

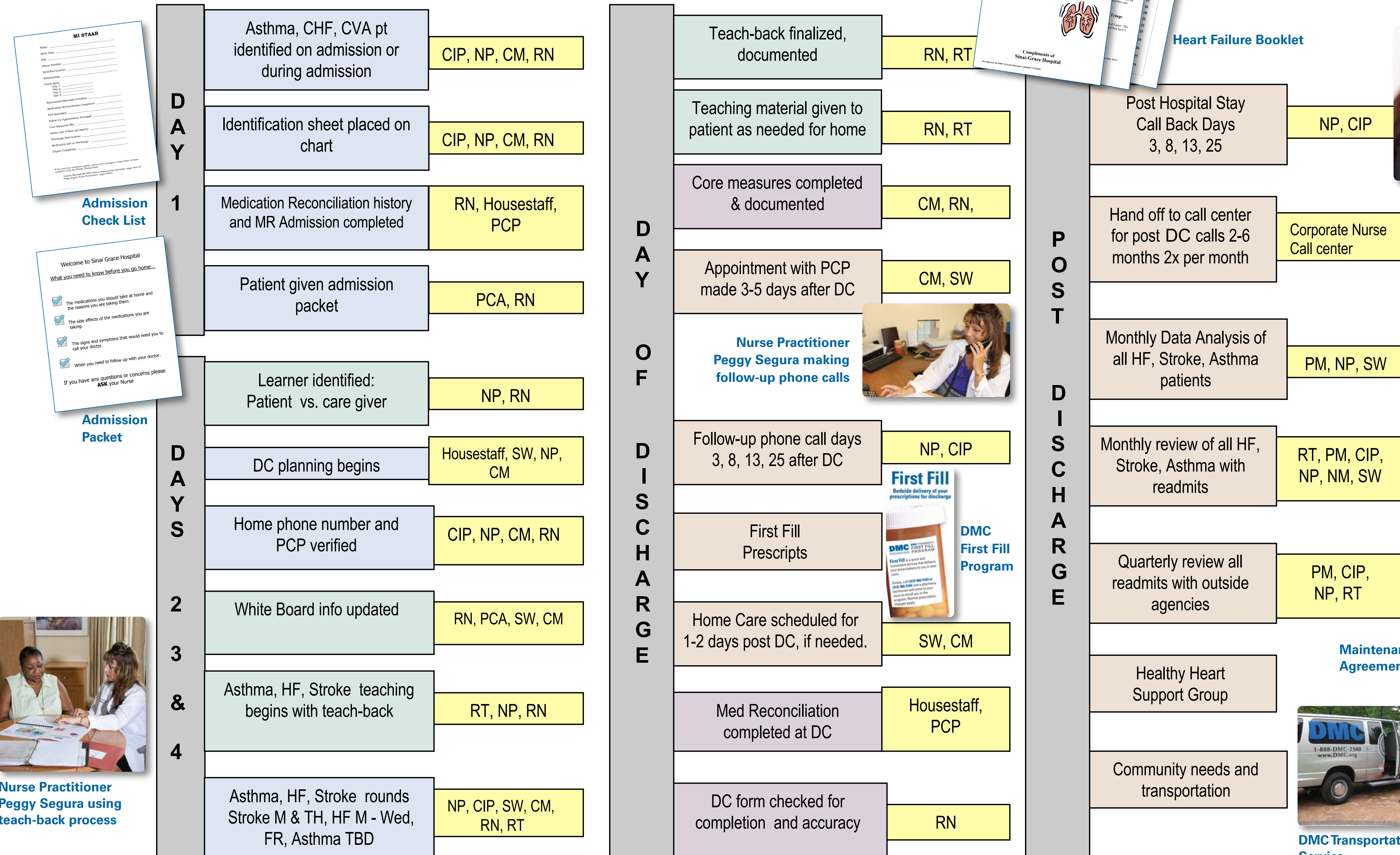


MI STA★AR Collaborative



Project Design

Four pillars to create an ideal transition home



Problem

A national need to reduce avoidable readmissions

Who We Are

- Community-based hospital
- Academic and private practice physicians in 40 specialties
- 8,108 average ED visits/month
- 2,601 average adj. discharges/month

