



# Baystate Medical Center

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February 3, 2011

# Enhanced Admission Assessment for Post-Discharge Needs

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- A **standardized assessment** is done on admission by RN and hospital case manager
- List of **current meds** is collected on every patient to expedite the hospital reconciliation process
- **Plan is customized and started to meet each patient and their family members' needs.** It is reviewed and revised based on the course of the illness and care while the patient is in the hospital



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# Multidisciplinary Rounds for HF Patients

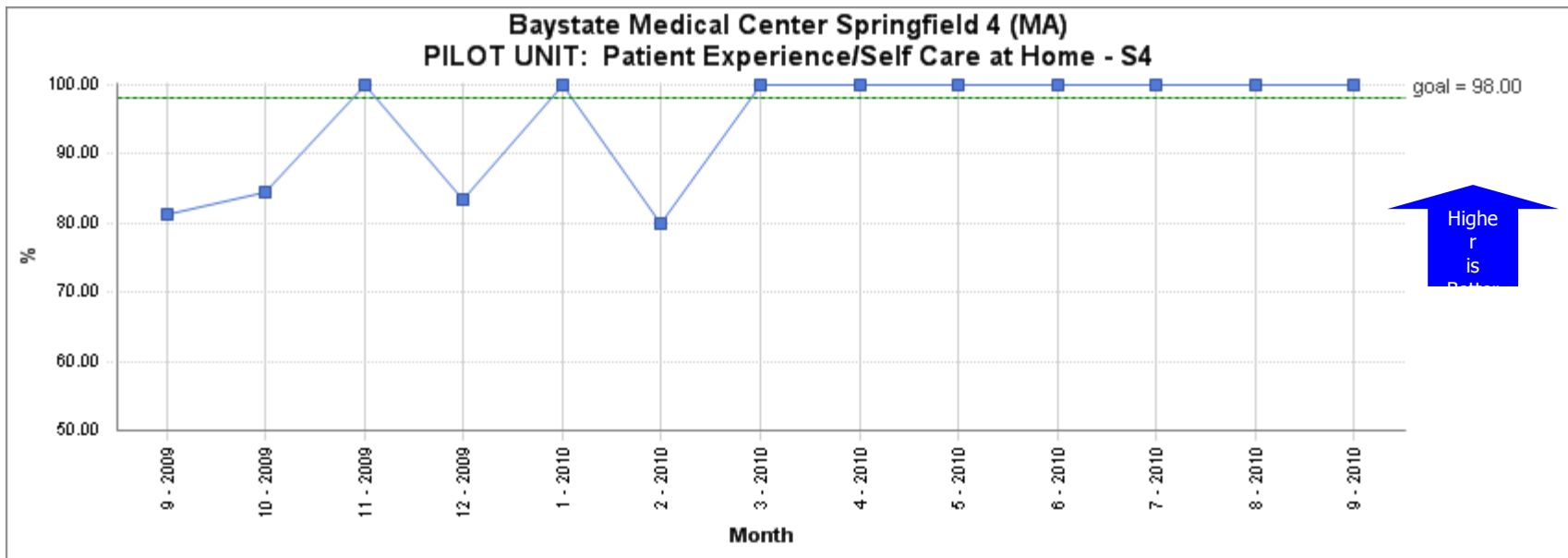
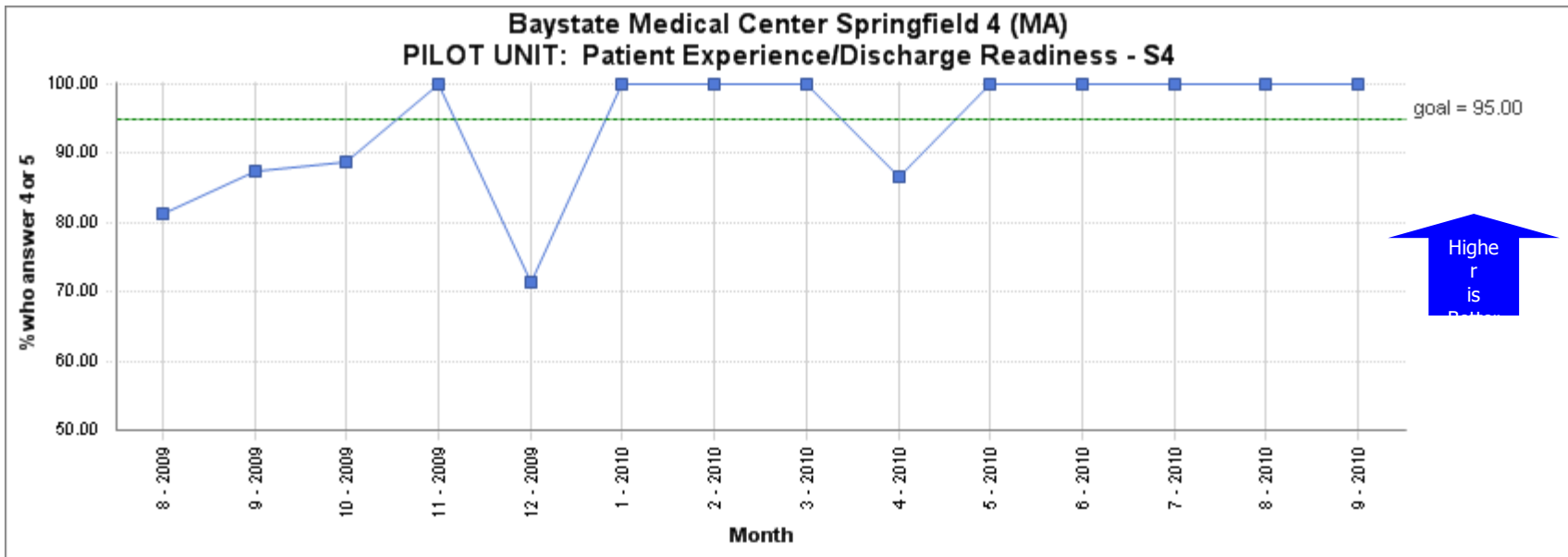
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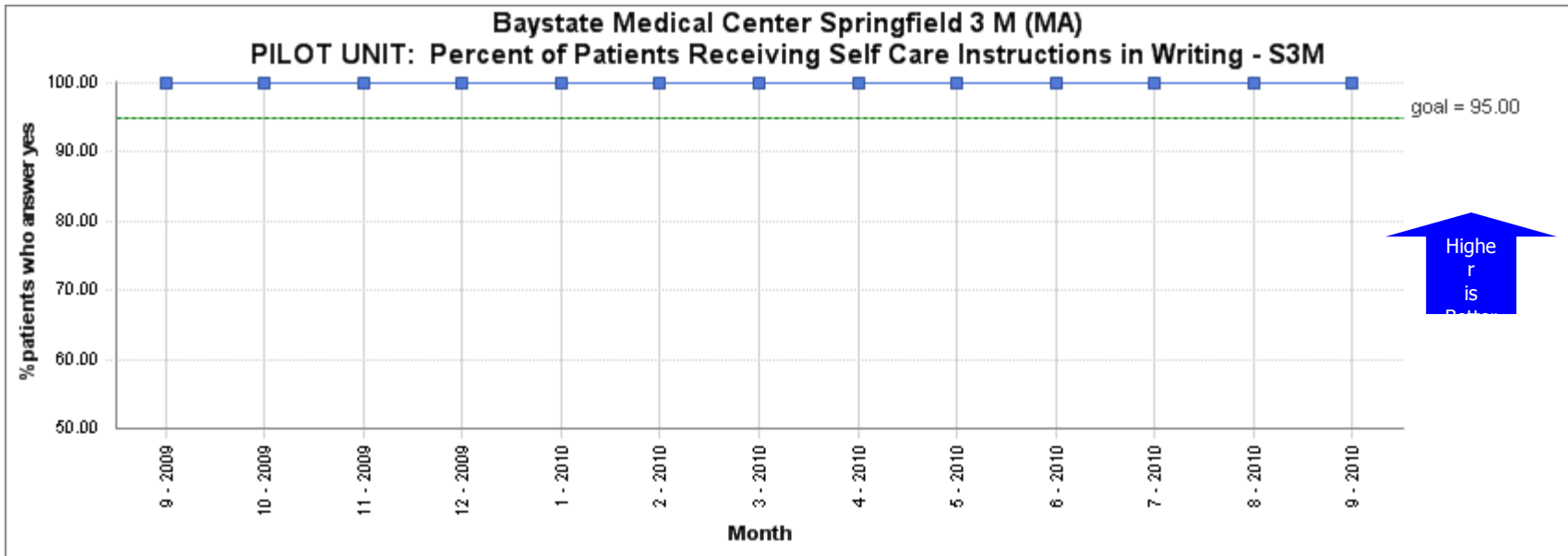
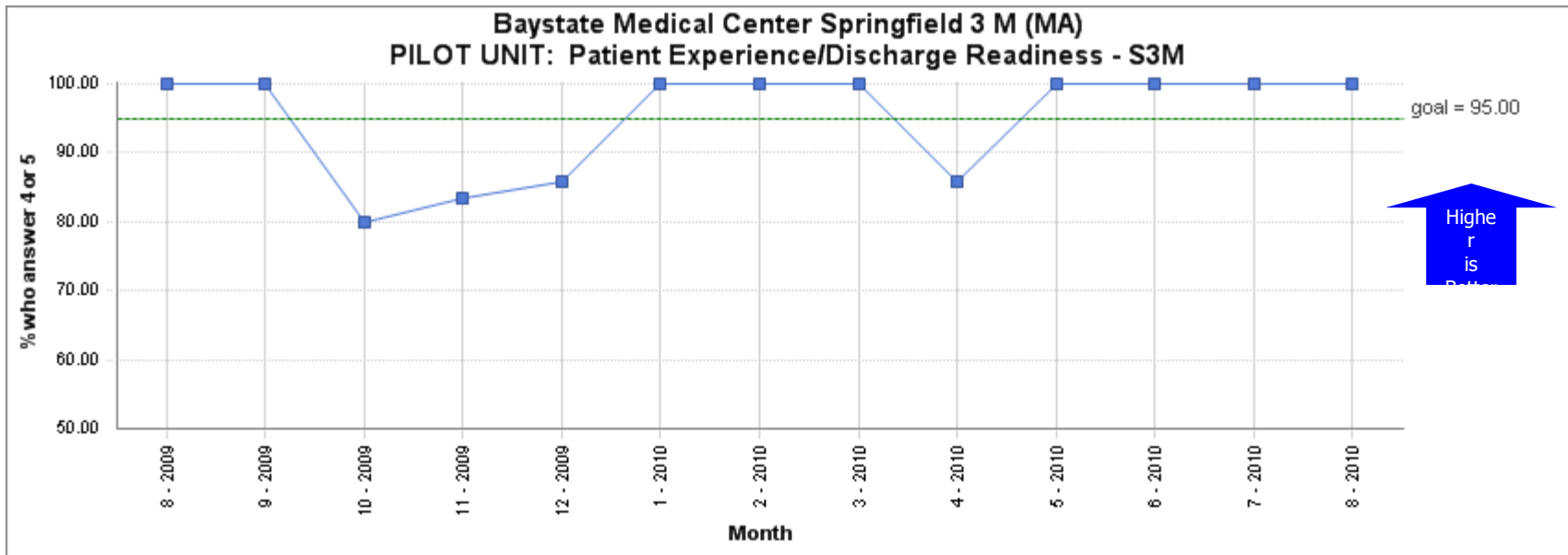
- **MDR care/table top rounds**
- **MD/RN/Coordinator/HCM/PharmD/Rehab/Clin Nutrition**
- **Focus: what missing? how are we doing?**
  - Discharge Plan (does it fit and make sense?)
  - Discuss weight difference daily
  - Fluid balance (goal is to match)
  - Core measures => EF; if <40% ACE/ARB; detailed DC Instructions
  - O2 needs
  - Diuretic Therapy (IV/PO)
  - Teach back %
- **Issues (i.e. nursing concerns/EOL/\$\$)**
- **At risk for readmission?**
  - Needs in the community setting according to assessment (teach back and gaps)



