Transitions of Care

Holton Community Hospital
Family Practice Associates

Objectives

- Describe the steps to implement a successful Transitions of Care initiative.
- Identify ways to measure the success of a Transitions of Care initiative.
- Demonstrate initiative value through the Return on Investment (ROI).

Holton Community Hospital
Family Practice Associates

12-Bed Critical Access Hospital

Located in Holton, Kansas – Population 3,278

162 Team Members

Call to Action

- Do we have adequate data to begin?
- Don't always look for the perfect data or the perfect change design before beginning a project.
- Flip to 75% implementation and 25% analysis

Timeline

- Patient Care Coordinator (PCC)
- Daily Huddle Implementation
- Follow-up Phone Calls
- Community Luncheons
- Readmission Review Tool
- Home Health Involvement
- Patient Education Notebooks
- Teach-Back

Patient Care Coordinator (PCC)

Position Created: January 2013

Responsible for the patient's ongoing case management and the coordination of their care. Support the efforts in managing complex patients by implementing a treatment plan and facilitating the patient's access to appropriate health care services and community resources. Supports patient self-management and increase knowledge of his/her disease process.

The primary focus of this position is to oversee and coordinate observation, inpatient, and swing bed care with discharge planning and utilization management activities. In doing so the care coordinator will facilitate appropriate resources and efficient patient progression through the continuum of health care resulting in the highest quality and the most cost effective care.

Daily Huddles

- Implemented: January 2013
- Focus: Patient Discharge and Education Needs
- Rules: Concise and Attendees Stand
- Attendees: PCC, Social Work, Nursing, Rehab, Pharmacy, Home Health and Risk Management

Follow-up Phone Calls

- Implemented: January 2013
- Focus: Patient Understanding of Discharge Instructions and Medications, Follow-up Appointment Arrangements
- Population: All Acute, Observation and Swingbed Discharges to Home
- Timeframe: 2 Days and 10 Days Post-Discharge

Community Luncheons

- Implemented: August 2013
- Focus: Patient Transitions within the Community
- Attendees: Local Hospitals, Nursing Homes, Home Health Agencies, Assisted Living Facilities, Community Service Organizations
- Frequency: Initially monthly

Reevaluate and Refocus

November 2013

- Staff Assigned to Other Projects
- Focus Became too Broad
- Project Scope Became Overwhelming
- Reevaluated Purpose and Goals

Readmission Review Tool

- Implemented: January 2014
- Focus: Readmission Reason and Ways to Prevent the Readmission
- Follow-up: Discussion with Care Team
- Reviewers: Transitions of Care Team

Home Health Involvement

- Implemented: May 2014
- Focus: Involve Home Health in Discharge Planning
- Actions: Home Health Attendance at Daily Huddles and Care Plan Meetings, Home Health and Rehab Meet Weekly

Patient Education Notebooks

- Implemented: November 2014
- Focus: Patient Education Regarding Discharge Instructions and Medications
- Target Audience: Patients with CHF, COPD, Diabetes or Multiple Co-Morbidities

Patient Education Notebooks

Tabs:

- Discharge Instructions
- Medications
- Diet
- Special Instructions (Weight log, BP log, glucose log, etc.)
- Exercise

Patient Education Notebooks

Tabs (Continued):

- Calendar of Appointments
- Questions for My Doctor
- Information for My Doctor (SOC document)
- DPOA/Living Will
- Insurance Information

Teach Back

- Implemented: May 2015
- Focus: Effective Patient Education
- Actions: Provided Teach Back Education to all Clinical Departments

