Community-Based Strategies for Reducing Preventable Readmissions

Creative Solutions Beyond the Hospital Walls

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Objectives

- Review History of Care Transitions at AAMC beginning 2011
- Strategies for utilizing post acute care providers to fullest capacity
- Lessons Learned
- Plans for Future Innovation

Who is Anne Arundel Medical Center?

- 380 Bed Acute Care Facility
- 4,000 Employees
- Epic EMR since 2009
- 1,000 Medical Staff Members
- Hospitalist Programs
- Accountable Care Organization
- Health Enterprise Zone: Community Health Centers

Living Healthier Together (2009)

Acknowledges the need to engage and align with the greater community to improve its health

2011: Reducing Readmissions Were Both Quality and Financial Aims for AAMC

- We kicked off with a community summit
- Invited stakeholders: care management, SNFs, home health, Department of Aging, community-based organizations, IT specialists, EMTs
- Community Assessment: many entities of varying scope and ability, nothing to connect the dots
- We began the hard work of forming a network

Our First Team Project: CHF

- Began with one type of advanced complex illness in order to test our network
- Hired a transitional nurse
- Collaborated with cardiology practices, DOA nurse, SNFs, home health, palliative care
- Result: reduced CHF readmissions

Our Post-Acute Provider Strategies

- SNFs and Rehab Centers
- Home Health Agencies
- Community-Based Organizations
- Community Physician Practices
- Families and Caregivers
- Community Health Workers
- Dialysis Centers

SNFs and Rehabs

- Began with a summit – invited ALL to the table, some 25 facilities were represented
- Discussed frustrations and needs
- Began to understand each other's worlds better
- Connected names with faces – reinforced collaboration, accountability

SNFs and Rehabs:

What They Requested

- Transfer summaries that clarify what MUST happen in the SNF's care of the patient
- Medication lists that make sense
- In-hospital contact persons
- Physicians on call who know their patients
- Options other than to call 911
- RN to RN calls during transfers

SNFs and Rehabs
What They Received

- Improved transfer summaries
- Improved medication lists
- Director of Care Management and Chair of Clinical Integration serve as liaisons and problem solvers
- AAMC hospitalists have taken on medical directorship roles at SNFs and rehabs
- Palliative care consults and family meetings at the SNFs and rehabs
- RN to RN handover in real time

Home Health

- Feedback Loop
  - Any patient readmitted within one week after discharge
  - Cause of readmission determined
  - Weekly conference call to review cases with home care agency

Community-Based Organizations

- Developed a portfolio of resources:
  - Department of Aging: social work, transportation
  - 211: wealth of resources for diverse needs
  - Partners in Care: transportation, bartering, enhancing sense of community
  - Friends of Arundel Seniors, others: installation of safety equipment in homes
  - Housing Authority of the City of Annapolis
  - Churches
  - Local EMTs
  - Caregiver Services

Community Physician Practices

- Serendipity:
  - Primary Care Practices: 75% of book of business involves payers providing rewards for reducing unnecessary admissions and readmissions!
  - CMS and other payers now reimbursing transitional care management codes.
  - Outpatient practice notification of admissions and discharges enhances follow-up in the community:
    - CRISP
    - AlecConnect (AAMC's free practice portal for community practices and facilities)

For those patients without a medical home. . . we grew our own.

- Two community health clinics accept all patients.
- Primary care patient-centered medical homes with a team approach: case management and medical interpreters embedded in practice
- Training of staff in cultural proficiency, community resources, conflict resolution

Families and Caregivers:

Our Most Common Post-Acute Providers

- Who is the caregiver?
- What do they need to know about the patient's condition?
- What do they need at home to help manage it and prepare for or avoid the next crisis?
- What obstacles stand in their way?

Families and Caregivers

- SMART discharge protocol
- Bedside interactive learning (iHEAL)
- Transitional care RN: calls and visits
- Simple tools: pill boxes and bathroom scales
- Community resources for transportation, meals, safety

Community Health Workers

- An outgrowth of our ACO care management team
- A “daughter for hire” that is a trusted extension of the primary care practice and well-versed in local community resources
- Eyes and ears to detect barriers to care: unsafe housing, malnutrition, literacy problems, social dysfunction

Dialysis Centers

- Monthly discussions on quality metrics and specifically readmissions
- Includes dialysis tech, nursing, physicians, care management
- Discuss barriers to successful self-management, brainstorm for solutions
- Consider partnering with Social Workers in Dialysis Unit
- Very difficult patient population

Lessons Learned

- Discharge planning must be replaced by care planning across the continuum
- We must partner maximally with community-based resources to address social needs that lead to readmissions
- External partnerships create new opportunities to enhance patient safety and care
- Standardizing documentation and notification processes across the spectrum of care enhances communication and increases the likelihood of reducing readmissions

Future

- Expand palliative care to patients' homes
- Explore creative relationships with EMTs
- Medication Dispensing at Bedside
- Expand collaboration with more SNFs/rehabs
- Mechanisms for sharing transparent data