Readmission Reduction Strategies: A Community Hospital’s Evidence-Based Practice Pilot Project

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ABSTRACT

All-cause thirty-day readmissions have been identified as being high cost and low quality. In 2012, the Center for Medicare and Medicaid Services (CMS) instituted the Readmission Reduction Program which enforces additional reimbursement penalties for hospitals that have excessive readmission rates.

This article outlines one hospital’s attempt to make a positive impact on readmission rates. Following the Iowa Model of Evidence-Based Practice, best practices were tailored and piloted. Outcomes supported identifying patients that were at-risk for readmission; however, multidisciplinary discharge team communication proved to be complex.

Key words: thirty-day readmissions, Iowa Model, readmission reduction penalty

INTRODUCTION

Over a decade ago, the Institute of Medicine (IOM) released a landmark report that described the healthcare system as being disjointed, chaotic, unsafe, and wasteful. Many governmental and private organizations have responded with recommendations for improvement. The Center for Medicare and Medicaid Services (CMS) has been a major driver for quality and safety improvements in healthcare.[1] One effective method of forcing improvement has been to negatively impact hospital reimbursement for poor quality and safety of care. Rehospitalizations or readmissions have been shown to be costly, wasteful, and ineffective in providing quality and safe care. The CMS enforced additional penalties, starting in the fiscal year 2013, for hospitals that have an excess of all-cause 30-day readmissions. One community hospital took positive action to reduce readmission events by piloting a practice change of their discharge process.

BACKGROUND KNOWLEDGE

In the year 2000, the Institute of Medicine (IOM) released a landmark report describing the state of the healthcare system.[2] Poor safety and quality care was evident by the statistics that were reported. Between 44,000 and 98,000 deaths a year were attributed to medical errors.[2] This report was followed by another IOM report which challenged healthcare providers and systems to adopt six aims for improvement: safe, timely, efficient, effective, equitable, and patient-centered care.[3] One area, which has since been identified as a gap in safe and quality care, is safe transitions from setting to setting. The Agency for Healthcare Research and Quality (AHRQ) has linked hospital readmissions with poor quality and safety of care during setting transitions.[4] Readmissions therefore reflect a gap in the IOM aims of patient-centered, safe, efficient, and effective care.
A readmission is defined as a repeat hospitalization following the most recent hospital discharge.\[5\] Ninety percent of readmissions within 30 days are considered to be unplanned and seventy-five percent are considered to be preventable.\[4,6\] Preventable readmissions reflect poor efficiency and effectiveness of the healthcare system and poorly coordinated patient-centered care. Additionally, readmissions are considered to reflect an unsafe transition between the hospital and the home-setting.

Nearly 20% of Medicare hospitalizations are followed by readmissions within 30 days.\[4,5,6,7\] MedPAC reported to the United States (US) Congress that readmissions are an area of high cost and low quality.\[5\] In fact, Medicare readmissions cost the government approximately $15 billion annually.\[5,6,8\] In response, beginning in October 2012, hospitals with above expected rates of readmissions are penalized with up to 1% less Medicare reimbursement.\[4\] According to the Patient Protection and Affordable Care Act and the Readmission Reduction Program, the payment reductions will be reduced by an additional 1% for the next three years.

**LOCAL PROBLEM**

A small community Ohio hospital recently agreed to participate in the Ohio Hospital Association (OHA) and the Ohio Patient Safety Institute (OPSI) Hospital Engagement Network (HEN). The HEN is funded by the Centers for Medicare and Medicare Services (CMS) and includes the Partnership for Patients (PFP) project. The PFP project is a quality improvement initiative that focuses on preventing patient harm from ten areas. Included in these ten focus areas are adverse drug events, catheter-associated urinary tract infections, surgical-site infections, central line-associated blood stream infections, injuries from falls and immobility, venous thromboembolism, obstetrical adverse events, pressure ulcers, ventilator-associated pneumonia, and preventable readmissions. The PFP’s overall three year goals are to reduce inpatient harm by 40% and readmissions by 20%.\[8\] Each hospital was to form or utilize an existing committee to oversee strategies for improvement for these high volume, high risk, and high priority areas.

