HOSPITAL MEDICINE™ SUMMIT

Collaborative Care Between Hospital-Based Clinicians and Community Specialists

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This CME activity is provided by Integrity Continuing Education, Inc.
This CNE/ACPE activity is jointly provided by Global Education Group and Integrity Continuing Education, Inc.

Learning Objectives

- Describe collaborative care and the roles of individuals and systems in collaborative care models
- Identify opportunities to improve collaborative care in transitions from acute to postacute settings
- Cite successful models of collaborative care

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Overview of Collaborative Care

Collaborative Care Definition

Cooperation regarding the diagnosis and/or treatment of an individual patient among two or more practitioners from different health fields

In healthcare, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients.

AMA. Collaborative Care. Accessed November 2, 2022. Available at: https://www.ama-assn.org/delivering-care/ethics/collaborative-care

AMA: The Individual Role in Collaborative Care

- Model ethical leadership by:
  - Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
  - Clearly articulating individual responsibilities and accountability
  - Encouraging insights from other members and being open to adopting them
  - Mastering broad teamwork skills
- Promote core values of honesty, discipline, creativity, humility, curiosity, and commitment to continuous improvement
- Help clarify expectations to support systematic, transparent decision-making
- Encourage open discussion of ethical and clinical concerns
- Foster a team culture in which each member's opinion is heard and considered and team members share accountability
- Communicate appropriately with the patient and family and respect their unique relationship as members of the team

AMA. Collaborative Care. Accessed November 2, 2022. Available at: https://www.ama-assn.org/delivering-care/ethics/collaborative-care

AMA: The Collective Role in Collaborative Care

- Advocate for the resources and support healthcare teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills
- Encourage their institutions to identify and constructively address barriers to effective collaboration
- Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to constructively address conflicts within teams that adversely affect patient care

AMA. Collaborative Care. Accessed November 2, 2022. Available at: https://www.ama-assn.org/delivering-care/ethics/collaborative-care

Discharge Planning: The Critical Component of Collaborative Care

- Successful discharge planning means realizing how your care setting can facilitate positive long-term patient outcomes
- Checklist to help guide the overall care coordination strategy may include:
  - ✓ Is the patient stable, safe, and improving at the next level of care?
  - ✓ Have realistic short- and long-term expectations been established in cooperation with the patient and care partner?
  - ✓ Have readmission risks been addressed?
  - ✓ Are high-quality postacute care choices being made with the discharge planning team's involvement?
  - ✓ Has the likely next-level-of-care setting been identified based on a comprehensive consideration of relevant factors?
  - ✓ Has the community physician been identified and made aware of the patient's presence in the facility? Is it necessary to contact that provider for background information about the patient

Goals of Successful Care Transitions

- Identify patients at high risk for rehospitalization
- Develop specific interventions to mitigate potential adverse events
- Reduce 30-day readmission rates
- Improving patient satisfaction and H-CAHPS scores related to discharge
- Improving flow of information between hospital and outpatient physicians and providers
- Improving communication between providers and patients

H-CAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems.

SHM. Advancing successful care transitions to improve outcomes. Available at: https://www.hospitalmedicine.org/clinical-topics/care-transitions/?gclid=CNzbq8uMvr8CFUlqfgodfL0Ahg

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Unmet Needs in Collaborative Care

