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Strategies for Quality Transitions of Care

Let’s Connect!

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Impact of Hospital Readmissions – Care Continuum

Overview of Hospital Readmissions

It Began with the Hospital Readmissions Reduction Program (HRRP)

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Not JUST for Hospitals/Acute Care – Impact Across the Continuum of Care

Readmission Measures are in place for:

- Skilled Nursing
- Home Health
- Physicians/Clinicians

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Impact across the continuum of care

- Patient/Client/Resident
- Relationships Between Providers
- Financial

It is Important that Every Member is Part of the Team

Source (2019): https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge

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Root Causes of Ineffective Transitions of Care

Source: https://www.jointcommission.org

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Top Reasons For Hospital Readmissions

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7326238/

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Focus on Client Needs

- Be Proactive
- Early Detection
- Educate
- Develop a Pan

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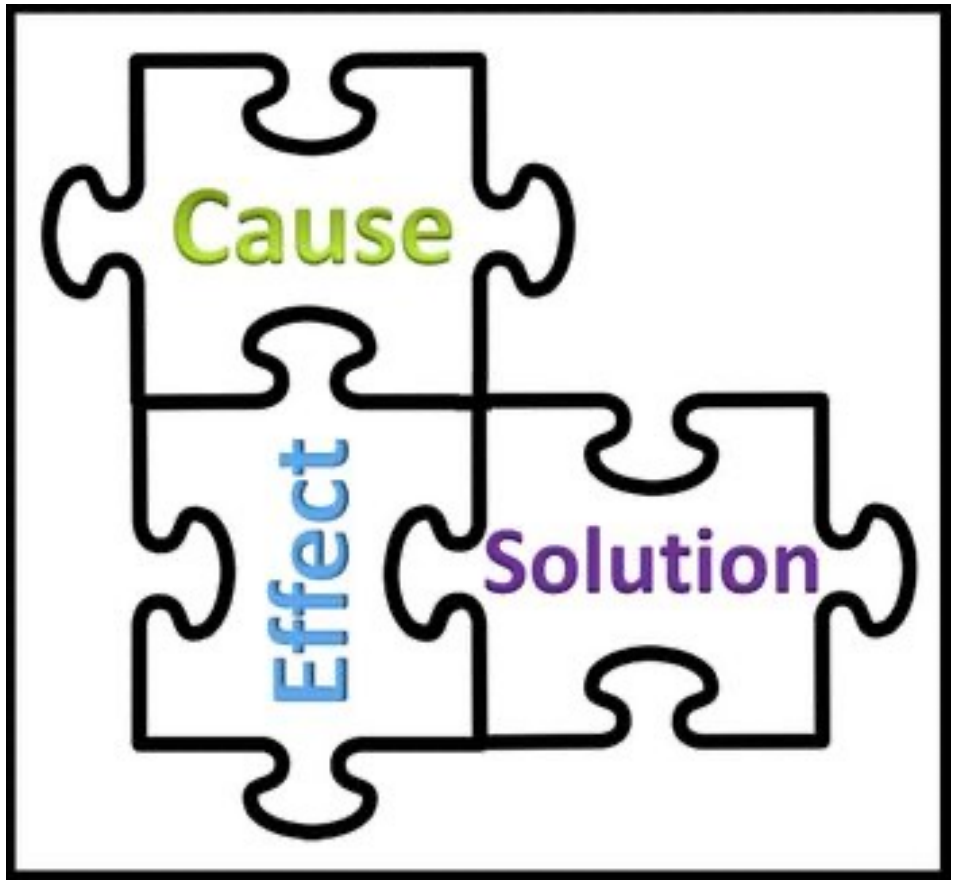
Key Strategies to Reduce Unnecessary Hospital Readmissions