This Doctor of Nursing Practice (DNP) student was offered the opportunity to be involved, in this new hospital partnership, through a capstone project. The involved hospital is a small acute-care 125 operational bed community hospital. The breakdown of licensed beds includes 32 operational medical-surgical/telemetry beds, 15 beds for an orthopedic surgical unit, 9 beds for a combined intensive-coronary care (ICU) unit, 50 beds for a long-term care unit, and 19 obstetric/nursery beds. The hospital’s Performance Improvement Committee (PIC) is serving as the PFP’s required oversight team. Due to potential financial impacts, the PIC team decided to target the reduction of all-cause 30-day readmissions as a priority. The PIC team then decided to form a smaller project team and named it the Readmission Reduction Team. The DNP student was the project leader and the Performance Improvement (PI) Coordinator was the team leader.

At the time of the HEN agreement, all-cause readmission metrics were not being collected nor trended. Retrospective all-cause 30-day readmission data, for this target hospital, was gathered by the DNP student and the PI Coordinator. For comparison, all-cause readmission rates from the first quarters of 2011 and 2012 were collected. In 2012, first quarter discharges totaled 1028 with total all-cause 30-day readmissions totaling 149. By dividing the total number of all-cause 30-day readmissions by the total number of discharges, the readmission rate was calculated to be 14.5%. For the first quarter of 2011, the total discharges were 975 and the total all-cause 30-day readmissions were 142. The calculated readmission rate for the first quarter of 2011 was 14.5%. It was concluded that all-cause 30-day readmission rates for the past two years, during the first quarter, were exactly the same and therefore comparable in overall sample. This first-quarter all-cause 30-day readmission rate was also consistent with this hospital’s overall 2011 all-cause 30-day readmission rate of 15%. These readmissions rates were consistent with, but slightly lower than, the national readmission rate of 19.6% for Medicare beneficiaries.\[4,6,7\]
INTENDED IMPROVEMENT

The American Hospital Association stated that decreasing preventable readmissions will improve quality of care and lower healthcare spending.[9] The National Priorities Partnership (NPP) cites the cost of preventable readmissions to be approximately $25 billion annually. In addition to cost, quality of care can be viewed in many ways including, but not limited to, patient satisfaction, patient safety, quality of life, value of healthcare services, ability of the patient to self-manage post-hospital care, patient injuries or death, and unplanned readmissions. Many strategies and programs have been initiated in an effort to research the causes and develop evidence-based practices for hospital readmission reductions.

The Agency for Healthcare Research and Quality cites a few causes for preventable readmissions as being poor transfer of information to the patients through discharge instructions, lack of timely follow-up post discharge, and lack of medication reconciliation.[4] These identified causes are supported by a 2006 survey that found that 60% of readmitted patients did not receive home self-management education, and 80% of readmitted patients did not receive a home health referral when they were eligible.[11] In a 2009 analysis of readmitted Medicare patients, 50% had not seen their primary physician between the time of hospital discharge and hospital readmission.[11]

The STate Action on Avoidable Rehospitalizations Initiatives (STAAR), supported by the IHI and The Commonwealth Fund, is one program that provides guidelines for readmission reduction strategies.[5] Strategies for improvement from the STAAR program include system-wide interventions across the continuum of care, comprehensive discharge planning with the patient and caregivers, patient and caregiver engagement and education on self-management, and post-discharge support.[5]

Strategies for improvement should include a clear discharge plan that is tailored to each patient and caregiver, nurse advocates that arrange follow-up care and appointments, and medication reconciliation and education.[10] The Re-Engineering Discharge (RED) project from the Boston University Medical Center outlined 11 components of the discharge process that were shown to decrease the Emergency Room (ER) use and readmission rates by 30%.[5] The RED project was developed with the theory that readmissions could be prevented if underlying causes were identified and addressed. The Boston University developed three intervention components that included: a Discharge Advocate that coordinated discharge information, patient education and after-care needs, an after-hospital care plan that was individualized for each patient, and a clinical pharmacist that was involved with after-care medication reconciliation and education.[12]

