Cultivating a Reliable Patient Transitions Program

nrc HEALTH | Via Christi HEALTH | Ascension

Learning Objectives

After viewing this webinar, participants will be able to:

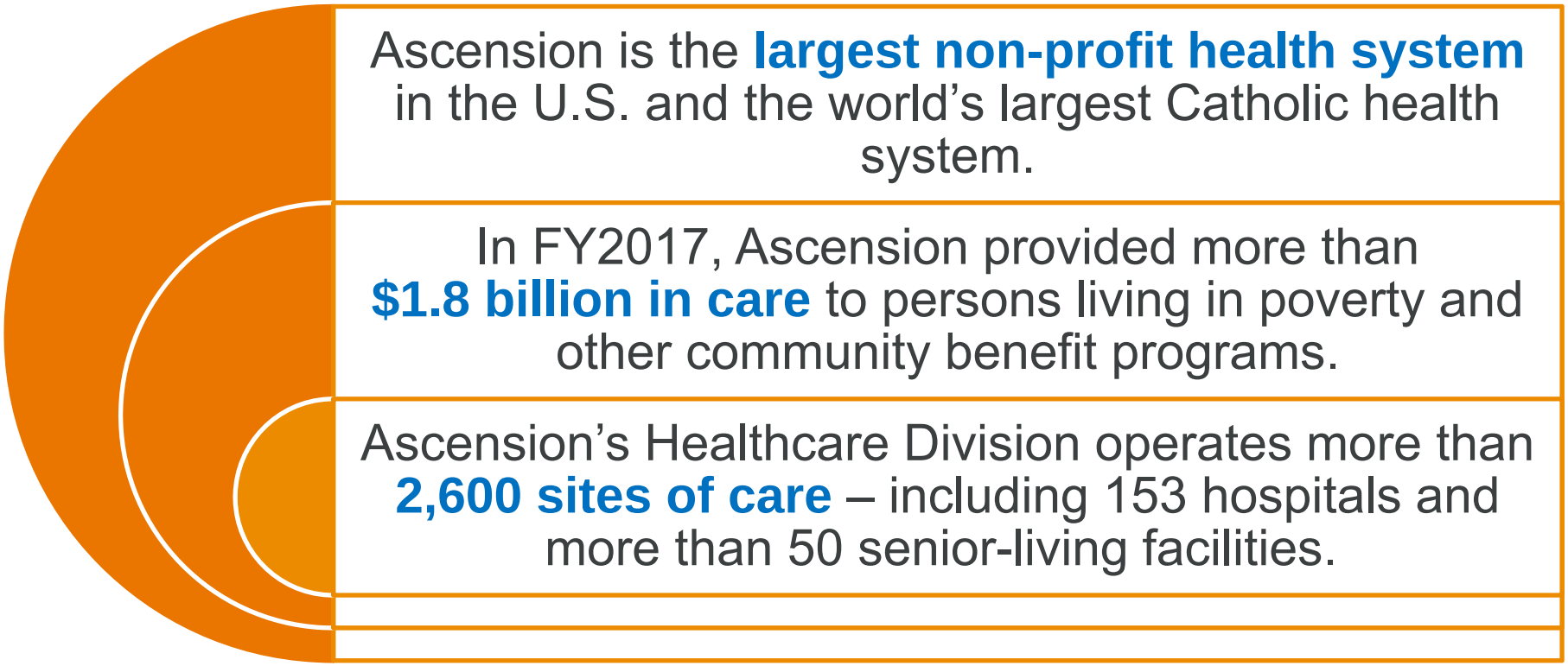
- Define Transitional Care and the benefits of developing safe transitions programs.
- Discuss non-traditional models of care developed to improve transitions and overall quality of life for participating patients.
- Identify the potential operational shortfalls and psychosocial barriers that patients face.
- Discuss opportunities to apply new models of care in your practice.

Today's Presenters

Robyn Chadwick, LSCSW
Vice President
Via Christi Hospital Wichita St. Teresa, Inc.

Charity Clark MSOHRD, BS, RRT
Director - Case Management, Transitional Care, Heart Failure Clinic, Community Cares & Cardiopulmonary Rehab
Via Christi Hospitals Wichita, Inc.

