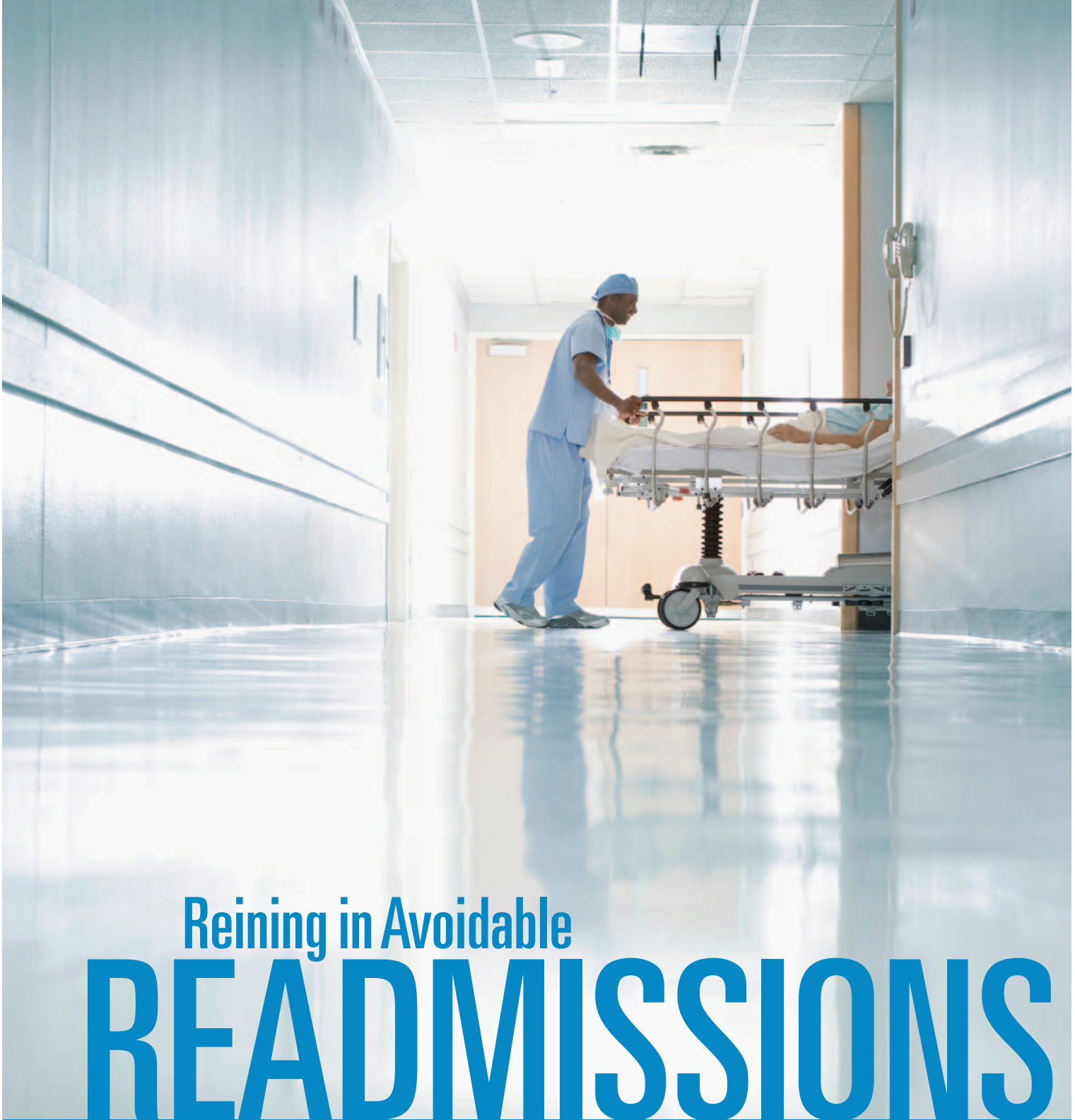
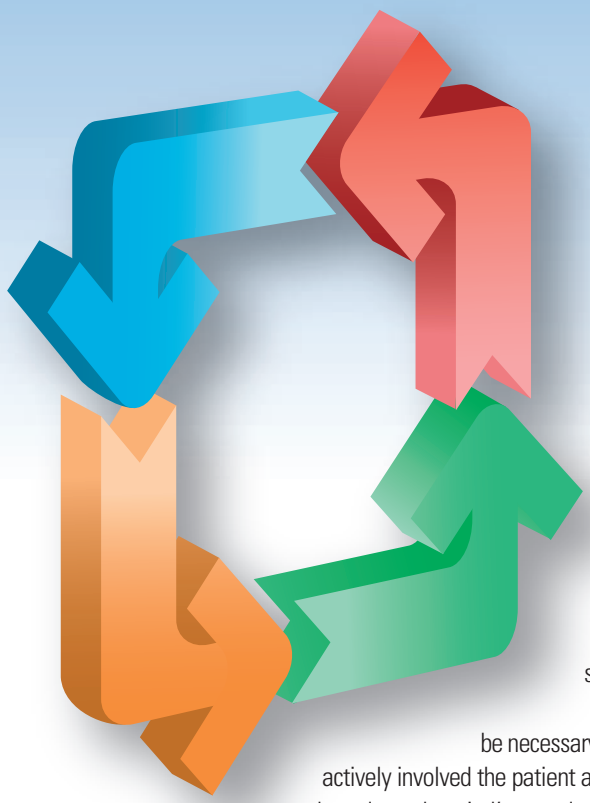


