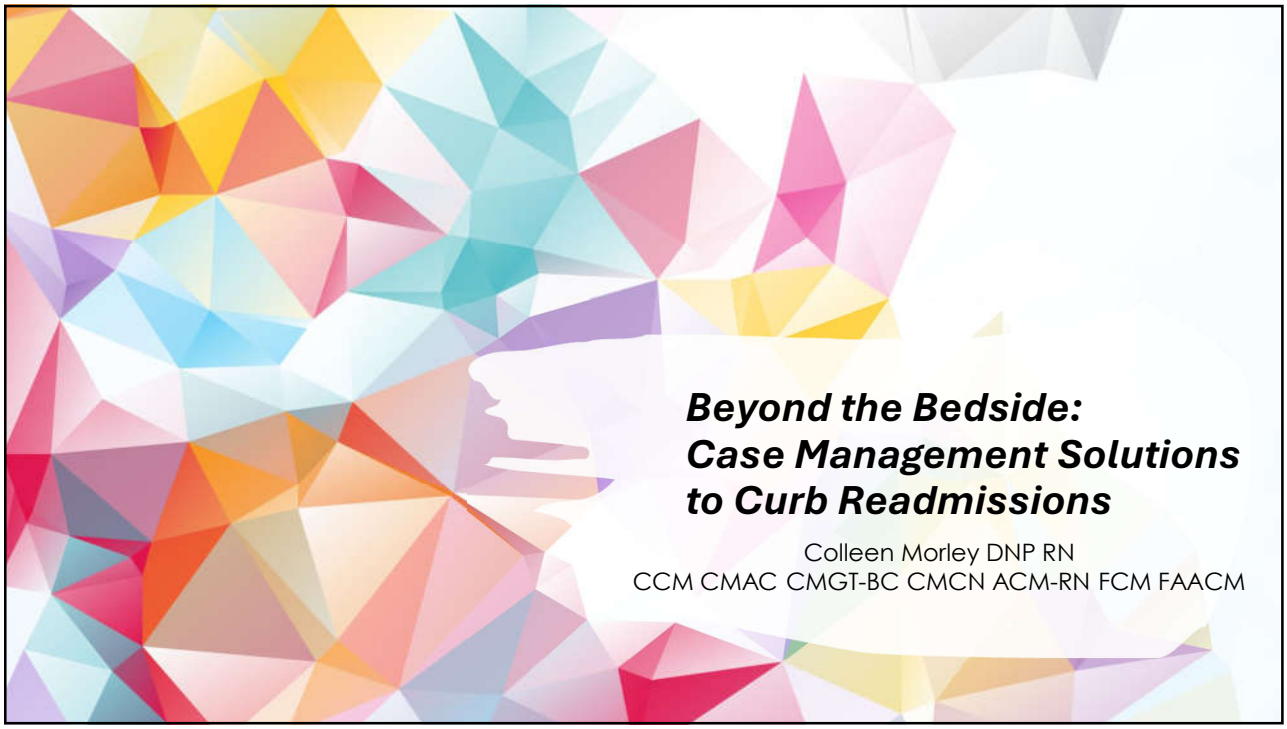

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Introduction

- Since its implementation in 2012 under the Affordable Care Act, HRRP has been a cornerstone initiative aimed at improving patient outcomes and reducing avoidable hospital readmissions. By financially penalizing hospitals with higher-than-expected readmission rates for certain conditions, the program has driven significant changes in how healthcare organizations approach quality improvement, care transitions, and patient engagement.
- In this session, we will provide a comprehensive overview of HRRP's impact over the past decade, highlighting key successes, ongoing challenges, and areas for growth. We will explore how hospitals have adapted to these policies, the clinical and financial outcomes achieved, and the evolving focus on social determinants of health and health equity.
- Looking ahead, we will discuss anticipated program expansions, potential policy shifts, and the integration of innovative strategies—such as technology-driven care coordination and personalized patient care—to continue advancing quality care and reducing readmissions.

Objectives

At the end of this presentation, learners will be able to :

1. Identify the primary drivers of hospital readmissions and how case managers can effectively address them.(CCMC Code of Professional Conduct Principle #7)
2. Utilize data-driven approaches to assess and mitigate readmission risk and foster collaboration across care teams to enhance patient-centered care and continuity.
3. Develop actionable plans to apply readmission reduction strategies within their own organizations by becoming familiar with EBP programs for readmission reduction.
4. Describe how using the readmission avoidance strategies covered in this lecture improve a clients' health and promotes wellness and autonomy.(CCMC Code of Professional Conduct Principle #2)
5. Compare and contrast the readmission avoidance care measures conveyed to those used in your own case management practice.(CCMC Code of Professional Conduct Principle #5)

Definition

- Hospital Readmission Reduction Program (HRRP)
  - The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions.
  - The program supports the national goal of improving health care for Americans by linking payment to the quality of hospital care.

(CCMC Code of Professional Conduct Principle #7)

What is a "Readmission"?

- A hospital readmission is defined as when a patient who had been discharged from a hospital is admitted again to any acute healthcare facility within a specified time frame.
- The original hospital stay is referred to as the "index admission" and the subsequent hospital stay is defined as the "readmission."
- Most common time frames for research purposes:
  - 30-day
  - 90-day
  - 1-year readmissions

Why Readmissions?

Quality of care

- Readmissions within 30 days of discharge for same/ similar diagnosis are deemed "potentially avoidable admissions"
- Perception of "failure of discharge plan"
- In addition to the financial risk, readmissions are publicly reported as quality metric and impact the facility's Medicare Star rating

Financial implications

- Penalties are levied on facilities with higher than average rates of readmission
- Admissions identified as "readmissions" will not be reimbursed

Statistics

Average Hospital Readmission Rates:

- **National Average:** As of 2024, the average hospital readmission rate in the United States is approximately 14.56%. This rate varies by state, ranging from 11.2% to 22.3%.

State-Specific Readmission Rates:

- **Massachusetts:** Hospitals in Massachusetts have the highest average readmission rate at 15.3%.
- **Hawaii:** Hawaii reports the lowest average readmission rate at 13.87%.

