Reducing 30 Day All Cause Readmissions

Lexington Regional Health Center

Lexington, NE

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Process of Identifying Need

- LRHC started our work with the Nebraska Hospital Association and HEN in 2012
- We had a baseline readmission rate of 11% which was greater than the national goal of 9%
- We chose to work on readmission and continue to work on readmissions because:
  - We had patients returning to the hospital who were not succeeding at home due to lack of:
    - Resources
    - Education regarding how to manage their disease process
    - A disconnect between acute and post acute services
    - Difficulty with follow-up and access to medical professionals
  - Our readmission rate was higher than expected and higher than the national goal
  - To ensure the patients we serve are able to sustain a quality life outside of the hospital setting in keeping with our mission. Our mission is to optimize the health of our patients and community through innovation and excellence in care, education and service.

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Process Improvement Methods

- The outcomes we wanted to achieve-
  - Optimizing the health of our patients and community
  - Enabling patients to succeed in their home setting post discharge
  - Reducing readmission rate
- A team was created to address readmission, and utilize the PDSA model
- The team's composition and focus:
  - Chief Nursing Officer, Frontline Nursing Staff, Health Information Management, Utilization Review, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, Social Worker, Respiratory Therapy, Home Health and Hospice, Laboratory, Safety and Risk Management, and Providers
  - This team meets monthly to examine the 30 day all cause readmission rate, chart review of the readmissions, patient interviewing and utilizes the PDSA model for continued improvement

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Process Improvement Methods

- Interventions selected to address the challenge-
  - Patient interviewing for cause
  - Stratification of risk
  - Multi-disciplinary huddles and rounding
  - Community collaboration
  - Post visit callbacks
  - Transition Visits
  - Quarterly meetings with skilled nursing facilities and assisted living facilities
  - Disease specific zone education
  - Patient and family advisory council
  - Formation of a transition team
  - Spanish community health worker
  - Transitional care management and chronic care management

