St. Vincent’s Hospital Westchester: Decreasing Adult Readmissions by Improving the Discharge Process

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St. Vincent’s Hospital Westchester is a 133-bed psychiatric facility in Harrison, N.Y., consisting of five inpatient psychiatric units, one chemical dependency unit and many outpatient programs. The hospital discharges approximately 3,000 inpatients per year. For 130 years, St. Vincent’s Hospital Westchester has provided compassionate care for thousands of people challenged by mental illness and addiction. More Westchester residents turn to St. Vincent’s for mental health treatment services than to any other facility in the county. The hospital is now part of Saint Joseph’s Medical Center, based in Yonkers, N.Y.

Challenge
The Centers for Medicare and Medicaid Services (CMS) has targeted hospital readmissions to reduce unnecessary health care spending and improve quality of care. St. Vincent’s Hospital Westchester recognizes reduced readmissions as indicative of good clinical care and, further, as a quality indicator of good and effective discharge processes. But, over the years, our adult readmission rates had been consistently above the national mean for psychiatric facilities. Our challenges were to reduce our readmission rate and improve patient satisfaction.

Preparation
In mid-2006, we convened a multidisciplinary team to address our unacceptably high rates of adult readmissions. The team included discharge planners, nurses, social workers, follow-up care specialists, and the associate medical director and VP of performance improvement — leadership involvement is always critical. We started out focusing narrowly on “just reducing readmissions,” but had little initial success. In the third quarter 2007, the hospital’s 15-day readmission rate of over 66 per 1,000 discharges was still 36% above the mean of 48.72. Further analysis found no pattern or demographic trend of readmitted patients. They were of all ages, units, diagnoses, living situations, etc.

These results led the team to realize that readmission rates were an outcome of the discharge process. We believed that we would better serve our patients and likely have better success by broadening our focus to improving the entire discharge planning process. Because our data showed most readmissions occurred within 15 days, with relatively few in the 16- to 30-day period, we adopted the 15-day rate as the relevant outcome measure. Our main objectives were to reduce the 15-day adult readmission rate to below the mean and improve patient satisfaction with discharge.

Solution
The Discharge Process Improvement Team examined the entire discharge planning and follow-up process to identify opportunities for improvement. We mapped out a 10-step process to meet our goals:

1. **Charter a multidisciplinary Discharge Process Improvement Team.** It should include representatives from quality, social work, discharge planning, nursing, medicine, admissions and follow-up care.
2. **Ensure patient’s contact information is correct (address, phone, emergency contact).** Up-to-date information helps expedite discharge. For example, inaccurate contact information for the patient’s family can delay discharge meetings. Accurate contact information is also crucial for post-discharge follow-up.

3. **Ensure financial information is up-to-date.** This helps the treatment team and discharge planner know where they can and can’t refer a patient for aftercare and whether a patient qualifies for transportation. Similarly, inaccurate information can delay filling prescriptions at our pharmacy on discharge day.

4. **Improve processes to store and return patient valuables.** Avoids disruption of discharge due to misplaced items, and reduces delays and negative patient experience.

5. **Ensure that patients fill medication prescriptions at the hospital pharmacy before leaving the hospital.** Analysis of readmissions revealed that the main reason for readmission of the psychiatric population was non-compliance with medications. Having their prescription in hand upon discharge helps to improve medication compliance, avoid medication errors, improve patient satisfaction and enhance the likelihood of patient’s continued stability after discharge.

6. **Upgrade and improve access to medication/diagnosis teaching tools.** Educated patients are more likely to understand and comply with their discharge plan. Weekly teaching groups are led by nurses on the unit. Lexicomp, a computerized medication and diagnosis information system, provides the most up-to-date information and can be personalized in various languages and educational levels.

7. **Organize the information given to patient at discharge.** A well-organized folder containing all the information patients need when they get home reduces their (and their families’) anxieties and contributes to continuity of care. We adapted a process from Dr. Brian Jack’s Re-Engineered Hospital Discharge (RED) program out of Boston University Medical Center. We give patients a folder that organizes all their discharge information, including discharge information sheets, aftercare appointments, phone numbers, emergency contacts, medications prescribed and a personalized medication/diagnosis information packet.

8. **Ensure that completed discharge summary is sent to after-care provider within 24 hours.** Discharge summaries contain vital treatment information.

9. **Use a Discharge Checklist to ensure all steps of the discharge process are addressed.** It’s easy to forget all the elements that go into a successful discharge. A list also organizes and provides a guide to the treatment providers so that no step is missed or forgotten.

10. **Post-discharge phone call to patient.** Within 24-48 hours of discharge, an RN specially trained in follow-up calls patients to see how they are doing, ensure that they are taking their meds, aren’t experiencing any side effects and, most importantly, to remind them of their aftercare appointment.

**Results**

Between third quarter 2007 and third quarter 2009, the adult readmission rate at St. Vincent’s Hospital Westchester decreased by 33% to levels well below the mean. As the percentage of patients filling prescriptions upon discharge increased, so has the percentage of readmissions decreased. Patient satisfaction with discharge (as measured by Press Ganey’s inpatient psychiatric patient satisfaction survey) soared in 2007 following the introduction of improved discharge process elements. The percentage of patients who “felt prepared for discharge” rose from 12% in 2006 to 65% in 2009. It’s not yet in the 90’s, to which we aspire, but clearly a massive improvement.

We believe a well-organized discharge process that includes meaningful patient education and follow-up is more likely to result in better adherence to the discharge plan, fewer readmissions and improved patient satisfaction. No single step will improve the discharge process or reduce readmission — rather all need to be part of the process. The success of this program can be replicated on any inpatient unit.
St. Vincent's Hospital Westchester
Patient Satisfaction Percentile Rankings - "Felt Prepared for Discharge"
2006-2009

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