Reducing Readmissions

Pat Teske, RN, MHA
January 15, 2016
Cynosure Health
Our AIM

Decrease preventable complications during a transition from one care setting to another, so that hospital readmissions would be reduced by 20 percent.
OR Progress

• Great work so far!
• 10% reduction in readmissions during HEN 1.0
• But more opportunity exists
1. Partnering with other hospitals in the local area to reduce readmissions
2. Tracking % of patients discharged with a follow-up appointment already scheduled within 7 days
3. Tracking % of patients readmitted to another hospital
4. Estimating risk of readmission in a formal way and using it to guide clinical care during hospitalization
5. Having electronic medical record or web-based forms in place to facilitate medication reconciliation
6. Using teach-back techniques for patient and family education
7. At discharge, providing patients with heart failure written action plans for managing changes
8. Regularly calling patients after discharge to follow up on post-discharge needs
9. Discharging patients with an outpatient follow-up appointment already scheduled
Result Highlights

• Hospitals that took up any 3 or more strategies had significantly greater reductions in RSRR compared with hospitals that took up only 0-2 strategies.

• -93 different combinations of strategies

• High and low performing groups both used recommended clinical practices.

• Four specific approaches distinguished high performers
  – Collaboration across departments/ disciplines
  – Working with post-hospital providers
  – Learning and problem solving
  – Senior leadership support
How About You?

- Three or more strategies
- Collaboration across departments/disciplines
- Working with post-hospital providers
- Learning and problem solving
- Senior leadership support
- Review your data
- Talk to your patients & providers
- Review Your Processes
- Review MRs

- Admission
- Teaching/Coaching
- Hand Over
- Acute Care Follow Up
- Post-Acute care support

- Do 5 structured interviews
- Review 5 charts

- Readmission Rates
- To – From
- Diagnoses
- Risk Groups
Data Analysis Example

• Use the most recent 12 months of data available. Using all hospital discharge data, exclude patients <18, all OB (DRG 630-679), discharges dead or transfers to another acute care hospital.

• Define a readmission as any return to inpatient status within 30 days of discharge from inpatient status.
Data Analysis Example

• Use the most recent 12 months of data available. Using all hospital discharge data, exclude patients <18, all OB (DRG 630-679), discharges dead or transfers to another acute care hospital.

• Define a readmission as any return to inpatient status within 30 days of discharge from inpatient status.
What You Might Want to Learn

• By major payer type:
  – Total number of discharges
  – Total number of readmissions
  – Rate = readmissions/discharges
  – Discharge disposition
    • Number home
    • Number home with home health
    • Number SNF
Data Questions

– With any coded behavioral health diagnosis
  • Discharges
  • Readmissions

– Number and/or percentage of readmissions occurring within 7 days of discharge

– Number of patients with ≥4 hospitalizations in past year
  • Total number of discharges in ≥4 group
  • Total number of 30-day readmissions among them
Top 10 DRGs by Payer

- What are they?
- Do they differ between payers?
- What percentage of readmissions do the top ten DRGs account for?
  - Usually less than 28%
### Medicaid
- Mood disorder
- Schizophrenia
- Diabetes complications
- Comp. of pregnancy
- Alcohol-related
- Early labor
- CHF
- Sepsis
- COPD
- Substance-use related

### Medicare
- CHF
- Sepsis
- Pneumonia
- COPD
- Arrhythmia
- UTI
- Acute renal failure
- AMI
- Complication of device
- Stroke
What was broken or unreliable?
What were the bright spots?
What did you learn?
Framing Your Approach

Risk for Readmission

Care Continuum
Match needs with resources

- Which patients will probably do well with “normal discharge”?
- Which patients need something more?
- Which patients need far more?
- How do you know?
- What do you do?
How About You?
<table>
<thead>
<tr>
<th>Risk for Readmission</th>
<th>Community</th>
<th>ED</th>
<th>Hospital Based</th>
<th>Immediate Post Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Special programs such as:</td>
<td></td>
<td>BASIC inpatient bundle + moderate to high bundle</td>
<td>BASIC post discharge bundle + moderate to high bundle AND stronger linkage with community programs</td>
</tr>
<tr>
<td></td>
<td>• Complex Care Management (CCM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disease specific programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP/care team management per patient needs with prioritized post discharge visit or outreach</td>
<td>BASIC inpatient bundle + moderate to high bundle:</td>
<td>7 day f/u appointment</td>
<td>7 day f/u appointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Care transitions nurse</td>
<td></td>
<td>Pharmacy intervention</td>
<td>f/u call(s)/visits</td>
</tr>
<tr>
<td></td>
<td>• Pharmacy intervention</td>
<td></td>
<td>Palliative care</td>
<td></td>
</tr>
<tr>
<td>Routine PCP/care team management per patient needs</td>
<td>Admit</td>
<td>BASIC inpatient bundle:</td>
<td>BASIC post discharge bundle:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discharge planning</td>
<td></td>
<td>Referrals</td>
<td>• Referrals</td>
</tr>
<tr>
<td></td>
<td>• Multidisciplinary rounds</td>
<td></td>
<td>Instructions</td>
<td>• Instructions</td>
</tr>
</tbody>
</table>
### Discharge Plan

