

30-day Readmission Survey

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Meet Mary Herberger and Monica Thurston, OMS 2



COMP-NW

Lebanon, OR

Satellite Campus of Western
University of Health Sciences in
Pomona, CA

First graduating class in 2015

College of Osteopathic Medicine

~200 first and second year
students on campus



Rural Health Track (RHT)

“Students participate in an innovative approach to learning about issues pertinent to the practice of medicine and addressing issues of population health in rural and/or underserved communities”

Meet with patients for 30-day readmission project

Hermiston Summer Immersion Program

HPV Vaccination Informational Sessions at OSU

Community Health Improvement Plan (CHIP)



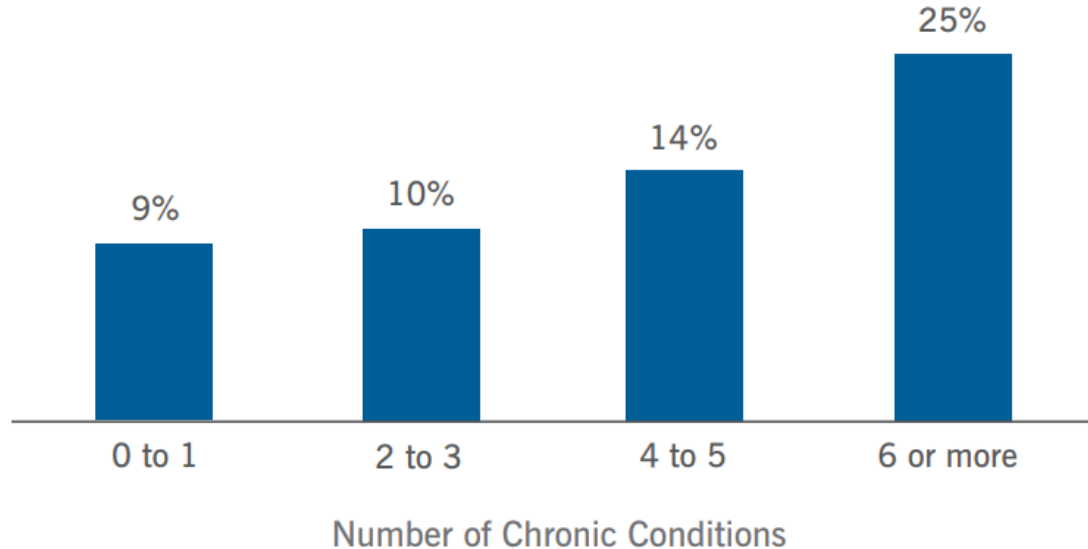
Background

- CMS 30-day readmission measure is a tool used to assess readmissions of patients >65 yo for an **“unplanned”** condition
- Affordable Care Act (ACA), the Hospital Readmission Reduction Program (HRRP) financially penalizes hospitals with higher than expected 30-day readmission rates
- 2,597 hospitals were penalized in the 2017 fiscal year resulting in > \$500 million dollars withheld by CMS

American Hospital Association

Medicare beneficiaries with multiple chronic conditions have higher readmission rates.