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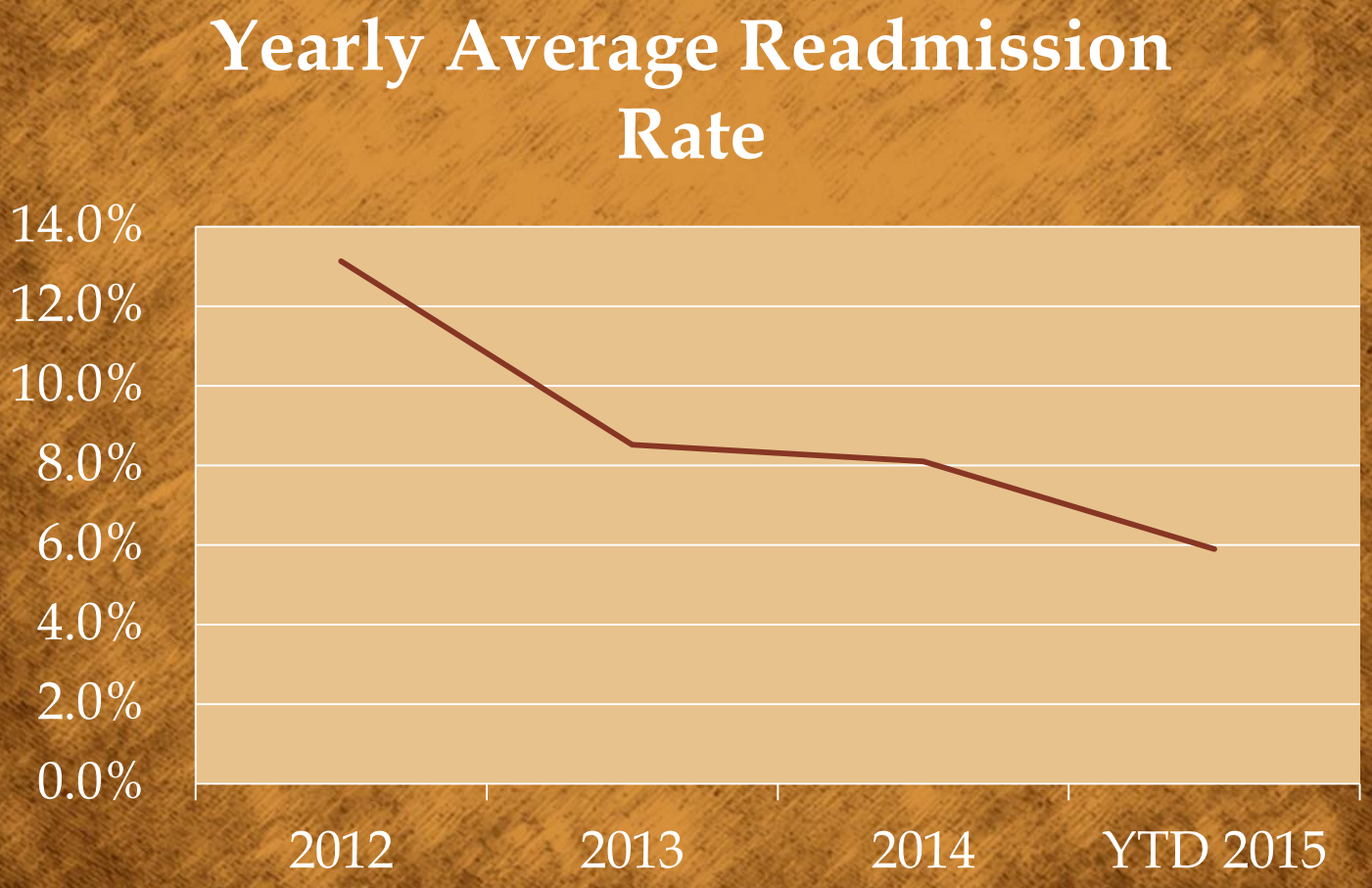
