Case Study | Griffin Hospital

This is CASE STUDY 1 of 4 from HealthLeaders Media Breakthroughs: Strategic Solutions for the Readmissions Challenge
Case Study | Griffin Hospital

Standardizing Community Care to Reduce CHF

Griffin Hospital in Derby, Conn., has 120 staffed beds and is the flagship of Planetree, an innovative patient-centered collaboration model that includes scores of hospitals with a major goal: putting patients’ needs first. Many of Griffin’s heart failure patients are not at stage I, but at stage II, III, or IV, with a variety of other chronic conditions. Several years ago, Griffin officials noticed that too many patients afflicted with CHF were being readmitted to the hospital, prompting some organizational reflection: With such high readmission rates, was the hospital truly being patient-centered?

“We’re not part of a huge system that has lots of hospitals in it, so we believe that we need to strongly stay on top of the cutting edge of what’s going on if we want to survive as a hospital,” says Kathleen Martin, vice president for patient safety and care improvement. “For that reason, quality is huge here. We have learned that excellent care with good outcomes and an exceptional patient experience will not matter if we don’t keep patients safe.”

As Griffin officials examined the hospital’s CHF procedures, they also opened discussions with nursing homes and home health facilities and were startled at what they found: major differences in standards of care. For example, the nursing homes were allowing too much sodium intake for patients, which is detrimental to heart care. That prompted the hospital to initiate collaborative relationships with other facilities and a specific plan of care under a “heart success” protocol that emphasized a commitment from Griffin—as well as agreements from skilled nursing and home health care facilities—to coordinate care after patient discharges to their respective facilities.

The protocol includes a checklist of guidelines, including a dietary and weight-control regimen. The hospital and other facilities
also agreed to provide teaching tools for patients and caregivers. Coordinated care and educational programs are important because at least 50% of patients do not see their physician between hospitalizations, Martin says.

Hospital officials credit the education efforts, which impact patients personally and healthcare facilities as a whole, for a sharp reduction of CHF readmission cases—from 15% to 7%, according to Martin. The reductions are crucial because by October 2012, CMS will begin penalizing hospitals for unnecessary readmissions within 30 days.

In 2009, the skilled nursing facilities and home health agencies with the highest readmission rates for CHF were invited by Griffin to join in a coalition to prevent readmissions. The program, known as “The Valley Gateway to Health,” was started to help prevent hospital readmissions, says Patrick Charmel, president and CEO of Griffin. The collaborative approach, he says, “takes our Planetree model of care, which emphasizes patient empowerment and education, into long-term care and community settings.” Patients need information tools, in part, to “effectively manage their disease,” Charmel says. In addition, the collaborative model not only works to “improve the health of the community we serve,” but sets the framework for a possible accountable care organization structure, according to the CEO. Various providers may be ACO partners in the future, Charmel notes.

Griffin officials began to realize they needed “to accept responsibility beyond the walls of the hospital in terms of what happens to these patients after we discharge them,” says Kenneth Dobuler, MD, chairman of the department of medicine at Griffin. With that in mind, Griffin’s leaders began negotiating with other facilities, looking immediately into “failures [that] were across the continuum of care, specifically with respect to transitions,” Dobuler recalls.

When the hospital met with the nursing homes, it was a “little bit scary at first,” Martin adds. “We quickly found out that none of us knew what the other people did.”

The nursing homes, it turned out, lacked nutrition guidelines. “Some facilities felt this is where the patient lived and they should have the option to eat whatever they wanted,” Martin relates. “There weren’t really any low-salt diets given to people in nursing homes.”

Too much sodium intake is one of the reasons “people bounce back with heart failure,” says Dorothea Wild, MD, chief hospitalist at Griffin. When she broached the topic with nursing home officials, they said, “Well, if we have people who are permanent residents here, then they sit where they sit, with their friends, and on the table is a saltshaker. And you know, we have a buffet-style menu and they choose whatever they want, and if they choose hot dogs and chili, then we have no way of stopping them.”
THE VICIOUS CYCLE OF CHRONIC DISEASE READMISSION

Griffin Hospital has initiated a collaborative arrangement with nursing homes and home health care facilities to overcome inconsistencies and lack of followup in patient care.

The saltshaker became a small symbol of larger issues that signaled lack of coordination with the nursing homes and the healthcare agencies. Other problems in this vein included the lack of home services following discharge from the hospital and the lack of specific follow-up care with patients' primary care physicians or cardiologists. In addition, Griffin officials found a great variance in readmission rates reported from nursing homes: Some were as high as 47%, while others were as low as 20%, Dobuler says. "Why would we be discharging our patients knowingly to a facility that had a readmission rate almost as high as 50%?" he asks. Eventually, this fact became a "wakeup call" for some nursing homes to join the collaborative.
Then there was the financial issue to consider. “If bundled payments ever came through, there would be a financial disincentive to sending patients to those nursing homes, and certainly if there were penalties from Medicare for readmissions, why would we, Griffin Hospital, want to discharge patients to a nursing home that had a readmission rate of 47% knowing that we were going to be penalized for those patients? Wouldn’t we be better off sending them to a nursing home that had a readmission rate of half that?” Dobuler asks.