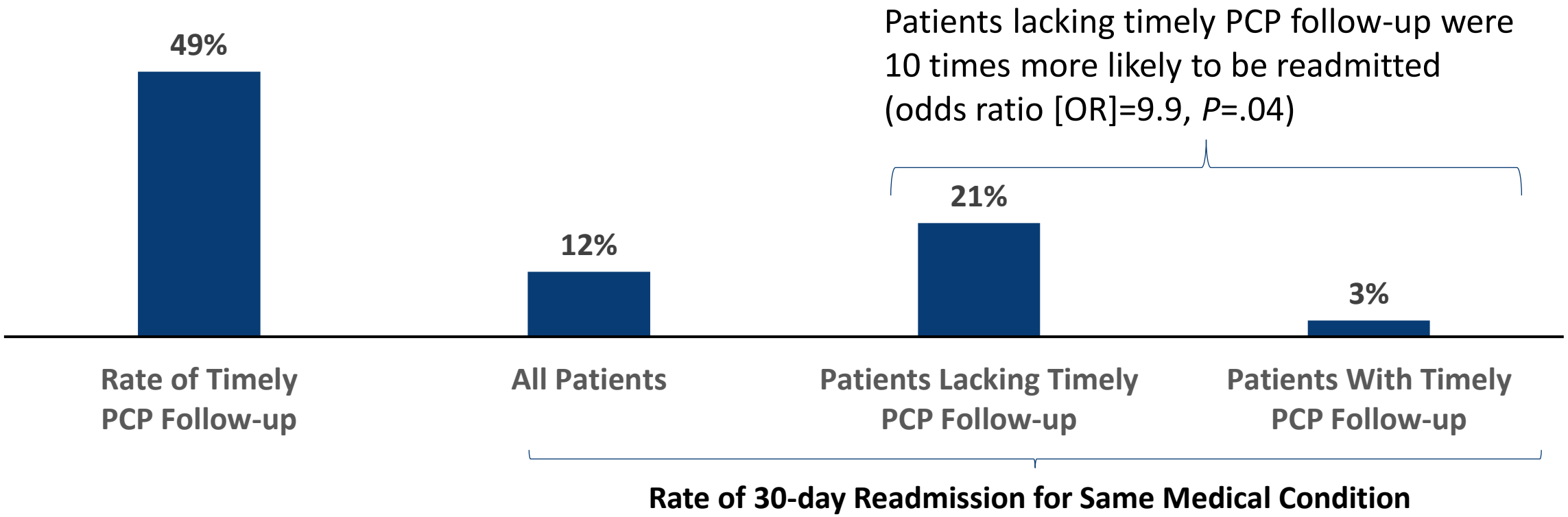
Poor Communication Between Clinicians: Most Common Root Cause

- Problems with communication between clinicians are pervasive and result in preventable patient harm
- Seminal studies have shown that poor levels of communication exist between clinicians at all levels of the health care system
- The Joint Commission has found that communication issues are the most common root cause of sentinel events (serious and preventable patient harm incidents)

AHRQ. Communication between clinicians. Available at: https://psnet.ahrq.gov/primer/communication-between-clinicians
HealthIT.gov. Improving hospital transitions and care coordination using admission, discharge and transfer alerts. May 2013. Available at: https://www.healthit.gov/sites/default/files/onc-beacon-lg1-adt-alerts-for-toc-and-care-coord.pdf

Timely PCP Follow-up Impact on Rate of 30-day Readmission

Rate of Timely PCP Follow-up and 30-day Readmissions Among 65 Patients Admitted to University of Colorado Hospital



PCP, primary care provider.

Misky GJ, et al. *J Hosp Med*. 2010;5(7):392-397.

Incomplete Referrals for Home Health

Nearly 1 in 3 patients discharged from a hospital with a discharge status of home health does not receive home health care

	Total (N)	Home Health Referral Completed (n)	Home Health Referral Completion Rate (%)
Overall	724,700	516,565	71
By condition			
Cardiac	171,758	116,832	68
Digestive/endocrine	70,129	43,384	62
Infections	93,814	61,422	65
Joint/musculoskeletal	229,973	191,228	83
Renal/bowel/bladder	50,981	32,774	64
Respiratory	99,255	64,518	65
Skin/wounds	8790	6407	73

Demiralp B, et al. *JAMDA.* 2021;22:1022-1028.

Impact of Ineffective Care Transitions

- Adverse outcomes for patients, including medication errors, clinical progression of illness, lack of postdischarge follow-up and avoidable emergency department visits
- Decreased patient and staff satisfaction
- Inappropriate use of resources
- Financial penalties through reduction in reimbursement from the Centers for Medicare & Medicaid Services (CMS) and other insurers

What Can We Do to Improve Collaborative Care for Our Patients?

