CARE COORDINATION
Brattleboro Memorial Hospital - Brattleboro, VT

In recognition of having reduced readmissions, and the distinction of being the New England hospital with the "Most Improved Performance."

Interventions to Reduce Readmissions: Interdisciplinary Care Transitions

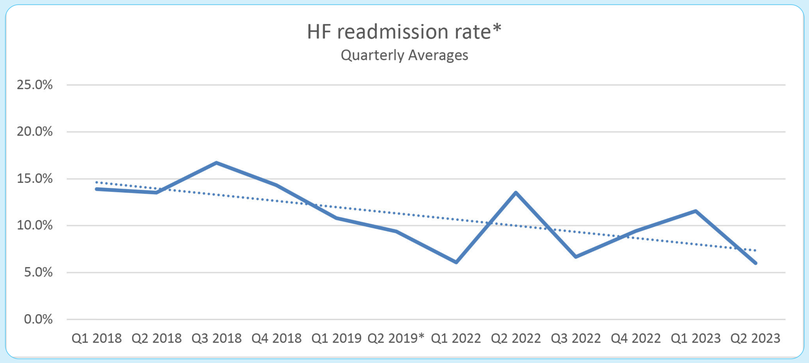
BACKGROUND

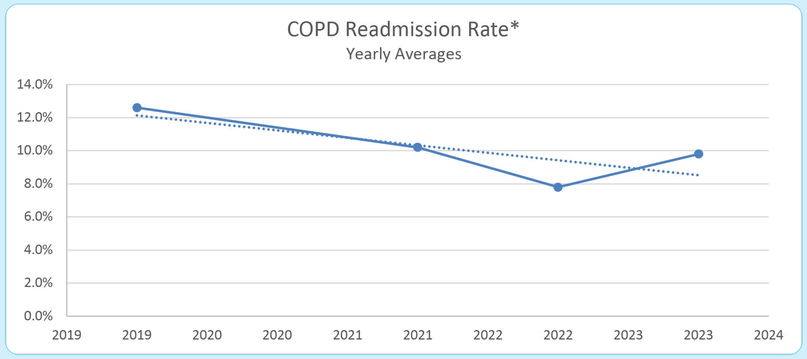
- A not-for-profit, 61-bed, community hospital, founded in 1904.
- Located in southeastern Vermont and serving a rural population of 55,000 people in 22 towns in Vermont, New Hampshire, and Massachusetts.
- All Brattleboro Memorial Hospital (BMH) providers share a common mission to provide exceptional health care delivered with compassion and respect.

In 2019, readmissions due to Constrictive Obstructive Pulmonary Disease (COPD) were at >15%; Heart Failure (HF) readmissions were at 15.8%; and Congestive Heart Failure (CHF) readmissions were the highest proportion of readmissions as well as the most common co-morbid condition associated with readmissions. Because of this, BMH leadership felt it was imperative to improve outcomes for these patients. The goal was to reduce COPD and HF readmissions to less than 10% (*internal data).

APPROACH

- The BMH team encouraged participation from units and departments which interact with patients who have COPD and/or HF. These staff members were designated as a "Clinical Community" and shared learning and insights freely.
- COPD interventions included: medication optimization for the admitted COPD patient, patient education on nutrition and COPD self-management, Care Management standardized assessment of barriers to success, arranging resources to address the barriers and securing all follow up appointments prior to discharge.
- HF interventions included: participation in the IPRO QIN-QIO Affinity Group, HF clinic follow up phone call next business day, an in-person follow up office visit with HF clinic within 7 days of discharge, and increasing cardiac rehab referrals or Wellness Rehab Program (initially grant funded and now hospital funded).
- BMH collaborated with IPRO QIN-QIO to develop a best-practice care transitions resource guide.
- Internal data was used to analyze process and outcome measures focused on inpatient and observation patients with all payor sources. Data was evaluated monthly using an iterative PDSA cycle approach.





RESULTS

BMH had an **HF** readmissions rate at baseline (2018-10 - 2020-09) that was 15.8% and most recent data (2022-09 - 2023-08) reflects a rate of 12.1%, achieving a relative improvement of 23.3%.

*This is based on Medicare FFS claims data tracked by the IPRO QIN-QIO.

COPD readmission baseline rate was 12.6% (2019) and most recent data reflects a rate of 8.7% (average of 2022-2023), achieving relative improvement of 30.1%. This represents avoiding approximately 12 COPD readmissions each year.

*This is based on internal data tracked by BMH Quality Department.

CONCLUSIONS

- A data-driven, interdisciplinary team was key to making impactful improvements. Strong leadership support was essential to sustaining participation in the workgroups.
- Future opportunities that the team intends to address include Primary Care COPD Action Plans and increased hospice referrals for eligible patients.

ACKNOWLEDGEMENTS

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Huge thanks to Travis Kumph for bringing Lean/Six Sigma training to BMH and improving the Quality Climate at BMH.

REFERENCES

Clinical Communities at Johns Hopkins Medicine: An Emerging Approach to Quality Improvement - PubMed (nih.gov)

This material was prepared by IPRO QIN-QIO, a Quality Innovation Network-Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication 12SOW-IPRO-VT-T2-A3-24-1485 [5/30/24] - CP