Hospital Readmissions

January 18, 2019

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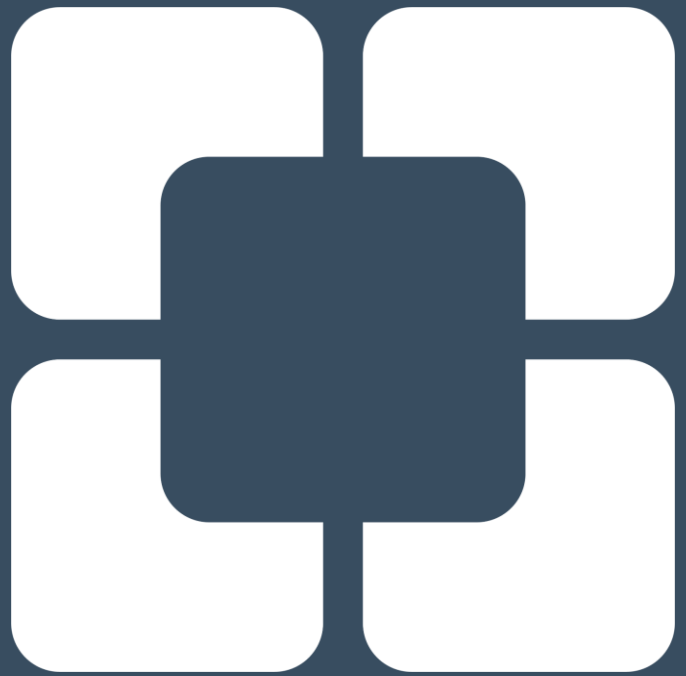
Cleveland Clinic

No Financial Disclosures to report.



Gerald & William

Readmissions

- What are they?
- Why are they important?
- What can we do about them?

Hospital Readmission Reduction Program

- FY 2012: Three diagnoses: PNA, AMI, CHF
- FY 2015: Expansion to COPD, THA/TKA
- FY 2017 : CABG
- FY 2019: Peer Quintiles per proportion of dual-eligible patients.

How much do hospitals lose?

- If above expected readmission rate,
- 1% reduction for FY 2013
- 2% reduction for FY 2014
- 3% maximum payment reduction, FY 2015

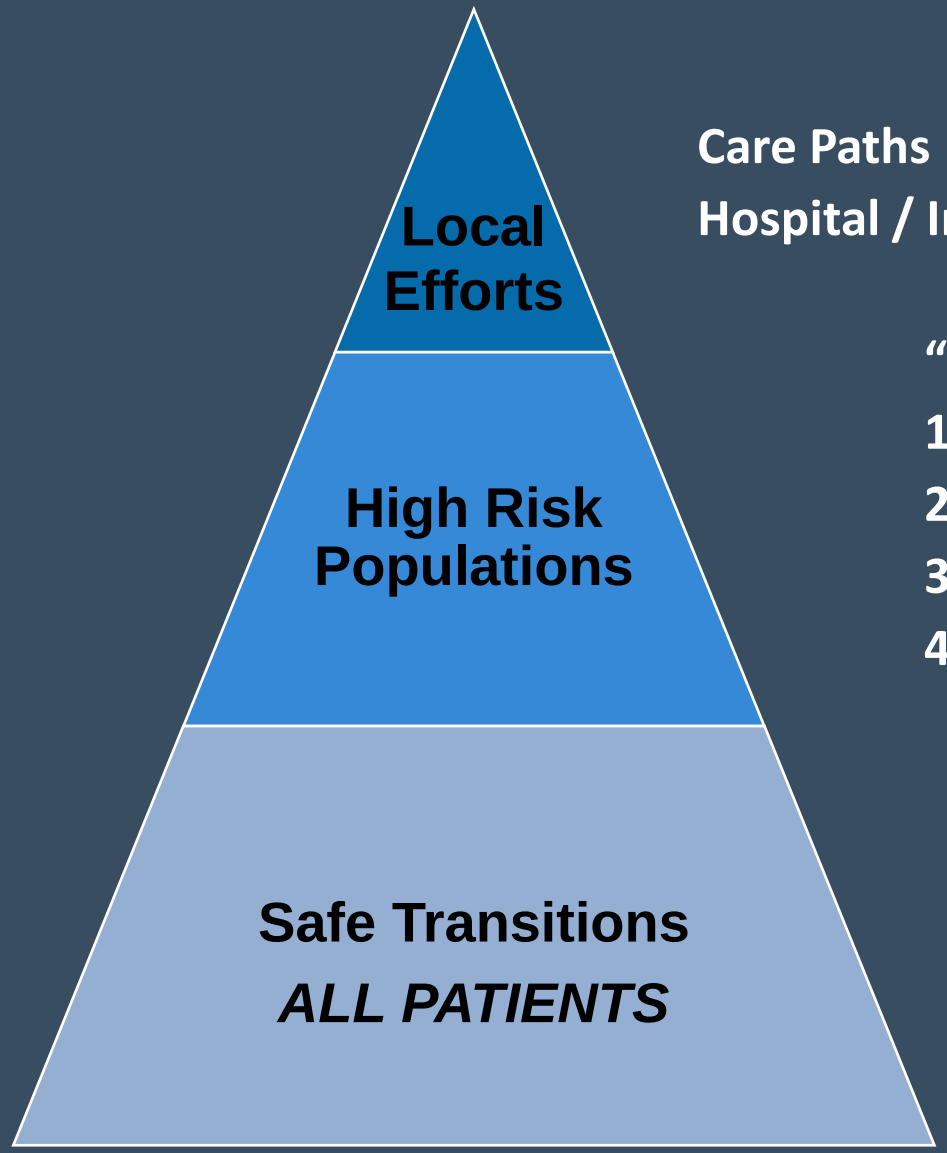
- Raters and Rankers, Reputation Pride!

