30 Day Readmissions
How Do You Avoid Them?
May 29, 2014
Objectives

• Present Triple Aim and role of readmissions in population health
• Discuss the role of readmissions in Medicare’s Value Based Purchasing
• Identify various tools for determining risk for readmission
• Discuss care management/transition roles and responsibilities related to high risk patients
• Present example of post acute follow up approaches to prevent readmissions
Session Objectives & Goals
Why reduce readmission rates...

Although the readmission rate is often presented as a measure of the performance of hospitals; it is also an indicator of the performance of an integrated health care system.
The Evolution of Hospitals to an Outcome Orientation
IHI’s Triple Aim

Goals

- Population Health
- Disease Management
- Access
- Care Coordination
- Navigation
- Resource Stewardship
- High Value Network

Tools

- Prevention
- Disease Registry Quality Measure
- Clinical Nurse Leaders
- Case Managers
- Disease Managers
- Robust reporting and dashboards

Outcomes

Clinical Outcomes
- Disease specific (Diabetes, Cardio, Resp)
- Preventive care
- Care coordination (all cause readmission, admission for ambulatory sensitive conditions)
- Member experience

Financial Outcomes
- Total medical PMPM

30 Day Readmissions
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Future State

Expense reduction

Decrease unit cost + Decrease utilization

Delivery Efficiency (service/care)

- All care team members practicing at the top of their license
- Streamlined work flow
- Process automation
- Decrease care process variation

Appropriate Utilization (level/type)

- Population health risk management strategies
- Care coordination and navigation
- Decrease variation in diagnosis and treatment

Revenue

Growth

Revenue

- Total population risk and global budget arrangements
- Bundle services and payment for episodes of care or chronic health conditions

... while increasing quality and member experience
# The Evolution of Hospitals

<table>
<thead>
<tr>
<th>Variable</th>
<th>Service-Oriented Organizations</th>
<th>Outcomes-Oriented Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of delivery organization</td>
<td>Aggregate and manage essential resources</td>
<td>Improve outcomes by reliably applying medical science to each patient</td>
</tr>
<tr>
<td>Primary measures</td>
<td>Transactions</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Locus of knowledge</td>
<td>Individual</td>
<td>Team/Organizations</td>
</tr>
<tr>
<td>Clinical perspective</td>
<td>Individual interactions</td>
<td>System design and implementation</td>
</tr>
<tr>
<td>Accountability</td>
<td>Individual</td>
<td>Shared</td>
</tr>
<tr>
<td>Clinician’s skill set</td>
<td>Clinical knowledge and judgment</td>
<td>Leadership</td>
</tr>
</tbody>
</table>

Hospital readmissions are common and costly.
Studies estimate a 30 day readmission rate in the US at 18%.
Among Medicare beneficiaries the estimated cost is $17B annually.

### Disease

<table>
<thead>
<tr>
<th>Disease</th>
<th>National Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>17.6%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>23.0%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>18.3%</td>
</tr>
<tr>
<td>Hip/Knee</td>
<td>5.4%</td>
</tr>
<tr>
<td>All Cause</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

Data: Medicare.Gov
Community Factors Effecting Readmission

Health Research and Educational Trust reports:

• Community factors, such as socioeconomic status, physician mix and nursing home quality, may affect hospital readmission rates more than previously thought

• Yale University School of Medicine in New Haven, Conn., found that these factors explain nearly half of the 60 percent of variation in hospital pooled 30-day readmission rates involving acute myocardial infarction, heart failure and pneumonia

• The results indicate that hospitals may be better able to reduce their readmission rates if they add community-based readmission reduction strategies to their ongoing improvement efforts, researchers said.
Medicare, Value Based Purchasing and Readmissions
Readmissions Adjustment for 2014

• CMS adjusted FFY 2014 IPPS payments to account for excess hospital readmissions under the Readmissions Reduction Program.

• The FFY 2014 program is limited to measuring excess readmissions for heart attack (AMI), heart failure (HF), and pneumonia (PN) patients.

• CMS adopted its proposal to modify the calculation of readmission rates for FFY 2014 and beyond to better account for planned readmissions.
  – To calculate the excess readmissions for FFY 2014, CMS will evaluate Medicare inpatient FFS claims from a 3-year data analyzed under the current year program.