Overview - Change of Condition

Strategies to Impact Transition of Care



- Identify the Reasons
- Implement Solutions

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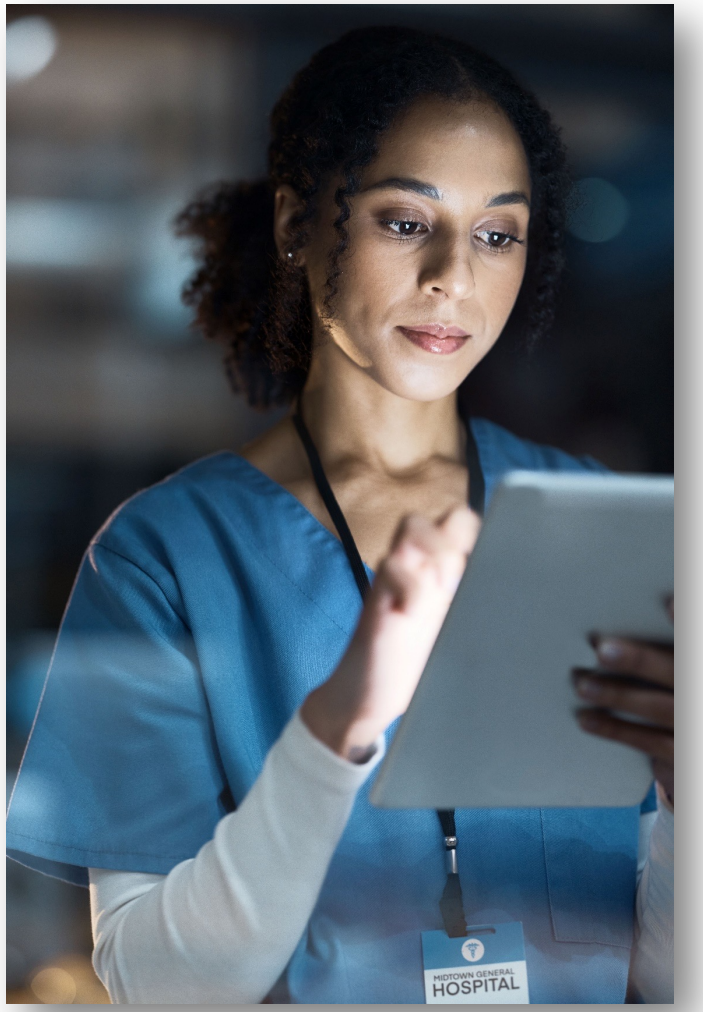
Strategies to Reduce Unnecessary Hospital Readmissions



- Solid Clinical Systems
- Education
- Clinical Competency
- Good Communication Processes

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Evidence-Based Model Across Post-Acute Care Continuum

Is a **quality improvement program** designed to improve the care of nursing home, assisted living and home health residents/patients with acute changes in condition

http://www.pathway-interact.com

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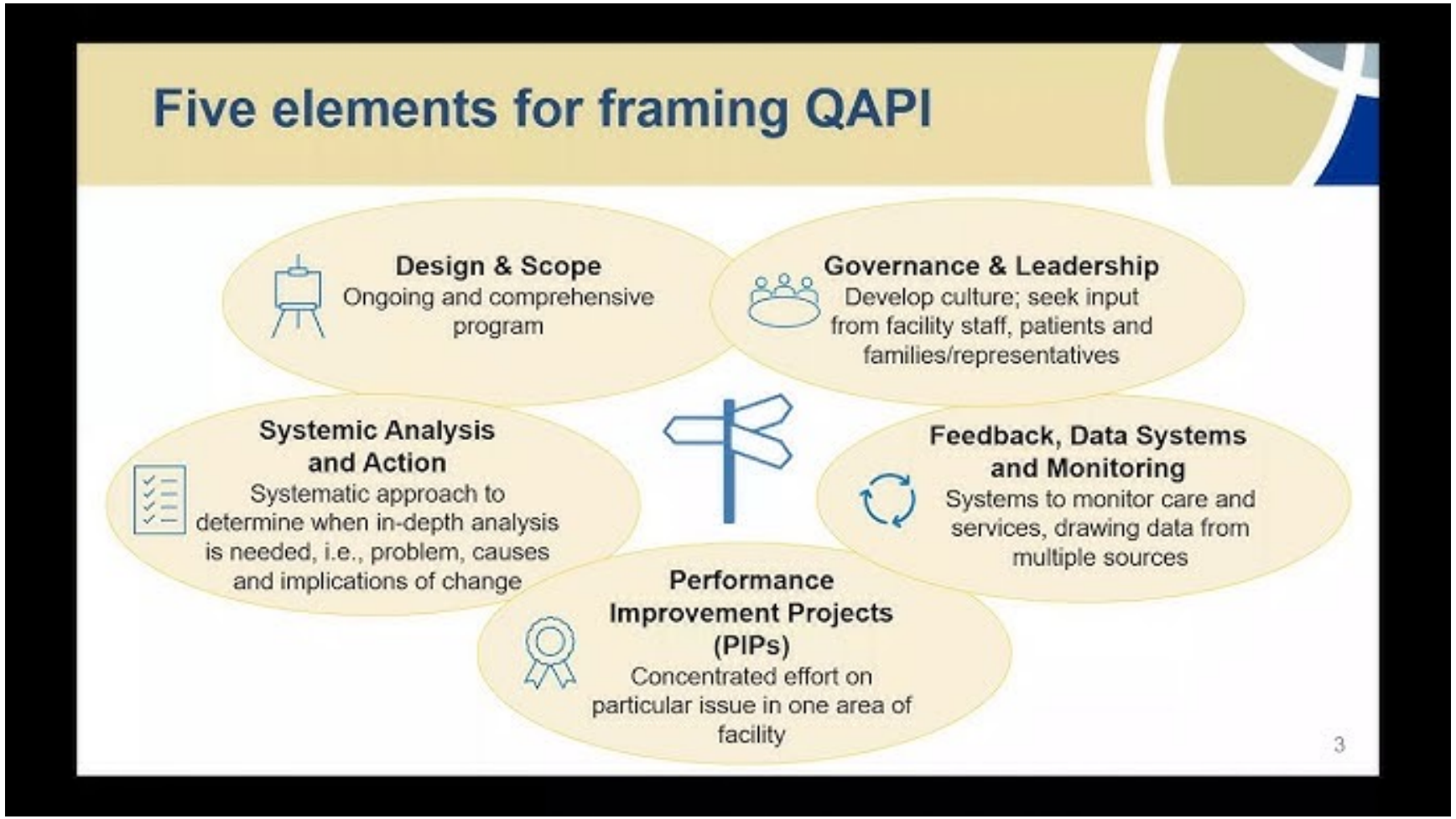
Organization Quality Assurance and Performance Improvement (QAPI) and Reducing Hospital Readmissions