- Data from 3 years ago penalizes you today.
- FY 2019 (begins October 1, 2018) adjusts Medicare payment to hospitals according to July 1, 2014 - June 30, 2017 performance.

The Ultimate Team Effort- What we can Do

- Inpatient, Pre-Discharge
- Outpatient, Post-Discharge
- Bridge/Transition work

Readmissions Strategy



Care Paths

Hospital / Institute-specific

"Core 4 Plus"

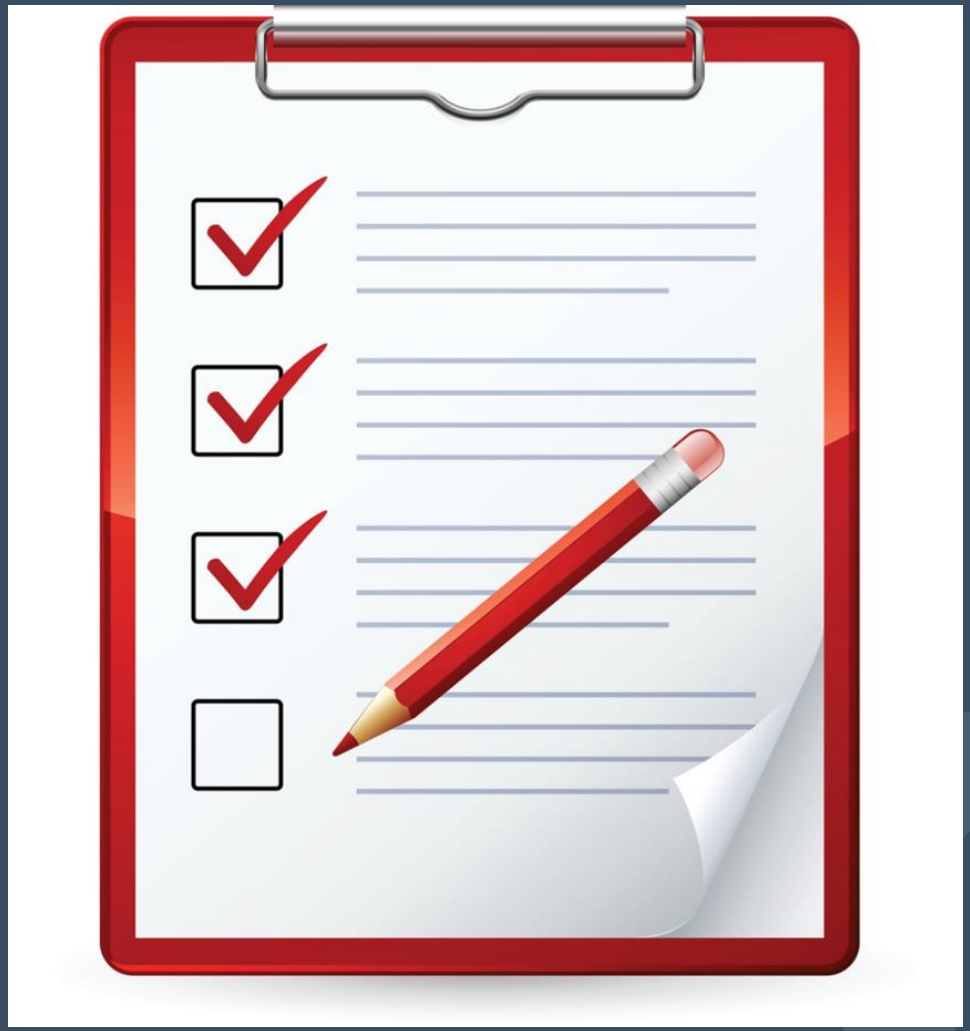
1. Pharmacy Med Reconciliation
2. Transitional Care Coordination
3. House Calls
4. 5 Day Follow Up

