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Back So Soon?

A Community Hospital Creates New Ways to Prevent Readmission

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ABSTRACT

Purpose/Objectives: Readmission prevention is part of the hospital's strategic plan. Why? Reducing hospital readmissions decreases patient suffering. It also reduces the Centers for Medicare & Medicaid Services financial penalty. But how do you do it? The hospital received a 2-year grant/"investment" from the Massachusetts Health Policy Commission to develop and implement creative, innovative ways of reducing readmissions. The goal was to reduce the 30-day readmission rate for two groups by 20%—adult high utilizers (4 or more admissions within a 12-month period) and adult discharges to post-acute care (PAC) services (skilled nursing facilities and home care agencies).

Primary Practice Settings: The primary practice settings for the initiative were the hospital, skilled nursing facilities, a short-term rehabilitation hospital, and the patients' homes. The patients were initially selected according to risk criteria determined by the hospital and then followed in the post-acute venue via telephone call and/or visit.

Findings/Conclusions: Enrollment consisted of 2,860 patients. The readmission rate for adult high utilizers fell from 40.1% to 24.6% (a 39% reduction). The PAC readmissions for both skilled nursing facilities and home health agencies fell from 12.9% to 12.5%—a small decrease. However, the overall PAC readmission rate for the CHART (Community Hospital Acceleration, Revitalization, and Transformation) program is significantly lower than the state's—the rate for home health agencies is 17.2% and for skilled nursing facilities is 20.0%—making the effort to reduce the readmission rate all the more challenging. The significant reduction in hospital readmissions is attributed to the work of the Readmission Prevention Team, which met daily to discuss patients. Team members shared perceptions on patient education, medication management, communication, and end-of-life care. The team developed innovative practices and protocols, which were then applied to the patients' care.

Implications for Readmission Specialists Practice/Case Management:

1. Having the same case managers consistently work with assigned high utilizers led to better understanding the motivations of the patients and easing transitions of care.
2. Starting end-of-life discussions early and having them regularly helped patients and their families gradually move into acceptance of palliative care or hospice.
3. Using Motivational Interviewing techniques helped all focus on the patients' goals.
4. Using teach-back techniques ensured that the patients/families/caregivers truly understood the education.
5. Having a team approach allowed discussions that were broader and more creative.

Key words: *Motivational Interviewing, readmission prevention, teach-backs*

Back so soon? Too often staff nurses silently ask themselves this question.

Hospital readmissions are common and costly. Historically, almost 20% of discharged Medicare patients were readmitted within 30 days (Orszag, 2019). These readmissions are often "the result of inadequate treatment such as medication mismanagement, lack of access to appropriate services, or poor care coordination across treatment settings" (Massachusetts Health Policy Commission, 2017, p. 13). The Affordable Care Act established the Hospital Readmission Reduction Program, which required Medicare to financially penalize hospitals that had relatively high readmission rates for fee-for-service patients. The Centers for Medicare & Medicaid Services first started imposing readmission penalties in fiscal year 2013, during which the maximum penalty was 1% of the hospital's base inpatient claims; this increased to 2% for 2014. It rose to 3% starting fiscal year 2015 and continues at this rate (Boccuti & Casillas, 2015).

Along with the federal health care mandates, Massachusetts established the Massachusetts Health

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Policy Commission (HPC) in 2012 as an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and innovative investment programs. The HPC's goal is better health and better care—at a lower cost—across the Commonwealth (Commonwealth of Massachusetts, 2020).

To address the need for creative ways to reduce hospital readmissions, "the Massachusetts Health Policy Commission (HPC) developed the Community Hospital Acceleration, Revitalization, and Transformation (CHART) program, established through Massachusetts' landmark cost containment law, Chapter 224 of the Acts of 2012. These investment programs are notable for emphasizing the importance of local care and community partnerships" (CHART, n.d.). The three outcome-oriented Primary Aims were as follows:

- Maximize appropriate hospital use (principally through reduction in readmissions and emergency department [ED] utilization);
- Enhance behavioral health care; and
- Improve hospital efficiency, quality, and safety. (CHART, n.d.)

One community hospital, choosing to focus on the first aim, applied for and received investment money to develop a hospital Readmission Prevention Team (RAPT) to create new practices that would lower its readmission rates. This case management team would be cross-disciplinary and interdependent in their specialty practice. The team focus would be reducing readmissions by improving the patients' clinical, functional, emotional, and psychosocial status (Commission for Case Manager Certification [CCMC], 2012–2020).

