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# Readmissions Reduced to 7.8% with Nursing Intervention at Home

Hospitals can significantly reduce readmissions with a multilayered program tailored to the needs of individual patients, according to the experience of an Arizona health system.

One of the program's strategies is to take some of the stress and responsibility off of case managers, says **Debra Richards**, MSN, RN, director of Sun Health Care Transitions, part of Sun Health, a non-profit healthcare organization in Surprise, AZ, focusing on care for seniors. She previously worked at a hospital implementing the organization's program for lowering readmissions.

As vital as case managers are to the discharge process and lowering readmissions, they can easily be overworked, Richards says. Prior to adopting the Sun Health strategies, her hospital depended on the case manager to send a referral to the care transitions team.

"A hospital case manager on an easy day has a ratio of 25 to one, so we found that the referrals really weren't getting done. It wasn't the fault of the case managers, because they were just so busy," Richards says. "When Sun Health put a patient liaison in the hospital, that person could screen the Medicare fee-for-service patients and introduce the program to them in the hospital, so it's not a cold call after discharge when they're tired, have home health coming, and doctor's appointments to be made."

> "A HOSPITAL CASE MANAGER ON AN EASY DAY HAS A RATIO OF 25 TO ONE".

Patients are more receptive to the program when it is introduced well before discharge, Richards says.

"They remember the nurse who came in the yellow scrub top who came in to see them and explained what we were going offer them," she says. "It makes a difference to



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have that connection well before the discharge process when there can be so much information to absorb and things to do. Then, when that same face appears later, they respond much better."

## Nurse Calls and Home Visits

Nurses in the Sun Health Care Transitions program follow, educate, and support patients for 30 days following their hospital discharge, including conducting home visits and phone calls to help patients better self-manage their health conditions and, in turn, reduce the need to be rehospitalized.

The nurses review patients' medication regimens, educate them on their conditions and potential red flags that could signal the need for medical attention, ensure timely physician follow-up care, and connect patients with helpful community resources.

At the time of discharge, the care transitions program is summarized for the patient, noting that a representative from Sun Health Care Transitions would contact him or her within 24-48 hours and providing a phone number to call if they have questions. Nurses prepare a personalized plan for contacting each patient, with a typical plan proceeding in this fashion:

- Prior to discharge: Bedside visit.
- First day after discharge: Phone call to assess the condition and answer any questions.
- Second or third day: Home visit.
- Seventh day: Phone call;
- 14th day: Phone call;
- 22nd day: Phone call;
- 30th day: Phone call.

The first phone call addresses general concerns, such as how the patient is feeling and whether he or she obtained the necessary medications, and whether the patient has made follow-up appointments with a physician. The caller also inquires about scheduling a visit from a nurse within the next 72 hours.

The home visit focuses on educating the patient about his or her particular needs and troubleshooting any problems that could interfere with healing.

"At the home visit, the RN goes over all the discharge paperwork, makes sure they're taking all their medications and not taking duplicate meds because they got a new prescription with a different name. If they're having trouble getting their prescriptions or getting through to their doctor's office to get an appointment, we will help them with that," Richards says. "We also provide them a binder of information for learning about their chronic diseases. They may have been admitted for a hip fracture, but it's their chronic heart failure that's likely to cause a readmission, so we help them learn how to care for that condition after a major surgery."

## RN Makes Action Plan

The patient is asked to have all of his or her medications out on a table when the nurse is scheduled to visit, so they can be assessed for any conflicts. This is particularly important with some patients who hold on to old medications, Richards says. Her own father always had a bag of current medications and a bag of old medications that he saved just in case he needed them again.

"We can help them dispose of those old meds so that they're not hanging around and potentially having a bad effect when the patient confuses them for another medication or decides to start taking an old medication again without a doctor's order," she says.

