New York Transitions of Care Pilot Project: Sharing Best Practices

Northeast Cerebrovascular Consortium

14th Annual Summit

Pre-Conference Nursing & Practical Application Symposium

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Disclosures

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- Michelle Vallelunga, MS RN CNRN SCRN
- Ann Leonhardt-Caprio MS, RN, ANP-BC
- Shannon Scarpello, BSN & Nancy Stoll, RN, BSN

No Disclosures

Presentation Overview

Overview of Transitions of Care Pilot Ian Brissette, PhD

Incorporating Post Discharge Data Collection into Quality Measurement Michelle Vallelunga, MS RN CNRN SCRN

Engaging Homecare Partners & Increasing Uptake of Home Visits
Ann Leonhardt-Caprio MS, RN, ANP-BC

Engaging Primary Care to Support the Stroke Patient Post Discharge
Shannon Scarpello, BSN & Nancy Stoll, RN, BSN

New York Transitions of Care Pilot Project

Twelve-month project completed to support New York's Coverdell Grant (April 2018-April 2019)

Goals were to:

- Initiate 30-day post discharge data collection with at least 5 patients discharged home using GWTG Follow-Up Form;
- Engage key partners to support improvements in discharge process and post-discharge care for stroke patients

Transitions of Care Framework

Data Collection

Ongoing collection of patient information to identify needs and measure outcomes

Partners

Institutions and individuals involved in care of stroke patients

Improvements

Changes in care process to address gaps and improve care

Ongoing Coordination

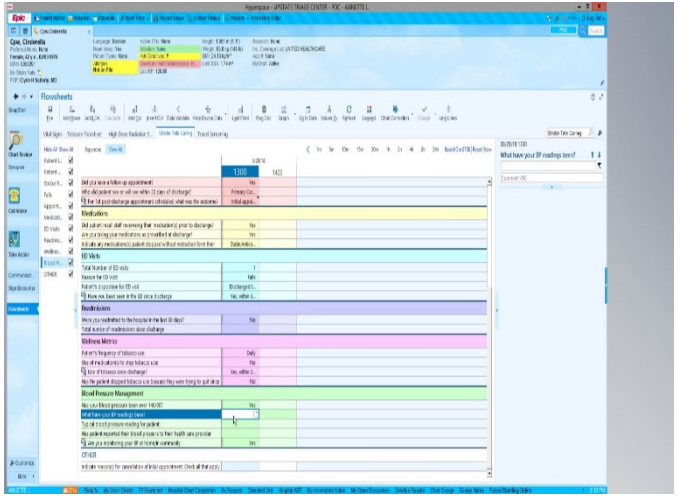
Stroke TOC Best Practice: What was ours and why?

- Capitalized on our strengths: large academic medical center, CSC, Syracuse NY, expert triage RNs already doing follow up calls for other services willing to also do stroke, Nursing director TOC Champion
- Stroke program staff to coordinate and analyze data- quality driven -one step at a time
- Needed a starting point: Post Acute Stroke care has several barriers: “silo” model and disconnect, no prescribed follow up until 90 days, and specialist mentality with PCP should manage the patient

Michelle Vallelunga MS RN CNRN SCRN
Data and Quality Coordinator
Upstate University Hospital

Implementation Steps:

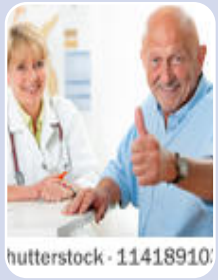
- New Stroke Telecare Flowsheet built in EPIC
- Lists of stroke discharges home emailed weekly/bi-weekly to transfer center manager
- 3 attempts to reach patient over a few days, call responses logged into flowsheet and saved as Telephone Encounter with short note. Information and referrals to resources given as needed
- Completed lists emailed back to Stroke program
- Flowsheet responses entered into GWTG tool
- Stroke clinic providers educated on process to review call flowsheet prior to other calls or visits
- Started conversations within hospital based Stroke team about need for TOC plan
- Interviewed Heart Failure and other programs who had existing TOC model/Navigator role for background



Challenges we faced

- “Stick to the script” for standardization we may have asked different items
- Some confusion: No coordinated expectations at discharge with patients/families as to when they would be called for what
- 30% of discharged patients follow up in their home area- Northern NY 1-2 hrs away
- Change in staff and management at the stroke clinic

How did we do??



