CommonSpirit

FY2024
Acute Care Quality Goal

Readmissions within 7 Days Toolkit

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Introduction

Reducing preventable and unplanned hospital readmissions is a national priority for payers, providers, and policymakers seeking to improve health care and lower costs. On October 1, 2012, as part of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) began to reduce payments to hospitals with excessive re-hospitalization rates through the Hospital Readmissions Reduction Program. Re-hospitalizations are costly, potentially harmful, and often avoidable. It is estimated that roughly two million patients are readmitted to our hospitals every year, costing Medicare $26 billion; official estimates suggest that $17 billion or 65% of those costs represent potentially avoidable readmissions.

CommonSpirit Health data reveals 34% of readmissions occur within the first 7 days for patients discharged with the initial diagnosis of sepsis, heart failure, COPD or pneumonia. Nationally the highest rates of readmission were seen within the first 72 hours of discharge for these high risk DRGs. The percentage of preventable early readmissions (within 7 days post-discharge) and late readmissions (between 8 and 30 days post-discharge) are 36.2% and 23.0%, respectively, which suggests that a 7-day window may be more accurate than a 30-day window for measuring quality of hospital care.

Hospital leaders and key stakeholders must engage and identify high risk readmission DRGs, formulate a collaborative, multidisciplinary task force team and implement strategies to improve the discharge process across the continuum of care. Interventions designed to improve the care transition from hospital to home have been shown to be effective at reducing hospital readmission. Efforts should focus on identifying the primary cause(s) related to readmission by assessing the patient's access and compliance to medical follow up, medication management and necessity for community resources and services (e.g., transportation and home care). Whenever possible, interventions should support and facilitate patient and family empowerment to increase the patient's capacity for self-care through comprehensive, structured education and teach back early in the hospitalization.

Measure Definition
Readmissions within 7 Days

Objective
Reduction of any cause readmission within 7 days of discharge

Rationale
Reducing preventable and unplanned hospital readmissions is a national priority for payers, providers, and policymakers seeking to improve health care and lower costs. Readmissions can result from a diversity of reasons, including: reported symptoms (e.g., shortness of breath), lack of compliance or inability to fill prescriptions, lack of medical follow-up and the missed opportunity to provide critical patient resources. CommonSpirit Health data reveals 34% of readmissions occur within the first 7 days for patients with a high readmission score or discharged with the initial diagnosis of sepsis, heart failure, COPD or pneumonia. Efforts to reduce readmission should be focused on assessing the patient's ability to manage health care needs, identifying social determinants or barriers to accessing health care, and when needed, integrating supportive community resources.

Metric
Percentage of encounters for which the patient was readmitted to the same facility within 7 days among acute care inpatient encounters

Numerator
Count of the index encounters in the denominator population in which the patient was readmitted to the same facility within 7 days as a non-elective acute care inpatient **(Readmission)**

Inclusion criteria:

Index encounters in the denominator population with the following:

- Readmission encounter type of Inpatient (I in Midas) AND
- Readmitted for any cause to the same facility AND
- Readmission encounter admission/start date within 7 days of the discharge/end date of the index encounter

Exclusion criteria:

Index encounters for which the readmission encounter is any of the following:

- Admit status equivalent to Elective (this only applies to the numerator/readmit encounter, it does not apply to the denominator)
- Readmit inpatient encounters for Rehabilitation, Behavioral Health, Skilled Nursing, Hospice, Non-Acute Care Substance Use/Chemical Dependency, Residential Psychiatric Inpatient Units, or other Non-Acute Care Settings
- ICD codes for inpatient delivery and newborn encounters (Z37 and Z38)

Denominator
Count of discharged acute care inpatient encounters **(Index admission)**

Inclusion criteria:

- Encounter type of Inpatient (I in Midas)
- Any Admit Status (Elective, Emergency, Info. Unavailable, Trauma, Unknown, Urgent, Unscheduled)

Exclusion criteria:

- Index inpatient encounters for Rehabilitation, Behavioral Health, Skilled Nursing, Hospice, Non-Acute Care Substance Use/Chemical Dependency Residential Psychiatric Inpatient Units, or other Non-Acute Care Settings (this Service field is found in the Encounter module in Midas)
- ICD codes for inpatient delivery and newborn encounters (Z37 and Z38)
- Discharge disposition equivalent to Death ("expired" in Midas), Left AMA (includes Elopement, Left Before Treatment Complete (LBTC), Left Without Being Seen (LWBS), Left Without Treatment (LWOT)), or Discharged to Outside Acute Care (Transfers i.e. for a higher level of care)

Note: Regarding the drill down on CDB1076 numerator – the encounters that appear in the drill down are the index encounter account numbers, not the readmit encounter account numbers. This can cause confusion since because you're drilling down on the numerator/readmit encounter, you are expecting to see the readmit encounter number. However, Midas summarizes the data by the index encounter, not the readmit encounter.

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Data Source: Midas

How to use the 7 Day Readmission Toolkit

Reducing preventable and unplanned hospital readmissions is a national priority for payers, providers, and policymakers seeking to improve health care and lower costs. Tools and evidence-based strategies have been developed to facilitate facility implementation of our 7 day readmission reduction strategies.

7 Day Readmission Reduction Strategies for Success

- Identify high risk patients for readmission – establishing a mechanism to identify patients at high risk for readmission allows for the matching of the intensity of the discharge planning process to the risk of readmission.
- Match intensity of discharge planning to risk of readmission – ensure Multidisciplinary Rounds (MDRs) are completed on patients following a high risk patient admission as determined by the DRG or readmission risk score.
- Refer patients to the most appropriate post-acute setting – focus on the discharge disposition with the least restrictive setting needed to prevent readmission.
- Provide comprehensive patient discharge education – providing individualized patient and family discharge education is pivotal to improving patient outcomes, elevating healthcare quality and reducing unplanned readmissions.
- Promote cross-continuum communication – when hospitals, post-acute providers, home care agencies, patients and families work together to ensure patients are engaged in their care, follow treatment plans and get help before chronic conditions take a turn for the worse, better long-term health outcomes can be achieved for patients while limiting unplanned trips to the acute setting.
- Establish a multidisciplinary facility Readmission Committee – engaging in a monthly multidisciplinary readmission meeting, focusing on developing process improvement strategies and utilizing data to drive initiatives is a key strategy to reduce readmissions.

Please use these strategies and tools to implement these identified evidence-based strategies across all CSH facilities.

Readmission Toolkit Resources

Tool/Resource	Link	Description
Readmission Chart Audit Tool	Link to Resource	This tool focuses on the review of the medical records of the currently readmitted patient to gather readmission reduction opportunities.
Readmission Patient Interview Tool	Link to Resource	This tool helps understand from the patient and family perspective why the patient returned to the hospital and to help identify internal and external opportunities for readmission reduction efforts.
Patient & Family Sepsis Education	Link to Resource	This one page educational pamphlet will help patients and their loved ones to know what the definition of sepsis is, what the treatments are, what symptoms to watch for and when to seek medical attention and any potential long-term effects of having sepsis.
Discharge Risk Assessment	Link to Resource	A risk assessment tool to better understand the patients risk level, life-limiting conditions, skilled needs and other post discharge needs.
Care Transitions Assessment	Link to Resource	This tool helps optimize coordination of services to ensure appropriate and safe care transitions.
Teach-back Resources	Link to Resource	Teach-back is a technique for health care providers to ensure that they have explained medical information clearly so that patients and their families understand what is communicated to them. The attached information is a robust toolkit to provide training to staff and validate teach-back education techniques.
Zone Tools	Link to Resource	Zone Tools are one-page reference tools used to assist patients in managing high-risk health conditions at home
Elsevier Patient Education	Link to Resource	High Risk DRG patient education that provides an overview of the patient's condition, causes and risks, treatments, medications, when to contact their physician, and more. Access the Elsevier icon on your computer desktop for high-risk DRGs Education Guides and additional DRG education resources.
Post-Acute Sepsis Education Tools & Templates	Link to Resource	These tools are to be used when collaborating with post acute care facilities and providers to assist in their education for sepsis identification.
iPET Video High-Risk Readmission	Link to Resource	Table of available patient education modules for high risk DRGs. Vendor, Video title, length in minutes and language available.

