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Changing Mindsets to Transform Care

By Susan Spreeman, RN, former Director of Clinical Operations for a major cardiovascular group

As shifting payment models increasingly press hospitals to improve patient outcomes, our fundamental mindset regarding care delivery must change accordingly. The traditional fee-for-service workflows have fostered unintentional results, including processes that perpetuate readmissions and mindsets in how patients seek medical attention.

That became abundantly clear for 20+ cardiologist practicing at a Southeastern regional hospital. This cardiology group partnered with the hospital and initiated a far-reaching project to reduce readmission rates for congestive heart failure. The project drove a dramatic transition from a focus on care services to a focus on the patient as a person. As a result, the cardiology group earned CMS recognition for reducing 30-day readmissions by more than 50 percent over four years.

Compartmentalized services: gaps, overlaps and readmissions

In initiating the project to reduce readmissions, the cardiologist engaged TAVHealth, a service provider specialized in eliminating barriers to health for vulnerable patients. The first step was to map out care delivery from admission, through post-discharge. With many heart patients also under hospital care for such comorbidities as cancer and diabetes, the mapping was often startlingly complex. Charting workflows across care teams revealed what is likely an all-too common occurrence – patients were being treated with a patchwork of services as multiple clinicians followed standard protocols for their functions.

Those protocols, grounded in fee-for-service, left care gaps and created overlaps that contributed directly to avoidable readmissions. The biggest gaps: Patients discharged with poor understanding of actions to take going forward, and cardiologists preparing highly detailed discharge summaries that seldom made it to primary care physicians.

The biggest overlap: Multiple post-discharge calls from various caregivers that confused patients. As a result, nearly half of the cardiology group's congestive heart failure patients were not attending follow-up appointments that were established prior to hospital discharge. These follow-up calls were developed from payment models that did not emphasize patient education and transitional care, two key elements in preventing deterioration and relapse.

The fix: focusing on the patient as a person

The next step was implementing a three-pronged approach to reducing readmissions, which included:

- Adjusted workflows. With workflows documented in the project's initial phase as a guide, the heart failure team made multiple adjustments to close gaps and eliminate overlaps wherever possible.
- Automated collaboration. A collaboration platform, configured specific to a congestive heart failure patient's needs and operating on real-time data, greatly streamlined and standardized all patient engagements and transitional care.
- Patient education. A clinic coordinator reviewed existing educational materials, identified missing and deficient elements and created a standard library of effective materials that were reviewed with patients beginning at admission – not discharge. The heart failure team is then accessible to patients after discharge to problem solve and partner in their care. This approach has created new patient mindsets and pathways that prevent readmission.

Changing mindsets, producing results

The result is mission accomplished for the original project, with 30-day readmission rates among heart failure patients reduced from 17.8 percent to 8.2 percent. That currently frees up an average of seven hospital beds per day for new cases, rather than tying them up with patients readmitted for reasons that have proven to be avoidable.

Readmission-reduction efforts were planned and implemented with physician engagement and feedback, and enthusiasm grew as data began providing evidence of positive results. This gelled into a new mindset driven by the understanding that collaboration is key to enhancing the care continuum. As TAVHealth CEO Jamo Rubin has written in this publication, truly improving all aspects of care requires that providers understand care as the patient sees it. In adopting that view, the cardiologist and supporting clinicians at this hospital today operate with a higher level of coordination and commitment to delivering a complete return to health. ■