

Welcome to the Canon Hospice Community Health Show, brought to you by Canon Hospice and the Akula Foundation. Canon Hospice is a locally owned and operated home and inpatient hospice. The Akula Foundation is the non-profit aspect of Canon Hospice. All donations and fundraising activities at Canon Hospice are directed to the foundation. The goal of the Akula Foundation is to provide hospice care to indigent patients, to sponsor a children's bereavement camp held each year and to provide hospice and general health education to the community.

Segment 1

Sue May (Host) : Good morning and thank you for joining us here at the Canon Hospice Community Health Show my name is Sue May I'm your host and our guest today is Laurie Robinson. Laurie you're the director of quality with the Louisiana Health Care Review. Ok Laurie thanks so much for being with us here today, now tell us first of all what is Louisiana Health Care Review?

Laurie Robinson (Louisiana Health Care Review Quality Improvement Director): Louisiana Health Care Review is the Medicare quality improvement organization or QIO for Louisiana. Medicare has contracts all over the nation in every state with quality improvement organizations to help promote patient safety for Medicare beneficiaries which trickles to other patients as well but to promote patient safety in providers across the state.

Sue: Now you said you're contracted through Medicare

Laurie: Right

Sue: So does that mean organizations who are Medicare providers are the ones that would need to work with you on their quality improvement

Laurie: Absolutely. As part of their conditions of participation with Medicare they agree to participate in quality initiatives. Look at their practices, look at how they take care of patients, look at what happens at the bedside. And as they identify opportunities to improve they work with us to make that happen.

Sue: Now let me ask you, being a hospice agency we know a lot about quality. It's a big part of the new conditions of participation that have come down for us.

Laurie: Exactly

Sue: And of course quality is top for us, you know we have our own QA department that does all these things. How would Louisiana care review assist a company such as Canon Hospice in the health care review process?

Laurie: Well we offer free consultation to all providers across our state at all levels so we work with hospice agencies, with home health agencies, with hospitals, with nursing homes, skill care units

with rehab units who are looking for that free service that free consultation for us to come in and look at processes as an outsider looking in identify opportunities and then help you identify the right tool and right intervention to implement as well as measure and show your outcome.

Sue: Let me ask you this, because this is such a part of what a lot of health care organizations do every day that is try to perfect the things that we do and make sure we're doing things the right way. Even though most of us have our own departments that do QA, you come in and assist the QA department to perfect their plan, is that what this is about?

Laurie: That's exactly right that's exactly right. And you know often times we are because we have a network of national quality improvement leaders we have access to best practice standards and tools that are out there that are being shared across the nation. The amount of information out there for improvement is overwhelming and often times we find is providers have lots of things they can do but just don't know where to find that tool that fits best in their organization. Not everything works for everybody.

Sue: Give me a scenario of how you would come into an agency and what you would focus on and assist them.

Laurie: An example would be acute care re-hospitalization rates for home care for instance. We have quality improvement specialists that help agencies look at their acute care re-hospitalization rate and then based on that rate they look at common practices and how they're caring for patients. And what we find is often times there may be a communication tool that works well between the home health or nurse care for the patient in the home setting and the physician. That may be the issue. There may be that there's not a risk assessment that's being formed in the assessment of the patient to determine who would be a patient that would be high risk for readmission and how do we want to maybe care for that patient or that significant other that's caring for that patient a little bit differently. So it may be something that we use to help them with assessment, help them with communication. It may be an electronic health record that they're trying to embark on and don't really know how to get as quality bells and whistles built in there so we help with that, and then we help other providers as well. It's mainly an outside eye coming in and assessing, looking at processes and policies that are in place, see if we can based on our knowledge and what we've seen shamelessly steal from another provider perhaps, or maybe create a new tool that fits or tweak an existing tool that fits, test it, and show some good outcomes.

Sue: And your services are free of charge to providers?

Laurie: Free of charge

Sue: Wow, that's a good price to pay I'm telling you.

Laurie: I'm telling you

Sue: But because you've been given the opportunity to do this through Medicare how do you approach agencies about getting them or do agencies come to you and say help us?

