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Reducing Regional Hospital Readmissions: The PAVE Project

By *Patricia J. Yurchick, RN, MBA, CPHQ*

An important focus of health care reform, avoidable readmissions are a goal of many national, state, and regional initiatives that aim to improve transitions across the continuum of care. There is good reason for this!

A study published in the *New England Journal of Medicine* reported that 20% of Medicare patients were readmitted to the hospital within 30 days of discharge and more than one third were readmitted within 90 days. More than half of the patients discharged with a medical diagnosis did not have a physician office visit between their discharge date and the readmission date. The estimated cost of these unplanned readmissions exceeds \$17 billion dollars annually.¹

These findings mirror statistics in specific regions of the country. For example, the Pennsylvania Health Care Cost Containment Council (PHC4), an independent state agency that collects, analyzes, and reports data about the cost and quality of health care in Pennsylvania, recently reported an overall hospital readmission rate of 19.1% for selected conditions in southeastern Pennsylvania (SEPA), compared to 18.2% in western Pennsylvania and 16.2% in central/northeastern Pennsylvania.²

An initiative, the Preventing Avoidable Episodes Project (PAVE), is under way in the SEPA region to address issues related to transitions of care and, ultimately, to reduce readmission rates in the region. The project is guided by and funded through the Partnership for Patient Care (PPC), a unique enterprise involving the Health Care Improvement Foundation (HCIF), Independence Blue Cross (IBC), and health care providers in the SEPA region. PAVE is a multiyear quality and safety initiative.

HCIF is a nonprofit organization founded in 1980 as a 501(c)(3) affiliate of the Delaware Valley Hospital Council (DVHC) of the Hospital & Healthsystem Association of Pennsylvania. The DVHC is a membership organization representing more than 50 acute and specialty care hospitals and health systems, over 30 facilities that provide inpatient behavioral health services, and 20 facilities that provide physical rehabilitation in SEPA. Although HCIF became an independent organization in 2008, it maintains strong ties with DVHC. HCIF is governed by a Board of Trustees with strong hospital leadership experience and a Clinical Advisory Committee that provides guidance regarding clinical priorities.

HCIF's vision is to make the Greater Philadelphia region the safest place in the nation to receive health care by building partnerships with the health care providers in the region. HCIF is funded through the PPC - in large part by IBC, a leading health insurer in SEPA with 2.4 million members. Additional contributions from the region's hospitals help support the PPC. HCIF identifies 1 or 2 major initiatives each year. In the spring of 2010, PAVE was launched via a major educational conference to introduce the region's hospitals to numerous national and regional efforts to improve care transitions and to reduce preventable readmissions.

Given the compact geography and abundance of facilities, patients in SEPA may receive care at any number of hospitals. Thus, patients may elect to be readmitted to hospitals other than those from which they were discharged. Because the magnitude of this issue is not fully understood, providers have come to realize the benefit of working together to create common regional solutions. As a result, PAVE was well received by health care organizations in the region. Close to 30 hospitals have chosen to participate including cancer care organizations, children's

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hospitals, home health care and hospice agencies, and community-based service organizations.

The overall goal of PAVE is to reduce readmission rates by 10% over the course of the 18-month project time line. Project leaders hypothesize that this goal can be achieved by improving transitions of care from one provider to the next, increasing patient and family engagement in the management of the patient's health care plan, and engaging providers and health care professionals along the entire continuum of care.

Rather than addressing processes within distinct provider organizations, PAVE plans to achieve its goal via 3 workgroups designed to address related issues across the care continuum. Each workgroup is charged with developing at least 1 innovative approach with regional impact. With over 120 individual participants representing health care professionals across the health care delivery spectrum, a true collaborative spirit will be fostered.

Recognizing the impact of medication errors on readmissions, the Medication Management Workgroup was formed to:

- Identify best practices concerning medication reconciliation.
- Define the role of pharmacy in the discharge and postdischarge processes.
- Evaluate the role of information technology in the medication management process.

Close to 50 individuals - pharmacists, case managers, nurses, quality and patient safety professionals, and physicians - from participating organizations have joined this workgroup.

The Care Transitions Workgroup, formed to address issues related to the process of care delivery across the care continuum, focuses on developing

recommendations regarding effective coaching and handoff techniques and improving the overall collaboration and coordination of care. Over 60 medical professionals, including physicians, nurses, case managers, and quality and risk professionals, are involved in this workgroup.

The Personal Health Record Workgroup's task is to develop a framework for the personal health record by identifying key data components, comparing available formats and vendors, and recommending a process for data collection and completion. This workgroup's 35 members are professionals in the areas of health care delivery and information technology.

An Expert Advisory Panel convened for the PAVE Project is comprised of national experts in the field of care transitions and regional thought leaders. The role of the panel is both to advise and to serve as a resource for the 3 workgroups and project leaders for the duration of the project.

Another important component of PAVE is its focus on baseline and ongoing measurement. Readmission rates, monitored throughout the project, are the metric by which success will be determined. PHC4 publishes readmission data across the Commonwealth; however, the data are not timely enough to support the needs of the PAVE Project. Because no single ideal source of readmission data exists, multiple sources will be used. Readmission data as published through the DVHC will be tracked throughout the project.

Participating hospitals are required to complete a Transitions of Care Survey prior to the start of the project to identify strategies and targeted interventions at each site. The survey consists of 32 questions about the facility's strategies to reduce unplanned readmissions by improving

care transitions and its approach to measurement relative to readmissions. Aggregate results will be shared with all participants.

Post project, the survey will be readministered to see which strategies were implemented. In addition, a focused chart review of patients who were readmitted will be conducted at each participating hospital to identify trends and potential issues at the site and to help guide the workgroups in their activities.

Finally, interviews with patients who were readmitted and their families will be conducted using a standardized tool, the Care Transitions Measures (CTM)-3 Tool, developed by Eric Coleman, MD, from the University of Colorado. The 3 questions contained in the CTM-3 concern discharge readiness at the previous admission. They focus on preferences of the patient and family, patient and family understanding of responsibilities, and patient and family understanding of the purpose of medications. These interviews will be used to identify shortcomings in the current discharge practices at each site and will inform workgroup discussions.

Throughout the PAVE project, each workgroup's progress will be communicated through discussions, status reports, and teleconferences. In addition to facilitating communication within and among workgroups, webinar technology will enable workgroups to share best practices and innovative approaches implemented elsewhere in the nation.

With dedicated leadership and commitments from health care organizations, SEPA is beginning to improve the way health care is delivered. PAVE brings together health care providers who previously may not have collaborated in the complex care of patients. By fostering

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an environment of mutual sharing and learning, PAVE leaders hope that new synergies will be created.

Although the overall outcome measure is a reduction in readmission rates at participating hospitals, success also will be measured by demonstrated improvement in care transitions and communication; standardization of processes across the organizations; and

by the relationships cultivated among providers. Patients and their families will be the ultimate beneficiaries of the unique approaches that are born of these new relationships.

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