Reining in Avoidable READMISSIONS

Research by Bill Santamour

OPEN



Reining in Avoidable READMISSIONS

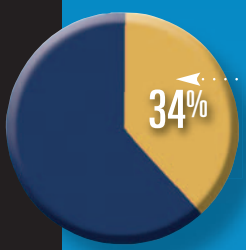
Helping patients stay out of the hospital once they've been discharged has been a longtime quality-improvement priority for many hospitals and health networks. Now it's become a financial priority, too, thanks to provisions of the Patient Protection and Affordable Care Act that set penalties for hospitals with higher-than-average rates of avoidable readmissions for patients with specified conditions.

The key word is avoidable. Medical experts say a zero rate of readmissions is not only impossible to achieve, it would not be desirable. Many readmissions are pre-planned for necessary follow-up care, such as chemotherapy treatments for certain cancer patients. A large percentage of readmitted patients are elderly, have multiple chronic conditions, and face complex and sometimes confusing medical regimens when they return home. What's more, penalizing providers indiscriminately for all readmissions might discourage some from bringing patients back even when it would be appropriate.

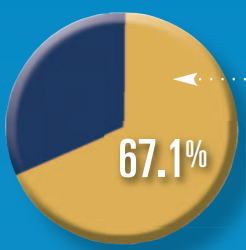
Nevertheless, health care professionals agree that many readmissions would not be necessary if planning for post-discharge started early, was much more robust and thorough, actively involved the patient and her family, created a strong partnership with all post-acute care providers and was based on a hospital's own data as well as evidence-based best practices culled from national quality projects.

This gatefold provides a snapshot of the issues surrounding avoidable readmissions—why they are a concern, how you can understand their impact specifically on your hospital, and how tools like the *Health Care Leader Action Guide to Reduce Avoidable Readmissions* can help you achieve this particular quality-improvement goal.

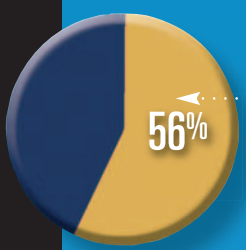
By The Numbers



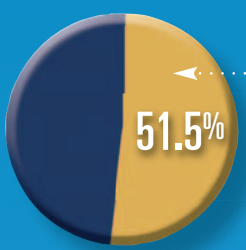
Percentage of patients who were readmitted within 90 days.



