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URMC hospitals strive for 'Safe Transitions' to the home

Strong and Highland hospitals tap phone calls, fast follow-up appointments to reduce readmissions and promote patient- and family-centered care



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HOSPITALIZED PATIENTS PINE FOR THE COMFORTS OF HOME — BUT STAYING HOME AFTER DISCHARGE PROVES ELUSIVE FOR MANY.

"National data shows that nearly one in five Medicare patients winds up back in the hospital within 30 days," said division chief of General Medicine Marc Berliant, M.D. "These readmissions place undue physical, emotional and financial stress on our most vulnerable patients."

And — especially in a community like Rochester, where inpatient beds are almost always full — avoidable readmissions strain already harried emergency departments and maxed-out hospitals.

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Berliant said. "To achieve this, we'll need to deliver a patient- and family-centered care experience that equips them with the tools and knowledge they need to continue their recovery on their own."

That's why, in the first quarter of 2011, Strong Memorial Hospital will take on one of its most ambitious patient care projects: improving the discharge experience in an effort to reduce 30-day readmission rates by 15 percent. Berliant—in collaboration with director of Social Work and Patient & Family Services Kelly Luther and associate director of Cardiovascular Nursing Anna Lambert—launched the "Safe Transitions" initiative on all adult medical and surgical units in early January.

Costly in every sense

While the dollar figures surrounding rehospi-

talizations are sobering — they result in more than \$17 billion in federal health care spending each year — patients themselves suffer the most when they unexpectedly return to the hospital.

"For these patients, it's unnerving. They miss work, they worry. There are more medical bills," Berliant said. "In some cases, it can even cause them to doubt our clinical decision making."

Avoidable readmissions are also costly for hospitals, which stand to be penalized — and have their reputation tarnished. Last year, a three-year review published by the Centers for Medicaid & Medicare Services (CMS) put this particular quality measure under the public microscope.

"We only expect more transparency in the future," Berliant said. "For patients, Continued on back



Safe Transitions

Continued from front

that's a really great thing. But it also means missteps can cost hospitals revenue — and market share.”

Currently, when hospitals readmit patients within 30 days for any condition or complication related to their initial visit, CMS has the prerogative to lump the two hospital stays together, reimbursing for just one. In the future, there could even be more pervasive penalties — perhaps reduced reimbursement rates across the board for hospitals with consistently high readmission rates.

Where we stand, what we're doing

Strong Memorial's goal to facilitate safer transitions and reduce 30-day readmission rates is a massive challenge, Berliant admits. The hospital currently sees 5.4 percent of its patients return within 30 days for the same (or a related) condition (for Highland, 3.8 percent return). Many come back within 48 hours.

But when we do this, we'll be a top 10 performer out of nearly 100 academic medical centers reporting to the University HealthSystem Consortium, he said.

“We need to intercept these patients sooner, and one of the best ways is to work with community providers to build an early-warning-system,” Berliant explained. “If we partner better with primary care doctors, we can detect possible deterioration in patients early on, many times addressing a problem right in the PCP's office.”

To that end, a key piece of the new “Safe Transitions” initiative involves identifying “high-risk” patients who are predisposed to readmission later on.

“We've created some rules of thumb,” Berliant explained. “For instance, certain conditions — like congestive heart failure, pneumonia — or medication regimens — like anti-clotting drugs — automatically place a patient in the high-risk camp. Or perhaps they had a previous readmission within three months. Either way, we literally flag their charts so the entire health care team knows.”

Depending on whether staff classify a patient as high- or standard-risk, every discharge will now include:

- **An information transfer.** 24 hours after a

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patient leaves, a “STAT” summary is sent electronically to his primary care doctor — detailing the medication changes we've made, what happened during his inpatient stay, etc.

- **A phone call home to the patient.** Also within 24 hours, a member of the care team will loop back with patients to: (1) ensure that patients are taking medicines as planned; (2) affirm that a PCP follow-up appointment is on the calendar; and (3) remind patients that we care about their recovery and want to address any remaining concerns.

- **An appointment on the books.** Making sure patients visit their PCP (or specialist, if appropriate) promptly after discharge (three to five business days, depending on risk-level) provides another safety net.

- **A conversation with a PCP** (for high-risk patients only). We're encouraging that a provider team member connects with the patients PCP for a good, old-fashioned dialogue.

“Nurses, specialists, hospitalists, community physicians are going to partner in unprecedented ways,” Berliant said. “But don't be mistaken — the most important partners in this initiative will be our patients and their families.”

Practicing patient- and family-centered care

While the comforts of home beckon, leaving the inherent safety of the hospital can be unnerving. How can we prepare patients for the transition?

“The key word is ‘empowerment,’” Berliant said. “We need patients to take more ownership of their care — and the best way to do that is by engaging them throughout the



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course of their inpatient stay.”

This “patient- and family-centered” approach calls for a lot of education — and plenty of room for the patient to speak-up.

“We want to forge a real patient and caretaker partnership,” he said. “By the time patients head home, we want them to be in the habit of participating fully — discussing the goals of their care, voicing their choices. We want to empower them to really understand their medications — proper dosage, each pill's purpose, possible side effects. We want them to know how to spot for symptoms of deterioration, what to do if a setback occurs, and who to call during that first day back home.”

What will success look like?

“Obviously, lower readmission rates,” Berliant said. “But the most important measure circles back to the patient experience, their satisfaction. If we can give them a smoother, safer transition home, our efforts will not have been in vain.”

Want to learn more about the initiative?

Visit <http://bit.ly/safetransitions> to hear Dr. Berliant discuss the effort in more detail.