

“Use of Modified LACE Tool to Predict and Prevent Hospital Readmissions”

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LACE

What is LACE?

- Tool that scores a patient on four variables with a final score predictive of readmission within 30 days.

Why was it chosen?

- Predictive of readmissions with patient population at Chinese hospital. Paper tool, used existing resources.

What else was done?

- Risk scores are available at discharge. All key elements of safe discharge validated with Discharge Plan Checklist.

What will I leave with?

- A link to a paper tool and an Excel® spreadsheet at the end

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Objectives

- Know about predictive models in relation to readmissions.
- Know what the LACE Tool is, and its limitations.
- How to use and score the Modified LACE Tool in the clinical setting reliably.
- How to incorporate the Modified LACE Tool within the Readmission Alert Discharge Plan.
- How to use the Modified LACE Tool to monitor readmissions within 30 days.

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Background

- The Center for Medicare and Medicaid Services will be looking at potentially preventable readmissions, (PPRs) as an indicator of care and also will be adjusting reimbursements for PPRs.¹
- The Center for Medicare and Medicaid posts hospital readmission rates on the web site <http://www.hospitalcompare.hhs.gov/>.
- “Rehospitalizations among Medicare beneficiaries are prevalent and costly.”²

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Background

- The Patient Protection and affordable care act addresses the need to “implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge...” within the context of Section 2717. Ensuring the Quality of Care.³
- Hospitals need to identify potentially preventable admissions, (PPRs) in order to control readmissions rates.⁴

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Background

- How can patients who are at high risk of being readmitted be identified so that further readmissions can be avoided by enhancing the discharge process?
- The answer to this question is through the use of predictive models to flag patients at risk for readmission

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Predictive Models

- The Patients at Risk of Re-admission tool (PARR) This tool is used in the United Kingdom. It uses secondary care data to predict the likelihood of readmission; patients are given a score from 0-100.⁵
- High-impact User Management Model (HUM) developed by Dr Foster. This tool uses past hospitalization data to predict likely readmission.⁶
- Combined Predictive Model (CPM). More robust tool than the PARR, involves data mining stratifies populations with risk banding.⁷

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Predictive Models

- Adjusted Clinical Groups (ACG®) Suite of morbidity-based analytical tools which draw on demographic, diagnostic, pharmacy and service utilization data from primary and secondary care.⁸
- Developed at John Hopkins University: ACG® System identifies patients at high risk, forecasting healthcare utilization and setting equitable payment rates. The ACG® System is a "person-focused" approach which allows it to capture the multidimensional nature of an individual's health over time.⁹

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Predictive Models

- Potentially Preventable Readmissions™ (PPR™) Solutions.
- Developed by Dr Norbert Goldfield, “uses administrative data to identify hospital readmissions that may indicate problems with quality of care.”¹⁰
- Commercially available from 3M™ Potentially Preventable Readmission Grouping Software: Identifies potentially preventable readmissions using powerful clinical grouping logic.¹¹

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Predictive Models

- Probability of Repeated Admission Instrument (Pra™) series of 8 survey questions¹² “Prediction of readmission using the Pra™ was better than chance.”¹³ “readmission of high (vs. low) Pra™ patients was 6 times more likely. Pra’s™ promising predictive ability may add valuable discharge planning information.”¹⁴
- Pra™ was further refined into the PraPlus™ “which consist of a 17-item questionnaire (the eight questions of the Pra™, plus nine additional questions questions about medical, functional ability, living circumstances, nutrition and depression).”¹⁵ Licensing available from John Hopkins University.

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Generic Predictive Models

- Multicenter Hospitalist Study (MCH) done at 6 US academic medical centers. Seven patient characteristics noted to be significant predictors of unplanned hospital admission within 30 days of discharge.¹⁶
- Health Insurance Status
- Marital Status
- Having a regular physician
- Charlson comorbidity index
- Short Form-12 physical component score
- Prior hospital admission within last 12 months
- Hospital length of stay longer than 2 days¹⁷

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Generic Predictive Models

- The LACE Index.

Dr Carl van Walraven et al., looked at 48 patient-level and admission level variables for 4812 patients discharged from 11 hospitals in Ontario. Four variables were independently associated with unplanned readmissions within 30 days.¹⁸

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Four variables are independently associated with unplanned readmissions within 30 days.

1. Length of stay.
2. Acuity of the admission.
3. Comorbidities using the Charlson comorbidity index.¹⁹
4. Emergency room visits in the past 6 months.

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Scoring the LACE Tool.

Patients are scored on:

1. Length of stay.
2. Acuity of the admission (patients admitted as observation status are scored 0 points, if admitted as an inpatient 3 points).
3. Comorbidity is assessed by type and number of comorbidities, (comorbidity points are cumulative to maximum of 6 points).
4. Emergency room visits during the previous six months.

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Modified Attributes of LACE Tool.