Early Discharge Planning

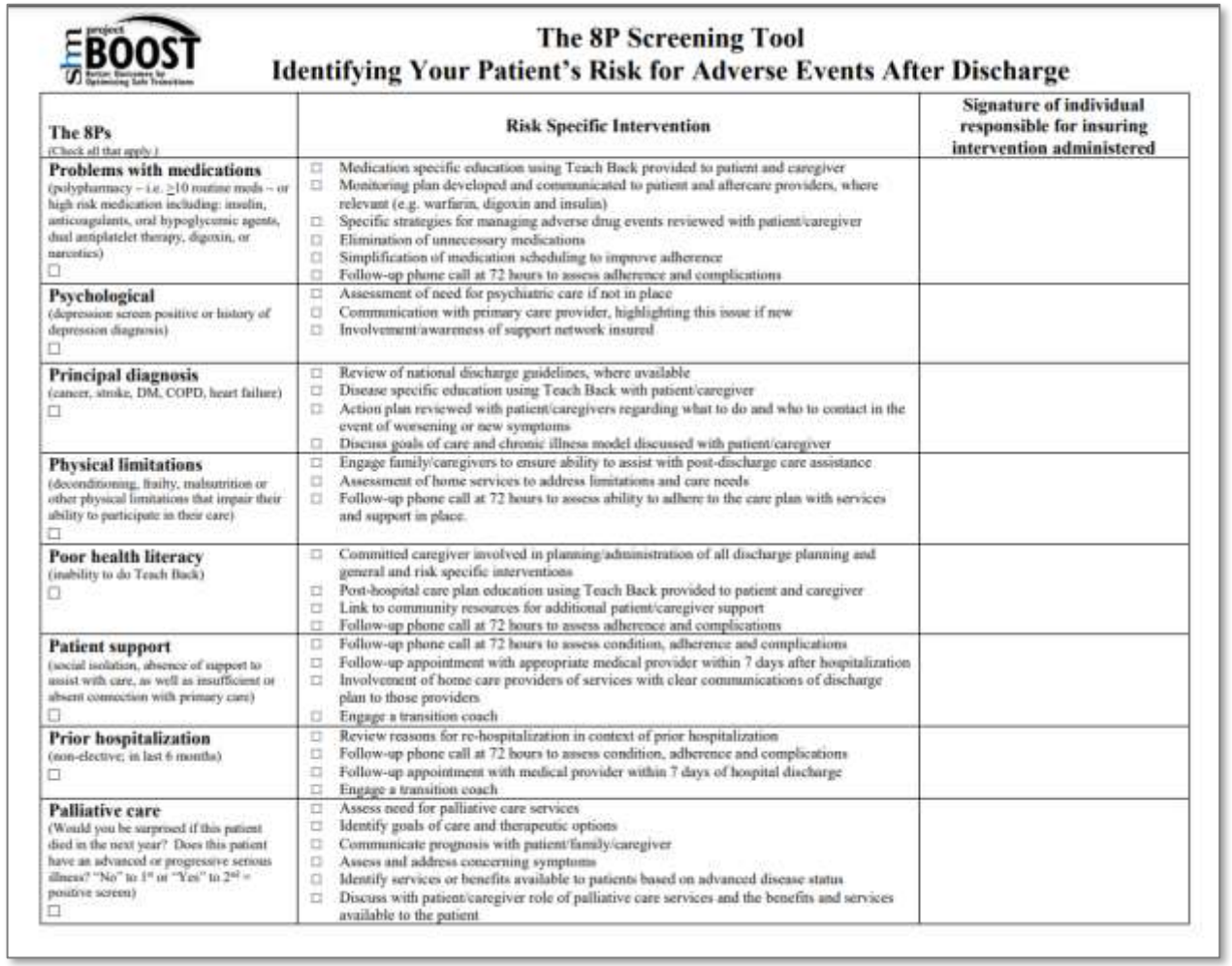
- Early discharge planning can significantly decrease hospital length of stay (LOS), readmission risk, and mortality risk

