

# WPSC Conference

## Reducing rehospitalizations, a rural hospital experience

Whitman Hospital &  
Medical Center  
Denise Fowler, RN, MS  
Chief Clinical Officer



# Whitman Hospital & Medical Center

- 25 bed critical access hospital
- Public district hospital, located in southeast Washington
- Services: ED, Med/Surg, OB & pediatrics  
Surgery/Procedures, full range of support services

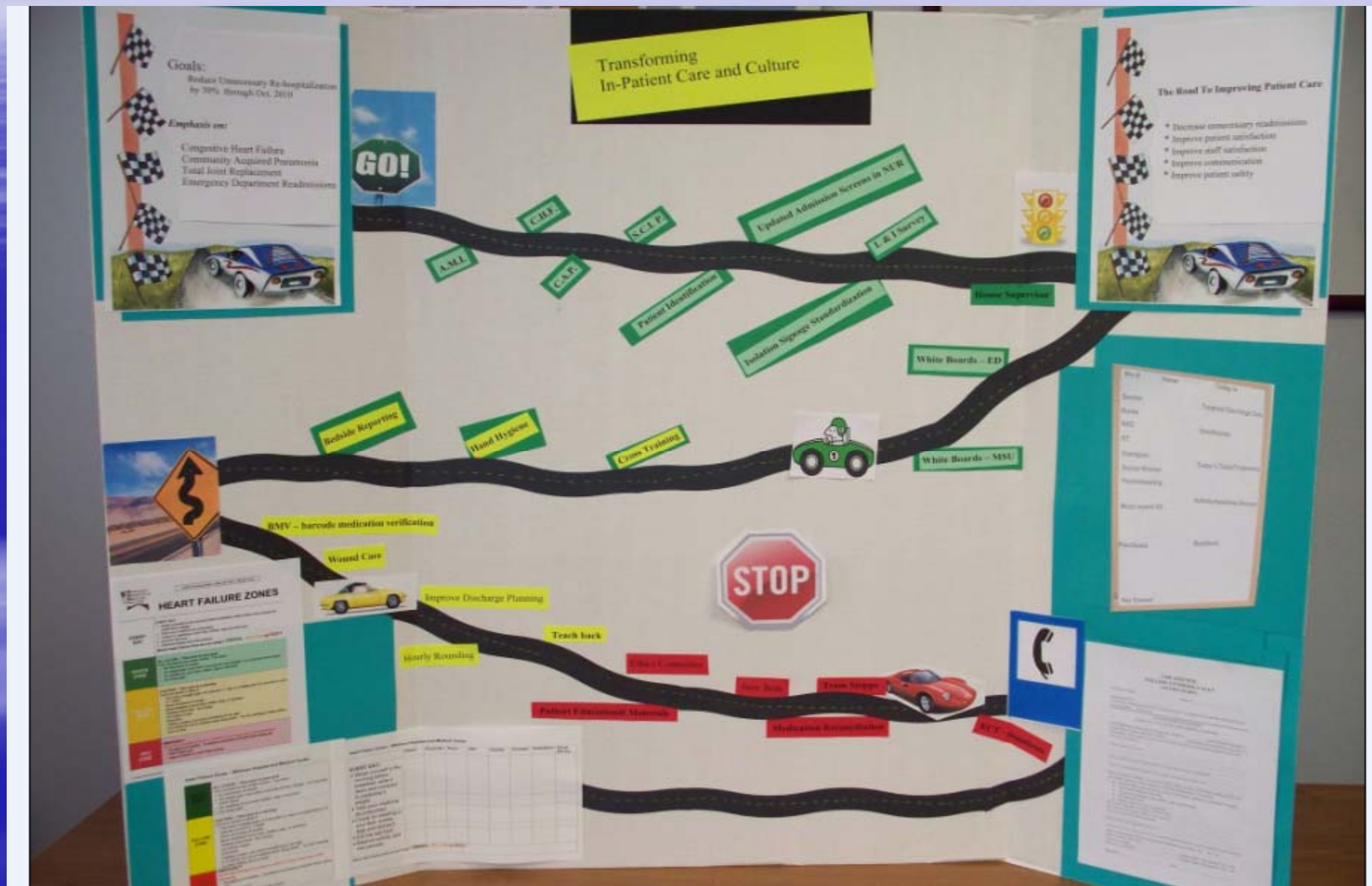
# Our Team

- Internal Team: Patients, staff nurses, nursing assistants, social worker, radiology, laboratory, physical therapy, ED, dietary, respiratory, education, UR/CM, PI, managers, physicians and CCO
- Cross continuum team: members of above team plus continuum partners including medical office practice, SNF, assisted living, home health, adult day health and Council on Aging

# WHMC Projects

- Began with developing a Transforming Inpatient Care and Culture (TICC) team with WSHA and NWONE
- Team joined State Action on Avoidable Rehospitalizations (STAAR) project with WSHA and IHI
- Developed Continuum of Care team out of work related to above teams to provide seamless care to our patients and the communities we serve

# Our Journey





# WHMC Project

- Aim: Reduce 30 day rehospitalization by 30% by October 31, 2010
- Outcome measures:
  - Improve patient satisfaction with discharge process
  - Reduce 30 day rehospitalization – overall and in CHF, CAP and TJR
  - Reduce Length of Stay - overall and in targeted populations
  - Improve whiteboard compliance to 100% each shift
  - Improve percent of follow-up phone calls including teach back (80% of information)

# Creating an Ideal Transition Home

- I. Perform Enhanced Admission Assessment for Post-Hospital Needs
- II. Provide Effective Teaching and Enhanced Learning
- III. Conduct Real-Time Patient and Family-Centered Handoff Communication
- IV. Ensure Post-Hospital Care Follow-Up

*IHI Ideal Transitions*

# Similar Work

- Project Red
- BOOST
- Care Transitions Intervention <sup>SM</sup>
- CMS Discharge Checklist
- INTERACT II
- Transitional Care Nursing Model
- Best Practices Intervention Package (BPIP)
- Transforming Care at the Bedside (TCAB)



# BOOST

Society of Hospital Medicine | Quality Initiatives for H...

