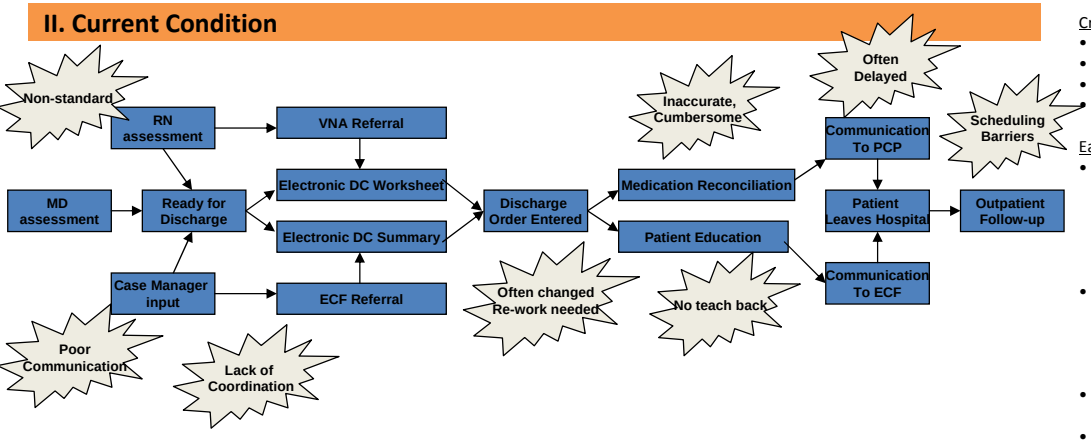
Preventing Avoidable Rehospitializations

Owner/ Date	J.Yang A.Carr	9/25/09	9/28/09		

I. Background

- Increasing attention nationally on avoidable rehospitalizations as quality of care metric and source of unnecessary healthcare cost
- Medicare data suggests that rehospitalization rates average approximately 20% nationally
- In near future, anticipate payors will be withholding reimbursements for care related to avoidable rehospitalization

II. Current Condition



III. Analysis

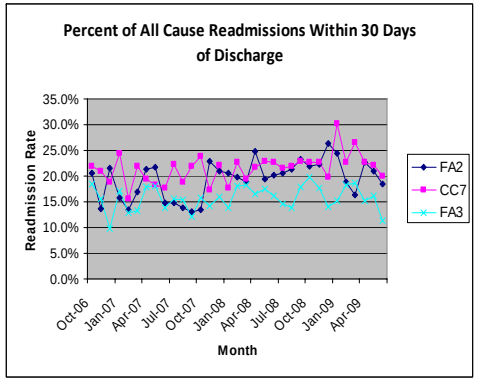
- BIDMC has a higher rate of avoidable rehospitalizations compared with national average:

	BIDMC	National Average
Heart Attack:	**22.9%**	**19.9%**
Heart Failure:	**27.5%**	**24.5%**
Pneumonia:	**21.4%**	**18.2%**

- BIDMC scores higher in HCAHPS Patient Satisfaction metrics:

"Help Needed After Discharge"
BIDMC: **84.17%** National Average: **80% "yes"**
"Information in writing about symptoms to look for post discharge"
BIDMC: **92.17%** National Average: **80% "yes"**

Unit-based Readmission Rates



IV. Goals/Targets

1. Reduce all cause readmission rate on pilot units (CC7, Farr 2, Farr 3) by 25% from baseline by Oct 2010
2. Improve HCAHPS patient satisfaction data relating to discharge to at least 90% responding "yes" by Oct 2010

V. Proposed Countermeasures

BIDMC Enrollment in STAAR Initiative:
- State Action on Avoidable Readmissions
- Multi-state initiative funded by Commonwealth Fund
- Technical guidance from Institute of Healthcare Improvement
- Application of Lean improvement strategies to reduce readmissions

Create an ideal transition out of the hospital: "Four Pillars for Improvement"
- Enhance assessment of post-discharge needs
- Enhance teaching/learning
- Enhance communication at discharge
- Ensure timely post-acute follow-up

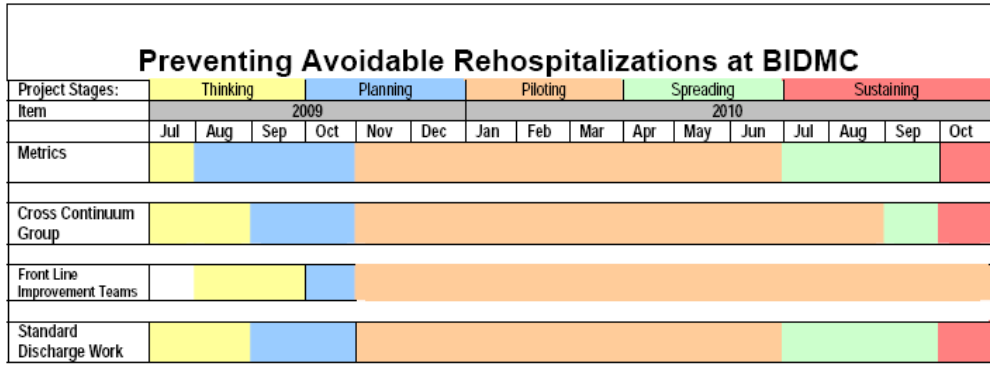
Early Proposed Counter Measures:
- Create Standard Work
  - Multidisciplinary Care Coordination Rounds format/agenda
  - Discharge Checklist
  - Readmission Risk Stratification
  - "Get Ready – Get Set – Go" MD Discharge Preparation
  - "Teach-back" RN-patient education
- Improve Reliability
  - Care Connections, Ambulatory Practice, Discharge Clinic
  - VNA home assessments for all high risk patients
  - Real-time verbal signout for all ECF-bound high risk patients
  - Discharge summaries complete on day of discharge for all patients
- Eliminate Waste/Improve Efficiency
  - Revise electronic discharge planning application
- Eliminate Defects
  - Improve electronic medication reconciliation application

Organizational Framework for Improvement

Front-line Improvement Teams
- Unit-based
- Multidisciplinary
- Project Map
- Idea System
- Weekly Meeting
- Rapid-cycle Change
- 5/15 Reports

Cross-Continuum Workgroup
- BIDMC, Hebrew Senior Life
- Inpatient-Outpatient Care Collaboration
- Enhanced coordination with VNA groups, extended-care facilities, ambulatory practices
- Oversee and facilitate work of Front-line Improvement Teams
- Monthly report to STAAR Initiative
- 5/15 Reports

VI. Implementation Plan



VII. Follow Up

- Monitor unit-based readmission rates
- Assess compliance with standardized discharge processes
- Audit reliability of follow-up appointments
- Ongoing case reviews of rehospitalized patients