Readmissions: The Price of Doing Business?

By Jaan Sidorov, MD, FACP

She was elderly, frail, stubborn and proud. She also remembered the value of a dollar and resented the price of her medicines. Having to reconcile the costs of rent, food, and her pills, she'd turn off the air-conditioning, occasionally have just a slice of bread with cheese for dinner, and skip some of her pills. Since she suffered with chronic atrial fibrillation, not following an expensive and complicated medication regime resulted in her repeatedly becoming one of Medicare's dreaded “avoidable readmission” statistics.

Doctors who provide hospital–based, hands-on care will readily tell you that it's remarkable that such patients survive and make it out of the hospital in the first place. Toss in the impact of social and behavioral factors outside the scope of clinical medicine, and it's practically guaranteed that many of Medicare's frail elderly like this will be readmitted within 30 days of discharge.

Apostasy you say?

Readers of Readmission News who think so may be surprised by a recent article published in the New England Journal of Medicine that questions the overall wisdom of Medicare's national focus on reducing readmissions. Authors Karen Joynt and Ashish Jha make some good points:

Scaling Project RED and Project BOOST: Eight Ways that Technology can Help Reduce Readmissions

By Joanne Rohde

Let's face it: despite all kinds of incentives, financial and otherwise, statistics overwhelming indicate that the problem of readmissions isn't improving. What other industries have a 20% return rate? While there are certainly issues that will and should land people back in the hospital, there are also many patients who shouldn't go back. Most experts believe 9-10% readmissions are really where we should be as a country.

- Some 19% of all Medicare patients entering the hospital will be back within 30 days, and 34% within 90 days, costing America $19 billion per year.

Readmission costs on key diseases among the commercially insured, including congestive heart failure, heart attack, and pneumonia, total $6 billion; added to the above Medicare patient readmissions, this means we are spending $25 billion a year on readmissions.

Despite providers' best efforts, huge communications gaps exist when patients transition from hospital to other care settings, or to home -- gaps that can drive up avoidable readmission rates and patient safety issues. The data is astounding, really:
Editor’s Corner

Raymond Carter, Senior Editor, Readmissions News

Each month we feature a brief profile of a different Readmissions News Advisory Board member. This month it is our pleasure to introduce Dr. Martin Kohn from IBM.

Dr. Marty Kohn is the Chief Medical Scientist for Care Delivery Systems in IBM Research, using health and business analytics to support the goals of major healthcare clients and refine IBM’s approach. He is a leader in developing Watson, the computer that won “Jeopardy!”, for healthcare applications. He supports IBM’s healthcare efforts in patient-centered collaborative care and is a member of the Healthcare Transformation research team.

Dr. Kohn has been involved in developing and implementing IBM’s solution for addressing the challenges to primary care and access to healthcare. His work includes developing the Watson supercomputer for medical applications, healthcare analytics, and researching policy initiatives and trends in health care both domestically and internationally. He speaks frequently on the issues of healthcare transformation, primary care, and the Patient Centered Medical Home.

Dr. Kohn is a co-author of IBM’s white paper “Patient-Centered Medical Home – What, Why and How.” He also works with the Industry Solutions Laboratory in Hawthorne, NY, developing methods and demonstrations for the future of integrated healthcare.

Dr. Kohn was previously with IBM Healthcare Strategy and Change, which helped healthcare systems and clinicians optimize process and make best use of health information technology. He has published multiple articles and book chapters on healthcare analytics as well as clinical and management subjects. He has four patents submitted on healthcare analytic methodologies.

Dr. Kohn is an emergency physician with over 30 years of hospital-based experience. His career has been dedicated to improving health care operations, and he has started many new programs, both on the hospital and system-wide level. Change management has been a staple of his career, using skills acquired from his education and work in research engineering, health care research methodology and health care operations. He is a member of the world Economic Forum steering committee on sustainable care models. He is a Certified Physician Executive and a Fellow of both the American College of Emergency Physicians and the American College of Physician Executives.

He is a key resource in project design and implementation to assure that the scope and process are compatible with needs and expectations of healthcare professionals in the clinical setting. Dr. Kohn spent more than thirty years in full time clinical practice and healthcare management.

His extended training and experience in health care management, policy and operations, as well as his background as a systems engineer, enable him to communicate with all stakeholder groups. He has had major roles in addressing the interaction between clinical process and information technology in projects involving information sharing, clinical process re-design, patient access and policy.

