Disclosures

- Verification of participation will be noted by signing in via the chat box.

- No influential financial relationships have been disclosed by planners or presenters which would influence the planning of the activity. If any arise, an announcement will be made at the beginning of the session.

- No commercial support has influenced the planning of the educational objectives and content of the activity. Any commercial support will be used for events that are not CE related.
Disclosures

- There is no endorsement of any product by DUHS associated with the session.

This program is supported by a Geriatric Workforce Enhancement Program (GWEP) grant (U1QHP28708) from the U.S. Bureau of Health Professions Health Resources and Services Administration (HRSA).
Objectives

• Define the core principles of high quality transitions of care from SNF to home

• Describe a process and model for improving SNF to home transitions that engages teams from facility, health system, community and PC practice

• Identify a role for options counselors in aiding the transitions process
Case

• 85 year old retiree from Durham
• Still works as a substitute teacher
• Widowed and living alone for last 5 years
• Underwent elective total knee replacement with expectation of returning home
• Course complicated by blood loss requiring multiple transfusions, progressive weakness
• Discharged from hospital to SNF for rehab
Case (2)

Medical problems

1. Hypertension
2. Coronary artery disease— s/p stent in 2005
3. Osteoarthritis--- s/p lumbar laminectomy
4. Transient ischemic attack
5. Interstitial lung disease
6. GERD
7. Benign prostatic hyperplasia
Case (3)

- Discharged to local skilled nursing facility for rehabilitation—noted to have cough and congestion, residual delirium, poor sleep and ankle swelling (HOPE consultation)

- Near time of discharge, noted to have the following issues:
  - Delirium improved but now with signs and symptoms of depression
  - Cough and congestion improved—on Levofloxacin
  - Fluctuations in weight and ankle swelling

- Before discharge from SNF to home, patient referred for review at Duke Well Geriatrics Rounds
Case (4)

• Last PCP visit:
  1. Amlodipine
  2. Metoprolol
  3. Lovastatin
  4. Meloxicam
  5. Aspirin

• Discharge:
  1. Amlodipine
  2. Metoprolol
  3. Lovastatin
  4. Rivaroxaban
  5. Pantoprazole
  6. Levofloxacin
  7. Aspirin
Case (4)

- Concerns at discharge:
  - Manage and monitor depression
  - Follow up with PCP
  - Communicate concerns regarding hospitalization and related health events—e.g. delirium, respiratory infection, fluid overload
  - New medications, old medications
# Improving Transitions

<table>
<thead>
<tr>
<th>Pre Discharge Interventions</th>
<th>Post Discharge Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver and Patient Education</td>
<td>Timely Follow-up</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>Timely PCP communication</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Follow-up telephone call</td>
</tr>
<tr>
<td>Appointment Scheduled Before Discharge</td>
<td>Patient hotline</td>
</tr>
<tr>
<td></td>
<td>Home visit</td>
</tr>
</tbody>
</table>

**Interventions Bridging the Transition**

- Transitions Coach
- Patient Centered Discharge Instructions
- Provider Continuity

*Interventions to Reduce 30-Day Rehospitalizations: A Systematic Review Ann Intern Med 2011*
Patient-Centered Discharge Instructions

- Patient-friendly information
- Summarizes the interprofessional team perspectives
- Like a recipe for the patient to follow at home
Best Practice: Transitioning from SNF to Home


- Defined issues and developed best practices perceived as feasible for SNF physician and PCP practices to accomplish
Pitfall #1:
PCP does not know patient has been admitted to the SNF

- SNF provider: Identify the correct community PCP
- PCP: Confirm and update PCP information and fields in charts
Pitfall #2: Delay in follow-up with PCP after SNF discharge

- **SNF**: Schedule a follow-up appointment with the PCP within 7 days post-discharge from SNF

- **PCP**: Expedite scheduling of patients being discharged from a SNF
Pitfall #3: Lack of exchange of information about patient’s care

- SNF: Transmit discharge summary and instructions to the PCP office prior to the follow-up appointment or within 72 hours of discharge from SNF, whichever comes first.

- PCP: Read, follow-up, and include information from the SNF physician in the outpatient medical record.

- SNF: Verbal report given by SNF nurse and/or physician.