Employees 2240
 Beds 404
 Adult/Peds Patient Days 103,375
 Adult/Peds Discharges 19,560
 Births 1,598
 Emergency Visits 95,134
 Average LOS 5.6
 Ambulatory/ Professional Visits 99,658
 Operating Profit \$14,794,000

Project Aims

- To implement interventions that improve:
 - Self-management of chronic diseases by patient or caregiver
 - Post-discharge follow-up
 - Coordination of care between providers and across the continuum of care by promoting seamless transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable readmission to the hospital
 - Medication reconciliation and management

• Goal is to decrease ALL readmissions by 20% from baseline

• Initial focus on HF patients. Baseline readmission rate for HF= 33.2%; target readmission rate: 20% or 26.57%

Lessons Learned

- New programs need to be embraced from the top
- Phone calls from discharge need to be front loaded in the first week
- Build on what you have
- Use EMR and other technologies to enhance processes

Cross Continuum Team

Conrad Mallett, President, Executive Leader
Katie Flannigan, MS, PA-C Administrative Director Department of Medicine
 MI STA★AR Project Manager
Peggy Segura, FNP-BC Nurse Practitioner Department of Medicine
 MI STA★AR Day-to-Day Leader
Juanita Marshall, RN, LIP Clinical Improvement Specialist
Katrina McCree, MA Community Affairs Director

Paru Patel, Pharm. D Administrative Director, Clinical Effectiveness
 Heather Somand, Pharm. D Manager, Pharmacy
 Joan Valentine, BSN Assoc. V.P., Patient Care Services
 Jennifer Tenorio, MSW Manager, Social Work
 Marcy Gottesman, BSN Clinical Improvement Specialist, Heart Failure
 Mohamed Siddique, M.D. Chief of Medicine

Gregory Berger, M.D. Director, Primary Care Center
 Murtaza Hussain, M.D. Primary Care Community Physician Liaison
 Daniel Taylor, M.D. Associate Vice President, Medical Affairs
 Camelia Arsene, M.D., Ph.D Director, Research
 Craig Bailey, M.D. Resident, Internal Medicine

Cathy Dockery, ADN, BSN, MBA/HCM Vice President, Patient Care Services
 Elmira Nixon, MSN Administrative Director Med Surg
 Pamela Edmond, NP Administrative Director, Telemetry Units
 Venetra Darnell, RN Administrative Director, Med Surg
 Lacinda Luke, BSN Clinical Manager, 4W Telemetry Pilot Unit

Brandye Preyer, BSN Clinical Manager, 3W Telemetry Pilot Unit
 Tshombe Brooks, BSN Clinical Manager, Stroke and Rehabilitation
 Robin Ross, BSN Director, Cardiovascular Services
 Jennifer Unsworth, PA-C Cardiovascular Services
 Emma Lampkin, CNS Nurse Educator, Cardiology

Kim Parker, NP Stroke
 Regina Mailey, MSN CNS Stroke
 Roy Williams, RT Director, Respiratory Therapy
 Sal Morrone, RT Case Manager, Respiratory
 Liz McDowell, RN CNS ICU
 Karen Moore, RT Clinical Information Specialist

Pillar 1

Perform Enhanced Admission Assessment for Post-Hospital Needs

A. Include family caregivers and community providers as full partners in completing standardized assessments, planning discharge, and predicting home-going needs.

B. Reconcile medications upon admission.

C. Initiate a standard plan of care based on the results of the assessment.

Pillar 2

Provide Effective Teaching and Enhanced Learning

A. Identify all learners on admission.

B. Customize the patient education process for patients, family caregivers, and providers in community settings.

C. Use "Teach-Back" daily in the hospital and during follow-up phone calls to assess the patient's and family caregivers' understanding of discharge instructions and ability to perform self-care.

Pillar 3

Conduct Real-Time Patient and Family-Centered Handoff Communication

A. Reconcile medications at discharge.

B. Provide customized, real-time critical information to the next care provider(s).

Pillar 4

Ensure Post-Hospital Care Follow-Up

A. High-risk patients: Prior to discharge, schedule a face-to-face follow-up visit (home care visit, care coordination visit, or physician office visit) to occur within 48 hours after discharge.

B. Moderate-risk patients: Prior to discharge, schedule follow-up phone call within 48 hours and schedule a physician office visit within five days.

