Best Practices for Better Care: Hospital Readmissions

Debra Picone, PhD, RN
Quality and Safety Engineer
Office of Clinical Quality, Safety and Performance Improvement

National Readmission Statistics

- 17.6% Medicare Patients readmitted within 30 days (2005)
  - 1 in 5 are back in hospital within a month
  - 13% were related admissions
  - Cost $17 billion for returned trips

- 10% ETC visits are due to complications related to a recent hospitalization (2008)

- Most readmissions occur with the 1st week post discharge with the highest volume on the 2nd day post discharge

- CMS Revenue Forfeited
  - 30-day readmission rate > national average
    - 2,200 hospitals face penalty; 278 (9%) face maximum penalty
CMS Target Populations

- 2012/2013
  - AMI
  - CHF
  - Pneumonia
  - Hospital-Wide Readmission (HWR)
  - Total Hip Arthroplasty (THA)
  - Total Knee Arthroplasty (TKA)
- 2014 Proposed
  - COPD
  - Stroke

Premise

- Readmissions result from a “fragmented system or care”
  - Leave patients to their own devices
  - Patients unable to follow instructions they do not understand
    - Chronic disease and new disease onset
    - Health Literacy Issues
  - No follow-up care and
  - Not taking their medications or too many meds
- Most readmissions may be corrected with quality care
  - Not all readmissions can be prevented
- Better care in the hospital
- Better care in the home
The Revolving Door: A Report on U.S. Hospital Readmissions
By: Dartmouth Atlas Project, and Perry Undem Research & Communications
Publisher: Robert Wood Johnson Foundation
Published: 2/11/2013

“shows that hospitals and their community allies made little progress from 2008 to 2010 at reducing hospital readmissions for elderly patients”

Percent of Patients Readmitted within 30 Days of Discharge
2010 Readmission Percentages by Hospital Referral Region

This interactive map demonstrates variation in readmission rates for Medicare patients after they are discharged from the hospital for medical or surgical conditions. This data show age, sex, and race-adjusted 30-day readmission rates by hospital referral regions for 2010. Hospital referral regions represent regional health-care markets for tertiary medical care. The data from the Centers for Medicare & Medicaid Services on 100 percent sample of fee-for-service Medicare beneficiaries who needed in the hospital referral regions and had Part A and Part B coverage. Discharges are identified as medical or surgical using the Medicare diagnostic-related group (DRG) system. Hospitalizations with the same DRG are counted as a single hospitalization. Readmissions of patients who were transferred to another hospital are counted if they met the criteria above. Patients are excluded when the patient had any inpatient hospitalization in the 90 days prior to cohort admission date. This differs from the CMS definition which only excludes acute care hospitalizations in the 30 days prior to cohort admission date.

National Initiatives

- Case management to address discharge needs at admission
- Pharmacist involvement
  - Rounding, reduce poly-pharmacy, medication reconciliation
- Multidisciplinary Discharge-Planning Tools
  - Daily team meetings/rounds/huddles
  - Forms and tools for communication
    - Risk assessment
    - Discharge checklist
    - Medication calendar
    - Unit based report cards
    - White boards
National Initiatives

• Education of Patient/Caregiver
  – Teach back methods
    • I hear I forget
    • I see and I remember
    • I do and I understand
  – Caregiver fills in the gaps

• Arrange patient contact within 48-72 hours of discharge
  – Review discharge instructions, confirm understanding of follow-up care, counsel as needed

• Make follow-up appointments within two days of discharge
  – Follow-up to be sure patient kept the appointment

National Initiatives

• Community partnership with clinics, physicians, home health, LTC, and support groups

