FR2- Are we Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care

Friday, March 23
11:00 AM - 12:00 PM

Session Description

This session will discuss key factors leading to ineffective care transitions, emphasize the need for a new approach to delivering transitional care, and describe an integrated approach to achieve optimal transitional care. This approach is based on best practices of different models of care transitions and has not been implemented yet. It has seven key elements based on factors that can help achieve effective care transitions: (1) effective communication among providers; (2) discussion of goals of care and advance directives; (3) functional assessment; (4) medication reconciliation; (5) co-ordination and effective implementation of a care plan; (6) timely and quality discharge summaries; (7) patient-centered instructions and risk-related education.

Learning Objectives

Implement key elements of an effective care transitions into patient care.

Establish strong communication and collaboration with community physicians, and hospital, and home care teams to provide optimal patient care during care transitions.

Implement strategies for effective communication with patients, families and care teams during care transitions.

Presenter(s): Alicia Arbaje, MD, MPH; Michele Bellantoni, MD, CMD; Fatima Sheikh, MD, MPH, CMD

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Are we Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care

Bridging the Gaps: Understanding and Improving Older Adults’ Care Transitions across Healthcare Settings - Arbaje

Speaker Disclosures

Dr. Alicia I. Arbaje

Dr. Arbaje has no financial relationship(s).

Learning Objectives

Alicia I. Arbaje, MD, MPH, PhD

1. Define and describe national patterns of older adults’ care transitions
2. Present challenges healthcare providers, older adults, and caregivers face during care transitions
3. Identify areas for improvement in post-acute and long-term care

Transitional Care

A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.

Coleman, EA. J Am Geriatrics Soc. 2003 (51)4:549-55

Older Adults’ Transition Patterns in the U.S.

1 in 4 transition annually
1 in 3 transition 2+ times after discharge
Half of transitions are to hospital and back
The rest are not easily predictable

Sato, M, Arbaje, AI, et al., Gerontologist. 2010 (31)2:170-8
Coleman, EA. Health Serv Res. 2003 (39)5:1449-65

Objectives

Alicia I. Arbaje, MD, MPH, PhD

1. Define and describe national patterns of older adults’ care transitions
2. Present challenges healthcare providers, older adults, and caregivers face during care transitions
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**WARNING**

Some people will find this very uncomfortable.

Every care transition is potentially a cross-cultural care transition.

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One person’s story...

“I'd say about 50% of the time there seems to be something that requires a call to the doctor to get straightened out.”

Home care nurse

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A surprise behind every door: Information overload

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Unintended consequences: Information overload

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Does this look familiar? Information scatter

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Objectives

Define and describe national patterns of older adults’ care transitions

Present challenges healthcare providers, older adults, and caregivers face during care transitions

Identify areas for improvement in post-acute and long-term care

Alicia I. Arbaje, MD, MPH, PhD
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Best Practices

SGIM-AMDA-AGS Consensus Best Practice Recommendations for Transferring Patients’ Healthcare from Skilled Nursing Facilities to the Community

<table>
<thead>
<tr>
<th>Transition Issue</th>
<th>Process Improvement Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF-PCP Transition Issue</td>
<td></td>
</tr>
<tr>
<td>PCP does not realize that patient is admitted to SNF</td>
<td>Identify correct PCP and include ID in SNF chart</td>
</tr>
<tr>
<td>Schedule follow-up appointment with PCP in 1-3 days of SNF discharge</td>
<td>Expedite scheduling of patients discharged from SNF</td>
</tr>
<tr>
<td>Information on care received at SNF and follow-up needed not received by outpatient team</td>
<td>Transmit discharge instructions to PCP or formal discharge summary w/in 72 hours of discharge</td>
</tr>
<tr>
<td>Prepare staff to receive verbal report</td>
<td>Ensure patient receives phone call after discharge</td>
</tr>
</tbody>
</table>

SNF-PCP Transition Issue

Patient delays follow-up with PCP after SNF discharge

Schedule follow-up appointment with PCP w/in 1-3 days of SNF discharge

Expedite scheduling of patients discharged from SNF

Patient does not receive outpatient follow-up appointment

Schedule follow-up appointment with PCP as per SNF discharge summary w/in 72 hours of discharge

Expedite scheduling of patients discharged from SNF

Information on care received at SNF and follow-up needed not received by outpatient team

Transmit discharge instructions to PCP or formal discharge summary w/in 72 hours of discharge

Prepare staff to receive verbal report

Upon return to home, patient has questions, faces inaccurate med rec, or does not receive vital services

Ensure patient receives phone call after discharge

Best Practices

SNF-PCP Transition Issue

Patient delays follow-up with PCP after SNF discharge

Schedule follow-up appointment with PCP as per SNF discharge summary w/in 72 hours of discharge

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Contact Information

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Connect with me on

www.hopkinsmedicine.org/geriatrics
Are we Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care
Hospital-SNF Collaboration - Bellantoni

Speaker Disclosures
Dr. Bellantoni has no financial relationship(s).

