Readmission Rates in Florida Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Mar’08</th>
<th>Mar ’09</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>13.3%</td>
<td>12.6%</td>
<td>&lt;8%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>12.8%</td>
<td>10.5%</td>
<td>&lt;6.5%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>7.5%</td>
<td>6.8%</td>
<td>&lt;4%</td>
</tr>
<tr>
<td>Bypass Surgery</td>
<td>12.6%</td>
<td>12.6%</td>
<td>&lt;8%</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>5.7%</td>
<td>5.6%</td>
<td>&lt;2.5%</td>
</tr>
</tbody>
</table>

AIM is to achieve these target readmission rates by December 31, 2010

Achieving the target

<table>
<thead>
<tr>
<th></th>
<th># of patients</th>
<th># readmitted</th>
<th>Target</th>
<th># Patients NOT readmitted</th>
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<tbody>
<tr>
<td>CHF</td>
<td>49,196</td>
<td>6,186</td>
<td>&lt;8%</td>
<td>2,251</td>
</tr>
<tr>
<td>AMI</td>
<td>12,892</td>
<td>1,349</td>
<td>&lt;6.5%</td>
<td>511</td>
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<tr>
<td>Pneumonia</td>
<td>40,267</td>
<td>2,739</td>
<td>&lt;4%</td>
<td>1,120</td>
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<tr>
<td>CABG</td>
<td>8,519</td>
<td>1,073</td>
<td>&lt;8%</td>
<td>392</td>
</tr>
<tr>
<td>Hip/joint</td>
<td>24,978</td>
<td>1,409</td>
<td>&lt;2.5%</td>
<td>785</td>
</tr>
</tbody>
</table>
Reducing Avoidable Hospital Readmissions

Steve Hines, PhD
Vice President, Research
Health Research and Educational Trust

June 4, 2010
Florida Hospital Association Meeting

The Health Research and Educational Trust (HRET)

- A 501(c)(3) affiliate of the American Hospital Association, established in 1944.
- HRET Mission: Transforming health care through research and education.
- U.S. Agency for Healthcare Research and Quality (AHRQ) has contracted with HRET to bring free patient safety resources and tools to interested hospitals & health systems

AHRQ Funds HRET to Help Hospitals

- AHRQ funds HRET to provide technical assistance for hospitals and other providers.
- HRET’s most common partners are state hospital associations, also QIOs, others.
- HRET can offer technical assistance with using AHRQ products and support, such as free webinars, and expert trainers at state conferences.
- If we cannot help, we often can refer to someone who can.
Overview of Presentation

- Review recent evidence of the extent and causes of avoidable hospital readmissions.
- Describe congressional action in Patient Protection and Coverage Act.
- Describe support now available to help hospitals respond to heightened concern and financial pressures.

Studies of Rehospitalizations

- Nearly 20% of Medicare hospitalizations are followed by readmission within 30 days.
- 90% of rehospitalizations within 30 days appear to be unplanned, the result of clinical deterioration.
- MedPAC: 75% of readmissions preventable, adding $12 Bn/yr to Medicare spending.
- Only half of the patients rehospitalized within 30 days had a physician visit before readmission.
  - Unknown if lack of physician visit causes readmissions—but poor continuity of care, esp for many chronically ill patients.
- 19% of Medicare discharges are followed by an adverse event within 30 days—2/3 are drug events, the kind most often judged “preventable.”

How Many Readmissions are Avoidable?

- Evidence suggests many rehospitalizations are preventable--
  - Many rehospitalized before seeing a physician
  - Inter-hospital and inter-state variation
  - Randomized clinical trials testing interventions
- What proportion of readmissions are truly “avoidable”? No one knows.
- Probably hospitals, physicians, HHAs, nursing homes and pharmacists can prevent more readmissions working together than hospitals can by improving discharge process alone.
OASIS data in 2008 AHRQ National Healthcare Quality Report

30-day Hospital
Ambulatory
Rate
Sensitive Admit Rate
NH Resident
Admit Rate

Short Term
.88
.65
.001
.001

Long Term
.62
.76
.75
.001
.001
.001

Home Health
.45
.62
.51
.58
.001
.001
.001
.001

Possibilities:
• Quality of nursing home, home health agency, and primary care drive both admission and readmission rates
• Patient characteristics that lead to admissions also lead to readmissions
• Practice patterns in non-hospital settings that lead to admissions for these groups also lead to readmissions

Certainties:
• You will not solve your readmission problem without understanding factors leading to admissions
• Reducing readmissions cannot be done within the walls of the hospital
• Must understand the big picture factors, while focusing on specific challenges and their solutions
Common Process Breakdowns Resulting in Potentially Avoidable Readmissions

- Poor transfer of information to patient:
  - Poor patient understanding of how to use medications after hospital discharge
  - Patient doesn’t understand warning signs that warrant an emergency call to their physician

- Poor transfer of information to ambulatory caregivers:
  - Hospital to nursing home staff
  - Hospital to primary care physician
  - Lack of clarity on end of life care preferences

Common Process Breakdowns Resulting in Potentially Avoidable Readmissions (continued)

- Lack of timely post-discharge physician visit:
  - Primary care physician unaware of hospitalization
  - Patient has no transportation to primary care physician
  - Patient has no primary care physician

- Poor patient knowledge and non-disclosure of current drug therapy, and/or inadequate medication reconciliation, can yield drug therapy duplication or interaction.
- Many patients are unlikely to ascribe adverse effects to causes, might not ask for change in drug therapy.

Reported Diagnosis-specific Reasons for Avoidable Readmissions

- COPD, Pneumonia Patients—
  - Many patients need, but do not receive, home health care.
  - Pneumonia readmissions may reflect need for end of life care.

