One in five elderly patients discharged from a hospital is readmitted within 30 days, according to a HealthAffairs study. And though many of these return trips are unavoidable—unexpected complications that arise after the patients return home, for example—hospitals can and should prevent many readmissions.

In this FierceHealthcare eBook, we highlight readmission reduction strategies that hospitals are implementing before, during and after discharge to improve care coordination of vulnerable elderly patients and those with multiple chronic conditions who may fail to follow discharge instructions, don’t properly take medications or don’t arrange follow-up care.

In this eBook, you’ll learn the 12 components that make up Project RED, a program developed by Boston University Medical Center to improve care coordination around patient discharge, and how social workers coordinate post-hospital discharge care for older adults at Rush University Medical Center in Chicago.

That’s not all. Sacred Heart Hospital in Eau Claire, Wis. shares how integrated care helped the facility achieve better patient outcomes and lower costs. And Tina Paulson, R.N., nurse manager at the 25-bed Baystate Mary Lane Hospital in Ware, Mass., reveals the strategies the community hospital has employed to reduce patient fall rates in its critical care and medical-surgical unit.

As Pat LuCore of Sacred Heart points out, these initiatives help fulfill the mission that most clinicians aim for when they enter the healthcare profession: Providing high-quality care of patients.
Four Strategies for Reducing Hospital Readmissions

BY HEATHER LINDESEY

Penalties levied through the Centers for Medicare & Medicaid Services (CMS) Hospital Readmission Reduction Program, are “on everyone’s radar screen,” says Michael Henderson, M.D., chief quality officer for Cleveland Clinic Health System, a nonprofit multispecialty academic medical center in Ohio. “They’ve made everyone pay more attention to reducing readmission rates.”

As a healthcare provider, “you never want patients to be readmitted,” says Cheryl Bailey, R.N., chief nursing officer and vice president of patient care services at Cullman Regional Medical Center, a 145-bed facility in Cullman, Ala. “It hurts them and the bottom line of the hospital.”

Fortunately, four strategies can help hospitals reduce the number of patients who return for more care within 30 days of discharge.

1. IMPROVE PATIENT COMMUNICATION AND EDUCATION

Communication breakdowns surrounding the discharge process “happen every day in every hospital, and they put patients at risk for readmission,” says Bailey. While healthcare providers deliver discharge instructions, patients are often focused on heading out the door, as they are ready to go home and are not carefully listening to what’s being said, she says.

Moreover, primary caregivers often aren’t in the room, and any questions they may have about medication can be difficult for patients to answer once they’re home, says Bailey.

To reduce readmissions, hospitals should consider starting patient education long before discharge. For example, Sacred Heart Hospital, a 250-bed center in Eau Claire, Wis., established a pilot program requiring healthcare providers to begin teaching patients at admission about taking care of their disease at home. “This way information isn’t completely new to them at discharge,” says Julia Lyons, the hospital’s quality resources director.

Since implementing the program, patients tend to have fewer questions during hospital follow-up calls. Sacred Heart Hospital has reduced readmissions by about 15 percent since last year, although this can’t be attributed to any one initiative, Lyons says.

In addition to educating them about their medical conditions, tell patients who to call if they have questions about their medication, says Marcia Colone, Ph.D., system director of care coordination and clinical social work at UCLA Health System, which includes two medical centers, a psychiatric hospital, a children’s hospital and a medical group in Los Angeles, Calif.

Education about medications should address how to fill prescriptions, when and how to take drugs and the importance of adherence.

Medications can be especially confusing to patients if they have a new diagnosis, Lyons says. However, conducting a medication reconciliation and sending patients home with a full list of the drugs they should take can help avoid any problems, she says.

Hospitals also need to provide patients with detailed information about their follow-up appointments and tell them what to do if their condition changes, Colone says. “You have to be sure they know how to contact their primary care doctor and what they should do if they don’t get a response right away,” she adds. Patients need access to a live person at the physician’s office, rather than a recording, so they can describe their red flag symptoms.

