A Patient-Centric Transitions of Care Collaboration for Heart Failure (HF) Focused on Reducing Readmissions

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Background:
Strategically, Ocean Medical Center (OMC) has been focused on reducing readmissions as a result of CMS’s readmission reduction program. This program financially incentivizes hospitals that improve communication and care coordination efforts, and better engage patients and caregivers in post discharge planning. Due to the complex nature of transitions of care, it was critical to align coordination related to key inpatient touchpoints while identifying existing gaps in the discharge process. Objective was to gain a full understanding of the complexity of the discharge process and identify/prioritize key care gaps as the opportunity to better improve the transition of care.

Project Aim:
Reduce readmission rates over a 6 month period by implementing a transitions of care program focused on key care gaps in the discharge process; with the overarching goal of achieving, exceeding, and sustaining performance better than the national HF readmission rate (21.6%).

Project Design/Strategy:
OMC developed patient resources and implemented a pilot program to understand the complexity of the patient discharge process, and to identify and prioritize key care gaps as the opportunity to improve upon the transitions of care for HF patients thus better preparing patients for the next phase of their care.

Outcomes:
Data reflects that this project was successful in our institution. Among the pilot population, readmissions were reduced by about 50%. Staff compliance with completing and providing the patient resources also steadily increased as the pilot program progressed.

Changes Made:
To improve the patient transition of care, interviews were conducted with key clinical team members to uncover best practices and opportunities for discharge resource consistency and enhancement. As a result, resources were developed that were tailored specifically to patients, care givers, and discharge teams. These resources included a patient contract and action plan, medication management checklist, and discharge instruction plans.

Multidisciplinary Team Support and Participation: (OMC) James Clarke, MD; Vincent Vivona, DO; Lisa Antonacci, PharmD; Kirsten Zabilowicz, RN, CPHQ; Mimi McNicholas, MSN; Janice McDermott, BSN; Lisa Antonacci, PharmD; Marqueta Demaio, RN; Jennifer Harper, BSN; Georgina Muth-Maurelli, APN; (BMS) Curtis Swain, M.Ed; Howard Becker, R.Ph., PAHM; Stephen Robinson, MBA; Francis Lobo, Pharm.D., MS, PhD.

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