

# Care Team Collaboration Solutions:

## Impact on Discharge Planning, Readmission Rates, and HCAHPS Scores

**Objective:** To understand how mobile care team communication and collaboration solutions including dynamic care team directory and secure text messaging can enhance patient discharge planning, help lower hospital readmission rates, and increase HCAHPS scores; using the example of a heart failure patient.

**Key Issue:** Congestive heart failure is the leading cause of hospitalization among adults > 65 years of age in the United States.<sup>1</sup> Hospital readmission for a patient with congestive heart failure is quite common, costly, and yet, potentially preventable. The Medicare Payment Advisory Commission recently concluded that a large proportion of re-hospitalizations could be prevented with an improved discharged planning process and more efficient team coordination of care.<sup>2</sup>

**Background:** Nationwide, U.S. hospitals waste over \$12 billion annually as a result of communication inefficiency among care providers; while the subsequent increase in length of stay (LOS) accounts for 53% of the annual economic burden.<sup>3,4</sup> A comprehensive interdisciplinary discharge plan, as noted by advanced practice nurses, has demonstrated short-term reductions in patient readmissions.<sup>5</sup> Interdisciplinary team communication is pivotal to successful outcomes in hospital settings; as differing roles and levels of expertise among the care team specialties need to collaborate in order to solve multifaceted and complex patient care problems.<sup>6</sup>

**What impact does HF have?** Congestive Heart Failure sometimes abbreviated and referred to as “heart failure” (HF) is a major clinical and public health problem and a leading cause of hospitalization and healthcare costs in the United States today. HF occurs when the heart is unable to pump sufficiently to maintain blood flow to meet the body’s needs. Despite a decline in HF-related hospitalizations during the past decade, readmission rates for patients with HF have not decreased. According to the Centers for Medicare and Medicaid (CMS), up to 25% of patients hospitalized with HF are readmitted within 30 days.<sup>7</sup> The readmissions program, created under the Affordable Care Act, evaluate how often patients treated with HF had to return to the hospital within 30 days of discharge. Facilities with too high a readmission rate saw their Medicare payments docked up to 3% by 2015.<sup>8</sup>

**Question:** What part can Clinical Communication and Collaboration (CC&C) solutions play in hospital discharge planning to help prevent readmission for a HF patient and enhance HCAHPS scores?

**Integrated systems of care** are warranted in this mobile technology world for workflow success. The issue is that due to the many disparate systems, gaps exist in team communication. We understand that discharge planning is a key element of continuity of care for persons leaving the hospital so it makes sense that a unified communications platform that crosses the care continuum would be utilized.<sup>9</sup> A unified platform means bringing together disparate systems including voice, messaging, alarms, and alerts. Ensuring that communications get to the right people at the right time is pivotal for a timely patient discharge.

“U.S. hospitals waste over \$12B annually as a result of communication inefficiency”

## HCAHPS and “Preventable Readmission”

A preventable readmission is defined as one occurring within 30 days of discharge and is clinically related to the previous admission if there was a reasonable expectation that it could have been “prevented by providing quality care in the initial hospitalization, with improved coordination of care between patient care teams to adequately planned discharge.”<sup>10</sup> Beginning in 2012, the Centers for Medicare & Medicaid Services implemented the Hospital Readmissions Reduction Program (HRRP), which reduces payments to hospitals with excess readmissions for HF. Coordinating care and making the patient transition smoother leads to improved HCAHPS scores. Better HCAHPS scores help protect revenue.

As part of the “Hospital Consumer Assessment of Healthcare Providers and Systems” (HCAHPS) survey, care coordination measures endorsed by the National Quality Forum is the 3-item Care Transitions Measure (CTM-3), which focuses on discharge transition.<sup>11</sup> The 3-item measure accounts for over 80% of the variance within the 15-item scores. The measure is specific to hospital discharge care coordination and focuses on patients’ understanding of their care plan.

See Table 1

**TABLE 1: CTM-3**

**1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Don't Know/Don't Remember/Not Applicable

**2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Don't Know/Don't Remember/Not Applicable

**3. When I left the hospital, I clearly understood the purpose for taking each of my medications.**

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree
- Don't Know/Don't Remember/Not Applicable

**Question:** How can a CC&C platform help with these 3 transitional needs?

**It takes a team:** The rate of preventable readmissions may be reduced by transitional care interventions, which are defined as a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer from the inpatient setting to home.<sup>12</sup> The American College of Cardiology/American Heart Association 2013 guidelines for the management of HF emphasize coordination between multidisciplinary departments, with pharmacy being a primary participant (for the obvious reason that pharmacological treatment is central to HF management). Moreover, this coordination of care is essential to properly provide the required HF disease-management education prior to hospital discharge.<sup>13</sup> Failure to follow a coordinated plan of care often contributes to the high rates of HF 30-day re-hospitalization and mortality seen across the United States.

