BACK AGAIN? MANAGING THE CONUNDRUM OF READMISSIONS

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FACULTY

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**Toni G. Cesta, Ph.D., RN, FAAN** is Partner and Healthcare Consultant in Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating acute care and community case management models, new documentation systems, and other strategies for improving care and reducing cost. The author of eight books, and a frequently sought after speaker, lecturer and consultant, Dr. Cesta is considered one of the primary thought leaders in the field of case management. Dr. Cesta writes a monthly column called “Case Management Insider” in the Hospital Case Management journal in which she shares insights and information on current issues and trends in case management. Prior to her current work as a case management consultant, Dr. Cesta was Senior Vice President – Operational Efficiency and Capacity Management at Lutheran Medical Center in Brooklyn, New York.
LEARNING OBJECTIVES

1. Explain the healthcare reform readmission penalty program.

2. Identify key strategies for reducing readmissions.

3. Discuss a process to predict patients who might readmit.

4. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.

5. Evaluate case management protocols and penalties.
READMISSIONS

- A continuum of care problem
- Solutions will need to come from the acute care and community sides of health care
THE CONTINUUM OF CARE

- Ambulatory Care
- Acute Care
- Rehabilitation
- Skilled Nursing and Long Term Care
- Home Health
- Hospice
- Patient and Social Support Network
- ACOs or Integrated Systems

Bundled Payments
Shared Savings
Capitation

Bundled Payments
Shared Savings
Capitation
ACOs AND READMISSIONS

A type of payment and delivery reform model that starts to tie provider reimbursements to:
- Quality metrics
- Reductions in the total cost of care

FOR AN ASSIGNED POPULATION OF PATIENTS
ACOs MAY REDUCE READMISSIONS

- A part of the Affordable Care Act, an ACO depends on tight care coordination
- Readmissions can be avoided if care outside the hospital has been aggressive and better coordinated

HealthCare.gov 2011
Impetus for Readmission Penalties:
High, Costly Readmission Rates

Readmission rates within 30 days of discharge…The NEJM study found 50% of readmitted non-surgical patients didn’t see a community doctor for follow-up.

Source: Rehospitalizations among Patients in the Medicare Fee-for-Service Program, Jencks et al., New England Journal of Medicine, April 2, 2009.
WHAT DO READMISSIONS LOOK LIKE?

- 77.6% are medical
- 22.4% are surgical
- 1/5 OR 19.6% of the 11,855,702 Medicare beneficiaries discharged from hospitals are readmitted within 30 days
- 34% are re-hospitalized within 90 days
MD VISITS

- 50.2% of the patients who were re-hospitalized within 30 days after a medical discharge to the community, did not see their doctor within those 30 days.

- THE average length of stay of a re-hospitalized patient is 0.6 days longer than patients with the same diagnosis.
MEDICAL PATIENTS

- Heart Failure (7.6%)
- Pneumonia (6.3%)
- COPD (4%)
- Psychoses (3.5%)
- GI Problems (3.1%)

30 DAY READMISSION RATES
NEW ENGLAND JOURNAL OF MEDICINE APRIL 2, 2009
SURGICAL PATIENTS

- Cardiac stent placement (1.6%)
- Major hip or knee surgery (1.5%)
- Other vascular surgery (1.4%)
- Major bowel surgery (1%)
- Other hip or femur surgery (.8%)

30 DAY READMISSION RATES
NEW ENGLAND JOURNAL OF MEDICINE APRIL 2, 2009
HOSPITAL DISCHARGE COUNSELING

- Less than 50% of patients can state their diagnosis
- Less than 50% of patients can list all their medications
- Less than 25% of patients can state common side effects and what to expect from their meds
- Patients taking 3 or more meds are more likely to have problems with medication knowledge


**MEDICATION ADHERENCE**

- In a study in the elderly, 38% of patients did not have an understanding of how to take their meds (Spiers, 2004)

- Nearly 75% of hospitals reported that only 1 – 25% of patients received medication discharge counseling (Pederson, 2004)

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PROBLEMS/QUESTIONS

• Hospital stays are episodic and are only a small part of the overall management of a patient
  ■ Difficult to plan for transition vs. discharge

• Hospital staff must take on full responsibility of initiating the coordination of care

• How can the primary care provider be engaged more effectively so that his / her role is not reactive
NOT ALL READMISSIONS ARE AVOIDABLE – BUT SOME ARE!

