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GroupHealth

MacColl Center for Health Care Innovation

Redesign of the Hospital Discharge: Patient-Centered Care to Improve Safety, Cost and Outcomes

Moderator:

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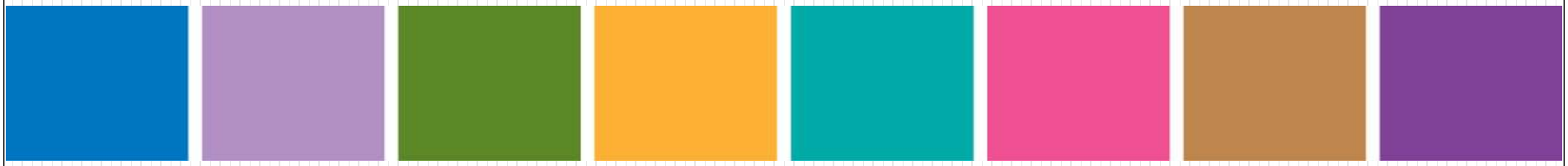
Speaker:

Kelly McGrath, MD, Chief Medical Officer, Clearwater Valley Hospital and Clinics



Transitions and Patient Centered Care :

Patient-Centered Care to Improve Safety, Cost and Outcomes

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Clearwater Valley Hospital & Clinics

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CVHC

- 23 Bed Critical Access Hospital with 3 associated rural health clinics in Clearwater and Idaho Counties
- Patient-Centered Medical Home
- 8 Family Medicine Physicians, 3 Physicians Assistants, 1 General Surgeon and 4 ED physicians
- CVHC serves 15,000 Patients in an area greater than the state of Delaware
- Population density is 4 people / square mile (rural designation is 100 / square mile)
- Only Emergency Department along 240 miles of Highway 12

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Population Challenges

Compared with the rest of Idaho, this population is:

- *Older*
- *Significantly lower per capita income*
- *Lower levels of education*

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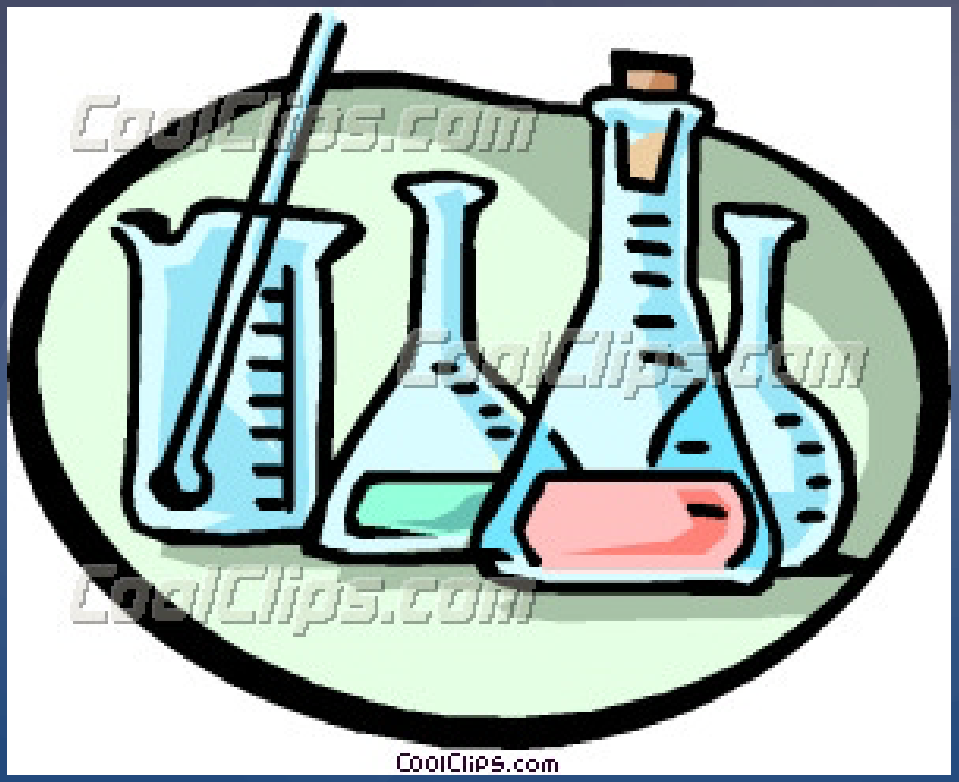
Perfect Laboratory For Health Care :



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Patient Centered Medical Home

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Three-Part Aim:

- Improve the health of the population
- Enhance the patient experience of care (quality, access & reliability)
- Reduce or control cost of care

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Why Focus on Hospital Discharge?:

- Care transition = high risk to patients
- AHRQ "top ten" safety step for hospitals
- Critical events & patient safety
- Highest risk/cost population
- Opportunity to leverage PCMH advantages to improve high risk population health

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Healthcare Cost Inequality

22% US
Health Care
$Costs $

1%
US Population

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Safer Transitions:
The Journey

Project Team

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Project Goals

- Improve Safety / outcomes around Hospital Discharge
- Reduce 30, 60 & 90 day Hospital Readmission Rates
- Reduce 30 Day ED Utilization
- Reduce Net Healthcare Costs in Our Patient Population
- Improve Patient Experience through PCMH & VNS
- Quantitatively Measure Project Outcomes to Assess Effectiveness

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Strategy / Methods

- Reduce Errors in Discharge Process
- Educate patient to recognize problems / understand plan of care
- Frequent contact with patient post discharge to correct errors and alter treatment plan as needed

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Strategy / Methods

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5 Degree Error

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10 Degree Error

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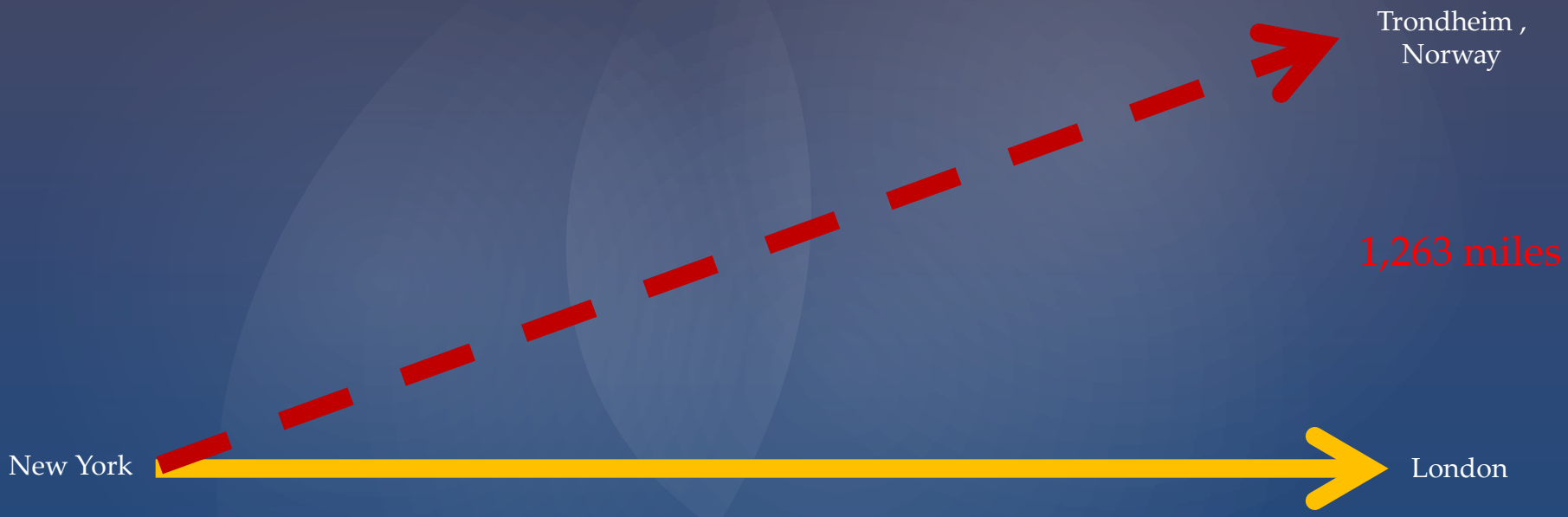
20 Degree Error



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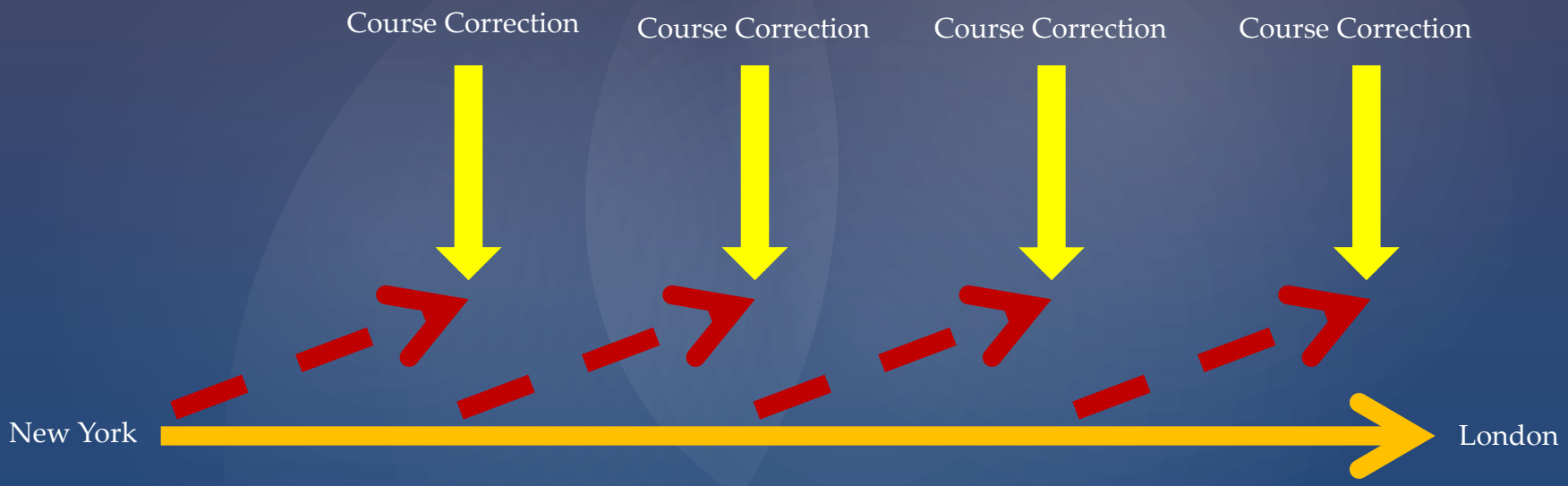
20 Degree Error with Corrections



