Care Coordination and Reducing Avoidable Readmissions: Efforts at the hospital level

Bedside Delivery of Medications at Discharge and a combined Callback/Appointment Service for patients with Targeted Disease processes
HCA South Atlantic Division & Grand Strand Regional Medical Center, Myrtle Beach

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Top Care Transitions Improvements

- Standardized multidisciplinary readmission team with monthly data
- Medical Staff engagement through risk adjusted data
- Implementation of partner pharmacy for a discharge medication program
- Consult a Nurse Call Back program for targeted chronic disease patients
Grand Strand Regional Med Center Plan to reduce Avoidable Readmissions

- HCA Pilot hospitals identified with standard work flow assessment
- Task force created October of 2012
- CMS targets reviewed and goals defined through completion of gap analysis
- Action plan created to include 5 areas of focused effort
  - Patient and family education
  - Physician care activities in the hospital
  - Call Back service to assist with medication and physician appointment follow up post discharge
  - Focused review of discharge plans (of initial admission) for patients readmitted within 30 days
  - Improved medication reconciliation process and institution of collaboration with community pharmacy to facilitate patient going home with prescribed medications at discharge
Partnership with Community Pharmacy

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Grand Strand Regional Call Back Service

• All patients with a DC diagnosis of AMI, HF or PN are called at home within 72 hours but on average of 24 hours.

• Patients are asked several questions with focus on
  – Understanding of symptoms to watch for
  – Understanding of discharge medications
  – Do they have their medications
  – Follow up appointments
  – Service they received
Lessons Learned

• Total team engagement and physician leadership essential
• Stabilization of staffing (Case Management) essential for continued coordinated efforts
• Trauma Service went live in 2012 and energy diverted with challenges of a new service line
• Early information on call back service and pharmacy discharge programs is positive to meet post discharge needs of patients.
• Essential to partner with community members (HH, offices, SNF) and share readmission challenges to adjust preparation of patients for discharge.