STRATEGIES TO REDUCE READMISSIONS

Delivering whole-person transitional care

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New York State Partnership for Patients HIIN Readmissions Launch Webinar
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Agenda

- The importance of effectively engaging patients and caregivers
  - Who?
  - Why?
  - How?
- Resources

Objectives

Being patient and caregiver-centered requires us to:

- Understand ***who*** is at risk of readmission
- Understand ***why*** patients return to the hospital
- Listen for ***all*** transitional care needs and readmission risks
- Be ***helpful***: facilitate, advocate, connect

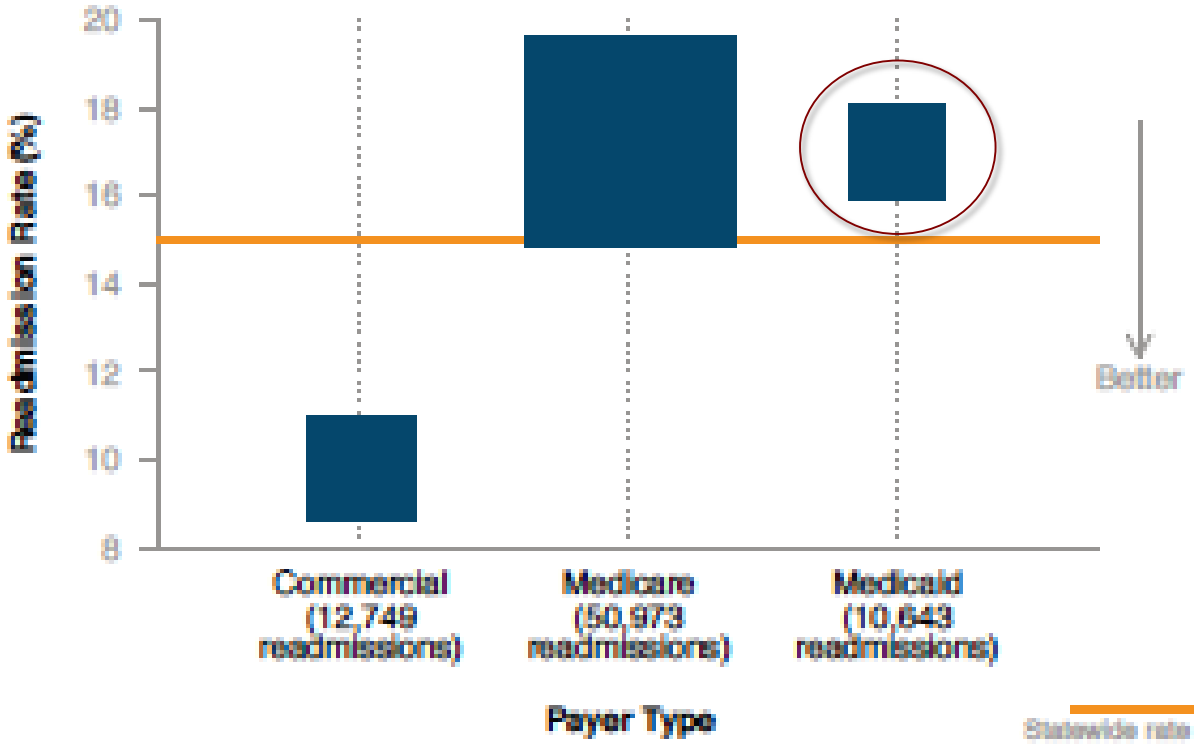
WHO

Who is at risk of readmission?

5. READMISSIONS BY PAYER TYPE

Figure 6: All-Payer Readmission Rates by Payer Type, July 2012 to June 2013

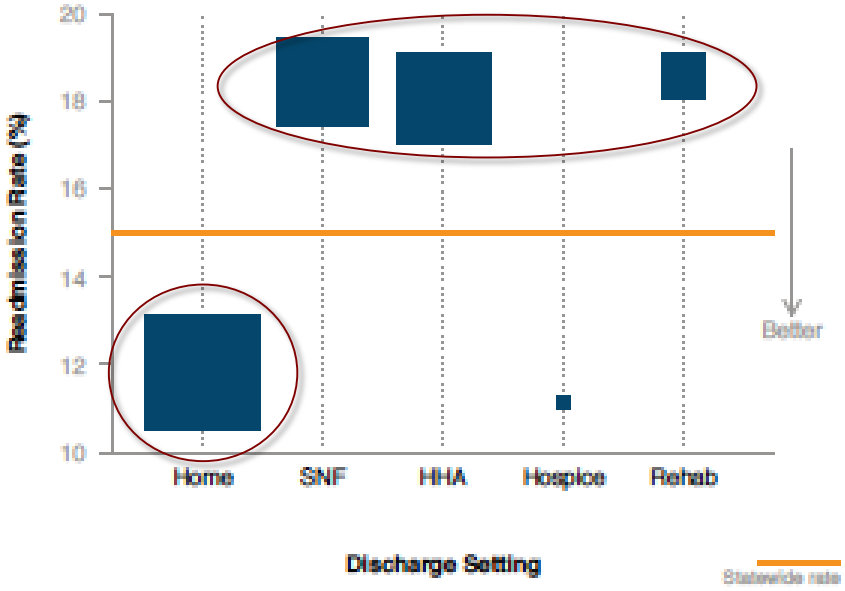
Readmission rates varied by payer type; patients with commercial payers had lower readmission rates than those with public payers.