Key Strategies for Success

1 Identify patients at high risk for readmission

- Establishing a mechanism to identify patients at high risk for readmission allows for the matching of the intensity of the discharge planning process to the risk of readmission. This can be accomplished by utilizing the readmission risk score or focusing on high risk DRGs. At CommonSpirit Health, the high risk DRGs include: Sepsis (871, 872), Heart Failure (291), Pneumonia (193), and COPD (190).
  - Establish a mechanism to identify patients at high risk for readmission using a readmission risk score or the identification of high-risk DRGs.
  - Educate nursing, physicians, care coordinators, and pharmacists regarding the risk score or DRGs.
  - Develop conversations around high-risk patients during multidisciplinary rounds, implement action and discharge planning to address the patient's risk.
  - Promote early engagement of care coordination in assessing the high-risk patient's care needs and the plan for transition of care.
  - Ensure accurate PCP information is in the Electronic Medical Record during each hospital encounter. Work with your local teams to develop workflows and processes to update the PCP information real time. Inaccurate PCP information has a downstream impact on transitions of care handoffs. If a patient does not have a PCP, work with your local physician groups and develop a plan to connect patients to providers.
  - Develop a process to promote collaboration and communication with the patient's primary care provider after admission, prior to discharge, and immediately post discharge.

2 Match the intensity of discharge planning to the risk of readmission

- Ensure Multidisciplinary Rounds (MDRs) are completed on patients following a high-risk patient admission as determined by the DRG or readmission risk score. The MDRs should include, at a minimum, the provider, acute care and post-acute care coordinators, and nursing. The team should focus on assessing and identifying the patient's medical acuity and social situation.
  - If a high-risk DRG readmission occurs, identify the primary cause(s) leading to readmission and develop a focused plan of care to address the cause(s).
  - Assess the patient's threshold and potential need for post-acute care resources. Engage with either local community resources to assist with those needs or your ambulatory partner(s) to help support a plan to assist with follow through with services beyond discharge.
  - Assess the patient's understanding of how to manage the exacerbation of symptoms and if needed, provide education on how to prioritize next steps. Partner with ambulatory teams in your area to continue education beyond discharge.
  - Provide scripting when necessary to convey that it is in the patient's best interest to utilize post-acute care resources. Where possible, provide specific contact information including phone numbers and names for those post-acute services.

3 Refer patients to the most appropriate post-acute setting

- Focus on the discharge disposition with the least restrictive setting to prevent readmission.
- Connect patients with community resources i.e. Clinics.
- Partner with the high-risk patient's health plan or Continuing Care team (where available) to manage post discharge care and provide access to resources.
- Post-Acute Narrowed networks bring high quality providers together to focus on common goals, resulting in higher quality, better throughput, improved outcomes and lower readmissions that lead to better patient experience. The development of narrowed networks is encouraged and patient education on the narrowed network is established during discharge planning while ensuring the protection of patient choice.
- Collaborate with the Continuing Care team on management of Value-Based patients (ACO, CAPPED, MSSP, BPCI) after discharge (7 days, 14 days and 30 days).