Statistics Over Time

2013

19.8% Medicare Overall Readmission rate

34% readmitted within 90 days

50.2% of patients did NOT have PCP visit within 30 days of DC

2021

15.5% Medicare Overall Readmission rate

30% readmitted within 90 days

48.8% of patients did NOT have PCP visit within 30 days of DC

2023

14.56% Medicare Overall Readmission rate

Readmitted within 90 days: not yet available

50% of patients did NOT have PCP visit within 30 days of DC

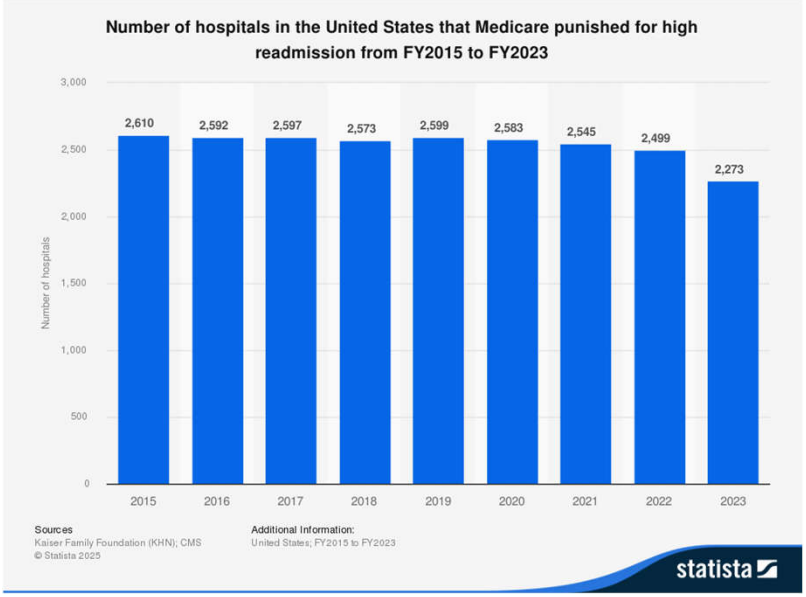
Costs

Medicare Spending on Readmissions	2015: $26 billion 2019: $29 billion 2022: $26 billion* •Pneumonia removed from calculations under CV-19 exclusion
CHF	2012: 34.0%/ $65 billion in care costs 2019: 21.9%/ $43.6 billion in care costs 2022: 23.0%/ $54 billion in care costs
COPD:	2012: 27.0%/$32.1 billion in care costs 2019: 19.7%/$49 billion in care costs 2022: 19.0%/ $60 billion in care costs

(CCMC Code of Professional Conduct Principle #7)

Periods and Penalties

- In FY2023, from the 5,236 hospitals Medicare assessed for hospital readmissions, 2,273 (or 42 %) were penalized for readmission rates exceeding 30-day risk-standardized readmission rates.
  - For FY 2023, Pneumonia diagnosis continues to be excluded. Will return for evaluation in 2025.



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Understanding the Root Causes of Readmissions

- Clinical Drivers
  - Diagnoses
  - Medication Issue
  - Follow up
- Non-Clinical Drivers
  - SDoH concerns
  - Health equity
  - Patient perspective

Conditions/Procedures

- CMS includes the following six condition or procedure-specific 30-day risk-standardized unplanned readmission measures in the program:
- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia (excluded for 2020-2024)
- Coronary artery bypass graft (CABG) surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

Medication Adherence

Medication adherence—the extent to which patients take medications as prescribed—is crucial for effective disease management and reducing hospital readmissions. Nonadherence can lead to suboptimal health outcomes, increased morbidity, and higher healthcare costs.

- **Prevalence:** Approximately 50% of patients with chronic diseases do not take medications as prescribed. In the U.S., 3.8 billion prescriptions are written annually, yet many are not taken correctly. (CDC, 2024)
- **Economic Impact:** Medication nonadherence contributes to direct healthcare costs ranging from $100 billion to $300 billion annually in the United States. (CDC, 2024)
- **Increased Readmission Rates:** Nonadherence is associated with higher rates of hospital admissions. Studies indicate that patients with low medication adherence have a 2.54-fold higher odds of 30-day readmission compared to those with high adherence. (CDC, 2024)
- **Medication-Related Readmissions:** Medication-related problems, including nonadherence, are significant contributors to hospital readmissions. Research shows that preventable medication-related readmissions often reflect prescribing problems and adherence issues.

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Follow Up

Timely outpatient follow-up visits have been associated with reduced 30-day all-cause readmissions for patients with heart failure. A systematic review and meta-analysis published in 2024 reported that outpatient follow-up visits were linked to a 21% lower risk of 30-day all-cause readmission for heart failure patients. (CDC, 2024)

Implications:

- **Improved Care Coordination:** Early post-discharge follow-up facilitates better care coordination, allowing healthcare providers to address potential complications promptly, adjust treatment plans, and reinforce patient education.
- **Enhanced Patient Engagement:** Timely follow-up visits encourage patient engagement in their care, promoting adherence to medications and lifestyle modifications essential for recovery.
- **Reduced Healthcare Costs:** By decreasing the likelihood of readmissions, timely follow-up can lead to significant cost savings for both healthcare systems and patients.
- **Policy Implications:** Recognizing the benefits of timely follow-up, Medicare has implemented payments for transitional care management services to incentivize early post-discharge follow-up, aiming to reduce readmission rates and improve patient outcomes. (JAMA, 2024)

(CCMC Code of Professional Conduct Principle #2)

Non-Clinical Drivers

Social Determinants of Health (SDoH): Transportation, housing, food insecurity, health literacy.

Health equity and the patient's perspective.

(CCMC Code of Professional Conduct Principle #2)

SDoH Impact on Readmissions

Non-clinical factors, commonly referred to as social determinants of health (SDoH), significantly influence hospital readmission rates. These determinants encompass the conditions in which individuals are born, grow, live, work, and age, and they play a crucial role in health outcomes.

Key Social Determinants Impacting Readmissions:

- **Socioeconomic Status (SES):** Lower SES is associated with higher readmission rates. Patients from disadvantaged backgrounds often face challenges such as limited access to healthcare resources, inadequate health literacy, and financial constraints, all contributing to increased likelihood of readmission. (BMC, 2024)
- **Education Level:** Limited education can impede a patient's ability to comprehend discharge instructions and manage post-hospitalization care effectively, leading to higher chances of readmission. (BMC, 2024)
- **Housing Instability:** Unstable housing situations can hinder recovery by limiting access to a safe environment conducive to healing, thereby increasing the risk of readmission. (CMS, 2024)
- **Social Support:** Lack of a robust support system may result in inadequate assistance with post-discharge care, medication management, and follow-up appointments, elevating readmission risks. (CMS, 2024)

(CCMC Code of Professional Conduct Principle #2)

- **Predictive Value of SDoH:** Incorporating SDoH into predictive models enhances the accuracy of identifying patients at risk for 30-day readmissions. Studies have shown that models including factors like income, education, and housing status outperform those relying solely on clinical data. (BMC, 2024)
- **Impact of Specific SDoH Factors:** Research indicates that patients residing in socioeconomically disadvantaged neighborhoods have a higher likelihood of readmission. For instance, individuals from areas with high poverty rates experience increased readmission rates compared to those from more affluent communities. (BMC, 2024)

Implications for Healthcare:

- **Comprehensive Patient Assessment:** Evaluating SDoH during patient assessments enables healthcare providers to identify individuals at elevated risk for readmission and develop tailored interventions. (CMS, 2024)
- **Targeted Interventions:** Addressing specific SDoH factors, such as providing resources for stable housing or enhancing access to social support services, can mitigate risks associated with readmissions. (CMS, 2024)
- **Policy Development:** Recognizing the influence of SDoH on health outcomes underscores the need for policies that address these determinants, promoting health equity and reducing disparities in readmission rates. (CMS, 2024)

(CCMC Code of Professional Conduct Principle #2)

Health Equity

Health equity, encompassing the fair and just opportunity for all individuals to achieve optimal health, significantly influences hospital readmission rates. Non-clinical drivers, such as social determinants of health (SDoH), play a pivotal role in this context.

