Achieving Care Continuity

Best Practices for Building a System That Never Discharges the Patient
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Available Within Your Nursing Executive Center Membership

In recent years, the Nursing Executive Center has developed many resources to assist nurse leaders in coordinating care across the continuum. Select resources are shown here. All resources are available in unlimited quantities through the Nursing Executive Center.

Coordinating Care Across the Continuum

**Nurse-Led Strategies for Preventing Avoidable Readmissions**
*Best Practices for Coordinating Care for Complex Patients Across the Continuum*
- Building a Readmission Prevention Strategy
- Ensuring Patients Are Discharged to the Appropriate Care Setting
- Facilitating Seamless Transfer to the Post-Acute Care Setting

**The Integrated Nursing Enterprise**
*Lessons from Leading Cross-Continuum Organizations*
- Guiding Patients to the Appropriate Care Setting
- Ensuring Interdisciplinary Collaboration Across Care Settings
- Instilling a System-Level Perspective Among Frontline Nurses

**Preventing Avoidable Hospital Admissions**
*Strategic Considerations for Nurse Executives*
- Identifying Patients at Greatest Risk for Preventable Admissions
- Achieving Patient Buy-In to Self-Management Goals
- Re-Engaging Patients Missing Care

**Nursing’s Role in Safeguarding Acute Care Margins**
*Thirteen Key Objectives and Recommended Initiatives*
- Preventing Unnecessary Readmissions
- Redistributing Siloed Patient Care Tasks to a Cross-Continuum Navigator
- Preempting Unnecessary Hospital Utilization

**AVAILABLE ONLINE**
To access these resources or order hard copies of the publications, please visit the Nursing Executive Center’s website: advisory.com/nec.
Advisors to Our Work

The Nursing Executive Center is grateful to the individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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<th>Organization</th>
<th>Individual(s)</th>
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<td>Milwaukee, WI</td>
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<td>Cincinnati Children’s Hospital Medical Center</td>
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<td>Trinity Mother Frances Hospitals and Clinics</td>
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<td>Yale-New Haven Hospital</td>
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<td>Paula Crombie</td>
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<td>Michael Ferry</td>
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<td>Sue Fitzsimmons</td>
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Executive Summary

The Mandate to Provide Seamless, Cross-Continuum Care

All too often, patients receive fragmented, episodic care—which leads to suboptimal clinical outcomes, avoidable health care utilization, and unnecessary spending.

Fragmented care is costly to both the nation and individual health care providers. Researchers estimate inadequate care coordination leads the US to waste between $25 and $45 billion each year. And individual providers are increasingly accountable for the total cost of care for their patients. Neither the country, nor providers, can afford to continue to deliver fragmented and episodic care.

Building a Health System That “Never Discharges” the Patient

To break down silos and deliver continuous care, health care providers need to fundamentally rethink how patients transition between settings. Currently, the central element of any transition is a patient being “discharged” from one setting and “admitted” to the next. But by definition, “discharging” a patient implies clinicians are relieved of the burden of responsibility for a patient’s care.

Health systems must broaden their aspiration to include building a health system that “never discharges” the patient. The goal is for clinicians in any setting to feel responsible for a patient’s care across the full continuum. For example, nurses on an inpatient medical unit feel responsible for the care and outcomes of their patients both on the medical unit as well as all other care settings the patients go to across the continuum—including primary care clinics, ambulatory clinics, post-acute care facilities, and patients’ homes.

Avoiding the Trap of Perfecting One Transition at a Time

When it comes to building a health system that “never discharges” the patient, the Nursing Executive Center recommends against a one-off approach in which leaders perfect one individual transition before moving to the next. This effort can be compared to assembling a puzzle—and piecing together each care setting one by one.

The challenge with this approach is perfecting each transition is time consuming and resource intensive. There are simply too many “puzzle pieces” for it to be feasible. In addition, this approach can lead to a piecemeal end result, rather than a cohesive system that seamlessly supports patients as they move through the care continuum.

To build a system that “never discharges” the patient, the Nursing Executive Center strongly recommends leaders address underlying, systematic issues that affect all patient transitions. The goal is to implement strategies that improve transitions across multiple care settings at once—rather than working setting by setting.

Read the Study in Full to Learn More

Achieving Care Continuity equips nurse leaders with four imperatives to build a system that “never discharges” the patient. The four imperatives to achieve care continuity are:

1. Equip clinicians to provide continuous care.
2. Promote clinician ownership for cross-continuum care.
4. Scale up support for vulnerable patients.

Read the complete study for detailed guidance and best practices to act on each imperative.
Why We Need to Stop Thinking About “Care Transitions”
Despite health care leaders’ best efforts to improve care coordination, patients continue to receive fragmented, episodic care. This manifests as care delivered in one-off visits in high acuity settings, or as avoidable utilization. According to recent studies, more than 70% of ED visits are avoidable, 4.4 million hospital trips are preventable, and 18% of hospitalized patients are readmitted within 30 days.

Huge Opportunity for Improvement

Percentage of ED Visits That Are Avoidable in the US

- 71%

4.4M

Estimated number of preventable trips to US hospitals each year

18%

30-day all-cause readmission rate


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.
Not only does siloed care delivery lead to sub-optimal outcomes, it is also costly. Researchers estimate the US wastes between $25 and $45 billion annually from inadequate care coordination.

The benchmarks shown here provide a closer look at the cost of poorly coordinated care. They show the difference in per-member per-month costs for patients whose care is “loosely managed” versus “well managed.” According to this data, patients with loosely managed care cost at least $100 per month more than those with well-managed care.

Health care providers are keenly aware of the high cost and sub-optimal outcomes that result from siloed care delivery. Accordingly, there is strong work already underway to improve care transitions.

### Poor Coordination Costing Billions Nationally

#### Difference Between “Loosely Managed” and “Well-Managed” PMPM Spending

<table>
<thead>
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<th></th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare</th>
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<tr>
<td>Loosely Managed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Managed</td>
<td>$100.48</td>
<td>$131.84</td>
<td>$449.79</td>
</tr>
</tbody>
</table>

Estimated annual amount of wasteful spending resulting from inadequate coordination


1) Per member per month.
2) 2011 data from Milliman.
3) 2011.
A common starting point for improving care transitions is preventing readmissions. And new policies—including Medicare’s Hospital Readmissions Reduction Program—have created financial incentives that make readmissions a logical place for health care leaders to start. For organizations tackling readmissions, the Nursing Executive Center recommends reviewing our publication *Nurse-Led Strategies for Preventing Avoidable Readmissions*. As shown here, it offers a strategic framework and best practices for improving two specific transitions in care: the transition from acute care to post-acute care, and from acute care to home.

Access *Nurse-Led Strategies for Preventing Avoidable Readmissions* on advisory.com/nec.

### 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

**Facilitating Seamless Transfer to the Post-Acute Care Setting**

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

Source: Nursing Executive Center, *Nurse-Led Strategies for Preventing Avoidable Readmissions*, 2011; Nursing Executive Center interviews and analysis.
While preventing readmissions is a strong starting point for improving care transitions, providers need to expand their efforts. This is because providers are increasingly accountable for the total cost of care for patients. As illustrated here, providers already assume full risk for uninsured patients, Medicaid Managed Care patients, and health system employees. Over time, many health care providers will assume full risk for additional patient populations, such as patients within an Accountable Care Organization (ACO) and commercially insured patients.

Being accountable for total cost of care means organizations must focus on all care transitions—not just the two transitions that are part of typical readmission efforts—because unnecessary health care spending occurs at many points along the care continuum. While preventable readmissions costs Medicare about $12 billion annually, this is only a portion of the estimated $25 to $45 billion annual cost of inadequate care coordination in the US.

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Populations for Which Health Care Providers Assume Full Risk

- Uninsured, Medicaid Managed Care, Health System Employees
- ACO Patients
- Commercially Insured Patients

**Estimated annual amount of wasteful spending resulting from inadequate coordination**

- $12B Estimated annual cost of preventable 30-day hospital readmissions
- $25B-$45B Estimated annual amount of wasteful spending resulting from inadequate coordination

There is an additional benefit to better coordinating care and improving transitions between all settings: it keeps patients within your network.

This benefits all health care providers regardless of their payment environment. For providers in a fee-for-service environment, higher patient volumes drive revenue. For providers in capitated contracts, keeping patients in network means they can control spending by providing care in the lowest-cost, clinically appropriate setting within the network.

Keeping Patients in Network Through Care Coordination

Coordination 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>
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<tbody>
<tr>
<td><strong>Benefit of Keeping Patients in Network</strong></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.
In sum, health care providers’ future success will hinge on improving transitions between all care settings. But before taking action, it is important to clarify what it means to “improve transitions.”

Currently, the central element of any transition is a patient being “discharged” from one setting and “admitted” to the next. But this concept of “discharging” a patient contributes to siloed care delivery. By definition, “discharging” a patient implies clinicians are no longer responsible for the patient’s care.

In order to improve care transitions between all settings and deliver seamless care across the continuum, health systems must broaden their aspiration beyond “discharging” patients from one setting to the next. Instead, health system leaders must build a health system that “never discharges” the patient. The goal is for clinicians in any setting to feel responsible for a patient’s care across the full continuum. For example, nurses on an inpatient medical unit feel responsible for the care and outcomes of their patients both on the medical unit as well as all other care settings the patients go to across the continuum—including primary care clinics, ambulatory clinics, post-acute care facilities, and patients’ homes.

**Clarifying Our Aspiration**

*Building a System That “Never Discharges” the Patient*

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**Definition of “Discharge”**

- “To relieve of a charge, load, or burden”
- “To release from an obligation”

_Merriam-Webster Dictionary_
When it comes to building a health system that “never discharges” the patient, the Nursing Executive Center recommends against a one-off approach in which leaders perfect one individual transition before moving to the next. This effort can be compared to assembling a puzzle—and piecing together each care setting one by one.

The challenge with this approach is that perfecting each transition is time consuming and resource intensive. There are simply too many “puzzle pieces” for it to be feasible. In addition, this approach can lead to a piecemeal end result, rather than a cohesive system that seamlessly supports patients as they move through the care continuum.

To build a system that “never discharges” the patient, the Nursing Executive Center strongly recommends the second approach shown on this page, in which leaders address underlying, systematic issues that affect all patient transitions. The goal is to implement strategies that improve transitions across multiple care settings at once—rather than working setting by setting.

The following pages describe how this systems approach has been applied to a select patient population.

Source: Nursing Executive Center interviews and analysis.
Some progressive organizations have already begun implementing a systems approach to improving care continuity for select patients. An example comes from Premier Health in Dayton, Ohio.

Premier has designed a program to improve cross-continuum care for their 1% most costly patients, regardless of condition. A key component of the program is a navigator who serves as patients’ primary entry point to the health system and collaborates with inter-professional team members to ensure all of their patients’ health and social needs are met. An excerpt of Premier’s “Top 1% Navigator” job description is shown here.

The following pages describe key elements of Premier’s Top 1% Navigator Program.

A complete version of Premier’s Top 1% Navigator job description can be accessed through an online version of this publication on advisory.com/nec.

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**Care Navigator Role Gaining Momentum**

**Excerpt of Top 1% Navigator Job Description at Premier Health**

Premier Health

**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 nontraditional 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.

---

**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, expanded program to include 175 patients across multiple Premier hospitals; new model includes two RNs, two MSWs, one LPN, one health coach
- Expanded program serves 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 select 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%
First, Premier selects patients for the program by analyzing ED encounters and admissions. Second, a navigator team of an RN and an MSW share a panel of 50 patients. Third, one of the two navigators is on call 24 hours per day, seven days per week. This enables the team to collectively serve as the single point of contact for the patient. Fourth, navigators coordinate with a multidisciplinary care team to meet patients’ medical and psychosocial needs. Fifth, navigators use remote telemonitoring for select1 patients. Sixth, navigators adjust the intensity of their support to each patient’s risk level. Additional details on how this is done are on the following page.

Establishing a First Line of Defense for the Top 1%

Key Elements of Premier’s Top 1% Navigator Program

1) Remote telemonitoring used primarily for CHF, COPD, and other selected high-risk (high-touch) group patients as deemed appropriate.

<table>
<thead>
<tr>
<th>Patients selected for program based on number of ED encounters and admissions</th>
<th>RN and MSW navigator team shares panel of 50 patients</th>
<th>Navigators available 24/7; serve as primary point of contact for patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigators coordinate multidisciplinary care team to meet medical and psychosocial needs</td>
<td>Navigators track patient health via remote telemonitoring1 (including patients with CHF and COPD)</td>
<td>Navigators interact with patient minimum of twice per month; can be as often as 21 times per month</td>
</tr>
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</table>

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.
Even within the top 1% of most costly patients, leaders should further stratify patients within the navigator program to provide adequate support to those who need it most.

As shown here, Premier stratifies patients in their Top 1% Navigator Program into three different groups, based on how much support they need.

Low-touch patients meet monthly with the RN navigator. To make sure they stay on track, an LPN or health coach calls them every other week to check in.

Medium-touch patients meet weekly with the RN navigator, twice per month with the MSW navigator, and three times per month with an LPN. An LPN or health coach also calls medium-touch patients every other week.

High-touch patients receive the most hands-on support. In addition to multiple visits with the two navigators each month, they have several in-person and telephone check-ins with other members of the care team. Finally, the RN navigator observes select high-touch patients through remote telemonitoring.

### Elements of Navigator Support Based on Risk Stratification Level

<table>
<thead>
<tr>
<th>Risk Stratification Level¹</th>
<th>Low Touch</th>
<th>Medium Touch</th>
<th>High Touch</th>
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<tbody>
<tr>
<td><strong>Classification Criteria</strong></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>
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<tr>
<td><strong>Time in Category²</strong></td>
<td>2-4 months</td>
<td>Minimum 4 months</td>
<td>Minimum 30 days</td>
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<tr>
<td><strong>Care Team-Patient Contact per Month</strong></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>
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</tbody>
</table>
| **Care Team Interactions with Patient** | • RN Navigator visit once a month  
 • MSW Navigator support as needed  
 • LPN or health coach phone call every other week | • RN Navigator visit twice a month  
 • MSW Navigator visit twice a month  
 • LPN visit three times per month  
 • LPN or health coach phone call every other week | • 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 telemonitoring³ |

---

1. Premier refers to the three risk stratification levels within the program as “low risk,” “rising risk,” and “high risk,” respectively.
2. Time spent by patient in risk category before reevaluated and moved to new category (e.g., from rising-risk to low-risk).
3. Remote telemonitoring used primarily for CHF, COPD, and other selected high-risk group patients as deemed appropriate.

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.
Even though Premier’s Top 1% Navigator Program is resource intensive, it allows Premier to reduce net costs because it is focused on only the 1% most costly patients.

Leaders at Premier report over a 50% decrease in hospital utilization by program participants and a net cost reduction of over $300,000 in the first six months of the program.

Deploying patient navigators is a highly effective way to improve care continuity for the highest-risk patients. But they are also too expensive to provide for every patient. And health care providers need to not only improve care continuity for the most acute patients—but for all three patient populations shown here: high risk, rising risk, and low risk.

To build a system that “never discharges” the patient (and not just the 1% most costly), leaders must pursue a systematic approach for improving care transitions that can be applied to all patients.

Looking Beyond the Top 1%

Managing Three Distinct Patient Populations

1) High-risk patients include the top 5% highest-cost patients (including the top 1%).

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.
Many organizations hope their EMR and IT infrastructure will be the systematic solution that improves care transitions for all patients. The aspiration is that IT can bridge silos between settings by improving the flow of information.

However, IT systems have not yet realized their promise. For example, 100% of accountable care organizations surveyed in 2014 reported interoperability issues.

More importantly, even if IT infrastructure is perfected, it won’t sufficiently improve care continuity. There are at least two reasons why.

First, the output of an IT system is only as good as the information clinicians enter into the system. Put another way, a perfect IT system cannot overcome the challenge of clinicians entering incomplete or inaccurate information into the EMR.

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

ACOs Struggling with Lack of EMR Compatibility

100%
Percentage of ACOs in 2014 reporting interoperability issues

“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 C, et al., October 2014 Report prepared for ONC

CFOs Betting on the EMR to Achieve Care Continuity

Health Care Leaders’ Priorities for Capital Investment

Health Care Information Systems (Including EMR) and IT Infrastructure

Upgrades to Existing Facilities

Process Improvements for Operational Efficiencies

Merger, Acquisition, or Other Partnership

Clinical Technology

New Facilities

Funding for Pension, Benefits or Self-insurance

Compliance with Safety Codes

No Capital Investment Planned

68%
47%
45%
33%
32%
26%
6%
6%
6%
The second reason the EMR alone will not sufficiently improve care continuity is the EMR doesn’t solve the underlying clinician workflows that result in episodic care. Many episodes of care are focused only on the patient’s specific complaint—not on the patient’s broader health needs. For example, only 2% of primary care visits include a depression screening, and 85% of medication order errors at admission are caused by inaccurate medication histories. To improve care continuity, leaders need to identify and address underlying workflow issues. Otherwise, leaders run the risk of automating workflows that perpetuate episodic care.

And existing clinical workflows are just one of the challenges leaders will need to overcome to build a health system that “never discharges” the patient. Additional challenges are shown on the following page.

### Form Follows Function

**Providers Must Address Underlying Clinician Workflows**

#### Percentage of Primary Care Physician Office Visits That Include Depression Screening

- 2%

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

- 85%

To help leaders deliver continuous care for all patients, the Nursing Executive Center identified the most significant root causes of why patients currently receive fragmented, episodic care.

The first root cause is clinicians are not equipped to provide continuous care. The underlying reasons include the following: clinicians lack necessary information, they aren’t sure how to provide continuous care, and they don’t have the time.

The second root cause of fragmented, episodic care is clinicians only feel accountable for care in their immediate setting. The underlying reasons include the following: clinicians have a setting-specific perspective, and they don’t feel responsible for patients’ needs beyond their immediate care setting.

The third root cause of fragmented, episodic care is patients and families don’t manage their care effectively. The underlying reasons include the following: patients aren’t motivated to manage their care, they don’t know how to manage their care, and they face economic roadblocks to managing their care.

By systemically addressing these root causes, leaders can build a health system that “never discharges” a patient. The following page provides a framework for doing so.

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

A complete version of the root cause analysis can be accessed through an online version of this publication on advisory.com/nec.
Achieving Care Continuity

Best Practices for Building a System That Never Discharges the Patient

To help nurse leaders overcome the key root causes of why patients receive fragmented, episodic care, the Nursing Executive Center identified four imperatives to build a system that “never discharges” the patient. The imperatives are shown in bold on this page. Each imperative has at least one underlying strategy, shown in italics. The numbered best practices are the building blocks for achieving a strategy.

The first imperative is to equip clinicians to provide continuous care by ensuring they have easy access to “need-to-know” information and enabling them to connect the care plan across settings. The second imperative is to promote clinician ownership for cross-continuum care by broadening the front line’s perspective beyond their own setting and incentivizing continuous care. The third imperative is to instill patient and family ownership for self-care by appealing to patients’ personal motivators for involvement and equipping patients and families with tools for self-management. The fourth and final imperative is to scale up support for vulnerable patients by investing in targeted services for select populations, such as medically complex patients, patients with mental health and substance abuse issues, homeless patients, and frail elderly patients.

To achieve care continuity for all patients, leaders must implement at least one practice for each imperative. For optimal impact, the Nursing Executive Center recommends implementing one practice per strategy.

The remainder of this publication describes each imperative in turn, with details on the associated strategies and key components to implement each of the practices.

