Using Lean and Six Sigma Tools to Reduce 30 day Readmission Rates

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Director
Overview

• UF Health Background
• MECS Background
• Problems Statement
• Goals and Objectives
• Best Practices
• Project Plan and Schedule
• Project Execution
• Lessons Learned
• Initiative Status
• Contact Information
UF Health Background

- Located in Gainesville, Florida
- Primary teaching hospital for UF Health’s College of Medicine
- North Campus: 630-bed tertiary care facility (142 ICU beds)
- South Campus: 192 private inpatient beds
- More than 500 physicians representing 110 specialties
- Private, not-for-profit hospital and Level I Trauma Center
Management Engineering Consulting Services (MECS)

• Originated in 1968
• 7.0 FTE’s (Currently)
  • Director
  • Senior Engineers
  • Staff Engineers
  • Internship Program
  • Ad-Hoc Projects with MHA Interns, Student project groups
• Educational Background
  • Minimum BSIE required
  • Various Masters Degrees in Management and Engineering
Problem Statement

• UF Health’s risk-adjusted readmission rate is higher than expected according to data from the Center for Medicare and Medicaid Services (CMS).
• Higher penalties will be incurred if readmission rate is not improved
  • Penalties will increase in subsequent years
• The discharge process contributes to the high rate of readmission
Goals and Objectives

• Outline the current process
• Identify factors in the current process that contribute to unplanned readmissions
• Develop strategies to standardize process utilizing best practices identified by the University Health System Consortium (UHC)
• Implement standardized discharge process
# UHC Best Practices

## Adherence to Best Practice

<table>
<thead>
<tr>
<th>BEST PRACTICE</th>
<th>WHAT</th>
<th>WHO</th>
<th>WHEN</th>
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<tbody>
<tr>
<td>Assess risk</td>
<td>Polypharmacy - Previous Admits - No PCP</td>
<td>MD - RN - Case Manager</td>
<td>On Admission</td>
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<tr>
<td>Begin at admission</td>
<td>Identify Post DC needs - Ensure PCP - Educate Patient - Create Plan</td>
<td>MD - RN - Case Manager</td>
<td>Throughout Hospitalization</td>
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<tr>
<td>Schedule follow-up appoints</td>
<td>Specific Follow-up Appointment within 7 Days</td>
<td>Case Manager</td>
<td>Before Discharge</td>
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<tr>
<td>Teach back</td>
<td>Patient Explains in Own Words</td>
<td>IP TEAM</td>
<td>Throughout Hospitalization</td>
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<tr>
<td>Medication reconciliation</td>
<td>Discharge Meds Reflect Previous and New Meds</td>
<td>MD - Pharmacist</td>
<td>At Discharge</td>
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<tr>
<td>Written discharge plan</td>
<td>Useful, Accurate, Understandable, Information</td>
<td>MD - RN - Case Manager</td>
<td>At Discharge</td>
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<tr>
<td>DC Summary to PCP</td>
<td>Complete &amp; Transmit DC Summary</td>
<td>MD - HIM Team</td>
<td>At Discharge</td>
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<td>Discuss end of life wishes</td>
<td>Patient's Desires Considering Prognosis - Options</td>
<td>MD</td>
<td>Clinic - Before Discharge</td>
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<td>ED - alternatives to admission</td>
<td>HomeCare - Clinic</td>
<td>ED Team</td>
<td>In ED</td>
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<tr>
<td>Phone follow-up</td>
<td>Reinforce Teaching - Answer Questions - Manage Issues</td>
<td>Person Familiar with Patient</td>
<td>Within 72 Hours After Discharge</td>
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</tbody>
</table>
Project Plan

- Break current process down into 4 processes representing different stages of patient care: Day of Admission, Admission to Discharge, Day of Discharge, After Discharge

- Apply UHC recommendations to each stage of patient care and evaluate them for feasibility

- Kaizen Events

- Develop standardized processes
Project Plan

• Pilot the Ideal Process
  • Pilot Study to last 4 to 6 weeks
  • Assess and adjust task functions as needed
  • Track changes

• Assessment of the Pilot Study
  • Conduct interviews and review metrics to assess successes and shortcomings
  • Refine new process to allow standardization among all other clinical areas
## Project Timeline

