University & Maryland Charles Regional Medical Center

Coalition/Cross Continuum Team

Deconstructing Silos and Using the Materials to Build Community Bridges

Presented by Mary Hannah RN, BSN, Transition Case Manager



Our Team's History

- Our name: Coalition/Cross Continuum Team
- First meeting commenced on March 15, 2013
- Began due to a recommendation of MHA to start this initiative for readmission reduction
- Meeting (usually) monthly
- Started with 10 members and now at 54 (5 physicians) and continuously growing
- Readmission rates as we began had reached a peak of 10.45% and at present are 8.1%
- Shared the starfish story during our second meeting

The Starfish Story



Original Story by: Loren Eisley

One day a man was walking along the beach when he noticed a boy picking something up and gently throwing it into the ocean.

Approaching the boy, he asked, What are you doing?

- The youth replied, The youth replied, Throwing starfish back into the ocean. The surf is up and the tide is going out. If I don't throw them back, they'll die.
- Son, the man said, don't you realize there are miles and miles of beach and hundreds of starfish? You can't make a difference!

After listening politely, the boy bent down, picked up another starfish,

and threw it back into the surf. Then, smiling at the man, he said

I made a difference for that one.

My Pop Pop (Joseph A. Farrall)

My inspiration and love for geriatrics





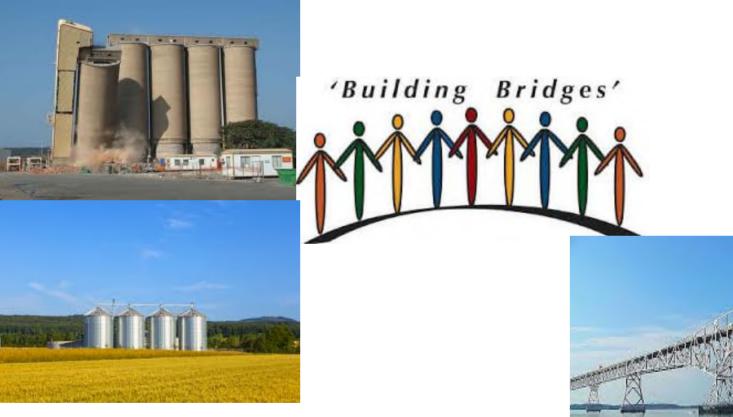


Deconstructing Silos of Care Teams





Building Community Bridges and Promoting Teamwork





Mission and Goal of this Team

- The *mission* behind this coalition is to foster smooth transitions in care from hospital to community to ultimately increase quality of care while decreasing hospital readmissions.
- The **goal** of care coordination is to make sure our community's needs are understood, that a process is in place to develop a plan of action, and that there is good communication between

health care teams.



Benefits of Having this Team

- Powerful alliances
- Team directory in place and growing (started by our third meeting)
- Team meetings are wonderful networking opportunities
- Sharing inspirational stories and case reviews
- Identifying critical topics to address
 - Medication reconciliation
 - Patient handoffs during transfers
 - Community needs for physician follow-up
 - Transportation issues



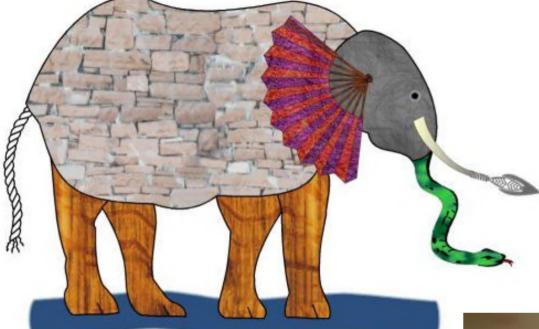
Challenges of Having this Team

- Monthly meetings...usually (weather, scheduling conflicts, and trying different days of the week)
- Coordination of presentations/last minute cancellations
- Keeping the meetings on a positive note
- Setting group goals



- Setting the scene for collaboration and not competition
- Finding "just the right size" and differing perspectives

THE BLIND MEN AND THE ELEPHANT





Survey Given to the Team

- How can we as patient care providers facilitate warm handoffs with transitioning patient care?
- What would you or your organization like to see this group accomplish in the future?
- Have you used the Coalition/Cross Continuum Team directory or contacts made through these meetings, and if yes how many times?
- Please circle below the topics you would be interested in having presented to this group and number them in order of importance starting at 1 for the most important topics.
- a. CRISP/Chesapeake Regional Information System for our Patients
- b. HIPAA rules related to transitions of care
- c. Charity Tracker
- d. MAP/Maryland Access Point
- e. Transportation Resources in this Community
- f.Affordable Care Act- changes to expect

Sample Meeting Agenda

Community Coalition/Cross Continuum Team

April 23, 2014 0930-1100

Nagula #2 Conference Room

Agenda

- Introductions of hospital team and community based providers
- Review UM CRMC internal readmission data and current Readmission Rates at this time
- Share a brief video about patient health literacy and education
- Invite partners to share transition efforts and brief stories on patient education and teach back
- Discuss the MHA Transitions: Handle with Care Project, post project data improvements, and next steps with the NH/ALF Checklist/sticker for transfer packets
- Presentation by Francesca Johnson the Healthcare Solutions Specialist from Sanofi about Diabetic Resources (10:00 AM)
- Education opportunity updates for staff and patients
- Present a case review of a readmission from this month if time allows

(We will be serving a light breakfast)

Presentations We have Shared

- Every meeting we share internally collected readmission data
- CRISP-Chesapeake Regional Information System for our Patients
- HIPAA related to transitions of Care
- Sanofi DM education presentation
- Understanding the roles of ACO, Managed Care Coaches, Medical Homes, and Medical Malls
- Cardiac and Pulmonary Rehab. and Better Breathers Club
- Philips presentation on Lifeline and Medication Distribution Machine

The Woman and the Mechanic... The Patient and the Hospital

- Health literacy
- Fear to admit lack of knowledge
- Readmissions











Spin-off Meetings and Projects

- MHA Communication Project
- Transportation Summit meetings
- ED Coalition of Care
- EPS Inpatient Assistance Program



- Chronic Pain/Behavioral Health Management
- Letter of support for a local clinic to get funds for hiring an NP
- CM huddle presentation from Fenwick Landing on Adult Medical Day Care
- Our DON is offering nursing education set-up for internal staff to all our team partners (sepsis, wound care, informed consent)
- Star Fish of the Month Award

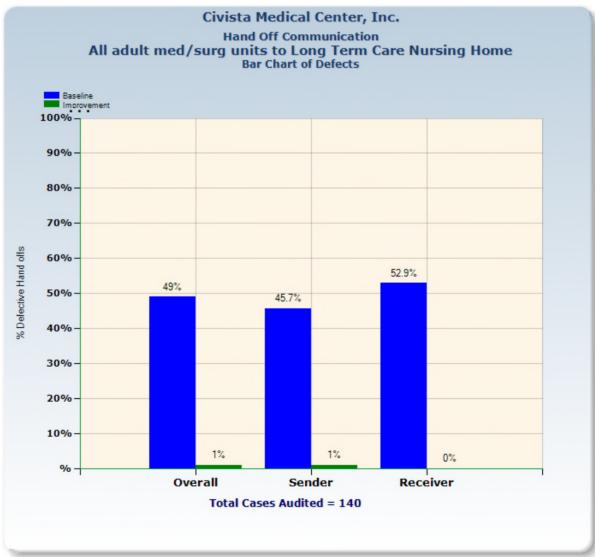
Criteria for Star Fish of the Month Award:

- I. Internal (work at UM CRMC) or external members of the Coalition/Cross Continuum Team
- 2. The member or members that "make a difference" by exemplifying behaviors or actions that go above usual job related activities
- The noted actions behind deserving the award should support our Coalition mission: fostering smooth transitions in care from hospital to community to ultimately increase quality of care while decreasing hospital readmissions
- 4. May receive this award once per calendar year

