Welcome to today’s session!
Please use chat to “All Participants” for questions
For technology issues only, please chat to “Host”
WebEx Technical Support: 866-569-3239
Dial-in Info: Communicate / Join Teleconference (in menu)
Agenda

• Collaborative Overview
• Using the IHI Diagnostic Tool
• Mapping the Discharge Process
• “Gemba” – the importance of observation
• Next steps
Mission

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

Reduce all cause, all payer, 30 day readmissions by 20% from the 2010 baseline

Reduce hospital reported readmission rate for pilot unit by 20% from June 2014 baseline
Measuring Processes to Reach Goals

• Increase the number of patients in the pilot unit or population who undergo assessment for risk of readmission to 95%.

• Increase number of patients in the pilot unit or population who are assessed to be at high risk of readmission who are scheduled for a follow-up physician visit within 7 days of discharge from hospital to 95%.

• Increase the number of patients in the pilot unit or population who are assessed to be at high risk of readmission who receive a follow-up visit or telephone call to 95%.

• Test and implement process improvements in four key areas: enhanced assessment of post-hospital needs, effective teaching/enhanced learning, ensuring post-hospital care follow-up and providing real-time handover communications.

• 10% improvement or national 25th percentile in scores on four HCAHPS dimensions
Methods

• Pilot Unit / Spread to other units
• Multidisciplinary tiered project team
• **Assessment of 5 recent readmissions**
• Observations
• Process maps
• Risk assessment
• Follow up appointments and follow up calls or visits
Methods

• Test improvement in 4 key areas:
  – Enhanced assessment of patient post-hospital needs
  – Effective teaching and enhanced patient learning
  – Ensuring post-hospital care follow-up
  – Providing real-time handover communications

• Implement and spread improvements
• Community engagement readiness assessment
• Community cross continuum team
Methodology Background

- Transforming Care at the Bedside (TCAB)
- Hospital to Home (H2H)
- STate Action on Avoidable Rehospitalizations (STAAR)
Determinants of Preventable Readmissions

- Patients with generally worse health and greater frailty are more likely to be readmitted.
- Identification of determinants does not provide a single intervention or clear direction for how to reduce their occurrence.
- There is a need to address the tremendous complexity of variables contributing to preventable readmissions.
- Importance of identifying modifiable risk factors (patient characteristics and health care system opportunities).
- Preventable hospital readmissions possess the hallmark characteristics of healthcare events prime for intervention and reform > leading topic in healthcare policy reform.

Determinants of preventable readmissions in the United States: a systematic review

Reliable, Evidence-based Care in all Care Settings

- Hospitals
- Ambulatory Care Clinics
- Skilled Nursing Facilities
- Home
- Home Care & Community Resources
• Effective patient and caregiver education and self management training during hospitalization and after discharge
• Anticipatory guidance for self care needs at home
• Reliable referral for home health care visits
• Effective management and communication of changes in medication regimens
• Timely and clinically meaningful communication (handoffs) between care settings
• Early post-acute care follow-up
• Proactive discussion of advance care planning and end of life preferences
Key Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home

1. Perform an Enhanced Assessment of Post-Hospital Needs
2. Provide Effective Teaching and Facilitate Learning
3. Provide Real-Time Handover Communications
4. Ensure Post-Hospital Care Follow-Up
### Number of Process Changes Related to the 4 Key Changes

<table>
<thead>
<tr>
<th>Key Changes</th>
<th>CMWF/IHI STAAR Initiative</th>
<th>SHM Project BOOST</th>
<th>Project RED</th>
<th>ACC/IHI Hospital to Home (H2H)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Perform Enhanced Admission Assessment for Post-Hospital Needs</td>
<td>1 ➔ 2 ➔ 3</td>
<td>1 ➔ 2</td>
<td>1</td>
<td>1 ➔ 2</td>
</tr>
<tr>
<td>II. Provide Effective Teaching and Facilitate Learning</td>
<td>1 ➔ 2 ➔ 3</td>
<td>1 ➔ 2 ➔ 3</td>
<td>1 ➔ 2 ➔ 3 ➔ 4</td>
<td>1 ➔ 2</td>
</tr>
<tr>
<td>III. Conduct Real-Time Patient and Family-Centered Handoff Communication</td>
<td>1 ➔ 2 ➔ 3 ➔ 4</td>
<td>1 ➔ 2 ➔ 3 ➔ 4</td>
<td>1 ➔ 2 ➔ 3</td>
<td></td>
</tr>
<tr>
<td>IV. Ensure Post-Hospital Care Follow-Up</td>
<td>1 ➔ 2</td>
<td>1</td>
<td>1 ➔ 2 ➔ 3</td>
<td>1</td>
</tr>
</tbody>
</table>
IHI’s Roadmap for Improving Transitions & Reducing Avoidable Rehospitalizations

