Improving Outcomes Through Re-engineered Care Transitions:

The New York Experience

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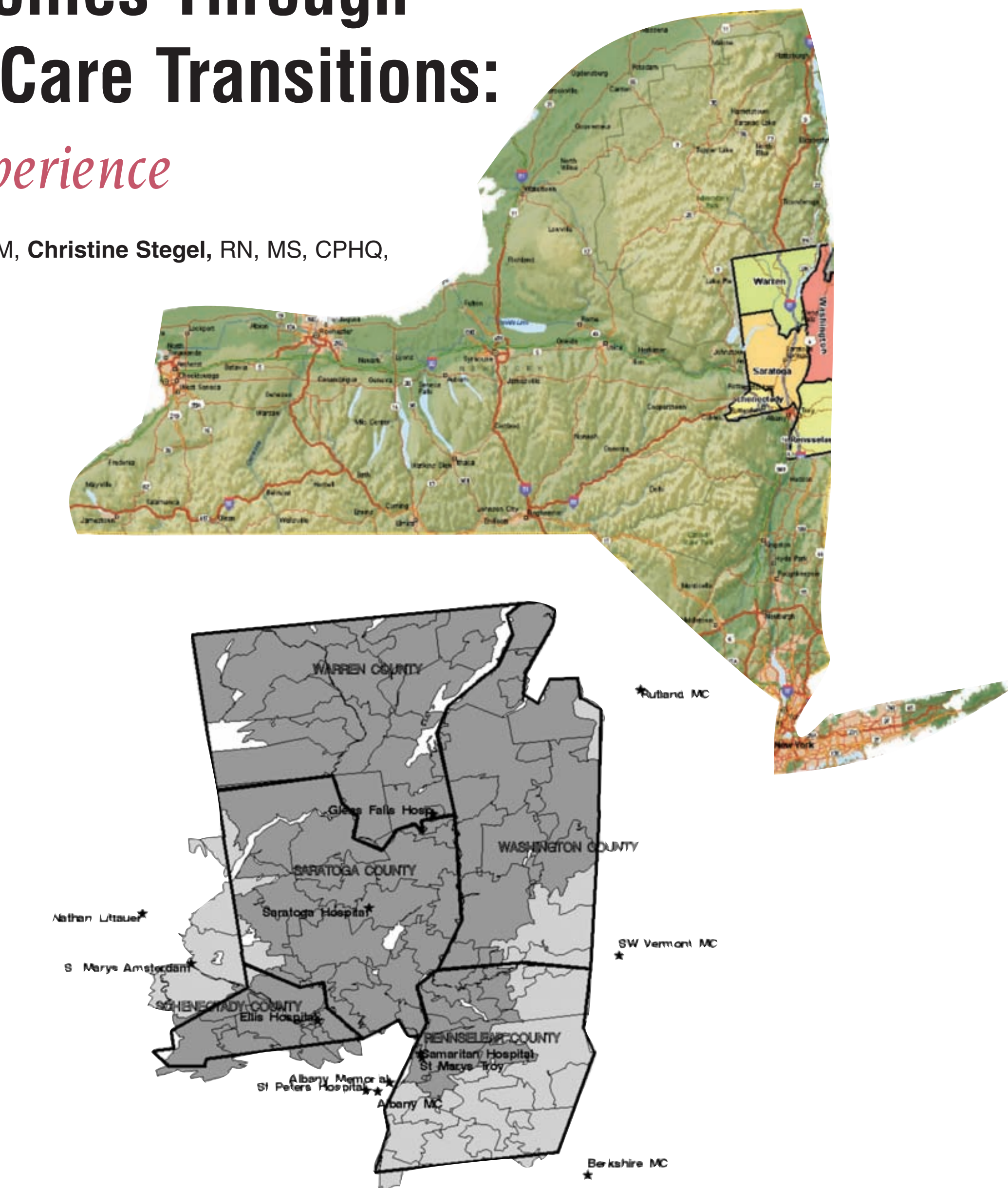
The Centers for Medicare & Medicaid Services (CMS) is funding an initiative with 14 state-based Quality Improvement Organizations (QIOs) to test a variety of interventions and approaches to improving the quality of care for Medicare beneficiaries as they transition from one setting to another. A primary objective of the Care Transitions Theme is to reduce unnecessary hospital readmissions and the resultant morbidity, mortality and quality of life issues. The project began in August 2008 and will continue through July 2011. The structure of this CMS initiative provides QIOs the flexibility to develop approaches tailored to local needs, while using evidence-based interventions to target improvement across settings.



