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Transitional Care: Partnering for Population Health

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About Us

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Our Start and Our Journey

- MHA provided the start
- Mayo Clinic Model
- Set out on a mission with a vision
- Getting our ducks in a row
- Soap Box Repetition
- The value we provide = WIN! + WIN!
- COVID

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Our Vision

- Our Med Surg Floor
- Post-acute care facility of choice
- Quality of care
- Meet patient acuity needs
- Economic benefits

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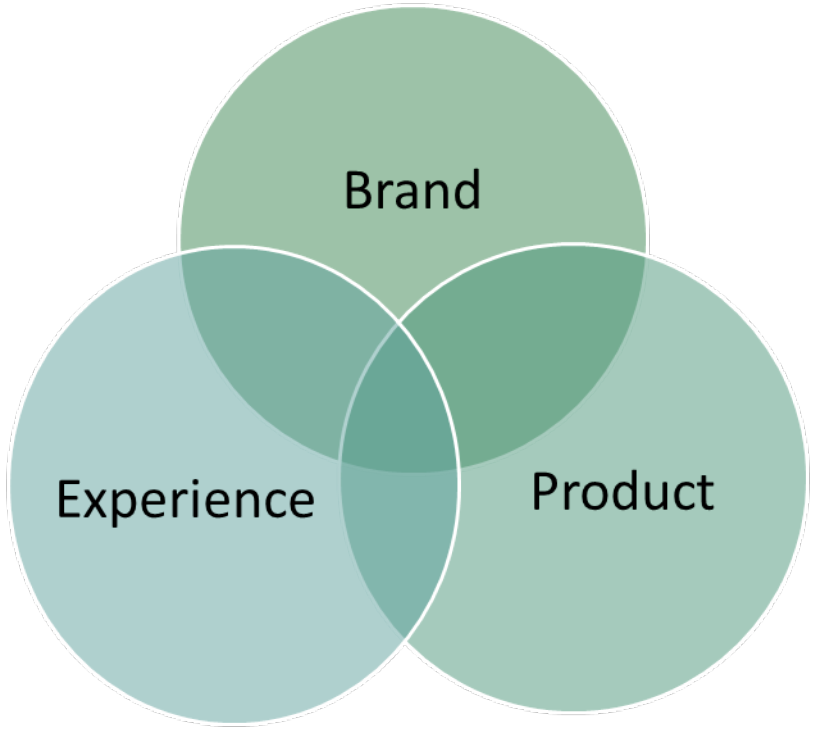
Transitional Care Value

- Drive patient value
- Patient experience
- Patient benefits
  - Private rooms
  - Low Nurse ratios
  - DI/RT/Lab access
  - MD access
  - IV interventions
  - Adjust care



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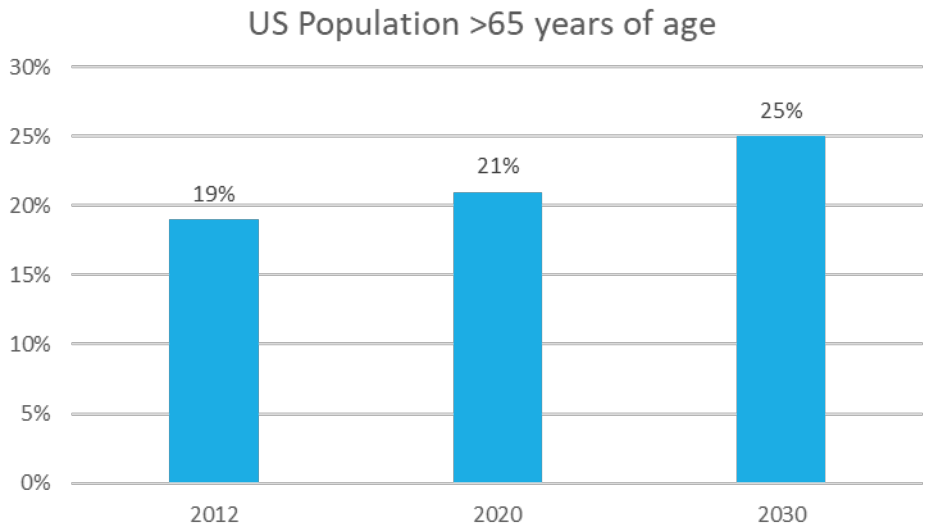
The Population We Serve

