It Takes a Village to Stay at Home Safely

Chris Attaya
VP of Business Intelligence, SHP

Marybeth Glasheen-Wray, PT, MMSc.
Clinical Rehab Coordinator, Christiana Care VNA

Rossana P. Tocci, MSN, RN
Nurse Manager, Christiana Care VNA

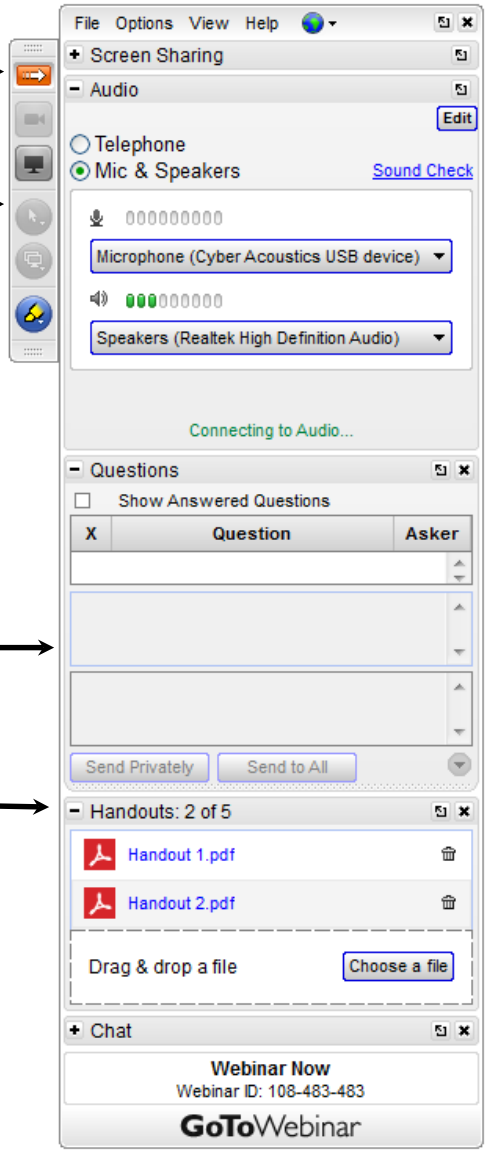
Naomi R. Stump
Executive Assistant, Christiana Care VNA

SHP
STRATEGIC HEALTHCARE PROGRAMS

CHRISTIANA CARE
HEALTH SYSTEM

Enhancing Your Webinar Experience

Click the red arrow on the upper left to hide the GoToWebinar control panel
To access the audio portion of the webinar, use your computer speakers or call the number shown in the “Audio” section of the GoToWebinar control panel Make sure the volume on your speakers or phone is turned up as high as necessary If you call in to the webinar and experience poor audio quality, please try hanging up and calling in again
Use the “Questions” section of the GoToWebinar Control Panel to submit any questions you have during the webinar
Expand the “Handouts” section to download any relevant webinar materials



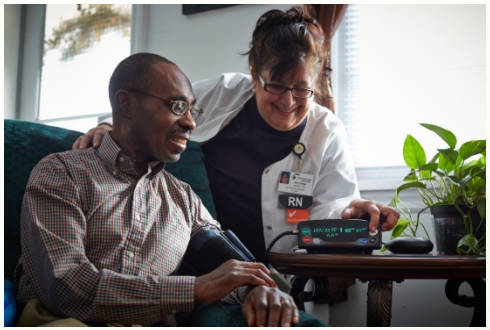
All presentations are recorded, so if you have technical problems, all is not lost!

