Improving Transitions to Reduce Readmissions

Proper transitions out of the hospital are essential to patients and care providers in order to reduce readmissions and ensure that proper care continues and follow-up occurs.

Domain

Processes to Support Care:
Processes that are essential to support and maintain the delivery of care to all types of patients, across all units and settings in the hospital

Aims

Efficient:
The appropriate use of resources at the least expense to the patient, provider, and care setting

Timely:
Care delivery that is prompt and provided without delay to mitigate any harm to a patient

Safe:
Delivery of care in a manner that minimizes any risk of harm to a patient

Equitable:
Care delivered fairly, with consideration to need, and with no other discriminating factors

Process Attributes

Cost to Implement
The monetary resources required to implement this process

Moderate: In addition to the improvement effort, relies on additional personnel and/or technology

Time to Implement
The amount of time, from months to years, it will take on average to establish this process

1 to 2 years

Difficulty to Implement
The challenges of implementing this process

Most Challenging: Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations

Level of Evidence
The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale

Some Evidence: Level III — Studies published with some control included
Details

Elements

• **Implement enhanced assessment of patients on admission**
  - Include family, caregivers, and community providers as full partners in standardized assessment, discharge planning, and predicting home-going needs.
  - Reconcile medications on admission.
  - Initiate a standard plan of care based on the results of the assessment.

• **Provide effective teaching and enhanced learning**
  - Identify the learner(s) on admission (i.e., the patient and family caregivers).
  - Design the patient education process to improve patient and family caregiver understanding of self-care.
  - Assess the patient and family caregivers’ understanding of discharge instructions and ability to do self-care using the Teach Back method.

• **Ensure effective patient- and family-centered handoffs**
  - Reconcile medications for discharge.
  - Establish a process to ensure that critical information is transmitted to the receiving physician and/or home health agency or other care providers at the time of discharge.
  - Provide customized, real-time critical information to the next care provider(s) that accompanies the patient to the next institution.

• **Provide post-acute care follow-up**
  - For patients at high risk for readmission: Prior to discharge, schedule a face-to-face follow-up visit (home care visit, care coordination visit, physician office visit) to occur within 48 hours after discharge.
  - For patients at moderate risk for readmission: Prior to discharge, schedule a follow-up phone call within 48 hours after discharge and schedule a physician office visit within 5 days.

Outcomes

• **Harm**: Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)
• **Patient Satisfaction**: Increased patient satisfaction (e.g., HCAHPS Willingness to Recommend, HCAHPS Hospital Rating)
• **Readmissions within 30 Days**: Decreased readmissions within 30 days

Service Lines and Critical Functions

• Applies in All Patient Settings
• Transitions and Continuity

Key Measures

• 30-day readmission rate
• Patient satisfaction with discharge preparation

Reasons and Implications

**Importance for Patients and Families**
Patients and families are frustrated when discharges are not planned or done well. Poorly managed discharges can harm patients’ health and well-being, inconvenience families, and increase costs in the health care system and to patients and their families.
Requirement, Standards, Policies, and Guidelines

- Agency for Healthcare Research and Quality (AHRQ)
- American Society of Health-System Pharmacists (ASHP)
- Centers for Medicare & Medicaid Services (CMS)

9th Scope of Work

- National Priorities Partnership (NPP)
  - Patient and Family Engagement
  - Safety
  - Care Coordination
  - Palliative and End-of-Life Care
  - Overuse

- National Quality Forum (NQF)
  Patient Safety Safe Practice 2010
  Safe Practice 15: Discharge Systems
  Safe Practice 17: Medication Reconciliation
  Safe Practice 28: Venous Thromboembolism Prevention

- The Joint Commission (TJC)
  National Patient Safety Goals:
  - Standard PC.04.01.03: assessed needs and the organization’s ability to meet those needs.
  - Standard PC.04.01.05: informs and educates the patient
  - Standard PC.04.02.01: information about the care, treatment, and services provided to the patient to other services providers
  - Standard NPSG.08.02.01: the complete and reconciled list of medications to the next providers
  - Standard NPSG.08.03.01: a complete and reconciled list of the patient’s medications is provided directly to the patient

- The Leapfrog Group
  Leapfrog’s Resource Utilization Measures & Severity-Adjustment Models
  Associated with work on the NQF measures

Financial Implications

- Expense reduction for the health care system can occur due to fewer unnecessary readmissions.
- Expense increases can occur due to unfunded coordination of care visits for at-risk patients.
- Revenue increase can occur due to hospitals’ ability to bring in patients with greater revenue when readmissions are reduced.
- Revenue reduction can occur due to loss of readmissions when hospitals rely on the readmissions for revenue.

Prerequisites

None for this process
Additional Resources

- **The Commonwealth Fund**
  Why Not the Best?
  Comparative performance data on readmission rates and patient experience

- **The Joint Commission (TJC)**
  The Joint Commission Accreditation Program: Hospital
  National Patient Safety Goals - Effective January 1, 2011

- **National Transitions of Care Coalition (NTOCC)**
  The National Transitions of Care Coalition (NTOCC) is a group of concerned organizations and individuals who have joined together to address problems associated with transitions of care of patients from one practice setting to another. NTOCC was founded in 2006 by the Case Management Society of America (CMSA) and sanofi-aventis, U.S. to define solutions addressing those gaps that impact safety and quality of care for transitioning patients, particularly seniors. The NTOCC website provides links to participating organizations.

- **IHI/Commonwealth Foundation How-to Guide: Creating an Ideal Transition Home**
  This resource guides IHI’s efforts to provide targeted technical assistance in select high-priority areas to address systemic barriers to reducing avoidable rehospitalizations.

- **US Department of Health and Human Services**
  Partnership for Patients

- **Society of Hospital Medicine**
  BOOST

- **Agency for Healthcare Research and Quality (AHRQ)**
  Discharge Toolkits

- **The Commonwealth Fund**
  Article: Preventing Readmissions with Improved Hospital Discharge Planning

- **Centers for Medicare & Medicaid Services (CMS)**
  QIOs in the 9th Scope of Work 14 pilot states

- **American Society of Health-System Pharmacists (ASHP)**

- **WHO Patient Safety Solutions**
  Communication During Patient Handoffs

- **American College of Cardiology (ACC)**
  Hospital to Home (H2H) National Quality Improvement Initiative

**Information Compiled By**

Gail A. Nielsen, BSHCA, Education Administrator, Clinical Performance Improvement, Iowa Heath System; George W. Merck Fellow and Faculty, IHI