Setting the Stage
Describe how this project is consistent with your strategic plan.

> At Mount Desert Island Hospital, we serve a close-knit island and surrounding communities through a 25-bed critical access facility in Bar Harbor and a network of area health centers—all designed to provide comprehensive healthcare for residents and visitors.

> Our mission is to provide compassionate care and strengthen the health of our community by embracing tomorrow’s methods and respecting time-honored values. We believe in compassion, community, improvement, integrity, respect, and teamwork.

Why did you select this project and what methods were used to identify the need?

> We envision ourselves to be our community’s medical home by pursuing innovative models throughout the continuum of care. Our integrated system will be the standard by which others are measured. One initiative we have worked on and continue to work on is readmissions.

> Nearly 20% of Medicare patients who are discharged from a hospital are readmitted within 20 days. There is a growing body of evidence suggesting that unplanned readmissions are associated with lower quality of care. Unplanned readmissions can be the result of ineffective discharge processes including discharge planning, medication reconciliation, failed handoffs and insufficient patient education.

> Readmissions are reviewed at state level gatherings including the Maine Rural Health & Primary Care Program which is made up of mainly Critical Access Hospitals and a few larger facilities. The QIN/QIO supplies hospitals with admission data which is reviewed by our Readmissions Team. The Palliative Care Team for two years has also monitored readmissions and offers recommendations for symptom management. An interdisciplinary huddle is held to review the patient, barriers to better health, and progression of chronic diseases.

Project Design
Who was involved in the improvement effort?

> An interdisciplinary team made of nurses, providers, pharmacists, a social worker, and respiratory therapist.

What strategy was developed to focus on improvement?

> COPD Rescue Kits: We have COPD Rescue Kits for patients with chronic COPD. The kit consists of an antibiotic and a steroid. The patient is given a script which can be filled at any time and used when certain criteria are met, zone dependent.

> CHF Rescue Kits: We have a CHF algorithm for the Outpatient Nurse Care Managers to follow if a patient meets certain criteria. One element to the kit is an oral diuretic.
DATA COLLECTIONS AND RESULTS

Describe the data collected and results demonstrated from the start to end of the project?

> As an organization, we have dramatically improved our readmissions steadily since March 2018. Below are graphs supplied to us by the Health Research and Educational Trust which allow us to see our organization’s trend line over the past two years.

In 2018 we selected a readmission goal of 5%. The US National rate from 2014 to 2017 was 16%.

> In 2017, our All Payer/All Cause Readmissions to our hospital averaged a rate of 6.85%.

> In 2018, in our first 3 quarters, we averaged a readmission rate of 3.83%.

(1) HIIN Items – Readmissions within 30 Days (All Cause) – HIIN-READ-1

continued >
> At right is a graph of our internally monitored All Payer/All Cause Readmissions compared to our readmissions goal.

> We support a culture of safety. We look at reducing inappropriate and unnecessary care that could lead to harm. We aim to prevent and minimize harm in all settings. We ensure all care delivered incorporates patient and family preferences. We partner with the Maine Hospital Association to review readmission improvement efforts and compare data among the Critical Access Hospitals in the state.

> We recently put together a Readmission Charter. The purpose of this steering committee is to consolidate current work. This steering committee will base their structure on the Quality Assurance and Process Improvement (QAPI) approach by establishing clear objectives for the strategic and operational direction of Mount Desert Island initiatives to address readmissions.
LESSONS LEARNED AND NEXT STEPS

> We will continue to enroll patients to the BBBL program as appropriate. We promote evidence-based community interventions to prevent and treat chronic diseases.

> We will continue prescribing a COPD rescue kit to those patients who qualify, along with the CHF Rescue Kits.

> We will continue to offer Diabetes Self-Management classes. We promote self-management.

> Our Care Management team will continue tracking patients who are admitted to our facility, in addition to other facilities. Care Callers will initiate and offer consultation.

> The Weekend Care Clinic will remain open on weekends and holidays. We aim to improve access to care within our communities.