Readmissions as an Example of Preventable Harm

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Hospital Readmissions Reduction Program

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

- Included diagnoses:
  - AMI
  - PN—CAP, Aspiration PN, Sepsis pts with PNA POA [severe excl]
  - HF
  - COPD
  - THA/TKR
  - CABG [FY'17]
- Pure penalty program with up to 3% payment risk

A Deceptively Simple Formula

Hospital Staff, Patient, and Family/Friend Must:

- Know the diagnosis
- Know key tests and treatments performed
- Know what the treatment plan [meds, appts]
- Know red flag symptoms, common side Effects/Failure points.
- Know who/how to contact if something is not going well

Not My Father's Medicine

- Patients need to be sicker than ever to get into the hospital
- Hospital lengths of stay are getting shorter
- Patients are not well when they are discharged—they are "well enough. . . ."
- Patient understanding and participation is key to successful health maintenance
- As a general rule, "case management" and education are not recognized by the reimbursement system
- Increasing sub-specialization of care and fewer "general practitioners" available—especially for the Medicare population
- Dichotomy between inpatient and outpatient care provision

Barriers to Safe Discharges

- Health (Il)Literacy': Nearly **half** of adults have trouble understanding simple health information (procedure consent, prescriptions, oral instructions)

  Vastag, B. **Low health literacy called a major problem.** *JAMA*. May 12 2004;291(18):2181-82

- Less than half of patients discharged from academic general medicine know their diagnoses, treatment plan or side effects of prescribed medications

  Powell, CK. **Resident recognition of low literacy as a risk factor in hospital readmission**. *JGIM* 20(11):1042-4, 2005 Nov.

- Post-hospitalization patients typically identified multiple concerns including understanding their progress, activity, insurance, medications, and pain control

  Makaryus, AN. **Patients' Understanding of Their Treatment Plans and diagnosis at discharge**. *Mayo Clin Proc*. August 2005;80(8):991-994

Typical Discharge Process

- *Complex process involving multiple disciplines
- *Discharges can be urgent & unplanned with pressure to cut length of stay
- *Time constraints on clinicians who educate, prepare patients for transition
- Poor Communication with PCPs:
  - Direct communication between hospital physicians and primary care physicians occurred infrequently (3%-20%).
  - Availability of a discharge summary at the first post-discharge visit was low (12%-34%)
  - Discharge summaries often lacked important information such as diagnostic test results (missing from 33%-63%), treatment or hospital course (7%-22%), discharge medications (2%-40%), test results pending at discharge (65%), patient or family counseling (90%-92%), and follow-up plans (2%-43%)

    Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. ***Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care***. JAMA 2007; 297:831-41.
- *Unsafe discharges are an under-recognized significant issue that has heretofore received almost no attention from health care providers

    ***Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care**. Coleman EA. *Ann Intern Med.* 2004;140:533

The Space Between Hospital Care the Next Provider

Pending test results:

- Many patients (41%) are discharged with test results still pending.
- Many of these results (10%) can change management
- Physicians are often (61%) unaware of test results returning after discharge that may change management
- Poor communication between hospital and ambulatory providers

What I Believe

- People in healthcare are superior people
- People come to health care to make a difference in the lives of others
- Contracts and job descriptions are necessary, but not sufficient for greatness
- Spectacular, industry defining things happen when you tap mission motivation

Results: Two Years of Readmission Work Across 40 Beds at a 500 bed community Hospital

	Volume	CMI	LOS	Readmit Rate	Mortality Rate
Before <70	1088	1.26	5.34	13%	0.46 %
After < 70	3103	1.48	5.58	7%	0.64%
Before >/=70	434	1.30	5.93	15.9%	1.84%
After >/= 70	1526	1.49	6.13	8.7%	1.9%

Flipsides of the Same Coin

- Length of Stay [LOS] and Readmissions are intimately related
- You can’t have great success with one without also focusing on the other
- LOS represents an accepted metric associated with substantial financial value
- Readmissions is the quality/safety counterbalance
- Quality/Safety is the product made by the process of operations

$50 White Board with the $1 Million Impact

- Main Whiteboard in RN Station

Rm#	Name	Transitions	DOA	LOS*	Age	Dx	PCP	Symbols

- Pt Room Whiteboard

Day/Date	RN for shift and station #	Charge RN Name	How to Call into RM	Key Fam Contact and #
IMS MD/#	Consulting MDs	How to Call Dietary	Plans for Day: Dx, tests, results	Dispo info PCP name & f/u