### Improve the Discharge Team Project Schedule

**As of July 24, 2013**

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<td>1. Initial Baseline data collected.</td>
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<td>1a) Collect, identify, and define UHC benchmark data.</td>
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<td>1b) Document current discharge process.</td>
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<td>1c) Additional data collection.</td>
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<td>2. Review processes.</td>
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<td>2a) Assess process and adherence to UHC recommendations.</td>
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<td>2b) Identify additional Shands specific factors in the DC process contributing to readmission.</td>
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<td>2c) Define new process that promotes adherence to recommendations.</td>
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<td>2d) Create and define metrics for pilot study. Establish Bridge to Pilot Study.</td>
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<td>3. Pilot a standardized DC process. (Family Medicine)</td>
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<td>4a) Conduct interviews and review metrics to assess pilot successes and shortcomings.</td>
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<td>4b) Refine new process that will allow standardization among all hospital departments.</td>
<td><strong>MECS, Quality, Family Medicine</strong></td>
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Project Team

• MECS
  • Project Management
  • Process Facilitators

• Sebastian Ferrero Office of Clinical Quality and Patient Safety
  • Subject Matter Experts on Clinical Services
  • Clinical Data Analysis

• Family Practice Medical Group
  • Multidiscipline Medical Service Team consisting of Nurses, Doctors, Case Managers, and Pharmacists
Sebastian Ferrero Office of Clinical Quality and Patient Safety

• Oversees Clinical Quality Improvement at UF Health

• Departments include:
  • Clinical Risk Management
  • Quality
  • Patient Experience
  • Process Improvement
  • Quality Analytics
PROJECT PLAN
Development of Standard Process

- Preparation
  - Documented Current Processes in all 4 stages of the Patient’s Care
  - Documented Current Metrics

- Kaizen Events
  - Nine - 2 hour Kaizen sessions were conducted to create the proposed process in all 4 Stages
    - Current Process Validated
    - Process Gaps and Root Causes Identified
    - Brainstormed Opportunities for Improvement
    - Created a New Ideal Process
Validation of current process

KAIZEN EVENT
Current Process – After Discharge
# Ideal Process - After Discharge

## Flowchart

- **Doctor**:
  - Follow-up with patients on phone (3% currently)
  - Prescribe appropriate medication and follow-up
  - Document encounter in EPIC

- **Nurse**:
  - Contact bedside nurse
  - Document medication and procedure

- **Pharmacy**:
  - Receive information on medication
  - Document encounter in EPIC

- **Patient & Family Services**:
  - Close loop with patient

- **Social Worker**:
  - Complete medication issues
  - Document encounter in EPIC

- **Patient & Family**:
  - Contact bedside nurse
  - Document medication and procedure

- **Access Center**:
  - Make follow-up appointment with patient
  - Document encounter in EPIC

- **Home Care/ Hospice/ SNF**:
  - Close loop with patient (ensure all tasks are complete)
  - Document encounter in EPIC
Ideal Process- Day of Discharge

Day of Discharge – Ideal Process

Doctor

- Morning rounding
- Write orders/prescriptions

Nurse (Discharge Nurse)

- Pharmac. rep. go on rounds with team to see potential discharge(s)
- Discharge (counseling if needed)
- Nursing rounds (quick ~8:30 AM)
- Identify necessary items to be completed before discharge
- Update NAVICARE (coordinate with ADTU and CM, circle between 3 parties)
- Screen and prioritize earliest discharge patients (complete first)
- Communicate any barriers encountered (Case Manager, Nurse, ADTU, MD, etc.)
- Check with Case Manager/Nurse for any discharge issues
- Finalize discharge summary
- Write discharge orders

Pharm.

- Go on rounds with team to see potential discharge(s)
- Facilitate medication reconciliation prior to discharge (from MD)
- Facilitate med to beds/new prescriptions and refills.

Case Manager

- Electronic pre-round
- Identify potential discharges
- Assess for discharge readiness
  - Available SNF/Home
  - Internal/External requirements
  - Barriers
- Identify discharge issues

ADTU

- Go on nursing rounds (quick ~8:30 AM)
- Triage cases with DC Nurse, DC Facilitator, Pharmacy
- Review/update interdisciplinary lab in EPIC
- Go on physician rounds (~7:30 AM)

Social Worker

- Facilitate arrangements and communicate to team and patient/family
- Social Worker determines if psychosocial (i.e. transportation, family) barriers exist that would hinder a patient’s discharge

Patient & Family

- Patient and family participation
- Patient leaves

UHC Recommendation 1 – Assess Risk
- Case manager review

UHC Recommendation 4 – Teach Back
- AVS for all discharged patients

UHC Recommendation 5 – Medication Reconciliation
- Facilitate medication to beds/new prescriptions and refills

UHC Recommendation 6 – Provide Written Discharge Plan
- Finalize AVS (new version)

UHC Recommendation 7 – Communicate DC Summary to Next Provider
- MD communicates DC summary to PCP

Room in ADTU and ride available within hour?