Project Site and Reasons for Change

Winchester Hospital in Winchester, MA, is a 230-bed community hospital. Its leaders applied for and received a CHART investment to develop a RAPT to develop and implement new practices to reduce the hospital's readmission rate.

Program

A RAPT was developed consisting of a nurse practitioner (NP), a pharmacist, a social worker (SW), and five registered nurses (RNs) who were Readmission Prevention Specialists (RPSs). This team met daily, led by the NP, to discuss the patients enrolled in the program and collaborate on care planning. The CHART team provided home visits as needed. Often, two or more members visited a CHART patient when needs were identified. Examples of these visits were as follows: (1) an RN and an SW visiting a patient who had frequent hospitalizations related to substance use disorder; and (2) an RN and an NP visiting a patient to discuss end-of-life care. These visits continued until the goal of care was met.

The RAPT focused on two target populations:

- All patients with high utilization rates (more than three hospitalizations within the past 12 months) who were 65 years or older and not eligible for care management through another entity such as an accountable care organization or other payer case manager.
- All adult patients discharged to post-acute care (PAC).

The goal was to reduce 30-day patient readmission by 20% within each group.

Patients were enrolled in the readmission program through the RPSs. Each RPS covered one or two assigned inpatient units where they attended patient care rounds and identified patients at high risk for readmission. The nurses met with their patients on the unit and explained how the free program worked and that the RPS would follow the patient for 30 days postdischarge. The RPSs gave each patient a unique 2½" × 5" business card that included a photograph of the clinician and contact information. Often the clinicians wrote notes on the back of these cards, reminding the patients when they would receive a call or visit.

The clinicians wrote readmission prevention plans (RPPs) based on the BOOST tool, an evidence-based intervention developed and tested by the Society of Hospital Medicine to identify high-risk patients (Hansen et al., 2013). This RPP was a part of the electronic health record (EHR) and was used in the ED when a CHART patient returned to the hospital. The RPP helped ED clinicians triage the CHART patients because it contained unique information not quickly accessed in the EHR. Tables 1 and 2 are RPPs developed for the same patient 7 months apart.

After the high utilizers were enrolled in the CHART program, the team pharmacist reviewed the medication orders and made recommendations to the nurses. The pharmacist also worked with the inpatient pharmacists and hospitalists to ensure that the patients were discharged on the safest and most effective medication regimen. In addition, the pharmacist went on home visits with the RPSs, conducting medication reconciliation and providing patient education and financial information as needed. The SW was employed by a local Area Agency on Aging and met with CHART patients as well as their families

TABLE 1
ED Readmission Prevention Plan (June 21, 2018) Patient BG

Situation and Background: Multiple ED and hospital admissions
Principal Concerns/Issues: COPD, EtOH, and nicotine abuse
Prior Hospitalization: Frequent hospitalizations
Physical Limitations/Fall Risk: SOB with home O_2; frail from protein malnutrition; EtOH and nicotine use have decreased
Poor Health Literacy: No, knowledgeable for her condition and health care needs
Problems with Medications: No, uses Very Good Pharmacy but noted that they are expensive
Psychosocial/Cognitive Issues: No, was concerned at last STR visit that she was getting confused but SLT testing found her cognition WNL; approximately 3 months since last hospitalizations and seems more stable with new apartment and community services
Palliative Care/Hospice Need: Yes, Care Dimensions Palliative Care
Support System/Living Situation: Currently living in a studio apartment but states she only has money for the next 3 months' rent
Recent Discharge Disposition, Providers, and Caregivers:
Home Care Agencies/SNF (Dates): D/C from Care 1 Wilmington (pulmonary rehab) on Jun 20, 2018; LHAH home care, Care Dimensions Palliative Care
Community Agency/Elder Service: Merrimack Valley Elder Services—Homemaker and MOW; asking rep to assist with filling out MassHealth application
Recommendation: Assess adherence/barriers to previous discharge plan
Has new pulmonologist with appointment on Jun 26, 2018—ascertain whether she has seen him

Note. COPD = chronic obstructive pulmonary disease; D/C = discharged; ED = emergency department; LHAH = Lahey health at home; MOW = meals on wheels; SLT = speech language therapist; SOB = shortness of breath; STR = short term rehab; WNL = within normal limit.

and caregivers. These meetings took place at the hospital, skilled nursing facility (SNF), and home.

