Readmissions Reboot

Kickoff Webinar
November 21, 2019
A new focus on an old issue
What Drives Improvement in Readmissions?
Drivers for Improvement in Readmissions

Reduce Readmissions

- Use data to inform improvement activities
- Improve standard hospital transitions of care
- Deliver enhanced services based on need
- Collaborate with providers and services across the continuum
Driver #1: Use Data to Inform Improvement Activities

Use data to inform improvement activities

- Analyze data to inform your targeting approach
- Understand root causes of readmissions; elicit the patient, caregiver and provider perspectives
- Periodically update your approach based on findings; articulate your readmission reduction strategies
- Develop a performance measurement dashboard to use data to drive improvement
Big Data, Little Data

**BIG DATA...**
Lots of people
Lots of voices
Lots of information

**LITTLE DATA...**
One unique person
One small voice
One individual customer

**BIG DATA SPOTS A TREND, WHILE LITTLE DATA SPOTS AN OPPORTUNITY.**
### Hospitalwide All-Condition, All-Payer, and Payer-Specific Readmission Analysis (adult, non-OB)

#### Table 1. Readmission Rate

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td># discharges</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
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<tr>
<td># readmissions</td>
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<tr>
<td>Readmission rate</td>
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</table>

#### Table 2. Percentage of Discharges and Readmissions

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Uninsured</th>
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<tbody>
<tr>
<td>% of total discharges</td>
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<tr>
<td>% of total readmissions</td>
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#### Table 3. Days Between Discharge and Readmission

<table>
<thead>
<tr>
<th></th>
<th>All</th>
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<tbody>
<tr>
<td># of readmissions within 0-4 days of discharge</td>
<td>#DIV/0!</td>
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<tr>
<td># of readmissions within 10 days of discharge</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td># of readmissions between days 0-30 of discharge</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>% of readmissions in 0-4 days</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>% of readmissions in 0-10 days</td>
<td>#DIV/0!</td>
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<tr>
<td>% of readmissions in 0-30 days</td>
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</tbody>
</table>
“THE KEY TO GOOD DECISION MAKING IS NOT KNOWLEDGE. IT IS UNDERSTANDING.”

—Malcolm Gladwell

BLINK
# Little Data – What Our Patients Tell Us (The REAL Story)

## Readmission Discovery Tool

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<tbody>
<tr>
<td>Ordered/discharge</td>
<td>y</td>
<td>y</td>
<td>y</td>
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<td></td>
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<td></td>
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<td>1</td>
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<tr>
<td>Follow-up post-discharge</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
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<tr>
<td>Follow-up appointment scheduled within 7 days</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
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<tr>
<td>Understanding of instructions validated through teach back</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>2</td>
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<tr>
<td>Final call within 72 hours of discharge</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td></td>
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<td>7</td>
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## Instructions

- Error Y if process was performed. Error NA if not applicable, e.g., prob of STD, no app expected. Add any additional key processes you use in your task. Leave blank if unable to determine.

## Discharge Disposition

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</thead>
<tbody>
<tr>
<td>Home</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td></td>
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<tr>
<td>Home with Home Health</td>
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Driver #2: Improve Hospital Care Transitions Processes

- Engage patients and their families to identify the learner, understand care preferences and assess risk for readmission.
- Facilitate interdisciplinary collaboration on readmission risks and mitigation strategies.
- Develop a customized care transitions plan that includes patient preferences, risk factors and post discharge contact info.
- Use teachback and other health literacy tactics to optimize patient/caregiver understanding.
- Timely post-discharge follow up with patient and/or caregiver.
Driver #3: Deliver Enhanced Services Based on Needs

Deliver enhanced services based on assessed needs of the patient

- Palliative care
- Condition specific programs
- Pharmacy interventions
- Complex care management
- Emergency Department pause
Driver #4: Collaborate with Providers and Agencies Across the Continuum

- Collaborate with providers and agencies across the continuum
- Identify clinical, behavioral, social and community-based support organizations that share the care of your high-risk patients
- Convene a cross continuum of providers and agencies that share the care of your high-risk patients
- Improve referral processes to make linking to social, behavioral and community-based services more effective and efficient
Bright Spots
Bright Spots

- Use of data to select target populations and priorities
- Interdisciplinary collaboration / Improved educational practices
- Condition specific programs / Complex care management
- Pharmacy involvement in care transitions
- Stronger collaborations with SNF & HH
Opportunities
Opportunities

- Learning from and engaging with patients
- Learning what matters most to patients
- Improved health literacy / validating understanding through effective teachback
- Use of an ED pause / mechanism to discuss complex patients prior to admit
- Discussion about/referrals to Palliative Care
- Collaboration with Behavioral Health, Social/Community Resources
What Are YOUR Bright Spots and Opportunities?
The Stream Approach
The Offer

• Five-part virtual learning series
• Peer sharing of successful strategies to reduce readmissions
• Tools and resources to help focus the work
• Individual hospital team coaching
The Ask

• Complete the discovery tool prior to the next session
• Determine the number of readmissions needed to reduce each month in your organization in order to reach the reduction goal
• Attend all five learning sessions and agree to take action between calls
Get Started

- Identify YOUR Readmission reduction goal
- Identify YOUR target population
- Apply population-specific strategies
- Complete the Readmissions Discovery Tool by interviewing the next 10 readmitted patients this month
Readmissions Resources

- Readmissions Change Package
- ASPIRE Guide
- Trail Guide
- Readmissions Top Ten Checklist
- Readmissions Whiteboard Video Series
- HRET-HIIN Hospital Wide Topics LISTSERV
- Huddle for Care Discussion Forum
- IHI Improving Transitions How To Guide
- BOOST – Better Outcomes by Optimizing Safe Transitions
- LACE – Risk Assessment for Readmissions

Thank You!

Kim Werkmeister, BA, RN, CPHQ, CPPS
Cynosure Health
kwerkmeister@cynosurehealth.org