Discharge Solutions to Prevent Hospital Readmissions

Sue Dill Calloway

RELIAS LEARNING

Speaker

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Objectives

1. Explain the ‘teach back’ method and how it can be used to reduce hospital readmissions.
2. Discuss the importance of sending a discharge summary to the primary care physician before the first post-hospital visit.
3. Outline methods for hospitals to reduce unnecessary readmissions.

Discharges
What's New and the IMPACT Act

RELIAS | LEARNING

IMPACT Act

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

IMPACT Act

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

Public Law 113–185
113th Congress

An Act

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

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

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

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

SECTION 1. SHORT TITLE.

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

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

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

42 USC 1395lll.

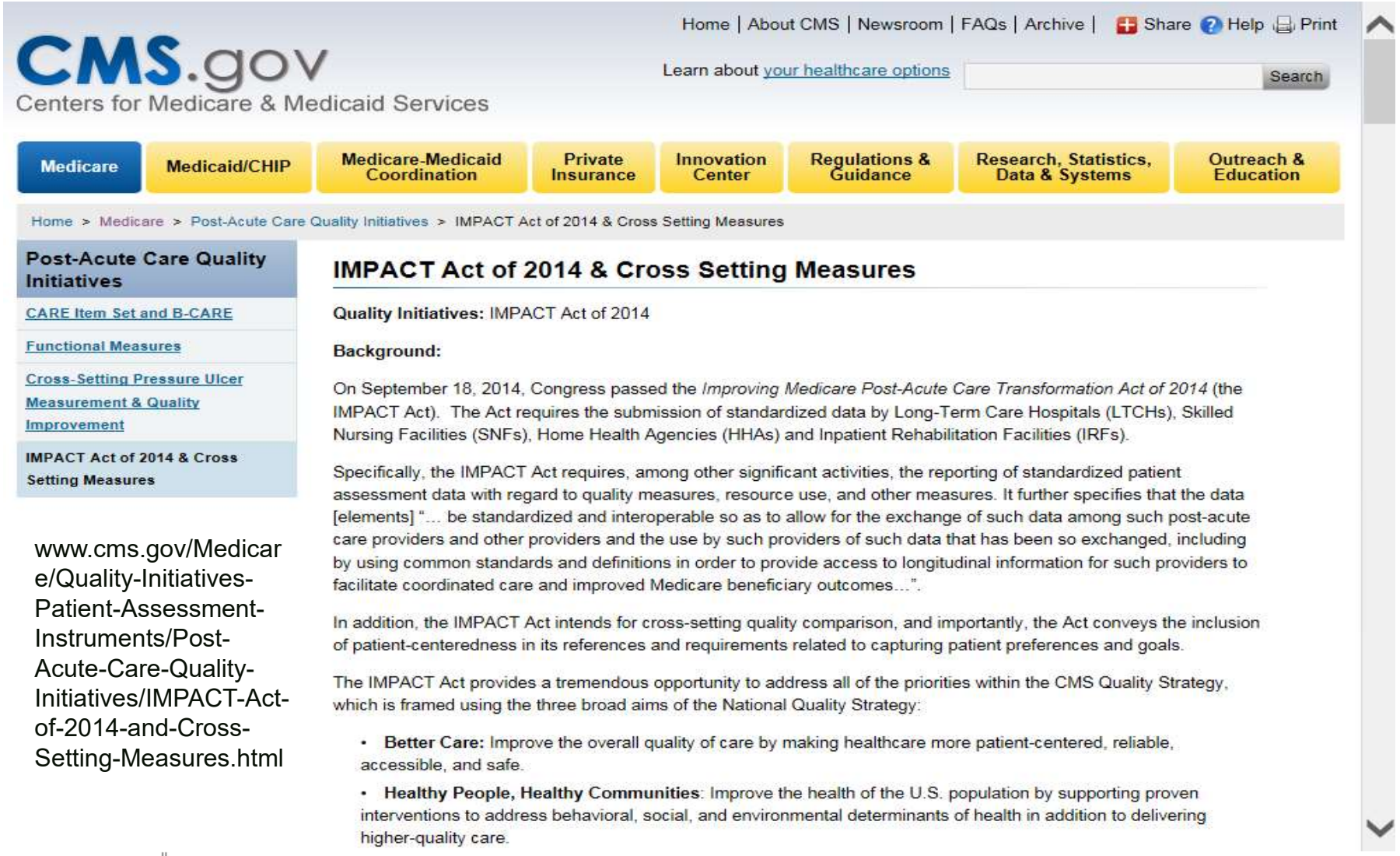
"SEC. 1899B. STANDARDIZED POST-ACUTE CARE (PAC) ASSESSMENT DATA FOR QUALITY, PAYMENT, AND DISCHARGE PLANNING.

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

IMPACT Act

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

CMS Website on IMPACT Act



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

Post-Acute Care Quality Initiatives

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

IMPACT Act of 2014 & Cross Setting Measures

Quality Initiatives: IMPACT Act of 2014

Background:

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

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

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

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

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

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

Standardize Patient Assessments

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

Standardize Patient Assessments

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

Quality Measures to be Reported

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

Reporting of Quality Measures

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

Table 1: Timeline for New Quality Domains*				
Quality Domains	**HHAs**	**SNFs**	**IRFs**	**LTCHs**
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018
*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.				

Proposed Changes in CMS Discharge Planning in 2018

RELIAS | LEARNING

Discharge Planning Proposed Changes

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-P]

RIN 0938-AS59

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

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

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

ACTION: Proposed rule.

CMS Proposed Discharge Planning

FEDERAL REGISTER

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

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

Part IV

Department of Health and Human Services

Centers for Medicare and Medicaid Services

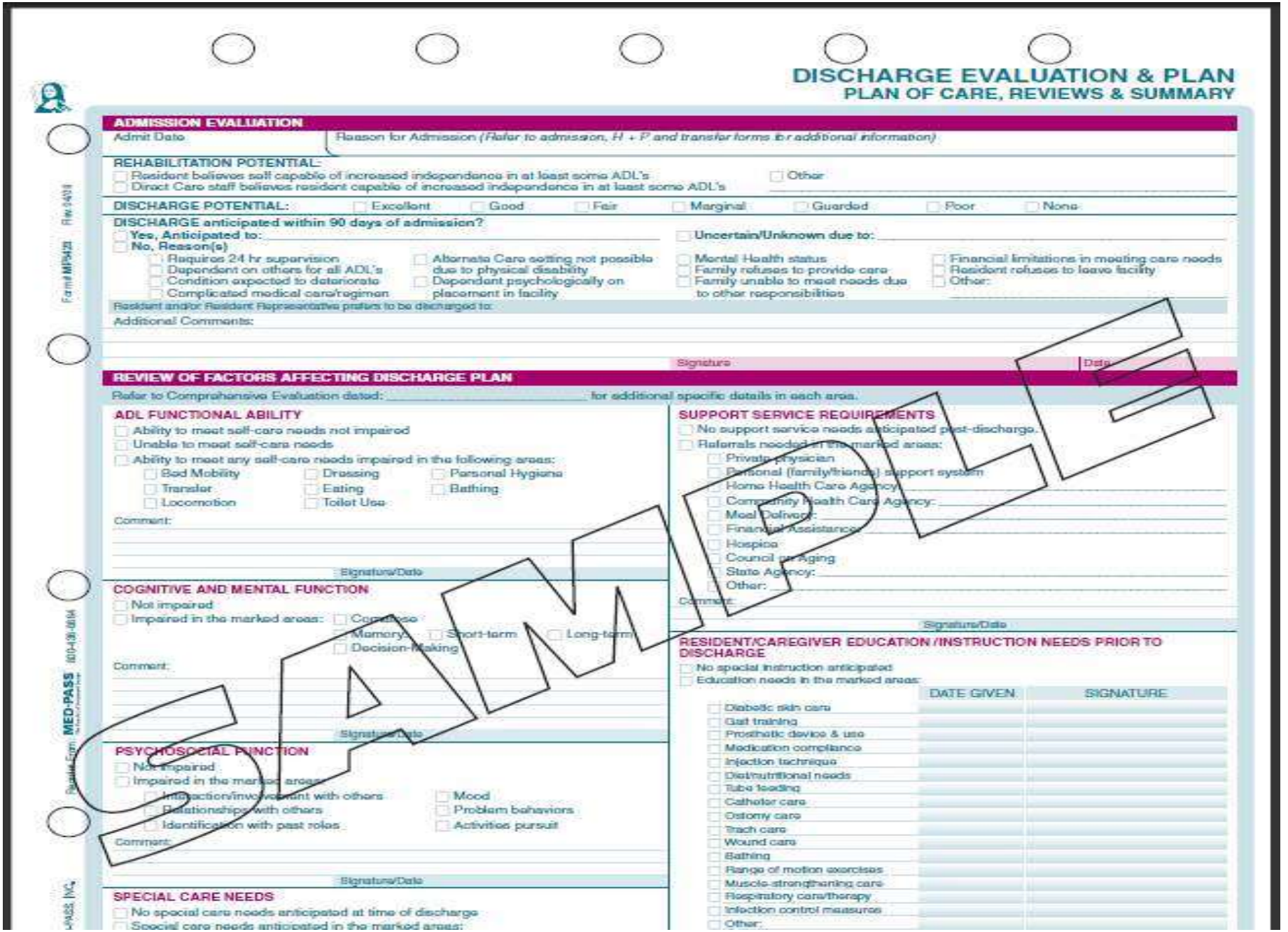
42 CFR Parts 482, 484, 485
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule

Proposed Discharge Planning Changes

- Hospitals will be required to use data to assist patients during discharge planning process
  - Must take into consideration patient's goals and patient preferences
- Would need to incorporate many 8 things into the discharge plan evaluation so will need to redo the form
  - Such as admitting diagnosis, relevant co-morbidities, past medical history, past surgical history, anticipated needs, readmission risk, and relevant psychosocial history and more
- Must do discharge plan within 24 hours

CMS Hospital CoPs Proposed Changes

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



DISCHARGE EVALUATION & PLAN
PLAN OF CARE, REVIEWS & SUMMARY

ADMISSION EVALUATION

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

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

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

DISCHARGE anticipated within 90 days of admission?
- Yes, Anticipated to:
- Uncertain/Unknown due to:
- No, Reason(s)
  - Requires 24 hr supervision
  - Dependent on others for all ADL's
  - Condition expected to deteriorate
  - Complicated medical care/regimen
  - Alternate Care setting not possible due to physical disability
  - Dependent psychologically on placement in facility
  - Mental Health status
  - Family refuses to provide care
  - Family unable to meet needs due to other responsibilities
  - Financial limitations in meeting care needs
  - Resident refuses to leave facility
  - Other:

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

Additional Comments:

Signature | Date

REVIEW OF FACTORS AFFECTING DISCHARGE PLAN

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

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

Comment:

Signature/Date

COGNITIVE AND MENTAL FUNCTION
- Not impaired
- Impaired in the marked areas:
  - Conclusive
  - Memory
  - Short-term
  - Long-term
  - Decision-Making

Comment:

Signature/Date

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

Comment:

Signature/Date

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

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

Comment:

Signature/Date

RESIDENT/CAREGIVER EDUCATION /INSTRUCTION NEEDS PRIOR TO DISCHARGE
- No special instruction anticipated
- Education needs in the marked areas:

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

SAMPLE

CMS Hospital CoPs Proposed Changes

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

CMS Hospital CoPs on Discharge Planning

RELIAS | LEARNING

The Conditions of Participation (CoPs)

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

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

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual

Appendix

Email questions **hospitalscg@cms.hhs.gov**

- 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. 151, 11-20-15)

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

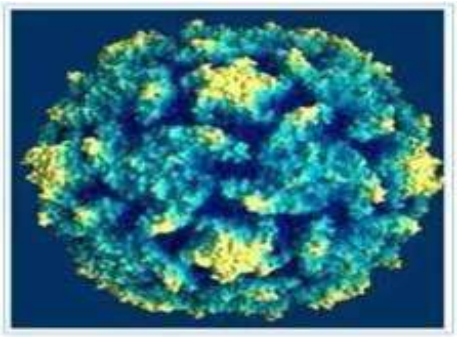
Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module

