Preventing Readmissions

Challenges To Implementing Readmission Reduction Programs

Webinar for HEN hospitals
Joint Commission Resources
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Objectives

- Review patient safety issues at hospital discharge
- Introduce Project RED as an example of hospital based readmission reduction program
- Present first steps in hospital readmission reduction
- Discuss how to overcome challenges to implementation

“Perfect Storm" of Patient Safety

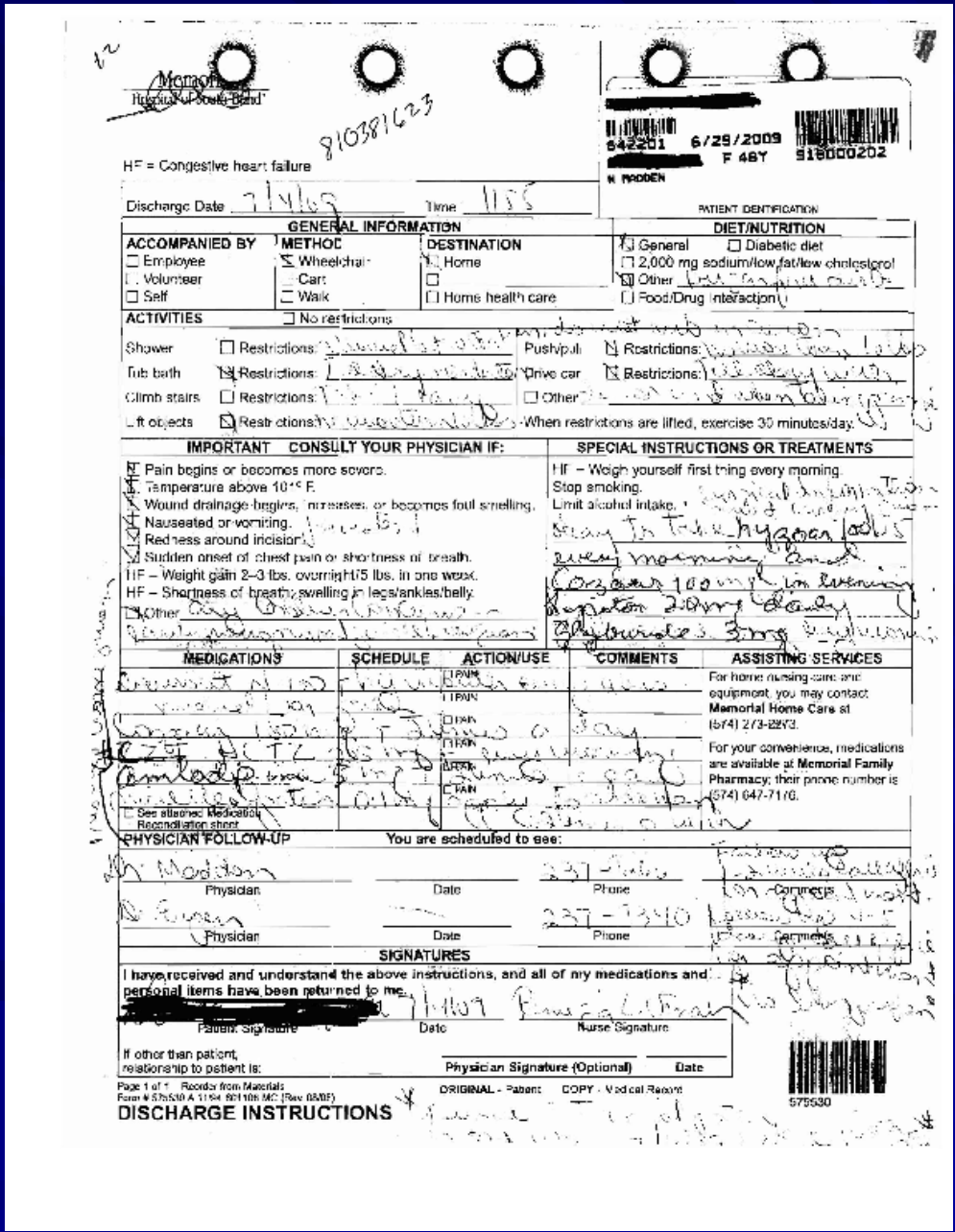
The hospital discharge is non-standardized and frequently marked with poor quality.

