Preventing Readmissions: Evidence & Conjecture

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Conflict of Interest

I have no real or perceived conflict of interest that relates to this presentation. Any use of brand names is not in any way meant to be an endorsement of a specific product, but to merely illustrate a point of emphasis.

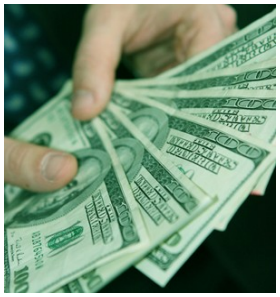
Objectives

Learning objectives for this presentation:

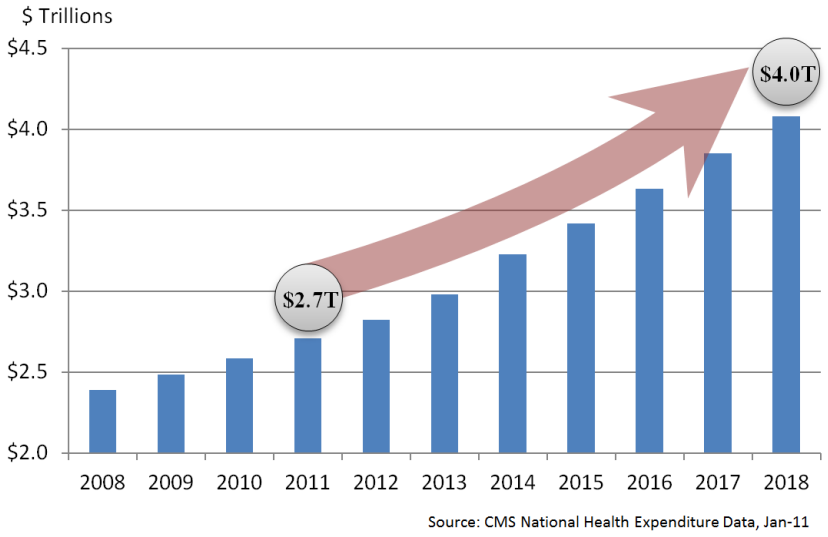
- Define "potentially preventable" readmissions
- Explain financial implications relating to readmissions
- Discuss various programs/processes that may impact readmission reductions

Increasing Pressures

- Increased financial incentives to control healthcare costs
- Increased demands to improve safety and quality of care
- Increased public scrutiny



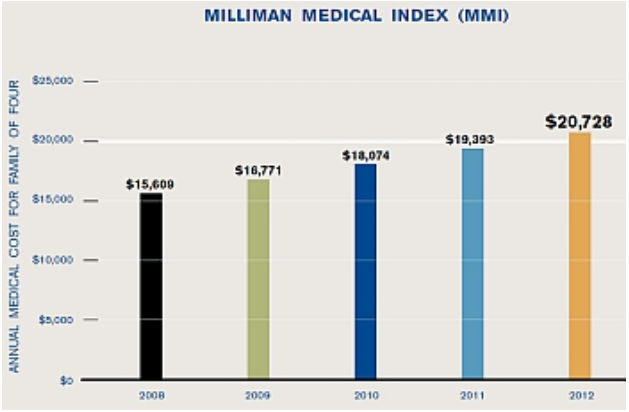
Total U.S. Healthcare Expenditures



Source: CMS National Health Expenditure Data, Jan-11

Why Focus on Readmissions?

