annual meeting

Implementation of Transitional Care Models

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Tips on Getting Started and Keeping It Going

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Tips on Getting Started and Keeping It Going

(*"Interventions to Reduce Acute Care Transfers")*

Is a **quality improvement program** designed to improve the care of nursing home residents with acute changes in condition

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Tips on Getting Started and Keeping It Going

- The program and tools were revised based on CMS pilot study, and input from front-line NH staff and national experts
- The revised program and *INTERACT II* Tools are available at: http://interact2.net

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Tips on Getting Started and Keeping It Going

- Effective implementation is critical to long-term sustainability of the program
- The program cannot be effectively implemented or sustained without ***strong support from facility leadership***

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Tips on Getting Started and Keeping It Going

General Principles

1. Make ***INTERACT*** a key aspect of your facility's quality improvement activities and QAPI program
2. Implementation should be ***consistent with the way you provide care in your facility***
   - Integrate the ***INTERACT*** program and tools into your everyday practice
3. ***Recognize that organizational change takes time -*** programs such as ***INTERACT*** can take several months to fully implement

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Tips on Getting Started and Keeping It Going

Overcoming Barriers to Implementation

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Tips on Getting Started and Keeping It Going

Overcoming Barriers to Implementation (1)

Barriers	Strategies to Overcome
"We don't have a problem with hospital transfers"	Regularly track hospital transfers and follow trends; you may have a problem and not know it
"We don't have control over who gets admitted"	Using INTERACT tools to improve management of acute changes and communication with physicians and emergency rooms staff will give you more control
"The doctors won't cooperate"	The medical director and the primary care providers must buy in to the INTERACT program

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Overcoming Barriers to Implementation (2)

Barriers	Strategies to Overcome
"Families want residents hospitalized"	Families need to be educated about the risks as well as benefits of hospitalization
"We could get sued"	There is no fail-safe way to prevent law suits – but the INTERACT program provides tools for evidence-based and expert recommended care, and improves communication and documentation

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Overcoming Barriers to Implementation (3)

Barriers	Strategies to Overcome
"We don't have the staff or time"	Improving the management of acute changes in condition has to be a priority of the facility and its leadership
"We have too many other things going on"	INTERACT must be one of the major quality improvement initiatives at the facility
"We are in our survey window"	INTERACT implementation will result in improved care and adherence to multiple F Tags and other requirements

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Overcoming Barriers to Implementation (4)

Barriers	Strategies to Overcome
"Things don't go well when the Champion is not here"	Appointing a co-champion and embedding INTERACT tools into everyday practice will help overcome staff absences and turnover
"We already have similar forms and processes"	Use your tools, or use or modify the INTERACT tools based on what your facility already has in place

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Tips on Getting Started and Keeping It Going

Sustaining the Program (1)

1. Ensure ongoing leadership support
2. Make ***INTERACT*** a permanent part of your quality improvement activities and one of your programs for QAPI
3. Appoint and train a Co-Champion
4. Have new staff undergo training

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Tips on Getting Started and Keeping It Going

Sustaining the Program (2)

5. Continue to track changes in rates of hospital transfer and how you manage acute changes in condition
6. Learn from you Quality Improvement Review tools
7. Visit the ***INTERACT*** website for updates and new resources: http://interact2.net
8. Don't hesitate to contact us through the website

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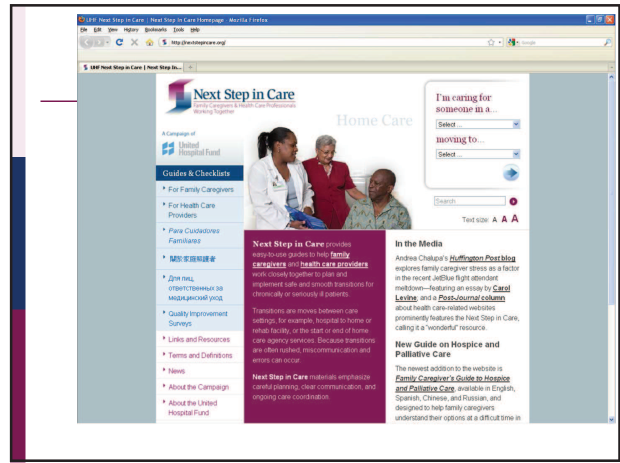
Why family caregivers are important to transitions

Many transition plans assume a considerable amount of family care. The best-laid transition plans will fall apart if one key partner—the family—cannot fulfill professional expectations.

- If family is not involved in planning, they may not understand what is expected of them.
- They also have no opportunity to refuse, or to have barriers accounted for in the care plan.
- To provide care, family needs ongoing training and support.
- No one can absorb all the information and instructions given at discharge without follow-up. *Early preparation* and *post-discharge follow-up* are key.

