Nobody Puts Baby…Back in the ER

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Quality Insights
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Objectives and Goals

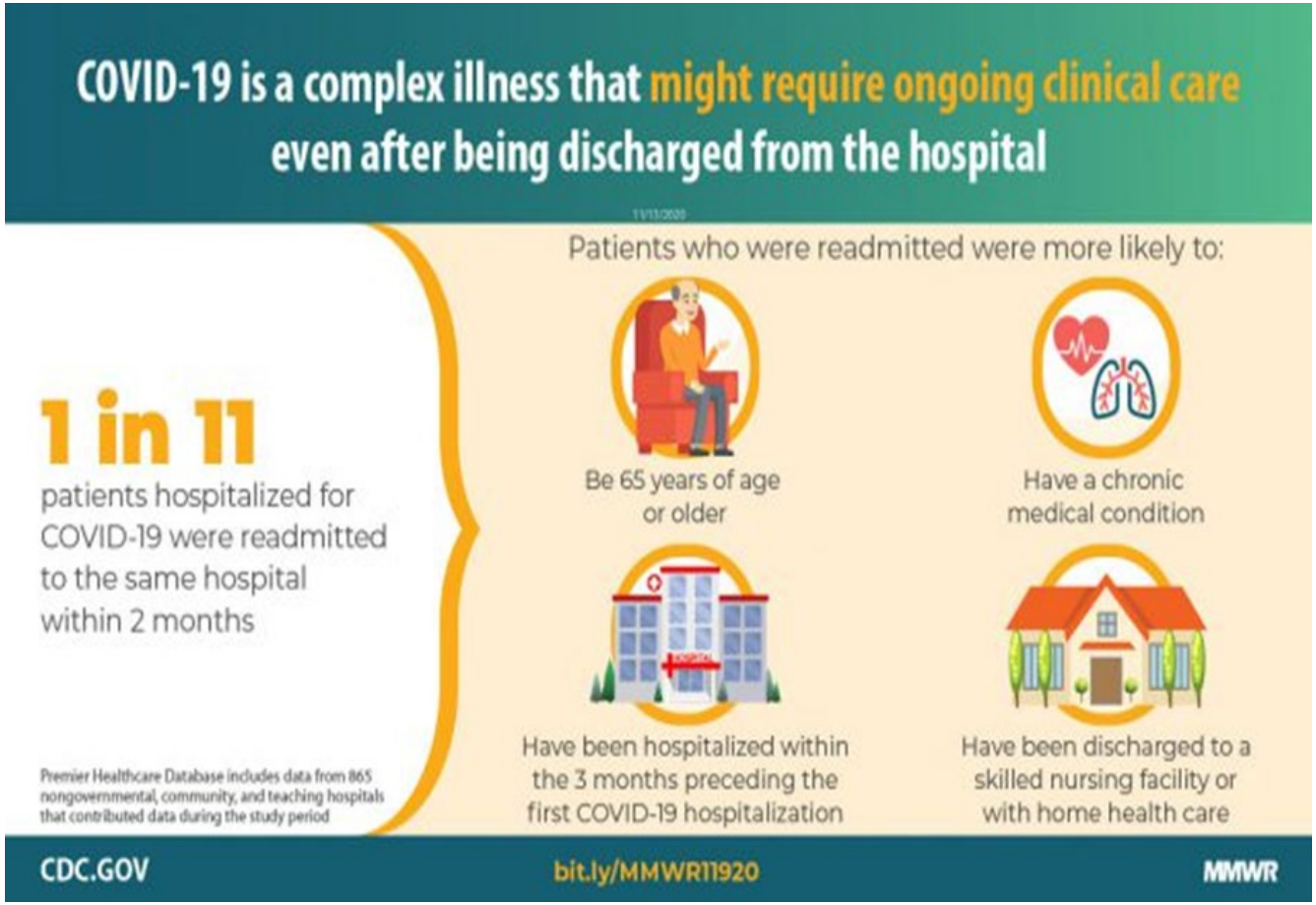
- Discuss the number of readmissions nationwide and specifically in West Virginia and Pennsylvania.
- Look at causes and risks for readmissions.
- Examine contributing factors for readmissions.
- Review a Joint Commission study that examines readmissions after a diagnosis of COVID-19.
- Identify best practices to decrease the number of readmissions.