Learning Objectives
By the end of the session, participants will be able to:
- strengthen the partnership among hospital and SNF providers to reduce complications, shorten convalescence, and lower health care costs.

Johns Hopkins Medicine Alliance for Patients (JMAP)
Track 1 ACO, founded 2014
38,000 Medicare beneficiaries

https://www.hopkinsmedicine.org/alliance_patients/

Accountable Care Organization Data on 2017Q2 SNF Discharges per 1000 Person Years Compared with other Track 1 ACOs

- 44.1% SNF stay >21 days (Consortium average 41.1%)
- 17.2% SNF stay with 30-day readmission (15.0%)
- Opportunity: $59/beneficiary savings, $2.2 million

A Review of Recent ACO SNF Data

SNF LOS and readmissions now identified as a target area for JMAP by PREMER

SNF Utilization considered third highest opportunity for JH Medicine ACO
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Hospital-SNF Collaboration - Bellantoni

Hospital System-SNF Collaborative Value Proposition for Patients, SNFs, Hospitals & Providers

- Improve Patient Care (HLM Priority)
  - Improve patient-centered care for higher risk population of older adults transitioning to the community, with an increased focus on care coordination and transitioning to next best practices

- Improve SNF Network
  - Create 3 high volume targeted SNFs to achieve desired outcome
  - Improve data and data-sharing among SNFs, including hospital-specific data elements and payers

- Improve Transitions in Care
  - Improve collaboration with SNFs for better availability of staff beds and improved sense of follow-up outcomes
  - Material to be developed post-transition to ensure SNF infrastructure and performance
  - Reduce hospital readmission and improve continuity of care

- Accelerate Data/Endurance
  - Deliver level of data and collab.Healthcare readiness for high risk SNFs and hospital data

- System-wide Collaborative
  - Leverage a system-wide governance and collaboration structure among SNFs, hospitals, and affiliated facilities
  - Create an unified approach to transitions in care with supporting strategies

1. Create a System-Wide SNF Collaborative

2. Support and collaborate with existing JHHS hospital efforts

- Federally funded resource to support SNF collaborative, available at no cost
- Receive Medicare claims-based data and reports to support collaborative, including hospital-specific goals
- Receive reports and data-based reports to support collaborative, including hospital-specific goals
- Leverage an unified approach to transitions in care with supporting strategies
- Provide support to engage project teams within SNFs in quality improvement efforts

Procedures to Establish Hospital-SNF Collaborative

- Complete chart signatures for Quality Improvement Organization
- Complete collaboration agreement signatures (prescription for data sharing)
- Ensure consultant agreement for site, Hospital, Regenstrief, and site agreed upon

SNF Engagement

- Identify SNF's and HLM to Broad Stakeholder Meeting
- Development of shared definition of quality measures

Broad Marketing Concepts

- Hospital/Health System Board of Directors, Physician Advisory Board, Hospital Staff Meeting, Hospital Staff Council, Staff Association Leadership
- HLM-stakeholder leadership inclusion, executive, Medical, Nursing, Administration, Strategy, Rehab Services, Case Management

Data/Analytics

- Scheduled updates and dissemination of dashboard
- Return on investment analysis

Transitions of Care

- Ensure SNF documentation and standardization of measures at the hospital level
- Complete risk-mitigation strategy, identify system-wide internal and external
- Share new opportunities for care management as a component of hospital health system and regional efforts

Health Quality Innovators (QIO) Care Transitions Project

Benefits of Participation:
- Federally funded resource to support SNF collaborative, available at no cost
- Participate in monthly CHF meetings, execute interventions, and improve care transitions
- Receive reports and data-based reports to support collaborative, including hospital-specific goals
- Leverage an unified approach to transitions in care with supporting strategies
- Provide support to engage project teams within SNFs in quality improvement efforts

