AHC Media

January 25, 2016

Discharge Solutions to Prevent Hospital Readmissions

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Speaker

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Objectives

- Explain the importance of using ‘teach back’ to confirm the patient’s understanding of the discharge instructions.
- Discuss the importance of sending the discharge summary to the PCP before the first post-hospital visit.
- Discuss issues that impact healthcare protocols and practices.

Discharges
What's New and the IMPACT Act

IMPACT Act

- The IMPACT Act is a federal law that has been passed which will affect all hospitals including CAHs
- A patient is scheduled for a total hip and asks which of the following post-care setting has the best outcomes and how much does it cost?
  - Discharge home with home health care, inpatient rehab, LTC hospital or the SNF advertised as a rehab center
- What do you tell the patient?
- Lack of comparable information across the different settings made it difficult for policymakers and providers to figure out the most appropriate setting

IMPACT Act

Copy of law free at
www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf

Public Law 113–185
113th Congress

An Act

Oct. 6, 2014
[H.R. 4994]

To amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Improving Medicare Post-Acute Care Transformation Act of 2014.
42 USC 1305 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Medicare Post-Acute Care Transformation Act of 2014" or the "IMPACT Act of 2014".

SEC. 2. STANDARDIZATION OF POST-ACUTE CARE DATA.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

42 USC 1395lll.

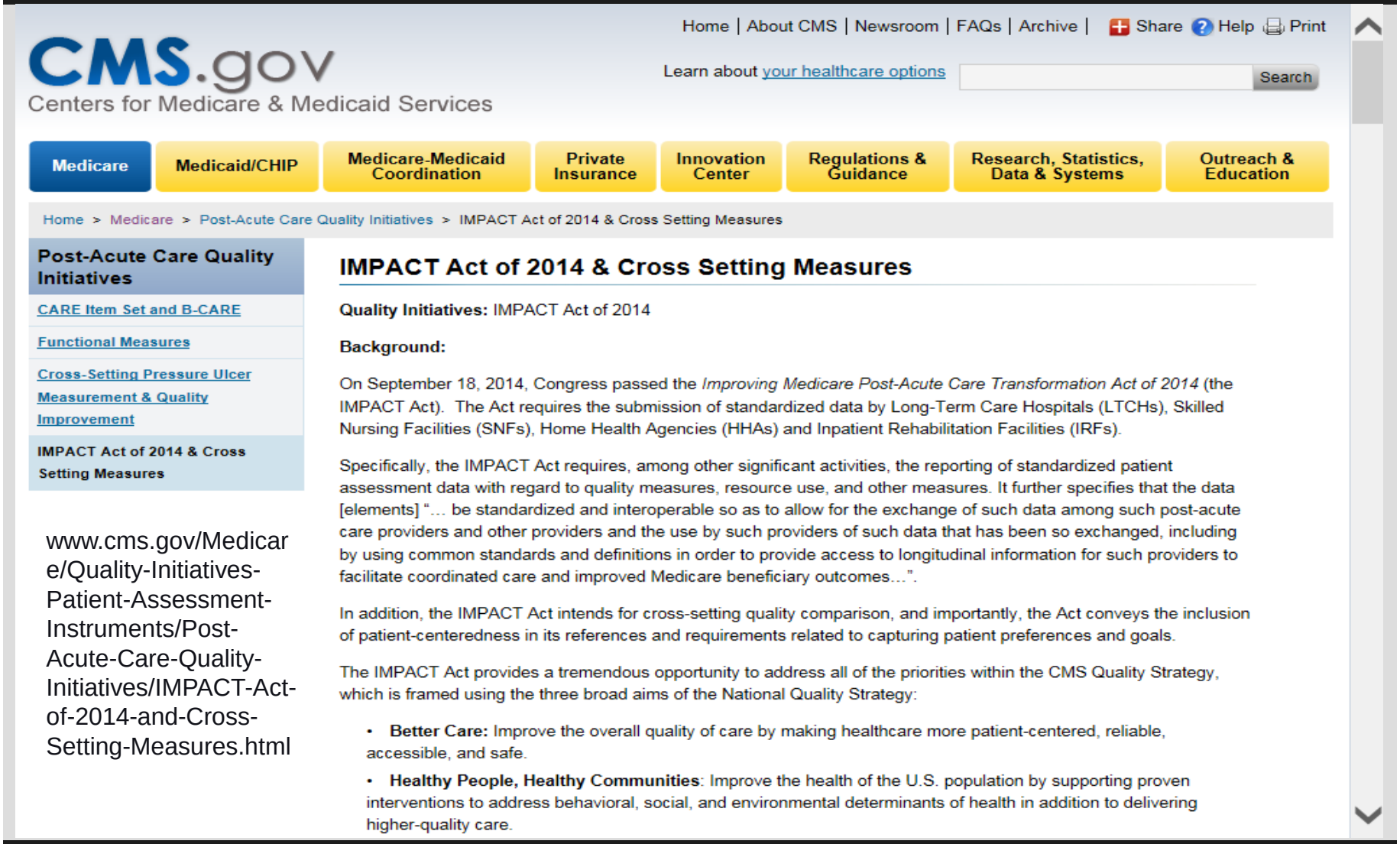
"SEC. 1899B. STANDARDIZED POST-ACUTE CARE (PAC) ASSESSMENT DATA FOR QUALITY, PAYMENT, AND DISCHARGE PLANNING.

"(a) REQUIREMENT FOR STANDARDIZED ASSESSMENT DATA.—
"(1) IN GENERAL.—The Secretary shall—
"(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—
"(i) standardized patient assessment data in accordance with subsection (b);
"(ii) data on quality measures under subsection

IMPACT Act

- Signed by the President on October 7, 2014
- Stands for “Improving Medicare Post-Acute Care Transformation Act of 2014”
- Wants to standardize the information collected between the four post-acute care providers (PACs)
- Want to improve quality of care across the provider settings and reduce readmissions
- Wanted to improve hospital and discharge planning
- CMS has a website on the IMPACT Act

CMS Website on IMPACT Act



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Home > Medicare > Post-Acute Care Quality Initiatives > IMPACT Act of 2014 & Cross Setting Measures

Post-Acute Care Quality Initiatives

- CARE Item Set and B-CARE
- Functional Measures
- Cross-Setting Pressure Ulcer Measurement & Quality Improvement
- IMPACT Act of 2014 & Cross Setting Measures

IMPACT Act of 2014 & Cross Setting Measures

Quality Initiatives: IMPACT Act of 2014

Background:

On September 18, 2014, Congress passed the *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act). The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).

Specifically, the IMPACT Act requires, among other significant activities, the reporting of standardized patient assessment data with regard to quality measures, resource use, and other measures. It further specifies that the data [elements] "… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…".

In addition, the IMPACT Act intends for cross-setting quality comparison, and importantly, the Act conveys the inclusion of patient-centeredness in its references and requirements related to capturing patient preferences and goals.

The IMPACT Act provides a tremendous opportunity to address all of the priorities within the CMS Quality Strategy, which is framed using the three broad aims of the National Quality Strategy:

- **Better Care:** Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- **Healthy People, Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html

Standardize Patient Assessments

- Each PAC will have to standardizing the following information on **five** things regarding patient assessments:
- Functional status, such as mobility and self care at admission and before discharge
- Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia
- Special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and TPN

Standardize Patient Assessments

- Medical conditions and co-morbidities, such as DM, CHF, and pressure ulcers
- Impairments, such as incontinence and an impaired ability to hear, see, or swallow
- Other categories deemed necessary and appropriate by the Secretary
  - Claims data will be aligned with the standardized patient assessment data
- So hospitals and PACs will need to change their admission assessment forms to collect this data
  - RN does admission assessment no later than 24 after admission

Quality Measures to be Reported

- There are five requirements quality measures that will have to be collected and reported by the PACs
- Functional status, cognitive function, and changes in function and cognitive function
- Skin integrity and changes in skin integrity
- Medication reconciliation
- Incidence of major falls
- Accurately communicating the existence of and providing for the transfer of health information and care preferences from a hospital to another provide

Reporting of Quality Measures

Reporting of Quality Measures. To the extent possible, the Secretary shall require reporting of such new quality measures through the PAC assessment instruments.

Table 1: Timeline for New Quality Domains*				
Quality Domains	**HHAs**	**SNFs**	**IRFs**	**LTCHs**
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018

*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.

Proposed Changes in CMS Discharge Planning in 2016

Discharge Planning Proposed Changes

- October 30, 2015 CMS proposes to revise the hospital discharge planning standards again
  - Published in FR November 3, 2015 http://federalregister.gov/a/2015-27840
- Includes hospitals, CAH, LTC hospitals, inpatient rehab, and home health agencies
- To bring them into closer alignment with current practices and to reduce unnecessary readmissions
- To implement the requirements of the IMPACT Act- Improving Medicare Post-Acute Care Transformation

This document is scheduled to be published in the Federal Register on 11/03/2015 and available online at **http://federalregister.gov/a/2015-27840**, and on **FDsys.gov**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-P]

RIN 0938-AS59

https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27840.pdfand is 125 pages

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

CMS Proposed Discharge Planning

FEDERAL REGISTER

Vol. 80 Tuesday,
No. 212 November 3, 2015

www.gpo.gov/fdsys/pkg/FR-2015-11-03/pdf/2015-27840.pdf

Part IV

Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Parts 482, 484, 485
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule

Proposed Discharge Planning Changes

- Hospitals will be required to use data to assist patients during discharge planning process
  - Must take into consideration patient's goals and patient preferences
- Would need to incorporate many new things into the discharge plan so will need to redo the form
  - Such as admitting diagnosis, relevant co-morbidities, past medical history, past surgical history, anticipated needs, readmission risk, and relevant psychosocial history and more
- Must do discharge plan within 24 hours

CMS Hospital CoPs Proposed Changes

- Applies to inpatients, observation, surgery or other same day surgery patients
- 3 requirements for discharge planning P&P including it must be reviewed by the board
- The discharge process must regularly reevaluate the patient's condition to identify any changes that would require modification of the discharge plan
  - Hospitals may want to have process where discharge planners/social workers do a discharge planning evaluation on all patients and do daily chart review to determine if any changes

DISCHARGE EVALUATION & PLAN
PLAN OF CARE, REVIEWS & SUMMARY

SAMPLE

ADMISSION EVALUATION

Admit Date | Reason for Admission *(Refer to admission, H + P and transfer forms for additional information)*

REHABILITATION POTENTIAL:

- ☐ Resident believes self capable of increased independence in at least some ADL's
- ☐ Direct Care staff believes resident capable of increased independence in at least some ADL's
- ☐ Other

DISCHARGE POTENTIAL: ☐ Excellent ☐ Good ☐ Fair ☐ Marginal ☐ Guarded ☐ Poor ☐ None

DISCHARGE anticipated within 90 days of admission?

- ☐ **Yes, Anticipated to:**
- ☐ **No, Reason(s)**
  - ☐ Requires 24 hr supervision
  - ☐ Dependent on others for all ADL's
  - ☐ Condition expected to deteriorate
  - ☐ Complicated medical care/regimen
  - ☐ Alternate Care setting not possible due to physical disability
  - ☐ Dependent psychologically on placement in facility
  - ☐ Mental Health status
  - ☐ Family refuses to provide care
  - ☐ Family unable to meet needs due to other responsibilities
  - ☐ Financial limitations in meeting care needs
  - ☐ Resident refuses to leave facility
  - ☐ Other:
- ☐ **Uncertain/Unknown due to:**

Resident and/or Resident Representative prefers to be discharged to:

Additional Comments:

Signature | Date

REVIEW OF FACTORS AFFECTING DISCHARGE PLAN

Refer to Comprehensive Evaluation dated: _____ for additional specific details in each area.

ADL FUNCTIONAL ABILITY

- ☐ Ability to meet self-care needs not impaired
- ☐ Unable to meet self-care needs
- ☐ Ability to meet any self-care needs impaired in the following areas:
  - ☐ Bed Mobility
  - ☐ Transfer
  - ☐ Locomotion
  - ☐ Dressing
  - ☐ Eating
  - ☐ Toilet Use
  - ☐ Personal Hygiene
  - ☐ Bathing

Comment:

Signature/Date

COGNITIVE AND MENTAL FUNCTION

- ☐ Not impaired
- ☐ Impaired in the marked areas:
  - ☐ Comprehension
  - ☐ Memory: ☐ Short-term ☐ Long-term
  - ☐ Decision-Making

Comment:

Signature/Date

PSYCHOSOCIAL FUNCTION

- ☐ Not impaired
- ☐ Impaired in the marked areas:
  - ☐ Interaction/involvement with others
  - ☐ Relationships with others
  - ☐ Identification with past roles
  - ☐ Mood
  - ☐ Problem behaviors
  - ☐ Activities pursuit

Comment:

Signature/Date

SPECIAL CARE NEEDS

- ☐ No special care needs anticipated at time of discharge
- ☐ Special care needs anticipated in the marked areas:

SUPPORT SERVICE REQUIREMENTS

- ☐ No support service needs anticipated post-discharge.
- ☐ Referrals needed in the marked areas:
  - ☐ Private physician
  - ☐ Personal (family/friends) support system
  - ☐ Home Health Care Agency: _____
  - ☐ Community Health Care Agency: _____
  - ☐ Meal Delivery: _____
  - ☐ Financial Assistance: _____
  - ☐ Hospice
  - ☐ Council on Aging
  - ☐ State Agency: _____
  - ☐ Other: _____

Comment:

Signature/Date

RESIDENT/CAREGIVER EDUCATION /INSTRUCTION NEEDS PRIOR TO DISCHARGE

- ☐ No special instruction anticipated
- ☐ Education needs in the marked areas:

	DATE GIVEN	SIGNATURE
☐ Diabetic skin care		
☐ Gait training		
☐ Prosthetic device & use		
☐ Medication compliance		
☐ Injection technique		
☐ Diet/nutritional needs		
☐ Tube feeding		
☐ Catheter care		
☐ Ostomy care		
☐ Trach care		
☐ Wound care		
☐ Bathing		
☐ Range of motion exercises		
☐ Muscle-strengthening care		
☐ Respiratory care/therapy		
☐ Infection control measures		
☐ Other:		

Form MP9428 Rev 04/09
Popular Form: MED-PASS 800-426-6684
©PASS, INC.

