Abington Jefferson Health

The Implementation of a Homecare Based Bundle Payment Navigation Program

Heather Peiritsch MSN, RN
Bundle Payment Program Manager
Abington-Jefferson Health

Program Objectives

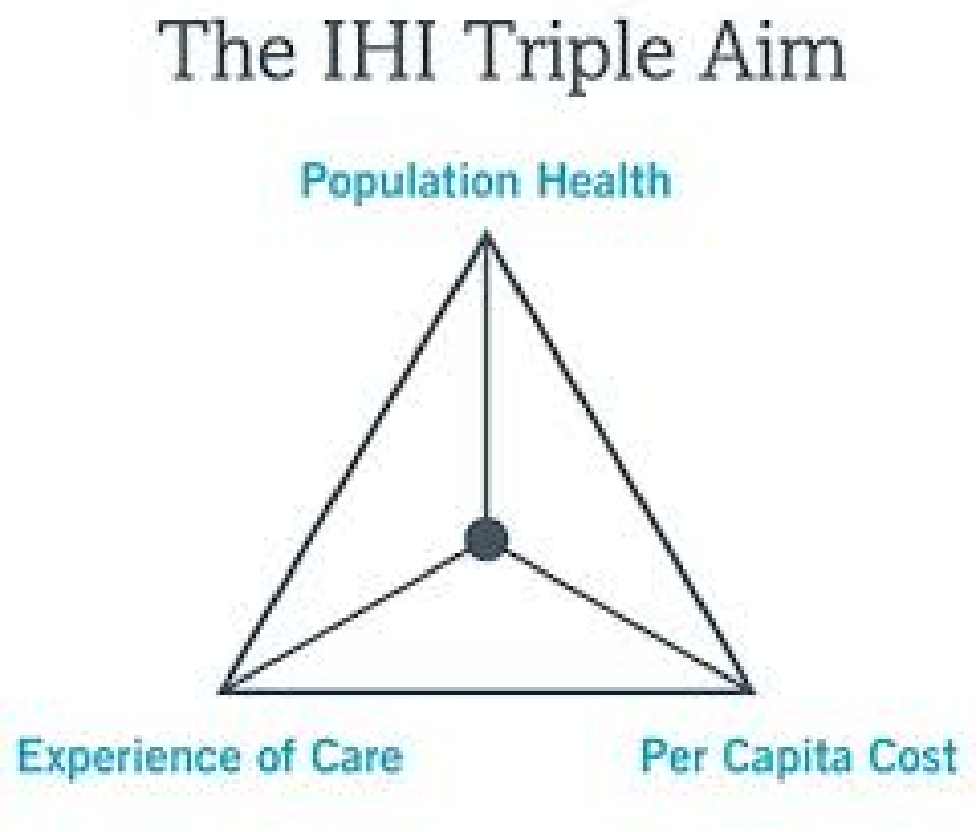
- At the completion of this session the learner be able to discuss the initiatives on what led to the development and implementation of a homecare based bundle payment program.

- At the completion of this session the learner will be able to recognize the importance of collaboration and communication with both inpatient teams and post acute providers.

- At the completion of the session the learner will be able to have increased knowledge on the challenges faced with implementing a bundle payment program.

Why Nurse Navigation Program?

The IHI Triple Aim



http://www.ihi.org/Engage/Initiatives/TripleAim

Abington's Bundle Program Goals

Cost

- Readmission Reduction
- SNF placement and SNF LOS
  - *Patients will go to the safest, lowest level of care as soon as medically stable*

Quality

- Care Redesign
- Patient satisfaction and Engagement
  - *Patients will have a great hospital experience*

Coordination

- Acute and post-acute provider alignment
  - Patients will have excellent care coordination

Abington Bundle Strategy

- 4/1/15: Joint replacement bundle
  - Ended June 30, 2016
- 7/1/15: Bi-Lateral joint replacement bundle
  - Ended June 30, 2016
- 10/1/15: CHF and Stroke bundle
  - Will end on **September 30, 2018**

The Nurse Navigator

- Navigates the patient from the hospital admission through 90 days after discharge from the inpatient setting.
- Establishes a relationship with patient/family while patient is on the hospital unit
- Calls patients discharged from the hospital within 24-72 hours
- Collaborates and communicates with multidisciplinary inpatient and outpatient teams.

The Nurse Navigator

- Engages the patient/caregiver to develop strategies to guide positive change and self-responsibility for managing their disease process.
  - Goal Setting
  - Teach Back technique
  - Motivational Interviewing

- Develops “Zone” action plan and educates patient/caregiver and community partners on its use
  - Signs and Symptoms
  - No added sodium diet
  - Daily weights
  - Who to call

Controlling heart failure at home

How do I feel today?