- Per capita spending → $13,708 in 2020



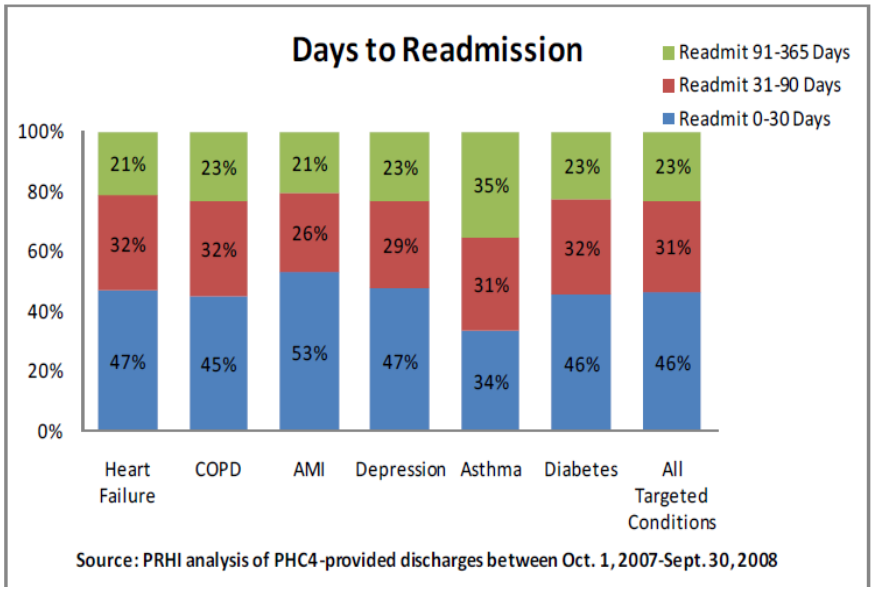
Why Focus on Readmissions?

- Financial Pressures
  - Overall spending on healthcare expected to grow 5.8% per year through 2020
  - Per capita spending on healthcare
    - $8,327 in 2010 → $13,708 in 2020
  - 17% of GDP → 20% of GDP in 2020
  - Spending on readmissions: $15 to $18 billion

Why Focus on Readmissions?

- Quality of Care Pressures
  - 30-day readmission rates: 20% (90-day: 34%)
  - Readmit: 0.6 day longer LOS than other patients in the same DRG
  - Cost to Medicare: > $17 billion
  - 90% of readmissions were unplanned
  - 40% - 75% potentially preventable

Stephen F. Jencks, M.D.
NEJM, April 2009


Days to Readmission
Readmit 91-365 Days
Readmit 31-90 Days
Readmit 0-30 Days
100%
80%
60%
40%
20%
0%
21%
32%
47%
23%
32%
45%
21%
26%
53%
23%
29%
47%
35%
31%
34%
23%
32%
46%
23%
31%
46%
Heart Failure
COPD
AMI
Depression
Asthma
Diabetes
All Targeted Conditions
Source: PRHI analysis of PHC4-provided discharges between Oct. 1, 2007-Sept. 30, 2008

