Reducing Readmissions with Multidisciplinary Teamwork

Topical Areas of Focus

Topical areas of focus for this project include patient safety, quality improvement and patient experience.

Executive Support

Covenant Health Plainview (CHP) is dedicated to providing our community with world class health care, close to home. Our 68-bed facility is home to over 300 healthcare professionals whose mission is to consistently deliver the best possible care to our patients and our community. To help us keep this commitment, we are affiliated with Covenant Health, the region's largest health system and St. Joseph Health System in California. Covenant Health Plainview is a faith-based, not-for-profit healthcare institution, striving every day to provide our region with the country's top providers, including both surgeons and specialists. Our diverse, inclusive team ensures our ability to satisfy the healthcare needs of our community. Our goal is to provide excellent quality care in a safe environment, while consistently exceeding the service expectations of our patients and visitors. Key metrics in the areas of quality, safety and experience are utilized to identify potential opportunities to enhance care delivery. Performance scores are reviewed weekly and monthly by the leadership team, staff, board members and physicians to monitor and identify areas that may need improvement. When opportunities are identified action plans are implemented and evaluated so we can ensure we are meeting our goals.

Executive Summary

Excessive avoidable readmission rates have forced Medicare to implement the readmissions reduction program due to a reported spending rate of $17.8 billion a year on

readmissions that could have been avoided. A fragmented health care system and lack of communication has left discharged patients confused about follow-up care, medications, and financial resources leading to unnecessary hospital readmissions and deterioration of their disease processes. Hospitals are actively seeking ways to reduce readmissions in order to avoid penalties. Covenant Health Plainview is an acute care hospital that has taken the lead in an innovative strategy to improve patient education, communication, and partnerships. The result has been an impressive reduction in readmissions, along with a priceless impact on the culture of the healthcare team. Healthcare professional have rejected the jaded culture of labeling patients as non-compliant, frequent fliers, and drug seekers, and are rather embracing a culture of assisting and encouraging patients to become engaged and empowered in managing their own disease processes leading to healthier lifestyles and healthier communities. Frontline staff has engaged in understanding the barriers that discharged patients experience, the prominence and impact of low health literacy, and the resources that patients lack in achieving a healthier lifestyle.

Background, Relevance and Efforts

With the implementation of the Medicare Readmission Reduction Program in fiscal year 2012, Covenant Plainview began to critically review and analyze readmission data. Results of the FY2013 Readmission Reduction program led to a $49,000 penalty. Readmission rates were as high as 33% for all payers and 27% for Medicare/Medicaid patients. Although the penalty at the time might not have reflected a great financial impact, we knew the included patient populations along with the penalties would continue to increase. Of course, much more important than the financial impact, large or small, was the acknowledgement that readmission rates of 33% and 27% were completely unacceptable from a quality standpoint. We needed to

intervene in the interest of patient safety and quality. CHP initially met regularly with outside agencies in the community and the region (home health, nursing homes, meals on wheels, local pharmacies, Adult Protective Services, etc.) to improve communication and processes associated with patient hand-off and care transitions. Chart reviews were performed to identify reasons for readmissions thereby allowing us to change some of our discharge processes. Through this review, we recognized that many of our patients were being readmitted within a 24-72 hour timeframe. Case Management assessed 100% of our admissions for discharge needs and provided educational opportunities for nursing home staff on early recognition of worsening conditions. All of these efforts were successful in improving relations, communications and in developing needed process changes however, there was no noticeable decrease in the readmission rate.

Development of the Care Transition Program: Scope, Process, Strategies and Tactics

In researching navigator programs, CHP identified opportunities to improve upon the traditional model, and decided to develop their own program. This led to the development and implementation of the Care Transition Team. A readmission task force was developed with members from the quality department, case management, nurse managers, respiratory therapy and the chief nursing officer. This team reviewed charts and discussed readmissions. Case Management monitored LACE scores and identified high-risk patients for readmission, sending this information to the Acute Care Services Nurse Manager (NM) who served as the program coordinator. The NM would then review the chart and visit with the patient to assess the need to be on the program and to obtain consent. Parameters were determined to identify high risk patient populations to be included in the program.