• Readmissions Reduction Program is not budget neutral.
Readmission Adjustment Factor

- Unlike the VBP program, the Readmissions Reduction Program is not budget neutral.
  - Hospital-specific payment penalties are up to 2.0% (1% in 2013)
  - Capped reduction amount will increase to 3.0% next year
- FY 2014 program will cut about $227 million from the IPPS.
Readmission Adjustment Factor

• As with VBP, the readmission factor will be applied to base DRG operating amounts.

• Based on final readjustment factors:
  - 34% of hospitals have a factor of 1.0 and see no payment changes.
  - 1% of hospitals have a factor of 0.9800 and will be subject to the maximum penalty of 2%.
  - 65% have a factor between 0.9800 and 1.0 and will see some level of decrease in payments.
Readmission Measure Exclusions

• The NQF endorsed readmission measures to be excluded from the group of index admissions:
  - Hospitalizations for patients with an in-hospital death.
  - Hospitalizations for patients without at least 30 days post discharge enrollment in Medicare FFS.
  - Hospitalizations for patients discharged against medical advice.
  - Transfer
  - Multiple admission within 30 days of a prior index admission.
Proposed Readmission Measures for 2015

2014 Measures +

• Chronic Obstructive Pulmonary Disease (COPD)
• Total Hip Arthroplasty
• Total Knee Arthroplasty

In 2017, CMS will add:

• Coronary Artery Bypass Graft (CABG)
Identifying Risk for Readmission
Modeling techniques such as decision trees are able to predict readmissions with high accuracy

Segment Coding
- Readmission rate of more than 30%
- Readmission rate between 25 and 30%
- Readmission rate of less than 25%

All Patients
  Readmission Rate 24%

Had Chest Pain
  Readmission Rate 30%

Did Not Have Chest Pain
  Readmission Rate 22%

Had Chronic Pulmonary Disorder
  Readmission Rate 29%

Did Not Have Chronic Pulmonary Disorder
  Readmission Rate 21%

Age More than 50 Years
  Readmission Rate 33%

Age Less Than 50 Years
  Readmission Rate 27%

Had Peripheral Vascular Disease
  Readmission Rate 31%

Did Not Have Peripheral Vascular Disease
  Readmission Rate 21%
Each Patient Falls Into One of the “Nodes” With a Readmission Risk

- **Readmission:** 3,398 (12.1%)
- **Population:** 28,059 (100%)

Does the patient have any previous admissions? Readmission: 3,398 (12.1%)
Population: 28,059 (100%)

- **Readmission:** 312 (15.6%)
- **Population:** 1,995 (7%)

Does the patient have any diagnosis related to kidney/urinary tract? Readmission: 949 (29.4%)
Population: 3,229 (12%)

- **Readmission:** 76 (9.5%)
- **Population:** 804 (3%)

Does the patient have any diagnosis related to mental disease and disorders? Readmission: 111 (11.2%)
Population: 995 (4%)

- **Readmission:** 288 (7.6%)
- **Population:** 3,792 (14%)

Is the patient admitted as an emergency case? Readmission: 534 (5.2%)
Population: 10,172 (36%)

- **Readmission:** 121 (18%)
- **Population:** 674 (2%)

Does the patient have any diagnosis related to respiratory system? Readmission: 562 (16.1%)
Population: 3,491 (12%)

- **Readmission:** 140 (10.2%)
- **Population:** 1,370 (5%)

Does the patient have any diagnosis related to kidney/urinary tract? Readmission: 562 (16.1%)
Population: 3,491 (12%)

- **Readmission:** 6 (9)
- **Population:** 5 (2%)

Is the patient older than 74 years? Readmission: 288 (7.6%)
Population: 3,792 (14%)

- **Readmission:** 6 (9)
- **Population:** 5 (2%)

Does the patient have any diagnosis related to mental disease and disorders? Readmission: 140 (10.2%)
Population: 1,370 (5%)

- **Readmission:** 121 (18%)
- **Population:** 674 (2%)

- **Readmission:** 562 (16.1%)
- **Population:** 3,491 (12%)

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- **Readmission:** 534 (5.2%)
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Does the patient have any previous admissions? Readmission: 3,398 (12.1%)
Population: 28,059 (100%)

- **Readmission:** 949 (29.4%)
- **Population:** 3,229 (12%)

Does the patient have at least 2 previous admissions? Readmission: 949 (29.4%)
Population: 3,229 (12%)

