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Initiation of a Transition Program: Two Million Melvins

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Abstract

This article summarizes the plan and process to develop a transitions in care initiative at an academic health center (AHC) located in the Midwest. Provided are recommendations for nurse executives who want to implement a transitions model of care in their organization through the adoption of an evidence based, phone follow up process using a protocol. Early findings of implementing the transitions program include improvements in patients' understanding of their plan of care, satisfaction and appreciation of the phone contact, mitigation of medication discrepancies and a reduction in 30 day readmissions.

Keywords

Transitions; readmissions; protocols; follow-up; C-TraC

According to the Centers for Medicare & Medicaid Services (CMS) nearly 1 in 5 Medicare patients or approximately 2 million people are readmitted to the hospital within 30 days of discharge which costs the federal government about \$17.5 billion annually.¹ The average cost of a readmission paid for by Medicare is \$18,000.² Hospitals with high rates of readmissions for certain conditions, as defined by CMS and mandated by the Affordable Care Act, may lose up to 2 percent of Medicare reimbursement in 2014 and potentially 3 percent in 2015.¹ The computation for the dollars withheld from Medicare is based on a complex formula. Dollars are reserved in the previous year, and through a formulaic process of identifying all-cause readmissions, a percentage is calculated and equated into dollars returned or dollars withheld. The goal of this Medicare initiative is to decrease readmission rates and, thereby, improve care quality while simultaneously decreasing the overall cost of

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care. Initiatives that improve transitional care quality (i.e., the quality of care provided in the peri-discharge period) have been shown key to reducing readmission rates.

Review of Literature

There are several difficulties identified in transitioning the care of patients after a hospitalization including patient non-compliance, poor communication and lack of intentional hand offs.^{3,13} Additionally, there can be seen a lack of care coordination, multiple specialists caring for patients and a focus on the “disease” rather than the whole patient, as contributing to unnecessary healthcare and a proclivity for readmission within 30 days of discharge.^{4,14} It has been suggested that the transition of care between inpatient and outpatient settings demonstrate significant patient safety issues and deficits in quality in our current system of care.⁵ Reported are inconsistent assessment criteria at discharge, varying levels of expertise and risk tolerance for making decisions which may result in the discharge of vulnerable persons before they are ready.⁶ Patients may also be discharged with unmet needs and before the full effect of planned treatments are known.

Often a patient’s comorbidities are overlooked by the healthcare team and plans to address the needs of “the whole person” are not addressed.⁷ Insufficient engagement of patients and their families by the healthcare team, to plan for the transition from acute care to another setting, has been shown to be a contributor to confusion and ensuing readmission.⁸ In addition, providers may not understand the support services available to patients such as home based telemonitoring, community based services and agency home visits.⁹ All of these scenarios have a potential impact on patient’s preparedness to transition to home.

The discharge process can be described as “random events connected to highly variable actions with only a remote possibility of meeting implied expectations.”¹⁰ While this organization was trying to standardize the discharge process, there remained variability from unit to unit and nurse to nurse. The organization may experience as many as one hundred discharges in a single day and it was realized each patient was not receiving the appropriate time needed to prepare them for discharge, to ascertain their understanding of their disease, review of medications and demonstrate self-care in a standardized way.

Local Problem

The all-cause readmission rate for this 592 bed Academic Health Center (AHC), located in the Midwest, in June of 2013 was 12.3 percent.¹ Several tactics had been deployed to communicate more effectively around the plan of care post discharge to minimize readmissions. First, the AHC’s patient-targeted discharge packet was updated and reorganized, replacing a previous discharge packet which was found to be very cumbersome and many times inaccurate. Additionally, the hospital instituted having the inpatient primary nurse contact the patient by phone within 72 hours of discharge. But this practice was found to be inconsistently followed, because the inpatient nurses would often get busy with their hospitalized patients and not make the necessary connections. When calls were made, the timeframe was anywhere between 24 and 96 hours post-discharge. It was estimated that 60 percent of patients were contacted through this initiative, and of those contacted roughly 30

percent had questions about medications or post discharge care. Also, the specialist, resident or fellow who cared for them as an inpatient, was frequently no longer responsible for the patient and the nurse wouldn't know to whom to pose the patient's questions. This phone-based process was inefficient and lacked a standardized approach. Ultimately, the CNO determined that a more standardized and systematic approach to transition patients was warranted.

The CNO assigned the Director of Geriatrics to research various models for transitioning patients from the inpatient units to their home or another setting. Transition in care models were studied and considered. During the literature review, however, a protocol driven, phone based, nurse led model, called the Coordinated- Transitional Care (C-TraC) Program, developed by Dr. Amy Kind, was revealed. Dr. Kind, a geriatrician, conducted an 18 month pilot which demonstrated a one third reduction in readmissions through the C-TraC process. The program was attractive as the AHC serves the same small urban and much larger rural geography, as the organization Dr. Kind was associated with. After meeting with Dr. Kind and validating the findings from the literature, the C-TraC program was selected to further study and vet with the organization's CEO. (April, 2013)

Providing support to patients in this region's geography is challenging. While many of the patients served are contiguous to the medical center, a vast number of patients are from rural locales. Coupled with the CMS's impetus to reduce unnecessary readmissions, creating innovative processes to support patients outside of the hospital setting was a strategic imperative for this AHC. Initiatives to reduce readmissions are also foundational to the success of accountable care organizations with a focus on managing the health of various populations.

Purpose

The purpose of this project was to reduce readmissions through the establishment of a pilot program using the C-TraC program, a phone-based, protocol-driven, low-cost, nurse-led, transitional care model.¹¹ The intent was to connect with the patients telephonically up to 30 days post discharge to mitigate current confusion around the discharge plan and to identify potential medication discrepancies. The change being initiated was a consistent, standardized way to engage patients post discharge.

