THE CHALLENGE
The bottom line in today’s pay-for performance healthcare environment is about keeping patients out of the hospital and from being readmitted. Healthcare providers are working diligently to set up collaborative programs to make sure each patient is on a care plan to maintain their health and minimize or eliminate any hospital stays.

Intalere member Verde Valley Medical Center, a 99-bed facility with 11 senior behavioral clinics located 15 miles from Sedona, Ariz., like many similar facilities throughout the country, was struggling with how to reduce readmissions in its facility. Realizing it would take a concerted, integrated effort, especially in a relatively rural setting, they began the process of community integration. They instituted quarterly meetings that included membership from local skilled nursing facilities, assisted living facilities, durable medical equipment providers, hospice, home care, acute rehab, senior centers and care agencies to help ensure smoother care, coordination and movement between inpatient and outpatient settings.

THE SOLUTION
One of the most critical aspects of the continuum of care team created by Verde Valley Medical was to bring together disparate sources of data and turn it into useful information for reducing readmissions. This information needs to be analyzed and communicated across the entire integrated network of providers and facilities to promote continuous quality improvement, thereby further decreasing the overall cost of care.

The team was divided into three units: Strategic, Discharge Planning and Education. They initially discussed their challenges and barriers and how they could coordinate better quality of care enhancement for patients.

One of the first pillars of the program was the establishment of a Transitions of Care program through the formalization of a relationship with the Verde Valley Caregivers group, a 300-400 strong volunteer network that assists 20 new patients per month. They visited patients in the hospital and within 24 hours of discharge, performing tasks such as med reconciliation and home safety checks, while providing transportation to follow-up appointments, therapy, dialysis, etc.

Verde Valley also established the CHF (Congestive Heart Failure) Wellness Program, a six-week multidisciplinary outpatient heart failure teaching and exercise program for all heart failure patients. It provided early identification of heart failure patients presenting to the emergency department or early after admission and involved an advanced practice nurse for patient management.
and long-term follow up, including telemedicine services. Readmits for CHF have consistently been below 2 percent, with a 0 percent readmission rate during many months.

Another pillar of the program was the Community Care Network which focused on patients at risk for readmission and frequent emergency department visitors. The network utilized a volunteer health coach to visit patients after discharge, involved telemedicine technology in many cases and the engagement of a nurse practitioner, who taught healthcare coach classes and served as a liaison between the primary care physicians and patients in their homes.

In addition, Verde Valley added a Discharge Clinic to see patients within five days of discharge, a practice meant to further reduce the time to see a practitioner, assess any potential issues and further prevent readmissions. This was done, in part, after a root cause analysis of readmits revealed the average number of days between the admission and readmission was six days and that more than 55 percent of patients waited greater than seven days for an appointment. There was also a discharge nurse added to the process to support the discharge process and engage the scheduling department to schedule follow-up appointments at time of discharge.

THE OUTCOME

The initiative demonstrated clinical outcomes enhanced by tracking and communicating patient care across the care continuum, including transitions. Employing managers, nurses and nursing assistants to perform care coordination and utilization management proved to be a key component of success.

Over the course of 19 months the all cause readmission rate at Verde Valley went from 11.7 percent to 6.4 percent, a nearly 50 percent reduction. In terms of Medicare Part A and B patients, the readmit rate was reduced from 8.2 percent to 2.6 percent.

Supporting not only the healthcare, but also the wellness needs of patient populations, will require healthcare providers to put into action comprehensive enhancements in their processes and technology to guarantee effective delivery of quality services such as Verde Valley did in this example. Additionally, they will need to be committed to alignment with their physicians, payers, employees and patients, as well as their communities. To accomplish this goal, providers must engage organizations with integrated solutions to help implement and manage a population health management program.

(Adapted from an Intalere Healthcare Achievement Awards submission, 2014.)