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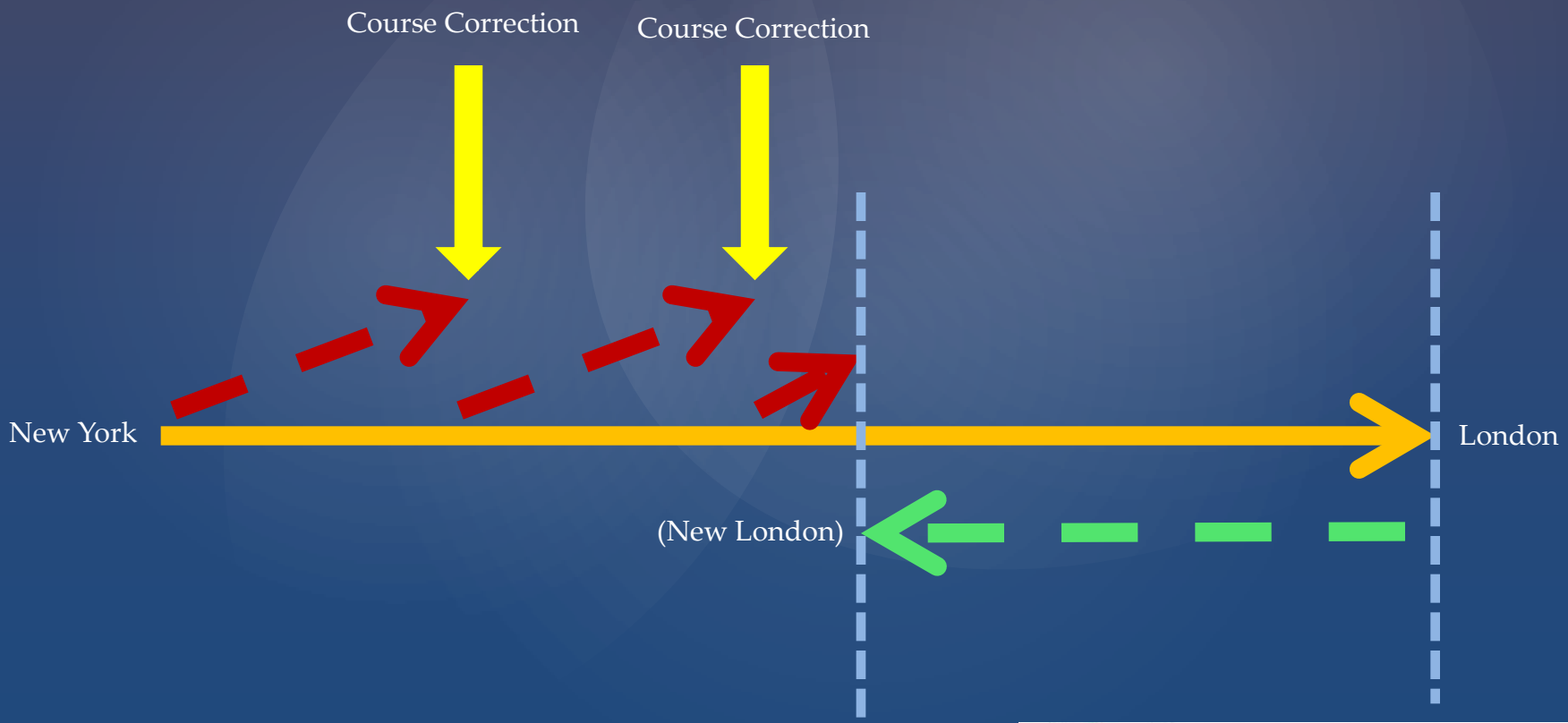
Shorten the distance



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PROJECT BASELINE DATA

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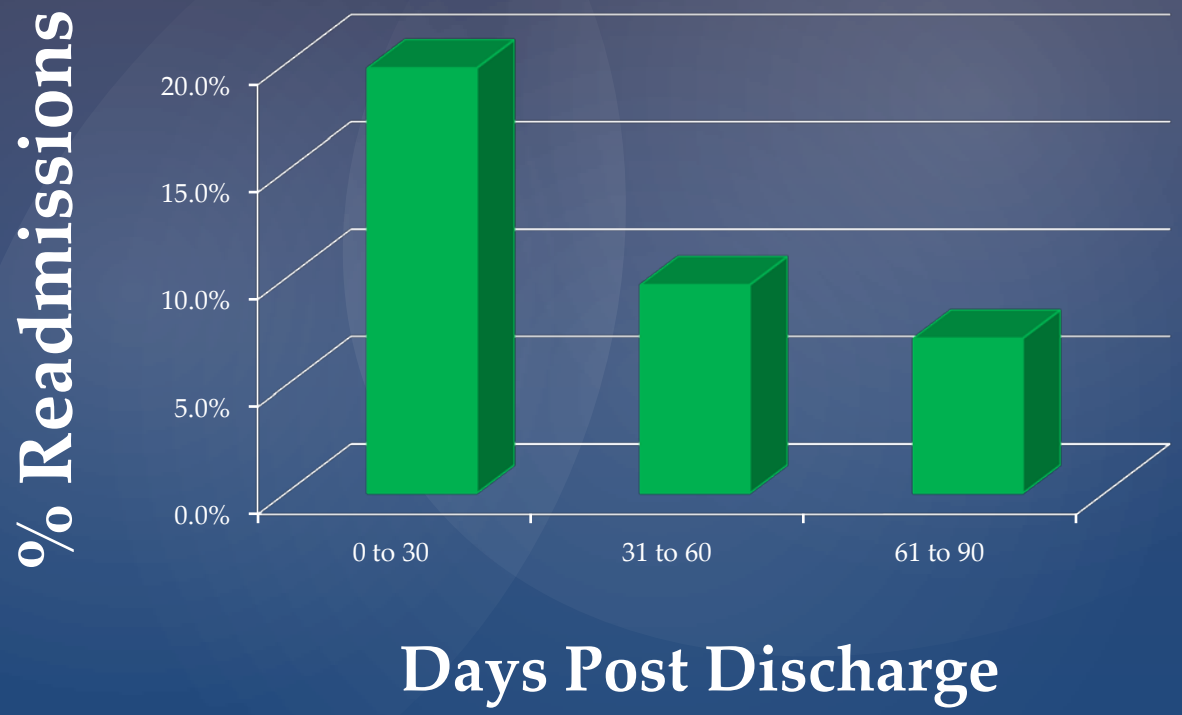
CVH Readmission Rates



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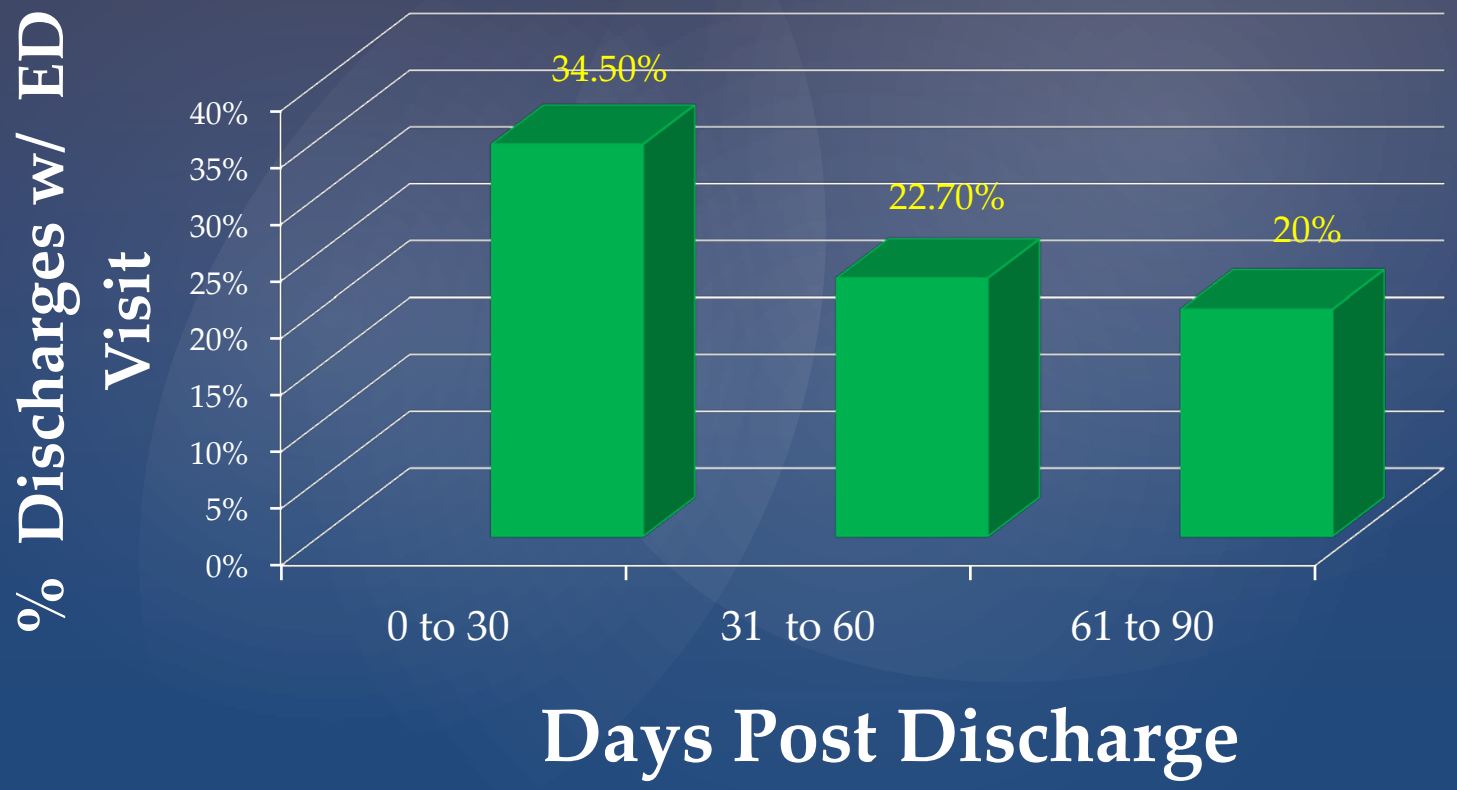
Risk of ED Visit After Discharge



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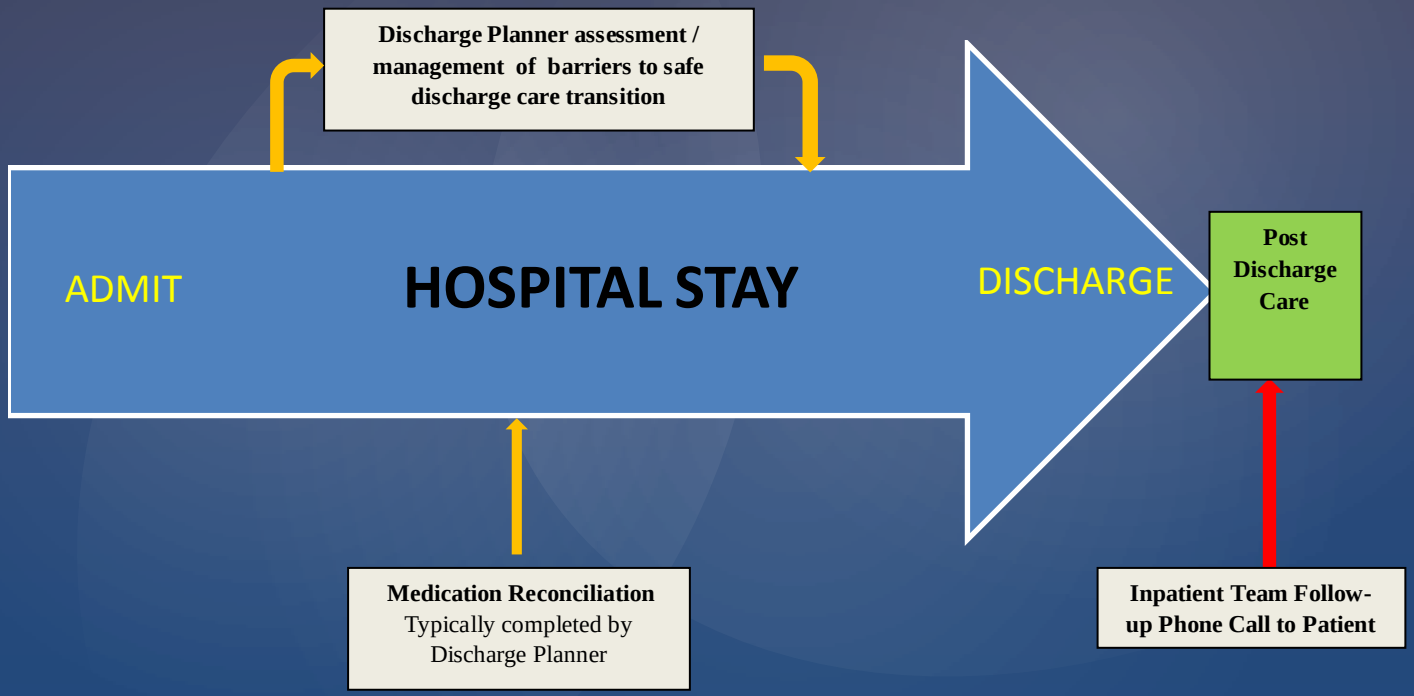
Discharge Redesign Methods

