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Physician Organization Name: Genesys PHO
Practice Name: Ascension Medical Group Genesys/ Participating Independent Primary Care Physicians
Practice Address: 3495 S Center Rd. Burton, Mi 48519
How many physicians in practice: 116
Description of Care team: The care team consists of a MD/DO, RN, LPN, MSW and MA

Executive Summary

- Genesys PHO identified a high rate of readmission from Skilled Nursing Facilities prompting Genesys PHO to identify the SNF having the highest number of GPHO admissions as well as the highest readmission rate.
- The identified facility had 322 admissions with a readmission rate of 27% within 30 days of admission to the SNF and a post discharge readmission rate of 23.3% within 30 days of discharge from the facility.
- A Health Navigator with SNF experience was employed to become embedded at the identified facility.
- The Health Navigator met face to face with all identified willing GPHO primary care physician assigned patients admitted to the facility within 3 business days to begin preparation for discharge. The Health Navigator notified the PCP of the SNF admission and was available for questions.
- Working in conjunction with SNF MSW, nurses and the attending physician, barriers to discharge were identified and community resources engaged as appropriate.
- The Health Navigator met with patient/caregiver the day prior to or the day of discharge to review medications and follow-up appointment dates and times.
- The SNF Health Navigator communicated the discharge and pertinent clinical information to the Health Navigator embedded in the PCP office for follow-up.

Category of Submission:
Care Management Workflow

Title of Submission: Developing a Care Management Workflow to Transition Patients Home from the Skilled Nursing Facility

When did the intervention start and end?
This intervention started in February 2018 and is ongoing.

Who developed the program/intervention, and how?
The Population Health Analytics team at Genesys PHO, at the request of the Care Management team, was able to identify the skilled nursing facility with the highest number of admissions for GPHO patients. That facility was also identified as having the highest readmission rate. The program was developed in conjunction with the skilled nursing facility administration, skilled nursing facility staff and the GPHO Care Management team.

Description of the Program/Intervention:
After identification of the SNF readmission issue by the Population Health Analytics team, the GPHO Care Management team felt it prudent to place a Transition of Care Health Navigator in the identified facility. Many patients were admitted from the hospital without the knowledge of the PCP. The Transition of Care Health Navigator would see GPHO patients at the bedside within 3-5 days of admission. The patient was instructed that the nurse would work with the patient, caregivers, SNF and PCP to ease the transition home. If verbal consent for engagement was elicited the Transition of Care Health Navigator visited the patient on a regular basis to assess needs, educate and collaborate with the facility staff in discharge preparation including assisting with discharge barriers. The PCP was notified of admission to the facility for all GPHO patients regardless of engagement.

The Transition of Care Health Navigator was able to act as a liaison between the PCP and the skilled facility. Because the nurse was an extension of the PCP office, the patients spoke more freely and voiced concerns of which the facility was unaware.

The Transition of Care Nurse Health Navigator was present at the time of discharge. The skilled nursing facility nurse reviewed the discharge instructions as well as performed a medication reconciliation. The Transition of Care Nurse Health Navigator met with the patient and caregiver for clarification of instructions or medications.

A follow-up appointment was made for the patient. The PCP was notified of the discharge. As warranted, a referral was made to the PCP embedded Health Navigator for follow-up for 30 days.

How were patients identified for the program/intervention?
The embedded Transition of Care Health Navigator receives an updated census of patients each morning from the skilled nursing facility. After ascertaining the patient is assigned to a GPHO PCP, the first visit is completed. The patient receives education on the program, Care Management and questions are answered.

How was success measured?
Prior to inception of this project, Care Management was not a critical piece of SNF transition and many times the PCP was unaware of the SNF admission. Unfortunately, there was poor follow-up for post SNF discharges. This appeared to contribute to a high readmission rate thus effecting the quality of life for these patients. Success would be measured in several areas:

1. The variance in the rates of SNF Readmission from the poor performing SNF facility compared to all other SNF facilities, using both 30 days from the date of SNF Admission and 30 days post SNF Discharge.
2. The engagement rate of patients with the Transition of Care Health Navigator
3. Rate of engagement post discharge
4. Rate of Readmissions for patients engaged in TOC and Health Navigation post SNF discharge.

