IMPACT

Impacting Patients Across Care Transitions

Partnering with Lifeguard Ambulance

St. Vincent's HEALTH SYSTEM

ASCENSION HEALTH

Goal

The key goal for reducing readmissions for CHF, AMI, Pneumonia, THA/TKA, and COPD is effective person-centered interventions achieved by eliminating the silos across care transitions, appropriate use of available resources, and new models of care to manage patient populations most vulnerable for acute care readmissions, chronic disease management, and inappropriate use of the emergency department.

Program Development

- Completion of Gap Analysis
  - Compare Preventing Readmissions Bundle with current processes to identify areas of improvement.
- Review of Data
  - Review 12 months of readmission data to determine:
    - Common causes for readmission
    - Average day of readmission within 30 days
    - Post-Acute setting the patient was discharged to
    - Post-acute care setting for readmission (home health, skilled nursing facility, home etc.)
- Multi-disciplinary team
  - Nurse Practitioners, nurses, pharmacists, case managers, chaplains, physicians, social workers, outcomes managers, information technology (IT), emergency medical technicians (EMTs).

Preventing Readmissions Bundle

- Use of High Risk for Readmission Tool
- Improving the Discharge Planning Process and immediate Post-discharge Care Coordination Process
- Eliminating Barriers to Primary Care Services for Patients
- Implementing Transitional Care Services
- Collaborating with SNFs, HH agencies and family members on optimizing care protocols
- Utilizing Palliative Care Services

High Risk for Readmissions Tool

- Selected LACE tool
  - Length of Stay
  - Acute Admission versus Observation
  - Co-Morbidities
  - ED Visits in last six months
- LACE tool completed as early in the admission as possible
- Template built in EMR
- Built alerts and daily reports for team members
  - Emails sent automatically at completion of LACE tool
  - Daily productivity report
  - Daily Discharge report

Improving the Discharge Planning and immediate Post-discharge Care Coordination Process

- Education
  - Booklets created specific to diagnosis
  - Education provided by multiple disciplines
- Medication Reconciliation throughout the care transitions
- Built “Trigger” in Midas to assist in identification of most appropriate post-acute care setting
- Implemented gap assessment tool into Midas to identify needs post-discharge
- Assist with acquiring or providing resources to meet self-care needs in the home (education, scales, BP cuff, financial assistance)

Eliminating Barriers to Primary Care Services for Patients

- Dial-A-Nurse schedules PCP appointments (48 to 72 hours)
- Follow-up to determine if PCP appointment occurred
- Communication hand-off to providers and post-acute care providers/facilities
  - Provide PCP patient information before scheduled appointment
  - Letter faxed to PCP when patient enrolls in IMPACT
  - Updates provided to PCP throughout 30 days after patient phone calls and patient visits

Implementing Transitional Care Services

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Care Transition Partners

- Care Transition Partner (CTP) Hospital Visit
  - Educates patient while in the hospital
  - Enrolls in IMPACT
- CTP Post-Discharge Visits
  - Visit in the home within 48 to 72 hours post-discharge
  - Educates patients and family members
  - Completes medication reconciliation
  - Develops 30 Day Care Plan
    - Physical Assessment
    - Determines frequency of calls and visits to include:
      - Care Transition Partner-Nurse Practitioner
      - Social Worker
      - EMT (Partnered with Lifeguard Ambulance Service)

Care Transition Partners

- Care Transition Partner-Social Worker
  - Psychosocial Support
  - Socioeconomic assessment and identification of resources
    - Transportation
    - Medication Assistance
    - Community Resources
  - Substance Abuse
  - Depression Screening
- Care Transition Nurse Tele-Management Program
  - Created to connect with those patients who do not wish to have home visits or who may not score out as high risk for readmission but would benefit from some type of management
  - Focus
    - Chronic Disease Management
    - Readmissions
    - ED Utilization
    - Navigation

Care Transition Partners

- Nursing Homes, Skilled Nursing, Inpatient Rehab
  - Visits patients within 24 to 48 hours of discharge
    - Ensure smooth transitions
    - Follows patient for 30 days post-discharge
    - Works in collaboration with the nursing staff, family, and medical director
  - Works with staff to develop protocols

Care Transition Partner

- Care Transition Pharmacist
  - Provide focused education for targeted population
  - Work to identify and improve best practice for a more comprehensive and accurate medication reconciliation process
  - Works with physician to identify alternatives in medication
  - Oversee pharmacy tech model of care

- Care Transition Pharmacy Tech
  - Complete medication reconciliation process for targeted population to ensure comprehensive and accurate list of medications
  - Coordinate delivery of post-discharge medications to the bedside

Collaborations

- Creation of collaboration with post-acute care providers
  - Home Health
  - Skilled Nursing
  - Inpatient Rehab
  - Nursing Homes
  - Assisted Living
  - Long Term Acute Care
  - Community Agencies
- Expectations
  - Monthly submission and review of readmission data for preferred partners to identify opportunities for improvement and trends
  - Development of mechanisms for better communication across the care continuum
  - Alignment of resources with all post-acute care providers and payers
  - Utilization of identical education materials to reduce confusion for patient and family members

Early Learnings and Challenges

- Difficulty in identification of Patients with CHF, AMI, Pneumonia, and COPD
- Challenge to schedule appointments with PCP within 48 to 72 hours post-discharge
- Lack of alignment of post-acute care providers
- Access to patient information across care transitions
  - No interface, lack of timely access to patient information by all providers of care
- Lack of resources/Competing for resources
- Patient and family engagement

Keys to Success

- Measure, Measure, Measure
- Continuous evaluation of data
  - Deep dives into readmissions by individual patients
  - Review of measures to determine what is working
- Routine meetings with team (weekly huddles and monthly results meetings)
- Multi-disciplinary team approach
- Inclusion of community partners
- Willingness to change (often)

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