Another approach to consider is actively engaging patients in learning critical information, rather than handing them a stack of educational material to take home, which can be overwhelming. UCLA Health is creating a simplified checklist for individuals to complete before discharge, focusing on when follow-up appointments will occur, changes in medications, the warning signs and symptoms of their condition and who to contact if worsening symptoms occur, says Nasim Afsar-manesh, M.D., associate chief medical officer, assistant clinical professor of medicine and neurology at UCLA Health System, which includes two medical

and safety in the departments of medicine and neurosurgery, at UCLA Hospitals in Los Angeles, Calif.

2. ESTABLISH BETTER PATIENT FOLLOW-UP

Follow-up is another key but potentially overlooked component of care that can help to reduce readmissions. “It’s easy to say we’re following up with patients, but are we actually doing it?” Henderson says. “If you’re making follow-up appointments with patients, are they also being helped with their transportation needs?”

While conducting follow-up calls at hospitals may be routine, tailoring the conversation to a patient’s specific condition is especially valuable, says Lyons. Sacred Heart, which calls all patients within 24 hours of discharge to confirm they are filling their prescriptions and to see whether they are having difficulty understanding their care or condition, recently created special callbacks to those diagnosed with pneumonia to discuss specific symptoms because relapse of the condition often isn’t obvious.

Tapping into community resources can also improve patient follow-up. In addition to having a case management department that works with patients to ascertain whether they have the ability to care for themselves after discharge, “we have a county transition coordinator who can refer patients to [and] who can assist with transportation or other issues that occur once they are home,” says Lyons.

Bringing follow-up care directly to patients is another strategy hospitals are using to reduce readmissions. UCLA Health has partnered with a community agency that uses coaches to visit Medicare patients...
to review their care, schedule appointments and teach them to contact their physician to answer questions about medications. Through a recently implemented program, the health system is also trying to determine whether having two nurse practitioners visit patients recently discharged from skilled nursing facilities reduces repeat hospitalizations.

If budget allows, investing in additional medical facilities for patients to use after they leave the hospital can also improve follow-up care. For example, to provide support during the vulnerable 30-day post-discharge period, UCLA Health opened a new evaluation and treatment center, which offers more intensive services than a primary care office and ensures that “patients have a place to go before they get into trouble and go to the ER,” says Afsar-manesh. While outcomes data aren’t available yet, “anecdotally, we have faculty who said they were sending their patients to the emergency department and instead sent them to the center,” she says.

3. EMBRACE TECHNOLOGY

Technology is increasingly helping hospitals to track and provide much of the information and education patients need for their care, which, in turn, may help to reduce readmissions.

Specifiﬁcally, much of the logistics of patient follow-up, such as post-discharge appointments and medication reconciliations, can be coordinated through the electronic health record, says Afsar-manesh.

Adopting additional technology, such as, patient education applications that providers can use at discharge, may also reduce readmissions. Cullman Regional Medical Center began using a healthcare application that nurses can use to pull up a discharge education template based on an individual’s medical condition and then record themselves giving tailored instructions to the patient. Once patients are home, they can listen to the discharge education audio recording, as well as any pre-pocketings about caring for their condition via the phone or Internet. Web users are able to access additional audio and video ﬁles on their condition and link to other health information sites.

The medical application was ﬁrst tested in the 31-bed stepdown unit, where patients with congestive heart failure, acute myocardial infarction and pneumonia receive care. Within six months, the unit experienced a 15 percent reduction in 30-day readmissions, so the center rolled out the technology to other parts of the hospital.

4. EVALUATE CAUSES OF READMISSION

Whatever strategies hospitals decide to implement, assessing the reasons surrounding patient readmissions can help centers to further reﬁne and develop their programs.

Upon readmission, staff at UCLA Health contact the patient’s discharging physician and outpatient providers to conduct a mini root-cause analysis, says Afsar-manesh.

“We ask, ‘What were some of the things we could have done differently for patients to keep them healthy, and what do we need to do to improve care in the future?’ We’re constantly engaged in preventing readmissions.”

