Improving Care Transitions: The Waccamaw Community Story

Family Caring for Family

GEORGETOWN HOSPITAL SYSTEM
Objectives:

• To understand the importance of identifying community resources, mapping resources, identifying gaps, and building bridges to support social and economic needs while promoting behavioral changes.

• To understand the components of a transitional care program; building a patient-centered continuum of services with an emphasis on communication, activation, and engagement.
Why Care Transitions is important to us…

• Supporting the Triple Aim:
  • Improving Patient Experience & Outcomes
  • Improving Care Efficiencies
  • Improving the Health of our Population

• Optimizing the Care Continuum
  • Providing the Right Care at the Right place at the Right time

• Also….
  • Avoiding Payment Penalties
Building Community Partnerships

• Identifying partners
  – Across the continuum
  – All participants are welcome

• Transparency & Trust
  – Sharing data, processes, and outcomes
  – Opening lines of communication

• Building Relationships
  – Currently sharing experiences and reviewing cases
Mission Statement

- To form relationships with community organizations, other stakeholders including consumers, and healthcare providers to achieve a set of common goals.
- Goals include reducing unnecessary hospital readmissions, improving information transfer between healthcare providers and patients, developing consistent workflow processes, and increasing patient activation and satisfaction.
Shared Vision: Providing Care Across the Continuum

- Community Population Health
- Acute Care Services
- Patient/Support Person
- Care Transition Services
- Post-Acute Care Services
Presented in collaboration with:

Georgetown Hospital System
Georgetown Community Care Network
Amedisys Home Health
NHC Healthcare
Acute Care Transitions
~Moving Beyond the Walls of the Hospital~

Family Caring for Family
Transitional Care Coordinator Role
Common Themes

- Focus on Education
- Transparency
- Sharing best practices
- Sharing Outcome data
- Thinking “Out Side the Box”
- Open Communication
Why Transitional Care

• Hospital prospective
  - Readmission Penalties
  - HCAHPS scores
  - Improved Patient Outcomes
• Benefits to Patient
  - Active participate in their care management
  - Improved Quality of Life
Our Journey…

- Informatics System
- Inpatient Nursing Units
- Transitional Care Coordinator
- Case Management Discharge Planning
- Post Discharge Phone Calls
- Volunteer Health Coaches
- Extended Care Providers
- Community Agencies
- Root Cause Analysis With CCME
Nursing Units
- Improvements in Education Process
- Teach Back
- Medication Reconciliation
- Scheduling D/C Appointments

Transitional Care Coordinator (TCC)
- Educate High Risk Dx
- Communicates with RN
- Assists CM with D/C Needs
- Post Discharge Phone Calls

Waccamaw Area Agency on Aging. Neighbor to Neighbor
- Health Coach Program
- Care Giver Education Program
- Care Giver Support Group
- N 2N Volunteer Transportation

Extended Care Providers (ECP)
- Monthly meeting with ECP
- Notification from SNF and HHA to TCC when pt D/C from services
- Communicating Pt needs to ECP
Where We Are Now

- TCC now see all High Risk dx regardless of age or payer source
- Daily Discharge Huddles
- Lean Six Sigma Teams
  - Post Discharge Appointment scheduling
  - Communication with SNF and ED
  - Preventing COPD readmissions
- Education Improvement Task Force
- Readmissions reviews
  - Weekly Meetings with HHA
  - Monthly Meetings with SNF
Improving Care Transitions and Decreasing Readmissions

Team Approach

Patient → Hospital

PCP

Community

Extended Care Providers
Post-Acute Connection
Skilled Nursing Facility

Family Caring for Family
National HealthCare, Garden City
Our role in reducing Hospital Re-Admissions

Culture Change:
• With in the Nursing Facility
• With our Physicians
• With the Hospital
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
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
National HealthCare, Garden City
Culture Change with the Hospital

