Designing & Delivering Whole-Person Transitional Care

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NJHA HIIN Readmissions Conference

September 13 2017

Objectives

1. Describe why knowing your own hospital's readmission data is essential for effectively designing successful readmission reduction strategies

2. Consider whether your hospital understands the root causes of readmissions from a "whole-person,"- not just clinical- perspective

3. Identify components of the ASPIRE model that can be applied to refresh or strengthen your hospital's readmission reduction efforts

What is your hospital's readmission reduction goal?

Medicare Penalty Created Blinders

1. Diagnosis-based focus

2. Medicare focus

3. Limited our understanding of who is at risk of readmission

4. Focused, project-itis limits system redesign – hard to break through to hospital-wide results

AHRQ Reducing Medicaid Readmissions Project

- Identify the ***similarities & differences*** in readmission patterns for Medicare v. Medicaid patients

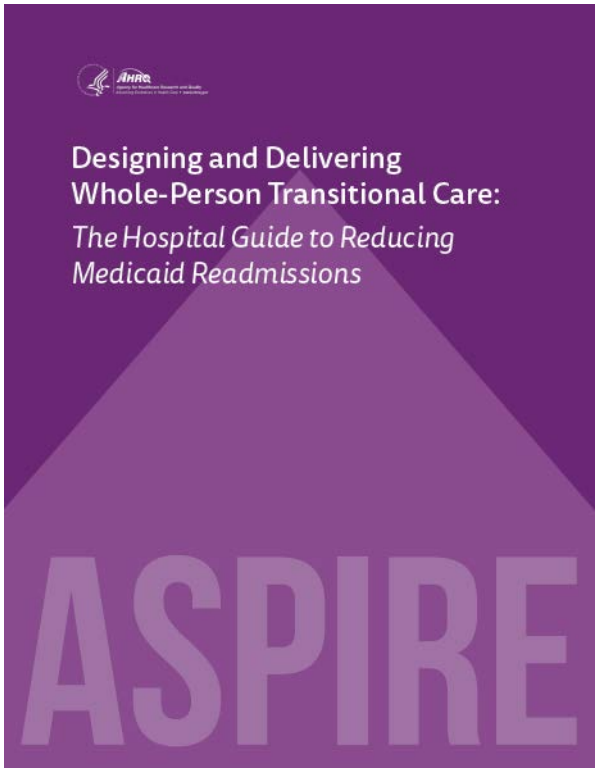
- Explore whether the models developed for older adults ***apply*** to the Medicaid population as well

- Create a guide for hospitals to ***expand and adapt strategies*** to reduce readmissions – to apply to a ***broader, all payer*** population

Hospitals with Hospital-Wide Results

- Know their data –
  - *Analyze, trend, track, display, share, post*
- Broad concept of "readmission risk"
  - *Way beyond case finding for diagnoses*
- Multifaceted strategy
  - *Improve standard care, collaborate across settings, enhanced care*
- Use technology to make this better, quicker, automated
  - *Automated notifications, implementation tracking, dashboards*