Steps to date:
- Complete participation agreement support from all 5 HLM hospitals and JHHC
- Charter gathered and signed by JHHC
- Official project kick-off on 3/23/2018
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Standardization of Physical, Cognitive and Functional Status

Early Assessment of Post-hospital Care Needs
The Edmonton Frail Scale

Assessment of Physical and Functional Status
Activity Measure for Post-Acute Care (AM-PAC) Instrument
Measures 3 functional domains
Basic mobility
Daily Activities
Applied Cognition

Predicting Discharge Disposition
Research Report

AM-PAC “6-Clicks” Basic Mobility Short Form

Phys Therapy 2014;94:379-391
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**AM-PAC"6-Clicks" Daily Activity Short Form**

<table>
<thead>
<tr>
<th>Please check the box that reflects your (the patient's) best answer to each question.</th>
<th>Unable</th>
<th>A Lot</th>
<th>A Little</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pulling on and taking off regular lower body clothing?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. Bathing including washing, rinsing, drying?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. Toiling, which includes using toilet, bucket, or cathet?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. Pulling on and taking off regular upper body clothing?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. Taking care of personal grooming such as brushing teeth?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6. Eating meals?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**AM-PAC Scores by Discharge Setting**

<table>
<thead>
<tr>
<th>Validation Sample</th>
<th>Mobility Score</th>
<th>Daily Activity Score</th>
<th>Discharge Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>82%</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>Specificity</td>
<td>72%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Positive Predictive Value</td>
<td>75%</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Negative Predictive Value</td>
<td>80%</td>
<td>75%</td>
<td></td>
</tr>
</tbody>
</table>

**Transition in Care Documentation of Physical and Functional Status**

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Standardized Score</th>
<th>Date Before Admission</th>
<th>Date</th>
<th>Date Discharge</th>
<th>Discharge Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM-PAC 6-Clicks Mobility</td>
<td>Mobility Assessment</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Functional Independence Measure (FIM) total</td>
<td></td>
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<tr>
<td>Edmonton Frailty Scale</td>
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<td></td>
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<tr>
<td>Falls Risk Assessment</td>
<td></td>
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</tbody>
</table>

**Standardized Assessments of Cognition**

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Standardized Score</th>
<th>Date Before Admission</th>
<th>Date</th>
<th>Date Discharge</th>
<th>Discharge Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montreal Cognitive Assessment (MOCA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Confusion Assessment Method (CAM)</td>
<td></td>
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**Johns Hopkins Medicine SNF Collaborative Transitions in Care Upgrades to Transfers Documents**

- Upgrades to EPIC Transitions in Care Document
- Addition of standardized assessments of physical, cognitive, and functional status
- Documentation of Goals of Care, Social Support, and recommendations for next phase of medical care
- Re-ordering of information- supporting diagnostics summarized at end of summary

**Checklist of Transfers in Care Documents**

- Demographic Facesheet
- POLST- copy of Advance Directives, when available
- Discharge Summary
- Medication Administration Record- includes last dose of medication
- Case Management Summary/Interdisciplinary Rounds Tool
- Admission History and Physical
- Summary of Laboratory Data
- Summary of Radiology Data
- Rehab Services Initial and Discharge Consultation Notes- Physical Therapy, Occupational Therapy, Speech Therapy
- Box for personal items- dentures, glasses, hearing aids, documentation of ambulation devices

Jette DJ et al. Physical Therapy 2014;94:379-391
Are we Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care

Hospital-SNF Collaboration - Bellantoni

Thinking about the Future
A Broader View of Post Acute Care

- JHM/SNF collaborative has brought together JHHS hospitals, JHHC, and JHU in a collaborative approach to managing care across the continuum. The infrastructure can support the growth of this work over time
- Total cost of care and alternative payment strategies (ie: bundled payments) requires consideration of other levels of PAC
- Opportunities to integrate EHR-based changes through the collaborative that are beneficial in transitions to all post-acute settings
- Participating in JHHCG Professional Advisory Council for ongoing integration with Home Care for transitions to home

Take Home Points

- Standardized Assessments of Clinical Conditions, Treatments, Data Hospital/SNF data sharing: CMS-funded QIO, ACO, Consultant Hospital-SNF Collaborative- multi-disciplinary meetings
Are we Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care

- Sheikh

Learning Objectives

1. Discuss a new approach to care transitions
2. Define steps involved in implementation of such approach
3. Discuss steps involved in evaluation of the effectiveness of new approach

