

Care Transitions: A World of Nursing Opportunities

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**Commonwealth of
Massachusetts**
Executive Office of Health and
Human Services



Massachusetts Strategic Plan for Care Transitions

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For the Massachusetts State Quality Improvement Institute (SQII) of the
Executive Office of Health and Human Services

Definition

- A *care transition* is the transfer of a patient from one setting of care or one set of providers to another during the course of an episode of care.
- Related terms:
 - Care coordination
 - Discharge planning
 - Care management
 - Transitions coaching
 - Continuity of care

Barriers to Effective Care Transitions

Structural

- Lack of integrated care systems
- Lack of longitudinal responsibility
- Lack of standardized forms and processes
- Incompatible information systems
- Lack of care coordination and team-based training
- Lack of established community links

Procedural

- Ineffective communication
- Failure to recognize cultural, educational or language differences
- Processes are not patient-centered nor longitudinal

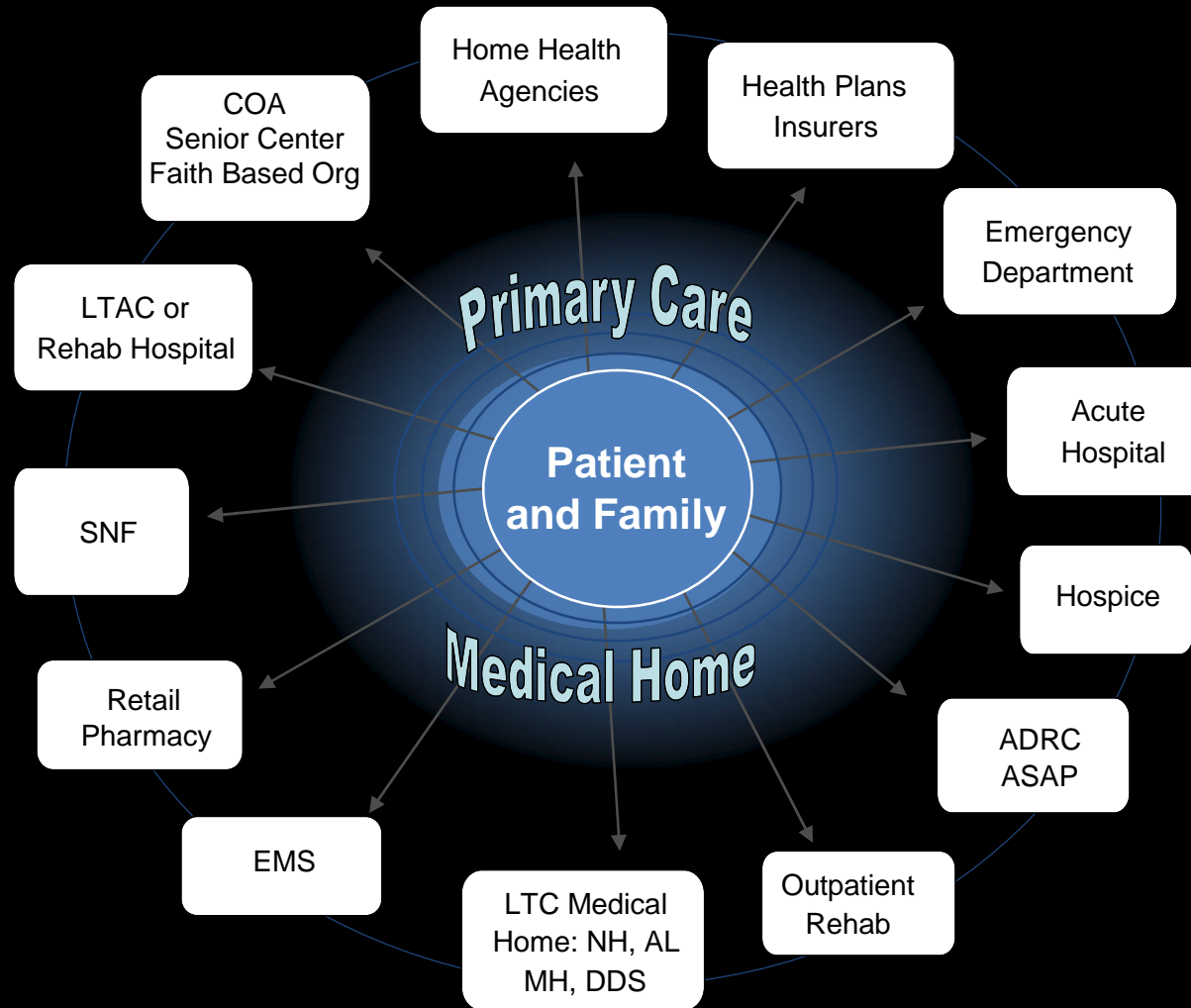
Performance Measurement and Alignment

- Underuse of measures to indicate optimal transitions
- Compensation and performance incentives not aligned with care coordination and transitions
- Payment is for volume of services rather than incentivized for outcomes

Model for Care Transitions Infrastructure

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Massachusetts Strategic Plan for Care Transitions: Purpose

- To create a “living document” that:
 - Creates a vision for optimal transitions in care for everyone in Massachusetts
 - Sets broad goals and actionable steps that will lead to implementation
- To ensure that this work is aligned with related state and federal health care, payment reform efforts and HIT strategies

The Vision

- Interdisciplinary teams delivering safe, effective, and timely care that is culturally and linguistically appropriate within and across settings
- Aligning
 - Clinical care (individuals)