Home Log-in Community Career Center QI Resource Rooms

QUESTIONS CONTACT SITE MAP

SEARCH

QUALITY INITIATIVES

Home | Project Team

Professional Development Implementation Guide Exchange Information

How to Use First Steps Best Practices Analyze Care Delivery Track Performance The BOOST Intervention Continue to Improve Education Resources Clinical Tools QI Basics

**project BOOST**  
Better Outcomes for Older adults through Safe Transitions

**How Do I Become A BOOST Site?**

There are several levels of involvement.

**Project BOOST- Free Informational Webinar**  
May 24th, 2011 at 2:00 p.m. EDT  
Presenter: Mark V. Williams, MD, FACP, FHM  
Principal Investigator, Project BOOST  
[Click here to register](#)

Steps to apply:

1. Complete & Submit the online application
2. Submit a Letter of Support from an Executive Sponsor to Lauren Valentino at [lvalentino@hospitalmedicine.org](mailto:lvalentino@hospitalmedicine.org).


**APPLY Now**

Any site can access the BOOST toolkit via the resource room free of charge at [www.hospitalmedicine.org/BOOST](http://www.hospitalmedicine.org/BOOST). Over 1600 sites have downloaded the complete Implementation Guide which serves as a portable version of the resource room and will walk you through the steps improve the discharge process.



ABOUT SHM  
MEMBERSHIP  
EDUCATION  
QUALITY INITIATIVES  
QI Current Initiatives and Training Opportunities  
QI Basics  
QI Clinical Tools  
QI Resource Rooms  
Clinical Blog: Hospital Medicine Quick Hits  
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**BOOSTing Care Transitions Resource Room Project Team**

# PROJECT RED



A Research Group at  
Boston University Medical Center



Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality & National Heart, Lung and Blood Institute

- Home
- Development of the RED
- Components of the RED
- Implementing Project RED
- Meet Louise...
- New & Improved Toolkit
- Toolkit
- Our Team
- Recognitions
- Newsroom
- Presentations
- Publications & Abstracts
- Funding
- Links
- Receive Updates
- Contact Us

## Project RED (Re-Engineered Discharge)

Project **Re-Engineered Discharge** is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction. Virtual patient advocates are currently being tested in conjunction with the RED. In addition, Project RED has started to implement the re-engineered discharge at other hospitals serving diverse patient populations.

Project RED is supported by grants from the **Agency for Healthcare Research and Quality (AHRQ)** and the **National Institutes of Health (NIH)-National Heart, Lung and Blood Institute (NHBLI)**. The contents of this website are solely the responsibility of Brian Jack, MD and Boston Medical Center and do not necessarily represent the official view of or imply endorsement by AHRQ, the U.S. Department of Health and Human Services, the NIH or NHBLI.

### Latest Project RED News

Re-engineered discharge project dramatically reduces

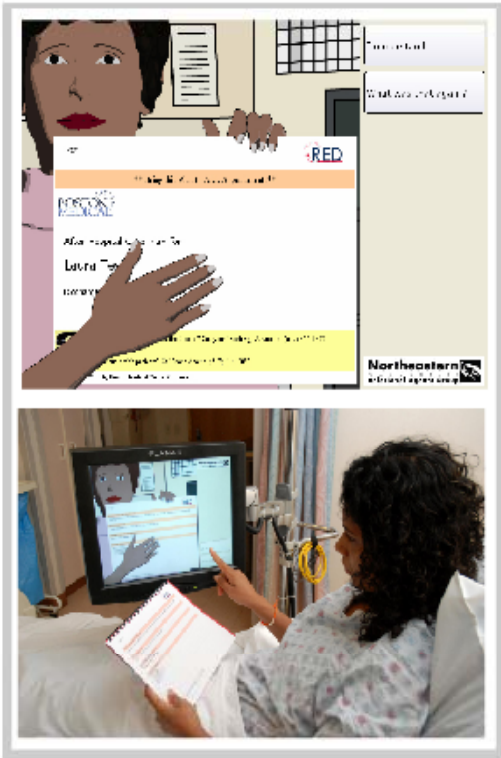


Photo: Glenn Kulshel

# INTERACT



## Interventions to Reduce Acute Care Transfers

[Home](#) ♦ [About INTERACT](#) ♦ [INTERACT II Tools](#) ♦ [Educational Resources](#) ♦ [Links to Other Resources](#) ♦ [Project Team](#) ♦ [Contact Us](#)

### What is INTERACT?

INTERACT is an acronym for "Interventions to Reduce Acute Care Transfers". The INTERACT Program includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

### Login for INTERACT Curriculum participants



[Click here to login](#)



[Click here to register / Champions and Co-Champions o](#)



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[Learn more about INTERACT](#)

[INTERACT II Tools](#)

[Educational Resources for INTERACT](#)

[What is the purpose of the INTERACT?](#)

 [Announcements](#)

# Team Process

- Conducted small tests of change
- Listened to monthly calls and gathered lots of great ideas (steal shamelessly)
- Met weekly
- Involved everyone across the hospital
- Involved partners
- Took advantage of moment of change to add other pieces into the project



# Whiteboard

- Piloted whiteboards numerous times including staff, patients and providers
- Boards in all inpatient rooms except safe room
- Chalk board in safe rooms
- MD uses to round
- RN uses with bedside report
- Board includes entire team
- Set targeted discharge date