The final step and the most unique strategy for this program was to utilize our front line staff members that were caring for the patients in the hospital to follow the patients at home. This provided a more trusting relationship, not only with the patients and families, but with the physicians. Because the medical staff is familiar and comfortable with the nursing staff, they found comfort knowing that the nurses that were assisting the patients with communication and education at home were already familiar with the patients and their plan of care from the hospital setting. Our Chief Medical Officer was also actively involved in the program and assisted with the development of education assessment tools and policies. The staff was educated on goals, duties and expectations, with a strong emphasis on health literacy, communication and education. It was strongly reiterated to the team that they were not functioning in the role of home health. The goal was to teach and empower the patients to care for themselves and to learn about resources and how to communicate with health care providers.

Initially, the groups selected for program participation included a small population of CHF, Pneumonia, Diabetes and COPD patients. This later expanded to include patients with Sepsis and those undergoing Total Joint procedures. In addition to the diagnostic groups, patients included in the program had a LACE score of > or = 10 or were positive for an additional high risk indicator with any LACE score (LACE is a predictor of readmission risk; L – Length of Stay of the index admission; A – Acuity of the admission; C – co-morbidities; E – number of ED visits within the last 6 months). The education evaluation tool is completed by the nurse at each home visit. This tool provides an assessment of the patient's understanding of their disease process including appropriate self-management, and determines whether the patient has a primary care provider including accurate contact information. The tool also assesses the patient and care giver's knowledge and ability to identify early warning signs of worsening conditions,

verbalize medications – including dosages and reason for taking medications, and ascertains that the patient has an organized system for taking medications correctly. The scoring system associated with this provides guidance on how often the patient needs to be seen. A risk evaluation tool is also completed on the initial visit. This tool evaluates risk for falls, access to nutrition, adequacy of living conditions, tobacco/substance abuse, depression and/or anxiety, family support/involvement and financial resources. Patients are followed for 30 days, however if the team identifies a need for additional support, time in the program will be extended.

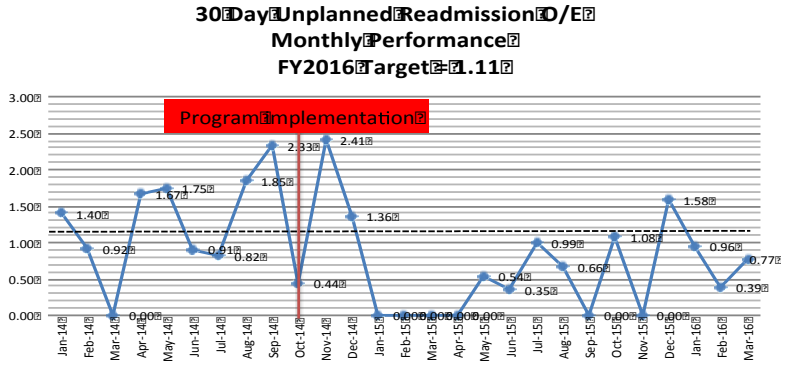
The most significant challenges along this journey were early identification of high-risk patients, encouraging patients to consent to program participation, developing effective community partnerships, and gaining a holistic understanding of the barriers associated with low health literacy. Working with multidisciplinary teams and building relations, not only within our hospital, but throughout the region has helped in overcoming many of these challenges. Improved communications with case management in morning huddles provides an on-going assessment of patient needs as these needs often change from the initial admission assessment. This has assisted greatly in early identification of patients most in need of this program. Engagement of these patients and their caregivers early in their stay, assists with a positive view of the program and this, along with building trust, has encouraged consent for program participation. Active participation with our community committee increased our knowledge of resources including adult protective services, pharmacies that have home delivery service, providers from the Department of Aging and Disability Services that assist with cleaning, daily care, and grocery shopping, Meals on Wheels, and home health agencies that provide social workers. Participation with the Health Quality Institute provided us with educational tools for staff and patient education along with building relations and communications, sharing ideas and

successes to reduce readmissions. Health Literacy can be a very abstract concept for many healthcare providers. One of the greatest benefits of this program is having the nurses actually go into the homes of their patients. They witness the reality of the debilitating impact of low health literacy and lack of resources for self-care. This has provided immeasurable encouragement and motivation of the Covenant Plainview team to make a difference in their community, because the results of this program are proving that they can. The team is inspired to drive this change and to use their own expertise and compassion to empower and engage patients in the care of their disease processes.

