

REDUCING READMISSIONS

Improving Care Across Settings and Over Time

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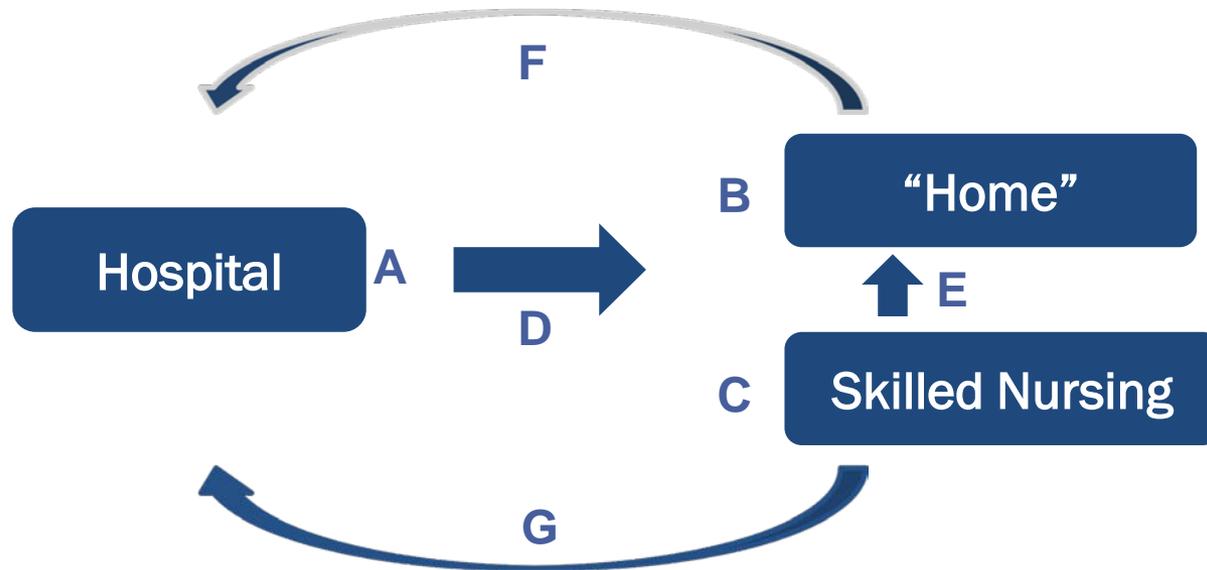
Roadmap

- 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)

