Readmissions Change Package

Contact

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The Problem

- A 2009 study in the *New England Journal of Medicine* demonstrated that almost one-fifth (19.6 percent) of Medicare patients were readmitted to the hospital within 30 days of discharge and 34 percent were readmitted within 90 days.
- This research estimated that the annual cost to Medicare alone of unplanned hospital readmissions exceeds $17 billion.
- A 2010 America's Essential Hospitals 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 with a 2010 baseline by Dec. 8, 2014.

How will we know that a change is an improvement?

Measures

Outcome:

- 30-day all-cause, all-payer hospital readmission rate

Process (select a minimum of two):

- Percent of cases for which defined and separate lists of discontinued, new and continued medications is present in the medical record
- 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 seven days of discharge
- Percent of cases for which there is documentation of a follow-up phone call within 72 hours of discharge

See EHEN data measure specifications manual for full details: http://essentialhospitals.org/groups/ehen/data-collection/

What changes can we make that will result in improvement?

This change package does not endorse any particular model or care system. Rather, it highlights common approaches and practices, many of which are supported by research and/or significant use in multiple hospitals.

Use a key driver diagram to connect aims, key drivers, and interventions. The diagram creates a learning structure that organizes the theory of improvement for a specific aim and results in a model that can be shared with the improvement team, frontline staff, and hospital leaders. A key driver template is available for use at http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/06/Readmissions_Key-Driver-Diagram.pdf

Primary Driver	Change Ideas	Resources
Patients at risk for readmission	• Use a risk of readmission assessment tool and validate it using your own data. • Make readmission risk assessments easy for all to see and address. • 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 there is a standard.	• Modified LACE tool http://essentialhospitals.org/wp-content/uploads/2013/12/Modified-LACE-Index-Tool.pdf • BOOST 8Ps http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf • EHEN Webinar: Who's at Risk? Identifying Patients in Danger of Rehospitalization http://essentialhospitals.org/webinar/whos-at-risk-identifying-patients-in-danger-of-rehospitalization

Primary Driver	Change Ideas	Resources
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. • 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. 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.	• AHRQ MATCH Toolkit http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/match.pdf • EHEN Webinar: Building Health Literacy: Essential Steps and Practical Solutions http://essentialhospitals.org/webinar/building-health-literacy-essential-steps-and-practical-solutions/ • North Carolina Health Literacy Toolkit http://www.nchealthliteracy.org/toolkit/tool5.pdf • Coleman Medication Reconciliation Form http://essentialhospitals.org/wp-content/uploads/2014/04/Care-Transitions-Prgm-MDT-multiple-events.pdf • EHEN Webinar: Improve Care Transitions with Medication Reconciliation http://essentialhospitals.org/webinar/improve-care-transitions-with-medication-reconciliation/

Primary Driver	Change Ideas	Resources
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 skilled nursing facility/nursing home to create a concise transfer form. • Evaluate best practices and resources and already developed tools. • 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.	• Project RED after Hospital Care Plan (AHCP) http://www.bu.edu/fammed/projectred/publications/AHCP-English%20Word%20Version.doc • Coleman Personal Health Record. http://essentialhospitals.org/wp-content/uploads/2014/04/Care-Transitions-Prgm-MDT-multiple-events.pdf • The Remington Report describes models used in the 9th SOW Care Transitions Theme http://www.cfmc.org/integratingcare/files/Remington%20Report%20Sept%202013%20QIO%20Care%20Transitions.pdf • Interventions to Reduce Acute Care Transfers (INTERACT) http://interact2.net/tools.html
Adequate follow-up and community resources	• Schedule follow-up appointment with post-acute care provider/PCP within seven 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 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.	• Post-Discharge Phone Call Resource Collection http://essentialhospitals.org/wp-content/uploads/2013/12/Post_Discharge_Phone_Call_Scripts.ppt • Follow-up Phone Call Documentation Tool (Contra Costa) http://essentialhospitals.org/wp-content/uploads/2014/04/proact_phone_clinic_tool_rev3-4-2013.docx • Standard Work for Transition Care RN for Phone Clinic (Contra Costa) http://essentialhospitals.org/wp-content/uploads/2014/04/Standard-Work-Transition-Care-RN-phone-clinicrev2-10-13.docx