The RN also develops an action plan that helps the licensed practical nurses who make the follow-up phone calls after the visit, guiding them to ask the right questions for that patient. For instance, the LPN might ask if the patient's weight is increasing or whether there has been any progress in scheduling a doctor's appointment that was proving difficult. If the patient has seen a physician, the nurse asks how that went and whether there was any change in medication.

It is important to have RNs make the house call, explains **Jennifer Drago**, MBA, MHSA, FACHE, executive vice president for population health with Sun Health. The LPNs are fine for making contact with the patient, but an RN is necessary for some of the key tasks during the home visit, she says.

"We've specially picked our RNs because of their backgrounds in chronic disease, and many of them have experience in home care so they know what to look for when they go into the home," she says. "As RNs, they can do much more than a lay person or a volunteer — or even a social worker, in some respects — would be able to do in terms of educating the patient about chronic disease and addressing medication reconciliation in the home."

The nurse making the call also asks about wound care, though that is not an issue that is specifically addressed at the home visit.

"Even though we don't do wound care as part of this program, it's useful to have someone reach out and ask that question because maybe they don't have home health and don't realize that it's a bad thing when the wound is getting red and hurting," Richards says. "We can direct them to the proper care for that and follow up to make sure they're getting it."

The program is different from what most hospitals do because the nurses are able to devote more time and attention to the patient after discharge, Richards says. Most hospitals simply don't have the resources to see and contact patients regularly after discharge, she says.

"From a hospital's point of view, they usually can accomplish

## Lower Readmissions Don't Always Save Money

A new study from Los Angeles-based Cedars-Sinai Medical Center suggests that lower readmissions do not always mean saving money for the hospital.

A Cedars-Sinai-led team of investigators evaluated the effectiveness and financial benefit of quality improvement programs at medical centers in the United States and elsewhere. Teryl Nuckols, MD, director of the Division of General Internal Medicine in the Cedars-Sinai Department of Medicine, and colleagues conducted a systematic review of data from 50 quality improvement studies involving more than 16,700 patients, finding that quality improvement interventions reduced readmissions by an average of 12.1% for heart failure patients and 6.3% for older adults with diverse health issues. (*An abstract of the study is available online at http://bit.ly/2snIjNz.)*

Financial savings from those reduced readmissions were inconsistent. The average net savings for health systems was $972 per person among heart failure patients and average net losses of $169 per person among other patients. However, the authors note that costs varied so widely across studies that they could not conclude definitively whether these interventions saved or lost money.

When looking specifically at older adults, the researchers found that the biggest net savings came from interventions that engaged patients and caregivers, such as nurses or pharmacists training patients and family members about how to manage medications after discharge, which types of activities are appropriate, and which symptoms might represent something serious.

In a statement issued with the release of the study, Nuckols said she was surprised that the interventions didn't save more money. The results counter a widely held belief that reducing readmissions should save money by preventing additional costs for return hospital stays, she said.

"Hospitalization is very expensive, so avoiding even a few readmissions should have saved a lot of money," she said. "Our findings suggest that there is no guarantee of net cost savings once the implementation costs associated with efforts to prevent readmissions are considered." ■

one discharge call after the patient goes home, if they're lucky enough to connect with them. It's a one-time call and you're not in the home," Richards says. "Going into the patient's home is what is really golden. The patient can tell the case manager about the home and living conditions, but the case manager really has no clue. When I go to the home, I can see that this person is a hoarder, or has throw rugs everywhere — all sorts of safety issues that we can address however necessary."

The Sun Health Care Transitions program costs about $340 per patient to implement, but Drago says that expense is more than recouped by reducing readmissions. The return on investment typically is 150% to 200%, she says.

Patients participating in the program have rated Sun Health Care Transitions an average 4.74 on a scale of 5 in a satisfaction survey after the end of their transition programs, and more than 99% said they would recommend the program to others.

The Care Transitions program was launched in November 2011, and since then there have been 11,861 patients enrolled. The 30-day readmission rate for Sun Health Care Transitions patients is 7.72%, demonstrably lower than the national Medicare average, Richards notes.

