The Military Health System's

PARTNERSHIP FOR PATIENTS CAMPAIGN

SAFE CARE SAVES LIVES

Implementation Guide for Readmissions

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

PARTNERSHIP FOR PATIENTS

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Contents

1. Introduction

This implementation guide was created to support the Partnership for Patients, a national initiative sponsored by the Department of Health and Human Services to reduce harm in health care facilities. Military Health System leadership has pledged its support to the PfP, and has made a commitment to specific, identified aims. Improving the quality and safety of health care in all Department of Defense facilities will only be possible with universal support at *every* level in the MHS.

This guide is one of 10 harm-specific guides designed to assist you as you implement identified evidence-based practices to improve patient care. Common to all guides are resources that support efforts to educate the health care team by providing MHS-selected EBPs and quality improvement strategies.

In addition, implementation strategies and tools relevant to all harm categories are included in an additional guide titled "Practical Applications for Process Improvement and Change Management." This guide supports efforts to equip the health care team with rapid-cycle process improvement methods and engage the health care team through the use of change management strategies.

2. Readmissions Evidence-Based Practices

2.1 Background Information

Hospital readmissions within 30 days may occur due to an unrelated diagnosis or a planned course of treatment, but they are coming under increased scrutiny due to the perception that some readmissions are the result of poor care or a lack of coordinated care and may be avoidable. In order to help patients heal without complications that may result in readmissions, the PfP has set the following goal:

By the end of 2013, preventable complications during a transition from one care setting to another will be decreased so that all hospital readmissions would be reduced by 20% compared to 2010.[1]

[1] *Partnership for Patients: Better Care, Lower Costs.* (2011, -) HHS. http://www.healthcare.gov/compare/partnership-for-patients/

While no agreed upon criteria exists to define preventable readmissions that might be preventable and those which might not be preventable, it is generally accepted that many could be avoided by developing a more cohesive plan of care that is clearly communicated to the patient and family upon discharge. For purposes of this PfP goal, the focus is on reducing all readmissions. The key components of this effort are medication reconciliation, communication handoff, post-discharge access and post-discharge plan of care.

30-Day Readmission Burden of Illness

- Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, costing approximately $26 billion annually
- An estimated 75 percent of Medicare readmissions are avoidable
- Approximately one in 12 adults discharged from the hospital will be readmitted within 30 days
- One-quarter of all readmissions within 30 days are unrelated by condition

Sources:

1. Roadmap to Better Care Transitions and Fewer Readmissions. DHHS. http://www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html. Accessed 6/12/12.
2. Sommers A, Cunningham, P. Physician Visits After Discharge: Implications for Reducing Readmissions. National Institute for Health Care Reform, 2011. http://www.nihcr.org/reducing_readmissions.html. Accessed 6/12/12.
3. Reid, G. Readmissions Costs Even Higher than Suspected. Healthcare Finance News, February 2012. http://www.healthcarefinancenews.com/news/readmission-costs-even-higher-suspected. Accessed 6/12/12.

2.2 Risk Factors

According to the HHS, several factors may affect the risk of unplanned, unintended readmissions[2]:

- Patient characteristics (demographics, socioeconomic status, behaviors and disease states)
- Activities and events associated with the delivery of care in the hospital setting
- Environmental factors (housing, transportation and formal/informal supports and services)

[2] *Roadmap to Better Care Transitions and Fewer Readmissions* (2012) Department of Health and Human Services. http://www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html

Many risk factors such as age, socioeconomic status and morbidity are not within the health care system's control; however, several other factors can be mitigated, including reconciling medications with the patient, improving communication and planning for effective care transitions. Inadequate transition planning is more likely to affect patients with terminal illnesses and multiple chronic medical and mental health conditions, especially if proper post-discharge support is not in place.

2.3 Evidence-Based Practice Guidelines

The MHS has selected the Project Re-Engineered Discharge intervention for implementation at all Military Treatment Facilities. Developed by a research group at Boston University Medical Center, Project RED is a bundle of EBPs which improves the hospital discharge process by promoting patient safety and reducing re-hospitalization rates.

The RED intervention includes 11 discrete, mutually reinforcing components and has been shown to reduce re-hospitalizations by as much as 30 percent[3,4]:

Evidence-Based Practice Guidelines for Readmissions Prevention (Project RED)

- Educate the patient about his or her diagnosis throughout the hospital stay.
- Make appointments for clinician follow-up and post-discharge testing.
- Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up on the results.
- Organize post-discharge services.
- Confirm the medication plan.
- Reconcile the discharge plan with national guidelines and critical pathways.
- Review the appropriate steps for what to do if a problem arises.
- Expedite transmission of the discharge summary to the physicians and other services accepting responsibility for the patient's care after discharge.
- Assess the degree of understanding by asking the patient to explain the details of the plan in their own words.
- Give the patient a written discharge plan at the time of discharge.
- Provide telephone reinforcement of the discharge plan and problem-solving two to three days after discharge.

