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Reducing Hospital Readmissions

2012 ADGAP Leadership Retreat

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UCSF Division of Geriatrics

Introductory Points

- **Penalties start in 2013 for hospitals with high risk-adjusted readmission rates**
- **Health Reform Provides Opportunities:**
  - Innovations funding
  - Independence at Home Demonstrations
  - Section 3026 of HR 3590: Community-based Care Transitions Program
- **Readmissions are common**
- **Interventions are Heterogeneous and Work … Sometimes**

Readmissions are Common for Medicare Beneficiaries Over 65 Years

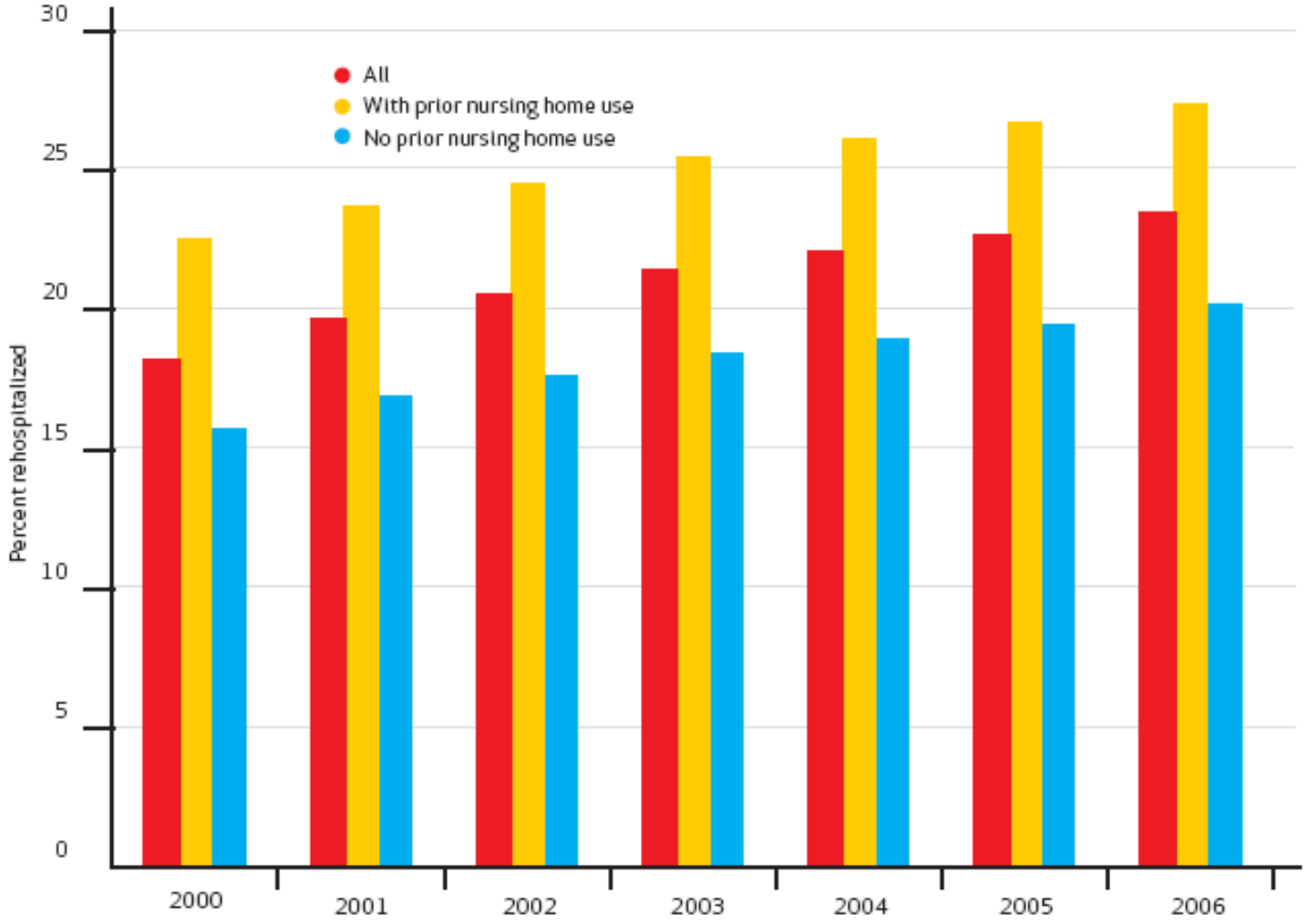
- **1974 – 1977: 15.6%**
- **2003 – 2004: 19.6%**
  - Most often with CHF (9%) or pneumonia (7%)
  - 50% did not see MD after discharge
  - 90% were unplanned rehospitalizations
- **8-20% of readmissions attributable to substandard inpatient care**
- **MedPAC estimates 75% may be avoidable**

