Bridging Acute and Post-Acute Care to Improve Outcomes

Esther Pandey, DNP, MS, RN

March 28, 2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

Esther Pandey, DNP, MS, RN

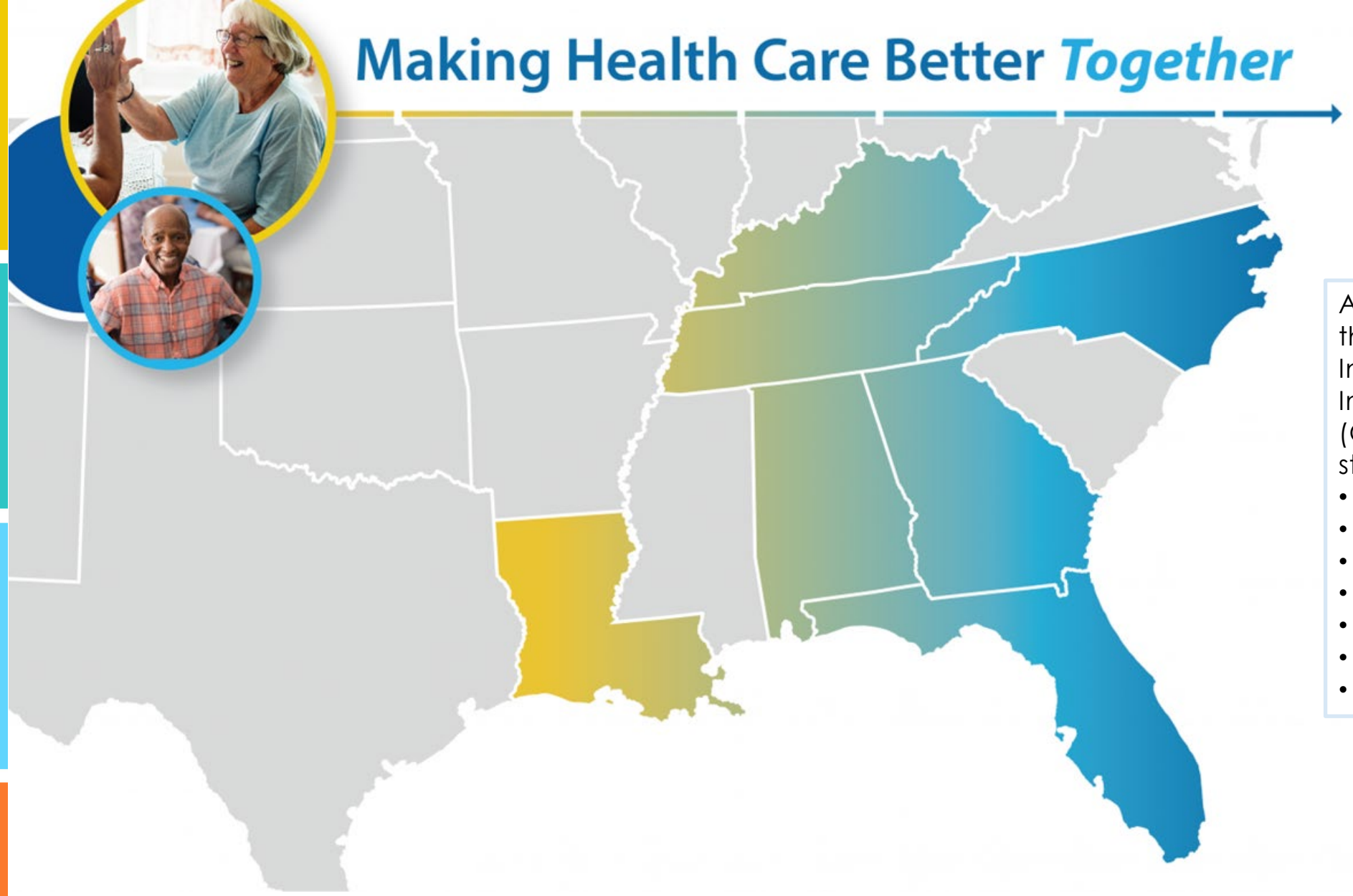
SYSTEM VICE PRESIDENT OF CARE TRANSITIONS FOR MOUNT SINAI HEALTH SYSTEM

Esther Pandey, DNP, MS, RN, is responsible for hospital throughput and discharge planning across the organization. Working with senior system leadership, she executes care delivery re-design strategy to ensure efficient operations, while maintaining high quality of care. As a population health champion, she is focused on achieving value-based outcomes. She serves on the board of the Mount Sinai/Contessa joint venture and advocates for the growth of Mount Sinai at Home care delivery that includes Hospital-at-Home, home infusion, and other home-based services.

An innovative and data-driven leader, Esther has successfully implemented new technology to integrate the medical records of over 60 post-acute care providers, enhancing care coordination activities between organizations. She has been nationally recognized by CMS IPRO for her work to drive quality improvement through the use of analytics and key performance indicators. She launched a communication hub to effectively share best practices with partnering organizations and has centralized skilled nursing facility transfers across the health system to reduce excess acute care days. She has automated data exchange between the hospital and managed care organizations to improve communication and accountability.

Esther has over 10 years of experience in post-acute care clinical and financial operations. Prior to joining Mount Sinai, she was a Corporate Director at ArchCare overseeing strategic clinical initiatives for their skilled nursing facilities, home care division, and health plans. Previously, Ms. Pandey was a Regional Director and Administrator for Premier Home Health Care, Inc.'s private duty and certified home health divisions in New York City. She started her career as a visiting nurse with a passion to maintain patients safely at home, in the environment they know and prefer.

Esther holds a Doctor of Nursing Practice degree from Yale University. She received her Bachelor and Master of Science degrees from New York University. She holds an adjunct faculty role at Mount Sinai's Phillips School of Nursing where she teaches health policy. She is a fellow of the New York Academy of Medicine, a member of Sigma Theta Tau International honor society, and is LEAN six sigma green belt certified.



