CASE STUDY: TRANSITIONS OF CARE / READMIT PREVENTION

PREVENTING UNNCESSARY HOSPITAL READMITS

Example patient presentation
92 yo female patient well appearing and fit for her age, admitted for bi-literal colostomy drainage due to diverticulitis. She was treated with IV antibiotics during hospitalization and discharged with instructions to continue with oral antibiotics.

Greater Good Health program
GGH NP visited patient at home within 2 days post discharge from hospital and observed abnormal fluid discharge from drainage. Discovered patient did not receive antibiotics. NP initiated a course of oral antibiotics, educated the patient and daughter on importance of antibiotic compliance and placed orders that had been pended for home health. NP communicated plan with PCP and also ensured follow up with GI.

Patient is recovering well at home and did not readmit to the hospital (now post discharge from index hospitalization - 100 days).

CLIENT CHALLENGE

Healthcare Partners is a full risk, fully delegated medical group who was seeing rising readmission rates in a particular region in their network. Their internal teams had several competing priorities and the programs they built were not making an impact. They sought an expert partner to take on the challenge. GGH reduced readmit rates by 23% for this client.

COLLABORATIVE SOLUTION

- NPs recruited and trained within 30 days of contract
- NPs are employed by GGH, credentialed by HealthCare Partners (HCP)
- GGH NPs are listed as a provider in their network
- Integrated into HCP’s technology, systems, referral portals, and data
- GGH NPs receive extensive training: risk stratification, transitions of care levers, how to perform successful in-home assessments
- GGH NPs work with hospitalists and care managers to ensure proper and timely referrals before discharge from acute facility
- Weekly IDT meetings to review TOC and HR patient panels, addressing barriers, concerns, escalate need for referral follow up
- Readmission “saves” and follow-up in real time
- GGH NPs refer to HCP’s existing programs - including palliative care or care management, if appropriate
- GGH NPs focus on completion of Advanced Directives and POLST
- Resulted in 23% reduction in 30-day readmit rates for the high-risk patients (LACE > 10)

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