Continuity of Care: A Community Collaborative

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Learning Objectives

• 1. Explain the importance of community collaboration for patient continuity of care and reducing avoidable hospital readmission.

• 2. Identify effective strategies for creating a community collaborative and how to increase patient engagement.

• 3. Describe how the role of the Transition Care Coach can bridge the gaps between hospitals, physicians and service providers, providing better continuity in care and decrease avoidable hospital readmissions.
Shawnee Mission Medical Center

- Located in Shawnee Mission, Kansas

Shawnee Mission Medical Center

- 504 bed Faith-Based Acute Care Hospital
  - Part of the Adventist Health System
  - Prairie Star
  - Corporate Care
  - New Site development

- Over 700 physicians

- Over 3000 employees
Continuity of Care

• Looking beyond the hospital walls

Continuity of Care

• What is continuity of care?
  • “For providers in vertically integrated systems of care: It is the delivery of a 'seamless service' through integration, coordination and the sharing of information between different providers.”

Continuity of Care

- Why is improving patient continuity of care important?
  - Reduce CMS penalties for high readmission rates
  - CMS Spending per Beneficiary (Oct. 1, 2014)
  - Increase HCAPS scores and patient satisfaction
  - More efficient use of resources

Continuity of Care

- Help patients avoid the “revolving door”
Continuity Requires a Community

• “If you build it (continuum of care collaborative), they will come”

Community Care Collaborative

Initiated by invitation from SMMC in 2011

• Monthly meeting at SMMC
• Initial group consisted of representatives from 4 to 5 area skilled nursing facilities

Growth by word of mouth

• 50 Agencies represented
• 105 Members in attendance
Community Care Collaborative

- Face to Face
  - “First name” partnerships
  - Creating “out of the box” pathways for patient care

Community Care Collaborative

**Monthly meetings**

- Case studies of patient readmissions to identify barriers and opportunities in transitions of care
- Development of common handoff tool that meets needs of hospital and external agencies
- Pooling of resource information and tools
  - File of Life
  - TPOPP
  - Interact
Community Care Collaborative

Monthly meetings (continued)

- Trend readmission data specific to various agencies/facilities to use in forming stronger community partners
- Venue to provide education about national or local policy, trends and strategies that affect hospital readmissions
- Facilitate networking and discussion among community providers
  - “Breaking down silos”

Community Care Collaborative

New in 2013

- Disseminating readmission rates to SNF’s, LTAC’s, and Acute Rehab’s; Closer collaboration with key stakeholders
- Enhancing patient education post-acute stay
- Cerner readmission application
- Adding additional diagnosis
  - COPD and joint replacement
- SNF Transition Care Coaches
Community Care Collaborative

- Respiratory therapy services added in Transitions Care
  - Additional coaching for COPD and PNA patients

- Collaboration with PCP and Specialty groups
Transition Care Coordinators

Transitions Care Coaches

- 0.5 FTE BSN
- 0.5 FTE LMSW

- Build relationships with patients and families and facilitate care transitions

- **Bridge the gap** between hospital and community healthcare providers increasing continuity of care.

Role of Transition Care Coach

**Facilitates Transition to Community Provider Prior to Discharge**

- Makes appointments for patients to follow up with physician within one week post discharge.

- Assesses what the barriers are to post-discharge patient care.
  - Transportation
  - Support

- Facilitates information exchange between transitions of care.
  - Reconciled Medication List
  - Discharge Summary
Role of Transition Care Coach

Facilitates Patient Self-Care

- Provides education regarding medications and care management issues
- Develops emergency rescue plan and whom to call
- Assesses patient needs and engages appropriate support for patient and family/caregivers for ongoing care

Role of Transition Care Coach

Community Collaboration Post Discharge

- Collaborates with community health care providers to create better patient care transitions
- Provides education for community agencies regarding patient care
  - Health management programs for community care facilities/staff
- Visits to patients at their homes and care facilities with every transition in care. Transition Care Coach and patient relationship remain the constant through each transition
- Identify barriers in transitions of care within the community
Role of Transition Care Coach