"Core Four"

1. Admission Med Rec in 24H
2. Discharge Med Rec
3. Discharge Summary in 48H
4. Follow Up Appointment

What We Can Do About Readmissions

- Utilize Checklists

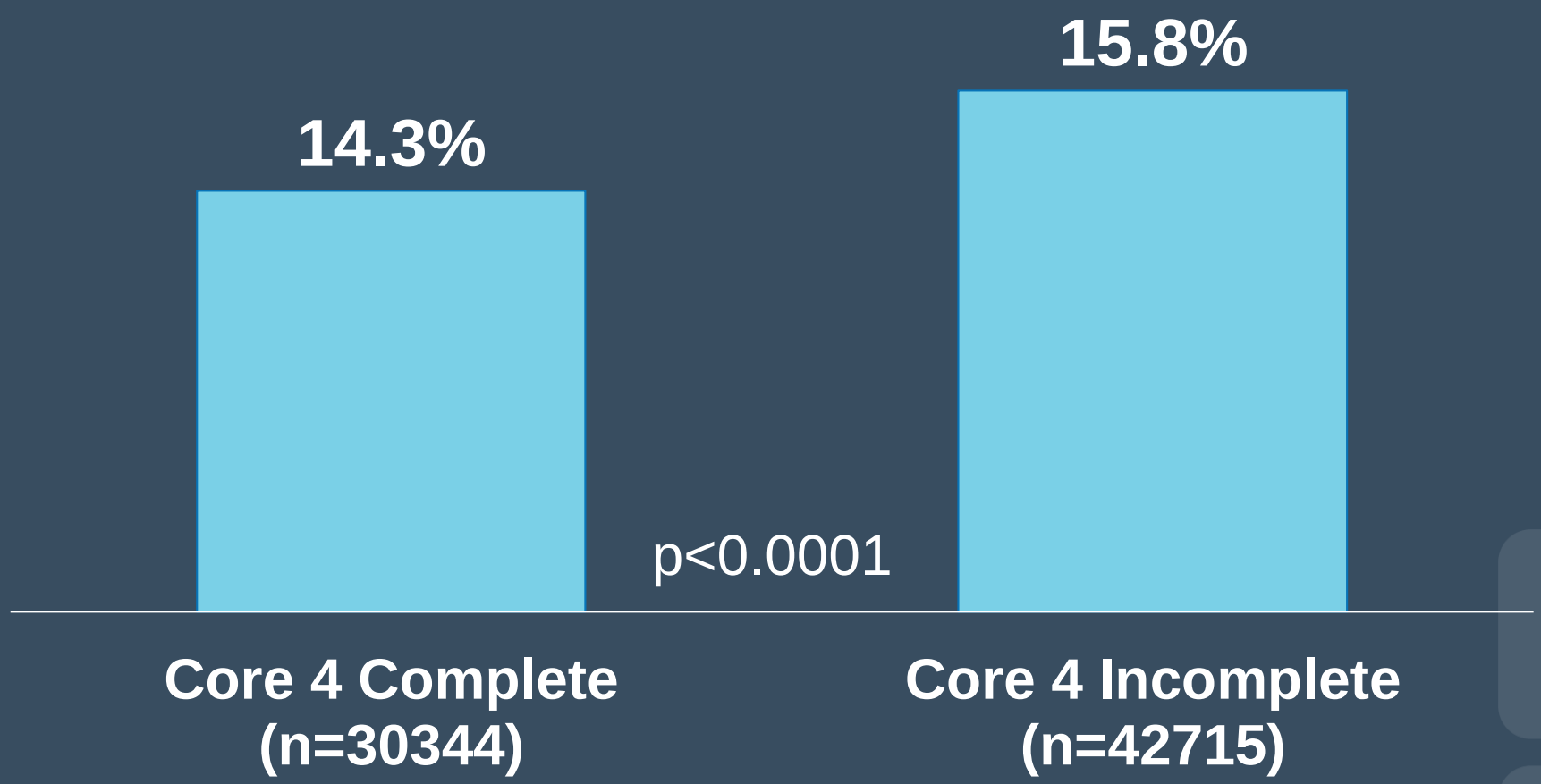


What We Can Do About Readmissions

- Utilize Checklists
  - Identify what's most important to the Transition
    - Admission Medication Reconciliation
    - Discharge Medication Reconciliation
    - Follow up Appointment Scheduling
    - Discharge Summary Completion

Readmission Rate - Medical DRGs

Cleveland Clinic Enterprise Discharges (Jan-Sep 2017) n=73059



What We Can Do About Readmissions

- Utilize Checklists
- Focus on High Risk Patients

Risk Stratification Tools

- LACE
  - Length of Stay
  - Acuity (Admission through ED)
  - Comorbidities
  - ED Visits within 6 months

Reset

Lace Index Tool

About

Calculate

[redacted]

1. Length of stay (days)?

2. Admission via emergency? No

3. Number of past emergency visits?

4. Comorbidities

- [ ] Previous Myocardial Infarction
- [ ] Cerebrovescular Disease
- [ ] Peripheral vascular disease
- [ ] Diabetes without complications
- [ ] Congestive heart failure
- [ ] Diabetes with end organ damage
