Quality Improvement Organizations
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HQSI

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

The Best of New Jersey: Care Transitions Communities

June 25, 2014

Healthcare Quality Strategies, Inc.
557 Cranbury Road ❖ Suite 21 ❖ East Brunswick, NJ 08816-5419
Phone: 732-238-5570 ❖ Fax: 732-238-7766 ❖ www.hqsi.org

This material was prepared by Healthcare Quality Strategies, Inc., (HQSI), the Medicare Quality Improvement Organization for New Jersey, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-NJ-C.8-13-22 07/2013

Webinar Checklist

- Materials will be available after the webinar
- Submit chat questions to “All Participants”
- Phone lines have been muted during presentations
- Evaluation poll at the end of the webinar

Overview

10th Scope of Work - Care transition communities

- Top achievements (August 2011-Today!!)

Success stories

- Atlantic-Cape – Community-wide education programs
- Sussex County – Public-private partnerships
- Central Jersey – Area Agencies on Aging and Care Transitions
- Greater Trenton – Changing culture in post-acute and long term care
- South Jersey – Patient success stories

Questions and answers

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Your communities, your partners!

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Reaching across NJ

112
Health
providers

26
Community
partners

Over 290,000
Medicare
beneficiaries

10 Counties

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By the numbers

6,900
fewer
admissions
(2011 to 2013)

Nearly 3,000
fewer
readmissions
(2011 to 2013)

Over $26
million saved
(2011 to 2013)

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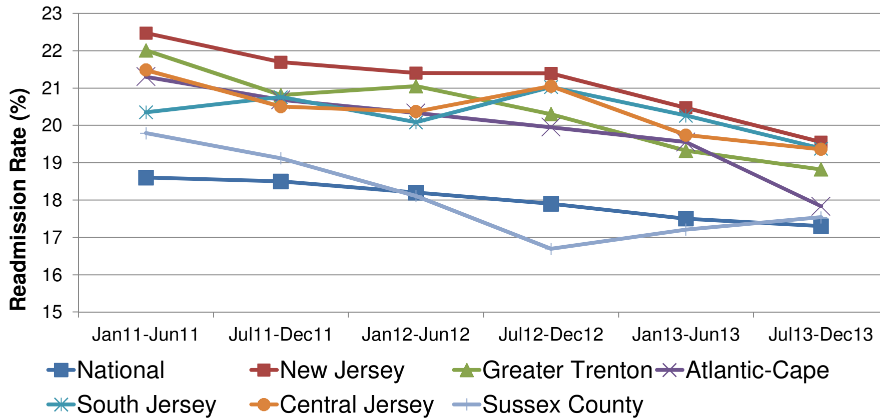
Top 5 Achievements

- Reducing 30-day readmissions and admissions
- Driving down home health and skilled nursing readmission rates
- Integrating advance care planning
- Improving coordination for high risk patients
- Making an impact on health disparities

Reducing Readmissions and Admissions

Medicare FFS Beneficiary Readmission Rates by Race or Ethnicity – National, New Jersey and Communities



SOURCE: HQSI's analysis of ICPC Scorecard for New Jersey prepared by the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

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Top Achievers – Reducing Admissions

- Between 2011 to 2013
  - Sussex County – 12.46% reduction
  - Central Jersey – 10.79% reduction
  - Greater Trenton – 9.63% reduction

Well done!

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Top Achievers – Reducing Readmissions

- Between 2011 to 2013
  - Sussex County – 23.24% reduction
  - Greater Trenton – 18.26% reduction
  - Atlantic-Cape – 16.95% reduction

Excellent!

