

Preventing/Reducing Rehospitalizations

Kanmi Arogundade, MSN, APN-C, CNML
President, Angelic Helpers LLC

Program Purpose

- To provide attendees with effective knowledge of interventions to reduce rehospitalizations across patient populations and settings of care.

Learning Objectives

- Most common disease process and diagnosis leading to rehospitalizations.
- Methods of providing advanced care and support to our patients.
- Improving communication across various levels and transitions of care.
- Engaging staff to identify warning signs before it escalates
- Improving admission and discharge process.

Readmission Defined.

- The Center for Medicare and Medicaid Services (CMS) in 2012, defined readmission as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital.

Re-hospitalizations among patients in the Medicare Fee-for-service Program

➤ New England Journal of Medicine

Stephen F. Jencks, MD, MPH, Mark Williams, MD and Eric A Coleman, MD MPH.

Abstract

- 1 in 5 Medicare beneficiaries are readmitted within 30 days
Which equates to 2.3 million patients
- National cost of over \$17 Billion
- Half of patients readmitted had no physician contact
- 70% of surgical readmits were for chronic medical conditions.
- Potentially 40% of all Readmissions are preventable

Hospital Readmission Reduction Program

- Brief overview

- The HRRP is a reimbursement penalty approach for general acute care hospitals that have readmissions deemed “excess” by CMS
 - Began fiscal year 2013 (October 1, 2012)
 - Reduction is capped at 1% in 2013, 2% in 2014 and 3% in 2015 and beyond
 - Reductions apply to total DRG reimbursement
 - But readmissions deemed excess are determined using 3 specific conditions endorsed by the National Quality Foundation (NQF)
 - Acute Myocardial Infarction
 - Heart failure
 - Pneumonia

Avoidable Readmissions

- Readmissions are seen as a indicator of quality of care
 - Only valid when we know what % of readmissions were avoidable.

- A review was done on 34 studies published between 1966 and 2010 looking at readmissions that were deemed avoidable
 - Found: 24% were deemed avoidable

- Also noted that adults in the US received only 54.9% of recommended care²

1. Carl Van Walraven, MD MSc, Carol Bennett, MSc, Alison Jennings, MA, Peter C. Austin, PhD, Alan Forster, MD MSc. Proportion of hospital readmissions deemed avoidable: a systematic review. April 19-11 vol183 no. 7 E391-E402

2. Elizabeth McGlynn, Steven Asch, John Adams, Joan Keeseey, Jennifer Hicks, et al. The Quality of Health care delivered to adults in the united states. NEJM.

Readmission Factors

- AARC webcast August 28-12 “Hospital to Home-efforts at Reducing Hospital Readmissions”. Greg Spratt BS, RRT; Kimberly Wiles BS, RRT; Becky Anderson RRT.
- 69% were non compliant with meds
- 51% lacked knowledge: How to use Therapy Devices
- 45% inadequate knowledge of medications
- 42% unable to self manage care
- 37% had no follow up visit with Physician
- 31% develop infection post discharge

NO LONGER PERMANENT

The Problem...

OUR READMISSION RATE WAS HIGHER THAN WE THOUGHT

The Gap...