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VP of Care Transitions

Mount Sinai Health System

Mount Sinai

Mount Sinai Health System

43,000+
Employees

7,000+
Physicians

8 Hospitals
3,919 Beds

1
Leading Medical School
Icahn School of Medicine at Mount Sinai

2,600+
Residents and Fellows

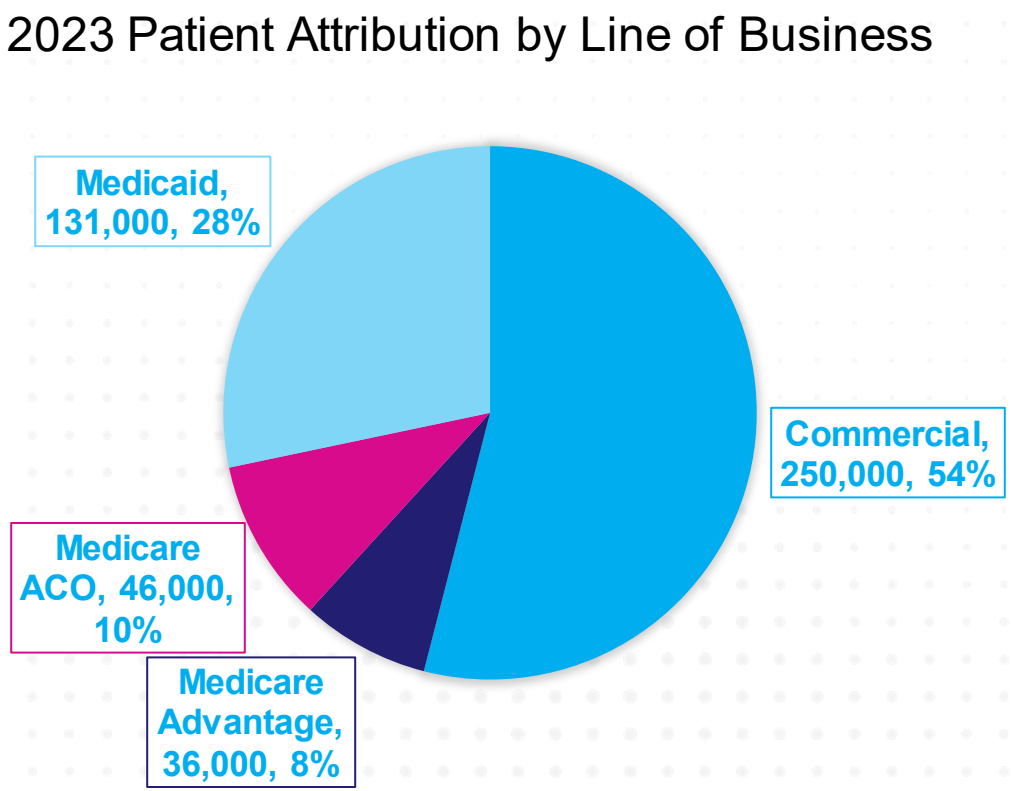
3.7M
Patient Visits Annually

$11.3B
Revenue Annually

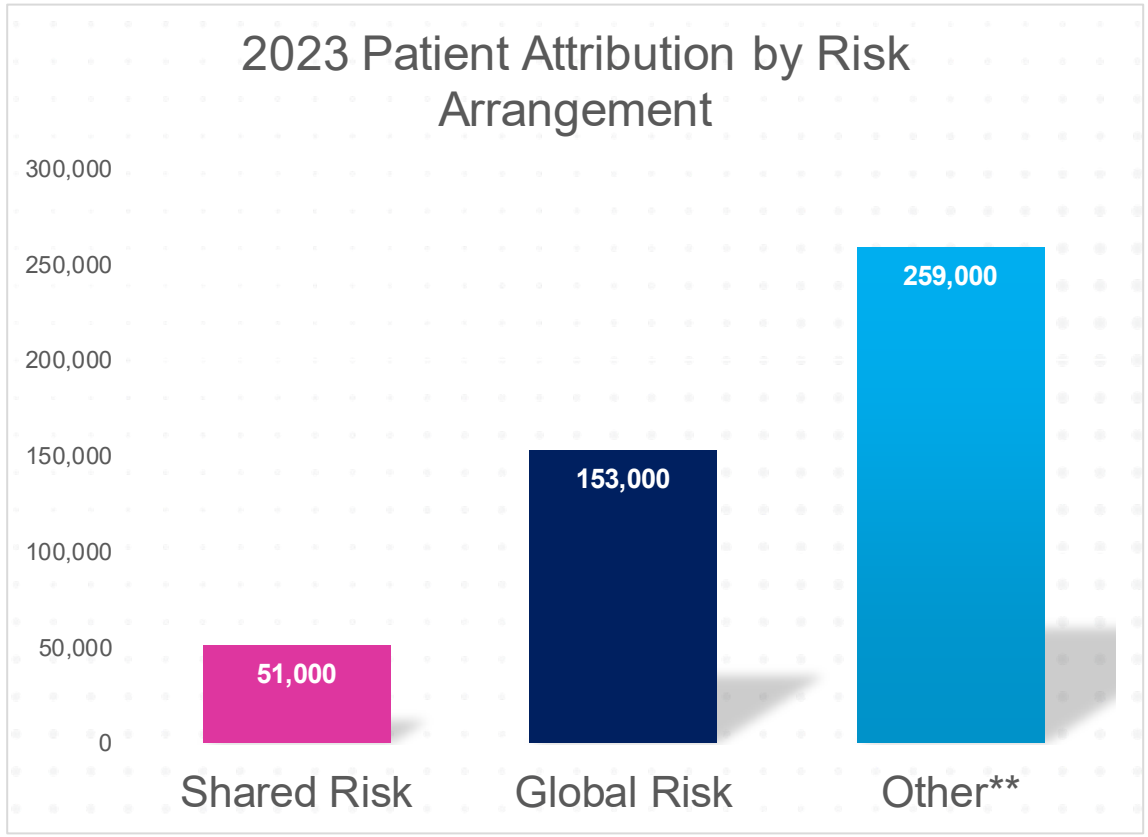
1
School of Nursing
Phillips School of Nursing at Mount Sinai