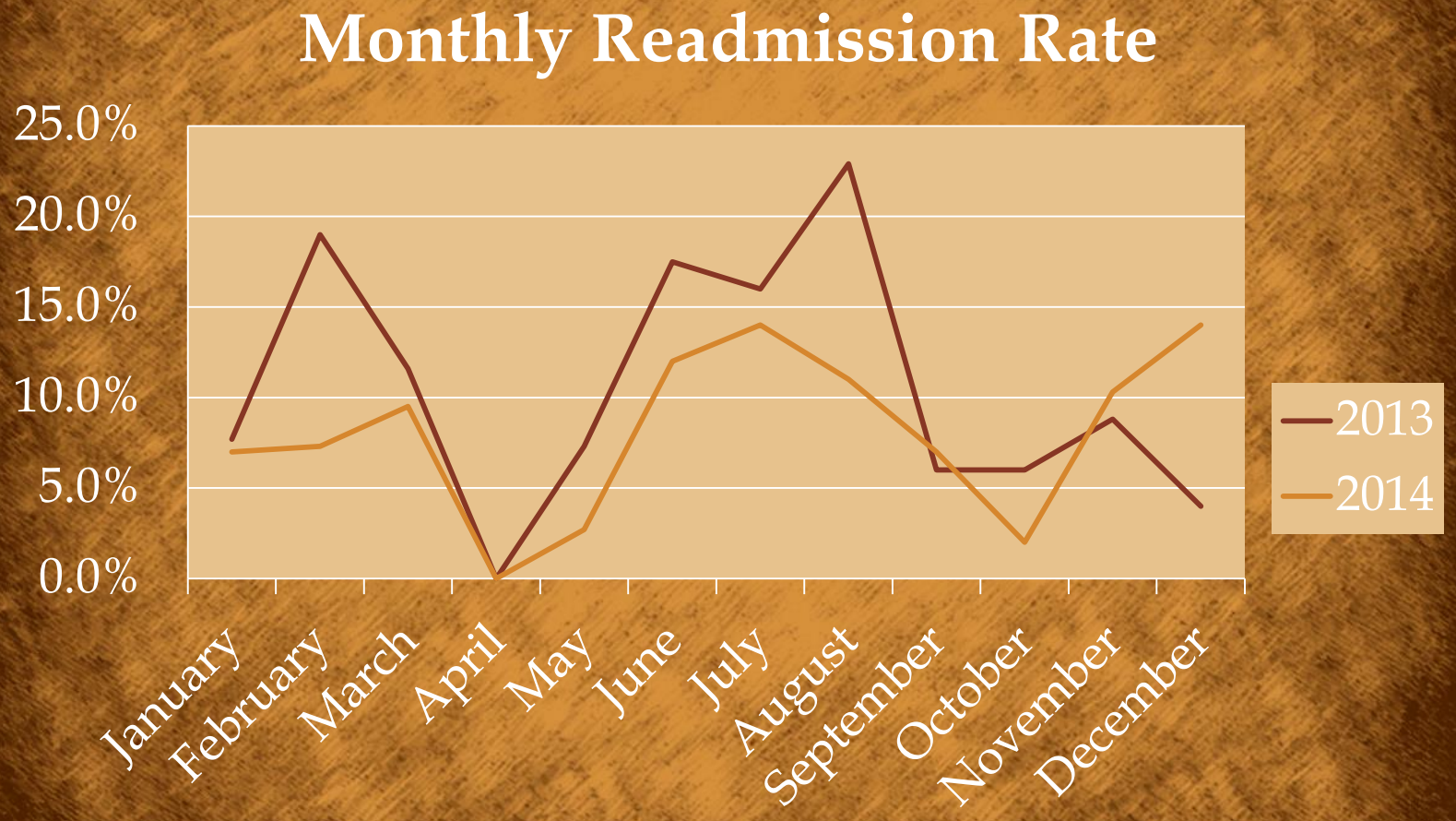
Evaluation

