HRET HIIN CASE STUDY

QUEST FOR EXCELLENCE

AHA CENTER FOR HEALTH INNOVATION

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Advancing Health in America

REDUCTION IN READMISSIONS THROUGH CARE TRANSITIONS PROGRAM

Gila Regional Medical Center (GRMC)

Silver City, NM

SETTING THE STAGE

Describe how this project is consistent with your strategic plan and how leadership guided and sustained performance expectations.

> The healthcare landscape requires consistent effectiveness to promote safety and quality outcomes as measures for success and value-based reimbursement. It is of utmost importance to GRMC to embrace opportunities to improve the care transitions across the care continuum. While the primary purpose of this project is to establish a program that will support the continuum of care in the outpatient, acute care and community settings, there is a direct correlation resulting in a reduction of avoidable readmissions.

Why did you select this project and what methods were used to identify the need?

> GRMC's Utilization Review Committee closely monitors key utilization metrics on a monthly basis, including readmissions within 30 days of initial discharge. It was noted that GRMC's readmission rate was significantly higher than the national average. After reviewing, analyzing and discussing the readmission data, the UR Committee voted to re-evaluate and institute the Care Transitions program with a more comprehensive scope of interventions by partnering with physician's practices, community-based health care programs, and community social support services.

PROJECT DESIGN

Who was involved in the improvement effort

> Case Management began a care transitions pilot in 2016, with inpatients screened face to face by the care transitions nurse. Moderate success was achieved. In 2017 a senior baccalaureate nursing student conducted a capstone focused on care transitions. The at-risk population was identified using an analytical approach, a new program was designed with expansion of scope of interventions.

What methodology was used?

> The PDSA methodology was used. The analysis component of the cycle focused more on **why did it work** rather than **did it work**.

How was the data collected and how you used the data to guide your process improvement efforts?

> GRMC serves a population that has particular challenges that were continually considered in the basic program design. Per capita, Grant county residents are older, poorer, and sicker.

> The program design includes interventions and strategies that demonstrated effectiveness in the initial pilot program. These, in combination with implementation of new interventions found to be successful in evidence based care transitions models, became the framework of the new care transitions program.

RESULTS

Describe the results including patient outcomes, process changes and service delivery results.

> **Risk-adjusted planned and unplanned readmissions day 1-7**

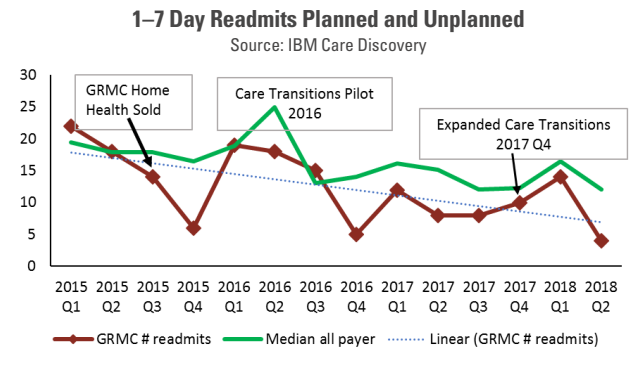
By 2016 Q1, GRMC saw day 1-7 readmission counts return to the comparative median. Analysis of the readmitted patients showed a need for better support through the discharge transition, therefore the Care Transitions Pilot Program was initiated. The program helped stabilize readmissions and ran through 2016 Q4. By 2016 Q4, the day 1-7 readmission count had decreased to 36% below the median. (See graph top right.)

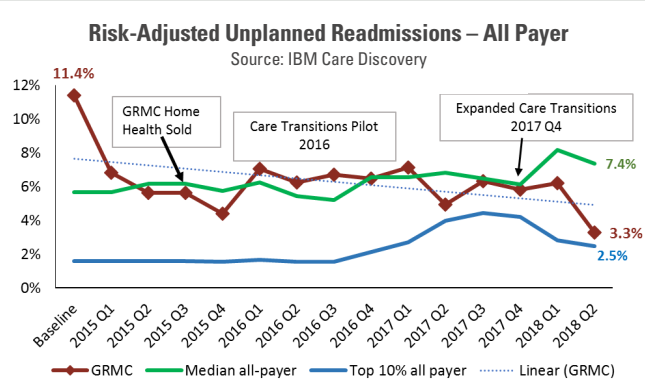
> **Risk Adjusted Unplanned Readmissions**

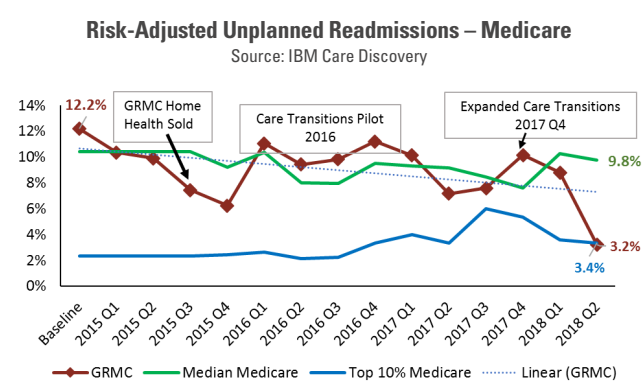
GRMC baseline all-payer unplanned readmission rate is 11.4%, and the Medicare baseline is 12.2%. In 2015 Q1 and Q2 that rate had returned to the comparative median. The sale of the Home Health agency resulted in a decrease in readmissions for 2015 Q3 and Q4. Medicare readmissions showed a greater decrease in the last 2 quarters of 2015. The Care Transitions Program pilot demonstrated moderate stabilization of the readmission rates and ran through 2017 mid Q1 until it was discontinued. During 2017 Q4, the Expanded Care Transition Program was initiated and fully implemented in January 2018. In 2018 Q2 readmissions began running near the top 10% benchmark. (See graphs middle and bottom right.)

> **HCAHPS Care Transitions Domain**

In 2016 Q2, the Care Transitions Domain was 59.7 with a national top 10% benchmark of 61 that was attributed to the implementation of the Care Transitions Program Pilot. HCAHPS scores declined steadily as the program was phased out. In 2017 Q4, the expanded Care Transitions Program Domain began an upward trend through 2018 Q2. The 2018 Q2 score was 61.8 compared to a 41.9 in 2017 Q3.







LESSONS LEARNED

Care Transitions must be an organization wide endeavor rather than conducted by a single department or individual.

> Clear understanding of medication management is essential at the time of discharge to prevent the need to return to the hospital.

> Post discharge calls are scripted to assure consistency between callers. Calls are conducted by nurses and patient care technicians.

> No patient is discharged without having a PCP assigned and a follow-up appointment scheduled.

> Close working relationships are established with key community based case management programs (e.g. Social Detox Center; Health Home program for patients who have both a SMI and chronic medical condition.)

SPREAD AND SUSTAINABILITY

> This Care Transitions program model can easily be replicated by any hospital or facility without having to purchase expensive software, using current staff, and establishing collaborative working relationships with outpatient clinics and community programs.

> GRMC is committed to keep this program as a long-term ongoing initiative, closely monitoring health outcomes, readmission rates and patient experience scores.