410+
Network Outpatient Practices

Over 460,000 Lives in Value-Based Contracts



Risk Distribution of Lives in Value-Based Contracts*



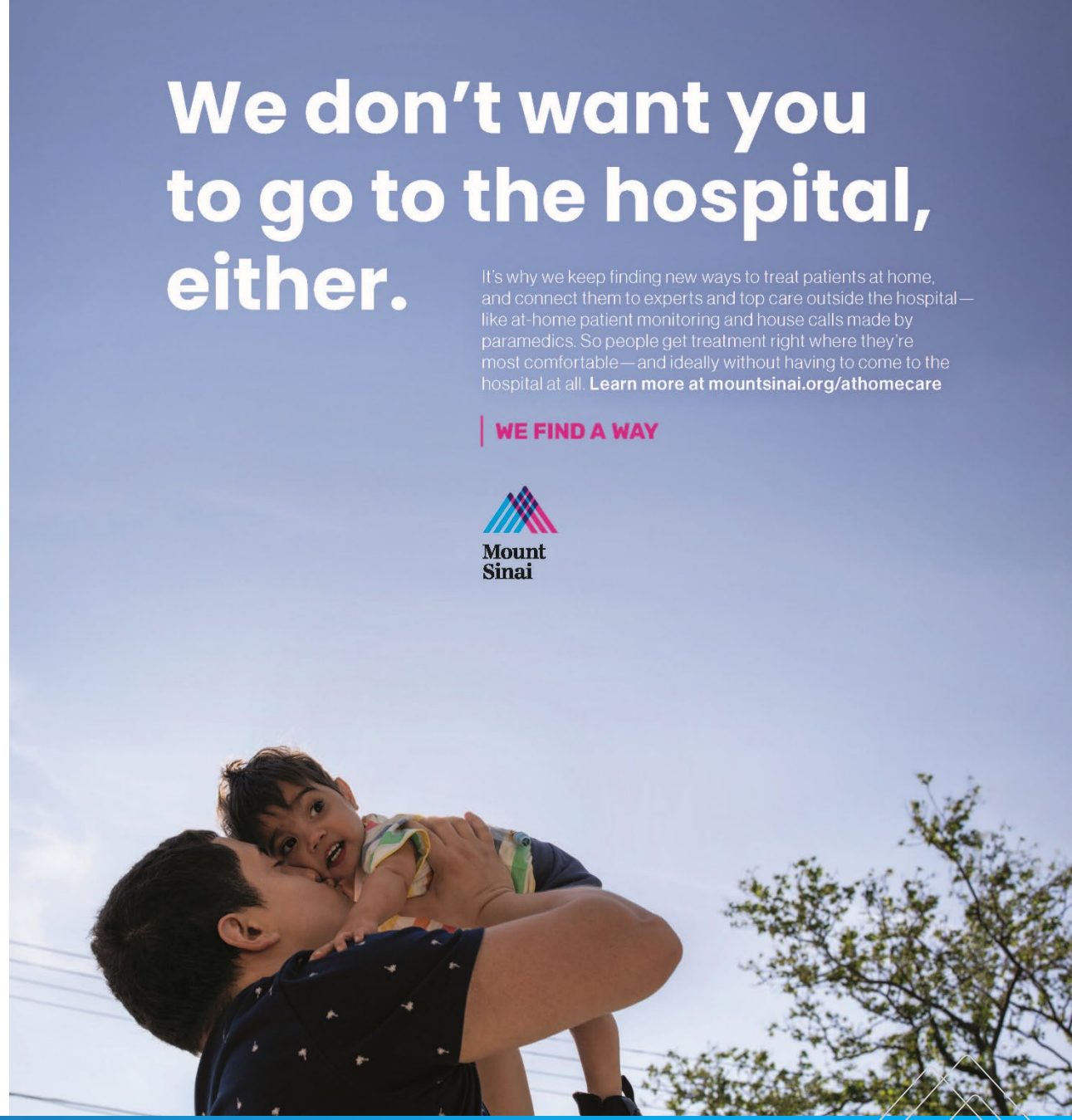
*Mount Sinai manages $4.2 billion in total medical cost for these attributed lives

**Other includes Pay for Performance, Shared Savings, Upside Only

In-Home Services

Mount Sinai's in-home offerings

- Hospitalization at Home
- Palliative Care at Home
- Rehabilitation at Home
- Home Health Care
- Home Infusion
- Home Dialysis
- Community Paramedicine
- Remote Patient Monitoring
- Visiting Doctors – Adult and Pediatric



Why do we need to do this work?

We do **NOT** own our own SNFs

>8,000

discharges to SNFs each year

>$100M

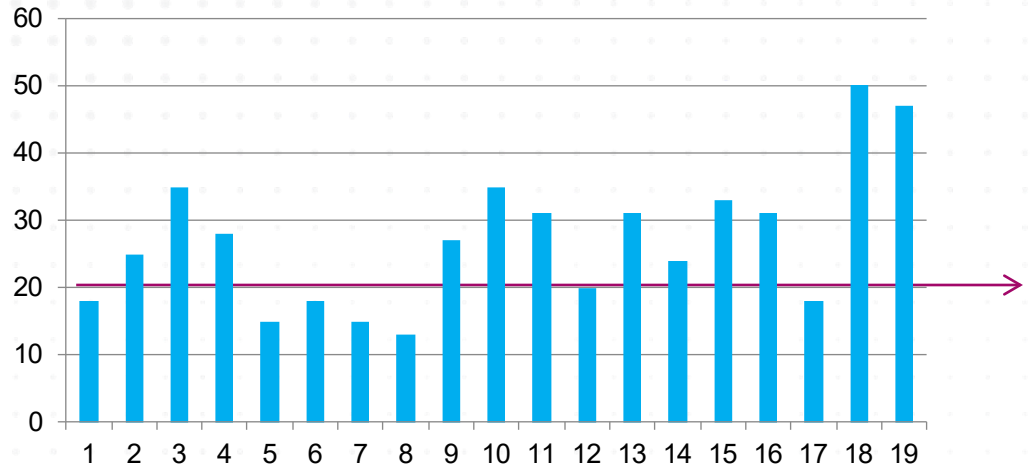
in annual ACO spend

130 SNFs

in 10-mile radius of 10029 (ZIP code of main hospital facility)

Where we started in 2017…

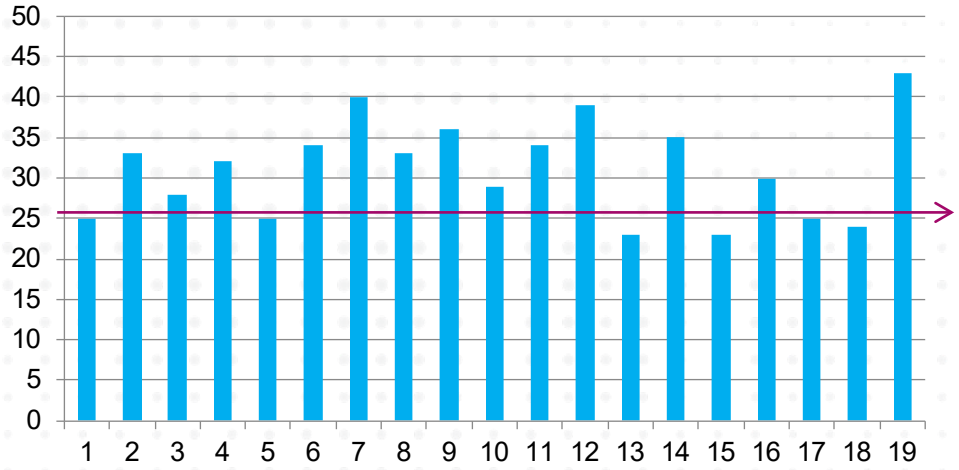
Direct Re-admit Rate for MSSP



NY State Benchmark CMS NH Compare

60% of discharges are going to 19 facilities

ALOS for MSSP



Milliman well controlled LOS

80% of discharges are going to 54 facilities

Source: Claim Star: Date Range: 3/1/16-2/28/17

How CMS defines quality:

- Overview
- Health inspections
- Staffing
- Quality measures
- COVID-19 vaccination rates
- Fire safety inspections & emergency preparedness
- Penalties