Readmission Rate *



* Data compiled by HCH

Readmission Rate *



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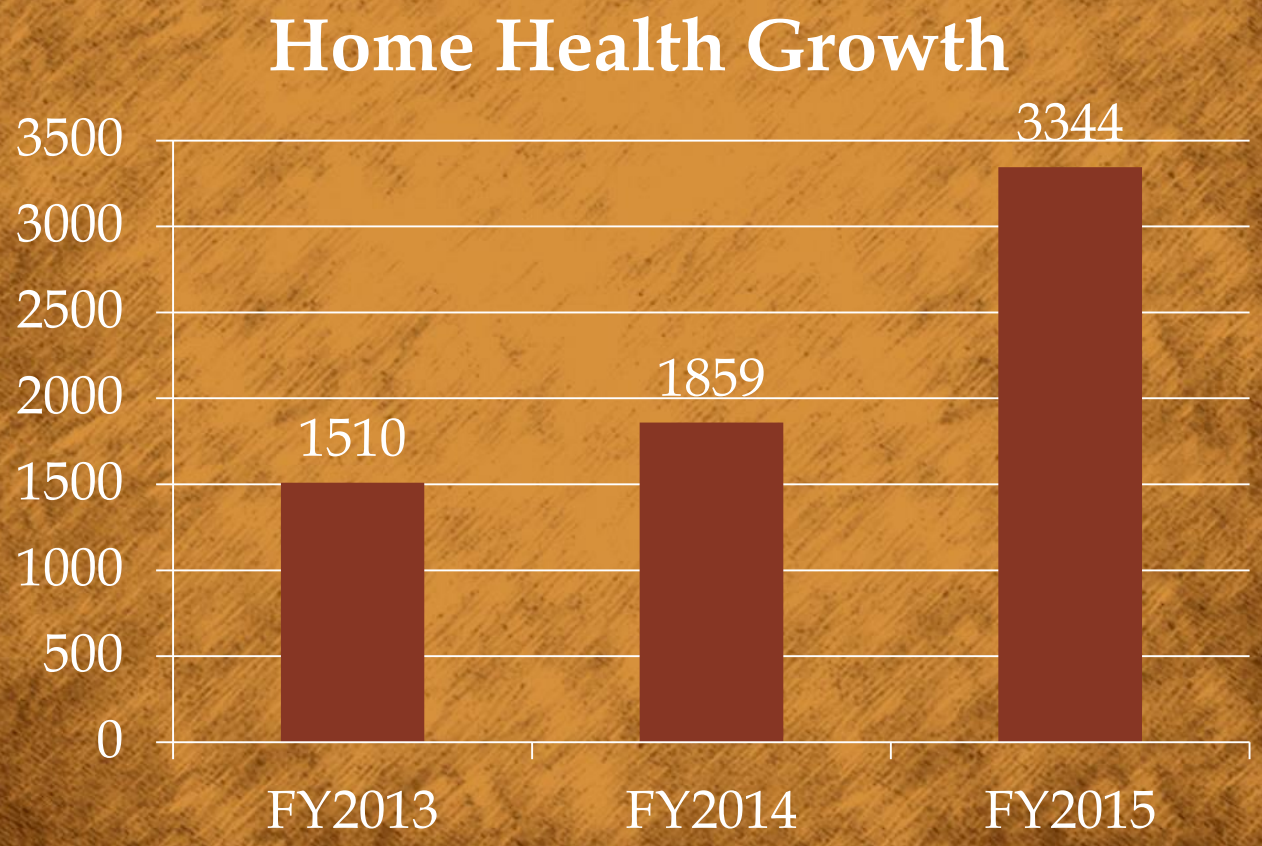
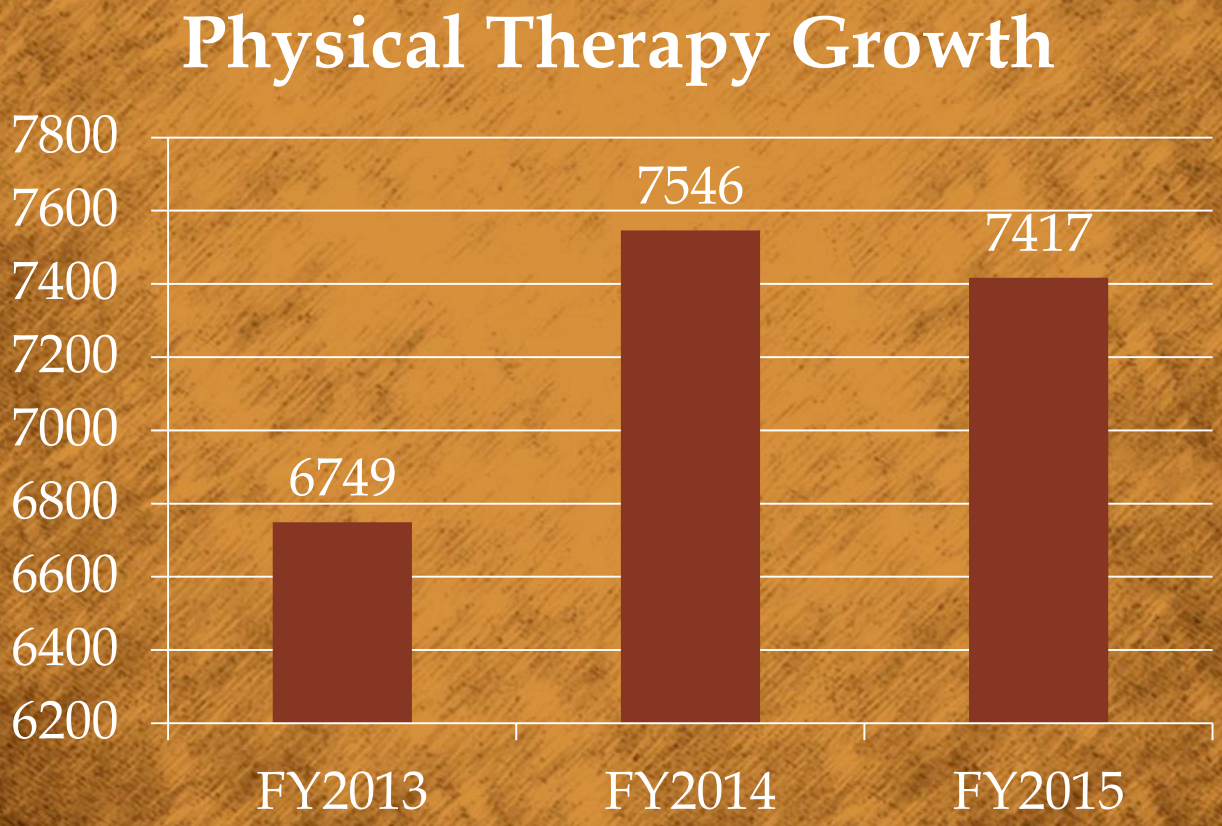
Return On Investment

