Keck Medical Center of USC

Moving the Titanic: Reducing Readmissions Utilizing an Optimizing Transitions of Care (OTC) Committee

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Learning Objectives

- Identify three leader/facilitator traits necessary for a committee to be effective
- Identify 3 member traits necessary for a committee to be effective
- Explain why clarity around outcome and process measures are essential to achieving committee goals
- Illustrate why it is important to be able to identify simple versus complex strategies to achieve goals and how and when to deploy them
- Identify 3 tools to potentially integrate into your readmission prevention practice and why they would help you achieve your goals

Background

In 2018, our internal and academic peer data regarding readmission rates for our Keck Hospital of USC patients revealed that, despite attempts at reducing readmission rates, we were not making the progress we desired, or our patients deserved. We determined to reduce the amount of 14-day and 30-day readmissions by harnessing the power of a formal multidisciplinary team working towards a common goal. The work of the committee was crucial in creating and executing on complex strategic goals to reduce readmissions

Goals

- Decrease readmission rates
- Positively impact CMS HRRP Program
- Improve the Transition of care continuum
- Improve outcomes/Decrease morbidity and mortality
- Harness knowledge from the multidisciplinary team
- Analyze service-Lines and Multi-visit patients
- Standardize the discharge process across entities
- Improve EDAC metrics
- Improve Vizient Quality & Accountability Scorecard

