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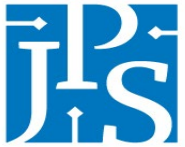

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Reducing Readmissions: Targeted Approaches for Vulnerable Patients

Andrew O'Brien, MD, Faculty, Hematology

Jason Russ, MD, Hospitalist and Assistant Professor of Clinical Medicine

Steve Roumpf, MD, MBA, Associate Chief Medical Officer, IU Health Medical Center

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Learning Objectives

- Describe how to apply data analysis to identify a target population for reducing readmissions.
- Explain the methods used to decrease 30-day readmissions in frequently admitted patients with sickle cell disease.

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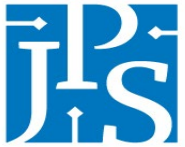

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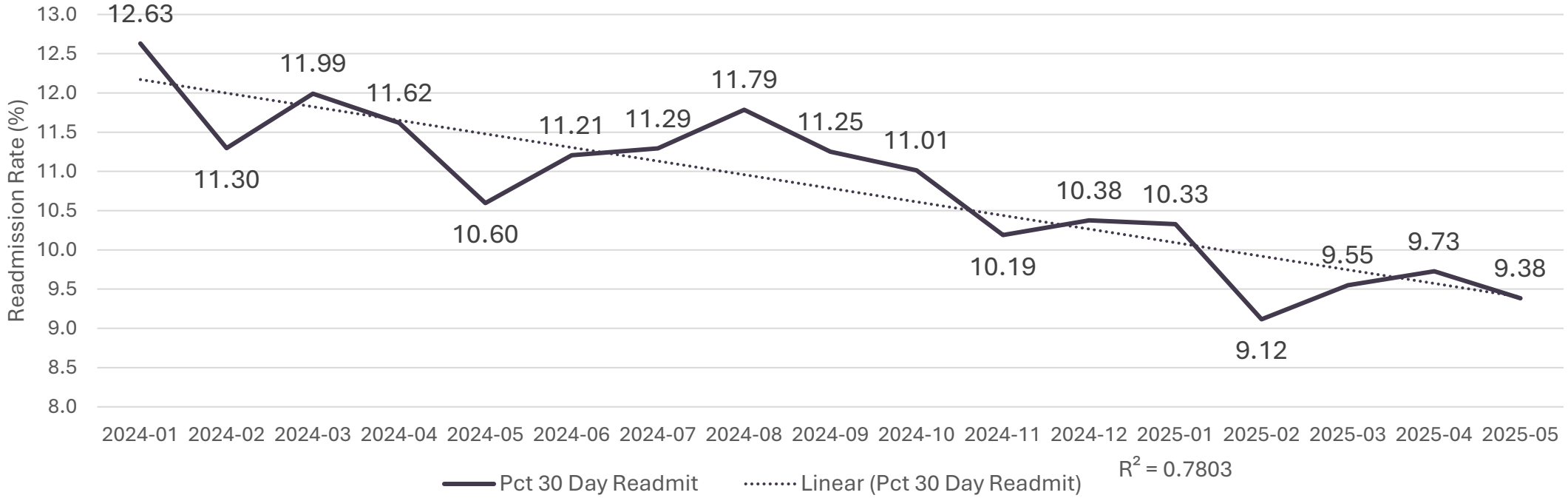
Acknowledgements

- Dr. Ben Hunter
- Dr. Kate Pollard
- Jamie Birkle
- Allison Hemmelgarn
- Dhwani Patel, NP
- Danielle Caviness
- Dr. Lana Dbeibo

IU Health Medical Center Monthly 30-Day Readmission Rate



- 7.36% of total Adult Medical Center (AMC) readmissions were due to readmissions for the General Medicine Blood Disorder subservice line, majority of these being sickle cell disease (SCD) in 2023
- Patients with SCD were treated with marked inconsistency, often resulting in unnecessary and prolonged hospitalizations

