Reducing Readmissions

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Before We Begin

- **No financial disclosures to report**
- **I never worked as a hospital administrator**

Presentation Outline

- Definitional Terms
- Defining the Scope of the Problem
- Reviewing Financial Penalties and Motivation for Improvement
- Review Proven Successful Strategies and Approaches
- Summary

Definitional Terms

- Hospital Stay - Any type of overnight hospital stay
- Observation Stay - Any extended, non emergency room stay in a hospital that the patient's insurance provider does not recognize as a formal inpatient admission
- Admission - Hospital stay accepted by patient's insurance for inpatient reimbursement
- Readmission - Hospital stay accepted by the patient's insurance as an admission within 30 days after an admission discharge
- Payer = Patient Insurance provider

A Hospital Reappearance Does Not Equate a Readmission

- Post inpatient discharge emergency visits alone usually do not count as readmissions
- Post discharge observation stays usually do not count as readmissions
- Inpatient admissions after a discharged emergency room visit or observation stay do not count as readmissions

Why Do Readmissions Deserve Attention?

- Unplanned readmissions typically represent a failure of the healthcare system
- Patient inconvenience and increases their chance of HAIs or experiencing iatrogenic error
- Depending on a patient's insurance plan, can be costly for the patient
- Often produce a financial penalty and reduced reimbursement for a hospital
- Estimated to Medicare is 17 billion per year alone[1]

Why is there an increased focus on Readmissions in recent years?

- CMS began reporting readmission rates in 2009[2]
- In 2012, it launched the Hospital Readmissions Reduction Program through The Affordable Care Act focusing on 3 diagnoses[3] :
  - Acute MI
  - Heart Failure
  - Pneumonia
  - Later added COPD and Knee Replacements
- The financial penalty increased over time and landed at 3% of the base reimbursement rate[3]

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Further Financial Considerations

- Many private insurers followed CMS to institute their own readmission penalties[4]
- Other private insurers operate in managed care environment where any hospital stay can consume a significant amount of the operating budget
- Most hospitals operate at a 1 to 5% margin[5]

The Effect Of Financial Penalties

- Reduction in readmission rate[6,7]
- Increased Mortality?
  - A few studies have shown increased mortality[7]
  - Most studies have shown no link[8]

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Causes of Ineffective Care Transitions[9]

- Breakdowns in Communication
- Patient Education
- Accountability

Why Do Readmissions Happen?

- Complex problem of the healthcare system, not a hospital alone
- Contributory factors:
  - Hospital Quality of Care
  - Outpatient Provider Quality of Care
  - Nursing Home/LTAC Quality of Care
  - Personal Patient Barriers to Care: Language, Transportation, Financial, Cognitive and Support for ADLs and iADLs
- Eliminating readmissions completely is likely impossible

Readmissions Characteristics

- Most Hospital Readmission rates are between 10 and 25% for most hospitals[10]
  - These rates have been improving in recent years, due to financial pressure and increased innovation for improvement
- Typically 90% are unplanned[11]
- Studies estimate that approximately 25% to 75% of readmissions are preventable[11,12]

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What are Causes of a Preventable Readmission?[12,13]

- Premature discharge
- Ignoring the goals of care for patients with serious illnesses
- Failure to communicate important information to outpatient providers
- Failure to Provide Discharged Patients with Appropriate Education and Guidance
- Premature Emergency Room Decision Making

Early vs Late Readmissions[14]

- 7 day readmissions (early) are more often associated with preventable errors than 30 day admissions (late)
- Early readmissions are more often associated with errors stemming from inpatient management at or before discharge:
  - Medication management
  - Communication Errors
  - Lack of appropriate arrangement of follow up

Most Frequent Medical Conditions Associated with Readmissions[15]

- Myocardial Infarction
- Pneumonia
- COPD Exacerbation
- Cardiac Arrhythmias
- Sepsis

An Approach to Reducing Readmissions

- Use a QI approach: DMAIC, Model for Improvement, etc
- Identify successful strategies implementable in your organization
- Implement on at risk patient populations for greatest effect and standardize if possible

At Risk Populations[16,17,18]

- Frequent Healthcare Users
- Patients with Socio-Economic Barriers
  - Uninsured, Transportation Barriers, Overall Financially Strained
- Patients without a robust Support System, unable to complete ADLs or IADLs
- Language Barriers
- High Disease Burden
  - Takes Six or More Medications
- Discharged on weekend or holiday

Research Supported Strategies to Reduce Admissions

Inpatient: Effectively Staff Nurses and Ancillary Providers[19,20]