CMS Hospital CoPs Proposed Changes

- 5 things must be in the discharge summary including medication reconciliation and the side effects of each drug must be disclosed
  - Must include follow-up care, pending tests, planned additional testing, and contact information of provider
- Discharge instructions and discharge summary must be given to provider within **48 hours**
- Pending test results must be sent to the provider within 24 hour of their availability

CMS Hospital CoPs on Discharge Planning

The Conditions of Participation (CoPs)

- CMS has regulations since1986 which are called the CoPs
  - Tag numbers are section numbers and go from 0001 to 1164 and discharge planning starts at tag 799
  - Questions email to **hospitalscg@cms.hhs.gov**
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** [2]
  - Hospitals should check the CMS Survey and Certification website once a month for changes

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

CMS Hospital CoP Manuals new address

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

CoP Manual Also Called SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 149, 10-09-15)

Transmittals for Appendix A

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_Appendixtoc.pdf

Survey Protocol

Introduction

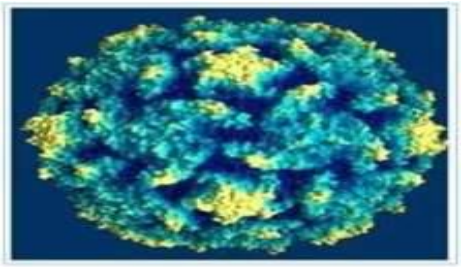
- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module

Psychiatric Unit Survey Module

Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module



CMS Survey and Certification Website

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

CMS Survey Memos

Title	Memo #	Posting Date	Fiscal Year
Revised Hospital Guidance for Pharmaceutical Services and Expanded Guidance Related to Compounding of Medications	16-01-Hospital	2015-10-30	2016
Advanced Notification: Revisions to State Operations Manual (SOM), Appendix C – Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services	16-02- CLIA	2015-11-06	2016
Impact of Nursing Shortage on Hospice Care	15-01-Hospice	2014-10-03	2015
Information for Hospitals and Critical Access Hospitals (CAHs) Concerning Possible Ebola Virus Disease	15-02-Hospitals/CAHs	2014-10-10	2015
Implementing the New Moratorium on Establishment of New Long-Term Care Hospitals (LTCH) or New LTCH Satellites, or Increases in LTCH Beds	15-03 Hospitals	2014-10-10	2015
National Background Check Program (NBCP) Grant Award Updates	15-04-ALL	2014-10-24	2015
Tests Subject to Clinical Laboratory Improvement Amendments (CLIA) Edits Downloadable File on the CLIA Internet Page - Informational Only	15-05-CLIA	2014-10-24	2015
Nationwide Expansion of Minimum Data Set (MDS) Focused Survey Background	15-06-NH	2014-10-31	2015
Effect on Microbiology Laboratories Due to the Removal of References to the Clinical Laboratory Standards Institute (CLSI) and to CLSI Documents	15-07-CLIA	2014-10-31	2015
Information for Clinical Laboratories Concerning Possible Ebola Virus Disease	15-08-CLIA	2014-11-07	2015

Discharge Planning Memo

- CMS issues 39 page memo on May 17, 2013 and final transmittal July 19, 2013 and in current manual
- Revises discharge planning standards
- Includes advisory practices to promote better patient outcomes
  - Only suggestions and will not cite hospitals
  - Call **blue boxes**
- The discharge planning CoPs have been reorganized
- A number of tags were eliminated
  - The prior 24 standards have been consolidated into 13

Discharge Planning

- Must have a discharge planning (DP) process that applies to all patients
- Rewritten to reflect recent literature in care transitions
- Must ensure DP P&Ps are implemented consistently
- Involve patient in the plan of care
- Must identify at early stage all patients who are likely to suffer adverse event if no DP is done
- Includes what should be in DP assessment

Nurses Admission Assessment

Part I: Admission Routine

Date: **Time:** | **T:** **P:** **R:** **$O_{2\ Sat:}$**

Mode: ☐ amb ☐ gurney ☐ w/c ☐ other | **B/P:** Rt Lt:

Via: ☐ admitting ☐ ER ☐ OR ☐ other | **Height:** **Weight:** ☐ Stand ☐ Bed ☐ Stated

Admitting MD: **Family MD:**

Admitting Diagnosis:

Chief Complaint: (per patient)

Allergies: **Latex:** ☐ balloons ☐ bananas

☐ NKDA ☐ gloves ☐ pineapple

Type of Reaction: ☐ mult OR ☐ avocados

LATEX 4 or > - order latex free cart ☐

Valuables List: (describe jewelry, clothing, etc.)

VALUABLE envelope to Safe ☐

☐ Glasses ☐ Contact lenses ☐ Dentures ☐ Partial/bridge ☐ Hearing aid ☐ Refused safe

Nurse Signature (if other than nurse completing remainder of assessment):

Part II: Patient History

Patient History: (major illnesses/operations/major injuries)

☐ Hypertension ☐ COPD ☐ Diabetes ☐ Cancer ☐ Anesthesia issues

☐ Heart Disease ☐ Asthma ☐ Hepatitis ☐ Seizures ☐ None

☐ Stroke ☐ TB ☐ Ulcer ☐ Mental Disorder

☐ Cardiac other ☐ Respiratory other ☐ Kidney Disease ☐ General other

To OR & anesthesia issue HX; call MD ☐

Specify others not listed above and Surgeries:

SMOKING & yes to MI, Pneu, CHF: give Ed. ☐

Alcohol/Drug Use: ☐ Yes ☐ No Type: Daily Amt: ☐ Quit

Tobacco Use: ☐ Yes ☐ No Type: Daily Amt: ☐ Quit

FLU/PNEU If no, do Screen form ☐

Admitting Diagnosis: AMI, Pneumonia, CHF: ☐ Yes ☐ No

Vaccinations:

Flu Shot within past 12 months ☐ Yes ☐ No ☐ Refused

Pneumonia Shot in past 5 years ☐ Yes ☐ No ☐ Refused

CM Flu/Pneu Referral ☐

Family History:

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Asthma ☐ TB ☐ Diabetes ☐ Kidney ☐ Anesthesia

Pneumonia Shot in past 5 years ☐ Yes ☐ No ☐ Refused

Family History:

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Asthma ☐ TB ☐ Diabetes ☐ Kidney ☐ Anesthesia

☐ Cancer ☐ Seizures ☐ Blood Disorder ☐ Mental Disorder ☐ None ☐ Other:

Psychosocial/Economic/Discharge:

Marital Status: ☐ Married ☐ Single ☐ Widowed

Family: ☐ Lives With ☐ Lives Alone

Lives In: ☐ Home ☐ Nursing Home ☐ Other

Occupation: ☐ Full Time ☐ Part Time ☐ Retired ☐ Other

Requests Visit from Business Office Rep or HELP Program ☐ Yes ☐ No

Activity Level: ☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bedrest

Suspected Abuse/Neglect: ☐ Yes ☐ No

Emotional Status: ☐ Cooperative ☐ Anxious ☐ Depressed ☐ End of Life

Concerns with Hospitalization: ☐ Child Care ☐ Home Life ☐ Religious/Cultural Practices

Emergency Contact: POA: ☐ yes ☐ no Relation: Phone:

Nearest Relative: Relation: Phone:

Info. Obtained from: ☐ Patient ☐ Family ☐ Other

FINANCE Referral ☐

SS or CM Referral ☐

ANXIETY ☐ poc#1

GRIEF ☐ poc #2

KNOW DEF poc #3 ☐

SPIRITUAL poc #4 ☐

Patient Label

Functional Assessment

					SKIN ISSUES: Wd Care Referral ☐	MS: POC ☐

NORTON SCALE

Norton Scale (Skin Risk Assessment)

Reprinted with permission. Doreen Norton, Rhoda McLaren, and A.N. Exton-Smith, *An Investigation of Geriatric Nursing Problems in Hospitals*, National Corporation for the Care of Old People (now Centre for Policy on Ageing), London, 1962.

Physical Condition	1. Very bad	2. Poor	3. Fair	4. Good	
Mental Condition	1. Stupor	2. Confused	3. Apathetic	4. Alert	
Activity	1. Bed	2. Chair Bound	3. Walk Help	4. Ambulant	
Mobility	1. Immobile	2. Very Limited	3. Slightly Limited	4. Full	
Incontinence	1. Doubly	2. Usually/Urine	3. Occasional	4. Not	
Notes:	If 14 or less, evaluate appropriateness for Plan of Care.			Total Score	

SKIN: poc#15 ☐

FUNCTION

Functional Trigger Assessment:

		Usual ADL	Admit ADL	Total Score = Usual-Admit
Code:	OT feeds self/dressing/ADLs			
4 = 100% of care	PT gait/transfers			
3 = 75% of care	ST swallow/expression/comprehension			

2 = 50% of care

1 = 25% of care

0 = N/A - (acute time limited condition)

ADL: poc# 16 ☐

FUNCTION: Referral to Phys. Med. if change ☐

FALL RISK

Fall Risk (Risk Assessment)

☐ **Level I** — any patient

☐ **Level II** - *Has two or more of the following risk factors*

- ☐ age >65
- ☐ history of falls (immed or within past 3 mo.)
- ☐ taking fall related medications (hypnotics, analgesics, psychotropics, antihypertensive, diuretic, laxative)
- ☐ mod to severe physical impairment (includes mobility or visual/hearing deficits)
- ☐ occasional or frequent cognitive impairment

FALL RISK II: poc#17 ☐

Page 3 of 4

Patient label

Discharge Planning

- Must do DP at least 48 hours in advance of discharge and must implement the plan
- Must make sure discharge is not delayed due to hospital's failure to do DP
- The hospital must provide a DP evaluation to patients at risk, or as requested by the patient or doctor
- Must have process for making patients or their representative aware they can request a DP evaluation

Discharge Planning

- Discharge evaluation is more detailed in contrast to the screening process
- Hospitals are expected to have knowledge of capabilities of the LTC and Medical homes and services provided
- Will the patient need PT, OT, RT, hospice, home health care, palliative care, nutritional consultation, dietary supplements, equipment, meals, shopping, housekeeping, transport, home modification, follow up appointment with PCP or surgeon, wound care etc.

Discharge Planning

- The hospital must reassess the discharge plan if factors affect the plan
- Must send necessary medical information (like discharge summary) to providers that the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first
- If patient needs HH or LTC must provide patients a list as it is freedom of choice
- Hospital must transfer or refer patients to the appropriate facility or agency for follow up care

CMS Worksheet

Discharge Planning

CMS Hospital Worksheets History

- CMS had three pilot studies on the three worksheets
- These include **discharge planning,** infection control, and QAPI (performance improvement)
- Final ones issued November 26, 2014
- These are important and every hospital should be familiar with these
- Used during validation surveys and certification surveys
- Also may just show up to use the 3 worksheets and usually a two day stay

Discharge Planning Worksheet

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: **November 26, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Public Release of Three Hospital Surveyor Worksheets

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- ***Three Hospital Surveyor Worksheets Finalized*:** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.
- ***Final Worksheets Made Public:*** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

Final Discharge Planning Evaluation Tool

Centers for Medicare & Medicaid Services

Hospital Discharge Planning Worksheet

Name of State Agency: _____

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of observation, interviews with hospital staff, review of the hospital's discharge planning program documentation including policies and procedures, and review of medical records.

The interviews should be performed with the most appropriate hospital staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Section 1 Hospital Characteristics

1. Hospital name: _____

2. CMS Certification Number (CCN): ☐☐☐☐☐☐

3. Date of site visit:

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

Discharge Planning Worksheet P&P

- Is there a discharge planning process for certain categories of outpatients such as **observation, ED** patients and **same day surgery patients**?
  - Could add questions to the nursing admission assessment tool and include in questions asked in pre-admission tests for OP surgery
- Are **discharge P&P** in effect for all inpatients?
  - Is there evidence on every unit that there is discharge planning activities?
  - Are staff following the discharge planning P&P?
    - Tag 800, 806, and 818

Discharge Planning P&P

Section 2 Discharge Planning – Policies and Procedures

Elements to be assessed		Surveyor Notes
2.1 Implementation of discharge planning policies and procedures for inpatients:		
2.1a For every inpatient unit surveyed is there evidence of applicable discharge planning activities?	○ Yes ○ No	
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	○ Yes ○ No	
NOTE: If no for either 2.1a or 2.1b the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to identification of patients needing discharge planning, 42 CFR 482.43(a) (Tag A-0800); discharge planning evaluation, 42 CFR 482.43(b) (Tag A-0806); and/or developing and implementing the discharge plan, 42 CFR 482.43(c) (Tag A-0818)		
2.2 Does the discharge planning process apply to certain categories of outpatients?	○ Yes ○ No	
If yes, check all that apply: ○ Same day surgery patients ○ Observation patients who are not subsequently admitted ○ ED patients who are not subsequently admitted ○ Other		
2.3 Is a discharge plan prepared for each inpatient?	○ Yes, skip to question 2.8 ○ No, go to question 2.4	

Are Staff Aware of Your DP Policy?

DISCHARGE PLANNING

PURPOSE:

To promptly identify patient discharge needs.

To coordinate timely discharge planning during the hospital stay so that patient needs are met and continuity of care is not interrupted by discharge from the acute care setting.

POLICY:

I. Discharge Planning begins on admission and continues throughout the hospital stay as needs are identified and care is planned to meet those identified needs.

II. Following identification of anticipated discharge needs, the nurse and/or physician shall consult the appropriate department for assistance in meeting the patient's needs. In addition, the family and/or significant other shall be notified as soon as possible regarding the discharge needs of the patient as appropriate so that they can be involved in the decision making and ongoing care for the patient.

III. Discharge Planning screening criteria included in the Admission Assessment must be completed **within 8 hours of admission by the RN or RN Applicant** and are utilized to determine if either Case Management or Social Services should be consulted.
(See Nursing Policy A- 12, Admission, Transfer and Discharge Assessments).
http://team.uhsystem.com/uhsprivate/inpatientnursing/A-12.pdf

A. Social Services Consults

Social Services shall be consulted and recommendations incorporated into the Plan of Care when a patient meets any of the following admission screening criteria:

1. Adoption Case
2. Medication assistance
3. Crisis and/or supportive counseling
4. Elderly, adult and child protective service cases

Preventing Unnecessary Readmissions

Hospitals Penalized for Excess Readmissions

- **First** year started October 2012 and Medicare penalized 2,217 hospitals and forfeited $280 million dollars for excess readmission rates at 1% rate
  - 2 million Medicare patients are readmitted within 30 days per year
- **Second** year, starting with October, 2013, hospitals forfeited $217 million dollars and 2% rate
- **In 2015,** fourth year**,** at a 3% rate and there were 2600 hospitals that forfeited 420 million dollars

Bonuses and Penalties for Hospitals

- Medicare has two payment incentive programs for hospitals
  - Medicare cut payments by 1% and this money was set aside for a bonus pool ($850 million) for those that did better than average on a number of measures
- One given bonuses and penalties for how well they perform on 24 quality measures called VBP or value based purchasing
  - The second penalizes hospitals with **excess readmission rates**
- Hospitals could gain up to 1.25% in payment or lose as much as 3.25% for the programs combined

Hospital Readmissions Reduction Program

- Program has reduced the number of hospital readmissions
- 17% of Medicare patients are still readmitted within 30 days
- All but 209 of the hospitals penalized this year were also penalized last year (Kaiser Health News)
- 4th year started October 2015
- Average Medicare reduction is 0.61% per patient stay and 38 hospitals got the max 3% reduction
- Will also punish hospital with higher rates of infection

Hospitals Penalized for Excess Readmissions

Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties

By **Jordan Rau** | August 3, 2015

http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties

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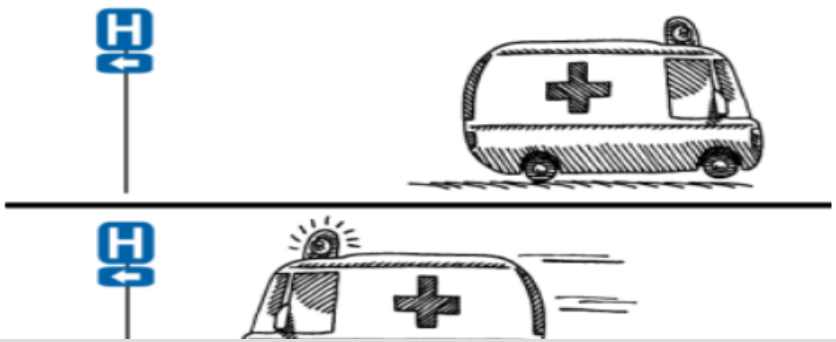
Once again, the majority of the nation's hospitals are being penalized by Medicare for having patients frequently return within a month of discharge — this time losing a combined $420 million, government records show.

