READMISSIONS REDUCTION: AVOIDING THE AVOIDABLE

Zero Harm: Readmissions:

- Community Memorial, Turtle Lake*
- Northwood Deaconess, Oct 16-Sept 17
- Sakakawea Medical Center, July 17-Sept 18
- Cooperstown Medical Center, Feb 17-Oct 18

Will be evaluating again when all of April data is in.
Readmission Rate-30 Day All Cause, Innovate-ND Hospitals

Innovate-ND Hospital Readmission Rates: Monitoring Period
Readmission Rates of Mid-10 Innovate-ND Hospitals at Baseline

Readmission Rates of Lowest 10 Innovate-ND Hospitals at Baseline
STRATEGIES TO REDUCE READMISSIONS

- Discharge planning checklist
- Engaging patient and family – bedside report/huddles
- Post discharge follow-up calls
- Discovery tool
- Readmissions interviews
- Community collaboratives – referrals to services and supports available within the community
- Customized transitional care plan
- Teach back
- Advanced Care Planning
- Data Stratification

ST. ANDREW'S HEALTH CENTER

Jenifer Lauckner, RN and Molly Palm, LSW

LINTON HOSPITAL

Liz Hansen, RN

PEER SHARING: WHAT WORKS!
REDUCING READMISSIONS

- Our focus was on patient education and teaching because we felt our patients deserved more education related to their diagnosis.
- Patient survey results would show they were not given enough information.
- When discharging a patient, many were in a hurry to go home and we felt like they were not taking the time to ask questions.
INTERVENTIONS

- Upon admission the patient is given a pocket folder with their name and admission date on the front of it. This folder contains:
  - Advanced Directive information
  - PPSV23 and PCV13 information
  - Ask Me 3 Information
  - A Guide to Smoking Cessation - Fact Sheet
  - Souris Basin Transportation hours, pricing, and phone number

- Also included in the folder are:
  - A Senior Resource Guide
  - A First Light Home Care Pamphlet
- Discharge Planning Assessment
- Social History Assessment
- Bedside Shift Report
  - Lets the patient know what the plan is for their care for the upcoming shift
  - Formed a committee to come up with a process for this consisting of 3 RNs and the ANM
INTERVENTIONS

The ANM or Charge Nurse makes discharge follow-up calls
- A template is used in the patient chart notes to document what is covered during the call
- A copy of this documentation is placed in a folder to refer to if the patient were to be readmitted for the same diagnosis

PATIENT AND FAMILY ENGAGEMENT

Patients and their Families or caregivers are invited to care plans on Wednesdays covering all care areas
- PT/OT, Activities, Social Services, Nursing, Pastoral Care, and Dietary are present

Patients families are invited to be present at bedside shift report if the patient would like
Measuring Progress

PARTNERS

- Bottineau County Social Services
- St. Andrew’s Clinic
TOOLS/RESOURCES

- **Tools we developed:**
  - Ask Me 3 Assessment
  - Discharge Follow Up Call Template
  - Folders to keep all patient discharge info together

SUSTAINABILITY

- Education is done at our monthly nursing meetings along with any updates
CONTACT INFORMATION

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This material was prepared by Innovate-ND, leaders of the HRET Hospital Improvement Innovation Network in North Dakota.
READMISSIONS

- Known issue for hospitals nationwide
- What is the best way for our facility to have meaningful contact with the affected patients?
- Goal: Looking to reduce readmission rate, measured by HRET/HIIN data.

INTERVENTIONS

- Review of the data
- Full-time Case Manager: Duties and Tools
- Patient follow-up calls
- Schedule follow-up appointments for the patient
LEADERSHIP/Physician/Front-Line Staff Engagement

- CEO Robert Black and COO/CNO Lukas Fischer
- All providers
- Clinical hospital nurses-process changes
- How did we achieve buy-in?

Patient and Family Engagement

- Initiate contact at admission
- Daily follow-up as needed
- Close contact at discharge
- CARE ACT (Included in the Case Manager’s Assessment)
  - Record family caregiver’s name on admission
  - Notify family caregiver when discharge is near
  - Include family caregiver in discharge instruction
RESULTS

SUSTAINABILITY

- Provide updates during staff meetings
- Ask staff for concerns on processes
- Checklists
LESSONS LEARNED

- Meaningful communication with the patient and/or caregiver
- Monitor-Documentation of those communications

CONTACT INFORMATION

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What ideas will you take home?

- Discharge planning checklist
- Engaging patient and family – bedside report/huddles
- Post discharge follow-up calls
- Discovery tool
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- Community collaboratives – referrals to services and supports available within the community
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STRATEGIES TO REDUCE READMISSIONS
INNOVATE-ND WRAP UP

- ND Readmissions Mini-Collaborative
- Care Transitions Awareness
- Spring Falls-Delirium Sprint
- Opioid Stewardship
- ND-HIIN

Onward and upward!

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