About Via Christi, a part of Ascension



Introduction to Via Christi Health

- Largest provider of healthcare services in Kansas.
- 12 fully/partially owned or managed acute-care hospitals across the state
- Provides care across the continuum, including inpatient/outpatient rehabilitation, outpatient clinics, senior-living facilities, and home health care

What is Transitional Care?

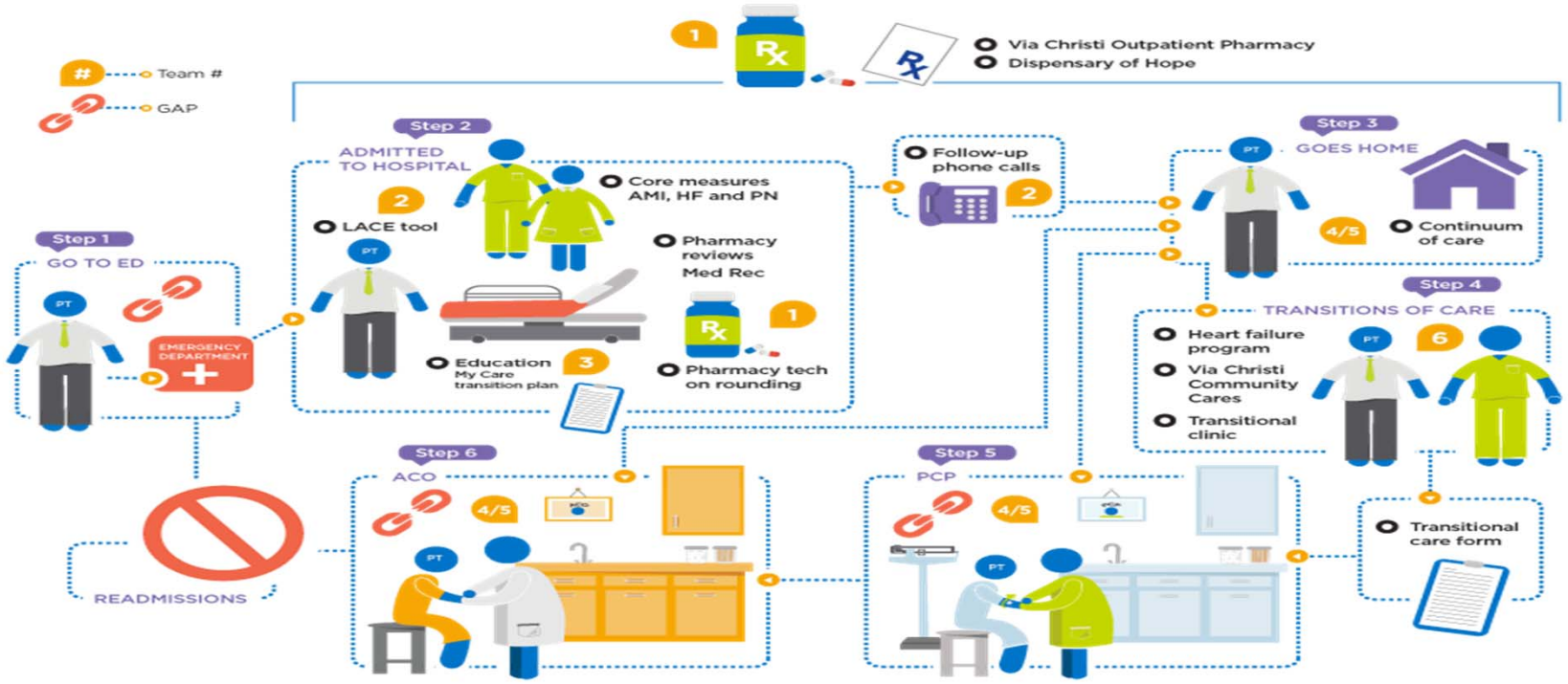
Transitional Care encompasses a broad range of services and environments designed to promote the safe and timely transfer of patients from levels of care or across settings, and has emerged to bridge the gap between and among a diverse range of providers, services and settings.