1  Equip Clinicians to Provide Continuous Care

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

1. The Critical Patient Information Summary
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

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 Experience
9. Community-Focused Nursing School Rotations

   Incentivize Continuous Care

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

3  Instill Patient and Family Ownership for Self-Care

   Appeal to Patients’ Personal Motivators for Involvement

12. Personally Motivating Goal Incorporation
13. Nonclinical Peer Advisor

   Equip Patients and Families with Tools for Self-Management

14. Inpatient-Based Key Caregiver Skill Building
15. Recorded Transition Instructions
16. Personalized Patient Support Line
17. Daily Text Reminders

4  Scale Up Support for Vulnerable Patients

   Invest in Targeted Services for Select Populations

18. NP-Led Clinic for the Medically Complex
19. Justice Department Partnership for Behavioral Health
20. ED Alternatives for Homeless Patients
21. Remote Telemonitoring for the Frail Elderly

Source: Nursing Executive Center.
Imperative 1

Equip Clinicians to Provide Continuous Care

Ensure Easy Access to “Need-to-Know” Information
Practice #1: The Critical Patient Information Summary
Practice #2: Motivational Interviewing
Practice #3: Patient Preference Discussion Guide

Connect the Care Plan Across Settings
Practice #4: Shared Cross-Setting APN
Practice #5: Cross-Continuum Care Agreement
Practice #6: Cross-Continuum Care Pathway
The first imperative for building a system that “never discharges” the patient is to equip clinicians to provide continuous care. In order to do so, leaders will need to ensure clinicians have easy access to “need-to-know” information. And to succeed, they’ll need to overcome two key challenges. The first challenge is that critical “need-to-know” patient information is often buried in a patient’s record. All too often, patient records contain an overwhelming amount of information, and clinicians must click through multiple screens to hunt down key details. The second key challenge is that despite the amount of information in a patient’s record—often some “need-to-know” information is missing.

The three practices in this section will help leaders overcome each challenge in turn.

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**Struggling to Access “Need-to-Know” Information**

**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)

Source: Nursing Executive Center interviews and analysis.
Practice #1: The Critical Patient Information Summary

Practice in Brief

Leaders develop a shortlist of “need-to-know” patient information, and hardwire a method of summarizing that information in a prominent location in the patient’s record. The goal is to ensure clinicians in all care settings can readily access a core list of critical patient information and make more informed decisions about their patients’ care.

Rationale

Important details about a patient’s condition, medical history, and socioeconomic situation are often either “buried” within patients’ records—requiring clinicians to click through multiple screens in the EMR—or missing altogether. By summarizing critical patient information and ensuring it is readily accessible to caregivers in all settings, organizations can better equip clinicians to address patients’ needs in a timely manner.

Implementation Components

**Component #1: Survey Clinicians on “Need-to-Know” Information**
Leaders survey clinicians at multiple care settings to determine what specific patient information is most critical for providing coordinated, cross-continuum patient care.

**Component #2: Develop Shortlist of Most Critical Patient Information**
Leaders use survey results to develop a list of patient information that is most important for care continuity. The Nursing Executive Center recommends including no more than 15 pieces of patient information.

**Component #3: Hardwire Transmission of Critical Patient Information Summary Across Care Settings**
Leaders hardwire a system for transmitting the Critical Patient Information Summary across care settings. Depending on the level of EMR compatibility, this may include using the EMR, a secure email to the receiving care site, or a fax.

Practice Assessment

This practice is an effective strategy for ensuring clinicians have ready access to the information they need to provide timely and efficient care in any setting. While applicable to all organizations, this practice may be more difficult to implement for organizations without an EMR that is integrated across settings.
Component #1: Survey Clinicians on “Need-to-Know” Information

The first component of this practice is to survey clinicians in multiple settings and ask them what patient information is essential for providing coordinated, timely care.

As a starting point for the survey, the Nursing Executive Center proposes the starter list of “need-to-know” patient information shown here.

Defining “Need-to-Know” Patient Information

<table>
<thead>
<tr>
<th>Information That Should Be Easily Accessible to Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Patient’s Perspective</td>
</tr>
<tr>
<td>2  Primary Care Provider</td>
</tr>
<tr>
<td>3  Accurate List of Medications</td>
</tr>
<tr>
<td>4  Prescribers of Each Medication</td>
</tr>
<tr>
<td>5  Main Diagnoses</td>
</tr>
<tr>
<td>6  Relevant Risk Assessment Scores</td>
</tr>
<tr>
<td>7  Payer Status</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center interviews and analysis.
Practice #1: The Critical Patient Information Summary

Surveys can be further customized to each organization. The example shown here comes from Mayo Clinic. Leaders at Mayo Clinic chose to ask primary care clinicians what specific information they would need to help their patients successfully transition from hospital to home. While Mayo chose to survey their primary care team members, organizations can also survey clinicians in other settings—including hospitals, skilled nursing facilities, home health, etc.—to determine the critical patient information.

A complete version of Mayo’s Primary Care Team Survey can be accessed through an online version of this publication on advisory.com/nec.

Asking the End Users What’s Most Useful

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 transition1? (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 ADLs2
- Other: _______________________

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

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 is 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

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1) The transition in this case is from the hospital to home.
2) Activities of daily living.

Source: Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.

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advisory.com
Component #2: Develop Shortlist of Most Critical Patient Information

The second component of this practice is to use the survey results to select a limited number of pieces of “need-to-know” patient information that will be readily available to every caregiver in every setting.

Leaders at Mayo Clinic used the results of their primary care clinician survey to develop a patient discharge summary which contains the “need-to-know” patient information for caregivers in the next setting.

A complete version of Mayo’s Patient Discharge Summary can be accessed through an online version of this publication on advisory.com/nec.

Calling Out Key Information from Hospital to Clinic

Mayo’s Patient Information Summary Page¹

Information Included in Mayo’s Patient Information Summary Page

- Dates of hospitalizations
- Primary diagnosis
- Secondary diagnosis
- Reason for admission
- Hospital course
- Procedures performed
- Pending studies
- Discharge medications
- Discontinued medications
- Discharge disposition
- Risk level²
- Discharge instructions provided to patient and caregiver(s)
- Follow-up recommendations
- Follow-up contact information

¹From hospital to primary care clinic.
²Included in automated electronic health record inbox communication.

Source: Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.
Component #3: Hardwire Transmission of Critical Patient Information Summary Across Care Settings

The third component of this practice is to hardwire a mechanism for consistently transmitting critical patient information across settings.

Leaders can use any of the three options shown here to ensure all clinicians have ready access to the key patient information.

At Mayo Clinic, IT experts designed a system in which the hospital EMR automatically generates a summary page with critical information and sends it to the primary care team via the EMR.

The Nursing Executive Center has previously shared effective strategies for transmitting critical patient information between care teams or two care settings. Descriptions of the practices and the titles of the relevant publications are shown here.

Recap of Practices for “Unburying” 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</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>Tool</td>
<td>Safety Sign-On Screen</td>
<td>Achieving Top-of-License Nursing Practice</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>

Access Nurse-Led Strategies for Preventing Avoidable Readmissions and Achieving Top-of-License Nursing Practice on advisory.com/nec.
Practice #2: Motivational Interviewing

Practice in Brief

Leaders provide staff with training and tools for using Motivational Interviewing; the goal is to equip clinicians to surface critical patient information that informs a patient’s ability to follow their care plan.

Rationale

Without key patient information, clinicians may unintentionally build care plans that their patients cannot follow. Because key patient information can be potentially embarrassing for patients to share (for instance whether or not a patient can afford a prescribed medication), it isn’t effective for clinicians to ask patients point-blank questions. Instead, clinicians should use Motivational Interviewing. Motivational Interviewing is a technique that is designed to put patients at ease and help clinicians more effectively elicit critical information.

Implementation Components

Component #1: Prioritize Motivational Interviewing Training for Caregivers Who Work with High-Risk Patients
Leaders require all caregivers who work directly with high-risk patients (e.g., care managers, health coaches) to complete Motivational Interviewing training.

Component #2: Encourage All Frontline Staff to Use Motivational Interviewing Techniques (Optional)
Once leaders feel they’ve adequately prepared caregivers who work with high-risk patients to use Motivational Interviewing techniques, leaders expand Motivational Interviewing training and support to all caregivers at the organization.

Practice Assessment

This practice is an effective strategy to ensure clinicians have the key patient information they need to create an appropriate care plan. The Nursing Executive Center highly recommends this practice for all organizations.

Nursing Executive Center Grades
Practice Impact: A-
Ease of Implementation: B+

1) A patient-centered interviewing technique designed to help surface patient information that may be sensitive, but necessary to make important decisions about the patient’s care plan.
An important piece of information often missing from the patient record is the patient’s perspective. To provide continuous care, clinicians need to understand the patient’s perspective—especially information that can affect their ability to follow their care plan. But patients don’t always proactively volunteer this information to their caregivers. This reticence can have a direct impact on a patient’s health and care, as shown in this example. The patient shown here was readmitted because he couldn’t afford his prescribed medication. If the care team had understood the patient’s perspective, they would have explored alternative medications to ensure the patient could afford to fill the prescription.

### Why Capturing the Patient’s Perspective Matters

**Representative Scenario**

<table>
<thead>
<tr>
<th>Patient prescribed asthma inhaler; $100 out-of-pocket cost</th>
<th>Patient experiences asthma attack; results in ED visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient unable to afford medication; does not fill prescription</td>
<td>Patient readmitted 18 days after discharge</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center interviews and analysis.
Practice #2: Motivational Interviewing

Since patients may feel uncomfortable sharing potentially embarrassing or sensitive information, it isn’t effective for clinicians to ask patients point-blank questions about the patient’s ability (or desire) to follow their care plan. Instead, clinicians should use Motivational Interviewing. This is an evidence-based technique in which clinicians ask questions in a non-judgmental way. The goal is to put patients at ease and enable them to feel more comfortable sharing their perspective. A comparison of the two interview techniques is shown here.

The rest of this practice shares guidance on how to incorporate Motivational Interviewing into staff training and patient interactions.

A Proven Strategy: Motivational Interviewing

<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 effect 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>

Source: MINT, http://www.motivationalinterviewing.org; Nursing Executive Center interviews and analysis.
Practice #2: Motivational Interviewing

The first component of this practice is to prioritize Motivational Interviewing training for clinicians who work with patients at high risk for extensive, and avoidable, health care utilization. Leaders at Carolinas HealthCare System require all caregivers who work directly with high-risk patients\(^1\) to complete Motivational Interviewing training. The training includes a two-day, in-person course on Motivational Interviewing Basics. These clinicians are expected to incorporate Motivational Interviewing techniques into all interactions with high-risk patients.

The second component is to encourage all staff to use Motivational Interviewing techniques when appropriate. Leaders at Carolinas offer optional Motivational Interviewing courses and provide supplemental training resources to help all staff master Motivational Interviewing skills.

Prioritizing Motivational Interviewing for High-Risk Patients

Key Components of Motivational Interviewing at Carolinas

**Component #1:**
Prioritize Motivational Interviewing Training for Caregivers Who Work with High-Risk Patients

Motivational Interviewing training mandated for care managers and health coaches; used in daily interactions with Medicaid Access II patients

**Component #2:**
Encourage All Frontline Staff to Use Motivational Interviewing Techniques

Motivational Interviewing training available to all Carolinas staff; strongly encouraged for use with all patients

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\(^2\) 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

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\(^1\) Care managers and health advocates in both outpatient and inpatient settings.  
\(^2\) Community Care Partners of Greater Mecklenburg.
A summary of the supplemental training resources provided to frontline staff at Carolina’s HealthCare System is shown here.

The first resource is an online webpage for staff to share their experiences with Motivational Interviewing and learn about upcoming trainings. The second resource is a quarterly forum for staff to meet in-person to discuss insights and lessons learned from their experiences using Motivational Interviewing. The third resource is a system-wide coaching network, through which experienced clinicians and health coaches shadow and provide constructive feedback to clinicians and coaches who are new to Motivational Interviewing techniques.

Providing Staff with Support to Use and Master Skills

Supplemental Motivational Interviewing Resources at Carolinas

<table>
<thead>
<tr>
<th>Online Webpage and Discussion Board</th>
<th>Face-to-Face Meetings</th>
<th>Coaching Network</th>
</tr>
</thead>
</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

Source: Carolinas HealthCare System, Charlotte, NC; Nursing Executive Center interviews and analysis.
Practice #3: Patient Preference Discussion Guide

--- Practice in Brief ---
Clinicians use patient-friendly decision aids to review specific treatment plan options with patients; the goal is to elicit patients’ input at important decision points in order to identify the treatment plan best suited to each patient.

--- Rationale ---
Clinicians often make patient care decisions without knowledge of factors that influence a patient's willingness or ability to follow care instructions (for example, a patient’s inability to swallow a pill). By using decision aids to discuss specific trade-offs between treatment options with patients, clinicians can incorporate patients’ input into their care plans and set them up for success.

--- Implementation Components ---

**Component #1: Use Patient-Friendly Language in Decision Aids**
Leaders ensure decision aids use clear language at a low reading level and incorporate visuals as appropriate to assist clinicians in explaining medical and financial implications of treatment options.

**Component #2: Highlight Key Pros and Cons of Each Treatment Option**
Decision aids show side-by-side comparisons for different treatment options—including comparisons of cost, potential side effects, and frequency of administration (for medications).

**Component #3: Document Patient Preferences in Patient Record**
Clinicians document patient preferences in the EMR for future reference.

--- Practice Assessment ---
This practice is an effective means of surfacing information about patients’ preferences and ability to adhere to their care plan. It is recommended for all organizations. Leaders can either create home-grown decision aids and training resources or use readily available, free tools.

--- Nursing Executive Center Grades ---
Practice Impact: A
Ease of Implementation: C+
Clinicians often make patient care decisions without knowing factors that influence a patient’s willingness or ability to follow a care plan—for instance concerns about the cost of medication or a fear of needles. To incorporate patients’ perspectives and identify the right treatment plan for each patient, clinicians at Mayo Clinic use Patient Preference Discussion Guides.

A sample Patient Preference Discussion Guide for diabetes is shown here. In order to choose between several potential type 2 diabetes medications, the discussion guide compares potential medications across key considerations including: daily routine, cost, and anticipated patient weight change. Clinicians can use either printed or electronic versions of the discussion guide during patient interactions.

Key components of integrating Patient Preference Discussion Guides into practice are described on the following page.

Reviewing Trade-Offs Between Options with Patients

Excerpt from Mayo’s Diabetes Medication Choice Decision Aid

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, and 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

The first component of this practice is to create (or use) Patient Preference Discussion Guides that have clear, patient-friendly language and visual aids.

The second component is to show a side-by-side comparison of each option to make it easy for patients to see the benefits and drawbacks of each.

The third component is to permanently capture patients’ perspectives by documenting their preferences and other relevant information in the EMR.

Fortunately, leaders don’t have to design their own Patient Preference Decision Guides from scratch. Through Mayo Clinic’s Shared Decision Making National Resource Center’s website, leaders, clinicians, and researchers can download Mayo Clinic’s decision aids and related implementation resources at no cost.

In addition to the Diabetes Medication Choice Decision Aid shown on the previous page, Mayo offers the following Patient Preference Decision Guides: Osteoporosis Medication Choice, Depression Medication Choice, and Cardiovascular Primary Prevention Choice.

Capturing the Patient’s Perspective with Decision Aids

Key Components of Mayo’s Decision Aids

Component #1:
Use Patient-Friendly Language in Decision Aids

Component #2:
Highlight Key Pros and Cons of Each Treatment Option

Component #3:
Document Patient Preferences in Patient Record

Plug and Play Resources from Mayo

Resources to Introduce Decision Aids to Clinicians and Leaders

Three-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

Decision Aids Available at Mayo

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

Source: Shared Decision Making National Resource Center, http://shareddecisions.mayoclinic.org; Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.
Researchers at Mayo Clinic conducted a randomized trial to test the efficacy of shared decision making aids. In the trial, researchers randomly assigned patients presenting in the ED with chest pain (and at low risk for acute coronary syndrome) to either meet with a clinician using a Patient Preference Decision Guide or receive standard care.

The researchers reported that patients using the decision aids had more appropriate utilization, increased knowledge, and greater satisfaction in the decision-making process compared to those receiving standard care.

### Benefitting from Patient Input at Mayo

#### Key Findings from Mayo’s Chest Pain Trial

<table>
<thead>
<tr>
<th>More Appropriate Utilization</th>
<th>Increased Patient Knowledge</th>
<th>Greater Patient Satisfaction in Decision-Making Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of Patients Admitted to Observation Unit for Stress Testing</strong>&lt;br&gt;n=204</td>
<td><strong>Average Number of Questions Correct on Post-Visit Survey</strong>&lt;br&gt;n=204</td>
<td><strong>Percentage Answering “Strongly Agree” on Satisfaction Survey</strong>&lt;br&gt;n=204</td>
</tr>
<tr>
<td>Standard Care</td>
<td>Patient Input</td>
<td>Standard Care</td>
</tr>
<tr>
<td>77%</td>
<td>58%</td>
<td>3.0</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

1) Decisional Conflict Scale.

The first imperative for building a system that “never discharges” the patient is to equip clinicians to provide continuous care. To achieve this imperative, leaders will need to follow two strategies. The first strategy is to ensure easy access to “need-to-know” information, which is discussed on pages 24 through 38 of this publication. The second strategy is to connect the care plan across settings, which is discussed on the following pages.

The status quo is clinicians in each care setting create and execute their own care plans. This prevents caregivers from delivering continuous care across the continuum by introducing the potential for gaps in care, duplication in care, and potentially conflicting patient education. This is shown by the example on this page in which each setting-specific care plan calls for post-discharge follow-up calls. As a result, the patient receives several uncoordinated, redundant phone calls.

The practices in this section provide three options to connect the care plan across settings. The first relies on a unique nursing role to connect the care plan across the continuum, the second uses a formal agreement, and the third embeds a Cross-Continuum Care Pathway into the EMR.
Practice #4: Shared Cross-Setting APN

Practice in Brief

An APN (advanced practice nurse) jointly employed by health system and skilled nursing facility (SNF) provides direct patient care for high-risk patients and facilitates their handoffs as they transition from the hospital to SNF, and from the SNF to home.

Rationale

When patients don’t receive consistent, appropriate care across settings, it can lead to avoidable readmissions (or avoidable utilization). (For instance: a SNF admits a patient to their facility from a nearby hospital, but the SNF doesn’t know hospital clinicians recently adjusted the patient’s medication regime. The patient deteriorates and is readmitted to the hospital.) One way to ensure patients receive consistent, appropriate care is to charge a single individual with overseeing their care in each setting. The Shared Cross-Setting APN holds the responsibility of working with a group of high-risk patients to ensure they receive appropriate care in each setting, and have a smooth transition to the next level of care.

Implementation Components

Component #1: Identify Which SNFs to Partner With
Health system leaders deploy an APN at SNFs that have high readmission rates and a large volume of patients from their hospitals.

Component #2: Identify High-Risk Patients (at Identified SNFs) for APN to Support
Health system leaders identify patients (at targeted SNFs) who have been to one of their hospitals and are at high-risk for readmission (e.g., LACE score greater than 13).

Component #3: APN Provides Direct Patient Care to High-Risk Patients at SNF and Home
APN performs key aspects of direct patient care to high-risk patients at SNF and their home—including assessments, medication reconciliation, and test ordering—to ensure the high-risk patients receive high-quality clinical care and patients’ care is consistent across settings.

Component #4: APN Teaches SNF Clinicians How to Handle High-Risk Patient Needs
APN educates SNF clinicians on how to meet the needs of high-risk patients, such as ways to identify early warning signs of patient deterioration—and how to avoid unnecessary hospital readmissions.

Component #5: Facilitate Handoffs Into and Out of Identified SNFs for High-Risk Patients
APN conducts verbal handoff between hospital staff and SNF staff. APN partners with home care staff to evaluate patient acuity and identify any additional needs when the patient transitions from the SNF to home.

Practice Assessment

This is a powerful strategy for ensuring patients receive seamless (and high-quality) care across multiple settings. Partnering organizations jointly fund the role, and all partners have the potential to benefit by providing more coordinated care and preventing unnecessary health care utilization. Since this practice relies on a clinician rather than technology, it is especially recommended for organizations striving to connect the patient’s care plan across settings, but don’t have a fully integrated EMR.

Nursing Executive Center Grades

Practice Impact: B+
Ease of Implementation: B+
The first option for connecting a care plan across the continuum is to designate a person to connect the care plan in different care settings. Valley Health System used this strategy and created the Shared Cross-Setting Advanced Practice Nurse (APN) role.

The Shared Cross-Setting APN provides direct patient care for high-risk patients at select SNFs and facilitates their handoffs as they transition from the hospital to SNF, and from the SNF to home. Valley Health System (including a hospital and home care agency) and the partnering SNF jointly fund the role. An excerpt of Valley’s Cross-Setting APN job description is shown here.

