Enhance the Health of Your Community

Partner with Healthcentric Advisors

A Member of the IPRO QIN-QIO

Care Transitions Leader Meeting
Vermont Program for Quality in Health Care
September 30, 2020

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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Objectives

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1. Consider CMS' Quality Aims and Contracts
2. Review QIO tasks
3. Consider Care Transitions – Evidence Based and Real Work Application
4. Explore Community approach to COVID-19

Healthcentric Advisors, IPRO, and Qlarant collaborating under the IPRO QIN-QIO

- Addressing CMS' Quality Aims
- Supporting implementation and strengthening of innovative, evidence-based, and data-driven methodologies to support improvements
- Offering enhanced resources and support to healthcare providers, communities, and the patients they serve
- Promoting patient and family engagement in care

The IPRO QIN-QIO Region

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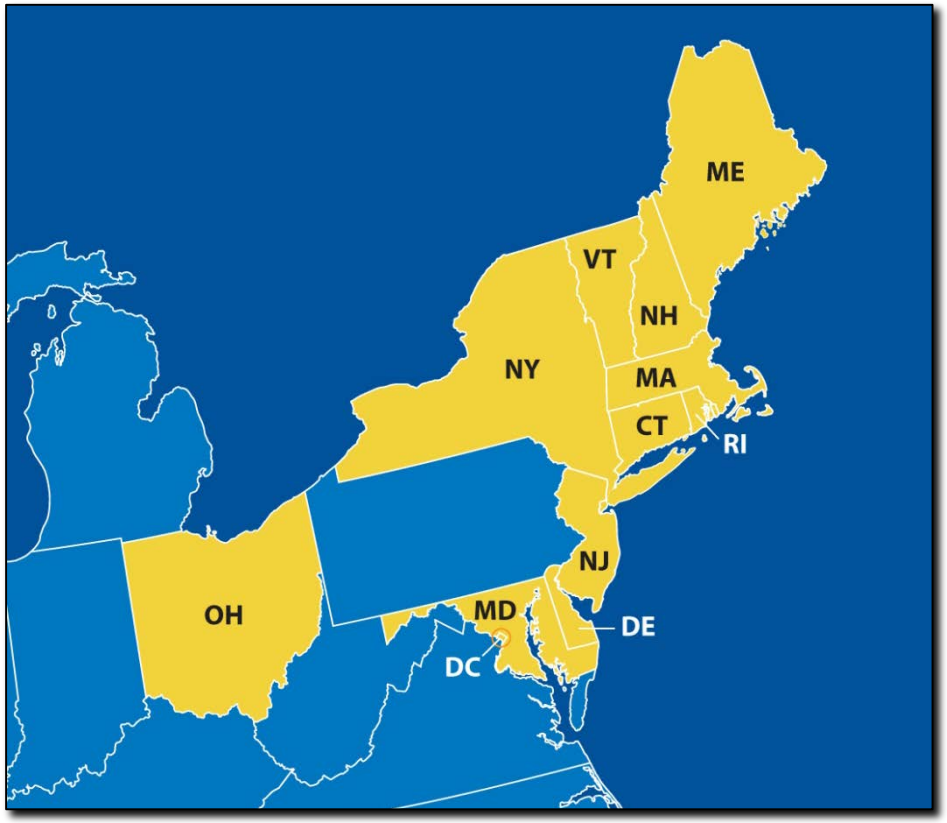
Healthcentric Advisors: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island

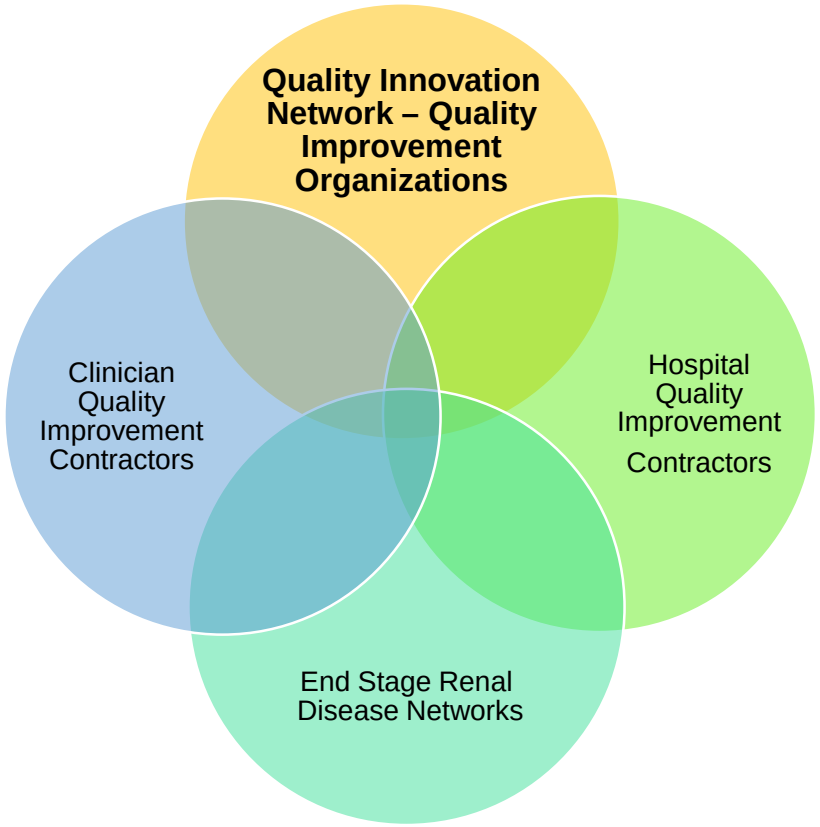
IPRO: New York, New Jersey, Ohio

Qlarant: Maryland, Delaware, District of Columbia



Working to ensure high-quality, safe healthcare for 20% of the nation's Medicare beneficiaries

CMS' Network of Quality Improvement and Innovation Contracts Unique Tasks to Collectively Achieve 5 Aims



- Aim 1: Increasing Access to Behavioral Health & Reducing Opioid Misuse
- Aim 2: Improving Patient Safety
- Aim 3: Preventing & Managing Chronic Disease
- Aim 4: Improving Care Transitions
- Aim 5: Enhancing Nursing Home Quality

Special Focus Across All Aims

Health Information Technology

Health Equity

Patient & Family Engagement

Rural Health

12th SOW – QIO Tasks

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*Improve **Nursing Home Quality** & Enhance the **Health of Your Community***

