RHP9 Improvement Collaborative – ED/Readmissions

(Access Cohort, ED/Readmissions Cohort, & Chronic Disease Cohort)

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AIM
(Purpose)

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PRIMARY DRIVERS
(Category 1&2 Projects)

- Expand Capacity (1.1, 1.2, 1.7, 1.8, 1.9, 2.1, 2.10)
- Clinical Assessment & Monitoring (1.3, 2.2, 2.6, 2.7, 2.11)
- Identify Patients at High Risk for Readmission (2.8, 2.9, 2.12)
- Patient Experience (1.4, 2.4)
- Follow-up Care/Community Resources (Cohort Driven)

SECONDARY DRIVERS
(Milestones & Metrics)

- Workforce Development
- Open New Clinics (Primary/Specialty)
- Expand Existing Clinic Services
- Implement Technology-Assisted Services to Support or Deliver Care
- Chronic Disease Registries
- Implement Evidence Based Interventions
- Medication Management
- Care Transition Programs
- Potentially Preventable Disease Screening & Reduction
- Patient Navigation Programs
- Patient Satisfaction
- Culturally Competent Care
- Self-Management Support
- Directory of Regional Resources
- Health Information Exchange Systems

CHANGE CONCEPTS
(Actionable Items)

- Hire new staff
- Staff trained/educated
- Create incentive programs
- Staff member participating in incentive programs
- Open new clinics
- Track number of primary care/specialty care encounters
- Patients receiving healthcare services through new technology (i.e., Telemedicine, Telehealth))

- Disease registries implemented
- Providers receive monthly registry reports on their patients with selected conditions.
- Target population screened and with a plan of care documented
- Target population patients with documented improved healthcare outcomes (i.e., diabetes, immunizations, etc.)
- Medications reconciled & monitored

- Schedule patients for timely follow-up appointment (between 3 days and 2 weeks post discharge)
- Assess/screen patients within target population and document plan of care
- Patients provided peer mentors
- Hospital prevents potentially preventable diseases cases

- Track Results of HCAHPS and CAHPS composite measures
- Enroll target population in self-management education/support programs
- Patients report higher quality of life
- Improve retention and graduation rates for established classes
- Establish new self-management programs
- Patients report improved understanding of care

- Number of partners who have a supportive care program and are entered into the directory
- Percent of patients who are referred to supportive care
- Percent of patients who use supportive care after referral

REGIONAL OUTCOME MEASURE
(Reported Monthly to RHP9

- **Percentage of patients assigned a primary care physician**
- **Number of patients screened for specific healthcare condition (i.e., diabetes, blood pressure, heart failure)**
- **Decrease in 30 day readmission rate**
- **Percentage of patients with a scheduled appointment within 3 days to 2 weeks post discharge**
- **Improve patient satisfaction scores**
- **Improved patient outcomes**
- **Improved patient adherence to taking prescribed medications**
- **Percentage of patients with chronic conditions receiving dental care**
- **Number of new patients entered into chronic care registry**
- **Number of telehealth/telemedicine encounters**

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