Reducing Readmissions

5 Practical Strategies for Your Work in 2012

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Collaborative Healthcare Strategies

American Hospital Association

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5 Practical Strategies

1. Know your **data** (perform a root cause analysis)
2. Know your **partners** (meet them and work together)
3. Know what's **going on** (align within and across orgs)
4. Know your **high risk** patients (identify and manage)
5. Know the best practices & **start testing** (don't delay)

Strategy 1: Know your data

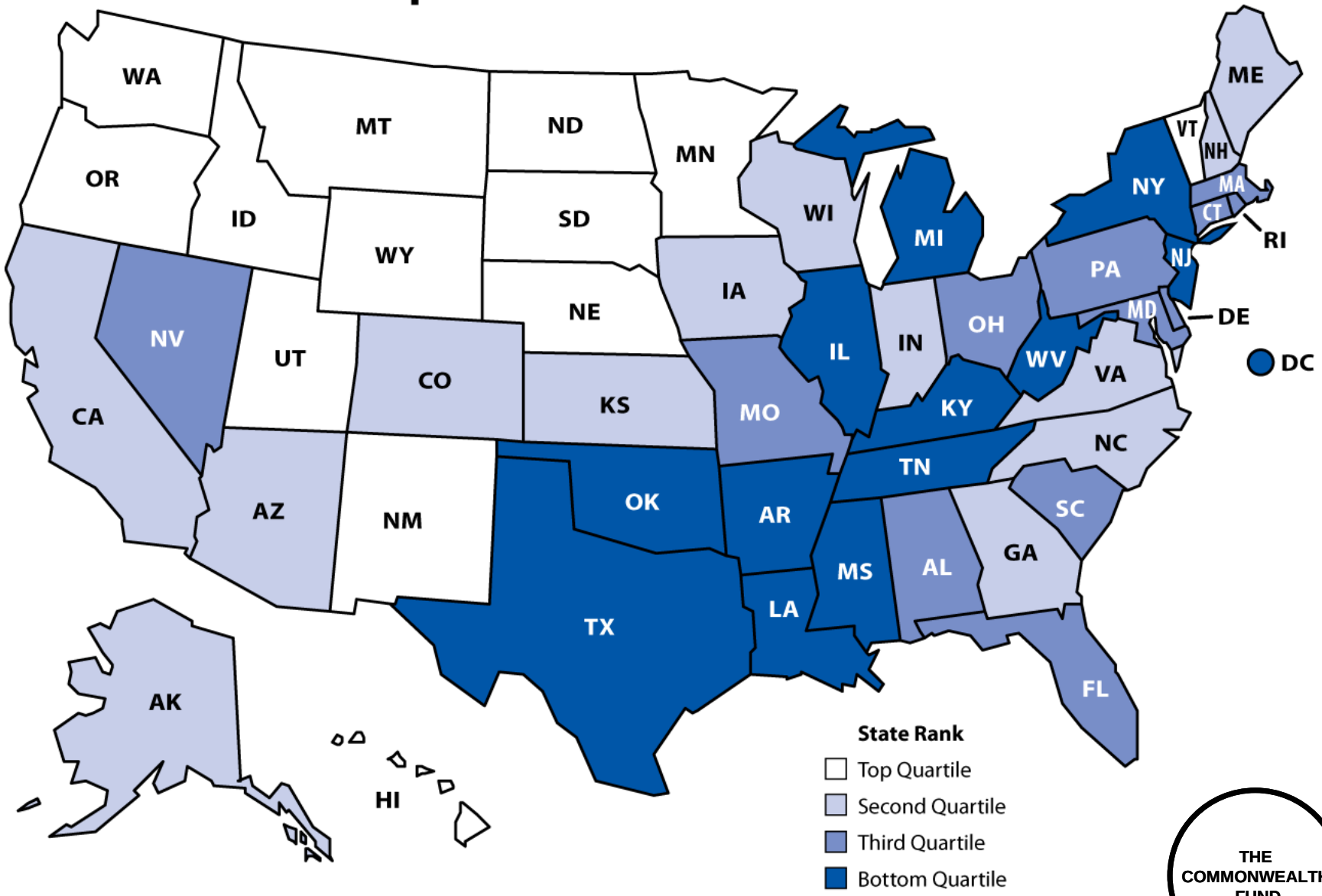
Perform a community-based RCA

Strategy 1: Know your data

"Community-based" Root Cause Analysis

1. Community- level data (region, state)
2. Organization- level data (hospital, SNF, HH)
3. "Cross-continuum team" feedback
4. Readmission review/interviews

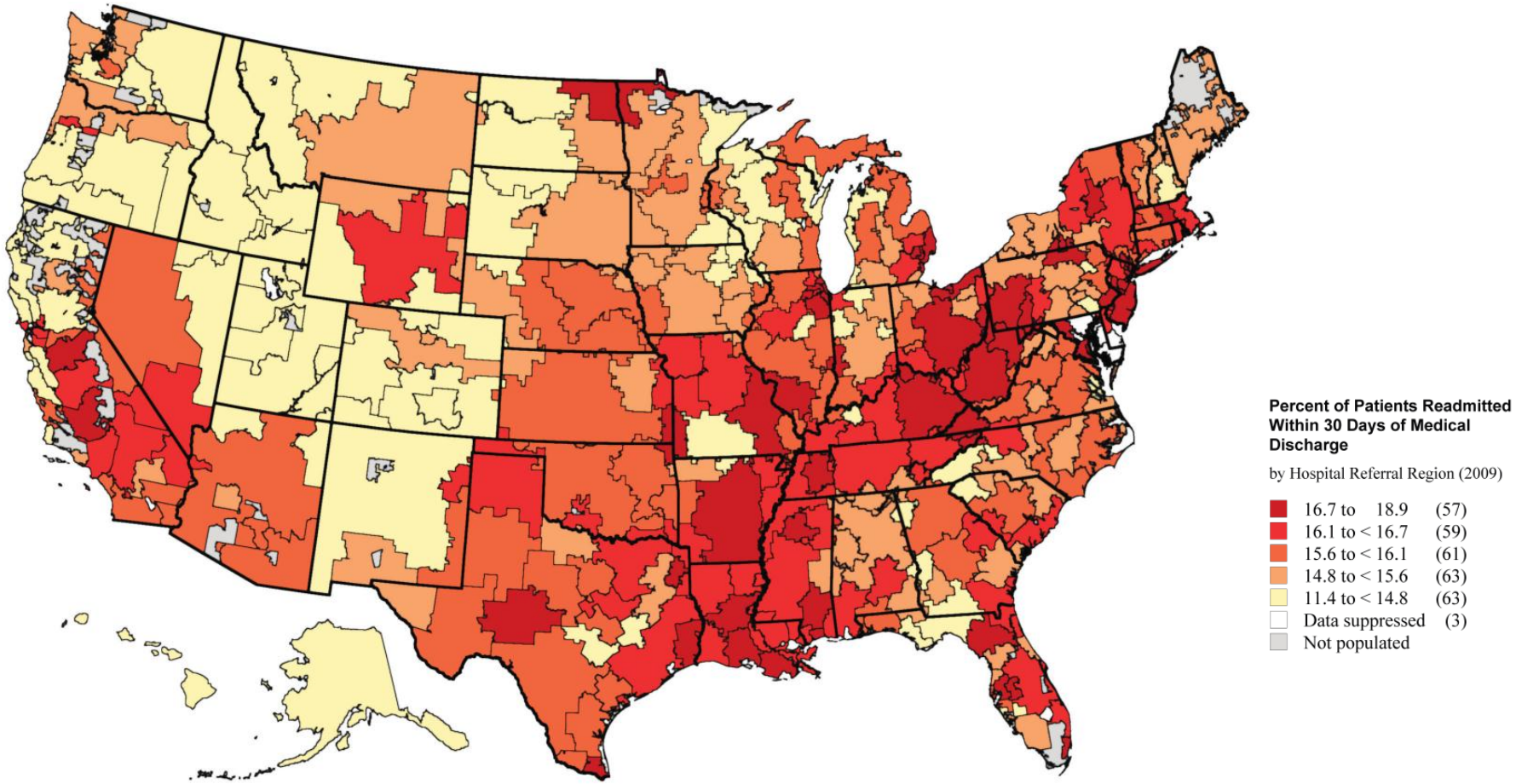
State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