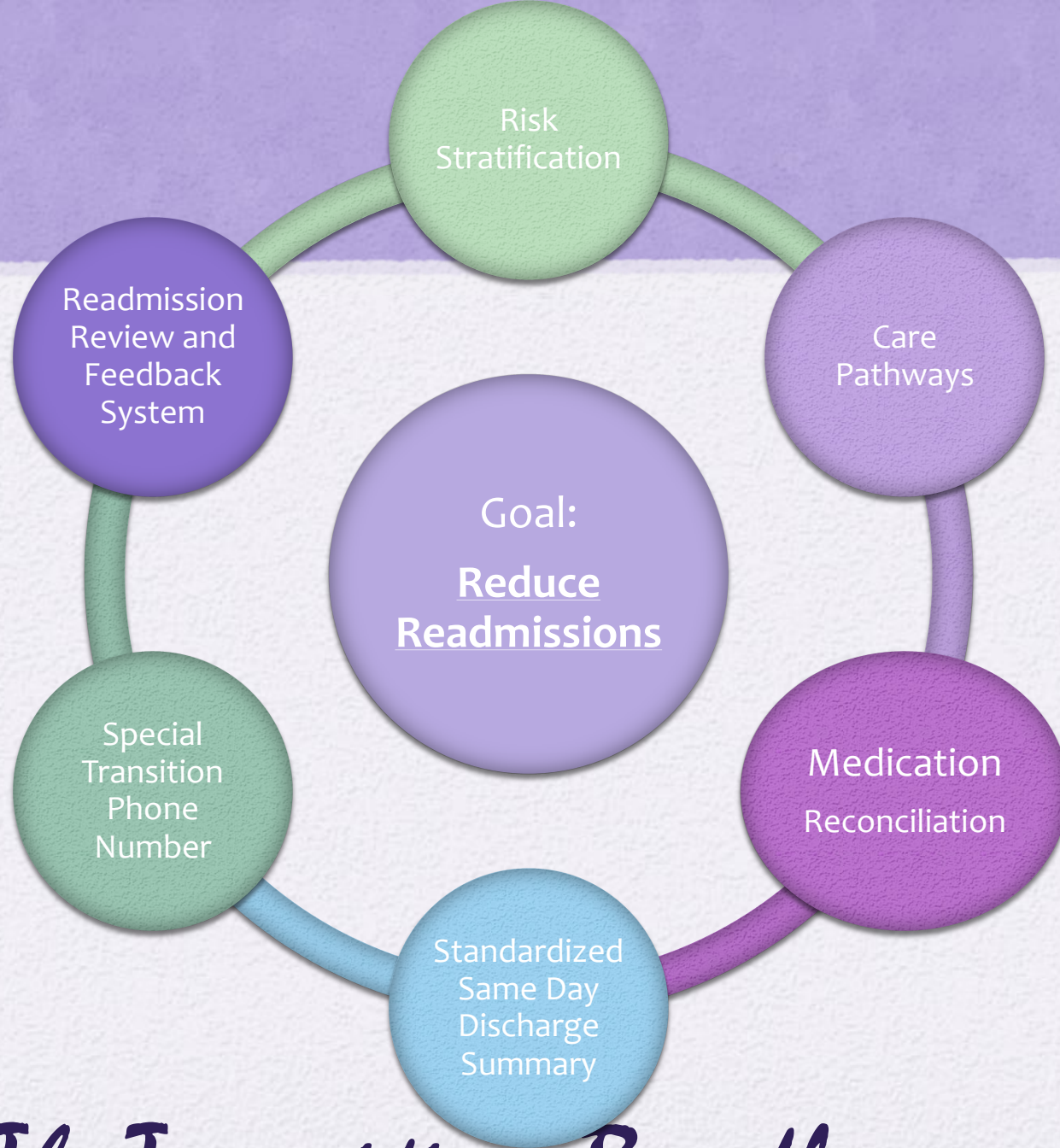
OUR READMISSION REDUCTION STRATEGIES WERE
“ONE-SIZE-FITS-ALL”

The Solution(s)...

