REDUCING READMISSIONS

A Quality Effort at the Heart of System Redesign

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Collaborative Healthcare Strategies
Lexington, Massachusetts
Objectives

1. Inventory
2. Align
3. Leverage
Roadmap

1. Why Readmissions?
2. Data and Root Causes
3. Crafting a Cross-Continuum Portfolio of Efforts
4. 5 Recommendations
WHY READMISSIONS?
Why Readmissions?

- Frequent
- Costly
- Performance is highly variable
- Actionable for improvement
Rehospitalizations are Frequent

Medicare FFS 2007:
• 20% at 30 days
• 35% at 90 days
• 67% are re-hospitalized or deceased at 1 year

Mor. Et al. The Revolving Door of Rehospitalization from Skilled Nursing Facilities. Health Affairs 2010.
Rehospitalizations are Costly

• Medicare: **$18 Billion** spent on 30-day rehospitalizations annually

• **$25 billion** for all patients in US annually

• Substantial sums for state healthcare economies, where data exist
  • MA: all payer 30-day “PPR”= 377,000 hospital days → **$577M** annually
  • PA: all payer 30-day RA= **$2.5B** annually
  • NY: all payer 30-day RA= **$3.7B** annually
Rehospitalization Rates are Highly Variable

Percent of Patients Readmitted Within 30 Days of Medical Discharge by Hospital Referral Region (2009)

- 16.7 to 18.9 (57)
- 16.1 to < 16.7 (59)
- 15.6 to < 16.1 (61)
- 14.8 to < 15.6 (63)
- 11.4 to < 14.8 (63)
- Data suppressed (3)
- Not populated

Source: Dartmouth Atlas 2011
Actionable for Improvement

- 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

Actionable for Improvement

- 42 million family caregivers
- 46% perform nursing tasks
- 75% of them manage medicines
- 33% of them do wound care
- 66% of the patients had no VNA

“We ask caregivers to do things that would make even nursing students tremble…”
~ Susan Reinhard
AARP Public Policy

“We asked family caregivers how they learned to manage …medications and 61% said, ‘I learned on my own.’”
~ Carol Levine
United Hospital Fund

Available at: http://www.uhfny.org/publications/880853.
Actionable for Improvement

• Care Transitions Intervention: self management coaching
• Transitional Care Model: Advance-practice nurse management
• RED: Structured and enhanced discharge process
• BOOST: Structured discharge process
• STAAR: Structured discharge process & cross-continuum team
• QIO-demonstration: community-coalition based implementation
• INTERACT: Reduce avoidable SNF-hospital transfers
• Bridge: SW-led post-discharge supportive services
Why Readmissions?

• A measurable reflection of care across settings
• Reflection of fragmented delivery system
• Improvement on readmission rates would likely reflect:
  • Improvement in provider-patient communication
  • Improvement in provider-provider communication
  • Improvement in linkage to follow up care
  • Engagement of patient/caregiver in self-management
• Impact on acute-care utilization (ED, admissions)
READMISSIONS DATA

National, state, community, organization
Medicare Readmissions in Maryland

In 2010, Maryland had the highest readmission rates in the United States among Medicare eligible patients

- 21.6 percent (MD) versus 18.2 percent (US)

*Health Services Cost Review Commission, 2012*
Diagnoses that Frequently Lead to Readmission
Maryland 2012, all payer, not just Medicare

1. Heart failure
2. Sepsis
3. COPD
4. Pneumonia
5. Renal failure
6. Bipolar disorder
7. Kidney & UTI
8. Arrhythmia
9. Major depression
10. Schizophrenia
11. Cellulitis
12. Stroke

15,879 readmissions!
20% reduction would avert 3,176
@ $10k each → $31.7M savings
@ LOS= 4.5d → 14,291 days
Leading Readmission Diagnoses
Beware of blinders created by diagnosis-focus

- Heart failure
- Sepsis
- COPD
- Renal Failure
- Post-operative

% of All Readmissions
- 4.9%
- 4.7%
- 2.8%

What is the impact of focusing on the top cause of readmissions?
Estimate 30,000 RA in MD per year; 5% of RA are due to HF
5% x 30,000 = 1,500 HF readmissions
Aim for a 20% reduction in HF readmissions
.2 x 1,500 = 300 avoided readmissions
Total impact of the successful targeted effort on overall RA
300 / 30,000 = 1% reduction overall
Example insights from your own data analysis

- 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
  - Reducing readmissions by 20% = **180 avoided RA**
- 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 this group, 495 30-d RA; **rate 38%**
  - Among this group, 55% d/c to home with no services (N=716)
  - Top 10 dx: same HF, RF, UTI, COPD, GIB, sepsis, esophagitis
There Is No Silver Bullet.....
Caution measuring outcomes for any single process improvement

• 523 readmissions:
  • 250 (47%) deemed potentially preventable
  • Found an **average of 9 factors** contributed to each readmission

• Assessed factors relating to 3 phases of care:
  • 57% readmissions involved an issue of care during 1st hospitalization
  • 67% involved an issue during the discharge process
  • 79% involved an issue relating to follow up care

• 250 readmissions identified 1,867 factors!