Discharge Goals Checklist Used in the Interprofessional Rounds
• Home health: Not needed, needed, and date home health contacted • Placement: Going home; data when facility contacted if not going home • Equipment/supplies: Needed for home after discharge (eg, walker, bed, oxygen, dressings) • Home medication precertifications required (eg, enoxaparin, filgrastim, pegfilgrastim, insulin): List precertification required and data completed • Transportation home: Personal ride (note when responsible party notified of discharge date/time); taxi (note when social worker notified of discharge date/time) • Outpatient appointments: None required; appointments made; patient instructed to call office for appointment • Discharge medication prescriptions written: None required; on medical record

Gabriel S, et al. *MedSurg Nursing*. 2017;(4):236.

SHM Project Boost: 8P Screening Tool

- Helps to identify a patient's risk for adverse events after discharge
- Screens for:
  - Problems with medications
  - Psychological issues
  - Principal diagnosis
  - Physical limitations
  - Poor health literacy
  - Patient support
  - Prior hospitalizations
  - Palliative care



The 8P Screening Tool
Identifying Your Patient's Risk for Adverse Events After Discharge

The 8Ps (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problems with medications (polypharmacy – i.e. ≥10 routine meds – or high risk medication including: insulin, anticoagulants, oral hypoglycemic agents, dual antiplatelet therapy, digoxin, or narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or history of depression diagnosis) ☐	☐ Assessment of need for psychiatric care if not in place ☐ Communication with primary care provider, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Physical limitations (deconditioning, frailty, malnutrition or other physical limitations that impair their ability to participate in their care) ☐	☐ Engage family/caregivers to ensure ability to assist with post-discharge care assistance ☐ Assessment of home services to address limitations and care needs ☐ Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place.	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions ☐ Post-hospital care plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with appropriate medical provider within 7 days after hospitalization ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers ☐ Engage a transition coach	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with medical provider within 7 days of hospital discharge ☐ Engage a transition coach	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness? "No" to 1st or "Yes" to 2nd = positive screen) ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address concerning symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient	

Quality Improvement Organizations. Care coordination. Available at: https://www.hsag.com/care-coordination
SHM Project Boost. 8P Screening Tool. Available at: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

Identify Indicators for High Risk of Readmission: HOSPITAL Score

HOSPITAL Score

Attribute	Points if Positive
Low hemoglobin at discharge	1
Discharge from an oncology service	2
Low sodium level at discharge (<135 mEq/L)	1
Procedure during hospital stay (ICD10 coded)	1
Index admission type urgent or emergent	1
Number of hospital admissions during the previous year	
0-1	0
2-5	2
>5	5
Length of stay ≥5 days	2

- Validated tool uses 7 available clinical predictors to accurately identify patients at high risk of avoidable hospital readmission within 30 days
- Has been shown to have superior discriminative ability over some prediction tools
- May be a more useful tool in moderate sized community hospitals
- Scoring:
  - 0–4 Low Risk
  - 5–6 Intermediate Risk
  - ≥7 High Risk

Robinson R. *PeerJ*. 2016:4:e2441.

Identify Indicators for High-risk of Readmission: LACE Index

LACE Score

Attribute	Points if Positive
Length of stay	
Less than 1 day	0
1 day	1
2 days	2
3 days	3
4-6 days	4
7-13 days	5
≥14 days	7
Acute or emergent admission	3
Charlson Comorbidity Index score	
0	0
1	1
2	2
3	3
≥4	5
Visits to emergency department in previous 6 months	

- Validated tool uses four variables to predict the risk of death or 30-day readmission after hospital discharge
- Length of stay (L), Acuity of the admission (A), Comorbidity of the patient (C) and Emergency department use in last 6 months before admission (E)
- Scoring:
  - 0-4 Low Risk
  - 5-9 Moderate Risk
  - >9 High Risk

Robinson R. *PeerJ*. 2016:4:e2441.

