Reducing Hospital Readmissions and The Critical Role of Physician Leadership

The Process of Designing our Readmission Reduction Plan, the Final Plan and the Critical Role of Physician Leadership

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Medical Director, Continuum of Care Department
Morristown Medical Center, Atlantic Health System
Morristown, NJ 07960
Jeffrey.Epstein@AtlanticHealth.org
Presentation Outline

Morristown Medical Center
   Where I come from
   What we are doing
Our Discharge Checklist and our Discharge Planning Meetings
   What we have done
   How we have done it
What are the problems that could lead to high Readmission rates
   The Audience Participation Part of our Presentation 😊
What is Wrong with Post Discharge Care
   Post Discharge Planning in the Perfect World
   The Critical Importance of strong Physician Leadership
Will we seriously address the readmission problem anytime soon
   Medicare Incentives to Reduce Readmissions by October 2012
   Our Commercial Insurance Contracts with Regards to Readmissions
   Should we work hard to reduce readmissions now?
Project RED
   Project RED Plus
Morristown Medical Center
Morristown Medical Center

Beds: 650
ED Visits per Year: 80,000
Admissions per Year: 38,000

Residency Programs: Medicine, Surgery, OB/GYN, Pediatrics, ER, Radiology
Level One Trauma, Cardiac Surgery, Interventional Cardiology
Cancer Center, Children’s Hospital, Cardiac Center
United Healthcare Consortium
Affiliated with Mt. Sinai Medical School
Jets, Atlantic Health Join Forces in Naming Facility

By Marissa Shorenstein
Posted Oct 23, 2007

The New York Jets today announced a 12-year naming rights agreement with Atlantic Health, a leading health care association in Northern New Jersey...
The Answer to our Readmission Problem is not Magical
It is really pretty Simple!

"I think you should be more explicit here in step two."
Discharge Process Planning Meetings & Initiative

Chief Nursing Officer, Nurse Manager of Nursing Education,
Director of the Continuum of Care Department, Medical Director of Continuum of Care

Purpose:
Reduce Delays in Discharge and Improve the Quality of our Discharges
Safe and Effective Discharges: Coordination of Care

The Reason this Process Improvement Initiative Was Put in Place:
Delays in Discharge
National Attention on Readmissions and Post Discharge Coordination of Care

Specific Problems:
Waiting until Discharge Order Written before beginning Discharge Process
Suboptimal Patient and Family Education at the time of Discharge
Discharge Process Lacked Quality Improvement Process

Our Plan to Address the Issues and Problems Above:
Pre-Discharge Checklist
Project RED: Re-Engineering Discharge
Post Discharge Care Oversight and Coordination
Readmission Reduction
The Work Group and Schedule

Weekly Meetings
Leadership:
   Nurse Manager of Nursing Education
   Director of the Continuum of Care Department
   Medical Director of the Continuum of Care Department
Work Group:
   MD/DO Hospitalist
   Chief of Family Practice
   Nurse Manager
   Information Technology/EMR Leadership
   Coordinator of Social Workers
   Coordinator of Case Managers
   Manager of Physical Therapy
   Manager of Quality
Initial Work Done by the Group

1. Pre-Discharge Checklist
   1. Reminder Cues for Care Team
   2. Communication Tool
2. Study and Learn about Project RED
3. Identify Key Players in Initiative
   1. Nurses, Care Managers, Social Workers, PT/OT
   2. Patients and their Families
   3. Hospitalists
   4. Receiving Physicians
   5. Home Health Agencies
   6. Post Discharge Facilities
4. Identify Possible Pilot Populations of Patients
   1. CHF, Pneumonia, COPD, MI
   2. Specific Commercial Plans
   3. Medicare and Elderly
5. Develop Plan of Implementation
## Pre-Discharge Check List

**For Use as a Discharge Tool to Anticipate Discharge Needs of the Patient**

Admission Date: __________ (initiate on admission). Not a permanent part of the medical record.

