PREVENTABLE READMISSIONS

Contact

Vickie Sears, RN, MS
Improvement Coach
NAPH Safety Network
vsears@naph.org
202-585-0133

http://tc.nphhi.org/Collaborate

The Problem

- A 2009 study in the *New England Journal of Medicine* demonstrated that almost one-fifth (19.6%) of Medicare patients were readmitted to the hospital within 30 days of discharge and 34% were readmitted within 90 days.
- This research estimated that the annual cost to Medicare alone of unplanned hospital readmissions exceeds $17 billion.
- A 2010 NAPH readmissions survey identified drug/alcohol abuse, patients not following up with appointments, homelessness, and patients not filling prescriptions as the top contributors to rehospitalization.

What are we trying to accomplish?

AIM Statement

- Reduce hospital readmissions by 20 percent compared to the baseline by Dec. 31, 2013.

How will we know that a change is an improvement?

Measures

Outcome:

- 30-day all-cause hospital readmission rate or count (monthly reporting to NSN)

Process (Select a minimum of 2):

- 30-day all-cause hospital readmission rate or count (monthly reporting to NSN)
- Percent of cases for which defined and separate lists of discontinued, new and continued medications is present in the medical record (monthly reporting to NSN)
- Percent of cases for which the discharge summary was completed and transmitted/made available to post care provider within 72 hours
- Percent of cases for which there is documentation that a follow-up appointment was coordinated within 7 days of discharge
- Percent of cases for which there is documentation of a follow-up phone call within 72 hours of discharge

What changes can we make that will result in improvement?

This change package does not endorse any particular model or care system. Rather, common approaches and practices are highlighted, many of which have research support and/or significant experience with multiple hospitals to warrant consideration. Hospitals should review the models listed in the key resources section and determine which approach is more effective for their structure, patient population, and most importantly, the leading causes of readmissions for their patients.

Primary Driver	Change Ideas
Patients at risk for readmission	✓ Use a risk of readmission assessment tool and validate it using your own data. See Appendix A: Modified LACE tool. ✓ Make readmission risk assessments easy for all to see and address. See Appendix B: Core Readmission Risk Calculator. ✓ Use risk assessment findings to stratify/identify patients' intervention group such as high/low risk. ✓ Assign health coach to high-risk patients. ✓ Adopt an enhanced admission assessment for discharge needs. ✓ Find out who the primary caregiver is (if it is not the patient) and include them in discharge planning. ✓ Communicate who the primary caregiver is to members of the health care team, use white board, chart special entry, etc., so that there is a standard place for this information. ✓ Involve case management and discharge planners early in stay.
Self-management skills	✓ Perform accurate medication reconciliation at a minimum on admission and at discharge so that the medication list is as accurate as possible. See Key Resources: AHRQ MATCH toolkit. ✓ Educate patients regarding each medication, need for medication, and method of obtaining and taking medication once discharged. ✓ Provide clearly written medication instructions using health literacy concepts. ✓ Involve pharmacy in medication reconciliation process. ✓ Develop patient-centered diagnosis and symptom educational tools that use health literacy concepts. ✓ Standardize educational materials across units and departments. ✓ Involve patients and families in development of materials. ✓ Train clinical staff on teach-back using role play and observe their technique once trained. See Appendix C: NC Health Literacy toolkit. o Use "I" statements when speaking with patient and caregiver. "To make sure I did a good job explaining your medications, can you tell me …?" o Validate patient and caregiver understanding of discharge instructions. o Script specific teach-back questions for staff
Coordination of information across the continuum	✓ Prior to leaving the hospital, determine what after-hospital resources and appointments are needed and ensure they are incorporated in the after-care plan. ✓ Create a concise, standardized discharge form ✓ Work with SNF/nursing home to create a concise transfer form ✓ Evaluate best practices and resources and already developed tools such as the Project RED after Hospital Care Plan (AHCP) and Coleman Personal Health Record. See Key Resources section below. ✓ Obtain accurate information about primary care physician at the time of admission. ✓ Send completed discharge summary to post care provider/ PCP within 72 hours of discharge.

Primary Driver	Change Ideas
Adequate follow-up and community resources	✓ Schedule follow-up appointment with post-acute care provider/PCP within 7 days of discharge. ✓ Work with patient and care providers to determine any barriers to making and attending follow-up appointment(s). ✓ Implement post discharge follow-up phone calls within 24-72 hours to reinforce discharge plan and identify any problems. ✓ Develop partnerships with community networks such as health ministry, pharmacies, the Office on Aging, or cardiac rehabilitation centers. ✓ For those patients who are at the highest risk of readmission, consider home health referrals, home visits, telehealth referrals, etc. ✓ For patients without a PCP, work with health plans, Medicaid agencies and other safety net programs to identify a PCP. Consider hospital follow-up clinics run by hospitals, or NPs if timely access to a PCP is not available.