SHP STRATEGIC HEALTHCARE PROGRAMS

CHRISTIANA CARE HEALTH SYSTEM

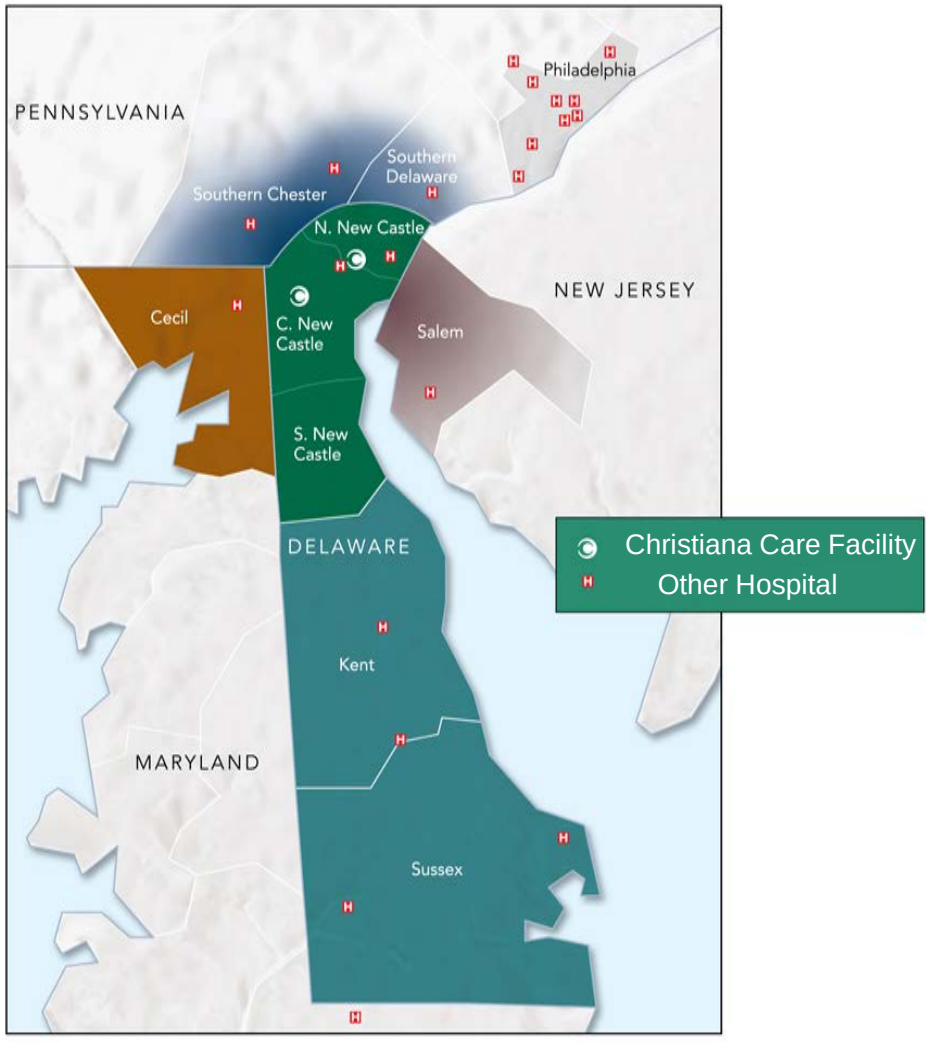
Christiana Care Health System

- Primary Care Office Visits: 227,295
- Home Health Care Visits: 312,537
- Admissions: 53,072
  21st in the nation
- Surgeries: 38,712
  29th in the nation
- ED Visits: 187,317
  21st in the nation
- Births: 6,469
  32nd in the nation



CHRISTIANA CARE HEALTH SYSTEM

Introduction to VNA



- **312,537 Visits per Year**
- **638 Employees**
- **Territory includes the State of Delaware and limited services in Cecil County, MD**
- **2 Branch Offices (New Castle & Kent Counties)**

Opportunity for Improvement

- **Transform the current case conference model to one that is patient-centered, goal-driven and conducted efficiently to reduce Acute Care Hospitalization for Medicare patients.**

Objectives

- Describe the progression of case conferences moving from 30-60 minutes to 5 minutes
- Define ‘flow of case conferencing’
- Discuss impact on hospitalization
- Describe efficient use of SBAR
- Discuss path forward

Background / Current Knowledge

- **Acute Care Hospitalization** (ACH) is defined as the percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay (planned hospitalization are excluded).[2]

- CCVNA utilizes **Strategic Healthcare Programs, LLC** (SHP) as an analytics and benchmarking tool for our Medicare patients, including screening for hospitalization risk.