Anderson GF, Steinberg EF. NEJM 1984; 311:1349-53.

Jencks SF et al. NEJM 2009; 360: 1418-28.

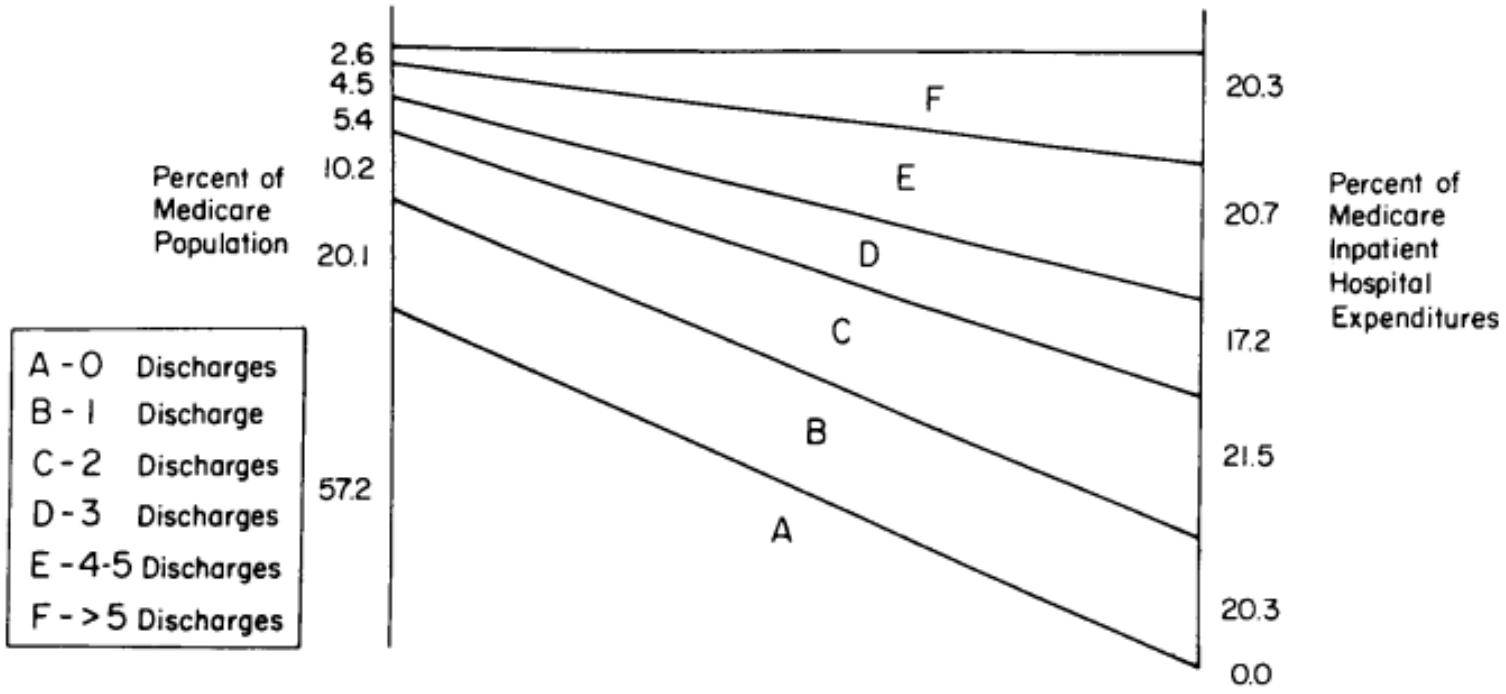
Ashton CM et al. Ann Intern Med 1995; 122: 415-421.