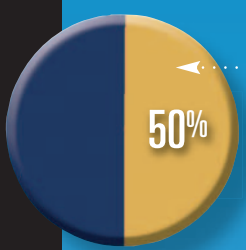
Percentage of patients who were discharged with medical conditions and were rehospitalized or died within one year of discharge.



Percentage of patients who were readmitted within one year.



Percentage of patients who were discharged after surgical procedures and were rehospitalized or died within one year of discharge.



Percentage of patients who were readmitted within 30 days and had not visited a physician between discharge and readmission.

Almost one-fifth of Medicare beneficiaries who were discharged from a hospital were readmitted within 30 days. These rehospitalizations cost Medicare $17.4 billion in 2004.

Source: "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program", Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H., *New England Journal of Medicine,* April 2, 2009

The Crux of the Law

Under the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services will compile national data on readmission rates for eight conditions selected by the Health & Human Services secretary.

Starting in FY 2013, hospitals with readmission rates above the 75th percentile will have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is rehospitalized with a preventable readmission within seven days and by 10 percent if the patient is readmitted within 15 days.

> "Medicare payment reductions for excess readmissions are calculated by a formula that divides the observed rate by the expected rate, then subtracts a standard quality value of 1. Thus, for example, a hospital with an expected congestive heart failure readmission rate of 190 cases out of 1,000 but an observed rate of 200 readmissions for the year (a 20 percent readmission rate versus the 19 percent anticipated, or 1 percent excess readmissions) will collect not $80,000 less than the $8 million it bills to Medicare for care to those 1,000 CHF patients (1 percent). Rather, it will be paid $421,053 less!"
>
> —David Ollier Weber, *H&HN Weekly*, Sept. 27, 2010

Source: Deloitte Center for Health Solutions, Health Care Reform Memo, July 12, 2010, www.deloitte.com

The Top Seven Readmissions

These seven conditions accounted for nearly 30 percent of Medicare spending on readmissions in 2005.

Condition	Type of admission	Number of admissions	Readmission rate	Average Medicare payment for readmission	Total spending
HEART FAILURE	Medical	90,273	12.5%	$6,531	$590 million
COPD	Medical	52,327	10.7%	$6,587	$345 million
PNEUMONIA	Medical	74,419	9.5%	$7,165	$533 million
AMI	Medical	20,866	13.4%	$6,535	$136 million
CABG	Surgical	18,554	13.5%	$8,136	$151 million
PTCA	Surgical	44,293	10.0%	$8,109	$359 million
OTHER VASCULAR	Surgical	18,029	11.7%	$10,091	$182 million
TOTAL FOR TOP 7		318,761			$2.296 billion
TOTAL DRGS		1,134,483			$7.98 billion
% OF TOTAL DRGS OF TOP 7		28.1%			28.8%

Sources: 3M Company analysis of 2005 Medicare discharge data; MedPac Report to Congress, June 2007

Three Guiding Principles

1. Coordinate post-hospital care across settings.
2. Take quick action to reconcile patient medications and schedule follow-up appointments with primary care physicians and specialists.
3. Engage patients and families to play active roles in managing their health needs.

Source: California HealthCare Foundation, 2010

Checklist: Developing a Detailed Self-Portrait

As part of the STate Action on Avoidable Rehospitalizations (STAAR) initiative, hospitals in four states—Massachusetts, Michigan, Ohio and Washington—in January began using a worksheet to track their five most recent rehospitalizations. The worksheet begins with nine questions about each of the readmitted patients.

- ❑ **1.** What was the number of days between the last discharge and this readmission date?
- ❑ **2.** Was the follow-up physician visit scheduled prior to discharge?
- ❑ **3.** If yes, was the patient able to attend the office visit?
- ❑ **4.** Were there any urgent clinic/ED visits before readmission?
- ❑ **5.** What was the functional status of the patient on discharge?
- ❑ **6.** Was a clear discharge plan documented?
- ❑ **7.** Was evidence of "teach-back" documented?
- ❑ **8.** List any documented reason(s) for readmission.
- ❑ **9.** Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?

