

Reducing Acute Care Hospitalization Readmissions for My Choice Family Care Older Adults through Telephonic Post-Discharge Assessment Utilization

Each year we choose a project to improve the lives of our members and the care they receive. A few previous topics include managing hypertension, cognitive screening, reducing behavioral restraints, and empowering members to navigate advance care planning. These projects are approved and reviewed by a third-party external quality organization and reported to the State of Wisconsin.

Hospital Readmissions

Increasing readmission rates has become a national concern. Readmissions are costly, often preventable, may be an indication of poor quality of care, and can negatively impact members.

My Choice Family Care already works closely with hospitals when our members are in the hospital. Care Teams and our Hospital Liaison work with hospital staff to get members back into their homes as quickly as possible with the supports they need.

In 2019, we chose to expand our efforts and specifically focus on a project to reduce readmissions for older adults (65 and older) enrolled in My Choice Family Care.

Project Aims

- Goal 1: Increase the number of post-discharge contacts completed with older adult members.
- Goal 2: Reduce the number of older adult members who return to the hospital within 30-days of discharge.

Activities

My Choice nurses researched evidence-based over the phone assessment tools shown to reduce hospital readmissions. We selected a tool and adapted it to be relevant to our members.

Care Teams will be trained on the new tool and Care Team nurses will use it to check-in on members within 3-days (72-hours) of the member leaving the hospital.

The tool, along with education and assistance scheduling follow-up appointments, should help reach both project goals and lead to long term improvements with fewer hospitalizations for My Choice Family Care members.

