Completing the Transition: Role of Community Care Settings

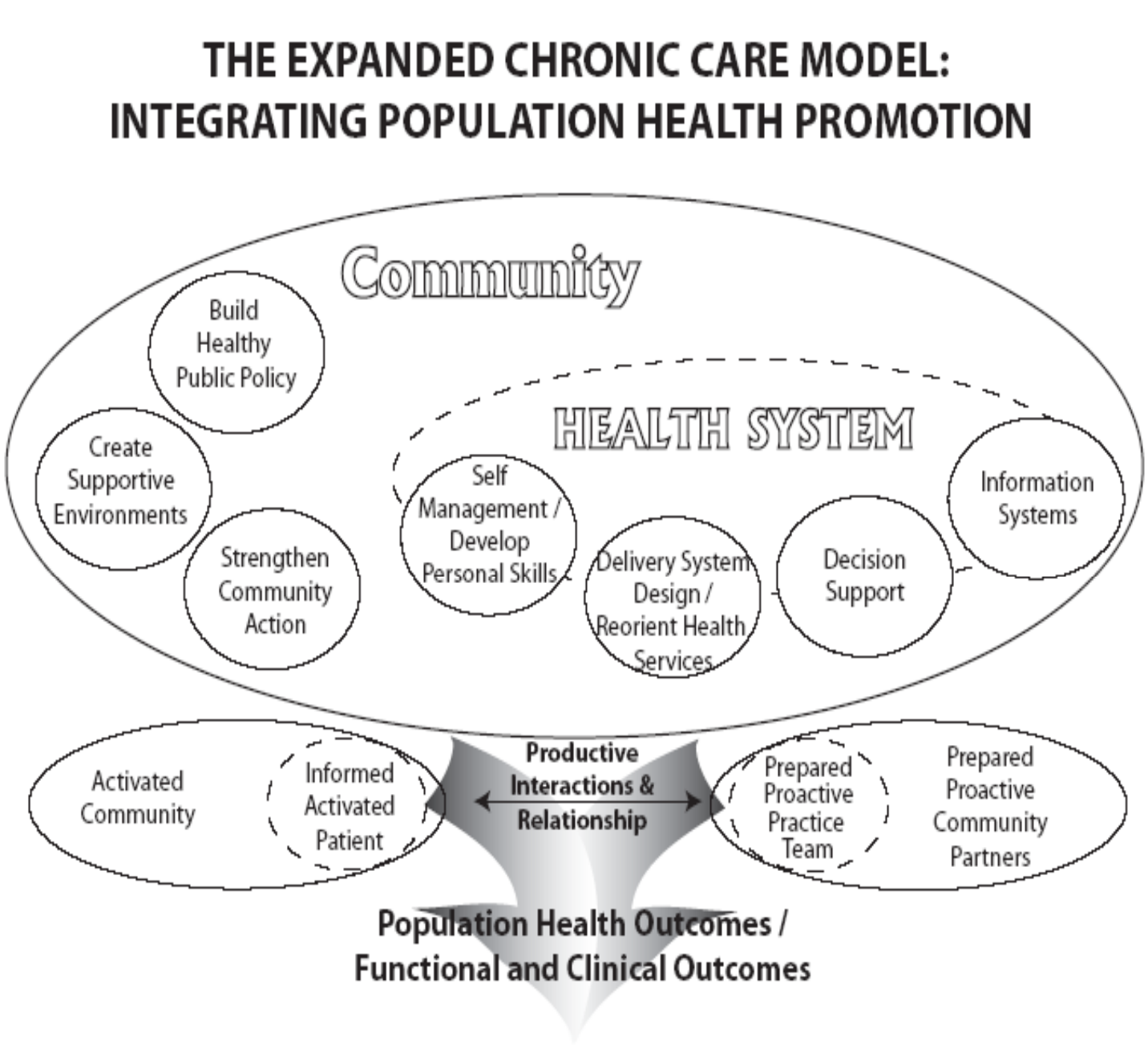
Robert Schreiber, MD, February 4th, Framingham MA

"This presenter has nothing to disclose."

