TMF Health Quality Institute

QI Snapshot

Brief #04

Addressing Patient Social Needs to Reduce Hospital Readmissions

A small, rural Texas hospital, with the aim of reducing readmissions among high-risk Medicare beneficiaries, implemented a post-discharge nursing Transition Care Team program with 135 patients. Based on needs, patients received one to three home visits per week from the nursing team for 30 days post hospital discharge. The program, focusing on health literacy, patient education and non-medical needs, reduced the overall readmission trend (from 17.9 percent to 12.5 percent) over a two-year period. Patient satisfaction also improved among a subsample of transition patients. Using new ground rules like a non-judgmental approach to frequently admitted patients and focusing on patient education and non-medical needs, similar nursing programs and approaches could be successful in reducing hospital readmissions, improving patient satisfaction and fulfilling patient needs beyond the hospital stay.

Project Overview

Project Intervention

A nursing team at a hospital in Plainview, Texas, created a transitions of care program with the overarching goals of reducing readmissions and improving patient satisfaction among high-risk Medicare beneficiaries. The hospital's Transition Care Team (TCT) program was designed to educate patients about their disease process via post-discharge home visits that focus on literacy and non-medical needs. The innovative TCT program used new ground rules to create trusting patient-nurse relationships. The evaluation of the TCT program spans the initial implementation period from November 2013 to November 2015. This retrospective evaluation examined both the hospital readmission rate trend over this two-year period and patient satisfaction and quality of care from a sample of program participants.

Methods

The small (68-bed) hospital serves about 42 percent Medicare fee-for-service (FFS) beneficiaries, with roughly 7 percent dual eligible for Medicare and Medicaid annually. The county's average total family income is $59,574, with 39 percent of the population (over age 25) having no high school diploma and over 18 percent of the population experiencing food insecurity.

Patient selection for the TCT program was based on those who were identified as at risk. At-risk patients included Medicare beneficiaries 65 years or older hospitalized for congestive heart failure (CHF), pneumonia, diabetes and/or chronic obstructive pulmonary disease (COPD). To risk stratify patients with these four conditions, the team used the LACE tool, assessing length of stay, acuity of the admission, co-morbidities and emergency department visits within the previous six months, to identify patients at risk for readmission. For TCT enrollment, patients had to meet one of the following criteria:

- A LACE score of 10 or higher (high risk for readmission)
- Readmitted within 30 days with CHF, pneumonia, diabetes and/or COPD
- Newly diagnosed with CHF, pneumonia, diabetes and/or COPD *regardless* of LACE score
- Discharged to home (including those receiving home health) and long-term care facilities

The team used an assessment patients filled out in the hospital to test patients' comprehension and management of their disease, knowledge of medications and dosages, and access to a primary care provider (PCP). Based on total assessment and needs, the TCT nurse visited patients once, twice or three times a week for 30 days post discharge to work on the fields from the assessment (patient education, disease management, health literacy, medication review). Per the initial in-home evaluation of risk for falls, access to appropriate nutrition, adequacy of living conditions, tobacco/substance abuse, depression, anxiety, social support and financial resources, the TCT nurse assisted the patients in finding and coordinating contact with the appropriate resources. A weekly report was also sent to the patients' PCP communicating patient resource needs.

Assessment

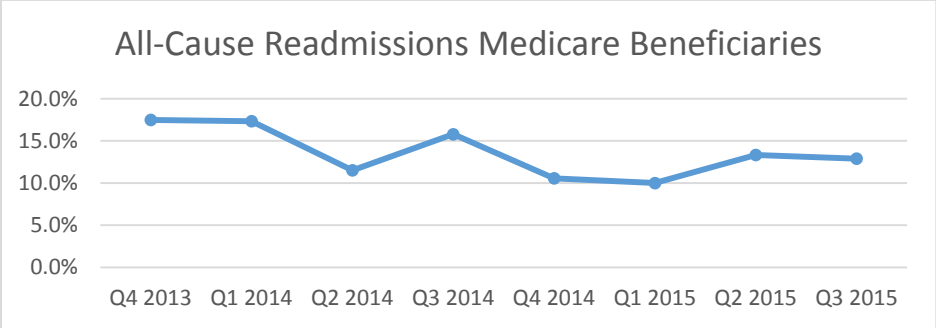
A total of 135 out of 152 identified Medicare beneficiaries completed the TCT program from the last quarter of 2013 to the last quarter of 2015. For the 135 program patients, 89 (66 percent) were male and 46 (34 percent) were female. Roughly half of the program patients had a primary diagnosis of COPD and half had a primary diagnosis of CHF. However, most of the patients had multiple diagnoses, with a combinations of either CHF and COPD, CHF and pneumonia, or COPD and pneumonia. In addition to the presence of a combination of diagnoses, four patients were seen for sepsis, three patients were seen for new onset of diabetes and two patients were seen for other conditions not defined.