 - Public health (populations)
 - Health policy (payment and organization of services)

Some Elements of Care Common to Most of the Transitions Models

- Medication management
- Assessing patient's understanding/ability to follow care plan
- Discharge support
- Coaching for primary care physician visit
- Use of home visits
- Screening for cognitive ability
- Use of centralized health record
- Involving family and other caregivers
- Arranging community-based support services

What is Known?

National Examples of Best Practices

- The Care Transitions Model (Coleman)
- The Transitional Care Model (Naylor)
- Project RED or Re-Engineered Discharge (Jack)
- The Continuity Assessment Record and Evaluation (CARE) Tool (CMS)

Existing Care Transitions Models in Massachusetts

- INTERACT II
- STAAR
- MOLST
- BOOST
- RED
- Partners Healthcare System Clinical Transitions Project
- Sommerville Hospital Study
- Massachusetts Pressure Ulcer Collaborative
- Aligning Forces for Quality Project (RWJ)
- Patient-Centered Medical Home
- Medicare High Cost Beneficiaries Demo (MGH)
- ADRCs/ASAPs

What is Known About Costs & Savings?

- Jencks, Williams, Coleman study in *NEJM* 2009
 - Cost to Medicare in 2004 from unplanned rehospitalizations was \$17.4 billion
- Mor et al study in *Health Affairs* 2010
 - Cost of rehospitalizations of SNF/LTC patients in Massachusetts in 2006 was \$146 million
 - Rehospitalization rate was 22.6% in this population

What is Known About Costs & Savings?

- The Care Transitions Model (Coleman)
 - Annual Cost= \$74,310 for 379 patients (\$196 per patient).
 - Estimated Annual Cost Savings: \$844 per patient
- The Transitional Care Model (Naylor)
 - The total intervention cost was \$115,856 (\$982 per patient).
 - One study demonstrated mean cost savings of \$5000/patient
- The Guided Care Model (Boult)
 - Randomized studies indicate cost savings of \$1364 per patient (\$75,000 per nurse)
- Project RED (Jack)
 - Randomized Studies showed cost savings of \$380/patient

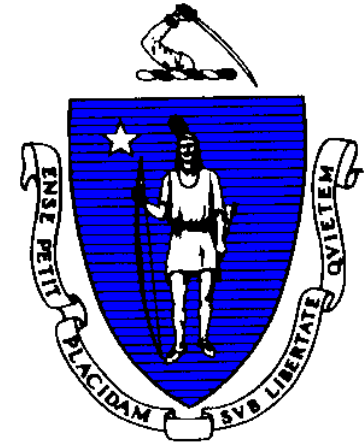
From: The Lewin Group, December 16, 2009 Care Transitions Workgroup

