Presented in collaboration with:

Georgetown Hospital System
NHC Healthcare
Objectives:

• Understand the importance of care transitions as it relates to health care and population health.
• Understand the importance of collaboration, communication, and engagement throughout the transition process.
• Identify key process changes and goals in the acute care setting to integrate patient and support person engagement, including the provision of appropriate post-acute services.
• Understand the skilled nursing facility role in care transitions.
Waccamaw Regional Care Transition Program
Quarterly Readmissions

Source: This material was prepared by CFMC, the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. February 28, 2014 report date.
FY2014 SMART Goal(s):
Reduce 30 day all cause readmissions to 5.9% in FY2014

Drivers & Measures:

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Initiatives</th>
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<tr>
<td>IT Systems Integration</td>
<td>Improve alerts/decision support within EHR</td>
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<td>Improve physician documentation (alerts/prompts for key documentation)</td>
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<td>Standardized use of order sets</td>
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<td>Teamwork / Communication</td>
<td>Accountable Care Team Structure</td>
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<td>Standardized Communication &amp; Handoffs (Standardized Interdisciplinary Bedside</td>
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<td>Rounding (SIBR) / Safety Huddles / Discharge Huddles/post-acute handoffs)</td>
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<td>Appropriate resource</td>
<td>Standardized care pathways for key diagnoses (COPD, PN, CHF, Syncope, Sickle Cell)</td>
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GHS Readmissions

KEY NOTES:
2014 FYTD performance continues to be lower than prior FY. WCH is performing better than national average. GMH continues to be worse than national average for FYTD but is showing a downward trend in most recent 3 months.
Why Focus on Transitional Care?

- **Triple Aim Outcomes**
  - Improving Patient Experience
  - Improving Population/Community Health
  - Managing Efficiencies of Care

- **Serving a Population with:**
  - Chronic Disease Prevalence
  - Barriers to Services:
    - Health Literacy Concerns
    - Financial Constraints

- **Healthcare Reform**
  - Appropriate Utilization of Services
  - Readmission Penalties
Building Blocks of Care Transitions

Transitional Care
- Case Management
- Community Care Network
- Community Health
- Post Acute Transitional Care
- Discharge Pharmacy

Extended Care Provider Collaborative
- Human Services Collaborative
- Hospice Joint Venture
- Home Health Joint Venture

- Building Relationships
- Improving Communication
- Engaging Caregiver Support

Bundled Payment Care Initiative
- Non-homebound Pilot Program
Strategic Transformation

• **Activation**
  • Education along the care continuum
    • All points of patient contact
    • Community Outreach
  • Community Presence
    • Joint Ventures
    • Partnerships – formal and informal

• **Access**
  • Outpatient Services
  • Community Care Network
  • Physician Services
  • Free Clinic
  • Federally Qualified Health Centers

• **Accountability**
  • Care Pathways
  • Preventive Care Screenings and Services
  • Decrease inappropriate E.D. visits
  • Increase Primary Care Physician visits
Community Outreach & Care Transitions:
Community Health Needs Assessment

- Chronic Disease Hot Spots
- Risk Factors
- Integration of Health Promotion in the Community
SOCIAL
(suspension lines)

PUBLIC BENEFIT ACCESS
TRANSPORTATION
BEHAVIORAL CHANGE
HEALTH EDUCATION

BRIDGING THE GAP

MEDICAL HOME
MEDICATIONS
SPECIALTY CARE AND DIAGNOSTIC TESTING
DENTAL/VISION/BEHAVIORAL HEALTH

HEALTH (pillars)
Shifting Focus to the “Health” in “Healthcare”

Healthy Outcomes Initiative (HOP)
- Chronic Disease Care Pathways.
- Diabetes, COPD, CHF, Asthma, Hypertension
- Coordination and continuity of care.

Engaging Community & Industry
- Better Choices, Better Health Program – Engaging Patients in Self Care Management
- Building and Strengthening relationships with the community and industry.

Engaging the Faith Community
- Health Fairs and Screenings
- Health Education Programs
- Cholesterol, Diabetes, B/P, and BMI screenings, Speakers, First Aid, CPR, and Smoking Cessation Classes, Flu Shots
Engaging the Acute Care Team in a Successful Discharge Plan
Accountable Care Units

• A Unit-based Team Approach
• Interdisciplinary Bedside Rounds
• Performance and Outcome Metrics – unit level
• Physician and Clinical Nurse Leadership
• Case Management Navigation
• Coming soon….
Identifying Potential Discharge Barriers: Discharge Huddles
Discharge Huddles

Goals:

- Optimize Patient Experience and Outcomes
- Increase HCAHPS Scores
- Opportunity to identify and fill in gaps in discharge plan
- Assure patient is ready for discharge
- Decrease Readmission Rates
Afternoon Discharge Huddles

Purpose

• Identify & Review Next Day Discharges
• Increase Multidisciplinary Communication
• Early identification of potential barriers
• Smooth Transition for patient, support persons, and post-acute providers
Morning Discharge Huddle

Day of discharge is the last chance to identify any unresolved problems before a patient is sent home.