- Loose Ends
- Communication
- Poor Quality Info
- Poor Preparation
- Fragmentation
- Great Variability
- Many Adverse Events

- 39.5 million hospital discharges per year
- Costs totaling $329.2 billion per year!
- 20% of Medicare pts readmitted within 30 days

N Engl J Med 2009 2;360(14):1418-28.

A Real Discharge Instruction Sheet



Memorial Hospital of South Bend

642201 6/29/2009 F 48Y 918000202

N RODDEN

PATIENT IDENTIFICATION

HF = Congestive heart failure

Discharge Date 7/1/09 Time 1135

GENERAL INFORMATION

ACCOMPANIED BY	METHOD	DESTINATION
☐ Employee	☒ Wheelchair	☒ Home
☐ Volunteer	☐ Cart	☐
☐ Self	☐ Walk	☐ Home health care

DIET/NUTRITION

☒ General ☐ Diabetic diet
☐ 2,000 mg sodium/low fat/low cholesterol
☒ Other
☐ Food/Drug Interaction

ACTIVITIES ☐ No restrictions

Shower	☐ Restrictions:	Push/pull	☒ Restrictions:
Tub bath	☒ Restrictions:	Drive car	☒ Restrictions:
Climb stairs	☐ Restrictions:	☐ Other	
Lift objects	☒ Restrictions:	When restrictions are lifted, exercise 30 minutes/day.	

IMPORTANT CONSULT YOUR PHYSICIAN IF:

☒ Pain begins or becomes more severe.
☐ Temperature above 101° F.
☐ Wound drainage begins, increases, or becomes foul smelling.
☐ Nauseated or vomiting.
☐ Redness around incision.
☒ Sudden onset of chest pain or shortness of breath.
HF – Weight gain 2–3 lbs. overnight/5 lbs. in one week.
HF – Shortness of breath/swelling in legs/ankles/belly.
☐ Other

SPECIAL INSTRUCTIONS OR TREATMENTS

HF – Weigh yourself first thing every morning.
Stop smoking.
Limit alcohol intake.

MEDICATIONS	SCHEDULE	ACTION/USE	COMMENTS	ASSISTING SERVICES
				For home nursing care and equipment, you may contact **Memorial Home Care** at (574) 273-2273.
				For your convenience, medications are available at **Memorial Family Pharmacy**; their phone number is (574) 647-7176.

☐ See attached Medication Reconciliation sheet

PHYSICIAN FOLLOW-UP You are scheduled to see:

Physician	Date	Phone	Comments
Physician	Date	Phone	Comments

SIGNATURES

I have received and understand the above instructions, and all of my medications and personal items have been returned to me.

Patient Signature Date Nurse Signature

If other than patient, relationship to patient is: Physician Signature (Optional) Date

Page 1 of 1 Reorder from Materials Form # 575530 A 11/04 801106 MC (Rev 08/08)

ORIGINAL - Patient COPY - Medical Record

575530

DISCHARGE INSTRUCTIONS

Pt Safety Collides with Public Policy!

Patient Protection and Affordable Care Act

Payments changes for discharges occurring on or after October 1, 2012.

RED Checklist

Eleven mutually reinforcing components:

1. Medication reconciliation
2. Reconcile dc 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. Dc summary to PCP
11. Telephone Reinforcement

Adopted by National Quality Forum as one of 30 "Safe Practices" (SP-11)

How Is RED Delivered

- Discharge Educator
  - Collect Information
  - Package Information
  - Teach Patient
- After Hospital Care Plan
- Communicate with Source of Ongoing Care
- Follow-up phone call

Personalized cover page

** Bring this Plan to ALL Appointments**

BOSTON MEDICAL CENTER

PROJECT RED

After Hospital Care Plan for:

John Doe

Discharge Date: October 20, 2006

Question or Problem about this Packet? Call your Discharge Advocate: (617) 414-6822

Serious health problem? Call Dr. Brian Jack: (617) 414-2080

Updated list of all medicines

EACH DAY follow this schedule:

MEDICINES

What time of day do I take this medicine?	Why am I taking this medicine?	Medication name Amount	How much do I take?	How do I take this medicine?
 Morning	blood pressure	PROCARDIA XL NIFEDIPINE 90 mg	1 pill	By mouth
	blood pressure	HYDROCHLOROTHIAZIDE 25 mg	1 pill	By mouth
	blood pressure	CLONIDINE HCl 0.1 mg	3 pills	By mouth
	cholesterol	LIPITOR ATORVASTATIN CALCIUM 20 mg	1 pill	By mouth
	stomach	PROTONIX PANTOPRAZOLE SODIUM 40 mg	1 pill	By mouth

APPOINTMENTS PAGE

** Bring this Plan to ALL Appointments**

John Doe

What is my main medical problem?

Chest Pain

When are my appointments?

Tuesday, October 24th at 11:30 am	Thursday, October 26th at 3:20 pm	Wednesday November 1st at 9:00 am
Dr. Brian Jack Primary Care Physician (Doctor)	Dr. Jones Rheumatologist	Dr. Smith Cardiologist
at Boston Medical Center ACC – 2nd floor	at Boston Medical Center Doctor's Office Building 4th floor	at Boston Medical Center Doctor's Office Building 4th floor
For a Follow-up appointment	For your arthritis	to check your heart
Office Phone #: (617) 414-2080	Office Phone #: (617) 638-7460	Office Phone #: (617) 555-1234

APPOINTMENT CALENDAR

October 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20 Left hospital	21
22	23 Pharmacist will call today or tomorrow	24 Dr. Jack at 11:30 am at Boston Medical Center ACC – 2nd floor	25	26 Dr. Jones at 3:20 pm at Boston Medical Center Doctor's Office Building – 4th floor	27	28
29	30	31				

PRIMARY DIAGNOSIS PAGE

Congestive Heart Failure.

Heart failure, also called Congestive Heart Failure is a serious condition in which the heart can no longer pump enough blood to the rest of the body.

<u>Things you need to do:</u>

Fill all of your medicine prescriptions, finish your medicine and take as directed.

Rest as needed.

Weigh yourself daily and write it down.

Call your doctor right away if you have:
-Weight change by ___ pounds for ___ days
-Sudden weakness
-Trouble breathing
-Serious cough

Do not smoke. Avoid other's smoke.

Keep all of your follow-up appointments.

