St. Thomas Elgin General Hospital Cuts 7- and 28-Day Readmission Rates in Half Following IDEAS Training—Saving Money and Improving Care

Overview: Transitions from one care setting to another are a persistent quality gap across the province, one that can negatively impact both patient outcomes and system costs when a lack of appropriate follow-up results in worsening health and hospital readmissions. Data shows that follow-up with primary care within 7 days of discharge contributes to readmission avoidance. St. Thomas Elgin General Hospital consistently experienced higher than expected readmission rates, but since completing the IDEAS program, the changes they implemented resulted in a nearly **50% decrease in readmissions** and **cost avoidance of $325,000**.

The Problem:

St. Thomas Elgin General Hospital (STEGH) consistently experienced higher than expected readmission rates (~20% actual, compared to ~16% expected). When they looked at the data, they saw that the overall percentage of patients attending a follow-up appointment with a primary care physician within seven days of discharge from hospital was lower than the provincial average. What's more, only 41% of discharge summaries were sent from the hospital to the community primary care provider within 48 hours—so when patients did have a follow-up appointment, the physician was often unaware that their patient had been in hospital because they had not received a discharge summary. This was clearly problematic, and STEGH turned to IDEAS to learn the skills that would enable them to improve.

"We learned so much from IDEAS. It was a good way to share and network, to get ideas from others. Within our LHIN we had other London hospitals closer to us where we met quarterly to share, network and get ideas from one another."

Tania Pinheiro, Process Improvement Specialist
St. Thomas Elgin General Hospital

Results: Setting an overall aim of decreasing readmission rates for Acute Medical Patients, STEGH's IDEAS team tested a number of change ideas targeting problem areas of the transition. Change ideas included implementing and communicating process measures in a way that introduced an element of friendly competition which led to physicians vying to be the first to reach 100% compliance on their discharge summary completion. As a result, since October 2015, the overall percent of discharge summaries sent from hospital to primary care within 48 hours has been sustained at **more than 90%.** They also implemented a process for scheduling appointments which resulted in **100% of patients having a scheduled follow-up appointment prior to discharge** (for patients who have a primary care physician). These and other changes introduced led to a **50% reduction in the readmission rate** in comparison to the same period the previous year, thereby **reducing costs** and **improving patient outcomes**. During the 8-month period of implementing the project, STEGH realized cost avoidance of more than $325,000 due to fewer readmissions.

Achievements

- **100% of patients** who have a primary care physician now have follow-up appointments scheduled post-discharge
- **More than 85% of discharge summaries are now sent within 48 hours**, up from 41% before participating in IDEAS
- 7- and 28-day readmission rates have shown a nearly **50% decrease** resulting in **savings of more than $325,000.**
- This indicator is now an organizational accountability, including in STEGH's annual QIP and their Leadership Scorecard.