IPRO has targeted five contiguous counties in the state's Upper Capital Region – Rensselaer, Saratoga, Schenectady, Warren and Washington – that are composed of urban, rural and suburban communities. The provider community consists of five acute care hospitals, six home health agencies, 28 nursing homes, five dialysis centers, five hospice organizations, several physician health networks and primary care practices, three major payors and two Regional Health Information Organizations (RHIOs). The region's home health agencies, which will be the focus of this article, include public health departments, private visiting nurse services, and agencies that are part of integrated health systems.

Despite this diversity, the five-county region forms a cohesive care community with common referral patterns. The region has existing coalitions and partnerships that share the common goal of improved communication and care management, as well as an interest in collaborating with IPRO and its provider community for the Care Transitions Initiative.

Within each of these communities the opportunity exists to improve care coordination across the continuum. Participating providers are focusing their efforts on the high prevalence diagnoses that are commonly linked to potentially avoidable hospital readmissions but are amenable to better care coordination – acute myocardial infarction (AMI), heart failure (HF) and pneumonia. These diagnoses are a primary focus of New York's Care Transitions Project; some providers have chosen to focus on other diagnoses as well, such as chronic obstructive pulmonary disease (COPD), end-stage renal disease (ESRD) and diabetes.

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Partnering With Providers And The Community

In addition to the providers described above, we are partnering with a number of community-based organizations to educate Medicare beneficiaries and their caregivers about how to take charge of their health care and navigate the health care system. To kick off our project, we held a special community-wide event that was attended by providers and community stakeholder representatives, with keynote speaker Carol Levine from the United Hospital Fund's Next Step In Care Program. This was preceded by a learning session, featuring care transitions experts Eric Coleman, MD, MPH, and Mary Naylor, PhD, FAAN, RN, which was attended by providers, payors, provider associations and Department of Health representatives.

The New York project plan is focused on achieving CMS goals:

- Reduce overall all-cause 30 day readmission rates by at least two percent;
- Reduce 30 day all-cause readmission rates by at least two percent for AMI, heart failure and pneumonia;
- Implement evidenced-based interventions to improve communication, transfer of information, patient/caregiver self-management and follow-up care;
- Improve patient satisfaction as measured by the Hospital Care Quality Information from the Consumer Perspective (HCAHPS) performance for discharge information and medication communication.

Based on our review of the literature and knowledge of the health care community, we decided to encourage the use of a number of priority intervention strategies by providers working with us:

- Train participants in the Care Transitions Intervention (CTI) Coach Model;
- Focus on cross-setting medication reconciliation and medication discrepancy monitoring and communication;
- Put systems into place within the acute care setting to ensure beneficiaries have a seven-day post-acute discharge physician visit incorporated into discharge instructions;
- Make follow-up phone calls post-discharge to assess compliance with medications and discharge plan;
- Utilize "Teach Back" method for patient/caregiver education;
- Stimulate development of cross-setting partnerships;
- Encourage patient/caregiver self-management;
- Facilitate assessment for palliative care management;
- Utilize telehealth for high-risk patient populations;
- Develop standardized transfer of patient information.

Home Health Agencies Come On Board

When we initiated the project, we learned that many home health agency staff had not had the opportunity to work with other local providers on care transition issues. We encouraged sharing and structured training, using the Institute for Healthcare Improvement (IHI) Collaborative Model, with three learning sessions. Our team facilitated county-specific provider meetings to support partnership development and cross -setting sharing of care coordination. The focus of these meetings was to shift the paradigm of care management away from "siloed" care delivery, to patient-centered care.

One year after our initial meeting, our six participating home health agencies shared their best practices with peers in a panel presentation during the Home Care Association of New York State Clinical and Technology Conference, demonstrating the successes achieved in improving patient outcomes and in partnering with local referral sources. We fully expect that these Care Transitions home health providers will be serving as resources for others in the state, as well as nationally, as care transition programs become more widely adopted. Following are some of the New York Care Transitions agencies' experiences so far.

Telehealth Helps Keep Patients at Home

Warren County Public Health Services CHHA, a public agency in a rural part of the region with a census of 300 patients, has found that it could reduce its rehospitalization rate from 40% to 12% and decrease its Emergency Department utilization rate by 67% for heart failure and chronic obstructive pulmonary disease patients through home telemonitoring and disease management protocols. The initiative, which started five years ago, has been expanded as part of Care Transitions to include post-coronary artery bypass graft (CABG), renal disease, atrial fibrillation and other high-risk conditions.

