

*CMMI Innovation Advisor Paula Suter, Sutter Care at Home:*

# Putting the Patient at the Center of Care

*Paula Suter, of Sutter Care at Home, joins the Alliance for a discussion of her work with the Center for Medicare and Medicaid Innovation's Innovation Advisors Program. The goal of the Innovation Advisors Program is to improve healthcare delivery for Medicare, Medicaid and CHIP beneficiaries.*

*Ms. Suter, who serves as the Director of Integrated Chronic Care Management at Sutter Care at Home, is a nationally recognized clinician. Her work focuses on designing, implementing and assessing patient-centered healthcare delivery programs targeted at*

*caring for chronically ill patients. In addition to her work at Sutter, Ms. Suter frequently speaks on best practices in chronic care management, writes articles on caring for patients with chronic disease and sits on the executive committee for a national healthcare quality initiative. You can read more about the Home-Based Chronic Care Model™ that she co-developed in Home Healthcare Nurse, by [clicking here](#).*

*We sat down with Paula to learn more about her project and to get her perspective on the role of home care in current healthcare delivery system reforms.*

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**What is your role in health system reform as an Innovation Advisor and what contribution will your program make to the home care community?**

I see myself as an Innovation Advisor and as a person that is here to learn as much as I can about healthcare economics, how to analyze projects and operations research, and evaluate whether

improvement projects are really making a difference. The purpose of the Innovation Center is to build collaborative groups to support others in their own delivery reform efforts. Through the work we do in our projects, I am hoping to learn how to better drive organizational change and how to best evaluate changes so that I can help others do so in the future.

Sutter Care at Home (Sutter) is implementing a Center Of Excellence for Integrated Chronic Care Management (ICCM) with the express purpose of equipping the existing national infrastructure of home care clinicians with the competencies and best practices needed to obtain the triple aim outcomes of healthcare reform. I am confident that the training, development, and competencies gained through the IAP work will give me the skills to be able to offer guidance and support to others in our sector.

In terms of contribution, I have two hopes. First, I really hope to make an impact on how our sector views the role of a patient in the care delivery process. Our Integrated Chronic Care model focuses on the patient's future goals, aspirations and desires so that these goals guide the care that the patient receives.

There's a great article in the most recent issue of Health Affairs, "Living Life My Way" by Amy Berman. [To read, click here](#). The article is written from the patient's perspective and she illustrates, in her journey with terminal breast cancer, the importance of making sure that the healthcare team really understands the patient's goals and their rights to make informed decisions. As she says in her article, "It's outrageous that we're more likely to receive full disclosure when buying a house than when seeking medical care." The heart of our Integrative Chronic Care model, and now - building on that model- our Community-based Transitions Model, is that clinicians have the skills to establish trusting relationships to engage and connect with patients. Starting with the first interaction, clinicians utilize these skills to build trust and identify the patient's goals and put these patient specific goals at the center of care.

My second goal is to highlight home health's value in the care transitions process. Current care transitions models being implemented throughout the country today highlight care areas of emphasis such as a thorough medication reconciliation and management process, teaching patients about symptoms and

actions for exacerbations, and ensuring a timely physician visit post hospital discharge. These processes have long been recognized as requisite competencies in home health care delivery. I hope to demonstrate that we are the ideal transitions coach and that we can realize impressive outcomes that meet the triple aim of reform - maybe even more impressive than what has been realized by other models, as we have some unique advantages those models don't have, such as the ability to see a patient over a longer period of time. A great example would be a patient with multiple chronic diseases who also suffers with depression. We know this patient is less likely to take an active role in self-management of their chronic disease and more likely to be non-adherent. If we care for them at home beyond a few weeks, we have the ability to monitor their response to treatment and seek additional interventions as time goes on, resulting in better outcomes. The ability to care for patients over the long term will help us realize better outcomes and recognize the home as a central point of care.

### **Tell me about your model of home-based healthcare delivery.**

The objectives of my community-based transition project are to expand the role of home health professionals in providing transition of care services in the hospital and home settings, and to restructure in-home care processes to better support transitioning patients. A systematic approach, when considering home health patients discharged from the hospital with a high risk of readmission, is a logical fit for home health practice redesign, as coaches are taking on new roles as healthcare resources are dwindling. Utilizing existing home health providers (who provide many coaching functions already within the current healthcare structure) may negate the need to add another provider layer and associated cost to the patient's care team.

