

Protecting the Most Vulnerable

The Critical Role of Nursing

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Some touch-points for our conversation....

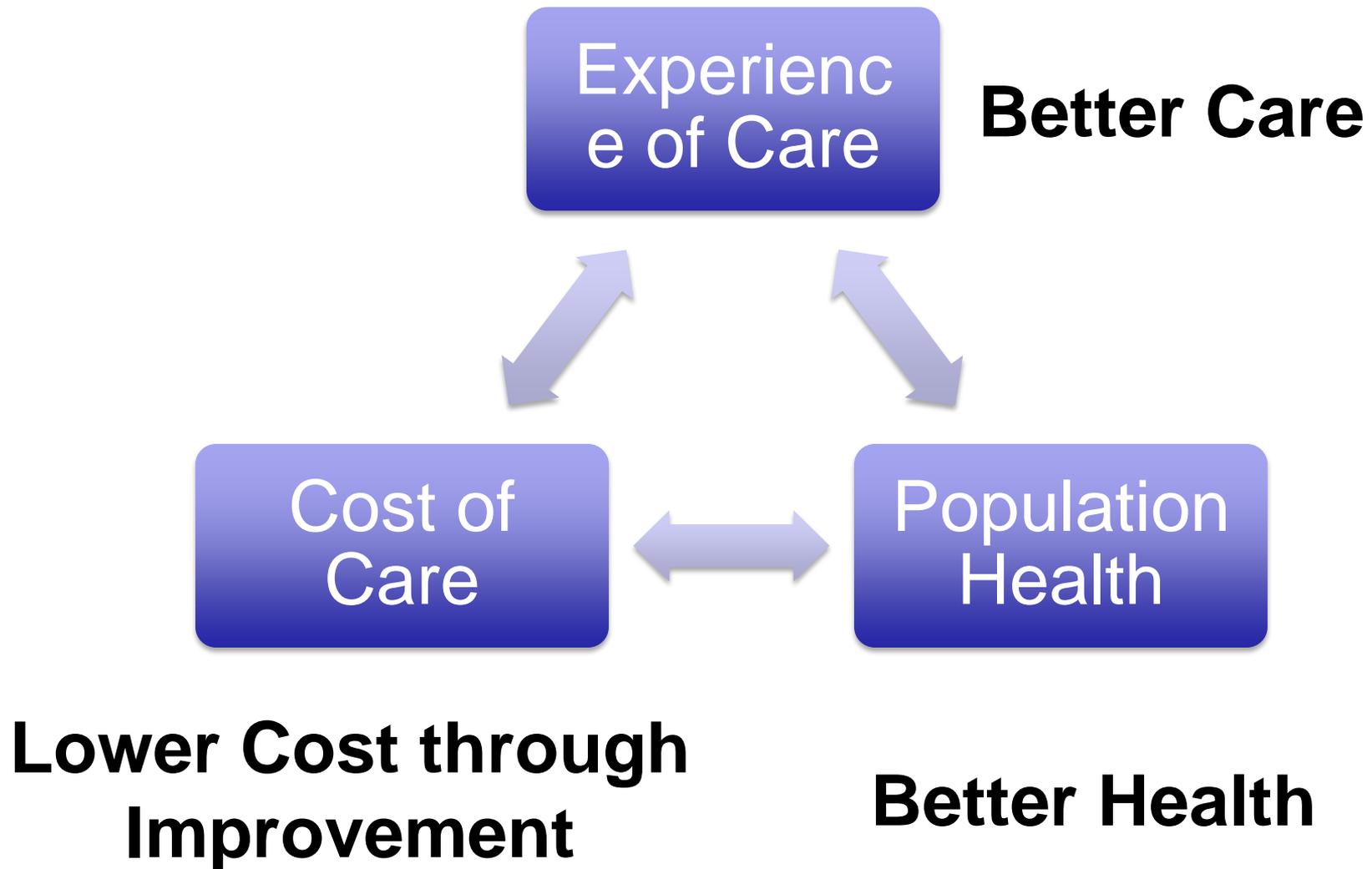
- The Three-Part Aim
- A population-based view of the work we do
- Care management vs. care coordination / segmenting the population
- Change / Improvement and strategic alignment
- Measurement to guide improvement
- Preventable Admissions / Readmissions as a case in point.

Time to do some work

At the end of our time together...

- What change are you going to test?
- Who needs to be involved?
- When will you test it (next Tuesday?)