MA Strategic Plan: Principles and Key Recommendations

Principles

Key Recommendations

<p>1. Timely feedback and feed forward of information</p>	<ul style="list-style-type: none"> ▪ Standardized, minimum dataset ▪ Cross-continuum teams ▪ Enhanced early post-acute care follow up
<p>2. Communication Infrastructure</p>	<ul style="list-style-type: none"> ▪ Contact information provided ▪ Living database ▪ Medication tracking
<p>3. Patient and Family Engagement</p>	<ul style="list-style-type: none"> ▪ Patient and/or advocacy group representation
<p>4. Accountability for care remains with the sending set of providers</p>	<ul style="list-style-type: none"> ▪ Handoff responsibility ▪ Identifiable provider
<p>5. Provider and Practice Engagement</p>	<ul style="list-style-type: none"> ▪ Education/Best Practices ▪ Mentors
<p>6. Standardized process and outcome measures, based on nationally endorsed measures</p>	<ul style="list-style-type: none"> ▪ Collaboration with Expert Panel on Performance Measurement
<p>7. Payment reform</p>	<ul style="list-style-type: none"> ▪ Incentive alignment ▪ Data transparency



Revised tools based on CMS pilot study,
and input from
frontline nursing home staff and national experts

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Fund*

www.interact2.net

Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

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Arizona State and Emory Universities
Massachusetts Department of Public Health
Mass Senior Care
Florida Atlantic University
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Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

- Current financial incentives in the Medicare fee-for-service program foster the overuse of diagnostic tests and interventions that do not benefit many elderly patients, and can result in morbid and costly complications
- Care can be improved at reduced costs
 - Savings can be reinvested to improve care
- One major example in the geriatric population is **potentially avoidable acute care hospitalizations and hospital readmissions**

Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

1 in 5 Medicare fee-for-service patients admitted to an acute hospital are re-admitted within 30 days

THE NEW ENGLAND JOURNAL OF MEDICINE

SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D.,
and Eric A. Coleman, M.D., M.P.H.

N Engl J Med 2009; 360:1418-28

Hospital Readmissions within 30 days from SNFs are Common

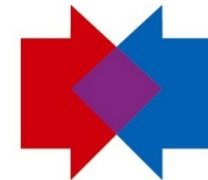
- Of ~1.8 million SNF admissions in the U.S. in 2006, **23.5% were re-admitted to an acute hospital within 30 days**
- Cost of these readmissions = **\$4.3 billion**

Mor et al. Health Affairs 29 (No. 1): 57-64, 2010

Hospitalization of Nursing Home Residents

- **Common**
- **Expensive**
- **Often traumatic to the resident and family**
- **Fraught with many complications of hospitalization**

(e.g. deconditioning, delirium, incontinence/catheter use, pressure ulcers, polypharmacy)