He received his undergraduate and MS degrees in engineering at the Massachusetts Institute of Technology, did post graduate study in Systems Analysis at Stanford University, and earned his medical degree from Harvard Medical School. He did his residency in emergency medicine at University of Chicago Hospitals and was a William Kellogg Fellow in the New York University School of Public Administration.
Family Member Involvement – A Key to Successful Hospital-to-Home Transitions

By Lily Sarafan, MS

It is a sad but well documented fact that the United States spends more on health care - $2.6 trillion in 2010 – than any other nation in the world, yet despite this enormous investment in our national health, ranks 37th in health care quality behind Greece, Colombia, Chile, and Costa Rica according to the World Health Organization. Among the many causes of this disparity, three stand out: unnecessary care, uncoordinated care, and avoidable care. The Economist estimates that these three inefficiencies alone account for over $300 billion dollars per year in unnecessary spending.

We will focus on one area in particular – avoidable hospital readmissions. As estimated by the Medicare Payment Advisory Commission, almost one in five Medicare patients will be readmitted to the hospital within 30 days of discharge, and the $15 billion in financial costs are not the only costs these readmissions create. There is also another, less obvious cost – a heavy emotional and health toll on the patients and their families.

Avoidable hospital readmissions are typically caused by insufficient post-hospitalization care, failure to adhere to recommended medication or therapy regimens, and lack of physical support for the discharged patient. Beginning this year, the Centers for Medicare and Medicaid have changed their reimbursement schedule to essentially penalize hospitals with high readmission rates.

Hospitals and healthcare professionals across the nation are teaming up with care facilities, home care agencies and other sources of post-hospitalization support in order to adapt to the new regulations. Ideally, this will mean better long-term care for patients and broader support for recovery at home.

While medical providers are implementing procedures to prevent readmissions, patients and families should take note of a few important tips to facilitate a successful transition from hospital to home. The best thing you can do if your loved one is hospitalized is to gather information -- learn about skilled nursing, home health care and private duty home care; consider recovery options at home or within facilities; and collect opinions from the doctors, nurses and discharge planners within the hospital.

Based on our work on effective hospital discharge and post-hospitalization care processes, we offer ten suggestions for family members that will greatly increase the chances of a successful hospital-to-home transition and prevent an unwanted hospital readmission:

1. Understand your care options prior to discharge. If your loved one prefers to recover at home, make these feelings known to the hospital discharge team.
2. Write a list of your loved one’s prescription drugs, over-the-counter drugs, supplements and vitamins, including your regular dosage and medication times. Make sure the medical team is aware of any drugs your loved one was taking prior to hospitalization to prevent unintended complications.
3. Obtain a list of home medical equipment, such as a walker or hospital bed, to facilitate recovery at home. You should plan to acquire and install this equipment prior to discharge.
4. If regular therapy, testing or medical check-ups are required, write down a schedule of the appointments, including relevant contact information.
5. Ask the hospital staff to demonstrate any tasks that require special skills, such as changing a bandage. Try to understand and master these tasks before you leave the hospital environment.
6. Ask the discharge team about common issues for patients in similar circumstances, what you can do to reduce your loved one’s risk and what you should do in the event of emergency.
7. Understand your loved one’s physical limitations and areas where he or she will need support. For example, mobility issues may prevent your loved one from safely walking around the house or up and down the stairs.
8. Create a regular schedule with your loved ones and any professional care providers involved in your loved one’s post-hospitalization care. Regular check-ins are critical in order to monitor progress and catch minor issues before they become major complications.
9. Ask to speak with a social worker if have concerns about coping with your loved one’s illness. A social worker can provide you and your family with information on managing the condition, available support groups and other resources.
10. Request written discharge instructions and a summary of your loved one’s current health status. Bring this information and the medication list with you to any follow-up medical appointments.

The best thing you can do if your loved one is hospitalized is to gather information -- learn about skilled nursing, home health care and private duty home care; consider recovery options at home or within facilities; and collect opinions from the doctors, nurses and discharge planners within the hospital.

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Family Member Involvement...continued

Planning for discharge is the first step of the post-hospitalization recovery process, but the road to recovery can be long and trying. The stress of recovery takes its toll on the entire family; individuals who care for a loved one suffer from fatigue, exhaustion and weakened immune systems. Over half of all family caregivers have some clinically significant symptoms of depression. Take advantage of the free information and resources available to you and contact a professional if you need further support.

Dr. David Carr, Clinical Director, Division of Geriatrics and Nutritional Science at Washington University School of Medicine, agrees. “Hospital readmissions are not only detrimental to a patient’s mental and physical health and expensive, but they can result in hospital penalization. Readmissions are often the result of inadequate support and supervision following the patient’s discharge orders upon returning home. Having a structured, professional hospital-to-home program promises benefits to the patient and the hospital by working in conjunction with the patient’s medical team to ensure discharge orders are followed and intervention occurs before a readmission is necessary.”

We often mistakenly assume that we can’t play a role in the efficiency of our institutions. We can prevent thousands of avoidable hospital readmissions by being proactive and valuing ourselves as resources in our communities. Together, we can help create a healthier America and a more cost efficient health care system.

