CARE TRANSITIONS
Albany Medical Center - Albany, NY

In recognition of ongoing commitment to quality, and longstanding focus on improving transitions of care.

ALBANY MED Health System

ALBANY MEDICAL CENTER

Albany Medical Center Post-Acute Care Coalition

BACKGROUND

Albany Medical Center (AMC) is the anchor of the Albany Med Health System. AMC includes a 766-bed hospital, which offers the widest range of medical and surgical services in the region, and Albany Medical College, which includes a biomedical research enterprise and the region's largest physician practice with more than 500 doctors.

As the only academic medical center within a 150-mile radius, AMC is committed to patient care, medical education, and biomedical research, serving the Capital Region's three million people.

From https://www.albanymed.org/our-story

The Agency for Healthcare Research and Quality (AHRQ) cites the main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.[1] Studies across the country show that there are sometimes gaps in communication and coordination that can put patients' health and well-being at risk when patients move from one setting or type of care to another.

The AMC Post-Acute Care Coalition (PACC) is a group of healthcare providers in the New York Capital District that collaborate with the goal to bridge communication and care coordination to ensure safer and more effective transitions of care. The PACC comprises healthcare leaders from nearly 50 skilled nursing facilities, one home health agency, and multidisciplinary hospital representatives.

APPROACH

To support cross-setting communication, enhanced care coordination, and patient self-management, AMC partnered with the IPRO QIN-QIO and invited key healthcare and community stakeholders with whom they shared patients to actively participate as PACC members.

The PACC works together to develop strategies and implement evidence-based interventions that address the unique challenges facing healthcare since the start of the pandemic. This includes a focus on:

- Supporting prevention and management of chronic disease
- Improving care transitions to reduce unnecessary hospital utilization
- Identifying opportunities to enhance patient and family engagement
- Reducing health inequities
- Addressing social determinants of health for the high utilization population

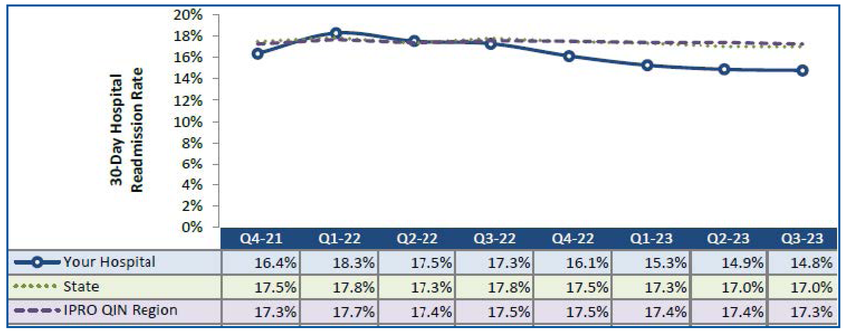
IPRO QIN-QIO Resources shared with and reviewed by the PACC include:

- "Nursing Home Naloxone Policy & Procedure Toolkit"
- "Go to the Hospital or Stay Here? A Decision Guide for Patients and Families"
- "Skilled Nursing Facility Rehospitalization Risk Assessment Tool"
- "FAST FACTS for ED Transfers from Post-Acute Care Provider"
- "Dialysis and Nursing Home Hand-Off Communication Tool"
- "Community Resource Tool"

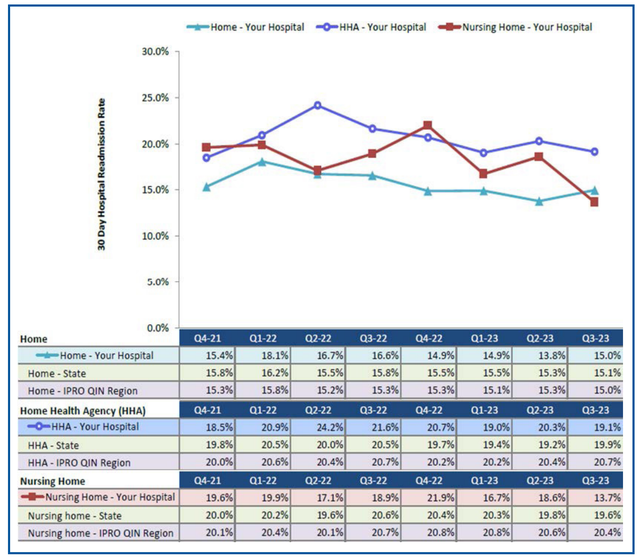
RESULTS

Albany Medical Center has demonstrated a 15% relative improvement rate in all cause 30-day readmissions for the Medicare Fee-for-Service (MFFS) population, reducing its readmission rate from 19.7% for the 10/01/18-09/30/20 time period to 16.7% for the 09/01/22 – 08/31/23 time period.

