Culpeper Regional Hospital (CRH) is a not-for-profit, general medical and surgical hospital in Culpeper, VA. The 67-bed facility is part of the larger Culpeper Regional Health System (CRHS), which also includes a number of ambulatory care centers.

**Project Summary:**
Through their Bridges of Care Partnership, CRH and the Rappahannock-Rapidan Community Services Board/Area Agency on Aging (RRCSB/AAA) collaborated to provide care during the transition from hospital to home for residents in the rural county of Culpeper, VA. The overarching goal was to reduce thirty-day readmissions for Medicare patients who had been diagnosed with diabetes, chronic obstructive pulmonary disease (COPD), heart failure, or acute myocardial infarction. During fiscal year (FY) 2010, Culpeper Regional Hospital experienced 10.96% overall readmissions for all diagnoses. Also during FY 2010, readmission rates were twice as high for Medicare patients with diabetes (27.59%), COPD (24.22%), and heart failure (24.53%).

**Objectives:**
1. Identify patients’ designated RRCSB/AAA Senior Advocate during admission to CRH.
2. Establish a protocol for effective communication involving family, caregivers, and the Senior Advocate as full partners in assessment, discharge planning, and predicting at-home needs.
3. Provide effective post-acute care follow-up.
4. Evaluate project outcomes.

**Leadership:**
- H. Lee Kirk, Jr., FACHE, President and CEO
- Cynthia S Colson, Executive Director of Culpeper Regional Hospital Foundation

**Primary Investigator(s):**
- Karen Harris, RN, CPHQ, Quality & Patient Safety Officer

**Results:**
- 23% decrease in readmissions for hospital-to-home patients
- 44% decrease in readmissions for nursing home patients

**Savings:**
$1,008,209 in savings
Results:
CRH and RRCSB/AAA utilized a web-based software system to identify patients who were receiving services through RRCSB/AAA. The team established protocols to ensure effective communication among CRH case managers/social workers and the Senior Advocates. CRH Patient Educators and the Senior Advocates provided post-acute care follow-up upon discharge. If referred for services, Senior Advocates followed-up with patients to resolve barriers to obtaining medication, coordinating transportation to physician follow-up appointments, and scheduling home visits if the patient required additional support. Patient Educators contacted patients following discharge to answer questions about the discharge plan, medications, or physician follow-up appointments. The Bridges of Care Partnership reduced readmissions from 11.98% to 9.22%, saving 70 readmissions. The cost savings was $1,008,209.

Project Continuation:
Culpeper Regional Hospital has continued its effort to reduce readmissions and has also reached out to other community partners. Although CRH initially encountered challenges with incompatible information systems with outside facilities, the institution overcame these difficulties and has had continued success working with nursing homes and home care. At the end of FY 2012, all-cause readmission rates were reduced to 8.1% as a result of the implementation of these programs/initiatives a cost savings of $1,008,209 was realized.

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