- PCP: Prepare outpatient staff for reception of verbal report from SNF staff.
Pitfall #4: Lingering issues at SNF discharge

- Questions from patient, caregiver
- Accurate medication list
- Actual receipt of vital services (e.g. DME, home health, therapy)
- SNF physician and PCP: Ensure patient receives a phone call within 48 hours following SNF discharge.
SNF to Home Process Map

- Patient Discharge Anticipated
  - New diagnoses
  - Change in medications
  - Change in function
  - Change in cognition
  - Change in advance directive
- Medications/Script
- Nursing care
- Therapy
- Durable Medical Equipment
- Follow-up Appointments
- Information Given to Patient and/or Surrogate, Support
- Patient Discharged to Home
- Information Transmitted to PCP
- Home Nursing Phone Contact and Visits
  - Therapy Phone Contacts and Visits
  - SNF Staff Phone Contact (Variations)
- PCP
Steps for Improving Transitions from SNF to Home

1. Set expectations for the sending and receiving provider teams
2. Conduct Interprofessional Care Transition Meetings
3. Tailored communication strategies
4. Target specific outcomes for improvement
5. Engagement of “third party” services from health system and community
Duke Connected Care

- Established in 2013 as a Clinically Integrated Network

- 1800+ providers, 11 practices
  - 8 non-Duke, independent community practices

- Provides care management, data & analytics support, quality reporting for participants

- Owns value-based component of two contracts
  - Medicare Shared Savings Program (MSSP)
  - Cigna Collaborative Accountable Care (CAC)
Payer and DCC execute a value-based agreement that defines the attributed population, quality and cost targets, care management fees and shared-savings methodology.

DCC provides population health services.

DCC providers bound to value-based contracts via participation agreements.

Payer disburses care management fees and shared savings to DCC based on overall quality and cost performance.

DCC distributes shared savings to DCC Participants.

Payer reimburses DCC providers directly on a FFS basis via existing, provider-specific FFS contracts.
Where do ACO savings come from?

<table>
<thead>
<tr>
<th>Focus</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition management, better access to PCPs and primary care</td>
<td>Decreased admissions, readmissions, decreased length-of-stay</td>
</tr>
<tr>
<td>Coordinating with PAC settings</td>
<td>Optimal utilization, minimizing return admissions</td>
</tr>
<tr>
<td>Smart use of the ED</td>
<td>Decreased utilization of avoidable ED, stressing urgent care</td>
</tr>
<tr>
<td>PCP assignment, medication management</td>
<td>Smarter use of available resources and referrals</td>
</tr>
</tbody>
</table>
Care Management

• Northern Piedmont Community Care
  – One of 14 Community Care of NC networks
  – Provides community-based care management for Medicaid population

• DukeWELL
  – Initiated as an employee health care management program out of the Private Diagnostic Clinic
  – Team of care managers and coordinators who work to improve the value, quality, and ease of care for patients managing chronic disease
  – Provides services for “DukeWELL Eligible” patients
DukeWELL Elig: Y
Transition Challenges

- **Hospital**
  - Discharge Summary
  - Discharge to Outside Facility Form
  - Advance Directive Information

- **SNF**
  - SNF Discharge Summary
  - Medication Administration Record (MAR)

- **PCP**
  - Accurate Medication List
  - Accurate Problem List with Accompanying History
SNF Coordination Services

- DukeWELL RN and MSW
- Duke HomeCare and Hospice Coordination (DHCH)
- Geriatric rounds
  - Includes geriatrician, PharmD, DHCH, and DukeWELL care management
- DCC/NPCC Home visits
- Palliative care screening and coordination
SNF RN and MSW Workflow

Assess all “DukeWELL Eligible” DUHS discharges to SNFs

Visit select patients and coordinate care with SNF staff; Refer select pts to DHCH

 Advocate for patient needs, educate patient and family, assist in reconciling discrepancies

Document in Epic and keep PCP informed of patient status

Ensure outstanding issues are addressed at initial PCP visit

Coordinate care with home health, hospice, palliative care, PCP, NPCC, and other community resources

Serve as communication hub for Pt/ PCP/ SNF/ Family or HPOA
# DukeWELL SNF RN Outputs

<table>
<thead>
<tr>
<th>Action</th>
<th>Sept 2016</th>
<th>1/1-9/30/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face Patient Encounters</td>
<td>25</td>
<td>165</td>
</tr>
<tr>
<td>- SNF and clinic visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Resource Connections</td>
<td>9</td>
<td>52</td>
</tr>
<tr>
<td>- Duke Family Support, SHIIP, Triangle J, PACE, HELP, Palliative Care, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duke HomeCare and Hospice Referrals</td>
<td>8</td>
<td>58</td>
</tr>
</tbody>
</table>
DukeWELL Referral Options

• To refer a patient for SNF coordination, use ambulatory referral to DukeWELL
  – *Indicate in comment box that message is for SNF services*
  – *Patient must be “DukeWELL Eligible” to receive services*

