Readmissions Reboot

Webinar #4
February 18, 2020
A new focus on an old issue

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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

Reduce Readmissions
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
Driving Improvement With the Use of Data: Finding OUR Target Population

How do we identify the patients that need us to collaborate the most?
What About Us? Can We Improve Our Communication With Each Other During Care Transitions?
Collaborating Across the Continuum

1. Who is doing what across the continuum? (inventory)
2. Who shares in the care of our patients? (resources)
3. Can we meet? (relationships)
Finding Agencies for Collaboration

- Highest utilization for your population
- Referral sources
- Community agencies
Working With Partners

HOSPITALS, PHARMACIES

PATIENTS AND CAREGIVERS

SKILLED NURSING FACILITIES, LONG TERM CARE

MEDICAL HOME

HOME CARE AGENCIES, PALLIATIVE CARE

BOARD AND CARE ORGANIZATIONS
Lessons from the Field
Questions for the Group

• What is working well for communication across the continuum of care?

• What do you see as a real opportunity or challenge to effective communication across the continuum?
Prepare to Partner with Other Organizations

Reach out

Prepare data on your hospitals’ target population, how many target population discharges there are per day/week, and a description of your working understanding of what factors contribute to readmissions.

Prepare

Prepare questions to learn more about the services they offer and their capabilities.

Prepare
Ask

**Capacity:** Ask the provider/agency to consider whether they have capacity to accept a consistent volume of referrals. What volume of referrals could they absorb?

**Timeliness:** Timely post-hospital contact is a priority, ask the provider/agency to work with you on developing a process to ensure linkage to services, optimally prior to discharge or within 1-2 days.

**Getting started:** Ask the provider/agency if you can test the new process of linking high-risk patients to their services on the next 10 patients who have a need for their services.
Simple But Effective

- Get people in the same room
- Learn what everyone has to offer
- Learn what everyone's frustrations are
- Start with one issue and go from there
Build the Relationships

• Hold regularly scheduled monthly meetings.
• Start with a "coalition of the willing"—doesn’t need to be perfect.
• Invite new partners/agencies as you learn about them.
• Allow 3-4 months for the group to gel.
• Start with common agenda items:
  • Readmission data.
  • Readmitted patient stories.
  • Readmission stories from "receiver" perspective.
  • Handoff communication.
  • What information do "receivers" need that they frequently don’t have?
Strategies: Circle Back

• Follow up call to receiving provider of care:

  • Did patient arrive safely?
  • Did you have all the information you needed at time of transfer?
  • Were medication orders correct?
  • Did the patient’s presentation accurately reflect the information received?
  • Is the patient and/or family satisfied with the transition?
  • Have we provided everything you need to care for the patient?
Strategies: Co-Management

- Navigators
- Weekly check in calls for shared patients
- Touch points in care to communicate together
Strategies:
Reach In – Transition Out

- Know where your patients are across the care continuum
- Don’t wait for discharge to get involved
- Can you be informed when your patient is admitted?
Hospital and Skilled Nursing
3 C’s Strategy
“3Cs”: COLLABORATION

- SNF monthly meetings
- SNF administrators and directors of nursing (DONs) invited
- Development of mutual goals that are patient-centered
- Dialogue opened and issues addressed
- Case reviews of all 7-day readmissions - trends & action items identified
“3Cs”: COMMUNICATION

Standardized Hospital to SNF Checklist

Standardized SNF to Hospital Checklist

Verbal handoff by nurse practitioner (NP) for high risk patients

Follow-up phone call by NP within 24-48 hours of discharge

Telepresence follow-up on high risk patients
“3Cs”: COMPETENCY

Provided SNF RNs and LVNs education on specific topics (i.e. COPD, HF, Aspiration Pneumonia)

Needs assessment performed for future topics

Provided education at SNF meeting on special topics (i.e. Palliative Care and Conservatorship Process)
INTERACT® Tools Library

Click on the links below to view resources and download tools to support your INTERACT™ QIP:

- INTERACT® Version 4.0 Tools For Skilled Nursing
- INTERACT® Version 1.0 Tools For Assisted Living
- INTERACT® Version 1.0 Tools For Home Health Care
- Printed INTERACT® Tools – available from MED-PASS, more information click here.

Download: https://pathway-interact.com/interact-tools/interact-tools-library/
Lessons from the Field
Your Turn

• Who should we be partnering with in our organization?
• What kind of collaboration is already occurring in our organization?
• Where should we be meeting? (Is an opportunity already in existence that we can leverage?)
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
- INTERACT Tools


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Thank You!  
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