Northwest Community Healthcare Presents:
The LINCT Program:
Liaison In Nursing Care Transitions
Building an Integrated System of Care

Dina Lipowich, MSN, APN, NEA-BC

Director, Inpatient Medical Nursing and Geriatric Programs

July 27, 2014

Northwest Community Healthcare

Demographics:

- 496-bed **Chicago, IL** area community hospital founded in 1959
- 30,000 Inpatients, 350,000 Outpatients, 43,000 home care visits annually
- 50% > 65 and older

A Community Hospital of Distinction:

- ANCC MagnetTM Recognition for Nursing Excellence
- Primary Stroke Center, Joint Commission Certified 2012
- Palliative Care Program, Joint Commission Certified 2014

New Realities in Healthcare

Factors Affecting Change

- **Trends**

  Aging population → Increased healthcare costs

  - 1 in 10 Americans is older than 60
  - By 2050 numbers will double

- **Reimbursement**

  Volume → Value Based

- **Customers**

  - Patient experience → Published Data
  - Physicians → Referrals

Changing Model of Healthcare

Preparing for the Future:

Strategies for Building an Integrated System of Care

Quality

Partnership

Cost Containment

Care Across the Continuum

Exceptional Patient Experience

Defining "Quality" in Healthcare

Healthcare Quality Indicators

- **Decrease** Length of Stay based on Diagnosis
- **Prevent** Hospital Acquired Conditions (HACs)
- **Maximize** Patient satisfaction
- **Prevent** 30-day hospital readmissions

Community Demographics

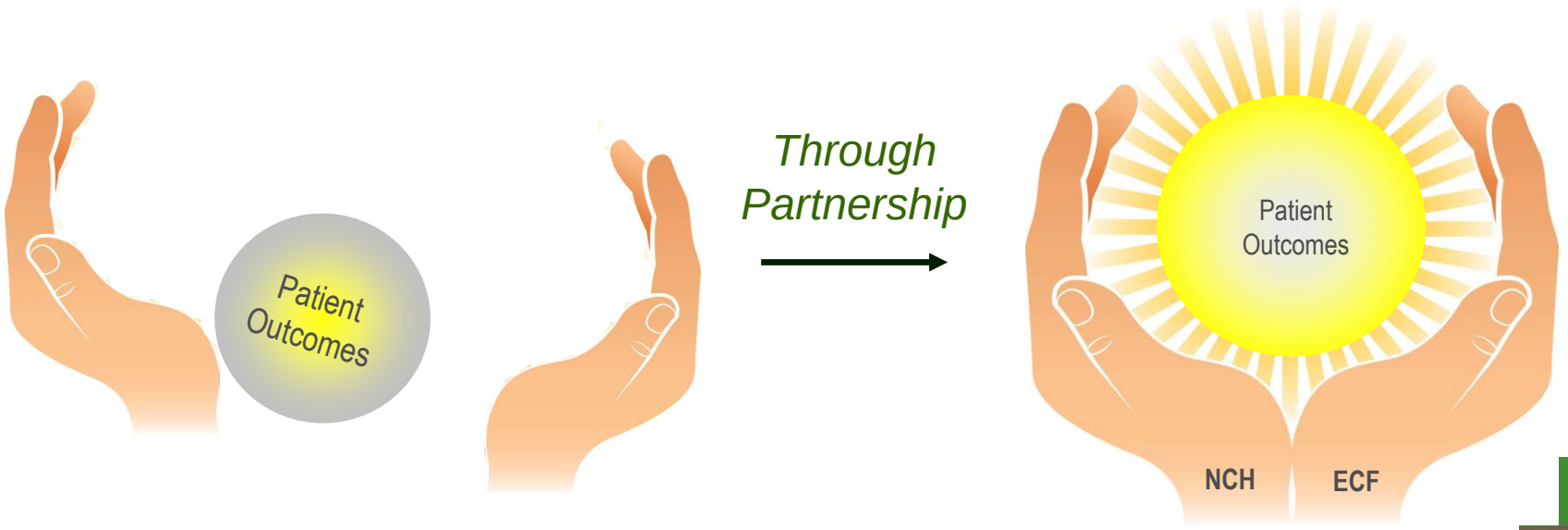
Understanding the Populations We Serve

- Elderly patients with chronic medical problems are at highest risk for repeated 30-day readmissions.
- Nationally, 1 in 5 patients returns to the hospital within 30 days, costing the federal government $17.4 billion annually.
- In 2011, nearly **21%** of patients discharged to area Extended Care Facilities (ECFs), returned to our hospital within 30 days.
- A breakdown in continuity of care is a factor for repeated and frequent readmissions.