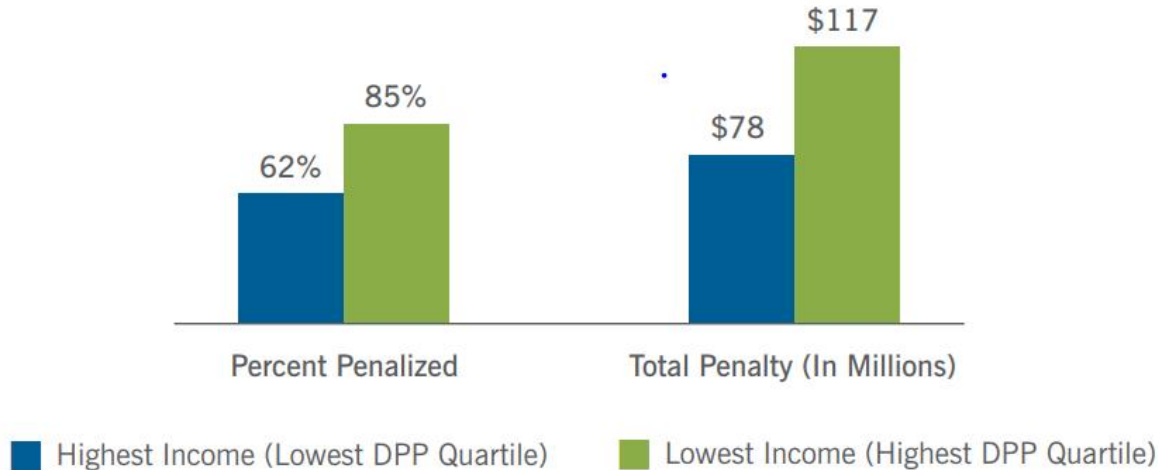
Chart 3: 30-Day Readmission Rates for Medicare Fee-for-Service Beneficiaries, by Number of Chronic Conditions, 2011



American Hospital Association

Hospitals with a larger percentage of low-income patients are more likely to incur a HRRP penalty.

Chart 5: Hospitals Incurring an HRRP Penalty, by DPP Quartile, FY 2015⁽¹⁾



30-day Readmission Project

- Samaritan Lebanon Community Hospital staff assesses admitted patients to see if they fit inclusion/exclusion criteria
- COMP-NW RHT students meet with patient prior to discharge
- Students follow-up with two phone calls and two home visits during the 30 days after discharge from the hospital
- After 30 days, or if patient is readmitted, students fill out survey that addresses the following:
 - Patient demographics
 - Patient understanding of discharge instructions and compliance

Case 1

- Demographics: 83 y.o. caucasian male
- Co-morbidities: Atrial fibrillation (on anticoagulant), foot drop, 3 mos status post mechanical fall with lumbar compression fractures, gait instability dependent on ambulatory assistive devices
- Initial Presentation: Emergency department with **fever** and **shortness of breath**.
- Hospital Course: Diagnosed with **bacterial pneumonia** and treated with IV ceftriaxone



Case 1: Discharge Instructions

Documented by Medical Care Team	Patient's Reported Understanding
<p data-bbox="247 434 784 470">Complete course of doxycycline.</p> <p data-bbox="247 571 830 607">Maintain appropriate calorie intake.</p> <p data-bbox="247 751 850 831">Follow up with primary care provider in 1 week.</p>	<p data-bbox="1029 434 1624 514">“My wife picked up my prescription from Wal-Mart, I need to finish that.”</p> <p data-bbox="1029 571 1566 694">“I am supposed to eat a lot more food, they gave me high calorie shakes in the hospital.”</p> <p data-bbox="1029 751 1615 831">“I have to schedule an appointment with my doctor this week.”</p>

Case 1: Social Support

- Married
 - Wife was an excellent advocate for patient's health and ensured that his discharge instructions were executed
 - She ensured that he was consuming adequate calories and communicated health goals with primary care physician
- Good support from children
 - Son flew in from Arizona following his discharge
 - He managed the farm and took care of his



Case 1: Living Situation

- Home is located about 15 minutes outside of the rural community of Lebanon, OR
- Lives in a small ranch style home with a split-level kitchen and dining room
- Has several acres of land with animals
 - Patient and his wife are the sole caretakers of 2 horses, several chickens, 2 dogs and a cat



Case 1: Summary

- Diagnosis of bacterial pneumonia, treated with antibiotics
- Patient was competent and compliant with discharge instructions
- Stable home environment, without socioeconomic barriers
- Excellent social support system
- Adequate follow up and ongoing treatment from primary care physician



Case 1:



Do you think that this patient returned to the hospital within 30-days of discharge?