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Driving Down Post-acute Readmission Rates

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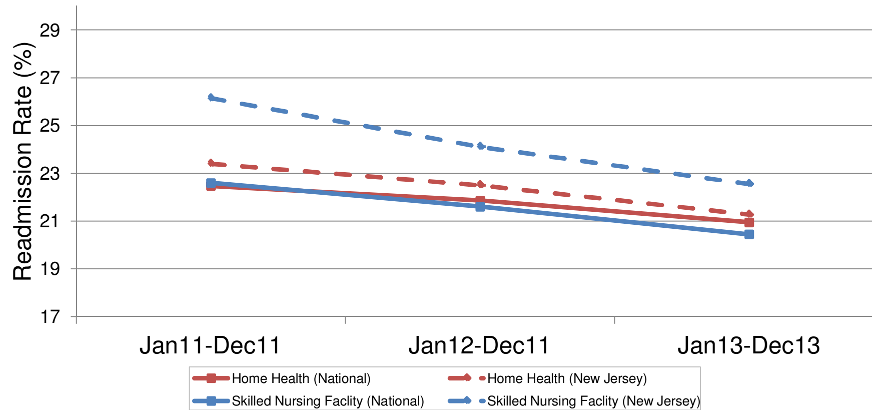
Readmission Rates by Discharge Disposition



SOURCE: HQSI's analysis of ICPC Scorecard for New Jersey prepared by the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Top Achievers – Readmissions from Home Health Agencies

- Between 2011 to 2013
  - Sussex County 26.25% to 18.86%
  - Atlantic Cape 22.82% to 20.64%
  - Greater Trenton 23.69% to 22.29%

Great job!

Top Achievers – Readmissions from Skilled Nursing Facilities

- Between 2011 to 2013
  - Sussex County 25.74% to 20.73%
  - Greater Trenton 29.25% to 24.13%
  - Central Jersey 26.77% to 22.73%

Amazing!

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Integrating Advance Care Planning

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Statewide Momentum Building

- December 2011 – Governor Christie signed POLST into legislation
- Providers have integrated various advance care planning documents into their systems
- Provider education
- Community education

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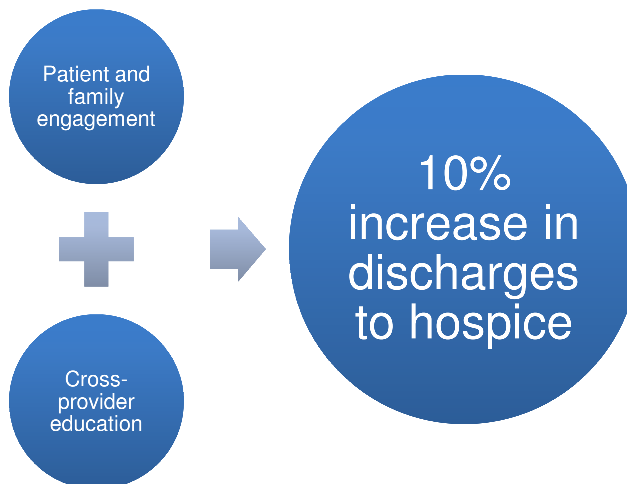
Top Achiever – South Jersey!



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Improving Coordination for High Risk Patients

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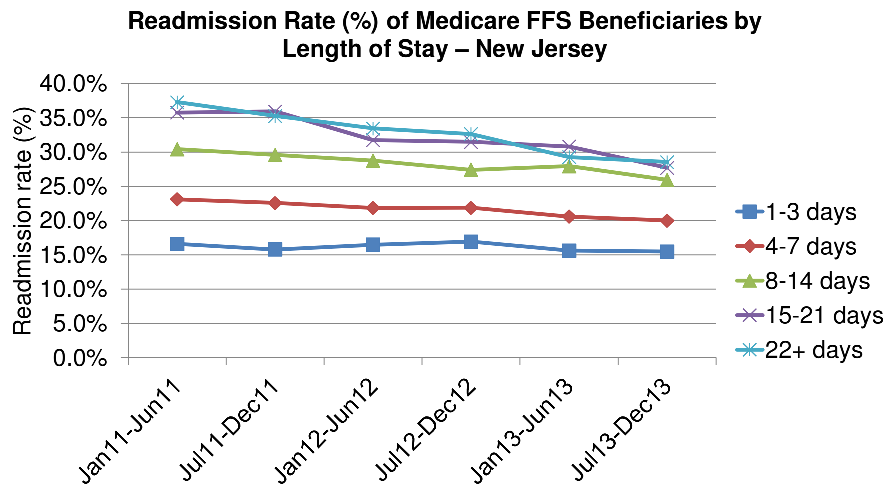
Readmission Rates by Length of Stay (in days)



