Blount Memorial Hospital Transition of Care Program

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Select Groups of DRGs with Readmission Penalties

- Acute myocardial infarction
- Congestive heart failure
- Pneumonia
- Added in 2014 - Elective hip and joint replacements and COPD exacerbation
- Future additions
  - CVA
  - Diabetes Mellitus
  - Renal Failure
  - Eventually will be applied to all DRG readmissions

Identifying High Risk Patients

- Age
- Multiple Co-morbidities
- Impaired Function
- Deconditioning
- Poor or Lack of Social Support
- Depression or other Mental Health history
- Cognitive Impairment

Implementation of the Transitions of Care Program

- Readmission (TOC) Team
  - Physician Champion
  - Transition Coordinator
  - Health professionals (LPNs) for Home visits/Follow-up calls

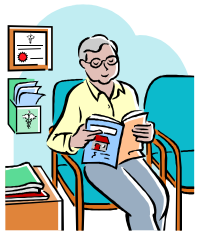
- Multi-disciplinary Care
  - Case Management/Social Work (Discharge Planning)
  - Discharge/Primary Nurse
  - Family
  - Pharmacists (inpatient and outpatient)
  - Home Health Team (RN, SW, Therapists)
  - Physical, Occupational, and Speech Therapists
  - Primary Care Physicians office staff
  - Health Coaches (post discharge)

Pre-Hospital Discharge Education

- Face-to-face contact with patient and family prior to discharge
- Identify resources/services needed at time of discharge
- Opportunity for Pharmacy Role for:
  - Review of discharge meds
  - Education on new meds to include: use, dosage, side effects, costs, drug interactions, monitoring
- Arrangement for Home Services or transfer to Skilled Nursing Facility for rehab and post facility discharge

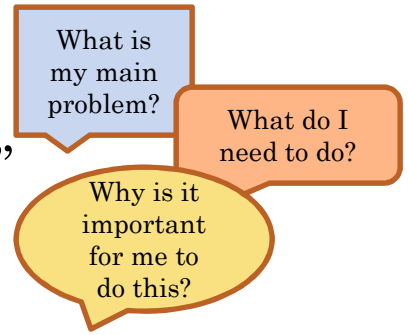
Post-Hospital Discharge Education

- Post- discharge follow-up
  - Follow-up phone call within 24-48 hours following discharge
  - Home visit within 7 days of discharge
    - Home safety
    - Medication adherence and understanding, look for polypharmacy
    - Health literacy – "Ask Me 3", educational handouts
    - Review schedule of F/U appointments, testing,
    - Financial status – poverty level, affordability of treatment and meds
    - Communication between PCP, hospital, patient and other services
    - Transportation to PCP visit, pharmacy, grocery store, etc.



  - Repeat phone call and second home visit the week following PCP visit
  - 30-day follow-up phone call
  - Additional phone calls or visits to be determined at the time of the second home visit or at physician request.

Tips for Avoiding Hospital Readmissions



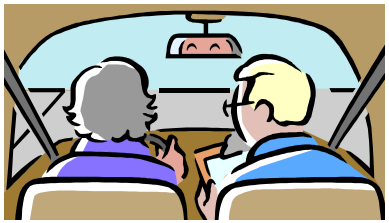
- Ask questions before leaving hospital – "Ask Me 3"
- Take medication as prescribed
- Follow-up with your doctor within 7 days of discharge
- Know what to look for in regards to signs and symptoms
- Make your recovery a **priority** which means taking charge of your health

Challenges in Educating Elderly Patients

- Illiterate about health issues (Hooyman, N.R., & Kiyak, H.A. (2011).
  - Lack of education
  - Cultural/Language barriers
- Physical restraints
  - Visual disturbances
  - Memory retention decreases, short attention spans
  - Loss of independence and decline in function
  - Anxiety
- Environmental influences
  - Poor lighting
  - Small letters
  - Financial restraints

Introducing A Health Coach

- Partnership with Maryville College
- Intensive 3 week course during J-term.
  - Physician and other health care professionals presentations
  - Role playing
- 10 students individually selected from six various departments
- Alternatives to keeping patients healthy and out of the hospital
  - Keeping physician appointments
  - Diet review/Food inventory
  - Vaccinations/Medications
  - Exercise
  - Socialization
  - Driving
  - Companionship
  - Advance Directives
  - Overall taking care of self



Primary Care Health Provider Role

- Transition of Care visit following discharge
- Physician Engagement
- Improved communication between provider and hospital team
- Utilizing local pharmacy and other health related services

Conclusion

- Focus for health care today will help to lower costs, increase quality of care and ensure better health for the elderly patient.
- Cannot be done alone. Must involve health care providers, community, caregivers and most importantly the patient.
- Collaboration amongst health care providers
- Merging toward a patient centered approach to provide safe and effective health care.