Achieving Care Continuity
Best Practices for Building a System that Never Discharges the Patient
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Achieving Care Continuity

Best Practices for Building a System that Never Discharges the Patient

Road Map

1. Why We Need to Stop Thinking About “Care Transitions”
2. Best Practices for Building a System that Never Discharges the Patient
3. Returning to Our Larger Ambition
Huge Opportunity for Improvement

Percentage of ED Visits that are Avoidable in the US

1) Based on Truven Health Analytics analysis of 6,135,002 ED visits in 2010. "Avoidable" includes all ED visits except those for which medical care was required within 12 hours in the ED setting.
2) CMS, 2012.


A Common Starting Point for Improving Transitions

Nurse-Led Strategies for Preventing Avoidable Readmissions

Leveraging the Inpatient Stay to Equip Patients for Long-Term Self-Management

1. Scale Interventions to Level of Risk
2. Identify and Activate Key Learners
3. Equip Patients with Accurate and Easily Actionable Post-Discharge Instructions
4. Ensure Patients Are Discharged to the Appropriate Care Setting
5. Elevate PAC Quality to Ensure Safe Care for Complex Patients
6. Enable a Safe Transition Home with Immediate Follow-Up Care for Most Vulnerable Patients

To access Nurse-Led Strategies for Preventing Avoidable Readmissions, visit advisory.com/nec/publications.

Source: Nursing Executive Center, Nurse-Led Strategies for Preventing Avoidable Readmissions, 2011.
Building a System that Never Discharges the Patient

Evolution of Patient Care Perspective

Perfecting Individual Transitions

Achieving Care Continuity

Source: Nursing Executive Center interviews and analysis.

Poor Coordination Costing Us Billions Nationally

Difference Between “Loosely-Managed” and “Well-Managed” PMPM\(^1\) Spending\(^2\)

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loosely Managed</td>
<td>Well Managed</td>
<td>Loosely Managed</td>
</tr>
<tr>
<td></td>
<td>$100.48</td>
<td></td>
<td>$131.84</td>
</tr>
</tbody>
</table>

$12B

Estimated annual cost of preventable 30-day hospital readmissions

$25B-$45B

Estimated annual amount of wasteful spending resulting from inadequate coordination\(^2\)


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Providers Increasingly Accountable for Total Cost of Care

Populations for Which Health Care Providers Assume Full Risk

- Uninsured, Medicaid
- Managed Care
- Health System Employees

ACO Patients

2015

Time

Keeping Patients In Network Through Care Continuity

Continuity Benefits All Organizations, Regardless of Payment Environment

Benefits of Keeping Patients in Network by Reimbursement Structure

<table>
<thead>
<tr>
<th>Reimbursement Structure</th>
<th>Fee for Service</th>
<th>Fully Capitated Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit of Keeping Patients in Network</td>
<td>Drive revenue through increased patient volumes</td>
<td>Control spending through high-quality, in-network care</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center interviews and analysis.
### Health Care Leaders’ Priorities for Capital Investment

<table>
<thead>
<tr>
<th>Priority</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care information systems (including EMR) and IT infrastructure</td>
<td>68%</td>
</tr>
<tr>
<td>Upgrades to existing facilities</td>
<td>47%</td>
</tr>
<tr>
<td>Process improvements for operational efficiencies</td>
<td>45%</td>
</tr>
<tr>
<td>Merger, acquisition, or other partnership</td>
<td>33%</td>
</tr>
<tr>
<td>Clinical technology</td>
<td>32%</td>
</tr>
<tr>
<td>New facilities</td>
<td>26%</td>
</tr>
<tr>
<td>Funding for pension, benefits or self-insurance</td>
<td>6%</td>
</tr>
<tr>
<td>Compliance with safety codes</td>
<td>6%</td>
</tr>
<tr>
<td>No capital investment planned</td>
<td>6%</td>
</tr>
</tbody>
</table>

1) Responses to the survey question, “What are your organization’s top three priorities for capital investment in the next 12 to 18 months?” n=125.
2) Indicates leader has no capital investment planned in the next 12 to 18 months.
3) Based on an online survey of 62 ACOs conducted by eHealth Initiative and Premier.
4) The Office of the National Coordinator for Health Information Technology.

### ACOs Struggling with Lack of EMR Compatibility

<table>
<thead>
<tr>
<th>Percentage of ACOs in 2014 reporting interoperability issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
</tr>
</tbody>
</table>

“There may be a gap between the needs of the health care sector and the readiness of vendors in the health IT market to meet those needs.”

Robinson et al., October 2014
Report prepared for ONC

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### EMR Alone Not a Silver Bullet

Records Only as Good as the Information Entered

**Representative Scenario**

**“Garbage In”**

Clinician enters incomplete or inaccurate information into the EMR

**“Perfect IT System”**

Top-of-the-line EMR and supporting IT infrastructure; all technical aspects of system working as intended

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EMR Alone Can’t Fix Inadequate Clinician Workflows

Percentage of Primary Care Physician Office Visits that Include Depression Screening

Percentage of Medication Order Errors at Admission Caused by Inaccurate Medication Histories

Care Navigator Role Gaining Momentum

Excerpt of Top 1% Navigator Job Description at Premier Health

Premier Health
Job Description: Advanced Illness Management Navigator, RN or MSW

Position Summary: The Navigator will be an integral member of the Advanced Illness multidisciplinary team. Together with nurses, social workers and community health coaches, the Navigator will oversee the enrollment of new patients into the project, assess health care needs and oversee care plan implementation, help develop care management strategies, and work with team members to provide linkages for the various health and social needs of patients with cost effective solutions.

Nature and Scope: Must have available phone to communicate and transportation, with appropriate licensure and insurance, to visit homes and other sites. Interacts with physicians, nurses, social workers and other disciplines, administrative personnel, and community resources.

Qualifications: Ability to effectively provide clinical care to socially and medically complex patients in a variety of non-traditional settings; Ability to work collaboratively in a team and manage multiple priorities, utilize effective time management skills, and exercise sound administrative and clinical judgment; Demonstrated ability to work well with people of various ages, backgrounds, ethnicities, and life experiences.

Collaborates with RN or MSW to serve medical and non-medical needs

One navigator on call to be available to patient 24/7 by phone

Complete RN and MSW Top 1% Navigator Job Descriptions in Appendix.
Case in Brief: Premier Health

- Five-hospital health system headquartered in Dayton, Ohio; includes over 100 sites of service
- In March 2014, piloted community-based navigator program for 25 patients generating greatest number of readmissions and ED visits at one Premier hospital; staffed by one RN and one MSW
- Navigators serve as single point of contact for all patient medical and community resource needs; coordinate with patient’s primary care clinician, home health
- Navigators are available to patient 24/7 by phone; conduct community-based patient visits, call patient on regular basis (frequency based on patient needs); timeframe of care is 10 months
- By January 2015 will have expanded program to include 175 patients across multiple Premier hospitals; new model includes two RNs, 2 MSWs, one LPN, one health coach
- Expanded program will serve patients with the greatest number of admissions, and patients 64 and older with a large number of admissions by CMS hospital penalty diagnosis
- CHF, COPD, and high-risk patients are monitored by the RN Navigator via remote telemonitoring; monitoring units include ancillary tools for weight, pulse oximetry, blood pressure; parameter triggers directly alert navigator of any abnormality, navigator then contacts patient
- 180 days post-implementation of top 1% navigator pilot, reduced readmission rate of patient group by 52%, reduced monthly costs for patient group by 50%

Benefiting from a Focus on the Top 1%

Hospital Utilization of Patients in Top 1% Navigator Program at Premier Health

- Before Pilot
- 180 Days Post-Pilot

52% decrease

$307,942
Total net cost reduction in first six months of Top 1% Navigator program at Premier
Key Elements of Premier’s Top 1% Navigator Program

Patients selected for program based on number of ED encounters and admissions

RN and MSW navigator team shares panel of 50 patients

Navigators available 24/7; serve as primary point of contact for patient

Navigators interact with patient minimum of twice per month; can be as often as 21 times per month

Navigators coordinate multidisciplinary care team to meet medical and psychosocial needs

Navigators track patient health via remote telemonitoring (including patients with CHF and COPD)

1) Remote telemonitoring used for CHF and COPD patients only.

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Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.

Scaling Support to Level of Patient Risk

Elements of Navigator Support Based on Risk Stratification Level

<table>
<thead>
<tr>
<th>Risk Stratification Level</th>
<th>Low Touch</th>
<th>Medium Touch</th>
<th>High Touch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification Criteria</td>
<td>Patients without hospital encounter in last 30 days, OR minimal number of medications, controlled disease symptoms</td>
<td>Patients with 1-2 ED visits in last 30 days without admission, OR multiple/advanced illness, multiple medications, uncontrolled symptoms, psychosocial barriers</td>
<td>Patients with observation, admission, or two or more ED visits in last 30 days, OR multiple advanced illnesses, multiple medications, uncontrolled symptoms, psychosocial barriers</td>
</tr>
<tr>
<td>Time in Category1</td>
<td>2-4 months</td>
<td>Minimum 4 months</td>
<td>Minimum 30 days</td>
</tr>
<tr>
<td>Care Team-Patient Contacts per Month</td>
<td>Minimum 3 per month x 2 months, OR 2 per month x 4 months</td>
<td>Minimum 10 per month</td>
<td>Minimum 20 per month</td>
</tr>
<tr>
<td>Care Team Interactions with Patient</td>
<td>• RN Navigator visit once a month • MSW Navigator support as needed • LPN or health coach phone call every other week</td>
<td>• RN Navigator visit once a month • MSW Navigator visit twice a month • LPN visit three times per month • LPN or health coach phone call every other week</td>
<td>• RN Navigator visit twice a month • MSW Navigator visit twice a month • Health coach visit twice a month • LPN visit twice a month • LPN or health coach phone call three times a week • RN Navigator tracks patient metrics with remote telemonitoring</td>
</tr>
</tbody>
</table>

1) Time spent by patient in risk category before reevaluated and moved to new category (e.g., from rising-risk to low-risk).

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Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.
Managing Three Distinct Patient Populations

- **High-Risk Patients**: 5% of patients; usually with complex disease(s), comorbidities
- **Rising-Risk Patients**: 15-35% of patients; may have conditions not under control
- **Low-Risk Patients**: 60-80% of patients; any minor conditions are easily managed

Drilling Down to the Root Causes

Root Causes of Patients Receiving Fragmented, Episodic Care

Complete Root Cause Analysis in Appendix.
Finding the 80/20

Key Root Causes of Patients Receiving Fragmented, Episodic Care

Patients receive fragmented, episodic care

- Clinicians not equipped to provide continuous care
  - Clinicians don’t have necessary patient information
  - Clinicians don’t know how
  - Clinicians don’t have time

- Clinicians only feel accountable for their immediate setting
  - Clinicians have a siloed, setting-specific perspective
  - Clinicians’ incentives focus on site-specific care

- Patients and families don’t manage their care effectively
  - Patients lack motivation
  - Patients don’t know how
  - Patients face economic roadblocks

To access Achieving Top-of-License Nursing Practice, visit advisory.com/nec/publications.

Source: Nursing Executive Center interviews and analysis.

Four Imperatives for Achieving Care Continuity

Best Practices for Building a System that Never Discharges the Patient

1. Equip Clinicians to Provide Continuous Care
   - Ensure Easy Access to “Need-to-Know” Patient Information
   - Connect the Care Plan Across Settings

2. Promote Clinician Ownership for Cross-Continuum Care
   - Broaden the Front Line’s Perspective Beyond Their Own Setting
   - Incentivize Continuous Care

3. Instill Patient and Family Ownership for Self-Care
   - Appeal to Patients’ Personal Motivators for Involvement
   - Equip Patients and Families with Tools for Self-Management

4. Scale Up Support for Vulnerable Patients
   - Invest in Targeted Services for Select Populations

Source: Nursing Executive Center interviews and analysis.
Why We Need to Stop Thinking About “Care Transitions”

Best Practices for Building a System that Never Discharges the Patient

Returning to Our Larger Ambition

1. The “Critical Eight” Survey
2. Motivational Interviewing
3. Patient Preference Discussion Guide

Ensure Easy Access to “Need-to-Know” Information

Connect the Care Plan Across Settings

4. Shared Cross-Setting APN
5. Cross-Continuum Care Agreement
6. Cross-Continuum Care Pathway

1. Equip Clinicians to Provide Continuous Care
Two Key Challenges

Information Is Buried
Patient record contains large amount of patient information; clinicians struggle to find most critical information in the moment

Information Is Missing
Patient record missing key pieces of information (e.g., details about patient's home environment)

What is the “Need-to-Know” Patient Information?

The “Critical Eight” Pieces of Information

Information that Should Be Easily Accessible to Clinicians

1. Patient's Perspective
2. Primary Care Provider
3. Accurate List of Medications
4. Prescribers of Each Medication
5. Main Diagnoses
6. Relevant Risk Assessment Scores
7. Payer Status
8. __________________________

Source: Nursing Executive Center interviews and analysis.
Calling Out Key Information from Hospital to Clinic

Mayo’s Patient Information Summary Page

- Dates of hospitalization
- Primary diagnosis
- Secondary diagnosis
- Reason for admission
- Hospital course
- Procedures performed
- Pending studies
- Discharge medications
- Discontinued medications
- Discharge disposition
- Risk level
- Discharge instructions provided to patient and caregiver(s)
- Follow-up recommendations
- Follow-up contact information

Complete Patient Information Summary Page in Appendix.

Case in Brief: Mayo Clinic

- 13-hospital health system headquartered in Rochester, Minnesota
- Leaders developed summary page of patient information to send to primary care team when patient is discharged from the hospital; goal to ensure primary care clinicians have information they need to provide appropriate care to patient
- Hospital EMR automatically generates patient information summary page and sends it to the Mayo primary care team EMR inbox; summary page contains patient information from hospital EMR; the patient information summary page is limited to key patient information, including patient risk level, hospital course, and medications
- Patient information summary page developed by task force comprised of representatives from all four Mayo regions; to determine what information to include on the summary page, task force members surveyed primary care clinicians
- Mayo leaders rolled out summary page in Q1 2013 for high-risk patients; the patient information summary page is currently used for all patients across all four Mayo regions
- Leaders report reduction in readmissions since implementing summary page
Mayo’s Survey Questions for Primary Care Teams

8) What information is most helpful for you to be able to assist the patient with this transition? (Select all that apply.)

- Wound care/dressing changes
- Current medications
- Follow-up appointments
- Significant psychosocial history
- Medical concerns
- Chronic disease management concerns
- Reason for hospitalization
- Recent surgeries/procedures
- Level of assistance/support systems
- Safety concerns
- Education needs (e.g., medication reinforcement)
- Level of pain/quality of sleep
- Ability to complete ADLs
- Other: _______________________

11) Please specify any other concerns or areas for improvement.

Complete Primary Care Team Survey in Appendix.

Recap of Practices for “Un-Burying” Information Across Settings

<table>
<thead>
<tr>
<th>Practice</th>
<th>Capsule Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-Facility Patient Summary Tool</td>
<td>Hospital and local PAC facilities jointly identify information to include on hospital’s universal transfer form</td>
<td>Nurse-Led Strategies for Preventing Avoidable Readmissions</td>
</tr>
<tr>
<td>After-Hospital Ticket to Ride</td>
<td>Hard-copy form highlights patient’s most crucial health care information; travels with patient during transfer from hospital to PAC setting</td>
<td>Nurse-Led Strategies for Preventing Avoidable Readmissions</td>
</tr>
<tr>
<td>Safety Sign-On Screen</td>
<td>Informatics team consolidates critical, patient-specific safety information on a single screen in the EMR that can be accessed from anywhere in the patient record</td>
<td>Achieving Top-of-License Nursing Practice</td>
</tr>
</tbody>
</table>

To access Nurse-Led Strategies for Preventing Avoidable Readmissions and Achieving Top-of-License Nursing Practice, visit advisory.com/nec/publications.
Why Capturing the Patient’s Perspective Matters

Representative Scenario

Patient prescribed asthma inhaler; $100 out-of-pocket cost

Patient experiences asthma attack; results in ED visit

Patient unable to afford medication; does not fill prescription

Patient readmitted 18 days after discharge

Practice #2: Motivational Interviewing

A Proven Strategy: Motivational Interviewing

Sample Journal Articles Reporting Benefits of Motivational Interviewing

- *Health Psychology, 2007*
  - Using Motivational Interviewing as a Supplement to Obesity Treatment

- *Transfusion, 2010*
  - An Adapted Post-Donation Motivational Interview Enhances Blood Donor Retention

- *Addiction Sciences & Clinical Practices, 2012*
  - Enhancing Brief Intervention with Motivational Interviewing in Primary Care Settings

- *Journal of Substance Abuse Treatment, 2013*
  - Preconceptional Motivational Interviewing Interventions to Reduce Alcohol-Exposed Pregnancy Risk

Source: Nursing Executive Center interviews and analysis.
## Examples of Incorporating Motivational Interviewing Techniques into Patient Interaction

<table>
<thead>
<tr>
<th>Traditional Interviewing</th>
<th>Motivational Interviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Can you pay for your medication?”</td>
<td>“Most people have trouble paying for their medications—is this something you might struggle with as well?”</td>
</tr>
<tr>
<td>“Your blood pressure is extremely high; you need to change your diet.”</td>
<td>“What do you think you can cut down your intake of fried food to?”</td>
</tr>
<tr>
<td>“Weight gain is a potential side affect of this medication.”</td>
<td>“A lot of people are concerned about gaining weight when they take this medication.”</td>
</tr>
<tr>
<td>“Can you get to your next physician appointment?”</td>
<td>“A lot of people have trouble getting reliable transportation to their physician office. Would you like some help with that?”</td>
</tr>
<tr>
<td>“Are you a smoker? How much do you smoke each day?”</td>
<td>“Would you mind if we talked about your smoking? How do you feel about it?”</td>
</tr>
</tbody>
</table>

### Addressing Potential Pitfalls

“You’re asking for personal information from people who are used to going through checkboxes. But who’s really listening? I knew people were leaving their medications at the pharmacy and not picking them up. And I knew that people wouldn’t tell you things like that.”

