

CMS-Funded Care Transitions Health Care Quality Improvement Project Cuts Hospital Readmission Rate In Coached Population

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Potentially avoidable hospital readmissions are a national health care problem affecting 17.6 % of all Medicare patients, and costing \$12 billion annually, according to a 3M analysis of 2005 discharge claims data from the Centers for Medicare & Medicaid Services (CMS). The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that Medicare measures.

In general, rehospitalization rates and health care utilization

vary substantially across geographic locations, suggesting opportunities for improvement in areas with higher observed rates. The 2007 Commonwealth Fund State Scorecard Data Tables reported Louisiana as having the highest Medicare 30-day readmission rate in the country, (23.8% of all discharges of fee-for-service Medicare beneficiaries aged 65 and older in 2003, admissions due to 31 select conditions); the 2009 State Scorecard showed a slightly improved rate of 21.3%. Six months (10/08 through 3/09) of CMS data warehouse claims collected from the Baton Rouge, Louisiana hospital service delivery area of all Medicare beneficiary discharges also reflected a high 18.81% readmission rate.

CMS designed a project to test various methods for reducing avoidable hospital readmissions in 14 communities defined by hospital service areas across the country, including Baton Rouge, Louisiana. A primary objective of the Care Transitions Project is to reduce unnecessary all-cause hospital Medicare readmissions by 2% and the resultant exposure of the patient to risk and poor patient satisfaction with the health care delivery system. eQHealth Solutions was awarded the project and the work began in the Baton Rouge community on August 1, 2008. The project is scheduled to conclude on July 31, 2011.

Building A Foundation For Success

Recruitment and assessment of providers began early in the project. The eQHealth Solutions Care Transitions project team knew that hospital C-suite leadership and medical staff support were crucial to the project's success. Engaged leadership and medical staff would be a key element in driving improvement in this project. Since hospital leadership is still judged by its ability to attract admissions, the Care Transitions project team dedicated much time and effort to making the business case for reducing readmissions.

The health care reform bill discussion occurring at the same time we were working to recruit and implement interventions proved both a distraction and a catalyst. Providers were very concerned and cautious about the impact the legislation would have on their finances. We used specifics in the legislation related to readmission and care coordination to support our cause. The team gained hospital leadership support by highlighting *(more on page 12)*

how reducing avoidable readmissions reduces cost, reduces patient risk of hospital-acquired conditions and improves patient satisfaction. All five acute care hospitals in the Baton Rouge hospital service area were recruited.

Home health agencies, nursing homes, hospice agencies and physician practices in the Baton Rouge community were also targeted for project participation. Thirty-six home health agencies, twenty-six nursing homes, and three hospice agencies agreed to participate and are currently focusing on interventions to address the readmission problem.

Collaborative meetings and individual consultations with participating Care Transition project providers were also key activities begun early in the project. Individual provider assessments were completed to evaluate processes and identify drivers of readmission. Assessments revealed that the drivers of readmission were common among hospital providers in the Baton Rouge hospital service area and included the following;

- Fragmented data and poor communication between providers, between providers and patients, and between providers and caregivers.
- Medication errors and the lack of a method to consistently reconcile medications.
- Inadequate risk stratification of patients (not properly identifying all patients who have a discharge risk).
- No patient follow-up with the physician within 30 days after discharge.
- Poor communication between hospitalists and primary care practitioners.
- Lack of disease-specific protocols in hospital settings.
- Inappropriate end-of-life care with under-utilization and lack of knowledge about hospice.
- Low patient compliance, health literacy, and knowledge of community resources.
- Lack of a mechanism for hospital providers to track rehospitalization rates internally and report to leadership.

Once specific drivers were determined, project collaborators divided the drivers into three primary categories and providers from all settings met to collaborate on project design and interventions.

Designing An Intervention Plan

Interventions were designed to address drivers of readmission in these categories:

- Standard and known process drivers,
- Information transfer drivers,
- Patient activation drivers.

Standard and known process drivers are related to a provider's processes (e.g., illegible nursing discharge instructions).

Information transfer drivers are related to the flow of critical information about the care of the patient from care setting to care setting. An example would be primary care physicians who do not have access to a discharge summary or knowledge of a patient's hospital stay when doing a post-discharge follow-up.

Patient activation drivers are related to actions that patients or caregivers take (or do not take), such as not making a required follow-up appointment with a physician after discharge.

Many interventions are currently being tested to address these drivers. For example, patient coaching is currently being utilized in the Baton Rouge community to improve patient adherence with recommended post-discharge care, which will impact the patient activation driver. The Care Transitions program is a compilation of many small interventions that target specific areas in which patients need support in order to fully activate.

Empowering Patients: Coaching

When designing our coaching program, we shaped it to meet the care community's specific needs and characteristics. Many questions evolved during our collaborative meetings that helped to mold our processes. We considered such questions as:

- Who would employ the coach?
- What would the coach's credentials need to be?
- What patient criteria would define patients eligible for coaching?
- How would referrals be made to the coaching program?
- How would the case load size be optimized for each coach?
- How would we track and report data about the program?