- [ ] Chronic pulmonary disease
- [ ] Mild liver disease
- [ ] Tumor - any kind (including lymphoma or leukaemia)
- [ ] Dementia
- [ ] Renal disease (moderate or severe)
- [ ] AIDS
- [ ] Liver disease (moderate or severe)
- [ ] Metastatic solid tumor

MEDICAL ADMINISTRATION

HOSPITAL Score

Determine risk of avoidable hospital readmission

Hemoglobin <12 g/dL or 120 g/L at discharge?

- Yes
- No

Discharge from an Oncology service?

- Yes
- No

Sodium <135 mEq/L at discharge?

- Yes
- No

Procedure performed during hospital stay?

A procedure is defined as any ICD-9 coded procedure, such as endoscopy, hemodialysis, heart cardiac catheter, paracentesis or thoracocenthesis, transfusion, computed tomography scan or magnetic resonance imaging, or percutaneous transluminal coronary angioplasty

- Yes
- No

Index admission type?

- Urgent or emergent
- Elective

Risk Stratification Tools

- LACE Index Tool (online)
- HOSPITAL score (online)
  - Hg <12
  - DC from Oncology service
  - Sodium <135 meQ/L at DC
  - Having a Procedure during the stay
  - Index Admission Type (non elective)
  - # Hospital Admissions during a year
  - Length of Stay >/ 5 days.

