A2/B2: Reducing Avoidable Hospital Readmissions

Pat Rutherford RN, MS
Vice President, IHI
Agenda

- Context and Evidence for Reducing Avoidable Readmissions
- Getting Started
- Promising Approaches for Reducing Readmissions
- Key Changes for Hospitals to Improve the Transition from Hospital to Home
Session Objectives

• Describe common problems that contribute to readmissions

• Identify promising approaches to reduce avoidable readmissions

• Describe four key strategies for creating an ideal transition from the hospital to home or to other community-based care settings
CONTEXT AND EVIDENCE FOR REDUCING AVOIDABLE READMISSIONS
Manifestations of Poor Transitions

• Absence of appropriate follow-up care and support services
• Inadequate support for self-care needs
• Extra burden on patient and family caregivers for care coordination
• Increase in patient harm from medication errors
• Greater use of hospital and emergency room
• Higher costs of care
“The Billion Dollar U-Turn”

- 20% Medicare beneficiaries readmitted within 30 days
- $17B in Medicare spending; est. $25B across all payers annually
- 76% potentially avoidable
  - CHF, CAP, AMI, COPD lead the medical conditions
  - CABG, PTCA, other vascular procedures lead the surgical conditions
- Medicare 30-day readmission rate varies 13-24% across states; Variation greater within states

Mark Taylor, The Billion Dollar U-Turn, Hospitals and Health Networks, May 2008
Commonwealth Fund State Scorecard on Health System Performance. June 2009
State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009
State Variation: Hospital Admissions Indicators

Percent

Best state  Top 5 states average  All states median  Bottom 5 states average  Worst state

50

43

40

31

28

19

9

7

23

22

18

14

13

Nursing home residents readmitted to hospital within 30 days

Top 5 states

1. Oregon
2. Utah
3. South Dakota
4. Nebraska
5. Idaho

Nursing home residents admitted to hospital

1. Minnesota
2. Arizona
3. Oregon
4. Utah
5. Colorado

Nursing home patients readmitted to hospital within 30 days

1. Utah
2. Vermont
3. Idaho
4. South Dakota
5. Montana

Home health patients admitted to hospital

1. Utah
2. Washington
3. North Dakota
4. Oregon
5. South Dakota

DATA: Medicare readmissions—2006–07 Medicare 5% SAF Data; Nursing home admission and readmissions—2006 Medicare enrollment records and MEDPAR file; Home health admissions—2007 Outcome and Assessment Information Set
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009
Readmissions Among Patients in the Medicare Fee-for-Service Program

- 2007 Medicare data analysis finds:
  - One in five Medicare Beneficiaries are readmitted in 30 days
  - 67% are readmitted or deceased at 1 year
  - 24% of 30-day readmissions are to another hospital
- Among medical patients readmitted at 30 days:
  - 50% no bill for MD service between discharge and readmitted
- Among surgical patients readmitted at 30 days:
  - 70% are readmitted with a medical DRG

The Revolving Door Of Rehospitalization From Skilled Nursing Facilities

ABSTRACT Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting and can increase the likelihood of medical errors related to care coordination. Payment incentives in Medicare do not encourage providers to coordinate beneficiaries’ care. Revising these incentives could achieve major savings for providers and improved quality of life for beneficiaries.
The Major Challenges

• Potentially preventable rehospitalizations are prevalent, costly, burdensome for patients and families and frustrating for providers

• No one provider or patient can “just work harder” to address the complex factors leading to early unplanned rehospitalization

• Problem is exacerbated by a highly fragmented delivery system in which providers largely act in isolation and patients are usually responsible for the own care coordination

• Most payment systems reward maximizing units of care delivered rather than quality care over time
Review of the literature shows wide variation in definitions of readmission, assessments of which readmissions could potentially be avoided, and identification of factors that may prevent readmission.

The proposed 28-day readmission rate is likely to reflect a balance between hospital and community factors that might influence readmission; 15 percent to up to 20 percent of readmissions could be regarded as avoidable.