	 Green zone You are in control.	 Yellow zone Take action today. Call: _____	 Red zone Take action now! Call: _____
Is my weight up? My healthy weight: _____	No change in my weight.	My weight is up: • 3 pounds overnight • 5 pounds since last week	My weight is up: • 5 pounds overnight
Do I have swelling?	I do not have swelling.	I have swelling in my: • Foot, ankle or shin • Knee or thigh	I have swelling in my: • Belly – feels bloated or pants are tighter • Hands or face
Am I short of breath?	I do not feel short of breath: • Breathing is normal • Sleep is normal	I feel short of breath or cough while: • Walking or talking • Eating • Bathing or dressing I need to use more pillows when I sleep.	I feel: • Short of breath or wheeze at rest • Less alert I need to sleep sitting up to breathe.
How is my energy level?	My energy level is normal.	I am too tired to do most of my normal activities.	I am so tired that I can hardly do any of my normal activities.
My other signs of heart failure:			Chest pain or pressure that does not go away.

The Nurse Navigator

- Assists patient to schedule primary care physician or specialist appointment
  - Ensures patient is seen within 7-14 days of hospital discharge.
- Assists the patient/caregiver in clarifying unclear discharge instructions and ensures the medication reconciliation is correct.
- Thorough clinical assessment
- Actively participates in the goal of reducing re-hospitalizations.

The Nurse Navigator

- Initiates patient and caregiver referrals to community agencies and services as needed; provides necessary follow up to ensure service utilization
  - Homecare
  - Van service
- Documents assessments and interventions in the appropriate EMR
- Maintains and tracks the patient's level of care and activities in approved database
- Hand over to physician practice care manager –if applicable

Challenges that led to Opportunities

Partnerships
Inpatient Hospital Teams

Established internal multi-disciplinary teams

- ✓ **Monthly disease specific "team" meetings**
- ✓ **Education throughout the continuum**
- ✓ **Shared Statistical data—scorecards**
- ✓ **Just in time feedback—service recovery**
- ✓ **Readmission review**

Case Management/Social Work Department

Home First

Preferred Providers

Physical Therapy

"24 hour supervision required"

Palliative Care Team

Jefferson Health Home Care

- Heart Failure Home Care Team
  - ✓Multi-disciplinary high utilization case reviews
    - Readmissions
  - ✓Warm handover from navigators
- All Teams
  - ✓Process for contacting navigators upon patient discharge
  - ✓Collaboration with Navigators
    - Increase navigator calls for high risk patients
    - Handover after homecare discharge
  - ✓Telemonitoring services

Jefferson Health Physician Network

- Collaboration with practice care managers
  - 7 day follow up appointments
  - Same day sick appointments
  - Outpatient prescriptions for testing
  - Referral for Homecare
  - Warm handovers

- Ability to read Care Provider notes
- Write a direct email to Care Provider with concern

Skilled Nursing Facilities

- **Goals: Decrease Utilization, Decrease length of stay**

- Sent RFP's out to all Community facilities
  - Chose 4 Preferred Providers for Abington; 2 for Lansdale
  - Receiving high volume already
  - All providers have high Quality Star Ratings
  - Medical Directors on staff

Preferred Skilled Nursing Facility Providers:

- Established point person for nurse navigator contact
  - ✓Weekly touch point: phone call, email, fax
  - ✓Tool developed for report
  - ✓Look closely at the patient's clinical care, length of stay, therapy goals.
  - ✓Recognition of clinical challenges
  - ✓Emergency Room Utilization
  - ✓Readmission Review

- On site Education
  - ✓Abington's disease specific Clinical Nurse Coordinator's and Specialists
    - ✓Guidelines and Pathways
  - ✓Meetings with Medical Directors and Physiatrists
    - Clinical issues and length of stay

Preferred Skilled Nursing Facility Providers:

- Multi-disciplinary monthly meetings
  - ✓ SNF leadership
  - ✓ Agenda items known in advance
- High utilization review
  - ✓ Clinical issues
  - ✓ Length of stay
- Unblinded scorecards
- Development of new processes

Post Acute Community Partners

- Weekly calls made to all post-acute facilities patients are discharged to
  - ✓ Establish relationships with facilities (SNF, LTC, ALF/PC)
  - ✓ Education about Navigation Program and goal
  - ✓ Established point person for contact

- Homecare
  - ✓ Establish a connection for collaboration on patient's care
  - ✓ Language barrier
  - ✓ Abington best practice educational materials and protocols
  - ✓ Zone management tools