In the fourth year of federal readmission penalties, 2,592 hospitals will receive lower payments for every Medicare patient that stays in the hospital — readmitted or not — starting in October. The Hospital Readmissions Reduction Program, created by the Affordable Care Act, was designed to make hospitals pay closer attention to what happens to their patients after they get discharged.

Since the fines began, national readmission rates have dropped, but roughly one of every five Medicare patients sent to the hospital ends up returning within a month.



Readmission Penalties by States KHN

Medicare Readmission Penalties By State, Year 4

Medicare evaluated the readmission rates of the nation's hospitals in determining the fourth year of penalties in the Hospital Readmissions Reduction Program. Medicare will apply the penalties to all its payments for patient stays between Oct. 1, 2015, and Sept. 30, 2016. In this chart, the first column after the state name shows the total number of hospitals penalized in each state. That is followed by the percent of each state's hospitals that were penalized. That calculation includes hospitals exempted from the fines, such as those serving veterans and children. The final column shows the average penalty for penalized hospitals. *The penalties do not apply to Maryland hospitals, as that state has a unique reimbursement arrangement with Medicare, and thus Maryland is not included in this table.

State Name	Number of Penalized Hospitals	Percent of All Hospitals Penalized	Average Hospital Penalty (Percent)
Alabama	72	79	0.61
Alaska	7	33	0.44
Arizona	49	62	0.48
Arkansas	41	53	0.83
California	224	65	0.4
Colorado	25	32	0.29
Connecticut	28	90	0.66
Delaware	5	71	0.35
District of Columbia	7	78	0.77
Florida	154	81	0.67
Georgia	89	67	0.47
Hawaii	10	56	0.33
Idaho	4	10	0.58
Illinois	113	62	0.72

Texas is 203 54 0.53

List of Readmission Penalties by Hospital

http://cdn.kaiserhealthnews.org/attachments/MedicareReadmissionPenaltiesByHospital,Year4.pdf

Medicare Readmission Penalties By Hospital, Year 4

Medicare will apply these readmissions penalties to reimbursements from Oct. 1, 2015, through Sept. 30, 2016, which is the 2016 federal fiscal year (FY2016). This chart shows the penalties for all four years of the program. Maryland hospitals were not penalized because the state has a unique reimbursement arrangement with Medicare. Also exempt are certain cancer hospitals, critical access hospitals as well as hospitals dedicated to psychiatry, rehabilitation, long-term care and veterans. Medicare also excluded hospitals that had too few cases to be fairly evaluated.

Source: Kaiser Health News and the U.S. Centers for Medicare & Medicaid Services

Republication Note: The readmission data in this story and charts is assembled, interpreted and analyzed by KHN using five files from the federal Centers for Medicare & Medicaid Services. KHN's data is free to republish and should be credited to Kaiser Health News or Kaiser Health News and the U.S. Centers for Medicare & Medicaid Services.

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Hospital	Address	City	State	ZIP Code	FY2013 Readmission Penalty	FY2014 Readmission Penalty	FY2015 Readmission Penalty	FY2016 Readmission Penalty
ALASKA NATIVE MEDICAL CENTER	4315 DIPLOMACY DR	ANCHORAGE	AK	99508	0.23%	0.45%	0.49%	0.34%
ALASKA REGIONAL HOSPITAL	2801 DEBARR ROAD	ANCHORAGE	AK	99508	0.00%	0.01%	0.00%	0.57%
BARTLETT REGIONAL HOSPITAL	3260 HOSPITAL DR	JUNEAU	AK	99801	0.00%	0.00%	1.27%	0.45%
CENTRAL PENINSULA GENERAL HOSPITAL	250 HOSPITAL PLACE	SOLDOTNA	AK	99669	0.07%	0.09%	1.41%	1.02%
CORDOVA COMMUNITY MEDICAL CENTER	PO BOX 160 - 602 CHASE AVENUE	CORDOVA	AK	99574	Not Assessed	Not Assessed	Not Assessed	Not Assessed
FAIRBANKS MEMORIAL HOSPITAL	1650 COWLES STREET	FAIRBANKS	AK	99701	0.00%	0.00%	0.07%	0.13%
KANAKANAK HOSPITAL	P O BOX 130	DILLINGHAM	AK	99576	Not Assessed	Not Assessed	Not Assessed	Not Assessed
MAT-SU REGIONAL MEDICAL CENTER	2500 SOUTH WOODWORTH LOOP	PALMER	AK	99645	0.10%	0.01%	0.92%	0.48%
MT EDGECUMBE HOSPITAL	222 TONGASS DR	SITKA	AK	99835	0.00%	0.00%	0.00%	0.00%
NORTON SOUND REGIONAL HOSPITAL	1000 GREG KRUSCHEK AVENUE (P O	NOME	AK	99762	Not Assessed	Not Assessed	Not Assessed	Not Assessed
PEACEHEALTH KETCHIKAN MEDICAL CENTER	3100 TONGASS AVENUE	KETCHIKAN	AK	99901	Not Assessed	Not Assessed	Not Assessed	Not Assessed
PETERSBURG MEDICAL CENTER	PO BOX 589	PETERSBURG	AK	99833	Not Assessed	Not Assessed	Not Assessed	Not Assessed
PROVIDENCE ALASKA MEDICAL CENTER	BOX 196604	ANCHORAGE	AK	99508	0.00%	0.00%	0.00%	0.12%

Hospital	Address	City	State	ZIP Code	Readmission Penalty	Readmission Penalty	Readmission Penalty	Readmission Penalty
BAYLOR MEDICAL CENTER AT TROPHY CLUB	2850 E STATE HIGHWAY 114	TROPHY CLUB	TX	76262	0.00%	0.00%	0.00%	0.00%
BAYLOR MEDICAL CENTER AT UPTOWN	2727 EAST LEMMON AVENUE BUILD	DALLAS	TX	75204	0.00%	0.00%	0.00%	0.00%
BAYLOR ORTHOPEDIC AND SPINE HOSPITAL A	707 HIGHLANDER BLVD	ARLINGTON	TX	76015	0.00%	0.00%	3.00%	3.00%
BAYLOR REGIONAL MEDICAL CENTER AT GRA	1650 W COLLEGE ST	GRAPEVINE	TX	76051	0.31%	0.09%	0.00%	0.00%
BAYLOR REGIONAL MEDICAL CENTER AT PLA	4700 ALLIANCE BOULEVARD	PLANO	TX	75093	0.00%	0.03%	0.77%	0.92%
BAYLOR SCOTT & WHITE EMERGENCY MEDIC	900 EAST WHITESTONE BLVD	CEDAR PARK	TX	78613	Not Assessed	Not Assessed	0.00%	0.00%
BAYLOR SCOTT & WHITE MEDICAL CENTER- V	2400 N INTERSTATE HIGHWAY 35E	WAXAHACHIE	TX	75165	0.00%	0.00%	0.68%	0.66%
BAYLOR SURGICAL HOSPITAL AT FORT WORT	1800 PARK PLACE AVENUE	FORT WORTH	TX	76110	0.00%	0.00%	2.76%	3.00%
BAYLOR SURGICAL HOSPITAL AT LAS COLINA	400 WEST INTERSTATE 635 SUITE 10	IRVING	TX	75063	0.00%	0.00%	0.63%	0.00%
BAYLOR UNIVERSITY MEDICAL CENTER	3500 GASTON AVE	DALLAS	TX	75246	0.00%	0.00%	0.00%	0.00%
BAYSHORE MEDICAL CENTER	4000 SPENCER HWY	PASADENA	TX	77504	0.01%	0.17%	0.28%	0.23%
BAYSIDE COMMUNITY HOSPITAL	200 HOSPITAL DRIVE	ANAHUAC	TX	77514	Not Assessed	Not Assessed	Not Assessed	Not Assessed
BELLVILLE GENERAL HOSPITAL	44 N CUMMINGS	BELLVILLE	TX	77418	0.47%	0.51%	0.71%	0.31%
BIG BEND REGIONAL MEDICAL CENTER	2600 HIGHWAY 118 NORTH	ALPINE	TX	79830	Not Assessed	Not Assessed	Not Assessed	Not Assessed
BOWIE MEMORIAL HOSPITAL	705 EAST GREENWOOD AV	BOWIE	TX	76230	0.64%	0.61%	0.73%	0.76%
BRAZOSPORT REGIONAL HEALTH SYSTEM	100 MEDICAL DRIVE	LAKE JACKSON	TX	77566	0.00%	0.00%	2.14%	1.46%
BROWNFIELD REGIONAL MEDICAL CENTER	705 EAST FELT STREET	BROWNFIELD	TX	79316	0.00%	0.00%	0.00%	0.36%
BROWNWOOD REGIONAL MEDICAL CENTER	1501 BURNET DR	BROWNWOOD	TX	76801	0.00%	0.00%	0.78%	0.07%
BURLESON ST JOSEPH HEALTH CENTER	1101 WOODSON DRIVE	CALDWELL	TX	77836	Not Assessed	Not Assessed	Not Assessed	Not Assessed
CARE REGIONAL MEDICAL CENTER	1711 W WHEELER AVENUE	ARANSAS PASS	TX	78336	0.00%	0.00%	0.00%	0.00%
CEDAR PARK REGIONAL MEDICAL CENTER	1401 MEDICAL PARKWAY	CEDAR PARK	TX	78613	0.79%	0.52%	0.97%	1.33%
CENTENNIAL MEDICAL CENTER	12505 LEBANON ROAD	FRISCO	TX	75035	0.32%	0.14%	0.42%	0.68%
CENTRAL TEXAS MEDICAL CENTER	1301 WONDER WORLD DRIVE	SAN MARCOS	TX	78666	0.00%	0.00%	0.14%	0.14%
CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF M	6720 BERTNER	HOUSTON	TX	77030	0.00%	0.00%	0.00%	0.08%
CHILDRESS REGIONAL MEDICAL CENTER	HWY 83 NORTH	CHILDRESS	TX	79201	0.32%	0.27%	0.09%	0.00%
CHILLICOTHE HOSPITAL DISTRICT	303 AVENUE I	CHILLICOTHE	TX	79225	Not Assessed	Not Assessed	Not Assessed	Not Assessed
CHRISTUS HOSPITAL	2830 CALDER AVENUE	BEAUMONT	TX	77702	0.07%	0.26%	0.31%	0.19%
CHRISTUS JASPER MEMORIAL HOSPITAL	1275 MARVIN HANCOCK DRIVE	JASPER	TX	75951	0.00%	0.00%	0.00%	0.25%
CHRISTUS SANTA ROSA HOSPITAL	333 NORTH SANTA ROSA STEET	SAN ANTONIO	TX	78207	0.00%	0.00%	0.00%	0.00%
CHRISTUS SPOHN HOSPITAL ALICE	2500 E MAIN STREET	ALICE	TX	78332	0.55%	0.00%	0.00%	0.00%
CHRISTUS SPOHN HOSPITAL BEEVILLE	1500 E HOUSTON HWY	BEEVILLE	TX	78102	0.00%	0.01%	0.53%	0.33%

2016 Not Much Different Than 2015

Readmissions Penalty Comparison, FY 2015 to FY 2016

	FY 2015	FY 2016	Change last year to this year
No penalty	21.6%	21.6%	0.0%
-0.0001% to -0.49%	42.6%	44.0%	1.3%
-0.50% to -0.99%	19.6%	18.9%	-0.7%
-1.0% to -1.49%	8.9%	8.4%	-0.4%
-1.50% to -1.99%	3.8%	3.2%	-0.5%
-2.0% to -2.49%	1.5%	1.5%	0.0%
-2.50% to -2.99%	1.3%	1.5%	0.2%
-3.0%	0.7%	0.8%	0.1%

www.advisory.com/research/financial-leadership-council/at-the-margins/2015/09/cms-final-readmissions-penalties

AHA Recommends Socioeconomic

FACTSHEET

Hospital Readmissions Reduction Program

THE ISSUE

The Affordable Care Act (ACA) required the Centers for Medicare & Medicaid Services (CMS) to penalize hospitals for "excess" readmissions when compared to "expected" levels of readmissions, beginning on Oct. 1, 2012.

In fiscal year (FY) 2013, payment penalties were based on hospital readmissions rates within 30 days for heart attack, heart failure and pneumonia. In 2015, CMS will add readmissions for patients undergoing hip or knee replacement, and in 2016, readmissions for patients with chronic obstructive pulmonary disease. CMS is likely to add other measures in the future.

AHA POSITION

America's hospitals are focused on reducing unnecessary readmissions. However, the Hospital Readmissions Reduction Program (HRRP) is deeply flawed and must be reformed to adequately account for socioeconomic factors of communities and appropriately exclude unrelated readmissions that are not related to the initial admission. AHA supports the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2014 (H.R. 4188), which would adjust the HRRP to account for certain socioeconomic and health factors that can increase the risk of a patient's readmission, such as being dually eligible under Medicaid and Medicare.

WHY?

www.aha.org/content/13/fs-readmissions.pdf

- **The formula fails to account for sociodemographic factors, depriving the neediest hospitals and their patients of critical resources.** A body of research demonstrates that readmissions are higher in communities that are economically disadvantaged. Koenig and colleagues demonstrated this relationship in Health Services Research in 2013, as shown in the chart below. Hospitals with the highest proportion of dually eligible patients constitute the

Are Safety Net Hospitals Penalized?

- Looking at readmissions for MI, CHF, pneumonia
  - Added hip or knee replacement (TKA, THA) and COPD
  - 2017 will add CABG Readmission
  - Update in 2016 IPPS to include pneumonia to include aspiration pneumonia and sepsis but not severe sepsis
- Hospitals lobbying Medicare and Congress to take into account socio-economic backgrounds of patients
  - National Quality Forum is evaluating if this should be considered in calculating readmissions
  - CMS says some safety net hospitals have been able to keep their admission rates low

Patient Mix Penalized Safety Net Hospitals

- JAMA publishes article Sept 2015 that says that the only risk adjusted characteristics approved by Medicare penalizes safety net hospitals
  - These are age, sex, and diagnosis
- States there are other ones that direct impact readmission rates that should be considered
  - Race, educational level, poverty, disability and other socio-economic factors
- Current round penalizes 2,600 hospitals of $420 million dollars

Patient Mix Penalizes Safety Net Hospitals

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John Commins, for HealthLeaders Media , September 29, 2015

HealthLeaders Media
Efficient Purchasing and Performance
Sponsored by: TRUVEN HEALTH ANALYTICS

Relying only on risk-adjustment characteristics approved by Medicare—age, sex, and diagnosis—puts safety net hospitals in line for significant financial penalties for higher readmissions rates, researchers say.

More research is suggesting that a hospital's patient mix has a direct bearing on readmissions rates.