My work will be to partner with other home health agencies that have an interest in hardwiring our

Community Based Transition Model. They will work with me to implement the model and to track and pool our data so that we can demonstrate, as a sector, what we can do. The model includes a redefined role for an in-hospital health coach who is a home health professional. At the hospital, the hospital staff identifies patients who are at high risk for re-hospitalization and who are appropriate for home care. Once the patient selects our agency, our health coach – a home health professional (typically a registered nurse) begins the transition process with initial patient education on the signs and symptoms of exacerbation and the identification of their long-term goals. Our coach also identifies the patient concerns related to going home. The key is to engage the patient at the hospital before discharge.

We have redefined the first visit in the home. During the first visit, the focus is on the patient's goals coupled with priority areas for effective and safe transitions of care, as opposed to completing OASIS. The first visit takes place within 24 to 48 hours of the patient's discharge. This is an extremely critical time to focus on patients with issues that may result in their going back to the hospital. We make sure that the patient is safe in the home. For example, we might focus on the medication reconciliation process and high-risk medications, making sure that the patient has a reliable method of medication administration and that the patient understands the actions and side effects to watch for related to their high-risk medications. We reinforce the signs and symptoms of exacerbation, and the actions the patient needs to take should these signs appear. Then, after the initial visit, the clinician sees the patient the very next day to complete the OASIS assessment. This timeline allows us to see the patient in a more timely manner and meets the patients needs when they have them. We want to keep the patient from that "revolving door" process of going back to the hospital.

Our model also includes a high risk protocol with interventions such as ensuring clinicians present

these patients weekly at case conferences for the first 30 days of care, use of health literacy expert approved educational materials, new critical risk assessments such as identifying the risk of patient medication error, and the use of telehealth for high risk patients.

### **What type of existing clinical protocols do you rely on for your program? Did you develop new protocols of your own?**

We started with Wagner's Chronic Care Model, and tried to derive the best from the best and combine these best practices in a comprehensive way that best supports the patient in the community. For example, we incorporated key components of transitions models that are being replicated now across the country, including Dr. Mary Naylor's model and Dr. Eric Coleman's model of care transitions. We also incorporated best practices from palliative care models because we really want to focus on supporting all care transitions.

The other important work I relied heavily on when I developed the protocol is the Institute for Healthcare Improvement's (IHI) best practices on care transitions from hospital to home healthcare titled, "How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations." [To access the guide, please click here.](#) I found the IHI tool to be one of the most valuable resources for an overview of what works best in the care transitions process.

### **Tell me about a typical beneficiary in your program.**

Sutter Care at Home, which is implementing this protocol first, will target patients with heart failure, chronic obstructive pulmonary disease, and pneumonia. Patients with these diagnoses will be evaluated for risk of readmission based on the use of the IHI re-hospitalization risk tool. Our hospital partner for this project will administer the tool as close to hospital admission as possible, giving us time to work with the patient as a health coach. The tool evaluates whether the patient

has been hospitalized in the past year more than twice and whether the patient can teach back the signs and symptoms of exacerbation or whether they have little confidence in their ability to self-manage. The tool works well because it is not disease specific and it can be used for various types of patient populations. In addition to the IHI tool, our electronic health records (EHRs) enable us to “tag” these high risk patients in the system so we can follow their progress.

As far as the number of patients in the program, it is hard to predict how many overall will be included because I’m still gathering data from the three other agencies regarding their daily census and the percent of their census that is Medicare and high risk for re-hospitalization. We project that we’ll work with about 50 patients a month, but we haven’t completed those projections yet.

**Are you working with any partner organizations on your program? How did you decide which partners to work with?**

Sutter Care at Home will function as the pilot test site but we are also working with home health organizations in Minnesota, Rhode Island, and Washington state. We selected these partners based on their participation in our ICCM training program that provides clinicians with a solid foundation in chronic care management and self-support. We invited agencies that have trained their staff in the ICCM course in the past to participate and asked if they would be interested in testing the protocol. Two of these partners are free-standing agencies, which I’m excited about because it will be interesting to see how our model works when the providers are not part of a healthcare or hospital system. I’m hoping the free-standing agencies will be able to approach hospitals in their areas to suggest partnerships to achieve aligned goals (both their goals and the hospital’s goals), thus improving the patient’s transition experience and health outcomes in their community. One of my project partners is a system agency. I also have a personal

care agency that is interested in participating in the educational aspects of this program.

