Reducing Readmissions

Data Collection and Strategies

Presented by:
Nicole Hedeen, MBA, RT(R), CPHQ, CPSO
Director of Quality
Avita Health System

Objectives

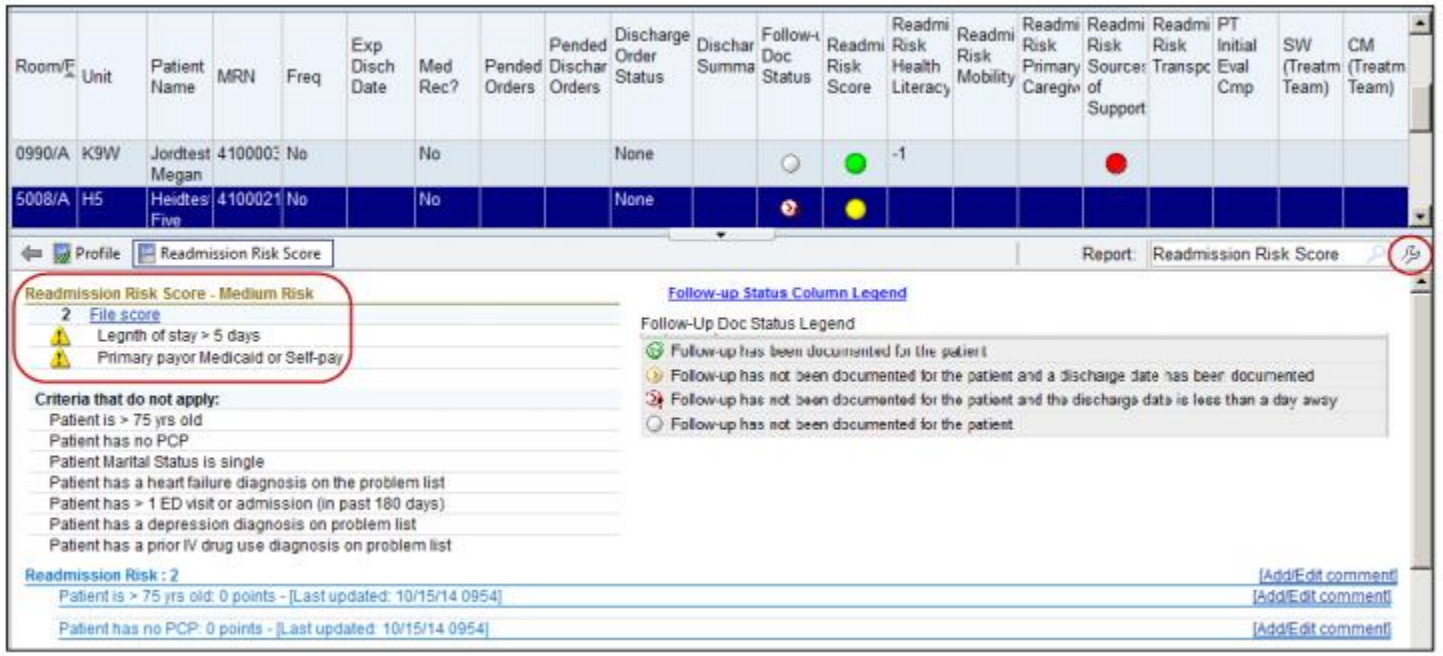
- Describe data collection tools and strategies for reducing readmissions, with emphasis on COPD population.
  - Analyze readmission data for trends, including diagnosis, discharging hospitalist, home health service, nursing home, transitional care appointment after first admission, days elapsed since discharge to readmission
  - Readmission interview tool/interdisciplinary care team huddles
  - Social worker initiative to make PCP appointment for patients prior to discharge. Tracking of transitional care management appointments by provider.
  - COPD discharge planning tool
  - COPD Bridge Visit

Data Collection

- Analyze readmission data for trends
  - Diagnosis
  - Discharging hospitalist
  - Discharge disposition (home, home health, nursing home)
  - Did the patient have a follow-up appointment after discharge from their first admission?
  - Days elapsed from discharge to readmission

Readmission Interview Tool and Readmission Risk Score

- Identify patients at risk for subsequent readmissions
  - Contributing factors to first readmission
- Interview was first collected on paper
  - Transitioned to Epic August 2017



Interdisciplinary Team Huddles

- Held daily at 10 am
  - Physician or CNP, Social workers, Case Management, Therapies (PT/OT, Speech), Pharmacy, Patient Care Coordinator, Dietician
- Discussion
  - Who is a readmission?
  - Patients being discharged and discharge plan
    - Nursing home placement, prior authorizations
  - Medication assistance, Part D enrollment
    - “Meds to Beds”
  - Changes in code status
  - Prescriptions needed
    - Patients being discharged on IV antibiotics
  - Self-pay patients/involvement of financial counselors

Follow-up Appointments/ Transitional Care Management Appointments

- Appointments are scheduled for the patient with their PCP prior to leaving the hospital for inpatients and observations
  - Calls made by social worker
  - Scheduled inpatient surgeries and nursing homes excluded
  - Form also faxed to the office as another reminder
- Challenges
    - Patients without PCP
      - Physician Referral Line
    - Response from PCP office
- Analyzing data by PCP
  - Issues with getting patients into office soon enough?