Session Objectives

Participants will be able to:

- Provide an overview of the role community providers can play in improving transitions in care.
- Indentify opportunities for enhancing care coordination with: Home Care Organizations; Community-Based Service Organizations; Skilled Nursing Facilities; Physician Office Practices and Clinics; and Palliative Care Programs and Services.



The Expanded Chronic Care Model, (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).

- System and contractual integration becomes clinical integration

- OPT-IN Optimum Performance Standards for Care Transition To and From Home Care

- Shared use of clinical pathways, teach back and other risk screening tools

- Better patient care!!! Reduced readmissions!!

HOME CARE ALLIANCE of MASSACHUSETTS
www.thinkhomecare.org

Contact Info:
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Community Care Linkages

Community Care Linkages is a strategic initiative to effectively integrate services of the Massachusetts *Aging Services Access Points (ASAPs)* into the evolving healthcare delivery system.

Who are the MA ASAPs?

- 27 Not-for-Profit Organizations
- A 35 year old statewide network linking community resources to individuals and their families
- Managing 70,000 covered lives annually in home care programs (Over $350m of services across MA)
- Bring value to evolving community based health care systems.

www.Communitycarelinkages.org
www.masshomecare.org

ASAPs Capabilities

- Statewide, interdisciplinary, experienced care management infrastructure and vendor network
  - entry point for community supports for adults with chronic conditions and their caregivers
  - eyes and ears in the home & community
- 103 Coleman-Model Transition Coaches trained
- Options Counseling
  - Educate consumers and families about community resources during hospital, SNF and/or rehab stay
- Well positioned to support hospital, physician practice and SNF initiatives to reduce readmissions and improve care transitions

Recent comments about Options Counseling services:

…brings knowledge of community resources and public benefits and how to navigate the system. If he doesn't know he does the research quickly.

…so valuable that he can see the patient in any setting, assists in continuity of care especially for difficult, complex cases.

…provides a point of accessibility to community resources right into the hospital that we never had before

…some of these older and disabled patients usually stayed in the hospital a lot longer before Options Counseling.

ASAPs Programs and Services

Evidence Based Programs

Care Transitions (The Coleman Model)

