Hospitals use specialized team, including pharmacists, to promote post-discharge care coordination

BETH ISRAEL-LAHEY HEALTH SYSTEM

Addison Gilbert Hospital in Gloucester and Beverly Hospital in Beverly are two community hospitals within the Beth Israel-Lahey Health System. Together, the hospitals partnered on a CHART investment to explore opportunities to reduce preventable readmissions among patients with complex health care needs.

Challenge

Patients with a high degree of social complexity require more time and support from emergency department (ED) staff compared to the average ED patient. These patients may also be more likely to revisit the ED, especially if their care outside of the hospital is not well-coordinated.

Action

In 2016, Addison Gilbert and Beverly Hospitals each received a CHART grant to develop and implement a strategy to manage socially complex patients with the goal of reducing 30-day returns by 20 percent. The hospitals secured $3.77 million in CHART funding to support this intervention. The team defined their target population as any patient who had been hospitalized more than four times in the past year, had a readmission to the hospital within 30 days of a previous visit or were socially complex. Socially complex patients generally included those patients with a substance use disorder, patients experiencing homelessness, those with a disability, and patients who were dually eligible for Medicare and Medicaid. They also had a number of patients who needed end-of-life care and palliative consultation. By the program's definition, approximately 35 percent of all discharges qualified to participate in the program.

The program was built around a High Risk Intervention Team (HRIT), which provided wraparound services and support to eligible patients. During the grant period, the HRIT consisted of a nurse practitioner, two registered nurses, a pharmacist, and two social workers. Patients who were eligible for the program were enrolled and received an ED care plan developed by a social worker. Care plans varied depending on patient needs, but focused on ensuring that the patient had access to and was taking the correct medications; that they were receiving the follow-up appointments they needed; and that their social needs, for example, housing or food, were being met. The care plans were developed by an HRIT social worker or case manager, and were then reviewed and approved by someone on the medical team.

What is CHART?

The project described in this case study was supported by a Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment from the Commonwealth of Massachusetts Health Policy Commission (HPC). The CHART program made innovative investments in the Commonwealth's community hospitals with the goal of establishing a foundation for sustainable care delivery. CHART funds enabled the hospitals to develop new care models designed to help patients avoid costly acute care settings like the emergency department by assessing local needs, modifying services, and expanding relationships with medical, social, and behavioral health community organizations.

The HRIT worked hard to develop strong relationships with both the patients and partners in the community, including skilled nursing facilities, behavioral health providers, visiting nurses and primary care practices. Once the care plan was established, social workers would follow-up with patients at home visits to make sure that they were able to follow the plan. Social workers coordinated with others who the patient was regularly seeing, such as visiting nurses, or the patient's primary care physician. Pharmacists also performed specialized home visits to check on the patients' adherence to their medication regimen and helped to trouble-shoot if the patient had a difficult time with any aspects of obtaining or taking their medication. Pharmacists were also able to perform medication reconciliation in the home to make sure that patients were on the correct medications and that they understood how to take them properly.

Ultimately, the team was successful in reducing ED revisits among the patients enrolled in the program. The team was so successful that the hospitals decided to maintain the HRIT, but program staffing has been optimized since the grant funding came to an end in 2018. Now, the team at Addison Gilbert includes a pharmacist and a social worker and the Beverly team includes a pharmacist and three social workers. The hospitals share a recovery coach who provides specialized support to patients in recovery. Funding for the program is provided by both hospitals as well as through some billing for outpatient psychotherapy done by the social workers.

Lessons Learned

- Social workers form the backbone of the team and serve a key role in coordinating with other care providers, helping patients stay on-track and addressing the patients' social needs.
- Using the PreManage ED solution allows a hospital to get a better understanding of a patient's recent ED visits, even if the visits took place at different hospitals. It is especially helpful if other hospitals have taken the time to input basic notes about the patient's care plan.

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