LINCT Program

Liaison In Nursing Care Transitions

Partnership for continuity of quality care for patients during transition between the hospital and extended care continuum



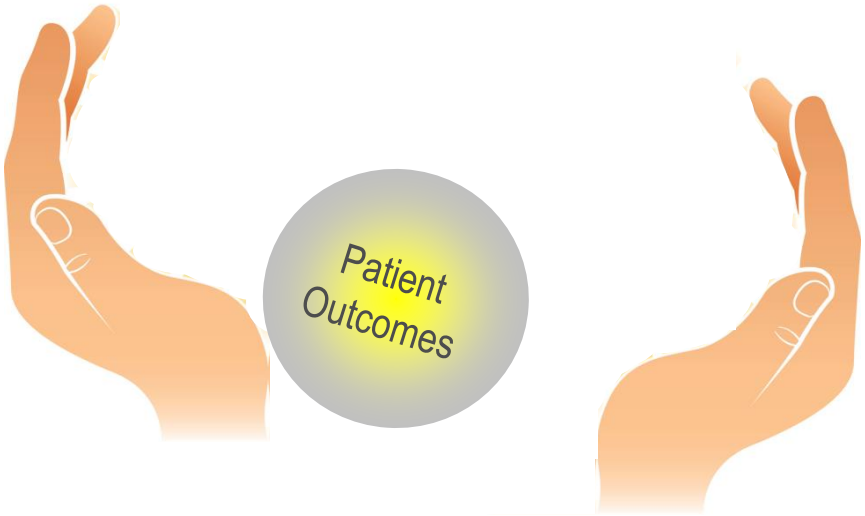
From… **Fragmentation**

To… **Continuity**

LINCT Program

Problem of Readmissions

- Create doubt about quality of care
- Impact patient satisfaction
- Create congestion in the Emergency Department
- Contribute to payer penalties



LINCT Program Objectives

Improve quality outcomes

- Prevent avoidable 30-day readmissions from partner ECFs.
- Improve patient satisfaction with transition of care.
- Reduce hospital length of stay for patients discharged to partner ECFs.

LINCT Program Structure

Based on Transparency and Communication

- Partnerships established with community ECFs.
- Education to empower nurses, patients, and families for optimal transitional experience.
- Navigation by hospital nurse to oversee patient transition from hospitalization up to 30 days post-discharge to ECF.
- Monthly interdisciplinary meetings at ECF: Readmission statistics, cases, high risk patients, trends and opportunities.

LINCT Program Nurse

INPATIENT FUNCTIONS:

- Receives referrals for patients transitioning to partner ECF.
- Rounds on patients during hospitalization.
- Assesses patients for readmission risk.

OUTPATIENT FUNCTIONS:

- Rounds with patients and staff within 24-72hrs of discharge to ECF and up to 3 times per week for 30 days.
- Collaborates with interdisciplinary team to determine best plan of care.
- Facilitates inter-professional monthly quality review on readmitted patients.
- Provides education for ECF staff on symptom management and recovery.

LINCT Program Strategies

- INTERACT Program
- Government Health Coverage and Benefits: Skilled 30 Day Window or Rule
- Advance Directives and Planning Ahead

LINCT Program Strategies

INTERACT (www.interact2.net)

INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) is a quality improvement program that focuses on the management of acute change in patient's condition.

INTERACT includes clinical and educational tools and strategies for use in every day practice in ECFs:

- Communication tools
- Care paths
- Readmission tracking tools
- Readmission case review tools

LINCT Program Strategies

Government Health30 Day Window

Helping clinicians, patients, and families understand all the options under government health program coverage.

- Inpatient hospitalization may not be the only option for patients in need of extended nursing care:
- Patients discharged from hospital after 3 consecutive nights may qualify for admission to ECF within 30 days.
- Patients discharged from an ECF may qualify to be readmitted within 30 days.