Risk Stratification Tools

- LACE Index Tool (online)
- HOSPITAL score (online)
- 8 Ps (Society of Hospital Medicine)
- Cleveland Clinic Readmission Risk Score
- SNF Prognosis Score (JAGS March 2018)
- Plus more

Readmission Risk Factors

Labs

- Sodium
- Hemoglobin
- BUN
- Albumin

Comorbidities

- CKD
- COPD
- Delirium
- Drug Abuse

Medications

- # of Med Classes
- Anticoagulants

Utilization

- Insurance
- # ED Visits

What We Can Do About Readmissions

- Utilize Checklists
- Focus on High Risk Patients
- Meet Patients Where They Are… Literally

High Risk = Higher Support

- Paramedicine
- CNP
- Transitional Care Pharmacy
- Primary Care Outreach with Care Coordinators/ Navigators/ Advocates

Paramedicine

Alan Neuhauser, “Paramedics Step Up to Cut Hospital Readmissions” US News. October 9, 2014.

CNP to Home

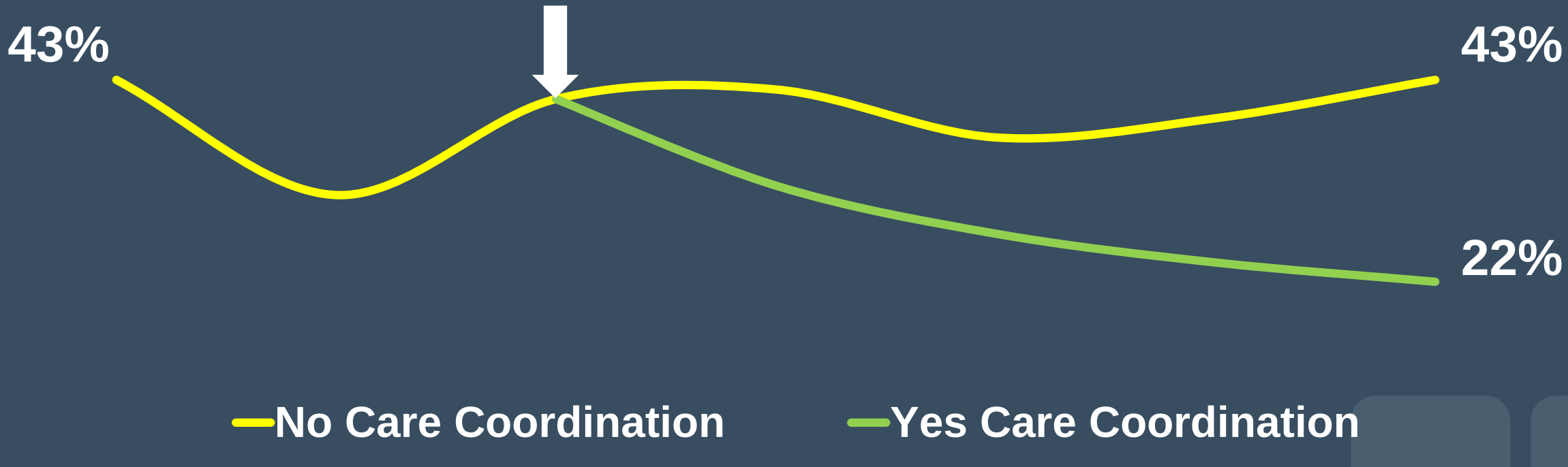
Transitional Care Pharmacists

High Risk = Higher Support

- Paramedicine
- CNP
- Transitional Care Pharmacy
- Primary Care Outreach with Care Coordinators/ Navigators/ Advocates

Transitional Care Coordination & Readmission Rates

High Risk Patient Discharges
(Apr-Oct 2017)



What We Can Do About Readmissions

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- Engage the Patient

What We Can Do About Readmissions

- Utilize Checklists
- Focus on High Risk Patients
- Meet Patients Where They Are… Literally
- Engage the Patient
  - Effectiveness of Teachback
  - Written Plan

project BOOST
Better Outcomes for Older adults through Safe Transitions

Patient PASS: A Transition Record

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because _____

If I have the following problems ...

1. _____
2. _____
3. _____
4. _____
5. _____

I should ...