The latest evidence comes from Harvard researchers, who published a study this month in *JAMA Internal Medicine* that factors race, education level, poverty, disability and other socio-economic factors when measuring hospital readmissions.

Study lead author Michael L. Barnett, MD, a fellow in general internal medicine and primary care at Harvard Medical School and Brigham and Women's Hospital, says that relying only on risk-adjustment characteristics approved by Medicare—age, sex, and diagnosis—puts safety net hospitals in line for significant financial penalties for higher readmissions rates.

Barnett recently spoke with *HealthLeaders Media* about his study findings and offered some recommendations that could level the playing field for hospitals with more challenging patient demographics. The following is an edited transcript.

Michael L. Barnett, MD

HLM: What prompted you to do this study?

Barnett: The hospital readmissions reduction program is very much top of mind for hospitals across the country. The third round of penalties was just announced and almost 2,600 hospitals face penalties of $420 million for excess readmissions and 90% of those hospitals were penalized last year.

It appears that hospitals that serve disproportionate numbers of safety net patients get higher penalties and are disproportionately penalized more severely than other hospitals. There has been an active debate to what extent should the readmissions reduction program, which does not take into account any factors other than age

GAO Finds Hospital Care Unaffected 2015

- GAO finds that Medicare's quality incentive program for hospitals
- Which provides bonuses and penalties based on performance (VBP program)
- Has **not** led to demonstrated improvements in its first three years
- In 2015, Medicare gave benefits to 1,700 hospitals and reduced payments to 1,360 hospitals based on their mortality rates, patient reviews, degree of improvement and other measurements

HOSPITAL VALUE-BASED PURCHASING:

Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality-of-Care Trends

GAO-16-9: Published: Oct 1, 2015. Publicly Released: Oct 1, 2015.

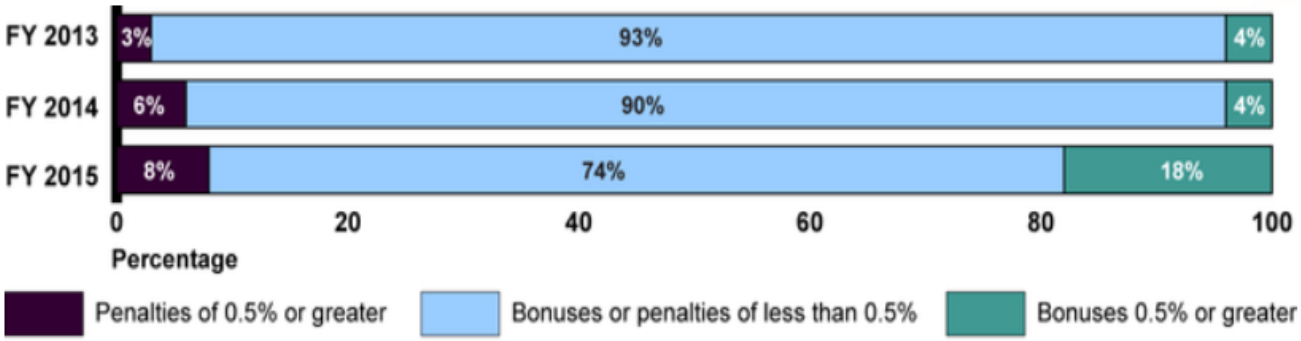
HIGHLIGHTS | VIEW REPORT (PDF, 49 PAGES)

Share Thi

What GAO Found

The bonuses and penalties received by most of the approximately 3,000 hospitals eligible for the Hospital Value-based Purchasing (HVBP) program amounted to less than 0.5 percent of applicable Medicare payments each year. GAO found that safety net hospitals, which provide a significant amount of care to the poor, consistently had lower median payment adjustments—that is, smaller bonuses or larger penalties—than hospitals overall in the program's first three years. However, this gap narrowed over time. In contrast, small urban hospitals had higher median payment adjustments each year than hospitals overall, and small rural hospitals' median payment adjustments were similar to hospitals overall in the first two years and higher in the most recent year.

Figure: Distribution of Hospital Value-based Purchasing Bonuses and Penalties Greater Than or Less Than 0.5 Percent, Fiscal Years 2013 through 2015



Source: GAO analysis of CMS data. | GAO-16-9

Additional Materials:

- Highlights Page: (PDF, 1 page)
- Full Report: (PDF, 49 pages)
- Accessible Version: (PDF, 56 pages)

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GAO Report Oct 30, 2015

United States Government Accountability Office

Report to Congressional Committees

October 2015

www.gao.gov/assets/680/672899.pdf

HOSPITAL VALUE-BASED PURCHASING

Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality-of-Care Trends

GAO Study

- Most hospitals saw their Medicare payments increase or drop by less than half a percentage point
- 74 % of hospitals fell within that range, with a median bonus of $39,000 and a median penalty of $56,000
- Safety-net hospitals, which serve more poor patients, tended to do worse than hospitals overall

10 Top Medicaid Readmission Criteria AHRQ

- 1. Septicemia (except in labor) — $319 million (17,600 total readmissions)
- 2. Schizophrenia and other psychotic disorders — $302 million (35,800 total readmissions)
- 3. Mood disorders — $286 million (41,600 total readmissions)
- 4. Congestive heart failure (non-hypertensive) — $273 million (18,800 total readmissions)
- 5. Diabetes mellitus with complications — $251 million (23,700 total readmissions)

10 Top Medicaid Readmission Criteria AHRQ

- 6. Chronic obstructive pulmonary disease and bronchiectasis — $178 million (16,400 total readmissions)
- 7. Alcohol-related disorders — $141 million (20,500 total readmissions)
- 8. Other complications of pregnancy — $122 million (21,500 total readmissions)
- 9. Substance-related disorders — $103 million (15,200 total readmissions)
- 10. Early or threatened labor — $86 million (19,000)

Readmission Reduction Program

- CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios
  - See CMS website on readmission reduction program
  - Also higher rates of readmission for all causes increases the chance of being selected when the third pilot of CMS worksheets was done
  - CMS website has the formulas to calculate the readmission adjustment factor and to compute the payment adjustment amount

Formula to Calculate Readmission Adj Factor

Formulas to Calculate the Readmission Adjustment Factor

Excess readmission ratio = risk-adjusted predicted readmissions/risk-adjusted expected readmissions

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (excess readmission ratio for AMI-1)] + [sum of base operating DRG payments for HF x (excess readmission ratio for HF-1)] + [sum of base operating DRG payments for PN x (excess readmission ratio for PN-1)]

*Note, if a hospital's excess readmission ratio for a condition is less than/equal to 1, then there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges

Ratio = 1 - (Aggregate payments for excess readmissions/ Aggregate payments for all discharges)

Readmissions Adjustment Factor =

- For FY 2013, the higher of the Ratio or 0.99 (1% reduction);
- For FY 2014, the higher of the Ratio or 0.98 (2% reduction).

Formula to Compute Payment Adjustment

Formulas to Compute the Readmission Payment Adjustment Amount

Wage-adjusted DRG operating amount* = DRG weight x [(labor share x wage index) + (non-labor share x cola, if applicable)]

*Note, If the case is subject to the transfer policy, then this amount includes an applicable payment adjustment for transfers under § 412.4(f).

Base Operating DRG Payment Amount = Wage-adjusted DRG operating amount + new technology payment, if applicable.

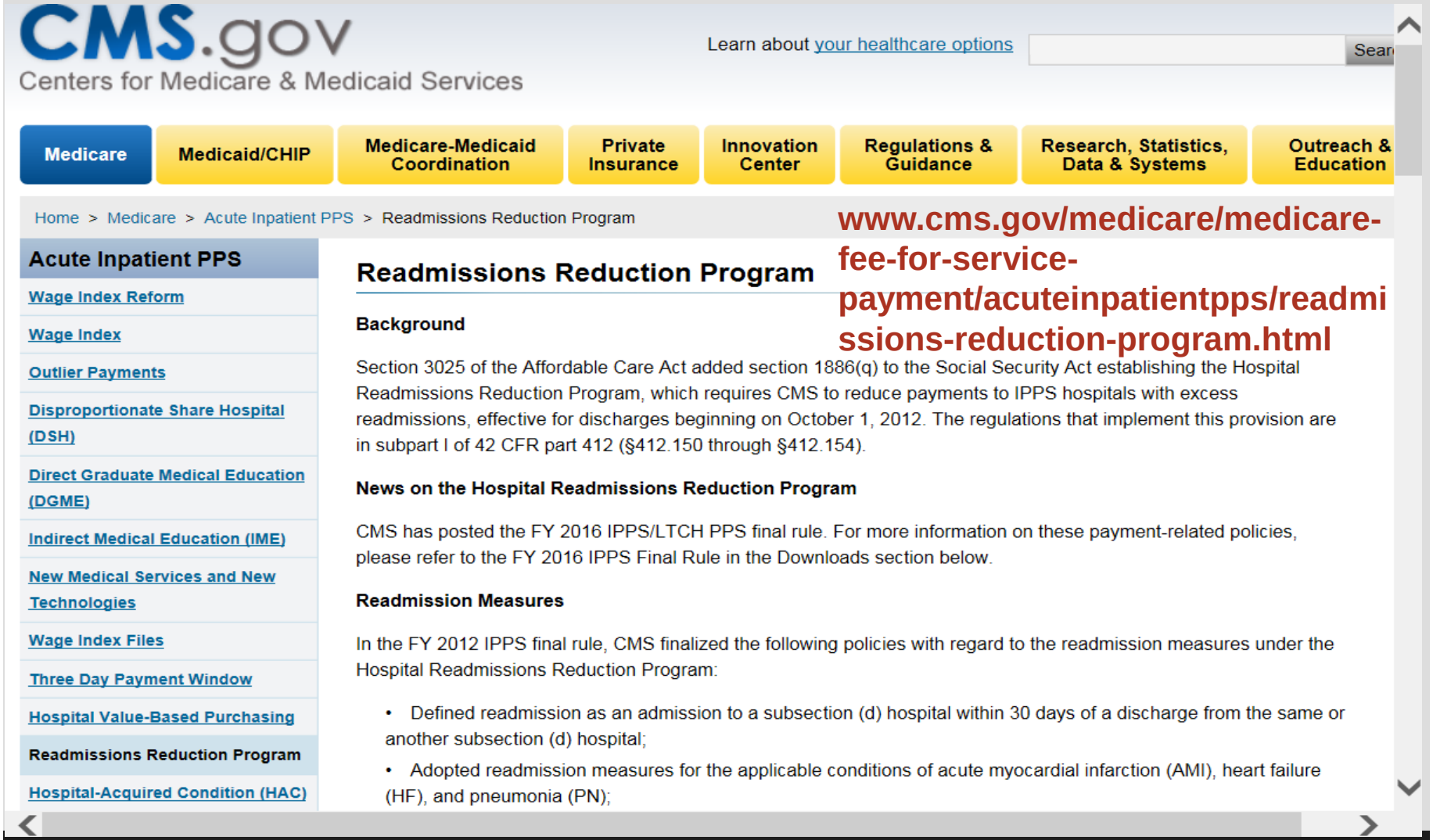
Readmissions Payment Adjustment Amount = [Base operating DRG payment amount x readmissions adjustment factor] - base operating DRG payment amount.

*The readmissions adjustment factor is always less than 1.0000, therefore, the readmissions payment adjustment amount will always be a negative amount (i.e., a payment reduction).

CMS Website Hospital Readmissions

- Lists the following:
  - Name of hospital
  - Provider number and state
  - Measure (readmission PN, AMI, HF etc.)
  - Number of discharges
  - Excess readmission rate
  - Predicted readmission rate
  - Expected readmission rate
  - Number of readmissions with start and end date of data
  - Used 3 years of discharge data and at least 25 cases

CMS Readmission Reduction Website



CMS Readmissions Reduction Program

- CMS Readmission program started FY 2012 (starting Oct 2012) IPPS rules defined readmission as admission within 30 days
- Started with measures for **MI, pneumonia** and **heart failure** first
- Established methodology to calculate excess readmission rate compared to national average
- Risk adjusted as endorsed by National Quality Forum which included patient demographic characteristics, comorbidities, and patient frailty
  - Used 3 years of discharge data and at least 25 cases

Patient Protection and Affordable Care Act

- The Patient Protection and Affordable Care Act or PPACA (also abbreviated ACA) was the law that set up the financial penalties for hospitals with excessive readmissions
- The law establishes a VBP program, or value-bases purchasing, to pay hospitals for their actual performance
- Included initiatives to prevent hospital readmission through a comprehensive program for hospital discharge planning

CMS Website Hospital Readmissions

Medicare.gov | Hospital Compare
The Official U.S. Government Site for Medicare

www.medicare.gov/hospitalcompare/readmission-reduction-program.html

Hospital Readmissions Reduction Program

In October 2012, CMS began reducing Medicare payments for Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions. Excess readmissions are measured by a ratio, by dividing a hospital's number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia, hip/knee replacement, and COPD by the number that would be "expected," based on an average hospital with similar patients. A ratio greater than 1 indicates excess readmissions.

More information on how payments are adjusted.

More on the calculations.

Hospital Readmissions Reduction Program data

Data.Medicare.gov MENU

Hospital Readmissions Reduction Program

	Hospital Name	Provider Number	State	Measure Name	Nu
1	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-AMI-HRRP	7
2	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-COPD-HRRP	6
3	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-HF-HRRP	9
4	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-HIP-KNEE-HRRP	3
5	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-PN-HRRP	4
6	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-AMI-HRRP	1
7	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-COPD-HRRP	6

Readmission Resource

- One of the richest resources is the Partnership for Patients
- States have had a 20% reduction in hospital readmissions since 2010
- There are 46 organizations participating in the community based care transitions program
- Under resources is section on readmissions and care transitions
- Resources on Project RED, Care Transitions, BOOST, Transitions in Care, IHI, INTERACT, STARR, H2H, GRACE, and more including toolkits

Readmission Resources Partnership 4 Patients

CENTERS FOR MEDICARE & MEDICAID SERVICES
PARTNERSHIP FOR PATIENTS

- About the Partnership
- Where Partnerships are in action
- Get involved
- Resources
- Contact us

Resources

Readmissions and Care Transitions

http://partnershipforpatients.cms.gov

The information contained in these resources does not necessarily reflect the views of the Partnership for Patients, the Centers for Medicare and Medicaid Services, The United States Department of Health and Human Services, nor the United States government.

Title	Description
"Project RED (Re-Engineered Discharge)" (Boston University)	Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces rehospitalization rates. The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components, and has been proven to reduce rehospitalizations and increase patient satisfaction.
"Care Transitions Program®" (University of Colorado)	During a four-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home.
"Project BOOST" (Society of Hospital Medicine)	"Better Outcomes for Older Adults through Safe Transitions," a national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to

"TCM Overview" (Transitional Care Model)	The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The heart of the model is the Transitional Care Nurse (TCN), who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. While TCM is nurse-led, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists and other members of the health care team in the implementation of tested protocols with a unique focus on increasing patients' and caregivers' ability to manage their care.
"Medicare Demonstrations: Details for Community-Based Care Transition Program" (U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services)	The Community-Based Care Transitions Program (CCTP) goals are: to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. The demonstration will be conducted under the authority of Section 3026 of the Affordable Care Act of 2010.
Care Transitions in Action: From Hospital to Home in Two Communities (U.S. Department of Health & Human Services, Administration on Aging)	Social worker-based hospital to home care transitions program.
"An Early Look at a Four-State Initiative to Reduce Avoidable Hospital Readmissions" (Institute for Healthcare Improvement [IHI])	State Action on Avoidable Rehospitalizations (STAAR) aims to reduce rates of avoidable rehospitalization in Massachusetts, Michigan, Ohio, and Washington by mobilizing state-level leadership to improve care transitions. It includes enhanced assessment of post-discharge needs, enhanced teaching and learning, enhanced communication at discharge, and timely post-acute follow-up.
"Health Care Leader Action Guide to Reduce Avoidable Readmissions" (Health Research & Educational Trust) [PDF, 664KB]	This resource guide is designed to serve as a starting point for hospital leaders to assess, prioritize, implement, and monitor strategies to reduce avoidable readmissions.

