INTERACT Implementation Learning in Action Collaborative Webinar 6: Readmission Tracker

March 18, 2016
11:30 am – 12:30 pm EST

Quality Improvement Organizations
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Learning In Action Collaborative

During this 6 month, action oriented, virtual collaborative participants will:

- Receive education, coaching, and resources from experts in the field
- Develop strategies to reduce avoidable hospital readmissions
- Learn about evidence-based INTERACT tools and have the opportunity to implement interventions to reduce hospital readmissions: QI tools, capabilities list, transfer forms, SBAR, and STOP and WATCH
- Build a community of practice with their peers and share successes and challenges
- Learn to use data in a meaningful way to improve care

Welcome

- All webinars will be recorded and can be accessed at

  http://atlanticquality.org/initiatives/care-coordination/care-coordination-sc/

- Meeting norms:
  - Flexibility and understanding with technology
  - Engagement and participation in discussions and peer-to-peer sharing
  - Focused attention

Collaborative Timeline

(All webinars are scheduled on Thursdays from 11:30 am -12:30 pm EST)

October 8, 2015 – Kickoff Webinar #1: Readmission Tracker

October 19-23, 2015 Check in/Coaching call (15-30 min)

November 5, 2015 – Webinar #2: Capabilities List

November 9-13, 2015 Check in/coaching call (15-30 min)

November 19, 2015 – Webinar #3: Transfer Forms

December 7- 16, 2015 Check in/coaching call (15-30 min)

January 7, 2016 – Webinar #4: SBAR

January 25-29, 2015 Check in/coaching call (15-30 min)

February 18, 2016 – Webinar #5: Stop and Watch

February 29- March 4, 2015 Check in/coaching call (15-30 min)

March 10, 2016 – Webinar #6: Readmission Tracker/ Next Steps

Proposed QI pilot

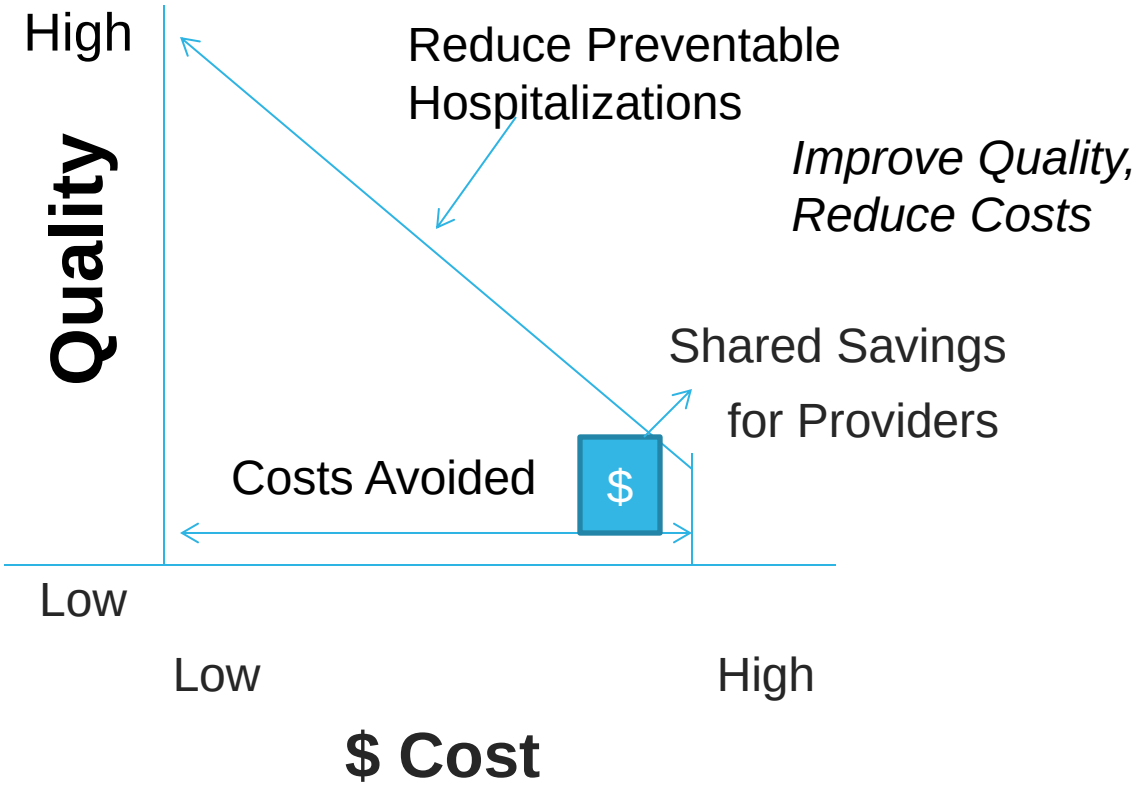
Tracker implementation and data collection

