

Rehospitalization: The Challenge and The Opportunity

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The good news is

- The train is moving

The scary news is

- The train is moving

Evidence of movement

- 250-400 hospitals engaged in projects to reduce rehospitalization
- 14 communities
- 3 states
- High likelihood of payment changes in Medicare to reward lowering rehospitalization rates.

An all-payer problem

- In Medicare there are about 2.5 million rehospitalizations within 30 days of discharge at a cost of about \$17 billion a year.
- Non-Medicare *rates* are lower, but with more total non-Medicare hospitalizations the rehospitalization totals appear to be similar. This suggests that costs might also be similar.

Sources: AHRQ, FL, AARP, and other state data.

A population at high risk:

- Two-thirds of Medicare fee-for-service medical discharges are rehospitalized or dead within a year.
- Half of Medicare fee-for-service surgical discharges are rehospitalized or dead within a year.
- The risk of rehospitalization increases quite slowly with age, so patients who do not have Medicare are probably also at high risk.

Aim

Eliminate preventable 30-day
rehospitalizations
by preventing the clinical
deterioration that causes them

“Preventable”

- Preventable rehospitalizations result from care failures in the period immediately before or after transition from hospital to the next source of care.
- These care failures result in clinical deterioration that leads in turn to rehospitalization.
- Our aim is to fix the care around the transition so the patient stays well.

“Eliminate”

- A system failure that harms a patient is a safety event.
- At this time, we do not know what fraction of rehospitalizations in 30 days are preventable, but intervention studies suggest 20-50% today.
- We do not believe that medically inappropriate rehospitalization decisions are a major part of the problem.

How:

Effective, pervasive, and durable spread and implementation of strategies that have been part of effective prevention in trials.

These strategies will include not only hospitals but also practitioners and other providers as well as patient/family education, support, and empowerment.

Rehospitalization as a perfect crisis

- Safety
- Cost
- Patient experience
- Urgency (trust fund bankrupt 2017)

Rehospitalization as a perfect crisis

- Already there is real momentum for change.
- Success is a step toward reducing the fragmentation of care
- Because initiatives at this point are largely collaborative they are less politically charged.
- If we succeed we have created a precedent for changing health care that may help to save it.
- If we fail, not so good.

What Kinds of Changes?

Three Goals:

At discharge:

1. Every patient/family knows what medication to take and can get it.
2. Every patient/family knows the signs of danger and who to call if they occur.
3. Every patient/family has a prompt follow-up appointment and can keep it.

Processes Believed to Be Effective

- Family involvement
- Coaching/Care Transition Management
- Contact point/follow-up call.
- Follow-up appointments/visits
- Family and patient education with teachback
- Prompt information forwarding
- Medication reconciliation
- Physician outreach
- Nursing home protocols
- Risk screening
- Coordination among sequential providers

Identifying high-risk patients

- History of rehospitalization
- Failed teach-back
- Longer stay than expected
- High-risk DRGs (e.g.: heart failure, psychosis)
- Poor, disabled, or on dialysis

But the algorithms miss many patients who are rehospitalized, the energy involved in screening might be better spent on systems change.

Managing the transition: A few examples

- Re-engineering the discharge process -- Jack
- Advanced practice nurse follows patient from before to after discharge -- Naylor
- Transitions coaching program -- Coleman

Payment Reform

- Reward low rehospitalization rates or penalize high rates.
- Generally directed at hospitals, but other providers and practitioners are vital.
- Medicare is the most likely immediate major change agent, but a number of other payers seem to be considering joining.

Payment Reform – Intended effects

- Incentive:
 - Creates the financial case that hospitals and improvement advocates have said is necessary.
- Message
 - This matters
 - We no longer penalize you for doing it right
 - We reward, or at least prevent penalties, if you succeed

Payment reform – Risks

- Access barriers
 - Diversion of recently-hospitalized patient in the ER into extended ER stays or observation stays.
 - Delays of rehospitalization by physicians called for advice or disposition
 - Damage to safety net providers because the poor are at higher risk.