**VP Clinical Care Management Carolinas HealthCare System**

### Case in Brief: Carolinas HealthCare System

- 7,460-bed health system headquartered in Charlotte, North Carolina; consists of over 900 care locations including hospitals, physician practices
- Staff attend Motivational Interviewing (MI) Basics course, which covers evidence-based interviewing techniques; the goal of the training is to teach clinicians to ask questions that encourage truthful responses and sharing from patients
- Training attendance is encouraged for both clinical and non-clinical staff involved in patient advocacy and coaching; training is mandatory for CCPGM\(^1\) care management staff (care managers and health advocates) in both outpatient and inpatient settings
- Two-day training sessions offered locally; cost for training is $100 per staff member; training sessions are generally reimbursed by department
- Carolinas has a variety of internal motivational interviewing resources available to staff, including a system-wide coaching network, and mentor-mentee shadowing program to launch in 2015; shadowing program will provide opportunities for experienced clinicians and health coaches to shadow and provide constructive feedback to clinicians and coaches who are new to motivational interviewing techniques

\(^1\) Community Care Partners of Greater Mecklenburg.
Prioritizing Motivational Interviewing for High-Risk Patients

Use of Motivational Interviewing at Carolinas

Mandatory for Care Managers
Motivational interviewing training mandated for care managers and health coaches; used in daily interactions with Medicaid Access II patients

Encouraged for All Staff
Motivational interviewing training available to all Carolinas staff; strongly encouraged for use with all patients

Providing Staff with Support to Use and Master Skills

Supplemental Motivational Interviewing Resources at Carolinas

Online Webpage and Discussion Board
Online webpage offers a forum for staff to share their experiences, learn about upcoming trainings, and access resources

Face-To-Face Meetings
Staff meet on a quarterly basis to discuss insights and share lessons learned

Coaching Network
Mentor-mentee program provides opportunities for staff to practice techniques with more experienced coaches
Excerpt from Mayo’s Diabetes Medication Choice Decision Aid

<table>
<thead>
<tr>
<th>Daily Routine</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metformin</strong></td>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>24</td>
<td><strong>Metformin</strong> (Generic available)</td>
</tr>
<tr>
<td>AM/PM</td>
<td>$0.10 per day</td>
</tr>
<tr>
<td></td>
<td><strong>Insulin</strong></td>
</tr>
<tr>
<td>AM/PM</td>
<td>(No generic available – price varies by dose)</td>
</tr>
<tr>
<td></td>
<td>Lantus: Vial, per 100 units: $10</td>
</tr>
<tr>
<td></td>
<td>Pen, per 100 units: $6</td>
</tr>
<tr>
<td></td>
<td>NPH: Vial, per 100 units: $30</td>
</tr>
<tr>
<td></td>
<td>Pen, per 100 units: $30</td>
</tr>
<tr>
<td></td>
<td><strong>Pioglitazone</strong> (Generic available)</td>
</tr>
<tr>
<td>24</td>
<td>$10.00 per day</td>
</tr>
<tr>
<td>AM/PM</td>
<td><strong>Liraglutide/Exenatide</strong> (No generic available)</td>
</tr>
<tr>
<td>24</td>
<td>$11.00 per day</td>
</tr>
<tr>
<td>WEEKLY/AM/PM</td>
<td>$900 / 3 months</td>
</tr>
</tbody>
</table>

Take in the hour before meals.

Additional topics covered within Diabetes Medication Choice Decision Aid include low blood sugar, daily sugar testing, and weight change.

Case in Brief: Mayo Clinic

- 13-hospital health system headquartered in Rochester, Minnesota
- In 2010, developed multidisciplinary Mayo Clinic Shared Decision Making National Resource Center to advance patient-centered medical care by promoting shared decision making (SDM) throughout Mayo and the nation; Center focuses on developing and implementing patient decision aids for chronic conditions and diseases
- Decision aids designed for use during the clinical encounter to create conversations between patients and clinicians to identify the option that best suits the patient’s informed preferences
- Decision aids and supplementary training resources available for conditions including diabetes medication choice, cardiovascular primary prevention choice, depression medication choice
- Mayo currently integrating validated aids into EMR to streamline use and embed into clinician workflow
- All SDM tools produced by Mayo available to other institutions at no cost; training resources for clinicians and education tools for leaders are also available at no cost.

Capturing the Patient’s Perspective with Decision Aids

Key Elements of Mayo’s Medication Choice Decision Aid

- **Highlights Pros and Cons of Each Option**
  Side-by-side summary of options makes it easy for patients to see benefits and drawbacks of each medication

- **Written in Patient-Friendly Language**
  Clear language and visuals assist clinicians in explaining medical and financial implications of options

- **Discussion Outcome Documented in EMR**
  Clinician documents patient preference and relevant aspects of conversation for future reference

Other Decision Aids Available at Mayo

- Depression Medication Choice
- Osteoporosis Medication Choice
- Diabetes Medication Choice
- Cardiovascular Primary Prevention Choice

Plug and Play Resources from Mayo

Resources to Introduce Shared Decision Making to Clinicians and Leaders

- **3-Minute Videos**
  Videos show role play of clinician using tools with patient

- **Ready-to-Use Storyboards**
  Storyboards outline how clinicians can incorporate decision aids into their workflow

- **Toolkits for Managers**
  Presentation slides and discussion guides help managers introduce shared decision making to clinicians and frontline staff

All of Mayo’s shared decision making resources are free and available at http://shareddecisions.mayoclinic.org.
Key Findings from Mayo’s Chest Pain Trial

**More Appropriate Utilization**

<table>
<thead>
<tr>
<th>Standard Care</th>
<th>Patient Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Patients Admitted to Observation Unit for Stress Testing</td>
<td>n=204</td>
</tr>
<tr>
<td>77%</td>
<td>58%</td>
</tr>
</tbody>
</table>

**Increased Patient Knowledge**

<table>
<thead>
<tr>
<th>Standard Care</th>
<th>Patient Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Questions Correct on Post-Visit Survey</td>
<td>n=204</td>
</tr>
<tr>
<td>3.0</td>
<td>3.6</td>
</tr>
</tbody>
</table>

**Greater Patient Satisfaction in Decision-Making Process**

<table>
<thead>
<tr>
<th>Standard Care</th>
<th>Patient Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Answering “Strongly Agree” on Satisfaction Survey</td>
<td>n=204</td>
</tr>
<tr>
<td>40%</td>
<td>61%</td>
</tr>
</tbody>
</table>

“Our decision aids improve the patient’s ability to engage in a conversation, and the [clinician]’s ability to extract information from this discussion… combining their expertise and evidence with patient preferences so they can arrive at a decision together.”

Victor Montori, MD

Mayo Clinic Shared Decision Making National Resource Center

---

**Sharing Information Across Settings and Organizations**

Emerging Strategies for Patient Information Access and Sharing Across Organizations

**Epic Care Everywhere**

Tool in Epic EMR used to securely share information between health care organizations; at least one organization must be Epic-user

**Regional Health Information Exchange**

Disparate health care information systems electronically share patient information

**Cross-Organization ED High-Utilizer Alert**

Hospitals share care plan, patient information for limited group of ED high-utilizer patients with other EDs in close geographic proximity

**Other?**


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1. Equip Clinicians to Provide Continuous Care

Ensure Easy Access to “Need-to-Know” Information

1. The “Critical Eight” Survey
2. Motivational Interviewing
3. Patient Preference Discussion Guide

Connect the Care Plan Across Settings

4. Shared Cross-Setting APN
5. Cross-Continuum Care Agreement
6. Cross-Continuum Care Pathway

Practice #4: Shared Cross-Setting APN

Using an APN to Extend Care into the Next Setting

Excerpt of Shared Cross-Setting APN Job Description at Valley Health System

Valley Health System
Job Description: APN, Care Navigator

Job Summary: To act as a facilitator of collaboration across the care continuum. To interface with acute care and extended care facilities, foster physician relationships, assist in the coordination and facilitation of clinical review of potential clients. Provides clinical leadership, expertise, collaboration, consultation, and mentorship to promote evidence-based nursing practices. To develop and evaluate a program of care using transitional models of care.

Education: Masters Degree/MSN program which includes pharmacology in its required curriculum. Certification as a Nurse Practitioner in the State of New Jersey, Clinical Nurse Specialist, or Advanced Practice Nurse by a national accrediting organization, which is approved by the Board.

Experience: Two plus years of clinical experience in the home health setting, acute care setting, skilled nursing facility, physician’s office, or in a community setting.

Hospital employee positioned primarily in SNF; coordinates care across hospital, SNF, home

Funded by hospital (25%), SNF (50%), home care (25%)

Complete Shared Cross-Setting APN Job Description in Appendix.
Using an APN to Extend Care into the Next Setting

Case in Brief: Valley Health System

• One-hospital health system headquartered in Ridgewood, New Jersey
• System created Shared Cross-Setting APN role to provide support for SNF staff in caring for Valley patients; the goal of this role is to provide a bridge between the SNF and The Valley Hospital and Valley Home Care clinicians
• APNs are responsible for direct care and care coordination for select patients determined “high-risk” (LACE score >13, diagnoses including COPD, heart failure, hip and knee replacement, and other criteria)
• APNs round daily on patients in SNF, provide education to SNF staff on handling complex needs; when patients are discharged from the SNF, the APNs work with home care staff to evaluate patient acuity and ensure the patient is equipped with appropriate resources at home; APNs visit the patient at home if the patient is ineligible for home care and needs support after discharge from the SNF
• The Shared Cross-Setting APN’s salary is divided equally between Valley Health System and the SNF at which the APN is positioned; The Valley Hospital is responsible for 25%, Valley Home Care pays 25%, and the SNF pays 50%
• Valley first introduced the Shared Cross-Setting APN role in July 2013, and introduced a second Shared Cross-Setting APN to a second SNF in September 2013
• Since introduction of Cross-Setting APN role, the readmission rates of patients from participating SNFs to The Valley Hospital have decreased by 47% (SNF 1) and 58% (SNF 2)

Providing Continuity from Hospital to SNF to Home

Responsibilities of Valley Health System’s Shared Cross-Setting APN

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Hospital</th>
<th>SNF</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access patient hospital record to prepare SNF staff for patient needs; if patient returns to ED, coordinate with ED clinician to determine appropriate care</td>
<td>Perform medication reconciliation on patient admission to SNF; round on patients daily; order tests when necessary</td>
<td>Visit patient home if ineligible for home care but needs additional support</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cross-Continuum Coordination</th>
<th>Hospital</th>
<th>SNF</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal handoff with hospital staff upon patient admission to SNF</td>
<td>Equip staff to handle patients’ complex needs; provide feedback after adverse events occurring in the SNF</td>
<td>Coordinate with home care staff to evaluate patient acuity, additional patient needs</td>
<td></td>
</tr>
</tbody>
</table>
Partnering with SNFs with Greatest Need

Representative SNF Selection Criteria

<table>
<thead>
<tr>
<th>SNF</th>
<th>Percentage of Patients Sent from Hospital to Specific Facility</th>
<th>Readmission Rates from SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koons Nursing Center</td>
<td>5.8%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Vega Wellness Center</td>
<td>32.4%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Raine Nursing Home</td>
<td>10.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Fox Health and Rehab</td>
<td>15.6%</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

1) Representative data.
2) Pseudonym.

Promising Early Results

<table>
<thead>
<tr>
<th>SNF</th>
<th>Percentage of Patients Readmitted to Valley from Shoshanna Nursing</th>
<th>Percentage of Patients Readmitted to Valley from Floyd Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoshanna Nursing</td>
<td>Baseline: 42.67%</td>
<td>Baseline: 35.29%</td>
</tr>
<tr>
<td></td>
<td>8 Months Post-Implementation: 22.50%</td>
<td>8 Months Post-Implementation: 14.96%</td>
</tr>
</tbody>
</table>

1) Pseudonym.
2) First month of Shared Cross-Setting Nurse in SNF.
Getting Everyone on the Same Page

Lehigh Valley's Breast Care Management Cross-Continuum Care Agreement

The Cooperative Care Agreement for care of the High Risk and Invasive Breast Cancer Patients will define for all parties named above the types of referral, consultation, and co-management arrangements available. This agreement will specify who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements. This agreement will define expectations regarding the information content requirements, as well as the frequency and timeliness of information flow within the referral process. This is a bidirectional process reflecting the needs and preferences of both the referring and consulting physician and other health care professionals. This agreement will specify how secondary referrals are to be handled and situations of self referral. This agreement will also maintain a patient-centered approach including consideration of patient/family choices, ensuring explanation/clarification of reasons for referral, and subsequent diagnostic or treatment plan and responsibilities of each party, including the patient/family. This agreement will include regular review of the terms of the care coordination agreement by all parties. In addition there will be a mechanism for all parties to periodically evaluate each other’s cooperation with the terms of the care coordination agreement, and the overall quality of care being provided through their joint efforts.

Complete Cross-Continuum Care Agreement in Appendix.

Source: Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.

Case in Brief: Lehigh Valley Health Network

- Four-hospital health system based in Allentown, Pennsylvania; system includes community health centers, a health plan, primary care clinics and specialty care clinics
- Oncology service line leaders held an exercise to map patient flow and found gaps in care resulting from lack of delineation of responsibilities between care sites; in response, leaders created a Cross-Continuum Care Agreement to clarify what care site is responsible for what aspects of patient care
- The Cross-Continuum Care Agreement is signed by the network primary care practice, the hematologic oncology practice, breast health services, and the surgical oncology practice
- The Cross-Continuum Care Agreement outlines responsibilities of each care site, including what care site is responsible for scheduling follow-up appointments for abnormal results, notifying the patient’s primary care clinician with updates, and conducting screens and tests
- Since implementing the Cross-Continuum Care Agreement, the average time from appointment to biopsy decreased from several weeks to less than one week
Clearly Delineating Responsibility

Breast Care Management Cooperative Care Agreement Responsibilities by Care Site

<table>
<thead>
<tr>
<th>Care Site</th>
<th>Care Responsibilities</th>
</tr>
</thead>
</table>
| Lehigh Valley Physician Practice (LVPP)       | • Order routine screening mammography as per LVHN\(^1\) standard  
• Order diagnostic mammography; ultrasound for patients presenting with breast symptoms, abnormal findings on examination  
• Schedule screening, diagnostic mammogram at Breast Health Services; refer uninsured patients to Healthy Women Program or Breast Coalition Program |
| Breast Health Services (BHS)                  | • Perform routine mammogram as per policy  
• Report normal mammogram to LVPP within 72 hours; refer patient back to LVPP for routine care, follow up mammograms  
• When biopsy results positive for Atypia, invasive breast cancer, facilitate subsequent referrals to surgery, Breast Multidisciplinary  
• Communicate abnormal mammogram, biopsy results to primary care within 24 hours; make referral on behalf of PCP to High Risk Breast Clinic |
| Lehigh Valley Surgical Oncology (LVSO)         | • See patients at next scheduled clinic to evaluate for biopsy  
• Notify PCP of self-referrals to clinic by patients  
• Schedule diagnostic breast imaging in BHS when necessary; assist with scheduling appointments for Breast Multidisciplinary Clinic, High Risk Breast Clinic within one week of receiving biopsy results when appropriate  
• Forward dictated note to LVPP including recommendations, plan for follow up |
| Hematology Oncology Associates (HOA)           | • Schedule patients within 6-12 weeks of receiving request; notify patients of appointment  
• Provide comprehensive cancer risk assessment, recommendation for cancer surveillance  
• Notify LVPP and LVSO of patient’s plan of care  
• Obtain insurance authorization for specialty testing if recommended for patients |

1) Lehigh Valley Health Network.  
2) Breast Imaging-Reporting and Data System.  
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Source: Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.

Getting Leaders and Staff Onboard

Key Steps in Developing Lehigh Valley's Cross-Continuum Care Agreement

**Involved Key Stakeholders in Multiple Care Sites**  
Project lead interviewed clinicians from participating care sites to map out ideal patient flow, uncover gaps in care

**Showcased Benefits to Staff to Achieve Buy-In**  
Leaders presented ideal patient flow to clinicians to demonstrate how adherence to agreement benefits patients

**Presented Final Draft for Clinician Sign-Off**  
Project lead presented agreement to each participating care site for sign-off

**Navigators Available to Answer Questions for Staff**  
Navigators designated as point-person to educate frontline staff and answer their questions

©2015 The Advisory Board Company • advisory.com • 29761D  
Source: Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.
### Improving Timeliness of Care, Reimbursement

#### Average Time from Appointment to Biopsy

<table>
<thead>
<tr>
<th>Days</th>
<th>Before Cooperative Care Agreement</th>
<th>After Cooperative Care Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>~14-28</td>
<td></td>
<td>~1-7</td>
</tr>
</tbody>
</table>

#### Percentage of Cases Reimbursed for Services

<table>
<thead>
<tr>
<th></th>
<th>Before Cooperative Care Agreement</th>
<th>After Cooperative Care Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Source: Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.

### Practice #6: Cross-Continuum Care Pathway

#### Surgical Pathways a Strong Starting Point

**Excerpt of Joint Replacement Care Pathway**

- **Outpatient**
  - Pre-Op Surgical Visit
- **Inpatient**
  - Pre-Op Preparation
  - Preparation, Operation, PACU
  - Inpatient Stay and Discharge
- **Outpatient**
  - Post-Discharge Rehab, Care

### Surgical Preparation, Operation, and Post-Anesthesia Care

1) Post-anesthesia care unit.

Source: Primer, Inc. and Institute for Healthcare Improvement, “Integrated Care Pathway for Total Joint Arthroplasty,” premierinc.com; Nursing Executive Center interviews and analysis.
Identifying Conditions Ripe for Cross-Continuum Pathways

Key Considerations for Prioritizing Care Pathway Development

The more questions you answer with a “yes,” the stronger the case for building a cross-continuum care pathway for the disease or condition.

1. Is patient flow between settings for this disease or condition generally predictable?
2. Is there a sizable patient population whose primary care need is this disease or condition?
3. Are there gaps in care between relevant care sites and settings affecting patient care and patient outcomes for this disease or condition?