Designing and Delivering Whole-Person Transitional Care: *The ASPIRE Guide*

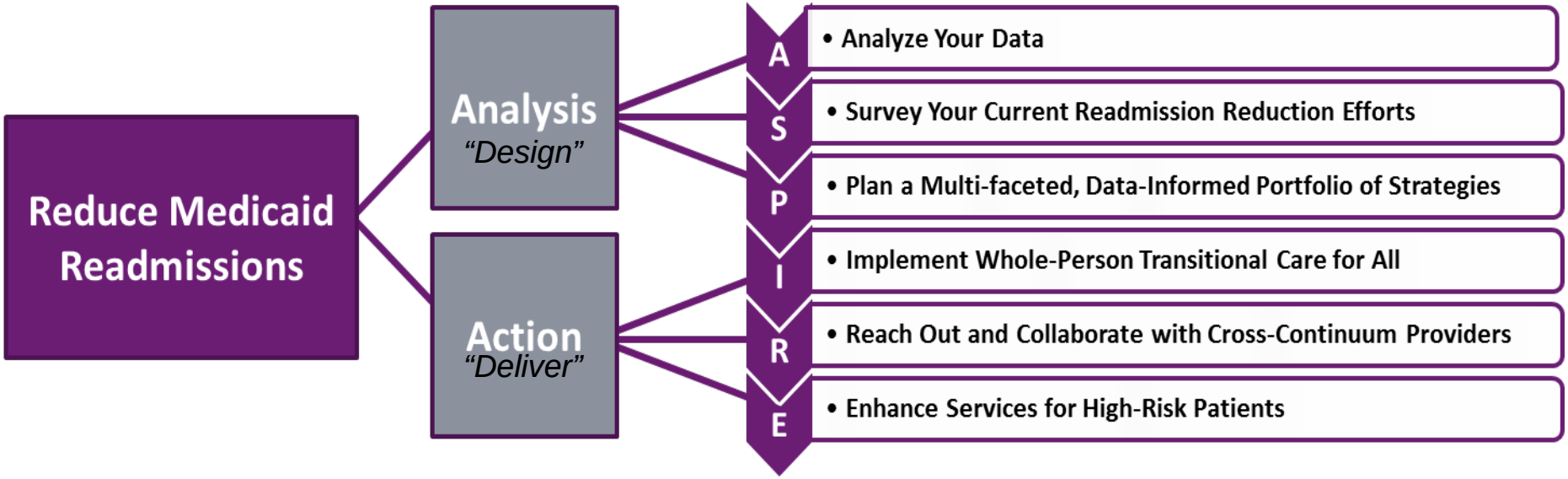


13 customizable tools

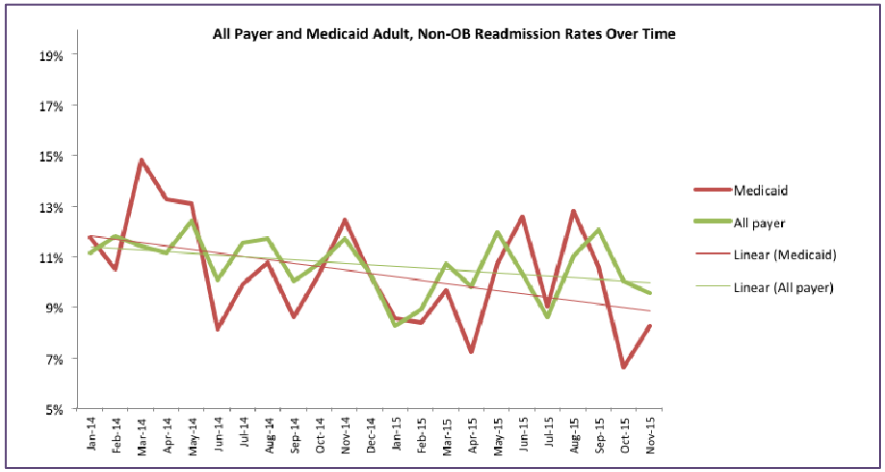
6-part webinar series

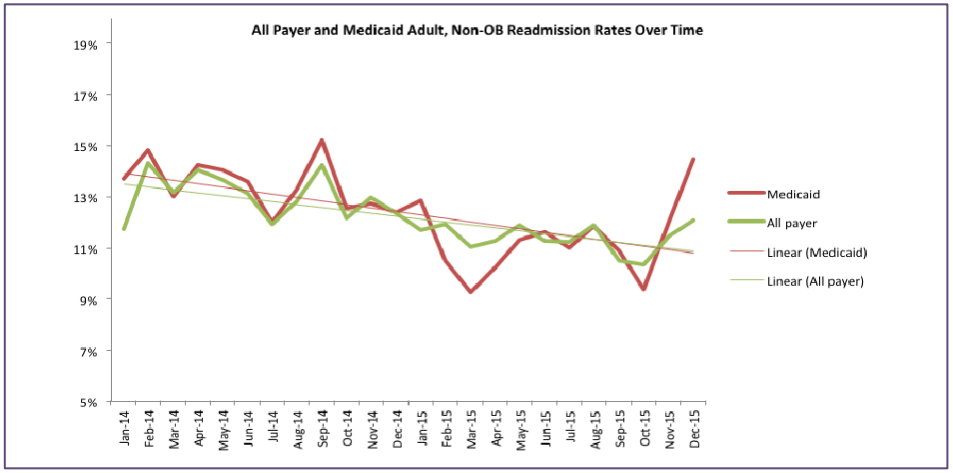
https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

