Shared Accountability on Every Shift Reduces Hospital Readmissions

Herminia Shermont, MSN, RN, NE-BC
Bolanle Bukoye, MSPH
Disclosures

• No disclosures
• There are no financial interests or relationships to disclose
• This presentation does not include discussion of any commercial products or services
Learning Objectives

• Discuss strategies to improve accountability and work culture with discharges
• Discuss utilization of discharge bundle and standardization of teach-back method
• Highlight interventions to reduce readmissions in high risk patient population
Polling Exercise--Instructions
How to vote via the web or text messaging

From any browser
Pollev.com/bolanlebukoy162
Enter your response
Submit response

From a text message
To: 22333
bolanlebukoy162<your response>
Your poll will show here

1
Install the app from pollev.com/app

2
Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help
or
Open poll in your web browser
Your poll will show here

1. Install the app from pollev.com/app
2. Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help
or
Open poll in your web browser
Why readmissions?

The Children’s Hospitals’ Solutions for Patient Safety National Network

This network established three primary goals

• 40% reduction in hospital acquired conditions

• 25% reduction in serious safety events

• 20% reduction in readmissions
Why Readmissions?

- 21.8% of patients admitted to pediatric hospitals are readmitted annually (Tsai T.C., et al., 2013)

- Readmissions account for 18.8% of all admissions (Berry J.G., et al., 2013)

- Over $3.4 billion of total inpatient charges (Berry J.G., et al., 2013)
Why Readmissions?

Hospitals face Medicare payment penalties for high readmission rates

You again?!
I don’t feel well.

Boston Children’s Hospital
Primary Aim

• To reduce avoidable 7-day readmission rates by 20% through the implementation of a discharge bundle and teach-back method for discharge teaching

  – Operational Definition: Number of readmissions that occur within 7 days of discharge (<=7). All patients are included who are defined as inpatient or under observation at the hospital.
Secondary Aim

• To evaluate caregiver comprehension of important discharge information
Aims and Drivers for Improvement

Reduce unplanned readmissions occurring within 7 days of discharge from the hospital (20% reduction in readmissions over a 3 year period)

- Improve patient/family discharge readiness and ability to self-manage post discharge
- Improve handoff of care by partnering with oncoming nurse using the teach-back methodology at each
- Identify trends in unplanned and preventable readmissions
- Create highly effective and collaborative multidisciplinary team
  Single team approach

Involve primary caregiver in discharge planning process
Provide appropriate, consistent and timely discharge instructions to patient/family throughout their hospital stay
Interview patient/family to ensure understanding of important discharge instructions before they leave the hospital

Create and disseminate video demonstrating teach-back and hand-off at change of shift
Ensure competent frontline staff nurses with knowledge of teach-back methodology
Engage patient/family at each shift by reviewing discharge plans and addressing knowledge gaps

Develop RCA tools and readmission database to capture readmissions within 7 days
Analyze and disseminate data on a monthly basis
Conduct root cause analysis for all readmissions
Monthly case presentations to discuss findings

Leadership engagement and support at all levels
Shared decision making and accountability
Coordination of care across the continuum
Coordination of Care Across the Continuum

- Boston Children’s Hospital
- Community Based Primary Care Practices
- Patient and Family

Continuity of Care
Improving Individual Experience of Care

- Utilize teach-back method with all handoffs and across continuum
- Earlier involvement of PCP pre- and post-discharge
- Single team approach across the continuum
- Close communication Gap
- Alignment of tools and resources across the continuum
- Leverage technology

Boston Children’s Hospital
Shared Mission

A strong organizational structure that encourages accountability with every individual involved in the discharge process from admission to post-discharge and in all handoffs of care will help lead to success

“A Shared Mindset”
Administration/Leadership
Accountability

• Identify a clear vision

• Align with the strategic and corporate goals

• Work toward a “shared mindset” culture
Shared Accountability

• How many times have you heard your staff nurses complaining that the evening or night nurses left all the discharge paper work to be completed by the day staff?
Shared Accountability (cont)

• Partner with every nurse on every shift

• Partner with patient/family each shift

• Conducts leadership spot checks
Shared Accountability (cont)

- Anchoring normative behaviors at all handoffs will lead to culture change with discharge
- How we work with each other is the basis of success
Accountability Model

- Leadership engagement
- Align with strategic goals
- Shared accountability culture
- Partnership with Patient/Family
- Earlier involvement pre- & post-discharge
- Single team approach across the continuum of care
- Care coordination
- Handoff communication
- Data Transparency
The Importance of Health Literacy

- Ability to read, understand, and use health information to make appropriate healthcare decisions and follow instructions for treatment (American Medical Association & American Medical Association Foundation, 2003)
Health Literacy: What do we know?