- The **SHP Risk of Hospitalization Alert** uses a complex formula based on CMS risk adjustment methodology in conjunction with proprietary analysis involving ICD-9 codes to predict moderate to high risk

[1] http://www.rand.org/pubs/occasional_papers/OP323.html (accessed August 26 2015)

[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html

Background / Current Knowledge

- **Case conferences have been standard practice in home care and utilized with moderate to high risk patients; however our approach was often reactive to clinician's perception of non-adherence and complex social situations.**

- **Logistics for case conferences have been challenging**
  - Clinicians are off-site providing care and office-based meeting time impacts staff productivity
  - Identified need for case conference often occurred near discharge
  - Duration of a case conference often was one hour and focused around clinician's plan of care

- **CCVNA was introduced to the Integrated Care Management (ICM)* model during leadership training in October 2014**
  - The new case conference approach is patient-centered, utilizing the patient's stated goal as the anchor to the plan of care. Focus is on behavior change and building patient confidence.

*Integrated Care Management Transitions of Care
Sutter Health, Center for Integrated Care

Baseline Data

- The overall **ACH Risk Adjusted Rate** for CCVNA **FY14** was **25.11%** as compared to SHP National **23.70%**

All Acute Care Hospitalizations

Date Range	Count	Cases	Observed	Risk Adjusted		SHP National
June 2014	87	443	19.64%	20.39%		23.63%
12 Months	1,213	5,465	22.20%	25.11%		23.70%

SHP (Strategic Healthcare Programs, LLC)

- **Hospitalization Alert**: Jan-June 2014 the percentage of patients alerted as *moderate to high risk* was **28.1%** as compared to the SHP National **28.7%**
- **Alerted & Hospitalized**: Of those alerted **34.2%** were hospitalized as compared to the SHP National **38.1%**

SHP Risk of Hospitalization Alert

Risk for Hospitalization: Patients that triggered the SHP Risk of Hospitalizations Alert	You						SHP National	
	Alert Triggered		Alert Triggered & Hospitalized				Alert Triggered SOC/ROC	Alert Triggered & Hospitalized
	#	%	#	%				
Moderate Risk	690	24.8%	211	30.6%			23.9%	35.1%
High Risk	93	3.3%	57	61.3%			4.8%	53.0%
All at Risk	783	28.1%	268	34.2%			28.7%	38.1%

SHP (Strategic Healthcare Programs, LLC)

Action Plan

- New Case Conferences based on the ICM model were piloted in October 2014
  - Managers and clinicians from each discipline were included in case conference
  - Moderate to high risk patients identified by analytics tool were scheduled
  - Clinicians were reminded to utilize SBAR in preparation
- Discussion often lasted 30 minutes per patient
- High quality care planning resulted, but not sustainable given patient volume

Action Plan

- In January 2015 key clinicians and managers completed formal ICM training. The goal of the education was to promote meaningful, timely information exchange through SBAR and interviewing to elicit the patient's goal
- Case conferences resumed using new skills learned
- New skills focused on proficient use of SBAR, as well as ICM model's three key ingredients to effective case conferencing:
  - Good Planning
  - Good Structure
  - Good Facilitation

Action Plan

- **Good Planning**
  - List of patients on agenda communicated on Thursday of the previous week via email to managers and clinicians for case conferences on Monday.
  - Each conference had a designated time allotment
  - Staff received written instruction as to how to prepare using SBAR, including video examples of effective and ineffective communication during case conferencing

Please find below the case conference list for Monday, August 1st. If you are unable to attend in person, please dial in to: *(877) 555-1212 Participant code: 123 345 7899*.

