REDUCING READMISSIONS

Improving Care Across Settings and Over Time

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Roadmap

• Reducing readmissions by working across settings

• Five practical strategies for your consideration in 2013
WORKING ACROSS SETTINGS

Expanding the impact of your efforts by partnering
Portfolio of complementary efforts

- Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations
- Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations
- Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations
Cross-Setting Portfolio

• **Improve hospital-specific transitional care process:**
  - Re-Engineered Discharge (RED), Better Outcomes for Older Adults through Safe Transitions (BOOST), State-Action on Avoidable Re-hospitalizations (STAAR), Hospital to Home (H2H), Next Step in Care

• **Improve Sub-Acute Nursing Facility (SNF) and Home Health (HH) transitional care processes:**
  - Interventions to Reduce Acute Care Transfers (INTERACT), front-loading HH episodes (Visiting Nurse Service New York State)

• **Provide new transitional care services:**
  - Self management coaching, nurse navigators, social workers

• **Provide ongoing management for very high risk:**
  - High-utilizer care management over time

• **Link to community-based supports and services:**
  - Area Agency on Aging (AAA), Aging and Disability Resource Center (ADRC), nutrition programs, housing
The STAAR Initiative
State-Action on Avoidable Rehospitalizations
Why “State-Action?”

Opportunities to improve care transitions exist:
- Within settings
- Between settings
- Across numerous settings, over time
- Within disciplines
- Among disciplines
- Across clinical and non-clinical boundaries

And providers face barriers that they alone can not solve:
- Creating and aligning payment policies
- Timely data and Information sharing
- Culture (competitiveness, collaboration, leadership)

Two-part, concurrent strategy

- Mobilize providers across the continuum to work on improving care transitions; provide quality improvement technical assistance; and

- Recruit and engage state-level leadership to provide visibility and mobilize solutions to common systemic challenges
The STAAR Cross-Continuum Collaborative: 
*Optimize the transition for all patients*
1. Know your data
2. Form a cross-continuum team
3. Review transitions across settings
Improve standard of care for ALL patients

1. Identify Risk
2. Patient/Caregiver Learning
3. Timely Communication
4. Timely Follow-Up
CREATING & ALIGNING A STATE PORTFOLIO

Example of Massachusetts
Massachusetts State-Action:
A Portfolio of Complementary Efforts

- Care Transitions Forum
- State Strategic Plan on Care Transitions
- Division of Health Care Finance and Policy Potentially Preventable Readmissions Committee, providing hospitals state wide rehospitalization reports
- Health Care Quality and Cost Council expert panel on performance measurement
- Quality inspectors trained in elements of a good transition
- Vetted standard transfer forms between all settings of care
- Hospital requirement to form patient/family advisory councils
- Medical Orders for Life Sustaining Treatment (MOLST) state wide rollout
- Interventions to Reduce Acute Care Transfers (INTERACT)
- Medical home demonstrations; new applications coordinate training on principles of optimal transitions with STAAR
- Aging Services Access Points (ASAPs) join cross continuum teams
- State-wide education and outreach for Centers for Medicare and Medicaid (CMS) Community-based Care Transition Program (CCTP)
- Office of the National Coordinator for Health Information Technology Challenge grant to create electronic universal transfer forms
STAAR Cross Continuum Team Organizations
Home Health Agencies, Office Practices, Nursing Homes, SNFs, etc

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Multi-Payer Medical Home Initiative

N=46
INTERACT Nursing Homes/SNFs
(INTErventions to Reduce Acute Care Transfers)
Aging Service Access Points

N=116 trained care transition coaches
MOLST Pilot & IMPACT Pilot
(Medical Orders for Life Sustaining Treatment)
(Improving Post Acute Care Transitions)

Worcester “Galaxy” Meeting with STAAR, MOLST, IMPACT, INTERACT
# Table of Contents: Cross-Continuum Teams