• In-patient issues
  ■ Discharged too soon
  ■ Poor or inadequate discharge plan
  ■ No plan for follow-up care

• Out-patient issues
  ■ Patient does not have or does not keep MD appointment
  ■ Medication compliance
CATEGORIES OF REASONS FOR READMISSIONS

- Medical readmission for an acute decompensation of a chronic problem
  - Unrelated to the reasons for initial admission
  - Plausibly related to the pre or post discharge care
- Medical readmission for an acute medical complication
  - Plausibly related to care during the initial admission
• Medical readmission for
  ■ A continuation or recurrence of the reason for the initial admission or closely related condition

• Readmission for a surgical procedure
  ■ To address a continuation or recurrence of the problem causing the initial admission

• Readmission for a surgical procedure
  ■ To address a complication resulting from care during the initial admission
APPLICABLE CONDITIONS

Condition selected by the secretary

- Represent Conditions that are High volume or high expenditure
- Have been Endorsed (currently NQF)
- Limited exclusions For unrelated to the prior discharge
READMISSION MEASURES

Proposing to adopt the following for FFY2013 “Applicable Conditions”

• 30 Day Risk-Standardized Heart Failure (HF)
• 30 Day Risk-Standardized Heart Attack (AMI)
• 30 Day Risk-Standardized Pneumonia (PN)

Hospitals must have 25 discharges for each of these three measures

Based on three years of data (July 1, 2009 – June 30, 2012)
EXCLUDED FROM READMISSIONS

- Discharged Against Medical Advice (AMA)
- In hospital deaths
- Not enrolled In Medicare For 30 days Post discharge
- Transfers to Other acute care facilities
- Same day Discharges (AMI only)
READMISSION RISK ADJUSTMENT

Adjusts for case-mix difference based on the clinical status of the patient

- Demographic variables
- Comorbid diseases
- Indicators of patient frailty

Does not adjust for

- Admission source / discharge disposition
- Socioeconomic status (SES)
CMS READMISSION FOCUS ON UNPLANNED READMISSIONS

Payment Penalty Cap – 1%

Initial Set
FFY 2013
• Heart Attack
• Heart Failure
• Pneumonia

Payment Penalty Cap – 2%

Expanded Penalty
FFY 2014
• Heart Attack
• Heart Failure
• Pneumonia

7/1/09 – 6/30/12

Proposed Penalty Cap – 3%

FFY 2015
Expanded Set
• COPD
• Total Hip and Knee Replacements
• Heart Attack
• Heart Failure
• Pneumonia
• Hospital-Wide Rate of Unplanned Readmissions (internal medicine, surgery/gyn, cardiorespiratory, cardiovascular, neurology)

7/1/10 – 6/30/13
SETTING YOUR BASELINES

• GO TO WWW.HOSPITALCOMPARE.HHS.GOV

To get your rates for Heart Failure, Heart Attack and Pneumonia

• Check your rates to see if you are:
  ■ Within National Average
  ■ Above National Average
  ■ Below National Average
THREE – PRONGED APPROACH

1. Pre-Admission
   1. Emergency Dept.
   2. MD Office

2. In-Patient Stay
   1. Patient Education
   2. Discharge Planning
   3. Family Caregiver Assessment

3. Patient Management in the Community
   1. Medical Home
   2. Health Home
ED CASE MANAGEMENT –
THE FIRST LINE OF DEFENSE

• Gatekeeping – Identification of potential readmissions before they are readmitted!
• Assessment and plan for alternatives to admission if appropriate
• Initial information as to the cause of the return visit to the ED
NURSING’S ROLE DURING IN-PATIENT STAY

- Patient education
  - Booklets
  - Videos
  - Reinforcement
- Discuss plan of care on rounds
- Discharge summary including contact numbers for continuing care services
- Ensure that there is a follow-up appointment
CASE MANAGEMENT’S ROLE DURING IN-PATIENT STAY

- Arrange for every patient to have a discharge appointment
- Verify that every patient has transportation to their appointment
- Provide for at least one home care visit where appropriate
- Refer high risk patients to Health Home of other community case management program where available
- Make follow-up phone calls
CASE MANAGEMENT’S ROLE DURING IN-PATIENT STAY

- Follow best practice guidelines for diagnosis management
- Reinforcement with patient
  - Medication adherence
  - Home care
  - PCP follow-up appointments
- Education
  - Patient
  - Family
- Discuss discharge summary and plan with community MD
- Reconcile medications on admission and discharge
- Discuss plan of care on rounds
COMMUNITY CASE MANAGEMENT’S ROLE DURING IN-PATIENT STAY

- Discuss admissions with in-patient case manager and MD
- Provide patient with a community contact should exacerbation of illness occur
COMMUNICATION DURING CARE TRANSITIONS

**VERBAL**
- Systemized methods for making sure that the person taking care of the patient speaks to the person to whom the patient is going to be taken care of.