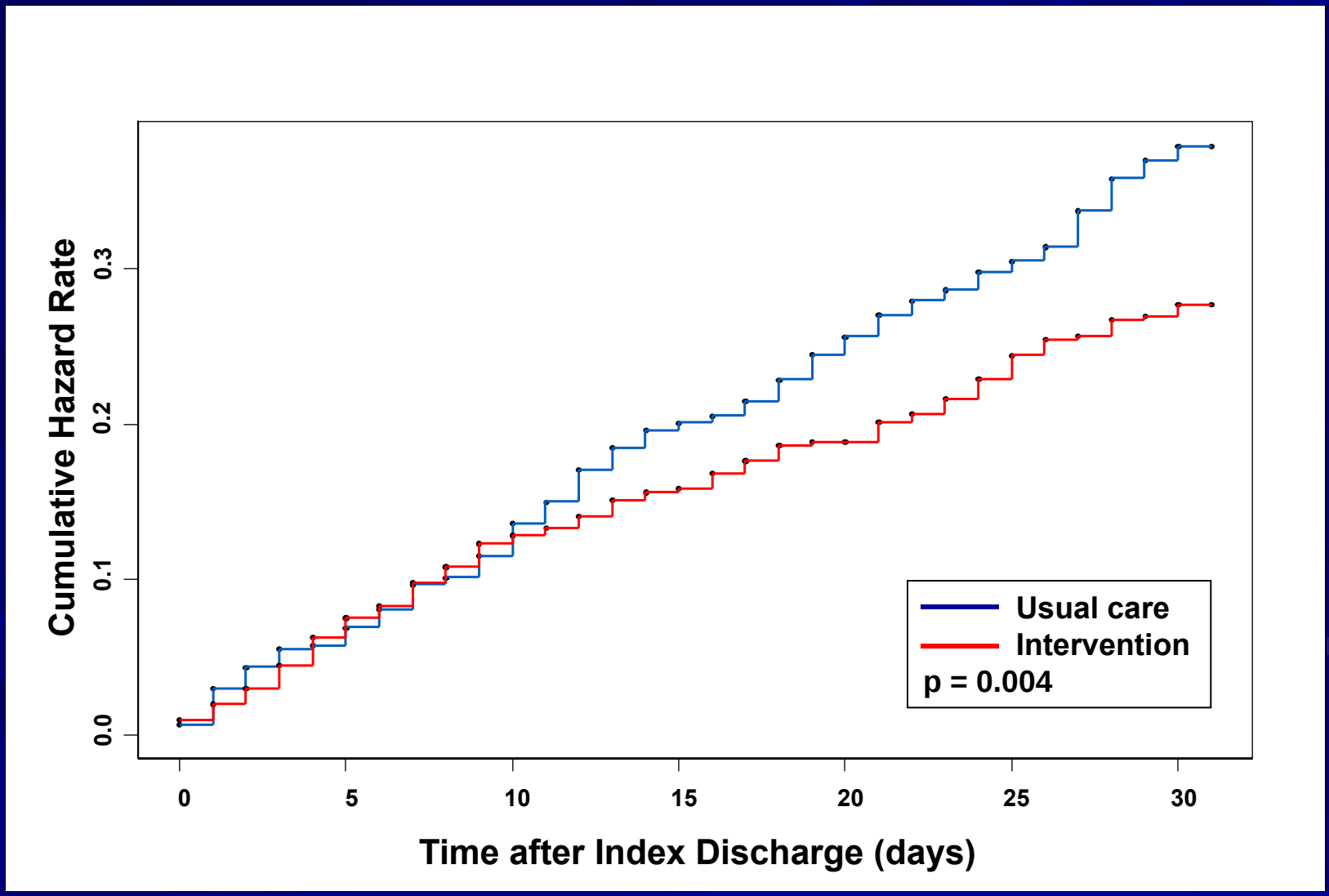
What did we find?

Primary Outcome:
Hospital Utilization within 30d after Discharge

	Usual Care (n=368)	Intervention (n=370)	P-value
Readmissions			
Total # of visits	76	55	
Rate (visits/patient/month	0.20	0.15	
ED Visits			
Total # of visits	90	61	
Rate (visits/patient/month)	0.24	0.16	
Hospital Utilizations *			
Total # of visits	166	116	
Rate (visits/patient/month)	0.45	0.31	0.009