Laurie: Well, every three years Medicare starts a new what we call a Scope of Work, which is a contract. And we focus on some of the same things every three years that we know are going to be hot items for a very long time, surgical care improvement as it relates to infection. Heart failure and how we care for patients with heart failure when they come to a hospital. Acute care re-hospitalization for home health agencies, pressure ulcers for nursing homes. But what CMS also does is they look at what's going on in the nation in the scope of years and they decide, "you know what, here's something we want to focus on, and we want you to recruit providers to work on this and show us what tools will work." So for instance in this scope of work, Methicillin-Resistant Staphylococcus Aureus, MRSA, the big-bad-bug, was one of the initiatives they asked to focus on in hospitals. So we took a few hospitals in the state and said, "Hey, are you willing to work with us?" Recruited them to work with us, and they are helping us to identify the tools that really work so when we get those then we share those with all the hospitals in our state

Sue: Let me ask you this, what type of professionals are working with you to make this happen, what are the credentials that they have to be able to pass this knowledge along to us?

Laurie: All of our staff have education in quality improvement, and have even most of them have worked actually in quality improvement in a provider setting. We have a mixed bag of credentials, everything from certainly registered nurses and physicians that are clinicians, but also we have pharmacists, we have wound care specialists who help us in our pressure ulcer initiatives. We have just a wide variety of professionals that contribute to the overall scope of the project.

Sue: When you come in to do an assessment, or assist of an agency by doing your assessment of how you can help them, how long are you in there in that agency working with them?

Laurie: It really just depends on the agency and where they are in and how sophisticated they are in their quality improvement. You know we have worked with agencies that have unlimited resources owned by large corporations that have a corporate quality structure to single owned by family shop that don't have a lot of resource but have a shell of a quality department that's making it work but we need to do a little bit more work with because they don't have all the bells and whistles of say as a big corporation. It really just depends on what we find when we get there. We have a standard assessment that we usually create at the beginning of every scope of work so that we know the questions we need to ask we know that protocols are very important we know that leadership assessment is real important too because if leadership is not supportive then we have to go at this a little bit differently than we initially thought. We have standard pieces of the assessment that we build prior to going out. And then it just depends on what we find when we get there. Each provider is treated individually; their needs are met based on what their needs are. Cultures in different organizations are different you know we have to take all those things into account. It's almost like patient care, you wouldn't treat a patient with congestive heart failure the same across the board; everybody's got a little bit something different that makes them unique that you need to address and that's the approach we try to take.

Sue: We're going to take our first break. We'll be back in just a few moments, please stay tuned.

Segment 2

Sue: Alright, we're back here listening to the Canon Hospice Community Health Show and I'm talking with Laurie Robinson, she is with Louisiana Health Care Review. Laurie, all the information that you gather when you go to these agencies to assist them with their quality assessment of problem solving and such in their facilities, what do you do with all the information?

Laurie: The information that we gather certainly is private and confidential with that facility. We don't share that with CMS with regards to the provider name, we share aggregate data with the community we work with because it's important to see where we start baseline, where we're benchmarking to try to get because you have to have a goal.

Sue: Exactly

Laurie: That information is kept between the quality improvement specialists and that provider. We share that data with the group that worked together in collaboration. As providers disclose, but it's kept within the relationship of the quality improvement specialist and the provider. I think that's what makes it work. Providers are willing to be more transparent because they can be and because they can trust the folks they're working with.

Sue: Exactly. And that's a really important point truly because just in listening to what you're doing I know as a health care organization the first thing we'd be thinking is, "ok, well this is some very sensitive data that we're dealing with." Not that I'd even question that you would have a confidentiality contract. But you're collecting data, so something is usually done with that but like you said it would sort of be anonymously collect and put together with all the agencies you're dealing with. How many agencies are you dealing with right now in Louisiana?

Laurie: We're working with 22 hospitals on surgical care infection prevention; we're working with six hospitals on MRSA prevention, we're working with over 53 nursing homes on pressure ulcers and physical restraints. We're working in the Baton Rouge community with 5 hospitals all the home health hospice and nursing homes on care transitions and safe transitions and then we're also working with 8 hospitals on pressure ulcers. Quite a few.

Sue: That's quite a few projects. Let's talk about the Care Transitions Project which is really your baby, isn't it?

Laurie: It is.

Sue: Talk to me about what it is and what you're trying to accomplish with this project.

