Reducing Readmission Case Stories Discussion of Successes

University of California, San Francisco
Maureen Carroll RN, CHFN
Transitional Care Manager
Heart Failure Program Coordinator

UnityPoint Cedar Rapids Iowa
Peg Bradke RN, MA
Vice President, Post Acute Care
UnityPoint Health St. Luke's

University of California, San Francisco

- Mission: The reason that we exist is Caring, Healing, Teaching, and Discovery
- Top 10 Hospitals (US World and News past 13 yrs)
- 722 licensed beds; 28,000 admissions,
- New UCSF Mission Bay Hospitals
  - Benioff Children's Hospital
  - Betty Irene Moore Woman's Hospital
  - Bakar Cancer Hospital
  - Ron Conway Family Gateway Medical Building

The Cross Continuum Team

- Multidisciplinary cross continuum team – it takes a village;
- Family caregivers, nurses, physicians, senior leadership, case managers, social workers, dieticians, pharmacists, nurse practitioners, home care team, palliative care, Care Support team, chaplains, managers, community partners, SNF liaisons, outpatient clinic liaisons, community clinics liaisons, and more

The Cross Continuum Team

- Excellence in Transitions of Care – ETOC
- Workgroups – Hospital wide readmission projects
- Data review and management
- Highlights on progress on projects/programs
- Inpatient and outpatient programs
- Senior leadership participation
- Office of Population Health

Cross Continuum Teams

UCSF Housecalls

UCSF Care Support

UCSF-Hastings Medical Legal Partnership for Seniors

UCSF Center for Geriatrics Care

UCSF Bridges

St. Luke's Hospital - UnityPoint Health System

- Private hospital – Cedar Rapids, Iowa
- Affiliate in the UnityPoint Health System
- Licensed for 500 Beds with more than 17,000 admissions
- Truven Top 100 Hospital – 5 years; Heart Hospital - 3 years
- Iowa Recognition for Performance Excellence Gold Award - 2010
- Joint Commission Disease-Specific Recertifications in Stroke (2006-14), Heart Failure (2008-14), Total Joint (2008-14) and Palliative Care (2010-14).
- Society of Chest Pain Center – Chest Pain Certification (2010, 2013)
- Magnet Re-designation – 2014
- Mayo Clinic Care Network – 2014

CCT – Transition to Home

Our mission: "To give the healthcare we'd like our loved ones to receive"

- Meets monthly
- Reviews readmissions for each month related to core diagnosis to assess causes and opportunities for improvement
- Reviews process and outcome measures
- Continually testing and improving, aggregating the experiences of patients, families and caregivers
- Each site/level of care reports on testing occurring in their area

Transition to Home Team Members

- Inpatient Nursing Units
  - Manager
  - Care Managers
- Palliative Care
- Home Care
- Respiratory Care
- Emergency Dept.
- Case Management
- CardioPulm. Rehab.
- Pharmacy
- Nurse Practitioners
- UnityPoint Clinics Reps
- Critical Access Hospital
- Community SNF's
- Hospitalist Rounding Nurses
- Outpatient Social Services
- Inpatient Social Services
- Performance Improvement

Several Subgroups Report into the Larger Transition to Home Team

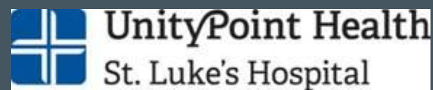
- Data Management
- Patient Education Processes
- Home Care
- SNF/Nursing Facilities Work Processes
- Physician Clinic Processes
- Case Management/Social Work/Care Coordination

Several members of the Transition to Home team are members of the hospital ACO and Population Health Management work. Information is bidirectional between these teams.

Program Overview

Overview of the Process

- Standardized evidence-based care through order sets.
- Patient Education/Teaching:
    - Utilizing Universal Health Literacy Concepts
    - Enhanced teaching materials
    - Teach back
- Utilization of whiteboard to individualize patient's plan of care and communicate to team.
- Bedside Report
- Transition to Home Huddles



Continuum of Care (Cont'd)

Touch points post discharge:

- Home Care - care coordination visit 24 to 48 hours post discharge on high-risk patients
- Physician Clinic follow-up appointment made prior to discharge for 3-7 days after
- Work closely with PCP offices on Transitional Code (TCM) and Patient Centered Medical Home
- Standardized tool for transfer of information to nursing facilities for next level of care.
- Telehealth monitor available through Home Care
- Emergency Department Consistent Care Program
- Advanced Medical Team
- Outpatient Social Worker
- Palliative Care Program

The Foundation

- Monthly Heart Failure Grant Meetings with Multidisciplinary Team
- Comprehensive Patient Education
- Care coordination
- Implemented IHI Evidence Based Interventions
- Development of Data Collection System
- Patient Advisory Group, Heart Healthy classes on unit
- Palliative Care Collaboration
- Staff trained on Teach Back & HF Education
- Patient stories shared to drive change
- Focus on Continuum of Care - Communication and Collaboration

Patient Interventions

- Patient Identification- Daily Chart Reviews
- Extensive Patient and Family education
- Referrals: Inpatient and Outpatient
- Follow-up Appointments
  - Within 7 days for primary HF, COPD, PNA,AMI
  - Heart Failure Clinic NPs visits for high risk patients
  - Outpatient programs for high risk patients
- Follow-up calls
  - Increased with automation to 5/month
- Medication Reconciliation- Pharmacist consult
- Discharge Summaries- within 48 hours
- Hand off Communication to Outpatient providers
- Care at Home Programs – High Risk patients

Outpatient Focus

- Collaboration with Outpatient Providers
  - Skilled Nursing Facilities, Home Care Agencies, Primary Care Physicians, and Cardiologists
- "Virtual Team" Email to connect providers (in/outpatient)
- Geriatric Transitions, Consultation, and Comprehensive Care (GeriTraCCC) started UC–Care Support at Home
- MD House Calls for High Risk HF Patients (Aug 2010)
- Advanced Heart Failure Clinic; High Risk pts- NP follow up
- In-services for staff, home care, skilled nursing staff
- Hospital wide projects to standardize and improve discharge process and readmission projects