• Readmission performance feedback
  – Drill down to cause
  – Physician specific
  – Administration data review
<table>
<thead>
<tr>
<th>Barriers</th>
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<tbody>
<tr>
<td><strong>Patient</strong></td>
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<tr>
<td>- Medication non-adherence</td>
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<tr>
<td>- Lack of access to primary care</td>
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<tr>
<td>• 25% do receive follow-up care</td>
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<tr>
<td>- Health literacy</td>
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<tr>
<td>• &lt;50% of patients can articulated diagnosis, treatment plan or side effects of medication</td>
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<tr>
<td><strong>Provider/System</strong></td>
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<tr>
<td>- Staffing limited for tight management of care transitions</td>
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<td>- Communication with PCP</td>
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<tr>
<td>• Direct communication occurs &lt;20% of time</td>
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<td>- Test Management</td>
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<td>• 66% of PCP do not know results of tests done during the hospitalization but not available at time of discharge</td>
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<td>• 10% of these require follow-up</td>
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<td>- Failure to investigate reason for non-adherence</td>
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<table>
<thead>
<tr>
<th>What were we doing to Prevent Readmissions?</th>
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<tbody>
<tr>
<td>- Follow-up telephone calls</td>
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<tr>
<td>- NICU, Burn Unit, Oncology, Cardiology, General Medicine</td>
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<tr>
<td>- Discharge Checklist</td>
</tr>
<tr>
<td>- NICU</td>
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<tr>
<td>- Timely follow-up appointments</td>
</tr>
<tr>
<td>- NICU</td>
</tr>
<tr>
<td>- My Discharge Plan</td>
</tr>
<tr>
<td>- White Boards</td>
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<tr>
<td>- All units</td>
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</table>
My Discharge Plan

**MY DISCHARGE PLAN**

- Planning for your care (Ask your care team or hospital environment to come and see us) to help you feel comfortable, please see this information. It will help to make sure that everything is in order before you leave. Each member of your care team will speak with you before you leave. We want you to feel comfortable and safe. Please let us know how we can help.

- What can we do to help you
- Cut down on your hospital length of stay.
- Questions to ask the care team before leaving the hospital.
- Questions to ask your care team.
- Questions to ask the care team when you leave.

**MY CARE TEAM**

- My Doctor’s Name and Phone Number

**WHO SHOULD I CALL IF I HAVE A PROBLEM?**

<table>
<thead>
<tr>
<th>Hospital Phone Number</th>
<th>Local: 319-356-1234</th>
<th>Toll-Free: 866-777-847</th>
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</thead>
</table>

**QUESTIONS AND NOTES**

Thank you for letting us care for you.

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**Best Practices for Better Care**

- Joint venture initiated by Association of American Medical Colleges (AMC) and University HealthSystem Consortium (UHC)
- Ensure safer surgery through use of surgical checklists
- Reduce infections from central lines using proven protocols
- Reduce hospital readmissions for high-risk patients
- Teach quality and patient safety to the next generation of doctors
- Research, evaluate, and share new and improved practices
BPBC Tool Kit (UHC and Society of Hospital Medicine)

• Process Tools
  – Project Charter
  – Gap Analysis
  – Implementation Plan

• Networking
  – Peer Hospitals
  – Experts

• Reference Materials
  – Webinars, Articles, BOOST

• Data Collection
  – Front line surveys and ongoing data collection

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*Percent of Total Admissions Readmitted*

- **AMI**
- **CHF**
- **PNEUM**

![Graph showing percent of total admissions readmitted for AMI, CHF, and PNEUM categories over time.](image-url)
Time Table with Deliverables

<table>
<thead>
<tr>
<th>Task</th>
<th>Dates</th>
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<tbody>
<tr>
<td>Enrollment</td>
<td>Ends July 1, 2012</td>
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<tr>
<td>Baseline data collection</td>
<td>Through July 24, 2012</td>
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<tr>
<td>Informational conference calls</td>
<td>June 5 and 26, 2012</td>
</tr>
<tr>
<td>Project charter submission deadline</td>
<td>July 24, 2012</td>
</tr>
<tr>
<td>Gap analysis complete</td>
<td>July 24, 2012</td>
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<tr>
<td>Collaborative conference call #1</td>
<td>July 24, 2012</td>
</tr>
<tr>
<td>Implementation plan complete</td>
<td>August 2012 - Implementation November 2012</td>
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<tr>
<td>Collaborative conference calls #2-#11</td>
<td>Monthly August 2012 - July 2013</td>
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<tr>
<td>2nd Front Line Staff Survey</td>
<td>September 2012</td>
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<tr>
<td>Implementation</td>
<td>November 2012</td>
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<td>3rd Front Line Staff Survey</td>
<td>April 2013</td>
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<tr>
<td>Knowledge transfer Web conference</td>
<td>February 12, 2013</td>
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<tr>
<td>Midyear checkup call</td>
<td>July 2013</td>
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Phase 1 Plan (1-3 months)

