northern health
the northern way of caring

Location: GR Baker Memorial Hospital
Contact: Dr. J. Fine
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REDUCING READMISSION RATES OF FRAIL ELDERLY PATIENTS AT G.R.BAKER HOSPITAL

AIM STATEMENT

To reduce readmission rates of frail elderly patients in GR Baker Hospital by:
1. Using and scoring the Modified LACE Tool in the clinical setting reliably
2. Developing an effective discharge planning process
3. Effectively involving the IPT, family and caregivers in the discharge planning process

BACKGROUND

"Rehospitalizations among Medicare beneficiaries are prevalent and costly".
Ref: Jencks, Williams and Coleman. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. New England Journal of Medicine, 2009; 360; 1418-28

"Hospitals need to identify potentially preventable readmissions (PPR's) in order to control readmission rates".
Ref: Goldfield, McCulloch et al. Identifying Potentially Preventable Admissions. Health Care Financing Review, Fall 2008; 30 (1): 75-91

CURRENT STATE

- Chronic overcapacity
- At any one time 70%-90% of inpatients are >65
- Increased mortality
- Increased morbidity – nosocomial infections, reduced mobility, increased falls, functional decline
- Reduced patient satisfaction

NEXT STEPS/SUSTAINING THE GAINS

Develop Enhanced Discharge Planning processes when a person is identified as high risk for readmission:
- Develop meeting structure to discuss cases, develop a complex care plan, and identify shared documentation
- Early involvement and collaboration with patient and caregivers
- Patient will be 'flagged' in Cerner as high risk for re-admission
- LACE scores will be added to the acute care huddle board
- Explore if complex care plan can be shared through Cerner
- Sharing of information: primary care provider, IPT, appropriate acute care services

Early connection with the IPT:
- Document LACE score and complex care plan in CMOIS
- Use LACE score to prioritise high risk patients and allocate resources
- PCN to meet with the patient prior to discharge
- PCN to see patient within one week of discharge to ensure all elements of the plan are working