Key Resources

- **Re-engineered Discharge (RED)** strives to minimize post-discharge hospital utilization by using standardized discharge interventions that include patient education, comprehensive discharge planning, and post discharge telephone reinforcement. Developed in a safety net hospital. http://www.bu.edu/fammed/projectred/index.html

- **The Care Transitions Intervention (Eric Coleman)** is a 4-week hospital-based model utilizing a Transitions Coach who conducts an initial hospital visit and assessment, works with the patient to complete discharge checklist, utilizes personal health records, provides medication management, and makes three follow-up phone calls. http://www.caretransitions.org/

- **Project BOOST (Better Outcomes for Older Adults through Safe Transitions)** is toolkit for improving hospital discharge, including screening/assessment tools, a discharge checklist, transition record, teach-back processes, risk-specific interventions, and written discharge instructions. http://www.hospitalmedicine.org/ResourceRoomRedesign

- **The Transitional Care Model (Mary Naylor)** is a 1-3 month hospital-based model utilizing a Transitional Care Nurse who conducts an initial hospital visit and assessment with subsequent home visits, provides medication management, coaches patients for follow-up visits/accompanies them, and conducts follow-up phones calls during weeks without a home visit. http://www.transitionalcare.info/

- **The MATCH Toolkit (Medications at Transitions and Clinical Handoffs)** helps hospitals improve medication reconciliation, a critical component of a successful discharge. http://www.ahrq.gov/qual/match/

- **STAAR (STate Action on Avoidable Rehospitalizations)**, which is supported by the Institute for Healthcare Improvement, is a multi-state effort to improve care transitions. http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx

- **Community Care Transitions Toolkit** by the Colorado Foundation for Medical Care, a resource

center on community-based transitions.
http://www.cfmc.org/integratingcare/toolkit.htm

- The **Remington Report** describes models used in the 9th SOW Care Transitions Theme http://www.cfmc.org/integratingcare/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf

Understand Your Current Process and Data

Before selecting the evidence-based approaches to test/implement, perform a diagnostic assessment of your current situation. Knowing your readmission rates and trends and will help your team make informed decisions on which strategies will impact the goals. Consider both quantitative and qualitative data in your review.

Analyze readmission rates for the past 12 months for the following trends:

- What is your readmission rate by month?
- What types of patients are readmitted (age, sex, payer source, populations, service lines, etc.)?
- What is your highest risk group?
- Where are patients discharged to?
- Where are patients being readmitted from?
- What are the primary and secondary diagnoses?

Interview readmitted patients/caregivers

- Talk with five patients and their caregivers who had been previously discharged and are now readmitted to gain insight into why they think the readmission occurred.
- Identify what processes could be modified or changed to fill the gaps.
- Use the sample patient/caregiver Assessment tool in Appendix D.

Interview the PCP or other providers

- Ask the PCP or other health care providers who cared for the patient after discharge why they think the readmission occurred.
- Work with providers to determine what information is most valuable for them to receive post discharge.
- Use the sample provider assessment tool in Appendix E.

What can your processes tell you?

- Review current admission process.
- Understand how patients and caregivers receive and use information.
- Review written educational materials.
- Understand your coaching processes.
- Understand your post-acute follow-up processes.
- Use the sample Process Assessment tool in Appendix F.

Other Recommendations

- Designate reduction of preventable readmissions as an organizational strategic priority.
- Make readmissions a standing agenda item on senior leadership and hospital board meetings.
- Use run charts to track and trend results over time. Share data/results routinely with staff and leadership. User friendly excel tools are available at http://tc.nphhi.org/Collaborate.
- Hold convening meetings to solicit advice and support from the community on how to reduce readmissions.
- Convene a group of patients and caregivers to review educational materials before they are disseminated.

Appendices

Appendix A: Modified Lace Tool

Appendix B: Core Readmission Risk Calculator predicts a patient's likelihood of hospital readmission within 30 days of discharge for heart attack, heart failure or pneumonia. http://www.readmissionscore.org

Appendix C: NC Health Literacy toolkit, which includes information about the teach-back method and videos. http://www.nchealthliteracy.org/toolkit/tool5.pdf

Appendix D: IHI STAAR Diagnostic Tool Assessment or Patient/Caregiver Interview Tool

Appendix E: Provider Interview Tool

Appendix F: Process Review Tool