Status Quo at Project Start



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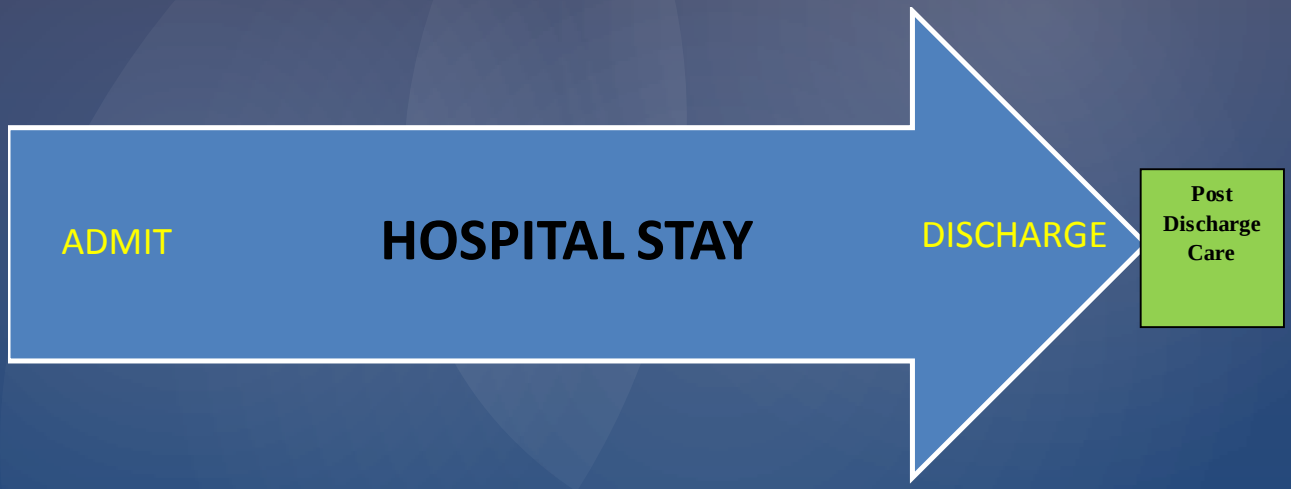
Hospital Admission



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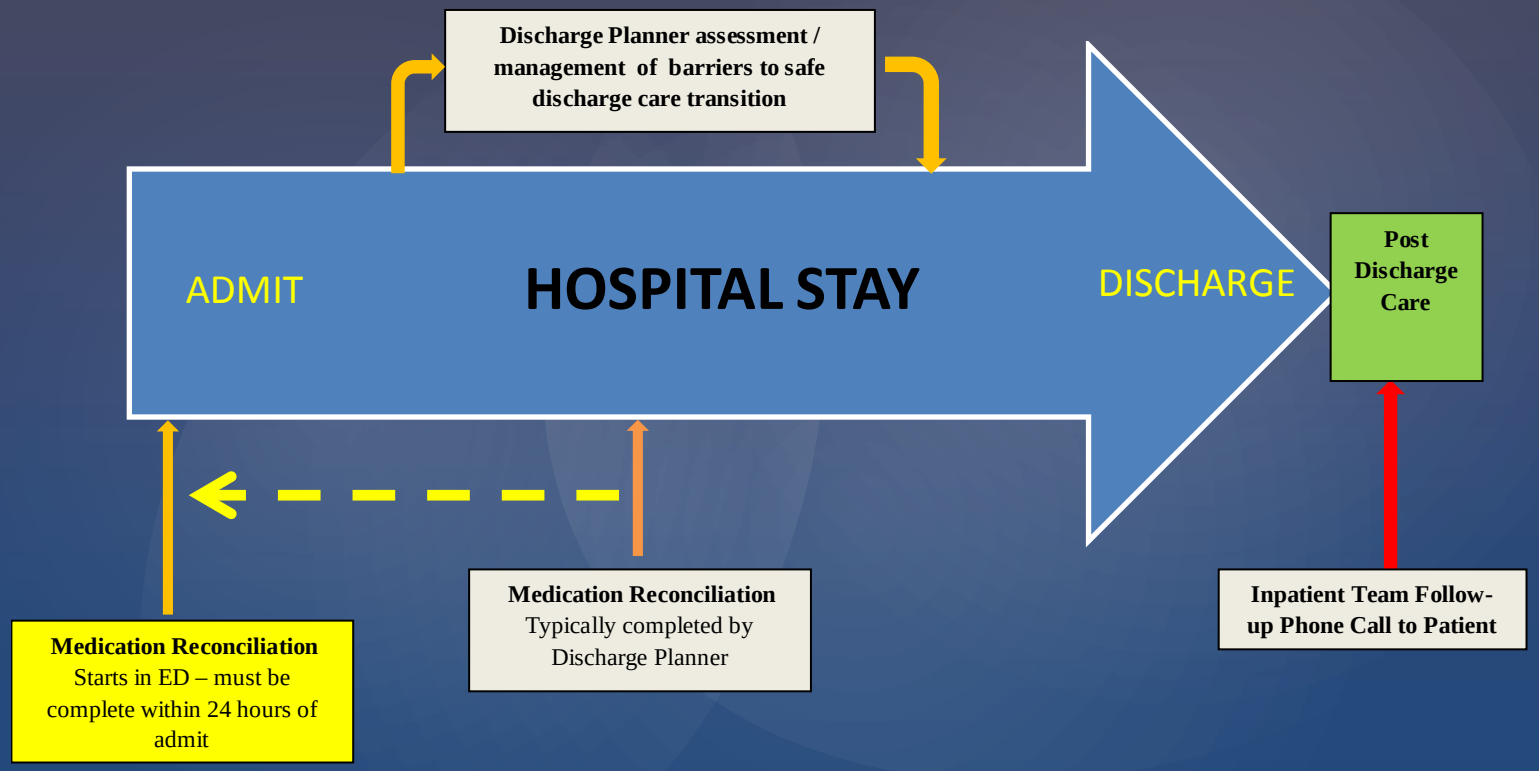
Medication Reconciliation



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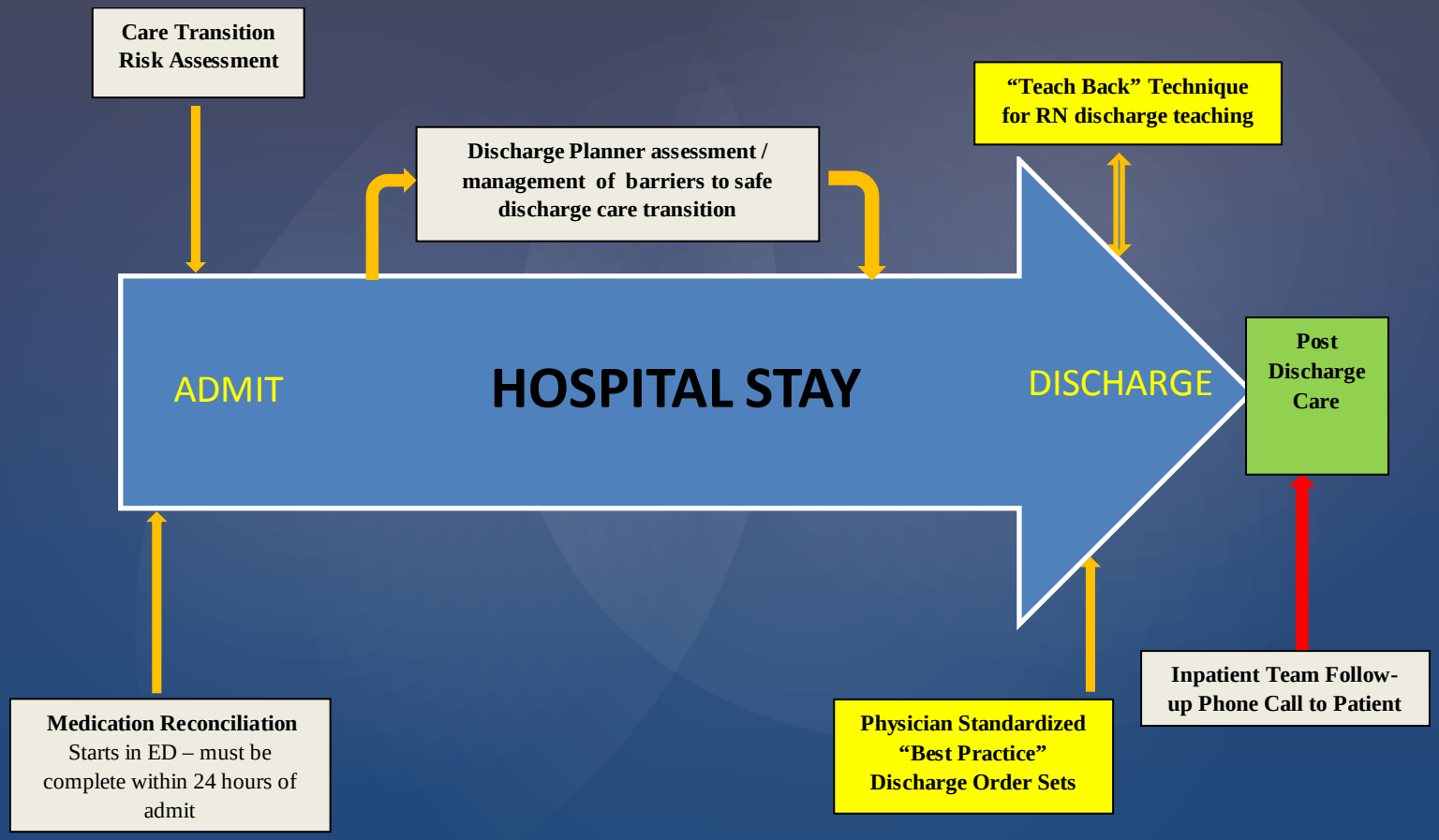
Teach Back / MD Orders