• Developing better relationships with open lines of communication

• Becoming an active member of the Care Transitions Program

• Monthly meeting to discuss recent re-admissions
Home Health Connections

Family Caring for Family
The Process
Acute Care to Home Health

• Making Care Transitions Work Between Acute Care and Home Health

Hospital: The Care Team as well as Patient/Family
Care Transition Coordinator
Care Center/Chronic Care Coordinator/Primary Care Physician
Home Health Team

• The continuation of all the good work that has been done in the hospital.
• Looking toward the future Health Care at home,
  its not your “old” Home Health Care.
From Marketing To Operations

- Change of Focus for our hospital Care Transition Coordinator

CTC had multiple facilities

CTC embedded in Waccamawaw Hospital
Relationship

• More time to work daily to find the right solution for each patient
• Focused on Quality rather than Quantity
Working together to Climb the mountain of ever changing healthcare

• No longer working as individuals, but focusing on the team concept at all times will make the difference in outcomes!
The Big Piece of the Puzzle: Being Real with One Another

• The missing piece sometimes just is being real and being honest with one another
• Communicate, Communicate, Communicate!
Community Resources

Family Caring for Family

GEORGETOWN HOSPITAL SYSTEM
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Care Coordinator  
Georgetown Hospital System  
Georgetown Community Care Network  
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Community Asset Map

Service Gap
- Private Dental Practices
- HPGC
- Helping Hands
- St. James Santee Health Center
- Smith Free Clinic
- MUSC Emergency Extraction
- etc...

Some Capacity
- Welvista
- St. James Santee Health Center
- Local Pharmacies
- Smith Free Clinic
- $4 Formularies
- etc...

Capacity
- Neighbor-to-Neighbor
- Medicaid Van
- St. James Santee Health Center
- Friendship Place
- Careteam
- Coastal RTA
- Healthy learners
- etc...

Dental
- Urgent/Emergency Care
  - Free standing urgent care centers
  - Hospital Emergency Departments

Specialty & Diagnostic Services
- Behavioral Health
  - Waccamaw Center for Mental Health
  - Coastal Summoning Counseling Center
  - Smith Free Clinic
  - St. James Santee-Cherokee Site
  - Inappropriate ED
  - Lighthouse Care Center
  - Alcohol/Substance Abuse Commission
  - etc...

Outreach
- Media
- Senior Centers
- Community Centers
- Service providers...i.e. Salons/Barbers
- Faith Community

Human Services
- Helping Hands
- Neighbor to neighbor
- Healthy Learners
- Friendship Place
- Salvation Army
- Habitat for Humanity
- Housing Authority
- Area Agency on Aging
- etc...

Funding Supports
- Bunnelle Foundation
- United Way
- Waccamaw Community Foundation
- Duke Endowment
- Yawkey Foundation
- GHS Foundation

Primary Care Medical Homes
- St. James Santee Health Center
- Smith Free Clinic
- GHS Providers
- Private Providers
- Inappropriate ED
- Careteam
- etc...

Health Education Providers
- Diabetes Care (Andrews/Chapoo)
- Super Pastry
- GHS Community Health Education
- GHS Care Transitions
- Gail Guzko, R.Ph., Ph.D.
- St. James Santee Health Center
- Smith Free Clinic
- DBHIC
- Georgetown County Alcohol & Drug Abuse Commission
- etc...

Stage/Community Agencies
- DBHIC
- Veterans Administration
- Georgetown County Alcohol & Drug Abuse Commission
- Waccamaw Regional COG
- Waccamaw Center for Mental Health
- Georgetown County DDS
- Georgetown County First Steps
- etc...