Trends In Rehospitalization Rates From Skilled Nursing Facilities: 2000–2006



SOURCE Authors' calculations using Medicare inpatient and skilled nursing facility claims and eligibility data and the Minimum Data Set, Centers for Medicare and Medicaid Services.

Readmissions Cost a Lot



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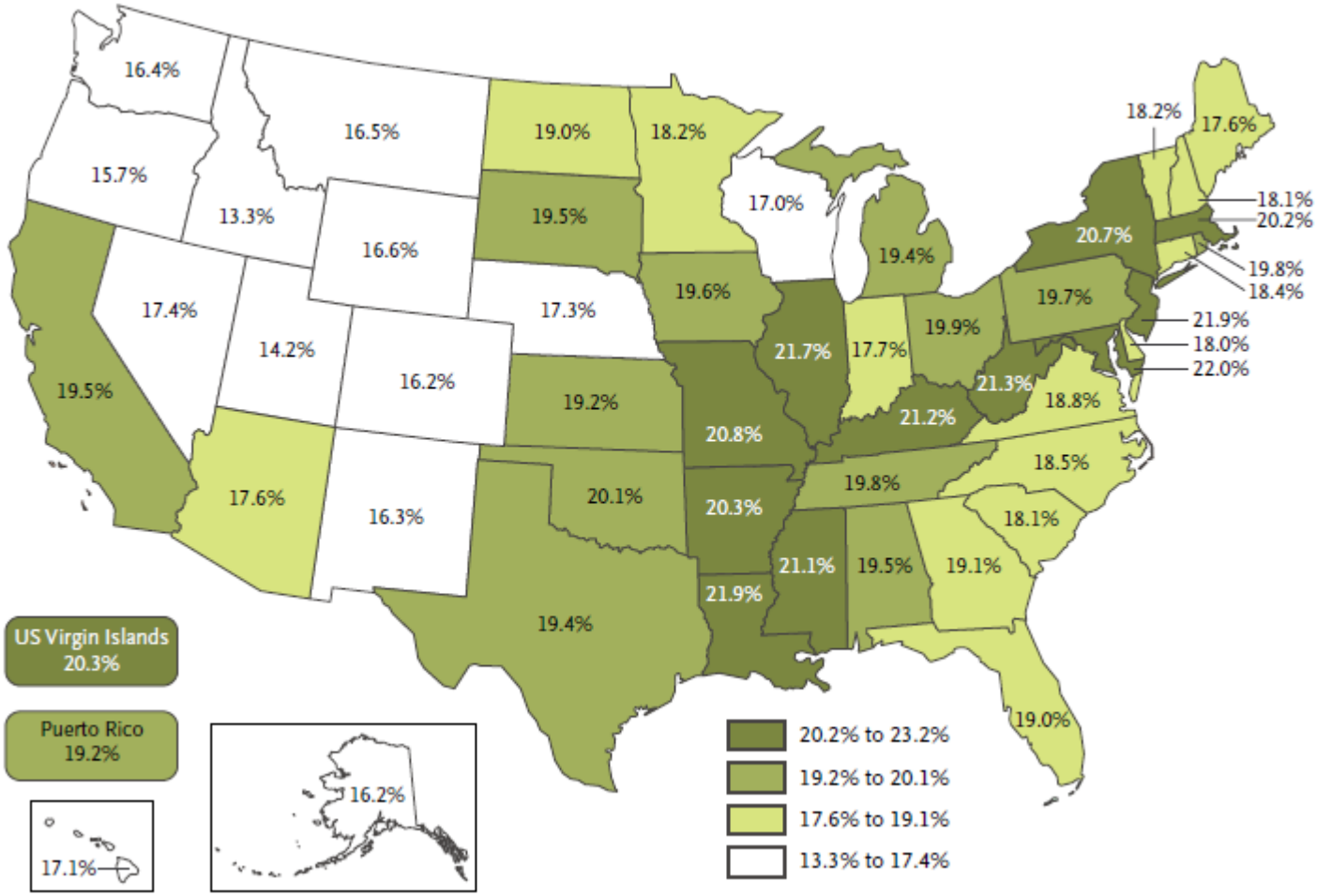
Readmission Rates Vary



