Background

To begin reducing their readmission rates within the context of quality improvement mandates embrace strategies of quality improvement in healthcare. One such strategy requires hospitals to initiate a pilot program addressing 100% of all discharges to home to help identify those factors that might result in unplanned readmissions within 30 days with the expectation that we could make treatment program adjustments to mitigate these potential issues. Each patient is called within 7-10 days of discharge by the Nurse Practitioner involved in their care during the inpatient stay. Key areas addressed include medication management, access and initiation of indicated therapies, status of nutrition, hydration, bowel, bladder, skin, and pressure relief, follow up appointments and any barriers hindering compliance with any of the above. Data is being collected, identified issues are being addressed, and readmission data is being tracked.

Introduction of Spain Rehabilitation Center (SRC)

UAB Spain Rehabilitation Center is one of the Southeast’s foremost providers of comprehensive rehabilitation care. As an integral part of UAB Health System, Spain Rehabilitation Center has over 40 years of experience in offering a level of care that is unsurpassed in Alabama. We are a 49 private bed rehabilitation hospital designed to address every aspect of a patient’s rehabilitation, including physical, social and psychological health. Patient care teams include physiatrists, nurses, nurse practitioners, physical therapists, occupational therapists, speech/language pathologists, recreation therapists, music therapists, psychologists, social workers, orthotic/ prosthetic and other health care professionals from all areas of the UAB Health System as needed. Our team offers a comprehensive care plan that coordinates treatment to meet each patient’s individual needs.

• Given the potential financial penalty for readmissions within 30 days we decided to assess our potential risk.

Medicare is preparing to penalize hospitals with frequent, potentially avoidable readmissions, which by one estimate cost the government $12 billion a year. This reports highlight the amount of resources wasted by reimbursing care provided for potentially avoidable reasons for readmission that would lead to a defined intervention course. Consequently we decided to assess our potential risk.

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Program Changes Implemented

• Increased emphasis by physician/resident/NP team in medication education to improve compliance
• Earlier referral to outpatient therapy to improve timely scheduling of for multi-service patients
• Increased emphasis and education on home exercises programs for all therapy disciplines to better bridge waiting time for outpatient appointments
• Increased referral to home health for patients in rural areas for improved access to therapy services
• Identified need for better process for follow up visits with both primary care and specialty physicians

Next steps

• Plan to use the patient care manager (PCM) system recently implemented in the acute care setting to complete the post discharge phone calls
• PCM RNs will manage any care coordination issues identified and refer any rehab specific issues to the Rehab RNs
• On-going data analysis
• Review patient satisfaction surveys to assess any impact on satisfaction as a result of the post-discharge phone calls

References and Contact

http://www.beckershospitalreview.com/quality/5-core-concepts-to-reduce-readmissions.html

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