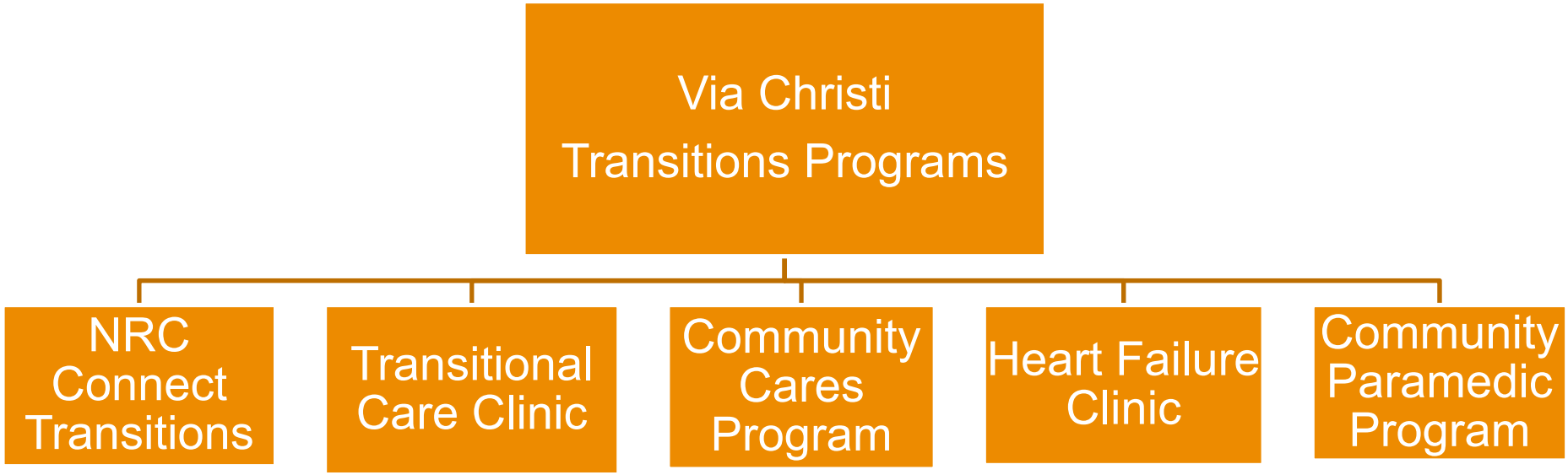
Naylor, M. “Transitional Care: A Critical Dimension of the Home Healthcare Quality Agenda.” Journal for Healthcare Quality, 2006;8(1):48-55.

Consequences

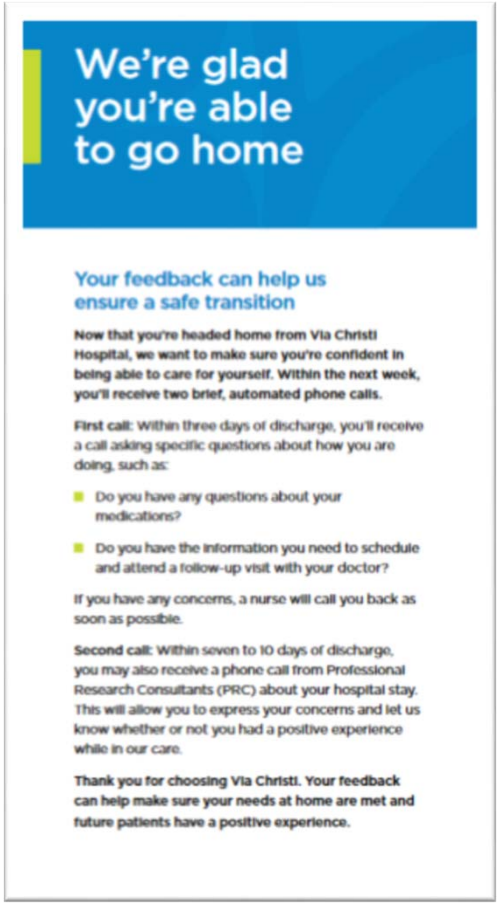
- Decline in health and functional status
- Preventable hospital readmissions
- Increase in cost to the patient/organization
- Suboptimal chronic-disease management

Readmission Roadmap




Via Christi
Transitions Programs
NRC
Connect
Transitions
Transitional
Care Clinic
Community
Cares
Program
Heart Failure
Clinic
Community
Paramedic
Program

Discharge – What's Next?