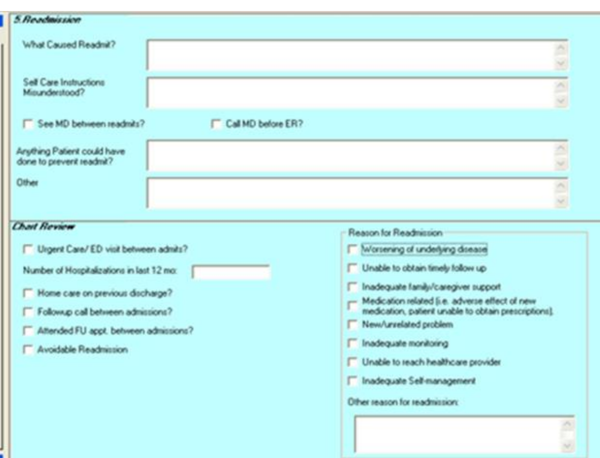
Assessment

UCSF MDR Improvements

- Quieter space
- New team monthly- welcome and orientation
- Clear expectations for all members
- Readmission discussions
- What can we do differently?
- Address level of support needed
- Risk discussed

Readmission Interviews

- Gain perspective of patient and family caregivers
- Reach out to inpatient and outpatient providers
- Notification of # of admissions in past year, 30 and 90 day readmits, and possible factors
- Low health literacy
- Lack of support
- Medication challenges
- Transportation challenges
- Assessments: Cognitive, depression, functional, motivation


5.Readmission

What Caused Readmit?

Self Care Instructions Misunderstood?

See MD between readmits?

Call MD before ER?

Anything Patient could have done to prevent readmit?

Other

Chart Review

Urgent Care/ ED visit between admits?

Number of Hospitalizations in last 12 mo:

Home care on previous discharge?

Followup call between admissions?

Attended FU appt. between admissions?

Avoidable Readmission

Reason for Readmission

Worsening of underlying disease

Unable to obtain timely follow up

Inadequate family/caregiver support

Medication related (i.e. adverse effect of new medication, patient unable to obtain prescriptions)

New/unrelated problem

Inadequate monitoring

Unable to reach healthcare provider

Inadequate Self-management

Other reason for readmission:

The Patient Story …
to share and learn from

Enhanced Assessment

- During Admission Assessment, the patient and family are asked, “Who would you like to have present when we provide your discharge information?”
- Medication reconciliation: Dedicated Admission Center RN’s complete home medication list and prepare an appropriate list for physician to address.
- Readmission Interviews

Whiteboard

Welcome To: Room Number: 408-B Phone #: 319-369-7561

Patient Name:
Please Call Me:
One Thing You Should Know About Me:

The Most Important Thing To Me During My Hospital Stay:

Today's Date:
Anticipated Discharge Date:

Plan and Goals For The Day:

Health Care Team:
Nurse:
Tech:
Doctors:
Therapists:

Test - Treatments - Procedures:

Diet:

Activity:

Safety Alerts/ Special Needs:

Pain Management Goal:
Our Goal is to ALWAYS help control your pain!
0 1 2 3 4 5 6 7 8 9 10
My Pain Goal:
My Last Pain Medication:

Family - Patient Comments:

Key Contact Person:

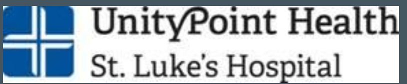
Quiet Time
12:30 pm to 1:30 pm / 2:00 am to 4:00 am

St. Luke's Hospital
Iowa Health
A better place to be
Mission: To give the healthcare we'd like our loved ones to receive.

UnityPoint Health
St. Luke's Hospital

Multidisplinary Rounds

- Bedside shift report
  - To involve patient and family caregivers as partners in care
- Daily discharge huddles
  - Identification of patient/family needs/concerns
  - Daily goals are reviewed
  - Available support for patient: need for Palliative Care Referral
  - Educational needs
  - Identification of home care needs/other levels of care
  - Nurse sensitive indicators: fall risk, skin issues

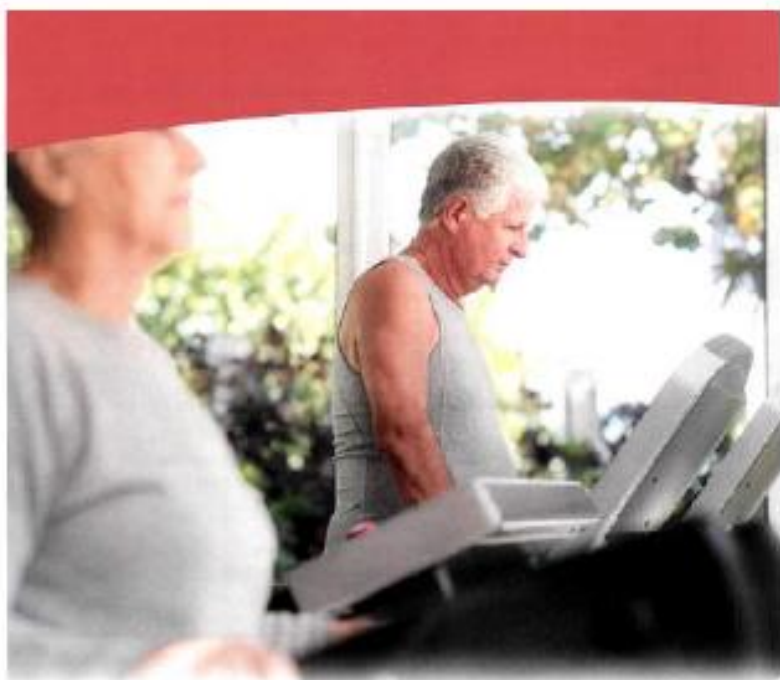


Patient Education/Teach Back

Enhanced Teaching and Learning

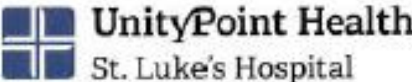
- Same materials are used across the continuum: in the hospital, with home care, long-term care settings and the clinics.
- Short, succinct patient/family education packet
- Teach Back questions part of packet
- Patient teaching flowsheets “close the loop” to help staff nurses address Teach Back and assure the documentation and use of Teach back.

