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CONFERENCE ABSTRACT

Reducing Avoidable Readmissions in Toronto for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Community-Acquired Pneumonia (CAP) and Gastrointestinal (GI) Diseases

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Introduction

Reducing avoidable readmissions is an important focus to improve patient care and end unnecessary hospitalization. Toronto had a readmissions rate of 18.3% and CHF, COPD, CAP and GI Diseases were identified to have the highest readmission rates in Toronto Hospitals. This work was established to lead a cross-sectoral, integrated approach to reduce avoidable 30-day readmissions by exploring and understanding readmissions data, drivers and best practices and implement a regional strategy supporting best practices in local environments. The focus was to leverage small investment for big impact. It resulted in a reduction in hospital 30-day readmission rates up to 30%.

Aims Objectives Theory or Methods

Project groups worked in partnership with patients, acute and rehab hospitals, physicians, primary care clinicians and home and community care providers across Toronto. Over 200 people and organizations participated. This work included the following: patient profiles were developed (including social equity factors); patient surveys and interviews were conducted; clinician workshops were facilitated and leading practices identified. Integrated approaches were implemented in hospitals, community and primary care. Clinical champions were identified and physician engagement was measured. A regional, transparent performance scorecard was developed to motivate partners and identify gaps.

Highlights or Results or Key Findings

Project groups developed and implemented strategies:

- Patient oriented discharge summaries (PODS) for Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Community-Acquired Pneumonia and Gastrointestinal Diseases. They were validated and standardized by patients, families/caregivers and physicians.

- Increasing referrals to community services especially for the first 14 days post discharge. The Enhanced Home at Last Program was tailored to patients at high risk for readmission and based on patient feedback. It provides effective transitions through transition coaches and personal support worker supports for patients at home after leaving the hospital.
- Standardized best practices built into existing care pathways. This includes: PODS, completing/sharing discharge summaries with primary care providers within 48 hours, medication reconciliation and referrals to home/community care
- Continuing emphasis on physician and leadership engagement within hospitals and primary care, throughout the project. An important success factor.
- Hospital booking primary care appointments before discharge so patients are seen within 7 days of discharge

Conclusions

Results have been remarkable which has led to a reduction in hospital 30-day readmission rates of up to 30%. This has resulted in better patient outcomes and utilization. Toronto is now one of the lowest in Ontario, with a readmission rate of 12.6%, which demonstrates sustained results.

Implications for applicability/transferability sustainability and limitations

This created knowledge that others can follow to reduce avoidable hospital readmissions through:

- Identifying quality gaps. Establishing avoidable readmission targets.
- Tailoring transition supports in the community.
- Enhancing/measuring primary care linkages.
- High provider engagement throughout.
- Integrated approaches with organizational and clinical accountability.
- Patient engagement.
- Ongoing monitoring and feedback.
- Sustaining momentum.