Early follow up with the primary care provider

Identify roles and responsibilities within existing positions to ensure sustainability
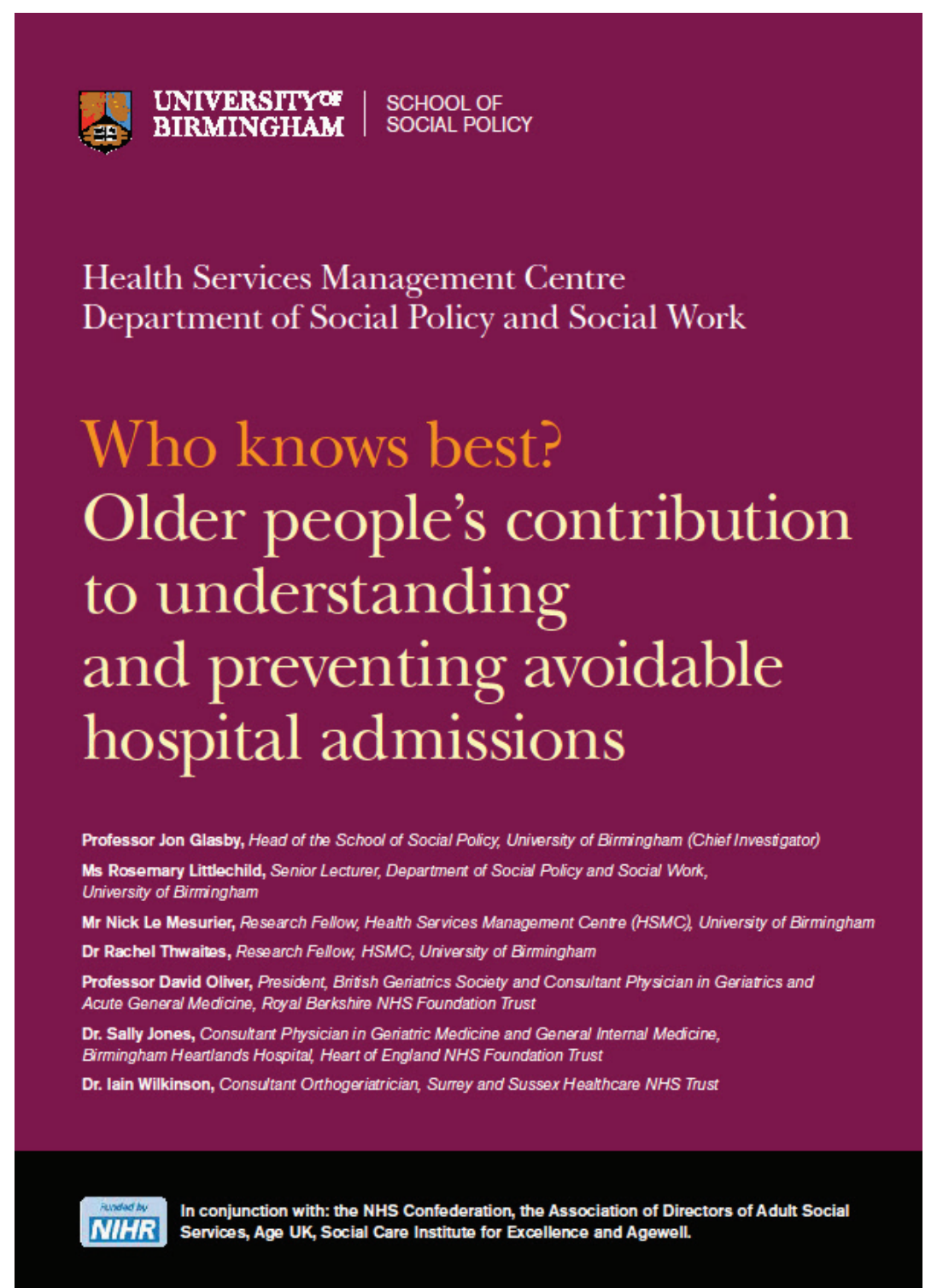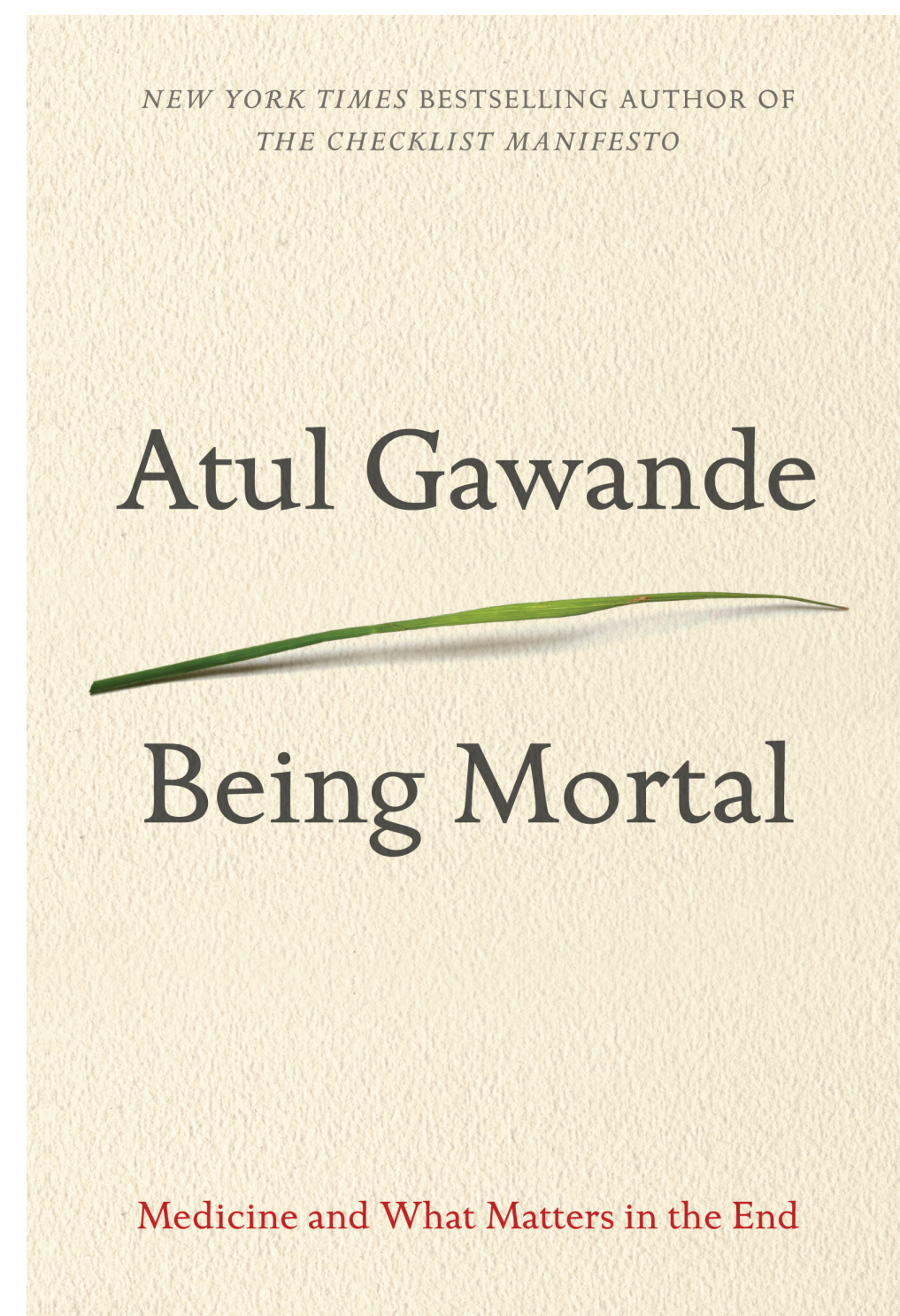
SOLUTION

