

Challenging Tradition: A Hospital Without Walls



Newton Medical Center



Collaborative work toward improving clinical
outcomes for super users

Objectives

- Identify a potential community partner
- Describe shared population problems
- Explain which baseline metrics and/or measurable outcomes would best depict collaborative success
- Describe methods to carry out delivery goals through utilization of existing resources



Not so super

SUPER USERS



“Problem children”

Super users: 3 visits in 90 days

1. ED: Young adults with psychosomatic issues
2. EMS and ED super users who need social work assistance
3. Chronically ill older adults who rely on EMS and hospital frequently

Locations

- Community
- Long term care facilities (50% of readmissions from LTCF)

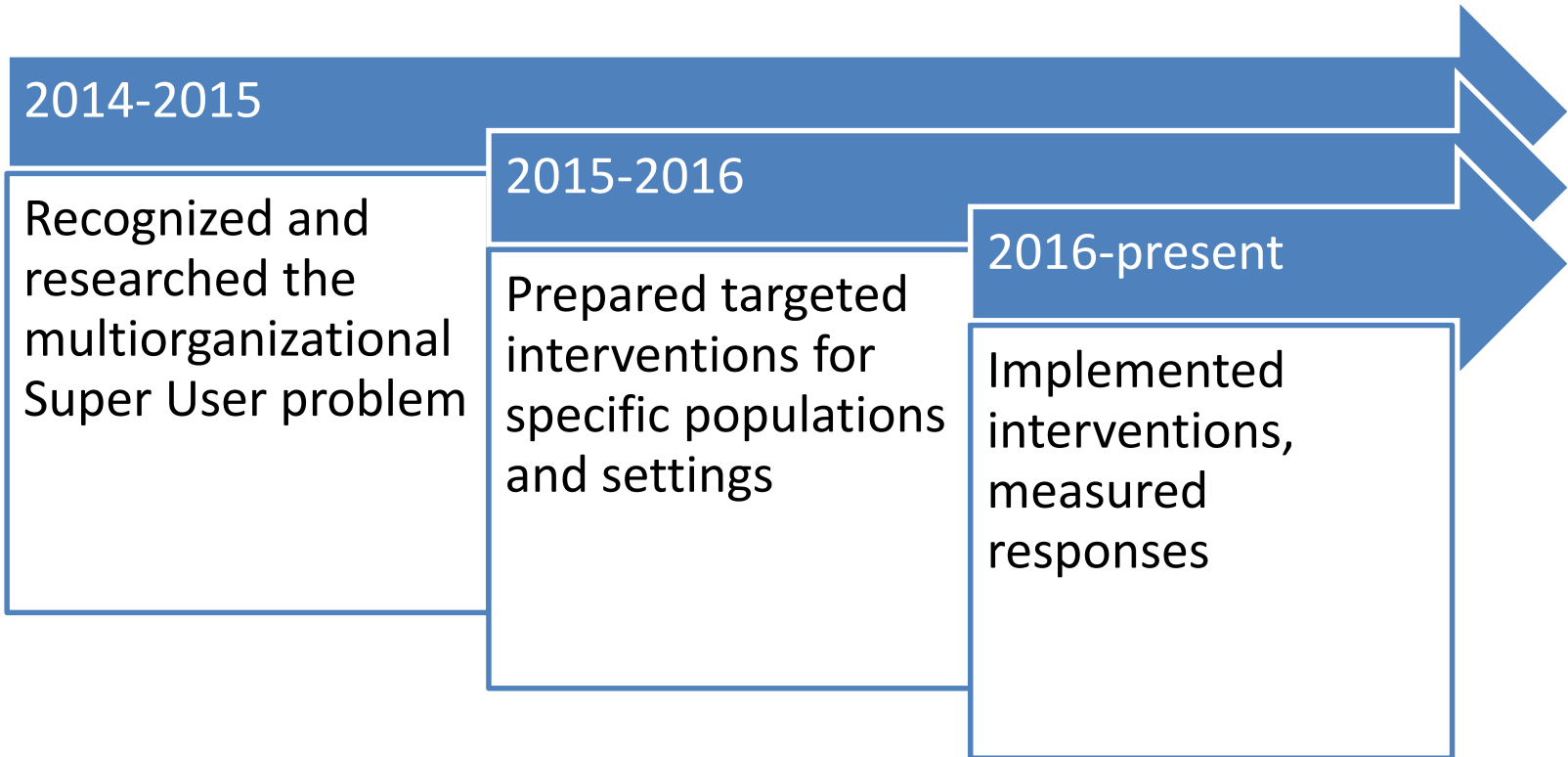


2015 Initiatives

- Transitional Care Task Force
 - CHF Readmission Reduction Program
 - Right On Track Program
- ED Community Case Management
- Community Paramedicine
 - Fall prevention



Timeline



Newton Medical Center



103-bed, not-for-profit facility dedicated to providing health care services to residents of Harvey County and surrounding counties



Super User Goals

Apply IHI Triple Aim

Navigate super users to resources in the right settings, at the right cost, for the right outcomes

Reduce ED super users

- Note NMC evaluation of super utilizers and NFEMS did not always intersect



Problem Child #1

“CAROLINE”



Sweet Caroline

- 5 admissions and 1 ED visit
- PMH: A-fib and CHF
 - 9 days on inpatient rehab unit in addition to stays on acute
 - Dc'd home with HHS
 - Readmitted for CHF 16 days later
 - DC'd to area nursing facility
 - CHF zone education done with facility
 - CHF follow up calls done with facility
 - ROTP initiated- weekly phone calls/ APRN home visit
 - Patient did not readmit



Goals:

Decrease readmissions in CHF patients

Improve transition from NMC to home.
Improved self-monitoring

Improve transitions between NMC and facilities

Congestive Heart Failure Zones After Hospitalization

Zone	What this Zone Means
Green (all clear)	
