AMI Readmission Reduction Program: “Never Discharge a Patient”

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BACKGROUND

Readmission for acute myocardial infarction (AMI) significantly contributes to preventable morbidity and health-care costs. Our aim was to test whether using the Transitions of Care (TOC) program resulted in reduced 30-day readmission after AMI.

METHODS

Advent Health Sebring Hospital along with Patient Engagement Advisors [PEA] developed a robust Transitions of Care Program (TOC) as a pilot project.

The TOC program extends care for the AMI patients and caregivers as they transition through the continuum of care beyond the hospital wall. It ensures the patient have the tools and support needed to successfully attain healthy outcomes.

A small team of pharmacy technicians were hired called ‘Transition Specialists’ [TS] to staff all clinical settings across the campus, providing in-person and telephonic support 24x7, 7 days a week. Transition Specialists each carry an iPad with proprietary built application (PNS) interfaced to ADT, clinical orders/diagnosis, retail pharmacy, and ambulatory systems.

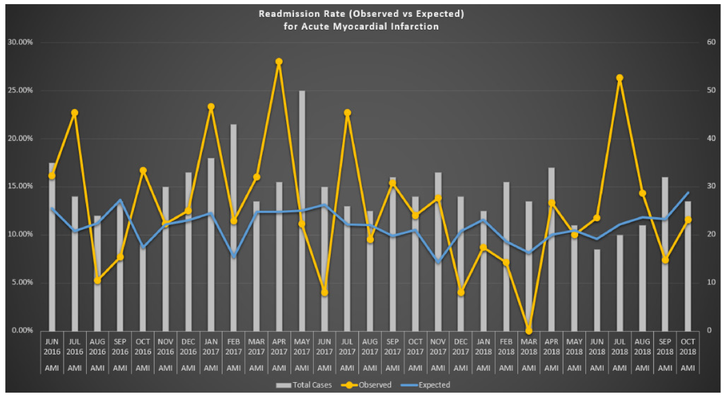
The team first developed a branded enrollment program named “Healthy 360°”. A highly developed process of engaging and enrolling patients into the program.

The targeted patients are rolled out in phases:
Phase 1: ER, Observation and Acute discharges
Phase 2: SNF and ALF discharges to home
Phase 3: Home Health / In Home Integration

The PNS systems loads all high risk populations and allows the team to prioritize their day.
The TS participates in multi-disciplinary rounds, then formulates a comprehensive action list which include.

- **Scheduled follow up appointments with physicians.** This also includes expectation setting for post-acute services (Home Health / SNF/ALF processes aligned with Healthy 360°).
- **Coordination of transportation** logistics from home to clinic
- **Medications** (bed side delivery, prior authorizations, eligibility for free medications for uninsured patients by looking at patient assistance from drug companies).
- **Nutrition support** (providing in-home clinically built meals in 7, 14, and 21 day increments with low sodium diet, diabetic diets).
- **Establishment of an inpatient pharmacy**

A combination of alerting mechanism through the PNS system allows real time notifications for missed patients and follow up requirements. Daily evaluations of analytic tools and generated reports from a team of analysts are submitted to aid operational teams as they evaluate support, eligibility and contract requirements.



RESULTS

84% of all patients have been directly offered the Healthy 360° program

99% of all patients have voluntarily accepted and enrolled into the Healthy 360°program

Scheduled appointments prior to discharge have increased from 27% to 63%

67% of all patients are showing up for scheduled appointments.

AMI readmission rates have reduced to 15% since implementation and fallen below expected rates for the fiscal year November 2017 to October 2018, which translates to $180,000 savings in penalties.

The excess readmission ratio for AMI was <1 (0.8882).

CONCLUSION

Readmissions for patients with AMI were significantly reduced since the implementation of the unique Transitions of Care (TOC) program which extends health care beyond the four walls of the medical care facility and never truly discharges the patient.

DISCLOSURES

Dr Shimshak: Boston Scientific, Endologix,
Other authors: None

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