**Responsible Personnel**

**Anticipated Discharge Date:** __________

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**Other:**

Please return form when complete to Wendy Silverstein, Shared Governance office, Box 23. Thank you.
# PRE-DISCHARGE CHECK LIST

For use as a discharge tool to anticipate discharge needs of the patient.

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**Responsible Personnel**

**Anticipated Discharge Date:**

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Initial Work Done by the Group

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   1. Reminder Cues for Care Team
   2. Communication Tool
   2. **Study and Learn about Project RED**

3. Identify Key Players in Initiative
   1. Nurses, Care Managers, Social Workers, PT/OT
   2. Patients and their Families
   3. Hospitalists
   4. Receiving Physicians
   5. Home Health Agencies
   6. Post Discharge Facilities

4. Identify Possible Pilot Populations of Patients
   1. CHF, Pneumonia, COPD, MI
   2. Specific Commercial Plans
   3. Medicare and Elderly

5. Develop Plan of Implementation
Reserve Your Seat for this Webinar Today!

Reducing Hospital Readmissions through Utilization of PROJECT RED:
Discover an Evidence Based Hospital Discharge Process to Reduce
Unnecessary Hospital Utilization and Improve Patient Safety

Friday, June 10, 2011
12:30 - 1:45 PM EDT

The hospital discharge is a complex, multi-step process requiring integrated communications among the inpatient care team, primary care team, community services, the patient and patient's family. Preliminary work included intensive study of the discharge process borrowing methodologies from engineering. This process includes mapping, failure mode effect analysis, probabilistic risk assessment, root cause analysis, and qualitative analysis to define what we call RED, which is a set of mutually reinforcing components characterizing a high quality hospital discharge.

Register Now  Learn More

Agenda

This webinar will cover the following:

- Discuss potential risks for patients post hospital discharge
- Delineate principles of the re-engineered discharge
- Describe components of the RED intervention
- Discuss the RED RCT- primary and secondary outcomes
- Identify the role of information Technology

Speaker

Chris Manasseh
Director, Family Medicine Inpatient Services
Boston University Medical Group

Who Should Attend

From Hospitals, Skilled Nursing Facilities and Post-Acute Care Facilities
A Transdisciplinary Approach to Reducing Readmissions

With the changes in reimbursement related to readmissions within thirty days before us, case management’s role in managing and reducing readmissions has never been more important. Gate keeping at the front end, effective patient education and discharge planning, and safe and timely hand-offs to the community are all necessary to managing and reducing your readmission rates.

This 90-minute webinar by case management experts Dr. Toni Cesta and Bev Cunningham, RN, MS, will focus on tips and strategies that you can use to reduce your readmission rates that are cost-effective and successful. Also discussed will be ways in which to partner with other care providers across the continuum as well as physicians and nursing staff within the hospital setting.

Learning Objectives:

- Describe the CMS structure for payment changes regarding readmissions.
- Review tools and techniques for assessing your hospital’s state of readiness to reduce readmissions.
- Discuss strategies that you can implement in your organization to positively affect a reduction in your readmission rates.

To find out more about this webinar or to register, please go online to www.ahcmedia.com or call 1-888-800-9484 and mention code 40A4508/FM04106 when registering.

Thursday, July 21, 2011
12:00 - 1:30 PM ET

Credits
1.5 CNE Contact Hours
1.5 CCMC Clock Hours pending

Register Now

Speakers

Toni G. Cesta, Ph.D., RN, FAAN is Senior Vice President for Operational Efficiency and Capacity Management at Lutheran Medical Center in Brooklyn, New York. She also serves as Health Care Consultant and partner in Case Management Concepts, LLC, a consulting company assisting institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost.