INTERACT

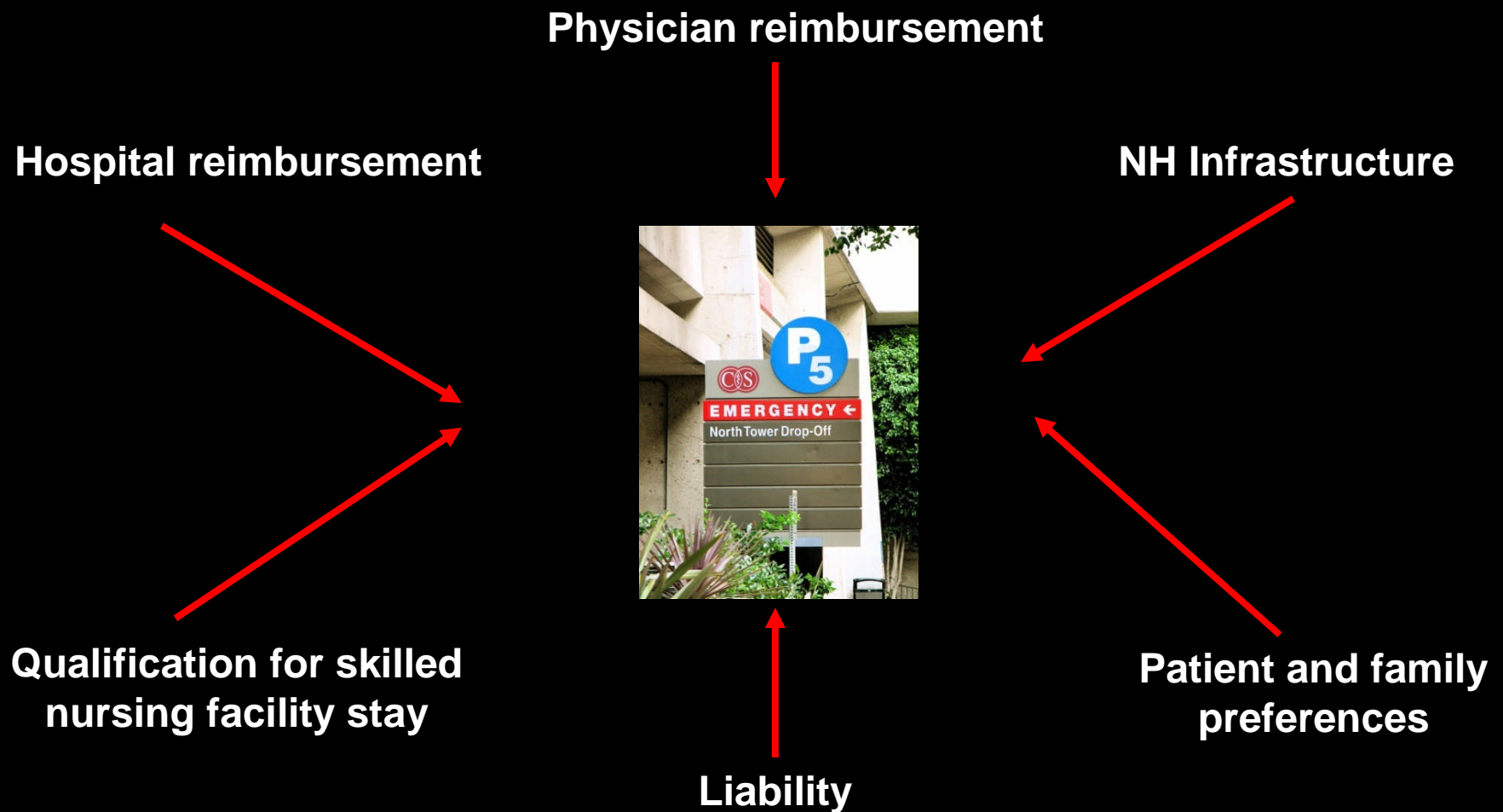
Interventions to Reduce Acute Care Transfers

Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

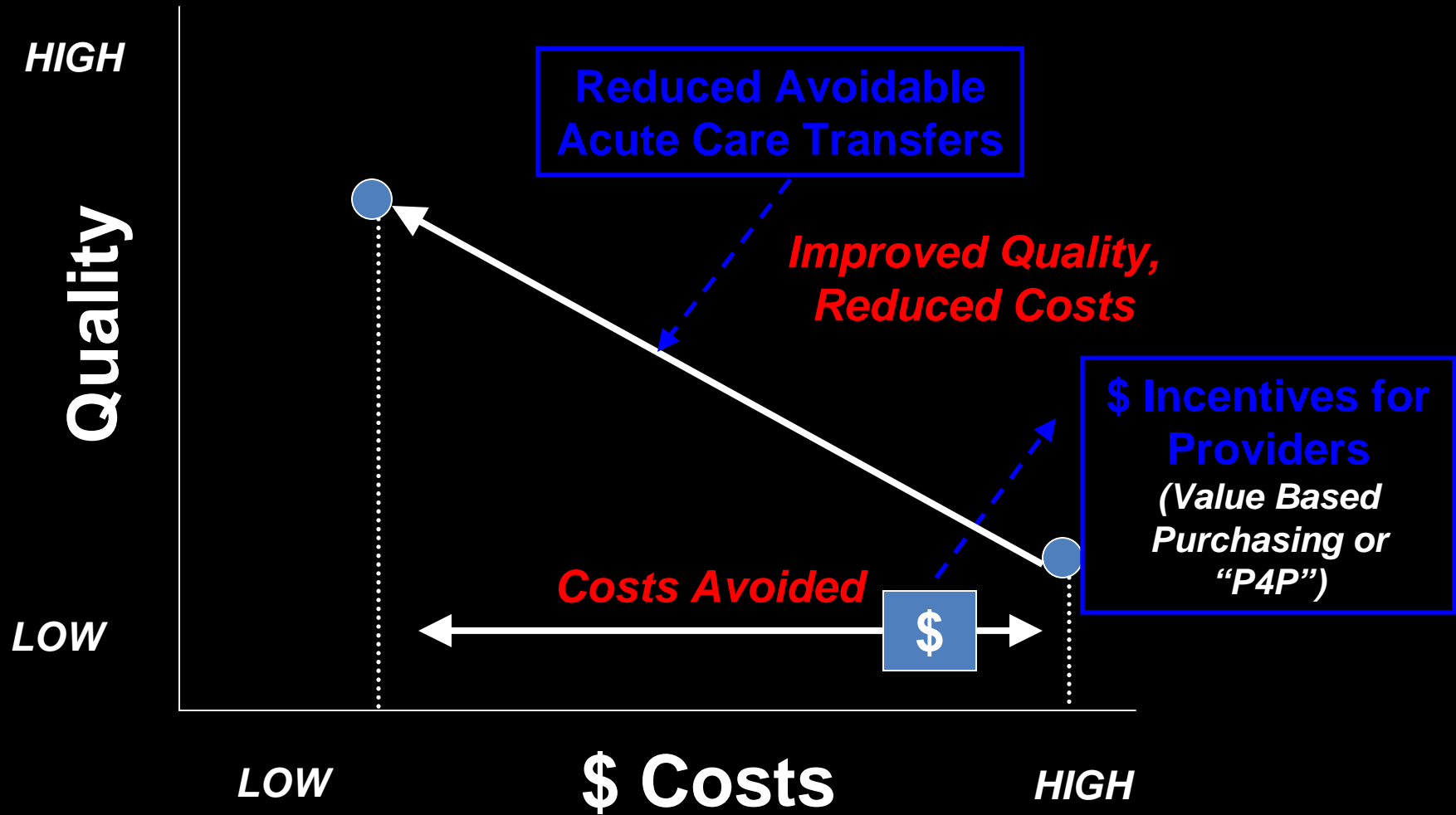
Background

- **Why try to reduce hospitalizations from NHs?**
 - Hospitalization is often bad for frail older patients
 - Care can be improved at reduced cost
 - Financial and regulatory incentives are likely to change over the next few years, although currently incentives all favor hospitalization

What are the Incentives for Providers?



Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations



CMS Special Study Awarded to the Georgia Medical Care Foundation

- **18 month project (7/06 – 1/08)**
- **Develop and pilot test tools and strategies to reduce potentially avoidable acute hospitalizations of nursing home residents**

Joseph G. Ouslander, MD, Clinical Consultant, GMCF, Professor of
Medicine and Nursing, Emory University

Mary Perloe APRN-BC, GNP - Project Coordinator, GMCF

JoVonn Hughley, MPH - Evaluation Specialist, GMCF

Tracy Rutland, MBA, MHA – Quality Improvement & Education Specialist

Linda Kluge RD, LD, CPHQ – Nursing Home Project Manager, GMCF

Gerri Lamb, PhD, RN – Professor, School of Nursing, Emory University

Adam Atherly, PhD – Associate Professor, School of Public Health, Emory
University

Jeff Hibbert, PhD – Data Analyst/Statistician, GMCF

Expert Panel – 10 members

CMS Special Study Results

Of 200 hospitalizations, an expert clinician panel rated **2/3** as *potentially avoidable*