THE COMMONWEALTH FUND

Hospital Referral Region Data



Source: Dartmouth Atlas 2011

State-level Data

- HEN/P4P is all-payer
- National data is typically Medicare FFS only
- Access all-payer data at state level
  - HCUP (AHRQ)
  - State-wide Discharge Database
  - Multi-stakeholder collaboration
    - Washington and Michigan in STAAR

Boutwell et al. An Early Look at a Four-State Effort to Reduce Hospital Readmissions. *Health Affairs.* July 2011.

Hospital Data

- Hospital Analytics
  - Total discharges annually; # patients
  - All-cause 30-day readmission rate and #
  - Discharge disposition (Home, HHA, SNF, LTAC, etc)
  - Day of week; time of day
  - Top 10 discharge dx; top readmission dx – by # and %
  - Discharging/readmitting service
  - High utilizers (>3 hospitalizations past 12 months)

Example Insights of Data Analytics

- 6,478 Medicare FFS admissions among 4,732 people
- 6,148 Medicare FFS alive discharges (some exclusions)
- 908 30-day readmissions; 14% all cause readmission rate
- 50% 30-day readmissions <10 days of d/c; 25% <96h
- Top 10 RA dx: HF, RF, UTI, sepsis, GIB, arrythmia, COPD, syncope, gastritis/esophagitis, PNA/respiratory infection
- 369 people (8%) hospitalized >3 times; used 1339 H (22%)
  - Among high utilizers, 495 30-d RA; rate 38%
  - Among high utilizers, 55% d/c to home with no services
  - Top 10 dx: same HF, RF, UTI, COPD, GIB, sepsis, esophagitis

Community-wide Data

- QIO (Quality Improvement Organization)
  - Provide all-setting readmission data
  - Identify major “transitions” partners

- Cross-continuum team data sharing
  - NH/SNFs know who they send to the ED
  - Home health agencies know 30-d RA rates

Qualitative Insights

- 81% of patients requiring assistance with basic functional needs failed to have a home-care referral

- 64% said no one at the hospital talked to them about managing their care at home

Clark PA. *Patient Satisfaction and the Discharge Process: Evidence-Based Best Practices.* HCPro, Inc.; 2006.

STAAR Readmission Diagnostic Review Tool (Excerpt)

Ask Patients and Family Members:

How do you think you became sick enough to come back to the hospital?

Did you see your doctor or the doctor's nurse in the office before you came back to the hospital?

Yes ☐ If yes, which doctor (PCP or specialist) did you see?

No ☐ If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Ask Care Team Members in the Community:

What do you think caused this patient to be readmitted?

After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient's circumstances that contributed to the readmission.