- The first attribute, **L**ength of stay, was not modified.
- The second attribute, **A**cuity of the admission, was modified so that patients admitted as inpatients are given 3 points, patients placed in observation status are give 0 points.
- The third attribute, the **C**harlson comorbidity Index, was modified to include renal disease, diabetes and peptic ulcer disease. Instructions were added on scoring the Charlson comorbidity Index.²⁰
- The fourth attribute, **E**mergency room visits in the past 6 months, was not modified.

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LACE Tool in the Clinical Setting

- For ease of use the LACE Tool was modified into a table format.
- The LACE Tool was modified into an Excel® spreadsheet.

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Modified LACE Tool

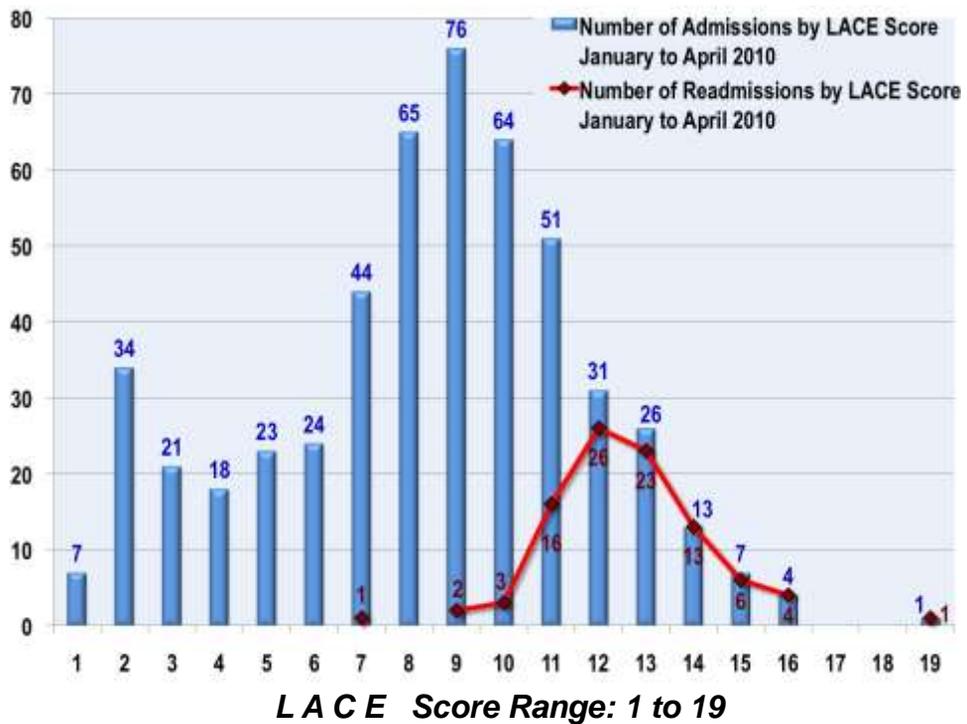
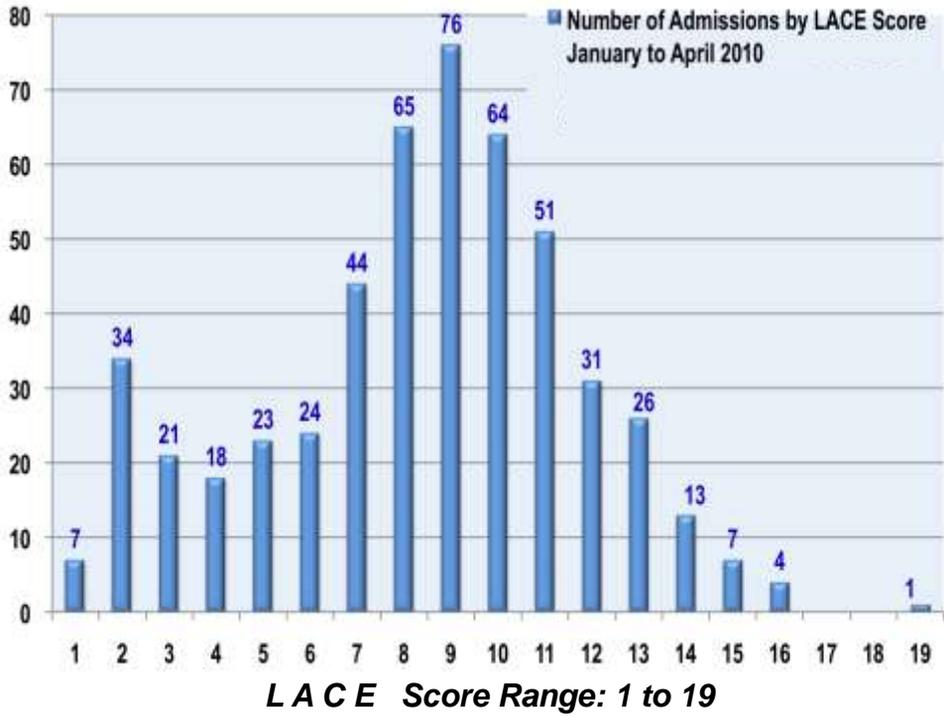
Attribute	Value	Points	Prior Admit	Present Admit
L ength of Stay	Less 1 day	0		
	1 day	1		
	2 days	2		
	3 days	3		
	4-6 days	4		
	7-13 days	5		
	14 or more days	6		
A cute admission	Inpatient	3		
	Observation	0		
C omorbidity: (Comorbidity points are cumulative to maximum of 6 points)	No prior history	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		
E mergency 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 →				