- Cardiac Patients—
  - Cardiologists may rely on primary care, not arrange follow up care for heart failure patients.
  - Readmissions appear to be much higher for heart failure patients with behavioral diagnoses.
Reported Diagnosis-specific Reasons for Avoidable Readmissions

- Post-surgical Patients—
  - Surgeons not arranging for post-surgical primary care.
  - Inadequate teaching of the patient in caring for their body after surgery:
    - Incision care
    - Post-CABG patients, expecting to be pain free, seek readmission for angina
- Dialysis Patients—
  - A population that is very vulnerable to drug therapy changes during hospitalization.

Congressional Action in Health Reform to Address Avoidable Readmissions

- Public reporting of readmission rates.
- Penalties against hospitals with “excess” readmissions (above expected rates) for targeted conditions will be imposed, starting October 1, 2013.
- Sole community hospitals, Medicare-dependent small rural hospitals, and low volume conditions are exempt from penalties.

Support for Hospitals in Reducing Avoidable Readmissions
HRET Leadership Guide

Provides strategies for you to--
- Examine your hospital’s current rate of readmissions.
- Assess and prioritize your improvement opportunities.
- Develop an action plan of strategies to implement.
- Monitor your hospital’s progress.

Medicare Support for Reduction in Hospitals’ Avoidable Readmission Rate

- Health Reform allocated $500 Mn for hospital-community organization partnerships to help hospitals to reduce readmissions—priority given to organizations in AoA projects and those serving rural and underserved populations.
- QIOs might be assigned to assist hospitals in the 10th Statement of Work (August 2011)—an expansion of 9th SoW project in 14 States.

Mathematica Study of Evidence of Effective Care Coordination (March 2009)

- Most "evidence" showing care coordination impact is unreliable
- Mathematica found 3 types of interventions have been effective:
  - Transitional care interventions (Naylor and Coleman)
  - Self-management education interventions (Lorig and Wheeler)
  - Coordinated care interventions (Select sites from the Medicare Coordinated Care Demonstration)
Mathematica Study: Key Components of Effective Transitional Care

- Patients first engaged while hospitalized
- Followed intensively post-discharge
- Receive comprehensive post-discharge instructions on medications, self-care, and symptom recognition and management
- Patients reminded/encouraged to keep follow-up physician appointments

Mathematica Study–Effective Transitional Care Intervention: Naylor et al. (2004)

- Targeted patients hospitalized for CHF
- Used advanced practice nurses (APNs)
- 12-week intervention; highly structured protocols
- RCT (118 treatment, 121 control)
- 1 year post-discharge follow-up
- Intervention patients had: 34% fewer rehospitalizations per patient
- Lower proportion rehospitalized (45% vs. 55%)
- 39% lower average total costs ($7,636 vs. $12,481)

Mathematica Study–Effective Transitional Care Intervention: Coleman et al. (2006)

- Used APNs as transition coaches
- Targeted patients hospitalized for various conditions
- Patients received (1) tools to promote cross-site communication, (2) encouragement to take a more active role in their care, (3) continuity/guidance from transition coach
- RCT (379 treatment, 371 control)
- Lowered rehospitalization rates at 90 days: For any reason (17% vs. 23%); For initial condition (5% vs. 10%)
- Lowered hospital costs 19% over 180 days ($2,058 vs. $2,546)
Overview of Project RED:
Reengineering Hospital Discharge

- RED is an NQF Safe Practice
- RED can be delivered following 11 key components and using the After Hospital Care Plan (ACHP) tool
- RED can decrease hospital use
  - 30% overall reduction
  - Savings of $412 per patient
- Success through elimination of barriers
  - Coordination and change are challenging
  - Providers must collaborate and work together
- Using health IT to implement RED could help--
  - Improve delivery of care
  - Further improve cost savings and build the business case

Project RED: Principles of the Newly Re-Engineered Hospital Discharge

1) Explicit delineation of roles and responsibilities
2) Discharge process initiation upon admission
3) Patient education throughout hospitalization
4) Timely accurate information flow:
   - From PCP ➪ Among Hospital team ➪ Back to PCP
5) Complete pt. discharge summary prior to discharge
6) Comprehensive written discharge plan given to pt. prior to discharge
7) Discharge information in pts. language and literacy level
8) Reinforcement of plan with patient after discharge
9) Availability of case management staff outside of limited daytime hours
10) Continuous quality improvement of discharge processes
Project RED Discharge Checklist

Eleven mutually reinforcing components:
1. Medication reconciliation
2. Reconcile discharge plan with national guidelines
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone reinforcement

Project RED: Automated Discharge Workflow

Two vendors now offer Project RED Support

Boston Medical Center has a vendor, Engineered Care, providing Project RED’s electronic patient education system.
Contact: Alex Martinez
alex.martinez@engineeredcare.com
(415) 297-7783

JCR is offering a manual Project RED process with AHRQ funding.
Contact: Deborah Nadzam
dnadzam@jcrinc.com
(630) 261-5048
Other AHRQ-funded Tools that may Help Reduce Avoidable Readmissions

- HCAHPS (especially domains 5 and 9):
  - Explaining about medications
  - Information on recovery at home

Variation in Florida Hospital Scores on these Items

<table>
<thead>
<tr>
<th></th>
<th>Explain Meds</th>
<th>Give Info on Recovery at Home</th>
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</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>33%</td>
<td>64%</td>
</tr>
<tr>
<td>25th %</td>
<td>48%</td>
<td>74%</td>
</tr>
<tr>
<td>50th %</td>
<td>53%</td>
<td>77%</td>
</tr>
<tr>
<td>75th %</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td>Maximum</td>
<td>72%</td>
<td>94%</td>
</tr>
</tbody>
</table>

Other AHRQ-funded Tools that may Help Reduce Avoidable Readmissions

- Consumer brochures encouraging patients to ask questions about medications and follow-up care.
- *Staying Active and Healthy with Blood Thinners*, a 10-minute DVD to reduce complications for patients discharged with instructions to take a blood thinner.
- Improving Warfarin Management—to help clinicians establish an ambulatory anticoagulation clinic.