# ED Chalk Board

**What am I waiting for?**

Waiting for results

Lab: \_\_\_\_\_

X Ray: \_\_\_\_\_

CT: \_\_\_\_\_

Meds: \_\_\_\_\_

**Home Care/Instructions:**

Driver: \_\_\_\_\_

Medical Provider: \_\_\_\_\_

RN: \_\_\_\_\_

Nurses Aide: \_\_\_\_\_

RT: \_\_\_\_\_

If you have questions, please ask your nurse





# Bedside Report

- Standardized process RN to RN, includes patient and family if present.
- Update whiteboard at handover with patient
- Handover shift to shift
- Handover ED to MSU (nurse pulls pt to MSU)
- Handover PACU to MSU (PACU brings pt to room)

# Teach Back

- Focus groups: CHF, CAP, THR, TKR
- Modeled materials off of CHF zones
- Teach patients the basics – goal is green zone, then build from there
- Combine patient education book, zones and teach back tool with each patient contact
- Reassess teach back during follow-up phone call



# Introduction of Teach Back

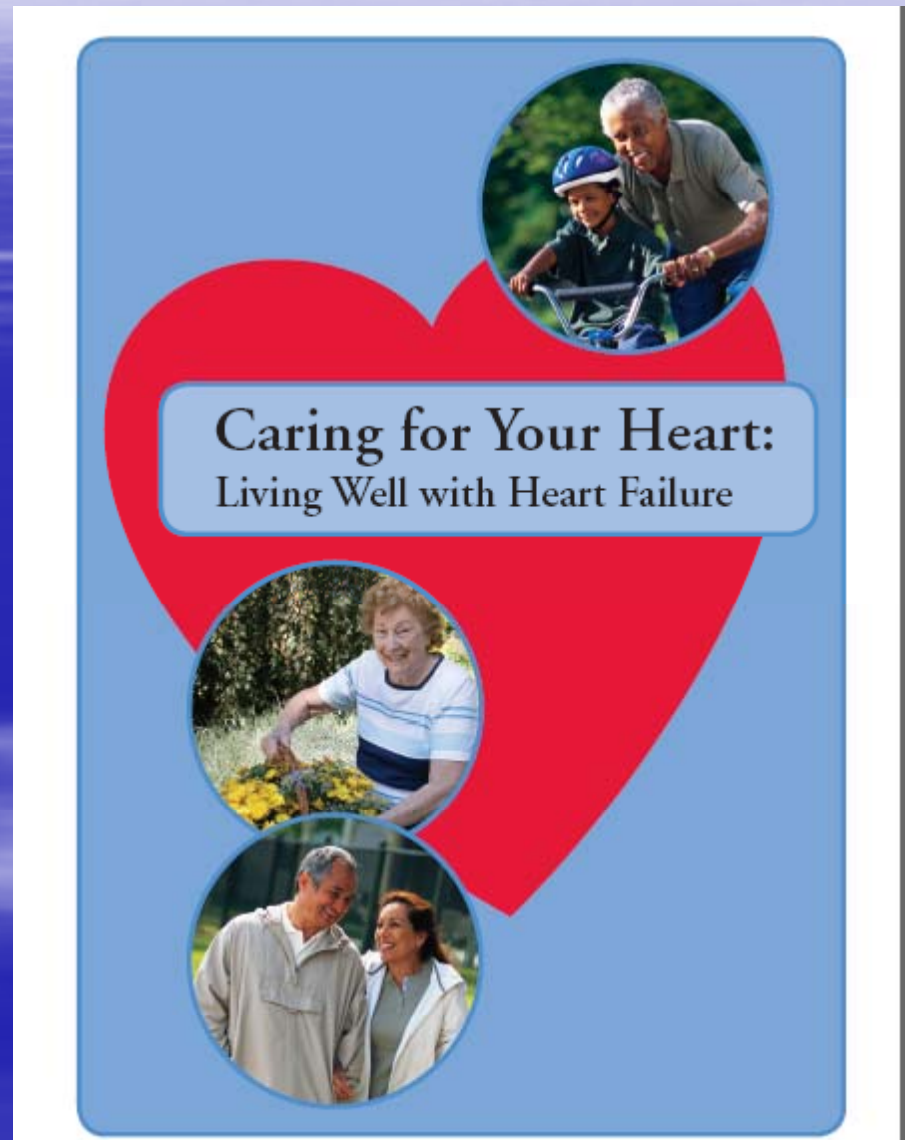
- The "Teach Back" Method is simply teaching your patient in a clear manner and then asking them to repeat *in their own words* what you just taught them. This method allows you to check your patient's understanding of your instructions.
- It is not a test but a method to ensure they understand what has been taught to them – you can say "I want to be sure that I did a good job explaining your blood pressure medications, because this can be confusing. Can you tell me what changes we decided to make and how you will now take the medication?"
- In the hospital setting we begin small and build on the information shift to shift and day to day to ensure to patient has a good understanding.

# Teach Back - CHF Materials

Adopted from:

University of  
North  
Carolina

Health  
Literacy



## Things You Can Do to Live Well with Heart Failure



Take your medicines (every day) correctly.



Eat less salt.



Exercise regularly.



Check yourself each day.