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

STAAR Strategy

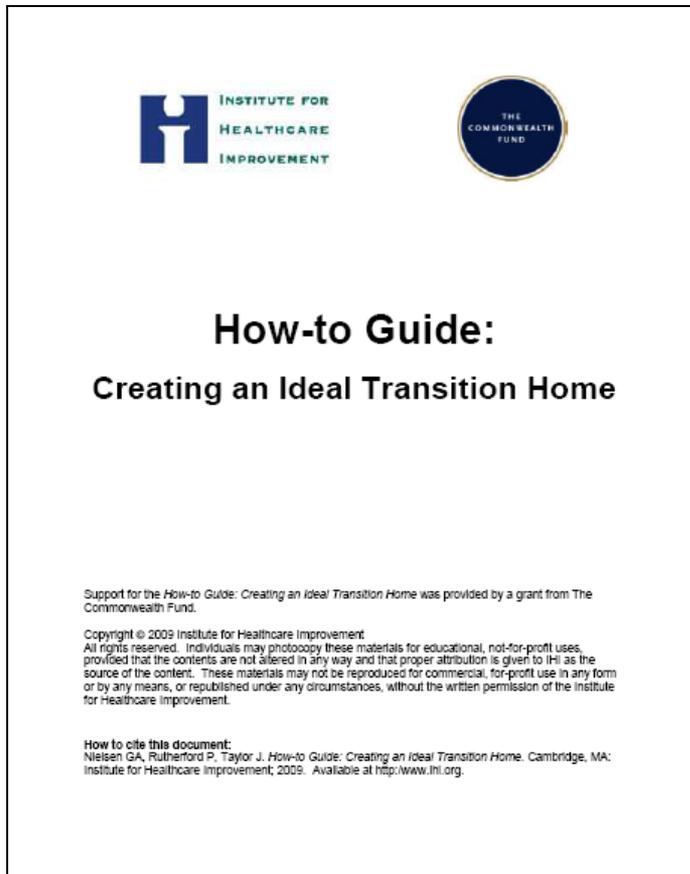
Two-part, concurrent strategy

- 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

STAAR Initiative

State Action on Avoidable Rehospitalizations



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

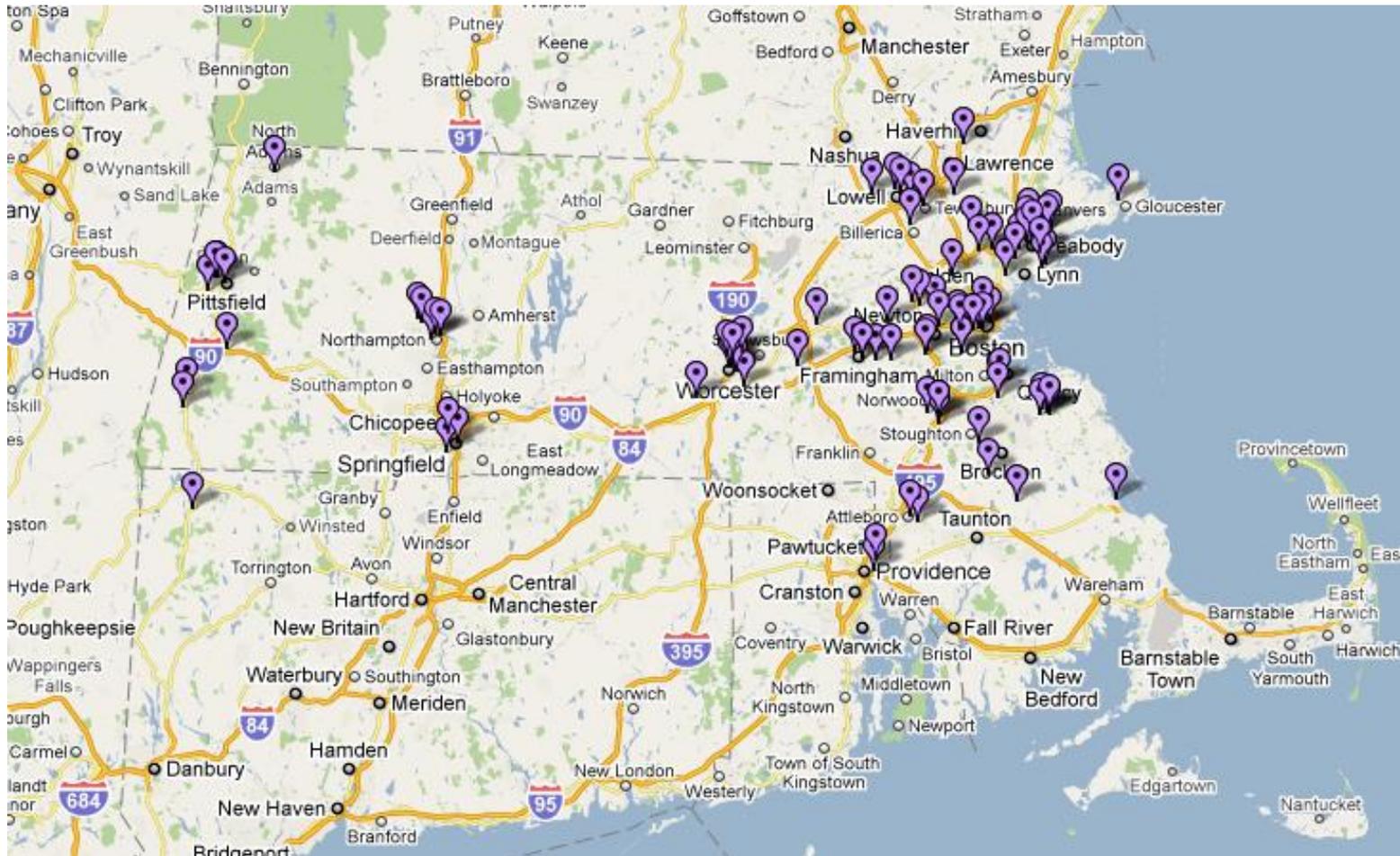
STAAR Hospitals



N=50

STAAR Cross Continuum Team Organizations

Home Health Agencies, Office Practices, Nursing Homes, SNFs, etc



N>250

INTERACT Nursing Homes/SNFs (INTERventions to Reduce Acute Care Transfers)



