No Financial Disclosures to report.
Gerald & William
Readmissions

• What are they?

• Why are they important?

• What can we do about them?
Hospital Readmission Reduction Program

- FY 2012: Three diagnoses: PNA, AMI, CHF
- FY 2015: Expansion to COPD, THA/TKA
- FY 2017: CABG
- FY 2019: Peer Quintiles per proportion of dual-eligible patients.
How much do hospitals lose?

- If above expected readmission rate,
- 1% reduction for FY 2013
- 2% reduction for FY 2014
- 3% maximum payment reduction, FY 2015

- Raters and Rankers, Reputation  Pride!
• Data from 3 years ago penalizes you today.

• FY 2019 (begins October 1, 2018) adjusts Medicare payment to hospitals according to July 1, 2014 - June 30, 2017 performance.
The Ultimate Team Effort—What we can Do

- Inpatient, Pre-Discharge
- Outpatient, Post-Discharge
- Bridge/Transition work
Readmissions Strategy

Care Paths
Hospital / Institute-specific

“Core 4 Plus”
1. Pharmacy Med Reconciliation
2. Transitional Care Coordination
3. House Calls
4. 5 Day Follow Up

“Core Four”
1. Admission Med Rec in 24H
2. Discharge Med Rec
3. Discharge Summary in 48H
4. Follow Up Appointment

Local Efforts

High Risk Populations

Safe Transitions
ALL PATIENTS
What We Can Do About Readmissions

• Utilize Checklists
What We Can Do About Readmissions

• Utilize Checklists
  - Identify what’s most important to the Transition
    • Admission Medication Reconciliation
    • Discharge Medication Reconciliation
    • Follow up Appointment Scheduling
    • Discharge Summary Completion
Readmission Rate - Medical DRGs
Cleveland Clinic Enterprise Discharges (Jan-Sep 2017) n=73059

Core 4 Complete (n=30344) - 14.3%
Core 4 Incomplete (n=42715) - 15.8%
p<0.0001
What We Can Do About Readmissions

- Utilize Checklists
- Focus on High Risk Patients
Risk Stratification Tools

- LACE
  - Length of Stay
  - Acuity (Admission through ED)
  - Comorbidities
  - ED Visits within 6 months
# HOSPITAL Score

Determine risk of avoidable hospital readmission

<table>
<thead>
<tr>
<th>Decision</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hemoglobin &lt;12 g/dL or 120 g/L at discharge?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge from an Oncology service?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium &lt;135 mEq/L at discharge?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Procedure performed during hospital stay?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Index admission type?</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent or emergent</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
</tr>
</tbody>
</table>
Risk Stratification Tools

• LACE Index Tool (online)
• HOSPITAL score (online)
  - Hg <12
  - DC from Oncology service
  - Sodium <135 meQ/L at DC
  - Having a Procedure during the stay
  - Index Admission Type (non elective)
  - # Hospital Admissions during a year
  - Length of Stay >/ 5 days.
Risk Stratification Tools

• LACE Index Tool (online)
• HOSPITAL score (online)
• 8 Ps (Society of Hospital Medicine)
• Cleveland Clinic Readmission Risk Score
• SNF Prognosis Score (JAGS March 2018)
• Plus more
# Readmission Risk Factors

<table>
<thead>
<tr>
<th>Labs</th>
<th>Meds</th>
<th>Utilization</th>
<th>Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium</td>
<td># of Med Classes</td>
<td>Insurance</td>
<td>CKD</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>Anticoagulants</td>
<td># ED Visits</td>
<td>COPD</td>
</tr>
<tr>
<td>BUN</td>
<td></td>
<td></td>
<td>Delirium</td>
</tr>
<tr>
<td>Albumin</td>
<td></td>
<td></td>
<td>Drug Abuse</td>
</tr>
</tbody>
</table>

- Labs
  - Sodium
  - Hemoglobin
  - BUN
  - Albumin

- Comorbidities
  - CKD
  - COPD
  - Delirium
  - Drug Abuse

- Medications
  - # of Med Classes
  - Anticoagulants

- Utilization
  - Insurance
  - # ED Visits
What We Can Do About Readmissions

• Utilize Checklists
• Focus on High Risk Patients
• Meet Patients Where They Are… Literally
High Risk = Higher Support

- Paramedicine
- CNP
- Transitional Care Pharmacy
- Primary Care Outreach with Care Coordinators/ Navigators/ Advocates
Paramedicine