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Methodology

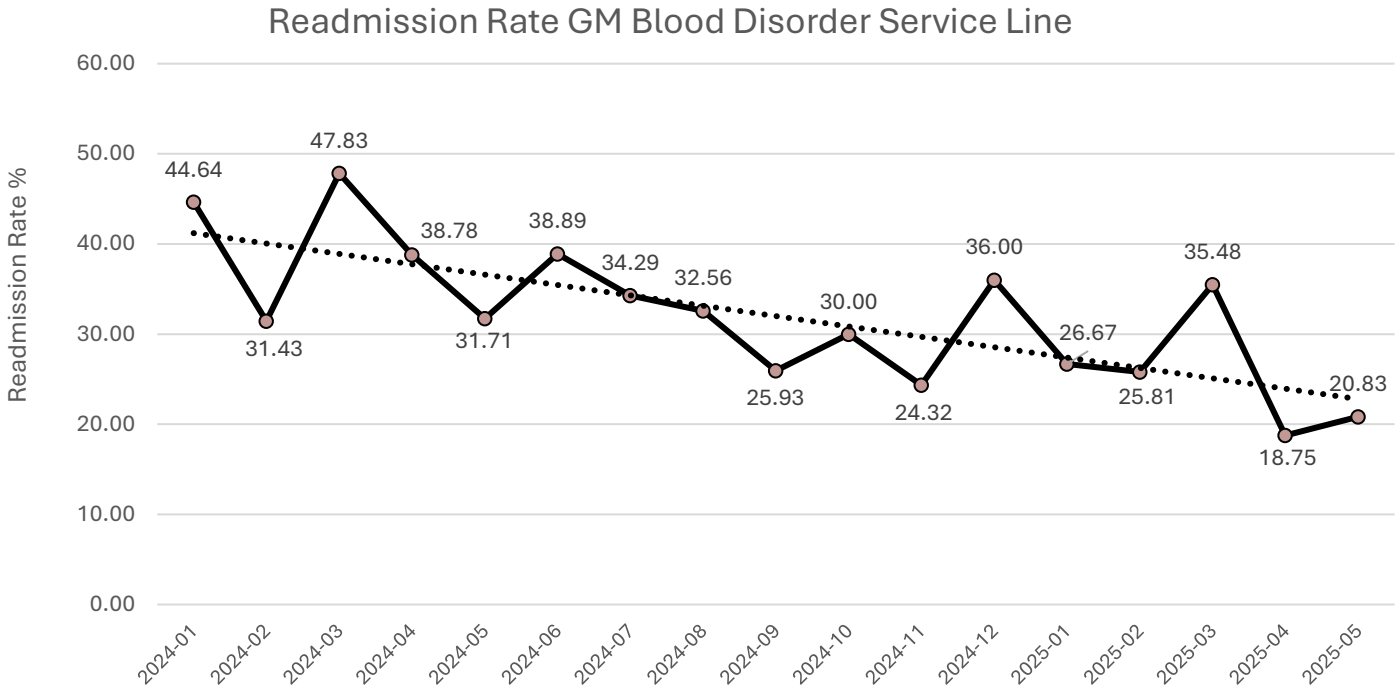
- **Collaborative Team-Based Care**
  - Hematology SCD specialist, Emergency Room (ED), Hospitalist, Nursing & Care Management
  - Engage patients in process longitudinally

- **Individualized Acute Care Plans (ACPs):**
  - Initial focus on high-risk, frequent readmitted patients
  - Focused on appropriate medical care, Not a “NO ADMISSION” plan, Not a behavior contract
  - Entered EMR, with patient specific strategies for testing, pain management and admission criteria

- **Outpatient Support & Transitions**
  - Dedicated social worker, engaged chaplaincy
  - Direct linkage to specialized Sickle Cell Clinic with infusion chairs

Outcomes

- The work began in March 2024, with the first care plans entered the EMR April 1
- At the end of October 2024, 22 patients with SCD had ACPs in place
- October 2024, the SCD readmission rate had improved to 36.4%, a 20% reduction from the 2023 baseline
- In 2023, the 30-day readmission rate for SCD-related admissions was 45%, compared to 23% for grouped Academic Medical Centers (AMCs).
- 2023 to 2024, General Medicine Blood Disorders had 78 fewer readmissions and had a 592 LOS day reduction for readmission