- Institutional Support
- Form Multidisciplinary Team
- Complete Charter
  - Goals/Objectives/Return on Investment
- Analyze Current Processes
- Review Baseline Data
Better Practices for Better Care (BPBC) – AAMC/UHC Project

Executive sponsor – Dick LeBlond
BPBC Coordinator – Debra Picone
Data Liaison – Debra Picone and Mary Kay Brooks
Readmissions Project
Project liaison – Debra Picone
Physician liaison – Chaitanya Are

Team Members:
Linda Abbott, RN
Sam Gurian, RN
Kelly Ernst, RN
Eric Linson, Administrator
Anita LeBlond, Hospitalist
Dave Weetman, Pharmacist
Jeanette Muller, RN Navigator
Karen Hanson, RN Navigator
Hillary Mosher, MD
Rosemary Wilhelm, Social Worker
Taj Jaheen, MD
Ben Perry III, MD

IHC IQ

Project Charter
THE TOOL KIT

Due: July 24, 2012
To: Laurie Hersh

Project: Reducing Preventable Readmissions Improvement Collaborative – 2012
Schedule: August 2012 – 12 months

Your name, organization and email:

1. PROJECT TITLE AND BRIEF DESCRIPTION
   Reduce the 7-day and 30-day readmission rate for all causes for three select patient populations. This project will focus on the implementation of select evidenced-based interventions to reduce readmissions.

2. PERFORMANCE OPPORTUNITY/SCOPE
   - The project will focus on three patient populations: AMI, CHF, CAP admitted to IRP, ICU, ER/EM/PCU.

3. CASE-OF-CHANGE (Potential ROAs)
   a. Reduction of Readmission Rate at all causes
   b. Implementation of best practices to prevent readmission
   c. Improved patient discharge experience and follow-up

4. STRATEGIES TO BE IMPLEMENTED
   a. Follow-up appointments within 7 days of discharge
   b. Telephone follow-up within 72 hours of discharge
   c. Complete comprehensive readmission risk assessment and discharge readiness assessment. (Use multidisciplinary team to implement discharge plan based on assessed needs)
   d. Use teach-back technique to assess patient/caregiver understanding of Health Care needs and care
   e. Provide written discharge instructions to family/caregiver and summary of PCP plan of discharge
   f. Complete medication reconciliation on admission and discharge

5. PERFORMANCE MEASURES
   a. Baseline
   b. Goal

December 2012
Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-day readmission rate all selected diagnoses (related and unrelated)</td>
<td>5.1</td>
<td>20% reduction</td>
</tr>
<tr>
<td>30-day readmission rate AMI, Pneumonia, CHF (related and unrelated)</td>
<td>Data Not Available</td>
<td>20% reduction</td>
</tr>
<tr>
<td>Percent of cases for which there is documentation (defined as description of date/time/location) of a follow-up appointment was coordinated within 7 days after discharge.</td>
<td>10%</td>
<td>20% improvement</td>
</tr>
<tr>
<td>Percent of cases for which there is documentation of a follow-up phone call within 72 hours of discharge.</td>
<td>20%</td>
<td>20% improvement</td>
</tr>
<tr>
<td>Percent of cases for which the discharge summary was completed and transmitted/made available to post acute provider within 72 hours.</td>
<td>10%</td>
<td>20% improvement</td>
</tr>
<tr>
<td>Percent of cases for which a comprehensive risk assessment was performed within 24 hours of admission.</td>
<td>0%</td>
<td>20% improvement</td>
</tr>
<tr>
<td>Percent of cases for which defined and separate lists of discontinued, new, and continued medications are present in the medical record.</td>
<td>100%</td>
<td>100%</td>
</tr>
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Reducing Readmissions Collaborative - Gap Analysis

Project: Reducing Readmissions Collaborative
Institution Name: University of Iowa Hospitals and Clinics
Individual Completing This Form: Debra Sicone