We're glad you're able to go home

Your feedback can help us ensure a safe transition

Now that you're headed home from Via Christi Hospital, we want to make sure you're confident in being able to care for yourself. Within the next week, you'll receive two brief, automated phone calls.

First call: Within three days of discharge, you'll receive a call asking specific questions about how you are doing, such as:

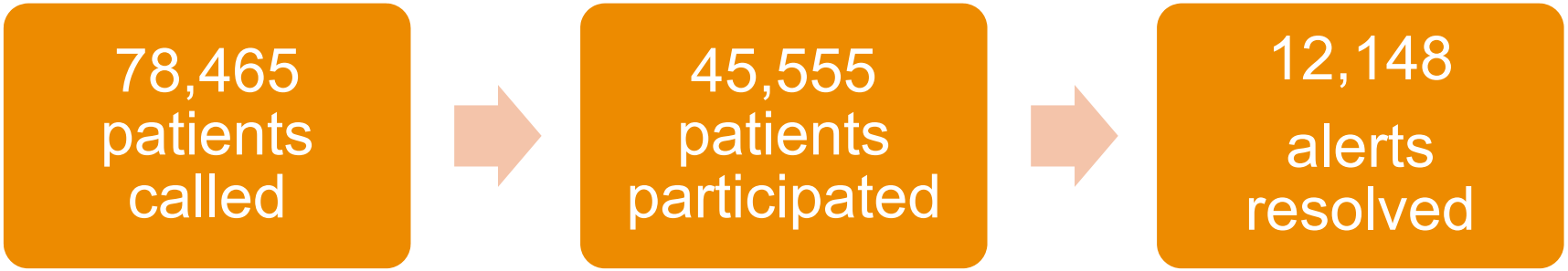
- Do you have any questions about your medications?
- Do you have the information you need to schedule and attend a follow-up visit with your doctor?

If you have any concerns, a nurse will call you back as soon as possible.

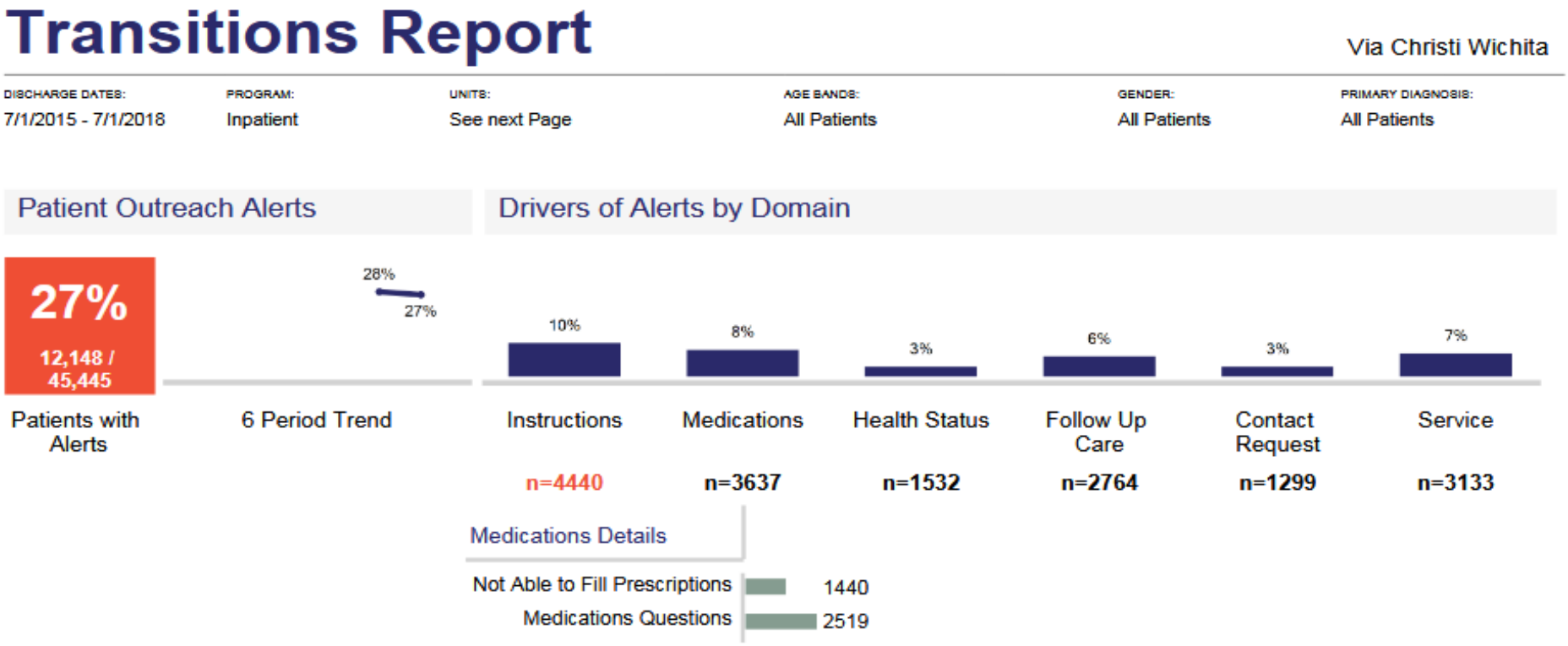
Second call: Within seven to 10 days of discharge, you may also receive a phone call from Professional Research Consultants (PRC) about your hospital stay. This will allow you to express your concerns and let us know whether or not you had a positive experience while in our care.