Working with **1,458** of the nursing homes across the network

- **31** Nursing Homes in Vermont

Coalition Building in communities that encompass at least **65% of the Medicare beneficiaries** in each state

- **2** Community Coalitions – Vermont
- **86** across QIN-QIO region

Patient centered

Data driven

Evidence based solutions

Best practice

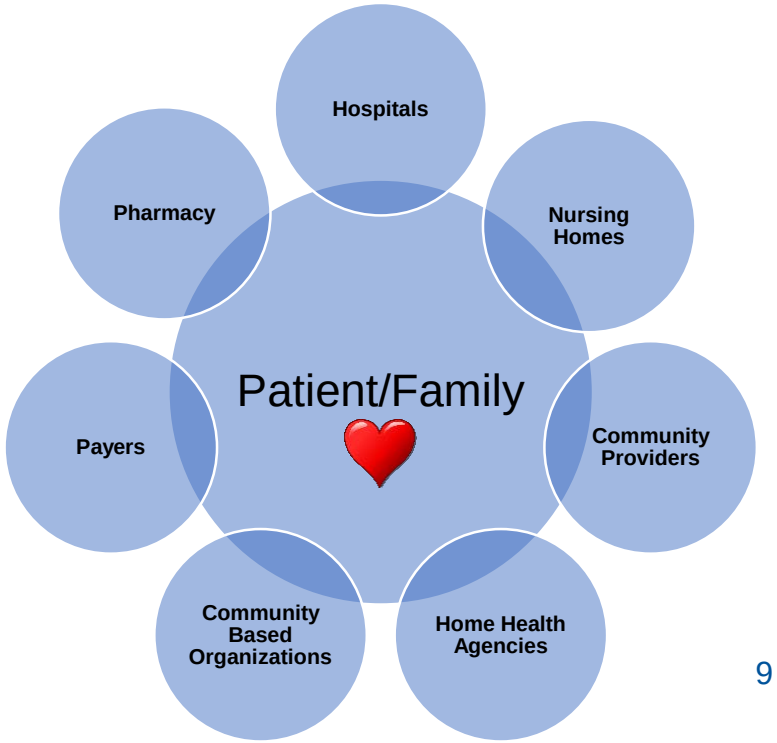
Peer support across the network

- *A Nursing Home Collaborative with individual technical assistance to…*

1. Improve the mean Total Quality Score for all nursing homes
2. Decrease opioid prescribing
3. Reduce adverse drug events (ADEs)
4. Reduce hospitalizations for nursing home onset *Clostridiodes difficile*
5. Reduce healthcare-acquired infections
6. Reduce emergency department visits & readmissions for short stay nursing home residents

Community members collaborating to improve overall health of the community, specifically…

1. Increase access to behavioral health services
2. Decrease opioid prescribing and overdose deaths
3. Reduce adverse drug events (ADEs)
4. Prevent and manage chronic disease, with focus on cardiac care, diabetes and chronic kidney disease
5. Enhance care transitions to reduce unnecessary hospitalization, with a focus on high utilizers



Step Up to Learn From Others

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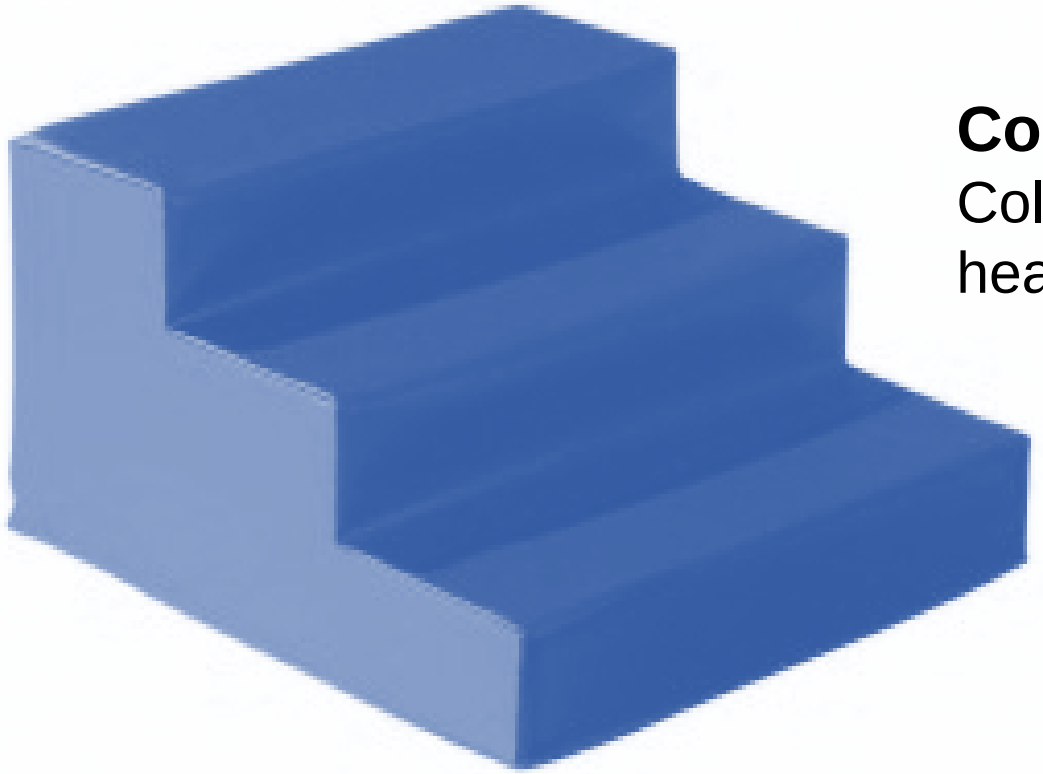
Learning & Action Network

Invitation only spot light on success sharing, affinity groups & ECHO sprints – with peers from our 11 state & DC network



Community Coalitions*

Collaborative approach to improve overall health of community

Provider Based Quality Improvement

Refine internal processes and improve outcomes with evidence-based tools/resources

