Hospital Perspectives: Addressing Key Challenges with Reducing Readmissions

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Hi! I'm Casey.

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- Nurse x 17 years
- Experience in Clinical Management, LTC, Home Health/ Hospice, Med/Surg, and Quality Leadership
- Resident of Glasgow, KY
- 11 years recent hospital experience at TJ Samson Community Hospital (2012-2023)
- 4 dogs, 3 kids, 1 husband ☺

Key Objectives

Participants will be able to:

- Identify the primary challenges that hospitals encounter with readmissions
- Learn how to apply the quality improvement process to the discovery of opportunities for change.
- Identify PI tools that can be used to formulate potential solutions in the interest of reducing unplanned readmissions.

Let's talk about Jack.

At a glance….

- 83 years old

- Chronic health issues: COPD, Kidney Disease, High Cholesterol, High Blood Pressure

- Frequent readmissions due to either high blood pressure or breathing issues (usually both at the same time!)

Let’s discuss the things that may be setting Jack up for failure in terms of a positive post-discharge outcome.

We know Jack pretty well in the ER. We *like* Jack.

- What did EMS say?
- Do we rush?
- Do we assume things?
- Does JACK assume things?
- How's your ER patient load that day?
  - Staffing
  - Acuity
- What day is it?
- What time is it?
- How are your OTHER units staffed?
- Got any inpatient beds free?
- What does that med rec look like?
- What did we do last time?
  - Did that work?
  - For how long?
- Who is your doc?
- Equipment all available and working like it should?
  - Are we playing seek-and-find with the bladder scanner again?

Now Jack is in Observation

- What does that handoff look like?
- How long is your admission assessment?
- Does Jack allow a full assessment?
- How skilled is your nurse?
- Is there a delay in care due to transition?
- Are consults placed in a timely fashion?
- Are consults conducted in a timely fashion?
- Is today Sunday?
  - Diagnostics
  - Pharmacy
  - CM
- He's not technically admitted- do we begin discharge planning?

Now Jack is Admitted….

-How often is he seen?
-What trends are identified?
- Have we looked at that history yet?
- Have you heard from his family?
- Who is waiting on that bed?

….and now Jack is going home

- Or is he? (HH? Rehab?)
  - Who can take him?
  - What does he need?
- Speed of coordination
  - Waiting on your order
  - You're going home *today.*
  - Did the specialists sign off?
  - Is there a diagnostic still pending?
- Discharge education
- Medication reconciliation
- Transportation coordination
  - Portable O2?
  - Reliable method?
- He's out the door

No wonder we're gonna see Jack back here in 4 days!

Let’s eat the elephant.

The Key Steps of the QI Process:

1. Select and define the problem.
2. Define your goal.
3. Assess your current state.
4. Define how you will measure your progress
5. Communicate your goal.
6. Build your process.
7. Implement your process.
8. Standardize your process.
9. Trend your progress.
10. Tweak ad hoc.

The Key Steps of the PI Process:

1. Select and define the problem. = **Frequent unplanned readmissions.**
2. Define your goal. = **Reduce unplanned readmissions by ___% by _____.**
3. Assess your current state.
4. Define how you will measure your progress
5. Communicate your goal.
6. Build your process.
7. Implement your process.
8. Standardize your process.
9. Trend your progress.
10. Tweak ad hoc.

The Key Steps of the PI Process:

1. Select and define the problem.
2. Define your goal.
3. Assess your current state. = **Trends. Who is being readmitted? What are the key diagnoses? Patient Demographic? Specific Units?**
4. Define how you will measure your progress
5. Communicate your goal.
6. Build your process.
7. Implement your process.
8. Standardize your process.
9. Trend your progress.
10. Tweak ad hoc.