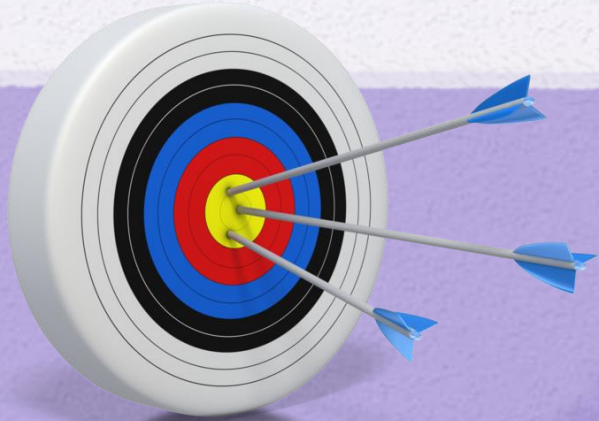
DEVELOP READMISSION REDUCTION STRATEGIES THAT ARE TAILORED
ACCORDING TO A MEMBERS RISK OF READMISSION

Changing Paradigms

Traditional focus	Transformational Focus
Immediate Clinical needs	Comprehensive needs of the whole person
Patients are the recipients of care and the focus of the care team	Pts and family members are essential and active members of the care team.
Variety of different teams	Cross continuum Team with a focus on the pts experience over time



The Transition Bundle



Know Your Population and Where to
Focus Your Efforts / Resources

Risk Stratification

Why are your patients better in their homes than in the hospital?

ASSISTED LIVING



HOSPITAL



KPCO Adult Medicine Risk Pool



- Transition call from TCC team within 48-72 hours
 - Medication Reconciliation
- Appoint booking / confirmation
- Phone visit with PCP within 7 days
- Override to higher level of care or forward to RNCC if necessary



Same as low risk, except:

- Office visit with PCP within 7 days



Same as low and medium risk, except:

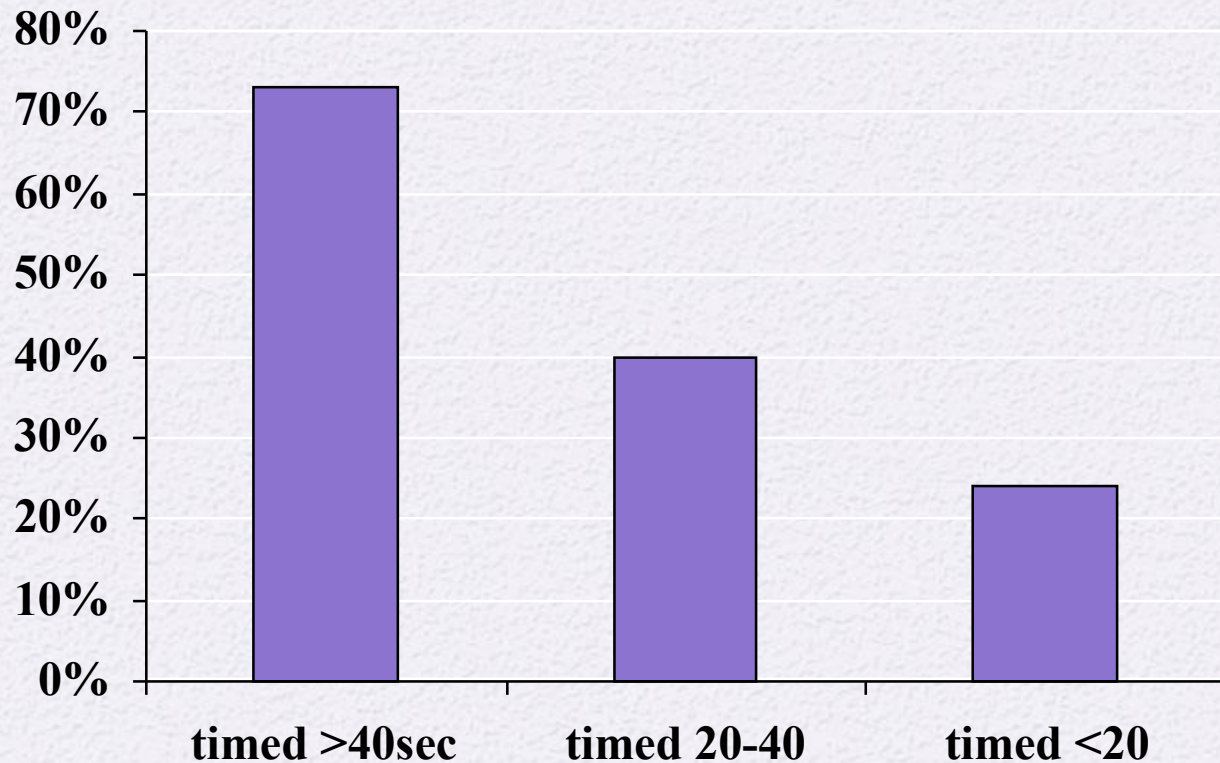
- PACT home visit within 72 hrs
- PCP appointment per PACT APN recommendation

