Readmissions Driver Diagram

AIM	Primary Driver	Secondary Driver	CHANGE IDEAS *Health Literacy and Health Equity Impact*	MEASURE of Effectiveness
	What are the main factors that influence our aim?	What factors affect the performance/influence our primary drivers?	What theories can we test? Questions: Do we have control of this? Can we fix the problem?	How will we measure our effectiveness?
By November 30th, 2021, we will reduce hospital readmissions by 5% in Illinois communities.	**Continuity of Care for Super-Utilizer Patients***	**Identification and communication of high-risk patients early**	Increase utilization of "Welcome to Medicare" preventive visits, Annual Wellness, and Chronic Care Management visits	100% follow-up calls to nursing home by transition nurse with script Patient survey; Number of times outreach is done
		Increase use self-management programs	Increase screens and referrals to self-management programs (e.g., diabetes prevention program (DPP)	
		Case Management	Case management for the super-utilizer patients, including education, monitoring, support, etc. • Engage social workers • Refer to community agencies (e.g., AAA) Chronic care management program and transitional care management program; patients identified through annual wellness visit and understanding what preventive services they need We are having our case managers call and ensure the follow up appointments are being scheduled and being followed after a hospitalization. We also task "our" hospitals to call back every ED patient visit, transferred patients, and discharged patients. • Pay for quality contracts to contact clients after inpatient or ER visits. We are using HEDIS guidelines. Primarily super utilizers of Behavioral Health clients	

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		Social determinants of health (SDOH) **Limited access to care (rural communities)**	Address language barriers; creating proper materials for patients and educating providers; employ healthcare navigators; ex: be able to explain Medicare/Medicaid eligibility and benefits Implement a program for screening for SDOH in ED; screening tool accessible with your phone; connect dots between inpatient, ED, and community Refer to community agencies Employ community health workers to connect patients with community resources to assist with social determinants, finding a PCP, etc. Community Health Workers that educate uninsured/under-insured residence about Medicare/Medicaid, and Marketplace. We are also based in one large health system where we perform the same function. Every client that works with us is educated and assisted with getting a PCP	# of electronic referrals through SDOH platforms
		Undiagnosed cognitive impairment	Ask person receiving discharge instructions if they are the primary caregiver	
		Not the appropriate level of care	Implement post discharge follow-up calls for patient education	

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	Care Transitions	**Improve communication at points of transition.** **System tracking for admissions, discharges, transfers (ADTs)**	Implement SBAR Tool while communicating during care transitions Better communication with patients and more timely communication with readmission hospitals • Transmission Based Precautions • Communication with patients, families, caretakers on process, future of continuation of care, timeline, expectations, etc. • Parish Nurses- Faith Community Nurses call/visit their parishioners after discharge from our hospital or Nursing Facilities • Knowing if a patient has had numerous admissions to the hospital and/or known or suspected non-adherence to plan of care is good info up front as we know we need to modify traditional approaches • Our hospital has a manager in Case Management that is the person to look at and follow up on Transitions in Care; works with Nursing Facilities and ER to do this as well; look at high-risk factors (e.g., chronic conditions) • Having a social worker involved for all of the patients with underlying mental health issues that impede their ability to care for their medical problems. • For Long Term Care, good communication on behavioral health issues. Honest responses with current treatments/approaches. We task "our" hospitals to call back every ED patient visit, transferred patients, and discharged patients; includes discharge to all settings.	

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			Assess discharge setting to identify any red flags and ensure proper care will be provided Program having some first responders (e.g., firefighters, EMTs, other community services) to check on patients Standardized transfer communication form completed with each discharge; referenced in event of a readmission; consider using paper forms if systems cannot connect electronically.	
		Increase coordination of care program visits	Improve adoption and utilization of transitional care management and advanced care planning.	
		Social Determinants of Health (SDoH) **Fixed income – unable to afford medications**	Address social needs at discharge (e.g., food, transportation, COVID restrictions) Ensure patient has Internet access for telehealth	
		Prevent readmissions • **Family member unable to care for patient who returns to the ER for help** • **Family member or patient unable to follow directions as given or didn't understand challenges with care**		

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	Adverse Drug Events (ADEs)	**Medication reconciliation**	Implement Medications at Transitions and Clinical Handoffs (MATCH) Toolkit and distribute the ADE Trigger Tool to at least 5 patients	
		Medication adherence – improve patient communication • **medication regimens** • **start dates** • **frequencies of PRN medications** • **knowledge deficit for new meds**	Patient education (pharmacy, clinic, hospital) on new meds; drug regimen review Provider education on new meds	
	Opioid Related Misuse	**Pain management (healthcare providers and pharmacies)**	Register for and check your state or jurisdiction's Prescription Drug Monitoring Program (PDMP)	
		LTCF pain management programs	Send 10 tabs of narcotic home with patients; make a f/u appt with their PCP who will be in control of patient's narcotic usage once they are home Distribute medication disposal kits; educate patients and families on proper medication disposal Start gradual does reduction (GDR) process and monitor patient's level of pain tolerance	
		Alternative methods for pain control	Use non-opioid options for managing pain • Non-pharmacological therapies • Heat • Ice • Medication-assisted treatment (MAT)	

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		Stigma	Engage community groups to help with stigma, taking steps leading up to the ultimate goal of rehab	
		Support systems	Resource referrals, community resources, reviewing patient's chart to see risk, educating patient on coping mechanisms	
		Patient education – increasing patient and caregiver education for proper use and awareness of overdose	Share the GeriatricPain.org FAST FACTS pain assessment information with patients, their families, and caregivers Safe use of opioid handout(s) at discharge, including: • Appropriate use of variety of pain management tools • Instructions for safe dispose of unused opioids following recovery	
		Patient education – proper disposal of medications no longer needed	Distribute medication disposal kits; educate patients and families on proper medication disposal Promote National Prescription Drug Take Back Day (April 24, 2021)	

*(Super utilizer defined as small proportion of patients who account for disproportionate amount of utilization and cost)

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