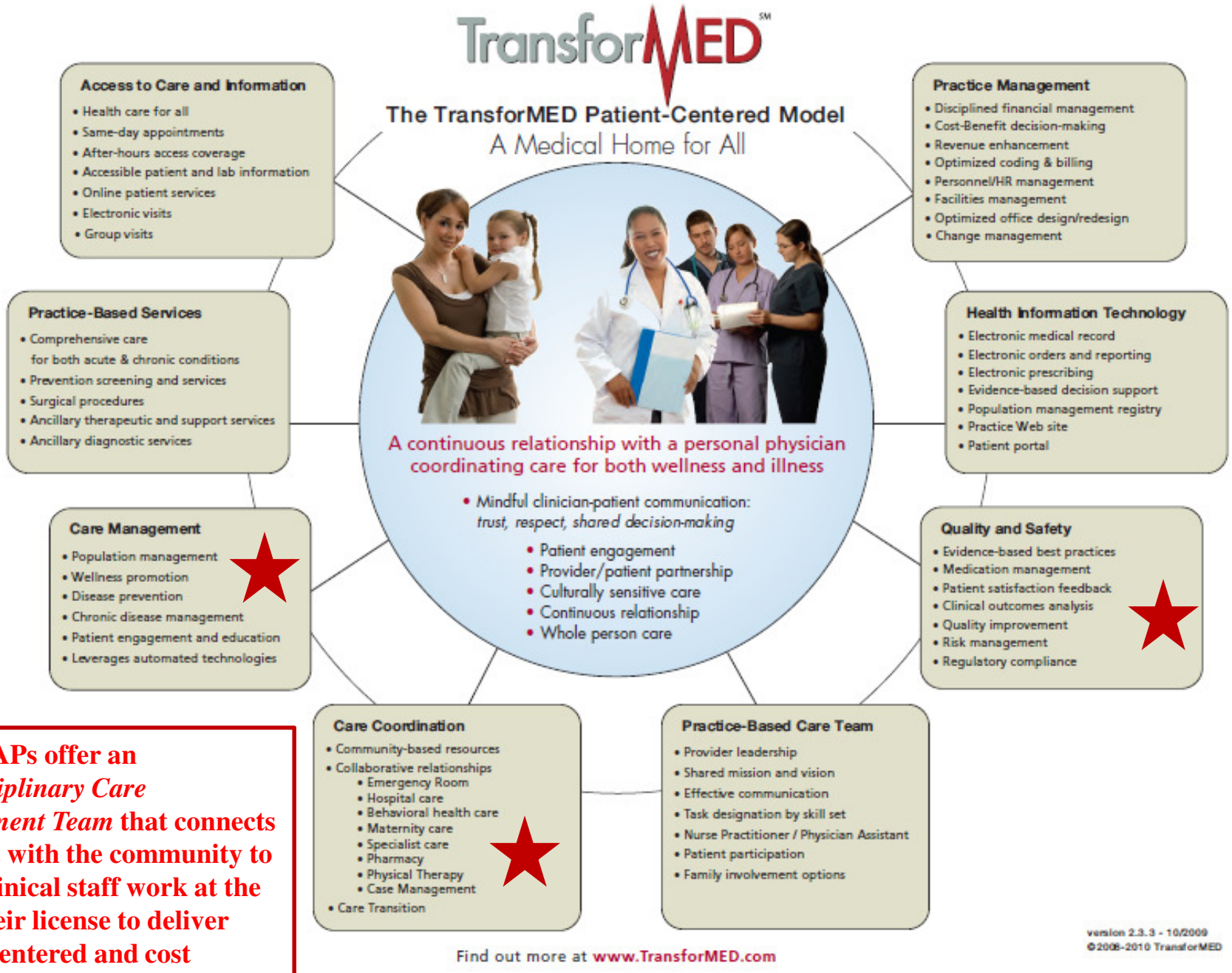
- Patient Centered
- Interdisciplinary
- Addresses continuity of care across settings and practitioners
- Uses Personal Health Record
- Teaches Self Management

Healthy Aging Programs

- Chronic Disease Self Management (Stanford Program) 176 leaders trained statewide
- Diabetes Self Management
- Mental Health and Depression Screening
- Matter of Balance Fall Prevention
- Healthy Eating
- Power Tools for Caregivers

Community-Based Supports

- Home assessments of a person's **functional** ADL's & IADL's
  - Cognition, Depression and Nutritional Screening
  - Home Safety Assessment
  - Advance Directives
- Caregiver supports
- Authorize, purchase and monitor home & community-based services (extensive vendor network)
- Medication management assistance
- Nursing Home Pre-Admission Screenings
- Counseling on Community Options
- Elder Abuse & Neglect Investigations and Intervention
- Referrals to wellness/disease prevention resources



ASAPs offer an *Interdisciplinary Care Management Team* that connects practices with the community to assure clinical staff work at the top of their license to deliver patient-centered and cost effective care.

STAAR Team Collaboration

ASAP

- Deliver care transitions services
- Provide trained coaches and Options Counselors
- Provide oversight and support while in the community
- Data sharing / confidentiality
- Meet regularly with hospital STAAR team

STAAR Team/Hospital

- Identify & refer patients based on inclusion/ exclusion criteria
- Facilitate coaches and Options Counselors doing hospital visits
- Data sharing / confidentiality
- Meet regularly with coaches and Options Counselors

Elder Services Merrimack Valley, Inc. Transition Coach Partnership with Saints Medical Center STAAR Team

A 63 year old female was referred to Elder Services for Transition Coaching from Saints Medical Center after a 2 day stay due to exacerbation of COPD. Additional diagnoses include: HTN, Depression, Anxiety, obesity and new diagnosis of CHF. After review of Coleman model red flags and medications, coordination with PCP for follow up pulmonary rehab services, the Transition Coach spoke to her about attending the Chronic Disease Self Management Program that she can attend at Saints Medical Center. She has enrolled along with her sister and they are thrilled with the added support to keep her on the healthy track. She also has expressed her pleasure that the transition coach has taken such an interest in how she is doing and that she knows she has someone she can contact for support. (Refer to handout for full story)