Quality Assurance Performance Improvement



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Quality Assurance Performance Improvement

PDSA MODEL

Source: https://www.aapacn.org

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Engaging the Patient/Resident/Client

Client Engagement

- Family Involvement
- Communication
- Education
- Discharge
- Follow up

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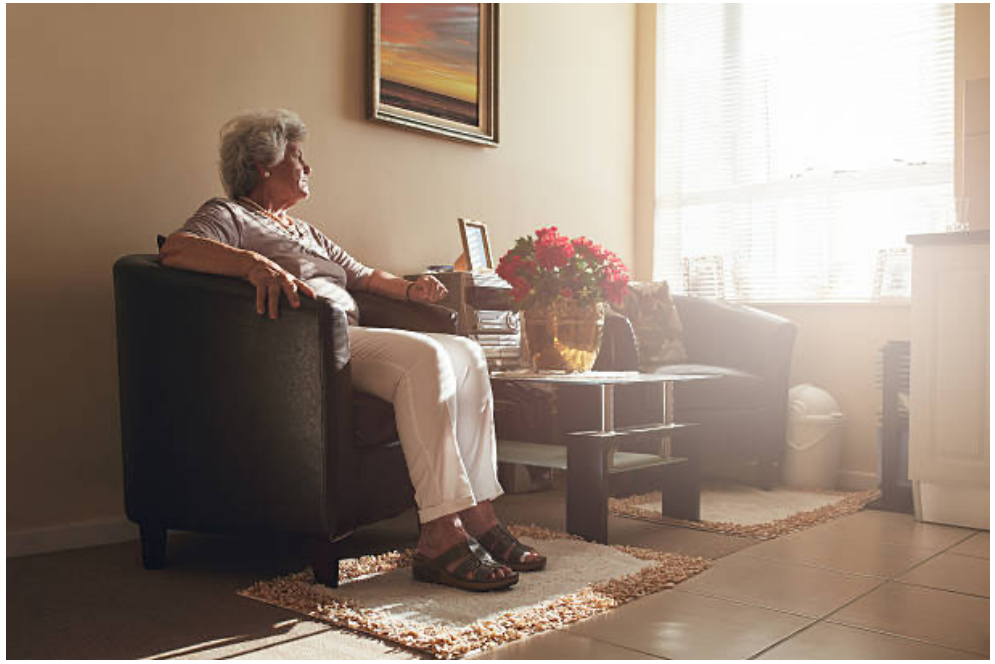
Best Practice Approaches

Best Practice Across the Continuum

- The INTERACT™ Quality Improvement Program: www.pathway-interact.com
- AMDA: Transitions of Care Clinical Practice Guideline: https://paltc.org/product-store/transitions-care-cpg
- Module 1: Detecting Change in a Resident's Condition. Content last reviewed March 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod1.html

Best Practice Scenario
How Can We Help?



- Home and family situation
- Diagnosis
- Discharge instructions
- Risk of readmission
- Follow up with primary provider

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Ways to Reduce Hospital Readmissions

- Discharge
- Pick up
- Nurse assessment
- Care plan
- Risk assessment
- Self management assessment

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Ways To Reduce Hospital Readmissions

- Educate Patient on Changes of Condition and Condition
  - Define what is considered a Change in Condition?
  - How To Identify A Change in Condition?
  - How To Manage a Change in Condition
  - What tools are you providing for review?

- Provide additional resources
  - CFC RN toolkit - show example
  - Others?

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Complete Medication Reconciliation in Hospital!

https://www.ahrq.gov/patient-safety/settings/hospital/match/chapter-3.html

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Home Base Community Provider is the **PERFECT** partner to help reduce readmissions

Result = Experience sense of safety which helps recovery become more manageable and improves outcome.

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Question and Answers

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- The INTERACT™ Quality Improvement Program: www.pathway-interact.com

References and Resources

- Agency for Healthcare Research and Quality. Patient Safety Network. Readmissions and Adverse Events After Discharge. September 7, 2019: https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge
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- AMDA, The Society for Post-Acute and Long-Term Care Medicine™: Transitions of Care Clinical Practice Guideline: https://paltc.org/product-store/transitions-care-cpg