Mission

To improve transitions in care and reduce avoidable hospital readmissions.
Overview

• Review readmission collaborative measures
  – Process measures
    • How to report in QDS
    • Screening tools
    • **Best practice around follow-up calls**
    • Challenges, barriers and strategies
  – Outcome measures
    • Hospital wide rates
    • Unit/population rate
# Readmission Collaborative Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>Definition</th>
<th>Source &amp; Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-payer, hospital-wide 30-day readmission rate</td>
<td>20% reduction from hospital’s 2010 baseline</td>
<td>All patients seen a second time by the same hospital, regardless of clinical condition or payer.</td>
<td>Quarterly, data taken from claims data</td>
</tr>
<tr>
<td>Readmission rate for population/unit</td>
<td>20% reduction from 2010 baseline (or first available)</td>
<td>Hospital selects unit or population of focus. Hospital defines readmit criteria.</td>
<td>Hospital submits data monthly, due on the 20th of the month. Ex. July data due August 20th; August data due September 20th.</td>
</tr>
<tr>
<td>Percent of patients given assessment for risk of readmission</td>
<td>95%</td>
<td># of patients given assessment/# patients in the pilot unit/population</td>
<td>Hospital submits data monthly, due on the 20th of the month. Ex. July data due August 20th; August data due September 20th.</td>
</tr>
<tr>
<td>Percent of high-risk patients whose follow-up appointment is scheduled within 7 days</td>
<td>95%</td>
<td># of patients who are scheduled for a follow-up within 7 calendar days / # patients assessed at high risk</td>
<td>Hospital submits data monthly, due on the 20th of the month. Ex. July data due August 20th; August data due September 20th.</td>
</tr>
<tr>
<td>Percent of high-risk patients who have a follow-up phone call within 3 days</td>
<td>95%</td>
<td># of patients who have a follow-up phone call within 3 business days of discharge / # patients assessed at high risk</td>
<td>Hospital submits data monthly, due on the 20th of the month. Ex. July data due August 20th; August data due September 20th.</td>
</tr>
<tr>
<td>Percent of high-risk patients who cannot be reached for a follow-up phone call</td>
<td>&lt;5%</td>
<td># of patients called 2 or more times who cannot be reached/# patients assessed at high risk</td>
<td>Hospital submits data monthly, due on the 20th of the month. Ex. July data due August 20th; August data due September 20th.</td>
</tr>
</tbody>
</table>
Timeframe

• First due date was August 20\textsuperscript{th}.
• It’s not too late to report your July data.
• If the 20\textsuperscript{th} of the month is a weekend or holiday, data is due the following business day. See the data manual for schedule for exact due dates.

Next due date: September 20\textsuperscript{th}
% of patients assessed for high risk of readmission

- **Numerator:** Number of patients discharged from pilot unit or population who have been assessed for high risk of readmission
- **Denominator:** All patients discharged from pilot unit or population

**Goal:** 95% of patients will be assessed
What do I do if my hospital doesn’t have a screening tool yet?

- Hospitals should report all process measures, even if they don’t have a screening tool yet.
  - Many hospitals are in this boat!
- How to report?
  - Patients assessed at high risk of readmission
    - Numerator=Number of patients assessed at high risk=0
    - Denominator=All patients on unit
  - Other process measures: Zero out of Zero
    - Numerator=Zero
    - Denominator=Zero
What the data entry looks like

### QDS Data Entry

Please note: If you are using Internet Explorer version 8 or earlier you may need to turn off Compatibility Mode in order to use this feature. Please see the linked instructions: [www.howtogeek.com/128289/how-to-disable-compatibility-mode-in-internet-explorer/](http://www.howtogeek.com/128289/how-to-disable-compatibility-mode-in-internet-explorer/)

If you have trouble, call or email Laura Ammons at 919-677-4146.