Top 10 Evidence-based Interventions

See www.HRET-HEN.org

1. Develop a data-informed targeting strategy to identify target populations with higher than average rates of readmissions. Deliver enhanced readmissions reduction strategies to these "target population" patients.
2. Identify root causes of readmissions based on interviewing patients, caregivers and providers. Prioritize your improvement strategies based on those that will address the root causes of readmissions among your patients.
3. Improve care transition processes for all patients, regardless of readmissions risk. Refer to the proposed practices articulate in the proposed CMS Condition of Participation for Discharge Planning.
4. Provide a customized transitional care plan for all patients.
5. Effectively communicate with patients and caregivers. Use translation services, teach-back, motivational interviewing and materials written in plain language.
6. Deliver enhanced readmission reduction services for your target populations based on their root causes of readmissions.
7. Design a high utilizer approach for patients with four or more admissions per year. Identify their "driver of utilization," and use care plans to improve care across settings.
8. Engage the emergency department as a new site of readmission reduction activities.
9. Collaborate with clinical, behavioral, and social service providers to improve cross-setting care processes for shared patient populations. Ensure you are aware of the services and supports that are available from other providers and agencies in your community.
10. Measure what you implement, driving to reliable delivery of improved processes

Evidence-based Change Packages

- Five change packages (bundles of interventions) have been shown to work in controlled trials—
  1) Coleman's Care Transitions Intervention
  2) Jack's Reengineered Hospital Discharge (Project RED)
  3) Evans' early, systematic discharge planning
  4) Koehler's pharmacist patient education, medication reconciliation, phone follow-up
  5) Naylor's Transitional Care Model
- Individual parts of these change packages have not yet been proven to work by themselves—to increase likelihood of a beneficial effect, implement the whole bundle

(Source: Hansen et al, Ann Intern Med. Oct 2011;155:520-528)

On-line Care Transitions Resources

- Project RED
  - http://www.ahrq.gov/professionals/systems/hospital/red/index.html
- BOOST
  - http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27659
- Eric Coleman
  - http://www.caretransitions.org/
- STAAR
  - http://www.patientcarelink.org/Improving-Patient-Care/ReAdmissions/STate-Action-on-Avoidable-Rehospitalizations-Initiative-STAAR.aspx
- Mary Naylor
  - http://www.innovations.ahrq.gov/content.aspx?id=2674
- INTERACT
  - http://www.interact2.net/

Engaging the Team

- Have you ever thought the world would be a better place if only everyone would let you call the shots?
- Have you ever thought why am I doing job x when person y is really expert in that? Or why is person y doing what I could really do best?
- Have you ever had the experience that no one completed the task that was everyone's job?
- Have you ever found out the hard way that no one was responsible for something important?
- Have you ever felt that the patient was getting in the way of our care process?
- Have you ever felt the rhetorical questions would never end?

Setting the Tone

- We’re not making incremental change, we’re redesigning the care experience from the patient’s perspective
- You have to try something 7 times before you decide you don’t like it
- Acknowledge that new process = more work for about 6 weeks
- Roles not Ranks in group discussions
- Can only say what you can contribute to the solution, no matter how small that might be
- Weekly mtgs to ask what’s going well, who should be recognized, what are the barriers, homework follow up
- Accountability belongs to all of us
- Homework should flow uphill
- **No IT requests**

It’s All About the Meds

- One in five general medicine patients experiences an adverse event (resulting from medical management) within two weeks of hospital discharge (The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital. Forster AJ. *Ann Intern Med.* 2003;138:161-167)
  - 66% of these events are adverse drug events, 17% are related to procedures
  - **33%** of these events **lead to disability**
  - Two-thirds of these events are preventable or ameliorable

NAS Institute of Medicine (IOM): *Preventing Medication Errors*, July 2006

- "Medication errors and preventable adverse drug events (ADEs) [are] a very serious cause for concern….defined as any injury due to medication, [ADEs] are common…at least 1.5 million preventable ADEs occur each year"
- <u>Hospital</u>: 380,000-450,000 preventable ADEs/year
  - "These are likely underestimates"
- <u>Ambulatory Care</u>: 530,000 preventable ADEs per year among Medicare enrollees
  - Over 180,000 life-threatening or fatal ADEs per year, of which more than 50% may be preventable
- <u>Long Term Care</u>: 800,000 preventable ADEs/year.
  - This is "likely an underestimate"
- Does not include errors of omission

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Who? What? Where? When? How?