Impact of Health Equity on Readmission Rates:

- **Disparities in Readmissions:** Studies have identified consistent racial, ethnic, and geographic disparities in hospital readmissions. For instance, data from 2006 to 2015 indicate that certain minority groups and residents of specific regions experience higher readmission rates, underscoring the influence of SDoH on health outcomes. (CMS, 2024)
- **Socioeconomic Factors:** Patients from lower socioeconomic backgrounds often face challenges such as limited access to healthcare resources, inadequate health literacy, and financial constraints, all contributing to increased likelihood of readmission. (BMC, 2024)
- **Insurance Status:** Insurance status is a critical factor contributing to disparities in hospital readmission rates. Uninsured or underinsured patients may encounter barriers to accessing follow-up care, leading to higher readmission rates. (Great Plains QIN, 2024)

Implications for Healthcare Systems

- **Need for Comprehensive Strategies:** Addressing these disparities requires healthcare systems to implement comprehensive strategies that consider SDoH. This includes developing targeted interventions to support vulnerable populations and reduce readmission rates. (CMS, 2024)
- **Policy Development:** Recognizing the influence of SDoH on health outcomes underscores the need for policies that address these determinants, promoting health equity and reducing disparities in readmission rates. (CMS, 2024)

(CCMC Code of Professional Conduct Principle #2)

Patient Perspective

Patients' perceptions of hospital readmissions vary, with some viewing them as preventable and indicative of inadequate care, while others see them as necessary for managing health complications.

Patient Perspectives on Readmissions:

- **Perceived Preventability:** A study comparing patient and provider views found that patients were more likely to consider their readmissions preventable compared to physicians. This suggests that patients may perceive readmissions as avoidable events, potentially reflecting gaps in care during or after the initial hospitalization. (BMJ, 2024)
- **Patient Perceptions and Engagement:** Patients' understanding of their health conditions, perceived self-efficacy in managing their health, and satisfaction with care received influence their adherence to discharge plans and subsequent health outcomes.
- **Self-Assessment of Readmission Risk:** Research indicates that patients can reasonably predict their own risk of readmission. In a survey of general medicine patients, those who believed they were at higher risk of readmission were more likely to be readmitted within 30 days. This self-awareness highlights the importance of engaging patients in discussions about their health status and discharge plans. (MDEdge, 2023)
- **Impact on Patient Experience:** Unplanned readmissions can negatively affect patients' perceptions of their healthcare experience. Feelings of frustration, anxiety, and dissatisfaction may arise, particularly if patients believe the readmission could have been prevented with better communication or care coordination (BMJ, 2024).

(CCMC Code of Professional Conduct Principle #4)

Patient Perspective

Implications for Healthcare Providers:

- **Enhancing Communication:** Understanding that patients may view readmissions as negative experiences underscores the need for clear communication regarding discharge instructions, follow-up care, and potential warning signs of complications.
- **Patient Engagement:** Involving patients in care planning and decision-making can empower them to manage their health more effectively, potentially reducing the likelihood of readmission.
- **Addressing Patient Concerns:** Healthcare providers should actively seek and address patient concerns about their readiness for discharge to mitigate feelings of unpreparedness that could lead to readmission.

(CCMC Code of Professional Conduct Principle #4)

Throughput vs. Readmissions

- Throughput: the effective movement of patients along the internal care continuum.
- Length of stay issues (DRG payment, GMLOS)

- Columbia University Business School Study entitled "Should Hospitals Keep Their Patients Longer?" (Bartel, et al, 2020)
  - 6.6 M Medicare patients followed.
  - Compared the potential benefits of a one day extended hospital stay to those of outpatient care in terms of reduced readmissions, death rates and costs.

- The study found that waiting an extra day to discharge patients can:
  - Reduce the mortality risk for pneumonia patients by 22 percent
  - Reduce the mortality risk for heart attack patients by 7 percent
  - Result in five-to-six times more lives being saved compared with outpatient care
  - Decreases the risk of readmission for severe heart attack patients by 7 percent

- Hypothesis: keeping patients hospitalized for an extra day would help them reach a higher level of stability and would give doctors and nurses more time to educate them about post-discharge behavior.

- Some of their more detailed findings:
  - Letting high-severity heart-failure patients stay in the hospital for one more day decreases their readmission risk by 7 percent.
  - Keeping all pneumonia patients who have Medicare fee-for-service plans in the hospital for an extra day would save 19,063 lives.

Protecting Patient Rights and Dignity

Respecting Patient Autonomy:
•Reducing avoidable readmissions empowers patients to manage their health at home, honoring their right to make decisions about their care.

Ensuring Equitable Care:
•Addressing social determinants of health (SDoH) reduces disparities in readmissions, ensuring all patients have equal access to care and support.

Promoting Health Literacy:
•Providing clear, understandable discharge instructions supports patients' right to information and promotes informed decision-making.

Maintaining Continuity of Care:
•Effective care transitions and follow-up prevent disruptions in care, safeguarding the patient's right to consistent and quality healthcare.

Protecting Patient Well-being:
•Avoiding unnecessary hospital stays reduces physical and emotional stress, preserving the patient's dignity and improving their overall well-being.

Fostering Trust in Healthcare:
•Proactively preventing readmissions builds patient trust in the healthcare system, reinforcing the right to receive compassionate and effective care.

Supporting Independence:
•By preventing avoidable hospitalizations, patients retain control over their daily lives, supporting their dignity and independence.

Quality Care and Cost Reduction

- **Ethical Discharge Practices:**
  - **Avoiding Premature Discharges**
  - **Preventing "Revolving Door" Admissions**
  - **Equitable Healthcare Delivery**
  - **Addressing Social Determinants of Health (SDoH)**
  - **Tailored Care Plans**
- **Improved Quality of Care:**
  - **Comprehensive Care Coordination**
  - **Patient-Centered Care**
  - **Cost Reduction**
  - **Lower Healthcare Expenditures**
  - **Efficient Resource Allocation**
  - **Enhanced Patient Satisfaction and Trust**
  - **Better Patient Experience**
  - **Holistic Care**

(CCMC Code of Professional Conduct Principle #4)

Case Manager's Role in Reducing Readmissions

- **Coordination Across the Continuum**
- Comprehensive discharge planning with early risk assessments.
- Multidisciplinary communication: Physicians, social workers, pharmacists, and community teams.

(CCMC Code of Professional Conduct Principle #5)

Tools and Models for Success: Established

- Risk assessment tools:
  - **LACE Score**
  - **HOSPITAL Score**.
- Evidence-based models:
  - **Project RED** (Re-Engineered Discharge).
  - **Care Transitions Intervention (CTI)**.
  - **BOOST (Better Outcomes by Optimizing Safe Transitions)**.

Strategies for Effective Care Transitions

Comprehensive Discharge Planning
- **Individualized Care Plans:** Tailor discharge instructions to meet each patient's specific medical, social, and emotional needs.
- **Clear Communication:** Use plain language and culturally appropriate communication methods to ensure patients and caregivers understand care instructions.
- **Patient and Family Involvement:** Engage patients and families in discharge planning to encourage adherence to care plans.

Medication Reconciliation
- **Accurate Medication Lists:** Verify and update all medications during the transition of care to prevent errors.
- **Patient Education:** Explain medication purposes, dosages, and side effects to improve adherence.
- **Pharmacy Involvement:** Involve pharmacists in discharge planning to address potential medication barriers.

Scheduling Timely Follow-Up Appointments
- **Before Discharge:** Schedule follow-up visits with primary care providers or specialists before the patient leaves the hospital.
- **Appointment Reminders:** Provide patients with reminders through calls, texts, or written instructions.
- **Telehealth Options:** Offer virtual follow-up visits for patients with transportation or mobility challenges.

