A Novel Approach to Reducing Readmissions

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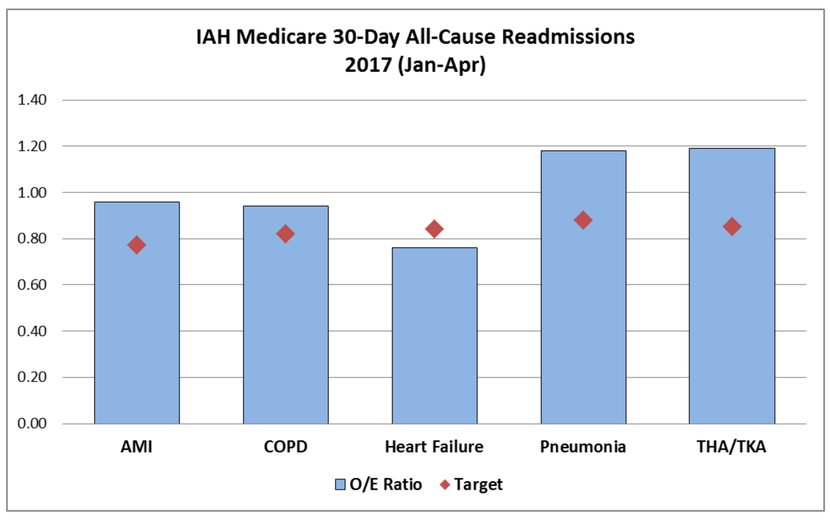
Introduction

Hospital readmissions within 30 days of an acute hospital stay are associated with unfavorable patient outcomes and financial penalties. The Centers for Medicare and Medicaid Services (CMS) define those most at risk of readmission as Medicare patients 65 and over with a primary diagnosis of acute myocardial infarction (AMI), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), pneumonia, and elective hip and knee surgeries.

The maximum penalty is 3% of total Medicare payments to the hospital. FY2017 readmission penalty for Inova Alexandria Hospital was 2.06% ($943,164) which was higher than the national average (0.73%) – money better invested in patient care, research, technology and education.

Project Goals

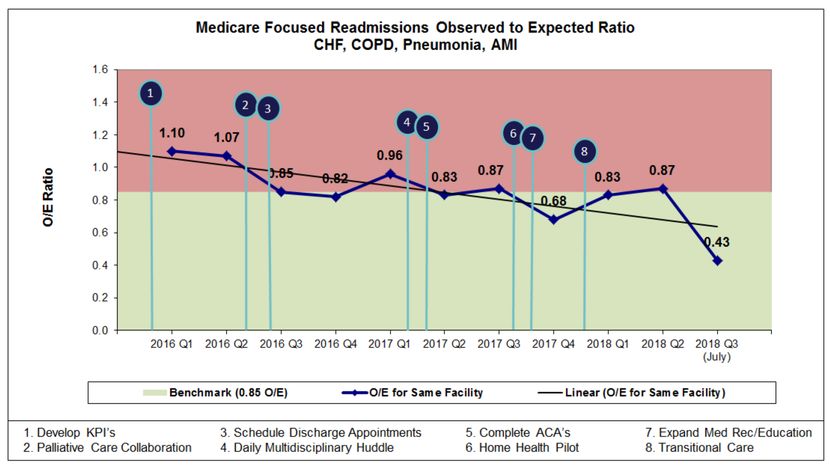
The goal was to decrease preventable readmissions for Medicare patients 65 and over with an active diagnosis of AMI, CHF, COPD, pneumonia, and elective hip/knee surgeries.



Multidisciplinary Team

Executive Sponsor/CMO
Case Management
Quality
Clinical Nutrition
Nursing
Pharmacy
Palliative Care
Rehabilitation
Respiratory Therapy
Transitional Care Management

