Effective Readmission Reduction Strategies: Closing the Revolving Door by Improving Patient Care

Aim
To decrease avoidable admissions, targeting a ratio of observed to expected readmissions of less than 1.0.

Background & Relevance
Historically, approximately 1 in 5 Medicare patients were readmitted to the hospital within 30 days of discharge. This accounted for an estimated $17 billion annually in Medicare expenditures that may have been largely avoided – an expense that is now being shifted to hospitals under the ACA’s Hospital Readmission Reduction Program. Improvements in patient care can reduce readmissions and ease this financial burden.

Team Members
Our efforts to reduce readmissions is a collaborative effort among Senior Leadership, Physicians and Nurses; and across the Education, Pharmacy, Dietary, Case Management, and Quality Improvement Departments.

Lessons Learned
To Close the Revolving Door:
- Repeatedly ask: “Is this a safe discharge?”
- Deliver clinical excellence to every patient at every encounter
- Practice a high level of communication across the Care Team
- Provide a smooth transition to the next level of care by assuring patients understand their treatment plan, have access to further care, have been given the right medications, and have a support system in place
- Give PCPs access to the discharge summary and plan of care

Interventions
- The Emergency Department’s Care Transition Team includes a dedicated Case Manager 7 days per week/16 hours per day
- Every admitted patient is assigned a “readmission risk” score
- Daily work lists flag 30-day readmissions
- Medication reconciliation is conducted on admission (by a Pharmacy Tech in the ED) and again at discharge.
- Daily Interprofessional Care Rounds Monday - Friday
- Any staff member can request a Palliative Care Team consultation
- Patients and their primary caregivers are educated using the “teach-back” method; “After Visit Summary” is reviewed with patient before discharge; and nurses may request Pharmacy review medications with patients if necessary
- Case Management schedules follow up appointments prior to discharge
- Referral to a Post-acute Physician Panel member if the patient does not have a primary doctor
- Post discharge phone calls are made within 48 hours
- Special focus on CHF patients: Nursing, Pharmacy, Dietary and Case Management are provided a list of these patients daily; Quality Improvement tracks CHF education and conducts post-discharge phone calls
- Regional Readmission FMEA to find the gaps and bridge them

Next Steps
- Conduct physician review of readmission cases
- Investigate funding opportunities to establish an FQHC staffed by a Nurse Practitioner

A Spider Chart is an excellent quality improvement tool that provides a two-dimensional snapshot of three or more variables. The Spider Chart above simultaneously displays the PHMC Readmission O/E Ratio from June 2015 – May 2016, computed using a 12 month moving average, for 8 separate diagnosis. Data points in the highlighted area represent better than expected OE Ratios. Overall, our Readmission OE Ratio was 0.94 during the period, and trending downward over the past several years.