MHA Transitions: Handle with Care Project

- Identified the need for better transitions of care for the NH/ALF transfers
- Project involved hand-off communication from UM CRMC to CCNRC, Genesis
 La Plata and Genesis Waldorf
- Vulnerable population and critical need for accuracy of medical record and warm hand-offs between staff

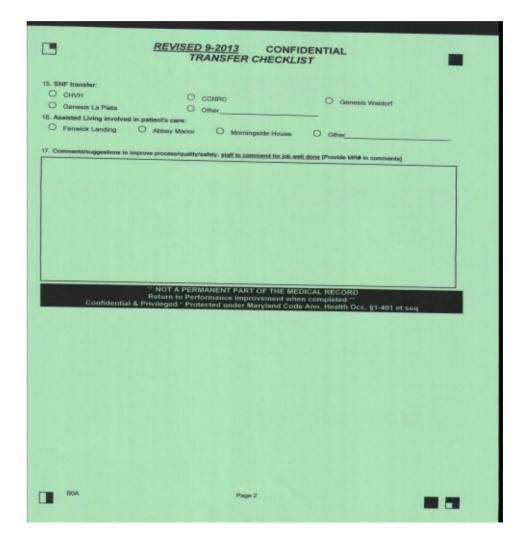
Baseline Data Defect Rates of Communication



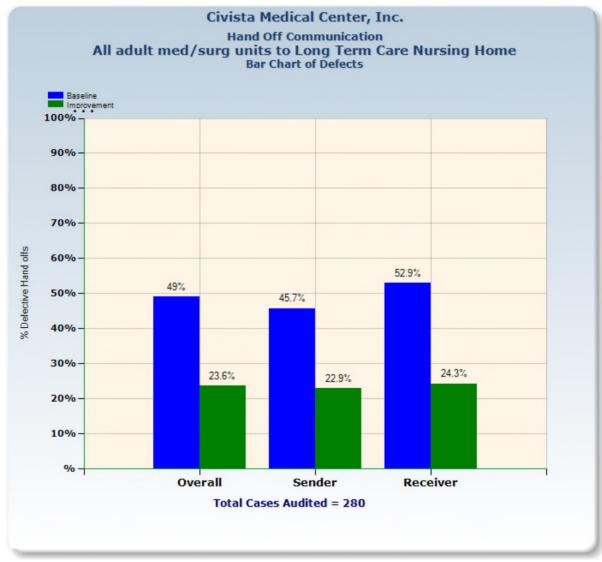
Implemented Checklist for Transfers to NH/SNF/ALF Front of Form

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13. Risk for falls		0.0
14. Risk for readmission		0.0
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Implemented Checklist for Transfers to NH/SNF/ALF Back of Form



Improvements Data Post Project Implementation



Checklist Form Transformed to List Printed on Envelopes

PATIENT NAME:

DESTINATION:

#To call report:

DATE/TIME OF PICK UP:

MODE OF TRANSPORTATION: (circle one)

CAR W/CVAN AMBULANCE OTHER

MUST BE INCLUDED IN THIS PACKET:

- □ NURSING SUMMARY/COPY EKGs
- □ H&P
- □ MOST RECENT TRANSFER SUMMARY
- □ COPY OF DISCHARGE ORDER
- □ MOST RECENT MAR
- □ MEDICATION RECONCILIATION FORM
- □ PCS FORM

INCLUDED IF APPROPRIATE:

- □ ORIGINAL PSYCH CERTS
- □ MA for all Medicaid Patients
- □ CD of Diagnostics
- □ Narcotic RXs for NH/SNF
- □ ALL NEW MED RXs for ALF

Other:

#TO CALL BACK W/ QUESTIONS:

Quotes Shared with our Team

- "When the pace of change outside the organization, exceeds the pace of change inside the organization, the organization will surely fail." Jack Welch Former CEO, GE
- "Be the change that you wish to see in the world" Mahatma Gandhi
- "If you want to go fast...go alone. If you want to go far...go together." —African Proverb
- "They may forget what you said, but they will never forget how you made them feel." Carl W. Buechner
- "I can do things you cannot, you can do things I cannot; together we can do great things."
 — Mother Teresa



My Secret Readmission Tool





The Serenity Prayer

God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.