- Consistent use of Tracker for 3-6 months
- Monthly coaching calls with AQIN – SC team
- Data analytic support from AQIN – SC
- Technical assistance with data collection, trends, and intervention development based on evidenced based best practice
- Coaching call scheduled:

  April 21, 2016 11:30 am -12:30 pm

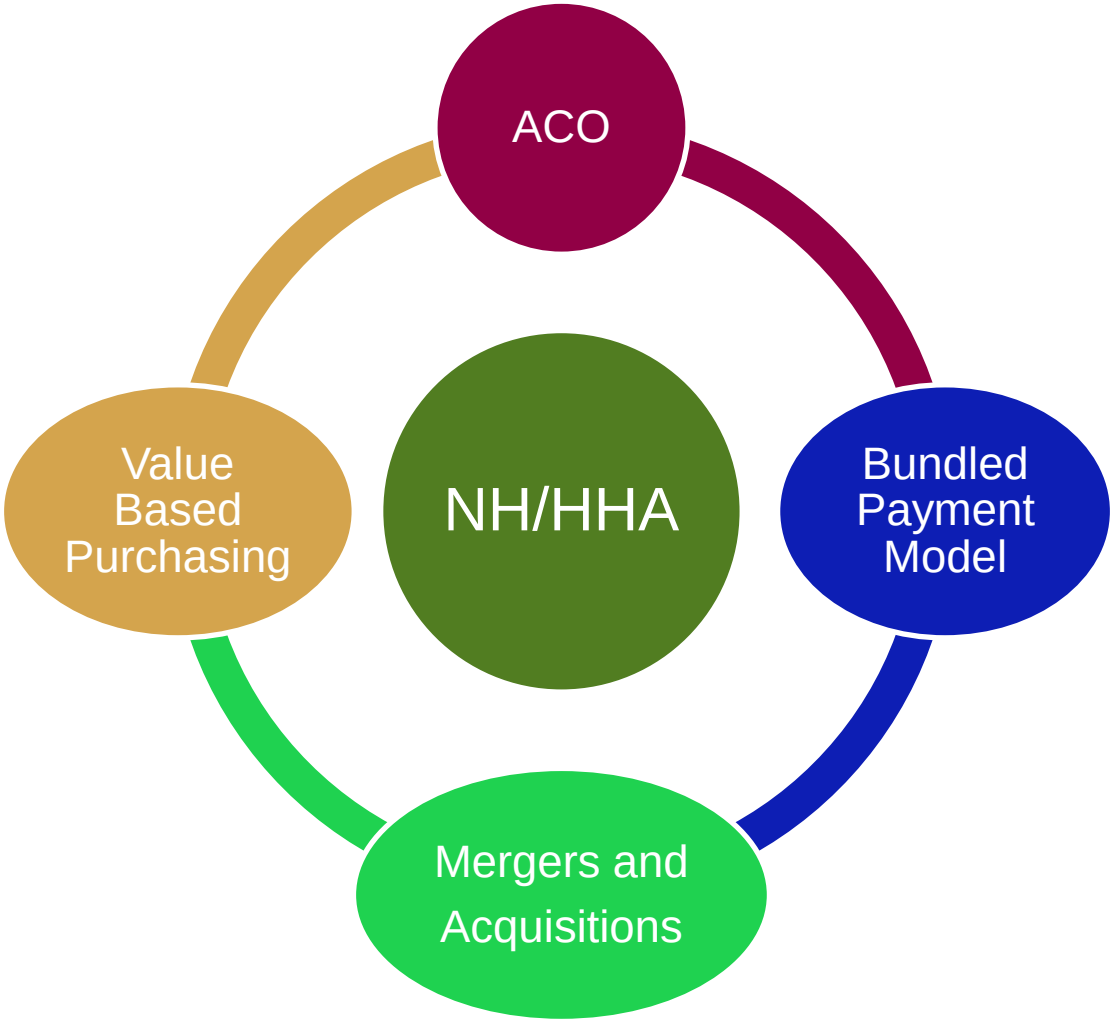
The INTERACT Program

Opportunities for You and Your Facility



INTERACT®

Where will you be in 5 Years?



