Care Transitions: Readmission Rate Reduction
Mission: Improve the health and well-being of the people in the Iowa Great Lakes region.

Vision: The place where patients want to come, providers want to practice, and people want to work.

Objectives

- Describe the journey utilized to reduce inpatient readmissions.
- Describe the role of the members of the Readmission Lean Team and their impact on readmissions at Lakes Regional Healthcare.
- Share future strategies of the Readmissions Team to continue to reduce readmissions and provide safe, quality care for the people of the Iowa Great Lakes.
Readmission Definition:

The National Quality Forums (NQF) definition of a readmission is: occurring when a patient is discharged from the acute care hospital to a non-acute setting (example: Home Care, skilled, rehabilitation or home) and then admitted to the same or another acute care hospital within 30 days from the day of discharge.

Readmission Team

Vice President of Nursing
Director of Inpatient Services
Quality Measures Specialist
Utilization Review Coordinator
Resource Nurse
Resource Coordination Nurse (ER)
Respiratory Therapist

Recently Added:
Social Worker
Director of Home Care and Hospice
Director of Clinic Operations
LRH’s Journey:

- Monitored and tracked 2011 readmissions.
- Initiated discharge planning on admission.
- Determined high risk criteria; completed by Resource nurse on day of admission.
- Provided patients with a thorough social service assessment during hospitalization to include:
  - meals
  - medication set-up
  - financial needs
  - durable medical equipment
  - transportation needs
  - post hospital community services
LRH’s Journey continued

- Implemented standardized orders according to CMS guidelines and evidence-based practices.
- Implemented Respiratory Therapy services to provide 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 continued

- Increased interdisciplinary care conference on all high risk and swing bed patients from once to twice a week.
- Invited Long-term care facility staff, assisted living staff, home care staff, patients, and families to attend Care Conferences to discuss discharge planning and concerns.
- The discharge orders included physician ordered follow-up appointments for post-discharge monitoring. This includes long term care and assisted living patients.
LRH’s Journey continued

- Developed and implemented a process for follow up appointments; if the provider office is closed, the appointment is made the next business day by the ward secretary and the patient is notified by hospital staff.
- Encouraged influenza and pneumonia vaccination to patients that met qualifying criteria on admission or discharge.

LRH’s Journey continued

- Developed LRH “Transition of Care” visit – a one time, free home care visit for high risk patients that do not meet home care criteria. The visit includes:
  - Medication review
  - Diet, and
  - Discharge education.
- Contracted with outside agency to provide follow-up for patients discharged with CHF and COPD for 30 days post-discharge.
LRH’s Journey continued

• Developed a standardized “report off” to help with the care transition process and to prevent a lack of communication.
• Completed education with home care, long-term care, assisted living, and residential care facility staff regarding the 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 of HF, Pneumonia and MI.

LRH’s Journey continued

• 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.
• Teach Back education completed for all staff.
Readmission Process

• All readmissions are evaluated by Utilization Review Nurse and admitting physician at time of readmission.
• LRH currently utilizes the STAAR model as a reference for evaluation and prevention of readmissions.
• All readmissions are evaluated monthly by our Readmission Team with the following reviewed:
  • Reason for readmission to determine root cause analysis.
  • Preventable causes for readmission.
  • If post-hospital services were utilized prior to readmission.
  • Amount of time between admissions

Readmission Process

• Were patient needs prior to discharge addressed appropriately.
• Discuss, trend and monitor readmissions.
• Readmission information reviewed by staff, administration, Medical Staff and Board of Trustees.
• Concerns or trends noted during the chart review provided to the Utilization and Physician Peer Review Committee.
Transitional Care Management

• Avera Lakes Family Practice and Avera Spirit Lake Medical Center are physician/practitioner office groups which are provider based clinics and a department of the hospital.

• Clinic staff call the patient or the patient’s care giver within two business days to assess how the patient is doing, any needed interventions, and remind the patient of their scheduled follow up appointment. The face to face visit between the patient and provider is done within 7-14 days.
Results/Outcomes

Teach Back Observations

Handoff Communication

2/28/2014
Future Steps

• Continue to monitor all cause readmissions and utilize community services upon discharge.

• Add hospital pharmacist to LRH Transition of Care Team meetings for additional information.

• Continue to improve medication reconciliation (medication errors is a common cause of readmissions).

Conclusion

• Lakes Regional Healthcare has improved the safety and care transition of our patients by preventing readmissions as evidenced by a readmission rate reduction from 7.9% in 2012 to 6.08% in 2013.

• HEN/PfP goal was a 20% reduction in readmissions and LRH has demonstrated this reduction.
LRH has made numerous changes to help in the prevention of readmissions. Education to both staff and post hospital providers has had an impact on the readmission rates and improved the care transition communication. HEN participation would not have been possible without the support of our Board of Trustees, Leadership, Physicians and front line staff.
Future Steps

- Continue to monitor all cause readmissions and utilize community services when applicable upon discharge.
- Add hospital pharmacist to LRH Transition of Care Team meetings.
- Incorporate incident reports in the investigation of readmissions.
- Continue to improve medication reconciliation (medication errors is a common cause of readmissions).
- Address how we observe teach back education.
- Improve patient education.
Preventing readmissions is a group effort. A single organization or person working independently cannot prevent readmissions.

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Questions?