Specific components of implementing a Shared Cross-Setting APN are described on the following pages.

A complete version of Valley Health System’s Shared Cross-Setting APN job description can be accessed through an online version of this publication on advisory.com/nec.

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.

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 Shared 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)

Source: Valley Health System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.
Component #1: Identify Which SNFs to Partner With

The first component of this practice is for hospital leaders to identify the SNFs with which they want to use an APN to connect care plans.

To do this, leaders at Valley used two criteria. First, they identified SNFs that had a large volume of Valley Hospital patients. Second, they further narrowed the list by selecting the SNFs with the highest readmission rates to Valley.

Component #2: Identify High-Risk Patients (at Identified SNFs) for APN to Support

The second component of this practice is to determine which patients the Shared Cross-Setting APN will focus on ensuring have a consistent care plan cross-setting. To be most cost-effective, APNs should focus their time on patients who are at highest-risk for readmissions.

Valley’s Shared Cross-Setting APNs focus their efforts on patients with a LACE score greater than 13 and patients with specific diagnoses with readmissions penalties, including COPD, heart failure, and hip and knee replacement.

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 Center²</td>
<td>5.8%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Vega Wellness Center²</td>
<td>32.4%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Raine Nursing Home²</td>
<td>10.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Fox Health and Rehab²</td>
<td>15.6%</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

1) Representative data.
2) Pseudonym.

Focusing APN Time on Highest-Risk Patients

Valley’s Criteria for Patients for Cross-Setting APN to Support

- **Readmission Risk Assessment Score**: Patients with a LACE score greater than 13
- **Diagnosis-Specific Criteria**: Patients with one of the following diagnoses: COPD, heart failure, hip and knee replacement

Source: Valley Health System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.
Component #3: APN Provides Direct Patient Care to High-Risk Patients at SNF and Home

The third component of this practice is to ensure high-risk patients receive consistent care in multiple settings by having the APN provide direct patient care to select patients at both the SNF and the patient’s home.

Valley’s Shared Cross-Setting APNs perform the direct patient care activities shown here. At the SNF, the APN performs medication reconciliation, rounds on patients daily, and orders needed tests. After SNF patients are discharged home, the APN visits any patients needing additional support who are not eligible for home care.

Ensuring Consistent, High-Quality Care at SNF and Home

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

SNF

Perform medication reconciliation on patient admission to SNF; round on patients daily; order tests when necessary

Home

Visit patient home if ineligible for home care but needs additional support

Component #4: APN Teaches SNF Clinicians How to Handle High-Risk Patient Needs

The fourth component of this practice is for APNs to help SNF staff identify—and address—changes in a patient condition that would lead to a preventable readmission.

Valley’s Shared Cross-Setting APN does this in two ways.

First, the APN teaches SNF staff how to identify early warning signs of patient deterioration and when to call a physician or APN for additional support.

Second, the APN leads a retrospective analysis of any adverse events, highlighting opportunities to prevent future occurrences.

Educating SNF Staff on Complex Patient Care

Representative Education to SNF Staff Provided by Shared Cross-Setting APN

Proactive Education

During normal patient rounds at SNF, APN identifies any “red flags” and teaches SNF clinicians how to critically think through the patient care situation, including whether or not to escalate the need by alerting an APN or physician

Retrospective Analysis

After adverse event, APN leads root cause analysis exercise with SNF staff to determine how event could have been prevented, educate on any relevant aspects of clinical care contributing to event

Source: Valley Health System, Ridgewood, NJ, Nursing Executive Center interviews and analysis.
Component #5: Facilitate Handoffs Into and Out of Identified SNFs for High-Risk Patients

The fifth component of this practice is for the APN to facilitate handoffs for high-risk patients between the hospital and SNF, and the SNF to each patient’s home. If a patient must return to the ED, the APN communicates directly with ED staff to ensure they have all the relevant information about the patient’s condition.

Providing Continuity from Hospital to SNF to Home

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

Only eight months after Valley implemented the Shared Cross-Setting APN at two SNFs, readmission rates from the two participating SNFs to Valley dropped dramatically.

Leaders at Valley report that several other SNFs have expressed interest in partnering with Valley to implement a Shared Cross-Setting APN.

Promising Early Results

<table>
<thead>
<tr>
<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>42.67%</td>
<td>35.29%</td>
</tr>
<tr>
<td>Baseline</td>
<td>Baseline</td>
</tr>
<tr>
<td>22.50%</td>
<td>14.96%</td>
</tr>
<tr>
<td>Eight Months Post-Implementation</td>
<td>Eight Months Post-Implementation</td>
</tr>
</tbody>
</table>

1) Pseudonym.
2) First month of Shared Cross-Setting Nurse in SNF.

Source: Valley Health System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.
Practice #5: Cross-Continuum Care Agreement

Practice in Brief
Leaders in multiple care settings collaboratively create a process map outlining which settings are responsible for specific aspects of patient care; the goal is to prevent duplication and gaps in care across participating care sites.

Rationale
Duplications and gaps in care often occur between settings when clinicians don’t know which site is responsible for specific elements of patient care. By collaboratively forming an agreement that clarifies responsibilities for each aspect of patient care across settings, clinicians have a clear understanding about which elements of care they must provide, and patients are more likely to have a seamless experience.

Implementation Components

Component #1: Involve Key Stakeholders from Multiple Care Settings
Project leader interviews clinicians from participating care sites to map out ideal patient flow across settings.

Component #2: Showcase Benefits to Staff to Achieve Buy-In
Leaders present ideal patient flow across care sites to clinicians to demonstrate how adherence to agreement benefits patients.

Component #3: Present Final Draft for Clinician Sign-Off
Project leader receives sign-off on the agreement from clinician representatives from each participating care site.

Component #4: Designate an Expert at Each Care Site to Answer Staff Questions
Leaders assign a navigator at each care site to field questions and educate frontline staff on the agreement.

Practice Assessment
This practice requires an upfront investment in leaders’ time for process mapping and rollout, but it is an effective strategy for coordinating care pathways across sites without a fully integrated, cross-continuum EMR. For optimal results, leaders should reassess the agreement on an annual basis.

Nursing Executive Center Grades
Practice Impact: A-
Ease of Implementation: B
Practice #5: Cross-Continuum Care Agreement

The second option for connecting a care plan across settings is to develop an agreement that clarifies which settings are responsible for specific aspects of patient care. This approach was used by oncology service line leaders at Lehigh Valley Health Network, who created a Cross-Continuum Care Agreement to clarify care delivered within breast care management services. The agreement, shown here, specifies which of four care sites within Lehigh’s oncology service line is responsible for specific care activities.

To facilitate timely care, the agreement outlines expected time frames for key activities. For example, Breast Health Services is expected to report a normal mammogram to Lehigh Valley Physician Practice within 72 hours and an abnormal mammogram within 24 hours.

Lehigh followed four key components, outlined on the following page, to develop the Cross-Continuum Care Agreement.

A complete version of Lehigh Valley Health Network’s Cross-Continuum Care Agreement can be accessed through an online version of this publication on advisory.com/nec.

### Clearly Delineating Responsibility

**Lehigh Valley’s Breast Care Management Cross-Continuum 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 LVHN¹ 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 Clinic  
• 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 to 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.

Source: Lehigh Valley Health Network, Allentown, PA, Nursing Executive Center interviews and analysis.
The first component is to involve key stakeholders from multiple care settings. Lehigh’s project leader interviewed clinicians from all participating care sites to map out the ideal patient flow for breast care management patients.

The second component is to showcase the benefits of the agreement to staff in order to achieve buy-in. Leaders at Lehigh presented the ideal patient flow to clinicians across all participating care sites in order to demonstrate how adherence to the agreement benefits patients.

The third component is to receive signoff on the final draft from all participating care sites, which Lehigh’s project leader completed prior to rollout.

The final component is to designate an expert at each care site to answer staff questions. Leaders at Lehigh assigned a navigator at each care site as the go-to person to educate frontline staff on the agreement.

**Developing the Cross-Continuum Care Agreement**

**Key Components of Lehigh Valley’s Breast Care Management Cross-Continuum Care Agreement**

- **Component #1:** Involve Key Stakeholders from Multiple Care Settings
- **Component #2:** Showcase Benefits to Staff to Achieve Buy-In
- **Component #3:** Present Final Draft for Clinician Sign-Off
- **Component #4:** Designate an Expert at Each Care Site to Answer Staff Questions

**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 hematology 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

Source: Lehigh Valley Health Network, Allentown, PA; Nursing Executive Center interviews and analysis.
After implementing the Cross-Continuum Care Agreement, the average time from appointment to biopsy for breast care management patients at Lehigh decreased from weeks to days. Additionally, because part of the agreement describes how to secure reimbursement for the care each site delivers, the percentage of reimbursed breast care management cases more than tripled.

### Improving Timeliness of Care, Reimbursement

#### Average Time from Appointment to Biopsy at Lehigh

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

#### Percentage of Cases Reimbursed for Services at Lehigh

<table>
<thead>
<tr>
<th></th>
<th>Before Cooperative Care Agreement</th>
<th>After Cooperative Care Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</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

Practice in Brief

Leaders develop condition-specific care pathways that span across multiple care settings and are integrated into the EMR; the goal is to prevent unnecessary gaps or duplication in care across settings by ensuring clinicians at all participating sites follow a common, predetermined care pathway.

Rationale

There is often ambiguity about which aspects of patient care caregivers in each setting are responsible for providing—as well as which protocols they should follow. By developing a Cross-Continuum Care Pathway that delineates specific caregiver or care team responsibilities at different settings, leaders can improve care continuity across settings and prevent unnecessary gaps or duplication in patient care.

Implementation Components

**Component #1: Identify Conditions Suitable for a Cross-Continuum Care Pathway**
Leaders select conditions which need Cross-Continuum Care Pathways. Strong candidates are conditions that have a predictable progression, have high volumes, and for which there are often gaps or duplication in care (such as multiple x-rays).

**Component #2: Develop Pathways with Input from Clinicians Across the Continuum**
Leaders select representatives from each participating care setting and clinical area to develop the Cross-Continuum Care Pathway. In addition to key clinical experts, the Nursing Executive Center recommends including administrative and IT representatives to ensure a smooth implementation and roll out.

**Component #3: Track Individual Caregiver Compliance with the Cross-Continuum Care Pathway**
Leaders publicly share performance reports that track individual clinician compliance with the Cross-Continuum Care Pathway to motivate clinicians to follow the pathway.

Practice Assessment

While it takes a lot of time and energy to develop a Cross-Continuum Care Pathway, it is a highly effective strategy for preventing unnecessary gaps and duplication in patient care across settings. The Nursing Executive Center recommends this practice for all organizations with a fully integrated, cross-continuum EMR.

Nursing Executive Center Grades

Practice Impact: A
Ease of Implementation: C
The third option for connecting the care plan across settings is to embed a Cross-Continuum Care Pathway into the EMR. The Nursing Executive Center recommends this option for organizations with a fully integrated, cross-continuum EMR.

To date, most Cross-Continuum Care Pathways have been developed for surgical procedures, such as the joint replacement care pathway shown here. Since the flow of care delivery for patients undergoing a surgical procedure is generally predictable, it is a logical starting point for cross-continuum pathways.

Organizations that have already implemented cross-continuum surgical pathways may be ready to expand their efforts beyond surgical procedures. The next page shares an example of a Cross-Continuum Care Pathway for a medical condition.
Practice #6: Cross-Continuum Care Pathway

In 2014, leaders at Bellin Health Care Systems implemented a Cross-Continuum Care Pathway for patients with acute low back pain, an excerpt of which is shown here. The pathway specifies which aspects of care for acute low back pain patients are carried out by a specialist, the primary care provider, the physical therapy team, and in the patient’s home.

IT leaders at Bellin fully integrated this pathway into the EMR. It prompts caregivers at each setting with the specific actions they need to take (e.g., the PCP is prompted to refer the patient to a specialist if specific red flags are observed).

Bellin followed three key components, outlined on the following pages, to implement the Cross-Continuum Care Pathway for patients with acute low back pain.

A complete version of Bellin’s Acute Low Back Pain Care Pathway can be accessed through an online version of this publication on advisory.com/nec.

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></td>
<td>Addresses treatment options, refers to PT</td>
<td>PT refers patient back to PCP if patient not improving</td>
<td>PCP follows up with patient in 5-7 days if refuses PT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PT team establishes treatment plan</td>
<td>PT discharges patient if improves, provides one-week phone follow-up</td>
</tr>
<tr>
<td></td>
<td>PCP refers patient to specialist after repeat assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Source: Bellin Health Care Systems, Green Bay, WI; Nursing Executive Center interviews and analysis.
Component #1: Identify Conditions Suitable for a Cross-Continuum Care Pathway

The first component of this practice is to determine which conditions are strong candidates for a Cross-Continuum Care Pathway. The more “yes” answers given to the three questions shown here, the stronger the case for building a Cross-Continuum Care Pathway.

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?

Component #2: Develop Pathways with Input from Clinicians Across the Continuum

The second component of this practice is to incorporate input from expert, interdisciplinary team members from all involved care settings into the pathway development. Leaders at Bellin formed an interprofessional team with the representatives shown here to lead the development of their acute low back pain pathway.

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, NEWHVN

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 nonclinical (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)

1) Northeast Wisconsin Health Value Network.

Source: Bellin Health Care Systems, Green Bay, WI; Nursing Executive Center interviews and analysis.
Component #3: Track Individual Caregiver Compliance with the Cross-Continuum Care Pathway

The third component of this practice is to publicly share performance reports that track individual clinician compliance with the Cross-Continuum Care Pathway. This final component is designed to promote accountability and motivate clinicians to adhere to the pathway components relevant to their role.

The Nursing Executive Center recommends the four steps shown here for sharing individual performance data.

Even with an integrated, cross-continuum EMR in place, it took leaders and clinicians two years to develop and implement Bellin’s first Cross-Continuum Care Pathway for a medical condition.

But leaders at Bellin believe the benefits of a highly coordinated care pathway outweigh the effort. They plan to replicate the development and implementation process for four other medical conditions: chronic heart failure, diabetes, CHD and prevention, and stroke.

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

2012
- 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)

2013
- Reviewed evidence-based protocols for acute low back pain
- Mapped out ideal workflow for acute low back pain care pathway

2014
- Integrated acute low back pain pathway into Epic
- Trained staff on use of pathway protocols

2015
- Plan to replicate roll-out for two other pathways (CHD prevention, diabetes)

Other Pathways in Development at Bellin
- Chronic heart failure
- Diabetes
- CHD and prevention
- Stroke

Source: Bellin Health Care Systems, Green Bay, WI; Nursing Executive Center, Instilling Frontline Accountability, 2011; Nursing Executive Center interviews and analysis.
Imperative 2

Promote Clinician Ownership for Cross-Continuum Care

Broaden the Front Line’s Perspective Beyond Their Own Setting
Practice #7: Cross-Continuum Shared Governance
Practice #8: Alternative Care Setting Experience
Practice #9: Community-Focused Nursing School Rotations

Incentivize Continuous Care
Practice #10: Continuum-Focused Leader Incentive Plan
Practice #11: Frontline Organizational Alignment Bonus
The second imperative for building a system that “never discharges” the patient is to promote clinician ownership for cross-continuum care. To achieve this, leaders will need to ensure frontline staff have a cross-continuum perspective and feel responsible for patient care outcomes across the continuum.

This will require a cultural shift. Currently, frontline staff typically focus their attention on care delivered on their immediate shift, unit, or care setting. In the example shown here, a critical care nurse feels responsible only for what patients need in the ICU—and isn’t considering (let alone feeling ownership for) the patient’s recovery at home or follow-up in an outpatient clinic.

While frontline caregivers should always prioritize delivering safe and effective care to their assigned patients, unless they feel ownership for providing continuous care, they may not fully understand what patients need to be successful in other settings.
It’s not surprising that many clinicians only feel ownership for care delivered on their immediate unit or setting. Many elements of clinical education and health system organizational design help create a siloed perspective—and even serve as barriers to a cross-continuum perspective among frontline staff. Key barriers are shown here. For example, frontline caregivers typically interact only with other caregivers at their immediate care site. And frontline staff performance goals are nearly always setting- or unit-specific.

The five practices in this section promote clinician ownership for cross-continuum care by overcoming these structural barriers. The first three practices aim to help broaden staff members’ perspectives beyond their own setting, and the remaining two practices aim to incentivize staff to deliver continuous care.

**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

Source: Nursing Executive Center interviews and analysis.
Practice #7: Cross-Continuum Shared Governance

--- Practice in Brief ---
All frontline staff (regardless of setting) are represented through a shared governance council; through shared governance representation, frontline staff gain a better understanding of the organization as a whole—beyond their specific care site and setting—and what patients need to be successful across the continuum.

--- Rationale ---
With the exception of patient handoffs, most frontline staff only interact with care team members in their immediate care setting. As a result, frontline staff often have a setting-specific perspective about patient care and don’t fully understand how to set their patients up for success in other care settings. By having frontline staff from all settings represented in shared governance, leaders can build a cross-continuum perspective among frontline staff.

--- Implementation Components ---

**Component #1: Create an Ambulatory Shared Governance Council (if it doesn't exist)**
Leaders introduce ambulatory shared governance by determining: the number and type of ambulatory representatives for the council, the selection process for ambulatory nurse representatives, and the logistics for ambulatory shared governance council meetings.

**Component #2: Align Inpatient and Ambulatory Councils**
Leaders align inpatient and ambulatory shared governance councils by holding pre-council planning sessions with inpatient and ambulatory council chairs or fully integrating ambulatory representatives into the system-wide shared governance council.

--- Practice Assessment ---
This practice is recommended for all organizations with both inpatient and ambulatory care settings. In addition to broadening the frontline’s perspective beyond their own setting, this practice also has the potential to improve cross-continuum collaboration and ambulatory staff engagement. It is easier to implement for organizations that already have an inpatient shared governance structure in place. Along with having representation across settings, shared governance ideally includes representation across disciplines as well (e.g., pharmacy, therapy, etc.).

--- Nursing Executive Center Grades ---
Practice Impact: B+
Ease of Implementation: B
One well-established tool for broadening frontline perspectives is shared governance. As shown here, 86% of surveyed nurse executives reported having a shared governance structure in place.

Shared governance can help staff understand issues outside of their own unit. For example, staff participating in shared governance may have the opportunity to provide input on professional practice standards that affect their entire hospital. As a result, staff can gain a broader understanding of how patient care is delivered throughout their entire hospital, rather than only their specific unit.

While shared governance structures are common, many are limited to inpatient settings and comprised of only hospital-based representatives. To truly broaden frontline staff perspectives beyond their own setting, the Nursing Executive Center recommends developing a cross-continuum shared governance program—one that includes representatives from multiple care setting types (e.g., inpatient, ambulatory, home health, etc.). By having frontline staff from all settings represented in shared governance, leaders can cultivate a cross-continuum perspective among frontline staff.

### An Established Tool to Broaden Frontline Perspective

**Percentage of CNOs Who Report Having Shared Governance**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>86%</td>
<td>n=199</td>
</tr>
</tbody>
</table>

1) In response to the survey question, "Which of the following [shared governance structures] do you currently have in place at your organization?"

Source: 2014 NEC Changing Role CNO Survey, Advisory Board Survey Solutions, Nursing Executive Center interviews and analysis.

### 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.
Practice #7: Cross-Continuum Shared Governance offers specific guidance for putting an effective cross-continuum shared governance structure in place.

An example of a cross-continuum shared governance structure is shown here. This comes from Aurora Health Care, which recently integrated representatives from ambulatory clinics into an existing inpatient shared governance structure. As shown here, ambulatory representatives now sit on six system-wide councils, five of which have representatives from both inpatient and ambulatory settings.

The following page describes the first component of this practice—how leaders at Aurora determined the right structure for their ambulatory shared governance council.