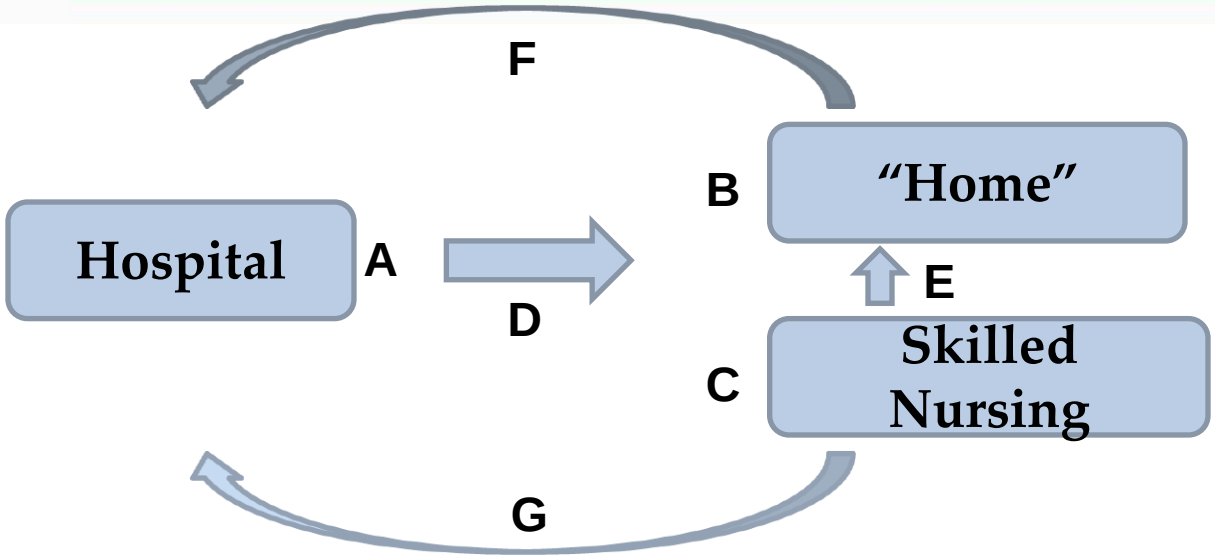
Readmission Diagnostic Interviews

- Review 5-10 readmissions every 6 months
- Elicit the story behind the chief complaint or admitting dx
- Engages the “hearts and minds” and catalyzes action toward joint ***cross-setting*** and ***patient-centered*** problem-solving
- Small sample sufficient to elicit high leverage opportunities

Strategy 2: Know your partners

Meet them and work together

Cross-Continuum Efforts



A: Improve ***transition out*** of the hospital

B: Improve ***reception into*** the community-based home environment

C: Improve the ***reception into*** the skilled nursing facility/rehab/VNA care

D: Provide ***supplemental transitional care services*** for high-risk patients

E: Improve the ***transition out*** of the SNF to community-based home environment

F: Improve the ***communication of key elements*** when sent from home to ED

G: Improve the ***communication of key elements*** when sent from nursing care to ED

Cross-Continuum Efforts

- Improving the discharge process:
  - RED, BOOST, STAAR, H2H
- Improving quality of NH and HH care:
  - INTERACT, Advancing Excellence, VNSNYS
- Transitional care between settings:
  - Self-management coaching,, Transitional Care Model, BRIDGE
- Enhanced ongoing management for very high risk:
  - Medical Home, PACE, Evercare, HF Clinics, POLST, CCTP
- Linkage to community-based supports and services
  - Area Agencies on Aging, Aging and Disability Resource Centers

Cross-Continuum Teams

- The most *transformational* recommendation in STAAR
- Reinforces readmissions are not only a hospital issue
- Training ground to develop competency for evolving to integrated and value based models
- Enhances uptake of QI efforts in a *multiplier effect*

Form a Cross-Continuum Team

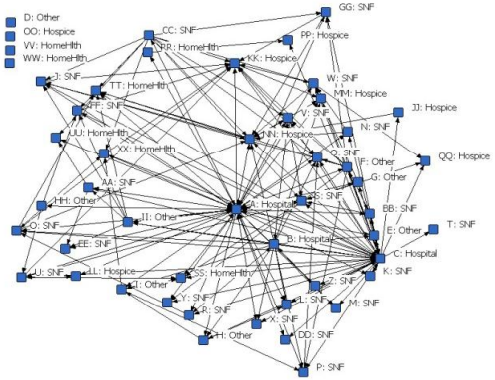
Start simple:

- 2-3 nursing homes/SNFs
- 2-3 home health agencies
- Hospice
- Elder services agency, AAA