Preventing emergency readmissions to hospital, A scoping review. Ellen Nolte, Martin Roland, Susan Guthrie, Laura Brereton. RAND Europe research prepared for the UK Department of Health (England) 2012.
What is Your Understanding of the Problem....

- in your hospital?
- In your health system?
- In your region?
- In your country?
Effects of Care Coordination

- 15 randomized trials
- Determine whether care coordination programs reduced hospitalizations and Medicare expenditures and improved quality of care for chronically ill Medicare beneficiaries
- Nurses provided patient education and monitoring (mostly via telephone) to improve adherence and ability to communicate with physicians (twice per month on average)
- Viable care coordination programs without a strong transitional care component are unlikely to yield net Medicare savings. Programs with substantial in-person contact that target moderate to severe patients can be cost-neutral and improve some aspects of care

Determinants of Preventable Readmissions

- Patients with generally worse health and greater frailty are more likely to be readmitted
- There is a need to address the tremendous complexity of variables contributing to preventable readmissions
- Identification of determinants does not provide a single intervention or clear direction for how to reduce their occurrence
- Importance of identifying modifiable risk factors (patient characteristics and health care system opportunities)
- Preventable hospital readmissions possess the hallmark characteristics of healthcare events prime for intervention and reform > leading topic in healthcare policy reform

The Bad News: There are No “Silver or Magic Bullets”!

…no straightforward solution perceived to have extreme effectiveness

Conclusion: “No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.”

The Good News: There are Promising Approaches to Reduce Rehospitalizations

• Improved transitions out of the hospital
  – Project RED
  – BOOST
  – IHI’s Transforming Care at the Bedside and STAAR Initiative
  – Hospital to Home “H2H” (ACC/IHI)
• Reliable, evidence-based care in all care settings
  – PCMH, INTERACT, VNSNY Home Care Model
• Supplemental intensive care management for high risk patients
  – Care Transitions Intervention (Coleman)
  – Transitional Care Intervention (Naylor)
  – Proactive palliative care for patients with advanced illness
  – Evercare Model
  – Heart failure clinics
  – Intensive care management from primary care or health plan
GETTING STARTED
Recent Evidence

• Gives us reason for pause
• Results are unimpressive and join growing number of mixed or negative studies in disease management/case management/care coordination
• We need to be careful not to over emphasize assessment, care planning, and patient education compared to patient/family caregiver engagement
• Time to shift from provider-centered care to patient-centered care
Harold D. Miller, President and CEO, Network for Regional Healthcare Improvement and Executive Director, Center for Healthcare Quality and Payment Reform
What can be done, and how?

There exist a growing number of approaches to reduce 30-day readmissions that have been successful locally

Which are high leverage?
Which are scalable?

Success requires engaging clinicians, providers across organizational and service delivery types, patients, payers, and policy makers

How to align incentives?
How to catalyze coordinated effort?
Getting Started

1. The Hospital CEO Selects an Executive Sponsor and a Day-to-Day Leader to lead the improvement work
2. Executive Sponsor convenes a Cross-Continuum Improvement Team
3. Team Identifies opportunities for improvement using:
   a. In-depth review of the last five rehospitalizations
   b. 30-day all-cause readmission rates
   c. Patient experience data on communications and discharge preparations
4. Select one or two pilot units or a pilot population and develop an aim statement for the initial work; develop a scale-up strategy and plans to spread successful interventions
Strategic Questions for Executive Leaders

• Is reducing the hospital’s readmission rate a strategic priority for the executive leaders at your hospital? Why?
• Do you know your hospital’s 30-day readmission rate?
• What is your understanding of the problem?
• Have you assessed the financial implications of reducing readmissions? Of potential decreases in reimbursement?
• Have you declared your improvement goals?
• Do you have the capability to make improvements?
• How will you provide oversight for the improvement initiatives, learn from the work and spread successes?
Cross Continuum Teams

A team of staff in the hospital, skilled nursing facilities, home health care agencies, office practices, and patients and family members:

• Provide oversight and guidance
• Help to connect hospital improvement efforts with partnering community organizations
  – Identifies improvement opportunities
  – Facilitates collaboration to test changes
  – Facilitates learning across care settings
• Provide oversight for the initial pilot unit work and establishes a dissemination and scale-up strategy
Cross Continuum Teams

- CCTs is one of the most transformational changes in IHI’s work to improve care transitions
- CCTs reinforces the idea that readmissions are not solely a hospital problem
- There is a need for involvement at two levels:
  1) at the executive level to remove barriers and develop overall strategies for ensuring care coordination
  2) at the front-lines -- power of “senders” and “receivers” co-designing processes to improve transitions of care
- The new competencies developed in CCTs (where team members collaborate across care settings) will be a great foundation integrated care delivery models (e.g. bundled payment models, ACOs)
Quotes from Cross Continuum Team Members

“It is a lot of work to establish this team, but it is worth it.”

“The conversations change when everyone is at the table. It feels good to have us all in the room with the patient at the center of our work.”

“Even if we haven’t moved the numbers, we have moved the mindset.”

“Staff at different sites of care pick up the phone; they didn't before.”

“We make more referrals to home care as a result of the improved communications.”

“The CCT will last beyond this initiative. All future initiatives will benefit from the open communications and less siloed care.”

“We are making great strides in opening the communication of patient care between our diversified organizations. It is truly encouraging after 40+ years in health care to see this transformation.”
Diagnostic Case Reviews

• Provide opportunities for learning from reviewing a small sampling of patient experiences

• Engage the “hearts and minds” of clinicians and catalyzes action toward problem-solving
  — Teams complete a formal review of the last five readmissions every 6 months (chart review and interviews)
  — Members from the cross-continuum team hear first-hand about the transitional care problems “through the patients’ eyes”
Worksheet B: Interviews with Patients, Family Members, and Care Team Members

If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

Ask Patients and Families:

How do you think you became sick enough to come back to the hospital?

Did you see your doctor or the doctor’s nurse in the office before you came back to the hospital?

Yes □ If yes, which doctor (PCP or specialist) did you see?

No □ If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Ask Care Team Members:

What do you think caused this patient to be readmitted?
Rebecca’s Story

Rebecca Bryson lives in Whatcom County, WA and she suffers from diabetes, cardiomyopathy, congestive heart failure, and a number of other significant complications; during the worst of her health crises, she saw 14 doctors and took 42 medications. In addition to the challenges of understanding her conditions and the treatments they required, she was burdened by the job of coordinating communication among all her providers, passing information to each one after every admission, appointment, and medication change.

http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx#videos
Rebecca’s Story

Rebecca said if she were to dream up a tool that would be truly helpful, it would be something that would help her keep her care team all on the same page. Bryson described typical medical records as being “location or process centered, not patient-centered.” She also describes how difficult it can be for patients to navigate a large health care system. Rebecca summarizes her experience in this way – “Patients are in the worst kind of maze, one filled with hazards, barriers, and burdens.”

http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx#videos
Video Ethnography

Benefits

• Leverage patient, staff, and physician voices to drive change and improvement – real people’s voices motivate change in ways that other data cannot.

• Uncover ‘why’ something is happening, often explaining discrepancies between what people say and what they do, and identifying needs that people can’t always articulate explicitly.

Video Ethnography is the rapid, applied use of ethnographic methods using video to capture observation and interviews in order to analyze and then share key findings with performance and quality improvement teams, leaders, and others across an organization or institutional context.

• Watch the video: http://kpcmi.org/what-we-do/evaluationanalytics/returning-home-video/

• Read impact in Health Affairs Article: http://content.healthaffairs.org/content/31/6/1244.abstract

• Try it yourself with our toolkit! http://kpcmi.org/cmi-news/tool-kits/
Systems of Care

“The quality of patients’ experience is the “north star” for systems of care.”