Addressing Social Determinants of Health (SDoH)
- **Screen for SDoH Risks:** Assess for housing instability, food insecurity, transportation needs, and access to care.
- **Community Resource Referrals:** Connect patients with community organizations for support services, such as transportation, food programs, and housing assistance.
- **Care Coordination:** Involve case managers or social workers to address identified social needs.

Utilizing Standardized Tools and Checklists
- **Discharge Checklists:** Use standardized checklists to ensure all critical discharge steps are completed (e.g., medication reconciliation, follow-up appointments).
- **Electronic Health Records (EHR) Integration:** Leverage EHRs to flag high-risk patients and streamline discharge tasks.
- **Risk Assessment Tools:** Implement tools to identify patients at high risk for readmission and tailor interventions accordingly.

Care Coordination Across Settings
- **Multidisciplinary Team Collaboration:** Engage physicians, nurses, pharmacists, social workers, and case managers in discharge planning.
- **Handoff Communication:** Ensure clear, concise information transfer between care settings (e.g., hospital to home health or skilled nursing facilities).
- **Transitional Care Programs:** Implement programs like Transitional Care Management (TCM) to support patients during vulnerable periods after discharge.

Patient Education and Self-Management Support
- **Teach-Back Method:** Confirm patient understanding of care plans by asking them to repeat instructions in their own words.
- **Symptom Monitoring Plans:** Educate patients on recognizing early signs of complications and when to seek help.
- **Health Literacy Tools:** Provide written and visual aids to support understanding of complex health information.

(CCMC Code of Professional Conduct Principle #5)

Post-Discharge Follow Up

- Telephonic calls
  - Single post-DC call
  - Organized follow up program
- Home visits
- Telehealth integration
  - Post-Discharge follow up
  - Facilitating PCP visits

The expansion of telehealth services under the CARES Act led to a significant increase in telehealth utilization for post-discharge follow-up. In April 2020, telehealth accounted for 46% of follow-up visits, though this proportion declined to 13% by September 2020.

Future of Hospital Readmission Reduction

Who is Responsible?

Shared Accountability:

- Readmission reduction requires a collaborative approach involving multiple stakeholders:
  - **Hospitals**: Responsible for implementing robust discharge planning, coordinating care transitions, and addressing clinical and non-clinical patient needs.
  - **Primary Care Providers**: Essential for ensuring continuity of care, conducting timely follow-ups, and addressing emerging health issues.
  - **Specialists**: Play a critical role in managing chronic conditions and preventing complications that could lead to readmissions.
  - **Post-Acute Care Teams**: Include home health agencies, skilled nursing facilities, and rehabilitation centers. Their role is to provide quality care and seamless communication with hospitals and outpatient providers.
  - **Patients/Caregivers:** Play a vital role in reducing readmissions by actively following discharge instructions, managing medications, and attending follow-up appointments. Their engagement in symptom monitoring, timely communication with healthcare providers, and participation in shared decision-making are essential for preventing complications and supporting recovery.
- Effective coordination across these teams ensures that patient care remains continuous and patient-centered.

Penalty and Accountability Strategies

- Medicare Penalties:
  - **Current penalties:** Up to 3% reduction in annual Medicare payments for excess readmissions.
  - **Value-based penalties:** Hospitals held accountable for outcomes under **HRRP** and Value-Based Purchasing.
- Moving beyond hospitals, accountability is being extended to providers and health systems:
- **Accountable Care Organizations (ACOs)**: Focus on coordinated care across settings, aligning incentives to reduce avoidable readmissions.
- **Bundled Payments**: Payment models like Bundled Payments for Care Improvement (BPCI) link reimbursements to patient outcomes across the care continuum.

(CCMC Code of Professional Conduct Principle #7)

Emerging Strategies for the Future

- **Value-Based Care Models**
  - Shifting focus to quality outcomes vs. volume of services.
  - Examples: Medicare's **Bundled Payments for Care Improvement (BPCI)** Collaboration and Coordination across the continuum of care for a defined episode of care
  - Comprehensive Care for Joint Replacement (CJR): focus on Joint Replacement, coordinated transitions/alignment of financial incentives

(CCMC Code of Professional Conduct Principle #7)

Transitional Care Management (TCM) Codes & Readmission Reduction

- **Care Coordination Models**
  - Enhancing care across settings: Inpatient → outpatient → home.
  - Importance of transitional care management (TCM) services (CMS billing code 99495/99496).
  - These codes incentivize comprehensive post-discharge care, ensuring that patients receive timely and coordinated support during their most vulnerable period after leaving the hospital.

TCM Component	Benefit
Early Follow-Up (2 Days)	Identifies and addresses early complications.
Medication Reconciliation	Prevents medication errors and adverse drug events.
Care Coordination	Aligns care plans across providers and services.
SDoH Assessment and Support	Reduces non-clinical barriers to recovery.
Patient/Caregiver Education	Enhances self-management and adherence to care plans.
Higher Reimbursement	Encourages providers to prioritize comprehensive transitional care.

(CCMC Code of Professional Conduct Principle #5)

Predictive Analytics to Identify High-Risk Populations

- **Risk Stratification Models:** Predictive analytics use patient data (e.g., medical history, comorbidities, SDoH) to identify individuals at high risk for hospital readmissions.
- **Early Intervention:** By flagging high-risk patients, healthcare providers can implement targeted interventions such as enhanced care coordination, home health services, and tailored discharge plans.
- **Data-Driven Decisions:** Advanced algorithms analyze large datasets to predict complications and guide clinical decision-making, improving proactive care management.

Patient Focused Technology

Remote Patient Monitoring (RPM)

- **Continuous Health Monitoring:** Wearable devices and home monitoring tools track vital signs (e.g., blood pressure, weight, glucose levels) in real-time, enabling early detection of clinical deterioration.
- **Timely Interventions:** RPM allows healthcare providers to intervene promptly when patients show signs of worsening conditions, reducing the risk of hospital readmission.
- **Chronic Disease Management:** Patients with conditions like CHF or COPD benefit from daily health tracking, empowering them to manage their health more effectively.

Patient Portals for Engagement and Self-Management

- **Access to Health Information:** Patient portals provide secure, 24/7 access to medical records, discharge instructions, lab results, and medication lists, promoting transparency and patient engagement.
- **Medication Adherence Support:** Portals offer medication reminders and refill notifications, reducing the likelihood of missed doses and associated complications.
- **Secure Messaging:** Direct communication with healthcare providers through portals allows patients to ask questions, report symptoms, and clarify care plans, enhancing continuity of care.

(CCMC Code of Professional Conduct Principle #1)

Tech in Practice

Integration of SDoH Data into Care Models

- **Comprehensive Patient Profiles:** Integrating social determinants of health into electronic health records (EHRs) provides a holistic view of patient needs, guiding personalized care plans.
- **Community Resource Connection:** Predictive models can trigger referrals to social services, addressing non-clinical factors that contribute to poor outcomes and readmissions.

Telehealth and Virtual Care

- **Post-Discharge Follow-Up:** Telehealth visits ensure timely follow-up care, addressing barriers like transportation and mobility limitations.
- **Chronic Disease Check-Ins:** Virtual visits facilitate regular check-ins for chronic disease management, reducing the need for in-person appointments and preventing readmissions.
- **Expanded Access to Care:** Telehealth bridges care gaps, particularly for rural and underserved populations, ensuring equitable healthcare access.

