Strategies to Reduce 30 Day Readmissions Through Improved Discharge Process
Improving the Discharge Process

Problem
SUF’s risk-adjusted readmission rate is higher than expected per CMS. Our discharge process contributes to our high rate of readmission.

Objectives
• Outline the current care process (admission through discharge).
• Identify factors in the current discharge process that contribute to unplanned readmissions.
• Develop strategies to standardize the discharge process using the UHC defined best practices.
• Implement a standardized discharge process that is consistent, reliable, and sustainable.
Identified Factors that Contribute to Readmissions

• **Day of Admission**
  – Medicine Reconciliation is often incomplete or insufficient.
  – Communication and Workflow issues
  – Time and resources
  – EMR information is not visible to all clinical staff involved in patient care (i.e. Nurses/Doctor vs Case Managers)

• **Between Admission and Discharge**
  – Communication is reactive, not proactive
  – Patient Non-compliance, psychosocial influences
  – Clinical Staff Time Constraint and Logistical Issues
  – Constant patient turn-over;
Identified Factors that Contribute to Readmissions

• Day of Discharge
  – Ancillary Service availability
  – Pressure to discharge quickly
  – Discharge volume impeded implementation of some proposed changes
  – Decision for D/C not made until Attending MD has completed rounds
  – Medication Reconciliation and DC Summary time and accuracy issues

• After Discharge
  – No process in place!
# UHC Best Practices

<table>
<thead>
<tr>
<th>BEST PRACTICE</th>
<th>WHAT</th>
<th>WHO</th>
<th>WHEN</th>
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<tbody>
<tr>
<td>Assess risk</td>
<td>Polypharmacy - Previous Admits - No PCP</td>
<td>MD - RN - Case Manager</td>
<td>On Admission</td>
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<tr>
<td>Begin at admission</td>
<td>Identify Post DC needs - Ensure PCP - Educate Patient - Create Plan</td>
<td>MD - RN - Case Manager</td>
<td>Throughout Hospitalization</td>
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<tr>
<td>Schedule follow-up appoints</td>
<td>Specific Follow-up Appointment within 7 Days</td>
<td>Case Manager</td>
<td>Before Discharge</td>
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<tr>
<td>Teach back</td>
<td>Patient Explains in Own Words</td>
<td>IP TEAM</td>
<td>Throughout Hospitalization</td>
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<tr>
<td>Medication reconciliation</td>
<td>Discharge Meds Reflect Previous and New Meds</td>
<td>MD - Pharmacist</td>
<td>At Discharge</td>
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<tr>
<td>Written discharge plan</td>
<td>Useful, Accurate, Understandable, Information</td>
<td>MD - RN - Case Manager</td>
<td>At Discharge</td>
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<tr>
<td>DC Summary to PCP</td>
<td>Complete &amp; Transmit DC Summary</td>
<td>MD - HIM Team</td>
<td>At Discharge</td>
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<tr>
<td>Discuss end of life wishes</td>
<td>Patient's Desires Considering Prognosis - Options</td>
<td>MD</td>
<td>Clinic - Before Discharge</td>
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<tr>
<td>ED - alternatives to admission</td>
<td>HomeCare - Clinic</td>
<td>ED Team</td>
<td>In ED</td>
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<tr>
<td>Phone follow-up</td>
<td>Reinforce Teaching - Answer Questions - Manage Issues</td>
<td>Person Familiar with Patient</td>
<td>Within 72 Hours After Discharge</td>
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## UHC Guidelines vs. Current Process

<table>
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<tr>
<th>Adherence to Best Practice</th>
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<tr>
<td>Assess risk</td>
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<tr>
<td>Begin discharge at admission</td>
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<tr>
<td>Schedule follow-up appoints before discharge</td>
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<tr>
<td>Teach back</td>
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<tr>
<td>Medication reconciliation</td>
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<tr>
<td>Provide a written discharge plan</td>
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<tr>
<td>Communicate DC Summary to the next provider</td>
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<tr>
<td>Discuss end of life wishes</td>
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<tr>
<td>Identify alternatives to admission in the ED.</td>
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<td>Follow-up with patients by phone</td>
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Identified Goals for Nursing

• Increase accuracy of admission history, including PTA medications and actual or anticipated discharge needs
• Improve communication in EMR and across the interdisciplinary teams
• Recommend changes in EMR that would enhance discharge process (some occurred with the upgrade in JULY)
• Increase pharmacy involvement on admission and discharge with medication reconciliation
• Ensure accurate and complete discharge instructions (AVS)
• Follow up phone call in 1-3 days after discharge
• Interview all 30 day re-admission patients
Assess Risk & Begin at Admission

• Enhanced Processes
  – Discharge needs identified and communicated on admission and throughout care
• Ensuring PCP identified or established for each patient
• Increased effective communication across didactics to enhance discharge process
Schedule Discharge Appointment and Medication Reconciliation

- Enhanced Processes
  - Ensure each patient had a follow-up appointment prior to discharge (if applicable)
  - Revised discharge appointment goal from 7-10 days to 3-7 days post discharge
  - **Currently, calling patients in room to schedule appointment prior to discharge**
  - Obtained Pharmacist access to complete PTA medication reconciliation (including pharmacy query)
Teach Back and Written Discharge Plan

• Enhanced Processes
  – Implemented teach back method throughout patient stay and at discharge
  – Manually modified discharge instructions (AVS) to ensure accurate, concise information (case by case)
  – Obtain accurate contact information for follow-up phone call
  – Assess health literacy (REALM)
  – Begin using online patient education platform
D/C Summary to PCP and Follow-up Phone Call

- Enhanced Processes
  - PCP established/identified on discharge summary
    - CM now able to revise PCP in EPIC
  - Reinforced medication reconciliation and follow-up appointment at time of discharge and during follow-up phone call
  - Follow up phone call completed by FM pharmacist
    - Pharmacist is now able to connect patients directly to Access Center to ensure follow up appointments are made
  - Unit 65 staff nurses completing non-FM patients
  - Accurate documentation in EMR of post discharge phone call
End of Life Care & Alternatives to ED Admissions

• Identified other work teams whom are addressing these initiatives
  – Palliative Care Team
  – Advanced Directive Team (work in progress)
  – Care One Clinic @ UFHealth
  – Family Medicine After Hours Clinic
Correctly Reconcile Discharge Medications

Correctly Reconcile Discharge Medications

%
Follow-up Phone Call within 48-72 Hours

- April 2013: 0%
- May 2013: 10%
- June 2013: 20%
- July 2013: 30%
- August 2013: 70%
- September 2013: 60%
6 Month Rolling Average Re-Admission Rate

- 1/2013-6/2013: 24.00%
- 3/2013-8/2013: 23.50%
- 6/2013-11/2013: 23.00%

Graph showing the decline in re-admission rates over the specified periods.
Next Steps.....

- Roll out process to other Med/Surg units (housewide)
- Achieve 3 days or less on all Med/Surg follow up appointments
- EMR changes to address Interdisciplinary Discharge Tab capability
- Educate all new staff and physicians as to current process
- DON’T GO BACKWARDS.......ensure everything that has been implemented to this point continues, regardless of the pilot!
Questions and Comments

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