Introducing Aurora’s Cross-Continuum Shared Governance Structure

Overview of Aurora’s System-Wide Council 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, and 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

Source: Aurora Health Care, Milwaukee, WI; Nursing Executive Center interviews and analysis.
**Component #1: Create an Ambulatory Shared Governance Council (if it doesn’t exist)**

To create an ambulatory shared governance council, leaders at Aurora answered the three key questions shown here. Notably, the first question is to determine how many representatives will serve on the ambulatory council. Like Aurora (which has 200 ambulatory clinics), many organizations will not be able to select a representative from each ambulatory facility.

For organizations that already have an ambulatory shared governance council in place, we recommend reviewing how your organization answers these questions to confirm you have the appropriate number of representatives and right mix of staff and manager representatives.

<table>
<thead>
<tr>
<th>Key Questions</th>
<th>Aurora’s Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many representatives will we have on the ambulatory council?</td>
<td>16 RNs and two managers participate</td>
</tr>
<tr>
<td>How will we select ambulatory nurse representatives for the council?</td>
<td>RNs apply through selective application process; council structure has equal representation from specialty and primary care clinics</td>
</tr>
<tr>
<td>How will we enable representatives across geographies to participate in meetings?</td>
<td>Council members may attend monthly meetings from regional hubs via phone or video conference</td>
</tr>
</tbody>
</table>

Source: Aurora Health Care, Milwaukee, WI; Nursing Executive Center interviews and analysis.
To ensure ambulatory sites have strong representation in shared governance, the Nursing Executive Center recommends using a selective application process to choose ambulatory representatives. An example of the selective application process from Aurora is shown here. Interested ambulatory nurses must submit an application that includes: their resume, two letters of recommendation, and an essay describing specific examples of times they demonstrated relevant skills—including “problem solving” and “diplomacy.”

Setting a High Bar for Council Membership

Excerpt of Aurora’s Ambulatory Shared Governance Application

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 an example of 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: 
Signed ____________________________

A complete version of Aurora Health Care’s Ambulatory Shared Governance Nurse Application can be accessed through an online version of this publication on advisory.com/nec.

Source: Aurora Health Care, Milwaukee, WI; Nursing Executive Center interviews and analysis.
Component #2: Align Inpatient and Ambulatory Councils

The second component of this practice is to align the inpatient and ambulatory councils. There are two options for doing so.

The first option is to fully integrate ambulatory representatives into the system-wide shared governance council. Leaders at Aurora use this approach and have both inpatient and ambulatory representatives sit on system-wide committees, including the System Nursing Practice Council and System Nursing Professional Development Council.

The second option is to keep inpatient and outpatient council meetings separate—but hold pre-council planning sessions with inpatient and ambulatory council chairs. At Gundersen Health System, select inpatient and outpatient representatives meet monthly to jointly set the agenda for each council, enabling the group to address any issues that span across settings.

For more information on Gundersen’s shared governance structure, see The Integrated Nursing Enterprise at advisory.com/nec.

Two Options for Aligning Inpatient and Ambulatory Councils

<table>
<thead>
<tr>
<th>Before Cross-Continuum Shared Governance</th>
<th>After Integration into System-Wide Shared Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 2014, Aurora had inpatient shared governance and a council structure that did not include ambulatory RNs</td>
<td>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</td>
</tr>
<tr>
<td>Prior to 2005, nursing leaders and staff representatives sat on seven nursing shared governance councils; there was no coordination between the ambulatory council and other six councils</td>
<td>In 2005, nursing leaders consolidated seven nursing councils into three councils: Inpatient, Outpatient, and Nursing Marketing and Communications; a group representing cross-continuum nursing interests jointly plans all council agendas during pre-council planning sessions</td>
</tr>
</tbody>
</table>

Source: Gundersen Health System, La Crosse, WI; Aurora Health Care, Milwaukee, WI; Nursing Executive Center, The Integrated Nursing Enterprise, 2013; Nursing Executive Center interviews and analysis.
Practice #8: Alternative Care Setting Experience

--- Practice in Brief ---

Frontline nurses either shadow a peer—or deliver direct patient care—in a care setting that isn’t their primary work site; the goal is to help frontline nurses better understand care in different settings, and how to help patients achieve successful outcomes across the continuum.

Rationale

Most frontline nurses spend the majority of their career in a single care setting, such as a hospital or primary care clinic. As a result, frontline nurses often have a setting-specific perspective and don’t fully understand what their patients will need to be successful in other care settings. By allowing nurses to see (and possibly deliver) care at a different care setting, leaders can help frontline nurses understand the larger picture of patient care and better prepare patients for care beyond their specific setting.

Implementation Components

**Option #1: Cross-Setting Nurse Shadowing**

Frontline staff shadow a peer in an unfamiliar care setting; leaders equip shadowing nurses with a set of learning objectives to maximize the value of the experience.

**Option #2: Blended Inpatient/Outpatient RN Role**

Frontline staff opt into an ongoing job rotation and alternate the setting in which they provide care—spending half of their week at an inpatient site and the other half in an outpatient site.

Practice Assessment

This practice is a highly effective strategy to broaden frontline nurses’ perspectives beyond their own care setting. While Option #1 requires leaders to cover the cost of nurses’ time spent shadowing, Option #2 is cost neutral. However Option #2 involves considerable administrative complexities—including creating new job descriptions, ensuring rotating staff are up to date on all necessary inpatient and outpatient competencies, and recruiting staff into the position. Both options are easier to implement at organizations without union representation.

--- Nursing Executive Center Grades ---

Practice Impact: A-
Option 1’s Ease of Implementation: C+
Option 2’s Ease of Implementation: C
An effective way to expand an individual’s perspective is to provide an opportunity to “walk in another person’s shoes”—or experience what another person’s life is like on a day-to-day basis. One well-known program which provides this opportunity is the Fulbright U.S. Student Program. Fulbrighters live and work in their host country—enabling them to gain an in-depth understanding of its culture.

The practice described on the following pages applies the same principle to frontline nurses. The goal is to immerse frontline nurses in a previously unfamiliar care setting to allow them to gain a more holistic understanding of cross-continuum patient care.

There are two primary options for allowing a nurse to “walk in another nurse’s shoes.” The following pages explore each in turn.

---

**Broading Young Professionals’ Perspectives**

**Fulbright Program 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: Cross-Setting Nurse Shadowing

The first option is to have a frontline staff member shadow a peer in an unfamiliar care setting.

To provide nurses with a broader understanding of the care continuum, leaders at Intermountain Healthcare implemented this approach. Intermountain’s shadowing program allows inpatient and ambulatory nurses within the same service line to shadow a peer for 24 hours over the course of three months. For example, a nurse in the NICU can shadow a peer in a pediatric clinic, and vice versa.

To ensure nurses participating in the program have a meaningful shadowing experience, leaders set clear learning objectives and ask shadowing nurses to write clinical narratives about their experience. The following page provides further detail on these learning objectives.

### Shadowing to Expand Frontline Nurses’ Perspective

<table>
<thead>
<tr>
<th>Current Nurse Shadowing Pairings at Intermountain</th>
<th>Key Elements of Shadowing Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICU – Pediatric Clinic</td>
<td>Lasts 24 hours over three months</td>
</tr>
<tr>
<td>Labor &amp; Delivery – Perinatal Clinic</td>
<td>Formal learning objectives</td>
</tr>
<tr>
<td>Med/Surg – Wound Clinic</td>
<td>Participants record observations in provided journal</td>
</tr>
</tbody>
</table>

### 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 the program, and be engaged in the advancement of nursing care delivery
- During their annual orientation program, program manager conveys the program’s learning objectives to nurses (and their managers) before the exchange experience

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.
The learning objectives of Intermountain’s nurse shadowing program are shown here. They include: understanding the challenges frontline caregivers face in another setting, and how patients access the other setting and move through it. The goal is to help participants improve their own nursing practice and better meet patient needs.

### 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

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.
Option #2: Blended Inpatient/Outpatient RN Role

The second option for this practice is to embed cross-setting rotations into a frontline caregiver’s role. Leaders at Cincinnati Children’s Hospital Medical Center wanted to pursue this approach and, in order to identify the most effective way to embed rotations across settings into a frontline role, they piloted the four models shown here.

Leaders ultimately implemented the model shaded in red. Under the selected model, nurses spend 50% of their week in an inpatient setting and 50% of their week in an outpatient setting. For example, a nurse might work in a cardiology step-down unit on Monday and Tuesday and in an ambulatory cardiology clinic on Wednesday and Friday.

The following page provides further detail on how Cincinnati Children’s structures the Blended Inpatient/Outpatient RN Role.

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

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
- 10 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

Source: Cincinnati Children’s Hospital Medical Center, Cincinnati, OH; Nursing Executive Center interviews and analysis.
The key elements of Cincinnati Children’s Blended Inpatient/Outpatient RN Role are shown here. Two nurses within the same service line are paired—with one working half of the week in an inpatient setting and the other working the same schedule in an outpatient setting. For the second half of the week, the two nurses switch sites. Each nurse assumes full care responsibilities while working at either site.

Cincinnati Children’s has Blended Inpatient/Outpatient RNs in the service lines shown here. Currently the way the role is filled is when an outpatient position opens, two interested inpatient nurses from the same service line jointly fill the role.

Early participants in Cincinnati Children’s Blended Inpatient/Outpatient RN Role have shared positive feedback, a sampling of which is shown here. Participants note the role can help nurses better prepare patients for success across the continuum.

---

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

<table>
<thead>
<tr>
<th>Rotations Within Same Service Line</th>
<th>Time Split Between Inpatient and Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Responsibility During Rotations</td>
<td>Interested Inpatient Nurses Jointly Fill Empty Outpatient Role</td>
</tr>
</tbody>
</table>

### Rotation Program Service Lines

- Neurosurgery
- Pulmonary
- Orthopedics
- Oncology
- Nephrology
- Cardiology
- Pediatrics
- 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.
Leaders interested in this practice should weigh the implementation considerations shown here.

Regarding training, the first option, Cross-Setting Nurse Shadowing, requires only minimal training, since shadowing nurses do not provide direct patient care. In contrast, implementing a Blended Inpatient/Outpatient RN Role requires intensive upfront training so nurses can provide patient care in both settings.

Regarding cost, both options are FTE neutral, but leaders must cover the cost of nurses' time for Cross-Setting Nurse Shadowing. Other than upfront training costs, Blended Inpatient/Outpatient RN Roles are cost neutral.

Regarding logistics, implementing a Blended Inpatient/Outpatient RN Role is more logistically challenging than Cross-Setting Nurse Shadowing. For the Blended Inpatient/Outpatient RN Role, the managers at rotating nurses' inpatient and outpatient sites need to coordinate on scheduling and performance reviews.

Regarding workforce demographics, Cross-Setting Nurse Shadowing is most appropriate for experienced RNs—since "host" RNs need to thoroughly explain the care and processes in their setting to shadowing RNs. In contrast, Blended Inpatient/Outpatient RN Roles may be most appealing to new graduate RNs.

### Weighing the Options

#### Implementation Considerations

<table>
<thead>
<tr>
<th>Option</th>
<th>Training</th>
<th>Cost</th>
<th>Logistics</th>
<th>Workforce Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-Setting Nurse 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>Blended Inpatient/Outpatient RN Role</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 graduate nurses who don't have set practice expectations</td>
</tr>
</tbody>
</table>

Source: Intermountain Healthcare, Salt Lake City, UT; Cincinnati Children’s Hospital Medical Center, Cincinnati, OH; Nursing Executive Center interviews and analysis.
Practice #9: Community-Focused Nursing School Rotations

Practice in Brief
Nursing school leaders require students to complete a clinical rotation in a community-based care setting; the goal is to expand nursing student clinical experiences beyond acute care and equip new graduate nurses to help patients manage their care across the continuum.

Rationale
Most nursing schools offer only hospital-based clinical rotations. This means nursing students have limited exposure to patient needs beyond acute care. By requiring students to complete a community-based, non-hospital clinical rotation, nursing students gain a better understanding of the broader patient care continuum, and it can prepare them to think beyond only their patients’ care needs as a practicing nurse.

Implementation Components

**Component #1: Collaborate with Nursing School Leaders to Identify Non-Hospital Care Sites for Clinical Rotations**
Health system leaders and academic partners collaboratively secure non-hospital care sites in the community for nursing student clinical rotations, such as schools, independent living facilities, and summer camps.

**Component #2: Integrate Community-Based Rotations into Nursing School Curriculum**
Nursing school instructors use facilitated discussions, written assignments, and oral presentations to incorporate community-based clinical experiences into classroom learning objectives. This alignment helps nursing students synthesize and cement their clinical experience in the classroom.

Practice Assessment
This practice requires substantial up-front collaboration with academic partners, but is strongly recommended as a strategy for helping nurses understand patient care across the continuum early in their careers. To identify potential sites for community-based clinical rotations, nursing school and health system leaders should consider tapping into their own professional networks and affiliations in the community.

Nursing Executive Center Grades
Practice Impact: B
Ease of Implementation: C+
A powerful way to help nurses understand the broader care continuum early in their careers is to expose nursing students to non-hospital based care during clinical rotations. However, there are at least two common barriers to offering non-acute clinical rotations. The first is finding sufficient sites for community-focused rotations. Second, even if students participate in a non-acute clinical rotation, many programs do not meaningfully integrate community-focused rotations into the classroom learning experience.

The following practice addresses both of these barriers.

**Component #1: Collaborate with Nursing School Leaders to Identify Non-Hospital Care Sites for Clinical Rotations**

The first component of this practice is to collaborate with academic partners to secure non-hospital care sites for nursing student clinical rotations.

Examples of potential community-focused rotation sites are shown here. To identify potential rotation sites, nursing school and health system leaders should consider tapping into their own professional networks and affiliations in the community, including community-based non-profits with which health system administrators are involved.

**Recognizing Barriers to Non-Acute Rotations**

**Two Common Barriers**

- Insufficient Number of Community-Focused Rotation Sites
- Experiences Not Discussed in School

**Thinking Outside the Hospital Walls to Identify Rotation Sites**

**Potential Sources of Community-Focused Rotation Sites**

- Elementary schools
- Independent living facilities
- Daycare center for medically complex children
- Summer day camp for children

Source: Nursing Executive Center interviews and analysis.
An example of tapping into professional networks and identifying a creative location for a non-acute care clinical rotation comes from The University of Iowa College of Nursing. At Iowa, all undergraduate BSN students complete six weeks of community-based clinical experience in gerontological nursing. Students spend three weeks conducting assessments and taking histories of healthy older adults in the community. Students spend an additional three weeks working with a preceptor at an adult day care, assisted living facility, hospice, or home care. To secure these opportunities, leaders at University of Iowa College of Nursing leveraged their relationships with retired faculty living in the community.

Iowa’s Community-Based Geriatric Rotation

Key Elements

<table>
<thead>
<tr>
<th>Well Visits</th>
<th>Community-Based Living Center Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td></td>
</tr>
<tr>
<td>• Three-week rotation</td>
<td>• Three-week rotation</td>
</tr>
<tr>
<td><strong>Learning Objectives</strong></td>
<td></td>
</tr>
<tr>
<td>• Conduct health assessment</td>
<td>• Understand resources available to older adults to make appropriate referrals</td>
</tr>
<tr>
<td>• Take health history</td>
<td>• Gain experience speaking with members of other care teams</td>
</tr>
<tr>
<td><strong>How Iowa Sourced Rotation Site</strong></td>
<td>• School administrators on boards of participating rotation sites</td>
</tr>
<tr>
<td>• Retired faculty living in community-based living centers</td>
<td></td>
</tr>
</tbody>
</table>

Case in Brief: The University of Iowa College of Nursing

- Established in 1898, the University of Iowa College of Nursing is headquartered in Iowa City, Iowa
- All undergraduate BSN students required to complete 90 hours of clinical experience in gerontological nursing with guidance of preceptors and faculty; clinical experiences coordinated with in-class seminars to enhance application of gerontology content and to debrief clinical experiences
- Six-week rotation includes three-week rotation in community (well visits) and three-week rotation in hospice, adult day health care, assisted living, or home health care (community-based living center visits)

Source: University of Iowa College of Nursing, Iowa City, IA; Nursing Executive Center interviews and analysis.
Component #2: Integrate Community-Based Rotations into Nursing School Curriculum

The second component of this practice is to integrate community-based rotations into classroom learning. Students in Iowa's Geriatric Rotation integrate their clinical experiences into the classroom through classroom discussions, written assignments, and oral presentations.

A complete version of University of Iowa College of Nursing's Geriatric Rotation Syllabus can be accessed through an online version of this publication on advisory.com/nec.

Effective community-based nursing school rotations are a collaborative effort between health system leaders and nursing school leaders. To help facilitate a dialogue about creating community-focused nursing school rotations, we offer the discussion questions shown here.

Aligning Rotation and Classroom Experiences

Excerpt of Iowa’s Geriatric Rotation Syllabus

Adult/Geriatric Clinical Practicum

Course Description

The course provides an in-depth clinical experience designed to apply basic and complex concepts of nursing care for adults of all ages in a variety of settings. Particular attention is focused on older adults. Development and application of critical thinking skills necessary to understand disease process and the associated signs and symptoms, interventions, and outcomes is emphasized.

Course Objectives

- Perform basic and complex patient-centered nursing interventions safely
- Discuss nursing outcomes of relevance to each client
- Collaborate with clients, significant others, health team members and/or community-based agencies when planning and delivering care and services
- Support the psychological well-being of individuals in health, illness, and end-of life
- Promote accurate, effective patient-centered education across settings
- Demonstrate critical thinking in the provision of care to address the needs of adults with particular attention to the unique needs of older adults

Course required for all undergraduate BSN students
Rotation includes both inpatient and community-based clinical care experiences
Students apply learnings from clinical care experiences through written assignments and oral presentations

Collaborating with Nursing School Leaders to Create Effective Community-Focused Rotations

Key Questions for CNOs to Ask Academic Partners

1. Where are people in our community receiving care outside of hospitals?

2. If you could select three community-focused sites for student clinical rotations, which sites would you choose?

3. What barriers currently prevent you from offering community-focused rotations? How can my organization help you overcome those barriers?

Source: University of Iowa College of Nursing, Iowa City, IA; Nursing Executive Center interviews and analysis.
The second imperative for building a system that “never discharges” the patient is to promote clinician ownership for cross-continuum care. To achieve this imperative, leaders will need to follow two strategies. The first strategy is to broaden the front line’s perspective beyond their own setting, which is discussed on pages 58 through 74 of this publication. The second strategy is to incentivize continuous care, which is discussed on the following pages.

Currently leader and frontline incentives reinforce silos between care settings. Most leaders’ performance goals are setting-, site-, or unit-specific, like the representative manager performance goals shown here. Moreover, to the extent frontline staff have individual performance goals or incentives, they are even more likely to be site- or unit-specific metrics.

The two practices in this section incentivize leaders and staff on cross-continuum performance—helping to break down silos between care settings.

**Current Incentives Perpetuate Site-Specific Care**

**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
- Percentage of patients with influenza vaccination received
- Number of patient visits

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

Source: Nursing Executive Center interviews and analysis.
Practice #10: Continuum-Focused Leader Incentive Plan

Practice in Brief
Organization includes at least one cross-continuum metric on all leaders’ incentive plans; the goal is to incentivize leaders to focus on organization-wide performance—not just performance for their facility or care setting.

Rationale
Most leader incentive plans focus on facility- or setting-specific performance (e.g., HCAHPS scores or length of stay). These siloed metrics reinforce siloed care delivery. By including at least one cross-continuum metric on leader incentive plans, organizations give leaders concrete motivation to focus on cross-continuum performance.

Implementation Components

Component #1: Include at Least One Cross-Continuum Metric on Leader Incentive Plans
Senior leaders select one or more continuum-focused goals to include in all leader incentive plans. The goals should be measured at the system level (rather than facility or unit level). Potential cross-continuum metrics to consider incorporating into incentive plans are: readmission rate, medication adherence, and patient portal registrants.

Component #2: Tier Incentive Pay Structure by Level
Senior leaders structure the leader incentive plan so that it scales to each leader’s level within the organization. More senior leaders (e.g., executives, directors) should have more of their bonus tied to organization-wide performance than frontline leaders (e.g., managers, frontline supervisors).

Practice Assessment
While this practice requires substantial executive buy-in, it is a highly effective strategy to promote ownership for cross-continuum care. This practice is easier to implement at organizations that already have a leader incentive plan in place.