INDICATOR
Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)
Percent of Residents with Pressure Ulcers That are New or Worsened (Short Stay)
Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)
Percent of Residents Assessed for and Given Pneumococcal Vaccine (short stay)
Percent of Residents who Newly Received an Antipsychotic Medication (Short Stay)
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)
Percent of High-Risk Residents with Pressure Ulcers (Long Stay)
Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long Stay)
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay)
Percent of Residents With a Urinary Tract Infection (Long Stay)
Percent of Low Risk Residents Who Lose Control of their Bowel or Bladder (Long Stay)
Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)
Percent of Residents Who Were Physically Restrained (Long Stay)
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)
Percent of Residents Who Lose Too Much Weight (Long Stay)
Percent of Residents Who Have Depressive Symptoms (Long Stay)
Percent of Residents Who Received Antipsychotic Medication (Long Stay)
CMS 5-Star Quality Overall Rating
CMS 5-Star Quality Rating for Health Inspections
CMS 5-Star Quality Rating for Overall Staffing
CMS 5-Star Quality Rating for Quality Measures

Defining Quality for Us

Re-admissions for hospital discharges

Re-admissions for ACO patients

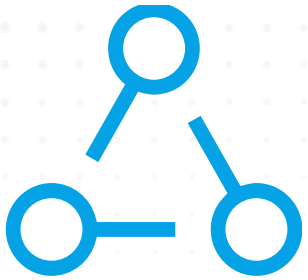
Length of stay

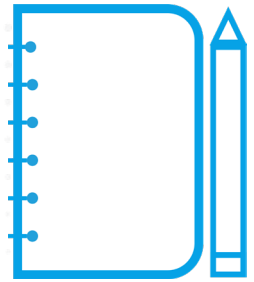
Servicing Medicaid Population

Acceptance of referral

Timeliness of referral processing

Meeting with Post-Acute Partners





Leadership	Onboarding	Training	Monitoring
Alignment on mission and vision	Developing an interdisciplinary team	How to use tools	Weekly call Monthly JOC

Foundation of Trust- What can we do together?

Readmissions Review Tool

Patient Name: _____ **Review Date:** _____

SNF Readmission Review Tool

Index Hospital Information

MSHS MRN*	
Primary Insurance	
Hospital discharge diagnosis	
Hospital discharge date	
Hospital LOS	
Warm handoff performed MD to MD	☐Yes ☐No
Warm handoff performed RN to RN	☐Yes ☐No

SNF Information

SNF name*	
Bundle case	☐Yes ☐No
SNF MRN*	
SNF LOS prior to transfer*	
SNF admitting diagnosis	
Date of latest Med Rec	
Date and time of transfer to hospital*	
Readmitting hospital name*	
AMAC Call prior to transfer	☐Yes ☐No
MOLST sent to hospital	☐Yes ☐No

*answers will be automated

Care Transitions Considerations

1. Was the readmission planned? **If yes, please do not complete the rest.** If no, please answer the following questions below.
   ☐Yes
   ☐No

2. What information was shared during warm handoff from MSHS to SNF that was related to potential reasons for readmission?
   _____

   Additionally, who did you speak with during warm handoff?
   ☐ MD
   ☐ NP
   ☐ RN
   ☐ SW
   ☐ Other, please explain_____

3. Did you receive a copy of the patient's chart and the discharge instructions upon the patient's arrival at the SNF?
   ☐Yes
   ☐No

10. Was the MSHS team called prior to the transfer (Discharging MD, Patient's/outpatient's PCP, outpatient specialist, MSH ED)?
    ☐Yes
    ☐No, please explain: _____

11. What kind of advanced care planning started or continued at SNF?
    ☐Palliative Care (symptom management)
    ☐Goal of Care Discussion
    ☐Hospice
    ☐DNR/DNI
    ☐Do Not Hospitalize
    ☐None

12. Has patient had numerous (such as > 1 month) visits to any hospital ED with or without admission? If yes, number of visits?
    ☐Yes, Number of ED visits/admissions: _____
    ☐No

13. Could any of the services or treatments that the patient required have been delivered at the SNF? Please explain.
    ☐ Yes, please elaborate: _____
    ☐ No

14. This readmission could have been avoided if appropriate interventions had been facilitated:
    ☐ Strongly Agree
    ☐ Agree
    ☐ Disagree
    ☐ Strongly Disagree

15. What information, if any, could MSHS have provided to the SNF in order to prevent the readmission?
    ☐ Enhanced communication with SNF
    ☐ Escalation back to the discharging team to discuss the patient prior to discharge
    ☐ Goals of Care Plan
    ☐ None
    ☐Other_____

16. From a greater health system perspective, is there a service or process that is not currently in place or available to you that could have changed the outcome for this patient/prevented the readmission?
    ☐ Yes, please elaborate: _____
    ☐ No

Readmission Reviews

Improving Hospital to SNF transfers

Heart Failure RN-RN Handoff

Patient Identifier	Plan of Care/To-Do: Specific tasks with instructions	Active Issues and Recent Event
Name	Wound Care	Issues to monitor for
MRN/DOB	Respiratory Care	Anticipated problems
	Daily Weights	Contingency Plan
Patient Background	Diet	
Age	PCP Name & number	Patient Education
Gender	Appointments	Heart Failure Booklet
Weight on admission		
Weight on discharge	Pending Studies and Recent labs (with dates)	~INTERACTIVE WITH QUESTIONS
Precautions	CMP	~CHECK FOR UNDERSTANDING, "Read-Back"
	BNP	
Admission Information	Mg	
Date of Admission	CBC	
Reason for Admission	INR, as needed	
Attending MD at discharge	EKG	
Nursing Unit #	Chest X-ray	
Advance Care Plan	Procedures	
Caregiver		
	Medications:	
Brief Clinical History	ACE Inhibitor/Neprilysin Inhibitor/ Angiontensin II Receptor Blocker	
Hospital course	Aldo Blocker	
Operations/Procedures	Anti Arrythmic	
Consult (s)/ Name (s)/ Number(s)	Beta Blocker	
	Diuretic	
	other medications	

