Health Care Leader Action Guide to Reduce Avoidable Readmissions

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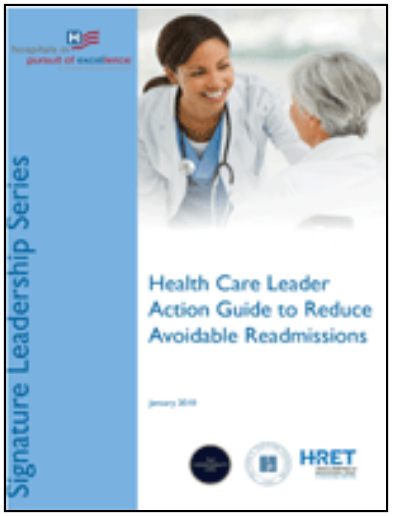

Osei-Anto A, Joshi M, Audet AM, Berman A, Jencks S. *Health Care Leader Action Guide to Reduce Avoidable Readmissions.* Chicago, IL: Health Research & Educational Trust, January 2010. Access at http://www.hret.org/care/projects/guide-to-reduce-readmissions.shtml.

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Studies of Rehospitalizations

- Nearly 20% of Medicare hospitalizations followed by readmission within 30 days
- Only half of patients re-hospitalized within 30 days had a physician visit before readmission
  - Unknown if lack of physician visit causes readmissions—but poor continuity of care, especially for many chronically ill patients
- 19% of Medicare discharges followed by an adverse event within 30 days—2/3 are drug events, the kind most often judged "preventable"
- Potential high cost savings – unplanned readmissions cost Medicare $17.4 billion in 2004 (source: Jencks, et al., NEJM, 2009)

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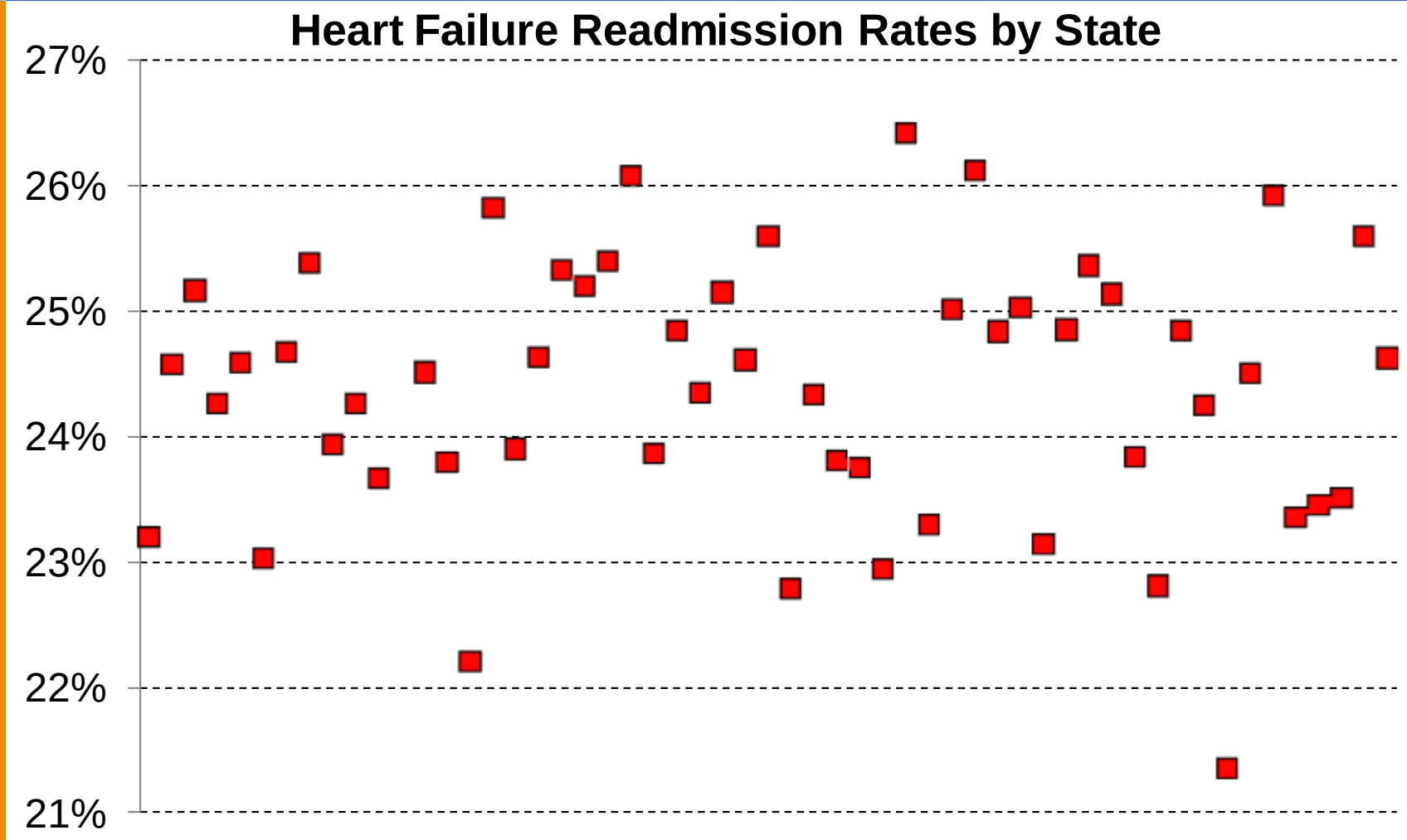
Variation