Nursing Executive Center Grades
Practice Impact: A
Ease of Implementation: B
To incentivize continuous care, the Nursing Executive Center recommends introducing cross-continuum incentives to leaders before introducing them to frontline staff. We recommend starting with leaders for at least three reasons.

First, leaders have broad purview and can impact the performance of a large portion of the organization.

Second, there’s a potential for a “halo effect.” Since leaders rely on staff to enhance performance on specific goals, frontline staff are likely to also feel a greater sense of ownership for cross-continuum care.

Third, since many health care organizations already have a leader incentive program in place, it may be possible to modify an existing incentive plan by including cross-continuum goals—rather than starting from scratch. The data shown here suggests that among high-performing organizations nearly all have incentives for executives, more than 70% have incentives for directors, and nearly 40% have incentives for managers.

The practice on the following pages describes how to design a leader incentive plan to promote a sense of ownership for cross-continuum performance among a health system’s leaders.
Component #1: Include at Least One Cross-Continuum Metric on Leader Incentive Plans

The first component of this practice is to select one or more continuum-focused goals to include in all leader incentive plans. At Premier Health, a portion of incentive pay for all leaders is based on system-wide performance on the organization’s scorecard metrics. Several of these metrics, such as “Medicare mortality” and “readmission,” span across care settings.

Notably, incentive pay for all leaders at Premier is linked to the same metrics. For example, all leaders have the system-wide readmission ratio as a performance metric on their incentive plans.

Linking Incentives to System Scorecard Metrics

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>
<tr>
<td></td>
<td>• Readmission</td>
</tr>
<tr>
<td></td>
<td>• Patient safety indicators</td>
</tr>
<tr>
<td></td>
<td>• Central line associated blood stream infection</td>
</tr>
<tr>
<td></td>
<td>• HCAHPS</td>
</tr>
</tbody>
</table>

Physician partnership

• Physician satisfaction survey
• Physician satisfaction survey with EHR

Competitive strength and financials

• Cash flow margin
• Cost per CMI adjusted discharge

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)

Source: Premier Health, Dayton, OH; Nursing Executive Center interviews and analysis.
Component #2: Tier Incentive Pay Structure by Level

The second component of this practice is to structure the leader incentive plan so it scales to each leader’s level within the organization. Since more senior leaders (e.g., executives, directors) have broader purview, they should have more of their bonus tied to organization-wide performance than frontline leaders (e.g., managers, frontline supervisors).

As shown here, Premier ties a larger percentage of executive and director incentive pay to system-wide performance on scorecard metrics than for frontline managers.

Evidence suggests focusing leaders on cross-continuum metrics can improve cross-continuum performance. Premier’s system-wide readmission ratio decreased after senior leaders added it to the organization’s system-wide scorecard metrics. While this practice is only one component of a broader readmissions reduction strategy, leaders at Premier point to the incentive plan as a key driver in their reduction in system-wide readmissions.

<table>
<thead>
<tr>
<th>Role</th>
<th>Type of Incentive</th>
<th>Percentage of Incentive Based on Organization-Wide Performance</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>

Premier’s Incentive Pay by Role

Cross-Continuum Incentives Driving System-Wide Decrease in Readmissions

Premier System-Wide Readmission Ratio
Before and After Inclusion in Incentive Plan

1) Based on scorecard metrics.
2) Observed over expected ratio.

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

Leaders employ a house-wide bonus system with straightforward payout structure to focus frontline staff on key cross-continuum goals.

Rationale

If frontline staff have performance goals or incentives, they nearly always focus solely on unit- or site-specific performance (such as a unit’s core measure compliance or a clinic’s patient experience scores). Focusing frontline staff solely on the performance of a single site of care can contribute to siloed care delivery. By creating an organizational alignment bonus that includes cross-continuum metrics, leaders can foster frontline ownership of care that spans beyond their immediate unit and care setting.

Implementation Components

Component #1: Create Simple, Easy-to-Understand Bonus Payout Structure
Leaders create a house-wide bonus structure that frontline employees can easily understand, including only one or two metrics and explaining potential payouts in frontline-friendly terms.

Component #2: Include a Cross-Continuum Metric in the Bonus Program
Leaders select a cross-continuum metric as one of the bonus program goals.

Component #3: Keep Goal Performance Top of Mind
Leaders employ a comprehensive, multipronged outreach campaign to ensure staff maintain attention to bonus goals beyond once-a-year payouts.

Practice Assessment

This practice is a strong strategy to focus frontline staff on cross-continuum performance. Notably, this practice is possible for unionized organizations, since it is a no-risk, all-reward bonus, with the same amount given to everyone in the organization. Initial development of the bonus program structure and comprehensive communication plan requires a moderate investment of leader time. Leaders should incorporate a financial trigger into the bonus policy to ensure the organization can fund the payouts.

Nursing Executive Center Grades

Practice Impact: A-
Ease of Implementation: B
To incentivize frontline staff to deliver continuous care, the Nursing Executive Center recommends designing a frontline organizational alignment bonus that includes a cross-continuum metric. We recommend a bonus program over other types of frontline incentives for three reasons.

First, leaders can incorporate a financial trigger into the bonus program’s design to ensure the organization can truly afford to pay the bonus. (In other words, the intent is for organizational performance to fund the bonus. If performance is strong, staff receive a larger bonus. If performance isn’t strong, then staff receive a smaller bonus—or none at all.)

Second, unlike merit pay, organizational alignment bonuses are independent of performance reviews, so a bonus plan can be introduced without impacting the performance evaluation process.

Finally, an organizational alignment bonus is possible for unionized organizations, since it is a no-risk, all-reward bonus, in which all frontline staff receive the same amount. Descriptions of alignment bonuses at two unionized organizations are shown here.

The practice on the following pages describes the three key components for implementing an organizational alignment bonus that promotes cross-continuum care.
Component #1: Create Simple, Easy-to-Understand Bonus Payout Structure

The first component of this practice is to employ a simple bonus structure that helps staff understand the goals and potential rewards. Scripps Health developed a straightforward and easy-to-understand program that encourages staff to maintain their focus on bonus program goals.

Four key elements of Scripps' Success Shares bonus program are shown here. First, the program has a funding trigger: financial performance, measured by a simple EBIDA\(^1\) target, determines whether staff will be eligible for a bonus. Second, the program focuses on a single performance metric—system-wide HCAHPS performance.\(^2\) Third, leaders predetermine award pool amounts. Staff learn one year in advance what the exact payout will be for hitting goal targets, making the program tangible and real. Fourth, leaders communicate awards in a language easily understood by frontline staff. Scripps represents bonus amounts as “days’ pay” rather than a percentage of base salary to help staff easily grasp potential rewards.

Since introducing the Success Shares program, Scripps has seen significant improvements in patient satisfaction, as shown here.

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Improving Patient Satisfaction Through Frontline Bonus Program

Key Elements of Scripps’ “Success Shares” Bonus Program

- **$** Bonus funded if organization hits system-level EBIDA\(^1\) target; only pay out if EBIDA target hit
- **Diagram** Bonus linked to system-wide HCAHPS performance
- **Target** Maximum payout equivalent to five days pay, awarded annually
- **Speech bubble** Award amount communicated in terms of “number of days’ pay” in order to be easily understood by staff

System-Wide HCAHPS Performance at Scripps

- **Line graph** System-wide HCAHPS performance from FY 2005 to FY 2013, showing improvement after the introduction of the Success Shares program.

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% to 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.
2) In 2013, leaders at Scripps added a second performance goal to their Success Shares bonus program.

Source: Scripps Health, San Diego, CA; HR Advancement Center, Hardwiring Accountability at the Front Line, 2012; Nursing Executive Center interviews and analysis.
Component #2: Include a Cross-Continuum Metric in the Bonus Program

The second component of this practice is to select a cross-continuum metric as one of the bonus program goals.

A cross-continuum metric is one that all settings can influence in some way—even if the influence is indirect. A starter list of potential cross-continuum metrics to include in a frontline staff bonus program is shown here.

Organizations that already have a frontline organizational alignment bonus in place—but have a setting-specific performance metric (e.g., HCAHPS)—can add a second, cross-continuum performance goal to the program.

Organizations that would like to incorporate a second goal should follow the guidance listed here. In particular, to avoid making the program too complex, the Nursing Executive Center recommends including no more than two performance goals (excluding the financial trigger).

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
- Number of eligible community members connected to appropriate health resources
- Percentage of patients with listed PCPs
- 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

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)

Source: Nursing Executive Center interviews and analysis.
Component #3: Keep Goal Performance Top of Mind

The third component of this practice is to keep goals top of mind for frontline staff throughout the year. For its Success Shares program, Scripps employs the multipronged communication campaign shown here.

A particularly effective method for keeping frontline staff focused on the bonus program across the year is to share an online calculator that estimates the current bonus amount each staff member would receive based on organizational performance to date.

Scripps offers an online bonus calculator on their intranet site. A screenshot of the calculator is shown here. Staff can visit the tool anytime, enter their information, and see their potential award in real time, further reinforcing the connection between payouts and performance.

Update Staff on Goal Progress, Not Just Payouts

Scripps Health’s Success Shares Program Communication Plan

<table>
<thead>
<tr>
<th>Communication Tools and Collateral</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year-end award statement by site</td>
<td>Annually</td>
</tr>
<tr>
<td>Video email from senior leadership</td>
<td>Annually</td>
</tr>
<tr>
<td>Articles and regular features in Inside Scripps, around Newsletters, E-Source, and Resource</td>
<td>Monthly</td>
</tr>
<tr>
<td>Provide updates and information to site newsletter articles</td>
<td>Monthly</td>
</tr>
<tr>
<td>Monthly performance scorecard (for internal posting and distribution) for all business units</td>
<td>Monthly</td>
</tr>
<tr>
<td>Program overview brochure mailed to employee homes</td>
<td>Beginning of fiscal year</td>
</tr>
<tr>
<td>Incorporate updates into Managers’ Hotsheet</td>
<td>Monthly</td>
</tr>
<tr>
<td>Web page and calculator</td>
<td>Ongoing – monthly update</td>
</tr>
<tr>
<td>FAQ introducing second performance goal on productivity</td>
<td>One time</td>
</tr>
</tbody>
</table>

Seeing the Real-Time Impact of Performance on Bonus

Scripps Health Incentive Payout Calculator

**Step 1: Select business unit**

**Step 2: Tool auto-populates EBIDA, patient satisfaction score**

**Step 3: Enter hourly rate of pay**

**Step 4: Tool auto-calculates estimated incentive award**

Source: Scripps Health, San Diego, CA; HR Advancement Center, Hardwiring Accountability at the Front Line, 2012; Nursing Executive Center interviews and analysis.
Money Not the Only Motivator
Nonfinancial Incentives Clearly Impactful for Staff

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

<table>
<thead>
<tr>
<th>Nonfinancial Incentives</th>
<th>Financial Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Praise from Manager</td>
<td>Cash Bonuses</td>
</tr>
<tr>
<td>67%</td>
<td>60%</td>
</tr>
<tr>
<td>Attention from Leaders</td>
<td>Salary Increases</td>
</tr>
<tr>
<td>63%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Money Not the Only Motivator
Nonfinancial Incentives Clearly Impactful for Staff

While financial incentives can be powerful motivators, nurse leaders should not overlook nonfinancial incentives. In fact, national cross-industry data suggests praise and attention from leaders is at least as impactful—if not more so—as financial incentives.

The Nursing Executive Center’s publication, *The National Prescription for Nurse Engagement*, offers several practices to help nurse leaders effectively use a powerful nonfinancial incentive: meaningful recognition. The table shown here highlights three practices on this topic. Any of these could be used to reward strong cross-continuum performance.

Center Resources on Tying Recognition to Goals

<table>
<thead>
<tr>
<th>Practice</th>
<th>Capsule Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager’s Frontline Recognition Kit</td>
<td>Leaders provide each unit manager with a kit containing staff members’ home addresses, note cards, stamps, and tips for providing meaningful feedback; goal is to equip managers to easily send personalized, handwritten notes to staff members’ homes following exemplary performance</td>
</tr>
<tr>
<td>Principled Recognition Triggers</td>
<td>Unit managers and executive leaders establish clear performance criteria, tied to specific goals, that determine when staff receive special rewards or recognition</td>
</tr>
<tr>
<td>Executive’s Frontline Recognition Process</td>
<td>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</td>
</tr>
</tbody>
</table>


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1) Respondents include executives, managers, and employees of global companies from a range of sectors.
2) Respondents selecting “extremely” or “very effective.”

Instill Patient and Family Ownership for Self-Care

Appeal to Patients’ Personal Motivators for Involvement
Practice #12: Personally Motivating Goal Incorporation
Practice #13: Nonclinical Peer Advisor

Equip Patients and Families with Tools for Self-Management
Practice #14: Inpatient-Based Key Caregiver Skill Building
Practice #15: Recorded Transition Instructions
Practice #16: Personalized Patient Support Line
Practice #17: Daily Text Reminders
Instill Patient and Family Ownership for Self-Care

The third imperative for building a system that “never discharges” the patient is to instill patient and family ownership for self-care.

A growing body of research shows that patients who are more activated (have the knowledge, skills, and confidence to manage their own health) have better outcomes. For example, in a study of over 4,000 patients, researchers found that patients who were highly activated had better outcomes across a variety of measures—including medication adherence and quality of life—compared to patients who exhibited lower levels of activation.

Patients with low activation levels not only have poorer outcomes, they are more costly. For example, one study published in *Health Affairs* found that the cost of treating asthmatic patients with the lowest activation levels was 21% higher than the cost of treating patients with the highest activation levels.

The six practices in this section can help leaders drive patient engagement by promoting patient and family ownership for self-care. The first two practices help clinicians appeal to patients’ personal motivators for involvement. The remaining four practices help clinicians equip patients and families with tools for self-management.

**Patient Ownership Driving Better Outcomes**

**Association of Patient Activation with Outcome Measures**

n=4,108; p<0.0001

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

**The Steep Price of Disengagement**

**Costs for Asthmatic Patients**

21% higher

<table>
<thead>
<tr>
<th></th>
<th>Patients with High Activation</th>
<th>Patients with Low Activation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Adherence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Life Rated “Good/Very Good”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Practice #12: Personally Motivating Goal Incorporation

Practice in Brief
Clinicians work closely with each patient to identify a personal, meaningful, and long-term health goal. Clinicians then use this goal to create a care plan with interim milestones for patients. The aim is for patients to see a clear connection between their adherence to their care plan and their ability to achieve their desired health goal.

Rationale
Many patients lack motivation to follow care plans. This is often because their care plans don't connect to their personal goals (e.g., the ability to return to work or take a trip). When clinicians develop a care plan that directly connects to a patient's personal goals, they engage patients in their care and inspire them to follow their care plan.

Implementation Components

Component #1: Surface a Meaningful, Long-Term, Personal Goal
Clinicians use Motivational Interviewing techniques to help patients identify a long-term, personal health goal. The goal should be meaningful to the patient and something they are willing to work hard to achieve.

Component #2: Include Interim Milestones in the Care Plan That Illustrate Progress Toward the Selected Goal
Clinicians include interim milestones in the care plan that clearly map towards the patient's selected goal. The aim is to clearly illustrate how adhering to the care plan will help the patient achieve his or her long-term goal.

Component #3: Communicate the Patient's Goal to All Care Team Members
Clinicians ensure all members of the care team are aware of each patient's personal goal by either documenting the goal in a prominent location in the patient's record or discussing the patient's goal during interdisciplinary care conferences.

Practice Assessment
This practice is an effective means of inspiring patients to follow their care plan. It is highly recommended for all organizations.

Nursing Executive Center Grades
Practice Impact: B+
Ease of Implementation: A-
Practice #12: Personally Motivating Goal Incorporation

Often patients aren’t motivated to follow their recommended care plan because they don’t see a connection between their care plan and their personal priorities (e.g., the ability to return to work or take a trip). All too often, that is because the care plan reflects the clinician’s priorities—but not the patient’s. That is the case in the example shown here. In this example, the clinician’s goals are clinically appropriate, but are not explicitly connected to the patient’s priorities.

Many organizations have begun to incorporate goals that are personally meaningful for patients into their care plan—but the focus is often on short-term goals (for instance walking up a flight of stairs and leaving the hospital by a certain date). Select strategies for short-term collaborative goal setting are shown here. However, few organizations integrate patients’ long-term, personal goals into their care plans, or show patients how achieving key health care milestones can help them reach their longer-term goals.

Key components of incorporating a patient’s long-term goal into the care plan are described on the following page.

Setting the Course for Patient-Centric Goals

Still Not Appealing to Patients’ Ultimate Goals

<table>
<thead>
<tr>
<th>Clinician Goals</th>
<th>Patient Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim</strong></td>
<td>“We need to make sure your blood pressure levels normalize before discharge.”</td>
</tr>
<tr>
<td><strong>Long-Term</strong></td>
<td>“I want to travel abroad with my family later this year.”</td>
</tr>
<tr>
<td></td>
<td>“I just want to get back to work tomorrow.”</td>
</tr>
</tbody>
</table>

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>

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; Nursing Executive Center interviews and analysis.
Practice #12: Personally Motivating Goal Incorporation

The first component is to use Motivational Interviewing techniques to surface meaningful long-term goals. Pages 30 through 34 of this publication provide further guidance on Motivational Interviewing. The second component is to build a care plan that includes interim milestones clearly linked to the patient’s selected goal. The third component is to communicate the patient’s personal goal to all care team members, by either documenting it in a prominent location in the patient’s record or discussing it during interdisciplinary care conferences.

An example of the potential impact of including personally meaningful longer-term goals in care plans is shown here. Sarah was a young teen with a non-progressive neuro-muscular disorder. She needed reconstructive surgery on both legs, and had to complete intensive physical therapy to recover. As shown here, Sarah’s caregivers mapped key milestones in her care plan to her ultimate goal of attending summer camp. By developing a care plan that was linked to Sarah’s personal goal, caregivers motivated Sarah throughout the recovery process and helped her achieve her personal goal.

Setting Meaningful Goals for Long-Term Engagement

Key Components of Personally Motivating Goal Incorporation

Component #1: Surface a Meaningful, Long-Term, Personal Goal
Component #2: Include Interim Milestones in the Care Plan That Illustrate Progress Toward the Selected Goal
Component #3: Communicate the Patient’s Goal to All Care Team Members

Sarah’s Story in Brief
- Young teen with nonprogressive neuro-muscular disorder, full cognitive ability
- Bracing no longer effective; Sarah needs full reconstructive surgery from the knees down, a multisite 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

Sarah’s Countdown to Sleep Away 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

- 7 months to camp
  Schedule surgery with enough time to recover for camp
- 16 weeks to camp
  Travel to hospital for multisite 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 physical therapy (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!

Source: Nursing Executive Center interviews and analysis.
Practice #13: Nonclinical Peer Advisors

Practice in Brief
Leaders deploy peer advisors to build trust between patients and the health system. A Nonclinical Peer Advisor is a member of a patient’s community who is uniquely positioned to relate to patients’ everyday challenges; the goal is to build strong relationships with patients who might otherwise be disengaged, and inspire them to access the resources they need to manage their health.

Rationale
Patients don’t always trust or relate to their clinicians. For example, some patients believe their caregivers’ recommendations are in direct conflict with their personal religious beliefs. And some patients with lower socioeconomic status believe their caregivers don’t understand the daily challenges and chronic stressors they experience. As a result, these patients may not feel comfortable seeking help and may even delay care until they require hospitalization. Nonclinical peers—who share a similar background to the patients they partner with—can increase the health of patients by encouraging patients to follow their care plan and connecting them with the resources to do so.

Implementation Components

Component #1: Identify the Target Patient Population
Leaders use three screening criteria to identify patient populations suitable for a Nonclinical Peer Advisor: patients who are under-represented in an organization’s health care workforce, have a high rate of health care utilization, and have difficulty communicating effectively with clinicians.

Component #2: Find a Peer Advisor Who Can Relate to the Target Population
Leaders use clear selection criteria and a targeted recruitment strategy to find qualified applicants who can meet the needs of the patient demographic being served.

