RARE Tools
To Prevent Readmission

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Conflicts of Interest

- Cindy Conkins declares no conflicts of interest.
- Kathryn Kuhlmey declares no conflicts of interest.
- Megan Undeberg is the current recipient of Title III-D grant funding through the Arrowhead Area Agency on Aging.

Objectives:

- Define RARE and RED campaigns and overall impact on patient care and disease state management
- Identify key disease states that benefit from utilization of RARE tool utilization
- Demonstrate utilization of RARE tools in a health systems approach
- Discuss use of RED initiative to trigger development of county-wide safety net

Minnesota Statistics

- Nearly 1 in 5 Medicare patients discharged from Minnesota hospitals readmitted within 30 days
- 18 states have lower readmission rates than Minnesota

RARE Campaign

- Overall Goal:

- Prevent 4000 avoidable readmissions within 30 days of hospital discharge from July 1, 2011 and December 31, 2012

- Achieve PRR (potentially preventable readmissions) rate statewide of 0.80

Alignment with “Triple Aim”

- Triple Aim Goals at Improving

1. Population Health
2. Patient Care Experience
3. Affordability of Care

Key Disease States: At Risk for Readmission

- CHF
- COPD
- Psychoses
- Intestinal Problems
- Various surgeries
  - Cardiac
  - Joint
  - Bariatric
- 6 or more medications
- Depression and/or poor cognition
- Hospitalization within last 6 months
- Discharge from hospital on weekend or holidays

RARE Campaign: 5 Key Areas

- Comprehensive Discharge Planning
- Patient and Family Engagement

- Medication Management

- Transition Care Support
- Transition Communications

RED Initiative

- Developed at Boston University Medical Center
- Re-Engineered Discharge Intervention
- Patient-Centered
  - Improved readiness for self care
  - Reduction in preventable readmissions

Goals with RED Initiative

- Ensure intentional, adequate patient education while on-site
- Design hand-offs to next stage of healthcare
- Prevention of lost-to-follow-up phenomenon

Our Focus

- COPD
- CHF

- At risk for readmission due to chronicity
- High users of medications
- Typically involves older adults at risk for loss in transitions

Stats

- May 2012: initiated program
- To date:
  - 35 COPD patients
  - 35 CHF patients
- Success?

Identification Process

- Upon admission to CMH
  - Medication reconciliation by nurse
  - Identification of current chief complaint
  - “Highlighted” patient if CHF or COPD

-Clipart courtesy Microsoft Office

Target Patients: Flow Process at CMH

- Engineered stay once identified with COPD or CHF
- Planning for discharge begins at admission
- Key Tool:
  - The Little Black Binder

Key Contents of Binder

- Divided segments for total disease state management
- Involves all levels of care
- Triggers transitions of care and planned discharge to home and beyond

Results

- Successful outcomes
- PRR rate: 0.83
- More Important: Development of new programs

Identification of Risk Factors Upon Discharge

- Cloquet demographics (Megan: complete)

- What can we do?

Two Focal Areas Upon Transition

- Follow-up with medications
- Detailed medication therapy management with pharmacist

- Development of at-home resources and team
- New initiative within the community

Medication Therapy Management

- Initial Counseling
  - Medication counseling upon discharge by in-patient pharmacist
  - Verified changes to at-home medications
  - Ensured prescriptions called to retail pharmacy
  - Answered questions

Transition Process:
Safe Medication Use

- Follow-up Phone Call at 3-5 days post-discharge
- Reviewed medications
- Answered questions
- If pharmacist perceived confusion or hesitation, home visit scheduled

Home Visits: CHF

- Patient 1 related to coordination of care with Fond du Lac tribal health services
- Discharged on Friday
- Medications delivered to hospital prior to discharge
- Visiting nurses from tribal services came on weekend
- Medication boxes set up; pre-inpatient medications used
- Included discontinued medications such as Plavix (clopidogrel)
- Pharmacist home visit on Tuesday; corrected medications
- Counseling with patient and discussion with Fond du Lac pharmacy and social services clarified care

Home Visits: COPD

- Patient living at home with daughter, grandson, and great-granddaughter
- Provides daycare for 3 y.o. great-granddaughter
- Oxygen use and continued cigarette smoking by patient and family members
- Reviewed medications
- Educated on role of inhalers and lung health
- Discussed risk factors for exacerbation
- Implemented patient assistance program paperwork for help with Spiriva
- Provided numbers for community-based in-home services for help

Evolution of Process

- Initial success of CMH program led to further association with the Arrowhead Area Agency on Aging
- New development of community roundtable

Community Roundtable

- Monthly meetings with community key players

Successful Outcomes

- Development of transitional care team to Raiter Clinic
- Alignment of social service processes to community resources
- Improvement of integration of healthcare systems, home, family, and community

Catalyst for the Community Roundtable

- Federal grant to the MN Board on Aging/Area Agencies on Aging
  - Establish community coalitions in pilot communities with representation from health and home and community based service providers
  - Explore ways to better integrate care planning and improve ability of older adults to remain independent in their homes

Area Agencies on Aging Partners in Bridge Building

- Committed to "Triple Aim"
- Extensive aging-related expertise
- Strong community connections
- Good portal to publically subsided, private and voluntary service networks for older adults
- Through Senior LinkAge Line®, experienced with one to one consultation of older adults/their families
- Committed to developing evidence-based health promotion /disease preven. programs

Steps Leading to First Round Table

- Area Agency on Aging /Medication Management Project Connection
- Introduction to Hospital Discharge Planner
- Small core group discussed interest in building community coalition and brainstormed on potential members
- AAAA and Cloquet Community Memorial Hospital co-convened first meeting first large group gathering August, 2013