Navigating Care Systems
- Care Coordination
- Linkage to Medical Homes
- Social Support Needs Assessment
- Assessing Social Determinants of Health
- Benefit Bank Screenings
- Planning of Interventions

Georgetown Community Care Network
Bridging the Gap

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lbonesteel@georgetownhospitalsystem.org
Pathways to Care Coordination
9,996 uninsured, ages 19 - 64 in Georgetown County
Income at 138% of poverty $16,755.00
Specialty care & Diagnostic Testing
Medications
Dental/Vision/Behavioral Health
Medical Home
Public Benefit Access
Transportation
Behavioral Change
Health Education
Community Health Resource Center
Hospital ER
Bridging the Gap
Health (pillars)
Summary & Conclusion…

Family Caring for Family
We didn’t look so good….

GMH = 0.73% penalty reduction instead of 0.77%

WCH = No change, still full 1% reduction
Burning Platform for Change
## Identifying our Post Acute Opportunities

### Readmission by Discharge Status

**Medicare Traditional Only; Excludes Rehab**  
**October 2011 - September 2012**

<table>
<thead>
<tr>
<th>Discharge Status</th>
<th>GHS</th>
<th>South Carolina Hospitals</th>
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<tbody>
<tr>
<td></td>
<td>Readmits</td>
<td>Volume</td>
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<tr>
<td>DISCHARGED TO HOME OR SELF CARE</td>
<td>385</td>
<td>3158</td>
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<tr>
<td>DISCHARGED TO HOME HEALTH ORG.</td>
<td>166</td>
<td>948</td>
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<tr>
<td>DISCHARGED/TRANSFERRED TO SNF</td>
<td>130</td>
<td>713</td>
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<tr>
<td>DISCHARGED/TRNSFRD TO ANOTHER REHAB FACILTY</td>
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<td>308</td>
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<tr>
<td>DISCHARGED/TRANSFERRED TO ICF</td>
<td>22</td>
<td>93</td>
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<tr>
<td>DISCHARGED TO HOSPICE-HOME</td>
<td>12</td>
<td>174</td>
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<tr>
<td>DSCHRGD/TRNSFRD TO A LTC HOSPITAL</td>
<td>6</td>
<td>36</td>
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<tr>
<td>DISCHARGED TO HOSPICE-MEDICAL FACILITY</td>
<td>3</td>
<td>102</td>
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<tr>
<td>DISCHARGED/TRANSFERRED TO PSYCH HOSP</td>
<td>3</td>
<td>27</td>
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So What Do We Do Next?

• Data Analysis
  – Drill down on where patients were going
  – Drill down on provider specifics

• Focused Reviews
  – Chart reviews
  – Patient interviews
  – Focus groups

• Identifying Partners
  – Common goals
  – Supportive leadership
  – Engagement of staff
Readmissions Reduction Program
FY2013 to FY2014 Change

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<thead>
<tr>
<th></th>
<th>FY2013</th>
<th>FY2014</th>
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<tbody>
<tr>
<td>Maximum Penalty</td>
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</tr>
<tr>
<td>No Penalty</td>
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WCH

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<thead>
<tr>
<th></th>
<th>FY2013</th>
<th>FY2014</th>
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<tbody>
<tr>
<td>Improved</td>
<td>0.9900</td>
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GMH

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<tr>
<th></th>
<th>FY2013</th>
<th>FY2014</th>
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<tbody>
<tr>
<td>Worse</td>
<td></td>
<td>0.9917</td>
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Penalties:
- Improved: 0.9900
- Worse: 0.9917
## CMS Readmission Penalties

<table>
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<tr>
<th>Hospital</th>
<th>FY 2013 Penalty</th>
<th>FY 2014 Penalty</th>
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</thead>
<tbody>
<tr>
<td>Georgetown Memorial Hospital</td>
<td>0.73%</td>
<td>0.83%</td>
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<tr>
<td>Waccamaw Community Hospital</td>
<td>1.00%</td>
<td>0.47%</td>
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“A significant reduction in readmissions at one of the hospitals gives assurance that your community is on the right track. Waccamaw hospital had the largest penalty reduction in the state and stands as evidence of the excellent job you have done in care transitions.”

*Tanishah Nellom, MSPH*  
Care Improvement Specialist  
The Carolinas Center for Medical Excellence
Questions??