Lily Sarafan, MS is President of Home Care Assistance, providing live-in and hourly home care services and personnel. She is co-author of Happy to 102: The Best Kept Secrets to a Long and Happy Life (June 2009), The Handbook on Live-in Care: A Guide for Caregivers (August 2011), and From Hospital to Home Care: A Step-by-Step Guide to Providing Care for Patients Post-Hospitalization (January 2012). She may be reached at lsarafan@homecareassistance.com.

Scaling Project RED...continued

Despite providers’ best efforts, huge communications gaps exist when patients transition from hospital to other care settings, or to home -- gaps that can drive up avoidable readmission rates and patient safety issues. The data is astounding, really:

- Direct communication between hospital physicians and primary care physicians occurs in only 3 to 20 percent of cases. Journal of the American Medical Association, 2007
- 78% of patients discharged from the ER do not understand their diagnosis, their ER treatment, home care instructions, or warning signs of when to return to the hospital. – Annals of Emergency Medicine, June 2000

Yet technology is already playing a powerful role in addressing readmissions at many leading institutions. The work of evidence-based programs such as Project RED and Project BOOST show meaningful reductions in readmissions -- up to 30% -- by addressing key issues such as better communications with follow-on medical professionals, caregiver involvement in the discharge process, patient engagement and education, and the scheduling of follow-on care before the patient is discharged.

Scalability, however, is another matter. With over 600 hospitals piloting these evidence-based programs, and getting impressive results in their pilots, most run smack into a brick wall. Providers can’t scale these initial manual efforts to educate, schedule, and stay in touch with patients -- intensive processes are needed to really move the needle at the hospital level. That’s where appropriate technology can change the equation, and allow these hospitals to do what’s right for every patient, not just a sample population.

Eight Steps to Using Technology

Eight of the eleven components of Project RED and Project BOOST can be optimized by software, and readily scaled to address many critical touch-points on the provider IT network. Specifically, technology helps RED and BOOST implementations deliver consistent patient engagement, increase the effectiveness and efficiency of the nursing staff without increasing headcount, and measure results via a real time dashboard. This leads to lower readmissions, improved PCP follow-through rates, and ultimately an improved patient experience.

Most of these changes aren’t rocket science, and they don’t require lengthy IT development efforts and costly extensions to the EHR. Rather they’re simple ways to use technology to deliver data the hospital already owns, but may needlessly lock into “silos” of information, instead of pushing it out toward the primary care physicians who can use it. These changes also may replace outdated approaches with less impact and efficiency.
Scaling Project RED …continued

- Patient engagement via touch screen, instead of static brochures or paper handouts. Tablets with text-to-speech capability in particular can reach virtually every patient regardless of computer skill to learn about their condition and prepare for aftercare.

- Real-time risk scoring, instead of failing to flag patients who have the potential to be readmitted – so clinicians can gauge readmission risks BEFORE the patient is discharged. Our motto is that discharge planning should start at the time of admissions, so appropriate interventions can be put into place from the start.

- Automated delivery to clinical summaries provided in real time to community providers – not via faxes.

Here are eight ways that providers can follow Project RED’s lead and use technology to re-engineer the discharge process.

1. **Expedite Transmission of the Discharge Summary.** Timely visits to an outpatient physician are an important part of the care plan. Yet only an estimated 12 to 34% of physicians receive discharge summaries by the time the patient makes his or her first post-discharge visit. Many hospitals resort to fax machines and remote access procedures, neither of which accommodates the busy reality of the outpatient physician. Modern Web technology solves this problem elegantly. Unwieldy hospital chart data can be automatically transformed into clean clinical summaries, and pushed in real-time to community care providers:
   - Securely transmit information to the physicians and nurses in simple, easy to use browser format – no Citrix clients, combing through lists of patients, or getting 20-page charts
   - Logically summarize and edit the key information and transmitting to the right place and time. Doctors should be able to access the information they need in thirty seconds on a single page
   - Make the customized summaries available to users via the device of their choice: smartphones, tablets, and/or PCs

2. **Educate Patients throughout the Stay.** National statistics suggest that at discharge only 42% of patients are able to state their diagnosis, and only 37% able to state the purpose of their medications. In order to take control of their health and well-being, patients must have a baseline of health literacy. A visit to the hospital is an ideal time to begin the process by asking core questions such as these: Why have you been admitted? What is happening to your body? How can you recognize future symptoms? What should you do when complications arise?

   Technology is ideally suited to:
   - Reviewing concepts
   - Presenting text with sound, video and interactivity that improve uptake
   - Providing pictures to facilitate greater understanding

3. **Confirm the Medication Plan.** Unlike scrawled prescription details on a discharge form, tablet and mobile displays can include actual photos of pills, along with doses, instructions on how and when to take the pills, and other information. Providing this in an easy to use graphical format makes certain those with different language or literacy levels can follow along.