The SW assessed the patients' psychosocial well-being as well as community service needs and made appropriate referrals. The SW went on home visits with the RPSs to help provide greater access to community resources and strengthen patient rapport.

The NP, in addition to leading the morning huddle, focused her attention on patients returning to the hospital through the ED. If a CHART patient was readmitted to the ED within 30 days of discharge, the patient's name was flagged on the ED tracker board. The NP worked with the ED clinicians to facilitate the CHART patient's return home or transfer to an SNF if medically safe to do so. She made use of both the CHART team's knowledge of the patients and the CHART RPP in the EHR, when available. When CHART team members knew that one of their patients was going to the ED, they either contacted the NP and gave her relevant information or pointed her to the RPP.

Evaluation and Action Plan

A baseline was determined for both the high utilizers and the PAC patients. The high utilizer readmission rate was 40.1%, whereas the post-acute patients' rate was 12.9%.

The RAPT met daily to discuss patient needs and weekly to discuss program needs. Data were also collected quarterly to submit to the HPC as requested.

When the CHART patients were discharged from the hospital, the RAPT sprang into action. The RPSs called the patient within 48 hr of discharge

TABLE 2
ED Readmission Prevention Plan (February 8, 2019) Patient BG

Situation and Background: Multiple ED and hospital admissions
Principal Concerns/Issues: Currently at Amberwood STR in Haverhill; unsafe discharge so they are keeping her; she has notice of eviction from her landlord and no place to go
Prior Hospitalization: Many
Physical Limitations/Fall Risk: Home O_2, new use of CPAP, which she feels is helpful
Poor Health Literacy: No, very knowledgeable of her care
Problems with Medications: Worries about expense
Psychosocial/Cognitive Issues: Anxiety over her living situation
Palliative Care/Hospice Need: Had been on palliative care but was D/C because she had been stable
Support System/Living Situation: Limited social network; needs a place to live safely
Additional information: Being evicted from her Amherst apartment; has a case manager at Elder Service of Merrimack Valley (A at 978-266-5429). The patient is on the emergency housing list for Amherst. She applied for MassHealth but was denied initially related to selling her family home which she had minimal payment for. Resubmitting information to MassHealth in the hopes that the initial denial will be rescinded. Currently living at Brentwood STR because unsafe related to home living situation
Recent Discharge Disposition, Providers, and Caregivers: Currently at Amberwood STR, Haverhill
Home Care Agencies/SNF (Dates): Has used LHAH; Care Dimensions for Palliative Care
Community Agency/Elder Service: Uses Elder Services of Merrimack Valley
Recommendation: Assess Adherence/Barriers to Previous Discharge Plan
If appropriate, stabilize the patient and send back to Amberwood STR for her medical needs

Note. CPAP = continuous positive airway pressure; D/C = discharged; ED = emergency department; LHAH = Lahey health at home; SNF = skilled nursing facility; STR = short term rehab.

A baseline was determined for both the high utilizers and the PAC patients. The high utilizer readmission rate was 40.1%, whereas the post-acute patients' rate was 12.9%.

Discharge plans were developed with input from the team, as well as the family, to ensure a safe transition back home.

to make sure home care services were in place, to conduct medication reconciliation, and to find out whether a physician follow-up appointment had been made within 5–7 days of discharge. Using the teach-back method (Peter et al., 2015), the RPSs taught the patients about signs and symptoms to watch for and when they should call their physician. The RAPT used the teach-back method, which is a way of checking understanding by asking patients to state in their own words what they need to know or do for their health or disease management. It is a way to confirm that the health care provider explained things in a manner that the patient understands (Agency for Healthcare Research and Quality, n.d.). If the RPSs decided the patient needed more information or had ongoing medical issues, the RPSs would continue to call to follow their progress during the 30 days.

