

Using Patient Navigators and Education to Improve Post-Acute Transitions

Emerging innovators in post-acute care delivery models are finding ways to provide patient-centered, quality care to integrate today's fragmented delivery system into a cohesive integrated delivery model. The American Hospital Association (AHA) Section for Long-Term Care and Rehabilitation is excited to host the following presentations from the leadership of the University of Maryland Rehabilitation Network and several Kentucky One Rehabilitation and Long-Term Care Hospitals as they share how they use Patient Navigators, Transition of Care Teams, and Internal Education strategies to successfully integrate various levels of post-acute care within their own health care systems and the surrounding community. Our speakers will share:

- What it takes to ensure successful transfers through the use of Patient Navigators;
- Strategies used by Transition of Care Teams to ensure patients are in the appropriate settings at the appropriate time, particularly in rural areas;
- How through the use of marketing and education of the post-acute services available, one can increase the referrals within a statewide system as well as the surrounding community.

Patient Navigator Program



UNIVERSITY *of* MARYLAND
REHABILITATION &
ORTHOPAEDIC INSTITUTE

Patient Navigator Program

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Traumatic Brain Injury Unit

University of Maryland Rehabilitation & Orthopaedic Institute

University of Maryland Rehabilitation & Orthopedic Institute

Licensed as an acute care hospital

134 Post Acute Care Beds

98 Inpatient rehabilitation

36 Chronic

(16 Dually Licensed)

Four Distinct Units

- Traumatic Brain Injury
- Spinal Cord Injury and Multi- Trauma
- Stroke
- Comprehensive Rehabilitation

Triple Aim- Mandated Under ACA and Released March 21, 2011

Better Care:

- “Improve the overall quality, by making health care more patient patient-centered, reliable, accessible and safe”

Healthy People/Healthy Communities:

- “Improve the health of the US population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering higher quality care”

Affordable Care:

- “Reduce the cost of quality health care for individuals, families, employers and government”

Maryland is Exempt from Medicare Payment

- We currently operate under a Centers for Medicare and Medicaid Waiver

Global Budget

- Limits on per-capita expenditures for hospital services and a focus on improving healthcare quality and population-health outcomes.
- Receive an agreed-upon amount of revenue each year regardless of the number of people we treat and the amount of services we deliver.
- Focus on readmission and the total cost of Medicare spending.

*Traditional Roles of a Patient Navigator*⁷

- Promote safety, health and wellness
- Creative problem solving
- Educate Patient and Families on Chronic conditions
- Support patients while they navigate the medical system
- Ensure understanding of medical care and treatments
- Build relationships with healthcare providers, patients and resource providers
- Reduce barriers that keep patients from receiving timely appointments, treatments or DMEs
- Directing patients to resources for financial, legal, administrative, psychosocial, or employment support.



Our Function in the Patient Navigator Role

- Assist patients and caregivers in navigating through appropriate services in our continuum
- Facilitate participation in services- attend appointments, coordinate communication between providers and the patient, seek collaboration in coordinating care, and help the patient self-manage
- Maintain systems that include identifying potential clients, internal and external, that would benefit from coordinated services, building networks and referral patterns
- Participate in business development regarding specific patient diagnosis
- Serve as a resource for community education



Initial Findings

- Inadequate number of community based primary care physicians comfortable managing the care of individuals with certain conditions; brain injury, spinal cord
- Access to transportation
- Prevalence of substance abuse/smoking/violence
- Challenges maintaining communication once discharged to Skilled Nursing Facility.
- Inadequate comparable baseline data for measuring success

What qualifies someone for Patient Navigation?