- Effectively staffing nurses during the discharge transition has shown to reduce readmissions
- Nurse staffing is also connected with inpatient mortality

Inpatient: Assess and Address Patient Comprehension and Need for Ancillary Support

- Address language barriers
- Address cognitive deficits and review the discharge process with a patient's caregiver if possible

Inpatient: Empathy Training[21,22]

- Studies on the importance of empathy in reducing readmissions alone are mixed
- Patients with high levels of anxiety are more likely to readmit later
- Empathy encourages two-way communication between staff and the patient and may reduce anxiety throughout the discharge process

Inpatient: Self Management Education Strategies Before Discharge

- Have shown readmission reduction rates as much as 30%[23,24]
- Often focus on medication management and symptom monitoring, can be administered on a computer for patients able to complete on their own
- Dependent on patient adherence and effectiveness can vary wildly based on the patient population

Other Inpatient Interventions

- Embedding specialized trained Nurse Practitioners, Case Managers, and even volunteers during the discharge period[25]
- Standardized discharge packet administered by trained planners and pharmacists[26]
- Standardized protocol for communication with outpatient providers, post hospitalization SNFs and LTACHs
- Ensure documentation is completed in a timely manner

Outpatient: Ensure Rapid Follow Up

- Follow up with PCP or specialist within 7 days[27,28]
- Post hospitalization phone call[29]
  - Multiple Studies have shows a significant reduction in readmissions with follow up phone call targeting at risk patients
- Address transportation barriers for follow up if possible

Outpatient: Home Monitoring[30,31]

- Remote monitoring using biomarkers or technology
- Biomarkers are often obtained by homecare nursing or outpatient lab draws
- Technological answers include use of implantable cardiac devices and telephone communicated weigh, blood pressure, pulse oximetry, heart rate, etc
- Largely dependent on patient compliance

Other Outpatient Interventions

- Mandatory home visits with PCP or nurses to improve follow up[32]
- Nurse-driven protocolized outreach program involving phone calls and case management[33]
- Risk based home intervention with both nursing and pharmacists[34]
- Standardize communication between ER and former inpatient providers on hospital reappearance

Inpatient and Outpatient: Transitional Care Interventions and Navigator Teams[35]

- Repeatedly show reductions in 30 day readmissions
- Usually consist of trained navigators, nurses, pharmacists or other ancillary care providers
  - Coach and educate patients on the discharge process
  - Medication management and verification
  - Communication with primary care and specialist teams
  - Post discharge phone call within 3 days and repeated monitoring symptom management

State Action on Avoidable Rehospitaliztions (STAAR), and Hospital to Home (H2H)[36]

- STAAR was a mutli-State Program Active from 2009 to 2013 including Hospitals in MA, MI, and WA
- H2H was a national effort from 2009 to 2012
- STARR encouraged collaboration across organizational boundaries
- Both focused on medication management, patient education, and early follow up.

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The Commonwealth Fund Analysis of these Studies[36]

- Studied data from 478 hospitals participating in these studies and found
- Findings: Discharging patients with follow up appointments made was the only single measure that had a significant reduction in risk standardized readmission rates
- However, hospitals that participated in 3 or more activities had significantly greater reductions in risk standardized readmission rates

Cooperation with Payers' Incentive Programs

- Insurance providers may provide their own post hospitalization navigators or nursing access to prevent hospitalizations
- Ensure ease of access for incentive programs

Research Validated Toolkits to Start Improvement Available at AHRQ

- Project RED (Re-Engineered Discharge)[26]
  - Mostly Inpatient Toolkit designed at Boston University that focusing on arranging follow up, educating the patient, and performing a post hospitalization phone call within 3 days
- Project Boost (Better Outcomes by Optimizing Safe Transitions)[37]
  - Mostly Inpatient Toolkit as above with the addition of standardized PCP communication

Summary of Approach to Reduce Readmissions

- Use a standardized QI approach
- Identify patient population most at risk for readmission and target them
- Identify MULTIPLE effective strategies implementable in your healthsystem
- Ensure rapid follow up
- Collaborate and communicate with local healthcare organizations as much as possible
  - Post Hospitalization Skilled Nursing facilities/Rehabs
  - Home Health Organizations
  - Pharmacies
  - Other Health Systems

Overall Summary

- Readmissions are a major cause of financial strain for both patients and hospitals and represent poor quality of care
- A significant proportion of readmissions are preventable
- Significant reductions in readmission rates can be achieved using standardized toolkits and low cost interventions
- Ensuring rapid follow up is probably the single most effective intervention to implement, but research suggests implementing multiple strategies simultaneously will achieve the most success

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