3. READMISSIONS BY DISCHARGE SETTING

Figure 3: All-Payer Readmission Rates by Discharge Setting, July 2012 to June 2013

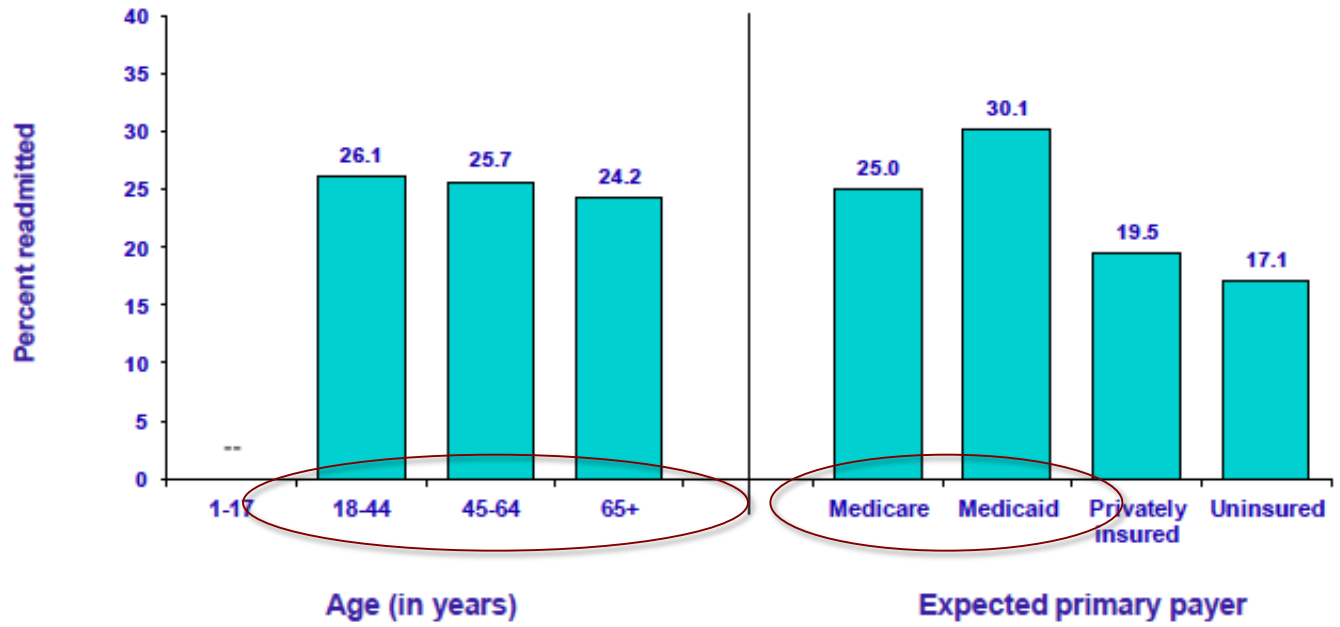
Patients discharged to home (without home health agency care) and hospice have lower readmission rates than those discharged to post-acute care.



Source: Massachusetts Center for Health Information and Analysis

Discharge Disposition	Medicare (% discharges to)	Medicaid (% discharges to)
Discharge to Home	55%	84%
Discharge to SNF/IRF/LTAC	24%	5%
Discharge to Home with Home Health	14%	8%

Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

-- Indicates too few cases to report.

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

AHRQ Agency for Healthcare Research and Quality

STATISTICAL BRIEF #172

April 2014

Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011

Anika L. Hines, Ph.D., M.P.H., Marguerite L. Barrett, M.S., H. Joanna Jiang, Ph.D., and Claudia A. Steiner, M.D., M.P.H.

Methods:
- Used CCS groupers
- Included OB

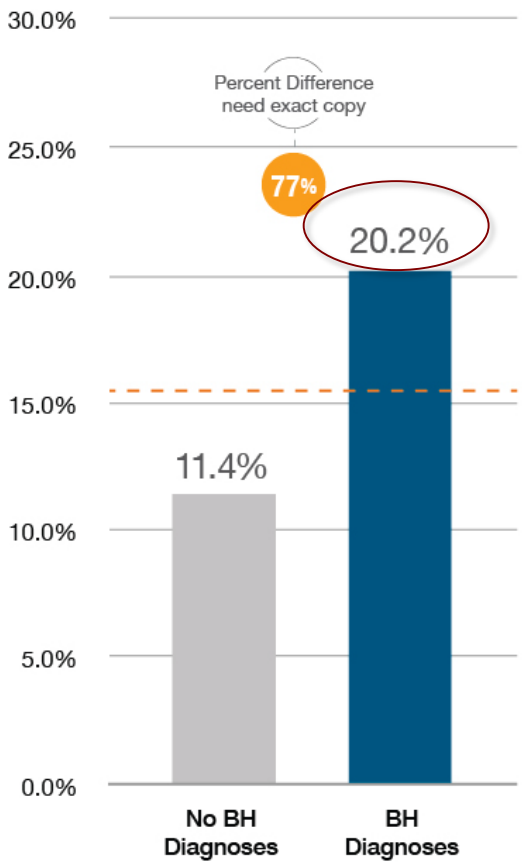
Top 10 Medicaid Dx:

1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. *Comp. of pregnancy*
5. Alcohol-related
6. *Early labor*
7. **CHF**
8. Sepsis
9. **COPD**
10. Substance-use related

Top 10 Medicare Dx:

1. **CHF**
2. Sepsis
3. **Pneumonia**
4. **COPD**
5. Arrythmia
6. UTI
7. Acute renal failure
8. **AMI**
9. Complication of device
10. Stroke

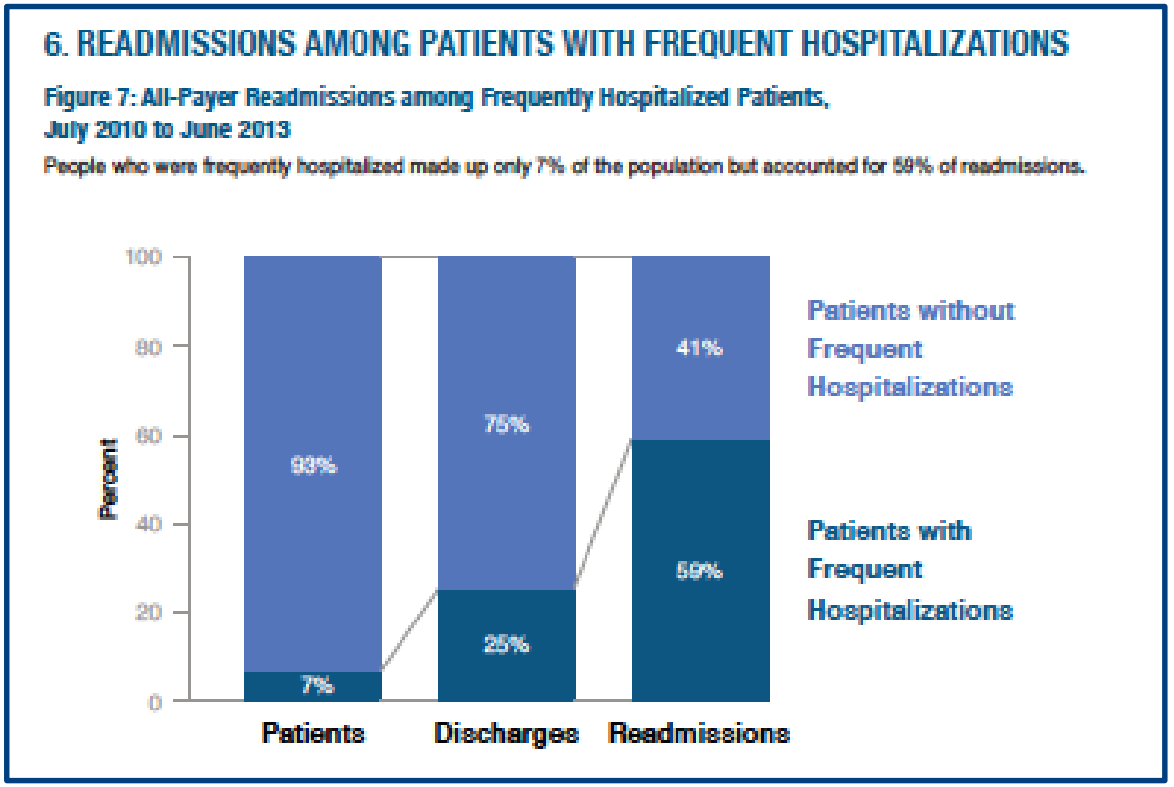
Readmission Rate: Any Behavioral Health Condition



Massachusetts Center for Health Information and Analysis, 2016.

Readmissions for Patients with High Utilization

- 4+ hospitalizations/year
- Readmission rate 40% v. 8%
- 74% of discharged to home
- Top Discharge Diagnoses:
  - Mood disorders
  - Schizophrenia
  - Diabetes
  - Chemotherapy
  - Sickle cell
  - Alcohol
  - Sepsis
  - Heart Failure
  - COPD



Massachusetts Center for Health Information and Analysis, 2016
Jiang et al. HCUP Statistical Brief #184 Nov 2014

Ask your patients "Why"

Elicit the personal/caregiver perspective; root causes

Take a "whole person" view of readmission risks, causes

- 41 woman with HIV; hospitalized for pneumonia, started on HIV medications and antibiotics and told to follow up with HIV and PCP providers. Readmitted 8 days later.
- 61 man with 8 hospitalizations this year for shortness of breath returns to the hospital after 10 days with shortness of breath.
- 86 man with recently diagnosed prostate cancer hospitalized initially for abdominal pain, readmitted 1 day after discharge for abdominal pain.

"Billing data aren't going to tell you whether a patient needed a pharmacy intervention, needed a place to live, or couldn't afford their medications."

41 woman with HIV hospitalized with pneumonia

- 1st hospitalization:
  - Longstanding HIV, never previously hospitalized
  - Diagnosed with pneumonia, found to have high HIV viral load
  - Lives with mother – unaware of her HIV
- At discharge:
  - Discharged on new anti-retroviral medications
  - Discharged on new antibiotics for the pneumonia
  - No infectious disease or primary care appointments made
- Readmission:
  - Returned 8 days later for persistent coughing
  - Returned because instructions said return if symptoms don't improve
  - "It would have helped if they made the appointment for me"

61 man with 8 hospitalizations this year for SOB

- 1st hospitalization:
  - This really isn't his "first" hospitalization, is it?
  - Intern H&P presents case as if new presentation to hospital
  - Discover he is marginally housed
  - Discover he has personality disorder issues
  - Refuses to work with physical therapy
- At discharge:
  - Patient can not be placed in facility due to a criminal history
  - Discharged to "home," told to follow up with PCP (hasn't been in > a year)
- Readmission:
  - Reports he gained 20 lbs in 8 days
  - "Oh honey, it always takes them about a week to tune me up"
  - Grabs remote, turns on TV and orders dinner

