Following the Patient's Healthcare Journey

AGENDA
for
Reducing Readmissions and Improving End-of-Life Care
Breakout Workshops

Best Western Royal Plaza, Marlborough, MA
February 7, 2013, 8:30am-3:30pm

Breakout Sessions:
1. Avoiding Readmissions: Planning for An Exacerbation
2. MOLST/Improving End-of-Life Care
3. Successful Strategies for Reducing Readmissions

Breakout #1: Avoiding Readmissions: Planning for an Exacerbation (10am-11:15am)

Topic and Speaker	Title	Objectives
Managing exacerbations by readmission to a SNF (40 minutes)		

• **Judy Girouard, RN**
• **Phyllis Peterson, RN**
• **Sandra McLaughlin, RN**
 	
Policy Issue Discussion (5 minutes)
	Regional Vice President for Life Care Centers of America
	
	Director of Nursing Life Care of Plymouth
	
	Area Director, BAYADA Home Health Care
		How to manage an exacerbation of the patient's condition post-discharge by readmitting to a skilled nursing facility
		
		The program under current Medicare payment rules
		• What are the Medicare payment rules – what is required for readmission to SNF
		• Describe the role/activities of home health agency and Skilled Nursing facility
		  o Coordination on discharge planning from the SNF to home, with home health services
		  o When there is an exacerbation after discharge from the SNF to home, what are the elements of the program/process to ensure appropriate care for the patient – for home health, for physician, for SNF
		• Lessons learned from the Henry Ford Case Study, and Lessons learned from your Life Care of America/home health agency experience
		
		Opportunity to expand this program if Massachusetts gets the waiver of the three day rule
		• What might be different programmatically to consider admission to a SNF for an

		exacerbation if there is a waiver of this rule • Talk about reform legislation re: waiver; ask people if they have evidence
Home Health Agencies Reducing Readmissions (30 minutes)		
• **Gina Mazza, RN** • **Jim Culhane, MSW, MBA**	Partner, Total Performance Director, Fazzi Associates Director of Home Care and Personal Services, VNA of Manchester and S. New Hampshire	• Ohio Council for Home Care and Hospice project - Lessons Learned/Critical Success Factors for Reducing Readmissions • Elements that are key to success in reducing readmissions

Breakout #2: Improving End-of-Life Care, incorporating MOLST (11:20am-12:20pm)

Topic and Speaker	Title	Objectives
Strategies for improving End of Life Care		
• **Jeanne Ryan, MA, OTR, CHCE, COS-C** • **Greg Bird, RN, MS** • **Michael Tarmey, RN**, • **Shirley Conway, RN, MSN, MBA, LNHA, BC, HPCNA** • **Fay Curtis, RN, MS**	Executive Director VNA & Hospice of Cooley Dickinson/ Cross-Continuum Services Sr. V.P. for Patient Care Services & CNO – Lahey Health Director for Behavioral Health Services, Lahey Health Director Geriatric Initiatives, Senior Adult Unit, Addison Gilbert Hospital Lahey Health Director, Acute Care Services Lahey Health	• Strategies for implementing MOLST at the physician and community levels • Practical implications for implementing MOLST at the hospital level • Incorporating MOLST into related activities & goals (e.g., Advance Care Planning) • Discussion will include how to take: o Action steps needed for success o Identify key stakeholders o Utilize MA MOLST resources o Incorporate education strategies
Preparing your community to use Medical Orders for Life Sustaining Treatment		

• **Christine McCluskey, RN, MPH**	MOLST Expansion Director, Commonwealth Medicine	○ **Strategies for improving End of Life Care** ○ A description and update on MOLST implementation in Massachusetts ○ available resources and plans for expansion throughout MA ○ Discussion of MOLST along the advance care planning continuum ○ Preparing for MOLST implementation in health care institutions

Breakout #3: Successful Strategies for Reducing Readmissions (2:30pm-3:30pm)

Topic and Speaker	Title	Objectives
Lessons learned from the cross continuum work: (30 minutes)		
• **Barbara Marullo, RN** • **Stacey Rebelo, RN**	Program Manager, Quality Improvement and Patient Safety Hallmark Health Clinical Services Consultant, Golden Living	Lessons learned from the cross continuum work: • Decreasing readmissions by using data from research of readmitted patients and patient interviews. • Interventions: Nurse to Nurse Warm calls; Pharmacy Consults; ED Treat and Return Policy
From the perspective of the physician office practice: (30 minutes)		
• **Kate Koplan, MD, MPH**	Director of Medical Management, Atrius Health	Atrius Health practices role in managing care/Patient centered Medical Home, and their plans/ expectations for partner facilities (hospitals, SNFs, home health) for care management • Describe the expectations/ partnership related to care management/care transitions - especially for discharge transitions and associated medication reconciliation (highlight anything

		related to readmission)- with: - hospital - SNFs - home health agencies • Criteria/expectations standards metrics IT transfer • Different expectations in different phases • Coordinating case management/care management specifically (how to avoid multiple case managers calling the patient)