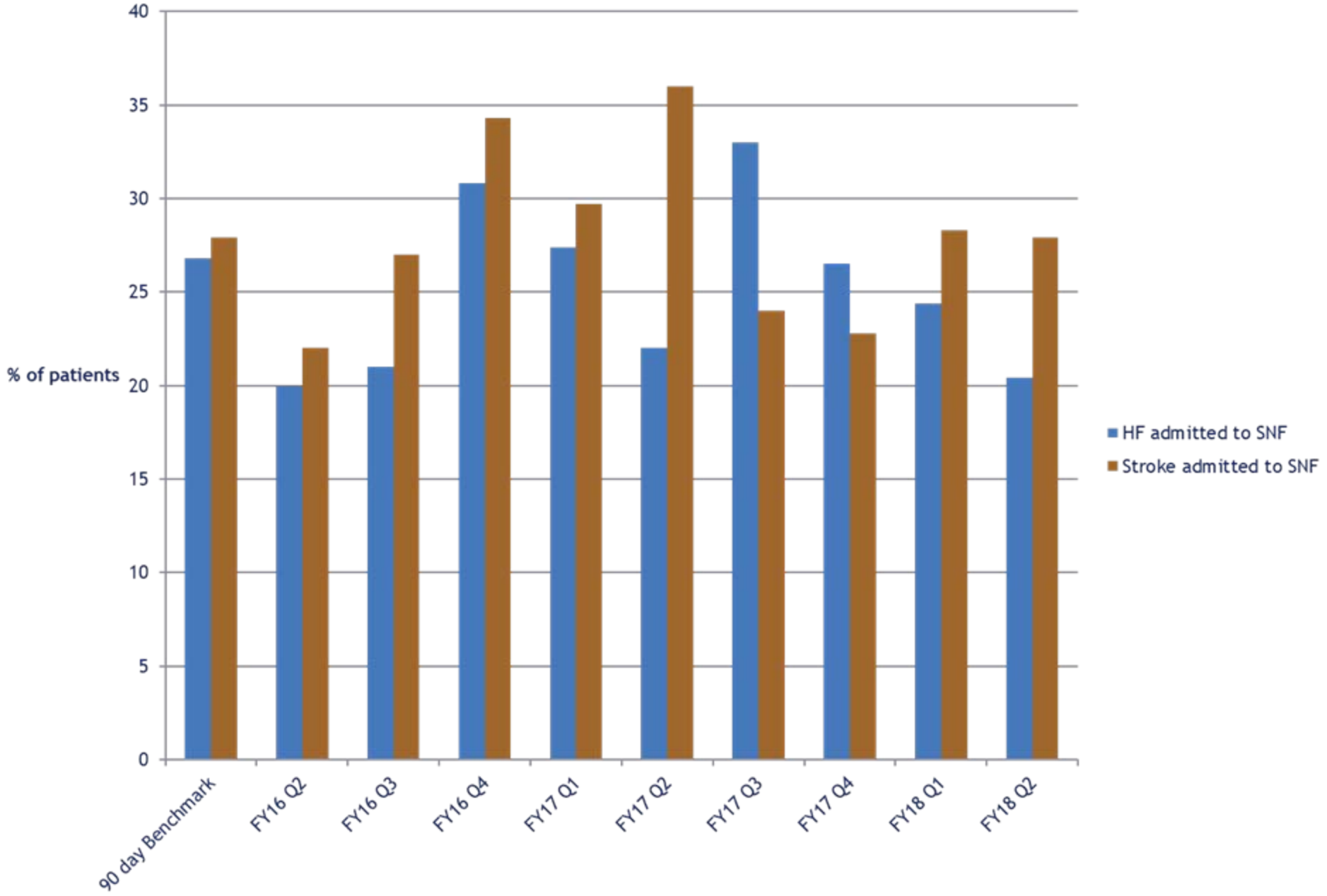
Abington - Jefferson Health Scorecard

SNF Facility - CMS Data April 2016			A	B	C	D	E	F			
Unit(s)	Desired Direction	As Of							Variance	PA Goal	National Avg
Overall Star Rating (out of 5)	▲	7/26/2016	4	4	5	5	4	4			
Health Inspection	▲	7/26/2016	4	4	5	4	4	3			
Staffing	▲	7/26/2016	4	3	3	5	4	4			
Quality Meaures	▲	7/26/2016	4	4	2	5	3	3			
% improvment in function	▲	7/26/2016	57%	66%	77%	73%	54%	74%		63%	64%
% hospitalized after a nursing home admission	▼	7/26/2016	17%	27%	33%	30%	24%	17%		20%	21%
% who had an outpatient ED visit	▼	7/26/2016	9%	9%	11%	12%	9%	11%		10%	12%
% successfully discharged into the community	▲	7/26/2016	67%	63%	69%	41%	58%	67%		55%	55%