LINCT Program Strategies

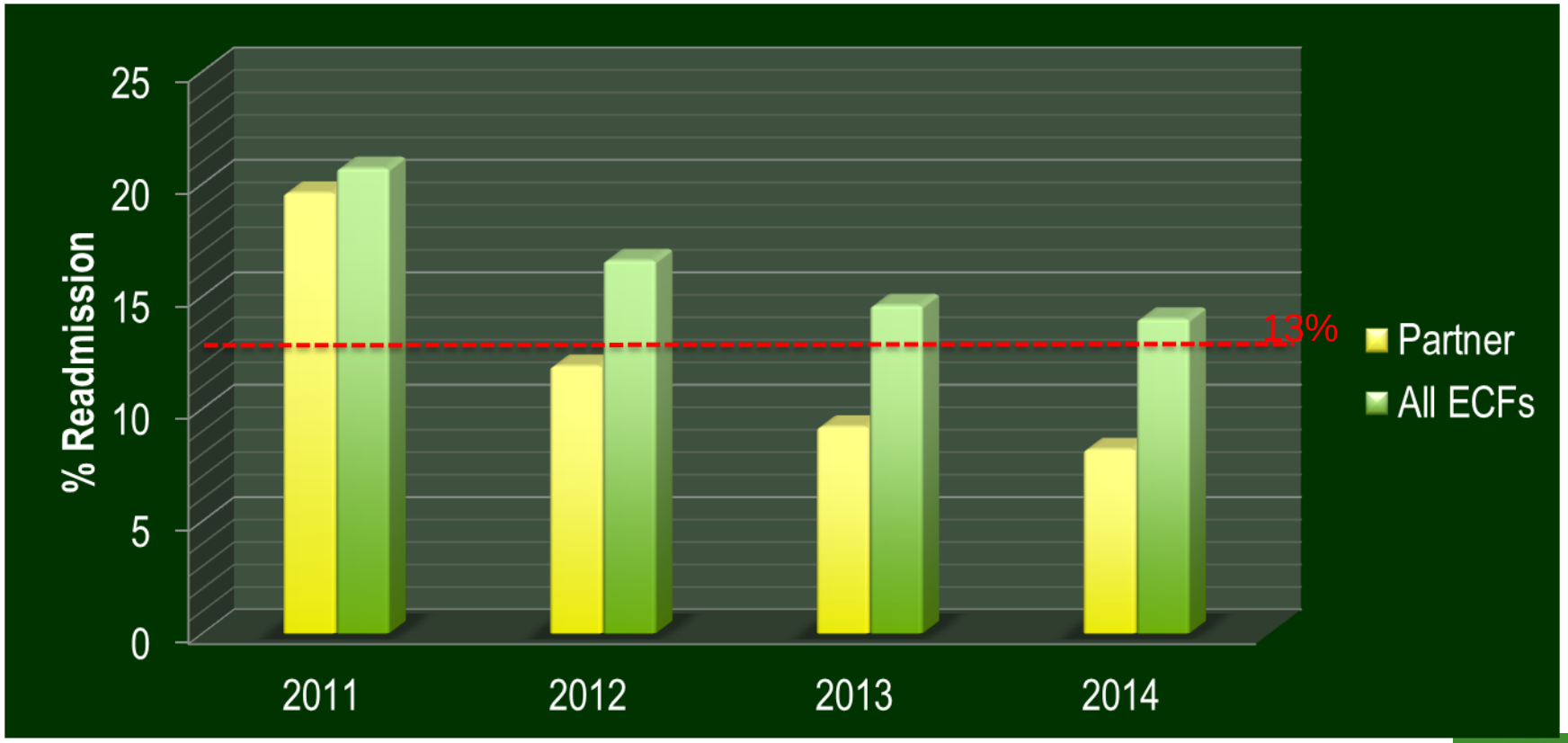
Advance Directives and Planning Ahead

Partnering to improve communication and planning for patients with serious advanced illnesses during and post-hospitalization.

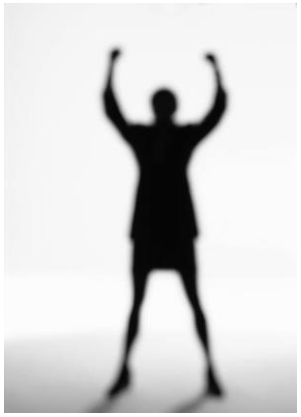
- Increase awareness of Medical Power of Attorney designations for patients transitioning to ECFs post-hospitalization.
- DNR: Do Not Resuscitate.
- POLST: Physician Orders for Life Sustaining Measures.

LINCT Program

30-Day Readmission Rates



LINCT Program Success



Quality

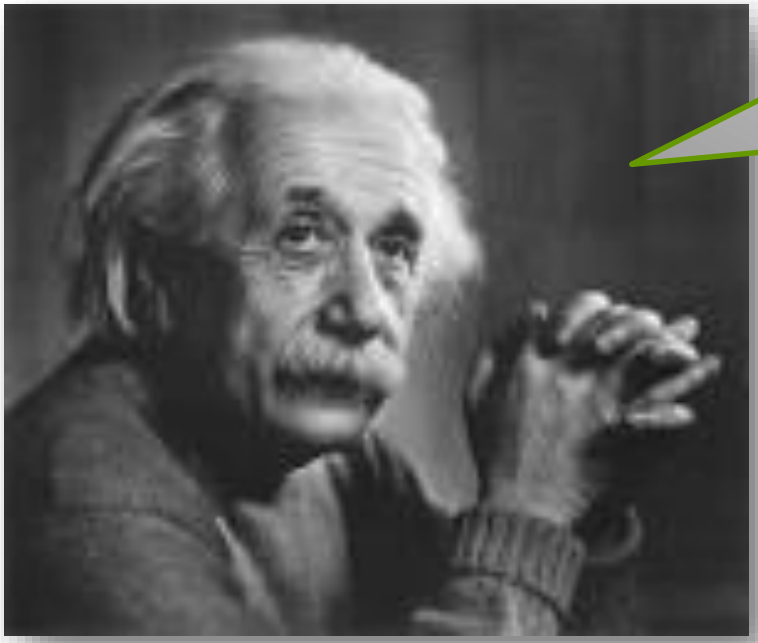
Partnership

Cost Containment

Care Across the Continuum

Exceptional Patient Experience

A Word About Innovation…



If you always do what you always did, you will always get what you always got.

[Albert Einstein]