Your goal weight: _____ <ul style="list-style-type: none">No increase in shortness of breathNo swellingNo weight gainNo chest painNo decrease in your ability to maintain your activity level	<ul style="list-style-type: none">Your symptoms are under controlContinue taking your medications as orderedContinue daily weightsFollow low salt dietKeep your physician appointments
Yellow (caution)	
If you have any of the following symptoms, call your physician: <ul style="list-style-type: none">Weight gain of 3+ pounds in 2 daysIncreased coughIncreased swellingIncrease in shortness of breath with activityIncrease in the number of pillows neededAnything else physically bothering you	Your symptoms may indicate that you need an adjustment of your medications. Please make a follow up appointment as soon as possible. Name: _____ Number: _____ Instructions: _____
Red (medical alert)	
If you have any of the following symptoms, call your physician immediately: <ul style="list-style-type: none">Unrelieved shortness of breath (even while resting)Unrelieved chest painWheezing or chest tightnessNeed to sit in chair to sleepWeight gain or loss of 5+ pounds in 2 daysConfusion	This indicates that you need to be evaluated by a physician. Call your physician right away. Physician: _____ Number: _____



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- Assessments

- CM Follow-up Call
SNF-CHF



- Skilled Nursing
Facility Plan of
Care - CHF

Phone Call Date			
Phone Call Time			
Discharge orders received and understood	<input type="radio"/> Yes	<input type="radio"/> No	Comment:
Implemented daily weights	<input type="radio"/> Yes	<input type="radio"/> No	Comment:
Facility protocol in place if 3-5 lbs weight gain noted	<input type="radio"/> Yes	<input type="radio"/> No	Comment:
Is patient on sodium-restricted diet?	<input type="radio"/> Yes	<input type="radio"/> No	Comment:
Diuretic administered as ordered	<input type="radio"/> Yes	<input type="radio"/> No	Comment:
Arrangements made for outpatient follow-up with PCP	<input type="radio"/> Yes	<input type="radio"/> No	Comment:
Follow-up call comments	<input type="radio"/> Yes	<input type="radio"/> No	Comment:



Right On Track: Readmission Prevention Program



NMC's Right on Track Program

Right on Track is a free program offered by Newton Medical Center to assist you in maintaining optimal health after discharge from acute care.

