Reducing Re-Hospitalization Rates

Presented by:
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Objectives

• Review the possible future QIP measures related to ESRD patient hospitalization and re-admission
• List 3 of the 8 ‘Ps’ that are associated with increased patient re-admissions risk
• Review how a standardized documentation tool and clinical process may reduce re-hospitalizations rates
Possible Future QIP Measures

• In draft 2015 QIP regulations, CMS included the following possible future QIP measures:
  – Standardized Mortality Ratio (SMR)
  – *Standardized Hospitalization Ratio (SHR)*
  – 30-day Readmission Rate

• CMS further stated that the SHR and SMR will be published on Medicare Compare web site – before QIP measure adoption
BOOSTing Care Transitions

• Quality initiative by the Society of Hospital Medicine (SHM)
• BOOST – Better Outcomes for Older Adults Through Safe Transitions
• Lists risk factors associated with re-admissions per literature

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/06Boost/03_Assessment.cfm
BOOSTing Care Transitions
Risk Factors – 8 P’s

1. Problem medications
   - Warfarin
   - Insulin
   - Digoxin
   - Aspirin with clopidogrel (Plavix)

2. Psychological
   - Depression, new or history of

3. Principal diagnosis
   - Cancer
   - Stroke
   - Diabetes, glycemic complications
   - COPD
   - Heart Failure

4. Polypharmacy
   - 5 or more
### BOOSTing Care Transitions

**Risk Factors – 8 P’s (cont.)**

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<td>5.</td>
<td>Poor health literacy</td>
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<td>6.</td>
<td>Patient support</td>
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<td>6.1</td>
<td>Formal or informal care giver</td>
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<td>7.</td>
<td>Prior Hospitalizations</td>
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<tr>
<td>7.1</td>
<td>In last 6 months</td>
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<td>7.2</td>
<td>Single most predictive risk factor!</td>
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<td>8.</td>
<td>Palliative Care</td>
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<td>8.1</td>
<td>Only limited number of eligible patients receive these services</td>
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<td>8.2</td>
<td>Engaging these services shown to improve symptom mgmt</td>
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<td>8.3</td>
<td>Increased patient satisfaction</td>
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BOOSTing Care Transitions

- Tool for identifying and addressing re-hospitalization risks
- Original BOOST tool:
BOOSTing Care Transitions

- Hospitals may or may not utilize BOOST tool
- Consider tool modifications for dialysis center use
BOOSTing Care Transitions
Dialysis Center Utilization

- Clinical processes to leverage tool to reduce re-hospitalization rates
  - Modify tool for post hospitalization use
  - Interval between discharge and tool application
  - Specific care team assignment(s) to apply tool
  - Interval / assignment for follow up
  - Integrate into TIME as progress note template
- Request copy from HII (which was modified for outpatient provider use)
Client Processes

• Client feedback on current processes
• Future plans
• Tools / templates used
Questions

It's QUESTION TIME!!