In that period, Sun Health would have expected 2,111 readmissions without the transition program, but the actual readmissions were 916. That's a reduction of 57%, yielding an estimated savings of $16 million, Richards says. *(One recent study suggests the savings from lower readmissions may not be as great as some quality leaders expect. See the story in this issue.)*

The good figures for 30-day readmissions continue, Drago notes, with 60-day readmissions at 15.2% (compared to 23.8% at partner hospitals not using the program) and 18.4% at 90 days (compared with 29.5% at the other hospitals).

"The reduction we had actually increases in that 90-day window, and we attribute that, in part, to the work we do around chronic disease, because they don't usually get that kind of information, or they're not very receptive to it. We catch them at a vulnerable time when they've just been discharged and they're engaged because they want to know how not to go back to the hospital," Drago says. "The work with medications also is important, and there is a significant impact from being in the home and looking for the social determinants of health that can impact the person's physical health. We as healthcare professionals focus so much on the physical, of course, but if someone doesn't have transportation or air conditioning or access to food, their health is going to suffer." ■

### SOURCES


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# Using Family as Informal Caregivers Cuts Readmissions 25%

Hospitals never seem to have enough resources, but you might be overlooking people who could be effective in improving post-discharge care and reducing readmissions: the friends and family of the patient.

Including family and friends means more than just letting them sit in on discharge instructions, says **Juleen Rodakowski**, OTD, OTR/L, assistant professor in the Department of Occupational Therapy in the University of Pittsburgh's School of Health and Rehabilitation Sciences. She is the lead author of a recent report on using informal caregivers to reduce readmissions, the first to quantify the post-discharge impact of caregiver integration into discharge planning on healthcare costs and resource utilization. *(An abstract of the study is available online at: http://bit.ly/2rFEeI1.)*

Her research found that integrating informal caregivers into the discharge process can cut readmissions by 25%, a finding that she says validates the Caregiver Advise, Record, and Enable (CARE) Act, which has been adopted by more than 30 states and the District

## CARE Act Requires Hospitals to Ask About Caregivers

The Caregiver Advise, Record, and Enable (CARE) Act requires hospitals to give inpatients the opportunity to formally identify a caregiver, such as a friend or relative, who can provide assistance with aftercare following discharge.

The act has been adopted by more than 30 states and the District of Columbia. When it became effective in the state of New York in 2016, the New York State Department of Health issued an advisory to all hospital CEOs about the need to comply. The letter stated that "The New York State Department of Health expects hospitals to develop a policy and procedure to implement the requirements of the CARE Act."

"Patients are not required to designate caregivers, and caregivers are not obligated to perform after-care tasks for patients. The patient must consent to disclose the patient's health information to the caregiver if the patient wants to designate a caregiver," the letter stated. "If the patient does designate a CARE Act caregiver, the hospital must include the name and contact information of the caregiver in the patient's discharge plan."

The Department of Health explained that the hospitals must attempt to notify the caregiver of the patient's transfer to another healthcare facility, and it must attempt to contact the caregiver prior to a patient's discharge to his or her residence so that the caregiver can provide after-care assistance in accordance with the hospital's instruction to the caregiver.

"The hospital as soon as possible prior (and if possible, 24 hours prior) to the patient's discharge must consult with the identified caregiver along with the patient regarding the patient's after-care needs at his or her residence," the letter said. "The hospital must offer caregivers instruction in all after-care tasks, taking into account the capabilities and limitations of the caregiver. Instruction to the caregiver is only required for patients being discharged to their homes, not patients being discharged to other healthcare facilities."

The health department also stipulated the following requirements:

- A demonstration of the after-care tasks. The demonstration may be performed live by a member of the hospital's workforce authorized to perform the after-care task, or it may be a recorded demonstration.
- After the patient and the caregiver have been given an opportunity to ask questions about the after-care tasks, questions will be answered.
- The hospital must document in the medical record that the instructions were provided to the caregiver.