Bev Cunningham, RN, MS is a Vice...
Risk Specific Interventions

Once you have completed 7P risk assessment and identified the patient’s high risk characteristics, you should begin planning the patient’s transition. This process highlights that transition planning begins on admission and progresses throughout the hospitalization. Of note, additional risk factors may be identified during the hospitalization (e.g., initiation of a high risk medication or development of a high risk principal diagnosis). If this occurs, institutions are encouraged to review the 7P risk specific interventions and consider implementing them during the hospitalization or prior to discharge, as feasible and appropriate.

In addition to risk specific interventions, all patients should receive all the components of the Universal Patient Discharge Checklist:

- General Assessment of Preparedness (GAP) assessment completed with issues addressed.
- Medications reconciled with preadmission list.
- Medication use/side effects reviewed using teach-back with patients/caregivers.
- Teach-back used to confirm patient/caregiver understanding of diagnosis, prognosis, self-care requirements, and symptoms of complications requiring immediate medical attention.
- Action plan for management of symptoms/side effects/complications requiring medical attention established and shared with patient/caregiver using Teach-Back.
- Discharge education plan completed, taught, provided to patient/caregiver at discharge.
- Discharge communication provided to post-hospitalization care providers.
- Documented receipt of discharge information from principal care providers.
- Direct communication with principal outpatient provider at discharge.
- Telephone contact arranged within 72 hours of discharge in order to assess the patient’s condition and adherence and to reinforce follow-up.
- Medication Safety: Warfarin
- Agency for Healthcare Research and Quality (AHRQ) Your Guide to Coumadin®/Warfarin Therapy
Initial Work Done by the Group

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5. Develop Plan of Implementation
TEAMWORK
Share Victory. Share Defeat.
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5. Develop Plan of Implementation
Possible Pilot Populations

Acute MI, CHF, Pneumonia: The Initial Focus of CMS
Horizon Patients with CHF:
   Horizon, our largest Insurer has a CHF Readmission Reduction Pilot Project
Our Elderly Population is at high risk for Readmissions within 30 days
Medicare Patients and the Elderly are high risk
More Opportunity for Improvement
No need to expend resources on 28 year old in for knee injury repair
Initial Work Done by the Group

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Reducing Readmissions is Simple but NOT Easy!

Come up with a plan that will work in your institution
Get buy-in from all Essential Parties
Measure Outcomes and Improve the Process

Better patient care
Higher Patient Satisfaction
Extra Work for all Involved
Improved Communication between Providers
More Educated and Involved Patients
Better Patient Outcomes
What are some problems that could lead to the readmission rate being so high?
What is Wrong with our Post Hospitalization Care

1. Patients do not see their primary care physician within days of their discharge
   1. They are not told to see their doctor within days of discharge
   2. Appointments are not made at the time of discharge
   3. Primary Care Doctors are too busy to see these patients within days of discharge

2. Patients are sent to facilities where the quality of care is not optimal
   1. The quality of Long Term Care Facilities or Rehabilitation Facilities has a great deal of variation
   2. Patients cannot be evaluated adequately at these facilities
      1. No exam rooms, equipment, labs or x-ray
   3. Doctors are not always available on a daily basis to evaluate patients in the facility if they develop an acute problem

3. The hospital care team does not communicate well with the post hospital care team
   1. No phone calls
   2. Discharge Summaries are not dictated or available
   3. Discharge Notes are short, incomplete and inadequate

4. The hospital care team does not communicate well and effectively with the patient and the patient’s family
   1. Patients and their care givers are not adequately educated
   2. If they are educated, they are not predisposed to learn at the time of the acute admission
   3. There is no follow up education and reinforcement after discharge
   4. Inadequate resources are available to the patient and their family after discharge
The Post Discharge Plan in the Perfect World

