did to grow Cross Continuum Programs

- Changed CDH Palliative Physician Model to Staff Model
- Adding full-time NP
- Responded to CAPC info by creating Community Education Model
- Utilized PFAC Members as Community Ambassadors
- Led MOLST Roll-Out
- Presented Statewide on Palliative Programs at CDHC/VNAH

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2010-2014 What we did to grow Cross Continuum Programs

- Educated Community on Care Choices
- Educated cross-continuum groups on motivational interviewing to decrease readmission
- Trained on motivational interviewing
- Increased Hospice presence in SNFs

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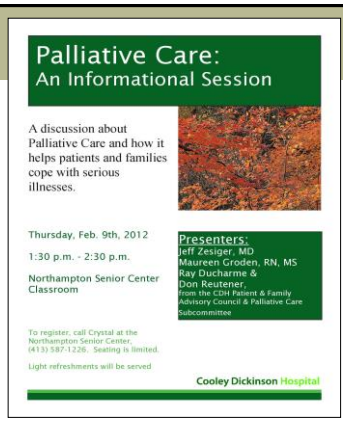
Palliative Care:
An Informational Session

A discussion about Palliative Care and how it helps patients and families cope with serious illnesses.

Thursday, Feb. 9th, 2012

1:30 p.m. - 2:30 p.m.

Northampton Senior Center Classroom

Presenters:
Jeff Zesiger, MD
Maureen Groden, RN, MS
Ray Ducharme &
Don Reutener,
From the CDH Patient & Family Advisory Council & Palliative Care Subcommittee

To register, call Crystal at the Northampton Senior Center, (413) 587-1228. Seating is limited.

Light refreshments will be served

Cooley Dickinson Hospital

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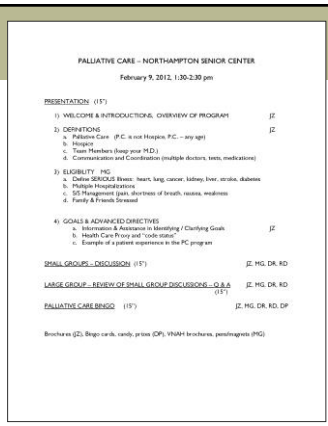
PALLIATIVE CARE – NORTHAMPTON SENIOR CENTER

February 9, 2012, 1:30-2:30 pm

PRESENTATION (15')

1) WELCOME & INTRODUCTIONS, OVERVIEW OF PROGRAM — JZ

2) DEFINITIONS — JZ
   a. Palliative Care (P.C. is not Hospice, P.C. – any age)
   b. Hospice
   c. Team Members (keep your M.D.)
   d. Communication and Coordination (multiple doctors, tests, medications)

3) ELIGIBILITY MG
   a. Define SERIOUS Illness: heart, lung, cancer, kidney, liver, stroke, diabetes
   b. Multiple Hospitalizations
   c. S/S Management (pain, shortness of breath, nausea, weakness
   d. Family & Friends Stressed

4) GOALS & ADVANCED DIRECTIVES
   a. Information & Assistance in Identifying / Clarifying Goals — JZ
   b. Health Care Proxy and "code status"
   c. Example of a patient experience in the PC program

SMALL GROUPS – DISCUSSION (15') — JZ, MG, DR, RD

LARGE GROUP – REVIEW OF SMALL GROUP DISCUSSIONS – Q & A (15') — JZ, MG, DR, RD

PALLIATIVE CARE BINGO (15') — JZ, MG, DR, RD, DP

Brochures (JZ), Bingo cards, candy, prizes (DP), VNAH brochures, pens/magnets (MG)

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2012-2013 Community Presentations

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2012-2013 Community Presentations

The Conversation Continues: Nuts and Bolts of End of Life Care. Introducing MOLST to the Community

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MOLST Roll-Out

- Video made to Train Physicians in MOLST Conversation
- Patients/Community members must be trained to participate in MOLST discussions if they are to receive the care they want
- Video is being used to train community members to be active participants in MOLST conversations
  - Senior Centers
  - ALFs
  - Independent Living Facilities
  - Website for video http://www.cooley-dickinson.org/main/media/10.aspx

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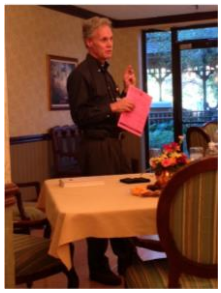
Community MOLST Presentation