- Yes
- No

Make additional appointments

Check for availability of discharge order

Best assignment to ADTU NAVICARE

Last check on patient, review AVS (print/teach)

Patient leaves
Current Process – Admission to Discharge

Days Between Admission & Discharge – Current Process

Doctor
- Rounds to Assess IP/OP status and impact on discharge plan. Assesses new patients for level of care needs.

Nurse
- Rounds with Doctor to Assess IP/OP status and impact on discharge plan. Assesses new patients for level of care needs.
- Works with CM and SW to verify pt. is ready for discharge.
- Verifies pt. meets all the requirements (labs and procedures) for discharge & makes necessary adjustments.
- Note: RN should be educating patients on all new medications, procedures, diagnosis/disease.

ADTU
- Review new admissions and tests from prior day, look for barriers to discharge, and print documents for doctors.

Pharmacy
- Review new orders for all new medications and dosages.

Charge Nurse
- Review admissions and tests from prior day, look for barriers to discharge, and print documents for doctors.
- Rounds with Doctor to Assess IP/OP status and impact on discharge plan. Assesses new patients for level of care needs.
- After identifying tentative discharges, meet with all nurses to go over discharge plans and see new patients.
- Reconvenes with doctor after doctor meets with attendings to confirm/cancel discharges.

UHC Recommendation 1
- Assess Risk
- Case Manager review

Case Manager
- Review admissions and tests from prior day, look for barriers to discharge, and print documents for doctors.
- Round with Doctor to Assess IP/OP status and impact on discharge plan. Assesses new patients for level of care needs.
- After identifying tentative discharges, meet with all nurses to go over discharge plans and see new patients.
- Reconvenes with doctor after doctor meets with attendings to confirm/cancel discharges.

Patient & Family
- Address psychosocial as well as transportation and medications issues that were identified by team members.
- Make arrangements and update patient record accordingly.

Patient Transport
- Address psychosocial as well as transportation and medications issues that were identified by team members.

Social Worker
- Address psychosocial as well as transportation and medications issues that were identified by team members.

NOTE: Case Managers currently work 12 hour shifts to improve assessment of patients and communication with clinical personnel.

Update discharge disposition (Homecare, DME, transportation, etc) and create or updates referrals

Assess impact on insurance

Address psychosocial as well as transportation and medications issues that were identified by team members

Make arrangements and update patient record accordingly
Ideal Process - Admission to Discharge

Doctor
- Pre-round and talk to nurse
- Morning report with sign-out with night team
- Assess pt. level of care and identify barriers to discharge
- Round first to patients who are planned to be discharged
- Communicate with Case Manager and Nurse to discuss discharge plans and ongoing assessments and after discharge orders
- Round on rest of patients
- Sign off to Case Manager

Nurse
- Nurse to nurse shift report
- Charge nurse and Case Manager report highlight to nurse
- Coordinate care of patient and team plan
- Staff nurse rounds with doctor
- Communicate with family and plan for discharge
- Verify patient needs at requirements
- Communicate discharge and record in EPIC

ADTU
- UHC Recommendation 4 - Teach Back
- UHC Recommendation 1 - Assess Risk

Pharmacy
- Pharmacy representative rounds with doctor
- Medication education
- Contact medication financial counselor

Charge Nurse
- Assist with Team Sack when contacted by Nurse

Case Manager/Liaison
- Electronic report with doctor
- Communicate with nurses to record identified day of discharge in interdisciplinary plan
- Case patients
- Co-ordinate
- Assess patient readiness for discharge plan
- Make internal referrals
- Request external referrals
- Coordinate follow-up appointments
- Start populating discharge instructions

UHC Recommendation 4 - Teach Back
UHC Recommendation 1 - Assess Risk

Homemade Liaison
- Social Worker
- Patient & Family
- Discharge Facilitator
- Coordinate all patient external referrals
- Plan and Jolee send email

