Emerson Hospital

Building a Strong Community

Partnership For Patients

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Melissa Saalfield, Patient and Family Representative

Care Transitions Collaborative

- 3 Physician Champions
- Board Members
- Care Management: Director of CM, CM for Emergency Services, Social Work Supervisor
- Patient Quality and Safety staff
- Community Partners from Senior Services, COAs Skilled Nursing Facilities, Local Pharmacist, Ambulance provider
- Patient and Family representatives

Goal of Care Transitions Collaborative

- Meets monthly to identify gaps in care transitions and work together to:

1. Prevent unnecessary re-admissions
2. Improve communication between patients, caregivers, families and providers
3. Develop a post acute assessment program

What do you want to accomplish?

- Set the tone for transparency
- Respect and service excellence
- Establish goals for a working meeting
- Collaboration vs. hospital domination

Keeping the Momentum Going

- Set the rules for Collaboration, Transparency and Trust
- Invite outside speakers to keep the team engaged
- Rotate case presentations and bring the failures
- Understand each others worlds
- Establish meeting schedule for the year and respect time constraints

Lessons Learned

- Involve Senior Leadership
- Avoid including marketer and consultant involvement
- Physician Champions
- Small tests of change

The Physician’s Perspective

Health Literacy

- Literature-based evidence shows that effectively teaching patients about their conditions, medications, and care processes requires various avenues and materials.
- Some people are visual learners, some learn by reading, and some learn by doing.
- The “teach-back” methodology has been found to provide the most effective way to identify a patient’s understanding of the education provided.

Health Literacy

- Working with the Care Transition Collaborative to standardize our written material, so we give consistent information accounting for the learners Health Literacy level.

- Identify tools and strategies for providing various methodologies for learning.

Identified Learner.

- **It may not always be the patient!**
- How to ask the question?
  - While you are here, who else should be included in teaching about your health?
- Identify where this information is accessible for all care team members so the right learner/s are involved in the patient's teaching.

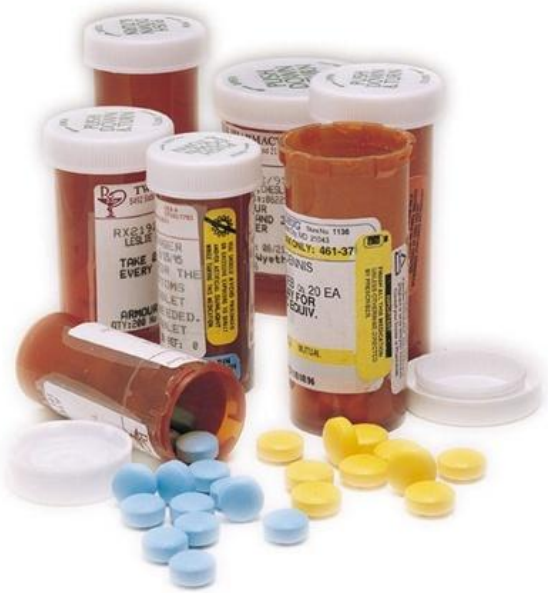
ED Care Manager Role

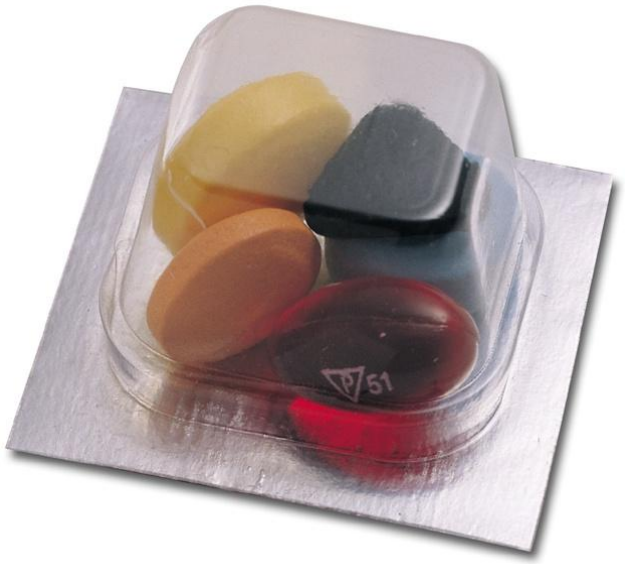
- Assess patient for appropriate level of care
- Work with SNF and HHA thru the Care Collaborative to establish warm hand-offs in both directions
- Work with SNF and HHA thru the Care Collaborative to establish standard teaching tools
- Work with the high risk population as they arrive in ED to establish appropriate care needs to manage their care throughout the continuum of care.

A Patient Family Perspective

What would you rather your Mother do…?

