What is the Role of the Hospitalist in Avoiding Readmissions?

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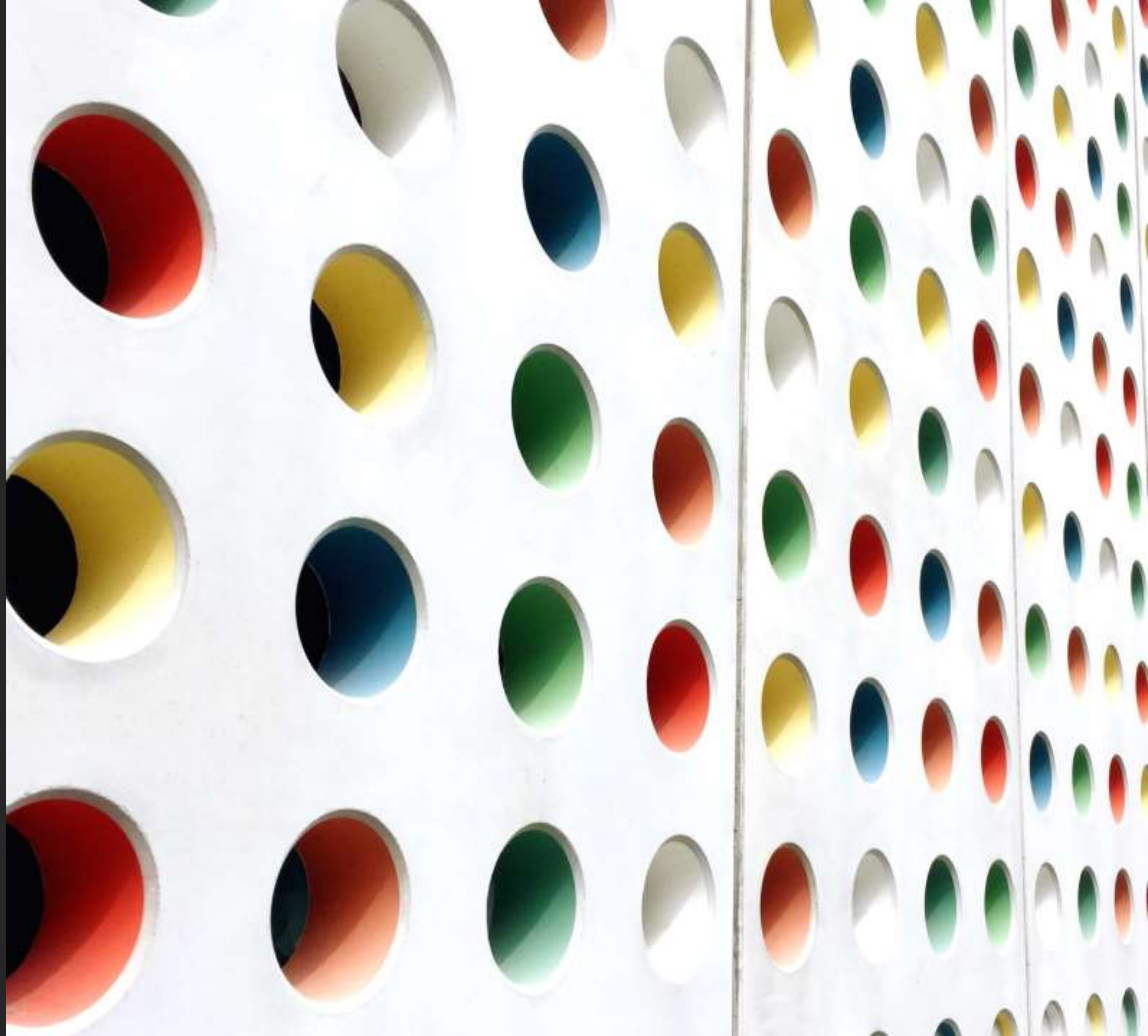

Who Am I?

Financial Disclosures

I have no financial disclosures or conflicts of interest.

Readmissions: What’s the BIG Deal?

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- Payment reductions are applied to **all Medicare fee-for-service** base operating diagnosis-related group payments during the FY (October 1 to September 30).

- The payment reduction is capped at 3 percent

What is HRRP?

The Hospital Readmissions Reduction Program (HRRP) is a Medicare **value-based purchasing program** established in 2012 that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, **reduce avoidable readmissions**. The program supports the national goal of improving health care for Americans by linking payment to the quality of hospital care.

What Diagnoses Does HRRP Monitor?

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia
- Coronary artery bypass graft (CABG) surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

Social Determinants of Health

Did you know that a patient's risk for readmission is directly linked to how/where they were born as well as the conditions in which they live, grow and age?

Social Determinants of Health

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Who is at Risk?

- Those who are uninsured or underinsured
- The non-compliant
- Elderly patients
- Patients with psychiatric disorders
- Patients without family/community support
- Low health literacy
- Differently abled (mental or physical)
- Those patients living in food deserts
- Patients with low income

What is the Hospitalists Role in Preventing Readmission?

1. Expect the Unexpected
2. Use Your Resources
3. Ask Questions
4. Anticipate Your Patients Needs
5. Lead Communication
6. Know the Rules
7. Educate

Expect the Unexpected

1. "I don't have a ride home."
2. "How much is this medication going to be?"
3. "I don't feel well enough to go home today."
4. "I cannot take care of myself and I do not have any help at home."
5. "I have been weak at home. I may fall."