**BUNDLE** Interventions & Measure as All-or Nothing for Outcomes
CREATING A CROSS-CONTINUUM PORTFOLIO

Process improvements, targeted services & aligned efforts within and across settings
Hospital Domains to Reduce Readmissions

Reduce readmissions

- Quality inpatient care
- Standardize care processes
- Provide enhanced services to high-risk
- Collaborate with area providers
- Assess for readmission risk
- Engage patient and caregiver in learning
- Communicate with receiving providers
- Ensure timely follow up
- Follow up calls
- Home visits
- Coaching/ skill building
- Complex clinical care

Complex clinical care
Cross-setting Portfolio

- 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:
  ➢ RED, BOOST, STAAR, H2H, Next Step in Care

• Improve SNF and Home Health transitional care processes:
  ➢ INTERACT, front-loading HH episodes

• Provide new transitional care services:
  ➢ Self management coaching, nurse navigators, care coordinators

• Provide ongoing management for very high risk:
  ➢ High-utilizer, high risk population management, Evercare

• Link to community-based supports and services:
  ➢ AAA, ADRC, nutrition programs, respite, housing w/ services
Regional / State Portfolio

- Hospital
- Home
- Skilled Nursing

- Quality Error-Free Inpatient Care
- Patient, Caregiver and Public Engagement
- State-wide Data, Uniform Measurement
- National, State, Local Leadership
- Incentives for Change and Penalties for Inaction
- Technology Enhancements
- Legal Issues

Clarity on care preferences
The STAAR Initiative
State-Action on Avoidable Rehospitalizations
Why “State-Action?”

Opportunities to improve care transitions to reduce readmissions exist:

- Within settings
- Between settings
- Across numerous settings, over time
- Within disciplines
- Among disciplines
- Across clinical and non-clinical boundaries
STAAR Strategy

Two-part, concurrent strategy

- Mobilize providers across the continuum to work on improving care transitions; 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 care for all patients

1. **Enhanced Assessment of Patients:** Identifying high-risk criteria and meeting needs; engaging pt/family/outpt to identify needs

2. **Enhanced Teaching and Learning:** change focus from what providers tell patients to what patients/caregivers *learn*

3. **Real-time Communication:** timely, clinically meaningful information exchange with opportunity for clarification

4. **Timely Post Acute Care Follow-Up:** clinical contact (call, home health visit, office visit) within 48h or 5 days depending on risk
<table>
<thead>
<tr>
<th>Recommended Changes</th>
<th>% Testing</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-Continuum Team</td>
<td>100%</td>
<td>Understanding mutual interdependencies, the hospital-based teams co-design care processes with their cross-continuum partners to improve the transition out of the hospital</td>
</tr>
<tr>
<td>Diagnostic Review</td>
<td>100%</td>
<td>Teams perform a diagnostic review of five recently readmitted patients to understand transitions from the perspective of the longitudinal patient experience and to identify opportunities for improvement</td>
</tr>
<tr>
<td>Enhanced Teaching</td>
<td>91%</td>
<td>Utilizing health literacy principles, effectively teach patients about their conditions, medications, and self-care</td>
</tr>
<tr>
<td>Enhanced Assessment</td>
<td>76%</td>
<td>On admission, perform a comprehensive assessment of patients’ post-discharge needs and initiate a customized discharge plan</td>
</tr>
<tr>
<td>Timely Follow-up</td>
<td>76%</td>
<td>Based on assessed risk of readmission, schedule post-hospital care follow-up prior to discharge</td>
</tr>
<tr>
<td>Communication</td>
<td>66%</td>
<td>Provide customized, real-time critical information to the next care provider(s); Provide the patient and his or her family caregiver with written self-care instructions</td>
</tr>
</tbody>
</table>
Cross Continuum Teams

- The most *transformational* recommendation in STAAR
- Reinforces that readmissions are not solely a hospital problem
- Considered the training ground to develop competency for evolving to integrated care delivery models (e.g. bundled payment models, ACOs)
- Greatly enhances uptake of QI action in a *multiplier effect*
Readmission Diagnostic Interviews

