IMPROVING CROSS-SETTING CARE

Creating partnerships between “senders” and “receivers”

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Collaborative Healthcare Strategies
Lexington MA
Objectives

• Identify 3 specific examples of collaborative efforts across settings to reduce readmissions

• Identify 3 ways hospitals, post-acute, and community provider/agencies can collaborate to improve care across settings to reduce readmissions

• Identify 3 specific actions that your organization can take to initiate or strengthen efforts to improve care across settings to reduce readmissions
Agenda

• Examples of cross-setting collaboration
  • Build on examples from panel
  • Invite examples from the audience

• Table work
  • Please pull out “table work” packet

• Report out next steps
  • Audience shares 1-3 specific actions to build cross-setting collaboration
COLLABORATION ACROSS SETTINGS

5 specific examples
<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital - SNF</td>
<td>Warm handoffs</td>
</tr>
<tr>
<td>SNF - ED</td>
<td>INTERACT packet</td>
</tr>
<tr>
<td>ED - SNF</td>
<td>Treat-and-Return</td>
</tr>
<tr>
<td>Hospital - PCP &amp; Specialists</td>
<td>Doc-to-doc handoff platform</td>
</tr>
<tr>
<td>Hospital - PCP</td>
<td>“Receiver-redesigned” d/c summaries</td>
</tr>
<tr>
<td>Hospital – Social/Elder Services</td>
<td>Co-locate liaison, include in rounds</td>
</tr>
<tr>
<td>ED - Community Mental Health</td>
<td>Effective linkage to services</td>
</tr>
<tr>
<td>ED – Community Mental Health</td>
<td>Timely triage to post-ED care</td>
</tr>
<tr>
<td>ED – County Public Health</td>
<td>Directly connect with service</td>
</tr>
<tr>
<td>Hospital – PAC &amp; agencies</td>
<td>Cross-continuum team meetings</td>
</tr>
</tbody>
</table>
Example 1: Hospital to SNF Warm Handoffs
Carolinas HealthCare “SNF Circle Back”

- Problem: early readmissions from SNF
- Test:
  - warm handoffs to SNF
  - Call back to SNF 3-24 hours after transfer to answer questions
- Details:
  - RCA revealed SNF-readmission patterns
  - Hospital readmission champion met with SNFs to discuss shared goals
  - Hospital (with some leadership effort) asked SNF to participate in this communication
  - RN calls nurse at SNF
  - SW or care coordinator calls for follow up clarification 3-24 hours after transfer
  - Daily workflow (with some modifications for weekends, done next business day)
  - Follow up calls are scripted and documented in Allscripts system
  - Pilot on paper with 1 RN and 1 SW
  - Pilot expanded to RN call report to SNF
  - Pilot expanded to add follow up calls
  - Pilot expanded to build questions into Allscripts
  - Expand to all; new standard of practice

Source: Emily Skinner, Carolinas Healthcare System
Example 1: Hospital to SNF Warm Handoffs
Carolinas HealthCare “SNF Circle Back”

SNF Circle Back Questions
1. Did the patient arrive safely?
2. Did you find admission packet in order?
3. Were the medication orders correct?
4. Does the patient’s presentation reflect the information you received?
5. Is patient and/or family satisfied with the transition from the hospital to your facility?
6. Have we provided you everything you need to provide excellent care to the patient?

Insights
- Transitions are a PROCESS (forms are useful, but only a tool to achieve intent)
- Best done ITERATIVELY with COMMUNICATION

Source: Emily Skinner, Carolinas Healthcare System
Example 2: SNF to ED
INTERACT: Interventions to Reduce Acute Care Transfers

Stop and Watch
Early Warning Tool

If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

STOP

Seems different than usual
Talks or communicates less
Overall needs more help

WATCH

Pain – new or worsening; Participated less in activity
Ate less
No bowel movement in 3 days; or diarrhea

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition

Help with walking, transferring, toileting more than usual

SBAR Communication Form
and Progress Note

Before Calling MD / NP / PA:
☐ Evaluate the resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate; temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
☐ Review Record: Recent progress notes, labs, orders
☐ Review an INTERACT Care Plan or Acute Change in Condition File Card, if indicated
☐ Have Relevant Information Available when Reporting
(i.e. medical record, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION
The change in condition, symptoms, or signs I am calling about is/are __________________________________________________________

This started on ________/______/______ Since this started it gotten:  ☐ Worse  ☐ Better  ☐ Stayed the same

Things that make the condition or symptom worse are __________________________________________________________

Things that make the condition or symptom better are __________________________________________________________

This condition, symptom, or sign has occurred before:  ☐ Yes  ☐ No

Treatment for last episode (if applicable) __________________________________________________________

Other relevant information __________________________________________________________

BACKGROUND

Resident Description
This resident is in the NH for:  ☐ Post-Acute Care  ☐ Long-Term Care
Acute Care Transfer Document Checklist