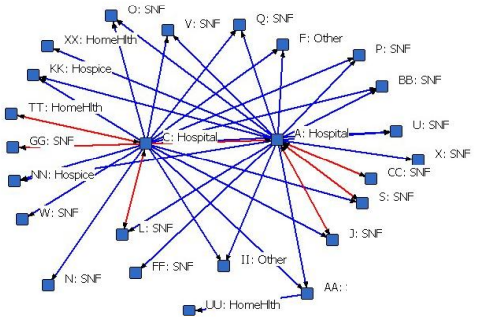
Strategy 2: Know your partners

(ICPCA NCC)
Integrating Care for Populations and Communities Aim National Coordinating Center

Social Network Analysis (SNA)



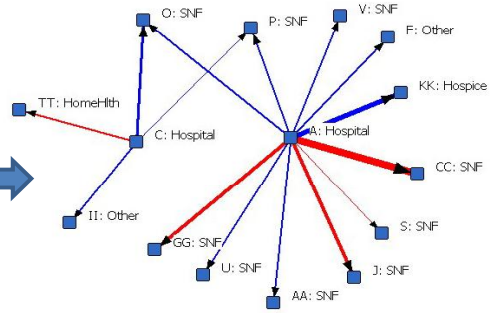
Represents all transitions in community



Represents providers who share 10 or more transitions

Red connectors represent provider pairs with high numbers of readmissions. The wider the connectors the greater the number of shared transitions.

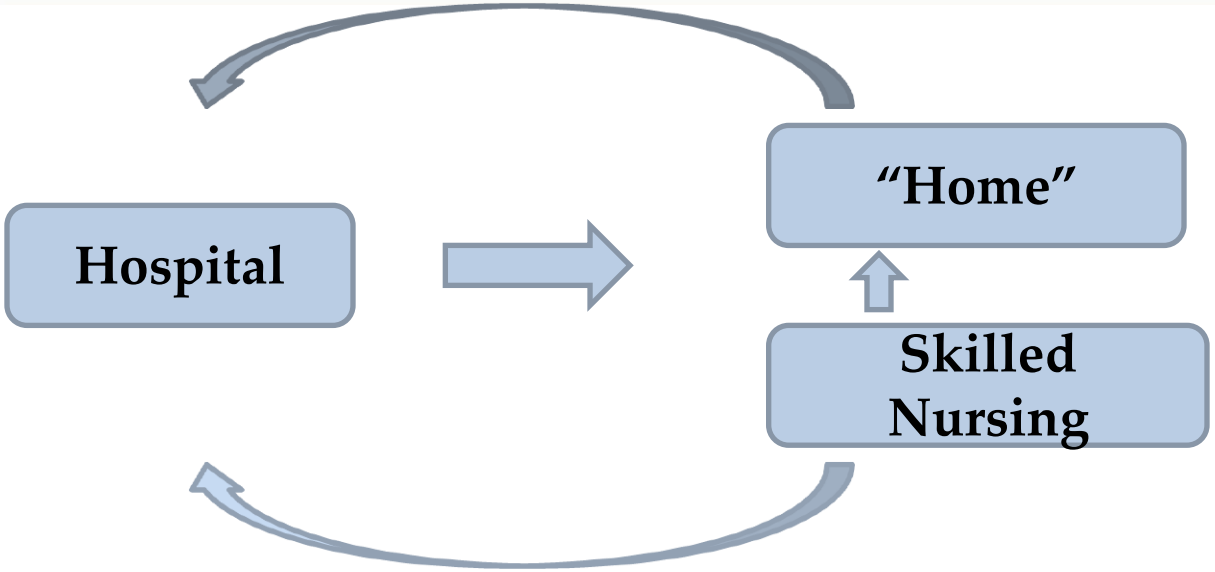
Represents providers who share 30 or more transitions



Strategy 3: Know what's going on

Inventory efforts and align within and across organizations

Portfolio of Complementary Efforts



1. Hospital: RED, BOOST, STAAR, H2H, HEN
2. NH/SNF: INTERACT
3. Elder Services: self-management coaching, options counseling
4. Enhanced clinical services: high-risk care management, HF clinic
5. Improved communications, clarity on care preferences (MOLST)

What programs are out there?