<table>
<thead>
<tr>
<th>Estimated Discharge Date</th>
</tr>
</thead>
</table>

---

### Patient Board Features

- **St. Rose Hospital Excellence in Care**
- **Room Number**
- **Dietary Restrictions** Yes/No
- **Communication**
- **Questions for Your Doctor**
- **Today’s Plan**
  - Pain Scale: 0 (No Pain) to 10 (Worst Possible)
  - Emoticons for Pain Levels:
    - 0: Happy Face
    - 2: Mellow Face
    - 4: Neutral Face
    - 6: Sad Face
    - 8: Very Sad Face
    - 10: Worst Possible
- **Please Call Don’t Fall**
  - Wash with Soap and Water Only
Medications

- Perform accurate medication reconciliation at admission, at any change in level of care and at discharge

- Does your patient leave your care setting with a clear list of which medications they should take once they get home?
Yale study: Medication errors, confusion common for hospital patients

Published: Monday, December 03, 2012

- 377 patients at Yale-New Haven Hospital, ages 64 and older, who had been admitted with heart failure, acute coronary syndrome or pneumonia, then discharged to home. Of that group, 307 patients -- 81 percent -- either experienced a provider error in their discharge medications or had no understanding of at least one intended medication change.
**MEDICATION PAGE (1 of 3)**

**EACH DAY** follow this schedule:

**MEDICINES**

<table>
<thead>
<tr>
<th>What time of day do I take this medicine?</th>
<th>Why am I taking this medicine?</th>
<th>Medication name</th>
<th>Amount</th>
<th>How much do I take?</th>
<th>How do I take this medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>blood pressure</td>
<td>PROCARDIA XL</td>
<td>NIFEDIPINE</td>
<td>90 mg</td>
<td>1 pill</td>
</tr>
<tr>
<td></td>
<td>blood pressure</td>
<td>HYDROCHLOROTHIAZIDE</td>
<td>25 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>blood pressure</td>
<td>CLONIDINE HCl</td>
<td>0.1 mg</td>
<td>3 pills</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>cholesterol</td>
<td>LIPITOR</td>
<td>ATORVASTATIN CALCIUM</td>
<td>20 mg</td>
<td>1 pill</td>
</tr>
<tr>
<td></td>
<td>stomach</td>
<td>PROTONIX</td>
<td>PANTOPRAZOLE SODIUM</td>
<td>40 mg</td>
<td>1 pill</td>
</tr>
</tbody>
</table>
CTM3

HCAHPS 23
During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

HCAHPS 24
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

HCAHPS 25
When I left the hospital, I clearly understood the purpose for taking each of my medications.

• How are you doing on question 25?
• VPB
  – HCAHPS questions are 30% of your score
WELCOME
UCSF Patient Advisory
What does this mean?

There is a bear in a plain wrapper doing flip flops on 78 handing out green stamps.
Health Literacy

- Do you formally assess the health literacy of your patients?
- Most health materials are written at a level that exceeds the reading skills of the average high school graduate.

- **Health literacy** is the concept of reading, writing, computing, communicating and understanding in the context of health care.
1. If you eat the entire container, how much sodium will you eat?  
   Answer: 200 mg

2. If you are allowed to eat 60 milligrams of sodium as a snack, how much ice cream could you have?  
   Answer: 1 serving, or 1/4 cup, or 1/4 of the container

3. Your doctor advises you to reduce the amount of sodium in your diet. You usually eat 2000 milligrams of sodium each day, which includes one serving of ice cream. If you stop eating ice cream, how much sodium would you eat each day?  
   Answer: 1950

4. Pretend that you are allergic to the following: Penicillin, peanuts, latex gloves and bee stings. Is it safe for you to eat this ice cream?  
   Answer: No