Source: Commonwealth Fund and the Institute for Healthcare Improvement, 2010

Three Key Stages of the Care Delivery Process

The Health Care Leader Action Guide to Reduce Avoidable Readmissions from Hospitals in Pursuit of Excellence describes a step-by-step routine that hospitals and other providers should take at three points in the care delivery process.

1 DURING HOSPITALIZATION

- Risk screen patients and tailor care.
- Establish communication with PCP, family and home care.
- Use "teach-back" to educate patient about diagnosis and care.
- Use interdisciplinary/multidisciplinary clinical team.
- Coordinate patient care across multidisciplinary care team.
- Discuss end-of-life treatment wishes.

2 AT DISCHARGE

- Implement comprehensive discharge planning.
- Educate patient/caregiver using "teach-back".
- Schedule and prepare for follow-up appointment.
- Help patient manage medications.
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners.

3 POST-DISCHARGE

- Promote patient self-management.
- Conduct patient home visit.
- Follow up with patients via telephone.
- Use personal health records to manage patient information.
- Establish community networks.
- Use telehealth in patient care.

Source: Health Care Leader Action Guide to Reduce Avoidable Readmissions, *Hospitals in Pursuit of Excellence*, 2010

Four Tools to Get Started

The *Health Care Leader Action Guide to Reduce Avoidable Readmissions*

www.hret.org/care/projects/guide-to-reduce-readmissions.shtml

Produced by Hospitals in Pursuit of Excellence, this is the American Hospital Association's strategic platform to accelerate performance improvement and support health reform implementation. Among other things, the guide outlines major strategies organized by the level of effort required to implement them and describes the actions needed to achieve them. An appendix spotlights hospital and other provider initiatives for the various strategies, what actions they took, and the key players involved within the organization. Support was provided by the Health Research & Educational Trust, the Commonwealth Fund and the John A. Hartford Foundation.

Transitional Care Model

www.transitionalcare.info

Developed by Mary Naylor, R.N., and colleagues at the University of Pennsylvania, TCM involves 10 key elements:

1. The Transitional Care Nurse (TCN) as the primary coordinator of care to assure consistency of provider across the entire episode of care
2. In-hospital assessment, preparation and development of an evidenced-based plan of care
3. Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge
4. Continuity of medical care between hospital and primary care physicians facilitated by the TCN accompanying patients to first follow-up visits
5. Comprehensive, holistic focus on each patient's needs including the reason for the primary hospitalization as well as other complicating or coexisting events
6. Active engagement of patients and their families and informal caregivers, including education and support
7. Emphasis on early identification and response to health care risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to readmissions
8. Multidisciplinary approach that includes the patient, family, informal and formal caregivers as part of a team
9. Physician-nurse collaboration
10. Communication with, between, and among the patient, family and informal caregivers, and health care providers and professionals

Care Transitions Intervention

www.caretransitions.org

This four-week program, developed by Eric Coleman, M.D., and colleagues at the University of Colorado, gives patients and their caregivers information and help in self-managing their health as they transition from hospitals to home. The model comprises four components:

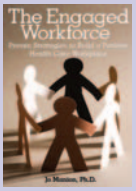
1. A patient health record that consists of the essential care elements for facilitating interdisciplinary communication during the care transition
2. A structured checklist of critical activities to empower patients before discharge from the hospital or nursing facility
3. A session with a transitions coach in the hospital to help patients and their caregivers understand and apply the first two elements and assert their role in managing transitions
4. Transitions coach follow-up visits in the home or skilled nursing facility and phone calls designed to sustain the first three components and provide continuity across the transition

Project BOOST

www.hospitalmedicine.org/BOOST

Developed by the Society of Hospital Medicine, Project BOOST—Better Outcomes for Older Adults through Safe Transitions—focuses on improving the hospital discharge process. The resource room provides expert and evidence-based interventions advocated by the Joint Commission, the National Quality Forum, the Institute for Healthcare Improvement, and the Agency for Healthcare Research and Quality. The toolkit embraces patient-centered care, empowering patients to play a more active role in their care.