Results of the Effort

The efforts of this program have proven to be successful. Readmissions have been reduced from a baseline of 11.2% (FY2014) to 5.4% (FY2015). The program has been in place approaching two years (implemented October 2014). Following program initiation, a monthly readmission rate of zero for the measured high-risk populations was sustained for four consecutive months (Jan. 2015 – April 2015). Nearly two years later, the program is not only sustained, but is running strong. The monthly 30 Day Readmission rate has sustained better than target for the past 15 months, with the exception of December 2015 during which a change in program leadership led to a decrease in performance.

Covenant Plainview



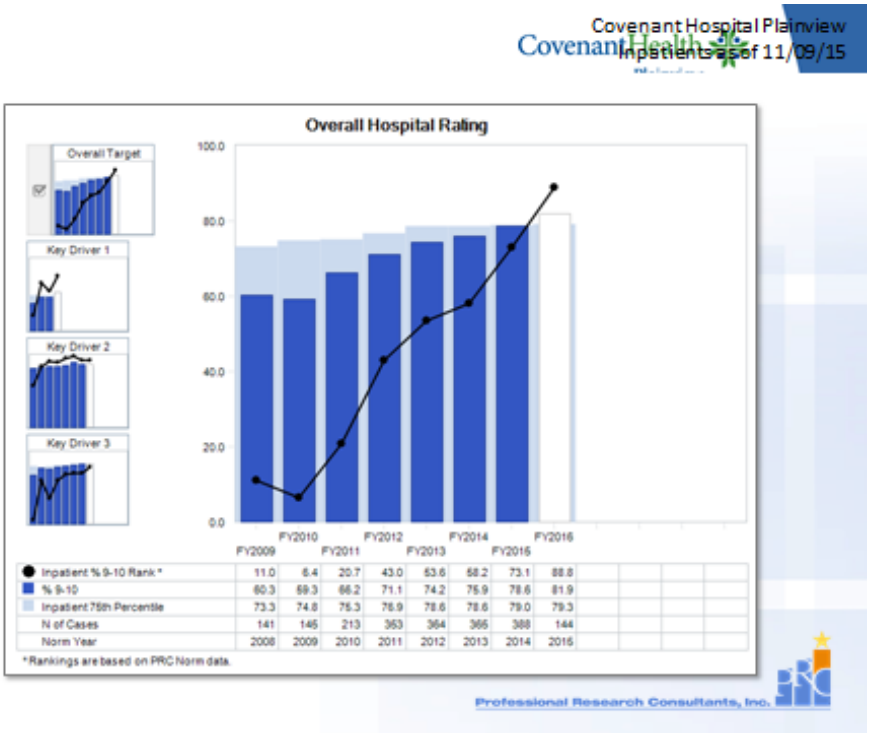
However, as noted previously, the results of the effort went well beyond the numbers and statistics. There has been a noticeable shift in the culture of the staff. Frontline nurse teams have developed a more informed, compassionate perception of patients who are struggling to obtain and maintain good health. Rather than labeling these individuals, the team is now working together, brainstorming and collaborating on how we can assist our patients and remove barriers to care.

Significance of Results and Outstanding Achievement

As these plans, processes and teams were implemented there was a significant increase in our PRC customer satisfaction scores from a Q1 FY2015 baseline of a 19th percentile ranking to a 93rd percentile ranking Q4 FY2015. This high was sustained until Q4 FY2016 when a change in leadership over the Care Transition Team and the nursing units led to a decrease to the 15th percentile. However, upon establishment of new leadership, the program returned to its success, with the PRC scores rapidly increasing back to the 86th percentile for Q1 FY2017 YTD.

Although we regretted seeing our scores drop to this level, it reinforced the efficacy of the program and the need to have continuous monitoring and evaluation of patients at high risk for readmission.

This initiative has had a tremendously positive impact on our organization. It has allowed staff to become more understanding of the barriers that many patients experience after discharge. Employees that once identified patients as "frequent fliers", "drug seekers" and "non-compliant" are no longer labeling patients in this manner. After hearing stories from team members and some experiencing them on a first hand basis, staff have become more aware of patient needs after discharge and the need for improved communication and education. The employees also feel that this is allowing them to build more trusting relations with our community thereby improving our overall hospital ranking.



