Care Transitions:
What Does It Really Look Like?

Selena Bolotin, LICSW
Director WA Patient Safety & Care Transitions

June 5, 2014
• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day

• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington

• QIOs: the largest federal network dedicated to improving health quality at the community level
Is There Progress in South King County?

- 2010  18.3% readmit rate
- 2013  16.2% readmit rate
- % improvement exceeds WA state average
- Still higher than state average
- Increase in ED and Observation visits
- Significant decrease in Nursing Home readmits in 2013
- More data
  - South King Community Report 4Q 2013 [www.agingkingcounty.org/CTconference/](http://www.agingkingcounty.org/CTconference/)
  - WA & Multiple Communities [www.qualishealthmedicare.org/community-involvement/reducing-rehospitalizations/readmissions-data](http://www.qualishealthmedicare.org/community-involvement/reducing-rehospitalizations/readmissions-data)
South King Opportunities

• Improvements in silos and small groups – no overarching structure
• Non dual readmit rate 14.2% -- dual readmit rate 21.1
• Rates of readmit greater for non white populations
Panel Members

• Listen for focus on three care transitions drivers
  -- Standard and known processes
  -- Communication
  -- Patient and family engagement
Panel Members

• Bruce Rehm, Manager, Operational Improvement
  Harrison Medical Center

• Nikole Jay, Executive Director
  Judson Park

• Mary Dunlap & Andy Barrett
  Donna’s family members
How KC4TP Got Started

• **Kitsap County Cross Continuum of Care Transitions Project**
• First community meeting 3/29/12
• Steering Committee formed and wrote charter
• Utilized IHI STAAR Initiative framework of potential interventions – removed the need for root cause analysis and development of interventions
• **How to move from great conversation and interesting ideas to actions and results:**
  – Charter
  – Measureable goals
  – Project leadership coaching
  – Plan - Do - Check - Adjust (PDCA)
Mission/Purpose:
- In support of the CMS Partnership for Patients initiative, our mission is to improve safety, quality of care and the patients’ satisfaction as they experience care transitions within Kitsap County.

Vision:
- Our vision for Kitsap County health care:
  - Patients will be satisfied with the level of coordination and collaboration between healthcare providers as they transition from one care setting to another
  - Partnership and coordination between care providers across the County and the Continuum of Care
  - A reliable network of care providers in Kitsap County that will continue to provide care for our patients

Goals:
- Support our community hospital in their efforts to reduce Medicare all-cause readmission rate from 13.5% to 12.8% as measured February-April 2014
- Support our community SNFs in their efforts to reduce all-cause readmissions rate from 19% to 16% by 12/31/2013
- Support our community Home Health agencies in reducing their readmission rates (specific target TBD)
- Patient satisfaction score improvement:
  - HMC: response to HCAHPS survey questions #19 & #20
  - SNF: began patient sat reporting 9/2012
  - HH: PG score improvement for question #17

Scope:
- In scope:
  - Processes that support effective care transitions between member organizations
- Out of scope:
  - Project management of member organizations’ improvement projects
  - Mandating particular EMR software platforms
Structure:

- A coalition of Kitsap County health care, including representatives from
  - Community hospitals
  - Skilled Nursing facilities
  - Home Health agencies
  - Assisted Living facilities
  - Hospice & palliative care
  - Specialty and primary care clinics
  - Other agencies that support the health of our community

- Steering Committee Members:
  - Annette Crawford, Administrator, Stafford Healthcare at Ridgemont
  - Frances Greaves, RN, Care Transitions Program Coordinator, Harrison Medical Center
  - Denise Hughes, RN, Supervisor OAS, Kitsap Mental Health
  - Barry Johnson, Administrator, Kitsap Aging & Long Term Care
  - Michelle Mathiesen LPN, Practice Administrator, Kitsap Medical Group
  - Lauren Newcomer RN, Director, Quality & Operational Improvement, Harrison Medical Center
  - Diane Wasson, RN, Executive Director, Home Health, Harrison Medical Center
  - Carol Higgins, Quality Consultant, Qualis Health (OT) (Advisory member)
  - Bruce Rehm, Manager, Operational Improvement, HMC (project/program manager, subcommittee coach)

- Meeting Frequency:
  - Steering committee will meet bi-monthly until further notice.
  - All-Partners meeting to occur quarterly

Responsibilities & Deliverables:

- Adopt the IHI Guides as a roadmap and improvement framework
- Steer our partner organizations in identifying and leveraging readmissions improvement work for the betterment of the partnership as a whole
- Provide data as needed to support agencies for reporting purposes
- Provide oversight and guidance to partner organizations in meeting their goals
- Serve as a point of contact to other groups doing this work (e.g., WSHA, Qualis)
Key Ideas

• Agree to clear & measurable goals
  – SMART (specific, measureable, attainable, relevant, time-bound)

• Start small, spread when successful (“small tests of change”)
  – Fewer barriers to getting started (e.g., cost, scheduling constraints, etc.)
  – Reduce the risk of unintended consequences and disruptions to daily operations
  – Prove it works – then people will ask for it

• Involve the stakeholders
  – Truly understand what’s happening and what is needed by participants to make a change – and make it stick
  – No surprises, no guessing