Limits of payment reform as tool

- Payment policy is a relatively blunt tool to change care.
- We have never before created this kind of pressure to change the healthcare system.
- People (and hospitals) may do bad things when their survival is threatened by demands they do not know how to meet.

A modified payment strategy

- It may be safer to combine payment reform with other strategies than to rely on payment reform alone.
- Risk may be reduced if other forces push in the same direction and reduce the needed size of payment incentives.
- Assistance for incentivized hospitals makes appropriate responses more possible.

Balancing Strategies

Some promising strategies to supplement payment reform

- Leadership
- Technical Assistance
- Community partnerships
- Measure standardization
- Rapid data availability
- Patient/family empowerment
- Accreditation, licensure, and survey/certification

Leadership and messaging :

- Rehospitalization is not a data error: it is a clear and present danger to patients and the viability of health care.
- Most of us – payers, purchasers, hospitals, practitioners, other providers – have helped to create this problem by using and abusing fee-for-service, building silos around what we do, and maintaining ignorance of things we don't want to know.
- It is not someone else's problem: it is ours.

Other Leadership Messages:

- It is pointless to blame people for working in a broken system.
- Measures of rehospitalization are imperfect but they are plenty good enough to track improvement.
- Rehospitalization is not just a hospital problem, it is a community problem.
- Although a community approach would be best, we cannot wait until everybody agrees.