Thank you for choosing Via Christi. Your feedback can help make sure your needs at home are met and future patients have a positive experience.

NRC Health Connect Transitions 7/1/2015 – 7/1/2018



Connect Transitions Call Alerts



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Ways the Report Information is Leveraged

- Process improvement
  - Example: Peg tube education
- Safety huddles
- Unit-specific feedback
- Recognition tool

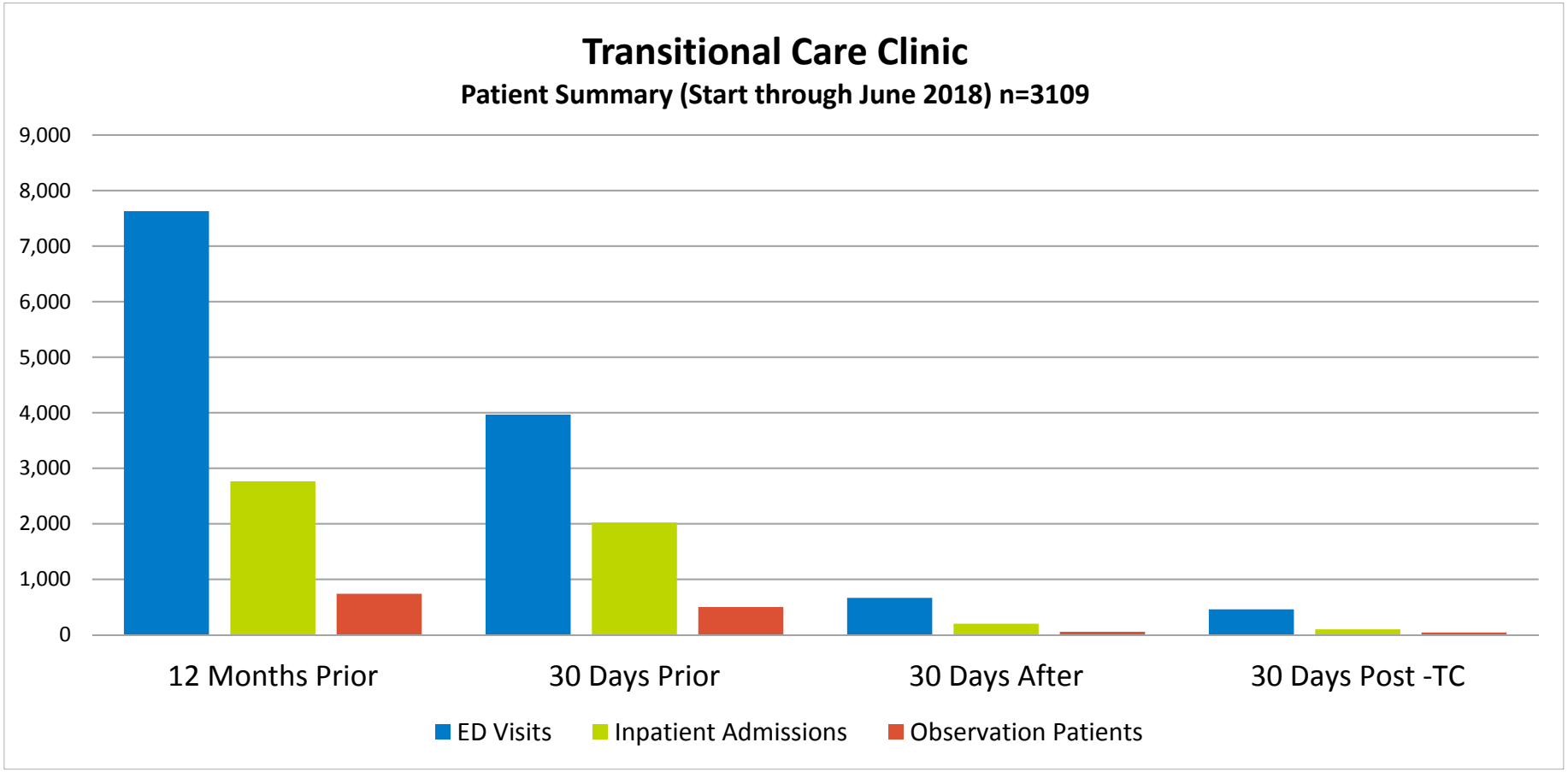
Connect Transitions Call Examples

- #1 – Cannot afford medication
- #2 – Discharge instructions
- #3 – Follow-up care

Transitional Care Clinic

- Unassigned patients discharging from the hospital or ED visit
- Relationship Based Care
  - Teach autonomy
  - Assist with resources
  - Address barriers
    - Socioeconomic
    - Psychosocial

- Establish with a permanent provider for primary care in 30-60 days


Transitional Care Clinic
Patient Summary (Start through June 2018) n=3109
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
12 Months Prior
30 Days Prior
30 Days After
30 Days Post -TC
ED Visits
Inpatient Admissions
Observation Patients

Community Cares

- APRN house-call model
- Caring for patients with advanced COPD and heart failure
  - Collaboration with primary care and specialists
  - 24-hour/7-day coverage
  - Emergency plan
  - Improved quality of life
- Decrease exacerbations
- Palliative care

Seeing Beyond the Bedside

- "Non-compliance"
- Care provided in the clinical setting accounts for merely 20% of our overall health
- The remaining 80% of our health is impacted by behavioral, environmental and socioeconomic factors

Magnan, S. 2017. "Social Determinants of Health 101 for Health Care: Five Plus Five." *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. doi: 10.31478/201710c.

