Influencing 30 Day Readmission Rates through Improved Care Transitions

Case Study

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Statement of Problem

Recognizing the need to improve the health of their community, a hospital owned family medicine practice was invited to participate in the work being done at the hospital level to reduce hospital readmission rates.

The Institute for Healthcare Improvement's 2013 guides for improving transitions from the hospital to other settings report that of the two trillion dollars spent on healthcare in the United States, nearly one third is spent on hospitalizations. It is estimated that twenty percent of these hospitalizations are readmissions occurring within thirty days of discharge.[1] [2] [3]

According to a 2009 article in the New England Journal of Medicine; during a study of claims data from 2003-2004, one in five Medicare patients were re-hospitalized within thirty days, half of these patients did not see an outpatient physician within thirty days of discharge, and Medicare expenditures for potentially preventable re-hospitalizations might be as high as $12 billion a year. In 2004, Medicare payments for unplanned readmissions accounted for about $17.4 billion in hospital payments. [4]

In 2008, The Institute for Healthcare Improvement first introduced the triple aim of simultaneously:

- Improving population health
- Improving the patient experience of care, and
- Reducing per capita cost [5]

This primary care practice embraced the premise of the triple aim by striving to reduce hospital readmissions for their patients, and recognized that primary care providers have an obligation to participate in the care transitions of their patients from the hospital setting.

Arriving at Alternative Solutions

In 2010, recognizing the importance of reducing re-admissions and improving the health of the community, the ambulatory family medicine practice began working to reduce readmissions by improving follow up with patients and caregivers after hospitalization. Discharged patients were contacted by phone within forty eight hours of discharge from the hospital. This workflow proved to be successful in the area of improved patient experience, but did not demonstrate improvement in readmission rates or improvement in the health of populations. Simultaneously, the hospital was offered the opportunity to be involved in a system wide effort to reduce thirty day re-hospitalizations, with help from a Cardinal Health grant. "The Cardinal Health Foundation has a unique mission, strategy and target audience. In addition to *their* work preventing prescription drug abuse and improving community health, the Foundation provides financial support to healthcare organizations that want to hit the daily double of cost effectiveness: improving quality and controlling costs—at the same time." [6]

Alternative Decisions Considered

If the practice continued with the practice centric approach (no change to current workflows), the environment would remain in the control of the office, with collaboration remaining exclusively between patients, providers and staff. Patients could remain in their comfort zone, working with providers and clinical staff they know and trust. Inopportunely this would reduce the likeliness of a partnership with all potential patient resources and would not consistently involve the larger

care team, such as registered nurses from the in-patient setting and other important care partners from the hospital setting including social workers, pharmacists and physical therapists.

Adopting an organization wide approach would create collaboration among the larger care team, including hospital clinical staff, nursing home staff, home health services, care managers, and community resources. Developing these relationships with the family medicine practice would allow patients to realize a broader range of support from many partners in the care team. Adopting an organizational approach would also provide the opportunity for the practice's clinical staff to participate in standardized care transitions training and allow them to participate on the care transitions committee alongside hospital clinical and ancillary services staff. This would result in improved access to and evaluation of readmissions data and the ability to collaborate with other committee members in sharing improvement ideas (learn and share best practices). Concerns with adopting an organizational approach included the consideration that post hospitalization communication to the patients would now come from several sources such as hospital registered nurses, social workers, home health staff as well as the practice clinical staff. The practice realized that this may be confusing and redundant to their patients. It was also imperative that the medical record be accessible and kept current by the care team with regard to services provided to the patients and that clear lines of communication to the primary care provider be established by all members of the care team.

Chosen Solution

To continue with the practice centric process would not improve readmission rates. The Quality and Safety Department spear headed the enterprise to improve the process for improving care transitions from the hospital setting to home and other outpatient facilities by adopting an

organization wide approach to care transitions. The opportunity to receive grant support was a positive influence on the decision to aggressively improve care transitions.

Implementation

In 2010, with support from the Cardinal Health grant, a care transitions committee was convened by the hospital quality department. This effort was spearheaded by the vice-president of the quality and safety department. The committee sought representation from various areas of patient care, both in-patient and out-patient. Regular attendees included the hospital social worker, registered nurses from the in-patient medical surgical floor, a physical therapist, a pharmacist, a representative from the local home health agency, representation from a local nursing home and representation from one of the out-patient primary care offices. The committee also included a representative from the health system that the local hospital was affiliated with. This person acted as a liaison between the smaller local community and the larger organization that was working toward the same goal of improved care transitions and reduced hospital readmissions.

