Reducing Avoidable Readmissions

September 28-29, 2015 – Boston, MA

Instructions for Optional Pre-work Assignment: Case Reviews

Purpose: Case reviews help us to identify where to start or where to focus next in improving transitions in care and reducing avoidable readmissions. As few as five cases are valid samples to discover typical failures that resonate with the frontline teams.

Part 1: Chart Reviews of Patients
Complete a chart review (5 if possible) on patients, readmitted to the same facility within 30 days of discharge, using the tools in the Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted. Chart reviews should be conducted by physicians or nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. Worksheet Part 3 is a reference list of typical failures. The intent is to learn how we might prevent these failures that we once thought impossible to prevent.

Part 1: Reflective Summary of Chart Review Findings
Chart reviewers fill out the responses on findings from chart review. The reflection is a summary of one or more chart reviews.

The interviews that follow can be used to look for opportunities without chart reviews if time before the Seminar doesn’t allow the full case study review

Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community
If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview. Complete interviews with patients and present family members and call care team members who have seen the patient in the community in the past 30-60 days e.g., primary or specialty care provider, home care nurse, social worker, or health/transitions coach. Use a separate interview sheet (page 3) for each interview

Part 2: Summary of Interview Findings
Interviewers fill out the responses on findings from one or more chart reviews, reflecting on themes that emerge, surprises, questions that arise, what you are now curious about, what you might do next, and what assumptions about readmissions or transitions that you held previously are now challenged? Use the list of typical failures to trigger ideas and surface themes. Discuss these findings with your team or an interested frontline group. Ask what resonates from your findings, what surprises them, and what they think you might look at or test next.
## Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted

### Part 1: Chart Reviews of Patients

Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. Worksheet Part 3 is a reference list of typical failures. The intent is to learn how we might prevent these failures that we once thought impossible to prevent.

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
<th>Patient #4</th>
<th>Patient #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between the last discharge and this readmission date?</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
</tr>
<tr>
<td>Was the follow-up physician visit scheduled prior to discharge?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, was the patient able to attend the office visit?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Were there any urgent clinic/ED visits before readmission other than any leading to admission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Functional status of the patient on discharge?</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was a clear discharge plan documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was evidence of “Teach Back” documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the patient asked to describe in her/his own words why s/he was readmitted?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>List any documented reason/s for readmission</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 1: Reflective Summary of Chart Review Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?
Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community

If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

**Ask Patients and Family Members:**

How do you think you became sick enough to go back to the hospital?

Did you see your doctor or the doctor’s nurse in the office before you came back to the hospital?

- Yes  
- No

If yes, which doctor (PCP or specialist) did you see? [ ]

If no, why not? [ ]

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

**Ask Care Team Members in the Community:**

What do you think contributed this patient to be readmitted?

*After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient’s circumstances that contributed to the readmission.*


Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 2: Summary of Interview Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?
Diagnostic Worksheet: Part 3: List of Typical Failures in Discharge Preparations

Typical failures associated with patient assessment:
- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for the discharge;
- Unrealistic optimism of patient and family to manage at home;
- Failure to recognize worsening clinical status in the hospital;
- Lack of understanding of the patient’s physical and cognitive functional health status may result in a transfer to a care venue that does not meet the patient’s needs;
- Not addressing whole patient (underlying depression, etc.);
- No advance directive or planning beyond DNR status;
- Medication errors and adverse drug events; and
- Multiple drugs exceed patient’s ability to manage.

Typical failures found in patient and family caregiver education:
- Assuming the patient is the key learner;
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient’s level of health literacy or current health status;
- Failure to ask clarifying questions on instructions and plan of care; and
- Non-adherent patients (resulting in unplanned readmissions): lack of compliance with self-care, diet, medications, therapies, daily weights, follow-up and testing; or lack of adherence due to patient and/or family-caregiver confusion.

Typical failures in handover communication:
- Poor hospital care (evidence-based care missing/incomplete);
- Medication discrepancies;
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps;
- Poor communication of the care plan to the nursing home team, home health care team, primary care physician, or family caregiver;
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis;
- Discharge instructions missing, inadequate, incomplete, or illegible;
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions);
- Having the care provided by the facility unravel as the patient leaves the hospital (e.g., poorly understood cognition issues emerge); and
- Poor understanding that social support is lacking.

Typical failures following discharge from the hospital:
- Medication errors;
- Discharge instructions that are confusing, contradictory to other instructions, or are not tailored to a patient’s level of health literacy;
- No follow-up appointment or follow-up needed with additional physician expertise;
- Follow-up too long after hospitalization;
- Follow-up is the responsibility of the patient;
- Inability to keep follow-up appointments because of illness or transportation issues;
- Lack of an emergency plan with number the patient should call first;
- Multiple care providers; patient believes someone is in charge;
- Lack of social support; and
- Patient lack of adherence to self-care (e.g., medications, therapies, daily weights, or wound care) because of poor understanding or confusion about needed care, transportation, how to get appointments, or how to access or pay for medications.