READMISSION REDUCTION PROJECT

Regional West Medical Center

Scottsbluff, NE 69361

Process of Identifying Need

- Evaluation of Internal Data – 30-Day Readmission Rate; Disease/Specialty Readmission Rates
- CMS Readmission Reduction Program Data
- Review of RWMC Peer Review Cases
- Quality Committee Review and Prioritization based on Scope, Risk, Impact, etc.

Process Improvement Methods

IHI Model for Improvement

Four Phases in the Life Cycle of an Improvement Project

1. Innovation – Coming up with new ideas for change
2. Pilot – Testing the change on a small scale
3. Implementation – making the change the new standard process in a defined setting
4. Spread – Implementing the change in several settings and hardwiring the change

Institute for Healthcare Improvement. *Open School – Improvement Capability. 2015. Retrieved from http://app.ihi.org/lms/home.aspx*

Process Improvement Methods

Pt Name	MR #	Admit Date/Time	Location	Account	Prior Account	Prior Admit Date	Prior D/C Date

Summary:	
Chart Review:	
# Days Between Last D/C & Readmit?	
On Home O2 At Initial Admission?	Y/N
Home O2 Addressed In Home Med List?	Y/N
On Home O2 w/in 24 hours of Discharge?	Y/N
Was There a Clear D/C Plan Documented?	Y/N
From A SNF?	Specify
Any Social Conditions Appear To Be Contributing To The Readmit?	Explain
D/C Summary Available Within 24 Hours?	Y/N
Patient Interview:	
What Brought You To The Hospital On _____?	Explain
Did You Feel You Were Ready For Discharge When You Were Dismissed?	Y/N
Did You Receive Discharge Instructions Prior To Discharge?	Y/N
Was There Anything That Was Unclear Or Confusing For You When You Left The Hospital?	Y/N
Were You Able To Follow All Discharge Instructions?	Y/N
Were You Able To Get Your Prescription Medications?	Y/N
Has Anything Gotten In The Way Of You Taking Your Medications?	Y/N
Did You Have A F/U Visit Scheduled Prior To D/C?	Y/N
Were You Able To Go To Your F/U Visit?	Y/N
Did You Attempt To Get Into Your Provider Prior To Being Readmitted?	Y/N
I See You Went _____, How Did It Go Once You Got There?	Explain
Did You Have Someone To Help Care For You After You Were Discharged? Who?	Y/N
Is There Anything Else You Would Like Me To Know?	
Care Team Interview:	
I Am Working To Improve Care Transitions & Decrease Avoidable Readmissions. I Am Calling About _____, Would You Have A Couple Minutes To Visit With Me?	
He/She Was Admitted From _____ To _____, And Again From _____ To _____. Did You Receive Information About The Initial Admission?	Y/N
Did You Have Contact With Them After The Initial Discharge? If So, Were There Points Of Confusion About The Plan Of Care, Symptoms, Or Other Issues I Should Be Aware Of?	Y/N
Why Do you Think They Were Readmitted? Explain	
Do You Think There Was Anything Additional Either Clinically Or Socially That We Could Have Done Better To Prevent This Readmission?	Y/N
Comments:	
Category Assignment	
Progression Of Disease With Patient Compliance	**A**
Exacerbation Of Disease Without Patient Compliance	**B**
New Diagnosis Not Related To Last Admission	**C**
Planned Surgery Admission	**D**
Post-Op Complication From Procedure In Last 30 Days Surgeon:	**E**
ETOH/Substance Abuse	**F**
Contributing Factors (See Midas List)	
Comments:	_____

