EFFECTIVE STRATEGIES TO REDUCE HOSPITAL READMISSIONS

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Why are re-hospitalizations an issue? (1)

- 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, experts estimate that 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge.
- According to an analysis conducted by the Medicare Payment Advisory Committee (MedPAC), up to 76 percent of rehospitalizations occurring within 30 days in the Medicare population are potentially avoidable.
- Avoidable hospitalizations and rehospitalizations are frequent, potentially harmful and expensive, and represent a significant area of waste and inefficiency in the current delivery system.
Why are re-hospitalizations an issue??

- Poorly executed care transitions negatively affect patients’ health, well-being, and family resources and unnecessarily increase health care system costs.
- Continuity in patients' medical care is especially critical following a hospital discharge. For individuals with multiple chronic conditions, this transition takes on even greater importance.
- Research shows that one-quarter to one-third of these patients return to the hospital due to complications that could have been prevented.
- Unplanned rehospitalizations may signal a failure in hospital discharge processes, patients’ ability to manage self-care, the quality of care in the next community setting (office practices, home health care, and skilled nursing facilities), and lack of appropriate care resources for high-risk patients.
“We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do.”

— Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science*
Objectives

- Discuss care transitions and where interventions are useful
- Improved patient education and home management support and family engagement
- Multidisciplinary team management with collaboration prior, during and after each hospitalization (RCA)
- Discuss medical problems associated with hospitalization and know the post acute care providers capabilities
- Seamless exchange of health information
- Improve patient and family engagement
- Continuous present and advance care planning for patient-centered care planning at the end of life
Abe Billings

- 88 year old man with history of CHF, diabetes, CKD, and stroke with aspiration
- Has advanced care plan-fix fixable things; DNR (LaPOST)
- Lives at home with daughter (J), daughter (P) very involved
- PCA care 2 hrs in AM, 2 hrs in PM 7 days a week
- Comes to PACE 5 days per week
  - Develops SOB over the weekend after crawfish boil and goes to ED.
  - Found to have CHF-diuretics increased
  - Discharged home with daughter (J)
Abe Billings

- Comes to PACE on Monday
- Medications reconciled-new increased dose of diuretics identified
- Comes to PACE 5 days per week-VS/weighed daily-decreasing 1#/day
  - Treated with antibiotics
  - Diuretic decreased due to increase in creatinine.
- Discharged to home with antibiotics, neb treatments and no diuretics!
Abe Billings

- Daughter (J) is going out of town, daughter (P) is caring for him in her home
- Different scale-no change in weight since discharge
- Daughter (P) less comfortable with care needs
- Develops shortness of breath
- 911 is called--LaPOST honored
- Admitted with CHF/acute MI develops AKI on CKD
- Palliative plan ensues
- Admitted to inpatient hospice
- Peaceful death
Broad categories of Interventions

- Enhanced care and support during transitions
- Improved patient education and self management support
- Multidisciplinary team management
- Patient centered care planning at the end of life
Enhanced Care and Support at Transitions

- Improved discharge processes
  - Project RED (reengineered discharge) Reduced by 30% (only in 1st 6 mos)
  - Discharge form

- Early post discharge follow up
  - Review of this literature (single home visit/increased clinic fu or phone contact/both/ continuous home care-2 disciplines) reduced rehospitalizations by 25%
  - Telephone based case management and patient education in a Hispanic population did not show any benefit on hospitalization rate

- Front loaded home care visits – CHF but not DM 2.6% decrease only

- Remote monitoring
  - CHF 14-80% reduction
  - Asthma not statistically significant
  - All cause 14-55%

- Nurse led transition care services (Coleman and colleagues) 8.3% vs 11.9% at 30 days and 16.7% vs 22.5% at 90 days
**Improved Patient Education and Self Management Support**

- **Patient education and self management support**
  - *Mostly in inpatient setting*
  - *CHF decreased 35% over 9 months but as much as 56%*

- **Disease or case management**
  - *36 RCT on 6 had significant reductions in rehospitalizations but pooled numbers reduced 1st rehospitalization by 8% and subsequent all cause by 19%*
  - *Most successful is the EVERCARE intervention*
    - Risk stratified/100 enrollees per NP/0.35 hospitalization per 100 vs 0.89 control
    - Some decrease in rehospitalization in serious mental illness and COPD

- **Multidisciplinary Team Management**
  - *Most effective 20-25% reduction*
Patient Centered Care Planning at End of Life

- Screening and referral to hospice
  - Decreased hospitalization 40-50% over 30-180 days
  - Intervention at NH coupled with communicating to PCP increased hospice admissions and decreased hospitalizations
What does this really mean?