Management of Patient Expectations

- Set realistic patient expectations for life after hospital discharge
- Identify gaps between what patient expects to happen and what care team anticipates
- Educate the patient and family on the following:
  - Scope of the patient's condition
  - Plans for postdischarge care
  - Responsibilities of the patient and his or her family in the patient's treatment and recovery
  - Treatment and recovery time frames

Ease the Way. Set realistic patient expectations for life after hospital discharge. Available at: https://www.gebauer.com/blog/realistic-patient-expectations

Notify the Community Physician: CMS ADT Notifications

- Effective May 1, 2021, CMS requires health IT systems capable of sending/receiving ADT messages to provide the ability to send ADT event notifications to patient-designated providers and organizations
- Events notifications for a patient's admission, discharge, or transfer
  - Inpatient admissions
  - Emergency department
    - Presented
    - Discharged
  - Observation admission/registration
  - Transfer
    - From outpatient to inpatient
    - Unit Transfers are not required
  - Discharge

ADT, Admission, Discharge, and Transfer.

CMS.gov. Available at: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/advance-copy-interoperability-and-patient-access-rule-admission-discharge-and-transfer-notifications-0

Identify Next-level Care Setting

- Next level of care recommendations may include:
  - Appointment with outpatient clinician or entity
  - Medical follow-up
  - Social work and benefits follow-up
  - Pending legal issues, eg, follow-up with probation officer
  - Peer support, ie, Alcoholics Anonymous, Narcotics Anonymous
  - Home-based services

Joint Commission: Is there documentation in the medical record of a continuing care plan which includes next level of care recommendations AND was the continuing care plan including next level of care recommendations transmitted to the next level of care provider no later than the **fifth postdischarge day?**

Joint Commission National Quality Measures. Available at: https://manual.jointcommission.org/releases/TJC2015A1/DataElem0140.html

Collaborative Care Successful Models

South Texas Physician Alliance (STPA) Heart Failure Reduction Program

- STPA, an independent physician association serving the Lower Rio Grande Valley, worked with health care communication company LeadingReach to digitally coordinate care for heart failure patients
- The 30-day program is initiated when the hospital sends a collaborative referral for a HF patient
- Care team members use a digital platform for confirming appointments, communicating issues via a team chat function, and sharing documents
- Readmission rates for heart failure reduced 13% as a result of the program

HF, heart failure.

Cardiology Today. Novel collaborative care program reduces HF readmission rates. Available at: https://www.healio.com/news/cardiology/20220311/novel-collaborative-care-program-reduces-hf-readmission-rates

Project Re-Engineered Discharge (RED)

- RED consists of a set of 12 mutually reinforcing actions that a hospital undertakes during and after the hospital stay to ensure a smooth and effective transition at discharge
- Case studies of successful use of RED:
  - Bakersfield Memorial Hospital: 30-day readmissions for Medicare patients dropped over a 6-month period 11.3% from 25%; all-payer 30-day readmissions dropped to 6.5% from an average of 7.5%
  - St. Mary's Medical Center: Introduced RED in December 2013 for HF patients and saw readmissions for this population drop to 7.7% from 22.2% percent, helping to reduce all-cause readmissions to 5.7%
  - St. Mary's Medical Center: Introduced RED with HF patients, which helped the facility reduce the hospital's overall readmissions rate by more than 20%

Sullivan JL, et al. *Jt Comm J Qual Patient Saf*. 2018 Nov;44(11):663-673.

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Program Summary

Summary

- Collaborative care consists of cooperation regarding the diagnosis and/or treatment of an individual patient among two or more practitioners from different health fields
- Successful discharge planning is a critical component of collaborative care
- Communication between providers is the most common root cause of sentinel events
- A variety of tools and strategies exist to assist with improvement of collaborative care
- Successful collaborative care models may provide guidance towards improving practice in other similar organizations

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Thank you!

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