But the nursing homes weren’t the only problem. There were huge differences in transitions of care and to avoid preventable readmissions, Griffin had to have a shared model providing “same page” care to patients, Martin says. “We all used different teaching tools. What was nice was that, after the first few months, I think we developed a comfort level with each other and the ability to actually talk about what happens when someone is readmitted.”

To its credit, Griffin not only looked outward for sources of its readmission dilemma, but it also examined its own procedures involving CHF, with an eye on decreasing the rebound effect. Dobuler says Griffin initiated a multidisciplinary team focused on the emergency department and CHF. Patients with CHF would be examined by cardiologists, and a “dietitian would discover any opportunities to improve their adherence to low-salt diets,” says Dobuler. Patients also would meet with specially assigned case managers to ensure they had necessary services in place and pharmacists to review medications and educate them on their regimen to avoid rehospitalization.

Further, Griffin established an outpatient CHF clinic, Dobuler says. “Many of our nursing homes are not certified to administer intravenous medications, so [patients] can be transported to the CHF clinic, get their Lasix [a drug used to treat fluid retention in CHF patients] monitored, and be sent back to the nursing home, as opposed to just doing it in the hospital emergency department. So that’s another layer we added to the mix to avoid readmissions.”

Continued discussions between the hospital and the nursing homes are necessary to maintain the continuum of care, and they have meetings monthly. The hospital maintains contact with the patient for a month after discharge, and follows up with the patient’s primary care physician as well. The information gathering after
Case Study | Griffin Hospital

In 2012, Griffin has reported 99% patient satisfaction scores, an increase of 2% since 2007. To measure satisfaction of patients, Griffin contracts with an independent, private market research firm to conduct phone surveys of 100 discharged patients—about 15%—each month.

“Patient discharge involves hospitalists, too,” says Wild. The hospital “trains resident physicians and sensitizes them to what kind of information they need to provide patients on discharge, and how they need to talk to patients, to at least understand what’s driving readmissions,” she adds. “Everybody in the collaborative can work on the things that go well, and things that don’t go well.”

Regular post-discharge communication with the patient is an essential part of the effort. “The hospital makes phone calls every week for four weeks after the patient is discharged,” says Navitha Wodder, MD, research assistant for patient satisfaction and readmissions. “And we do ask the patients if they go to the doctor and what does the doctor say—if everything was OK. We monitor that. And the list of patients who go to nursing homes, we ask the nursing administrator to give us the feedback about the patient almost every week, or every other week. So they do give us feedback: what’s going on, if they saw the doctor, how is their weight, and things like that. We are monitoring patients for 30 days after discharge.”

It was important that Griffin Hospital coordinate education programs with the patients themselves, but accomplishing this is difficult because many heart failure patients are elderly, says Martin. “The first thing from the hospital perspective is that we need to know their support system,” he says, which is especially important for older patients. “So teaching them isn’t always enough: You need to teach the person who’s making the meals for them in their home or who’s taking them to the doctor.”

To help patients, the hospital has a program known as “teach back,” which includes a brochure for patients (created by the University of North Carolina) that details what they need to know to help prevent readmissions, such as proper nutrition, regular physician appointments, and other checklists, Martin says. The brochure also is used at nursing and homecare facilities. “The visiting nurse comes out and uses the same brochure for teaching,” he adds.

Through its education programs and the collaborative arrangements with nursing homes and home health agencies, Griffin expects to expand its efforts beyond CHF. “We assume that once we establish the process with heart failure, we’ll be able to move on to other chronic diseases and see what we can do to all come together in managing that care,” Martin says. “Every time the hospital reduces readmission rates it helps the hospital and especially the patient. It’s not high quality of life when you’re back in the hospital every few weeks,” she reflects. “It’s a terrible thing. You don’t want to be in a hospital if you don’t have to be.”

“We needed to accept responsibility beyond the walls of the hospital in term of what happens to these patients after we discharge them. Why would we be discharging our patients knowingly to a facility that had a readmission rate almost a high as 50%?”

Kenneth Dobuler, MD, chairman of the department of medicine, Griffin Hospital
About Amedisys
As the health care system continues to evolve, Amedisys champions innovative approaches to providing home-based care to high-risk and chronically ill patients. As an ally to hospitals, we work together to coordinate a continuum of care focused on improving patient outcomes, satisfaction, and quality of life.

Amedisys is a leading provider of health care at home, as the nation’s largest home health and fourth-largest hospice provider. With an eye on the future, we’ve invested in the clinical expertise and infrastructure necessary to deliver quality health care and care coordination services.

Learn more about how we can bring the continuum of care home for your patients at www.amedisys.com/breakthroughs, or call 866-308-4004.

About HealthLeaders Media
HealthLeaders Media is a leading multi-platform media company dedicated to meeting the business information needs of healthcare executives and professionals.

To keep up with the latest on trends in physician alignment and other critical issues facing healthcare senior leaders, go to: www.healthleadersmedia.com

Sponsorship
For information regarding underwriting opportunities for HealthLeaders Media Breakthroughs, contact:

Paul Mattioli, Senior Director of Sales
800/639-7477
pmattioli@healthleadersmedia.com

Looking for the rest of the issue?
To view this full issue of HealthLeaders Media Breakthroughs: Strategic Solutions for the Readmissions Challenge, please click here to download: www.healthleadersmedia.com/breakthroughs