Focus on Quality

heart.org/quality
Readmissions and Heart Failure

Jane Brock, MD, MSPH
Colorado Foundation for Medical Care
April 23, 2013

This material was prepared by CFMC (PM-4010-118 CO 2013), the Medicare Quality Improvement Organization for Colorado under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
The hottest topic in healthcare reform

Medicare To Penalize 2,211 Hospitals For Excess Readmissions

- 19.6% readmitted in 30d
- $17.4 Billion (2004)

Hospital readmissions ≠ Transitional care

BUT..

Gaps in transitional care = Higher readmissions

Evidence based on reduction of unwanted readmissions
Continuity of Care Errors

- 366 patients discharged from the hospital with a follow-up appointment with their PCP within 2 months

- Medication Continuity Error 42%
- Test follow-up Error 8% (41%)
- Work-up Error 12% (22%)

Compliance with Medication

- Used at least one med not ordered: 64%
- Failed to use at least one med ordered: 73%

Of all drugs ordered at discharge, 32% not taken at all.

19% Experience an ‘Adverse Event’

Forster et al. The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital
## Elements of Discharge and Readmissions

<table>
<thead>
<tr>
<th>Discharge component</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Various elements of discharge documentation</td>
<td>None Significant</td>
</tr>
<tr>
<td>Presence of family documented during DC teaching</td>
<td>.60 (.36-1.01)</td>
</tr>
<tr>
<td>Discharge summary available within 7 days</td>
<td>1.00 (.99-1.00)</td>
</tr>
<tr>
<td>F/U appt made by hospital personnel prior to DC</td>
<td>1.21 (1.05-1.37)</td>
</tr>
<tr>
<td>Number of medications in discharge documentation</td>
<td>1.02 (1.01-1.04)</td>
</tr>
</tbody>
</table>

The Role of Discharge Planning

Standardized electronic discharge instructions with embedded computerized medication reconciliation*

• Readmission/ED visit 30 days  No effect
• Readmission within 30 days  OR = 1.08 (1.01-1.16)

No correlation between hospital performance on discharge planning measures and readmissions ¥

Predicting Who’s Coming Back

Risk prediction – Kansagara et al. *JAMA* 306(15), 2011

- 26 validated models
- Potentially useful for clinical discrimination = 13
- Discriminative ability poor – moderate
- Best performers included SES, MH, substance abuse, and functional status
- LACE – easy to apply, $c=0.68^*$
- CHF risk prediction, $c = 0.72$, includes SES, MH, SA$^\wedge$


Disparities SES and Readmissions

Heart Failure

- Black Medicare patients’ readmissions higher (RR=1.09, 106-1.13) than white patients*
- Income significantly associated with readmission in heart failure (adjusted odds ratio for quartile 1:4 comparison, 1.18; 95% confidence interval, 1.10 to 1.26, p <0.0001).**


What Patients Think

- 1) symptom focused (rather than diagnoses based)
- 2) readmission was unavoidable, often due to the inexorable progression of HF
- 3) self-blaming for behaviors related to self care
- 4) health care system failures, including premature discharge from index hospitalization.

Patients gave multi-dimensional reasons

Clinician charting often did not list the same reasons

Summary of what we know...

- Readmissions are prevalent and costly
- Adverse events associated with hospital discharge are common
  - And about ¼ of them are readmissions
- Patients are not taking ideal med regimens
- Not f/u on meds, tests and workups is common
  - And not f/u on workups causes real problems..
- Real room for improving hospital-receiver communication
  - But value of PCP f/u unclear – probably varies
  - Might not be as powerful as hospitalist f/u
- Creating the perfect in-house discharge process probably won’t make enough difference
- SES is probably related to readmission risk
  - But the CMS measures do not adjust for it
- Ideal risk identification strategies are unavailable..
- Clinicians often have a different perspective on what led to the readmission than patients do
But most importantly...

- Context is everything

\[ M + C = O \]
The Care Transitions Theme, 2008

FFS Medicare beneficiaries living in zip codes of interest

Target Population

FFS beneficiaries discharged from hospitals of interest

795,157
We started with hospitals...
What did the QIOs actually DO?
Building a Community Initiative

The Role of community-based non-medical support increasingly apparent

I think it’s an elephant!
Re-hospitalization, Intervention vs. Comparison

-5.7% (p<.001)
-2.1% (p=.08)
P=.03 (difference)
Why are people readmitted?

