Puget Sound Health Alliance
July 2013

Spotlight on Improvement

"Spotlight on Improvement" highlights real stories of current efforts, including: programs being initiated; practices being implemented; and outcomes being targeted and/or achieved. They're are an opportunity for learning from others as well as a spark for further ideas on how we may work together to improve health care quality in the region."

Whatcom County:

Collaborating to Improve Care Transitions

Background

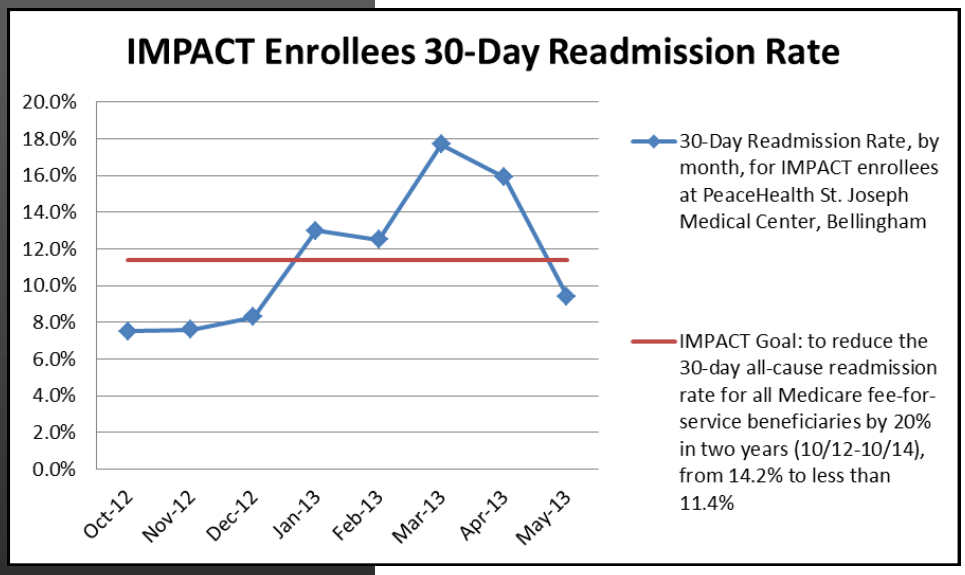
The Whatcom Alliance for Health Advancement (WAHA)[1], the Northwest Regional Council (NWRC)[2], and PeaceHealth St. Joseph Medical Center (PHSJMC)[3] are collaborating to improve patient care and reduce preventable hospital readmissions through **Improving Care Transitions (IMPACT)**. WAHA has received funding from the Center for Medicare and Medicaid (CMS) Community-based Care Transitions Program (CCTP)[4] to provide this service.

Problem

Patients are discharged with sometimes confusing medical information. In a 2009 *Annals of Emergency Medicine* publication, researchers measured emergency room patients' understanding of 4 domains:

1) Diagnosis and cause;
2) Emergency Department (ED) care;
3) Post ED care, and
4) Return instructions.

The results found that 78% of patients did not understand one of the domains and 51% did not understand two of the discharge instruction domains.[5]



Solution

In October 2012, IMPACT began serving Medicare fee-for-service beneficiaries discharged from PeaceHealth St. Joseph Medical Center (PHSJMC) who had the most need for help in their transition out of the hospital. These "high need" patients are identified through a risk stratification tool that ranks patients according to their risk of readmission at the point of admission. The tool was developed by WAHA and PHSJMC for use in this population and borrowed from other evidence-based frameworks, such as the 8P's from the BOOST[6] tool (1. problem medications, 2. punk (depression), 3. Principal diagnosis, 4. Polypharmacy, 5. Poor health literacy, 6. Patient support, 7. Prior hospitalization, and 8. Palliative care).

The overall aim of IMPACT is to empower patients to actively manage their health and reduce preventable hospital readmissions. IMPACT works with patients both during and after the hospital stay.