* Where Applicable

Evidence Based Practice

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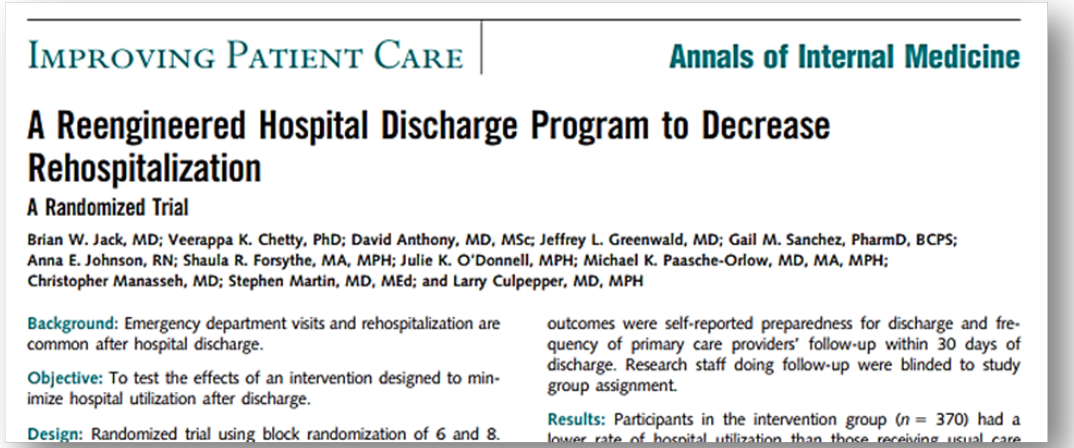
Project RED Re-Engineered Discharge

- 30% fewer hospital readmissions within 30 days of discharge
- Decreased ED use from 24% to 16%
- Increased PCP follow up
- Improved patient "readiness for discharge"
- Enhanced patient satisfaction

Piloted in SNF: 10.2% had hospital readmission or ED visit vs 17.4% of control patients



IMPROVING PATIENT CARE | Annals of Internal Medicine

A Reengineered Hospital Discharge Program to Decrease Rehospitalization

A Randomized Trial

Brian W. Jack, MD; Veerappa K. Chetty, PhD; David Anthony, MD, MSc; Jeffrey L. Greenwald, MD; Gail M. Sanchez, PharmD, BCPS; Anna E. Johnson, RN; Shaula R. Forsythe, MA, MPH; Julie K. O'Donnell, MPH; Michael K. Paasche-Orlow, MD, MA, MPH; Christopher Manasseh, MD; Stephen Martin, MD, MEd; and Larry Culpepper, MD, MPH

Background: Emergency department visits and rehospitalization are common after hospital discharge.

Objective: To test the effects of an intervention designed to minimize hospital utilization after discharge.

Design: Randomized trial using block randomization of 6 and 8.

outcomes were self-reported preparedness for discharge and frequency of primary care providers' follow-up within 30 days of discharge. Research staff doing follow-up were blinded to study group assignment.

Results: Participants in the intervention group (n = 370) had a lower rate of hospital utilization than those receiving usual care

Adapting Project RED

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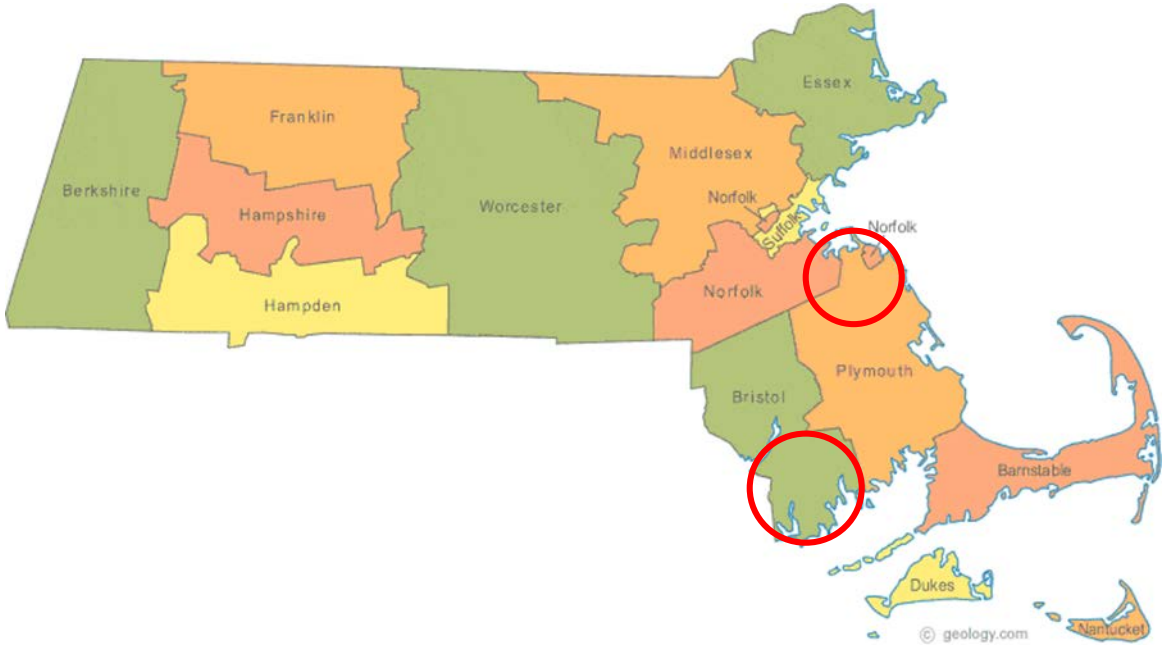
Special Innovation Project

- Collaborative community cross-setting effort
  - SNFs, ASAPs, Hospitals, Home Health Agencies
- Pilot began August 2016, CMS granted extension for Year 3
- Southeastern MA – pilot started in New Bedford area, expanded to Brockton area



11 Key Elements

1. Medication reconciliation
2. Reconcile discharge plan with National Guidelines
3. Follow-up appointments
4. Post-discharge services
5. Outstanding tests
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone Reinforcement

*Community Connections

SNF Stays Allow More Time to Prepare

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After Care Plan 7-10 Days Prior to Discharge

