Reducing Hospital Readmissions
An MSW Intern’s Experience

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With the looming Medicare penalties and the release of $500 million in CMS (Center for Medicare & Medicaid Services) grant funding, preventable readmissions have quickly become a priority on healthcare agendas across the nation. Hospitals nationwide are asking questions – How can we reduce our readmission rate? How can we more safely discharge our patients? How can we help individuals stay in the community once they leave the hospital? There are no simple answers to these questions, but the first step is to answer a different question - What factors contribute to the readmissions in our hospital?

Step 1: Target Population
With limited resources, the first step was to determine the target population for the readmission reduction initiative. By reviewing existing readmission statistics for the hospital, it was determined that individuals over the age of 60, with one or more chronic illness, and 3 or more hospital readmissions within 12 months would be the focus of the assessment.

Step 2: Assessment Interview
Once a patient was identified by Case Management staff to meet all of the criteria for the readmission reduction initiative, an assessment interview was completed by the MSW intern. The goal of the assessment interview was to explore factors that frequently lead to hospital readmissions including education about disease process/symptom management, physician follow-up, medication management, nutritional needs, access to transportation, in-home services, and discharge planning.

Step 3: Interview Findings
Over the course of 3 months, 41 patient interviews were completed.

Key interview findings are listed below:

Common diagnoses were: COPD (Chronic Obstructive Pulmonary Disease), CHF (Congestive Heart Failure), Pneumonia, and Diabetes

- 73% of patients were readmitted from home
- 63% of those readmitted from home had no supportive services in place
- 34% of patients were readmitted to the hospital within 7 days post-discharge
- 24% of patients were readmitted to the hospital 8-14 days post-discharge
- 51% of patients needed education about their disease process
- 30% of patients needed education about symptom management
- 50% of patients did not follow up with their physician post-discharge
- 38% of patients had a limited understanding of their medications

Step 4: Community Partners
Another important step in analyzing our hospital readmissions was to discuss concerns with community partners such as home health agencies, skilled nursing facilities, physician offices, and care management
programs. For this initiative, 8 community agencies were asked to discuss the drivers of hospital readmissions, from their perspective.

Key findings from the partnership surveys are listed below:

- Lack of advanced care planning or discussion of advanced directives in the hospital
- Primary care providers not consistently notified of a patients’ hospitalization
- Discharges to facilities occurring late in the day pose problems for obtaining records, medication reconciliation, and doctors’ orders
- Community providers had difficulty obtaining accurate medication reconciliation information with the discharge summary

**Step 5: Root Cause Analysis**

After reviewing the results of the patient interviews and the partner surveys, 10 factors were identified in the Root Cause Analysis, as the major drivers of our hospital readmissions.

These 10 factors were:

1. Education about the disease process
2. Physician follow-up post-discharge
3. Discharge planning process (i.e. late discharges, non-inclusive of caregiver, etc.)
4. Medication management/reconciliation
5. Homecare services/Community supports
6. Teach back, symptom management
7. Comorbid chronic diagnoses
8. Inaccurate/incomplete information provided to skilled nursing facilities during handoff
9. Patients unaware of care plans at the time of discharge
10. Coordination of hospital staff (i.e., lack of consistent staffing, high census, etc.)

**Step 6: Current Efforts to Reduce Readmissions**

Once these service gaps were identified through the Root Cause Analysis, the hospital began to address the unmet needs and provide better services to patients. The following are initiatives that were developed in response to the findings:

- Our hospital applied for the CMS Community-Based Care Transition Program Grant to obtain funding for a 3-year Transition Coach Program that would specifically assist the target population identified in this readmission reduction initiative. If received, the grant would allow coaches to assist high-risk patients during the transition back to the community, post-discharge from the hospital.
- A ‘Care Logistics’ pilot program was initiated on one unit. In this model, case managers and discharge planners work closely together, emphasize effective communication, and focus on thorough discharge planning practices.
- Case managers in the pilot program now schedule follow-up physician appointments for the patients upon discharge.
- The PACT Checklist (Patient and Caregiver Transition Checklist) was created to give patients more control over their discharge planning process.
- New medication reconciliation software was introduced hospital-wide.
- Disease-specific patient education materials were developed by a subcommittee and dispersed to case management staff for use on hospital units.
A Care-Transitions subcommittee was formed to discuss the readmission reduction initiative on a continuing basis.

Conclusions
To ensure that our patients receive the best possible care, we needed to explore the drivers of readmissions within our hospital by interviewing patients and engaging community providers in the discussion. Once problems were clearly identified and supported with data, specific goals could be established, and initiatives set into motion to provide patients with safe transitions at each step of their medical journey.