Component #3: Focus the Role on What Peer Advisors Are Uniquely Positioned to Do
Leaders scope the role of the Nonclinical Peer Advisor to ensure patients served receive culturally competent care and support. Sample responsibilities of Nonclinical Peer Advisors include: teaching self-management skills, maintaining a network of community resources, educating clinicians on culturally competent care, and serving as a bridge between patients and the care team.

Component #4: Scale Training to Level and Type of Responsibilities
Leaders adjust the content and duration of Nonclinical Peer Advisor training to reflect the responsibilities of the Nonclinical Peer Advisor role.

Practice Assessment
This practice is a highly effective way to engage hard-to-reach patients. While it may not be cost neutral, Nonclinical Peer Advisors are less costly than clinicians and can assume a subset of clinician responsibilities (e.g., some aspects of patient education). To minimize costs, leaders should consider collaborating with another health care or community-based organization to pool resources and implement the practice jointly.
There is rising interest in the role of CHWs\(^1\). As shown here, the US Bureau of Labor Statistics projects the growth of CHWs to more than double the national average occupational growth through 2022.

The goal of the CHW is to inspire patients to follow their care plan and access supporting resources in the community. A CHW is a member of the patient’s community who is uniquely positioned to relate to patients’ everyday challenges. Because CHWs share common ground with patients, they can build strong relationships with patients who might otherwise be disengaged, and inspire them to access the resources they need to manage their health.

While many organizations have similar goals for the CHW role, there is wide variation in how leaders staff, train, educate, and deploy CHWs. Some organizations provide only minimal training and design the CHW role to exclusively provide nonclinical support, while others require a clinical degree and build elements of clinical care into the job description.

The practice on the following pages outlines the key components for deploying CHWs that exclusively provide nonclinical support. For the purpose of this publication, we call them “Nonclinical Peer Advisors.”

---

1) Community Health Workers.
Component #1: Identify the Target Patient Population

The first component of this practice is to identify patient populations suitable for a Nonclinical Peer Advisor. Leaders should use the three screening questions shown here to identify patients who: are under-represented in the organization’s health care workforce, have a high rate of health care utilization, and have difficulty communicating effectively with clinicians.

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

Determining the Patient Population of Focus

Component #2: Find a Peer Advisor Who Can Relate to the Target Population

The second component of this practice is to recruit Nonclinical Peer Advisors who can relate to the target patient population. Sample Nonclinical Peer Advisor selection criteria—including characteristics to look for and characteristics to avoid—are shown here. For example, it can be helpful to deploy a Nonclinical Peer Advisor who has the same condition as the target patient population, but the Nonclinical Peer Advisor won’t be effective if he or she isn’t healthy enough to be reliable.

Defining Desired Characteristics of Advisors

Sample Nonclinical Peer Advisor Selection Criteria

<table>
<thead>
<tr>
<th>Characteristics to Look For</th>
<th>Characteristics to Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative of the target population (e.g., ethnicity, sex, religion, etc.)</td>
<td>Laser focus on their chronic condition</td>
</tr>
<tr>
<td>Speaks native language of target population (if applicable)</td>
<td>Over-achievers who may intimidate other patients</td>
</tr>
<tr>
<td>Literate, able to read manuals, materials</td>
<td>Judgmental</td>
</tr>
<tr>
<td>Natural leader, ability to motivate others</td>
<td>Too sick to be reliable</td>
</tr>
<tr>
<td>Able to commit to time requirements of position whether paid or unpaid</td>
<td>Overly enthusiastic about their way of managing their condition</td>
</tr>
<tr>
<td>Servant leader mentality</td>
<td></td>
</tr>
<tr>
<td>Shares similar health challenges but manage condition effectively, good days and bad days</td>
<td></td>
</tr>
</tbody>
</table>

To find qualified applicants for the role, leaders should consider the nontraditional recruitment strategies shown here. For example, leaders can ask clinicians to recommend previous patients who are highly engaged and can easily relate to the target patient population. This recruitment strategy is especially effective if the target patient population is disease-focused (e.g., patients with a chronic condition, such as asthma or diabetes).

**Component #3: Focus the Role on What Peer Advisors Are Uniquely Positioned to Do**

The third component of this practice is to clearly scope the role of Nonclinical Peer Advisors in order to fully leverage their unique skills and capabilities. Regardless of patient population, there are four responsibilities that Nonclinical Peer Advisors are uniquely positioned to accomplish, shown here. Leaders can include all four responsibilities into the Nonclinical Peer Advisor role or focus on a narrower subset.

**Representative Responsibilities of Nonclinical Peer Advisors**

- **Teach Self-Management Skills**
  - Lead self-care sessions as part of peer support group
- **Educate Clinicians on Culturally Competent Care**
  - Help clinicians understand how to provide socially competent care to their patient populations
- **Maintain Network of Community Resources**
  - Develop relationships with various community organizations that can meet needs of their patients
- **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

Component #4: Scale Training to Level and Type of Responsibilities

The fourth component of this practice is to adjust the content and duration of training to reflect the responsibilities of the Nonclinical Peer Advisor role. For example, if Nonclinical Peer Advisors are tasked with teaching patients self-management skills, then the Nonclinical Peer Advisors should receive training on health education. Similarly, if Nonclinical Peer Advisors are tasked with building relationships with patients and the clinical care team, they should receive training on group facilitation techniques.

### Aligning Training with Type of Peer Advisor Role

<table>
<thead>
<tr>
<th>Sample Nonclinical Peer Advisor Responsibility</th>
<th>Associated Nonclinical Peer Advisor Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teach patients self-management skills</td>
<td>Health education focused on relevant chronic condition(s)</td>
</tr>
<tr>
<td>Strengthen relationships between patients and clinicians</td>
<td>Group facilitation techniques</td>
</tr>
<tr>
<td>Connect patients with community-based resources</td>
<td>In-depth review of social service agencies in community</td>
</tr>
</tbody>
</table>

Source: Nursing Executive Center interviews and analysis.
When a Nonclinical Peer Advisor is effectively deployed, the role can significantly improve the ability of patients to self-manage their condition. An example of this role in action comes from Scripps Health. At Scripps, Nonclinical Peer Advisors help patients with diabetes manage their condition through a diabetes care and education program that addresses the specific needs of culturally diverse populations. Key elements of the role are shown here.

First, care team members recruit peer advisors from existing patients participating in the program who demonstrate leadership skills. Second, peer advisors complete 40 hours of training from care team members on the program curriculum, Motivational Interviewing, and facilitation techniques.

Third, Scripps hires peer advisors as either full-time employees or contractors. Fourth, the peer advisors lead peer sessions to help diabetes patients manage the day-to-day aspects of the condition. They cover material in the patient’s native language using patient-friendly terms. Fifth, peer advisors track and record patients’ clinical indicators, and report those back to the care team. Finally, if a patient isn’t meeting his or her clinical targets, the peer advisor alerts the care team.

Peer Advisors Helping Patients with Diabetes

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 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 ADA1 Goals

Case in Brief: Scripps Health

- Four-hospital system headquartered in San Diego, California
- In 1997, Project Dulce was 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 patients’ native language and at 3rd to 4th grade reading level; patients attend eight weekly two-hour classes covering topics such as nutrition, exercise, and diabetes management; class size limited to 10 to 15 patients
- 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 patients’ 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 one-third of the cost of an RN

1) American Diabetes Association.

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advisory.com
Leaders at Scripps Health report strong results after deploying Nonclinical Peer Advisors. The program has served 18,000 patients to date, and Scripps estimates a net savings of $537 per participant per year. Although the program requires additional staffing costs, leaders note that the cost of a Nonclinical Peer Advisor is only about a third of the cost of a registered nurse.

Nonclinical Peer Advisors Reducing Cost

Cost Savings per Patient at Scripps Health

$537 cost savings per patient yearly

Pre-Intervention Costs per Patient  
Post-Intervention Costs per Patient

The third imperative for building a system that “never discharges” the patient is to promote patient and family ownership for self-care. To achieve this imperative, leaders will need to follow two strategies. The first strategy is to appeal to patients’ personal motivators for involvement, which is discussed on pages 89 through 98 of this publication. The second strategy is to equip patients and families with tools for self-management, which is discussed on the following pages.

Even if patients are motivated to follow their care plan, they may not have the knowledge, skills, and confidence to follow their care instructions. A recent study from the National Center for Education Statistics found that more than 90% of patients did not understand some aspect of their ED discharge instructions.

It isn’t surprising that patients have trouble understanding written discharge instructions. As shown here, almost half of adults in the US read at “Basic” or “Below Basic” prose literacy levels.

1) Deficits in understanding of instructions included the following aspects of instructions: diagnosis, medication, home care, follow-up, return to ED.
2) As of 2003.

Leaders have two key opportunities to better equip patients for self-management. The first opportunity is to build patients’ knowledge, skills, and confidence before they leave the hospital. The second opportunity is to leverage technology to enable patients to better manage their conditions outside the hospital.

The four practices in this section will help leaders act on each opportunity in turn.

Helping Patients Stay on Track

Two Key Opportunities

Leverage Inpatient Stay to Build Self-Management Skills

Leverage Technology to Enable Personalized At-Home Support

Source: Nursing Executive Center interviews and analysis.
Practice #14: Inpatient-Based Key Caregiver Skill Building

Practice in Brief

During a patient’s hospital stay, clinicians train the patient’s at-home key caregiver (often, a family member) to perform care activities; the goal is to equip at-home caregivers to independently perform care activities after patients leave the hospital.

Rationale

Caregivers often lack the skills or confidence needed to properly care for their loved ones at home. By teaching caregivers key aspects of care while the patient is still at the hospital, the care team can build the skills and confidence of at-home caregivers and better prepare them to independently care for patients at home.

Implementation Components

**Component #1: Recruit Key Caregivers for Inpatient-Based Skill Building**
Pre-surgical nurse (or other care team member) screens patients and their caregivers for inclusion in the caregiver skill-building program. Key considerations include: the caregiver’s willingness to participate and the type of care the caregiver will need to deliver at home.

**Component #2: Train Key Caregivers in Patient Care Activities**
Bedside nurse collaborates with the key caregiver to clearly define which responsibilities they will assume across the inpatient stay and teaches them how to perform those activities.

**Component #3: Provide Daily Oversight for Caregivers During Inpatient Stay**
Bedside nurse checks in on key caregivers regularly throughout the inpatient stay to ensure they are appropriately recording their care activities into paper-based care diaries.

**Component #4: Document Caregivers’ Activities in Patient Record**
Nursing assistant transfers information from caregivers’ care diaries into the EMR daily so the information becomes part of the patient’s permanent record.

Practice Assessment

This practice is minimally resource intensive and an effective way to prepare family caregivers to independently care for their loved ones at home. It is especially recommended for patients undergoing procedures with a relatively predictable length of stay and post-surgical treatment plan to make the workflow of the process efficient for the care team and so care team members can appropriately teach the key caregiver the necessary aspects of care while the patient is in the hospital.

Nursing Executive Center Grades

Practice Impact: B
Ease of Implementation: B+
An effective practice for ensuring a patient’s at-home caregiver is prepared to safely and effectively deliver care at home is to provide them ample opportunity to practice during the inpatient stay. Intermountain Healthcare gives at-home caregivers this opportunity through a program called “Partners in Healing.” It has four components, shown here.

The first component is to recruit caregivers for participation in the program. At Intermountain, pre-surgical nurses invite interested thoracic and vascular surgery patients—and their caregivers—to participate in the program.

The second component is to train participants to perform patient care activities. Bedside nurses collaborate with participants to determine which responsibilities they will assume and teach them how to perform those activities during the patient’s hospital stay.

The third component is to provide daily oversight for participants. Program participants are asked to record their care activities in a care diary. Bedside nurses check the care diaries regularly to ensure participants appropriately complete the activities they agreed to perform.

The fourth component is to document caregivers’ activities in the patient record. A nursing assistant enters the information from the care diary into the EMR each day so it becomes part of the patient’s permanent record.

## Integrating Caregivers into the Care Team

### Key Components of Intermountain’s “Partners in Healing” Program

1. **Component #1:** Recruit Key Caregivers for Inpatient-Based Skill Building
2. **Component #2:** Train Key Caregivers in Patient Care Activities
3. **Component #3:** Provide Daily Oversight for Caregivers During Inpatient Stay
4. **Component #4:** Document Caregivers’ Activities in Patient Record

### 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\(^1\) transfers information into EMR
- 76% of patients reported the program enhanced their transition and 84% reported they would highly recommend the program

---

\(^{1}\) Certified Nursing Assistant.
The heart of any program designed to build at-home caregiver’s skills is the training the at-home caregiver receives during the acute care episode. Family caregivers participating in Intermountain’s “Partners in Healing” program choose from a pre-vetted list of activities shown here, to select which patient care activities they will perform during the inpatient stay. Care activities performed by program participants include using an Incentive Spirometer and changing the patient’s TED hose.

To document care delivered by family caregivers, Intermountain requires participants to write down the activities they perform in a care diary, an excerpt of which is shown here. Nursing assistants transfer the information from caregivers’ care diaries into the EMR daily so the information becomes part of the patient’s permanent record.

Complete versions of Intermountain’s “Partners in Healing” Training Points and Care Diary for Caregivers can be accessed through an online version of this publication on advisory.com/nec.

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Training Family Members During the Hospital Stay

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

Pre- and Post-Surgical Teaching: Partners in Healing

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.

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 a.m.</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 a.m.</td>
<td>750-1000 x10</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 a.m.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 p.m.</td>
<td>500-750 x10</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 p.m.</td>
<td></td>
<td></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.

---

1) For example, caregivers must wear gloves when performing care tasks with bodily fluids.

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.
“Partners in Healing”—or Inpatient-Based Key Caregiver Skill Building—can improve caregivers’ skills and confidence and equip them to independently perform care activities after patients leave the hospital.

As shown here, patient and caregiver participants in Intermountain’s “Partners in Healing” felt the program enhanced their transition home.

### 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

n=25

- **76%**

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

n=25

- **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”*

Source: Intermountain Healthcare, Salt Lake City, UT; Nursing Executive Center interviews and analysis.
The Nursing Executive Center offers additional practices for teaching patients and family caregivers self-management skills during the inpatient stay. The Center recommends the following practices from *Nurse-Led Strategies for Preventing Avoidable Readmissions*, shown here.

Access *Nurse-Led Strategies for Preventing Avoidable Readmissions* on advisory.com/nec.

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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>
</tbody>
</table>

Practice #15: Recorded Transition Instructions

Practice in Brief

Clinicians record personalized discharge instructions that patients can access on demand (by phone or computer); the goal is to improve patient comprehension of their care plan by providing a supplement to written discharge instructions.

Rationale

Patients often have questions about their discharge instructions after they leave the hospital—and for many, written discharge instructions don’t answer their questions. By recording the discharge instructions they deliver to patients in the hospital, clinicians provide patients and family members with an additional reminder of discharge instructions. This can better equip patients and families to manage their care at home.

Implementation Components

Component #1: Record Regularly Scheduled Discharge Education Session
With the patient’s permission, clinicians record their normal discharge education session at the patient’s bedside using a portable device (e.g., tablet or cell phone); the recording also captures any questions from patients about the instructions and their answers.

Component #2: Upload Recorded Transition Instructions
Clinicians forward recording to a secure landing page provided by the vendor.

Component #3: Provide Patients with a Unique Code to Access Their Personal Recording
Clinicians show patients how to access audio recording of transition instructions—through a unique access code that patients can use from either a phone or computer.

Component #4: Monitor Patient Utilization to Proactively Identify Patients with Questions
Software tracks how often patients access their audio transition instructions; clinicians reach out to patients who are accessing the instructions far more than expected to see if the patient needs additional support.

Practice Assessment

Although this practice requires up-front and ongoing vendor costs, it has the potential to prevent readmissions caused by patients failing to comprehend their self-care instructions. The Nursing Executive Center especially recommends this practice for patients requiring complex treatment plans (e.g., transplant patients).

Nursing Executive Center Grades

Practice Impact: A
Ease of Implementation: B
There are four key components to Practice #15: Recorded Transition Instructions. The first component is to record the regularly scheduled discharge education session. With the patient’s permission, a clinician uses a mobile device to record the normal discharge education session at the patient’s bedside.

The second component is to upload the recorded transition instructions to a secure landing page provided by a vendor.

The third component is to provide patients with a unique code they can use to access their personal recording. Patients can enter the access code over the phone or online to hear the recording of their discharge instructions.

The final component is to monitor patient utilization and proactively identify patients with questions. Vendor software can track how frequently each patient accesses his or her discharge instructions. This can allow clinicians to reach out to patients who access their instructions more than expected to see if they have any questions or need any additional support.

### Bolstering Instructions with an Audio Recording

#### Key Components of Recorded Transition Instructions

1. **Component #1:**
   - Record Regularly Scheduled Discharge Education Session

2. **Component #2:**
   - Upload Recorded Transition Instructions

3. **Component #3:**
   - Provide Patients with a Unique Code to Access Their Personal Recording

4. **Component #4:**
   - Monitor Patient Utilization to Proactively Identify Patients with Questions

### Representative Patient Utilization

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Times Accessing Recorded Instructions (Past Week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Cleo</td>
<td>4</td>
</tr>
<tr>
<td>James, Fiona</td>
<td>2</td>
</tr>
<tr>
<td>Doe, John</td>
<td>3</td>
</tr>
<tr>
<td>Taylor, Amy</td>
<td>18</td>
</tr>
<tr>
<td>Dodd, Casey</td>
<td>3</td>
</tr>
</tbody>
</table>

RN’s can log into the software system and identify patients who have accessed their instructions multiple times and may need a follow-up phone call.

Source: Vocera, http://www.vocera.com/sites/default/files/resources/VOC_7351_VCE_DS_Good_to_Go_USA_RG.pdf; Cullman Regional Medical Center, Cullman, AL; Nursing Executive Center interviews and analysis.
Leaders at Cullman Regional Medical Center implemented Recorded Transition Instructions to improve patient-to-provider communication during discharge and ensure patients remember their care instructions.

Since using Recorded Transition Instructions, Cullman reported a 15% reduction in their overall readmission rate. Leaders at Cullman also noted improvements in patient satisfaction related to discharge education and planning.

### Multiple Benefits from Recorded Transition Instructions

#### Percentage of Patients Readmitted at Cullman Regional Medical Center

- **Pre-Implementation**:
- **Post-Implementation**: 15% reduction

#### Case in Brief: Cullman Regional Medical Center

- 145-bed hospital located in Cullman, Alabama
- In 2011, Cullman implemented a system that records patients’ discharge instructions in order to improve patient-to-provider communication during discharge and ensure patients can remember instructions
- Leaders report 15% reduction in readmissions and 62% improvement in HCAHPS scores related to the quality of discharge education and planning

Source: Vocera, http://www.vocera.com/sites/default/files/resources/VOC_7351_VCE_DS_Good_to_Go_USA_RG.pdf; Cullman Regional Medical Center, Cullman, AL; Nursing Executive Center interviews and analysis.
Practice #16: Personalized Patient Support Line

Practice in Brief

Through a 24/7 centralized support line, remote nurses extend the capacity of the primary care team by using the patient’s medical record—including clinician notes, laboratory results, and discharge instructions—to provide in-the-moment guidance, direct patients to the appropriate level of care in real time, and use standing orders to prescribe select medications when indicated.

Rationale

Patients managing their care at home often have specific questions about a change in their symptoms, or how to follow their care instructions properly. While most primary care practices field patient questions, patients must often wait several hours (or even days) to receive answers. And if patients can’t wait to access their primary care provider, they can speak directly with an after-hours triage nurse—but often find the triage nurse doesn’t have access to their clinical records. To get real-time answers, some patients “play it safe” by visiting an urgent clinic or ED, which may be unnecessary and costly. Other patients “take their chances” and choose not to seek help. As a result, they may take their medications incorrectly or fail to receive the medical attention they need. Through a Personalized Patient Support Line, clinicians can provide detailed, customized medical advice in the moment and guide patients to the appropriate level of care.

Implementation Components

Component #1: Showcase Benefits of Support Line to Achieve Primary Care Practice Buy-In
Leaders highlight benefits of support line to primary care practices and explain how the support line will help the primary care practices and not hinder their business.

