

Discharge Solutions to Prevent Hospital Readmissions



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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 affect healthcare protocols and practices.

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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

128 STAT. 1952 PUBLIC LAW 113-185—OCT. 6, 2014
Copy of law free at
www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf

Public Law 113-185
113th Congress
An Act
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,
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:
"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 (c)."

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



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

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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

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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.

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Proposed Changes in CMS Discharge Planning in 2017



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 EDays.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-P]

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27840.pdf> and is 125 pages

RIN 0938-AS59

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

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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

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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

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The Conditions of Participation (CoPs)

- CMS has regulations since 1986 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

¹www.gpoaccess.gov/fr/index.html ²www.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. 1/11, 11-29-15)

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

Transmittals for Appendix A

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

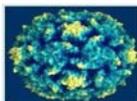
Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module

Hospital Swing Bed Survey Module

Regulations and Interpretive Guidelines

Email questions
hospitalscg@cms.hhs.gov



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:	Room:	Nurse:
Mode: <input type="checkbox"/> amb. <input type="checkbox"/> amb. <input type="checkbox"/> other	BP:	Ht:	Lt:
Vital: <input type="checkbox"/> admittng <input type="checkbox"/> EKG <input type="checkbox"/> O2 <input type="checkbox"/> other	Weight:	<input type="checkbox"/> Patient <input type="checkbox"/> Bed <input type="checkbox"/> Other	
Admitting MD:	Family MD:		
Admitting Diagnosis:			
Chief Complaint: (per patient)			
Allergies:	Latex: <input type="checkbox"/> balloons <input type="checkbox"/> bananas	LATEX	<input type="checkbox"/> latex free diet
Type of Reaction:	<input type="checkbox"/> hives <input type="checkbox"/> anaphylaxis		
Valuable List: (denture jewelry, clothing, etc.)	<input type="checkbox"/> must call <input type="checkbox"/> available	VALUABLE	<input type="checkbox"/> none
<input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Dentures <input type="checkbox"/> Partial/Denture <input type="checkbox"/> Hearing aid <input type="checkbox"/> Refused safe			
Nurse Signature (of other than nurse completing remainder of assessment)			
Part II: Patient History			
Patient History: (major diseases/operations/trauma injuries)			
Hypertension: <input type="checkbox"/> CO/CPD	Diabetes: <input type="checkbox"/> Cancer: <input type="checkbox"/> Anesthesia: <input type="checkbox"/> None		
Heart Disease: <input type="checkbox"/> Asthma	Tobacco: <input type="checkbox"/> Seizures: <input type="checkbox"/> None		
Stroke: <input type="checkbox"/> TB	Liver: <input type="checkbox"/> Mental Disorder: <input type="checkbox"/> None		
Cancer: other: <input type="checkbox"/> Respiratory: other: <input type="checkbox"/> Kidney Disease: <input type="checkbox"/> General: other: <input type="checkbox"/> None			
Specify others not listed above and surgeries:			
Alcohol/Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: <input type="checkbox"/> Daily Awd <input type="checkbox"/> Out	FLU/PRU	<input type="checkbox"/> None
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: <input type="checkbox"/> Daily Awd <input type="checkbox"/> Out		
Admission Diagnosis: AMI, Pneumonia, COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vaccinations:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	ICM	<input type="checkbox"/> None
Flu Shot within past 12 months:			
Pneumonia Shot in past 5 years:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		
Family History:			

