St. Joseph Health
St. Jude Medical Center

Care Transitions

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Burning Platform: Quality

- Many readmissions can likely be avoided.
- Readmissions often occur because hospitalized patients & their caregivers are not adequately prepared to execute the post-discharge self-care plan & participate in their own care coordination activities, including:
  - adhering to complicated medication regimens
  - arranging for follow-up care from different providers
- Patients & caregivers may also have difficulty in accessing providers for their follow-up needs, due to transportation issues & other social or financial problems.
- This lack of preparation & inadequate follow-up care make patients vulnerable to medication errors, exacerbations of symptoms, & other problems that commonly result in readmissions.

Burning Platform: Cost

- Preventable hospital readmissions cost the U.S. health care system $25 billion yearly
- Unplanned readmission cost Medicare $17.4 billion (2004 data)
- 20% of Medicare patients were readmitted in 30 days of discharge
- Estimated first day savings for reducing avoidable hospital readmissions in Orange County $13,485,154 (Medicare) & $3,066,727 (Medi-Cal)

Evidence-based Practices

- Care Transition Intervention by Eric Coleman
- Project BOOST by Society of Hospital Medicine
- Transitional Care Model by Mary Naylor
- Re-Engineered Discharge (RED) by Boston University Medical Center
- STAAR Initiative by Institute of Healthcare Improvement
- Health Literacy Campaigns like St. Luke's Teach Back & Institute of Healthcare Advancement
- Health Coaching by California HealthCare Foundation

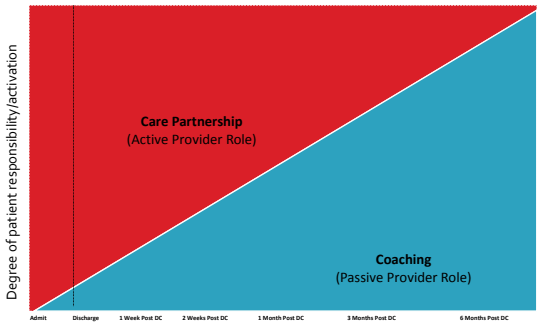
One hospital alone cannot prevent readmissions

It takes a collaborative community effort

Our Mission

- The Care Transitions Department is dedicated to providing a comprehensive program to improve the continuity of care and quality of life for moderate to high risk readmission patients through the post discharge phase (and beyond if indicated) by focusing on optimal therapy, self-care management, multi-disciplinary support and community connectness.

Our Methodology



Department Overview

- Chief Medical Officer
- Director, Patient Populations
- Manager, Care Transitions
  - Discharge Liaison
  - Discharge Follow-up Call RNs
  - Disease Specific RNs (Stroke, Diabetes, HF, COPD)
  - Care Navigators

Discharge Liaison

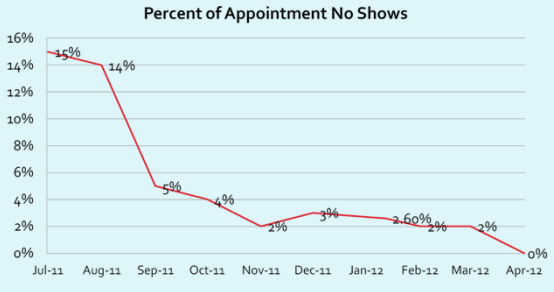
- **What is a Discharge Liaison?**
  - The Discharge Liaison (DL) works to schedule appropriate follow-up appointments prior to the hospital discharge. However, it is not enough to schedule the appointments; efforts are also made to make certain the patient can physically attend the appointment. This entails e-mailing appointments reminders, appointment coordination, transportation applications and/or working with the patient's family members. The DL works closely alongside Case Management and the Care Navigators to receive and make referrals.

Discharge Liaison

- **Services to Patients**:
  - Meets with patient and assesses follow up appointment needs
  - Schedules follow up appointments
  - Assesses for transportation to appointment
  - Uses interpreters as appropriate
  - Provides appointment calendar with location map
  - Electronically sends appointment to patient as requested
  - Other needs as they may present themselves
- **Program Goal:**
  - The goal of the program is to reduce the number of appointment "no shows" and unnecessary hospital readmissions/ED visits for patients.