- Teams complete comprehensive review of the last five readmissions every 6 months (chart review and interviews)

- Members from the cross continuum team hear first-hand about the transitional care problems “through the patients’ eyes”

- Engages the “hearts and minds” of clinicians and catalyzes action toward problem-solving

- Opportunities for learning from reviewing a small sampling of patient experiences abound
Can I ask you and your family members:
How do you think you became sick enough to come back to the hospital?

story about the patient’s circumstances that contributed to the readmission.
Enhanced Readmission Risk Assessment

- Most common intervention implemented during ARR Y1
- Family caregivers and community providers are an important source of information about home-going needs of patients
- Many are embedding questions from the Readmission Review into all assessments of recently readmitted patients
- Assessing needs must be paired with addressing needs…. 
Effective Teaching and Learning

- Clinicians readily embrace Teach Back techniques to enhance patient and family caregiver education
  - Most successful process improvement change; spread not only from unit to hospital, but throughout continuum
  - Identify the “learner;” not always the patient
- There is value in planning multiple teaching sessions with patients and family caregivers
- Providers share teach-back key messages and materials across settings
Real-Time Communication

- Communicate clinically relevant information that the receiving provider needs to manage the patient
  - “warm handoff” with opportunity for clarification
- Re-define the discharge summary and when it is completed
- Written care plans for patients and family caregivers should use clear, user-friendly formats for describing care at home
**Timely Follow-Up**

- High risk patients need clinical contact within 48 h
  - Does not need to be an MD office visit

- Most challenging process improvement is to schedule MD visits
  - Successes occur when MD practices are part of cross continuum effort
  - New CPT codes in Medicare for transitional care follow up

- Use follow up phone calls to reinforce same plan of care, teaching messages
“Non-compliance”

Medication Discrepancy Tool

51% patient-level factors:
- Nonintentional nonadherence: 34%
- Intentional nonadherence: 5%
- Didn’t fill rx: 5%
- Other 1%

49% system factors:
- d/c instructions incomplete or illegible: 16%
- Conflicting information: 15%
- Duplicate rx: 8%
- Incorrect instructions: 4%
- Other: 7%

Coleman RARE webinar 2012
INTERACT
Interventions to Reduce Acute Care Transfers

- Set of process improvements for SNF/NH settings
- Identify & manage changes in clinical condition without sending to ED
- Establish clear & known goals of care
- Improve CNA, RN to MD communication (SBAR)
- Improve SNF to Hospital ED communication (INTERACT form)
- Provides a NH Capabilities List to better match pt need w/ services
  - 20-30% reductions in hospitalizations

VERSION 3.0
- Includes recommended Hospital-SNF form/information elements
- Emphasize warm handoffs, joint readmission reviews
# Nursing Home Capabilities List

**This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.**

**Facility**

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel</td>
</tr>
</tbody>
</table>

Code “Y” for yes or “N” for no to indicate the availability of each item in your facility.

### Capabilities

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Clinician Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility five or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility five or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### Diagnostic Testing

<table>
<thead>
<tr>
<th>Test</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stat Labs with turnaround less than 6 hours</td>
<td>Y</td>
</tr>
<tr>
<td>Stat X-rays with turnaround less than 6 hours</td>
<td>Y</td>
</tr>
<tr>
<td>IVs</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Bladder Ultrasound

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### Venous Doppler

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### Cardiac Echo

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### Swallow Studies

<table>
<thead>
<tr>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>

### Consultations

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>Y</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Y</td>
</tr>
<tr>
<td>Hematology</td>
<td>Y</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Y</td>
</tr>
<tr>
<td>Other Physician Specialty Consultations</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Social and Psychology Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
<td>Y</td>
</tr>
<tr>
<td>Psychological evaluation and counseling by a Licensed Psychologist</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Therapies on Site

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>Y</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Y</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Y</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Pharmacy Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency list with common medications for acute conditions available</td>
<td>Y</td>
</tr>
<tr>
<td>New medications filled within 2 hours</td>
<td>Y</td>
</tr>
</tbody>
</table>

### Other Specialized Services (specify)

<table>
<thead>
<tr>
<th>Service</th>
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# Nursing Home to Hospital Transfer Form

<table>
<thead>
<tr>
<th>Resident Name (first, middle, last initial)</th>
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</thead>
<tbody>
<tr>
<td>Tel</td>
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</tbody>
</table>