Pneumonia Shot in past 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Family History:		
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Asthma <input type="checkbox"/> TB <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney <input type="checkbox"/> Anesthesia		
<input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Mental Disorder <input type="checkbox"/> None <input type="checkbox"/> Other:		
Psychosocial/Economic/Discharge:		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		FINANCE Referral
Family: <input type="checkbox"/> Lives With <input type="checkbox"/> Lives Alone		
Lives In: <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other		
Occupation: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Other		SS or CM Referral
Requests Visit from Business Office Rep or HELP Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity Level: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedrest		
Suspected Abuse/Neglect: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emotional Status: <input type="checkbox"/> Cooperative <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> End of Life		ANXIETY <input type="checkbox"/>
Concerns with Hospitalization: <input type="checkbox"/> Child Care <input type="checkbox"/> Home Life <input type="checkbox"/> Religious/Cultural Practices		POCF#1 <input type="checkbox"/>
Emergency Contact: <input type="checkbox"/> POA <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: <input type="checkbox"/> Phone: <input type="checkbox"/>	ORCF <input type="checkbox"/>
Nearest Relative: <input type="checkbox"/> POA <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: <input type="checkbox"/> Phone: <input type="checkbox"/>	POC #2 <input type="checkbox"/>
Info. Obtained from: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Other		KNOW DEF <input type="checkbox"/>
		POC #3 <input type="checkbox"/>
		SPIRITUAL <input type="checkbox"/>
		POC #4 <input type="checkbox"/>
Page 1 of 4	Patient Label	

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
 - Will update discharge planning with final changes
- 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



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

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

SUBJECT: Public Release of Three Hospital Surveyor Worksheets

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.

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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 personnel 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: / / - / /

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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

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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
- In 2017 2,597 hospital will forfeit \$528 million

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)
- 5th year started October 2016 to Oct 2017
- 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

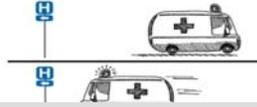
Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties

By Jordan Rau | August 3, 2015
<http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicare-readmission-penalties>

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
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List of Readmission Penalties by Hospital

Medicare Readmission Penalties by Hospital, Year 4
<http://cdn.kaiserhealthnews.org/attachments/MedicareReadmissionPenaltiesByHospital,Year4.pdf>

Medicare Readmission Penalties by Hospital, Year 4

Medicare will apply these readmission 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 psychiatric, 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

Regulation Note: The readmission data in this story and charts is assembled, interpreted and analyzed by KHN using raw 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. KHN's republishing rules can be found [here](#).

Hospital	Address	City	State	ZIP Code	FY2013 Readmission Penalty	FY2014 Readmission Penalty	FY2015 Readmission Penalty	FY2016 Readmission Penalty
ALABAMA MATERNAL MEDICAL CENTER	4711 DIPLOMACY DR	ANCHORAGE	AK	99508	12.73%	10.47%	10.47%	10.54%
ALASKA REGIONAL HOSPITAL	5265 DENAR ROAD	ANCHORAGE	AK	99508	10.00%	10.01%	10.00%	10.01%
BARTLETT REGIONAL HOSPITAL	1200 HOSPITAL DR	BARCELON	AK	99802	10.00%	10.00%	12.27%	10.41%
CENTRAL PENNSYLVANIA GENERAL HOSPITAL	226 HOSPITAL PLAZA	SCARSDALE	AK	99669	10.07%	10.09%	14.41%	13.02%
CONROCK COMMUNITY MEDICAL CENTER	300 BOX DR 400 CONROCK AVENUE	CONROCK	AK	99574	Not Assessed	Not Assessed	Not Assessed	Not Assessed
FAIRBANKS MEMORIAL HOSPITAL	5400 COMLEY STREET	FAIRBANKS	AK	99703	10.00%	10.00%	10.07%	10.13%
KARAKAMAR HOSPITAL	912 BOX DR	ELLINGWOOD	AK	99576	Not Assessed	Not Assessed	Not Assessed	Not Assessed
MAUI JO REGIONAL MEDICAL CENTER	2200 SOUTH WOODNORTH LOOP	PALMER	AK	99645	10.00%	10.01%	10.00%	10.48%
MFT EDGECLIFF HOSPITAL	2222 TONGASS DR	SITKA	AK	99833	10.00%	10.00%	10.00%	10.00%
NEVADA SOUTH REGIONAL HOSPITAL	3300 SHERIDAN AVENUE OFF CAMP	SPRINGFIELD	AK	99782	Not Assessed	Not Assessed	Not Assessed	Not Assessed
PEAK-HEALTH KETCHIKAN MEDICAL CENTER	1330 TONGASS AVENUE	KETCHIKAN	AK	99903	Not Assessed	Not Assessed	Not Assessed	Not Assessed
PITTSBURGH MEDICAL CENTER	400 BOX 100	PITTSBURGH	AK	99813	Not Assessed	Not Assessed	Not Assessed	Not Assessed
PROVIDENT ALASKA MEDICAL CENTER	BOX 10000	ANCHORAGE	AK	99508	10.00%	10.00%	10.00%	10.12%