Tools for Assessing Your Current State

Fishbone Diagram (aka Ishikawa, aka Cause-and-Effect)

Process Mapping (aka Flowchart)

A3 Tool (Steps 2-4)

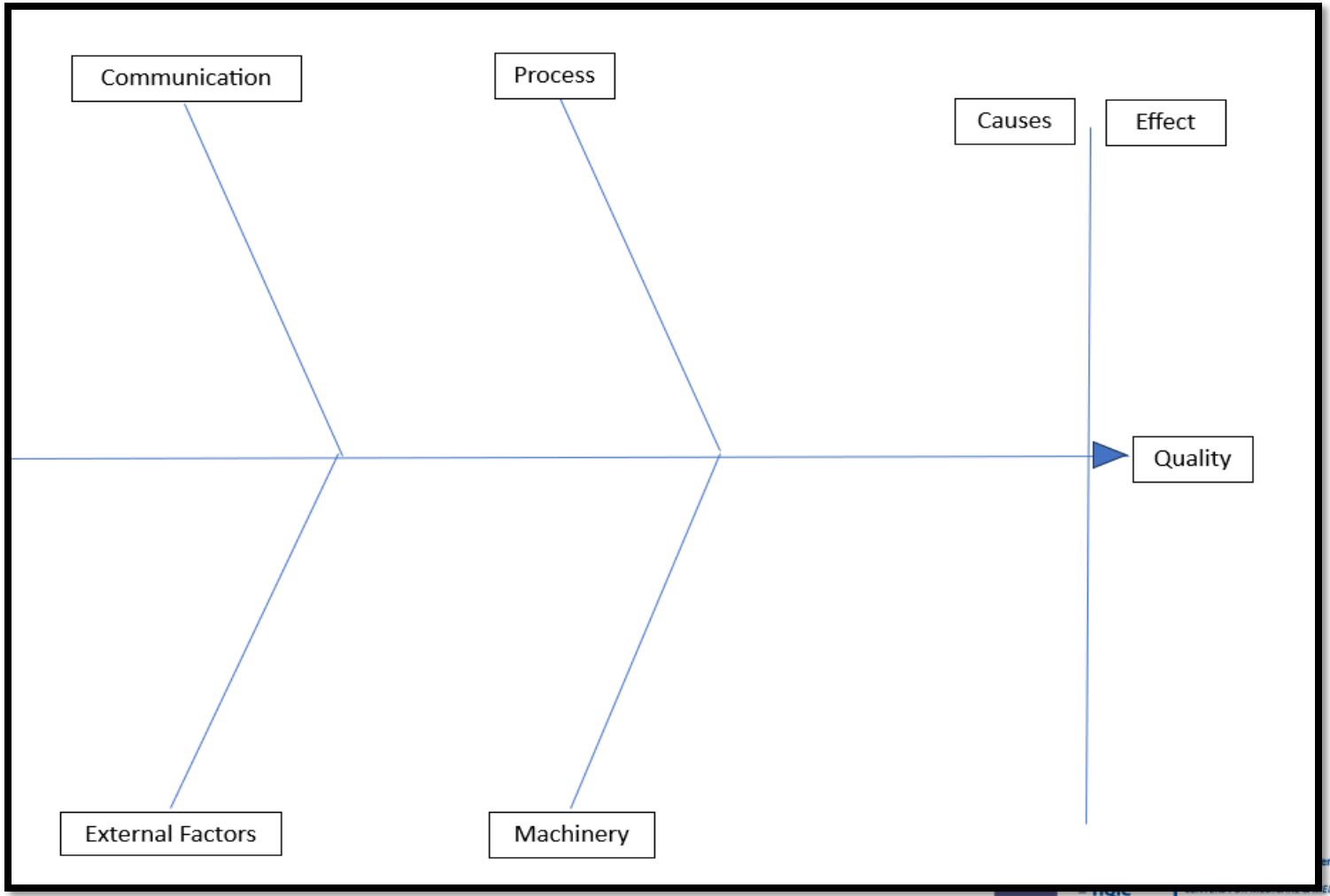
Affinity Diagram

Brainstorming

Pareto (for prioritization)

For Jack, let's use a combo of two tools:

1. Fishbone
2. Process Mapping


Communication
Process
Causes
Effect
Quality
External Factors
Machinery

We know Jack pretty well in the ER. We *like* Jack.

