Readmission Road Show

The drive from here to there

Pat Teske RN, MHA

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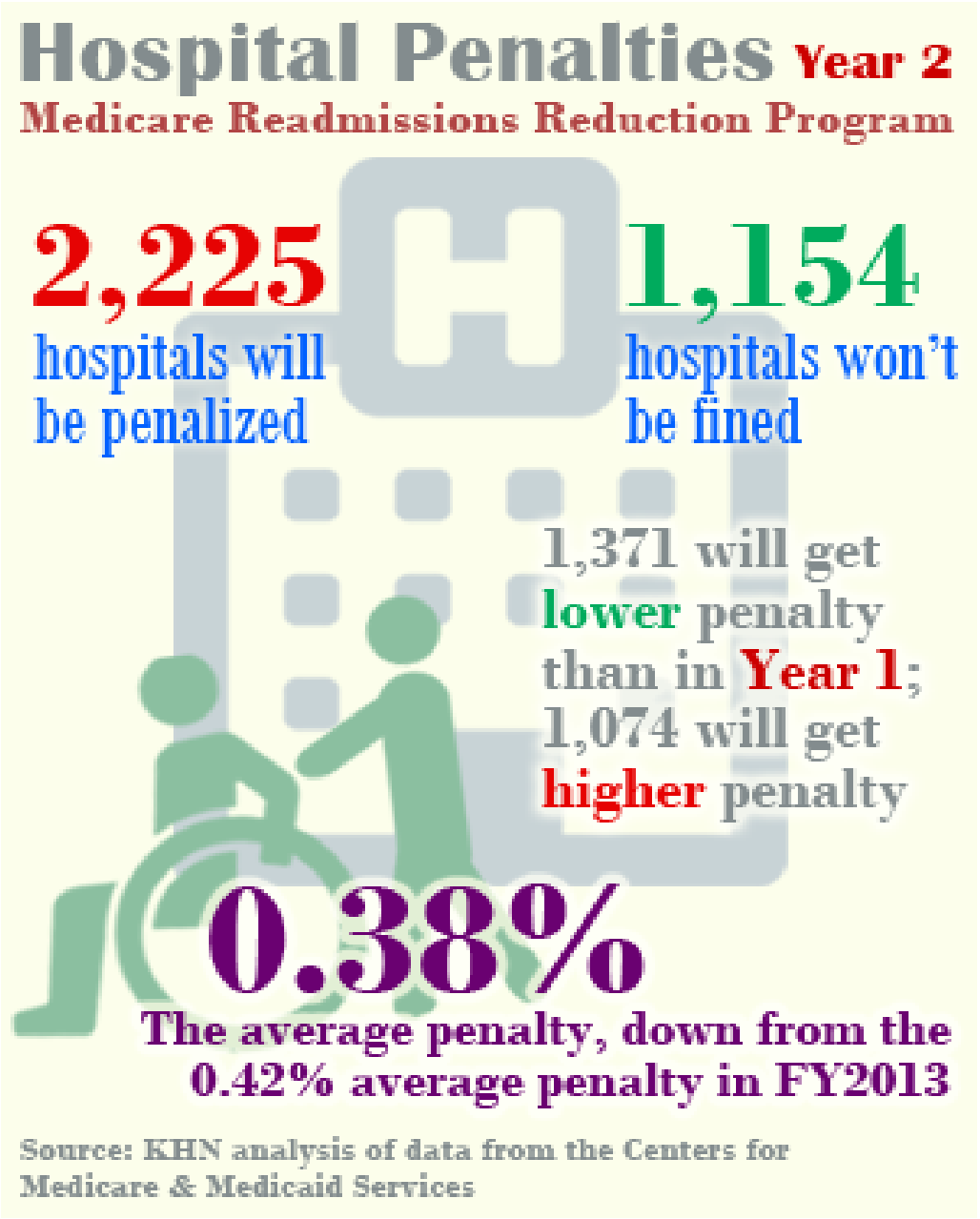
We can do better

- 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 wheel chair 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.



CMS finalized the inclusion of COPD, Total Hip Arthroplasty and Total Knee Arthroplasty for FY 2015

20% Reduction by 12/31/13

- Where did you start?
- Where are you now?
- What's working?
- What's not working?
- How far to you need to drive?
- Which road(s) should you take?

A few things we know

- There is no one thing
- There is no one person
- Interventions are both easy and amazingly difficult at the same time

Doing things the same way will NOT reduce readmissions


Understanding
and overcoming
our barriers


RCA - GAP
Analysis


• Readmission Rates
• To – From
• Diagnoses
• Risk Groups
• Do 5 structured interviews
Review your data
Talk to your patients & providers
Review Your Processes
Review MRs
• Admission
• Teaching/Coaching
• Hand Over
• Acute Care Follow Up
• Post-Acute care support
• Review 5 charts

What was broken or unreliable?


What were the
bright spots?

What did you learn?

Suggested Practices

- Conduct enhanced admission assessment of discharge needs and begin discharge planning at admission
  - What's included in that assessment?
  - Who is responsible to do it?
  - How are findings communicated?
  - How are findings acted upon?

Possible questions

- Why do you think you were admitted to the hospital?
- How do you think you became sick enough to come back to the hospital?
- At your last discharge from the hospital, did you get education on how to manage your health after going home?
- At your last discharge from the hospital, did you get a list of your medications before going home? Did you understand how to take those medications?
- Who is your primary care/main doctor? Do you see a specialist?
- When was the last time you saw your doctor before coming to the hospital?
- Who goes with you when you see your doctor?
- (if not seen in the last 14+ days) Did you have any problems getting to see your doctor?
- When you are at home, has anything gotten in the way of you taking your medications? Who helps you with your medications?
- Do you have a method set up for organizing and taking your medications at home?
- Tell me about the kinds of meals you eat typically eat each day? Who prepares your meals?
- What concerns you most about going home? How could someone help you feel more comfortable going home? Who helps you and takes care of you at home?
- What do you think needs to happen for you to be able to stay healthy enough to stay home?
- How confident are you about deciding whether you need to go to the doctor or whether you can take care of a health problem yourself?
- Would you find it helpful if someone from the hospital were to meet with you while you are here and help you schedule the follow-up appointments with your doctor before you leave the hospital?
- What do you think about someone checking in with you by telephone after you are discharged; to see how you are doing and if there is anything that you need assistance with?

St. Rose HOSPITAL

Excellence in Care

ROOM#

DAY

DATE

DOCTOR

NURSE

NURSE ASSISTANT

0 NO PAIN | 2 MILD PAIN | 4 MODERATE PAIN | 6 SEVERE PAIN | 8 VERY SEVERE | 10 WORST POSSIBLE

TODAY'S PLAN

PLEASE CALL DON'T FALL

WASH WITH SOAP AND WATER ONLY

DIETARY RESTRICTIONS ☐ Yes ☐ No

COMMUNICATION

QUESTIONS FOR YOUR DOCTOR

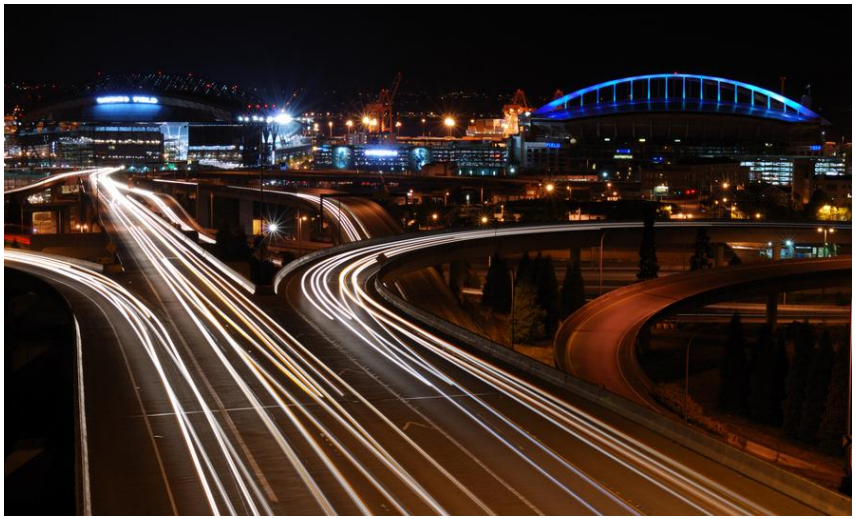
DISCHARGE PLAN

ESTIMATED DISCHARGE DATE _____

Suggested Practices

- ❑ Conduct formal risk of readmission assessment;
- ❑ Align interventions to patient's needs and risk stratification level

Match resources with needs



- Which patients will probably do well with “normal discharge”?
- Which patients need something more?
- Which patients need far more?
- How do you know?
- What do you do?