Other AHRQ-funded Tools that may Help Reduce Avoidable Readmissions (continued)

- Prevention Quality Indicators measure the treatment of ambulatory care-sensitive conditions where good outpatient care can reduce the risk of hospitalization or re-hospitalization.
- TeamSTEPPS, a process to improve communication and teamwork among hospital staff throughout the patient stay, including what can be a hectic discharge process. Involves training a team for 2-3 days.
Comments and Questions?
Project RED
The Re-Engineered Discharge

JCR's AHRQ-funded Project
Florida Hospital Association
June 4, 2010
Deborah M. Nadzam, PhD, FAAN
Project Director
dnadzam@jcrinc.com - 630-261-5048

Discussion to include:

- Background re: AHRQ Contract and task assignment to JCR
- Overview of Project RED intervention
- Overview of JCR AHRQ-funded project

AHRQ-funded Knowledge Transfer Project

- Background
  - Knowledge Transfer/Implementation contract
- Task assignment: Project RED intervention
- Secure and support participation by 50 hospitals and health systems
Principles of the Newly Re-Engineered Hospital Discharge

1. Explicit delineation of roles and responsibilities
2. Discharge process initiation upon admission
3. Patient education throughout hospitalization
4. Timely accurate information flow: From PCP ➔ Among Hospital team ➔ Back to PCP
5. Complete patient discharge summary prior to discharge

(continued)

6. Comprehensive written discharge plan provided to patient prior to discharge
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RED Checklist

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7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone reinforcement

Adopted by National Quality Forum as one of 30 US “Safe Practices” (SP-15)
Key to the Project RED Intervention:

- Discharge Advocate
- Care plan for patient use after discharge
- Post-discharge follow up with patient

Discharge Advocate (DA)

- Notified when patients in target population are admitted/diagnosed
- Initiates action steps associated with Project RED
- Initiates Care Plan
- Facilitates discharge planning rounds

Discharge Advocate (cont.)

- Educates patient and family about condition, medications, other treatments, post discharge plans, and follow up ordered by the physician
- Reviews Care Plan with patient and family
- Collects measurement data specific to project and patient population
Discharge Advocate

- Clinically Competent
- Credible
- Confident
- Coordinator
- Communicator
- Connection with Patient

11 RED Components Enable
Discharge Advocates to:

- Prepare patients for hospital discharge
- Help patients safely transition from hospital to home
- Promote patient self-health management
- Support patients after discharge through follow-up phone call

Sections of the Care Plan

- Date of D/C; name and contact info for physician and D.A.
- Medications
- Pending tests and results
- Follow-up appointments
- Calendar
- Other orders (diet, activity, etc)
- Information about disease/condition
  - When and how to reach physician or go to E.D.
- Form for writing own questions down
- Map of campus for locating appointments
- Other information about your center (optional)
After Hospital Care Plan

John Doe
Discharge Date: October 20, 2006

Morning

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Medication</th>
<th>Dose (mg)</th>
<th>Route</th>
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<tbody>
<tr>
<td>8 am</td>
<td>Blood pressure</td>
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<td>1 tab</td>
<td>By mouth</td>
</tr>
<tr>
<td>8 am</td>
<td>Glucose level</td>
<td>5% Dextrose</td>
<td>500 ml</td>
<td>IV</td>
</tr>
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</table>

Nursing Notes

- Monitor patient for signs of infection.
- Provide adequate休息.
- Monitor blood pressure and glucose levels.

Evening

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Questions

Dr. Jai

23rd March 2023, 10 am

Good luck for today's visit. The conversations with Dr. Jai:

I have questions about:

☐ my medicines
☐ my pain
☐ feeling stressed

What other questions do you have?

Dr. Jai: “I really appreciate your coming today. How have you been since our last visit?”

Noncardiac Chest Pain

- Pressure in the chest
- Sharp or stabbing pain
- Pain relieved by resting
- Pain not relieved by nitroglycerin

If you develop any changes in your symptoms:

- Call your doctor
- Visit the emergency department
- Go to the nearest hospital

If you have any questions:

Revised: 3/2023
Post Discharge Follow-Up

- Transmit D/C summary and care plan to PCP
  - Fax: insure it is received and legible
  - Electronic: scan/email if possible; insure it is received
- Follow-up phone call to patient-72 hours
  - Caller uses script inclusive of medication and follow-up appointment understanding
  - Need for second call by clinician determined

Challenges to Implementation: Medical Team Related

- Busy medical team: discharge receives low priority in the work schedule of inpatient clinicians
- Discharge is relegated to least experienced team member
- Last minute test/consultations resulting in delay of final discharge plan and medication list
- Inaccurate medication reconciliation
- Discharge medication reconciliation started on the day of discharge

Challenges to Implementation: Hospital Related

- Lack of resources and financial incentives to sustain discharge programs
- Standardized discharge papers: not personalized or in language of patient
- Resistance to change by clinicians
- Financial pressure to fill beds as soon as they are empty
Challenges to Implementation: Patient Related

- Patient without a Primary Care Physician
- Limited or no insurance coverage
- Inability to pay for medication co-pays
- Long wait times when calling health centers
- Late discharge; less effective teaching to patients who are anxious to leave

Ready for Project RED?