• Be as fact-based (data-driven) as possible

• Ensure meetings are well-managed:
  – Agenda/objectives
  – Action items identified and assigned
  – Keeping minutes is a good idea – over time we forget how we got where we are
Program Management Structure

- Program = series/collection of projects that are related by their contribution to an overarching program goal
- Projects done by sub-teams
- Sub-teams started with an assigned coach
- Sub-teams report to Steering Committee once monthly
- Project charter for sub-teams on next slide
**Failure Identified for Action**

- IHI Key Change “ensure the SNF is ready and capable to care for the resident”
- SNF staff interviews revealed inconsistent and untimely nurse to nurse report prior to SNF transfers

**Strategies in Implementation**

- Improve consistency, timing of nurse to nurse report
- Implement standardized tool/form to be used by hospital and SNF nurses
- Key Improvement Measure: Pilot on TCU first goal = 100% usage per transfer and before patient arrives at SNF

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<thead>
<tr>
<th>Milestone/Activity</th>
<th>Start</th>
<th>Finish</th>
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<tbody>
<tr>
<td>Interview SNF nurses to determine if they receive info needed from hospital to adequately care for patient.</td>
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<tr>
<td>Develop and implement Warm Handover pilot with PCU Nurse Manager</td>
<td>12/11/12</td>
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<tr>
<td>Present SNF interview results and Warm handover pilot project proposal to Information Exchange Committee</td>
<td>12/12/12</td>
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<tr>
<td>Present current status of pilot project to Information Exchange Committee</td>
<td>1/16/13</td>
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<tr>
<td>Develop Warm Handover monitoring tool</td>
<td>1/11/13</td>
<td>1/11/13</td>
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<tr>
<td>Present Warm Handover tool to all SNFs</td>
<td>1/18/13</td>
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**Recent Accomplishments**

- Increase use of Warm Handover tool for 100% of all PCU discharges to a SNF

**Obstacles/Barriers**

- PCU does not have a high SNF discharge population
- Expand Warm Handover pilot project to another Hospital Unit
Triple Aim and Shared Responsibilities

• Healthcare Trajectory Long View

• Accountable Care - Shared Risks and Outcomes

• Quality Care, Better Patient Experience, Lower Cost
  • Developing partnerships to ensure safe transitions
  • Providing sub-acute services outside of hospital setting
  • Reducing emergency 911 calls
  • Leverage these advantages to lower rate of hospital readmissions
Before Sub-Acute Stay

- Ease of Access to Sub-Acute Setting
- Transitional Support-Community Liaison
- Warm Handovers
- Risk Assessment
- Complex Disease Management
- Pre-Hab
- Short-Stay Orientation
During Sub-Acute Stay

- Daily MD, ARNP and 24/7 RN
- Wound Care MD
- Holistic Wellbeing Focus in Discharge Planning
- On site - Psychologist, LMHPs and FT Chaplain
- Complex Disease Management Protocols and Care Pathways
- Interact Tools Integrated in EMR
- Patient and Family Education
- Home Safety, Home Health, Social/Community Svc Coordination
- Assistance to schedule Physician appts, Labs, Tests & Transport
Thirty-day Hospital Readmission Rates

- Judson Park maintains high performance in managing readmission rates **below state and national norms**.
- We manage **low re-hospitalizations rates** with Interact Tools and 7 day a week MD and ARNP onsite support and a high RN staffing ratio.

(Communities for Safer Transitions of Care Re-hospitalizations Report Data for Medicare Claims, published March 2014)
After Sub-Acute Stay

- Warm Handover to next Care Provider
- Attending MD to PCP Handover
- Follow-up Call 1 week and 3 weeks
- Return to Sub-Acute vs Readmit to Hospital
- Satisfaction and Expectations Survey
- Return for Outpatient Therapy
- Holistic Lifestyle Programs at Judson Park
- Readmit Data – Root Cause all Levels of Care and Home Health Partner Review
  - Desire to look together at Readmit Data with hospital partners
What's next?

- South King County Providers Group Update
- Leading Age WA – Partnership and Collaboration Cmte
- ACOs and Preferred Continuing Care Networks – Rainier Health Network and MultiCare ACO
- Shared Data and Collaborative Risk Management

**My Biggest Wish**

Engage S. King County hospitals and physician leaders more strategically in sharing data, outcomes, processes and quality improvement initiatives. Where providers like me and my team, with CCRC and sub-acute services and expertise, are invited to the table in a true collaborative partnership, to together achieve the Triple Aim.
Judson Park – CCRC & Sub-Acute
Nikole Jay
Executive Director
23600 Marine View Drive South
Des Moines, WA 98198
Direct Line: 206-870-6600
Cell: 206-391-1360
njay@abhow.com

www.judsonpark.com
www.abhow.com
8 months of health care

8 hospital stays

4 different hospitals

4 Skilled Nursing Homes (SNFs)

21 meds on D/C

20 -Doctors

And Countless Nurses
• Caring Healthcare Workers restricted by Systems
• Lack of Medical Records Access
• No Coordination with Family or Primary Dr.
• Transition is Fragmented

• What Happens to Patients Without Family?

Caregivers
Mary Dunlap & Andy Barrett
Questions?

Selena Bolotin, LICSW
Director, WA Patient Safety & Care Transitions
selenab@qualishealth.org
206-288-2472

For more information:
www.QualisHealthMedicare.org/

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