Example of MI Packet



Heart Attack

What you need to know and do



1. **What warning signs and symptoms do you need to call to your doctor?**

   Answer:

   - **Angina/Chest discomfort** – may be felt as chest discomfort, arm, back, shoulder or jaw discomfort. May feel like indigestion or upper stomach discomfort. Any discomfort like you had with your heart attack.
   - **Weight gain** – of 3 pounds in one day or 5 pounds in one week. Swelling in your feet, legs, or ankles.
   - **Dizziness/lightheadedness** – If you are dizzy when sitting, standing still, or when lying down.
   - **Shortness of breath** - shortness of breath that is new or unusual for you.
   - **Fatigue/tiredness** – so tired/fatigued that you cannot complete your usual activities.
   - **Unusual heart rate** – your heart beat feels irregular, is beating too fast, too slow or skipping beats.
   - **Medication side effects** – you think you may be having a side effect from one of your medicines.

2. **How do you know if you may be having a heart attack?**

   Answer:

   - You have discomfort in the jaw, chest, shoulder, arms, back or upper stomach area that lasts more than a few minutes. It may go away and come back again.
   - Fullness, indigestion or choking feeling
   - Shortness of breath, with or without chest discomfort
   - Breaking out into a cold sweat, feeling sick to your stomach

   For Women – Any of the symptoms listed above or any of the following:

   - Women can have a heart attack without having chest discomfort.
   - General sense of uneasiness or that something is just not right.
   - Unexplained fatigue, weakness, tiredness (sometimes for days).
   - Discomfort in upper stomach area, indigestion type feeling.

3. **What should you do if you think you are having a heart attack?**

   Answer:

   - **Call 9-1-1 right away**…. **Do Not** drive yourself.
   - Tell 9-1-1- and the hospital you think you might be having a heart attack.

4. **What are the most important things for you to do after you have had a heart attack?**

   Answer:

   - If you smoke or use tobacco products, you need to quit.
   - Be active every day. Exercise as instructed by cardiac rehab.
   - Eat foods that are lower in fat and salt.
   - Take your medicines as prescribed by your doctor.
   - Keep your appointments with your doctors. Do not miss any.
   - Go to (start a) Cardiac Rehabilitation program.

Example: MI 2nd page with TB questions

1. **What warning signs and symptoms do you need to call to your doctor?**

   Answer:

   - **Angina/Chest discomfort** – may be felt as chest discomfort, arm, back, shoulder or jaw discomfort. May feel like indigestion or upper stomach discomfort. Any discomfort like you had with your heart attack.
   - **Weight gain** – of 3 pounds in one day or 5 pounds in one week. Swelling in your feet, legs, or ankles.
   - **Dizziness/lightheadedness** – if you are dizzy when sitting, standing still, or when lying down.
   - **Shortness of breath** - shortness of breath that is new or unusual for you.
   - **Fatigue/tiredness** – so tired/fatigued that you cannot complete your usual activities.
   - **Unusual heart rate** – your heart beat feels irregular, is beating too fast, too slow or skipping beats.
   - **Medication side effects** – you think you may be having a side effect from one of your medicines.

2. **How do you know if you may be having a heart attack?**

   Answer:

   - You have discomfort in the jaw, chest, shoulder, arms, back or upper stomach area that lasts more than a few minutes. It may go away and come back again.
   - Fullness, indigestion or choking feeling
   - Shortness of breath, with or without chest discomfort
   - Breaking out into a cold sweat, feeling sick to your stomach

   For Women – Any of the symptoms listed above **or** any of the following:

   - Women can have a heart attack without having chest discomfort.
   - General sense of uneasiness or that something is just not right.
   - Unexplained fatigue, weakness, tiredness (sometimes for days).
   - Discomfort in upper stomach area, indigestion type feeling.

COPD Action Plan

Which zone are you in today? Green, Yellow or Red		For You to Do
Green Zone	**All Clear - You are feeling well** ▪ Your breathing is normal for you ▪ The color of your phlegm is clear or white ▪ You can do your normal activities without unusual tiredness or shortness of breath ▪ Your appetite is good ▪ You are sleeping like you normally do ▪ You can think clearly	▪ Take your daily medicines as prescribed by your doctor, even if you are feeling good ▪ Eat healthy foods. ▪ Be active every day (get up and do things) Include some exercise, like walking, in your daily routine ▪ Balance your activity with some rest periods ▪ **Use Pursed Lip Breathing** ▪ Do not smoke. Make your home and car smoke free. Stay away from smoke areas.
Yellow Zone	**Caution - You are feeling worse** ▪ You are more short of breath. You are wheezing or coughing more than usual ▪ You have unexplained changes in your weight ▪ You have more swelling in your feet, legs or ankles ▪ You notice changes in your phlegm (thicker, color, amount) ▪ You are using your rescue inhaler(the fast acting one) or your nebulizer more often than usual ▪ You are more tired and can not do your usual activities ▪ You have a fever and chills ▪ You are sleeping poorly. Your symptoms wake you up.	▪ Limit your activities ▪ Check your oxygen system to make sure it is working correctly ▪ Make sure you have been taking your medicines Have you forgotten any today? ▪ **Use Pursed Lip Breathing** ▪ Call your doctor if your weight gain is 3 pounds in one day OR if you have a weight gain of 5 pounds or more in 1 week. ▪ Eat smaller meals more often during the day rather than 3 big meals in a day. ▪ Use your nebulizer or rescue inhaler (fast acting one), as prescribed by your doctor. ▪ **Call your doctor if your symptoms don't improve. Don't wait longer than 2 days**
Red Zone	**Emergency - You feel you are in danger** ▪ You have severe shortness of breath (You feel like you cannot breathe or catch your breath while resting) ▪ You have chest pain ▪ You feel faint ▪ You are more sleepy and have difficulty staying awake ▪ You feel confused or are very drowsy. ▪ Your speech is slurred ▪ You have bluish color to your lips or fingernails.	**Call 911 or go the hospital Emergency Room**