Overall, hospital programs and subsequent evaluations at UCLA Health have resulted in an absolute reduction of readmissions by 1 to 3 percent, according to Afsar-manesh.

“This doesn’t sound like a lot but when you look at how challenging it is to move the dial, this signiﬁes great strides,” she says. 

Discharge Planning Essentials: Reducing the Risk of Falls

▶ When preparing a patient for discharge, it’s critical to take every measure possible to set the patient up for a successful return to life at home. New or altered medications must be explained. Activity and/or diet restrictions must be discussed. Durable medical equipment may need to be procured. In-home care may need to be arranged. But while these are indeed important, it’s often something much simpler that causes discharged patients to return to inpatient care: a preventable fall.

FALLS ARE COMMON

Approximately one in three adults over the age of 65 will experience a fall each year. Yet only half of these seniors will discuss the possibility of falls with their healthcare providers.

This risk increases dramatically when medications are altered or new physical restrictions are present. Spending dedicated time discussing falls prevention can help reduce the risk of your patients experiencing a potentially debilitating fall. Here are some key considerations to cover.

MEDICATIONS

Patients being discharged with new or different combinations of medications may have entirely new and unexpected side effects. Amongst those sometimes overlooked:

• Urgency or Constipation: Patients may rise and proceed too rapidly towards a bathroom when surprised by the need to eliminate.

• Light Sensitivity: Newly light-sensitive patients may find navigating familiar surrounds surprisingly treacherous.

• Orthostatic Hypotension: Patients who feel normal while seated may lose their balance due to a quick drop in blood pressure when they rise due to this common side effect.

ENVIRONMENT

To best mitigate the risk of falls, the home should be prepared for the returning patient. Each room should be surveyed to remove clutter and tripping hazards. Grab bars in bathrooms and railings for stairways should be securely installed.

Here are some speciﬁc examples to be implemented in the bedroom:

• Prepare a nightstand with room for necessities that must be accessed from bed. Clear the floor of tripping hazards such as shoes or slippers and lose rugs. Provide a phone or Lifeline device within easy reach. Remove or place accessory furniture in an out-of-the-way location. Provide a photo- or motion-sensitive nightlight to provide visibility during periods of darkness. Ensure electrical or device cords away from areas of foot traffic. Finally, locate any necessary DME or assistive devices such as walkers near enough the bed to permit ease of use.

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PHILIPS


• Based on the number of undetected falls that have been reported to Philips Lifeline by U.S. AutoAlert subscribers for the period from January 2012 through July 2012. Undetectable falls can include a gradual slide from a seated position—such as from a wheelchair—which may not register as a fall. AutoAlert does not detect 100% of falls. If asked, you should always press your button when you need help.

“ We’re constantly engaged in preventing readmissions.”

NASIM AFSA R - MA N E SH, M.D., S.F.H.M., ASSOCIATE CHIEF MEDICAL OFFICER, EXECUTIVE DIRECTOR OF QUALITY AND SAFETY IN THE DEPARTMENTS OF MEDICINE AND NEUROSURGERY, UCLA HOSPITALS, LOS ANGELES, CALIF.
Combats Patient Readmissions

BY JOANNE FINNEGAN

Two proven models help patients stay out of the hospital

> With the potential loss of revenue on the line from reduced Medicare payments for higher-than-average readmissions, hospitals are putting resources and energy into efforts to improve their discharge planning and transition care processes.

One way to prevent readmissions—and avoid Medicare penalties—is to focus on patients’ care after they leave the hospital by improving coordination between hospitals and other care settings and community services, and offering enhanced patient education and support.

PROJECT RED CHECKLIST MEANS DISCHARGE TASKS NOT OVERLOOKED

There are a number of different initiatives that hospitals can use as models for their own programs. One nationally recognized initiative is Project RED, the shortened name for Project ReEngineered Discharge, which targets preventable readmissions.