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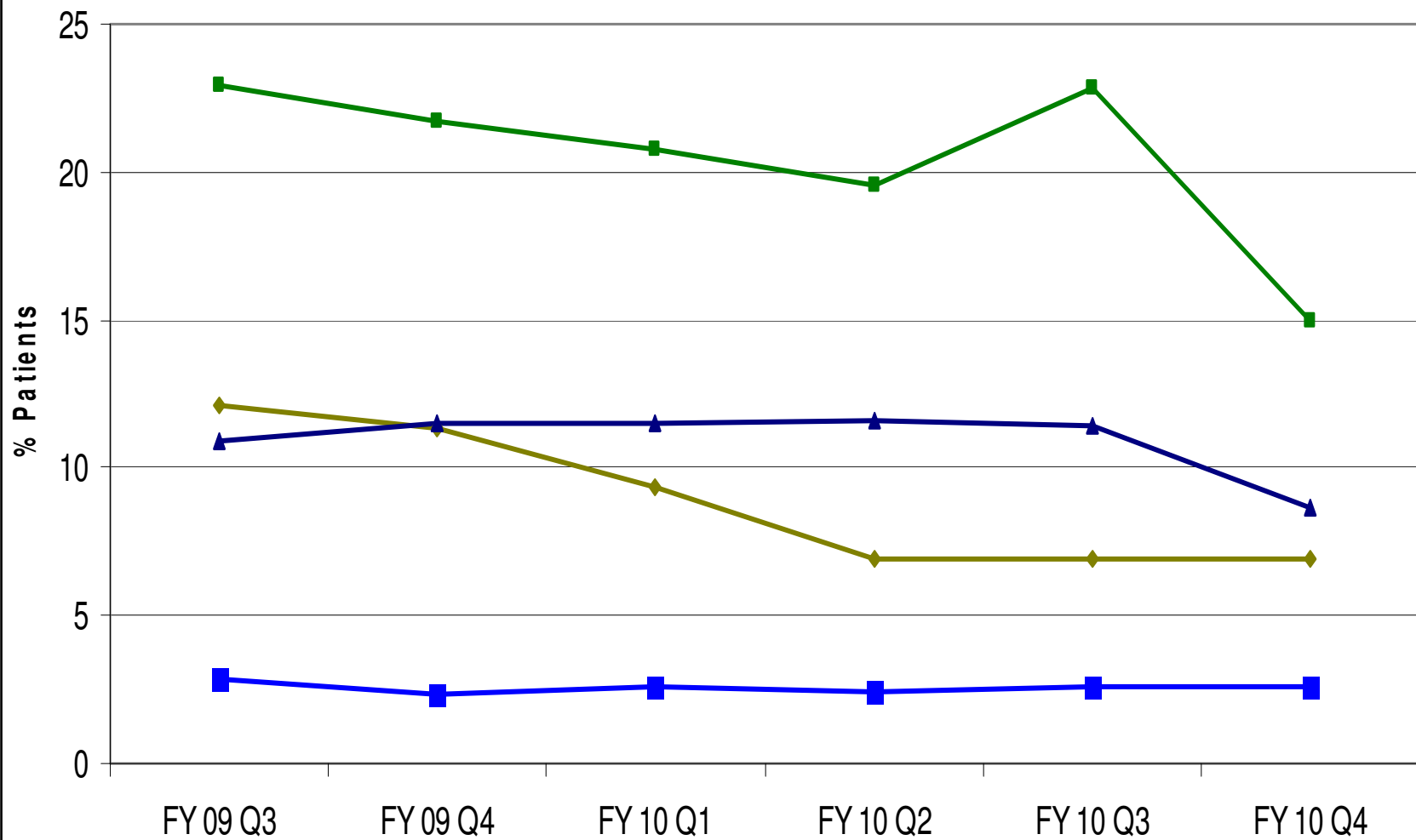






# BMC 30 Day Readmission Rates

- HF Related
- HF All Cause
- All Cause
- Related



# Keys to Success

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- Persistence and reinforcement/high visibility
- Senior leader support
- Multidisciplinary cooperation & collaboration
  - Accurate, timely and relevant data
  - Communicate – flexibility
  - Right people
- Willing to try changes and take a risk
- Develop reliable systems (strive for  $10^{-2}$  >90%)
  - Incorporate into workflow
  - Make changes easy => transparent => meaningful

***Make The Right Thing The Easy Thing***