Improving Care Transitions and Reducing Readmissions

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HAYSMED

- Hays Medical Center is a private, not-for-profit hospital formed by the 1991 merger of two religiously affiliated facilities, and provides the only tertiary level services in the region.
- 207-bed facility provides medical, surgical and pediatric care along with cardiac, neonatal and intensive care units; cancer, joint and spine care, diagnostic imaging and eye surgery center; emergency department, rehabilitation, hospice and lifeline.
- Large Critical Access hospital network

Objectives

- Describe implementation process used at HaysMed and community collaborative to help reduce readmissions
- Discuss interventions involved to improve care transitions across the community continuum

Readmissions feel like….

Avoidance of readmissions

- Why is it necessary?

-Patient Safety

-Reimbursement

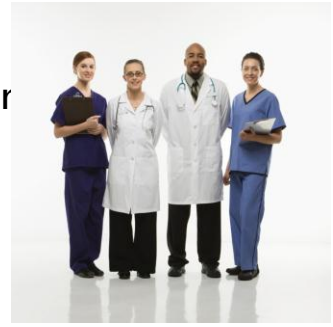
-Quality

RED

- Explored and implementation of Re-Engineered Discharge (RED) program
- RED is an Agency for Healthcare Research and Quality funded program designed to reduce the fragmented care of delivery during the transitions from one level of care to another, thereby improving quality, reducing readmissions and other related costs, and improving patient health and satisfaction

INTERVENTIONS

- Multidisciplinary approach
- Education program
- Patient Focused
- Team meetings
- Primary Care Provider
- Transportation
- Follow up calls



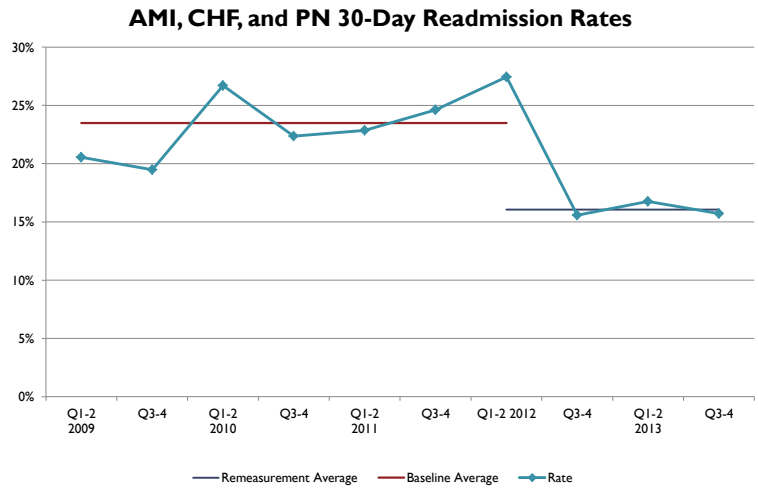
RED Implemention

- CHF-May 2012
- Pneumonia-October 2012
- MI-December 2012
- COPD-April 2014

COPD ZONES

EVERY DAY	**EVERY DAY:** •Take Prescribed Medications •Use Oxygen as prescribed •**AVOID** smoking •Balance activity and rest periods Which COPD zone are you in today? GREEN, YELLOW OR RED?
GREEN ZONE	**ALL CLEAR - This is your goal zone** Your symptoms are under control: •You are able to do usual activities •No cough •No wheezing •No shortness of air •No chest pain •You are able to control your symptoms with prescribed medications
YELLOW ZONE	**CAUTION- This zone is a warning** If you are experiencing the following, call your Doctor's office: •Increase in sputum and/or the color has changed •Cannot complete usual activities without resting •Feel more tired •Increased cough, wheezing or shortness of air (take rescue inhaler as prescribed) •Difficulty sleeping due to COPD symptoms •Increased swelling of your feet, ankles or legs •Feel like you have a "chest cold" •Decreased appetite
RED ZONE	**EMERGENCY** **Go to the emergency room or call 911, if you have:** •Difficulty in speaking or slurred speech •Sudden increase in shortness of breath at rest, not relieved by medications •Skin grayish in color, or lips, or finger tips are blue •Increased or irregular heart beat •Dizziness, feel faint, or sudden increase in anxiety, chest pain •Yellow symptoms for greater than 48 hours

Hays Med Readmission Data



Readmission rates produced by the Kansas Foundation for Medical Care, Inc. using Medicare Fee-for-Service claims data provided by the Centers for Medicare & Medicaid Services. May 2, 2014