This **or** ***THIS?***





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Color Coded Calendar Cards assist patients and caregivers with identifying the correct administration time…

- **Routine Meds -**
  - **Yellow:** Morning
  - **White:** Mid-Day
  - **Orange:** Evening
  - **Blue:** Bedtime
- **Other Meds -**
  - **Green:** PRN
  - **Red:** Stat meds or Controlled Substances

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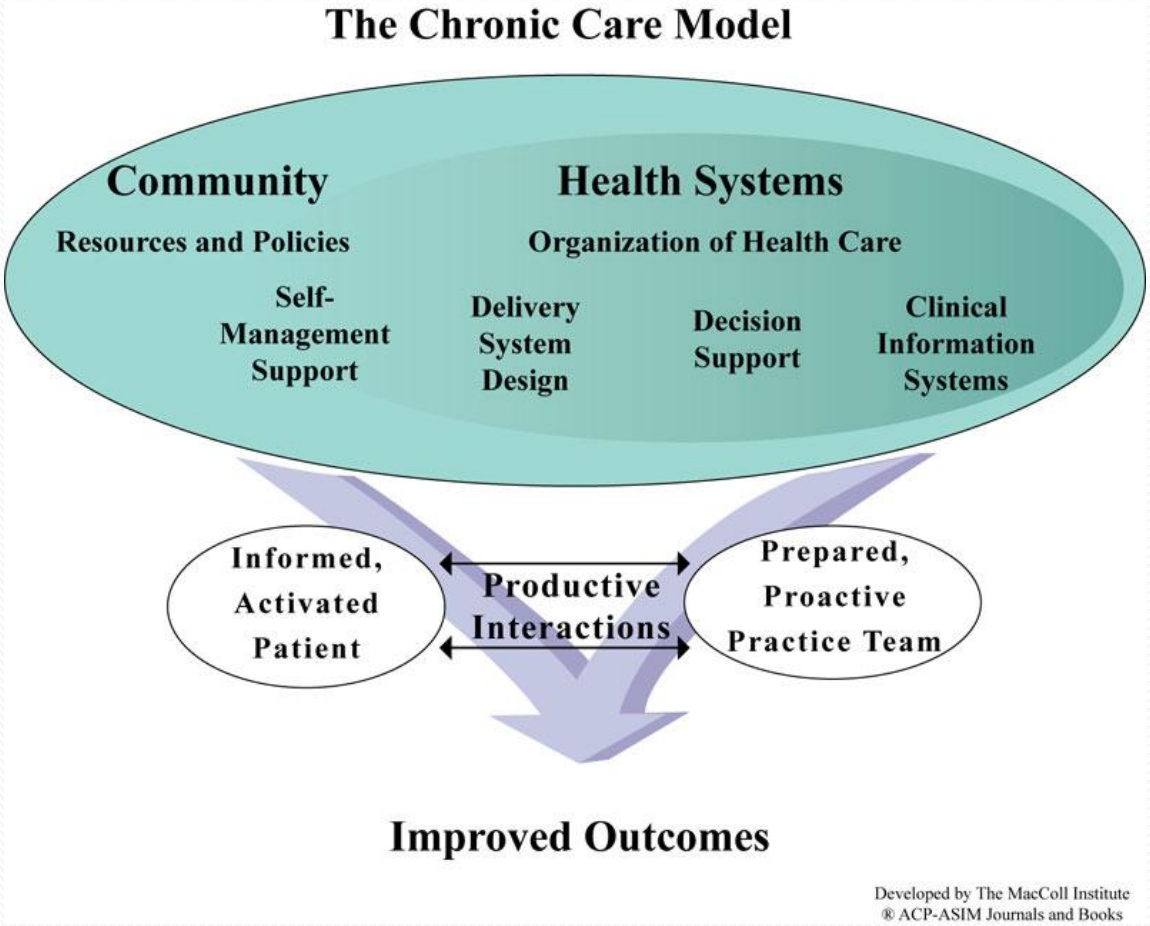
ASAP/Community services wrap around the medical system



Why community supports are essential to health care reform

- 40-50% readmissions due to non-medical reasons
  - Proctor, 2000, Health and SW 25(2):87-96(10)
- 50% of health based on lifestyle and behavioral factors
  - McGinnis and Foege,JAMA 1996 & CDC
- 29% US population provides care for a chronically ill, disabled or aged family member
  - National Alliance for Caregiving 2009

Minuteman Senior Services

"eyes and ears in the Community"

- Care Transitions Support across settings
- Community Care Coordination/Navigation
- Home and Community Based Services
- Caregiver Support
- Evidence Based Healthy Aging Programs
- Population Health


THANK YOU