Next Step in Care: Three major activities

- Direct outreach to caregivers through Next Step in Care website – www.nextstepincare.org
- Transitions in Care-Quality Improvement Collaborative (TC-QuIC) – a learning collaborative focused on family caregivers in transitions
- Work with community agencies to train staff to use Next Step in Care materials before a crisis occurs



Next Step in Care Website

- 23 family caregiver guides
  - Newest guides: Urgent Care Centers, LGBT Caregiving
  - In preparation: Guide to Hospitalist Care
- All in English, Spanish, Chinese, Russian
- 6 guides for health care providers
- Quality improvement surveys for different settings
- Links and resources
- Guide on how to use website
- Glossary

Transitions in Care-Quality Improvement Collaborative

- TC-QuIC Round One –ended June 2011
- Round Two ends June 2012
- Total of 37 teams from hospitals, nursing home rehab programs, home care agencies, hospices working in partnerships
- Use IHI Model for Improvement
- Next Step in Care tools and selected materials
- Online community
- Monthly webinars and 4 all-day Learning Sessions
- Regular coaching and consulting

Lessons Learned

- No participant team had systematic way to identify family caregiver; even if identified, not recorded in patient chart
- Inconsistent understanding of discharge process in same institution and among same discipline (i.e., nurses)
- Reducing readmissions may compete with reducing length of stay
- Any improvements have to work for staff on all shifts and in different care settings
- Changing technology or creating better forms is no substitute for changing staff behavior and attitudes
- Improvements helped staff as well as families and patients

Thank you!

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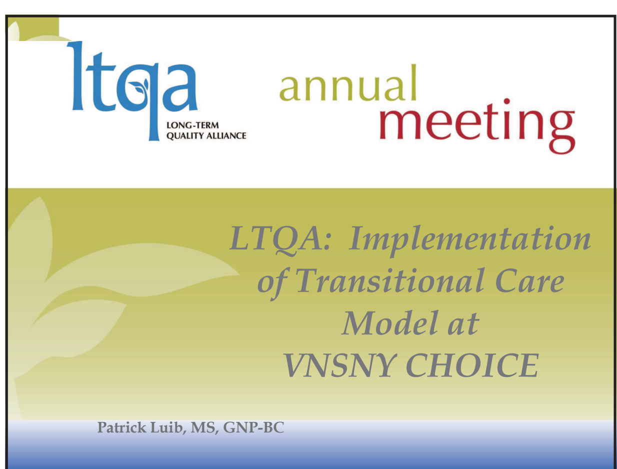

VNSNY CHOICE Health Plans

Managed Care Plans for High-Cost Chronically Ill Dual-Eligibles

	Medicaid Managed Long Term Care (MLTC)	Medicare Advantage (Special Needs Plan and Part D)	Managed Long Term Care Plus
Census	10,049 members **(Jan. 2012)**	7,983 members (Jan. 2012)	90 members (Dec 2011)
Benefits and Services Provided	Alternative to long-term institutional care. 14 home and community–based services, including care management, nursing home, adult day care, home-delivered meals	All services in Medicare Parts A, B and D; Hospitals, Doctors, Labs, Rxs Supplemental: Dental, Vision, Hearing, and Transportation benefits	Combines services offered in Medicaid MLTC and Medicare Advantage Special Needs Plan. However, provides less supplemental benefits due to cost shifting
Payment Source	NYS Medicaid, partially capitated, rates risk-adjusted by population (2-year payment lag)	Medicare Advantage (CMS), fully capitated, risk adjusted by individual	Separate payments from NYS and CMS – (Lower combined premium)
Providers	1,900 Network Providers 29 Nursing Homes	2,200+ Primary care phys, 5,800+ Specialists, 37 Hospitals, 32 Nursing Homes, Labs, Pharmacies	Full networks for both VNSNY MLTC and Medicare Special Needs Plan

1916 MLTC members are virtually enrolled in both Medicaid MLTC & MA SNP (Dec 2011)

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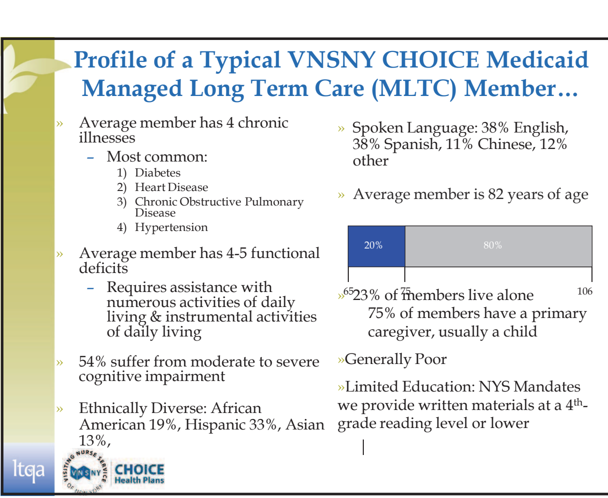

Transitional Care Protocol

	SUCCESSES	CHALLENGES
HUMAN FACTORS	• MD satisfaction • Interdisciplinary team (IDT) communication • Training & support	• Updating IDT of staffing changes
EQUIPMENT FACTORS	• Online referral system • Encrypted email s	• Online provider directory
CONTROLLABLE ENVIRONMENTAL FACTORS	• Member selection	• Medicare rounds • Weekend coverage
UNCONTROLLABLE EXTERNAL FACTORS		• Primary care activities • Collaborating with Out of Network providers • Gathering hospital clinical information • 30-day episode

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160

Transitional Care Protocol: Outcomes

Average Distribution of Care Communication Activities

1% 5%
10%
22%
12%
50%

- Contacts with MDs or NPs
- Contacts with Nurses
- Contacts with HHAs
- Contacts with Family
- Contacts with SPARK
- Contacts with Others

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161