A Project to Reengineer Discharges Reduces 30-Day Hospital Readmission Rates

April 11, 2014
About the QIO Program

Leading rapid, large-scale change in health quality:

- Goals are bolder.
- The patient is at the center.
- All improvers are welcome.
- Everyone teaches and learns.
- Greater value is fostered.
About TMF

TMF Health Quality Institute focuses on improving lives by improving the quality of health care through contracts with federal, state and local governments, as well as private organizations. For nearly 40 years, TMF has helped health care providers and practitioners in a variety of settings improve care for their patients.
Statement of Problem: Readmissions

- Hospitalizations consume 31 percent of the $2 trillion in total health care expenditures in the United States
  - 1 in 4 (25 percent) of hospitalizations are avoidable
  - 1 in 5 (20 percent) of all hospitalizations result in 30-day readmissions
What is an Unplanned Readmission?

- A hospitalization within 30 days of discharge that was not foreseen at discharge
- Unplanned re-hospitalizations are almost always urgent or emergencies
- They often signal failure of the transition from hospital to another source of care
- Most frequent reasons in Texas:
  - Congestive Heart Failure
  - Bacterial Pneumonia
  - Urinary Tract Infection
  - Chronic Obstructive Pulmonary Disease
CMS/QIO Care Transitions Project Goals

- Improve coordination of care
- Reduce 30-day re-hospitalization rates
- Project’s long-term goal:
  - Sustainability of improvement through cross-setting collaboration and hardwiring interventions
TMF’s Role

- Provide technical assistance with
  - Community coalition formation
  - Root cause analyses
  - Intervention selection and implementation plan
  - Measurement
  - Application for participation in a formal Care Transitions Program

- Provide quarterly readmission metrics
CMS/QIO Care Transitions Project Areas
Texas: The Lower Rio Grande Valley Region

- **Providers:**
  - 5 hospitals
  - 3 inpatient rehab facilities
  - 1 LTAC
  - 16 nursing homes
  - 53 home health agencies
  - 7 hospices
  - 12 dialysis facilities
  - physicians
The Harlingen HRR 30-day all-cause readmission rate was 22% (4,273 of 19,783 discharges)

According to data from the Dartmouth Atlas of Health Care, Medicare costs and usage in the Harlingen region had also been ranked among the highest in Texas and the nation in 2005, the most recent data available at the time of the project’s development.

The Harlingen region had the second-highest total costs in the nation; the highest was the McAllen HRR, which borders the Harlingen HRR to the west. For more on the Dartmouth Atlas
Hospital Level Initial Findings

- 23.3% quarterly readmission rate for Medicare FFS patients

<table>
<thead>
<tr>
<th>Region and Provider</th>
<th>Weeks</th>
<th>Discharges with a 30-day Readmit</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Harlingen Region</td>
<td>Week 1</td>
<td>1,555</td>
<td>37.0%</td>
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<tr>
<td></td>
<td>Week 2</td>
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<td>Week 3</td>
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<td>Week 4</td>
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<tr>
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<tr>
<td></td>
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<td>143</td>
<td>23.0%</td>
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<tr>
<td></td>
<td>Week 3</td>
<td>118</td>
<td>19.0%</td>
</tr>
<tr>
<td></td>
<td>Week 4</td>
<td>144</td>
<td>23.2%</td>
</tr>
</tbody>
</table>
Summary of Results

Percent of Hospital Readmission within 30 Days
(quarterly rate)

Based on Medicare FFS claims data. Relative improvement rate 35.6% for subject hospital.
Semi-Annual Readmission Rate per 1,000 Beneficiaries for the Community

• Absolute improvement: 5.7% fewer readmissions per 1,000 beneficiaries
• Relative improvement: 15.3%
Texas Care Transitions Project Results

Total Savings: $11,696,180

- Texas 30% ($3.5 million)
- All other QIOs 70% ($8.2 million)
Key Practices Leading to Results

- Conduct staff interviews and interdisciplinary meetings to discuss the current discharge process and compare with Project RED components, identify barriers and areas for improvement.
- Analyze project data: Facility’s 30-day readmission rate, discharge disposition (i.e., home, SNF, IRF and LTACH) in relation to 30-day readmission rates.
- Evaluate current HCAHPS scores related to the Hospital discharge process.
Key Practices Leading to Results

- Education of medical staff including physicians
  - Medication reconciliation
  - Health literacy and patient safety
- Concurrent data monitoring
- Community-wide partnership with downstream providers
  - Use of EHR to improve hand-off communication
  - Active involvement in Regional Workgroup meetings
It’s a Community Problem
Community-wide Effort

Across All Care Settings

- Interventions promote seamless transitions across care settings, focusing on patients’ discharge from hospitals to other levels of care
- Hospitals, IRFs, HHAs, SNFs, LTAC’s, Dialysis, Hospice, Physicians
- Interventions that target the highest readmission risks
  - By diagnosis
  - By frequency of readmission
RED “Takeoff” Checklist

Eleven mutually reinforcing components:
• Follow-up Appointments
• Outstanding Tests and Studies
• Postdischarge Services
• Patient Education
• Medication Reconciliation
• Dc summary to PCP
• What to do if a problem arises
• Assess patient understanding
• Written discharge plan
• Reconcile Plan with National Guidelines
• Telephone Reinforcement

Adopted by National Quality Forum as one of 30 "Safe Practices" (SP-11)
Implementation

All components of Project RED were implemented and monitored in several phases over time throughout the facility.

- Team approach to administering all eleven components
- Nursing, Care Management, Pharmacy and Core Measures Team all contributed to process
Monitoring for Effectiveness

Patient Discharge Survey

Patient Name/Tracking Number

Admission Date

Discharge Date

Instructions: Please circle your answer to each question below.

1. I was taught about my diagnosis during my hospital stay.
   Yes    No    Don't Know

2. I have follow-up appointments with my physicians.
   Yes    No    Don't Know

3. I have been told about test results or studies that have not been completed before I go home.
   Yes    No    Don't Know

4. If I need home health care, medical equipment or other help or services after I go home it has been arranged.
   Yes    No    Don't Know

5. I understand what to do and who to call if a problem arises after I am home.
On Going Work

- Hospital part of Community-based Care Transitions (CCTP) Project
- Palliative care program to address end-of-life issues
- Coordination of outpatient dialysis needs by an on-site social worker
- A weekly readmission project report to hospital management
- Continuing quarterly workgroup meetings with post–acute care providers
- Screening in the ED by certain skilled nursing facilities and long-term acute care hospitals prior to admission
- Redesign of patient follow-up phone calls to make interventions sustainable
Advice to Others Embarking on this Work

- Develop and foster an internal and external team approach to address readmissions
- Survey patients and obtain their input on the care and education that they are being provided
- Implement interventions and monitor to identify areas for improvement and success
- Collaborate with other providers and stakeholders
Resources

- Texas QIO
  http://TexasQIO.tmf.org

- Project RED
  https://www.bu.edu/fammed/projectred/

- Partnership for Patients
  http://partnershipforpatients.cms.gov/

- Community-based Care Transitions Program
Other Resources


For more information

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