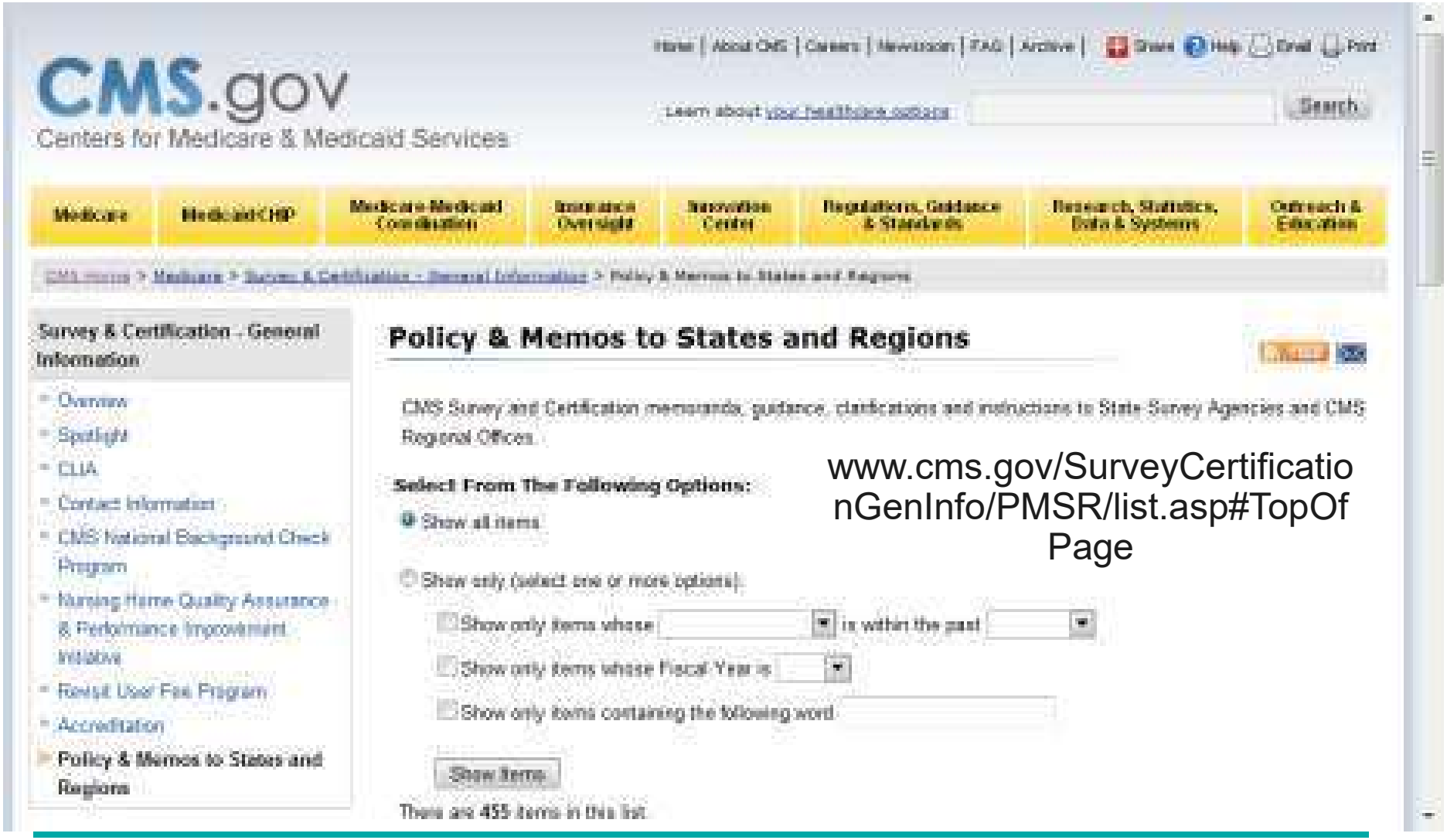
Hospital Swing-Bed Survey Module

Regulations and Interpretive Guidelines

Email questions
hospitalscg@cms.hhs.gov



CMS Survey and Certification Website



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

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Impact of Nursing Shortage on Hospice Care	17-01-Hospice	2016-10-21	2017
Save the Date: Training for Phase 1 Implementation of New Nursing Home Regulations	17-03-NH	2016-10-24	2017
Release of the Fiscal Year (FY) 2017 Dialysis Facility Reports (DFR) and End Stage Renal Disease (ESRD) Core Survey Materials	17-02-ESRD	2016-10-21	2017
Transplant Centers: Clinical Experience Requirements	17-04-Transplant	2016-10-28	2017
Information on the Implementation Plans for the Emergency Preparedness Regulation	17-05-ALL	2016-10-28	2017
Fiscal Year (FY) 2015 Minimum Data Set (MDS) Focused Survey Summary	17-06-NH	2016-11-04	2017
Advance Copy - Revisions to State Operations Manual (SOM), Appendix PP-Revised Regulations and Tags	17-07-NH	2016-11-09	2017
Civil Money Penalty (CMP) Reinvestment Resource Web Page	17-08-NH	2016-11-18	2017
Infection Control Pilot: 2017 Update	17-09-ALL	2016-11-18	2017
Critical Access Hospital (CAH) Appendix W Revisions	17-10-CAHs	2016-12-01	2017

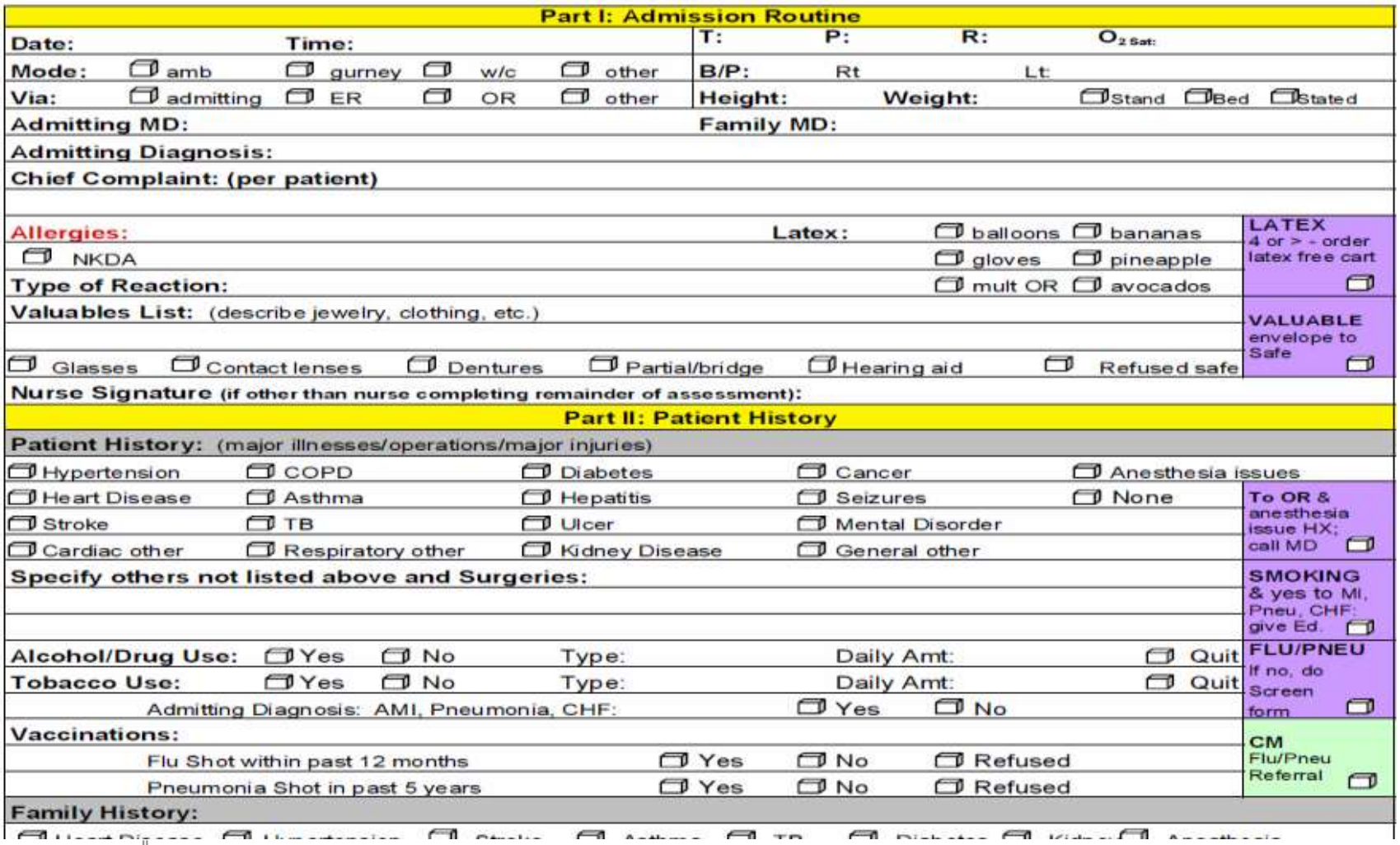
Discharge Planning Memo

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

Discharge Planning

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

Nurses Admission Assessment



Part I: Admission Routine

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

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

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

Admitting MD: **Family MD:**

Admitting Diagnosis:

Chief Complaint: (per patient)

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

☐ NKDA ☐ gloves ☐ pineapple

Type of Reaction: ☐ mult OR ☐ avocados

LATEX 4 or > - order latex free cart ☐

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

VALUABLE envelope to Safe ☐

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

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

Part II: Patient History

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

☐ Hypertension	☐ COPD	☐ Diabetes	☐ Cancer	☐ Anesthesia issues
☐ Heart Disease	☐ Asthma	☐ Hepatitis	☐ Seizures	☐ None
☐ Stroke	☐ TB	☐ Ulcer	☐ Mental Disorder	
☐ Cardiac other	☐ Respiratory other	☐ Kidney Disease	☐ General other	

To OR & anesthesia issue HX; call MD ☐

Specify others not listed above and Surgeries:

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

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

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

FLU/PNEU If no, do Screen form ☐

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

Vaccinations:

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

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

CM Flu/Pneu Referral ☐

Family History:

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

Family History:

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

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

Psychosocial/Economic/Discharge:

Marital Status: ☐ Married ☐ Single ☐ Widowed

Family: ☐ Lives With ☐ Lives Alone

Lives In: ☐ Home ☐ Nursing Home ☐ Other

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

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

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

Suspected Abuse/Neglect: ☐ Yes ☐ No

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

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

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

Nearest Relative: Relation: Phone:

Info. Obtained from: ☐ Patient ☐ Family ☐ Other

FINANCE Referral ☐

SS or CM Referral ☐

ANXIETY ☐ poc#1

GRIEF ☐ poc #2

KNOW DEF poc #3 ☐

SPIRITUAL poc #4 ☐

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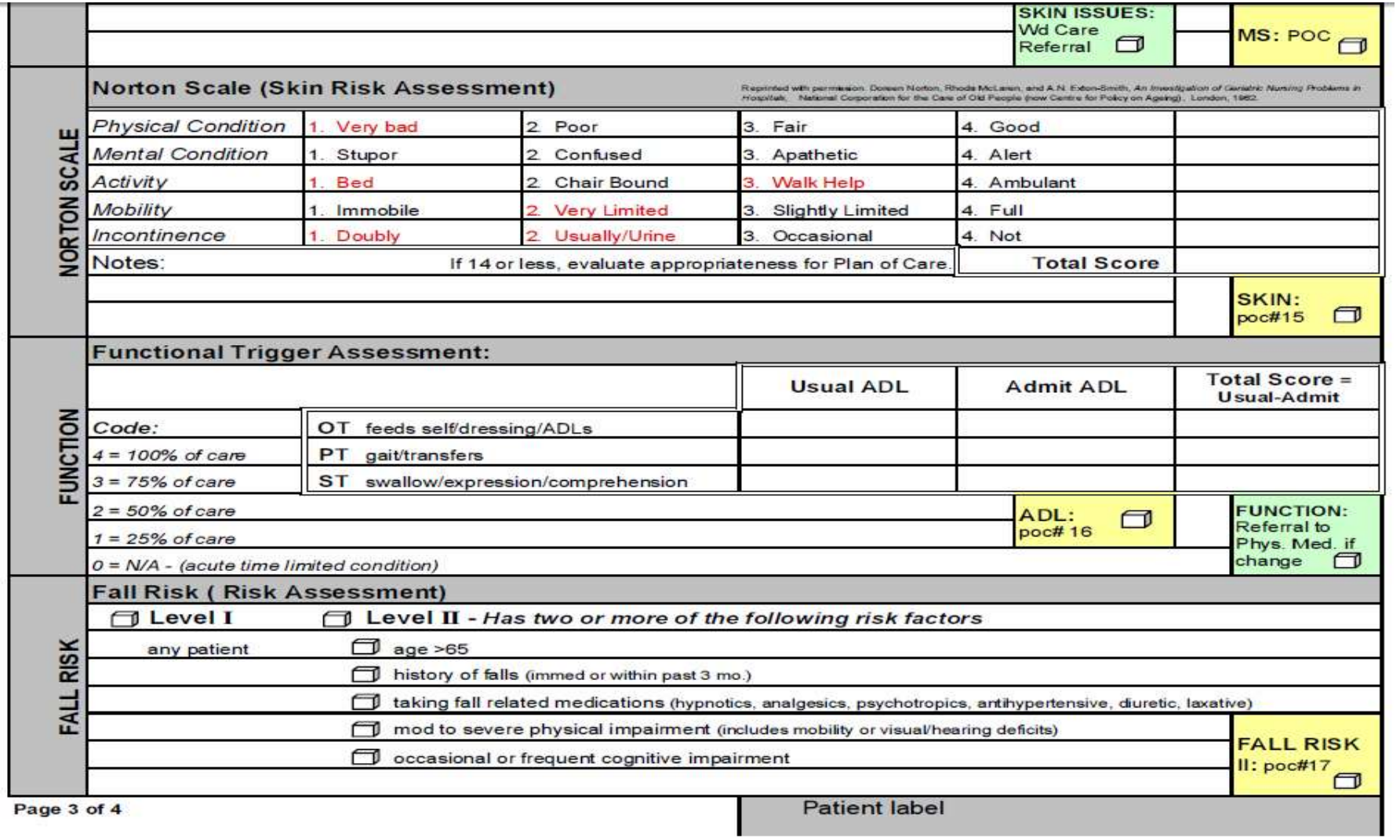
Patient Label

Functional Assessment



SKIN ISSUES: Wd Care Referral ☐

MS: POC ☐

NORTON SCALE

Norton Scale (Skin Risk Assessment)

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

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

SKIN: poc#15 ☐

FUNCTION

Functional Trigger Assessment:

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

2 = 50% of care

1 = 25% of care

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

ADL: poc# 16 ☐

FUNCTION: Referral to Phys. Med. if change ☐

FALL RISK

Fall Risk (Risk Assessment)

☐ **Level I** any patient

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

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

FALL RISK II: poc#17 ☐

Page 3 of 4

Patient label

Discharge Planning

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

Discharge Planning

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

Discharge Planning

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

CMS Worksheet
Discharge Planning

RELIAS | LEARNING

CMS Hospital Worksheets History

- 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

SUBJECT: Public Release of Three Hospital Surveyor Worksheets

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

Memorandum Summary

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

Final Discharge Planning Evaluation Tool

Centers for Medicare & Medicaid Services

Hospital Discharge Planning Worksheet

Name of State Agency: _____

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

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

Section 1 Hospital Characteristics

1. Hospital name: _____
2. CMS Certification Number (CCN): ☐☐☐☐☐☐
3. Date of site visit:

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

Discharge Planning Worksheet P&P

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

Discharge Planning P&P

Section 2 Discharge Planning – Policies and Procedures		
Elements to be assessed		**Surveyor Notes**
2.1 Implementation of discharge planning policies and procedures for inpatients:		
2.1a For every inpatient unit surveyed is there evidence of applicable discharge planning activities?	○ Yes ○ No	
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	○ Yes ○ No	
NOTE: If no for either 2.1a or 2.1b the hospital would be at risk on a non-PSI, non-pilot survey for a deficiency citation related to identification of patients needing discharge planning, 42 CFR 482.43(a) (Tag A-0800); discharge planning evaluation, 42 CFR 482.43(b) (Tag A-0806); and/or developing and implementing the discharge plan, 42 CFR 482.43(c) (Tag A-0818)		
2.2 Does the discharge planning process apply to certain categories of outpatients?	○ Yes ○ No	
If yes, check all that apply: ○ Same day surgery patients ○ Observation patients who are not subsequently admitted ○ ED patients who are not subsequently admitted ○ Other		
2.3 Is a discharge plan prepared for each inpatient?	○ Yes, skip to question 2.8 ○ No, go to question 2.4	

Are Staff Aware of Your DP Policy?