Heart Failure Clinic

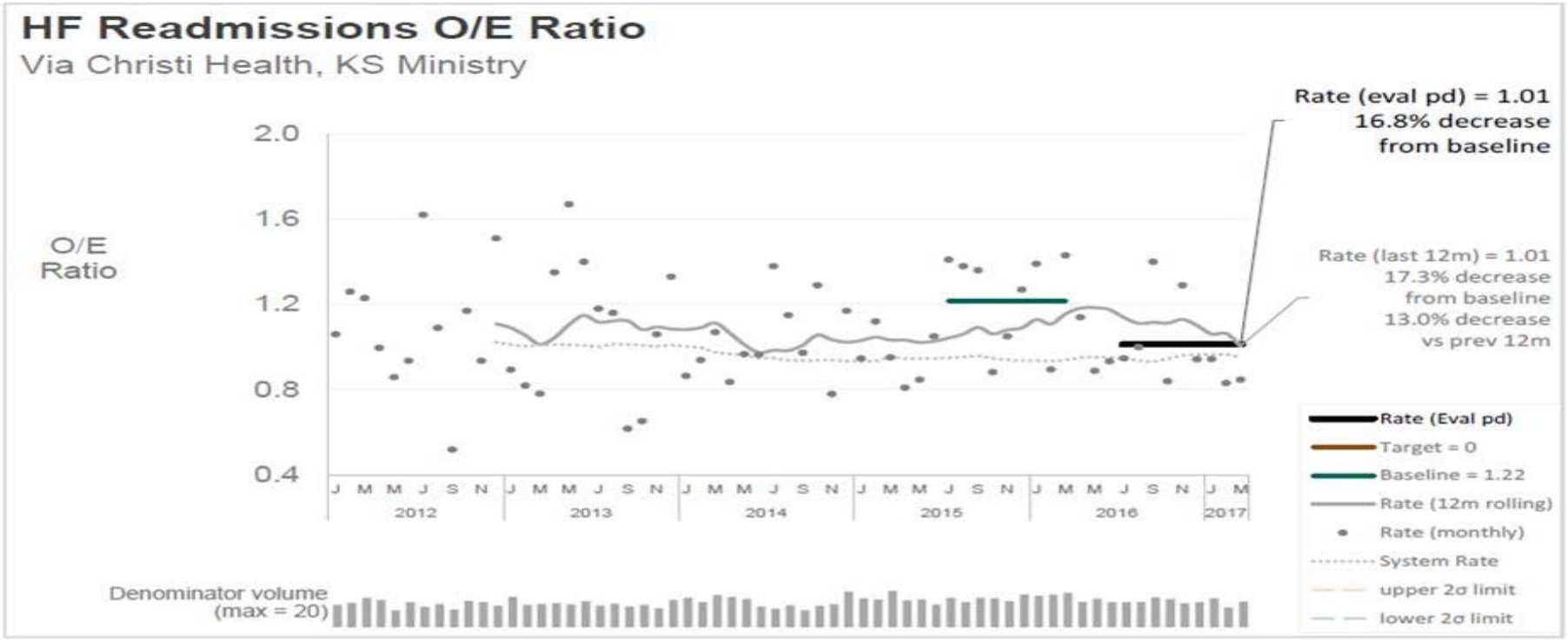
Person–centered care model:

- Disease management education
- Medication management
- Acute crisis intervention
- Readmission reduction

New initiatives:

- Health literacy – video education books
- Patient support group
- Community paramedic