- There are certain points of care where medication errors occur more frequently
- Approximately 60% of errors occur when patients are admitted, transferred to another unit or discharged.

Rozich JD, Resar RK. **Medication Safety: One Organization's Approach to the Challenge**. *J Clin Outcomes Manag*. 2001; 8:27-34.

An Excellent Place to Begin

- Studies Show That Pharmacist-Recorded Medication Histories Result in Higher Accuracy and Fewer Medical Errors.
  - Gleason KM, Groszek JM, Sullivan C, et al. Reconciliation of Discrepancies in Medication Histories and Admission Orders of Newly Hospitalized Patients. *Am J Health Syst Pharm*. 2004;61:1689-1695.
  - Bond CA, Raehl CL, Franke T. Clinical Pharmacy Services, Hospital Pharmacy Staffing and Medication Errors in United States Hospitals. *Pharmacotherapy.* 2002; 22:134-147.
  - Nester TM, Hale LS. Effectiveness of a pharmacist-acquired Medication History in Promoting Patient Safety. *Am J Health Syst Pharm.* 2002;59:2221-25.
- Yet, pharmacists conduct the medication history only 5% of the time in most US hospitals.
  - Bond CA, Raehl CL, Franke T. Clinical Pharmacy Services, Hospital Pharmacy Staffing and Medication Errors in United States Hospitals. *Pharmacotherapy.* 2002; 22:134-147.

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Benefits of Bedside Delivery of Medications Before Discharge

- Ensures patients are actually able to receive their medications.
    - Prior authorization
    - Exhorbitant co-pays
    - Unusual drug not routinely on shelf-stock
- Provides opportunities to reduce cost to patient
    - Can ensure most preferred tier in class of drug selected
    - Can access prescription savings/co-pay assistance from vendor/partners
  - $6,389 prescription savings with co-pay assistance and coupons. For 369 pts that received a total of 921 prescriptions through Walgreen's bedside delivery in July 2011
- Patient Satisfier/High Touch Experience

Med Rec Expert Tips

- Take care in the way you ask your questions. Ask patient about typical day and what meds they take in a.m., p.m., evening, bedtime
- Link Meds to medical conditions. Probe for other commonly prescribed meds, e.g., diuretics in patient with heart failure on a typical "cocktail," short-acting insulin in patients on Lantus, etc
- Pay attention to Med Suffixes, especially ER, XR, CD etc.
- Clarify all Dosages. Don't assume that the instructions on the bottle reflect the dose or frequency the patient is actually taking them.
- Even if you have all the correct meds, doses, and frequency, the patient may ACTUALLY be taking them differently either due to confusion, memory impairment, dependence. They may actually take PRN meds in a scheduled fashion and vice-versa. Home health records and description of meds found in the home can be invaluable.

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Med Rec Expert Tips, continued

- Ask specifically about OTCs, Herbals, Vitamins, and Supplements
- Record the name, number, and location of the pt's pharmacy and use their info to help ensure accurate reconciliation
- Focus on particular "problem meds" like digoxin, coumadin, insulin, theophylline, antihistamines to guide important follow-up questions about diet, drug interactions.
- Ask the patient which physician prescribes which Meds
- Stress the importance of maintaining an accurate list of medications AND request they bring that list to every interaction they may have with ANY and EVERY physician.
- Ask about medications that were recently stopped and the reason why.
- Never ever trust someone else's history always do a primary verification

Perfect Partners in an Imperfect World

- 90% of health care is delivered in the ambulatory environment, but the accountability moment is in the hospital
- Maximize the value of the captive audience when you have it
- It's not about where you are today, it's about the rate of change.