Our Approach-Integrated Care Transitions Approach (ICTA)

Goal:
To improve the care transitions of patients across the continuum of the healthcare system

Based on:
- Best practices from other care transitions models
- SGIM-AMDA-AGS Consensus Best Practice Recommendations
- Factors identified by The Joint Commission

Lindquist, L. “SGIM-AMDA-AGS Consensus Best Practice Recommendations” J Gen Int Medicine, 2016
The Joint Commission, HOT TOPICS IN HEALTH CARE, 2012

Our Approach-Integrated Care Transitions Approach (ICTA)

Components:
- 4 characteristics which address care transitions across all healthcare settings
- 7 key elements for each care transition

Sheikh, F., Gathwala, G., Solano, M., Christiansen, C., Lathem, J., Arbaje, A.
A CALL TO BRIDGE ACROSS SILOS DURING CARE TRANSITIONS
The Joint Commission Journal on Quality and Patient Safety, ‘In Press’
Are we Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care - Sheikh

1. ADAPTABILITY ACROSS SETTINGS

- Discharge summary for a patient discharging from the hospital to a PAC
- Transfer summary from PAC to the hospital
- Transfer summary from PAC to home

2. Adaptability to changing clinical status of patient

- STEP 1: Identification of a clinical change in a patient through symptom monitoring
- STEP 2: Reassessment and modification of the care plan
- STEP 3: Communication of the care plan at the time of transition to the receiving care team with expected trajectory
- STEP 4: Reassessment of the care plan for any improvement or decline after the interventions

3. Appreciation of different roles of key stakeholders in care transitions

- Recognition and appreciation of the expertise and capabilities of the older adult and caregiver (availability, cognitive ability, functional status, health literacy, and management capabilities)
- Recognition and appreciation of the expertise and capabilities of the home care staff and medical providers
- Delivery of tailored education to the abilities of the caregivers and other key stakeholders

4. Adaptability to changing nature of care teams across continuum of care

- STEP 1: Identification of the care team at each level of care transitions
- STEP 2: Effective and thorough transfer of care from the discharging care team to the receiving care team
- Step 3: Reassessment of team composition after each transition.

Key elements of the ICTA

1. Effective communication among providers
2. Discussion of goals of care and advance directives
3. Functional assessment
4. Medication reconciliation
5. Co-ordination and effective implementation of care plan

Key elements of the ICTA

6. Timely and quality discharge summaries
7. Patient-centered instructions and risk-related education
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**Learning Objectives**

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Steps involved in Implementation

Care transitions from

Home -> Hospital -> Home
Post-acute care (PAC) -> Home
Hospital

Care Transitions to Home

- Transitions of care from hospital to home, post-acute care (PAC) to community, and, community to the hospital
- Transition Team
  - Transition Navigator
  - Clinicians
  - PAC team
  - Home care team

PAC to Home- Pilot Project

At Admission
- Interview of the patient and caregivers
- Medication reconciliation (hospital, home)
- Assessment of the caregiver and support systems at home

During facility stay
- Participation of care plan meetings
- Initiation of a focused discharge plan
- Patient-centered education

At the time of discharge:
- Follow-up appointment with the PCP within 7 days of discharge
- Transmission of discharge summary to the PCP (and home care agency) within 72 hours of the discharge
- Recognition of patient literacy level and engagement
- Patient-centered instructions and focused risk-related education

After discharge:
- Follow-up for first 30 days via phone calls
- Initial phone call after 48-72 hours of discharge
- Coordination of care with:
  - Patient and families
  - PAC provider
  - PCP in the community
  - Specialists/consultants
  - Home care team
  - Other disciplines at PAC

Checklist for Transition Navigator for follow-up calls

- Medications
- Durable Medical Equipment
- Home care
- Appointments (PCP, specialists, hemodialysis, laboratory tests)
- Emergency room visit(s) and hospitalizations
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Learning Objectives

1. Discuss a new approach to care transitions
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3. Discuss steps involved in evaluation of the effectiveness of this new approach

Evaluation of the Program-Ongoing

- Phone-call data
- Data about re-hospitalizations
- PCP satisfaction data
- Patient satisfaction data

Future direction…..

Further research is needed to assess-
- Cost effectiveness of the approach
- Improvement in medical care of complex patients
- Efficacy of different methods to foster collaboration among providers
- Policies in a healthcare settings

Many Thanks!!

Johns Hopkins School of Medicine
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