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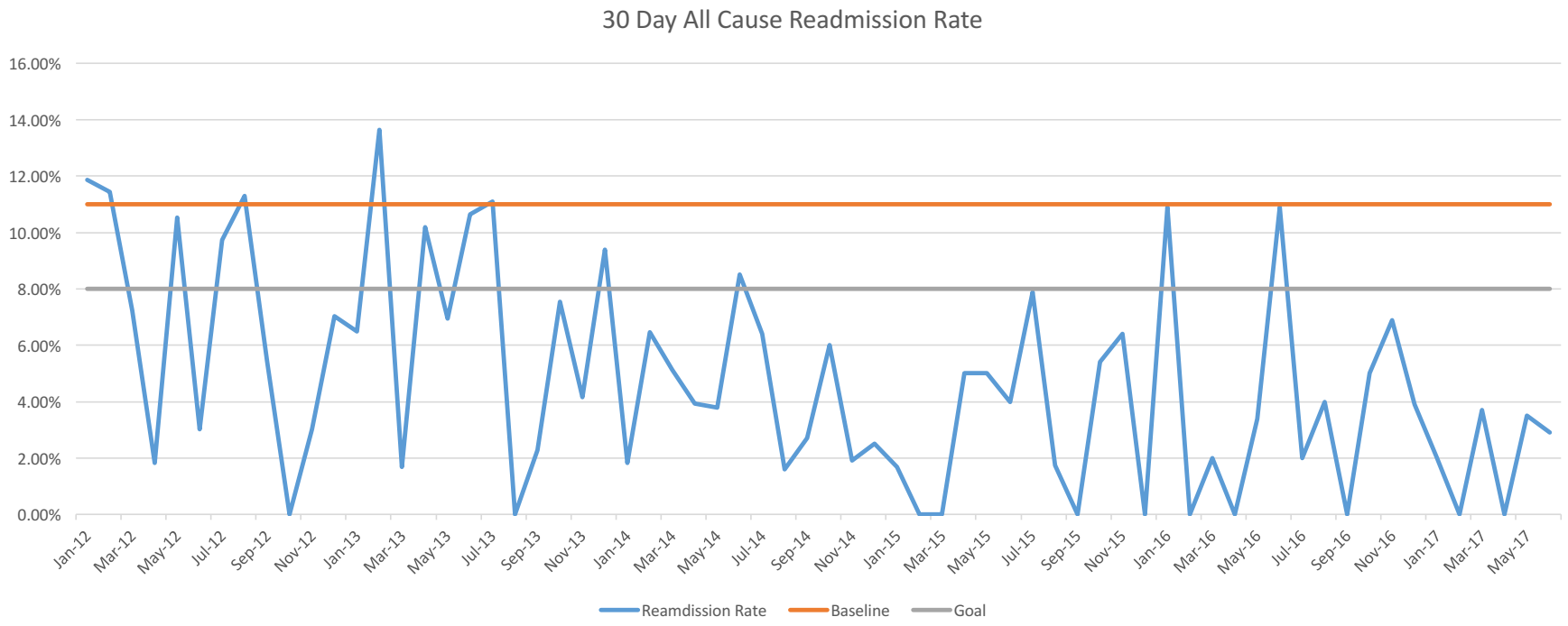
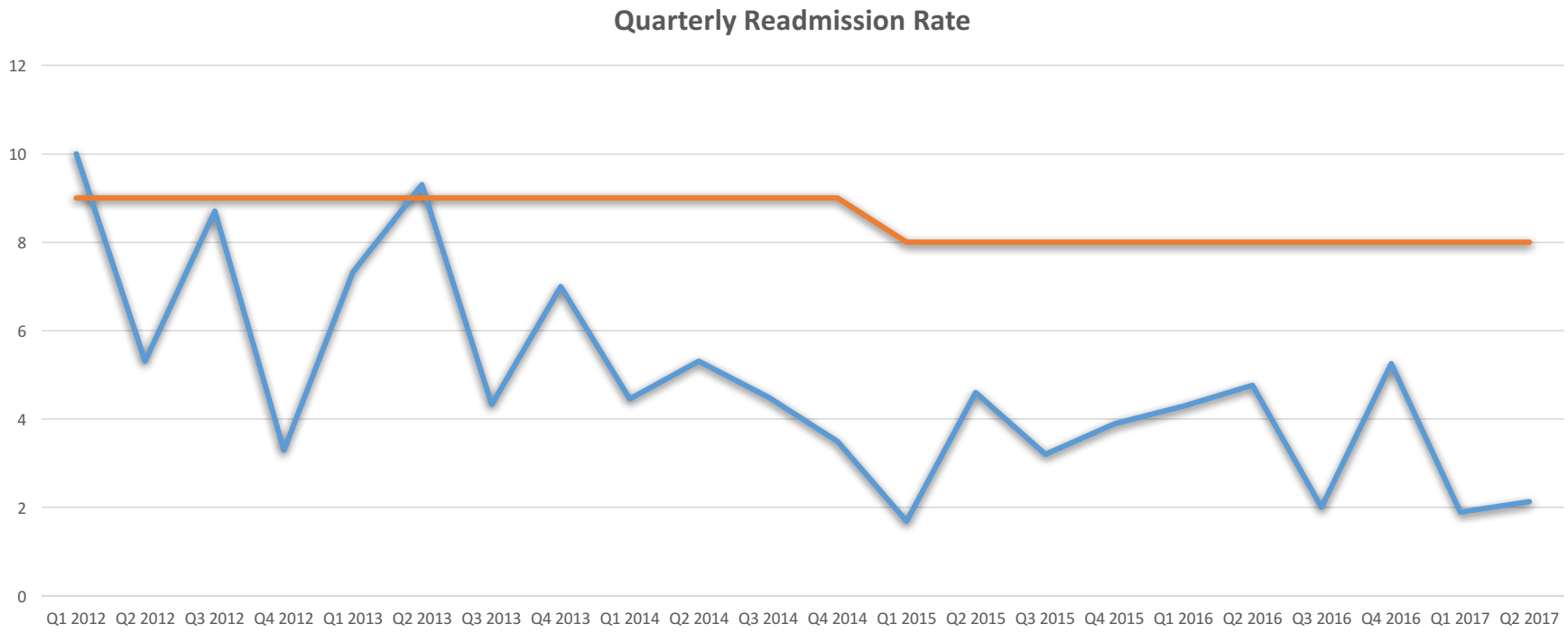
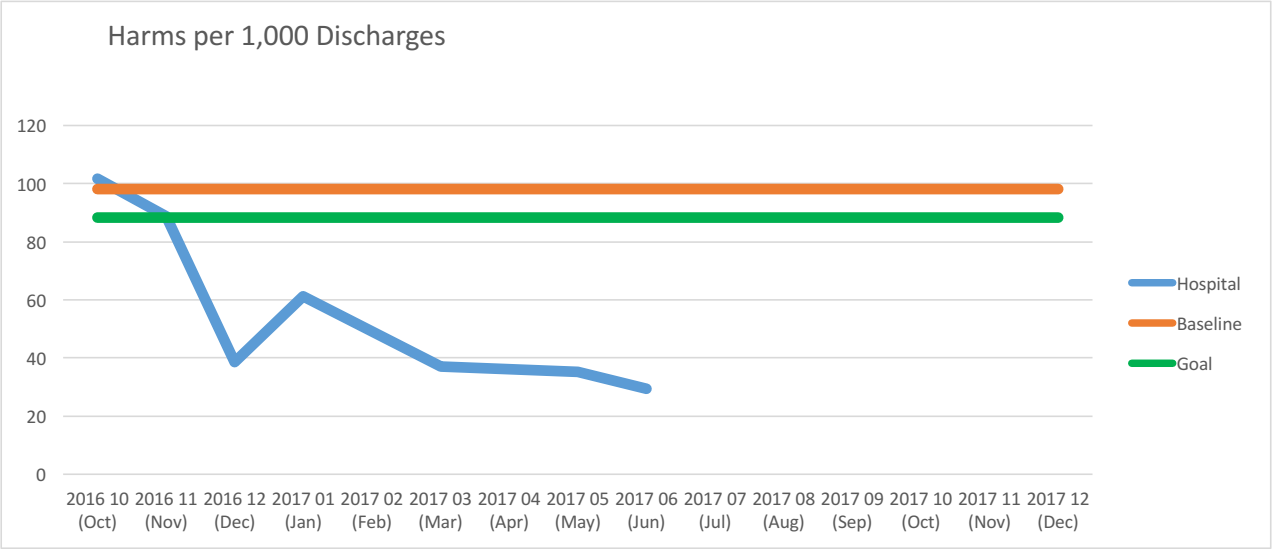
82% Reduction in Readmissions Since 2012