	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	69%	31%
Other	65%	35%
HIGH Hospitalization Rate Homes	75%	25%
LOW Hospitalization Rate Homes	59%	41%
TOTAL	68%	32%

CMS Special Study Results

Expert panel members rated improving quality of care for assessing acute changes, more involvement of primary care MDs and/or NPs/PAs, ability to do stat lab tests and IV fluids, improved advance care planning, and providing less futile care as important in reducing avoidable hospitalizations

Factors

Better **quality of care** would have prevented or decreased severity of acute change

One **physician visit** could have avoided the transfer

Better **advance care planning** would have prevented the transfer

The same **benefits** could have been achieved at a lower level of care

The resident's overall condition limited his ability to **benefit** from the transfer

Resources Needed

Physician or physician extender present in nursing home at least 3 days per week

Exam by **physician or physician extender** within 24 hours

Nurse practitioner involvement

Registered nurse (as opposed to LPN or CNA) providing care

Availability of **lab tests** within 3 hours

Capability for **intravenous fluid** therapy



***A Toolkit to Improve Nursing Home Care by
Reducing Avoidable Acute Care Transfers and Hospitalizations***

Care Paths

Communication Tools

Advance Care Planning Tools

CMS Pilot Study Results

- Tools and implementation strategies were pilot tested in 3 Georgia NHs with relatively high hospitalization rates
- 3 detailed case studies
- Limited generalizability

Ouslander et al: J Amer Med Dir Assoc 9: 644-652, 2009

CMS Pilot Study Results

The *Transfer Review* form was a key component

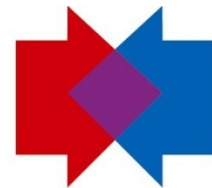
Almost 40% of the hospitalizations were rated as potentially avoidable by NH staff in their retrospective review

Most NH staff indicated they liked the tools and found them helpful

Some tools perceived as too much added paperwork

Some staff preferred different formats

Hospitalizations were significantly reduced (proportion rated as avoidable was reduced by 28%; total frequency of hospitalizations reduced by 50%)



INTERACT

Interventions to Reduce Acute Care Transfers

CMS Special Study Results

The overall frequency of hospitalizations
was reduced by 50%

	Baseline		Intervention (6 months)	
Facility	No. of Hospitalizations	Hospitalizations per 1000 resident days	Hospitalizations per 1000 resident days	% Reduction from Baseline
1	168	3.14	1.77	44%
2	138	2.81	1.17	58%
3	133	3.31	2.11	36%
All 3 facilities	439	3.07	1.54	50%

How can we work together to reduce potentially avoidable hospitalizations of NH residents?

