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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