Participate in care
### Current Process – Day of Admission

#### Day of Admission – Current Process

<table>
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<tr>
<th>Role</th>
<th>Tasks</th>
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</table>
| **Doctor**    | - Patient admitted<br>- Can PCP be identified?<br>- Adjust medications with PCP for medical needs and history<br>- Review orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Rounds with doctor to assess IP/OP status and impact on discharge plan<br>- Assesses new patients for level of care needs<br>- Identifies tentative discharges<br>- Meets with all nurses to go over discharge plans and see new patients<br>- Reassess new patients for level of care needs<br>- Reconvenes with doctor after doctor meets with attending to confirm/cancel discharges<br>- Reviews and approves documentation and charges for new discharges<br>- Updates discharge disposition (Homecare, DME, transportation, etc.) and creates or updates referrals<br>- Reviews and approves new patients for level of care needs<br>- Reviews PCP for medical records and history<br>- Generates alcohol, tobacco, and other drug (ATOD) screening<br>- Generates alcohol, tobacco, and other drug (ATOD) screening assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Updates EPIC navigator for medical reconciliation<br>- Completes ADL assessment<br>- Completes Nutrition assessment<br>- Completes Gait screening<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Assesses impact on insurance<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Nutritional assessment<br>- Completes ADL assessment<br>- Completes Gait screening<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br|- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening<br>- Completes Abuse/Neglect screening assessment<br>- Completes ADL screening assessment<br>- Completes Gait screening assessment<br>- Completes Nutrition assessment<br>- Generates PT/OT, SLP consult<br>- Generates CM/SW consult<br>- Completes Abuse/Neglect screening
| **Nurse**     | - Nurse contacts doctor to fix errors<br>- Complete discharge planning section in EPIC<br>- Identify and verify living arrangements<br>- Complete nutrition assessment<br>- Complete ADL screening assessment<br>- Complete Abuse/Neglect screening assessment<br>- Complete ADL screening<br>- Complete Gait screening<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment
| **Pharmacy**  | - Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Looks at EPIC to review all new admitted patients<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required
| **Charge Nurse** | - Complete discharge planning section in EPIC<br>- Identity and verify living arrangements<br>- Complete nutrition assessment<br>- Complete ADL screening assessment<br>- Complete Abuse/Neglect screening assessment<br>- Complete ADL screening<br>- Complete Gait screening<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult
| **ADTU Nurse** | - Complete discharge planning section in EPIC<br>- Identity and verify living arrangements<br>- Complete nutrition assessment<br>- Complete ADL screening assessment<br>- Complete Abuse/Neglect screening assessment<br>- Complete ADL screening<br>- Complete Gait screening<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult<br>- Complete Gait screening assessment<br>- Complete Nutrition assessment<br>- Complete PT/OT, SLP consult<br>- Complete CM/SW consult
| **Case Manager** | - Review new admissions and tests from prior day, look for barriers to discharge and print documents for doctors<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required<br>- Reviews patients for level of care needs<br>- Reviews orders for appropriateness of medications and dosage<br>- If red flags exist in the orders, informs doctor of changes required
| **Social Worker** | - Address psychosocial as well as transportation and medications issues that were identified by team members<br>- Make arrangements and update patient record accordingly
| **Patient & Family** | - Address psychosocial as well as transportation and medications issues that were identified by team members<br>- Make arrangements and update patient record accordingly
Ideal Process - Day of Admission

1. UHC Recommendation 1 - Assess Risk
   - Doctor review
   - Nurse contacts doctor to fix error
   - Nurse adds note in EPIC for accuracy
   - List all current allergies and medications
   - Complete Discharge Planning section in EPIC
   - Identify and verify ongoing need for services
   - Complete Nutrition Assessment
   - Is a consult needed?
     - Yes
       - Generate PT/OT/SLP consult
     - No
       - Complete Abuse/Neglect screening
       - Is a consult needed?
         - Yes
           - Generate CM/DW consult
         - No
           - Complete discharge plan
1. UHC Recommendation 2 - Begin Discharge at Admission
   - Case manager review
   - Review charts and tests of new admissions to look for barriers to discharge
   - Discuss with new patients and engage in discharge planning
   - Meet with nurses to go over discharge plans and see new patients
   - Thoroughly assess new patients discharge plan
   - Make appropriate referrals
   - Update discharge instruction (Discharge, DME, transportation, etc.)
   - Start on discharge plan (After Discharge Plan)

3. UHC Recommendation 3 - Teach Back
   - Doctor compares with PCP and medical records
   - Admitting MD updates EPIC either directly or through order
   - Completes discharge planning checklist in EPIC
   - Identify and verify ongoing need for services
   - Complete Discharge Planning section in EPIC
   - Complete nutrition assessment
   - Is a consult needed?
     - Yes
       - Generate PT/OT/SLP consult
     - No
       - Complete Abuse/Neglect screening
       - Is a consult needed?
         - Yes
           - Generate CM/DW consult
         - No
           - Complete discharge plan

4. UHC Recommendation 4 - Teach Back
   - Patient Education and Discharge Plan
   - Assessment complete after completion of all labs in EPIC