Triple Aim (IHI) Three Part Aim (CMS)



Prevention and
Wellness

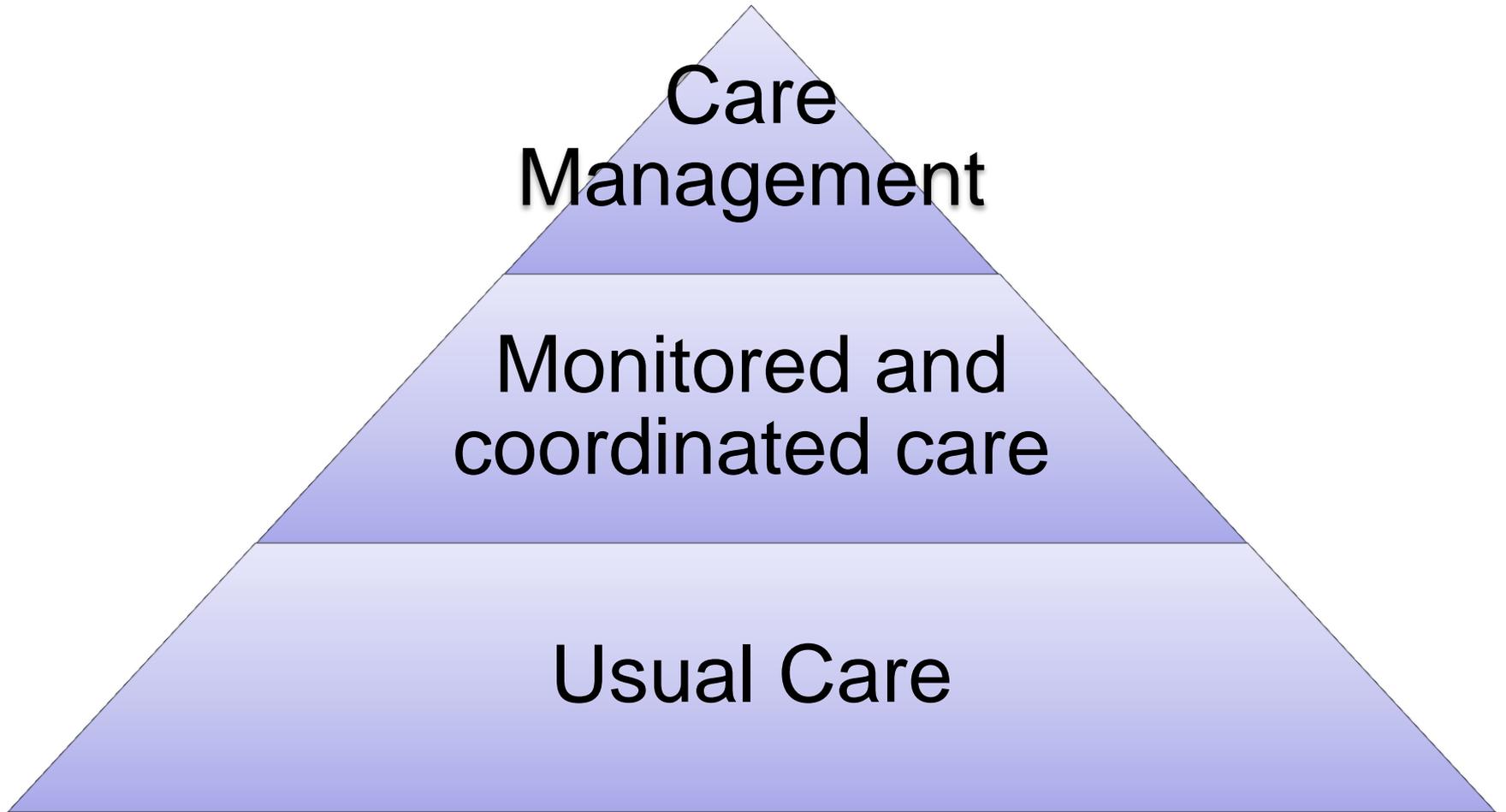
Acute Care

Care for a
Population

Management of
Chronic
Conditions

Care
Management

Segmenting the Population



What does it take to produce change in
a system?

Will

(leadership and alignment)

Ideas

Execution

(testing and implementing changes)

(Institute for Healthcare Improvement – IHI)

Measurement to Guide Improvement

What are we trying to accomplish – what's the aim?

What change will result in improvement?

How will we know that the change is an improvement?

(Model for Improvement – API)

- Set an aim: What, how much, by when
- Select measures will tell you whether you are making progress toward that aim.
- Test changes to get you where you want to go.
- Use the measures to help guide your testing

Transitions in Care
from one setting or system of care
to another

A Case Study in the Role of Nursing as
Care Manager

and / or

How to change a health care system
one test at a time.....

Patients tell us...