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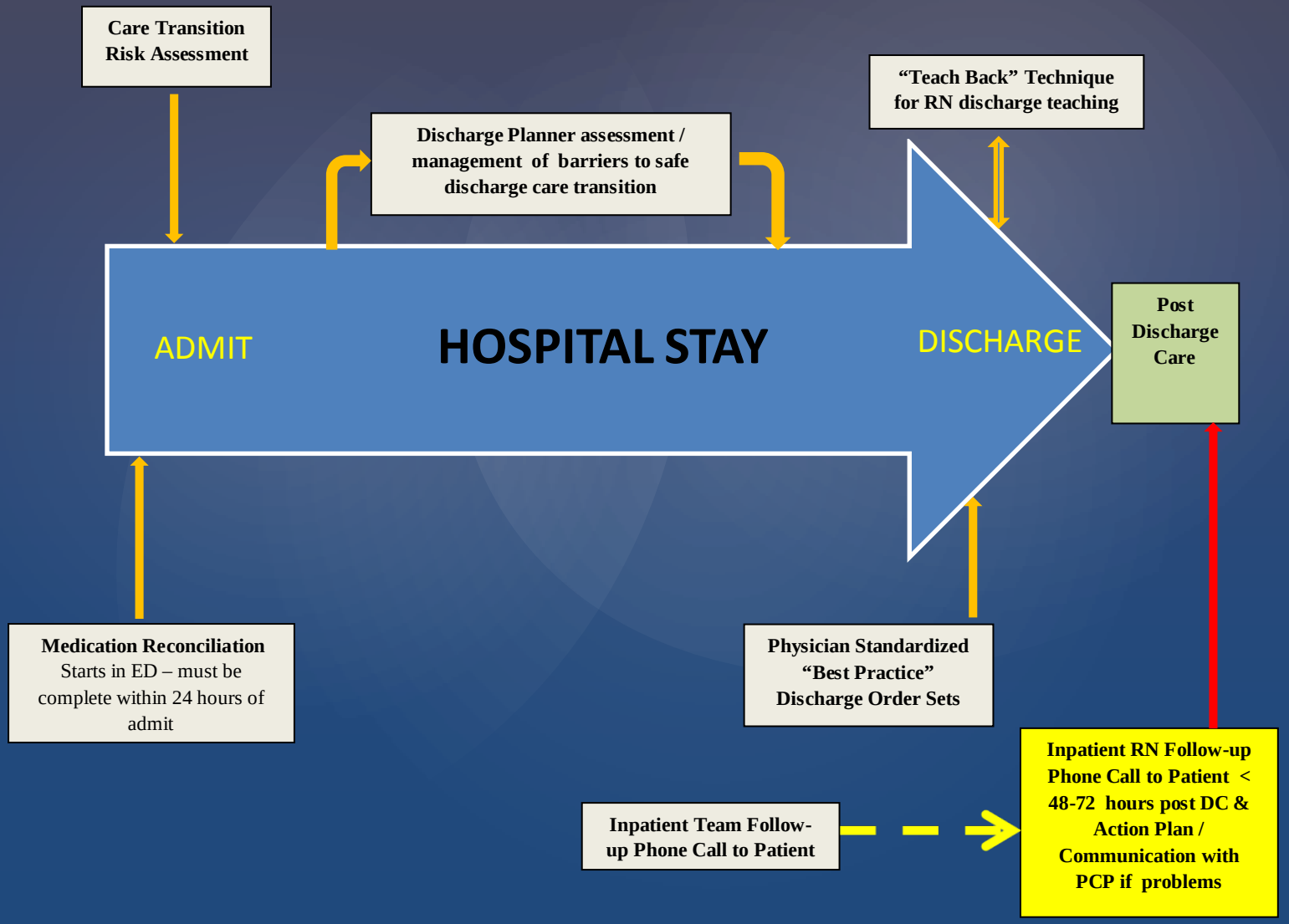
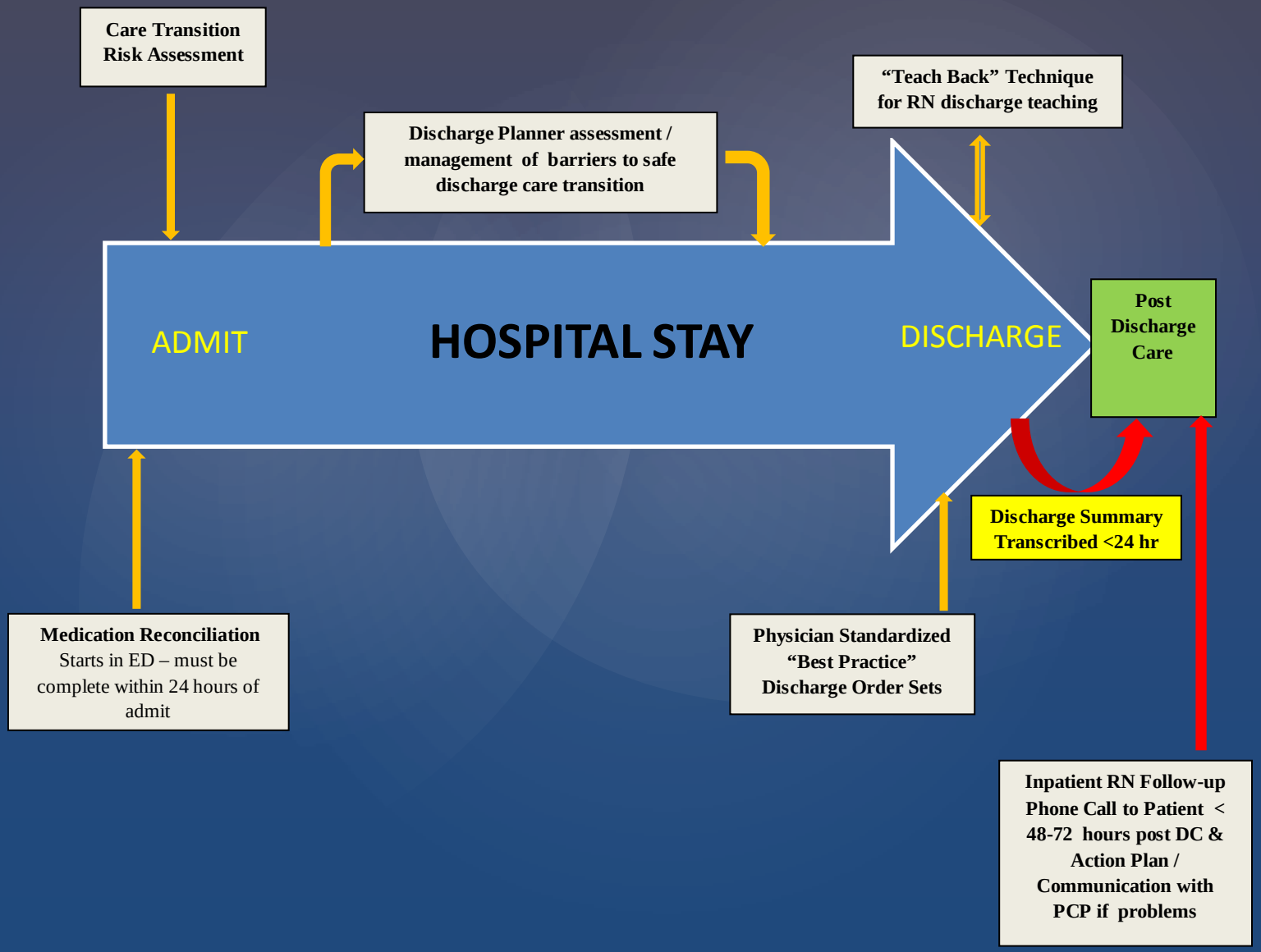
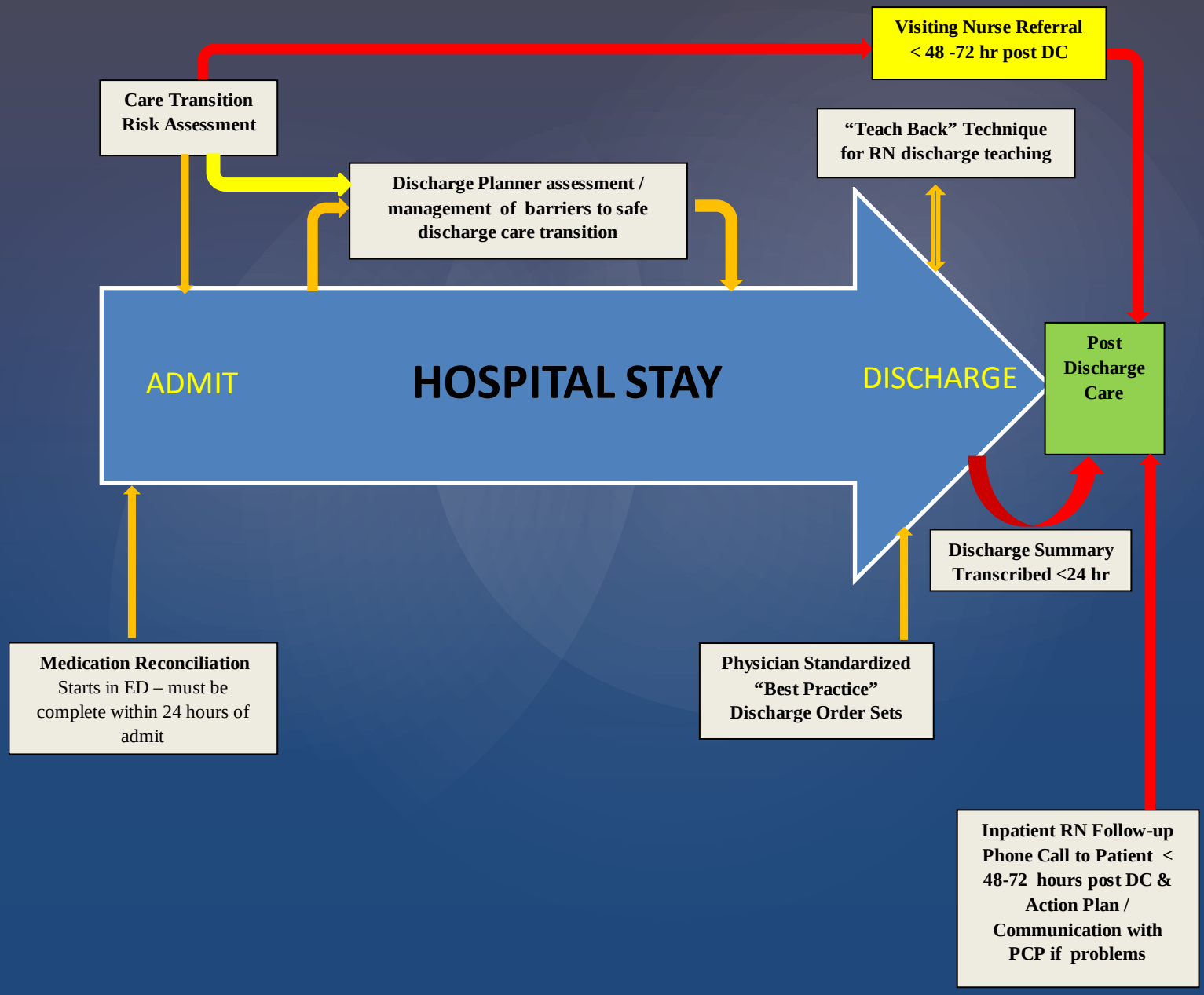
Improve Follow up Calls