- No health insurance at discharge
- History of rehospitalizations
- Co-morbidities
- Alcohol and/or substance abuse history
- Inadequate family support
- Language or communication barriers
- No primary care doctor established
- Transportation barriers
- Homelessness
- History of non-adherence



Patient Navigation Process

Patient is referred to the patient navigator by a member of the rehabilitation team

The navigator meets with patient and loved ones at some point before hospital discharge. Also, the navigator attends the family conference if applicable

Navigator follows up within 48 hours of discharge to see how things are going

A phone call is placed at least once a week to check in

After a minimum of 45 days the patient is evaluated for continued services

Protocols vary by patient type



Outcome Goals for Patient Navigation

- Decrease re-hospitalization rates
- Increase attendance of follow up appointments
- Maximize safety and independence
- Improved quality of life
- Provide education to the community as appropriate to facilitate the goals listed above
- Primary Care prior to discharge
- Back to work



Strategies to prevent loss at follow up

Build stronger relationships with co-workers and social workers at Skilled Nursing Facilities

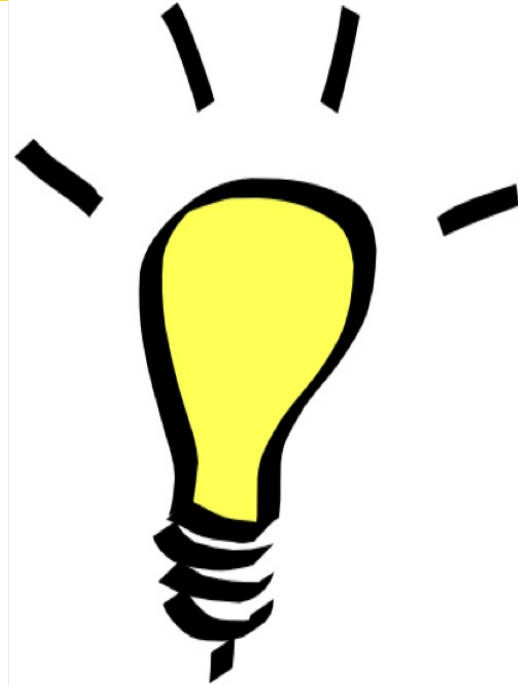
Begin and promote alcohol and substance abuse support group for individuals with Brain Injuries

Try and obtain lifeline phones for patients without cell phones

Build relations with Payers through education

Gain immediate access to data via Chesapeake Regional Information System for our Patients, or CRISP.

Regional health information exchange (HIE) serving Maryland and the District of Columbia. comprehensive view of a patient's medical history, including clinical data from an array of sources across Maryland



Program Development

- Establishing Outcome Measurement Tool and Database
- Implementation of a substance and alcohol abuse support group for Brain Injured individuals
- Further Integration and Coordination of services within the University of Maryland Medical System
- Community Education

KentuckyOneHealth Frazier Rehab Institute & Continuing Care Hospital



Overview

- Frazier is a comprehensive rehabilitation system providing therapy in IRF and acute care settings for inpatient and outpatient rehab needs
 - 88 inpatient beds, 30+ outpatient locations
- Rehabilitation service provider for several KentuckyOne Health facilities
- Partnership with the University of Louisville providing world-class research, clinical programs, and medical education

World-Class Rehabilitation!

- Spinal Cord Medicine – Model System
- Movement Disorders Program – NPF Center of Excellence
- Brain Injury
- Cardiology
- Pulmonary
- Pediatrics
- Stroke

Multidisciplinary Programs/Services

- Patient and family
- Registered nurse
- Certified Nursing Assistants
- Respiratory therapist
- Physical therapist
- Occupational therapist
- Speech therapist
- Exercise physiologist
- Dietician
- Recreational therapist
- Psychologist
- Physician
- Athletic Trainers

Specialty Services

- Locomotor Training
- Adapted Sports / Animal Assisted Therapy
- Aquatic Therapy
- Assistive Technology Resource Center
- Community Fitness and Wellness
- Neuro Rehab Program
- Support Groups and Family Education