- Introduce and engage/review with patient/caregiver

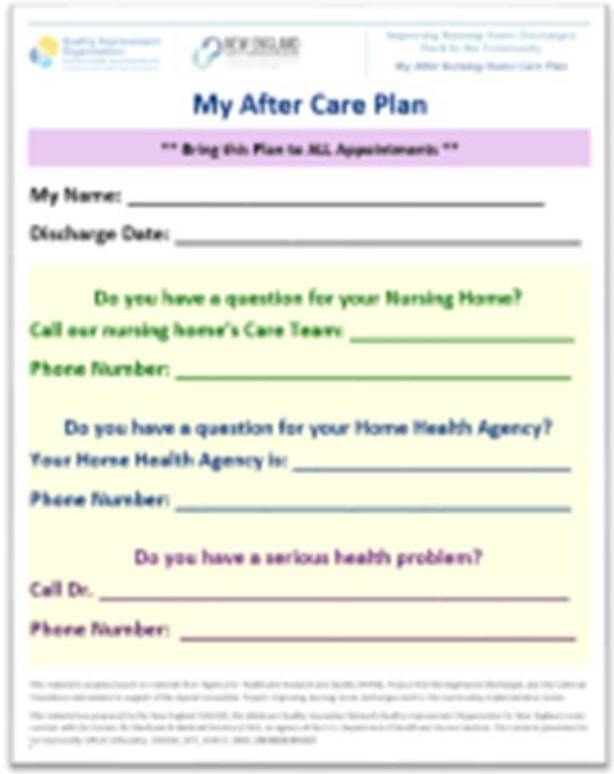
After Care Plan at Discharge

- Build upon previous engagement

Connecting to Community

- Community Physician
- Home Health
- Aging Service Access Point (ASAP)

Follow-up Call at 2 days



My After Care Plan

** Bring this Plan to ALL Appointments **

My Name: _____

Discharge Date: _____

Do you have a question for your Nursing Home?

Call our nursing home's Care Team: _____

Phone Number: _____

Do you have a question for your Home Health Agency?

Your Home Health Agency is: _____

Phone Number: _____

Do you have a serious health problem?

Call Dr. _____

Phone Number: _____

Implementation and Evaluation

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Admission

- Assess needs
- Identify caregiver
- Engage & educate pt/caregiver
- Discharge plan

Discharge

- Connect with community providers
- Connect with community services

Follow Up

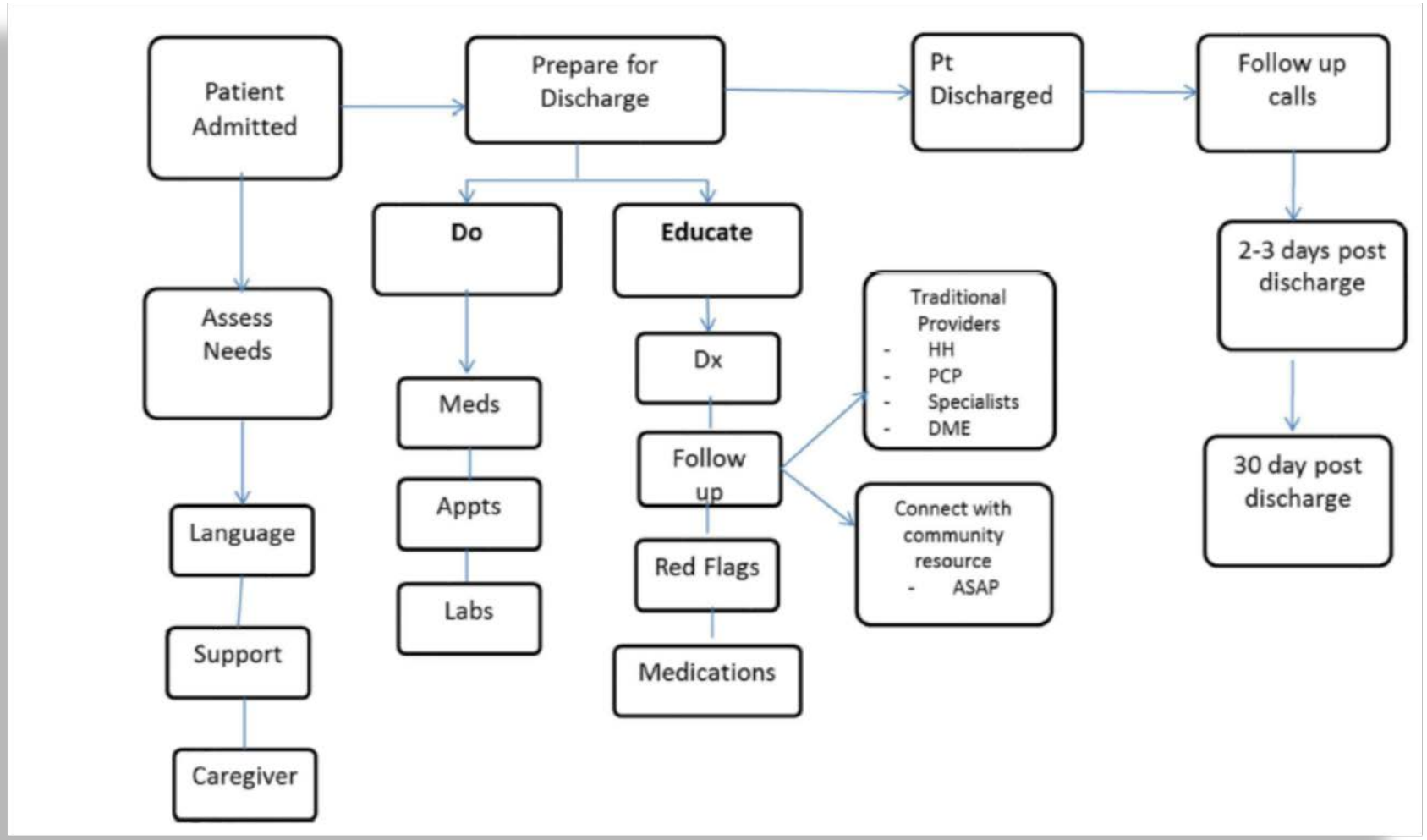
- Validate connections and address needs (48-72 hrs)

Assessment

- 30 day follow up call to assess impact of intervention

Building the Process

No Extra Work Please!