86 man with prostate cancer and abdominal pain

- 1st hospitalization
  - Completed diagnosis and staging evaluation as outpatient
  - Started on oxycodone as needed for pain
  - Patient presented with constipation x 8 days
  - Resolved in ED; admitted anyway
- At discharge
  - Added bowel regimen
- Readmission
  - Daughter in NJ dropped everything to rush to dad's side
  - Saw him at home and asked if he had any pain; he said yes
  - She brought him back to ED requesting admission to address pain
  - Patient did not want to be readmitted, but did not want to argue with loving daughter

Do not over-medicalize root causes of readmissions

- Kaiser Permanente team reviewed 523 readmissions across ~14 hospitals:
  - Found an average ***of 9 factors*** contributed to each readmission

- Philadelphia team interviewed patients who returned to ED after discharge:
  - Average age ***43*** (19-75)
  - ***Majority had a PCP***; most reported ***no problem*** filling medications

- Found primary root cause for return: ***fear and uncertainty***
- Patients need more ***reassurance*** during and after episodes of care
- Patients need access to advice ***between*** visits

Feingenbaum et al Medical Care 50(7): July 2012
Rising et al, Annals of Emergency Medicine 2015

HOW?

Adopt a data-informed, whole-person approach

What is a "Data-Informed" Approach?

Why Take A Data-Informed Approach?

- Many readmission reduction efforts have been launched in direct response to Medicare readmission penalties
- The discharge diagnoses in the penalty program are not the top reasons for readmissions in the Medicare population
- There are many high risk patients that go without improved transitional care when the focus is just on penalty conditions

►***A data-informed approach is a more patient-centered approach***

Data-Informed Approach

- Understand root causes of readmissions among your patients
- Design and implement readmission reduction efforts that are designed to address common root causes of readmissions
- Design and implement readmission reduction efforts that will effectively meet the transitional care needs of patients/caregivers
- Track implementation and outcome data to continuously improve processes to reach your goal

► ***A data-informed approach is responsive to root causes and is designed to better meet patient/caregiver transitional care needs***

Why Take a "Whole-Person" Approach?

Whole-Person Approach

Analyses highlight the multi-factorial causes of readmissions

- Patient interviews
- Root cause analysis

Experience in the field has found success with transitional care models that address clinical, behavioral, and social needs

- Interdisciplinary, social work, social service models appear effective
- Several "clinical" approaches have been ***adapted*** to include social work, navigation, advocacy, resources to address basic needs

"Whole-Person" Adaptations to Transitional Care

- Navigating
- Hand-holding
- Arranging for….
- Providing with….
- Harm reduction
- Meet "where they are"
- Patient/caregiver priorities first
- Relationship-based

Whole-Person Approach

- Successful readmission reduction teams state:
  - "We look at the whole person, the big picture"
  - "We always address goals and ask what the patient wants"
  - "We meet the patient where they are"
  - "First and foremost it's about a trusting relationship"
  - "You can't talk to someone about their medications if there is no food in the fridge"
  - "We do whatever it takes"

Using Care Plans to Improve Care Over Time and Across Settings

Types of Care Plans: Observations from the Field

- **Longitudinal Care Plan**
  - A comprehensive plan to achieve health-promoting goals and objectives. Specific goals regarding clinical, behavioral, and/or functional status are often included, and are measured via serial assessments over time. Longer term; care management over time.

- **Transitional Care Plan**
  - Identifies post-hospital needs, patient priorities, and readmission risks and the plan to address those needs, priorities and mitigate risks in the 30 days post discharge. Focus on ensure linkage to providers and services within the 30 day transitional period.

- **ED Care Plan**
  - Summary information for the ED provider to inform safe, effective, and consistent care in the ED and facilitate discharge with team-based follow up, as appropriate.

RESOURCES

"Designing and Delivering Whole-Person Transitional Care: The AHRQ Hospital Guide to Reducing Medicaid Readmissions"