Discharge Liaison in Action

Outcome Metrics



Discharge Follow-up Phone Call RNs

- **What is a Discharge Follow-up Phone Call RN?**
  - The Discharge Follow-up RN contacts inpatient and observation discharges to the home setting within 24-72 hours of discharge. They discuss follow-up needs (appt., DME, home health) and review medications via teach-back, as well as any additional needs, such as real-time triage and emotional support.

Discharge Follow-up Phone Call RNs

- **Services to Patients**:
  - Medication review and education
  - Discharge plan of care review and education
  - Follow-up
  - Referrals
- **Program Goal:**
  - The goal of the Program is to reduce the number all-cause hospital re-admissions and ED visits within 30 days of hospital discharge.

Discharge Follow-up Phone Call RNs in Action

Disease Specific RNs

- **What are the Disease Management/ Care Transitions RNs?**
  - These RNs are specially trained in Diabetes, Heart Failure/COPD, and Stroke to support the long term needs of patients with those diagnoses. Patients with chronic diseases require ongoing education and support for their conditions. Applied coaching models can successfully support patients and caregivers to adapt to the necessary lifestyle changes associated with their condition.

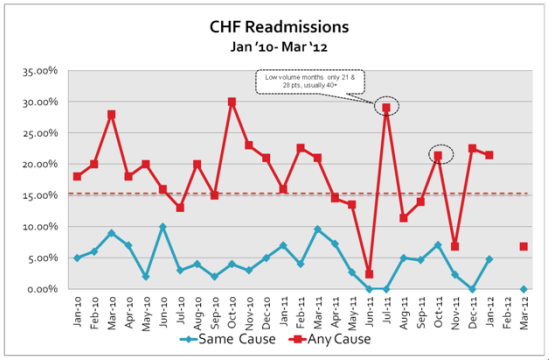
Disease Specific RN

- **Services to Patients**:
  - Disease management through coaching
  - Quality of life assessment
  - Medical therapy/drug evaluation and education
  - Nutritional assessment and education
  - Follow-up
  - Advance planning
- **Program Goal:**
  - The goal of the Program is to reduce the number all-cause hospital re-admissions for program participants within 30 days of hospital discharge and show an improvement in the quality of life via EuroQol-5D.

Disease Specific RNs in Action



Outcome Metrics



Care Navigation

- **What is a Care Navigator?**
  - Care Navigators establish linkage between recently discharged patients from the hospital and community resources/services via regular home visits and telephone contact. They assist the patient in fulfilling their hospital Discharge Plan of Care, doctor's appointments, therapies, as well as other needs the patient may express for 30 to 60 days following discharge.

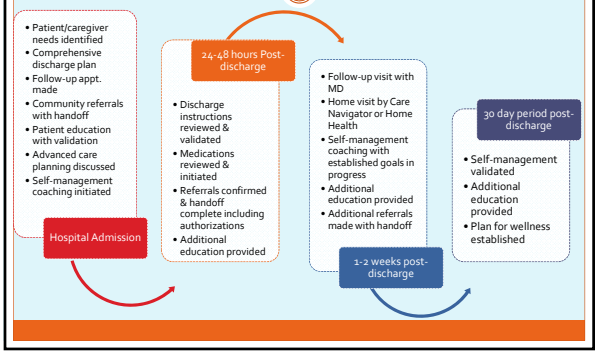
Care Navigation

- **Services to Patients**:
  - Review & follow-up discharge plan
  - Assist with scheduling follow-up appointments
  - Home safety/ fall risk assessment
  - Linkage to community resources/transportation
  - Medication Check/Review
  - Other needs as they may present themselves
- **Program Goal:**
  - The goal of the Care Navigation Program is to reduce the number of unnecessary hospital readmissions/ ED visits for patients.

Care Navigator in Action

Outcome Metrics

Road to Success



The Missing Links

- Patients must have a medical home
- Transitional EMR
- Community collaboration is essential
- Health literacy & learning validation must be addressed
- Mental health issues need close follow-up too
- Advanced decision making should be discussed
- Cultural competence factors into patient/provider relationships

Outcomes to Celebrate

"I've never felt better."

Any Questions?

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