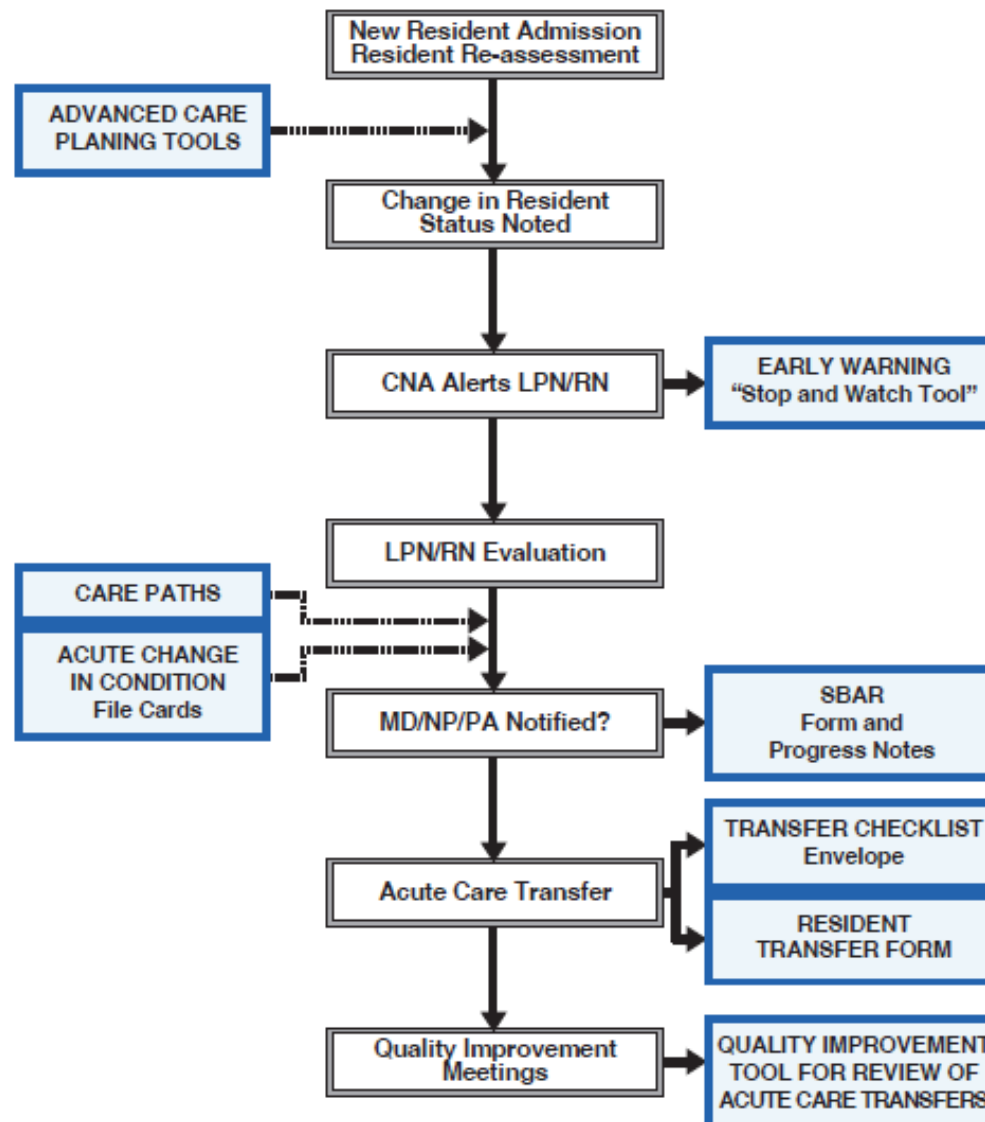
- We must recognize that:
 - Hospitalizations are often bad for residents under our care
 - Financial and regulatory incentives are going to change
- CMS and states must provide support for infrastructure in NHs:
 - Staff training for recognition and management of acute changes in clinical status
 - Adequate reimbursement for higher acuity care
- Clinical practice guidelines and tools that assist with the assessment and management of acute changes in clinical status must be made available in formats that are feasible to incorporate into

Objectives for tools are to assist with:

- Anticipatory Planning
- Early recognition of change
- Communication
- Safe Management in the Nursing Home
- Transitional Care
- Continuous Improvement



Using the INTERACT^{II} Tools in Every Day Work in the Nursing Home



Each Strategy and Tool is Part of an Integrated Process

HOW does this process happen in your facility?

- Discussion & documentation of advance directives
- Discussions about potential for hospitalization
- Early recognition of change in status
- Documentation & communication of change in status
- Decisions to transfer
- Transitional care
- Process improvement



More than just a set of new tools

Requires changes in thinking and culture to:

- *Anticipate common reasons for transfers* – assess and act early
- *Reduce communication barriers* – between CNAs, nurses, PCPs; and between NHs and hospitals
- *Clarify roles* – whose responsibility is it to prepare family members for possible transfer decisions and the options? Does it happen?
- *Implement continuous improvement process* – with consistency and intent to change process and outcomes