1. Patients and Families are smart and educable
2. Education and information is provided during the hospital stay and after the hospital stay
3. Patients and families are highly motivated to get well and stay well
4. The hospital team communicates clearly and extensively with the post hospitalization team via phone calls and written material (dictated discharge summaries and detailed written discharge forms)
   1. Doctor to Doctor
   2. Nurse to Nurse
   3. Physical Therapist to Physical Therapist
   4. Wound Care Specialist to Wound Care Specialist
5. The care is “Patient Centered” so the patient and family are in control and their doctors are helping them by providing advice and guidance
   1. The patient knows all their problems and the plan for each problem
   2. The patient knows all their medications and which problem the medication is intended to help
   3. Their doctors know all their problems and the plan for each problem
   4. Their doctors know all their medications and the reason for each medication
   5. All consultants as well as their Primary Care Doctor knows all of this
6. The patient is seen by the post discharge team within a day or two of discharge and is seen as frequently as needed to keep the patient “tuned up” and “doing well”
The Critical Role of Physician Leadership

As you work with the Task force, certain key critical decisions have to be made and advocated for very strongly. You need a Physician Champion to get all doctors to buy-in to the program

Dictate Quality Discharge Summaries with Critical Elements in a Problem-Oriented Fashion

Dictate with 24 hours
PCP’s see their patients within 48 hours of Discharge
Hospitalists call the PCP to discuss the Patient
Post Discharge Facilities Improve the Quality of their Care and the Quality of the Patient Evaluations in their facilities
Complete Paperwork prior to Discharge so patients can carry with them to their PCP

You need a doctor who knows what doctors are really capable of so they can’t say “no” when the answer can be and should be “yes”

You need a doctor who can advocate as the Hospitalist, the PCP in the office and the Receiving Physician in the Post Discharge Facility
The Future - Will This Happen?

Incentives

- Direct incentives
- Indirect incentives

Variable incentives

- Sectoral incentives
- Macro-economic incentives

Enabling incentives
When will there be a serious Effort to Reduce Readmissions?

When the financial incentives are made perfectly clear to all parties!
The health reform legislation introduces a Hospital Readmissions Reduction Program that will affect hospitals' Medicare inpatient payments. **For fiscal years beginning on or after October 1, 2012, inpatient payments to hospitals will be reduced if a hospital experiences "excessive" readmissions,** which will be defined by HHS, within a specified period following discharge for a heart attack, heart failure, or pneumonia. Certain planned readmissions will be exempted under this program. The health reform legislation authorizes HHS to designate additional conditions to the readmission list beginning in fiscal year 2015. **Hospitals with excessive readmissions for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to readmissions deemed excessive.** In addition, hospitals' performance with respect to these readmissions will be publicly reported by HHS, which will include publication on the Hospital Compare Web site. The amount of the payment reduction and other terms and conditions of this program will be established by HHS at a later date.
In this article it states,

"The Readmission Reduction Program will penalize hospitals with high readmission rates. Essentially CMS will assess the ratio of each hospital's readmission rate in comparison to the national average for three target conditions: acute MI, heart failure and pneumonia. If the ratio is greater than one, CMS will reduce the facilities aggregate Medicare payment."
Background
As mandated under PPACA and detailed in the FY12 Inpatient Prospective Payment System (IPPS) Proposed Rule, short-term acute care hospitals with higher than expected 30-day risk-adjusted readmission rates for heart failure, acute myocardial infarction (heart attack) and pneumonia discharges between July 1, 2008 through June 30, 2011 will receive reduced Medicare payments starting in FY2013, capped at a maximum of 1% of inpatient payments. These penalties will increase in subsequent years to a maximum of 2% in FY2014 and 3% from FY2015 onwards. Additionally, the program will expand the list of targeted conditions beyond the initial three in FY2015. The first-year impact estimated in this report incorporates details from the PPACA, the FY12 IPPS Proposed Rule and CMS’s QualityNet website, along with assumptions for certain provisions not addressed in the legislation.