Please come prepared to discuss patient assessments that indicate the patient may have a significant barrier to overcome, especially with regard to condition self-management, and some ideas for what actions will be needed to help ensure the patient does not experience an unnecessary re-hospitalization.

Case Managers, please send me the "S" and "B" via email and I will enter ahead of your scheduled meeting.

If you are not working the day of the meeting, please give your Manager the info on your patient to present on your behalf.

If the patient is in the hospital, a SNF or has been discharged, we WILL still discuss the patient as a learning item for everyone.

If you are unable to attend in person, please dial in to: (877) 555-1212 Participant code: 123 345 7899#.

- Review the video for Ineffective Case Communication by clicking here
- Review the video for Effective Case Communication by clicking here

CC Date	Time	Location	Patient	Case Manager	Aide	MSW	OT	PT	SLP
1-Aug	2:00	Boardroom	Doe, Jane						
1-Aug	2:05	Boardroom	Doe, John						
1-Aug	2:10	Boardroom	Smith, Gary						

Action Plan: SBAR Communication

		Patient's Stated Goal: ***"Return to Senior Center to mingle with friends"***
S	**Situation** • Brief • Grab the listeners' attention • Convey immediate need • Speak clearly	Patient is a 85 y/o female with diagnosis of DM, HTN, R heel ulcer and gait dysfunction.
B	**Background** • Sets the context • Only the relevant circumstances to this situation • Prepare details in advance	Patient lives alone and is a fall risk. Referral source concerned about cost of supplies and meds
A	**Assessment** • Long term goal and current SMART goal • Making progress toward goal? • If not, what do you think the problem is? • What could cause this patient to go back to the ER/Hospital? Be specific	Patient has difficulty with: • Checking blood sugars • Reaching heel for dressing changes • Obtaining food (refrigerator noted to be empty) • Paying bills (received notice from electric company may turn off power)
R	**Recommendation** • What do you suggest be done that may help the situation? • Other disciplines needed? • Other services needed? • What can prevent an ER visit/hospitalization? • Appropriate visit plan? • Follow up issues with MD? • Safety Issues	Nursing & PT continue 3x/wk; Add on OT for IADLs and MSW for socio-economic needs; • Coordinate with family to identify support network • Meals on Wheels • DART transportation for return to community • Ministry of Caring for food pantry & support • Establish outpatient physician and rehab appointments at discharge

Action Plan

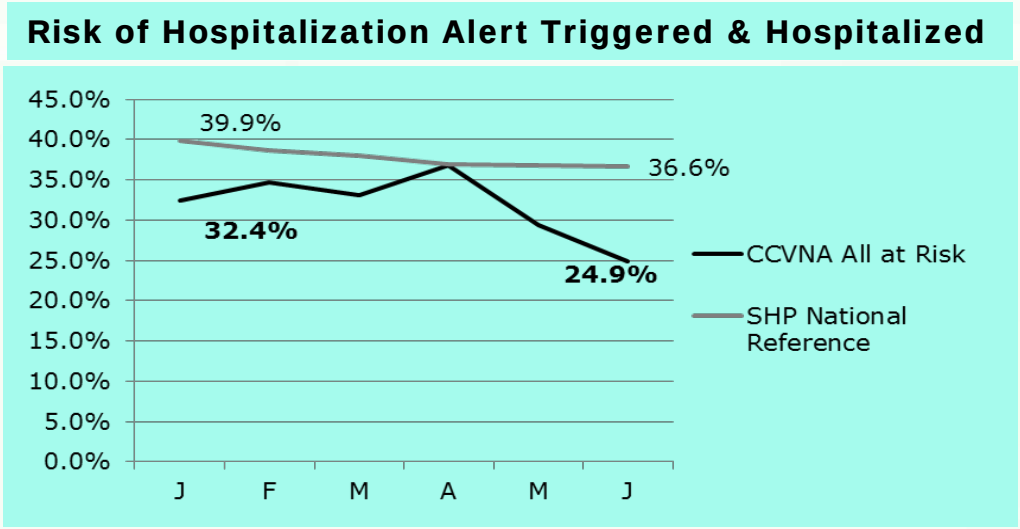
- **Good Structure**
  - **Meeting begins and ends on time**
  - **Patient's record, including medication list is projected to ensure all are on same page**
  - **Focus of Case Conference = Patient's Goal**
    - **Patient's-stated goal and how our plan of care can help them attain**
      - *"Dance at my son's wedding"*
      - *"Return to Senior Center to mingle"*
      - *"Travel to Europe before I die"*
    - **Patient's motivation and confidence**