4. **Assess Understanding with Teach-back Processes.** Health care is one of the few industries that haven’t recognized that talking at a sick patient without give-and-take contributes to patients only retaining 15% of what they hear. Most education studies show that teach-back -- asking questions and assessing whether the patient “got it” -- improves retention tremendously.

5. **Make Follow-up Appointments.** Patients who lack an outpatient appointment at the time of discharge represent 50% of readmitted cases nationwide. Relying on patients to make this initial appointment when they return home increases the risk that the appointment-setting will not happen. Instead, an easier and faster way is to automate both the appointment setting and the verification that the appointment is kept. Reminder systems can track date/time of medical appointments and equipment deliveries for the patient and their caregivers and family members.

6. **Provide a Written Discharge Plan.** Discharge plans are communicated to patients orally as an eight-minute list of things they need to do. Can you remember eight or nine things that someone tells you, even if you’re not sick? We need to make written discharge plans that can be referred to by the patient, their physicians, family members, and caregivers as often as they need after discharge.

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Scaling Project RED...continued

With an estimated 1.4 billion smartphones on the market by 2015 – 500 million loaded with at least one health-related application – the time has come to consider smarter discharge plan delivery to patients as well. Electronic discharge plans can provide at-a-glance information for easier understanding and follow-through.

6. **Organize Post-discharge Services.** Synthesizing aftercare appointments into a simplified one-page overview can facilitate understanding and compliance. It’s also a place where social worker support and payment considerations can be built into the provider-patient dialogue in a non-intrusive way.

7. **Assess Patient Risk.** Technology can simultaneously streamline the discharge process for the clinician and identify risk factors.

- When a discharge coordinator uses a mobile device, they can be guided through the many steps in the hospital’s discharge process.
- Input gathered by the discharge coordinator can feed a real-time dashboard of risk factors such as whether the patient is leaving the hospital with their medication, with a primary care physician appointment, with transportation to their appointment, and whether the patient has questions on their care.
- An early-warning dashboard can help clinicians to zero in on particular issues with each patient.

Businesses turn to technology to add efficiency and consistency where manual methods lack them. It’s time we follow the business world’s lead and add to what we have learned from evidence-based initiatives like Project RED and Project BOOST by selectively implementing technology where it can best assist the discharge process. Doing so is already engaging patients, lowering 30-day readmission scores, and improving patient satisfaction.

Joanne Rohde is CEO of Axial Exchange, based in Raleigh, NC, which won the ONC Developer Challenge Competition for software applications for “Ensuring Safe Transitions from Hospital to Home.” She can be reached at jrohde@axialexchange.com.
Readmissions: The Price of Doing Business? ...continued

1. **What is the evidence?** While a "readmission" is widely viewed as a failure of not having gotten it right the first time, in-depth chart reviews of readmitted patients reveal that only 12% - 25% are truly preventable. It’s remarkable that an evolving nationwide emphasis on "evidence-based" health care has been hijacked by the rhetoric of reducing costs.

2. **Multiple causes:** Not getting it right the first time is less of a cause for a readmission than family members who are hundreds of miles away, poor community supports, and lingering poverty. Since this is especially true for patients living at the margins of society, the small rural and underfunded safety net hospitals that serve this population are particularly vulnerable to what could turn out to be a blunt-force payment policy.

3. **Death is the most effective solution:** Hospitals that perform well in keeping patients with end-stage illness alive to discharge are ironically destined to have higher readmission rates.

4. **Priorities:** Trying to reduce readmissions will consume hospitals' time and resources better spent on other patient safety initiatives. This not only includes reducing avoidable infections and "never events," but other more mundane needs such as addressing patient preferences for treatment as well as increasing meaningful patient satisfaction rates.

Drs. Joynt and Jha have two good recommendations:

1. Focus on those readmissions occurring within 3-7 days. Those patients are more likely victims of poor discharge planning that is outside the hospitals’ control.

2. Limit the diagnosis-related-group (DRG) bundled payments to coverage of a readmission within a few days of discharge.

And, as is common among the health care academics and policymakers, multiple other recommendations were missed. Here are three of them:

1. Medicare should learn how to incent, adopt, and pay for "best practices" from in and outsourced nurse-led telephonic follow-up and coaching programs that have led to meaningful decreases in readmissions for the patients who are at greatest risk.2 3 This includes the option of "outsourcing" this patient support to third party disease management service providers who can quickly provide a readmission reduction program on a turnkey basis. This, in turn, could allow hospital leadership (and Accountable Care Organizations, by the way) to devote their attention to other critical patient safety needs.