- **Readmission:** 305 (19.8%)
- **Population:** 1,538 (5%)

Does the patient have any diagnosis related to kidney/urinary tract? Readmission: 949 (29.4%)
Population: 3,229 (12%)

- **Readmission:** 305 (19.8%)
- **Population:** 1,538 (5%)

Is the patient’s condition medical or surgical? Readmission: 312 (15.6%)
Population: 1,995 (7%)

- **Readmission:** 312 (15.6%)
- **Population:** 1,995 (7%)

Surgical

- **Readmission:** 76 (9.5%)
- **Population:** 804 (3%)

60 Day Readmissions

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Brigham and Women’s Study of Factors Predicting Readmission in Medical Patients

Of those patient characteristics—such as age and whether the patient required a caretaker—the researchers identified the seven that best predicted which patients would be readmitted, including:

1. Number of admissions within the prior year;
2. Length of hospital stay;
3. Sodium levels at discharge;
4. Number of procedures during first admission;
5. Whether the patient was discharged from the oncology department;
6. Hemoglobin levels at discharge; and
7. Whether the admission was elective or non-elective.
## Modified Lace Tool

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Value</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS</td>
<td>Less than 1 Day</td>
<td>0</td>
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<tr>
<td></td>
<td>1 Day</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Days</td>
<td>2</td>
<td></td>
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<tr>
<td></td>
<td>3 Days</td>
<td>3</td>
<td></td>
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<tr>
<td></td>
<td>4-6 Days</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7-13 Days</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14 Days or More</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Acute Admission</td>
<td>Inpatient</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Comorbidity (cumulative to a maximum of 6 points)</td>
<td>No prior history</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DM no complications, Cerebrovascular disease, Hx of MI, PVD</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, Lymphoma, any tumor, moderate to severe renal disease</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dementia or connective tissue disease</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate or severe liver disease or HIV infection</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metastatic Cancer</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Emergency room visits during the previous 6 months</td>
<td>0 visit</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 visit</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 visits</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 visits</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 visits</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Take the sum of the points and enter the total. If score is 10 or greater, patient is considered at high risk.
Approaches to Readmission Assessments
Readmission Assessment
Identification of a Readmitted Patient

- Nursing Assessment may include a question related to most recent admission in any hospital or visit to emergency room
- With an electronic health record a bold R may be used to flag for readmission in the last 30 days
  - May print on census sheets/worksheets/reports
  - Noted on a header
  - If working in a system with shared records, can be programed to show any admission within the system
# Readmission Assessment – Sample Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted Patients Interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1</strong> Patient Account Number:</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> Days between last DC and readmission?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was a follow up physician appointment made prior to previous hospitalization discharge?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>If no, did you have any trouble making a follow up appointment?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Have you seen the doctor since the first hospitalization?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> Was home health care ordered after index hospitalization?</td>
<td></td>
<td>Drop down box</td>
</tr>
<tr>
<td><strong>4</strong> Was home health care ordered after index hospitalization?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4a</strong> If yes, what company?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4b</strong> If yes, when did they make their first visit?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5</strong> Did you go to another facility after discharge from the previous hospitalization?</td>
<td>Y/N</td>
<td>Drop down box SNF, LTACH, LTC, Rehab Hospital</td>
</tr>
<tr>
<td><strong>6</strong> Did the pt recall having discharge instructions from the previous hospitalization?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>6a</strong> Did anyone else in your family receive instructions?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>7</strong> Did the pt follow a low sodium diet?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>8</strong> Do you weigh yourself daily?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>9</strong> Did you fill all your prescriptions from the previous hospitalization?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>9a</strong> Did you take all your medications routinely?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>9b</strong> Did you set up your medications each day?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>9c</strong> How do you remember to take your medications?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you make any visits to an Emergency Dept or Urgent Care since the last admission?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>10</strong> Did any social conditions contribute to the readmission?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>11</strong> Transportation?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>11b</strong> Money for medication or physician visits?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>11c</strong> Housing?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>12</strong> Do you live alone?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>13</strong> Is there anyone at home that you take care of?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>12a</strong> Does anyone help take care of you?</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td><strong>14</strong> How do you think you became sick enough to come back to the hospital? (CHF Dx)</td>
<td>Drop down box</td>
<td></td>
</tr>
<tr>
<td>How do you think you became sick enough to come back to the hospital? (non CHF Dx)</td>
<td>Drop down box</td>
<td></td>
</tr>
</tbody>
</table>

30 Day Readmissions

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May 2014
### Readmission Assessment - Decision Tree Screen Shot

#### Readmission Questions:

- **Days between last DC and readmission**: 
  - Yes
  - No
  - PCP
  - Specialist
  - Urgent Care
  - Other care...

