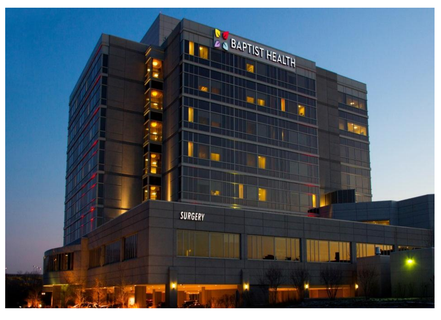
2015 QUALITY & EQUITY ROADMAP
Decreasing Hospital Readmission Rates for Vulnerable Populations

American Hospital Association®

Organization and Team



Baptist Health Louisville
Louisville, KY
519 licensed beds

Clinical Outcomes Nurses:
Tina Kilcourse; Tonya Wiegand; Kathy Miles; Sandy Keith; Ariel Young; Casie Kichler, Coordinator; Not pictured: Diana Huber, Portia Steele, Whitney VanVactor

Project Goals

- Engage the entire health care team through a clear communication plan to identify vulnerable, high risk patients
- Implement strategies to mitigate risk of readmission
- Prepare patients to self-manage care and successfully navigate a safe transition of care
- Decrease readmission rates

Problem Description

- Current national average for hospital readmissions: 16%[1]
- $17.4 billion annual impact to Medicare[2]
- Common causes for readmission[3]:
  - Poor medication management
  - Poor coordination of care
  - Lack of follow up care post discharge
  - Knowledge deficit regarding self-care

1) CMS (2014)
2) Jencks, S. F. , Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009; 360:1418–1428.
3) Advisory Board. (2011). Nurse led strategies for preventing avoidable readmissions.

Improvement Strategies

- LACE tool to identify high risk patients
- Daily, intensive education using teach-back methodology
- Medication calendar at discharge
- Follow up appointment made within one week of discharge
- Follow up phone calls at day 3, 7, 14, & 21
- Transitional Care Clinic visits to reinforce education, medication reconciliation

Measuring for Risk

Modified LACE Tool

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay *Please give a LOS of 3 days on Admit*	Less 1 day	0		
	1 day	1		
	2 days	2		
	3 days *Admit default*	3		
	4-6 days	4		
	7-13 days	5		
	14 or more days	6		
Acute admission	Inpatient	3		
	Observation	0		
Comorbidity: (Comorbidity points are cumulative to maximum of 6 points)	No prior history	0		
	DM no complications, Cerebrovascular disease, Hx of MI, PVD, PUD,	1		
	Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, lymphoma, any tumor, cancer, moderate to severe renal disease	2		
	Dementia or connective tissue disease	3		
	Moderate or severe liver disease or HIV infection	4		
	Metastatic cancer	6		
Any admits including ER visits during previous 6 months	0 visits	0		
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
Take the sum of the points and enter the total				

My Daily Medication Calendar

Generic	Brand	Dose	What it's for...	Before Breakfast	Breakfast	Lunch	Supper	Nighttime
aspirin		81mg	Protects the heart		x			
atorvastatin	Lipitor	40mg	Improves your cholesterol					x
calcium	Caltrate 600	1 tab	supplement		x			
carvedilol	Coreg	6.25mg	↓ blood pressure & heart rate		x			x
donepezil	Aricept	10mg	memory					x
lisinopril	Zestril	5mg	↓ blood pressure		x			
multivitamin		1 tab	supplement		x			

Take if needed:

Generic	Brand	Dose	What it's for...
acetaminophen	Tylenol	650mg	take every 4 hours as needed for pain / fever

Patient/Guardian Signature: _____ Date: _____ Time: _____

Clinical Outcomes Nurse Signature: _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____

Results

CMS Population	CY 2013 Readmission Rate (Internal hospital data)	CY 2014 Readmission Rate (Internal hospital data)
HF	17%	15%
COPD	17%	12%
PN	13%	11%

HCAHPS Top Box Responses for HF, COPD, PN DRGs	CY 2013	CY 2014
Nurses explain in way you understand	63.3%	68.8%
Discharge Information: Info regarding symptoms/problems to look for	91.2%	92.6%
Care Transitions	46.9%	52.7%
Good understanding managing health	45.2%	47.3%
Understood purpose of taking meds	53.3%	60.0%

Lessons Learned

- Empower patients and families to self-manage care through education using teach-back methodology
- Set up a safety net for patients by scheduling timely follow up appointments and making follow up phone calls post discharge
- Medication management is key component to preventing readmissions

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