Performance Improvement Project 2020

Reducing Risk of 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 hospitalized. 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 2020, we chose to expand our efforts to focus on the 30-day post-discharge primary care physician follow-up appointment.

Project Aims

Goal 1: Increase the number of post-discharge contacts completed with older adult members.

Goal 2: Increase the number of scheduled post-discharge follow-up appointments within 30 days of discharge.

Activities

My Choice nurses will continue to use the evidence-based telephonic assessment tool shown to reduce hospital readmissions. The tool was slightly modified based on feedback collected in 2019.

Care Teams will be re-trained on the 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 on health literacy 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.