UnityPoint Health
St. Luke's Hospital

Example from EPIC
Patient Teaching Flowsheet

Point Description/Learner Progress:

Description:
heart failure exacerbation signs and symptoms

Learner	Ready?	Method	Res...	Comments	Taught By	Date	Time	Status
P	A	TB	ATB	Educated pt and daughter about S &S of CHF	CHAPMAN, KERI N	10/23/20'	1252	Done

Learner
- P: Patient
- F: Family
- S: Significant
- C: Caregiver
- O: Other
- Mom: Mother
- Dad: Father
- G: Guardian
- FP: Foster

Readiness
- E: Eager
- A: Acceptance *
- N: Nonacceptance
- R: Refuses

Method
- E: Explanation
- D: Demonstration
- H: Handout
- I: Interpreter
- V: Video
- C: Class/Group
- TB: Teach back *

Response
- VU: Verbalizes Understanding
- DU: Demonstrated Understanding
- NR: Needs Reinforcement
- NL: No Evidence of Learning
- RT: Refused Teaching
- ATB: Able to teach back *
- UTB: Unable to teach back

Teach Back Utilized with Discharge Instructions

- Can you show me on these instructions:
  - How you find your doctors' office appointment?
  - What other tests you have scheduled and when?
- Is there anything on these instructions that could be difficult for you to do?
- Have we missed anything?
- Who will you call if you have questions?

Discharge SmartPhrase

Successful teach-back of After Visit Summary (AVS) complete:
__ Yes
__ No
__ N/A
__ Additional teaching can be found under the Patient Education tab

Teach-back of AVS completed with:
__Patient
__Co-Learner - _________
__N/A

Prescriptions:
__Called
__Faxed
__Escribed
__Sent with patient
__N/A

Discharged per:
__Wheelchair
__Ambulatory
__Cart/stretcher
__Carried out by:____________

Nursing Report called to:
Facility/Home Care Agency name: ___________
Person receiving report: _________
__N/A

Discharge Instructions Faxed to:
Facility/Agency name: ___________
Home Care Agency: __________
__N/A

Note:

Epic Screen Shot

Healthcare Log/Calendar

My 2015 Healthcare Log

This is your Healthcare log please fill it out to the best of your ability and bring to all of your healthcare appointments. We encourage you to use pencil to allow for revisions.

Appointment Checklist:

- ❑ Updated Medication List
- ❑ Healthcare Logs
- ❑ Insurance Card

Your Home Medical Equipment Providers:

Oxygen

Provider:

Phone:

CPAP Mask

Provider:

Phone:

Nebulizer

Provider:

Phone:

Mobility

Provider:

Phone:

UnityPoint at Home - Home Medical Equipment

UnityPoint at Home knows there really is no place like home. Our Home Medical Equipment professionals understand your home care needs. That is why we offer the finest, most comprehensive home-based medical services in this area -- 24 hours a day.. **For more information on how we can help you call 319.369.8686**

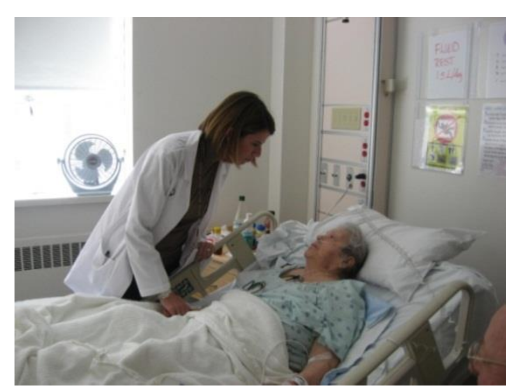
Your Community Providers:

Resource	Provider	Phone Number
Meals		
Transportation		
Lifeline		

Copy in binder

UnityPoint Health
St. Luke's Hospital

Patient Education



- Teach Back Technique- WORKS
- Health Literacy principles
- Multiple languages- use of interpreters
- Input from patients and family caregivers
- Same materials and technique across the Continuum of Care
- Educate patient regarding diagnosis, self –care management, and importance of follow up
- Lesson Learned: *Listen* before we teach. Ask open-ended questions
- Goal for Patient: *Take action when you notice a change in your health*

Real-Time Handover

Real-Time Handover Communications

- "Warm Hand-overs" to Skilled Nursing Facilities, Home care agencies, outpatient clinics, and providers
- Email-notifications to inpatient team, case manager, consultants, HF clinic, home care RNs, SNF and PCP on admission
- Creates a "Virtual Care Team"
- Time consuming but valuable
- Unites the entire team working on transition of care
- Importance of Home Care referrals
  - Medication reconciliation
  - Focus on self management skills

Email to Team on Admission:

Dear Medical Team,
We wanted to let you know that we are following Mr. XXXXXXXXXXX in the Heart Failure / Transitional Care Program . We are very familiar with this high risk patient from previous admissions (5th in past 4 months). We have provided education, initiated palliative care consults, and coordinated services in the past . We would like to provide as much support as possible for the patient and family.