5. If the patient answered “no” to question 5, ask: Why not?  
   Answer: Because it contains peanut oil

**SCORE = TOTAL # ANSWERED CORRECTLY**

**Interpretation**
- 0 – 1: suggests high likelihood (>50%) of limited literacy
- 2 – 3: indicates the possibility of limited literacy
- 4 – 5: almost always indicates adequate literacy

**Nutrition Facts**

<table>
<thead>
<tr>
<th>Serving Size</th>
<th>½ cup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Servings per container</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount per serving</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Calories</td>
<td>250</td>
</tr>
<tr>
<td>Fat Cal</td>
<td>120</td>
</tr>
<tr>
<td>%DV</td>
<td></td>
</tr>
</tbody>
</table>

| Total Fat | 13g | 20% |
| Sat Fat   | 9g  | 40% |
| Cholesterol| 28mg| 12% |
| Sodium    | 50mg| 2%  |
| Total Carbohydrate | 30g| 12% |
| Dietary Fiber | 2g |
| Sugars     | 23g |
| Protein   | 4g  | 8%  |

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

**Ingredients:**  Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.
Adult Healthcare Literacy

<table>
<thead>
<tr>
<th>Monitor My Heart Failure Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breathing</strong></td>
</tr>
<tr>
<td>呼吸</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td><strong>Swelling</strong></td>
</tr>
<tr>
<td>水腫</td>
</tr>
<tr>
<td><strong>Weight</strong></td>
</tr>
<tr>
<td>體重</td>
</tr>
<tr>
<td>RECORD WEIGHT</td>
</tr>
<tr>
<td><strong>Action</strong></td>
</tr>
<tr>
<td>採取行動</td>
</tr>
<tr>
<td><strong>Caution</strong></td>
</tr>
<tr>
<td>注意</td>
</tr>
<tr>
<td><strong>Danger</strong></td>
</tr>
<tr>
<td>危険</td>
</tr>
<tr>
<td><strong>Good</strong></td>
</tr>
<tr>
<td>1 天增 2 磅或 1 週增 3 磅</td>
</tr>
<tr>
<td>1 day gain 2 lbs or 3 lbs in 1 week</td>
</tr>
<tr>
<td><strong>Caution</strong></td>
</tr>
<tr>
<td>再次</td>
</tr>
<tr>
<td><strong>Danger</strong></td>
</tr>
<tr>
<td>危險</td>
</tr>
<tr>
<td><strong>Good</strong></td>
</tr>
<tr>
<td>體重增加</td>
</tr>
<tr>
<td><strong>Caution</strong></td>
</tr>
<tr>
<td>打電話</td>
</tr>
<tr>
<td><strong>Danger</strong></td>
</tr>
<tr>
<td>我需要去中國醫院</td>
</tr>
<tr>
<td>I NEED TO GO TO CHINESE HOSPITAL</td>
</tr>
</tbody>
</table>

Chinese Hospital  
845 Jackson Street, San Francisco, CA 94133  
www.chinesehospital-sf.org  
03-25 2010
# PROJECT RED ..... Enhanced Patient Teaching Tool (EPTT)

**PROJECT RED COORDINATOR:** ____________________________

<table>
<thead>
<tr>
<th>Patient Name: ____________________________</th>
<th>Room # ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. Discharge Date: ____________________</td>
<td>PCP: __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Medications</th>
<th>Dietary</th>
<th>Transportation</th>
<th>Home</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of MD's</td>
<td>List of Meds</td>
<td>Dietician Consult</td>
<td>Yes No</td>
<td>Environment</td>
<td>Dx. Educ.</td>
</tr>
<tr>
<td>Appointments</td>
<td>Rx &amp; Refills</td>
<td>Restrictions</td>
<td>Directions to Appts</td>
<td>Stairs</td>
<td>See MD?</td>
</tr>
<tr>
<td>Lab Work</td>
<td>Medication Schedule</td>
<td>Family Educ.</td>
<td>Bus/Bart/Cab</td>
<td>Pets</td>
<td>Go to ER?</td>
</tr>
<tr>
<td>What to bring ..</td>
<td>Talk Back / Demo</td>
<td>Bus/Bart/Cab</td>
<td>Children</td>
<td>Children</td>
<td>Talk Back</td>
</tr>
<tr>
<td>Med. Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Self Care College