**Basic key  
concepts to  
teach each  
patient and their  
key learner**



## How to Eat Less Salt

Avoid or limit these high salt foods:



fast food



frozen meals



hot dogs, bacon,  
smoked meat



pizza



cheese



canned beans  
and vegetables



instant  
hot cereals



canned or  
potted meat



sauces and  
seasonings



snack foods



canned and  
smoked fish



canned soup

Dietitian can mark in book those foods the patient typically eats and make recommendation that rest of care team can reinforce



1200 W Fairview Street, CoMax, VA 99111 509.397.3435

## HEART FAILURE ZONES

<b>EVERY DAY</b>	<p>EVERY DAY:</p> <ul style="list-style-type: none"><li>• Weigh yourself in the morning before breakfast, write it down and compare to yesterday's weight.</li><li>• Take your medicine as prescribed.</li><li>• Check for swelling in your feet, ankles, legs and stomach.</li><li>• Eat low salt food.</li><li>• Balance activity and rest periods.</li></ul> <p>Which Heart Failure Zone are you today? <b>GREEN, YELLOW or RED?</b></p>
<b>GREEN ZONE</b>	<p>ALL CLEAR – This zone is your goal Your symptoms are under control. You have:</p> <ul style="list-style-type: none"><li>• No shortness of breath.</li><li>• No weight gain more than 2 pounds (it may change 1 or 2 pounds some days).</li><li>• No swelling of your feet, ankles, legs or stomach.</li><li>• No chest pain.</li></ul>
<b>65</b> <b>YELLOW ZONE</b>	<p>CAUTION – This zone is a warning Call your doctor's office if:</p> <ul style="list-style-type: none"><li>• You have a weight gain of 3 pounds in 1 day or a weight gain of 5 pounds or more in 1 week.</li><li>• More shortness of breath.</li><li>• More swelling of your feet, ankles, legs, or stomach.</li><li>• Feeling more tired. No energy.</li><li>• Dry hacky cough.</li><li>• Dizziness.</li><li>• Feeling uneasy, you know something is not right.</li><li>• It is harder for you to breathe when lying down. You are needing to sleep sitting up in a chair.</li></ul>
<b>RED ZONE</b>	<p>EMERGENCY Go to the emergency room or call 911 if you have any of the following:</p> <ul style="list-style-type: none"><li>• Struggling to breathe. Unrelieved shortness of breath while sitting still.</li><li>• Have chest pain.</li><li>• Have confusion or can't think clearly.</li></ul>



# Back of CHF Zones

## **Patient Teach Back – Congestive Heart Failure**

- What zone am I in today?
- What is the name of the water pill I take?
- Why do I need to weigh myself everyday?
- What foods are bad for me?
- How do I check for swelling?
- What action do I need to take in the Green Zone?
- What action do I need to take in the Yellow Zone?
- What action do I need to take in the Red Zone?
- What is your ideal Zone?

# CHF Teach Back/Care Plan

		Patient	Physician	Nurse	NAC	Dietitian	Therapist	Respiratory	Social
<b>GREEN ZONE</b>	<b>ALL CLEAR – This zone is your goal</b> Your symptoms are under control. You have: <ul style="list-style-type: none"> <li>No shortness of breath.</li> <li>No weight gain more than 2 pounds (it may change 1 or 2 pounds some days).</li> <li>No swelling of your feet, ankles, legs or stomach.</li> <li>No chest pain.</li> </ul>								
	<b>EVERY DAY:</b> <ul style="list-style-type: none"> <li>Weigh yourself in the morning before breakfast, write it down and compare to yesterday's weight.</li> </ul>								
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	<ul style="list-style-type: none"> <li>Take your medicine as prescribed.</li> </ul>								
	<ul style="list-style-type: none"> <li>Check for swelling in your feet, ankles, legs and stomach.</li> </ul>								
	<ul style="list-style-type: none"> <li>Eat low salt food.</li> </ul>								
<b>RED ZONE</b>	<b>EMERGENCY</b> Go to the emergency room or call 911 if you have any of the following: <ul style="list-style-type: none"> <li>Struggling to breathe. Unrelieved shortness of breath while sitting still.</li> <li>Have chest pain.</li> <li>Have confusion or can't think clearly.</li> </ul>								
	<ul style="list-style-type: none"> <li>Balance activity and rest periods.</li> </ul>								
	Which Heart Failure Zone are you today? , YELLOW or ?E								

# Handovers

- Bedside reporting including patients and families
- Rounding with MD – determining targeted date of discharge
- SBAR internally between departments
- RN TO RN report to SNF, Assisted Living & HH
- Home Health participates in “morning meeting” to help with discharge planning
- Developed Continuum of Care committee

# RN to RN Report to Continuum



Patient Name: \_\_\_\_\_

☐ Nursing Home ☐ Assisted Living ☐ Home Health ☐ Hospice  
☐ Other: \_\_\_\_\_

Hospital Admit Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

<b>Mental Status</b>	<b>Behavior</b>	<b>Skin Condition</b>	<b>Isolation</b>
<input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful	<input type="checkbox"/> Appropriate <input type="checkbox"/> Noisy <input type="checkbox"/> Belligerent <input type="checkbox"/> Withdrawn <input type="checkbox"/> Combative <input type="checkbox"/> Suspicious <input type="checkbox"/> Other _____	<input type="checkbox"/> Good <input type="checkbox"/> Dry <input type="checkbox"/> Fragile <input type="checkbox"/> Bruises <input type="checkbox"/> Red Areas <input type="checkbox"/> Open Areas <input type="checkbox"/> <u>Decubs</u>	<input type="checkbox"/> Contact <input type="checkbox"/> Enteric <input type="checkbox"/> Respiratory <input type="checkbox"/>
<b>Weight Bearing</b>	<b>Impairments</b>	<b>Incontinence</b>	
<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/> On _____ Leg(s)	<input type="checkbox"/> Speech <input type="checkbox"/> Dementia <input type="checkbox"/> Hearing <input type="checkbox"/> Depression <input type="checkbox"/> Vision <input type="checkbox"/> Anxiety	<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder <input type="checkbox"/> Date of last B.M. _____	
<b>A.D.L. Functions</b>		<b>Social Information</b>	
<b>Bathing</b> <i>Independent</i> <i>Partial Assist</i> <i>Total Assist</i> <b>Eating</b> <i>Independent</i> <i>Partial Assist</i> <i>Total Assist</i> <b>Dressing</b> <i>Independent</i> <i>Partial Assist</i> <i>Total Assist</i> <b>Mobility</b> <i>Independent</i> <i>Partial Assist</i> <i>Total Assist</i> <b>Toileting</b> <i>Independent</i> <i>Partial Assist</i> <i>Total Assist</i> <b>Transfers</b> <i>Independent</i> <i>Partial Assist</i> <i>Total Assist</i>			
<b>Additional Pertinent Information</b>			
<b>Code Status/POLST:</b> <b>Special Precautions:</b> <b>High Risk Behaviors:</b>  <b>Durable Medical:</b> <input type="checkbox"/> Oxygen _____ <input type="checkbox"/> Walker <input type="checkbox"/> W/C <input type="checkbox"/> Special Bed <input type="checkbox"/> Assistive Devices:		<b>Height/Weight:</b> _____ <b>Continue Daily Weight?</b> <b>Immunizations given:</b> Influenza _____ Pneumococcal _____ <b>Diet</b> _____ <b>Pain Management:</b>	