Transition from Hospital to Home
- Enhanced Assessment
- Teaching and Learning
- Real-time Handover Communications
- Follow-up Care Arranged

Post-Acute Care Activated
- MD Follow-up Visit
- Home Care (as needed)
- Social Services (as needed)
  or
- Skilled Nursing Facility Services
- Hospice/Palliative Care

Supplemental Care for High-Risk Patients *
- Transitional Care Models
- Intensive Care Management (e.g. Patient-Centered Medical Homes, HF Clinics, Evercare)

* Additional Costs for these Services

Improved Transitions & Coordination of Care

Reduction in Avoidable Rehospitalizations

Patient and Family Engagement
Cross Continuum Team Collaboration
Evidence-based Care in All Clinical Settings
Health Information Exchange & Shared Care Plans
How-to Guide:
Creating an Ideal Transition Home to Reduce Avoidable Rehospitalizations
Avoid Assumptions
# Worksheet A: Chart Reviews of Patients Who Were Readmitted

Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses from the hospital and community settings. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients.

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
<th>Patient #4</th>
<th>Patient #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between the last discharge and this readmission date?</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
</tr>
<tr>
<td>Was the follow-up physician visit scheduled prior to discharge?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, was the patient able to attend the office visit?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Were there any urgent clinic/ED visits before readmission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Functional status of the patient on discharge?</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was a clear discharge plan documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was evidence of “Teach Back” documented</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>List any documented reason/s for readmission</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Reflective Summary of Chart Review Findings

- What did you learn?
- What trends or themes emerged?
- What, if anything, surprised you?
- What new questions do you have?
- What are you curious about?
- What do you think you should do next?
- What assumptions about readmissions that you held previously are now challenged?
Worksheet B: Interviews with Patients, Family Members and Care Team Members

- **Ask Patients and Families:**
  - How do you think you became sick enough to come back to the hospital?
  - Did you see your doctor or the doctor’s nurse in the office before you came back to the hospital?
    - Yes
    - If yes, which doctor (PCP or specialist) did you see?
    - No
    - If no, why not? Describe any difficulties you had to get an appointment or getting to that office visit.
  - Has anything gotten in the way of your taking your medicines?
  - How do you take your medicines and set up your pills each day?
  - Describe your typical meals since you got home.

- **Ask Care Team Members:**
  - What do you think caused this patient to be readmitted?
  - After talking to the provider and the care team about why they think the patient was readmitted, write a brief story about the patient’s circumstances that contributed to the readmission:

NoCVA Hospital Engagement Network
Summary of Interview Findings

- What did you learn?
- What were the most common failures discovered?
- What trends or themes emerged?
- What, if anything, surprised you?
- What new questions do you have?
- What are you now curious about?
- What do you think you should do next?
- What assumptions about readmissions that you held previously are now challenged?
Process Mapping

Linda Touvell McNeill, BSN, RN
CCME Care Improvement Specialist

May 5, 2014
What is a Process Map?

A visual step-by-step diagram of a process in sequential order using symbols.
Why a Process Map?

• Insight
• Illustration
• Complete picture of current process
• Identify areas for improvement
• Comparison
Simple Tools

Flow charts use three shapes

- Activity or task
- Direction
- Question or decision point
Where to Start

• Define the process to be mapped.

• Discuss and decide on the boundaries of your process.