The letter clarified that instructions to the CARE Act caregiver would not negate the need for home healthcare or other services, and patients must still be assessed for the need for healthcare services as part of the discharge plan. ■

of Columbia, as well as proposed Medicare regulations that require caregiver identification and training before patients leave a healthcare facility. *(See the story in this story for more on the CARE Act.)*

"We've always had the notion of family and friends helping patients after discharge, but they are taking on more and more care responsibilities for patients. With the advent of new technologies and clinical developments that make home care more beneficial for patients, these caregivers are being asked to do more," Rodakowski says. "They might be called on for medication management, including some that are fairly complex, along with wound care and using medical equipment in the home. We're finding that caregivers are capable of all this as long as we give them the necessary support, and they're willing, especially when they understand how much this can influence keeping their loved ones from going back to the hospital."

## No Single Type of Caregiver

The person taking on the role of informal caregiver will vary greatly from patient to patient, Rodakowski notes. But whoever steps into that role, the hospital must provide training for that caregiver, she says.

Much of the strategy with informal caregivers seems obvious, teaching a friend or family member the information that a groggy and possibly distressed patient isn't going to absorb well, but the CARE Act helps solidify the surrounding work processes, says **Connie Feiler**, RN, MSN, senior manager of patient education at the University of Pittsburgh

Medical Center (UPMC). UPMC adopted the CARE Act requirements April 1 and the law took effect in Pennsylvania on April 30.

"Now, on admission, we're asking every patient if they would like to designate a home caregiver, someone they would like to be involved with the discharge process and afterward at home," Feiler says. "Most people would readily agree that that makes sense, but the CARE Act provides a structure to make that happen consistently and effectively."

Informal caregivers can provide support for medical tasks and activities critical to the daily life and health of someone who had a recent hospital or nursing home stay, explains senior author **A. Everette James**, JD, MBA, director of the University of Pittsburgh's Health Policy Institute and its Stern Center for Evidence-Based Policy.

"While integrating informal caregivers into the patient discharge process may require additional efforts to identify and educate a patient's family member, it is likely to pay dividends through improved patient outcomes and helping providers avoid economic penalties for patient readmissions," he says.

James notes that a recent Congressional Budget Office analysis found that caregivers provide 80% of all community-based long-term services and support for older adults. He, Rodakowski, and their colleagues systematically reviewed 10,715 scientific publications related to patient discharge planning and older adults, focusing the meta-analysis on the 15 publications describing randomized, controlled trials that included enough relevant information and data to draw insights into the influence of discharge planning on hospital readmissions.

The studies included 4,361 patients with an average age of 70 years. Two-thirds of the caregivers were female, and 61% were a spouse or partner, while 35% were adult children, Rodakowski says.

The research indicated that integrating caregivers into discharge planning resulted in a 25% reduction in risk of the elderly patient being readmitted to the hospital within 90 days, and a 24% reduction in risk of being readmitted within 180 days, when compared with control groups where no such integration occurred.

## Different Ways to Implement

The healthcare organizations that integrated informal caregivers did so in various ways, but they had common themes and patterns, Rodakowski says. Common strategies included connecting patients and caregivers to community resources, providing written care plans and medication reconciliation, and using learning validation methods such as teach-back, where the caregiver demonstrates his or her training to an instructor, typically a nurse.

Feiler notes that, like with patients, the education for their informal caregivers must be tailored to what works best for the individual.

"Hospitals typically give loads of printed materials because it is helpful to have something to refer to when you go home, but we know that, often, patients also like a demonstration of things like drawing and injecting insulin. Others like videos they can watch at home," she says. "We include the caregiver in that whenever possible, and we build in the education early enough in the workflow so that we have time, rather than trying to do it all five minutes before discharge."

There was no clear indication that any particular type of healthcare professional was better at educating the informal caregivers, Rodakowski says, and the study included a variety of healthcare settings.