Predictors of Readmission

- Older age (especially >85 years)
- Men
- Blacks
- ESRD
- Previous readmission
- Dx and Longer LOS on previous hospital stay
- Hospital's readmission rate

Jencks SF et al. NEJM 2009; 360: 1418-28

Interventions to Prevent Readmission

Predischarge Intervention	Postdischarge Intervention
Patient education	Timely follow-up
Discharge planning	Timely PCP communication
Medication reconciliation	Follow-up telephone call
Appointment scheduled before discharge	Patient hotline
	Home visit
Intervention Bridging the Transition	
Transition coach	
Patient-centered discharge instructions	
Provider continuity	

Hansen LO et al. Ann Intern Med 2011; 155: 520-28.

Effects of Interventions to Prevent Readmission

- **16 RCTs with >4500 patients**
- **Most interventions were multicomponent "discharge bundles"**
- **11 RCTs found reduction in readmission rates, 5 did not (5 were statistically significant)**
- **Mean absolute reduction: 3.8%**
- **Median absolute reduction: 3.6%**
- **5 interventions with statistically significant effects:**
  - 1: early discharge planning in high-risk patients
  - 4: discharge bundles with patient-centered discharge instructions & post-discharge phone call

Hansen LO et al. Ann Intern Med 2011; 155: 520-28.

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Conclusion

- **Time of Opportunity!**

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Tell Your Stories … In JAMA's "Care of the Aging Patient

CARE OF THE AGING PATIENT
FROM EVIDENCE TO ACTION

The Patient Who Falls
"It's Always a Trade-off"

Mary E. Tinetti, MD
Chandrika Kumar, MD

Falls are common health events that cause discomfort and disability for older adults and stress for caregivers. Using the case of an older man who has experienced multiple falls and a hip fracture, this article, which focuses on community-living older adults, addresses the consequences and etiology of falls; summarizes the evidence on predisposing factors and effective interventions; and discusses how to translate this evidence into patient care. Previous falls; strength, gait, and balance impairments; and medications are the strongest risk factors for falling. Effective single interventions include exercise and physical therapy, cataract surgery, and medication reduction. Evidence suggests that the most effective strategy for reducing the rate of falling in community-living older adults may be intervening on multiple risk factors. Vitamin D has the strongest clinical trial evidence of benefit for preventing fractures among older men at risk. Issues involved in incorporating these evidence-based fall prevention interventions into outpatient practice are discussed, as are the trade-offs inherent in managing older patients at risk of falling.

The Patient's Story

Mr Y, an 89-year-old retired salesman, lived independently until 3 years ago. He had a right humeral fracture in 2006 and a left hip fracture 3 months later. After hip fracture repair and rehabilitation, he moved in with his daughter, a physical therapist.

Mr Y's medical history includes coronary artery bypass grafting and porcine aortic valve replacement in 2003; dementia; hypertension; gout; peptic ulcer disease; macular degeneration; and bilateral hearing aids. In 1992, Mr Y fractured his right hip in a bar brawl; he used alcohol heavily until a few years ago.