- Lots of people evaluating successful strategies to improve rehospitalizations
- Heart failure is the most common population studied
- Variety of approaches are used
- No single intervention is best!
Care team processes:

- Care planning (including advance directives)
- **Medication reconciliation (this process includes patient and family)**/Expand the role of the pharmacist in transitions of care
- Improve communication during transitions between providers, patients and caregivers
- Test tracking (laboratory, radiology, and other diagnostic procedures) before and after hospitalization
- Tracking of referrals to other providers or settings of care-what were the results
- Admission and discharge planning
- Follow-up appointment tracking
- End-of-life decision making
The patient plays a key role in medication reconciliation and should be educated on the importance of managing medication information at the time of discharge or at the end of an outpatient encounter. This education should include the importance of:

- Giving a list to their primary care provider.
- Updating their own list when medications are discontinued, doses are changed, or new medications (including OTC medications) are added.
- Carrying their medication information at all times in case of an emergency.

This can help ensure patients are prepared to share an accurate medication list with their health care providers at each health care encounter.
Tips for Conducting a Patient Medication Interview

I. Medication Information

To obtain or verify a list of the patient’s current medications, you should inquire about:

- Prescription medications
- Over-the-counter (OTC) drugs
- Vitamins
- Herbals
- Nutraceuticals/Health supplements
- Respiratory therapy-related medications (e.g., inhalers)

Full dosing information should be captured, if possible, for each medication. This includes:

- Name of the medication
- Strength
- Formulations (e.g., extended release, controlled delivery, etc.)
- Dose
- Route
- Frequency
- Last dose taken
II. Medication History Prompts
Incorporating various types of “probing questions” into the patient interview may help trigger the patient’s memory on what medications they are currently taking. Here are some suggestions:

- Use both open-ended questions (e.g., “What do you take for your high cholesterol?”) and closed-ended questions (e.g., “Do you take medication for your high cholesterol?”) during the interview.
- Ask patients about routes of administration other than oral medicines (e.g., “Do you put any medications on your skin?”). Patients often forget to mention creams, ointments, lotions, patches, eye drops, ear drops, nebulizers, and inhalers.
- Ask patients about what medications they take for their medical conditions (e.g., “What do you take for your diabetes?”).
- Ask patients about the types of physicians that prescribe medications for them (e.g., “Does your ‘arthritis doctor’ prescribe any medications for you?”).
- Ask patients about when they take their medications (e.g., time of day, week, month, as needed, etc.). Patients often forget to mention infrequent dosing regimens, such as monthly.
- Ask patients if their doctor recently started them on any new medicines, stopped medications they were taking, or made any changes to their medications.
- Asking patients to describe their medication by color, size, shape, etc., may help to determine the dosage strength and formulation. Calling the patient’s caregiver or their community pharmacist may be helpful to determine an exact medication, dosage strength, and/or directions for use.
- For inquiring about OTC drugs, additional prompts may include:
  - What do you take when you get a headache?
  - What do you take for allergies?
  - Do you take anything to help you fall asleep?
  - What do you take when you get a cold?
  - Do you take anything for heartburn?

2 For a full range of medications as defined by The Joint Commission, refer to its accreditation material.
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- Follow-up appointment tracking
- End-of-life decision making
Communications with patient and family caregivers

- How do you think you became sick enough to come to the hospital?
- How do you take your medicines at home? Side effects? Problems?
- Describe typical meals at home or at a restaurant?
- When did you last talk with MD/NP/RN? What did you talk about?
- What worried you before you came to the hospital?
Identify the caregivers! (1)

- Family caregivers represents those individuals who are directly involved in the care of the patient at home or at other community care settings.
  - Visitors to the hospital are not necessarily the persons who best understand the home environment, or the issues of regarding the transfer to another care setting.
  - Nor are visitors necessarily the persons who will help the patient with self-care at home.