"What this shows is that no matter the setting and the details of who, what, and when the education was provided, the integration of informal caregivers was effective in reducing readmissions," Rodakowski says. "It was a variety of discharge planning interventions, so the study results supported the overall concept of informal caregivers rather than specific ways to implement that strategy."

## Possible with Most Patients

Integrating informal caregivers is possible in most cases, Feiler says. Most patients have someone who can step into the role, usually a family member, but Feiler notes that a significant number will have a neighbor or other friend who can help. If the patient has no one to designate as a caregiver, UPMC can provide assistance through case managers and home care services.

Patients also are free to decline having a home caregiver, and the person originally selected may change during the hospital stay or after, Feiler notes.

"The wife might say her husband will do it, just automatically, but then during the hospital stay the husband might realize he doesn't want to give injections or be responsible for other aspects

of the care after discharge," she says. "They usually can find someone else who is a better fit."

UPMC built the strategy into its electronic medical record with alerts during the hospital stay to remind clinicians to ask about designating a caregiver, and another prior to discharge to remind clinicians to include the caregiver in discharge and schedule a time for education.

Informal caregivers are not a substitute for home care services, explains **Linda Waddell**, RN, MSN, CJCP, CPPS, senior manager of quality and crisis intervention at UPMC. Not all patients require home care services, but those that do still can benefit from an informal caregiver, she says. Likewise, having an informal caregiver does not rule out the professional home caregiver.

"If the patient also needs a home care nurse, the informal caregiver is still there to support the patient and continue to learn how to assist the patient at home," Waddell says. "There may be additional services that should be provided by a home care nurse, but that nurse is not going to be there with the same frequency that an informal caregiver might be. That designated caregiver is still going to be an important part of the patient's recovery process." ■

### SOURCES


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# Most Hospitals Penalized in HRRP All Five Years

CMS penalized more than half of hospitals participating in the Hospital Readmissions Reduction Program (HRRP) initiated by the Affordable Care Act in all five years of the program — but penalties were less common for hospitals treating the most medically complex patients, according to a recent analysis.

The penalties also could have increased significantly but did not, notes lead author **Michael P. Thompson**, a postdoctoral fellow in the Department of Preventive Medicine at the University of Tennessee Health Science Center in Memphis. *(An abstract of the report is available online at: http://bit.ly/2pQ2FOS.)*

Thompson and his colleagues focused on the characteristics of hospitals that received penalties during all five years, how penalties changed over time, and the relationship between baseline and subsequent performance. They found that in fiscal years 2013 to 2017, slightly more than half of the hospitals were penalized but the average penalties remained modest. They doubled from 0.29% to 0.60%, remaining low despite increasing opportunities for penalization, Thompson says.

"Even though conditions for readmission were added during this period, the size of the penalties did not increase all that much," he says. "There was a slight increase but not as much as we expected considering the increased opportunity for more penalties, simply because more conditions were included in the

program. That was surprising."

Penalties were more common in urban hospitals, major teaching facilities, large hospitals, for-profit hospitals, and those that treated larger shares of Medicare or socioeconomically disadvantaged patients.

## Complex Care Not a Factor

"Surprisingly, hospitals treating greater proportions of medically complex Medicare patients had a lower cumulative penalty burden compared to those treating fewer proportions of these patients," the study authors wrote.

The researchers also found that hospitals with high baseline penalties in the first year continued to receive significantly higher penalties in subsequent years.

"I think that was mostly based on the fact that penalties were assessed based on your performance relative to your peers, and if you start off high you are going to remain high even if you are improving," Thompson says. "That is somewhat concerning and leads to the larger issue of how we do pay-for-performance. If we do it solely off performance, you may have to make extra effort to drop below your peers who also may be improving. If you're both improving at the same rate, you're still going to be relatively worse or relatively better than your peers, depending on where you started."