ASAPs: Community-Based Partners

As community-based organizations, we…

- serve our clients **for life**, not episode focused.
- have a **holistic** approach to support individuals in their homes.
- serve individuals **across all care settings.**
- are the **eyes and ears** of medical professionals in the home.
- provide **one door** to many services to support individuals in their homes.*
- are the **best value** to improve the health of your community/patients.
- have served your community/patients for **30+years** and continue to do so today.
- are **partnering now**:
  - STAAR teams;
  - CCTP, Section 3026, PPACA;
  - Options Counseling;
  - Coleman Coaches; and
  - Evidence-based Health Aging Programs.

***Navigating Across Care Settings: Choices for Successful Transitions* (NACS)**

$400k AoA funding to deliver evidence-based "Coleman" Care Transition Intervention (CTI) to 300 people - elders and adults with disabilities - over two year period who have been hospitalized with congestive heart failure, chronic obstructive pulmonary disease or diabetes. Coleman Plus services provided, refer to description.

* "Vetted" network of vendors that support individuals in their homes, i.e., meals, transportation, house cleaning, home repair, etc.

Community Care Linkages

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Contact information for 27 ASAPs: www.masshomecare.org

Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

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Building Evidence

- CMS Pilot
- Commonwealth Fund Project
- Practice Change Fellowship

Purpose of the Toolkit

- Aid in the early identification of a resident change of status
- Guide staff through a comprehensive resident assessment when a change has been identified
- Improve documentation around resident change in condition
- Enhance communication with other health care providers about a resident change of status

Working Together on STAAR Cross Continuum Teams

- QI Form
- CHF materials
- Job Shadow
- Advance Directives

www.interact2.net

- About INTERACT
- INTERACT Tools
- Educational Resources
- Links to Other Resources

MA Patient-Centered Medical Home Initiative and Managing Transitions

Marge Houy, Senior Consultant
Bailit Health Purchasing, LLC

Background

- 46 primary care sites selected (list provided)
- Key program components:
  - 3-year multi-payer, multi-stakeholder initiative
  - Medical Home Facilitator support
  - Participation in 9-session Learning Collaborative
  - Enhanced data sharing with payers
  - 32 are receiving additional payments from payers and opportunity to share savings
  - Robust evaluation by UMass

Key Patient Focus and Approach to Care Management

- Identify high risk patients, including those recently hospitalized or at risk for hospitalization
- Clinical Care Management, including
  - Risk stratification and tailored interventions
  - Transition management
    - Obtaining IP admissions info from payers w/in 24 hours
    - Clinical contact within 24-hours of inpatient discharge
    - Clinical contact within 2 days of ER visit, if seen for a documented chronic illness problem

Timeline

- 11/10 through 3/11: Pre-work period
  - Building basic infrastructure, including measurement reporting capabilities
- 3/29-30: First Learning Session
  - Focus on EB care, patient-centered care and engaged leadership
- 6/29-30: Second Learning Session
  - Focus on managing high-risk patients, care transitions

STAAR-PCMHI Links

- Great opportunity for PCMHI practices to create strong linkages with STAAR hospitals. Will be trained on:
  - IHI best practices for managing transitions from hospital to practices
  - Uniform discharge form when available
  - STAAR program and opportunity to participate on local Cross Continuum Teams
- Bi-weekly PCMHI-STAAR meetings to plan and build linkages

MOLST Demonstration Update

Massachusetts STAAR Learning Session

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Center for Health Policy and Research

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Commonwealth Medicine Division