Patients who were going to SNFs seemed to especially like the idea that a nurse from the hospital would visit them and monitor their progress. They often reported feeling secure, knowing that someone they knew from the hospital was following their care. Case managers at the SNFs came to know these nurses and invited them to the patients' discharge planning meetings. At these meetings, the RPSs learned how the patients were progressing in their recovery from the physical therapists, occupational therapists, speech–language therapists, and nurses. Discharge plans were developed with input from the team, as well as the family, to ensure a safe transition back home. The unique contribution and perspective that the RPSs brought to these discharge meetings were their knowledge of the patients from seeing them in the hospital and, in many cases, having had a long-term relationship with them.

When a CHART patient was readmitted to the hospital within 30 days, the CHART team conducted a root cause analysis (RAC) using the 5-Why technique (Percapio et al., 2008). The 5-Why technique is one of the most widely taught approaches to RCA in health care with its use promoted by the World Health Organization, The Joint Commission, and the Institute of Healthcare Improvement. The 5-Why technique "creates an aha moment by revealing the hidden influence of a distance cause" (Card, 2017). The CHART team used this deep dive approach to understand the underlying cause of the patient's readmission. For example, one patient was readmitted with shortness of breath and fluid overload. The RPS, delving into the situation, found that the patient's wife had stopped the diuretic because his legs were "skinny." The RPS quickly focused on teaching the wife about the treatment of heart failure.

Through conducting "5 Whys" on the readmitted CHART patients, the CHART team identified ways care could be improved. As an example, after several patients on a prednisone taper were readmitted with shortness of breath, the CHART team realized that the tapers might have progressed too rapidly. So they developed a Prednisone Taper Protocol. The RPS subsequently asked two questions to patients discharged with a prednisone taper:

- Do you have increased shortness of breath while walking?
- On a scale of 0–10, with 1 being extremely short of breath and 10 being not at all short of breath, what number would you give your breathing?

If breathing was the same or becoming worse, the patient was instructed to call the doctor to see whether the taper might need to be slower. The physician typically slowed the taper. The result: "failed prednisone taper" decreased as a cause for readmission.

To work effectively with CHART patients and better promote change, team members realized they needed to understand their patients better. Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reason for change within an atmosphere of acceptance and compassion

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(Motivational Interviewing Network of Trainers, 2020). Extensive training in MI (Levensky et al., 2007) was provided, and the team members made it a standard practice in caring for their patients. It was not uncommon to hear a clinician say, "What is your goal?" and "How important is this to you?" It put the focus on patients' priorities rather than the goals of the CHART clinicians.

End-of-life care was a common theme. The CHART team received training in this area and became more comfortable talking about palliative and hospice care. Because the RPSs met with the nursing and physician staff regularly on their assigned units and at the SNFs, they were able to comfortably introduce discussions on end of life. One example was a 61-year-old woman with advanced chronic obstructive pulmonary disease (COPD) who had become a high utilizer. The RPS met with her and her husband and developed a therapeutic relationship with them. They had refused home care initially but the patient soon returned to the hospital. On the next discharge, the couple accepted home care. The RPS also taught her about palliative care and she agreed to try it. But she was again soon readmitted to the hospital. The RPS learned that on very hot, humid, summer days the patient's home was not conducive to her health needs because of a broken air conditioner. When she was discharged after her next readmission, her air-conditioning was still not working and she agreed to go to an SNF but was readmitted from there two more times.

A discharge planning meeting was held before her last discharge from the SNF. Palliative care was again brought up for her to consider, but, to the surprise of her team, she asked for hospice instead. Her frequent readmissions had helped her understand the seriousness of her disease and she realized that she preferred to be home with her family rather than in a hospital or SNF. As a result of this experience and others, the CHART team realized that patients at the end of their lives might need several readmissions before they come to terms with their illness. Introducing the concept of palliative care and hospice earlier in the patient's illness may make it easier for them to choose hospice sooner.

Educating the CHART patients was a priority. The CHART team worked with hospital nurses to develop education packets on common diagnoses related to readmissions, such as heart failure, pneumonia, and COPD. A modified stoplight teaching tool (see Figure 1) was used initially, but the critical information the patients needed to know about their disease was found only in the yellow light, which highlights the important symptoms that patients need to recognize, alerting them to contact their health care provider immediately—before they end up in the ED. This yellow light information is now the patient teaching focus for both the hospital nurses and the RPSs in educating patients on readmission prevention. It is called the "Call Me Campaign," and it tells patients that the physician wants them to call when they experience certain symptoms or notice certain signs.