(CCMC Code of Professional Conduct Principle #2)

Outpatient and Community Support Strategies

Integrated Chronic Disease Management Programs (CDMPs)

- **Definition:**
  Chronic Disease Management Programs are coordinated care models designed to manage long-term conditions (e.g., heart failure, diabetes, COPD) through proactive, patient-centered interventions.

Key Components:

- **Comprehensive Care Plans:** Personalized treatment plans based on patient health status, goals, and risk factors.
- **Multidisciplinary Teams:** Involving physicians, nurses, dietitians, pharmacists, social workers, and health coaches.
- **Regular Monitoring and Follow-Up:** Routine assessments, symptom tracking, and proactive management.
- **Patient Education:** Ongoing education on disease management, medication adherence, and lifestyle changes.

Impact:

- Reduces hospital admissions by addressing issues before they escalate.
- Improves disease control and overall quality of life.

Community-Based Support Services

Strategies:

- **Partnerships with Community Organizations:** Collaborating with local nonprofits, faith-based groups, and social services to provide holistic care.
- **Community Health Workers (CHWs):** Utilizing trained CHWs to support patients with navigation of health and social services.
- **Social Determinants of Health (SDoH) Screening:** Identifying and addressing barriers like food insecurity, housing instability, and transportation needs.

Impact:

- Enhances patient engagement and self-management.
- Reduces non-clinical barriers that contribute to poor health outcomes.

Medication Management and Adherence Support

Strategies:

- **Pharmacist-Led Medication Therapy Management (MTM):** Comprehensive medication reviews to prevent errors and improve adherence.
- **Simplified Medication Regimens:** Using combination medications or adjusting dosing schedules for better compliance.
- **Automatic Prescription Refills and Reminders:** Utilizing technology to remind patients about medication refills and doses.

Impact:

- Reduces medication-related complications.
- Minimizes preventable readmissions due to non-adherence.

Policy Beyond the HRRP Impacting Readmissions

Policy and Legislative Directions

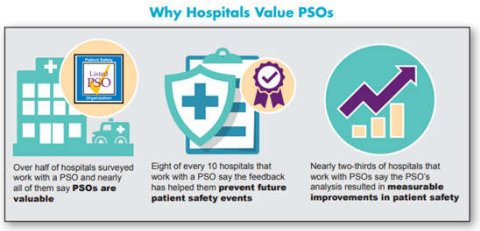
- The **IMPACT Act (2014)**: Standardized post-acute care measures.
- CMS alignment with the **Meaningful Measures Initiative** to focus on actionable outcomes.
- Expansion of ACO models to encourage collaboration across care settings.

(CCMC Code of Professional Conduct Principle #7)

Evidence-Based Practices in Readmission Reduction

Patient Safety Organizations (PSO)

- Created in 2005, under the Patient Safety and Quality Improvement Act.
- Voluntarily reporting quality and patient safety data from individual providers and healthcare organizations.
  - Goal: Learning and creating solutions
- 2019: over ½ of acute care facilities are working with PSOs and 8-0% say the feedback and analysis on patient safety events have helped to prevent similar future events.
- Avoidable readmissions fall into Patient Safety



Findings from the September 23, 2019 Final Report: Patient Safety Organizations: Hospital Participation, Value, and Challenges from the Office of The Inspector General, Department of Health and Human Services, OEI-01-17-00420.

There are eight patient safety activities that are carried out by, or on behalf of a PSO, or a healthcare provider:

1. Efforts to improve patient safety and the quality of healthcare delivery
2. The collection and analysis of patient safety work product (PSWP)
3. The development and dissemination of information regarding patient safety, such as recommendations, protocols, or information regarding best practices
4. The utilization of PSWP for the purposes of encouraging a culture of safety as well as providing feedback and assistance to effectively minimize patient risk
5. The maintenance of procedures to preserve confidentiality with respect to PSWP
6. The provision of appropriate security measures with respect to PSWP
7. The utilization of qualified staff
8. Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system

AHRQ, 2022

Agency for Healthcare Research and Quality Innovations Exchange

- The Hospital Readmissions landing page on the AHRQ site contains links to vetted tools, data, and research to help hospitals reduce preventable readmissions.
  - Tools from the Project RED (Re-engineered Discharge) toolkit, Project BOOST bundle as well as the patient facing "Taking Care of Myself: A Guide for When I Leave the Hospital" and the comprehensive "Designing and Delivering Whole-Person Transitional Care" which provides evidence-based strategies that can be adapted a hospital setting.
- The AHRQ site also hosts the Nationwide Readmissions Database developed as part of the Healthcare Cost and Utilization Project (HCUP).
  - This database is one of the largest (thirty-five million discharges) single sources of readmissions data across the nation, representing hospital readmission data for all payers, uninsured populations and across all demographics.
- The HCUP home site is also hosted here, along with the Health IT projects database (projects that leverage technology to reduce readmissions) as is the Patient Safety Organization (PSO site.
  - Created in 2005, under the Patient Safety and Quality Improvement Act., the PSO was developed to collect Voluntarily reported quality and patient safety data from individual providers and healthcare organizations with a goal of learning and creating solutions to patient safety concerns.

AHRQ Resources

Early Days Interventions

- Early in the evaluation of readmission impact, Kay (2006) established a 'continuum of care' at Carolinas Medical Center, Raleigh, NC; following a CHF patient from admission through connection to post-acute resources, using a multidisciplinary team approach and included referral to a home health program, which followed patients in the community over a six (6) week period after discharge, to assess, educate, evaluate and identify early intervention opportunities.
- Readmissions decreased as well, from 18.2% to 11%.
- This study demonstrated that structured care continuum development by specially trained professionals created a measurable reduction in readmissions for the target population. Furthermore, patients reported increased quality of life.
- Glaser and El-Haddad (2015) reviewed the risk for readmission for patients discharged without post-acute services and reported that the incidence of readmission was over 30% higher in the discharged to outpatient follow-up population than it was for the population actively linked to post-acute services or follow-up.

Community Based Care Transitions Program

- Under CMS Innovation Center, started 2012 with 17 partners
- The CCTP, launched in February 2012, ran for 5 years. Participants were awarded two-year agreements that may be extended annually through the duration of the program based on performance.
- Community-based organizations (CBOs) used care transition services to effectively manage Medicare patients' transitions and improve their quality of care.
- Funded by up to $300 million in total funding was available for 2011 through 2015.
- The CBOs were paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level.
  - CBOs were only paid once per eligible discharge in a 180-day period for any given beneficiary.
  - Decrease in costs for INP, NH and OBS costs
  - Increase in costs in HHC services
  - Decreased readmissions by 12.92%

Source: Centers for Medicare & Medicaid Services

Table 3.3. Estimated Association Between Program Participation, Outcomes, and CCTP Impacts for the First 33 Months of Participation for 44 Continuing Sites