Process Improvement Principles

Resident Focus

Leadership Involvement

Team-Based

Data and QI Tools

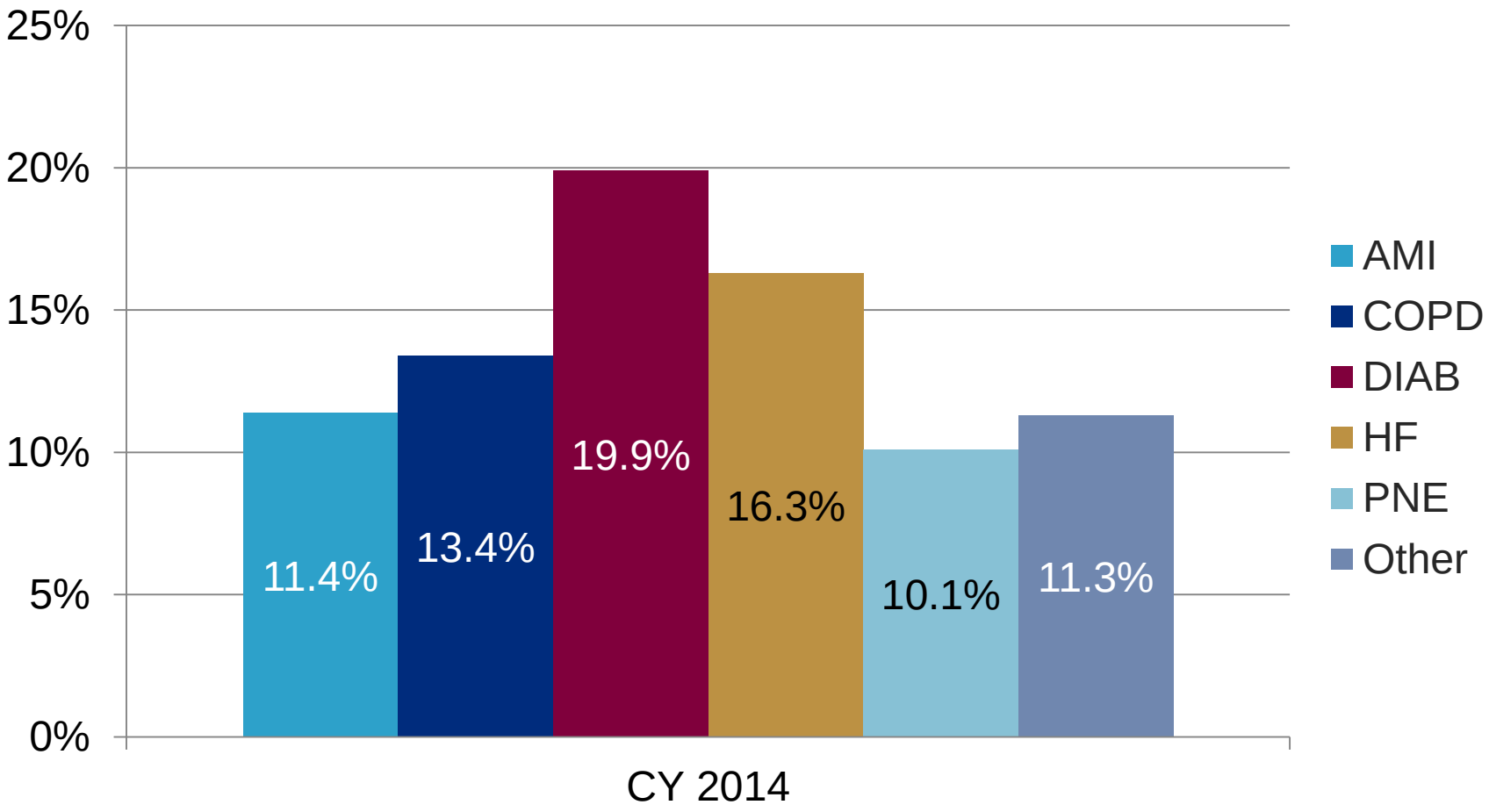
Just Culture

Prevent Overcorrection

Staff Empowerment

Continuous Improvement

SC Diagnosis-Specific Readmissions



SC overall readmission rate is 11.7%

Lessons Learned

- How have you implemented any of the tools discussed in this webinar series?
- Challenges and Barriers associated with tools?
- What successes have you encountered?

Readmission Tracker

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Readmission Tracker

Confidentiality is important. Please DO NOT transmit this form with patient/resident-identifying information.

