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Ten Essential Steps for Your Readmission Reduction Program

By KimSu Marder Lead Care Manager Health Catalyst

Ten common care management steps, when implemented during the first 30 days after discharge, can help health systems reduce avoidable hospital inpatient readmission rates—an increasingly important outcomes improvement metric.

A readmission, according to the HRRP, is an admission to a hospital facility within 30 days of discharge from the same or different facility. This makes the first 30 days after a patient returns home a critical point in care management. According to the Briggs National Quality Improvement and Hospitalization Reduction study, of the 707 homecare agencies it surveyed, over 60 percent of those with the lowest percentage of hospital readmissions utilized common post-discharge strategies. In addition to impacting patient welfare and quality of care, readmissions also affect a health system's bottom line: since the Affordable Care Act established the Hospital Readmission Reduction Program (HRRP) in 2012, organizations face financial penalties for unacceptably high readmission rates among Medicare and Medicaid patients.

This article describes 10 steps care managers should take, during the first 30 days after a patient returns home from an acute care facility, to keep their patients safe and healthy, and avoid unnecessary readmissions—and associated costs and penalties.

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Ten Care Management Steps to Avoid Readmission During the First 30 Days After Discharge

Care managers, after ensuring their patient has been safely discharged home from an inpatient setting, can use a 10-step checklist to prevent unplanned or avoidable readmissions during the first 30 days after discharge.

These common strategies work like a pilot's pre-flight checklist—no matter how many times a pilot has flown, he or she always references a prescribed list of steps before each flight to ensure safety and preparedness. Similarly, care managers should follow a checklist to ensure optimal post-discharge care at home. Common strategies ensure that communication between the patient, family, and clinician is open and without gaps; the patient and caregivers understand the care plan; the patient has regular contact with the care team; and patients are more confident in their own self-care abilities.

Step 1: Call the patient within two days of discharge.

The care manager calls the patient within two days of discharge and conducts a post-discharge assessment, which covers critical aspects of the patient's discharge plan:

- Does the patient understand the condition that led to hospital admission?
- Does the patient understand newly prescribed medications—what they are for and how to take them?
- What are the dates and times of follow-up appointments—with both the primary care provider (PCP) and any new specialists?
- What are the patient's options for transportation to and from the appointment?
- For what signs and symptoms should the patient call the PCP or 24-hour nurse line?
- If the patient is a Medicare beneficiary, has one of their healthcare professionals followed CMS face-to-face visit requirements for transitional care management billing?

Step 2: Assess the patient's self-care capacity.

Even though visiting nurses may intermittently come to the patient's home, the care manager must ask several questions to determine the patient's capacity for self-care on a 24-hour basis:

- Can the patient understand and carry out the recommended treatment plan?
- Does the patient have someone to call if they need help (other than in an emergency)?

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- Does the care manager have permission to speak with the patient's caregiver? If the patient has a spouse or significant other (caregiver), ensure that this person understands the care plan, the medications, and has the capacity to care for the patient.
- Is the patient at risk for depression? If the patient is at risk for depression, ask the PCP for the most appropriate next step, be it a referral, a medication or counseling.
- Can the patient or caregiver plan meals and shop for groceries?
- Can the patient perform activities of daily living, such as showering, toileting, and transferring from a bed to a chair and a chair to a bed?

If the patient can't care for himself or herself, and doesn't have a caregiver at home, the care manager will suggest a home health aide (HHA) or a personal care attendant (PCA), if the patient qualifies. Each state may have different requirements.

Step 3: Frontload homecare and ensure patient 'touches', if appropriate.

If a patient doesn't have a family caregiver available, lives alone, has cognitive deficits, is below functional baseline, or has been diagnosed with a new condition, maximizing patient touches during the first two weeks after admission is important. According to the Briggs study, patient touches include telephone calls from a care manager or non-clinical support staff, and initial visits from a physical therapist, occupational therapist, speech therapist, HHA, or social worker/behavioral health specialist.

The Briggs study indicates that more frequent patient touches result in improved outcomes (lower readmission rates) and improved patient self-care confidence. Ideally, the care manager performs the assessment visit (patient touch) within one day after discharge.

Frontloading is defined as four or more patient touches by a nurse, care manager, social worker, or therapist. Fewer than three visits during the first two weeks raises risk for readmission, per the Briggs findings, and a higher frequency of visits and intensity of care align with improved outcomes.

Step 4: Conduct a home safety evaluation.

The care manager requests a home safety evaluation as soon as possible. Ideally, in cases that discharge directly home rather than to a rehab facility (e.g., some total joint replacements), a home safety evaluation happens prior to discharge. In some cases, a home health agency (e.g., Visiting Nurse Association) will work with the patient, family, discharge planner, and care manager to see the home before, or on the same day as, discharge to identify fall risks (e.g., loose area rugs, clutter in common areas, and lack of shower grab bars).

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Step 5: Order and install durable medical equipment prior to discharge.

The case manager from the discharging facility often arranges durable medical equipment (DME), such as a hospital bed, oxygen, CPAP machine, or nutritional supplements. The care manager then reviews the facility case manager's orders, and collaborates with therapy and the home health agency to see what is still needed.

The care manager will communicate with the home health agency about unmet needs—raised toilet seats, commodes, walkers, etc.—prior to discharge. The home health agency can arrange select DME, such as stair lifts and specialized wheel chairs or walkers, after the initial visit. When there's a gap between when the DME is ordered and when it is delivered, some communities have wheel chair loaner programs, and medical supply companies may be able to deliver equipment on a rental basis.

