Reducing Hospital Readmissions Using a Team Approach

Lakes Regional Healthcare

Inpatient Capacity: 36 beds
- 28 medical/surgical inpatient beds
- 5 OB
- 3 ICU/CCU

Mission Statement:
Improve the health and well-being of people in the Iowa Great Lakes region
Objectives

- Describe the journey utilized to reduce inpatient readmissions
- Describe the successes and recognize the continued opportunities identified during the team improvement processes
- Discuss future plans to reduce hospital readmissions

LRH’s Journey

- Monitored readmissions with like diagnosis
- Monitored and tracked all cause readmissions
- Developed the Readmissions Team with the goal to reduce pneumonia readmissions
  - Vice President of Nursing
  - Director of Inpatient Services
  - Quality Measures Specialist
  - Utilization Review Coordinator
  - Resource Nurse
  - Resource Coordination Nurse (ER)
LRH’s Journey

- Determined high risk criteria. High risk criteria determination completed by admission nurse on day of admission.
- Provided patients with a thorough social service assessment during hospitalization (including meals, medication set-up, financial needs, and transportation needs)

LRH’s Journey

- Implemented standardized pneumonia orders according to CMS guidelines and evidence-based practices. Continuously monitored use of pneumonia order sets and when not utilized, discussed with physicians why they were not.
- Respiratory provided thorough education to patients with home respiratory equipment to include cleaning of all respiratory equipment (CPAP, BIPAP, O2, nebulizer machine and tubing, and incentive spirometer).
LRH’s Journey

- Initiated discharge planning on admission. Increased use of community resources in this process.
- Increased interdisciplinary care conference on all high risk and Swing Bed patients from once to twice a week. Long-term care facility staff, assisted living staff, home care staff, patients, and families invited to attend to discuss discharge planning and concerns.
- Encouraged physicians to make follow up appointments for post-discharge monitoring (including home/assisted living patients) on day of discharge.
- Process developed and implemented whereby when making follow up appointments, if the provider office is closed, the appointment is made the next business day by the Resource Nurse and the patient is notified by hospital staff.
LRH’s Journey

- Developed LRH “Transition of Care” – a one time, free home care visit for high risk patients that do not meet home care criteria to review medications, diet, and discharge education.
- Contracted with outside agency to follow up with patients discharged with CHF and COPD for 30 days post-discharge.
- Developed a standardized report to help with the care transition process and to prevent a lack of communication.

- Revised the transfer form to ensure all necessary information and orders are clear on discharge.
- LRH Partnership for Patients Team created to address 10 focus areas, one of which was readmissions (with a goal to decrease complications during transitions of care from one setting to another)
LRH Partnership for Patients

Team members include:
- President/CEO
- Vice President of Patient Care
- Vice President of Nursing
- Director of Inpatient Services
- Quality Improvement Specialist
- Quality Measures Specialist
- Nursing staff
- Utilization Review Coordinator
- Director of Pharmacy
- Lean Facilitator
- Laboratory Manager
- Director of Surgical Services
- OB Supervisor

Monthly Meetings Held to Discuss:
- HEN results
- Pertinent changes to work plan
- Updated educational opportunities
- Future plan of actions
- Webinars
LRH’s Journey

- Completed education with home health, long-term care, assisted living, and residential care facility staff regarding impact of hospital readmissions, readmission prevention, and improving care transitions. CEUs were provided to long-term care facility staff regarding assessment/care of patients when returning from the hospital and early warning signs.

LRH’s Journey

- Completed follow up phone calls on days two and five for all CHF, pneumonia, acute MI and high risk patients, including patients discharged with home care, long-term care, assisted living, and residential care facility services.
LRH’s Journey

- Expanded the Readmissions Team to discuss all cause readmissions instead of diagnosis specific.
- Formed an interdisciplinary team to discuss readmissions during hospitalization, completing a root cause analysis on all readmissions using the STARR model.

Future Steps

- Continue to monitor all cause readmissions and utilize community services when applicable upon discharge.
- Add local pharmacist to LRH Readmissions Team meetings for additional information.
- Continue to improve medication reconciliation (medication errors is a common cause of readmissions).
Future Steps

- Teach back education to be arranged with staff.
- Monthly readmission meetings to be developed to discuss the root cause analysis of previous month readmissions. All LRH departments and community services that were involved with patient care will be invited to attend.

Results

LRH 30-Day Pneumonia Readmission Rate (%)
Sep 2011 – April 2013

Team Effort Began Sept. 2011
Results

LRH 30 Day Pneumonia Recurrence Rates
2007-2010 vs 2012/2013

U.S. Pn Recurrence Rate 2007 – 2010: 18.3
LRH Recurrence Rate 2007 – 2010: 17.6
Average LRH Pn Recurrence Rate March - August, 2012: 14
Average LRH Pn Recurrence Rate Sept, 2012 – April, 2013: 4.2

Results

LRH Readmission Rates by Category
Oct 2012 – April 2013
Results

LRH All Categories Readmission Rate vs Goal
Oct 2012 – April 2013

Take Home Note

Preventing readmissions is a group effort. A single organization, working independently, cannot prevent readmissions.
Questions?

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