Healthy Gulf Coast Care Transitions

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“Hospital-to-nursing home transfers are some of the most logistically complicated safety challenges in the American medical system.”

Silos of Care

- Hospitals and nursing facilities are separate silos of care.
- Individual hospitals and nursing homes differ widely from each other within each silo.
- Staff members in hospitals and nursing homes have little knowledge of the capabilities or requirements within the other type of facility. This knowledge gap can create adversarial relationships if not bridged.
- Successful patient transfer systems between hospitals and nursing homes must create a method of communication between those entities.

Project RED
- Brian Jack, MD of Boston University
- Designed Project RED to improve the hospital discharge process through strategies that promote patient safety.
- Developed 11 steps from time of admission to discharge.
- Examples: Informing patient of diagnosis throughout their stay, organize post acute services, make follow up appointments, confirm medication reconciliation, review appropriate steps if problem arises...


Project RED (ReEngineered Discharge) Research
30-Day Readmissions Root Cause Analysis Process revealed:
- A weak or fragmented discharge plan.
- Miscommunication or failure to communicate important information at the time of transition.
- Inadequate preparation of patients for discharge or self-management.
- Inadequate medical follow-up with patients after discharge.
- Inadequate or poor communication with patients or caregivers or both about medications, tests, and red flags (such as signs and symptoms) of a deteriorating health condition.

Crossing the Quality Chasm
- Raised awareness of poorly organized and complex “hand-offs”.
- Called for swift changes.
- Boldly stated-- incremental process improvement efforts would not meet the challenge.
- By reinventing healthcare systems, care would be safer, more integrated, more available, and more reliable.
- Focus on “high reliability”, borrowed from aviation and nuclear power industries.
High Reliability and Care Transitions

What needs to happen?
- Promote a culture of transparency.
- Understand the root cause analysis process or “process of care investigation”.
- Face barriers head on and be willing to challenge the status quo.
- Encourage feedback from frontline staff and eliminate leadership behaviors which promote fear.
- Anyone involved in a particular transfer, no matter what their role, should be empowered to stop the process until safety requirements have been completed similar to an operating room when someone has observed a break in sterility.

Foster team work, beyond the walls of our organizations.

Healthy Gulf Coast Care Transitions

• Coalition evolved through the collaboration of hospitals, skilled nursing facilities, home health care agencies, hospices, and beneficiaries in Mobile and Baldwin counties.
• Initial charter was established in 2012.
• Created 501(c)3 in 2013.
• In 2015, broadened the scope to include Medicare and Medicaid beneficiaries.
• Revised charter goals to reflect CMS 11Th scope of work.
• Partnered with Quality Improvement Organization (AQAF) to foster engagement of key stakeholders.
Healthy Gulf Coast Care Transitions

A community partnership to promote better health through improved care transitions for community residents living in Mobile and Baldwin Counties

Goals

- Reduce 30-day readmission rates by 20% in the defined community by July 2019.
- Reduce adverse drug reactions among our participants by July 2019.
- To implement community level process improvement efforts through root cause analysis and transparency of readmission data by 2016.
- To facilitate the adoption of evidence based care transition processes among healthcare providers through the dissemination and education of information, best practices, and research by 2016.
- Increase community tenure, as evidenced by the increased number of nights spent at home, for Medicare beneficiaries by 10%, by July 2019.

Actions / Interventions

- Quality Improvement community level work groups
- Identification of perceived barriers to safe care transitions
- InteractII Training
- Chronic Disease Self-Management Program (Stanford program)
- Survey: Internal QI process at organizations
- Regional meetings with SNF Administrators and DONs to improve collaboration
- Restructured meetings to improve clinical engagement
- New Medication Task Force
Empowering Patients / Caregivers

- CMS Patient choice requirement recognizes options must be meaningful
- Interact: Capabilities List
- Used by Inpatient Case Managers / Care Coordinators to guide “meaningful choices”
- Educated inpatient staff
- Entering 2nd edition phase

Example: Crowne Healthcare of Mobile, LLC Implementation of Improvements

- SBAR
- Stop and Watch
- Care Paths on MARs for assessment guides (for SNF nurses)
- Capabilities list at ED
- QI Tool to review each 30 day readmission
- Weighing CHF patients upon admission to SNF and DAILY
- Daylight IQ Software program-alert charting-disease management software