- Patients are aging (Older Population, 2019)
  - ~33% demographic >65 years of age
- Comorbidities increasing (Grunier, 2017)
  - >74% patients have 3+ chronic conditions
  - <1% have no comorbidities



Source- US Census Bureau

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Economic Value

- MS-DRG
  - Assigned payment regardless of care and LOS
  - GMLOS exceeded?
  - Operating margins at stake?

- Bed availability

- **Transitional care as a variance reduction opportunity**

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Target Populations

- Not exclusive
- Target diagnoses (with and without comorbidities)
  - Respiratory complications
  - Heart failure
  - Infectious diseases
  - Sepsis
  - CVA
  - Joint replacement
  - Kidney & Urinary Tract

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Identifiable Barriers

- Team alignment/Shared Mental Model
- Staff support
- Outside the box
- “What ifs”
- Transportation
- Bariatric equipment
- Admission timing (weekend, late evening)
- Decision turn around time

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Exclusions

- Dialysis
- IV Chemotherapy and Radiation (unless on hiatus)
- Ventilators or Extensive Respiratory Care (Vapotherm)
- TPN
- Psychiatric Consultation
- Certain Insurances

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Best Practices

INTAKE

- Transfer follow up calls
- Rapport with external customers
- Referral process
- Community provider engagement

DURING STAY

- Care team
- Huddle
- High risk screening
- Patient rounding
- Discharge follow up calls

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TeamSTEPPS Huddle

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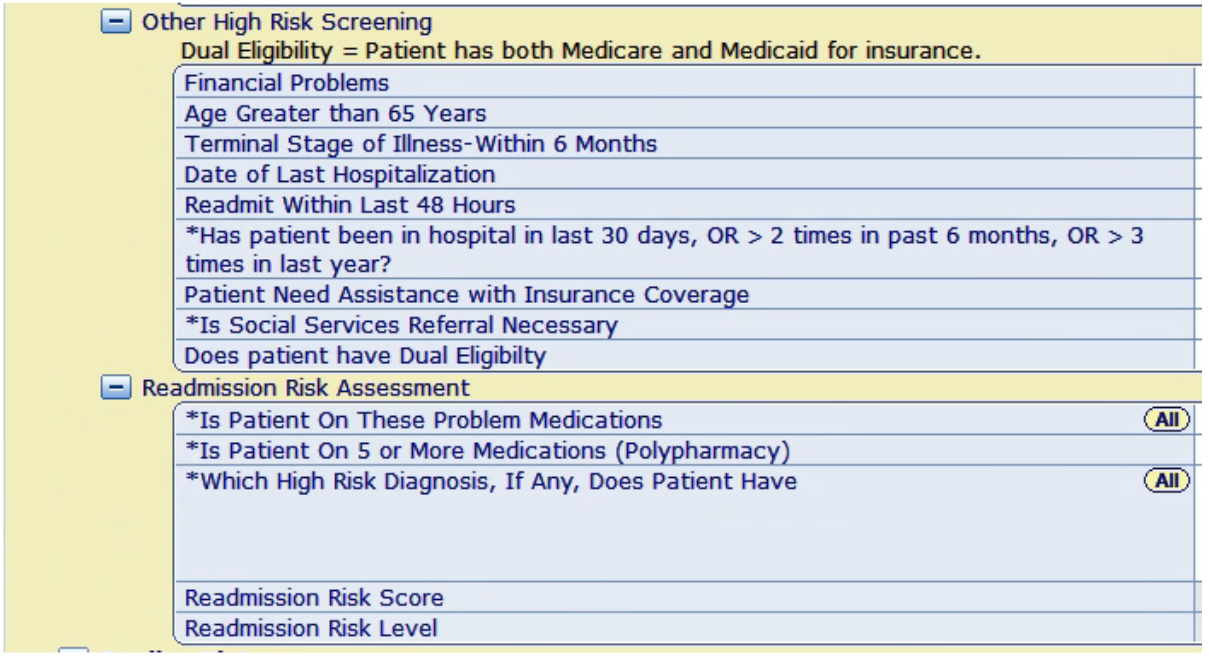
Quantitative High-Risk Screen