DISCHARGE PLANNING

PURPOSE:

To promptly identify patient discharge needs.

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

POLICY:

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

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

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

A. Social Services Consults

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

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

Preventing Unnecessary Readmissions

RELIAS | LEARNING

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 which is now at 3% rate
- 2 million Medicare patients are readmitted within 30 days per year
- In 2018, the 6th year, there were 2,573 hospital who will forfeit $564 million
- In 2017, added CABG and changed how pneumonia readmissions are calculated

Hospitals Penalized for Excess Readmissions

- 2017 more than half of the hospitals are penalized for higher 30 day readmission rates
- By 2017 nearly $1 billion in penalties have been imposed so far
- In 2017, the number of hospitals penalized was about the same as last year
- It's just the amount hospitals were penalized was the largest at 564 million in 2018
- National readmission rates have dropped since the Hospital Readmissions Reduction Program HRRP

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 gives 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 and down to **15.6% in 2017**
- 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

Hospital Readmissions Reduction Program

- Kaiser found 1,621 hospitals have been penalized in all five years
- Excess readmissions are measured by a ratio
- This is calculated by dividing a hospital's number of predicted" 30-day readmissions by the number that would be "expected based on an average hospital with similar patients
  - This is done for heart attack (AMI), heart failure (HF), pneumonia (PN), hip/knee replacement, (THA/TKA) and COPD and CABG added 2017
  - A ratio greater than 1.0000 indicates excess readmissions

Hospital Readmissions Reduction Program

- The fines in 2017 are based on data of Medicare patients who left the hospital from July 2012 and June 2015
- The payment cuts apply to all Medicare patients
- Not just those with the 6 conditions
- 49 hospitals received the maximum fine
- The average penalty was 0.73% of each Medicare payment
- This is up from 0.61% last year and higher than in any other year

Hospital Readmissions Reduction Program

- One reason the penalty is up is also due to the addition of coronary bypass graft surgery or CABG
- Maximum reimbursement does not affect special Medicare payments for hospitals that treat large numbers of low-income patients or train residents
- Hospitals receive information on the FY2017 results in their hospital-specific report or HSRs
- This includes a summary of their results and the national observed readmission rates
- These are provided via the QualityNet portal

Hospital Readmissions Reduction Program

- The chart on the next page lists the readmission penalty for each hospital
- It lists the following:
  - Hospital name, provider number and state
  - Measure name such as readmission for CABG, HF. PN, etc.
  - The number of discharges and readmissions
  - Excess and predicted readmission rate
  - Expected readmission rate
  - Start and end date of the data

List of Hospital Penalties 2017

Hospital Readmissions Reduction Program

In October 2012, CMS began reducing Medicare payments for Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions. Excess readmissions are measured by a ratio, by dividing a hospital's number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia, COPD, hip/knee replacement, and coronary artery bypass graft surgery by the number that would be "expected," based on an average hospital with similar patients. A ratio greater than 1.0000 indicates excess readmissions.

More information on how payments are adjusted.

More on the calculations.

Hospital Readmissions Reduction Program data

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

Data.Medicare.gov

MENU

Hospital Readmissions Reduction Program

	Hospital Name	Provider Number	State	Measure Name
1	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-AMI-HRRP
2	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-CABG-HRRP
3	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-COPD-HRRP
4	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-HF-HRRP
5	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-HIP-KNEE-HRRP
6	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-PN-HRRP
7	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-AMI-HRRP
8	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-CABG-HRRP
9	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-COPD-HRRP
10	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-HF-HRRP
11	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-HIP-KNEE-HRRP
12	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-PN-HRRP
13	ELIZA COFFEE MEMORIAL HOSPITAL	010006	AL	READM-30-AMI-HRRP
14	ELIZA COFFEE MEMORIAL HOSPITAL	010006	AL	READM-30-CABG-HRRP
15	ELIZA COFFEE MEMORIAL HOSPITAL	010006	AL	READM-30-COPD-HRRP

Readmission Penalties by States KHN

- Kaiser also publishes an easy to read chart of the penalties for 2017
- It is listed by state
- It includes the hospital's name along with city and state
- It shows the penalty for each of the five years of the Medicare readmission penalty program
- It also shows the number of years penalized
- CAH, Maryland hospitals, certain cancer hospitals, rehab, LTCH and veterans hospitals are exempt

Readmission Penalties by States KHN

Medicare Readmission Penalties By Hospital, Year 5

Medicare will apply these readmissions penalties to reimbursements from Oct. 1, 2016, through Sept. 30, 2017, which is the 2017 federal fiscal year (FY2017). This chart shows the penalties for all five years of the program. Maryland hospitals were not penalized because the state has federal permission to set its own Medicare payment rules. Also exempt are certain cancer hospitals, critical access hospitals as well as hospitals dedicated to psychiatry, rehabilitation, long-term care and veterans. Medicare also did not levy penalties against hospitals that had too few cases to be fairly evaluated.

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

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

Hospital Name	City	State	FY2013 (%)	FY2014 (%)	FY2015 (%)	FY2016 (%)	FY2017 (%)	No. Yrs Penalized
ALASKA NATIVE MEDICAL CENTER	ANCHORAGE	AK	0.23	0.45	0.49	0.34	0.23	5
ALASKA REGIONAL HOSPITAL	ANCHORAGE	AK	0	0.01	0	0.57	1.19	3
BARTLETT REGIONAL HOSPITAL	JUNEAU	AK	0	0	1.27	0.45	0.04	3
CENTRAL PENINSULA GENERAL HOSPITAL	SOLDOTNA	AK	0.07	0.09	1.41	1.02	1.28	5
FAIRBANKS MEMORIAL HOSPITAL	FAIRBANKS	AK	0	0	0.07	0.13	0.08	3
MAT-SU REGIONAL MEDICAL CENTER	PALMER	AK	0.1	0.01	0.92	0.48	0.92	5
PROVIDENCE ALASKA MEDICAL CENTER	ANCHORAGE	AK	0	0	0	0.12	0	1
YUKON KUSKOKWIM DELTA REG HOSPITAL	BETHEL	AK	0.33	0.27	0	0	0	2
ANDALUSIA REGIONAL HOSPITAL	ANDALUSIA	AL	0.59	0.33	0	0.14	0.36	4
ATHENS-LIMESTONE HOSPITAL	ATHENS	AL	0.04	0	0.09	0.54	1.12	4
ATMORE COMMUNITY HOSPITAL	ATMORE	AL	0.95	1.08	0.8	0.25	0.17	5
BAPTIST MEDICAL CENTER EAST	MONTGOMERY	AL	0.36	0.12	0.39	0.3	0.05	5
BAPTIST MEDICAL CENTER SOUTH	MONTGOMERY	AL	0.75	0.27	0.67	0.44	0.87	5

https://kaiserhealthnews.files.wordpress.com/2016/08/medicarereadmissionpenaltiesyear5_pdf_final1.pdf

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

Resource Understanding the HRRP

UNDERSTANDING THE HOSPITAL READMISSIONS REDUCTION PROGRAM

Readmission is defined as an admission to an IPPS acute care hospital within 30 days of a discharge from the same or another IPPS acute care hospital.

The Hospital Readmissions Reduction Program, mandated by the Affordable Care Act, requires the Centers for Medicare & Medicaid (CMS) to reduce payments to IPPS hospitals with excess readmissions. The first penalty affecting payment was for discharges beginning October 1, 2012.

Unlike the Value-based Purchasing (VBP) program, this is a penalty program and a hospital cannot get additional monies, only lose money as result of their performance. What is similar to the VBP program is that the penalty for the Readmission Reductions Program affects the base DRG for discharges. It also applies to the federal fiscal year, which starts October 1 and goes through September 30 of the following year. The penalties increase every year up to a maximum of 3% reached in FY2015.

Readmissions Measures

FY2013 & FY2014 *(added algorithm to exclude planned admissions)*

- 30 day Readmissions Acute Myocardial Infarction (AMI),
- 30 day Readmissions Heart Failure (HF)
- 30 day Readmissions Pneumonia (PN);

FY 2015 Additions

- 30 day Readmissions chronic obstructive pulmonary disease (COPD)
- 30 day Readmissions elective total hip arthroplasty (THA) and total knee arthroplasty (TKA)

FY 2016 No Additions

FY 2017 Additions

- 30 day Readmissions coronary artery bypass graft (CABG) surgery

These same measures are used for the inpatient quality reporting (IQR) program. However, because they are applied to a different set of hospitals, the results might vary slightly from the rates.

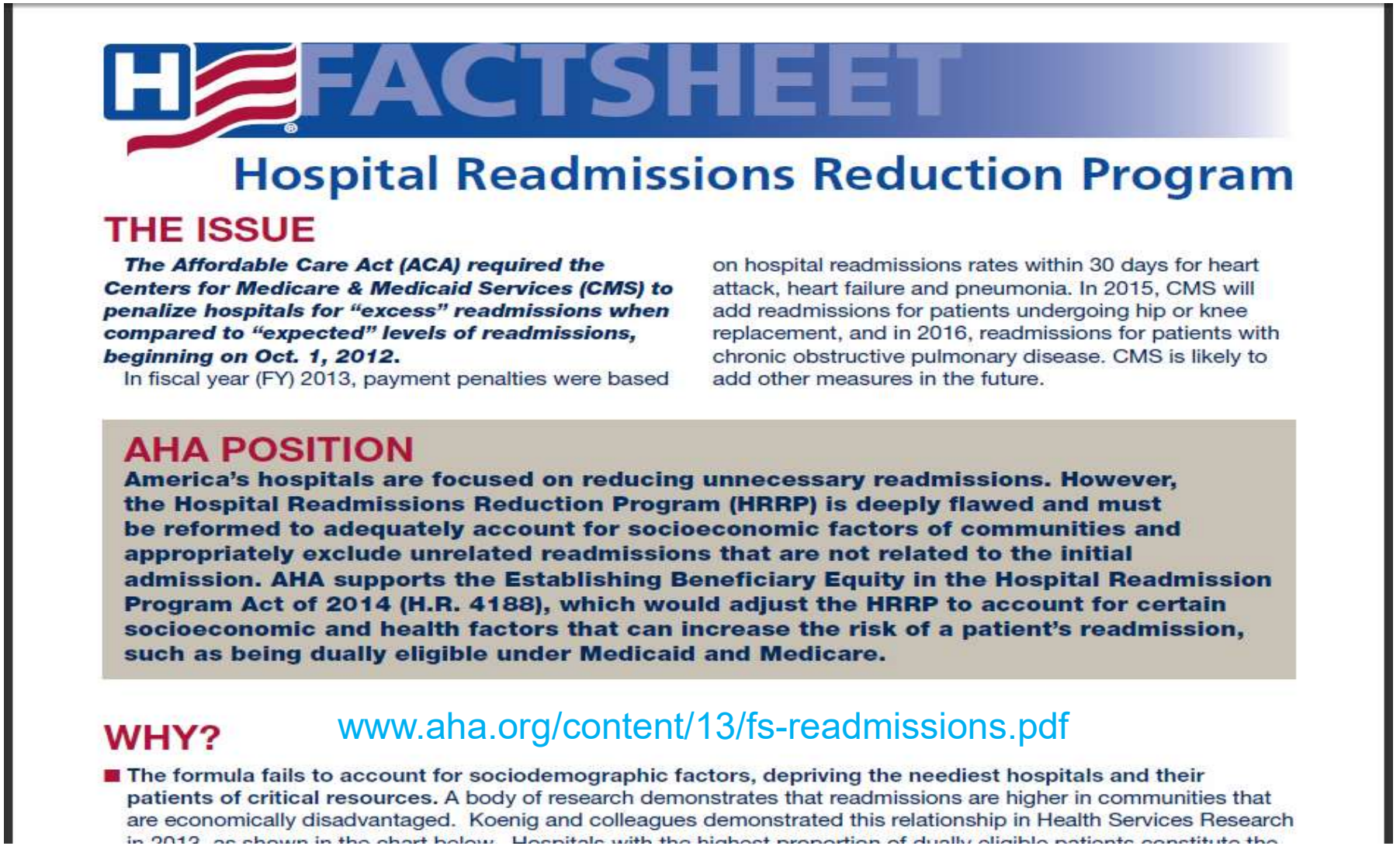
Eligibility/Performance Period

- Three years of discharge data
  - FY2013 July 1, 2008 to June 30, 2011
  - FY2014 July 1, 2009 to June 30, 2012
  - FY2015 July 1, 2010 to June 30, 2013
  - FY2016 July 1, 2011 to June 30, 2014
- Minimum of 25 cases

Penalizing Safety Net Hospitals and the Cures Act

RELIAS | LEARNING

AHA Recommends Socioeconomic



FACTSHEET

Hospital Readmissions Reduction Program

THE ISSUE

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

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

AHA POSITION

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

WHY?