On arrival at his daughter's home, Mr Y reported left hip pain and an unsteady gait. He became delirious when taking oxycodone ER, 10 mg every 12 hours. In June 2007, his daughter brought Mr Y to see Dr C, a geriatrician, who noted pruritus, chronic rhinorrhea, and weight loss. Mr Y scored 28 of 30 on the Folstein Mini-Mental State Examination[1]; he missed the date and recalled 2 of 3 objects at 5 minutes.[1] Mr Y's recall of 2 words, plus his abnormal clock drawing (eFigure, available at http://www.jama.com), indicated a positive screen for demen-

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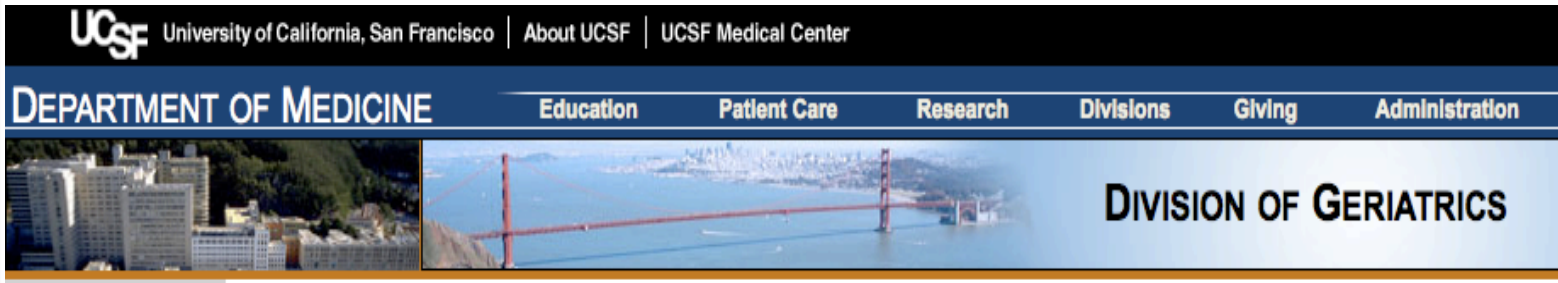

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- Fellowship
- Education
- Research
- Patient Care
- Philanthropy
- Resources
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- About Us
- Intranet

Care of the Aging Patient

Care of the Aging Patient: From Evidence to Action

We Are Soliciting Your Patient Stories

The editorial team for the *Journal of the American Medical Association* series, Care of the Aging Patient: From Evid Action invites you to contribute a patient story to inspire a future article.

Contributors whose Patient Story is selected for an article will be acknowledged in *JAMA* and will receive a $500 honorarium. In the editorial team can provide a letter confirming this peer-reviewed contribution.

About the Series

Care of the Aging Patient is produced by a University of California, San Francisco editorial team and appears bi-monthly in *JAMA* case-based series is designed to inform clinical practice and influence policy in care of older individuals. Excerpts from patient, f clinician interviews, along with the Patient's Story case history, drive the narrative of an evidence-based, peer-reviewed article t authored by an invited expert in the field. Cases illustrate the approach and management of the entire spectrum of geriatric syn disease, including the psycho-social-spiritual aspects of aging.

Choosing a Patient Story

We seek compelling patient stories that introduce a topic that will be of interest to JAMA's readers. Topics of particular interest f can be viewed here. Other topics will also be considered.

For each patient story, relevant participants should be available for an interview with the Managing Editor of "Care of the Aging These participants ideally include the patient, a family member, the main physician, and others on the care team.

What Can We Do, Individually and Together?

- **Reframe the "magic" of medicine**
  - Put reductionism in context
- **Elevate evidence, recognize uncertainty**
- **Regulate the Commons, Expand access**
- **Restrain commercialism in medicine**
- **Nurture our professionalism as a moral community**