# Discharge Checklist

- Modifying checklist from Eric Coleman
- Small tests of change – many modifications to form
- Working to hardwire into electronic medical record.....work in process
- Link to continuum work as well – Family Home Care has similar checklist



# Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> I have been involved in decisions about what will take place after I leave the facility</li><li><input type="checkbox"/> I understand where I am going and what will happen to me once I arrive.</li><li><input type="checkbox"/> I have the name and phone number of a person I should contact if a problem arise during my transfer.</li><li><input type="checkbox"/> I understand what my medications are, how to obtain them and how to take them.</li><li><input type="checkbox"/> I understand the potential side effects of my medications and whom I should call if I experience them.</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> I understand what symptoms I need to watch out for and whom to call should I notice them.</li><li><input type="checkbox"/> I understand how to keep my health problems from becoming worse.</li><li><input type="checkbox"/> My doctor or nurse has answered my most important questions prior to leaving the facility.</li><li><input type="checkbox"/> My family or someone close to me know that I am coming home and what I will need once I leave the facility.</li><li><input type="checkbox"/> If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.</li></ul> |
|---|---|

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A Hartford Foundation and the Robert Wood Johnson Foundation.

# Risk for Re-Admission Tool

## Re-Hospitalization Risk Assessment

Purpose: Screening tool to identify those at risk of re-hospitalizations

Date: \_\_\_\_\_ Anticipated Date of Discharge: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_

### Prior Pattern: Check all that apply.

- ☐ > 3 hospitalizations or ED visits in past 3 months
- ☐ History of falls
- ☐ Re-hospitalizations within 30 days – Automatically schedule follow-up appointment with physician 48 hours

### Chronic Conditions: Check all that apply

- |                               |  |                                       |  |
|-------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> CHF  | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Obesity      | <input type="checkbox"/> Liver failure |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Renal failure | <input type="checkbox"/> Hypertension |  |

### Risk Factors: Check all that apply

- |   |   |
|---|---|
| <input type="checkbox"/> More than 2 secondary diagnoses                        | <input type="checkbox"/> Pressure or stasis ulcer |
| <input type="checkbox"/> Low social economic status/limited financial resources |   |
| <input type="checkbox"/> Poor prognosis for improvement                         | <input type="checkbox"/> Lives alone              |
| <input type="checkbox"/> Short life expectancy                                  | <input type="checkbox"/> Limited support network  |
| <input type="checkbox"/> Help with managing medications needed                  |   |
| <input type="checkbox"/> Non-compliance with medication regimen                 | <input type="checkbox"/> ADL assistance needed    |
| <input type="checkbox"/> Home safety risks                                      | <input type="checkbox"/> Difficulty reading       |
| <input type="checkbox"/> Dyspnea  | <input type="checkbox"/> Confusion                |

# Boxes checked \_\_\_\_\_

- ☐ 0 – 2 low risk – appointment to be 5 – 7 days
- ☐ 3 – 5 moderate risk – appointment to be 3 – 5 days
- ☐ 6 or > high risk – appointment to be within 2 days

Post discharge needs:

- ☐ Home health

# Discharge/Follow-Up Process

- High risk for readmission
  - High risk patients seen in clinic 2 days post-discharge
  - Moderate risk patients seen in clinic 3 -5 days post-discharge
- Follow-Up phone call made 48 – 72 hours after discharge to evaluate care and re-test teach back recall

# Continuum Of Care Committee

- Partners from across the continuum
  - Physician Office Practice, SNF, AL, HH, Adult Day Health, Counsel on Aging
- Work based off of IHI toolkits
  - Guide for Field Testing: Creating an Ideal Transition To Skilled Nursing Facility
  - Guide for Field Testing: Creating an Ideal Transition To Clinical Office Practice
- CMS Project - INTERACT II

# Continuum Of Care Team

- Reconcile plan of care and medications – number 1 concerns/failures in transition
- RN to RN report to SNF, AL, HH
- Creating handover tool from SNF to hospital
- Shared tools from INTERACT II
  - Stop and Watch tool for nursing assistants
  - SBAR handover in SNF, AL to help with calling MD