Community Based Services

Outpatient Rehab Facilities, 30 + locations

Manage/provide rehab services in acute facilities

Jewish Hospital

Jewish Hospital Shelbyville

St. Mary's and Elizabeth Hospital

St. Joseph – London

St. Joseph Mt. Sterling

Flaget Memorial Hospital

Scott Memorial Hospital, Indiana

Taylor Regional Hospital

Joint Ventures

Southern Indiana Rehab Hospital

60 bed, inpatient facility

34 IRF beds, 26 SNF Beds

Partnership with Floyd Memorial, Baptist Health

Outpatient locations- Hospital

Bridgepointe Pediatrics

Hunter Station

River Ridge

Quality Outcomes

Accredited by Joint Commission and Commission on Accreditation or Rehab Facilities, multiple specialty accreditations

Results exceed national & regional comparison database

- Inpatient discharges to home
- Discharge FIM(functional) score
- Pressure ulcers
- Urinary Tract Infections
- Wound Care

Patient Satisfaction

- Inpatient 82nd percentile top box
- Outpatient 85th percentile, top box
- Numerous favorable patient comments

University Of Louisville Partnerships

- Department of Physical Medicine and Rehabilitation
- Residency Training program
- Neurology/Neurosurgery
- Pediatric Rehabilitation
- Clinical and Translational Research
- Neurorecovery Network
- National Grant Funding
- Educational Offerings

Frazier Rehab/UL Research Partnerships

- Dr. Susan Harkema, national leader in SCI research
- Human Locomotor Research Center
- Epidural Stimulation
- Parkinson's Disease

KentuckyOne Health

- Statewide rehab service enhancement and expansion
- Management expertise
 - Clinical Outcomes
 - Staffing
 - Productivity
- Electronic Medical Record
- Consultative support

Long-Term Acute Care Hospital Admission Criteria Change

- Effective for Cost Reporting Year during CMS's FY16, LTACH reimbursement will occur for Chronically Critically Ill (CCI) patients only
- Continuing Care Hospital (CCH) leaders educate system hospital presidents and CMOs on this new criteria change
- Goal: The patient is in the right level of care at the right time to improve/maintain his/her optimum level of health.

Clinically Integrated Network

- KentuckyOne continuum
 - Acute care
 - IRF
 - LTAC
 - SNF
 - Home Health
- KentuckyOneMedical group



Episodes of Care: Major Joint Replacement

Criteria for SNF Participation

1. Current Licensure
2. Federal and State Compliance
 - a) no civil penalties in the past two years.
 - b) No deficiencies that place the facility in immediate jeopardy or cause actual harm to patients.
3. Federal Quality Standards – 3 Star or Higher on the CMS Compare Website

(25 Points Each)

1. Access - 24/7 and response within 2 hrs
2. 30 Day Readmission – less than 18%
3. RN Care Providers – CMS 5 Star on CMS Nursing Home Compare
4. Patient Satisfaction – Greater than 87%

Episode Flash Report - FY15 to FY16

	FY15	FY16
Hospital Average LOS	4.5	2.3
% Discharged to IRF	10%	1%
% Discharged to SNF	50%	33%
% To Home with Home Health	29%	56%
SNF Average LOS	19	17
<i>Readmissions</i>	16%	8%
<i>% Joint Academy Attend</i>	~ 40%	74%
<i>Use of Standard Implant</i>	95%	99%
<i>Surgery Time Out Call</i>	100%	100%

Keys to Success

- Physician collaboration and champions
- Consistent education of the patient
- Comprehensive Care Coordination Team
- Early post acute service interventions
- Constant CM interaction with HH and SNF
- 3 day SNF Wavier from CMS

- ✓ Alignment of clinical pathways (anesthesia, pain control, surgery risk, antibiotics)
- ✓ Fracture patients (notification, education of patient & family, post-acute placement)
- ✓ Grow depth and scope of post-acute network

Components of a Successful Program

1. Physician and Facility Engagement
2. Episode Steering Team
3. Frequent Orthopedic Joint Academy for Patients
4. Clinical Pathways for Pre/Op/Post Phases
5. 90-day Multi-disciplined Care Coordination Team
6. Post Acute Network (CIN approved SNFs and HHs)

Questions?

Thank You!