The Community Connection

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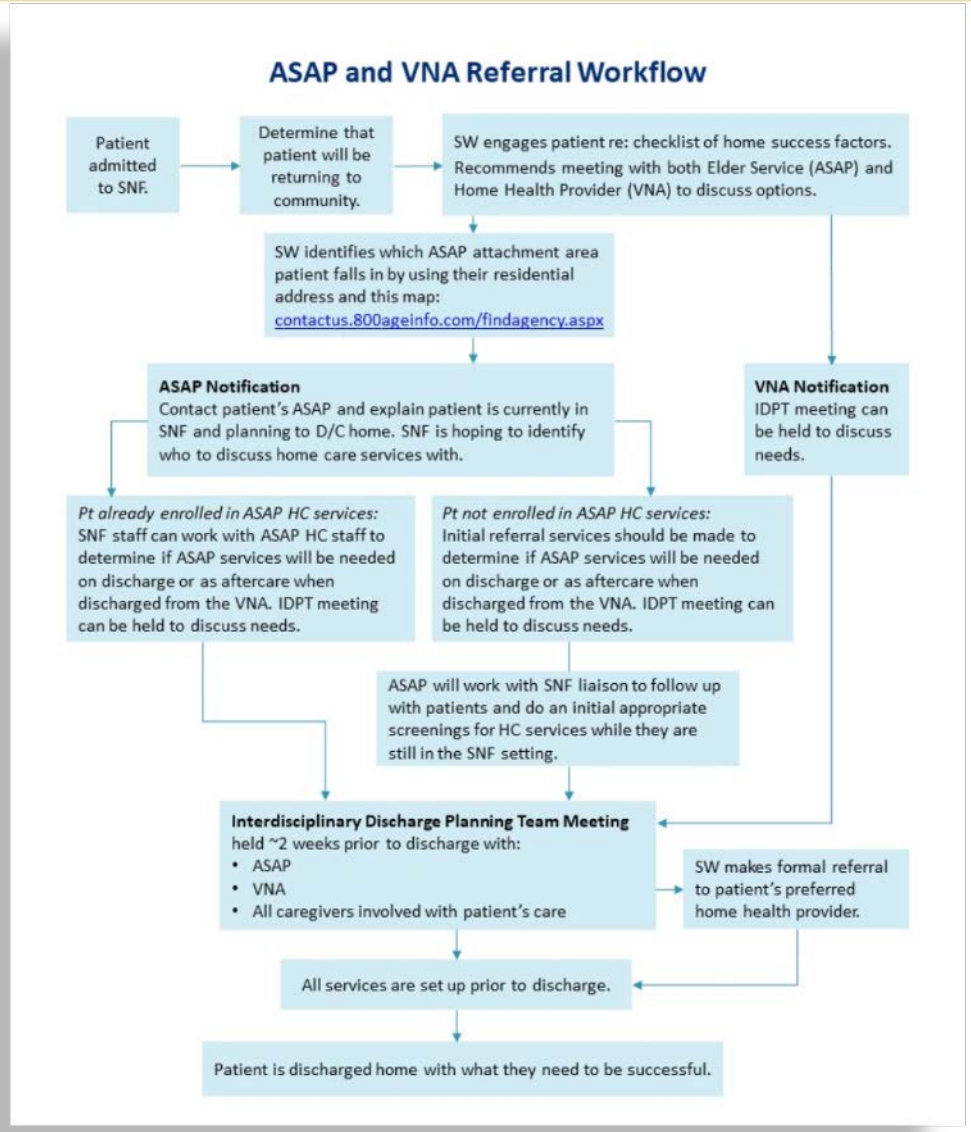
Area Agencies on Aging (AAAs)/Elder Services

Home Health/VNA

PCP and/or Specialist – physician in the community



The Impact

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Partnering with hospitals, nursing homes, home health and local aging services, we impacted

5,649 patients

Promising initial results in both pilot and expansion facilities…

Readmissions Snapshot

Measure	Pilot Group		Expansion Group	
Outcome Measures (Claims)*	1/1/17 - 3/31/17 (*baseline*)	1/1/19 - 3/31/19	7/1/18 - 9/30/18 (*baseline*)	1/1/19 - 3/31/19
30 Days Post Hospital Discharge	10.44% (26/249)	6.28% (15/239)	9.47% (18/190)	12.79% (28/219)
30 Days Post SNF Discharge	15.66% (39/249)	13.39% (32/239)	24.21% (46/190)	21.46% (47/219)
60 Days Post SNF Discharge	26.91% (67/249)	19.70% (47/239)	32.63% (62/190)	25.11% (55/219)
90 Days Post SNF Discharge	29.72% (74/249)	24.70% (59/239)	38.42% (73/190)	30.14% (66/219)

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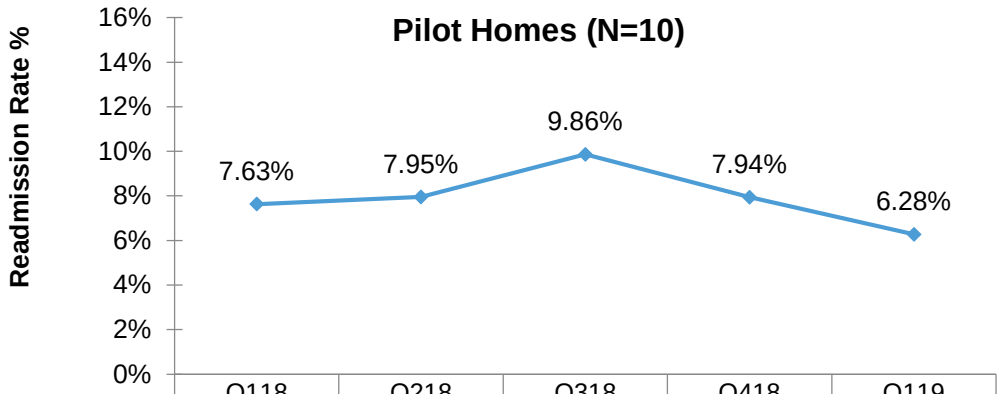
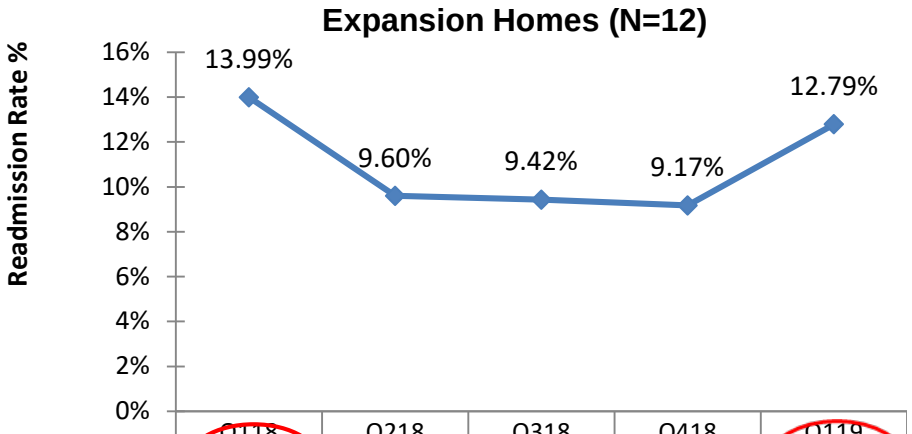
Meaningful Comparisons: 30 Days Post Hospital Discharge