2. As the regulations, guidelines, and policies grow in scope and complexity around the issue of readmissions, language recognizing that local standards of care, socioeconomic considerations, and patient preferences play a role in readmission metrics will need to be developed. While we continue to learn how to account for these extra-clinical factors, hospitals and physicians need to be given some leeway in being protected from bureaucrats’ rigidly applied payment rules and malpractice lawyers’ creative searches for new theories of liability.

3. And as the science of reducing readmissions continues to evolve, we'll also need to recognize that "perfect" is truly the enemy of patient good. If no patient can be discharged until there is certainty that every eventuality has been accounted for, patient wards will overflow while doctors and hospital administrators battle over length of stay versus readmission rates. "Zero" avoidable readmissions will never be achieved. We don’t know what the "right" readmission rate is, or how to discern which rate is right for which hospital. Until we know "the number," how can we know what is good or bad?

The patient with the atrial fibrillation described above survived multiple readmissions. As the quality improvement personnel began to swarm around her, I pointed out that, as a not-for-profit enterprise devoted to the "care" of persons regardless of their ability to cope, this patient was the price of doing business. There will always be readmissions and to think that we can "warranty" payment our way out of it is a pipedream.

Dr. Jaan Sidorov is an independent health care consultant in Harrisburg, PA and author of the Disease Management Care Blog. He can be reached at jaans@aol.com.

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**Thought Leader’s Corner**

Each month, *Readmissions News* asks a panel of industry experts to discuss a topic of interest to the hospital community. To suggest a topic, write to Editor@ReadmissionsNews.com.

**Q. If you had to pick the top two factors affecting an unplanned hospital readmission, what would they be?**

“It’s pretty well settled that the death of a friend or relative, divorce, financial pressures, moving, and a few other traumatic events are the most stressful in any person’s life. The problem is in many cases, when these events will happen is not known. Even if the patient knows when some of these things will happen, like a move or divorce, in most cases the case manager assigned to track the patient’s adherence to their plan of care still won’t.

This creates two problems that directly impact readmissions -- patient communication and lack of lifestyle data. It is crucial that patients understand the full scope of events that affect their plan and communicate these events to their caregiver. It is also possible for payers, providers, and pharma to begin looking at big data to better understand the people they are treating, not just their diseases.”

Bill Fox, JD, MA
Senior Director of Healthcare
LexisNexis Risk Solutions
Philadelphia, PA

“Some unplanned hospital admissions are related to suboptimal medication use and safety issues. These can be related to: (1) clinician factors -- inappropriate prescribing, improper dosages, poor monitoring and follow-up management; (2) patient factors -- non-adherence, health literacy issues, health beliefs; or (3) system factors -- lack of care coordination across multiple prescribers, lack of real-time knowledge shared among all the patient's providers when a medication is discontinued, added, or changed upon, or any care transition (place of care and provider of care).

These are examples of preventable medication gaps in care that can be addressed with improving medication management practices and including a pharmacist as a health-care team member. Closer attention must be paid to medication reconciliation at all points of patient care to assure that any medication changes are understood by the patient and all the patient’s health care providers.”

Marie Smith, PharmD
Henry A Palmer Professor in Community Pharmacy Practice
Assistant Dean, Practice and Public Policy Partnerships
University of Connecticut School of Pharmacy
Storrs, CT

“The patients’/care givers’ inability to follow discharge instructions and medication availability between settings and at discharge are two factors affecting unplanned hospital readmissions. To mitigate these factors, healthcare facilities participating in the MPRO (Michigan’s Quality Improvement Organization) readmission initiatives identify the ‘learner’ on admission, who may not be the patient. ‘Teach back’ and ‘Show Back’ are utilized, in a non shaming way, to confirm the learners understanding. The ‘Teach Back’ promotes communication between healthcare workers and patients. ‘Show Back’ confirms the learner’s understanding through re-demonstration, e.g., identifying key content on food labels. Healthcare facilities are encouraged to share the ‘Teach Back’ and ‘Show Back’ content with the next setting, reinforcing the same message.

Medications may not be available at the next setting of care or at home. Michigan hospitals are providing patients with a supply of medications at discharge to ‘bridge’ them until their post discharge visit with their physician. Some hospitals provide a three day supply of medications ‘bridging’ the patient transition to the nursing home. This allows time for medication reconciliation and acquisition of medications. ‘Bridging’ eliminates missed doses due to inability to access medications in a timely manner.”