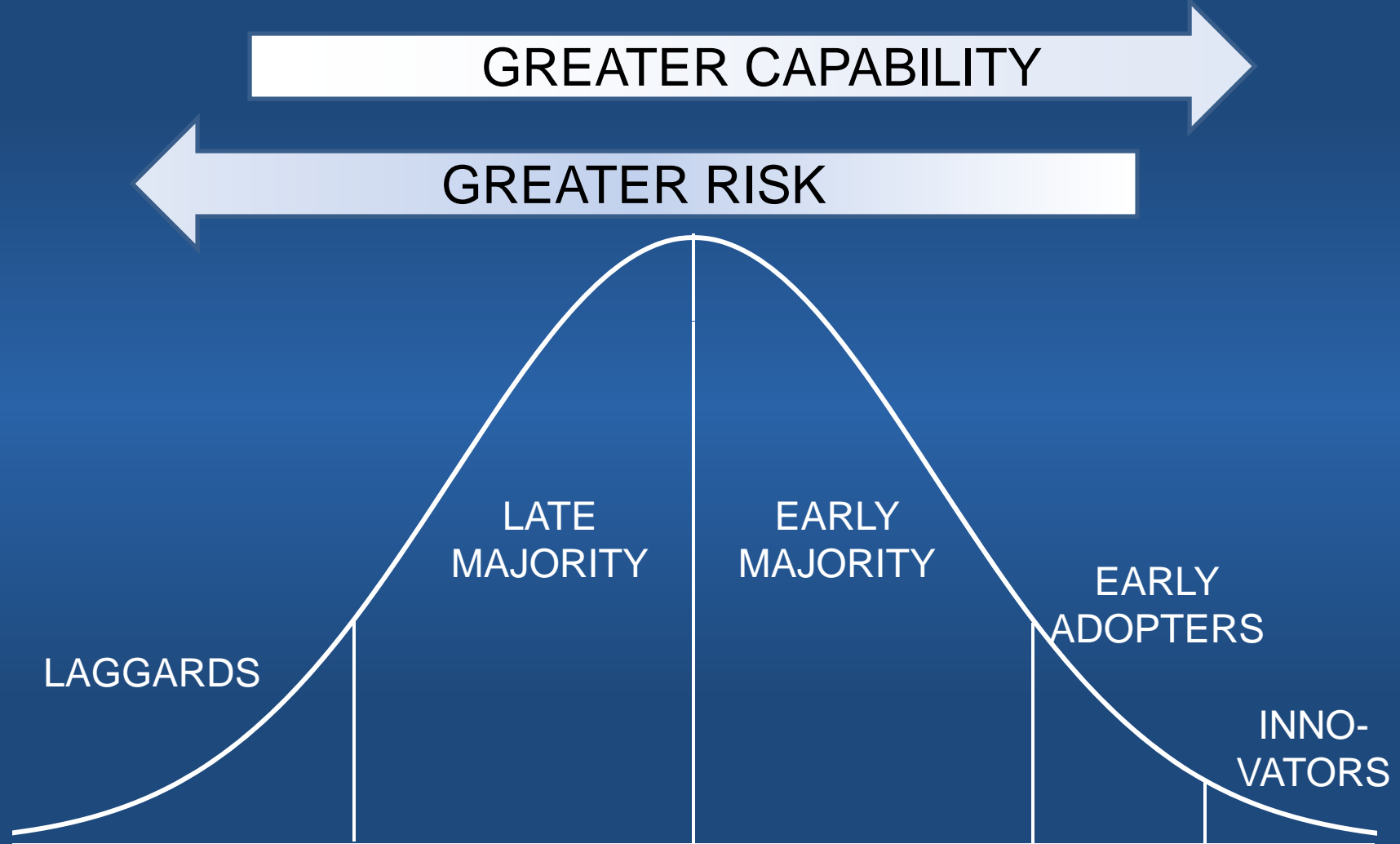
Community partnerships

- Patients, practitioners, providers, and community social agencies comprise a social system (perhaps dysfunctional).
- This social system can become a community, especially if new payment rules change the value equation.
- Specifically, payment reform can make the efforts of post-hospital providers to keep the patient healthy valuable to the hospital.

Effective transition management is a team sport

- The team must have a system for supporting the transition, as a dance company must to manage its transitions or a football team to pass a ball.
- Scheduling follow-up appointments and reconciling medications is challenging for the system, but far more challenging for patient and family without system support.
- The value of coffee, donuts, and the mayor.

Providers are not the same



from: Rogers, E. *The Diffusion of Innovation*

Providers are not the same

- *Early adopters* need technical assistance to succeed – and there is some chance they will get it because that's where efforts focus.
- *Early majority* need assistance in positioning themselves to make changes, especially physician–hospital partnerships.
- *Late majority* need assistance in understanding what they must do and in seeing the task as doable.

Culture issues in hospitals

- We're always told to keep beds filled.
- Our responsibilities end at the sidewalk.

These are issues for the hospital board, not the finance office.

Culture issues in hospitals

- “We have too many noncompliant patients.”
- “We can’t control what care patients get after they leave.”
- “Nursing homes and home health agencies just send the patient to the emergency room because they don’t want to do the hard work.”

These are issues of knowledge, imagination, and will.

How Do We Start?

Acknowledge the problem

- About 90% of 30-day rehospitalizations appear to be unplanned.
- Clinical trials suggest that 20%-50% of these rehospitalizations are preventable with better, coordinated care around discharge.
- Risk adjustment and other statistical procedures do not make the problem go away.

Decide to act

- This is an accountable executive decision, whether taken by a CEO or a Board or both.
- Today. Many approaches work well and waiting for the “best” approach is procrastination.
- Deferring action because your rate of rehospitalization is already below average is not prudent.

Lead community organization

- Seems likely that the best lead organization will be a payer or payer organization, a hospital association, or a government agency.
- Can be statewide or more local.
- The hospital itself must buy in because that's where the patient is.

Choose an approach

- One hospital will focus on heart failure because there is a clinical champion.
- Another will choose medication reconciliation because it is already a priority.
- Another will choose follow-up appointments because the medical staff is interested.

It is important to model teamwork and communication.

Monitoring and Managing

- We need to see this effort as an enterprise that we will need to adjust as we learn from the experience.
- This requires an organization to monitor both the prime measure (rehospitalization rate) and balancing measures (observation days, ER visits, and others) and recommend adjustments to a steering committee.
- Monitoring should be near to real time.

Rehospitalization as a perfect crisis

- This is a big, expensive issue.
- There are effective interventions.
- If we do it right we can improve care while we are saving money.
- Already there is real momentum for change.

Rehospitalization as a perfect crisis

- Success is a step toward reducing the fragmentation of care
- Because initiatives at this point are largely collaborative they are less politically charged.
- If we succeed we have created a precedent for changing health care that will hold promise for helping to save it.
- If we fall short, not so good.