- Trial use of the LACE assessment tool to identify those patients who are at high risk for readmissions
- Implement process to complete a LACE assessment on all patients >65ys who are admitted to acute care
- Identify the structure and processes to provide high risk patients with an Enhanced Discharge

  Two process mapping sessions have been completed with a multidisciplinary team (acute care, community care, and the primary care home)
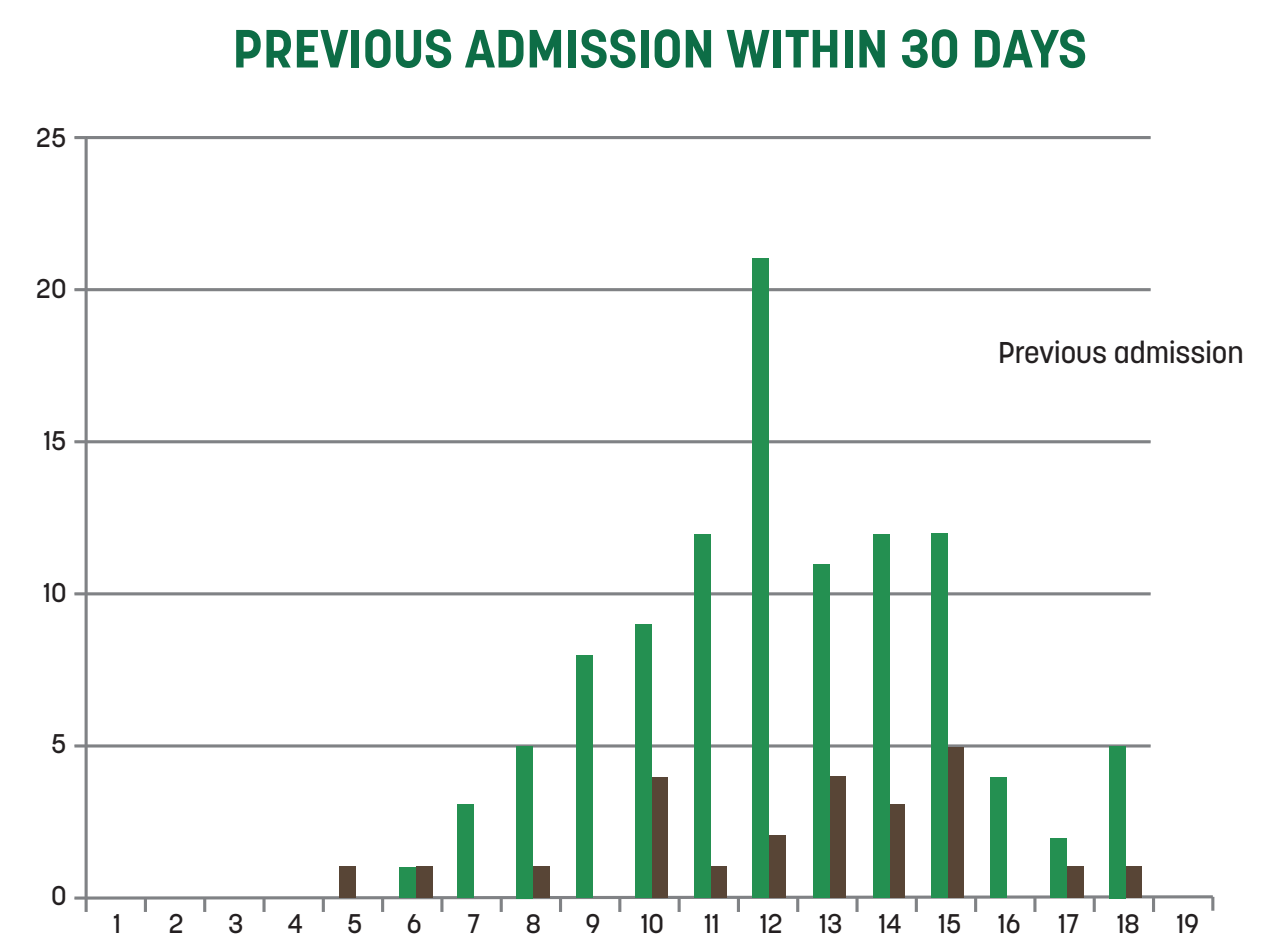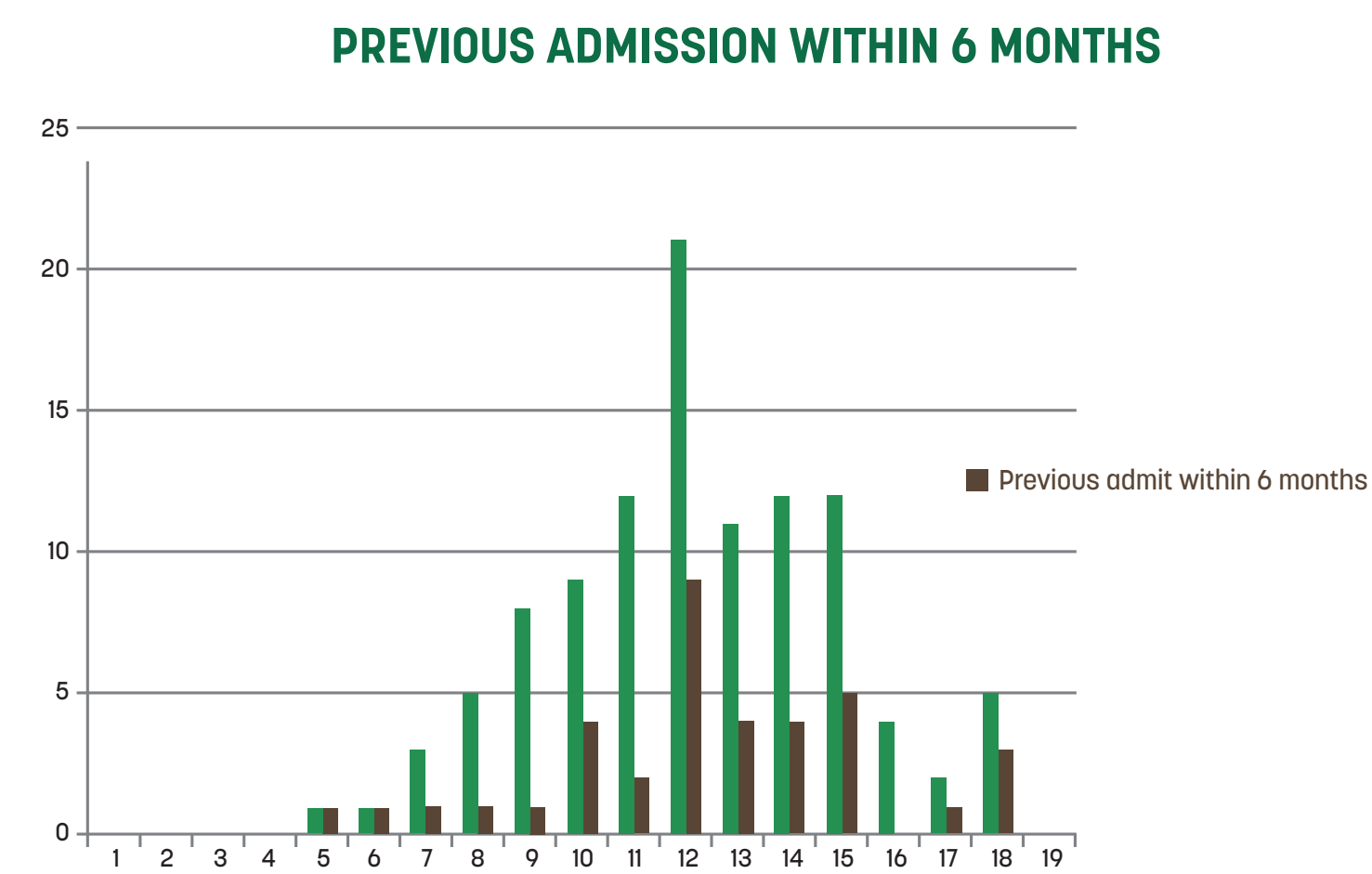