Over the next 30 days you can expect:

- Frequent follow up calls from the NMC Community Case Manager to ensure your progression.
- One visit from a nurse practitioner (at your home, nursing home, etc.) to evaluate your health status and needs within 14 days from discharge.
- Collaboration with your primary care physician as needed.
- Collaboration with your health care team (nursing home staff, home health, home maker staff, etc.)

Your successful return to the community following your hospitalization is very important to us. Thank you for allowing us to participate in your care.

With any questions about the Right on Track program, please call (316) 894-8222.

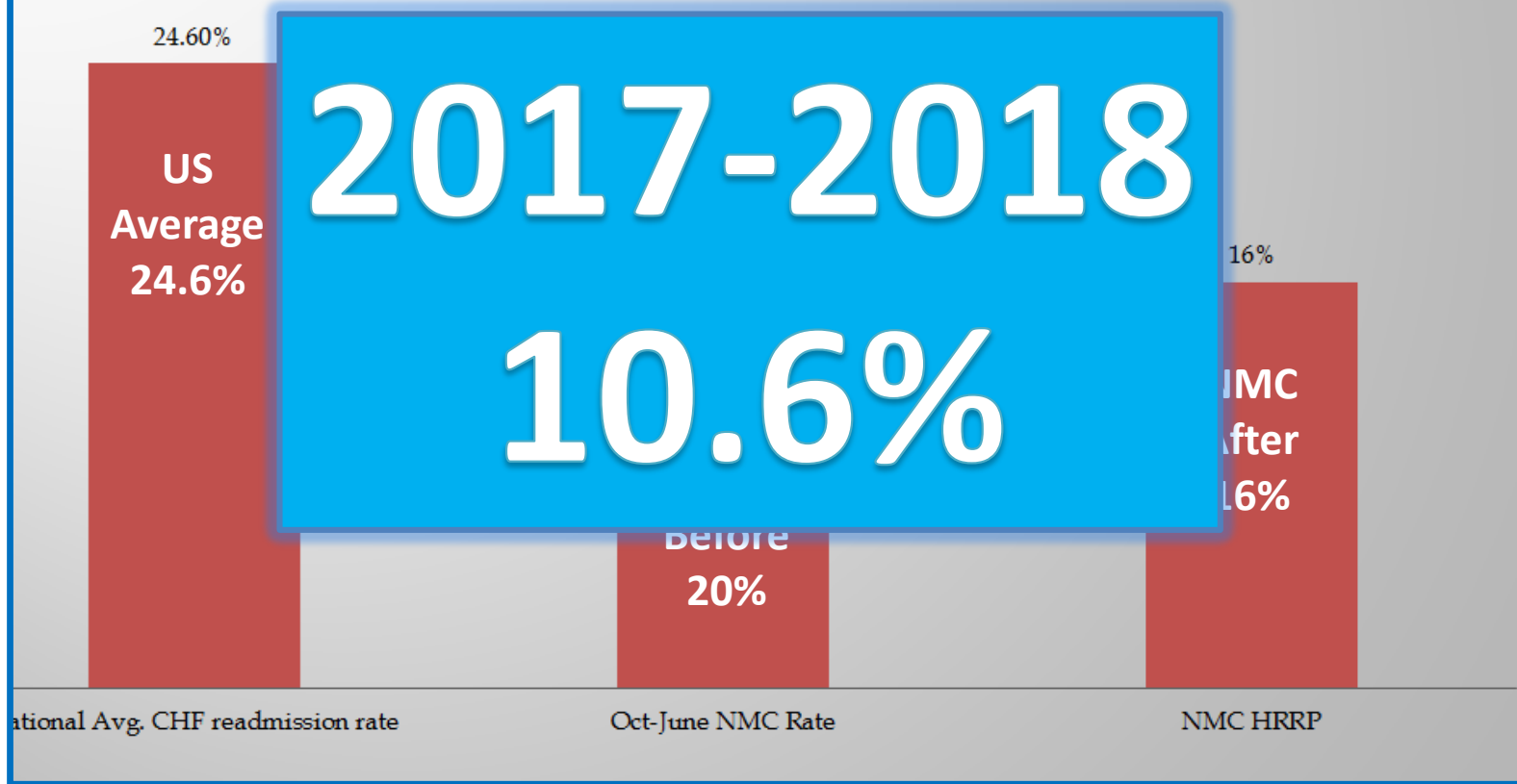


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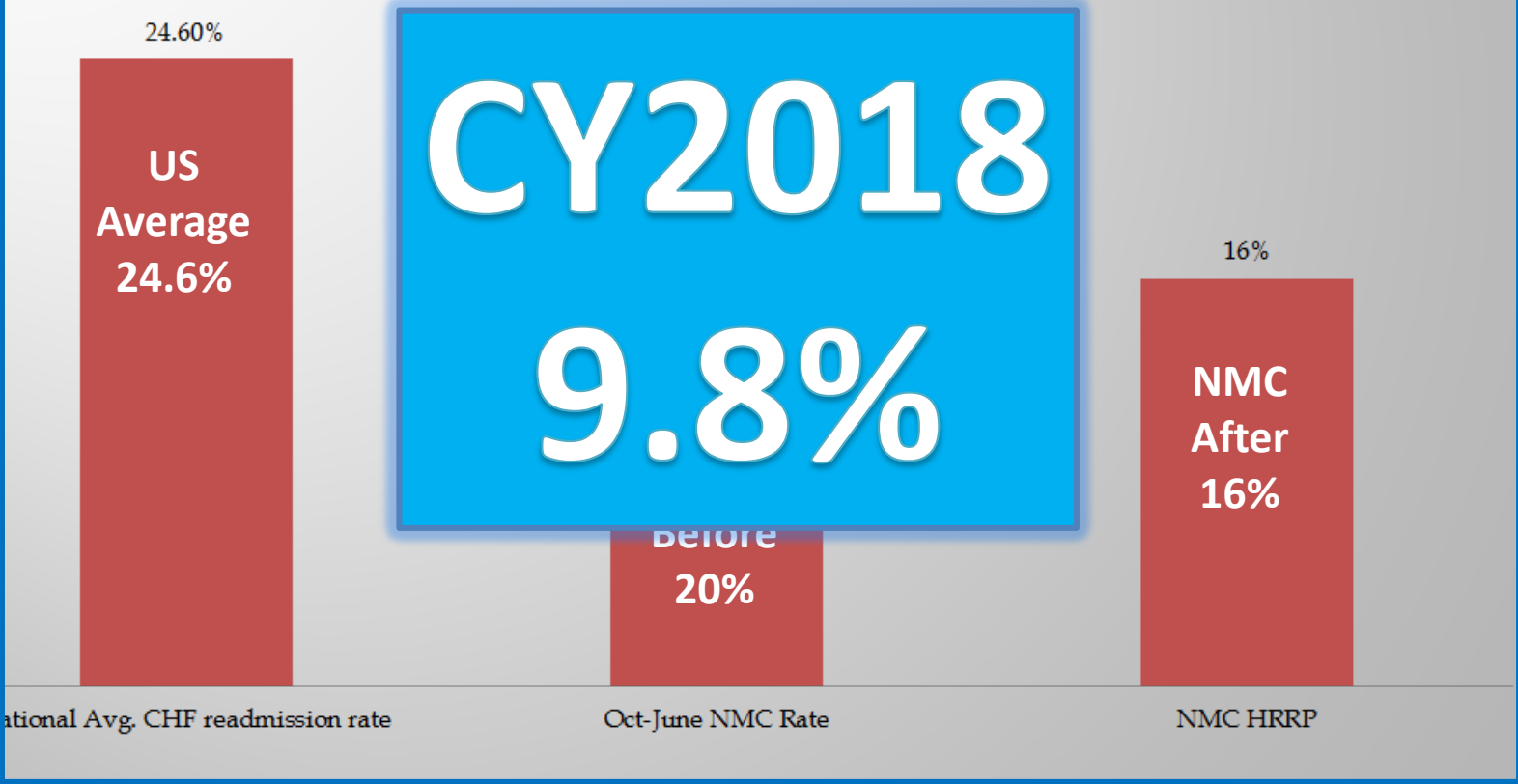
CHF Initiative