N>200

Aging Service Access Points



N=116 trained care transition coaches

MOLST Pilot & IMPACT Pilot

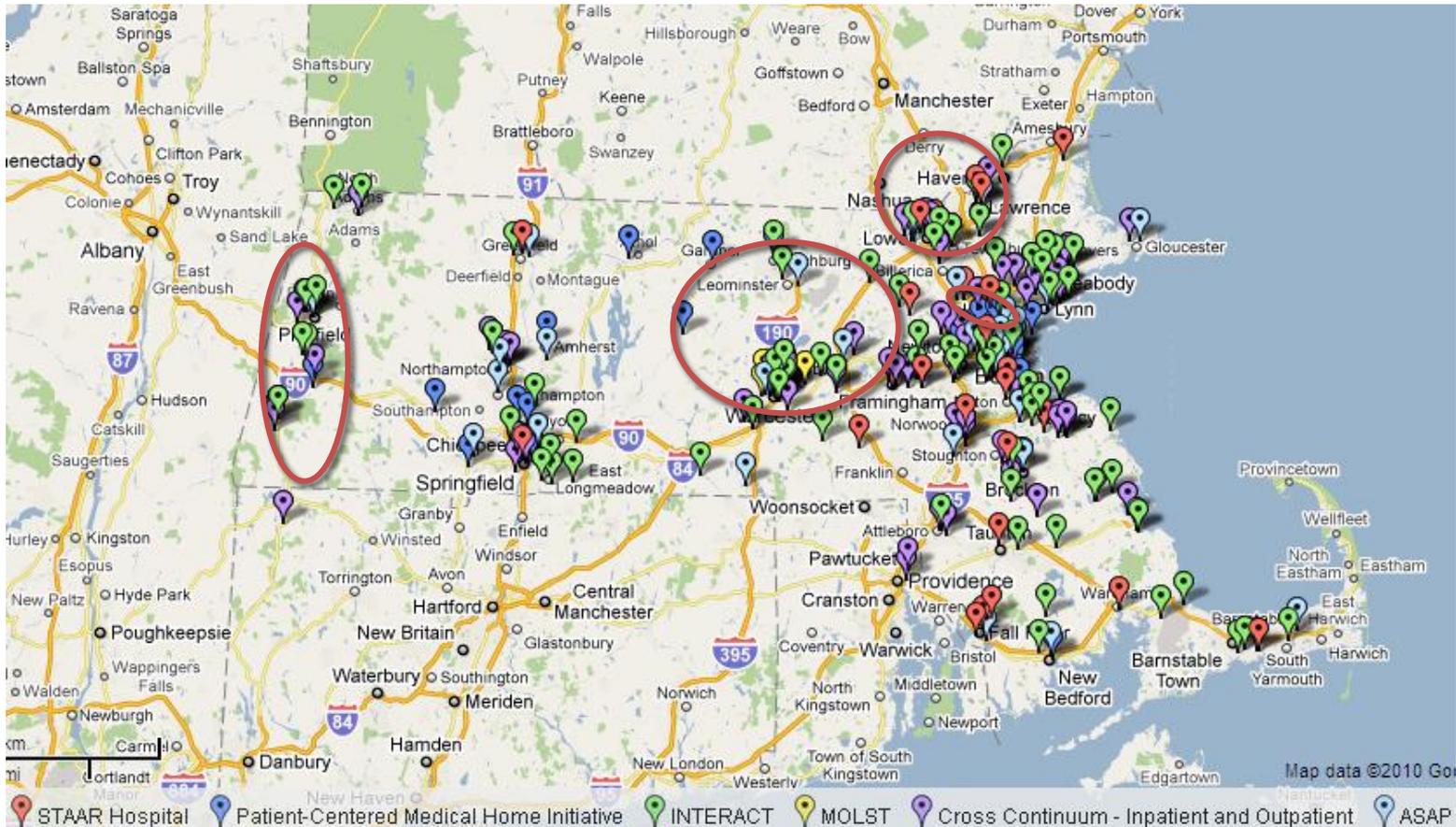
(Medical Orders for Life Sustaining Treatment)

(Improving Post Acute Care Transitions)



Worcester “Galaxy” Meeting with STAAR, MOLST, IMPACT, INTERACT

CMS CCTP Programs (4)



N>300

2012

Reducing Readmissions:
Highlights from
Massachusetts STAAR
Cross-Continuum Teams

Table of Contents: Cross-Continuum Teams

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

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

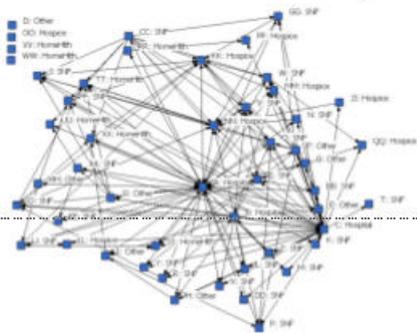
Example Insights from running your own data

- 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

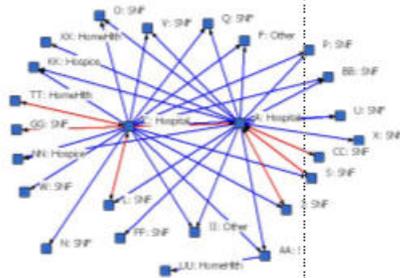
*Available from your state Quality Improvement Organization
 ?maybe NY Medicaid can create similar reports?*

Social Network Analysis (SNA)



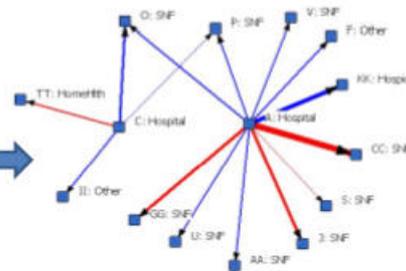
← Represents all transitions in community

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 10 or more transitions

→ Represents providers who share 30 or more transitions



(ICPCA NCC)

Integrating Care for Populations
 and Communities Aim
 National Coordinating Center

Social Network Analysis (SNA)

(ICPCA NCC)

Integrating Care for Populations

tions

51

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

Emergency Department (ED):

1. Case Manager in ED
2. Treat & return to SNF

Hospital

Essential info: meds, goals

Practices & Visiting Nurse:

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

“Home”



Targeted transitional care services



SNF: transition improvement

“Skilled Nursing”

SNF/Nursing Home:
INTERACT

INTERACT forms



Hospital:

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

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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