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Avoidable Readmissions

- Evidence suggests many rehospitalizations are preventable
  - Many re-hospitalized before seeing a physician
  - Inter-hospital and inter-state variation
  - Randomized clinical trials testing interventions
- What proportion of readmissions are truly “avoidable”? No one knows.
- While most efforts to reduce readmissions are outside of the hospital’s control, there are still actions that hospitals can take to make a difference.
- Hospitals, physicians, HHAs, nursing homes, and pharmacists may prevent more readmissions working together than hospitals can by improving discharge process alone.

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What Does This Mean?

- Possibilities
  - Quality of nursing home, home health agency, and primary care drive both admission and readmission rates
  - Practice patterns in non-hospital settings that lead to admissions for these groups also lead to readmissions
  - Patient characteristics also a factor
- Certainties
  - Factors leading to readmissions must be understood to solve the problem of readmissions
  - Reducing readmissions cannot be done within the walls of the hospital
  - Big picture factors must be understood while focusing on specific challenges and their solutions

Four Steps for Hospital Leaders

1. Examine your hospital's current rate of readmissions
   - *For different conditions, by practitioner, by readmission source, and at different timeframes*
2. Assess and prioritize your improvement opportunities
   - *By specific patient populations, stages of care process, organizational strengths, and priorities*
3. Develop an action plan of strategies to implement
   - *Involve key stakeholders (e.g., care team, community, patients, families, and caregivers)*
4. Monitor your hospital's progress
   - *Monitor regularly by conditions, by practitioner, source, and timeframes*

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Strategies to Implement Along Care Continuum

To effectively implement the strategies identified in the three tables, hospitals may need to involve key stakeholders in the care delivery process: patients, physicians, pharmacists, social services, nutritionists, physical therapists, and the community.

Table 1: During Hospitalization

- Risk screen patients and tailor care
- Establish communication with primary care physician (PCP), family, and home care
- Use "teach-back" to educate patient/caregiver about diagnosis and care
- Use interdisciplinary/multi-disciplinary clinical team
- Coordinate patient care across multidisciplinary care team
- Discuss end-of-life treatment wishes

Table 2: At Discharge

- Implement comprehensive discharge planning
- Educate patient/caregiver using "teach-back"
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners

Table 3: Post-Discharge

- Promote patient self management
- Conduct patient home visit
- Follow up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care

Strategies to Implement During Hospitalization

Table 1: During Hospitalization—Strategies to Prevent Readmissions

Strategies	Level of Effort	Actions
Risk screen patients and tailor care	Low	• Proactively determining and responding to patient risks • Tailoring patient care based on evidence-based practice, clinical guidelines, care paths, etc. • Identifying and responding to patient needs for early ambulation, early nutritional interventions, physical therapy, social work, etc.
Establish communication with PCP, family, and home care	Low	• PCP serving as a core team member of patient care delivery team • Informing family or home care agency of patient care process and progress
Use "teach-back" to educate patient about diagnosis and care	Low	• Clinician educating patient about diagnosis during hospitalization

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Strategies to Implement During Hospitalization (contd.)

