Together We’re Better: Extending Patient Care Outside the Hospital Walls

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What Challenges to Working Together with Other Providers in **Your** Community do you see??
The City of Glendale, California
Our Community.....

• We are our own City in the County of Los Angeles
• Our service area includes about 881,000 people including second and tertiary service areas
• There are three hospitals in the immediate community: Glendale Adventist Medical Center, Glendale Memorial Hospital and Health Center, and USC Verdugo Hills Hospital
• Each hospital is owned by a different entity so we are “competitors” in many things – but not when the issue is the right thing for the community
• Multicultural: Armenian, English, Spanish
Three Competitor in the Room…..

- We share medical staff
- We share hospital staff
- We complete our community needs assessment together
  Senate Bill 697
- We belong to the same community organizations
- We all belong to the Glendale Healthier Community Coalition
History of Our Coalition

• The Glendale Healthier Community Coalition was formed in 1993 by the three Glendale Hospitals and several community groups

• In 2003, a subgroup was formed, “The Consortium of Safety Net Providers”. This group included the hospitals and several community organizations whose mission was to provide care and services for those at risk/in need

• As a burgeoning issues, the Consortium identify reduction in re-hospitalization as a focus for the group in 2011

• Additional members were invited to work with us to address this issue (Health Services Advisory Group (HSAG))
Participating Organizations:
- All for Health, Health for All (FQHC)
- Armenian Nurses Association
- City of Glendale
- Community Foundation of the Verdugos
- Comprehensive Community Health Centers, Inc.
- DiDi Hirsch Mental Health Services
- Family Medicine Center
- Glendale Healthy Kids
- Glendale Unified School District
- Salvation Army of Glendale
- Verdugo Hills Medical Associates
- Valley Nonprofit Resources
- Wellness Works
- Glendale YMCA
- Glendale YWCA
CCTP Becomes Available

- Glendale Memorial applied as a single hospital with Partners in Care Foundation (as the CBO) in September 2011 and were not awarded
- An extensive root cause analysis was conducted for that application and those findings were validated at the other sites
- Based upon findings of that RCA, we realized we needed to work with our non-hospital partners to address the issue of re-hospitalization
What We Learning About Our Community

- Approximately **32% of our readmissions** were for patients discharged from us to **skilled nursing facilities**
- Another **15-20%** received **home health services**
- Approximately **70%** of re-hospitalizations go back to the **first hospital**
- **30%** of re-hospitalizations go to **another facility**, mostly one of the three of us
What We Did

• We formed on-going working groups with the skilled nursing facilities and home care agencies we all used
• First meetings were held in December 2011 and February 2012 respectively
• Focus of the first meeting was to develop a mutual understanding of the issue, the impact on the hospitals, gain consensus that this was an area that we wanted to address collectively, and identify topics areas for future meetings
And Our Partners Present:

Preventing Avoidable Re-Hospitalization, Partnering With Our Skilled Nursing Facilities

December 16, 2011
0730-0900
Glendale Memorial Hospital and Health Center Auditorium

Glendale Memorial Hospital and Health Center
A member of CHW

Glendale Adventist Medical Center
Adventist Health

ASCENCIA
Lifting People Out of Homelessness

Verdugo Hills Hospital
On-Going Meetings

- We have continued to meet quarterly with each group
- We rotate the host site and the agenda topics are based upon group decision
- The groups have gotten larger through word of mouth
Positive Outcomes for the Collaboration

• We were recognized as a formal “Community” by HSAG
• Provided Interact II® tools/education for SNF’s
• Provided a number of patient educational tools for HHA’s
• Provided education for SNF on having those difficult conversations related to end of life with a guest speaker, a palliative care nurse
• We hosted the first joint meeting with the SNF’s and HHA’s in January 2013 and they have continued to meet together quarterly since then
More Positive Outcomes for the Collaboration

- Developed standardized hand-over communication tools for Hospital to SNF, SNF to Hospital, Hospital to HHA, and HHA to Hospital. Tools were developed by the working groups from multiple samples.
- Provided education regarding management of patients with co-existing psychiatric issues in the home – speaker mental health nurse specialist
- Working with Ascencia for issues associated with homelessness including addressing frequent ED users
- Provided demonstration of software for SNF to reduce re-hospitalizations
Latest Projects for SNF/HHA Group

• We are completing a capability spread sheet for the hospitals to use to identify the best sources for after hospital care
• We have asked the SNF’s and HHA’s to provide us with THEIR re-hospitalization data
• We are working on having representatives from local insurance provide meet with us to discuss the advantages of authorizing care following acute hospitalization
Some of Our Challenges

- Initially, many thought these were “marketing meetings”
- We do not always have the same participates
- Meeting planning and preparation is very time consuming; we all wear many hats
CCTP Program Award as a Community

We applied to CMS as a community in September 2012 and have been accepted as a “CCTP partnering organization”. We began enrolling patients in May 2013 with Partners in Care Foundation as our “CBO”
Samples of Our Tools

• Hand off tools
• Capability spread sheet
• Readmission data form
June Simmons and Partners in Care Foundation
Review of Flipchart Challenges and Open Discussion
Questions?

Thank you
And
Good Luck!!!