Implementing the INTERACT II Toolkit

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INTERACT II

Funded by the Commonwealth Fund

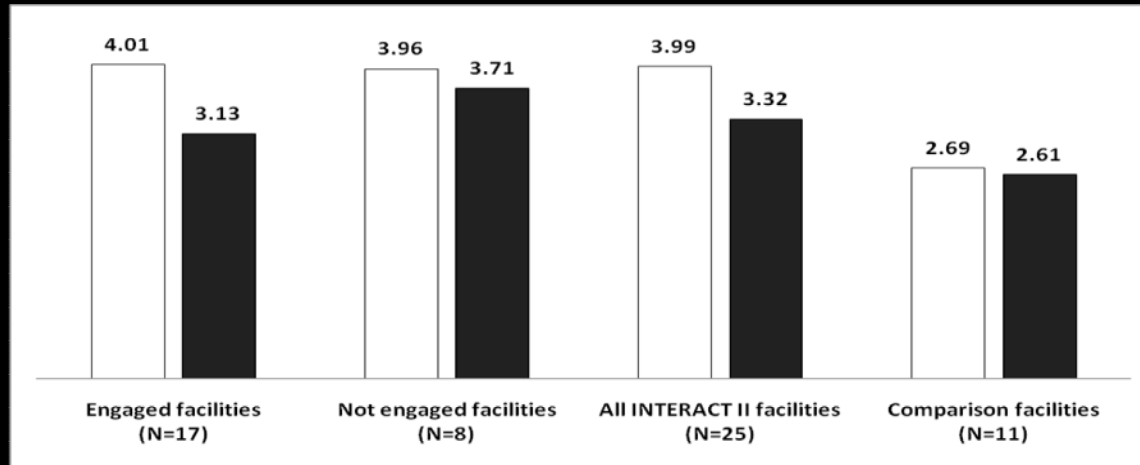
- Principal Investigator: Dr. Joseph G Ouslander
- Co-Principal Investigator: Dr. Gerri Lamb
Independence Foundation and
Wesley Woods Chair
Associate Professor of Nursing
Emory University
- Collaborators: Laurie Herndon, MSN, GNP-BC
Senior Project Coordinator
Alice Bonner, PhD, RN
Co-Investigator
Massachusetts Department of Public
Health

Multidisciplinary teams from MA, NY, and FL

Methods

- Toolkit refined
- Implement and evaluate refined toolkit in 30 nursing homes in MA, NY, FL for 6 months
 - What works and what doesn't
 - What does it take to make it work?
- Champion
- Collaborative calls

INTERACT II Collaborative Preliminary Results



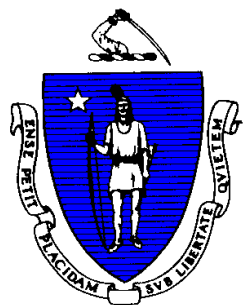
Facilities	Mean Hospitalization Rate per 1000 resident days (SD)		Mean Change (SD)	95% Confidence Interval	p value	Relative Reduction
	Pre intervention	During Intervention				
Engaged facilities	4.01 (2.56)	3.13 (2.27)	- 0.90 (1.28)	-0.23 to -1.56	0.01	24%
Not engaged facilities	3.96 (1.79)	3.71 (1.53)	- 0.26 (1.83)	-1.79 to 1.27	0.69	6%
All INTERACT II facilities	3.99 (2.30)	3.32 (2.04)	- 0.69 (1.47)	-0.08 to -1.30	0.02	17%
Comparison facilities	2.69 (2.23)	2.61 (1.82)	- 0.08 (0.74)	- 0.41 to 0.58	0.72	3%



www.interact2.net

The INTERACT II Tools, educational materials, and implementation strategies were developed by Drs. Joseph Ouslander, Gerri Lamb, Alice Bonner, and Ruth Tappen, and Laurie Herndon with input from a variety of direct care providers and national experts in a project supported by the Commonwealth Fund based at Florida Atlantic University.

Initial versions of the INTERACT Tools were developed by Dr. Ouslander and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a special study contract from CMS.



Statewide Strategies (INTERACT II and STAAR)

- Next Steps: statewide or regional expansion
- Adapting INTERACT II for the “real world”
 - which tools and processes will you use and how?
 - Train the Trainer
- Massachusetts has gone from 9 INTERACT demonstration homes to over 100 homes by 1/1/2011
- New STAAR hospitals signing up 1/2011



Thank You!

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