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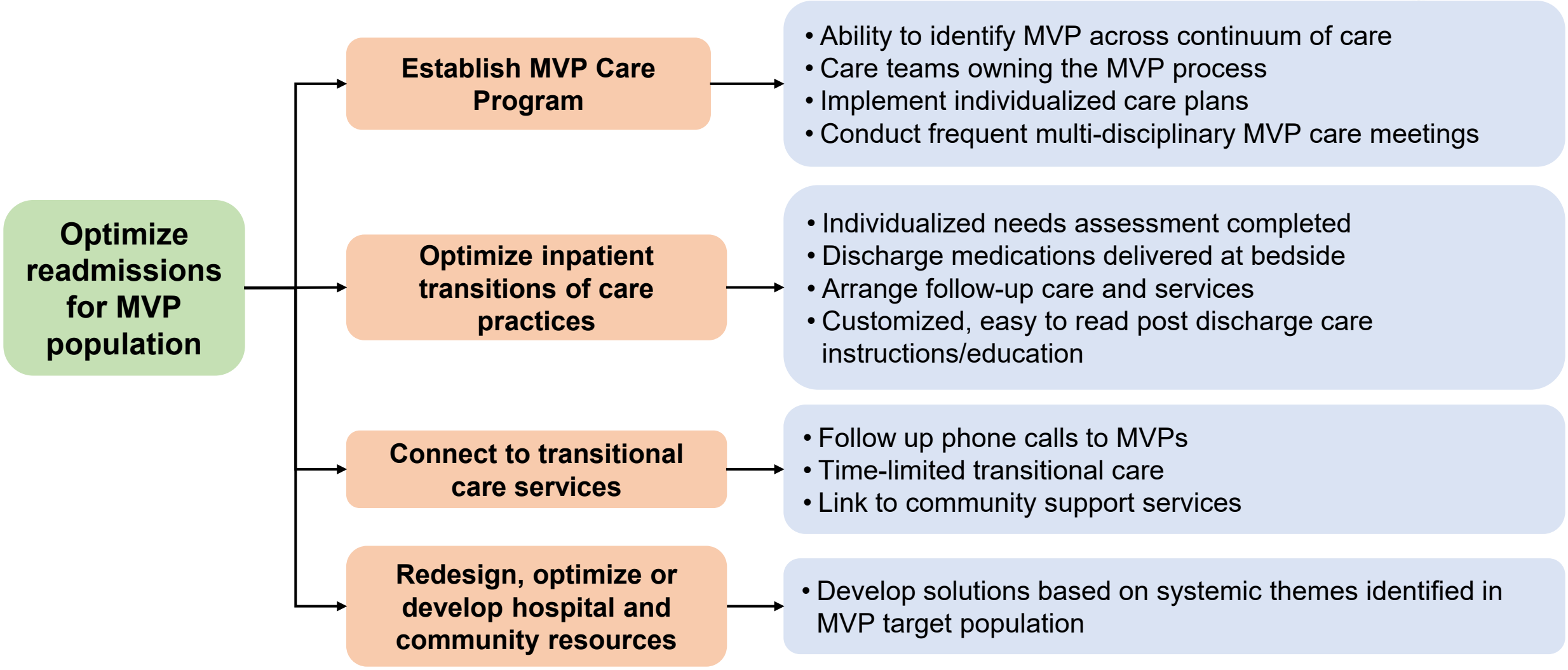
Acknowledgments