Cloquet Membership

- Home Care
- Community Non-profit serving elderly – family caregivers
- Hospital
- Clinic
- Public Health
- Mental Health
- Alzheimer's Association
- Hospice
- Skilled Nursing Facility
- Pharmacy
- Fire Department
- Mental Health

A distribution list of 34 individuals

Goals Identified by the Community Group

- Improve referrals between providers
- Identify at-risk patients / consumers
- Educate the public and providers on:
  - How to access services
  - How to prevent crisis
  - How to manage risk factors

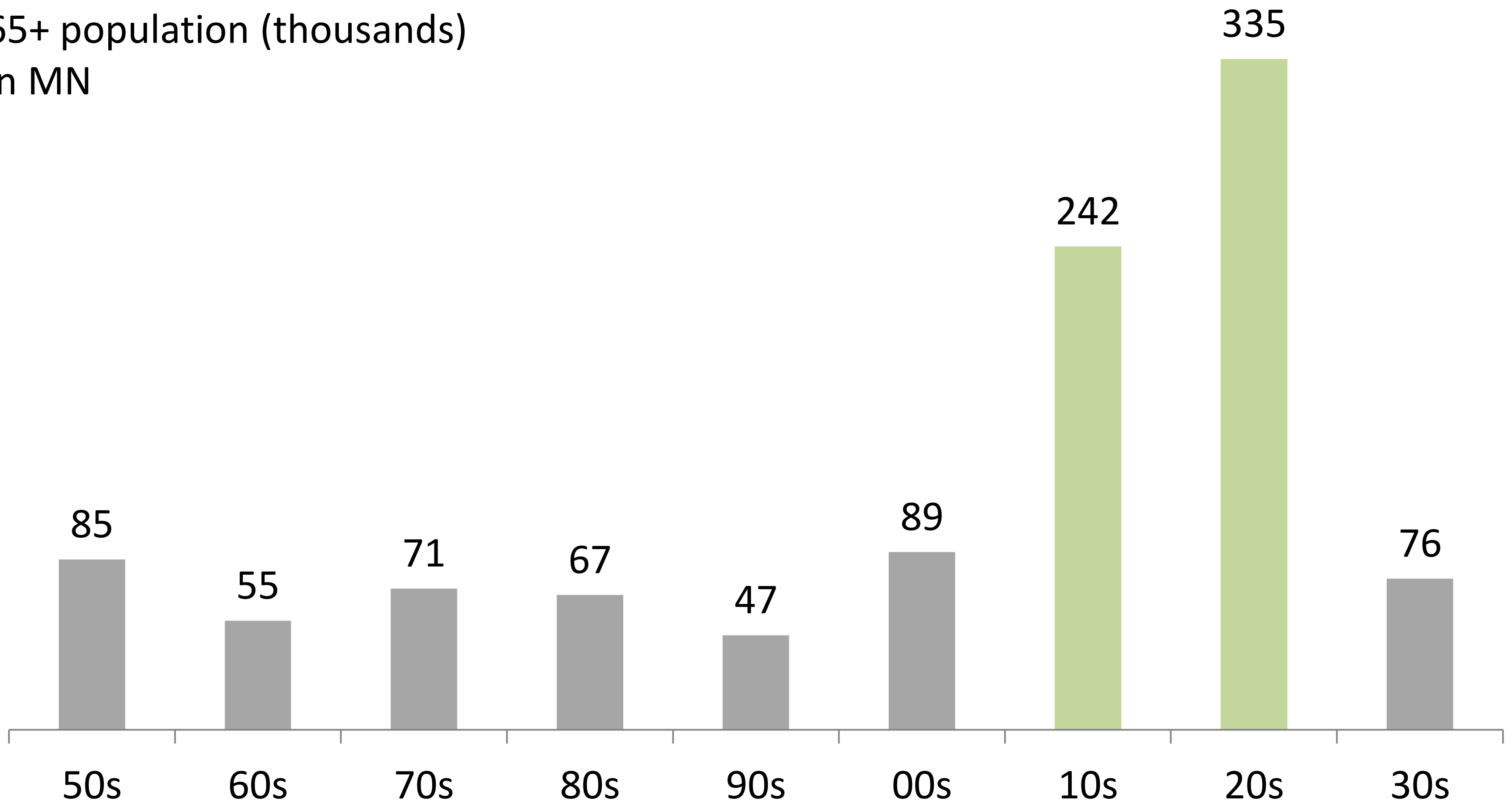
Meetings

- Monthly
- At hospital
- 1 hour – at noon
- End with two 5 minute presentations from service providers – explain their services

Accomplishments After 7 Meetings

- Buy in
- Group goals
- New relationships
- Referral directory
- Strategies for educational outreach
- Review of tools for possible use in identifying at-risk elders
- Examining ACT on Alzheimer’s toolkit for becoming a dementia friendly community

Growth in Older Adult Population



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Results:
Is This Working?

- Total number of patients identified:
- Number of readmissions:
- Time to readmission:

Components of Improvement

- Pharmacy and Medication Therapy Management
- Patients were always counseled prior to discharge
- Pharmacists often shredded face sheet prior to forwarding patient name for transition call
- Resulted in change in overall process

New Approach to Pharmacy Services

- MTM Pharmacist enlisted second year pharmacy student from College of Pharmacy

- Long-term project is tracking and following of COPD and CHF patients for 2 years

- 3 phone calls
  - 1-3 days post-discharge
  - 1 month post-discharge
  - 3 months post-discharge

- Target start date: June 16, 2014

Contact Information

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For Area Agency on Aging contact informaiton in your area:

www.mn4a.org

Other :

www.mnhelp.info

www.mnlivewellathome.org

Senior LinkAge Line®

1-800-333-2433

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