– Nursing to assure patient is back to baseline.
– Discharge planning is completed by Case Management.
– TCC has assessed high risk for readmission patients.
– Respiratory Therapy’s input on patient’s needs.
– Physical Therapy’s recommendations addressed.
– Pharmacist has addressed high risk medications and to assure discharge medications are reviewed.
– Dietary needs are reviewed by dietician.
Post-acute Outreach
Centralized Post Discharge Phone Calls

SRC-D/C Call Pilot
Follow Up Requests
(June 2013-June 2014)

- Prescription/Med: 523
- F/U Appt: 204
- Diet: 58
- D/C Instructions: 62
- Home Health: 66
- Change of Care: 20
- Recognition: 66

85% success/contact rate
Post-discharge Appointment Scheduling: After Office Hours and Weekends

• Opportunity – gap in appointments scheduled for patients discharged when community offices are closed.

• Rapid Cycle Improvement:
  – March 2014 – pilot SRC process
  – April 2014 - pilot unit-based process
  – July 2014 – spread process to all units
Non-Homebound Pilot Program
- A Non-traditional approach to healthcare at home

• Who?
  – High Risk for Re-admission
  – Chronic Disease Condition (COPD)
  – Does not qualify for traditional homecare services or sub-acute services

• How?
  – Transitional Care Coordinator identifies qualifying patient
  – Communication with attending physician
  – Patient agrees/consents to participate

• Why is this important?
  – Enhance education & follow-up
  – Safety Net service – 30 days post-acute discharge
Non-Homebound Program
A Success Story

• 90% Successfully Transitioned to Home

• Expanding program to include patients needing focus on Medication Reconciliation.
Georgetown Hospital System

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Culture Change

• With in the Nursing Center
• With our Physicians
• With the Hospital
National HealthCare, Garden City

- 2012 30 Day Re-Admission Data
- Waccamaw Hospital
- 234 Admissions (Part A)
- 51 Re-Admissions with in 30 days
- **21.7%**
National HealthCare, Garden City

• 2013  30 Day Re-Admission Data

• Waccamaw Hospital
• 221 Admissions (Part A)
• 27 Re-Admissions with in 30 days
• 12%
National HealthCare, Garden City

• 2014 30 Day Re-Admission Data
  – 1st Quarter Data

• Waccamaw Hospital
• 54 Admissions (Part A)
• 6 Re-Admissions with in 30 days
• 11%
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Culture Change with in the Nursing Center

• Interact II tools

• Stop and Watch Tool
  – CNAs
  – This is an early warning tool that will help our CNAs identify potential problems to report to our Nurses

• SBAR Tool
  – Nurses
  – This is a communication tool that our nurses use when calling a physician
  – This tool forces the nurse to identify the 1. Situation
    2. patient background information
    3. current assessment or appearance of the patient
    4. what request are we making to the physician

Without this information the physician may be more inclined to send the patient to the hospital
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Culture Change with in the Nursing Center

• Consistent Assignments

• Ongoing Education and Reinforcement

• Utilizing all partners in the facility
  • Therapy, Housekeeping, Dietary, etc.

• Adding Re-Admissions to our weekly interdisciplinary meetings
National HealthCare, Garden City
Culture Change with our Physicians

• Meeting with all of our Physician to include them in our re-admission goals

• What can we treat in house rather than sending a resident to the hospital?

• Directing their patients to us rather than home with no services

• Adding a full-time Nurse Practitioner to our team
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Culture Change with the Hospital

• Becoming an active member of the Care Transitions Program

• Developing better relationships with open lines of communication

• Monthly meeting to discuss recent re-admissions
National HealthCare, Garden City
Culture Change with the Hospital

• Developing better relationships with open lines of communication

"The readmission review with NHC Garden City is a relationship building opportunity that focuses on identifying gaps in care focusing on interventions that will improve patient outcomes. Because the relationship is built on patient outcomes and not fault finding with the facility or hospital we are able to honestly discuss opportunities to change processes, improve education, refer for further review, and realize that some hospitalizations are unavoidable".
• Developing better relationships with open lines of communication

I would also state that these reviews have resulted in specific education for our physicians, nurses, therapists, and case managers. This has also led to our development of a discharge huddle which provides us the opportunity for a multi-disciplinary team "stop the line" review of readiness for discharge. I think as a direct result of our relationship and transparency we have engaged our staff to understand that discharge to a skilled nursing facility should go beyond "bed availability" and include "readiness for discharge".
National HealthCare, Garden City

Where do we go from here?
National HealthCare, Garden City

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