Settings/Sectors	Programs
Hospitals	BOOST, RED, STAAR, H2H, CMS HEN
Community Teams	QIO ICPC, STAAR, CCTP
Skilled Nursing Facilities, NH	INTERACT
Home Health Agencies	HHQIC BPIP, VNSNYS
Aging Services	AoA grants, AAA, ADRC
Transitional Care Services	TCM (Naylor), CTI (Coleman), BRIDGES
Health Information Technology	ONC Beacon, ONC Challenge Grants, CAST
Public Engagement	Aligning Forces for Quality, CMS
Multi-Sector Engagement	AHRQ Chartered Value Exchange, HHS P4P
Person/ Caregiver Engagement	UHF Next Step in Care, AHRQ guide, AARP
Housing with Services	SASH
LTSS Providers	LTQA Innovative Communities, CAST

Where are these programs active?

Program	State/Setting
BOOST	26 states; 82 hospitals
RED	>300 hospitals
H2H	50 states; 1141 hospitals
Care Transitions Intervention	>36 states, >450 organizations
STAAR	4 states; 152 H; >600 xc partners
QIO Care Transitions Demo	14 communities; 682 xc partners
Aligning Forces for Quality	16 regions
ONC Beacon Communities	17 communities
AHRQ Chartered Value Exchanges	24 communities
Aging and Disability Resource Centers	50 states
QIO Care Transitions, CMS HEN	50 states
INTERACT	>400 sites

xc=cross-continuum

Massachusetts State-Action:
A Portfolio of Complementary Efforts

- Care Transitions Forum
- State Strategic Plan on Care Transitions
- Division of Health Care Finance and Policy PPR Committee, providing hospitals state wide rehospitalization reports
- HCQCC Expert Panel on Performance Measurement
- NH Surveyors trained in elements of a good transition
- Vetted standard transfer forms between all settings of care
- Hospital requirement to form patient/family advisory councils
- MOLST (Medical Orders for Life Sustaining Treatment)
- INTERACT (Interventions to Reduce Acute Care Transfers)
- Medical home demonstrations; new applications coordinate training on principles of optimal transitions with STAAR
- Elder Services Agencies join cross continuum teams
- State-wide education and outreach for CMS CCTP; 4 CCTPs
- ONC Challenge grant (IMPACT) to create electronic universal transfer forms