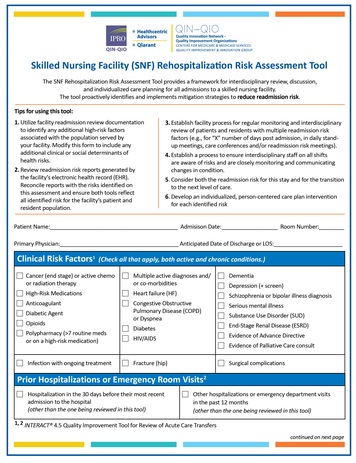
The 2023 Q3 Hospital Care Transitions Report[1], produced by the IPRO Partnership for Community Health team, demonstrates this decline over the past several quarters for 30-Day Readmissions. The 30-Day Readmissions by Discharge Status (Home, Home Health, and Nursing Home) also demonstrate a general downward trend. Albany Medical Center's MFFS all cause 30-day readmission rate has been below the NYS and IPRO QIN-QIO region rates for the four quarter period from July 1, 2022 – September 30, 2023.



	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23
Your Hospital	16.4%	18.3%	17.5%	17.3%	16.1%	15.3%	14.9%	14.8%
State	17.5%	17.8%	17.3%	17.8%	17.5%	17.3%	17.0%	17.0%
IPRO QIN Region	17.3%	17.7%	17.4%	17.5%	17.5%	17.4%	17.4%	17.3%



Home	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23
Home - Your Hospital	15.4%	18.1%	16.7%	16.6%	14.9%	14.9%	13.8%	15.0%
Home - State	15.8%	16.2%	15.5%	15.8%	15.5%	15.5%	15.3%	15.1%
Home - IPRO QIN Region	15.3%	15.8%	15.2%	15.3%	15.3%	15.1%	15.3%	15.0%
Home Health Agency (HHA)	**Q4-21**	**Q1-22**	**Q2-22**	**Q3-22**	**Q4-22**	**Q1-23**	**Q2-23**	**Q3-23**
HHA - Your Hospital	18.5%	20.9%	24.2%	21.6%	20.7%	19.0%	20.3%	19.1%
HHA - State	19.8%	20.5%	20.0%	20.5%	19.7%	19.4%	19.2%	19.9%
HHA - IPRO QIN Region	20.0%	20.6%	20.4%	20.7%	20.2%	20.2%	20.4%	20.7%
Nursing Home	**Q4-21**	**Q1-22**	**Q2-22**	**Q3-22**	**Q4-22**	**Q1-23**	**Q2-23**	**Q3-23**
Nursing Home - Your Hospital	19.6%	19.9%	17.1%	18.9%	21.9%	16.7%	18.6%	13.7%
Nursing home - State	20.0%	20.2%	19.6%	20.6%	20.4%	20.3%	19.8%	19.6%
Nursing home - IPRO QIN Region	20.1%	20.4%	20.1%	20.7%	20.8%	20.8%	20.6%	20.4%



Skilled Nursing Facility (SNF) Rehospitalization Risk Assessment Tool

The SNF Rehospitalization Risk Assessment Tool provides a framework for interdisciplinary review, discussion, and individualized care planning for all admissions to a skilled nursing facility. The tool proactively identifies and implements mitigation strategies to **reduce readmission risk**.

Tips for using this tool:

1. Utilize facility readmission review documentation to identify any additional high-risk factors associated with the population served by your facility. Modify this form to include any additional clinical or social determinants of health risks.
2. Review readmission risk reports generated by the facility's electronic health record (EHR). Reconcile reports with the risks identified on this assessment and ensure both tools reflect all identified risk for the facility's patient and resident population.
3. Establish facility process for regular monitoring and interdisciplinary review of patients and residents with multiple readmission risk factors (e.g., for "X" number of days post admission, in daily stand-up meetings, care conferences and/or readmission risk meetings).
4. Establish a process to ensure interdisciplinary staff on all shifts are aware of risks and are closely monitoring and communicating changes in condition.
5. Consider both the readmission risk for this stay and for the transition to the next level of care.
6. Develop an individualized, person-centered care plan intervention for each identified risk

Patient Name:_____ Admission Date:_____ Room Number:_____

Primary Physician:_____ Anticipated Date of Discharge or LOS:_____

Clinical Risk Factors[1] *(Check all that apply, both active and chronic conditions.)*

