IMPACT

Impacting Patients Across Care Transitions

Partnering with Lifeguard Ambulance

St. Vincent's HEALTH SYSTEM

ASCENSION HEALTH

Background

- Clinical Integration and Clinical Excellence Committee at the Ascension level developed the “Preventing Readmissions Bundle.”
- Six Ascension Health Systems serving as alpha sites committed to implementation of the readmissions bundle utilizing innovative and creative strategies.

Goal

The key goal for reducing readmissions for CHF, AMI, and Pneumonia is effective patient-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.

Future Diagnosis

- COPD
- Total Hip Arthroplasty
- Total Knee Arthroplasty

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

- Schedule PCP appointments within 7 days
- 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: Care Transition Nurse

- Care Transition Nurse (CTN) Hospital Visit
  - Educates patient while in the hospital
  - Enrolls in IMPACT
- CTN Post-Discharge Visit within 48 to 72 hours of discharge
  - Educates patients and family members
  - Completes medication reconciliation
  - Completes Physical Assessment
  - Develops 30 Day Care Plan
    - Determines frequency of calls and visits to be made by the Care Transition Nurse, EMT, and Social Worker for the next 30 days
    - All care plans are person-centered and reflect the patient's risk for readmission.

Implementing Transitional Care Services: Social Worker

- Assessment of Social Situation
- Assessment of Resources
- Prescription Assistance
- Transportation Assistance
- Depression Screening
- Disease Management Education

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Implementing Transitional Care Services: EMT

- Collaborates with CTN to implement 30 Day Care Plan
  - Completes patient calls and visits
  - Educates patients and family members
  - Completes medication reconciliation
  - Completes Physical Assessment
  - Provides “rescue” call number

Collaborating with SNFs, HH agencies, and family members

- Identification of preferred partners
- Identification of post-acute care facilities with high readmissions
- Developing mechanisms for better communication
- AQAF Coalition

Utilizing Palliative Care Services

Program development underway.

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What really happens?

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Early Learnings and Challenges

- Difficulty in identification of patients with CHF, AMI, and Pneumonia
- Challenge to schedule appointments with PCP within 7 days 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
- 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 team meetings with team
  (weekly huddles and monthly results meetings)
- Multi-disciplinary team approach
- Inclusion of community partners
- Willingness to change

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