Action Plan

- **Good Facilitation**
  - Keep discussion related to SBAR
  - Facilitate learning and provide ongoing mentoring
  - Wrap up discussion with recap of action steps
    - Designee documents in patient's record
  - Compliment excellent work to promote positive culture
  - End case conference on a positive note

Results

- **Efficiency in case conferencing improved!**
  - By June 2015, the average time to complete a case conference on an individual patient was **6 minutes** as compared to **30 minutes** initially
- **As clinicians perfected their skills a decline was noted in hospitalization for moderate to high risk patients**



Results

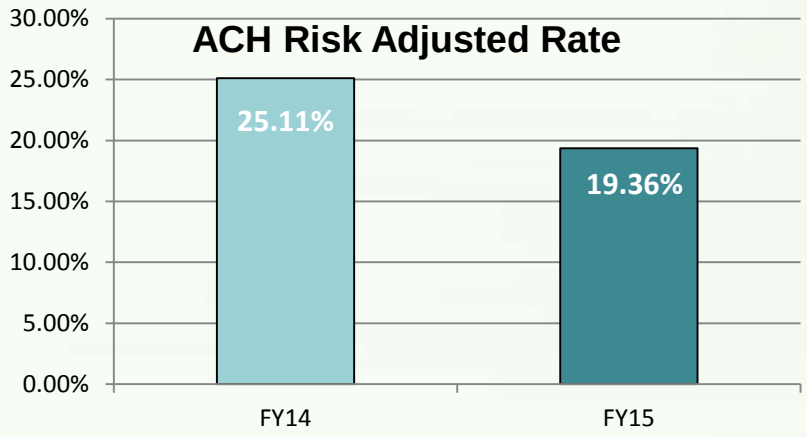
- The overall **ACH Risk Adjusted Rate** for CCVNA **FY15** was **19.36%** as compared to SHP National **23.67%**

All Acute Care Hospitalizations

Date Range	Count	Cases	Observed	Risk Adjusted		SHP National
June 2015	103	559	**18.43%**	**16.01%**		23.02%
12 Months	1,238	6,266	**19.76%**	**19.36%**		23.67%

SHP (Strategic Healthcare Programs, LLC)

