BayCare Health System

Since the beginning of 2013, BayCare has been rolling out standard interventions to reduce readmissions at its 11 hospitals. Most of the hospitals are currently focused on HF, Pneumonia and AMI for Medicare patients, however some interventions are applied to all patients. The Children’s hospital is focused on asthma.

Every patient with one of the target diagnoses is evaluated for readmission risk within 48 hours of admission. Patients at high risk are referred to a social worker who initiates appropriate consults to address the factors where the patient is at high risk. When there is a need to set priorities, Medicare patients get the highest priority. Patients and their families receive education about their disease state and their medications. The bedside nurses conduct the education using a teach back method. If patients will be dependent on a family member or other care giver post discharge the bedside nurse contacts that person and schedules a time for them to come in to receive education.

At the time of discharge all patients leave the hospital with a folder containing educational materials about their disease and medications, a list of symptoms to look for, their discharge plan, information about a post discharge PCP visit, and suggestions of where to get help if they need it Patients are told to schedule an appointment with their ambulatory provider within a week after discharge, and that visit can be scheduled during the discharge process if that is acceptable to the patient. If patients are uninsured, unable to access a free clinic or unable to pay for an appointment, the hospital will pay for the first post discharge visit. Patients are also encouraged to take advantage of covered home health services post discharge.

Discharge medication delivery is being implemented at all hospitals in the system. Eventually, all patients will have the option of getting their discharge prescriptions delivered to them before discharge. If patients choose this option, they receive a follow up call from the pharmacist within 48-72 hours after discharge. All patients are also called by a nurse who cared for them in the hospital within 48 hours after discharge. The nurse uses a prepared script to check the status of the patient, make sure they are taking the right medications, and make sure they have a scheduled follow up visit.

The EHR system flags any patient that comes to the ED or is admitted to the hospital within 30 days of discharge. The case manager is alerted when any patient is readmitted and performs a root cause analysis to determine whether the readmission could have been avoided.
The readmissions initiative has also included the SNFs associated with each hospital. The hospital staff meet with the administrative and nursing director to review any readmissions that have occurred from the SNF and to identify what could be done to prevent the readmission.

**Lessons Learned**
It takes a team to reduce readmissions. Assigning one person to make it happen will not work.

Trying to implement change while a new EHR is being installed complicates the transition.

Discussing the root cause of a patient’s readmission on multidisciplinary rounds helps inpatient providers appreciate the challenges of care outside their four walls.

Both ambulatory and inpatient physicians need to understand the need to change, and they respond best to data. For example showing data that show that patients that are seen within a week after discharge do better motivates physicians to adopt this as a model.

**Future Plans**
Complete the roll out of all standard processes for all target patients at all hospitals

Complete planning for interventions to reduce readmissions for the next set of Medicare diagnoses that will fall within the penalties

Evaluate the effectiveness of the current teach back education program Improve use of palliative care
Evaluate the feasibility of home visits or increased telephone contacts post discharge

Automate the process for notifying PCPs when their patients are admitted or discharged from the hospital. Automatically send the discharge summary to the PCP.