Quarterly Readmission Rate



Recent Harms Prevented



Most Recent Month Harms/1,000 Discharges	29.4	
(% Improvement)	70.0%	
Number of Harms Prevented to Date (*)	23	
Cost Savings to Date (*)	$206,526	
Est. # Harms to Prevent to reach goal	0	

Lessons Learned

- What we have learned/gained-
  - The importance of a patient and family advisory council and the feedback they can provide to facilitate successful implementation of projects is instrumental to success
  - The knowledge gained from sharing ideas with participating hospitals is invaluable
  - The multitude of resources provided has been extremely valuable in our journey to reduce readmissions; from measurement tools, to actual interventions, to implementation
  - The synergy that occurs through collaboration with multiple organizations and other participating hospitals
- What we have learned from our patients-
  - Involve them in the discharge plan from the beginning; set goals; teach them in the way they choose to learn
  - Look at each patient differently- what works for one doesn't work for all
    - Cultural competence is extremely important when working with different ethnicities
  - Patients input prior to implementing new measures is invaluable
  - Have them be a part of the TEAM
- Replicating these results is obtainable by using the vast amount of resources available through the Hospital Improvement Innovation Network and the Hospital Research and Education Trust
  - Take these resources and customize them for your organization
  - Examine your readmissions case by case to determine interventions that will assist your organization to succeed
- Lexington Regional Health Center's results are sustainable through the continued use of the PDSA model and organization wide commitment to provide high quality care

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