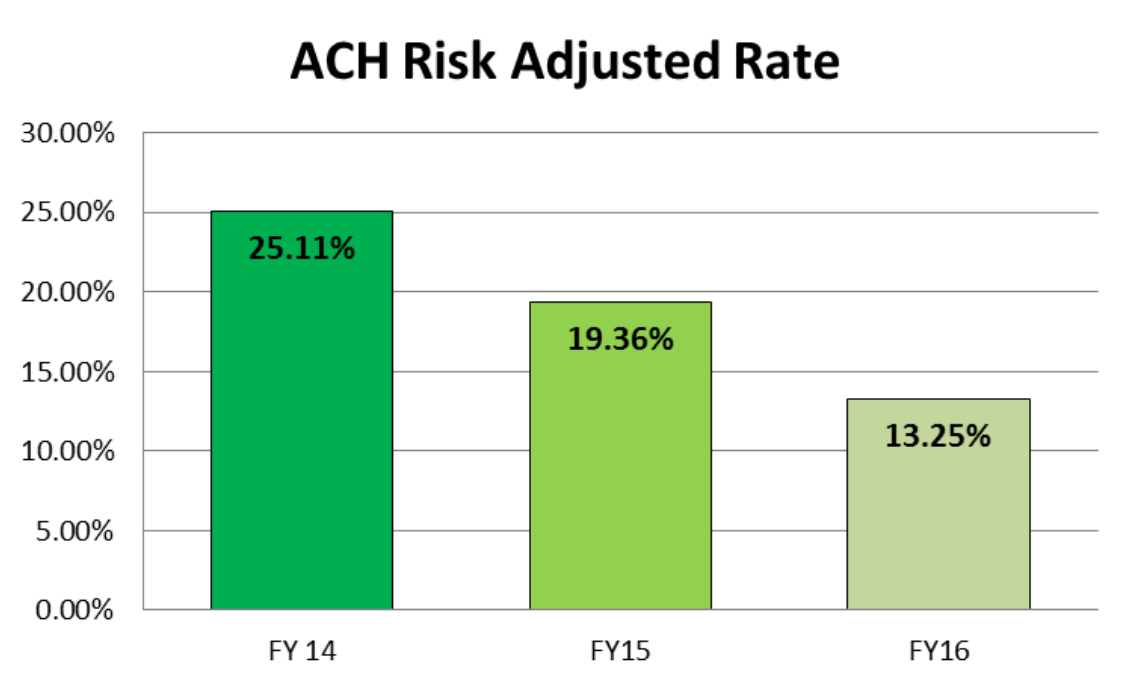
- **Transforming our case conference model corresponded with 5.75 percentage point reduction in ACH for our Medicare patients as compared to the previous year.**



CHRISTIANA CARE HEALTH SYSTEM

Sustainable Results

Date Range	Count	Cases	Observed	Risk Adjusted	SHP State (DE)	SHP National
December 2016	121	582	**20.79%**	**14.32%**	19.72%	23.18%
12 Months	1,370	6,970	**19.66%**	**13.25%**	19.25%	23.47%



Success Stories

- **S:** 68yo male with metastatic lung cancer and caregiver refusing hospice.
- **B:** Patient quickly deteriorating, recent dx w/mets to bone. Pulmonary function tests were declining. Patient now having great difficulty with ambulation and shortness of breath.
- **A:** Patient's goal is to attend son's wedding in 2 weeks.
- **R:** Nurse and therapist worked with patient and family to follow treatment guidelines and recommendations.

Conclusion: Patient's family and wedding party came to the home the day of the wedding for patient to be a part of his son's special day. Patient passed away at home shortly thereafter.