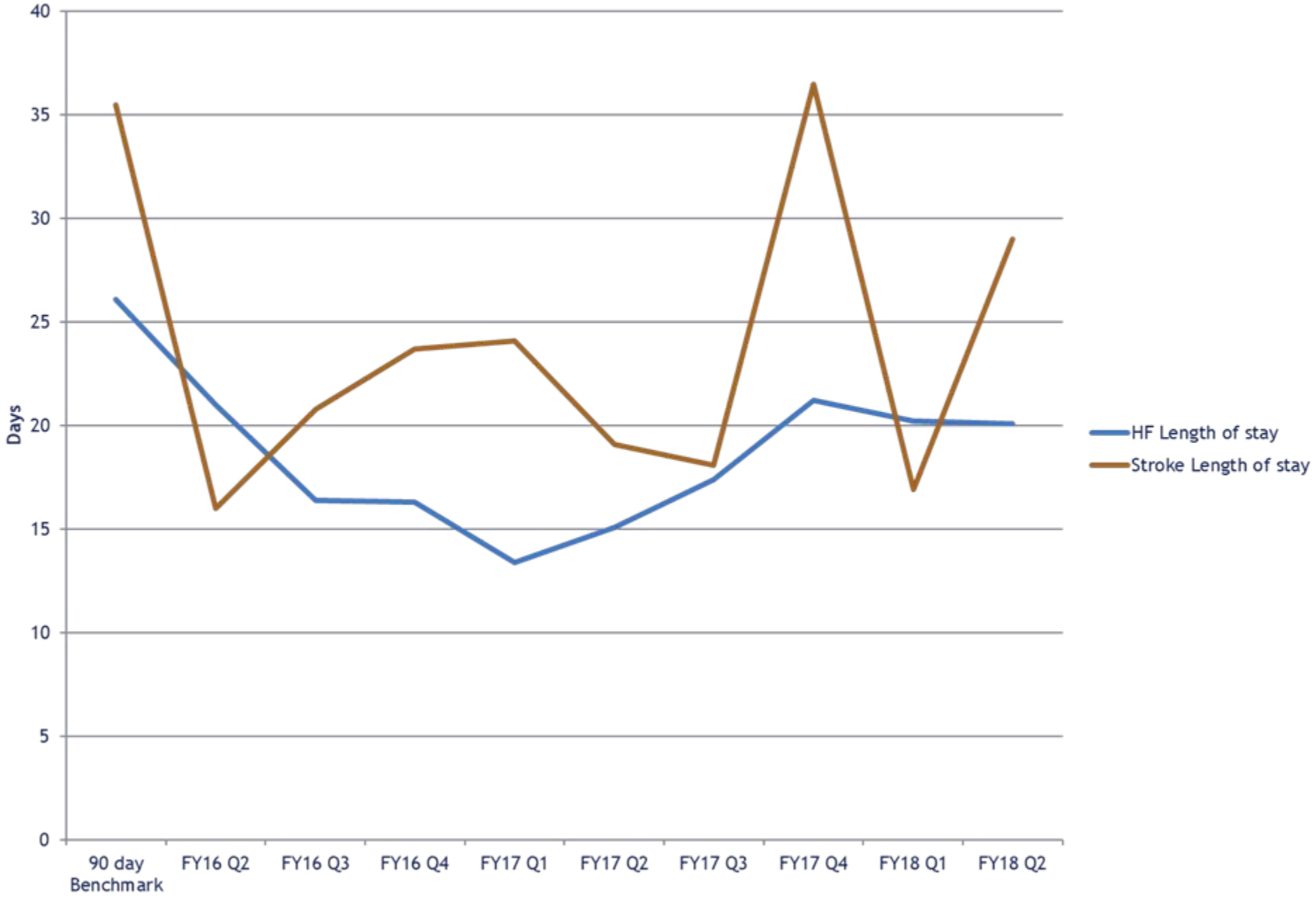
BUNDLE STATISTICS			A	B	C	D	D	D		
Unit(s)	Desired Direction	As Of							Variance	Benchmark
HF Patients		7/15/2016	9.00	2.00	0.00	0.00	13.00	12.00		
HF Readmission	▼	7/15/2016	0.00	0.00	0.00	0.00	7%	9%		0
HF LOS (episode)		7/15/2016	23.00	21.00	0.00	0.00	18.00	14.00		14 days
HF LOS (occurrences)		7/15/2016	23.00	21.00	0.00	0.00	17.00	12.00		
Stroke Patients		7/15/2016	8.00	6.00	4.00	0.00	10.00	8.00		
Stroke Readmission	▼	7/15/2016	5%	0.00	5%	0.00	5%	3%		0
Stroke LOS (episode)		7/15/2016	24.00	24.00	17.00	0.00	25.00	21.00		21 days
Stroke LOS (occurences)		7/15/2016	18.00	24.00	13.00	0.00	21.00	19.00		
Total Point Value (out of 24 points)		7/15/2016	16	17	12	11	11	17		