<table>
<thead>
<tr>
<th>Suggested Best Practice</th>
<th>Suggested Best-Practice Strategy</th>
<th>Identify barriers to best practice implementation, Consider systems, procedures, people, equipment, etc.</th>
<th>Will your team choose to implement this practice or component of care? If not, explain why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify trends in readmitted patients across your organization</td>
<td>Not done</td>
<td>Data base compiled and measures personnel recently assigned to conduct the review for these populations.</td>
<td>Yes</td>
</tr>
<tr>
<td>Conduct a select chart review of readmitted patients to identify underlying issues that resulted in readmission and prepare for implementation of process change.</td>
<td>Initiated for last quarter for high risk populations that data have not been disseminated.</td>
<td>No process for data dissemination established.</td>
<td>Yes</td>
</tr>
<tr>
<td>MONITOR readmission rates by diagnosis, practitioner, source, and time frame and provide feedback to providers and units.</td>
<td>Recently completed for hospital staff only</td>
<td>UHC will provide for diagnosis.</td>
<td>No assigned resources available to analyze and disseminate data.</td>
</tr>
<tr>
<td>Help patients make follow-up appointment within 7 days of hospital discharge including date, location, and time of appointment.</td>
<td>Practice rates across departments of whether follow-up appointments are scheduled before the patient is discharged. Conducting a pilot project with a discharge planner that assigns the patient in the planning and preparation for discharge that includes identification of follow-up needs.</td>
<td>Appointments may not be available within 7 days. Our patients are from large geographical areas and connecting with a PCP before discharge is difficult. Many patients do not have a PCP and there is no process for assisting patient to identify/schedule PCP.</td>
<td>No established policy and procedure for scheduling follow-up appointments with PCP. Exit home with statement patient to...</td>
</tr>
</tbody>
</table>
Implementation Phase 2 (4-6 Months)

- Redesign Care Process
- Engage Staff in Input and Education
- Develop Policies, procedures, forms and other tools
- Evaluate Metrics

Ideal Process Chart: Patient Discharged To Home
Implementation Plan

Project: LPBC Readmissions
Individual Completing This Form: Debra Picone, RN

| Scheduled | Team | Targeted Completion | Actual Completion | Performance Issues | Communication and/or Training Schedule: | Communication and/or Training Completion: | Implementation Status | Implemented
|---------------------|------|---------------------|-------------------|--------------------|------------------------------------------|-------------------------------------------|-----------------------|---------------------
| Initial Visit - Admission Assessment | O. Picone | 10/1/2012 | 11/1/2012 | n | 10/1/2012 | 11/1/2012 | n | 11/1/2012 | 11/1/2012 |
| 1st follow-up visit - 1 week | O. Picone | 10/1/2012 | 11/1/2012 | n | 10/1/2012 | 11/1/2012 | n | 11/1/2012 | 11/1/2012 |
| 2nd follow-up visit - 1 month | O. Picone | 10/1/2012 | 11/1/2012 | n | 10/1/2012 | 11/1/2012 | n | 11/1/2012 | 11/1/2012 |
| 3rd follow-up visit - 3 months | O. Picone | 10/1/2012 | 11/1/2012 | n | 10/1/2012 | 11/1/2012 | n | 11/1/2012 | 11/1/2012 |
| 4th follow-up visit - 6 months | O. Picone | 10/1/2012 | 11/1/2012 | n | 10/1/2012 | 11/1/2012 | n | 11/1/2012 | 11/1/2012 |
| 5th follow-up visit - 1 year | O. Picone | 10/1/2012 | 11/1/2012 | n | 10/1/2012 | 11/1/2012 | n | 11/1/2012 | 11/1/2012 |

Admission Assessment
**Goal:** Perform a comprehensive readmissions risk assessment at the time of admission including: prior hospitalization, polypharmacy, high risk for readmit disease status.

<table>
<thead>
<tr>
<th>Goal: Perform a comprehensive readmissions risk assessment at the time of admission including: prior hospitalization, polypharmacy, high risk for readmit disease status.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacist</strong></td>
</tr>
<tr>
<td>Review the 8P form and how to use</td>
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### 8P Risk Assessment Tool