RWMC Readmission Investigation Tool

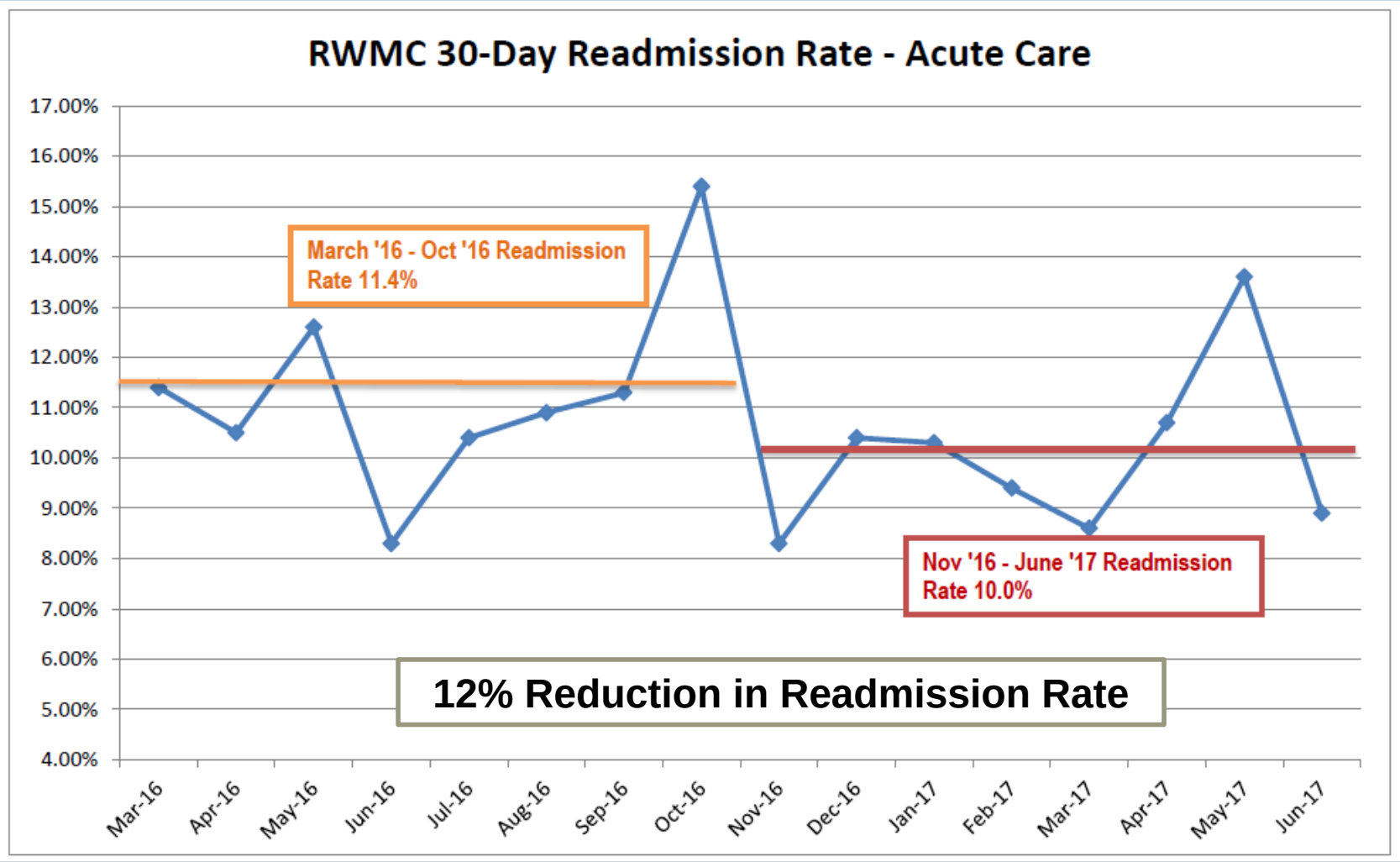
Chart/Record Review

Patient/Family Interview

Care Team Interview

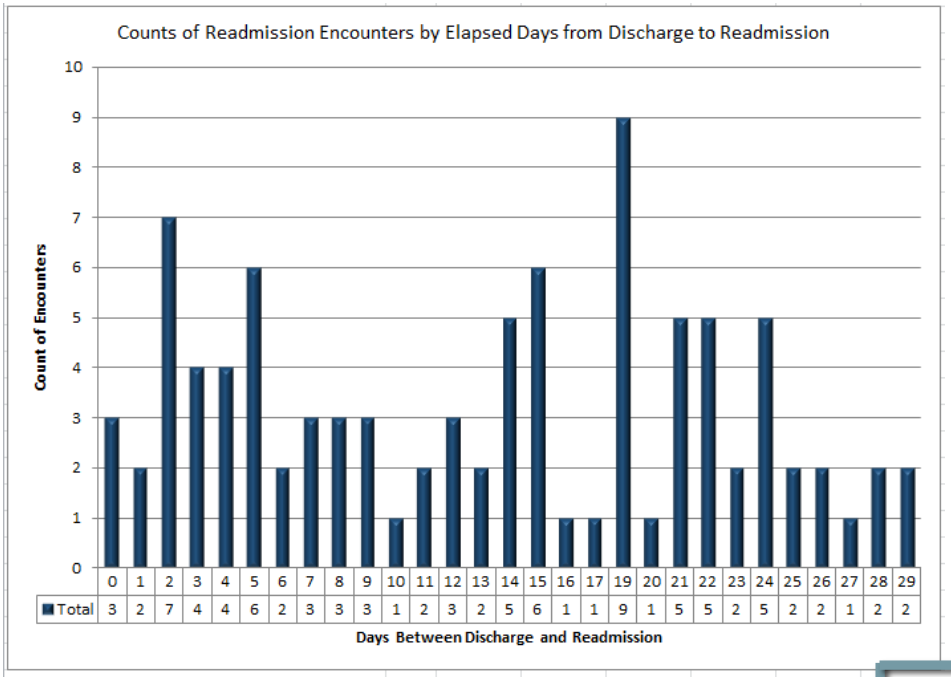
Summary/Classification

Results


RWMC 30-Day Readmission Rate - Acute Care
17.00%
16.00%
15.00%
14.00%
13.00%
12.00%
11.00%
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
March '16 - Oct '16 Readmission Rate 11.4%
Nov '16 - June '17 Readmission Rate 10.0%
12% Reduction in Readmission Rate
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17

