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)

Experiences of Care

- Better Care

Cost of Care

Population Health

Lower Cost through Improvement

Better Health
Prevention and Wellness

Management of Chronic Conditions

Care for a Population

Acute Care

Care Management
Segmenting the Population

Monitored and coordinated care

Care Management

Usual Care
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…?”

Eric Coleman, MD
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
How most evidence-based care transitions programs see the world...
How it really is...

Public Health Nursing / CHRs / 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.

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

IHI: Creating an Ideal Transition to the Clinical Office Practice

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.

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

• Healthcare.gov

• The Aging Network and Care Transitions: Preparing Your Organization Toolkit
  – [www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx)

• Care Transitions Quality Improvement Organization Support Center
  – [www.cfmc.org/caretransitions/](http://www.cfmc.org/caretransitions/)

• Institute for Healthcare Improvement (IHI)
  – [www.ihi.org/explore/Readmissions/Pages/default.aspx](http://www.ihi.org/explore/Readmissions/Pages/default.aspx)