

MSTCVS-QC Readmission Reduction Practices



Preoperative

- Identify patients at high risk for readmission using program's historical data or by screening all patients using a readmission prediction tool.
 - Phase of Care Readmission Evaluation Tool – Henry Ford Macomb
 - LACE tool
- Post discharge follow-up appointments scheduled at the same time as OR rather than instructing patient to call for appointment.
- Preoperative education focusing on what to expect during entire episode of care.

In-Hospital Discharge Planning and Care Coordination

- Begin discharge planning and teaching upon admission to the hospital. Determine who the patient's primary caregiver at discharge will be and schedule discharge teaching with the patient and caregiver.
- Daily interdisciplinary rounds that include home care, social work, and case management to determine discharge needs and disposition.
- Review printed discharge instructions (don't forget to assess patient and caregiver reading level) with patient and caregiver daily once discharge date is determined. Printed discharge information is provided in the patient's preferred language and use pictures for patients with low literacy.
- Provide patient with arm band that has phone number(s) (office, MD, midlevel provider) that the patient or caregiver may call when they have questions and that emergency room personnel will call if the patient returns to the ER. The band serves as a reminder for the patient and caregiver to call when necessary and is also an alert for other medical personnel to notify the surgeon if the patient is being seen in the ER or clinic, so he or she may see the patient and determine whether the patient should be readmitted.

Post-Discharge

- Discharge summary is sent to the patient's primary care physician.
- Patients instructed to call any time before going to the Emergency Room.
- Patients are visited by home health nurse within 24 hours.
- Office visit scheduled with NP or PA within 3 days of discharge.
- Use communication template or critical path to communicate expectations to Extended Care Facilities and Home Health Agencies.
- Conduct post discharge follow up phone calls at specific intervals depending on readmission risk. High risk patients should be called within 24 hours of discharge. Follow up phone call is scripted and includes medication reconciliation questions.
- Consider having high risk patients return to the office within 5 to 7 days after discharge. Factors contributing to readmission are rarely sudden and can often be managed in the outpatient setting when discovered early on. Recognition of these factors requires understanding of cardiac surgery.
- EMR alert to notify CT surgeon when patient is admitted to the ER.

Post-Readmission – Learning from Defects

- Case review using LFD tool.
 - Phase of Care Evaluation of Readmission (POCER)