Case Example: Readmissions Debrief: Closing the Quality Loop

Best Practice: VNA Care of New England

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VNA Care of New England has implemented a ‘weekly debriefing’ to review every patient readmitted to the hospital from the home health services. The agency’s Readmission Prevention Team is charged with looking for preventable causes or patterns that could be addressed through improvements in agency processes or reducing gaps in care. For each case the team evaluates for missed opportunities, asking questions such as:

- Did we frontload?
- Did we visit in a timely manner?
- Did the patient postpone the visit?
- Did the agency follow up on orders or order changes?

At the team meetings, case information is projected onto a screen so that the whole team can review the data and individual case features to identify preventable issues. The group invites clinical managers to participate in this process of assessing and identifying ‘root causes’ of readmissions. This quality improvement group may generate recommended improvements at the end of the meeting.

As a result of these meetings, VNA Care New England the agency has noticed that patient refusal for a visit can be a red flag. The agency also began to see trends suggesting the need for scheduling changes to ensure clinical staff availability. Now, the clinical evaluator of the patient, not the scheduler, makes the decision about whether to see the patient immediately after admission. The agency also carefully evaluates performance data for changes in quality measures.

Many patients discharged to home are extremely frail, and even when the agency follows every care pathway they have found it is often difficult to prevent readmissions. However, this approach ensures that the organizations has programs and strategies in place to maximize effective services for high risk patients.

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