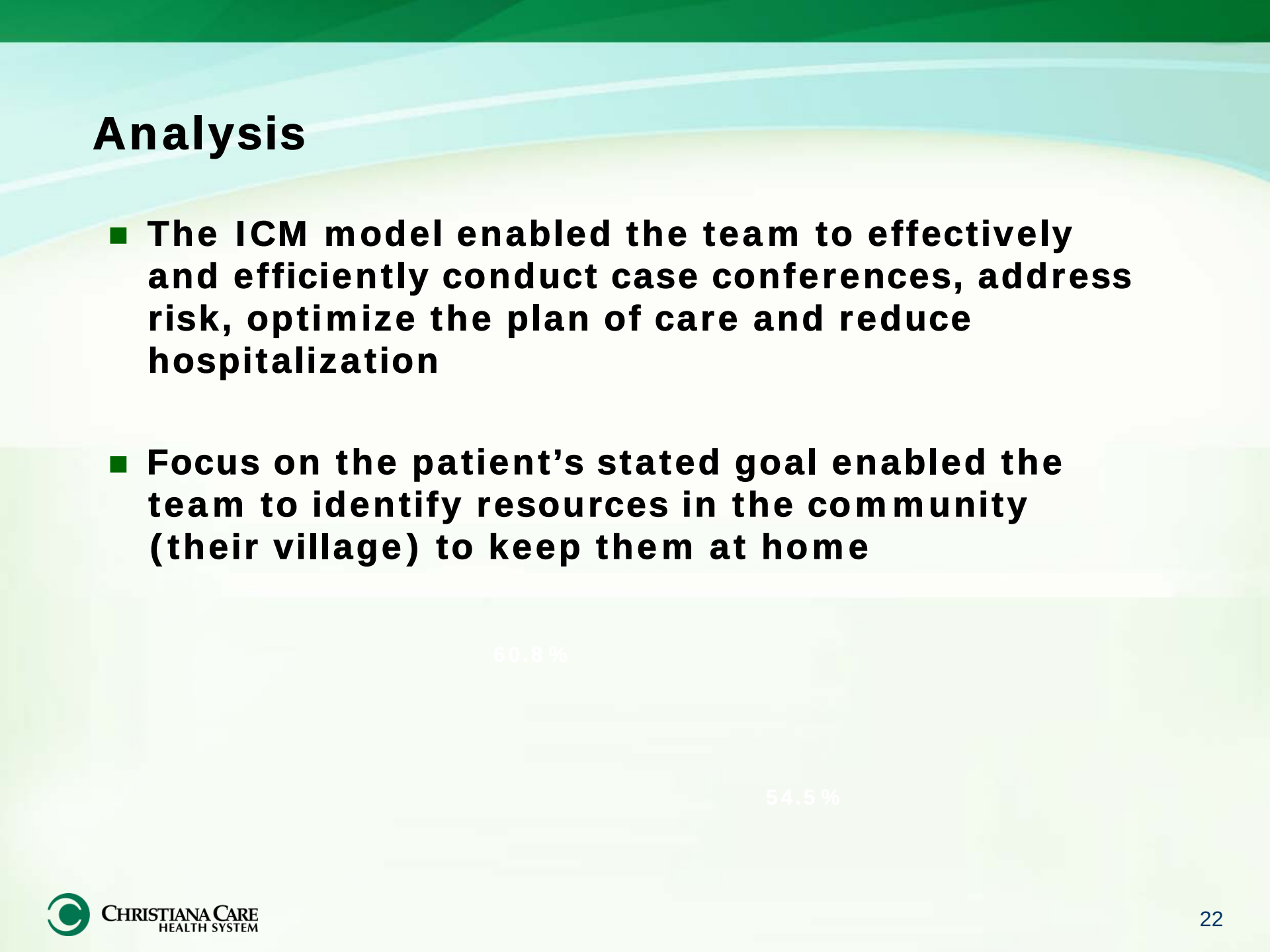
Lessons Learned

- 1,370 patients were discussed in case conference through 12/31/16
- Consistency was reached with holding case conference as a recurring mandatory meeting on Mondays at same time of day
- Complicated cases should be discussed at the end of each case conference to minimize delays in other cases

Analysis

- The ICM model enabled the team to effectively and efficiently conduct case conferences, address risk, optimize the plan of care and reduce hospitalization

- Focus on the patient's stated goal enabled the team to identify resources in the community (their village) to keep them at home