Case 1: Barriers to Health

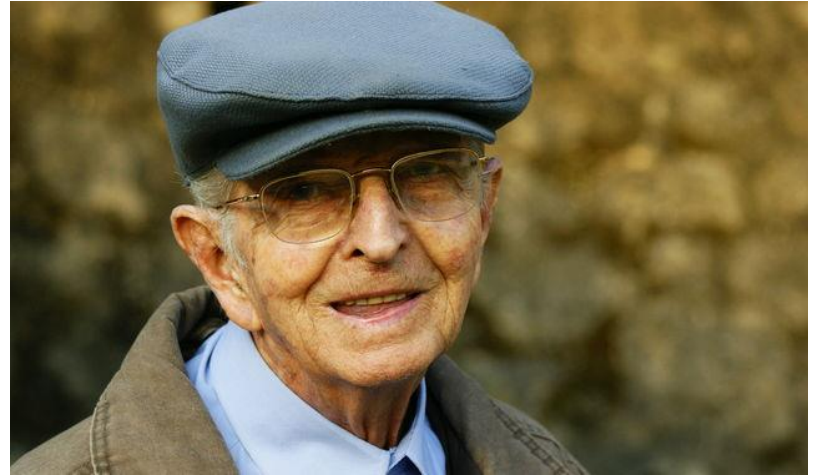
Ambulation:

- Patient had a history of mechanical falls and foot drop
- Weakness secondary to pneumonia
- Split level home with stair separating main living areas
- One walker in the home and only used on the lower level



Case 2

- Demographics: 77 y.o. caucasian male
- Co-morbidities: multiple
- Initial Presentation: Emergency Department with **confusion** and **abdominal pain**
- Hospital Course: CT scan confirmed bowel obstruction but surgeon determined patient was not a good candidate for surgery.



Case 2: Discharge Instructions

Documented by Medical Care Team	Patient's Reported Understanding
Changes in patient's medications (>5 medications).	"I don't know what the doctor was talking about, I don't take those medicines.
Stay on all-liquid diet for 3-4 weeks.	"I can only have soup and broth. I liked the Ensure, but I can't afford to get more."
Follow up with primary care provider in 1 week.	"How do I schedule an appointment with the doctor who saw me in the hospital?" "My primary care provider can't get me in for 2-3 months."

Case 2: Living Situation

- Widow
 - Lives with a significant other, however, she is 3 years post stroke and thus has memory impairment and cannot drive.
 - Significant other has family nearby that can aid in transportation when patient is unable to drive
- No children
- Lived in small duplex with split-level kitchen



Case 2: Economic Situation

- Ensure
 - Patient was given a six-pack of Ensure from his primary care physician
 - Enjoyed the Ensure, but unable to buy more due to price
- Prescriptions
 - Did not express difficulty with paying for prescriptions



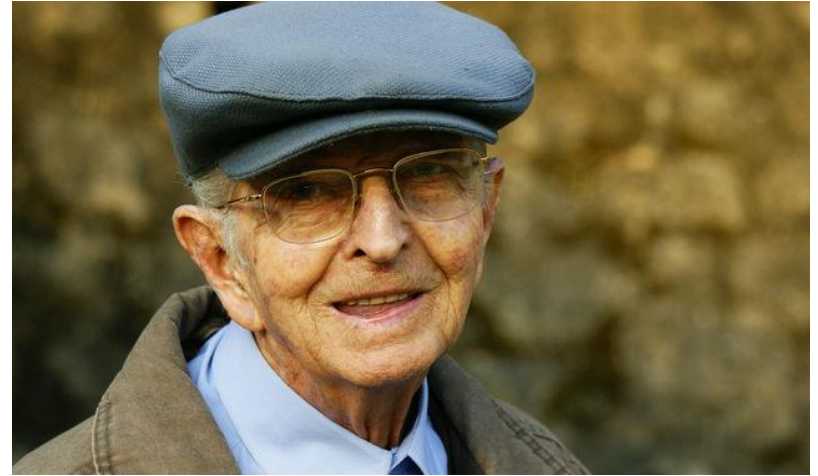
Case 2: Cultural Beliefs

- Vinegar
 - Patient reported having chronic hiccups for the past 10 years, had been self medicating with spoonfuls of vinegar
 - He was educated on stopping this practice during admission to hospital but reported to have continued treating his chronic hiccups with vinegar