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Limitations

- The patient population used by Walraven et al¹⁸ in their study is different from the patient population at Chinese Hospital so the LACE Tool will have to be studied with the patient population at Chinese Hospital.
- Chinese Hospital Nursing Department did a chart review of 509 unplanned admissions from January to April 2010 using the Modified LACE Tool.

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Scoring the Modified LACE Tool

- Upon admission the patient's record will be checked to see if the patient was discharged within 30 days of the present admission.
- In that case the previous admission will be assigned a LACE score.
- The present admission will be assigned a projected LACE score based on 3 days Length of Stay (LOS).

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How to use and score the Modified LACE Tool in the clinical setting reliably.

- Nurses were in serviced in group settings using case studies. Here are four case studies to score.

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Case Study # 1

Mrs. Q presented with abdominal pain to the Emergency Room today, June 9th. Mrs. Q was sent to the 3rd floor for observation of abdominal pain. She has a history of metastatic liver cancer and dementia. She was recently discharged on August 8th from General hospital. The previous admission she went to see her PCP on August 3rd and her PCP had her directly admitted to General hospital for pain control and dehydration. Due to her caretaker taking her to her PCP for regular follow-ups she has not been to an Emergency Room for 8 months.

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Modified LACE Tool				
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 →				

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Modified LACE Tool

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0		3
	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		0
	Observation	0		
Comorbidity: <small>(Comorbidity points are cumulative to maximum of 6 points)</small>	No prior history	0		6
	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	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 →				9

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Case Study # 2

Mrs. W went to see her PCP and she sent Mrs. W to General Hospital as a direct admit today, June 9th to the 3rd floor for hyperglycemia and severe anemia. She has a history of chronic renal failure and has diabetes which has lead to neuropathy of her lower extremities and partial blindness in her right eye. She was recently discharged on January 8th from General hospital. The previous admission she went to see her PCP on January 3rd and was directly admitted to for thrombosis of a right AV graft. She has been to the Emergency Room 10 times in the last 5 months due to hypoglycemia.

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Modified LACE Tool				
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: <small>(Comorbidity points are cumulative to maximum of 6 points)</small>	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 →				

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Modified LACE Tool				
Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0		3
	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		3
	Observation	0		
Comorbidity: <small>(Comorbidity points are cumulative to maximum of 6 points)</small>	No prior history	0		4
	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		4
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
Take the sum of the points and enter the total →				14

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Case Study # 3

Mr. X presented with chest pain in the Emergency Room at Community hospital. He is admitted today June 9th to the telemetry unit for chest pain. He has CHF, COPD and had a previous MI 4 years ago. He went to the emergency room at General hospital on May 24th for SOB and was admitted for pneumonia; he was discharged on May 29th. He had an emergency room visit at Community hospital on November 28th for SOB but after two albuterol treatments he was sent home.

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Modified LACE Tool				
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 →				

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Modified LACE Tool

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0	4	3
	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	3	3
	Observation	0		
Comorbidity: (Comorbidity points are cumulative to maximum of 6 points)	No prior history	0	5	5
	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	2
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
	Take the sum of the points and enter the total →			

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Case Study # 4

Mr. Y presented to the Emergency Room at General hospital and was diagnosed with a lower GI bleed. The hospitalist admitted him as inpatient today, June 9th. Mr. Y has a history of PUD. He was recently discharged on May 18th from General hospital. The previous admission he went to see his PCP on May 16th with palpitations and was directly admitted to General hospital for new atrial fibrillation which converted to normal sinus rhythm after being given digoxin. He had an Emergency Room visit on January 2nd, but EKG showed sinus tachycardia of 110; he was sent home after lab work was negative.

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Modified LACE Tool				
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: <small>(Comorbidity points are cumulative to maximum of 6 points)</small>	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 →				

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Modified LACE Tool

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0	2	3
	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	3	3
	Observation	0		
Comorbidity: <small>(Comorbidity points are cumulative to maximum of 6 points)</small>	No prior history	0	1	1
	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	1
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
Take the sum of the points and enter the total →				

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Developing a Discharge Plan Checklist

- Discharge from the hospital and the transition to home or another facility requires that there is a complete handoff to address key elements to ensure a safe discharge.²¹

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Developing a Discharge Plan Checklist

- The Society of Hospital Medicine assembled a panel of care transition researchers which developed a checklist of processes and elements required for an ideal discharge.²²
- The Pennsylvania Patient Safety Advisory further refined this checklist which focuses on medication safety, patient education and follow-up plans.²³

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Developing a Discharge Plan Checklist

- This Discharge Plan Checklist was modified for use at Chinese Hospital to validate that key elements for a safe discharge have been completed.