<table>
<thead>
<tr>
<th>Risk Factor for Readmission</th>
<th>Risk Specific Interventions</th>
</tr>
</thead>
</table>
| Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) | □ Medication specific education using Teach Back provided to patient and caregiver  
□ Monitoring plan developed and communicated to patient and caregivers, where relevant (e.g. monitoring, digoxin and warfarin)  
□ Specific strategies for managing adverse drug events reviewed with patient/caregiver  
□ Follow-up phone call at 72 hours to assess adherence and complications (Navigator or designated RN) |
| Psychological (depression screen positive or h/o depression diagnosis) | □ Assessment of need for psychiatric aftercare if not in place  
□ Communication with aftercare provider, highlighting the issue if new  
□ Communication with aftercare providers, highlighting the issue if new  
□ Consult Social Service to assist with involvement/awareness of support network in place |
| Principal diagnosis (cancer, stroke, DM, COPD, heart failure) | □ Disease specific education using Teach Back with patient/caregiver (all providers)  
□ Action plan reviewed with patient/caregiver regarding what to do and who to contact in the event of worsening or new symptoms (all providers)  
□ Disease goals of care and chronic illness model discussed with patient/caregiver  
□ Discuss goals of care and chronic illness model discussed with patient/caregiver |
| Polypharmacy (≥10 more routine meds) | □ Notify pharmacist to assist with elimination of unnecessary medications  
□ Notify pharmacist to assist with simplification of medication scheduling to improve adherence  
□ Follow-up phone call at 72 hours to assess adherence and complications (Navigator or designated RN) |
| Poor health literacy (inability to do Teach Back) | □ Committed caregiver involved in planning/administration of all general and risk specific interventions  
□ Aftercare plan education using Teach Back provided to patient/caregiver  
□ Link to community resources for additional patient/caregiver support  
□ Follow-up phone call at 72 hours to assess adherence and complications (Navigator or designated RN) |
| Patient Support (absence of caregiver to assist with discharge and home care) | □ Follow-up phone call at 72 hours to assess adherence and complications (Navigator or designated RN)  
□ Follow-up appointment with discharge medical provider within 7 days  
□ Follow-up appointment with discharge medical provider within 7 days |
| Prior Hospitalization | □ Review admissions for risk determinants of readmission  
□ Review discharge summary for risk determinants of readmission  
□ Review discharge summary for risk determinants of readmission  
□ Order specific interventions as identified on the 8P tool |
| Planning (Advanced Care) | □ Assure “Honor Your Care Wishes” are completed. If not contact Neana Clark via e-mail to arrange a facilitator to meet with patient to complete  
□ For chronic symptom management consider consult to palliative care |

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### Goal: Educate the patient about post discharge needs

<table>
<thead>
<tr>
<th>Patient</th>
<th>Unit Clerk</th>
<th>Name</th>
<th>Social Worker</th>
<th>Physicians/Nurse Practitioner</th>
<th>Team</th>
<th>Questions/To Do</th>
</tr>
</thead>
<tbody>
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</table>

- Complete a discharge planner for each patient to assist in releasing the patient.
- Ensure that each patient has a discharge planner.
- Give the patient the education information after discussing the diagnosis.
- Teach content in stages to build repetition and reinforce understanding.
- Conduct and reinforce teaching using teach-back techniques.
- Report on patient progress at end of shift report.
- Print off patient education instructions on day of admission and give to the patient.
- Teach content in stages to build repetition and reinforcement.
- Conduct and reinforce teaching using teach-back techniques.
- Identify patients who are unable to understand and/or comply with the discharge instructions.
- Identify interventions to assist these patients.
- Roll out discharge planners to 4RC and 6RC.
- Reinforce teach-back education (develop power point presentation).
- Discuss at Bed-huddles regarding the discharge planner.
- Check pneumonia education to make sure it emphasizes finishing antibiotic and call in if not feeling better.

### Goal: Help patients make a follow-up appointment within 7 days of hospital discharge including date, location, and time of appointment

<table>
<thead>
<tr>
<th>Social Service</th>
<th>Unit Clerk</th>
<th>Name</th>
<th>Physicians/Nurse Practitioner</th>
<th>Team</th>
<th>Questions/To Do</th>
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- Assist in finding follow-up appointments for patients who do not have insurance or may not get this opportunity and need home health services.
- Contact the PCP or Physician office to make the appointment when ordered..
- Update the contact information for the PCP on admission assessment and provide changes to unit clerk.
- Identify the physician responsible for following up.
- Physician to order 7 day F/U appointment in EPIC as soon there is an idea of discharge date (day 2 or day 3).
- Discuss at Bed-huddles regarding the follow-up appointment and PCP.
- What if no appointment available within 7 days?
  - Consider VNA
  - Consider Home Health
  - Try Internal Medicine or Free clinic
- Can we request priority for discharge patients for 7 day appointments through scheduling?
- Dashboards need to be updated with columns for PCP.
- Make EPIC report of patients without PCP.
**Goal:** Arrange contact by telephone within 72 hours of discharge in order to assess the patient’s condition, adherence, and to reinforce follow-up.

