# Key Transitional Care Interventions Needed to Decrease Readmissions and Emergency Department Return Visits

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Reducing readmissions and emergency department return visits has long been considered a key indicator of healthcare quality. A variety of strategies and methodologies have been employed to achieve these goals, with their effectiveness depending on factors such as the type of organization, its vision and leadership, and its organizational culture, budget, and population health, among others. Studies have shown that care coordination and transitional care initiatives delivered within 14 days of hospital discharge can significantly reduce readmission rates. This article shares our most effective transitional care interventions that have contributed to our success in reducing readmissions and emergency department return visits.

**KEY WORDS: Readmissions; emergency department; transitional care; care coordination; patient-centered care.**

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## PROBLEM

A variety of strategies and methodologies have been employed to reduce readmissions and emergency department (ED) return visits. The effectiveness of these strategies depends on multiple factors, such as the type of organization, its vision and leadership, and its organizational culture, budget, and population health, among others.[1,2,3] Studies have shown that care coordination and transitional care initiatives delivered within 14 days of hospital discharge can significantly reduce readmission rates.[4,5]

CMS measures healthcare institutions' communication and care coordination to reduce avoidable readmission through the Hospital Readmission Reduction Program while encouraging the institutions to provide person-centered care.[6] Healthcare organizations evaluate customer value based on quality, cost, and time delivered.[7] Healthcare institutions have chronic bed shortages, exacerbated by the high rates of readmission and longer stays seen in vulnerable populations and also in patients with high risk of avoidable readmissions.[8] Our objective was to implement strategic transitional care delivery at the right time to decrease readmissions or to readmit patients earlier rather than later for intensive care services.

## AIM STATEMENT

Our aim was to evaluate and deliver critical processes and interventions and evaluate their impact on reduction of readmissions and ED return visits. We hypothesized that the implementation of processes, risk stratification, patient and family education, intervention in response to adverse events, and addressing medical adherence would decrease the rate of readmissions and ED return visits.

## INNOVATION

Our strategy focused on three pillars: friendly stakeholders' referrals and hand-offs; patient experience–centered care; and lean methodology.

1. **Patient referrals:** Providers can refer patients based on their clinical judgment, regardless of patients' follow-ups. Patients who were unable to get a primary care appointment within 14 days were targeted and arrangements were made for them to follow up at the post-discharge clinic (PDC). Providers were able to request PDC follow-ups by calling patient navigator coordinators (PNCs), dragging the patient's name from their patient

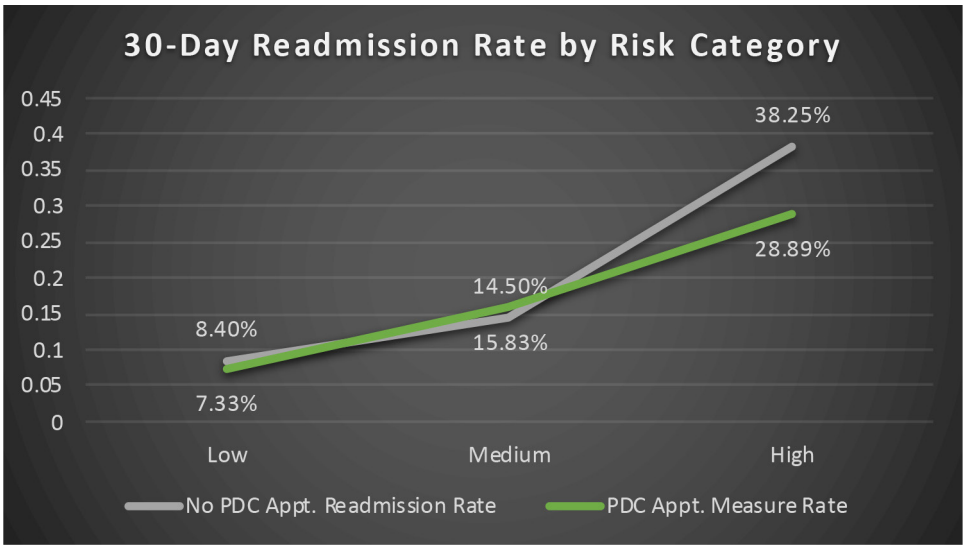



**Figure 1.** The data indicates a substantial decrease in the 30-day readmission rate for high-risk patients who received care at the post-discharge clinic. These individuals experienced a 24% reduction in their risk of readmission.

list to the PDC share folder on EPIC, or calling the PDC director for an appointment.