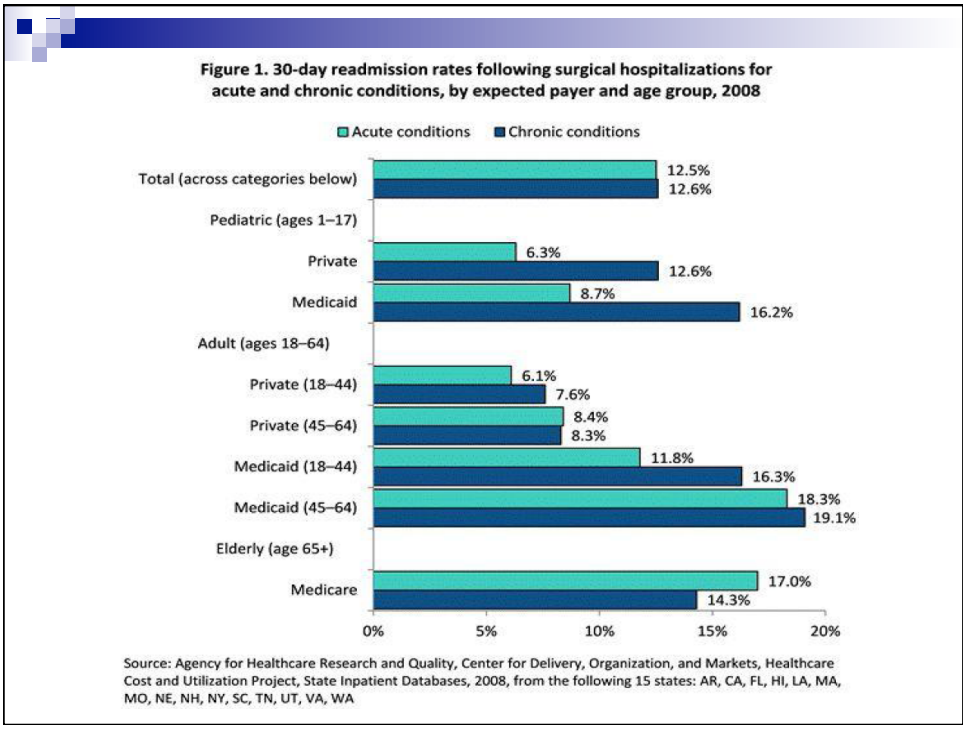
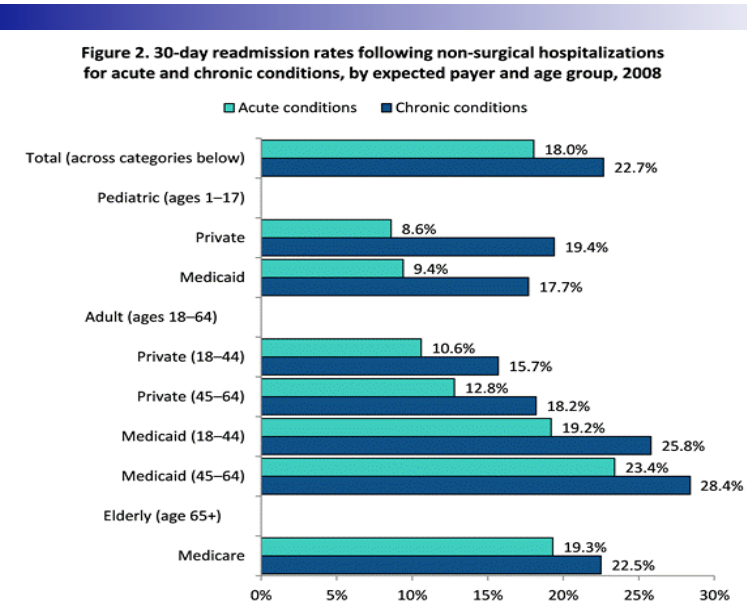


Figure 1. 30-day readmission rates following surgical hospitalizations for acute and chronic conditions, by expected payer and age group, 2008
Acute conditions
Chronic conditions
Total (across categories below)
12.5%
12.6%
Pediatric (ages 1–17)
Private
6.3%
12.6%
Medicaid
8.7%
16.2%
Adult (ages 18–64)
Private (18–44)
6.1%
7.6%
Private (45–64)
8.4%
8.3%
Medicaid (18–44)
11.8%
16.3%
Medicaid (45–64)
18.3%
19.1%
Elderly (age 65+)
Medicare
17.0%
14.3%
0%
5%
10%
15%
20%
Source: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, State Inpatient Databases, 2008, from the following 15 states: AR, CA, FL, HI, LA, MA, MO, NE, NH, NY, SC, TN, UT, VA, WA



Why Focus on Readmissions?

- Public Scrutiny
  - Hospital Compare, Leapfrog, US News, Etc.
    - Transparency - Public reporting of performance
  - Perception of Quality of Care
    - Competition for business
    - Patient satisfaction

Defining "Readmission"

- What it is NOT
  - It is NOT *primarily* about mistakes being made in the care of patients while hospitalized
  - It is NOT something you can manage in isolation – it concerns the performance of others beyond your facility

Defining "Readmission"

- What it is NOT
  - Exclusions
    - Conditions requiring significant follow-up care (e.g. CF, CA, multiple traumas)
    - Conditions requiring unique follow-up care (e.g. neonatal/obstetrical, eye care)
    - AMA discharge status because the intended care could not be completed.