Laurie: Well first let me say that I'm proud of the Baton Rouge community and Louisiana because we're one of only 14 states that were chosen to work on this project. Louisiana Health Care Review had to write a proposal that would be successful and accepted in the CMS Washington world. And it was because we had the support of all the community providers in Baton Rouge that made this go. They saw community strength and said if it can happen it will happen in Baton Rouge, and one year later it is happening in Baton Rouge and it's because the providers are committed to make this go. It's one of 14 projects in the nation, it's a 3 year project and basically what we're trying to do is reduce unnecessary readmission to the hospital.

Sue: Wow, that's big

Laurie: That covers a gamut of providers because a lot of people touch the patient. Now we've looked at all the reasons we think why patients readmit to the hospital. We've studied it some in the Baton Rouge area, but now that we're working on the project it's really becoming more evident

that health care has way passed up the patient and it's become so technical and so sophisticated and so IT savvy that we've left the patient behind. And so how do we reconnect with the patient and really understand what the patient's telling us and what they need so that when they do have an acute care episode and they're discharged that we meet all those needs and empower them to care for themselves, navigate this crazy system we've created and stay out of the hospital.

Sue: Yeah, it sounds crazy that we're health care review and we're talking about trying to keep people out the hospital but it is an education process and I'm sure people who are listening who are health care professionals identify with us immediately but those of you who are not in health care most are probably saying, "why would they try and keep us out of the hospital?" Because the hospital is designed to take care of crisis situations and we're trying to focus more and more I know on especially emergency room admissions and to get people to understand the purpose for that place and how it should be properly used. Health care initiatives are wide open right now, listening to our president the other night we're all talking to our legislatures right now because those of us who are working in health care have some great concerns about the future of health care. When I see something like this happening though I see some positives because the things we're talking about the things you're looking at really do look at cost savings. When a type of health care whether it be home health, hospice the nursing home or the hospital are used improperly that costs you and I dollars. The ramifications of what you're doing are far reaching and I really applaud your efforts.

Laurie: And you know I've always said I've been in health care I've been a nurse for over 25 years, I've always said this: "the dollars will take care of themselves. If you treat the patient where they need to be treated what they need at the time they need it and that's all. It will take care of itself." So what we're focusing on is appropriate patient care at the right level of care, the right services connected to the patient need and making sure that transition to home is safe.

Sue: Boy I like that a whole lot. It seems like that's what we're trying to do every day.

Laurie: Now I can tell you in this community just looking at the initial data and this is claims data from Medicare beneficiaries that were discharged when we started this project. It was very telling to see the underutilization of hospice and home health. Of the claims data we looked at, a two-quarter hunk of data, of all the Medicare beneficiaries discharged in this area there was only a 1% admission to hospice.

Sue: That's sad.

Laurie: It was, and you know what we're doing? We're looking at why. And home health was only at like a 24%, and we know we have sick CHF patients, we know patients that are going home after a heart attack are scared when they get there and how comforting would it be for a nurse to come out a day or so later and reinforce that they're doing ok and there is life after a heart attack, or there is life with CHF, or you can go home and die with dignity if you have cancer. So what's the deal here? Why are we not looking at this?

Sue: I could do a whole another show with you on the underutilization of home health and hospice services. A lot of it I think is the stigma of what people don't understand about it; people hear the word hospice and automatically assume it involves death. And hospice is not about death it's about life, it's about the quality of life and making sure that people understand the end stages of the disease they're dealing with. It's definitely not a killing field, it's not a place where people go to die it's a place they go to live and it's usually in their home where they want to be. It's far reaching and the support services are what really make it different but then there's home health that is there to help that transition of care it's such a huge part of it. Our biggest challenge everyday is to educate our medical professionals.

Laurie: You're absolutely right. And you know part of where we're going to go in this project, this is the beginning. To help dispel some of the myths about hospice about the reimbursement, about how you get referred about the fact that you're not locked in if you get better you can opt out. Patients feel like once they lock in or doctors actually feel like once they lock in, they're locked in. People don't understand the benefits as it relates to the medicine, the equipment, the things that patients need that are so costly that are not covered by Medicare in the end of life that hospice helps with. We're doing our patients a disservice if we don't give them the information for them to make an informed decision about how they want to transition home. So how do we get those informational visits and how do we increase that referral? So we're going to work on that in this project because it's so critical for this project.

Sue: Amazing. When we come back we'll talk about some of the project aims. We're going to take our last break here and we'll be back in just a few moments.

