

CareTrek™: Reducing Readmissions Through Cross-Setting Work Groups



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The current healthcare environment is extremely fragmented. As a result, as a patient transfers between different locations (or different levels of care in the same location), he/she may experience poor outcomes. When the transfer process is not coordinated properly, the patient is left in a vulnerable state and at an increased risk of rehospitalization. Ensuring the coordination and continuity of healthcare as patients transfer is critical to improving the quality and outcomes of patient care and in preventing potentially unnecessary readmissions.

Through a competitive procurement, CIMRO of Nebraska, the Nebraska Medicare Quality Improvement Organization (QIO), was awarded one of 14 contracts across the country by the Centers for Medicare & Medicaid Services (CMS) to conduct a cutting-edge initiative to improve care transitions and reduce avoidable rehospitalizations.

CIMRO of Nebraska's local project, CareTrek, is being implemented in a two-county area within the Omaha metropolitan area (Douglas and Sarpy counties). The focus is improving the sender-re-

ceiver relationship between healthcare providers. Devising a way to transfer discharge instructions and maintain a current medication list in a way that works for both the discharging and admitting provider is the key to success.

Approximately 18,000 Nebraska Medicare beneficiaries are admitted each year to hospitals in Douglas and Sarpy counties. Of those, nearly one in six are rehospitalized within 30 days, according to Medicare claims data. Medicare patients also report greater dissatisfaction related to discharge than to any other aspect of

care measured by CMS.

A Medicare Payment Advisory Commission (MedPAC) study found that 75 percent of all 30-day hospital readmissions of Medicare patients in 2005 were potentially preventable. A two percent reduction in readmissions in the Omaha metropolitan area alone would save over three million dollars per year. These staggering statistics indicate that there is room for improvement and a strong incentive for change. CareTrek provides an opportunity to significantly impact the health-care experience for Nebraska residents.

CareTrek recruitment efforts included the seven comprehensive Prospective Payment Systems (PPS) hospitals in the Omaha metropolitan area, 27 Skilled Nursing Facilities (SNFs), eight hospice agencies, 20 home health agencies (three of which are combined hospice and home health agencies) and ten dialysis centers owned by three different corporations. Faith-based organizations, including parish nursing, senior assistance programs and community organizations were also invited to participate.

Using data available through the CMS claims warehouse, patterns of care in the community were identified. Approximately half of the discharges evaluated were made directly to home, without any post-acute care services other than physician office visits. This accounted for approximately 10,000 total discharges. The next largest group, about 4,000 beneficiaries, was admitted to SNFs for post-acute care.

Using community and provider-specific data, CIMRO of Nebraska identified consistent patterns of patient flow between facilities. CIMRO of Nebraska used this data; along with the MedPAC June 2007 report to Congress, *Promoting Greater Efficiency in Medicare*, to engage senior leaders of the seven PPS hospitals. Brief, data-driven meetings were held with hospital quality staff and medical officers. Key contacts were identified to help facilitate communication and participation in cross-setting community work groups. To better understand the discharge process from the perspective

of the sender, each hospital provided information about its own discharge process.

With support of the hospital senior leadership, a community-wide educational event was held. Presentations included care transitions models and evidence-based interventions; including Project RED (Re-Engineered Discharge), The Care Transitions InterventionSM, Project BOOST and Mary Naylor's Transitional Care Model.

As a result, the CareTrek community has selected a variety of interventions to implement. Most interventions have initially been implemented by cross-setting collaborative teams. CIMRO of Nebraska was responsible for recruitment and also facilitated collaborative efforts.

Five cross-setting work groups were established to focus on the following:

1. Improving communication between hospital and SNFs (one hospital and four SNFs)
2. Defining discharge information needed by home healthcare as a receiver (six hospitals and eight home health care agencies)
3. Improving the discharge process using a known intervention, Project RED
4. Developing a known and standard process of sender-receiver communication of the medication list (one hospital, two SNFs and two home healthcare agencies)
5. Implementing of the Care Transitions InterventionSM

These workgroups identified three distinct opportunities for improvement: a) establish a known and standard communication between the sender and receiver, b) improve medication management through the use of 'one true list' and c) enhance the discharge process.

To complete the necessary tasks, many of the providers were working on implementing multiple interventions simultaneously. Best practices and lessons learned with each collaborative group were shared with the broader CareTrek community.

