2014 Gage Awards

Reference #	7489908
Status	Complete
Name of hospital or health system	Henry Ford Health System (HFHS)
Name of project	HFHS-SNF Community Partnership Model
CEO name	Nancy Schlichting
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
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Within which of the two categories does your application best align?	Quality

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	Objective: Detroit's Henry Ford Health System (HFHS) recently formed a Care Coordination Initiative to standardize transition of patient care across all System points of care with an aim to improve patient outcomes and reduce hospital readmissions. A Skilled Nursing Facility (SNF) Readmissions Reduction Team aimed to improve coordination of patient care between the System's four acute care hospitals (Henry Ford Hospital, Henry Ford Wyandotte Hospital, Henry Ford Macomb Hospital, and Henry Ford West Bloomfield Hospital) and post-acute care facilities including Henry Ford Home Care and Henry Ford SNFs as well as community SNFs and home care agencies (HCAs). In 2011, as part of this team, Henry Ford Wyandotte Hospital led the development of a community partnership model for hospital-SNF care coordination. Based on its early success, this model was spread to all HFHS acute care hospitals in 2013. Model Design: The community partnership model for SNF care coordination began with a System-wide team comprised of representatives from case management, the Henry Ford Physician Network which includes Henry Ford Medical Group and private practice physicians, and home care, followed by the establishment of hospital-based teams. Hospital teams identified and contacted those SNFs receiving the largest volume of referrals from HFHS to assess interest in collaboration to reduce readmissions. Each hospital team held bimonthly multidisciplinary meetings with SNF representatives to identify primary reasons for readmission and trends with potential opportunities for improvement. Site visits at each participating SNF were conducted by hospital physician and case management leaders to meet with SNF owners and medical/nursing directors, review specific performance measures, and create strategies to improve quality and outcome measures. Care coordination process improvements included verbal handovers from inpatient to SNF settings and creation of outpatient appointments to avoid emergency room visits. Data Sources: Measures tracked were the SNF discharge readmission rate, primary diagnoses for readmissions, and readmission trends from root cause analysis. These measures comprised a readmission report card for each SNF. Report cards identified unique needs by SNF which were discussed bimonthly. SNF performance reviews were conducted at each facility twice a year. Findings: For Henry Ford Wyandotte Hospital, the community partnership model led to a 38% reduction in readmissions from 10 partner SNFs in over 22 months from 2011-2013. For all HFHS hospitals, the model resulted in a 9.4% reduction in readmissions from 46 partner SNFs from January to August 2013 compared to same period in 2012 (significant at p=0.03 on Chi-square analysis). Conclusions: Based on its success, the community partnership model for hospital-SNF care coordination became standardized in 2013

	throughout HFHS. To further improve quality, a HFHS-SNF Quality Committee was established to develop additional quality metrics in each facility.

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	The community partnership model for hospital-SNF care coordination aimed to reduce 30-day hospital readmissions for SNF patients by developing a standardized process for the continuity of care for hospital patients discharged to SNFs. Recommendations were made by the hospitals to improve communication within the facilities, improve continuity of care for patients, and implement initiatives to address identified trends where opportunities existed. Facility Roles and Responsibilities Process development was led by designated teams at each hospital and SNF. The hospital team was comprised of a physician leader, case management leader, and data analyst. The physician leader participated in SNF site visits, reviewed data with each facility, and provided feedback on clinical or quality concerns. The case management leader made initial contact with identified facilities, defined expectations for the SNF, and facilitated collaborative meetings with all facility partners. The data analyst identified top-volume facilities, developed monthly report cards for each facility, and provided the readmission case list for root cause analysis. Process Improvements Process improvements aimed to standardize transition of patient care between the hospital and SNF and coordination of patient care at the SNF. •Communication: The situation-background-assessment-recommendation (SBAR) protocol was used to improve communication between nursing staff and physicians at the SNFs. The interventions to reduce acute care transfers (INTERACT) protocols were used to develop triage services at SNFs to assess patient conditions and severity to minimize unnecessary readmissions. •Transition of Patient Care: Hospitals developed a flagging process to alert SNFs of patients at high risk for readmission. SNFs were encouraged to maintain continuity of care processes by ensuring that when patients required readmission they were transferred to the originating hospital. Some SNFs conducted multiple follow-up phone calls to every patient discharged home from SNFs (at 1, 3, 7, 14, and 21 days). With implementation of the electronic medical record system Epic at HFHS, SNFs are in the process of gaining preauthorized read-only access to medical information for patients admitted to their SNF. •Coordination of Patient Care: SNFs share best practices resulting in the development of protocols and pathways for congestive heart failure, chronic obstructive pulmonary disease, pneumonia/respiratory conditions, urinary tract infections, and mental status changes. They have also hired additional specialty staff based on identified opportunities such as Respiratory Therapists, RN Supervisors, Clinical Liaisons, Wound Care, and physician specialists. Daily rounds were implemented at some SNFs to mirror hospital multidisciplinary rounds. This helped the SNFs to stay informed of changes in patient conditions, be able to intervene more

	rapidly, and communicate to reduce unnecessary readmissions. Other examples of coordinated care included elimination of emergency room (ER) visits for long-term catheter replacement and for head CT post-fall by instituting a new process for outpatient appointment scheduling.

