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National Provider Call

National Partnership to Improve Dementia Care in Nursing Homes

August 19, 2014

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Agenda:

• Welcome & Partnership Updates	Michele Laughman, CMS
• Successful Care Transitions	
– Role of physician leadership	Dr. Leonard Gelman, AMDA
– Importance of open communication across care settings	Dr. Melissa Mattison, Harvard Medical School; Beth Israel Deaconess Medical Center
• Next Steps	Michele Laughman, CMS
• Question & Answer Session	

Welcome

Partnership Updates

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The Role of Physician Leadership in Creating Successful Care Transitions

Leonard M. Gelman, MD, CMD

President, AMDA-The Society of Post-Acute and Long Term care

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Agenda:

- Goals of care
- Care delivery process
- Transitions
- Communication
- Barriers to effective transitions
- Accountability
- Quality Assurance & Performance Improvement (QAPI)

Goals of Care:

- **Hospital – disease centered**

VS.

- **Nursing home – functionally driven quality of life paradigm**
  - Patient centered not disease centered
  - But still need to be cognizant of the disease process

Goals of Care:

- **Nursing home – functionally driven quality of life paradigm**
  - More complex treatment regimens and care plans that require a close working relationship with the entire care team.
  - Psychosocial considerations
  - Functional considerations
  - Increasing patient acuity
  - Knowledge gaps of family members
  - Unrealistic expectations
  - **Need for greater physician involvement, both as educator and family mediator**

Care Delivery Process:

- The care delivery process is a set of steps related to assessing and managing the causes and consequences of illnesses and impairments in human beings
- Attain and maintain optimal physical function in the context of, and as a foundation for, personal and psychosocial function

Care Delivery Process – 6 STEPS:

- Recognition/Assessment
- Problem definition
- Diagnosis/Cause-and-effect analysis
- Identifying goals and objectives of care
- Selecting interventions/planning care
- Monitoring of progress

*Must be performed in all settings of care, at all times, but this rarely happens

Care Delivery Process – 6 STEPS:

- Recognition / Assessment
  - Gather essential information about the individual
- Problem definition
  - Define the individual's problems, risks, and issues
- Diagnosis/Cause-and-effect analysis
  - Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences

Care Delivery Process – 6 STEPS:

- Identifying goals and objectives of care
  - Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met
- Selecting interventions/ planning care
  - Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks
- Monitoring of progress
  - Review individual's progress toward goals

Medical Director:

- F 501
  - Implement resident care policies
  - Coordinate medical services
- Must become more involved from a regulatory and operational perspective

Transitional Care – Definition:

- A set of actions designed to ensure coordination and continuity of care
- It should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences, and health or clinical status
- It includes logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition

Care Coordination:

- The deliberate organization of patient care activities among two or more participants (including the patient and/or family) involved in a patient's care to facilitate the appropriate delivery of health care services
- Organizing care involves the marshaling of personnel and other resources to carry out all required patient care activities
- This is often managed by the exchange of information among participants responsible for different aspects of the care

Scope of the Problem:

- It is common for patients in the long-term care community (LTCC) to be transferred from one care setting, level of care, or caregiver team to another
- It is also all too common for adverse events and avoidable complications to occur as a result of **poor communication and coordination** among caregivers, health care professionals, and the patient during such transitions

Communication Deficiencies:

- During the discharge process, hospital and primary care physicians rarely communicate with each other directly
- Hospital discharge summaries often do not identify the responsible hospital physician, main diagnosis, physical findings, discharge medications, **rationale for specific care,** or follow-up care plans and rarely provide information about tests pending at discharge or counseling provided to the patient or family
- Admitting History and Physical, Emergency Department (ED) evaluation

Communication Deficiencies:

- Practitioners in different care settings often fail to ensure:
  - The essential elements of the patient's care plan that were developed in one setting are communicated to the next team of clinicians
  - The necessary steps before and after a patient's transfer are properly and fully executed
    - Preparation for the goals of care delivered in the next setting
    - Arrangements for follow-up appointments and laboratory testing
    - Reviewing the current medication regimen
  - The requisite information about the care the patient received from the sending care team is communicated to the receiving care team

Communication Deficiencies:

- Many practitioners involved in transitional care have not practiced in the settings to which they are sending patients, are unfamiliar with the care-delivery capacity of these settings, and may transfer patients inappropriately

Segmentation of Primary Medical Care Services:

- Primary Care Physicians (PCPs) in a traditional practice setting frequently suffer from a serious information and communication gap
  - For example, a patient may be hospitalized under the care of a hospitalist and subsequently admitted to an Skilled Nursing Facility (SNF) under the care of an SNFist
  - Upon the patient's return to the community, the PCP is often asked to resume care and approve multiple services and prescriptions required as a result of the episode of illness—an illness about which the PCP may have little or no knowledge

Barriers to Effective Care Transitions:

- Delivery System-Level Barriers
- Clinician-Level Barriers
- Patient-Level Barriers

Delivery-System-Level Barriers:

- Each care setting functions as a “silo” that lacks formal relationships with other care settings
- Information systems (e.g., interoperable computerized records) designed to facilitate the timely transfer of patient information across care settings do not exist
- Financial incentives to promote transitional care, collaboration across sites, and accountability are lacking
- Insurance coverage issues frequently drive service delivery
- Process has received too little attention from health policy makers

Clinician-Level Barriers:

- A single clinician rarely provides continuous care for a patient across care settings
- Clinicians and hospitalists may consult multiple specialists about each patient
- A string of follow-up appointments may also be generated without consideration of their relevance to the patient's overall care goals
- Care managers and social workers, who once provided longitudinal care oversight across settings, now are predominantly assigned to specific care settings

Patient-Level Barriers:

- Patients and families presume that their health care professionals will take care of their needs across the continuum of care and often assume incorrectly that the providers involved in their care are sharing adequate information
- Older patients and their caregivers are often not adequately informed about their disease process and the next steps in their care so that they are able to optimize the care the patient receives in the next setting

Patient-Level Barriers:

- Patients and caregivers may not feel empowered to express their preferences or provide input to the patient's care plan
- "Take-home" information that patients receive in different care settings may provide conflicting information and leave patients and their caregivers confused

Factors considered by patients and caregivers to be most valuable to them during care transitions:

- Assistance with medication self-management
- A patient-centered record owned and maintained by the patient to facilitate cross-site information transfer
- Timely follow-up with primary or specialty care
- A list of “red flags” indicative of a worsening condition and instructions on how to respond to them

Accountability:

- Facilities should designate staff positions whose responsibilities include management of care transitions
- Individuals in these positions should be appropriately trained and empowered to develop relationships with their counterparts (i.e., staff with responsibility for managing care transitions) at sites to which the facility transfers patients or from which it receives transferred patients

Accountability:

- A single individual should bear overall responsibility for ensuring that all steps relating to a care transition are carried out in the correct sequence and in synergy with all the other "performers" in the process
- Individual accountability for specific tasks must be supported by a facility-wide culture that places a high priority on safe transitions and considers them to be everyone's responsibility

Importance of Documentation:

- Clear communication of appropriate patient information is the foundation of patient safety and of good care transitions
- An equally accepted fundamental need is that of respect for patient autonomy
- Documentation will need to satisfy facility-specific standards in addition to those of regulatory, licensure, and reimbursement entities

Institutional Commitment – QAPI:

- Essential to overcoming barriers to effective transitions
- Facilities may wish to adopt policies and procedures to guide specific transitions, such as that of a nursing home resident to the ED or hospital
- QAPI – measurement of processes involved in transitions

Interactions with Other Facilities:

- Medical Director
- Joint quality committee with participation by hospitals, SNFs, Assisted Living Centers (ALCs), home health agencies and any other facilities that are involved in patient transitions
- Visits
- Case manager is to serve as a bidirectional link

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Importance of Open Communication Across Care Settings for Successful Care Transitions

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Conflicts of Interest:

- Relevant: None
  - Contributor to Up-to-date and Practical Reviews in Hospital Medicine
  - Consultant: Imprivata

Agenda:

- Transitions in Care (TIC) – Complications
  - Common, Costly, Morbid, Preventable
- Pitfalls and Vulnerabilities
- Existing Solutions
- Innovations

Sound Familiar?