Transferring Care at the Bedside (TCAB), a Robert Wood Johnson Foundation supported care-delivery philosophy, utilizes four-core elements to create an ideal transition home: enhanced admission assessment of post-discharge needs, enhanced teaching, enhanced patient-centered hand-off communication, and enhanced post-acute follow-up care.[5] Project BOOST (Better Outcomes for Older Adults through Safe Transitions), supported by The Society for Hospital Medicine (SHM), is another program that includes strategies for patient education, improved discharge processes, and a more fluid transition between care settings. This project utilizes a team approach for a discharge process that identifies patients at risk for readmissions, prepares the patient and caregiver for the discharge transition, utilizes a teach-back process, and communicates key information to follow-up clinicians.[5]

Clearly, best-practice readmission-strategies have common themes that can be tailored to each healthcare organization. This project hospital utilized the Readmission Reduction Team to map their current discharge process, identify gaps in the process, and tailor best practice strategies for a pilot project. From the pilot, the team gathered and analyzed monthly data to make final recommendations to the overseeing hospital PIC team.
STUDY QUESTION

The **problem was all-cause readmissions of patients** to the hospital following a discharge from the hospital within 30 days or less; the **intervention was to** tailor best practice readmission strategies to one small hospital’s 32 operational-bed medical-surgical/telemetry unit; the comparison was usual discharge procedures from retrospective record analysis compared to best practice discharge processes tailored to this unit; the expected **outcome was the** reduction in all-cause 30-day readmission rates; and the timeframe was within three months. The final PICO-T question was: since all-cause 30-day readmissions reflect poor quality care and are costly, how can best practice discharge strategies be tailored, for one small hospital’s 32 operational-bed medical-surgical/telemetry unit, to reduce 30-day readmission rates compared to the current and usual discharge procedures, within a three-month period?

METHODS

The Iowa Model of Evidence-Based Practice (EBP) is primarily utilized as a guide for practitioners to improve healthcare outcomes. This model provides a framework for a planned action process with assumptions of a team approach. The Iowa Model has been requested for use at least 1200 times and has been cited at least 95 times in nursing journals, thus supporting credibility.[13] This project leader used the Iowa Model to guide the team through the exploration and implementation of best practices to reduce all-cause 30-day readmission rates.

The Iowa Model is composed of a series of triggers, tasks, and decision points. Triggers are factors that stimulate the team to think about a practice or action and question the rationale. A trigger will initiate questions, research, and innovations. There are problem-focused triggers such as quality improvement data and knowledge-focused triggers such as organizational standards and guidelines.[14] There are two decision points in the Model that prompt the team as to whether they should progress. The Model steps include asking the research question, forming a team, assembling and synthesizing the evidence, piloting a practice change, evaluating the change for adoption, monitoring the outcome data, and disseminating the results.[14,15]

The project was started by forming an ad hoc team of key staff members to analyze the issues and develop best practice strategies for all-cause readmission reductions. The project leader and PI Coordinator met with the Chief Nursing Officer (CNO) and the Chief Quality Officer (CQO) to discuss the formation of a Readmission Reduction Team. It was decided that the team would be comprised of front-line discharge staff including the PI Coordinator, Infection Control (IC) Nurse, Care Manager, Social Worker, Unit Manager, staff Registered Nurse (RN), Clinical Pharmacist, and Respiratory Therapist. Since the most commonly readmitted patient diagnosis is heart failure, acute myocardial infarction, and pneumonia [5, 8, 10,] it was decided that the readmission reduction strategy would be focused on the unit that admits these types of patients, Unit 3.

The goal of this project was to improve patient/family-centered care for this acute-care hospital, 32-bed unit by reducing all-cause 30-day readmissions. Following the Iowa Model of Evidence-Based Practice, the team worked through four main objectives. First, the team researched and analyzed the best practices for strategies that could be tailored to match the hospital. Second, the team planned and implemented a pilot project of a tailored best-practice strategy. Third, the team monitored the implemented strategies for consistency and compliance and collected monthly readmission rates for evaluation. Fourth, data from the pilot study was analyzed to determine adoptions or revisions of the final recommendations. The expected overall outcome measure was to reduce the all-cause 30-day readmission rate by 3% within a three-month pilot period.
The team met to map the current discharge process and assess for gaps as compared to best practices for reducing all-cause 30-day readmissions. Best practices were used for comparison from the BOOST project, TCAB strategies, the RED project, and the STAAR initiatives (Table 1).