Component #2: Support Line RNs Access Patient Records and Document Care in the EMR
Support line RNs have real-time access to the patient’s electronic medical records, including clinician notes, laboratory and radiology results, and discharge instructions. Support line RNs document all support line interactions and care recommendations into the EMR.

Component #3: Integrate Standardized, System-Wide Care Protocols and Tools into Support Line RN Workflow
Support line RNs use the same standardized care protocols and tools as other clinicians across the system, ensuring the care provided by support line RNs is consistent with the level of care quality provided throughout the system.

Component #4: Centralize Support Line RNs Under One Virtual Call Center
Nurses staffing the support line work from home, but field calls through a centralized call center and report up through one management structure.

Practice Assessment

This practice is a highly effective method for providing real-time support for patients at home, and reducing inappropriate health care utilization. It also allows leaders to offer a flexible staffing option that may appeal to experienced nurses. However, it requires a sizeable investment, including a virtual call center platform and RNs to staff the support line. This practice is easier to implement at organizations that own or are affiliated with primary care practices operating from the same EMR.

Nursing Executive Center Grades

Practice Impact: A
Ease of Implementation: C
Achieving Buy-In from Primary Care Clinics

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

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 use 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

Source: Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.
**Component #2: Support Line RNs Access Patient Records and Document Care in the EMR**

The second component of this practice is to give support line RNs real-time access to the patient’s electronic medical records, so they can view the patient’s history and document care provided.

Mayo’s support line RNs have real-time access to the patient’s full Mayo record, including clinician notes, laboratory and radiology results, and discharge instructions. They document their care recommendations in the EMR after every interaction with a patient through the support line.

**Component #3: Integrate Standardized, System-Wide Care Protocols and Tools into Support Line RN Workflow**

The third component of this practice is to integrate standardized care protocols and tools into support line RNs’ workflow. This ensures the care provided by support line RNs is consistent with the level of care quality provided throughout the system.

Key features of Mayo’s decision-support software that support line RNs use in patient interactions are shown here. Notably, support line RNs can use standing orders to prescribe select medications when indicated.

---

**Support Line RNs Access EMR and Document Care**

**Mayo Support Line RNs’ Interactions with EMR**

- **View Full Mayo Record**
  - Have real-time access to all patient records across Mayo, including clinician notes, laboratory and radiology results, and discharge instructions

- **Document Support Line Interactions**
  - Record own patient interactions in each patient’s EMR, including care recommendations

---

**Using the Same Protocols and Tools System-Wide**

**Features of Mayo’s Decision-Support Software for Personalized Patient Support Line**

- Uses standardized care protocols and tools across Mayo
- Includes over 140 algorithms and 28 protocols
- Enables support line RNs to prescribe select medications when indicated through standing orders

**Conditions support line RN can prescribe for include**
- conjunctivitis
- UTI

Source: Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.
Component #4: Centralize Support Line RNs Under One Virtual Call Center

The fourth and final component of this practice is to organize support line RNs under one virtual call center—regardless of where they are physically located.

Mayo’s Personalized Patient Support Line RNs work from home, but field calls through a centralized call center and report to the same supervisor. The support line connects each patient calling the line to the next available support line RN, regardless of the patient’s and RN’s geographic locations.

A personalized patient support line enables patients to quickly access the most appropriate and cost-effective level of care. Leaders at Mayo estimate the support line has allowed their system to achieve $1.25 million in cost savings from six pilot clinics alone. They attribute the cost savings to patients seeking a more appropriate level of care as a result of calling the support line.

In 2013, Mayo expanded the reach of the support line to support 82 clinics across three states.

Creating a Centralized, Virtual Call Center

Key Aspects of Mayo’s Centralized, Virtual Call Center

- **Support Line RNs Work from Home**: Working from home enables flexible schedule for staff and reduced overhead for leaders
- **Patients Connected to Next Available RN, Regardless of Location**: Virtual integrated platform allows patients from any participating Mayo primary care practice to connect with first available support line RN

Over a Million in Savings from Redirected Care

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

- **$1.25M**
  - Cost savings from redirected care through support line in 2013
- **66%**
  - Patients directed to more appropriate level of care

Source: Mayo Clinic, Rochester, MN; Nursing Executive Center interviews and analysis.

1) The majority of Mayo’s support line RNs work remotely, but a few work from a hub location.
2) 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.
Practice #17: Daily Text Reminders

--- Practice in Brief ---
Clinicians use an automated software program to send text messages to patients that remind them to perform self-care activities. Patients can respond to text messages to ask questions or indicate when they need additional support. The goal is to help patients properly manage their care at home.

--- Rationale ---
Patients often struggle to consistently remember to perform daily self-care activities. By providing patients with short, actionable reminders via text message, health care organizations can help patients adhere to their care plan with minimal staff time. Further, by having patients respond to automated text messages with their own text messages back to the care team, clinicians can provide targeted support to only those patients requiring intervention.

--- Implementation Components ---
**Component #1: Automate Daily Self-Care Text Message Reminders**
Automated system sends text message alerts to select patients to remind them of their daily self-care actions.

**Component #2: Clinicians Respond as Needed to Patients' Texts**
Automated system receives text responses from patients and alerts clinicians when there are high-level alerts (indicating serious issues) and low-level alerts (indicating care coordination issues). Clinicians respond to high-level alerts by calling patients directly and low-level alerts by coordinating with other care team members.

--- Practice Assessment ---
This practice is an effective way to help patients adhere to their care plan. While it requires up-front and ongoing costs, all text reminders are automated and require minimal clinician effort; clinicians only need to intervene when the system alerts them that select patients require further support.

--- Nursing Executive Center Grades ---
Practice Impact: B
Ease of Implementation: B
There are 100,000 mobile health applications currently available, and researchers project the revenue of mobile health applications to grow tenfold between 2013 and 2017.

This profusion of new technology presents a strong opportunity to engage with patients in their health and better equip them to manage their care independently.

A growing number of research studies show that texting patients can be an effective way to provide frequent, real-time “nudges” that help them remember to consistently follow their care plan. For example, patients who received automated text-based reminders were more than twice as likely to quit smoking as patients who used traditional self-help materials.

Key components of Practice #17: Daily Text Reminders are described on the following pages.

---

**Health-Related Apps on the Rise**

**Current and Projected Size of Global Mobile Health Application Market**

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue (in Billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>$2.4</td>
</tr>
<tr>
<td>2017</td>
<td>$26</td>
</tr>
</tbody>
</table>

Tenfold growth

100,000

Mobile health apps in the market in March 2014

---

**Acknowledging the Power of the “Nudge”**

**Text Messages Impacting Patient Confidence and Outcomes**

<table>
<thead>
<tr>
<th>Description</th>
<th>Control Group</th>
<th>Text4Baby Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Mothers Agreeing They Are Prepared to Be New Mothers</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>Percentage of Patients Who Quit Smoking</td>
<td>3%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Threefold increase

---

1) Revenue from mobile health applications, and the services that go with them, worldwide.

Component #1: Automate Daily Self-Care Text Message Reminders

The first component of this practice is to automate text messages for select patients to remind them of their daily self-care actions.

In 2012, leaders at the University of Chicago offered a mobile diabetes management program to employee health plan members with type 1 or type 2 diabetes. Patients in the program received daily automated text messages which asked them questions about their diabetes self-care activities or gave concise advice on self-care. Sample automated texts to program participants are shown here.

Text Messages Offer Bite-Sized, Actionable Reminders

Automated Text Messages Sent to Diabetics at University of Chicago Medicine

- What is your weight today?
- Do you need a prescription refill?
- It’s 8 o’clock. Time to take your medication.
- Eating foods low in salt can lower blood pressure.

Case in Brief: University of Chicago Medicine

- 568-bed academic medical center located in Chicago, Illinois
- In May 2012, University of Chicago offered mobile diabetes management program to employee health plan members using mHealth program CareSmarts; 74 patients with type 1 or type 2 diabetes participated in program; CareSmarts technology pushes text messages to patients asking questions about diabetes self-care activities and providing self-care education
- Nurse manages program, enrolling participants and tracking alerts that indicate intervention is needed; during pilot, participants sent and received average of 3.4 text messages per day; over six-month intervention period, patients triggered an average of one alert per month
- HbA1c levels of participants declined from 7.9% to 7.2% and total cost of care per participant declined by $812; net savings per patient $437 after $365 per patient cost of providing program

Component #2: Clinicians Respond as Needed to Patients’ Texts

The second component of this practice is to enable clinicians to intervene when patients need additional support.

Each day of the pilot, a nurse at the University of Chicago tracked inbound text messages from patients. When a text message indicated a patient needed additional support, the nurse triaged the message as a high-level alert (indicating serious issues) or low-level alert (indicating care coordination issues). The nurse responded to high-level alerts by calling patients directly and low-level alerts by coordinating with other care team members.

Following the six-month pilot of Daily Text Reminders at University of Chicago, the average hemoglobin A1c levels of participants declined from 7.9% to 7.2%. Leaders at University of Chicago reported a net savings of $437 per patient in the pilot.

Using Patient Responses to Scale Care Team Support

Process for Engaging Patients in Self-Care with CareSmarts

Improving Clinical Outcomes for Diabetics and Reducing Costs

HbA1c Levels for Patients Participating in University of Chicago’s CareSmarts Pilot

<table>
<thead>
<tr>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.9%</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

$437
Net savings per patient

1) Program cost $375 per pilot participant, total cost of health care decreased by $812 in pilot. Current program cost of CareSmarts has decreased to $100 per patient.

An automated text message system is one of many technologies leaders can use to help patients manage their care at home.

Additional technologies for supporting patient self-management are shown here.

For more information on low-cost technologies, visit the Care Transformation Center Blog at advisory.com.

---

No Shortage of Technologies to Support Patients

Sample Technologies to Support Patient Self-Management

<table>
<thead>
<tr>
<th>Technology</th>
<th>Capsule Description</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill Bottle Alert</td>
<td>Glowing pill cap gives audible and visual alert to patients when they should take their medication; patient can also receive refill reminders, and phone calls when dose is missed</td>
<td>Connected Health: health technology research center associated with Partners Healthcare</td>
</tr>
<tr>
<td>Take-Home iPad with Preloaded Applications</td>
<td>Caregivers of severely wounded patients provided iPad stocked with apps to help care for patient; example apps include medical record access and ability to refill prescriptions</td>
<td>Veteran's Health Administration: federal health care provider for veterans</td>
</tr>
<tr>
<td>Health System Mobile Application</td>
<td>Mobile application provides patients with access to several features including: access to medical records, symptom checker, 24/7 access to a consulting nurse, nearest location, and wait times for prescriptions or lab results</td>
<td>Group Health Cooperative: health care system and insurer headquartered in Seattle, Washington</td>
</tr>
</tbody>
</table>

Imperative 4

Scale Up Support for Vulnerable Patients

Invest in Targeted Services for Select Populations
Practice #18: NP-Led Clinic for the Medically Complex
Practice #19: Justice Department Partnership for Behavioral Health
Practice #20: ED Alternatives for Homeless Patients
Practice #21: Remote Telemonitoring for the Frail Elderly
The fourth imperative for building a system that “never discharges” the patient is to scale up support for vulnerable populations.

The first three imperatives outlined in this publication will help leaders achieve care continuity for the majority of patients. However, some patient populations are more vulnerable to receiving fragmented, episodic care than the general population. To ensure continuous care for these patients, leaders must create systems that provide additional support.

There are four patient populations that represent the majority of vulnerable patients needing additional support: medically complex patients, patients with mental health and substance abuse issues, homeless patients, and frail elderly patients. To determine which patient population(s) their organization should target with additional support, leaders should consider the three questions shown here.

The four practices in this section each focus on one of the four vulnerable patient populations respectively. Each practice requires an up-front investment but also demonstrates a financial return on investment resulting from reduced health care utilization.

### Vulnerable Patient Populations

<table>
<thead>
<tr>
<th>Medically Complex Patients</th>
<th>Practice #18: NP-Led Clinic for the Medically Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Abuse Patients</td>
<td>Practice #19: Justice Department Partnership for Behavioral Health</td>
</tr>
<tr>
<td>Homeless Patients</td>
<td>Practice #20: ED Alternatives for Homeless Patients</td>
</tr>
<tr>
<td>Frail Elderly</td>
<td>Practice #21: Remote Telemonitoring for the Frail Elderly</td>
</tr>
</tbody>
</table>

### 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?

Source: Nursing Executive Center interviews and analysis.
Practice #18: NP-Led Clinic for the Medically Complex

--- Practice in Brief ---
Leaders establish a specialized ambulatory clinic, led by a nurse practitioner (NP), designed to meet the needs of medically complex patients; the goal is to give patients with complex conditions the comprehensive support they need to effectively manage their care outside of the hospital.

Rationale

Patients with multiple comorbidities (or other complex conditions) often require both medical and social services, and coordinated support from a wide variety of caregivers. However, standard primary care practices are often ill-equipped to provide the intensive care these patients need. As a result, complex patients have high rates of hospital utilization and are costly to the health care organization. By tailoring a clinic's infrastructure to provide a range of support services and delivering care with an NP-led interprofessional team, leaders can more closely meet the needs of medically complex patients.

Implementation Components

**Component #1: Select an Easily Accessible Location for the Clinic**
Leaders select a location for the clinic that is easy for most patients to access (e.g., near an affiliated hospital or along a bus route).

**Component #2: Set Clear Criteria for Clinic Eligibility**
Emergency department and primary care clinicians use predetermined criteria to identify patients eligible for clinic services and make referrals. The clinic is reserved for patients whose needs cannot be met by standard primary care practices.

**Component #3: NP-PCP Team Collaboratively Conducts In-Depth Initial Patient Visit**
NP and physician internist collaboratively conduct a 60-minute initial visit to determine each patient's care management needs and identify appropriate wraparound services (e.g., social work, home care).

**Component #4: NP Coordinates On-Site Support Services and Manages Follow-Up Visits**
NP works closely with a multidisciplinary team of caregivers and leads all follow-up visits.

**Component #5: NP Regularly Reassesses Patient's Need for Support**
NP routinely reevaluates patients to determine whether they still need the additional support provided by the clinic for the medically complex. When a patient's complex needs are resolved, the NP transitions the patient to primary care.

Practice Assessment

This practice is an effective means of bridging gaps in care for select complex patients by providing more comprehensive and highly coordinated care management services. Although it requires a sizeable investment, the practice has the potential to reduce health care utilization for some of the organization's most costly patients.

Nursing Executive Center Grades

Practice Impact: A
Ease of Implementation: C+
The first vulnerable patient population requiring additional support is medically complex patients.

Medically complex patients often require both medical and social services, and coordinated care from a wide variety of disciplines. However, standard primary care practices are often ill-equipped to provide the intensive care these patients need. As shown here, the average adult primary care visit lasts only 20 minutes.

Because they often do not receive all the care they need in a traditional primary care visit, medically complex patients have high rates of hospital utilization and are costly to treat. As shown here, the one-third of Medicare beneficiaries with four or more chronic conditions consume nearly three-quarters of total Medicare spending.

Current System Not Enough for the Medically Complex

<table>
<thead>
<tr>
<th>20.8 Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average duration of adult primary care visit</td>
</tr>
</tbody>
</table>

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

Distribution of Medicare FFS1 Beneficiaries by Number of Chronic Conditions and Total Medicare Spending

2010

<table>
<thead>
<tr>
<th>Percentage of Beneficiaries with 4+ Conditions</th>
<th>Percentage of Total Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>37%</td>
<td>74%</td>
</tr>
</tbody>
</table>


1) Fee-for-service.
To meet the needs of medically complex patients outside of the hospital, some progressive organizations have established specialized, NP-led clinics, designed to exclusively provide care for medically complex patients.

One example is Trinity Mother Frances Hospitals and Clinics’ Intensive Medical Home for complex patients. Care for patients is managed by an NP, and the clinic is staffed with the interprofessional team shown here.

The following page outlines the five key components of Trinity Mother Frances’ NP-Led Clinic for the Medically Complex.

### Staffing a Clinic for Medically Complex Patients

#### Intensive Medical Home Care Team

**Members at Trinity Mother Frances**

<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>

### 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), and/or 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

Source: Trinity Mother Frances Hospitals and Clinics, Tyler, TX; Nursing Executive Center interviews and analysis.
The first component of this practice is to select an easily accessible location for the clinic. Trinity Mother Frances’ clinic is conveniently located on-site at the system’s largest primary care facility.

The second component is to set clear patient eligibility criteria. ED and primary care clinicians at Trinity Mother Frances use the predetermined criteria shown here to identify patients eligible for clinic services and make referrals. Patients referred to the clinic have an average of three chronic conditions.

The third component is to have an NP and PCP jointly conduct an in-depth initial patient visit. At Trinity Mother Frances, an NP and PCP collaboratively conduct a 60-minute initial visit to determine each patient’s care management needs and identify appropriate wraparound services.

The fourth component is to have an NP coordinate on-site support services and manage follow-up visits. The NP at Trinity Mother Frances independently leads all follow-up patient visits and ensures the clinic’s mental health clinicians and clinical pharmacists support patients as needed.

The fifth component is to regularly reassess the patient’s need for support. When a patient’s complex needs are resolved, Trinity Mother Frances’ NP transitions the patient to primary care.

Establishing a Clinic for Medically Complex Patients at Trinity

Key Components of Trinity Mother Frances’ NP-Led Clinic for the Medically Complex

Component #1:
Select an Easily Accessible Location for the Clinic

Component #2:
Set Clear Criteria for Clinic Eligibility

Component #3:
NP-PCP Team Collaboratively Conducts In-Depth Initial Patient Visit

Component #4:
NP Coordinates On-Site Support Services and Manages Follow-Up Visits

Component #5:
NP Regularly Reassesses Patient’s Need for Support

Eligibility Criteria for Trinity Mother Frances Hospitals and Clinics NP-Led Clinic for the Medically Complex

- 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 hospitalizations with medical disease(s)
NP-led clinics for medically complex patients can lead to improved care outcomes and cost savings. An example of an NP-led clinic with strong outcomes is Mackenzie Health’s heart failure clinic.

In 2014, leaders at Mackenzie Health, located in Ontario, Canada, established this NP-led clinic specifically for heart failure patients. The clinic is staffed by one NP who has extensive experience working with heart failure patients.

The NP begins working with heart failure patients while they are hospitalized and also oversees their care post-discharge. During a patient’s hospitalization, the NP actively participates in the patient’s care planning and daily care, in collaboration with cardiologists, nurses, and allied health professionals. During the outpatient follow-up period, the NP provides tailored health education, adjusts medications as needed, and makes referrals as appropriate for advanced heart failure therapy.

Since opening the clinic, Mackenzie’s 30-day readmission rate for heart failure patients has decreased from 23% to zero. Leaders estimate $1 million in cost avoidance during just the first six months of the NP-led heart failure clinic.

Improving Outcomes for the Medically Complex with a Dedicated Clinic

30-Day Heart Failure Readmission Rate at Mackenzie Health

<table>
<thead>
<tr>
<th>Before Heart Failure Clinic</th>
<th>After Heart Failure Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>23%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

$1M

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 a 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 one to three 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

Source: Mackenzie Health, Richmond, Ontario; Nursing Executive Center interviews and analysis.
Practice #19: Justice Department Partnership for Behavioral Health

Practice in Brief

Leaders within the health system and local justice department collaboratively build a crisis center for patients who have both behavioral health needs and medical needs; the goal is to decrease inappropriate ED use by behavioral health patients and better meet their needs in the community.

Rationale

Individuals with untreated behavioral health conditions often cycle between prisons and emergency departments, neither of which is equipped to fully address behavioral health needs. Building a crisis center that provides medical and behavioral care can help break this cycle and better meet the needs of these patients in their community.

Implementation Components

Component #1: Establish a Crisis Center for Patients with Behavioral Health and Low-Intensity Medical Needs

Health care system leaders establish a crisis center that is fully equipped to treat individuals with behavioral health and low-intensity medical needs. The center is staffed by physicians, psychiatrists, nurses, and social workers. Patients receive behavioral health evaluations, consultations, and referrals to outpatient support and community resources.

