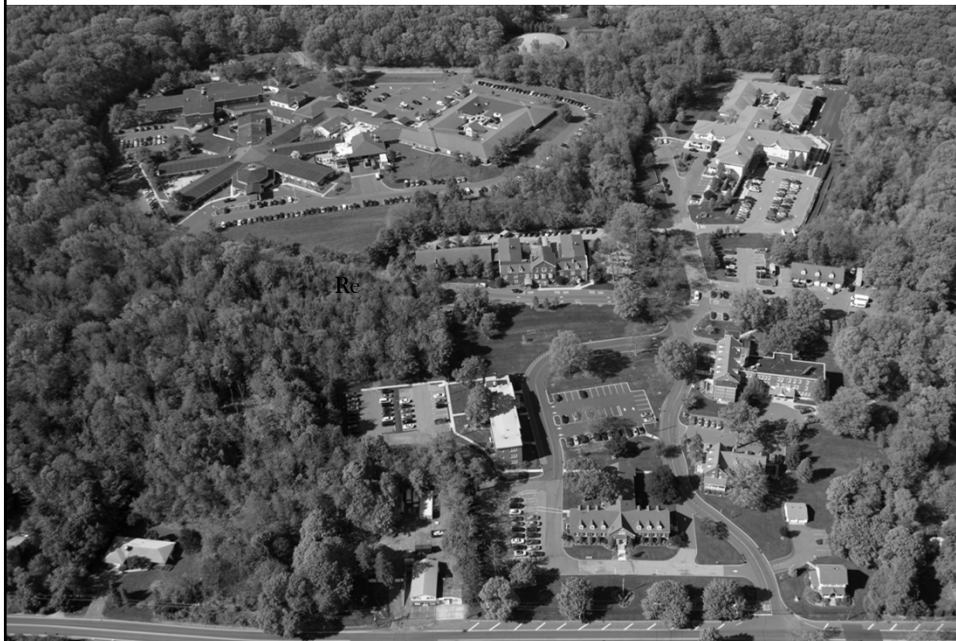





REDUCING UNNECESSARY READMISSIONS

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	<h2 data-bbox="492 317 1218 373">Readmissions Project Timeline</h2> <ul data-bbox="492 415 1242 930" style="list-style-type: none"> <li data-bbox="492 415 1112 464">• Initiation date: August 2009. <li data-bbox="492 474 1203 569">• Tracking and trending: Post-acute care unit. <li data-bbox="492 579 1177 674">• Review tracking & trending data; observe for patterns. <li data-bbox="492 684 1242 930">• Organize readmissions review team: Medical Director; Nurse Manager; Admissions Director; Case Manager; Social Service Director; Educator; Rehabilitation Services Director; HIM Director
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	<h2 data-bbox="492 1184 1218 1241">Readmissions Project Timeline</h2> <ul data-bbox="492 1283 1258 1766" style="list-style-type: none"> <li data-bbox="492 1283 1214 1430">• Develop readmission project tools: spreadsheet; review tool; quality monitor report. <li data-bbox="492 1440 1258 1640">• Education session re: readmissions, purpose of project; review tools; interventions; action plans; monitoring; question/answer session. <li data-bbox="492 1650 1218 1766">• Initiate weekly readmission review meetings: October, 2011.
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	<h2>Readmissions Project Timeline</h2> <ul style="list-style-type: none"> • Increasing physician involvement. • Weekly mailing of spreadsheet. • Monitor for trends: heart failure; respiratory: pneumonia & COPD; infections: UTI; anemia. • Discuss trends with team, quality coordinating counsel, staff meetings, and senior leaders.
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	<h2>Readmissions Project Timeline</h2> <ul style="list-style-type: none"> • Identify education, policy/practice protocol, and system/process opportunities. • Collaborate with referring acute care providers to share information and identify opportunities for improvement. • Continue to monitor data; identify trends; initiate action plans for opportunities to improve.
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Recent Developments

- External Case Manager: proactive partner in process.
- Re-evaluation of admission acceptance practices.
- Improved flow time: admission review turn around time.
- Atlantic ACO
- Partnership for shared APN with The Valley Hospital, Ridgewood, NJ.

Progress Report : 2013

30-day All Cause Readmission Rate:

2012 = 19%

2011 = 23.1 %

2010 = 25%

Focus: CHF, Pneumonia, and UTI.

Discharge planning process: Medication management therapy; timely follow-up appointment; initiation of home care services within 48 hours; discharge telephone calls.



Suggested Resources

- Advancing Excellence in America's Nursing Homes
- INTERACT
- Robert Wood Johnson Foundation



Questions?