Recommendations:
1. *Bridges Program- MD home visits*
2. *UC RN home care*
3. *Pharmacist consult for discharge medications*
4. *Follow up appointment within 7 days*
5. *Goals of care discussion/Palliative care consult*

The goal of this program is to provide our Medicare patients and families with as much information and support as possible to enable them to safely manage their care during this vulnerable post hospitalization period, and to prevent avoidable 30 day readmissions. We will be following patients with primary heart failure, COPD, PNA, and AMI. We will be sharing information through tracking of the readmissions to identify trends and to learn from. The focus of the program is as follows;

- *In-house consults when indicated – dietary, pharmacist, palliative care*
- *Goals of care conversations initiated (by the team or PCS) for all patients admitted 3 times within a year*
- *RN/PT home care visits whenever deemed appropriate*
- *Follow up appointments scheduled within 7 days for primary heart failure patients and 14 days for all others at time of discharge*
- *Follow up calls through the UCSF discharge phone call program and by the transitional care program for patients identified as high risk for readmissions*

Please let us know if there is anything that we might do to assist and thank you for the great care that you provide our patients!

Real-Time Handover Communications

- Interagency standardized transfer form
- Warm handover Communication
- Work with Clinic and the TCM code
- ARNP's assigned to Post Acute Facilities to oversee care management
- Transition Feedback opportunities

Support Programs

Support Programs

- Consistent Care Program (EDCCP) Patients who had Emergency Room visits >12 times in previous 12 months.
- Care Plan is developed by a team coordinated by an assigned Social Worker.
- Communication tool provides data specific to patient's medical Hx. and current medical needs, and Goals of Care for when patients presents again.
- Advance Medical Team
- High Risk patients assigned a Care Navigator to work with them across the continuum.
- Team includes resource for Outpatient Social Work and Pharmacy consult for medication management.

Support Programs

- Heart Failure Clinics
- MD/NP home visits programs
- Outpatient Palliative Care program
- Health Care Navigators
- ACO case managers
- Discharge phone calls program

UCSF Automated Calls Program

- Goal: All patients receive a discharge phone call- 80%
- Currently: ED, Neuro, Medicine, Ortho, Cardiac
- Disease Management
- Heart Failure, COPD, AMI
  - Specific calls –promotes accountability
  - 4-6 additional calls over 30 days

Post Discharge Automated Call Program

UCSF Medical Center

What You Need To Know About Your Heart Failure Follow-Up Phone Calls

We care about your health in the hospital and at home. Please expect a series of automated phone calls from *1 (415) XXX XXXX* so we can see how you are doing as you recover, and **provide help if needed**.

You will receive **6 separate phone calls** during the month after leaving the hospital from our automated system.

1. You will get an **automated call** within 3 days of leaving the hospital and **one about every 5 days.**

2. **You will be asked a few questions.** Please answer the questions using the phone keypad.

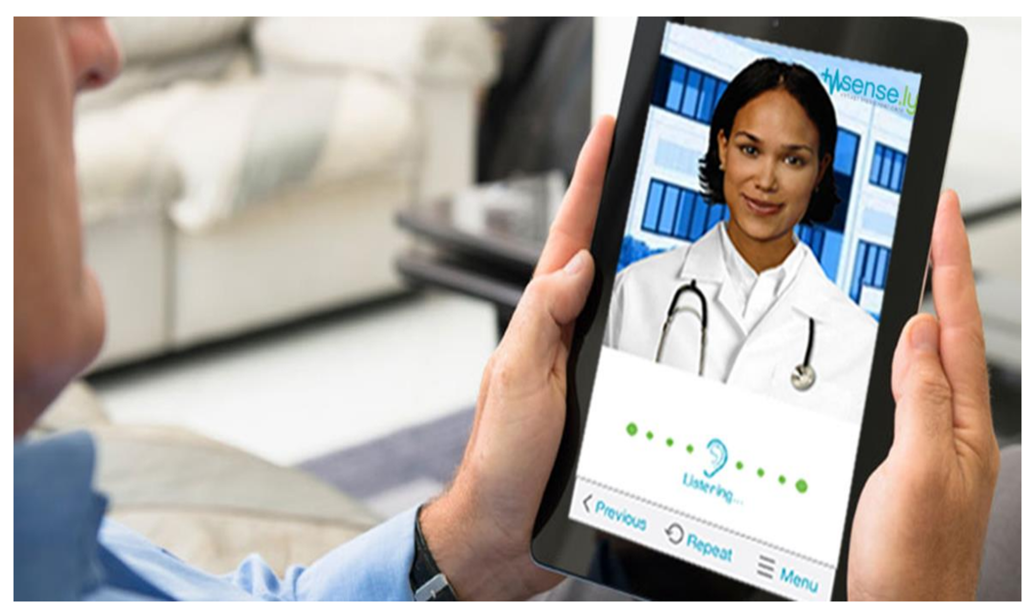
3. **Based on your answers**, a clinician will call you to offer help and instructions.

A Clinician Will Call You Back Based On Your Responses to the Following:

1. Do you have any questions about the instructions you were given about caring for yourself at home?
2. If you were given a prescription, were you able to fill your prescription, or do you have any questions about how to take your medications?
3. Are you having shortness of breath or unexpected symptoms?
4. Are you weighing yourself?
5. Have you gained more than 3 pounds in a day or five pounds in one week?
6. Are you following a low salt diet?
7. Do you need help making a follow-up appointment or to schedule home care?
8. Will you be able to attend your follow up appointment?
9. Were you satisfied with your stay at UCSF Medical Center?

