Presby's Story Readmissions

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HRET
HEALTH RESEARCH & EDUCATIONAL TRUST
In Partnership with AHA

Objectives & About Us

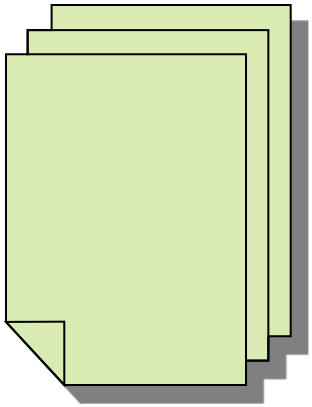
- For over a 100 years, the Ashford Presbyterian Community Hospital or “El Presby”, has maintained its reputation as one of the most advanced nongovernmental hospitals in the Caribbean,
- Located in the San Juan Tourist Area: *El Condado,*
- Offers Primary & Secondary Care and Ambulatory Services,
- Licensed 200 Beds serving mostly the Metro/North part of the Island,
- Providing medical assistance to nearby Caribbean island residents and receiving a lot of Puerto Rico’s tourist population
- Our mission is to

  “provide excellence in service with human quality”

Tests & What we Learned

Started to analyze and test some basic components:

- **FOR THE PATIENT**
- Does patient receive understandable and complete discharge **education** prior to leaving the hospital?
- Does patient receive understandable and complete discharge **education** as to medications the patient should continue post-discharge?
- Does patient receive information of care post-discharge or possible symptoms post-discharge?
- **FOR THE HOSPITAL**
- Analyze our resources
- Look for evidence of best practices
- Collect a baseline data



Barriers & How we Resolved

BARRIERS

1. Patient behavior or compliance with post treatment
2. Poor relationship between physician, nurses and patient
3. Assure continuity of care post-discharge
4. Little cooperation from family members