Heart Failure Outcomes FY'17

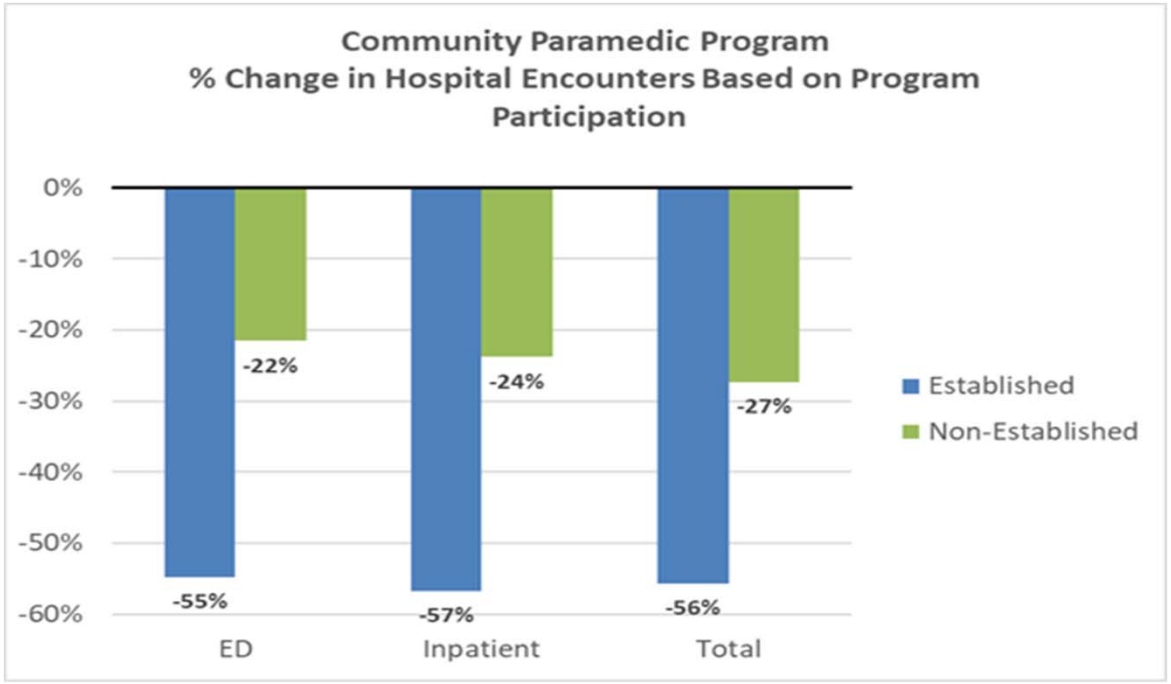


Evaluation period: Jul 16 - Mar 17. The evaluation period performance (1.01) shows a 16.8% decrease from baseline.

FY'18 Community Paramedic Program

- June 2017 – business agreement, Via Christi and Sedgwick Co. EMS
- $80,000 – Ascension grant for one full-time paramedic
- Community paramedic home visit within 72 hours post-discharge following heart-failure hospitalization and follow-up to 30 days

Community Paramedic Data



Our Transitional Gaps Learnings

Operational shortfalls:

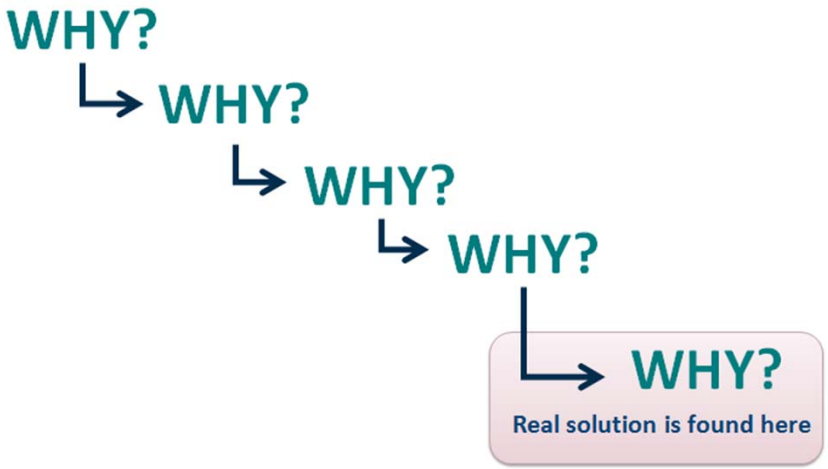
- Poor communication (inpatient to outpatient)
- Patient did not receive or understand discharge instructions
- Medication reconciliation incorrect
- No follow-up appointment

Psychosocial/socioeconomic issues:

- Inability to pay for meds or doctor visits
- Inability to get to appointments
- Low health care literacy
- Behavioral health needs

The 5 Whys Exercise

- Think about a difficult patient-care situation or a patient who has been labeled “non-compliant”.
- Write down some reason you feel this patient has been deemed to be non-compliant.