ASPIRE Framework



All Cause, All Payer 30-day Readmissions
ASPIRE Field Work Hospitals



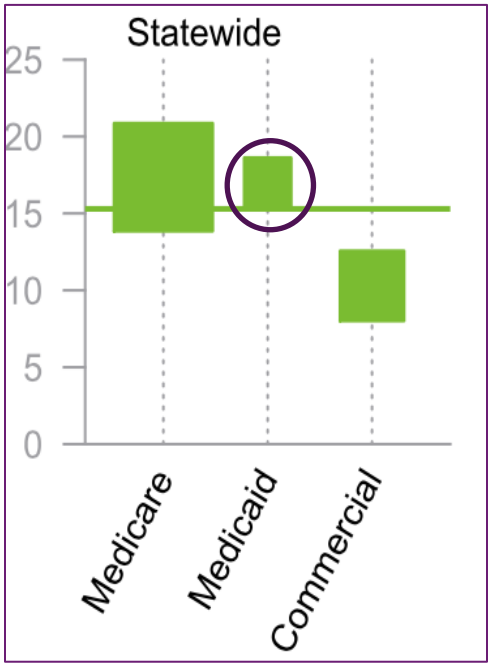


Design

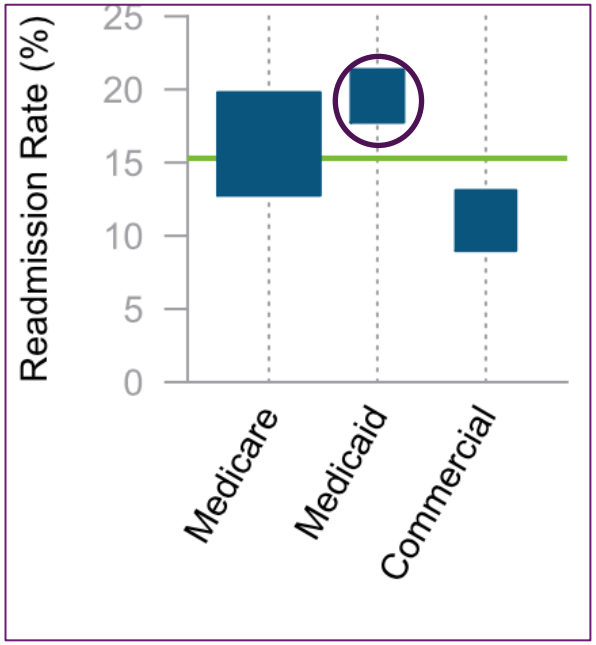
Use your data, address root causes, and make sure the math works!