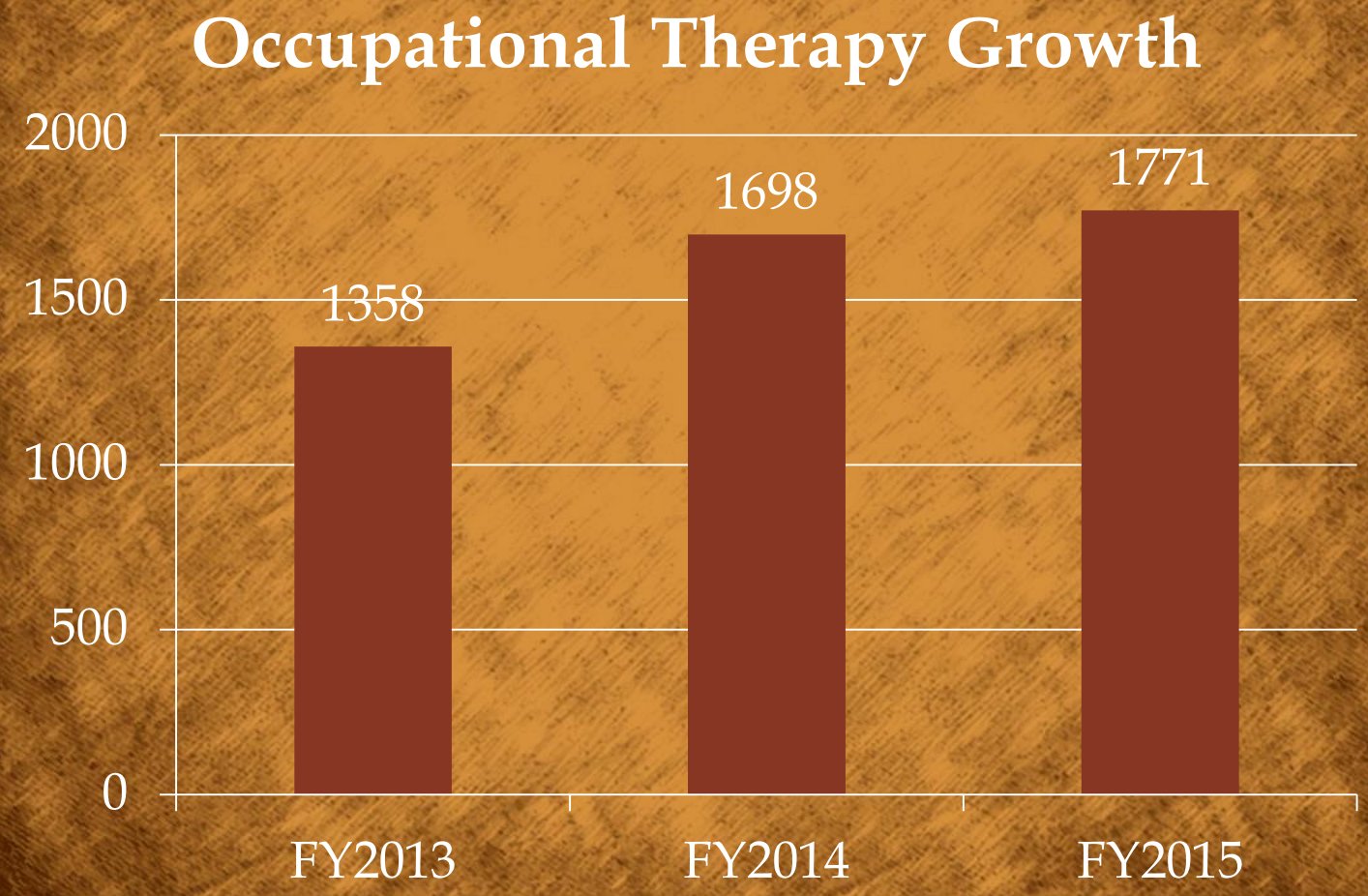
Home Health


Home Health Growth
3500
3000
2500
2000
1500
1000
500
0
1510
1859
3344
FY2013
FY2014
FY2015