Moving forward…

- COPD Discharge Planning Tool

COPD Discharge Planning Tool

Admission Date_____	Admission Baseline:	Barriers / Issues with Self-Care
Diagnosis: □ Respiratory Failure □ COPD □ Pneumonia	□ SpO2 Documented □ ABG □ Chest X-Ray □ EKG □ Flu Vaccine □ Pneumonia Vaccine □ Other	____Visual problems ____ Hearing problems ____Reading difficulty ____ Communication ____No transportation ____ No PCP ____Unreceptive ____ Learning disability ____Financial ____ Transportation ____Depression ____ Homeless ____Drug dependency ____Lack of support system ____Environmental Factors

RESPIRATORY NEED	**OBTAIN ORDER / CONTACT**
□ **Pulmonologist Consult**	□ Physician Name _____
POTENTIAL CONSULTS: □ Respiratory Therapy □ Dietician □ Pharmacy □ Physical Therapy □ Occupational Therapy □ Speech Therapy	**Date Completed:** □ Respiratory Therapy_____ □ Dietician_____ □ Pharmacy_____ □ Physical Therapy_____ □ Occupational Therapy_____ □ Speech Therapy_____

Cardio/Pulmonary Rehab **Call on all patients admitted with the above diagnosis** **(Galion ext: Bucyrus ext: Ontario ext:)**	**Date Completed:** _____
Home equipment needs assessed	□ **Call DME (date)** _____
Home Oxygen/Nebulizer need assessed	□ **RT to perform (date)** _____
Financial assistance /resource eligibility **Advance Directives**	□ **Consult Case Manager (date)** _____
Does the patient smoke? Is the patient motivated to stop?	□ **Consult to smoking cessation (date)** _____ □ **Nicotine replacement while inpatient**
Does the patient qualify/agree to a sleep apnea study?	□ **Scheduled date/time** _____

PRESCRIPTIONS FOR D/C

Summary of Skills/Problems AT DISCHARGE	**Discharge Date** _____		
□ 8P completed			
□ Understands medications	□ Yes	□ No	□ Needs assessed
□ Inhalation technique	□ Yes	□ No	□ Needs assessed
□ Good body position to reduce shortness of breath	□ Yes	□ No	□ Needs assessed
□ Capable of defining his/her baseline	□ Yes	□ No	□ Needs assessed
□ Identifies signs of deterioration	□ Yes	□ No	□ Needs assessed
□ Knows available resources in case of worsening	□ Yes	□ No	□ Needs assessed
□ Patient agreeable to **COPD Transitional Care Clinic**	Date/Time of Appt _____		□ Pt refuses
If patient does not agree to a visit, please fax this paper to the provider with whom the patient will follow-up with after discharge.			
Follow-up Appointment Physician: _____	Date/Time_____		

Management plans and “SOS” packs

Moving forward…COPD Bridge Visit

WHO:

All patients admitted or discharged with diagnosis of COPD.

WHAT:

Navigator/Social Worker/TBD

- Reiterate discharge instructions. Ask what is/isn't working at home.
- Ensure all necessary follow-up appointments have been made and transportation available. Make contact with the offices to schedule/reschedule as needed. If transportation is not available, make contact with agency resources to secure transportation (like who?).
- Compile list of questions for physician, if applicable.

COPD Bridge Visit

Pharmacist

- Medication adherence and health literacy assessments
- Review of medications
  - Review of inhaler technique and need for aides (spacers, etc.)
  - New medications, med regimen changes, general med review (brown bag)
    - Proper admin, side effects, patient questions, reason for taking, etc.
  - Provide or review medication calendars (ex: prednisone tapers)
  - Any unfilled prescriptions, possibility of getting them filled at ONT with home delivery that day
  - Review cost of medications relative to compliance and correct any cost avoidance non-adherence via contact with originating prescribers.
- Review of any antibiotics prescribed at discharge (dose, duration, appropriateness, bug-drug mismatch, etc.)
- Pharmacist managed smoking cessation enrollment (via collaborative practice agreement) and clinic appointment set for those with a desire to quit smoking
- Vaccination history review and administration (pneumococcal and influenza)
- Visit report created for clinic physician as well as PCP to include interventions and concerns as well as any need for further follow up (i.e., high risk for medication non-adherence, correctly taking a new prescription, recommendation for reinforcement of proper inhaler technique at PCP visit, etc.)

COPD Bridge Visit, cont'd

WHEN

Try to get patient scheduled for the soonest clinic, as most readmissions occur within 3-5 days post discharge.

WHERE

TBD

WHY

COPD readmissions accounted for 32% of the health system's readmissions in 2016. 20% of those COPD readmissions occurred within 5 days of discharge. Even if primary care physicians and providers could see COPD patients sooner in the office, there would not be enough time to spend with patients to cover the level of detail and education that would be covered during the bridge visit clinic. A major advantage of the bridge visit clinic is ensuring the follow-up appointments are scheduled, which helps facilitate patients actually getting to their PCP.

The Hospital Readmissions Reduction Program requires a reduction to a hospital's operating DRG payment based on the hospital's risk-adjusted readmission rate during a 3-year period for AMI, HF, PN, COPD, THA/TKA, and CABG when that hospital has excess readmissions. Hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across all of their Medicare admissions—not just those which resulted in readmissions.

Questions?