Alternatives might include basing pay-for-performance on changes relative to previous performance or some established benchmark, he notes. The continuation of the high baseline penalties through the five years could lend support to arguments in favor of those options, he says.

Continuing to assess quality in this way could have unintended consequences if hospitals continue to receive penalties every year, even when they are improving quality, Thompson says. If hospital leaders start to feel like they can't win no matter how they try, some may stop trying so hard to improve quality, he suggests.

Thompson notes that the 21st Century Cures Act now allows the HRRP to allow for dual-eligible status.

"It will be interesting to see how penalties will be modified based off of that. Knowing the type of patients your hospital treats will become increasingly important in understanding where your burden might lie," he says. "If you're a hospital that treats disadvantaged, lower socioeconomic status patients you probably already know that you're going to have a harder time with this policy. So understanding where you lie relative to your peers is the first step, and then you may have to take greater steps to reduce readmissions, with larger investments. You can't just do what everyone else is doing because you have to do more to avoid penalties in the future."

Thompson says adjusting for socioeconomic factors could change the situation significantly if the system begins comparing hospitals that have similar proportions of dual eligibles.

"It's going to shake up who are the winners and losers, who receives a penalty and who doesn't," he says. "In the current paradigm of penalties we can expect a continuation of the penalties we've seen in the past five years, and the same patterns that suggest some hospitals are at a real disadvantage, but factoring in socioeconomics could turn a lot of this on its head." ■

### SOURCE


- Michael P. Thompson, Postdoctoral Fellow, Department of Preventive Medicine, University of Tennessee Health Science Center, Memphis. Email: mthompson@uthsc.edu.


## Guide Available for Including Informal Caregivers

Hospital leaders seeking guidance on how to integrate friends and family as informal caregivers at discharge can consult a resource made available by the Canadian Patient Safety Institute (CPSI) and Patients for Patient Safety Canada (PFPSC).

Written by both patients and providers, *Engaging Patients in Patient Safety – a Canadian Guide* provides tools to encourage a partnership. The guide is organized into four chapters, each focused on a different aspect of patient engagement in patient safety and each containing a "What You Can Do" section that gives users concrete ideas for action.

The guide is designed to be used in all healthcare settings and will be updated periodically as new evidence and best practices in patient engagement emerge. The guide is available online at: http://bit.ly/2rs6ZEX. ■

# Hospitals Working on Becoming More Age-friendly

Hospitals across the country are working toward creating a culture that provides better quality care to aging Americans, with the aid of The John A. Hartford Foundation (JAHF), a nonprofit, nonpartisan organization. The initiative began about two and a half years ago when JAHF President **Terry Fulmer**, PhD, RN, FAAN, and her colleagues began looking at ways to improve care transitions and the way episodes of care are addressed for an aging population.

"We know that 10,000 turn 65 every day in this country, and we think there will be a demand for care that will rise more than 200% in the next decade," she says. "We spend about a trillion dollars in hospital costs every year, and a lot of that is Medicare. That confluence of incredibly expensive care and elder people means that we need to be thinking about how to create a system that creates value and continuity across systems."

JAHF offers multiple resources online at: www.johnahartford.org, and is working with the Institute for Healthcare Improvement in Cambridge, MA, to develop strategies for better quality of care.

JAHF has partnered with five health systems that provide care in 40 states. That work, begun in January, has identified the following four key elements that can be applied to any hospital or health system:

- **What matters to the patient.** "If what matters to the patient is living long enough to see a grandson's wedding, you're going to take one strategy, but if what matters to the patient is something different, you're going to provide a different kind of care," Fulmer says.
- **Communication**
- **Mobility**
- **Mentation, or mental activity.** This includes confusion, delirium, and mood.

"Those four elements are the basis for a prototype to improve care for older people across all healthcare systems," Fulmer says.