Self Care College – an innovative approach to activate patients. Healthcare workers often forget that we only care for patients a small fraction of their lives. Certainly when patients are hospitalized, we can control metrics such as daily weights, glucose monitoring, blood pressure control, and dietary content. However, when the patient leaves for home, he only spends a few minutes per week with a healthcare provider. Trying to reconcile that disconnect was the impetus for designing the Self-Care College (SCC). Patients with CHF are enrolled in the Self-Care College, and instead of the traditional passive method of lecture and educational handouts, SCC patients are asked to actively participate in their healthcare duties while in the hospital just like they will do when they go home. Patients are observed as they weigh themselves, reconcile their medications and create a medication planner. They are also asked what they eat and then given helpful dietary choices based on their responses. Most importantly, after the patient has been through the three modules, the team huddles to ensure that the patient is adequately prepared to transfer to their next healthcare destination. If not, recommendations are made to their provider to ensure a smooth transition. By engaging the patient to participate in the process, the patient is activated to assume responsibility for their care. The Self-Care College team often says, “You don’t learn to ride a bike by reading a book, neither should you be asked to learn how to manage CHF by reading a pamphlet.” Learning is best done by doing. The SCC looks forward to helping patients “take off their training wheels and learn to guide their own disease path.”

Lee Greer, M.D., MBA
Chief Quality and Safety Officer
North Mississippi Health Services
Tupelo, Ms 38801
662 377-3000
Teach back top 10 list

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.

How do you know it is really happening and your staff are proficient?
Post discharge calls

• Determine who is responsible for making the calls.
• Remember the purpose of the calls.
• Tell the patient you will be calling them.
• Ask what is a good time?
• What is the best number to use?
• Learn if others are making calls and what they are asking.
• Use your findings to improve your processes!
Post discharge appointments

• Who is responsible to make the appointment?
• How to you involve the patient?
• How are appointments made?
How About You?
What’s New

• Teams
  – Inter-professional
  – Non-clinician

• Technology
  – Automation
  – Tele-presence
  – Education

• Emergency Department
  – Embedded staff or consultation prior to admission

• Highest Utilizer Strategies
  – Complex care management
  – Community paramedics
  – Behavioral health and substance abuse

• Standard Work
  – SMART discharge instructions
• At WVU Hospitals, in Morgantown, W.V., physicians and medical residents teamed up to see their patients at the hospital’s outpatient clinic, within 7 to 14 days after discharge.
  – A psychologist, pharmacist and nurse case manager soon joined the team.
  – Medical residents talk with patients before discharge, explaining the follow-up process and ensuring patients have a pre-scheduled appointment.
  – The nurse case manager tracks all appointments, contacting patients until they are seen.
  – On clinic days, the team huddles in the early afternoon and sees patients afterward.
  – With this team-based follow-up care, 80-85 percent of patients are seen within 14 days of discharge.

• One additional benefit: discharge summaries have improved now that residents use their own summaries for the follow-up.

• Karen Fitzpatrick, M.D., quality director, WVU Family Medicine, says buy-in from physicians was quick “as we talked about the high value to patients.” Team-based care after discharge provides “one-stop shopping” for patients, and their feedback has been positive. fitzpatrickk@wvuhealthcare.com

What is the composition of your care transition team?
# Augmenting with Non-Clinicians

<table>
<thead>
<tr>
<th>Congregational Health Network</th>
<th>UCSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care navigators</td>
<td>• RSP</td>
</tr>
<tr>
<td>– Focus on social needs</td>
<td>– New grads</td>
</tr>
<tr>
<td>– High touch</td>
<td>– Public health background</td>
</tr>
<tr>
<td>– Know their communities</td>
<td>– Coordination/navigation</td>
</tr>
<tr>
<td>– Passion for the work</td>
<td>• If so, how?</td>
</tr>
</tbody>
</table>

• Are you using non-clinicians in your care transitions work?
Technology

Tele-presence

Automation

Are you using technology in your care transitions efforts? If so, how?
Connecting through Care Book
Good-to-go

• Video tape discharge teaching
• Give video to patient to-go
Emergency Department Efforts

1. Process to inform ED staff that this person had a prior admission
2. Pause to interact in-person or on the phone with a care transitions team member
3. Decision
   a) Admit
   b) Observation
   c) Home with follow up

What are you doing in your EDs?
Highest Utilizer Strategies

- Identify highest utilizers
- Learn what drives their utilization
- Meet the needs

What are you doing for your highest utilizers?
### Standard Work

- **Signs**
  - What they are
  - What to do

- **Medications**
- **Appointments**
- **Results to track**
- **Talk to me about these three things**