Date of transfer: __________________________

Primary diagnosis/Reason for admission: __________________________

Who to Call at the Nursing Home to Get Questions Answered

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code Status</th>
<th>Full Code</th>
<th>ODM</th>
<th>OAI</th>
<th>Other</th>
</tr>
</thead>
</table>

### Key Clinical Information

Reason for transfer:

Is the primary reason for transfer for diagnostic testing or medication administration?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### Usual Mental Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
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</table>

### Usual Functional Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Notes</th>
</tr>
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<tbody>
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<td></td>
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</table>

### Additional Clinical Information

<table>
<thead>
<tr>
<th>Condition</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Date of last bowel movement or other gastrointestinal function

<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Date of last bladder voiding function or other urological function

<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

---

**Form Completed By:** (name/title) __________________________

**Signature:** __________________________

**Report Called In:** (name/title) __________________________

**Date:** __________ / __________ / __________

**Time:** __________ / __________ / __________
Carolinas HealthCare “SNF Circle Back”

- Multi-hospital system in North Carolina
- Pilot in one hospital; commitment to spread system-wide if effective
- Problem: early readmissions from SNF
- Test:
  - warm handoffs to SNF
  - Call back to SNF 3-24 hours after transfer to answer questions
- Details:
  - RCA revealed SNF-readmission patterns
  - Hospital readmission champion met with SNFs to discuss shared goals
  - Hospital (with some leadership effort) asked SNF to participate in this communication
  - RN calls nurse at SNF
  - SW or care coordinator calls for follow up clarification 3-24 hours after transfer
  - Daily workflow (with some modifications for weekends, done next business day)
  - Follow up calls are scripted and documented in Allscripts system
  - Pilot on paper with 1 RN and 1 SW
  - Pilot expanded to RN call report to SNF
  - Pilot expanded to add follow up calls
  - Pilot expanded to build questions into Allscripts
  - Expand to all; new standard of practice

Source: Emily Skinner, Carolinas Healthcare System
SNF Circle Back Questions
1. Did the patient arrive safely?
2. Did you find admission packet in order?
3. Were the medication orders correct?
4. Does the patient’s presentation reflect the information you received?
5. Is patient and/or family satisfied with the transition from the hospital to your facility?
6. Have we provided you everything you need to provide excellent care to the patient?

Insights
- Transitions are a PROCESS (forms are useful, but only a tool to achieve intent)
- Best done ITERATIVELY with COMMUNICATION

Source: Emily Skinner, Carolinas Healthcare System
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 PPR Committee, providing hospitals state wide rehospitalization reports
- HCQCC 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
- 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
- ASAPs join cross continuum teams
- State-wide education and outreach for CMS CCTP
- ONC 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

© Collaborative Healthcare Strategies
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
Massachusetts Care Transitions Programs
Collaborative Action + Policy Action

Massachusetts Quarterly Admission and Readmission Rates:
January 1, 2009 to September 30, 2012
Source: Medicare Part A Claims Data

Admissions per 1,000 Beneficiaries

Start of 10th SOW
EXAMPLES FROM THE FIELD
Baystate Medical Center, MA
Outcome Improvements

30-Day All-Cause Pilot Unit Readmissions

Springfield 4: 34 bed acute care unit specializing in caring for heart failure and short stay cardiac patients

Launch of MA STAAR Collaborative

Percent Readmissions

4% 9% 14% 19% 24% 29%

Sep-08 Nov-08 Jan-09 Mar-09 May-09 Jul-09 Sep-09 Nov-09 Jan-10 Mar-10 May-10 Jul-10 Sep-10

UCL LCL % Readmission Baseline Mean
Baystate Medical Center, MA
Outcome Improvements

30-Day All-Cause Pilot Unit Readmissions

Springfield 3M: 34 bed acute care nursing unit specializing in caring for general medical populations

- Launch of MA STAAR Collaborative
- ID Learner on admission fully implemented
- Ask Me 3/Teach-Back fully implemented
- Increased VNA referrals, instituted RN call-backs
- White board goals for the day fully implemented
- MDR fully implemented

Percent Readmissions

- UCL
- LCL
- % Readmission
- Baseline Mean

COLLABORATIVE HEALTHCARE STRATEGIES
30 Day Readmissions for UCSF Heart Failure Program: Primary and Secondary HF Diagnosis

- 2009 Average = 24%
- 2010 Average = 19%
- 2011 Average = 13%
- 2012 Average = 10%

Goal Line: 16% (30% reduction)

Population: 65 and older on three units
UCSF Number (v %) of Readmissions

Number of patient readmissions cut in half
St Luke’s Hospital 3 years focus on HF
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 & implement (no silver bullet)
Thank you!

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