Readmission Update eNewsletter

- This is an excellent resources and is free
- Published monthly
- Includes usually about 10 or 12 evidenced based studies
- Excellent for hospitals to use that have a readmission committee
- To sign up go to www.healthcareenewsletters.com/subscribe.html

Free Readmission Newsletter

READMISSIONS UPDATE eNEWSLETTER

Covering the Latest Developments in Medicare Readmissions Policy, Pilots, and Practice

VOLUME 6 - ISSUE 82
OCTOBER 30, 2015

Welcome to the Medicare Readmissions Update eNewsletter

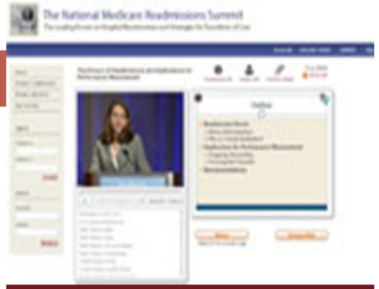
Editor: Philip L. Ronning

This issue sponsored by

The The Sixth National Accountable Care Congress and the

The Eleventh National Value-Based Payment and Pay for Performance Summit

FEATURED 2013 READMISSIONS SUMMIT STREAMING AUDIO



The Drivers of Readmissions and

READMISSIONS UPDATES

Is Observation Status Substituting for Hospital Readmission?

The readmissions reduction efforts of CMS appear to be having unintended consequences for patients in Medicare and in the commercial market. Hospitals with readmission rates above the national average now receive lower payments across-the-board from Medicare; the higher the rate of "excess" readmissions, the greater the penalty. The fines are intended to push hospitals to provide better care for their patients to avoid having patients return. When patients do return to the hospital, the efforts to reduce readmissions may unintentionally

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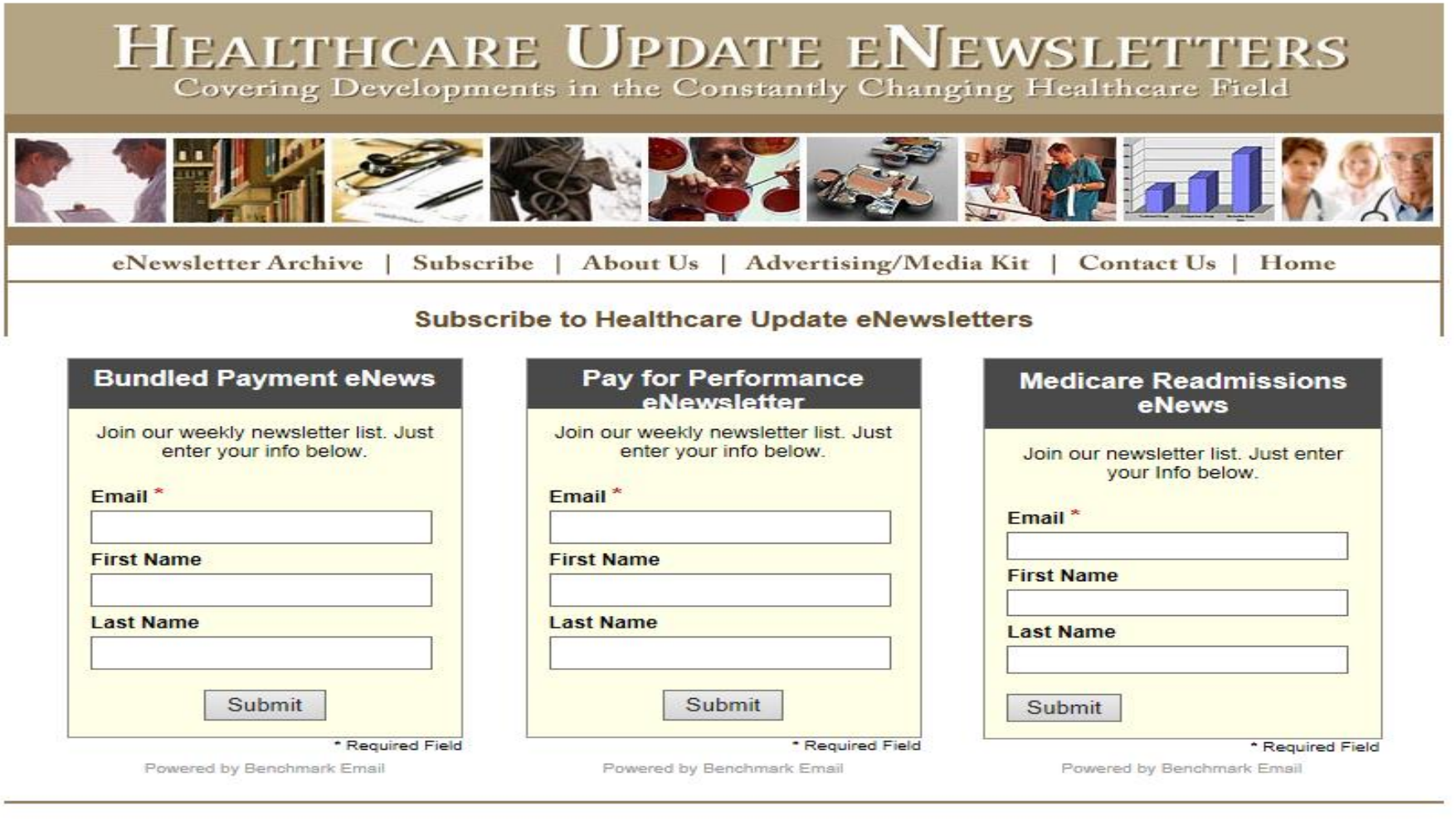

www.healthcareenewsletters.com/subscribe.html

Readmission Update Newsletter Topics

- Hospital compare offers data on % of patients with THA and TKA who were readmitted and excess readmission data
- 24 evidenced based practice competencies to ensure staff have knowledge and skills which can reduce complications and costs by 30%
- Role of chronic conditions in readmissions
- 20 item tool that predicts patients with increased risk of readmissions
  - Called the 8P scale of the target screen of BOOST

Readmission Update Newsletter Topics

- Some hospitals have a RED team or a committee to reduce unnecessary readmissions
- Following the evidenced based literature for tips to help reduce the unnecessary readmission rate can help
- Medicare identifies the best and worst hospitals for THA and TKA
- Hospitals with more elderly and poor patients likely to face readmission penalties
- Hospitals prohibit early elective C-sections

The 8Ps:
Assessing Your Patient's Risk For Adverse Events After Discharge

Risk Assessment: 8P Screening Tool (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

Readmission Update Newsletter Topics

- 13 most frequent primary diagnoses for readmissions
  - COPD, CHF, cardiac ischemic disease, arrhythmia, CV disease, ADE, renal failure, nutritional and metabolic disorders, venous thromboembolism, liver disorders, GI disorders, infectious diseases and neoplasm
- Some hospital readmissions are avoidable
  - Most common reason for readmission related to chronic medical conditions
- Hospital reduces readmissions by 37% by using analytics to help which course of treatment is most effective

Readmission Update Newsletter Topics

- Readmissions for Medicare patients fall for a second year
  - Average avoidable readmission rate for first 8 months of 2013 was 18% and in 2015 was 17%
  - Rate had been at 19% for five years
  - This means 130,000 fewer readmissions
- New model predicts risk for readmission from LTC
- Indiana Health Information Exchange (IHIE) details its use of predictive analysis to reduce readmission rates

Articles in Readmission Update

- Racial and economic disparities are prevalent in hospital readmission rates
- Hospital readmissions for COPD highest among black patients
- A shorter delay to primary PCI for STEMI patients was associated with a reduced rate of readmission
- Ten proven ways to reduce readmission
  - www.beckershospitalreview.com/quality/10-proven-ways-to-reduce-hospital-readmissions.html

Ten proven Ways to Reduce Readmission

- Understand which patient populations are at greatest risk of readmission
  - Healthcare Cost and Utilization Project suggest that Medicaid and uninsured patients are at higher risk
- Target patients with limited English proficiency
- Join a readmission prevention focus collaborative such as a state hospital initiative
- Ensure patients schedule a seven day follow up appointment or less
- Implement a robust home healthcare program

Ten proven Ways to Reduce Readmission

- Clearly communicate post-discharge instructions
- Install telemonitoring technology in the homes of chronically ill patients
- Effectively staff nurses during patient care
  - Researchers found higher RN overtime staffing increased readmissions as well as ED visits
  - Meanwhile, higher non-overtime RN staffing was found to decrease ED visits indirectly due to improved discharge teaching quality and discharge readiness

Why Patients Are Readmitted

- They do not know their diagnosis and do not understand what is wrong with them
- Confused on what medications to take and when
- Primary care physicians are not provided with important information about hospitalization or test results (CMS to require sending within 48 hours)
- A follow up appointment is not scheduled
- Patient or family members lack proper knowledge to provide needed care
- Dartmouth Institute Study 4 page document 2013

Readmission Rates to Hospital and ED

- Readmission rates to hospitals within 30 days
  - Medical conditions national average is 16.1%
  - Surgical procedures national average is 12.7%
- ED visit rate within 30 days
  - Medical conditions national average is 18.8%
  - Surgical procedures national average is 15.2%
- 14 days outpatient visit rate national average 62.5%
- Dartmouth Institute study 2013

Care About Your Care:
Tips for Patients When They Leave the Hospital

www.dartmouthatlas.org/downloads/reports/Atlas_CAYC_092811.pdf

Leaving the hospital sounds simple. But all too often, patients find themselves back in a hospital bed—or even the emergency room—within a matter of weeks of going home. Many of these return visits could be avoided if doctors and nurses coordinated patients' care better and if patients, their caregivers and hospital staff did a better job of planning for the day the patient leaves.

This article will help you LOOK at the care you get and understand what good care for patients who are leaving the hospital looks like, help you LEARN what you can do to make sure you get the best possible care, and help you LIVE better by taking action to get better care.

From hospital to home – and back again?

When all goes well, patients understand the reasons they were admitted to the hospital and exactly what to do to take care of themselves when they leave. When all goes well, patients take their medications on time and check in with a doctor or nurse they see regularly, often called the primary care provider. When all goes well, patients' specialists communicate with their primary care doctors and nurses, making sure that everyone has the information they need to care for patients. When all goes well, patients get the care they need once they are home and don't have to go back to the hospital because of complications.

Unfortunately, that's not always what happens.

There are many reasons why patients have to go back to the hospital unnecessarily:

- Patients may not completely understand what is wrong with them.
- Patients may be confused about what medicines they should take and when they should take them, and they may not take the right medication at the right time.
- Hospital staff may not communicate important information to patients' primary care providers.
- Patients may not schedule needed follow-up appointments with their primary care providers or specialists.
- Hospital staff may not inform patients or their primary care providers of test results that could affect their care.
- Family members may not know how to help provide care at home.

Whatever the cause, a common result is that patients end up returning to the hospital. Every year, unnecessary visits back to the hospital cost billions of dollars and take millions of patients away from their families, friends and homes. It is an especially big problem for patients on Medicare.

LOOK: See how poorly coordinated care can send patients back to the hospital

Robert Wood Johnson Foundation

The Dartmouth Atlas of Health Care

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Recent Articles in Readmission Update

- It takes a team approach to reduce readmissions
- Home Monitoring Reduces Readmissions
- Heart Failure Program Cuts Readmission Rates by 30%
- Is Reducing Hospital Admissions an Answer?
- Care by Hospitalist Offset by Higher Readmissions
- A Look at the 7 Hospitals with Highest Rates of Readmissions

Recent Articles in Readmission Update

- Study published Dec 2013 in BMJ found the following;
  - Studies 11,000 adult discharges from Boston Medical Center
  - 22.3% were readmitted within 30 days
  - Only 8% were potentially avoidable readmissions
  - Comorbidities were the most common cause of readmission and most common readmits were infection, neoplasm, heart failure, GI disorders and liver disorders
  - Study concluded need to have a strategy that focuses on **managing chronic comorbidities** and not just the primary reason for admission

Post Hospital Syndrome

- Readmissions can be due to post hospital syndrome
- Readmissions due to stress, sleep loss, pain, discomfort, malnutrition and inactivity that occurs with hospitalization
  - Discharge assessments need to go beyond the cause of the initial hospitalization
- Need implement interventions to eliminate sleep disturbances, minimize pain, address nutritional deficiencies and increase physical activity
- NEJM January 10, 2013

The NEW ENGLAND JOURNAL of MEDICINE

Perspective www.nejm.org/doi/full/10.1056/NEJMp1212324

Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk

Harlan M. Krumholz, M.D.

N Engl J Med 2013; 368:100-102 | January 10, 2013 | DOI: 10.1056/NEJMp1212324

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Article | References

To promote successful recovery after a hospitalization, health care professionals often focus on issues related to the acute illness that precipitated the hospitalization. Their disproportionate attention to the hospitalization's cause, however, may be misdirected. Patients who were recently hospitalized are not only recovering from their acute illness; they also experience a period of generalized risk for a range of adverse health events. Thus, their condition may be better characterized as a post-hospital syndrome, an acquired, transient period of vulnerability. This theory would suggest that the risks in the critical 30-day period after discharge might derive as much from the allostatic and physiological stress that patients experience in the hospital as they do from the lingering effects of the original acute illness. At the time of discharge, physiological systems are impaired, reserves are depleted, and the body cannot effectively defend against

Audio Interview

Interview with Dr. Harlan Krumholz on a condition of generalized risk after patients are discharged from the hospital. (17:28)

Telemedicine Reduces Readmission 10/5/2015 AHA News

CHAIRMAN'S FILE

hospitals in pursuit of excellence

Telemedicine Reduces Readmissions

A unique telemedicine consultation between a rural hospital and skilled rehabilitation/nursing facility is dramatically reducing patient readmissions. **Atlantic General Hospital**, a 62-bed facility in Berlin, MD, discharges many patients to a local, privately owned post-acute care facility. In January 2015, Atlantic General used grant dollars to purchase telemedicine equipment and peripherals. If a patient's status changes after discharge, providers at the facility consult an Atlantic General hospitalist, who performs a patient exam by video with assistance from the facility's clinical staff. The hospitalist then recommends interventions or readmits the patient directly to the hospital, bypassing the ED. Since the

Telemedicine Reduces Readmission

- 62 bed rural hospital in MD discharges many patients to a private post-acute care facility
- Used grant dollars to buy telemedicine equipment
- If status of resident changes after discharge, then LTC facility consults hospitalist
- Then recommends interventions or readmits patient directly to the hospital, bypassing the ED
- Has reduced readmissions by more than half
- Readmission range between 11 and 15%
  - For more information contact mfranklin@atlanticgeneral.org

CMS Report 2014

- CMS says multiple factors contribute to hospital readmission rates
  - Premature discharge
  - Poor quality of care
  - Lack of education to patients before they left
- Most common patients returning to the hospital were CHF, COPD, pneumonia and high blood pressure
- 85% of hospitals had an average readmission rate
- 8% of hospitals had a higher rate or 364 hospitals

CMS Hospital Compare

- Put in hospital, city, or zip code to locate
- Gives general information such as address, type of hospital, ED, use of safe surgery checklist, track lab values electronically, etc
- Can click on tabs to get more information such as patient experience results, complications, and readmissions and deaths
- Lists 30 day unplanned admissions
- Includes readmissions on COPD, MI, CHF, Pneumonia, Stroke, CABG, THA, TKA,

CMS Hospital Compare Website

Español | A A A | Print

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Medicare.gov | Hospital Compare

The Official U.S. Government Site for Medicare

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Home

Share

www.medicare.gov/hospitalcompare/search.html

Find a hospital

A field with an asterisk (*) is required.