# INTERACT II



- *communication tools*
- *clinical care paths*
- *advanced care planning tools*



## EARLY WARNING TOOL

### "Stop and Watch"

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident \_\_\_\_\_

**S**eems different than usual

**T**alks or communicates less than usual

**O**verall needs more help than usual

**P**articipated in activities less than usual

**A**te less than usual (Not because of dislike of food)

**N**

**D**rank less than usual

**W**eight change

**A**gitated or nervous more than usual

**T**ired, weak, confused, or drowsy

**C**hange in skin color or condition

**H**elp with walking, transferring, toileting more than usual

Staff \_\_\_\_\_

Reported to \_\_\_\_\_

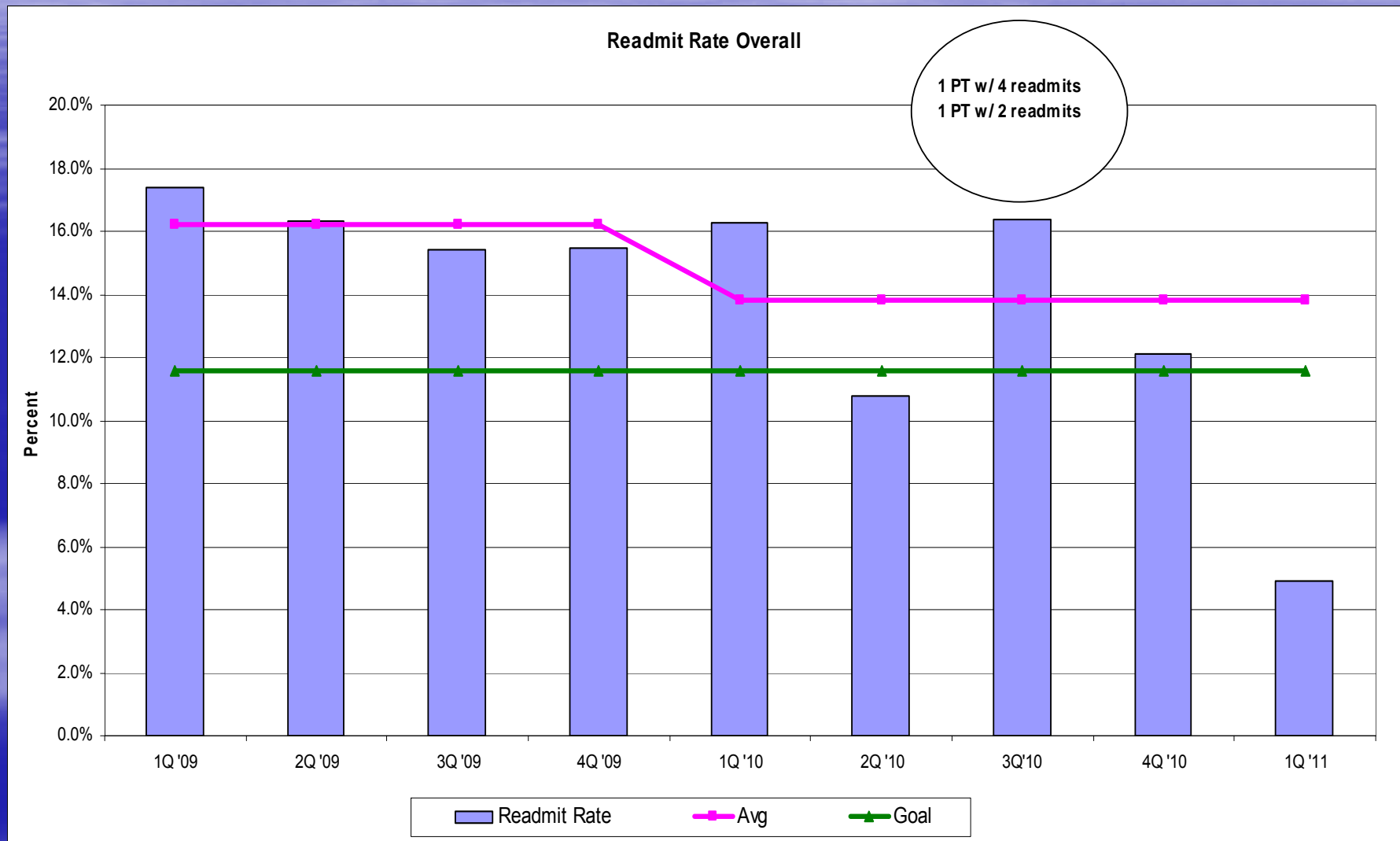
Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_

