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Piedmont HEALTHCARE

Improving Transitions of Care for Patients with Pneumonia

COSTLY PNEUMONIA READMISSIONS MAY SIGNAL QUALITY ISSUES

Approximately two-thirds of U.S. hospitals face financial penalties from CMS because of high 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia. The most recent reported median 30-day risk-standardized readmission rate for patients over age 65 with pneumonia is 15.8 percent. Not all hospital readmissions are preventable, but high readmission rates may signal issues with care quality, effectiveness of discharge instructions, and smooth transitioning of patients to their home or other setting.[1]

Health systems that implement best practices for transitioning patients to post-discharge settings have demonstrated reduced avoidable readmissions, reduced costs, and improved patient care.[2] As part of its ongoing efforts to improve quality, Piedmont Healthcare identified opportunities for improving transitions of care for Medicare patients with pneumonia.

LACK OF ACTIONABLE DATA HINDERED IMPROVEMENT EFFORTS

Piedmont needed to proactively identify patients who should be included in the transitions of care program, and needed to standardize care, streamline processes, and use best practices to improve transitions from hospital to home for Medicare patients with pneumonia.

Efforts were limited, as actionable data was difficult to obtain in a timely manner, negatively impacting the ability to identify patients in the hospital who could benefit from additional support to smooth the transition from hospital to home.

Piedmont leaders also lacked evidence regarding the effectiveness of care transition interventions on readmission rates. This made it difficult to make the case that Piedmont should continue to invest in the staffing model needed to support the care transitions program.

ANALYTICS TRANSFORMED TRANSITIONS OF CARE

Piedmont recognized the need to standardize pneumonia care across the entire system, developing and implementing an evidence-based care pathway for patients with pneumonia. Transitions of care was identified as an important component of that evidence-based care, particularly to address 30-day readmissions. As part of a systemwide effort, Piedmont convened a steering committee of clinicians with expertise in managing care transitions. The committee identified three best-practice care transition interventions to implement for the Medicare population:

- Follow-up phone call within 48-hours of discharge.
- Follow-up appointment with the appropriate care provider made prior to discharge.
- Follow-up appointment scheduled within seven-days of discharge and, in some cases, additional care management services after discharge.

> Robust data and analytics have helped us to identify and prioritize additional care support that may be needed beyond the hospital setting, ensuring a smooth hand-off between the hospital and the clinic.
>
> Matt Robinson
> Director of Clinical Integration

To improve Piedmont's ability to identify patients who might benefit from additional transitions of care assistance, the organization leveraged the Health Catalyst® Analytics Platform and broad suite of analytics applications, including the Pneumonia Improvement Application. Piedmont uses the application to help drive efforts to reduce pneumonia mortality, LOS, readmissions, and cost.

The analytics application provides detailed data for care management clinicians to easily identify patients who should be included in the transitions of care program. It also allows clinicians to advocate for appropriate physician services to care for each patient, ensuring use of the standard pneumonia care pathway and order sets. Prior to discharge from the hospital, care management clinicians confirm that follow-up appointments are scheduled with the appropriate providers. Appointments are scheduled to occur within seven-days of discharge. If needed, arrangements are made for additional post-discharge care management services.

In addition to coordinating the initiation of post-discharge services, care management clinicians use the analytics application to identify patients who have been discharged within the last 48-hours. Using this list, clinicians make follow-up calls to bridge the gap between discharge from the hospital and the first follow-up clinic visit.

Using the application, Piedmont can visualize compliance with the care transition interventions and the impact of those interventions on readmissions, including:

- The percentage of patients who receive a follow-up phone call within 48-hours of discharge.
- The percentage of patients who have a follow-up appointment scheduled prior to discharge from the hospital.
- The percentage of patients who successfully arrive at their scheduled follow-up appointment within seven-days of discharge.
- The ability to compare the readmission rate for patients with or without interventions.

Actionable data allows leaders to validate care transition performance and supports them in explaining the rationale behind the staffing and resources required to operationalize the transitions of care program.

RESULTS

In less than one year, Piedmont streamlined transitions of care for its Medicare patients with pneumonia and achieved impressive improvements:

- 26 percent lower readmission rate for patients who receive all transitions of care interventions.
- Nearly 70 percent of patients receive follow-up phone calls within 48-hours of discharge.
- 31.9 percent relative improvement in patients who have a follow-up appointment scheduled prior to discharge.
- 70 percent relative improvement in patients who have a follow-up appointment with the appropriate provider within seven days of discharge.

WHAT'S NEXT

Piedmont is committed to improving transitions of care, including expanding services to other populations to further reduce readmissions.

REFERENCES

1. Agency for Healthcare Research and Quality. (2016). *Chartbook on care coordination – Transitions of care.* Retrieved from https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html
2. Dreyer, T. (2014). Care transitions: Best practices and evidence-based programs. *Center for Healthcare Research & Transformation.* Retrieved from https://www.chrt.org/publication/care-transitions-best-practices-evidence-based-programs/

ABOUT HEALTH CATALYST

Health Catalyst is a mission-driven data warehousing, analytics, and outcomes improvement company that helps healthcare organizations of all sizes perform the clinical, financial, and operational reporting and analysis needed for population health and accountable care. Our proven enterprise data warehouse (EDW) and analytics platform helps improve quality, add efficiency and lower costs in support of more than 50 million patients for organizations ranging from the largest US health system to forward-thinking physician practices.

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