Please note that unlike CMS’s other high profile quality initiative, the Hospital Inpatient Value Based Purchasing Program, which allows high performing hospital to earn a bonus payment, the Hospital Readmissions Reduction Program is a penalty-only plan designed to recover payments from hospitals that have received additional revenue associated with readmitted patients. As such, this program will have no financial impact for hospitals with risk-adjusted readmission rates below the national average on all applicable conditions.

--- The Advisor Board Company Website, August 8, 2011
These percentages were calculated from Medicare data on patients discharged between July 01, 2007 and June 30, 2010. They don’t include people in Medicare Advantage Plans (HMO or PPO) or people who don’t have Medicare.

**Rate of Readmission for Heart Failure Patients**

Lower Percentages Are Better

10% 15% 20% 25% 30% 35% 40%

U.S. National 30-Day Rate of Readmission for Heart Failure Patients = 24.8%

Number of Medicare Patients Admitted for Heart Failure

Based on 1247 patients

Based on 1115 patients

Based on 1521 patients

Range of uncertainty around estimated death rate

(*interval estimate*)

Legend

\( \hat{x} \% \rightarrow \) Estimated death rate (risk-adjusted)
Rate of Readmission for Heart Attack Patients

Lower Percentages Are Better

10%  15%  20%  25%  30%  35%  40%

U.S. National 30-Day Rate of Readmission for Heart Attack Patients = 19.8%

Based on 1105 patients
Based on 294 patients
Based on 995 patients

Legend

Range of uncertainty around estimated death rate
("interval estimate")

x% ← Estimated death rate (risk-adjusted)
Rate of Readmission for Pneumonia Patients

Lower Percentages Are Better

10% 15% 20% 25% 30% 35% 40%

U.S. National 30-Day Rate of Readmission for Pneumonia Patients = 18.4%

19.6
No Different than U.S. National Rate

18.1
No Different than U.S. National Rate

21.7
Worse than U.S. National Rate

Number of Medicare Patients Admitted for Pneumonia

Based on 1014 patients

Based on 982 patients

Based on 732 patients

Legend

Range of uncertainty around estimated death rate
("interval estimate")

x% ← Estimated death rate (risk-adjusted)
Why is this Being Looked At

- 4.4 Million Hospital Stays that are the Result of Potentially Preventable Re-Admissions
- $30 Billion per year
- 10% of all money spent to Hospital Care
Here are the contracts with specific readmission language (DRG case rate contracts). Call me anytime today if you need further info/want to discuss. I'm in all day.

**Aetna:**
Patients readmitted within 7 days shall be considered to included in the previous admission if the MS DRG assignment is identical and the reason for the readmission is due to improper discharge. (This is not defined) The intent is to insure the hospital only discharges patients at the appropriate time and not prematurely. Furthermore the following exceptions to the rule shall apply for patient readmitted within 7 days from the previous discharge (PTCI patients undergoing procedure for multiple stent insertion, CHF, chronic chemical dependency and alcoholism).

**Cigna:**
Cigna's Ms DRG Case Rate includes all care provided for a Participant's readmission with the same discharge diagnosis if the readmission occurs within 72 hours of the Participant's discharge, and Payor will not provide additional reimbursement to Hospital for such readmission.

**Horizon:**
Readmissions within 15 days for the same DRG and or any complications resulting from the initial admission will not be separately reimbursed whether or not the admission is considered medically necessary. The reimbursement for the first admission will be considered payment in full for both admissions.

**Oxford/United:**
United will not deny payment for re admissions. United and facility will establish a review process whereby at the discretion of United potentially all re admissions United believes were the result of a premature discharge. This review will be conducted by Facility's Medical Director or their designee with United's Medical Director or their designee. Those re-admissions where it is agreed by both Medical Directors the cause of the re-admission was a result of a premature discharge will be subject to the recovery of the DRG payment for the second admission. In instances where the Medical Directors cannot agree on whether a re-admission was result of a pre-mature discharge, the case will be referred to an external peer review organization for resolution.
Should we do it now?