Primary Driver	Change Ideas	Resources
Patient and family education	• 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. • Train clinical staff on teach-back using role play and observe their technique once trained. • Use "I" statements when speaking with patient and family/caregiver, e.g., "To make sure I did a good job explaining about your urinary catheter, can you tell me…?" • Script specific teach-back questions for staff. • Perform bedside patient-focused multidisciplinary rounds. • Include patient advisors on improvement teams and committees. • Include patient advisors on governance safety committees.	• North Carolina Health Literacy Toolkit http://www.nchealthliteracy.org/toolkit/tool5.pdf • Partnership for Patients PFE inventory: http://www.healthcarecommunities.org/Communities/MyCommunities/PartnershipforPatients/PartnershipforPatients/Documents.aspx?EntryId=44670 • AHRQ Guide to Patient and Family Engagement in Hospital Quality and Safety http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html • EHEN Patient and Family Engagement Webinar Series http://essentialhospitals.org/groups/ehen/patient-and-family-engagement/ • IPFCC Partnering with Patients and Families to Enhance Safety and Quality: A Mini Toolkit http://www.ipfcc.org/tools/downloads.html • Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals (Joint Commission) http://www.jointcommission.org/roadmap_for_hospitals/

Evidence-Based Models

Hospitals should review the models listed to determine which approach may be more effective for their structure, patient population, and most importantly, the leading causes of readmissions for their patients.

- **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 an essential hospital. http://www.bu.edu/fammed/projectred/index.html

- **The Care Transitions Intervention (Eric Coleman)** is a four-week hospital-based model utilizing a transitions coach who conducts an initial hospital visit and

assessment, works with the patient to complete a 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/RR_CareTransitions/CT_Home.cfm

- **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/

- **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 community-based care transition models used in the 9th SOW Care Transitions Theme http://www.cfmc.org/integratingcare/files/Remington%20Report%20Sept%202013%20QIO%20Care%20Transitions.pdf

Other Recommendations

Recommendation	Ideas	Resources

Understand current process	• Perform a diagnostic assessment.
	• Interview caregivers to identify what processes could be modified or changed.
	  o 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.
	  o Identify what processes could be modified or changed to fill the gaps.
	• Interview the PCP or other providers.
	  o Ask who cared for the patient after discharge and why they think the readmission occurred.
	  o Work with providers to determine what information is most valuable for them to receive post discharge.
		• Joint Commission Resources Reducing Readmissions System and Patient Tracer http://essentialhospitals.org/wp-content/uploads/2014/04/JCRHEN_Readmission_Tracer-FINAL.3.13.docx
		• IHI STAAR Diagnostic Tool Assessment or Patient/Caregiver Interview Tool http://essentialhospitals.org/wp-content/uploads/2013/12/ReadmissionsDiagnosticTool_STAAR1.pdf
		• Patient Interview Tool http://essentialhospitals.org/wp-content/uploads/2013/12/Sample-Patient-Interview-Tool.doc
		• Provider Interview Tool http://essentialhospitals.org/wp-content/uploads/2013/12/Provider-Interview-Tool.doc
		• Process Review Tool http://essentialhospitals.org/wp-content/uploads/2013/12/Process-Review-Tool.doc
		• Day of Discharge Staff Interview Tool (Contra Costa) http://essentialhospitals.org/wp-content/uploads/2014/04/Interview_Questions-_Day_of_DC.docx
		• Interview with Readmitted Patients or Caregivers (Contra Costa) http://essentialhospitals.org/wp-content/uploads/2014/04/Interview_with_Readmitted_Patients.docx

Recommendation	Ideas	Resources

Analyze the data	• Analyze readmission rates for the past 12 months for the following trends:
	  o What is your readmission rate by month?
	  o What types of patients are readmitted (age, sex, payer source, populations, service lines, etc.)?
	  o What is your highest risk group?
	  o Where are patients discharged to?
	  o Where are patients being readmitted from?
	  o What are the primary and secondary diagnoses?
	• Use run charts to track and trend results over time. Share data/results routinely with staff and leadership.
		• Multi-Run Chart Tool http://essentialhospitals.org/wp-content/uploads/2013/12/Macro-Version_Multi-Run-chart-tool_Added-2014.xlsm

Implement leadership practices to support improvement teams	• Conduct housewide daily safety huddles. • Governing body adopts systemwide safety goals. • Perform "reality rounds," or scripted, regular rounds by leaders, focused on discovering and fixing operational barriers to safety practices (ex., care coordination for discharged patients). • Designate reduction of preventable readmissions as an organizational strategic priority. • Make readmissions a standing agenda item on senior leadership and hospital board meetings.	• EHEN Leadership for Safety Webinars http://essentialhospitals.org/institute/ehen-leadership-safety-program/ • Examples of Data Displays Across the EHEN http://essentialhospitals.org/wp-content/uploads/2014/04/Combined_Data-Display-Example-Packet.pdf