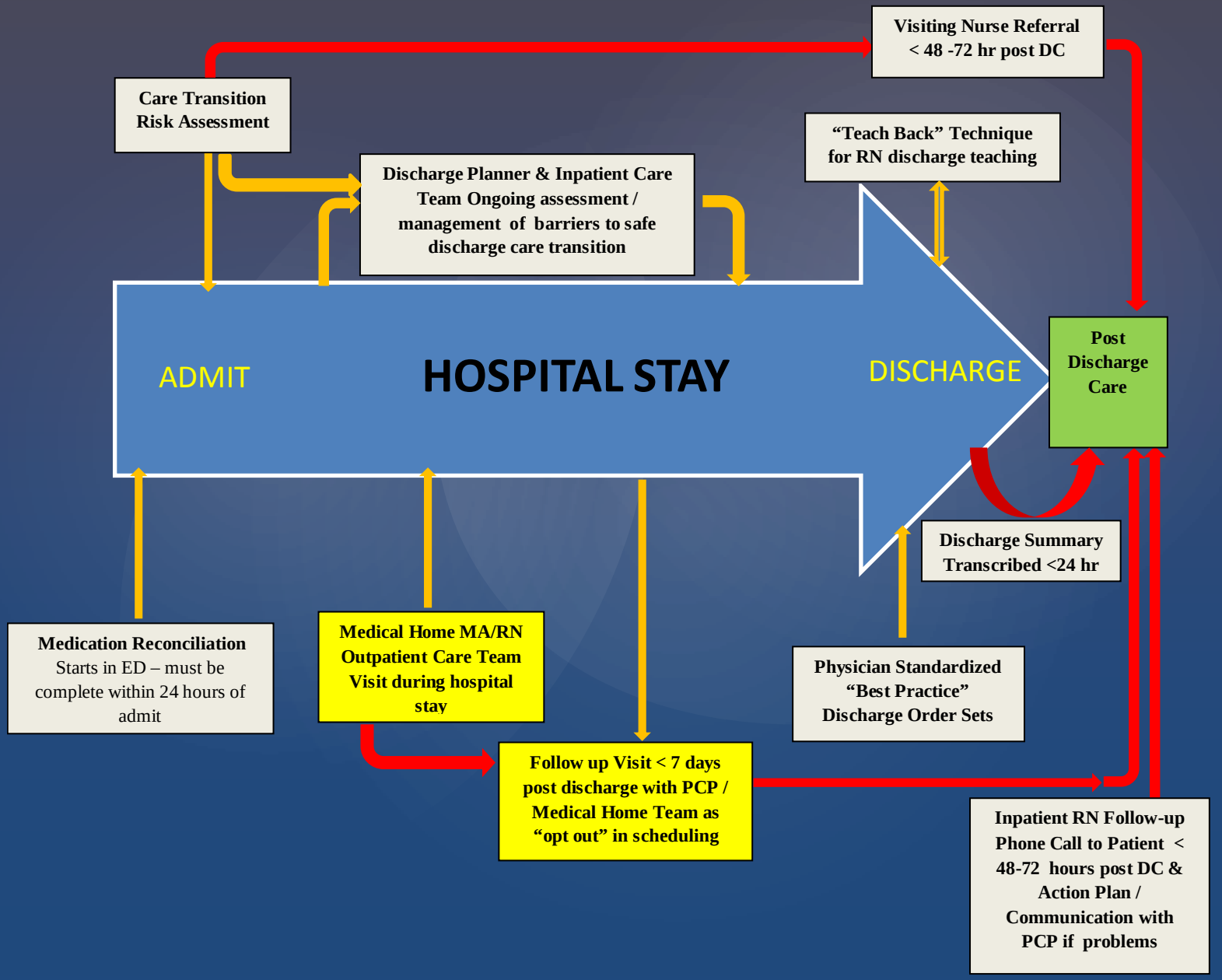
Improved Transcription Times



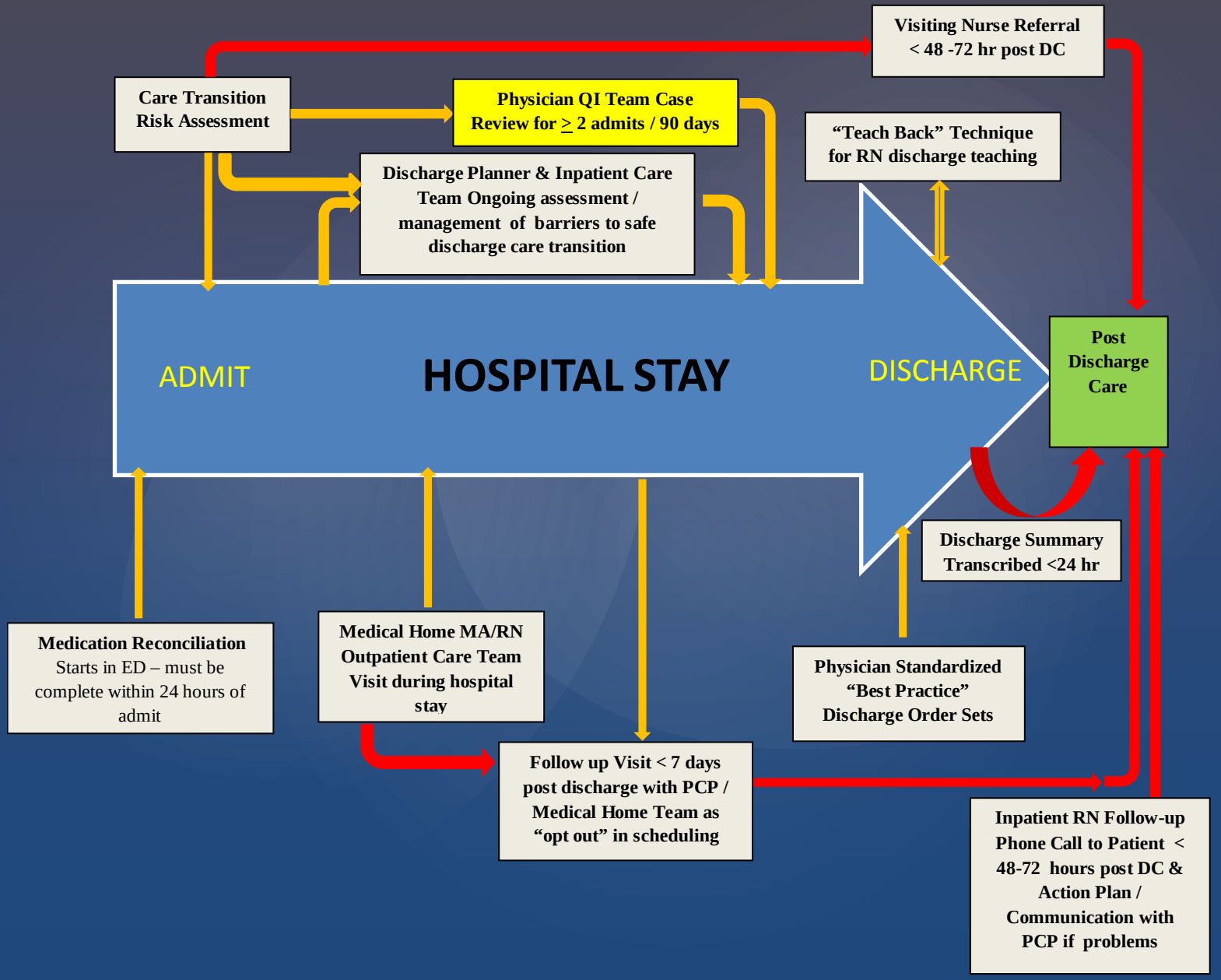
VNS "opt out" Referral



Patient Centered Medical Home



High Risk Case Review



Outcome Data

