Reducing Readmissions Through Transitional Care Management

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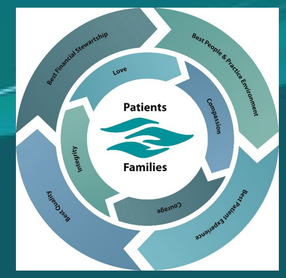


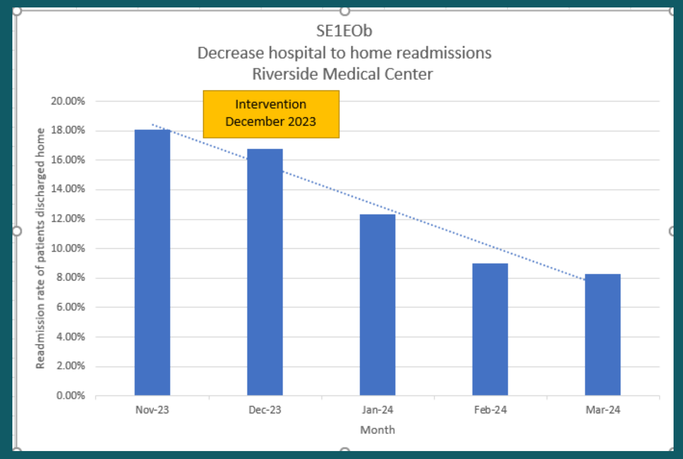
Introduction

Effective transitional care is critical in ensuring continuity and quality of patient care as they move from one healthcare setting to another, especially to their homes, following hospital discharge. We at Riverside Healthcare are constantly seeking to improve quality of care in our community. As we explore the objectives, structure, and processes of transitional care management, one of the many ways we pursue in improving patients' transitions of care back to the community is to reduce unplanned and avoidable hospital readmissions. A key element in that process is facilitating timely follow- up with Providers through Transitional Care Visits (TCVs). Our goal in this initiative is to increase the capture rate of Transitional Care Visits, and subsequently reduce the readmission rate among the TCV eligible population (discharges to home from index hospitalization).

Methods

- Outreach calls to patients consist of medication reconciliation, to ensure they are aware of the date and time of their appointments, and have a transportation plan in place.
- With the new process initiative, Population Health Care Team will need to obtain access and training on the scheduling functionality in Epic EMR.
- This allows the Care Coordinators to update the Transitional Care Visit to accommodate the patient's preference while on the outreach call with the patient. This allows for greater patient satisfaction, autonomy, and likelihood of compliance in appointment attendance.
- Outcomes will be tracked by readmissions rates in order to attempt to isolate the subset of patients which excludes patients who were discharged to Acute/ Subacute Rehab, Long Term Acute Care Hospitals and Skilled Nursing Facilities who are ineligible for TCVs. After learning and educating the stakeholders (RMG Leaders and Staff), this workflow was updated and went live in December 2023.

Results



- In June of 2023 the TCV capture rate was 49.7% and the readmission rate from home discharges was 20.8%.
- After finalizing the workflow changes for Population Health Care Coordination Transitional Care Outreach Encounters in December of 2023, the TCV capture rate in January of 2024 was 57.4%, in February 59.4% and in March 66.1%.
- During the corresponding months the Medicare All-Cause Readmission Rate for patients discharged home from their index admission was 12.3% in January of 2024, 9.0% in February, and 8.3% in March.

Discussion

Transitional care visit is designed to bridge the gap between hospital care and the patient's return to their home environment. During this visit, healthcare providers assess the patient's medical, psychological and social needs, ensuring that they are adequately supported during their recovery. Transitional care management's key components include a comprehensive review of the patient's discharge instructions, medication reconciliation, identification of potential barriers to recovery, and coordination of follow up care with primary care providers and specialists. By focusing these critical areas we prevent complications, promote adherence to treatment plans, and enhance patient satisfaction. This data suggests that patients who receive a transitional care visit are less likely to experience hospital readmissions and are more likely to have a successful recovery. This process improvement initiative highlights the importance of structured transitional care visits in improving patient outcomes, emphasizing the need for ongoing communication and collaboration among healthcare teams to support patients during this vulnerable period.

References

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