	Q118	Q218	Q318	Q418	Q119
Readmission %	7.63%	7.95%	9.86%	7.94%	6.28%
Number of Readmissions	18	19	21	20	15
Number of Disch. To Home Setting	236	239	213	252	239

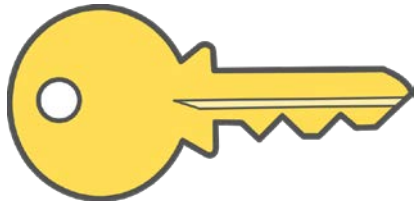


	Q118	Q218	Q318	Q418	Q119
Readmission %	13.99%	9.60%	9.42%	9.17%	12.79%
Number of Readmissions	34	19	18	21	28
Number of Disch. To Home Setting	243	198	191	229	219

Relative Improvement at Q1 2018 to Q1 2019

- 17.69% - Pilot
- 8.58% - Expansion

Keys to Success



Engage Leadership

- Train Staff
- Develop Champions

- Quarterly Learning Collaborative Meetings
- Bi-Monthly Peer Sharing Calls
- Monthly Technical Assistance

Track Progress

Assess Impact

Adherence to a process – building it in. Not redesigning a program, but building an efficiency and accountability in an existing process

Community Collaboration

- Get involved as soon as possible to connect patients with needed services
- Interdisciplinary Discharge Planning Team Meeting involvement