- Next Steps to participate in JCR Project
  - Secure leadership commitment
  - Identify targeted populations to begin
  - Determine approach for developing After Hospital Care Plan
  - Identify staff: Project Leader, Project Team, Physician Champion, Discharge Advocate(s)

Project Expectations

- Secure executive sponsorship
- Assign project team and project leader
- Identify targeted population of patients*
- Determine approach for generating the care plan for patient’s use after D/C*
- Identify discharge advocate(s) and staff to make post-discharge phone calls
- Participate in pre-training conference call
## Project Expectations cont’d

- Participate in web conference training
- Schedule bi-weekly consulting calls with assigned JCR consultant
- Provide data to JCR re: readmission, ALOS, patient satisfaction, resource investments, RED processes
- Participate in all-site web conference discussions
- Participate in case-study interviews

## Identify Targeted Patient Population

- Start small!
- Approaches to consider
  - Specific patient care unit
  - Diagnostic group
  - Physician’s patient group
  - Combination of above
- Also
  - English-speaking patients
  - Discharged home
  - Access to telephone

## Generating the AHCP

- “Manual” – use of template for discharge advocate (DA) to enter all required data
  - AHRQ template: [www.ahrq.gov/qual/goinghomeguide.htm](http://www.ahrq.gov/qual/goinghomeguide.htm)
  - Mimic BMC’ AHCP
- Provide template to your IT department and request that they integrate with existing systems
- Purchase software and integrate it with your existing systems
Timeline for Project

- June - JCR-sponsored training begins
  - Recorded and live web conferences
  - Virtual Consultation begins
- July – hospitals’ launch of Project RED intervention
  - Virtual Consultation continues bi-weekly
  - Training for additional hospitals (launch in August)
- August – December
  - Pilot implementation continues
  - Monthly measurement
  - Bi-weekly consultation
- September - Web Conference for participants
- October – Case study interviews
- December – JCR-funding and support concludes
  - Hospitals continue and spread Project RED intervention!

To participate in JCR’s AHRQ-funded project focused on Project RED

Contact Deborah Nadzam
dnadzam@jcrinc.com
630-261-5048
Components of the Re-Engineered Discharge (RED)

1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing and
   - Make appointments with input from the patient regarding the best time and date of the appointment.
   - Coordinate appointments with physicians, testing, and other services.
   - Discuss reason for and importance of physician appointments.
   - Confirm that the patient knows where to go, has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
   - Be sure patient understands the importance of such services.
   - Make appointments that the patient can keep.
   - Discuss the details about how to receive each service.
5. Confirm the Medication Plan.
   - Reconcile the discharge medication regimen with those taken before the hospitalization.
   - Explain what medications to take, emphasizing any changes in the regimen.
   - Review each medication’s purpose, how to take each medication correctly, and important side effects to watch out for.
   - Be sure patient has a realistic plan about how to get the medications.
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.
   - Instruct on a specific plan of how to contact the PCP (or coverage) by providing contact numbers for evenings and weekends.
   - Instruct on what constitutes an emergency and what to do in cases of emergency.
8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient’s care after discharge that includes:
   - Reason for hospitalization with specific principal diagnosis.
   - Significant findings. (When creating this document, the original source documents – e.g. laboratory, radiology, operative reports, and medication administration records – should be in the transcriber’s immediate possession and be visible when it is necessary to transcribe information from one document to another.)
   - Procedures performed and care, treatment, and services provided to the patient.
   - The patient’s condition at discharge.
   - A comprehensive and reconciled medication list (including allergies).
   - A list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up.
   - Information regarding input from consultative services, including rehabilitation therapy.
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan.
   - May require removal of language and literacy barriers by utilizing professional interpreters.
   - May require contacting family members who will share in the care-giving responsibilities.
10. Give the patient a written discharge plan at the time of discharge that contains:
    - Reason for hospitalization.
    - Discharge medications including what medications to take, how to take them, and how to obtain the medication.
    - Instructions on what to do if their condition changes.
    - Coordination and planning for follow-up appointments that the patient can keep.
    - Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge.
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.
Implementing Re-Engineered Hospital Discharges (Project RED)  
Frequently Asked Questions

The following frequently asked questions focus on implementing the Re-engineered Hospital Discharge (Project RED) intervention. Project RED re-engineers the workflow process and improves patient safety by using a nurse discharge advocate who follows specific steps shown to improve the discharge process and decrease hospital readmissions.

The Re-Engineered Hospital Discharge project, known as Project RED, was developed by Brian Jack, M.D., Associate Professor of Family Medicine at Boston University and Timothy Bickmore, Ph.D., Assistant Professor in the College of Computer and Information Science at Northeastern University, through a Partnerships in Implementing Patient Safety grant from the Agency for Healthcare Research and Quality. The project is designed to re-engineer the hospital workflow process and improve patient safety by using a nurse discharge advocate who follows 11 discrete, mutually reinforcing action steps shown to improve the discharge process and decrease hospital readmissions. Patients who have a clear understanding of their after-hospital care instructions, including how to take their medicines and when to make follow-up appointments with their doctors, are 30 percent less likely to be readmitted or visit the emergency department than patients who lack this information, according to a study by Dr. Jack that appeared in the *February 3, 2009, Annals of Internal Medicine.*

The Project RED toolkit includes the following:

- **Training Manual**—This workbook for health professionals details how to deliver a safe and effective hospital discharge.
- **After Hospital Care Plan Sample Form**—The After Hospital Care Plan is designed to clearly present the information needed by patients to prepare them for the days between discharge and the first visit with their ambulatory care physician.
- **Computerized Workstation to Print the After Hospital Care Plan**—This document describes the computerized workstation and the process used to create and print the After Hospital Care Plan.

The following are some frequently asked questions—and answers—about Project RED.

**Instructions for Follow-up Medical Appointments Post-Discharge**

1. **A component of Project RED is that the primary care physician (PCP) appointment is scheduled. Who is responsible for scheduling the appointment?**

   In the Project RED study, the nurse was responsible for speaking to the patient to identify times that they were available for an appointment and to note the PCP name and location. The nurse would also consult with the patient's medical team to find out if there were specific requests about the timeframe for the appointment. The nurse would schedule the appointment if she or he had time. Otherwise, the nurse would ask the research assistant to schedule the appointment.

2. **When is the appointment scheduled?**

   The appointment is scheduled prior to discharge. Staff tried to make every appointment within two weeks after discharge. The patient would be informed of this appointment before discharge by writing it on his or her After Hospital Care Plan. The only exception was that patients discharged on Saturday or Sunday would have to wait until Monday for an appointment to be scheduled. Subsequently, staff called the patient to inform them of the appointment time and make sure they would be able to go.