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

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

Are Safety Net Hospitals Penalized?

- Looking at readmissions for MI, CHF, pneumonia
  - Added hip or knee replacement (TKA, THA) and COPD
  - 2017 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
- The article states there are other ones that directly impact readmission rates that should be considered
  - Race, educational level, poverty, disability and other socio-economic factors
- 2017 there were 2,597 hospitals that were penalized 528 million dollars

Patient Mix Penalizes Safety Net Hospitals

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John Commins, for HealthLeaders Media , September 29, 2015

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

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

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

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

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

Michael L. Barnett, MD

HLM: What prompted you to do this study?

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

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

2016 Study Hospitals Higher Minority Patients

- Study of hospitals that serve a higher proportion on minority patients
- Found that the following factors account for 65% of increased odds for readmission:
  - Race, low income, and insurance status
- Examined outcome and patient factors in more than 168,000 colorectal surgery patients treated in 374 hospitals
- Said CMS should account for **socio-economic factors** when comparing readmission rates
  - www.surgjournal.com/article/S0039-6060(16)30475-5/fulltext

Do hospital factors impact readmissions and mortality after colorectal resections at minority-serving hospitals?

Presented at the 11th Annual Academic Surgical Congress in Jacksonville, FL, February 2–4, 2016.

Elizabeth M. Hechenbleikner, MD, Chaoyi Zheng, MS, Samuel Lawrence, BA, Young Hong, MD, Nawar M. Shara, PhD, Lynt B. Johnson, MD, Waddah B. Al-Refaie, MD, FACS

Altmetric 3

DOI: http://dx.doi.org/10.1016/j.surg.2016.08.041

Article Info

Abstract | **Full Text** | References | Supplemental Materials

Background

Minority-serving hospitals have greater readmission rates after operative procedures including colectomy; however, little is known about the contribution of hospital factors to readmission risk and mortality in this setting. This study evaluated the impact of hospital factors on readmissions and inpatient mortality after colorectal resections at minority-serving hospitals in the context of patient- and procedure-related factors.

Methods

More than 168,000 patients who underwent colorectal resections in 374 California hospitals (2004–2011) were analyzed using the State Inpatient Database and American Hospital Association Hospital Survey data. Sequential logistic regression analyses were performed to determine the associations between minority-serving hospital status and 30-day, 90-day, and repeated readmissions.

Results

Thirty-day, 90-day, and repeated readmission rates were 11.2%, 16.9%, and 2.9%, respectively. Odds for 30-day, 90-day, and repeated readmissions after colorectal resections were 19%, 20%, and 38% more likely at minority-serving hospitals versus non-minority-serving hospitals, respectively ($P < .01$), after controlling for age, sex, comorbidities, year, and procedure type. Patient factors accounted for up to 65% of the observed increase

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Report

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Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors

Released: January 12, 2016

www.nationalacademies.org/hmd/Reports/2016/Accounting-for-Social-Risk-Factors-in-Medicare-Payment.aspx

REPORT AT A GLANCE

- Conceptual Framework for Social Risk Factors (PDF)

Download the cover image and citation slide >>

The U.S. Department of Health and Human Services, acting through the Office of the Assistant Secretary for Planning and Evaluation, has asked the Institute of Medicine of the National Academies of Sciences, Engineering, and Medicine to convene an ad hoc committee to identify social risk factors that affect the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. The committee's work will be conducted in phases and will produce five brief consensus reports. In this first report, the committee presents a conceptual framework and describes the results of a literature search linking social risk factors, including socioeconomic position, to health-related measures of importance to Medicare payment and quality programs.

The 21st Century Cures Act

- The federal law makes adjustments to the Hospital Readmissions Reduction Program (HRRP) to account for socioeconomic status
- Became Public Law No. 114-255
- Signed by the President 12/13/2016
- Section 15002 and will effect fiscal year 2019
- Secretary can take into account changes in risk adjustment

The 21st Century Cures Act

- The Secretary may consider removal as a readmission of an admission that is classified within one or more of the following: transplants, end-stage renal disease, burns, trauma, psychosis, or substance abuse
  - Many happy to see that CMS will now adjust performance measure for socio-economic status and other factors that affect patient outcomes
- MedPAC shall conduct a study to review all hospitals admissions
- And determine if readmissions are related to any changes in outpatient and emergency services

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114th Congress (2015-2016)
www.congress.gov/bill/114th-congress/house-bill/34
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Rep. Bonamici, Suzanne [D-OR-1] (Introduced 01/06/2015)
Committees:
House - Science, Space, and Technology | Senate - Commerce, Science, and Transportation
Committee Reports:
S. Rept. 114-146
Latest Action:
12/13/2016 Became Public Law No: 114-255. (All Actions)
Roll Call Votes:
There have been 3 roll call votes
Tracker:
Introduced
Passed House
Passed Senate
Resolving Differences
To President
Became Law
More on This Bill
Constitutional Authority Statement
CBO Cost Estimates [3]
Subject — Policy Area:
Health
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Summary: H.R.34 — 114th Congress (2015-2016)
All Bill Information

2018 IPPS Rules

- CMS changed the socioeconomic adjustment approach for FY 2019 Hospital Readmissions Reduction program
  - As mandated by the 21st Century Cures Act
- CMS would assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and Medicaid
- So compare hospitals to each others in determining extent of excess readmissions
- In Federal Register August 14, 2017 see page 59
  - www.federalregister.gov/public-inspection

This document is scheduled to be published in the Federal Register on 08/14/2017 and available online at https://federalregister.gov/d/2017-16434, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 414, 416, 486, 488, 489, and 495

[CMS-1677-F]

RIN 0938-AS98

https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-16434.pdf

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

Dual Eligible Patients

- The law requires Medicare to take into account patient background when calculating payment reductions
- Dual eligible patients are disproportionately expensive for hospitals
- They constitute 18% of Medicare patients
- These patients are clear outliers in terms of costs
- They are very complex patients
- This is first step toward risk adjustment for social and economic challenges

Improvements and GAO Report

RELIAS | LEARNING

Rate of Improvement 2016

- A study published by the Annals of Internal Medicine found the rate of improvement greater among lower performing hospitals
  - Reduced 95.1 per 10,000 discharges
- The readmission penalties have decreased the rate of readmissions
  - Examined hospitals for MI, CHF, and pneumonia
- The rate of reduction at high performing hospitals was 67.6 per 10,000 discharges
  - High performing hospitals are those penalized with a 1% reduction

Annals of Internal Medicine®

ORIGINAL RESEARCH | 27 DECEMBER 2016

Readmission Rates After Passage of the Hospital Readmissions Reduction Program: A Pre-Post Analysis

Jason H. Wasfy, MD, MPhil; Corwin Matthew Zigler, PhD; Christine Choirat, PhD; Yun Wang, PhD; Francesca Dominici, PhD; Robert W. Yeh, MD, MSc

Article, Author, and Disclosure Information

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http://annals.org/aim/article/2594952/readmission-rates-after-passage-hospital-readmissions-reduction-program-pre-post

Abstract

Background: Whether hospitals with the highest risk–standardized readmission rates (RSRRs) subsequently experienced the greatest improvement after passage of the Medicare Hospital Readmissions Reduction Program (HRRP) is unknown.

GAO Finds Hospital Care Unaffected

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

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HOSPITAL VALUE-BASED PURCHASING:

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

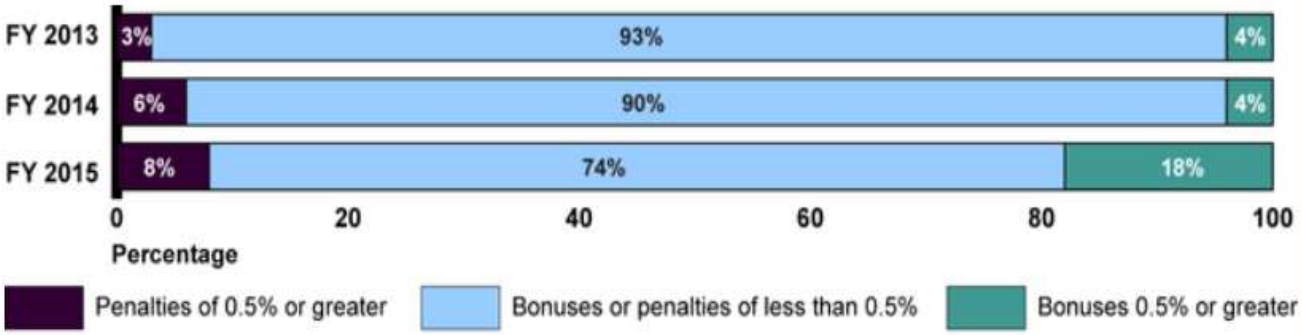
GAO-16-9: Published: Oct 1, 2015. Publicly Released: Oct 1, 2015.

HIGHLIGHTS | VIEW REPORT (PDF, 49 PAGES) | Share Thi

What GAO Found

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

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



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

Additional Materials:

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

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GAO Report

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)

CMS Readmissions Reduction Program

RELIAS | LEARNING

Readmission Reduction Program

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

Formula to Calculate Readmission Adj Factor

Formulas to Calculate the Readmission Adjustment Factor

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

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

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

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

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

Readmissions Adjustment Factor =

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

Formula to Compute Payment Adjustment

Formulas to Compute the Readmission Payment Adjustment Amount

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

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

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

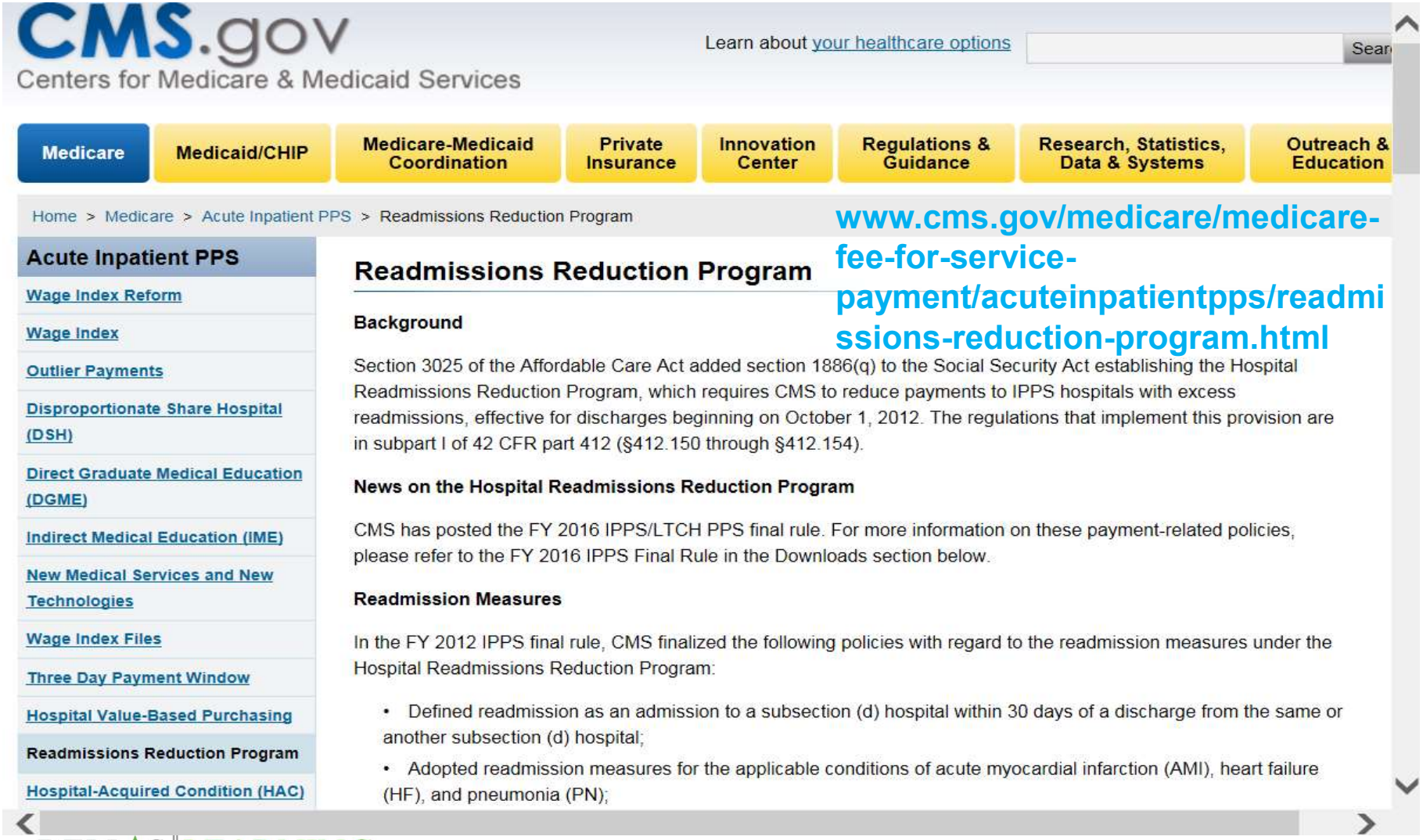
Readmissions Payment Adjustment Amount = [Base operating DRG payment amount x readmissions adjustment factor] - base operating DRG payment amount.

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

CMS Website Hospital Readmissions

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

CMS Readmission Reduction Website



History of HRRP Readmissions

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

Patient Protection and Affordable Care Act

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

CMS Website Hospital Readmissions

Hospital Readmissions Reduction Program

In October 2012, CMS began reducing Medicare payments for Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions. Excess readmissions are measured by a ratio, by dividing a hospital's number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia, COPD, hip/knee replacement, and coronary artery bypass graft surgery by the number that would be "expected," based on an average hospital with similar patients. A ratio greater than 1.0000 indicates excess readmissions.

More information on how payments are adjusted.

More on the calculations.

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

Hospital Readmissions Reduction Program data

Data.Medicare.gov

MENU

Hospital Readmissions Reduction Program

	Hospital Name	Provider Number	State	Measure Name
1	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-AMI-HRRP
2	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-CABG-HRRP
3	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-COPD-HRRP
4	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-HF-HRRP
5	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-HIP-KNEE-HRRP
6	SOUTHEAST ALABAMA MEDICAL CENTER	010001	AL	READM-30-PN-HRRP
7	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-AMI-HRRP
8	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-CABG-HRRP
9	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-COPD-HRRP
10	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-HF-HRRP
11	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-HIP-KNEE-HRRP
12	MARSHALL MEDICAL CENTER SOUTH	010005	AL	READM-30-PN-HRRP
13	ELIZA COFFEE MEMORIAL HOSPITAL	010006	AL	READM-30-AMI-HRRP
14	ELIZA COFFEE MEMORIAL HOSPITAL	010006	AL	READM-30-CABG-HRRP
15	ELIZA COFFEE MEMORIAL HOSPITAL	010006	AL	READM-30-COPD-HRRP

CMS Guide to Reducing Readmissions

RELIAS | LEARNING

CMS Guide to Preventing Readmissions

- 2016 the 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

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

GUIDE TO
PREVENTING
READMISSIONS
AMONG
RACIALLY AND
ETHNICALLY
DIVERSE
MEDICARE BENEFICIARIES
www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
CMS

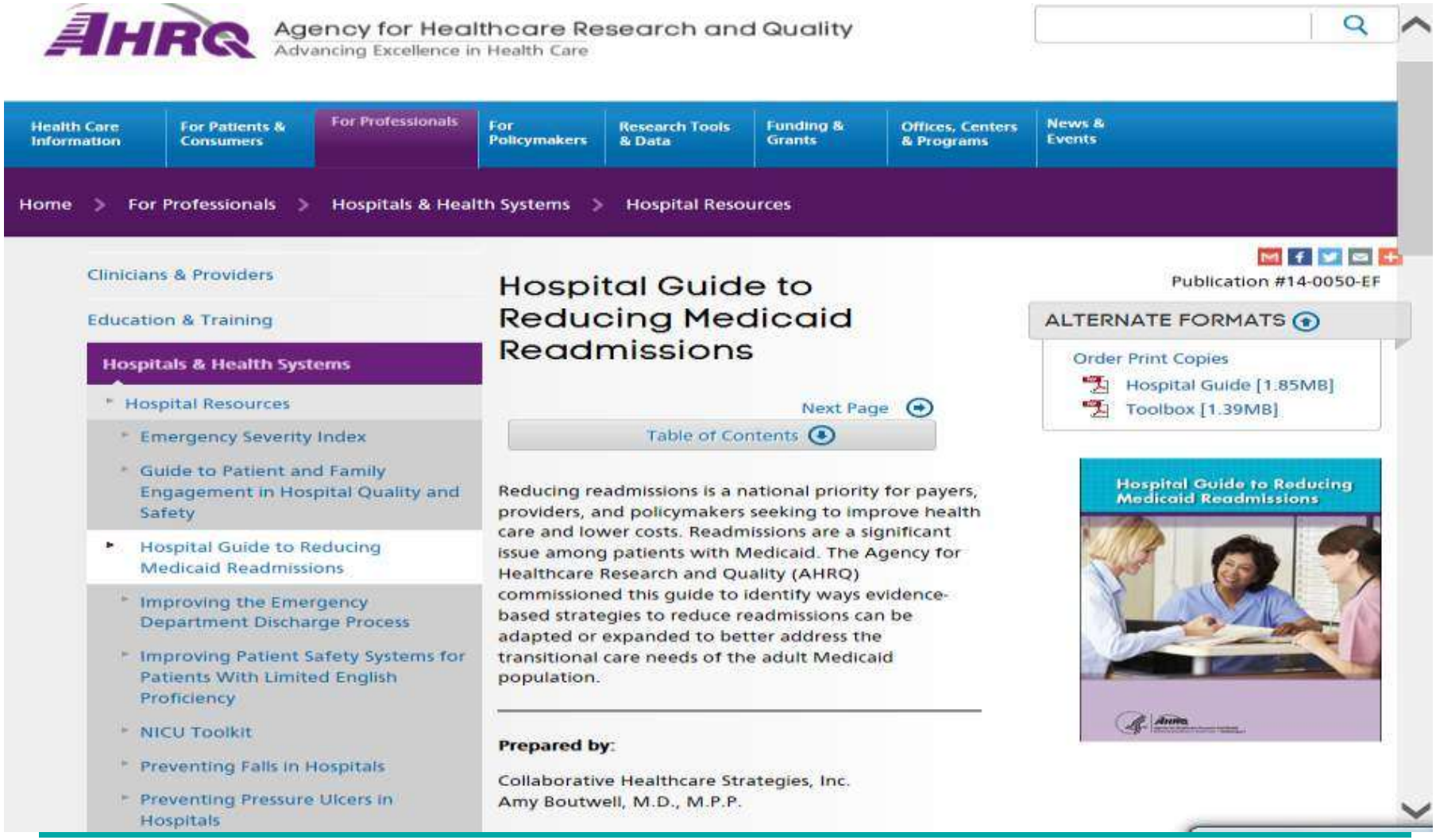
AHRQ On Reducing Readmissions

RELIAS | LEARNING

AHRQ Reducing Medicaid Readmissions

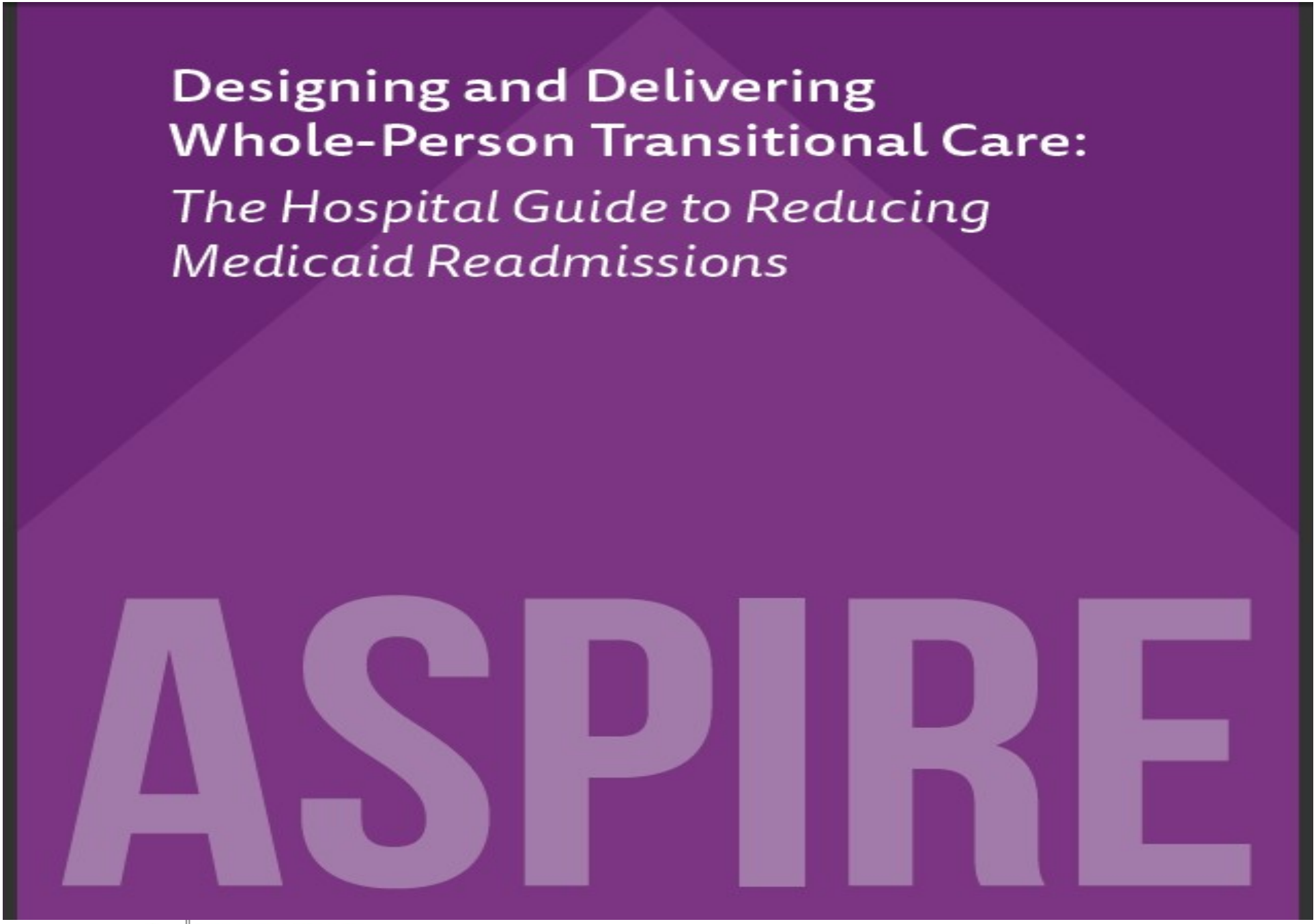
- AHRQ publishes a free guide to reducing Medicaid readmission
- Used evidenced based strategies and can be used to reduce readmissions for all patients
- Field tested by hospitals and quality improvement collaboratives
- 13 chapters including one on ED plans
- 94 pages
- www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

AHRQ Hospital Guide to Reducing Readmissions



Designing and Delivering Whole-Person Transitional Care:

The Hospital Guide to Reducing Medicaid Readmissions



AHRQ Hospital Guide to Reducing Readmissions

- Medicaid all-cause 30 day readmission rates for patients 21-44 (19.2%) and 45-64 (21.6%) are higher than Medicare readmissions (17.3%)
- Medicaid heart failure readmission rates are higher than Medicaid rates (29.1% versus 23.7%), all cause 30 day readmission rates
- Medicaid patients face social and economic challenges
  - Low literacy, language barriers, discontinuities in coverage, unstable housing, and poverty which contribute to higher readmission rates

AHRQ Hospital Guide to Reducing Readmissions

- Medicaid population has a higher rate of behavioral health issues
- In Massachusetts, 61% of Medicaid patients had a behavioral health condition as opposed to 40% of the adult population
- 25% of the readmissions occurred within 4 days of discharge
- 50% of readmissions occurred within 10-11 days of discharge
- Section on what hospitals did to reduce readmissions

Inventory all activities and operational assets that can be considered to improve care so as to reduce readmissions. Some of the assets you have in place may not be exclusively focused on or designed to reduce readmissions, but they are part of what your organization has potentially available to leverage, such as:

- Board or executive-level priority to reduce readmissions.
- Specific readmission reduction goal.
- Financial, quality, or other incentives to reduce readmissions.
- Presence of executive, administrative, or clinical champions.
- Transitional care services and staff (e.g., pharmacist technicians or pharmacists to conduct medication reconciliation, care navigators).
- Department- or service-line-based improvement efforts (e.g., initiatives led by nursing, case management, social work, quality, cardiology, pulmonary, hospital medicine, ED).
- Cross-setting collaborations (e.g., preferred providers, co-located liaisons, existing committees that promote coordination of care or effective referral practices).
- Information technology systems (e.g., readmission flags, workflow prompts, regular readmission reporting).
- Managed care, value-based, or risk contracts that reward decreased utilization or quality performance in transitional care (including accountable care organizations, bundled payment teams).

AHRQ Resources On Hospital Discharge

Re-engineering the Hospital Discharge: An Example of a Multifaceted Process Evaluation

www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol2/Anthony.pdf

David Anthony, VK Chetty, Anand Kartha, Kathleen McKenna, Maria Rizzo DePaoli, Brian Jack

Abstract

Introduction: The transfer of patient care from the hospital team to primary care and other providers in the community at the time of discharge is a high-risk process characterized by fragmented, nonstandardized, and haphazard care that leads to errors and adverse events. The development of interventions to improve the discharge process requires a detailed evaluation of the process by a multidisciplinary team. **Methods:** Using the resources of the Boston University–Morehouse College of Medicine AHRQ Developmental Center for Patient Safety Research (funded by the Agency for Healthcare Research and Quality), multidisciplinary teams have been assembled to identify and address the sources of error at discharge. To better understand the current hospital discharge process, the researchers have applied a battery of epidemiologic and quality control methods taken from industry. These include probabilistic risk assessment, process mapping, qualitative analyses, failure mode and effects analysis, and root cause analysis. The researchers describe each of these methods and discuss their experience with them, displaying concrete tools that have arisen from their application. **Conclusions:** A detailed, multifaceted process analysis has provided us with powerful insight into the many patient safety issues surrounding the discharge process. The generalizable methods described here have produced the re-engineering of the discharge process, allowing for the planning of a clinical trial and significant improvements in patient care.