89 % had initial appointment completed prior to 30 day call

64 % of patients called stated they had a follow up appt scheduled prior leaving hospital

59% report checking their BP outside healthcare visits post dc

5% of patients were seen in the ED post discharge

59% of tobacco users on admission reported using tobacco at 30 days post dc

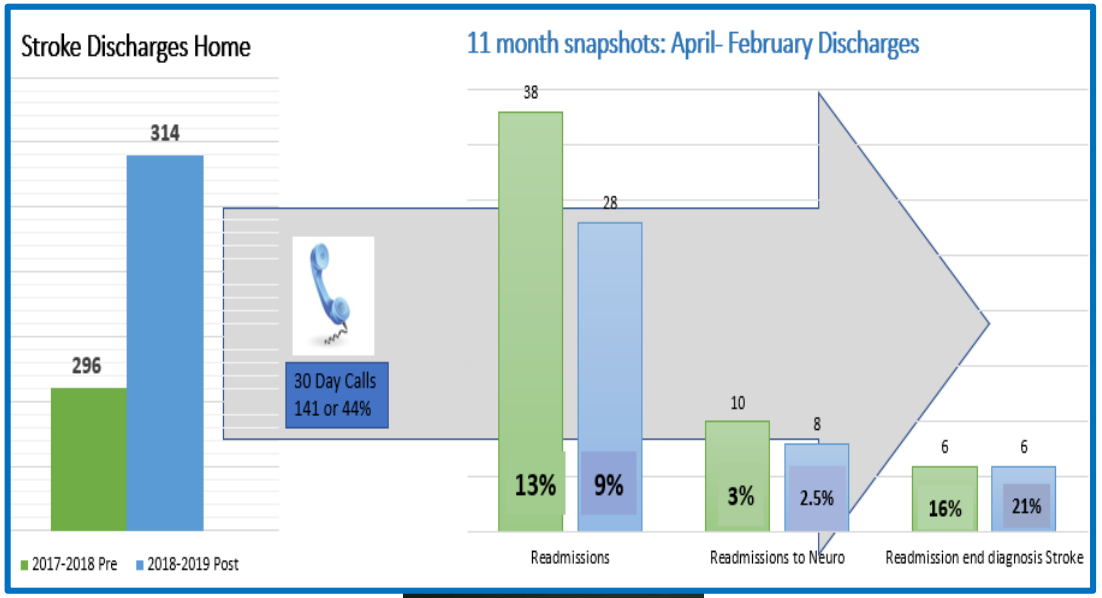
2% reported 2 or more falls prior to 30 day call

3% reported stopping their meds without instruction from a provider

Benefits we have seen:

- Transfer Center RNs are now fully invested and will be continuing the 30 days calls after the pilot

- Potential for less problems at the 90 day visit –earlier intervention
- Secondary stroke prevention conversations
- Recognized need to re-design our Stroke Education Packet to address medication adherence and follow up appointments
- “Buy in” by staff willingness to come to the table –build relationships



Engaging Homecare Partners and Increasing Uptake of Home Visits

Ann Leonhardt-Caprio, MS, RN, ANP-BC

Stroke Program Coordinator, Strong Memorial Hospital

Co-Director of Quality and Safety, Department of Neurology

University of Rochester Medical Center

DNP Student, University of Rochester School of Nursing

MEDICINE *of* THE HIGHEST ORDER

UR MEDICINE | STRONG MEMORIAL HOSPITAL

Why Partner with Home Care?