4 Provide comprehensive patient discharge education

- Providing individualized patient and family discharge education is pivotal to improving patient outcomes, elevating healthcare quality and reducing unplanned readmissions. Nurses and other healthcare team members are responsible for educating, advocating and preparing patients and their family members for a safe transition home. Engaging the patient and family in the discharge process early in the admission process provides the utmost opportunity to assess the patient's knowledge and self-care ability, establish a customized plan to address gaps, barriers and supportive service needs, and implement a comprehensive discharge education program.
  - Determine the patient's preferred language and, if Limited English Proficient, engage Language Services when assessing knowledge, understanding, and comprehension.
  - Using teach-back, assess the patient's understanding and compliance related to self-care and disease management early in the admission process, including:
    - Primary diagnosis, symptoms, and comorbidities.
    - Awareness of emergent signs and symptoms and what to do in cases of emergency and non-emergency situations.
    - Medications-related query: reason for taking, potential adverse reactions, interactions, scheduling multiple medications.
    - Activity restrictions or limitations related to the disease process.
    - Ability to schedule and keep medical appointments.
    - Home social support
- Establish a multidisciplinary team approach to discharge planning that involves key disciplines based on the patient's defined needs (i.e., Nursing, Acute Care Coordination, Pharmacy, and Respiratory Therapy).
  - Assess and identify barriers for a safe discharge home in areas including self-care management, transportation issues, cost of medicine, prior authorization of medications, scheduling and keeping medical appointments, and the need for additional supportive services.
  - Engage key multidisciplinary team members in discharge planning to provide education, support, and community resources.

- Offer patient and family discharge education through written materials and videos specific to sepsis, heart failure, COPD, and pneumonia. System approved educational materials are available for multiple diagnoses.
  - Utilize Interactive Patient Engagement Technology (iPet) patient education videos available for Dignity Health facilities during admission and 30 days post discharge.
  - Utilize high risk Discharge Teaching Guide.
- Complete the online education module titled Importance of Discharge Planning for High Risk Readmissions (Loaded into CHI and Dignity Health Learning Management Systems).
  - Engage local post-acute and ambulatory partners to continue the process of education and the plan of care beyond discharge and into the most appropriate next phase of care.

5 Promote cross-continuum communication

- Increase cross-continuum communication to improve patient transitions and prevent readmissions. Connect with your local C4 team.
  - Medication Strategies
    - Pharmacist-facilitated medication management has reduced medication errors and readmission rates in several published studies. The interventions reduce readmissions by improving the quality of patient care and decreasing the chance of significant medication-related errors. Pharmacy consultation for patients on a polypharmacy regimen is effective in educating patients and reducing the number of medication complications.
    - Accurate medication reconciliation on admission and discharge is the first step in helping to reduce medication-related errors.
- Multidisciplinary Team
  - Multidisciplinary rounds are an excellent way to improve throughput, reduce length of stay and readmissions, and improve patient satisfaction. These meetings help the care team identify patient discharge needs and improve multidisciplinary collaboration.
- Schedule follow-up PCP appointment
  - Scheduling post discharge appointments within three days of discharge results in a substantial increase in timely PCP follow-up, allowing for early intervention to decrease acute readmissions. Connect with local teams to align patients that are not assigned a PCP (or the PCP is unclear) to help facilitate that connection.
- Palliative Care Consults/Advanced Care Planning Referrals
  - Studies have demonstrated that patients seen by an inpatient palliative care team have reduced readmission rates and palliative home care has been shown to impact readmissions positively. Previous studies have found that patients prefer to remain at home whenever possible to treat an acute illness and near the end of life.
  - Advanced Care Planning has shown to help reduce hospital readmissions by having clear patient preferences and treatment goals of care. It increases the likelihood that healthcare providers and families understand and comply with patients' preferences when they cannot speak for themselves.

- Warm Hand Off
  - Clear communication and transparency are critical among patients, providers, and caregivers to ensure a warm hand off of patients to the next appropriate level of care and accepting providers. Use the I-PASS hand off process to ensure standardized framework for communication.
- Discharge Phone Calls
  - Research has shown that making a single person-to-person connection telephonically within 24-48 hours post discharge results in those patients having higher compliance with their care plan and significantly lower readmission rates.

