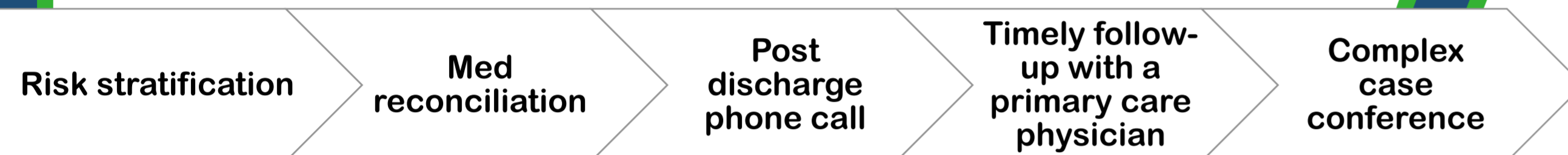


Context

Readmission or deaths following hospital discharge are serious, common and costly. The ability to accurately predict the risk of poor outcomes following hospital discharge would allow health care providers to focus post discharge interventions. We know the discharge process is often disjointed and confusing, we can do better!

Our Process

Primary Care Nurses in clinic track patients discharged through hospital via Netcare. Nurses assign a **LACE** index score, a Canadian tool designed to predict risk of unplanned 30-day readmission and death.¹ Interventions are then based on a patients' risk category and clinical frailty score.² This work is modeled after elements of a transitional bundle of care program in Kaiser Permanente:³

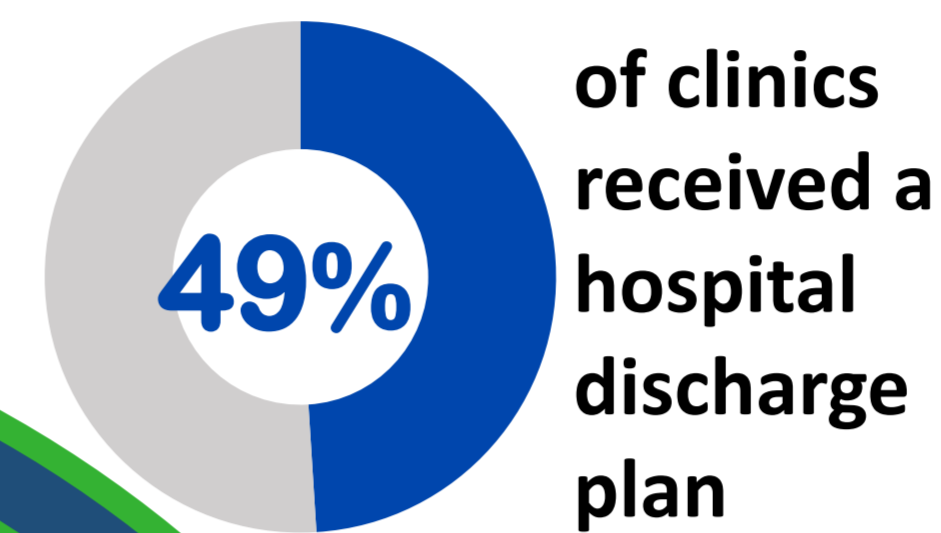


Risk for unplanned 30-day readmission and death following hospital discharge

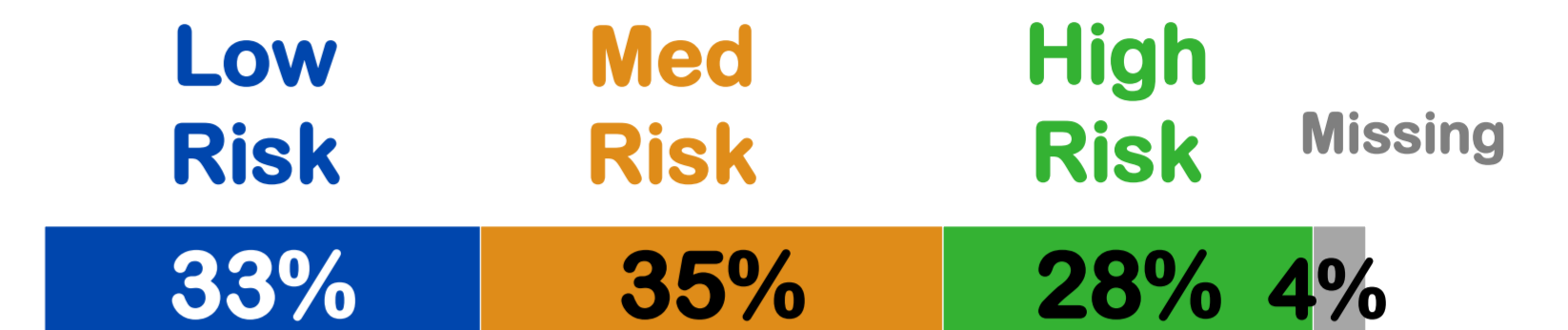
	LOW	MED	HIGH
LACE SCORE →	0-6	7-10	11+ (or clinical frailty 6+)
Med Rec		✓	✓
Post hospital visit with family doc		✓ ≤14 days	✓ ≤7 days
Phone interview with nurse			✓
Complex care conference			✓

28 clinics (29% of PCN)