Setting the Stage

The CNO set forth in capturing the essence of the transitions initiative using a logic model framework to assist in evaluating the effectiveness of a potential pilot. The key elements included:

1. Clarity and definition of the problem to solve
2. Identification of key stakeholders
3. Outline of strategies to be deployed
4. Detail of anticipated outcomes and evaluation plan

In addition, the Director of Geriatrics and the CNO detailed the anticipated resources needed and the associated budget required for those resources identified.

It was recommended that the AHC hire two transition in care nurses (TCN) to launch the initiative. The plan included the TCNs enrolling patients while they were inpatients and then following up with the patients via telephone once they were discharged. The TCNs would commit to as many phone calls as necessary within 30 days post discharge to make sure patients understood the plan of care and were following their prescribed therapeutic regime. Using the C-TraC protocol as a guide, inconsistencies that could lead to readmission would be revealed.

The CNO met with the senior-most stakeholder, the Chief Executive Officer (CEO) and walked her through the detail outlined above. While supportive in concept, it was noted supporting one initiative would divert dollars from another potential one. It was requested that the CNO and Director of Geriatrics present the problem, assumptions and anticipated outcomes to the executive team of the hospital. Prior to the executive meeting, the CNO identified additional key stakeholders and met with them individually to explain the initiative and to address their concerns and questions. The stakeholders included the Chief Operating Officer, Chief Financial Officer and the Chief Medical Officer. Meeting individually with these stakeholders was a key success factor to the adoption of the initiative as the CNO could speak to the concerns of each individual prior to the formal large group meeting.

The business case was presented at the next executive meeting including the current readmission rate for the organization, the potential dollars at risk as the with-hold from Medicare and the plan to better transition patients to another setting post discharge. Questions were asked and additional discussion ensued. At this point in the presentation, the Director of Geriatrics and the CNO suggested a depiction of what this initiative looked like at the patient level. A true story of a patient “Melvin” was shared with the group. This was a second key success factor of interpreting figures, data and processes into a scenario people can understand. John Kotter suggests numbers can only get one so far in persuasion and change.¹² One must be able to “see” something and “feel” something before they can commit to change.

The CNO and Director of Geriatrics reported an estimate in excess of two million readmissions in the United States annually or put in a different way, “two million Melvins” being readmitted each year. While the business and financial impact is fundamental to operational decision making, the consequences of doing or not doing something related to the care of patients must be well understood. Once the executive team understood the current state of ill defined transitions processes and ill prepared patients post-discharge, they approved the plan to initiate a pilot for care transitions adopting the C-TraC program. The essentials of the pilot included hiring the two transitional care nurses, acquiring equipped space for telephonic work and engaging and educating the organization about this transitional effort.

Results

In the first 12 months of the initiative, the TCN have successfully enrolled 863 patients for follow-up phone calls on 4 inpatient medical units. The genesis of enrollment began by the TCNs receiving a report each morning entailing eligible patients for C-TraC follow-up. They then visited the patients on the inpatient units, introduced themselves and described the follow-up program with the intent to engage and enroll the patient. The TCNs offered that the follow-up may simply entail one phone call or could result in additional calls if the patient needed continued support and education, up to and potentially beyond 30 days post discharge.

Of the patients enrolled, 24 percent had at least one post-discharge medication discrepancy identified and rectified through C-TraC. The patients who had follow up through the C-TraC program experienced a lower 30 day all cause readmission rate of 9.2 percent as compared to the overall readmission rate for all adult patients during the same time period of 12.3 percent. Additionally, the CEO and other stakeholders have commended the transitions team in the program establishment and these early successes. Equally important is the tremendous satisfaction and appreciation we have heard from the patients and their families. Representative comments from patients were, "I more fully understood my treatment plan, I found the phone calls reassuring regarding my progress, the nurse is sincere and really cares." The transitions program is now out of the pilot phase and has been expanded through the addition of 2 more transitional care nurses to cover all the inpatient medical units. Discussions are on-going to determine resources needed to expand the transitions program to the hospital's surgical units.

Conclusion

Transitioning patients safely and appropriately from inpatient care to another setting is a national problem. Establishing consistent, standardized evidence based processes for transitioning patients is an imperative for senior hospital executives. To achieve a sustainable transitions process, this nurse executive researched the literature and developed a business case to pilot a transitions program at this AHC. Identifying key stakeholders, creating a logic model and a proposed budget supporting the business case and linking the data to real patient case studies, contributed to the successful adoption of the C-TraC transitions program. The pilot successfully demonstrated an improvement in readmissions and has now been expanded to additional units.

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Table 1**Melvin**

Melvin <ul style="list-style-type: none">• Melvin is 82 years old• He lives with his wife in a multiple story home• He has a history of coronary artery disease, bilateral prostate hypertrophy and history of rectal cancer• He is independent in the community and manages his own medications
Hospital Admissions <ul style="list-style-type: none">• Melvin had three hospital admissions for syncope and falls within 14 days• He sustained four hospital admissions between 9/19/13 and 11/5/13
Medication Issues <ul style="list-style-type: none">• Melvin had 20 medication issues<ul style="list-style-type: none">◦ He was discharged with 19 medications; he was taking an additional 10 herbal supplements◦ The supplements were not on electronic health record medication list◦ Melvin did not think of the supplements as “medications”◦ He was not taking cardiovascular medications as prescribed because his supplements stated they were for “heart health”• The mix of prescribed and herbal medications were contributing to syncopal episodes leading to the readmissions