SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

PRIME GRANT: IMPROVING CARE TRANSITIONS

HISTORICAL CONTEXT

- Prior to Affordable Care Act; hospitals were not accountable for the health and well-being of patients upon discharge from the Acute side or the Emergency side of patient care.

- With the ACA came the idea that hospital quality includes post discharge outcomes and the first measure of quality was the number of patients that came back and were readmitted within 30 days.

HISTORICAL CONTEXT

- With the emergence of the population health movement and the push to reduce hospital stays and utilization in general, hospitals can not longer afford to take the short view of patient care.

- The future of healthcare involves both the provision of care in the hospital but also the coordination of care once the patient leaves our setting.

HISTORICAL CONTEXT

- Hospitals become stewards of the life long journey of health and well-being for their community members and through innovation and collaboration, become partially responsible for the health of the community they serve.
- Since this is a new concept hospitals are receiving funding, through grants for innovative ways to make the transition to population health as a strategic goal.

WHAT IS THE PRIME GRANT?

- Funded by CMS and administered by CDPH; grants to tertiary care, county and district hospitals to fund innovation and evidence based strategies for healthcare delivery.
- Funded over 5 years to transform an aspect of care delivery.
- Focus of SVH grant: Improving Care Transitions
- Expectation: transform healthcare through innovation, must be stretch

DUAL FOCUS

- Inpatient to next provider: managing patients for at least 30 days to reduce the likelihood of readmissions
- ED patient to next provider: manage at risk patients with the primary care provider to reduce ED utilization

WHY CARE TRANSITIONS?

- Opportunity to improve:

1. Handoffs between providers;

2. Manage transition over a 45 day period post hospitalization;

3. Improve medication reconciliation on admission, at discharge and within 30 days post discharge;

WHY CARE TRANSITIONS?

- Opportunity to:

4. Develop a community health coaching role;

5. Improve the patient experience during transitions of care; and

6. Build network of community support agencies.

GRANT POPULATION?

- Medi-Cal patients are primary, ages 18-65+
- Will also include Medicare patients as our census is low and it makes sense
- Departments: IP, ED, Skilled Nursing and Healing at Home

HOW?

- Multidisciplinary Steering Committee for oversight

Current Members: Drs Robert Cohen & Ellen Barnett, Chris Kutza, Steven Lewis, Allison Evanson, Peggy Zuniga, Barbara Lee, Alison Kelly (Community Health Coach); Kathryn Crouch ad hoc (Ceres Project)

Needed: SVH Community Case Manager, community member, SCCHC rep, La Luz rep and sub committee project participants. Meritage ad hoc?.

WHAT ARE WE GOING TO DO?

- Revise and improve the discharge process:

1. Improve med rec and discharge instructions

2. Provide a transfer record to patient and next provider at time of discharge

3. Follow up phone calls with in 48 hours of discharge to review discharge instructions, confirm med pick up and prepare for follow up appointment with PCP.

WHAT ARE WE GOING TO DO?

- 4. Follow up phone calls and/or home visit by Community Health Coach and/or CM/Social Worker every 7 days through 45 days post discharge with interface to PCP as needed.

- 5. Build a cadre of volunteer Community Health Coaches. Collaborate with colleges, schools and community organizations to develop roles, map workflows, develop core competencies and training.

HOW DO WE MEASURE SUCCESS?

- Initially by achieving infrastructure goals that are due to be completed and implemented by June 30, 2017

<u>Infrastructure goals</u>:

Expand Case Management Into ED/Community

Build Midas Community Case Management module for tracking and data management

Build ability to track and document medication reconciliation within 30 days of discharge

Build transitional record with all elements

Integration of Community Health Coaches into program

HOW DO WE MEASURE SUCCESS?

- Pay For Performance begins last half of 2017

Metrics:

Medication Reconciliation and completed discharge instructions at time of discharge;

Medication reconciliation within 30 days of discharge;

Patient leaves with a transition record and the transition record is provided to the PCP;

HOW DO WE MEASURE SUCCESS?

Performance on the three Care Transitions questions from HCAHPS;

30 day all cause readmission rate; and

ED Utilization Rate.

The metrics above are all defined by the grant. We may want to add some metrics for out own program performance improvement as continuous improvement is a big piece of this project.