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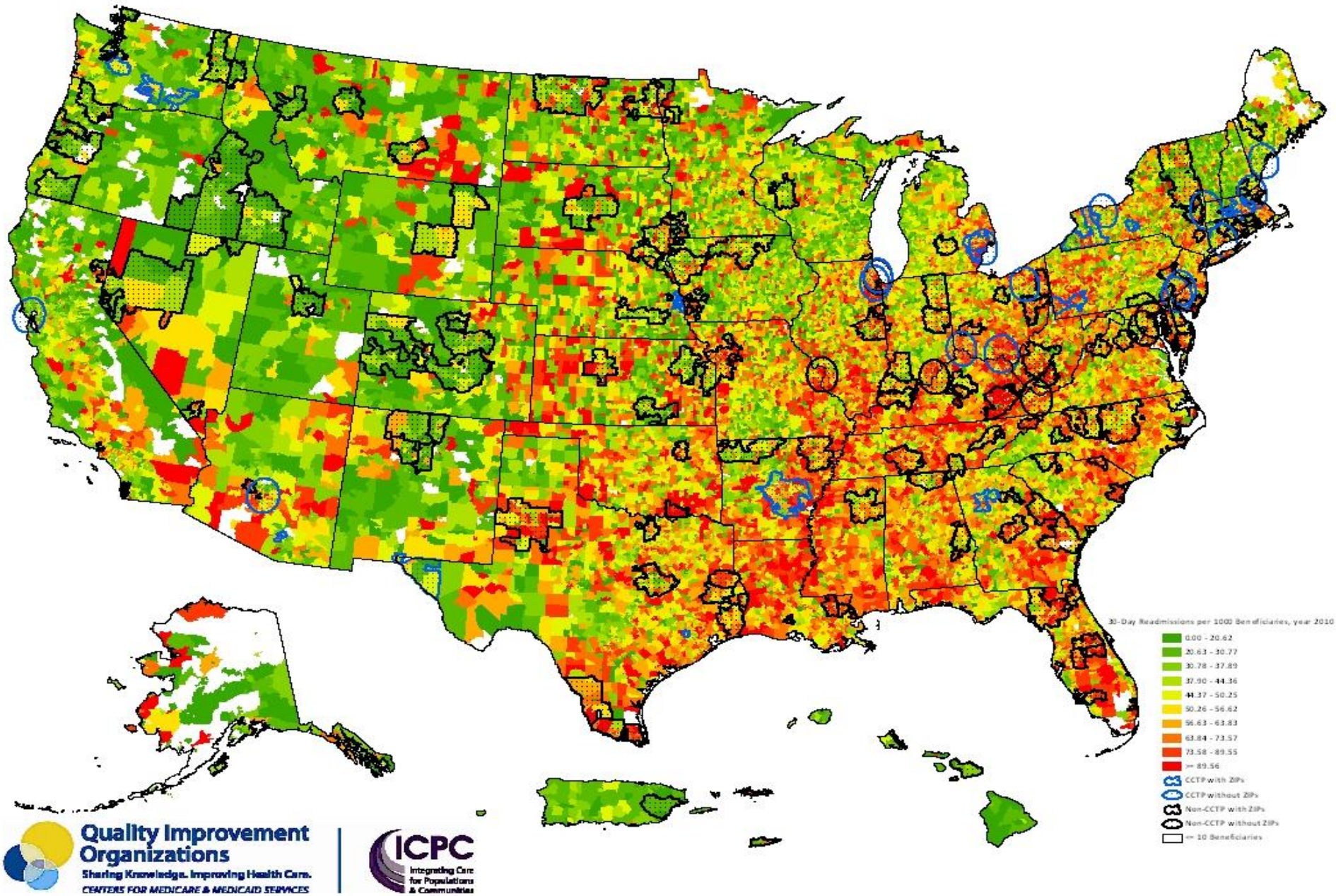
Strategy 3: Inventory & Align Efforts