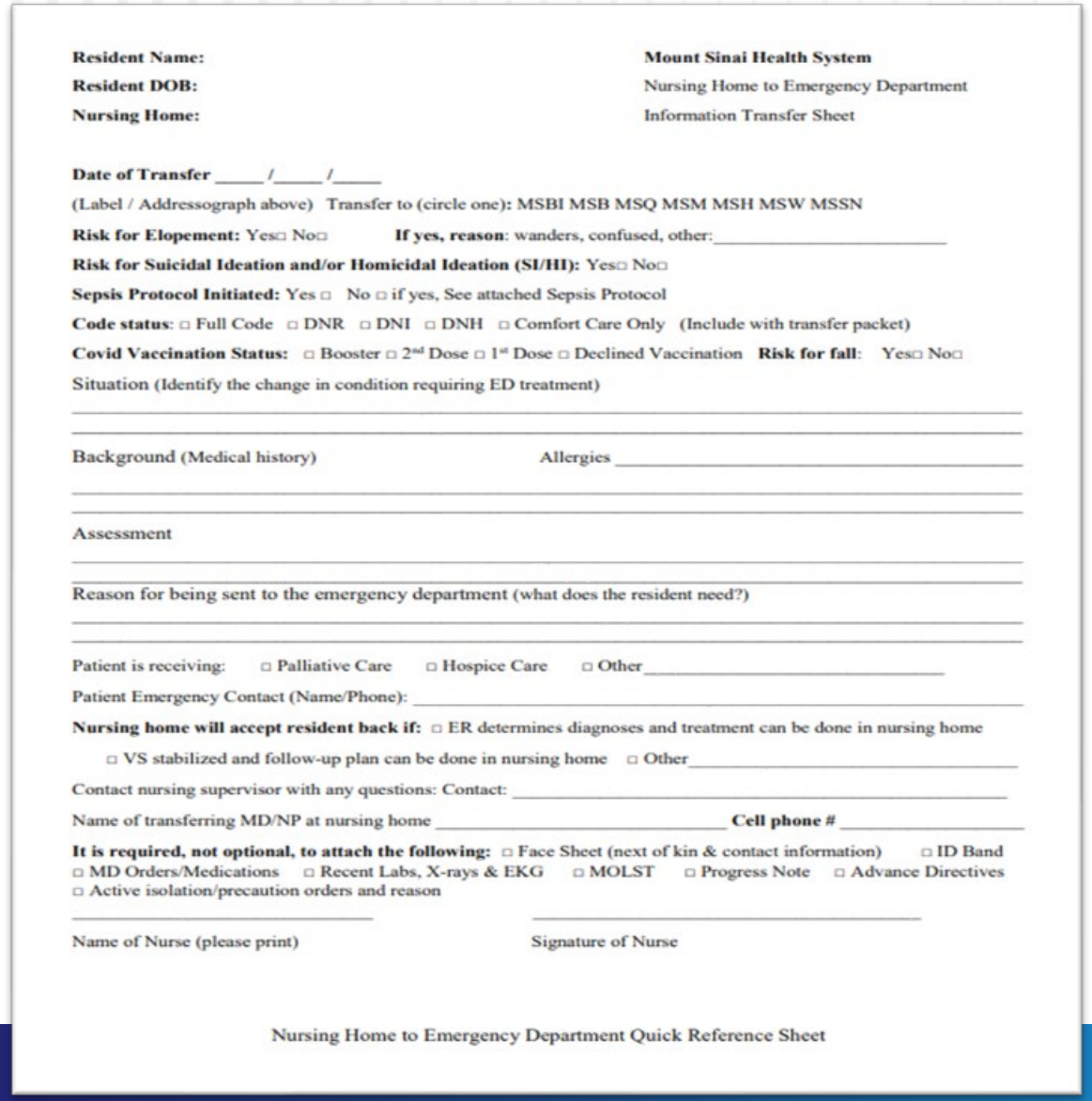
Mount Sinai Health Partners

SNF Warm Handoff Script

- Overview of patient's course, including key results, procedures, pending results
- Biggest concern / risk for readmission (eg, recurrence of hyponatremia)
- To Do list (eg, GI appt, when to consider restarting meds, order f/u CT scan)
- Main reasons for SNF referral (eg, deconditioning, IV abx)
- Presence of lines/catheters, including indications
- GOC/Advanced directives, if relevant
- MSH clinician contact information, for callback if needed

Readmission Reviews

Improving SNF to Hospital Transfers



Resident Name:
Resident DOB:
Nursing Home:

Mount Sinai Health System
Nursing Home to Emergency Department
Information Transfer Sheet

Date of Transfer _____/_____/_____
(Label / Addressograph above) Transfer to (circle one): MSBI MSB MSQ MSM MSH MSW MSSN
Risk for Elopement: Yes□ No□ **If yes, reason**: wanders, confused, other:_____
Risk for Suicidal Ideation and/or Homicidal Ideation (SI/HI): Yes□ No□
Sepsis Protocol Initiated: Yes □ No □ if yes, See attached Sepsis Protocol
Code status: □ Full Code □ DNR □ DNI □ DNH □ Comfort Care Only (Include with transfer packet)
Covid Vaccination Status: □ Booster □ 2nd Dose □ 1st Dose □ Declined Vaccination **Risk for fall:** Yes□ No□
Situation (Identify the change in condition requiring ED treatment)
_____
_____
Background (Medical history) Allergies _____
_____
_____
Assessment
_____
_____
Reason for being sent to the emergency department (what does the resident need?)
_____
_____
Patient is receiving: □ Palliative Care □ Hospice Care □ Other_____
Patient Emergency Contact (Name/Phone): _____
Nursing home will accept resident back if: □ ER determines diagnoses and treatment can be done in nursing home
□ VS stabilized and follow-up plan can be done in nursing home □ Other_____
Contact nursing supervisor with any questions: Contact: _____
Name of transferring MD/NP at nursing home _____ **Cell phone #** _____
It is required, not optional, to attach the following: □ Face Sheet (next of kin & contact information) □ ID Band
□ MD Orders/Medications □ Recent Labs, X-rays & EKG □ MOLST □ Progress Note □ Advance Directives
□ Active isolation/precaution orders and reason
_____ _____
Name of Nurse (please print) Signature of Nurse

Nursing Home to Emergency Department Quick Reference Sheet

ED Transfer Line

- Call ED prior to transfer to give warm handoffs

Palliative Care Triage Line

- Meet Palliative Care Criteria
- Benefit from goals of care discussion
- Reoccurring readmissions

Weekly Rounding

SAR Primary DX: **PMH:** **Cognition:** **Living/Social/Environmental:** **Referring Hospital:** **PCP: (**confirming community PCP with SNF)	**Functional Status:** Ambulation: Stairs: Bed mobility: Transfer: Wheelchair: ADLs Upper: Lower: Toileting: **Medical Needs:** Wounds / IV / Pain/ Drains **Medicaid:** **MLTC:** **Anticipated discharge date:** **Discharge Plan:**