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baystate Franklin Medical Center</td>
<td>4</td>
</tr>
<tr>
<td>Baystate Medical Center</td>
<td>7</td>
</tr>
<tr>
<td>Beth Israel Deaconess Hospital – Needham</td>
<td>9</td>
</tr>
<tr>
<td>Beth Israel Deaconess Hospital – Milton</td>
<td>13</td>
</tr>
<tr>
<td>Cambridge Health Alliance</td>
<td>15</td>
</tr>
<tr>
<td>Cape Cod Hospital</td>
<td>21</td>
</tr>
<tr>
<td>Cooley Dickinson Hospital</td>
<td>25</td>
</tr>
<tr>
<td>Falmouth Hospital</td>
<td>31</td>
</tr>
<tr>
<td>Good Samaritan Medical Center</td>
<td>34</td>
</tr>
<tr>
<td>Holyoke Medical Center</td>
<td>38</td>
</tr>
<tr>
<td>Lawrence General Hospital</td>
<td>41</td>
</tr>
<tr>
<td>Massachusetts General Hospital</td>
<td>46</td>
</tr>
<tr>
<td>Merrimack Valley Hospital</td>
<td>51</td>
</tr>
<tr>
<td>Milford Regional Medical Center</td>
<td>55</td>
</tr>
<tr>
<td>Newton Wellesley Hospital</td>
<td>59</td>
</tr>
<tr>
<td>Northeast Health System</td>
<td>62</td>
</tr>
<tr>
<td>North Shore Medical Center</td>
<td>66</td>
</tr>
<tr>
<td>Norwood Hospital</td>
<td>68</td>
</tr>
<tr>
<td>Saint Anne’s Hospital</td>
<td>70</td>
</tr>
<tr>
<td>Saints Medical Center</td>
<td>75</td>
</tr>
<tr>
<td>South Shore Hospital</td>
<td>79</td>
</tr>
<tr>
<td>Sturdy Memorial Hospital</td>
<td>83</td>
</tr>
</tbody>
</table>
5 RECOMMENDATIONS
Recommendations

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)
Step 1: Know your data

“Community-based” Root Cause Analysis

Consists of:

1. Data analytics (hospital, SNF, HH)
2. “Cross-continuum team” input
3. Patient, caregiver interviews
Step 1: Know your Data

Example Insights from running your own data

- 6,478 Medicare fee-for-service (FFS) admissions among 4,732 people
- 6,148 Medicare FFS alive discharges (some exclusions)
- 908 30-day readmissions (RA); 14% all cause readmission rate
  - Reducing readmissions by 20% = 180 avoided RA
- 50% 30-day readmissions <10 days of discharge; 25% <96h
- Top 10 RA diagnoses: heart failure (HF), renal failure (RF), urinary tract infections (UTI), sepsis, gastro-intestinal bleeding (GIB), arrhythmia, chronic obstructive pulmonary disease (COPD), syncope, gastritis/esophagitis, pneumonia/respiratory infection
- 369 people (8%) hospitalized >3 times; used 1339 hospital days (22%)
  - Among high utilizers, 495 30-day RA; rate 38%
  - Among high utilizers, 55% discharged to home with no services (N=716)
  - Top 10 diagnoses: same HF, RF, UTI, COPD, GIB, sepsis, esophagitis
Step 2: Know your partners

Available from your state Quality Improvement Organization

maybe NY Medicaid can create similar reports?

Social Network Analysis (SNA)

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

Represents all transitions in community

Represents providers who share 10 or more transitions

Represents providers who share 30 or more transitions
Cross-Continuum Team

“We were working on improving processes within the hospital but we also know that because hospital stays are short and patients typically are not fully recovered when they are discharged, we had to involve other providers in the community.”

*Kris Zitrick, Director of Quality Management Charles Cole Memorial Hospital*

“At the first meeting we realized that the community partners had no knowledge of what we were doing as a hospital to prevent readmissions and that we needed to be educated about the role of the post-acute providers about what happens when they take over the care of the patients.”

*Bonnie Kratzer, Director of Case Management, Charles Cole Memorial Hospital*

*Specific actions: share information about efforts, educate about capabilities of organizations, decrease silos, form relationships, sense of teamwork and putting patients first, standard transition forms*
Step 3: Inventory and Align Efforts

Hospital:
1. Standardize process for all
2. Target: high risk, high utilizer

SNF/Nursing Home:
INTERACT forms

“Skilled Nursing”

“Home”

Emergency Department (ED):
1. Case Manager in ED
2. Treat & return to SNF

Essential info: meds, goals

Targeted transitional care services

Practices & Visiting Nurse:
1. Early follow up & medication reconciliation
2. Refer to AAA
3. Clarify goals of care

SNF: transition improvement

INTERACT forms

COLLABORATIVE HEALTHCARE STRATEGIES
Step 3: Inventory and Align Efforts

Partner to improve shared processes

1. Shared patient education materials
2. Consistent use of teach-back & teaching points
3. Medication management across settings
4. Timely communication between providers
5. Consistent caregiver engagement in care plan
6. Warm handoffs
7. Notification of primary care physician (PCP) of ED visit/admission
8. Awareness of & linkage to community resources
Step 4: Identify High Risk Patients

• Identify based on hospital and/or payer data

• Collaborate among providers in a community

• Pilot proactive outreach and optimize resources
Step 5: Move from Pilot to Portfolio

- Avoid looking for one single solution – develop portfolio
- Don’t over-plan – iterate as you go
- Standardize improved transitional care process for all
- Collaborate to deliver transitional care services for target populations

The majority of success stories to date would say they built on the set of existing recommendations but ultimately theirs is a unique solution
Thank you

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