N>300

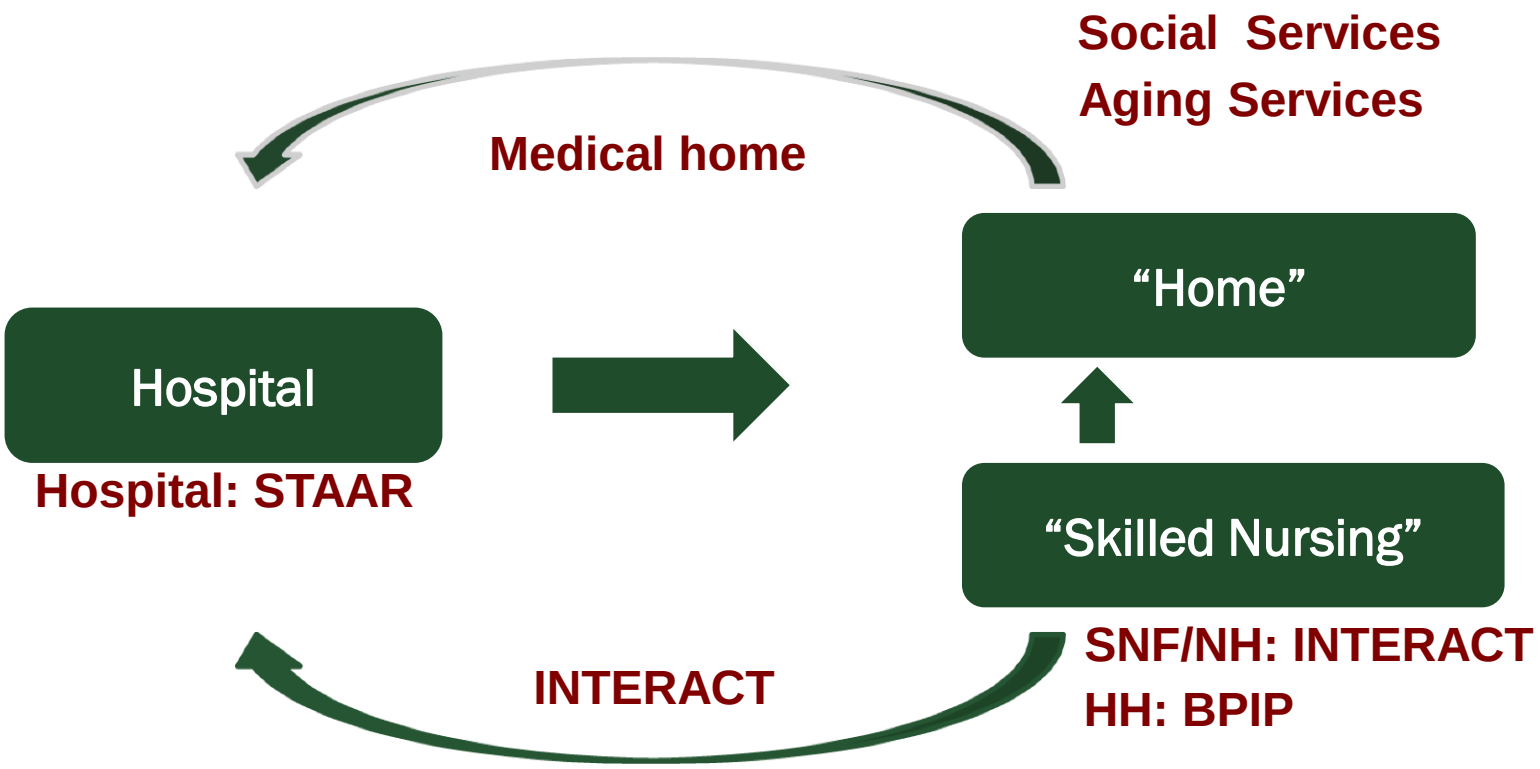


Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ICPC
Integrating Care for Populations & Communities

This material was prepared by the Colorado Foundation for Medical Care (CFMC), the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. [AS-4010-090 CO 2012]

Your Local Strategy



Strategy 4: Manage High Risk Patients

- Criteria: clinical, social, utilization
- Payer (uninsured, Medicaid)
- Frequent utilizers among providers– Detroit CARR and FUSE

Strategies:

- HIPPA: request permission
- Daily readmission reports
- Daily high-risk reports
- “Enhanced assessment” for high-risk

Strategy 5: Move to Testing, Don't Delay

Best practices aligned across programs:

- Reliable checklist
- Adopt "teach-back techniques"
- Clear, feasible plan in place prior to discharge
- Communicate to receiving clinician at the time of discharge
- Deliberate, redundant reconciliation of medications
- Work collaboratively with post-acute providers
- Follow up <5 days
- Link to services and supports

Step 5: Move to Testing, Don't Delay

- Avoid looking for one single solution
- Don't overplan launching; *"what can you do by Tuesday"*
- Start with something that is a good fit for staff, strenghts
- Measure what you try, and review frequently

The majority of success stories would say they built on existing recommendations but ultimately theirs is a unique solution

Don’t-Miss Resources

Providers and Communities Toolkit
http://www.cfmc.org/integratingcare/toolkit.htm
http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx

Aging Service Providers Toolkit
http://www.aoa.gov/AoA_programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

Resources for Patients
http://www.cfmc.org/integratingcare/patient_resources.htm

Actual Tools from Teams across US:
http://www.cfmc.org/integratingcare/toolkit_interventions.htm

Thank you

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