–Don Berwick
What experience of care is the “north star” aim for your system of care?
PROMISING APPROACHES TO REDUCE AVOIDABLE READmissions
The Good News: There are Promising Approaches to Reduce Rehospitalizations

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  – Evercare Model
  – Heart failure clinics
  – Intensive care management from primary care or health plan
Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans

Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

Transition from Hospital to Home or other Care Setting

Primary & Specialty Care

Triage, Access
Review Plan & Post-Plan
Assess, Plan & Support Management
Coordinate Care

Home Health Care

Skilled Nursing Care Centers

Teaching & Learning
Assessment of Needs
Plan for AcuityCare
Healthcare Communications

The State Action on Avoidable Rehospitalizations Initiative (STAP)
Improving the Transition from the Hospital to Home or other Care Settings
Process Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home
How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations

How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx
Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

Key Design Elements

Patient and Family Engagement
Cross-Continuum Team Collaboration
Health Information Exchange and Shared Care Plans

Transition from Hospital to Home or other Care Setting

Primary & Specialty Care
- TCTPR
- PCP
- PM
- ACC
- PMP
- Care Coordination

Home Health Care
- BHC
- NHC
- PCC
- ALL
- PHA
- Post-Acute Care

Skilled Nursing Care Centers
- LTC
- Nursing Homes
- Hospice
- Palliative Care
- Open Visits
- Support Groups

Transition to Community Care Settings and Better Models of Care
Evidence-based Care in Community Settings

GEISINGER
ProvenHealth℠ Navigator

VISITING NURSE SERVICE OF NEW YORK

INTERACT II
Interventions to Reduce Acute Care Transfers
Transition from Hospital to Home or other Care Setting

Transition to Community Care Settings and Better Models of Care

Primary & Specialty Care
- Timely Access
- Review Plan & Fall Prep
- Assess, Plan & Monitor Management Support
- Coordinate Care

Home Health Care
- Review Plan & Fall Prep
- Access, Plan & Monitor Management Support
- Coordinate Care

Skilled Nursing Care Centers
- Access, Plan & Monitor Management Support
- Coordinated Care

Supplemental Care for High-Risk Patients

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Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans
Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure
More Effective Interventions for High-risk Patients


KEY CHANGES FOR HOSPITALS TO IMPROVE THE TRANSITION FROM HOSPITAL TO HOME
How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

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Institute for Healthcare Improvement, June 2012

http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionstoReduceAvoidableRehospitalizations.aspx
## Changing Paradigms

<table>
<thead>
<tr>
<th>Traditional Focus</th>
<th>Transformational Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate clinical needs</td>
<td>Comprehensive needs of the whole person</td>
</tr>
<tr>
<td>Patients are the recipients of care and the focus of the care team</td>
<td>Patient and family members are essential and active members of the care team</td>
</tr>
<tr>
<td>GPS location team (teams in each clinical setting)</td>
<td>Cross Continuum Team with a focus on the patient’s experience over time</td>
</tr>
</tbody>
</table>
## Changing Paradigms

<table>
<thead>
<tr>
<th>Traditional Focus</th>
<th>Transformational Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay in the hospital and timely discharges of patients</td>
<td>Initiating a post-acute care plan to meet the comprehensive needs of patients</td>
</tr>
<tr>
<td>“Handoffs”</td>
<td>Senders &amp; receivers co-design “handover communications”</td>
</tr>
<tr>
<td>Clinician teaching</td>
<td>What are the patient and family caregivers learning?</td>
</tr>
</tbody>
</table>
IHI’s Key Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home

1. “How can we gain a **deeper understanding of the comprehensive post-discharge needs of the patient** through an ongoing dialogue with the patient, family caregivers and community providers?”

2. “How can we gain a **deeper understanding of patient and family caregiver understanding and comprehension** of the clinical condition and self-care needs after discharge?”

3. “How can we develop a **post-acute care plan** based on the **assessed needs and capabilities** of the patient and family caregivers?”

4. “How can we **effectively communicate post-acute care plans** to patients and community-based providers of care?”

*Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2012.* Available at www.IHI.org.
Be Smart, Leave S.M.A.R.T. This Discharge Journal Belongs to:

**Signs** I should look for and who I should call when I leave:


**Medication** notes:


**Appointments** I will go to:

- **Appointments already scheduled:** [Doctor/Practice/Location] [Date/Time]


- **Appointments I need to schedule:** [Doctor/Timeframe for Visit]


**Results** for follow-up:


**Talk** with me more about at least three things:


Call askAAMC at 443-481-4000 for urgent health questions after you leave the hospital.
<table>
<thead>
<tr>
<th>Welcome To:</th>
<th>Room Number: 408-B</th>
<th>Phone #: 319-369-7561</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Please Call Me:</td>
<td>Today’s Date:</td>
</tr>
<tr>
<td>One Thing You Should Know About Me:</td>
<td>Anticipated Discharge Date:</td>
<td>Plan and Goals For The Day:</td>
</tr>
</tbody>
</table>

The Most Important Thing To Me During My Hospital Stay:

<table>
<thead>
<tr>
<th>Health Care Team:</th>
<th>Test - Treatments - Procedures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse:</td>
<td></td>
</tr>
<tr>
<td>Tech:</td>
<td></td>
</tr>
<tr>
<td>Doctors:</td>
<td></td>
</tr>
<tr>
<td>Therapists:</td>
<td></td>
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<table>
<thead>
<tr>
<th>Diet:</th>
<th>Pain Management Goal:</th>
</tr>
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</table>

Our Goal is to ALWAYS help control your pain

<table>
<thead>
<tr>
<th>Activity:</th>
<th>My Pain Goal:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Safety Alerts/ Special Needs:</th>
<th>My Last Pain Medication:</th>
</tr>
</thead>
</table>

| Family - Patient Comments: | |

Key Contact Person:

Quiet Time
12:30 pm to 1:30 pm / 2:00 am to 4:00 am:

Example of a Bedside White Board
Ongoing Assessment of Post-Hospital Needs

- Take 5 – establish a relationship and build trust
- Nurses and members of the care team take a stance of appreciative inquiry or as an investigative reporter
  - Ask patient and family caregivers - “why do you think you needed to come to the hospital?”
  - Ask the “5 Whys”
  - Ask patient and family caregivers - “what are you most worried about when you go home or to the next care setting?”
“5 Whys” Root Cause Analysis

1. **WHY?**
   patient not taking meds at home

2. **WHY?**
   no $ for meds

3. **WHY?**
   no insurance

4. **WHY?**
   not completed application for Medicaid

5. **WHY?**
   needs helps with filling out the application

6. **WHY?**
   Real solution is found here
By Howard K. Koh, Donald M. Berwick, Carolyn M. Clancy, Cynthia Baur, Cindy Brach, Linda M. Harris, and Eileen G. Zerhusen

New Federal Policy Initiatives To Boost Health Literacy Can Help The Nation Move Beyond The Cycle Of Costly ‘Crisis Care’

ABSTRACT Health literacy is the capacity to understand basic health information and make appropriate health decisions. Tens of millions of Americans have limited health literacy—a fact that poses major challenges for the delivery of high-quality care. Despite its importance, health literacy has until recently been relegated to the sidelines of health care improvement efforts aimed at increasing access, improving quality, and better managing costs. Recent federal policy initiatives, including the Affordable Care Act of 2010, the Department of Health and Human Services’ National Action Plan to Improve Health Literacy, and the Plain Writing Act of 2010, have brought health literacy to a tipping point—that is, poised to make the transition from the margins to the mainstream. If public and private organizations make it a priority to become health literate, the nation’s health literacy can be advanced to the point at which it will play a major role in improving health care and health for all Americans.
NEW CONCEPT: Health Information, Advice, Instructions or Change in Management

Assess Patient Recall & Comprehension Ask Patient to Demonstrate

Explain / Demonstrate New Concept
Patient Recalls and Comprehends/ Demonstrates Mastery

Clarify & Tailor Explanation

Re-assess Recall & Comprehension Ask Patient to Demonstrate

Adherence/ Error Reduction

Coaching to Always Use Teach-back

Giving staff knowledge on teach-back and its effectiveness is important. But, to change from a long-standing patient education habit of asking yes/no questions like “Do you have any questions?” to one of using teach-back to confirm understanding via the patient’s own words, takes coaching.