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Discharge Plan Checklist: (LACE score ≥ 11 suggests high risk for readmission)

Presenting problem that precipitated hospitalization identified and shared with patient/ family/caregiver.

Patient/ family/caregiver educated on primary DX and secondary DX.

Patient/ family/caregiver given a written schedule of discharge medications and instructions on purpose and cautions.

Preadmission and discharge medications reconciled and patient/ family/caregiver are aware of new medications, change in dose or frequency and medications that should be discontinued.

Patient/ family/caregiver educated on anticipated problems and appropriate interventions relative to disease and symptom management.

Patient/ family/caregiver have been educated on diet and activity.

Patient discharged with a follow-up appointment within one week of discharge if physician concurs.

Patient/ family/caregiver can identify primary care physician and consultants; knows about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911.

Patient/ family/caregiver can give a brief summary of discharge instructions when asked.

RN: Print and Sign Name: _____ Date: _____

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Readmission Alert Discharge Plan (RAAD Plan)

- The Readmission Alert Discharge Plan was developed as a two page form.
- The Modified LACE Tool is on the front page.
- The Discharge Plan Checklist is on the back page.

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Nursing: Readmission Alert Discharge Plan

1) **Assess Prior Admit:** by reviewing old chart, obtain history from patient/family/caregiver and/or checking OC system.

If patient was discharged 30 days or less prior to present admission than score previous admission for

L (Length of Stay), A (Acute Admission), C (Comorbidity) and E (Emergency Room Visits past 6 months).

Check Prior admission at the top of page two and enter LACE score.

2) **Assess Present Admit:** by a projected Length of Stay of 3 days (3 points), Acute Admission, Comorbidity and ER Visits.

Check Present admission at the top of page two and enter projected LACE score for 3 days LOS, 4-6 days LOS and 7-13 days LOS

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 →				

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RAAD Plan (Readmission Alert Discharge Plan)

Admitting RN assesses prior admission, (if discharged 30 days or less) & present admission with Modified LACE Tool
The RN who discharges the patient will complete the Discharge Plan Checklist

- Prior admission** (30 days or less): patient discharged on _____ with a LACE score of ()
- Present admission:** admitted on _____ If present LOS is 3 days projected LACE score is ()
If present LOS is 4-6 days projected LACE score is ()
If present LOS is 7-13 days projected LACE score is ()

Discharge Plan Checklist: (LACE score ≥ 11 suggests high risk for readmission)

- Presenting problem that precipitated hospitalization identified and shared with patient/ family/caregiver.
- Patient/family/caregiver educated on primary DX and secondary DX.
- Patient/family/caregiver given a written schedule of discharge medications and instructions on purpose and cautions.
- Preadmission and discharge medications reconciled and patient/ family/caregiver are aware of new medications, change in dose or frequency and medications that should be discontinued.
- Patient/family/caregiver educated on anticipated problems and appropriate interventions for disease management.
- Patient/family/caregiver have been educated on diet and activity.
- Patient discharged with a follow-up appointment within one week of discharge if physician concurs.
- Patient/family/caregiver can identify primary care physician and consultants; knows about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911
- Patient/family/caregiver can give a brief summary of discharge instructions when asked.

RN: Print and Sign Name: _____ Date: _____

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Piloting the Readmission Alert Discharge Plan (RAAD Plan)

- Nursing supervisors and the nurse manager piloted this project in August 2010 and scored all unplanned admissions with the Modified LACE Tool.
- The staff nurses completed the Discharge Plan Checklist.

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Piloting the Readmission Alert Discharge Plan (RAAD Plan)

- The staff nurses were given in-service on scoring the Modified LACE Tool through case studies to ensure consistency in scoring.
- In December, 2010 staff nurses scored each admission using the Modified LACE Tool

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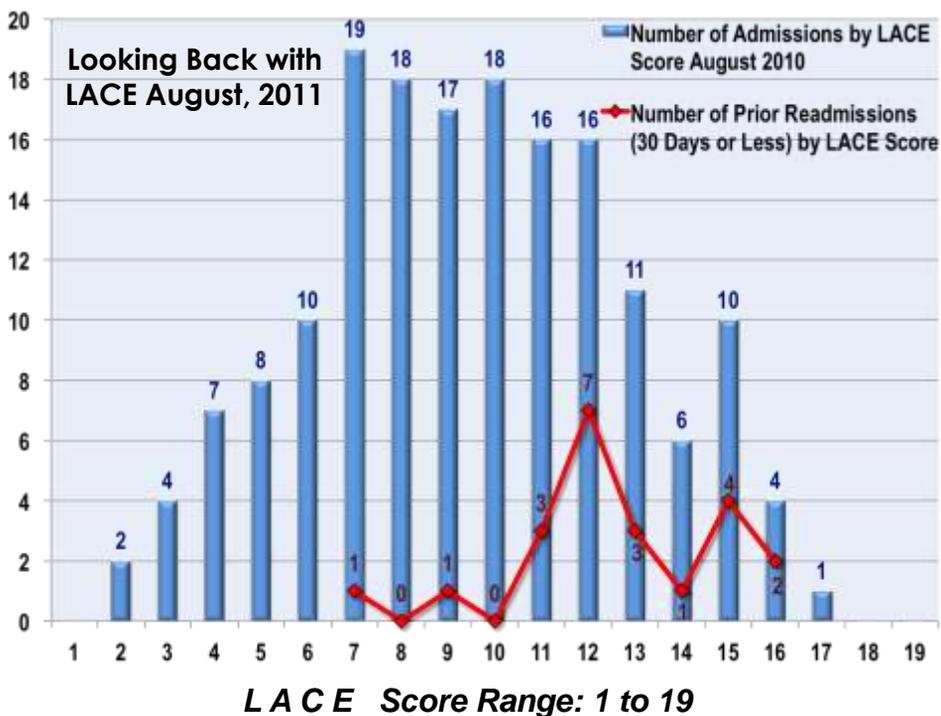
Readmission Alert Discharge Plan (RAAD Plan)