Risk Assessments

- Internal
  - Derived from your own data
  - Automatic vs. manual
  - Score vs. bucket
- External e.g. BOOST, LACE
- IHA Risk Simulation

- Example
  - Low = Routine discharge
  - Medium = Enrollment in ProjectRED
  - High = ProjectRED + CTI if going home or warm hand off if going to SNF

Discharge Plan Checklist: (LACE score ≥11 suggests high risk for readmission)

- ❑ Presenting problem that precipitated hospitalization identified and shared with patient/ family/caregiver.
- ❑ Patient/ family/caregiver educated on primary DX and secondary DX.
- ❑ Patient/ family/caregiver given a written schedule of discharge medications and instructions on purpose and cautions.
- ❑ Preadmission and discharge medications reconciled and patient/ family/caregiver are aware of new medications, change in dose or frequency and medications that should be discontinued.
- ❑ Patient/ family/caregiver educated on anticipated problems and appropriate interventions relative to disease and symptom management.
- ❑ Patient/ family/caregiver have been educated on diet and activity.
- ❑ Patient discharged with a follow-up appointment within one week of discharge if physician concurs.
- ❑ Patient/ family/caregiver can identify primary care physician and consultants; knows about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911.
- ❑ Patient/ family/caregiver can give a brief summary of discharge instructions when asked.

RN: Print and Sign Name: _____ Date: _____

Suggested Practice

- ❑ Perform accurate medication reconciliation at admission, at any change in level of care and at discharge

- Does you patient leave your care setting with a clear list of which medications they should take once they get home?

Yale study: Medication errors, confusion common for hospital patients

Published: Monday, December 03, 2012

- 377 patients at Yale-New Haven Hospital, ages 64 and older, who had been admitted with heart failure, acute coronary syndrome or pneumonia, then discharged to home. Of that group, 307 patients – 81 percent -- either experienced a provider error in their discharge medications or had no understanding of at least one intended medication change.

EACH DAY follow this schedule:

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medication name Amount	How much do I take?	How do I take this medicine?
 Morning	blood pressure	PROCARDIA XL NIFEDIPINE 90 mg	1 pill	By mouth
	blood pressure	HYDROCHLOROTHIAZIDE 25 mg	1 pill	By mouth
	blood pressure	CLONIDINE HCl 0.1 mg	3 pills	By mouth
	cholesterol	LIPITOR ATORVASTATIN CALCIUM 20 mg	1 pill	By mouth
	stomach	PROTONIX PANTOPRAZOLE SODIUM 40 mg	1 pill	By mouth

CTM3

HCAHPS 23

During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

HCAHPS 24

When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

HCAHPS 25

When I left the hospital, I clearly understood the purpose for taking each of my medications.

- How are you doing on question 25?
- VPB
  - HCAHPS questions are 30% of your score

Pharmacists do it best

- Pharmacist-Recorded Medication Histories Result in Higher Accuracy and Fewer Medical Errors.
  - Gleason KM, Groszek JM, Sullivan C, et al. Reconciliation of Discrepancies in Medication Histories and Admission Orders of Newly Hospitalized Patients. Am J Health Syst Pharm. 2004;61:1689-1695.
  - Bond CA, Raehl CL, Franke T. Clinical Pharmacy Services, Hospital Pharmacy Staffing and Medication Errors in United States Hospitals. Pharmacotherapy. 2002; 22:134-147.
  - Nester TM, Hale LS. Effectiveness of a pharmacist-acquired Medication History in Promoting Patient Safety. Am J Health Syst Pharm. 2002;59:2221-25.

Available Resources

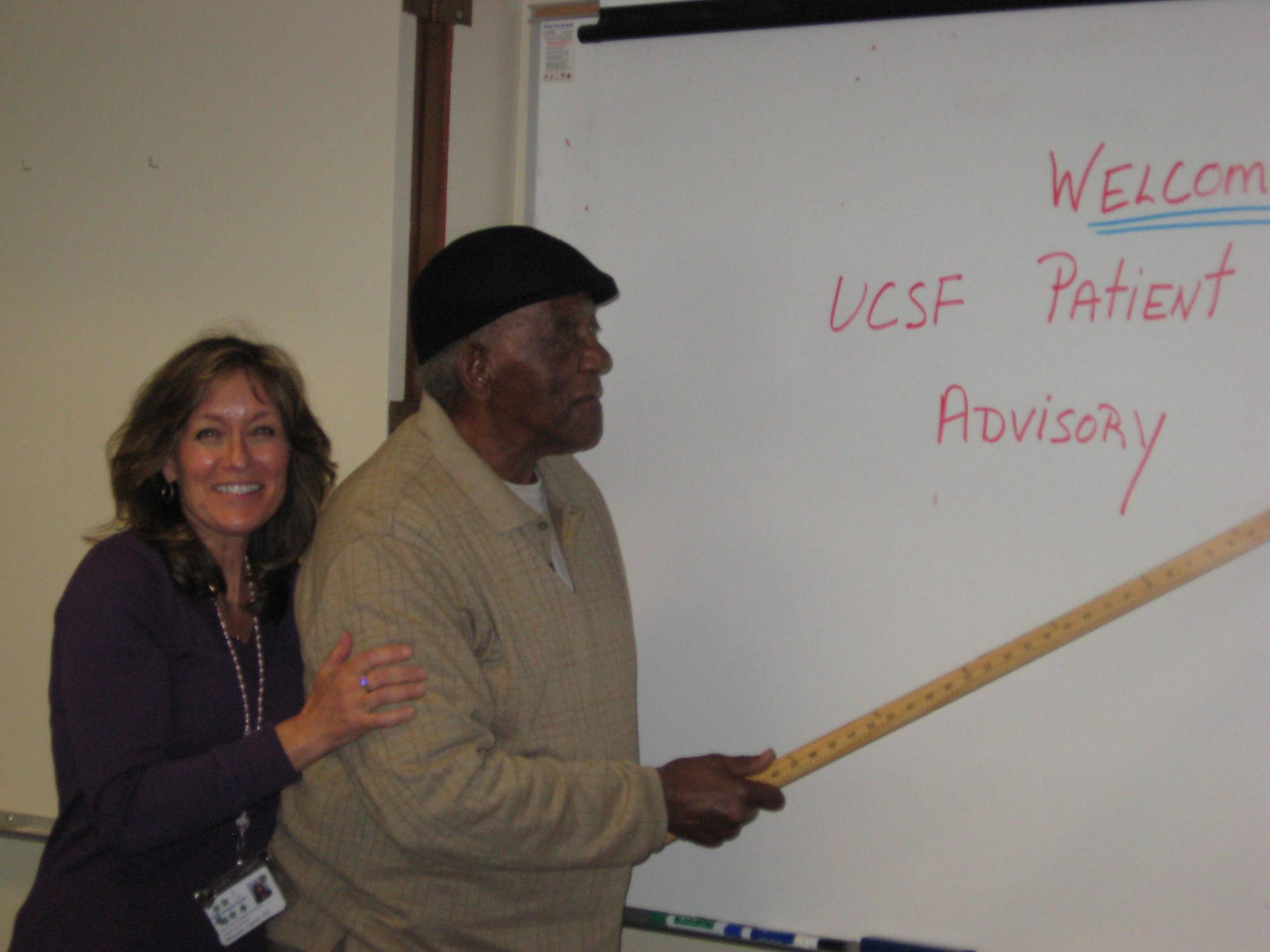
- Pharmacists in *outpatient* hospital pharmacies and hospital clinics could counsel patients
- Community pharmacists can make calls to patients and be paid through the Medicare Medication Therapy Management (MTM) benefit or other MTM plan
- Other services:
  - Walgreens “Well Transitions” program
  - Home Health Agency
  - Home Health Pharmacist combination

