Reducing Preventable Hospital Readmissions and Transitions of Care Journey

Grinnell Regional Medical Center

Inpatients
• 23 Medical/Surgical beds
• 5 ICU beds
• 3 Stepdown beds
• 7 OB beds
Objectives

- Describe the 2012 Readmission Prevention Plan and share results
- Discuss 2013 strategies and implementation of the Transition Program
- Discuss continued improvement opportunities identified for consideration

2012 Prevention Plan

- Reviewed current literature and other readmission reduction programs.
- Worked with healthcare team and our UR committee to develop action plan.
- Developed a screening tool for identification of patients that are high risk for readmission.
- Comprehensive assessments for high risk patients developed.
Comprehensive Assessment

- Social/living situation
- Support system
- Mobility
- ADL/IADL’s
- Medication
- Transportation
- Financial

Discharge Plan (DCP):
2012 Prevention Plan

- Daily multidisciplinary plan of care rounds
  - Pharmacy
  - Social worker
  - Dietician
  - Physical Therapy
  - Home Care
- Follow-up appointment with PCP scheduled within 7-10 days.

2012 Prevention Plan

- Improved hand-off communications to PCP offices, Home Health agencies and Nursing Facilities.
- Implemented follow-up phone calls to patients and/or caregiver within 1-3 business days of discharge for high risk patients discharging home.
- In depth review of readmissions as they occur.
- Increased focus on readmissions at UR committee.
  ➔ More data shared-actionable items identified.
Results
2013 Strategies

- Great Administrative support for this mission.
- Restructured Central Intake/Care Coordination – joined as one team under one supervisor.
- Retreat to brainstorm ideas for our future and increase team cohesiveness completed in August 2012.

2013 Strategies

- Ideas
  - Technology to improve efficiency
    - Dual computer screens – can have the EMR and other programs up at same time.
    - UR log spreadsheet in shared folder.
  - Standardized processes
    - One Call Admission process – physician calls Care Coordination team for bed, we assess for correct status, call house supervisor for a bed.
2013 Strategies

- New position created through absorbing a former Patient Educator position into our team with a focus more on the Health Coach model.

- New position - Transition Coach.
Transitions Program – Getting Started

• Reviewed many readmission reduction programs
  – BOOST, Project Red, STARR etc…
• Reviewed our readmission Medicare claims data from Telligen – trends identified
  ➢ Common diagnosis
  ➢ Age group
  ➢ Discharge status
  ➢ Zip Code

Transitions Program – Getting Started

• Diagnosis – pneumonia, CHF, septicemia, GI hemorrhage, COPD – start with some of these diagnosis
• Age group – 81-86 y/o – changed high risk screening tool to reflect this
• Discharge status – nursing facilities – share trends at nursing facility quarterly meetings, encourage Interact II or similar tool
• Zip Code
Transitions Program

• Modeled after Project RED
  ➢ Promotes patient-centered, standardized approach to discharge planning
  ➢ Patient education, discharge planning, communication hand-offs and post-discharge follow-up services for 30 days

• Transition Coach

• Acute admissions with primary diagnosis at discharge of CHF, Pneumonia, acute MI or COPD

Transitions Program

• Standardized admission and discharge order sets for each diagnosis.

• Transition Team – Transition coach, care coordinator, pharmacy, social services, dietician
  ➢ Needs assessment
  ➢ Identify 1-3 patient specific focus areas
  ➢ Patient specific action plan
  ➢ Patient education using teach back method
Transitions Program

• Communication with team/providers
  ➢ Plan of care rounds
  ➢ White boards in patient rooms
  ➢ Discharge communication checklist on chart
  ➢ Chart notes
  ➢ Verbal

Transitions Program

• Discharge
  ➢ Standardized order sets - finalizing
  ➢ Medication reconciliation
  ➢ Physician F/U scheduled in 3 business days of discharge
  ➢ Education reviewed with patient and caregiver
  ➢ Discharge resources notified
  ➢ Communication handoffs completed – fax info to PCP office
Transitions Program

• Post-discharge follow-up services
  ➢ Complimentary home visit within 1-3 business days after discharge
  ➢ Weekly phone calls or more as needed for 30 days
  ➢ Communication with Home Health agency or Nursing Facility weekly for 30 days also
  ➢ Continued communication with PCP through the 30 days

Transition Program Stats May & June

• Patient Numbers: 20
• Readmissions: 2
• Discharge to Nursing Facility: 9
• Discharge to Home with HHC: 1
• Discharge to Home: 9
• Also tracking: Visit or call within 3 business days, Weekly calls completed, medicine, transportation & f/u visit issues.
Transitions Program – ongoing

• Continue building relationships and resources lists with community partners.
• Participate in community improvement groups.
• Monitor best practices.

Grinnell Regional Medical Center Transitions Program
Your Guide for Going Home

Returning home after a hospital stay can be a major transition. Grinnell Regional Medical Center (GRMC) is committed to partnering with you, your family and healthcare providers, to be sure your transition home is safe, smooth and successful for you. Our Transitions Program provides extra support for you and your family during this important time.

The GRMC Transitions Program is for patients who have experienced pneumonia, heart failure, chronic obstructive lung disease (COPD), or a recent heart attack. Through this program, you and your family will receive:

• Personalized visits during your hospital stay with the Transitions Team. The Transitions Team includes a Transition Coach Nurse, Care Coordinator Nurse, and representatives from the follow departments: Pharmacy, Social Services, Nutrition and Respiratory Therapy.
• Transitions notebook to take home with you.
• Education and teaching material about your disease
• Personalized action plan created with you, your family, and healthcare team to take home.
• Arrangements for a follow-up visit with your physician’s office to ensure progress toward your recovery.
• Free home visit with the Transition Coach Nurse who will assist your transition from hospital to home.
• Weekly follow-up phone calls from the Transition Team for 30 days to provide opportunities for review of your action plan, medications and any questions or concerns you or your family are experiencing.

The GRMC healthcare family looks forward to partnering with you, your family and healthcare providers. We appreciate the opportunity to assist with identifying and providing you and your family with the tools and resources to be successful at home.
Patient Specific Action Plan for ________________________________

Key focus areas:
1) __________________________________________________________
2) __________________________________________________________
3) __________________________________________________________

Diet: _________________________________________________________

Activity: ____________________________

Next Physician Follow-up appointment: ___________________________

Outstanding tests: ____________________________

Daily Actions (know your baseline):
1) Review action plan questions. What Zone are you in? Green, Yellow, Red?

FACES: F- Fatigue, A- Activity, C- Cough, E- Edema, S- Shortness of breath
2) Take medications as doctor ordered
3) ____________________________
4) ____________________________
Continued Improvement Opportunities

- Increase patient education materials/library.
- Develop a weekend discharge checklists for staff.
- Review our skilled/swing bed program and processes.
- Review comprehensive assessments to add reviews for functional status, treatment adherence, and mental status for high risk patients.

Resources

Project Red
http://www.bu.edu/fammed/projectred/

Case Management Society of America
http://www.cmsa.org/

Agency for Healthcare Research and Quality
http://www.ahrq.gov/

Institute for Healthcare Improvement – STAAR project
http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx

National Transitions of Care Coalition (NTOCC)
http://www.ntocc.org/

Hospital to Home
http://h2hquality.org/

Mercy Affiliates meetings