Care Pathways According to Risk of Readmission

Hazards of Hospitalization in the elderly.

- Functional decline
- Delirium
- Nosocomial infections
- Psychosis
- Decline in muscle strength
- Medication errors
- Reduced bone density
- Inability to return to prior functional level
- Sensory deprivation

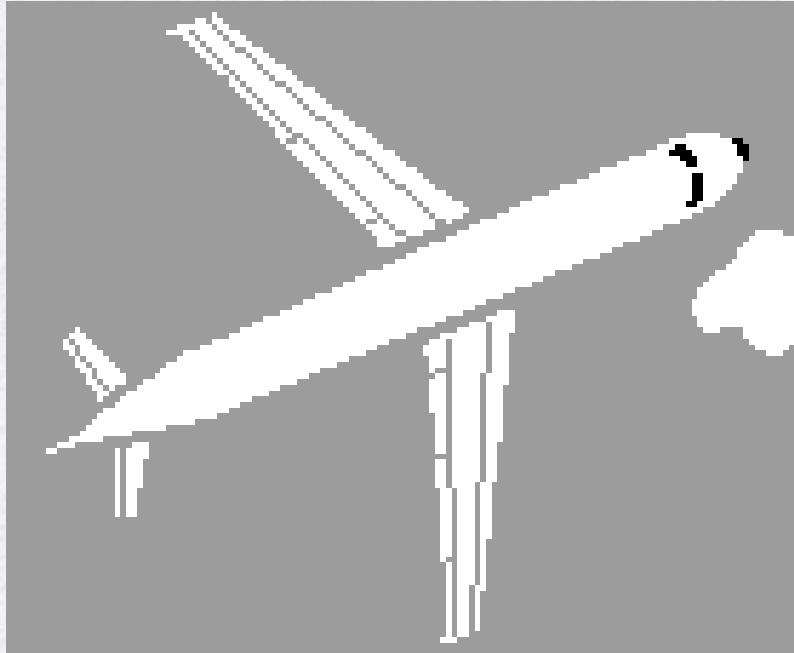
Functional decline



Hansen, etal, JAGS, 47: 360-365, 1999

Proactive/Preventative Patient Care

- “Hospital-acquired infections kill 99,000 Americans each year.”



- “That’s equivalent of a jumbo jet full of passengers crashing every other day.”
- **35,967 Deaths Annually from Hospital-Acquired Pneumonia²**

¹www.safepatientproject.org

²Nicolau et al. “Redefining Success for VAP: 360-Degree approach”,
JMCP June 2009, Vol. 15, No. 5