Results and Limitations

With 2,860 enrolled patients, the CHART team succeeded in reducing the readmission rate for high utilizers by 39%, dropping the rate from a baseline of 40.1% to 24.6%—a dramatic decrease within 24 months (CHART, n.d.) (see Figure 2).

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CALL YOUR DOCTOR!

PREVENT FUTURE HOSPITAL STAYS

Once you are discharged from the hospital, call your Primary Care Physician's office and schedule a follow-up appointment. Managing your symptoms before needing emergency care will benefit your health significantly.

When your COPD is under control:
- I am breathing without shortness of breath
- I am able to do daily activities
- My sputum (spit) is easy to cough up
- My appetite is good
- I am sleeping well
- I am able to exercise as advised by my doctor.

Continue:
- Your usual treatment/medications
- Avoid cigarette smoke and inhaled irritants.

CAUTION ZONE

Dr._____, wants to see you before you need hospital care. Call your doctor right away when you start experiencing any of the following:

- It is harder to breath
- I am needing my rescue medication more often
- I am coughing/wheezing more
- The sputum (spit) is discolored and thicker
- I am having trouble sleeping
- I do not have an appetite
- I have a fever
- I am having trouble concentrating
- I need more pillows to sleep at night

These are signs your COPD may be worsening.

Call the office immediately!

Doctor:_____

Phone Number:_____

I promise to call my doctor when I start having difficulty.

X_____

Patient Signature Date

PATIENT COPY

Winchester Hospital
A member of Lahey Health

FIGURE 1
Call Your Doctor (COPD Action Plan).

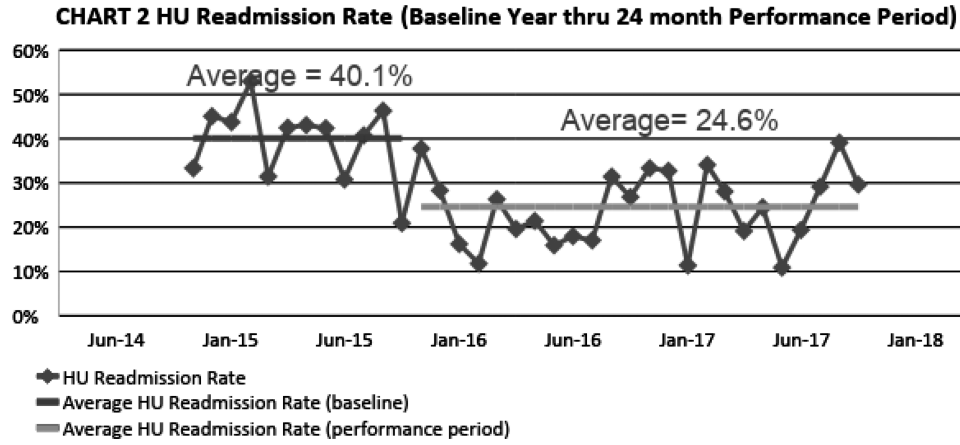

FIGURE 2
High utilizer readmissions. HU = high utilizer.

The PAC readmission rate dropped from 12.9% to 12.5%, a 0.4% decrease, which did not achieve the 20% reduction. But according to the Massachusetts Center for Health Information and Analysis (2019), the SNF annual readmission rate for 2017 was 20% and that for home health agency care was 17.2%. (The CHART data included both SNFs and home health agencies and were not broken out by individual category.) Even though the PAC decrease was small, the overall PAC readmission rate for Winchester Hospital is significantly lower than the state's average (see Figure 3).

So, although many hospital clinicians are helping patients recover from an illness or injury, the CHART RAPT, through the development of these innovative processes, is helping patients stay out of the hospital. The nurse no longer needs to silently ask, "Back so soon?"