Methods/Tools

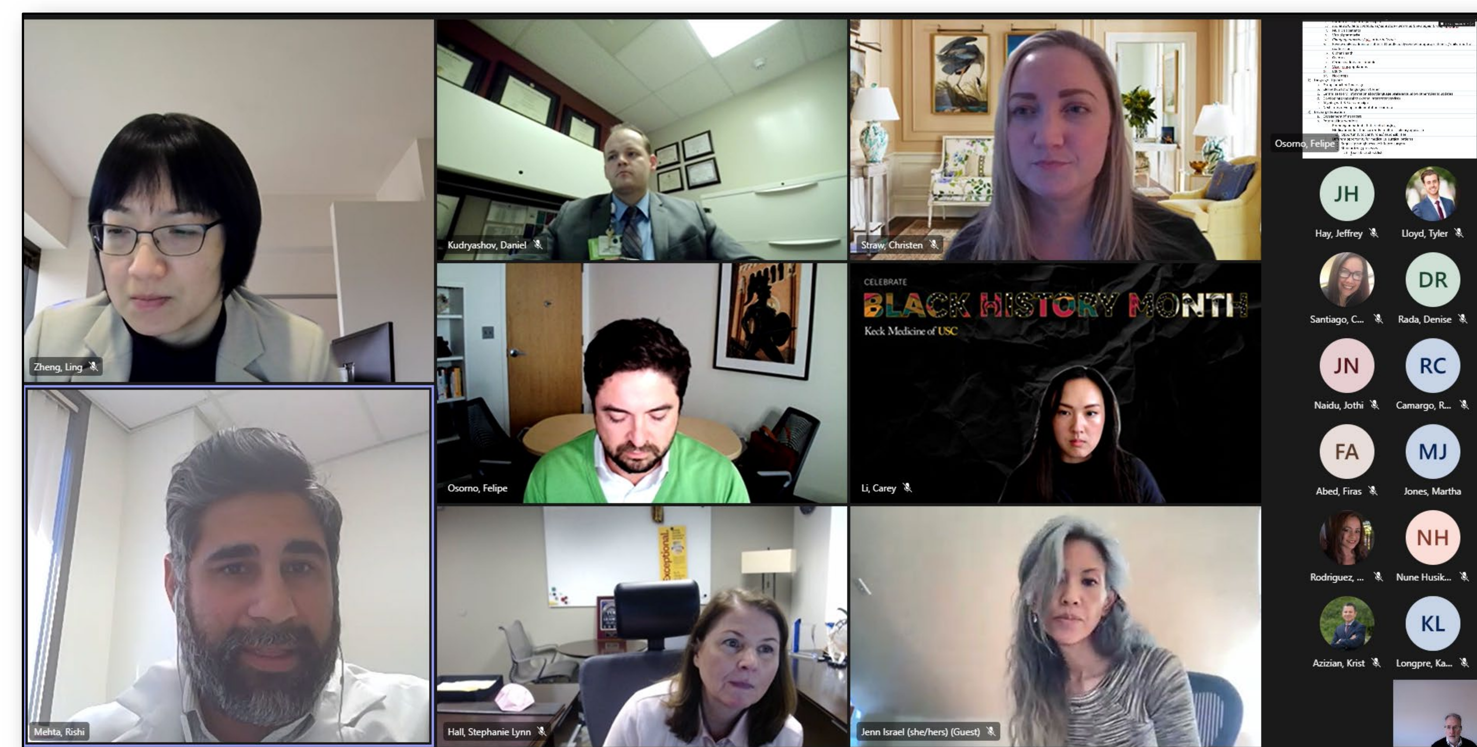
OPTIMIZING TRANSITIONS OF CARE COMMITTEE

Membership

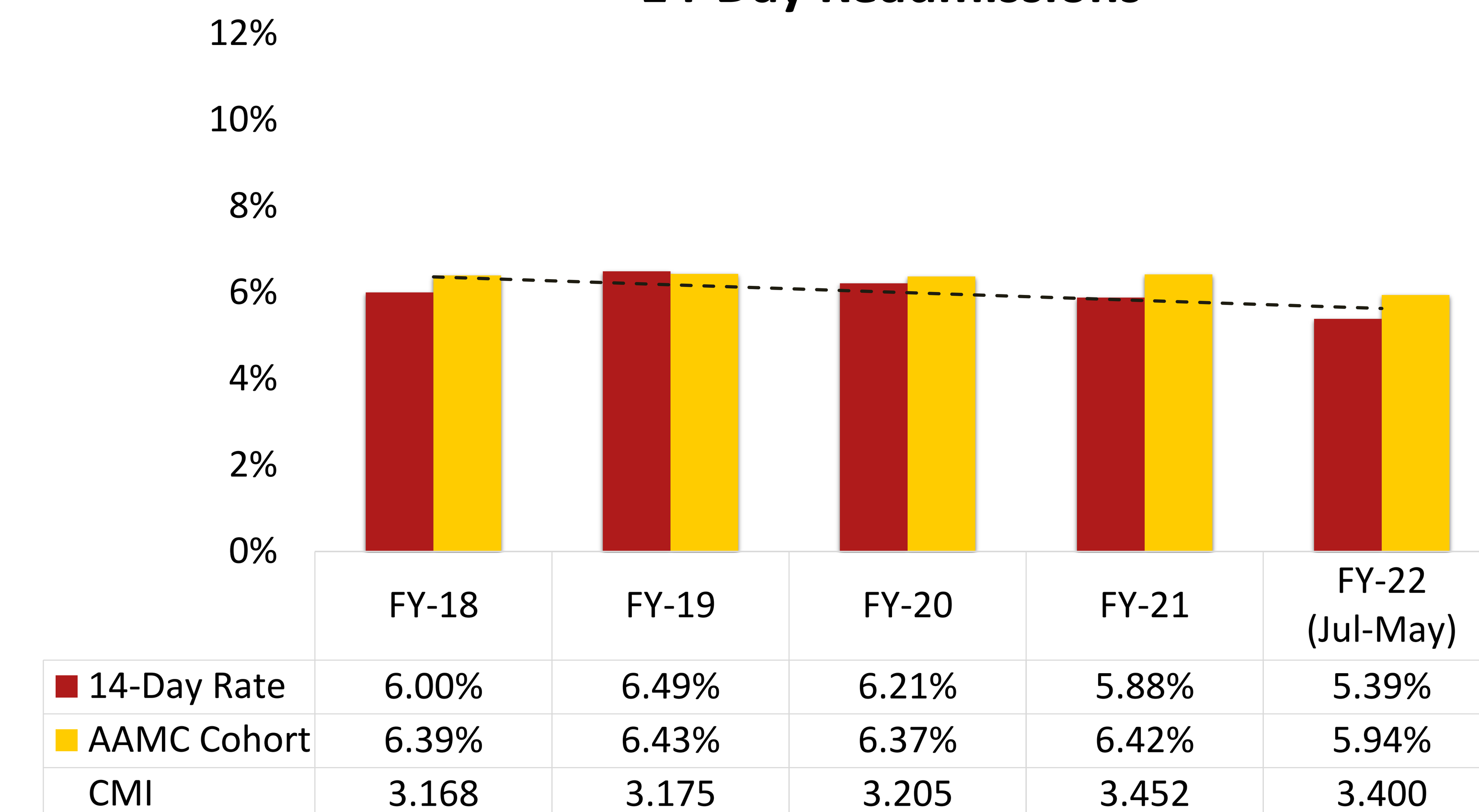
- Co-led by Executive Administrators of Continuum of Care Operations and Quality
- Inpatient Quality
- Continuum of Care/Value Improvement leadership and staff
- Chief Medical Officer
- Pharmacy
- Hospitalist Medical Director and faculty
- Discharge Planning
- Ambulatory Quality
- Information Technology
- Nursing Case Management
- Social Services
- Informatics and Analytics
- Ad-Hoc specific service line Attending Physicians