- At the hospital: A discharge coordinator meets with the patients, while in the hospital, encouraging patients to participate in free "coaching" services, described below. On average, patients agree 80% of the time.
- After the hospital: Once enrolled, patients are assigned a "coach" who follows-up with a home visit and three phone calls over the next 30 days. The coach works individually with the patients and their caregivers to assist them in better understanding their health, medication self-management, addressing any "red flag" issues, and connecting them to their primary care provider.

The goal of IMPACT is to "reduce the 30-day all-cause readmission rate to PHSJMC for Medicare fee-for-service beneficiaries by 20% in two years, from 14.2% to less than 11.4%."

Puget Sound Health Alliance

Want to recommend a program for an upcoming Spotlight?

Contact us!

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About the Alliance

The Puget Sound Health Alliance, an Aligning Forces for Quality Community, is a non-profit made up of those who provide, pay for and use health care, working to improve quality of care at a price more people can afford. More than 165 organizations have joined the Alliance, including The Boeing Company, Starbucks, Puget Sound Energy, WA State Health Care Authority, King County and many other employers, physician groups, hospitals, consumer organizations, unions, health plans, pharmaceutical companies, associations and others.

A cornerstone of the Alliance work is the Community Checkup, a regional report to the public comparing the performance of clinics and hospitals for basic measures of quality care in the Puget Sound area.

Results

- As of the end of June 2013, 764 Medicare beneficiaries were enrolled in IMPACT, of whom, 88 were readmitted within 30 days, or 11.5%.
- Between October 2012 and June 2013, the cumulative 30-day readmission rate for IMPACT enrollees was 11.5%, and ranged between 7.5% and 17.7%, depending on the month.

Challenges and Opportunities

Like starting any multi-organizational initiative, the challenges have been many:

- Findings showed that only 50% of the IMPACT enrollees receive the planned home visit from their coach. The main drivers are patient's belief that they no longer need help (16%) or a family member declines the home visit (16%). Additionally, scheduling the home visit can be a challenge.
- Better coordination with skilled nursing facilities (SNF) that receive 19% of discharges but are the source of 24% of readmits. SNFs have limited access to information on their patients after they have been discharged home or if they are readmitted to the hospital, making continuity of care both a challenge and an opportunity.
- Connecting to Primary Care is critical for improved longitudinal care and yet only 25% of patients saw their primary care provider within 7 days of discharge. To address this, WAHA is working with PeaceHealth Medical Group on a fully embedded coaching model. In this model the coach is part of the patient's care team and can provide a warm hand off directly to the patient's primary care provider.

Keys to success

- Data collection to drive continuous quality improvement.
- Collaborating with partners and understanding organizational barriers has been essential in providing patient-centered care.
- Providing staff with real-time data on who is admitted and their risk of admission allows for efficient triaging and targeted enrollment, while also allowing staff to spend more time with patients.

Community-based Care Transitions Program (CCTP) is an initiative of the Partnership for Patients, a nationwide public-private partnership launched in April 2011 that aims to cut preventable errors in hospitals by 40% and reduce preventable hospital readmissions by 20% over a three-year period. CCTP's goals are to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program.

For more information on IMPACT, contact:

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Resources

1. Center for Medicare and Medicaid (CMS) Community-based Care Transitions Program (CCTP): http://innovation.cms.gov/initiatives/CCTP
2. Whatcom Alliance for Health Advancement (WAHA): www.whatcomalliance.org
3. Northwest Regional Council (NWRC), the regional Area Agency on Aging: www.nwrcwa.org
4. PeaceHealth St. Joseph Medical Center (PHSJMC): www.peacehealth.org/st-joseph
5. Engel, et al. (2009). Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware of When They Do Not Understand? *Annals of Emergency Medicine*, 53(4), 454-461.
6. BOOST, Society of Hospital Medicine: www.hospitalmedicine.org/AM/Template.cfm?Section=Home&CONTENTID=27659&TEMPLATE=/CM/HTMLDisplay.cfm