3. **Did you have a target timeframe for scheduling PCP or specialist follow-up appointments, and if so, what was it and why?**

   The target timeframe for scheduling PCP or specialist follow-up appointments was within two weeks post-discharge. Nurses in the Project RED study were able to schedule follow-up appointments for more than 80 percent of patients within that timeframe at health centers or with their primary care physicians. Researchers chose two weeks as the timeframe based on suggestions from the medical team that this was the appropriate timeframe in order to foster continuity of care.
4. Are the phone calls from the pharmacy and other post-discharge phone calls normally made by a nurse?

The phone calls from the pharmacist to the patient to discuss medications occur independently from any other post-discharge phone calls.

**Discharge Advocate**

5. What type of commitment is required from providers, nurses, and other hospital staff to make implementation successful?

The research study found that it is not only important for a majority of the providers, nurses, and other hospital staff to support the new process, but also that they commit to making the process successful. The type of commitment required by providers, nurses, and other hospital staff depends on several factors such as the hospital's patient population and patient needs, as well as the number of hospital personnel allocated to carry out the Project RED intervention.

6. What is the ratio of the discharge advocate to discharge patient, and how many patients can a discharge advocate discharge per shift, on average?

In the Project RED study, the ratio of the discharge advocate to discharge patient was 1:2, and on average, one patient was discharged per day. However, because it was a research study, there were several factors that limited the ability of the discharge advocate to care for more patients:

- Lack of staff: The discharge advocate typically worked six hours on the weekdays and five hours on the weekends (e.g., Monday through Friday from 8:00 a.m. to 2:00 p.m., weekends from 10:00 a.m. to 3:00 p.m.) which is less than a typical eight-hour shift.
- Time to generate After Hospital Care Plan: It took a considerable amount of time to generate the After Hospital Care Plan because the discharge advocate had to populate it manually (the electronic software to generate the After Hospital Care Plan was not available at the time).
- Lack of integration with medical team: The discharge advocates were not integrated with the medical team. Therefore, they did not have access to the medical team's data on the patients and had to ask patients more questions than they would have otherwise.

Researchers anticipate that discharge advocates would be able to care for more patients in the normal hospital setting given that these research limitations would either not exist or they would be minimized.

7. Does the discharge education associated with Project RED allow physicians to bill at a higher level?

Physicians can bill for two different levels of discharge education. In general, physicians who perform discharge education using Project RED can bill at the higher level (CPT Code 99239), which would allow them to bill approximately $32 more per discharge.

8. How have providers, nurses, and other hospital staff responded to the use of the virtual discharge advocate?

Project RED has been well received so far. To understand nurse reaction, a brief test was conducted during an in-service for nurses. Half of the nurses received a briefing on Project RED, and the other half had a one-on-one interaction with one of the virtual nurses and performed some trust-building exercises. They had a personalized 10-minute chat with the virtual nurse. The test found that nurses with the opportunity for a one-on-one interaction were significantly more accepting of the system, more likely to recommend it to their patients, and felt significantly less threatened by it.

9. Is the virtual discharge advocate technology only available as a stand-alone application or can it be built into other existing discharge planning programs a hospital may have?

The virtual discharge advocate technology is available as a stand-alone application and can also be built into other existing technology. The system can be integrated directly into the hospital information technology environment. In addition, staff training is available on how to deliver the discharge materials and information.
10. Was it necessary to enter all patient data at the nurses’ workstation, or did the program interface with the hospital’s electronic medical record (EMR) and pull in some information?

Currently, it is necessary to manually enter all data in the workstation. Project RED is working on integrating the software with the hospital electronic medical record, but that project has not been completed.

**Discharging Patients to Nursing Homes and Assisted Living Facilities**

11. What do nursing homes and assisted living facilities think of the discharge tools?

In some cases, Project RED study subjects were discharged to a nursing home. In such cases, nursing home personnel provided positive feedback, saying, "This After Hospital Care Plan is terrific. We used to only get the discharge summary, and it is very unclear from a discharge summary what we are supposed to do." The staff and the nursing homes benefited from a clearer presentation of what the patient needs to do, when the appointments are, what tests are pending, what the diagnosis is, how to follow up on any problems, and how to reach the clinician that is covering for them.

It should be noted that the Project RED study did not enroll patients that were admitted from nursing homes, skilled nursing facilities, and rehabilitation centers for research purposes. However, the Project RED intervention could be adapted to meet the needs of these patients and their care facilities.

12. How do you best educate family members about discharge instructions when patients are being discharged to a nursing home or assisted living facility?

The Project RED research study found that the best way to educate family members about discharge instructions was through both the paper-based and electronic version of the After Hospital Care Plan. Often a nurse does not have time to provide education to a family member separately after he or she has already provided education to the patient. With the After Hospital Care Plan, an organization can provide family members the necessary information they need to take care of their elderly relative. Using the electronic version of Project RED, a nursing home can simply invite family members to sit and meet Louise, the virtual discharge nurse, and go through everything that they need to know to take care of their elderly family member.

**Evaluation of Project RED**

13. Have there been any post-discharge followup studies to determine if improvement has been sustained and gains maintained?

Project RED has collected hospital readmission data up to 90 days post-discharge. These data will be analyzed in the near future in order to answer this question. However, it has been observed that the vast majority of the readmissions occurred within the first 30 days after discharge. Therefore, this is a specific area in which Project RED investigators are interested given that no further intervention is provided after the pharmacist phone call, which occurs two to four days post-discharge.

14. What software, electronic forms, and process ideas can be shared to test Project RED at other organizations?

Researchers tested Project RED by tracking various process and patient outcome measures. In order to better understand how well staff were using Project RED to discharge patients, researchers examined a variety of process measures, including the number of patients who received the After Hospital Care Plan, instruction from the discharge advocate, follow-up telephone calls, as well as the number of patients who had their medications reconciled. Researchers also reviewed various patient outcome measures, including patient satisfaction measures and hospital readmission rates.