- **Where were they before the last hospitalization?**
  - To come to the ER
  - To make an appointment with office
  - Did not visit at all
  - Did not get a call back
  - Could not get to office during office hours
  - Referred to another physician
  - Other

- **Did you use the resources that were provided for you at discharge?**
  - Yes
  - No
  - SF
  - LTACH/LTC
  - Home care
  - Hospice
  - Ed

- **Preferred Language**:
  - English
  - French
  - Spanish
  - German
  - Dutch
  - Flemish
  - Swedish
  - Norwegian
  - Greek
  - Italian
  - Hebrew

- **Did the you follow the recommended/prescribed diet?**
  - Yes
  - No

- **Have you fallen since your previous hospitalization?**
  - Yes
  - No

- **Where/How did you fall?**
  - Other...

- **Medications**:
  - Did your caregiver fill all your prescriptions?
  - Did you take all your medications routinely?
  - Did you use newly prescribed medicines immediately after discharge?
  - Did you continue to use old medicine regimen?
  - Did your caregiver set up your medications each day?
  - How do you remember to take your medications? (pillbox, medication box, checklist, caregiver, setting alarm, other care team...)

- **Social/Living**:
  - Did any social conditions/situations contribute to your readmission?
  - Housing
  - Transportation
  - Money for medication/physician visits
  - Other (use comments)

- **Do you live alone?**
  - Yes
  - No

- **Who lives with you?**
  - Grandparent(s)
  - Other relative(s)
  - Parent(s)
  - Sibling(s)
  - Significant other

- **Does anyone else take care of you?**
  - Yes
  - No

- **How much time (hours) does your caregiver devote per day to you?**
  - Greater than 4 hours
  - Greater than 8 hours

### Readmission Status:

- Complete
- Unable to obtain all this info
- In progress
- Not applicable for this readmission

### Information Source:

- Patient
- Family member
- Significant other
- Other (use comments)

### Follow-up Care Needs:

- No needs identified at...
  - Medications
  - Transportation
  - DME/Supplies
  - Financial
  - Mental...
Readmission Assessment
Triggers for Interdisciplinary Referrals

When a patient answers a specific question as “yes” or “no”, the Nurse should remember to make a referral to the identified interdisciplinary team:

<table>
<thead>
<tr>
<th>Question</th>
<th>Interdisciplinary Team Needing Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you follow the recommended/prescribed diet? <em>(If no)</em></td>
<td>• Nutrition</td>
</tr>
<tr>
<td>Have you fallen since your previous hospitalization? <em>(If yes)</em></td>
<td>• Physical Therapy</td>
</tr>
<tr>
<td>Did you make your medication routinely? <em>(If no)</em></td>
<td>• Bedside Nurse – <em>education</em></td>
</tr>
<tr>
<td></td>
<td>• Attending Physician – <em>side effects</em></td>
</tr>
<tr>
<td></td>
<td>• Pharmacy – <em>side effects</em></td>
</tr>
<tr>
<td></td>
<td>o MD consults</td>
</tr>
<tr>
<td></td>
<td>• Care Management – <em>financial</em></td>
</tr>
<tr>
<td>Did any social conditions / living situations contribute to your readmission? <em>(If yes)</em></td>
<td>• Care Management or Social Work</td>
</tr>
</tbody>
</table>
Approaches to Reduce Readmissions
“Success in reducing readmissions lies in effectively partnering to not only achieve better outcomes but also to reduce the fragmentation and lack of support that so often comes with transitions between providers and care settings.”