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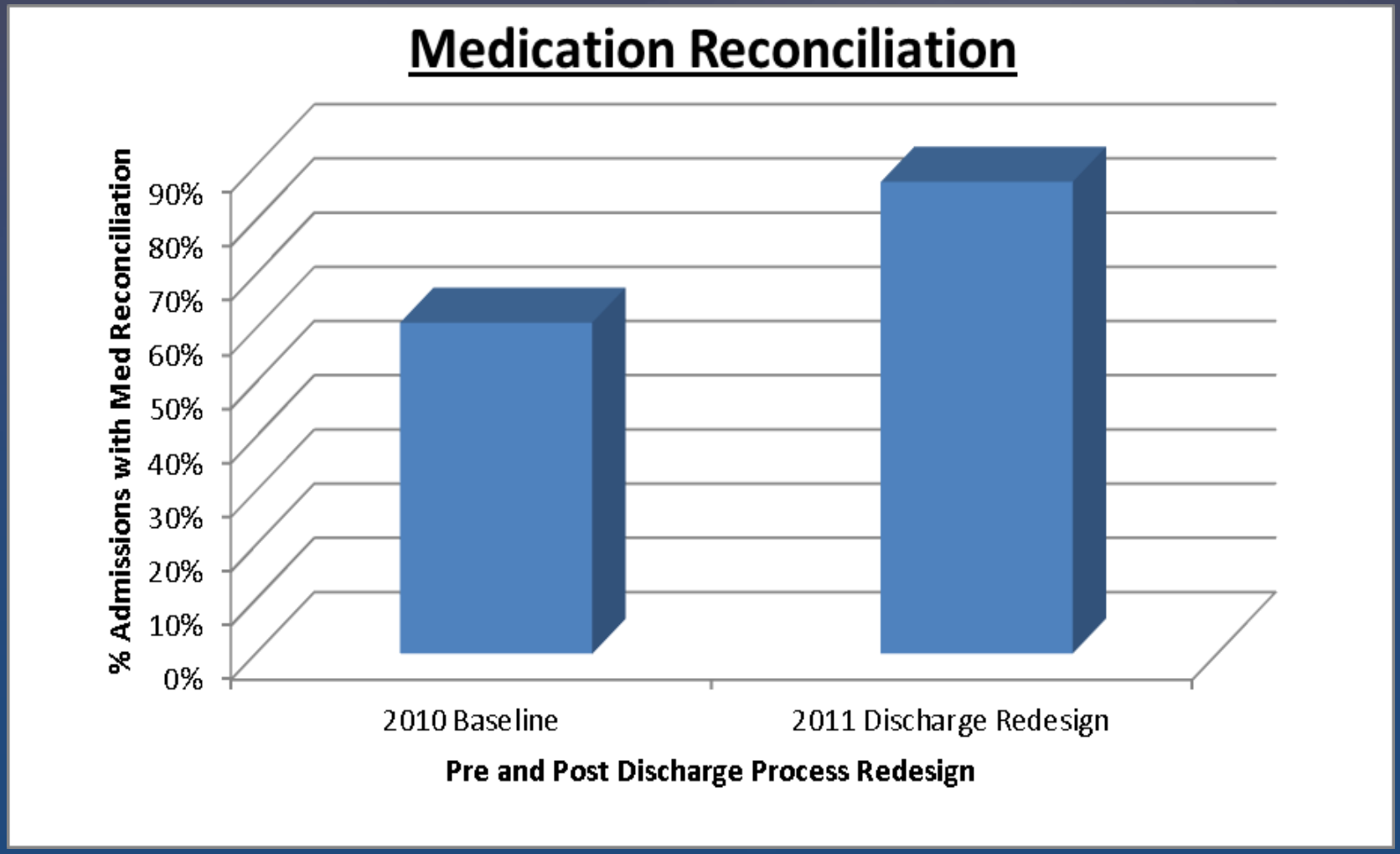
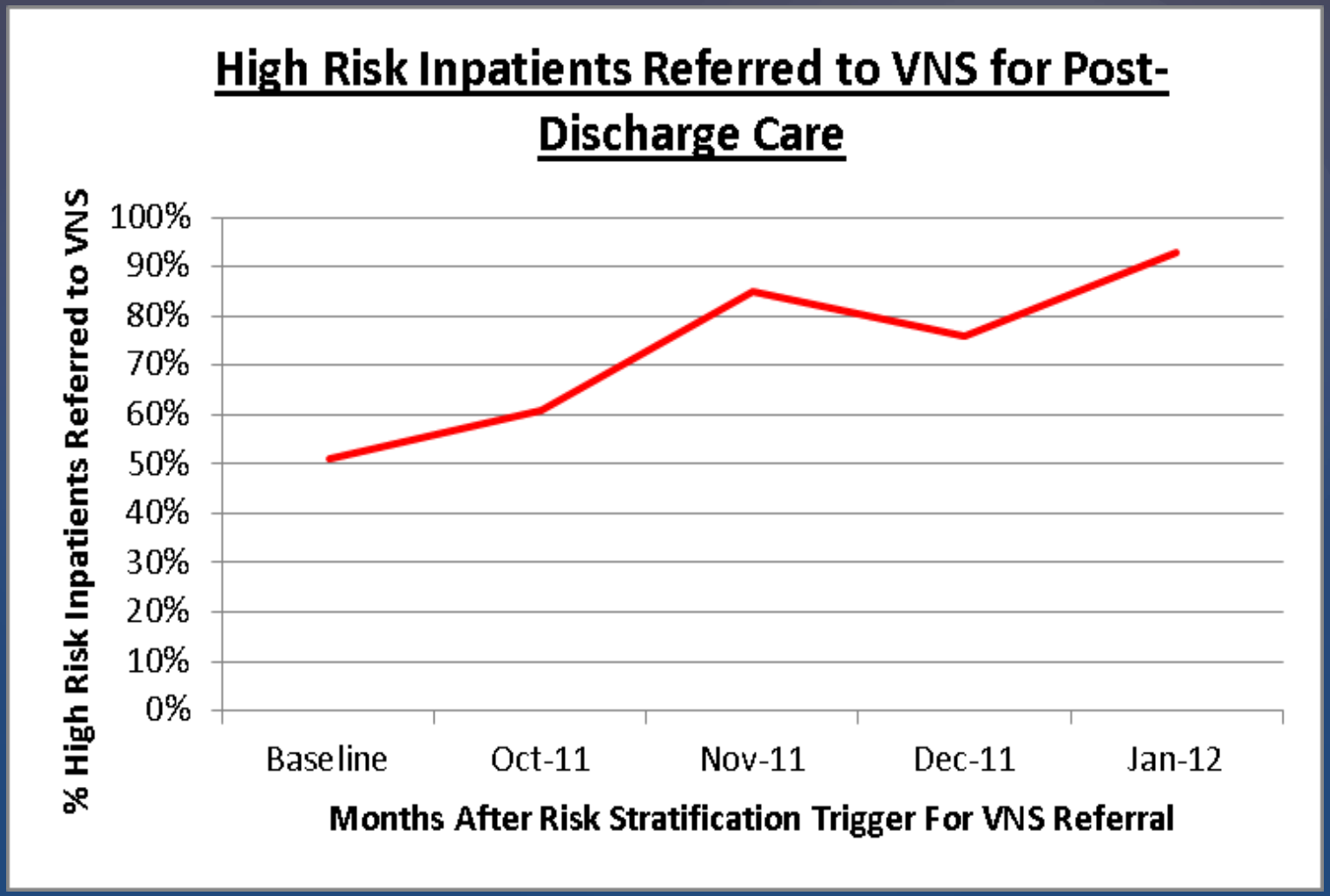
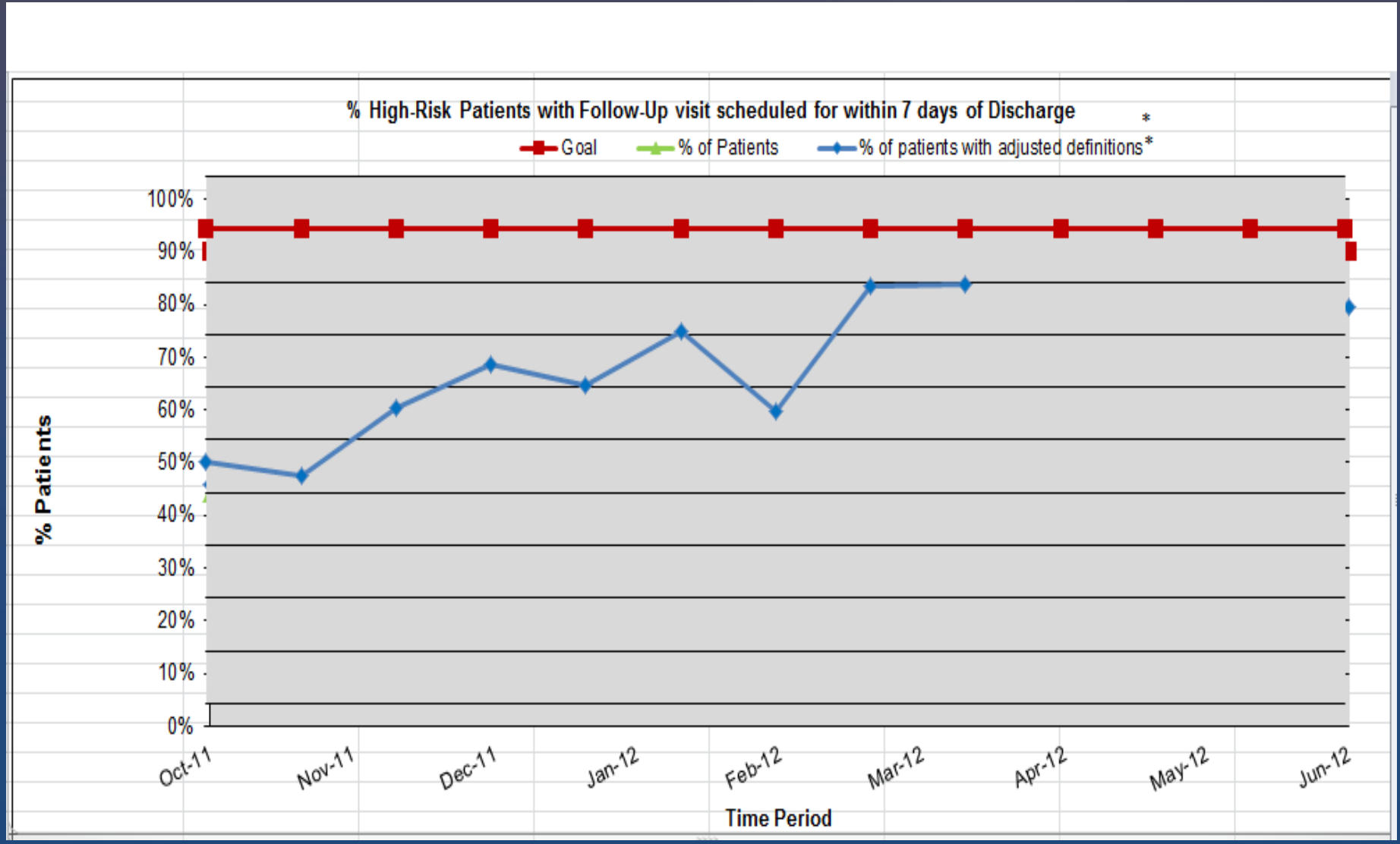
Medication Reconciliation