CNP to Home
Transitional Care Pharmacists
High Risk = Higher Support

- Paramedicine
- CNP
- Transitional Care Pharmacy
- Primary Care Outreach with Care Coordinators/ Navigators/ Advocates
Transitional Care Coordination & Readmission Rates
High Risk Patient Discharges (Apr-Oct 2017)
What We Can Do About Readmissions

• Utilize Checklists
• Focus on High Risk Patients
• Meet Patients Where They Are... Literally
• Engage the Patient
What We Can Do About Readmissions

• Utilize Checklists
• Focus on High Risk Patients
• Meet Patients Where They Are… Literally
• Engage the Patient
  - Effectiveness of Teachback
  - Written Plan
<table>
<thead>
<tr>
<th>I was in the hospital because</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I have the following problems ...</td>
</tr>
<tr>
<td>1. ____________________________</td>
</tr>
<tr>
<td>2. ____________________________</td>
</tr>
<tr>
<td>3. ____________________________</td>
</tr>
<tr>
<td>4. ____________________________</td>
</tr>
<tr>
<td>5. ____________________________</td>
</tr>
<tr>
<td>Important contact information:</td>
</tr>
<tr>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td>2. My hospital doctor:</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td>3. My visiting nurse:</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td>4. My pharmacy: ______________</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td>5. Other: ____________________</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My appointments:</th>
<th>Tests and issues I need to talk with my doctor(s) about at my clinic visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On: /____ at <strong>:</strong>_ am/pm For:</td>
<td>1. ____________________________________________________________________</td>
</tr>
<tr>
<td>For: ____________________________</td>
<td>2. ____________________________________________________________________</td>
</tr>
<tr>
<td>2. On: /____ at <strong>:</strong>_ am/pm For:</td>
<td>3. ____________________________________________________________________</td>
</tr>
<tr>
<td>For: ____________________________</td>
<td>4. ____________________________________________________________________</td>
</tr>
<tr>
<td>3. On: /____ at <strong>:</strong>_ am/pm For:</td>
<td>5. ____________________________________________________________________</td>
</tr>
<tr>
<td>For: ____________________________</td>
<td></td>
</tr>
<tr>
<td>4. On: /____ at <strong>:</strong>_ am/pm For:</td>
<td>1. ____________________________________________________________________</td>
</tr>
<tr>
<td>For: ____________________________</td>
<td>2. ____________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>3. ____________________________________________________________________</td>
</tr>
</tbody>
</table>

I understand my treatment plan. I feel able and willing to participate actively in my care:

Patient/Caregiver Signature ____________________________

Provider Signature ____________________________

Date /____ /____
Real-Time Readmission Interviewing
63 Patients Face to Face
October 2017 through January 2018

• Do you know the name of your doctor who’s taking care of you in the hospital?
  YES 51 patients = 81%

• Do you have a PCP?
  YES 60 patients = 95%
63 Face to Face Interviews

• What brings you back to the hospital?
  - SOB 12
  - Fever 10
  - Fall 7
  - Bleeding 6
  - Uncontrolled pain 3
  - Weakness 2
Do you think your coming back into the hospital (readmission) could have been avoided?

- **NO** 49 patients = 78%
- **YES** 13 patients = 21%
- **YES/NO** 1 patient = 1%
Is there anything your Doctor could have done to prevent your coming back into the hospital?

• **NO** 47 patients  = 75%
• **YES** 15 patients (6 said longer stay; 1 shorter stay)
Is there anything *you* (the patient) could have done?

- **NO** 44 patients = 70%
- **YES** 12 patients
If you had more information on nutrition, specifically what to eat or drink after you went home, would that have helped prevent you from coming back?

- NO 56 = 89%
- YES 7
Think back to the last hospital stay. Did you feel ready for discharge?

- **YES** 40 = 63%
- **NO** 23
Do you have enough support at home?

- **YES** 45 patients = 71%
- **NO** 7 patients
Give a Plan, Give a Path
What We Can Do About Readmissions

• Utilize Checklists
• Focus on High Risk Patients
• Meet Patients Where They Are… Literally
• Engage the Patient
• Give a Plan, Give a Path (and tell the patient, tell the SNF, etc)
• Realize that we ALL can play a part to decrease readmissions
What You Can Bring Back

• Life-Support to the Transitions
  - Checklists help
    • Consider making a Discharge Checklist
    • ... or an Intake Checklist (into PCP office)
  - Risk Stratification tools can help
  - Meet patients where they are
  - Consider close Care Coordination
  - Help Patients Understand the Transition
Cleveland Clinic

Every life deserves world class care.
Visualizing High Risk Patients

EPIC Discharge Readiness Tool (Patient-level)