Use Your Resources

1. Social Workers
2. Case Management
3. PT/OT
4. Wound Care
5. Administration

Ask Questions

1. What questions can I answer for you?
2. Do you anticipate any issues obtaining your medications?
3. Do you live alone or with family?
4. Do you have a PCP?
5. Have you fallen recently?
6. Are you able to afford your medications?

Anticipate Your Patients Needs (And Do It Early)

1. DME
2. Palliative Care/Hospice
3. Medication Assistance
4. Home Health Care
5. Wound Care
6. Transportation

Facilitate Strong Communication

1. Interdisciplinary/Multidisciplinary Rounds
2. Docs and SW/CM
3. Docs and PT/OT
4. Docs and Nursing
5. Docs and Wound Care
6. Docs and Patient/Family

Know The Rules

1. Does the facility you are discharging your patient to require a COVID PCR? Do they take weekend admissions?
2. Are there special circumstances surrounding prescribing narcotics at the SNF/Rehab?
3. Do you need a 6 Minute Walk Test within 48 hours of discharge in order to ensure home oxygen?
4. Does the patient's insurance require prior authorization for SNF placement?

Educate. Educate. Educate.

1. Patients and Their Families

- Follow up instructions
- Medications
- Disease Process/Diagnosis
- Expectations

2. Nursing Staff/Ancillary Staff

- Discharge Instructions
- Wound Care

Question #1

Dr. Jones has asked you to admit his patient Jennifer Lewis to your service. She is a 70 YO active female who is a former tennis professional. He plans to do an elective left knee replacement this afternoon and anticipates she can be discharged tomorrow (Thursday) afternoon. She has a history of HTN, but her BP is well controlled with metoprolol. The plan for discharge includes outpatient rehab and pain control. In your experience, Dr. Jones can be difficult to track down in the afternoons given his surgery schedule. What should be your game plan for Ms. Lewis's discharge on Thursday?

Question #1

A. Given this will be an outpatient procedure, you will need to write her discharge orders. Dr. Jones will likely take care of setting up her outpatient rehab services.

B. Ms. Lewis is essentially healthy and does not have many needs. You will write her pain medications and discharge her home.

C. You will contact her PCP to arrange outpatient follow-up, PT/OT and pain management.

D. In addition to prescribing medications, discuss any barriers to discharge with Ms. Lewis and involve Social Work/Case Management to ensure her outpatient needs are met.

E. Write for her pain medications, have the Case Manager arrange OP follow up with her PCP and arrange OP PT/OT.

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Question #2

Which of the following is a diagnosis monitored by The Hospital Readmissions Reduction Program (HRRT)?

A. DKA

B. Total Knee Arthroplasty

C. ESRD

D. Atrial Fibrillation with RVR

E. Liver Cirrhosis

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Question #3

According to HRRT guidelines, how are readmissions subject to the 3% maximum penalty defined?

A. Any readmission that occurs within a 30-day period.

B. Multiple admissions for one of the specified diagnoses within a 7-day period from discharge.

C. Readmission for any diagnosis within a 3-day period from discharge.

D. Readmission for specified diagnoses within 7-days of discharge when the patient was inpatient for at least 48 hours.

E. Higher than expected readmission rates for certain diagnoses within a 30-day period.

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Question #4

Mr. Tom Hanks is an 82 YO male who presents to your hospital frequently complaining of SOB. He has a known history of Atrial Fibrillation, COPD and CHF. He is not inconsistently compliant with his medications. He lives alone and gets severe anxiety when he feels he cannot breathe. He has home oxygen, but he has difficulty navigating around his home with his rolling walker. His oxygen is non-portable and he only uses it when he is in distress. He tends to be hospitalized at least twice a month. In the past, he has declined home healthcare services.

Question #4

What can you do to decrease his frequency of hospitalization?

A. Talk with him and inquire about whether he has family support.

B. Talk to him and insist he go home with HHC at discharge. Tell him you will have Case Management arrange it for him.

C. Discuss with him his reservations about using HHC and ask him to consider other options such as SNF or ALF.

D. Call Adult Protective Services (APS) and advise them he lives alone and express your concern for his welfare.

E. Inform him he will have to go to a SNF because you do not feel safe discharging him home alone.

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Question #5

Ms. Judith Washington is a 67 YO female who was admitted overnight for Acute Coronary Syndrome (ACS) and noted to have elevated troponins and EKG changes. She has known CAD with prior stent placement to the LAD. Cardiology plans to perform a Right and Left Heart Catheterization today. After discussing the plan with Ms. Washington, she has expressed her concerns about going home alone. Her husband recently died of COVID and her children live out of state. She has asked if she can stay a few more days just to be sure her chest pain does not return or get worse.

Question #5

Ms. Washington is high risk to return to the ED after discharge. What steps should be taken to try to prevent Ms. Washington from returning to the ED?

A. Reassure her that her symptoms will not return if she is compliant with her medications and after intervention.

B. Discuss her diagnosis, the care plan, her follow-up instructions and tell her exactly what to expect prior to leaving the hospital.

C. Make sure she has aspirin, a beta blocker, statin therapy, nitroglycerin and controlled BP prior to DC.

D. Advise her to call her Cardiologist and PCP after discharge to arrange close follow-up.

E. Make sure she has PT/OT evaluation prior to discharge.

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Questions?