Quote for today

In the end, we only regret the chances we didn't take, relationship we are afraid to have, and the decisions we waited too long to make.

Case Review #1

• 53 y/o female with Hx. of COPD, tobacco abuse 60-pack year, HTN, anxiety, and chronic migraines. This was her 1st hospitalization this year at UM CRMC, yet has been in multiple other facilities. Patient scored a 5 on the risk for rehospitalization assessment. Patient admitted for PNE and exacerbation of COPD. Social issues: no insurance, transient lifestyle, has a PCP in Ohio. Post discharge patient called by Grace, the discharge coordinator, from MDICS, and patient was stating she felt "worse". Grace then called the Transition Case Manager for a clinical follow-up call. When this TCM spoke to the patient she had only been given a one day supply of her abx. to complete her course. They had originally wrote a rx. For another abx. that patient was unable to afford. Patient had received the community rx. discount card from CM and education on COPD and PNE. This CM recorded all reported symptoms and went and discussed the case with the doctor. The patient was clear that without another abx. she knew she would return to ED. The doctor reviewed the case and wrote a rx. for a 7 day supply of Augmentin. The TCM faxed this to the patient's pharmacy of choice.

Case Review #2

77 y/o male with Hx. CAD, DM, HTN, Prostrate CA, Laryngeal CA and a new neck mass present on his CT. Patient had been to the ED 4 times for 2013 and was admitted once. Patient admitted for tracheal bronchitis and acute respiratory insufficiency. TCM met with patient for discharge planning and education. Patient scored a 4 on the risk for rehospitalization assessment. Patient was set-up with needed DME prior to discharge. Patient was planning to go to GWUH for surgery within 2 weeks of discharge and wanted HHC set-up after that time. Patient socially lives alone and has a son involved in his care and that spoke for his father due to this patient's voice being very low in volume. TCM left a BC with this son prior to his discharge. 2 days post discharge this son called this TCM frantic due to his father was very anxious and felt he needed home oxygen set-up. CM looked at last room air saturation which was 94% on room air. CM able to reach out to LinCare the DME provider preference of the son. An overnight pulse-oximetry test was ordered for that night and home O2 orders were given. The patient agreed to pay out of pocket if he did not qualify for insurance to cover the cost. 2 PA's were both helpful in writing the needed Rxs. from LinCare quickly facilitated the requests of this CM and needs of this patient. He had called both the police and rescue squad prior to the son's call to the TCM. After getting the oxygen he was able to stay home until going to GWUH for his surgery.

Case Review #3

57 y/o female, Hx. CHF, IDDM, depression, MI, HTN, CVA. Patient scored a 9 on the risk for rehospitalization. Readmission 24 days post last discharge for exacerbation of CHF, HTN, DM. Social concerns include: Husband died from brain CA in June 2012. They owned a home which went into foreclosure after she was laid off. Patient has pending MA, receives \$340.00 monthly from FedEx retirement [her husband's benefit], applied for Widow's benefit's through SSI in January 2013, which she should have by April or May 2013. She also receives \$200.00 in food stamps. Pt states she has a vehicle. Pt is a resident of Charles County, no children, no living relatives, and is not connected to a church. Was living with a neighbor, yet on this hospitalization states she can no longer stay with her friend and does not want to live with any one else. Now living in her car and that is where she would be discharged to after her discharge. Case management team determined this to be an unsafe discharge due to cannot manage IDDM and CHF living in a car. Began to call for housing or shelter options. After many calls found housing through Catholic Charities, able to get patient connected with a Baden appt. in La Plata for approx. 2 weeks post discharge date. Provided patient with teaching and a charity glucometer, scale, and BP cuff. Patient is residing in a catholic charities home and is doing well.

Conclusion



- Reducing readmissions and safe transitions takes a whole community effort
- We can use the materials gained from deconstructing silos to build our bridges
- The bridges into our community are the only way to achieve the triple aim of our future healthcare: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. If our aim stays on these goals, our quality of care will increase and readmissions will continue to decrease

