

## What are the challenges to establishing a continuum of care?

- Silos of communication - few established lines of communication between all the providers
- We incent them NOT to communicate (disincentives)
  - 45% admissions from NH to hospital unnecessary
  - Nursing home notices a problem and the caretakers want the patient to go to hospital and NH fears liability if they do not send her and something drastic happens, so they send patient even though it is a non-serious issue that could have been dealt with in the NH. The hospital is happy because they only make money when patients sent and NH doesn't suffer financially and is relieved of liability
  - Hospitals make MORE money when patients re-admitted
- General health illiteracy
- Elderly are trained to call 911 for everything rather than calling 24 hour hotline from healthcare provider first
- Ex: 2 docs give patient 2 different medication doses: need some 3<sup>rd</sup> party way to monitor meds
- Currently NH get no money for taking all the risk

## How do you communicate with providers across a continuum of care?

- Early warning tool for improving communication between providers, ex. When patient transferred is STOP and WATCH program (see presentation). System to organize communication
- Universal Transfer Form / transfer checklist that is standardized to some extent
- Some programs in place now are listed that improve training and documentation tools:
  - Statewide Care Transitions Forum
  - STAAR State Action Against re-Hospitalization
  - INTERACT - Intervention to Reduce Acute Transfers
  - MOLST - Medical Orders for Life Sustaining Treatment
  - IMPACT - Intervention to Improve Acute Transfers - what do you need to do your job? Receiver of patient would have all info needed

## What are the strategies for improving patient transitions across the continuum?

- Alter incentives between nursing homes (NH) and hospitals (ER) so that NH keeps patients for acute conditions they are well equipped to handle

- Medicare Nursing Home value based purchasing - better tools
  - Ex. Red Light (ER)
  - Yellow light - Call Hotline
  - Green Light
- Improve transition out of the hospital
- Many different forms and companies that provide Personalized Health Record (PHR)
  - Patient has a USB memory stick with their records on it
  - . Ex. Living Record (audience)
  - Longitudinal Care Plan that lives in the Cloud..
- PHR in the "cloud" where a virtual record is kept and all interested parties are authorized to access it so that siblings, HC proxies if there are several can view the record at will
- (audience) a refrigerator magnet or other visible reminder for elderly to call their 24 hour hotline first
- Program for patient advocates/managers
- Family training
- Medicare value based purchasing
- Better medication monitoring - 2 docs give patient 2 different recommendations currently, fix this