CDC: COVID-19 Readmission Numbers

- Among 126,137 unique patients with an index COVID-19 admission during March–July 2020, 15% died during the index hospitalization.
- Among 106,543 (85%) surviving patients, 9% (9,504) were readmitted to the same hospital within 2 months of discharge through August 2020.
- Readmissions occurred more often among patients discharged to a skilled nursing facility (SNF) (15%) or those needing home health care (12%) than among patients discharged to home or self-care (7%).

CDC: COVID-19 Readmission Numbers

- The odds of hospital readmission increased with age among persons aged ≥65 years, presence of certain chronic conditions, hospitalization within the 3 months preceding the index hospitalization, and if discharge from the index hospitalization was to a SNF or to home with health care assistance.


COVID-19 is a complex illness that might require ongoing clinical care even after being discharged from the hospital
11/13/2020
1 in 11
patients hospitalized for COVID-19 were readmitted to the same hospital within 2 months
Premier Healthcare Database includes data from 865 nongovernmental, community, and teaching hospitals that contributed data during the study period
Patients who were readmitted were more likely to:
Be 65 years of age or older
Have a chronic medical condition
Have been hospitalized within the 3 months preceding the first COVID-19 hospitalization
Have been discharged to a skilled nursing facility or with home health care
CDC.GOV
bit.ly/MMWR11920
MMWR

Medicare Readmissions: WV Days 1-30

Measure:	**Readmission Rate**	**15.5%**
Numerator:	All-cause readmissions among Medicare FFS beneficiaries to any short-term acute, critical access, or psychiatric hospital in WV within 30 days of hospital discharge	583
Denominator:	Discharges among Medicare FFS beneficiaries from **ANY SHORT-TERM ACUTE, CRITICAL ACCESS, OR PSYCHIATRIC HOSPITAL IN WV** during the measurement period **with a primary diagnosis of COVID**	3,773
Exclusions:	Transfers, deaths	
Measurement Period:	11/1/2020 - 10/31/2021	
Benchmark	Achievable Benchmark of Care (ABC): The overall performance level of short-term acute, critical access, and psychiatric hospitals in WV with the lowest rates that account for at least 10% of all discharges during the measurement period	**8.4%**

Medicare Readmissions: PA Days 1-30

Measure:	**Readmission Rate**	**15.9%**
Numerator:	All-cause readmissions among Medicare FFS beneficiaries to any short-term acute, critical access, or psychiatric hospital in PA within 30 days of hospital discharge	3,422
Denominator:	Discharges among Medicare FFS beneficiaries from **ANY SHORT-TERM ACUTE, CRITICAL ACCESS, OR PSYCHIATRIC HOSPITAL IN PA** during the measurement period **with a primary diagnosis of COVID**	21,580
Exclusions:	Transfers, deaths	
Measurement Period:	11/1/2020 - 10/31/2021	
Benchmark	Achievable Benchmark of Care (ABC): The overall performance level of short-term acute, critical access, and psychiatric hospitals in PA with the lowest rates that account for at least 10% of all discharges during the measurement period	**8.2%**

Comorbidities and Age Impact

- Among hospitalized patients with COVID-19, those readmitted had a higher burden of comorbidities than the non-readmitted.
- Within the first 12 days from discharge, readmission reasons were more likely to be associated with COVID-19, while those happening later were related to other reasons.
- Readmissions are greater for those over age 65.
- The number of deaths related to people over the age of 65 is 97 times higher than the number of deaths among people ages 18-29 years old.

Minority Health Impact

- A person's risk of severe illness from COVID-19 increases as the number of underlying medical conditions they have increases.
- Some people are at increased risk of getting very sick or dying from COVID-19 because of where they live or work, or because they can't get health care. This includes many people from racial and ethnic minority groups and people with disabilities.

Minority Health Impact: Studies Have Shown…

- Racial and Ethnic Minority Groups
  - Dying from COVID-19 at younger ages
  - Often younger when they develop chronic medical conditions
  - May be more likely to have more than one medical condition
- People with Disabilities
  - More likely than to have chronic health conditions, live in shared group (congregate) settings, and face more barriers in accessing health care.
  - More likely to get COVID-19 and have worse outcomes

Joint Commission Findings on COVID-19 Readmissions

- Of the 576 patients, 76 (13.2%) had an unplanned hospital revisit within 30 days of discharge, including 21 ED visits without admission (3.6%) and 55 readmissions (9.5%).
- The median number of days to revisit was 8 (interquartile range 3–18).
- Of the 55 patients who had a readmission, 5 (9.1%) died in the hospital or were discharged to inpatient hospice, and 5 (9.1%) were readmitted twice in the 30-day period.