INSTRUCTIONS:

Column B - Enter patient/resident initials or name
Column C - Enter date of hospital discharge
Column D- Enter full name of discharging hospital
Column E- Enter the date post discharge services (home health or skilled nursing) began
Column F- *This field will automatically populate when a date in column E is added*

	Name	Hospital Discharge Date	Discharging Hospital	Date follow up service initiated	Day of Week
1	JOHN SMITH	1/21/2015	ABC Regional Hospital	1/25/2016	Monday
2					
3					
4					
5					

Readmission Tracker

Confidentiality is important. Please DO NOT transmit this form with patient/resident-identifying information.

INSTRUCTIONS

(Examples are provided in row 11

Column B - Enter patient/resident name or initials
Column C - Use drop down menu to select payment method (Medicare Part A, Self Pay, etc.)
Column E - Enter the date of transfer to hospital
Column F- Use the drop down menu to select the time of day the transfer occurred
Column G - Enter the name of practioner ordering transfer
Column H - Use drop down menu to select the primary diagnosis/reason for transfer
Column I - Use the drop down menu to select tranfer outcome
Column J - Enter known dates of prior hospitalizations
Column K - Enter free text notes/comments
Column M - Use the drop down menu to indicate is patient/resident frequently utilizes the services provided by your

	Name	Payment Status	Date of Transfer to Hospital	Transfer: Time of Day	Practitioner Ordering Transfer	Primary Diagnosis for Transfer	Outcome of Transfer	Date(s) of prior hospital visits within 12 months (if known)	Notes/Comments (including comorbidities)	Is this a frequent utilizer of care?
1	bob	Medicare Part A	12/15/2015	Evening (7pm--midnight)	george	COPD, asthma, bronchitis	Admitted, status uncertain	12/8/2015, 11/30/15	smoker	Yes
2										
3										
4										
5										