Source:
Components of Project Re-engineered Discharge, https://www.bu.edu/fammed/projectred/components.html

[3] *Project RED: Re-Engineered Discharge homepage.* https://www.bu.edu/fammed/projectred/index.html
[4] *Project RED Takes Aim at the Blues. (2011)* News from Boston Medical Center. https://development.bmc.org/page.aspx?pid=567#story3

In an effort to improve the quality and safety of health care delivery, care management bundles have been created. ***A care bundle is a set of evidence-based interventions*** that, when used together, significantly improve patient outcomes. The Project RED Toolkit includes a bundle of EBPs, and tools to guide implementation and monitoring efforts.

Critical to a comprehensive discharge plan is confirmation and reconciliation of discharge medications. The Joint Commission's National Patient Safety Goal #3 addresses medication reconciliation, as it relates to patient safety, by requiring that organizations "maintain and communicate accurate medication information," and "compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies."[5]

The MHS has endorsed another intervention strategy in addition to Project Red, medication reconciliation, for use in all MTFs. The Institute for Healthcare Improvement's How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation) includes tools and resources to ensure that a patient's medication regime is coordinated with admission, transfer and discharge medication orders.

Evidence-Based Practice Guidelines for Medication Reconciliation (IHI)

- Collect the patient's medication list upon admission and obtain a detailed description of the medication. If this isn't possible, collect the list of home medications and compare it with the list of admission orders within 24 hours.
- When transferring the patient from one level of care to another, consult the patient's home medication list, current medication orders and the transfer orders.
- At discharge, consult the patient's home medication list and current medication orders and compare them with the discharge medication orders to ensure that medications are appropriately continued, resumed or discontinued. Share the list with the patient and next provider in care or the coordinator of care for that patient.

Source:
IHI How-to Guide: Prevent Adverse Drug Events by Implementing Medication Reconciliation
http://www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx Accessed 6/14/12.

[5] *National Patient Safety Goals*. (2012) The Joint Commission. http://www.jointcommission.org/standards_information/npsgs.aspx

2.4 MHS 30- Day Readmission Prevention Performance Measures

The MHS has selected the following process and outcome measures to track performance:

Descriptions	Data Source	Metric

• Average time to notify Patient Centered Medical Home about new admission
• Average time from admission to initiation of care plan – only for patients who meet all criteria
• Percent of patients' Primary Care Providers notified within 24 hours discharge
• **Percent of follow-up phone calls made within 48-72 hours**
• Percent of follow-up calls requiring second call by pharmacist (if non-pharmacist makes first call)
• Percent of patients completing post-discharge survey (30 days after discharge)
• Completion of care plan details
  ○ **Percent of care plans with medication list included**
  ○ Percent of care plans with care needs included (e.g., exercise, diet, main problem, when to call doctor)
  ○ **Percent of care plans with follow-up appointments listed**
  ○ Percent of care plans with pre-arranged discharge resources identified (e.g., home health, durable medical equipment)
  ○ Percent of care plans with pending tests listed
	Project RED	Process Measure

• OB, infants less than a year old and cancer patients are excluded	MHS PHP	Outcome Measure

3. References

Boston University Medical Center (2011) . Project RED Toolkit. http://www.bu.edu/fammed/projectred/toolkit.html Accessed 7/11/12.

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4. Appendix

4.1 Attachment A: Readmission Prevention Bundle Compliance Form

Readmission Prevention Bundle – Compliance

Objective: To provide documentation of compliance with readmission prevention bundle.
Instructions: Assess guideline compliance at 3-, 6- and 12-month intervals and document progress toward full compliance.

Readmissions Prevention EBP Compliance Checklist	Yes	No	Identified Barriers/ Plans to Overcome Barriers
MHS-Endorsed EBPs (Project RED)[6]			
1. Educate the patient about his or her diagnosis throughout the hospital stay.			
2. Make appointments for clinician follow-up and post-discharge testing.			
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.			
4. Organize post-discharge services.			
5. Confirm the Medication Plan.			
6. Reconcile the discharge plan with national guidelines and critical pathways.			
7. Review the appropriate steps for what to do if a problem arises.			
8. Expedite transmission of the discharge summary to the physicians and other services accepting responsibility for the patient's care after discharge.			
9. Assess the degree of understanding by asking the patient to explain the details of the plan in their own words.			
10. Give the patient a written discharge plan at the time of discharge.			
11. Provide telephone reinforcement of the discharge plan and problem-solving two to three days after discharge.			

[6] *Project RED: Re-Engineered Discharge.* https://www.bu.edu/fammed/projectred/components.html