RELIAS

Reducing Readmissions at Katherine Shaw Bethea

↓ 8.6 percent

With a streamlined process encompassing many care teams and historically siloed practices, the clinical leaders and staff at Katherine Shaw Bethea reduced their COPD readmissions by 8.6 percent

Background

At one point, 1 in 5 patients returned to the hospital within 30 days of their discharge.[1] The introduction of financial penalties in 2012 for hospitals with higher than average readmission rates brought this issue to the forefront. Now, hospitals are focused on ensuring medication lists are accurate and that a clear line of communication exists between the hospital and outpatient care teams—and it is paying off. Patients who presented in the hospital with heart attacks, heart failure, or pneumonia are now 20 percent less likely to be readmitted after their initial discharge.[2]

Readmissions are complicated issues usually involving medically complex patients, several care teams operating in silos, and several process failures and breakdowns. This glaring lack of care coordination leads to another hospital visit far too often.

Challenge

Combating preventable readmissions requires a coordinated team of nurses, respiratory therapists, physicians, and clinicians from ambulatory, outpatient, and inpatient care settings who can assess the entire system of care to appropriately standardize the entire process.

To reduce variation and streamline patient care processes across diverse care settings and for medically complex patients, the following attributes of a highly reliable system must be in place:

- Empirical use of data to set clear, measurable goals across care teams and staff
- Clinical focus and specific improvement targets with assigned ownership across teams and settings
- Coordinated care to reduce variation and achieve consistency in practice
- Accountability to improvement goals residing with each care team and their part of the process
- Executive oversight and individual performance targets aligned to system-wide goals

With readmission challenges, successful plans include many care teams and clinical leaders from a variety of care settings. Multidisciplinary clinical teams must assess care variation within specific patient cohorts to understand to identify which patients are experience the biggest readmissions challenges. Clinical focus is a critical aspect to driving an effective clinical improvement effort to ensure the most vulnerable or likeliest patients to experience a readmission are being assessed for potential process standardization.

Executive staff at Katherine Shaw Bethea understood these components were necessary in their journey to becoming a high-performance organization and decided to apply this thinking to combat their COPD readmissions issue.

A multidisciplinary team was organized with representation from hospital leadership, quality staff, nursing directors, inpatient and ambulatory providers, discharge planners, and respiratory therapists.

The clinical focus and success of the organization was defined initially and then responsibility allocated to each clinical team and leader. Coordinated care requires group accountability with each team focusing on their unique aspect of the care process—empowered by performance insights and transparency into patient outcomes.

Solution

Transparency to patient outcomes and the identification of specific issues and process failures are critical components of driving focus. The team at Katherine Shaw Bethea outlined aspects of care practices that needed to change to positively effect patient outcomes. Each clinical team defined their standard to be adopted and in line with the care protocol spanning the full continuum of care. Collectively, each of their new care practices and defined standards would create a streamlined, coordinated care pathway for each patient admitted with COPD.

The clinical leaders and staff reduced their COPD readmissions by 8.6 percent, an estimated cost savings of $125,000 annually.

A cadence of accountability was established to continuously monitor the implementation of new practice standards against the desired patient outcome. Each team engaged their staff, provided relevant clinical education, and aligned clinicians with improvement goals and their projected impact on patient care.

Emergency Department protocols were adopted to appropriately identify a COPD patient in need of inpatient care. This became the trigger for the care pathway and initiated a set of care processes to be followed throughout the inpatient episode of care. These processes even extended into the ambulatory setting to include post-discharge respiratory treatment plans and primary care management.

Inpatient nurses and physicians knew the care protocol and standardized discharge process, requiring a referral to outpatient respiratory therapy. Once discharged, the respiratory therapists followed their order set for post-discharge COPD management and patients experienced a well-organized, patient centric treatment and management plan meeting their unique needs.

Results

With a streamlined process encompassing many care teams and historically siloed practices, the clinical leaders and staff at Katherine Shaw Bethea reduced their COPD readmissions by 8.6 percent, an estimated cost savings of $125,000 annually. Partnering with Relias Analytics and the team of clinical performance management consultants has provided significant benefits for Katherine Shaw Bethea by improving financial outcomes and patient lives.

LEARN MORE

Resources
1 https://www.nejm.org/doi/full/10.1056/NEJMsa0803563#t=article
2 https://www.npr.org/sections/health-shots/2017/07/18/537696772/pushing-hospitals-to-reduce-readmissions-hasnt-increased-deaths

ACU0618FS1697-00

(877) 200-0020

RELIAS