1. _____
2. _____
3. _____
4. _____
5. _____

Important contact information:

1. My primary doctor:
   _____
   (___) _____
2. My hospital doctor:
   _____
   (___) _____
3. My visiting nurse:
   _____
   (___) _____
4. My pharmacy: _____
   (___) _____
5. Other: _____
   _____

My appointments:

1. _____
   On: __/__/___ at __:__ am/pm
   For: _____
2. _____
   On: __/__/___ at __:__ am/pm For:
   _____
3. _____
   On: __/__/___ at __:__ am/pm
   For: _____
4. _____
   On: __/__/___ at __:__ am/pm
   For: _____

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand my treatment plan. I feel able and willing to participate actively in my care:

_____
Patient/Caregiver Signature

_____
Provider Signature

____/____/_____
Date

Other instructions:
1. _____
2. _____
3. _____

Real-Time Readmission Interviewing

63 Patients Face to Face October 2017 through January 2018

- **Do you know the name of your doctor who's taking care of you in the hospital?**

  YES 51 patients = 81%

- **Do you have a PCP?**

  YES 60 patients = 95%

63 Face to Face Interviews

- **What brings you back to the hospital?**
  - SOB 12
  - Fever 10
  - Fall 7
  - Bleeding 6
  - Uncontrolled pain 3
  - Weakness 2

Do you think your coming back into the hospital (readmission) could have been avoided?

- **NO** 49 patients = 78%
- **YES** 13 patients = 21%
- **YES/NO** 1 patient = 1%

Is there anything your Doctor could have done to prevent your coming back into the hospital?

- **NO** 47 patients = 75%
- **YES** 15 patients (6 said longer stay; 1 shorter stay)

Is there anything you (the patient) could have done?

- **NO** 44 patients = 70%
- **YES** 12 patients

If you had more information on nutrition, specifically what to eat or drink after you went home, would that have helped prevent you from coming back?

- **NO** 56 = 89%
- **YES** 7

Think back to the last hospital stay. Did you feel ready for discharge?

- **YES** 40 = 63%
- **NO** 23

Do you have enough support at home?

- **YES** 45 patients = 71%
- **NO** 7 patients

Give a Plan, Give a Path

What We Can Do About Readmissions

- Utilize Checklists
- Focus on High Risk Patients
- Meet Patients Where They Are… Literally
- Engage the Patient
- Give a Plan, Give a Path (and tell the patient, tell the SNF, etc)
- Realize that we ALL can play a part to decrease readmissions

What You Can Bring Back

- Life-Support to the Transitions
  - Checklists help
    - Consider making a Discharge Checklist
    - … or an Intake Checklist (into PCP office)
  - Risk Stratification tools can help
  - Meet patients where they are
  - Consider close Care Coordination
  - Help Patients Understand the Transition

