SBAR: Unplanned Readmission Risk Stratification Tool

Situation	**On Wednesday, December 10, RWJBarnabas Health will go live with the Unplanned Readmission Risk Stratification Tool in Epic.**
Background	We utilized the Epic-released model for unplanned readmission risk; fine-tuning and validating on our specific RWJBH population across the health system. This allowed us to calibrate specific color-coded thresholds (Red/Yellow/Green) to ensure the scores accurately reflect risk within our patient population.
Assessment	The local validation data demonstrates a high Positive Predictive Value (PPV) at the top tier, making it a high-impact target for resource allocation. **Red** Threshold (Risk Score 41+): Patient has **50%** chance of readmission - (~50% PPV or 1 in 2 patients were readmitted) **Yellow** Threshold (Risk Score 23-40): Patient has **33%** chance of readmission - (~33% PPV or 1 in 3 patients were readmitted) **Green** Threshold (Risk Score 15-22): Patient is near **baseline** rate of readmission - (~25% PPV or 1 in 4 patients were readmitted) Currently, discharge resources are applied broadly rather than being weighted toward these high-risk cohorts.
Recommendation	Each member of the Interdisciplinary Team has a role in ensuring these high-risk patients have the tools, education and resources during and after their hospital stay to decrease their risk for readmission. Each member will focus on the following: **Provider:** Crosscheck the After Visit Summary (AVS) for accuracy, ensure the medication history and reconciliation are complete and accurate, and that follow-up appointments are scheduled and communicated to the patient. **Pharmacy:** Continue to do a thorough medication history review with a focus on patients identified as high risk for readmission. **Nursing:** Continue to fully complete patient medication history during admission; complete the SDOH assessment during admission; provide focused, diagnosis-specific education both during admission and upon discharge; and provide medication education (Meducation) on discharge. **Case Manager:** Confirm home care start of care within 48 hours for patients identified as high risk for readmission. **Population Health:** Schedule post-discharge follow up visit(s) before hospital discharge and complete follow-up phone calls 24 to 48 hours after discharge for patients identified as high risk for readmission.