Defining "Readmissions"

- Potentially Preventable Readmission (PPR)
  - A return hospital admission
  - Within 30 days of discharge
  - Clinically related to the initial admission

Readmission Chains

- A sequence of readmissions that are all related to a single initial discharge
  - Essentially an episode of related hospitalizations
  - Provides a more precise description of the readmission pattern associated with the care given during/after specific types of initial discharges

Example of a Readmission Chain

Initial Admission:	CABG Surgery
Readmission:	Post-op Wound Infection
Readmission:	PTCA

- Without Readmission Chains: readmission sequence is a CABG discharge with one readmission followed by an unrelated PTCA admission
- With Readmission Chains: a CABG discharge and two related readmissions
  - Post-op infection and PTCA are related to initial CABG surgery

Potentially Preventable Readmission Rates

	Patients readmitted to hospital within:		
	7 days	15 days	30 days
Rate of potentially preventable readmissions	5.2%	8.8%	13.3%
Spending on potentially preventable readmissions	$5 billion	$8 billion	$12 billion

Source:
Recreated from table within: Medpac (June 2007). *"Report to the Congress: Promoting Greater Efficiency in Medicare"*, p 107, from 3M analysis of 2005 Medicare discharge claims.

Defining "Readmissions"

- Potentially Preventable Readmission (PPR)
  - Could have been prevented through:
    - Improved quality of care in the initial hospitalization
    - Better discharge planning
    - Improved post-discharge follow-up
    - Improved coordination inpatient/outpatient health care teams

Hospital Readmissions Reduction Program

- ↓ payments for discharges to hospitals in the highest 25% of readmissions for AMI, HF, Pneumonia starting Oct 1, 2012
- Penalties
  - Oct 2012: 1% reduction
  - Oct 2013: ↑ to 2% reduction
  - Oct 2014: ↑ to 3% reduction

Benefits of PPR Payment Reduction Program

- ↑ payment for hospitals that have low PPR rates
- ↓ payment for hospitals with high PPR rates
- Introduces an explicit P4P component
- By altering payment on a case-by-case basis the incentive to reduce PPRs is reinforced for each patient strengthening the effectiveness of the incentive to improve quality.

Project RED: Re-Engineered Discharge Program

Components of the RED

- Educate throughout the hospital stay
- Give the patient a written discharge plan & assess pts understanding
- Confirm the medication plan
- Make appointments for follow-up w/patient input
- Organize post-discharge services
- Expedite transmission of the discharge summary to clinicians accepting care of the patient.
- Call the patient 2-3 days after discharge to reinforce the discharge plan and help with problem-solving.

The Evidence

- Four Broad Categories
  - Improved Quality of Inpatient Care
    - Better Patient Education
    - Improved Self-Management Support
  - Better Discharge Planning
    - Improved Transitions
  - Better Post-Discharge Follow-Up
    - Improved Multidisciplinary Management
    - Improved coordination inpatient/outpatient health care teams
  - Improved Patient-Centered Care Planning at End of Life
    - Palliative Care

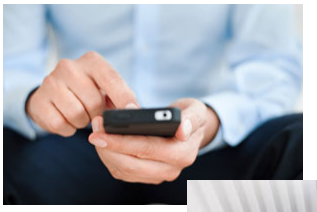
Improved Patient Education & Self-Management Support

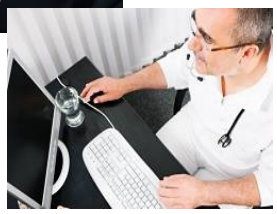
- Increased time for patient education and self-management skills in the inpatient setting

  "…resetting how much pts/family need to know about their disease, treatment and care to a higher level of understanding & awareness" *Stephen Jenks*
- Early post-discharge follow-up
- Specialized case management
  - Prompt notification whenever a "frequent flyer" comes into ED or even before that, when paramedics are called to patient's home

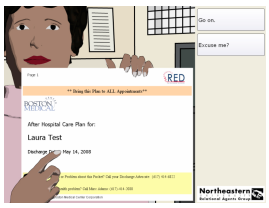
Using Technology for Better Patient Education and Self-Management

- Keeping in touch with patients (telehealth)
- There's an app for that?