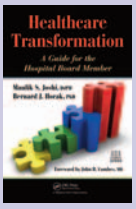
Resources



The Engaged Workforce: Proven Strategies to Build a Positive Health Care Workplace

Jo Manion, PhD, RN, NEA-BC, FAAN, 460 pages, 7" x 10",
AHA Order Number: 088709
$86 (AHA members, $69)

Written for senior- and mid-level- leaders within the workforce who are looking to awaken enthusiasm and commitment in their work lives, work teams, and organizations. It provides guidance and proven interventions from business literature and recent research in sociology, psychology, and organizational development that identify the most effective strategies for creating positive work environments.



Healthcare Transformation: A Guide for the Hospital Board Member

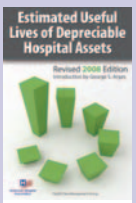
Maulik S. Joshi, DrPH
Bernard J. Horak, PhD; Foreword by John R. Combes, MD
128 pages, 6" x 9",
AHA Order Number: 196129

This book helps leaders make the transformative changes necessary to elevate their organization's quality and safety performance and deliver better health care. It concisely presents the 10 major transformers for health care and explains how boards can understand and use these examples to change their own organizations.

Strengthening Ethical Wisdom: Tools for Transforming Your Health Care Organization

Jack A. Gilbert, EdD, FACHE
239 pages, 7" x 10",
AHA Order Number: 058102,
$59 (AHA members, $49)

A practical, research-based guide for strengthening workplace and personal ethics. Step-by-step explanations, case examples, and questionnaires help readers identify and manage the ethical drift to which health care management and staff can succumb to under the daily pressure to do more with less.



Estimated Useful Lives of Depreciable Hospital Assets, Revised 2008 Edition

Introduction by George S. Arges
72 pages, 6" x 9",
AHA Order Number: 061179
$60 (AHA members, $50)

Meets the needs of financial professionals responsible for administering and documenting capital investments. It provides clear life span estimates in reference tables for the major equipment and capital asset investments found in hospitals and physician group practice and physician offices.

Engaging Patients as Safety Partners: A Guide for Reducing Errors and Improving Satisfaction

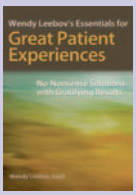
Patrice L. Spath, Editor
291 pages, 6" x 9",
AHA Order Number: 181203
$74 (AHA members, $66)

Aids health care professionals in understanding how patients and families can partner with practitioners to reduce medical errors and how practitioners can mitigate the effects of mistakes when they do occur. This book helps health care professionals recognize and overcome barriers that inhibit consumer involvement in patient safety improvement.

Wendy Leebov's Essentials for Great Personal Leadership

Wendy Leebov, EdD
109 pages, 7" x10",
AHA Order Number: 042201,
$32 (AHA members, $26)

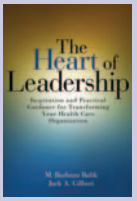
Provides valuable problem-solving and leadership skills and tools (exercises, checklists, scripts, etc.) to mid-level administrators, department heads, clinical leaders, and anyone who brings a passion to their work. Each chapter captures the essence of emotionally intelligent leadership and focuses on effective solutions that lead to job satisfaction.



Wendy Leebov's Essentials for Great Patient Experiences

Wendy Leebov, EdD
126 pages, 7" x 10",
AHA Order Number: 042202,
$35 (AHA members, $28)

Provides specific problem-solving solutions to daily problems that alienate patients and their families and lead to subpar patient satisfaction experiences. Full of working tips for administrators, department heads, nurses and anyone who is responsible for patient contact services. Contains exercises, checklists, meeting plans, question guides, scripts, and coaching techniques—plus an appendix of additional resources.



New

The Heart of Leadership: Inspirational and Practical Guidance for Transforming Your Health Care Organization

Barbara Balik – Jack A. Gilbert
290 pages, 6" x 9", AHA Order Number: 108105
$76 (AHA members, $69)

The book examines the leadership characteristics of ten diverse transformational leaders from a variety of work environments who have produced better results than many of their peers in similar circumstances. It illustrates the important point that it is not what these leaders *do* as much as it is *who they are*.