After determining answers to these questions, the team was deployed to begin project field work.

Since it was initially difficult for participating providers to appreciate the benefits of employing a coach, eQHealth Solutions decided to employ the coaches. The coaches are not clinicians but have some medical background and experience in quality improvement. With the QIO-employed coaches, providers in our community have been able to experience the benefits while studying the process. Our coaches and many of our providers attended a training provided by The Care Transitions ProgramSM team led by Dr. Eric Coleman. The project's success has helped two Baton Rouge participating hospitals justify hiring coaches to sustain the program once eQHealth Solutions completes the care transitions project for CMS in July of 2011. These coaches will train under the QIO staff during the transition period.

Some of the criteria used to select patients appropriate for coaching were established by the project requirements:

- Fee-for-service Medicare beneficiaries who live in a designated ZIP Code area, and are able to play a part in self-care or have a caregiver.
- Discharge disposition must be home with no additional support services.
- Diagnosis of CHF, pneumonia, AMI or COPD.
- Patient must consent to participate in the program.

Presently, referrals come from case management and hospital medicine teams. Referrals are made at the time of admission using the patient census. A good working relationship with these teams is critical to success. We provide in-services to the hospital teams regarding the referral process and criteria. We follow up with regular feedback.

Coach Interaction	Plan of Care	Medication	Follow up	Red Flags	Goal
Hospital Visit	Review activity, diet and special instructions. Be sure questions are answered by the treatment team before discharge.	Review medications. Complete Medication Reconciliation Form. Include patient ability to obtain new medications.	Review plan for MD follow-up. Make appointment if needed.	Review disease-specific red flags. Establish who the patient will call.	Set personal goal.
Day 2 Telephone	Review discharge instructions. Discuss barriers patient may have.	Review medication side effects. Confirm that medications were obtained. Establish who to call with questions before changes are made.	Encourage patient to make an appointment. Prepare questions for the appointment if scheduled before next follow-up.	Assess patient based on responses to disease-specific questions. Quiz patient on symptoms that may indicate that the condition is worsening.	Discuss patient plan to reach his or her goal.
Day 7 Telephone	Review diet, activity and fluid restriction, etc.	Review medications; discuss administration method.	Role play questions to be addressed in appointment.	Assess patient. Reinforce who to call and when.	Discuss status of goal, barriers and solutions.
Day 14 Telephone	Discuss barriers and solutions to recommendations.	Review medications and any side effects or changes.	Discuss changes in plan of care and medications after visit.	Assess patient. Reinforce who to call and when.	Adjust goal if needed; discuss progress.
Day 21 Telephone	Encourage adherence; explore barriers.	Review medications and any side effects or changes.	Encourage contact with physician for questions.	Quiz patients on red flags. Address any questions.	Set new goal or discuss progress toward original goal.
Day 30 Telephone	Reinforce continuing to focus on plan of care.	Review medications and any side effects or changes.	Reinforce writing list of questions to address with the physician.	Reinforce who to call and when.	Reinforce goal setting for the future.

The eQHealth Solutions Model

Our model (above) includes coaches making hospital visits followed by telephone sessions on days two, seven, 15, 21 and 30 post-discharge. Coaches complete discharge sessions with patients in which the post-discharge plan of care is reviewed. Medication reconciliation is a part of this process as well as follow-up appointment scheduling. A personal health record is completed, red flags (or warning signs) are reviewed, and the patient sets a personal goal. Telephone sessions reinforce all of these components. Patient tools that include a medication reconciliation form; a personal health record; disease-specific red flag sheets and stickers; and follow-up appointment cards make up the coaching packet. These tools are another way to reinforce the information with the patient and caregivers. The coach obtains written consent from the patient to participate.

Results

Our first patient was coached in March 2009. Since that time, 239 patients have completed the coaching intervention. Of those 239 patients, only 17 have been readmitted within 30 days, which makes our project-to-date readmission rate for the coached population 7%. We tracked risk factors and found that 80% of the patients coached were on more than three routine medications and suffered from three or more co-morbidities.

The 239 patients accepted into coaching have completed the

coaching process, including the 30- and 45-day follow-up. Many patients are referred but not admitted to the pilot project because they do not meet the criteria established. Of the 955 patients referred, 25%, or 239, met the criteria for acceptance into the program. Reasons patients are not admitted include: patient being enrolled in a Medicare Advantage plan, patient living out of the service area, patient discharged before the initial interview and discharge services do not match the medical record.

All cases referred are reviewed by eQHealth Solutions coaches and hospital staff. This review process fosters education and communication about discharge needs and improves discharge planning. Working through the referral process has proved to be an intervention in itself.

Conclusion

Patients can be part of the solution to reducing avoidable readmissions. In our experience with coaching, patients have been successful engaging in self-care and have improved their skills in navigating the health care delivery system. Faced with the resource barrier early on, we realized that the QIO would need to hire the coaches and then work with providers on a sustainability plan. The intervention took off, and we now have providers hiring coaches to complement their hospital medicine, discharge planning and cardiac rehab teams. **RR**

References available upon request.