Utilization of Tools to Avoid Common Pitfalls in Care Coordination

Orange Regional Medical Center Experience

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About ORMC

- 1 of 2 hospitals that make up Greater Hudson Valley Health System
- 353-bed non-profit medical center located in Middletown, NY
- Employs over 2,400 healthcare professionals
- More than 600 physicians on medical staff

The Readmissions Dilemma

- Solving the puzzle is extremely difficult
- Hospitals have been working on it for years
- Involves factors both within and without of the health system's control
- Involves risk adjustment methodology, documentation, coding and much more

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Analysis of Dilemma

- Internal process and data
- Engage community resources and processes
- Created tools and formalized processes

Summary of Action Items

- Coordination and communication across all components of the hospital spectrum
  - ORMC Readmission Prevention Collaborative, community-wide effort involving key stakeholders (hospital, physicians, SNFs, etc.)
  - Refinement, expansion of internal readmission meetings

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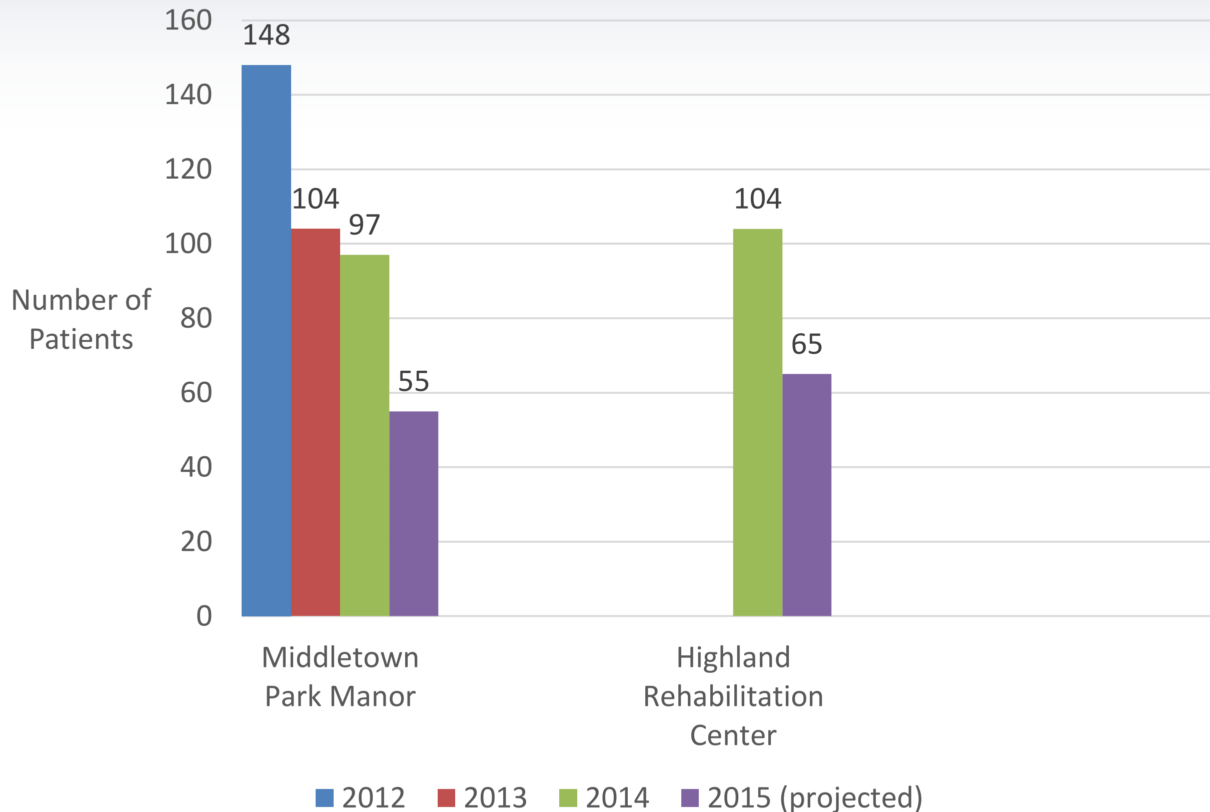
Summary of Action Items

- Development of internal methods and tools
  - ED and SNF communication
  - Daily transitional care meeting
  - Care Coordinators / community liasons
  - Shared access to Epic
  - Education to SNFs
  - Palliative care (advanced directives – eMOLST)
  - Nexus Health service program tool

ORMC SNF Outcomes



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Reassessment and Data Analysis

- Significant improvement with SNFs
- Ongoing improvement with internal workflow process
- Numbers for Medicare penalty not changing
- Engaged Nexus Health as a focused service tool

Using Tools to Ensure Safe Transitions from Facility to Home

Virginia Feldman, M.D.

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Common Points of Breakdown

- Medication
- Transition to primary care physician
- Patient self advocating
  - Recognizing signs and symptoms that are red flags
  - Willingness and ability to call for help
- Psychosocial issues
  - Transportation
  - Support system

Nexus Health Transition Process

- Begins at Admission
  - Appointments scheduled prior to discharge
  - Medication delivery to bedside prior to discharge
  - Clinical Teach Back

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Patient Follow-up Process

- Follow-up begins within the first 24 hours post-discharge and continues through 30-day window
- Patient phone calls
  - 24 hours after discharge
  - Day before and after first physician visit
  - Week 2, 3, 4 after discharge
  - Red Flag: Patient declines visiting nurse service

After Discharge Follow-Up Calls
24 hours post discharge

- Initial focus (24 hr post-discharge)
  - Medication delivery
    - Ensure delivery and DME
    - Eliminate gaps, barriers to receiving meds
  - Transportation
    - Ensure facilitation and follow through
  - Primary care follow-up visit
    - List of questions for PCP
    - Medication list

After Discharge Follow-Up Calls Pre and Post Physician Appointment

Pre Physician Visit

- Reinforce time and location of appointment
- Remind patient to bring medications to appointment
- Remind patients to bring list of questions

Post Physician Visit

- Review care plan
- Reinforce through Clinical Teach Back

After Discharge Follow-Up Calls
Weeks 2,3,4 post discharge

- Continue to follow unresolved issues
- Reinforce appointments if scheduled
- Clinical Teach Back

ORMC Outcomes

Jan – May 2015

Diagnosis	ORMC Rate	Nexus Health Rate	Variance
CHF	25.47%	12.99%	49%
Pneumonia	23.93%	10.96%	54%
All Admits	20.65%	15.88%	30%

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NexusConnexions™

- Response to recognized gap in tools
- Infrastructure present to do the work
- Tool to track tasks
- Scripts provided for phone calls
- Employees clinical and non clinical
- Beta site opportunity