• 40 - 80% of medical information is immediately forgotten by learners (Kessels, 2003)
• 51% of medical information is incorrectly understood by learners (McGuire LC, 1996; Anderson JL et. al. 1979 )
• Education is often crammed into brief sessions on the day of discharge (AHRQ, 2013)
• Family/caregiver is not always taught the discharge plan (Gulanick, M, 2002)
Readmissions: Top Reasons

• Incomplete or missing discharge instructions
• Patients do not understand plan of care
• Medication Reconciliation
• Follow-up appointment not scheduled timely
• Lack of knowledge of who to call if problems arise at home
Discharge Bundle: Checklist of Safe Discharge

- Does the medication list in the electronic health record match the patient's medication list in the discharge summary?
- Did the patient and/family verbalize who to call if questions or problems should arise?
- Could the patient/family repeat the discharge plan utilizing teach-back?
- Was a follow-up appointment scheduled for the patient prior to discharge?
Teach-Back: In 3 Easy Steps

Assess Knowledge
- What is the name of your pain pill?
- What should you call your doctor about?

Assess Attitude
- Why is it important for you to take your medication?
- What is important to avoid...?

Assess Behavior
- How will you remember to take your pills?
- How will you plan on changing your dressing?
Teach-Back: Improve Patient Hand-offs

- Communicate during handoffs
  - What has been taught?
  - What needs to be taught?
  - How is the family is learning best?
Discharge Bundle: Pilot Initiative (2013)

Surgical Unit's Compliance on Discharge Bundle (n=261)

% Compliance

Pre-intervention

Post-intervention

- Follow-up
- Able to repeat plan
- Know who to call
- Medication reconciliation

May
June
July
Aug
Sept
Oct
Nov
Discharge Bundle: How are we doing?

Hospital Wide % Compliance with Discharge Bundle CY2014

- F/U Appointment Scheduled
- Able to Repeat Discharge Plan
- Know Who To Call
- Medication Reconciliation
"Oh my, this is great, if I had been asked this at my last admission, then we probably wouldn't have bounced back like we did. I wasn't prepared when I went home and didn't know what I was supposed to monitor for or how to react to things. This is so great, you should really do this for all your patients."

- Patient/family
Staff Response

“This is a great example that our new teach back method is appreciated by patients and we should continue this method with all our discharged patients. They may not all react with as much enthusiasm, but it makes the parent stop and think and then restate what you have just taught them.”

-Nurse
Dissemination

Phase I
• Formation of interdisciplinary committee with nurse-physician co-leadership
• Created online module for Teach-back method
• Established baseline rate for outcome measures
• Developed nursing discharge bundle
• Identified pilot units
• Identified and trained unit champions to reinforce teach-back principles and audit compliance with the discharge bundle
• Conducted weekly audits on pilot units
• Monitored readmissions and conducted root cause analysis for patients readmitted within 7 days
• Created different communication strategies to disseminate readmission initiative
• Periodic leadership observations at handovers of care

Phase II
• Enrolled five additional units including one satellite unit
• Established baseline for readmission rates and compliance with discharge bundle
• Developed resource manual for each unit
• Conducted 2 hour training session for leaders and unit champions
• Educated staff on intervention utilizing the online learning module
• Assigned resources from pilot units to newly enrolled units to provide support on key elements of the initiative
• Developed REDCap™ root cause analysis tool to evaluate all unplanned readmissions
• Bi-weekly meetings held to review audit results, outcomes and readmissions

Phase III
• Enrolled seven additional units
• Identified additional resources to support hospital-wide data collation and management
• Conducted monthly meetings with stakeholders hospital-wide to review overall progress with discharge bundle and readmissions
• Created partnerships with community-based care transition programs
Dissemination Strategy