- What did EMS say? - Communication
- Do we rush?
- Do we assume things? - Communication
- Does JACK assume things? - Communication
- How's your ER patient load that day?
  - Staffing
  - Acuity
- What day is it? - Communication
- What time is it? - Communication
- How are your OTHER units staffed?
- Got any inpatient beds free?
- What does that med rec look like? - Communication
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- Who is your doc?
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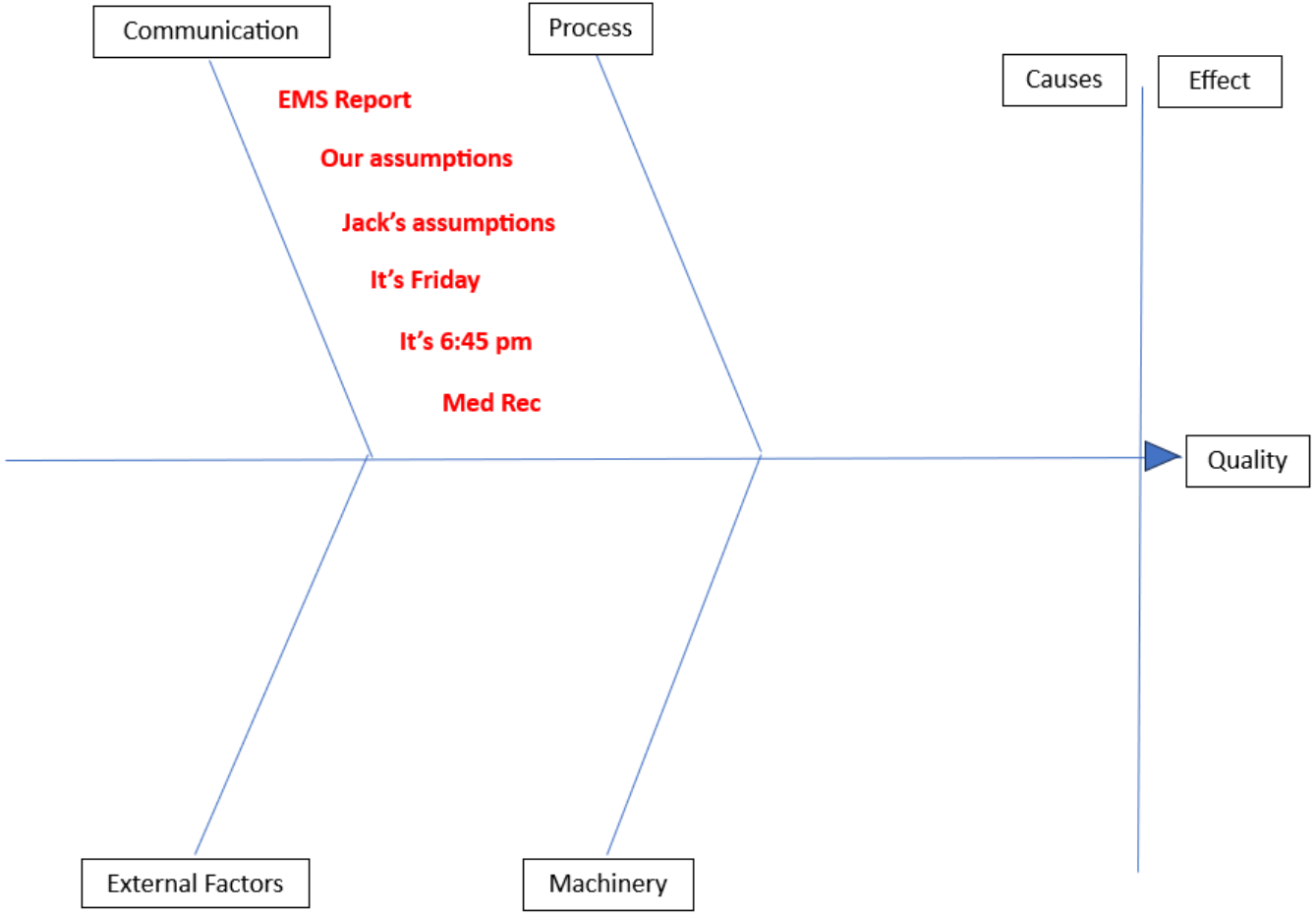
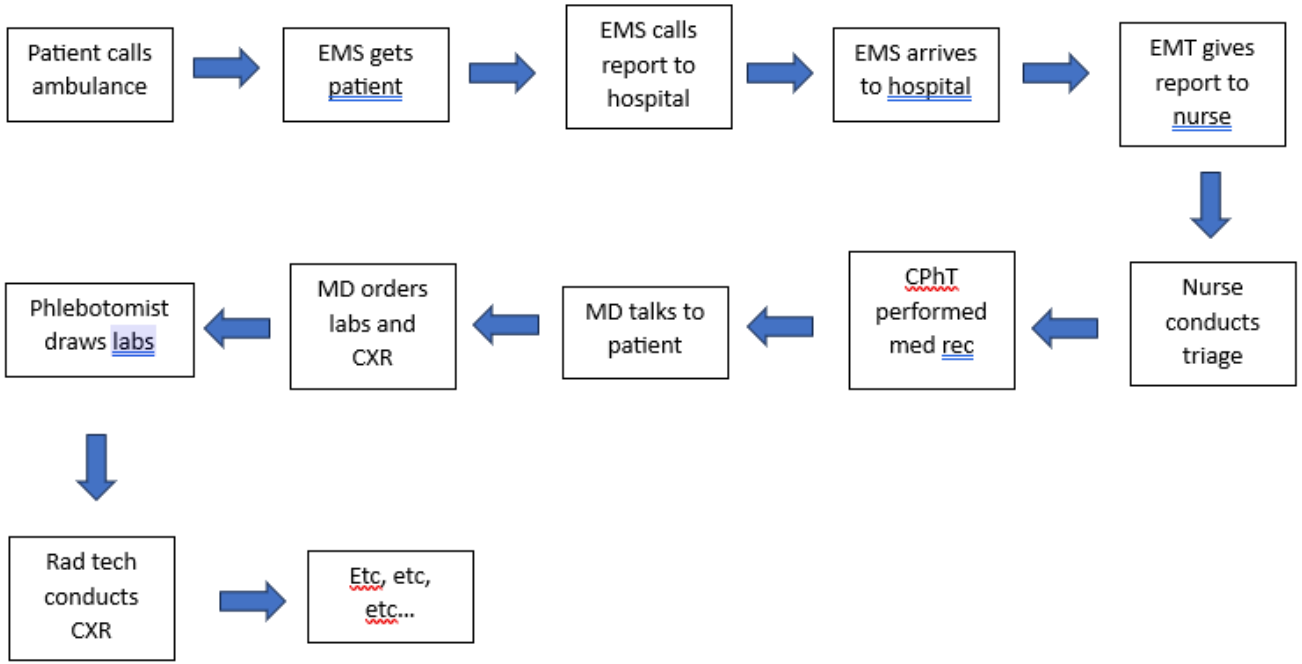
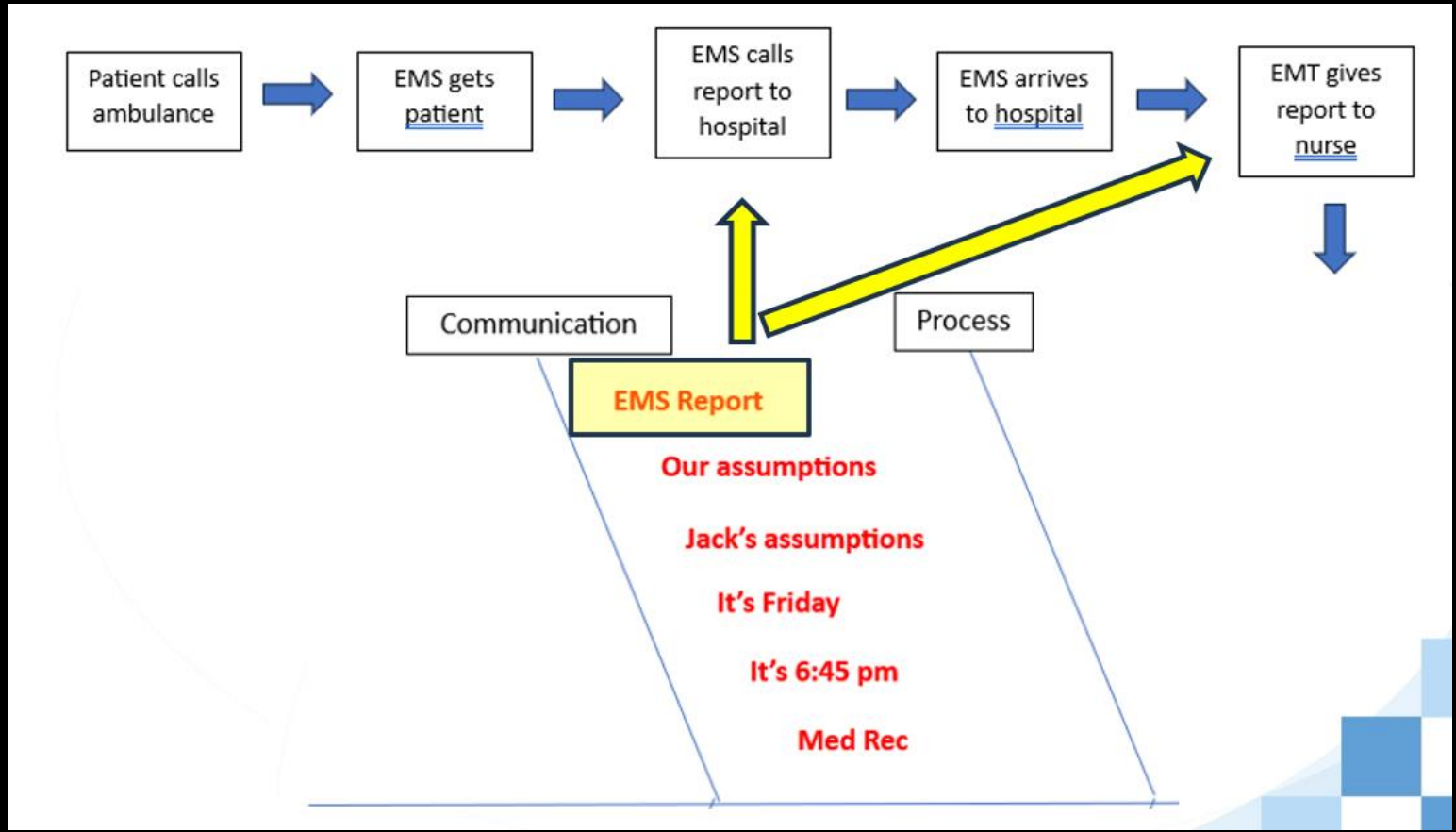
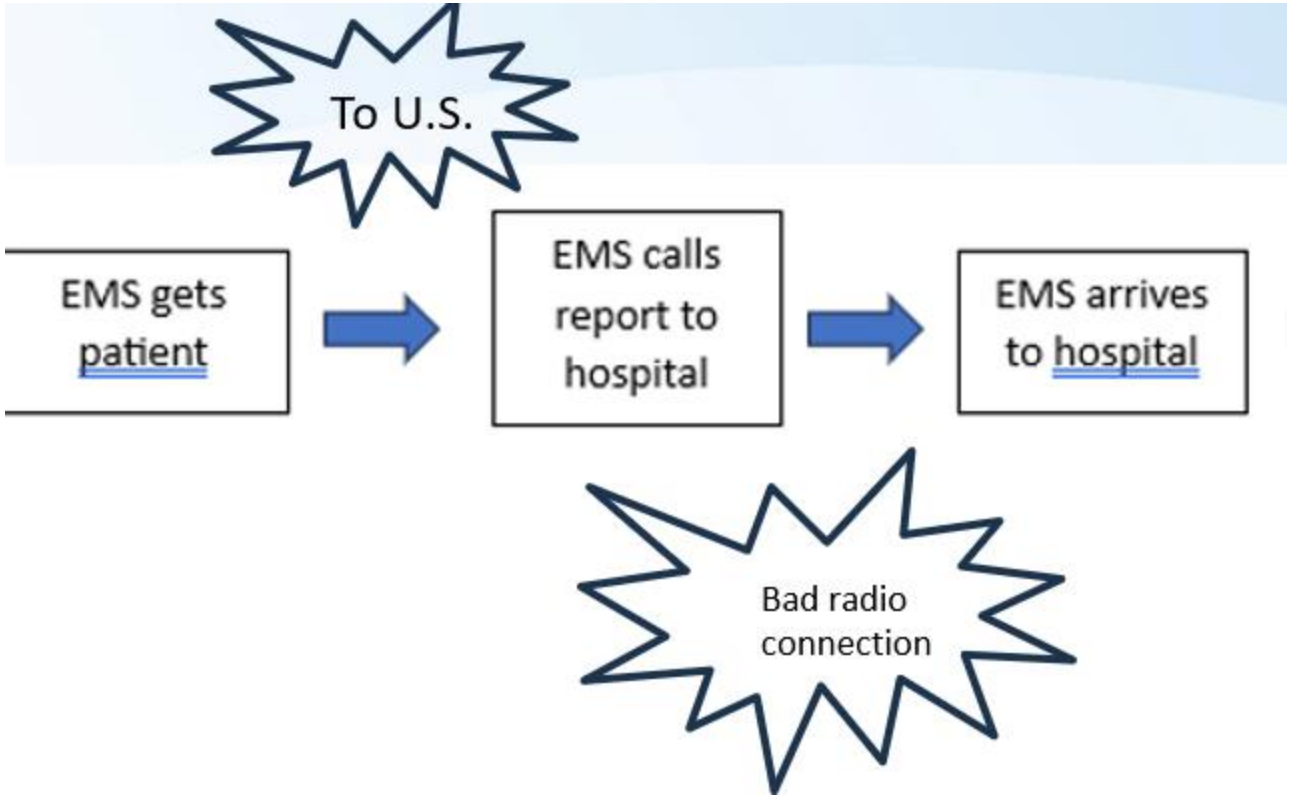
  - Are we playing seek-and-find with the bladder scanner again?




