Lee Memorial Health System's Comprehensive Care Transitions Program

Summary

Over the last three years, Lee Memorial Health System has built a comprehensive program for care transitions to improve quality and reduce costs, measured at the highest level by the 30-day all cause readmission rates. Data from our partnership in the FHA/FMQIA collaborative "No Place Like Home" now shows that Lee Memorial Hospital and HealthPark Medical Center have reached a 15.9% rate, which is better than both national (18.2%) and Florida (18.9%) rates. Specific readmission reductions for AMI and Heart Failure exceed the first year goal after only six months in this collaborative.

We track and analyze readmission and discharge data, and learn from national best practices. LMHS has revamped services from admission through acute care treatment while also educating and empowering patients. The program combines high tech and high touch, and we have already transferred components to other hospitals, skilled nursing facilities, assisted living facilities, home health agencies and patient homes. We developed an original High Risk Stratification Tool to be used at admission to quickly assess patient risks and set standards for specific care while a patient is hospitalized and when they are discharged. Teach Back education was provided to Nursing and Case Managers system wide and to several home health agencies.

HealthPark Medical Center has been accredited as a CHF Center. They are opening an Observation Unit for diaphoresis and discharge.

At discharge, several pathways for care exist; Telehealth Remote Monitoring, Care Transitions personal coach, or the Interact II supported care at skilled nursing facilities.

Telehealth remote patient monitoring through Lee Memorial Home Health combines technology and high-quality medical attention, providing home medical management. Currently, more than 250 patients utilize remote patient monitors, and more than 6,000 patients have been

monitored since the program launched in 2010. Data shows that the 30-day readmission rate for all telehealth patients is 9 percent. Our success was featured as a best practice by our national technology partner, Honeywell.

LMHS developed Care Transition Nurse "coaches" to meet with patients prior to discharge and then at home with their caregiver to address medical concerns, medication discrepancies, patient condition red flags, safety issues and setting specific personal health goals. (Att. G) Home medication discrepancies dropped from 80% to 5% when the program piloted at HealthPark Medical Center. A binder titled "My Personal Health Record" is provided for documentation and education for patients in the hospital and at home. The 30 day readmission rate for patients enrolled in Care Transitions is now at 6 percent.

Educational handouts for CHF, COPD and Pneumonia have been standardized and are used system wide. A COPD program is in the 3rd month of trial, and of 19 patients (repetitive readmission) only 1 patient was readmitted.

LMHS partnered with skilled nursing facilities and home health agencies to develop a Community Collaborative and Action Plan. Upon discharge, patients return or transition to a skilled nursing facility, assisted living or hospice facility. To improve quality care and reduce readmissions, Lee Memorial Health System adopted the quality improvement program INTERACT II. LMHS staff who are INTERACT certified are training community facilities to use the INTERACT Tools to focus on acute changes in resident conditions. Seventeen area skilled nursing facilities have completed training and meet monthly to discuss process implementation, barriers and education. Since the implementation of INTERACT II, skilled nursing readmissions decreased from 20% to 17.5%. INTERACT III training will be rolled out to area assisted living facilities and home health companies in 2014.

A Stanford University best practice program for Chronic Disease Self-Management was implemented to "train the trainer" of social service agencies to provide 6 weeks of education to

residents, with the goal of improving the overall health of patients with chronic conditions. The program has provided a 20% decrease in costly ED visits, and a 10% decrease in hospital readmissions.

We have implemented two programs that focus on preventing malnutrition in high risk and indigent patients after discharge; the Fresh at Home Meal Delivery Pilot, and a partnership with the Harry Chapin Food Bank to provide food vouchers to area food banks.

The Lee Physician Group, comprised of over 300 primary and specialty care physicians is implementing the medical home model and should be certified soon.

With enthusiastic staff, patient and community support, we continue to expand both the depth and breadth of our system-wide Comprehensive Care Transitions Program.