Video of the Project RED process

- https://www.youtube.com/watch?v=JAZY7ONtJZc&feature=youtu.be

Impact of COVID - 19

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USA

6,916,292

TOTAL CASES

USA

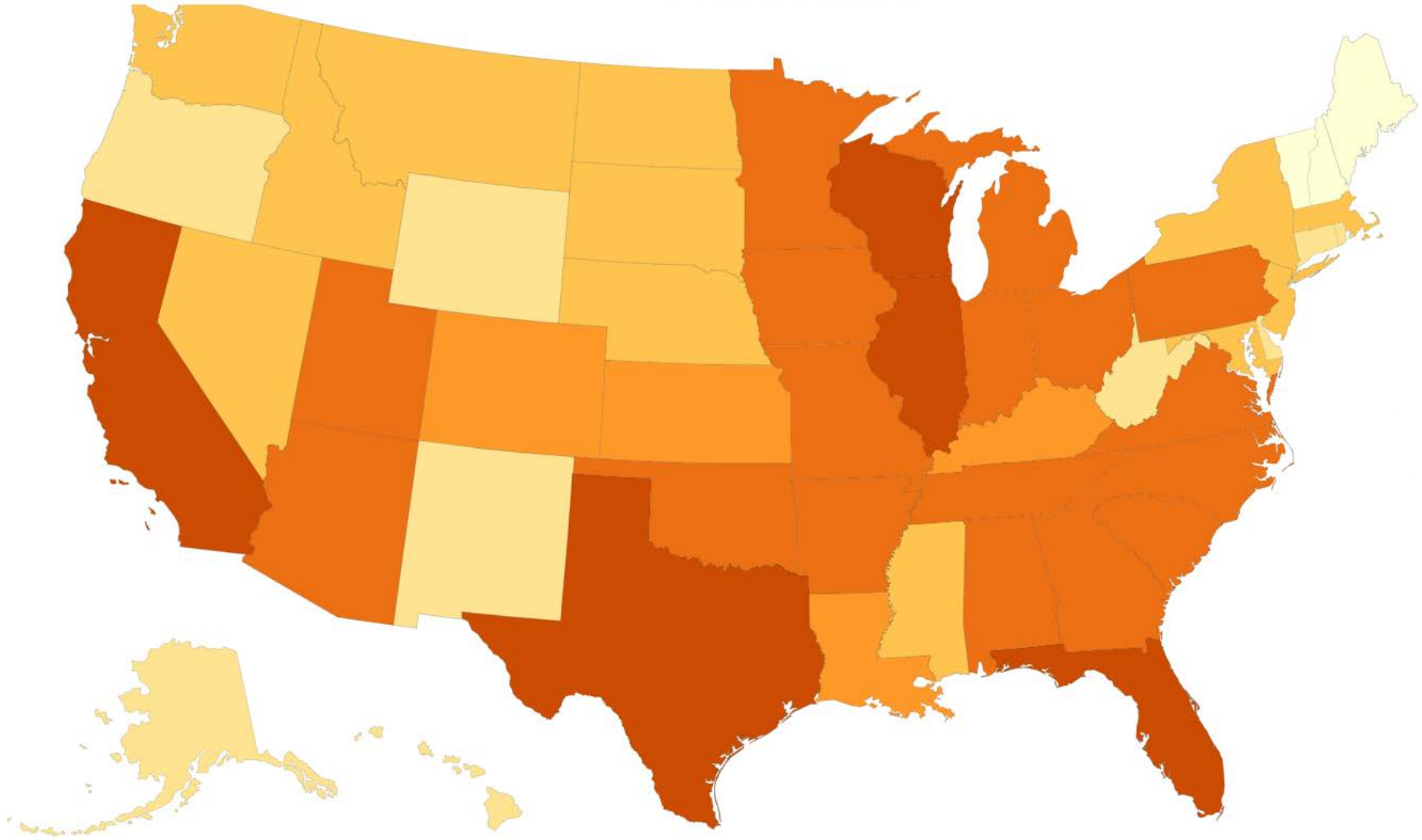
201,411

TOTAL DEATHS

USA

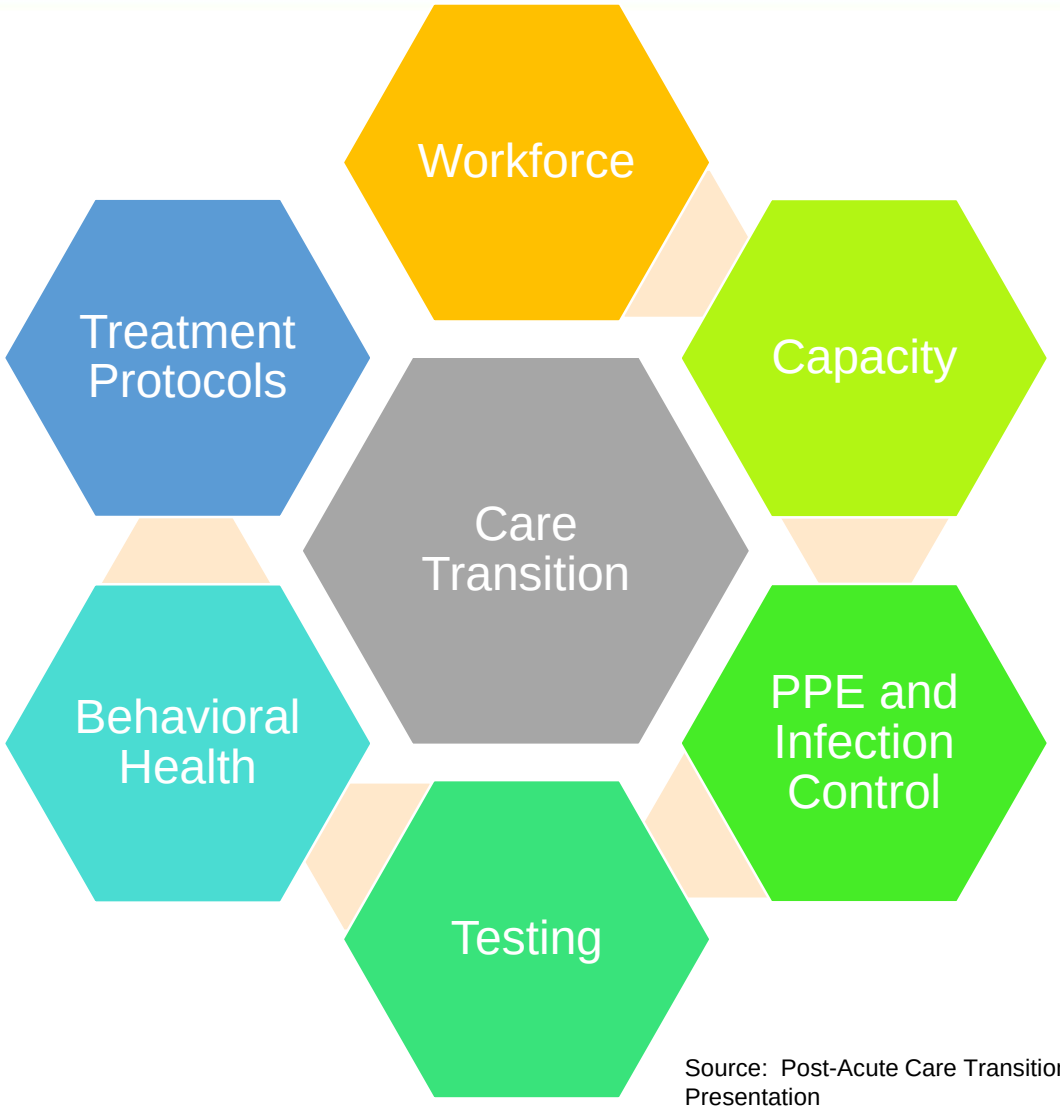
302,715

Cases in Last 7 Days



*CDC 09/24/2020

Coordinated Efforts
A Whole System Approach



Source: Post-Acute Care Transitions & Emergency Preparedness Workgroup: Summary of Progress, MHA Presentation

Coordinated Efforts
A Whole System Approach

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Workforce

Coordinated Efforts
A Whole System Approach

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Capacity

Coordinated Efforts
A Whole System Approach

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PPE and Infection Control

Coordinated Efforts
A Whole System Approach

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Testing

Coordinated Efforts
A Whole System Approach

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Treatment Protocols

Coordinated Efforts
A Whole System Approach

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Advanced Care Planning

Ariadne Labs'
Serious Illness Care Program

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COVID-19 Response Toolkit

- Patient Resources
- Inpatient Resources
- Outpatient Resources
- Long-term Care Resources
- Translations
- Crisis Resources
- Webinar Recordings

Source: https://covid19.ariadnelabs.org/serious-illness-care-program-covid-19-response-toolkit/#inpatient-resources

Best Practices During COVID-19

Lessons from a Community

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Daily huddles during peak, typically 15 mins maximum

Participants Included:

- Hospitals in the community
- Skilled Nursing Homes
- Home Health
- SNFist and Physicians
- Ombudsman
- Assisted Living

Structured report out:

- Announcements (QIO, Hospital, SNFist)
- Equipment (PPE, ventilators, needs)
- How many COVID positive patients/ pending?
- Accepting patients- bed capacity
- COVID units?
- Staffing

Lessons from a Community

Processes that worked

- **Testing and Diagnostics-** cohorting; immediate quarantining of symptomatic patient; admission quarantine unit, proactively leaving rooms open so able to act more quickly.
- **Goals of Care-** workgroup formed of SNFist, hospice staff and emergency physicians; spearhead conversations at the bedside either at hospital or nursing home
- **PPE**- hospital assisted in sterilization, piloted mask, creative solutions to gowns
- **Discharge phone calls-** post discharge calls occur next day, utilized the LACE tool.
- **How was rehab being delivered?** developed COVID Rehab teams consisted of PT, OT, SP
- **Dementia Units-** dedicated staff in each unit, so didn't share staff, healthy hands cart

Lessons from a Health System

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Paving the way with expert support

- ICAR Assessment
- Co-developed cohorting plans
- Decision to use 14 days to clear a resident from isolation
- Consideration of other resident impacts and development of best practices.
  - Showering
  - Smoking
  - Socialization
  - Disorientation
  - Depression

Lessons from a Health System

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Leverage Existing Connections