<table>
<thead>
<tr>
<th>Strategy Categories</th>
<th>BOOST (Society for Hospital Medicine)</th>
<th>STAAR (Institute for Healthcare Improvement)</th>
<th>RED (Boston Univ.)</th>
<th>TCAB (Robert Wood Johnson Foundation &amp; IHI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Discharge</td>
<td>1. Identifies at risk</td>
<td>1. Enhanced assessment of needs</td>
<td>2. Discharge Advocate</td>
<td>1. Enhanced assessment of needs</td>
</tr>
<tr>
<td>Discharge</td>
<td>1. Multidisciplinary team approach</td>
<td>2. Hand-over communication</td>
<td>2. Outstanding tests communicated to next provider</td>
<td>2. Patient-centered hand-off</td>
</tr>
<tr>
<td></td>
<td>4. Enhance follow-up care</td>
<td>5. Written discharge plan</td>
<td>5. Written discharge plan</td>
<td>4. Follow-up care arranged</td>
</tr>
<tr>
<td>Post-Discharge</td>
<td></td>
<td>1. Telephone reinforcement</td>
<td>1. Follow-up telephone call</td>
<td></td>
</tr>
</tbody>
</table>

Common best-practice strategies include identifying patients that are at-risk for readmission, medication reconciliation, clear and consistent communication across healthcare providers and settings, teach-back education, follow-up appointments made prior to discharge, and follow-up telephone calls after discharge.

ETHICAL ISSUES

The project leader was a Doctor of Nursing Practice (DNP) student as well as a contingent employee of the hospital. Hospital approval was obtained from the Chief Nursing Officer (CNO), Chief Quality Officer (CQO), Chief Administrative Officer (CAO), and the Medical Director of Quality Improvement. Institutional Review Board (IRB) approval was also obtained from the DNP student’s university. All identifying patient data was collected for aggregate data trending only. All confidential patient information was either shredded, once counts and percentages were calculated, or kept locked and confidential with the hospital PI Coordinator. Only counts, percentages, diagnoses, and locations of admission and discharges were trended and reported.

INTERVENTION

Barriers and facilitators were analyzed. The team was limited to strategies that utilized current staffing patterns. Additional barriers included potential resistance from discharge staff members for any change that
may affect individual roles and responsibilities. In addition, any potential strategies that may affect physician practices were expected to be met with resistance. Facilitators included the involvement of the OHA, the care managers, and the social workers. Financial implications of excessive readmissions were also seen as a positive influence for change.

The team recognized that communication between care providers were often inconsistent. All care providers had their own electronic charting section but there was no single area that summarized discharge plans. Poor communication has been well documented as a barrier to effective discharge planning.[16,17,18,19,20] In addition, there was no assessment tool being used to identify patients at-risk for readmission. Best practices indicate that early assessment and recognition of readmission risks is a significant piece of discharge planning. The team felt that these two areas would be a good start to improving the discharge process.

The pilot project took place on the hospital unit with the high readmission diagnoses (Unit 3). The team decided that a common communication tool would enhance discharge planning communication between care providers. Discussion was held regarding an electronic charting tool or a paper tool. For the three-month pilot, it was decided that a paper tool would be more appropriate. Within three months, the team could then evaluate the utilization of the tool and suggest improvements or changes that were needed. Two team members drafted a single-page communication tool that included areas for documentation of discharge needs and arrangements. A few checkboxes were placed on the sheet for easy identification of factors such as support-systems and living arrangements.