Hospital	Address	City	State	ZIP Code	Readmission Penalty	Readmission Penalty	Readmission Penalty	Readmission Penalty
BAHLOH MEDICAL CENTER AT TROPHY CLUB	2801 E STATE HIGHWAY 134	TROPHY CLUB	TX	75242	0.00%	0.00%	0.00%	0.00%
BAHLOH MEDICAL CENTER AT UPTOWN	2727 EAST LEMMON AVENUE BUILDING	DALLAS	TX	75204	0.00%	0.00%	0.00%	0.00%
BAHLOH ORTHOPEDIC AND SPINE HOSPITAL	1707 HIGHLANDER BLVD	ARLINGTON	TX	76015	0.00%	0.00%	0.00%	0.00%
BAHLOH REGIONAL MEDICAL CENTER AT GRASSY W COLLEGE ST	GRAPYVINE	GRAPEVINE	TX	76051	0.31%	0.00%	0.00%	0.00%
BAHLOH REGIONAL MEDICAL CENTER AT PLAZA 700 ALLIANCE BOULEVARD	PLAZA 700	PLANO	TX	75093	0.00%	0.00%	0.77%	0.52%
BAHLOH SCOTT & WHITE EMERGENCY MEDICINE EAST WHITESTONE BLVD	EAST WHITESTONE BLVD	CELESTIAL PARK	TX	78613	Not Assessed	Not Assessed	0.40%	0.00%
BAHLOH SCOTT & WHITE MEDICAL CENTER 13400 N INTERSTATE HIGHWAY 35E	13400 N INTERSTATE HIGHWAY 35E	WAKARUSA	TX	75265	0.00%	0.00%	0.68%	0.66%
BAHLOH SURGICAL HOSPITAL AT FORT WORTH 1800 PARK PLACE AVENUE	1800 PARK PLACE AVENUE	FORT WORTH	TX	76120	0.00%	0.00%	2.76%	0.00%
BAHLOH SURGICAL HOSPITAL AT LAS COLINAS 400 WEST INTERSTATE 635 SUITE 100	400 WEST INTERSTATE 635 SUITE 100	IRVING	TX	75063	0.00%	0.00%	0.63%	0.00%
BAHLOH UNIVERSITY MEDICAL CENTER	1550 GASTON AVE	DALLAS	TX	75246	0.00%	0.00%	0.00%	0.00%
BAYSHORE MEDICAL CENTER	4000 SPENCER HWY	PASADENA	TX	77504	0.07%	0.17%	0.26%	0.23%
BAYSIDE COMMUNITY HOSPITAL	200 HOSPITAL DRIVE	ARANSALAC	TX	77534	Not Assessed	Not Assessed	Not Assessed	Not Assessed
BEVILLVILLE GENERAL HOSPITAL	44 N CUMMINGS	BEVILLVILLE	TX	77828	0.47%	0.51%	0.71%	0.31%
BIG BEND REGIONAL MEDICAL CENTER	2800 HIGHWAY 138 NORTH	ALPINE	TX	79830	Not Assessed	Not Assessed	Not Assessed	Not Assessed
BOWIE MEMORIAL HOSPITAL	705 EAST GREENWOOD AV	BOWIE	TX	76230	0.64%	0.63%	0.73%	0.70%
BRAZOSPORT REGIONAL HEALTH SYSTEM	1001 MEDICAL DRIVE	LAKE JACKSON	TX	77566	0.00%	0.00%	2.14%	1.40%
BROWNFIELD REGIONAL MEDICAL CENTER	705 EAST FELT STREET	BROWNFIELD	TX	79316	0.00%	0.00%	0.00%	0.36%
BROWNWOOD REGIONAL MEDICAL CENTER	1550 BUNNET DR	BROWNWOOD	TX	76805	0.00%	0.00%	0.26%	0.27%
BURLESON ST JOSEPH HEALTH CENTER	1100 BLOSSOM DRIVE	CALDWELL	TX	77936	Not Assessed	Not Assessed	Not Assessed	Not Assessed
CARE REGIONAL MEDICAL CENTER	1711 W WHEELER AVENUE	ARANSALAC	TX	77836	0.00%	0.00%	0.00%	0.00%
CEDAR PARK REGIONAL MEDICAL CENTER	1401 MEDICAL PARKWAY	CEDAR PARK	TX	78613	0.79%	0.52%	0.57%	1.33%
CENTENNIAL MEDICAL CENTER	12505 LEBANON ROAD	PRISCO	TX	75085	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%
COS ST LOUIS HEALTH BAYLOR COLLEGE OF	6720 BETHUR	HOUSTON	TX	77030	0.00%	0.00%	0.00%	0.00%
CHILDRESS REGIONAL MEDICAL CENTER	1945 N NORTH	CHILDRESS	TX	79201	0.32%	0.27%	0.20%	0.00%
CHILUCOTHE HOSPITAL DISTRICT	303 AVENUE I	CHILUCOTHE	TX	79225	Not Assessed	Not Assessed	Not Assessed	Not Assessed
CHRISTUS HOSPITAL	2880 CALDER AVENUE	BEAUMONT	TX	77702	0.07%	0.26%	0.31%	0.19%
CHRISTUS JASPER MEMORIAL HOSPITAL	1275 MARVIN HANCOCK DRIVE	JASPER	TX	75955	0.00%	0.00%	0.00%	0.25%
CHRISTUS SANTA ROSA HOSPITAL	333 NORTH SANTA ROSA STREET	SAN ANTONIO	TX	78207	0.00%	0.00%	0.00%	0.00%
CHRISTUS SPHYNX HOSPITAL ALICE	2500 E MAIN STREET	ALICE	TX	78012	0.55%	0.00%	0.00%	0.00%
CHRISTUS SPHYNX HOSPITAL WEFVILLE	1300 E HODGSON HWY	WEFVILLE	TX	78070	0.00%	0.00%	0.15%	0.10%