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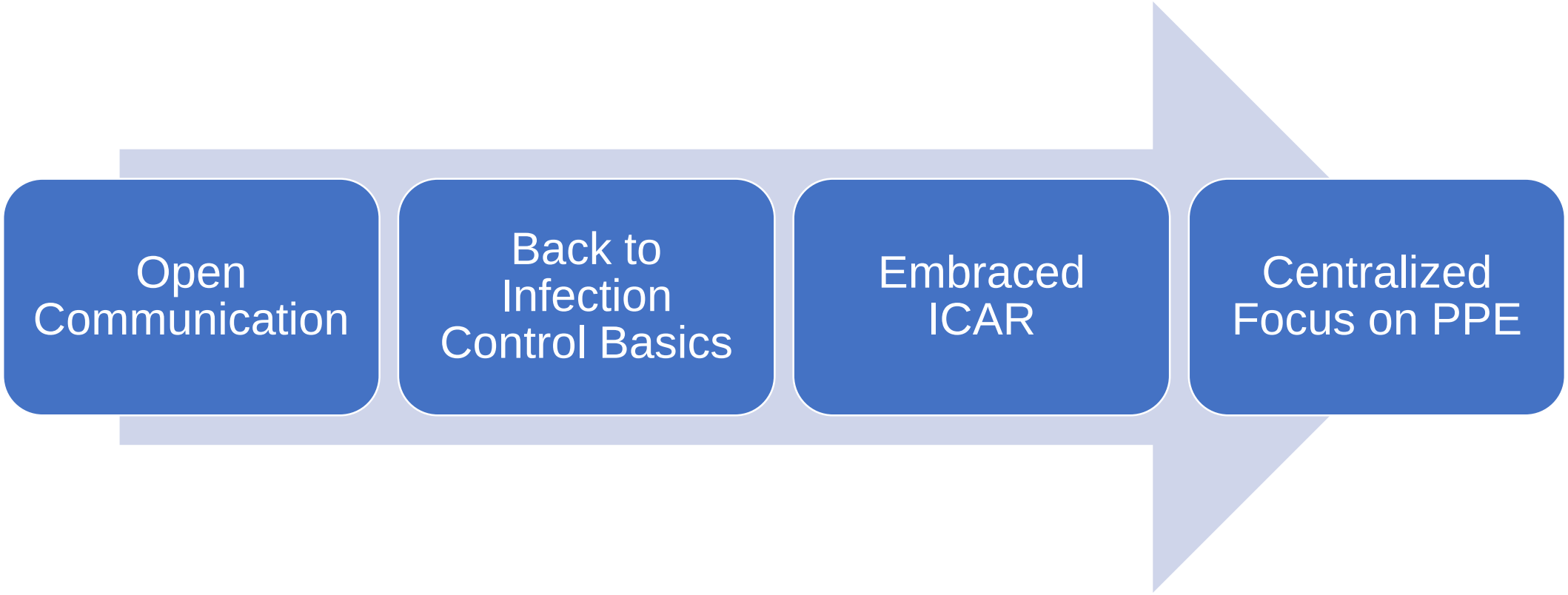
Immediate Actions- Before Protocols



Lessons from a Health System

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Provider Checklist

Precautions
□ Special Droplet/Contact precautions per policy
Advanced Directives
□ Code status:
□ Specific advanced directives:
Activity/mobility
□ Activity as tolerated
□ Mobility
Rehab
□ PT as indicated
□ OT as indicated
Diet / Supplements
□ Diet:
□ House supplement 4 ounces with each med pass
□ Offer 8 oz fluid in between meals unless contraindicated
□ HS snack
□ Increased assistance with meals
Labs
□ CBC / CMP on admission
□ PT/INR
□ Repeat WBC day 5-7
□ Lab other:

Oxygen
□ May apply oxygen (2-4 l/m) via nasal cannula to keep oxygen saturation > 90 %
□ Change oxygen tubing every 7 days and as needed
□ O2 Sat every shift
VS/Assessment
□ Vital signs every (4/8) hours and as needed
□ Cough: Y / N
□ Sore throat Y / N
□ Dyspnea Y / N
□ G/I complaints / symptoms Y / N
□ Fatigue / general malaise Y / N
□ Lack of appetite Y / N
□ Asymptomatic Y / N
House Stock Meds
□ Tylenol 325 mg (2 tabs) every 6 hours for fever / discomfort not to exceed 3 grams in 24 hours
□ House cough syrup 10 ml by mouth every 4 hours as needed cough
□ MOM 30 ml PO every day as needed constipation

https://qi.ipro.org/wp-content/uploads/Checklist_COVID-19_Provider.pdf

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Communication Checklist

What to do when you have your first positive case

- ✓ Inform resident of test results
- ✓ Inform resident representative of the positive COVID patient
- ✓ Inform MD of COVID positive results
- ✓ Inform Medical Director(s)
- ✓ DNS calls Regional Nurse
- ✓ Administrator calls Operations Director and Marketing Director
- ✓ Inform DPH Epidemiology –
- ✓ Inform DPH Health Care Quality – via Virtual Gateway reporting
- ✓ Inform Local Board of Health – (will likely request daily updates)
- ✓ Inform Hospice(s)
- ✓ Inform home VNA / Home care agencies
- ✓ Inform Liaisons / hospital
- ✓ Inform mobile x – ray and lab services / other outside services

https://qi.ipro.org/wp-content/uploads/Checklist-_First_COVID_Positive_Facility.pdf

CMS Toolkit of Best Practices

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Highlights on Transitions of Care

- District of Columbia: The COVID-19 Patient Transfer Communication Tool for Hospitals and Skilled Nursing Facilities allows sending and receiving facilities to document a patient's medical status related to COVID19. It is an algorithm which supports assessment of all hospitalized patients for COVID-19 before transfer to a post-acute facility (https://higherlogicdownload.s3.amazonaws.com/DCHA/751f0cb7-ab59-4ad3-8e48-c9a6ec516cea/UploadedImages/Documents/COVID-19_Patient_Transfer_Questionnaire_DCHA___DCHCA.pdf)
- Maine: Two large health systems collaborated with hospital, nursing home, and home health associations to create a protocol/recommendations for skilled nursing facility (SNF) transfers https://files.constantcontact.com/61812921601/bbba135e-b54a-4d96-8385-d3218b31397f.pdf

CMS Toolkit Source: https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-08-27-mlnc#_Toc49329802

Shared Challenges and Successes

- How did you partner across the continuum?
- What have been some of your challenges and barriers in caring for patients in your transition processes during COVID-19?
- What have been some of your successes in transitioning patients during COVID-19?

THANK YOU

Dawn Hobill MHA, PMP, CSM, LSSBB
Senior Program Administrator
T: 877.904.0057 X3314
Email: dhobill@healthcentricadvisors.org

100 Trade Center Drive
Suite G-700
Woburn, MA 01801

HealthcentricAdvisors.org