2016 CHF Readmission Rate Initiative



CHF Initiative

2016 CHF Readmission Rate Initiative



Moving Forward CY2018

- Expanded LACE assessment for all admissions
- Expanded ROTP to include all diagnoses

ALL READMISSIONS TO SAME HOSPITAL

5.5%

PEER GROUPS PER PEPPER 14.5-15.6%



Problem Child #2

“ELIZABETH”



Elizabeth's Emergencies

Problem

4 ED visits in 1 month for falls
and inability to care for self

Solution

3 CCM interventions
Placed in LTCF
No ED visits since then



Community Case Manager

- Patients with ≥ 3 ED visits in 90 days
- SW referral from Physician
- Referrals from Paramedicine
 - Lack of primary care provider
 - Lack of insurance
 - Psycho-social concern



Amanda Knowles, LBSW

NMC Community Case Manager

Newton Medical Center's Community Case Manager, Amanda Knowles, LBSW, is available to provide additional assistance to the high-risk population of Harvey County. She also serves as a resource to connect patients with outpatient services as needed, as well as a liaison for those patients who are not admitted to a bed, but still in need of assistance with referrals.



Amanda Knowles, LBSW
Community Case Manager

When to Refer:

- ED presentation three times in 90 days
- Socio-economic needs
- DNR or DPOA requested
- Homeless
- High-risk
- Physician or nurse referral

How to Refer:

- Call (316) 804-6020 (externally) or Ext. 1702 (internally).
- Place a social service consult request in Meditech and include reasoning for the request.



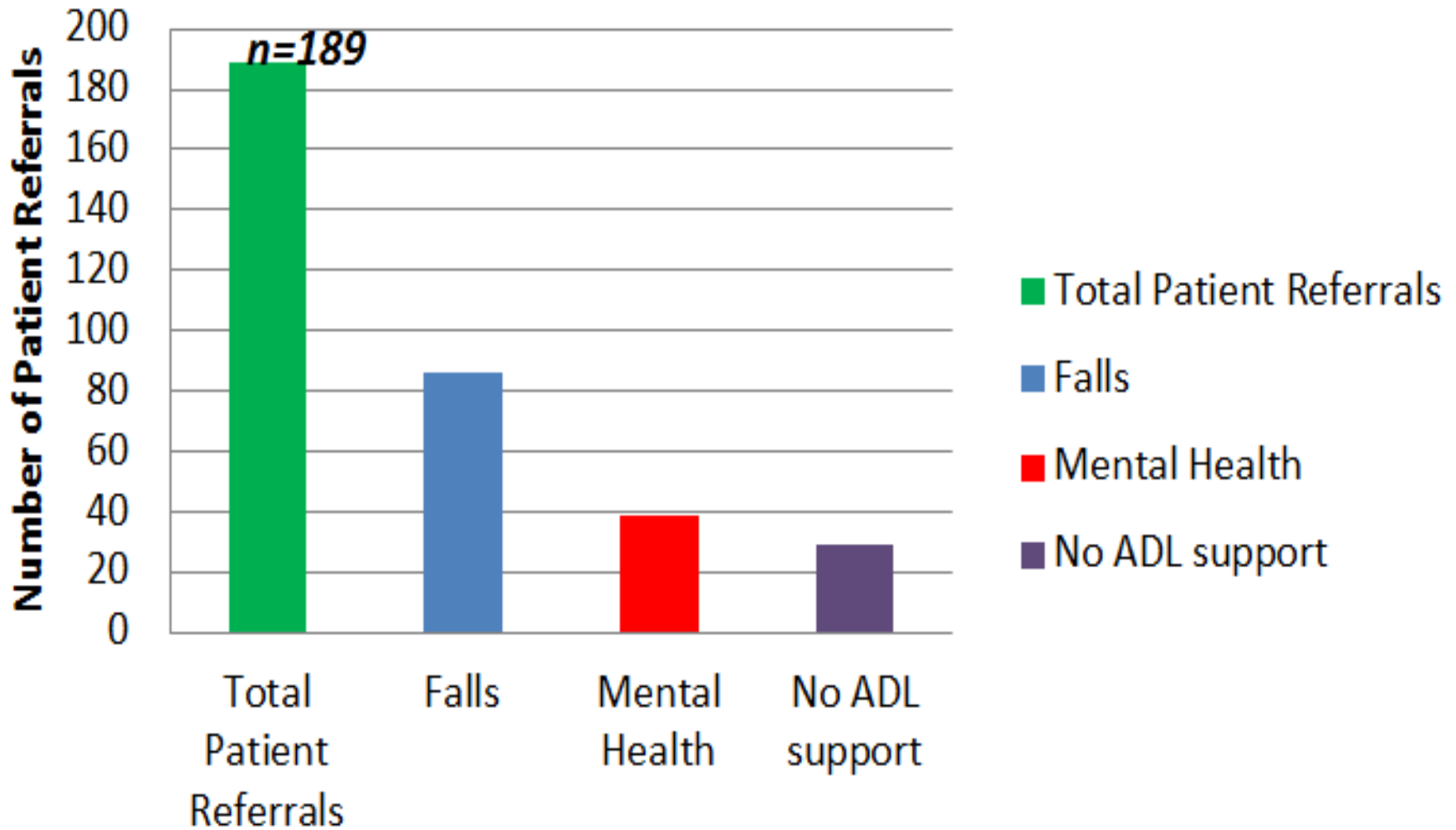
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(316) 804-6020 or Ext. 1702 | M-F, 8:30 a.m. to 5 p.m.