- ☐ Cancer (end stage) or active chemo or radiation therapy
- ☐ High-Risk Medications
- ☐ Anticoagulant
- ☐ Diabetic Agent
- ☐ Opioids
- ☐ Polypharmacy (>7 routine meds or on a high-risk medication)
- ☐ Multiple active diagnoses and/or co-morbidities
- ☐ Heart failure (HF)
- ☐ Congestive Obstructive Pulmonary Disease (COPD) or Dyspnea
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Dementia
- ☐ Depression (+ screen)
- ☐ Schizophrenia or bipolar illness diagnosis
- ☐ Serious mental illness
- ☐ Substance Use Disorder (SUD)
- ☐ End-Stage Renal Disease (ESRD)
- ☐ Evidence of Advance Directive
- ☐ Evidence of Palliative Care consult
- ☐ Infection with ongoing treatment
- ☐ Fracture (hip)
- ☐ Surgical complications

Prior Hospitalizations or Emergency Room Visits[2]

- ☐ Hospitalization in the 30 days before their most recent admission to the hospital *(other than the one being reviewed in this tool)*
- ☐ Other hospitalizations or emergency department visits in the past 12 months *(other than the one being reviewed in this tool)*

1,2 *INTERACT® 4.5 Quality Improvement Tool for Review of Acute Care Transfers*

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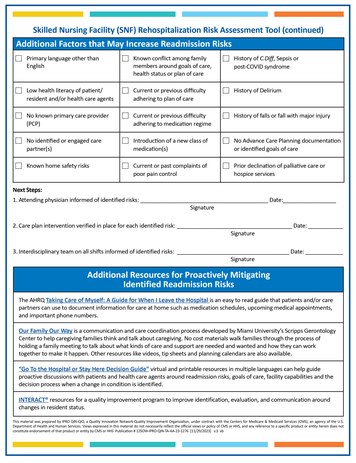

Skilled Nursing Facility (SNF) Rehospitalization Risk Assessment Tool (continued)

Additional Factors that May Increase Readmission Risks

- ☐ Primary language other than English
- ☐ Known conflict among family members around goals of care, health status or plan of care
- ☐ History of *C.Diff*, Sepsis or post-COVID syndrome
- ☐ Low health literacy of patient/ resident and/or health care agents
- ☐ Current or previous difficulty adhering to plan of care
- ☐ History of Delirium
- ☐ No known primary care provider (PCP)
- ☐ Current or previous difficulty adhering to medication regime
- ☐ History of falls or fall with major injury
- ☐ No identified or engaged care partner(s)
- ☐ Introduction of a new class of medication(s)
- ☐ No Advance Care Planning documentation or identified goals of care
- ☐ Known home safety risks
- ☐ Current or past complaints of poor pain control
- ☐ Prior declination of palliative care or hospice services

Next Steps:

1. Attending physician informed of identified risks: _____ Date:_____ Signature
2. Care plan intervention verified in place for each identified risk: _____ Date: _____ Signature
3. Interdisciplinary team on all shifts informed of identified risks: _____ Date: _____ Signature

Additional Resources for Proactively Mitigating Identified Readmission Risks

The AHRQ Taking Care of Myself: A Guide for When I Leave the Hospital is an easy to read guide that patients and/or care partners can use to document information for care at home such as medication schedules, upcoming medical appointments, and important phone numbers.

Our Family Our Way is a communication and care coordination process developed by Miami University's Scripps Gerontology Center to help caregiving families think and talk about caregiving. No cost materials walk families through the process of holding a family meeting to talk about what kinds of care and support are needed and wanted and how they can work together to make it happen. Other resources like videos, tip sheets and planning calendars are also available.

"Go To the Hospital or Stay Here Decision Guide", virtual and printable resources in multiple languages can help guide proactive discussions with patients and health care agents around readmission risks, goals of care, facility capabilities and the decision process when a change in condition is identified.

INTERACT® resources for a quality improvement program to improve identification, evaluation, and communication around changes in resident status.

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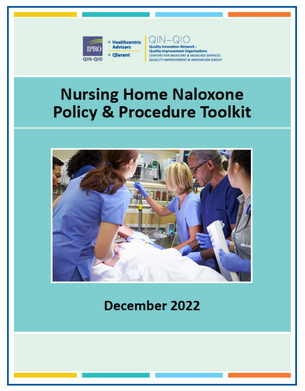

Nursing Home Naloxone Policy & Procedure Toolkit

December 2022

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REFERENCES

https://www.ahrq.gov/ncepcr/care/coordination.html

[1]Hospital Care Transitions Reports are produced quarterly at the hospital, community, and state levels. Data are based on CMS Medicare Fee-For-Service (MFFS) paid claims data

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