Nancy D. Vecchioni, RN, MSN, CPHQ
Vice President Medicare Operations
MPRO, Michigan’s Quality Improvement Organization
Farmington Hills, MI
Thought Leader’s Corner

“I believe there is one primary factor, not two: home care providers must be able to identify which patient populations are at highest risk of readmission -- if they can’t identify who’s in danger, they can’t prevent readmissions. NAHC data shows that reducing readmission rates by just two percent among home care patients would help 928,000 people avoid re-hospitalization and save upwards of $500 million in costs. Not to mention ease plenty of heartache for patients and their families. When I owned and operated a home health care agency, keeping patients, especially older patients, out of the hospital was a key challenge that we faced on a daily basis. So we started Medalogix in 2009, which uses predictive modeling to analyze a home health care agency’s own clinical data, isolating and flagging known medication risks that account for up to a third of all geriatric patient re-hospitalizations. In its first real-world application Medalogix was able to identify, with 90 percent accuracy, those most at risk patients. With this understanding, care providers are able to focus their attentions and help avoid rehospitalization.”

Dan Hogan  
President and CEO  
Medalogix  
Nashville, TN

“The impact of dementia and the fear of facts on their condition.”

Diana Waugh  
Principal, Waugh Consulting  
Waterville, OH

“Failure to have a follow-up visit with a primary care physician and failure to understand common side effects associated with medications.”

John Parker  
Informatics Scientist in Health Economics & Outcomes Research  
Blue Cross Blue Shield North Carolina  
Durham, NC

“For five years I have asked patients that I readmit to the hospital why they returned so soon after discharge. The top two answers from patients coming from home are some version of: (1) ‘I wasn’t feeling well (i.e., I’m worse, or not getting better as fast as I think I should) so I thought I should come back’ or (2) ‘someone (my doctor, an office RN, a home health RN) told me to go to the ED.’ Patients presenting from nursing homes or SNFs also have two primary answers: (1) ‘We (usually the family/caregivers) didn’t like the facility, so we called 911 to return to the ED’ or (2) ‘They noticed something was wrong (fever, labs, confusion) and sent me in to be checked out.’ Once in the ED, a recently discharged elder is highly likely to end up being admitted. We still assume that there is an unresolved clinical issue that led the patient back to the ED. In fact, root cause analysis reveals logistical, communication, or social support issues predominate.”

Amy Boutwell, MD, MPP  
Founder and President  
Collaborative Healthcare Strategies  
Boston, MA

“We frequently hear from clients that unplanned or preventable readmission are exacerbated by an incomplete picture of the patient as they transition from one point of care to another due to incomplete transfer of information. The first issue is the inability to acquire or consume free text information. Natural language processing tools can make free text more useful. The second is the lack of coordination among the different points of care, each relying on its unique systems and processes, which can be improved by establishing a care manager role to promote collaboration and integration.”

Michelle Blackmer  
Product Marketing  
IBM Content and Predictive Analytics  
Chicago, IL
NQF Upholds All-Cause Readmission Measure
The National Quality Forum (NQF) Board of Directors voted on June 25 to uphold its initial decision to endorse a new all-cause hospital-wide readmissions measure developed by Yale University and the Center for Medicare and Medicaid Services (CMS). The measure had been challenged through NQF’s official appeal process by seven hospital systems on the basis that many readmissions, including planned readmissions, do not reflect poor hospital quality.

The NQF board, however, affirmed that its role was to develop valid and reliable measures, not necessarily those used for payment or reporting. It then asked the Measure Application Partnership (MAP) to convene a special session over the summer to consider the complex issue of how to use this new measure as part of a broader set of care coordination measures applicable to all types of providers. CMS also agreed to defer use of this particular readmission measure in the new CMS Readmissions Reduction Program until MAP had deliberated and reported.

New Study of 30-Day AMI Readmissions
Researchers at the Mayo Clinic studied 3010 patients who were hospitalized in Olmsted County, MN with first-ever myocardial infarction from 1987 to 2010 and survived to hospital discharge. Overall, the rehospitalization rate was 18.6%; however, 30.2% of those readmitted were unrelated to the original diagnosis, and 27.2% were questionable. The authors’ conclusions were that comorbid conditions, longer length of stay, and complications of angiography and revascularization or reperfusion were associated with increased 30-day rehospitalization, but that many were unrelated to the original MI.

Cost of Readmissions in VHA Facilities
Researchers attempted to determine whether historic hospital readmission rates could be used to predict risk-adjusted patient readmission and to measure the costs of readmission, using data from 129 Veterans Health Administration facilities from 2005 to 2009 for the three conditions currently targeted by CMS (AMI, CHF, and pneumonia). The conclusion: hospital readmission rates in a previous quarter are not predictive of individual patient risk-adjusted readmissions or of patients’ inpatient hospitalization episode costs in the subsequent quarter. In fact, costs for readmitted patients were significantly higher for all three conditions than for patients who were not readmitted.

