Strategies for Success Under the New Medicare Waiver – Part 1

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
April 16, 2014
Agenda

• Do your readmission efforts serve these patients?

• Readmission reduction targets under the new waiver

• Expanding your portfolio of strategies – Part 1

• Discussion
Do your targeted efforts serve these patients?

- 77F recently hospitalized for an infected dialysis catheter returns to the hospital 8 days following discharge with shortness of breath.

- 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.

- 86M with cancer hospitalized for constipation and abdominal pain returns to the hospital 1 day after discharge with abdominal pain.

- 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with pneumonia.
Who is “High Risk” of Readmission?

- New diagnosis – needs teaching, clear instructions
- New medications – need medication review, instructions
- Complex medical – needs continued active management
- Complex social – isolated, active substance use, poverty
- Frailty/convalescence – weakened, less able to manage
- Skilled care needs- nursing, therapy, medication management
- Personal care needs- caregiver, meals, respite
- Access to care needs- no PCP, financial, transportation
- Navigating – low health literacy, language, cultural barriers
- Advocacy – direct assistance in accessing resources/support
- Care seeking patterns- accustomed to using ED for care
- Chronic recurrent symptoms- need palliative care & care plan
- End of life – goals of care decision making
Goal by 2018: From 49\textsuperscript{th} to US Average
Variation across the state
Examine your current strategy
Strategy for Success: Which transitions need attention?

59% of d/c to home
55% of all RA from home
19% RA rate
25,654 RA in from home 2012

12% of d/c to HH;
14% of all RA from HH
21% RA rate
6,262 HH RA in 2012

18% of d/c to SNF;
21% of all RA from SNF
22% RA rate
9,879 SNF RA in 2012
10% reduction

- 2,564 fewer Medicare RA from Home
- 626 fewer Medicare RA from HH
- 987 fewer Medicare RA from SNF

Among 46 hospitals:
- 56 fewer Medicare RA from home
- 14 fewer Medicare RA from HH
- 22 fewer Medicare RA from SNF

BY THE END OF 2014
- 9 fewer RA from home per month
- 3 fewer RA from HH per month
- 4 fewer RA from SNF per month
Expanding your portfolio of efforts
The 2014 “Playbook”
2014 Playbook

- Section 1: Overview
- Section 2: The Transitions: Handle with Care Driver Diagram
- Section 3: Critically Review Your Readmission Efforts to Date
- Section 4: Designing for Success: The Portfolio Strategy
- Section 5: Essential Action
  - Model Impact of Your Strategy
  - Improve Standard Care for All
  - Improve Transitions Across the Continuum
- Section 6: High Leverage Impact
  - Hospital to SNF
  - Hospital to HH
  - Hospital to Home with Services
  - Emergency Department Based Interventions
- Section 7: Special Topics
  - Medicaid Readmissions
  - Behavioral Health
  - Palliative Care and End of Life
Glossary and Links to Resources
Online Resources
Transitions: Handle with Care Initiative Presentations and Webinars
Template Press Release
Readmission Data Analysis
Readmission Interview Protocol
Cross-continuum Team Sample Letter and Agenda
Hospital to SNF Action Planning Worksheet
Hospital to Home Health Action Planning Worksheet
Hospital to Home Action Planning Worksheet
Excel Tool: Readmission Strategy Impact Estimator
Reducing Readmissions at the State Level

Providers Improve Care & Deliver Enhanced Services

Reduce All-Payer, All Cause 30-day Readmissions to Meet US National Average by 2018

State Leaders Mitigate Barriers & Accelerate Change
Critically Review Your Efforts to Date

- Every hospital is working on reducing readmissions
- Not every hospital is having success
- In fact, many hospitals have had limited success
- Even hospitals that have had success need to accelerate
- All eyes are on your hospital’s rates, numbers and pace of change

Now is a great time to review what is working, what is not working, & whether your pace of change is fast enough
Critically Review Your Efforts to Date

1. Understand why readmissions occur at your hospital
2. Review your data for yourself
3. Ask your patients & their families why readmissions occur
4. Inventory your current readmission reduction efforts
5. Revisit your readmission reduction strategy
6. Know your hospital’s readmission reduction goal in context of the “waiver test”
Understand Why Patients Are Readmitted