* Hospital utilization refers to ED + Readmissions

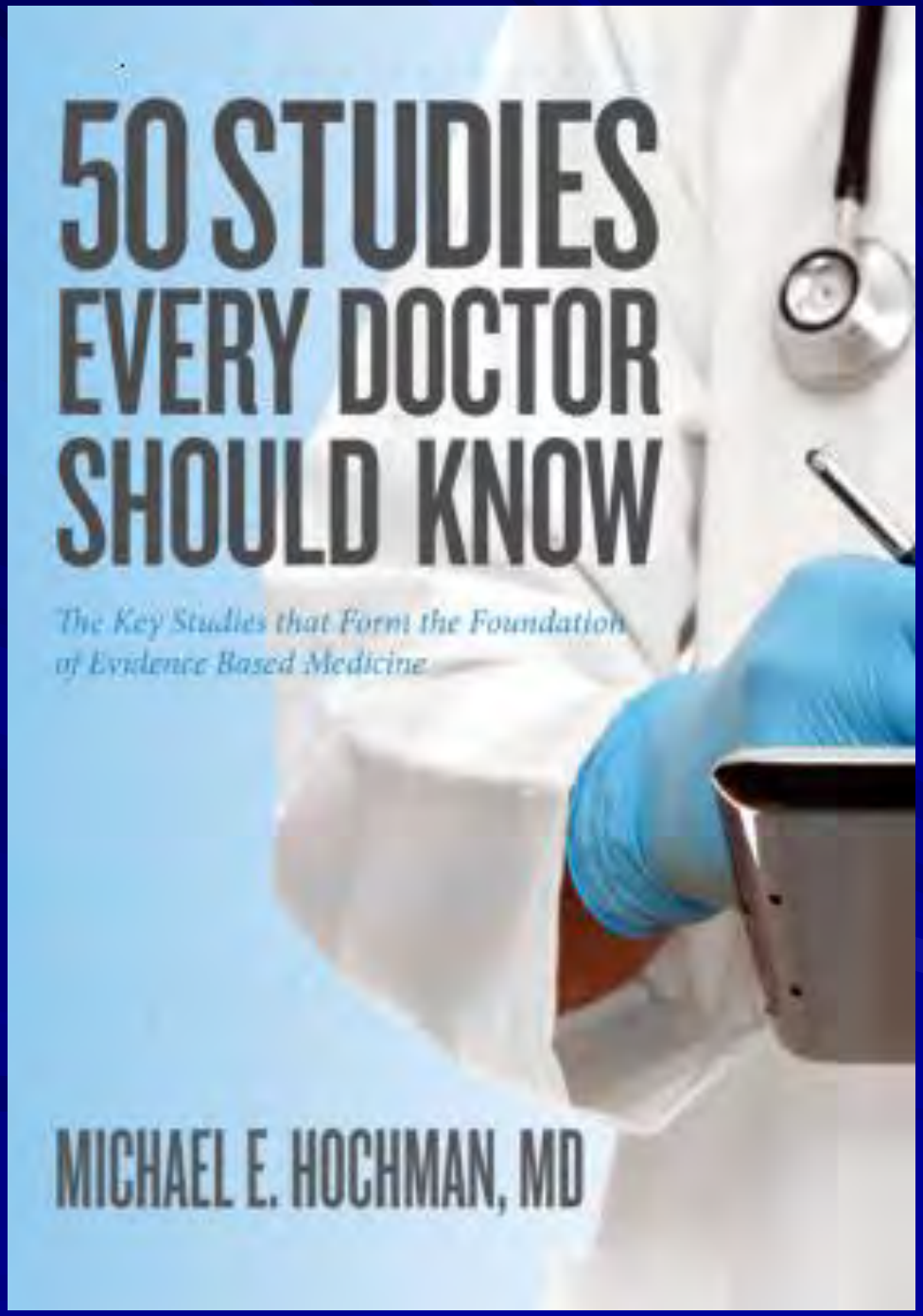
Cumulative Hazard Rate of Patients Experiencing Hospital Utilization 30 days After Index Discharge



Outcome Cost Analysis

Cost (dollars)	Usual Care (n=368)	Intervention (n=370)	Difference
Hospital visits	412,544	268,942	+143,602
ED visits	21,389	11,285	+10,104
PCP visits	8,906	12,617	-3,711
Total cost/group	442,839	292,844	+149,995
Total cost/subject	1,203	791	+412

Reducing readmissions from 20 to 15% saves Medicare 17 billion over 5 yrs


50 STUDIES EVERY DOCTOR SHOULD KNOW
The Key Studies that Form the Foundation of Evidence Based Medicine
MICHAEL E. HOCHMAN, MD

Lessons Learned From National Dissemination

AHRQ Contract to Study Dissemination

Toolkit

- *Overview of the Toolkit. Why is this Important?*
- *How to Begin Implementation at Your Hospital*
- *How to Deliver RED*
- *How to Conduct a Post-discharge Follow-up Phone Call*
- *How To Benchmark Your Improvement Process*
- *How to Deliver RED to Diverse Populations*

10 hospital beta sites across country

- Does RED work in the real world?
- What works? What doesn't? What are the barriers?
- How to Adapt RED for diverse populations

1. When to Start?

- “Heads on Beds”
  - Still fee for service
  - Currently no advantage to lowering ReAd
- When to start
  - Learning curve
  - Time to improve efficiency

2: Which Patients Get RED?

- Incremental vs All patients?
- If Incremental
  - By specialty?
    - Medical?
    - Surgical?
  - By Diagnosis
    - Heart Failure?
  - By geography
    - A specific floor or ward?
  - A specific health plan?
    - Hospital sponsored capitated plan?

3. Who Does DA Functions?

- Hire someone new?
- RN caring for the patient?
- Case manager?
- Social worker?
- Medical Staff?
- Some combination (team work?)