In terms of patient experience, the hospital wanted to identify how much knowledge the patient had prior to the TCT visit regarding their disease process, medications and how often they felt that staff provided education regarding these factors during their hospital stay. The hospital also wanted to know how helpful patients felt the TCT was in increasing their knowledge of medications and their disease process. To evaluate patient experience, 10 patients seen by a TCT member were randomly selected from the approximate 65 patients who completed the program in the first year (November 2013 to November 2014). The team assessed each patient via telephone interview and asked twelve questions regarding disease condition knowledge, quality of education and socioeconomic factors. Overall responses show improvement in knowledge and high patient satisfaction with the TCT program.

Outcomes

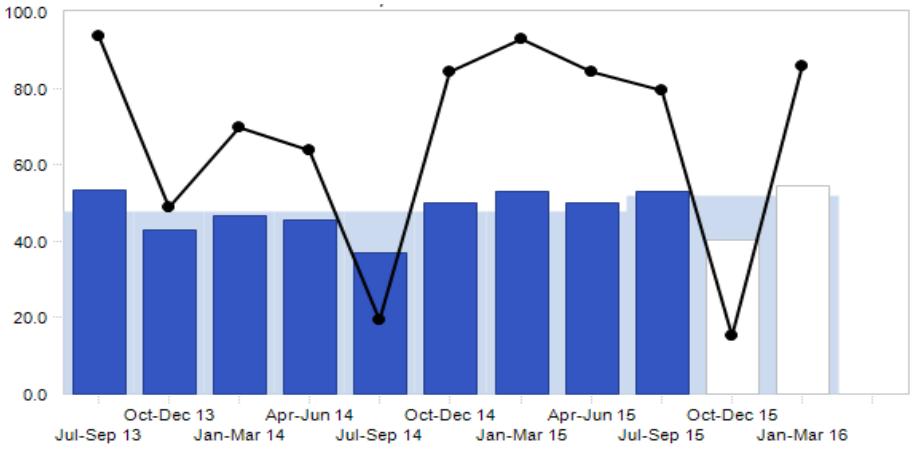
Specific readmission rates for the 135 program patients are not available; however, all-cause rates of 30-day readmissions (updated with Medicare FFS lag claims) for the 1,197 Medicare beneficiaries admitted and discharged from the hospital during the program period reveal improvement (steadily declining trend) from 17.9 percent to 12.5 percent (see Figure 1).

Figure 1. TCT Program Duration (Quarter 4 2013 – 2015): Hospital All-Cause Readmissions



Following the TCT program, the facility also demonstrated higher patient satisfaction scores as reported on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). For example, the patients' rating on "Staff took into account preferences when deciding health care needs" at an unacceptable 19 percentile in Fiscal Year 2014 changed to a ranking in the 85.8 percentile by March 2016 in the Medical Surgical/Intensive Care Unit (see HCAHPS Patient Preferences 2014 – 2016 in Figure 2).

Figure 2. HCAHPS Patient Preferences 2014 – 2016



	Jul-Sep 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	
Inpt Med/Surg % Strongly Agree Rank *	93.5	48.8	69.6	63.9	19.3	84.3	93.0	84.3	79.3	15.4	85.8
% Strongly Agree	53.5	42.9	46.7	45.6	37.0	50.0	53.1	50.0	52.8	40.3	54.5
Inpt Med/Surg 75th Percentile	47.9	47.9	47.9	47.9	47.9	47.9	47.9	47.9	51.8	51.8	51.8
N of Cases	43	49	60	68	54	68	64	68	89	77	22
Norm Year	2014	2014	2014	2014	2014	2014	2014	2014	2015	2015	2015

*Rankings are based on PRC Norm data.
**The data in this chart has been filtered.
+Marked bars are Statistically Significant

Lessons Learned

Per the hospital chief nursing officer, the TCT program enabled the hospital to build a nursing culture void of jaded attitudes and replace it with patient empathy and understanding. Critical elements of the program cited from nursing leadership included full support from hospital executive team, provision of home visits and addressing patient non-medical needs, particularly with food insecurity, safer living conditions and social support. Finding resources to support nonmedical needs is critical to advancing population health, quality of care and cost containment. As a result of the TCT program, the hospital formed a committee of community health care transitional and living facilities, pharmacies, adult protective services, outpatient clinics and food and transportation services to improve care transitions and assist patients. Hospital staff can form trusting patient-provider relationships if they're involved in patient's lives post-discharge with a non-bias, non-judgmental approach. Moreover, addressing patient non-medical needs as well as health literacy beyond the patient hospital stay can dramatically improve both readmissions and long-term health outcomes.

Note: Content of this QI Snapshot was adapted from a manuscript prepared by: Kris Calderon, PhD, CHES; Leslie Hackett, MAM/HCA, BSN, RN; Cindy Bigbee, MSN, RN; and Vanessa Andow, CPHQ