Boston University Medical Center, an inner city teaching hospital, developed Project RED to improve care coordination around patient discharge and reduce avoidable readmissions. Funded by the Agency for Healthcare Research and Quality, Project RED focuses on patient education while in the hospital, as well as staff follow-up after discharge to identify and resolve any problems the patient is having that could lead to a readmission.

Two major issues led the medical center to undertake a study to improve its discharge process—it did not have a standardized way of handling patient discharges and the process was fragmented, says Christopher Manasseh, M.D., a researcher at Project RED. One problem was that the medical center did not assign specific tasks to staff in charge of the patient’s discharge process. For example, when it came to providing education about the new medications a patient had to take upon discharge, one staff member might assume another already took care of it.

The medical center came up with a checklist that includes 12 components that staff must complete. Those action steps include scheduling follow-up appointments and tests, arranging for outpatient services, ordering medical equipment, and confirming medication plans. (See the list on p. 8). Every patient has a discharge plan that includes items, such as medication reconciliation and post-discharge services coordination.

A nurse serves as the patient’s discharge advocate and works with the patient’s medical team. Patient education begins as soon as feasible after admission, says Manasseh.

Instead of one lengthy (and likely overwhelming) session with a patient, the nurse reviews—and the person’s diagnosis one day, review medications another, and hold a third session about proper diet. The discharge advocate spends an average of 90 minutes with the patient during the hospital stay. At discharge, each patient receives a color-coded individualized instruction booklet that is sent to the patient’s primary care physician. The nurse reviews the instructions and asks patients to repeat the information and explain what they are to do.

When a patient leaves the hospital, the job is not finished. Originally, Project RED used pharmacists to make the follow-up calls to patients to resolve any problem with medications. Now the medical center has the nurse discharge advocate follow-up to identify and resolve any problems. Within 48 hours to 72 hours, the same nurse educator that the patient got to know in the hospital calls to see how he or she is doing. The nurse educator also reinforces the education the patient received as an inpatient, Manasseh says.

“It’s basically the patient telling you what he or she is doing,” he says. But along with asking about dialysis appointments or if a home health nurse has visited, the nurse also might ask about the patient’s Chihuahua or grandchildren. The phone call usually takes a good 15 minutes to 20 minutes.

“I think it is time well spent,” he says, noting that the interventions have helped the medical center to reduce readmission by 30 percent. It has also seen a dramatic improvement on patient satisfaction scores.

When healthcare leaders learn about Project RED, they often ask if it can be implemented without additional resources. “I say it’s worth investing in this. The return on investment is very high,” Manasseh says.

A ‘BRIDGE’ BETWEEN PATIENTS AND SUPPORT SERVICES

While Project RED’s success has been duplicated in other hospitals, it is not the only model that works. Bridge, a model used at Rush University Medical Center (RUMC) in Chicago, uses social workers rather than nurses to provide patient follow-up.

“Bridge is a transition of care model structured around social work practices and theory,” says Madeleine Rooney, MSW, LCSW, manager of transitional care for the health and aging department at RUMC.

In the Bridge model, social workers coordinate post-hospital discharge care for older adults. Efforts to reduce patient readmissions at the 671-bed Rush begin at admission and continue once patients go home or to other care facilities.

At Rush, a team of five full-time master’s-level social workers call patients after discharge. They make sure the patient understands his or her plan of care. They ask if the patient has made contact with a specialist or how his or her rehab is going, for example. They question the patient about medications and if the patient has filled his or her prescriptions. They might ask if the daughter who is supposed to help at home has been available or if the patient is anxious or depressed. The social workers also ask the patient’s caregivers about their stress.

The social workers coordinate with all of the elements that make up a person’s support system: family, community agencies, church communities and medical providers.

“Our ability to navigate obstacles is part of what makes Bridge unique,” Rooney says.

The social worker can stay involved in a patient’s care and follow-up for five days to 30 days or longer. Each social worker takes on about 10 new cases each week and on average each has about 12 to 15 cases open at a time.

