COUNTY OF PRINCE WILLIAM

OFFICE OF EXECUTIVE MANAGEMENT
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(703) 792-6600 Metro 631-1703 FAX: (703) 792-7484

Melissa S. Peacor
County Executive

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VACO 2013 ACHIEVEMENT AWARDS

PRINCE WILLIAM AREA AGENCY ON AGING

LEAP PROGRAM OVERVIEW

The Prince William Area Agency on Aging (Agency) and Novant Health Prince William Medical Center (Novant), along with multiple community partners who provide hospice, skilled nursing facility, assisted living facility, and home healthcare services, partnered to reduce hospital readmissions for persons experiencing heart failure. This partnership is called: LEAP: Learning, Expertise, Action, Partnership - *LEARNING from our communities to apply EXPERTISE in an ACTION oriented PARTNERSHIP.*

The Problem was clear: persons discharged with a primary diagnosis of heart failure were readmitted to the hospital within thirty days, 24% of the time. This causes anxiety for the patient and expense for the local healthcare system. The efforts of the initial partnership have reduced this disease specific type of readmission to 15% (as of 5/29/13).

Staffing: 4 (2 Agency on Aging, 2 Hospital) who also continue with their regular duties.

Cost: $5,000 (shared between the Agency and the Hospital)

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LEAP PROGRAM

Program Information

Locality: **Prince William County**

Program Title: ***LEAP***

Program Category: **Health/Human Services**

Contact Information

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The Prince William Area Agency on Aging (Agency) and Novant Health Prince William Medical Center (Novant), along with multiple community partners who provide hospice, skilled nursing facility, assisted living facility, and home healthcare services, partnered to reduce hospital readmissions for persons experiencing heart failure. This partnership is called: LEAP: Learning, Expertise, Action, Partnership - *LEARNING from*

our communities to apply EXPERTISE in an ACTION oriented PARTNERSHIP. It appropriately began on February 29, 2012, Leap Day, and continues today with monthly in-person meetings of the entire consortium as well as working task groups which meet outside of the monthly meetings. An official charter was drawn and signed by member organizations to partner with the Virginia Quality Improvement Organization (QIO), set goals, share data and provide community support to prevent avoidable readmissions.

The Problem was clear: persons discharged with a primary diagnosis of heart failure were readmitted to the hospital within thirty days, 24% of the time. This causes anxiety for the patient and expense for the local healthcare system. Root cause analysis of the readmissions showed elder population with chronic conditions and multiple co-morbidities were also facing under addressed End of Life issues. The efforts of the initial partnership have reduced this disease specific type of readmission to 15% (as of 5/29/13). End of Life care, as well as complex social needs for citizens wanting to maintain their independent living environment was an area the LEAP coalition could partner to resolve.

Now, the goal is to reduce readmissions for persons with other chronic diseases. The Agency, a Prince William County government human services agency, serves Medicare beneficiaries by providing in-home care coordination with a holistic framework. Partnering with Novant was necessary so that both of us could establish a relationship in order to work together on behalf of those in our community with chronic diseases who are repeatedly readmitted to the hospital. The Agency began by inviting Novant staff to the Long Term Quality Alliance meeting at the National Press Club in Washington, DC, in 2011. This group focuses on many healthcare issues but at this

particular meeting, the agenda included national efforts in reducing hospital readmissions of persons with chronic diseases. This day-long endeavor solidified a relationship because we both recognized that we each had expertise – the Agency, community-based services and resources knowledge and – Novant, healthcare and medical clinical knowledge.

Persons with chronic disease prefer to live in the community; this means they need long term services and supports. Some of these services and supports are provided or referred by the Agency. It has been our experience that sometimes the reason a person with chronic disease cannot live in the community is because their holistic needs are not met. They do not have transportation, accessible housing, appropriate nutrition, etc. In the most extreme cases, they do not know their options at all and just give up by calling 911 and go back to the hospital. Understanding their disease and its red flags are keys to staying at home and not being readmitted to the hospital. So is understanding their medications and taking charge of their care. This can be very difficult when you don't feel well, do not have a primary care physician, are afraid to ask questions of your physician and/or do not have a support system that can assist you in managing your care. For many, it is easier to call 911, which increases expense for local government. The Agency and Novant, by working together, can reduce the need for readmission.

All hospitals, due to the Patient Protection and Affordable Care Act, began to be financially penalized for readmissions within thirty days of discharge on October 1, 2012. Our partnership began to address this prior to this date because it was the right thing to do for our citizens. It wasn't an initiative to save the hospital funds, but rather to help provide more services to the community because they are best served when healthy and at

home. In fact, Novant was one of 3 hospitals in the Washington, DC/Northern Virginia area that did not receive readmission penalties in 2012. The Agency and Novant identified that by working together, we could accomplish great things.