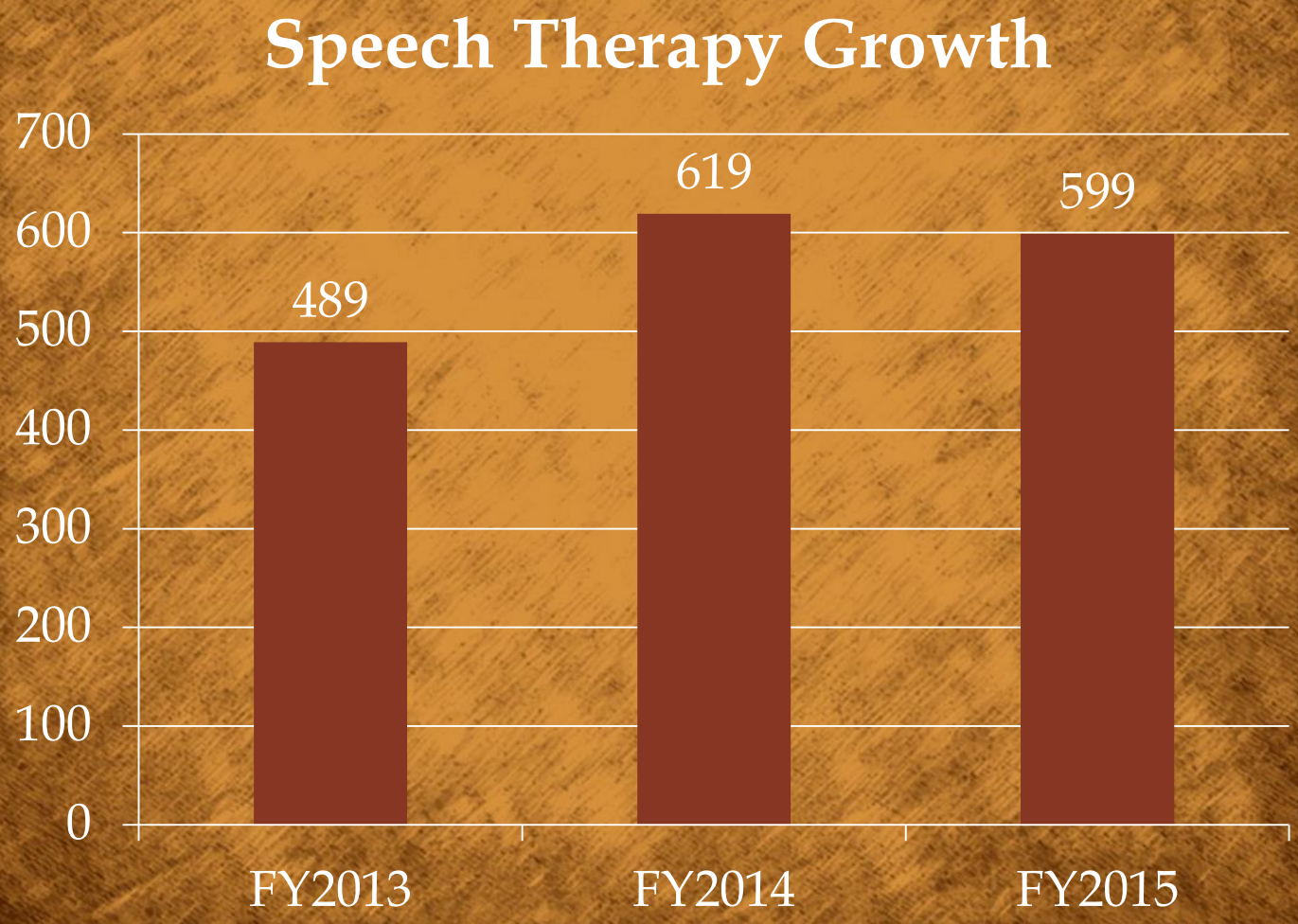
Physical Therapy



Occupational Therapy



Speech Therapy



Other Initiatives

- Dry Erase Boards
- Wall Markers for Distance
- Notepads
- Medication Rounds
- United Way Prescription Assistance Grant
- Monthly Senior Citizen Center Education Sessions
- Documentation of Patient Education

Holton Community Hospital
Family Practice Associates

Phone # 364-2116, ext 1171
Rm 117A Dial "5" to call out, local only
Preferred Visiting Hours: 10am - 9pm
2pm-4pm Naptime

Today's Date: _____

Your Care Team:

Doctor: _____

Nurse: _____

Aide: _____

Pain Management is OUR Goal!
Your Goal ☐

Baby's Name: _____

Birthday: _____

Time: _____

Weight: _____ **Length:** _____

Snacks available. Please just let us know what can get for you!

Checklist for Discharge:
- ☐ PKU Test
- ☐ Hep B Vaccine
- ☐ Birth Certificate
- ☐ Infant Photos
- ☐ Circumcision
- ☐ Hearing Screen
- ☐ D/C Instructions for Newborn
- ☐ D/C Instructions for Mom
- ☐ Period of Purple Crying
- ☐ Hospital to Home Video

% of Meals Consumed

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Intake	Output

Make sure Car Seat Is Ready

Everyone Wash Your Hands

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Today's Date: _____

Your Care Team:

Doctor: _____

Nurse: _____

Aide: _____

Goal D/C Date: _____

% of Meals Consumed
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

In	Out

- ☐ Fall Risk
- ☐ Bed/ Chair Alarm
- ☐ Skin precaution
- ☐ Turn Q2
- ☐ Other:

Activity Level: _____

- ☐ Independent
- ☐ SBA
- ☐ 1:1
- ☐ 2:1
- ☐ Lift

Wall Markers

TEAM MEMBERS

Holton Community Hospital
Family Practice Associates

Tammy Elliott
Mandy Bontrager
Dawna Leck
Zennie McClintock
April Zeller
Lisa Moore
Ric Gengler
Cody Utz

Transitions of Care Team

Holton Community Hospital
Family Practice Associates

Contact Information

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