HealtheHeart Study

- Nurse Avatar "Molly"
- Heart Failure management
- Calls recorded by Heart Failure Coordinators
- Weights, B/P, Heart Rate
- Promotes self care management
- Inpatient Survey- patients 65+ → positive feedback



UCSF Palliative Care Program

Palliative Care

- Palliative care proven to improve symptoms, quality of life, satisfaction, and patient and family outcomes
- 25% of our Heart Failure patients die within one year
- Up to one- half of deaths with Heart Failure are due to Sudden Death
- Palliative care prompts patients to think about all their options in the future and to start the important discussions for making plans
- Standard- consult on 3rd Readmission /Year
- New this year, PC MD on Heart Failure Service
- Increased palliative care options in outpatient setting- expansion

Pantilat and Steimle JAMA 2004;291:2476-82
Wright et al. JAMA 2008;300:1665-73
Morrison J Palliat Med 2005;8:S79-87

The Goals of Care Conversation:

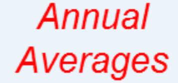
- When you think about the future what do you hope for?
- When you think about what lies ahead, what worries you most?
- How do you approach these decisions in “your” family?
- Sit and listen
- Wait full 2 minutes without a word

Steve Pantilat, MD
Director of the UCSF Palliative Care Program

UCSF Medical Center

Results

30 Day Readmissions
Primary & Secondary Heart Failure
UCSF Medical Center Heart Failure Program


Annual Averages
2009 = 24%
2010 = 19%
2011 = 13%
2012 = 12%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Goal Line:
Jan-09
Mar-...
May...
Jul-09
Sep-...
Nov-...
Jan-10
Mar-...
May...
Jul-10
Sep-...
Nov-...
Jan-11
Mar-...
May...
Jul-11
Sep-...
Nov-...
Jan-12
Mar-...
May...
Jul-12
Sep-...
Nov-...
Jan-13
Mar-...
May...

UCSF Medical Center

Medicare FFS 30 day Readmissions

	FY 2012	FY 2013	FY 2014	FY 2015 YTD
AMI	12.3%	15.8%	13.6%	**20%**
CHF	22.3%	17.0%	18.4%	**16.6%**
COPD	17.5%	13.5%	16.2%	**23.9%**
PNA	18.1%	13.3%	14.6%	**6.9%**

HF – 75% of patients in Transitions Program

UCSF Readmission Dashboard

UCSF Medical Center
UCSF Benioff Children's Hospital

Dashboard | Readm Details - UHC | Readm Details - CMS | Process Metrics | Exploration | Info

Data as of: 4/30/2015 (except for UHC)

Readmissions Dashboard

Current Selections

Clear All

Discharge Year

Discharge Month: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Discharge Service: *Unspecified, Adolescent Medicine, Advanced Lung Disease, Anesthesiology, BMT

Discharge Unit: 4 MEDSURG ICU MZ, 4E SURGERY MZ, 5 ADULT/SURG/ONC MZ, 5E/W ACUTE MZ, 6E PCRC, 6L ADULT ACUTE CARE

Hospital Return Type: Inpatient, Observation, ED

Readmission Rate - UHC Definition

11.9% FY 2015 YTD — 11.8% (Prior FY); 11.1% (Mar 2015)

Click to display the UHC definition of a readmission

Readmission Rate - UHC Definition (chart, 0%–15%, Mar 2014 – Mar 2015)

UHC FY 2015 Readmission Rate Goal - 11.63%

Readmission Rate - Medicare Value Based Purchasing Population

Medicare - HWR Rate: 11.8% FY 2015 YTD — 11.2% (Prior FY); 11.5% (Apr 2015)

Click to display the Medicare - HWR definition of a readmission

Readmission Rates - Medicare Fee For Service Populations

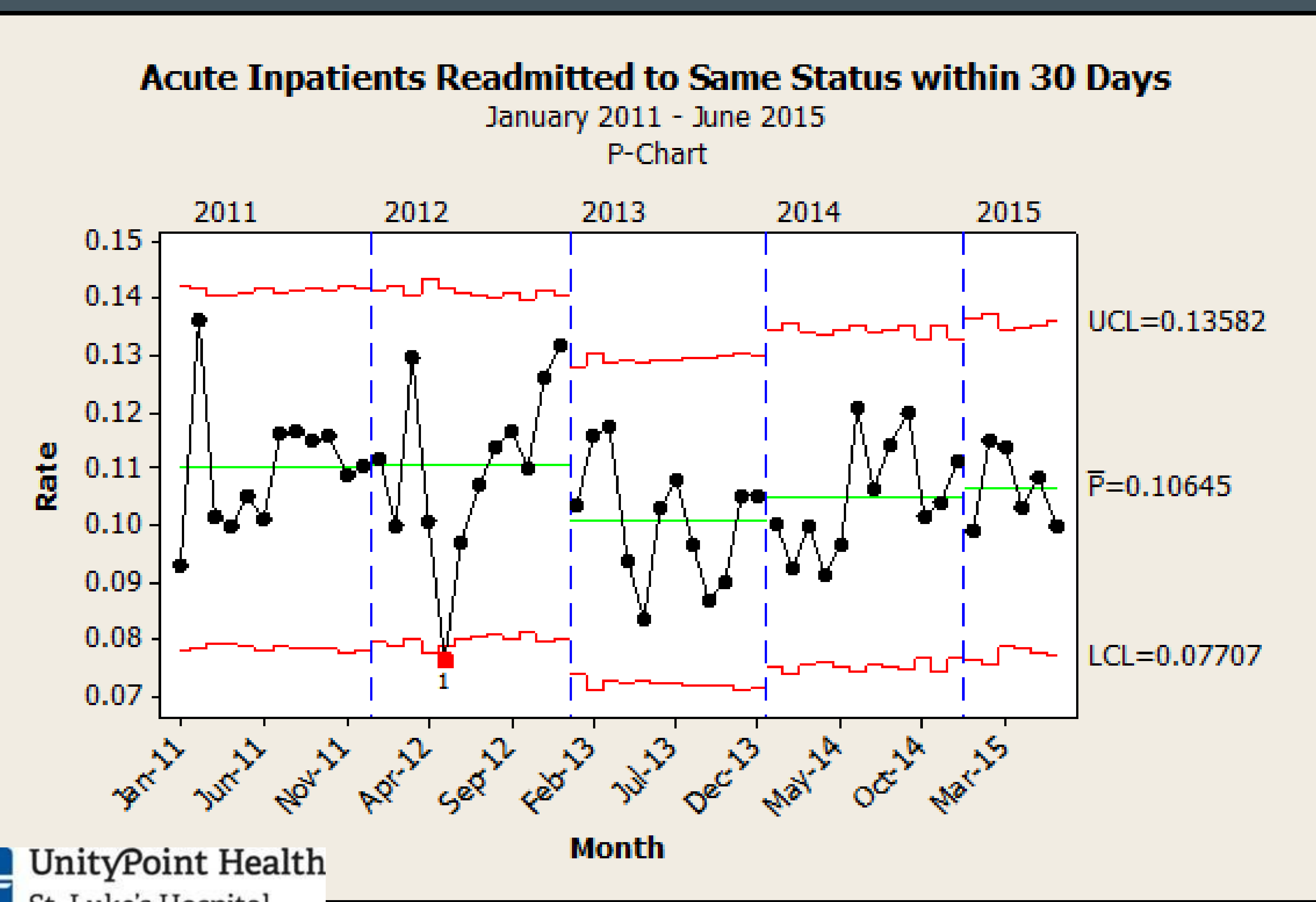
Measure	FY 2015 YTD	Prior FY	Apr 2015
AMI	18.8%	14.3%	50.0%
Heart Failure	17.2%	20.1%	11.8%
Stroke	8.7%	7.3%	14.3%
Pneumonia	7.0%	16.2%	0.0%
COPD	25.9%	17.4%	44.4%
THA / TKA	2.1%	3.2%	5.6%