4. What about Appointments?

- Who will make them?
  - DA, ward clerk, RN
- What if patient has no doctor?
- What if appointment only available in 6 weeks?
- Limited or no Insurance coverage

5. Who Makes the 2 Day Phone Call?

- DA?
- Pharmacist?
- Housestaff?
- RN Caring for patient?
- RN in the Primary Care Office?
- Contract to a Call Center?

- What if you can not reach them?
  - How many attempts to reach them?

- What if you identify a clinical problem?
  - Contact
    - Outpatient providers
    - Inpatient provider
    - Pharmacy?

6. What about the Discharge Summary?

- Can it be done at discharge?
- Is 30 days the norm?
- Who will send it to PCP?
- How do providers want to receive this information?

7. How Will You Produce the AHCP?

- How to Print?
  - A Word document?
  - Work with your own IT Department?
  - Engineered Care?
  - Do you have color printers?
- Who will enter data?
  - DA
  - RN
  - Ward clerk?
- Integration with hospital IT system

8. How will you identify pending tests at discharge?

- Is EMR able to identify?
- Agreement about who's responsible for follow-up?
  - PCP?
  - Specialist?
  - Hospitalist who ordered the test?

9. Which Patients Need More?

- What about frequent fliers?
- Behavioral health issues?
- Frail elderly?
- English as second language?
  - Interpreter availability
- Cognition
- Health literacy
- Social support
- Substance abuse
- Mobility/ isolation

Risk Factors for Readmission from RED Data

	IRR	95% CI	n
Health literacy	1.48	1.05, 2.08	703
Patient Activation	1.86	1.25, 2.76	681
Depression	1.73	1.27, 2.36	738
Frequent Utilizer	2.45	1.92, 3.15	738
Gender	1.62	1.28, 2.06	737
Substance Abuse	1.49	1.12, 1.98	738

Walley AY. *Journal of Addiction Medicine* 2011 Oct 4
Woz S. *BMJ Open* 2012; 2:e000428. doi:10.1136/ bmjopen-2011-000428
Mitchell S. *Journal of Hospital Medicine* 2010:5;378-384
Mitchell S. *Journal of Health Communications*, Submitted
Mitchell S. Patient Activation and Readmission. Submitted

Transitions - 3 Legs and 2 Ends

- 3 legged stool
  - hospital
  - community based
  - PCPs
- 2 Ends to a Transition
  - Models for PCP to pull into PC
- What is a good readmission vs. a bad readmission?

10. Medication Reconciliation

- Who will do it?
- How do you get med staff to do it in a timely way?
- How do you know it is correct?
- Timing of final medication reconciliation
- How to communicating with the physician team
- How to tracking, coordinate, communicate changes in pre-hospital, in-hospital and post-hospital med lists

Advice From Our Discharge Educators

- Discharge plan is discussed **daily** – huddles work
- Discharge teaching happens throughout the hospital stay
- Teach-back works
- Be sure day of discharge is not a surprise
- Discharge is not rushed
- Appointments
  - What days are good for you?”
  - Review plan for travel to appointment
- Confirm phone number for follow-up call
- Be sure the AHCP is correct
- Give AHCP to as many as possible

Role of Senior Leadership

- Align with organization's strategies & priorities
- Set the vision and the goal
- Communicate Commitment
  - Newsletter, grand rounds, M+M, RCA, emails
- Provide resources & staff
- Appoint implementation team leader
- Set policies to integrate across organizational boundaries
- Get IT on board
- Hold people accountable
- Recognize and reward success

Role of Implementation Team

- Recruit a collaborative, interdisciplinary team
- Identify process owners and change champions
- Staff Engagement -- Energize staff
- Analyze current discharge process
- Analyze your Readmission rates
- Set goals
- Build skills to provide RED
- Trouble shoot as intervention is rolled out
- Measure Your Process and Outcomes

Conclusions

- Hospital Discharge is low hanging fruit for quality improvement
- Translating a RCT to the real world is hard
- Hospital based interventions can help reduce readmissions
- Changing the Culture of Hospitals is Hard
- Emphasis now on Implementation
- Efficiency is the key

Questions

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http://www.bu.edu/fammed/projectred/