



**READMISSIONS PILOT PROJECT GOAL**

The primary goal of NYSPFP’s readmissions pilot project is to reduce readmissions and examine key processes in the care delivery system for every patient on admission, throughout the hospital stay and at discharge. Through the pilot, NYSPFP aims to assist hospitals in identifying their strengths and weaknesses so they can make thoughtful decisions about how to improve patient care and readmission prevention work and spread those findings and successes hospital-wide.

**PILOT PROJECT OVERVIEW**

Hospitals participating in the pilot project must select at least one unit in which to work. The hospital team will commit to working within the pilot infrastructure to understand their current strengths, weaknesses, and systems and implementing responsive clinical practices based on these analyses. Hospitals will be urged to consider all of this work in the context of future plans to spread these practices, processes, and advancements hospital-wide.

**NYSPFP is asking hospitals to commit to the following:**

- Engage hospital team in NYSPFP educational programming.
- Implement key strategies, as determined by NYSPFP, to reduce readmissions specific to hospital needs.
- Participate in the pilot project improvement and tracking activities.
- Evaluate lessons learned from the pilot and design a plan to hardwire and spread best practices.
- Participate in a regional learning session to be held in fall 2014 and submit a poster that highlights your hospital’s findings, successes, and lessons learned through participating in the pilot program.

**PILOT DESCRIPTION**

The NYSPFP Pilot Project will take a three-phased approach. During each phase, hospital participants will conduct the activities detailed below as well as other interventions, as appropriate.

ACTIVITY	TIPS & STRATEGIES
<ul style="list-style-type: none"> <li>• Participate in NYSPFP Readmission Prevention Pilot Kick-Off event.</li> <li>• Prepare for Pilot.</li> </ul>	<ul style="list-style-type: none"> <li>• Introduce pilot and identify team members:               <ul style="list-style-type: none"> <li>• Readmissions champion</li> <li>• Hospitalists</li> <li>• Executive patient services</li> <li>• Staff RNs</li> <li>• Discharge planner</li> <li>• Case manager</li> <li>• Social worker</li> <li>• PT/OT</li> <li>• Pharmacy</li> <li>• Nutrition</li> <li>• Respiratory Therapy</li> <li>• Other</li> </ul> </li> <li>• Evaluate all-cause readmission rates from hospital units to assist with selection of pilot unit.</li> <li>• Assign roles, responsibilities, and accountability for pilot unit.               <ul style="list-style-type: none"> <li>• Determine which professional staff will be responsible for mitigating risks during the pilot.</li> </ul> </li> <li>• Educate team members and staff.</li> </ul>

Preventable Readmissions Initiative – 2014 Pilot Project To Reduce Readmissions (continued)

ACTIVITY	TIPS & STRATEGIES
<p><b>Phase I: Admission</b></p> <ul style="list-style-type: none"> <li>Identify patients on admission who are at risk for readmission.</li> <li>Assemble a team to address interventions that will mitigate risk.</li> </ul>	<ul style="list-style-type: none"> <li>Identify and engage a designated family caregiver or other caregiver.</li> <li>Utilize a patient risk assessment tool to identify patients in need of post-hospital care and discharge planning.</li> <li>Conduct assessment of “any risk” for potential readmissions. (see NYSPFP Checklist)</li> <li>Conduct initial risk assessment within 24 hours of admission/transfer.</li> <li>Refer at-risk patients to the appropriate designated team member to immediately begin a care plan.               <ul style="list-style-type: none"> <li>Prevent deterioration,</li> <li>Provide the appropriate services, and</li> <li>Prepare and educate the patient and family/caregiver for discharge. (examples: dietitian to address nutrition, therapy to address functional status, RN to address patient education, etc.)</li> </ul> </li> <li>Conduct thorough medication reconciliation on admission and address any discrepancies.</li> <li>Begin planning and implementation of risk mitigation strategies from admission.</li> <li>Ensure all of the above utilizing the NYSPFP resources/tools or the hospital’s internal tools.</li> <li>Monitor pilot progress utilizing hospital’s internal tools or NYSPFP tools.</li> <li>Work with NYSPFP project manager.</li> <li>Use PDSA cycles, adapt, spread, hardwire. Consider how processes that are successful might be expanded hospital-wide.</li> </ul>
<p><b>Phase 2: Hospital Stay</b></p> <ul style="list-style-type: none"> <li>Prepare patient and caregiver for discharge.</li> <li>Conduct ongoing patient reassessment to identify new or changing risk factors.</li> <li>Ensure systems for multidisciplinary communication, coordination, planning and evaluation.</li> </ul>	<ul style="list-style-type: none"> <li>Utilize a team patient-centered approach to ensure comprehensive communication and timely exchange of information. For example:               <ul style="list-style-type: none"> <li>Bedside white boards</li> <li>Purposeful rounding</li> <li>Structured hand-offs</li> <li>Standardized communication tools (i.e. TeamSTEPPS)</li> <li>Daily goals sheets</li> </ul> </li> <li>Utilize patient centered approach to set goals for care and education.</li> <li>Conduct continuous and effective patient and caregiver education and empowerment.</li> <li>Use teach-back or other method for ensuring understanding of education and discharge preparation.</li> <li>Perform repeat risk assessment if indicated by change in patient status indicated by team members.</li> <li>Address palliative or end of life care.</li> <li>Monitor pilot progress utilizing hospital’s internal tools or NYSPFP tools.</li> <li>Work with NYSPFP project manager.</li> <li>Use PDSA cycles, adapt, spread, hardwire.</li> </ul>

Preventable Readmissions Initiative – 2014 Pilot Project To Reduce Readmissions (continued)

ACTIVITY	TIPS & STRATEGIES
<p><b>Phase 3: Discharge</b></p> <ul style="list-style-type: none"> <li>• Ensure patient and family/caregiver are fully prepared for post hospital care.</li> <li>• Provide timely and thorough communication to post hospital providers.</li> </ul>	<ul style="list-style-type: none"> <li>• Implement key interventions for an effective discharge, including:             <ul style="list-style-type: none"> <li>• Providing comprehensive patient-centered discharge instructions,</li> <li>• Ensuring timely oral and written communication with post hospital care providers,</li> <li>• Conducting follow-up phone calls within 48-72 hours of discharge, and</li> <li>• Identifying primary care provider and coordinating follow-up physician visit within 7 days. Make all follow up appointments with specialists/services if able.</li> <li>• Provide contact information for patient question or concerns.</li> </ul> </li> <li>• Utilize teach-back approach to test and ensure patient and family caregiver understanding of their care plan.</li> <li>• Ensure thorough medication reconciliation at discharge with a particular emphasis on understanding/addressing discrepancies.</li> <li>• Provide communication to post hospital providers verbally and in writing upon discharge. Ideally discuss post hospital needs with post hospital providers.</li> <li>• Monitor pilot progress utilizing hospital's internal tools or NYSPFP tools.</li> <li>• Work with NYSPFP project manager.</li> <li>• Use PDSA cycles, adapt, spread, hardwire.</li> </ul>