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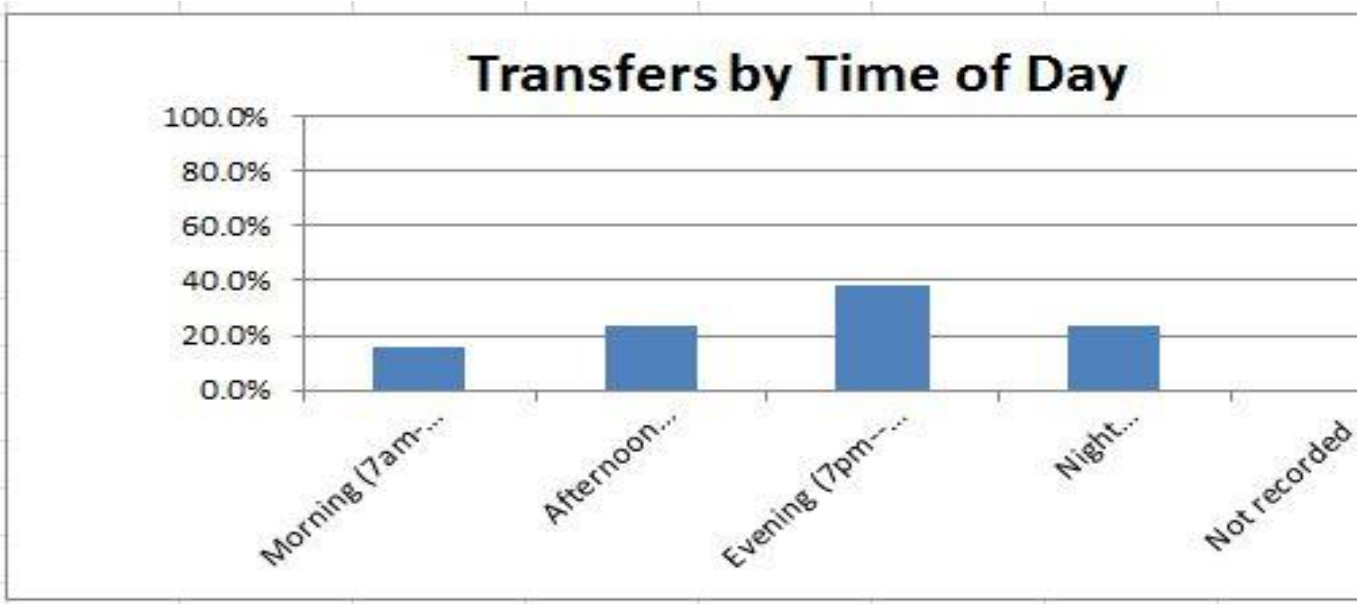
Transfers by Time of Day
100.0%
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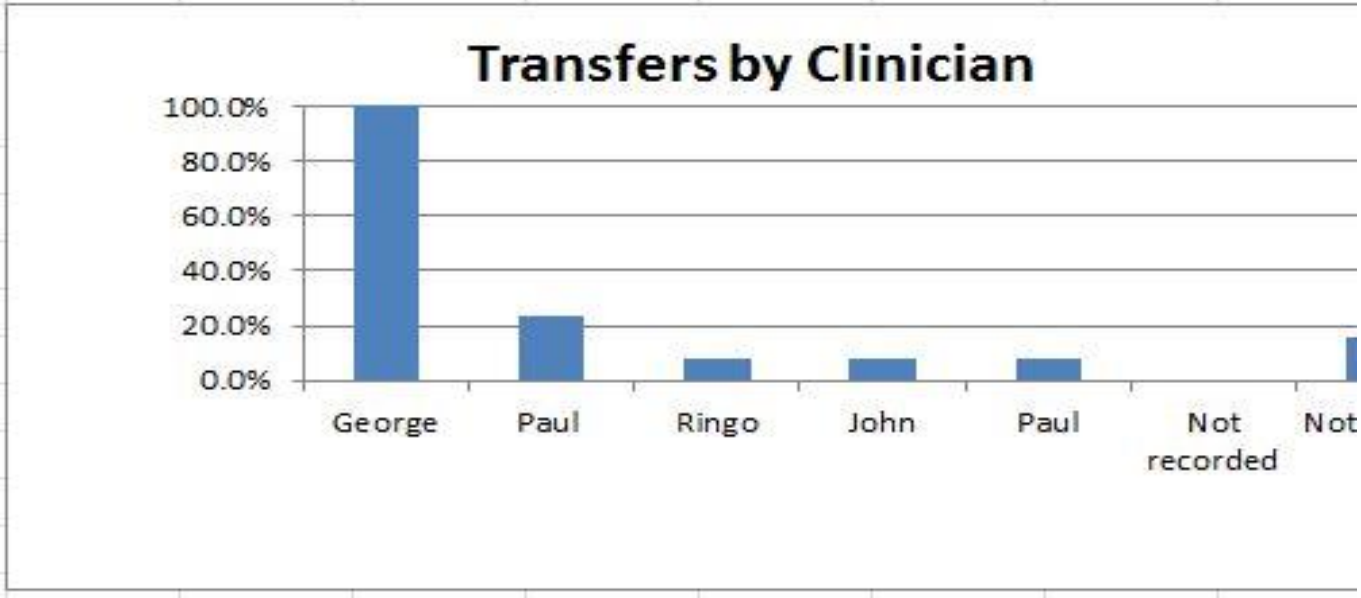
Morning (7am-...
Afternoon...
Evening (7pm-...
Night...
Not recorded