Outcomes

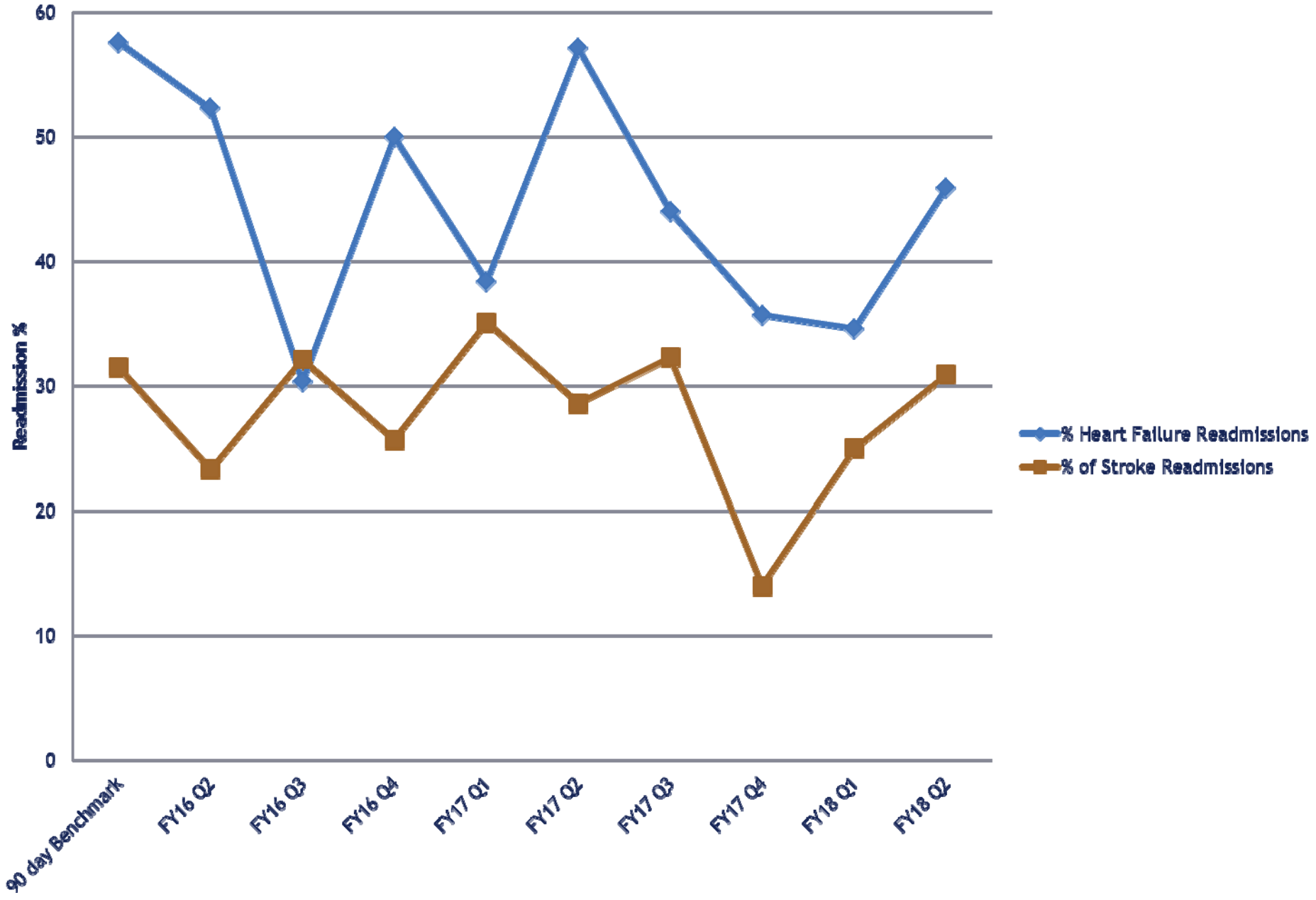
Patients admitted to SNF



Preferred Provider Length of Stay



90 Day Readmission Rates for Heart Failure and STroke



Heart Failure Bundle Dashboard
DRG 291, 292, 293

GOAL	CMS Baseline 2009-2012	October 2015-April 2018	Change From Baseline
Reduce the number of heart failure bundle patients admitted to SNFs	26.8%	24.6%	**2.2%**
Reduce SNF days for HF bundle patients	27.31 days	24.44 days	**2.87 days**
Reduce HF Bundle 90 day Readmissions	57.6%	43.5%	**14.1%**