**Measure:** Readmissions Collaborative 2014  
**Time Period:** Q3 2014

#### 30 Day Readmission Rate for Unit/Population

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hospital Defined Readmissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of discharges from the pilot unit/population</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Assessment for High Risk of Readmission

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients Assessed</td>
<td>90</td>
<td>97</td>
<td>94</td>
</tr>
<tr>
<td># of Patients in the Unit/Population</td>
<td>100</td>
<td>102</td>
<td>101</td>
</tr>
</tbody>
</table>

#### Follow-up scheduled within 7 days

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients Scheduled for F/U</td>
<td>11</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td># of High Risk Patients in the Unit/Population</td>
<td>20</td>
<td>25</td>
<td>22</td>
</tr>
</tbody>
</table>

#### Followup Calls or Visits within 3 Days

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of High Risk Patients Receiving F/U call or visit</td>
<td>20</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td># of High Risk Patients in Pilot Unit/Population</td>
<td>20</td>
<td>25</td>
<td>22</td>
</tr>
</tbody>
</table>

#### Patients Who Can't be Reached for a F/U Call or Visit

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of High Risk Patients who can't be reached</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td># of High Risk Patients in Pilot Unit/Population</td>
<td>20</td>
<td>25</td>
<td>22</td>
</tr>
</tbody>
</table>
How to enter data if a hospital does NOT have a screening tool or has not screened

**QDS Data Entry**

**PLEASE NOTE:** If you are using Internet Explorer version 8 or earlier you may need to turn off Compatibility Mode in order to use this feature. Please see the linked instructions: [www.howtogeek.com/129269/how-to-disable-compatibility-mode-in-internet-explorer/](http://www.howtogeek.com/129269/how-to-disable-compatibility-mode-in-internet-explorer/)

If you have trouble, call or email Laura Ammons at 919-577-4146.

**Measure:** Readmissions Collaborative 2014

**Time Period:** Q3 2014

<table>
<thead>
<tr>
<th>30 Day Readmission Rate for Unit/Population</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hospital Defined Readmissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of discharges from the pilot unit/population</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment for High Risk of Readmission</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients Assessed</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># of Patients in the Unit/Population</td>
<td>100</td>
<td>102</td>
<td>101</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up scheduled within 7 days</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients Scheduled for F/U</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># of High Risk Patients in the Unit/Population</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up Calls or Visits within 3 Days</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of High Risk Patients Receiving F/U call or visit</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># of High Risk Patients in Pilot Unit/Population</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients Who Can’t be Reached for a F/U Call or Visit</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td># of High Risk Patients who can't be reached</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># of High Risk Patients in Pilot Unit/Population</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Submit Answers
% of high risk patients whose follow-up visit is scheduled within 7 days

- 7 days = 7 calendar days
- Patients who die in hospital may be excluded from this measure
- Hospice, transfer, and AMA patients should be included if they are assessed at high risk
Measure details

• What if next site of care is responsible for making follow-up appointment?

• Hospital can count patient as having follow-up visit scheduled if:
  – Hospital tells the next site of care that patient is at high risk for readmitting
  – Hospital tells next site of care that patient needs follow-up within 7 days
  – Hospital reasonably believes next site of care will act on this recommendation
Discussion

• What problems or barriers are you encountering with scheduling the follow up appointment within 7 days? With patients who are going home? How about patients who are transferring to other sites of care?
% of high-risk patients who have a follow-up phone call within 3 days

- Patients who die while in hospital can be excluded.
- 3 days = 3 business days
- If patient is discharged to next site of care, they can be counted as receiving a phone call—provided next site of care is informed the patient is at high risk of readmission.
- In some cases, a party other than the hospital may be responsible for making these calls. In this case, the hospital can count the call as having been made—provided the hospital has done some due diligence to verify that the third party is actually conducting these calls.
% of high-risk patients who cannot be reached for a follow-up phone call

• Patients who die in hospital can be excluded from this measure
• This measure is designed to help your hospital evaluate success of your efforts to reach patients by phone
  – Are there challenges to get phone calls made reliably?
  – Are staff making the calls, but just not reaching patients?
Poll

Have you started making the follow up phone calls to high risk patients?

Yes

No
Poll

Who makes the follow-up phone calls to high risk patients?

Nurse
Case Manager
Unit clerk
Other
Follow-up Phone Calls

How do you coordinate the calls with others who also make follow-up calls?
Follow-up Phone Calls: Impact

Post-discharge phone calls reduce readmissions: patients who received the call were 23% less likely to be readmitted within 30 days of discharge

Harrison, PL; Hara, PA; Pope, JE; Young, MC; Rula, EY. The Impact of Postdischarge Telephonic Follow-Up on Hospital Readmissions, Population Health Management, Feb. 2011, Vol. 14, No. 1, 27-32.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128446/
Follow-up Phone Calls: Impact

Patients who get the call have a higher rate of attendance at the follow-up physician visit and fewer adverse outcomes.