Segment 3

Sue: Alright, we're back here for our last segment here with Laurie Robinson, Director of Quality and Project Director for Care Transitions Project with Louisiana Health Care Review. Laurie tell us a little about the project aims for the Care Transitions Project.

Laurie: Sure, primarily it's to support patients of families through the discharge process. It's also to reengineer the discharge process with providers and help them take a real look at the process itself and also to improve communication between the clinician and the patient, but mainly to empower the patient to take some, with the tools, to take the ownership of their health care and their discharge. Every day when we go in patients' rooms we find patients are a little bit submissive to the health care professional, and we don't want it that way, but it's just what it's evolved to be. Health care is scary, we use these big terms, we don't listen, we're always in a hurry, we have a lot of tasks to perform. We want to do a good job, we don't get up every day to not take good care of patients, but it's the nature of the work that we do, we've become more and more separated from the patient. So how do we get back to the patient, reconnect to the bedside and connect to the patient and listen? Part of that has been through our transition coaching model that we have created in this community. And what that is, real briefly, is a transition coach is assigned to a patient, and this coach does not provide medical care, it's just a navigator. We know patients are not getting follow up appointments in the time they need to between hospitalizations. We know that patients are coming back within thirty days and there's no appointment in that time frame. Patients need that follow-up. They need their doctor to tell them things are okay, they need that doctor to reevaluate those medicines. They need that doctor to hear what the barriers are for them. This transitions coach helps them to do that. Something as simple as medication reconciliation understanding what the medication discharge plan is. We looked at this process with hospitals and we actually sat through the process with several patients and just observed. And to no fault of any provider, the patient is given the third sheet of a carbon copy written in somebody's handwriting they don't know in the terminology that's foreign. So this process, the coach actually takes a medication reconciliation sheet that we have created and the patient writes in their own handwriting the discharge medicines. How powerful? The patient gets home, they recognize their own handwriting. The writing, the actual task of writing the medicine, how to take it, how many.

Sue: Education process right there.

Laurie: Is reinforcing what we told the patient, and it's in an obnoxious hot pink piece of paper. So when we call the patient two days later, we say, "get out your hot pink piece of paper, and did you get that Levaquin filled, that's the first medicine on the sheet? They know exactly what we're

talking about. It's like the bell has gone off. We also assist them with the follow-up appointment. We've navigated for them in some instances where they told us, "I'll never get in." You just need to tell the receptionist when you need to get in. "I'll never get in." And so we actually navigate through with them. We also coach them on key questions to ask in that doctor's visit, so when you get there you bring the pink piece of paper and your bag of medicines and here's what you need to ask when you get there. Write down two questions you want an answer to and they do, and believe it or not when they get there they ask them because when we call them back after the appointment we hold them accountable to those two questions. Now we're not providing nursing care we're providing coaching, we're providing a person to assist them, to navigate through a very sophisticated, complicated system. It's not anything that's rocket science, but it's reconnecting to the patient, it's understanding if they don't have the medicines to fill the medicine prescription, it's understanding they don't have transportation, it's helping that caregiver because we coach caregivers as well. It's coaching that caregiver to know when they need a break, to know how to get the resources. To reconnect with the patients' goal which is to get back to the dog, they could care less what our goal is.

Sue: Oh my gosh yes.

Laurie: They don't want to know what the clinician's goal is that's just discharging him. They want to know if Fifi's okay and if there's groceries in the refrigerator, and we've forgotten about that, you know, we've totally forgotten about that. The other thing we do is we have the patient set a patient goal. Not my goal as a nurse, which is to keep you under a certain weight if you have CHF keeping you on your Lasik's and etc. It's to put my shoes on and go to church on Sunday. That's the goal, and when the patient can connect to the goal, the patient takes ownership. We try to force our goals down their throat. You've got to stay under this weight, you can't have any sodium, you have to take this medicine, you can't do this, and really what they want to do is visit with their grandchildren on Sunday, they want to go to church, they want to buy their own groceries. They need to connect this health care back to their life. We need to recognize that their universe is not the hospital, it's their home. And we need to reengineer health care around their universe.

Sue: You know Laurie, you've given us a wealth of information and in our last seconds here, where should someone contact Louisiana Health Care Review if they want to participate in this program.

Laurie: www.lhcr.org