Revenue Cycle concerns: We get paid for readmissions
   Bad for Revenue
Quality of Care Issues
   Better Quality
Cost of Care Issues: Medicare and other Payers
   Tax Payers, Premiums, Employers
   Clearly better for Payers and Cost of Care
What is best for the patient?
   Clearly better for Patients
What is best for the hospital?
   Not Clear at this time in terms of revenue cycle
What is best for the doctors? Financially, Job Satisfaction
   Conflicting Incentives
5 Questions to Determine Readmission Rate Effectiveness
Joan Moss, RN, MSN, Senior Vice President, Sg2, for HealthLeaders Media, June 30, 2011

Question 1: What is our business exposure based on CMS penalties and future accountable care organization (ACO) quality reporting requirements?

Question 2: How can we reduce readmissions without adversely affecting our current financial goals?

Question 3: How can we better manage AMI, CHF and pneumonia patients?

Question 4: What post-acute referral locations create our greatest readmission risks?

Question 5: How can we more effectively manage readmissions overall?
5 Questions to Determine Readmission Rate Effectiveness

Joan Moss, RN, MSN, Senior Vice President, Sg2, for HealthLeaders Media, June 30, 2011

Hospitals have always known that reducing readmissions should be a priority quality goal but, until now, the payment incentives have not been in place. Like it or not, health care reform has provided a new impetus to do the right thing.

Financial penalties on providers with "excess" readmissions will begin in fiscal year 2013, but claims data collection on those penalties starts this October. The Centers for Medicare & Medicaid Services (CMS) measures readmissions within a 30-day time frame after patients are discharged for their initial admission. A readmission to any acute care hospital, for any reason, regardless of whether it is to the hospital from which the patient was originally discharged, or whether the readmission has any relation to the original hospital stay, will be counted. This is the definition of an "all-cause" readmission and does not exclude elective or planned admissions.

CMS will risk adjust readmissions penalties based on comorbidities and other patient variables, and initial penalties will focus on excess readmissions for congestive heart failure (CHF), pneumonia and acute myocardial infarction (AMI). Additional readmission penalties for chronic obstructive pulmonary disease (COPD), coronary artery bypass graft, percutaneous coronary intervention and other vascular procedures will begin in fiscal year 2015. What these penalties
What to do when you are ready to get serious of Readmission Reduction
How do you reduce Readmissions?

Prepare Patients and Families better for Discharge and Post Hospitalization Care
More Effective Transfer of Information from Hospitalists to Receiving Doctors
Improve your Post Hospitalization Care!
   Improve Care in Post Hospitalization Facilities
   Get Informed Patients to Informed Primary Care Doctors Sooner

Will this eliminate the problem?

No because some patients relapse within 30 days no matter how well they are cared for.

Will this reduce the number of readmissions?

Yes, absolutely because we generally do a poor job when it comes to Post Hospitalization Care!
RED: Why it was done, its drawbacks, the results and how it can be improved

1. Why it was done
   1. 25% of patient required outpatient workup and 1/3 did not get that workup
   2. 41% of patients had tests pending. 2/3 of time receiving doctor was not aware
   3. Discharge Summary was not available to receiving doctor 1/3 of the time
   4. 23% of patients had an adverse event after discharge. 2/3 could have been prevented or ameliorated
   5. Only 40% of patients knew their discharge diagnoses or their medications at the time of discharge
   6. An average of 8 minutes is spent preparing patients for discharge and patients only have an average of 2 questions

2. It’s Drawbacks
   1. Patient’s average age was 49 years old
   2. 50% of patients were Medicaid

3. The Results
   1. Readmissions reduced from 21% to 15%
   2. ED Visits reduced from 24% to 16%
   3. Total Readmissions plus ED Visits reduced from 45% to 31%
   4. Follow up visits increased from 44% to 62%