MTM

- As defined by the Medicare Modernization Act of 2003 (MMA), MTM services are designed to:
  - Review patient medication regimen
  - Counsel patients to enhance understanding and increase adherence
  - Detect adverse drug events, and patterns of overuse and underuse of prescription medications
  - Make corrective recommendations to prescriber
- Provided at no cost to *eligible* Medicare Part D (drug benefit) enrollees
- Pharmacists are paid by the Part D plan

Suggested Practice

- Provide patient education that is culturally sensitive, incorporates health literacy concepts and includes information on diagnosis and symptom management, medications and post-discharge care needs


WELCOM
UCSF PATIENT
ADVISORY

What does this mean?

- There is a bear in a plain wrapper doing flip flops on 78 handing out green stamps.

Printed Discharge Instructions

Your naicisyhp has dednemmocer that you have a ypocsonoloc. Ypocsonoloc is a test for noloc recnac. It sevlovni gnitresni a elbixelf gniweiv epocs into your mutcer. You must drink a laiceps diuqil the thgin erofeb the noitanimaxe to naelc out your noloc.

What it Says....

- Your physician has recommended that you have a colonoscopy. Colonoscopy is a test for colon cancer. It involves inserting a flexible viewing scope into your rectum. You must drink special liquid the night before the examination to clean out your colon.

Health Literacy

- Do you formally assess the health literacy of your patients?
- Most health materials are written at a level that exceeds the reading skills of the average high school graduate.

- *Health literacy* is the concept of reading, writing, computing, communicating and understanding in the context of health care

Not a yes/no?

Health Literacy Assessment
Adapted (sodium) Newest Vital Sign

1. **If you eat the entire container, how much sodium will you eat?**
   Answer: 200 mg

2. **If you are allowed to eat 60 milligrams of sodium as a snack, how much ice cream could you have?**
   Answer: 1 serving; or ½ cup; or ¼ of the container

3. **Your doctor advises you to reduce the amount of sodium in your diet. You usually eat 2000 milligrams of sodium each day, which includes one serving of ice cream. If you stop eating ice cream, how much sodium would you eat each day?**
   Answer: 1950

4. **Pretend that you are allergic to the following: Penicillin, peanuts, latex gloves and bee stings. Is it safe for you to eat this ice cream?**
   Answer: No

5. **If the patient answered "no" to question 5, ask: Why not?**
   Answer: Because it contains peanut oil

SCORE = TOTAL # ANSWERED CORRECTLY

Interpretation
0 – 1: suggests high likelihood (>50%) of limited literacy
2 – 3: indicates the possibility of limited literacy
4 – 5: almost always indicates adequate literacy

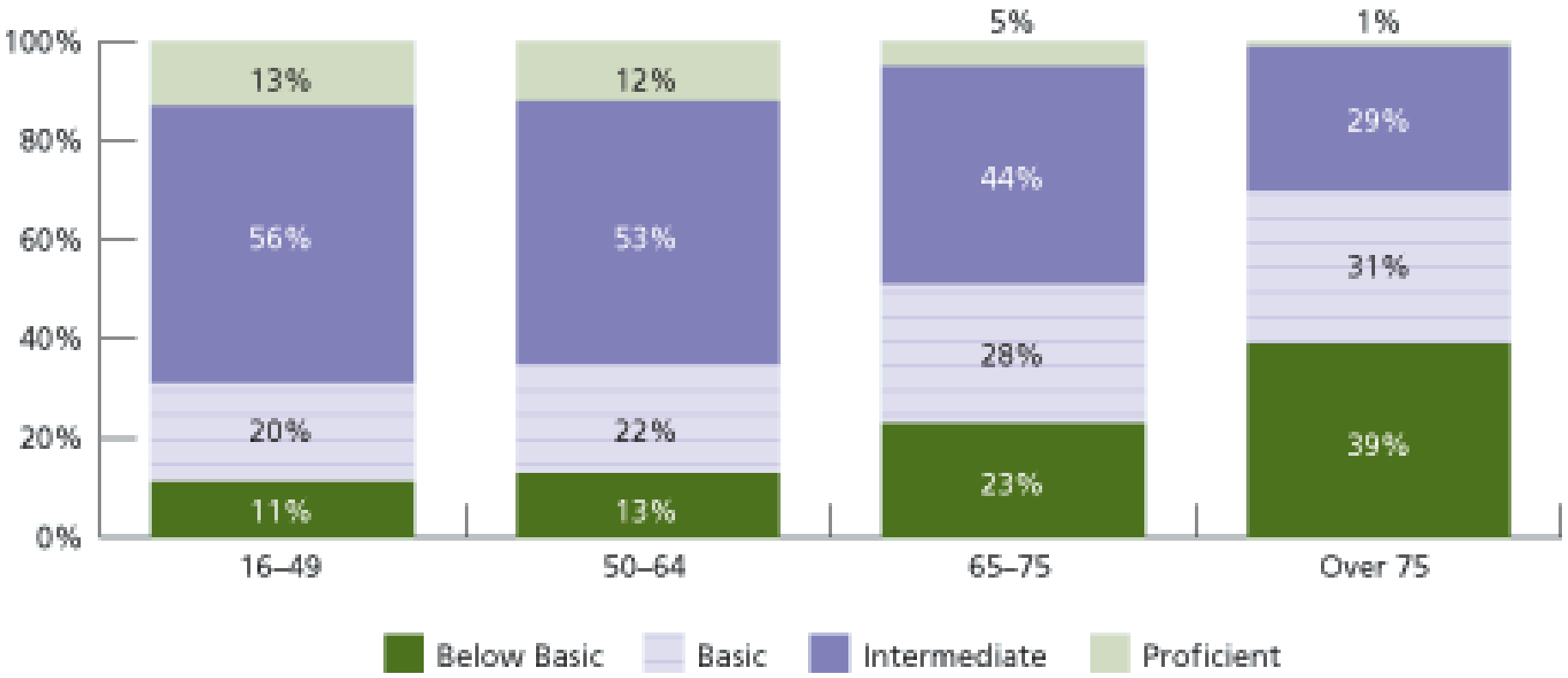
Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 50mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Adult Healthcare Literacy

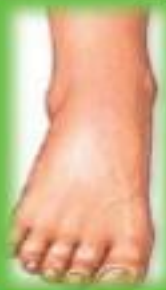
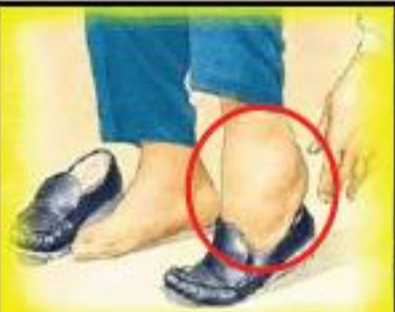
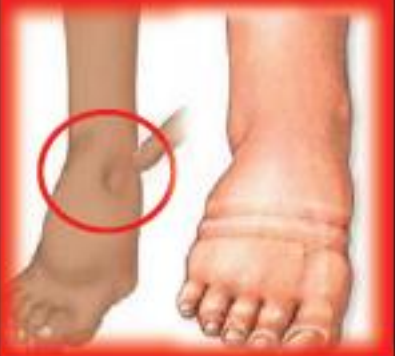
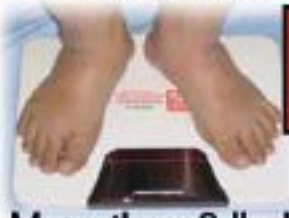


Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy

What to do

- Take a universal precaution approach in written material and a nuanced approach in verbal communication
  - 1. Measure: Newest Vital Sign tool
  - 2. Distribute: tested and clearly written/illustrated material that corresponds with education goals
  - 3. Pace and prioritize: teaching according to patient motivation and capability
  - 4. Offer additional resources on demand

自我監察心臟衰竭的症狀 Monitor My Heart Failure Symptoms

	呼吸 Breathing	水腫 Swelling	體重 Weight	採取行動 Action
好 Good				
注意 Caution			 1 天增 2 磅或 1 週增 3 磅 Gain 2 lbs in 1 day or 3 lbs in 1 week	
危險 Danger			 超過 3 磅!! More than 3 lbs!!	請送我到東華醫院 I NEED TO GO TO CHINESE HOSPITAL

PROJECT RED.....Enhanced Patient Teaching Tool (EPTT)

PROJECT RED COORDINATOR: _____

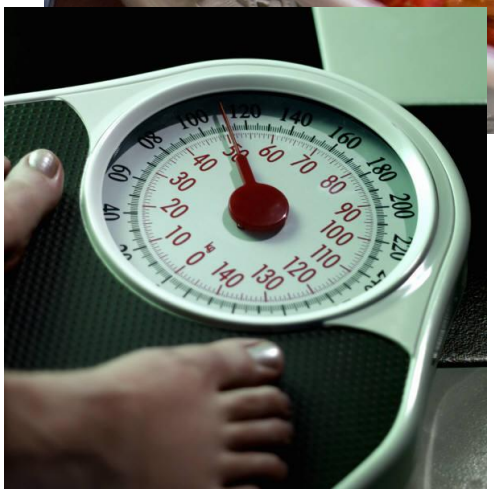
Patient Name: _____ **Room #** _____

Est. Discharge Date:_____ **PCP:**_____

Primary Care Physician	Medications	Dietary	Transportation	Home	Diagnosis
					
List of MD's	List of Meds	Dietician Consult	Yes No	Environment	Dx. Educ.
Appointments	Rx & Refills	Restrictions	Directions to Appts	Stairs	See MD?
Lab Work	Medication Schedule	Family Educ.	Bus/Bart/Cab	Pets	Go to ER?
What to bring ..	Talk Back / Demo			Children	Talk Back
	Med. Information				

Self Care College

Self Care College – an innovative approach to activate patients. Healthcare workers often forget that we only care for patients a small fraction of their lives. Certainly when patients are hospitalized, we can control metrics such as daily weights, glucose monitoring, blood pressure control, and dietary content. However, when the patient leaves for home, he only spends a few minutes per week with a healthcare provider. Trying to reconcile that disconnect was the impetus for designing the Self-Care College (SCC). Patients with CHF are enrolled in the Self-Care College, and instead of the traditional passive method of lecture and educational handouts, SCC patients are asked to actively participate in their healthcare duties while in the hospital just like they will do when they go home. Patients are observed as they weigh themselves, reconcile their medications and create a medication planner. They are also asked what they eat and then given helpful dietary choices based on their responses. Most importantly, after the patient has been through the three modules, the team huddles to ensure that the patient is adequately prepared to transfer to their next healthcare destination. If not, recommendations are made to their provider to ensure a smooth transition. By engaging the patient to participate in the process, the patient is activated to assume responsibility for their care. The Self-Care College team often says, “You don’t learn to ride a bike by reading a book, neither should you be asked to learn how to manage CHF by reading a pamphlet.” Learning is best done by doing. The SCC looks forward to helping patients “take off their training wheels and learn to guide their own disease path.”



Lee Greer, M.D., MBA
Chief Quality and Safety Officer
North Mississippi Health Services
Tupelo, Ms 38801
662 377-3000

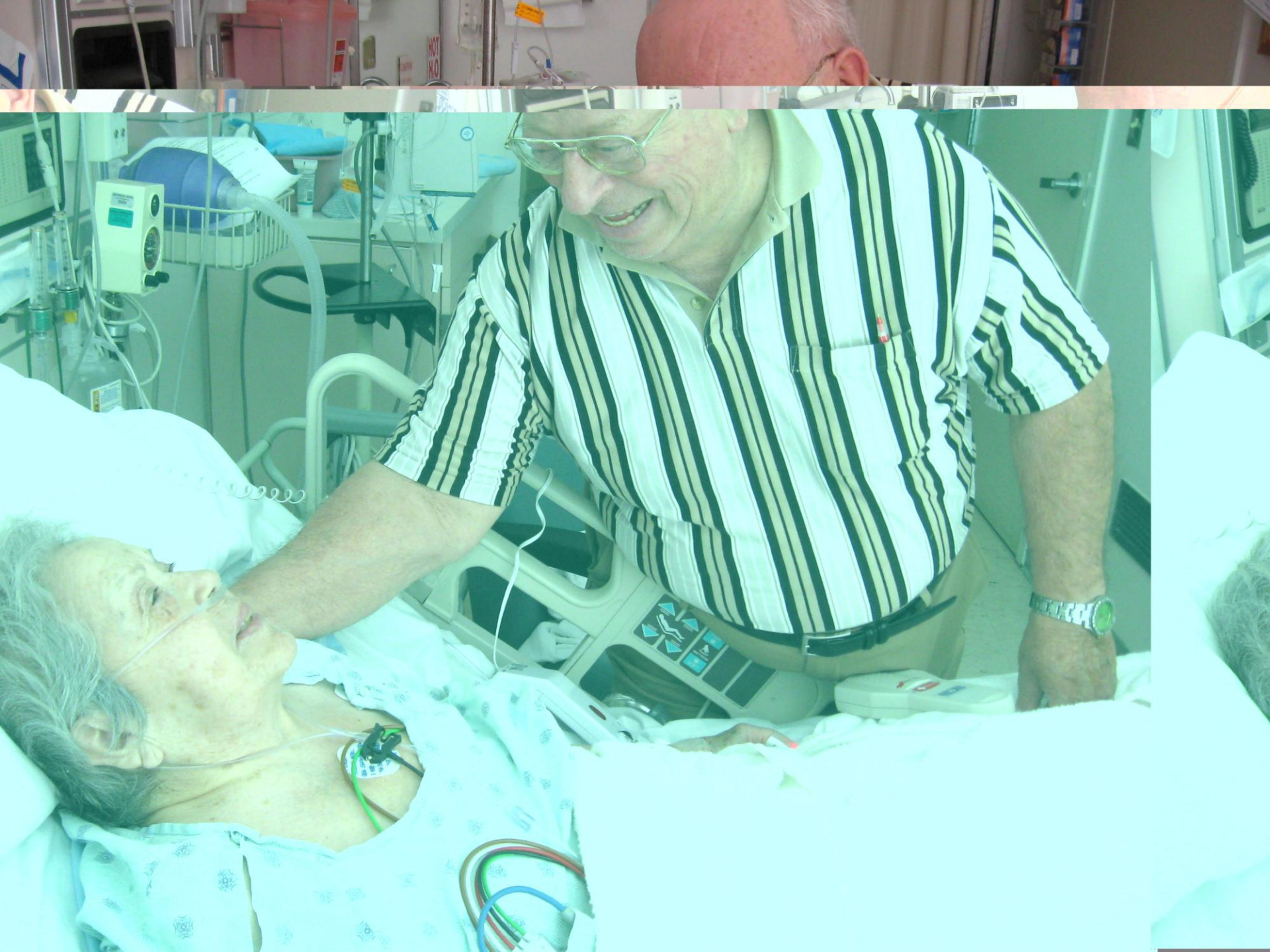
Good-to-go

- Video tape discharge teaching
- Give video to patient to-go

Suggested Practice

- ❑ Identify primary caregiver, if not the patient, and include him/her in education and discharge planning

- Who is responsible to obtain this information?
- Where is it located?
- How is it acted upon?