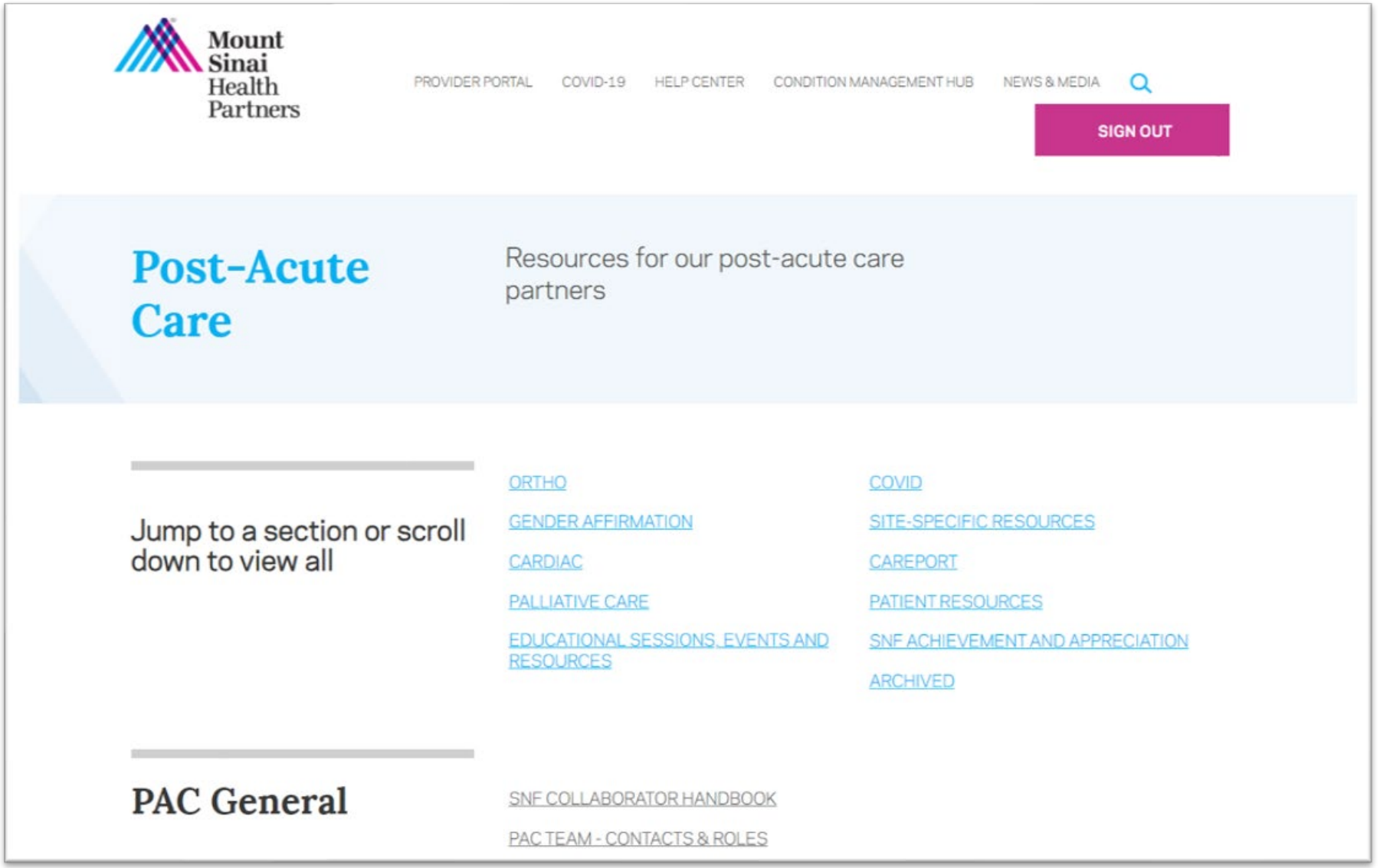
High quality care

- Patient demonstrates appropriate improvement in all functional activities
- Patient is receiving proper treatment for course complications
- Opportunities to coordinate and prevent a readmission
- Identify cases when PCP/Specialist involvement is necessary

Effective discharge planning

- Effective discharge planning, identifying barriers to discharge and risk factors for readmission
- Family training completed
- Referral to CHHA services, as needed
- Additional homecare services set in place (long-term or private hire)
- Involvement of family members in care plan meetings
- Recommendations about home modification to ensure patient safety and reduce fall risk post discharge

Training and Educational Resources



Semi-Annual Event

Agenda

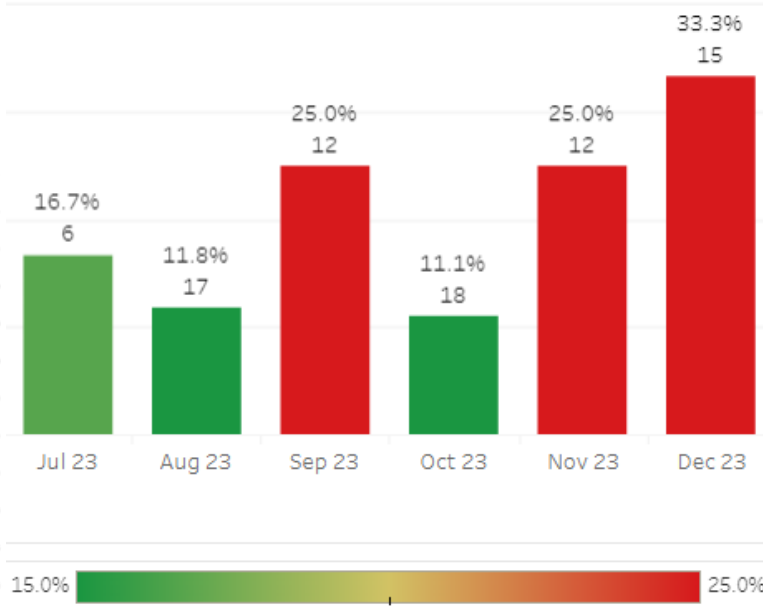
• **Welcome & Introductions**	*Mount Sinai Post-Acute Care & Mount Sinai Leadership*
• **Infection Prevention**	*Dr. Bernard Camins, Medical Director, Infection Prevention*
• **Nursing Home Transfers**	*Dr. Barbara Barnett, SVP & CMO Transfer Services & Robin Ferrer, System VP of Emergency Medicine*
• **The Preferred Network**	*Dr. Arshad Rahim, CMO & SVP, Population Health*
• **SNF Central Model**	*Alicia Tennenbaum, Executive Director, Care Transitions & Social Work*
• **Networking!**	*All*

Sample Scorecard

30 Day Rehospitalization, MSHS Discharges

Full 30 Day Readmissions

(includes patients discharged to home, transfers, hospice)



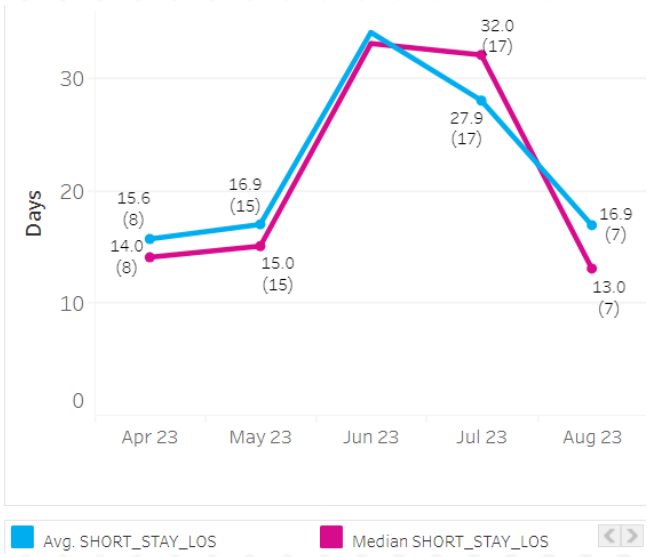
Lookback Period	Risk-Adjusted Performance
12-Months (11/01/2022 - 10/31/2023)	Better than expected
6-Months (05/01/2023 - 10/31/2023)	Better than expected
3-Months (08/01/2023 - 10/31/2023)	Better than expected
1-Month (10/01/2023 - 10/31/2023)	Better than expected