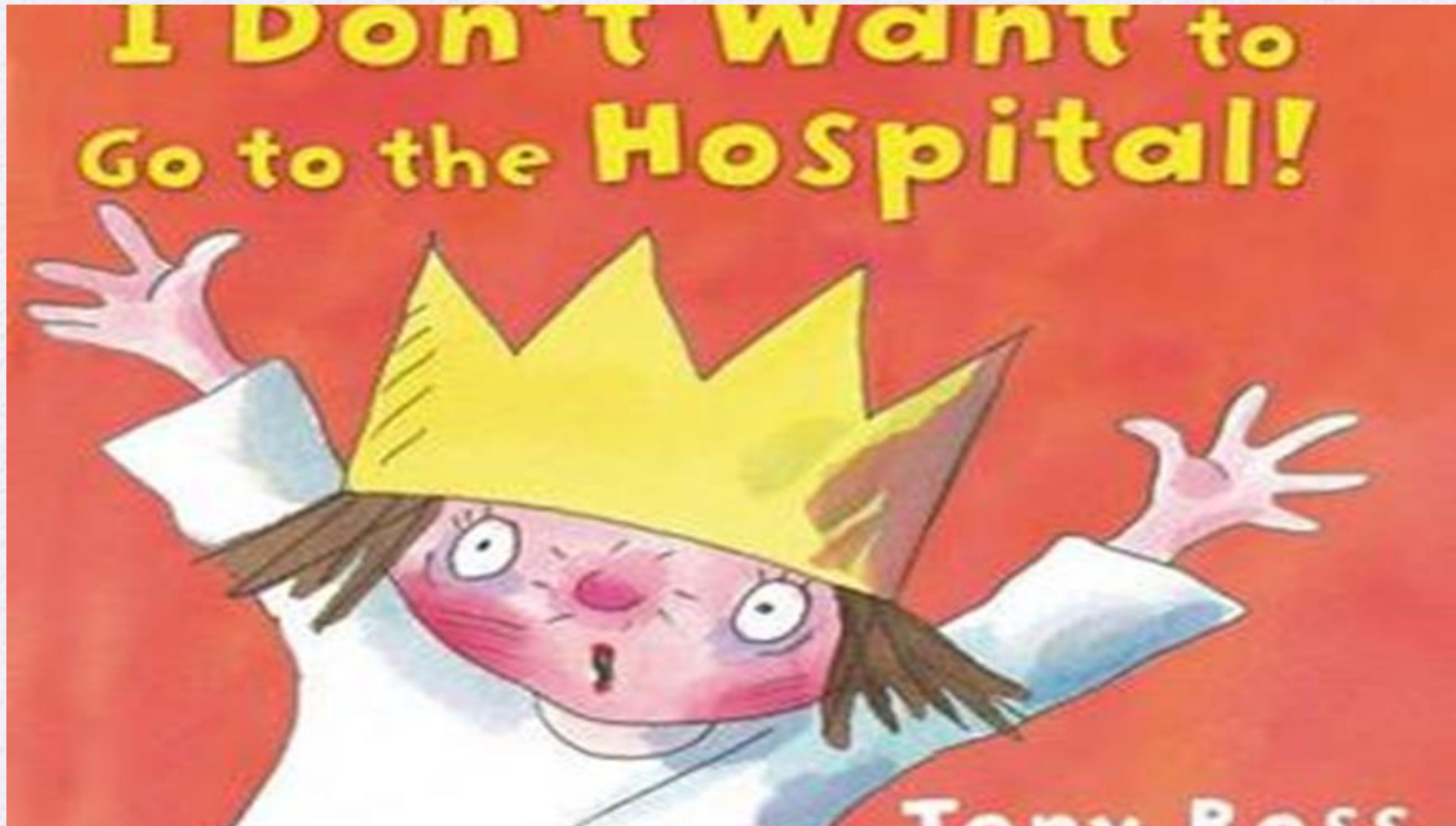
Common diagnosis leading to hospitalizations

- Falls
- Chest pain
- Urinary tract infections
- Acute pain
- Change in mental status
- Fever
- Acute confusion
- Urinary retention

The New York Times weighs in (April 24, 2015: Article by; Paula Span)

- 89 y/o patient with mild to moderate dementia
- Lives in a memory care unit
- Anxious and unhappy about hospitalizations.
- Able to receive care at his facility
- Able to get his weekly transfusions in the care center
- “People never came back healthier than when they left us.”

How do we prevent/reduce
rehospitalizations?



Know thy patient!

- Complete a thorough assessment of every patient in your facility.
- Know allergies, medical history, commodities and interest.
- Have living will and advance directives clarified.