3. Describe the results of the project. What data was used to support improvement results?	The community partnership model for hospital-SNF care collaboration led to a 6-point percentage reduction in 30-day readmission rates for Henry Ford Wyandotte Hospital's 10 participating SNFs over 22 months (SNF readmission rate of 20.4% in March 2011 versus 14.4% in January 2013). System-wide, for all four acute care hospitals, 30-day readmission rates for 46 participating SNFs decreased from 21.7% to 19.7% (January to August 2012 versus same period 2013). Chi-square analysis showed this decrease to be statistically significant (p=0.03). Individual hospital SNF readmission rates pre and post intervention are shown in the Table. HFHS Hospital 30-day SNF Readmission Rates % Change 2011 2012* 2013* Henry Ford Hospital 26.9%21.7% -5.2% HF Macomb Hospital 18.3%17.3% -1.0% HF West Bloomfield Hospital 22.8%20.2% -2.6% HF Wyandotte Hospital 22.0%20.0%19.8% -0.2% *Jan-Aug only The initial target was to decrease the overall readmission rate per facility by 2% annually. Many of the 46 participating SNFs individually have exceeded the targets whereas others have not. Henry Ford Macomb Hospital showed the lowest improvement of 1% yet started the community partnership model initiative with the lowest SNF readmission rate of all four hospitals. Henry Ford Wyandotte Hospital, the leader of this model partnership, showed a 3.6% improvement from 2011 to 2012. However, improvement was only 0.2% for January-August 2013. That slight improvement is due to poor performance of one specific SNF which contributes to the overall low performance of the group. The Wyandotte leadership team has met with leadership from this facility to provide expectations for improvement including an action plan. HFHS will begin to incentivize SNFs to improve quality by the establishment of a Preferred Provider List of those facilities who have achieved performance targets and improved the quality of care. Although all appropriate facilities will be identified for patients and families, the preferred providers will also be identified based on established metrics agreed upon by the HFHS–SNF Quality Committee. HFHS has also identified an aggressive 15% overall readmission target for 2014 for patients who have been transitioned to a SNF. The Wyandotte Hospital-SNF team's root cause analysis of readmission trends showed a lack of end of life planning by patients and their families as a contributing factor to SNF readmissions. Many SNF patients have complex medical end-stage conditions but continue to seek treatment that may prolong but not reverse their condition. An initiative to educate SNF patients and families,

	as well as the SNF clinicians, about end of life concerns is being developed.

4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	The success of this hospital-SNF community partnership model was directly related to the dedication and willingness of each facility's team to partner to improve patient care outcomes and reduce unnecessary SNF readmissions. While no new hospital employees were required to implement the model, teams devoted significant time and effort to build relationships with community SNFs and to achieve ongoing process improvements in the care coordination during transitions. Henry Ford Wyandotte Hospital's successful effort in developing and implementing the model in 2011-2012 led to the first HFHS-Community SNF Summit in 2013 with the second annual Summit planned for March 2014. This conference brings together participating hospital teams, SNF teams, and Home Care teams to discuss current progress, annual goals and measures, and process improvements for care transitions and care coordination of SNF patients. An informal agreement exists between the hospitals and SNFs and therefore this collaboration is voluntary. Implementation of the community partnership model included addressing barriers as they arose, such as helping SNFs to understand what was required by their teams to meet expectations, identify quality initiatives, and educate on how to perform root cause analysis. Some difficulty arose within our hospital teams to understand the benefits of working to implement initiatives to help support community SNFs. Other hospitals in the U.S. have undertaken initiatives to help reduce SNF readmissions such as for specific disease sets and improvements of transitions of care and quality of care. Our initiative appears to be unique in the implementation of multiple initiatives to improve transitions (e.g., placing case managers in the ER for direct placement of patients to SNFs, development of direct SNF scheduling of outpatient radiology appointments). Replication of our hospital-SNF partnership model is evident by its implementation at three additional acute care hospitals with positive results within one year. Our model does have limitations. Readmission rates are based on HFHS internal metrics which cannot account for patients who do not return to a System hospital. Readmission rates also fluctuate based on various factors which may not reflect the quality of care provided. For example, root cause analysis of SNF readmissions at Henry Ford Wyandotte Hospital showed that families expressed feeling less anxious when the SNF patient was transferred back to the hospital during difficult symptoms reflecting end of life transitions. The ability to track trends of root causes of SNF readmissions has helped to expand focus to quality metrics for the community partnership model. The HFHS-SNF Quality Committee was established in 2013 with members from each hospital and some participating SNFs. The Committee's goals are to assess, measure, and define quality metrics in post-acute care settings,

	such as staffing models, clinical integration, and measures reported on “Nursing Home Compare” website.
5. Describe how patients, families, and if appropriate, community was included in the work.	This model focused on the partnership between a community’s acute care hospital and SNFs. As a large, integrated health system with four acute care hospitals spread across southeast Michigan, HFHS did not have a standardized process for transition of patient care outside the System’s own care settings. This community partnership model developed by Henry Ford Wyandotte Hospital and subsequently spread to three other HFHS hospitals has led to partnership with 46 community SNFs/HCAs. While the goal of the partnership aims to reduce SNF patients’ hospital readmissions, the primary focus remains quality of patient care within and among care settings, whether inpatient or SNF or ambulatory care or the patient’s home. The first phase of the hospital-SNF community partnership involved development of teams and roll out of new processes and protocols including education of SNF partners about root cause analyses. Subsequent phases will extend involvement such as education to patients and families. For example, the trend of SNF patient hospital readmission (often multiple times) at end of life identified by Henry Ford Wyandotte Hospital–SNF teams has led to development of patient/family education initiatives. Additional education on end-of-life care is being developed by HFHS. This type of family/patient involvement has been identified as an objective for 2014 along with the addition of patients to a variety of teams at HFHS to better understand the impact of transitions of care from our patients’ points of view.
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