COVID not included in risk-adjusted evaluation

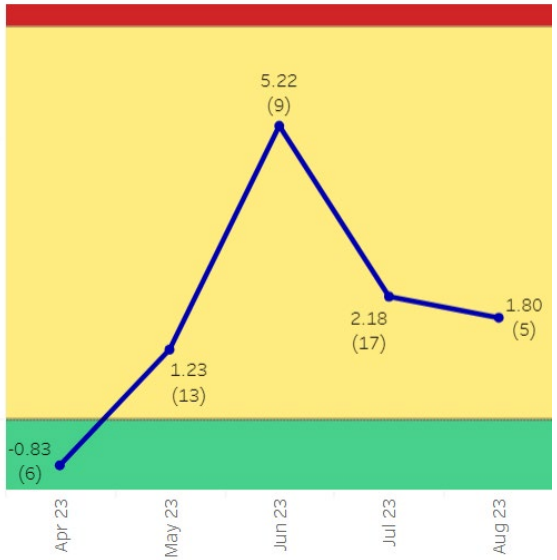
Sample Scorecard

Average Length of Stay, Attributed Lives

Average Length of Stay



ALOS Target Discharge Variance



Lookback Period	Risk-Adjusted Performance
12-Months (08/01/2022 - 07/31/2023)	Better than expected
6-Months (02/01/2023 - 07/31/2023)	Better than expected
3-Months (05/01/2023 - 07/31/2023)	Better than expected
1-Month (07/01/2023 - 07/31/2023)	Better than expected