6 Establish a multidisciplinary facility readmission committee

- Since implementing the Hospital Readmission Reduction Program, health systems have been working to reduce hospital readmission rates of high risk patients. Of these efforts, the interventions with a multidisciplinary, multicomponent approach have lowered readmission rates as well as improved patient care, patient adherence, and patient outcomes.
- Engaging in a monthly multidisciplinary readmission meeting, focusing on developing process improvement strategies and utilizing data to drive initiatives is a key strategy to reduce readmissions.
  - Evaluate the system gaps in care to identify resource needs and barriers to care transitions.
  - Promote utilization of evidence-based care principles and standards in managing patient populations and connect with the local 4C teams if available.
  - Identify, develop, and implement relationships, resources, and processes in support of value-based models of care and alternative payment models.
  - Educate and engage stakeholders regarding the strategy of the readmission team.
  - Ensure processes are in place to support consistent, high-quality care transitions.

Instructions for Gap Analysis Tool

What is this tool?

The purpose of the gap analysis is to provide goal improvement teams with a mechanism to:

- Compare the evidence-based "must have" improvement strategies with the processes currently in place within the facility
- Determine the "gaps" between current practices and identified best practices
- Provide a structured approach to documenting action plans to address identified "gaps"
- Provide a reference of available resources to support improvement efforts

Who should use this tool?

The Goal Champion or designee will facilitate completion of the gap analysis with participation from providers and other team members. Facilities should establish improvement teams or workgroups to develop action plans to address identified gaps and successfully deploy improvement strategies.

How can the tool help you?

Upon completion of the gap analysis, goal improvement team members will have:

- An understanding of the differences between current practices and evidence-based best practices related to optimal goal performance
- An assessment of the barriers that need to be addressed before successful implementation of best practices
- An awareness of available resources to support improvement efforts

Instructions

1. All gap analyses should be completed electronically on the Clinical Scorecard. The following document can serve as a reference. **Those facilities that met their system-established target for this goal in FY23 and achieved a minimum of the 50th percentile need only to indicate that on the top of the online gap analysis and then no further action is required. Please note that performing a gap analysis at a later time may be required if performance dips below the established FY24 target.**
2. If the improvement strategy is currently not in place, or associated elements are not addressed by current processes within your setting, use the Action Planning document to detail your action items, responsible individuals and estimated implementation date.

THANK YOU!

Gap Analysis

Division _____ Facility _____ Date of Completion _____

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
Identification of High Risk Patients	Do you have a process to identify patients at high risk for readmission?	☐ YES ☐ NO		
	If so, do you have or use a readmission risk score?	☐ YES ☐ NO ☐ N/A		
	What tool is used?	☐ N/A ☐ Cerner Admission Assessment ☐ Epic Readmission tool ☐ Other		
	Do you look at payer populations (Medicare/Medicaid) as a focus high risk group that impacts readmissions ?	☐ YES ☐ NO		
	Do you assess the readmission risk of sepsis patients during the index admission (patients requiring ICU care, longer LOS, TPN use and anemia)?	☐ YES ☐ NO		
	Have you educated nursing, physicians, case managers and pharmacists on risk scores and identification of high risk patients for readmission?	☐ YES ☐ NO		
Physician Champion	Do you have a Physician Champion?	☐ YES ☐ NO		
	Is the physician champion a member of the facility's multidisciplinary readmission team?	☐ YES ☐ NO		
	Is the physician champion helping to lead education and sharing performance data with the medical staff?	☐ YES ☐ NO		
Discharge planning for High Risk Patients	Do you incorporate a multidisciplinary team approach to discharge planning (care coordination, nursing, pharmacy, respiratory, nutrition, etc.)?	☐ YES ☐ NO		
	Do you have regularly scheduled Multi-Disciplinary Rounds (MDRs)?	☐ YES ☐ NO		
	Does someone from the care team verify insurance coverage for high cost medications prior to discharge?	☐ YES ☐ NO		
	Does someone confirm availability of prescribed medications at the local pharmacy?	☐ YES ☐ NO		
	Does someone from the care team verify coverage for equipment needs?	☐ YES ☐ NO		