Results

April & May 2017 Readmissions



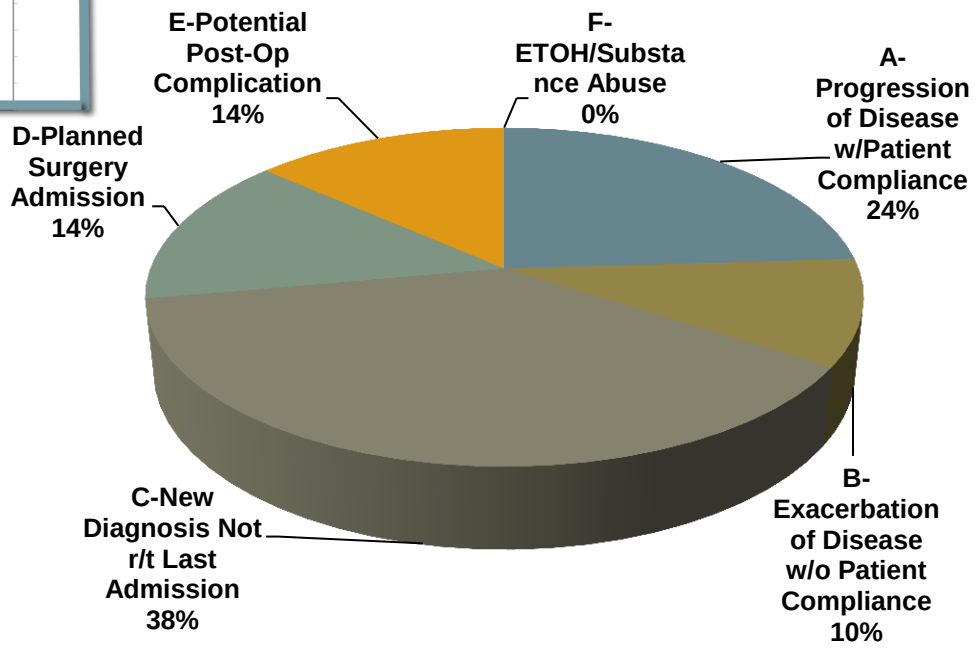
Trends – Readmission Categories

- Categories A, B, & E - Potentially Preventable (48%)
- Categories D & E - Presumably Not Preventable (52%)

Trends - Days from Discharge to Readmission

- Spikes in readmissions at 2-5 days post-discharge & again around week three
- Zero day readmissions represent transfers back to acute care from Acute Rehab and Behavioral Health

Q1 2017 Readmission Categories



Results

Patient/Family Interviews

	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	March '17
Total Pts Interviewed	20	10	16	18	12	4
% of Pts Who Stated They Felt Ready for Discharge	70%	70%	100%	72%	67%	50%
% Pts Who Stated They Received Discharge Instructions on Initial Admission	100%	100%	100%	100%	100%	100%
% of Pts Who Stated There was Nothing Confusing or Hard to Understand in Discharge Instructions	95%	90%	88%	89%	100%	100%
% of Pts who Stated They Were Able to Follow All Discharge Instructions	90%	90%	94%	100%	100%	100%
% of Pts who Stated They were Able to Obtain Prescription Meds at Index Dismissal	80%	100%	100%	94%	100%	100%
% of Pts who Stated Nothing had Gotten in the way of Taking their Medications	90%	80%	94%	72%	83%	75%
% of Pts who Stated they had a follow-up visit scheduled prior to initial Discharge	95%	100%	88%	100%	83%	100%
% of Pts who Stated they had Someone to Assist them at Home after their Index Dismissal	95%	90%	100%	94%	67%	100%
% of Pts who Stated they were able to Make it to their Follow-up Appointment	45%	80%	50%	61%	33%	25%

Lessons Learned

- Specific Opportunities for Improvement – Home Oxygen, Discharge Med Rec, Transitions to Home Care, Discharge Education
- Population Health Focus and Community Partnerships
- Need for Improved Documentation
- Patients' Perspectives on Readiness for Discharge
- Need for Readmission Risk Calculation (LACE) and Five-Day Follow-Up Appointments