Provider-Patient interface

Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

Unreliable system support

Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals
Interventions

Develop care plans
   include pt/family preferences
   include non-medical needs
Do quality discharge teaching
Give pts a reconciled med list
GIVE THEM MEDS
Make clear requirements for f/u care
Consider early home support

Support capacity for self management
   access to meds
   medication self-administration
   capability to f/u (transportation)
   self-management confidence
Support expression of preferences
Consider early home support
Interventions

Design cross-setting processes with your ‘downstream’ partners.. which includes non-medical home services

- Develop care plans include pt/family preferences include non-medical needs
- Do quality discharge teaching
- Give pts a reconciled med list
- Make clear requirements for f/u care
- Consider early home support
- Support capacity for self management
- GIVE THEM MEDS
- Make clear requirements for f/u care
- Capability to f/u (transportation)
- Self-management confidence
- Support expression of preferences
- Consider early home support
Most used Interventions

• Hospital discharge standardization protocols
  – RED/BOOST
  – Insufficient by themselves

• The Care Transitions Intervention
  – Activated patients cover a multitude of mistakes

• The Transitional Care Nursing Model
  – Proven in HF patients with high co-morbidity
  – An alternative medical care model

• INTERACT
  – Standardize communication and expectations between hospitals and nursing facilities; 68% transfers avoidable
Blah<br>blah<br>blah<br>,

Any questions?

No I’m good to go. Whatever you say is what we’ll do Doctor

What’s he saying? I sure hope my wife is getting this..

1. Patient activation trumps all
The Care Transitions Intervention
www.caretransitions.org

5 patient visits with a coach
30-50% reduction in readmissions
The CMS Discharge Planning Checklist

http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf
2. Last Phase of Life Perspective is Important

What do we mean by ‘chronic disease?’

Chronic disease treatment is inseparable from end of life care...
Organ System Failure (mostly heart and lung failure)

- Begin to use hospital often, self-care becomes difficult
- ~ 2-5 years, but death usually seems “sudden”
HF is important, but..

- Almost 50% of all HF readmissions are for a co-morbid disease
- HF readmissions reductions strategies do not always reduce readmissions from patients originally discharged with HF
- < 10% of all readmissions are related to HF*

Heart Failure specific models

- From the recent ACC scientific sessions
First check your coding...

12,851 patients admitted for HF and 2657 (20%) were readmitted.

50 patients readmitted with heart failure:
- 20/50 correctly diagnosed with HF on first admission
- 8 of those 20 correctly diagnosed with HF on readmission (40%)

http://circoutcomes.ahajournals.org/cgi/content/meeting_abstract/5/3_MeetingAbstracts2012/A117?sid=9188667f-0665-4983-9f56-77d538890edf
Multi-pronged Approach at University of Illinois

1. Improved nursing discharge education (sodium restricted diet, medication adherence, daily weight)
2. Detailed medication list given to patients
3. Scheduled f/u within 2 weeks with an APN heart failure specialist
4. Medications supplied prior to discharge
5. Follow-up phone call by APN 7-10 days after discharge
6. Additional billing dept review of patient records to ensure appropriate coding of HF admissions

Impact on 30-day readmissions:

27.1% to 18.2% (p = 0.000)

http://circoutcomes.ahajournals.org/cgi/content/meeting_abstract/5/3_MeetingAbstracts2012/A71?sid=db95f10c-719d-4ee6-8b6c-6d4143cd6831
Daily multidisciplinary rounds

- Ensure compliance with the established HQA Performance Measures
- Initiate appropriate discharge planning
- Assess functional status.

Scheduled f/u appointments with PCP or cardiologist

Medication and home management instructions at discharge

Phone call to PCP and next setting of care

Targeted in-home support following discharge

- High risk patients with f/u home visit by VNA and pharmacist
Resource from Connecticut

www.hearttalk.org

Recommended by The European Society of Cardiologists!

• Teaching your patients to live with Heart Failure
  • For clinicians
  • Includes conversations on palliative care/hospice
• Helping your patients to live with Heart Failure
  • for nursing assistants
• Living with Heart Failure
  • For patients and families
Key easy strategies...

- Know where your readmissions come from and schedule a meeting/form a team
- Get to know your social services agencies
- Ask your QIO for data..
- Join community based initiatives
- Examine DC teaching practices
  - Coach discharges
  - Elicit goals
- Train in end-of-life conversations
- f/u after ED visits
It’s clear that somebody has to do something and it’s incredibly pathetic that it has to be us”

Jerry Garcia