IHI Resources on Preventing Readmissions

RELIAS | LEARNING

IHI Resources on Readmissions

- IHI has many excellent resources on reducing avoidable readmissions
- Evidence shows the number of readmissions can be reduced by improving core discharge planning and transition process out of the hospital
- Includes a compendium of 15 promising interventions
- Has a number of how to guides
- www.ihi.org/Topics/Readmissions/Pages/default.aspx

Readmissions

SHARE

Reduce Avoidable Readmissions

Hospitalizations account for nearly one-third of the total $2 trillion spent on health care in the United States. In the majority of cases, hospitalization is necessary and appropriate. However, a substantial fraction of all hospitalizations are patients returning to the hospital soon after their previous stay. These rehospitalizations are costly, potentially harmful, and often avoidable.

Evidence suggests that the rate of avoidable rehospitalization can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management.

RECOMMENDED RESOURCES

Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions »

Effective Interventions to Reduce Rehospitalizations: A Survey of the Published Evidence »

How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations »

How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations »

How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations »

How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations »

http://www.ihi.org/resources/Pages/Publications/VisitingNu...

MORE ON THIS TOPIC

Visiting Nurse Service of New York's Choice Health Plans: Continuous Care Management for Dually Eligible Medicare and Medicaid Beneficiaries »

Gaining Ground: Care Management Programs to Reduce Hospital Admissions and Readmissions Among Chronically Ill and Vulnerable Patients »

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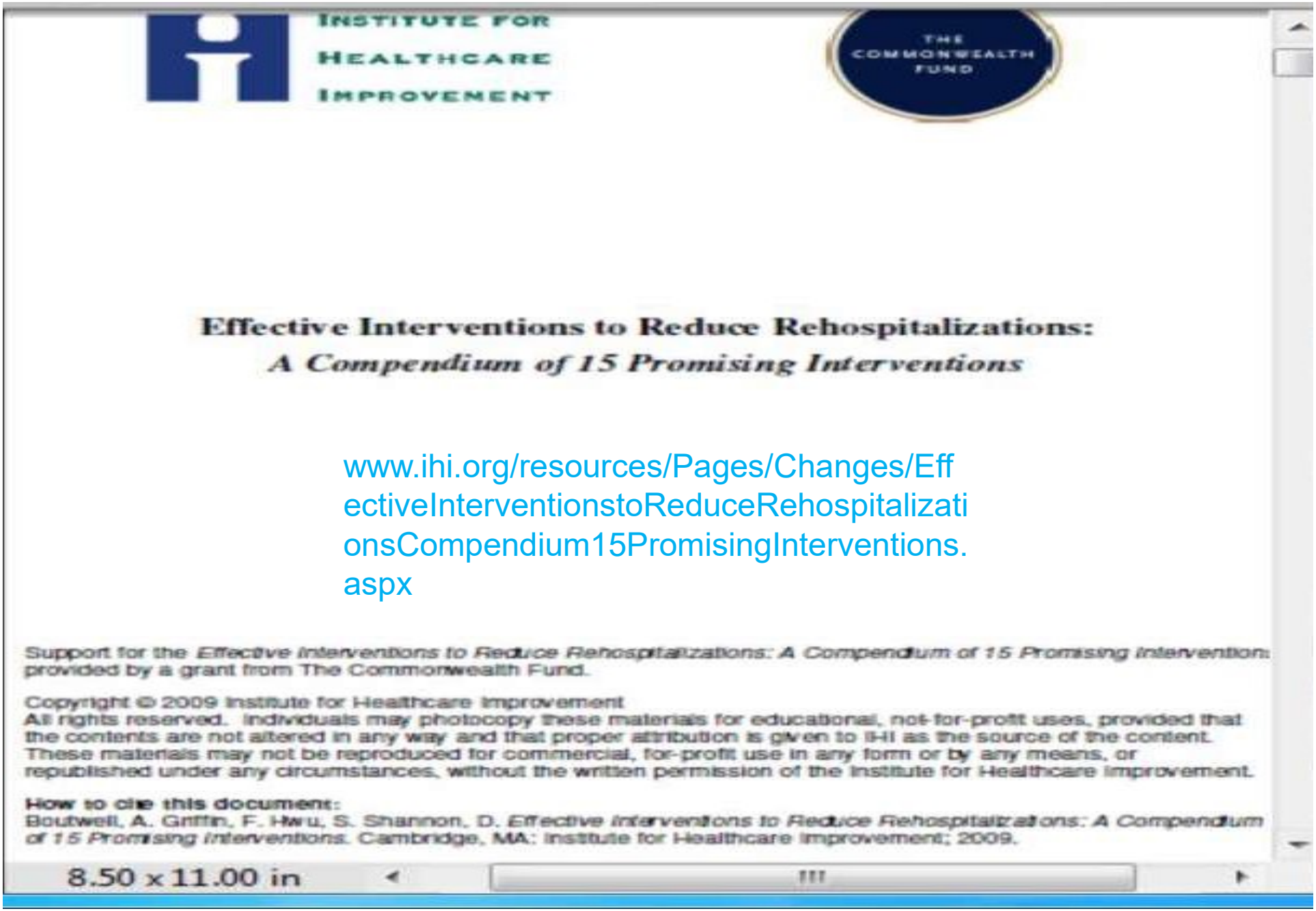
Gaining Ground: Care Management Programs to Reduce Hospital Admissions and Readmissions Among Chronically Ill and Vulnerable Patients »

Visiting Nurse Service of New York's Choice Health Plans: Continuous Care Management for Dually Eligible Medicare and Medicaid Beneficiaries »

View All »

Recommendations

- Educate patient about their diagnosis
- Call to reinforce discharge instructions
- Organize post-discharge services
- Review what to do it a problem occurs
- Confirm the medication plan
- Reconcile the discharge plan with national guidelines and clinical pathways
- Make follow up appoints for patients
- Ensure follow up of test results


INSTITUTE FOR HEALTHCARE IMPROVEMENT
THE COMMONWEALTH FUND
Effective Interventions to Reduce Rehospitalizations:
A Compendium of 15 Promising Interventions
www.ihi.org/resources/Pages/Changes/EffectiveInterventionstoReduceRehospitalizationsCompendium15PromisingInterventions.aspx
Support for the Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions provided by a grant from The Commonwealth Fund.
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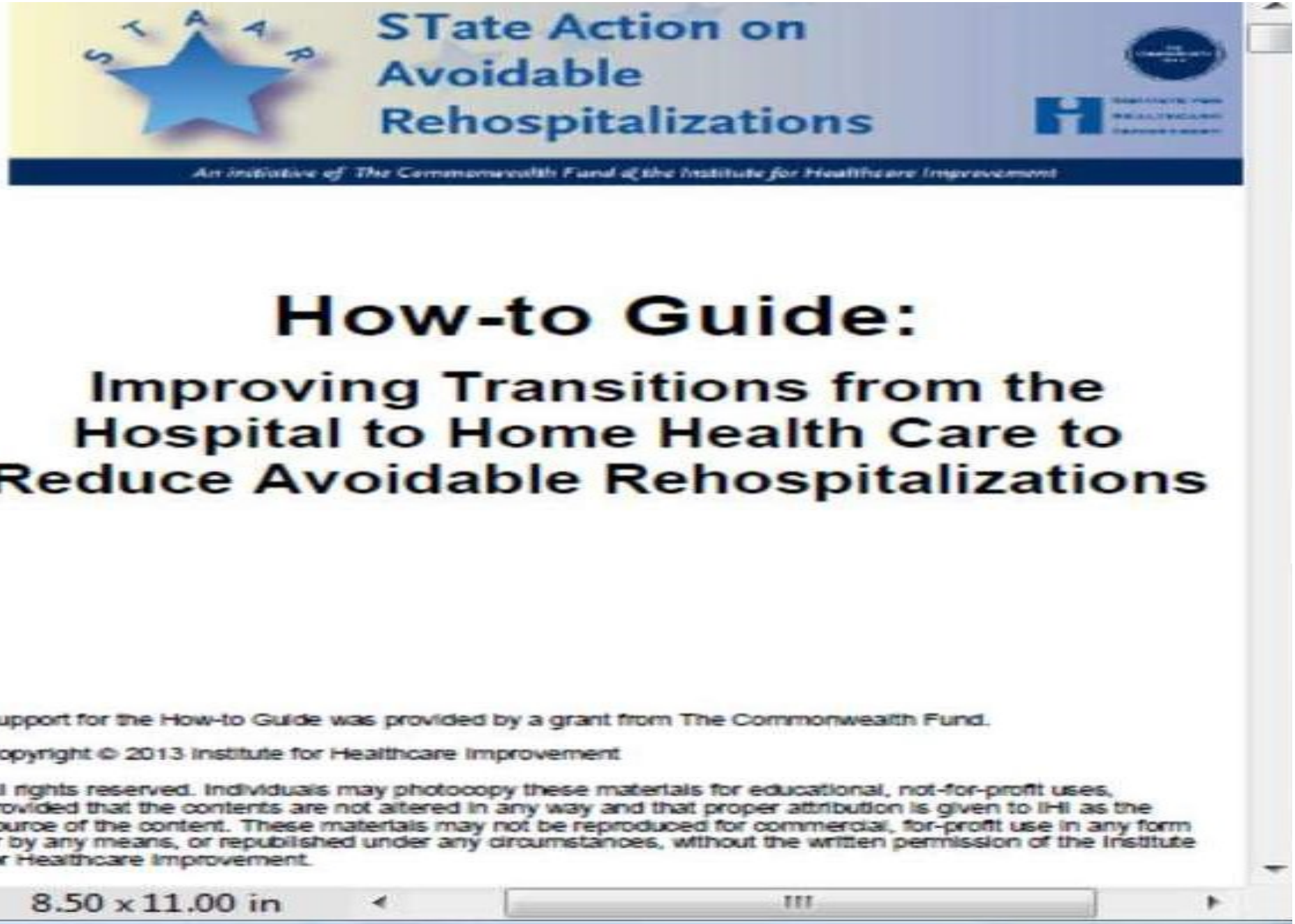
STate Action on Avoidable Rehospitalizations
An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement
How-to Guide:
Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations
Support for the How-to Guide was provided by a grant from The Commonwealth Fund.
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Partnership 4 Patients and Other Resources

RELIAS LEARNING

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

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

Patients with Malnutrition Readmission Rate

- A study released December 2016 found that readmission rate for patients with malnutrition is high
- The 30-day hospital readmission rate for patients with malnutrition was 23 per 100 initial hospital stays, compared with 15 per 100 for patients without malnutrition
- Nearly 1 in 3 for patients with postsurgical non-absorption stays were followed by a readmission for any cause within 30 days (30.2 per 100 and non-maternal and non-neonatal patients)

All-Cause Readmissions Following Hospital Stays for Patients With Malnutrition, 2013

Home | Databases | Tools & Software | Reports | Fast Stats | News & Events | Purchase HCUP Data | Technical Assistance | Data Innovations

STATISTICAL BRIEF #218

December 2016

https://hcup-us.ahrq.gov/reports/statbriefs/sb218-Malnutrition-Readmissions-2013.jsp?utm_source=AHRQ&utm_medium=EN-1&utm_term=&utm_content=1&utm_campaign=AHRQ_EN1_18_2017

All-Cause Readmissions Following Hospital Stays for Patients With Malnutrition, 2013

Kathryn R. Fingar, Ph.D., M.P.H., Audrey J. Weiss, Ph.D., Marguerite L. Barrett, M.S., Anne Elixhauser, Ph.D., Claudia A. Steiner, M.D., M.P.H., Peggi Guenter, Ph.D., R.N., and Mary Hise Brown, Ph.D.

Introduction

Recent estimates indicate that 7 percent of nonmaternal and nonneonatal hospital stays in the United States are for patients with malnutrition,[1] defined here as undernutrition characterized by lack of adequate calories, protein, or other nutrients needed for tissue maintenance and repair.[2] Malnutrition has been associated with longer and more costly hospitals stays, as well as a greater likelihood of comorbidity and death among hospitalized patients.[3] Conceptually, malnutrition may also contribute to *posthospital syndrome*, described as "an acquired, transient period of vulnerability" following hospitalization,[4] which may dramatically increase risk of readmission.[5,6]

There are many causes of malnutrition.[7,8] Some cases involve chronic starvation related to conditions such as anorexia nervosa. In other instances, malnutrition may be a consequence of an acute or chronic illness or injury, such as burns or cancer. This heterogeneity has complicated recognition and proper treatment of malnutrition in hospital-based settings, as well as efforts to develop a standard definition of malnutrition for clinical and surveillance purposes.[9,10]

Inpatient outcomes—including length of hospital stay, costs, and mortality—appear to vary by malnutrition type. In the United States in 2013, the in-hospital death rate was 12 percent for stays involving cachexia (i.e., wasting syndrome) and 8 percent for those involving protein-calorie malnutrition, compared with 2-5 percent for stays with other types of malnutrition, including postsurgical nonabsorption, nutritional neglect, weight loss or failure to thrive, and underweight diagnoses.[11] Compared with other types of malnutrition, hospital stays involving protein-calorie malnutrition had the longest average length of stay and the highest average cost per stay.[12]

Highlights

- In 2013, the all-cause 30-day readmission rate for patients with malnutrition was 23.0 per 100, compared with 14.9 per 100 for patients without malnutrition.
- Nearly 1 in 3 nonmaternal and nonneonatal stays for patients with postsurgical nonabsorption were followed by a readmission for any cause within 30 days (30.2 per 100).
- For all types of malnutrition combined, the rate of readmission was highest for index stays among adults aged 18-64 years, those paid by Medicaid, and those for patients residing in metropolitan areas.
- The readmission rate was similar across income levels for patients with malnutrition during an index stay; in contrast, the readmission rate decreased by income for patients without malnutrition at the index stay.
- The average cost per readmission was $16,900 for patients with protein-calorie malnutrition during an index stay and $17,900 for patients with postsurgical nonabsorption—26 and 34 percent higher, respectively, than the readmission cost for patients without malnutrition during an index stay ($13,400).
- Septicemia was the leading principal diagnosis at

Patients with Malnutrition Readmission Rate

- 7% of all hospital stays are for malnutrition
- Some causes include chronic illness such as burns or cancer and anorexia nervosa
- Highest was adults 18-64 on Medicaid and those living in metropolitan areas
- Average cost is also more
  - The average cost per readmission was $16,900 for patients with protein-calorie malnutrition per stay and $17,900 for patients with postsurgical non-absorption
  - This is26 and 34% higher, respectively, than the readmission cost for patients without malnutrition ($13,400).