- The admitting nurse initiates the RAAD Plan for all unplanned admissions by using the Modified LACE Tool and providing the LACE score which is then placed in the chart and is available for the patient's health team members.
- The discharge nurse references the LACE score to see if the patient is at high risk for readmission and utilizes the Discharge Plan Checklist to ensure all key elements are addressed to ensure a safe discharge.

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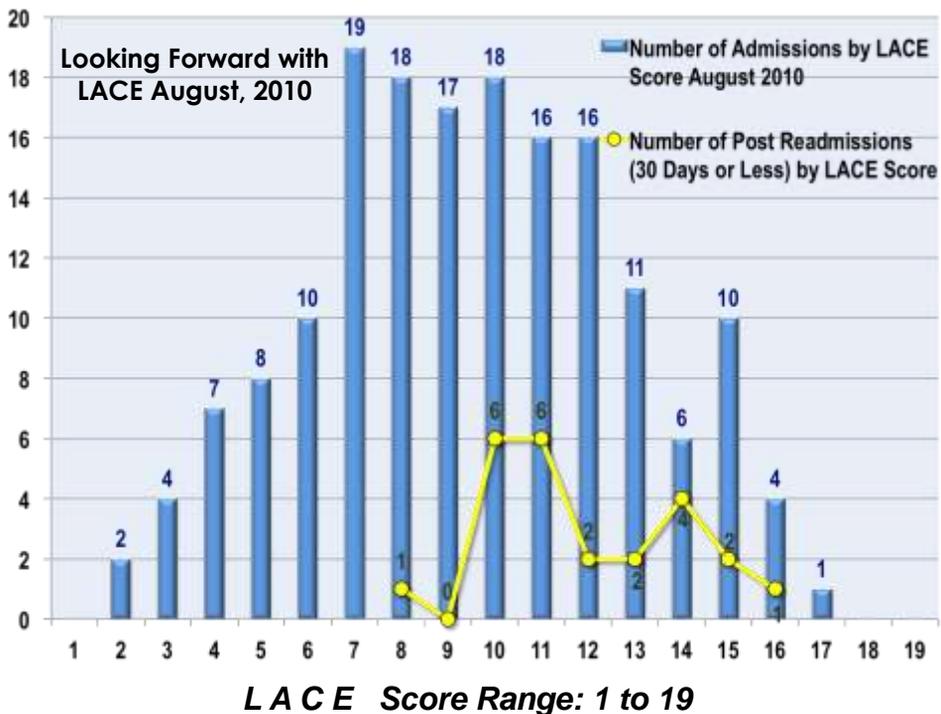
Looking Back with Lace August 2010