In addition, the team felt that it was important to identify patients at-risk for readmission. Once a patient was identified as being at-risk, additional attention could be placed on identifying needed discharge services related to the patient’s at-risk factors. Several at-risk tools and checklists exist in literature with few of them being studied for reliability or validity. IHI has identified characteristics of patients that are frequently readmitted. These characteristics include, but are not limited to, previous admissions, lower socioeconomic status, limited support, living alone, the need for assistance for activities of daily living, confusion, and difficulty reading. The BOOST program has an evaluation tool that screens eight points of risk including, but are not limited to, certain medications, certain psychological conditions, certain diagnoses, polypharmacy, patient support, and prior hospitalization.

Manning has a heart failure (HF) screening tool that includes, but are not limited to, HF as primary diagnosis, co-morbidities, certain serum blood levels, age greater than 65, ethnicity other than Caucasian, low socioeconomic status, and living alone.[21] The Blaylock Risk Assessment Screen (BRASS) was reported to be both valid and reliable in identifying patients at low, moderate, and high risk of readmission. Risk factors on the BRASS tool includes, age, living situation and support, functional status, cognition, behavior pattern, mobility, sensory deficits, number of previous admissions, number of medical problems, and number of prescribed medications.[22]

The team wanted a quick and easy assessment checklist that the Care Managers could complete with the data that is already gathered on admission. All of the common risk factors were reviewed for relevance in the population served by this hospital. The most used and relevant risk factors included: a readmission within 30 days, a high volume admission diagnosis, three or more chronic conditions, age 65 or older and living alone, needing assistance with activities of daily living (ADLs), and greater than eight scheduled medications per day. It was decided if a patient had 3 out of these 6 factors, that patient would be acknowledged as at-risk for readmission.
The process of the interventions was mapped, approved by all necessary hospital committees, and communicated to everyone involved. A two-sided tool was developed with one side being the at-risk assessment, and the other side being a multidisciplinary communication sheet. The Care Manager initiated the two-sided tool, completed the at-risk assessment, and indicated, with a checkbox, if the patient was identified as being at-risk for readmission. The two-sided communication sheet was then placed on the patient’s bedside clipboard. The communication sheet was to be utilized, by all entities caring for the patient, to communicate discharge needs, plans, or arrangements that were completed. In addition, the communication tool was to be utilized during discharge rounds to better coordinate care. The intent was that any healthcare provider could determine, at anytime, the patient’s readiness for discharge. Upon discharge, the two-sided tool was returned to the PI Coordinator.

One month was spent on educating all disciplines on the two-sided tool, the purpose of the tool, and process of utilizing the tool. Entities that were educated included the physicians, unit nurses, unit secretaries, care managers, social workers, respiratory therapists, physical therapists, occupational therapists, the dietician, clinical pharmacist, wound care nurse, intravenous therapy nurses, and medical records workers. After education was completed there was a one-week gap before the pilot could be initiated. Laminated reminders were posted in the physician lounge, care managers and social workers data stations, the unit’s charting area, and each patient bedside charting box. Email reminders were sent regarding the start date, purpose, and process of the pilot.

Once the pilot was initiated, daily checks were done by one of the Readmission Reduction Team members to ensure flow of the process and troubleshoot any problems. The two-sided tools were gathered on a daily basis and trended on a developed data collection tool. This tool included the patient’s date of admission, admission diagnosis, if a tool was initiated, the at-risk status, if the tool was returned, if the communication tool was utilized, to what extent the communication tool was utilized, whether the patient was readmitted within 30 days, and the diagnosis of the readmission.

**METHODS OF EVALUATION**

Donabedian identified operational components for measuring quality and quality improvement activities. Donabedian believed that monitoring was needed in the components of structure, process, and outcome. For this project, the structure was monitored and evaluated by examining the At Risk tool. The process was monitored and evaluated by analyzing how and by whom the communication tool was being utilized. The outcome was monitored and evaluated by calculating readmission rates.