“If not Bridge, there needs to be some transitional model or system in place that merges the inpatient and outpatient world,” Rooney says.
Q&A: How Baystate Mary Lane Hospital reduced patient falls

BY JOANNE FINNEGAN

HOSPITAL REPORTS NO PATIENT FALLS WITH INJURIES IN 2012 AND FIRST QUARTER OF 2013

The Agency for Healthcare Research and Quality estimates that each year as many as 700,000 to one million patients fall in U.S. hospitals and research indicates that nearly a third of these mishaps can be prevented. Fall prevention, the AHRQ states, requires an interdisciplinary approach to care in an organization that promotes teamwork, communication and individual expertise. One facility that has successfully implemented such a program is Baystate Mary Lane Hospital, a 25-bed community hospital in Ware, Mass., that is part of Baystate Health. The hospital has lowered fall rates in both its critical care and medical-surgical unit. To uncover the secrets to its success, FierceHealthcare interviewed Nurse Manager Tina Paulson, R.N., Linda Lechowicz, personal care technician, and Michelle Holmgren, public affairs director, about the hospital’s falls prevention program.

FierceHealthcare: What is Baystate Mary Lane Hospital doing to prevent patient falls?

Tina Paulson: I don’t think we have any unique strategies. What we have is a committed group of staff who don’t let anything go. For instance, we have a ‘no pass zone’ process where all call bells are answered whether it’s your patient or not. In the old days, it was ‘my side, your side, my patient, your patient.’ So we have taught all of our staff to respond to all calls unless they are with another patient at the time. We are talking about rolling this out through the entire organization. So what we have is a committed group of staff who don’t let anything go.

FierceHealthcare: What are other things that staff do?

Linda Lechowicz: We also have an alarm program. If a patient with a bed or chair alarm tries to get up, a recorded voice asks the patient to sit back down and use the call light to get somebody to come and help them. If we have a patient that speaks a foreign language, we will ask a family member for help recording the message. We might place them near the nurses’ corridors so we can quickly get to the patient. We put his name on the recording, maybe a special message. Whatever we can do to assist the patient. You have to see it work. It’s amazing. It comforts the patient to know that someone is there.

FierceHealthcare: How does the falls alarm system work?

Michelle Holmgren: My elderly mother-in-law was a patient and I can tell you the alarm program is so cool. In my mother-in-law’s case, the recorded voice said, ‘Ruth, stay in bed, we’re coming in and check you.’ When she started to wiggle around, it automatically addressed her urge to get out of bed. Someone came in shortly because the alarm went off, in addition to that voice recognition.

FierceHealthcare: How about patient’s culture?

Paulson: A lot of our patients might be a little confused, or have dementia, or Alzheimer’s disease and they tend to like to get up very quickly. We might place them near the nurses’ corridors so we can watch them closely or we may use sitters, which is a method we have used in the past. We do have patient care technicians who can sit with a group of patients who are confused or at fall risk.

FierceHealthcare: Can you personalize the message for every single patient? You can put their name, their nurse’s name, maybe a special message.

Paulson: One case I remember is where a gentleman just wanted to hear that his dog was OK. So we put his name on the recording, and a message telling him his dog was fine at home with so-and-so. Knowing his dog was OK distracted him and put him back in his chair. You can personalize the message for every single patient. You can put their name, their nurse’s name, maybe a special message. Whatever is the reason they want to jump up to get answers to, we relate it. The
In 2012, our general fall rate was 2.26; the average for our peer group was 2.89 falls per 1,000 patient days. For falls with injuries we were at zero percent, while the rate was 0.61 for our peer group. ... I'm proud to say we are still at zero percent for patient falls with injuries for the first quarter of 2013.

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The person who admits the patient to the bed will identify the patient as a fall risk. We put a pad under them or behind their back, depending on whether they are in a bed or chair. When you make the recording, you want to say the patient’s name right away. You want to stun them in the first three seconds. You say their name, identify yourself, ask them to sit down and tell them you will be right in.