Committee Strategic Implementations Examples

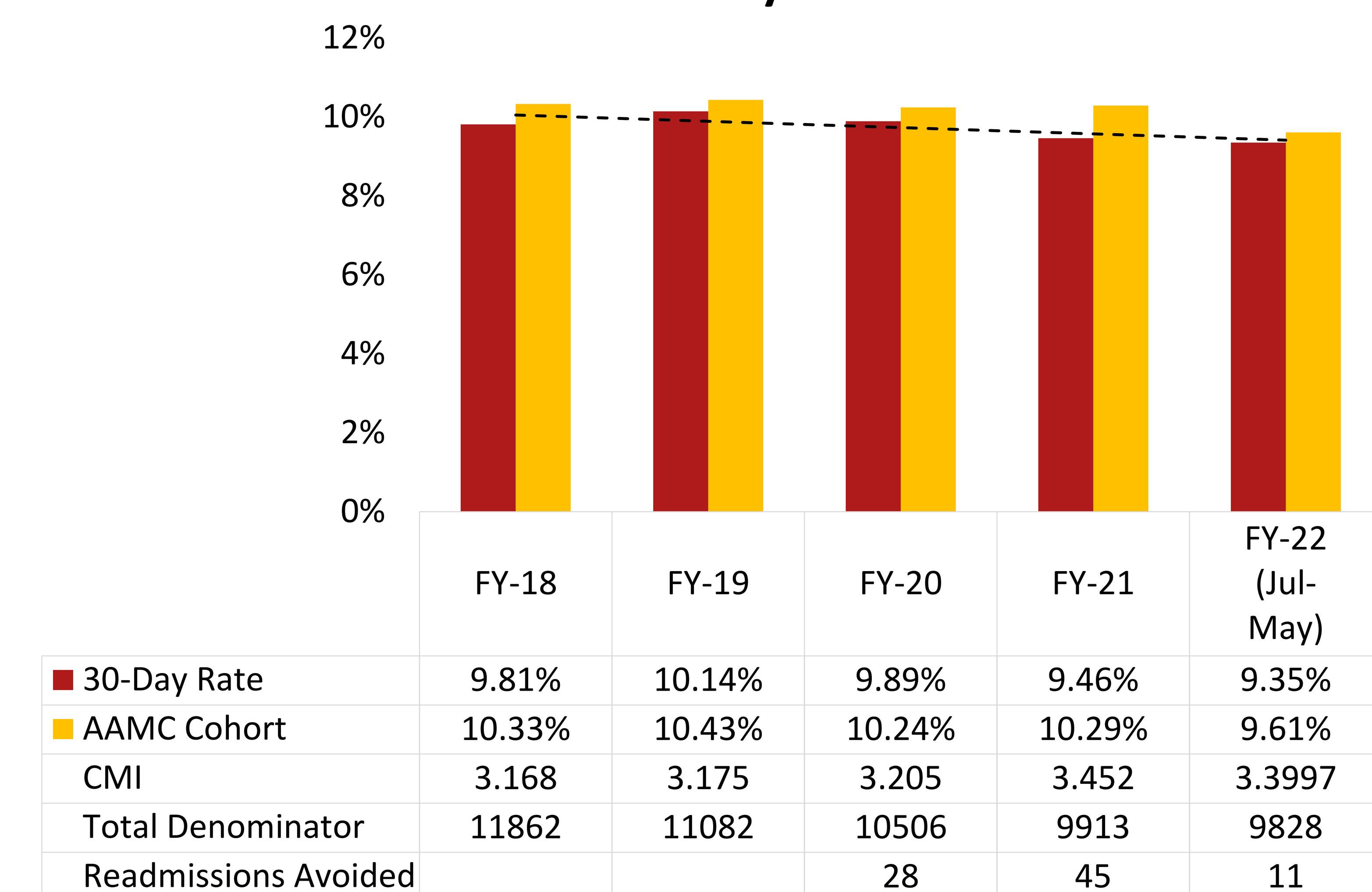
- Creation of a Daily Readmission Report
- Service-line drilldowns
- Participation in a Vizient Muti-Visit Patient Acceleration Network
- Clarifying the ordering workflow related to admission vs. observation
- Cipher Health post-discharge phone follow-up



Outcomes



	FY-18	FY-19	FY-20	FY-21	FY-22 (Jul-May)
14-Day Rate	6.00%	6.49%	6.21%	5.88%	5.39%
AAMC Cohort	6.39%	6.43%	6.37%	6.42%	5.94%
CMI	3.168	3.175	3.205	3.452	3.400



	FY-18	FY-19	FY-20	FY-21	FY-22 (Jul-May)
30-Day Rate	9.81%	10.14%	9.89%	9.46%	9.35%
AAMC Cohort	10.33%	10.43%	10.24%	10.29%	9.61%
CMI	3.168	3.175	3.205	3.452	3.3997
Total Denominator	11862	11082	10506	9913	9828
Readmissions Avoided			28	45	11

Key Takeaways

- Reducing readmissions can only be achieved through perseverance using a multidisciplinary approach
- Do not be discouraged by incremental reductions
- Be realistic about time frames to achieve complex strategy goals related to readmission
- Ensure all applicable disciplines are represented in your readmissions reduction team
- A Daily Readmission List is crucial to continuous focus and identification of common factors leading to readmission
- Ensure that "observation" order status is used accurately so as not to artificially inflate readmission numbers
- For those service lines that have high "readmitters", partner with physician liaisons to create and implement service line-specific interventions
- Focus analysis and interventions on Multi-Visit Patients
- Explore opportunities to address social determinants of care and address equity
- Consider use of an auto-discharge phone call vendor to address post-discharge questions related to medication, post-surgical questions etc.