4. How Can the Results be Improved
**Project RED (Re-Engineering Discharge)**

**Mutually Reinforcing Components**

1. Educate patient during stay. Educate every day.
2. Make Follow up Appointment with Receiving Doctor within 2 weeks of Discharge
3. Make sure Tests and Studies have appropriate follow up (Discharge Advocate). Organized Post Discharge Plan with Tasks.
4. After Hospital Discharge Plan (AHDP) and Discharge Summary to Receiving Doctor at Follow up Visit
5. Make sure post discharge plan is consistent with Clinical Guidelines and Pathways
6. Medication Reconciliation
7. Make sure patients understand their diagnoses and plan of care (Teach Back Method)
   1. Confirm Medication Plan and make sure Patients know why they are taking each Medication
   2. Make sure patients know what to do if certain problems arise
   3. Have a written Discharge Plan for the Patient (Diagnoses, Medications, Follow up plan, Pending tests and labs, Tests to be done
8. 72 hour phone call to patient
How can we do better than Project RED

1. Patients should be seen within 72 hours of discharge
2. Appointments should be made by hospital prior to discharge
3. All Discharge Summaries should be dictated within 24 hours of discharge
4. Every Problem on the Problem List should be addressed in the Discharge Summary
5. Discharge Summaries MUST be Dictated (not written)
6. Hospitalist calls the Receiving Doctor to have a real time conversation about the patient (sign out or “hand off”)
7. Patients should get a copy of their Medical Record to Read and Take to their Receiving Physician
   1. Admission H&P, ED Evaluation, Consultations, Discharge Summary, Radiology, Labs, Operative Reports, Anesthesia Reports, Procedure Reports
What Physicians and Hospital Systems have to do together

Dictate within 24 Hours of Discharge
Dictate a Quality Discharge Summary with is Problem Oriented
Get this Dictation to the Receiving Provider within 24 Hours
Make sure Patients are Seen Within 48 Hours of Discharge
Make Sure Post Discharge Care is High Quality
  From Home
  From the Post Discharge Facility
Make Sure Patients and Their Families are Informed and Educated
Make Sure Patients Have a Copy of their Medical Record which is Organized
What some Hospital Systems and Insurance Companies are Doing

1. Horizon of New Jersey: Scale and BP cuff for CHF patients
2. Grove City Hospital: “Home with Meds” Program.
   1. Discharged patients leave with a month’s worth of discharge medications arranged by morning, noon and bedtime
   2. A local pharmacist visits the hospital to counsel patients on medications
   3. That pharmacist also makes house calls if concerns arise with home-bound patients
3. Health First: Discharge Advocates make sure patients are seen within 7 days of Discharge
4. Independence Blue Cross in Philadelphia: Providing $5 million to a patient-safety initiative involving more than 70 hospitals and aiming to reduce readmissions by 10%.
"So you think that money is the root of all evil?" said Francisco d'Aconia. "Have you ever asked what is the root of money? Money is a tool of exchange, which can't exist unless there are goods produced and men able to produce them. Money is the material shape of the principle that men who wish to deal with one another must deal by trade and give value for value. Money is not the tool of the moochers, who claim your product by tears, or of the looters, who take it from you by force. Money is made possible only by the men who produce ... When you accept money in payment for your effort, you do so only on the conviction that you will exchange it for the product of the effort of others ... Those pieces of paper, which should have been gold, are a token of honor - your claim upon the energy of the men who produce ... Try to obtain your food by means of nothing but physical motions - and you'll learn that man's mind is the root of all the goods produced and of all the wealth that has ever existed on earth ... Wealth is the product of man's capacity to think ... Money is made - before it can be looted or mooched - made by the effort of every honest man, each to the extent of his ability. An honest man is one who knows that he can't consume more than he has produced ... To trade by means of money is the code of the men of good will. Money rests on the axiom that every man is the owner of his mind and his effort. Money allows no power to prescribe the value of your effort except by the voluntary choice of the man who is willing to trade you his effort in return. Money permits you to obtain for your goods and your labor that which they are worth to the men who buy them, but no more. Money permits no deals except those to mutual benefit by the unforced judgment of the traders. Money demands of you the recognition that men must work for their own benefit, not for their own injury, for their gain, not their loss - the recognition that they are not beasts of burden, born to carry the weight of your misery - that you must offer them values, not wounds - that the common bond among men is not the exchange of suffering, but the exchange of goods. Money demands that you sell, not your weakness to men's stupidity, but your talent to their reason; it demands that you buy, not the shoddiest they offer, but the best your money can find. And when men live by trade - with reason, not force, as their final arbiter - it is the best product that wins, the best performance, then man of best judgment and highest ability - and the degree of a man's productiveness is the degree of his reward. This is the code of existence whose tool and symbol is money ... Until and unless you discover that money is the root of all good, you ask for your own destruction. When money ceases to be the tool by which men deal with one another, then men become the tools of men ... Blood, whips and guns - or dollars ... Take your choice - there is no other - ...
Money
Quality of Care
Do the right thing
Be better at what you do
Help others
SHOW ME THE MONEY!
In summing up, I wish I had some kind of affirmative message to leave you with, I don't. Would you take two negative messages?