Resident Name: ____________________________________________
Facility Name: ____________________________________________ Tel: ______________________

Copies of Documents Sent with Resident (check all that apply)

- ____________________ Resident Transfer Form
- ____________________ Face Sheet
- ____________________ Current Medication List or Current MAR
- ____________________ SBAR and/or other Change in Condition Progress Note (if col)
- ____________________ Advance Directives (Durable Power of Attorney for Health Care)
- ____________________ Advance Care Orders (POLST, MOLST, POST, others)

Send These Documents if indicated:

- ____________________ Most Recent History and Physical
- ____________________ Recent Hospital Discharge Summary
- ____________________ Recent MD/NP/PA and Specialist Orders
- ____________________ Flow Sheets (e.g. diabetic, wound care)
- ____________________ Relevant Lab Results (from the last 1-3 months)
- ____________________ Relevant X-Rays and other Diagnostic Test Results
- ____________________ Nursing Home Capabilities Checklist (if not already at hospital)

Emergency Department:
Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

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Nursing Home to Hospital Transfer Form

<table>
<thead>
<tr>
<th>Who to Call to Get Questions Answered about the Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name / Title: _____________ Tel: ________</td>
</tr>
<tr>
<td>Reason(s) for transfer: __________________________________</td>
</tr>
<tr>
<td>Is the primary reason for transfer for diagnostic testing, not admission:</td>
</tr>
<tr>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>Relevant diagnosis: CHF COPD COP CHF DM Ca (active treatment): Dementia ☐ Other</td>
</tr>
<tr>
<td>Vital Signs: BP HR RR NPI</td>
</tr>
<tr>
<td>Most recent pain level: __________________ (or ☐ N/A)</td>
</tr>
<tr>
<td>Most recent pain med: __________________</td>
</tr>
<tr>
<td>Time(s): Time taken (am/pm): __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Usual Mental Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alert, oriented, follows instructions</td>
</tr>
<tr>
<td>☐ Alert, disoriented, but can follow simple instructions</td>
</tr>
<tr>
<td>☐ Alert, disoriented, but cannot follow simple instructions</td>
</tr>
<tr>
<td>☐ Not Alert:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Usual Functional Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ambulates independently</td>
</tr>
<tr>
<td>☐ Ambulates with assistance</td>
</tr>
<tr>
<td>☐ Ambulates with assistive device</td>
</tr>
<tr>
<td>☐ Not ambulatory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Clinical Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ SBAR Acute Change in Condition Note included</td>
</tr>
<tr>
<td>☐ Other clinical notes included</td>
</tr>
</tbody>
</table>

Resident Name (last, first, middle initial): ____________________________
DOB ______/_____/______ Language: ☐ English ☐ Other

- ☐ SNF/Rehab |
- ☐ Long-term |
- Date Admitted (most recent) ______/_____/______
- ☐ Primary diagnosis: for admission

Code Status: ☐ DNR ☐ DNI ☐ DNI ☐ Full Code ☐ Uncertain
- ☐ MD ☐ NP ☐ PA (name): __________________
- Tel: ________
Example 3: ED to SNF
Treat-and-Return

- Hallmark Health System
  - 2 hospital system, 70% admits via ED, hospitalists
  - 20 ED docs, 17 PAs
- ED Chief and Champion of this work explored myths of SNFs/EDs
  - Patients only seen once a month; can’t do IVs, etc
  - “ED admits everyone”
- Actions:
  - Discussion “why”
  - Education: our capacity/their capacity
  - Simplicity: establish contacts, standard transfer information
  - Feedback
- Results: increase in number of patients transferred from ED to SNF

Source: Dr Steven Sbardella, CMO and Chief of ED
Hallmark Health System Melrose, MA
Example 4: ED – Community Behavioral Health
Effective Linkage to Services

- Started by calling a meeting
  - ED director, clinic director, BH clinic director – didn’t know each other
  - Met weekly for 8 weeks
- ED based Behavioral Health Navigator position to:
  - Facilitate reliable access to outpatient care
  - Re-design ED workflows for referrals between all 3 entities
  - Design standing orders for frequent BH ED users
  - Establish individualized care plans
- Impact: successful linkage to care for frequent users
  - 1 patient with 26 ED visits in March has had no ED visits since May!
- Time to implement: 10 weeks.

Health Alliance Hospital, Massachusetts
Example 5: ED - County Public Health

Effective Linkage to Service

- Carroll County, Maryland
- County and Hospital have a formal partnership arrangement
- Health Department deployed BH peer navigators in ED
- Navigators directly connected with & followed patients
- ~30% reduction in utilization for high utilizing BH patients
Cross-Setting Collaboration

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Specific actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician to Physician</td>
<td>Real-time communication with PCP, specialists</td>
</tr>
<tr>
<td></td>
<td>Real-time redesigned discharge summary</td>
</tr>
<tr>
<td>Hospital to SNF</td>
<td>Biweekly “virtual rounds” with shared patients</td>
</tr>
<tr>
<td></td>
<td>RN/NP/MD rounding on d/c patients in SNFs</td>
</tr>
<tr>
<td>Hospital to PAC/agency</td>
<td>“Warm contact”</td>
</tr>
<tr>
<td></td>
<td>Include liaison in pre-discharge rounds</td>
</tr>
<tr>
<td>ED - Behavioral Health</td>
<td>Biweekly huddles to assess crisis/BH availability</td>
</tr>
<tr>
<td>ED - Agency</td>
<td>Co-locating agency staff to screen/link to services</td>
</tr>
</tbody>
</table>
Tool 5: Cross-Continuum Team Inventory Tool

Forming and using a cross-continuum team is essential to meeting the innumerable post-hospital needs of your diverse patient population. Partnering with post-acute and community-based providers and agencies is a key part of optimizing the transition out of the hospital and into the next setting of care. Many hospitals have initiated cross-continuum teams composed primarily of post-acute partners; additional partners will be needed to best meet the post-hospital needs of adult Medicaid patients. Use this tool to identify which cross-continuum partners you currently engage in readmission reduction efforts and to identify additional partners to engage. As you complete this tool, capture services available and obtain a contact name.

<table>
<thead>
<tr>
<th>Cross-Setting Provider or Agency</th>
<th>Post-hospital or Ongoing Services</th>
<th>Point Person/Email/Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult day health</td>
<td></td>
<td></td>
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<tr>
<td>Adult protective services</td>
<td></td>
<td></td>
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<tr>
<td>Agencies on aging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aging and disability resource centers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health providers, crisis teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health carve-out providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health centers, federally qualified health center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community based social workers</td>
<td></td>
<td></td>
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<tr>
<td>Community corrections system</td>
<td></td>
<td></td>
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<tr>
<td>Economic/financial counseling</td>
<td></td>
<td></td>
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<tr>
<td>High-volume Medicaid medical homes</td>
<td></td>
<td></td>
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<tr>
<td>High-volume Medicaid pharmacies</td>
<td></td>
<td></td>
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<tr>
<td>Housing advocates and homeless services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal aid</td>
<td></td>
<td></td>
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<tr>
<td>Medicaid agency (state) contact</td>
<td></td>
<td></td>
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<tr>
<td>Medicaid managed care organizations</td>
<td></td>
<td></td>
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<tr>
<td>Substance abuse treatment providers</td>
<td></td>
<td></td>
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<tr>
<td>Skilled nursing facilities</td>
<td></td>
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<tr>
<td>Home health agencies</td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Pain clinic</td>
<td></td>
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<tr>
<td>Physician practices</td>
<td></td>
<td></td>
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<tr>
<td>Public health nurses</td>
<td></td>
<td></td>
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<tr>
<td>Long-term acute care hospitals</td>
<td></td>
<td></td>
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<tr>
<td>Inpatient rehabilitation facilities</td>
<td></td>
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<tr>
<td>Assisted living facilities</td>
<td></td>
<td></td>
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<tr>
<td>Housing with services</td>
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</tbody>
</table>
Know Your Cross-Continuum Partners

• While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care capabilities of area long term care facilities and to factor this knowledge into the discharge planning evaluation.

• Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient’s needs in theory, but also can be implemented.

• This includes knowledge of community services, as well as familiarity with available Medicaid home and community-based services (HCBS), since the State’s Medicaid program plays a major role in supporting post-hospital care for many patients.

From CMS Conditions of Participation May 2013
OTHER EXAMPLES OF COLLABORATION

Audience members
TABLE WORK

Refer to table work packet; discuss with colleagues at tables
Table Work Report Outs - Hospitals

• What cross-setting providers do you meet with?

• How often?

• What do you discuss?

• Who’s missing?

• What is 1 barrier to engaging with new providers?
Table Work Report Outs- SNFs

- What readmission reduction strategies does your organization implement?

- Do your referring hospitals know about this?

- Do you track readmissions? Do you share with hospitals?

- What could be improved in collaboration between hospital and SNF?

- What is 1 thing your organization can do to improve collaboration across settings?
Table Work Report Out – Home Care, Hospice

• What actions does your agency take to reduce readmissions?

• Do your referring hospitals know about this?

• Do you track readmissions? Discuss with hospitals?

• What is 1 way collaboration between your setting and other providers can be improved?
Table Work Report Out - Service Agencies

• What services does your organization offer to reduce readmissions?

• Do your area hospitals know about this?

• What is 1 way that hospitals could coordinate better with your agency?

• What is 1 way that your agency can coordinate better with hospitals?
Table Work Report Out – Plans

- What does your health plan do to reduce readmissions?

- Do the hospitals know this? How?

- Is there any coordination between providers and the plan service offerings/programs?

- What is 1 way that your organization could collaborate better with hospitals?

- What is 1 way that hospitals could collaborate better with you?
Summary Thoughts & Wrap Up
Thank you!

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