

VCSQI Readmissions Reduction Protocol

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Hospital Readmission Definition – *inpatient admission to a hospital within 30 days of discharge from the same or another hospital*

Objective: To develop practical and applicable measures that each facility should be able to adopt for reducing readmissions after heart surgery.

Significance: CMS currently estimates that avoidable hospital readmissions account at \$17.4 billion, or 17% of the \$102.6 billion Medicare budget. The Median number of patients readmitted after CABG from the STS national database is 10%. VCSQI data on readmissions after CABG (2002-2014) ranges from 7.1% to 9.1%. Beginning in 2017, CMS will reduce payments to hospitals with excessive readmissions after CABG surgery. Hospitals that have implemented some form of readmission reduction programs were able to reduce readmission by 10 to 30%.

Role of Discharge Planner: This is critical to the successful implementation of a readmission reduction program. This person can be part of the CT surgery team or a member of a larger team that is focused on readmission reduction at the institutional level. Broad functions of a discharge planner include coordination of patient care before, during, and after the hospitalization for surgery:

1. Interaction with the patient and family
2. Keeping the Primary Care Provider (PCP) in the loop
3. Identifying consultants involved in patients' ongoing care including referring cardiologists
4. Involving the social worker in planning surgery
5. Monitoring the daily progress of patients after surgery
6. Setting up resources (pharmacy, physical/occupational therapy, home health care, followup appointments) for ongoing recovery outside of the hospital

For ease of implementation, the readmission reduction interventions are divided into three groups: Before Surgery, After Surgery and After Discharge from the Hospital.

Before Surgery:

1. Risk factor(s) identification
 - a. Female gender
 - b. Frail/Elderly
 - c. Multiple co-morbidities: diabetes, chronic lung disease, HF, PVD

- d. Renal failure
 - e. Current smoker
 - f. Anticipated D/C on anticoagulation meds
 - g. Lack of social or financial support
 - h. MI within 1 week of surgery
2. Optimize pre-existing conditions: Diabetes, COPD, Renal failure, Heart Failure
 3. Monitoring and completing planned treatments: antibiotics, steroid tapering, dental clearance, diuretics
 4. Select timing of non-urgent or emergent surgery: care giver identification and availability
 5. Screening for medications: NSAIDs, NOACs, antiplatelet agents and stopping them at the appropriate time before surgery date
 6. Social service support involvement: lack of prescription coverage, lack of insurance, coverage for recovery options
 7. Patient and family education: expectations and alternate arrangements

After Surgery:

1. In addition to the preoperative risk factors above, high risk patients after surgery include: patients who require >48hrs of ICU stay, those who develop any post-operative complications, stay for longer than 7 days in hospital or are being discharged to rehabilitation facility
2. The Discharge Planner should monitor daily progress with the CT team on rounds
3. Leave drainage tubes longer in heart failure and renal failure patients. Attend to pleural effusions with tap prior to discharge in these group of patients
4. Set a target discharge date
5. If consultation teams are involved, communicate the anticipated discharge date, schedule any follow-up appointments, and facilitate any outstanding tests/procedures that might delay discharge.
6. Involve patient and family in post-operative education, especially with medications
7. Accurate and concise medication reconciliation
8. Arrange for a 30-day supply of medications for those who do not have insurance or need assistance in obtaining medications
9. Convert necessary medications to acceptable alternatives available on the \$4 drug list to increase affordability
10. Provide written instructions in simple language with a clear print out of what conditions warrant an immediate call to the CT surgery office: incision care, pain medications and appropriate use, watch for symptoms of infection, daily weight recoding and when to communicate with significant change in weight, respiratory symptoms etc.

11. Utilize a teach-back program to increase patients' understanding of instructions
12. Provide contact information to the CT surgery team and **24/7 access to a CT team** member
13. Arrange for timely follow-ups: within a week with CT clinic, 2 weeks with PCP, and 3-4 weeks with cardiologist
14. Same day access to a CT surgery clinic
15. Arrange for home health care with third party if needed
16. Discharge summary to be sent to PCP and consultants' offices on the day of discharge; provide the **contact number** for more information
17. Discharge summary and contact person for additional information when sent to rehab facilities
18. Appointment and target INR with anticoagulation clinic/PCP if needed
19. If appropriate arrangements are not made for a safe discharge, delay discharging the patient

After Discharge:

1. CTS team embraces patient ownership with NO "deferring" to other specialties without communication of such
2. Phone call within 24hrs of discharge
3. Early enrollment in cardiac rehab
4. Confirm that prescriptions are filled and written instructions are at hand with contact numbers

Advanced Interventions:

1. Home with remote monitoring of HR, BP, weight, and pulse oximeter, with daily reports to CT office
2. Establish a process to receive a call from the Home Health agency prior to sending patient to ED
3. Set up a minor procedure room in CT clinic: tap pleural effusion, wound care
4. Resource utilization with ED: CT team contact person for ED staff to reach for any cardiac surgery patient
5. Admit to observation status in ED instead of inpatient admission to hospital
6. Decrease variation in care among surgeons with standardization and consistency
7. Implementation of Atrial Fibrillation prophylaxis protocols