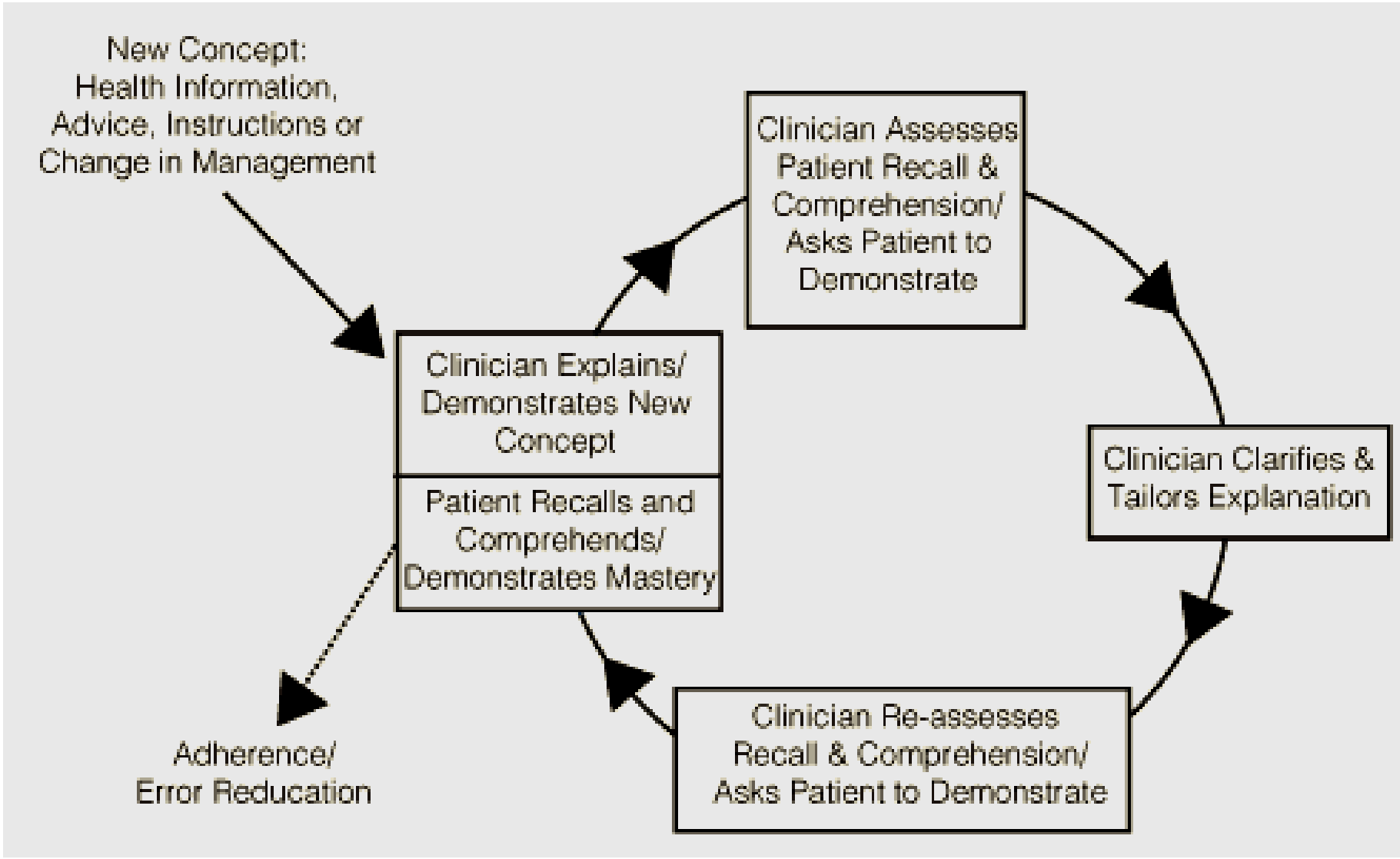
United Hospital Fund

- http://www.uhfnyc.org/publications/880905

Suggested Practice

- ❑ Use teach-back to validate patient and caregiver's understanding

- A way to make sure you—the health care provider—explained information clearly. It is not a test or quiz of patients.
- Asking a patient (or family member) to explain **in their own words** what they need to know or do, in a caring way.
- A way to check for understanding and, if needed, re-explain and check again.
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes.
- *Schillinger, 2003*


New Concept:
Health Information,
Advice, Instructions or
Change in Management
Clinician Explains/
Demonstrates New
Concept
Patient Recalls and
Comprehends/
Demonstrates Mastery
Adherence/
Error Reducation
Clinician Assesses
Patient Recall &
Comprehension/
Asks Patient to
Demonstrate
Clinician Clarifies &
Tailors Explanation
Clinician Re-assesses
Recall & Comprehension/
Asks Patient to Demonstrate

A patient's opinion

- Handing someone a sheaf 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.

Teach back top 10 list

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

How do you know it is really happening and your staff are proficient?

Teaching Teach Back

Suggested Practice

- ❑ Send discharge summary and after-hospital care plan to primary care provider within 24 to 48 hours of discharge

- Easy if….
  - You know who the PCP is
  - You have the summary done at discharge
  - You have a reliable way to get it there

Getting it right

- PCP information
  - Who, how, etc
- Physician support
  - Leadership
  - Feedback
- The process
- Check lists for other settings e.g. SNF
- When is a warm hand off needed

- In discharge summaries include: diagnoses, abnormal physical findings, important test results, discharge medications with rationale for new or changed medications, follow-up arrangements made, counseling provided to the patient and family, and tasks to be completed (eg, appointments that still need to be made and tests that require follow-up)
- Follow a structured template with subheadings in discharge communications
- When possible, use health information technology to create and disseminate discharge summaries

STANDARDIZED CHECKLISTS

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Patient Name:
MR#:
Physician Name:

Skilled Nursing Facility Checklist

AS Initials	RN Initials	Documents
		Gold Interfacility Transfer Form filled out by primary RN
		Skilled Nursing Interfacility Transfer (doctor's orders for SNF)
		Advanced Directive / POLST (if available)
AS Initials	**RN Initials**	**Printouts from ECHO**
		2 Facesheets (one for receiving facility / one for transport team)
		Medications given in the last 24 hours
		Medications given in the last 7 days (including immunizations)
		Triplicate prescriptions for narcotics (if appropriate)
		Lab results (ancillary, pathology labs reports) **CXR results / TB results as appropriate**
		OT / PT / Speech evaluations (including swallow evaluation if done)
		Rehab notes
		Wound care notes
		MD's Dictated Transfer Summary
AS Initials	**RN Initials**	**Copy from Chart**
		Copy of H&P (including consults)
		Doctor's progress notes from the last 7 days (could be in ECHO too)
		EKG copy with dictation (if done)
		Copy of Skilled Nursing Interfacility Transfer (doctor's orders for SNF) **and MD's Dictated Transfer Summary** (provided in separate envelope for patient or designated person)