Referrals CY 2016



Community Case Manager

- FY2018
- Average 4 ED consults per day
- Diagnoses
 - Self Care Deficits (ADLs)
 - Falls
 - Mental Health Crisis/ Addiction
 - Caregiver Fatigue
 - Uninsured/ Under-insured
 - No PCP



Newton Fire/ EMS

Service area: 275 miles

Service delivery: 28,000 people

3600 calls per year

Medical calls 80% of call volume



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Community Paramedicine

What should the future of
emergency service delivery
look like in our
community?

What do we already know?

How can we do better?



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What We Already Know

- Increasing 911 call volume
 - Very sick
 - Kind of sick
 - Not sick
- System Super-Users
 - >3 EMS calls in 90 days
 - Non-emergent
 - Non-medical
 - EMS / ED inappropriate
- Fire/EMS: Agency of Last Resort
 - Citizens doing what they're trained to do



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How Can We Do Better?



- Stabilize or contain call volume
- Deliver better service to at-risk & underserved
- Decrease superuser 911 use
- Prevent new superusers
- Decrease falls
- Improve quality of life
- Manage resources appropriately
- Engage community partners.



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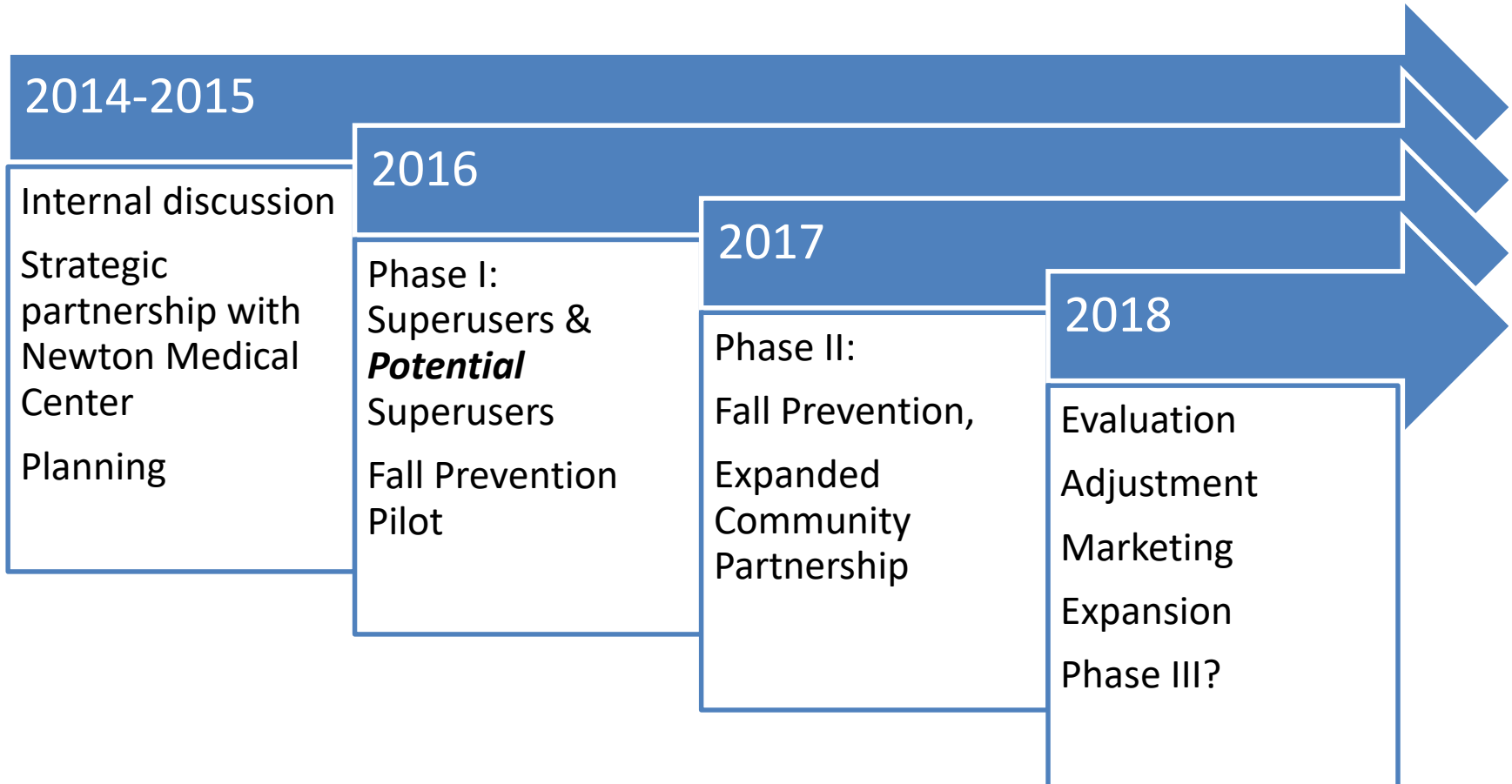
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Timeline



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Predictive Super-User Screening Tool