Readmissions by Payer

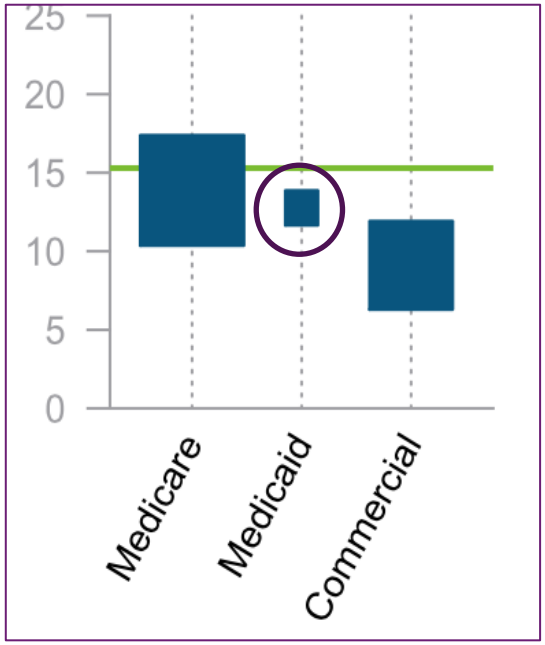
Statewide Pattern



Example Hospital A



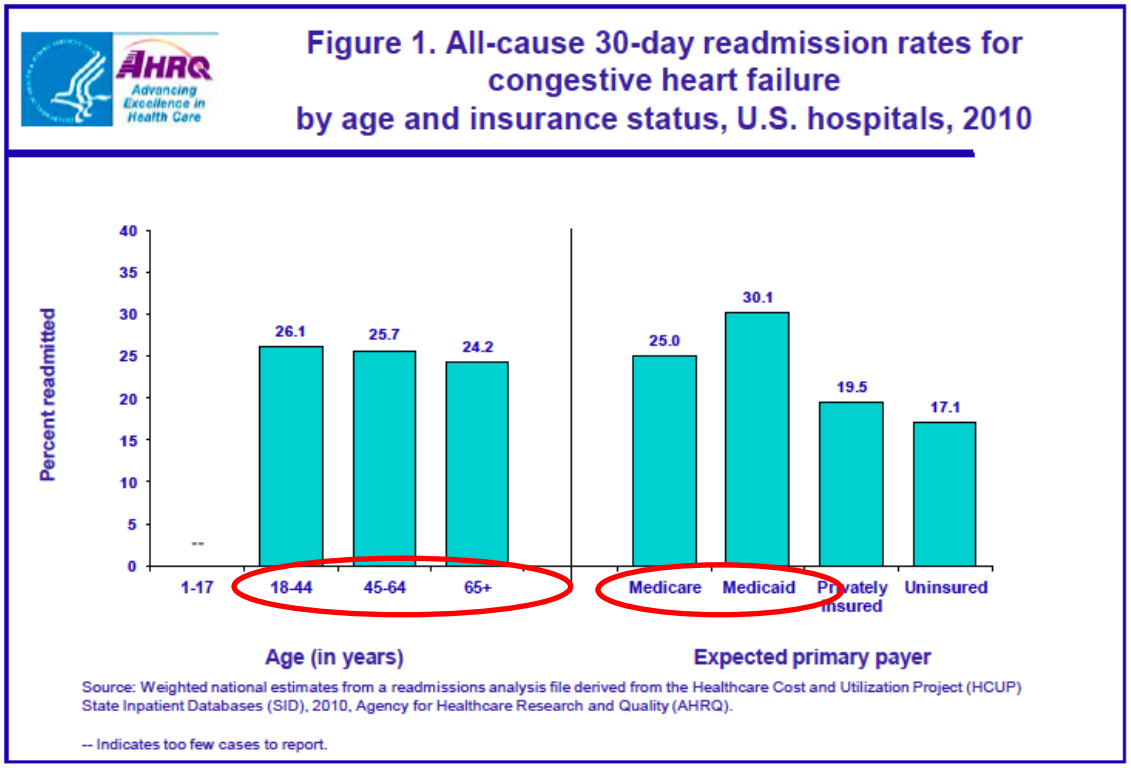
Example Hospital B

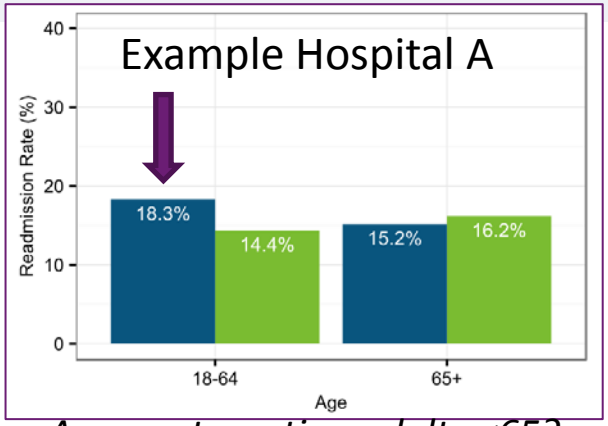


Are you targeting Medicaid?