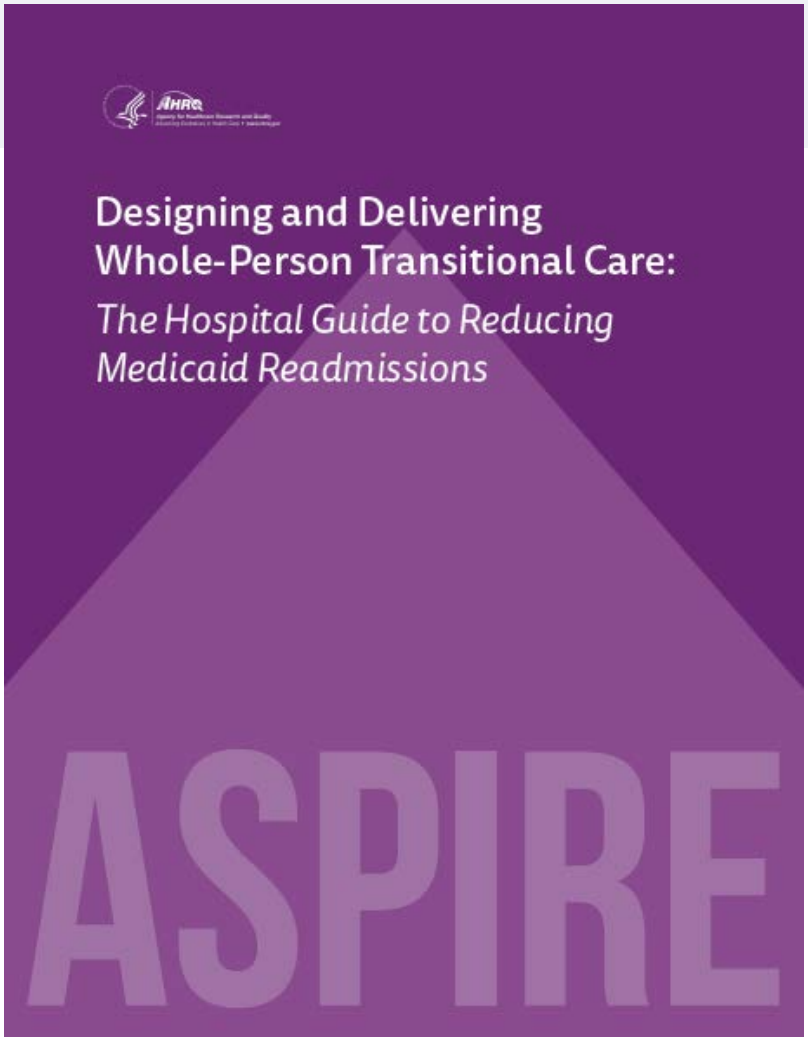


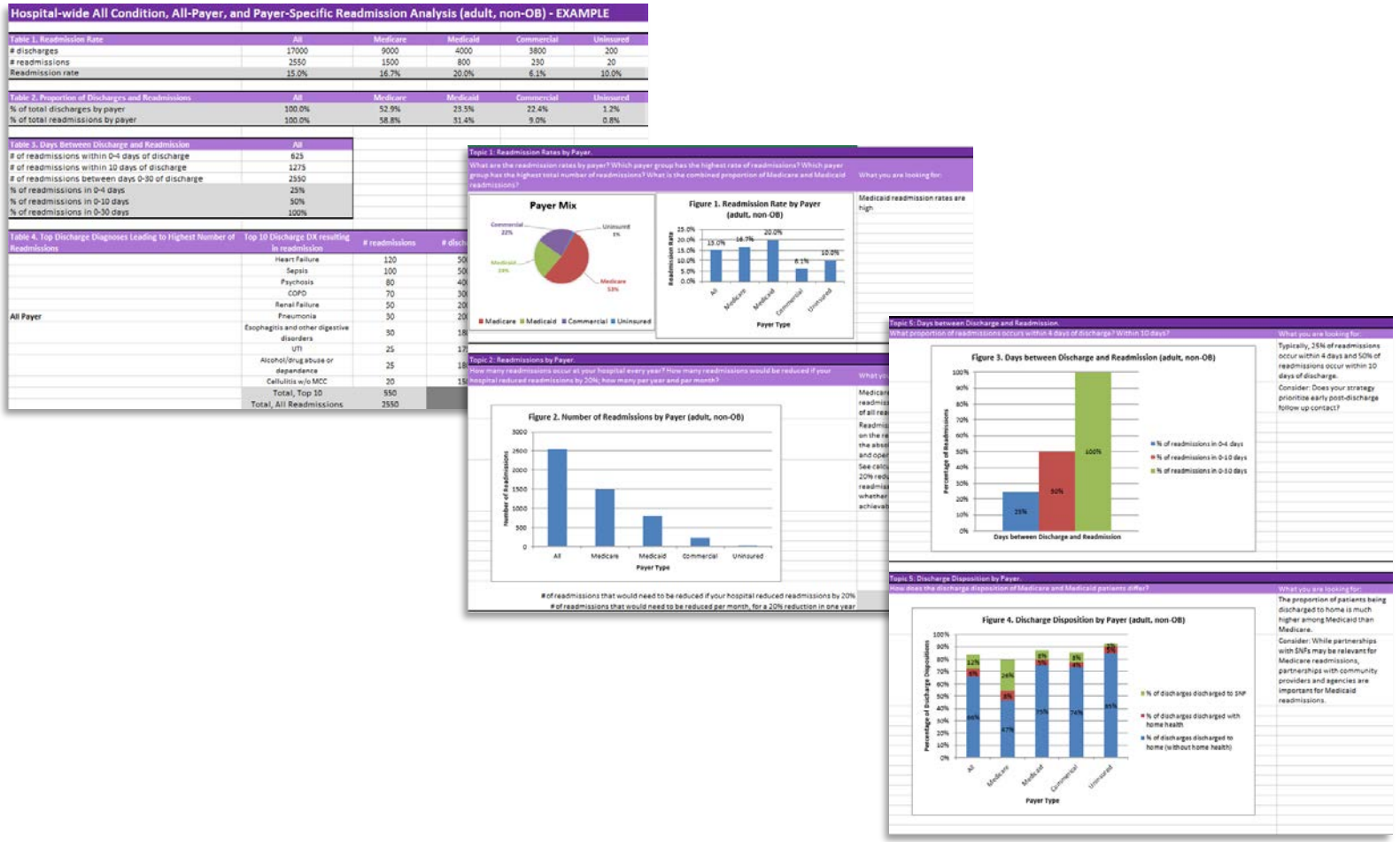
Table of Contents

List of Tools

The guide comes with 13 customizable tools to be used in hospital teams' day-to-day operations.