	Participant Cross-Sectional Analysis Using Participants' Discharges*			Difference-in-Difference (DiD) Analysis Using All Discharges*		
	Regression-Adjusted Comparison Mean	Regression-Adjusted Mean Difference From Comparison (SE)	% Difference*	Counter-Factual Mean*	Regression-Adjusted DiD Impact Estimate (SE)	% Difference*
30-day readmission rate, %	16.65	-2.15** (0.16)	-12.92	19.23	-0.04 (0.12)	-0.19
30-day acute care hospital/critical access hospital inpatient expenditures, $	2,101.67	-291.10** (34.47)	-13.85	2,442.28	-13.29 (26.48)	-0.54
30-day Medicare Part A and Part B expenditures, $	7,823.70	-679.87** (130.13)	-8.69	8,400.60	-2.17 (46.77)	-0.03
30-day net differences in Medicare Part A and Part B Expenditures per discharge (30-day Medicare Part A and Part B expenditures with per-eligible discharge rate), $	N/A	-319.90** (130.13)	N/A	N/A	N/A	N/A
30-day skilled nursing facility expenditures, $	2,283.60	-336.83** (93.04)	-14.75	2,249.64	14.59 (22.78)	0.65
30-day home health expenditures, $	704.58	221.01** (19.44)	31.37	656.33	2.87 (7.37)	0.44
30-day outpatient expenditures, $	386.61	1.37 (8.21)	0.35	428.46	5.19 (4.59)	1.21
30-day emergency department expenditures, $	40.82	1.36 (1.08)	3.32	47.80	-1.02* (0.70)	-2.14
30-day observation stay expenditures, $	39.87	-0.18 (2.10)	-0.46	37.64	1.24 (1.37)	3.30
Number of discharges (hospitals) in the sample		683,732 discharges (647 hospitals)			2,488,979 discharges (359 hospitals)	

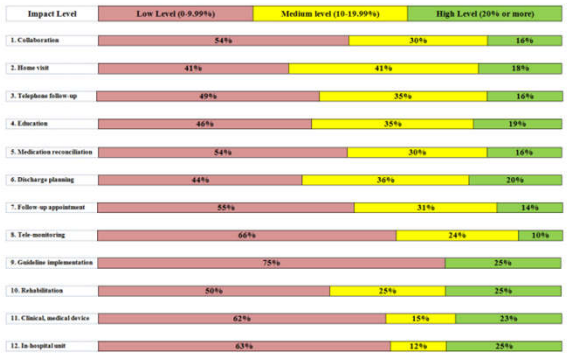
Notes: *p < 0.20, **p < 0.10, †p < 0.05, ††p < 0.01. N/A = not applicable. Medicare expenditures for services beginning in the 30-day post-discharge period and extending beyond this period were not prorated. The CCTP is not expected to influence utilization of some services, such as hospice and LTCH expenditures. Beneficiaries discharged to a LTCH have complex conditions, such as paralysis, organ failure, or conditions requiring prolonged mechanical ventilation, which require

Evidence-Based Practice Review Comprehensive Case Management Programs

- Care Transitions Initiative (CTI)
  - CTI data demonstrates a 13.8% readmission rate in the control group versus 8.9% readmission rate in the study group.
- RED (Re-Engineering Discharge) https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
  - Patient education and enhanced preparation for discharge
  - RED reported readmission rates decreasing from 24% to 16% on average.
- BOOST (Better Outcomes for Older Adults through Safe Transitions) https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
  - Screens for "8 P's"
  - Problems with Medications, Psychological, Principal Diagnosis, Physical Limitations, Poor health literacy, Patient support, Prior hospitalization and Palliative care.
  - BOOST reported a 21% reduction
- INTERACT (Interventions to Reduce Acute Care Transfers) https://pathway-interact.com/interact-tools/interact-tools-library/
  - Focus on transfers between post-acute levels of care and hospitals
  - Improve identification, evaluation and communication about changes in resident's status
    - SBAR
    - Decision Support Tools
    - "Stop & Watch" (high risk identification)
    - Advance Care Planning tool
    - Quality Improvement Tool for review of acute care transfers
- Transitional Care Intervention (TCI)
  - APRN led, meeting with patients pre-discharge, post-discharge phone call, active handoff to PCP, prescheduled follow up appts.
  - Results of this study demonstrated a readmission rate of 8.3% for the intervention group versus the control group's 36.8% readmission rate
- Bobay, Bahr and Weiss (2015) note that of the 32 hospitals surveyed many hospitals are utilizing one of these identified transitional care models as a base but have customized their programs by combining features of other models to address their specific populations and needs.
- PACC Program
  - Post-acute transition of care model initiated during the admission; utilizing focused patient/family education and a structured telephone outreach program through the immediate thirty-day post acute period for a target population of chronic condition patients.
  - Reduced COPD readmissions by 10.45% and CHF readmissions by 6.0% during pilot.
  - implemented at 42 hospitals across the country after pilot

EBP: Current Innovations, 2018 and on

- Review of Literature: 2018-2022
- Retrospective reviews
- Economic interpretation
- Intended vs Unintended Consequences
- Top 5 Recommendations identified
  - Most frequently studied and most successful strategies to decrease readmissions include those that are collaboration focused:
  - home visits, telephone follow-up, education and discharge planning.
- Incorporate Social Determinants of Health under 21st Century Cures Act



Impact Level	Low Level (0-9.99%)	Medium level (10-19.99%)	High Level (20% or more)
1. Collaboration	54%	30%	16%
2. Home visit	41%	41%	18%
3. Telephone follow-up	49%	35%	16%
4. Education	46%	35%	19%
5. Medication reconciliation	54%	30%	16%
6. Discharge planning	44%	36%	20%
7. Follow-up appointment	55%	31%	14%
8. Tele-monitoring	66%	24%	10%
9. Guideline implementation	75%		25%
10. Rehabilitation	50%	25%	25%
11. Clinical, medical device	62%	15%	23%
12. In-hospital unit	63%	12%	25%

Figure 2. Impact levels of interventions

Kash, et al, 2018

Reducing Readmissions

Pharmacist Led

- Zupec, et al (2022) note that 20% of hospital readmissions are medication related problems (MRP).
- This model utilized pharmacists to conduct hospital discharge visits to review medications and provide education to reduce adverse drug events and medication errors and ensure medication adherence through post-discharge calls.
- Program has the potential to achieve 15% reduction avoidable readmissions (based on current data extrapolation) and significant net savings to the hospital.

Primary Care Practice Led

- Spivack, et al (2021) developed a 12-point primary care readmission avoidance activity list.
- Activities include:
  - Receipt/Review of Hospital Discharge Summary within 72 hours of discharge
  - Medication reconciliation
  - Home visits
  - Case Manager/Health Coach in the practice
  - Regular follow up calls/telehealth visits in the 1st 30 days post-discharge
  - Health literacy evaluation
  - Patient centered education
  - Culturally tailored care
  - SDoH screening
  - Connection to resources for SDoH gaps
  - Incorporate patient centered care strategies
  - Shared decision-making model
- Findings: practices that perform 10/12 of these activities had a significantly lower risk of patient readmission.

- Safety Net hospitals has higher readmission rates versus more affluent hospitals.

Dx	Safety Net	More Affluent
AMI	1.020	0.986
PNA	1.031	0.984
CHF	1.037	0.977

- Adding Social Risk Factors (SRF) to Risk Adjustment has been demonstrated to decrease readmissions and the associated penalties. Furthermore, adding SRF at the patient level ensures that facility performance measures are not "adjusted away".

- Over ½ of safety net hospitals saw penalties decline.
  - 4.0-7.5% of facilities went from having a penalty to having ZERO penalty.
  - $17 M reduction in penalties for safety net hospitals (Joynt-Maddox, et al, 2019).