Improvement Methods

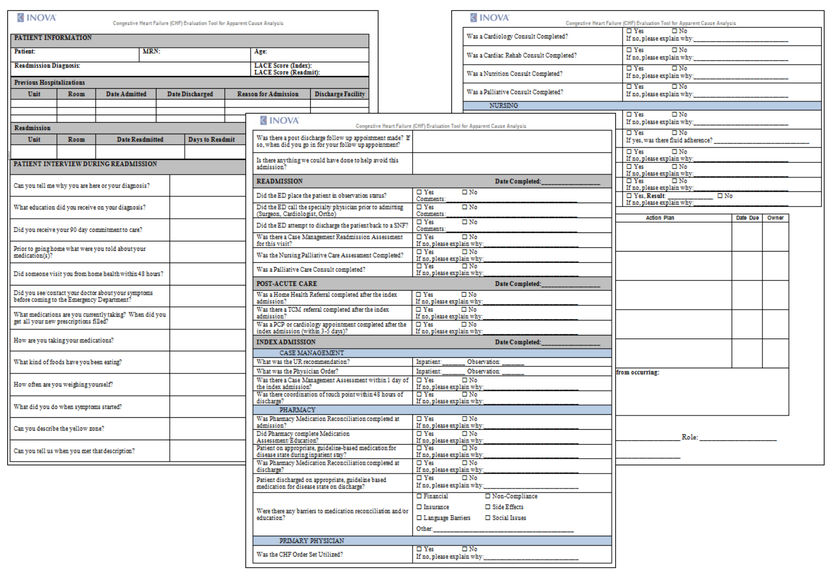


Multidisciplinary huddle

Develop standard work and key performance indicators (KPI's) for each focus diagnosis and by discipline to track and trend compliance with the Multidisciplinary Care Plan. Began a daily multidisciplinary huddle to review all Medicare focus diagnosis patients.

Apparent Cause Analysis (ACA)

For all identified readmissions, an ACA was completed and immediate actions were taken to remove any barriers. Involved team members met to identify the root cause of the readmission. Next steps and actions were identified and implemented.



Collaboration with Palliative Care

Increased early palliative care consults and positive culture change surrounding perception of palliative care at IAH.

Discharge Appointments

Schedule discharge appointments within 48 hours of discharge for all focused diagnosis patients, regardless of discharge disposition.

Home Health Pilot

Provide home health to high risk patients within 24 hours of discharge to patients, providing immediate intervention to any obstacles identified.

Increase in guideline-based therapy and accurate reconciliation for patients

Expand medication reconciliation at admission, medication education, and discharge medication reconciliation to all patients with AMI, CHF, PNA, or COPD. In addition, for CHF and COPD pharmacists also validated use of guideline based therapy.

Transitional Care Management (TCM)

Real time follow up with hospital staff on any challenges identified after patient's discharge.

Key Lessons

Lack of standardization and disciplines working in silos

- Standardization of various processes and of care coordination leads to fewer readmissions
- A daily huddle approach to a multi-disciplinary discussion leads to earlier intervention and clear communication of potential barriers to the patient and increased accountability

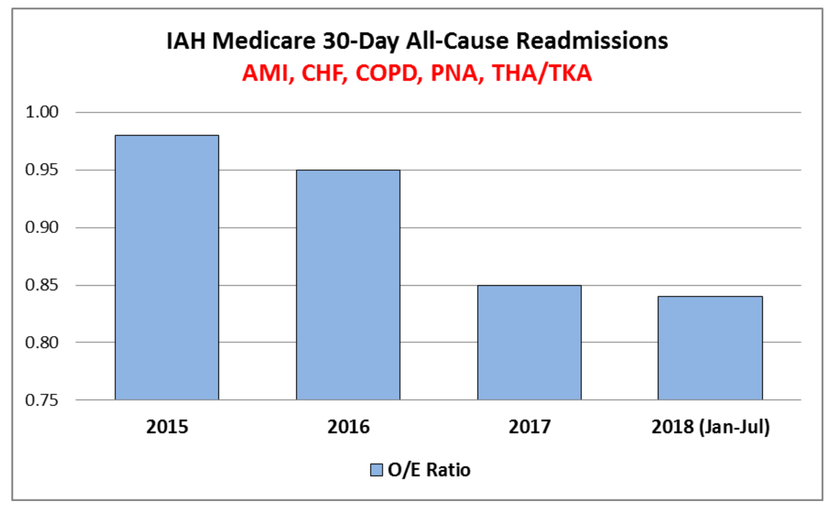
Initial engagement and participation by frontline staff

- Consistency of daily huddle and increased awareness of our readmissions was integral in improving outcomes for our patients

Lack of coordination for the patient's post-discharge follow up care

- Home Health and TCM involvement leads to closed-loop coordination and communication

Outcomes



We have made steady improvement since implementing our daily readmission huddle in May 2017. Increased awareness of our readmissions was integral in improving outcomes for our patients.

Next Steps

- Digital pathway will be utilized through GetWellNetwork to engage the patient by taking them through an educational program which is comprised of video content, comprehension questions, signs and symptoms self-checks, discharge readiness check list and care team notifications.
- Focused story-telling (Partners in Leadership) from ACA information with care team to improve performance.
- Team based rounding to drive patient engagement and self management of their chronic illness.