Health Care Leader Action Guide to Reduce Avoidable Readmissions

January 2010

Funded by The Commonwealth Fund.
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)
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.
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
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>
<thead>
<tr>
<th>Table 1: During Hospitalization</th>
<th>Table 2: At Discharge</th>
<th>Table 3: Post-Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk screen patients and tailor care</td>
<td>Implement comprehensive discharge planning</td>
<td>Promote patient self management</td>
</tr>
<tr>
<td>Establish communication with primary care physician (PCP), family, and home care</td>
<td>Educate patient/caregiver using “teach-back”</td>
<td>Conduct patient home visit</td>
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<tr>
<td>Use “teach-back” to educate patient/caregiver about diagnosis and care</td>
<td>Schedule and prepare for follow-up appointment</td>
<td>Follow up with patients via telephone</td>
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<tr>
<td>Use interdisciplinary/multi-disciplinary clinical team</td>
<td>Help patient manage medications</td>
<td>Use personal health records to manage patient information</td>
</tr>
<tr>
<td>Coordinate patient care across multidisciplinary care team</td>
<td>Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners</td>
<td>Establish community networks</td>
</tr>
<tr>
<td>Discuss end-of-life treatment wishes</td>
<td></td>
<td>Use telehealth in patient care</td>
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## Strategies to Implement During Hospitalization

### Table 1: During Hospitalization—Strategies to Prevent Readmissions

<table>
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<tr>
<th>Strategies</th>
<th>Level of Effort</th>
<th>Actions</th>
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| Risk screen patients and tailor  | Low             | • Proactively determining and responding to patient risks  
| care                              |                 | • 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, | Low             | • PCP serving as a core team member of patient care delivery team  
| family, and home care             |                 | • Informing family or home care agency of patient care process and progress                                                        |
| Use “teach-back” to educate      | Low             | • Clinician educating patient about diagnosis during hospitalization                                                                |
| patient about diagnosis and care  |                 |                                                                                                                                       |
## Strategies to Implement During Hospitalization (contd.)

### Table 1: During Hospitalization—Strategies to Prevent Readmissions

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<tr>
<td>Discuss end-of-life treatment wishes</td>
<td>Medium</td>
<td>• Discussing terminal and palliative care plans across the continuum</td>
</tr>
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</table>
| 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 |
## Strategies to Implement at Discharge

### Table 2: At Discharge—Strategies to Prevent Readmissions

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<tr>
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| 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 |
## Strategies to Implement at Discharge (contd.)

### Table 2: At Discharge—Strategies to Prevent Readmissions

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<tr>
<td>Help patient manage medication</td>
<td>Medium</td>
<td>• Managing patient medication with help of a transition coach</td>
</tr>
<tr>
<td>Facilitate discharge to nursing homes with discharge instructions and partnerships with nursing homes</td>
<td>Low–High</td>
<td>• Using standardized referral form/transfer form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Using nurse practitioner in nursing home setting</td>
</tr>
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</table>
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
### Strategies to Implement Post-Discharge

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<tr>
<td>Promote patient self-management</td>
<td>Low</td>
<td>• Using tools to help patient manage care plan post-discharge</td>
</tr>
<tr>
<td>Conduct patient home visit</td>
<td>Medium</td>
<td>• Conducting home and nursing home visits immediately after discharge and regularly after that</td>
</tr>
</tbody>
</table>
| 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 |
## Strategies to Implement Post-Discharge (contd.)

### Table 3: Post-Discharge—Strategies to Prevent Readmissions

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<tr>
<td>Use personal health records to manage patient information</td>
<td>High</td>
<td>• Including information on patient diagnosis, test results, prescribed medication, follow-up appointments, etc. on PHR</td>
</tr>
<tr>
<td>Establish community networks</td>
<td>High</td>
<td>• Developing public/private partnerships to meet patients needs</td>
</tr>
<tr>
<td>Use telehealth in patient care</td>
<td>High</td>
<td>• Monitoring patient progress through telehealth, e.g., electronic cardiac monitoring, remote patient telemonitoring</td>
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</table>
The Care Transitions Intervention\textsuperscript{SM}

- During a 4-week program, patients with complex care needs receive specific tools, are supported by a Transition Coach\textsuperscript{TM}, and learn self-management skills to ensure their needs are met during the transition from hospital to home.

Transition Coach\textsuperscript{TM} initial hospital or skilled nursing facility visit prior to discharge:
- Prepare for discharge and home visit
- Introduce PHR and Discharge Checklist

Transition Coach\textsuperscript{TM} follow up post-discharge:
- Conduct 1 home visit 24-72 hours post-discharge
- Conduct 3 follow-up phone calls
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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