Readmission rates are used as a before-and-after comparison metric. Since readmission rates are used by CMS to determine quality care and hospital reimbursement, they are an appropriate and measurable patient outcome. All-cause 30-day readmission rate is defined as the number of discharges that are readmitted, for any reason, within 30 days, divided by the total number of discharges. A hospital admission is defined, for this project, as an acute medical, surgical, or cardiac admission of an 18-year-old or older patient. For this project, a 30-day readmission is defined as an admission, to Unit 3, of a previously discharged patient from any unit within this target hospital within the first 30 days of the discharge and for any cause. Obstetric patients and corresponding infants were omitted from these counts. In addition, those readmitted patients that had originally been discharged from a different facility were omitted from these counts. The 30-day readmission rates were calculated for the hospital on a monthly basis. The metrics from the project months were compared to the metrics from the corresponding months of the previous year. The goal was to reduce the overall all-cause 30-day readmission rates by 3% as compared to the previous year.
Pilot outcomes were developed to measure the effectiveness and utility of the two tools. The first measure reflected the effectiveness of the At Risk tool, in identifying those patients who were at risk for readmission within 30 days. This was completed by comparing those 30-day readmission patients to the patients who were identified as being at-risk. The number of readmitted patients who were identified to be at-risk and were readmitted within 30 days were counted. The number of patients who were not identified as being at-risk but readmitted within 30 days were also counted. A simple risk ratio was calculated from a contingency table. This was used to help evaluate whether the team was accurately identifying patients at-risk. A risk ratio greater than 1.0 indicated a more than equal chance that the target group was more likely to be readmitted. This metric was utilized to monitor the structure of the quality improvement activity.

In addition, the initiation of the At Risk tool is a necessary part of the structure. In order to determine if the At Risk tool was being completed, a second outcome was measured. The total amount of Unit 3 admissions, observations, and transfers were divided into the number of completed At Risk tools. The goal was that 100% of patients on Unit 3 would have an At Risk tool completed. However, the success was dependent on the number of At Risk tools that were retrieved from the discharge charts and returned to the project or team leaders. Therefore, the rates of returned tools were also tracked.

The process was evaluated by analyzing the utilization of the multidisciplinary communication tool. Utilization was categorized as no documentation, check boxes only, or some discharge information including new recommendations. This allowed the team to analyze gaps in care, communication, and healthcare provider follow-through. To evaluate the overall three-month pilot, readmission rates, risk ratios, and utilization of the pilot tools were analyzed by the Readmission Reduction Team. This final data, as well as revisions and recommendations for adoption, were reported to the PIC team, the OHA representative, and other required hospital committees.

OUTCOMES

The trial was conducted from November 7, 2012 through January 31, 2013. During the fourth-month post-pilot (February 2013), the team met to evaluate the aggregated three-month data. Following Donabedian’s quality measurements, the process, structure, and outcomes were tabulated and analyzed. Recommendations were made regarding adoption and alterations of the pilot tools and process.

The two-sided At Risk and Communication tool was trended to evaluate if the tool was being initiated and utilized on all Unit 3 admissions, observations, and transfer patients. It was found that in November, 94% of all patients had a two-sided tool on their clipboard; in December, 86% had a tool; and in January, 84% had a tool. The team also tracked to see if the two-sided tool was returned to the PI Coordinator after the patient’s discharge. In November, 100% were returned; in December, 89% were returned; and in January, 85% were returned. The conclusion was that the goal of 100% was not met in two of the three pilot months. However, the majority of patients did have the Communication tool initiated and returned. The slight decline in percentages over the three months reflects a natural decline of compliance. In addition, during the months of December and January, the care manager staff was inconsistent due to illness and holiday time. Even with a low 84% of Communication tool initiation, it was felt that the analysis of data would represent the majority of Unit 3 patients.

Utilization of the Communication tool was analyzed. Returned sheets were reviewed for any communication of discharge needs. Three categories were trended: no documentation (the sheet was blank), check-boxes only, and discharge information or a new recommendation. Overall, it was observed that of 546 total sheets within three months, only 36% of the Communication tools were utilized for a discharge need or
The majority of Communication tools, 64%, were blank or had only one or two boxes checked.

