Reducing Readmission at STRHS Lawrenceburg

A Collaborative Approach to Getting, Keeping Patients Home

While most corporate models strive for repeat business and love to see frequently returning clients, hospitals are in the unique position of trying to keep their customers from coming back too soon after discharge. Preventable readmissions have a negative impact on the bottom line from both a financial and patient care standpoint.

For Southern Tennessee Regional Health System Lawrenceburg, part of the LifePoint Health system, reducing 30-day readmissions has been an ongoing journey that started in 2011. "Our readmission rate was pretty high – 10.3 percent within 30 days," Quality and Risk Management Director Judy Brewer, RN, BSN, CPHQ, recalled of the hospital's starting point at the end of 2010. "We realized we could not reduce readmissions solely by ourselves. It was going to have to be a community effort."

The circumstances impacting hospital readmissions are multifactorial with pain points all along the continuum of care. While the initial perception was that most unplanned readmissions were beyond the hospital's control, parsing through the data uncovered areas that could and should be improved during the inpatient stay, as well. Contributing factors include a fragmented medication reconciliation process, patients not being able to afford prescriptions, poor communication between hospital staff and community providers, confusion over discharge instructions, not having a designated family 'point person' to be responsible and accountable to assist with post-hospital care, and a general lack of patient understanding about their health condition.

Originally reaching out to area home health agencies and skilled nursing facilities, Brewer said it quickly became apparent community providers were facing a lot of the same issues as the hospital. "Everybody was working on readmissions, but there wasn't a collaborative effort," Brewer explained.

Creating awareness of the issue was the first step in the journey. By the end of 2011, the hospital had already seen a slight decline readmission rates, falling to under 10 percent. Very soon after the first community meetings, the group added physician practices to the collaborative effort and stressed improved communication between hospitalists and primary care providers.

"Right off the bat, we started making doctors' follow-up appointments for patients before they left the hospital," noted Brewer, who also has oversight of case management for STRHS Lawrenceburg.

Judy Brewer, Director Qality & Risk Management

"In 2013, we hosted a healthcare coaching seminar for everybody in the community health collaborative and a range of hospital staff," she continued. Brewer added event participants included pharmacists, nurses, physical and respiratory therapists, hospitalists, social workers and case managers from STRHS Lawrenceburg. The goal was to improve awareness of how and when patient instructions were being delivered and understood in the hospital and implemented after discharge.

"We were really good at just going in at the last minute and saying 'take this, this and this and do this and that,'" Brewer noted of the prior way discharge instructions were handled. "Now we start discharge planning as quickly as they come to the hospital," she continued of reinforcing care instructions and expectations all along the way to ensure patients and designated family caregivers are actually prepared at discharge.

"We screen all our patients on admission. If we deem them to be high risk, there are actions we take internally," she said of an effort launched in 2014. The hospital also evaluated hand-off communication strategies to improve transitions of care. "In 2016, we started a Hospital-to-Home program where we identify patients at high risk for readmission and implement post-hospital actions such as weekly phone calls to assess patient condition and progress with their discharge plan," she continued of the ongoing evolution in readmission reduction efforts.

Brewer has also spent a lot of time over the last seven years drilling down to better understand readmission numbers and identify patterns. Of the 10.3 percent readmissions at baseline in 2010, congestive heart failure and pneumonia patients made up the majority of readmissions with CHF totaling nearly 29 percent and pneumonia approximately 21 percent of all readmitted patients. With added emphasis on patient education regarding self-care and an internal evaluation to ensure the hospital was consistently following evidence-based practices such as early ambulation to improve outcomes, CHF readmissions dropped to 6 percent by 2014 and pneumonia to just 12 percent that same year.

While overall readmissions continue to trend downward and pneumonia readmissions fell to 7.2 percent in 2017, Brewer said the hospital saw a small uptick in CHF readmissions and the emergence of sepsis as a growing readmission diagnosis last year. She underscored the process is an ongoing journey … but one that is made easier by working collaboratively on a local level and tapping into statewide resources. Brewer said a representative from the Tennessee Center for Patient Safety (TCPS), a division of Tennessee Hospital Association (THA), recently conducted a sepsis presentation for the community collaborative group to highlight best practices and ensure steps are consistently taken in the inpatient setting and clearly communicated to patients and caregivers upon discharge to help drive sepsis readmissions back down.

Brewer credited working with the THA and being part of the regional Hospital Improvement Innovation Network (HIIN) as critical factors in improving overall readmission rates. Participating in the TCPS Preventing Readmissions Collaborative and the Sepsis Collaborative has provided easy access to evidence-based guidelines, ongoing education, and the opportunity to network with other health systems addressing similar concerns.

To keep best practices top-of-mind and foster ongoing partnership and communication, Brewer said the hospital hosts community collaborative events several times a year. Today, the group includes the original participants plus hospice providers, physician office staff members and the county health department. Brewer said the hope is to add community pharmacists and durable medical equipment suppliers in the near future. Working well together, she continued, will only become more critical as services continue to move out of the hospital and into community. "We're doing things in the home today that 20 years ago we would never have dreamed of doing," she pointed out.

By making sure everyone is aware of the game plan, readmission rates have been cut almost in half. "Ongoing collaboration between the hospital team and community providers has enabled us to decrease the readmission rate from 10.3 percent in 2010 to 5.4 percent through December 2017," said Brewer.

While that translates into a financial win for everyone involved during this era of value-based care, Brewer pointed out the real winners are the patients who return to the community better prepared to care for themselves and more confident that all their providers are working together as a team.

The Tennessee Center for Patient Safety, a department of the Tennessee Hospital Association, develops and shares hospital and health system success stories and promotes best practices.

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