SS  
RT  
NT

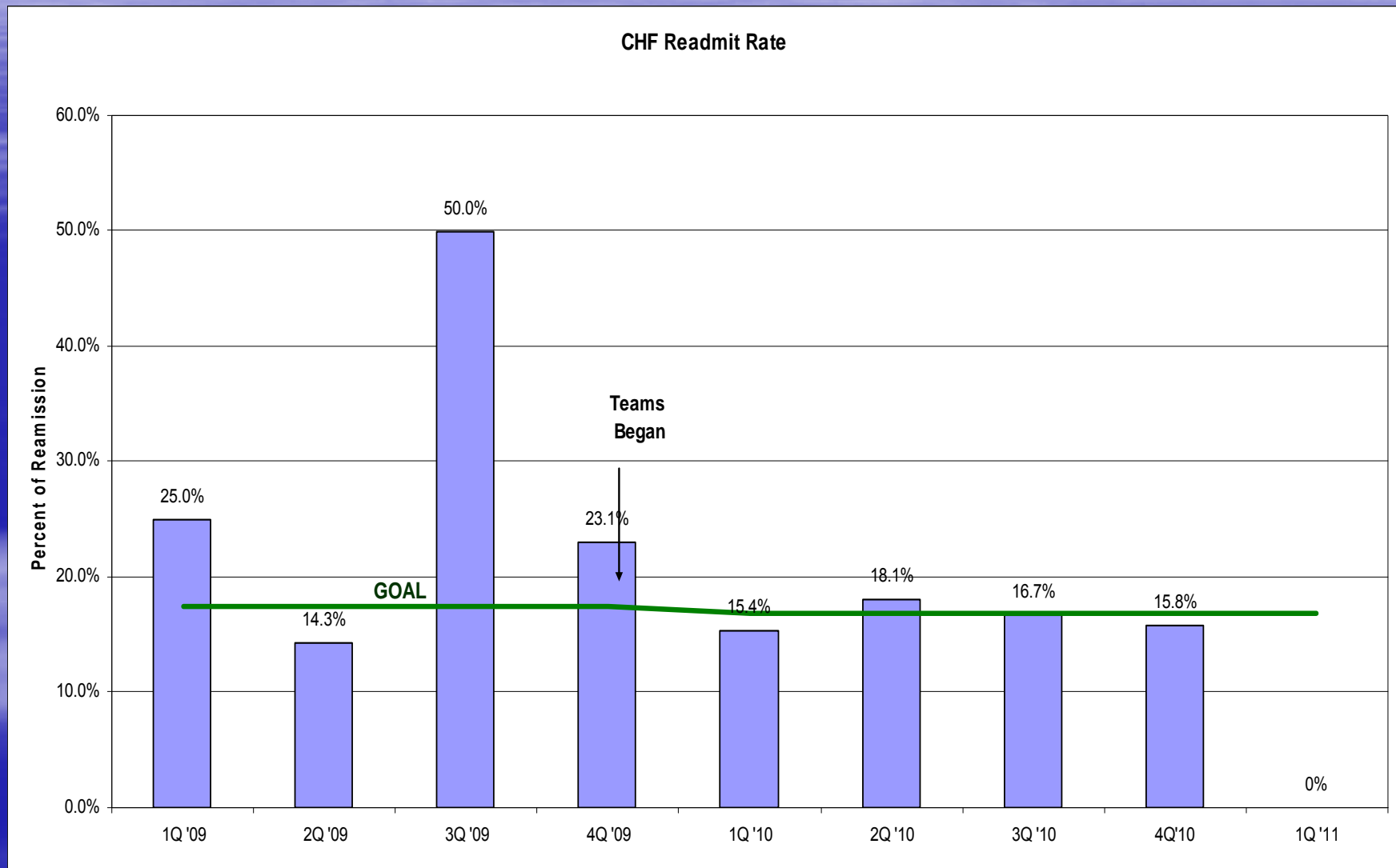
# Meeting the Mark

- Integrated key interventions into routine admission order set – used by all providers
- Went from retrospective review to concurrent review with interventions
- Added to dashboard along with TICC & STAAR measures
- Report data to providers, staff, and board
- Mini-root cause analysis to see why there was a failure in process (e.g. measure fall out, readmission within 30 days)
- Balancing financial considered while keeping the patients first