In addition, JAHF offers the following expectations for an age-friendly healthcare system:

- leadership committed to addressing ageism;
- a geriatric care prototype specific to older adults;
- clinical staff who are specifically trained and expert in the care of older adults;
- care teams that are high performing and can show measurable results for care of older adults;
- a systematic approach for coordinating care with organizations beyond their walls;
- a strategy to identify, coordinate with, and support family caregivers;
- a clear process for eliciting patient goals and preferences so as to define a plan of concordant care;
- expected outcomes;
- care that is concordant with the person's goals;
- promotes physical function and independence;
- prevents polypharmacy (too many medications, inappropriate medication, or the wrong dosage of medication for older adults);
- addresses common geriatric syndromes like falls, delirium, and incontinence;
- manages pain and symptoms;
- recognizes and supports the needs of family caregivers;
- in the community, recognizes increased risk and prevents needless decline;
- in the hospital, restores health;
- in transitions, proactively arranges for the necessary supports and services;
- seamlessly provides coordination between settings and providers. ■

## SOURCE


- **Terry Fulmer**, PhD, RN, FAAN, President, The John A. Hartford Foundation, New York City. Telephone: (212) 832-7788.


# HHS Says CMS Should Look Harder for Cheating Hospitals

Most hospitals are playing fair when it comes to reporting quality data, but CMS needs to look harder for those that are gaming the system with inaccurate information, according to a recent report from the Department of Health and Human Services (HHS).

CMS requires hospitals to self-report quality data and uses that information to determine financial penalties, and by law CMS must validate that data. In 2016, CMS reviewed the data of 400 randomly selected hospitals, as well as 49 hospitals targeted for failing to report half the healthcare-associated infections they had in the previous year, or for having low passing scores in the prior year's validation process.

Almost 99% of hospitals that CMS reviewed passed validation, CMS reports. CMS took action against the six that failed, including reducing their Medicare payments, and it offered training to hospitals to help improve the accuracy of the quality data that hospitals report.

"However, CMS's approach to selecting hospitals for validation for payment year 2016 made it less likely to identify gaming of quality reporting (i.e., hospitals' manipulating data to improve their scores). CMS did not include any hospitals in its targeted sample on the basis of their having aberrant data patterns," HHS reports. "Targeting hospitals with aberrant patterns for further review could help identify inaccurate reporting and protect the integrity of programs that make quality-based payment adjustments."

HHS notes that CMS selected none of the targeted hospitals using analysis-based criteria, such as aberrant data patterns or rapid changes in reporting. In fact, CMS identified 96 hospitals with aberrant data patterns, but did not target them for validation even though the agency can select up to 200 targeted hospitals for review, according to the HHS report.

HHS recommends that CMS make better use of analytics to ensure the integrity of hospital-reported quality data and the resulting payment adjustments. CMS could use analytics to select an increased number of hospitals in its targeted validation sample, HHS suggests, and it could analyze the data to identify outliers such as hospitals with data patterns that are substantially different from other hospitals, determine which of those outliers warrant further review, and add them to the sample.

"For example, CMS could use analytics to identify hospitals with abnormal percentages of patients who had infections present on admission; this might help identify hospitals that engage in some of the data manipulation" that is known to occur, the HHS report says.

The HHS report is available online at: http://bit.ly/2pJ0UCG. ■

# Patients Using Yelp to Choose Hospitals

With people using online reviews to choose nearly everything they buy, they eventually had to get around to including hospitals. A report from the Manhattan Institute and funded by the New York State Health Foundation suggests that Yelp can be useful in guiding patients to hospitals with better quality.

The study found that higher Yelp ratings are correlated with better-quality hospitals and particularly with rates of preventable readmissions. There also was a correlation between Yelp scores and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures for the hospitals in the study.

Yelp partnered with ProPublica in 2015 to publish average wait times, readmission rates, and the quality of communication scores for more than 25,000 hospitals, nursing homes, and dialysis clinics.

