Reducing the Revolving Door Syndrome:
Working together to reduce re-admissions

Jackie Beaton, Inpatient Flow Coordinator, GGH
Laurie Williamson, Clinical Educator Ambulatory Care/Clinical Pathway Coordinator, GGH
Sylvia Scott, Director, Clinical and Professional Services, GFHT
Tricia Wilkerson, Director, Quality Improvement & Evaluation, GFHT

Conflict of Interest Disclosure

- No conflicts of interest to disclose

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Session Objectives

- Understand the benefits from hospital and primary care perspectives of working together to address hospital readmissions versus working in silos
- Explain how care transitions impact avoidable and unavoidable readmissions for populations at risk
- Understand why COPD /CHF populations were targeted
- Describe tests of change undertaken
- Discuss lessons learned so far

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The Problem We are Trying to Solve

- Local data shows 42% of hospital readmissions that happen within 4 weeks will happen within 7 days of the last admission
- Lack of communication & collaboration between acute care & primary care = providers not having all of the information + uncoordinated patient care
- Patients feel confused and unsupported when their care team does not know what one another are doing

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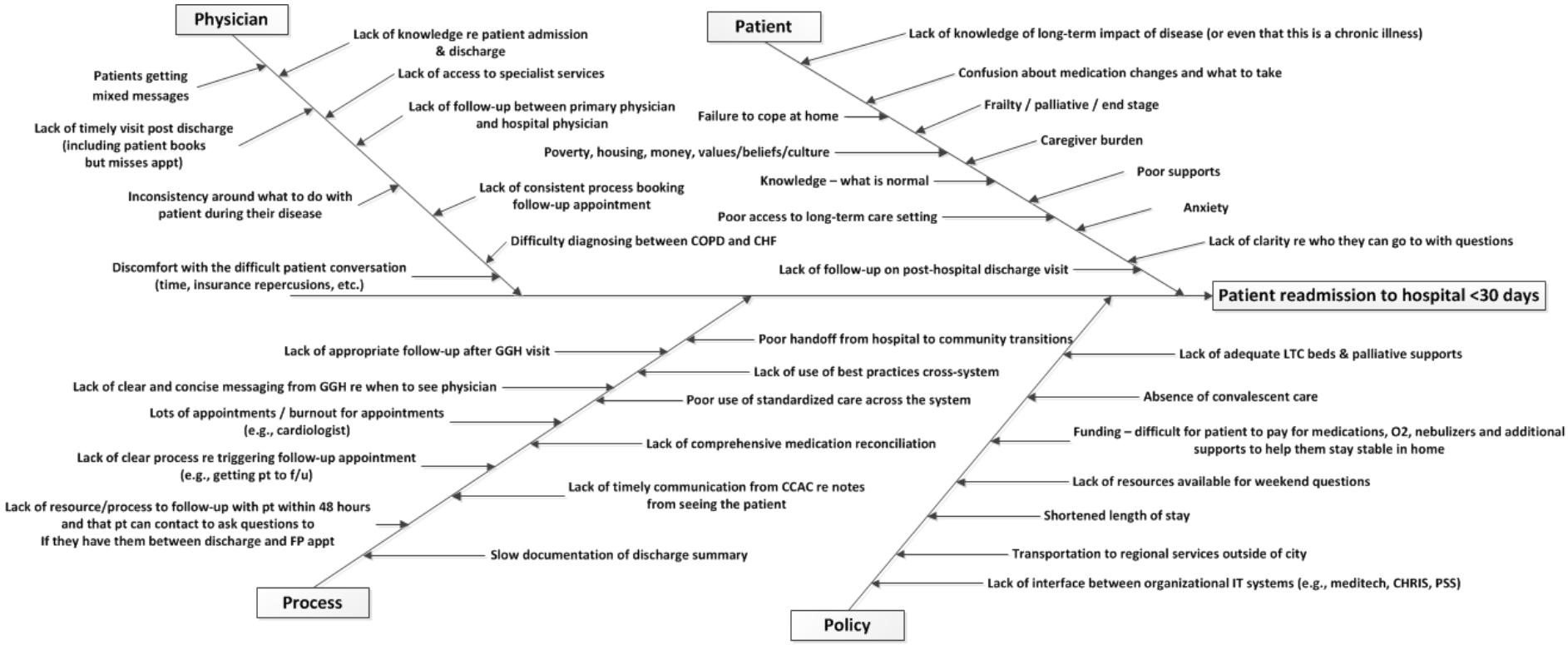
Understanding the Causes



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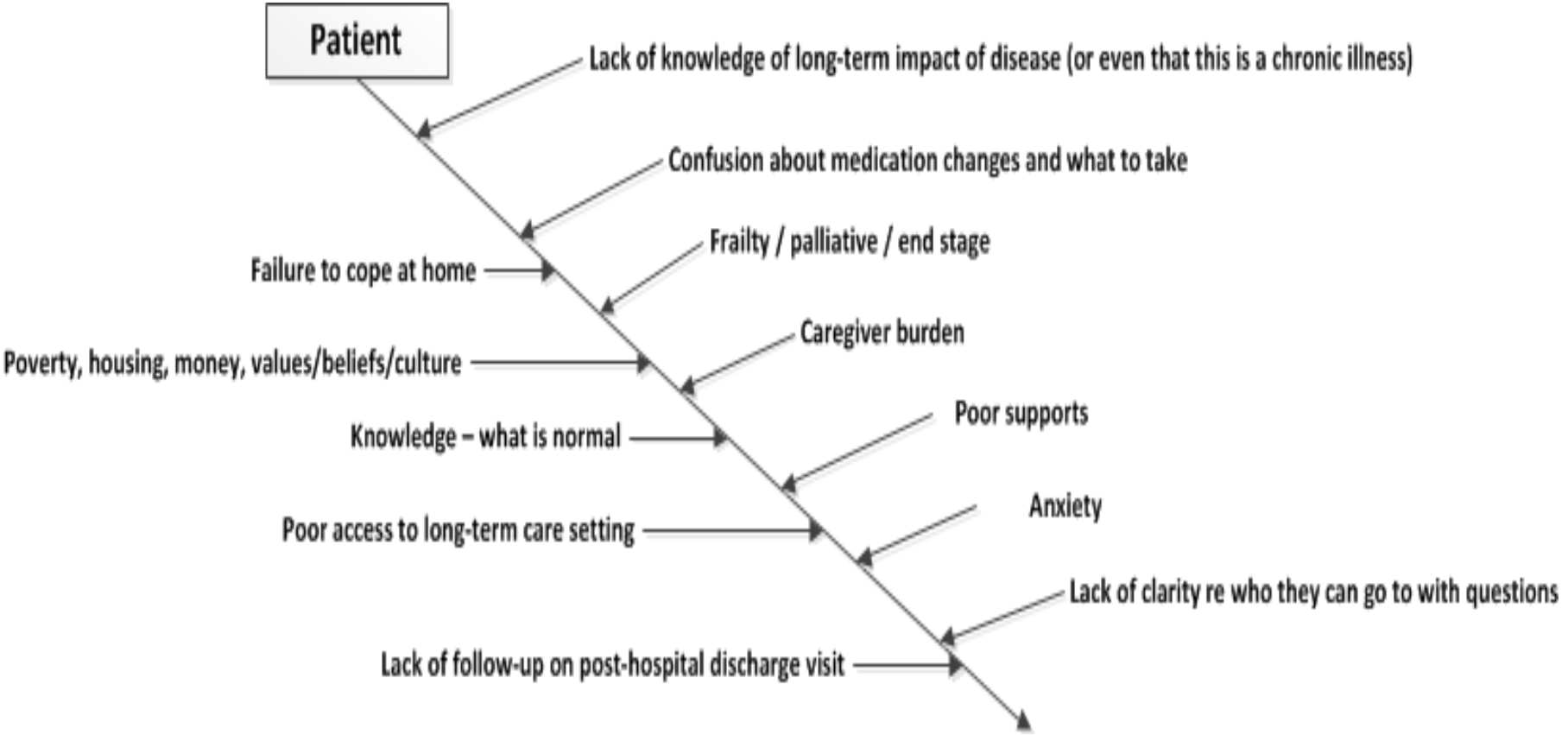

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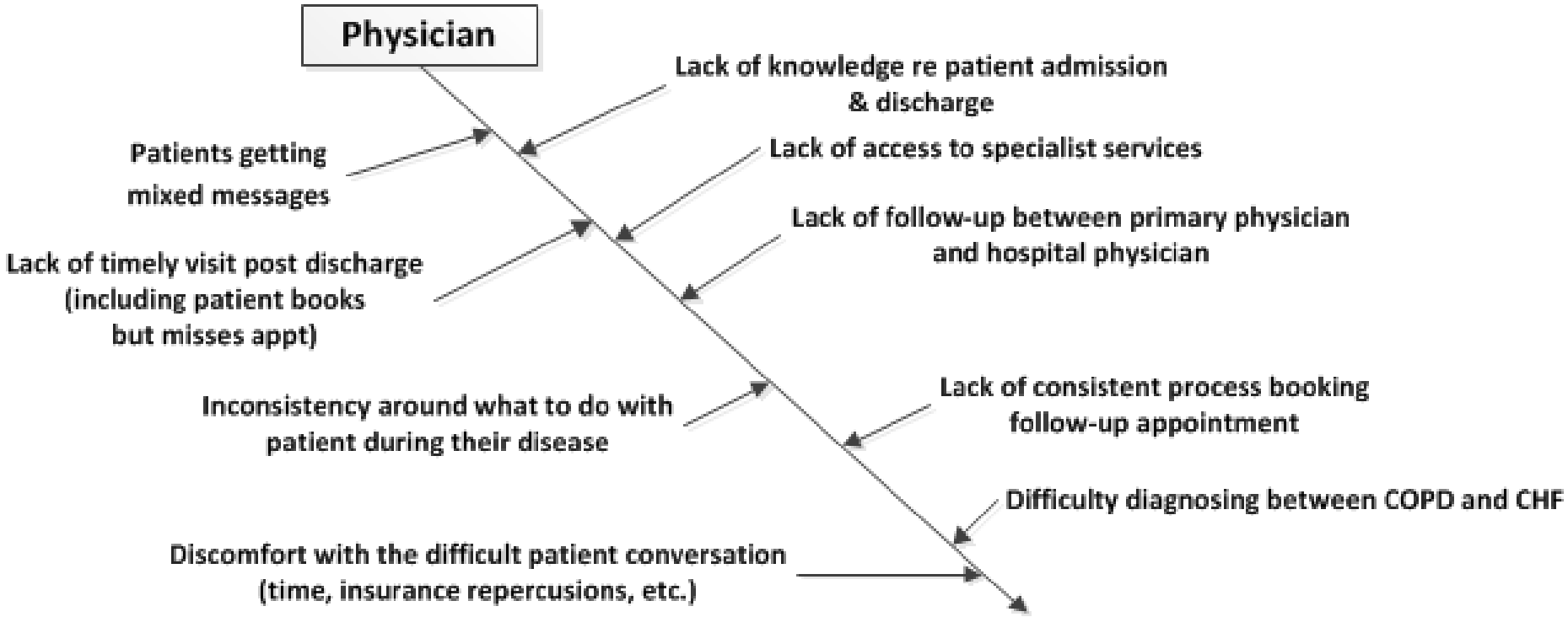

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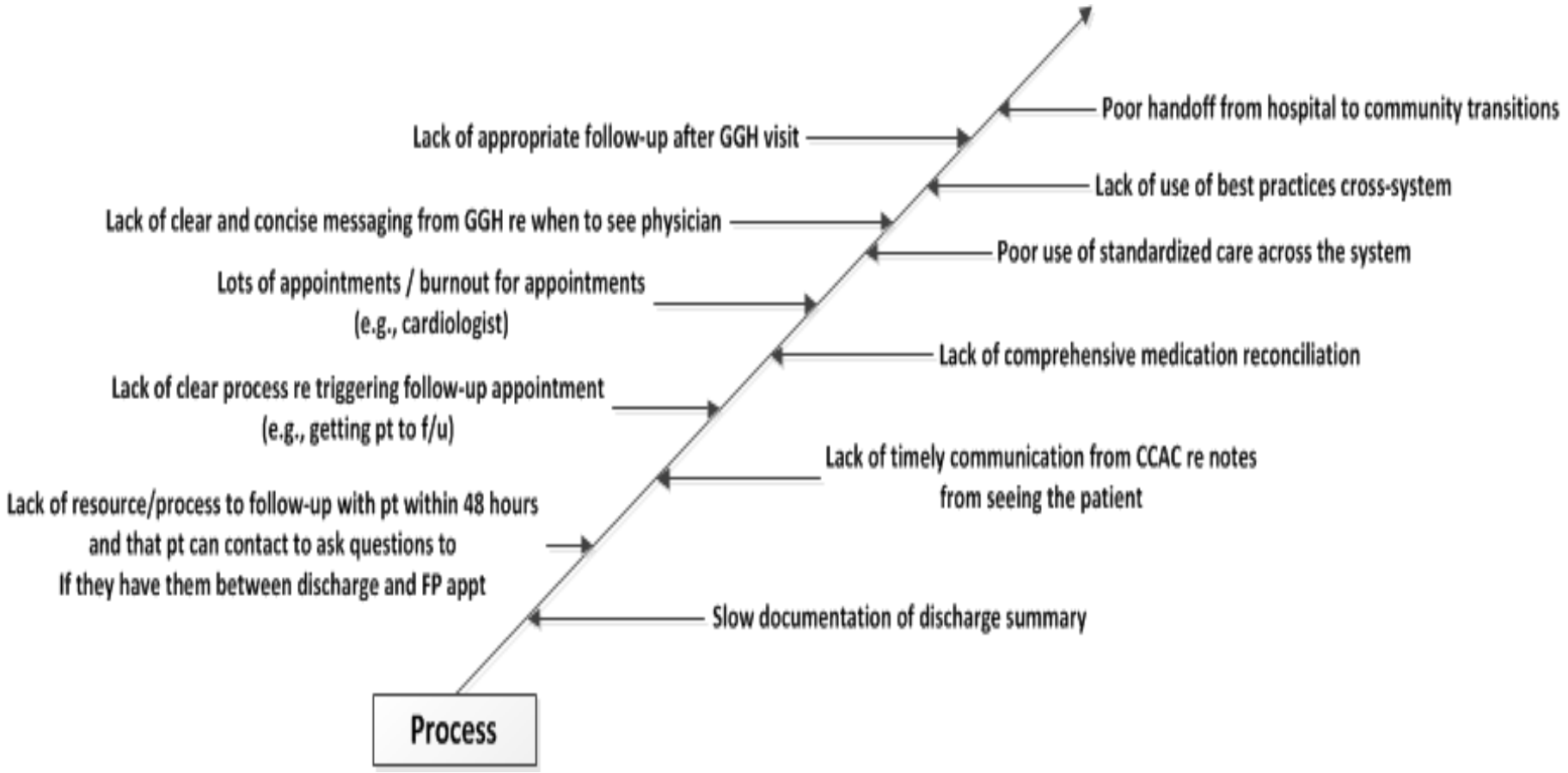

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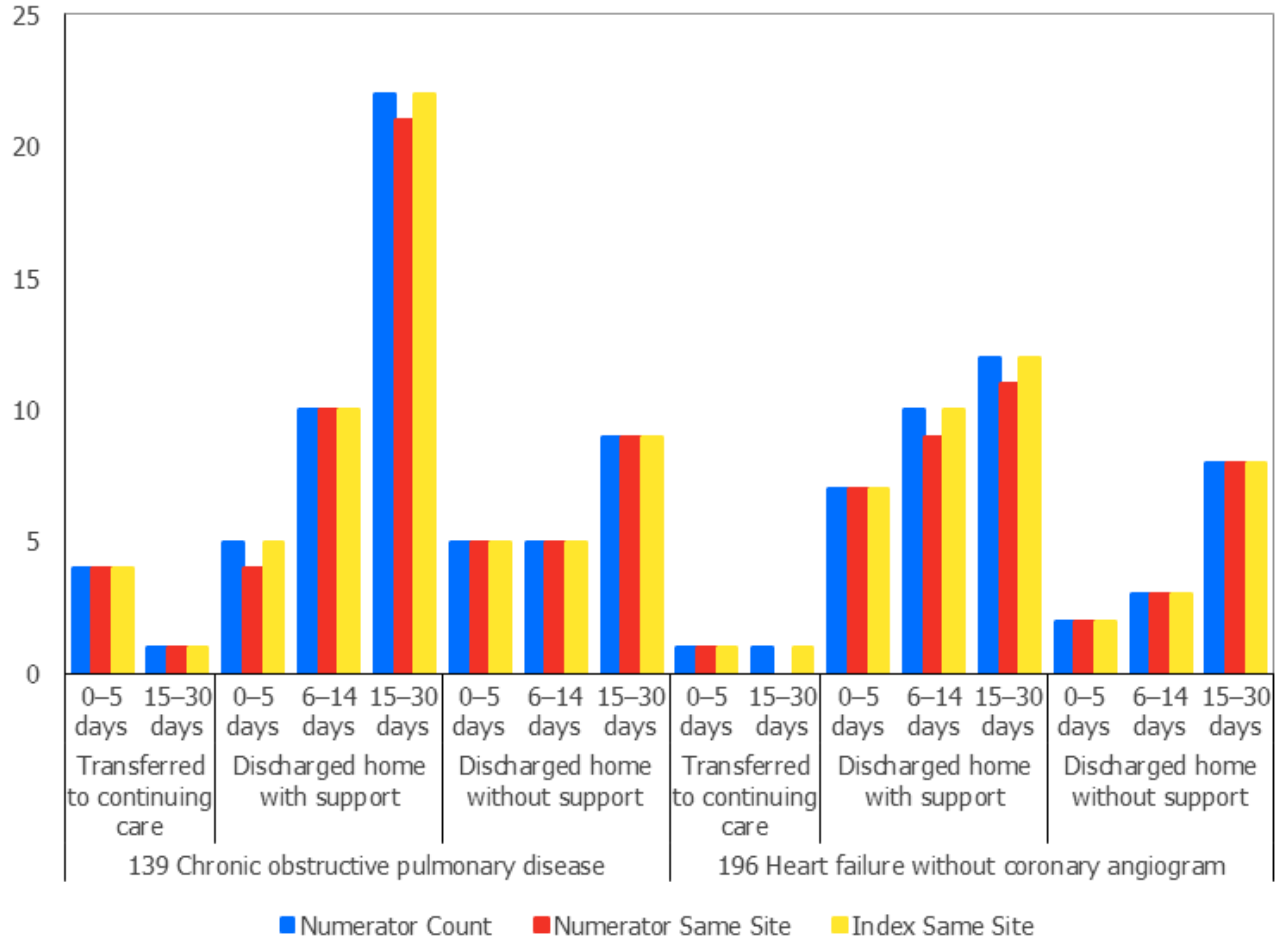
Readmission Days by Disposition



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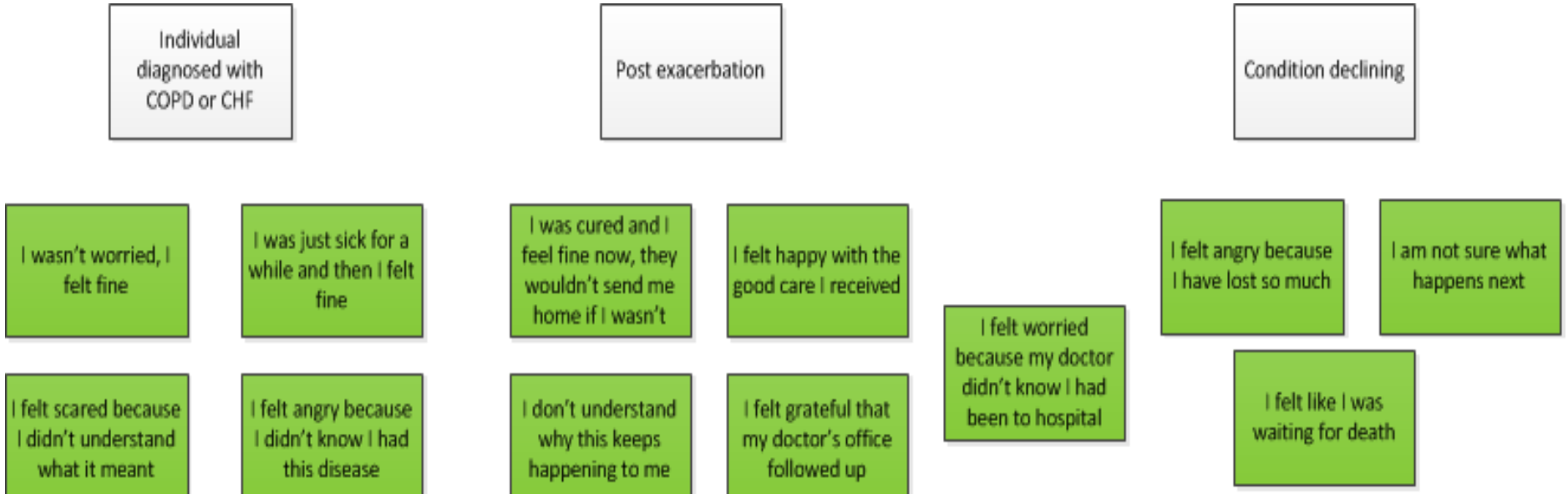
Understanding the Client Experience with the Current System



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What We Are Trying to Achieve

- To decrease readmissions for COPD and CHF (from 33% CHF & 28% COPD) by 5% by April 2016.

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Ground Ourselves in Value from the Client's Perspective

Client Value Statement

As an individual with COPD/CHF, I need for me & my support network:
To be part of the decisions about my care
To understand the options and their outcomes
To be respected for my decisions
To have timely access to the best care and supports to improve my quality of life

Co-design session with system partners identified the improvement opportunities to test

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Changes We Have Tested So Far

- Hospital providing discharge notes to primary care within 48-hours of discharge (I)
- Hospital fax to primary care requesting post-discharge appointment date and information about relevant tests and procedures as part of the QBP implementation (T)
- Primary care team visit with patient within 7 (14) days post discharge (in office or in home) (T)
- Primary care nurse participation in the hospital discharge rounds (A)
- Primary care pharmacist medication assessment and review post-hospital discharge (T)

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- Hospital charge nurse call to primary care team prior to patient discharge to discuss concerns and ensure scheduled primary care visit (including in-home team visit if needed) (T)
- Primary care nurse call patient within 48-hours of discharge (A)
- Primary care office call to patient within 48-hours of discharge to discuss concerns, ensure patient appointment with physician and primary care nurse (T)
- Primary care nurse appointment (in conjunction with physician appointment) to provide self-management support and navigation support (T)
- Hospital calculating LACE score to identify patients at high risk of readmission and trigger increased wrap-around care (P)

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Lessons Learned So Far

- Working on it together is important
  - Just ask – invite partners to work together
  - Pick a "good enough" measure and work on improving it together
  - Sharing order sets across the system to increase consistency
- Communication is key, key, key
  - It's about the conversations and working and learning together
  - There is a lot going on in isolation – "Lots of committees working on this but it is not translated into practice"
- Perception that human to human contact is a burden
  - Hospital staff need to feel okay about just calling the doctor's office
  - Primary care staff need to know the call may be coming & to shape what is expected

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- Involving the whole practice team is critical
  - Each practice needs to decide who they want their 'go-to person' to be
- Admission and readmission numbers are small and want to build consistent clinical competency
- Learn from PDSA cycles – there is as much to learn from changes we abandon as those we implement
- Spread to multiple hospital floors and multiple primary care clinics is challenging
  - It takes time
- Improvements are needed in the end of life care related to access and processes for non-cancer patients

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