Moving Beyond Surgical Pathways

Excerpt of Bellin’s Acute Low Back Pain Care Pathway

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Primary Care</th>
<th>Physical Therapy</th>
<th>Patient Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>If red flags, refers patient to specialist</td>
<td>Schedules patient assessment</td>
<td>PT team care provides patient with same-day appointment</td>
<td>Patient calls PCP with complaint of lower back pain</td>
</tr>
<tr>
<td>PCP refers patient to specialist after repeat assessment</td>
<td>Addresses treatment options, refers to PT</td>
<td>PT team establishes treatment plan</td>
<td>PCP follows up with patient 5-7 days if refuses PT</td>
</tr>
<tr>
<td>PT refers patient back to PCP if patient not improving</td>
<td></td>
<td></td>
<td>PT discharges patient if improves, provides one-week phone follow-up</td>
</tr>
</tbody>
</table>

Complete Acute Low Back Pain Care Pathway in Appendix.
Moving Beyond Surgical Pathways

Case in Brief: Bellin Health Care Systems

- Two-hospital health system based in Green Bay, Wisconsin; system includes several outpatient and rehab centers and home health care
- In 2012, formed interprofessional expert team to develop acute low back pain care pathway; team members include physician champion and representatives from administration, nursing operations, IT, clinic, physical therapy, emergency department, occupational health, radiology, neurosurgery, and other specialties
- Expert team responsible for creating pathway templates, standing protocols, order sets, establishing measures for clinician and system performance, annual review of condition-specific guidelines, templates, and report measures
- In 2014, implemented acute low back pain care pathway across health system, including hospitals and clinics; pathway templates and protocols integrated into Epic platform
- To promote use, leaders provide monthly paper-based updates to clinicians on protocol use and compliance
- Leaders plan to track success of pathway by measuring compliance with evidence-based pathway protocols, referrals to physical therapy, patient time off from work
- Cross-continuum pathway development in progress for CHD prevention, diabetes, chronic heart failure, and stroke; current plans call for rolling out CHD prevention and diabetes care pathways in early 2015

Locking in Clinician Support by Seeking Input During Development

Bellin’s Acute Low Back Pain Care Pathway Expert Team

- Physician Disease State Champion
- Nursing Operations Representative
- IT Representative
- Administration Representative
- Physical Therapist
- ED Representative
- Occupational Health Representative
- MRI Team Leader
- Quality Representative
- Specialists Representing: Chiropractic, Neurosurgery, Behavioral Health, Alternative Medicine, NEWHVN¹

Guidance for Involving Key Players in Care Pathway Development

- Recruit representatives from every care site touched by patient in ideal flow
- Solicit input from both clinical (e.g., service line nurses, physicians) and non-clinical (e.g., administration) areas
- Recruit care site representatives who can speak to capacity to adhere to pathway protocols (i.e., whether staffing can accommodate responsibility for more aspects of patient care)
Driving Pathway Compliance by Publicizing Individual Performance

Key Steps for Sharing Individual Performance Data

1. **Give sufficient notice.** Make staff aware of intent to track metric(s) at individual level at least six months in advance; gives staff time to adjust to idea, ask questions

2. **Limit number of metrics.** Track, share individual performance on no more than three metrics; when performance targets regularly met, phase out metric to focus on new goal

3. **Highlight top performers.** Whether sharing all data or not, use opportunity to recognize, reward top individual performers; counteracts potential punitive feel

4. **Link to outcomes.** Link individual compliance data back to larger outcomes (e.g., present individual discharge instruction compliance alongside readmission rates)

Not a Quick Change

Timeline of Care Pathway Implementation at Bellin

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Formed multiprofessional cross-setting team; Selected areas of focus for pathways; decided to start with acute low back pain due to impact on Bellin’s staff (e.g., missing work from low back pain)</td>
</tr>
<tr>
<td>2013</td>
<td>Reviewed evidence-based protocols for acute low back pain; Mapped out ideal workflow for acute low back pain care pathway</td>
</tr>
<tr>
<td>2014</td>
<td>Integrated acute low back pain pathway into Epic; Trained staff on use of pathway protocols</td>
</tr>
<tr>
<td>2015</td>
<td>Plan to replicate roll-out for two other pathways (CHD prevention, diabetes)</td>
</tr>
</tbody>
</table>

Other Pathways in Development at Bellin

- Chronic heart failure
- Diabetes
- CHD and prevention
- Stroke
2 Promote Clinician Ownership for Cross-Continuum Care

Broaden the Front Line’s Perspective Beyond Their Own Setting

7. Cross-Continuum Shared Governance
8. Alternative Care Setting Experiences

Incentivize Continuous Care

9. Continuum-Focused Leader Incentive Plan
10. Frontline Organizational Alignment Bonus

Frontline Nurses Often Caught Up in Their Immediate Unit and Setting

Representative Critical Care RN Perspective

Source: Nursing Executive Center interviews and analysis.
Acknowledging Structural Barriers

Sample Barriers to a Cross-Continuum Perspective

- Acute Care Focused Education
- Site-Specific Interactions
- Siloed Performance Goals
- Unit- or Site-Specific Shared Governance
- Siloed Organizational Structure
- Single Work Site

Practice #7: Cross-Continuum Shared Governance

An Established Tool to Broaden Frontline Perspective

Percentage of CNOs Who Report Having Shared Governance

1) n=199.
Differentiating Inpatient and Cross-Continuum Shared Governance

Inpatient Shared Governance

Frontline staff from **units within the hospital** participate in a decentralized management system in which they make decisions regarding inpatient professional practice.

Cross-Continuum Shared Governance

Frontline staff from **multiple care settings** (e.g., inpatient, ambulatory, home health, etc.) participate in a decentralized management system in which they make decisions regarding professional practice across the system.

Introducing Aurora’s Cross-Continuum Shared Governance Structure

Overview of Aurora’s System-Wide Council Structure

- **System Nursing Leadership Council**
  - **Inpatient Councils**
  - **Ambulatory Council**
  - **Site Nursing Coordinating Councils**
    - **Area Coordinating Council**
      - **System Nursing Practice Council**
      - **System Nursing Professional Development Council**
      - **System Nursing Management Council**
      - **System Nursing Innovations Council**
      - **System Nursing Informatics Council**
      - **Advanced Practice Registered Nurse Council**

Source: Nursing Executive Center interviews and analysis.

Source: Aurora Health Care, Milwaukee, WI; Nursing Executive Center interviews and analysis.
Introducing Aurora’s Cross-Continuum Shared Governance Structure

Case in Brief: Aurora Health Care

- 15-hospital system headquartered in Milwaukee, Wisconsin; system includes over 200 clinics in Illinois, Michigan, and Wisconsin
- In 2014, Aurora introduced an ambulatory shared governance council; the council includes 16 RNs and two managers; seven representatives are from specialty clinics, six are from primary care clinics, and three are from alternative care settings
- Ambulatory representatives join six system-wide councils: Site Nursing Coordinating Council (Ambulatory Council), System Nursing Leadership Council, System Nursing Coordinating Council, System Nursing Practice Council, System Nursing Professional Development Council, System Nursing Management Council
- To signal the importance of the launch of the ambulatory council, all ambulatory council members were required to attend the first ambulatory council meeting in person; council members’ managers and the system council president attended the first meeting along with ambulatory representatives; after the first meeting, ambulatory council members may conference into ongoing monthly meetings from regional hubs

Determining the Right Structure for Ambulatory Shared Governance Council

Key Questions

- How many representatives will we have on the ambulatory council?
  - 16 RNs and two managers participate

- How will we select ambulatory nurse representatives for the council?
  - RNs apply through selective application process; council structure has equal representation from specialty and primary care clinics

- How will we enable representatives across geographies to participate in meetings?
  - Council members may attend monthly meetings from regional hubs via phone or video conference
Setting a High Bar for Council Membership

Excerpt of Aurora’s Ambulatory Shared Governance Application

<table>
<thead>
<tr>
<th>Shared Governance Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please submit the following with your application:</td>
</tr>
<tr>
<td>• Current resume</td>
</tr>
<tr>
<td>• 2 letters of reference (1 from a supervisor)</td>
</tr>
<tr>
<td>• A letter explaining your interest in participating on the Shared Governance Council. Use the following statements as a guide to tell about yourself, and to describe the skills you possess that make you a good candidate.</td>
</tr>
<tr>
<td>• Give an example of a time when you demonstrated:</td>
</tr>
<tr>
<td>The ability to support change</td>
</tr>
<tr>
<td>Initiative</td>
</tr>
<tr>
<td>Leadership</td>
</tr>
<tr>
<td>Problem solving</td>
</tr>
<tr>
<td>Delegation</td>
</tr>
<tr>
<td>Diplomacy</td>
</tr>
<tr>
<td>• List your involvement in:</td>
</tr>
<tr>
<td>Special projects</td>
</tr>
<tr>
<td>Committees</td>
</tr>
</tbody>
</table>

I verify that I am an RN in good standing with a current license:
Signed______________________________________________________

Complete Ambulatory Shared Governance Application in Appendix.

Another Option for Aligning Inpatient and Ambulatory Councils

Before Cross-Continuum Shared Governance
Prior to 2014, Aurora had inpatient shared governance and a council structure that did not include ambulatory RNs

After Integration into System-Wide Shared Governance
In 2014, leaders added an ambulatory council to their existing shared governance model; they created an ambulatory council and ambulatory RNs also sit on system-wide committees

For more information on Gundersen’s shared governance structure, see The Integrated Nursing Enterprise at advisory.com/nec/publications.
Fulbright Scholarship Exposes Recent Graduates to Other Countries

“[The Fulbright program promotes] mutual understanding between people of the United States and the people of other countries of the world.”

Senator J. William Fulbright, 1945

Option 1

Shadowing to Expand Frontline Nurses’ Perspective

Current Nurse Shadowing Pairings at Intermountain

- NICU
- Pediatric Clinic
- Labor & Delivery
- Perinatal Clinic
- Med/Surg
- Wound Clinic

Key Elements of Shadowing Experience

- Lasts 24 hours over three months
- Formal learning objectives
- Participants record observations in provided journal
Case in Brief: Intermountain Healthcare

- 22-hospital integrated delivery system headquartered in Salt Lake City, Utah
- In 2013, leaders implemented the Nurse Exchange Experience; goal to provide nurses with broader understanding of the care continuum
- Currently, six nurses participate in exchange experience; nurse pairings are: NICU and pediatric clinic, labor and delivery and perinatal clinic, and med/surg and wound clinic; six nurses spend 24 hours over the course of three months in the paired unit or site
- Each participating RN must: have two or more years of experience, be in good standing, have a manager who is able to support him or her, express interest in participating in program, and be engaged in the advancement of nursing care delivery
- During annual orientation program, program manager conveys the program’s learning objectives to nurses (and their managers) before exchange experience

Setting Clear Expectations for Shadowing Experience

Intermountain’s Nurse Shadowing Learning Objectives

- **To understand**
  - The role of the RN
  - The care process
  - Challenges in the setting
  - The patient care operation
  - Clinical goals
  - Compliance and regulatory issues pertinent to nursing practice
  - The role of the patient and family in the care process
  - Patient access to the setting and movement through the setting
- **To hear**
  - About satisfiers in the setting
- **To dialogue**
  - Related to “what is important to know about nursing practice here”
  - Ideas for nursing practice evolution to meet future patient care needs

Formal learning objectives include challenges faced by clinicians in the other setting and patient flow in the other setting.
Benefiting from a Holistic Perspective

Option 2

Taking an Evidence-Based Approach

Overview of Inpatient/Outpatient Nurse Rotation Pilots at Cincinnati Children's

Pilot 1
Inpatient nurse worked in an outpatient setting for six months, then returned to the inpatient setting

Pilot 2
Inpatient nurse spent 50% of time in an inpatient setting and 50% of time in an outpatient setting for six months

Pilot 3
Inpatient nurse worked one day in an outpatient setting for six months and rest of the FTE in the inpatient setting

Pilot 4
Inpatient nurse hired to spend 50% of week in an inpatient setting and 50% of week in an outpatient setting permanently

Future State
Two nurses rotate in a co-op where one works inpatient while their counterpart works outpatient and then for the next schedule, they switch
Taking an Evidence-Based Approach

Case in Brief: Cincinnati Children’s Hospital Medical Center

- 621-bed pediatric hospital headquartered in Cincinnati, Ohio
- In 2013, began inpatient/outpatient nurse rotation pilots; goal to provide nurses with broader understanding of the care continuum
- In Cincinnati Children’s rotation program, when an outpatient nursing position opens, two inpatient nurses jointly fill the role; nurses spend cycles of time rotating between inpatient and outpatient settings within the same service line
- Ten sites participate: inpatient neuro surgery, nephrology in combination with dialysis unit, pulmonary clinic with IP trach unit, cardiology step down with cardiology clinic, ortho, and NICU with high risk infant follow-up clinic; gastroenterology and hematology in planning stage
- Since program inception, 19 nurses have participated in the rotation program
- Leaders conducting IRB-approved research study to test effectiveness of rotation programs on enhancing job role satisfaction and expanding perspectives

Embedding Rotations into Frontline Nurses’ Role at Cincinnati Children’s

Key Elements of Cincinnati Children’s Inpatient/Outpatient Blended RN Role

- Time Split Between Inpatient and Outpatient
- Rotations Within Same Service Line
- Full Responsibility During Rotations
- Interested Inpatient Nurses Jointly Fill Empty Outpatient Role

Rotation Program Service Lines

- Neurosurgery
- Nephrology
- Pulmonary
- Cardiology
- Orthopedics
- Pediatrics
- Oncology
- GI
Cincinnati Children’s Nurses Benefiting from Rotations

“Helped me understand what happens after the inpatient stay and prepare patients for care beyond the hospital.”

“It was rewarding to see the patient outside of their acute illness, and to see that they are doing well.”

“Families and patients were surprised and happy to see me in the clinic after I took care of them in the inpatient setting.”

Source: Cincinnati Children’s Hospital Medical Center, Cincinnati, OH; Nursing Executive Center interviews and analysis.

Weighing the Options

Comparing Nurse Shadowing and Rotations

<table>
<thead>
<tr>
<th>Option</th>
<th>Training</th>
<th>Cost</th>
<th>Logistics</th>
<th>Workforce Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shadowing</td>
<td>Minimal training (shadowing nurse does not provide direct patient care)</td>
<td>FTE neutral but likely need to cover cost for RN’s time in other setting</td>
<td>Requires coverage for RNs during shadowing</td>
<td>More appropriate for experienced RNs who can teach shadowing nurse</td>
</tr>
<tr>
<td>Rotation</td>
<td>Intensive upfront training (rotating nurse provides direct patient care in both settings)</td>
<td>FTE and cost neutral</td>
<td>Requires coordination between two managers for performance reviews; requires becoming familiar with two or more work settings</td>
<td>Most effective for new hires</td>
</tr>
</tbody>
</table>

Source: Cincinnati Children’s Hospital Medical Center, Cincinnati, OH; Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.
12 Tools for Translating Market Forces into Frontline Terms

Sample Toolkit Resources

- Nurse Manager “Cheat sheets”
  One-page primers on market forces impacting organizational strategy

- Plug-and-Play Videos
  Short, easy-to-digest videos for frontline staff on current market forces

- Ready-to-Use Posters
  Visuals that distill complex concepts into concrete actions for frontline staff

- Customizable Presentations
  PowerPoint slides and scripting for leaders to brief staff on tough messages

- Interactive Exercises
  Games for frontline staff and managers aimed at conveying budget constraints

To access The Market Force Course, visit advisory.com/nec/publications.

2 Promote Clinician Ownership for Cross-Continuum Care

Broaden the Front Line’s Perspective Beyond Their Own Setting

7. Cross-Continuum Shared Governance
8. Alternative Care Setting Experiences

Incentivize Continuous Care

9. Continuum-Focused Leader Incentive Plan
10. Frontline Organizational Alignment Bonus
Sample Performance Goals

- **Med/Surg Nurse Manager**
  - Unit HCAHPS scores
  - Unit fall rate
  - Unit pressure ulcer rate

- **Primary Care Clinic Nurse Manager**
  - Clinic patient satisfaction
  - Percent of patients with influenza vaccination received
  - Number of patient visits

- **Home Health Nurse Manager**
  - Home health patient satisfaction scores
  - Percent of home health patients readmitted to hospital
  - Medication adherence for home health patients

Practice #9: Continuum-Focused Leader Incentive Plan

Leader Incentives the Right Place to Start

Prevalence of Incentive Programs by Leadership Constituency

- **Top Executives**
  - High-Performing Organizations: 86%
  - Low-Performing Organizations: 68%

- **Directors**
  - High-Performing Organizations: 71%
  - Low-Performing Organizations: 47%

- **Managers/Supervisors**
  - High-Performing Organizations: 38%
  - Low-Performing Organizations: 32%
## Premier’s System-Level Scorecard Metrics

<table>
<thead>
<tr>
<th>Positive work environment</th>
<th>Quality and patient satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Employee survey</td>
<td>• CMS core measures</td>
</tr>
<tr>
<td>• Diversity representation</td>
<td>• Medicare mortality</td>
</tr>
<tr>
<td>• Performance management</td>
<td>• Surgical site infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician partnership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician satisfaction survey</td>
<td>• Readmission</td>
</tr>
<tr>
<td>• Physician satisfaction survey with EHR</td>
<td>• Patient safety indicators</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competitive strength and financials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cash flow margin</td>
</tr>
<tr>
<td>• Cost per CMI adjusted discharge</td>
</tr>
</tbody>
</table>

70% Percentage of executive and director incentive pay based on organization-wide performance on scorecard metrics

### Case in Brief: Premier Health

- Five-hospital integrated delivery system headquartered in Dayton, Ohio
- In 2012, Premier altered pay structure to incorporate system-wide goals into incentive pay; for executives/directors, 70% of pay at-risk based on system-wide goals; for managers, 25% of bonus based on system-wide goals; for frontline staff, 6% of merit pay based on system-wide goals
- Scorecard metrics include: positive work environment (employee survey, diversity representation, performance management), quality and patient satisfaction (CMS core measures, Medicare mortality, surgical site infection, readmission, patient safety indicators, central line associated blood stream infection, HCAHPS), physician partnership (physician satisfaction survey, physician satisfaction survey with EHR), and competitive strength and financials (cash flow margin, cost per CMI adjusted discharge)
## Tiering Incentives by Role

### Premier’s Incentive Pay Structure by Role

<table>
<thead>
<tr>
<th>Role</th>
<th>Type of Incentive</th>
<th>Percent of Incentive Based on Organization-Wide Performance¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executives and Directors</td>
<td>Pay at Risk</td>
<td>70%</td>
</tr>
<tr>
<td>Frontline Managers</td>
<td>Bonus</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Merit</td>
<td>6-25%</td>
</tr>
<tr>
<td>Frontline Staff</td>
<td>Merit</td>
<td>6%</td>
</tr>
</tbody>
</table>

¹) Based on scorecard metrics.