Transfers by Clinician
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George
Paul
Ringo
John
Paul
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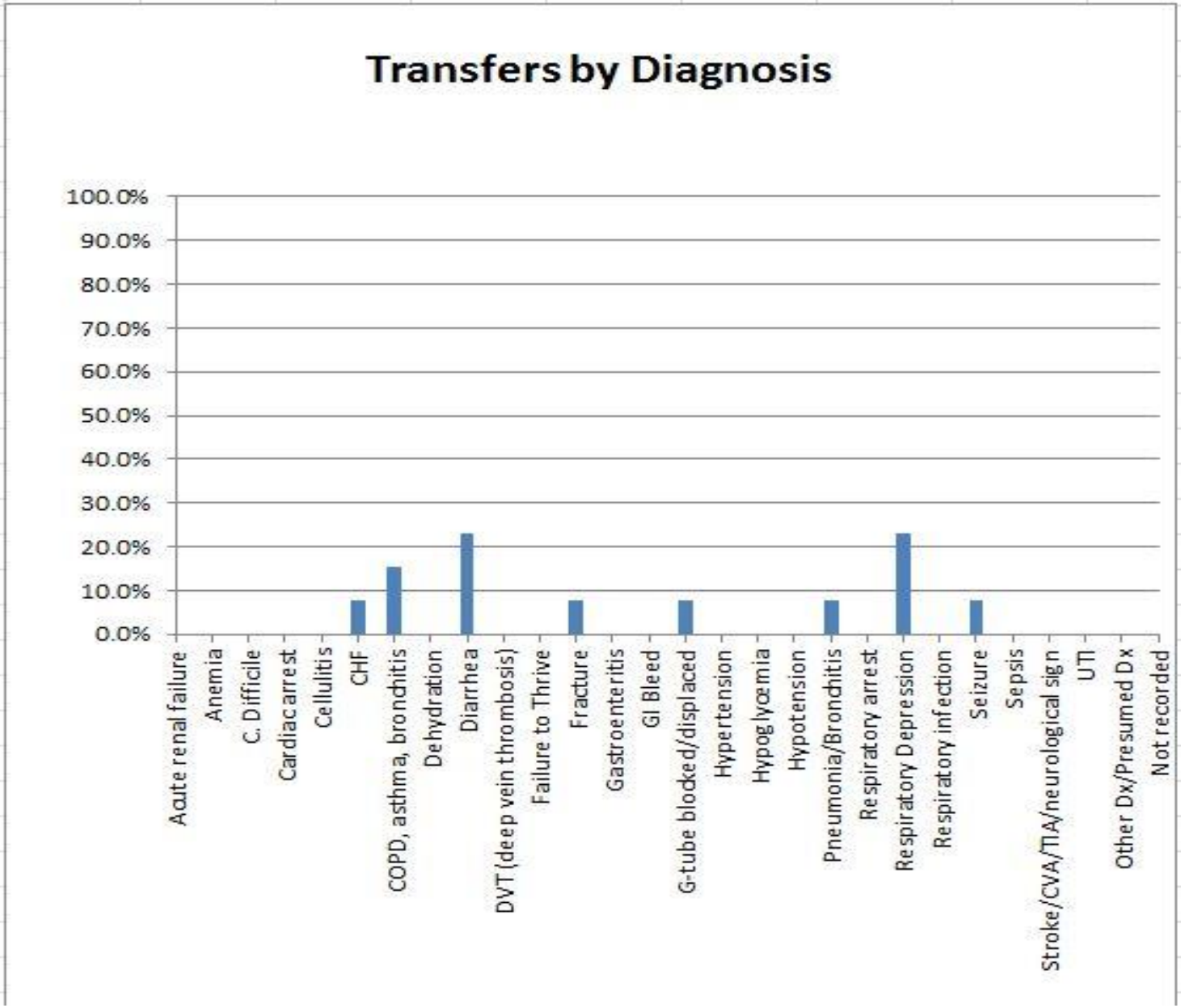
Transfers by Diagnosis
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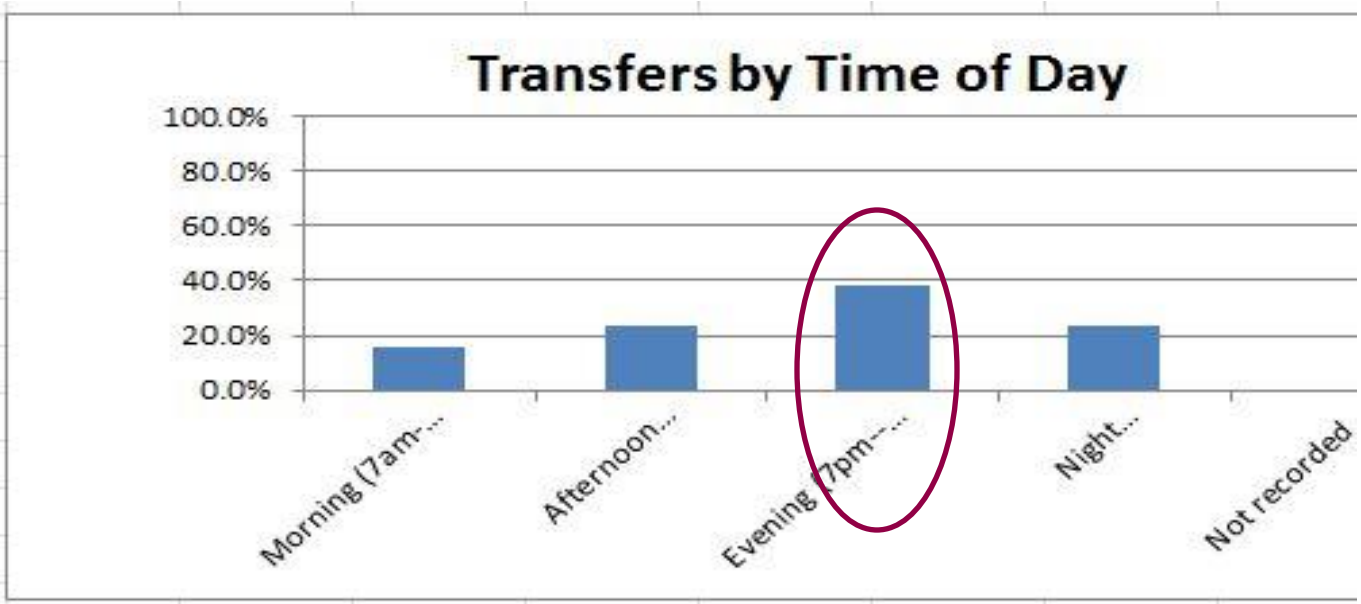
Acute renal failure
Anemia
C. Difficile
Cardiac arrest
Cellulitis
CHF
COPD, asthma, bronchitis
Dehydration
Diarrhea
DVT (deep vein thrombosis)
Failure to Thrive
Fracture
Gastroenteritis
GI Bleed
G-tube blocked/displaced
Hypertension
Hypoglycæmia
Hypotension
Pneumonia/Bronchitis
Respiratory arrest
Respiratory Depression
Respiratory infection
Seizure
Sepsis
Stroke/CVA/TIA/neurological sign
UTI
Other Dx/Presumed Dx
Not recorded

