Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

Learning Collaborative

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OVERVIEW

- The Transition in Care Program assists the indigent population in receiving timely, efficient access to care along with education and follow-up to manage their chronic diseases.
- Uses an enhanced discharge process called Project RED Re-Engineered
- Establishes partners including the interdisciplinary team and externals including skilled nursing facilities, home health agencies, and physician practices
- Requires education of hospital staff and continuous monitoring of the project Oversight Committee and the Steering Committee to implement and evaluate intervention

PROCESSES

Goals	Access to Care and outpatient resources	Preventation Care	Education/Self-Care
Decrease in Emergency Room visit Decrease in 30-Day readmissions Decrease in CHF and AMI admissions Increase in Family Health Center and visits to physician offices	Increase referrals to Home Health Agencies and for sub-acute rehabilitation Increase referrals for Cardiac rehabilitation Arrange transportation for office visits Coordinate participation in community programs: •Adult Medical Day Care •Chronic Disease Self-Management Programs	Age Appropriate screenings: •Colonoscopy •Mammogram •Pap Smear •Prostate Disease-Specific exams: •Ophthalmology •Podiatry •Cardiology •Endocrinology	Project Red After Hospital Care Plan Provide free scales to CHF patients

LEARNING COLLABORATIVE SURVEY

- Quality Improvement plan is 100% completed

- Monthly recurring meetings with external partners
  - SNFs
  - HHAs
    - Patient issues
    - Readmissions
    - Strategies
- Leadership Engagement
  - Weekly meetings with APN and Chief Nursing Officer
  - Bi-Weekly Steering Committee: APN, CNO, CMO
  - Monthly Oversight Committee: Executive and Management

LEARNING COLLABORATIVE SURVEY

- Plan-Do-Study-Act
  - Study stage:
    - Pilot program started in September 2014
    - Implemented intervention introduced in prior Progress Reports
    - Monitoring effects on population and opportunity for improvement
- Stage 1 Activities: 100% completed
- Stage 2 Activities: 80% completed
- Stage 3 tracking/collecting of DSRIP performance measure data is at 50%
- Stage 4 tracking/collecting of DSRIP performance measure data is at 50%
- Tracking/Data Collection: EOGH is working with NJ HITEC for data collection for the Stage 3 and 4 data measure

LEARNING COLLABORATIVE SURVEY

- Implementation challenges:
  - Access to medications and DME for charity care patients
- We have not been able to overcome this challenge

- Successes to date
  - Coordinating more outpatient sleep studies for patient reducing CHF readmissions

PROJECT RED RE-ENGINEERED

- The Re-Engineered Discharge (RED)Toolkit is funded by the Agency for Healthcare Research and Quality

- Boston University Medical Center has established 12 reinforcing components of the discharge process that has been proven to reduce rehospitalizations and increase patient satisfaction.

- Focus on education before and after leaving the hospital

TRANSITION IN CARE TEAM

- Director/Project Leader
  - Advance Practice Nurse
- Patient Navigator
  - Registered Nurse
- Pharmacist
- Administrative Assistant

PATIENT NAVIGATOR'S ROLE

- Identifies patients that meet criteria for DSRIP
- Introduces Transition in Care Program to the patient and family/caregiver
- Initiates action steps associated with Project RED
- Reinforces patient and family education on disease and co morbidities, medications, post-discharge plans, and follow-up orders by the physician
- Coordinate with case management department and Administrative Asst.
  - DME to the bedside or home on day of discharge
  - SNF or HHA referrals
- Coordinates plan of care with interdisciplinary team
- After Hospital Care Plan (AHCP)
  - Complete during hospitalization
  - Instruct patient/family on use
  - Completes and send patient home or to SNF with CHF or AMI education booklet

ADMINISTRATIVE ASSISTANT'S ROLE

- Under the direction of the APN:
  - Schedules f/u appointments with PCP for within 7 days of discharge and inform PN
  - Coordinate transportation for office visits
  - Ensures that charity care and Medicaid applications are initiated within 24 hours of admission
  - Forward discharge summary to the PCP within 12 hours of discharge

PHARMACIST'S ROLE

- Within 24 hours of admission:
  - Confirm accuracy of medication reconciliation initiated on admission
    - Ask patient's family to bring in all medication bottles
    - Call the patient's pharmacy to confirm most medications the patient currently takes.
- Discharge Process
    - The pharmacist will coordinate one of the following:
      - Call in the prescription to the patient's external pharmacy and have the medications delivered to the bedside or to the home for the same day.
      - If the patient does not have insurance and a Medicaid application was initiated during the hospitalization, our partner pharmacy will "loan" the patient 30-days of medications and "backbill" when the Medicaid is approved.
      - If the patient does not qualify, the hospital will cover the first 30-days of the patients' medications.

FOLLOW-UP VISITS

- Home visit or visit to SNF within 24 hours of discharge/transfer:
  - Medication reconciliation
    - Medication administration (nebs, injections)
    - Provide refills as per provider
  - Education: lifestyle modifications
  - Confirm follow-up appointments
  - Coordinate with Home health agencies
  - Pillboxes for all; scales for CHF patients
    - Fill pillbox weekly if needed to increase med compliance
  - Coordinate transportation for doctors' visits, outpatient testing
- If patient calls and is not feeling well
  - APN to conduct urgent home visit, if possible
  - Full Assessment and call physician to discuss status
  - Schedule visits to provider's office for within 24 hours or call 9-1-1 if needed

CHALLENGE AT EOGH

- **Access to medications and DME**
  - Charity care does not pay for medications
  - Some patients are undocumented
  - 1 charity care patient requires a BIPAP costing $4800

- **Other challenges** faced in the program
  - Refusal to participate in the program
  - Drug abuse/IV drugs
  - Homelessness
  - Transportation for f/u visits with PCP