- Amy Berman, Program Officer, The John A. Hartford Foundation
Focus on Transition Rather Than Discharge

Hospitals should:

• Make sure patients and caregivers understand their medications—and other care instructions—at the time of discharge;
• Follow up with a phone call or visit to patients to make sure their questions are answered
• Establish partnerships among all providers involved in a patient's care, in order to improve handoffs and share information
• Discharge patients to settings that can provide the care they need
• Schedule follow-up visits with their physicians
• Evaluate the patient's end-of-life care wishes
### Strategies to Reduce Avoidable Readmissions

**During Hospitalization**
- Risk screen patients and tailor care
- Establish communication with primary care physician (PCP), family, and home care
- Use teach-back to educate patient/caregiver about diagnosis and care
- Use interdisciplinary/multi-disciplinary clinical team
- Coordinate patient care across multidisciplinary care team
- Discuss end-of-life treatment wishes

**At Discharge**
- Implement comprehensive discharge planning
- Educate patient/caregiver using — teach-back
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners

**Post Discharge**
- Promote patient self management
- Conduct patient home visit
- Follow up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care

30 Day Readmissions
PwC

May 2014
## Readmission Bundles

<table>
<thead>
<tr>
<th>Condition</th>
<th>Follow up phone call (24, 48 or 72 hours)</th>
<th>PCP or clinic appt within 3 to 7 days</th>
<th>Surgeon appt within 14 days or as ordered</th>
<th>Transportation arrangements</th>
<th>Ongoing Home Health visits (PT, wound care, Home Health visits, etc.)</th>
<th>DME (specify supplies and equipment)</th>
<th>Medication needs (reconciliation, charity)</th>
<th>Community resources</th>
<th>Safety Net referrals</th>
<th>Acute Rehab</th>
<th>Skilled Nursing Facility</th>
<th>Long Term Acute Care</th>
<th>Hospice</th>
<th>Outpatient Therapy</th>
<th>Cardiac Rehab</th>
<th>Payor Case Manager</th>
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</thead>
<tbody>
<tr>
<td>COPD</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Hips &amp; Knees</td>
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**Telephonic Follow up Questions**

1. Are you feeling as expected?
2. Did you get your medications filled?
   - If answer no, how may I assist you?
3. Did you have any questions about your medications and their side effects? Are you experiencing issues?
4. When is your follow-up appointment? How are you getting there?
   - Suggestion – If appointment has taken place, how did it go?
5. Do you know what symptoms would require you to see your PCP or return to the hospital?
   - Suggestion – Review red flags and escalate to the PCP
6. Discuss any “Red Flag” responses related to (DM, COPD, HF, Med Rec, PCP Appointment, Post-Discharge Support, Other)
5. Is there anything else I can help you with today?
**Re-engineered Discharge Program (Project Red)**

- The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components and has been proven to reduce re-hospitalizations and yields high rates of patient satisfaction.

- One hospital reduced their readmission of patients with CHF from 50% to 9% in 6 months.

- Some components include:
  - Providing telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.
  - Give the patient a written discharge plan at the time of discharge that is easily read, understood and in a 14 font.
  - Making appointments for clinician follow-up and post discharge testing.
  - Review appropriate steps for what to do if a problem arises.
Nurse Led Clinics

- Nurse Practitioner led clinics provide free assistance to patients to reduce hospitalizations and readmissions, save money and keep patients healthy.

- Nurses provide basic but unmet needs:
  - Education – understanding their health condition.
  - Medication reconciliation and how to take meds properly.
  - Help patients monitor their conditions.
  - Help patients utilize medication and other assistance programs and resources.

- A pilot version of such a program reduced readmissions for their population to 7.5% (from 22.5%).
Case Management & Use of Technology

- By using a variety of technological advances, case managers in a variety of settings are working smarter and setting priorities for interventions based on feedback they get from remote monitoring of patients.
- Patient’s at Geisinger Clinic’ medical homes receive a combination of traditional case management and remote monitoring are 44% less likely to be readmitted to the hospital within 30 days.
- Billings Clinic monitors its remote heart failure patients using a telephone response system that makes daily calls to patients. When patients’ responses indicate clinical variances, nurses call and adjust the diuretics or electrolytes using a protocol developed by the cardiology department.
- Bayada Home Health Nurses have the option to use a telephone response system or home monitoring equipment to monitor at-risk patients in between visits.
Other Options

- Transition Housecalls – use of a Nurse Practitioner to visit the patient in their home 3-5 post discharge.
- Payor Disease Management Programs
- Hospitalists Clinics
- Physician practice case managers
- Disease specific clinics
- County resources such as Paramedic visits
The biggest problem in communication is the illusion that it has taken place.

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