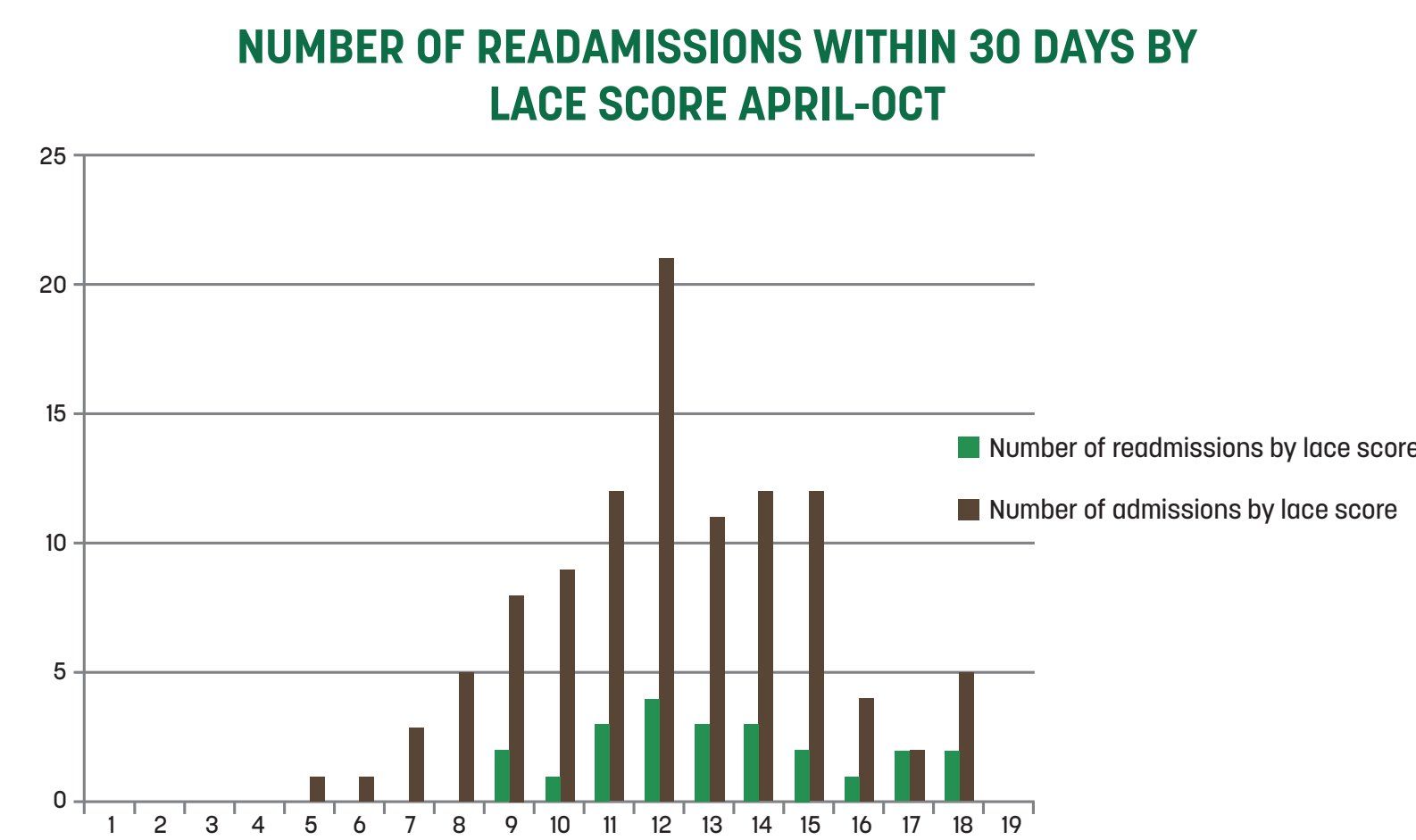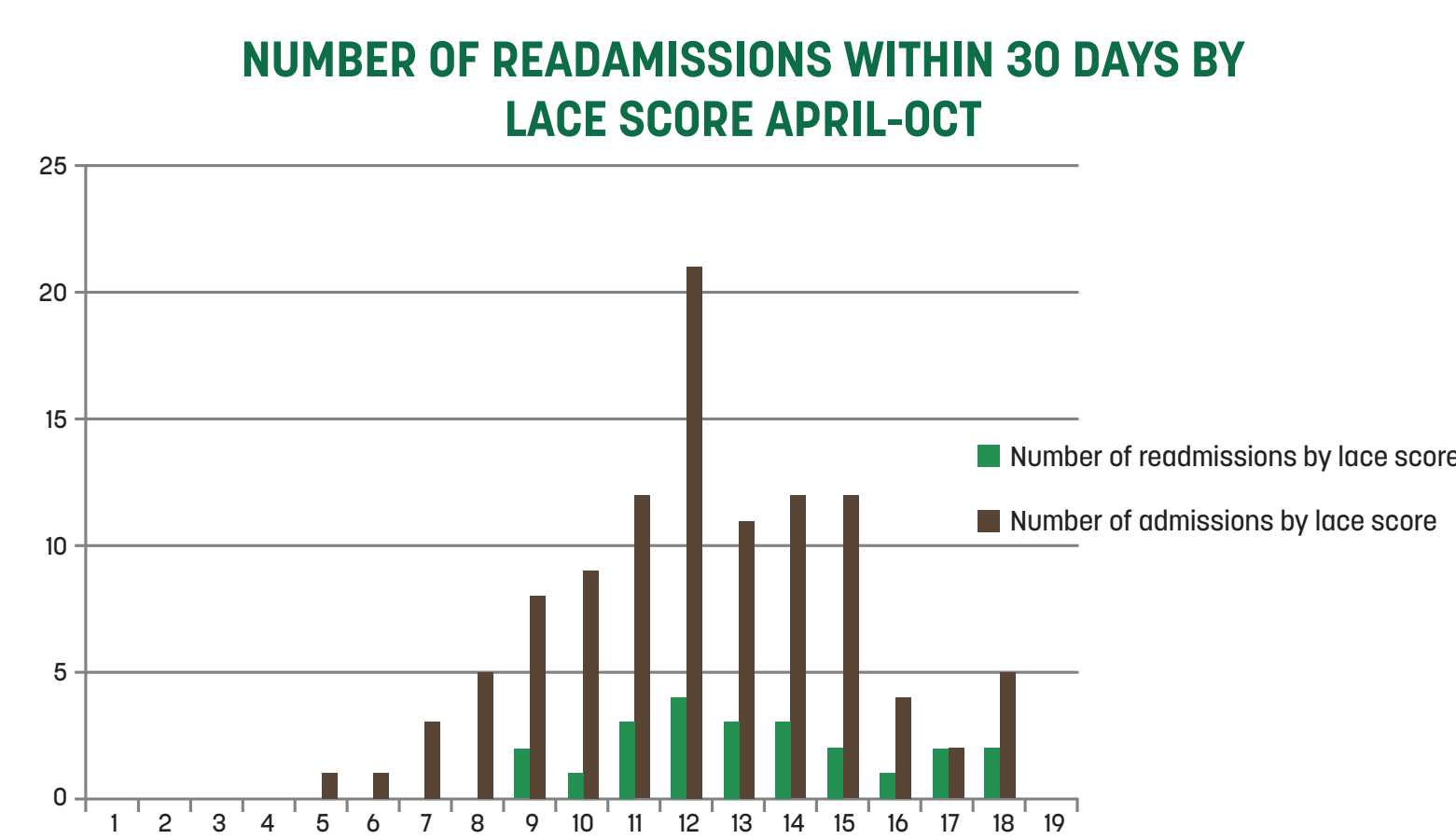
L = Length of stay **A** = Acuity **C** = Comorbitities **E** = Number of ER visits in past six months