"The telemonitor shows patients you are connected," says Sharon Schaldone, Assistant Director of Patient Services. "You can do a lot of teaching, as well as interventions and it provides immediate feedback to the patients to engage them in their care monitoring."

The telemonitor is installed by the nurse during the second home visit. It doesn't take the place of future home visits, but is a tool for monitoring, feedback and patient education. The patient is prompted to take his or her vital signs each day, and results are sent to an agency nurse. Each primary nurse monitors his or her own patients, and uses the monitor's vitals as a tool for education. Each patient receives a phone call every day from his or her nurse, even if vital signs are stable. In addition, visits are "front loaded" the first week of Start of Care / Resumption of Care, for 2-3 visits the first week and once a week thereafter.

The agency is continuing its concentration on reducing 30-day readmissions, with additional emphasis on improvement in the 60-90 day timeframe. The Warren CHHA is also adding other respiratory and cardiac diagnoses to its rehospitalization reduction efforts.

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Hospital Liaisons Play Key Role

Warren County has a care management liaison at Glens Falls Hospital, the community hospital serving Warren and Washington counties, as does Washington County Public Health. The agencies have collaborated with each other, and with the hospital, on finding ways to reduce the hospital's 30-day readmission rates. The initial goal was to work with any patient who had a rehospitalization. The liaison also enters the medication list from the patient's home into the hospital's medical record system to assist with medication reconciliation, and is involved in preventative teaching with patient and caregivers. "We talked with patients, communicated with their physicians and tried to discover why they went back in," says Schaldone. They had a finding that was surprising to some: Depression was a major reason for rehospitalization, as patients would not admit to themselves that they had a serious chronic illness and would not take charge of their own disease management. As a result of this discovery, the agency began partnering with a master's-prepared social worker from Warren & Washington County Mental Health Group who becomes involved during the patient's acute care hospitalization period as part of the multidisciplinary team including the patient, family/caregiver, home health, and hospital representatives.

The case of a man with renal disease provides an example of how this has worked. The man was not managing his diet, his fluid levels were far too high, and he was in the hospital every two weeks. The agency got the social worker involved as well as the whole team – including the man's family. It made contracts with the patient and got him engaged in self care. "It is easier to pull everyone together when someone is in the hospital," says Schaldone. The intervention has helped this individual accept responsibility for his chronic disease and actively participate in his plan of care, which has helped him better manage his care at home.

Palliative Care: A Transitions Issue

Washington County Public Health Service is somewhat unique in that it operates both a home health agency and a hospice. Theresa Roberts, Quality Improvement Director, and Ann Reynolds, Assistant Public Health Director of Washington County, brought the two groups together to look at hospitalization issues for COPD patients.

"We found that there is a big gap between teaching about the disease process and end of life care," says Roberts. "So we brought together a multidisciplinary team to bridge that gap and offer another avenue of care for end stage patients." The multidisciplinary team includes RN, LPN, social work, spiritual care, volunteer and community mental health representatives.

The team has been able to identify many successes, such as one patient with COPD who had been in the hospital 13 times in 2009. Since palliative care was initiated he has been in the hospital far less.

The Washington County care management liaison at the hospital visits the agency's patients and investigates the causes for readmission, providing feedback to both acute care and home health providers. The liaison can make palliative care recommendations, and can engage the patient, family members and the treatment team in a discussion about care options.

Care Transitions Coaches Advocate For Follow-Up

Allison J. Wait, MS, RN, Clinical Educator and Personal Health Coach for The Eddy VNA, part of the Northeast Health network, is working in the role of Care Transitions Intervention Coach. "This is about relationship building," according to Wait. "The process of coming into and leaving the hospital is so rapid that much can be lost in translation and it is good to have someone there to educate and teach patients how to advocate." As a coach, Wait visits patients in the hospital to explain the program and her role in assisting them to better manage their care at home. A home visit is then made by the coach within 24 to 48 hours of discharge to coach the patient/caregiver through medication reconciliation, identification of red flags and personal health goals and planning for his or her physician office visit within seven days of discharge. The coach then follows the patient for a 30 day time period through a series of follow-up phone call interactions.

Patients who previously had difficulty navigating the health care system have found Wait's coaching extremely helpful. One man was in the hospital for a heart failure exacerbation, yet not fully aware that he had the condition. Wait helped him cope with an unexpected weekend hospital discharge, confusion over medications and the lack of a primary care physician to take charge of the man's care after discharge. "I did not have a doctor or know about my health until recently,"

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. *9SOW-NY-THM7.2-10-09*

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the man says. "The coach program has helped me a lot." Wait adds that seeing this patient's progress has been very rewarding.

