Reducing Avoidable Readmissions Within 30 Days of Discharge
What We Know About Hospital Readmissions

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

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

Likely Factors

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

Known Factors

• Readmission rates will not be decreased without understanding factors that lead to readmissions.
• Reducing readmissions cannot be done by hospitals alone.
• Systems factors must be considered, even while focusing on specific challenges, solutions
Process Breakdowns That May Result in Potentially Avoidable Readmissions (1)

• Poor transfer of key information to patients
  – Incomplete understanding of medication instructions at discharge
  – Incomplete understandings of when to re-contact care provider

• Poor transfer of information to ambulatory care settings
  – Hospital to care facility staff
  – Hospital to primary care provider
  – Lack of clarity on desired end of life care
Process Breakdowns That May Result in Potentially Avoidable Readmissions (2)

• Lack of primary care provider follow-up
  – Primary care provider unaware of hospitalization
  – No transportation to primary care provider
  – No primary care provider

• Poor patient-family knowledge and non-disclosure of current medications, incomplete medication recommendation may cause duplication or interaction

• Patients may be unlikely to ascribe effects of causes; may not ask for change in medication therapy or discontinue medications
Known Diagnostic-Specific Reasons for Avoidable Readmissions

• COPD, pneumonia patients
  – Patients frequently need but don not receive home health care
  – Pneumonia readmissions may reflect need for end of life care.

• Cardiac patients
  – Cardiologists frequently reply on primary care to arrange follow-up visits

Readmissions are more frequent in patients with co-existent behavioral health diagnoses.
## Known Diagnostic-Specific Reasons for Avoidable Readmissions

<table>
<thead>
<tr>
<th>Post-Operative Patients</th>
<th>Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surgeons not arranging for post-surgical primary care</td>
<td>• This patient population is highly vulnerable to changes in medication therapy during hospital stay which impacts them post-discharge.</td>
</tr>
<tr>
<td>• Inadequate teaching for the patient in caring for themselves post-discharge</td>
<td></td>
</tr>
<tr>
<td>– Incision care</td>
<td></td>
</tr>
<tr>
<td>– Expectations for pain management</td>
<td></td>
</tr>
<tr>
<td>– Resuming activities of daily living</td>
<td></td>
</tr>
<tr>
<td>– Post-CABG patients seeking readmission for angina</td>
<td></td>
</tr>
</tbody>
</table>
Congressional Action in Healthcare Reform to Address Avoidable Readmissions

- Public reporting of hospital readmission rates
- Penalties against hospitals with readmissions above expected rates for targeted conditions were started on Oct. 1, 2013
  - Sole community hospitals, Medicare-dependent small rural hospitals and low-volume conditions are exempt.
Key Message:
Hospitals Need Support in Reducing Avoidable Readmissions
Most evidence demonstrates impact of care coordination is unreliable.

Study found three types of effective intervention

- Transitional care interventions (Naylor, 2004)
- Patient self-management educational interventions (Lorig, 1999; Wheeler, 2003)
- Interventions to coordinate care (Selected sites from Medicare Coordinated Care Demonstration)
Effective Transitional Care Interventions Identified by Mathematica Study

• Summary of Findings
  – Patients in intervention group had 34% fewer readmissions per patient over one year period
    o Specific focus on patients with CHF
    o Assigned APNs to follow patient
    o One year post-discharge follow-up of patient
  – Forty-five percent of intervention patients readmitted vs 55% of control group
  – Thirty-nine percent lower average total cost of care ($7,636 vs $12,481)
    -- (Reported by Naylor, 2004)
Specific Interventions From Mathematica Study

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

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

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

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