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Top Achievers – 15-21 Days Length of Stay Readmission Reduction

Between 2011 to 2013

- South Jersey – 43.97% to 28.33%
- Atlantic-Cape – 33.90% to 23.19%
- Central Jersey – 33.83% to 26.13%

NICE WORK!

Top Achievers – 22+ Days Length of Stay Readmission Reduction

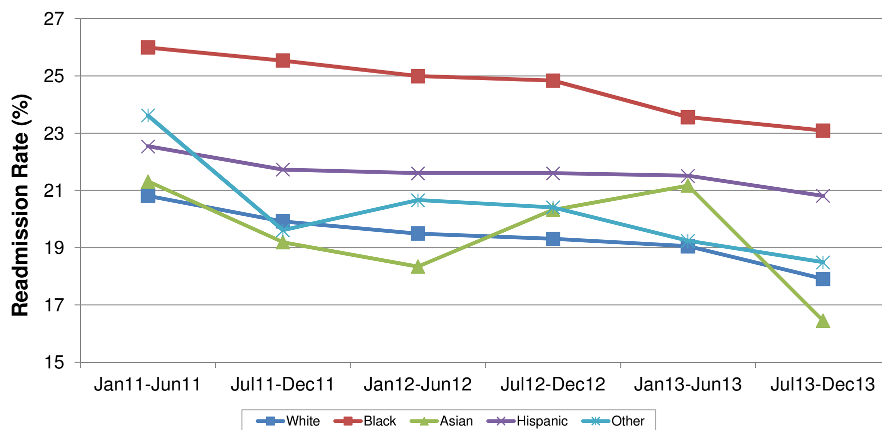
Between 2011 to 2013

- Atlantic-Cape – 43.48% to 30.51%
- Greater Trenton – 37.59% to 27.18%
- Central Jersey – 36.41% to 28.65%

WOW!

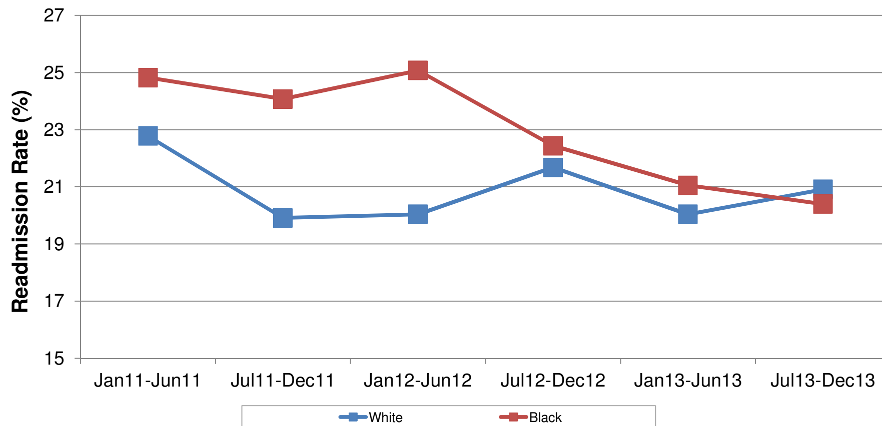
Making an Impact on Health Disparities

Medicare FFS Beneficiary Readmission Rates by Race or Ethnicity – New Jersey



SOURCE: HQSI's analysis of ICPC Scorecard for New Jersey prepared by the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Top Achiever – The Trenton Health Team



SOURCE: HQSI's analysis of ICPC Scorecard for New Jersey prepared by the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

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Congratulations and job well done!!!