Additional information regarding patient	
Pre-existing Medical Devices (circle all that apply) PICC line, wound vac, urinary catheter tube feeding other: **Reason:**	**Baseline Status (circle all that apply)** Verbal, Non-Verbal Alert & Oriented x 1 2 3 4
Isolation (circle all that apply) none MRSA, VRE, ESBL, C-DIFF, TB other:	**Ambulation Status (circle all that apply)** Bed bound, wheelchair, walker, cane, Ambulatory with assist Independently without assist
Other pertinent information:	

☐ Transportation form signed by MD present if required

Sending Nurse: _____ | _____
Print Name **Signature**

For Questions: _____ | _____
Department **Phone #**

SNF checklist 8/24/12

Skilled Nursing Facility → Emergency Department Checklist

Reason for Transport: _____

Patient Name	Code Status (circle one)	Conservator Yes / No Name and Phone #
	Full Code DNR Comfort Care *DNR with active care*	

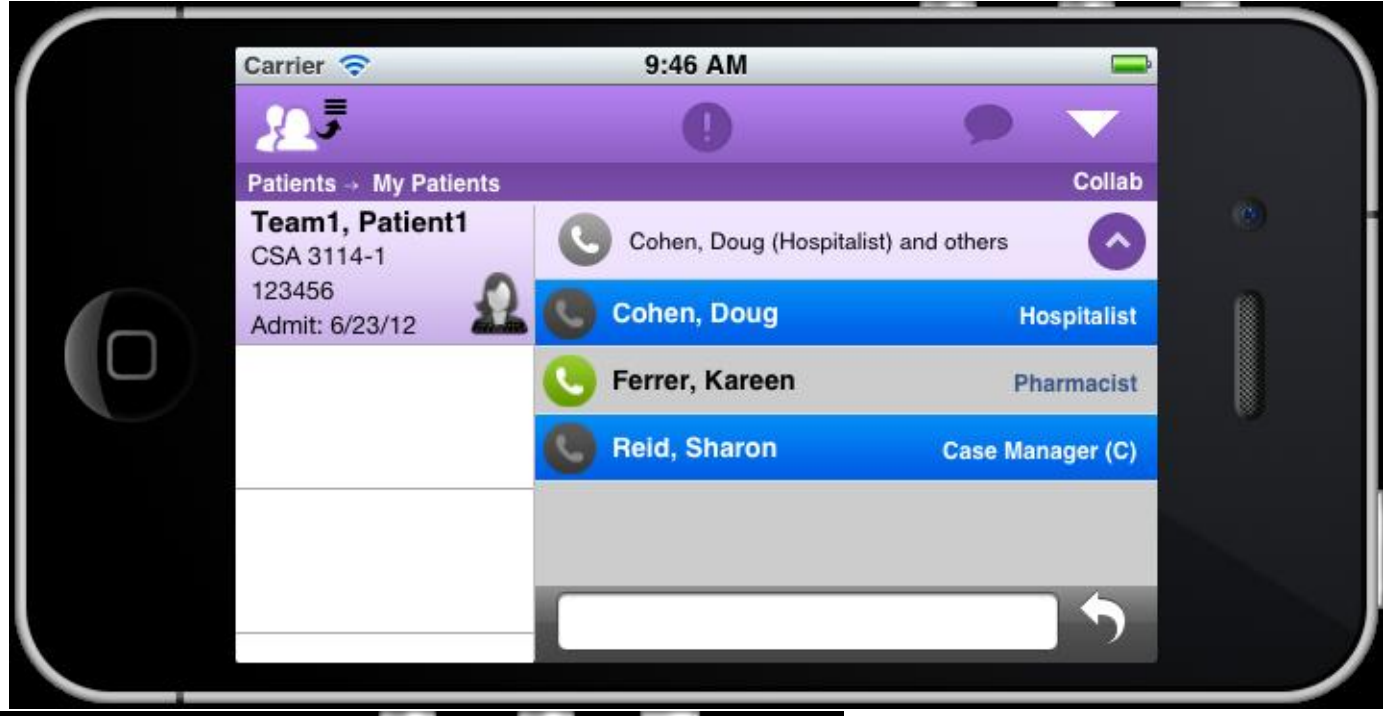
Skilled Nursing Facility Name	Sending Staff Name	DIRECT Phone # for clinical questions

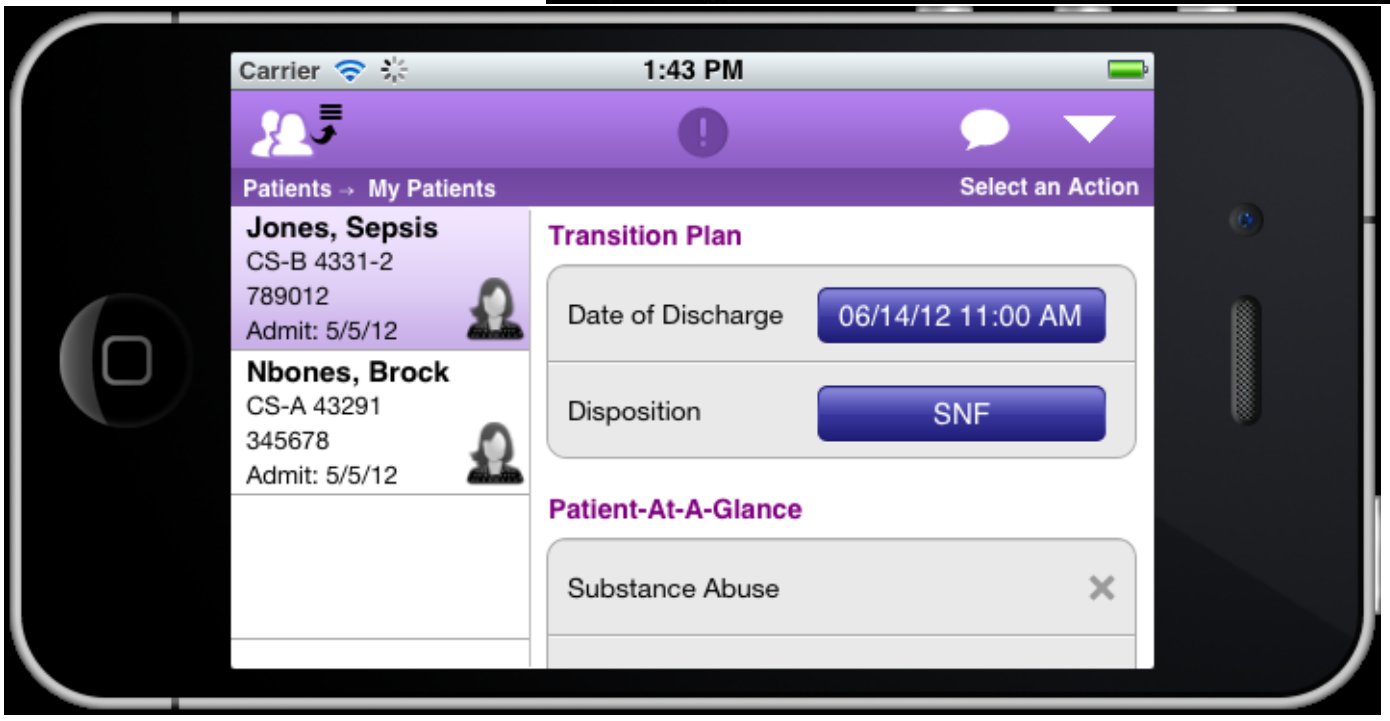
Staff Initial	Documents
	POLST / Advance Directive / Durable Power of Attorney (front of paperwork)
	Patient Facesheet (2nd)
	Medication List / Med Kardex (3rd)
	Pertinent / Recent Labs
	Physician Consults and Progress Notes, Nursing Notes (most recent)
	Other:

Pertinent Information regarding Patient	
Isolation (circle all that apply) none MRSA, VRE, ESBL, C-DIFF, TB other:	Pressure Ulcers or Wounds Yes / No (mark diagram)
Ambulation Status (circle all that apply) Bed bound, wheelchair, walker, cane, Independently without assist	
Baseline Status (circle all that apply) Verbal, Non-Verbal Alert & Oriented x 1 2 3 4	
Pre-existing Medical Devices (circle all that apply) PICC line, wound vac, urinary catheter tube feeding other:	
Other Pertinent Information	

SNF → ED revision 4/25/12

Connecting through Care Book





Suggested Practice

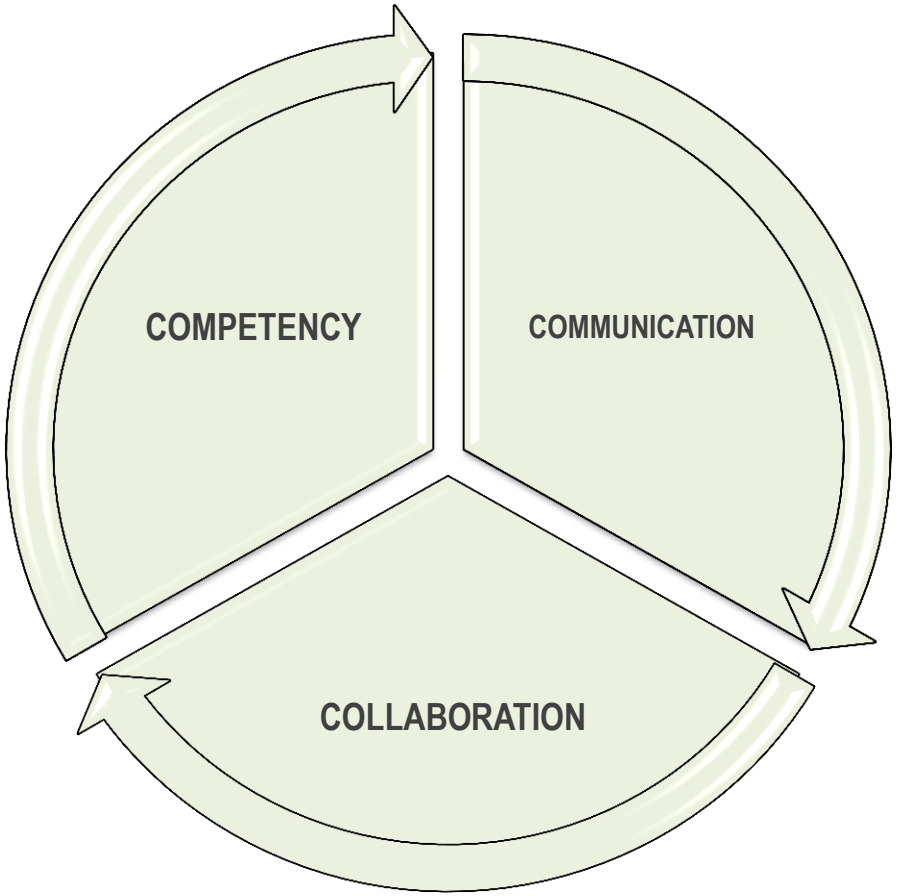
- Collaborate with post-acute care and community-based providers including skilled nursing facilities, rehabilitation facilities, long-term acute care hospitals, home care agencies, palliative care teams, hospice, medical homes, and pharmacists

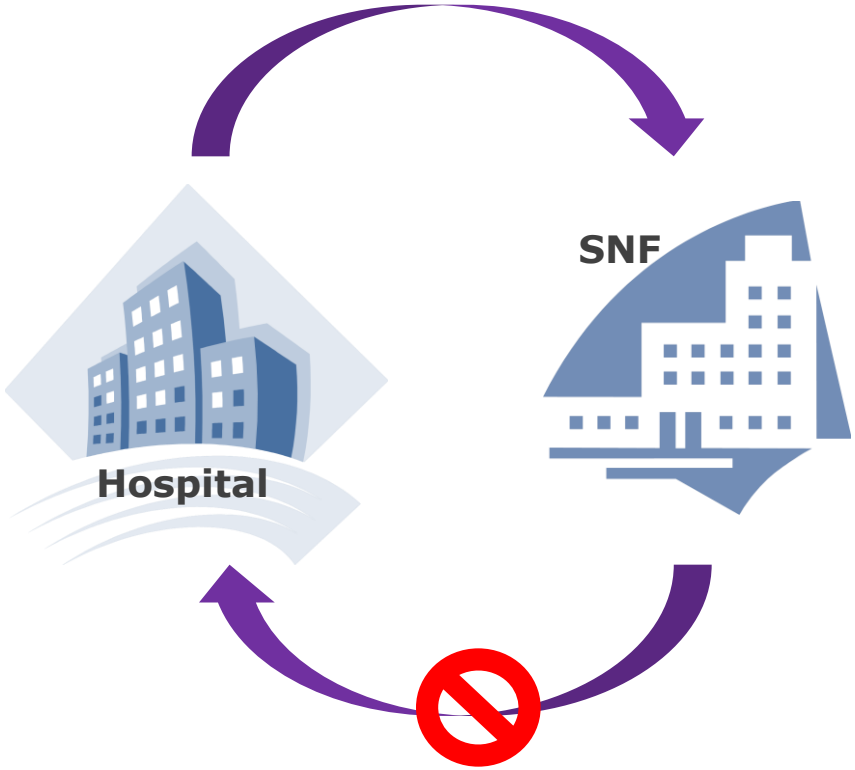

CommUnity

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

Skilled Nursing Facility Strategy: The “3Cs”





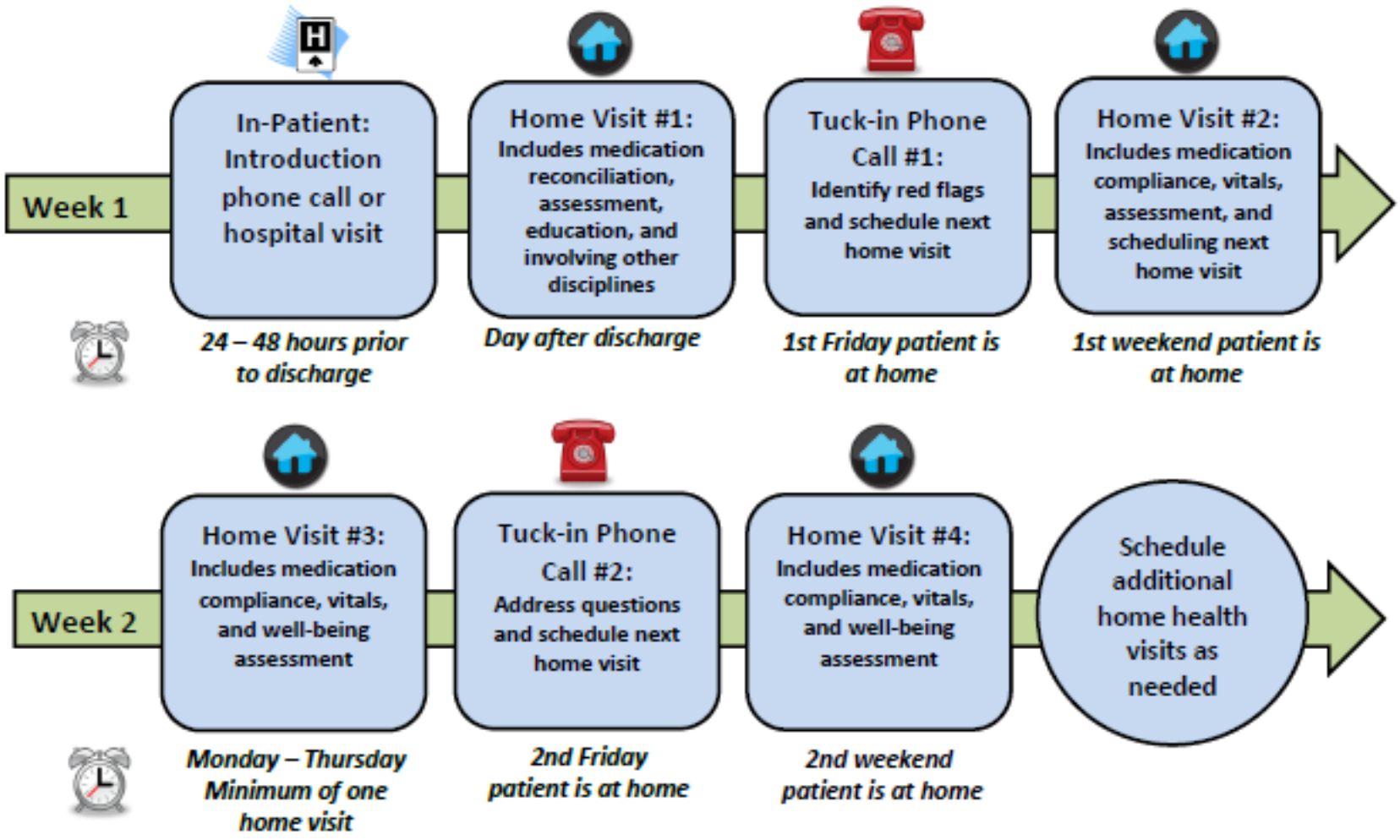
What's a SNFist?