<table>
<thead>
<tr>
<th>Telephone Contact</th>
<th>Unit Clerk</th>
<th>Nurse Navigator</th>
<th>Physicians/Nurse Practitioner</th>
<th>Team</th>
<th>Questions/To Do</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Use scripted telephone encounter to assess patient’s conditions, adherence to plan and scheduled follow-up (PCP/test or labs)</td>
<td>Contact LP for concerns or questions</td>
<td>Revisit telephone encounter documentation</td>
<td>Note designee for 4RC</td>
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<td>Designate weekend follow-up</td>
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<td>Develop a report in EPIC to determine who needs f/u phone call</td>
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<td>Correct CHF education (Kelly will lead)</td>
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</tbody>
</table>

**Goal:** Deliver the discharge information/plan directly to post-hospitalization care providers

<table>
<thead>
<tr>
<th>Registration</th>
<th>Unit Clerk</th>
<th>Nurse Navigator</th>
<th>Social Worker</th>
<th>Physicians/Nurse Practitioner</th>
<th>Team</th>
<th>Questions/To Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase emphasis on obtaining PCP information</td>
<td>Use scripted telephone encounter to assess patient’s conditions, adherence to plan and scheduled follow-up (PCP/test or labs)</td>
<td>Complete discharge summary at the time of discharge or no later than 72 hours post discharge and send to PCP</td>
<td>Ensure communication of planned discharge to all team members</td>
<td>Contact Susan to discuss PCP identification in registration process</td>
<td>Monday unit clerk to enter PCP information for weekend?</td>
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</table>
Goal: Complete a comprehensive admission and discharge medication reconciliation using the patient’s medication list, teach ADE management

<table>
<thead>
<tr>
<th>Patient</th>
<th>Nurse/Service</th>
<th>Staff</th>
<th>Pharmacist</th>
<th>Physician/Nurse Practitioner</th>
<th>Team</th>
<th>Operation/Role</th>
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<tr>
<td>Drug use and existing medications and medications using discharge plans?</td>
<td>Access with access to medication application</td>
<td>Residence, pharmacists doing medication using teach-back</td>
<td>Access with access to medication application</td>
<td>Residence, pharmacists doing medication using teach-back</td>
<td>Complete medication reconciliation if not done</td>
<td>Residence, pharmacists doing medication using teach-back</td>
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<td></td>
<td>Build EPIC report and work with pharmacists</td>
</tr>
</tbody>
</table>

Staff Education Plan

- Staff were involved every step of the process including creating workflows and accountability
- Group and Individual Meetings with Nursing Staff and Physicians
  - Overview
  - Unit specific data
  - Interventions
  - Teach back video
# Interventions and Accountability

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Primary Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Redmission Risk Assessment</td>
<td>Physician, Nurse Navigator (Assist)</td>
</tr>
<tr>
<td>2. Verification of PCP</td>
<td>Nurse, Unit Clerk (documentation)</td>
</tr>
<tr>
<td>3. Medication Reconciliation</td>
<td>Pharmacist, Physician (verify)</td>
</tr>
<tr>
<td>4. Return Appointment ≤ 7 days</td>
<td>Physician (order), Scheduler (UIC Health), Unit Clerk (Outside UIHC), Social Worker (when no PCP)</td>
</tr>
<tr>
<td>5. Discharge Instructions</td>
<td>Physician (order), Nurse (AVS)</td>
</tr>
<tr>
<td>6. Discharge Summary to PCP</td>
<td>Physician</td>
</tr>
<tr>
<td>7. 272 Hour telephone follow-up</td>
<td>Nurse Navigator, Designee (ARC)</td>
</tr>
<tr>
<td>8. Patient Education</td>
<td>ALL</td>
</tr>
<tr>
<td>9. Redmission Data</td>
<td>CQSPI</td>
</tr>
</tbody>
</table>

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## Intervention Phase 3 (6-9 Months)

- Monitor functioning of each intervention
- Reassess evaluation plan
- Keep stakeholders apprised of progress
Surveillance Phase 4 (10-12 Months and Beyond)

- Analyze data
- Adjust interventions
- Report to stakeholders and continue process or monitor/review/report
- Reinfuse
Questions?