For additional information on the types of measures used to test Project RED, please review the following article: "A Reengineered Hospital Discharge Program to Decrease Rehospitalization. A Randomized Trial," by Brian W. Jack, MD, et al., in the February 3, 2009, Annals of Internal Medicine, 150(3), pp. 178-187.
Cost and Implementation of Project RED

15. Is the After Hospital Care Plan a retail software product? How much does it cost to purchase and implement?

The software to create the After Hospital Care Plan is available for purchase and implementation at your organization.* The cost of the software varies based on multiple factors including, but not limited to, the size of your organization, the extent of training and support required, if your organization wants to integrate the After Hospital Care Plan into an existing electronic medical record, and if your organization wants to purchase the Virtual Discharge Advocate technology (i.e., the electronic version of Project RED). With the electronic version of Project RED, the amount of time the nurses need to teach the After Hospital Care Plan is greatly reduced.

For more information or if you are interested in implementing Project RED in your organization, please visit the Project RED Web site at http://www.bu.edu/fammed/projectred/.

*Boston Medical Center/Boston University School of Medicine has developed this product using professional and scientific methods, sources, and up-to-date clinical standards at the time of publication to confirm that the information contained in it is both reliable and valid. However, Boston Medical Center/Boston University School of Medicine and AHRQ caution that the product is to be utilized using the professional judgment of authorized physicians or nurses and staff directed and supervised by them. Each health care professional who decides to use this product or its content should understand that such use would be on the basis of that provider's professional judgment with respect to the needs and characteristics of the particular patients they are caring for. Boston Medical Center/Boston University School of Medicine and AHRQ disclaim any and all liability for adverse consequences or for damages that may arise out of or be related to the professional use or application by practitioners of the product or its content, including but not limited to, indirect, special, incidental, exemplary, or consequential damages. Furthermore, practitioners should be cautioned that professional and scientific methods and standards evolve over time. Therefore, attention should be given to possible progress in medical standards, techniques, and technology occurring after the production of this material.

Current as of June 2009

Internet Citation:
Hospital Discharge is a Complex Problem

- Non-standardized
- Marked with poor quality
  - 20% of Medicare patients readmitted within 30 days
  - 28% of post-discharge adverse events are preventable
- Pending tests not completed
  - 41% of inpatients discharged with a pending test
  - 2/3 of physicians unaware of results
  - 37% of results are actionable, 13% are urgent

RED Program: Discharge Checklist

1. Medication reconciliation
2. Reconcile discharge plan with national guidelines
3. Make follow-up appointments
4. Discuss outstanding tests
5. Organize post-discharge services
6. Written discharge plan
7. Review what to do if problem arises
8. Patient education
9. Assess patient understanding
10. Delivery discharge summary to PCP
11. Telephone Reinforcement

RED Software reinforces the provider workflow
Engineered Care Products

- After Hospital Care Plan (AHCP) Booklets
- RED Educator Unit
- RED Consulting

RED Lite is now available. For more information email: redlite@engineeredcare.com

After Hospital Care Plan Booklet

Features of the AHCP Booklet:
- Delivers Patient Data for Low Health Literacy
  - Reason for hospitalization
  - Discharge medication list
  - PCP contact information and picture
  - Calendar labeled with follow-up appointments and tests
- Branded for your organization

EMR Integration

AHCP Data Schemas are available to map to your current process

Data Interface depends on EMR
- HL-7 Integration for ADT events
- HL-7 capabilities for Medication data
- Today’s ascii discharge summaries can be parsed
- Database queries can be executed to gather data
- Direct integration into the EMR if it is extensible
**RED Educator**

- Optimize the discharge process
  - Use IT to overcome challenge of RN time
  - Provides standardized education for discharge
  - Documents patient understanding of the AHCP
- RED Educators available for lease
  - Integrates with RED Server

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**RED Educator – Patient Interaction**

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**RED Educator – Virtual Discharge Advocates**

- Emulate face-to-face communication
- Patients had higher satisfaction with virtual discharge advocates than with traditional providers for discharge education
- Determine competency

"I prefer Louise, she's better than a doctor; she explains more, and doctors are always in a hurry."

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PUTTING THE PIECES TOGETHER: REDUCING AVOIDABLE READMISSIONS

More Findings from Miami

Project Background

“Making the health care delivery system work reliably for very sick Medicare beneficiaries requires linking all clinical care providers and ensuring that transitions are thoroughly reliable. This work can only succeed when all of the community is engaged and working together, so the QIOs will serve to catalyze and coordinate the work across all care settings in the community.”

Barry M. Straube, M.D.
Director & Chief Clinical Officer
Office of Clinical Standards & Quality for CMS

Care Transitions Goals

Improve 30-day rehospitalization rates
• Improve AMI, PNE, and HF readmission rates
• Improve the number of physician follow-up visits among the patients who have been discharged from the hospital
• Improve hospital performance of patient satisfaction (HCAHPS) for patients receiving information about discharge and medications
Provider-Associated Readmissions

<table>
<thead>
<tr>
<th>Provider-Associated Readmissions (last claim)*</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>30.3%</td>
</tr>
<tr>
<td>Home (including ALF) *</td>
<td>23.6%</td>
</tr>
<tr>
<td>SNF</td>
<td>13.4%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>12.0%</td>
</tr>
<tr>
<td>HHA</td>
<td>11.4%</td>
</tr>
<tr>
<td>Other</td>
<td>9.3%</td>
</tr>
<tr>
<td>Totals</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Physician claims assigned to associated category/provider

Readmission Risk Modeling

- Based on beneficiaries' claims 2007-2008
- Tests patient characteristics to determine non-diseased based disparities
  - Age
  - Gender
  - Race/ethnicity
  - Dual eligibility
  - ESRD
  - Length of stay

- Tests the impact of:
  - Primary discharge diagnosis
  - Services utilized during hospital stay
  - Co-existing conditions defined during index hospitalization