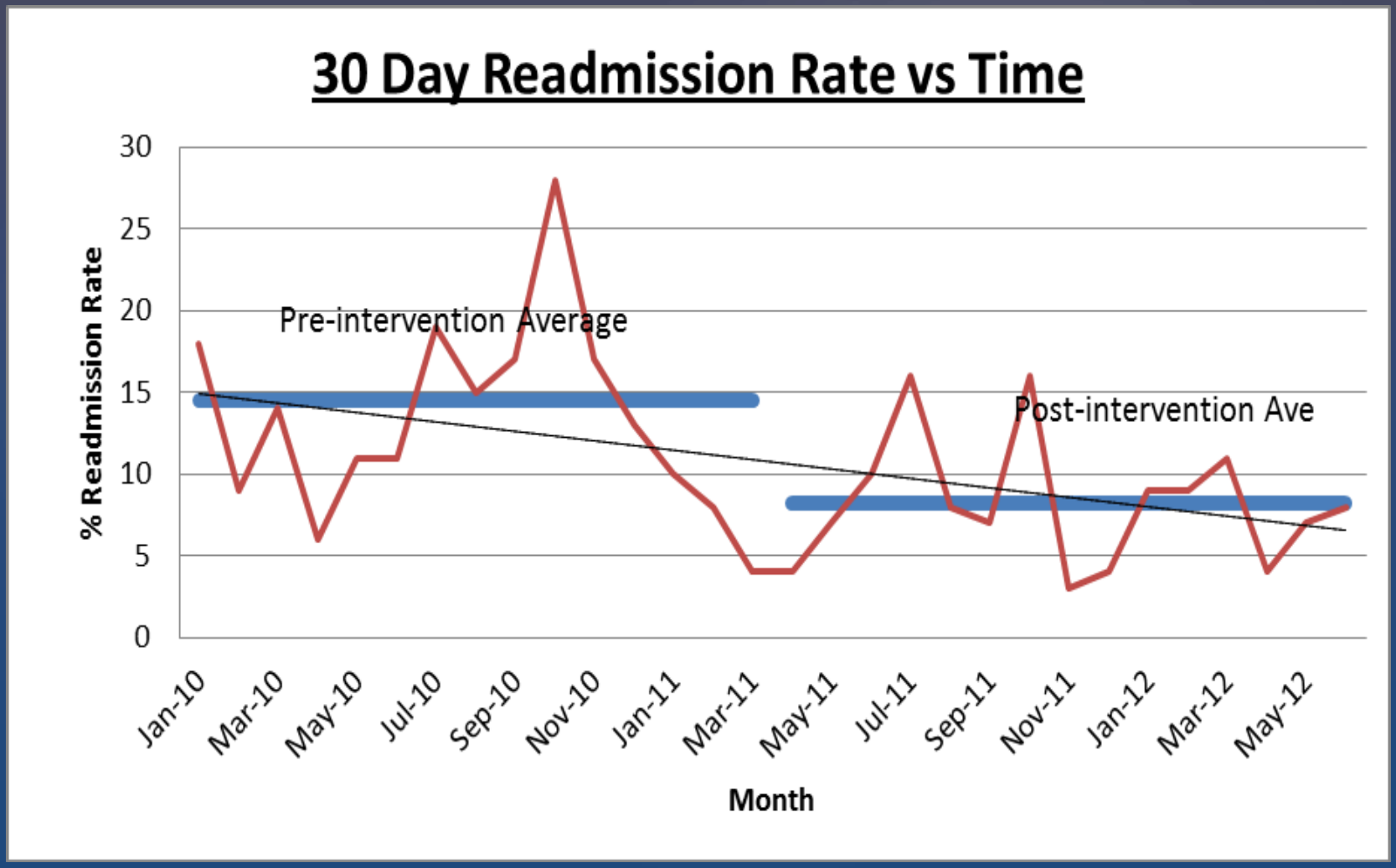
High Risk Patients with VNS Referral



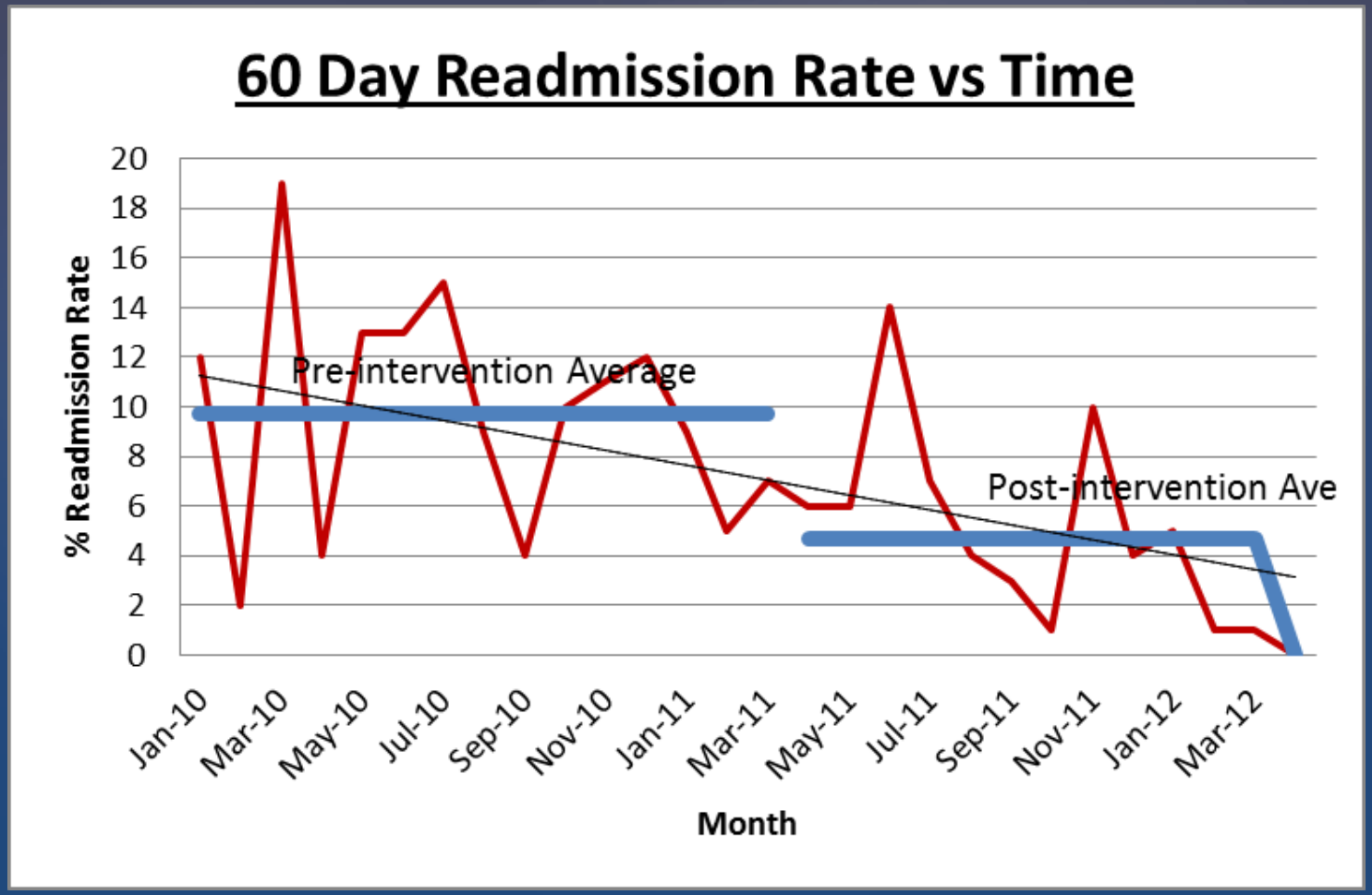
Patients with PCMH Follow up within 7 days