Stroke Bundle Dashboard
DRG 61, 62, 63, 64, 65, 66

GOAL	CMS Baseline 2009-2012	October 2015-March 2017	Change From Baseline
Reduce the number of Stroke bundle patients admitted to SNFs	27.9%	27.8%	**0.1%**
Reduce SNF days for Stroke bundle patients	32.20 days	31.20 days	**1.00 day**
Reduce Stroke Bundle 90 day Readmissions	31.5%	26.5%	**5%**

Hospital Readmissions Reduction Program

- In October 2012, CMS began reducing Medicare payments for Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions. Excess readmissions are measured by a ratio, by dividing a hospital's number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia, COPD, hip/knee replacement, and coronary artery bypass graft surgery by the number that would be "expected," based on an average hospital with similar patients. A ratio greater than 1.0000 indicates excess readmissions.

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Program Growth

- Growth of *Navigation Team*
  - ✓ COPD
  - ✓ AMI
  - ✓ CABG

- Skilled Nursing Facility Community Partners
  - ✓ Meetings every other month with 8 next highest referral sources

- Annual Symposium for Post Acute Providers (began 2016)
- Annual Skills Lab for Post Acute Providers (began in 2017)

Homebased Remote Telemonitoring Program

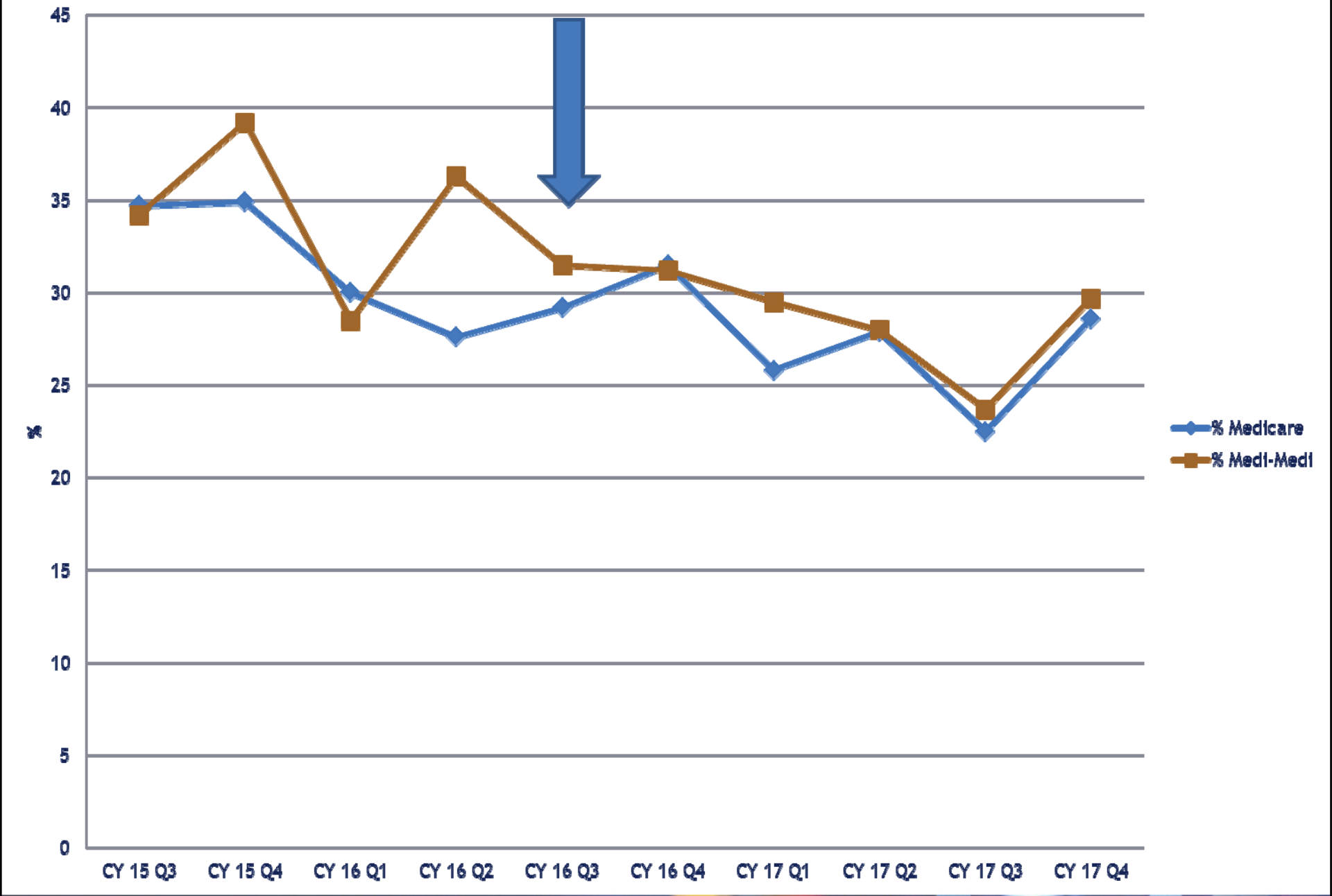
- Readmissions challenging
  - Multiple co-morbidities and complex health issues