Phase 1
Phase 2
Phase 3
Phase 4

2
7
14
16
## Factors contributing to avoidable readmissions

<table>
<thead>
<tr>
<th>Healthcare providers’ assessment of factors contributing to avoidable readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Factors</strong></td>
</tr>
<tr>
<td>- Poor documentation of equipment needs for home care</td>
</tr>
<tr>
<td>- Lacking partnership with home care agencies</td>
</tr>
<tr>
<td>- Patient/family not well informed</td>
</tr>
<tr>
<td>- Limited availability of care managers on weekends/holidays</td>
</tr>
<tr>
<td><strong>Community Factors</strong></td>
</tr>
<tr>
<td>- Lack of appropriate home care supplies</td>
</tr>
<tr>
<td>- Communication gaps with PCP</td>
</tr>
<tr>
<td>- Homecare agencies do not have clear understanding of patient’s plan of care</td>
</tr>
<tr>
<td>- Facilities not equipped to manage patients’ needs</td>
</tr>
<tr>
<td><strong>Patient/family factors</strong></td>
</tr>
<tr>
<td>- Anxiety related to new diagnosis</td>
</tr>
<tr>
<td>- Patients request early discharge for quality of life consideration</td>
</tr>
<tr>
<td>- Patients decline to follow up with primary care</td>
</tr>
</tbody>
</table>
## Readmissions: Root Cause Analysis

<table>
<thead>
<tr>
<th>List any documented physician/nurses reasons for readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did any social conditions contribute to the readmission? Please check all that apply.</td>
</tr>
</tbody>
</table>
| □ Transportation  
| □ Lack of money for medication  
| □ Lack of housing/poor housing conditions  
| □ Other  
| □ None |  
| Please categorize this readmission. |  
| □ Preventable  
| □ Possibly Preventable  
| □ Unpreventable |  
| Any additional comments regarding preventability of readmission: |  
|  
| Please categorize this readmission |  
| □ Related to prior admission  
| □ Unrelated to prior admission |
# Readmissions: Root Cause Analysis

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient education documentation included a follow up plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient education documentation included red flag/emergency signs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient education documentation included plan of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient education documentation included pain medication education sheet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there documentation of teach back?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Readmissions: Where should we focus our efforts?
Target Patient Population

• Otolaryngology
  – Tonsillectomy and Adenoidectomy (T&A) procedure
  – Root Cause Analysis conducted and retrospective chart reviews on patients post T&A. Findings include:
    • Dehydration
    • Post procedure bleeding
Target Patient Population

- Hydration initiative
  - Case control study to identify factors for readmission for dehydration postop T&A
  - Postop T&A patients to receive 1.5 maintenance fluids until discharge the next day or until noon of POD#1
  - Reduced readmission rate for patients post T&A
Target Patient Population: Outcomes

![Graph showing readmission rates over time with a line indicating a decrease in readmissions.]
Readmissions Hospital wide Data

Readmissions
Boston Children's Hospital

- Readmission Rate
- Readmission Centerline
- 20% reduction Goal
- Network Centerline

Boston Children’s Hospital
New Initiatives

• Conducting monthly meetings with representation from 16 inpatient units
• Developed RCA presentation template
• Select two units each month to present 7-day readmissions, retrospective chart reviews and interventions implemented
• Embedding into Clinical Practice Forums for discussion with interdisciplinary teams
Pearls of Wisdom

- Engagement of administration to frontline staff
- Accountability at all levels
- Closing communication gaps
- Transparency and dissemination of data
- Budget neutral
- Celebration of success
Continuity of Care--Ongoing Efforts

Boston Children’s Hospital

- Readmissions RCA
- Data transparency
- Increase number of case managers
- Population specific intervention

Patient/Family

- Patient/Family reported measures of care
- Patient experience
- Patient partnership

Community Based Primary Care Practice

- PPOC and CHICO collaboration
- Tool Re-design across the continuum of care
- Teach-back implementation
Pursuit of the Triple Aim

- Improve Individual Experience of Care
- Pursuit of the Triple Aim
- Population Health
- Reduce costs of care
Implementation of a discharge bundle, teach-back and shared accountability at all handoffs of care drives the success.
Acknowledgments

• Vincent Chiang, MD
• Aimee Lyons, MS, RN, cPNP, CCRN, NE-BC, EMT
• Sarah Clarke, MPH
• Paula Gaetano, MHA, BSN, RN, CCM
• Ellen Garofoli, MSN, RN
• Jean Gouthro, RN, CPN
• Kate Humphrey, MD
• Tonna Hession, BSN, RN
• Gail Hockman, BA
• Judy Mahoney, MSN, RN, NE-BC
• Shelly Pignataro, BSN, RN
• Jayne Rogers, MSN, RN, NE-BC
• Lexi Yusah, MSN, RN, ONC
• Jane Murphy, MS, RN, PPCNP-BC, CPHQ
• Glenn Focht, MD
• Jonathan Modest, MPH
• Elene Scheff, PT
• Cynthia Cookson, BS RRT AE-C
Questions