Redefining and redesigning hospital discharge to enhance patient care: a randomized controlled study. Balaban, RB; Weissman, JS; Samuel, PA; Woolhandler, S. J Gen Intern Med. August 2008; Vol. 23, No. 8, pp 1228-1233.
Follow-up Phone Calls: STAAR Guide

- Use Teach Back
- Has patient filled all prescriptions?
- Does patient know how and when to take medications?
- Does patient understand other critical elements of self-care?
- Does patient recall why, when and how to recognize worsening symptoms and when and who to call for help?
- Confirm date and time of follow-up physician visit and confirm arrangement of transportation to the visit.
Follow Up Phone Calls:
3 Decision Points

• Who should make the call?
• Which information is essential?
• What is the optimal timing?

Enhancing the Effectiveness of Follow-up Phone Calls to Improve Transitions in Care: Three Decision Points. Johnson, MB; Laderman, M; Coleman, E. Joint Commission Journal on Quality and Patient Safety, Vol. 39, No. 5, May 2013, pp.221-227
Poll

Which of these best practices have you used to reach high-risk patients?

• Before discharge, explain the reason you will be calling the patient.
• Before discharge, ask patient the best time and number to call
• Get alternate contact information from patient before discharge
• Communicate with family member or caregiver before discharge
Follow-up Phone Calls:
Additional References

Readmission rate (hospital-wide)

- Source: claims; hospital does not submit
- Brief definition: All payer, all-cause readmission rate—every patient, every reason, every time
- Not the same as the Medicare readmit rates
- Not risk-adjusted
- Observation patients not included
- Data available roughly 6 months after close of quarter
Collaborative readmissions rate (hospital-wide)

Note: This chart is updated on a quarterly basis. *Data are reported by quarter (e.g., 1/1/10 corresponds to 2010Q1). However, since calculating readmission rates requires a 30-day 'look forward' period, the most recent quarter displayed will only contain two months of data.
Unit/population readmission rate

- Each hospital should calculate a readmit rate for the unit/population it is working with
  - Work with your hospital resources—are there available reports which (roughly) track this population?

- Each hospital will define its readmit measure slightly differently
  - Data will be used to track progress relative to your baseline, but not to compare hospitals.
Considerations for unit/population readmission rates

- Include readmits back to any part of the hospital, not just back to your unit, if possible.
- Ideally, include readmits back to other hospitals (e.g., in your system).
- Talk to your hospital about how to handle same day ‘readmits’.
- Ideally, NoCVA suggests including observation patients.
• Big picture:
  – Use available hospital resources
  – It’s okay if your internal readmit report doesn’t perfectly capture your specific unit/population
  – Don’t get bogged down in readmit details—key question is whether your hospital can build/track a measure which will show movement in response to the work you do with this population/unit. You want feedback for your PI work!
Poll

Have you attempted to capture a unit level or population readmit rate for this project?

Yes
No
Discussion

What are the barriers or challenges you’ve encountered?

Have you reached out to any other hospitals, listserv or to your coaches to address barriers or questions?
Key points

• Thanks to those hospitals who are already reporting, even if you’re reporting zeros.
• Getting your data in is critical to the success of your project.
• Use your coaches and peers to help strategize about how to overcome barriers.
<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webinar: Partnering with Patient and Family to Determine Post-Hospital Needs and Providing Effective Teaching to Facilitate Learning</td>
<td>October 13, 1:30</td>
</tr>
<tr>
<td>Group Coaching Calls</td>
<td>November 10, 1:30</td>
</tr>
<tr>
<td>Webinar: Create and Activate Post-Hospital Care Follow-up and Provide Real-Time Handover Communications</td>
<td>December 9, 1:30</td>
</tr>
<tr>
<td>Learning Session 2</td>
<td>January, 2015</td>
</tr>
</tbody>
</table>
For more information, contact:

Laura Maynard, Director of Collaborative Learning, 
imaynard@ncha.org  919-677-4121

Erica Preston-Roedder, Director of Quality Measurement, 
eroedder@ncha.org  919-677-4125

Dean Higgins, Director of Operations and Project Manager, 
dhiggins@ncha.org  919-677-4212

Linda McNeill, NCACT Program Manager, 
lmcneil@ncha.org  919-677-4115

Elizabeth Mizelle, Data Analyst, 
emizelle@ncha.org  919-677-4124