Provide Education in-services to staff at area facilities

- Transition Care Coach RN provides disease specific patient care guidelines
  - In-service provided to ALL staff
- Provides earlier detection of signs and symptoms
- Higher compliance with care protocols
- Fosters relationship between facility and the hospital

Role of Transition Care Coach

Provides Wellness Education Program

COPD and CHF

- One hour information/education session
  - Nurse (CHF)
  - Social Worker (CHF)
  - Respiratory therapist (COPD)
- Ongoing supervised fitness program
  - Physical therapist/respiratory therapist
  - Exercise specialist
Tools of the Trade

- Use tools for patient engagement and education consistently along health care continuum
  - Motivational interviewing
  - Teach-back
  - Shared decision-making

Patient Engagement

- Patient centered care planning
  - Ascertain patients goals and wishes
  - Behavior modification based on agreed upon goals

Video: Motivational Interviewing: Evoking Commitment to Change
http://www.youtube.com/watch?v=dm-rJPCuTE
Patient Engagement

• Health Literacy Assessment

• The Institute of Medicine report Health Literacy: A Prescription to End Confusion provides this definition of health literacy:

  "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions"

• According to the American Medical Association report, Health Literacy and Patient Safety: Help Patients Understand,

  "poor health literacy is a stronger predictor of a person’s health than age, income, employment status, education level, and race"

Health Literacy Video

AMA Health Literacy Video - Short Version
http://www.youtube.com/watch?v=BgTuD7I7LG8
Teach Back

- Making information “stick” more effectively
- Creates an opportunity for dialogue in which the provider gives information, then asks the patient to respond and confirm understanding before adding any new information.
- Re-phrase if a patient is not able to repeat the information accurately
- Ask the patient to teach back the information again, using their own words, until you are comfortable they really understand it
- If they still do not understand, consider other strategies

Teach Back: Closing the loop
Teach Back Video

Teach Back Video--a technique for teaching patients
• http://www.youtube.com/watch?v=IKxjmpD7vY

Bridge Program

• Multi-visit patients (MVPs) to ED (12 visits/12 months)

• Engage patients and health care stakeholders
  • Plugs patient back into community care

• Expected outcome:
  • Decrease ED visits per MVP by 25%

• 0.5 RN and 0.5 LMSW
Results

**SMMC CHF Medicare Readmission Rate**

- Jan-December 2009: 22.4% (76/339)
- Jan-December 2010: 22.5% (72/320)
- Jan-December 2011: 22.9% (78/340)
- Jan-December 2012: 16.5% (50/302)

*28% decrease in readmissions from 2011*
21% decrease in readmissions from 2011

49% decrease in readmissions from 2011
CHF Readmission Rates*

w/ Medicare Exclusions
January 2013-June 2013

PNA Readmission Rates*

w/ Medicare Exclusions
January 2013-June 2013
AMI Readmission Rates*  
W/ Medicare Exclusions  
January 2013-June 2013

Where Transition Coach Patients Discharged To  
January 2012-December 2012
Where Transition Coach Patients Readmitted From January 2012 - December 2012

- Home: 40%
- Home Health: 27%
- SNF: 25%
- Acute Rehab: 6%
- LTAC: 2%
- Hospice: 0%

Where Transition Coach Patients Discharged To January 2013-June 2013

- Home: 40%
- Home Health: 23%
- SNF: 25%
- Acute Rehab: 3%
- LTAC: 5%
- Hospice: 8%
Where Transition Coach Patients Readmitted From January 2013 - June 2013

- Home Health: 37.5%
- Acute Rehab: 15%
- SNF: 32.5%
- LTAC: 2%
- Hospice: 0%
- Home: 15%

Questions/Discussion
Thank you!