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. Keener and colleagues demonstrated this relationship in Health Services Research.

Are Safety Net Hospitals Penalized?

- Looking at readmissions for MI, CHF, pneumonia
 - Added hip or knee replacement (TKA, THA) and COPD
 - 2017 added CABG Readmission
 - Updated 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
- 2017 2,597 hospitals are penalized 528 million

Patient Mix Penalizes Safety Net Hospitals

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Johns Commons, for HealthLeaders Media, September 29, 2015

HealthLead95
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.

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, sex, and diagnosis—



Michael L. Barnett, MD

GAO Report



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)

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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

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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).

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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

www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html

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

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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-based purchasing, to pay hospitals for their actual performance
- Included initiatives to prevent hospital readmission through a comprehensive program for hospital discharge planning

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CMS Website Hospital Readmissions

Medicare.gov | Hospital Compare 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 "predefined" 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

Hospital Name	Provider Number	State	Measure Name
1 SOUTHEAST ALABAMA MEDICAL CENTER	01001	AL	READM-30-AM-HRRP
2 SOUTHEAST ALABAMA MEDICAL CENTER	01001	AL	READM-30-COPD-HRRP
3 SOUTHEAST ALABAMA MEDICAL CENTER	01001	AL	READM-30-HF-HRRP
4 SOUTHEAST ALABAMA MEDICAL CENTER	01001	AL	READM-30-IP-KNEE-HRRP
5 SOUTHEAST ALABAMA MEDICAL CENTER	01001	AL	READM-30-IP-TH-HRRP
6 MARSHALL MEDICAL CENTER SOUTH	01005	AL	READM-30-AM-HRRP
7 MARSHALL MEDICAL CENTER SOUTH	01005	AL	READM-30-COPD-HRRP

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CMS Guide to Preventing Readmissions

- 2016 CMS Office of Minority Health releases a guide to reduce readmissions
- Notes racial and ethnic minority patients are more likely than their white counterparts to be readmitted within 30 days
- Readmission rates higher for CHF, MI, and pneumonia
- Seven key recommendations for hospitals
- Concrete examples of initiatives and strategies
- The Guide was developed in collaboration with the Disparities Solutions Center at Massachusetts General Hospital and the National Opinion Research Center (NORC) at the University of Chicago as part of the CMS Equity Plan for Improving Quality in Medicare

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CMS Guide to Preventing Readmissions

CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries

Date 2016-01-26
Title CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
Contact go.cms.gov/media

CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries

Today, the Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH), released a new Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries.

