Developing Programs to Reduce Hospital Readmissions

Key Design Elements to Consider from a Physician Group Perspective

A growing body of research reveals some promising approaches to reducing hospital readmissions. Based on the current research, this document summarizes key program design elements for physician groups to consider when developing programs to reduce hospital readmissions. A list of key references and resources, which provide more detail, is attached.

As you build a program to reduce readmissions, consider the following key elements...

1) Hand-off from hospital to the patient’s primary physician

- Partner with your local hospital(s) to develop simplified and standardized processes for transmission of the discharge summary to the patient’s primary physician and for scheduling (and arranging transportation for) follow-up visits.\(^1\)
  In addition, determine how to obtain timely information on your patients’ hospital admissions and emergency room visits to follow-up with patients and reinforce self-care.
- Schedule follow-up visits before discharge – Schedule a follow-up visit or phone call with the patient’s physician (or home care or care coordination clinician), depending on the patient’s risk status, within 48 hours after discharge (see below for risk stratification and see pages 16-19 in IHI’s How-to Guide for more information).\(^1\)
- Schedule a home visit – Schedule an initial home visit by a care coordinator within 24-72 hours after discharge to discuss the care plan and medications and coordinate follow-up services.\(^2,3\)

2) Updated care plan and patient education

- Develop an updated care plan at the first post-discharge visit – Use a tool (e.g., a care plan or personal health record) that is developed collaboratively with the patient, allows them to keep track of their plan of care and other important medical information, and reflects their ability to self-manage. The first iteration of the plan should reconcile the treatment plans and medications from pre-and post-hospitalization.\(^7,4\) The plan should be continually reassessed with the patient, family and providers.\(^2,3\) (Refer to the resources page for a link to a sample care plan.)
- Educate on warning signs – Teach patients how to identify “red flags”, or the early warning signs or symptoms that may lead to readmission, and how to seek help.\(^2,3\)
- Use the “Teach-back” method during post-discharge visits and phone calls. In this method, a patient is asked to repeat back in his or her own words the instructions they have been given, such as warning signs to watch out for, how to seek help, and how to take their medications properly.\(^1\)
Medication reconciliation and education is a key lever in reducing readmissions, as discrepancies often occur during transitions in care. In fact, “up to 70% of patients have a problem with medications when seen the first week after discharge...” 5

- Educate patients on medication use – Follow-up visits and phone calls should focus on teaching and reinforcing appropriate medication use. For example, a care coordinator or coach might spend the majority of the first post-discharge home visit: gathering all medications, prescriptions and the hospital discharge summary; quizzing the patient on medication use; sorting out any duplicates; and preparing the patient to speak with the PCP.6 Subsequent visits or phone calls might then reinforce the PCP’s directions for medication use.

- Assign a care coordinator who serves as a central point of contact for the patient and is responsible for coordinating follow-up services, such as home care, disease management classes, physician office visits, or palliative care. Some models use an Advanced Practice Nurse (APN) as the primary coordinator, while others have been shown to be effective using a variety of providers, such as nurses, social workers, student nurses and highly trained community workers.2

- Offer in-person visits for a defined period of time – One study on Medicare care coordination programs showed that successful programs included far more in-person visits, nearly one in-person contact per month per patient. For example, care coordinators often scheduled time to meet with a patient at the physician site before or after the patient’s appointment.7

- Promote continuity by ensuring the care coordinator remains in close communication with the patient’s physician(s), family and informal caregivers. In addition, assigning the same care coordinator to all of a given physician’s enrolled patients was shown to be a success factor in one study.7

Last, to assist with targeting individuals by level of risk, IHI offers a simple method for stratification:

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
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<tbody>
<tr>
<td>• Patient has been admitted two or more times in the past year.</td>
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<tr>
<td>• Patient is unable to teach back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home.</td>
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</tr>
<tr>
<td>• Patient has been admitted once in the past year.</td>
<td></td>
</tr>
<tr>
<td>• Patient or family caregiver has moderate degree of confidence to carry out self-care at home.</td>
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Source: How-to Guide: Creating an Ideal Transition Home, Institute for Healthcare Improvement
References and Resources

1 – A guide from IHI on improving the transition from hospital to home:

2 – Case studies of nine organizations with readmissions programs, including three California medical groups (John Muir Physician Network, HealthCare Partners, and Sharp Rees-Stealy Medical Group):

3 – A summary of 15 promising approaches to reduce readmissions:

4 – A guide for testing from IHI on improving the transition from hospital to the office practice (Please note: the steps in this guide are currently being tested to understand their impact on readmissions; IHI welcomes any feedback and learning on these suggested changes)

5 – High-level overview of the causes of readmissions and summary of promising models:

6 – Summary of a demonstration of Eric Coleman’s “Care Transitions Intervention” model in Colorado:

7 – A study of 15 Medicare care coordination programs, highlights the success factors of three programs:

8 – A comprehensive literature review on interventions to reduce readmissions:

9 – A review of care coordination models that impact hospitalizations in the Medicare population:

10 – A sample Aft After Hospital Care Plan (AHCP) provided by Project RED (Re-Engineered Discharge) at Boston University Medical Center: http://www.bu.edu/fammed/projectred/toolkit.html