Unintended Consequences of Readmissions
Mary Naylor, PhD, RN and five colleagues in a June 20 piece in Health Affairs examined three key programs created by the ACA that seek to improve care for older adults who need long-term services and supports – the Hospital Readmissions Reduction Program, the National Pilot Program on Payment Bundling, and the Community-Based Care Transitions Program. They cautioned that these programs fall short of their goals when it comes to this especially vulnerable population and might even cause unintended consequences. They urged payment policies that promote integrated care and better transitions of care and greater use of evidence-based approaches.

New Report on Canadian Readmissions
The Canadian Institute for Health Information has released a new report on hospital readmissions. In three jurisdictions where detailed emergency department (ED) data was available -- Alberta, Ontario and Yukon -- nearly 1 in 10 acute care patients returned to the ED within seven days of hospital discharge. Medical patients were most likely to be readmitted for COPD disease and heart failure; for pediatric patients the largest number of readmissions was for respiratory infection and pneumonia, the highest rate for those who had received chemotherapy or radiotherapy. For surgical patients, nearly one in 10 returned because of an infection, and almost 25% of women readmitted following a Caesarean section returned because of an obstetric or surgical wound infection. Predictors for readmission included very long or very short stays, males, age, income, residence in lower-income or rural areas, and comorbid conditions.

Hospitals Can Preview Readmissions Rates Used by CMS
Hospitals can preview their hospital-specific reports for the fiscal year 2013 Hospital Readmissions Reduction Program today through July 19 by downloading the reports at My QualityNet. Hospitals with higher-than-expected readmission rates will see reductions in Medicare payments in FY 2013.

AHA Urges CMS to Revise Readmissions Rule
The American Hospital Association wrote to CMS in June strongly urging that planned readmissions and readmissions unrelated to the incident condition be removed from calculations of readmissions rates used to judge hospitals and financially punish the outliers.
INDUSTRY NEWS

California Nixes LTC Readmissions Demo
The State of California is preventing organizations from participating in the CMS demonstration aimed at reducing hospitalizations from nursing homes because of perceived overlap with the State’s major demonstration on dual eligibles. The State’s view is that many aspects of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents overlap with its Implementation Demonstration proposal for Dual Eligible Beneficiaries. As a result the State is not supporting applications under the former initiative.

Intermountain Care Coordination Success
Intermountain Health’s 352-bed McKay-Dee Hospital in Ogden, Utah, reduced its readmission rates for pneumonia by almost 50% in two years to 7.8%. The success is credited to the Intermountain care coordination program, under which a care team of hospitalists, nurses, and care managers works off of specific protocols, with information available to all team members real time through an electronic health record. Although there is a specific pneumonia core measure checklist, the care coordination program applies to all patients.

AARC Checklist to Prevent ICU Readmissions
The American Association of Respiratory Care (AARC) last month published a third checklist aimed at identifying patients at greatest risk for readmission to the ICU following discharge. The checklist includes placing the respiratory therapist in a prominent position to triage and evaluate patients prior to discharge, thus enhancing the ability to ‘red flag’ those patients at greatest risk for a respiratory readmission. The checklist was developed through an educational grant from Masimo Corporation.

Follow Up Calls Predict Readmissions
A CipherHeath study of 602 CHF patients at Charleston Area Medical Center and their responses to automated follow up calls at 48 hours and seven days was able to identify patients who were 65% were likely to be readmitted than the cohort average. Patients with positive responses to both calls had a 13% readmission rate; those with a neutral or negative response on the second call had a 38% rate.

Axial Exchange, Mayo Clinic form Business Partnership
Axial Exchange, with investment support from the Mayo Clinic, has acquired a consumer facing mobile healthcare platform developed by Mayo that will help patients navigate a future hospital visit. Axial also has access to Mayo’s health content.

New York HEAL Grant Helps with Medicaid Readmissions
The HEAL NY grant program (Healthcare Efficiency and Affordability Law for New Yorkers) awarded $3.8 million to a consortium of seven hospitals to help reduce unnecessary Medicaid readmissions. Mental health diagnoses are the most common readmission reason. The three-year project expects to save $6 million by preventing unnecessary readmissions and emergency department visits by Medicaid beneficiaries.

Sentara Remote Patient Monitoring Pays Dividends
Sentara Healthcare in Chesapeake, VA began remote patient monitoring for patients with chronic diseases as a staff extender project but found that the technology produced dramatic reductions in hospital readmissions. The readmission rate for CHF patients on the monitoring program is only 1%, and for all monitored patients only 2%.

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The case manager is a licensed or certified professional who is specifically trained to do individual assessment. The care coordinator can be an effective resource coordinator, and can be an extender, but simply does not have the same broad skill set. We run into trouble when these different roles exist in non-integrated systems because when you have silos you are going to have duplication or gaps or both, neither of which promote quality, efficiency, or a good patient experience. Case managers and care coordinators work best as part of a care team where every member of the team works at the top of his or her skill set.