"We find that higher Yelp ratings are correlated with better-quality hospitals and that they provide a useful, clear, and reliable tool for comparing the quality of different facilities as measured by potentially preventable readmission rates, a widely accepted metric," the authors reported. "We do not argue that Yelp alone is, or can be, the only guide to quality hospitals. However, when people can choose where they will obtain care — as do patients with traditional Medicare coverage for elective or planned surgeries, or when consumers can choose among insurance options — Yelp ratings can provide a helpful guide."

The report suggests that when patients seek out specialists for surgical or other hospital procedures, these specialists' hospital privileges could factor in their decisions, providing another data point in addition the traditional referral. The usefulness of Yelp reviews should improve as the number of reviews increases, the study says.

The report is available online at http://bit.ly/2stEYMI. ■

# Gender Disparities Seen Most in Addiction Treatment

Gender disparities in healthcare are most likely to be related to follow-up care for alcohol and drug treatment, according to a report released by the CMS Office of Minority Health.

The recently released *Gender Disparities In Health Care in Medicare Advantage* is based on 2015 data. It examines 24 clinical care measures, indicating that women receive worse care than men for three measures, similar care for 16, and better care than men for five measures. Disparities in care were considered statistically significant if the difference between men and women receiving the care is three or more points after rounding. *(The full report is available online at: http://go.cms.gov/2qJ85LC.)*

Gender disparities were most pronounced in the category of avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls, in which men received significantly better care. According to the report, 61% of elderly men met the standard of care, compared to approximately 50% of elderly women.

Women received better care in some categories. The advantage for women was most prominent with follow-up within 30 days of discharge after a hospital stay for mental illness. Fifty-seven percent of women received follow-up care, compared to about 50% of men.

Women also received significantly better care than men in the following areas:

- Follow-up after a hospital stay for mental illness (within seven days of discharge) — women received better care by 4.8%.
- Diabetes care eye exam — by 3.2%.
- Management of COPD exacerbation with bronchodilator — by 3.6%.
- Rheumatoid arthritis management — by 3.1%.

Men received significantly better care than women in the following areas:

- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls — men fared better by 11.3%.
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia — by 8.3%.
- Initiation of alcohol or other drug treatment — by 6.3%. ■

# Industry Group Calls on Trump to Ease Regulation

A leading group in the healthcare industry is calling on President Donald Trump to make American healthcare great again by reducing the regulatory burden.

Citing the Feb. 24 executive order by President Trump ordering a reduction in "unnecessary regulatory burdens placed on the American people," the Federation of American Hospitals (FAH), which represents investor-owned hospitals, sent a letter recently to Health and Human Services Secretary Tom Price, calling for specific changes. They include suspending the hospital quality ratings system and readjusting bundled payment programs. Similar requests have been made by other healthcare groups since Trump was elected. *(The FAH letter is available online at http://bit.ly/2rFAYMT.)*

CMS also should permanently end the controversial home-health demonstration, the FAH letter says. The program is intended to reduce home health fraud in states that have historically seen high levels of fraud, but FAH says it is ineffective and poses a bureaucratic burden for the industry. ■

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# CE QUESTIONS

**1. In the discharge follow-up program described by Debra Richards, MSN, RN, what is the first patient contact by a transition nurse?**

a. At the bedside during the hospital stay.
b. At the time of discharge.
c. One day after discharge.
d. Two days after discharge.

**2. What is the estimated return on investment for the Sun Health Care Transitions program?**

a. 60% - 80%
b. 80% - 100%
c. 100% - 150%
d. 150% - 200%

**3. According to research led by Juleen Rodakowski, OTD, OTR/L, how much are readmissions reduced by integrating informal caregivers into the discharge process?**

a.15%
b 25%
c. 35%
d. 45%

**4. From 2013 to 2017, what percentage of hospitals were penalized in the Hospital Readmissions Reduction Program?**

a. More than one-quarter
b. More than half
c. More than two-thirds
d. More than three-quarters

# CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.