

## Aim

Identify gaps in care for patients readmitted within seven days to create a culture of accountability around readmission prevention and initiate process improvements

## Description

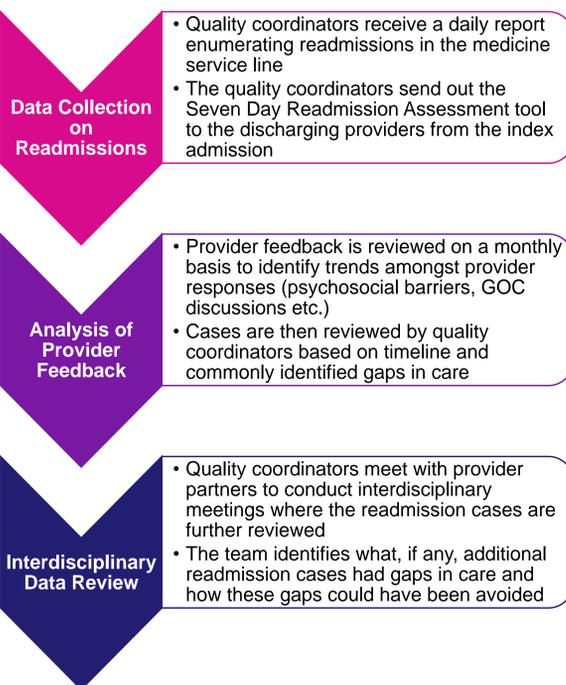
- The MSH developed and implemented a readmission review process for patients that returned within one week of discharge that includes provider notification and a standardized tool to identify gaps in care.
- The readmission assessment tool includes questions regarding the clinical circumstances and the use of appropriate interventions and resources prior to the readmission. This comprehensive approach identifies aspects of both clinical considerations and care transitions as potential areas of opportunity to avoid readmissions.
- A process was created to facilitate sharing of key findings with the hospitalist team, which prompts implementation of appropriate process improvement initiatives that leverage care transition resources.

## Project Design

- The Mount Sinai Hospital, an 1170 bed urban academic medical center, developed and implemented the Seven Day Readmissions Assessment tool and process in the hospitalist service line.
- The process includes a focus on collecting and evaluating physician feedback regarding patients who are readmitted within seven days of discharge and identifying root causes of these readmissions.

### The Readmission Assessment Tool includes questions such as:

1. What could have been done differently with regards to clinical management to keep the patient from returning
2. Was there a goals of care discussion?
3. What could have been done differently with regards to care coordination to keep the patient from returning
4. Did the patient and/or their family understand his/her discharge plan on the index discharge?
5. Could this readmission have been avoided if appropriate interventions had been facilitated?



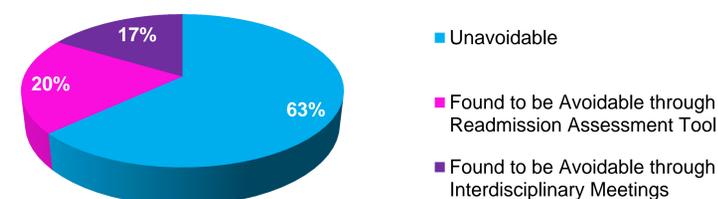
## Actions

- This initiative was developed by launching a seven day readmissions assessment tool and process to establish oversight and monitor physician feedback.
- Interdisciplinary meetings were formed between quality coordinators and physician partners to discuss readmissions that were deemed avoidable, narrow down root causes, identify process improvements, and optimize resource utilization.

## Results

- 212 readmission assessments were performed from Aug 2017 – May 2018.
- 78 readmission cases were deemed avoidable through either the Readmission Assessment Tool or Interdisciplinary Meetings (37%).

### Readmissions Aug 2017-May 2018



- Among the avoidable cases, reasons for readmission were multifactorial.
- 120 reasons were cited as appropriate areas for process improvements.

### Areas of Opportunity For Process Improvements

<b>Clinical Care</b>	
• Diagnosis Intervention/Medication Reconciliation	31
• Premature Discharge	
<b>Discharge Planning</b>	
• Interdisciplinary Communication	30
• Level of Care	
• Care Coordination	
• Outpatient Follow-up Appointment Scheduling	
<b>Education for Patient/Caregiver</b>	
• Disease Management	26
• Medication Compliance	
• Escalation Plan	
• Follow-up	
<b>Utilization of Observation Units</b>	10
<b>Post-Acute Care</b>	
• Care at SNF	8
• Care at CHHA	
<b>Medical Assistance Technology</b>	
• DME	6
• Medical Device (drain, tube, filter, trach)	
<b>Psychosocial Barrier</b>	5
<b>Palliative Care/Hospice</b>	4
<b>Total</b>	<b>120</b>

- As a result of these reviews and additional improvement initiatives, the readmission rate for the Medicine service line has decreased from 16.1% in 2017 to 15.3% 2018 YTD.

## Interdisciplinary Team

- The team involved in the Interdisciplinary joint review process consists of quality coordinators and physician partners.
- This team focuses in on cases that were initially deemed unavoidable in the assessment tool and evaluates which, if any, of these cases actually could have been avoided from a process perspective.

## Lessons Learned

- Implementation of a multi-layered review process that included an assessment tool and an interdisciplinary meeting was crucial to identifying all avoidable readmission cases. The assessment tool found 42 cases that could have been avoided and the interdisciplinary meetings determined the 36 additional cases could have been avoided.
- Expansion of the Readmissions Assessment to other service lines and hospitals within the Mount Sinai Health System will be pursued seeing as The Readmission Assessment tool is not too resource or time intensive.