1. Data Analysis
2. Readmission Review
3. Hospital Inventory
4. Community Inventory
5. Portfolio Design
6. Operational Dashboard
7. Portfolio Presentation
8. Conditions of Participation Handout
9. Whole-Person Transitional Care Planning
10. Discharge Process Checklist
11. Community Resource Guide
12. Cross Continuum Collaboration
13. ED Care Plan Examples

Tool 1: Data Analysis Tool



Hospital-wide All Condition, All-Payer, and Payer-Specific Readmission Analysis (adult, non-OB) - EXAMPLE

Table 1. Readmission Rate	All	Medicare	Medicaid	Commercial	Uninsured
# discharges	17000	9000	4000	3800	200
# readmissions	2550	1500	800	230	20
Readmission rate	15.0%	16.7%	20.0%	6.1%	10.0%

Table 2. Proportion of Discharges and Readmissions	All	Medicare	Medicaid	Commercial	Uninsured
% of total discharges by payer	100.0%	52.9%	23.5%	22.4%	1.2%
% of total readmissions by payer	100.0%	58.8%	31.4%	9.0%	0.8%

Table 3. Days Between Discharge and Readmission	All
# of readmissions within 0-4 days of discharge	625
# of readmissions within 10 days of discharge	1275
# of readmissions between days 0-30 of discharge	2550
% of readmissions in 0-4 days	25%
% of readmissions in 0-10 days	50%
% of readmissions in 0-30 days	100%

Table 4. Top Discharge Diagnoses Leading to Highest Number of Readmissions	Top 10 Discharge DX resulting in readmission	# readmissions	# disch
All Payer	Heart Failure	120	50
	Sepsis	100	50
	Psychosis	80	40
	COPD	70	30
	Renal Failure	50	20
	Pneumonia	30	20
	Esophagitis and other digestive disorders	30	18
	UTI	25	17
	Alcohol/drug abuse or dependence	25	18
	Cellulitis w/o MCC	20	15
	Total, Top 10	550	
	Total, All Readmissions	2550	

Topic 1: Readmission Rates by Payer.

What are the readmission rates by payer? Which payer group has the highest rate of readmissions? Which payer group has the highest total number of readmissions? What is the combined proportion of Medicare and Medicaid readmissions?

What you are looking for:

Medicaid readmission rates are high

Payer Mix

Figure 1. Readmission Rate by Payer (adult, non-OB)

Topic 2: Readmissions by Payer.

How many readmissions occur at your hospital every year? How many readmissions would be reduced if your hospital reduced readmissions by 20%; how many per year and per month?

Figure 2. Number of Readmissions by Payer (adult, non-OB)

# of readmissions that would need to be reduced if your hospital reduced readmissions by 20%

# of readmissions that would need to be reduced per month, for a 20% reduction in one year

Topic 5: Days between Discharge and Readmission.

What proportion of readmissions occurs within 4 days of discharge? Within 10 days?

What you are looking for:

Typically, 25% of readmissions occur within 4 days and 50% of readmissions occur within 10 days of discharge.

Consider: Does your strategy prioritize early post-discharge follow up contact?

Figure 3. Days between Discharge and Readmission (adult, non-OB)

Topic 5: Discharge Disposition by Payer.

How does the discharge disposition of Medicare and Medicaid patients differ?

What you are looking for:

The proportion of patients being discharged to home is much higher among Medicaid than Medicare.

Consider: While partnerships with SNFs may be relevant for Medicare readmissions, partnerships with community providers and agencies are important for Medicaid readmissions.

Figure 4. Discharge Disposition by Payer (adult, non-OB)

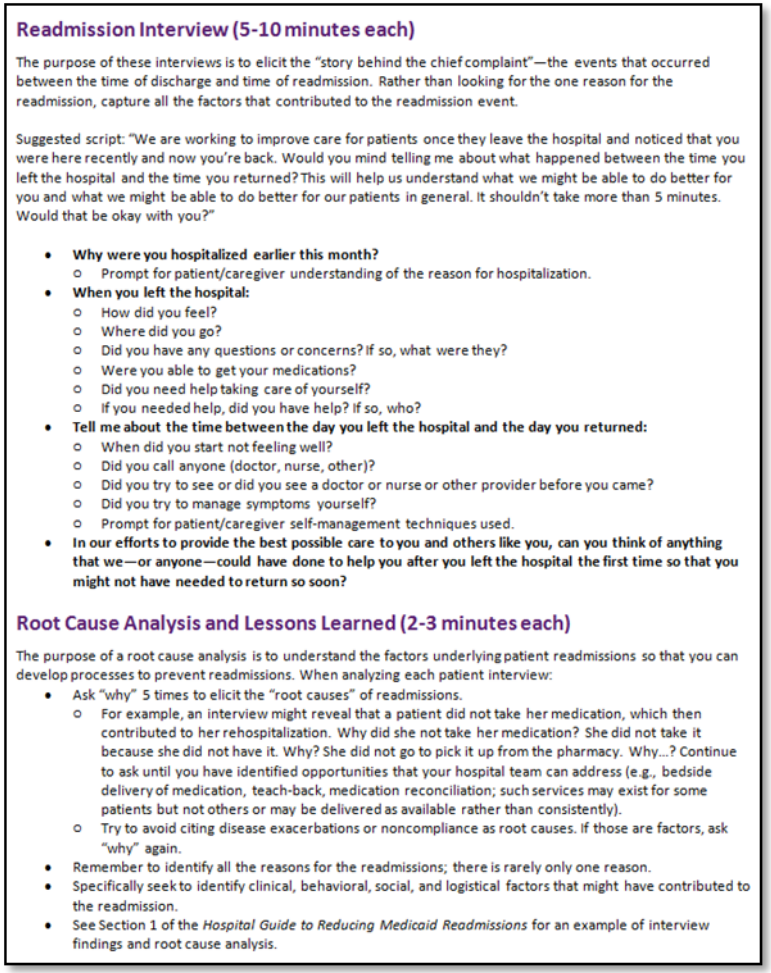
Tool 2: Readmission Review Tool

Purpose:

- To understand patient perspective
- To understand root causes
- To understand there are multiple factors
- To identify opportunities for improvement
- To develop a better plan for the patient
- To develop better services to offer

Recommendation:

- Conduct at least 5 during planning
- Review all readmissions



Readmission Interview (5-10 minutes each)

The purpose of these interviews is to elicit the "story behind the chief complaint"—the events that occurred between the time of discharge and time of readmission. Rather than looking for the one reason for the readmission, capture all the factors that contributed to the readmission event.

Suggested script: "We are working to improve care for patients once they leave the hospital and noticed that you were here recently and now you're back. Would you mind telling me about what happened between the time you left the hospital and the time you returned? 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. It shouldn't take more than 5 minutes. Would that be okay with you?"

- **Why were you hospitalized earlier this month?**
  - Prompt for patient/caregiver understanding of the reason for hospitalization.
- **When you left the hospital:**
  - How did you feel?
  - Where did you go?
  - Did you have any questions or concerns? If so, what were they?
  - Were you able to get your medications?
  - Did you need help taking care of yourself?
  - If you needed help, did you have help? If so, who?
- **Tell me about the time between the day you left the hospital and the day you returned:**
  - When did you start not feeling well?
  - Did you call anyone (doctor, nurse, other)?
  - Did you try to see or did you see a doctor or nurse or other provider before you came?
  - Did you try to manage symptoms yourself?
  - Prompt for patient/caregiver self-management techniques used.
- **In our efforts to provide the best possible care to you and others like you, can you think of anything that we—or anyone—could have done to help you after you left the hospital the first time so that you might not have needed to return so soon?**

Root Cause Analysis and Lessons Learned (2-3 minutes each)

The purpose of a root cause analysis is to understand the factors underlying patient readmissions so that you can develop processes to prevent readmissions. When analyzing each patient interview:

- Ask "why" 5 times to elicit the "root causes" of readmissions.
  - For example, an interview might reveal that a patient did not take her medication, which then contributed to her rehospitalization. Why did she not take her medication? She did not take it because she did not have it. Why? She did not go to pick it up from the pharmacy. Why…? Continue to ask until you have identified opportunities that your hospital team can address (e.g., bedside delivery of medication, teach-back, medication reconciliation; such services may exist for some patients but not others or may be delivered as available rather than consistently).
  - Try to avoid citing disease exacerbations or noncompliance as root causes. If those are factors, ask "why" again.
- Remember to identify all the reasons for the readmissions; there is rarely only one reason.
- Specifically seek to identify clinical, behavioral, social, and logistical factors that might have contributed to the readmission.
- See Section 1 of the *Hospital Guide to Reducing Medicaid Readmissions* for an example of interview findings and root cause analysis.

IMPROVING TRANSITIONAL CARE FOR ALL PATIENTS

CMS has recommended that hospitals should do the following to improve discharge planning - now referred to as "transitional care:" These expectations apply to Medicare and Medicaid patients.

- ✓ Have a documented discharge planning process, approved by the hospital's governing board;
- ✓ Provide discharge planning for all inpatients, observation patients, and certain ED patients;
- ✓ Analyze and track readmission rates;
- ✓ Review readmissions to look for patterns;
- ✓ Conduct root cause analyses on readmissions to assess whether the discharge planning process meets patients' needs;
- ✓ Craft a discharge plan that can be realistically implemented;
- ✓ Actively solicit the input of the patient and family/friends/support persons;
- ✓ Address behavioral health follow up as part of the discharge plan;
- ✓ Provide customized education to patients and their caregivers;
- ✓ Provide verbalized instructions using the teach-back technique;
- ✓ Arrange for (not just refer to) post-hospital services;
- ✓ Know the capabilities of post-acute and community-based providers, including Medicaid home-and community-based services;
- ✓ Provide patients data to help inform their choice of high quality post-acute providers;
- ✓ Know options for Medicaid long-term services and supports, or have a contact at the State Medicaid agency that can assist with these issues; and
- ✓ Follow up with high risk patients after discharge.

[Our hospital] is working to meet these expectations – and we need your help! Please contact your manager or supervisor if you have feedback or ideas to improve how we deliver safe and high quality transitional care to all of our patients. For more information, contact [Readmission Champion].

Tool 9: Whole-Person Transitional Care Planning

WHOLE-PERSON CARE TRANSITIONAL PLANNING TOOL

Readmission Risks and/or Post-Hospital Needs

Uncover patient's nonclinical issues and challenges in accessing post-hospital care to prevent avoidable hospitalizations in the future.

ACCESS TO AMBULATORY CARE

- ❑ No regular source of care
- ❑ Difficulty with transportation to medical care
- ❑ Work/family responsibilities pose barrier to appointments
- ❑ Regular use of emergency room for care

ACCESS TO BEHAVIORAL HEALTH CARE

- ❑ History of receiving behavioral health services
- ❑ Concern about emotional or mental health
- ❑ Alcohol or drugs affecting health and wellness
- ❑ Needs linkage to behavioral health services

FUNCTIONAL STATUS

- ❑ Functional limitations
- ❑ Cognitive limitations, including executive function
- ❑ Low self-activation or self-efficacy
- ❑ Disabled, may qualify for ADRC or other services

UNSTABLE/INADEQUATE HOUSING

- ❑ Lack of stable housing
- ❑ Lack of heat or cooling
- ❑ Environmental hazards affecting health (mold, etc.)
- ❑ Lack of safety and security within or outside the home

FINANCIAL INSECURITY

- ❑ Difficulty paying for basic survival needs (shelter, food)
- ❑ Difficulty paying medical-related costs (copays, supplies)
- ❑ Must prioritize survival versus medical needs

FOOD INSECURITY / ACCESS

- ❑ Lacks access to adequate amounts of food
- ❑ Lacks access to nutritious or medically appropriate diet

SOCIAL CONNECTION/ISOLATION

- ❑ Lives alone
- ❑ Lacks friends/family/connections

LEGAL ISSUES

- ❑ Barriers due to coverage, utilities, pending eviction
- ❑ Recent or repeated incarceration or detention

LANGUAGE OR LITERACY ISSUES

- ❑ Low literacy, low numeracy
- ❑ Low health literacy—diagnoses, medications, care plan
- ❑ Low or no ability to speak English

Actions to Take Prior to Discharge

Use the improvement motto, "See a problem, fix a problem." This list represents possible interventions you may identify for a patient. Modify it to meet the most common needs for your patient population.

INTERDISCIPLINARY CARE PLANNING AND COORDINATION

- ❑ Obtain high risk readmission team consult
- ❑ Contact an MCO, ACO, PCMH, Health Home care manager, as applicable
- ❑ Contact community clinical, behavioral and social service providers
- ❑ Obtain pharmacist consult
- ❑ Obtain social work consult
- ❑ Obtain pain management or palliative care consult, as applicable
- ❑ Obtain psychiatry consult, as applicable
- ❑ Develop individualized transitional care plan
- ❑ Share plan with ED, outpatient providers, community service providers

PROVIDE SERVICES

- ❑ Identify whether eligible for (Medicaid) health home and contact health home to initiate screening and enrollment process
- ❑ Contact MCO, ACP, PCMH, Health Home medical director if high risk patient is not currently in care management to advocate for enhanced services
- ❑ Arrange for bedside delivery of medications
- ❑ Discuss cost of medications, how will obtain, and modify as needed
- ❑ Discuss transportation and arrange as needed
- ❑ Offer to provide transitional care follow up services (if available)

ARRANGE FOR NEXT STEPS

- ❑ Ensure all patients have a PCP or temporary provider ("bridge" clinic)
- ❑ Schedule follow up with primary care provider
- ❑ Schedule follow up with relevant specialists
- ❑ Schedule follow up with behavioral health provider
- ❑ Initiate initial eligibility screen for services (health home, adult day, etc) or allow social/support service entity to screen patient prior to discharge
- ❑ Ask for best contact number for purposes of post-discharge follow up call

LINK TO POST-HOSPITAL SUPPORTS AND SERVICES

- ❑ Link to transitional care navigating and support services for 30 days
- ❑ Link to community behavioral health services
- ❑ Link to community health worker or navigator programs
- ❑ Link to housing with services agency
- ❑ Link to food program
- ❑ Link to county health department provided services
- ❑ Link to community/faith-based or volunteer services
- ❑ Link to Medical Legal Partnership
- ❑ Link to Adult Day Health
- ❑ Link to language-concordant navigation or advocacy services

TOOL 10: DISCHARGE CHECKLIST

This checklist is a tool to promote optimal adherence to the processes and practices outlined as guidance and/or proposed updates to the CMS Discharge Planning Conditions of Participation.[1] Review your current processes to identify the extent to which you current processes – including written discharge information and documentation – adhere to the intent of these discharge process elements. In addition, hospitals should have a written discharge process; regularly review readmissions to identify root causes of readmissions; use those insights to continually improve the discharge process.

HOSPITALS MUST PROVIDE THE FOLLOWING…	DETAILS PER THE CMS 2013 SURVEYOR GUIDANCE AND *015 PROPOSED RULE DOCUMENTS	STATUS
1. A discharge plan for all inpatients and observation patients	As specified in the November 2015 proposed Discharge Planning COPs#	❑
2. A brief reason for hospitalization and principal diagnosis	Many patients do not know why they were in the hospital.	❑
3. A brief description of hospital course of treatment	Many patients do not know what was done for them in the hospital.	❑
4. The patient's condition at discharge	Include cognitive function* Include functional status* Include social support structure*	❑
5. Specifically address comorbid behavioral health conditions	Include plan for follow up care for behavioral health conditions#	❑
6. A medication list – an actual list of medications, *not* a referral to the list in the medical record*	Identify changes made during the patient's hospitalization*	❑
7. A list of allergies	Food allergies* Drug allergies and drug intolerances*	❑
8. Pending test results	When the results are expected* How to obtain the test results*	❑
9. A copy of the patient's advance directive	Applicable when the patient is being transferred to another facility*	❑
10. A brief description of care instructions	Customized instructions for self-care* Consistent with the training provided to patient and caregiver*	❑
11. Effectively link patients to post-hospital clinical, behavioral and social services	The hospital must demonstrate knowledge of capabilities of post acute and community providers, including Medicaid providers, and social service providers*#	❑

THANK YOU FOR YOUR COMMITMENT TO REDUCING READMISSIONS

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