...Barriers

- Sicker patients coming from the hospital to SNF without having advanced directives in place
- Medication Reconciliation issues
- SNF physicians not familiar with patients and poor hand-offs in the hospital to SNF transfer process (lack of MD to MD phone call at time of transfer)
- Narcotic medications not available upon admission due to Rx, pharmacy logistics issues
- HMOs and co-pays resulting in shorter SNF lengths of stay and readmissions to the hospital
2014 SNF Readmission Rates

Skilled Nursing Facility 30-Day Readmission Rate

- Providence Hospital: 13.8%
- Coalition Community: 22.4%
- Alabama: 20.4%

Challenges
- Establishing trust.
- Getting the right individuals at the table.
- Lack of internal knowledge/ awareness of facility level readmission rates.
- Leadership to carry out the work "after the meeting."
- Finding common value in agreed upon interventions.
- Execution of interventions and management of the change process at individual organizational levels.
- Real time data measurement.
- Engagement of leaders and the "right people" in the RCA and QI process.

Person-centered Care Transitions
- Will I be given the right medications after transfers, medications that cause me no harm?
- Will the new team of people who care for me know my history and be professionally capable of returning me home again if possible?
- Will the new team talk to my personal physician?
- After my illness and hospitalization, what will happen to me next?
- Whatever happens, will I be comfortable?

Lessons Learned

1. Successful hospital-to-nursing home transfer systems must incorporate communication and cooperation between facilities to recognize each other's requirements and capabilities.

2. Warm Transfer Process: Person-to-person dialogue communication between sending and receiving physicians and nurses solves many of the safety and quality problems arising during patient transfers.

3. Good hospital-to-nursing home transitions are as important to lowering hospital readmission rates as the nursing homes' abilities to manage problems after transfers.

4. Root cause analysis and skills in the area of process improvement are essential competencies for key stakeholders in today's complex health care environment (e.g. SNF liaisons, DONs, NHAs, Hospital CM leaders, and front line case managers).

5. The success of broad scale QI efforts is contingent upon Ideas, the Will, and Execution of the leaders driving the change.

Translational Research: Disrupting the Status Quo

- Sad fact: Research rarely makes it to practice
- Studies have examined barriers to implementation
- Translational research shifts the focus to end users
- Relates to focusing how the change organizational culture
- Focus on embedding best practices into the workflow
- Redesigning care so that it is easy to do the right thing

Institute for Healthcare Improvement

"...successful health and health care organizations of the future will be those that can simultaneously deliver excellent quality of care, at lower total costs, while improving the health of their population..."

Nitin Lewis, Director of IHI’s Triple Aim for Populations focus area
Crossing the Quality Chasm

• Calls for swift change.
• Boldly stated—incremental process improvement efforts will not meet the challenges of today’s increasingly complex system.
• Layering new FTEs is not the answer.
• Teaching new skills to front line staff is part of the answer.
• Investigative skills and critical thinking are key to finding creative solutions that make sense to end users.
• Consider reinventing our healthcare systems to create care that is safer, more integrated, more available, and more reliable.
• Hospitals and the SNF industry must collaborate to create “high reliability” in the care transition process.
• Commit to being an agent for change and leading improvements in your organizations. The work cannot be done by just a few.

SAVE THE DATES

Mobile & Baldwin Counties HGCCT Upcoming Meetings

• May 6th from Noon - 1 p.m.
  Medication Task Force Charter signing at the Community Foundation in Mobile

• May 13th from 2 p.m. to 4:00 p.m.
  Community Foundation meeting with Skilled Nursing Facilities to provide education about “process-of-care investigation” to determine reasons for preventable 30 day readmissions. Attendees should be DONs, Administrators, and liaisons who come to hospitals to screen patients. Discuss examples of last random 5-6 readmissions and categorize type / reason for readmission.

• June 4th from 1:00 to 2:30: Five Rivers Coalition Meeting
  Send decision makers and DONs.
  Focus: Roll out of standardized “warm transfer” process for SNF patients using SBAR pocket cards / community wide education.