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The Real Deal

- Home Health is both over and under-utilized at the same time
- Find the landmines by developing relationships whose continuation is predicated upon transparency, MUTUAL benefit, understanding, communication and commitment.
- Be aggressive about inviting post-acute care providers into your team

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Pearls of Wisdom

- Likely that < 1/3 of pts admitted 4 or more times to your hospital in the last 12 mos. left the hospital with home health
- Medicare is the best payer for home health and hospice
- Probably only 25% of your patients are getting what was ordered exactly as ordered at d/c
- High rate of bounce back to hospital after inpatient rehab/SNF stays

BOOST PASS FORM

Patient PASS: A Transition Record

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because ____________________

If I have the following problems …	I should …	Important contact information:
1. ____________________	1. ____________________	1. My primary doctor: ______________ (____) ______________
2. ____________________	2. ____________________	2. My hospital doctor: ______________ (____) ______________
3. ____________________	3. ____________________	3. My visiting nurse: ______________ (____) ______________
4. ____________________	4. ____________________	4. My pharmacy: ______________ (____) ______________
5. ____________________	5. ____________________	5. Other: ______________ ______________

My appointments:	Tests and issues I need to talk with my doctor(s) about at my clinic visit:	
1. ______________ On: __/__/___ at __:__ am/pm For: ______________	1. ____________________	I understand my treatment plan. I feel able and willing to participate actively in my care:
2. ______________ On: __/__/___ at __:__ am/pm For: ______________	2. ____________________	______________ Patient/Caregiver Signature
3. ______________ On: __/__/___ at __:__ am/pm For: ______________	3. ____________________	______________ Provider Signature
4. ______________ On: __/__/___ at __:__ am/pm For: ______________	4. ____________________	____/____/____ Date
	5. ____________________	

Other instructions:
1. ______________________________
2. ______________________________
3. ______________________________

Teach Back Process

Step 1: Using simple language, explain the concept/process to the pt/caregiver.

Step 2: Ask the pt/caregiver to repeat in his or her own words how s/he understands the concept.

Step 3: Identify and correct misunderstandings

Step 4: Ask the pt/caregiver to demonstrate understanding again to ensure the misunderstandings are corrected.

Step 5: Repeat Steps 4 and 5 until the clinician is convinced of Comprehension.

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MEDICATIONS LIST on “After Hospital Care Plan”

Morning	heart	ASPIRIN EC 325 mg	1 pill	By mouth
	to stop smoking	NICOTINE 14 mg/24 hr	1 patch (for 4 weeks)	On skin
	Then, after 4 weeks use →	NICOTINE 7 mg/24 hr	1 patch	On skin
	Blood pressure	COZAAR LOSARTAN POTASSIUM 50 mg	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCI 0.5 % soln	1 drop	In your left eye
Noon	Blood pressure	ATENOLOL 75 mg	1 pill	By mouth
	Blood pressure	LISINOPRIL 40 mg	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCI 0.5 % soln	1 drop	In your left eye

Pearls of Wisdom About Discharge Appts

- Must have confirmed date and time before discharge
- Clearly established single person responsible with a back up if primary is out/at lunch
- Get direct access to MD office schedule with your aligned docs/key practices
- Train the [midlevels working for] specialists to leave appt times for the discharging hospitalist
- Within 1 week is ideal, sooner for patients with key pending tests, later ok for sophisticated, stable patients

Pearls of Wisdom on Follow-Up Calls

- 48 – 72 hrs is the sweet spot
- Must be a clinical call by a fairly sophisticated person
- Caller should have access to PASS/Discharge form and key info when making the call
- Use Teachback when making the call
- Document the results of the call *in the PCP's* electronic medical record and copy for hospital record
- Track connect rates to figure out best times to call and high risk patients you are unable to reach
- Track main issues that arise and interventions used to fix them
- Establish a clear escalation procedure for the caller to use when he/she cannot immediately solve the issue

Parting Thoughts

- Assume anything that can go wrong will go wrong and act accordingly
- If it isn’t written down, the plan didn’t happen
- If teach-back wasn’t used, the plan wasn’t effective
- If you don’t assess the physical, mental, social, and financial status of the patient, the plan can’t get executed
- If you don’t improve medication reconciliation/education, have follow-up appointments, and do a follow-up call at 48-72 hours, then the plan will get derailed.
- Shared care protocols with post-acute providers ensure consistent, quality outcomes and common expectations

Final Comments

- No Margin, No Mission; but without staying true to your mission, you'll never have sustainable margin
- Don't Collect Data you don't use, Use the Data You Collect
- Whatever your current performance is, you can do better
- Always Do the Right Thing No Matter How Difficult
- Never accept of yourself an effort dependent failure
- We have all the help we need—it's sitting in this room