### Cross-Continuum Incentives Driving System-Wide Decrease in Readmissions

<table>
<thead>
<tr>
<th>Premier System-Wide Readmission Ratio¹</th>
<th>Before and After Inclusion in Incentive Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>1.34</td>
</tr>
<tr>
<td>After</td>
<td>1.02</td>
</tr>
</tbody>
</table>

¹) Observed over expected ratio.

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.
Moving Down to the Front Line

Key Reasons to Start with Organizational Alignment Bonus for Frontline Staff

$ Self-funded
Payouts only occur if system hits EBIDA target

Independent of Performance Reviews
Stand-alone bonus doesn’t require any change to performance evaluation system

Possible For Unionized Organizations
Bonus does not conflict with agreed upon annual payments

Improving Patient Satisfaction Through Frontline Bonus Program

System-Wide HCAHPS Performance at Scripps

Key Elements of Scripps’ “Success Shares” Bonus Program

$ Bonus funded if organization hits system-level EBIDA target; only pay out if EBIDA target hit

Bonus linked to system-wide HCAHPS performance

Communicated to staff regularly through multiple channels (e.g., intranet, videos from senior leadership, scorecards)

Maximum payout equivalent to five days pay, awarded annually

Source: Scripps Health, San Diego, CA; HR Advancement Center, Hardwiring Accountability at the Frontline, 2012.

1) Earnings before Interest, Depreciation, and Amortization.
Case in Brief: Scripps Health

- Four hospital, five-campus, 1,343-bed system based in San Diego, California
- In 2006, implemented organization-wide “Success Shares” bonus program; payouts triggered by system performance against EBIDA\(^1\) target
- In 2013, introduced second performance goal linked to productivity; goal is to decrease volume-adjusted labor dollars by 1-3% at the entity level
- Maximum payout across both goals equal to eight day’s pay; goals considered separately when calculating final payout

\(^{1}\) Earnings before Interest, Depreciation, and Amortization.

Case in Brief: University of Illinois Medical Center

- 491-bed unionized hospital in Chicago, Illinois
- New contract includes quarterly bonus program tied to patient satisfaction outcomes
- Nurses who meet pre-set targets in emergency, inpatient, outpatient, and ambulatory services eligible for bonus of up to $250 per quarter
- Nurses voted to ratify three-year contract covering more than 1,000 nurses represented by Illinois Nurses Association in 2012

Case in Brief: Marshalltown Medical and Surgical Center

- 125-bed unionized acute care facility in Marshall County, Iowa
- Introduced Patient Satisfaction Improvement program to union contract in November 2014
- Nurses receive bonus on top of hourly rate if composite patient satisfaction score stays above pre-determined level for three consecutive quarters
- Bonus amount ranges between 3-4% of base pay; depends on composite score percentile
- Patient satisfaction\(^1\) has increased from 30\(^{th}\) to 91\(^{st}\) percentile since program implementation

\(^{1}\) HCAHPS top box score on communication with nurses.
Interdisciplinary Metrics Spanning the Continuum?

Starter List of Cross-Discipline, Cross-Continuum Metrics

- Adverse drug events
- Ambulatory-sensitive inpatient admissions
- AMI mortality rate
- Chronic care patient admissions rate
- Heart failure mortality rate
- Inappropriate ED visits
- Increased number of eligible community members connected to appropriate health resources
- Increased percentage of patients with listed PCPs
- Increased percentage of patient interactions conducted in patient’s primary language
- Medication adherence
- Medication errors
- Patient portal registrants
- Percentage of patients with well-managed HbA1c
- Percentage of patient panel with primary care visit once per year
- Readmission rate
- Revenue capture
- System-wide patient satisfaction
- Others?

Introducing a Second Performance Goal to Frontline Bonus Program

Things to Remember if You Include More Than One Goal in Frontline Bonus Program

- ✔ Every goal you add dilutes the size of the bonus pool
- ✔ Explain the rationale for the new goal to staff
- ✔ Keep the program simple: calculate and reward performance on each goal separately
- ✔ Don’t include more than two goals (excluding the financial trigger)
Money Not the Only Motivator

Non-Financial Incentives Clearly Impactful for Staff

Percentage of Employees\(^1\) Citing Incentive as Effective\(^2\) Motivator

<table>
<thead>
<tr>
<th>Incentive Type</th>
<th>Percentage</th>
<th>Effective Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Praise from Manager</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Attention from Leaders</td>
<td>63%</td>
<td>63%</td>
</tr>
<tr>
<td>Cash Bonuses</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Salary Increases</td>
<td>52%</td>
<td>52%</td>
</tr>
</tbody>
</table>

\(1\) Respondents include executives, managers, and employees of global companies from a range of sectors.

\(2\) Respondents selecting “extremely” or “very effective.”


Center Resources on Tying Recognition to Goals

Practice | Capsule Description
--- | ---
Manager’s Frontline Recognition Kit | Leaders provide each unit manager with a kit containing staff members’ home addresses, note cards, stamps, and tips for providing meaningful feedback; goal to equip managers to easily send personalized, handwritten notes to staff members’ homes following exemplary performance
Principled Recognition Triggers | Unit managers and executive leaders establish clear performance criteria, tied to specific goals, that determine when staff receive special rewards or recognition
Executive’s Frontline Recognition Process | Executive leader sends weekly email to entire organization to publicly recognize individuals or teams whose achievements helped advance organizational goals; standardized process for collecting names of staff to be recognized ensures the practice is sustainable

To access The National Prescription for Nurse Engagement, visit advisory.com/nec/publications.

3 Instill Patient and Family Ownership for Self-Care

### Appeal to Patients’ Personal Motivators for Involvement
11. Personally-Motivating Goal Incorporation
12. Non-Clinical Peer Advisor

### Equip Patients and Families with Tools for Self-Management
13. Inpatient-Based Key Caregiver Skill Building
14. Personalized Patient Support Line

---

**Patient Ownership Driving Better Outcomes**

**Association of Patient Activation with Outcome Measures**

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Level 1 (Low Activation)</th>
<th>Level 4 (High Activation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Adherence</td>
<td>86%</td>
<td>94%</td>
</tr>
<tr>
<td>Utilization of Self-Management Services</td>
<td>49%</td>
<td>61%</td>
</tr>
<tr>
<td>High Patient Satisfaction with Care</td>
<td>23%</td>
<td>69%</td>
</tr>
<tr>
<td>Quality of Life Rated “Good/Very Good”</td>
<td>38%</td>
<td>78%</td>
</tr>
</tbody>
</table>

1) n=4,108; p<0.0001.

The Steep Price of Disengagement

Solutions Require Integrating Care Model Redesign and Engagement

21% ↑
Costs for asthmatic patients with low activation versus highly activated patients

1.5M
ED visits due to COPD exacerbations

$100-300B
Cost of low adherence to medication

Patient Engagement Flashpoints

- Avoidable ED Utilization
  - Problems with medications
  - Skipped or forgot care plan steps

- Missed Follow-Up Steps
  - Underestimated need to meet with care team
  - Deprioritized visits on to-do list

- Missed Primary Care Utilization
  - Could not afford visit
  - Location was inconvenient


Practice #11: Personally-Motivating Goal Incorporation

Setting the Course for Patient-Centric Goals

Still Not Appealing to Patients’ Ultimate Goals

Clinician Goals

Interim
“We need to make sure your blood pressure levels normalize before discharge.”

Long-Term
“I’d recommend valve replacement surgery within the next six months.”

Patient Goals

“I just want to get back to work tomorrow.”

“I want to travel abroad with my family later this year.”

Source: Nursing Executive Center interviews and analysis.
Putting Short-Term Goals into Patient-Friendly Terms

Best Practices for Setting Short-Term Goals that Are Personally Meaningful to Patients

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Capsule Description</th>
<th>Organization</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home</td>
<td>RN health coach meets with patients not meeting their clinical targets to collaboratively set goals, using the Five A’s; RN coach follows up with patients to support goal progression</td>
<td>Mercy Clinics</td>
<td>Preventing Avoidable Hospital Admissions</td>
</tr>
<tr>
<td>Hospital</td>
<td>Nurse provides each patient a ROADMAP that outlines the care plan for their stay, which incorporates patient’s goals and questions</td>
<td>Lehigh Valley Health Network</td>
<td>Strengthening Interdisciplinary Collaboration</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Upon admission, nurse navigator elicits patient’s goal for the stay and sets functional outcomes patient must meet to reach that goal</td>
<td>Benedictine Health System</td>
<td>Members of the Post-Acute Care Collaborative can access Advancing Toward Population Management</td>
</tr>
</tbody>
</table>

To access Preventing Avoidable Hospital Admissions and Strengthening Interdisciplinary Collaboration, visit advisory.com/nec/publications.

Source: Nursing Executive Center, Preventing Avoidable Hospital Admissions, 2011; Nursing Executive Center, Strengthening Interdisciplinary Collaboration, 2012; Post-Acute Care Collaborative, Advancing Towards Population Management, 2013.

Setting Meaningful Goals for Long-Term Engagement

Sarah’s Story in Brief
- Young teen with non-progressive neuro-muscular disorder, full cognitive ability
- Bracing no longer effective; Sarah needs full reconstructive surgery from the knees down, a multi-site surgery requiring specialty care
- Surgery must occur within seven-month window to allow for necessary growth on backend
- Sarah is very active, loves to ski, and above all else wants to attend summer camp

Excerpt of Sarah’s PT Schedule

<table>
<thead>
<tr>
<th>Phase</th>
<th>WB status/Transfers/Gait</th>
<th>Range of Motion</th>
<th>Braces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Surgical (0-5 days)</td>
<td>Non/WBing; Dependent Lift or Scooting Transfer; sponge bath; bed pan</td>
<td>Post-op day 3: CPM 0-30 degrees; CPM used for a minimum of 30 minutes; 3x/day for each leg</td>
<td>Knee immobilizers Possible SLC with derotation bar</td>
</tr>
<tr>
<td>0-3 weeks</td>
<td>Non/WBing; Dependent Lift or scooting transfer; sponge bath, bedside commode</td>
<td>CPM increase 10-15 degrees every 5-7 days as tolerated with goal of reaching 70 degrees by 3 weeks</td>
<td>Knee immobilizers Possible SLC with derotation bar</td>
</tr>
<tr>
<td>3-6 weeks</td>
<td>Begin WBAT; Stand and Pivot Transfers with Assist standing with or w/o KI; progress to walking with a walker</td>
<td>Continue with CPM until 90 degree flexion achieved</td>
<td>Begin to wean off KIs to increase knee flexion range of motion and quad strength</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center interviews and analysis.
Sarah’s Countdown to Sleep Away Camp

7 months to camp
Schedule surgery with enough time to recover for camp

16 weeks to camp
Travel to hospital for multi-site surgery; seven-day inpatient stay; Sarah bearing no weight post-op; surgeon develops strict six week schedule to prepare for inpatient rehab

11 weeks to camp
Return for inpatient rehab after grueling six weeks of daily PT; Sarah ahead of schedule on certain functions

9 weeks to camp
Family adapts PT schedule to meet functional goals for camp (e.g., walking in all directions, sleeping without braces); Sarah has no days off; family revisits goal progression daily

June 22: Off to Camp!

Ultimate Goal: Attend Summer Camp
Sarah has attended camp for four years; fifth year is a major milestone; Sarah’s ultimate goal is to make it to camp after surgery

Practice #12: Non-Clinical Peer Advisor

Growing Demand for Community Health Workers

Current and Projected Number of Community Health Workers in US

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>40,500</td>
</tr>
<tr>
<td>2022</td>
<td>50,700</td>
</tr>
</tbody>
</table>

25%
Growth expected in community health worker role; outpacing average US occupational growth of 11%
The Wild, Wild West

Lack of Standardization in Community Health Worker Role

Representative Variability in Community Health Worker Role

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Representative Job Duties</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Coach</td>
<td>• Engage patients as active participants in their care</td>
<td>Bachelor’s degree or higher in health-related field such as health promotion, health education, athletic training, nutrition, etc.</td>
</tr>
<tr>
<td></td>
<td>• Provide wellness coaching to reduce or eliminate high-risk behaviors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coordinate care with other health-related resources for optimal patient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop and distribute health education materials</td>
<td></td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>• Establish trusting relationships with patients and families</td>
<td>High school diploma or equivalent</td>
</tr>
<tr>
<td></td>
<td>• Help patients set goals, attend appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide services such as first aid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide referrals to community agencies as appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide informal counseling</td>
<td></td>
</tr>
<tr>
<td>Community Health Consultant</td>
<td>• Build and model healthy professional relationships with patients</td>
<td>Associate’s degree in health or human services</td>
</tr>
<tr>
<td></td>
<td>• Support care plan adherence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Work with PCPs to identify at-risk patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Schedule patient appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conduct non-medical screenings and in-home assessments</td>
<td></td>
</tr>
</tbody>
</table>

How to Successfully Use Non-Clinical Peer Advisors

Key Steps

1. Identify the Target Patient Population
2. Find a Peer Advisor Who Can Relate to the Target Population
3. Focus the Role on What Peer Advisors Are Uniquely Positioned to Do
4. Scale Training to Level and Type of Responsibilities
Identify the Target Patient Population

Questions to Consider

1. Which populations are least represented by your clinicians and staff?

2. Which populations are frequently readmitted?

3. Which populations are clinicians and staff struggling to communicate with effectively?

Potential Target Populations

- Faith-based groups
- Immigrant populations
- Ethnic groups
- Behavioral health patients
- Substance abusers
- Chronic condition patients

Find a Peer Advisor Who Can Relate to the Target Population

Sample Peer Advisor Selection Criteria

Characteristics to Look For

- Representative of the target population (e.g., ethnicity, sex, religion, etc.)
- Speaks native language of target population (if applicable)
- Literate, able to read manuals, materials
- Natural leader, ability to motivate others
- Able to commit to time requirements of position whether paid or unpaid
- Servant leader mentality
- Share similar health challenges but manage condition effectively, good days and bad days

Characteristics to Avoid

- Laser focus on their chronic condition
- Over-achievers who may intimidate other patients
- Judgmental
- Too sick to be reliable
- Overly enthusiastic about their way of managing their condition

Source: Nursing Executive Center interviews and analysis.
Recruiting Qualified Applicants in Your Community

Sample Strategies for Recruiting Peer Advisors

- Promote Position at Volunteer Bureaus and Senior Centers
- Upload Notice on Patient Portal Landing Page
- Ask Clinicians to Recommend Favorite Patients
- Partner with Health Advocacy Organizations
- Recruit from Existing Peer Support Groups
- Post Position in Local Newspaper, Health Club

Focus the Role on What Peer Advisors are Uniquely Positionned to Do

Representative Responsibilities of Non-Clinical Peer Advisors

- **Teach Self-Management Skills**
  - Lead self-care sessions as part of peer support group

- **Maintain Network of Community Resources**
  - Develop relationships with various community organizations that can meet needs of their patients

- **Educate Clinicians on Culturally Competent Care**
  - Help clinicians understand how to provide socially competent care to their patient populations

- **Serve as a Bridge Between Patients and the Care Team**
  - Work concurrently with the patient and the care team to ensure patients are fully supported in meeting personal goals

Serving as a Bridge Between Patients and the Care Team

Key Elements of Peer Advisor Role at Scripps

Peer Advisor Selected from Current Patients Based on Demonstrated Leadership

Peer Advisor Receives 40 Hours of Training on Motivational Interviewing, Group Facilitation and Class Curriculum

Peer Advisors Employed by Scripps as Employee or Contractor

Peer Advisors Lead Peer Self-Management Education Groups

Peer Advisors Track Patient Self-Monitored Glucose Log, Review Lab Results

Peer Advisors Alert Care Team if Patients Not Meeting ADA Goals

Case in Brief: Scripps Health

- Four-hospital system headquartered in San Diego, California
- In 1997, Project Dulce started to help people with diabetes manage the day-to-day aspects of their disease through care management services and peer-led support groups
- Self-management education groups are led by peers also managing their own diabetes who cover material in patient’s native language and at 3rd-4th grade reading level; patients attend eight, two-hour, weekly classes covering topics such as nutrition, exercise and diabetes management; classes limited to 10-15 patients each
- Care team recruits peer leaders from existing patients participating in the program who are identified as natural leaders; the care team provides a three month long, 40-hour training to peer leaders; training covers program curriculum, motivational interviewing and facilitation techniques; once peers complete the full training, Scripps hires them as full-time employees or contractors
- Each peer advisor serves as a member of the care team; the peer is paired with a nurse to communicate patient needs; peers track patient’s self-monitored blood glucose log, have access to lab results and encourage PCP appointments; they actively track whether patients are adhering to ADA treatment goals and alert the care team if necessary
- Program has resulted in cost savings of $537 per patient; has served 18,000 patients to date and resulted in reduced HbA1c levels of participants; cost of peer educator is 1/3 cost of an RN


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### Peer Advisors Reducing Cost

#### Case in Brief: Methodist Le Bonheur

- Seven-hospital, 1,600-bed health system located in Memphis, Tennessee
- Developed the Congregational Health Network (CHN) to leverage social infrastructure of congregations to provide peer support to patients
- Congregation members serve as liaisons who support patients in the community for as long as the patient requires; liaisons help pastors provide health education to their congregation, provide social support to patients before and after their hospital stay, provide referrals to appropriate resources and help coordinate the transition to aftercare; liaisons are also responsible for working with the care team to ensure patients receive the right level of care
- Liaisons receive training in hospital visitation, aftercare, care for the dying, and mental health first aid
- Liaisons register patients for the network in the community (e.g., church or community health event) and navigators register patients while they are in the hospital; in addition to being paired with a liaison, registered patients can receive benefits such as lower out-of-pocket costs for health services, and classes on how to navigate the health system
- Leaders report cost savings of $4.4 M over nine months with 600 congregations, 700 liaisons, and 20,000 patient members

#### Cost Savings Per Patient

**Methodist Le Bonheur**
- Pre-Intervention Costs Per Patient: $220 cost savings per patient YTD
- Post-Intervention Costs Per Patient

**Scripps Health**
- Pre-Intervention Costs Per Patient: $537 cost savings per patient yearly
- Post-Intervention Costs Per Patient

*Source: Methodist Le Bonheur, Memphis, TN; Philis-Tsimikas, Athena, et al., “Community-Created Programs: Can They Be the Basis of Innovative Transformations in Our Health Care Practice? Implications from 15 Years of Testing, Translating, and Implementing Community-Based, Culturally Tailored Diabetes Management Programs”, Clinical Diabetes, 2012, 30: 156-163; Scripps Health, San Diego, CA; Nursing Executive Center interviews and analysis.*
Early Efforts to Standardize the CHW Role

State Efforts to Regulate Community Health Worker Role

**Oregon**
CHWs certified under state health authority’s 80 hour training qualify for reimbursement; CHWs, peer specialists, and navigators considered care team members

**Texas**
Since 2001, Advisory committee established core competencies to certify training programs; 3,000 CHWs state wide

**Map Key**
- Laws regulating CHWs in at least one of following areas: CHW advisory bodies, scope of practice, CHW certification, standard curriculum, reimbursement and integration into the care team
- No regulations in place

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1) Community Health Worker
2) Regulations in place as of December 2012.