• Discuss and decide on the level of detail to be included in the diagram.
High-level Flow Chart

- 3–6 blocks
- Large chunks of information

1. Identify process to be mapped
2. Create high level flow chart
3. Create a detailed map
4. Analyze the map
5. PDSA area chosen for improvement
Brainstorm Activities

- Get materials
- Find a meeting space
- Explain the exercise
- Invite team, include other departments/staff involved
- Determine length of meeting
- Write down all the activities that occur in each step
- Sequence the activities
- Define the beginning, end of the process to be mapped
- Ask someone with mapping experience to facilitate
Create the Flow Chart

1. Ask someone with experience to facilitate
2. Determine meeting time/date/space
3. Schedule meeting space
4. Explain the exercise
5. Gather needed materials
6. Invite team & include other departments
7. Define the boundaries of the process
8. Write down all the activities
9. Sequence the activities

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Verify Results

- Review with others
- Solicit feedback
- Make adjustments
Analyze the Exercise Information

• What events drive the process?

• What activities can be streamlined?

• Do any activities impact the patient negatively?

• Do any activities affect the patient positively?

• Suggestions for improvement?
PDSA

Identify an area to test a change (n = 1)
Tips for Successful Mapping

• Map the current process--not what you want or what the protocol says

• Involve stakeholders from the beginning

• Map *only* the process you want to improve

• Set expectation of safety

• Remember to cross department boundaries
BRRH: Patient Discharge Process Steps

**Step 1: Pre-discharge**
- **Staff Involved:**
  * Nursing Staff
  * Physician on Floor
- **Workflow:**
  1. Floor Nurse starts preparation of discharge instructions for patient during hospitalization
  2. Floor Nurse reviews new medications with patient as they are ordered
  3. Physician writes discharge orders

**Step 2: Case Management**
- **Staff Involved:**
  * Case Manager
- **Workflow:**
  1. Case Manager arranges HH (if needed)
  2. Case Manager helps patient with arrangements to pay for medications when discharged
  3. Case Manager arranges placement of patient if unable to return home to Skilled Nursing Facility

**Step 3: Follow-up Appointments**
- **Staff Involved:**
  * Nursing Staff
  * Unit Secretary
- **Workflow:**
  1. Unit Secretary schedules follow-up appointment with patient’s primary care physician
  2. Unit Secretary schedules any follow-up appointments with ancillary departments (if needed)
  3. Floor Nurse checks that follow-up appointments are correct and have been scheduled

**Step 4: Patient Discharge**
- **Staff Involved:**
  * Nursing Staff
  * Volunteer
- **Workflow:**
  1. Discharge checklist reviewed and completed
  2. Charge/Floor Nurse reviews discharge instructions and medications with patient
  3. Patient escorted out by Volunteer or Staff in wheelchair or ambulating if patient is able
  4. Patient is accompanied by Volunteer or Staff until ride arrives and patient leaves the facility
Your Action Item

- Process map of the discharge process
- Complete by June 18 and bring to F2F meeting
Questions?

lmcneill@thecarolinascenter.org

The Carolinas Center for Medical Excellence

www.ccmemedicare.org • (NC) 800-682-2650 • (SC) 800-922-3089

This material was prepared by The Carolinas Center for Medical Excellence (CCME), the Medicare Quality Improvement Organization for North and South Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-NC-C8-14-32
## Timeline

<table>
<thead>
<tr>
<th>Task</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>Complete leadership assessment and review on leadership 1:1 call</td>
<td>By May 19</td>
</tr>
<tr>
<td>Recruit and convene multidisciplinary, tiered, cross continuum project team</td>
<td>By May 5</td>
</tr>
<tr>
<td>Develop or review risk assessment; plan piloting or spread of risk assessment</td>
<td>By May 5</td>
</tr>
<tr>
<td>Prework Webinar #2: Observation of Patient Discharge Process and Process Mapping</td>
<td>May 5</td>
</tr>
<tr>
<td>Complete IHI Diagnostic Assessment of 5 recent readmissions</td>
<td>By June 18</td>
</tr>
<tr>
<td>Develop process map of patient discharge</td>
<td>By June 18</td>
</tr>
<tr>
<td>Prework Webinar #3: Data Overview</td>
<td>May 19</td>
</tr>
<tr>
<td>Develop plan to collect, submit and use your data</td>
<td>By June 18</td>
</tr>
<tr>
<td>In-person Learning Session</td>
<td>June 18</td>
</tr>
</tbody>
</table>
For more information, contact:

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

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

Dean Higgins, Project Manager, dhiggins@ncha.org