Woody Allen, The Comedy Years
Actually there is a Very Positive Message

Reducing Readmissions and Providing Better Care is Simple but Not Easy!

When Providers are Financially Rewarded for Taking Better Care of Patient, They Will Do It!

Get Ready because It is Coming

Even if it is Not in Your Financial Interest To Reduce Readmissions and Provide Better Post Hospitalization Care ... the Time Will Come and You Had Better Be Ready with A Robust and Effective Plan

Why Do It NOW?

Because if it the Right Thing To Do!
THE END
Additional Resources:

Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other health care setting. CMS. CMS Product No. 11376. Revised April 2010.

Innovating on “teach-back” to prevent avoidable readmissions. [www.advisory.com](http://www.advisory.com)

Preventing Avoidable Hospital Admissions: Strategic Considerations for Nurse Executives. Nursing Executive Center. The Advisory Board Company
Meeting Two:

Involve Chief of Family Practice
- Get information about their patients before seeing them in their office
- Have the opportunity to take care of their patients in the post discharge facilities
  - Medication Reconciliation
    - Don’t send their patient home on all new meds when they have meds they can use at home

Meaningful Use Requirement for Electronic Discharge Summary Form being developed by the Internal Medicine Department Teaching Service

Tools and Resources Already Available that people don’t know about
- Paper Pads which encourage patients and families to write down their questions and concerns
  - MyAtlanticHealth.org:
    - My Medical Profile Wallet Card

Pilot the Pre-Discharge Checklist on Unit F5W with involvement of Hospitalist Group and Nurse Manager and her Nursing Staff

Looking to improve Patient Satisfaction

Discussed making it a general practice to make follow up appointments for patients before they left hospital. This would ensure that they would be seen soon after discharge by their Primary Care Doctor.
Meeting Three:

Boston Medical Center: Project RED

**After Hospital Care Plan**

Medications
What is my main medical problem
When are my appointments (date, time, place, doctor, address, phone)
What exercises are good for me
What should I eat
What are my medication allergies
Where is my pharmacy (address and phone number)
Questions for the doctor
Calendar with Appointments
Patient Educational Information

Should Core Quality Measures be part of our Pre Discharge Checklist?
No as this will distract from the main purpose of this checklist

Physicians should be dictating their Discharge Summaries at the time of Discharge
The summary is better when the doctor remembers more
The summary can be typed and sent to the Primary Care Doctor
Problem Oriented Discharge Summary
Essential Elements of a Quality Discharge Summary

Avoid duplication of Effort
Are other departments working on this project
Are other hospitals in our System working on this project?