Readmissions News: Finally, tell us something about yourself that few people would know.
Cheri Lattimer: When I was in high school I had a real interest in music and had an opportunity for a college music scholarship. I asked my dad about this, and he said “Singers can starve to death, but nurses can always feed their families.” I went to nursing school.
Catching Up With …

Cheri A. Lattimer RN, BSN is Executive Director of the National Transitions of Care Coalition (NTOCC) and Executive Director of the Case Management Society of America (CMSA) as well as President and CEO of consulting firm CM Innovators. Her work is all about managing the transitions from one health care site to another or from facility to home. She talks about how well handoffs are done, whether penalties are appropriate, the nature and evolving role of the case manager, and herself.

Cheri A. Lattimer, RN, BSN
- Executive Director, National Transitions of Care Coalition (NTOCC)
- Executive Director, Case Management Society of America (CMSA)
- President and CEO, CM Innovators
- Board member, URAC and advisory panel member, Society of Hospital Medicine Project BOOST initiative
- Anna Reynvaan Lecture, University of Amsterdam (2009)
- BSN, University of Phoenix, clinical training at Good Samaritan Hospital

Readmissions News: You have a couple of different hats, but let’s start with your executive director role for the National Transitions of Care Coalition (NTOCC). Who are the members of the coalition?
Cheri Lattimer: We actually have four kinds of members. Our Advisory Council is a group of about 30 coalitions and associations who represent the founding members of NTOCC. Then we have about 4,000 subscribers to NTOCC via the web who follow our activities and reports. Interestingly, this group includes people from 83 different countries. Third, we have about 450 associate members, e.g. hospitals, health systems, health plans. And finally we have a Partners group, which is our group of sponsors.

Readmissions News: Effective communications and handoffs are critical when patients move from one health care setting to another. How well do you think we are doing in managing these transitions effectively and what areas do you see as still needing work?
Cheri Lattimer: We know the gaps and barriers, and we know what to do. How well we do is the question. The biggest challenge is ensuring bi-directional communication. We need to know if essential information was received and acted upon and if the receiving party knows who to call for questions. This includes not just the patient and family members, but the PCP and the involved specialists as well when patients are discharged from the hospital. We are moving in the right direction I think, but communication is clearly the biggest challenge because it involves behavior change. When I give talks to hospital audiences, I ask how many are doing follow-up calls after a discharge, and the response rate is around 50%. This is a problem.

Readmissions News: Is it appropriate to have financial penalties on hospitals and nursing homes for poor readmissions statistics, or should there just be incentives, technical assistance, and learning collaboratives?
Cheri Lattimer: Penalties do just that – they penalize – and they only affect part of the problem. Hospitals are not 100% responsible for preventable readmissions, nor are nursing homes. Do penalties help solve the problem? I’m not so sure. We have seen lots of examples of this over the years, but I would rather say let’s enable and reward good performance.

Readmissions News: You also have the executive director hat for the Case Management Society of America (CMSA). Health care reform and the experimentation with new payment and delivery models must bode well for new case managers just entering the job market, no?
Cheri Lattimer: Absolutely. In fact, there is an extreme shortage of case managers. Most of the calls I receive are about finding qualified, licensed case managers, and not just one or two – sometimes 20 or more. Case management is such a valuable piece of health care reform, and case managers who have spent time with the patient and family as part of the care team provide real added value in improving transitions. The new bundled payment models also represent a particularly good fit for the case manager role in a team-based approach. But it’s important to note that we are talking about licensed or certified case managers. CMSA and NASW (the National Association of Social Workers) have standards of practice for case managers, and these matter.

Readmissions News: How is the case manager of today different from the case manager of say the 1980s or 1990s? Are new roles making “case manager” and “care coordinator” definitions the same, or do you see a case manager as person oriented and a care manager as disease or population oriented?
Cheri Lattimer: The breadth of the case manager role has changed considerably over the past 20 to 25 years. Just look at the individual assessment as well as care coordination needs of today. The case manager has to do more than just coordinate care. Plus there is a difference in the educational set (nurse or social worker) and in the basic skill set. The case manager of today needs to know how to be an active listener, how to motivate patients and caregivers, and how to evaluate a patient’s confidence that s/he understands the treatment plan and medication regimen. These are skills that don’t just come from academic training; they are skills that are honed by experience.

Today we have medical case managers, disease management case managers, and behavioral case managers, but in the future these functions will reside in the same person. That’s why so many case managers now are going back into academic and training programs in order to learn all of these skills so they can truly serve the whole patient. This ability is especially important in managing the needs of dual eligibles, more and more of whom are being enrolled in managed care.

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