Patient calls ambulance
EMS gets patient
EMS calls report to hospital
EMS arrives to hospital
EMT gives report to nurse
Nurse conducts triage
CPhT performed med rec
MD talks to patient
MD orders labs and CXR
Phlebotomist draws labs
Rad tech conducts CXR
Etc, etc, etc…


Patient calls ambulance
EMS gets patient
EMS calls report to hospital
EMS arrives to hospital
EMT gives report to nurse
Communication
Process
EMS Report
Our assumptions
Jack's assumptions
It's Friday
It's 6:45 pm
Med Rec


To U.S.
EMS gets patient
EMS calls report to hospital
EMS arrives to hospital
Bad radio connection

….suddenly, the pathway forward is clear…..

Communication

Same EMR?

Timely documentation?

Complete documentation?

IDT?

What about HIS communication?

Bedside shift reports?

SDoH

-Widower

- Children live three states away

- Retired coal miner

- Fixed income

The deeper issues

Memory issues

Hopelessness

Staff perspectives

Time management

Conflict resolution

Communication skills

Ownership of Care

Process, process, process

External factors

Payor source

Availability of post-acute care

Community transportation options

Travel distance for follow up care

Tools for care plan adherence

One final caution: The Rabbit Hole

What questions do you have?

Thank you!

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