Readmission Newsletters and Articles

RELIAS | LEARNING

Do You Feel Ready to Go Home?

- 2017 study found the only consistent predicted readmission risk was if patients reported not feeling ready to go home on the day of discharge
  - Study in 4 European countries
  - 27.8% of readmissions were predictable
  - 14.4% were considered preventable
- US studies show only a minority of readmissions are preventable
  - Recent study shows only 25% preventable
  - Factors include insufficient communication with outpatient providers, failure to discuss care goals and ED readmits

Do You Feel Ready to Go Home?

Patients' and providers' perceptions of the preventability of hospital readmission: a prospective, observational study in four European countries.

https://psnet.ahrq.gov/resources/resource/29613

van Galen LS, Brabrand M, Cooksley T, et al; Safer@home consortium. BMJ Qual Saf. 2017 Jun 22; [Epub ahead of print].

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The use of readmission rates as a metric of care quality remains controversial, as United States–based studies have shown that only a minority of readmissions are preventable. This prospective cohort study, conducted in 4 European countries, sought to evaluate the preventability of 30-day readmissions after hospitalization from both clinician and patient perspectives. Investigators found that 27.8% of readmissions were considered predictable (by the majority of those interviewed) and 14.4% were considered preventable. However, there was little consensus between physicians, nurses, patients, and caregivers about whether readmissions were preventable and why readmissions occurred. The only factor that consistently predicted readmission risk was if patients reported not feeling ready to go home on the day of discharge. This study adds to the literature questioning the utility of readmission rates as a measure of the quality of care.

In US 25% of Readmission are Preventable

Preventability and causes of readmissions in a national cohort of general medicine patients.

CLASSIC https://psnet.ahrq.gov/resources/resource/29725

Auerbach AD, Kripalani S, Vasilevskis EE, et al. JAMA Intern Med. 2016;176:484-493.

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Preventing readmissions is a cornerstone of patient safety efforts. However, one concern about nonpayment for readmissions is that many may not be preventable. To determine whether they were preventable, this observational study investigated readmissions through patient and physician surveys along with chart review. Researchers determined that only one quarter of readmissions were preventable. Factors associated with potential preventability were premature hospital discharge, insufficient communication with outpatient providers, failure to discuss care goals, and emergency department decisions to readmit a patient who did not require a second inpatient stay. These results suggest that multiple interventions will be needed to avert readmissions, and such efforts will have limited impact since most readmissions are not preventable.

Psych and SUD Top Reason for Readmits

- 2017 study found that behavioral health issues and substance abuse are top reasons for readmissions
- This is among those who are **not** Medicare patients
- This accounts for nearly half of all 30 days readmissions
- Psychiatric disease most common diagnosis among patients ages 18-64
- Medicare patients account for 56% of all readmissions and 1.8 million admitted within 30 days

Short-term rehospitalization across the spectrum of age and insurance types in the United States

Jordan B. Strom, Daniel B. Kramer, Yun Wang, Changyu Shen, Jason H. Wasfy, Bruce E. Landon, Elissa H. Wilker, Robert W. Yeh

Published: July 10, 2017 • https://doi.org/10.1371/journal.pone.0180767

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180767

Abstract
Introduction
Materials and methods
Results
Discussion
Conclusions
Supporting information
References

Reader Comments (0)
Media Coverage (0)
Figures

Abstract

Few studies have examined rates and causes of short-term readmissions among adults across age and insurance types. We compared rates, characteristics, and costs of 30-day readmission after all-cause hospitalizations across insurance types in the US. We retrospectively evaluated alive patients ≥18 years old, discharged for any cause, 1/1/13-11/31/13, 2006 non-federal hospitals in 21 states in the Nationwide Readmissions Database. The primary stratification variable of interest was primary insurance. Comorbid conditions were assessed based on Elixhauser comorbidities, as defined by administrative billing codes. Additional measures included diagnoses for index hospitalizations leading to rehospitalization. Hierarchical multivariable logistic regression models, with hospital site as a random effect, were used to calculate the adjusted odds of 30-day readmissions by age group and insurance categories. Cost and discharge estimates were weighted per NRD procedures to reflect a nationally representative sample. Diagnoses for index hospitalizations leading to rehospitalization were determined. Among 12,533,551 discharges, 1,818,093 (14.5%) resulted in readmission within 30 days. Medicaid insurance was associated with the highest adjusted odds ratio (AOR) for

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
- Unfortunately ceased publication in 2017 but past editions are available
- To see past editions which have been archived go to www.healthcareenewsletters.com/subscribe.html

Readmission Newsletter Archived

READMISSIONS UPDATE eNEWSLETTER

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

VOLUME 6 - ISSUE 82
OCTOBER 30, 2015

Welcome to the Medicare Readmissions Update eNewsletter

Editor: Philip L. Ronning

This issue sponsored by

The The Sixth National Accountable Care Congress and the

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

FEATURED 2013 READMISSIONS SUMMIT STREAMING AUDIO

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

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

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

Readmission Update Newsletter Topics

- 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

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

Readmission Update Newsletter Topics

- Hospital reduces readmissions by 37% by using analytics to help which course of treatment is most effective
- New model predicts risk for readmission from LTC
- Indiana Health Information Exchange (IHIE) details its use of predictive analysis to reduce readmission rates

Articles in Readmission Update

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

Ten proven Ways to Reduce Readmission

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

Ten proven Ways to Reduce Readmission

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

Why Patients Are Readmitted

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

Readmission Rates to Hospital and ED

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

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

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

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

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

From hospital to home – and back again?

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

Unfortunately, that's not always what happens.

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

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

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

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

Robert Wood Johnson Foundation

The Dartmouth Atlas of Health Care

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Recent Articles in Readmission Update

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

Recent Articles in Readmission Update

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

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

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. Oanh 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.

Post Hospital Syndrome

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

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

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

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

Harlan M. Krumholz, M.D.

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

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Article | References

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

Audio Interview

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

Telemedicine Reduces Readmission 10/5/2015 AHA News

CHAIRMAN'S FILE

hospitals in pursuit of excellence

Telemedicine Reduces Readmissions

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

Telemedicine Reduces Readmission

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

Involve Caregiver in Discharge Planning

- Involve caregivers in the discharge of elderly patients can reduce readmission rates
- 2017 study said it can reduce 90 day readmissions by 25%
- Looked at 15 studies out of 10,915 abstracts which included 4,361 patients
- This includes complex treatments
  - Such as wound care, managing medications, and operating specialized medical equipment

Study: To reduce readmissions, involve caregivers in discharge planning

Written by Brian Zimmerman | April 03, 2017 | Print | Email

Integrating caregivers into the planning process of the discharge of elderly patients can significantly reduce 90-day readmission rates, the findings of a new study published in the *Journal of the American Geriatrics Society* suggest.

For the study, researchers conducted a systemic review of previous research designed to assess the effect of caregiver integration in discharge planning on healthcare costs. Across three databases containing 10,715 abstracts of studies related to patient discharge planning, researchers identified 15 that met criteria for inclusion. In total, the 15 studies included 4,361 patients.

www.beckershospitalreview.com/quality/study-to-reduce-readmissions-involve-caregivers-in-discharge-planning.html?tmpl=component&print=1&layout=default&page=

CMS Hospital Compare Data

RELIAS | LEARNING

CMS Report

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

CMS Hospital Compare

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

CMS Hospital Compare Website

Step 1 Pick a Hospital for Readmission Rate

Shows Rate of Unplanned Readmissions

Heart attack

Show Graphs | View More Details

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of readmission for heart attack patients	No Different than the National Rate	16.8%
Death rate for heart attack patients	No Different than the National Rate	14.1%

Heart failure

Show Graphs | View More Details

	RIVERSIDE METHODIST HOSPITAL	NATIONAL RATE
Rate of readmission for heart failure patients	No Different than the National Rate	21.9%
Death rate for heart failure patients	No Different than the National Rate	12.1%

Rate of Readmissions MI, CHF, and Pneumonia

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

Detailed Information About Each

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

The results show differences in hospital-wide readmission rates for Medicare beneficiaries. The results account for how sick patients were when they were hospitalized.

National rate of readmission for heart attack patients = 16.8%

Hospital name	Better than the national rate	No different than the national rate	Worse than the national rate
RIVERSIDE METHODIST HOSPITAL		X	

The table below shows the number of hospitals in each readmission rate category across the nation and the state.

Out of 4227 hospitals in the United States →	**12** hospitals were better than national rate	**2181** hospitals were no different than national rate	**26** hospitals were worse than national rate
	2008 hospitals did not have enough cases to reliably tell how well they are performing		
Out of 152 hospitals in Ohio →	**0** hospitals were better than national rate	**90** hospitals were no different than national rate	**0** hospitals were worse than national rate
	62 hospitals in Ohio did not have enough cases to reliably tell how well they are performing		

Rate of Readmission for 2016 and published in 2017

- Shows the national rate of readmission for each
- AMI is 16.8% and death rate is 14.1%
- Heart failure is 21.9% and death rate 12.1%
- Pneumonia is 17.1% and death rate 16.3%
- Stroke is 12.5% and death rate is 14.9%
- CABG is 14.4% and death rate is 3.2%
- TKA/THA is 4.6%
- COPD is 20% and death rate 8%
- **30 day readmission rate is 15.6%**

Many Good Resources Commonwealth Website

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

The Commonwealth Fund

Many Good Resources Commonwealth Website

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

What Have We Learned National Campaign

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

What Have We Learned National Campaign

National Campaigns to Reduce Readmissions: What Have We Learned?

Thursday, October 1, 2015

By Elizabeth H. Bradley, Amanda Brewster and Leslie Curry

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

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Toplines

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

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

What Did We Learn About National Efforts to Reduce Rehospitalizations?

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

Preventing Readmissions

RELIAS | LEARNING

Preventing Readmissions

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

Readmissions and Discharges

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

Readmissions and Discharges

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

Discharge Summary

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

Discharge Summary in Hands of PCP

- This is why CMS required this in the DP standards and worksheet
  - Incomplete handoffs lead to unnecessary readmission
  - Care transition important for high risk and the elderly
- States that the discharge summary or information summarizing the admission is in the hands of the PCP before the first post hospital visit
- If not appointment made then within 7 days
- In the 2017 proposed CMS hospital discharge planning rules on discharge planning will need to provide to practitioner within 48 hours

Readmissions and Discharges

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

Readmissions and Discharges

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

Pa Patient Safety Authority on Reducing Readmissions

RELIAS | LEARNING

PaPSA Checklist

Suggested Elements for a Discharge Checklist

Patient Name: _____ Physician Name: _____

Admission Date: _____ Discharge Date: _____

Primary Diagnosis: _____ Secondary Diagnoses: _____

Procedure(s): _____

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

Please check when task is completed.

Patient Education

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

Services to Provide

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

Lifestyle Modifications

___ Provide written discharge instructions that include the following:

____ Activity level

____ Diet

In Case of an Emergency

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

Miscellaneous

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

___ Give prescriptions to the patient.

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

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

Discharge Nurse Name: _____

Signature: _____ Date: _____

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

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

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

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ADDRESS:
Patient Safety Authority
333 Market Street
Lobby Level
Harrisburg, PA 17120
Educational Tools
http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/tk_discharge/Pages/home.aspx
Care at Discharge
Discharge is a critical juncture for transitioning to posthospital care, and incomplete discharge processes may cause harm to patients. Implementation of discharge planning upon patient admission, assignment of discharge coordinators, and use of checklists to facilitate standardization within the facility are risk reduction strategies to consider.
Browse by Topic
GO Discipline
GO Audience
GO Care Setting
GO Event
GO Patient Safety Focus
Educational Tools
Suggested Elements for a Discharge Checklist
This sample checklist includes suggested elements relevant to patient discharge.
Articles
Care at Discharge—A Critical Juncture for Transition to Posthospital Care
Discharge is a critical transition period for patients and a process that calls for education, assessment, follow-up, organization, confirmation, and review.

PaPSA on Preventing Readmission

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

PaPSA on Preventing Readmissions

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

RED Program and Resources

RELIAS | LEARNING

11 Essential Steps of RED Process

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

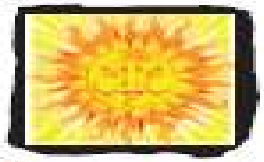
11 Essential Steps of RED Process

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

11 Essential Steps of RED Process

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

Medication List



What medicines do I need to take?

Each day, follow this schedule:

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

Outstanding Labs or Tests

Outstanding Labs or Tests

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

PENDING LAB TEST/STUDIES

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

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

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

Appointments for Follow Up

When are my next appointments?