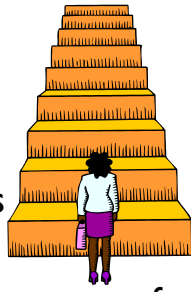
Expanding beyond the hospital…

- Kansas Foundation for Medical Care Integrating Care for Populations & Communities (ICPC) program started in May 2012.
- Committee included Critical Access Hospitals, Local Home Health agencies, Northwest Area Agency on Aging, Hays Medical Center, long term care facitilities

Northwest KS Care Transition Collaborative

- Discuss programs and services
- Barriers identified between agencies and for patients
- Sharing data
- Relationship building

Challenges Identified in community



- Transportation
- Communication between agencies
- Follow up appointments
- Services not available in rural areas
- Mental health not readily available
- Higher elderly population-The percentage of Americans age 65 years and older in the United States was 13%
- In 2010, in the Northwest KS area this average is 21.93% (US Census Bureau, 2010)

Community Interventions

- Created shared list of transportation resources and distributed to the community
- Provided Electronic Medical Record access to local nursing homes to create increased communication
- Hospital Case Managers shadowed Home Health Agencies
- Created "Patient Envelope" and "Patient Transfer Envelope" to standardize discharges and communication

Patient Envelope

Information Given To Patient

- ☐ Follow-up appointment
  - ☐ Made for patient
  - ☐ Patient to call on first business day to make appointment
    - Name & phone number _____
    - Name & phone number _____
- ☐ Follow-up test & procedures _____
- ☐ Prescriptions
  - ☐ New
  - ☐ Renewal
- ☐ Discharge instructions/medication list/discharge instructions
- ☐ Education information
- ☐ Advanced Directive information
  - ☐ Living Will ☐ DPOA ☐ POA ☐ Advanced Care Order
  - ☐ Does not have one-information provided
- ☐ Allergies _____
- ☐ Influenza vaccine
  - ☐ Current ☐ Declined ☐ Information Provided
- ☐ Pneumococcal vaccine
  - ☐ Current ☐ Declined ☐ Information Provided
- ☐ Recent lab reports ☐ Recent x-ray reports

Pending tests _____

Contact Information

You were dismissed from _____

Our contact phone number is _____

02/14 160828/m3476

Patient Transfer Envelope

Universal Transfer Checklist

- ☐ Receiving facility notified
- ☐ Receiving physician notified (if applicable)
- ☐ Transport team notified
- ☐ Family notified-name of person _____

Information Sent if indicated

- ☐ Transfer form
- ☐ Face sheet
- ☐ Medication forms
- ☐ Advanced Directive information
  - ☐ Living Will ☐ DPOA ☐ POA ☐ Advanced Care Orders
  - ☐ Does not have one-information provided
- ☐ Recent History & Physical
- ☐ Recent lab reports….typically last 3 days
- ☐ Culture reports
- ☐ Biopsy Report
- ☐ Recent x-ray reports….typically last 3 days
- ☐ Recent physician progress notes….typically last 3 days
- ☐ Case management/social worker notes
- ☐ Pending tests & who to contact _____

Contact Information

Transferring facility _____

Contact name & number _____

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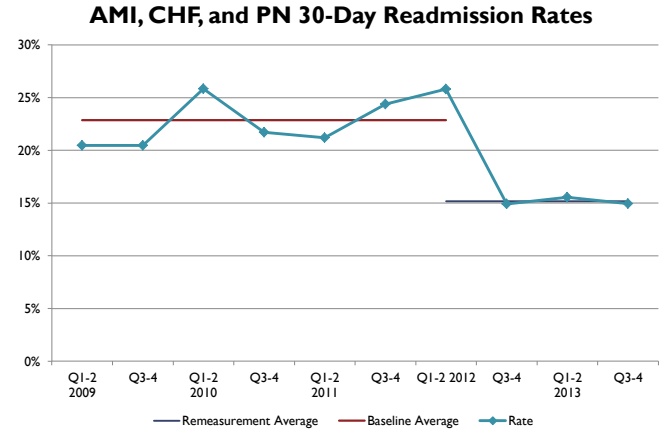
Community Interventions

- Created shared transfer sheets to increase communication
- Implemented readmission chart review tool
- Grant provided for patients that would benefit from Area Agency on Aging Services
- Worked with clinics awareness for need for follow up appointments within 5 days of post hospital stay
- Hays Med started quarterly meetings with all community CAH hospitals

Community Future Projects

- Palliative Care Growth
- Advanced Directives
- Transportable Physician Orders for Patient Preferences (TPOPP) start in region

Northwest KS Care Transition Collaborative Readmission Data



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References

Agency for Healthcare Research and Quality (2011). *Project RED. Retrieved from www.ahrq.gov*

U.S. Census Bureau (2010). *State and County Quickfacts: Kansas*. Retrieved from http://quickfacts.census.gov/qfd/states/20/20163.html