**ELECTRONIC**
- Checklists
- Time out forms
- Transitional minimum data sets
  - Give providers baseline information on the patient – can help avoid unnecessary readmissions

(Kelly, Mahoney, Bonner, et al. Use of a transitional minimum data set (TMDS) to improve communication between nursing home and emergency department providers. J Am Med Dir Assoc. 2011)
CAREGIVERS AND PATIENTS

• Caregivers sometimes complain that they are not involved in discharge process details
• Proactively involve informal and formal family caregivers during hospitalization and at discharge
DISCHARGE INSTRUCTIONS

When did you last look at yours?

- Are they legible?
- Do they use too much medical jargon?

Most patients do not remember much detail about their discharge instructions, so written communication and community follow-up are very important!!!
COMMUNITY CASE MANAGEMENT

- Target high-risk subgroups in a population-focused framework
- Integrate acute episodes with community continuum
- Track quality, clinical & cost outcomes
WHY CASE MANAGEMENT IN THE COMMUNITY?

System of Care designed to oversee the process and link steps

1. Keeps patients connected
2. Ensures that energy and resources are matched to patient needs.
3. Monitors outcomes and compares to evidence-based guidelines
4. Make sure these things get done
5. Makes sure it's simple and fits into daily practice
GOALS OF COMMUNITY CASE MANAGEMENT

- Reduce Emergency Department visits, readmissions and in-patient LOS
- Improve the coordination of services following discharge from hospital
- Integrate acute episodes with community continuum
- Improve quality and satisfaction with care
- Improve coordination of care across all levels
RISK IDENTIFICATION AND REFERRAL

- Identify people who are at greatest risk for readmission
- Stratify into high risk for case management interventions
- Refer to appropriate service based on risk (ie, high risk referred to Case Mgr)
RISK ASSESSMENT

- **Review Medical History**

- **Current Meds**
  - How are they obtaining them now?
  - Are they taking them regularly? (BP meds one month/diabetes meds the other month)

- **Current problems:**
  - Health Issues
  - Social: Family support system
  - Cultural: Beliefs, Values, Travel patterns

- **Financial income, assets:**
  - Do they qualify for Federal or special state/local programs

- **Socio Demographics**

- **Risk Assessments for probability of hospitalization and complexity of disease**
  - How do you perceive your health?
NURSE, SOCIAL WORK OR BACHELOR’S PREPARED CASE MANAGER?

- Nurse Case Managers and Social Worker CMs work collaboratively on Moderate and High Risk Patients
- Bachelor’s prepared CMs work with low risk patients.
- Nurse Case Managers direct their work on high risk or moderate risk, clinically complex patients.
- Social Workers focus on high or moderate risk patients with psychosocial and financial issues.
- Both provide patient education
- Both coordinate referrals as needed
CLINICAL INFORMATION SYSTEMS

Electronic Health Record

- Registries
  1. Clinical registries
  2. Disease Mgmt registries (payer, providers)
  3. Special Disease-specific templates

Patient Subgroups

- Providers and/or staff receive triggers for Disease Mgmt program (A1c – Diabetes Self-Management Referral, Psychiatric triggers such as medication adherence, substance abuse triggers)

Care Planning

- Triggers & Lists generated for those high risk (Blood glucose triggers to inpatient diabetes nurse educator)
- Share information with patients and providers to coordinate care
SELF-MANAGEMENT SUPPORT

- **Emphasize Patient Role**
  - Multiple providers send this message to patient
  - Case Manager assesses patient self-management readiness
- **Care Planning & Problem Solving**
  - Checklists & Question Templates
  - Use of motivational interviewing techniques
Case Management

**Community**

**Ancillary Services**

**Direct Care Providers**

**Physicians**

**Patient/Family**

CASE MANAGEMENT
QUALITY OUTCOME MEASURES

• Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays
• Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits
• Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders
• Goal 4: Improve Disease-Related Care for Chronic Conditions
• Goal 5: Improve Preventive Care
SUCCESSFUL DISCHARGE

- Educate the patient on their disease process and factors that can influence their condition
- Ensure the patient understands and has the resources to manage their disease after discharge from the hospital
- Ensure a “safe” discharge
- Ensure the patient understands the plan for transition of care into the post discharge setting
- Ensure the patient has access to the follow up care and therapy

CMSA, 2006
QUESTIONS TO BE ADDRESSED PRIOR TO DISCHARGE

1. What is wrong with me & what will this condition mean to my long-term health?
   - Ability to function
   - Increased susceptibility to other health problems
   - Factors that influence my condition
   - Factors that decrease recurrence or worsening

CASE MANAGEMENT ADHERENCE GUIDELINES, 2006
QUESTIONS TO BE ADDRESSED PRIOR TO HOSPITAL DISCHARGE

2. What do I need to do when I get home to treat my condition?

- Follow up appts or tests that need to be scheduled (who, what when, where)
- Follow up visits on a regular basis
- Transportation to get to my appts
- Special diet
- Exercise restrictions
- Return to work

