Purpose

To decrease 30 day readmission rates to 9%. Improve patient transitions from the acute care setting to the community setting.

Background

Transitioning patients from one care setting to the next was often a fragmented and unspecified process resulting in readmissions within 30 days of discharge. Hospital care providers traditionally ordered follow up to see primary care in 2 weeks following discharge, which is often too late to intervene and prevent readmissions. Care coordination was an unrealized effort that lacked adequate interdisciplinary communication. Analyzed readmission rates were not reflective of the reason for the readmission. Historical process changes were based on assumptions did not involve those closest to the work, and were unable to produce improvement. Initial efforts focused on congestive Heart Failure (CHF) readmissions, and were based on the hospital processes functioning as a silo.

Methods

- Form a cross continuum, interdisciplinary team.
- Develop a charter with a clear specified aim including a numerical goal & Specified time frame to accomplish the goal (IHI, 2014).
- Utilize Adaptive Design improvement methodology to identify opportunities and understand why this patient this time readmitted (Kenagy, 2009).
- Avoid making assumptions. Objectively observe transition processes (Kenagy, 2009).
- Ask why until an actionable cause is identified (Kenagy, 2009).
- Collaborate with providers to accommodate access to care within 3-5 days of patient discharge.
- Establish a specified work flow to communicate recommendations from hospital provider to community provider.
- Utilize and enhance Transitional Care Management (TCM) codes to ensure post discharge follow up phone calls occurs within 48 hours (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2013).
- Imbed best practices of teach back and chronic disease management across the care continuum (Sutter Health, 2013).
- Invest in the time to train and validate competency of teach back and disease management skills.

Conclusion

A downward trend in readmission rates from 11.5% in 2011 to 9% in February 2014 directly correlated with the described practice improvement methods.

Discussion

As healthcare moves into a world of accountability to our patients these efforts were a great benefit to them, additionally other positive outcomes were achieved.

- A decrease in the total number of hospital admissions over this timeframe has also been achieved with prevention of exacerbations and improvements to the overall health of the populations served.
- Reduction in overall costs has been recognized with this 2% decrease in readmissions.
- Interdisciplinary communication has improved as results of these meetings, and collaborating together on this shared vision to reduce readmissions and improve the patient’s experience.
- We have also re-specified processes such as the care coordination conference to include a specified interdisciplinary team, in which designated components of each patient record are discussed resulting in care team recognition and completion of appropriate referrals.
- Referrals such as palliative care, home health care, social and community services further support the health and wellness of the community.
- Components of each patients record are discussed. These discussions prompt the care team to recognize and complete appropriate referrals such as palliative care, home health care, social and community services.

References