The Agency identified staff to train with evidenced-based care transitions skills and invited Novant staff to join in the training. We had four people trained, two from Novant and two from the Agency. The Agency took the lead on providing care transitions one person at a time. Novant took the lead in building the community consortium, which included the Agency at all steps. This included an intense root cause analysis process which was facilitated by the Medicare Quality Improvement Organization (in Virginia called the Virginia Health Quality Center).

Novant case managers identify patients who meet agreed upon criteria for inclusion in the Agency run transitions program. The case managers describe the program to the patient, and if the patient agrees, they are referred to the Agency. The Agency staff can introduce themselves and the transitional care program to clients while being inpatients and Agency staff then follows up with a home visit. During these visits, the patient is empowered to understand their condition, recognize the red flags and practice conversations with their physician to aid in taking control of living in the community with the chronic disease. Novant facilitated the innovation of allowing county government staff to have the credentials to enter the hospital and speak with patients whom the hospital identified as at risk for readmission. Other hospitals and local governments are encouraged to replicate this model. Neither the hospital nor the local government needs to incur costs when they work together using existing staff and resources.

Total cost for the past three years have been under $5,000 for training and minimal travel which was split between Novant and the Agency. Currently, existing Agency staff provides the new program while performing other options such as counseling and care coordination duties, and existing Novant staff continues with their duties. What is different is that the hospital refers identified patients immediately while the patient is still in the hospital, and the Agency staff visits them there. In the past, Agency staff had to wait until discharge which was often too late to set up an appointment and visit before readmission.

Other collaborative efforts from LEAP include data shared by the VA QIO that is reviewed on a regular basis. This data includes Medicare admissions, visits to the ED, and readmissions. The Prince William County Demographer gave an extensive presentation on the population demographics for Prince William County. Prince William County Fire Department staff gave a program about the laws regarding ambulance service. A local city councilman and state Advance Directives registry project director coordinated a Health Care Decisions Week presentation at both the hospital and a local Assisted Living Facility. The area hospice agencies also partnered on these community education events. Planning is underway for more community awareness events.

A poster, which won George Mason University's 2012 Health Care Quality Improvement Award for Excellence in Public Health, is included which highlights the LEAP coalition's collaboration that led to the transitions program. The Agency and Novant were invited to share the program's highlights at the annual Virginia Hospital and Healthcare Association meeting in Richmond at which both Virginia and North Carolina

hospitals were in attendance. At first, noted by the attached poster, heart failure was the diagnosis that was the focus. Now, other chronic diseases such as diabetes, pneumonia and pulmonary disease will be highlighted.

In summary, the LEAP coalition, inspired by collaboration with the Agency, hospital, QIO, local nursing homes, hospices and home health agencies has benefited the community via multiple setting and multiple government resources. The innovation is collaboration across health and government settings to provide personal services to our community that result in consumer empowerment and reduced avoidable readmissions.

A Community LEAP

LEARNING from our community to apply EXPERTISE in an ACTION oriented PARTNERSHIP

LEARNING

Detailed Data Analysis:

- Higher Than Desired Readmission Rate for HF
- Highest Readmission Rate from Skilled Nursing
- End of Life Issues not being addressed

EXPERTISE

Identify the Community Experts:

- Skilled Care Facilities
- Home Health Agencies
- Hospice and Palliative Care Agencies
- Physician Practices
- Area Agency on Aging
- Virginia QIO

ACTION

Address the Barriers:

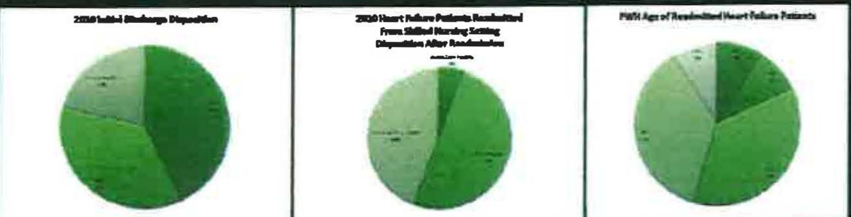
- Convene The Conversation
- Multi-disciplinary/Multi Agency Needs Assessment
- Create New Tools
- Create New Opportunities
- Create New Services

PARTNERSHIP

Create the Partnership:

- Extend The Invitation
- Create the Charter
- Honor the Commitment
- Evolve and Grow

Root Cause Analysis



Coalition Charter

Goals:

- Root cause analysis for Heart Failure readmissions
- Identify key factors for successful transitional care
- Improve quality of life for our patients living with Heart Failure
- Stronger community relations with transitional care agencies

Results:

- Decreased Heart Failure readmission rate by 33% in one year
- Increased Palliative Care and End of Life services at our hospital
- 100% patient compliance with prescheduled cardiology follow up appointments 6 months straight
- Signed community coalition charter with multiple community stakeholder agencies

Vision for the Future:

- Enhanced community stakeholders active involvement in reducing readmissions
- Improved access to End of Life services
- Improved Quality of Life for our community
- Decreasing overall readmission rate
- Saved Healthcare dollars

Cynthia Coleman, MA, RN

Prince William HOSPITAL

Kathy Tyrrell, BSN, RN