UPSTATE
MEDICAL UNIVERSITY

BOUNCE BACK RISK SCORE

LIVE on September 5, 2024

The new Upstate Bounce Back Risk Score aims to improve patient outcomes by proactively addressing the root causes of readmissions and ensuring comprehensive, personalized care.

Early and accurate prediction of patients at risk of readmission is essential to improve patient outcomes and reduce costs. Traditionally, our hospital system has used the LACE Plus score to predict 30-day readmissions and mortality. Working closely with Vizient, we have enhanced the LACE+ tool by adding two **new variables identified as strong predictors of readmission**.

The new Upstate Bounce Back Risk Score will be implemented on September 5, 2024.

Use Case

Accurately identifying individuals at risk for readmission enables us to tailor interventions early in the hospital stay. This includes connecting patients with a primary care provider (PCP), scheduling follow-up appointments with Connect Care, and providing ongoing support from patient navigators for high-risk populations.

New Calculation:

The updated Risk Score includes:

- No Primary Care Provider (1 point)
- Inpatient hospital admission within the last six months (excluding the current encounter) (1 point)
- LACE+ Score of 60 or higher (1 point)

New Upstate Risk Scores (0-3):

- **0: Low risk (green)**
- **1: Moderate risk (yellow)**
- **2: High risk (orange)**
- **3: Very high risk (red)**

Understanding Risk Scores:

Imagine Sarah, a patient who recently had surgery for a chronic condition. Without adequate support, Sarah struggles with medication management and lacks transportation for follow-up appointments, leading to repeated emergency department visits.

With the New Upstate Bounce Back Risk Score, Sarah's needs are identified early. She receives personalized support, including a PCP, assistance from a high-risk nurse navigator, and transportation services through Upstate's Round-Trip program. This comprehensive support system reduces readmissions and enhances care quality and outcomes for patients like Sarah.

Some Examples of High-Risk Readmission Scores Should Drive Practice:

- **Physicians:** Review scores during multidisciplinary rounds to address patient needs at discharge. **Evaluate moderate or higher risk patients for telemedicine, PCP affiliations, and nurse- navigator support**.
- **Pharmacists:** Prioritize high-risk patients for medication reconciliation, meds-to-beds enrollment, and potential MAP enrollment.
- **Case Managers:** Coordinate home health services, DME needs, and ensure PCP or Connect Care follow- up for moderate or higher risk patients. Consult SW if additional resources post discharge are needed.
- **Bedside Nursing:** Utilize additional resources early in admission, such as dietary consultations or diabetes education. At discharge, use teach-back methods to ensure patients and caregivers understand medications, complications, and when to seek care. Collaborate with CMs to ensure patients have a PCP appointment following discharge. Remind patients that their health is important to us and that they will receive a post discharge phone call that they should answer.