Successful Interventions

- Bridging interventions/span continuum of care (Rennke & Ranji, 2015; White et al., 2014)
- Focus: discharge planning, community & medication support, education, self-care (Hughes et al., 2018)
- Assess needs, provide education, interprofessional discharge plan, support for community integration (Cameron et al., 2016)

Home Care and Transitions of Care

- Home-care facilitated Coleman Transition Model in ischemic stroke patients: 42.7% readmission reduction over 6 months ($p=0.06$, treatment effect 1.7) (Caprio et al., 2017)
- Care manager home visit in addition to standard transitional care in NC Medicaid patients: lower readmissions 9.9% vs 15.2% ($p<0.001$) with no home visit (Jackson et al., 2016)
- Enhanced intensity rehabilitation at home for stroke patients unable to access outpatient care: decreased readmission rate and LOS (Langstaff et al., 2015)
- Home health care at minimum of 1 PT visit or 2 skilled nursing visits: lowered rehospitalization risk in older adults by 82% ($p<0.001$) and 48% respectively ($p<0.05$) (Wang et al., 2018)

Baseline State

1200 discharges annually

- 800-900 (67-75%) ischemic strokes

Approximately 50% of ischemic stroke patients discharged to home

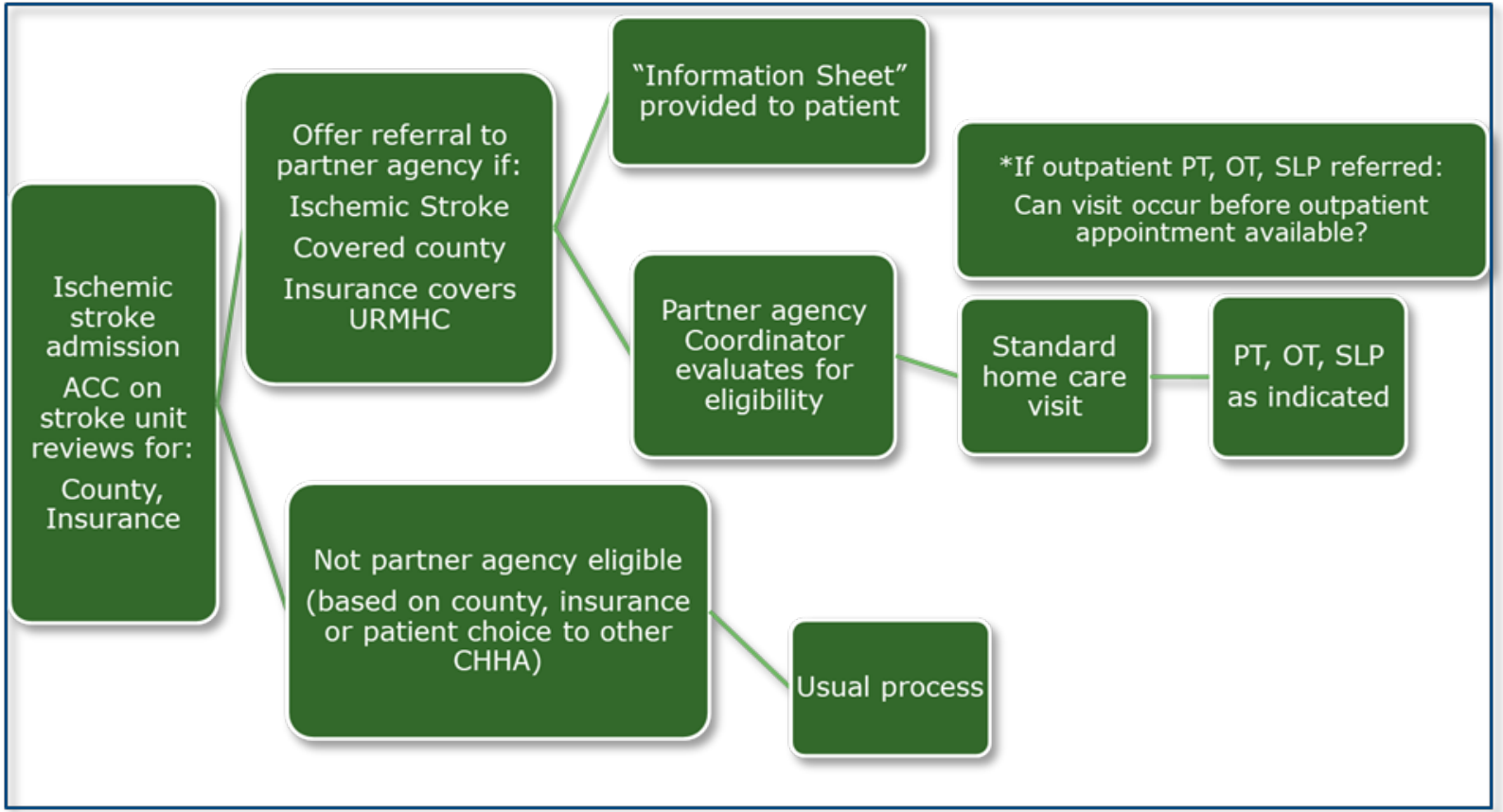
Readmission rate increased from 6.8% in 2015 to 9.2% in 2017