Implications for Readmission Prevention Team Practice and Case Management

The RAPT demonstrated the ideal of case management:

> A professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the "Triple Aim" of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. (CCMC, 2015, p. 4)

The interdisciplinary team met daily to discuss and collaborate on the identified high-risk patients. Many suggestions for interventions were explored during this time. If it was felt that a home visit would

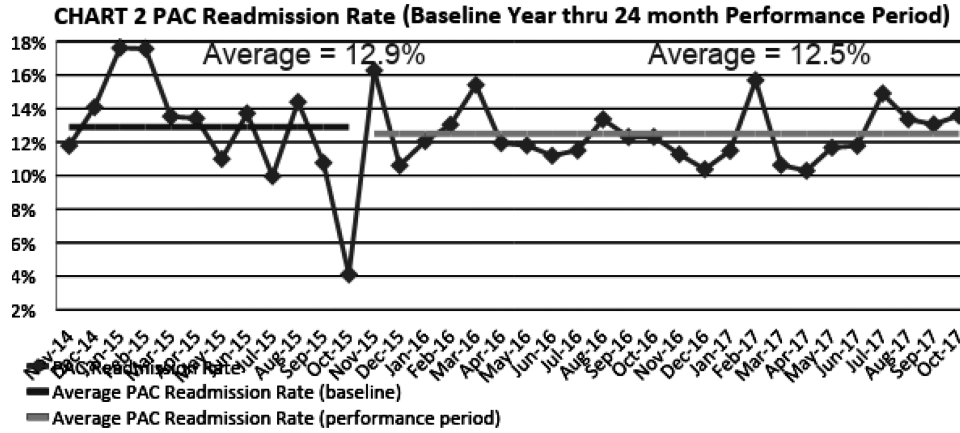

FIGURE 3
Post-acute care readmissions. PAC = post-acute care.

be beneficial, a meeting was set up with the primary disciplines involved in the particular need. Communication was vital in teaching the patients to make sure they truly understood what was needed and communication with the primary care physicians helped in providing appropriate care to the patients. Patients were followed for 30 days but because many were high utilizers of the hospital services, the care team would interact with them many times during the year, getting to know the patients' needs much greater. Educational needs were identified and developed with the patient in mind and shared with the hospital staff. The outcomes for the program showed the effectiveness with the substantial drop in readmissions for the high utilizers. The drop in the PAC patients was not as great due to the initial readmission rate not being high.

At the end of the 2 years, the RAPT reflected on what they had learned during this time. Some of the thoughts were as follows:

1. Having the same case manager consistently working with a high utilizer led to understanding the patient and the patient's needs better. The case manager did not have to "start from the beginning" but began where the patient was on the last visit. This knowing led to relationship development and an understanding of what the patient needed (see the ED RPPs).
2. Starting end-of-life discussions earlier was essential. The RAPT noticed that one discussion on palliative or hospice care usually was insufficient. Patients needed to process what this meant to them. Many patients were surprised that their illness was or could be life ending. When one RAPT member talked to her patient about this, the patient stated vociferously, "I didn't know I was that sick!"

The end-of-life discussions also were helpful for patients who were readmitted many times to the hospital and/or the SNF. They realized that they would much prefer being home in a comfortable setting with their loved ones versus the health care setting.

3. Using MI was helpful in learning what the patients valued and what their goals were. As case managers, we know the trajectory of care and expect patients to follow our path without the benefit of the clinicians knowing what the patient would want. Motivational Interviewing allows a discussion with the patient, leading and sharing what they are thinking and hoping to accomplish. It helps to produce a better patient outcome even if it is not what the health care provider feels it should be.
4. Using teach-back techniques surprised many team members regarding what they thought the patients knew as opposed to what they really knew. Many times patients were hearing-impaired or overwhelmed with anxiety. They would politely say yes or nod their head, indicating that they understood what was being shared. This technique led to many meaningful discussions when the patient could not respond appropriately and both the patient and the case manager were surprised at the question and response.
5. Importantly, the RAPT came away with an appreciation of interdisciplinary team effort. The team members realized that individually they did not have all of the answers that were needed. Other team members shared their knowledge and experience, which resulted in a creative, holistic way of caring for the patient.

Overall, the RAPT approached case management with the best intentions for the patient and the health care system. This particular case management approach proved beneficial in reducing the suffering of patients from hospital readmissions and lead to a significant reduction in hospital readmissions, which lead to a decreased financial penalty.

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This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749. LPD is also an approved provider by the District of Columbia, Georgia, and Florida CE Broker #50-1223.

Registration Deadline for Nurses: July 1, 2022

Disclosure Statement:
The author and planners have disclosed no potential conflicts of interest, financial or otherwise.

Payment and Discounts:
• The registration fee for this test is $24.95
• CMSA members can save 25% on all CE activities from *Professional Case Management* ! Contact your CMSA representative to obtain the discount code to use when payment for the CE is requested.

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