- Now ask the 5 Why’s to discover the root of WHY the patient has not adhered to the prescribed care plan.
- This can be done as a group exercise.



Actionable Takeaways and Tools

- Caring for patients doesn't stop at discharge.
- Many patients face barriers that are not identified until after discharge.
- Ask "WHY" and organize support to respond.
- Creating a bridge to post-acute resources is imperative to providing quality of care.

→ **Tools gained from today:**
  - → PDF of slides from today/recording
  - → Patient Postcard
  - → Transitions Script
  - → Readmissions Roadmap

Questions?


A JOURNEY OF A THOUSAND MILES
MUST BEGIN WITH A SINGLE STEP.
Quotivee

Upcoming Events

- **Quarterly Best Practice Webinars**
  - Building Patient Resiliency When There Are Changes in Health | January 23, 2019 | 12-1PM EST
- **Pediatric Collaborative**
  - March 5, 2019 | Dayton Children's Hospital I Dayton, OH
- **25rd Annual NRC Health Symposium**
  - August 14-16, 2019 | Save the Date I Nashville, TN

Register today at www.nrchealth.com/events

Contact Us

Webinar Questions/Comments

Dr. Jen Volland
JVolland@NRCHealth.com

General Questions

Info@nrchealth.com (United States)
Info@nrchealth.ca (Canada)

800-388-4264