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3 Instill Patient and Family Ownership for Self-Care

**Appeal to Patients’ Personal Motivators for Involvement**
11. Personally-Motivating Goal Incorporation
12. Non-Clinical Peer Advisor

**Equip Patients and Families with Tools for Self-Management**
13. Inpatient-Based Key Caregiver Skill Building
14. Personalized Patient Support Line

Patients Struggling to Understand Care Instructions

Percentage of Patients Not Understanding Some Aspect of ED Discharge Instructions

- 92%

Prose Literacy Levels of US Adults

- Proficient: 13%
- Below Basic: 14%
- Intermediate: 44%
- Basic: 29%

Helping Patients Stay on Track

Two Key Opportunities

1. Leverage Inpatient Stay to Build Self-Management Skills
2. Leverage Technology to Enable Personalized at Home Support

Sources:
1. Deficits in understanding of instructions included the following aspects of instructions: diagnosis, medication, home-care, follow-up, return to ED.

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Prose Literacy Levels of US Adults

- Basic
- Intermediate
- Proficient
- Below Basic

Percentage of Patients Not Understanding Some Aspect of ED Discharge Instructions

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Sources:

Helping Patients Stay on Track

Two Key Opportunities

1. Leverage Inpatient Stay to Build Self-Management Skills
2. Leverage Technology to Enable Personalized at Home Support

Sources:

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### Practice Makes Perfect

#### Practices for Teaching Self-Management Skills During the Inpatient Stay

<table>
<thead>
<tr>
<th>Practice</th>
<th>Capsule Description</th>
<th>Organization</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Learner Identification</strong></td>
<td>Nurse assesses patient’s self-management habits to identify who, besides the patient, should be present during discharge planning and patient education; goal to ensure patient education efforts include person most likely to carry out discharge instructions</td>
<td>Lehigh Valley Health Network</td>
<td>Nurse-Led Strategies for Preventing Avoidable Readmissions</td>
</tr>
<tr>
<td><strong>Three-Day Integrated Teach-Back</strong></td>
<td>Care team members sequence knowledge, attitude, and behavior education across three days, asking patients to teach back lessons daily; goal to ensure patients or key learners understand the patient’s condition, why key post-discharge actions are important, and how to consistently perform these actions</td>
<td>Lehigh Valley Health Network</td>
<td>Nurse-Led Strategies for Preventing Avoidable Readmissions</td>
</tr>
<tr>
<td><strong>Inpatient-Based Self-Management Skill Building</strong></td>
<td>Care team trains patient’s caregiver to perform care activities during inpatient stay to prepare caregiver for activities required for patient care post-discharge</td>
<td>Intermountain Healthcare</td>
<td>Today!</td>
</tr>
</tbody>
</table>

To access Nurse-Led Strategies for Preventing Avoidable Readmissions, visit advisory.com/nec/publications.

---

### Integrating Caregivers into the Care Team

#### Responsibilities and Roles for Intermountain’s “Partners in Healing” Program

- **Recruitment**
  - **Pre-Surgical Nurse**
    - Pre-surgery, assess patient fit for program (e.g., caregiver willingness, patient complexity)
    - Explain that program is voluntary
    - Document interest in log sheet for charge nurse

- **Orientation**
  - **Bedside Nurse**
    - Post-surgery, orient caregivers agreeing to participate in program
    - Review list of care activities, train caregiver to perform chosen activities
    - Explain use of care diary, tape diary to closet door
    - Place “Partners in Healing” sticker in charge nurse book, chart, cardex to signal participation

- **Daily Oversight**
  - **Bedside Nurse**
    - During patient stay, ensure care diary is being used properly, remains taped to patient’s door
    - Introduce “Partners in Healing” participant to oncoming nurse on next shift

- **Documentation**
  - **CNA**
    - Transfer information from caregiver’s care diary into EMR daily

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.
Integrating Caregivers into the Care Team

Case in Brief: Intermountain Healthcare

- 22-hospital integrated delivery system headquartered in Salt Lake City, Utah
- In 2008, Partners in Healing program piloted on thoracic surgery unit; has since expanded to vascular surgery unit; caregivers of surgical patients learn and perform care responsibilities while patient recovers in hospital; caregiver responsibilities range from routine tasks including ambulation and dietary needs, to medical tasks including changing TED hose and using incentive spirometer
- Nursing staff alert patient and caregiver to program prior to surgery to assess interest in participating; bedside nurse orients caregiver to program, provides caregiver with necessary materials following surgery
- Caregiver documents care activities in care diary, posted on closet door in patient room; bedside nurse ensures caregiver is properly documenting care; CNA transfers information into EMR
- 76% of patients reported the program enhanced their transition and 84% reported they would highly recommend the program

Training Family Members During the Hospital Stay

Excerpt of Intermountain’s “Partners in Healing” Training Points for Caregivers

1. Use Incentive Spirometer every 2 hours while awake
2. Cough with heart pillow
3. Get up to the chair for meals
4. Walk in hall
5. Assist with dietary needs
6. Change TED hose/Compression Boots
7. Get warm blankets as needed
8. Empty urine and record output
9. Wear gloves as needed
10. Understand fall risk prevention
11. Call for help with all equipment

Partner in Healing selects which activities they will perform and the bedside nurse provides instruction

Complete List of Training Points in Appendix.

1) For example, caregivers must wear gloves when performing care tasks with bodily fluids.
### Partners in Care Document Activities in Care Diary

#### Excerpt of Intermountain’s “Partners in Healing” Care Diary for Caregivers

<table>
<thead>
<tr>
<th>TIME</th>
<th>Incentive Spirometer</th>
<th>Chair for Meals</th>
<th>Walk in Hall</th>
<th>Fluids</th>
<th>Urine</th>
<th>TED/comp. boots</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 AM</td>
<td>X</td>
<td></td>
<td></td>
<td>240 mL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 AM</td>
<td>750-1000 x10</td>
<td>X</td>
<td></td>
<td>200 mL, yellow clear</td>
<td>Change</td>
<td></td>
</tr>
<tr>
<td>11 AM</td>
<td></td>
<td></td>
<td></td>
<td>Wash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 PM</td>
<td>500-750 x10</td>
<td>X</td>
<td>120 mL</td>
<td>400 mL, yellow clear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 PM</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Care diary taped to closet door in patient room and reviewed daily by bedside RN
- CNA transcribes documentation from care diary into EMR

Complete Care Diary in Appendix.

### Improving Caregiver Confidence in Caring for Loved One

#### Percentage of Patients and Caregivers Agreeing or Strongly Agreeing that “Partners in Healing” Greatly Enhanced Their Transition Home

- 76%

#### Percentage of Patients and Caregivers Agreeing or Strongly Agreeing that They Would Highly Recommend the Program to Other Patients and Families

- 84%

Preparing Patients for a Successful Transition

“I learned to trust myself as well as earn the trust of my wife once we leave the hospital.”

Participant in “Partners in Healing”
Key Features of Mayo’s Personalized Patient Support Line

- **Support Line RN has Full Access to EMR**
  - Including clinician notes, lab results, discharge instructions, etc.

- **Support Line RN Has Access to Protocols, Tools and Templates**
  - Standardizes care across system

- **Support Line RN Documents Interactions in EMR**
  - Ensures all care team members aware of patient interaction

- **Support Line RNs Serve Whole Region**
  - Patients from any Mayo clinic call support line 24/7 to speak to next available nurse, regardless of location; all support line nurses report to a common manager

---

**Case in Brief: Mayo Clinic**

- 13-hospital health system headquartered in Rochester, Minnesota with 88 physician clinics across three states in the Mayo Network
- In 2008, Mayo piloted nurse support line in six clinics; began expansion to 82 surrounding clinics across three states in July 2013
- Patients have 24/7 access to support line, can access support nurses through their PCP’s main office number
- Nurses serve as extension of primary care team with full access to view and document in EMR; nurses have authority to prescribe for some conditions (e.g., conjunctivitis, UTI)
- Nurses staffing support line utilize clinical decision support software developed by Mayo with over 140 algorithms and 28 protocols; nurses often able to give patients advice that enables them to care for themselves at home; patients calling support line directed to more appropriate level of care 66% of the time
- Nurses staffing support line work from home under a centralized call center
- In 2013, Mayo realized $1.25 million in cost savings across initial six clinics, with staffing for the line remaining cost neutral; 98% of patients satisfied with support line
Questions to Discuss with Potential Primary Care Partners

- How will the support line impact our PCP clinic’s workload?
- How does the support line nurse interact with the clinic-based care team?
- How will the support line impact the primary care clinic’s business?

Mayo’s Response

- Patients with low-acuity care needs can consult immediately with an RN, enabling clinicians to dedicate time to patients requiring an office visit.
- Support line nurse extends capacity of the clinic team by using patient’s record to view key information from clinicians and documenting support line interactions for other clinicians to see.
- Support line nurse ensures patient receives timely, appropriate care and reduces time PCP office spends triaging; increases patient satisfaction by providing a timely alternative to waiting for the PCP to return the patient’s call.

Over a Million in Savings from Redirected Care

Percentage of Patients Directed to a More Appropriate Level of Care from Mayo’s Support Line¹

66%

$1.25M
Cost savings from re-directed care through support line in 2013

¹) Determined by the patient’s answer to the question, “We’re directing you to (a care setting), what did you expect you would have done if you didn’t speak to the nurse today?” 66% of patients are directed by the support line nurse to a care setting that is different from where they initially expected to seek care. Results based off of cost savings from initial six clinics.

Source: Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.
Rethinking the Patient Engagement Strategy

**Chronic Disease Management Today**

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Ideal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal of education is clinically focused</td>
<td>Goal of education is skill development</td>
</tr>
<tr>
<td>Focus heavily on clinical knowledge</td>
<td>Implement behavior modification</td>
</tr>
<tr>
<td>Provide education in the physician’s office</td>
<td>Provide multiple sites, options for education</td>
</tr>
</tbody>
</table>

**“The Daily-ness of Disease”**

“We don’t have a systematic way of getting people to really buy into what I call the daily-ness of the disease—what it really means to have diabetes and have it every day for the rest of your life.”

*Shantanu Nundy, MD, Former Clinical Instructor at the University of Chicago Medicine*

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**Scale Up Support for Vulnerable Populations**

**Invest in Targeted Services for Select Populations**

15. NP-Led Clinic for the Medically Complex
16. ED Alternatives for Homeless Patients
17. Remote Telemonitoring for the Frail Elderly
Current System Not Enough for the Medically Complex

20.8 Minutes
Average duration of adult primary care visit

- Clinician does not have time to address psychosocial factors
- Patient leaves with incomplete understanding of instructions and next steps

Improving Outcomes for the Medically Complex with a Dedicated Clinic

30-Day Heart Failure Readmission Rate at Mackenzie Health

Before Heart Failure Clinic: 23%
After Heart Failure Clinic: 0%

$1M
Estimated cost avoidance in first six months of Mackenzie Health Heart Failure Clinic

Source: Mackenzie Health, Richmond, ON; Nursing Executive Center interviews and analysis.
Improving Outcomes for the Medically Complex with a Dedicated Clinic

**Clinic in Brief: Mackenzie Health’s Heart Failure Clinic**

- Clinic is part of Mackenzie Health, a health system headquartered in Ontario, Canada.
- In February 2014, established a clinic for heart failure patients to help them manage their care post-discharge; the clinic is located in Mackenzie Hospital.
- Patients visit clinic and receive follow-up phone calls from clinic’s NP until the patient is equipped to self-manage and transition back to primary care.
- The Heart Failure Clinic is staffed by one NP who has extensive experience working with heart failure patients; it is open two days a week; on each day, the NP sees five returning patients and two new referrals in partnership with cardiologist.
- While patient is hospitalized, NP actively participates in care planning and day-to-day care in collaboration with cardiologists, nurses and allied health professionals; during the outpatient follow-up period, NP provides tailored health teaching, adjusts medications as indicated, and makes referral for advanced heart failure therapy.
- The NP typically follows the patient for 1-3 months before the patient transitions back to primary care; follow-up duration is based on the patient’s risk for readmission and rate of recovery.

**Establishing a Clinic for Medically-Complex Patients at Trinity**

**Key Elements of Trinity Mother Frances' Intensive Medical Home**

- **Patients Referred to Clinic from Primary Care Clinics and the ED**
- **Convenient Location**
  - On Site of the Largest Trinity Mother Frances Primary Care Facility
- **First Patient Visit**
  - Is One Hour Long;
  - Attended by Physician and NP
- **Follow-Up Visits**
  - Conducted by NP;
  - Focus on Self-Management
- **Patients Are Discharged from Clinic to Primary Care When Complex Needs Resolved**
Establishing a Clinic for Medically-Complex Patients at Trinity

Case in Brief: Trinity Mother Frances Hospitals and Clinics

- Six-hospital health system based in Tyler, Texas; includes 36 clinic locations
- In June 2014, opened Intensive Medical Home for patients with high-intensity care planning needs; eligible patients include patients with three or more ED visits in six-month span, three or more chronic conditions (e.g., diabetes, COPD), acute medical illness with need for immediate follow-up to avoid admission or ED
- The Intensive Medical Home is located at Trinity Mother Frances’ largest primary care site; hours reflect typical primary care clinic; clinic is funded as one of Trinity Mother Frances’ 11-99 waiver projects
- Appointments conducted by physician internist and an NP; the physician internist conducts the first patient appointment along with the NP; the NP is responsible for all follow-up appointments
- Average visit duration is one hour; patient medical needs addressed, patient connected to wraparound services (social work, home care)
- Clinic staffing consists of two RNs, one LPN, one clinical pharmacist, and one mental health clinician; RNs responsible for care coordination, transition management, pre- and post-assessment; LPN responsible for patient rooming, paperwork, scheduling appointments

Setting Clear Criteria for Patient’s Inclusion in Clinic

Inclusion Criteria for Trinity Mother Frances Hospitals and Clinics Intensive Medical Home

- Three or more ED visits in span of six months
- Three or more chronic conditions (e.g., hypertension, diabetes, COPD); patient requires intensive care planning
- Acute medical illness with need for immediate follow-up to avoid readmission or ED visit (e.g., pneumonia, sepsis)
- One or more hospitalization with medical disease(s)

Average number of chronic conditions for Intensive Medical Home patients: 3
Staffing a Clinic for Medically-Complex Patients

Intensive Medical Home Care Team Members

<table>
<thead>
<tr>
<th>Role</th>
<th>FTEs</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP</td>
<td>1.0 per 600 patients</td>
<td>Sees patient for initial visit, all follow-up visits</td>
</tr>
<tr>
<td>PCP</td>
<td>0.5 per 600 patients</td>
<td>Sees patient for initial visit with NP</td>
</tr>
<tr>
<td>RN Navigator</td>
<td>1.0 per 200 patients</td>
<td>Primary point of patient contact; provides patient education, assists with care plan implementation</td>
</tr>
<tr>
<td>LVN Care Coordinator</td>
<td>1.0</td>
<td>Enrolls referrals, schedules appointments, conducts health screenings</td>
</tr>
<tr>
<td>Mental Health Clinician</td>
<td>1.0</td>
<td>Provides behavioral health treatment, support when needed</td>
</tr>
<tr>
<td>Clinical Pharmacist</td>
<td>1.0</td>
<td>Performs medication reconciliation at patient visit; provides ongoing medication counsel and support</td>
</tr>
</tbody>
</table>

Source: Trinity Mother Frances Hospitals and Clinics, Tyler, TX; Nursing Executive Center interviews and analysis.