### Data Element

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of adult discharges (exclude transfers, deceased, &lt;18 yrs, O/B)</td>
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<tr>
<td>2. Total number of individual patients</td>
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<td>3. Total number of 30-day readmissions</td>
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<td>4. Overall readmission rate (#/#1)</td>
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<tr>
<td>5. Discharge disposition, from #1</td>
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</tr>
<tr>
<td>a. Home</td>
<td></td>
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<tr>
<td>b. Home with home health</td>
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<tr>
<td>c. SNF</td>
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<tr>
<td>6. Number of days between discharge and readmission (frequency plot of discharge days 0-30 and the number of readmissions that occurred on each post-discharge day)</td>
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<tr>
<td>7. Top 10 discharge diagnoses resulting in readmissions (from the index discharge, run for each payer class)</td>
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<tr>
<td>8. High-utilizing population (H.U.)</td>
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<tr>
<td>a. Number of people hospitalized ≥3 times in the past 12 months (H.U.)</td>
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<tr>
<td>b. Total number of hospitalizations among H.U.</td>
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<tr>
<td>c. Discharge disposition of H.U.</td>
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<td></td>
</tr>
<tr>
<td>d. Top 10 discharge diagnoses among H.U.</td>
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</tbody>
</table>

### Readmission Interview Protocol

**Section 1: Brief chart review (10-15 minutes)**
Elicit the following basic information:
- Date of first admission:
- Date of first discharge:
- Chief complaint and medical issues during first hospitalization:
- Discharge disposition:
- Was a follow-up appointment made prior to discharge?
- Date of readmission:
- Days between discharge and readmission:
- Site of care readmitted from (home, SNF, home health, etc.):
- Readmission chief complaint and medical issues during the second hospitalization:
- Discharge disposition (if they are no longer in the hospital):

**Section 2: Patient/family caregiver interview (10-15 minutes)**
Suggested script: "We are working to improve the discharge process and noticed that you have been in the hospital twice recently. I’d like to ask you for about 10 minutes of your time to provide us with some feedback about what happened between the time you were discharged and the time you returned to the hospital. This will help us understand what we might be able to do better for you, and what we might be able to do better for our patients in general. Would that be OK with you?"

- Why were you in the hospital (dates of the admission)?
- What did the hospital team do to help you get ready to leave the hospital?
- Did the hospital team talk to you about what to do and expect once you left the hospital?
- Did you know who to call if you had questions or problems?
- Tell me about anything that was unclear or confusing or difficult for you when you left the hospital.
  - I see you went to discharged disposition. How did it go once you got there?
  - Did any new symptoms or issues come up after you were discharged?
  - Did you see a doctor, nurse, or other provider after you were discharged? Who?
  - Why do you think you needed to come back to the hospital?
  - Was there anything we could have done differently to help keep you from needing to come back?
  - Do you have any other suggestions for us?
  - Thank you!

**Section 3: Provider interview (3-5 minutes)**
Suggested script: We are working to improve care transitions and reduce avoidable readmissions. One of your patients was recently readmitted to our hospital and we’d like to ask you for your perspective about opportunities for improvement in our overall processes. It will take no more than five minutes of your time.

- Did you know the patient was admitted on (first hospital date)?
- Did you know the patient was being discharged to (setting on discharge)?
- Did the patient contact you after discharge?
- Did our hospital contact you at all about the admission or discharge plan? If so, describe interaction.
- Did you have contact with the patient after discharge? If so, describe the interaction.
- Why do you think the patient ended up being readmitted?
- Do you think there was anything that could have been done (socially or clinically) to prevent this?

*Adapted from the original IH STAAR Readmission Review Tool*
Crunching the numbers

*Will your current strategy get you to your goal?*
Let’s Run the Numbers:
*One Strategy Won’t Get Us There*

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare admits/year</td>
<td>5,000 admissions</td>
<td></td>
</tr>
<tr>
<td>Medicare RA rate</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td># Medicare RA/year</td>
<td>1,000 readmissions</td>
<td></td>
</tr>
<tr>
<td>Pilot project</td>
<td>200 high risk patients</td>
<td></td>
</tr>
<tr>
<td>Pilot group RA rate</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Expected # RA pilot</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Expected effect of pilot</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td># RA reduced by pilot</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td># Medicare RA/year</td>
<td>=1000 – 10 = <strong>990</strong></td>
<td>1%</td>
</tr>
</tbody>
</table>
Develop Portfolio Strategy

Improve standard hospital-based care for all
- Identify risks & mitigate
- Identify learner
- Use Teach-back
- Schedule early follow up
- Timely communication

Collaborate with “receivers” to improve transition
- “SNF Circle Back”
- INTERACT
- Cross-continuum teams

Provide enhanced services for high risk
- Transitional care
- Self-management coaching
- Intensive care management

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Improve standard care for all

All patients, not just high risk patients
CMS Issued New Discharge Planning Conditions of Participation May 2013 that require hospitals demonstrate the following:

1. Have a process
2. Know your data; track rates & review readmissions
3. Assess & reassess patients for post-hospital needs
4. Engage patients and caregivers
5. Teach self-care to patients & caregivers
6. Provide a written discharge plan for all inpatients
7. Communicate effectively with “receiving” providers
8. Know the capabilities of area providers, including support services
9. Arrange for post-acute services, including support services
Collaborate with Receivers

Form & establish transitional care practices between providers
Know Your Partners

Social Network Analysis (SNA)
• 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
**INTERACT: Interventions to Reduce Acute Care Transfers**

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**Stop and Watch Early Warning Tool**

If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

**SBAR Communication Form and Progress Note**

**Before Calling MD / NP / PA:**
- Evaluate the Resident: Complete relevant aspects of the SBAR form below
- Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
- Review Records: Recent progress notes, labs, orders
- Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
- Have Relevant Information Available when Reporting
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

**SITUATION**

The change in condition, symptoms, or signs I am calling about is/are ________________________________________________________

This started on __________ / _________ / ________ Since this started has it gotten:  □ Worse  □ Better  □ Stayed the same

Things that make the condition or symptom worse are ____________________________________________________________

Things that make the condition or symptom better are ___________________________________________________________

This condition, symptom, or sign has occurred before:  □ Yes  □ No

Treatment for last episode (if applicable) ________________________________________________________________

Other relevant information ________________________________________________________________

**BACKGROUND**

**Resident Description**
This resident is in the NH for:  □ Post-Acute Care  □ Long-Term Care
Acute Care Transfer Document Checklist

Resident Name: 
Facility Name: 

Copies of Documents Sent with Resident (check all that apply)
Documents Recommended to Accompany Resident

- Resident Transfer Form
- Face Sheet
- Current Medication List or Current MAR
- SBAR and/or other Change in Condition Progress Note (if any)
- Advance Directives (Durable Power of Attorney for Health Care)
- Advance Care Orders (POLST, MOLST, POST, others)

Send These Documents if indicated:

- Most Recent History and Physical
- Recent Hospital Discharge Summary
- Recent MD/NP/PA and Specialist Orders
- Flow Sheets (e.g., diabetic, wound care)
- Relevant Lab Results (from the last 1-3 months)
- Relevant X-Rays and other Diagnostic Test Results
- Nursing Home Capabilities Checklist (if not already at hospital)

Emergency Department:
Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

Nursing Home to Hospital Transfer Form

Sent To (name of hospital):
Sent From (name of nursing home):
DOB / / Unit

Contact Person:
Relationship (relative, guardian, or DPOA):
Tel:
Is this the health care proxy? No Yes
Notifies of transfer? No Yes
Aware of clinical situation? No Yes

Code Status: DNR, DNH, DNI, Full Code, Uncertain
MD/NP/PA in Nursing Home:
MD, NP, PA (name):
Tel:

Who to Call to Get Questions Answered about the Resident:
Name / Title:
Tel:
Reason(s) for transfer:

Is the primary reason for transfer for diagnostic testing, not admission? No Yes
Relevant diagnoses:
- CHF
- COPD
- CRF
- DM
- Ca (active treatment)
- Dementia
- Other

Vital Signs:
BP HR RR Temp pO2
Most recent pain level:
Most recent pain med:

Usual Mental Status:
- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, but cannot follow simple instructions
- Not Alert

Usual Functional Status:
- Ambulates independently
- Ambulates with assistance
- Ambulates with assistive device
- Not ambulatory

Additional Clinical Information:
- SBAR Acute Change in Condition Note included
- Other clinical notes included
Provide enhanced services

*The best “transition out” and “reception in” will not suffice for high risk*
“High Risk Care Teams”

• Sometimes a “coach;” increasingly multi-disciplinary team
  – Navigator
  – Behavioral health
  – Social Work
  – Pharmacist

• Address full complement of medical, social, logistical needs
  – Affordable medications; waiving office visit copayments
  – Transportation
  – Stable housing
  – Navigating the healthcare system, asking questions, making appointments

• Identify using combination of clinical and non-clinical criteria
  – History of high utilization, no PCP, numerous prescribers, numerous meds, behavioral health comorbidities, homeless….not “just” chronic disease
Let’s Run the Numbers:  
*Three-part strategy*

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</tr>
<tr>
<td># Medicare RA /year</td>
<td>1,000 readmissions</td>
<td></td>
</tr>
<tr>
<td>1. Improve standard care</td>
<td>5,000 admissions</td>
<td>(20% RA rate)</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Expected # RA reduction</td>
<td>100 RA avoided</td>
<td></td>
</tr>
<tr>
<td>2. Collaborate with receivers</td>
<td>1650 admissions (1/3 total)</td>
<td>(30% RA rate)</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Expected # RA reduction</td>
<td>99 RA avoided</td>
<td></td>
</tr>
<tr>
<td>3. Enhanced Service for Pilot</td>
<td>200 admissions</td>
<td>(25% RA rate)</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Expected # RA reduction</td>
<td>10 RA avoided</td>
<td></td>
</tr>
<tr>
<td>Total (*illustrative)</td>
<td>209 RA avoided*</td>
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<td></td>
<td>209/1000 = 20% overall*</td>
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Update Strategy Based on Impact Estimate

### Readmission Strategy Impact Estimator

Use this template to estimate the financial and readmission reduction impact of your portfolio.

**Template Available Online at:**

#### Readmission Reduction Impact and Financial Analysis Tool

<table>
<thead>
<tr>
<th>Basic Data</th>
<th>Example</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Number of (non-OB, adult) discharges, past year (#)</td>
<td>5000</td>
</tr>
<tr>
<td>B</td>
<td>Number of (non-OB, adult) readmissions, past year (#)</td>
<td>625</td>
</tr>
<tr>
<td>C</td>
<td>(non-OB, adult) readmission rate (calculation)</td>
<td>12.5%</td>
</tr>
<tr>
<td>D</td>
<td>Average cost (reimbursement) per (non-OB, adult) admission ($)</td>
<td>$9,000</td>
</tr>
<tr>
<td>E</td>
<td>Total cost readmissions, past year (calculation)</td>
<td>$5,625,000</td>
</tr>
</tbody>
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#### Impact of Readmission Reduction Strategies

**Strategy 1: Improve Standard Hospital Based Care for All**

| G          | Target population strategy 1 will serve (#) | ALL | your strategy |
| H          | Number of admissions strategy 1 will serve | 5000 | your data |
| I          | Readmission rate among target population (%) | 12.5% | your data |
| J          | Readmissions among target population (calculation) | 625 | calculate: HxI |
| K          | Estimated impact of strategy 1 in reducing readmissions (%) | 10% | your estimation |
| L          | Number of readmissions averted (calculation) | 63 | calculate: JxK |
| M          | Estimated savings of strategy (S, calculation) | $542,500 | calculate: LxD |

**Strategy 2: Intensive Community Social Service Support for High Utilisers**

| N          | Target population strategy 2 will serve (#) | 250 | your strategy |
| O          | Number of admissions strategy 2 will serve | 850 | your data |
| P          | Readmission rate among target population (%) | 30% | your data |
| Q          | Readmissions among target population (calculation) | 255 | calculate: OxP |
| R          | Estimated impact of strategy 2 in reducing readmissions (%) | 30% | your estimation |
| S          | Number of readmissions averted (calculation) | 77 | calculate: OxR |
| T          | Estimated savings strategy 2 (S, calculation) | $688,500 | calculate: SxD |

#### Total Strategy Impact

| U          | Total estimated readmissions avoided of strategies 1 & 2 (calculation) | 139 | calculate: L+S |
| V          | Readmission rate after strategies 1 & 2 implemented (calculation) | 9.7% | calculate: (B-U)/A |
| W          | Total estimated savings of strategies 1 & 2 | $1,251,000 | calculate: M+T |

#### Cost of Readmission Reduction Strategies

| X          | Estimated cost of implementing strategy 1 | $100,000 | your estimation |
| Y          | Estimated cost of implementing strategy 2 | $200,000 | your estimation |
| Z          | Total cost of implementing strategies 1 & 2 | $300,000 | calculate: X+Y |

#### Net Savings and Readmission Reduction

| Net savings | $951,000 | calculate: W-Z |
| Total readmission reduction | 22% | calculate: U/B |
Discussion

Are you examining your strategy?

What has been working?

What strategies are you thinking of testing?

What information do you need as you update your strategy for 2014 & to achieve the “waiver” test?
Strategies for Success Under the New Medicare Waiver – Part 2

May 21, 2014
2:00 – 3:00 p.m.
Thank you

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