* **Location**

Example: 45802 **or** Lima, OH **or** Ohio

ZIP code or City, State or State

Hospital name (optional)

Full or Partial Hospital Name

Search

Spotlight

- We've reorganized the data categories. Learn more.
- Compare hospital star ratings on the Survey of Patients' Experiences Tab. Learn more.
- Get PPS-exempt cancer hospital data.

Additional information

- **Hospital Compare data last updated**: October 8, 2015. Go to updates.
- Download the Hospital Compare database
- Get Hospital Compare data archives.
- Linking quality to payment:

Tools and Tips

- Learn how Medicare covers inpatient and outpatient hospital services.
- Use The Guide to Choosing a Hospital when comparing hospitals.
- Get tips for printing hospital information
- Compare other providers and plans

Shows Rate of Unplanned Readmissions

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of unplanned readmission for heart attack patients	No different than the National Rate	17.0%
Death rate for heart attack patients	No different than the National Rate	14.2%

▼ **Heart failure**

Show Graphs | View More Details

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of unplanned readmission for heart failure patients	No different than the National Rate	22.0%
Death rate for heart failure patients	No different than the National Rate	11.6%

▼ **Pneumonia**

Show Graphs | View More Details

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of unplanned readmission for pneumonia patients	No different than the National Rate	16.9%
Death rate for pneumonia patients	No different than the National Rate	11.5%

Rate of Readmissions MI, CHF, and Pneumonia

	RIVERSIDE METHODIST HOSPITAL	U.S. NATIONAL RATE
Rate of readmission for heart attack patients	No Different than U.S. National Rate	18.3%
Death rate for heart attack patients	No Different than U.S. National Rate	15.2%
Rate of readmission for heart failure patients	No Different than U.S. National Rate	23.0%
Death rate for heart failure patients	No Different than U.S. National Rate	11.7%
Rate of readmission for pneumonia patients	No Different than U.S. National Rate	17.6%
Death rate for pneumonia patients	No Different than U.S. National Rate	11.9%
Rate of readmission after hip/knee surgery	No Different than U.S. National Rate	5.4%
Rate of readmission after discharge from hospital (hospital-wide)	Worse than U.S. National Rate	16.0%

Detailed Information About Each

Heart attack - details

Data collection periods for all measures can be found here.

Table 1 of 2: Rate of unplanned readmission for heart attack patients

The table below shows how the 30-day unplanned readmission rates for the selected hospitals compare to the national observed rate of unplanned readmission for heart attack patients. The hospitals' performance results take into account how sick patients were before they were admitted to the hospital and differences in unplanned readmission rates that might be due to chance.

They do not include people in Medicare Advantage (like an HMO or PPO) plans. For more information, see How are the hospital readmission measures calculated?

National rate of unplanned readmission for heart attack patients = 17.0%

Hospital name	Better than the national rate (adjusted readmission is lower than national rate)	No different than the national rate (adjusted readmission is about the same as national rate or difference is uncertain)	Worse than the national rate (adjusted readmission is higher than national rate)
RIVERSIDE METHODIST HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See About the data: 30 day readmission and death rates for additional information about the data collection for the readmission measures.

Out of 4384 hospitals in the United States →	**30** hospitals were better than national rate	**2273** hospitals were no different than national rate	**23** hospitals were worse than national rate
	2058 hospitals did not have enough cases to reliably tell how well they are performing		
Out of 159 hospitals in Ohio →	**0** hospitals were better than national rate	**94** hospitals were no different than national rate	**0** hospitals were worse than national rate
	65 hospitals in Ohio did not have enough cases to reliably tell how well they are performing		

Rate of Readmission for MI is 18.3% 2014

30-Day outcomes: Readmission and death rates details

Table 1 of 8 Rate of readmission for heart attack patients

The rates displayed in this table were calculated from Medicare and VA data on patients discharged between July 1, 2009 and June 30, 2012. They do not include people in Medicare Advantage (like an HMO or PPO) plans.

Rate of readmission for heart attack patients shows a comparison between the 30-day readmission rates for the selected hospitals, and the U.S. national **rate of readmission for heart attack patients**. These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance. For more information, see How are the hospital readmission measures calculated?

Rate of readmission for heart attack patients compared to the U.S. national rate.

U.S. national rate of readmission for heart attack patients = 18.3%

Hospital Name	Better Than U.S. National Rate (Adjusted Readmission Is Lower Than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted Readmission Is About The Same As U.S. National Rate Or Difference Is Uncertain)	Worse Than U.S. National Rate (Adjusted Readmission Is Higher Than U.S. National Rate)
RIVERSIDE METHODIST HOSPITAL		X	

The 'total number' of hospitals in the table below is the total number of hospitals that had eligible admissions for this measure. See 30-Day Complication Measures for additional information about the data collection for the readmission measures.

Out of 4464 in the United States →	**23** hospitals in the United States were Better than U.S. National Rate	**2327** hospitals in the United States were No different than U.S. National Rate	**29** hospitals in the United States were Worse than U.S. National Rate
	2085 hospitals in the United States did not have enough cases to reliably tell how well they are performing		
Out of 157 in Ohio →	**0** hospital was Better than U.S. National Rate	**96** hospitals were No different than U.S. National Rate	**0** hospital was Worse than U.S. National Rate

National Rate of Readmission 2015

- 30 day unplanned readmission rates CMS
- COPD 20.2% and death rate is 7.7%
- MI 17% and death rate is 14.2%
- CHF 22% and death rate is 11.6%
- Pneumonia 16.9% and death rate is 11.5%
- Stroke 12.7% and death rate is 14.8%
- CABG 14.9% and death rate is 3.2%
- TKA/THA 4.8%

Many Good Resources Commonwealth Website

- The Commonwealth is a private foundation promoting high performing health care to improve quality of care
- It supports independent research on health care issues like readmissions
- Can search by putting in word “readmissions”
- The articles are free and you can sign up to get their e-alerts on their website at www.commonwealthfund.org/about-us

The Commonwealth Fund

Many Good Resources Commonwealth Website

- http://www.commonwealthfund.org/Content/Publications/Literature-Abstracts/2010/Jan/Preventing-Readmissions-with-Improved-Hospital-Discharge-Planning.aspx

What Have We Learned National Campaign

- Only **one** strategy that was consistently associated with reductions in readmissions
- Discharging patients with their follow-up appointments
- Hospitals that did 3 or more different strategies had significantly reduced their readmissions
- These hospitals used 93 unique combinations of strategies
- However, adding more was not associated with significantly more benefit

What Have We Learned National Campaign

National Campaigns to Reduce Readmissions: What Have We Learned?

Thursday, October 1, 2015

By Elizabeth H. Bradley, Amanda Brewster and Leslie Curry

www.commonwealthfund.org/publications/blog/2015/oct/national-campaigns-to-reduce-readmissions

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Toplines

- Findings from an evaluation of two rehospitalization reduction initiatives, STAAR and H2H
- Which readmissions reduction strategies, and how many, are most effective?

Many people, particularly older patients, are readmitted soon after being discharged from the hospital. These unexpected return visits are expensive and challenging for patients and their families, and costly for Medicare. Nearly 20 percent of Medicare beneficiaries experience an unplanned hospital readmission, with an estimated cost to the American public of about $26 billion per year. Avoiding or at least reducing unplanned readmissions is a national priority; however, readmission is a complicated process and not easy to predict or prevent. With support from The Commonwealth Fund, our research team at the Yale School of Public Health undertook a study between 2010 and 2015 to understand how this might be accomplished.

What Did We Learn About National Efforts to Reduce Rehospitalizations?

Hospitals that participated in national efforts to reduce readmissions, including the State Action on Avoidable Rehospitalizations (STAAR) and Hospital-to-Home (H2H) initiatives, reported that these efforts motivated them to focus on the problem of readmissions, experiment with various strategies to fix it, and learn from one another. Active from 2009 to 2013, the STAAR initiative focused on hospitals in Massachusetts, Michigan, and Washington. STAAR encouraged collaboration across organizational boundaries and focused on enhancing assessment of posthospital needs, patient

Preventing Readmissions

- Care Transitions Intervention and Transitional Care Model are two common interventions that focus on the post-acute care transitions
- Guided care and Geriatric Resources for Assessment and Care of Elderly are promising care coordination intervention models
- Technologies to improve medication adherence, medication reconciliation, patient monitoring, communication between clinicians, risk assessment are important aspects of care transitions

Readmissions and Discharges

- 40% of patients who were discharged had test results pending
- Many discharged patients had pending workups with interventions to be followed up by outpatient physicians
- More than 1/3 of the recommended follow ups were not followed
- Frequently because the discharge summary did not contain the details of the necessary work up
  - But availability of discharge summary increased likelihood of work ups being done
  - Tying up loose ends: discharging patients with unresolved medical issues. Moore C, McGinn T, Halm E. Arch Intern Med. 2007;167:1305-1311

Readmissions and Discharges

- Another study finds that 41% of inpatients were discharged with a study pending
- It was also discovered that 2/3 of the physicians were not aware of the results
- 37% of the tests required some action on behalf of the physician
- Inpatient physicians were dissatisfied with system for following up test results returning after discharge
  - Roy, Christopher etc. Patient Safety Concerns Arising from Test Results that Return after Hospital Discharge, Ann Intern Med 2005; 143(2):121-8

Discharge Summary

- Many were not done because the discharge summary was **not** available at the time of the first clinic or office visit
  - Later the RED study found that 78% of patients who went for the first post hospital visit the primary care physician did not have a discharge summary for the patient
  - This is one of the most important strategies to prevent unnecessary readmissions
  - Note NQF 34 Safe Practices to dictate the discharge summary when patient discharged and ensure it gets to the PCP timely and document this communication

Discharge Summary in Hands of PCP

- This is why CMS required this in the DP standards and worksheet
  - Incomplete handoffs lead to unnecessary readmission
  - Care transition important for high risk and the elderly
- States that the discharge summary or information summarizing the admission is in the hands of the PCP before the first post hospital visit
- If not appointment made then within 7 days
- In the 2016 proposed CMS hospital discharge planning rules on discharge planning will need to provide to practitioner within 48 hours

Readmissions and Discharges

- 37.2% of patients did not know the purpose of their medication
- Only 14% knew the side effects of the medications they were taking
  - Proposed 2016 rules will require education of side effects
- Only 41.9% of patients were unable to state their diagnosis
- Hospitals may want to focus on ensuring adequate **medication information**, discharge diagnosis and plan of care information to the patient
  - Patient Understanding of their Treatment Plans and Discharge Diagnosis at Discharge, Mayo Clinic Proceedings, Aug 2005;80(8):991-994

Readmissions and Discharges

- This lead to the development of a formal discharge checklist to ensure communication at discharge
  - Transition of care for hospitalized elderly patients—development of a discharge checklist for hospitalists. Halasyamani L, Kripalani S, Coleman E, et al. J Hosp Med. 2006;1:354-360
  - The Pa Patient Safety Authority has excellent resources including suggested elements for a discharge checklist
  - See Care at discharge—a critical juncture for transition to posthospital care. *Pa Pat Saf Advis 2008 Jun;5(2):39-43*

PaPSA Checklist

Suggested Elements for a Discharge Checklist

Patient Name: _____ Physician Name: _____

Admission Date: _____ Discharge Date: _____

Primary Diagnosis: _____ Secondary Diagnoses: _____

Procedure(s): _____

_____ ***Interpreter needed for patient with language/culture barrier***

Please check when task is completed.

Patient Education

____ Educate patient and/or family members about diagnoses, disease, and procedure(s).
____ Educate patient and/or family members about follow-up care for procedure(s), if indicated.
____ Provide patients with procedure and/or disease-specific educational materials.
____ Reconcile discharge medication list.
____ Educate patient and/or family members about the prescribed medications including medication administration, drug action, and side effects.
____ Provide written material for prescribed medications with all information noted above.

Services to Provide

____ Review pending test results and instruct patient about whom to call for results.
____ Schedule follow-up appointments with physicians and/or specialists as indicated.
____ Provide referrals for services ordered by physician (i.e., physical therapy, occupational therapy).

Lifestyle Modifications

___ Provide written discharge instructions that include the following:

____ Activity level

____ Diet

In Case of an Emergency

___ Educate patient about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911.

Miscellaneous

___ Perform a physical assessment to ensure that intravenous lines and other access ports are removed.

___ Give prescriptions to the patient.

___ Ask the patient and/or family members if they have any questions or concerns related to the patient's care.

___ To assess understanding of the discharge instructions, ask the patient and/or family members to give a brief (30 seconds) summary of discharge instructions.

Discharge Nurse Name: _____

Signature: _____ Date: _____

This form is provided as a sample only and is not meant to be used as is.

For more information, visit http://www.psa.state.pa.us.

This information has been adapted from:
Care at discharge—a critical juncture for transition to posthospital care.
Pa Pat Saf Advis 2008 Jun;5(2):39-43.

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PATIENT SAFETY AUTHORITY

Commonwealth of Pennsylvania

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ADDRESS:
Patient Safety Authority
333 Market Street
Lobby Level
Harrisburg, PA 17120

Educational Tools

http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/tk_discharge/Pages/home.aspx

Care at Discharge

Discharge is a critical juncture for transitioning to posthospital care, and incomplete discharge processes may cause harm to patients. Implementation of discharge planning upon patient admission, assignment of discharge coordinators, and use of checklists to facilitate standardization within the facility are risk reduction strategies to consider.

Browse by Topic

- GO Discipline
- GO Audience
- GO Care Setting
- GO Event
- GO Patient Safety Focus

Educational Tools

Suggested Elements for a Discharge Checklist
This sample checklist includes suggested elements relevant to patient discharge.

Articles

Care at Discharge—A Critical Juncture for Transition to Posthospital Care
Discharge is a critical transition period for patients and a process that calls for education, assessment, follow-up, organization, confirmation, and review.