New

Helping Physicians Become Great Managers and Leaders: Stratigies That Work

Laura Avakian
239 pages, 7" x 10"
AHA Order Number: 108106
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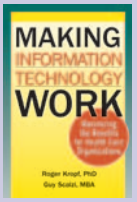
A book that will increase the success of physicians who lack the management experience for dealing with hospital or group practice staff and other administrative issues, and who find themselves newly appointed to leadership roles as department heads or in executive management. It supports a planned way of orienting physicians to successful managerial performance.



Making Information Technology Work: Maximizing the Benefits for Health Care Organizations

Roger Kropf, PhD, and Guy Scalzi, MBA
250 pages, 6" x 9",
AHA Order Number: 093001
$69 (AHA members, $55)

A book for senior executives, managers, and clinicians that covers the "before, during, and after" stages of an information technology project and provides guidance on how projects can be successfully managed. It shows readers how to assess IT project value before approval, monitor whether projects are on-time and on-budget, and measure performance after implementation.

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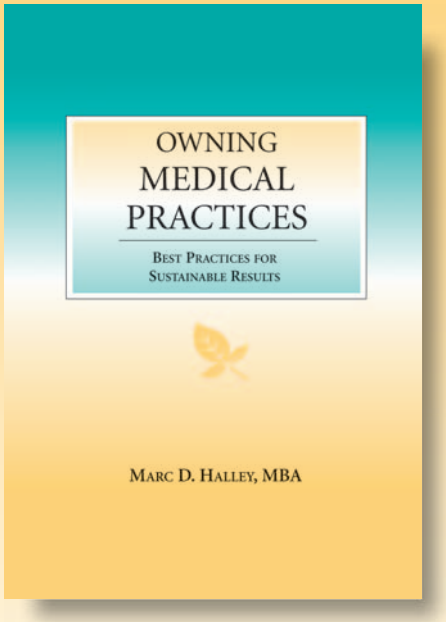

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- Sample Communication Matrix
- Physician Candidate Questionnaire
- Specialist of Choice Practice Evaluation
- Medical Practice Clinical Productivity Evaluation
- Potential Requirements for Mission-Critical Applications
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...the book is a toolbox brimming with concepts and guides directed at executives, planners, and operators.
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Sara A. Beazley, Editor

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Randy Cooper, SEGD

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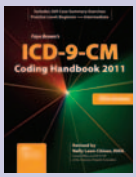

ICD-9-CM Coding Handbook, 2011, With Answers

Faye Brown

720 pages, 8.5" x 11",
AHA Order Number: 148045
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The *Handbook* helps coders understand the principles behind the classification system so they can apply the official coding advice contained in Central Office publications such as the *AHA Coding Clinic®*. The easy-to-use format, wide selection of review exercises, and thoroughness of detailed explanations have made it the leading book for coder training in hospitals and academic settings. The *Handbook* is designed to be used in conjunction with the three volumes of the *ICD-9-CM Coding Manual*. The *Handbook* content reflects the latest official coding guidelines and presents examples in clear, technically correct language. It is the only guide published in collaboration with the Central Office on ICD-9-CM of the American Hospital Association—the official industry body that prepares the quarterly *AHA Coding Clinic®*.

Also Available — **ICD-9-CM Coding Handbook, 2011, Without Answers**
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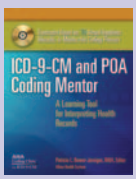

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Owning Medical Practices: Best Practices for Sustainable Results

Marc D. Halley, MBA

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AHA Order Number: 164010,
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Practical book that guides hospital executives whose organizations currently own medical practices and employ primary care and specialty physicians, plus those in organizations looking to expand their business. It enables executives to confidently understand and identify the "best practices" of how to successfully own and manage medical practices and how to integrate practices and physicians into their hospital strategies.

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Karen Gardner, Editor

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