COVID not included in risk-adjusted evaluation

Sample Scorecard

Additional Health System Measures, Monthly

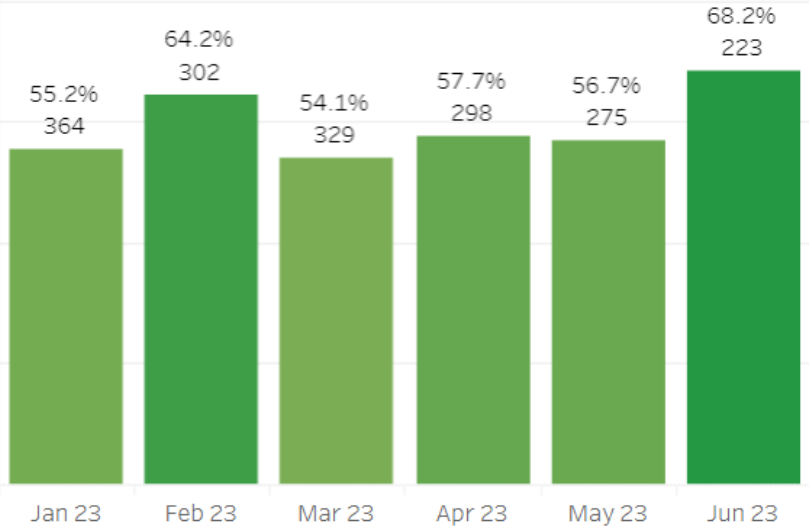
CMS Star Rating

3

CMS Star Rating Scale

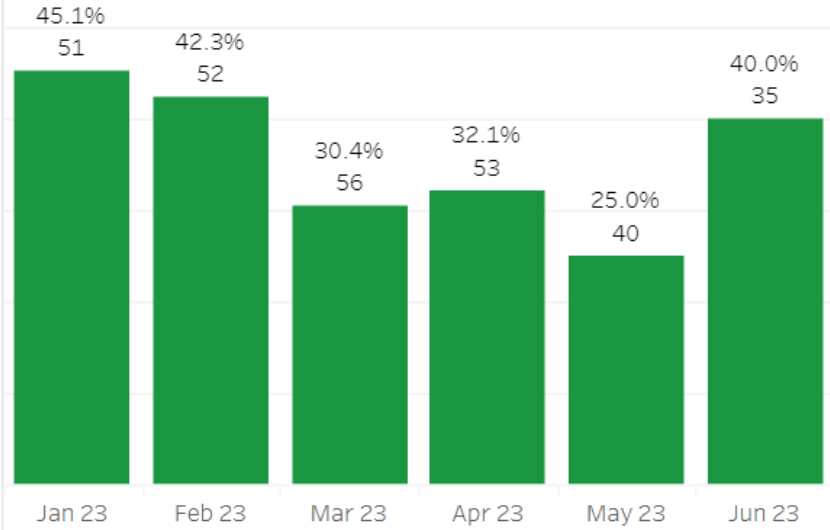
2 — 5

Acceptance Rate of Subacute Medicine and Rehab Referrals



10.0% — 70.0%

Acceptance Rate of Medicaid Subacute Medicine and Rehab Referrals



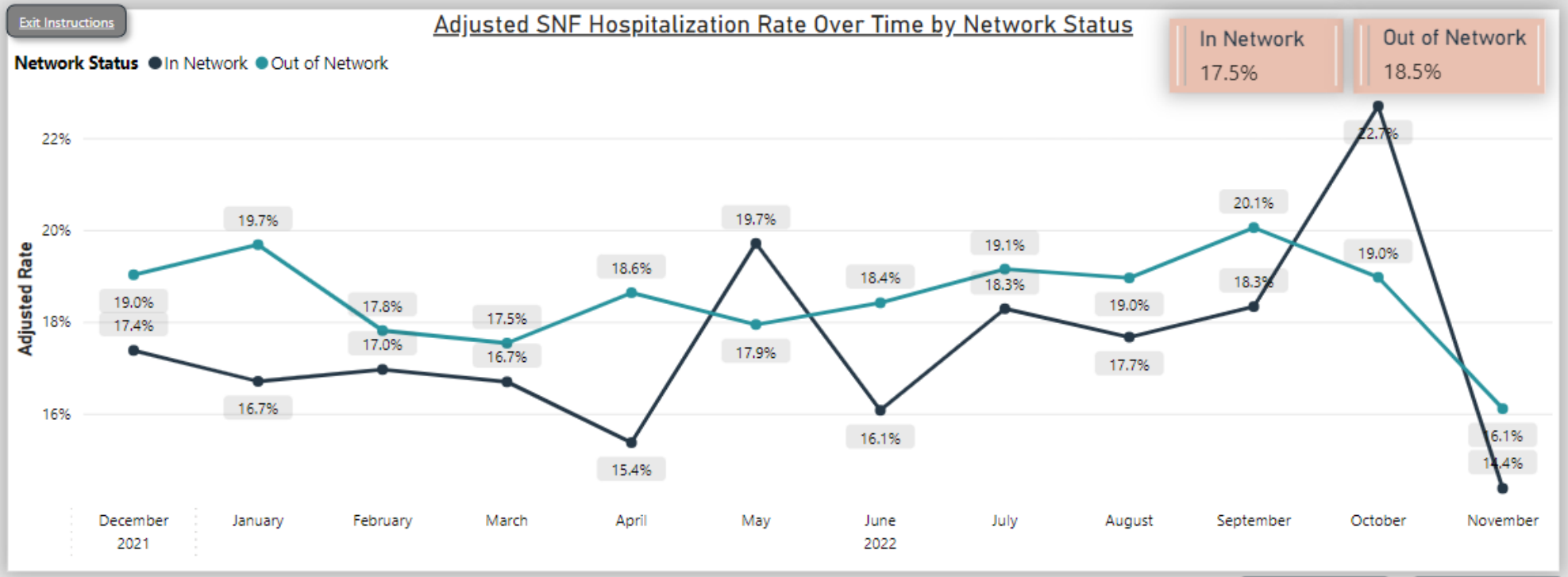
5.0% — 15.0%

Acceptance Rate of Subacute Medicine and Rehab Referrals

	Apr 23	May 23	Jun 23
Mount Sinai Beth Israel	1.7	1.5	3.8
Mount Sinai Brooklyn	2.1	1.4	1.8
Mount Sinai Hospital	2.1	1.6	3.4
Mount Sinai Queens	2.7	1.8	1.3
Mount Sinai Morningside	1.3	1.4	2.3
Mount Sinai South Nassau	1.1	1.0	3.5
Mount Sinai West	3.6	0.9	1.9

2.0 — 4.0

SNF Hospitalization Performance



Benchmarking:
National = 23.1%
NYS= 20%
Market= 24%

- Adjusted -

Adjusted Rate | Observed Rate

Year	2021		2022											Total
Network Status	December	Total	January	February	March	April	May	June	July	August	September	October	November	Total	
In Network	17.4%	**17.4%**	16.7%	17.0%	16.7%	15.4%	19.7%	16.1%	18.3%	17.7%	18.3%	22.7%	14.4%	**17.5%**	**17.5%**
Out of Network	19.0%	**19.0%**	19.7%	17.8%	17.5%	18.6%	17.9%	18.4%	19.1%	19.0%	20.1%	19.0%	16.1%	**18.5%**	**18.5%**
Total	**18.4%**	**18.4%**	**18.4%**	**17.4%**	**17.2%**	**17.2%**	**18.7%**	**17.4%**	**18.8%**	**18.4%**	**19.4%**	**20.4%**	**15.4%**	**18.0%**	**18.1%**

Outcomes of Acute and Post-Acute Care Collaboration

8 days

Decrease in SNF LOS

>2%

Reduction in SNF readmissions

$2.8M

Reduction in SNF spend

Thank You

Questions?

Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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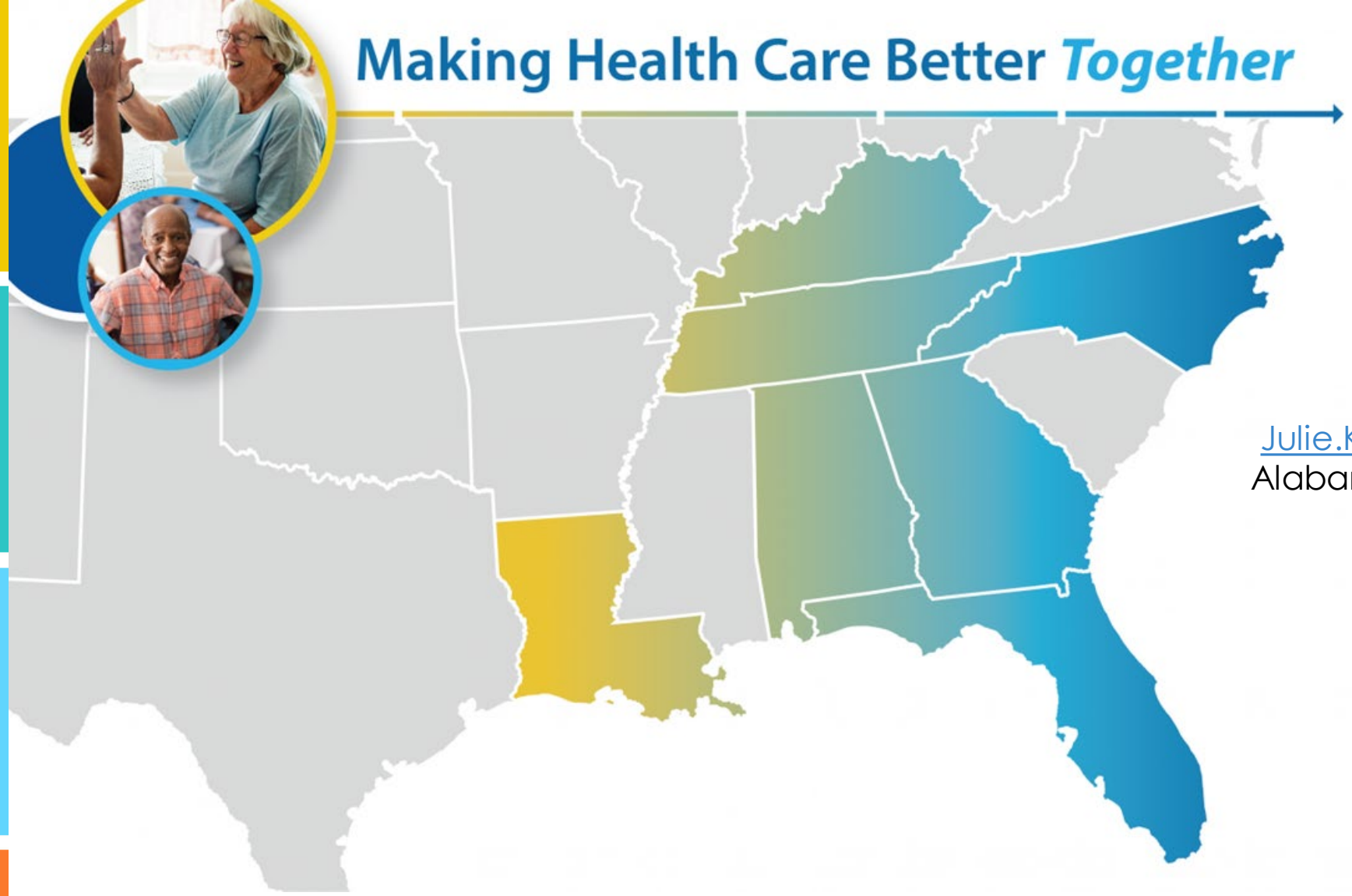

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