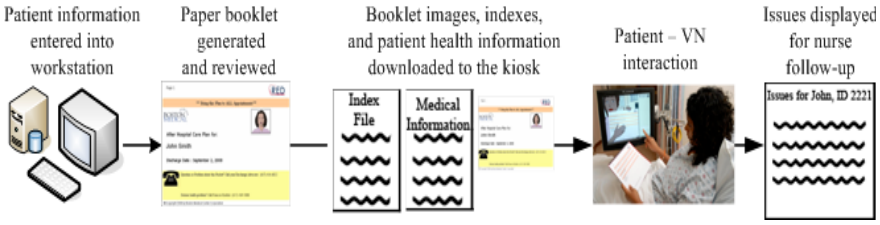




Virtual Patient Advocates



- Animated character
- Simulates face-to-face interaction
- 74% prefer Louise



Innovative Programs for Better Patient Self-Management

Missouri's Asthma Ready Clinic Program

- Teaches physicians and clinic staff about asthma and evidence-based care guidelines
- Teaches clinicians how to best teach patients to respond to changing conditions by adjusting medications at home.
- Emphasize the importance of formulating a long-term plan in partnership with the family.
- Provides educational material and equipment through grant funding

Better Self Management for COPD Patients?

- **VA Trial**
  - Comprehensive care management program for COPD
    - 209 patients in intervention group
    - 217 patient in usual care group
  - No reductions in hospitalizations
  - Study halted early due to an increased number of overall deaths in the intervention group
    - 28 vs 10 in usual care group

Better Discharge Process

- Enhanced Care & Support at Transitions
  - Establish follow-up plan before discharge
  - Medication on discharge
  - Dedicated nurse discharge advocate / coach (?)
    - One study: 12% readmission rate vs. 20% in control
  - Lengthen / More Detailed handoff process (?)
  - Earlier discharge summary / shared e-forms (?)
  - Front-loaded home care visits (?)

Better Post-Discharge Process: The Multidisciplinary Team

- Nurse-led programs
- Specialty-based follow-up
- Nutrition
- Exercise
- OT / PT / Speech
- Social work
- RT
- Medication review, Medication adherence interventions
- Patient education
- Enhanced monitoring
- Listen to the patient

The Discharge Process

- Multidisciplinary Rounds
  - Plan of Care
  - Patient Goals
- Strengthen care coordination across the continuum: Hospital-To-Home Initiatives
- Involve the Patient: “Transition Survival Skills”
- Follow-Up Plan

Grand-Aide Program

- Innovative workforce
- Closely supervised by RN and/or MD
- Use protocols to provide
  - Simple primary care
  - Disease management
  - Transitional care
- http://grand-aides.org/

Patient-Centered Care Management at the End of Life

- Listen to the patient
- Palliative care
  - Informed choices for non-emergent, end of life care issues
  - Counseling in the ED
- Hospice

Post-Discharge: Follow-Up

- Strengthen care coordination across the continuum: Hospital-To-Home Initiatives
- Case Management
  - Chronicle home setting to determine what caused readmission
  - Medication reconciliation
  - Scheduling f/u with physician
  - Social Services help
  - Appropriate/Innovative tx & equipment; compliance
- Frequent Follow Up Monitoring
  - Telehealth / Skype (?)
  - Intensive monitoring for at risk populations (homeless)
- Home Visits from various care providers

Know Your Data

- Case Management
- Collect actionable data on PPRs
  - At what rate are patients being readmitted back to my hospital? What is the frequency (1,2, 3 or more times)?
  - How often are they readmitted to other facilities?
  - Are there particular discharge settings from which readmissions are occurring?
  - Is there a pattern of readmissions within a particular service line or for a particular procedure?
  - Are there specific physicians that have greater potential to affect readmissions patterns?
  - How many dollars are associated with the different areas of readmissions?

Summary

- Failing to reduce readmissions could cost your hospital millions
- It is your responsibility to improve care through the continuum
- Use your expertise
- Investigate and speak out
- Do what's best for our patients

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Questions?

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