**FH:** How do you identify a patient who is at risk of falling?

**Paulson:** Some of it is by diagnosis alone: for instance, a patient with an altered mental status; anyone with dementia or Alzheimer’s; anyone with a neurological issue, such as a stroke or weakness. Sometimes it is based on age. But we have a fall risk assessment that we do every 12 hours on our patients. A certain score automatically tells us they are a fall risk. We have a list of different things that we do in response. We lower the beds. We put non-slip socks on all of our patients. We always put signs outside the door. We have signs on the patient records. We have care plans regarding falls. Everyone gets the rounds. Those are all the routine things. Someone who is at much higher fall risk we probably will cohort them and maybe they will be assigned a particular personal care technician to sit with that group so he or she will be under much better observation. You want that patient closer, not at one end of the hall. We have floor mats as well. If we really do feel someone is a big risk, we can put those all around the bed to protect them in case the patient falls out. We try not to restrain patients; I can’t even think of the last time we put a restraint on anyone at a fall risk.

**Lechowtiz:** We call in family, also. The family often says we should call them if the patient is confused or sundowning [Sundowning In 2012, our general fall rate was 2.26; the average for our peer group was 2.89 falls per 1,000 patient days. For falls with injuries we were at zero percent, while the rate was 0.61 for our peer group. ... I'm proud to say we are still at zero percent for patient falls with injuries for the first quarter of 2013. **FH:** How do you identify a patient who is at risk of falling? **Paulson:** Some of it is by diagnosis alone: for instance, a patient with an altered mental status; anyone with dementia or Alzheimer’s; anyone with a neurological issue, such as a stroke or weakness. Sometimes it is based on age. But we have a fall risk assessment that we do every 12 hours on our patients. A certain score automatically tells us they are a fall risk. We have a list of different things that we do in response. We lower the beds. We put non-slip socks on all of our patients. We always put signs outside the door. We have signs on the patient records. We have care plans regarding falls. Everyone gets the rounds. Those are all the routine things. Someone who is at much higher fall risk we probably will cohort them and maybe they will be assigned a particular personal care technician to sit with that group so he or she will be under much better observation. You want that patient closer, not at one end of the hall. We have floor mats as well. If we really do feel someone is a big risk, we can put those all around the bed to protect them in case the patient falls out. We try not to restrain patients; I can’t even think of the last time we put a restraint on anyone at a fall risk. **Lechowtiz:** We call in family, also. The family often says we should call them if the patient is confused or sundowning [Sundowning.

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Integrated care: It’s Not Only Possible, It’s Essential

By Alicia Caramenico

Two hospitals prove multidisciplinary efforts lead to better outcomes, lower costs

Efforts to control healthcare costs and reduce utilization requires all hands on deck—from all hospital departments and service lines. The most successful hospitals use multidisciplinary teams to integrate care for better outcomes and lower costs.

One such hospital is Montefiore Medical Center in the Bronx, N.Y. Once it recognized that patients who have behavioral health issues on top of chronic illness have poor outcomes and rack up significant healthcare costs, it integrated behavioral health and clinical care. Montefiore, comprised of four hospitals with 1,491 beds, formed a team to support primary care physicians that included a care manager to educate patients and perform necessary follow-up. A behavioral health manager to conduct onsite evaluation and short-term psychotherapy, a psychiatrist to provide individual consultations with complex patients and psychotropic medication management and telephone interventions to lower the cost of care, according to Henry Chung, M.D., vice president and chief medical officer, The Care Management Company, Montefiore Medical Center.

There have been models out there that are quite evidence-based that have demonstrated that if you use a team-based approach…you can really impact both medical outcomes and behavioral outcomes,” Chung says.

“Integration needs to occur, even if you don’t have initially the cost outcomes data to support it.”

Henry Chung, M.D., Vice President and Chief Medical Officer, The Care Management Company, Montefiore Medical Center, Bronx, N.Y.

BREAK DOWN SILOS

Multidisciplinary, integrated care isn’t new but with the fragmentation of healthcare services, it’s more important than ever to coordinate care, says Tom Lee, M.D., chief medical officer at the South Bend, Ind.-based healthcare consultancy Press Ganey.