- Engagement of patients to actively participate in the management of their illness
  - ✓Telemonitoring Program
  - ✓Wireless, bluetooth, 4G
  - ✓Monitors blood pressure, pulse ox, heart rate, weight
  - ✓Prioritizes acute cases alerting the nurse to the possibility of an issue. Triggers a call to the patient by the nurse.

Nurse Navigator Role in Telemonitoring

- Triages patients daily
- Facilitates care coordination
- Reassures patients regarding plan of care, Disease Management
- Helps with equipment set up, trouble shooting and pack up

Percent of Heart Failure Patients Re-hospitalized



Jefferson Health

Nurse to Nurse Handoff Tool

Use this tool to communicate accurate, significant clinical patient care information!

Situation

Patient Name:_____

Date of birth:_____Date of Admission:_____

Primary Language: · English · Other_____

Code Status at Discharge: · **Full Code** · **DNR** · **DNI** · **DNH**

Allergies: *None Yes* (describe)_____

Isolation: *None Yes(* list) · MRSA · VRE · C-Diff · ESBL · Other

Background

Diagnosis/Reason for Hospitalization_____

Significant PMH: None Yes_____

Procedure(s)/Treatment(s) during this hospitalization_____

Surgical wound/treatment: _____

Post-op date:_____

Immunizations given_____

Assessment

Vital Signs: T__BP_____HR___RR__Pulse Ox____

Weight at discharge:_____pounds

Oxygen use: **None Yes** SpO2_____% on _____liters

Neurological Status during this hospitalization:

· *Alert, oriented, follows instructions*

· *Alert, disoriented, but can follow simple instructions*

· *Alert, disoriented, but cannot follow simple instructions*

· *Not alert*

Speech at discharge: **Clear Slurred Garbled Aphasic**

Presence of pain **None Yes,** Pain Level _____/10

Pain meds given/time: _____

IV access **None Yes**, Site:_____ __**PIV CVL PICC**

PICC size and measurements: _____

last dressing change: date_____time_____

reason for access: _____

Diet: *Regular Low salt Diabetic Low Res*

*Tube Feed : placement of tube*_____

Weight bearing status: **NWB PWB FWB**

Ambulatory Status during this hospitalization:

· ***ambulates independently***

· ***ambulates with assistive device : Cane Walker Prosthesis***

· ***not ambulatory***

Braces/immobilizers_____schedule_____

Wound or Pressure Ulcer(s): **None Yes** --site/stage

appearance_____

last dressing change date/time_____

GU: **Continent or Incontinent**

Foley-Insertion Date_____D/C'd_____

reason for Foley:_____

GI: **Continent or Incontinent**

Date of last BM:_____

Abnormal labs/tests_____

Blood sugar:_____Insulin coverage____

Last Meds given/times:

Stop date for IV/PO antibiotics_____

Anticoagulation Therapy: ***None Yes***

(describe)_____

Last Coumadin dosage: (mg)_____

Most recent INR level/date:_____

Recommendation

At-Risk Alerts: **None Yes**_____

· Falls · Sepsis · Pressure Ulcer · Seizure · Aspiration

· ETOH · Withdrawal · Elopement · Suicide

Send prescriptions for controlled substance

Required Additional Information:

Patient Dishcarge date: _____

Abington Nurse Name_____

Facility Nurse Name_____

1

Patient Name: _____ **DOB:**____/____/_____

Facility Name: _____ **Nurse leader cell phone#:** _____**Fax:**_____

Covering Provider cell phone # : _____

2

Reason for Transfer / Consultation Question:

☐ **Fall / Injury:** ☐ Witnessed ☐ Unwitnessed ☐ Head trauma-known or possible ☐ No head trauma
☐ Localized pain ☐ Suspected fracture: _____
X-ray done ☐ Y ☐ N Blood thinners ☐ Y ☐ N