RESOLVED

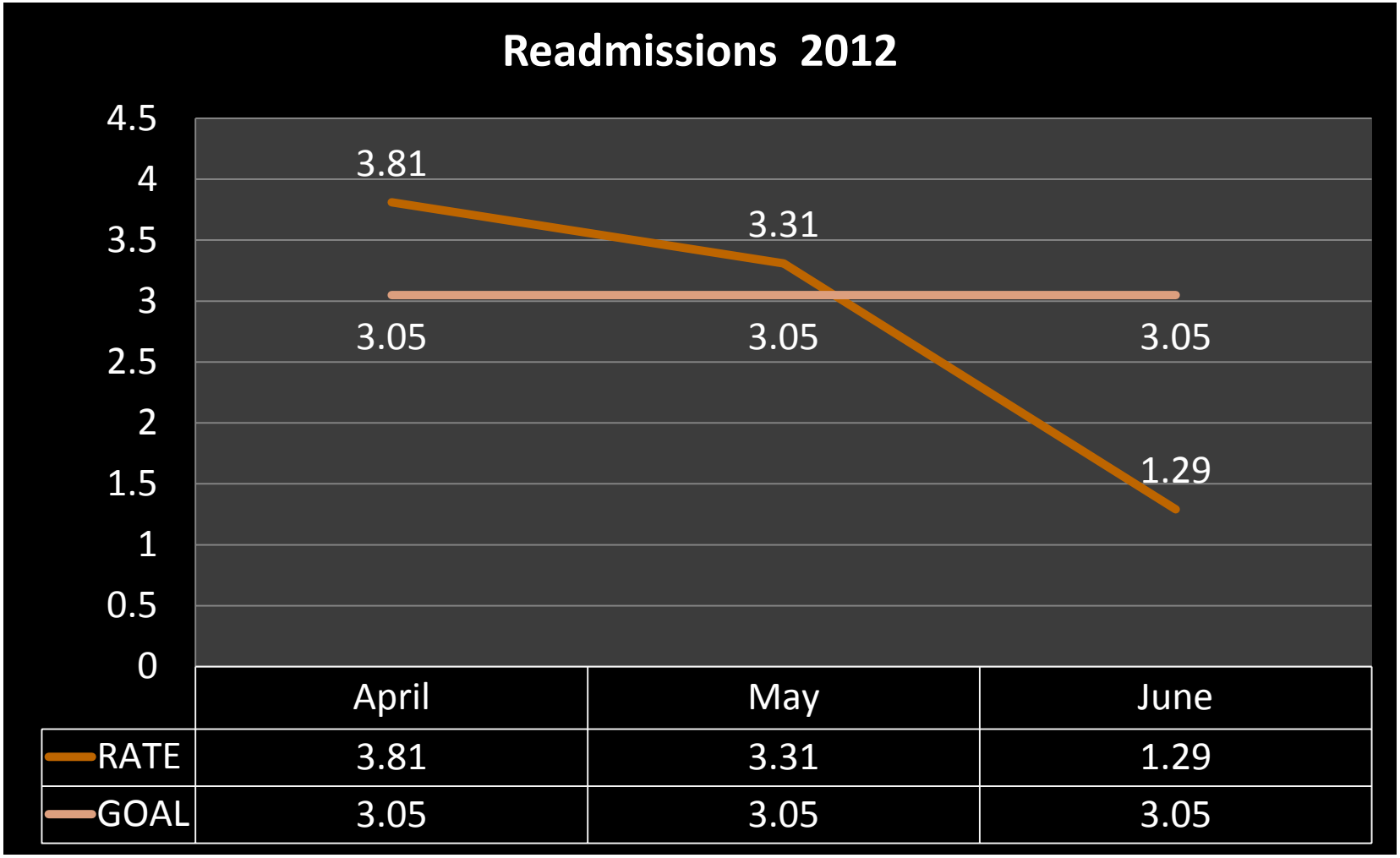
- ✓ 1. Discharge planners (care coordinators) interact with patients from admission to discharge. Information about their diagnosis, treatment, medications and post care is given.
- ✓ 2. Evaluate these situations through a patient satisfaction assessment, bring in your Patient Advocate.
- ✓ 3. Follow up with patient, communicate with the next health care provider if necessary.
- ✓ 4. Identify special needs early, promptly consult Social Work for assistance and guidance

Measures – What & How

- Currently measuring surgical / medical patients
  - All Medicare Patients and Medicare Advantage
  - 30 Days Readmissions
  - Knowing if Readmission time interval is less than 30 days than it was more than likely preventable
  - Do not assume a high hospital readmission rate indicates a hospital provides poor patient care, the analysis should be able to provide a root cause to focus on.

- Core Measure Analysis
  - Acute Myocardial Infraction (AMI)
  - Heart Failure (HF)
  - Surgical Care Improvement Program (SCIP)
  - Pneumonia Measures (PN)

GOAL: REDUCE READMISSION BY 20%



Advice for Others

- Identify your patient population
- You need team effort:
  - Physician, Quality, Infection Control, Discharge Planning, Social Work, Nursing and Case Managers

- Open Discussion is necessary:
  - In regular Utilization group meetings we discuss readmissions & analyze results (9:00 a.m./2:00 p.m.)
- Patient needs follow up:
  - Discharge Planning Secretary calls patient after 48 hours to check home care and skilled nursing services
  - Case Managers provide questionnaire for patient to complete concerning adequacy of discharge process

Wrap Up & Next Steps

- ❑ Regard Discharge Planning as a Teaching Opportunity
  - ❑ Make instructions simple, clear and precise (Go Slow)
  - ❑ Use Teach Back
- ❑ Practice and Document Patient Education
- ❑ Assure Patient knows what to do post discharge with post discharge symptoms
- ❑ Involve Family members early
- ❑ Have Discharge readiness for a safe and efficient transition of care

✓NEXT STEP: KEEP PERFORMANCE IMPROVEMENT AS A GOAL

Contact Information

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