Thanks to integrated care efforts, Sacred Heart Hospital in Eau Claire, Wis., was able to reduce fragmentation and break down its silos. For instance, in its program, daily patient rounds include the doctor, nurse and therapist, who together develop goals for each day, according to Pat LuCore, assistant administrator for Sacred Heart.

Similarly, its cancer program holds conferences with pathology, imaging, radiology, medical oncology, radiation oncology, nurse navigation and palliative care all participating in the discussions. She notes that having all the disciplines work together has helped the organization take all of the patient’s needs into consideration.

While attending one of these conferences, LuCore had what she calls an “a-ha moment,” realizing the multidisciplinary meetings involve healthy discussion about what is best for the patient. “That’s a pretty wide gamut of disciplines that are there all for the main goal of developing what is truly the best care for that patient.”

With similar goals in mind, Montefiore’s integrated care program involves nurse coordinators in depression self-management and social workers in the treatment plan and monitoring chronic conditions, according to Chung.

“From the patient perspective, they don’t see it as ‘oh, the social worker only cares about the behavioral condition and the nurse only cares about the medical condition.” No, everybody is caring about the whole person and what the total issues are to help them get the best outcome possible,” Chung says.

OVERCOME TURF BATTLES

It’s important to get multidisciplinary healthcare professionals to work closely with each other, but overcoming turf battles can present a challenge. So Sacred Heart routinely schedules the meetings to occur every two weeks around physicians’ schedules. The team also schedules the meetings on the same day of the week and at the same time so they can build their practices around them.

The meeting schedule highlights a key step to getting physicians on board with care coordination and integration efforts—removing roadblocks that get in the way of their day-to-day activities, according to Press Ganey CEO Patrick T. Ryan.

Also, to get various disciplines to play on the same team, LuCore recommends identifying physician and provider champions. Put individuals who have a passion for the service line on the integrated care team, she says.

BE INNOVATIVE AND NIMBLE

With multidisciplinary, integrated care, Sacred Heart has become more nimble in its care delivery. The industry is focused on evidence-based medicine to drive positive outcomes, but evidence-based guidelines can be limiting. To adhere to these guidelines without stifling innovation, hospitals must use an integrated approach, LuCore says.

For example, Sacred Heart’s cancer program aims to adhere to National Comprehensive Cancer Network guidelines, but if a surgeon doesn’t follow them, it can interfere with the radiation and oncology components of that patient’s care, she explains.

Integrated care also can help hospitals quickly shift patients to a lower level of care when necessary. For example, at Sacred Heart, a multidisciplinary team that includes a registered nurse, occupational therapist, physical therapist, case manager or social worker and a past patient lead an information session for patients and their significant other, friend or family member prior to joint replacement surgery to talk about the upcoming procedure and discharge plan. If the care team recognizes flaws in the plan, having everybody in the same room at the
As hospitals implement integrated discharge care, the appropriate level of post-discharge care needs to occur, even if you don’t have initially the cost outcomes data to support it.” Sacred Heart’s LuCore echoes those sentiments, urging hospitals to keep the focus on the patient and outcomes rather than finances. She notes most people enter healthcare because they want to take care of people, but once you put dollar signs on integrated care it becomes just another cost saving initiative. “That’s one of the benefits of it,” she says, “but it’s not why you would want to do multidisciplinary, integrated care.”

drive improvement efforts

As hospitals implement integrated care programs, they won’t see cost savings materialize for at least one or two years, Montefiore’s Chung notes. While evidence suggests an average $2,000 savings per patient after two years, he warns not to launch integrated care programs for the profits. “We do a lot of things in medicine because we know that it’s the right thing to do and we want good clinical outcomes, and good clinical outcomes will ultimately justify the approach,” Chung says. “Integration needs to occur, even if you don’t have evidence, because it’s the right thing to do.”