• Direct phone (Chris Kleinert, RN, CHPN): (919) 660-0748

• Main DukeWELL Phone: (919) 660-9355

• Email: christina.kleinert@duke.edu
# Additional Resources

<table>
<thead>
<tr>
<th>Health Optimization Program for Elders (HOPE)</th>
</tr>
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<tbody>
<tr>
<td>• <em>HOPE consult</em> (geriatrics team &amp; HOPE Nurse Practitioner)</td>
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<table>
<thead>
<tr>
<th>DCC/DukeWELL Geriatric Rounds</th>
</tr>
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<tbody>
<tr>
<td>• <em>Ambulatory referral to DukeWELL; Enter Geriatric Rounds in Comments.</em></td>
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</table>

<table>
<thead>
<tr>
<th>Duke HomeCare &amp; Hospice (DHCH) Services, including Bridge Program</th>
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<tbody>
<tr>
<td>• <em>Ambulatory referral to DukeWELL; Enter Home Health, Hospice, or Geriatric Rounds in Comments.</em></td>
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</table>

<table>
<thead>
<tr>
<th>DCC Home Visits</th>
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<tbody>
<tr>
<td>• <em>Ambulatory referral to DukeWELL; Enter Home Visit in Comments. Primarily limited to DUHS service area.</em></td>
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</table>

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<thead>
<tr>
<th>Duke Family Support Program or Project Care</th>
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<tbody>
<tr>
<td>• <em>Ambulatory referral to DukeWELL; Enter Geriatric Rounds in Comments.</em> Caregiver focused support and education for dementia patients. One-time home visits through Project Care.*</td>
</tr>
</tbody>
</table>
THE LOCAL CONTACT AGENCY AND OPTIONS COUNSELING

Jenisha Henneghan, PT, DPT, MPH
Options Counselor/Care Advisor
Triangle J Area Agency on Aging
OPTIONS COUNSELING: A DECISION SUPPORTED PROCESS.

• Listening to expressed preferences, values and needs
• Talking about options based on needs and preferences
• Supporting an individual to make informed decisions
• Supporting an individual to make connections with new and previously used Long-Term Services and Supports in the community
THE ROLE OF THE LOCAL CONTACT AGENCY (LCA) AND OPTIONS COUNSELING

• Provides facility based options counseling to residents who are interested in transitioning from the nursing home to the community.

• Collaborates with the facility (social worker, administrator, rehab team, etc.), the resident, and the resident’s support system to formulate a transitions plan.

• Works with the facility to enable a safe and appropriate discharge for the resident.

• Follows-up with the individual to see how well the plan worked and what other resources maybe needed.
WHO’S ELIGIBLE FOR OPTIONS COUNSELING?

• Older Adults
• Adults with a disability
• The individual that is willing and has the desire to participate in decision-making.
THE LOCAL CONTACT AGENCY (LCA) REFERRAL PROCESS

• An individual in the nursing home expresses their desire to return home or to community living.

• The nursing home makes a call to the MDS Call Center at 1-866-271-4894.

• The Call Center emails the referral to the Local Contact Agency.

• The LCA contacts the Nursing Home to confirm receipt of the referral.

• The LCA Options Counselor visits the individual at the facility to discuss the individual’s preferences, values and needs.
THE BENEFITS OF OPTIONS COUNSELING AND SUCCESSFUL CARE TRANSITIONS

• Provides individuals and their families the opportunity to make informed decisions that support a successful return home or to community living.

• Successful connections to long-term services and supports can assist with limiting hospital or nursing home readmissions.

• Improves individual health outcomes in the community, as well as improving one’s quality of life.
CONTACT INFORMATION

Jenisha Henneghan
Options Counselor/Care Advisor
4307 Emperor Boulevard, Suite 110
Durham, NC 27703
Phone: 919-724-2662
Email: Jhenneghan@tjcog.org
Back to the Case

- Discussed at Geriatrics Rounds
- Recommendations for adding Mirtazapine
- Arrangements for follow up with PCP 3 days after discharge
- Notes and updated medication list sent to PCP
- Patient, family education regarding safety and fall prevention
- PCP 1) updated med list in EHR  2) noted low BP and stopped Amlodipine 3) clarified plans for stopping post-op anticoagulation 4) ? Need for PPI
- Referral to Geriatrics Clinic for F/U of mood and memory
Conclusions

• Successful transitions between SNF and Home require vigilance on both sides with respect to communication

• Roles exist for “facilitators” to help improve the exchange of information, arrange followup and educate patients and families
Continuing Education Credits

• 1 hour of CE credit is being offered for this webinar.

• For the live webinar, to obtain the credit you must:
  • Add your name to the chat box (to verify attendance)
  • Complete the survey. The survey will open automatically at the end of the webinar and the link will be sent in a follow-up email.

• If you did not register for this webinar and would like CE credit, contact gero@duke.edu to receive the link for the survey.