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Community Dialogue on End of Life Choices 2014

Taking Control Over Your End if Life

- Community Dialogue with over 150 participants
- MOLST Completion
- VSED
- "Is it ethical to stop feeding my demented mother?"
- Care Choices: Ethical Decision-Making

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2014 Community Presentation

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2014 Community Presentation

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Post Acute Care Transitions Team (PACT)

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The Effect of Hospice on Hospitalizations of Nursing Home Residents

- ***Journal of the American Medical Directors Association***

Zeng, N.T. Makamel, D. B., Friedman, B. , Caprio, T. , Temken-Greener, H.

- Hospice enrollment is known to reduce risk of hospitalizations for nursing home residents who use it. We examined whether residing in facilities with a higher hospice penetration: (1) reduces hospitalization risk for nonhospice residents; and (2) decreases hospice-enrolled residents' hospitalization risk relative to hospice-enrolled residents in facilities with a lower hospice penetration.

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The Effect of Hospice on Hospitalizations of Nursing Home Residents

- **Results**
- In the last 30 days of life, 37.63% of nonhospice and 23.18% of hospice residents were hospitalized. Every 10% increase in hospice penetration leads to a reduction in hospitalization risk of 5.1% for nonhospice residents and 4.8% for hospice-enrolled residents.
- **Conclusions**
- Higher facility-level hospice penetration reduces hospitalization risk for both nonhospice and hospice-enrolled residents. The findings shed light on nursing home end-of-life care delivery, collaboration among providers, and cost benefit analysis of hospice care.

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Final Thoughts

"We work cooperatively with staff members of the committee to revise printed material available to the community and present information at forums held at Senior Centers and other locations serving elderly populations. The forums have been very successful and we enjoy interacting with those attending the sessions"

Howard, Ray, Don

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Questions?

References:

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- National Consensus Project for Quality Palliative Care. (2013). www.nationalconsensusproject.org/
- Temel, J.S. et al. (2010) *Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer*. New England Journal of Medicine, 363, 733-742.

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Leveraging Palliative Care: A Hospital to Home Based Approach

Presented by:
Robin Hynds, Lawrence General Hospital
Diane Martin, Greater Lawrence Family Health Center
Sarah Plante, Lawrence General Hospital

Lawrence General Hospital

Greater Lawrence Family Health Center

So good. So caring. So close.

Objectives

- Describe processes to engage high risk patients in care across continuum
- Describe processes for better coordination, decreased readmissions and attainment of Patient Centered Medical Home (PCMH) status
- Define how palliative care was utilized to meet triple aim goals

Lawrence General Hospital

History Lawrence General & Greater Lawrence Family Health Center

- **Disparate organizations but similar goals, mission and values**
  - Collaborated closely for more than 25 years
  - Work cooperatively with the City of Lawrence and Department of Public Health
    - focused programs on reducing obesity and the incidence of diabetes
- **Greater Lawrence Family Health Center (GLFHC)**
  - Independent Section 330 federally qualified health center, and NCQA Level 3 Patient Centered Medical Home
  - Has four sites within the City of Lawrence
  - Flagship site adjacent to the hospital campus
  - A fifth site, co-located inside LGH
  - Provides primary care for more than 50,000 residents of the Greater Lawrence community
    - 80% admitted to LGH
  - Operates a 30-resident Lawrence Family Practice Residency jointly with the Hospital

Lawrence General Hospital

Opportunity to Work Closer Together

- **Waiver through Centers Medicare and Medicaid Services (CMS) and Executive Office Health Human Services (EOHHS)**
  - Disproportionate Shared Hospital & Safety Net Providers
  - Serve patients who otherwise cannot afford or gain access to care
    - Higher proportion of Medicaid patients
- **Transformation of health care and triple aim goal**
  - Better health
    - Readmission reduction
    - Care coordination enhancements
  - Better experience
    - Increased access to needed services in local community (PCP, Specialists etc.)
    - Seamless transitions
  - Lower cost
    - Utilization of appropriate services

Lawrence General Hospital

The Journey Begins…

- **Root Cause Analysis**
  - Interdisciplinary analysis of readmission data (50 charts)
  - Revealed key contributing factors
    - Communication failures
    - Medication compliance failures
    - Post-hospitalization care coordination failures
    - Lack of addressing social determinants of health
    - End of life care challenges
      - 40% could benefit from Palliative Care
  - Diabetes, CHF and COPD large proportion of shared patients
    - Monitor rates of top diagnoses to measure effectiveness of interventions

Lawrence General Hospital

"Bringing the PCMH to the Bedside"

Lawrence General Hospital

How did we get there?