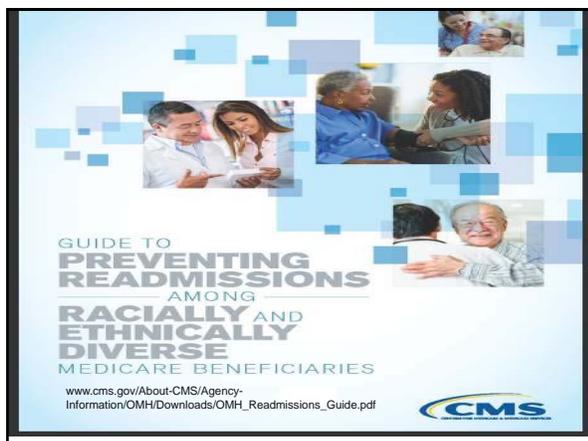
The Guide was developed in collaboration with the Disparities Solutions Center at Massachusetts General Hospital and the National Opinion Research Center (NORC) at the University of Chicago as part of the [CMS Equity Plan for Improving Quality in Medicare](#), and is designed to assist hospital leaders and stakeholders focused on quality, safety, and care redesign in identifying root causes and solutions for preventing avoidable readmissions among racially and ethnically diverse Medicare beneficiaries.

"CMS has an important opportunity and a critical role in preventing hospital readmissions while promoting health equity among diverse Medicare beneficiaries," said Cara James, Director of CMS's Office of Minority Health. "This Guide encourages action-oriented steps and solutions in achieving health equity, addresses reducing readmissions and focuses on our initiative of achieving better care, smarter spending, and healthier people throughout our health care system."

Racial and ethnic minority populations are more likely than their white counterparts to be readmitted within 30 days of discharge for certain chronic conditions, such as heart failure, heart attack, and pneumonia, among others. Social, cultural, and linguistic barriers contribute to these higher readmission rates.

The Guide provides:

- New, action-oriented guidance for addressing avoidable readmissions in this population by providing an



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

<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, or the United States government.

Title	Description
"Project RED (the 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 Transitional CareRN, 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)	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 measurable 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.healthcarenewsletters.com/subscribe.html

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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. Rensing

This issue sponsored by

The Sixth National Accountable Care Congress and the
The Eleventh National Value-Based Payment and Pay for Performance Summit

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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

The Drivers of
Readmissions and

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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

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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

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 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 assessing intervention administered
Problems and symptoms (medications, tests, and symptoms) apply # complete and correct, status, and other	1) Medication specific education using Teach Back provided to patient and caregiver 2) Monitoring plan developed and communicated to patient and adherence providers, where relevant (e.g. warfarin, digoxin and insulin) 3) Specific strategies for managing adverse drug events reviewed with patient/caregiver 4) Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression, anxiety, or other)	1) Assessment of need for psychiatric adherence of care in place 2) Communication with adherence providers, highlighting this issue if new 3) Involvement/treatment of support network initiated	
Principal diagnosis (cause, acute, etc.) (ORX, most likely)	1) Review of national discharge guidelines, where available 2) Disease specific education using Teach Back with patient/caregiver 3) Action plan reviewed with patient/caregiver regarding what to do and who to contact in the event of worsening or new symptoms 4) Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polyparmacy (5+ new or total meds)	1) Elimination of unnecessary medications 2) Simplification of medication scheduling to improve adherence 3) Follow-up phone call at 72 hours to assess adherence and complications	
Post health literacy (ability to do Teach Back)	1) Communication caregiver involved in planning administration of all general and risk specific interventions 2) Adherence plan education using Teach Back provided to patient and caregiver 3) Link to community resources for additional patient/caregiver support 4) Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of resources to assist with discharge and home care)	1) Follow-up phone call at 72 hours to assess conditions, adherence and complications 2) Follow-up appointment with adherence medical provider within 7 days 3) Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (re-admission, in last 6 months)	1) Review reasons for re-hospitalization in context of prior hospitalization 2) Follow-up phone call at 72 hours to assess conditions, adherence and complications 3) Follow-up appointment with adherence medical provider within 7 days	
Palliative care (What you do expect of this patient and the care team) Does the patient have an advanced or progressive illness? Yes or other	1) Address need for palliative care services 2) Identify goals of care and therapeutic options 3) Communicate prognosis with patient/family/caregiver 4) Assess and address holistic symptoms 5) Identify services or benefits available to patients based on advanced disease status 6) 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

