

Postoperative care

Planning for postoperative care: A key strategy for reducing readmissions

With the expansion of Medicare readmission penalties to elective total-knee and total-hip arthroplasty patients in 2014 comes an increasing demand for OR leaders to ensure better postdischarge care. To avoid readmissions, OR management will have to be more proactive about reducing length of stay and complications and providing for care transitions—factors that are all intertwined with readmissions. OR Manager spoke with perioperative services leaders at 3 different organizations to learn how they're incorporating care coordination into their workflows.

Under 1 umbrella

"OR management and staff have typically not concerned themselves with patients' care once they leave the OR, but I am now seeing the bigger picture," says Cindy Mahal-vanBrenk, MS, BSN, RN, CNOR.

Three years ago, all units connected with surgery were put under 1 umbrella at Advocate Lutheran General Hospital, Park Ridge, Illinois. Mahal-vanBrenk, the executive service line director for Advocate's Advanced Surgery and Orthopedic Institute, is responsible for 3 surgical inpatient units in addition to the preoperative, intraoperative, and postoperative care units.

At first, Mahal-vanBrenk says, she was not a fan of the 1-umbrella arrangement, but now she sees the advantages. "Having all of the surgical areas under me has made it easy for communication to flow back and forth, and the nurse managers of the inpatient units all like it a lot," she says.

Mahal-vanBrenk notes that she had to spend time learning about inpatient care and quality measurements. "When I just covered the OR, I really didn't know what our length of stay was. I didn't have to. I didn't know what our readmission rates were. I didn't know about postop care," she says.

Daily rounds are key

Key to care coordination are daily rounds through the inpatient units. Clinical managers, a nurse educator, a hospital care coordinator, a pharmacist, and an advanced practice nurse discuss the status of each patient in terms of the care continuum.

The bedside nurse reports on the patient, and the others listen and then ask questions. There is a lot of dialogue, and orders are entered as they are discussing the patient, says Mahal-vanBrenk. "These rounds help everyone get on the same page."

Presurgical assessment

Advocate's presurgical testing department does extensive preoperative preparation and coordination of care for patients and identifies readmission risks, says Mahal-vanBrenk. When patients arrive for surgery, plans already have been made for them to go to an extended care facility, or arrangements have been made for home health to assess them after surgery.

Patients can attend educational programs at the hospital or online before surgery. There is also an app they can use to learn about joint and spine surgery. The programs take patients through all the steps of surgery and provide information they

will need after discharge. They are asked questions such as where they are going after surgery and who is going to take care of them.

Measuring readmissions

The surgical department measures readmissions as part of its key result area. A report card captures outliers on measurements, which the quality department reviews.

"We have been doing this for a couple of years in an effort to coordinate care," says Mahal-vanBrenk.

Whether readmission rates have changed since all of the surgical areas came under 1 umbrella is hard to define, says Mahal-vanBrenk. Readmission rates for total hips and knees are zero.

Length of stay has decreased significantly because of preoperative and postoperative care coordination; however, length of stay is an integral measurement when looking at readmissions.

Not just for inpatients

Patients who have orthopedic procedures in an outpatient surgery setting also need care coordination to prevent them from experiencing problems that could bring them to the emergency room and possibly lead to admission.

A new program for postoperative teaching proved to be the answer to better care coordination for patients at the Massachusetts General Hospital (MGH) Orthopedic Surgery Center, Waltham.

Before implementation of the new teaching program, the surgery center's perianesthesia nurses would call patients the day after surgery, and frequently found they would have to start all over with their postoperative teaching.

"We would spend 45 minutes to an hour in the postanesthesia care unit [PACU] teaching patients their postoperative instructions and coordinating their care. Often the patients would wake up the next morning and have little or no memory of anything we taught them or where they had put their written discharge instructions," says Claire O'Brien, MBA, RN, CNOR, NE-BC, nursing director at the surgery center.

The nurses were frustrated and felt they weren't teaching the patients at the right time, says O'Brien.

Timing preoperative teaching

The combination of inpatient process improvement and research results led the surgery center team to look at how it could improve the discharge process and achieve the highest amount of retention by patients.

An inpatient discharge phone call program had been developed by Jeanette Ives Ericson, DNP, RN, FAAN, chief nurse and senior vice president for patient care services at MGH and her team as part of their innovations work, whereby they reach out to patients after discharge to make sure they are okay and have the help they need.

A research project focusing on nurse-coached intervention in ambulatory surgical arthroscopy patients had been done by Dorothy Jones, EdD, RN, FAAN, Connell School of Nursing, Boston College, and director of the Yvonne L. Munn Center for Nursing Research at MGH, in conjunction with Janet Quigley, MSN, RN, nursing director of the PACU at MGH; Dawn Tenney, MSN, RN, associate chief nurse, perioperative and GI endoscopy services at MGH; and their respective teams.

Despite the exhaustive postoperative teaching process, patients had many questions about their postoperative care once they left the ambulatory surgery center (ASC) and were discharged to home. ASC staff often received distress calls from patients who needed additional support.

The ASC designed and developed a program to teach patients their postoperative instructions before they were medicated for surgery. A position was created for a nurse to teach in a quiet space with fewer distractions than in a PACU. This program allows for hands-on practice with the equipment patients take home on the day of surgery.

Most patients arrive at the ASC 2 hours before their surgery. The teaching occupies patients in a meaningful way. In addition, patients can watch postoperative instructional videos on computers in the waiting area to learn about the ASC and their surgery, which helps reinforce the teaching.

This program has greatly increased the patients' retention of postoperative instructions and patient satisfaction scores, and it has decreased length of stay in the PACU. Patient feedback has been very positive.

"Patients really see the difference and the benefit of getting the information up front before they are medicated," says O'Brien.

Moving forward

O'Brien says she doesn't have any statistics on whether the teaching program has prevented patients from going to the emergency room because of postoperative problems. However, postoperative phone calls to patients the day after surgery that used to take 20 to 40 minutes have dropped to 5 minutes.

"We know our patients are capturing information in a different way and they have fewer questions because they retained what we taught them before we medicated them," she says. "This helps prevent problems that could send them to the ER."

Moving forward with care coordination, O'Brien says what they have found is that patients know what they need. "They have been extremely informative for us," she says. "We listen to their suggestions and make adjustments according to their feedback."

Coordinated care for all

On January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced healthcare organizations selected to participate in the CMS Bundled Payments for Care Improvement (BPCI) initiative, which was designed to provide higher quality of care and more coordinated care at a lower cost to Medicare. As part of BPCI, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Participants choose from Medicare's 48 episodes of care.

One of the organizations involved in BPCI is Catholic Health Initiatives (CHI), based in Englewood, Colorado. The CHI organizations participating in the BPCI initiative are focusing on joint replacements.

"To participate in BPCI, we knew we needed to better coordinate our care and we needed to do a risk assessment at the front end," says Camille Haycock, MS, RN, CHI's vice president for the care continuum.

CHI is using a combination of strategies to achieve this.

LACE index

The LACE index used to assess a patient's risk for readmission at CHI organizations was developed by Canadian researchers (<http://www.cmaj.ca/content/182/6/551.full>).

By quantifying a patient's risk of 30-day readmission or mortality postdischarge, the LACE index helps identify who might benefit from more intensive postacute care.

The LACE index focuses on 4 key variables:

- length of stay (L)
- acuity of the admission (A)
- patient comorbidity (C)
- emergency department visits within 6 months before admission (E).

The index has a potential score of 0 to 19.

“The LACE tool gives us a stratification index for our high-risk population,” says Dee Pentony, BSN, RN, CHI’s director of acute and postacute care management. For example, a surgical patient admitted with comorbidities would have a higher score, which would trigger Project RED interventions to be implemented.

Project RED

Project RED was developed by researchers at Boston University Medical Center to improve the hospital discharge process in a way that promotes patient safety and reduces readmissions (<http://www.bu.edu/fammed/projectred/index.html>). Use of the program resulted in 30% fewer readmission and emergency room visits at their hospital.

The RED (re-engineered discharge) intervention includes 12 components that have been proved to reduce readmissions and yield high rates of patient satisfaction (<http://www.bu.edu/fammed/projectred/components.html>).

A RED Toolkit, funded by the Agency for Healthcare Research and Quality, provides guidance in implementing the RED process for all patients, including those from diverse cultural backgrounds with limited English proficiency (<http://www.bu.edu/fammed/projectred/toolkit.html>).

Care managers in the ambulatory, acute, and postacute settings coordinate care for high-risk patients, notes Pentony. For example, she says, “if we have a patient coming in for a total hip that we have identified as a high risk for readmission, the OR managers, surgeons, care coordinators, and surgical team members have a discussion on what interventions need to be taken to make sure the patient isn’t readmitted, while ensuring high-quality care.”

Interventions include:

- sending the patient through the Joint Academy presurgery
- teaching the patient what to expect postdischarge, including how medications could interact
- making sure the patient has follow-up appointments with the surgeon and primary care physician prior to discharge.

Care coordinators make initial postdischarge follow-up phone calls within 1 to 3 days. Further calls are scheduled according to an assessment of the patient’s condition and the patient’s understanding of his or her condition.

CHI is tracking statistics monthly and has thus far in the first 6 months of this fiscal year realized a 6% reduction in readmission rates.

“Ensuring coordinated care made us focus on reducing readmissions,” notes Pentony. “The risk assessment and readmission reductions programs are now used on all patients in all CHI facilities, not just those participating in BPCI. We wanted to make sure we were planning for the best care for all patients.” ❖

—Judith M. Mathias, MA, RN

Reference

CMS Readmission Reduction Program. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>