Decreasing ED Use and Hospital Admissions

ED Utilization from Trinity Mother Frances’ NP-Led Clinic Patients

Baseline 1 12 Months at Clinic 66% decrease

Hospital Admissions from Trinity Mother Frances’ NP-Led Clinic Patients

Baseline 1 12 Months at Clinic 83% decrease

1) Average utilization for zero months at clinic.
Homeless Especially Vulnerable to Costly Care

Likelihood of homeless individual having an ED visit in the last year compared to non-homeless individual

Likelihood of homeless individual having unmet care needs in the last year compared to non-homeless individual

Average Patient Cost per Admission

$2,559 more

Non-Homeless Patients

Homeless Patients


Introducing Yale-New Haven Hospital’s Medical Respite Center

Yale-New Haven Hospital’s Medical Respite Program

12-bed facility located within Columbus House homeless shelter

Open to individuals lacking suitable housing, recovering from or preparing for medical condition or procedure

Maximum length of stay is 30 days

Program staffing consists of one program manager (1.0 FTE), one patient navigator (1.0 FTE), and one supervisor per shift (24/7; 2.0 FTEs)

Source: Yale-New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.
Introducing Yale-New Haven Hospital’s Medical Respite Center

Case in Brief: Yale-New Haven Hospital

- 1,541-bed hospital located in New Haven, Connecticut; part of Yale-New Haven Health System
- In 2013, partnered with local homeless shelter Columbus House, to provide respite care to homeless patients upon discharge from hospital
- Respite program staff funded by State of Connecticut grant, medical care at respite center reimbursed through Medicaid, other private insurance
- 12-bed facility located on third floor of Columbus House; staffing includes 24-hour supervisory staff, one shelter navigator (MSW), one program manager; home care nurses from local agencies visit daily, physician assistant from local clinic visits three times a week
- To connect patient to respite center, homeless patients flagged in hospital EMR, case managers verify eligibility and evaluate needs; shelter navigator meets with patient to explain program
- Eligible patients must lack suitable housing, be psychiatrically stable, be willing to remain substance-free during stay; eligible patients’ medical issues must be expected to be resolved in 30 days or less, must be independent in Activities of Daily Living
- Upon discharge from respite care, patients receive housing voucher based on public housing agency criteria for eligibility, and connected to primary care at local Yale-New Haven clinic
- Since establishment of Medical Respite Center, 29% reduction in readmissions of homeless population to Yale-New Haven Hospital; estimated Medicaid savings of $400,000

Creating a Safe Haven for Medical Recovery

Key Components of Yale-New Haven Hospital’s Medical Respite Program

- Open to Patients with Recent Acute Episode
- Patients Receive Daily Medical Care
- Patients Provided with 24-Hour Accommodation
- Patients Connected to Long-Term Housing Based on Eligibility
- Patients Receive Referral to Primary Care at Departure from Respite Program

Source: Yale-New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.

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1) Physician assistant.
Staffing the Medical Respite Program

Clinical Staff Roles

- **Home Care Nurse**
  - Visits shelter patients daily
  - Employed by local home care agencies
  - Visit reimbursed by patient insurance

- **Physician Assistant**
  - Visits shelter three times a week, checks on patients with more complex medical needs
  - Employed by Yale-New Haven Hospital

Non-Clinical Staff Roles

- **Medical Respite Center Supervisor**
  - Staff dedicated solely to Medical Respite Center, present 24/7
  - Salary funded by State of Connecticut grant; employed by Medical Respite Center

- **Medical Respite Center Navigator**
  - Assesses patients for eligibility
  - Secures housing vouchers and other community resources for patients
  - MSW-trained
  - Employed by Medical Respite Center

Setting Clear Inclusion (and Exclusion) Criteria for Patients Who Can Participate

**Inclusion Criteria**

- Lacks suitable housing:
  - Currently staying at a shelter
  - Residing on the streets
  - Doubling up with friends, unable to secure alternate arrangement

- Has an acute or post-acute medical illness requiring short-term care, or needs an environment in which to recover from/prepare for medical procedure

- Is able to comply with medical recommendations and program rules

**Exclusion Criteria**

- No medical need; primarily needs shelter/housing

- Dependent for ADLs\(^1\); unable to ambulate independently or with mechanic assistance; incontinent of bowel and/or bladder

- Requires hospital-level of care or other medical care (skilled nursing, rehabilitation hospital)

- Has primarily psychiatric need

1) Activities of daily living

Complete Checklist of Eligibility Criteria in Appendix.
Reducing Readmissions and Medicaid Spending

Average Monthly Readmission Rate for Homeless Patients at Yale-New Haven Hospital

Before Medical Respite Program Inception

After Medical Respite Program Inception

29% decrease

$400,000
Estimated annual Medicaid cost savings from Yale-New Haven Hospital’s Medical Respite Program

Practice #17: Remote Telemonitoring for the Frail Elderly

Seeing a Return from Remote Monitoring for Elderly

Readmission Rates at Methodist Le Bonheur

2014

~16%

10%

System Overall\(^1\)

Home Health Patients with Telemonitoring\(^2\)

76.5
Average age of patients enrolled in Methodist Le Bonheur’s remote telemonitoring program

100
Number of patients currently enrolled in Methodist Le Bonheur’s remote telemonitoring program

$750,000
Estimated annual savings\(^3\) from Methodist Le Bonheur’s remote telemonitoring program

\(^1\) Medicare 30-day readmission rate for Methodist Le Bonheur Healthcare adult hospitals.
\(^2\) Medicare 30-day readmission rate for Methodist Alliance Home Health patients with telemonitoring.
\(^3\) From avoided 30-day readmissions.
Case in Brief: Methodist Alliance Home Care

- Home health agency located in Memphis, Tennessee; part of Methodist Le Bonheur Healthcare
- In 2011, began providing remote telemonitoring in conjunction with home health program; started with 25 telemonitoring units, targeted CHF patients in first year
- Currently deploy telemonitoring to patient base of 100; broadly target rising-risk patients who have multiple comorbidities, eligible for Medicare, Medicaid; average user age 76.5 years
- Telehealth aides train patients and clinicians on using devices, troubleshoot technical issues at patient home; home health nurse monitors devices, and serve as point of contact for patient questions, responsible for patient follow-up
- Methodist Alliance does not receive any reimbursement for equipment rental fees or maintenance of devices, nursing staff; cost of use approximately $200 a month per patient, annual program cost $184,000
- Since establishing remote telemonitoring program, Methodist Alliance Home Health estimates savings of $750,000 per year in prevented hospital 30-day admissions

Optimizing Telehealth for Elderly Patients

Guidance for Nurse Leaders

- Use a Holistic Assessment to Capture Patient Risk
- Boost Enrollment with an Opt-Out Strategy
- Assign Patients According to Acuity
### Frail Elderly Often Overlooked in Standard Assessment

#### Typical Remote Monitoring Patient Selection Criteria

<table>
<thead>
<tr>
<th>Patient Selection Criteria</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient willing to participate?</td>
<td>Health Management</td>
</tr>
<tr>
<td>Yes</td>
<td>- Principal diagnosis</td>
</tr>
<tr>
<td>No</td>
<td>- Polypharmacy</td>
</tr>
<tr>
<td>What is the patient’s chronic disease diagnosis?</td>
<td>- Problem medications</td>
</tr>
<tr>
<td>COPD</td>
<td>- Prior hospitalization</td>
</tr>
<tr>
<td>Diabetes</td>
<td>- Palliative care</td>
</tr>
<tr>
<td>Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Other: _______________</td>
<td></td>
</tr>
</tbody>
</table>

**Psychosocial needs remain unevaluated**

#### Standardized Screening Tool at Vanguard Medical Group

| Risk Factors: |
| Health Management |
| - Principal diagnosis |
| - Polypharmacy |
| - Problem medications |
| - Prior hospitalization |
| - Palliative care |
| Behavioral Health |
| - Psychological |
| Social Frailty or Lifestyle |
| - Poor health literacy |
| - Lack of patient support at home |

**Need for remote telemonitoring triggered by four or more risk factors**

**Risk factors take into account patients’ frailty and lifestyle needs**

### Boost Enrollment with Opt-Out Strategy

**Opt-In Enrollment Strategy**

- Telemonitoring presented to patients as optional during follow-up
- Patients must proactively agree to participate in telemonitoring program

**Patients often decline participation**

**Opt-Out Enrollment Strategy**

- Patients introduced during hospitalization
- Program integrated into post-discharge planning

**Patients automatically enrolled unless they decline**

### Choosing Their Moment

“You want to introduce this strategy to keep people out of the hospital while they’re still in the hospital. It helps them realize that they’re willing to try anything to stay out. By the time they’re in follow-up, they may have forgotten how terrible they felt.”

Melissa Palacios, Telehealth Program Project Manager, Sharp Rees-Stealy
## Assign Patients According to Acuity

### Guidance for Nurse Leaders

<table>
<thead>
<tr>
<th>Sample Priority</th>
<th>Recommended Owner</th>
<th>Use of Remote Patient Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce hospital readmission rates</td>
<td>Care Management</td>
<td>Monitor patients with high-intensity chronic conditions (e.g., COPD, CHF) that require frequent clinician-patient communication</td>
</tr>
<tr>
<td>Emphasize wellness and preventive treatment</td>
<td>Patient-Centered Medical Home</td>
<td>Monitor patients with less acute chronic conditions (e.g., diabetes, hypertension) contributing to long-term patient health outcomes</td>
</tr>
</tbody>
</table>

---

### Targeting Support to the Right Patient Group

**Which patient population should you target for additional support?**

**Questions to Consider:**

- Which patient populations have needs that are unmet by your organization?
- What percentage of your total patient population is this group?
- How much is this population costing your organization, relative to your overall patient population?
Achieving Care Continuity

Best Practices for Building a System that Never Discharges the Patient

1 Equip Clinicians to Provide Continuous Care
   
   **Ensure Easy Access to “Need-to-Know” Patient Information**
   
   4. Connect the Care Plan Across Settings

2 Promote Clinician Ownership for Cross-Continuum Care
   
   **Broaden the Front Line’s Perspective Beyond Their Own Setting**
   
   4. Incentivize Continuous Care

   1. The “Critical Eight” Survey A-/B
   2. Motivational Interviewing A-B+
   3. Patient Preference Discussion Guide A/C+
   4. Shared Cross-Setting APN B+/B+
   5. Cross-Continuum Care Agreement A-/B
   6. Cross-Continuum Care Pathway A/C
   7. Cross-Continuum Shared Governance B+/B
   8. Alternative Care Setting Experience A-/C+
   9. Continuum-Focused Leader Incentive Plan A/B
   10. Frontline Organizational Alignment Bonus A-/B

Grade Key

Impact on Care Continuity (A = Highest Impact) / Ease of Implementation (A = Easiest to Implement)

Achieving Care Continuity

Best Practices for Building a System that Never Discharges the Patient

3 Instill Patient and Family Ownership for Self-Care
   
   **Appeal to Patients’ Personal Motivators for Involvement**
   
   11. Personally-Motivating Goal Incorporation A-/B
   12. Non-Clinical Peer Advisor A/B-

4 Scale Up Support for Vulnerable Patients
   
   **Equip Patients and Families with Tools for Self-Management**
   
   13. Inpatient-Based Key Caregiver Skill Building B/B+
   14. Personalized Patient Support Line A/C
   15. NP-Led Clinic for Medically Complex A/C+
   16. ED Alternatives for Homeless Patients A/C+
   17. Remote Telemonitoring for Frail Elderly A/C+

Grade Key

Impact on Care Continuity (A = Highest Impact) / Ease of Implementation (A = Easiest to Implement)
# Road Map

1. **Why We Need to Stop Thinking About “Care Transitions”**

2. **Best Practices for Building a System that Never Discharges the Patient**

3. **Returning to Our Larger Ambition**

## How Should You Sequence Your Efforts?

**Care Continuity Audit**

*Answer the questions below to assess which imperative(s) your organization should prioritize to improve care continuity. Multiple “yes” answers indicate the imperative is a priority.*

<table>
<thead>
<tr>
<th></th>
<th>Equipment</th>
<th>Promote Clinician Ownership for Cross-Continuum Care</th>
<th>Instill Patient and Family Ownership for Self-Care</th>
<th>Scale Up Support for Vulnerable Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Equip Clinicians to Provide Continuous Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Do clinicians spend excessive time searching for patient information?</td>
<td>- Are clinicians often unaware of how care is delivered in other settings?</td>
<td>- Are patients often unmotivated to follow their care plan?</td>
<td>- Are clinicians consistently struggling to meet the needs of specific patient populations?</td>
</tr>
<tr>
<td></td>
<td>- Do patients experience gaps or duplication in care across settings?</td>
<td>- Do clinicians only feel accountable for outcomes related to their immediate care setting?</td>
<td>- Are patients often confused about how to follow their care plan correctly?</td>
<td>- Are you failing to see an ROI on targeted efforts to improve continuity for a vulnerable population?</td>
</tr>
</tbody>
</table>
Care Continuity Guiding Us Toward Patient-Centered Care

**Present**

**Discharge**

“To relieve of a charge, load, or burden.”

“To unload.”

“To release from an obligation.”

**Future**

1. Equip Clinicians to Provide Continuous Care

2. Promote Clinician Ownership for Cross-Continuum Care

3. Instill Patient and Family Ownership for Self-Care

4. Scale Up Support for Vulnerable Patients

**Patient-Centered Care**

“The attributes [of patient-centered care] can be organized into four key areas: ‘whole person’ care, comprehensive communication and coordination, patient support and empowerment, and ready access.”

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1) Merriam-Webster definition of “discharge.”

2) Attributes of “patient-centered” care identified by the National Partnership for Women and Families through focus-group and survey research with patients.

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Appendix

• Premier Health’s Top 1% RN Navigator Job Description................................................................. 2
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Premier Health’s Top 1% RN Navigator Job Description

Position: Advanced Illness Management (AIM) Navigator, Registered Nurse (RN)

Date: ________________________________________

Approved By: ________________________________________

Executive Director

Organizational Unit: Clinical Operations

Reports To: Manager, Palliative Care

SUMMARY OF POSITION

The Registered Nurse Navigator will be an integral member of the Advanced Illness multidisciplinary team. Together with nurses, social workers and community health coaches, the RN Navigator will oversee the enrollment of new patients into the project, assess health care needs and oversee care plan implementation, help develop care management strategies, and work with team members to provide linkages for the various health and social needs of patients with cost effective solutions. The team works in the field in a variety of settings, including patient homes, medical centers, and the ED/inpatient floors of each city hospital.

DIMENSIONS

Interventions according to program and physician’s plan of care.

NATURE AND SCOPE

Must have available phone to communicate and transportation, with appropriate licensure and insurance, to visit homes and other sites. Interacts with physicians, nurses, social workers and other disciplines, administrative personnel, and community resources.

QUALIFICATIONS

• Current RN licensure in the State of Ohio
• 2-3 years of experience providing clinical services; experience in home care or community/outpatient setting preferred
• Ability to effectively provide clinical care to socially and medically complex patients in a variety of non-traditional settings
• Ability to work collaboratively in a team and manage multiple priorities, utilize effective time management skills, and exercise sound administrative and clinical judgment
• Demonstrated ability to work well with people of various ages, backgrounds, ethnicities, and life experiences
• Exceptional organizational and interpersonal skills, with attention to detail required; strong oral/written communication skills is a must
• Computer skills necessary
• Must be capable of standing, stooping, bending and lifting up to 50 lbs
• Other duties and responsibilities as directed

Source: Premier Health, Dayton, OH.
ACCOUNTABILITIES

1. Conduct initial assessments to potential patients eligible for enrollment
2. Work in conjunction with social worker on intake assessment including medical needs/barrier identification of patients referred and enrolled in the program; determine care plan; coordinate care plan and delegate tasks to team members
3. Engage patients across care settings such as the transition from hospital to home
4. Act as a liaison between hospitals, primary care providers, specialists, community resources and managed care/insurance plans on behalf of enrolled patients to ensure patient-centered coordination of care
5. Serve as a patient advocate and assist in the identification and improvement of service delivery
6. Promote wellness and the management of chronic diseases within the community
7. Improve healthcare access and promote client knowledge and behavior change
8. Provide direct supervision of the project’s clinical support staff including LPNs and health coaches; develop and maintain partnerships with hospitals, medical offices and local service organizations to broaden support services for patients
9. Enter and maintain electronic records, compile reports and complete other program documentation in a timely manner
10. Participate in interdisciplinary case conferences/team meetings/readmission meetings
11. Monitor collected data; ensure progress of care management towards programs goals

________________________________________  _________________________________________
Signature                                          Date
Premier Health’s Top 1% MSW Navigator Job Description

Position: Advanced Illness Management (AIM) Navigator, Medical Social Worker (MSW)

Date: ____________________________

Approved by: ____________________________
Executive Director

Organizational Unit: Clinical Operations

Reports to: Manager, Palliative Care

SUMMARY OF POSITION

The Social Worker will be an integral member of the AIM multidisciplinary team. Together with nurses and community health coaches, the Social Worker will assist in care plan implementation, provide short-term counseling to patients, help develop care management strategy for enrolled patients and help create linkages for the various health and social needs of patients. The team works in the field in a variety of settings, including patient homes, medical centers, and the ED/inpatient floors of each Premier Health hospital.

DIMENSIONS

Interventions according to program and physician’s plan of care.

NATURE AND SCOPE

Must have available phone to communicate and transportation, with appropriate licensure and insurance, to visit homes and other sites. Interacts with physicians, nurses, social workers and other disciplines, administrative personnel, and community resources.

QUALIFICATIONS

• MSW required; Current licensure (LSW, LISW preferred) in the State of Ohio
• 3-4 years’ experience providing clinical services; experience in home care or community/outpatient setting preferred
• Ability to effectively provide clinical care to socially and medically complex patients in a variety of non-traditional settings
• Ability to work collaboratively in a team and manage multiple priorities, utilize effective time management skills, and exercise sound administrative and clinical judgment
• Demonstrated ability to work well with people of various ages, backgrounds, ethnicities, and life experiences
• Exceptional organizational and interpersonal skills, with attention to detail required; strong oral/written communication skills is a must
• Computer skills necessary
• Must be capable of standing, stooping, bending and lifting up to 50 lbs
• Other duties and responsibilities as directed

Source: Premier Health, Dayton, OH.
Premier Health’s Top 1% MSW Navigator Job Description

ACCOUNTABILITIES

1. Work in conjunction with nurse navigator on intake assessment including social needs/barrier identification of patients referred and enrolled in the program; determine plan for care with nurse navigator; responsible for management and completion of social/behavioral tasks for each individual patient
   - Tasks may include, but are not limited to:
     o Education geared toward self-reliance and independence
     o Interventions aimed at reducing barriers to medical care
     o Coordinate behavioral health services
     o Assist patient in making appointments as necessary and accompany patients to appointments as needed
     o Referrals to community resource services
2. Engage patients across care settings such as the transition from hospital to home
3. Assist patients and their families with personal and environmental difficulties which predispose them toward illness or interfere with achieving maximum level of functioning and self-sufficiency
4. Act as a liaison between hospitals, primary care providers, specialists, community resources and managed care/insurance plans on behalf of enrolled patients to ensure patient-centered coordination of care
5. Serve as a patient advocate and assist in the identification and improvement of service delivery
6. Provide crisis intervention as needed
7. Provide direct supervision to the community health coach
8. Develop and maintain partnerships with local service organizations and community resources to broaden support services for patients
9. Provide Notary Public services to patient/family members in order to complete Advance Directives
10. Enter and maintain electronic records, compile reports and complete other program documentation in a timely manner, other administrative responsibilities as needed
11. Participate in interdisciplinary case conferences, staff meetings and team meetings
12. Play a consistent and active role in program development and growth
13. Meet on a regular basis with clinical supervisor to review case workload

________________________________________
Signature

________________________________________
Date
Root Causes of Patients Receiving Fragmented, Episodic Care

Patients receive fragmented, episodic care

- Patients don’t have insurance
- Patients lack transportation
- Patients don’t have access to care
- Patients don’t have economic resources

- Patients are not engaged in their care outside of the acute care setting
- Patients have resources to effectively engage in their care but don’t engage

- Patients don’t understand their care plan
- Patients can’t get information on where they should go for care
- Patients don’t know who to call for care

- Clinicians don’t know how to provide site-specific care
- Clinicians feel accountable for meeting patient needs beyond their immediate setting

- Clinicians have a discipline-specific focus on site-specific care
- Clinicians have a discipline-specific focus on their care site

- Clinicians report up to a site leader who doesn’t have a site leader
- Leaders lack incentives to focus on processes

Source: Nursing Executive Center interviews and analysis.
Mayo Clinic’s Primary Care Clinician Survey

Site Name: ____________________ Name of RN Completing Survey: ____________________

Please placing a checkmark next to the most applicable option, and complete text fields at the end of the survey.