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Atlantic-Cape Community Coalition Education Achievements

Denise Raymond
Senior Admissions & Marketing Director
Genesis Centers in Cape May

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Our Coalition Members

DePaul Health Care
The Shores at Wesley Manor
AtlantiCare
Diocese of Camden
Cape Regional Medical Center
Seacrest Village
Heartland
Genesis HealthCare
Fox Rehabilitation
Emeritus Senior Living
Healthcare Quality Strategies, Inc.
Compassionate Care Hospice
Eastern Pines Convalescent Center
Renaissance Pavilion
Bayada Home Health Care
Cape Visiting Nurse Association
Royal Suites Healthcare & Rehabilitation
Linwood Care Center by revera
Holy Redeemer
AcuityHealthcare
Shore Medical Center
Seniors Management North Health Care Centers

Reaching Medicare Beneficiaries

- Locations/Venues
  - Community health fairs
  - Senior center presentations
- Topics
  - 7 Essential Steps to Healthy Living
  - Personal health record
  - Medication management
  - Community programs
    - Nutrition
    - Exercise

Atlantic-Cape Health Fair Participation

Advance Care Planning

- Medicare Beneficiaries
  - Let's Talk Turkey
    - Turkey dinner for community with elder law speaker
    - One-to-one conversations
  - POLST
    - Create an awareness for advance care planning
- Providers
  - Employee education – April 16th (NHDD)
  - Let's Talk Turkey
    - ACP quizzes with prizes, turkey raffles
  - POLST

Heart Failure Education

- Cross-provider collaboration
  - Multitude of education tools for patients
  - Develop consistent message to patients
- Lessons learned
  - Education across the continuum
    - Challenges of a paper tool
  - Identifying cardiac patients with non-primary diagnosis
    - Maintaining cardiac protocols
    - Establishing progressive education plan

Care Transition Collaboration Successes

- Putting a face to a name
- Walking in the other providers' shoes
- Improving dialogue about transition barriers
- Physician meetings across the continuum
- Expanding patient record access
- Bringing pharmacists to the conversation

Contact Information

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Thank you!

SUSSEX COUNTY
TRANSITIONAL CARE PROGRAM

"Public Private Partnerships: A Unique Approach to Best Practice"

Stephen R. Gruchacz, Administrator
Department of Human Services

Sarah Balzano, RN
Transitional Care Coordinator

Transitional Care Program Social Workers:
Donna Green
Regina Hannapple
Elizabeth Larsen

Transitional Care Program (TCP)

Public Private partnership with County of Sussex, Newton Medical Center, and Premier Medical Associates created to offer support services to older adults who are at high-risk for readmission to the hospital or skilled nursing facility/rehabilitation.

TCP Case Management Model:

- Administers high-quality community based service options for individuals to live in least restrictive setting
- Creates unified model of care across Human Services' Divisions with core values/core services
- Eliminates barriers and creates increased accessibility to programs and services
- Share real-time patient information from all community service providers

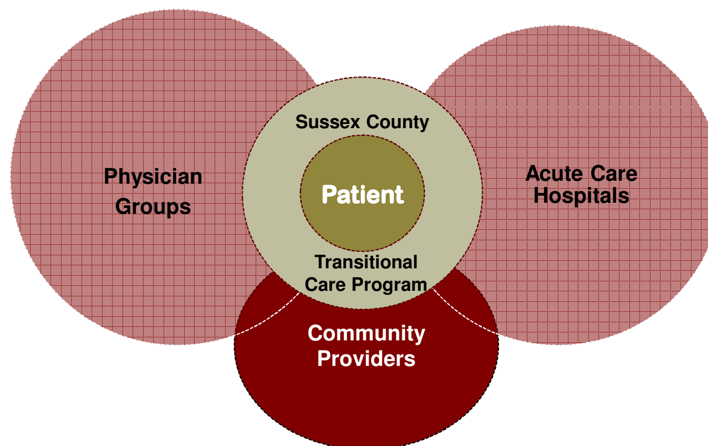
Aligning goals to work together to:

- Improve patient experience
- Improve outcomes
- Demonstrate affordability/sustainability
- Provide appropriate care in appropriate setting
- Coordinate wrap-around services
- Create opportunities for aging adults to remain in the home
- Demonstrate non-billable human services as integral in delivering effective care

Transitional Care Program Components

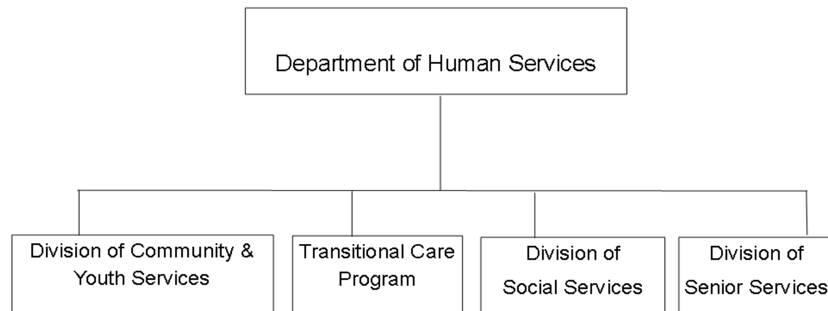
- **Transitional Care Program Transitions Coach**
  - Hospital, SNF/SAR, and Home Visits
  - Assistance with the completion of a Personal Health Record, identification of personal goal
  - Follow up phone calls weekly
  - Medication Reconciliation
  - Coordination of follow up visits to physicians and specialists
  - Assistance with identifying additional services needed to be successful at home and identify Red Flags
- **In-Home Services**
  - Home Health Assistance, Chore Services, Meal Delivery
  - Caregiver Support
- **Transportation**
  - Sussex County provided transport
  - Community and Youth Services
- **Health Promotion and Wellness**
  - Chronic Disease Self-Management Programs
  - "Take Control of Your Health" and Diabetes Self-Management"
- **Benefits/Insurance Counseling**
  - SHIP (State Health Insurance Assistance Program)
  - Medicare (A and B), Secondary Insurance Counseling, Medicare Part D Prescription Benefit, Prescription Assistance to the Aged and Disabled (PAAD)
- **Hospice**
  - Options Counseling, Coordination of Services
- **Social Services**
  - Jersey Assistance for Community Care giving
  - Managed Long Term Care Services and Supports
  - Medicaid
  - Screenings for Supplemental Nutrition Assistance Program (SNAP)
- **Gerontology**
  - Dr. George Wang, MD , PhD.
  - Transitional Care Program Medical Director
  - Newton Medical Center Geriatric Center of Excellence

Partnership Model



Sussex County Department of Human Services

Mission: To improve the quality of life of Sussex County residents through an integrated approach to comprehensive services that meets the needs of individuals, families and communities.



TCP 2013 Data

Total Individual High-risk Patients:	636	
Total Home visits:	463	
Total Telephonic Care Mgmt. Calls:	2223	
Total Number of 30 Day Readmissions:	33	**5% Readmission Rate**

Premier Medical Associates Post-discharge Follow-up Visits 10/1/13 – 1/31/14

Total Documented Discharges	329
Total Patients Seen Within 7-14 Days	304
% of Successful linkage to PCP follow-up	92%