Case 2: Summary

- Diagnosed with bowel obstruction, advised to go on all-liquid diet for 30 days
- Patient lives with significant other, however due to her stroke she is unable to provide adequate care
- Able to follow up with primary care physician within two weeks
- Moderate socioeconomic and cultural barriers



Case 2:



Do you think that this patient returned to the hospital within 30-days of discharge?

Case 2: Barriers to Health

Understanding of Discharge Instructions:

- Unable to be “compliant” with his home care and recovery due to misunderstanding of discharge instructions.
- Understanding of who he was supposed to follow up with was unclear.

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Case 2: Barriers to Health

Economic:

- All liquid diet required, but patient couldn't afford to purchase.
- Currently, a 6-pack of 8 oz Ensure costs \$8-9
- Ranges from 160 - 350 calories per bottle

Consequences:

- He felt progressively weak as he was unable to sustain himself on broth and water
- Sustained a fall 2 weeks after discharge

Case 3

- Demographics: 79 y.o. Male
- Co-morbidities: acute diastolic CHF, anasarca, HIT, obstructive sleep apnea, chronic renal insufficiency stage III, essential hypertension, and T2DM
- Initial presentation: Presented to the Emergency Department with abdominal **bloating**, **weakness**, and **dizziness**
- Hospital Course: Diagnosed with hypertensive emergency, treated and sent to rehabilitation center



Case 3: Discharge Instructions

Documented by Medical Care Team	Patient's Reported Understanding
<p>Weigh yourself every other day</p> <p>Report to PCP if gain more than 3 pounds in 2 days</p> <p>Follow a 2 gram sodium restriction and 2 liter fluid restriction diet</p> <p>Make arrangement for stress test as outpatient</p>	<p>Patient verbalized understanding of discharge instructions to students</p>

Case 3: Social Situation

- Son
 - Came in from out of town to help
 - Seemed to have a decent understanding of his father's situation



Case 3: Living Situation

- Rehabilitation center
 - Patient was discharged from hospital and immediately sent to a rehabilitation center to heal
 - He had 24 hour care from staff.



Case 3: Economic Situation

- Healthy food
 - Son mentioned that his father was often unable to spend money on healthy food options
- Prescriptions
 - Patient was able to pay for his 13 prescribed medications
- CPAP
 - Patient owned a CPAP machine, but was unable to pay for an updated mask that fit him more appropriately



Case 3: Summary

- Arrives at the hospital for abdominal bloating, weakness, and dizziness
- Multiple co-morbidities with a long list of prescription medications and CPAP
- Discharged to rehabilitation facility and has son to help



Case 3:



Do you think that this patient returned to the hospital within 30-days of discharge?

Case 3: Barriers to Health

- Poor understanding of current medical conditions, especially diabetes
 - Did not verbalize constraints on diet to rehabilitation center
- Possible miscommunication between facilities
 - Patient was given a high sugar dessert every day despite being diabetic
 - This worsened his health until the medical students stepped in



How do we improve patient health and reduce readmissions?

From what we've seen so far:

- Patient education and comprehension
- Concise discharge instructions
- Improve communication between facilities
- Economic support for essential medical supplies
- Improved screening for patients discharged home

But this isn't enough...

- Majority of healthcare happens outside of the hospital
- If we can identify trends in these barriers to health, then maybe we can anticipate these problems and develop a plan to prevent them

**I'M NOT
TELLING YOU
IT'S GOING
TO BE EASY**

**I'M TELLING YOU
IT'S GOING
TO BE
WORTH IT.**

- ARY WILLIAMS

Questions?