Our program design determined that Face-to-face contact with the Care Manager was the foundation of the project. Communication with the PCP as well as continued Care Management post SNF discharge were process-based metrics.

What were the program results? Include qualitative data/graphs
Upon comparison of baseline data from 2017 before implementation of the program and the 2018 data, a significant improvement was noted. For the first year of the program there was a 43.47% engagement rate with the embedded Transition of Care Health Navigator. Of the patients engaged with the embedded Transition of Care Health Navigator, 32.28% were referred to the Health Navigator embedded in the PCP offices (75% of which enrolled in our program).

Readmission rates from this facility were measured during the first 30 days of admission to the facility and 30 days following discharge from the facility, using all other SNF readmissions as the control group for comparison. The readmission rate during the first 30 days of admission to the facility for those patients with the embedded Transition of Care Health Navigator at the selected facility was 8.7% while those at other facilities demonstrated a readmission rate of 11.5%. This was a complete reversal of the trends from previous years.

	Total SNF Admissions	Admissions to SNF	Readmissions within 30 days of SNF Admit	Readmission Rate	Variance from all others
2017	Poor Performing Facility	306	39	12.75%	23.5%
	All Other SNF's	2848	294	10.32%	
2018	Poor Performing Facility	322	28	8.70%	**-24.3%**
	All Other SNF's	2054	236	11.49%	

Readmission rates 30 days post discharge from the facility also evidenced a decrease. The readmission rate for patients at other facilities with Care Management while in the facility was 10.7% while the readmission rate for those engaged with Care Management at the previously poorer performing facility was noted at 8.7%. In addition, of the patients with continued Care Management follow-up, the readmission rate was significantly lower by 11.1%.

	Total SNF Admissions	Admissions to SNF	Readmissions within 30 days of SNF Discharge	Readmission Rate	Variance from all others
2017	Poor Performing Facility	306	31	10.1%	7.3%
	All Other SNF's	2848	269	9.5%	
2018	Poor Performing Facility	322	28	8.7%	**-18.4%**
	All Other SNF's	2054	219	10.7%	

There were many variables effecting the outcomes in this project but the most significant hurdle was self-selection. Patients who might benefit from the program could opt out of participation. Non-compliance was another variable as agreement to follow-up with Health Navigation and actual participation were many times at odds. Additionally, the simple facts of life had an effect on the program as death is more prominent among the chronically ill. Examination of the outcomes have led to areas of opportunity. Engaging the patient at the facility is a first step. The continued engagement post discharge demonstrates the most significant effect on outcomes. Because of the identified variables, there will always be potential for re-work and improvement.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?

We hired the SNF TOC Nurse and worked collaboratively with the SNF management staff for onboarding and workflow of the program. We also developed the workflow of hand off to the PCP embedded Health Navigator and provided training to the Navigator, physician and office staff.

What are you proudest of regarding this submission? Why does this work matter?

Providing the patients with face to face contact with a transition of care Health Navigator while in the facility decreases the overall risk of harm to them. The Health Navigator is able to create a bond with the patient and/or primary caregiver, therefore better able to assess the patient's barriers that need to be addressed prior to discharge. The Health Navigator has the unique opportunity to work within the facility to assist with coordinating a safe discharge back to the home setting. Finally, the patient has the option to work telephonically with a Health Navigator to ensure that they remain engaged in their care. Reducing hospital re-admissions improves the quality of life for the patient and family members in many ways not only physically but emotionally.

How will your organization use the funds if your submission wins?

New funds will allow

- Introduction of new educational materials to provide the patients tangible resources to aid in communication between the patient and the primary care physician.
- Increase our patient portal to provide interactive communication using the tools provided above.
- Increase in outcome reporting tools for compliance and effectiveness.