



## Improving Care Transitions and Reducing Readmissions

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- 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

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### 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

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Readmissions feel like....



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Avoidance of readmissions

- Why is it necessary?
  - Patient Safety
  - Reimbursement
  - Quality

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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

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## INTERVENTIONS

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




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## RED Implementation

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

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COPD ZONES	
<b>EVERY DAY</b>	<p><b>EVERY DAY:</b></p> <ul style="list-style-type: none"> <li>•Take Prescribed Medications</li> <li>•Use Oxygen as prescribed</li> <li>•AVOID smoking</li> <li>•Balance activity and rest periods</li> </ul> <p>Which COPD zone are you in today? <b>GREEN, YELLOW OR RED?</b></p>
<b>GREEN ZONE</b>	<p><b>ALL CLEAR - This is your goal zone</b> Your symptoms are under control:</p> <ul style="list-style-type: none"> <li>•You are able to do usual activities</li> <li>•No cough</li> <li>•No wheezing</li> <li>•No shortness of air</li> <li>•No chest pain</li> <li>•You are able to control your symptoms with prescribed medications</li> </ul>
<b>YELLOW ZONE</b>	<p><b>CAUTION - This zone is a warning</b> If you are experiencing the following, call your Doctor's office:</p> <ul style="list-style-type: none"> <li>•Increase in sputum and/or the color has changed</li> <li>•Cannot complete usual activities without resting</li> <li>•Feel more tired</li> <li>•Increased cough, wheezing or shortness of air (take rescue inhaler as prescribed)</li> <li>•Difficulty sleeping due to COPD symptoms</li> <li>•Increased swelling of your feet, ankles or legs</li> <li>•Feel like you have a "chest cold"</li> <li>•Decreased appetite</li> </ul>
<b>RED ZONE</b>	<p style="text-align: center;"><b>EMERGENCY</b></p> <p>Go to the emergency room or call 911, if you have:</p> <ul style="list-style-type: none"> <li>•Difficulty in speaking or slurred speech</li> <li>•Sudden increase in shortness of breath at rest, not relieved by medications</li> <li>•Skin grayish in color, or lips, or finger tips are blue</li> <li>•Increased or irregular heart beat</li> <li>•Dizziness, feel faint, or sudden increase in anxiety, chest pain</li> <li>•Yellow symptoms for greater than 48 hours</li> </ul>

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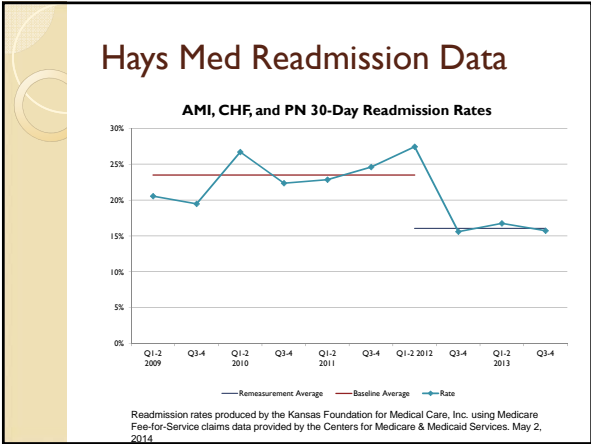
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### Expanding beyond the hospital...

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

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### Northwest KS Care Transition Collaborative

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



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### 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)




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### 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

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### 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 \_\_\_\_\_

Follow-up text & 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 \_\_\_\_\_

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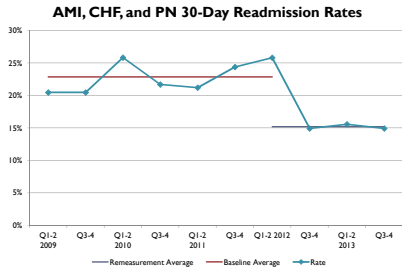
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## Northwest KS Care Transition Collaborative Readmission Data



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

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## References

Agency for Healthcare Research and Quality (2011). *Project RED*. Retrieved from [www.ahrq.gov](http://www.ahrq.gov)

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

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