TABLE 2: DOMAINS OF CARE COMMUNICATION & COORDINATION	
Primary Care Physician	<ul style="list-style-type: none"> <li>Provides and coordinates all general care, bringing in specialty care consults as warranted</li> <li>All patient orders come through PCP</li> </ul>
Cardiologist	<ul style="list-style-type: none"> <li>Focuses care on the heart and circulatory (vascular) system</li> </ul>
Nurse	<ul style="list-style-type: none"> <li>The epi-center of all patient care</li> <li>Provides direct care and care coordination</li> </ul>
Nursing Manager	<ul style="list-style-type: none"> <li>Supervises a group of nurses per unit(s) and determines workflow decisions</li> </ul>
Patient Care Assistant	<ul style="list-style-type: none"> <li>Assists the nurse in patient care, but is not able to initiate interventions w/o nursing directive</li> <li>Unable to give meds</li> </ul>
Pharmacy	<ul style="list-style-type: none"> <li>Experts on drug therapy</li> <li>Primary health professionals who optimize use of medication for the benefit of the patients</li> </ul>
Discharge Planner	<ul style="list-style-type: none"> <li>Nurse whose focus is to map and track the course of discharge from the time of admittance</li> <li>Works closely w/home care to coordinate seamless care transition</li> </ul>
Heart Failure Clinic	<ul style="list-style-type: none"> <li>Hospital-based clinic in which daily telephonic and digital technology determine home-based HF patient's weight and ECG rhythm</li> <li>Medication and treatment is regulated accordingly</li> </ul>
Social Work	<ul style="list-style-type: none"> <li>Focus is on the welfare of the patient and assuring that they have resources needed even if the patient is not able to afford that care upon discharge</li> </ul>
Physical Therapy	<ul style="list-style-type: none"> <li>Therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by disability (often associated w/HF)</li> </ul>
Wound Care Team (potentially)	<ul style="list-style-type: none"> <li>Often times w/HF patient's, there is involvement of lower leg wounds and ulceration due to advanced peripheral vascular compromise</li> </ul>
Respiratory Therapy	<ul style="list-style-type: none"> <li>Treatment and maintenance or improvement of respiratory functioning (as in patients with pulmonary disease and HF)</li> </ul>
Home Care	<ul style="list-style-type: none"> <li>A hospital-based team that works on preparing resources for transition home, assuring that the patient receives coordination of care to home</li> <li>Involves patient's insurance coverage</li> </ul>

**Team Coordination** Prior to talking about how care is communicated and coordinated, one must understand the domains of care. **See Table 2.** There are many disciplines on the patient care team. For illustrative purposes here, the focus will remain on the HF patient as one example.

When the question is asked about how the Vocera® Engage Platform can help with the 3 transitional needs highlighted in table 1, one must understand the magnitude of the care team, which is essential for the patient – in order to answer these three questions in a positive light. If patient perception is that the left hand doesn't know what the right hand is doing, the HCAHPS scores will plummet. Typically the patient and family are the best judges to identify if there is a gap in communication and coordination of care. Below, figure 1, illustrates the orbit and communication needed between disciplines on behalf of that one HF patient to achieve a successful discharge.

Let's examine the 3 questions that the patient will be asked, and why streamlined communication is essential to avoid gaps: 1) The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital; 2) When I left the hospital, I had a good understanding of the things I was responsible for in managing my health; 3) When I left the hospital, I clearly understood the purpose for taking each of my medications. Translated, each question is really asking the patients perception of the following....did the respective disciplines come to visit the patient along with a key family member to explain, educate, and dialogue regarding expectations for the transition home? Did the respective disciplines put the plan in writing that the patient and family member can understand when they get home? In figure 1 below, the communication that is needed between the nurse and various disciplines on behalf of the patient is complex. This complexity comes when disciplines must coordinate care together, i.e., pharmacy, home care, and discharge planner.

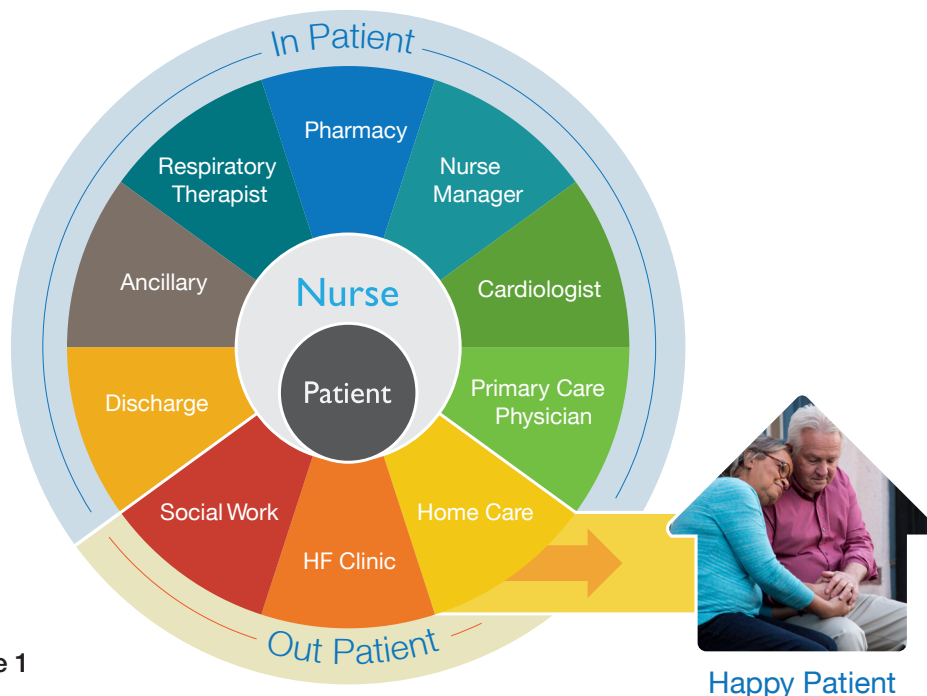


Figure 1

**Conclusion:** One unified communication platform that reaches across disciplines to coordinate patient care saves time and resources. When properly executed, the patient will experience an easier transition to home. When home care is steady, readmission rates are lower and HCAHPS scores are higher. Communication is an essential component in the discharge planning process.

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