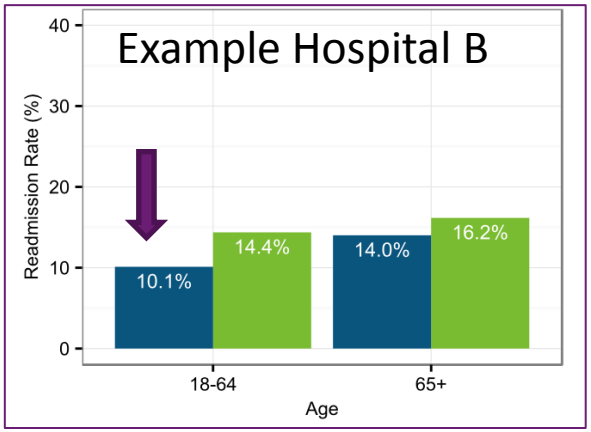
Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Readmissions by Age



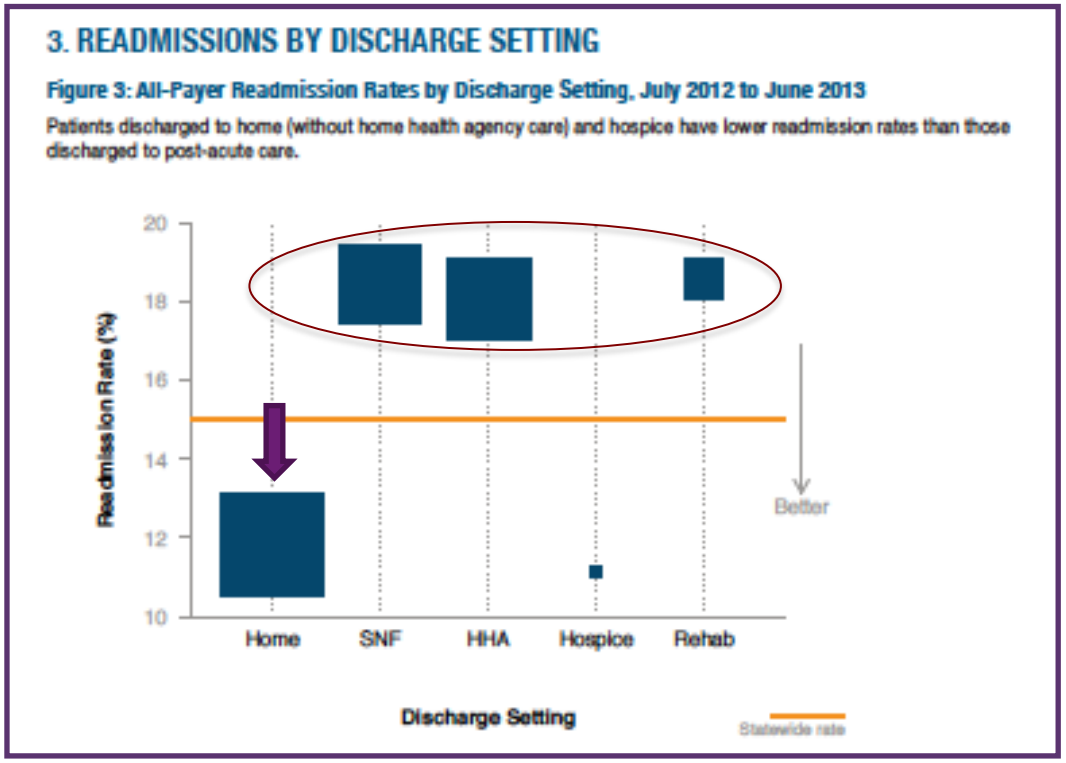


Are you targeting adults <65?



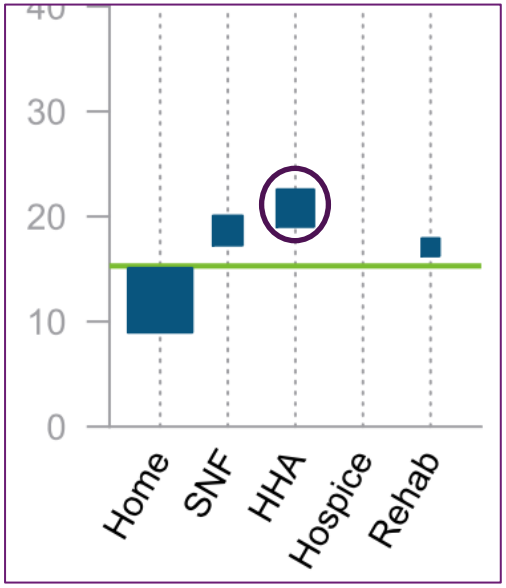
Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Readmissions by Discharge Disposition