*Please see the info tab for definitions

Hospital Returns w/in 30 days of D/C (IP, ED, OBS)

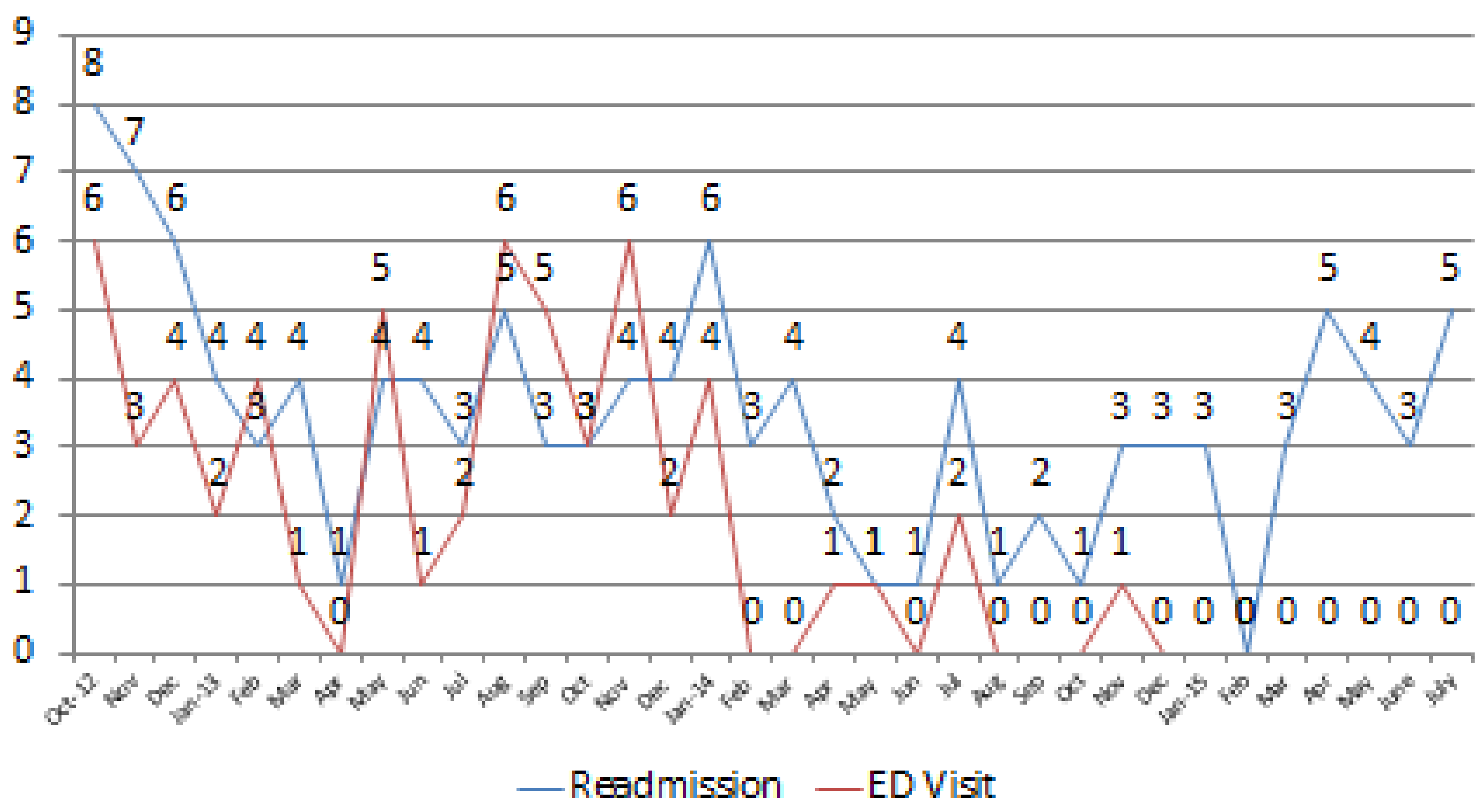
Legend: OBS; ED Returns; Readmissions (UHC Definition)

