Readmissions Reboot

Webinar #2
December 18, 2019
A new focus on an old issue
What Drives Improvement in Readmissions?
Drivers for Improvement in 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 of Data to Understand Who, What, Where, When, Why

- Who is being readmitted?
- What medical conditions are contributing to the most readmissions?
- Where are most readmissions coming from?
- How long after discharge are they returning?
- Why are patients returning? Determine the root cause of the unfulfilled need.
Are Our Patients Just Non-Compliant?

non-compliant

[nänkəmˈplıənt]

ADJECTIVE

non-compliant (adjective)

failing to act in accordance with a wish or command.
Patient Interviews

TOOL 2: READMISSION REVIEW TOOL

Purpose
Readmission reviews are designed to elicit the “story behind the story”: going well beyond chief complaint, discharge diagnosis, or other clinical parameters to understand the communication, coordination, or other logistical barriers experienced in the days after a patient’s discharge that resulted in a readmission.

For the purposes of designing a data-informed portfolio of strategies, conduct 5 to 20 of these interviews to elicit the patient/caregiver perspective, humanize readmissions, and understand root causes that go beyond diagnoses or other “ fácil” categories. Be sure to interview at least 5 Medicaid patients and 5 caregivers.

For the purposes of improving transitional care for all patients, consistently conduct a “readmission review” for each readmitted patient, using the information about the person’s actual challenges, barriers, or root causes to create a better discharge plan.

Description
Adapted from the well-known Institute for Healthcare Improvement’s State Action on Avoidable Rehospitalizations.
Now it’s your turn!

Discovery Tool: What Did You Learn?
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
Driving Improvement With Improved Communication During Transitions of Care
Ideal transition in care

- Discharge planning
- Complete communication of information
- Availability, timeliness, clarity, and organization of information
- Medication safety
- Educating patients to promote self-management
- Enlisting help of social and community supports
- Advance care planning
- Coordinating care among team members
- Monitoring and managing symptoms after discharge
- Outpatient follow-up
Engage Patients and Families

• Who is the caregiver?

• Do we have a standard method for gathering this info?
Assessing Risk for Readmission

### The 8Ps:
Assessing Your Patient’s Risk For Adverse Events After Discharge

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>Signature of individual responsible for ensuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>- Monitor medication changes and patient education before discharge.</td>
</tr>
<tr>
<td>Psychological</td>
<td>- Assess need for psychiatric follow-up.</td>
</tr>
<tr>
<td>Principal diagnosis</td>
<td>- Review of national discharge guidelines.</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>- Eliminate unnecessary medications.</td>
</tr>
<tr>
<td>Poor health literacy</td>
<td>- Commit to patient involvement in planning discharge.</td>
</tr>
<tr>
<td>Patient support</td>
<td>- Alternative care plan before discharge.</td>
</tr>
<tr>
<td>Prior hospitalization</td>
<td>- Follow-up phone call at 72 hours.</td>
</tr>
<tr>
<td>Palliative care</td>
<td>- Assess need for palliative care services.</td>
</tr>
</tbody>
</table>

### Modified LACE Tool

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Value</th>
<th>Points</th>
<th>Prior Admit</th>
<th>Present Admit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay</td>
<td>Less 1 day</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1 day</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2 days</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3 days</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>4-6 days</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>7-13 days</td>
<td>5</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>14 or more days</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute admission</td>
<td>Inpatient</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comorbidity</td>
<td>DM no complications, Carcerebrovascular disease, Hx of MI, PVD, PUD</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild liver disease, DM with end organ damage, CHF, COPD, Cancer</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leukemia, lymphoma, any tumor, cancer, moderate to severe renal dz</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dementia or connective tissue disease</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate or severe liver disease or HIV infection</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metastatic cancer</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Room visits during previous 6 months

<table>
<thead>
<tr>
<th>Emergency Room visits</th>
<th>0 visits</th>
<th>1 visit</th>
<th>2 visits</th>
<th>3 visits</th>
<th>4 or more visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Take the sum of the points and enter the total**

www.CynosureHealth.org
Teach-Back Humor

"TAKE WITH MEALS? NO PROBLEM! I EAT ALL THE TIME!"

www.CynosureHealth.org
Stop, Slow Down and Show Me

- Ask the patient (or family member) how they learn best.
- Provide instruction in plain talk
- Assess activation
  - Ability to manage meds
  - Understanding red flags
  - Medical Follow up Plan
  - Personal Health Record

www.CynosureHealth.org
How Do We Provide Information To Our Patients?

• Handing someone a stack of papers and going over a set of instructions won’t guarantee a successful transition from the hospital to home.

• People need more.

• They need a human touch, emotional recognition, and a sense that they’re not going to be left on their own as they try to recover from the setback that brought them to the hospital.
Examples: We Can Do Better

What was communicated:

• Here is a prescription for pain medication. Don’t drive if you take it. Call your surgeon if you have a temperature or are worried about anything. Go see your doctor in two weeks. Do you want a flu shot? I can give you one before you leave. If you need a wheelchair to take you to the door, I’ll call for one. If not, you can go home. Take care of yourself. You are going to do great!

What wasn’t communicated:

• Here’s a number to call if you have any questions. Here’s the medical expert who’s in charge of your follow-up care and how to reach him or her. Here’s the plan for your care over the next month, and here’s the plan for the next six months.

• Or this: You’re going to experience a lot of challenges when you get home. Here are the three or four concerns that should be your priorities. Here’s what your caregiver needs to know to help you most effectively. Here are resources in the community that might be of assistance.
Teach-back Resources

USE TEACH BACK
www.teachbacktraining.org
- Training videos
- Conviction & confidence scales
- Tips on making standard work

www.CynosureHealth.org
How Do We Prepare Our Patients For Discharge?

- **Discharge Paperwork/Instructions**
- **Discharge Phone Calls**
- **Make Follow Up Appointments**
- **Disease Specific Clinics**
Bright Spots and Opportunities

What is working well for communication with your patients?

What do you see as a real opportunity or challenge to effective communication with patients in your organizations?
Lessons from the Field
Many Resources Available to Guide Improvement
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


www.CynosureHealth.org
Thank You!

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