**How will you know when your model has succeeded?**

The whole goal of this program is not only to develop a model that’s effective but also to develop a model that can be replicated and sustained. Part of the project involves helping our partner agencies to hardwire the model in place. My first step in the project was to develop a readiness assessment – a very detailed assessment that each agency completed to identify areas where they needed to make process improvements (such as work flow issues). I will then provide training for the staff on the key coaching and transition competencies, including “Tip of the Month” sheets to reemphasize key model principles with the staff as the implementation takes place. Staff will also participate in quarterly webinars to problem solve, and they will receive all the materials we’re developing.

These materials will, in turn, help the agencies to incorporate new tools in daily practice such as one to identify patients at risk for medication non-adherence, tools that meet health literacy standards, and a new SBAR tool for patients and families. I’m hoping to assist – not just with putting the protocol in place, but to ensure that the protocol continues to be replicated in a standardized way. Toward that aim, I developed a measure regarding model integrity. Each team will complete a monthly worksheet that includes a model integrity score, a metric that measures how well the staff is complying with each component of the protocol. This will help me identify issues that the staff may need help with and will allow me to analyze which components of the protocol are the easiest or most difficult to replicate and which components have the greatest impact.

My hope is that my partner agencies will find that they receive substantial support when implementing the protocol. I want to be viewed as a partner, willing to assist them with the

implementation process and with achieving their agency and patient-specific goals.

If we achieve the outcomes we are striving for, I plan to write a paper describing the process, protocol, and outcomes to submit for publication so that others can learn from this work and possibly replicate the model further. Work at the planned Sutter Center for Excellence in Integrated Chronic Care will enable us to continue refining this model.

**What about other measures of success from CMS’s perspective, such as an impact on the Medicare home health benefit?**

I do have to evaluate my model in relation to CMMI’s three-part aim of better health care, better health and reduced costs through improvement and I selected metrics related to each of those aims. One metric that the program will track is 30 day readmissions on a monthly basis to see if we’re moving toward reduction. We’re also asking patients to report, at the start of care and at home health discharge, their personal assessment of health. I will look at the percentage of patients who had an improvement in their personal assessment of health over time. I will also track HCAHPS scores, especially Question 18, “Did the home health staff really listen to me?” to see if those scores improve over time.

With regard to a policy impact, I’m not sure the project is specifically aimed at affecting policy. I hope the project provides evidence and information for what home health can achieve so that we are actively pursued to participate in new payment models such as bundled payments and Accountable Care Organizations (ACOs). I would like us to be considered an important team member for Patient-Centered Medical Home models. I know that Julie Lewis’s project (another Innovation Advisor) will be evaluating care over the long term and hope that her project will also lend evidence for what home health can do in the non-acute community care space.

**What message would you share with other potential innovators in the home care community?**

The project has inspired more innovation across our system. One example is that in evaluating our curriculum, we realized there is very little guidance in the literature about how to improve physician-to-physician communication that is so necessary during transitions. We now have a work group addressing this issue and will hopefully fill that gap. I have the opportunity to speak at the conferences about the Innovation Advisors program, and so I hope to inspire others in our field to step out of their comfort zone and try new ideas that improve patient care. The exciting part is getting to know more innovative individuals in ours and other fields and realizing the power of sharing. I really believe this Innovation Advisors Program will generate better ideas and being a part of that is more exciting than I can convey. I encourage others in the home care sector to apply for the next cohort of the program because this will ultimately lead to better healthcare as we know it, and this is a way to contribute in a very meaningful way.

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*The Alliance would like to thank Ms. Suter for her time and insight. If you would like to learn more about the Innovation Advisors Program, please visit CMMI’s site [here](#). To suggest an Innovation Advisor for our interview series, please email your suggestion to C. Grace Whiting, Special Assistant, at [gwhiting@ahhqi.org](mailto:gwhiting@ahhqi.org).*