**Reducing Readmissions: SYSTEM Tracer**

Begin with general questions with your Performance Improvement Team; gather your answers to the questions below:

* + - 1. Describe your program for preparing patients for discharge from the hospital.

1. The Project Leader will create questions that come from synthesized Strengths, Weaknesses, Opportunities, Threats (S.W.O.T) analysis related to the readmission.
2. Review current state policies, protocols, standards specific to:
3. Initiating discharge planning
4. Preparing the patient/family for discharge (teaching, provision of information)
5. Describe the types of patients in your hospitals that tend to be readmitted for unplanned reasons (based on data if possible).
6. What data do you use to review your readmission trends?
7. What staff education about discharge planning is provided and to which staff?
8. Describe the patient care areas that you would like to trace. (For example, Emergency Department [E.D.] to unit to Operating Room [O.R.] to Intensive Care Unit (I.C.U.) and then general care unit.
9. Do you have all staff involved in the tracer or group sessions that you would like to have? (Nursing, physician, social work, case management, pharmacy, patient education, disease management, risk management/quality)

| **Reducing Readmissions System Tracer** | **Sample Tracer Observations/Questions:** | **Comments/Notes while tracing:** |
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| Readmission rates | 1. What are your baseline rates for unplanned, 30-day readmissions under study? 2. Is staff aware of the need to reduce unnecessary readmissions? Describe their understanding and how/what information is used to inform them. 3. What patients have high, unplanned readmission rates to your hospital? 4. What actions have you taken to understand and address reasons for readmissions? 5. What general solutions have you implemented to improve your discharge planning activities? 6. Ask the team to describe their past performance improvement methods: Stakeholder analysis, High Level Map, Defining the Problems: Root Cause/s Analysis for event of interest, Data Collection Process, Solutions generated that target root cause, Monitoring and Reporting Process, Leadership strategic priority, Accountability 7. Does your Information Technology have an active role in helping to automate the patient care plan? Describe the process and tactics used. |  |
| Patient Entry Points to the Hospital | 1. Describe your process for initiating discharge planning. When does it begin; who is responsible; what specifically do they do. 2. Is there a process for assessing the patient’s risk for readmission? Describe the process and review any tools used. 3. Who is responsible for assuring discharge planning activities occur for patients? How is this tracked and reported? 4. Describe the role of each staff member below, in terms of their discharge planning activities with/for the patient:  * Staff nurse * Nurse manager * Case manager * Social worker * Physician * Pharmacist * Patient educator (if they have) * Disease manager (if they have)  1. Describe your staff education programs related to discharge planning. What staff are included? 2. Do you use a standardized protocol for discharge planning? 3. How are patients taught self-care prior to discharge? Do they receive anything in writing? Review the teaching materials for lay language; use of visuals; reading level. 4. How is the patient’s family included in discharge teaching and planning? 5. Are teach back methods used? 6. Is discharge planning part of routine interdisciplinary rounding? Do daily/shift huddles occur to review the discharge plans? 7. Do you make follow up appointments for the patient? Are the appointments made with the patient and family’s input? Who is making the appointments? 8. Do you make a follow up phone call to the patient after discharge? If so, who makes the call, how soon after discharge is it made? Describe the process. 9. Do you send the next caregiver a summary of the patient’s hospitalization? How soon after discharge? 10. What would you recommend be changed to prevent readmissions? 11. Is the E.D. involved in the discharge process? If, yes how; if not, why not? 12. Describe whether community resources are involved in the process? Who are they; how are they involved? 13. Describe the use of clinics and/or other resources used to prevent readmission. 14. What happens when patients are discharged on week-ends or holidays? |  |
| Policies and Procedures | 1. What policies and procedures are in place to structure discharge planning and teaching? 2. Describe the management and updating of policies. When were they last updated? 3. Are evidence based strategies applied to each policy? |  |
| Quality Measurement and Improvement | 1. Are readmission trends analyzed? When are they reviewed and by whom? 2. Are reasons for readmission tracked? 3. What actions have been taken to reduce the occurrence of unplanned readmissions? 4. What actions have been effective and which have not been? 5. What actions would further reduce the occurrence of unplanned readmissions of patients? |  |
| Patient System Questions | 1. How do you assess the patient’s understanding of their condition; of their treatment; of their medications; of their need to act on early signs and symptoms? 2. What tools and processes are used to prevent conflicting discharge messages to the patient? 3. How is the patient’s language, culture, religious, and social-economic status considered? Describe how this relates to the preparation of preventing readmissions. 4. Are the patient – family suggesting improvements in how their discharge could change? Describe their input? 5. What strategies are used when the patient continues to not participate/partner in their care? 6. Are there readmission situations that can be predicted? What creative tactics can be used in these situations? 7. How are Hospice patients and/or Palliative Care patients prepared for their discharge? 8. If a patient is discharged with a scheduled procedure within 30 days, is this counted as a readmission? If yes, note this is not to be counted as a readmission because it is pre-planned. |  |

