NYSPFP Preventable Readmissions Initiative
Kick-off Webinar

January 25, 2017

A partnership of the Healthcare Association of New York State and the Greater New York Hospital Association

Agenda

TOPIC	SPEAKER
Recap of Hospital Engagement Network (HEN) 1.0 and 2.0 Readmissions Prevention Initiative	Nancy Landor, NYSPFP
NYSPFP Hospital Improvement and Innovation Networks (HIIN) Readmissions Programming	Kelly Donohue, NYSPFP
Strategies to Reduce Readmissions: Delivering Whole-Person Transitional Care	Amy Boutwell, M.D., M.P.P., Collaborative Healthcare Strategies
Question and Answer Session	All Participants

Recap of Hospital Engagement Network (HEN) 1.0 and 2.0 Readmissions Initiative

NYSPFP Readmission Work to Date

HEN 1.0

- Best practices models (BOOST, RED, etc.)
- Medication Reconciliation
- Tools, Materials, and Teach-Back
- Resource Book(s)

2014 Readmission Pilot

HEN 2.0

- Integration of best practices into "Daily Safety" checks
  - Referrals made to professional staff
  - P&F teaching and discharge instructions
  - Pharmacy involvement in high risk medications and medication reconciliation
  - Palliative care referrals

HEN 1.0 Pilot Project Recap

Phase 1: On Admission

- Identify patients on admission who are at “any risk” for readmission.
- Assemble a team to address interventions that will mitigate risk.

Phase 2: During the Hospital Stay

- Prepare patient and caregiver for discharge.
- Conduct ongoing patient reassessment to identify new or changing risk factors.
- Ensure systems for multidisciplinary communication, coordination, planning and evaluation.

Phase 3: At Discharge

- Ensure patient and family/caregiver are fully prepared for post hospital phase.
- Provide timely and thorough communication to post hospital providers.

Results

14.50%
14.00%
13.50%
13.00%
12.50%
12.00%

X Values

UCL 0.1379
CL 0.1326
LCL 0.1274

HEN 1.0
HEN 2

Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May Jul Sep Nov Jan Mar May

January 2010 to June 2016

NYSPFP Readmissions Tools and Resources

- NYSPFP Website Preventable Readmission Initiative Page
- Pilot Phases 1, 2, and 3 Tracking Tools
- Preventable Readmissions Action Planning Resource Guide

Appendix B. NYSPFP Readmission Action Plan Worksheet

Please complete the following grid as a guide for developing your work plan. List activities related to your team's strategy for implementing this initiative in your hospital and achieving your stated goals. Assign team member roles, target objectives, and timeframes. Be as specific as possible.

WHAT	HOW	WHO	
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			Ove mo
			Ove

HANYS Healthcare Association of New York State | GNYHA Greater New York Hospital Association

The Role of the Hospitalist in Reducing Readmissions

A NYS Partnership for Patients report prepared by the Healthcare Association of New York State and Greater New York Hospital Association

New York State Partnership for Patients

A partnership of the Healthcare Association of New York State and the Greater New York Hospital Association.

Preventable Readmissions Initiative
Action Planning Resource Guide

NYSPFP Hospital Improvement and Innovation Networks (HIIN) Readmissions Programming

NYSPFP Preventable Readmissions Initiative

- Goal:
    - To reduce hospital readmissions by 12%.
- Approach:
    - Domain 1: Patient and Family Centric Discharge
    - Domain 2: Care Transitions between Hospitals and Skilled Nursing Facilities

Domain 1: Patient and Family Centric Discharge

- Coordination with national and local experts including the American Institutes for Research (AIR) Patient and Family Engagement Contractor and the Institute for Patient and Family Centric Care (IPFCC)
- Programming in this domain will involve the following topics:
  - High-risk readmission assessment on admission
  - Alignment with New York State and federal regulations such as New York State's Caregiver Advise, Record, and Enable (CARE) Act;
  - Hard-wiring patient and family centric discharge planning processes
    - Emphasis on identifying the designated patient representative, caregiver, and/or discharge planner at the earliest point in time

Domain 1 (cont'd)

- Incorporating family or caregiver(s) into key steps of the discharge process:
  - Bedside rounds
  - Medication reconciliation
  - Discharge planning
  - Decision making
  - Post-discharge care
- Role of the hospitalist in preventing readmissions
- Guidance and support for "difficult conversations," e.g. palliative care and advanced care planning
- Post-discharge follow up and care coordination
- Promote family or caregiver as the patient navigator

Domain 2: Care Transitions between Hospitals and Skilled Nursing Facilities (SNFs)

- Leveraging combined experience in convening community coalitions between hospitals and SNFs
- Target hospital and SNF partners with significant readmission volume
- On-site collaboration and communication between providers
  - Build and strengthen relationships across care settings
  - Identify current SNF and ED capabilities
  - Process map to define current processes
  - Standardize communication tools
  - Advance care planning (in alignment with Domain 1)
  - Medication reconciliation

NYSPFP Preventable Readmission Initiative Measurement Strategy

- Outcome Measure
  - 30 day potentially preventable readmission rate (PPR)
  - All-condition, all-cause readmission rate
  - Medicare all-cause readmission rate

- Process Measure
  - HCAHPS: “Care Transitions” and “Discharge Information” scores
    - Aligns with patient/family engagement efforts
    - No manual data entry
    - Provides meaningful and actionable data