The assessment of patients that were identified as being at-risk for readmission was trended for the three pilot months. Of the total Unit 3 admissions, 40% of patients were identified as being at-risk; in December, 51% of the total Unit 3 admissions were identified as being at-risk; and in January, 49% of the total Unit 3 admissions were identified as being at-risk. The average of the Unit 3 admissions that were identified as being at-risk in the three month pilot was 47%. By using a risk-ratio contingency table, the probability of patients that were identified as being at-risk and readmitted within 30-days was calculated. The first data set was collected at the end of November. This data reflected the October admissions pre-pilot probability of at-risk patients who were readmitted within 30-days. The calculation revealed that those patients who were at-risk were seven times more likely to be readmitted. This at-risk screening however was completed during the readmission phase. The calculations for both December and January readmissions indicated that those patients who were identified as being at-risk were four times more likely to be readmitted.

Analysis of this data indicates that the At Risk tool was able to identify those patients that were four times more likely to be readmitted within 30 days. In addition, for the pilot months of November and December, the probability of patients identified as being at-risk and readmitted within 30 days was reduced from seven times more likely to four times more likely. This data reflects that the At Risk tool was effective and the pilot months showed an improvement in patient readmission risk. It is important to focus on these at-risk patients since they represent almost half of the total patient census on the target unit.

Outcomes were reflected in calculated readmission rates. To appropriately evaluate the outcomes of the pilot months, a month-to-month comparison of the current and previous year was completed. In November 2011, the readmission rate was 17.5%; in November 2012, the readmission rate was 13%. This indicates a 4.5 point reduction in the readmission rate. In December 2011, the readmission rate was 15%; in December 2012, the readmission rate was 13%. This indicates a 2 point reduction in the readmission rate. In January 2012, the readmission rate was 21.8%; in January 2013, the readmission rate was 16%. This indicates a 5.8 point reduction in the readmission rate. Overall, the average reduction in readmission rates, for the three-month pilot, was 4.1 points in the readmission rate.

DISCUSSION

The Communication tool was not shown to be utilized as the team had planned. Several factors could affect this as well. First, there was a one week delay between when the tools were initially planned to be implemented and when they actually were implemented. This delay could have led to a lack of interest, loss of a sense of urgency, or a lapse of memory regarding the use of the tool. Additionally, one of the Unit 3 team members went on medical leave before the implementation of the pilot. There was no contingency plan to replace her on the unit and therefore there was a void in the team’s daily follow-up plan. This same RN was also the only nursing staff that participated in discharge rounds. Consequently, discharge rounds also had a void with no nursing replacement.

The At Risk tool did indicate that care managers were able to identify patients that were at risk for readmission. However, during this three-month pilot, the patients who were identified as being at-risk did not receive any additional focused attention than the patients who were not at-risk. Further processes need developed to heighten awareness and better coordinate discharge needs of at-risk patients.
LIMITATIONS

One of the most significant limitations to this pilot was that the project leader was not available in the hospital on a daily basis. The project leader works full time outside of the hospital. While readily available by phone and accessible at least twice a week in person, a daily reminder or visit would have most likely improved compliance of the communication tool.

Lack of nursing presence in discharge rounds have been identified as a significant gap in continuity of care. Lack of coordination of discharge needs is evident in the identification of communication problems and yet no utilization of the communication tool. Finally, administrative support is needed to communicate and support quality care during the hospital stay and through the transition of settings.

CONCLUSION

The At Risk tool is seen as a positive way to identify patients in need of more focused attention regarding discharge needs. An electronic prompt would allow this at-risk status to be more visible and accessible to the healthcare team. Communication is a multi-faceted problem in any setting. Multidisciplinary teams are needed to properly care for today’s complex patients; hence necessary communication avenues are needed for coordinated discharge planning. A single electronic charting screen for discharge processes would be beneficial for communication coordination. Finally, a single person that coordinates discharge processes and follow-up care is well documented and supported in literature. Such a position has been called Transition Nurse, Discharge Nurse, Discharge Advocate, or Transition Advocate to name a few. Regardless of the name, if resources are available, it has proved to be successful in reducing readmission rates.[12,24,25,26]

CITATIONS

9. American Hospital Association. Trendwatch: examining the drivers of readmissions and


