Readmission Prevention: A Community Collaborative Approach

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Objectives

• Explain the importance of readmission prevention programs to facilitate patient continuity of care and the need for community and inter-disciplinary team collaboration to improve transitions in care.

• Identify effective strategies for developing community collaboration to improve transitions of care and reduce avoidable readmissions.

• Describe the role of the transition care coach in collaboration with community health care providers in reducing hospital readmission rates.
Shawnee Mission Medical Center

- Located in Shawnee Mission, Kansas

Shawnee Mission Medical Center

- 504 bed Faith-Based Acute Care Hospital
  - Part of the Adventist Health System
  - Prairie Star
  - Corporate Care
  - New Site development

- Over 700 physicians

- Over 3000 employees
Readmission Prevention

Why Develop a Readmission Prevention Program?

• Upcoming Medicare penalties.
  ▪ Proactive approach

  ▪ Higher quality patient care.
  ▪ More efficient use of resources
  ▪ Increase HCAPS scores
  ▪ Smoother transitions between levels of care

Readmission Prevention

• Help patients avoid the “revolving door”
Transitions in Care

SMMC Transitions in Care Program

- Initiative started by Chief Nursing Officer
  - Administrator of Case Management and Social Services
  - Director of Nursing Advancement and Professional Development

- Joined IHI Transitions In Care Collaborative and Project RED.
  - Case analysis: Bi-monthly calls
  - Tests of change: Team approach

Targeted Population

- Medicare
- CHF (add PNA and AMI in phase II)
- COPD added in 2013

Follow patients to all transition destinations

- Home
- Home with Home Health
- SNF, Assisted Living, LTC, LTAC, Hospice/Palliative Care, Rehab
- (Learned early all levels of care need transition care coach)
Internal Team

- Nursing
- Pharmacy
- Social Work
- SMMC Home Health
- Cardio-vascular services
- Nursing Education
- Transition Care Coach
- Physicians

Function of the internal multi-disciplinary team

- Team collaboration to assess for barriers and patient risk factors for care transitions.

- Integration of early high risk patient identification.

- Replace “discharge” with “transition”. Look beyond hospitalization.

- Enhance patient centered care.
External Transitions in Care Team

• “If you build it (continuum of care collaborative), they will come”

External Transitions in Care Team

Initiated by invitation from SMMC
• Monthly meeting at SMMC.
• Initial group consisted of representatives from 4 to 5 area skilled nursing facilities.

Growth by word of mouth
• 50 Agencies represented
• 105 Members in attendance
External Transitions in Care Team

**Improvement in transitions in care: Monthly meetings**

- Case studies of patient readmissions to identify barriers and opportunities in transitions of care
- Development of common handoff tool that meets needs of hospital and external agencies
- Pooling of resource information and tools
  - File of Life
  - TPOPP
  - Interact

**External Transitions in Care Team**

**TPOPP-Transportable Physician Orders for Patient Preferences**

- Appropriate for patients who are frail or have a limited amount of time to live.
- It travels with the patient between health care settings in order that a patients wishes are known and respected.
- It helps physicians, nurses and EMS personnel be better informed about wishes for care.
External Transitions in Care Team

Monthly meetings (continued)

• Trend readmission data specific to various agencies/facilities to use in forming stronger community partners

• Venue to provide education about national or local policy, trends and strategies that affect hospital readmissions

• Facilitate networking and discussion among community providers
  • “Breaking down silos”

Community

• Face to Face
  • “First name” partnerships
  • Creating “out of the box” pathways for patient care
Transition Care Coaches

Transitions Care Coaches
- .5 FTE BSN (Hours increased within a year)
- .5 FTE LMSW (Hours increased within a year)

- Build relationships with patients and families and facilitate care transitions
- Bridge the gap between hospital and community healthcare providers

Opportunities

- High number of readmissions were from SNF and home health agencies
  - Realized Transition Care Coaches interactions would extend beyond patient coaching

- Patient often needing higher levels of care post-discharge than anticipated
  - Right level of care

- Facilities and agencies voiced frustration of higher level of patient acuity
  - Address need for additional resources
Community

SMMC stepping out into the community

• Met with area agencies to introduce Transition Care Program and Transition Care Coaches to foster partnerships

• Provided program information in-services to the community

• Created “introduction” card for area facilities that identified a patient as part of the Transition Care Program
  • Provided program information
  • Transition Care Coach and contact information

Community

Provide education in-services to staff at area facilities

• Disease specific patient care guidelines.
  • In-service provided to ALL staff.

• Provides earlier detection of signs and symptoms.

• Higher compliance with care protocols.

• Fosters relationship between facility and the hospital.
Primary and Specialty Care

- Transition Care Coaches met with cardiologists (2 practices) and office staff to introduce program.
  - Increased volume of follow up appointments
  - Timing of follow up appointments
  - Barriers to patient completing follow up appointments

- Transition Care Coach to provide needed information.
  - Discharge Medication Reconciliation
  - Discharge Summary

Community Wellness

**Community Wellness Programs**

- COPD and CHF

- One hour information/education session
  - Nurse (CHF)
  - Social Worker (CHF)
  - Respiratory therapist (COPD)

- Ongoing supervised fitness program
  - Physical therapist/respiratory therapist
  - Exercise specialist
Case Study: Jim

- Patient, a 72 year old widowed male with multiple hospital readmissions declined home health at discharge, but agreed to follow up with TCC

- Follow up appointment scheduled with PCP prior to discharge; appointment desk employee alerts TCC that patient often misses appointments

- TCC learned from patient about problems with family transportation during first home visit and set up alternate rides to appointments

Case Study: Lillian
Case Study: Lillian

- Patient was advised to discharge to SNF, but went home with home health instead
- Home health nurse called TCC and PCP with concerns about the patient being unable to manage self-care at home
- Due to partnerships created in the monthly community transitions in care meeting, the TCC was able to facilitate moving the patient into a skilled nursing facility
- Patient and family stated they thought they “could manage” care and physical needs after discharge, and felt overwhelmed once home

Program Results
Program Results

SMMC CHF Readmission Rates
August 2011-December 2011

<table>
<thead>
<tr>
<th>Month</th>
<th>Non-Transition Coach</th>
<th>Transition Coach</th>
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<tbody>
<tr>
<td>August</td>
<td>38% (5/13)</td>
<td>31% (4/13)</td>
</tr>
<tr>
<td>September</td>
<td>17% (4/23)</td>
<td>0% (0/23)</td>
</tr>
<tr>
<td>October</td>
<td>35% (8/23)</td>
<td>11% (1/9)</td>
</tr>
<tr>
<td>November</td>
<td>0% (0/9)</td>
<td>0% (0/9)</td>
</tr>
<tr>
<td>December</td>
<td>25% (7/28)</td>
<td>17% (2/12)</td>
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Program Results

SMMC Monthly CHF Readmission Rate
Non-Transition Coach vs. Transition Coach
January 2012 - December 2012

<table>
<thead>
<tr>
<th>Month</th>
<th>Non-Transition Coach</th>
<th>Transition Coach</th>
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<tbody>
<tr>
<td>January</td>
<td>17% (4/24)</td>
<td>51% (10/19)</td>
</tr>
<tr>
<td>February</td>
<td>31% (5/16)</td>
<td>67% (4/6)</td>
</tr>
<tr>
<td>March</td>
<td>12% (3/25)</td>
<td>100% (3/3)</td>
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<tr>
<td>April</td>
<td>12% (3/25)</td>
<td>100% (3/3)</td>
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<tr>
<td>May</td>
<td>20% (4/20)</td>
<td>100% (3/3)</td>
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<tr>
<td>June</td>
<td>0% (0/20)</td>
<td>100% (3/3)</td>
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<tr>
<td>July</td>
<td>14% (2/15)</td>
<td>100% (3/3)</td>
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<tr>
<td>August</td>
<td>4% (1/23)</td>
<td>100% (3/3)</td>
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<tr>
<td>September</td>
<td>10% (2/20)</td>
<td>100% (3/3)</td>
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<tr>
<td>October</td>
<td>22% (4/18)</td>
<td>23% (6/26)</td>
</tr>
<tr>
<td>November</td>
<td>23% (6/26)</td>
<td>23% (6/26)</td>
</tr>
<tr>
<td>December</td>
<td>22% (4/18)</td>
<td>23% (6/26)</td>
</tr>
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Program Results

**SMMC CHF Medicare Readmission Rate**

- 22.4% (76/339) in Jan-December 2009
- 22.5% (72/320) in Jan-December 2010
- 22.9% (78/340) in Jan-December 2011
- 16.5% (50/302) in Jan-December 2012

28% decrease in readmissions

**SMMC Monthly PNA Readmission Rate**

- Non-Transition Coach vs. Transition Coach

- September 2012 - December 2012

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<th>Month</th>
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<th>Transition Coach</th>
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</thead>
<tbody>
<tr>
<td>September</td>
<td>13% (1/8)</td>
<td>13% (1/8)</td>
</tr>
<tr>
<td>October</td>
<td>14% (1/7)</td>
<td>14% (1/7)</td>
</tr>
<tr>
<td>November</td>
<td>13% (2/16)</td>
<td>13% (2/16)</td>
</tr>
<tr>
<td>December</td>
<td>13% (1/8)</td>
<td>13% (1/8)</td>
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Program Results

SMMC PNA Medicare Readmission Rate

- Jan-December 2009: 14% (40/286)
- Jan-December 2010: 15.1% (40/264)
- Jan-December 2011: 16.5% (42/254)
- Jan-December 2012: 13.1% (36/274)

21% decrease in readmissions from 2011

Program Results

SMMC Monthly AMI Readmission Rate
Non-Transition Coach vs. Transition Coach

- September 2012: 20% (1/5)
- October 2012: 20% (1/5)
- November 2012: 16% (1/6)
- December 2012: 0% (0/3)

Non-Transition Coach vs. Transition Coach
Program Results

**SMMC AMI Medicare Readmission Rate**

- Jan-December 2009: 24.2% (31/128)
- Jan-December 2010: 17.1% (20/117)
- Jan-December 2011: 19.8% (25/126)
- Jan-December 2012: 10.1% (8/79)

49% decrease in readmissions from 2011.

**Where Transition Coach Patients Readmitted From August 2011-December 2011**

- Home: 40%
- Home Health: 40%
- SNF: 20%
- Other: 10%
Program Results

Where Transition Coach Patients Readmitted From January 2012 - December 2012

- Home: 40%
- SNF: 25%
- Home Health: 17%
- Acute Rehab: 6%
- LTAC: 2%
- Hospice: 0%

Where Transition Coach Patients Discharged To January 2012-December 2012

- Home: 35%
- ALF: 26%
- SNF: 25%
- Home Health: 20%
- Acute Rehab: 1%
- LTAC: 1%
- Hospice: 9%
Program Results

• Of Patients Followed by a Transition Care Coach:

  • 59% of patients that did readmit had attended a follow up PCP appointment.

  • 88% of patients that did not readmit attended a follow up PCP appointment.

  • 37% of patients that readmitted were offered a recommended service post-discharge, but declined.

Wrap Up
Challenges

• **Who, When and What?**

  **Who** are the at risk patients - in “real time”?

  • **When** do we address end of life issues?
    - Hire of palliative care physicians

  • **What** level of care are we discharging the patient to?
    - Aim for highest level of care service with the first admission

Program Essentials

• Administrative support and physician champions

• Multi-disciplinary internal team
  • Strong palliative care program

• Community collaboration
  • PCP/Specialty care
  • Agencies/facilities

• Transition Care Coach role implementation
Readmission Prevention: Evolution

• Continual program assessment
  • Information exchange with other hospitals and readmission prevention programs

• Data collection
  • Refining data for trends

• Looking ahead
  • Program expansion

Questions and Discussion
Readmission Prevention: Evolution

• Reducing hospital readmissions...improving continuity of care...and making pigs fly!!!

Contact Information

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Thank you!