5. Patient and Family
   - Participate in care

6. Pharmacy
   - Review new ideas for accuracy and finalize list at ED prior to admission
   - Reviews orders for medications and dosage
   - If needed, reviews and makes changes required
   - Disease referral with Case Manager
   - Fill referral

7. Social Worker
   - Address psychosocial as well as transportation and medications
   - Make arrangements and update patient record accordingly

Doctor
- Patient needs to be admitted
- Ensure that outpatient records are complete and accurate
- Review and update outpatient medication list
- Discuss changes in medication list with patient
- Doctor fixes errors

Nurse
- Nurse contacts doctor to fix error
- Nurse adds note in EPIC for accuracy
- List all current allergies and medications
- Complete Discharge Planning section in EPIC
- Identify and verify ongoing need for services
- Complete Nutrition Assessment
- Is a consult needed?
  - Yes
    - Generate PT/OT/SLP consult
  - No
    - Complete Abuse/Neglect screening
    - Is a consult needed?
      - Yes
        - Generate CM/DW consult
      - No
        - Complete discharge plan

Case Manager
- Review charts and tests of new admissions to look for barriers to discharge
- Discuss with new patients and engage in discharge planning
- Meet with nurses to go over discharge plans and see new patients
- Thoroughly assess new patients discharge plan
- Make appropriate referrals
- Update discharge instruction (Discharge, DME, transportation, etc.)
- Start on discharge plan (After Discharge Plan)

Social Worker
- Address psychosocial as well as transportation and medications
- Make arrangements and update patient record accordingly
Summary of Key Changes

- Developed redundant processes
- Revised Electronic Medical Record (EMR) Software to better support discharge process
- Explicit exchange of readmission risk factors
- All disciplines apprised of discharge readiness
- Enhanced post-discharge support
- Follow-up phone calls
- Assigned complex discharge process and follow-up to a discharge nurse
- Assigned coordination with external agencies to a discharge facilitator
Verification and Validation

- Pilot Study
  - Original timeline set to run for 4-6 weeks
  - Pilot started in June 2013 with expected completion by the end of July (Validation period)
  - Pilot extended through December 2013 (Verification period)
  - Weekly status meetings to monitor progress and make adjustments
  - Administration regularly updated on status
Pilot Processes Implemented

• Schedule Discharge Appointment and Follow-up Phone Call
  • Revised the discharge follow-up appointment requirement from 7-10 days to 3-7 days
    • UF Health Patient Access Call Center arranging follow up appointment prior to discharge
    • Pharmacist now able to connect patients to the Patient Access Call Center to ensure appointments are generated
  • Follow up phone call completed by pharmacist
  • Accurate template developed documentation in EMR of phone call
Pilot Processes Implemented

- Medication Reconciliation
  - Provided Pharmacist access to Medication Reconciliation in EMR
  - Reinforced medication reconciliation at time of discharge and during follow-up phone call
Pilot Processes Implemented

- Teach Back and Written Discharge Plan
  - Implemented teach back method throughout patient stay as well as at discharge
  - Modified the After Visit Summary (AVS) to ensure accurate information
  - Discharging nurse conducts a more thorough AVS review
  - Obtain accurate contact information for follow-up phone call
  - Began health literacy assessment
Pilot Processes Implemented

- Discharge Summary to the Primary Care Physician (PCP)
  - PCP established or identified on discharge summary
Lessons Learned

- Multi-disciplined team effort is the best approach to decipher the readmission issue.
- Representation from all disciplines required at Kaizen Events.
- Timeline should be reviewed regularly to ensure project plan remains on track.
- Metrics should be posted throughout the project to communicate progress to the goal.
Initiative Status

• REALM Score incorporated into EMR
  – Used to identify health literacy issues to improve patient education

• Expand processes to other units?
  – Discharge Pilot Completed – December 2013
  ✓ Discharge phone calls by clinical leaders
  – Consider 3 day PCP follow-up appointments
Initiative Status

• Implement changes in EMR software
  • Revised AVS template
    • Limitations in EMR in correct generation of AVS (especially for medications)
  • Interdisciplinary Ready for Discharge Report
  • Print prescriptions on unit

• Medications
  • Meds to Beds
  • Increased Pharmacy involvement with discharge medication process
Initiative Status

• Expand financial screening assistance for managed care patients

• Explore options for addressing patient psychosocial issues by working with local organizations

• H.R. 4188 introduced in Congress in March 2014 addressing patient socioeconomic issues in the readmission penalty calculation
Monthly Urgent/Emergent Readmit Trending within 30 Days
Recent Discharge Date Range: 03/01/2013 to 02/28/2014

Fam Practice / 65MS

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Questions