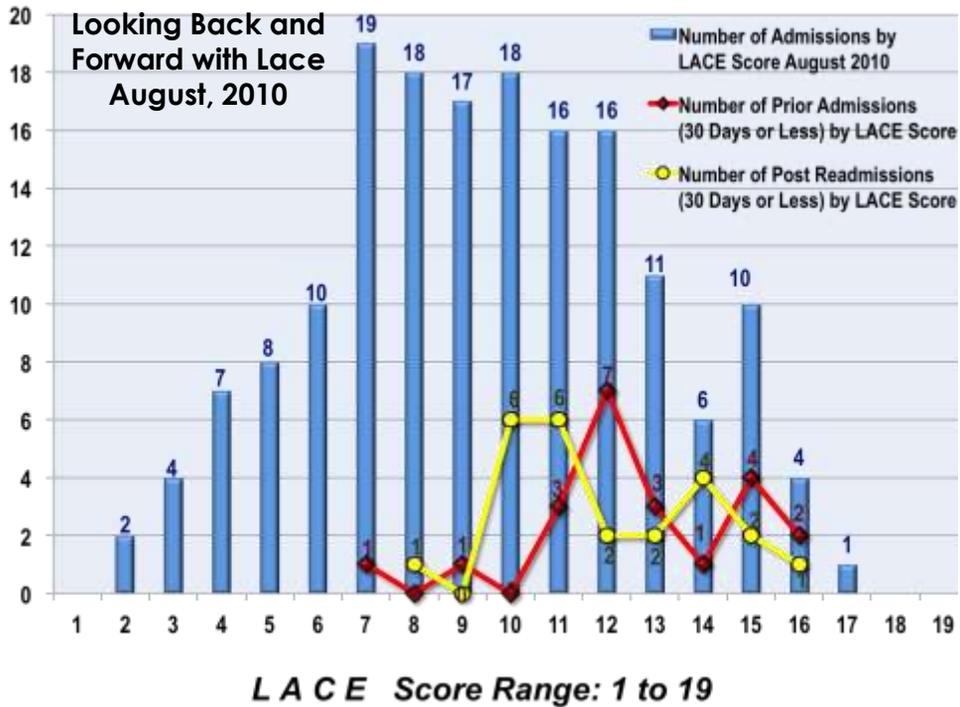
- The RAAD Plan provides data on whether a patient had a prior admission 30 days or less from the present admission.
- In the month of August 2010 there were 167 unplanned admissions, of these 167 admissions 22 of these patients had a prior admission 30 days or less from the present admission in August 2010.
- 20 readmits (90.9%) had a LACE score of 11 or greater.
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Looking Forward with Lace August 2010

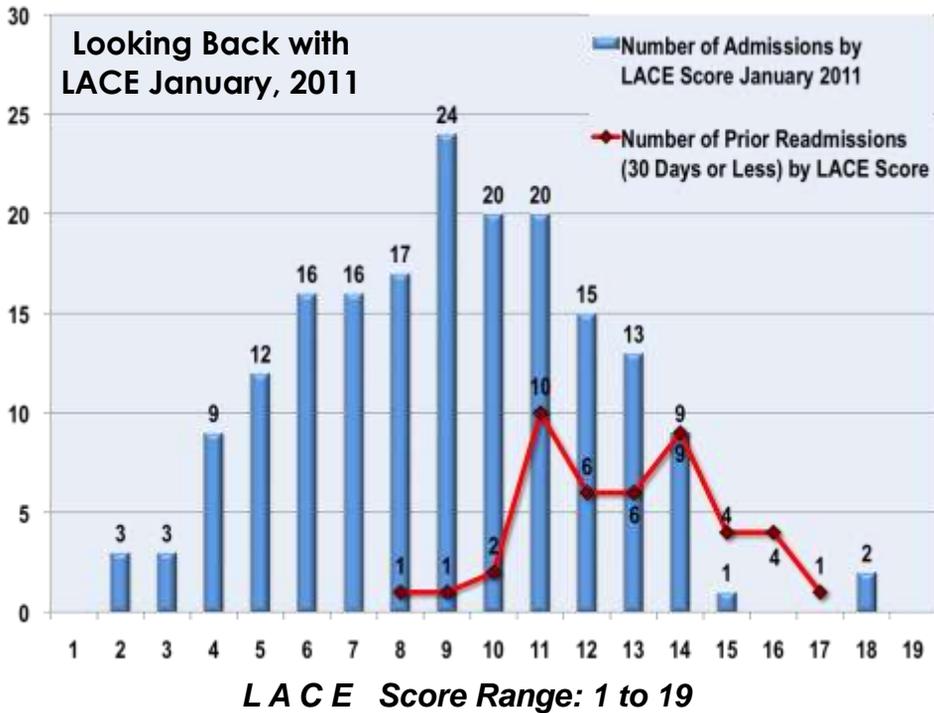
- The RAAD Plan provides an opportunity to see whether a patient once discharged is readmitted 30 days or less after the initial admission.
- In the month of August there were 167 unplanned admissions; of these 167 admissions 24 of these patients had a post admission 30 days or less from the present admission.
- 23 readmits (95.8%) had a LACE score of 10 or greater.