This initiative has also led to improved collaborative efforts among internal hospital departments, as well as with outside agencies to whom our patients transition for post-acute care. Our physical therapy manager recently stated that he sees more teamwork and improved communication among nurses and ancillary departments discussing patient needs. Implementation of this program provided a unique insight into the issue of low health literacy within our community. As nurses go into patient's homes, they gain a much more clear vision of the very real issues that face our patients following discharge, and the compounded impact of low health literacy in combatting these barriers. This has led to the development and implementation of focused education for our teams on the subject of health literacy, the associated barriers to health maintenance and effective interventions. Staff has learned how to engage and inspire patients as partners in their own health. Going into the homes and educating patients on when to notify their PCPs, improving their knowledge regarding diet, medications and disease processes has empowered patients to better care for themselves. This is much more than mere words for our teams, this has become their quest to improve the health of our community. Seeing and hearing these success stories and seeing improvements in our scores and ratings have given the staff a sense of pride in improving the quality of care in our facility and our community.

Sustainability and Scaling of Achievements

Covenant Plainview was able to take the proven concept of a Navigator Program, and through innovation and strong leadership enhance the design to achieve far reaching additional benefits. At the core of the sustainability of this program has been resilience and courage. The idea to utilize front line nurses as patient care extenders in the community is novel, and for many, a crippling concept with too many barriers to overcome from engagement and

reimbursement to prevention of burnout. These barriers have been overcome through transparency and strong, inspirational leadership. Routine monitoring and reporting of performance at all levels, including frontline team members, is essential to sustainability. Improving performance encourages continuation of the effort and lags in performance facilitate effective mechanisms for improvement. As we continue our journey, we have had the great opportunity to share our program and stories throughout the nation to help other hospitals reduce readmissions. As the healthcare system transitions to a model of population health, it is important for hospitals to share successes to foster healthier communities. Active involvement with our Regional TMF Health Quality Institute, as well as with the CalHEN 2.0 Hospital Quality Institute has been incredibly valuable in terms of sharing of best practices and learning from others. Much of our success has been related to active involvement in the Regional TMF Health Quality Institute efforts to reduce readmissions throughout the region. We have presented our program at TMF regional meetings, delivered webinars for TMF Health Quality Institute and CalHEN 2.0 Hospital Quality Institute, individual presentations for hospitals and health providers throughout the nation and the National Premier Conference in Washington, D.C. TMF submitted our program to CMS as their Quality Improvement Project. CHP was also recognized by Professional Research Consultants, Inc. with a Platinum Award in 2016 for "Achieving Excellence through Multidisciplinary Teamwork" and invited us to present a webinar on the improvement in our overall hospital rating. This recognition has motivated the employees at our facility to always go above and beyond for the customers we serve in our community and region and has made them proud to be a part of our CHP family, recognizing the need to step outside the walls of our comfort zone and promote healthier communities. CHP leadership are visible supporters of this program, not only in word, but in action. The CNO has participated in home

visits and discussions of health literacy and mechanisms to improve the health of the Plainview Community. She is a highly respected, inspirational leader who reminds the team that this is her covenant, as it is theirs – and together in partnership with each other, with patients and caregivers, and with post-acute community providers, they are making an impact and this success will continue.

Key Lessons Learned and Advice to Colleagues

The greatest lessons learned involve budget, data collection, record maintenance and consideration of adequate resources for managing and sustaining the program. Recognizing the dire need to implement the program to avoid further penalties we did not wait for a new budget year. We utilized money allocated for salaries from the Med-Surg department budget as this is where the majority of the impacted patients were identified. As we started seeing patients we also realized the need for emergency funds for initial assistance for prescriptions while patients waited on funding or income checks. We found employees taking up donations for this, donating scales and pill boxes so patients in need could have the tools they needed to care for themselves. We have now allowed a small budget for these emergency needs that arise. There is also more focus on the data so we can monitor the need for adjustments in the program along with maintaining better records on the number of patients that have participated in the program. Finally, as the program continues to grow there may be a need to have a coordinator that is solely dedicated to the program. The greatest advice would be to not be afraid to step outside the comfort zone, recognize the potential of your teams to truly impact the community outside the walls of hospitals. The impact to care teams when they recognize the barriers and challenges that patients face beyond discharge may facilitate a tremendous culture change, as teams are inspired to empower their communities to a healthier life.