During the five-month fishbowl series, the hospitals received active coaching on live virtual events and individual coaching calls with subject matter experts Amy Boutwell, MD, MPP and Pat Teske, BSN, MHA. What emerged from this learning experience was advisement in four primary domains.

**THOSE DOMAINS INCLUDE:**

- Articulate a goal and identify a target population
- Engage staff and leverage existing resources
- Link patients to follow-up services
- Work in the emergency department to avoid readmissions
### FISHBOWL LEARNINGS

1. **KNOW YOUR DATA; IDENTIFY YOUR OWN PATIENT POPULATIONS WITH HIGH READMISSION RATES.**

   Run your own hospital-wide, all cause readmission analysis. Based on what you learn decide which patient populations need a targeted approach.

   - Some hospitals noted high readmission rates for all heart failure or all COPD patients (not just Medicare beneficiaries).
   - One hospital noted that sickle cell patients had the highest readmission rates at their hospital — they never realized that until they ran their own readmission data analysis!
   - More than one hospital noted sepsis leads to the most readmissions, and due to this finding, they plan to learn more about the root causes of sepsis readmissions.

2. **UNDERSTAND THE ROOT CAUSES OF READMISSIONS, FROM THE PATIENT, FAMILY AND PROVIDER PERSPECTIVE.**

   It is frustrating to see patients for whom you’ve developed a discharge plan return to the hospital. Often, we assume that the reason the patient returned was a lack of compliance on their part. While this kind of thinking may make us feel better, it is flawed. To truly understand the reasons for readmission we must eliminate the notion of non-compliance and dig deeper to learn the root cause of readmissions.

   - Routinely interview readmitted patients to learn what happened between the day of discharge and the point at which they (or someone else) decided they needed to return to the emergency department.
   - Use your insights from readmission interviews to improve care for that patient.
   - Use your collective insights from all interviews to identify high-leverage improvement ideas.
   - One hospital shared the root causes of any readmissions in their daily huddle.
ARTICULATE A GOAL AND IDENTIFY A TARGET POPULATION (CONTINUED)

PRINCIPLE

3 MAKE THE GOAL REAL: QUANTIFY HOW MANY READMISSIONS OCCUR CURRENTLY AND HOW MANY READMISSIONS NEED TO BE AVOIDED PER MONTH TO REACH YOUR GOAL.

FISHBOWL LEARNINGS

Most hospitals track their monthly readmission rate. But it’s hard to imagine what 10% or 20% fewer readmissions really means. Translating a rate of improvement into a number helps!

To calculate your readmission reduction number:

\[
\text{Current number of readmissions per month in your target population} \times \text{percent reduction goal} = \text{number of readmissions to reduce per month}
\]

Example: 50 readmissions/month x 0.12 (12% reduction goal) = 6 fewer readmissions/month

ENGAGE STAFF AND LEVERAGE EXISTING RESOURCES

PRINCIPLE

4 ENGAGE STAFF BY SOLICITING THEIR INPUT AND IMPROVEMENT IDEAS.

FISHBOWL LEARNINGS

Quality improvement efforts are enhanced when the staff is engaged.

\> Solicit ideas for improvement from the staff and listen to their priorities and ideas.

\> Make the connection between their improvement ideas and the priorities of the hospital.

\> Take the time to engage in team building — one hospital shared that an ice cream social did the trick!

\> Enlist staff in problem solving and prioritization.

5 IMPROVE STANDARD TRANSITIONAL CARE FOR ALL: IMPROVE PATIENT EDUCATION MATERIALS AND METHODS.

FISHBOWL LEARNINGS

Educational materials are effective when they are simplified and customized.

\> Use health literacy principles when developing patient education materials.

\> SIMPLIFY — Use the “less is more” approach when developing materials.

\> Use materials developed by successful teams.

\> Test new materials, gather feedback and iterate before pursuing hospital-wide forms/ policy change processes.

Test new materials before seeking approval.
ENGAGE STAFF AND LEVERAGE EXISTING RESOURCES (CONTINUED)

**FISHBOWL LEARNINGS**

Teams in the fishbowl were creative in engaging existing staff to deliver transitional care services, such as readmission interviews, post-discharge calls and timely post-discharge office visits. Examples include:

> Unit nurses make post-discharge calls during days shift for patients who were discharged yesterday; a nurse leader checks in with the unit manager to ensure calls are completed.

> Volunteers were trained to meet at the bedside with readmitted (and other) patients to discuss their experience and solicit feedback.

> Respiratory Therapists (RT) were trained to make post-discharge calls for COPD patients; this worked well because the RTs often know these patients well.

> Pharmacy residents and family medicine residency clinics were utilized to provide timely appointments post-discharge.

> Nurse positions repurposed to provide transitional care for high risk patients.

> ED Case Managers to identify high risk patients when they register in the emergency department to facilitate readmission avoidance.

**LINK PATIENTS TO FOLLOW-UP SERVICES**

**FISHBOWL LEARNINGS**

Look at your data. You will likely see that 50% of your readmissions occur within 10 days of discharge.

> Is 1 week follow up (7 days) good enough to avoid a readmission? Why do you think so?

> How can you provide post-hospital support and contact within 1-2 days of discharges?

> Make post-discharge calls to identify and respond to issues early.

> Send a transitional care worker to do a home visit within ____ days of discharge.

> Offer a “bridge” appointment in a resident or pharmacy clinic.

> Schedule a post hospital visit in the office with the nurse practitioner or physician assistant.
Teams in the fishbowl used existing staff to provide enhanced transitional care to high risk patients:

> One team developed a “risk-response” tool; they identified several high risk groups, but rather than waiting to develop the risk-response process for all high risk groups, they decided to develop, test and implement a response for one high risk group at a time — building the “risk–response” set of processes as they go. This team identified polypharmacy and high risk medications as a high risk group, and their Director of Pharmacy did a bedside medication review, education and post-discharge phone call for patients who met this risk criteria.

> Another team had a transitional care nurse who had been deployed to provide transitional care services to patients with a variety of readmission risk factors. During the fishbowl, the team asked the transitional care nurse to focus just on patients with heart failure so that they could not only make measurable progress for this population, but to better articulate the “whole-person” approach that high risk patients need from the transitional care nurse visits, hospitalist clinics, clinics run by PharmD or other students.

Track your progress on making visits and on visit attendance.
THANK YOU

TO THE PARTICIPATING HOSPITALS FOR BEING AGENTS OF CHANGE TO REDUCE READMISSIONS.

Greenwood Leflore Hospital | Mississippi
Hancock Regional Hospital | Indiana
Memorial Medical Center | New Mexico
NCH Baker Hospital | Florida
Ransom Memorial Hospital | Kansas