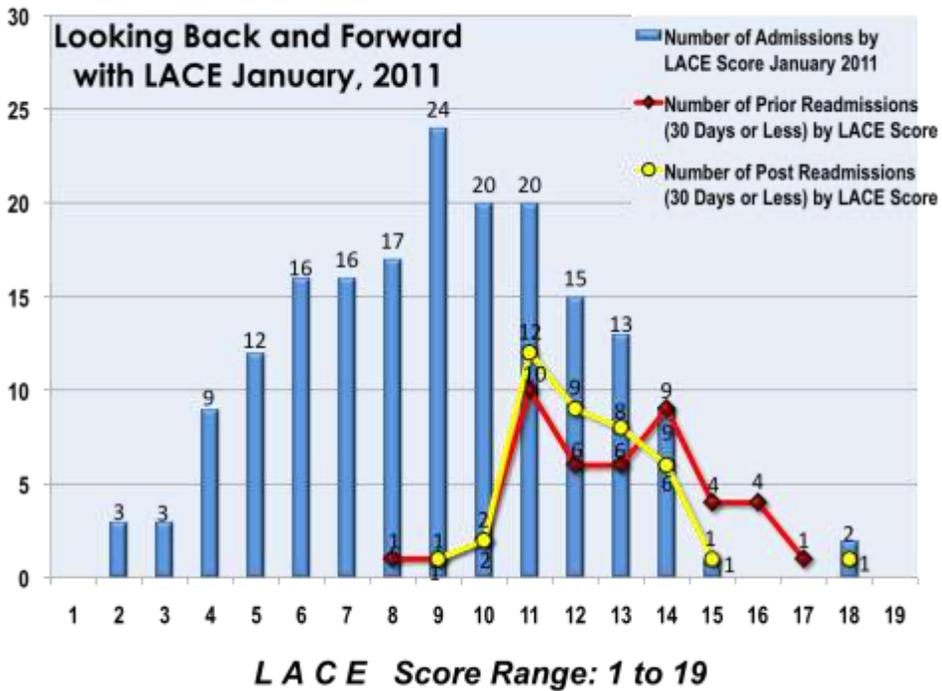
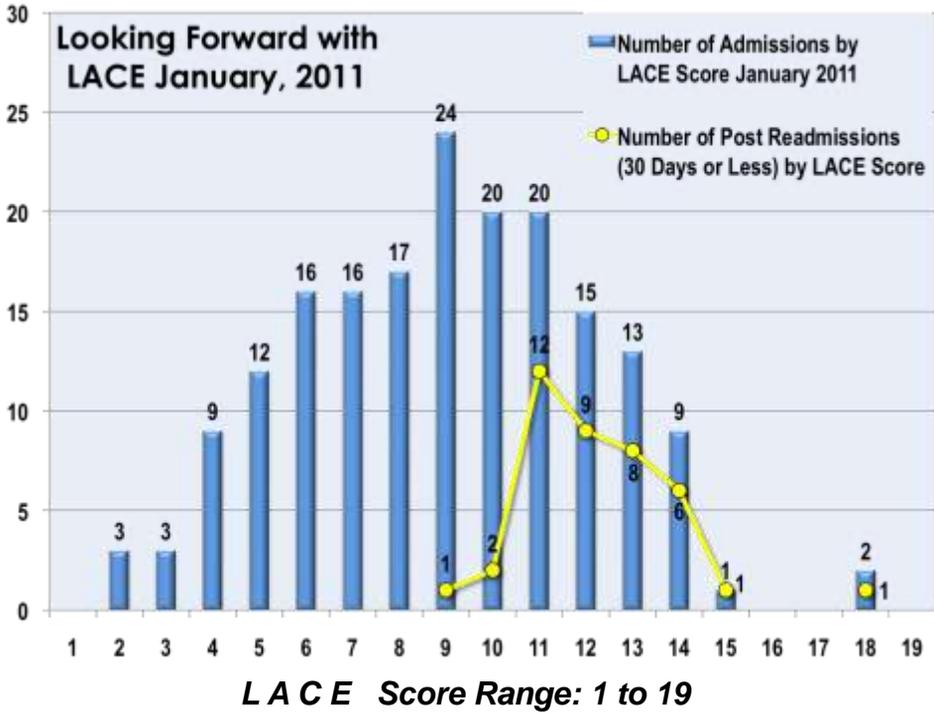
Looking Back with LACE January 2011

- The RAAD Plan provides data on whether a patient had a prior admission 30 days or less from the present admission.
- In the month of January 2011 there were 180 unplanned admissions, of these 180 admissions 44 of these patients had a prior admission 30 days or less from the present admission in August 2010.
- 40 readmits (90.9%) had a LACE score of 11 or greater.



Looking Forward with LACE January 2011

- The RAAD Plan provides an opportunity to see whether a patient once discharged is readmitted 30 days or less after the initial admission.
- In the month of January, 2011 there were 180 unplanned admissions; of these 180 admissions 40 of these patients had a post admission 30 days or less from the present admission
- 37 readmits (92.5%) had a LACE score of 11 or greater.



Conclusion

- Can an index, which can quantify risk of unplanned readmission within 30 days after discharge from a hospital, be adapted for clinical use to enhance the discharge process?
- The answer is yes.

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Conclusion

- This happened through the collaborative efforts of the nursing supervisors and nursing staff at Chinese Hospital.
- All unplanned admissions at Chinese Hospital are being assessed with the Modified LACE Tool.

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Conclusion

- Patients who were readmitted within 30 days from a prior discharge are identified to health team members.
- LACE scores for prior admissions, (if there was one), and projected LACE scores for the present admission are available to health team members to identify patients at risk for being readmitted.