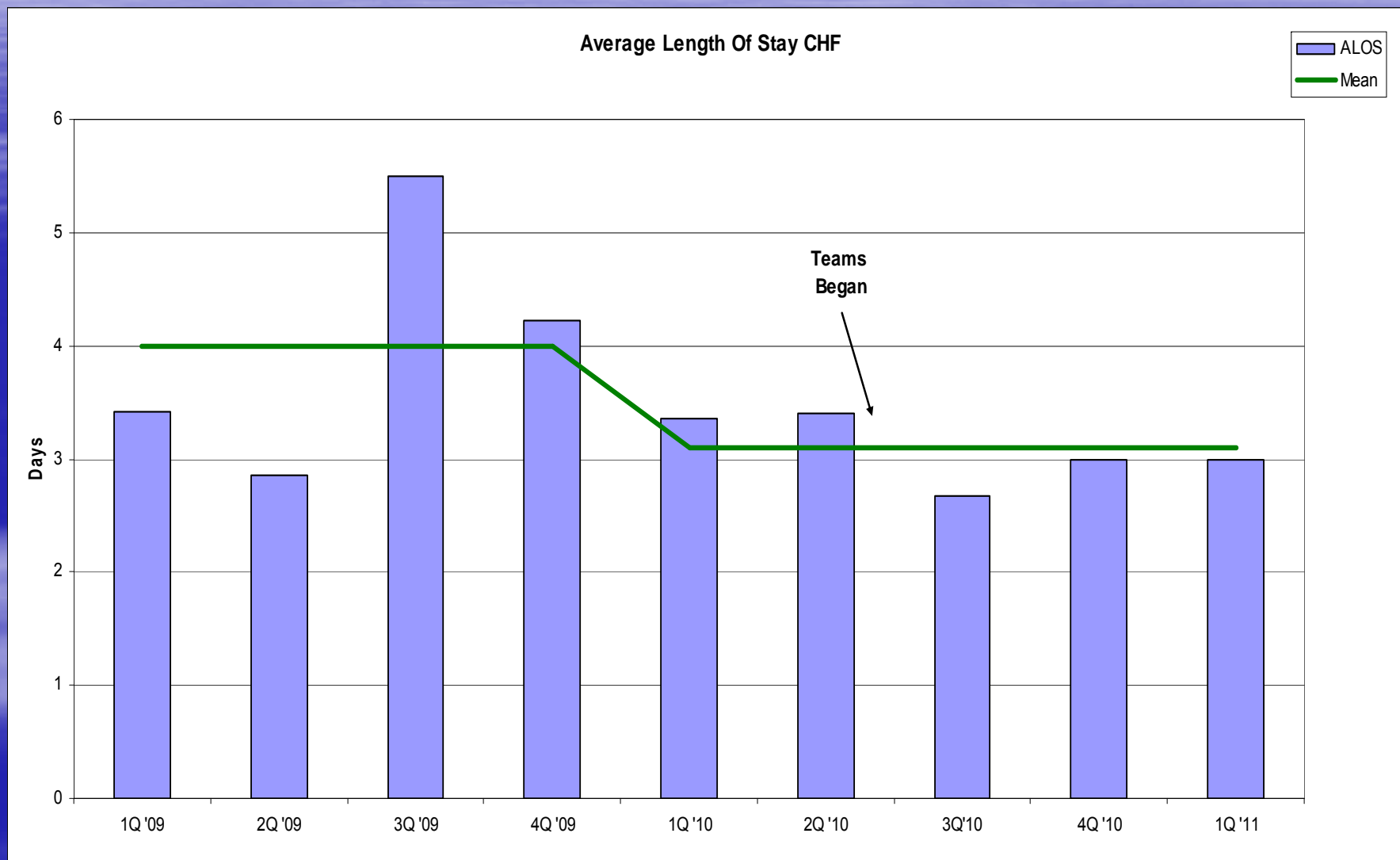
# Readmission Rate



# CHF Readmission Rate

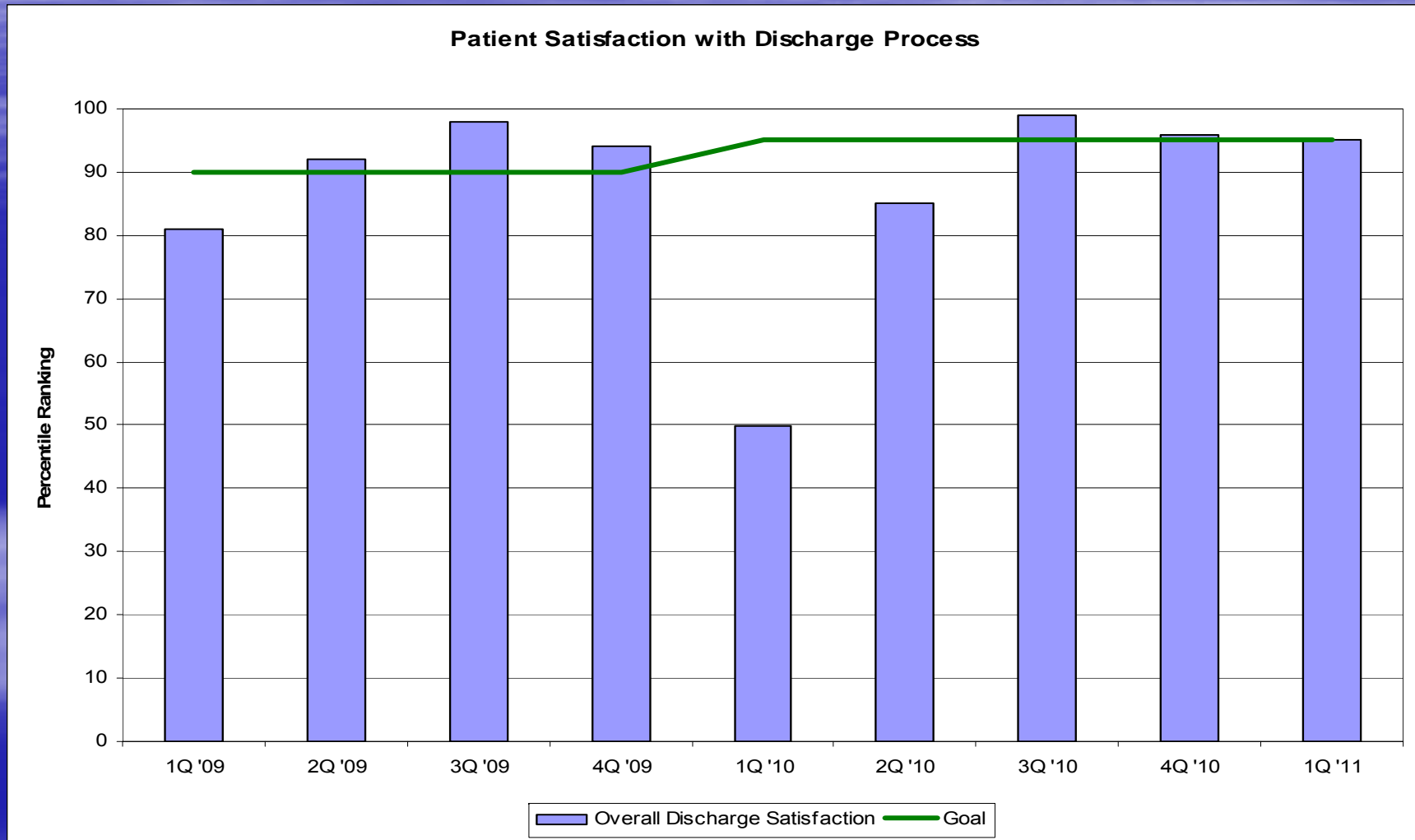


# CHF Length Of Stay





# Patient Satisfaction with Discharge Process Overall



# Lessons Learned

- Frontline staff driven is a must but some need to be nudged
- Patient and family input is a must
- Collaborative group (TICC, IHI, WSHA) great way to get new ideas
- Small tests of change really work
- Multidisciplinary team approach is key
- Scheduled meeting times makes work happen
- Fun and food help!

# What is new in this work?

- Partnership for Patients: Goals by end of 2013 prevent complications during transition from one care setting to another.
- The Care Transitions Opportunities – <http://www.cms.gov/DemoProjectssEvalRpts>
- Updated materials coming out from IHI soon on STARR updates

# State Action on Avoidable Rehospitalizations

## Smooth Transitions



- Cohesive plan of care at arrival
- Integrated plan at discharge (patient, family and care provider)
  - Coordinated follow-up call or visit
  - Timely visit to primary care provider
    - Reconciliation of medications
    - Coordinated education
- Support through care management

# Next Steps

- Continue work with TICC and STAAR
- Explore more community based efforts
- Next diseases: COPD and diabetes
- Smooth transitions across the continuum – leverage EMR
- Share learning's with representatives to help make a difference in legislation



# Questions??????????



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