

CASE STUDY

Collective Medical helps rural hospital decrease all-cause 30-day readmissions by 78%



“Every month we continue to improve. We now have the capabilities to not only understand what drives our readmission rates, but also to combat preventable readmissions at the source.”

- Joyce Bailey,
VP of patient care at
CHI St. Anthony

CHI St. Anthony Hospital

CHI St. Anthony Hospital (St. Anthony) is a rural hospital serving Pendleton, Oregon. The 25-bed critical access hospital is part of the Catholic Health Initiatives (CHI) family and currently houses a level four trauma center, four operating rooms, emergency services and an intensive care unit.

Challenge

In 2011, the Centers for Medicare and Medicaid Services (CMS) estimates that nearly 20 percent of Medicare patients were readmitted to a hospital within 30 days, costing more than \$26 billion per year. Like many hospitals, St. Anthony needed to improve on decreasing readmission rates, not only to cut costs, but for the benefit of its patients. Unfortunately, it is often not immediately clear what causes readmissions. Joyce Bailey, VP of patient care at CHI St. Anthony launched an investigation into the reasons behind readmission rates, so they could be properly addressed.

Solution

Working with Collective Medical – the nation’s largest care collaboration network – Bailey’s team implemented Collective EDie, a real-time, risk-adjusted event notification and care collaboration platform, to identify patients at risk for readmissions starting in the emergency department (ED). They found that patients with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) were among the groups contributing the most to St. Anthony’s readmission rate.

After review and investigation using the insights provided by the Collective platform, the team determined that these patients were given inadequate care instructions following discharge – leading to readmissions on days 3 and 20 after their initial visit. Bailey instructed her team of care managers to follow up with COPD and CHF patients within three days of being discharged. Care managers ensured the patient had an appointment with their PCP to receive necessary follow-up care and confirmed patients had been properly educated on their condition. For example, CHF patients were reminded to monitor any weight fluctuations and to cut back on their sodium intake.

Bailey explains that the Collective network not only identifies the factors behind readmissions, it provides an efficient communication and collaboration channel for everyone involved in the care of a patient. As part of the protocol, Bailey’s team also used Collective EDie to include and update care recommendations for patients at risk for chronic diseases. Specifically, physicians began screening for smokers and logging the data onto the network. Of the 1100 ED patients St. Anthony treated per month, 140 were smokers – all at high risk for COPD. After these high risk patients were identified, physicians emphasized the importance of smoking cessation, the consequences of not doing so, and strategies to help patients quit.

About Collective Medical

Collective empowers care teams to improve patient outcomes by closing the communication gaps that undermine care.

www.collectivemedical.com

Outcomes

CHI St. Anthony Hospital began using Collective EDie as a part of its re-admissions reductions algorithm in July 2015. The hospital redesigned a community collaboration program using the Collective platform as the technical backbone to identify patients at risk of readmission and share information with the broader care team.

In September 2015, the hospital started with a baseline rate of all-cause 30-day readmissions of eight percent.

- By January 2017, the hospital had reduced all-cause readmissions rates to three percent.
- By June 2018, the hospital had reduced all-cause readmissions rates to 1.72 percent.
- This represents a 78 % reduction in all-cause 30-day readmissions achieved in less than three years.

“ It’s all about identifying details to enact change. That’s why I love the Collective Network, if you can capture the details, you can manage them.”

- Joyce Bailey,
VP of patient care at
CHI St. Anthony