Proceed to the Patient Tracer

**Preventing Readmissions: PATIENT-Level Tracer**

The following tracer activities focus on specific patients, evaluating the assessment of the patient on admission for discharge planning needs, ongoing preparation of the patient, and actual readiness for discharge. We recommend you identify a newly-admitted patient to trace using specific questions noted below; and a patient who is being discharged on the day the tracing is being done - also asking the questions noted below in the corresponding section.

| Reducing Readmissions- PATIENT Tracer | **Sample Tracer Observations/Questions f** | **Comments/Notes while tracing:** |
| --- | --- | --- |
| Newly Admitted Patient | Review of Medical Record:   1. Where was the patient admitted from? 2. What is the primary reason for admission? 3. Is this a ‘readmission’ within 30 days of previous discharge (from this hospital or another)? If yes, what is the documented reason for readmission? 4. What is the patient’s perception of reason for admission noted? 5. What is the patient’s understanding of current condition and disease state noted? 6. Is there any notation of probable discharge disposition and needs noted? 7. Is there any notation of milestones patient will need to reach prior to discharge? 8. Was medication reconciliation completed on admission?   Interview admitting staff:   1. If able, ask the admitting physician:  * Reason for admission * Was this a readmission within 30 days of a previous hospital discharge? If yes, how do you think this readmission could have been prevented? * In general, what is your plan of care for the patient during this hospitalization? * Expectations for inpatient care (milestones prior to discharge) * Probable discharge disposition and needs  1. If possible, ask the admitting nurse:  * Reason for admission * Was this a readmission within 30 days of a previous hospital discharge? If yes, how do you think this readmission could have been prevented? * Patient/family’s understanding of current condition, reason for readmission * Your perception of patient’s needs and inpatient plan of care * Your perception of patient’s probable discharge disposition and needs * What are your plans for teaching the patient/family during the inpatient stay? * What other staff/departments will be important to include when planning this patient’s discharge?  1. If possible, ask the case manager:  * How were you contacted about this patient? * Reason for admission * Was this a readmission within 30 days of a previous hospital discharge? If yes, how do you think this readmission could have been prevented? * Patient/family’s understanding of current condition, reason for readmission * Your perception of patient’s needs and inpatient plan of care * Your perception of patient’s probable discharge disposition and needs * What are your plans for preparing the patient/family for discharge?  1. What other staff/departments will be important to include when planning this patient’s discharge? |  |
| Patient being discharged | Review of Medical Record:   1. Is there reference to discharge planning in patient notes every day during the inpatient stay? In which notes (physician? nursing? case mgr?) 2. What is the discharge disposition? 3. Is there documentation of patient/family teaching and understanding of the teaching? (Teach-back methods used)   Interview with staff:   1. What material is being given to the patient/family at discharge to guide their care after departure? 2. Is this material written in non-medical terms? 3. Who is completing the medication reconciliation form? 4. How is medication teaching being completed? 5. Were follow up appointments made for the patient or is patient expected to make them (if patient going home)? 6. Will anyone make a follow up call to the patient (if patient going home)? 7. If the patient is going to another health care facility, what is included in the handoff information?   Interview the patient/family   1. How are you feeling about leaving the hospital today? 2. If going home, do you feel prepared to care for yourself/your loved one? 3. Do you have follow up appointments to make? 4. Do you know what symptoms or conditions you should call your doctor about? Go to the emergency room for? 5. What printed materials were you given to take home with you? Do you understand them? 6. Is there any additional information or education you think you need before leaving the hospital? 7. Do you have any concerns about going home? |  |

The team will complete key findings and themes from the tracer and then begin building a high level process map inclusive of risk points for each step in the process. Please refer to the “How To” guides on the J.C.R. HEN’s website in the toolkit section and talk with your JCR consultant about the team’s tracer.