Reducing Preventable Readmissions

While it is clear that reducing preventable readmissions is not an easy task, the costs, both financially and human, are too great to not put the greatest effort forward. Reducing preventable readmissions is challenging because it requires the involvement and coordination of many individuals, departments and systems, both within and beyond the hospital's four walls. As with all improvement initiatives, resources of time and staff are required to identify and understand the hospital's current level of performance, to identify performance gaps, and to determine the appropriate interventions to address gaps and opportunities.[1]

To support hospitals in these efforts, a list of resources and strategies focuses on two key areas related to reducing preventable readmissions: knowing your data and eliciting patient and family perspectives in discharge and care transitions.

Know Your Data

All journeys require knowing the starting point to plan how to arrive at the destination. The journey to reducing readmissions begins with a clear understanding of each individual hospital's readmissions data.

One key step is to take a deep dive into hospital data using stratification to identify patient groups with higher-than-average readmission rates. Below are some data points to consider in data stratification.[1]

- hospitalwide, all-cause readmission rate
- by payer (Medicare, Medicaid, commercial, uninsured)
- race, ethnicity, language
- discharge disposition (skilling nursing facility, home health, home, other)
- behavioral health comorbidity
- timing of readmissions
- high utilizers with four or more admissions in 12 months
- top 10 discharge diagnoses leading to highest numbers of readmissions
- ZIP code or housing residence (group home, long-term care)

ORDINARY USES OF DATA[2]
Data is used to measure compliance, promote standardized achievements and evaluate effectiveness.

EXTRAORDINARY USES OF DATA[2]
Data can provide a window into organizational culture and relationships, the building blocks for innovation, and an opportunity to discover and build on areas of excellence.

The second key step in analyzing data is to gain knowledge directly from patients and families regarding root causes of readmissions.[1] Often, it is assumed the primary reason patients are readmitted is due to a lack of compliance on their part, but in reality, this is not the case. To truly understand the reasons patients are readmitted, hospitals must look beyond noncompliance and dig deeper to learn the root cause of readmissions.[3]

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Below are suggestions on how to gain information from the patient and family perspective regarding the root causes of readmissions.[1,3]

- Routinely interview readmitted patients to learn what happened between the day of discharge and the point at which they, or someone else, decided they needed to return to the emergency department. Develop an interview script/tool with the following questions.
    - Why do you believe you became sick enough to return to the hospital?
    - What do you think needs to happen differently when you go home this time?
- Review medical records of readmitted patients to identify reasons for each individual readmission.
- Aggregate the findings from these efforts into appropriate categories to gain a deeper understanding of the root causes.
- Combine the analysis of this patient-centered data with other stratified data to more accurately identify root causes and appropriately prioritize readmission reduction efforts.

Use these tools to support efforts in data drill down.

- HRET Data Drill Down Tool
- Readmission Review Tool (#2)
- Readmission Case Review and Analysis Tool

Elicit Patient and Family Perspectives in Discharge and Care Transition Planning

A recent study by the University of Pittsburgh Medical Center found that practicing meaningful family caregiver engagement and integrating caregivers into the patient discharge process can reduce hospital readmissions by 25 percent when compared with control groups where integration did not occur.[4]

Implementing the following practices with the patient and family can help prevent problems at home following discharge.[4,6]

- Recognize the patient and care partner, family or friend as integral members of the health care team.
- Discuss what life at home will be like.
- Review all discharge medications and any changes from prior to admission.
- Highlight warning signs and problems.
- Explain any test results.
- Make follow-up appointments prior to discharge.
- Use plain language to educate the patient and family regarding the patient's condition, discharge process and next steps at every opportunity throughout the hospital stay.
- Use teach-back to assess how well doctors and nurses are explaining diagnosis, condition and next steps to the patient and family.
- Listen to and honor the patient and family's goals, preferences, observations and concerns throughout the hospital stay.

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Use these tools to elicit information from patients and families to prevent unnecessary readmissions.

- AHRQ toolkit
- The 3 Building Blocks Supporting Patient Engagement Strategies
- AARP Law Supports Family Caregiver Engagement in Discharge
- Including Family Caregivers in Patient Engagement Strategies
- Ask Me 3® resources

HIINovative Practice: Implement a "Readmission Pause" in the ED[3,7]

If a patient returns to the ED within 30 days, they may not actually require (re)admission. To help discern the best course of action for each patient, consider a "readmission pause" in the ED by implementing the following.

- Create a flag for the ED staff identifying the patient as a potential 30-day readmit.
- Have resources available to the ED team to assess whether the patient has a care team/resources in place to continue care in an alternative setting after evaluation in the ED. Resources might include the ED case manager or social worker, transitional care nurse, community EMS provider, or health navigator.
- Make the process of treating and releasing the patient as easy as admitting the patient.

Resources:

- Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions (ASPIRE)
- Tool 2: Readmission Review Tool
- AHA's New Report: Improving Care for High-Need, High Cost Patients

HRET HIIN Resources:

- Readmission Checklist
- Readmission Change Package
- Whiteboard video series with Dr. Amy Boutwell
- Readmissions data collection fact sheet

References:

[1]Health Research & Educational Trust (February 2017). *Preventable Readmissions Change Package: 2017 Update.* Chicago, IL: Health Research & Educational Trust. Accessed at www.hret-hiin.org.

[2]Frampton, S., et al, (October 2008). *Patient-Centered Care Improvement Guide*. Planetree, Inc. and Picker Institute. Accessed March 2, 2018 at http://www.patient-centeredcare.org/

[3] HRET Readmissions Fishbowl Report accessed, February 22, 2018 at http://www.hret-hiin.org/Resources/readmissions/18/reducing-readmissions-fishbowl-report.pdf

[4]Heath, S., Family Caregiver Engagement Cuts Hos Readmissions by 25%,Retrieved from https://patientengagementhit.com/news/family-caregiver-engagement-cuts-hospital-readmissions-by-25

[5]Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Content last reviewed December 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html

[6] Teske, P., "AHRQ's New Care Transitions Toolkit", Message to: HRET HIIN Readmissions listserve. January 17, 2018.

[7]Health Research & Educational Trust. *ED Pause: Emergency Department Opportunity.* Chicago, IL: Health Research & Educational Trust. Accessed at http://www.hret-hiin.org/Resources/readmissions/17/readmissions_ed_pause.pdf

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