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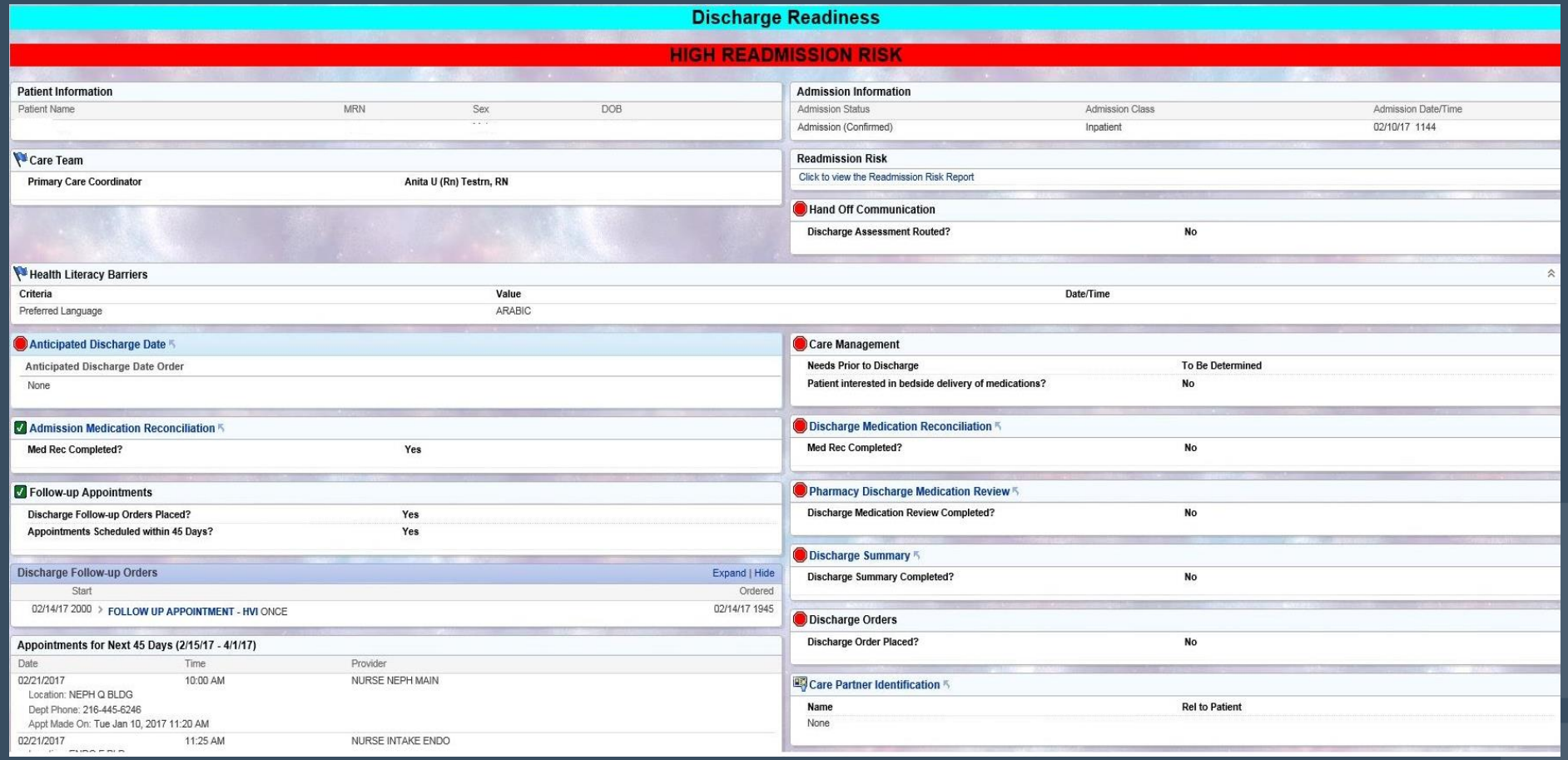
Every life deserves world class care.

Visualizing High Risk Patients

EPIC Discharge Readiness Tool (Patient-level)



Discharge Readiness

HIGH READMISSION RISK

Patient Information

Patient Name	MRN	Sex	DOB

Admission Information

Admission Status	Admission Class	Admission Date/Time
Admission (Confirmed)	Inpatient	02/10/17 1144

Care Team

Primary Care Coordinator	Anita U (Rn) Testrn, RN

Readmission Risk

Click to view the Readmission Risk Report

Hand Off Communication

Discharge Assessment Routed?	No

Health Literacy Barriers

Criteria	Value	Date/Time
Preferred Language	ARABIC	

Anticipated Discharge Date

Anticipated Discharge Date Order

None

Care Management

Needs Prior to Discharge	To Be Determined
Patient interested in bedside delivery of medications?	No

Admission Medication Reconciliation

Med Rec Completed?	Yes

Discharge Medication Reconciliation

Med Rec Completed?	No

Follow-up Appointments

Discharge Follow-up Orders Placed?	Yes
Appointments Scheduled within 45 Days?	Yes

Pharmacy Discharge Medication Review

Discharge Medication Review Completed?	No

Discharge Follow-up Orders Expand | Hide

Start	Ordered
02/14/17 2000 › FOLLOW UP APPOINTMENT - HVI ONCE	02/14/17 1945

Discharge Summary

Discharge Summary Completed?	No

Discharge Orders

Discharge Order Placed?	No

Appointments for Next 45 Days (2/15/17 - 4/1/17)

Date	Time	Provider
02/21/2017	10:00 AM	NURSE NEPH MAIN
Location: NEPH Q BLDG Dept Phone: 216-445-6246 Appt Made On: Tue Jan 10, 2017 11:20 AM		
02/21/2017	11:25 AM	NURSE INTAKE ENDO

Care Partner Identification

Name	Rel to Patient
None	