Performance Improvement Project 2019 Results

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 past topics include cognitive screening, reducing behavioral restraints, and empowering members to self-direct their services. 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 return members to their homes as quickly as possible with the supports they need.

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

Goals & Accomplishments

We set two goals for our 2019 project which would directly benefit members:

Goal 1*: Increase the number of post-discharge contacts Care Teams complete with older adults.*

While post-discharge contacts did increase, it did not reflect significant improvement by the end of our project.

Goal 2: *Reduce the number of older adult members who return to the hospital within 30-days of discharge.*

Within the timeframe of the project there was no indication that the new post-discharge tool had any effect on the likelihood of readmission.

Improvements accomplished through the project to sustain post-hospital care coordination:

- ✓ New Post-Discharge Telephonic Nursing Assessment Tool
- ✓ Comprehensive training of Care Team staff
- ✓ Online notifications to enable Care Teams to better manage hospitalizations in a timely manner