Revisiting Your Readmission Reduction Strategies

Julia Slininger, RN, BS, CPHQ
Vice President, Regional Quality Network
Hospital Quality Institute (HQI)
February 2, 2017
Participation in This Webinar

To connect to the audio portion of the webinar, dial toll-free 1.800.771.6917

1. To submit a question, click on the “Chat” option at the top right of the presentation.

2. The Chat panel will open.

3. Indicate that you want to send a question to the Host and Presenter.

4. Type your question in the box at the bottom of the panel.

5. Click on “Send.”
Meet the Presenter

Ms. Slininger has over 30 years of experience in healthcare performance improvement, patient safety, risk management, infection control, and medical staff peer review—helping providers improve processes and outcomes. Facilitating peer-to-peer learning between healthcare teams, she has led several collaboratives in the state of California focused on a variety of goals including patient safety, infection prevention, surgical care improvement, readmissions reduction, and care transitions.
Objectives for Today

1) Assess the strengths and weaknesses in your current readmission reduction strategies.

2) Implement targeted solutions to improve outcomes.
Rehospitalizations Among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, MD, MPH, Mark V. Williams, MD, and Eric A. Coleman, MD, MPH

• 1 in 5 Medicare patients rehospitalized in 30 days
• Half never saw outpatient doctor
• 70% of surgical readmissions—chronic medical conditions
• Costs $17.4 billion
Rates of Rehospitalization Within 30 Days After Hospital Discharge

Commending Hospitals’ Progress

• Carrots and sticks in healthcare reform
  – Readmission rate penalties
  – Hospital Engagement Network (HEN) resources with peer-to-peer learning
  – Special grants (i.e., Community-based Care Transitions Program [CCTP])

• Results of efforts to date
  – CalHEN hospitals reduced all-cause readmission by 9% in the aggregate
  – But the range of rates indicates more is possible
## Primary and Secondary Drivers

<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Change Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable discharge process</td>
<td>Educate patients about red flags</td>
<td>Use take-home checklist</td>
</tr>
<tr>
<td></td>
<td>Schedule follow up MD appointment</td>
<td>Case manager (CM) to schedule and give patient appointment card</td>
</tr>
<tr>
<td></td>
<td>Use teach-back to validate patient understanding</td>
<td>Train nursing staff on teach-back method</td>
</tr>
<tr>
<td>Enhance post-acute services based on need</td>
<td>Conduct risk assessment, safety check, and person-centered goals</td>
<td>Create an in-home safety and social needs check</td>
</tr>
</tbody>
</table>
Readmissions Reduction Algorithm

A picture is worth a thousand words!
CalHIIN Readmissions Reduction Diagram

1. Convene multidisciplinary workgroup
   - Map the current discharge process
   - Conduct fishbone analysis of perceived causes of readmission
   - Conduct case review retroactively and concurrently with patient interview

2. Determine which intervention(s) match the needs

- Mostly internal partners:
  - Improve patient/family education with “teach-back” and focus on Rx fill and use
  - Employ risk assessment tool to identify patients likely to return
  - Revise emergency department management of returns
  - Make MD follow-up appointment for patient and assure transportation is available

- Involves external partners:
  - Improve hand-off info to skilled nursing facility (SNF) and/or home health agency (HHA)
  - Contact/visit high-risk patients within 72 hours
  - More in-depth partnership with SNFs and HHAs to prevent returns

3. Does ongoing measurement evidence improvement?

4. Continue small test of change (STOC) and various interventions to continuously reduce preventable readmissions

5. Improved continuum of care
“Best Practices” Requirements

• Periodic reassessment and analysis
• Targeted strategies
• Innovative thinking
  – Small tests of change (STOC)!
Best Practices from the Southern California Readmissions Reduction Collaborative
Key Change Strategies

• Use “teach-back” in discharge planning
  – Video training (Better Outcomes to Optimize Safe Transitions [BOOST] or YouTube) helpful

• Post-discharge contact *mechanism*
  – Call or visit to review medications, safety, MD appointment, social and safety factors

• Partner with the emergency department (ED) and outpatient clinics
  – Creative (safe) options to inpatient (re)admission

• Partner with skilled nursing facilities (SNFs) and home health agencies (HHAs)
  – Improve the handoff
  – Recognize and address changes in condition
Next Steps

• (Re)assemble your team (CM/quality improvement [QI]/nursing)
  – Share the algorithm and conduct a current review of cases PLUS flowcharting or fishbone session

• Map out your approach to keep the improvement momentum going
  – Use a Gantt-style chart like the Plan Ahead Tool
  – Remember to design small tests of change to include purposeful Plan, Do, Study, Act (PDSA)
    • (Some things never get old!)
### Plan Ahead Worksheet

**AIM:**

Use the following table to list all the change ideas you would like to try. In the first column describe the changes that you will test. In the second column list the people who will be responsible for carrying out the tests of change. In the third set of columns, mark how long you expect the test to take using the following key: A=Planning  B=Start  C=In Progress  D=Fully Implemented

<table>
<thead>
<tr>
<th>Implementation Step Development or Small Test of Change</th>
<th>Persons Responsible</th>
<th>Timeline for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Month/2017 Date or Week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Month/2017 Date or Week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Month/2017 Date or Week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Month/2017 Date or Week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Month/2017 Date or Week</td>
</tr>
</tbody>
</table>
Plan, Do, Study, Act  Team Worksheet

Purpose of this test of change (hunch or idea to help accomplish Aim):

Plan (the change, predictions, and data collection):

The Change
What are we testing, and who is conducting the test?

Who are we testing the change on?

When are we testing?

Where are we testing?

Predictions
What do we expect to happen?

Data Collection
What data do we need to collect?

Who will collect the data?

When will the data be collected?

Where will the data be collected?
**Do** *(carry out the change), collect data, and begin analysis*
What was actually tested?

What happened?

Observations:

Problems:

**Study**
Complete analysis of data, summarize what was learned, compare data to predictions:

**Act**
What changes should we make before the next test cycle?

What will the next test cycle be?

Are we ready to implement the change?
Tools Provided Today

• Readmissions Reduction Algorithm
• Plan Ahead Chart
• STOC Planning Worksheet
Thank you!

Julia Slininger
jslininger@hqinstitute.org
For continuing education credit (1), please complete the evaluation at:

https://goo.gl/RyUxgg

If you registered online for this event, you will also receive the link via email.

A recording of today’s session will be available at:

www.hsag.com/calhiin/events

(Click on today’s event date to access the recording link)