---

**Be Smart, Leave S.M.A.R.T.**

<table>
<thead>
<tr>
<th>Signs</th>
<th>I should look for and who I should call when I leave:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication notes:</td>
<td></td>
</tr>
<tr>
<td>Appointments I will go to:</td>
<td></td>
</tr>
</tbody>
</table>
  - Appointments already scheduled: (Doctor/Practice/Location) (Date/time)
  - Appointments I need to schedule: (Doctor/Timeframe for Visit)
| Results for follow-up: | |
| Talk with me more about at least three things: | |

Call 443-481-4000 for urgent health questions after you leave the hospital.

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2014 Silver Award Recipient

ILPEX

HRET
Discharge Plan Checklist: (LACE score ≥11 suggests high risk for readmission)

☐ Presenting problem that precipitated hospitalization identified and shared with patient/family/caregiver.

☐ Patient/family/caregiver educated on primary DX and secondary DX.

☐ Patient/family/caregiver given a written schedule of discharge medications and instructions on purpose and cautions.

☐ Preadmission and discharge medications reconciled and patient/family/caregiver are aware of new medications, change in dose or frequency and medications that should be discontinued.

☐ Patient/family/caregiver educated on anticipated problems and appropriate interventions relative to disease and symptom management.

☐ Patient/family/caregiver have been educated on diet and activity.

☐ Patient discharged with a follow-up appointment within one week of discharge if physician concurs.

☐ Patient/family/caregiver can identify primary care physician and consultants; knows about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911.

☐ Patient/family/caregiver can give a brief summary of discharge instructions when asked.

RN: Print and Sign Name: ____________________________ Date: ______________
STANDARDIZED CHECKLISTS

Skilled Nursing Facility Checklist

<table>
<thead>
<tr>
<th>AS Initials</th>
<th>RN Initials</th>
<th>Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Cold Intrafacility transfer form filled out by primary RN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skilled Nursing Intrafacility Transfer (doctors orders for SNP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced Directive / POLST (if available)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Protocols from EDCH</td>
</tr>
</tbody>
</table>

2 Background (note for receiving facility / note for transport team)

Medications given in the last 24 hours

Medications given in the last 7 days (including immunizations)

Prescriptions for analgesics (if appropriate)

Lab results (cytology, pathology, labs reports)

CT / MRI / Speech evaluations (including swallow evaluation if done)

Robotic notes

Wound care notes

MD’s dictation transfer summary

AS Initials | RN Initials | Copy of Chart
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Copy of HPI (including consults)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doctor’s progress notes from the last 7 days (would be in EDCH too)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ERG copy with dictation (if done)</td>
</tr>
</tbody>
</table>

Copy of Skilled Nursing Intrafacility transfer (doctor’s orders for SNP) and MD’s dictation transfer summary (provided in separate envelope for patient or designated person)

Additional information regarding patient

Pre-existing Medical Devices (check all that apply)

PCC line, wound vac, urinary catheter

Vital signs

Baseline Status (circle all that apply)

Verbal, Non-Verbal

Alert & Cuffed x 1 2 3 4

Isolation (circle all that apply)

none, ARRA, VRE, ESBL, C-Diff, TB

Other:

Ambulation Status (circle all that apply)

Best nurse, wheelchair, walker, cane, independently without assist

Pressure Ulcers or Wounds (circle all that apply)

Mark diagram

Other pertinent information

Transportation form signed by MD present if required

Sending Nurse: ____________________________

Print Name: ____________________________

Signature: ____________________________

For Questions: ____________________________

Department: ____________________________

Phone #: ____________________________

HRET

Health Research & Educational Trust

In Partnership with AHA

ILPEX

Illinois Performance Excellence

2014 Silver Award Recipient

Skilled Nursing Facility → Emergency Department Checklist

Reason for Transport:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Code Status</th>
<th>Conservation [Yes/No]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Code DNR</td>
<td>Comfort Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DNR with active care</td>
</tr>
</tbody>
</table>

Skilled Nursing Facility

Name: ____________________________

Sending Staff Name: ____________________________

Direct Phone #: ____________________________

Documents

POLST / Advance Directive / Durable Power of Attorney (front of paperwork)

Patient Face sheet: (2nd)

Medication List / Med Kardex (3rd)

Pertinent / Recent Labs

Physician Consults and Progress Notes, Nursing Notes (most recent)

Other:

Pertinent Information regarding Patient

Isolation (circle all that apply)

none, ARRA, VRE, ESBL, C-Diff, TB

Ambulation Status (circle all that apply)

Best nurse, wheelchair, walker, cane, independently without assist

Baseline Status (circle all that apply)

Verbal, Non-Verbal

Alert & Cuffed x 1 2 3 4

Pre-existing Medical Devices (circle all that apply)

PCC line, wound vac, urinary catheter

Other Pertinent Information

WFR → 6D revision 4/25/12
CommUnity
Simple but effective

• Get people in the same room
• Learn what everyone has to offer
• Learn what everyone's frustrations are
• Start with one issue and go from there
Skilled Nursing Facility – 3 Cs

COMPETENCY

COMMUNICATION

COLLABORATION

Hospital

SNF

2014 Silver Award Recipient
Enhanced Home Health Program

A minimum of seven touch points to occur within the first two weeks of discharge.

**Week 1**
- **In-Patient:** Introduction phone call or hospital visit
  - 24 – 48 hours prior to discharge
- **Home Visit #1:** Includes medication reconciliation, assessment, education, and involving other disciplines
  - Day after discharge
- **Tuck-in Phone Call #1:** Identify red flags and schedule next home visit
  - 1st Friday patient is at home
- **Home Visit #2:** Includes medication compliance, vitals, assessment, and scheduling next home visit
  - 1st weekend patient is at home

**Week 2**
- **Home Visit #3:** Includes medication compliance, vitals, and well-being assessment
  - Monday – Thursday Minimum of one home visit
- **Tuck-in Phone Call #2:** Address questions and schedule next home visit
  - 2nd Friday patient is at home
- **Home Visit #4:** Includes medication compliance, vitals, and well-being assessment
  - 2nd weekend patient is at home
- **Schedule additional home health visits as needed**
Testing Your Plan

• Your plan will have several strategies such as:
  – Improvement in standard discharge
  – Collaboration with area SNFs
  – Enhanced services for targeted population(s)

• Current state (5,000 admissions):
  – Readmission rate is 15% = 750 readmissions

• Desired state:
  – Readmission rate to 12% = 600 readmissions
  – 150 fewer readmissions
Impacting Your Overall Rate

Strategy:

– Improve standard discharge care for all
– Expected impact 10%

What happens when it works...

Since this strategy impacts all patients, if we reduce our readmission rate by 10% from our improvements in the standard discharge process, we will reduce our readmissions from 750 to 675 preventing 75 readmissions.
Knowing This We Need to Do More

Strategy:

– Collaboration with area SNFs
– Expected impact 20%

What happens when it works...

5,000 discharges and 20% are discharged to SNFs = 1,000. Currently, our SNF readmission rate is 25% = 250. Since this strategy only impacts our SNF patients, if we reduce our readmission rate by 20% from our collaboration efforts, we would avoid 50 readmissions.

Adding the avoided readmissions from both strategies results in 125 less readmissions.
We STILL Need to Do More

• Strategy:
  – Specific patient population(s) approach e.g., HF
  – Expected impact 20%

What happens when it works...

200 HF patients with current readmission rate is 25% = 50. Since this strategy only impacts our HF patients, if we reduce our readmission rate by 20% from our enhanced approach, we would avoid 10 readmissions.
Adding Up Our Impact

Readmissions avoided:

75
50
+ 10

= 135 fewer readmissions
If Your Plan Does Not Add Up

Ask the following questions:

- Do the strategies we’re using apply to enough patients?
- Are we missing proven strategies?
- Given our patient population, how should we modify our plan?
<table>
<thead>
<tr>
<th>Risk for Readmission</th>
<th>Community</th>
<th>ED</th>
<th>Hospital Based</th>
<th>Immediate Post Hospitalization</th>
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<tr>
<td></td>
<td>Special programs such as:</td>
<td>BASIC inpatient bundle + Moderate to high bundle</td>
<td>BASIC post discharge bundle + moderate to high bundle AND Stronger linkage with community programs</td>
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<td>• Complex Care Management (CCM)</td>
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<td>PCP/care team management per patient needs with prioritized post discharge visit or outreach</td>
<td>BASIC inpatient bundle + moderate to high bundle:</td>
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<td>Routine PCP/care team management per patient needs</td>
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<td>BASIC post discharge bundle:</td>
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<td>BASIC inpatient bundle:</td>
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<td>• Multidisciplinary Rounds</td>
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<td>• Teach back</td>
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Q&A