Reducing Readmissions Through Team Communication

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Introduction

The Palliative Care (PC) teams at our health system's hospitals are at different stages. Data were gathered we recognized an opportunity to develop team integration with clinical and medical staff at each inpatient location and incorporate improved communication with the different levels of community care to reduce unplanned patient readmissions. Handoffs between service lines were improved through direct communication. Handoffs into the community were developed within our electronic health record so that our community partners could view the charts of their patients following discharge from acute care. They would be able to see the goals of care conversations that had already transpired and could pick up the conversations from the relevant point of planning rather than initiating the discussion.

Problem Statement

The interdisciplinary teams at each hospital were developed independently, each building on barrier identification of the earlier units to achieve consistent platforms of care to deliver best practice enforced results. The staffing of the teams was difficult to accomplish because of availability of experienced clinicians. Medical providers were hired at our largest hospital along with experienced social workers, nurses and chaplains. The smaller hospitals established a cooperative model with community partner providers and employed social workers, nurses, and chaplains. The first of these co-op staffing models attained certification in Advanced Palliative Care from the Joint Commission in 2013 and re-certified in 2015. Based on the data, two of the other hospitals started with community providers adding chaplains and social workers with the goal to have full team support. The result, this systematic approach led to a consistent growth in PC as a 'standard of care.'

Project Goals

Improve the timing to Palliative consults:

- Reduce hospital length of stay (LOS) with early consultation
- Reduce 30day readmissions with education and establishing informed 'goals of care'
- Facilitate patients/families to identify personal goals with POST documentation

Create health system strategies to:

- Improve care transitions
- Quality improvement
- Integrate palliative care to community and healthcare settings

Improvement Methods

Education developed for clinicians, providers and patients:

- POST facilitation training for team members
- Development of integrative therapy practice to support patient comfort
- Training for EMT providers to support patients at crisis in home
  - When a hospice patient is involved and identified when calling 911 the dispatcher calls the hospice provider and patches him/her through to the EMT as they arrive on the scene. They assess the situation and follow the recommendations to control the situation until the hospice provider can reach the scene or will stay with the patient/family while a patient dies to maintain comfort
- Transitions meetings with community partners to identify barriers and prevent unplanned readmissions

Improvement Achieved and Outcomes

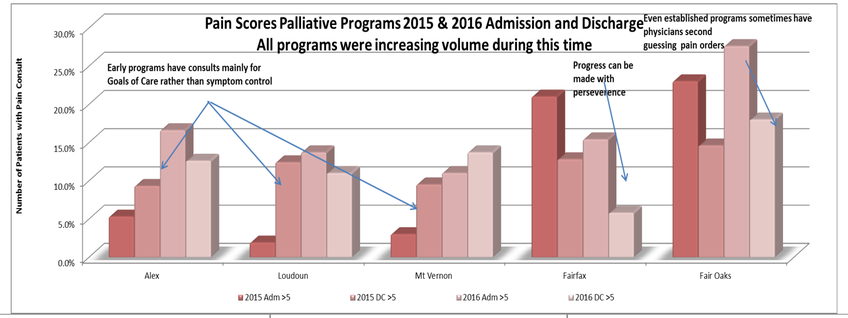
This systematic "team" approach to platform development led to:

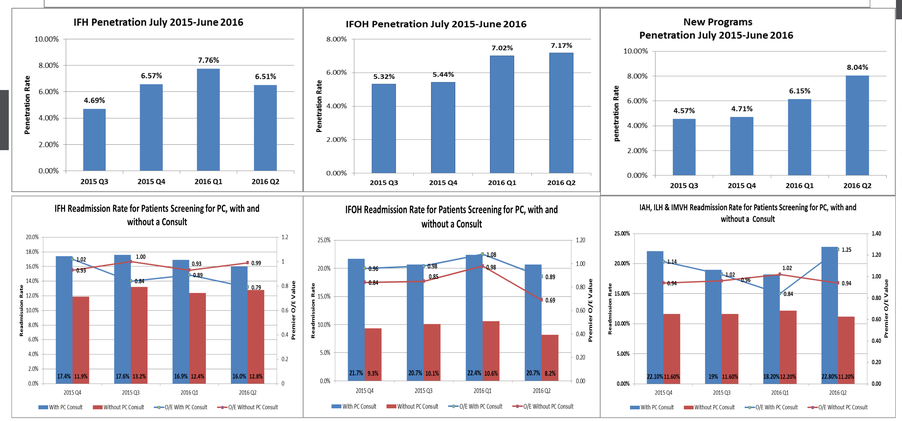
- Enhanced understanding by patients of options of care based on individual stage of illness by completed Advance Directives and/or POST forms
- Improved method of affirming goals of care with POST documentation including POA and family members
- Shorter length of stay with reduced 30day readmissions documented in database
- Reduced unplanned emergency room visits documented in database against general population
- Improved pain control once referrals for symptom control are initiated

