California Health Improvement Project (CHIP)
Patient Focused Interventions: Reduce Readmissions

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Problem Statement and Underlying Causes

Patients were being readmitted within 7 days at a high rate. Identification of multiple life limiting comorbid conditions were evident in physician history and physical and/or discharge summary but there was no evidence of health care team evaluation of likelihood for readmission or death due to these comorbid conditions. There are 17 long term care facilities within 10 miles of the hospital using RCH as their acute care treatment center. These residents with multiple life limiting conditions requiring residential care do contribute to the readmission rate.

High Readmission Without Evidence of Life Care Planning

Early Identification of Potential for Readmission with Documentation of Life Care Planning

Project Description

This CHIP's focus was to develop an organized intervention in hospitalized patients with a moderate to high probability of readmission or early death. Application of the intervention sequence would alert all members of the health care team.

Goal and Objectives

Goal:

A) Early identification and intervention in patients with moderate to high probability of readmission or early death due to the presence of life limiting conditions.
B) Improving the patient experience and reductions in readmissions is essential to the financial health of the organization in the presence of heightened awareness of quality initiatives in patient care and the Affordable Care Act mandate of value based purchasing.

Output-oriented Objective:

100% of admissions screened using evidence based tool, initiation of patient focused interventions for moderate to high probability of readmission or early death.

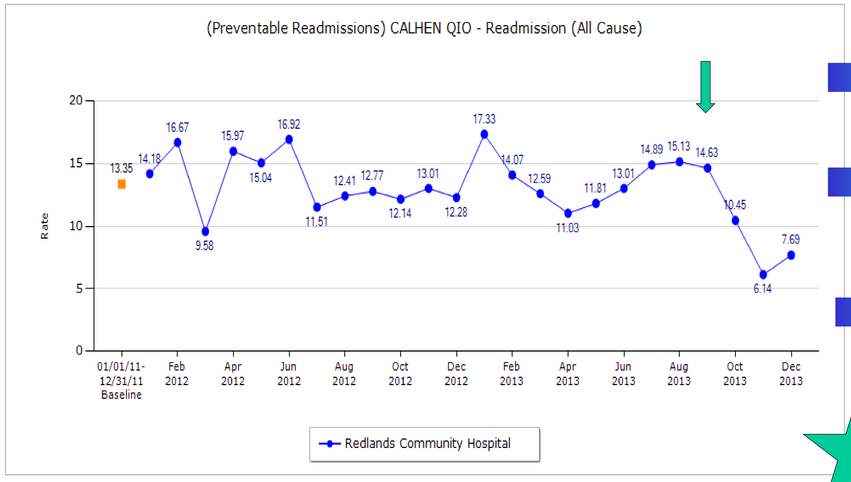
Outcome-oriented Objective:

Early identification and discussion regarding intensity of service in the hospital with reduction in readmissions.

Outputs & Outcomes

Outputs Achieved

- 100% of newly admitted patients screened using evidence based tool.
- Tool is imbedded in the electronic medical record with reference to algorithm based on scores.



Early identification and interventions resulted in documentation of advanced illness management in 100% of the medical records and an 18% reduction in readmissions to the hospital in identified patients.

The green arrow indicates the month of initiation of the use of the LACE tool and the application of interventions by the RN Case Managers utilizing the algorithm chart .

The "LACE" tool calculates the readmission risk score based on Length of stay, Acute admission through the emergency department, Comorbidities (based on the Charleston index) and Emergency department visits in the past six months. The higher the score indicates a higher risk for readmission or early death.

These interventions included family meetings to discuss goals of care, social service palliative care evaluation; Advanced Illness Management referral, Home Health referrals, POLST discussions with the attending and the patient with family/support system.

Outcomes Achieved

- 18% reduction in readmission for all causes and from all settings. (see graph).
- CMS has established a Star system for Value Based Purchasing and RCH is close to achieving 5 Star status.

Lessons Learned

Establish hospital wide education and demonstration of the tool and its elements.

With Value Based Purchasing, improving the patient experience and reducing readmissions are essential to financial health of the organization

Improve the patient experience by initiating Advance Illness planning in the presence of life limiting co morbid conditions

Hospital wide education and demonstration of the tool and its elements would have included the whole health care team for purposes of a consistent message being delivered throughout the patient's stay.

Early identification works!!!

Patient's First is our Focus

RCH is patient focused and committed to making a difference while contributing to patient safety. Reduction in length of stay with interventions designed to reduce readmissions are preventing patient exposure to the hospital environment

About My Organization

Redlands Community Hospital is a 225 bed facility located in Redlands, California which is midway between Los Angeles and Palm Springs. The hospital has been in existence for more than 100 years with 270 board certified physicians, 100 health plans, 1300 employees, and 300 volunteers.

The RCH mission is to promote an environment where members of the community can receive high quality care and service so they can maintain and be restored to good health.

RCH provides acute medical care, emergency room services, Maternal/Child Health Services, Behavioral Health inpatient care, as well as various community services and clinics,.

Contact Me

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CHCF HEALTH CARE LEADERSHIP PROGRAM

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http://futurehealth.ucsf.edu/