Most Significant Factors to Readmission

- Patient/caregiver misunderstanding of the discharge medication
- Inappropriate choice of discharge location
- Inadequate treatment of medical conditions
- Discharge without needed procedure
- Patient discharged too soon

Discharge Planning, Directly and Not Directly Related to the COVID-19 Pandemic

Discharge Planning	Not directly pandemic related	Directly pandemic related	*n*, total (% of cases, *N* = 20)*
Inappropriate choice of discharge location (for example, skilled nursing facility vs. home)	4	1	5 (25.0)
Patient discharged too soon from index hospitalization	2	1	3 (15.0)
Follow-up appointments not scheduled prior to discharge	2	0	2 (10.0)
Inappropriately long time between discharge and first follow-up with outpatient provider(s)	1	0	1 (5.0)

Medication Safety, Directly and Not Directly Related to the COVID-19 Pandemic

Medication safety	Not directly pandemic related	Directly Pandemic Related	Total Cases
Patient/caregiver misunderstanding of the discharge medication regimens	5	0	5 (25.0)
Errors in discharge orders	2	0	2 (10.0)
Patient/caregiver inability to manage medications at home/inadequate drug level monitoring	1	0	1 (5.0)

Diagnostic and Self-Management, Directly and Not Directly Related to the COVID-19 Pandemic

Diagnostic or therapeutic problems	Not Directly Pandemic Related	Directly Pandemic Related	Total Cases
Discharge without needed procedure	1	2	3 (15.0)
Inadequate treatment of medical conditions during the index admission (other than pain)	2	1	3 (15.0)
Missed diagnosis during the index admission	1	0	1 (5.0)
Educating patients and promoting self-management			
Patient lacked awareness of whom to contact, when to go (or not to go) to the ED	2	0	2 (10.0)
Patient or family had difficulty managing other self-care activities at home	2	0	2 (10.0)
Patient lacked awareness of follow-up appointments or other post discharge plans	1	0	1 (5.0)
Patient/family had difficulty managing symptoms at home	1	0	1 (5.0)

Community Support and Other, Directly and Not Directly Related to the COVID-19 Pandemic

Enlisting help of social and community supports	Not Directly Pandemic Related	Directly Pandemic Related	Total cases
Patient required additional or different home services than those included in discharge plans	2	0	2 (10.0)
Patient was not able to access services at home (or turned them down after plans were made)	0	1	1 (5.0)
Patient required additional help from patient's family, caregivers, friends that was not available or sufficient	1	0	1 (5.0)
Other			
Team did not relay important information to the primary care provider or other outpatient providers	2	0	2 (10.0)
Patient inappropriately sent from subacute facility to ED	1	0	1 (5.0)
Lack of disease monitoring (for example, following daily weights)	1	0	1 (5.0)

Interventions that May Have Prevented Hospital Revisits

Possible interventions	Potentially preventive interventions Non-pandemic related	Pandemic related	*n*, total (% cases, *N* = 20)[‡]
Improved self-management plan at discharge (for example, discharge coach, discharge information in the patient's own language, increased engagement of patient/caregiver to ensure understanding of the discharge plan)	10	3	13 (65.0)
Improved clarity, timeliness. or availability of information provided at discharge (for example, timely communication with postdischarge providers)	7	2	9 (45.0)
More complete communication of information (for example, improved discharge documentation)	5	2	7 (35.0)
Improved physician or care team recognition of or attention to patient symptoms (such as pain, dyspnea, depression, anxiety)	4	2	6 (30.0)
Improved coordination between inpatient and outpatient providers (for example, with primary care office, shared medical records, communication that includes all team members, provider continuity)	4	2	6 (30.0)
Improved discharge planning (for example, faster follow-up with ambulatory providers, appointments made at times patient could attend)	4	2	6 (30.0)