Component #2: Train Police Officers to Triage Individuals to the Appropriate Level of Care

Health care system leaders collaborate with the police department to determine when patients should be placed in the crisis center or sent to the ED. Through mandatory training, police officers learn to identify potential behavioral health or substance abuse issues and triage individuals to the most appropriate setting.

Practice Assessment

This practice is an example of a unique partnership between a health system and justice department. It had many successful outcomes: it improved the behavioral health of patients, reduced unnecessary ED visits and hospitalization, and improved community safety. While it requires a major investment to build a crisis center, the investment may be offset by reduced ED utilization.

Nursing Executive Center Grades

Practice Impact: A
Ease of Implementation: C
The second vulnerable patient population requiring additional support is mental health and substance abuse (MHSA) patients.

MHSA patients frequently interact with both the health system and justice department. As shown here, about one in eight ED visits involves MHSA patients, and almost half of patients with a serious behavioral health condition have been arrested at least once.

Struggling to Meet Behavioral Health Needs

<table>
<thead>
<tr>
<th>Percentage of ED Visits Involving Patients with Behavioral Health Conditions</th>
<th>Percentage of Patients with Serious Behavioral Health Conditions Arrested at Least Once During Their Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>~13%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Individuals with untreated behavioral health conditions often cycle between prisons and emergency departments, neither of which is fully equipped to meet behavioral health needs.

To break this cycle for MHSA patients and better meet the needs of MHSA patients in their community, leaders at one organization partnered with their local justice department to build a crisis center which is equipped to fully address behavioral health needs.

The following pages describe the key components of this practice.

A Vicious Cycle for MHSA\(^2\) Patients

Mental health needs not addressed in care episode

Returns to community, mental health needs not addressed

Arrested, sent to jail, mental health needs not addressed

1) Visits made to US hospital emergency departments in 2007 involving people with a mental disorder, substance abuse problem, or both.
2) Mental health and substance abuse.

Creating a Crisis Care Center

Key Elements of the Center for Health Care Services’ Crisis Care Center

- **16-Bed Facility**
- **Open to Receive Police Referrals 24/7**
- **Provides Patients with Food, Medication, Medical Care, Behavioral Health Assessment**

- **Average Length of Stay**
  - 22 Hours; Maximum Stay 48 Hours
- **Receives $486,600 of Annual Funding from UHS¹**
- **Staffed by Physicians, Psychiatrists, Nurses, and Social Workers**

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**Case in Brief: University Health System**

- 478-bed health system located in San Antonio, Texas
- Partnered with Bexar County justice department to develop appropriate triage for individuals encountered by police with medical, behavioral health needs, and reduce inappropriate incarcerations
- In 2006, the Center for Health Care Services established a 16-bed Crisis Care Center; Center provides 24-hour assessment, intervention services, extended observation, coordination into alternative care
- In 2012, crisis intervention training mandated for all Bexar County Sheriff/San Antonio Police officers; officers taught to de-escalate situation, evaluate, and triage patient to most appropriate setting; individuals with behavioral health needs and/or minor medical needs diverted to Crisis Care Center; individuals with medical needs requiring emergency-level care diverted to UHS ED
- Crisis Care Center staffed by physicians, NPs, and social worker; patients receive behavioral health evaluation, consultation, and referrals to outpatient support and community resources
- Crisis Care Center located in Center for Health Care Services’ Restoration Center which includes detoxification center and outpatient substance abuse services; in close proximity to University Hospital
- UHS contributes $486,600 annually towards Center for Health Care Services Restoration Division, includes Crisis Care Center
- After first year of Crisis Care Center, ED utilization decreased by 40%; estimated UHS cost savings was $4.7 million in first year

¹ University Health System.  
² The Crisis Care Center also receives funding from other local and state sources.  
Source: University Health System, San Antonio, TX; Nursing Executive Center interviews and analysis.
Practice #19: Justice Department Partnership for Behavioral Health

Bexar County’s Crisis Care Center is staffed with the interprofessional care team shown here. A physician provides medical care and refers patients to other outpatient providers or community resources as needed. An RN observes patients, administers medications, and addresses clinical needs. A social worker conducts behavioral health screens and determines the level of behavioral health support each patient needs. Finally, a psychiatrist treats any acute behavioral health conditions.

### Staffing the Crisis Care Center

#### Crisis Care Center Care Team Members

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Provides medical care, determines patient referral destination from clinic</td>
</tr>
<tr>
<td>RN</td>
<td>Provides medical care, patient observation</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Screens and assesses patient’s behavioral health needs</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Provides treatment for acute behavioral health needs</td>
</tr>
</tbody>
</table>

### Component #2: Train Police Officers to Triage Individuals to the Appropriate Level of Care

The second component of this practice is to train police officers to appropriately triage MHSA patients.

University Health leaders collaborated with the Bexar County Sheriff’s Office and San Antonio Police Department to determine when patients should be sent to the ED or Crisis Care Center. Patients with behavioral health needs and medical needs requiring emergency medical care are sent to the ED, and patients with behavioral health needs and only minor medical needs are sent to the Crisis Care Center.

### Sending Patients to Most Appropriate Setting Based on Medical, Behavioral Health Needs

#### Sample Police Diversion Pathway for MHSA\(^1\) Encounters

- Police officer assesses behavioral and medical needs
  - Individual has **medical needs requiring emergency care** (e.g., toxic ingestion, severe laceration)
    - Police officer sends individual to UHS\(^2\) ED
  - Individual has **behavioral health needs and medical needs not requiring emergency care**
    - Police officer sends individual to Crisis Care Center

\(^1\) Mental health and substance abuse.  
\(^2\) University Health System.

Source: University Health System, San Antonio, TX; Nursing Executive Center interviews and analysis.
Partnerships between health care providers and local justice departments can lead to improved care for MHSA patients and result in cost savings. Since opening the Crisis Care Center, Bexar County MHSA patients have received more timely care, and leaders at University Health System report a sizeable decrease in ED utilization by MHSA patients. Leaders at University Health System estimate $4.7 million in cost savings during the first year of the Crisis Care Center.

### Worth the Investment

<table>
<thead>
<tr>
<th>Wait Time for Medical Clearance Screening/Psychiatric Evaluation</th>
<th>ED Utilization by MHSA(^1) Patients at University Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Crisis Care Center</strong></td>
<td><strong>Before Crisis Care Center</strong></td>
</tr>
<tr>
<td>12-14 Hours</td>
<td><strong>20 Minutes</strong></td>
</tr>
<tr>
<td><strong>After Crisis Care Center</strong></td>
<td><strong>After Crisis Care Center</strong></td>
</tr>
</tbody>
</table>

**40% decrease**

$4.7M Estimated cost savings to UHS\(^2\) in first year of Crisis Care Center

---

1) Mental health and substance abuse.
2) University Health System.

Source: University Health System, San Antonio, TX; Nursing Executive Center interviews and analysis.
Practice #20: ED Alternatives for Homeless Patients

--- Practice in Brief ---

Health system leaders partner with a homeless shelter to provide respite care to homeless patients in need of low-intensity medical care; the goal is to provide a safe environment for homeless patients to heal following an acute care episode and prevent costly readmissions.

Rationale

Homeless individuals are more likely than others to use the ED—often because they do not have an appropriate place to care for themselves or recover from an illness or a procedure. By providing homeless patients with low-intensity medical needs with shelter and additional care resources, homeless patients are better able to follow their care plan and are less likely to have avoidable readmissions.

Implementation Components

Component #1: Set Clear Inclusion and Exclusion Criteria for Respite Care
To ensure respite beds are reserved for patients who will benefit the most from them, recommended inclusion criteria include: patients who lack suitable housing. Recommended exclusion criteria include: patients with a condition that requires intensive medical care that the center cannot accommodate.

Component #2: Facilitate Recovery Through 24-Hour Shelter and Daily Medical Care
Patients are allowed to stay at the center 24/7 to enable them to fully recover from their acute condition. Clinicians visit the medical respite center daily to care for patients.

Component #3: Provide Long-Term Housing to Eligible Patients
When patients are discharged from the medical respite center, center staff give eligible\(^1\) patients a housing voucher.

Component #4: Refer Patients to Primary Care
When patients are discharged, center staff refer patients to primary care services in the community.

Practice Assessment

This practice is recommended for organizations with high volumes of homeless patients; it has the potential for a large return on investment by decreasing avoidable health care utilization.

---

1) Based on public housing agency criteria.

Nursing Executive Center Grades

Practice Impact: A
Ease of Implementation: C+

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The third vulnerable patient population requiring additional support is the homeless.

Homeless patients are twice as likely as non-homeless patients to visit the ED and have unmet care needs. Homeless patients are also costly to care for. A recent study comparing the costs of homeless and non-homeless patient admissions at an academic medical center in Toronto, Canada, found that homeless patient admissions cost $2,559\(^1\) more than non-homeless patient admissions.

**Homeless Especially Vulnerable to Costly Care**

### Average Patient Cost per Admission

- **Likelihood of homeless individual having an ED visit in the last year compared to non-homeless individual:** 2x
- **Likelihood of homeless individual having unmet care needs in the last year compared to non-homeless individual:** 2x

<table>
<thead>
<tr>
<th>Non-Homeless Patients</th>
<th>Homeless Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Patient Cost</td>
<td>$2,559(^1) higher</td>
</tr>
</tbody>
</table>


1) Canadian dollars; after adjusting for age, gender, and resource intensity weight.
Some health care providers are partnering with homeless shelters to better meet the needs of homeless patients in the community. For example, leaders at Yale-New Haven Hospital partnered with a local homeless shelter (Columbus House) to provide respite care to homeless patients upon discharge from the hospital.

The Medical Respite Center, pictured here, is a 12-bed facility located within Columbus House. The center is open to homeless patients who are either preparing for (or recovering from) a medical procedure or have an acute or post-acute medical illness which requires short-term resolution and care. Staffing for the Medical Respite Center is funded by a grant from the state of Connecticut, and medical care at the center is reimbursed through Medicaid and private insurance.

The following page outlines the four key components of Yale New-Haven Hospital’s Medical Respite Program.

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

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 are connected to primary care at local Yale-New Haven clinic
• Since establishment of Medical Respite Center, there has been a 29% reduction in readmissions of homeless population to Yale-New Haven Hospital and an estimated Medicaid savings of $400,000

Source: Yale-New Haven Hospital, New Haven, CT. Nursing Executive Center interviews and analysis.
The first component of this practice is to set clear inclusion and exclusion criteria for patients receiving respite care. Patients at Yale New-Haven must meet the criteria shown at the bottom of this page to qualify for the program. For example, to be considered for inclusion in the program, patients must lack suitable housing—but they will be excluded if their condition requires intensive medical care that the center cannot accommodate.

The second component is to facilitate recovery through 24-hour shelter and daily medical care. Patients are allowed to stay at Yale-New Haven’s Medical Respite Center both day and night.

The third component is to provide long-term housing to eligible patients. When patients are discharged from the Medical Respite Center, a navigator gives housing vouchers to patients who meet the city’s public housing criteria.

The fourth component is to refer patients to primary care. When patients are discharged, Medical Respite Center staff connect patients to primary care services at a local Yale-New Haven clinic.

Creating a Safe Haven for Medical Recovery

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

Component #1:
Set Clear Inclusion and Exclusion Criteria for Respite Care

Component #2:
Facilitate Recovery Through 24-Hour Shelter and Daily Medical Care

Component #3:
Provide Long-Term Housing to Eligible Patients

Component #4:
Refer Patients to Primary Care

Inclusion and Exclusion Criteria for Yale-New Haven Hospital’s Medical Respite Program

**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; 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

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

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1) Activities of daily living.
To meet homeless patients' medical and psychosocial needs, we recommend staffing medical respite centers with both clinical and nonclinical staff.

Yale New-Haven and Columbus House staff their Medical Respite Center with a mix of clinical and nonclinical staff.

Clinical staff are shown on the left. A home care nurse visits patients daily, and a physician assistant visits the Medical Respite Center three times a week to check on patients with more complex medical needs. Nonclinical staff are shown on the right. A Medical Respite Center supervisor is on-site 24 hours per day, seven days per week to provide oversight. An MSW-prepared patient navigator connects patients with community resources.

---

### Staffing Yale New-Haven's 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

#### Nonclinical 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

---

Source: Yale-New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.
Medical respite centers can contribute to more appropriate health care utilization for homeless patients, as well as cost savings.

Since establishing the Medical Respite Center, the average monthly readmission rate for homeless patients at Yale-New Haven Hospital decreased by 29%. Leaders estimate that Medicaid saves $400,000 annually from Yale-New Haven’s Medical Respite Program.

Reducing Readmissions and Medicaid Spending

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

<table>
<thead>
<tr>
<th>Before Medical Respite Program Inception</th>
<th>After Medical Respite Program Inception</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29% decrease</td>
</tr>
</tbody>
</table>

$400,000

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

Source: Yale-New Haven Hospital, New Haven, CT; Nursing Executive Center interviews and analysis.
Practice #21: Remote Telemonitoring for the Frail Elderly

--- Practice in Brief ---
Leaders optimize their organization’s remote telemonitoring program for elderly patients; the goal is to cost-effectively meet the needs of frail elderly patients living at home and prevent future acute care episodes.

Rationale
Frail elderly patients are highly vulnerable to episodic care and preventable readmissions for numerous reasons. For example, they often live alone and have limited mobility, are commonly prescribed several medications to treat multiple symptoms or conditions, and are more likely than young patients to be forgetful or become confused about how to follow their provider’s instructions. By optimizing telemonitoring support for frail elderly patients, leaders can cost-effectively provide more continuous care for this vulnerable population.

Implementation Components

**Component #1: Use a Holistic Assessment to Capture Patient Risk**
Clinicians use an assessment that captures both medical and psychosocial risk factors to identify patients who would benefit from remote telemonitoring support.

**Component #2: Boost Enrollment with an Opt-Out Strategy**
Clinicians automatically enroll patients eligible for remote telemonitoring in the program; patients must actively decline to not receive remote telemonitoring services.

**Component #3: Scale Telemonitoring Support to Acuity Level**
Leaders assign patients to different levels of telemonitoring support based on acuity. Care management staff provide telemonitoring support for patients with high-intensity chronic conditions, and medical home (or primary care) staff manage telemonitoring for patients with low-intensity chronic conditions.

Practice Assessment
This practice is a highly effective and cost-efficient way to support frail elderly patients at home. It is recommended for all organizations, especially those with a high percentage of elderly patients in their community.

---

**Nursing Executive Center Grades**
Practice Impact: A
Ease of Implementation: C+
The fourth vulnerable patient population requiring additional support is the frail elderly. Frail elderly patients are highly vulnerable to episodic care and preventable readmissions for many reasons. These can include the following: patients often live alone and have limited mobility; they commonly have multiple chronic conditions, many of which are associated with high readmission rates—such as COPD, congestive heart failure and diabetes; and elderly patients are commonly prescribed several medications, but they are more likely than young patients to be forgetful or become confused about how to take their medications correctly.

To better meet the needs of frail elderly patients outside of the hospital, leaders should consider optimizing their organization’s remote telemonitoring program. The practice on the following pages describes the three key components of effectively deploying remote telemonitoring for frail elderly patients.

The Frail Elderly a Vulnerable Population

Sample Reasons

- Often Live Alone
- Limited Mobility
- Multiple Chronic Conditions
- Numerous Medications

Source: Nursing Executive Center interviews and analysis.
Component #1: Use a Holistic Assessment to Capture Patient Risk

The first component of this practice is to use an assessment that captures both medical and psychosocial risk factors to identify patients who would benefit from remote telemonitoring support.

Typical remote telemonitoring selection criteria, shown on the left, are condition-specific and overlook psychosocial needs. Vanguard Medical Group uses the more holistic screening tool, shown on the right, to identify patients for remote telemonitoring. Vanguard’s screening tool takes into account multiple risk factors, including behavioral health and social frailty. By using more holistic criteria, Vanguard more effectively captures frail elderly patients who are at risk for episodic care.

Frail Elderly Often Overlooked in Standard Assessment

Typical Remote Monitoring Patient Selection Criteria

Is the patient willing to participate?
Yes ☐
No ☐

What is the patient’s chronic disease diagnosis?
COPD ☐
Diabetes ☐
Heart Failure ☐
Other: _______________

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

Case in Brief: Vanguard Medical Group

- 23-provider primary care group based in Verona, New Jersey
- Sought standardized process to quickly consider patient needs across clinical and nonclinical factors
- Runs clinical, payer claims, and hospital discharge data through own algorithm to create standardized risk assessment across all payers and sites
Component #2: Boost Enrollment with an Opt-Out Strategy

The second component of this practice is to use an opt-out strategy to boost enrollment in the program.

All too often, organizations use an opt-in strategy for remote telemonitoring—requiring patients to proactively agree to participate in the program. But many frail elderly patients don’t opt-into telemonitoring for a variety of reasons—and opt-in strategies will fail to capture all patients who could benefit from the program.

To boost enrollment for vulnerable patients, Sharp Rees-Stealy Medical Group in San Diego, California, began using an opt-out strategy, in which qualifying patients are automatically enrolled in the program during hospitalization. To opt-out, patients must explicitly decline to participate.

Telehealth leaders at Sharp believe that this strategy helps to serve more patients and also drives patient buy-in—since it is introduced during the hospital stay and positioned as a strategy to avoid future hospitalization.

Sharp Rees-Stealy Finds Success with Opt-Out Policy

<table>
<thead>
<tr>
<th>Opt-In Enrollment Strategy</th>
<th>Opt-Out Enrollment Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemonitoring presented to patients as optional during follow-up</td>
<td>Patients introduced during hospitalization</td>
</tr>
<tr>
<td>Patients must proactively agree to participate in telemonitoring program</td>
<td>Program integrated into post-discharge planning</td>
</tr>
</tbody>
</table>

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

Case in Brief: Sharp Rees-Stealy Medical Group

- 450-physician medical group in San Diego, California
- Transitioned to opt-out policy to increase patient enrollment
- Conducts patient enrollment during post-discharge planning to integrate remote patient monitoring into initial care plan and emphasize importance of readmission prevention
Component #3: Scale Telemonitoring Support to Acuity Level

The third component of this practice is to adjust the level of remote telemonitoring support based on each patient’s acuity.

At Partners HealthCare, clinicians assign telemonitored patients to one of two dedicated teams. The care management team monitors patients with “high-intensity” chronic conditions, such as COPD, that require frequent patient-provider communication. The patient-centered medical home (PCMH) team monitors patients who have less-acute chronic conditions, such as hypertension.

Adjusting Level of Remote Telemonitoring Support Based on Patient Acuity

Guidance for Nurse Leaders

<table>
<thead>
<tr>
<th>Sample Priority</th>
<th>Recommended Owner</th>
<th>Use of Remote Telemonitoring</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>

Case in Brief: Partners HealthCare

- 15-organization integrated health system headquartered in Boston, Massachusetts
- Deploying remote patient monitoring (RPM) across large organization required high level of coordination across stakeholders
- Implemented two models of care to distribute RPM ownership by condition across care management and PCMH programs according to program goal

Source: Marketing and Planning Leadership Council, Telehealth: Scaling Remote Patient Monitoring Programs, 2014; Nursing Executive Center interviews and analysis.
Many organizations are seeing a return on remote telemonitoring programs for elderly patients. For example, Methodist Alliance Home Care (part of Methodist Le Bonheur Healthcare) provides remote telemonitoring in conjunction with their home health program. While Methodist’s program does not exclusively serve elderly patients, the program targets rising-risk patients who have multiple comorbidities, the average age of whom is 76.5 years old.

In 2014, the Medicare 30-day readmission rate for Methodist Alliance Home Care patients with remote telemonitoring was six percentage points lower than the overall Medicare 30-day readmission rate at Methodist Le Bonheur’s adult hospitals. Leaders at Methodist Alliance Home Care estimate an annual savings of $750,000 from their remote telemonitoring program from avoided 30-day readmissions.

### Seeing a Return from Remote Telemonitoring for Elderly

#### 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 is 76.5 years old
- Telehealth aides train patients and clinicians on using devices, troubleshoot technical issues at patient home; home health nurse monitors devices, serves as point of contact for patient questions, and is 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

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.

Source: Methodist Alliance Home Care, Memphis, TN; Nursing Executive Center interviews and analysis.