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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

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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

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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

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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

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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

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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

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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 CARE DELIVERY RESEARCH
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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

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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

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1 in 5 Discharges Have Abnormal VS

- 2016 study found 20% patients had abnormal vital signs such as elevated HR or low BP
- Found this was associated with increased risk of death and hospital readmissions
 - Looked at EHRs of 32,835 patients at six Dallas hospitals
- Discharge guidelines should include objective VS criteria
- Patients with 2 or more instabilities should most likely remain in the hospital
 - Nguyen, O.K., Makam, A.N., Clark, C. et al. J GEN INTERN MED (2016). doi:10.1007/s11606-016-3826-8

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2016 Study Finds 1 in 5 Discharged Abn VS

1 in 5 are discharged from hospital with unstable vital signs, and experience higher readmission and death rates

Aug 09, 2016 www.utsouthwestern.edu/newsroom/news-releases/year-2016/august/vital-signs-discharge-halm.html



Dr. Canh Nguyen (left), Dr. Anil Makam (center), and Dr. Ethan A. Halm (right) of UT Southwestern's Center for Patient-Centered Outcomes Research.

DALLAS — August 9, 2016 — Twenty percent of people hospitalized are released before all vital signs are stable, a pattern that is associated with an increased risk of death and hospital readmission, a new study by UT Southwestern Medical Center researchers shows.

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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 screenshot shows the top portion of a NEJM article page. The header includes the NEJM logo and the text 'The NEW ENGLAND JOURNAL of MEDICINE'. Below the header is a navigation bar with links for 'HOME', 'ARTICLES & MULTIMEDIA', 'ISSUES', 'SPECIALTIES & TOPIC', 'FOR AUTHORS', and 'CME'. The main title of the article is 'Perspective Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk' with the URL 'www.nejm.org/doi/full/10.1056/NEJMp1212324'. The author is listed as 'Harlan M. Krumholz, M.D.' and the publication date is 'N Engl J Med 2013; 368:1000-1002 | January 10, 2013 | DOI: 10.1056/NEJMp1212324'. There are social media share icons for Facebook, Twitter, LinkedIn, and YouTube. Below the title, there are tabs for 'Article' and 'References'. The 'Article' tab is active, showing the beginning of the text: '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 misguided. 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...'. There is also an 'Audio Interview' section with a small video player showing Dr. Harlan Krumholz.

The screenshot shows a news article from AHA News. The title is 'Telemedicine Reduces Readmission' with the date '10/5/2015 AHA News'. The article features a 'CHAIRMAN'S FILE' banner with the AHA logo and the tagline 'hospitals in pursuit of excellence'. Below the banner is a photo of a man in a suit and tie. The text of the article reads: '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...'. The article is dated 10/5/2015.

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,

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 hospital 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 readmissions 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 readmissions 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 measure.

Out of 4284 hospitals in the United States --	20 hospitals were better than national rate	2272 hospitals were no different than national rate	23 hospitals were worse than national rate
Out of 189 hospitals in Ohio --	0 hospitals were better than national rate	84 hospitals were no different than national rate	0 hospitals were worse than national rate
	2088 hospitals did not have enough cases to reliably tell how well they are performing		
	68 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 6 Rate of readmission for heart attack patients

The rates reported in this table were calculated from Medicare and VA data on patients discharged between July 1, 2008 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 = 18.2%

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 Outcomes for additional information about the data collection for the readmission measure.