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

Questions for my appointment

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

I have questions about:

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

Other questions or concerns _____

Project RED Tools

PROJECT RED
Re-Engineered Discharge

A Research Group at
Boston University Medical Center

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

BU Boston University School of Medicine

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

- Home
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Project RED (Re-Engineered Discharge)

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

Latest Project RED News

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

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

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

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

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

Release of Toolkit to Reduce Hospital Readmissions in the News

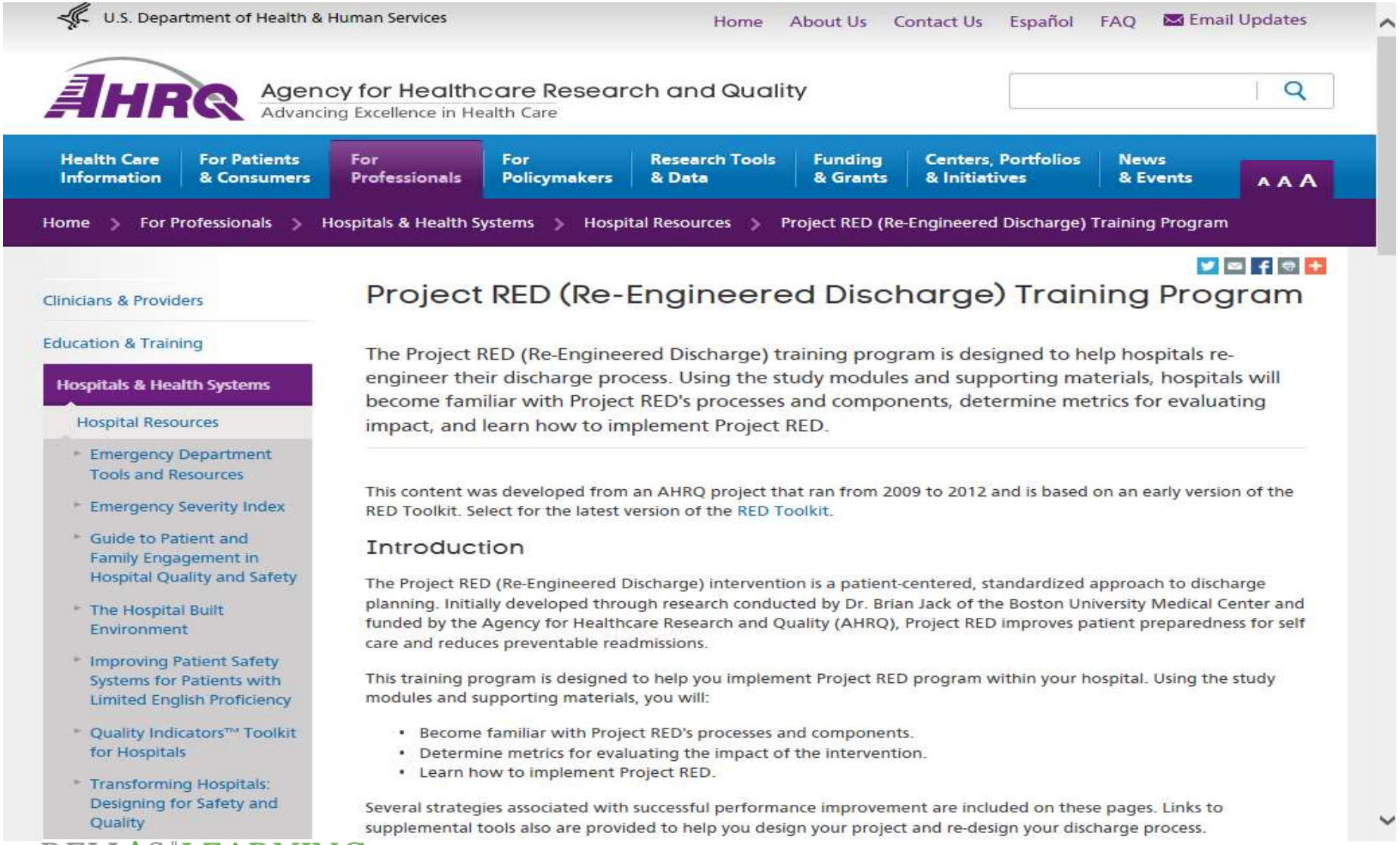
There has been a wide range of coverage about the release of the newly expanded RED toolkit, which we released on

Photo: Glenn Kulbako

Click for Project RED Toolkit

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

Updated RED Program



Contents

Module 1: Preparing to Redesign Your Discharge Program (PowerPoint® File, 3.8 MB)
Additional Materials:
- Building Your Cause and Effect Diagram
- Checklist for Post-Discharge Follow-up Phone Calls
- Defining Lean Waste and Potential Failure Modes
- Developing a High-Level Process Map and Swim-Lane Diagram
- Patient Care Plan Template
- Project Charter Template
- Project Leader Facilitation Guide

Module 2: The Re-Designed Discharge Process: Patient Admission and Care and Treatment Education (PowerPoint® File, 2.2 MB)
Additional Materials:
- Discharge Advocate's Data Collection Tool
- Project RED Metrics
- Questions for Patients in Targeted Population
- Questions for Primary Care Physicians Regarding Hospital Discharge Program
- Questions for Staff on Discharge Planning

Module 3: The Re-Designed Discharge Process: Patient Discharge and Follow-up Care (PowerPoint® File, 1.7 MB)
Additional Materials:
- Project RED Metrics
- Sample Script for Follow-up Phone Call

Module 4: Re-Engineering Patient Discharge: The Hospital Launch (PowerPoint® File, 1.4 MB)
Additional Materials:
- Building Your Cause and Effect Diagram
- Celebrate Team Success
- Defining Lean Waste and Potential Failure Modes
- Developing a High-Level Process Map and Swim-Lane Diagram
- Outline for Project Presentation
- Project RED Metrics
- Questions for Patients in Targeted Population

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

Clinicians & Providers
Education & Training
Hospitals & Health Systems
- Hospital Resources
  - Emergency Severity Index
  - Guide to Patient and Family Engagement in Hospital Quality and Safety
  - Hospital Guide to Reducing Medicaid Readmissions
  - Improving the Emergency Department Discharge Process
  - Improving Patient Safety Systems for Patients With Limited English Proficiency
  - NICU Toolkit
  - Preventing Falls in Hospitals
  - Preventing Pressure Ulcers in

Re-Engineered Discharge (RED) Toolkit

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A variety of forces are pushing hospitals to improve their discharge processes to reduce readmissions. Researchers at the Boston University Medical Center (BUMC) developed and tested the Re-Engineered Discharge (RED). Research showed that the RED was effective at reducing readmissions and posthospital emergency department (ED) visits. The Agency for Healthcare Research and Quality contracted with BUMC to develop this toolkit to assist hospitals, particularly those that serve diverse populations, to replicate the RED.

Select for the *Taking Care of Myself: A Guide for When I Leave the Hospital*, a booklet for patients based on the RED Toolkit.

Related Content

- Case Study: Penn Medicine Chester County Hospital Implements AHRQ Toolkit to Reduce Readmissions
- Case Study: AHRQ's RED Toolkit Helps Lower Readmissions in Dignity Health Hospitals

Publication: 12(13)-0084

ALTERNATE FORMATS

Order Print Copies
Re-Engineered Discharge (RED) Toolkit: Full Report [2.27MB]
RED Toolkit - All Forms [1.29MB]
RED Toolkit - All Forms [1.03MB]
Example After Hospital Care Plan (AHCP) [294KB]
Example After Hospital Care Plan (AHCP) [368.58KB]
AHCP Template for Manual Creation: English-Speaking Patients [118.6KB]
AHCP Template for Manual Creation: English-Speaking Patients [101.25KB]
Template for Manual Creation of the AHCP: Spanish-Speaking Patients [115.49KB]
Template for Manual Creation of the AHCP: Spanish-Speaking

3 Factors Leading to Errors at Discharge

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

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

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

3 Factors Leading to Errors at Discharge

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

Transitions Research

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

Patient Characteristics Play a Role

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

High Risk Screening Criteria

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

High Risk Screening Criteria

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

AHA Guide to Reduce Readmission and Recommendations

RELIAS LEARNING

AHA Reducing Avoidable Hospital Readmissions

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

AHA Guide to Reduce Readmissions

AHA 4 Steps

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

Develop Action Plan of Strategies

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

Strategies During Hospitals

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

Strategies During Hospitals

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

Strategies During Hospitalization

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

Strategies During Hospitalization

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

Ideal Discharge for the Elderly Patient: A Hospitalist checklist

Checklist Element	Particulars	Must Keep	Optional
Medication Education	• Written schedule of medication • Include Purpose (reason) and (if apt) Cautions(s) for each medication • Clinical Pharmacist involvement (especially if cognitive impairment, or ≥ 3 Medication changes	x x	 x
Cognition	Rather than a Folstein score, some description mention of mental capacity such as: • Lucid (full capacity for understanding and executive function, such as being able to follow instructions) • 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: • 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	 Cognitive status

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

Strategies During Hospitalization

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

Strategies During Hospitalization

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

Strategies During Hospitalization

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

Strategies at Discharge

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

Strategies at Discharge

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

Strategies at Discharge

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

Strategies at Discharge

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

Strategies at Discharge

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

Strategies at Discharge

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

Strategies at Discharge

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

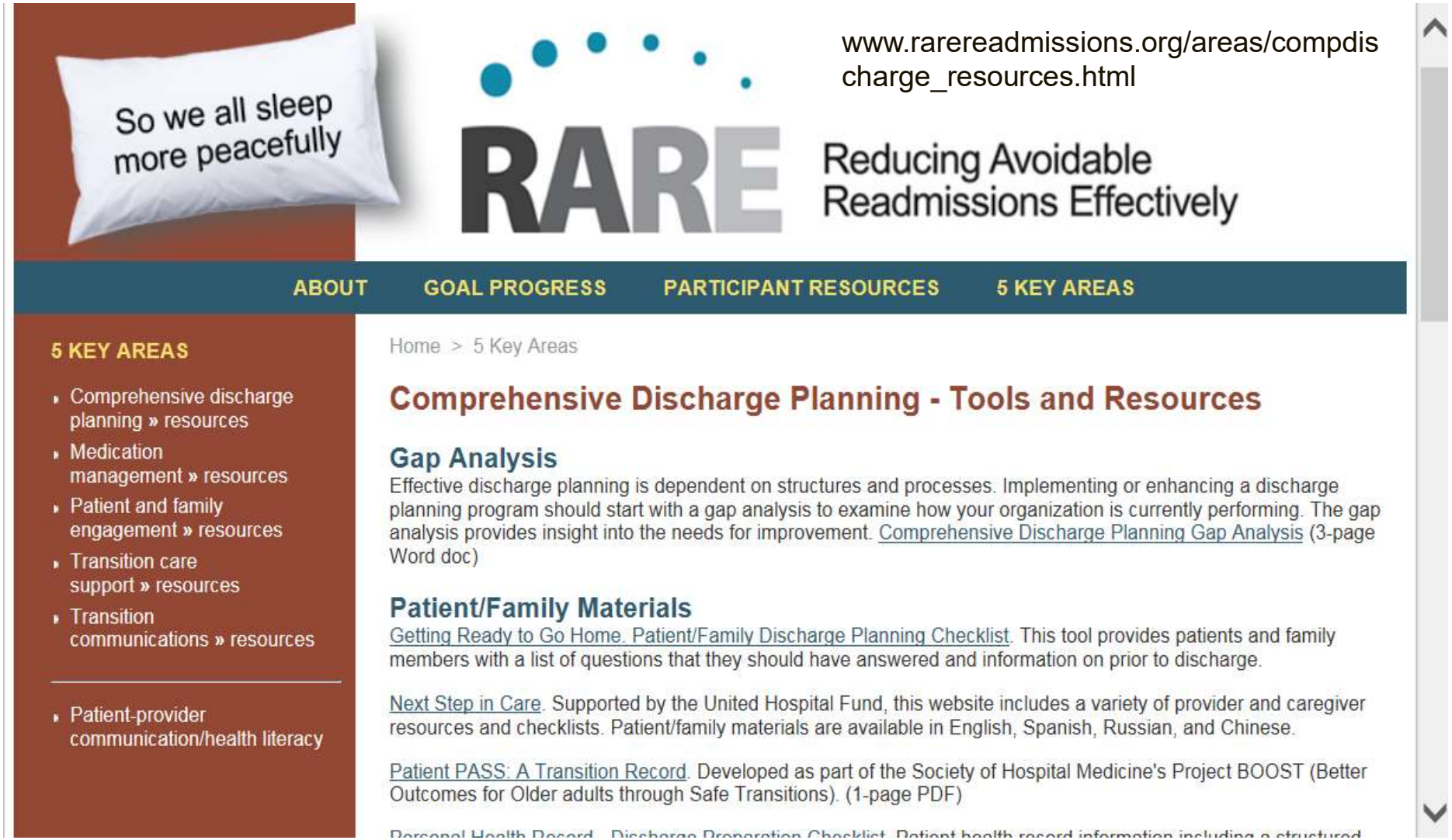
Strategies at Discharge

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

Strategies at Discharge

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

Resources from RARE



Gap Analysis for Discharge Planning

RARE Reducing Avoidable Readmissions Effectively

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

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

http://www.rarereadmissions.org/

RARE Reducing Avoidable Readmissions Effectively

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

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

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

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

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

The End! Questions??

- Sue Dill Calloway RN, Esq.
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- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education
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- Dublin, Ohio 43017
- 614 791-1468 (Call with questions, No emails)
- sdill1@columbus.rr.com
- See additional recommendations post discharge

THANK YOU

RELIAS | LEARNING

Additional Resources

RELIAS | LEARNING

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

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

Strategies Post Acute Care

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

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

Strategies Post Acute Care

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

Strategies Post Acute Care Technologies

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

Strategies Post Acute Care Technologies

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

Strategies Post Discharge

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

Strategies Post Discharge

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

The End! Questions???

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THANK YOU

RELIAS | LEARNING