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
Comprehensive patient education	Do you have nursing discharge education that begins upon admission to include: Illness and condition, medication education, Importance of scheduling follow up appointments with their provider and support services available?	☐ YES ☐ NO		
	Do you provide and review disease specific education (sepsis, CHF, HF, COPD, etc.) prior to discharge?	☐ YES ☐ NO		
	Do you prioritize discharge teaching early and prior to discharge?	☐ YES ☐ NO		
Medication Strategies	Do you utilize a teach-back process to verify patients' understanding of disease specific education?	☐ YES ☐ NO		
	Do you provide in depth medication education for patients with polypharmacy (6> medications) before discharge?	☐ YES ☐ NO		
	Do you consult your pharmacy team to provide medication education for high risk patients prior to discharge?	☐ YES ☐ NO		
	Do you have a meds to bed program?	☐ YES ☐ NO		
	Do you provide medication reconciliation at admission and at discharge?	☐ YES ☐ NO		
Care Continuum Collaboration	Do you partner with ambulatory personnel for follow-up care post-discharge for patients with chronic or high risk conditions?	☐ YES ☐ NO		
	Do you communicate with the patients' primary care physician during hospitalization and or prior to discharge?	☐ YES ☐ NO		
	Do you have a process to hand off patients to the primary care provider upon discharge?	☐ YES ☐ NO		
	Are post discharge phone calls made within 24-48 hours for high risk patients?	☐ YES ☐ NO		
	Are post-discharge appointments made with the primary care provider within 4 days of discharge?	☐ YES ☐ NO		
	Do you have a Post Acute Narrowed Network where you work closely with Post Acute providers to reduce readmissions?	☐ YES ☐ NO		
	If there is no Post Acute Narrowed Network in your market, do you meet with the post-acute facilities and agencies for readmission concerns and develop action plans?	☐ YES ☐ NO		

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
	Do you partner with health plans for patients with high-risk chronic conditions and referral completed prior to discharge?	☐ YES ☐ NO		
Readmission Meetings and Action Planning Strategies	Do you currently engage in monthly meetings to review readmissions?	☐ YES ☐ NO		
	If not, what other strategies are you doing to review readmissions as a team?			
	Does the readmission team have multidisciplinary participation, including physicians, nursing, care coordination, Post-acute care, pharmacy, palliative care, and quality/ risk?	☐ YES ☐ NO		
	Does the team identify and collaborate with various disciplines to improve care transitions?	☐ YES ☐ NO		
	Do you perform readmission chart audits, present findings at the readmission committee, and develop action plans?	☐ YES ☐ NO		
	Do you interview readmitted patients to understand why they came back to the hospital and develop action plans?	☐ YES ☐ NO		

Action Plan

Facility/Entity Name: _____

Completed By: _____ Date Initiated _____

Key Concept/ Process	Action Plan	Responsible Person	Estimated Completion Date	Monitoring/ Validation Process (How do you know it's happening?)

Additional Comments:

Champion Role Description

Recommended Role for MD Champion: Hospitalist Leader (preferred) or Lead Physician

Recommended Role for RN Champion : CNEO or designated Nursing Leader

Role Summary

Goal Champions lead the 7 Day Readmission initiative by performing the following key roles and responsibilities: participate in the review and analysis of data, propose strategic recommendations, implement key strategies to improve performance, educate stakeholders, participate in the facility multidisciplinary readmission committee meetings, and communicate progress to hospital leaders, medical staff, and front line clinicians.

