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Transitional Care Clinic comes to Asante Three Rivers

By Eric Loeliger, MD
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Asante is committed to measuring and improving clinical outcomes. Asante's **30-day readmission rate** is a vital metric with which we can evaluate the success of our efforts, and Asante Three Rivers Medical Center took a big step toward reducing the rate by opening its new Transitional Care Clinic in May.

The 30-day readmission rate tracks patients who have been admitted as inpatients for COPD, heart failure, total knee or hip replacement, pneumonia or sepsis. If any of those patients need to be readmitted to a hospital for any reason within 30 days of being discharged, they are counted as a "30-day readmission." Asante has made reducing the number of readmissions a priority at all three hospitals, and we report this measure on our Balanced Score Card under the Care of the Patient pillar.

During the past 18 months, multiple improvements have been made at Asante Three Rivers to reduce the 30-day readmission rate. Early identification of patients who are at high risk for being readmitted starts in the Emergency Department and continues throughout a patient's stay. Discharge planning, nursing, and social work all collaborate with patients and their primary providers to improve care and reduce barriers to healing so that readmissions are minimized. These efforts have reduced the hospital's overall 30-day readmission rate to an outstanding 8.9 percent rate, which is in the top one-fifth of all hospitals in the U.S. The national average is just under 18 percent and the average in Oregon is 14.2 percent, according to the Centers for Medicare and Medicaid Services. The 30-day readmission rate for all of Asante was at 9.25 percent as of the end of July.

The Transitional Care Clinic's opening is helping to further reduce that rate at Asante Three Rivers. The TCC is located in the Asante Center for Outpatient Health, adjacent to the Urgent Care Clinic.

When a patient is identified as being at high risk for readmission, staff members in the Discharge Planning unit attempt to arrange a follow-up appointment with the patient's primary care provider so the patient can be seen within one week of discharge. If a patient does not have a primary care provider, or if that provider is unable to see the patient within a week of discharge, the patient is given an appointment at the Transitional Care Clinic. The goal is to make sure that all high-risk patients are seen within seven days.

At a typical appointment in the clinic, patients are seen by a physician or a nurse practitioner from the hospitalist team. Discharge orders and medications are reviewed to determine if patients understand and are able to follow recommendations made during their discharge. Patients are examined to determine if they are continuing to improve. If there is any concern that a patient's health is deteriorating, early intervention is taken by the clinic's providers so that a readmission may be averted. Social work and discharge planning staff members are available during TCC

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appointments to address any barriers to health that may be identified.

Since opening in May, the clinic has expanded its hours to accommodate a growing list of patients. It is now open two days per week and may continue to expand as needed. To date, nearly 100 patients have been seen at the TCC following their discharge. Among the patients who have come to the clinic for follow up, 30-day readmission rates have been reduced to 5.8 percent. That is a tremendous reduction, particularly since it is measuring the readmission rate among a group of patients identified as being at a high risk for readmission.

Reducing readmission rates will continue to be a priority in fiscal year 2017. The TCC will continue to identify patients who may benefit from a transitional care appointment and will also look for more opportunities to deliver outstanding medical care to our community.

Asante News is published every Tuesday. Deadline for submission of articles is every Friday. Send via e-mail to *asantenews@asante.org*.
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