Readmission Huddles on an Acute Care of the Elderly (ACE) Unit

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Background

Readmission is a priority quality improvement focus in acute care. Readmission within 30 days (all cause) for Medicare patients from 2007-2011 was 19% and by 2012 it had improved slightly to 18.4% . Riverside Regional Medical Center opened an ACE unit in October 2013 and identified that readmission review was necessary given the level of frailty, complexity and vulnerability of ACE patients. The literature reflects early readmission often reflects underinvestment in transition care planning during the initial hospital stay

Abstract

Riverside Regional Medical Center, a 570-bed acute care facility in Newport News, VA, opened the n Acute Care of the Elderly (ACE) unit to provide the opportunity to implement evidence based nursing practices as recommended by Nurses Improving Care to Hospitalized Elderly (NICHE) . Recognizing that it takes a team to improve the quality of care of older adults, the unit uses an interdisciplinary approach and conducts interdisciplinary plan of care rounds daily.. It was clear shortly after opening the unit that several of our patients returned to the hospital in a short period of time after discharge .

Methods

The Interdisciplinary Plan of Care Team (IPOC) on ACE developed a readmission huddle form and process in order to identify priority areas of focus. Immediately after ACE IPOC daily rounds the team reviews all patients discharged from ACE that returned back to the hospital (information generated daily by information technology).
The form used was developed using evidence-based literature on readmission factors and modified based on the team's experience. The aggregate data is analyzed looking for trends/themes of focus .

Readmission Huddle ACE Unit

How often has the patient been readmitted or seen in the ED within the past three months?
Does this patient have a high risk diagnosis (AMI, HF, Pneumonia, COPD)?
Readmitted from home or another facility?
Readmitted for the same or unrelated cause?
Did the patient/family have specific care instructions at discharge?
Was there post discharge care coordination in place?
Was there post discharge primary care physician follow up?
What was the para-trend at discharge?

Potential factors contributing to re-admission

Non-adherence (care instructions, medications)
Discharged too soon (patient preference, provider decision)
New diagnosis on prior admission
Limited or no home support
Transportation issues
Placement unable to meet patient needs
Home situation not clear/accurate at discharge
Lack of financial resources
Psychosocial
End of life care
Lack of follow up with primary care physician

Results

Although currently there is only three months of data a few target areas have emerged.

- Readmissions are equally likely to return from home or long term care facilities
- Family caregivers are unrealistic in their ability to provide care in the home
- Patient/family unwilling or unable to follow the recommendations of the IPOC team regarding transition planning (placement, end of life care)
- Non or incomplete adherence with the recommended treatment plan (care instructions, medications, follow-up)
- Post-acute care facility unable to meet patient needs
- Failure to recognize the "high risk for readmission" situation

Conclusion and Next Steps

Interventions already initiated include more extensive patient and family education on caregiving, transitions and adherence, increased use of palliative care consults and a house calls program, and more extensive scrutiny for the high-risk. Next steps will involve more work with post-acute care facilities. Outcomes of success of interventions will be measured. The ACE IPOC team continues to collaborate with other initiatives within the health system exploring the reasons for readmission.

References

Medicare & Medicaid Research Review
2013: Volume 3, Number 2:
http://dx.doi.org/10.5600/mmrr.003.02.b0