- Identify patient DC needs
- Standard admit process
- Risk score drives consults



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Scorecard Utilization

- Quality metric development
  - 30 day readmission
  - Discharge dispositions
  - Referral volumes
  - Acceptance
  - ALOS (Average length of stay)
  - Patient days
  - Transfer follow up calls

	Key Measures
Clinical and Business Processes	Total External Referrals
	Total External Admissions
	Number External Denials
	*Total SWB Discharges (in and out house)
	*Patient Discharge Days
	Patient Round Volume
	Transfer Follow Up Calls
	30 Day SWB Readmission Rate
	Length of Stay
	DC Disposition (Home)
	DC Disposition (1st Time Nursing Home)
	DC Disposition (Home with Home health- PT/OT)
	DC Disposition (Hospice / Palliative Care)
	Facility Referrals

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Think About It

Just because the patient is “ready” to go home does not mean that patient is “safe” to go home…

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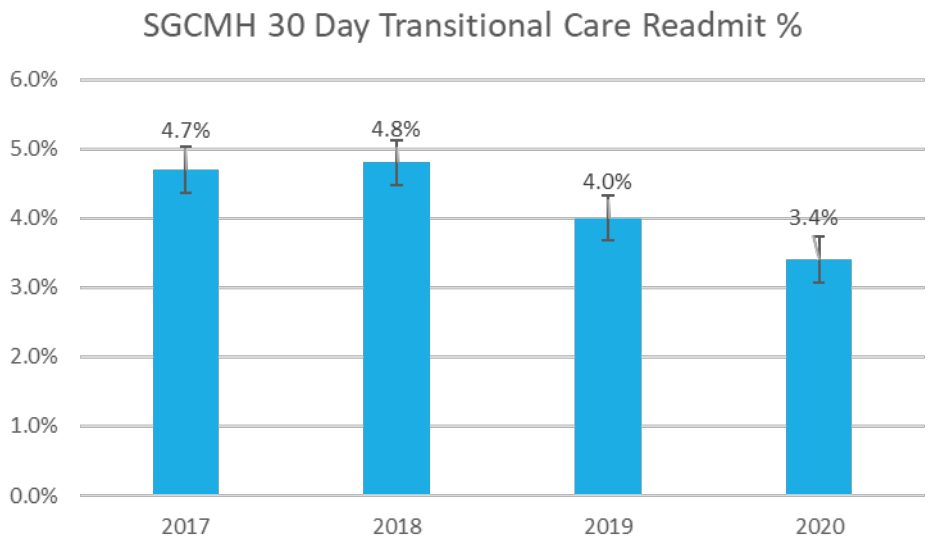
Readmission Risk

- Readmit rates (Lindsey, 2013)
  - Transitional Care 6-9%
  - Traditional SNF >20%
- 2019 CMS Penalties (Nelson, 2019)
  - Penalties affected >2,500 hospitals
  - Penalties average 0.71%
  - Up to 3%
- >50% readmission reduction (Ouslander et al, 2010)