- Community providers are all of the clinicians and staff who have a role in the care of the patient when they are at home or in a skilled nursing facility.
  - home health care, hospice, and palliative care nurses; primary care providers and specialists; skilled nursing facility staff; staff in elder and mental health services; or community service agencies
Collaboration with hospital medicine service

- All work for the same health system
- Have access to hospital EMR (Cerner)
- Monitor patient care in real time.
- Recommend contracted specialty care
- MD/NP communicate daily with hospitalist and specialists as well as PACE social worker/hospital discharge planning with transitions of care
- Offer to participate in family meetings or important decisions particularly about living arrangements.
- Orthopedics and neurosurgery admit to themselves. Usually HMS consult in these high risk patients.
- HMS is usually amazed at our abilities to assist.
Described below are eight risk factors (the 8Ps) we believe should be identified and addressed for all hospitalized patients. While many of the factors have been defined in different ways in the literature, we provide a sample definition.

- **Problems with medications:** Patients with polypharmacy — i.e. >10 routine medications — or who are on high-risk medications including anticoagulants (e.g. warfarin, heparin, Factor Xa or thrombin inhibitors), antiplatelet agents in combination (e.g. aspirin and clopidogrel), insulin, oral hypoglycemic agents, digoxin, and narcotics.

- **Psychological:** Patients who screen positive for depression or who have a history of depression. You may also choose to include anxiety and substance abuse in this screening.

- **Principal diagnosis:** Patients with a principal diagnosis or reason for hospitalization related to cancer, stroke, diabetic complications, COPD, or heart failure.
Project BOOST® Implementation Toolkit

Touch Points: Admission, During Hospitalization, and Discharge

- **Physical limitations**: Patients with frailty, deconditioning, or other physical limitations that impair or limit their ability to significantly participate in their own care (e.g. perform activities of daily living, medication administration, and participation in post-hospital care).

- **Poor health literacy**: Patients who are unable to demonstrate adequate understanding of their care plan as demonstrated by their inability to complete “Teach Back” successfully.

- **Poor social support**: The absence of a reliable caregiver to assist with the discharge process and to assist with care after the patient is discharged. This P also captures the concept of social isolation.
Project BOOST® Implementation Toolkit

Touch Points: Admission, During Hospitalization, and Discharge

- **Prior hospitalization**: Unplanned hospitalization in the six months prior to this hospitalization.

- **Palliative care**: When thinking about this patient, would you be *surprised* if the patient died within a year? Does this patient have an advanced or progressive serious illness? This risk factor would be triggered if you answered no to the first or yes to the second question.

Costs Vary by Initial Post-Acute Setting

Average Medicare Episode Payment for MS-DRG 291 (CHF) by First-PAC-Setting for 30-day Fixed-length Episodes (2007–2009)

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<th>Setting</th>
<th>Average Payment</th>
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Overall Average = $14,928

Notes: Dobson | DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2007–2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars.

Choosing your post acute care partners

- Physician/NP availability
  - 0.83 visits per month in FFS!
  - More frequent visits dramatically decreased unplanned discharges
  - Too many visits also does not improve the ROI (7-11 visits/month seems to be the magic #)

- Diagnostic testing availability
- Nursing assessment skills
- Clinical competencies of staff
- Nurse/MD-NP communication and understanding
- Advance directives, surrogate decision making, end of life planning
- Family expectations
- Transition issues
“People with serious illness have priorities besides simply prolonging their lives. Surveys find that their top concerns include avoiding suffering, strengthening relationships with family and friends, being mentally aware, not being a burden on others, and achieving a sense that their life is complete.”

― Atul Gawande, Being Mortal: Illness, Medicine and What Matters in the End
Bibliography


