Reducing Avoidable Readmissions Within 30 Days of Discharge

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What We Know About Hospital Readmissions

- Approximately 20% of Medicare hospital discharges are followed by readmission within 30 days.
  - 90% of these appear to be unplanned and a result from worsening health status.
- From MedPac: 75% of readmissions preventable.
  - $12B per year added to annual Medicare spending
- Only half of patients readmitted within 30 days saw a physician prior to readmission.
  - Unknown if this is a causative factor, but many patients severely, chronically ill.
  - Nineteen percent of Medicare discharges experienced adverse events within 30 days
    - Two-thirds related to medications and judged to be preventable.

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How Many Readmissions Can Be Avoided?

- No one knows for sure
- Evidence suggests
  - Patients frequently readmitted prior to seeing a physician
  - Inter-hospital and inter-state variation
  - Randomized clinical trials needed
- Likely that many more readmissions can be avoided through interprofessional collaboration than by improving discharges practices alone.

Factors in Readmissions

Likely Factors

- Quality of nursing home, home health agencies and primary care drive readmission rates.
- Patient characteristics that lead to admissions also lead to readmissions.
- Practice patterns in non-hospital settings for these agencies also drive readmissions

Known Factors

- Readmission rates will not be decreased without understanding factors that lead to readmissions.
- Reducing readmissions cannot be done by hospitals alone.
- Systems factors must be considered, even while focusing on specific challenges, solutions

Process Breakdowns That May Result in Potentially Avoidable Readmissions (1)

- Poor transfer of key information to patients
  - Incomplete understanding of medication instructions at discharge
  - Incomplete understandings of when to re-contact care provider
- Poor transfer of information to ambulatory care settings
  - Hospital to care facility staff
  - Hospital to primary care provider
  - Lack of clarity on desired end of life care

Process Breakdowns That May Result in Potentially Avoidable Readmissions (2)

- Lack of primary care provider follow-up
  - Primary care provider unaware of hospitalization
  - No transportation to primary care provider
  - No primary care provider
- Poor patient-family knowledge and non-disclosure of current medications, incomplete medication recommendation may cause duplication or interaction
- Patients may be unlikely to ascribe effects of causes; may not ask for change in medication therapy or discontinue medications

Known Diagnostic-Specific Reasons for Avoidable Readmissions

- COPD, pneumonia patients
  - Patients frequently need but don not receive home health care
  - Pneumonia readmissions may reflect need for end of life care.
- Cardiac patients
  - Cardiologists frequently reply on primary care to arrange follow-up visits

Readmissions are more frequent in patients with co-existent behavioral health diagnoses.

Known Diagnostic-Specific Reasons for Avoidable Readmissions

Post-Operative Patients

- Surgeons not arranging for post-surgical primary care
- Inadequate teaching for the patient in caring for themselves post-discharge
  - Incision care
  - Expectations for pain management
  - Resuming activities of daily living
  - Post-CABG patients seeking readmission for angina

Dialysis

- This patient population is highly vulnerable to changes in medication therapy during hospital stay which impacts them post-discharge.

Congressional Action in Healthcare Reform to Address Avoidable Readmissions

- Public reporting of hospital readmission rates
- Penalties against hospitals with readmissions above expected rates for targeted conditions were started on Oct. 1, 2013
  - Sole community hospitals, Medicare-dependent small rural hospitals and low-volume conditions are exempt.

Key Message:

Hospitals Need Support in Reducing Avoidable Readmissions

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Study of Evidence of Effective Care Coordination

- Most evidence demonstrates impact of care coordination is unreliable.
- Study found three types of effective intervention
  - Transitional care interventions (Naylor, 2004)
  - Patient self-management educational interventions (Lorig, 1999; Wheeler, 2003)
  - Interventions to coordinate care (Selected sites from Medicare Coordinated Care Demonstration)

Effective Transitional Care Interventions Identified by Mathematica Study

- Summary of Findings
  - Patients in intervention group had 34% fewer readmissions per patient over one year period
    - Specific focus on patients with CHF
    - Assigned APNs to follow patient
    - One year post-discharge follow-up of patient
  - Forty-five percent of intervention patients readmitted vs 55% of control group
  - Thirty-nine percent lower average total cost of care ($7,636 vs $12,481)

-- (Reported by Naylor, 2004)

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Specific Interventions From Mathematica Study

- Explicit delineation of care team roles, responsibilities
- Discharge process initiated upon admission
- Patient education throughout hospitalization
- Timely and accurate information flow
  - From PCP→Hospital Team→Back to PCP
- Complete patient discharge summary prior to discharge
- Comprehensive written discharge plan given to patient prior to discharge
- Discharge information in patient's language and literacy
- Reinforcement of plan with patient after discharge
- **Availability of case management staff outside of limited daytime hours**
- Continuous quality improvement of discharge process

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Special Considerations for After Hours Availability of Coordination and Support for Patients

- Case managers with on-site availability to assist with care coordination (special emphasis on ED)
- Develop strong collaborative relationships with community resources for after-hours coordination of care

Known Mutually Reinforcing Factors to Prevent Readmission

- Medication reconciliation
- Reconcile discharge plans with national guidelines
- Follow-up appointments scheduled and kept
- Follow-up on outstanding diagnostic tests
- **Post-Discharge Services**
  - Written discharge plans
  - What to do if problem arises
  - Patient education
  - Assess patient understanding
  - Discharge summary sent to PCP
  - Telephone follow-up and reinforcement

Areas to Consider for Post-Discharge Follow-up

- On-going evaluation of social, medical, financial and physical status
- Connect resources needed to comply, understand, and follow through plan of care
- Evaluate need for support at 90 days post-discharge
- Collect data on patient outcomes

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