Risk Adjusted Potentially Preventable Readmissions

The Problem
The Readmission Rate at BID-Plymouth (formerly Jordan hospital) exceeded our organizational goal of 10%. High readmission rates indicate the need for process redesign to ensure optimal utilization of community resources and meticulous discharge planning and patient/family education.

Aim/Goal
To reduce all cause 30 day preventable readmissions.

The Team
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The Interventions
- CVS bedside delivery program to have patient medications delivered prior to discharge to improve the med rec process and patient compliance.
- CM and UC workflow schedule patient follow up appointments. Goal is 72 hours after discharge.
- In-Home visits by NP

The Results/Progress to Date

Lessons Learned
- Very Small numbers
- Reporting capability and data to drill down and trend by MD, Dx, insurance etc. in order to identify corrective action plans
- Community MD buy- in to ensure PCP coverage and availability for non-emergent issues, stop the admission for placement and admissions to facilitate outpatient testing practice.
- SNF nursing education and medical director leadership to improve the capabilities to provide care in that setting.
- VNA resources in the home setting to avoid the 911 transfers to the ED.
- Increased utilization of hospice and palliative care to address end of life issues and advance directives.

Next Steps/What Should Happen Next
- Community education and partnership to avoid unnecessary ED visits/admissions.
- Improved communication from community providers regarding patient baseline status, services, code status, goals, etc.
- Daily and monthly review of all readmissions with notification to sending provider and certain MD’s (at their request) for their review.
- ED case management to triage potential readmissions to an alternate level of care when appropriate.
- VNA transition visit with the patient prior to discharge to assess and coordinate the plan of care.

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