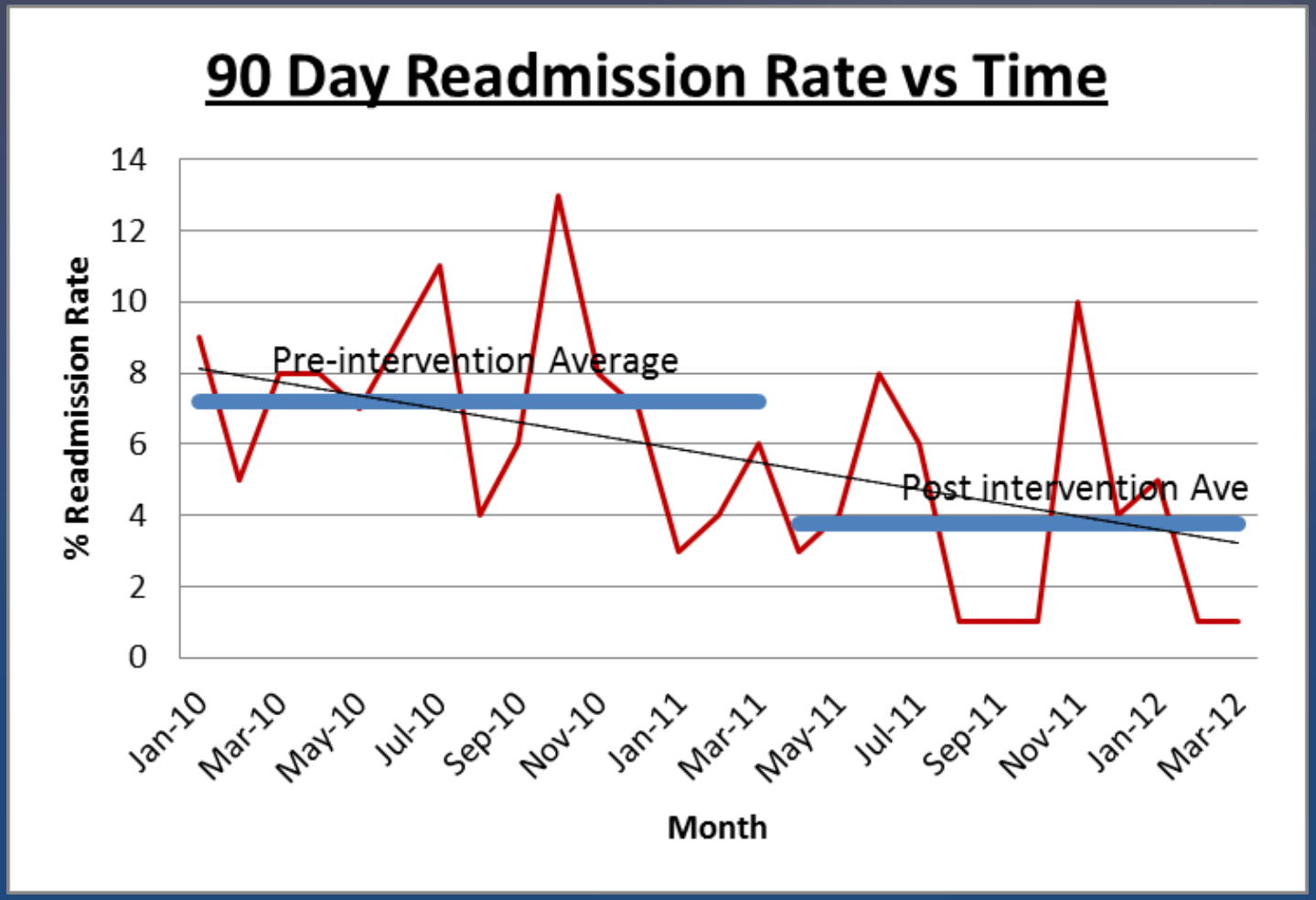
30 day Readmission Rates



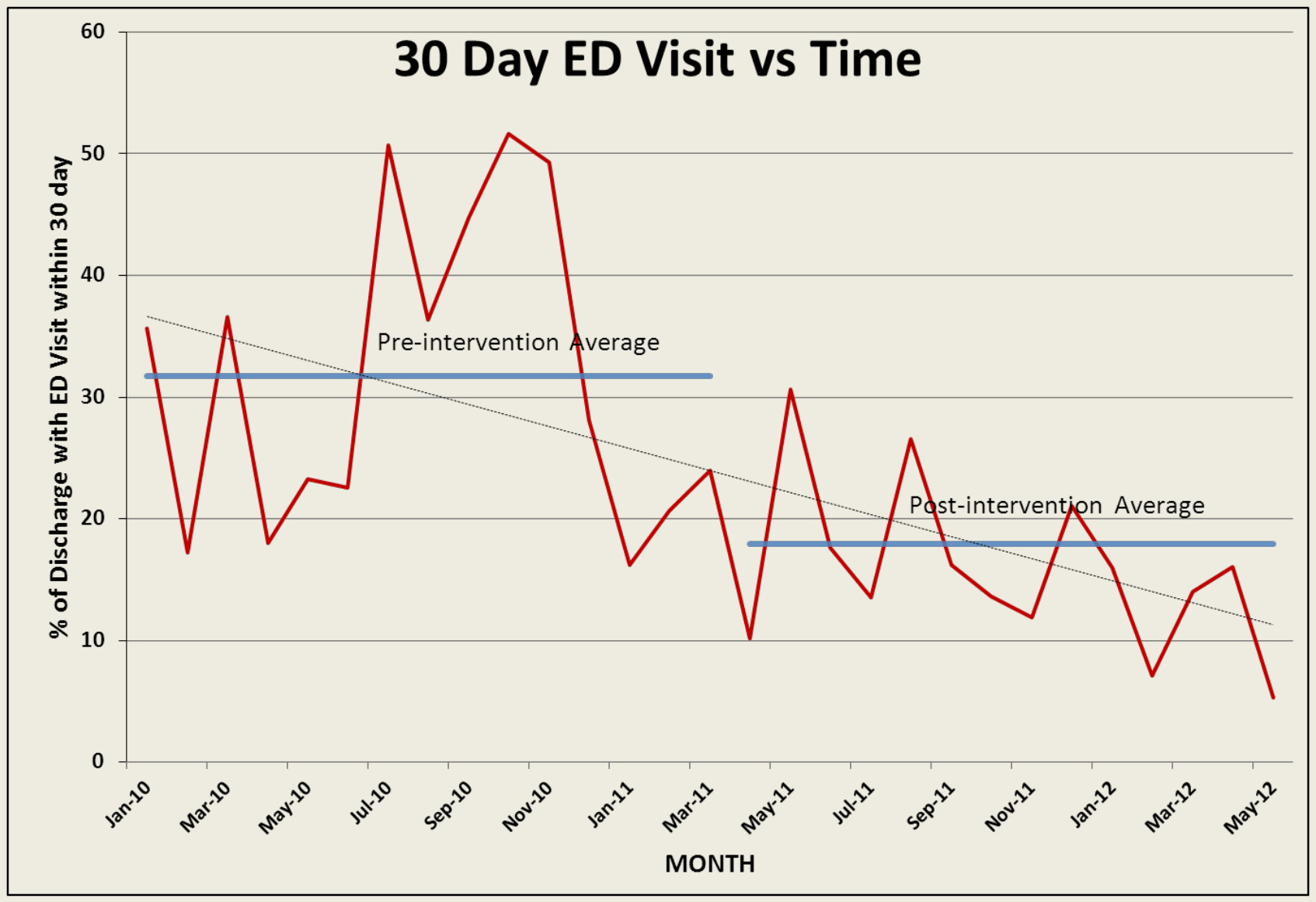
60 Day Readmission Rates



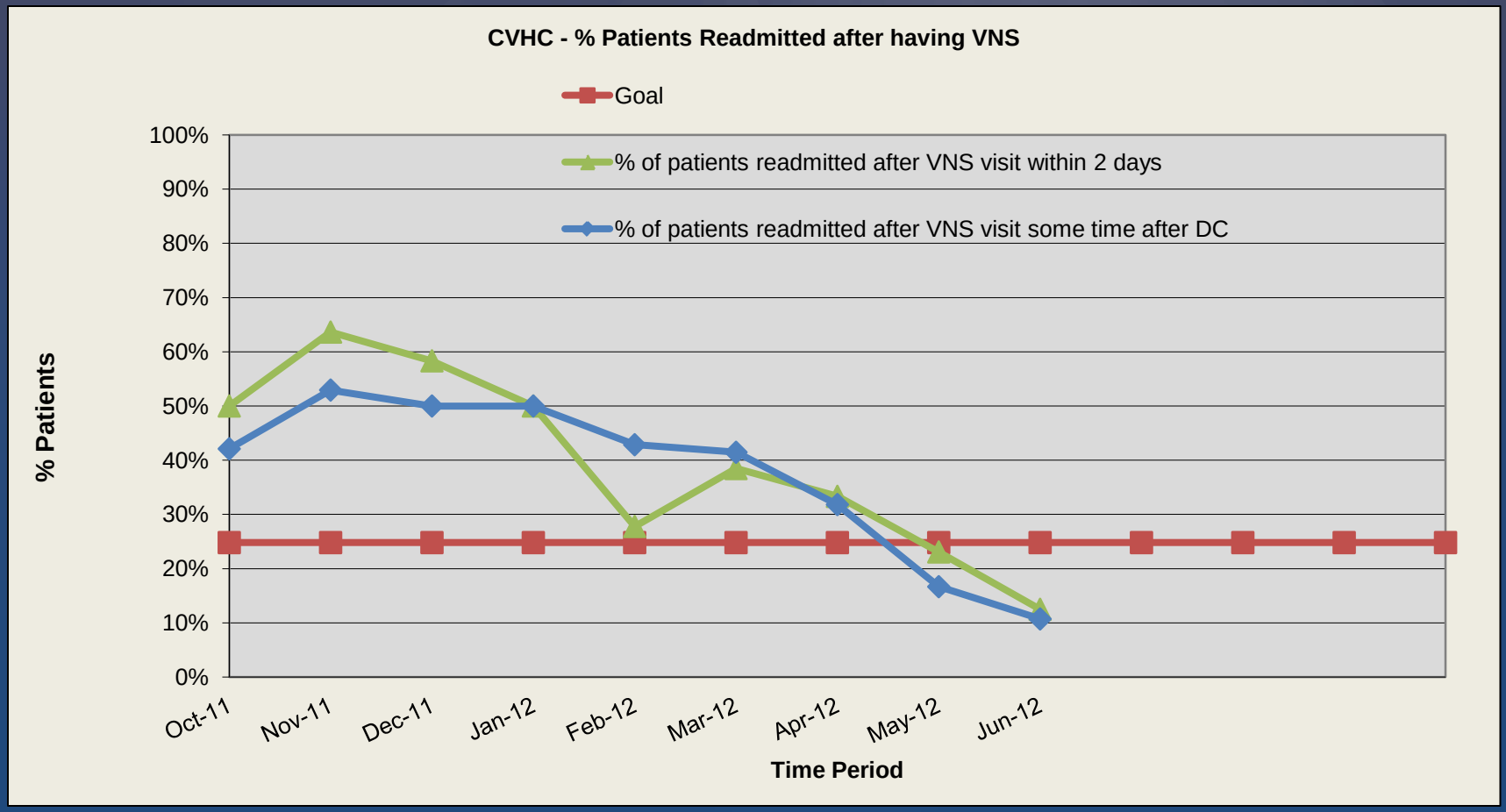
90 Day Readmission Rates



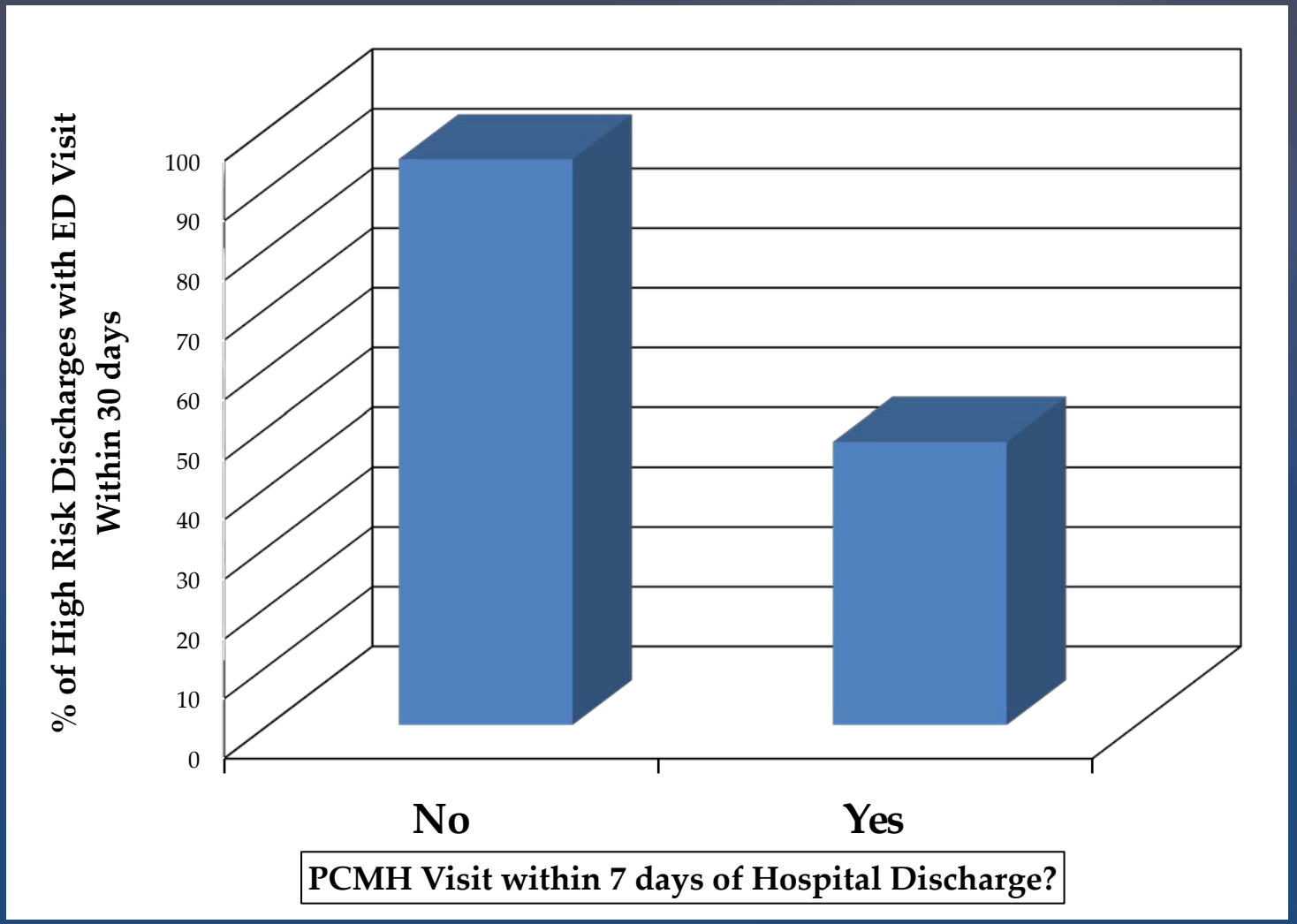
% Discharge With ED Visit Within 30 Days



Visiting Nurse Visits and Readmission



Risk of ED Visit Within 30 Days of Hospital Discharge



Estimated Savings

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Next Steps

- ✓ Use similar techniques for discharged patients with subsequent ED visit
- ✓ Continue to improve current processes
- ✓ Optimize health literacy / patient education techniques to improve patient role in self management
- ✓ Extend elements of process to our patient panels when they are hospitalized at other facilities outside our system
- ✓ Engage in discussions regarding reimbursement

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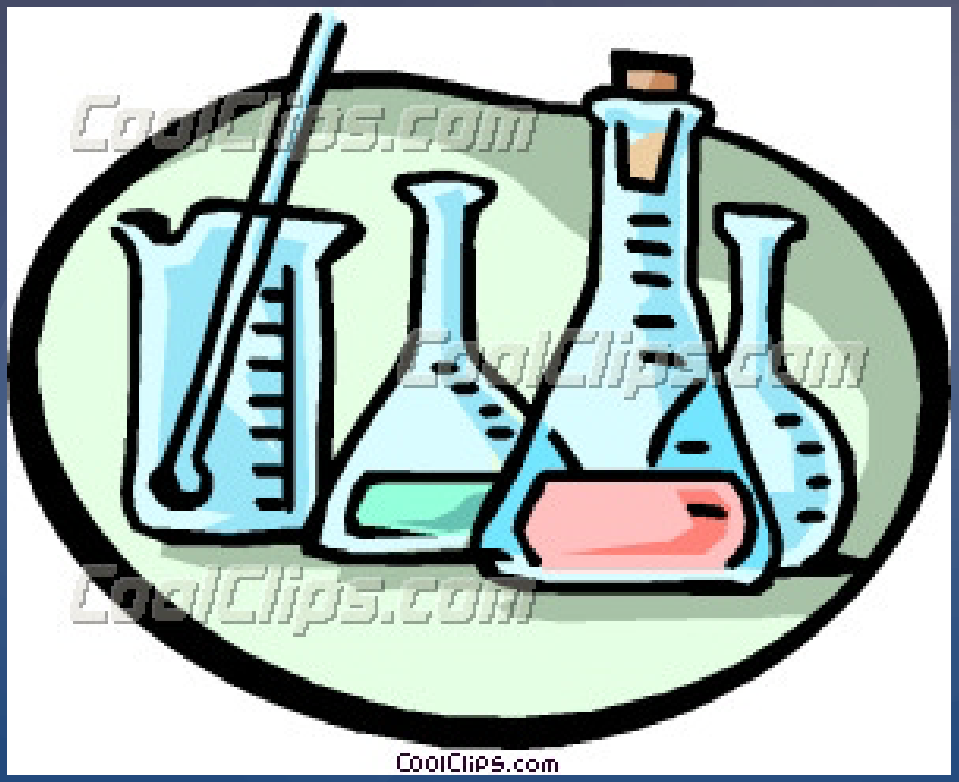
Take Our "Experiment"…



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…and climb your “mountains”

Patient Centered Medical Home – *the time has come!!!*

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Questions / Discussion?

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