What is it?

- A good first step in data collection - FACT FINDING
- Communication tool
- Helps to identify trends and opportunities in system improvement
- Useful for facilitating conversations with internal and external partners
  - Ex: High volumes of transfers occur on weekends/nights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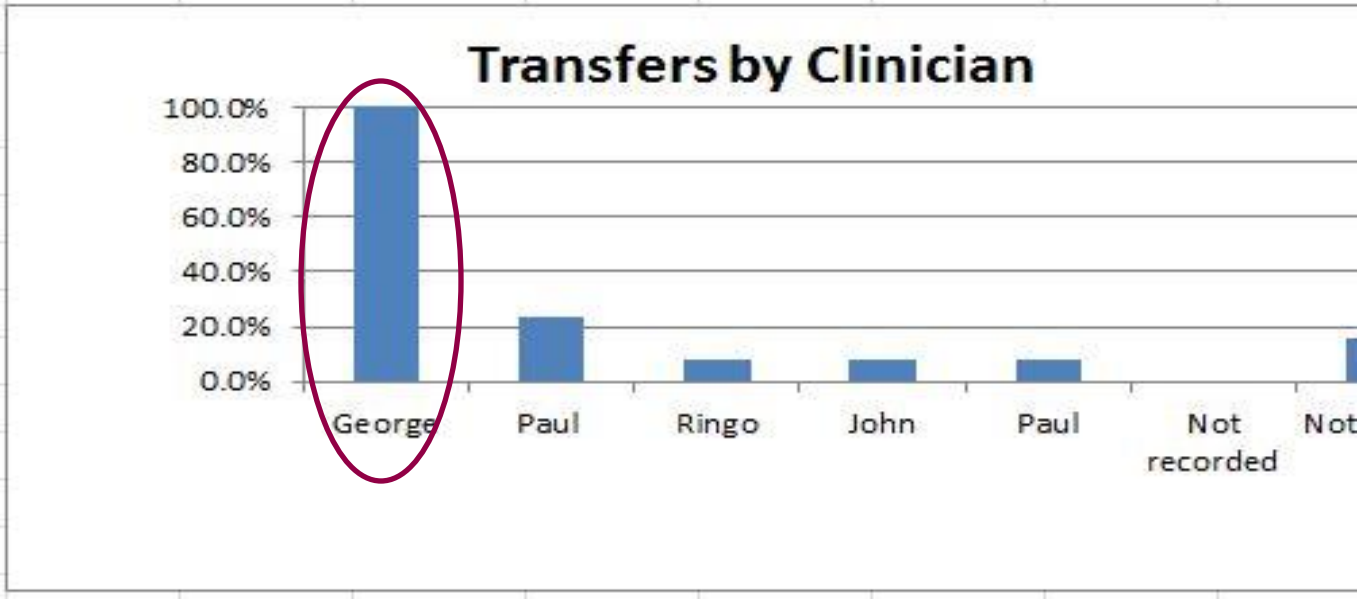
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60.0%
40.0%
20.0%
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Ringo
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Paul
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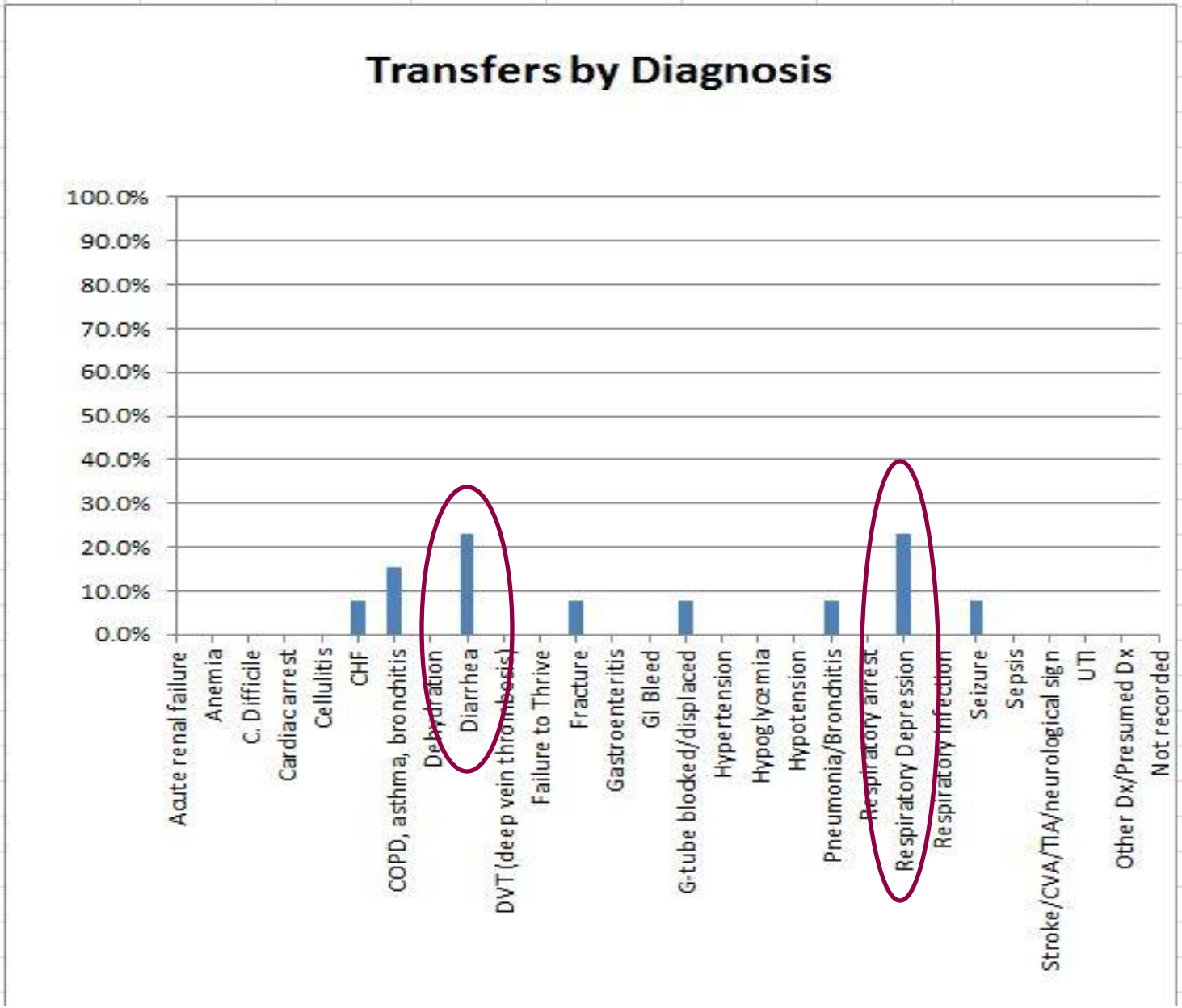
Not

Example:

- Most transfers occur between 7pm and midnight
- Clinician with highest transfers is George

What are the next steps?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Pneumonia/Bronchitis
Respiratory arrest
Respiratory Depression
Respiratory Infection
Seizure
Sepsis
Stroke/CVA/TIA/neurological sign
UTI
Other Dx/Presumed Dx
Not recorded

Example:

- Identified primary diagnosis for transfers back to hospital
  = Respiratory depression

  = Diarrhea
- Chart audit review indicates patients/residents
  - Opioid-related adverse drug event
  - Increased antibiotic use without corresponding diagnoses

What are the next steps?

Action Items:

- Track and review hospital readmission data and transfer data using the QI tools
- Join the coaching call scheduled for April 21, 2016
- Contact AQIN-SC team for individualized technical assistance

Thank you!

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