75% of readmitted patients were initially discharged to home

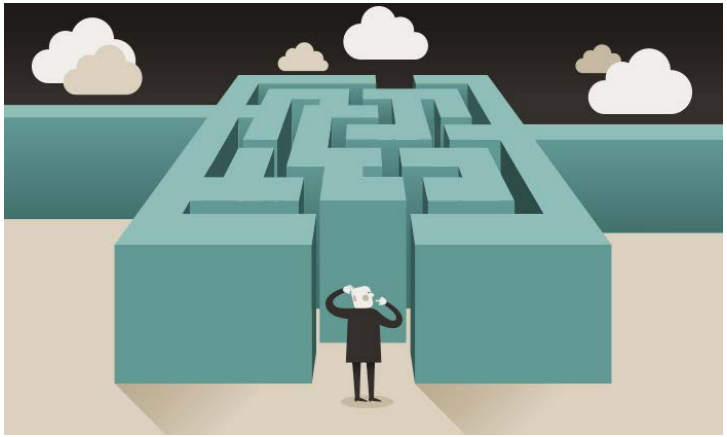
Certified home healthcare agency (CHHA) referral (Oct-Dec 2018)

- 45.2% of patients
- Process for referral: “If PT or OT suggest”

Improving the Process



Challenges



Too busy to think about referrals

“This is not my normal work flow”

Patients don’t want home care

No real-time data = no timely feedback

What does “home-bound” mean?

What does an inpatient nurse think a “skilled need” is?

I work in a hospital, I have no idea what happens at a home visit and how my patient could benefit

Benefits to Date

Increase in home care referrals

Increase in CHHA coordinator satisfaction

- Fewer last-minute referrals

Patient satisfaction

- “They encourage you, get you going. Make you feel stronger about doing activities. Definitely helped with transition of care.”
- “They were wonderful…they helped a great deal. They did check his medications and clarify he was on the right ones.”
- “Called right away and got the outpatient therapy transition arranged and was very helpful”

Engaging Primary Care to Support the Stroke Patient Post Discharge

Transitioning the patient from
Acute Hospitalization
to Home/Community

Catholic Health
Mercy Hospital of Buffalo

American Heart Association
American Stroke Association
CERTIFICATION
Meets standards for
Comprehensive Stroke Center

2019
GET WITH THE GUIDELINES
STROKE
GOLD

Collaboration is KEY to improved patient outcomes

Best Practice:

- ✓ Open communication between providers
- ✓ Comprehensive DC planning
- ✓ Complete and timely communication of information
- ✓ Prompt follow up visits after discharge

- Utilization of multidisciplinary approach
  - ✓ Identify gaps in transitions of care
  - ✓ Anticipate & identify barriers patients/families face post hospitalization

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Development of Transitions of Care Workgroup

- TOC Workgroup includes:

RN Care Coordinator	Primary Care	Social Work
Neuroscience Director	Home Care	Case Management
Stroke Coordinator	Rehab	

- Interactive Discussion challenges for each discipline
- Collaborative approach to improve continuity of care
- Engagement for post acute settings for feedback for acute care
- Sharing knowledge and resources

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Challenges

- Developing & maintain relationships with Primary Care
- Introducing acute care coordinator in to primary care workflow
- Effective communication and patient hand offs between sites of care
- Identifying person who will be liaison from acute care to communicate with primary care

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Benefits

- Breakdown of “Silo’s”
- Proactive approach to patient care
- Patient centered care
- Greater cohesion in care delivery
- Acute care is an additional resource to PCP office and patients
- Reassure patient team based approach to their care across the continuum

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