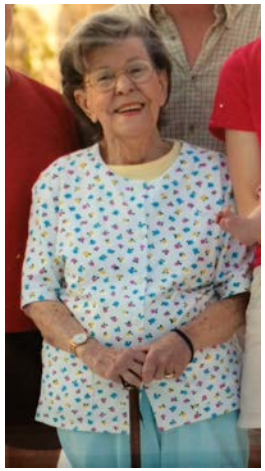
- 87 year old man admitted to the hospital with sepsis from a complicated UTI, stabilized, treated with IV ertapenem and discharged to sub-acute care; No information on duration of antibiotic therapy, follow up with Urology, or 'safety labs' required while on IV ertapenem
- 77 year old woman with COPD on supplemental oxygen 2L/min admitted to the hospital from her nursing home with increased oxygen requirements, new RLL pneumonia; No HCP/code status/preferred intensity of care information sent with patient
- 92 year old man falls at home onto his knee, fractures his patella and is placed in a knee immobilizer; He is seen by Ortho and PT and discharged to sub-acute rehab
  - Discharge Summary = non-weight bearing (NWB)
  - PT note = weight-bearing as tolerated (WBAT)

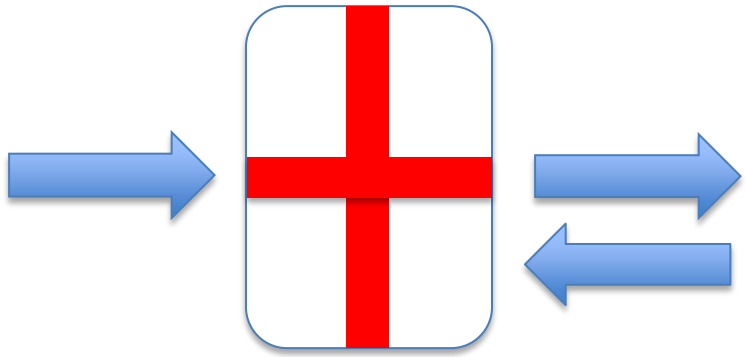
Transitions in Care (TIC) – Definition:

- "The term 'care transitions' refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness"
- "Care transitions is a team sport, and yet all too often we don't know who our teammates are, or how they can help." Eric A. Coleman, MD, MPH

http://www.caretransitions.org/definitions.asp

Multi-directionality of TIC:





Hospitalized s/p Fall,
Hip Fracture

A+ Sub-Acute Rehab facility

Delirious, depressed, refuses care

A+ Long-Term Care Facility

More depressed, delirious, pneumonia

Eric Coleman – 4 Pillars:

- Medication self-management: Patient is knowledgeable about medications and has a medication management system
- Use of a dynamic patient-centered record: Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings; The patient or informal caregiver manages the PHR
- Primary care and specialist follow-up: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions
- Knowledge of red flags: Patient is knowledgeable about indications that their condition is worsening and how to respond

http://www.caretransitions.org/four_pillars.asp

What about Nursing Home Population?

- Burden of cognitive and functional impairment
- Unable to participate in their own TIC
- Transitions are COMMON (and costly)
  - Readmissions (20-25% of Medicare beneficiaries)
  - Multiple outpatient specialists
  - ED/urgent care visits

Transitions in Care (TIC):

- Patient Centered TIC
  - Unique Patient Factors
  - Advance Directives
  - Accepting Site Clinical Team Prepared
  - Discharging Clinical Team with Sufficient Sign-out
  - Family/HCP Agreement and Understanding

Adapted from: https://www.nhqualitycampaign.org/files/Transition_of_Care_Reference.pdf

Challenges and Strategies:

- Challenges:
  - Historical inertia
  - Distrust of providers from other sites
  - Time, resources
- Strategies:
  - INTERACT
  - Project BOOST – Society of Hospital Medicine
  - Project RED

Innovations and Next Steps:

- Innovations
  - ECHO – Care Transitions (ECHO-CT) at Beth Israel Deaconess Medical Center
  - "Warm Handoffs" mandated for some select cases
- Next Steps:
  - Just do it

http://interact2.net/tools_v3.aspx

References:

- http://interact2.net/tools_v3.aspx
- http://www.hospitalmedicine.org/Web/Web/Quality___Innovation/Mentored_Implementation/Project_BOOST/Project_BOOST.aspx
- http://www.bu.edu/fammed/projectred/
- http://www.caretransitions.org/four_pillars.asp

Next Steps

Questions & Answer Session

Evaluate Your Experience:

- Please help us continue to improve the MLN Connects™ National Provider Call Program by providing your feedback about today's call
- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call

Thank You!

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- For more information about the Medicare Learning Network® (MLN), please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html
- For more information about the National Partnership to Improve Dementia Care in Nursing Homes, please visit https://www.nhqualitycampaign.org/dementiaCare.aspx