Results



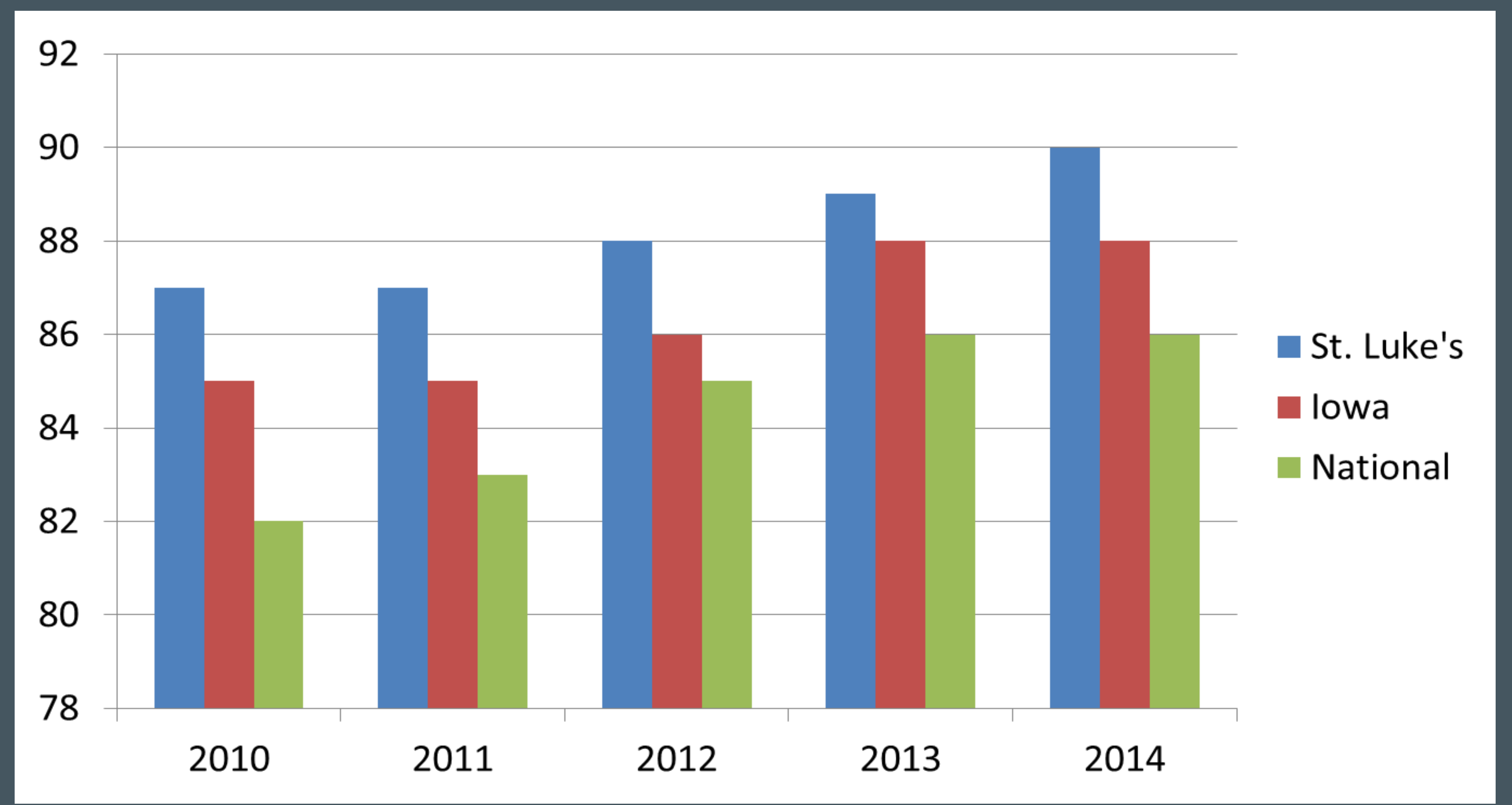
UnityPoint Health
St. Luke's Hospital

SNF Patients Admitted to St. Luke's ED or Into an Inpatient Status



UnityPoint Health
St. Luke's Hospital

HCAHPS RESULTS
DISCHARGE INFORMATION (% Yes)



The following questions make up this composite measure:

#19 – During hospital stay, did doctors, nurses or other hospital staff talk about whether you would have the help you needed when you left the hospital?

#20 - During hospital stay, did you get the information in writing about what symptoms or health problems to look out for after you left the hospital?

UnityPoint Health
St. Luke's Hospital

Lessons Learned

Lessons Learned

- Importance of engaged executive leaders and physicians.
- Patients and families help transform care in profound ways.
- The patient and family home environment must be understood.
- Involving frontline staff in the changes helps them understand why they are important and grows ownership by engaging them in redesign.

Lessons Learned (cont)

- The role of Information Technology in the process should be addressed simultaneously with the work.
- Ongoing monitoring of Process and Outcome Measures is important to hardwiring best practices.
- Using patient stories unleashes energy and participation that becomes evident in process and outcome results.
- The power of relationship building and collaboration of the cross-continuum team builds new ideas to work and removes many of the “silos’ in the care.

Lessons Learned…

- Collaboration with IHI – extremely valuable
- Dedicated Heart Failure/Disease Management Program Coordinators - accountable, reliable processes
- Willingness to test, trial, and change interventions
- Make efforts to move outside of silos
- Senior Leadership and Champions necessary
- Cohesive, committed multidisciplinary cross continuum teams

Lessons Learned…

- Palliative Care Team Collaboration
- Home Care collaboration and referrals
- Outpatient program & Community Partners essential
- Results are not immediate – takes time to show improvement
- Teach Back works – focus on Health Literacy
- Technology – great potential – Here to stay
- Power of the patient story to learn from and drive change