Strategies for Identifying and Decreasing Readmissions for Inpatient Rehabilitation

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Critical Elements: The Road to Inpatient Rehabilitation Compliance

Risk Factors for Readmission

- Unmet need for new ADL disabilities after return home from the hospital is particularly vulnerable to readmissions
- Patients’ functional needs after discharge should be evaluated and addressed


Readmissions

Hospital Readmission Among Older Adults Who Return Home With Unmet Need for ADL Disability

Efforts to reduce hospital readmissions should consider patient functional status as an important and potentially modifiable risk factor.

Readmissions

Approximately 11% of SCI patients experience Return to Acute (RTAC) during the course of rehabilitation for a variety of medical and surgical reasons. RTAC’s are associated with longer rehabilitation length of stay.

Efforts to reduce readmissions to acute care should include greater scrutiny of older, lower functioning patients with burn injury who are evaluated at admission to inpatient rehabilitation.
Critical Elements: The Road to Inpatient Rehabilitation Compliance Strategies

Practical Strategy Considerations

- Standardized IRF “SBAR” hand-off
- Lack of standardization of hand-off for:
  - Bladder and bowel function/management
  - Pain management
  - Completion of acute Care Plans
  - Lines/Drains/Airways
  - Tests/procedures completed prior to admission
  - Skin/Pressure Ulcers
  - Out of bed/activity level
  - Transfer level, use of special equipment/technique

Strategies to Prevent Readmissions

Dangers of Discharge

Initiatives to Reduce Readmissions

- MiPAD
- Medical Passport
- Follow-up telephone calls within 24 hours
- Physician Assistant/Nurse Practitioner assisting recent CSMC discharges in medical oversight
- Frailty Assessment

- Foundation identifying “Frail” outpatients to prevent admissions and if admitted to prevent readmissions
- Medication Reconciliation (source verification) throughout the continuum
- Case Manager throughout the continuum
MiPAD Table of Contents

1. Introduction
   - Handbook
   - Group Therapy
   - Team Members
   - Survey

2. My Condition
   - Diagnosis Specific Packet
   - Health and Well-Being
   - Medications

3. My Safety
   - Precautions
   - Safety in the Home
   - Disaster Preparedness

4. My Discharge
   a) Home Exercise Program
   b) Equipment
   c) Training
   d) Family Conference

5. My Contacts
   a) Medical Passport
   b) Support Services
   c) Business Card Holder

Example of Readmission Issue Identified

- Through the Brain Tumor Center of Excellence, developed standard protocol to address follow-up instructions regarding scalp wounds/care of scalp/incision site including follow-up telephone triage and weekly electronic report for readmissions specific to Brain Tumor index admission

Medical Passport/Portable Profile

- Medical Passport is an educational intervention that focuses therapeutic inputs from the interdisciplinary care team on the transition from hospital to home and promotes patient and caregiver self-management
Medical Passport/Portable Profile

Collaboration
- Care Coordination
  - Discharge Risk Assessment Tools
  - Assess if patient’s family members are competent caregivers
  - Assess patient’s home environment (e.g. prevention of falls and injuries)
- Patient Engagement
  - Transition between hospital and home
  - Coordinate appointments
  - Diet/nutrition and exercise/activity plan
- Referral Network
  - Referrals for post-acute care
  - Referrals for physician follow-up
- Technology (e.g. Telehealth)

Communication with Physicians
- Direct e-mails to physicians about readmissions

Transitions of Care Checklist
- Transition of Care Checklist should include:
  - Reconciled medications
  - Feeding/eating instructions
  - Weight parameters
  - Recommended exercises/activities
  - Report on the patient’s functional/communication/cognitive status
  - Contact information for the patient’s most recent care provider
  - Follow-up appointments
  - Follow-up on outstanding tests
  - Information of what to do if problem arises
  - Personal Health Record
  - Educate patients and assess understanding
  - Send discharge summary to primary care physician
  - Reinforce the discharge plan via telephone

Summary: Interventions to Reduce 30-Day Readmissions

Questions
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