One area in which Wait's agency has made significant progress is in getting patients to make follow up appointments within seven days of discharge. Many patients have not followed through on scheduling follow up primary care physician visits when they first get home, Wait says. "They don't understand why they need to see a doctor when they were just in the hospital." Because it can sometimes be difficult to get immediate appointments with physicians' offices, Wait scripts patients on what to say when they call, observes their call, and intervenes if necessary.

While some physician offices may not yet understand the role of the coach, Wait has gotten feedback from primary care offices that want to work more closely together on care transitions. IPRO also visits physicians and senior centers, explaining the program in more detail.

Redesigning Medication Management

Susan Ambrosy, Director of Quality Management for Seton Home Health, says that the biggest impact on care transitions issues has come from re-design of the Seton medication management process as part of an IHI initiative. The program has been enhanced through the Care Transitions Project.

If the patient being admitted is a Seton Home Health patient, the agency forwards a list of medications the patient is taking at home. This list is compared by the hospital pharmacist with admitting orders and to the data system of Health Information Xchange of New York, the local Regional Health Information Organization. The pharmacist also reviews lab data, diagnosis information and guidelines to confirm the drugs are appropriate. If there is any question, the pharmacist interviews the patient and then speaks directly with the physician to resolve the issue. Each nursing unit has a pharmacist located directly on the unit.

Upon discharge, the discharge summary, discharge orders, medication list provided by home health, and a list of active medications from the patient's hospital stay are given to the physician to review, compare and write prescriptions for discharge. The pharmacist confirms prescriptions are correct prior to the nurse giving them to the patient/family. If the patient has questions about the medications the pharmacist is brought in to address them directly, preferably with the family present.

In fall 2009, an additional step was added for patients in the Care Transitions project. The Seton Home Health office now faxes a list of all patients who will be seen the next day for home care following their hospital discharge. The pharmacist reviews all labs, tests, guidelines and the final discharge medications and enters any concerns/revisions into the computer system, so this process is completed prior to the nurse visiting the patient's home the next day.

"The home care nurse has access to the pharmacist, who can look back into the system to identify reconciled medications to address any medication issues the nurse identifies within the home setting," says Ambrosy. "The pharmacy is tracking any identified issues so they can determine the cause and intervene." Serious discrepancies are addressed with the physician. "This process has the potential to decrease the likelihood of an adverse medication event that could result in rehospitalization."

This home health agency has seen a statistically significant decrease in its OBQI Acute Care Hospitalization rate and a decrease in the number of adverse events related to emergent care for improper medication administration and medication side effects.

Prompt Home Care Intervention May Reduce Rehospitalizations

Prompt intervention with patients who have been hospitalized with heart failure is a Care Transitions emphasis of the Visiting Nurse Service of Schenectady and Saratoga Counties. "We want nurses to get to patients' homes within 24-48 hours of referrals," says Sharon Tedesco, the agency's Quality Improvement Utilization Review Manager. One way they do this is to ensure each patient has a scale to weigh him or herself, since even the slightest weight gain can indicate trouble in a heart failure patient. In many cases, the agency provides a scale, and has the patient report back on his or her weight between home visits.

The agency has also focused on improving staff assessment skills and interventions through sharing of best practice strategies and educational programs on a multidisciplinary level with staff. In addition, the agency focuses on medication reconciliation. It has worked collaboratively with Ellis Hospital, where the admission nurse records all of the patient's at-home medications. The list is reconciled at discharge, and is reviewed by one of two VNS liaison nurses, who work out of the hospital's discharge planning office. Once the patient is home, the visiting nurse reconciles the medications with those the patient has at home.

The VNS is also part of multidisciplinary rounds on the hospital's heart failure unit, where they educate patients about self-management before they go back home. The agency has been able to demonstrate improvement in its OBQI acute care hospitalization rate and continues to work towards the goal of preventing unnecessary readmissions.

Moving Forward: The Journey Continues

While IPRO's Care Transitions home health partners have taken differing approaches to reducing hospital readmissions, each agency has demonstrated that collaboration and a focused effort can make a major difference for patients across the continuum of care. The partnerships established as a result of this initiative are very strong, and we fully expect that they will continue to help the region's Medicare beneficiaries. **RR**

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