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Conclusion

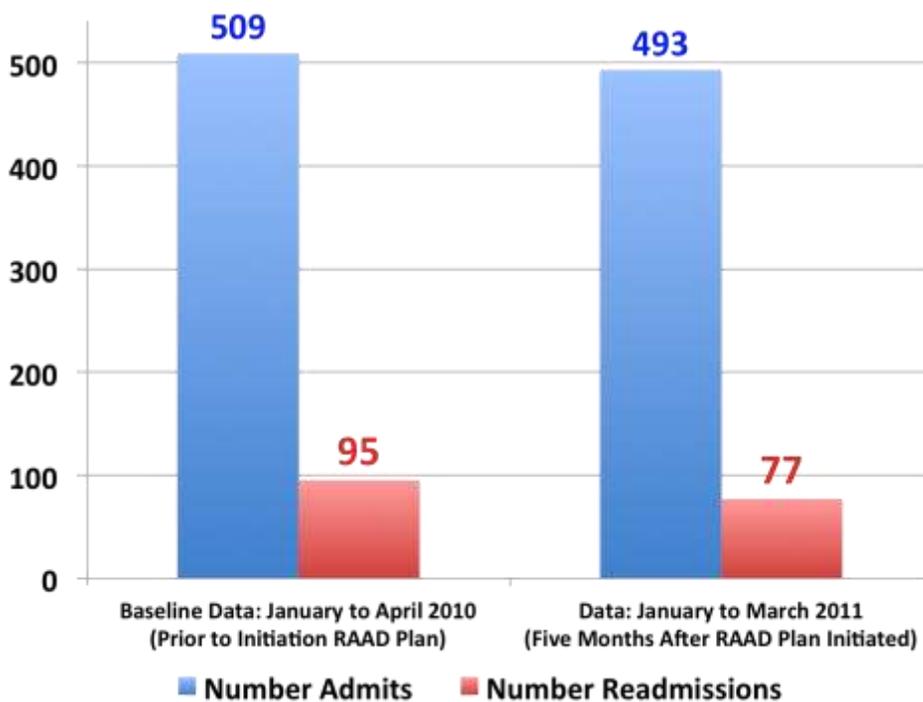
- LACE scores obtained at the time of discharge provides additional awareness of the risk for readmission.
- Further study of readmission data and LACE scores will be ongoing as part of the effort to control readmission rates.
- Future plan to look at one quarters worth of data and examine for readmission patterns.

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Final Thoughts

- Did this project make a difference in readmission rates at Chinese Hospital?
- Baseline data obtained from unplanned admissions from January to April 2010 prior to the initiation of the RAAD Plan showed 509 admissions of which 95 were readmitted.
- Data obtained from unplanned admissions from January to March 2011 five months after the initiation of the RAAD Plan showed 493 admissions of which 77 were readmitted.

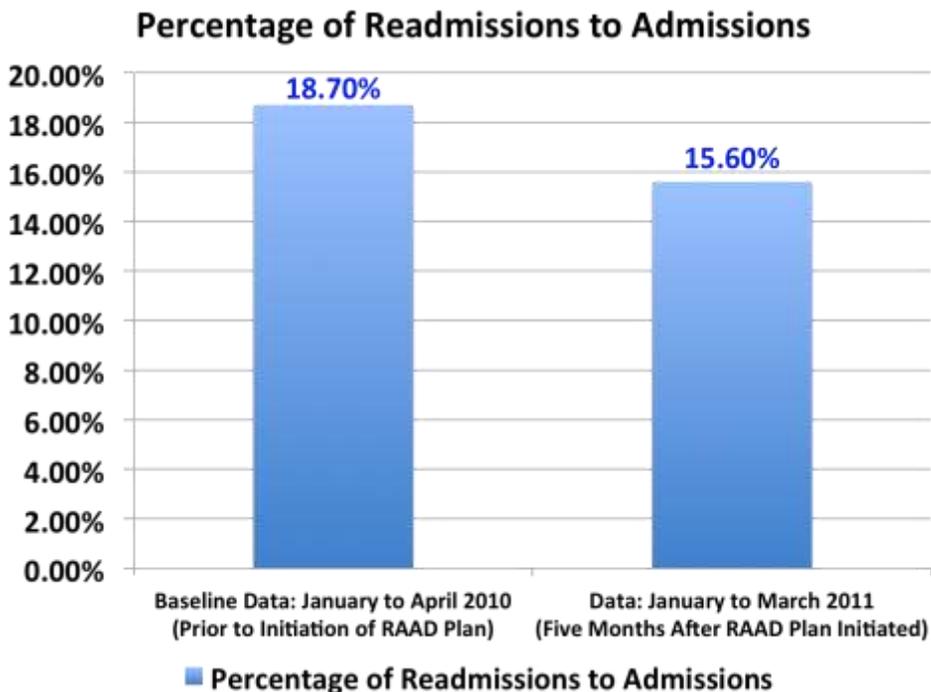
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Final Thoughts

- Baseline data obtained from unplanned admissions from January to April 2010 prior to the initiation of the RAAD Plan gives a percentage of readmissions to admissions of 18.7%.
- Data obtained from unplanned admissions from January to March 2011 five months after the initiation of the RAAD Plan gives a percentage of readmissions to admissions of 15.6%.

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Thank you

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Paper tool and Excel® spreadsheet available:

www.raadplan.com

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The End

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