- Created a joint team
- Job shadowing
  - observed gaps in patient
  - disconnect during transition of care
- Identified barriers
  - Cultural
  - Language
  - Communication (2 separate EHR)
- Identified roles
  - Clinical Nurse Leaders (CNLs)
  - Clinical Care Nurse Coordinators (CCNCs)
  - Clinical Pharmacist

Lawrence General Hospital

Created Improvement Plan

- Care Mapping
  - Identify GLFHC patients on admission
  - Shared access to both EHR
  - Risk stratify patients
  - Warm handoffs during Transition of Care
    - -TOC note developed
    - -Documentation in both EHR
    - -Outreach by CCNC and Clinical Pharmacist
    - -Ensure PCP follow up

Risk Level	Criteria	TOC Recommendations:
Level 1a.	• DKA (Diabetic Ketoacidosis) • "Diabetic HHS" or "HHS" (Diabetic Hyperglycemic Hyperosmolar Syndrome) • Newly diagnosed Type 1DM • Initiation of insulin for home, or change in home insulin regimen from once daily insulin injection to multiple daily insulin injections • Gestational Diabetes: new diagnosis or change in treatment regime • Recurrent Hypoglycemic events, Hypoglycemic unawareness or patient needed glucagon to treat	1a. STAT DSME w/in 4 days of discharge if d/c'd to home without VNA services
Level 1b.	• Uncontrolled DM with one or more of the following: A. A1C ≥ 11 B. Complex medical needs requiring close supervision (such as status post surgery, initiation of corticosteroids, and other conditions) • Newly diagnosed Type 2 DM (NOT on insulin) • Patient who meets high risk criteria as above but is discharged with VNA services other than HHVNA	1b. DSME on same day as f/u hosp w/PCP if possible, but w/in 10 days of discharge unless receiving DSME through Home Health VNA
Level 2	• DM w/A1C ≥7* but <11 • DSME Referral in Centricity **or** No referral in Centricity • Patient who meets high risk criteria as above but is discharged to Long Term Care Hospital, Skilled Nursing Facility, Rehab, Inpatient Psychiatric or other temporary care facility • Patients who are d/c'd from HHVNA and who received DSME support at home	Next Available DSME; for patients discharged from LGH to temporary facility, recommend next available DSME following discharge from temporary facility and/or HHVNA service
Level 3	• DM w/A1C ≥ 8* • DSME Referral in Centricity **or** No referral in Centricity	DSME at discretion of PCP at time of f/u for hospitalization

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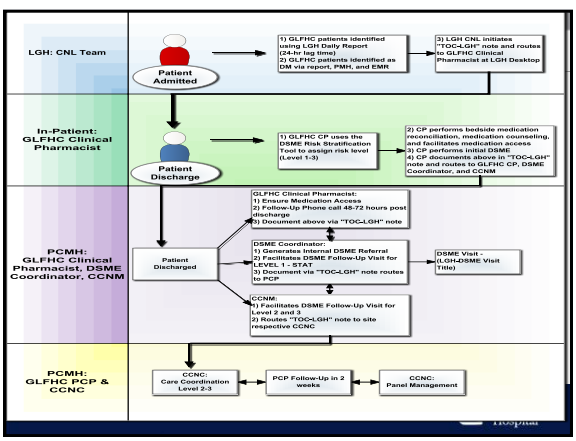

Outcomes of Care Mapping Pilot

Hospital Specific Measures

		6/1/11 - 5/31/12			6/1/12 - 5/31/13			6/1/13 - 5/31/14 Preliminary YTD		
30 Day All - Cause 18 + Diabetes Readmission Rate (6/1/13 - 2/28/14)	CMS IQR Definition Custom Report	25	140	**17.9%**	20	147	**13.6%**	8	101	**7.9%**
30 Day All - Cause 18 + Heart Failure Readmission Rate (6/1/13 - 2/28/14)	CMS IQR Definition Custom Report	87	346	**25.1%**	74	372	**19.9%**	51	303	**16.8%**