- Inadequately prepared
- Conflicting advice
- Unable to reach the right person – or don't know who to reach out to
- Completing tasks undone
 - “I wonder why they did this...?”
 - “I wonder why they didn't do that...?”

What's the problem?

- Hospitalizations account for about 33% of Medicare expenditures.
- About 1 Medicare patient in 5 is readmitted within 30 days of discharge. 1 in 3 within 90 days.
- Estimated 75% of readmissions are potentially preventable
- Avoidable Readmissions as a marker for a failure in transition of care.

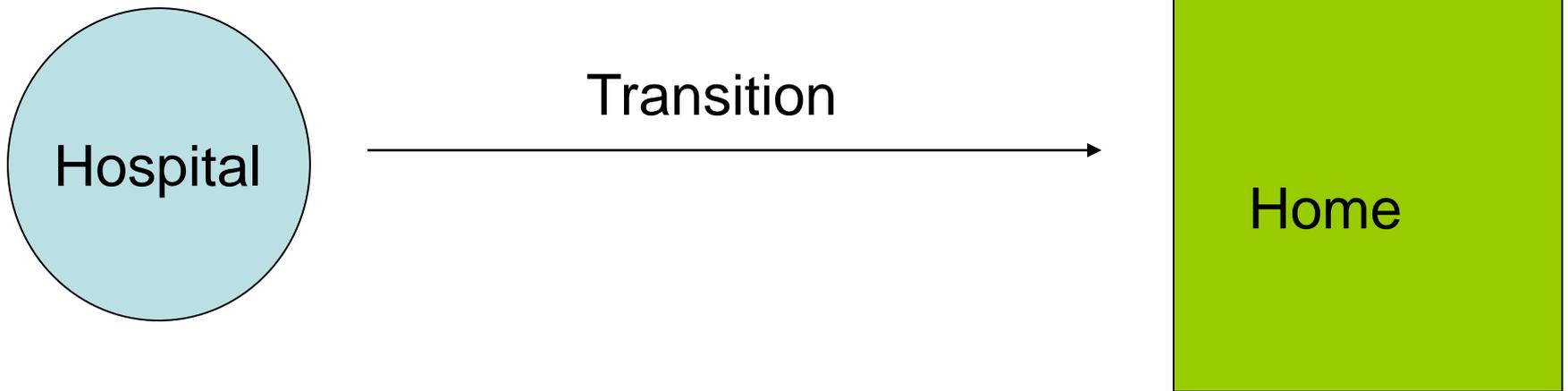
What else do we know?

- Only half of patients readmitted within 30 days had a physician visit before readmission
- 19% of Medicare discharges are followed by an adverse event within 30 days.
 - 2/3 of these are adverse drug events
- There is a correlation between potentially avoidable **admissions** and potentially avoidable **readmissions**

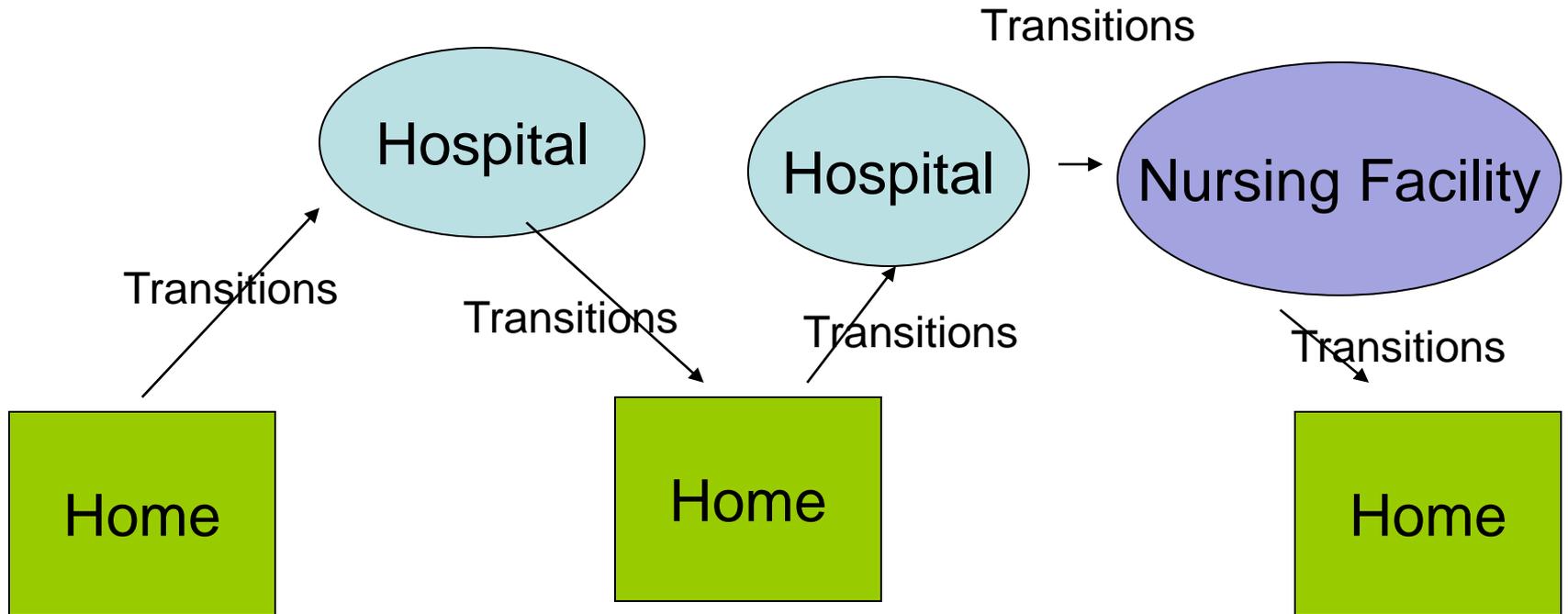
AHRQ / HRET: Reducing Avoidable Hospital Readmissions

