How to Partner with Hospitals to Prevent Re-hospitalization

October 28, 2015
NAHC Annual Meeting

Our Journey
Objectives

- Describe the history that led up to establishing this collaborative project
- Identify factors that contributed to high admission rate for colorectal patients
- Discuss the people and processes needed to put together an “effective“ action team and process
- Identify the process and outcome metrics established for the project
- Discuss the formal roll out of the Post Acute Care (PAC) efforts
- Discuss the planned activities to sustain the gains

Masonicare

- Based in Wallingford, with locations throughout Connecticut, Masonicare is Connecticut’s largest provider of health care services to seniors and a full continuum of care.
- Services include Home Health and Hospice, Private Duty, Acute care, Skilled Nursing Care, Long-term care, an MD practice, Clinics, Dementia Care, Assisted Living, and Retirement Communities.
- Masonicare Home Health and Hospice (MHHH) provides a full complement of services including Skilled Nursing, Therapies, Home Health Aides, MSW’s, Behavioral Health, Palliative Care, Hospice Care, Spiritual Care, Volunteers, Bereavement Support, Respite or Inpatient care. Specialty services are also available including, but not limited to WOCN’s, LSVT Big and Loud Program, Telemonitoring and a We Honor Veterans program.
St. Francis

- An integrated healthcare delivery system in central Connecticut
- Services cover the continuum of patient needs,
- Services provided independently and through partnerships, affiliations and relationships developed with other exceptional providers, like Masonicare
- Overall, Saint Francis Care provides access to almost 900 affiliated physicians, three hospital campuses, 12 satellite medical offices, and a variety of community clinics.

A whole new language

Alliances
- Process of care measures
- Shared Risk
- Bundled payment
- Recalibration of HHRG’s
- Health coaches
- Evidence based practice
- Outcomes
- Resource Capacity Management
- Pay for performance Patient Engagement
What is happening in Healthcare?

- Affordable Care Act passed in 2010
- The Triple Aim
- CMS Readmission Reduction Project
- Pay for performance
- Bundled payments
- Small group looks at specific population – colorectal patients and their readmission rate
- Prior home care/acute care relationship between Masonicare and St. Francis – that had been very successful
- Joint decision made that can make a difference – decrease the readmission rate and increase patient satisfaction of a specific population
- Post Acute Care Transition Project goes “live”

What is happening in healthcare?

- Hospital Acquired Condition Reduction Program
- Inpatient Hospital and Psychiatric Quality Program
- Value Based Purchasing Program
- Hospital Readmission Reduction Program
The Triple Aim

Improved patient experience
Improved clinical outcomes
Lower costs

Baseline data

LEVEL 1 DATA
Colorectal Readmission Rate Over Time

Discharges between October 2009 to November 2013
Inpatient colorectal readmissions vs colorectal/surgical discharges in 5% of
Five do nothing, our readmissions continue to be on the rise
Factors that contributed to high readmission rate

**Hospital**
- Patient skill with pouch
- Patient confidence
- Knowledge regarding how to deal with unexpected but known complications
- Inconsistent communication between providers
- Imperative to get patients out of hospital quickly

**Home Care**
- Patient skill with pouch at Home
- Patient understanding of diet at Home
- Patient confidence at Home
- Knowledge regarding how to deal with unexpected but known complications at Home
- Inconsistent communication between providers
- Need to assess the home environment and have the appropriate supplies on hand and support system

First meeting – starting the journey

**Hospital** – described and introduced
- Progress to date
- Physician champion
- Exit only team
- Review of data
- Staff Education
- Criteria for discharge

**Home Care** – described for acute care:
- Care of patient in the home
- Financial restrictions to providing care
- Environmental restrictions to providing care

Agreement
- We would work together!
We planned for success!!

- Learn about each other
- Begin with end in mind
- Created a plan
- Made a commitment

How do we come together to decrease readmission while keeping patient in the center of all we do?