1) Volume of high-risk patient messages received:
   - 0-2
   - 3-5
   - 6-10
   - >10

2) Volume of high-risk patient messages with follow-up:
   - 0-2
   - 3-5
   - 6-10
   - >10

3) Did you use the toolkit phone script for the initial assessment?
   - Yes
   - No

4) If you did not use the phone script, what best describes the reason why?
   - Our practice uses a different tool
   - The phone script was not readily accessible to me
   - I was uncomfortable using the phone script
   - Other, please specify: ____________________________

5) Time for each initial assessment call:
   - 0-2 minutes
   - 3-5 minutes
   - 6-10 minutes
   - >10 minutes, please specify: __________

6) Resources used for determining most appropriate patient intervention:
   - Hospital (discharge) summary in synthesis
   - Other medical record information, please specify: ____________________________
   - Clinic/practice protocols
   - Clinical/procedure notes
   - Provider recommendation/advice
   - Other, please specify: ____________________________
Mayo Clinic’s Primary Care Clinician Survey

7) Intervention most used for ongoing care:
   - Initial phone call assessment only
   - Office visit scheduled
   - Home visit (as applicable to practice)
   - Follow-up phone call
   - Other, please specify: __________________________

8) What information is most helpful to you to be able to assist the patient with this transition?
   - Wound care/dressing changes
   - Current medications
   - Follow-up appointments
   - Significant psychosocial history
   - Medical concerns
   - Chronic disease management concerns
   - Reason for hospitalization
   - Recent surgery/procedures
   - Level of assistance/support systems (e.g., family or friend, community resources)
   - Safety concerns (e.g., fall or aspiration risk)
   - Education needs (e.g., medication reinforcement, drain care)
   - Level of pain/quality of sleep
   - Ability to complete ADLs
   - Other, please specify: __________________________

9) On average, how often were you able to initiate an initial assessment call within 72 hours of receiving Message Center communication?
   - 100% of time
   - 75% of time
   - 50% of time
   - 25% of time
   - Never

10) What additional information would be helpful for you to provide ongoing care for a patient?

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________

11) Please specify any other concerns or areas for improvement:

   ________________________________________________________________

   ________________________________________________________________

1) Activities of daily living.
Per the institutional Discharge Summary Policy, the following categories are included in the discharge summary (sent from the hospital to the primary care team at time of patient discharge):

- **Dates of hospitalization** (admission and discharge dates)
- **Primary diagnosis** (the condition established after study that was found to be the reason for admission)
- **Secondary diagnoses** (all medical conditions that co-exist at the time of admission or develop during the hospitalization and require clinical evaluation, therapeutic treatment, or diagnostic procedures, even if resolved by discharge)
- **Reason for admission**
- **Hospital course** (care, treatment, and services provided)
- **Procedures performed** (if applicable)
- **Pending studies** (if applicable)
- **Discharge medications** including:
  - Continued medications (pre-admission medications to continue)
  - New medications (started during hospitalization and to continue)
  - Discontinued medications (pre-admission medications discontinued)
- **Condition at discharge**
- **Discharge disposition**
- **Discharge instructions** provided to the patient and caregiver(s)
- **Follow-up recommendations**
- **Follow-up contact information**
Valley Health System’s Shared Cross-Setting APN Job Description

APN, Care Navigator

PERSONAL AND CONFIDENTIAL

JOB DESCRIPTION INFORMATION

Job Summary:
To act as a facilitator of collaboration across the care continuum. To interface with acute care and extended care facilities, foster physician relationships, assist in the coordination and facilitation of clinical review of potential clients. Provides clinical leadership, expertise, collaboration, consultation and mentorship to promote evidence-based nursing practice. To develop and evaluate a program of care using transitional models of care, i.e. Naylor & Coleman.

Education:
Masters Degree/MSN Program which includes Pharmacology in its required curriculum. Certification as a Nurse Practitioner in the State of New Jersey, Clinical Nurse Specialist, or Advanced Practice Nurse by a national accrediting organization, which is approved by the Board.

Experience:
Two plus years of clinical experience in the home health setting, acute care setting, skilled nursing facility, physician’s office or in a community setting.

Special Skills:
Current and valid NJ State Professional Registered Nurse license. Certification through NJ State Board of Nursing, in accordance with the NJ Advanced Practice Nurse Certification Act. National or Board Certification as appropriate in area of specialty. American Heart Association Basic Life Support Healthcare Provider Certification. Collaborating Physician(s) of Record, as per the APN Act and Regulations, if appropriate to role. Demonstrates effective interaction and communication (oral, writing, presenting) skills. Effective organization skills and ability to perform work accurately and pay attention to details, often changing from one task to another without loss of efficiency or composure. Ability to function competently in stressful situations and a changing work environment related to changing patient needs, including working with patients with acute, chronic, and complex disease processes, and those who are dying. Ability to work cooperatively within the health-system; with patients and family members; and with multidisciplinary team members. Ability to utilize effective time management to set priorities, perform job related responsibilities, and respond quickly to emergency situations. Ability to use critical thinking and clinical reasoning skills effectively problem-solve and deliver care. *Reliable and applicable transportation as it relates to the responsibility of the job. Driver’s License - current and valid driver’s license, registration and insurance coverage required for all vehicles being driven for VHC business. Employees must adhere to all procedural guidelines in HR Policy 108 including demonstrating an acceptable driving record for the duration of their employment as long as driving continues to be a responsibility of the job.

Supervision Received:
Supervision by Director, Hospice.

Source: Valley Health System, Ridgewood, NJ.
Valley Health System’s Shared Cross-Setting APN Job Description

Working Conditions:
Travel between facilities.

Contacts/Customers:
Frequent contacts are with patients, family members, physicians, and peers, in a variety of situations.

OHSA Requirements:
OSHA Bloodborne Pathogen Category I
Employees in this job description are expected to have contact with bloodborne pathogens and as such they are required to be oriented and annually trained under the Federal Occupational Safety and Health Administration’s Bloodborne Pathogen Standard (C FR1910.1030).

Physical Efforts
Exposure to normal patient care area hazards, infections, puncture wounds, strains and sprains, blood-borne pathogens, HIV related illnesses, and varying noise levels. Requires lifting, pushing or pulling of up to 50-150 pounds occasionally with frequent lifting and carrying of up to 25 pounds; considerable standing, walking, sitting, reaching, filing, typing, and photocopying. Occasional stooping, kneeling, and crouching required. Constant talking and listening required.

EVALUATION REQUIREMENTS
• TB Compliance
• Mandatory Education
• Annual N95 Respirator Fit Testing
• Updated Professional Profile

STATEMENT OF UNDERSTANDING AND COMPLIANCE WITH THE VALLEY HEALTH SYSTEM CODE OF ETHICS
I, the employee, certify that I have read and understand the Corporate Compliance Program and the Code of Ethics and agree to abide by it during the entire term of employment. I certify that I have completed the new hire annual program on Corporate Compliance as part of Valley Health System’s annual mandatory education policy. I acknowledge that I have a duty to report any alleged or suspected violation of the Corporate Compliance Program or the Code of Ethics to the Compliance Officer. Unless otherwise noted below, I am not aware of any possible violation of the Corporate Compliance Program or the Code of Ethics.

S.E.R.V.E

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
<th>Rating Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>3</td>
<td>Role Model</td>
</tr>
<tr>
<td>M</td>
<td>2</td>
<td>More Often Than Not</td>
</tr>
<tr>
<td>I</td>
<td>1</td>
<td>Needs Improvement</td>
</tr>
</tbody>
</table>
Valley Health System’s Shared Cross-Setting APN Job Description

SERVE: SERVICE

1. Be Enthusiastic and Think Positively. Focuses on the positive. Exhibits a ‘can-do’ attitude.
2. Look for Ways to Serve. Proactively identifies opportunities to address departmental/organizational concerns by talking to management or acting immediately when the situation warrants. Serves on departmental/hospital-wide committees.
3. Really Listen. Demonstrates active listening skills, maintains eye contacts, responds appropriately and confirms understanding to ensure they heard correctly.
4. Remember the Value of Please and Thank You. Displays courtesy, professionalism and mutual regard towards patients, families, physicians and co-workers. Uses common courtesy when speaking and acknowledges work effort by saying thank you.
5. Smile and Say Hello. Greets people when arriving and leaving the work location. Introduces self by title and department. Immediately acknowledges customers. Uses scripting/telephone scripting when speaking with employees, physicians and customers. Demonstrates effective use of AIDET.

SERVE: EXCELLENCE

1. Be a Team Member. Places team success before individual recognition. Implements and supports team decisions. Is receptive to alternate approaches when one’s own point of view is rejected. Understand the meaning of compromise.
2. Communicate, Actively Utilizes the ‘Key Words at Key Times’ Standard. Confers with others to keep everyone updates and informed as necessary to ensure a functioning team. Uses AIDET skills and positive communication in tone of voice, body language and words. Communicates in English unless another language is necessary to provide service.
3. Cooperate and Help Others. Demonstrates willingness to work together with co-workers and customers.
4. Do More than Is Expected. Demonstrates initiative and provides assistance to team members both inside and outside the department without team member asking for help. Offers assistance generously.
5. Respond Timely. Responds in the required timeframe to management requests, regular job duties and to returning voicemail and emails. Is timely when coming to work, returning from break or lunch. Takes corrective action to prevent recurring problems with timeliness.

SERVE: RESPECT

1. Ensure Everyone’s Privacy. Consistently lowers the tone of voice when speaking on sensitive matters. Informs person they are taking steps to reduce tone of voice to contribute to his/her privacy. Consistently and proactively addresses the customers’ privacy needs. Discusses sensitive matters in a private forum, away from other staff.
2. Recognize and Encourage All. Seeks opportunities to provide effective feedback, recognition and encouragement and does so in a professional and respectful manner.
3. Remember Everyone Is Important. Demonstrates respect when dealing with all individuals regardless of title or level. Welcomes new staff to the unit/department assisting in orientation and comfort level with the area.
4. Respect Diversity. Consistently demonstrates sensitivity regarding diversity, cultural and religious beliefs and customs.
5. Take Pride. Maintains a clean, neat and professional appearance that adheres to the Hospital’s Personal Appearance Guidelines. Produces quality work. Wears ID Badge.

1. Activities of daily living.
Valley Health System’s Shared Cross-Setting APN Job Description

SERVE: VALUE
1. **An Apology Is Always Appropriate.** Apologizes readily. Participates in the Hospital’s Service Recovery Program.
2. **Help People to Their Destination.** Escorts individuals to their desired location. Appropriately directs phone calls. Assists other in locating items or people by showing them where the item of individual is located.
3. **Customers/Patients and Families Come First.** Responds appropriately to customer/patient requests.
4. **Take Ownership.** Sees projects through to ensure completion. Readily recognizes that the cleanliness of the Hospital is the responsibility of all employees and demonstrates this by taking necessary action.
5. **Value Everyone’s Time.** Works quickly and is respectful of patient’s/customer’s/co-worker’s time.

SERVE: ETHICS
1. **Be an Inspiration to Others.** Through words and actions, encourages others to perform to the highest standard. Leads by example and is a role model.
2. **Do What Is Right.** Considers the impact of one’s actions on team members and customers. Uses good judgment in dealing with others. Is willing to give and accept both positive and negative information.
3. **Honor Commitments.** Attends meetings regularly and participates appropriately. Does what he/she says they are going to do. Meets deadlines. Completes assignments on or ahead of the schedule.
4. **Play Fair/Tell the Truth.** Is honest in all words and actions. Distributes the same message and applies/follows rules consistently.
5. **Represent Valley Positively.** Uses every opportunity to speak and act positively about the department/hospital, both internally and externally. Avoids engaging in negative conversation.

RATING SCALE

<table>
<thead>
<tr>
<th>Rating Scale</th>
<th>Performance Level/Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>EE (Exceeds Expectations)</td>
<td>Exceeds expectations, requirements, and standards in many areas. Completes functions with accuracy in advance of schedule with few modifications required. Requires minimal direction in fulfilling duties and responsibilities.</td>
</tr>
<tr>
<td>2</td>
<td>AE (Achieves Expectations)</td>
<td>Achieves expectations, standards, and requirements. Completes functions within established time lines. Requires direction, assistance, and follow-up only with non-routine areas.</td>
</tr>
<tr>
<td>1</td>
<td>NI (Needs Improvement)</td>
<td>Needs improvement. Attempts to meet standards, but does not routinely satisfy all standards, expectations, and requirements. Responds to recommendations for improvement after prompting and supervisory counseling. Requires follow-up and direct supervision to complete assignments in a thorough and error-free manner. ACTION PLAN IS REQUIRED.</td>
</tr>
<tr>
<td>---</td>
<td>NA (Not Applicable)</td>
<td>Not applicable. The employee is NOT held accountable for this particular criteria.</td>
</tr>
</tbody>
</table>

Source: Valley Health System, Ridgewood, NJ.
Valley Health System’s Shared Cross-Setting APN Job Description

COMPETENCIES – Valley Health System

1. Practices as an autonomous and collaborative member of the healthcare team, demonstrating clinical expertise, differentiating between normal findings and those needing treatment, referral and/or consultation.
2. Evaluates transitional models of care, i.e., Naylor and Coleman, develops patient protocols, and establishes outcomes criteria and measurement in collaboration with long-term, assisted living and sub-acute care facilities, and the Valley Health System.
3. Provides care transition intervention activities in the following domains: Medication self-management and education, personal health record, post hospitalization/skilled nursing discharge physician follow up, and knowledge of “red flags” in care.
4. Functions as a Liaison b/w Medicine, Nursing, Patient, and Family and acts as a patient advocate to promote health and well-being within transitions in continuum of care. Utilizes resources as appropriate to prevent readmissions i.e Med Rec, follow-up phone calls, Home care, HF OUTPT Program.
5. Demonstrates advanced assessment skills within clinical specialty, providing evidence-based treatment interventions, to achieve positive outcomes for patients and families.
6. Provides clinical guidance and leadership through participation and/or representation for role specialty at unit, departmental and hospital meetings, committees, councils, task forces, and multidisciplinary rounds, as needed.
7. Prepare and submit timely and accurate data reports on care interventions.
8. Participates in the development and recommendation of evidence-based practice identifying the goal and desired measurable outcomes, which may include clinical, financial, process/system, and patient/family satisfaction.
9. Consults with other health providers on specialty population across all services.
10. Functions as mentor, educational resource, and consultant for staff in area of specialty, providing clinical expertise.
11. Identifies and assists in coordinating the acquisition of any needed special equipment, supplies, or consultations.
12. Conducts pre-admission/re-admission assessment visits, providing the information to assist in the completion of the MDS and initial nursing assessment in accordance with regulatory guidelines.
13. Participates in activities related to clinical outcome data collection, as well as performance improvement.
14. Identifies resident and interdisciplinary team educational needs and confers with clinical education department to provide educational resources to the interdisciplinary team, i.e., articles, handouts, poster, one-on-one teaching, and/or demonstration, and coordinate resident-related in-services.
15. Demonstrates understanding of the health care system and its component parts including levels of care (sites of care) and the roles of various care providers.
16. Performs approved procedures under collaborative practice agreement.
17. Demonstrates understanding that the care for the frail, elderly in long-term care is a complex process requiring team work and close interaction with the physician(s).
18. Demonstrates timely exchange of clinical information to Physician/s. Takes calls from the extended care facility on designated residents and contacts the Physician when necessary and as agreed upon with the Physician.
19. Maintains readily available patient database. Coordinates and facilitates specialty appointments and communication between specialists and the primary physician.
20. Conducts alternate regulatory visits if the Physician/facility desire allowing the Physician to focus on residents with active medical problems.
21. Demonstrates knowledge and ability to discuss important issues, such as advanced directive, with residents, family members, and facility staff.

ATTENDANCE CRITERIA (Outcomes measured by time and attendance reports, daily timesheets, and tracking systems.)

Number of unscheduled occurrences
Hours Worked EE (3) NI (1)

<table>
<thead>
<tr>
<th>Occurrence Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-520</td>
<td>0 occ. 1 occ. 2 occ. 3 &amp; more occ.</td>
</tr>
<tr>
<td>521-1040</td>
<td>1 occ. 2 occ. 3 occ. 4 &amp; more occ.</td>
</tr>
<tr>
<td>1041-1560</td>
<td>2 occ. 3 occ. 4 occ. 5 &amp; more occ.</td>
</tr>
<tr>
<td>1561-2080</td>
<td>3 occ. 4 occ. 5 occ. 6 &amp; more occ.</td>
</tr>
</tbody>
</table>

Source: Valley Health System, Ridgewood, NJ.
Valley Health System’s Shared Cross-Setting APN Job Description

OTHER REQUIREMENTS *(Manager and employee review of position requirements as applicable.)*

- PATIENT CARE SKILLS/EQUIPMENT: Utilizes other equipment safely and appropriately, as deemed necessary, for effective Agency operations (i.e., handheld devices, such as pulse oximeter, glucometer, doppler) and according to established procedures.
- PATIENT CARE SKILLS: Standard precautions as per policy.
- Maintains Specialty Certification(s): 
- Utilizes communications equipment (i.e., fax machine, telephone, printer copier, etc.) appropriately.