- Saba Asad, MD, MSHCLM, FACP, FHM
- Razaq Badamosi, MD, FCCP

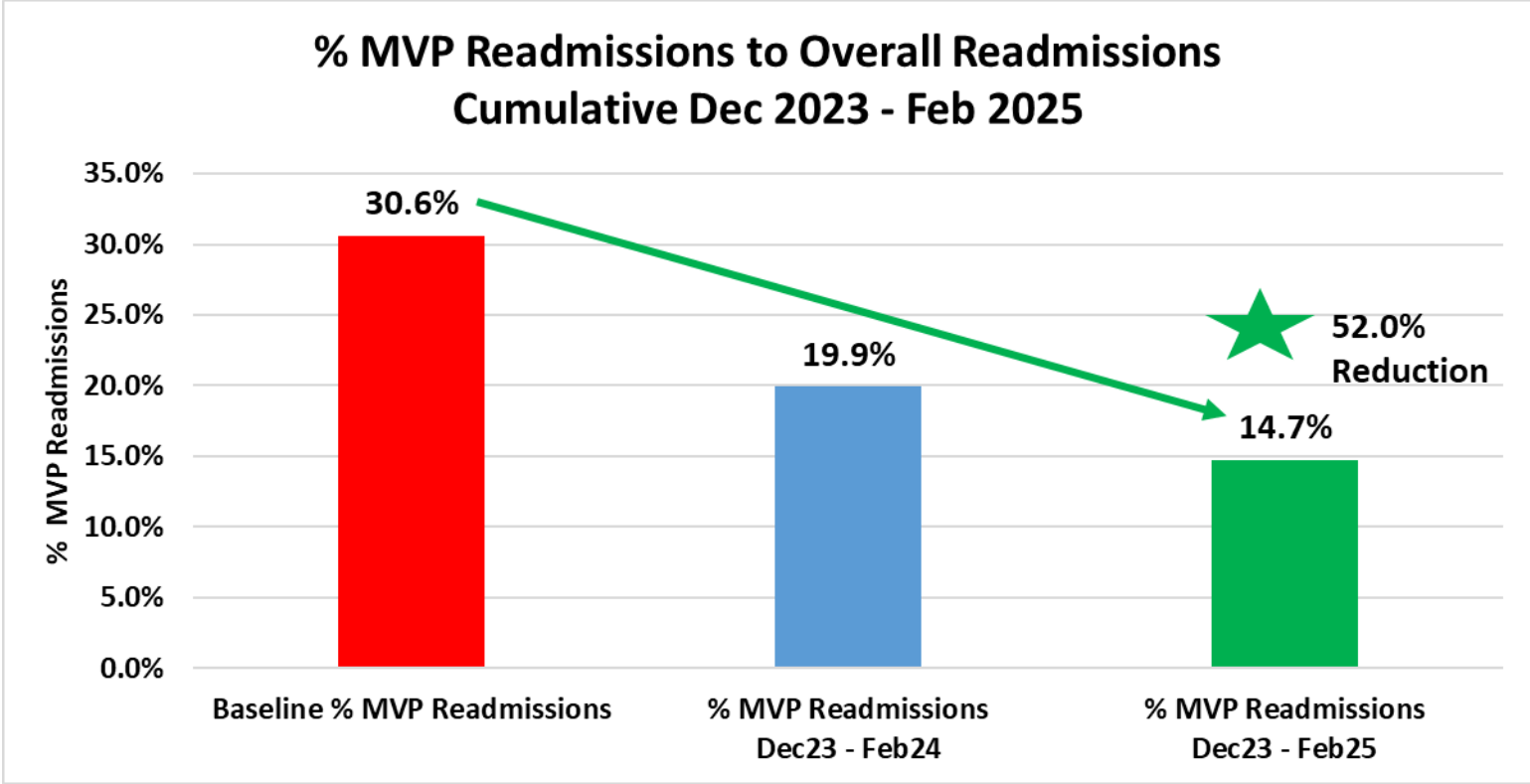
Background

- Safety net hospital with large indigent community, alcohol/substance dependency, underinsured, homeless and other at-risk social determinants of health (food insecurity and transportation)
- A 12-month historical analysis of all discharges and readmissions to identify target population
  - Programs in place for heart failure, diabetes, sepsis, etc.
  - Target population identified as patients with 3 or more readmissions in a rolling 12-month period, known as Multi-Visit Patients (MVPs)
- Literature review and SWOT analysis completed to identify intervention options

Interventions



Outcomes



12/2023 thru 2/2025 Cost Avoidance Estimation =	$5,658,000.00

Readmissions Source – MIDAS
Cost Source – JPS Health Network Finance

Lessons Learned

- Optimizing transitions of care from inpatient to outpatient is vital to reduce hospital utilization
  - Intensive Primary Care in the home for some multi-visit patients reduced readmissions
- 100% dedicated team is challenging to obtain and sustain, though extremely impactful
- Alcohol and substance dependency is a key factor and a difficult barrier to overcome
- Poverty influences nearly every health-related social needs (HRSN), and the broader social determinants of health (SDoH), requiring multi-sector collaboration, policy reform and long-term thinking to address upstream causes
- Multidisciplinary approach to care, particularly important between the disease specialists and the emergency department clinicians
  - Patient and family engagement with the plans
- Consistency of practice: implementation of best practice, high engagement of providers
- Utilizing EMR tools for implementation was key to driving the improvement

Key Takeaways

- Data driven approach to reducing preventable readmissions, particularly focusing on multi-visit patients
  - Implement mechanism in the EMR system to identify and flag multi-visit patients upon arrival to ED
- Understanding root cause and implementing appropriate evidence-based countermeasures for population and individual patient
  - Utilize focused multi-disciplinary team to meet frequently to identify readmission drivers, assess clinical/social needs necessary to provide wrap around services for patient
- Creating a monthly scorecard that is visible to all disciplines
- Creating a feedback loop during monthly multidisciplinary meetings
- Ongoing executive sponsorship and alignment to strategic initiatives is critical from point of origin to full implementation and sustainment.

Questions?

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