A) Establish Known and Standard

Communication between the Sender and Receiver. Two separate cross-setting work groups were established to improve the transition of care between hospitals and SNFs. Both groups included an individual hospital and four SNFs. While the groups identified diverse participants, focuses and interventions to implement, both aimed to develop a known and standard communication process between settings.

i) Communication Group One. One hospital and four SNFs expressed a willingness to work collaboratively to reduce readmissions. This group used self selection of partners, based on existing relationships and the number of transfers between institutions. Participants included case managers, social workers and administrators. This community learning group met for 18 months to improve communication between the hospital and receiving SNFs. CIMRO of Nebraska facilitated the meetings, which initially occurred monthly and then quarterly.

The group began by scheduling exchange visits. SNF staff visited the hospital to observe the discharge process and the hospital staff visited the SNF to observe the post-acute care admission process. Upon completion of the site visits, both the hospital and the SNF staff expressed a new understanding of the complexity of the process and a willingness to improve communication.

Based on information gathered during site visits, multiple interventions were implemented. Interventions included the use of nurse-to-nurse calls, evaluation of medical instability leading to hospital readmissions, the SBAR (Situation, Background, Assessment, Recommendation) process and training of SNF personnel on the use of the electronic lockbox, where medical information could be electronically transmitted and received. Concurrent data collection occurred.

Nurse-to-nurse calls: The group decided to initiate the nurse-to-nurse call at the time of transition. The calls were piloted in one unit at the hospital, but rapidly spread to all units. The SNFs expressed
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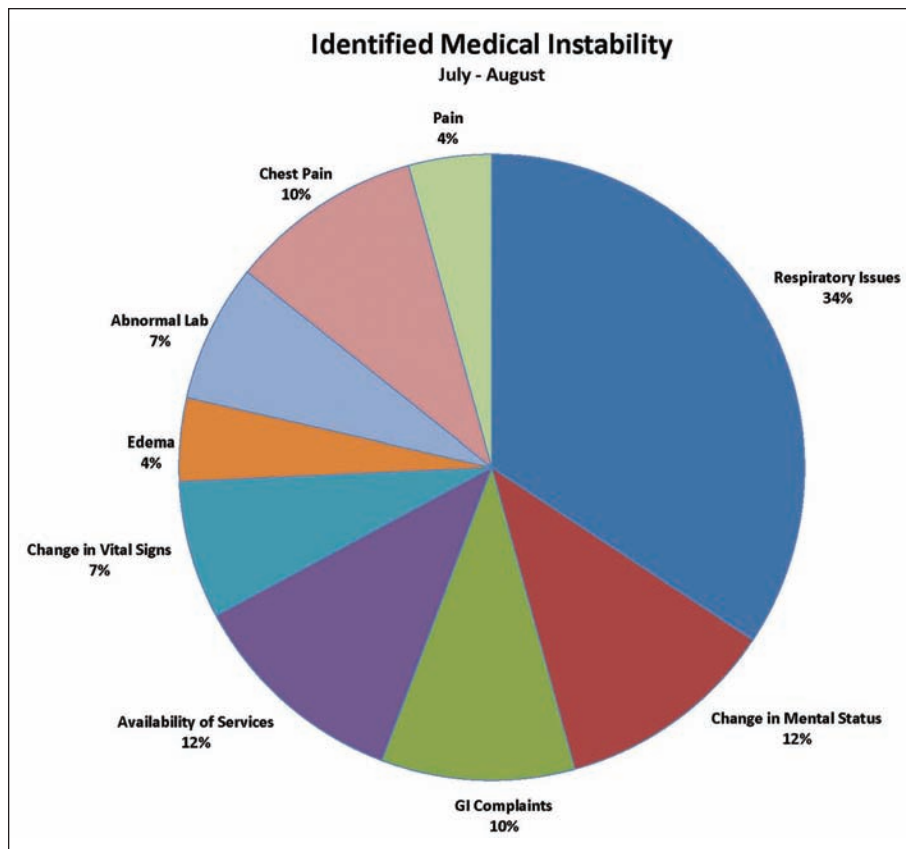
how important the calls were in providing needed information for appropriate transitional care. The nurse-to-nurse calls were also successful in reducing the need for follow-up calls from the SNF to the hospital and have become a known and standard process on all transfers from the hospital to the SNF. The SNFs reported they are also beginning to receive nurse-to-nurse calls from other area hospitals, a sign this process is spreading across the community.

Evaluation of medical instability and SBAR: When the SNFs reviewed the identified medical instability, the nursing staff felt a number of the reasons for transfer could be treated in the SNF, rather than transferring to the hospital. The documented medical instabilities leading to transfer back to the hospital are noted (see pie chart).