(CCMC Code of Professional Conduct Principle #3)

Impact of the Patient's Role in Readmission Reduction

- Patient's role in healthcare still not factored into Readmission Reduction
- Adherence to treatment plan?
- Health literacy status considered?
- Patient engagement/activation?
- No significant research available

Patient Engagement

Improved Health Outcomes

- Engaged patients are more likely to adhere to treatment plans, adopt healthy behaviors, and actively manage their health conditions.
- This leads to better health outcomes and reduced hospitalizations.

Enhanced Patient Experience

- When patients feel valued and empowered in their healthcare interactions, their overall experience improves.
- This fosters trust, reduces anxiety, and promotes better patient-provider relationships.

Cost Savings

- Engaged patients are more likely to seek preventive care and early interventions, reducing the need for costly emergency treatments and hospitalizations.

Efficient Healthcare System

- Patient engagement leads to more effective utilization of healthcare resources.
- When patients actively participate in their care, healthcare providers can allocate resources more efficiently and tailor treatments to individual needs.

Strategies for Promoting Patient Engagement

54

1. Shared Decision-Making
   - Involve patients in discussions about treatment options, risks, benefits, and alternatives.
   - Respect patient preferences and values when making decisions.
   - Encourage patients to ask questions and express their concerns.

2. Open Communication
   - Create a welcoming and nonjudgmental environment where patients feel comfortable sharing their thoughts and concerns.
   - Actively listen to patients and address their questions and worries.
   - Provide clear explanations using plain language, avoiding medical jargon.

3. Health Education and Information Dissemination
   - Offer educational resources that empower patients to understand their conditions and treatment plans.
   - Provide written materials, videos, and visual aids to enhance patient comprehension.
   - Tailor education to individual learning styles and preferences.

4. Patient Portals and Digital Tools
   - Utilize patient portals to grant patients access to their medical records, test results, and treatment plans.
   - Offer digital health tools, such as mobile apps, that allow patients to track their health metrics and receive personalized health information.

Promoting patient engagement through these strategies not only benefits patients themselves but also contributes to more effective, patient-centered healthcare delivery and improved overall health outcomes.

55

Patient Activation

Patient activation refers to the knowledge, skills, confidence, and willingness of patients to actively engage in their own healthcare. It's the level to which patients are equipped to take on a proactive role in managing their health, making informed decisions, and collaborating effectively with their healthcare providers.

Patient activation is often measured on a scale, where individuals progress from passive recipients of care to active participants in their health and wellness journey.

The concept of patient activation is closely related to patient engagement but focuses specifically on the patient's ability and motivation to manage their health effectively.

Higher levels of patient activation have been associated with better health outcomes, improved adherence to treatment plans, and reduced healthcare costs.

Key Similarities

1. Both patient engagement and patient activation emphasize the importance of involving patients in their care and decision-making processes.

2. Both concepts aim to improve patient outcomes, enhance patient satisfaction, and contribute to more effective use of healthcare resources.

Key Differences

1. Patient engagement is a broader concept that encompasses various strategies to involve patients in their care, while patient activation focuses specifically on the individual's readiness and ability to manage their health.

2. Patient engagement strategies may include creating supportive environments for patient participation, while patient activation strategies focus on equipping patients with the necessary tools to participate effectively.

3. Patient engagement emphasizes the collaborative relationship between patients and providers, whereas patient activation emphasizes patients' personal growth and development in managing their health.

Patient engagement and patient activation are interconnected concepts that complement each other.

Patient engagement strategies create an environment for patient activation to occur, while patient activation enhances patients' ability to engage effectively in their healthcare journey.

56

57

Patient activation measure (PAM)

The Patient Activation Measure (PAM) is a widely used tool developed by researchers Judith Hibbard and Helen Gilburt to assess an individual's level of patient activation.

The PAM is designed to measure the knowledge, skills, confidence, and motivation that a person has in managing their own health and healthcare.

It aims to determine where an individual falls on a continuum of patient activation stages, ranging from passive engagement to proactive and empowered self-management.

Increasing Levels of Activation

LEVEL ONE

Disengaged & Overwhelmed

Individuals are passive and lack confidence. Healthcare knowledge is low, goal orientation is weak, and adherence is poor.

"My doctor is in charge of my health."

↓

Segmentation 15-20%

LEVEL TWO

Becoming Aware But Still Struggling

Individuals have some health-care knowledge, but large gaps remain. They believe health is largely out of their control but can set simple goals.

"I could be doing more for my health."

↓

12-30%

LEVEL THREE

Taking Action & Gaining Control

Individuals have key facts and are building self-management skills. They strive for best practice behaviors and are goal-oriented.

"I am part of my healthcare team."

↓

30-35%

LEVEL FOUR

Maintaining Behaviors & Pushing Further

Individuals adopted new behaviors but may struggle at times of stress or change. Maintaining a healthy lifestyle is a key focus.

"I'm my own health advocate."

↓

20-25%

The Wonderful World of APPS

- Patient engagement/activation has long been a concern for the professional case manager.
- How can we get our patients/caregivers actively involved in their own care?
  - Digital technology can be a key strategy in patient engagement and activation.
- One key concept is linked to the practice of "neuromarketing"; technology is utilized to "capture the subject's attention and keep it concentrated on monetizable activities" (Mouchabac et al, 2021).
  - The concept behind this is that social interactions (attaining "likes" or earning "badges") create dopamine and keeps the individual engaged in the activity. Think of "going viral" or how many "likes" your social media posts get and the feeling associated with that.
- The current boom of healthcare apps for symptom tracking allows patients to track their symptoms related to their individual diagnosis can be a key to engaging patients in their own health management.
  - These types of apps allow for in-the-moment assessment and a real-time evaluation of symptoms with earlier detection of exacerbation, complication, or relapse. This is especially being seen in the mental health area. The number of mental health management, and counseling apps is exploding!
- Mouchabac et al (2021) postulate that these apps can provide a "digital dopamine" response that can be harnessed for positive use (more patient engagement, great health confidence) versus the more negative experience of digital addiction. The technology has the potential to get people "addicted" to being engaged, active participants in their own healthcare.

A Tour Around APP World

- Mobile apps can be a useful tool for provider education, patient self-management, education and reporting.
- Using the ever popular HEART FAILURE as an example, Athilingam & Jenkins' (2018) review of available apps at the time specific to heart failure management noted that there were 26 validated apps available at the time.
  - They noted that apps demonstrated "trends towards making an impact and offer a potentially cost-effective solution with 24/7 access to symptom monitoring as a point of care solution, promoting patient engagement in their own home care" (Athilingham & Jenkins, 2018, p.1)
  - My own quick search, on the Apple App Store and Google Play, show over 100 heart failure apps with four (4) star and greater reviews available on both stores.

APP Samples

PATIENT FACING: symptom trackers, can interface with other apps or patient portals to provide 'real-time' patient data to providers

a. Heart Failure Manager: This patient-facing app integrates with the Apple "Health" app and sends data daily to the patient's care team. This app tracks patient perspective on how they feel, activity levels, heart failure symptoms, appointment reminders, and a journaling feature. https://apps.apple.com/us/app/heart-failure-manager/id1364043356

PATIENT ROLE PLAYING GAME/PATIENT ENGAGEMENT: gives patients an opportunity to role play and practice decision making

a. Heart Failure Coach: This app, developed by the University of Pennsylvania Medical Center, is a patient engagement game where players manage the lifestyle choices of the game's main character who was recently released from the hospital after a diagnosis of Heart Failure. https://play.google.com/store/apps/details?id=com.simcoachgames.hearftailurecoach&hl=en_US&gl=US

b. Outcomes are determined by choices made throughout the 1st week post-hospitalization period (good self-management versus hospital readmission). This helps to reinforce patient education and self-management skills in a fun, non-threatening way.