Referral Data January 2013-December 2013

PAAD	68	SLMB	3	DME	11	Grocery Go Getters	4
JACC	67	GO	74	Respite	1	Rural Development	9
MOWs	23	Transit	46	ADRC	4	Nutrition Site	3
Medicaid	19	VA	2	HAAD	2	Norwescap	11
Chore	38	SNAP	12	AHCS	26	Legal Services	4
HHA	10	Hospice	18	LIHEAP	7	Meals That Heal	10
Stair Lift	2	Lifeline	14	SHIP	3	Senior Gold	6
Wellness	4	Farmers Market	2	Advanced Directive	4		

Program Partners/Investment

Partnership development:

- Premier Healthcare Associates and Newton Medical Center partnership provides Transitional Care Program:
  - Privileges to access patients and data
  - Inclusion in discharge planning
  - Inclusion of SCTCP staff in trainings and in-services
- Additional partners:
  - NJ State Department of Health and Human Services – Division of Aging Services
  - Health Care Quality Strategies, Inc. - NJ Care Integration Advisory
  - Bridgeway Rehabilitation Services
  - Karen Ann Quinlan Hospice
  - Compassionate Care Hospice
  - Grotta Fund

Funding:

- $100,000 matched cash investment by County and NMC, $100,000 in-kind investment by Premier and 3% Revenue Sharing Partner of their Atlantic ACO contract, 3% of Per Member Per Month Incentive Payment
- $45,000 in grants from State of NJ, $15,000 Title III Funding, $48,000 grant from Grotta Fund

THANK YOU!!

QUESTIONS???

For more information, please contact
Sarah Balzano, RN
Transitional Care Coordinator
973-579-0559 ext. 1247

Area Agencies on Aging
and
Care Transitions

June 25, 2014

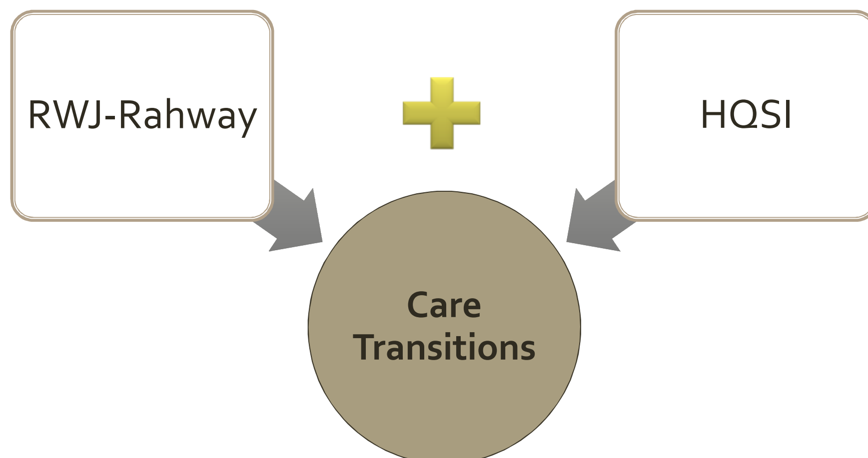
New Initiatives for the AAA

- The new reality for AAA's:
  Changing role as Global Options moves to the Managed Care Organizations
- Administration on Aging (AoA) encouraged AAA's to pursue alternative funding opportunities
- AoA and CMS publicly support and advocate for partnerships with the AAA's for CCTP

Potential Partners

- Hospitals
- Foundations
- CMS
- Community Based Organizations

The Creation of Care Transitions



Initial Challenges

- Staff predominately Social Workers, not RNs
- Not all CCTP models *accepted* SWs in the coaching role
- Pre-existing CCTP partnerships between community-based organizations and hospitals
- Obtaining support from AAA's without an active role in the coaching of patients

Initial Steps

- Invited to participate in the formation of the Central NJ Group
- Identified CCTP programs nationwide using AAA's
- University of PA opened up Mary Naylor model to SWs
- All partners buy-in
- UC AAA committed to training three staff during the application process.