NOTE: All diagnosis fields were identified using the 2005 HCC risk-adjustment model. Revenue & procedure codes were classified using utilization flags developed for the Healthcare Cost & Utilization Project (HCUP), sponsored by the Agency for Healthcare Research & Quality (AHRQ).
Results: Patient Characteristics

- Dual eligible
- ESRD
- Longer length of stays (>5.65)
- Prior readmission(s) in last 6 months
- Males (slight)
- African American (slight)

Results: Primary Discharge Diagnosis

- Congestive heart failure*
- Major psych disorders*
- Cardio-respiratory failure/shock*
- Metastatic cancer/acute leukemia#
- Chemotherapy/neoplasms#
- Artificial openings for feeding/elimination

* Impacts greatest number of patients
# Greatest risk for readmission

Results: Service Utilization

- Emergency department*
- EKG*
- Coronary care*
- Respiratory therapy*
- Ultrasound
- Renal dialysis#
- Mental health & substance abuse#

* Impacts greatest number of patients
# Greatest risk for readmission
Results: Co-existing Conditions

- Cardiac / Respiratory / Vascular*
- GI / GU
- Mental Health#
- Nutrition / Skin / Blood Disorders
- Cancer#

* Impacts greatest number of patients
# Greatest risk for readmission

The Care Transition Solution

The Care Transition Solution

Framework

- Adapted Eric Coleman’s* Care Transitions InterventionSM (CTI)
- CTI addresses patient empowerment through the intervention’s four pillars:
  - medication reconciliation,
  - physician follow-up,
  - disease management,
  - maintaining personal health record.

* www.caretransitions.org
Interventions

- Provider-specific (based on findings)
- Collaboratives
- Care Transitions Intervention<sup>SM</sup>
  - Coaching
  - 5<sup>th</sup> & 6<sup>th</sup> Pillars
- Educational Updates
  - Providers & Beneficiaries

Findings/Results

NOTE: All data represents 6-month periods through designated month unless otherwise stated.

Community 30-Day Readmission Rate
Condition Categories:
30-Day Readmission Rate by Physician Follow-Up

Impact of Physician Follow-Up on 30-Day Readmission Rates
Data period: October 2008 – September 2009

Impact of Physician Follow-Up on 30-Day Readmission Rates
Data period: October 2008 – September 2009
Impact of Physician Follow-Up on 30-Day Readmission Rates

Data period: October 2008 – September 2009

(statistically significant differences at $p \leq 0.05$)

Community: Pneumonia (5.03% of all discharges)

Community: COPD (4.75% of all discharges)

Community: UTI (4.12% of all discharges)

Other Characteristics

<table>
<thead>
<tr>
<th>Age Range</th>
<th>% of all Discharges N Stays=26,850</th>
<th>No Physician Follow-Up</th>
<th>Physician Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65 *</td>
<td>14.95%</td>
<td>39.53%</td>
<td>20.31%</td>
</tr>
<tr>
<td>65 - 69 *</td>
<td>12.30%</td>
<td>23.01%</td>
<td>13.99%</td>
</tr>
<tr>
<td>70 - 74 *</td>
<td>13.96%</td>
<td>34.16%</td>
<td>12.82%</td>
</tr>
<tr>
<td>75 - 79 *</td>
<td>15.43%</td>
<td>36.61%</td>
<td>12.78%</td>
</tr>
<tr>
<td>80 - 84 *</td>
<td>17.85%</td>
<td>38.21%</td>
<td>14.63%</td>
</tr>
<tr>
<td>85 - 89 *</td>
<td>14.89%</td>
<td>40.56%</td>
<td>15.60%</td>
</tr>
<tr>
<td>90+ *</td>
<td>10.62%</td>
<td>38.31%</td>
<td>16.36%</td>
</tr>
</tbody>
</table>

(statistically significant differences at $p \leq 0.05$)

Other Characteristics

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% of all Discharges N Stays=26,850</th>
<th>No Physician Follow-Up</th>
<th>Physician Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American*</td>
<td>5.99%</td>
<td>41.23%</td>
<td>19.55%</td>
</tr>
<tr>
<td>Hispanic *</td>
<td>36.01%</td>
<td>34.84%</td>
<td>14.38%</td>
</tr>
<tr>
<td>Caucasian *</td>
<td>55.08%</td>
<td>35.50%</td>
<td>15.61%</td>
</tr>
<tr>
<td>Other *</td>
<td>2.92%</td>
<td>30.00%</td>
<td>11.02%</td>
</tr>
</tbody>
</table>

(statistically significant differences at $p \leq 0.05$)

Other Characteristics

<table>
<thead>
<tr>
<th>Gender</th>
<th>% of all Discharges N Stays=26,850</th>
<th>No Physician Follow-Up</th>
<th>Physician Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male *</td>
<td>41.38%</td>
<td>37.12%</td>
<td>16.88%</td>
</tr>
<tr>
<td>Female *</td>
<td>58.62%</td>
<td>34.03%</td>
<td>13.82%</td>
</tr>
</tbody>
</table>

(statistically significant differences at $p \leq 0.05$)
Empowering Patients: Physician Follow-Up Care

- Educate office staff on the importance of scheduling “early” follow-up office visits.
- Reinforce with your patients the importance of making/keeping appointments soon after discharge.
- Ask patients to take their discharge paperwork to the visit – complete a medication reconciliation.
- Give recently discharged patients appointment priority.
- Encourage patients to bring written questions to the doctor’s visit. This practice improves the effectiveness of the patient/physician communication and time management.

Coaching Impact on Reducing Readmissions

- Offer coaching 1007+
- Coached patients 735 (Acceptance rate 73%)
  - Plus “Nutritional Support” 0/72 = 0%
Empowering Patients: Coaching

- Staff reinforces medication management with patients (including actions, side effects, and changed or discontinued meds).
- Help patients understand the importance of timely physician follow-up care (name, number, which first, time frame, etc.).
- Assist patients to set one goal for disease management (monitor weights, sodium intake, activity, etc.).
- Provide discharge instructions in patient’s/caregiver’s primary language (i.e., medication profile).