PORTALS: connect to hospital or practice electronic medical records for quick reference to test results and electronic communication to providers, from appointment scheduling and bill payment to medication management and quick text message conversations with providers.

More Tech

AI

Case Study: AI in Proactive Patient Management for Chronic Conditions

AI Integration in Chronic Disease Management Programs

- Outcomes: Proactive Intervention, Reduced Hospital Admissions, Enhanced Patient Engagement

- Challenges: Balancing Automation with Personalized Care

A healthcare organization integrated an AI-driven patient management system into its chronic disease management program. The AI tool continuously monitored patients with conditions such as diabetes, heart failure, and COPD by analyzing real-time data from wearable devices, electronic health records, and patient-reported outcomes. The system could predict potential exacerbations and alert case managers to intervene before a hospital admission became necessary.

The outcomes were significant. Patients enrolled in the program saw a marked reduction in hospital admissions and emergency room visits. Moreover, AI-enabled proactive management led to enhanced patient engagement, with patients becoming more involved in their care due to the timely interventions and tailored recommendations provided by the system.

However, the integration of AI also highlighted some challenges. While AI can automate routine monitoring and risk assessments, it is essential to balance automation with personalized care. Case managers had to ensure that the use of AI did not depersonalize the patient experience. Instead, they leveraged AI insights to enhance their interactions with patients, ensuring that care remained patient-centered and empathetic.

Case Study 1: Hospital A - Heart Failure Readmissions Reduction

Challenge: Hospital A faced high readmission rates among heart failure patients due to poor post-discharge self-care and medication adherence.

Solution: The hospital implemented a comprehensive strategy that combined patient engagement, patient activation, and readmission reduction efforts.

Strategies Implemented:

- 1. Engagement and Activation: Healthcare providers educated heart failure patients about their condition, treatment plans, and the importance of self-care. Patients were encouraged to ask questions, set personalized goals, and actively participate in their care decisions.
- 2. Patient Education: The hospital provided personalized educational materials in both print and digital formats, explaining heart failure management, medication schedules, and diet recommendations.
- 3. Communication: Nurses conducted thorough discharge planning discussions, ensuring patients understood their medications, warning signs, and the need for follow-up appointments.

Results: Over a one-year period, readmission rates for heart failure patients dropped by 25%. Patients reported higher satisfaction, better understanding of their condition, and improved adherence to treatment plans.

Practical Tips:

- Integrating Engagement and Activation: Incorporate patient engagement strategies during hospital stays, such as involving patients in care discussions and goal-setting.
- Patient Feedback: Regularly seek patient feedback about the clarity of instructions and their comfort level with post-discharge management.
- Technology: Implement a patient portal that provides access to educational resources, medication reminders, and secure communication with healthcare providers.

65

Case Study 2: Clinic B - Diabetes Patient Activation Program

Challenge: Clinic B noticed diabetes patients struggling with self-management, leading to frequent emergency visits and readmissions.

Solution: The clinic launched a patient activation program to enhance patients' ability to manage their diabetes effectively.

Strategies Implemented:

- Activation Assessment: The clinic utilized the Patient Activation Measure (PAM) to identify patients' activation levels and tailor interventions accordingly.
- Personalized Education: Patients with lower activation levels received targeted diabetes education, including understanding blood sugar monitoring, medication management, and dietary choices.
- Goal Setting: Patients worked with healthcare providers to set achievable diabetes management goals, fostering a sense of ownership over their health.

Results: Over the course of six months, patients in the program exhibited improved diabetes management, better adherence to medication regimens, and a significant reduction in emergency visits and readmissions.

- Practical Tips:
- Incorporating Patient Feedback:** Gather insights from patients about their challenges in managing diabetes and use this information to design effective interventions.
- Leveraging Technology:** Create a diabetes management app that provides personalized tips, tracks blood sugar levels, and offers rewards for meeting goals.

66

Practical Tips for Healthcare Providers and Organizations

1. Integrating Engagement and Activation

- Involve patients in care discussions and decisions to increase their sense of ownership.

- Encourage patients to set achievable health goals aligned with their preferences and needs.

2. Incorporating Patient Feedback and Preferences

- Regularly seek feedback through surveys, focus groups, or patient advisory boards

- Customize care plans based on patient preferences, lifestyle, and cultural factors.

3. Leveraging Technology for Communication and Education

- Develop a user-friendly patient portal offering educational resources and appointment scheduling.

- Utilize mobile apps to send medication reminders and deliver personalized health tips.

67

Addressing Challenges in Implementing Patient Engagement, Activation, and Readmission Reduction

Cultural Barriers

Challenge: Cultural differences can affect patients' understanding of healthcare information, willingness to engage, and adherence to treatment plans.

Strategies to Overcome

- Cultural Competence Training: Healthcare staff should undergo training to understand diverse cultural beliefs, practices, and communication styles. This helps in providing culturally sensitive care and building trust.
- Language Services: Offer interpreter services or translated materials to bridge language barriers and enhance patient-provider communication.

Health Literacy Disparities

Challenge: Patients with low health literacy struggle to comprehend medical information, making it difficult for them to actively engage in their care.

Strategies to Overcome

- Plain Language Communication: Healthcare providers should use clear and simple language when explaining medical terms and instructions to patients.
- Visual Aids: Utilize visual aids such as diagrams, videos, and infographics to enhance understanding of complex concepts.
- Health Literacy Initiatives: Implement programs that improve patients' health literacy through education and workshops, empowering them to navigate healthcare systems more effectively.

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68

Resource Limitations

Challenge: Limited resources, such as time, personnel, and funding, can hinder the implementation of comprehensive patient engagement and activation strategies.

Strategies to Overcome

- ❑ Prioritization: Focus on high-impact strategies that align with available resources, addressing the most pressing needs.
- ❑ Task Delegation: Delegate certain tasks to qualified non-clinical staff or use technology to streamline processes and save time.

69

Collaborative Partnerships with Community Resources

- Challenge: Resource constraints can be mitigated by collaborating with external organizations to support patient engagement and activation.

Strategies to Overcome

- ❑ Community Partnerships: Forge partnerships with community organizations, social services, and local clinics to provide patients with additional support beyond healthcare settings.
- ❑ Referral Systems: Establish referral systems that connect patients to community resources for further assistance with social determinants of health.
- ❑ Integrated Care Models: Develop integrated care models that incorporate both medical and community-based resources to holistically address patients' needs.

70

Future Directions

- The healthcare landscape is undergoing a transformation towards patient-centered care.
- Driver: a growing recognition of the importance of involving patients as active participants in their own health and well-being.
- This shift acknowledges that patients are more than just recipients of medical treatment; *they are partners in their care journey.*
- Patient-centered care places patients at the center, respecting their preferences, values, and needs, while also considering the impact of social determinants on health.

71

Conclusion

- HRRP has been successful at reducing 30-day hospital readmissions, especially during the initial 5 years of the program.
- Significant case management research, programs developed
  - Focus on patient education, patient engagement and better care transitions
- HRRP penalties may compromise safety net hospitals to be able to continue to provide care; solution working?
- Risk adjustment methods need improvement for better accounting of SDoH factors
- Patients/caregivers need to be part of the readmission avoidance team.

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