Step 6: Order an emergency alert/medication reminder system and preprogram important phone numbers on patient's phone (e.g., PCP, family member, pharmacy, etc.).

The care manager orders an emergency alert system immediately if the patient has a history of falls, is elderly or in a weakened state, or lives alone and has a high-risk diagnosis. The most critical part of this system, however, is educating the patient on its use, and emphasizing that the device must be worn at all times, especially in the shower or bathroom. There are also medication reminder systems available for patients with memory deficits.

All patients must have important contact numbers on speed dial in their phones. Some phone systems, available through community agencies, display of photo of the contact when the patient hits the contact's number. Ensure the patient knows how to use the speed dial function. If the patient does not have a cell phone, they can use a simple home phone with preprogrammed numbers.

Step 7: Implement fall prevention program, intervention, and education.

Although fall prevention may be included in the home safety evaluation, it warrants a separate category: falls are the primary cause of accidental deaths for people 65 and older, according to the Briggs study. Eighty-six percent of all hip fractures occur in patients 65 and older, and the National Institutes of Health (NIH) reports that an average of 21 percent of these patients die within one year of hip fracture. Findings also show that patients are five to eight times more likely to die within three months after a fracture.

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Step 8: Provide in-home education on new diagnoses or unmanaged chronic conditions.

In cases of newly diagnosed or unmanaged diabetes, the care manager arranges in-home education with a certified diabetes educator (if one is available through the home health agency). For new cardiac, COPD, or cancer diagnoses, the care manager makes sure both the home health agency and the care manager review these cases. If the patient requires dietary changes, and the patient and primary care provider are agreeable, arrange a nutrition consult.

The care manager has the patient teach back the in-home care plan to ensure they understand the condition, self-care, and signs and symptoms of worsening condition, as well as when to call the PCP or 24-hour nurse line, if available. If there is a language or cognitive barrier, the teach-back method ensures the patients understand the care plan more effectively than a nod or simple verbal confirmation (e.g., "Yes, I understand.")

Step 9: Connect the patient with community resources.

Community resources exist to help with many patient needs. A robust care management program will list community agencies that address patients' social, religious, and cultural needs:

- Transportation programs.
- Senior center activities.
- Meals on Wheels.
- Cultural and religious centers.
- Food pantries.
- Volunteer opportunities.
- Condition-specific organizations, such as the Alzheimer's Association and the American Cancer Society, and the Association for the Blind.
- Additional resources, if needed, such as housing, legal, and immigration services.

The care manager can collaborate with a social worker or the agency itself to arrange community resources for the patient. Some programs designate a non-clinical staff member or a community health worker to maintain a resource library. Some community resources have a representative who can visit the patient at home—an important service, as visits to high-risk patients offer more support and increase confidence in self-care and providing care for both the patient and the caregiver.

Step 10: Establish a best practice for follow-up phone calls after discharge.

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There are many variations in follow-up phone calls for the first 30 days. As with patient touches, which contribute to better outcomes, follow-up phone calls are a critical part of the care plan. Many care management programs require calling patients at two, seven, fourteen, and thirty days. There are specific questions for each patient call.

Suggested day two questions:

- How do you feel?
- Do you understand why you were in the hospital?
- Do you understand the discharge instructions?
- Did you get your medicine?
- Do you know how to take the medicine?
- Do you have someone to help?
- Do you know when to call the doctor (signs and symptoms or change in condition)?
- Do you have a follow-up appointment with the PCP and specialist (if needed)?

Suggested day seven questions:

- How do you feel (better, worse, or the same)?
- Which nurses or therapists have visited you?
- What other services do you have in your home?
- Do you have transportation to and from your follow-up appointment?
- If the patient has already been to the PCP or specialist, the care manager asks about that visit and if there are new instructions.
- During this call, the care managers should also reassess for depression and arrange a plan, if necessary.

Suggested day fourteen questions:

- How was your follow-up visit?
- Are you able to do more for yourself?
- What are your goals for the next two weeks?
- The care manager and patient set a two-week goal and a one-month goal, with no more than two specific, attainable, measurable goals (e.g., weighing themselves daily and calling PCP if weight changes by more than four pounds).

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Sample day thirty questions (referring to patient goals set on day fourteen call):

- How did you do on your goal?
- Were you able to weigh yourself every day?
- What should you change about the goals?
- How are you feeling now compared to the day after your discharge?
- What would you like my help with over the next month?

Care Management Doesn't End at Discharge

A patient's care doesn't end when they're discharged from the hospital or any other inpatient setting. The true continuum of care extends into the patient's daily life at home and in the community. However, the first 30 days after discharge require a more intensified management, as reducing risk of unnecessary readmission is paramount during this time.

Implementing the care management steps and strategies outlined in this article during those first 30 days post-discharge can help patients avoid gaps in care, incorrect medication use, and mitigate home-safety risks—a simple, care management "pilot checklist" will improve outcomes and lower patients' risk for avoidable readmissions.

About the Author

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KimSu Marder joined Health Catalyst in September 2015 as Care Manager Lead. Prior to coming to Health Catalyst, she worked for Tufts Health Plan as Care Management Relationship Manager. KimSu has a degree in Education from Lesley University, a degree in Nursing from Regis College, and is currently working on a Psychiatric Nurse Practitioner MSN at Regis College.

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