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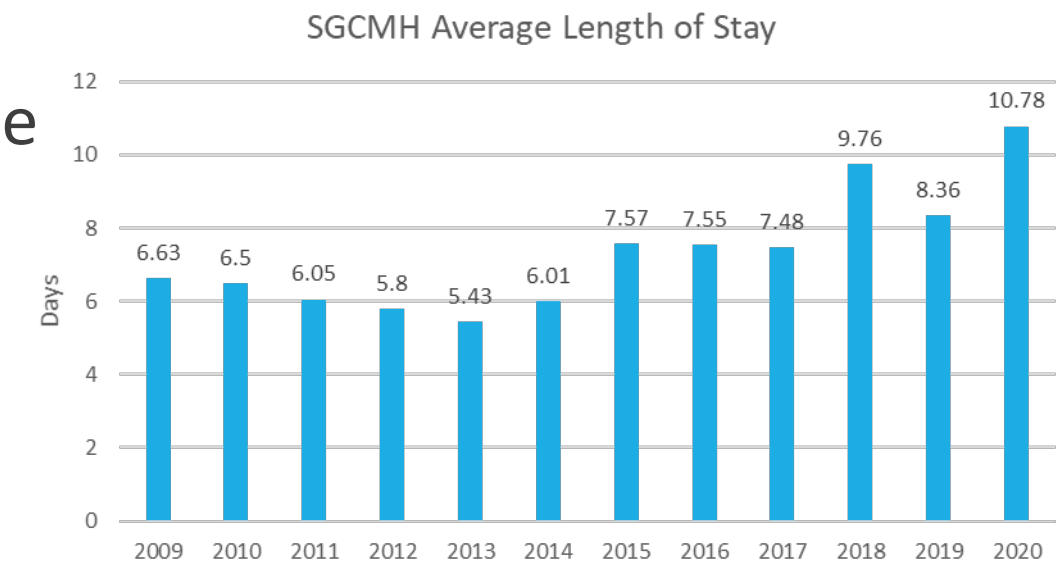
Length of Stay

- Timely transition home
  - 75% discharge home in reduced time
- ALOS (Casey, Moscovice, Stabler, 2019)
  - Swingbed average LOS 9-14 days
  - Traditional SNF 20+ days



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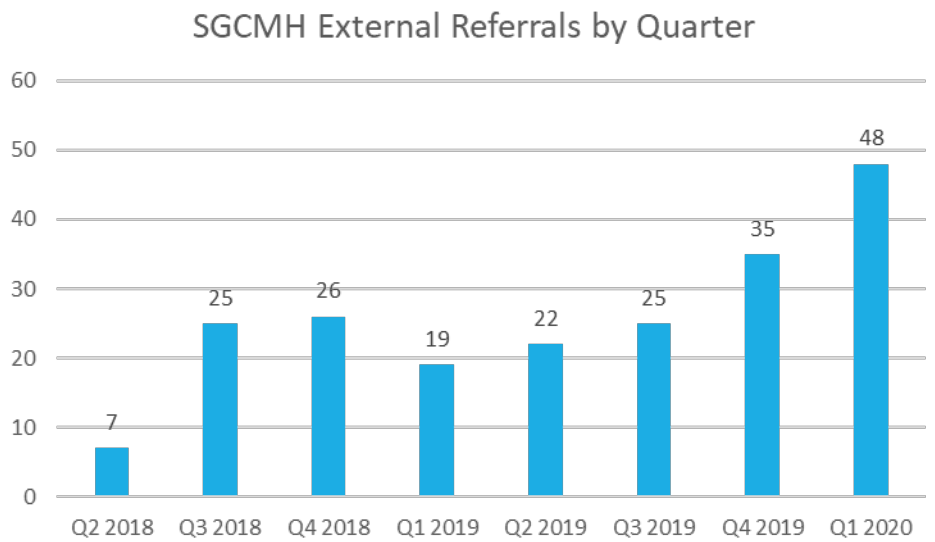
External Referrals

- June 2018- aligned with scorecards
  - Volume of referrals
  - Breakout by referral source
- Since 2017 over 180 patients successfully transitioned



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MHA Flex Support

- MHA team support
- TeamSTEPPS education
  - Communication
  - Empowerment

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Next Steps

- Ongoing evaluation of program growth
- Continue to refine scorecard
- Act on quality metrics
- Build relationships and collaborate
- Evaluate payers
- Early communication
- Assess social deterrents of healthcare

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Questions

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