Tools and Videos

- Coaching Tips (PDF)
- Observation Tool (PDF)
- Conviction and Confidence Scale (PDF)
- Making Teach-back an Always Event (PDF)
- Manager Perspective on Coaching (VIDEO)
- Coaching Keys (VIDEO)
- Coaching Overview (VIDEO)
- Coaching: Overcoming Obstacles (VIDEO)
- Coaching a Nurse to Always Use Teach-back (VIDEO)
- Coaching a Physician to Always Use Teach-back (VIDEO)

IOWA HEALTH SYSTEM

Working together. Making a difference.
Proposed Agenda for “Patient Care Rounds”

• What are the goals/reasons for this admission? Are the health care team’s goals and the patient/families’ goals in synch?

• What needs to happen during this hospitalization? What are the criteria for the discharge readiness?

• What is the likelihood that this patient will be readmitted in 30 days? Why (predictions re: potential problems)?

• What post-acute care plan should be put in place to meet the patient’s level of activation and to mitigate potential problems?

• Activate and communicate real-time post-acute care plans to patients, family caregivers and community providers
Conclusions: Most current readmission risk prediction models that were designed for either comparative or clinical purposes perform poorly. Although in certain settings such models may prove useful, efforts to improve their performance are needed as use becomes more widespread.

IHI’s Approach: Assess the Patients Medical and Social Risk for Readmission

![Figure 13: Categories of a Patient’s Risk of Rehospitalization](image)

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has been admitted two or more times in the past year</td>
<td>Patient has been admitted once in the past year</td>
<td>Patient has had no other hospital admissions in the past year</td>
</tr>
<tr>
<td>Patient or family caregiver is unable to Teach Back, or the patient or family</td>
<td>Patient or family caregiver is able to Teach Back most of discharge information and</td>
<td>Patient or family caregiver has a high degree of confidence and can Teach Back</td>
</tr>
<tr>
<td>caregiver has a low degree of confidence to carry out self-care at home</td>
<td>has a moderate degree of confidence to carry out self-care at home</td>
<td>how to carry out self-care at home</td>
</tr>
</tbody>
</table>

When are patients being readmitted?

- Initial readmissions spike within 48 hours of discharge
- 66% of readmissions occur within 15 days

Dianne Feeney is associate director of quality initiatives for the Maryland Health Services Cost Review Commission (HSCRC)
# How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations


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<tr>
<td><strong>Post-acute Follow-up Care</strong></td>
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</tr>
<tr>
<td>Prior to discharge:</td>
<td>Prior to discharge:</td>
<td>Prior to discharge:</td>
</tr>
<tr>
<td>- Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or home health care is the best option for the patient.</td>
<td>- Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit as ordered by the attending physician.</td>
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</tr>
<tr>
<td>- If a home health care visit is scheduled in the first 48 hours, an office visit must also be scheduled within the 5 days.</td>
<td>- Initiate home health care or transitional care services (e.g. CTI) is needed.</td>
<td>- Provide 24/7 phone number for advice about questions and concerns.</td>
</tr>
<tr>
<td>- Initiate intensive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g. heart failure clinics).</td>
<td>- Provide 24/7 phone number for advise about questions and concerns.</td>
<td>- Initiate a referral to social services and community resources as needed.</td>
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Post-acute Plan of Care for Residents Transitioning to SNFs or Rehab

- A reliable transition of care after the resident is discharged from the hospital (review plan of care, medication reconciliation, etc.)
- Continuity of care with an MD or APN
- Proactive advanced illness planning with the patient and family members
- Reliable evidence-based care in the SNFs (fall prevention, care of patients with HF, etc.)
- Timely assessment of changes in clinical status of residents and a plan to address common conditions
Co-Design of Handover Communications
Taking Care of Myself: A Guide for When I Leave the Hospital

http://www.ahrq.gov/qual/goinghomeguide.htm
Analysis of Results-to-Date

• Reducing readmissions is dependent on highly functional cross continuum teams and a focus on the patient’s journey over time.