Hospital  Home Care
Learning to see the same patient with 2 sets of eyes

Is it the same patient?

Next step

“WE SHARE THE PATIENT”

- Language we use (verbal and written)
- Joint patient resource book (that begins in the physician office)
- Decisions regarding resources: additional WOCN with agreement to be the provider at the 1st visit and then as needed
- Establishment of a communication tree between Home Care WOCN and Hospital for transfers, readmissions and questions regarding care
- Agreement to leave EGOS at the door – it is all about the patient!
Starting the journey/building a team

Exit Only Team

- Physician champion and educator
- Nursing educators

- WOCN – inpatient
- WOCN – outpatient
- Wound center
- Case Management

- MDs
- Physician Assistant
- Nurses
- CNAs

- Management from both institutions
- Data Analyst
- Facilitator
Team Education and Involvement

Dr. Amanda Ayers
Colorectal Surgeon
Physician Champion

Martha Obando RN-WOCN
Elizabeth Wlazlo RN-WOCN
The “EXIT ONLY” Team

Phases of team development – the blending of 2 cultures

- Forming
- Storming
- Norming
- Performing
- Measure Outcomes
Clear Goal

Decrease the rate of hospital readmission

Seamless transition between services providers

The patient sees us as 1 entity – same language, same tools, same resources

Provide a exceptional patient experience for both the patient and his/her family

Ready to start the journey/win the game

National Champions 2014-15

UConn Huskies

NCAA Women's Basketball

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Game Plan – Our Map

- Learn about each other
- Focus on the highest readmission group
- Find out why they are readmitted
- Smooth out the experience so that it is seamless
- Educate both groups regarding standards of practice
- Standardize the expectations
- Relentless look at what went right . . . And what went wrong
- Keep the lines of communication - OPEN

Game Changers:

2 dynamic leaders – 1 at Home Care agency and 1 at Hospital

Physician Champion - very committed

Data Analyst

Commitment to hire a WOCN at Masonicare

Trained facilitator

Ileostomy kit

Quarterly "deep dives"

Patient Resource Book
A team is as strong as its “weakest link”

Moving from 2 cultures to 1

It is all about the Patient!
Development of the tool kit
Ileostomy Kit

Criteria for Discharge with a New Ileostomy

In order to be discharged, you must do the following:

- Completed education with a Wound Ostomy Conference Nurse (DONE)
- Can empty pouch on own
- Can accurately record output from pouch
- Can change pouch with assistance
- Oral intake of 8-12 glasses of fluids daily x 48 hours (approximately equivalent to 2000 ml or 64 ounces)
- Ostomy output of between 500 ml and 1200 ml daily x 48 hours
- Ambulate around the floor at least 3 times a day

Participation in your self-care allows us to help you achieve independence.

Thank you!
Project RED: Patient Resource Book

OSTOMY
Patient Resource Handbook
Your Time in the Hospital ... and Your Return to Home

RED
Re-Engineered Discharge
Managing the colorectal patient as A Team!

Hospital

Home Care

The unplanned measurement of success – provided by a patient

“I feel like I am talking to the same person”
Our DATA

Colorectal Readmission Rate

Data compiled using the following DRGs: 329, 330, 331, 332, 333, 334, 344, 345, 346

Miles to Go Before We Are Done...
The Journey has begun

*Fiscal Year 2013 = 19.8%*
*Fiscal Year 2014 = 16.0%*
*Goal = 16.61%*
*Fiscal Year 2015 To Date = 15.6%*
*Goal = 15.7%*
*Fiscal Year 2012 = 16.9%*
Post Script – Establishment of a Post Acute Care Network

THIS PROJECT BECAME THE GOLD STANDARD

Contact Information

Susan F. Adams RN, BSN, PhD
Vice President of Alliance Integration
Masonicare
Wallingford, CT
sadams@masonicare.org

Ann Orr MS, RN
Performance Improvement Facilitator
St. Francis Hospital and Medical Center
Hartford, CT
aorr@stfranciscare.org