Interventions that May Have Prevented Hospital Revisits

	Not Pandemic Related	Pandemic Related	Total Cases
Improved attention to medication safety (for example, medication list with pictures, filling prescriptions prior to discharge or having them delivered to home, improved medication reconciliation)	4	1	5(25.0)
Provision of resources to manage care and symptoms after discharge (for example, follow-up phone call, nurse home visit, intensive disease management system, post discharge ongoing case management, access to index hospital team for questions/concerns after discharge)	4	1	5 (25.0)
Greater engagement of home and community supports (for example, nonclinical social support assistance such as adult day care, meals on wheels)	2	0	2 (10.0)
Financial, insurance, or transportation assistance	0	0	0 (0)
Improved advance care planning (for example, establishment of health care proxy, discussion of goals of care, palliative care consultation, hospice services)	0	0	0 (0)

Top 10 Readmission Diagnoses for WV

(1)	[a] COVID-19	1,077
(2)	[a] Bacterial infections; [b] Septicemia	562
(3)	[a] Respiratory failure; insufficiency; arrest	121
(4)	[a] Acute and unspecified renal failure	117
(5)	[a] Acute pulmonary embolism	92
(6)	[a] Chronic kidney disease; [b] Heart failure; [c] Hypertension with complications and secondary hypertension	85
(7)	[a] Gastrointestinal hemorrhage	73
(8)	[a] Cardiac dysrhythmias	72
(9)	[a] Fluid and electrolyte disorders	66
(10)	[a] Pneumonia (except that caused by tuberculosis)	51
Total		**2,316**

Top 10 Readmission Diagnoses for PA

(1)	[a] COVID-19	1,077
(2)	[a] Bacterial infections; [b] Septicemia	562
(3)	[a] Respiratory failure; insufficiency; arrest	121
(4)	[a] Acute and unspecified renal failure	117
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Total		**2,316**

Best Practices to Avoid Readmissions

Topic	Key Issues and Recommended Strategies
Discharge and care transitions	• Assure that the discharge time and destiny location are appropriate. • Provide early discharge planning and follow-up for patients at high risk for readmission. • Communicate with patients about the importance of early follow-up. Support may be needed to schedule appointments and address potential barriers to follow-up (e.g., lack of usual source of care, transportation issues, language barriers).
Usual Source of Care/Linkage to Primary Care	• Determine whether the patient is linked to a primary care provider or has a usual source of care. • If no linkage exists, attempt to provide a referral and ensure the patient gets connected to a primary care provider.
Language barriers and access to interpreter services	• Ensure that patients with limited English proficiency are aware of and have access to professional medical interpreter services during inpatient stays, during discharge, and when accessing post-hospital care. • Communicate discharge instructions in the patient's preferred language. Provide written materials at an appropriate literacy level (5th grade or lower, as recommended by the Joint Commission) and in the preferred language of the patient and/or caregiver. • Include family members and/or caregivers in care as appropriate, work with members of the extended care team (such as community health workers), and coordinate with traditional healers to help facilitate culturally competent care for patients with limited English proficiency.

Best Practices to Avoid Readmissions

TOPIC	Key Issues and Recommended Strategies
Health Literacy	▪ Conduct early screening and documentation of literacy and health literacy, and ensure providers are aware of the patient's level of health literacy at all stages of care. ▪ Provide discharge instructions and educational materials at an appropriate literacy level, and incorporate adult learning principles to facilitate patient understanding of diagnosis and treatment regimen. ▪ Simplify self-care instructions provided to patients. ▪ Use common words. **Avoid medical jargon**. Using relatable language is vital when working with patients with limited English proficiency who may experience additional communication barriers.
Culturally competent patient education	▪ Engage families in care transitions, as appropriate, and leverage cultural beliefs or practices that promote self-care and family or social support. ▪ Link patients to community-based educational programs offered by trusted institutions (e.g., faith organizations, cultural organizations) ▪ Address cultural factors that may predict medication non-adherence, such as patient perceptions regarding the benefits of Western vs. Eastern medicine and perceptions of susceptibility to disease/harm.
Social Determinants	▪ Connect patients with community-based resources such as adult day health programs, personal care, home-delivered meals, and services that address social determinants of health (e.g., housing and food security, transportation, employment). ▪ Connect uninsured and underinsured patients with supplemental health insurance, when possible. ▪ Encourage social support through community connections, use of health information technology, and community-based interventions that reduce social isolation and loneliness
Comorbidities	• Ensure appropriate referral to specialty care for comorbidities. • Implement policies that foster the use of multi-disciplinary disease management teams and provide payment for care coordination

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Questions?

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