MERIT RATING

<table>
<thead>
<tr>
<th>Performance Score Ranges</th>
<th>Percent Increase</th>
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<tbody>
<tr>
<td>2.75-3.00</td>
<td>Exceeds Expectations 2.40%</td>
</tr>
<tr>
<td>2.00-2.74</td>
<td>Achieves Expectations Calculated</td>
</tr>
<tr>
<td>0.00-1.99</td>
<td>Needs Improvement 0.00%</td>
</tr>
</tbody>
</table>

Source: Valley Health System, Ridgewood, NJ.
Lehigh Valley Health Network's Breast Care Management Cross-Continuum Care Agreement

Lehigh Valley Health Network

Breast Care Management
Cooperative Care Agreement Between:

PCMH: LEHIGH VALLEY PHYSICIAN PRACTICE (LVPP)
&
PCMH-N: HEMATOLOGY ONCOLOGY ASSOCIATES (HOA)
&
PCMH-N: BREAST HEALTH SERVICES (BHS)
&
LEHIGH VALLEY SURGICAL ONCOLOGY (LVSO)

PURPOSE:

The Cooperative Care Agreement for care of the High Risk and Invasive Breast Cancer Patients will define for all parties named above the types of referral, consultation, and co-management arrangements available. This agreement will specify who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements. This agreement will define expectations regarding the information content requirements, as well as the frequency and timeliness of information flow within the referral process. This is a bidirectional process reflecting the needs and preferences of both the referring and consulting physician and other health care professionals. This agreement will specify how secondary referrals are to be handled and situations of self referral. This agreement will also maintain a patient-centered approach including consideration of patient/family choices, ensuring explanation/clarification of reasons for referral, and subsequent diagnostic or treatment plan and responsibilities of each party, including the patient/family. This agreement will include regular review of the terms of the care coordination agreement by all parties. In addition there will be a mechanism for all parties to periodically evaluate each other’s cooperation with the terms of the care coordination agreement, and the overall quality of care being provided through their joint efforts.
AGREEMENT:
ALL PARTIES INCLUDING HEMATOLOGY ONCOLOGY ASSOCIATES (HOA), LEHIGH VALLEY PHYSICIAN PRACTICE (LVPP), BREAST HEALTH SERVICES (BHS) & LEHIGH VALLEY SURGICAL ONCOLOGY (LVSO) representing the Surgical Oncology Clinic agree to the following cooperative care principles as listed below:

“All parties agree to provide patient & family centered care, anticipate any special needs of the patient and families and arrange for appropriate interventions/accommodations if necessary, notify patient and family of plan of care and secondary referrals when appropriate. All parties agree to pre-treatment consultation if requested and to notify all related parties of patients with a no show status.”

Please refer to Figure 1 which illustrates the flow of patients getting mammograms from BHS, the return of the patient with a normal mammogram to the PCP for continuing primary care, the navigation of abnormal mammograms and biopsies, referral to the High Risk Breast clinic, and referral to the Breast MDC (Multi-disciplinary Clinic) of patients with invasive breast cancer.

1. LVPP will be responsible for ordering routine screening mammography at recommended intervals as per LVHN standard for screening mammography.

LVPP, in the clinical judgment of the PCP, will be responsible for ordering diagnostic mammography or ultrasound for patients presenting with breast symptoms or abnormal findings on breast examination.

LVPP will be responsible for initial scheduling of patient for screening (or diagnostic) mammogram at Breast Health Services and be responsible for referring uninsured patients to Healthy Women Program or the Breast Cancer Coalition Program through the Allentown Health Bureau at [phone number]. Assistance with completing the appropriate paperwork will be provided through [individual] at [phone number].

2. BHS will perform routine mammograms as per BHS policy, report normal mammograms to LVPP within 72 hours and refer patient back to LVPP for routine care and follow up for normal mammograms.

A breast diagnostic navigator is assigned to every patient with an abnormal mammogram until resolution of the findings, including navigating the patient to biopsy. When the biopsy results are positive for Atypia, LCIS, DCIS, or invasive breast cancer, a treatment navigator facilitates subsequent referrals to surgery or the Breast MDC.

BHS will perform additional views when indicated and perform biopsy at Breast Health Services for all patients with a BIRADS 4 or 5.

The BHS navigator/RN will communicate abnormal mammogram results and/or biopsy results and recommendations to the PCP within 24 hours. The navigator will also be empowered, on behalf of the patient’s PCP to make patient referrals to either High Risk Breast Clinic if pathology is atypical hyperplasia (ADH, ALH) or lobular neoplasia (Lobular Carcinoma In-situ,
Lehigh Valley Health Network's Breast Care Management Cross-Continuum Care Agreement

LCIS), to surgery if DCIS (ductal carcinoma in situ), or to Breast Multidisciplinary Clinic for all invasive breast cancers and will assist the patient with scheduling appointments.

A treatment navigator is assigned to all patients with a diagnosis of breast cancer and will follow them from the time of final pathology until completion of their treatments.

3. When requested by BHS, and per agreement, Surgical Oncology Specialty Clinic agrees to see all patients with a BIRADS 4a or 4b at the next scheduled Surgical Oncology Clinic to evaluate for biopsy. Patients with 4c or 5 mammograms will be recommended to undergo biopsy at the earliest opportunity—either in BHS or in surgical clinic.

In addition the breast clinic agrees to notify the PCP of self-referrals to the clinic by their patients. The clinic agrees to schedule diagnostic breast imaging in BHS when necessary, collaborate with the breast navigator to assist biopsy patients with scheduling of appointments for OR scheduling, High Risk Breast Clinic or Breast MDC within 1 week of receiving biopsy results when appropriate.

Surgical Oncology Specialty Clinic as part of LVPP and LVSO agree to permit recommendation by the BHS navigator for referral to the High Risk Breast Clinic for all patients with a final pathology of ADH, ALH, and LCIS. The navigator will recognize that some patients may wish to discuss the referral with either or both their surgeon and PCP before accepting an appointment.

The physicians of LVSO who oversee the Surgical Oncology Specialty Clinic agree that for the patients seen at this clinic they will forward a dictated note to LVPP including recommendations, patient and family discussions, patient and family decisions and plan for follow up.

4. HOA agrees to schedule High Risk Breast Cancer patients within 6-12 weeks of receiving a request from the BHS navigator, Surgical Oncology Clinic, LVSO or LVPP. HOA agrees to notify all parties of acceptance of referral, date of scheduled appointments for high risk patients and of any self referrals.

HOA agrees to provide a comprehensive cancer risk assessment, individualized for each patient and family needs, and provide a patient centered recommendation of care for cancer surveillance. When appropriate, HOA will recommend consideration of chemoprevention with tamoxifen, raloxifene or exemestane if patient is qualified. If patient accepts chemoprevention, HOA (Cancer Risk clinic) will recommend patient visits at 6 month intervals during the 5 year course of treatment to monitor side effects or toxicities from the chemoprevention agent.

HOA agrees to notify LVPP and the Surgical Oncology Clinic through a dictated note of patient’s plan of care including any recommendations made, patient and family discussions, patient and family decisions and plan for follow up. HOA agrees to help obtain insurance authorization for obtaining Breast MRI’s or specialty testing if recommended for patients by either HOA or the Surgical Oncology Clinic.

For any High Risk Breast patient identified by Surgical Oncology Clinic, BHS or HOA that has no primary care physician all parties will agree to automatically refer the patient to the Community
Lehigh Valley Health Network's Breast Care Management Cross-Continuum Care Agreement

Cancer Center Nurse Practitioner at LVPP for a comprehensive medical evaluation and to establish primary care with LVPP.

Patients with invasive breast cancer will be recommended by the breast navigator to the Breast MDC within 1 week of the diagnosis of invasive disease. The patient’s navigator will organize the initial MDC visit, prepare the patient for what will happen at the MDC, invite the PCP or PCMH care manager to the MDC, facilitate review of the patient’s case at the Breast Tumor Board, communicate the recommended care plan to the patient in writing, facilitate next steps in the care plan, whether it be additional diagnostic imaging, or appointments, and communicate the recommended care plan to the PCMH care manager within 24 hours of the MDC.

PERIODIC REVIEW:
This agreement will be reviewed annually by all parties unless otherwise requested.

We mutually agree to the above Breast Cancer Management Cooperative Care Agreement:

[representative], MD (LVPP)  Date

[representative], MD (HOA, Breast MDC)  Date

[representative], MD (LVSO)  Date

[representative], RN, BSN, MBA, OCN (BHS)  Date

[representative], RN, MA, AOCN (Breast MDC)  Date
Lehigh Valley Health Network's Breast Care Management Cross-Continuum Care Agreement

Figure 1

1. PCP; PCMH

2. BHS Navigator

3. Biopsy
   - BHS; Breast Clinic

4. Risk Assessment
   - CHWC

5. BHS Navigator

Normal mammogram, benign biopsy

Abnormal Mammogram

Intraductal cancer (DCIS) → surgical referral
Invasive disease → MDC (standard e-referral, PCP, invited to MDC)

Atypical Hyperplasia; LCS

Standard e-referral; PCP, PCMH notified

Recommendations; comprehensive medical evaluation if no PCP

Source: Lehigh Valley Health Network, Allentown, PA.
Bellin Health Care Systems’ Acute Low Back Pain Care Pathway

Patient calls with complaint of acute low back pain

Work related?

Yes
Schedule with PCP or OT Health

No
Schedule with PCP or available provider

Assessment (appropriate Hx and physical)

Red Flags?

Yes
Address as indicated

No
Provider addresses appropriate conservative treatment and activity restrictions, (patient education materials given)

Patient appt. not scheduled due to cost concerns, chiro. request, patient refuses PT

Follow-up phone call with patient 5-7 days

PT Extended Care Team appointment same day (FastCare concept first visit)

Treatment plan established (work comp requires regular follow-up)

Patient is improving
Advance activity, PT discharge as indicated (FOTO¹ completed)
One week phone follow-up by PT
Communicate with PCP

Patient is not improving
Refer back to PCP
Repeat physical assessment and mental health questionnaire if not completed by PT
Referral for further evaluation and treatment

Patient is noncompliant
Communication to PCP for further treatment decision

Direct Access PT

Source: Bellin Health Care Systems, Green Bay, WI.

¹ Focus on Therapeutic Outcomes, Inc.
Aurora Health Care’s Ambulatory Shared Governance Nurse Application

Date of Application: __________________
Name: __________________
Preferred Phone: __________________
Email Address: __________________
Clinic Site: __________________
Clinic Address: __________________
Aurora Start Date: __________________
Years as Practicing RN: __________________

Please submit the following with your application:

• Current Resume
• 2 letters of reference (1 from a supervisor)
• A letter explaining your interest in participating on the Shared Governance Council. Use the following statements as a guide to tell about yourself, and to describe the skills you possess that make you a good candidate.
  – Give a time when you demonstrated:
    • The ability to support change
    • Initiative
    • Leadership
    • Problem solving
    • Delegation
    • Diplomacy
  – List your involvement in:
    • Special projects
    • Committees

I verify that I am an RN in good standing with a current license:

____________________________________________________
Signature date

Email this application and attachments to:
or fax to attn:
Intermountain Healthcare’s “Partners in Healing”
Caregiver Teaching Points

Please explain that this program is to help family members prepare to take their loved one home. Thank you for teaching 1-2 family/friends of the patient. Prethoracic nurses, please be selective in choosing who would be appropriate for this. Make sure the significant other (S.O.) understands this is completely optional. This will begin after transfer to CVU 3 or 4, and the accepting transfer nurse will review this information with the S.O. at that time.

1. Use Incentive Spirometer every 2 hours while awake
   a) Review the respiratory teaching sheet
   b) Tell the S.O. that the nurses will continue to do this when they are away

2. Cough with heart pillow
   a) Show technique
   b) Remind the S.O. to request a heart pillow post-op if it was not yet given

3. Get up to the chair for meals
   a) Meals come at about 8 AM, 12 PM and 5 PM
   b) Call for help if needed (give an example)
   c) Do not try to get the patient up alone if help is needed

4. Walk in hall
   a) Review the activity handout
   b) Refer to the “Open Heart Surgery Pathway for RR Pts/Families” to know the appropriate activity level
   c) Cardiac rehab will take them on 2 walks a day, morning and afternoon
   d) Call for help if needed
   e) Call for help with all equipment

5. Assist with dietary needs
   a) Review specific dietary restrictions (fat/salt/sugar/fluid restrictions)
   b) Show dietary rooms
   c) Teach how to measure intake including the water pitcher in mL (30 mL=1 ounce) and where to record it

6. Change TED hose/Compression boots
   a) Teach how to do this; show picture on TED hose package
   b) Remind the S.O. to ask for TED hose if it was not yet placed after surgery
   c) Wash TED hose daily; show where detergent is

Source: Intermountain Healthcare, Salt Lake City, UT.
Intermountain Healthcare’s “Partners in Healing”
Caregiver Teaching Points

7. Get warm blanket as needed
   a) Show where they are
   b) Instruct S.O. not to take other supplies (cost/safety issue)

8. Empty urine and record output
   a) Flush urine and rinse urinal/hat
   b) Show how/where to record output (look at urinal/hat for milliliters)
   c) Write “clear” or “cloudy” and “yellow” or “amber”

9. Wear gloves as needed
   a) Whenever in contact with any body fluids
   b) Discuss universal precautions for ALL patients

10. Understand fall risk prevention
    a) Review the “Prevent a Fall” handout
    b) Always call for help if needed

11. Call for help with all equipment
    a) Reemphasize this point

12. Review contents of the bag
    a) Pen and care diary to tape near the grease board in the room
    b) Mark the checklist with the items they want to help with
    c) “Partners in Healing” tag (if the S.O. wants a break, do not wear the tag; the tag will allow them into the supply room)
    d) Water bottle
    e) Complimentary lunch pass to “Windows on the Wasatch” (hospital cafeteria)
    f) Stress ball
    g) Resource information (welcome letter, falls, activity, IS, surgery pathway, survey)

13. Please point out that the ultimate responsibility to patient care belongs with the RN and that we appreciate their willingness to help. Ask them to communicate any problems or concerns they may have with the nursing care. Also ask them to fill out the survey sometime during their stay and place it in the box at the front desk.

Thanks to each of you for helping teach the Partners in Healing program. This can be helpful to each of us in giving excellent nursing care to our patients in a busy environment.
Intermountain Healthcare’s “Partners in Healing”
Caregiver Care Diary

Instructions: Charge nurse reviews teaching points with caregiver. Caregiver determines which activities they are comfortable performing. Charge nurse checks off chosen activities on the checklist below. Charge nurse walks caregiver through how often to perform each activity and how to record each activity in the table below. Caregiver will fill out a new table daily. Charge nurse checks accuracy of information. CNA documents care activities in EMR daily.

Checklist After Surgery

- Deep breathe with Incentive Spirometer every 2 hours while awake
- Cough with heart pillow every 2 hours/as needed
- Get up to chair for meals 3 times a day (call for help as needed)
- Walk in the hall (Cardiac Rehab will contact you)
- Dietary needs (clarify daily dietary restrictions with nurse and assist as needed)
- Change and wash TED hose daily
- Place compression boots while in bed (if no TEDs)
- Get warm blankets as needed
- Empty urine and write amount (in mL), color (yellow or amber), and character (clear or cloudy)
- Wear gloves as needed
- Understand fall risk prevention
- Before and after all activity, call for help with all equipment (chest tube, IV pole, catheter, oxygen, etc.)

Date: _________________________________

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<thead>
<tr>
<th>Time</th>
<th>Incentive Spirometer</th>
<th>Chair for Meals</th>
<th>Walk in Hall</th>
<th>Fluids In 30 mL=1 ounce</th>
<th>Urine (amount, color, character)</th>
<th>TED/ Comp. Boots</th>
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Yale-New Haven Hospital's Medical Respite Center Checklist of Eligibility Criteria

The patient must:

- Lack suitable housing. This includes:
  - Currently staying at a shelter.

- Residing on the streets, outside, in a car, or some other place not meant for shelter.

- Doubling up with friend(s) or family, or temporarily in a motel, AND are unable to return or secure alternate arrangements.

- Have an acute or post-acute medical illness which requires short-term resolution and care, OR need an environment in which to prepare for or recover from medical procedures such as surgery, chemotherapy, radiation, endoscopy.

- Be independent in Activities of Daily Living (ADLs).

- Be able to transfer and ambulate independently or with mechanical assistance such as wheelchair, crutches, or cane.

- Be continent of bowel and bladder.

- Be tolerant of solid food and not require IV hydration (IV treatment is acceptable).

- Be free from signs or symptoms of influenza or tuberculosis (if unexplained cough, weight loss, or other symptoms of possible tuberculosis are present, the patient must have documentation of appropriate screening)

- Be alert and oriented and psychiatrically stable enough to accept and receive care and not interrupt the care of others. The patient must not be a danger to his/herself or others.

- Be cognitively able and willing to comply with treatment requirements of the Respite Program which, at a minimum, means accepting visiting nursing services, engaging with case management, and taking medications as prescribed.

- Be sick enough to need more than an emergency shelter bed for the night.

- Not be sick enough to require hospital-level care or other medical care (nursing home, psychiatric inpatient admission, rehabilitation hospital).

- Be able to comply with rules prohibiting substance abuse (drugs or alcohol) while in the program. Patients in methadone programs are permitted. Patients who have received benzodiazepine tapers for alcohol detox must be free of signs of withdrawal for at least 48 hours after their last dose.

- Have an expected length of stay in the Respite Program of 30 days or less. Medical issues to be addressed at the Respite Program should be time-limited and have an identified endpoint.

Examples of patients NOT suitable for the Respite Program are those who:

- Primarily have a psychiatric need.

- Primarily need shelter/housing, and do not have a medical need.

- Would be better served in a skilled nursing or hospice facility.