Nursing satisfaction with interdisciplinary team support is measured with blinded questionnaires. Interdisciplinary co-operation improved communication and increased referrals

Hospitalist/physician/provider education created an atmosphere conducive to best-practice

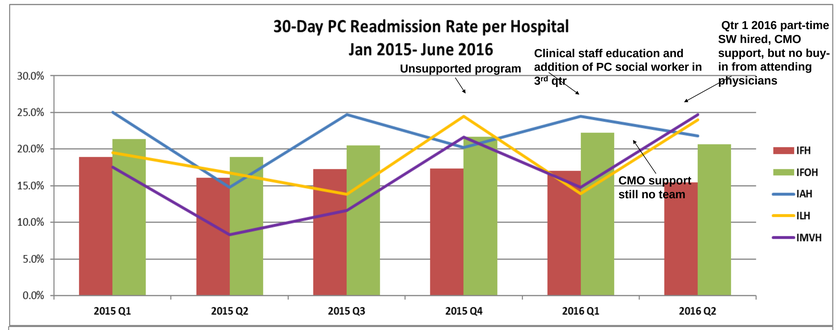
PC programs improved readmission rates but the length of stay was slightly longer until earlier consults were routine as each program developed, reinforcing the belief that early referrals accomplishes reduced length of stay, reduced readmissions, and subsequently lower healthcare cost. Newest programs are getting consults for goals of care but not symptom control. Employed model is collaborative with other employed physicians, and pain control recommendations are received more positively.

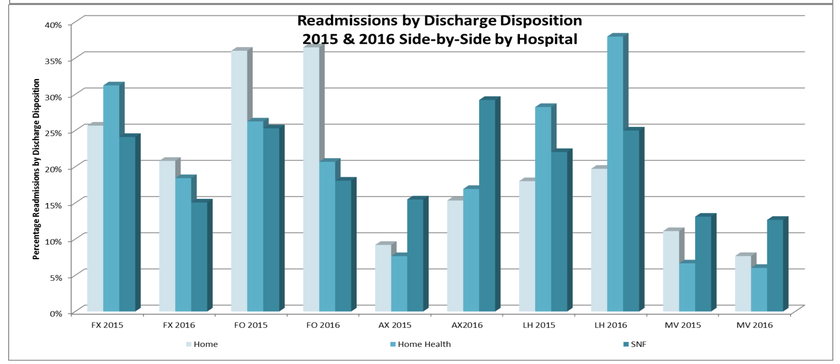




Outcomes (cont'd)

30-day readmissions before Palliative is involved is much higher throughout the system. Once patients are guided through goals of care and understand the options of care with the disease-specific benefits and burdens, they can make informed decisions, know what to expect and who to call instead of waiting for a crisis and going to the ED. Sometimes people are just not ready to accept their health status and must experience the "New Normal."





Recommendations

Education and consistency of practice stand out as methods to build a platform for care delivery but must be modified to the hospital culture and community served. As one patient put it, "This is concierge healthcare designed for my needs not someone else's." Patients and families like being part of the team. Trio rounding (physician, nurse, patient) are satisfiers by including the patient in their own care plan.

Seriously ill patients who receive palliative care feel that their care is more personalized to their goals of care and quality of life at any stage in the trajectory of their illness. The data of existing readmissions and number of emergency room visits following discharge leads one to conclude that ambulatory palliative care services may facilitate achieving optimum reduction in readmissions. We are in the planning stages of system-wide ambulatory care delivery. POST completion guides people through the options of care decisions. Community education will help in achieving buy-in from patients and their families.

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