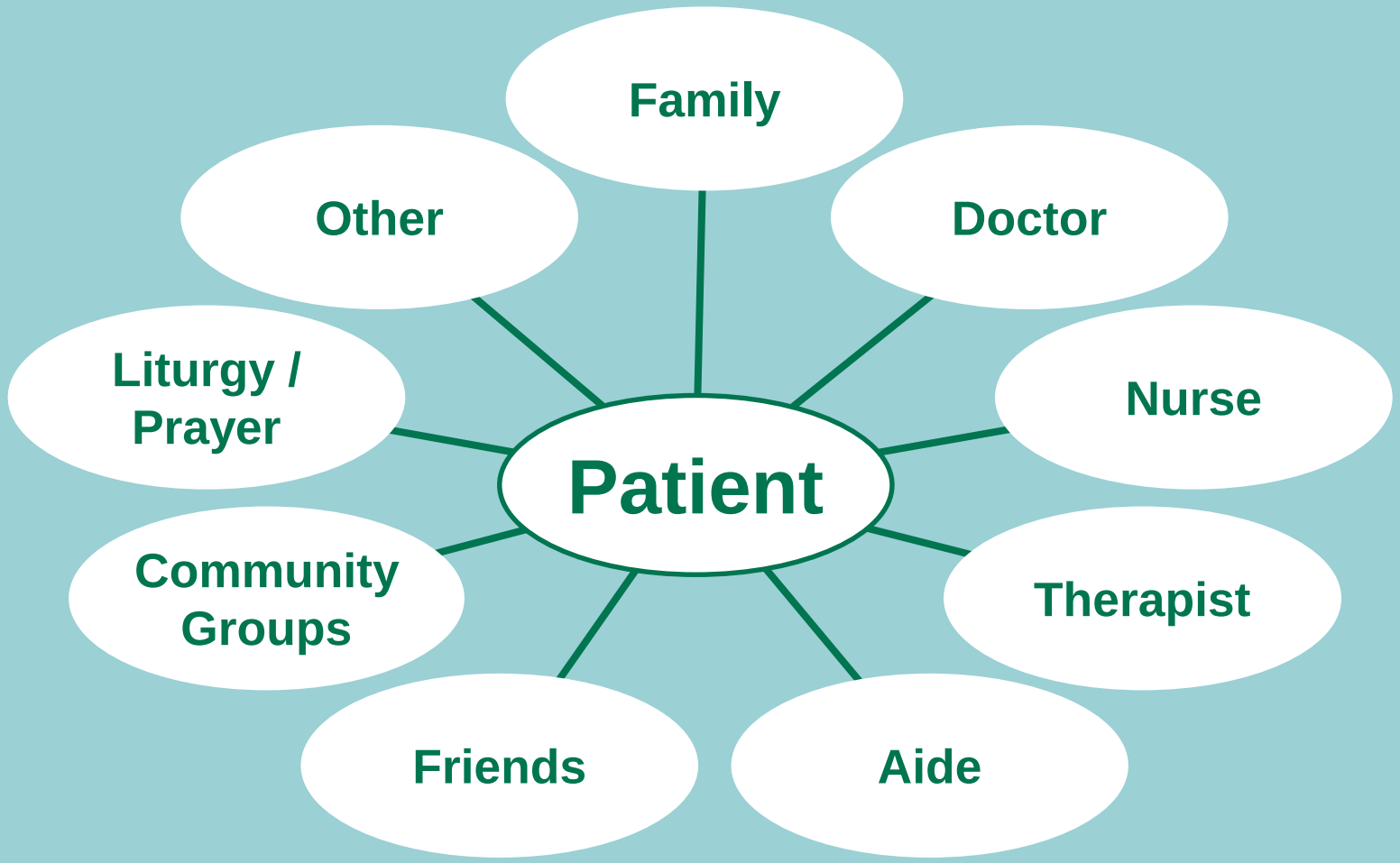
Path Forward / Next Steps

- Maintain efficiency in order to increase cases reviewed
- Increase use of technology – implement secure screen sharing (Lync) & video conferencing
- Increase interaction of clinicians based on location for case conference
- Build strength of our interdisciplinary teams and coordination across the continuum

Path Forward / Next Steps

- Develop team members to facilitate case conference (leadership advancement)
- Cultivate community partnerships to support patient staying safely at home
- Evaluate the impact case conferences have on clinical outcomes, patient satisfaction and employee engagement

Interventions & Activities



Questions?

SHP
STRATEGIC HEALTHCARE PROGRAMS

CHRISTIANA CARE
HEALTH SYSTEM

Thank you for attending our Webinar!

For more information, please contact:

Strategic Healthcare Programs

- Email: info@SHPdata.com
- Phone: (805) 963-9446

SHP
STRATEGIC HEALTHCARE PROGRAMS

CHRISTIANA CARE
HEALTH SYSTEM