• Improving transitions in care requires co-design of transitional care processes among “senders and receivers”.

• Providing intensive care management services for targeted high risk patients is critical.

• Reliable implementation of changes in pilot units or pilot populations require 18 to 24 months.
Detroit MC Sinai Grace
CHF All-Cause Readmissions

% Readmission

S-08 F-09 J-09 D-09 M-10 O-10 M-11 A-11 J-12 J-12 N-12

DMC
Sinai-Grace Hospital
Detroit Medical Center: Sinai-Grace
Numbers of HF Discharges and Readmissions

- Green line: number of discharges
- Red line: number of readmissions

DMC
Sinai-Grace Hospital
All-Cause 30-Day Readmissions
Heart Failure Readmissions (for Any Cause) within 30 Days

Percent

%HF to Any Reason

Median

ST. LUKE’S HOSPITAL
IOWA HEALTH SYSTEM
Histogram of Days between Initial Discharge Date and Readmission Date
Heart Failure as Initial Admission

- Incomplete medical management
- Wrong site of post-acute care
- Socio-economic factors
- Physician follow-up
- Med problems
- Patient compliance with regime
- Disease trajectory

Days between Initial Discharge Date and Readmission Date

Frequency

-6 -2 0 2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 32 34 36

Days between

- Mean 15.10
- StDev 8.773
- N 49

St. Luke's Hospital
Iowa Health System
30 Day All-Cause Readmissions

30 Day Readmissions for HF Pilot Nursing Units: Any Dx of HF

Goal Line: 16% (30% reduction)

2009 Average = 24%
2010 Average = 18 %
2011 Average = 13%
90-Day All Cause Readmissions for Heart Failure Patients

Average for 2009 = 40.2%
Average for 2010 = 31%
Average for 2011 = 26%

30% Reduction from 2006 (45.2%) to 2010

Goal Line: 31% (30% reduction)
UCSF Heart Failure Program

Case Study
INNOVATIONS IN CARE TRANSITIONS
November 2012

University of California, San Francisco Medical Center: Reducing Readmissions Through Heart Failure Care Management

DOUGLAS MCCARTHY

http://www.commonwealthfund.org/Publications/Case-Studies/2012/Nov/University-of-California-San-Francisco.aspx
Ohio Hospital Association Work Results in Hospital Readmission Reductions

AUGUST 2, 2012

OHA’s Quality Institute worked with the Institute for Healthcare Improvement to decrease hospital readmissions through the Ohio State Action on Avoidable Rehospitalizations (STAAR) Initiative. Eighteen hospitals participated, and results showed an eight percent greater reduction in STAAR hospitals’ readmissions than other Ohio hospitals’. The Columbus Dispatch reported that hospital readmissions in Ohio dropped six percent in 18 months and accredited the STAAR program as a factor in the decrease.
Summary

• Rehospitalizations are frequent, costly, and actionable for improvement
• The STAAR Initiative acts on multiple levels – engaging hospitals and community providers, communities, and state leaders in pursuit of a common aim to reduce avoidable rehospitalizations
• Working to reduce rehospitalizations focuses on improved communication and coordination over time and across settings
  — With patients and family caregivers;
  — Between clinical providers;
  — Between the medical and social services (e.g. aging services, etc.)
• Working to reduce rehospitalizations is one part of a comprehensive strategy to promote patient-centered care and appropriate utilization of health care resources
Resources

• http://www.ihi.org/explore/Readmissions/Pages/default.aspx
• http://www.ihi.org/offerings/Initiatives/STARIAR/Pages/default.aspx
• www.caretransitions.org
• www.NTOCC.org
• www.nextstepincare.org
• www.teachbacktraining.com
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http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm