

Improvement Project Charter

Prevent Readmission & Optimize Ambulatory Care Transition (PROACT)

Project Development Partners: CCRMC, CCHP and Public Health Departments
Clinical Departments: Internal Medicine & Family Medicine, Residency Training Program, Nursing, Social Services, Quality Improvement

What Are We Trying To Accomplish? AIM: *What do you aim to improve, how?*

- To improve patient care and to reduce 30-day hospital readmissions by ensuring the smooth transition of care from the inpatient to the ambulatory care setting by providing post discharge patient phone contact with an advanced level RN who will assess each patient within 48 hours of discharge for clinical stability and enactment of the discharge plan.
- This contact will involve clinical review and assessment skills guided by structured interviews. Clinical assessment of discharge instructions, medication adherence, review of pending studies and follow-up plan will be addressed during these interviews. When barriers or obstacles to carrying out the discharge plan are identified during this phone contact, the Transitional Care Nurse will triage to the appropriate provider and perform warm handoffs as needed to clinical providers, social work, financial counselors, etc.

WHY: *Why is this project important?*

- Patients are at risk during the transition from inpatient to ambulatory care settings for decompensation and subsequent hospital readmission.
- Contact with patients shortly after hospital discharge is becoming standard of care as the risks during this vulnerable period have become widely recognized, including by government and regulatory agencies.
- Patients often have a poor understanding of discharge instructions and commonly have difficulties obtaining medications and/or understanding how to take them.
- Information about the importance of followup appointments or outpatient studies is often poorly coordinated at time of discharge because of multiple factors that impede scheduling for this follow-up.
- Symptoms may worsen or new symptoms arise shortly after discharge which may need intervention. Other factors, such as insurance coverage difficulties, lack of transportation, and substance abuse, may impair patient ability to adhere to the discharge instructions.
- Early intervention within 24 to 72 hours after discharge by phone will improve patient's experience of the care associated with their hospitalization
- Contact within 24 to 72 hours after discharge will permit early identification of factors that may be increasing patient risk for recurrent morbidity and readmission. This will facilitate initiation of earlier interventions to prevent unnecessary morbidity or readmission.
- Additionally, Medicare reimbursement may be negatively affected by readmissions within 30 days of discharge. CMS' Inpatient Prospective Payment System includes The Hospital Readmission Reduction Program which lowers payment rates for Medicare discharges if hospitals have a higher-than-average readmission rate. This is to begin October 1, 2012.

How Will We Know A Change Is An Improvement? We will collect data on the following measures:

What will be measured?	Goal: To reduce [what] by [number, %] by: December 2013
Readmission rates	Decrease all-cause 30 day readmission rate by 20%.
Rate of kept hospital discharge clinic appointments	Increase the rate of kept hospital discharge appointments by 10%
Percent of discharged patients with contact attempted within 48 hours after hospital discharge	100%
Patient satisfaction with care during Hospitalization	Improvement by 20% of the scored measures on HCAHPS data related to communication around medications and follow-up care planning

MEASUREMENT PLAN: *How will you collect data?*

- Readmission rates are being collected. Readmission baseline should be limited to medical-surgical patients admitted to CCRMC and exclude OB/GYN, Psych and newborn admissions. Evaluation of data on quarterly basis (quarterly data points) with annual data points over the prior 5 years, if available.
- Hospital discharge appointment kept rate (excludes patients receiving ambulatory care outside system)
- Manually collect phone attempts and contact rate
- HCAHPS data reviewed to establish which baseline items will be followed and comparison time period will follow the quarterly and annual assessments as established.
- CTM-3 (Care Transitions Model -3) questions will become available to us and we will track prospectively.

What Change Can We Make That Will Lead To Improvement?

- Implement post hospital discharge phone calls to patients within 24 hours (48 to 72 hours after weekends) by experienced level RN or clinical pharmacist using scripted interview tool.
- Develop strategy for building information and referral network within the larger CCHS and geographic communities that will facilitate timely and appropriate interventions for patients when obstacles and barriers are identified

ACTIVITIES PLANNED: *What initial activities or PDSA cycles will you focus on?*

- Obtain updated data of average number of med-surg patients discharged daily: completed - average 15.3 patients per day during July 2012 through December 2012 period (most recent available data). During FY 2010 – 2011: average 15.7 med-surg patients discharged per day.
- Obtain quantitative and qualitative data about patients readmitted within 30 days of discharge through analysis of 3 years of discharges from CCRMC.
- Use PDSA cycles as part of residency QI training to improve our data collection tools for qualitative analysis of 30 day readmits involving chart reviews and patient interviews of in house patients
- Standard work and phone tool /script have been developed; revisions to be determined by q week review using PDSA during initial implementation.
- Develop auto-population of phone tool with cclink development/implementation.
- Develop geographically appropriate contacts for warm handoffs of patients to primary care clinic site providers; social work, financial counselors, etc.
- Develop process for maintaining communications and building alliances between service providers within CCHS and between CCHS and the community

BOUNDARIES: *What is included and excluded from the scope of the project?*

- Included: med-surg patients discharged from CCRMC.
- Excluded: OB and psychiatry.

RESOURCES: 1.6 FTEs Experienced level RNs to perform daily contacts with all patients; 0.5-1.0 FTE MSW/Case Manager to coordinate/build referral network and communication strategies as detailed above; 0.25-0.5 Clinical Pharmacist to assist with medication management and counseling ; 0.5-1.0 Data Programmer/Admin Asst.; 1.0 MD/Mid-level FTEs to perform clinical interventions on highest risk patients via phone clinic services or home visits to highest risk, clinical complex patients; 0.5 MD to provide clinical supervision and team leadership across the Transitional Care Program components.

TEAM MEMBERS: *Who will be on the improvement team?* Dr. Sara Levin; Dr. Natasha Pinto; Dr. Lyn Stromberg; Jaspreet Benepal, CNO; Kevin Drury, CQO, CCHP; Laurie Crider, Director Case Management Services, CCHP; Bhumiil Shah, Data Analyst; Abigail Kroch, Epidemiology, Public Health; Kate Schwarsharf, Director Homeless Services, Public Health; Sue Guest, Public Health Nurse; Residency QI project participants: Drs. Stratta; Merjavay; Ramos and Porteus

TIMEFRAME: *When do you expect the project to start and end?* Begin September 2012; permanent intervention

SPONSOR: *Who is sponsoring the project?* Dr. Chris Farnitano; Jaspreet Benepal; Patricia Tanqueray; Dr. Wendel Brunner; Anna Roth, CEO, CCRMC.

