MyMichigan Medical Gladwin Improving All Cause 30 Day Readmission

Julie Simon, BSN, RN, CMSRN
Manager Transitional Care & MSW
MyMichigan Medical Center Gladwin

Michele Wing, RN
Case Management
MyMichigan Medical Center Gladwin

Excellence in ImprovingAll-Cause 30 Day Readmissions

MyMichigan Health
UNIVERSITY OF MICHIGAN HEALTH

Background

MyMichigan Medical Center Gladwin is a 25-bed critical access hospital providing general medical and surgical care for IP and OP, Transitional Care, and 24-hour ED.

In 2023, one in five Medicare patients were readmitted:

- 75% could have been prevented with improved discharge planning.

- 64% of Medicare patients did not receive post-hospital care.

Our Process

Interventions

- • Readmission Tool
- • Risk for Readmission Huddle
- • High-Functioning Care Coordination Team

Activities

- • Review risk for readmission score.
- • Huddle to assess risk for readmission.
- • Huddle with transitional nurse and follow-up.

Strategies

- • Coordinate and improve post hospital care.

Interventions: A Closer Look

Intervention #1

Risk for Readmission Score

- •Use predictive analytic tool in EPIC.
- •Score risk of readmission within 30 days after discharge.
- •Patients who score in moderate to high-risk range will have a Risk for Readmissions scheduled during their admission.
- •Care Coordination Team ensures the patient receives the best discharge plan possible to avoid readmission and decease hospital mortality.
- •Scores are created by the patient's diagnosis, co-morbidities, lab results, medication, emergency room, hospital admission, PCP visits.

Interventions:A Closer Look (Continued)

Intervention #2

Risk for Readmission Huddle

- •The Case Manager will set a Risk Huddle Meeting for all moderate to high-risk range patients.
- •The Risk for Readmission team is comprised of nursing, a nursing manager, a hospitalist, a pharmacist, an OT, a PT, and a respiratory therapist.
- •Referral placed to Outpatient Care Manager for follow up 24-48 post discharge

Interventions: A Closer Look (continued)

Intervention #3

Transitional Care Huddle and Follow-up

- •Held huddle biweekly.
- •Team members included Transitional Care Manager, Managers of Home Care, Case Management, Hospice, Skilled Nursing Home Accepting Facilities.
- •Assess what went well, what didn't go well, and what could we do differently.
- •Determine if there were processes that needed to be changed to improve in transition of care across the continuum.

Results

- **•2021 Readmission Rate 13.3%**
- **•2022 Readmission Rate 13.7%**
- **•2023 Readmission Rate 10.3%**

Challenges

- •Adjusted scoring tool
- •Department, patient engagement and acceptance of the post discharge plan

Next Steps

- •Continue to build Care Coordination Teams.
- •Solidify huddle time with groups so all meet at the same time.