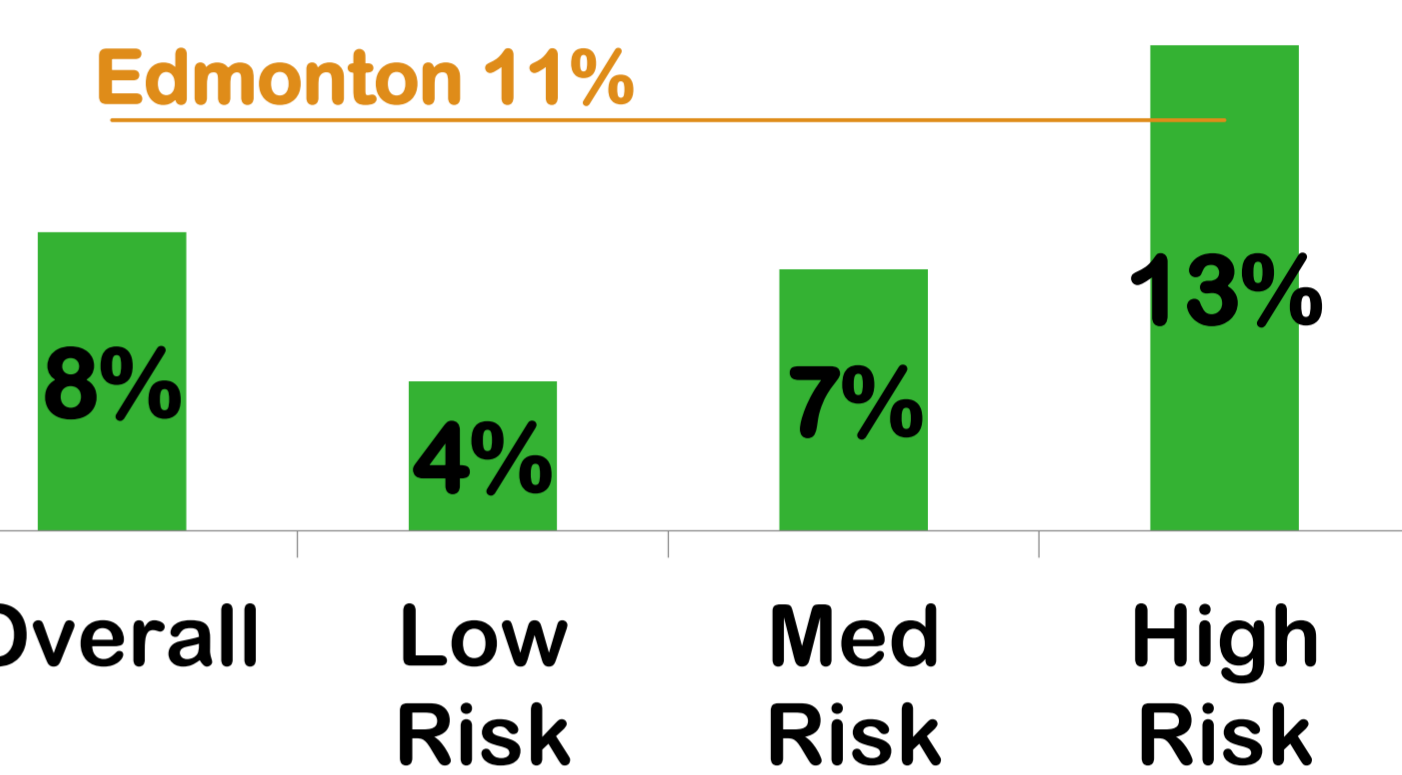
4,156 patients discharged



Our Findings



30-Day Hospital Readmission



Overall clinic rates vary 4% to 29%, while literature rates for high risk patients vary from 14% to 44%.

Our Key Wins

1. People (patients/doctors/nurses) quickly found value and engaged in this work
2. Home care introduced a System Case Manager resulting in early attachment to home care for patients and a connection for Primary Care Nurses
3. Netcare provided a practical reliable approach to identify people being discharged, it was fed to us and we didn't have to search for it
4. LACE tool was quick and easy to use to screen patients in and out



Length of Stay
Acuity of Admission
Comorbidities
Emergency visits ≤ 6 months

5. Our data results gained a lot of attention
6. Our Transitions of Care Algorithm has clear steps and is easy to follow

Our Learnings

Start With What Is Out There

We borrowed from a model/ study that was supported by strong evidence and adapted it to fit to our local context.

The Ikea Effect- We Love It More If We Made It

We started with four Primary Care Nurses who tested and modified the process, designed the post discharge call, and became champions.

Just Get Started

Get started and refine as you go- it will never be perfect so why wait.

Share, Share, Share!

Interest in the work has spread through sharing data and discussing trends i.e. we developed simple one-page summaries to promote discussion by clinic teams.

Small Tests of Change Is the Way to Go

The PDSA approach (4 clinics to 10 clinics, etc.. to 28 clinics) allowed us to test and refine i.e. we introduced the clinical frailty score after testing a suggestion made by one of our family physicians.

Sustain

- Monitor progress and trends over time
- Bring results back to clinic teams
- Keep talking about the work

Spread

- Identify new clinics for training
- Share with interested PCNs
- Self-study manual designed
- Share algorithm and findings

Advocate

- For routine family physician identification in hospital and timely discharge summaries
- Bring attention to missing Kaiser elements: standardized discharge summary, post hospital discharge hotline, and palliative care consult

Learn

- Ask questions of system data: When does the process work and when doesn't it? Are we making a difference? Is there a cost savings?
- Reflection on readmitted patients (chart reviews and patient/team interviews) to inform what's next/ missing

References:

1. Van Walraven et al. (2010). Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. Canadian Medical Association Journal, 182(6), 551-557.
2. Kahlon et al. (2015). Association between frailty and 30-day outcomes after discharge from hospital. Canadian Medical Association Journal, 187(11), 799-804.
3. Tuso et al. (2013). The Readmission Reduction Program of Kaiser Permanente Southern California- Knowledge Transfer and Performance Improvement. The Permanente Journal, 17(3), 58-63.