13 Characteristics

No Primary Care Physician

No Social Support

Medicare/Medicaid

Alcohol / Drug Abuse

Female

Psych problems

Fall Risk

Transportation

Home O2

Needs of Daily Living

Age 65+

Comorbidities

Smoker

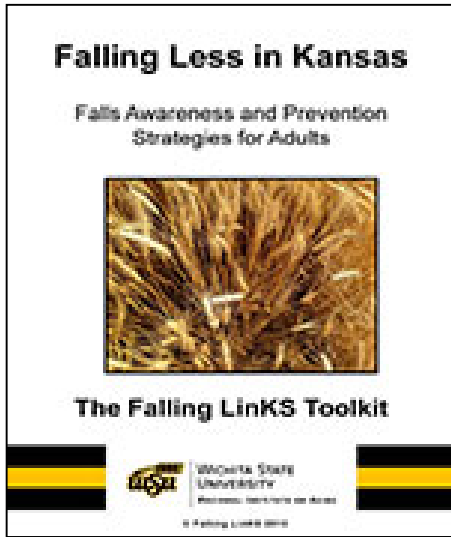
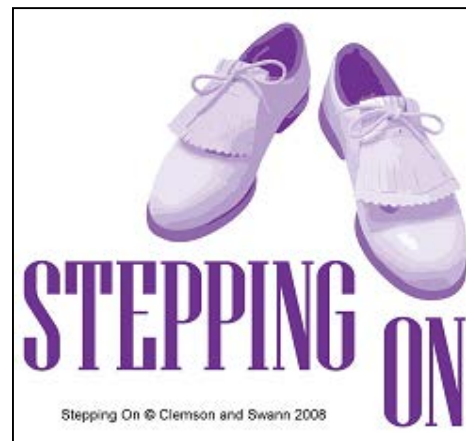
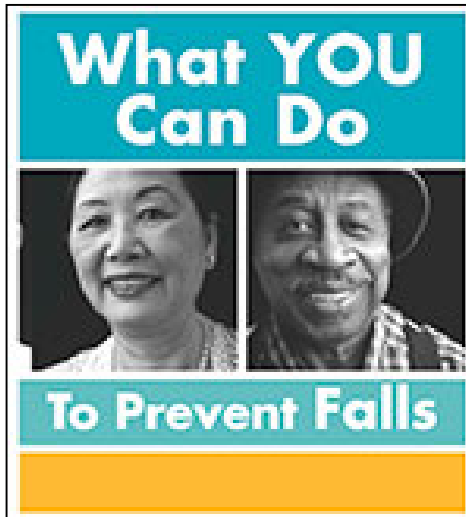


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Fall Prevention

- Falls >30% EMS Call Volume
- In-Home Appointments
- Risk Assessment & Follow-Up
- Social Interaction
- Other Safety / Prevention Opportunities
- Engaged Community Stakeholders
 - Home repairs & modifications
 - Equipment & supplies



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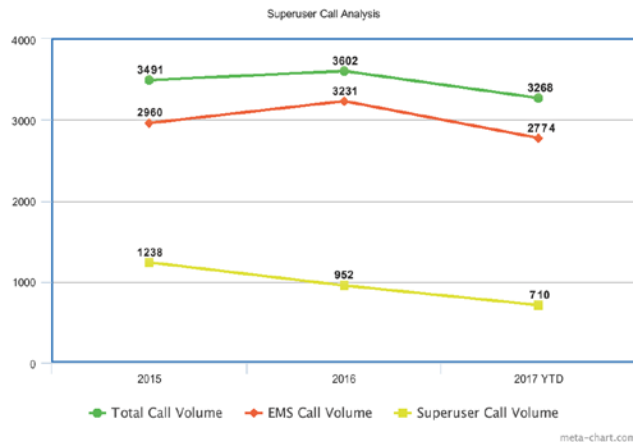
Community Paramedicine: Results

Objectives

- Stabilize / Contain Call Volume
- Decrease superuser 911 use

Results

- Fire/EMS Call Volume
 - 2015: +4%
 - 2016: +3%
 - 2017: Flat!
 - 2018: +1.6%



- Super-user Call Volume
 - 2015: 41%
 - 2016: 30%
 - 2017: 23%
 - 2018: 20%



Community Paramedicine: Results

Objectives

- Deliver better service to at-risk & underserved
- Prevent new superusers
- Decrease falls
- Manage resources appropriately

Results

- Navigation
 - Managed care
 - Staying home
- Slight SU increase
- Falls trending down
- Right crew / right patient
- No additional cost to citizens



Community Paramedicine: Results

Objectives

- Improve quality of life

Results

- Heightened feelings of health & satisfaction
- Increased social engagement
- Freedom from fatigue & pain
- Reduced emotional distress
 - “Being a burden”
 - Fear of the future
 - Someone is paying attention
- Other benefits
 - Focused risk reduction
 - Fire safety education
 - Smoke detectors



Community Paramedicine: Next Steps

Added inquiries about
mental health and
depression to in-field
screening tool

Direct referral to Prairie
View

Same-day appointments and
24/7 crisis hotline





Fall Prevention & Home Safety



FALL PREVENTION & HOME SAFETY

- Mission: To engage healthcare and community members in a proactive approach
- Maintain Independence
- In-home safety check
- Assistance with grab bars and hand railings



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