Outcomes

- The Central New Jersey Care Transitions Program application is approved by CMS.
- Union County staff are ready to coach and are assigned to RWJ Rahway
- Social work staff will also provide interventions with patients needing additional assistance beyond the scope of the Care Transitions program
- Goal is to serve 35 patients per month

Changing the Culture: Staying Relevant In Post Acute and Long Term Care

Kim Mersel
Director of Case Management
Hamilton Continuing Care

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Phone: 732-238-5570 ❖ Fax: 732-238-7766 ❖ www.hqsi.org

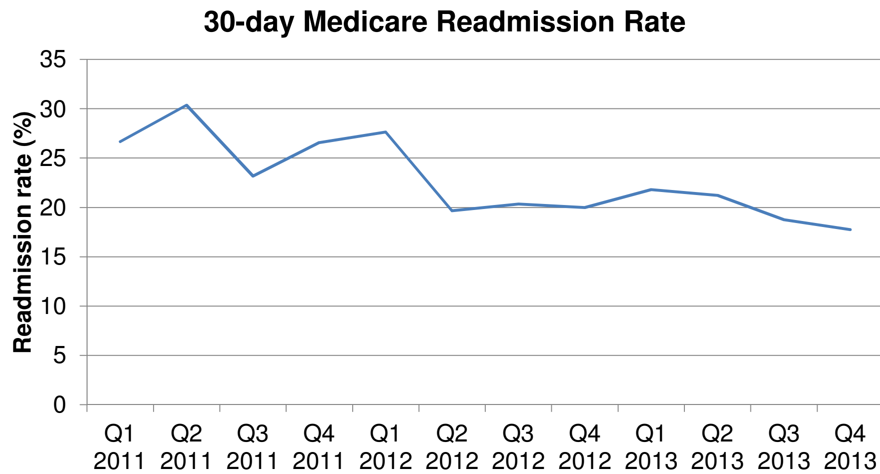
Hamilton Continuing Care

- Hamilton, New Jersey
- 177 bed facility
  - 35 rehab beds
  - 28 bed dementia unit
  - 114 long term care
- Services for residents and families
  - Rehabilitation services
  - Specialty care
  - Long term care
  - Memory care

Our Interventions

- INTERACT
  - Success with tracking
  - Expanded implementation pending
- Residency program
  - Pilot long-term care nurse residency program with HCANJ and Rutgers
  - Expose new nurses to care transitions
- eSNF
  - Advanced telemedicine (ED-level care at facility)

Reducing Readmissions



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Achieving Success

- Management staff education
- Applying best practices
- Stay current with trends
- Implement new technology
- Actively partner with community

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Contact Information

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Thank you!

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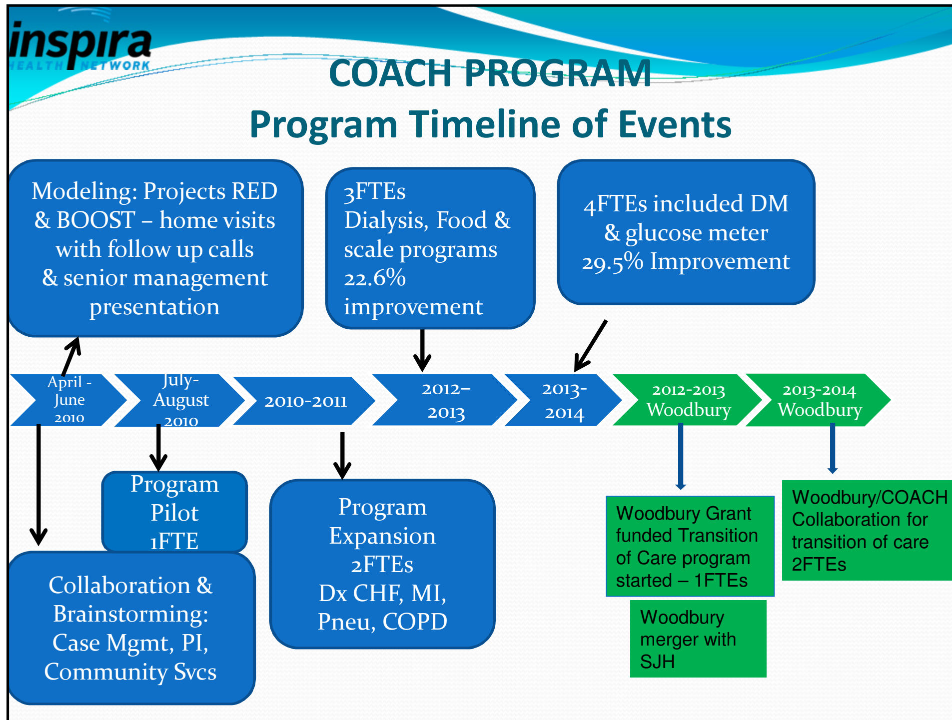
inspira HEALTH NETWORK