PaPSA on Preventing Readmission

- Had more than 800 reports in 3 ½ year period of harm from patients from incomplete discharge
  - 30% of patients did not receive verbal or written discharge instructions before they left the facility
  - Lack of medication reconciliation was evident and CMS mentions in worksheet and will require in 2016 in proposed discharge planning standards
- Essential parts of the discharge process include
  - Educating the patient and or family including what to do if a problem occurs; Assessing the patients understanding of the plan
  - Scheduling follow up appointments and Confirming the medication plan

PaPSA on Preventing Readmissions

- Some patients received another patients instructions
- Many patients did not have their IV access device removed prior to discharge
- Many patients returned with an IV site infection and or phlebitis
- Discharge of patients before test results were made available to the attending who would have postponed discharge based on the final results
- Many medication related issues such as lack of instructions

11 Essential Steps of RED Process

- Greenwald etc. identified 11 essential steps to the reengineered discharge process at Boston Medical Center
  - Educating patients and families about their diagnosis throughout the hospital stay
  - Assessing the patients' understanding of the plan by asking them to explain the plan in their own words
  - Advising the patient and family of any tests completed in the hospital with results pending at time of discharge and identifying the clinician responsible for the results

11 Essential Steps of RED Process

- Scheduling follow-up appointments and tests to be done following discharge
- Organizing services to be initiated following discharge
- Confirming the medication plan
- Reconciling the discharge plan with national guidelines and critical pathways when relevant

11 Essential Steps of RED Process

- Reviewing with the patient what to do if a problem occurs
- Expediting the transmission of the discharge summary to the healthcare providers who are accepting responsibility for the patient's care
- Giving the patient written discharge instructions
- Greenwald JL, Denham CR, Jack BW. The hospital discharge: a review of high risk care transition with highlights of a reengineered discharge process. *J Patient Saf* 2007 Jun;3(2):97-106.

Medication List

What medicines do I need to take?

Each day, follow this schedule:

Morning Medicines			
Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

Outstanding Labs or Tests

Outstanding Labs or Tests

Are any lab tests/studies pending? ☐ yes ☐ no ☐ unknown

PENDING LAB TEST/STUDIES

Lab test/ study name	Date done	Name of clinician to review/location	Day/Date subject will see clinician to discuss results?
1.		Same as PCP	Same as PCP
2.			
3.			

Some tests have been done while you have been in the hospital, but the results are not yet ready. A (test/study name) was done on (date of test/study). (Name of PCP) will review the results and discuss them with you during your appointment.

Depending on the results of your lab test(s)/studies, your doctor might adjust your treatment. We just talked about your scheduled appointment with (name of PCP). It is very important that you see your doctor on (date/time to see PCP) to find out if anything needs to be done or changed as a result of these tests. Again, if there is anything you don't understand or you are having trouble making an appointment, please call me. If I am not there, leave a message and we will call you back.

Appointments for Follow Up

When are my next appointments?

Day	Date
Time asdfasdf	
Doctor's name	Specialty
Address	
Reason for appointment	
Doctor's phone number	

Questions for my appointment

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

- ☐ My medicines _____
- ☐ My test results _____
- ☐ My pain _____
- ☐ Feeling stressed _____

Other questions or concerns _____

Project RED Tools

PROJECT RED
Re-Engineered Discharge

A Research Group at
Boston University Medical Center

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

BU Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality, National Heart, Lung and Blood Institute, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute

- Home
- Development of the RED
- Components of the RED
- Meet Louise...
- The Project RED Toolkit
- Our Team
- Recognitions
- Newsroom
- Presentations
- Publications & Abstracts
- Funding
- Links
- Hospitals Using RED
- Receive Updates
- Contact Us

Project RED (Re-Engineered Discharge)

Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction. Virtual patient advocates are

Latest Project RED News

A Project to Reengineer Discharges Reduces 30-Day Readmission Rates: A Texas hospital achieves improvement in its readmission rate by implementing Project RED. (PDF)

Project RED wins the 2013 Peter F. Drucker Award for Nonprofit Innovation
BU Today
By Leslie Friday
October 2, 2013

How an Avatar Nurse Can Help Health Care Handoffs
Dallas Business Journal
By Bill Hethcock
September 20, 2013

Health Care Leaders Think Big on a Small Budget
BU Today
By Leslie Friday
September 19, 2013

Readmission Rate 13% After Major Surgery
MedPage Today
By Michael Smith
September 18, 2013

Release of Toolkit to Reduce Hospital Readmissions in the News

There has been a wide range of coverage about the release of the newly expanded RED toolkit, which we released on

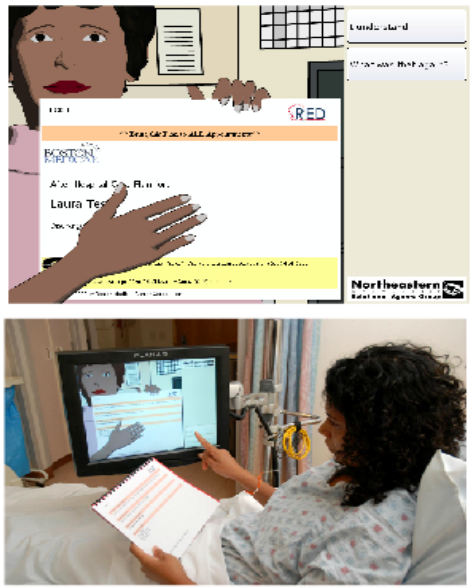
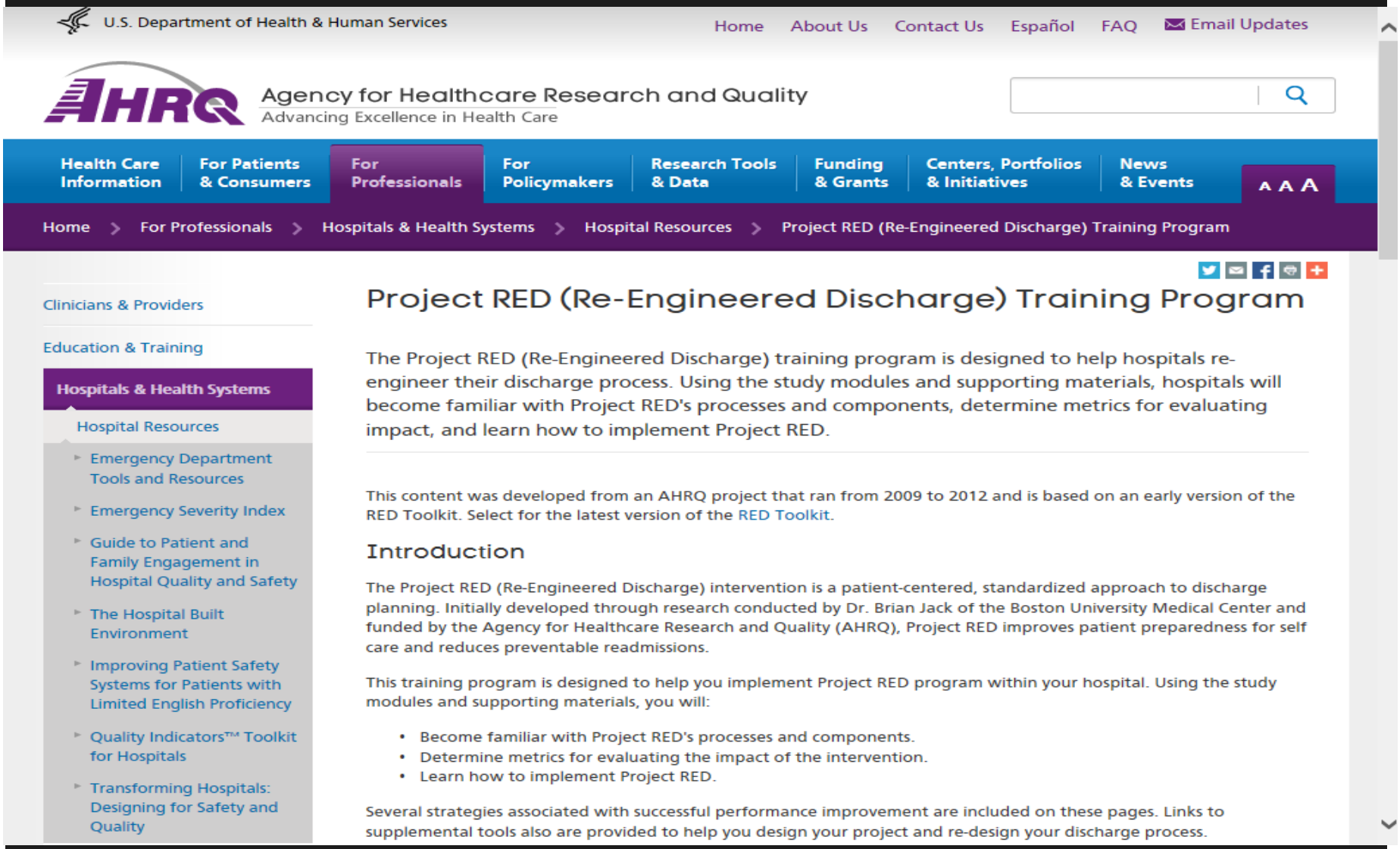


Photo: Glenn Kulbako

Click for Project RED Toolkit

http://www.ahrq.gov/professionals/systems/hospital/red/index.html

Updated RED Program



Contents

http://www.ahrq.gov/professionals/systems/hospital/red/index.html

3 Factors Leading to Errors at Discharge

- Greenwald etc identified factors that lead to error at discharge to three types

1. Hospital care system characteristics
   - Many hospitals don't get discharge summaries to PCP timely
   - Many errors around lack of medication reconciliation at discharge
2. Patient characteristics

- Factors in literature at risk for hospitalization include lack of social, financial, and familial support and low health literacy, lack of follow up and adherence to treatment

3 Factors Leading to Errors at Discharge

- 3. Clinician characteristics
  - These focus on quality and effectiveness of communication and
  - Timeliness and completeness of discharge summaries provided to subsequent caregivers
  - Clinicians with limited time or lack of effort put into educating patients at discharge lead to lack of patient understanding
  - This is why studies that used transition coaches to assist and encourage the patient to participate in their care were successful at unnecessary readmissions

Transitions Research

- Research on preventing unnecessary readmissions looks at the studies on improving transitions
- Transitions is the process designed to ensure coordination and continuity of healthcare as patients transfer between different locations or different levels of care
- We want to improve the transition to home, long term care, home health, assisted living or other post discharge places
- How do we do this right so the patient does not have a unnecessary readmission

Patient Characteristics Play a Role

- Through out this presentation are various evidenced based articles that discuss patient characteristics that increase the patient's readmission rate
- Hospitals should be aware of this research to determine high risk patients
- Patients with co-morbidities are high risk for readmissions
- The more chronic conditions the patient has the greater the likelihood or readmission
  - See chart on next page

High Risk Screening Criteria

- Patients who fall into any of these categories should be targeted for a comprehensive assessment
  - Over the age of 70
  - Multiple diagnosis and co-morbidities
  - Impaired Mobility
  - Impaired self care skills
  - Poor cognitive status
  - Catastrophic injury or illness
  - Chronic illness

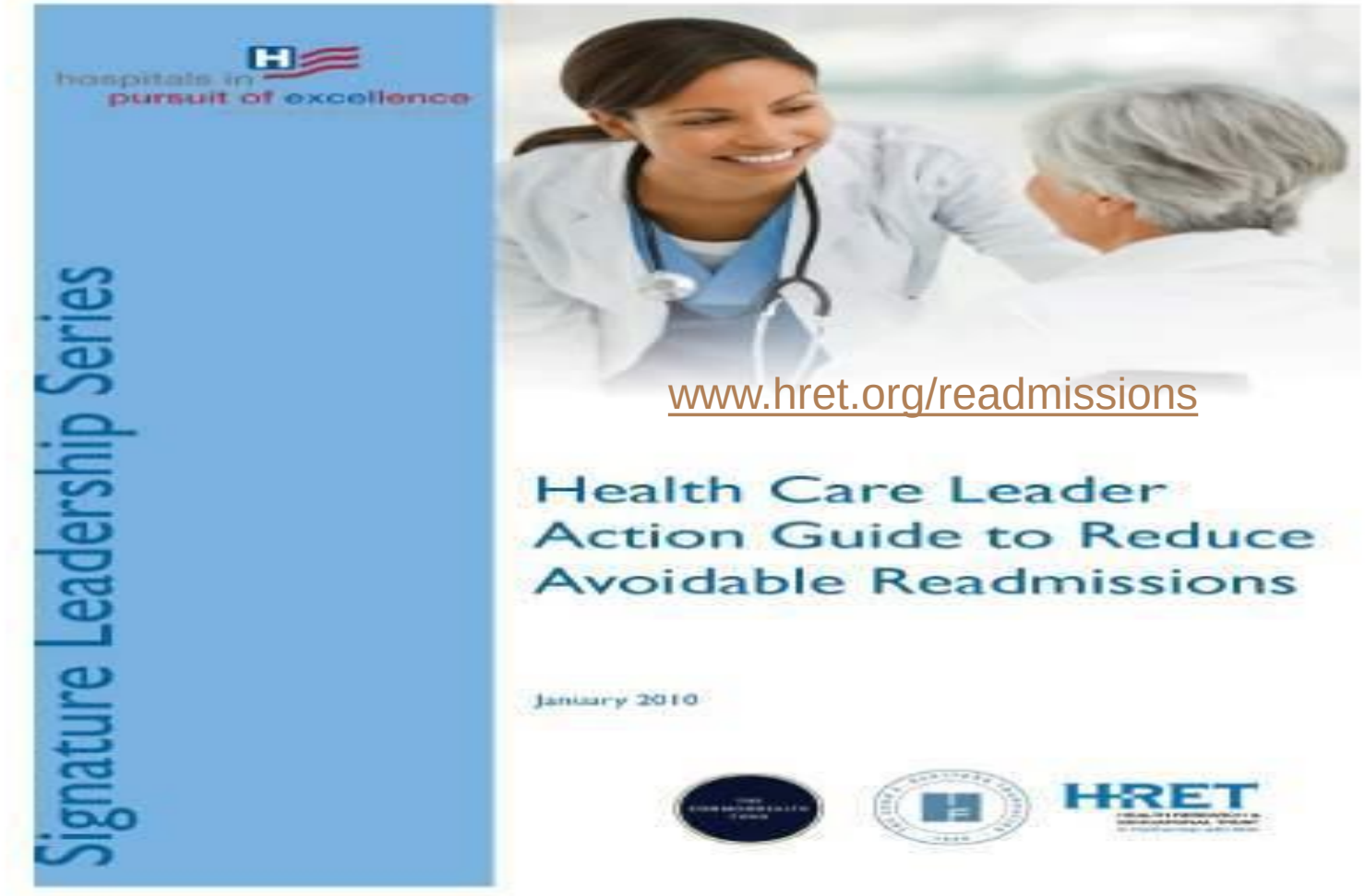
High Risk Screening Criteria

- Homelessness
- Poor social supports
- Anticipated long term health care needs
  - Such as new diabetic
- Substance abuse
- History of multiple hospital admissions
- History of multiple emergent care use
- Source; Suggested Model for Transitional Care Planning, NY State DOH, www.health.ny.gov/professionals/patients/discharge_planning/discharge_transition.htm, Accessed November 11, 2015