“Don’t be afraid to go back to the drawing board.” PAT LUCORE, ASSISTANT ADMINISTRATOR, SACRED HEART, EAU CLAIRE, WIS.

How do you extend your falls prevention efforts to discharged patients?

Paulson: We have to report to the Patient Care Links for Massachusetts (a healthcare quality and transparency collaborative comprised of Massachusetts hospitals, nursing leaders and home healthcare agencies). All of our falls go into a database. In 2012, our general fall rate was 2.26; the average for our peer group was 2.89 falls per 1,000 patient days. For falls with injuries we were at zero percent, while the rate was 0.61 for our peer group. The data we submitted for this year has not been publicized yet. But I’m proud to say we are still at zero percent for patient falls with injuries for the first quarter of 2013. Our current rate for falls themselves is half of what the peer group is. I feel very good about our statistics.

Lechowitz: I feel good on the floor as a personalized care technician. It means so much, especially for the extra TLC of the patient.

FH: How do you know your efforts are working?

Paulson: We have to report to the Patient Care Links for Massachusetts (a healthcare quality and transparency collaborative comprised of Massachusetts hospitals, nursing leaders and home healthcare agencies). All of our falls go into a database. In 2012, our general fall rate was 2.26; the average for our peer group was 2.89 falls per 1,000 patient days. For falls with injuries we were at zero percent, while the rate was 0.61 for our peer group. The data we submitted for this year has not been publicized yet. But I’m proud to say we are still at zero percent for patient falls with injuries for the first quarter of 2013. Our current rate for falls themselves is half of what the peer group is. I feel very good about our statistics.

Lechowitz: I feel good on the floor as a personalized care technician. It means so much, especially for the extra TLC of the patient.

FH: How do you extend your falls prevention efforts to discharged patients?

Paulson: We do a lot of education. My office is right here on my unit, I hear my staff all the time reiterating that. It’s a phenomenon associated with increased confusion and restlessness in patients with dementia; often occurring in the evening or while the sun is setting. Sometimes we do a phone call or sometimes they come in and talk to them. That helps a lot.

Don’t be afraid to go back to the drawing board.”

“Don’t be afraid to go back to the drawing board.” PAT LUCORE, ASSISTANT ADMINISTRATOR, SACRED HEART, EAU CLAIRE, WIS.

FH: How do you extend your falls prevention efforts to discharged patients?

Paulson: We do a lot of education. My office is right here on my unit, I hear my staff all the time reiterating the lessons to patients. We use the teach-back method. Maybe there are three key things a patient has to know before he or she leaves here. So we’ll teach on those three things and then we want the patient to repeat it back to us so they understand it. So when patients are a fall risk, I hear staff saying, ‘Ok, we put everything in place. I don’t want you getting up to go to the bathroom. Don’t get up before using your call bell.’ They repeat it and repeat it.

FH: With hospitals concerned about trying to prevent readmissions, are there steps you take to prevent falls when patients go home?

Lechowitz: I know the discharge planner does work well with patients and the patient’s family. They often tell them, ‘Mom may need more help at home’ or try to set up services.

Paulson: If there’s an identified need, such as a cane, a walker, a commode or a bed, because they can’t climb stairs or because they need to be on the first floor or are unsteady, we will order all that and have it here before they go home. We will not discharge them until the equipment has arrived. … We go over the different things to avoid at home, such as scatter rugs and other tripping hazards. If the patients still appear at risk when they go home, and they are not going to rehabilitation, we can print out educational information and our discharge plan that talks about falls.

FH: Are there any other strategies you can share?

Paulson: Some facilities are doing this and some are not. We do have bedside handovers. So at the beginning and end of every shift, nurses go into the patient’s room and introduce the oncoming shift. We go over safety data, including fall risk data. All of this together, done routinely and consistently, makes a difference.

Baystate Mary Lane Hospital

Patient Falls per 1,000 Patient Days

For the period of October 2011 - September 2012. Lower rate reflects better performance.

Data Source: MMA Patient Care Links Project

Lower is Better