2. **Risk stratification:** Patients were referred for appointments according to the EPIC risk of avoidable readmissions. High-risk patients were scheduled within 7 days; patients with low to moderate risk were scheduled within 14 days.
3. **Scheduling:** PNCs were granted direct access to PDC providers' schedules and were able to make appointments according to patient and family preferences.
4. **Virtual and in-person appointments:** The PDC started as a fully virtual clinic, transitioned to a hybrid model, and currently operates as an on-site clinic.
5. **In- and out-of-network patient care:** The PDC is the only clinic that accepts out-of-network patients who have been seen in our outpatient academic medical center (DCAM), by previous approval of the administration. Commercial out-of-network patients are billed at the in-network rate. The vast majority of the remainder has been or are being seen pending Medicaid insurance.
6. **Transitional care management:** Population Health nurses called the patient within 48 hours post-hospitalization to assess medical adherence and address questions.
7. **PDC visit footprint:** PDC visits focused on patient and family education regarding the patient's medical problems; medication reconciliation; identification of adverse events; medical adherence; and patient experience.
8. **Flexible schedules:** PDC providers are available for changes to scheduled times if patient family support is not available at the time of the appointment, or if the visit type needs to be changed to accommodate the patient's availability for appointments.
9. **Hand-off to primary care providers:** EPIC users' hand-off letters with PDC notes are sent to the patient's PCP. For PCPs who are not EPIC users, hand-off letters and PDC notes are faxed to their offices.
10. **PDC providers' friendly contact number:** Patients and providers are given a unique phone number to use to contact the PDC providers for non-emergency questions and any follow-up needed.
11. **Coordination of care:** PDC providers take the lead on coordinating services for their patients within the first 30 days post-hospitalization, or until they are being seen by their PCPs.
12. **Scorecard monitoring:** Designed scorecards to closely monitor performance.

## IMPACT

We saw the following outcomes in a population of 613 patients:

- The readmission rate for patients with high risk of avoidable readmission being followed at the PDC was 29% (Figure 1).
- The readmission rate for patients with a high risk of avoidable readmission *not* being followed at the PDC was 38%.
- The rate of ED return visits for patients with a high risk of avoidable readmission being followed at the PDC was 40% (Figure 2).
- The rate of ED return visits for patients with a high risk of avoidable readmission *not* being followed at the PDC was 51%.

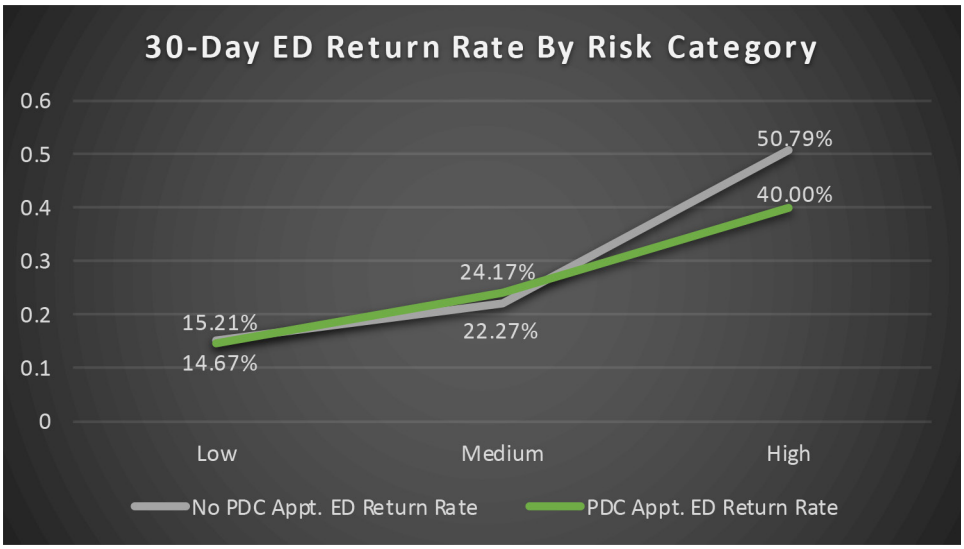



**Figure 2.** A substantial decrease is seen in the 30-day rate of emergency department return visits for high-risk patients who received care at the post-discharge clinic. These individuals experienced a reduction of 22% in their risk of return visits.

There was no difference in readmission reduction or ED return visits for patients with low or moderate risk of avoidable readmission.

## TAKEAWAYS

Our takeaways from this project were as follows:

- We focused on networking with the leadership that can support this project and used internal resources available in the organization to support daily operations and data analysis.
- We linked the organizational goals with the aims of the PDC and cited the cost-saving associated with it to produce momentum and urgency to implement the PDC.
- We found that extensive leadership experience in other organizations was key for effective strategic planning and implementation of the PDC.

## KEYS FOR INNOVATION

For other institutions considering a similar enterprise, we recommend developing a business plan based on the assessment needs of your organization and what you have observed regarding transitional clinics from other organizations. We also recommend considering a patient-centered hybrid PDC clinic (both virtual and face to face), with mentoring and close supervision of the processes, outcomes, and Plan-Do-Study-Act cycles.

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