CASE MANAGEMENT ADHERENCE GUIDELINES, 2006
QUESTIONS TO BE ADDRESSED PRIOR TO HOSPITAL DISCHARGE

3. Who should I contact if I have questions regarding my treatment after I am discharged?

4. What are the things that I need to watch for to know if my condition is getting worse and what should I do if these occur? Disease Specific Checklist

5. How will I pay for my outpatient medical services?
   - treatments and tests covered by my insurance?
   - meds covered by insurance?
   - can patient receive and pay for services if not covered
   - are there programs available to help pay for medical services and treatments

CASE MANAGEMENT ADHERENCE GUIDELINES, 2006
## Successful Discharge: Admission

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<th>Task</th>
<th>Assessment</th>
<th>Date</th>
<th>Reviewer</th>
<th>Notes</th>
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<td>Pt has ability to read, understand &amp; act on health info</td>
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<td>Pt understands reason for admission</td>
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<td>Med Review:</td>
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<td>Name &amp; Instruction</td>
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<td>Reason for use</td>
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<td>Benefit of med</td>
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<td>Side Effects &amp; Monitoring</td>
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<td>Adherence assess</td>
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<td>Technique review</td>
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<td>OTC product use</td>
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## Successful Discharge Plan: In-Patient Stay

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<td>Pt understands basic medical condition &amp; what factors can influence</td>
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<td>Pt Care Plan</td>
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<td>Med Review: Name &amp; Instruction Reason for use Benefit of med Side Effects &amp; Monitoring Adherence assess Technique review OTC product use</td>
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<td>Lifestyle Review: Exercise, Diet, Smoking</td>
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<td>Support/Follow Up Contacts</td>
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<td>Patient understands transition plan for care in post discharge setting</td>
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<td>Patient perceived barriers to treatment</td>
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Case Management Adherence Guidelines, 2006
ACTION ITEM #1
EXAMINE YOUR HOSPITAL’S CURRENT RATE OF READMISSIONS

- Examine readmit rates by
  - Diagnosis
  - Significant co-morbidities
  - Look for correlations with the patient’s severity of illness and co-morbidities
- Examine rates of high admitting MDs
- Determine if patterns of readmits make sense clinically
• Examine relationship between readmit source (home, nursing home, etc.) and readmit rate
  ■ Determine setting from which most patients are readmitted
Examine the relationship between readmit rates, mortality rates and length of stay

Examine the readmit rates at different timeframes
- 7 Days
- 15 Days
- 30 Days

Shorter timeframes may identify flaws in the discharge plan
Convene staff around these data sets to better understand the reasons for the patterns uncovered and areas for additional study.

Obtain comparative data on your hospital’s readmissions versus similar facilities.
ACTION ITEM #2

IMPROVE COMMUNICATIONS TO THOSE CARING FOR THE PATIENT AFTER DISCHARGE

- Examine whether or not readmitted patients have access to a primary care physician
- Improve timeliness of discharge summaries to referring physicians regarding continuing care and diagnostic testing and results
- Develop standard actions for transitions from hospital to next levels of care including MD office
• Improve the standardization of the discharge process, especially on weekends and off-hours
• Improve the delivery of discharge instructions to patients, especially those who do not speak English or have low literacy rates
• Improve the medication reconciliation process
ACTION ITEM #3
UNDERSTAND AND UTILIZE COMMUNITY RESOURCES

- Be aware of, and advocate for, improvement in patient access to transportation, a PCP / Medical Home, medication, and social services, particularly for the working poor, undocumented and those with limited resources
- Refer patients to community resources such as medical homes, health homes and other venues for coordination of care
ACTION ITEM #4
ADOPT INTERVENTIONS THAT MAY REDUCE READMISSIONS

• Provide post-discharge follow-up phone calls
• Connect patient to PCP if they do not already have one
• Ensure that essential discharge information is transmitted to the next provider of care and caregiver
• Standardize the discharge process, including off-hours and weekends
• Actively engage patients and families to realistically assess discharge potential, participate in discharge planning and achieve successful care continuity when the patient returns home

• Identify end-of-life issues earlier during an in-patient admission and address them prior to discharge, including connecting patients to community end-of-life care services
Connect patients who require complex care to a medical home or other program that can provide support and resources to patients and their caregivers 7 days per week, 24 hours per day.
• Implement ED case management with case managers and social workers who coordinate patients’ return to nursing homes or other post-acute services; identify whether patients need to be admitted and to what level
• Work with local PCPs, nursing homes and other providers to discuss and develop strategies to prevent ‘avoidable’ readmissions and contributing factors (poor communication, infections, end-of-life issues)
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Thanks! Questions???

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