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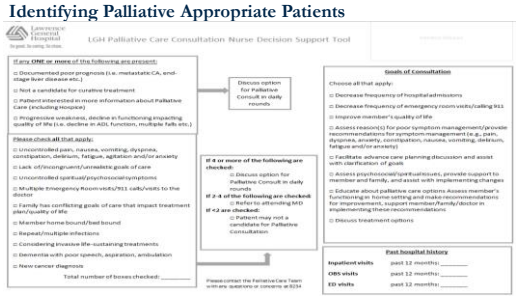
Identifying Palliative Appropriate Patients


LGH Palliative Care Consultation Nurse Decision Support Tool

If any **ONE or more** of the following are present:

- Documented poor prognosis (i.e. metastatic CA, end-stage liver disease etc.)
- Not a candidate for curative treatment
- Patient interested in more information about Palliative Care (including Hospice)
- Progressive weakness, decline in functioning impacting quality of life (i.e. decline in ADL function, multiple falls etc.)

Discuss option for Palliative Consult in daily rounds

Please check **all** that apply:

- Uncontrolled pain, nausea, vomiting, dyspnea, constipation, delirium, fatigue, agitation and/or anxiety
- Lack of/incongruent/unrealistic goals of care
- Uncontrolled spiritual/psychosocial symptoms
- Multiple Emergency Room visits/911 calls/visits to the doctor
- Family has conflicting goals of care that impact treatment plan/quality of life
- Member home bound/bed bound
- Repeat/multiple infections
- Considering invasive life-sustaining treatments
- Dementia with poor speech, aspiration, ambulation
- New cancer diagnosis

Total number of boxes checked: _____

If 4 or more of the following are checked:
- Discuss option for Palliative Consult in daily rounds

If 2-4 of the following are checked:
- Refer to attending MD

If <2 are checked:
- Patient may not a candidate for Palliative consultation

Please contact the Palliative Care Team with any questions or concerns at 8234

Goals of Consultation

Choose all that apply:

- Decrease frequency of hospital admissions
- Decrease frequency of emergency room visits/calling 911
- Improve member's quality of life
- Assess reason(s) for poor symptom management/provide recommendations for symptom management (e.g., pain, dyspnea, anxiety, constipation, nausea, vomiting, delirium, fatigue and/or anxiety)
- Facilitate advance care planning discussion and assist with clarification of goals
- Assess psychosocial/spiritual issues, provide support to member and family, and assist with implementing changes
- Educate about palliative care options Assess member's functioning in home setting and make recommendations for improvement, support member/family/doctor in implementing these recommendations
- Discuss treatment options

Past hospital history

Inpatient visits	past 12 months: _____
OBS visits	past 12 months: _____
ED visits	past 12 months: _____

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Interventions for Palliative Care Patients

- **Medication Reconciliation**
- **MOLST**
- **End-of-life wishes**
- **Health care proxy**
- **Follow-up appointments**
- **Outpatient palliative management**

All with the goal of:

- **Decreasing frequency of hospital admissions/ ED visits**
- **Improvement in quality of life**
- **Symptom management**
- **Education about palliative care options**
- **Support for psycho-social, spiritual and family issues**
- **Discuss treatment options**

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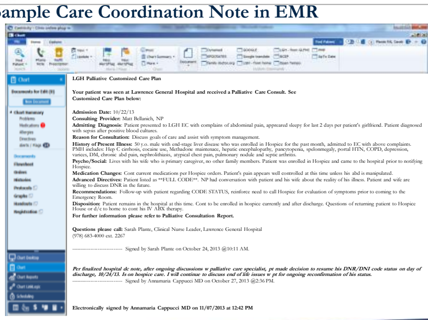
Sample Care Coordination Note in EMR



LGH Palliative Customized Care Plan

Your patient was seen at Lawrence General Hospital and received a Palliative Care Consult. See Customized Care Plan below:

Admission Date: 10/22/13
Consulting Provider: Matt Bellanich, NP
Admitting Diagnosis: Patient presented to LGH EC with complains of abdominal pain, appreared sleepy for last 2 days per patient's girlfriend. Patient diagnosed with sepsis after positive blood cultures.
Reason for Consultation: Discuss goals of care and assist with symptom management.
History of Present Illness: 50 y.o. male with end-stage liver disease who was enrolled in Hospice for the past month, admitted to EC with above complaints. PMH includes: Hep C cirrhosis, cocaine use, Methadone maintenace, hepatic encephalopathy, pancytopenia, spelonmegaly, portal HTN, COPD, depression, varices, DM, chronic abd pain, nephrolithiasis, atypical chest pain, pulmonary nodule and septic arthritis.
Psycho/Social: Lives with his wife who is primary caregiver, no other family members. Patient was enrolled in Hospice and came to the hospital prior to notifying Hospice.
Medication Changes: Cont current medications per Hospice orders. Patient's pain appears well controlled at this time unless his abd is manipulated.
Advanced Directives: Patient listed as **FULL CODE**. NP had conversation with patient and his wife about the reality of his illness. Patient and wife are willing to discuss DNR in the future.
Recommendations: Follow-up with patient regarding CODE STATUS, reinforce need to call Hospice for evaluation of symptoms prior to coming to the Emergency Room.
Disposition: Patient remains in the hospital at this time. Cont to be enrolled in hospice currently and after discharge. Questions of returning patient to Hospice House or d/c to home to cont his IV ABX therapy.
For further information please refer to Palliative Consultation Report.

Questions please call: Sarah Plante, Clinical Nurse Leader, Lawrence General Hospital
(978) 683-4000 ext. 2267

---------------------------- Signed by Sarah Plante on October 24, 2013 @10:11 AM.

Per finalized hospital dc note, after ongoing discussions w palliative care specialist, pt made decision to resume his DNR/DNI code status on day of discharge, 10/24/13. Is on hospice care. I will continue to discuss end of life issues w pt for ongoing reconfirmation of his status.
---------------------------- Signed by Annamaria Cappucci MD on October 27, 2013 @2:36 PM.

Electronically signed by Annamaria Cappucci MD on 11/07/2013 at 12:42 PM

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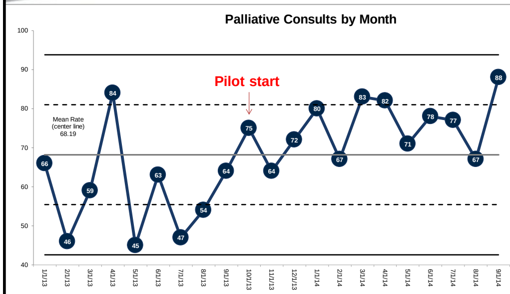

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Meaningful Care Coordination

Admission Month	Total Patients Age 55 and Over Screened for Palliative Consult	Total Palliative Care Consults Ordered and Coordinated with PCMH	% of Screened Patients with Palliative Care Coordination
Oct-13	150	8	5.3%
Nov-13	149	7	4.7%
Dec-13	144	12	8.3%
Jan-14	162	15	9.3%
Feb-14	157	11	7.0%
Mar-14	133	11	8.3%
Apr-14	159	9	5.7%
May-14	175	6	3.4%
Jun-14	130	11	8.5%
June '14			
Total (July 1, 2013 - June 30, 2014)	1359	90	6.6%

* All patients age 55 and over are screened for Palliative Consult using an evidence-based "Trigger Tool". Attending physician notified of qualifying criteria and decided whether consult would be beneficial on an individual basis based on conversation with the patient and family. Care Coordination consists of a Customized Palliative Care Plan documented in EHR.

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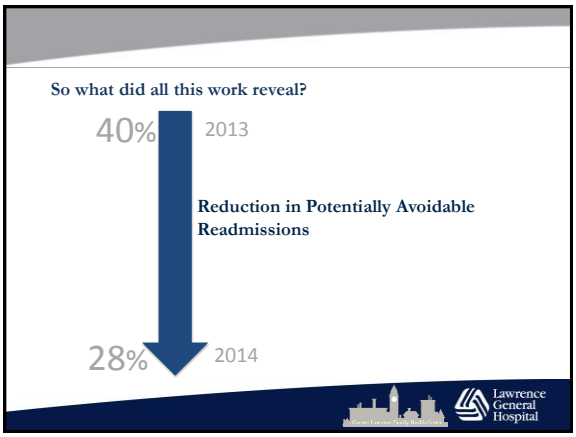
So what did all this work reveal?
40%
2013
Reduction in Potentially Avoidable Readmissions
28%
2014
Lawrence General Hospital