Improve quality of patient care through education

- Educate staff about what to look for, and preventative measures.
- Educate patient and family members on risk factors and goals/plans of care.
- Set up quarterly education programs for staff and patients of wellness care.



- Schedule times to discuss patients as a team
- Use a multi-disciplinary approach
- Involve front line staff
- Involve family in plan of care

Person centered care

- Treat patients as individuals
- Avoid cookie cutter approach to care
- Listen to feedback and don't downplay complaints.

Documentation leads to proper implementation

- Document care provided on a routine basis.
- Document accurately and precisely.
- Teach patients to document changes in health status e.g. blood pressure, spikes in blood glucose, etc.

Medication Reconciliation

- Have a list of medication typed and readily available.
- Use laminated cards.
- Have medications reviewed monthly, removing discontinued medications from list.
- Check for interactions and side effects.

Medication Management and Discrepancy Reconciliation

© Original Artist / Search ID: j100220

Rights Available from CartoonStock.com



The Care Manager as a Navigator

- Helps navigate care transitions
- Liaison between hospital and care facility
- Provides follow up while patient is hospitalized
- Serves as patient advocate
- Ensures carryover of care

Follow up is crucial

- Set up 3 day, 7 day, 15day, and 30 month reviews after readmit.
- Ensure that post hospitalization instructions and care plans are followed.
- Schedule follow up appointments even before patient is discharged from the hospital.

Best practice examples

- The SHOP program(Senior Healthcare Outreach Program)
 - Founded by a NJ physician
 - Provides on-site medical services
 - Patients are seen at senior centers once a week
 - Prescriptions checked, labs drawn, etc.

INRERACT TOOL

- What is INTERACT?
- INTERACT is an acronym for “Interventions to Reduce Acute Care Transfers”.
- 3 basic types
 - ✓ Communication tools
 - ✓ Care paths or clinical tools
 - ✓ Advance care planning tools.

(Source: Geriatric Nursing Journal, 34(2013) 84-85)

Case Study

Winning the Readmission Challenge

- Posted on 7 March. 2013 by Steve Moran 11
Comment

When hospitals look at post-acute senior care communities (skilled nursing & assisted living) their criteria are very simple:

- You can send them patients (first time admits) or you can't.
- You can help them reduce readmissions or you can't.
- Their patients like your community or they don't.
- Your care model is consistent with the hospitals or it's not.

Trinity Senior Living with 32 senior housing communities in Indiana, Maryland, Michigan and Iowa made a strategic decision to aggressively create a program of care that would address the need for hospitals to reduce admissions.

The dining service component was a critical part of the program because it is well documented that good nutrition and hydration improves resident wellness. Trinity teamed up with Undone Senior Dining Services to create the ultimate wellness dining experience .

Meals, snacks and even purees needs to look, smell and taste great . Without these elements, residents either won't eat well and what they do eat, will not have the nutritional components needed to promote wellness.

- Staff are trained to identify risk factors and respond early to changes in status that indicate increased risk.
- The dining service is closely coupled with Trinity Senior Living, therapy services, activity and educational programs to create a comprehensive coordinated program.

Outcomes

How effective a program like this is, involves answering two questions;

- Is resident health improving and are hospital readmissions dropping?
- How much does it cost?

Effectiveness;

Trinity is seeing significant measurable positive outcomes in areas that include: congestive heart failure, diabetes, hypertension, acute and chronic kidney disease, dyslipidemias, dehydration and un-prescribed weight loss with an end result of reducing readmissions.

In Summary

- The cost of rehospitization is far beyond financial.
- We owe it to our clients/patient to provide optimal care in an environment that is safe and that promotes well-being.
- Addressing problems before they escalate is crucial.
- Your readmission rate is a likely reflection of the care you provide.

<https://www.youtube.com/watch?v=pSY2yM3co9U>

Questions