The workgroup felt that improving the verbal report given by the SNF to the attending physician might reduce the number of transfers. This would require the SNF staff to clearly communicate relevant information to the physician on call. Information would include the resident's condition and available treatment options. To assist, CIMRO of Nebraska introduced the SBAR tool. The SNFs adopted the tool and educated their staff on its use. All participating SNFs reported consistent use of SBAR.

Use of electronic lockbox: During the collaborative discussion, the group realized that much of the needed transfer information was available to the SNFs through the hospital's electronic medical record. However, not many SNF staff were familiar with the process for accessing it. CIMRO of Nebraska assisted the SNFs in assessing how they were currently using the electronic system and whether additional staff access would be beneficial. The hospital provided additional access and training as requested by each SNF. This improved access to needed information, including medication lists, orders for follow-up and discharge summaries.

ii) Communication Group Two. A second hospital and 4 SNFs came together to work on sender-receiver communication related to the transfer form. This group worked to identify priority



information needed to ensure a safe transition from the hospital to the SNF. Key elements were identified by the team. These elements were incorporated into the hospital's electronic medical record templates. The templates were redesigned to include needed information without significant change in staff workflow. Participants agreed this collaboration produced a set of transfer documents that were concise, easy to read and contained needed transition information without duplication.

[See end of article for the Hospital to SNF Transfer Form Information \(3 pages\).](#)

Successes, lessons learned and best practices were reported in the CareTrek newsletter, *The Trek*, and shared with community partners at a community-wide event in September 2010.

Based on feedback, CIMRO of Nebraska hosted a series of educational WebEx presentations in July 2010 to help with skill building of nurses and caregivers. The educational series included training on diabetes, congestive

heart failure, management of dyspnea and Chronic Obstructive Pulmonary Disease (COPD). Trainings were also offered on the Interventions to Reduce Acute Care Transfers (INTERACT) II tools, which include clinical and educational tools and strategies for use in long-term care facilities.

Attendees have shared their appreciation for these learning opportunities. Information gained will save the facilities time in process improvement and record keeping. Feedback on plans to implement changes, as a result of participation, has also been shared.

The two cross-setting work groups have been successful in choosing and implementing evidence-based interventions focusing on the sender-receiver relationships between a hospital and SNF. We anticipate continued improvement and plan to share with the broader community as opportunities become available.

B) Medication Management: Developing "One True (useful) List." Two additional cross-setting groups were established to better understand and communicate the essential elements in the

transfer of a medication list and to help reconcile medication lists across the continuum of care.

i) Medication Group 1: Hospital discharge planners and home health agency staff agreed to collaborate to improve sender-receiver communication related to medication reconciliation. The group of six hospitals and eight home health agencies identified ten key elements for safe medication management.

1. On the discharge medication list, include the following key elements:
 - all the medications the patient was actively taking at discharge, regardless of administration method,
 - brand and generic name for each medication,
 - indication for use,
 - where and/or how it is to be administered,
 - time last dose given at the discharging facility.
2. On the discharge instructions, include a contact phone number from the discharging institution to be used for questions. This may be the case manager and/or discharge planner.
3. At discharge, send signed paper prescriptions with the patient for all medications to allow for timely refills at the patient's pharmacy of choice.
4. Include lab results on the transfer sheet, if appropriate, such as with Coumadin and IV antibiotics.
5. Automatically include the time and date the medication list was last updated.
6. Hospital discharge information, including current medication list should be sent to the primary care physician and specialist, as well as the post acute-care facility or agency.
7. Access to real-time electronic health record information for each patient.
8. Automatic receipt of the hospital discharge summary when available.
9. Community-wide standardization of the content of the current

medication lists across the continuum of care and from all provider settings.

10. Electronic version of current medication list.

ii) Medication Group Two: IPRO, the New York QIO, offered CIMRO of Nebraska an opportunity to work collaboratively on an Agency for Healthcare Research and Quality (AHRQ)-QIO learning community collaborative centered on medication reconciliation. The AHRQ-QIO Medication Reconciliation Learning Network Collaborative was launched in April 2010. Nebraska participants included one hospital, two home health agencies and two SNFs. The goal was improvement of sender-receiver communication, specifically surrounding medication reconciliation.

Bringing providers from different care settings together to tackle medication reconciliation was an important and critical first step. One of the most valuable realizations was that medication reconciliation is a challenge and responsibility for each care setting. Only by working in cross-setting teams can each provider setting understand each partners' responsibilities in medication reconciliation, what must be done at admission and discharge from each provider setting to give the beneficiary a current and correct medication list.

At the first collaborative meeting, the 'one true list' concept was introduced. The 'one true list' is the list of medications that have been reconciled prior to discharge from the hospital and shared with the next provider. Discussion with collaborative participants revealed that identifying the 'one true list' was an urgent priority and should be the first step in the process to improve medication reconciliation across provider settings.

All of the hospitals in the Omaha metro area were contacted and asked to provide an example of what they have determined to be their 'one true list.' To assist in the medication reconciliation process and to improve transitions of care, examples of the area hospitals' 'one true list' are being shared with all CareTrek participants.

Identification of the hospital's 'one true list' and process changes by the

post-acute providers has reduced the number of discrepancies noted in the discharge medication reconciliation list from the hospital when compared to the post-acute care providers' list at admission. There was an approximate five percent reduction in failure rate between admissions in March and September, 2010 when comparing discrepancies identified by chart audit.

As a result of the medication reconciliation collaborative, a channel of communication has been opened. This group plans to continue to work together. This effort will positively impact patient safety and information learned will be spread to others within the community.

The improvement in medication reconciliation has already spread throughout the community as the two groups complete their work. Results included:

- Computer-generated discharge lists developed as each hospital completed system redesign or implementation
- Communication of generic and brand names of medications in medication lists
- Implementation of the Care Transitions InterventionSM model to help patients maintain their own medication list
- Physician and pharmacist reconciliation implemented
- Improved process of sending the correct medication list to the primary care giver

This work has been transformational as the previously hand-written medication list has been replaced by improved, reconciled, computer-generated lists in the community.

C. Enhanced Discharge Process: Improving the Patient Experience. The process of hospital discharge is complex and sometimes difficult. CIMRO of Nebraska worked with all the hospitals in the targeted community to improve the discharge process. Several focus areas were determined, which include enhancing the existing in-house care manager model, providing mid-level providers help to assess the patient shortly after discharge and reformatting discharge instruction and medication lists.

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Disease-specific interventions targeted key diagnoses. Data analysis had revealed that heart failure patients were re-admitted most frequently, with a readmission rate of 25 percent. The total payment for rehospitalization for these patients was just under \$2 million.

CIMRO of Nebraska hosted a Care Transitions InterventionSM model training for CareTrek members. The focus was on patients returning to independent living after hospitalization. Care transition coaching continues in the Omaha community.

i) Project RED (Re-Engineered Discharge) To Improve Care. The most comprehensive implemented reengineering process occurred in one hospital that adopted Project RED (Re-Engineered Discharge). Project RED is founded on 11 discrete, mutually reinforcing components that have been proven to reduce rehospitalizations and yield high rates of patient satisfaction.

Project RED Components:

1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing and:
 - Make appointments with input from the patient about the best time and date for the appointment
 - Coordinate appointments with physicians, testing, and other services
 - Discuss the reasons for and importance of physician appointments
 - Confirm that the patient knows where to go, has a plan for how to get to the appointment; review transportation options and other barriers to keeping these appointments

3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
5. Confirm the Medication Plan.
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.
8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient's care after discharge.
9. Assess the degree of understanding by asking patients to explain in their own words the details of the plan.
10. Give the patient a written discharge plan at the time of discharge that contains:
 - Reason for hospitalization.
 - Discharge medications including what medications to take, how to take them, and how to obtain the medication.
 - Instructions on what to do if their condition changes.
 - Coordination and planning for follow-up appointments that the patient can keep.
 - Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge.
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.

One hospital formed a multi-disciplinary team to work on implementing several of the Project RED components with

those patients admitted with Congestive Heart Failure (CHF). Through the work of a clinical nurse leader, patients are being educated about their condition with a focus on discharge readiness. Nurses are working to better assess the degree of patient understanding of discharge information. Medication lists are being confirmed for accuracy with a clinical pharmacist. Follow-up physician appointments are made for the patient prior to discharge and are included on the written discharge plan of care. Telephone calls 2-3 days post-discharge reinforce the discharge instructions and the importance of the physician follow-up visit. This hospital has continued improving discharge transitions. Through community partnerships, scales for self-monitoring are being purchased for patients discharged with heart failure. Community nursing students are being considered for post-discharge home visits and post-hospitalization CHF classes are being offered. This hospital's efforts have resulted in a marked reduction in heart failure readmissions.

The spread of improvement is occurring as CareTrek partners are sharing what has been learned with organizations within and outside of the QIO community at the local, regional and national level. CareTrek has afforded the opportunity for Omaha healthcare professionals to positively impact patient care transitions and to reduce hospital readmissions. Individuals and organizations working on this initiative are pioneers shaping the future improvement healthcare. To achieve the kind of improvements necessary, providers have been called upon to implement interventions simultaneously to improve the process of care transitions. Using this multi-pronged approach has led and will continue to lead to a more comprehensive improvement effort.

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Hospital to SNF Transfer Form Information

| Elements | Description |
|--|--|
| Demographics | |
| Patient Name | First and Last name |
| Date of Birth | |
| Contacts | Key contacts for patient First and last name, relationship to patient |
| Transfer Support | Which family member/friend was with patient at hospital discharge |
| Current Medical Information | |
| Primary Care Physician | First and last name, phone number |
| Specialist | First and last name, phone number and specialty of physician following in SNF |
| Diagnosis list | Primary and secondary diagnoses; Listing of medical diagnoses, comorbid diseases and complications, include all diagnoses such as depression, dementia, malnutrition |
| Activities of Daily Living | At admission and upon discharge, any change in status |
| Height & Weight | Height and discharge weight |
| Amputations | Location |
| Paralysis, hemiplegia | Location |
| Adaptive Equipment | Cane, walker, wheelchair, electric chair, braces |
| Communication Aides | Hearing aides, glasses and if they are with patient |
| Swallowing status | Precautions for administration for medications, liquids or solids |
| Continence status | At admission and upon discharge, any change in status |
| Date of last bowel movement | |
| Immunization status | Date of flu and pneumonia vaccination; date of TB testing and results |
| Cognitive Issues | Alert to person, place and time. Any behaviors such as sundowning |
| History of psychological or socioeconomic issues | Family dynamics |
| Alcohol/Drug use | Date, substance and last use |

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|------------------------------------|---|
| Smoker | Last use |
| Advance Directive/Living Will | Does one exist and where is it |
| Power of Attorney | Does one exist with papers and where is it |
| Orders | |
| Medication List | List of medications to be administered in SNF; Brand and generic name, dose, diagnosis for each med, route of administration, last dose given, time of last dose, prn (Include script for level II medications) |
| Time of last pain med/antibiotic | Time of last pain meds |
| Length of treatment of medications | Need stop date on medications, specifically antibiotics, steroids |
| Diabetic treatment | Corrective sliding scale, frequency of blood glucose checks, parameters for calling PCP |
| Diet | Low sodium or anything other than regular, nutritional supplements |
| Tube feeding | Formula, rate, flush orders, insert date and tube size |
| IV | IV fluid, medication, flush orders, line |
| Respiratory treatment | List all respiratory devices, treatments, frequency and settings; O2 rate/method; Medication with diagnosis |
| Isolation | Organism, if organism is active or not, where if known |
| Wounds | Listing of pressure ulcer, surgical, vascular or diabetic wound; Location of wound/pressure ulcer, number and a stage of pressure ulcer; Dressing orders; Wound vac, insertion date, setting |
| Lab | Drug levels,, INR, etc. frequency |
| Bowel/Bladder Program | |
| Ostomy | Type of ostomy (colostomy, ileostomy), Care plan and products being used |
| Foley Catheter | Insertion date and size |
| Activity level | Weight bearing status |
| Physical therapy | Evaluate and treat |
| Occupational Therapy | Evaluate and treat |
| Speech Therapy | Evaluate and treat |

| | |
|--------------------------------|---|
| Follow-up appointments | Date, provider first and last name, phone number - indicate if appointment is scheduled or needs to be scheduled |
| | |
| Hospitalization History | |
| | |
| Attending Physician | First and last name, phone number of physician caring for patient during hospitalization |
| | |
| Consultants and Specialists | First and last name, phone number of all consultants/specialists caring for patient during hospitalization, indicate if will follow in SNF |
| | |
| Procedure List | List of all procedures done during hospitalization including surgery, chest tubes, ventilator support |
| | |
| Major Treatments | List of major treatments done during hospitalization including IVE fluids/meds, TPN , HBO treatment, chemotherapy, dialysis, transfusions, halo devices |
| | |
| Lab & X-ray results | Most current PT/INR, chest X-ray |
| | |
| Hospital Contact | First and last name, phone number of charge nurse on floor patient was transferred from |