☐ **Change in baseline mental status:** ☐ Y ☐ N , if **yes**, last time known to be well:_____
Indicate baseline mental status: _____

Sign and Symptoms that patient has: ☐ Resp. distress / hypoxia ☐ Altered mental status
☐ Hypotension ☐ Hypertension ☐ Chest pain ☐ Shortness of Breath
☐ Weight gain ☐ High or Low Temperature ☐ cough ☐ diarrhea
☐ Adverse drug event: ☐ Rash Other symptoms: _____
☐ **Other:** _____
Transfer to ETC at the request of ☐ **Patient** ☐ **Family** ☐**Physician** ☐**Other** _____

READMISSION ALERT ? (Last hospital DC < 30 days) YES / NO __ If yes, hospital name _____

3

Document Checklist (ensure all sent with Pt)
☐ **Code Status /** ☐ **POLST**
☐ Current meds (with route, schedule, last dose)
☐ Key progress notes / labs / radiology

Nursing Facility Capabilities :
☐ IVF ☐ IV Antibiotics ☐ Laboratory Testing
☐ Lovenox ☐ IV Diuretics ☐ Other:
*see opposite side for more extensive list
☐ MD/NP can see tomorrow?

4

Abington ETC Completes

ETC Provider please call covering Facility Provider with your questions or concerns

ETC Diagnosis:
Suggested treatment Plan:
Perceived Need at Nursing Facility:
☐ IVF ☐ IV Antibiotics ☐ Laboratory Testing ☐ Lovenox ☐ IV Diuretics ☐ Other:
Facility Physician/Provider to see patient tomorrow? ☐ Yes ☐ No

ETC Physician:_____
Facility Transfer Checklist (AH ETC Completes)
☐ Facility Confirms able to execute plan
☐ TIMING Facility Confirms able to accept patient A) immediately B) 4-6 hrs c) 6-12 hrs
**Options B and C -patient will not be readmitted back to the SNF

Facility: _____

Please fill out the below portion with the options: immediately, # of minutes, # hours or # days to indicate how long it will take for you to get the necessary people/supplies/medications to care for a returning patient.

Capabilities	Expected time frame
Frequency of Prescribing Care Provider (e.g., MD/NP/PA) in the Building	
Diagnostic Testing:	
Turn around for stat labs	
Turn around for xray	
EKG	
Bladder Ultrasound	
Venous Doppler	
Swallow Studies	
Therapies on Site:	
OT, PT, ST, RT	
Nursing Services:	
Frequent vital signs (q 2 hours)	
Strict I& O monitoring	
Daily weights	
Accuchecks	
Oxygen	
Nebulizer treatments	
BiPAP, CPAP capabilities	
Incentive Spirometry	
Interventions:	
IV fluids	
IV antibiotics	
IV push medications	
PICC insertion	
PICC management	
TPN	
Isolation	
Surgical drain management	
Tracheostomy management	
Analgesic pumps	
Dialysis	
Pharmacy Services:	
New medications filled	
Narcotic medications filled	

Delaware Valley Accountable Care Organization
DVACO

- Jefferson and Mainline Hospital's
- Aligned goals with Bundle Project
  - Decease SNF utilization
  - Decrease SNF length of stay
  - High quality care—Star Ratings
  - Care coordination
- Projects
  - Mobility Program—use of AMPAC scoring
  - SNF to Emergency Room Consult Process
  - HF/COPD Program in SNF's

Great Saves—Learning Opportunities
Heart Failure Readmission Prevention

- **Situation**
  - ✓ Report received from SNF, patient showing increased weights and shortness of breath at rest
- **Background**
  - ✓ Pt admitted to SNF from hospital, coded into HF bundle
  - ✓ Finished course of antibiotics for pneumonia
  - ✓ Treated for overload and had +SOB, received increased diuretic doses.
  - ✓ At discharge was placed back on pre-hospital dose of Lasix
- **Assessment**
  - ✓ Nurse Navigator communicated concern about rising weights and +SOB at rest—potential for fluid overload
- **Recommendations**
  - ✓ Patient placed on a 1500 cc fluid restriction, started on Lasix IV x 3 days and daily BMPs

Accolades

- “I am appreciative that you are calling, it lifts my spirits that I am being checked on. You don't realize how this makes a patient feel. It makes me feel like someone cares. I look forward to your next call.”

- “I love my phone calls from you. I like that I have a close relationship with you. You are my angel.”

- “Everything that I have experienced is 5-Star and really quite amazing.”

- “My experience has been like going to a restaurant from the appetizer to dessert, everything is in order and everyone knows their role.”