COACH PROGRAM Collaborating Options Across the Continuum of Healthcare

PATIENT STORIES

Patricia E. Heslop RN MSN APN
Tammy Scovern RN BSN, Transition Coach
Christy Zampitella RN BSN, Transition Coach

6/25/2014 56



COACH PROGRAM/TRANSITION OF CARE COLLABORATION

Here are the stories!!

Dialysis patient

- 37 year old African-American male.
- **History**: HTN, DM, CKD, Cardiomyopathy EF 25-30%, Asthma.
- SEPT 2013 – FEB 2014
  - 10 ED visits
  - 2 Observation adm.
  - 4 IP admissions

inspira HEALTH NETWORK

COACH PROGRAM/TRANSITION OF CARE COLLABORATION

Here are the stories!!

COPD patient

- 58 year old Caucasian female.
- **History**: COPD, HTN Asthma, Smoker 2PPD, Anxiety, LBP, Hypothyroidism.
- December 2013 to May 2014
  - 4 inpatient admissions – 1 to MSICU.
  - 1 ED visit

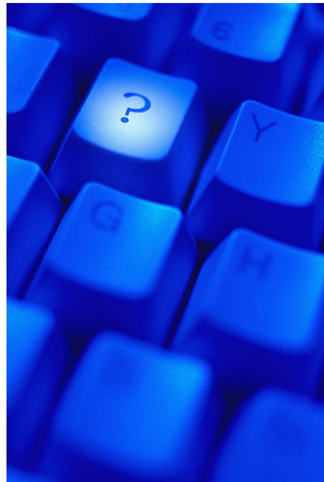
COACH PROGRAM

The Staff

The Interdisciplinary Team

Contact number – 856-641-7801

Questions and comments



- Use the chatbox to enter in your questions
  - Submit to “All Participants”
- Use the phone

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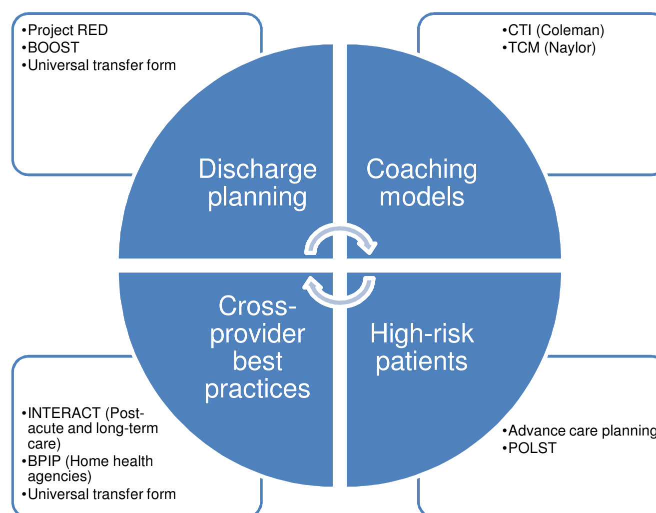
Keep up the Good Work!



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Our Challenge to You

Thank you!!

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