AHA Reducing Avoidable Hospital Readmissions

- Some readmissions can be avoided by evidenced based practice but the means for achieving this still remains controversial
- Preventing readmissions is a complex, system-wide problem that involves hospitals, physicians, other providers, patients and their families
- AHA created a framework
- AHA included a list of strategies that hospitals might find helpful in both documents
  - AHA worked with 3 states and got payer data on readmissions

AHA Guide to Reduce Readmissions



AHA 4 Steps

- First, examine your hospital's current rate of readmissions
- Second, assess and prioritize you improvement opportunities
- Third, develop an action plan of strategies to implement
- Fourth, monitor you hospital's progress

Develop Action Plan of Strategies

- Develop an action plan of strategies to implement
- This is why doing a literature search and have librarian obtain articles from evidence based research
- Need many in the community to work together to prevent unnecessary readmissions to the hospital
- See list of major strategies to reduce avoidable readmissions
- Need to use technology such as remote monitoring, electronic medical records and telehealth

Strategies During Hospitals

- Risk screen patients and tailor care
  - Tailor patient care needs based on evidenced based guidelines, clinical practice guidelines, care path
    - Develop pathways that include discharge steps consistent with these evidenced based guidelines
    - CHF CPG, CABG, Pneumonia pathways, Total hip and total knee pathways
    - Include actions to take if variances occur with CPG
    - Get with the guidelines, www.ahrq.gov and www.guidelines.gov

Strategies During Hospitals

- Give patient a complete written discharge plan
- Educate patients and families about their disease and diagnosis throughout the care continuum
- Make sure educational material is age appropriate, disease specific, and appropriate literacy level
- Have healthcare worker responsible for discharge planning and define scope of their responsibility
  - Have a social worker or discharge planner to provide discharge planning services
  - Some have discharge advocate

Strategies During Hospitals

- Be aware of research that shows patients at increased risk of readmission such as patients with low health literacy and use interpreters when needed
  - 20% of population reads at the 5th grade level
  - 78% of adults had trouble understanding simple health information (consent, prescriptions, discharge instructions)
    - Can not tell health literacy by looking so observe closely in elderly, unemployed, did not finish high school, born in US but English a second language, noncompliant, immigrant, can't name medications, forgot glasses and will read later, etc.
  - High risk patients also include history of readmission, failed teach back, longer stay than expected, high risk conditions, poor, disabled or on dialysis

Strategies During Hospitals

- Respond to patient needs for early ambulation, early nutritional interventions, PT, social work etc
  - Nursing assessment and identify criteria to see dietician timely
  - Quality and patient safety initiatives to improve surgical outcomes such as prevention of PE and DVT
- Develop a multidisciplinary team to evaluate and implement discharge needs
  - Consider a checklist of things to consider in the discharge process
  - See Society of Hospital Medicine at http://www.hospitalmedicine.org/AM/Template.cfm?Section=Quality_Improvement_Tools&Template=/CM/ContentDisplay.cfm&ContentID=8363

Ideal Discharge for the Elderly Patient: A Hospitalist checklist

Checklist Element	Particulars	Must Keep	Optional
Medication Education	• Written schedule of medication	x	
	• Include Purpose (reason) and (if apt) Cautions(s) for each medication	x	
	• Clinical Pharmacist involvement (especially if cognitive impairment, or ≥ 3 Medication changes		x
Cognition	Rather than a Folstein score, some description mention of mental capacity such as:		
	• Lucid (full capacity for understanding and executive function, such as being able to follow instructions)		x
	• Forgetful (some senescence or impairment of memory)		x
	• Dementia (or "Brain Failure" - incapable of reliable recall and/or executive function)		x
Discharge Summary	Needs to be written with the receiving caregiver in mind, including:		
	• Presenting problem(s) that precipitated hospitalization	x	
	• Primary and secondary diagnoses	x	
	• Key findings and test results	x	
	• Brief hospital course	x	
	• Discharge Med Reconciliation (see above)	x	
	• Condition at discharge (including functional status and cognitive status, if relevant)		Cognitive status
	• Discharge Destination (and rationale if not obvious)	x	

	• Any anticipated problems and suggested interventions. • Follow-up appointments with suggested management plan • Pending labs or tests • Recommendations of any sub-specialty consultants • Documentation of patient education and confirmation of patient understanding through teach-back	 x x x x	X
Patient Instructions	ε Provide instructions written at 6th grade level ε Any anticipated problems(s) and suggested intervention(s) ε 24/7 call-back number ε Teach-back to confirm patient understanding	X X X x	
Hazardous Medications (Forster et al)	Plans for proximate follow-up (about one week) tests and/or visits for patients taking (new or changed): ε Warfarin ε Electrolyte-disturbing medications (diuretics) ε CV drugs ε Corticosteroids, or Hypoglycemic agents ε Narcotic analgesics	x	Med specific management
Providers	Identify referring and receiving providers • Record in summary • Contact them and communicate immediate follow-up issues	 X X	
Follow-up Plan:	2 weeks generally, or sooner if hazardous medication or fragile clinical condition. Include any testing and/or provider visit appointments	X x	

Strategies During Hospitalization

- Consider putting together a hospital team to evaluate the literature and reengineer the discharge process in your hospital
  - Research shows increased number of readmissions due to phlebitis so consider annual orientation and credentialing of nurses to start IV
  - Strict adherence to the IV standards such as the IV Nurses Infusion Society Standards of Practice
  - Consider infusion nurses
  - Restart IVs started by squad under less than ideal circumstances
  - Strict adherence to how long IVs can stay in (CDC Intravascular Guidelines)
  - Have a process to ensure all **IVs** and IV access devices are removed prior to discharge

Strategies During Hospitalization

- Evaluate all patients on admission and throughout hospitalization for discharge planning
  - Physical therapist can assess ability to do ADL and environmental barriers in postdischarge care area and what services will be needed after discharge
- Discuss end of life care wishes
  - Some hospitals require code status of all patients upon admission
  - Studies found that often RRT or code called and then after wards patient was made a DNR
  - Pneumonia readmissions may reflect need for end of life care

Strategies During Hospitalization

- Develop community connections to eliminate barriers to successful transition
  - Need to build relationships with other healthcare providers, and public and private groups
  - Parish nurse programs, meals on wheels, etc.
  - Community partners that can help with nonmedical such as behavioral, health literacy, and cultural issues
- Engage families, patients and caregivers
  - Get their active participation, **teach back,**
  - Get their feedback in addressing healthcare delivery issues such as understanding discharge instructions

Strategies at Discharge

- Implement comprehensive discharge planning
  - Should be written out so the patient can understand
  - Should be comprehensive to include **medication** use, activity level, symptoms that patient should call the physician or return,
  - TJC has a discharge tracer
  - Provide discharge plan to patient
  - Make sure PCP gets discharge summary before first post hospital visit

Strategies at Discharge

- Reconcile discharge plan with national guidelines/CPGs
- Standardized checklist of transitional services
- Give patient care record including pending tests and who is responsible for the follow up results
- The detailed written discharge plan should include how to fill prescription along with a list of all medical problems
- Instruct patient to bring plan to all appointments

Strategies at Discharge

- Use **teach back method** to educate the patient and their care giver
  - Have the patient repeat back the instructions in their own words to make sure they understand the discharge instructions
  - Focus handoff information on patient and family
  - Make sure patient repeats back what to do if a problem arises
  - Make sure patient has it in writing the signs and symptoms to watch for

Strategies at Discharge

- Schedule the patient's follow up appointment
  - Make the appointment for all follow up appointments before the patient is discharged
  - Provide name of provider, times and information and directions to the patient in writing
  - The nurse case manager or discharge planner can schedule any further diagnostic tests that were ordered and inform PCP and include in discharge instructions and discharge summary
  - Also want to confirm services to be received before the patient leaves the hospital

Strategies at Discharge

- Develop standardized checklist to assess that all discharge components are completed
- Perform a final physical assessment with attention to the removal of all IV lines or other access ports
- Want to get a timely transfer of the discharge summary to the primary care physician and
- Follow up by telephone 2 to 3 days after discharge to assess optimal care and recovery

Strategies at Discharge

- Standardize the discharge instruction document and include:
  - Primary and secondary diagnosis, patient education, services to be provided
  - Dietary and other lifestyle modifications, medications, follow-up appointments
  - Pending tests
  - Adverse events or complications to watch for, and provider contact information for any problems that occur

Strategies at Discharge

- Assist the patient in managing their medications
  - Give patient complete list of medications at discharge
  - Include times to take and reason
  - Pharmacist role in assisting with understanding new medications or high risk medications
  - Some use MAR to have patient document when meds given
  - Use transitional coach to help
  - RARE program has recommendations for mental health patient

Strategies at Discharge

- Don’t just focus attention on the admitting diagnosis but also on the comorbidities patients have
  - Patients with neoplasm, heart failure, and chronic kidney disease had a higher risk of potentially avoidable readmissions
- When patient is admitted determine if admitted within last 30 days
  - If so some hospitals are doing a RCA or assessment of the reason for readmission
  - 50% to 60% more likely to be admitted again

Strategies at Discharge

- Timing of the physician follow up appointment may be important
  - One hospital found if patient saw doctor day 1-4 the chance of readmission is less than 6%
  - If appointment 6-10 days after discharge readmission rate was 6 to 13%
  - If visits on day 25 then chance went up to 29%
  - Readmission rate increased 1% for every day between discharge and the first physician visit
  - Article published Jan 8, 2014, Detroit Medical Center, Media Health Leaders

Resources from RARE

Gap Analysis for Discharge Planning

RARE Reducing Avoidable Readmissions Effectively

Comprehensive Discharge Planning
Gap Analysis of Best Practices/Strategies for Improvement

Component	Best practice/Strategy	Present	
Discharge Planning – Process	Conduct pre-discharge assessment of ability of patient/family to provide self-care (includes problem solving, decision making, early symptom recognition, and taking action, quality of life, depression and other cognitive and functional ability factors) Develop a comprehensive shared care plan using a shared decision making approach – consider patient values and preferences, social and medical needs Discharge summary and medication plan are complete and up to date Work with patient/family to prepare for the post discharge visit planning (goals, questions, concerns) Work with patient/family to complete		

http://www.rarereadmissions.org

RARE Reducing Avoidable Readmissions Effectively

Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders

The transition period between care settings is the most vulnerable time for patients and their caregivers. The unique vulnerabilities for patients with mental illnesses such as depression, mania, anxiety, schizophrenia and/or substance use disorders* heighten the need for coordinated transitions and aftercare. In 2010, depression was the fourth diagnosis by volume for readmissions in Minnesota according to the Potentially Preventable Readmissions data collected by the Minnesota Hospital Association.

This document is intended for health care professionals who provide care for patients in a variety of settings. It provides basic recommendations in five key areas that are well-recognized core strategies for care transition improvement along with recommendations

The RARE Campaign was established to focus efforts across the state to improve the quality of care for patients transitioning across care systems and to reduce avoidable readmissions by 20% by the end of 2012. For our patients this means 16,000 nights of sleep at home rather than in a hospital bed.

In preparing this document, a group of dedicated mental health stakeholders assembled to engage in dialogue regarding opportunities to improve care transitions for these patients. In addition to completing a literature review, the work group identified aspects associated with care of some mental health patients that can further challenge care transitions such as stigma associated with mental illnesses; siloed and fragmented care; barriers to involving family and/or friends

Strategies at Discharge

- When patient are discharged to LTC make sure transfer summary has detailed instructions
  - Make sure a complete list of medications to be taken are provided
  - Include comprehensive information on hospital care and what needs to be done for continuity of care (see CMS requirements in DP standards)
  - Partner with nursing home practitioners
  - Consider call back to see if any questions
  - Use NP in LTC facility

Strategies Post Discharge

- Promote patient self management
  - Patients with HTN monitor BP at home
  - Diabetics and patients on Coumadin use home monitoring devices
- Use personal health records or patient portals so patients have access to necessary information
  - Lab results, radiology results, request prescription refills, ability to email doctors, nurses, and staff with questions

Strategies Post Discharge

- Follow up with patients via telephone
  - Many of the transition programs involve calls or visits to the patient in the home
  - Some hospitals have the nurse call the patient to reinforce discharge instructions usually in 2-3 days
  - Some have pharmacist visit or call back if on high risk medications
  - Offer telephone support for period post discharge where the patient can call with questions

Strategies Post Discharge

- One author noted that hospitals, physicians, HHAs, nursing homes and pharmacist can prevent more readmissions by working together that hospitals can by improving the discharge process alone
  - Slide presentation on Reducing Avoidable Readmissions by Steve Hines PhD, June 4, 2010
  - Quality of LTC and HHA can drive readmission rates
- Establish community networks
  - Parish nurse programs, meals on wheels
  - Establish private/public partnerships to meet patient needs
  - Homeless shelters with medical care and dental care

Strategies Post Discharge

- The home visit includes an assessment of environmental issues that could result in readmission
  - No food in house, no heat, fall assessment, determine if need transportation for physician visit, make sure any durable medical equipment is connected correctly
  - Understands medications and ensure patient got their prescriptions filled

Strategies Post Acute Care

- Medication adherence
  - Devices that remind patients to take the right medication at the right time
  - Hospitals should take a serious look at this issue
  - Medication non-adherence contributes to 33%-69% of medication related hospital admissions
  - The New England Healthcare Institute estimates that $290 billion of health care expenditures could be avoided each year if medication adherence were improved

- Delate T, Chester EA, Stubbings TW, Barnes CA. Clinical outcomes of a home-based medication reconciliation program after discharge from a skilled nursing facility. Pharmacotherapy. Apr 2008;28(4):444-452.

Strategies Post Acute Care

- Strategies to increase medication adherence include;
- Simplifying the patient's medication regimen
- Identifying if the medication has untoward effects
- Improving patient self-efficacy and activation
- Providing cues or reminders to take medications as prescribed including creation of a patient MAR
  - New England Healthcare Institute. Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease. A NEHI Research Brief July 2009.

Strategies Post Acute Care Technologies

- Philips Medication Dispensing System
  - Dispenses 10-30 days worth of medications
  - Reminds patients to take it
  - Can alert physician and 3 others if pills not removed from dispenser
  - Provides alert and dispensing information
  - Has been shown to reduce hospitalizations
  - Especially good for those with cognitive problem who are on high risk meds such as Coumadin

Strategies Post Acute Care Technologies

- Mini-mental state exam (MMSE) correlates with medication adherence
- Medication reconciliation
  - Software that stores medication information and detects certain problems such as duplicate prescriptions
- Remote patient monitoring
  - Technology to help detect early deterioration of a patient's medical condition

Strategies Post Discharge

- Use telehealth in patient care
  - Technology can be used to help prevent readmissions
  - Use of EHR to support care coordination
  - Monitor patient progress such as electronic cardiac monitoring and remote patient tele-monitoring
  - Medication reminders and dispensers
  - In home diagnostic devices
  - Videoconferencing
  - See Technologies for Improving Post-Acute Care Transitions, September 2010

Strategies Post Discharge

- Hospitals should consider working with their state QIO
  - JAMA study found that hospitals working with QIOs in communities across the country experienced twice the reduction in readmissions compared with those that did not (Jan 23, 2013)
- Consider holding monthly meeting with your various partners such as nursing homes and home health staff
  - One study showed this reduced readmissions by 20.8% (Jan 2014 IPRO-NY's QIO)

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The End! Questions??

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