

Patient Education Key to Reducing Readmissions

Lee Memorial Hospital
Fort Meyers, FL
Beds: 355
<http://www.leememorial.org/>

The Problem

With the imminent decline in reimbursements for preventable readmissions by the Centers for Medicare and Medicaid Services, three years ago Lee Memorial Health System hired a consultant to help it devise the best method for reducing its 30-day readmission rates. At the time, 12% to 14% of its patients with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and pneumonia returned to the hospital within 30 days.

The Solution

Based on the consultant's recommendations, Lee Memorial's senior management determined it needed a comprehensive approach for decreasing readmissions that reached beyond the four walls of the hospital. After investigating different options, Lee Memorial decided to largely model its program after Dr. Eric Coleman's Care Transitions Program and sent several staffers to the Coleman program in the Division of Health Care Policy and Research at the University of Colorado's School of Medicine. It also incorporated elements of other programs, including Project Red and BOOST.

Lee Memorial formed a readmissions committee with representatives across its facilities, including the director of its skilled nursing facilities (SNFs), director of its home health operation, vice-president of acute care, and vice-president of post-acute as well as physicians, case management, process improvement, and the director of transitions program.

Within the hospital setting, Lee Memorial's efforts to reduce readmission resemble those of many other providers, starting with educating patients and families on post-discharge care using handouts approved by the hospital's CHF and pulmonary committees. The transitions team also tiers patients based on their readmission risks. It also changed the focus for discharge nurses, who now educate patients about diet, physical activity, recommendations for follow-up appointments and other areas designed to help patients once they leave the hospital.

Once patients leave the hospital, however, Lee Memorial goes one major step further than most providers with a four-week program for transitioning patients back into the community. It starts with

sending trained coaches to the discharged patients' homes within 48 hours to check on how they are doing. While there, the caregivers work with patients for two to four hours to help them succeed with their post-discharge recovery, from giving them a scale for monitoring their weight and reading food labels to helping organize medications, including setting timers or creating other reminders.

Its outreach into the community takes other forms as well. To address the problem of transient patients, the health system has been involved in setting up two clinics in the community for homeless and indigent. Since about 20% of the hospital's readmission were coming from skilled nursing facilities the transitions program forged strong relationships with the area's post-acute providers.

The Result

The improvement at Lee Memorial has been far-reaching, well beyond simply lowering preventable readmission for CHF, COPD and pneumonia to 2 percent. By working with patients at home, the transitions program has been able to identify shortcomings in hospital processes and bring that information back to Lee Memorial, creating a virtuous circle of improvement.

For example, patients were sometimes prescribed a generic version of a medication they were already taking, didn't realize they were same drug and ended up taking double doses. Or a prescription was too expensive, so the patient didn't fill it. After the transitions team brought these issues to the attention of Lee Memorial's hospitalist group, they stopped. Similarly, once the transition team discovered many patients who were prescribed nebulizers didn't know how to use them, the hospital added instructions on use to discharge planning. Another disconnect: Patients who had been identified as a fall risk in the hospital didn't receive an order for physical therapy after discharge.

Current Status

Lee Memorial continues to chip away at the root causes and process failures that can lead to preventable readmissions. In April, for example, the health system is launching a quality improvement effort focused on the transfer process from the hospital to all of the county's SNFs. Lee Memorial also is adding visits from nurse practitioners to discharged patients who have been moved to SNFs.

To bolster its efforts, the transitions team is applying for a grant to support greater education of patients' caregivers. And it holds monthly post-acute updates and education for Lee Memorial case managers, who didn't know they could arrange medication dispensers for patients' homes, for example.

Because of its impact on the entire health system, the transition team is growing. It now numbers 10 full-time employees, including a recently added respiratory therapist.

Pearls of Wisdom

The drive to reduce readmissions can only go so far without leaving the hospital and getting out into community, says Joan Carroll, RN, BA, CCM, CDMS, Director of Care Transition at Lee Memorial. “We need to continue care in the community and see what is really going on, not what patients tell us they are doing.”

Not only do patients benefit from this approach, so do the providers, notes Carroll. “We know where health care is going and the need for population health management. This program ensures integration, with information carried back to the hospital so care improves there, too.”

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