The committee adopted guidelines and principals from Project BOOST and Project RED. The acronym BOOST stands for, Better Outcomes by Optimizing Safe Transitions. Project BOOST aimed to enhance the hospital to home discharge transition. [7] Project RED (Re-Engineered Discharge) is a research group at Boston University Medical Center. This group "develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates".[8] The committee adopted a Project BOOST readmission risk assessment tool named the 8 Ps.[9] This tool allowed the hospital, at the time of admission, to evaluate a patient's risk for readmission based on ; polypharmacy, psychological concerns,

principal diagnosis, physical limitations, poor health literacy, poor social support, prior hospitalizations, and palliative care (does this patient have advanced serious illness?). Any identified risks prompted an intervention to address that risk. A patient with polypharmacy or a high risk medication profile would prompt a referral to the hospital pharmacist, who would then collaborate with the attending physician. A patient with poor social support would result in an intervention with the hospital social worker and the home health team. The hospital developed a new role called the patient care facilitator (PCF). These were registered nurses whose role it was to participate with the patient (and family) in navigating the care they received from the time of admission to the time of discharge; with the premise that discharge planning began at the time of admission. Physician practice personnel partnered with the PCFs and the care transitions nurse to fully coordinate post-hospitalization care.

Within the first year the committee recognized the importance of having regular meetings to include all of the area nursing homes. These were set up on a quarterly basis and the medical directors of the nursing homes were included. This yielded improved processes for patients transitioning from the hospital to a nursing home facility and improved communication about individual patient care transitions.

The role of the primary care practice became more fully appreciated as this work unfolded and the communication between the hospital nurse and the practice nurse developed into collaboration. Processes were put in place to ensure the practice's registered nurse was notified as the patient was being discharged from the hospital setting. Discharge instructions and medication lists were faxed to the practice. The medication list in the medical record was updated by the practice and the nurse was prompted to contact the patient by phone within forty eight hours of discharge. Standards were developed that established that any patient considered at high risk for readmission was scheduled in the office within seven days of discharge from the hospital.

Provider schedule templates were altered to ensure availability for these hospital follow up office visits.

Outcomes and Lessons Learned

Between 2009 and 2014 the hospital realized a 1.7% reduction in thirty day readmission to their facility, but a 2.7% increase in thirty day readmissions to all hospitals for their patients. Lack of improvement in rates led to a closer drill down of the data. The highest readmission related diagnoses were pneumonia and chronic obstructive pulmonary disease (COPD). A workgroup focused on improvement in care for patients with COPD was begun and involved a partnership between the hospital staff and the outpatient practices. The value of the role of a care transitions nurse was evaluated and led to the addition of another registered nurse care manager who followed patients in their home setting and worked to improve the health of patients living with poorly controlled chronic illness such as COPD and diabetes. The local hospital partnered with the health system to more closely review population health management outcomes and train practice staff in best practices to improve health outcomes for their patients. Closer partnerships with community providers including home health nurses, skilled nursing facilities and long term care facilities were formed. These partnerships produced benefits that included development of standardized processes in care transitions and care coordination for patients. The process of transformation yielded a decision to provide an off shoot committee that meets monthly to discuss specific readmission cases. This committee determines what other interventions and services may be provided to assist the patient in attaining better health, potentially reducing readmissions to the hospital. In the end, the effort to improve the health of their patients and reduce hospital readmissions yielded valuable lessons and resulted in improved systems and collaboration in serving the patients of the community.

Recommendations for Other Managers

As a practice manager it is important to remain informed and involved in the changes and improvements in the delivery of healthcare. Ambulatory care practice managers bring a different and important perspective to the in-patient setting. It is imperative to engage in the care transitions and care coordination process and to involve key staff in partnering with other care providers. Even though the readmission rates were not influenced in a positive direction, care delivered to the patients was improved. The collaboration between hospital and practice created exceptional workflows that led to long term partnerships with care managers in the in-patient and out-patient setting.

ENDNOTES

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