A SNFist is…

- A like hospitalist in a SNF setting
- Follows assigned patients who are coming to the SNF from an acute care facility
- Able to provide prompt access to medical management for SNF pt's
- Able to improve communication with families (goal setting)
- Either employed or contracted

Enhanced Home Health Program

A minimum of seven touch points to occur within the first two weeks of discharge.



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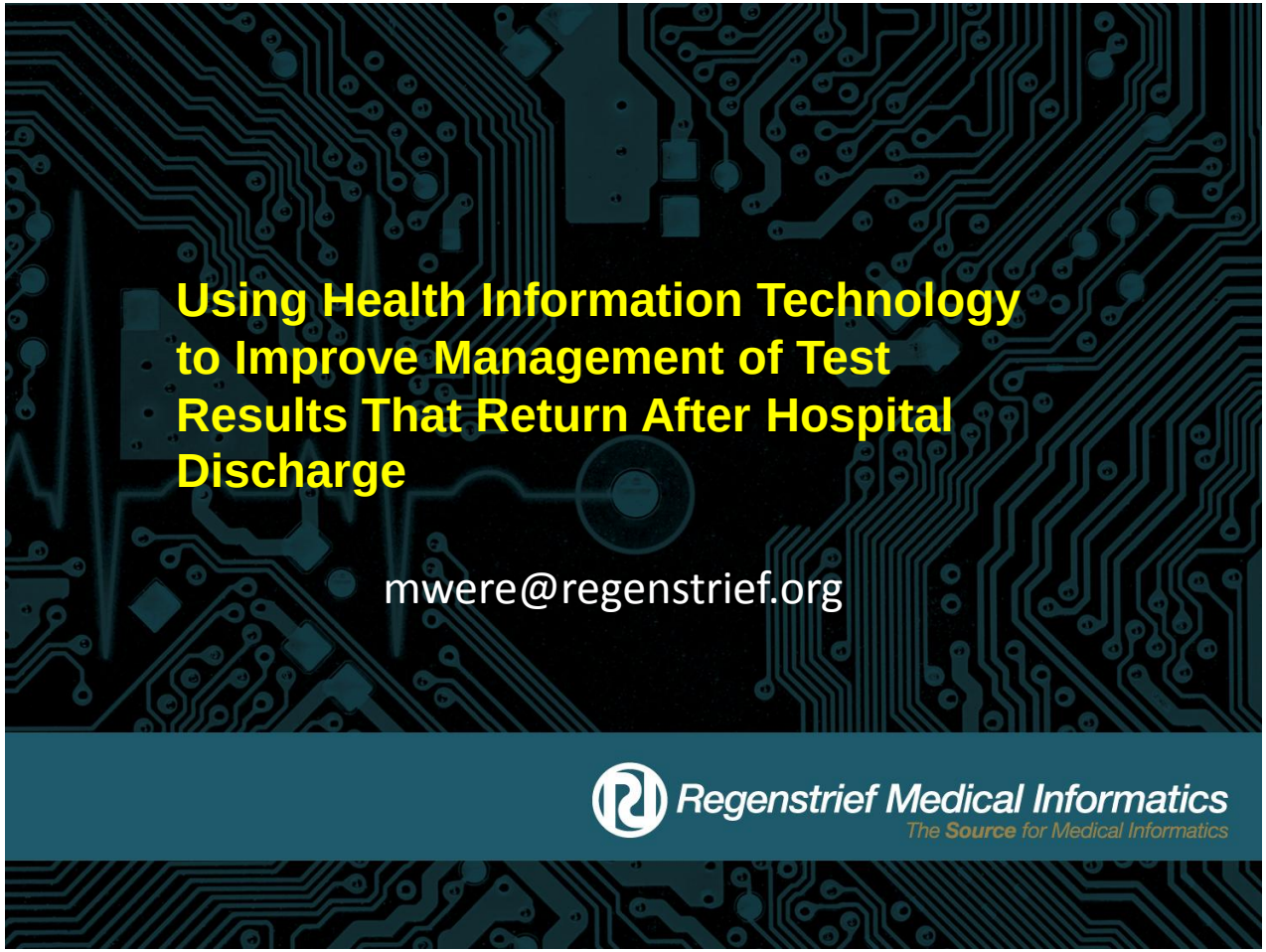
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.

HSAG

Suggested Practice

- Before discharge, schedule follow-up medical appointments and post-discharge tests/labs; for patients without a primary care physician, work with health plans, Medicaid agencies and other safety-net programs to identify and link patient to a PCP

Martin Were, MD, MS



How to's

- Who is responsible to make the appointment?
- How to you involve the patient?
- How are appointments made?

Suggested Practice

- Conduct post-discharge follow-up calls within 48 hours of discharge; reinforce components of after-hospital care plan using teach-back and identify any unmet needs, such as access to medication, transportation to follow-up appointments, etc

How to's

Don't

- Ask only yes/no questions?
- Ask is that clear, do you understand or do you have any questions?

Do

- Ask open ended questions
- Can you tell me which medications you took this morning vs. did you take your medications today?
- How are you going to get to your doctor's appointment vs. do you have a plan?

Do

- Determine who is responsible for making the calls.
- Remember the purpose of the calls.
- Tell the patient you will be calling them.
- Ask what is a good time?
- What is the best number to use?
- Learn if others are making calls and what they are asking.
- Use your findings to improve your processes!

Patient Involvement

- WHAT YOU CAN DO
  - Make sure we have explained your medications and follow up appointments so that you are sure you understand.
  - Know the signs and symptoms of your condition and when you should consult your primary care physicians or other provider.
  - Do not hesitate to ask questions - Speak up when you find yourself feeling muddled or unable to concentrate.

Stop, slow down & show me

- Feel free to stop the person handling your discharge and say, “Wait, slow down, I don’t really understand how I’m going to get along day to day and how all this is going to work.”
- Don’t leave until you feel more comfortable.
- Be willing to ask a nurse “show me how you do that” several times if necessary


FLUID
REST.
1.5 L/day


We’re doing a good job but…We still have a long way to go

Getting to our goal

What's preventing us from obtaining our goals?

What do we need to do differently?


Get into
the weeds


Hang in there


Thank You

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