Readmission Reduction Strategy Trial: Assessment and Communication Tool

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Problem:
All cause thirty-day hospital readmissions reflect poor quality care, unsafe transitions of care, and are costly. Best practices for transitions of care need to be implemented for improvement.

Evidence:
Nearly 20% of Medicare hospitalizations are readmitted within thirty-days of discharge (AHRO, 2010). Medicare readmissions cost the government approximately $15 billion annually (MedPAC, 2007).

Strategy:
A small community hospital formed a multidisciplinary team that followed the Iowa Model of Evidence-Based Practice to identify gaps in transition care, formulate a practice change, implement a three-month trial of the change, evaluate the results, and make final recommendations to administrative staff.

Practice Change:
A new process including a two-sided tool was developed. The process included identifying patients at risk for readmissions, alerting the discharge team, and implementing a discharge communication sheet.

Evaluation:
Collected monthly data included readmission rates, the percentage of patients that were identified as being at risk and readmitted within thirty-days, percentage of communication sheets that were utilized, and discharge needs that were acted upon from the communication sheet.

Results:
 Compared to the previous year, readmission rates were reduced. Those patients that were identified as being at risk were 4 times more likely to be readmitted. On average, 37% of communication sheets were utilized for new discharge needs. Only 3% of new discharge needs were acted upon and followed through to discharge. Upon questioning, most discharge members ignored the alerts.

Recommendations:
1. Expand existing electronic admission assessment tool to include at risk factors from the trial.
2. Involve Information Technology and develop a system that triggers an alert symbol in the electronic medical record for patients that triggers from the risk factor assessment.
3. Recommend the development of a new position, a Transition Nurse, to coordinate the transition of care across settings.
Lessons Learned:
1. Administrative and physician support and open communication are key factors for success.
2. Clear, consistent, and timely education is problematic with multiple disciplines involved.

Bibliography:


