LESSONS LEARNED

How a hospital-community partnership can reduce hospital readmissions

PROBLEM

Readmission rates for Medicare fee-for-service patients at Wadley Regional Medical Center (WRMC), in Texarkana, Texas, were higher than the Steward Health Care organizational goal.

Case Management Director Sara Endsley: *"To reduce readmissions, hospitals must communicate with external health care providers to identify and overcome gaps in, or barriers to, patient care."*

METHODS

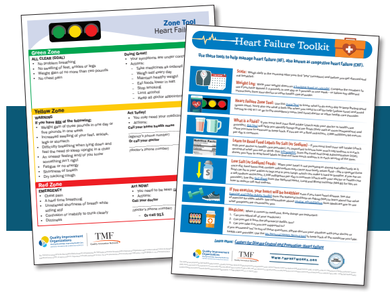
The TMF Quality Innovation Network-Quality Improvement Organization (QIN-QIO), worked with Sara Endsley, case management director at WRMC, to convene meetings that included external health care providers to address the readmissions issue, and provided claims and community Social Determinants of Health (SDOH) data. Hospital-specific data revealed gaps in care that encouraged further examination of that data to address quality issues.

Early on, the committee also included WRMC's chief executive officer and representatives from the cardiopulmonary, registration and medical records departments. Initially, the team met twice a month and monitored electronic health records to track a patient's care path and identify which of Texarkana's health care providers contributed to driving up readmissions. Those providers were asked to meet with the WRMC team to show how they planned to reverse the trend. Now that readmission rates are under control, the readmissions team meets quarterly.

INTERVENTIONS

Overcoming transportation barriers was among the strategies that stemmed from the readmissions committee meetings. The committee found that transportation prevented some patients—especially those who were wheelchair bound—from keeping their follow-up appointments. Because many of Texarkana's taxi companies could not accommodate patients with mobility issues, WRMC turned to Retreat Transportation Non-Emergent Transport to fill the gap. Specially equipped vehicles offered patients a safe ride from their homes to their primary care providers or other medical offices. When a patient reached out to Retreat multiple times, a company liaison contacted Endsley to establish the best care plan.

Retreat Transportation Non-Emergent Transport provides transportation to patients who require a wheelchair or other ambulatory services. Retreat works with home health providers, skilled nursing facilities and individual physician offices to prevent readmissions.



TMF conducted education with its patient-facing materials to help patients better manage chronic diseases that contribute to higher readmissions rates.

RESULTS

TMF staff led community meetings that helped hold community providers accountable. TMF provided claims-based outcomes data for all engaged community members; Health Equity SDOH data reinforced the locally-identified barriers. TMF encouraged medical and non-medical members of the community to collaborate and to improve care transitions and prevent readmissions. As a result, in the 12-month period studied, WRMC's Medicare Cost Report (MCR), all-cause readmission rates fell from 12.1% to 5.4%; the year-to-date comparison for the South Region shows that readmissions rates fell from 11.2% to 4.5%, well below Steward Health Care's 9% goal (see charts below).

WRMC's success in reducing readmissions rates serves as an example of how facilities can work with TMF to improve communication with community health care providers to improve patient care. Such a collaboration can be adopted by other health care entities to realize similar results.

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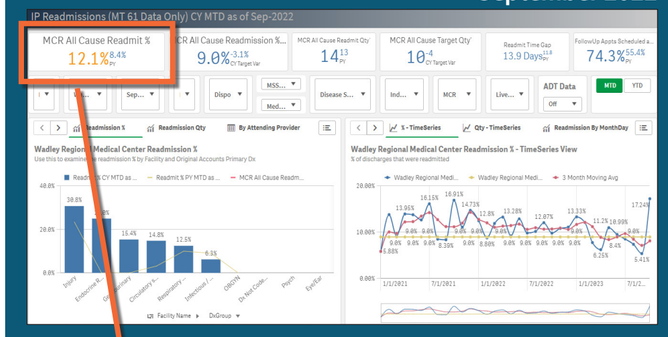

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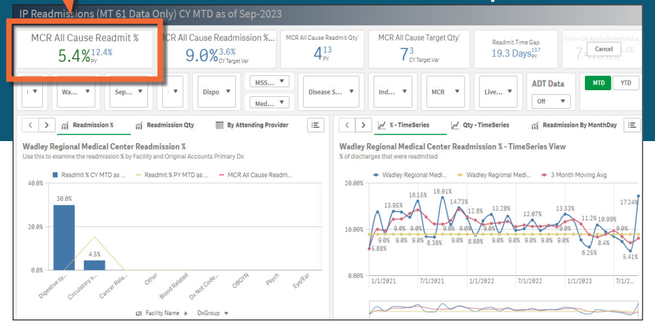

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