www.ahrq.gov/news/kt/red/readmissionsslides/readslides-contents.htm

How most evidence-based care transitions programs see the world...



How it really is...



Public Health Nursing / CHR's / Clinic / Senior Center

A Conceptual Roadmap

- Transition from hospital to home
 - Enhanced assessment
 - Teaching and learning
 - Real time “hand-off” and communication
 - Follow-up care arranged
- Activated Post-acute care
 - Follow-up in primary care
 - Information gathered in primary care
 - Home health care as needed
 - Social Services as needed
 - Hospice or palliative care
- Supplemental care for high risk patients
 - Transitional Care models
 - Intensive care management

High Leverage Interventions for Safe Transitions

- Effective patient and caregiver education and self-management training during hospitalization and following discharge; anticipatory guidance for self-care needs at home post-discharge.
- Reliable referral for home health care visits.
- Effective management and communication of changes in medication regimens whenever changes occur.
- Timely and clinically meaningful communication (handoffs) between care settings.
- Early post-acute care follow-up (by care coordinator, coach, telephone nurse, or clinician).
- Proactive discussions of advance care planning and/or end-of-life preferences and reliable communication of those preferences among providers and between care settings.

Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations. Institute for Healthcare Improvement; June 2011. www.ihl.org.

IHI: Creating an Ideal Transition to the Clinical Office Practice

1. Provide timely access to care following a hospitalization
 - Proactively identify hospitalizations
 - Appropriate f/up for high, intermediate, and low risk patients

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2. Prepare patient and clinical team for the visit.
 - Review the discharge summary
 - Clarify questions with hospital physician(s)
 - Reminder call to patient / family caregiver
 - Coordinate with home health / case managers if appropriate.

IHI: Creating an Ideal Transition to the Clinical Office Practice

3. During the visit: Assess patient and modify care plan
 - Patient goals, understanding of what led to hospitalization or ED visit, medications
 - Medication reconciliation
 - F/up plan – medication adjustment, test follow-up, further testing, future treatments,
 - Advance directives / preferences for care
 - Self management instructions, including warning signs
 - Review urgent or emergent care options.

IHI: Creating an Ideal Transition to the Clinical Office Practice

4. Communicate and coordinate ongoing plan

- Print reconciled, dated medication list for patient, family, home health, etc...
- Review changes to care plan with all
- Arrange f/up visits as appropriate

Measurement to Guide Improvement

- Rehospitalization within 30 days, 60 days, 90 days.
- Time to first contact after discharge
- Percent with medication reconciliation within 3 days of discharge
- Percent with discussion of advance directives

Now let's do some work....

- Where do we want to see improvement?
 - Care Transitions?
 - Frequent, potentially preventable hospitalizations
 - Frequent ER / Urgent Care visits?
 - Late or inadequate prenatal care?
 - Other?
- What's the aim (what, how much, by when)?
- What change might result in improvement?
- How will we know that change is an improvement?

Discussion

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Resources

- CMMI Community-Based Care Transitions Programs
 - <http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html>
- Healthcare.gov
 - www.healthcare.gov/center/programs/partnership/safer/transitions.html
- The Aging Network and Care Transitions: Preparing Your Organization Toolkit
 - www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx
- Care Transitions Quality Improvement Organization Support Center
 - www.cfmc.org/caretransitions/
- Institute for Healthcare Improvement (IHI)
 - www.ihl.org/explore/Readmissions/Pages/default.aspx