Out of 4844 in the United States --	23 hospitals in the United States were better than U.S. National Rate	2227 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
Out of 187 in Ohio --	0 hospital was better than U.S. National Rate	86 hospitals were No different than U.S. National Rate	0 hospital was 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		

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

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TOPICS PUBLICATIONS SURVEYS AND DATA GRANTS & FELLOWSHIPS

Improving Care for Those Who Need It Most

This Commonwealth Fund multimedia article offers a look inside the many challenges high-need, high-cost patients face on a daily basis, and about new approaches that have been developed to help providers segment their patient populations and tailor treatments.

MRI exams

Many Good Resources Commonwealth Website

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

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Preventing Readmissions with Improved Hospital Discharge Planning

January 7, 2010
Authors: A. K. Jha, E. J. Orav, and A. M. Epstein
Journal: New England Journal of Medicine, Dec. 31, 2009 361(27):2637-2645
Summary Writers: Deborah Lorber

View Citation E-mail Share Add To My Library Comments (0)
Print

Studies have shown that readmission rates in U.S. hospitals vary widely. Too often, the quality of care provided to patients during their transition from hospital to home or other care settings is poor: discharge instructions are not properly communicated, hospital and ambulatory care health records are not reconciled, or arrangements for follow-up care are not made. These shortcomings have captured the attention of policymakers and officials from the Centers for Medicare and Medicaid Services (CMS) and prompted efforts to collect and report data on discharge practices. In this

▪ <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

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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

Tags

- 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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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.

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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?

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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

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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

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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 of readmission
 - See chart on next page

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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

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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

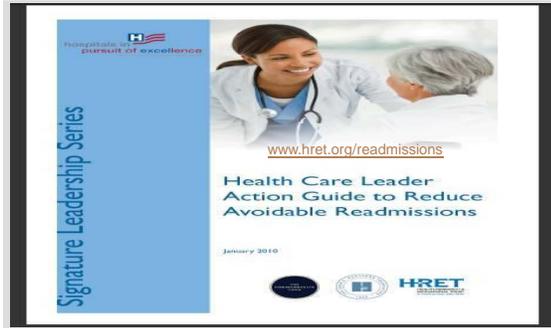
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AHA Reducing Avoidable Hospital Readmissions

- 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

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AHA Guide to Reduce Readmissions



AHA 4 Steps

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

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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

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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

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Strategies During Hospital

- 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

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Ideal Discharge for the Elderly Patient: A Hospitalist checklist

Checklist Element	Particulars	Must Keep	Optional
Medication Education	<ul style="list-style-type: none"> • Written schedule of medication • Include Purpose (reason) and (if apt) Cautions(s) for each medication • Clinical Pharmacist involvement (especially if cognitive impairment, or ≥ 3 Medication changes) 	x	x
Cognition	Rather than a Folstein score, some description mention of mental capacity such as: <ul style="list-style-type: none"> • Lucid (full) capacity for understanding and executive function, such as being able to follow instructions • Forgetful (some senescence or impairment of memory) • Dementia (or "Brain Failure" - incapable of reliable recall and/or executive function) 		x x x
Discharge Summary	Needs to be written with the receiving caregiver in mind, including: <ul style="list-style-type: none"> • Presenting problem(s) that precipitated hospitalization • Primary and secondary diagnoses • Key findings and test results • Brief hospital course • Discharge Med Reconciliation (see above) • Condition at discharge (including functional status and cognitive status, if relevant) • Discharge Destination (and rationale if not obvious) 	x x x x x x	Cognitive status

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	<ul style="list-style-type: none"> • 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	e Provide instructions written at 6 th grade level e Any anticipated problem(s) and suggested intervention(s) e 24/7 call-back number e 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): <ul style="list-style-type: none"> e Warfarin e Electrolyte-disturbing medications (diuretics) e CV drugs e Corticosteroids, or Hypoglycemic agents e Narcotic analgesics 	x	Med specific management
Providers	Identify referring and receiving providers <ul style="list-style-type: none"> • 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	

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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.

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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

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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

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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

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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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Thanks for attending! Questions??



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