Table 1: During Hospitalization—Strategies to Prevent Readmissions

Strategies	Level of Effort	Actions
Discuss end-of-life treatment wishes	Medium	• Discussing terminal and palliative care plans across the continuum
Use interdisciplinary/ multidisciplinary clinical team	Medium	• Team including complex care manager, hospitalists, SNF physician, case managers, PCPs, pharmacists, and specialists • Team including bilingual staff and clinicians (where needed)
Coordinate patient care across multidisciplinary care team	High	• Using electronic health records to support care coordination • Using transitional care nurse (TCN) (or similar role) to coordinate care

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Strategies to Implement at Discharge

Table 2: At Discharge—Strategies to Prevent Readmissions		
Strategies	**Level of Effort**	**Actions**
Implement comprehensive discharge planning	Medium	• Creating personalized comprehensive care record for patient, including pending test results and medications • Hospital staff communicating discharge summary to PCP or next care provider • Reconciling discharge plan with national guidelines and clinical pathways • Providing discharge plan to patient/caregiver • Reconciling medications for discharge • Standardized checklist of transitional services
Educate patient /caregiver using "teach-back"	Medium	• Reviewing what to do if a problem arises • Focusing handoff information on patient and family
Schedule and prepare for follow-up appointment	Medium	• Transmitting discharge resume to outpatient provider • Making appointment for clinician follow-up

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Strategies to Implement at Discharge (contd.)

Table 2: At Discharge—Strategies to Prevent Readmissions

Strategies	Level of Effort	Actions
Help patient manage medication	Medium	• Managing patient medication with help of a transition coach
Facilitate discharge to nursing homes with discharge instructions and partnerships with nursing homes	Low–High	• Using standardized referral form/transfer form • Using nurse practitioner in nursing home setting

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Project RED Discharge Checklist

Project RED calls for initiation of discharge process upon admission.

Eleven key components:

1. Medication reconciliation
2. Reconcile discharge plan with national guidelines
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone reinforcement

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Strategies to Implement Post-Discharge

Table 3: Post-Discharge—Strategies to Prevent Readmissions

Strategies	Level of Effort	Actions
Promote patient self-management	Low	• Using tools to help patient manage care plan post-discharge
Conduct patient home visit	Medium	• Conducting home and nursing home visits immediately after discharge and regularly after that
Follow up with patients via telephone	Medium	• Calling 2–3 days after discharge to reinforce discharge plan and offer problem solving • Offering telephone support for a period post-discharge • Calling to remind patients of preventive care

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Strategies to Implement Post-Discharge (contd.)

Table 3: Post-Discharge—Strategies to Prevent Readmissions

Strategies	Level of Effort	Actions
Use personal health records to manage patient information	High	• Including information on patient diagnosis, test results, prescribed medication, follow-up appointments, etc. on PHR
Establish community networks	High	• Developing public/private partnerships to meet patients needs
Use telehealth in patient care	High	• Monitoring patient progress through telehealth, e.g., electronic cardiac monitoring, remote patient telemonitoring

Care Transitions Program

- The Care Transitions Intervention℠
  - During a 4-week program, patients with complex care needs receive specific tools, are supported by a Transition Coach™, and learn self-management skills to ensure their needs are met during the transition from hospital to home.
  - Transition Coach™ initial hospital or skilled nursing facility visit prior to discharge:
    - Prepare for discharge and home visit
    - Introduce PHR and Discharge Checklist
  - Transition Coach™ follow up post-discharge:
    - Conduct 1 home visit 24-72 hours post-discharge
    - Conduct 3 follow-up phone calls

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First Interventions to Consider?

1. Risk screen upon admission for high risk rehospitalization – consider clinical and social factors
2. Use teach back during discharge
3. Schedule follow-up physician appointment
4. Telephone follow-up within 48 to 72 hours

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