Desired Skills

1. Understand the methodologies for identification of the high risk population
2. Identify key performance improvement strategies and their impact on reducing readmissions
3. Exhibit strong interpersonal skills and collaborative working relationships with stakeholders
4. Articulate the “why” and “how” and lead educational efforts for hospital leaders, clinicians, and medical staff

Functions and Duties as Goal Champion

Lead Hospitalist:

1. Lead Multidisciplinary Readmissions Committee
2. Review high-risk patient data, identify trends, and propose effective strategies
3. Share monthly performance data and identify most effective strategies to reduce readmissions
4. Build the platform for communication and collaborate with various stakeholders

CNEO or designated nursing leader:

1. Participate in Multidisciplinary Readmissions Committee
2. Identify best practice approach to integrate patient education into nursing workflow
3. Lead educational efforts to support patient discharge, including mandatory educational module, integration of high-risk Discharge Tip Sheets, and video education (as available)
4. Share monthly performance data with clinical staff and communicate and reinforce performance expectations

Frequently Asked Questions

Q If a patient is readmitted to another CommonSpirit Health Hospital in the same division, is it counted in the numerator as a readmission?

A No. Readmissions are counted in the numerator only when the patient is readmitted to the same facility from which he/she was discharged.

Q If a patient is admitted to a SNF or Psych unit at the same facility within 7 days of discharge, is it counted as a readmission?

A No. Readmissions are counted only if the patient is readmitted to inpatient status at the same discharging facility. Some exclusions can apply to hospital-licensed skilled nursing facilities (SNFs), rehabilitation centers and other centers that provide medically-necessary treatment.

Q If a patient is admitted to Observation status, discharged and returns to the facility within 7 days and becomes an inpatient admission, would this be considered as a readmission?

A No. The patient's initial admission must be identified as Inpatient for the patient to be considered a readmission. Both entries as an Observation status or Emergency Department visit are excluded from this readmission measure.

Q If a patient is readmitted to the hospital that had an initial encounter of AMA discharge disposition, are they included in the numerator?

A No. AMA discharge dispositions, even if they occur within 7 days of discharge, are excluded from the numerator.

Q If a patient is an acute to acute transfer are they included in the numerator?

A No. Acute to Acute transfers are excluded from the numerator.

Q If a patient is readmitted to the hospital within 7 days of discharge for a planned procedure, are they included in the numerator?

A No. Elective admissions for planned procedures, even if they occur within 7 days of discharge, are excluded from the numerator.

Q How does a patient access education videos on iPET (Dignity Health only)?

A Each facility has an Interactive Patient Engagement Technology (iPET) leader responsible for implementing the program at their facility. iPET offers personalized patient education videos on self-care, medical procedures, health conditions and safety measures to improve health literacy and patient outcomes related to discharge readiness.

On admission, the nurse should assist the patient in setting up a PIN # via the pillow speaker that will be used during their hospital stay and post discharge up to 30 days. Videos can be ordered by Providers, assigned by nurses and/or self-selected by patients. Link to access the iPET Sharepoint site and Patient Education Library: https://show.dignityhealth.org/team/iPET/SitePages/Home.aspx

Q What are the Elsevier Patient Education Guides and how do we implement them?

A The Elsevier Patient Education Guides are used by nurses to provide standardized discharge education for high-risk patients with an admitting diagnosis of Sepsis, COPD, CHF or Pneumonia. The nurse should review and reinforce the information when providing direct patient care or discharge teaching. During these sessions, the patient (and family) should be asked to provide "teach-back" to validate their understanding of the information. The Elsevier Patient Education Guides can be printed and given to the patient early in the admission process. Access the Elsevier icon on your computer desktop for high-risk DRGs Education Guides and additional DRG education resources.

Q What is the 'Importance of Discharge Planning for High-Risk Readmissions' learning module and how do we implement it?

A The Importance of Discharge Planning for High Risk Readmissions learning module is designed for nurses who participate in discharging patients. It will provide an overview of the top DRGs that result in readmissions, while outlining the nurse's role in planning and implementing patient discharge education via verbal teaching, written materials and/or videos.

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