Other Findings

Comparison: All vs. Same Hospital 30-Day Readmission Rates

- All Causes / All Hospitals
- All Causes / Same Hospital
The Crust: Shared Problem

Impact for Hospitals

- Prevent avoidable readmissions:
  - Reflect quality of care and safety.
  - Affect the hospital’s finances and community role.
- Improves National Patient Safety Goals and HCAHPS scores.
- Hospitals can lower their unnecessary/avoidable readmission rates, but success requires leadership commitment.

QUESTIONS

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Email: sstone@flqio.sdps.org

This material was prepared by FMQAI, the Medicare Quality Improvement Organization for Florida, under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

# FL2010F72T22211759
Health Reform Focus

• HF, AMI and PNE targeted for readmission penalty (readmissions - any cause)

• Penalties begin:
  – FY 2013: 1% payment reduction for readmissions
  – FY 2014: 2% payment reduction for readmissions
  – FY 2015: 3% payment reduction for readmissions

• Readmission performance measures: SNFs, physicians, Medicare Advantage

• Hospital/physician payment bundling during inpatient stay (pilot test currently)

Health Reform Update*

• May 27, 2010: Brian Whitman (Associate Director of Regulatory Affairs, American College of Cardiology)

• “While there are no specific details today, by law, financial penalties for excessive readmission rates will occur. This will not go away. We need to look at this right now.”

• Still in development: penalty & risk-adjustment calculations

• Proposed rule release: March 2011 with opportunity to respond

*Hosted by H2H
Collaborating with FADONA to Improve Care Coordination
FHA Readmission Collaborative
June 4, 2010

Overview

• Why Collaborate on Care Coordination?
• FHA and Florida Association Directors of Nursing Administration (FADONA) Activities
• Standardized Discharge Abstract Form Development
• Discussion

Why Collaborate on Care Coordination?

• Quality improvement opportunity
  – Provide care at the right place at the right time
• Health care reform and value based purchasing
  – Legislation, rules and regulations discuss two key areas impacting both hospitals and skilled nursing facilities:
    • Bundled payments for acute and subacute care (e.g., skilled nursing facilities, home care, rehab)
    • Reducing payments for readmissions
  – Commercial payers already declining payment for readmissions to the hospital
Why Collaborate on Care Coordination?

(Cont.)

- Public reported readmission rates
  - Centers for Medicare and Medicaid Services (CMS)
    - 30 day, "all-cause" readmissions for Heart Failure, Acute Myocardial Infarction and Pneumonia
    - Aggregate 3 years of data
  - Agency for Health Care Administration (AHCA)
    - 15 day, clinically related readmissions as measured by the 3M Potentially Preventable Readmission (PPR) methodology
    - Report rates for ~80 conditions (organized by 3M APR-DRG)
    - One year of data

FHA / FADONA Goal

- Shared goal to improve performance on quality measures
  - Reduce pressure ulcers
  - Reduce hospitalizations and readmissions from nursing homes
  - In Florida, readmission rates were highest for those patients discharged to a skilled nursing facility – 17.3%

FHA / FADONA – Specific Efforts

- Standardized Discharge Abstract Workgroup
  - Representatives from hospitals in the FHA readmission collaborative and skilled nursing facilities
  - From facilities across the state
  - Multidisciplinary
  - Co-chairs from FADONA and hospital system
FHA / FADONA – Specific Efforts (cont.)

- Standardized Discharge Abstract Workgroup
  - AHCA participation
    - History: CMS Region IV Office in 2006 formed Quality Improvement Steering Committee to identify means to reduce pressure ulcers.
    - Challenged with reducing the % of residents with pressure ulcers as specified in the Government Performance Results Act (GPRA).
    - One very important outgrowth of the work of the committee was the establishment of Positive Action-Critical Thinking “PACT”.
    - AHCA (Polly Weaver) asked FADONA to work within the Long Term Care community to work toward the CMS Region IV goal of reducing pressure ulcers by 1% per year over next three years.

FHA / FADONA Collaboration

- FADONA Participation
  - Pressure Ulcer reduction is consistent with FADONA’s Principles of Excellence established in August of 2009.
  - FADONA partnered with FHA to develop strategies for improving communication in the health care continuum between hospitals and nursing homes.
  - First goal is to develop standardized discharge abstracts.
  - Second goal is to concurrently determine Best Practices to reduce hospital readmissions and pressure ulcers.

Standardized Discharge Abstract Workgroup

- Purpose
  Create a form that facilitates a safe and streamlined transition from the hospital to the nursing home and from the nursing home to the hospital which reduces the likelihood of the patient being readmitted or unnecessarily hospitalized.
Standardized Discharge Abstract Form Development

- Process thus far
  - Brainstorming among workgroup members
  - Reviewed multiple forms from other organizations, other states, improvement initiatives, published research
    - Content
    - Terminology
    - Format

- Recommendations to Date (cont.)
  - One universal form will not work, need two separate forms
  - Forms should look similar and use standard terms and definitions
  - Contain critical information to enable a safe transfer of care
    - Do not duplicate information in medical record or on other forms
    - Other documents can be sent with patient/shortly after transfer

- Recommendations to Date (cont.)
  - Use checklists whenever possible but allow free-text entry as needed
  - Must be easy and fast to complete
  - Must include contact information
  - Look toward future with EHR
    - Electronic transmittal
    - Populate form with information from EHR
**Standardized Discharge Abstract Form Development**

- Recommendations to Date (cont.)
  - Develop an instruction sheet with common definitions
  - Education is critical to achieve shared understanding and consistent use

- Next Steps
  - Finalize draft form and move to pilot testing
  - Continue discussions with AHCA – modify 3008?
  - Finalize form, distribute, monitor use and impact on care processes

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**Discussion**