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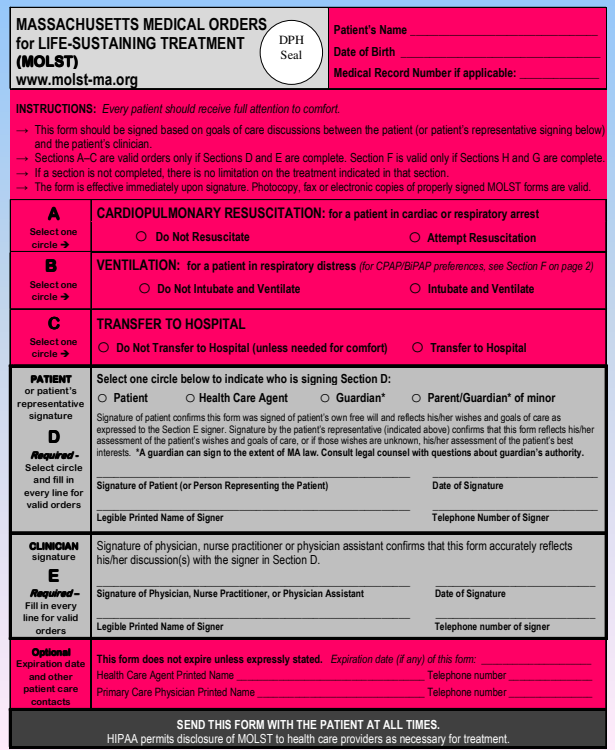
February 3, 2011



MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST)
www.molst-ma.org

DPH Seal

Patient's Name _____
Date of Birth _____
Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the patient's clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections H and G are complete.
→ If a section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A Select one circle →
CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest
○ Do Not Resuscitate ○ Attempt Resuscitation

B Select one circle →
VENTILATION: for a patient in respiratory distress *(for CPAP/BiPAP preferences, see Section F on page 2)*
○ Do Not Intubate and Ventilate ○ Intubate and Ventilate

C Select one circle →
TRANSFER TO HOSPITAL
○ Do Not Transfer to Hospital (unless needed for comfort) ○ Transfer to Hospital

PATIENT or patient's representative signature
D
Required - Select circle and fill in every line for valid orders

Select one circle below to indicate who is signing Section D:
○ Patient ○ Health Care Agent ○ Guardian* ○ Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign to the extent of MA law. Consult legal counsel with questions about guardian's authority.**

_____ _____
Signature of Patient (or Person Representing the Patient) Date of Signature
_____ _____
Legible Printed Name of Signer Telephone Number of Signer

CLINICIAN signature
E
Required – Fill in every line for valid orders

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

_____ _____
Signature of Physician, Nurse Practitioner, or Physician Assistant Date of Signature
_____ _____
Legible Printed Name of Signer Telephone number of signer

Optional Expiration date and other patient care contacts

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____
Health Care Agent Printed Name _____ Telephone number _____
Primary Care Physician Printed Name _____ Telephone number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

What is ***MOLST*** in Massachusetts**?**

- A way to help patients with serious advancing illness communicate their end of life treatment preferences *across all care settings*
- Results from the process of shared medical decision-making about life-sustaining medical treatments
- A standardized form (bright pink) for writing medical orders
- An appropriate way to meet the standard of care for honoring patient preferences about end-of-life care

MOLST Demonstration Project

- Focused on a region of the Commonwealth (Greater Worcester)
- Included nine settings across the continuum of care, where patients enter and transition through the health care system
- Settings included:
  - Acute Care
  - Primary Managed Care
  - Emergency Medical Services
  - Nursing Homes, Home Health, Hospice Care
- MOLST form implemented April 1, 2010

How Does MOLST Help to Avoid Unnecessary Re-Hospitalizations?

- Improves coordination of care during serious illness: documents preferences, at the appropriate time, for life-sustaining treatment in *all* settings
- May present earlier opportunity for palliative care or hospice discussion and referral
- Includes Do Not Hospitalize option
- Transported with patient during every care transition
- EMTs authorized to honor as medical orders

Status of Demonstration Project

- Not yet available for statewide implementation – final report for EOHHS Secretary Bigby in progress
- Seeking funding beyond June 2011 for expansion throughout Massachusetts
- Preparation for MOLST:
  - Identify a champion
  - Assemble a task force
  - Educate administrators about MOLST
  - Begin review of related policies &procedures
    - Limitation of Rx; health care proxy, advance directive; advance care planning; informed consent; withdrawal of Rx
  - See MOLST website: **www.molst-ma.org**