Readmissions

Leonard Hock, DO, MACOI, CMD, FAAHPM, HMDC

Goals and Objectives

- Become conversant in the language of Avoidable Readmissions.
- Understand and be able to use knowledge gained here to contribute to reducing Avoidable Readmissions.
- Know that you can make the difference in your hospitals to reduce readmissions.
- Support “What is important” to our patients.
- And maybe lobby America Samoa.

Readmissions are Expensive

- Total CMS spend in 2017 was $706 billion.
- Medicare A, B, C and D

- Readmissions conservative estimate was $17 billion.

- 5% of Medicare recipients spend 50% of dollars. Where?

Readmissions

- Hospital Readmission Reduction started 2012
- 1.5% penalty for AMI, CHF and pneumonia
- CMS contracted with vendors to reduce readmissions
- Health Service Advisory Group in Florida
- County and regional “Coalitions” across the state

How does Florida rate?

- 52 states and territories ranked for readmissions
- Florida is now 51, at the bottom.
- Florida average 30 day readmission rate is 18.9%
- Almost every Florida hospital is receiving a penalty
- Penalty now 3% for AMI, COPD, CHF, CABG, Pneumonia and Total hip and knee procedures.
- Penalty expected to increase and include all diagnosis.

Avoidable Readmissions

- Cultural belief that readmissions are due to some fault that can be corrected.
- Even in serious conditions, health can be improved and stabilized with perfect care.
- What are the faults?
- What would perfect care look like?

Avoiding Avoidable Readmissions

- Communications, handoffs.
  - Physician to physician discussion of the case.
  - Facility to facility patient reports.
  - Transfer forms, discharge summaries that are complete.
- Medication reconciliation.
  - Chain of custody of Rx
  - Medication review at each care setting.
- Post acute visits.
  - Monitoring and labs

The Brightest of the Bright

- Identify the root cause of potential readmission for each pt.
- Optimize transitions of care.
- Improve patient engagement and education.

So Where is Florida Now?

- 51 of 51
- At the bottom

- Why?

The Readmissions Problem Is…

- Physician to physician communication doesn’t happen
- Facility to facility reports are inadequate and inconsistent
- The transfer forms are incomplete or non existent
- Medications are a mess
- The root cause, if known, is rarely addressed
- Patient education is often a template computer form

L.A.C.E. Scoring for Readmissions

- L. Length of stay in current or last hospitalization
- A. Acuity. Was admission through ER or elective
- C. Complexities or comorbidities. The more the murkier.
- E. Number of ER visits in recent months. The more the worser.

C.A.R.I.N.G. Criteria in the ER*

- Cancer, stage IV
- Admissions, more than two in past year
- Resident of a nursing home
- ICU stay in recent past, multiorgan failure
- Non cancer diagnosis, already in hospice care
- Guidelines
- *Predictors of life limiting conditions

Perfect Care After Hospital Admission

- Has not been achievable
- Would not make a difference for life limiting prognosis

- So, what can be done to reduce avoidable readmissions?

And The Answer Is…

- Continue to strive for perfection
- Communication
- Follow up
- Care
- The right medications at the right time for the right reason
- Ask the patient what they want

Ask the Patient What They Want

- What do you think of your condition?
- After all that you have been through, what is most important to you today?
- Where would you want to be, hospital or home?
- Who would you want to be with you, intensivist or family?
- Would you want medical care to relieve discomfort?

How to Ask Them

- Sit down
- Ask don’t tell
- How do you feel about your situation?
- What is important to you?
- What kind of care do you want for the rest of your life?
- Listen
- Listen

Asking Them Works

- Asking patients what they want reduces readmissions
- An APRN, previously ARNP, study reduced readmissions
- Down to 3.8%

- What if they are cognitively compromised and can't answer?
- Principle of substituted judgement.

Florida's Future Ranking

- Maybe American Samoa will drop out

- Or perhaps we can do a better.
- Improved communication and transitions of care.
- Asking the patients what they want.

Thank you

Leonard Hock, DO
561 714-1531

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