Performance Excellence – Readmission Reduction Initiative

Performance Excellence is a regional effort involving multidisciplinary teams of physicians and staff from across the Southern California ministries. These teams are working together to implement best practices that will improve quality and outcomes, reduce costs and increase access to affordable care. One focus of this initiative is to reduce readmissions.

Readmission Overview

- Readmissions are stressful and costly for patients, and can often be avoided.
- A study published in the July 2012 issue of Medical Care estimates that nearly **half** of readmissions could have been prevented.
- The Medicare Payment Advisory Commission and the Senate Finance Committee reported that **one in five** Medicare beneficiaries is readmitted within 30 days at a cost of more than **$26 billion per year**.
- Reducing readmissions improves patient care and prevents unnecessary costs.

Readmission Reduction Initiative

- As part of the *Performance Excellence* initiative, a Readmission Reduction Collaborative has been formed. This collaborative consists of physicians and staff from across the region who are focused on identifying and implementing evidence-based tools and standardized processes proven to decrease readmissions of acute care patients age 18 and older being discharged to home.
- Several readmission reduction interventions will be piloted on the Medical Telemetry and Pulmonary Renal units at St Joseph Hospital, Orange (SJO) in late February (see page 2 for more information).
- The interventions will be adjusted based on the results of the pilot, and a full bundle of interventions will be rolled out to all Southern California ministries in the Summer of 2017 (see page 2 for more information).

Modified LACE Index

- A key element of the Readmission Reduction Initiative is the introduction of the LACE index.
- LACE is an evidence-based predictive tool used to determine a patient's readmission risk within 30 days post discharge.
- The LACE index uses the following four variables to determine a patient's risk of readmission:
  - **L** = Length of stay
  - **A** = Acuity of the admission
  - **C** = Comorbidities
  - **E** = ED visits within the past six months
- LACE scores range from 1 to 19. Patients with a LACE score of 11 or above are considered at risk for readmission; patients with a LACE score of 15 or above are at the highest risk for readmission.
- Patients' LACE scores will be available in MEDITECH.

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Phase One: Pilot Program at SJO

Who: Medical Telemetry and Pulmonary Renal units at SJO
When: February 20, 2017
What: The following evidence-based interventions will be piloted for medical patients age 18 and older being discharged to home:

Patient Population	Component	Description
All patients	**LACE index**	The LACE index is an evidence-based predictive scale used at discharge to determine a patient's risk of unplanned readmission within 30 days. LACE scores will be available in MEDITECH.
All Patients	**Standardized, three-pocket folder for patient information**	A folder to help patients manage printed information. One pocket is for information provided to patients during their stay. The second and third pockets are for medication details and other information regarding home care provided to patients at discharge.
Patients with medium-to-high LACE scores	**800 number for post-discharge questions**	Patients at medium-to-high risk for readmission will receive a yellow sticker on their patient information folder. This sticker has an 800 number where they can be connected to an RN from the centralized post-discharge call center. Patients should use this number after discharge and before their first post-discharge follow-up appointment for questions regarding medications, instructions for care at home, and other health concerns.
Patients with medium-to-high LACE scores	**Post discharge follow-up calls**	Patients may receive a follow-up call from a nurse at our post-discharge call center within 24 to 48 hours of discharge. The purpose of this call is to check on the patient and the status of their self-care at home.

Phase Two: Full Readmission Reduction Program Roll Out

Who: All Southern California ministries
When: Summer 2017
What: A full bundle of evidence-based interventions will be rolled out to all patients age 18 and older, being discharged to home. The bundle includes:

- Pilot program components listed above.
- Standardized documentation of home medications at time of admission.
- Follow-up appointment at discharge.
- Complex case conferences for patients with high LACE scores, as appropriate.
- Home Health referrals for heart failure patients, as appropriate.
- Palliative Care consult for patients with high LACE scores, as appropriate.

If you have questions about the Readmission Reduction Initiative, please contact Gail Lindsay or Cecilia Hunter.
If you have questions about the SJO pilot program, please contact Trish Cruz.

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