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0		
	1 day	1		
	2 days	2		
	3 days	3		
	4-6 days	4		
	7-13 days	5		
	14 or more days	6		
Acute admission	Inpatient	3		
	Observation	0		
Comorbidity (Comorbidity points are cumulative to maximum of 6 points)	No prior history	0		
	DM no complications, Cerebrovascular disease, Hx of MI, pVD, PUD	1		
	Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, lymphoma, any tumor, cancer, moderate to severe renal dz	2		
	Dementia or connective tissue disease	3		
	Moderate or severe liver disease or HIV infection	4		
	Metastatic cancer	6		
Emergency Room visits during previous 6 months	0 visits	0		
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
	Take the sum of the points and enter the total →			

PATIENT/CUSTOMER

NEW YORK TIMES BESTSELLING AUTHOR OF *THE CHECKLIST MANIFESTO*

Atul Gawande
Being Mortal
Medicine and What Matters in the End

UNIVERSITY OF BIRMINGHAM | SCHOOL OF SOCIAL POLICY

Health Services Management Centre
Department of Social Policy and Social Work

Who knows best?
Older people's contribution to understanding and preventing avoidable hospital admissions

PATIENT/CUSTOMER

NUMBER OF READMISSIONS WITHIN 30 DAYS BY LACE SCORE APRIL-OCT

NUMBER OF READMISSIONS WITHIN 30 DAYS BY LACE SCORE APRIL-OCT

PREVIOUS ADMISSION WITHIN 6 MONTHS

PREVIOUS ADMISSION WITHIN 30 DAYS

To date 107 LACE scores have been completed on those 65 years of age and older, excluding those deemed ALCP.

- Of those, 79 have scored 11 or above, indicating a **high risk** for readmission within 30 days - **74% of admissions**
- 33% had a previous admission within the previous six months.
- 21% had been readmitted within 30 days.
- 19% of previous admissions were admitted within 30 days.
- 13 patients were readmitted within 72 hours. (Includes 2 repatriations)

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