Readmission rates among all patients discharged to post-acute care are high

Example Hospital A

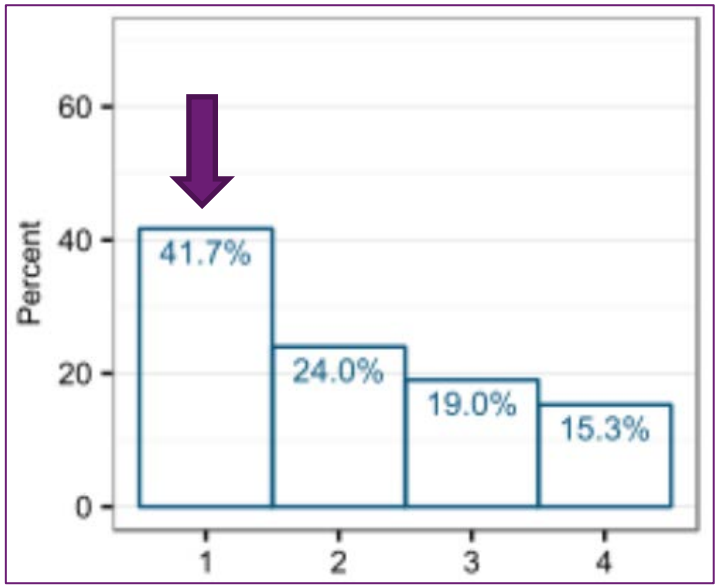


Are you targeting Home Health discharges?

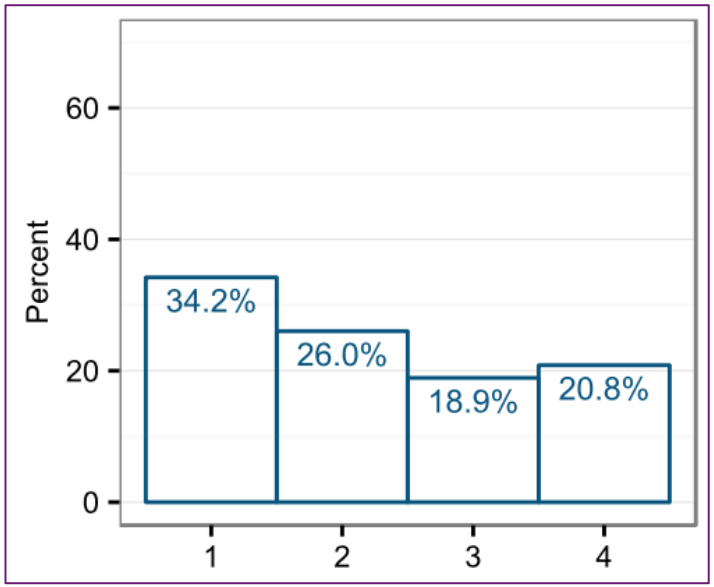
Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Timing of Readmissions

Example Hospital A



Example Hospital B



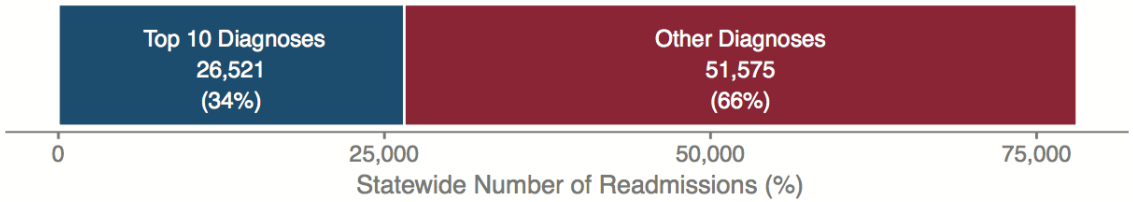
Are you focused on early readmissions?

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Discharge Diagnoses Leading to Most Readmissions

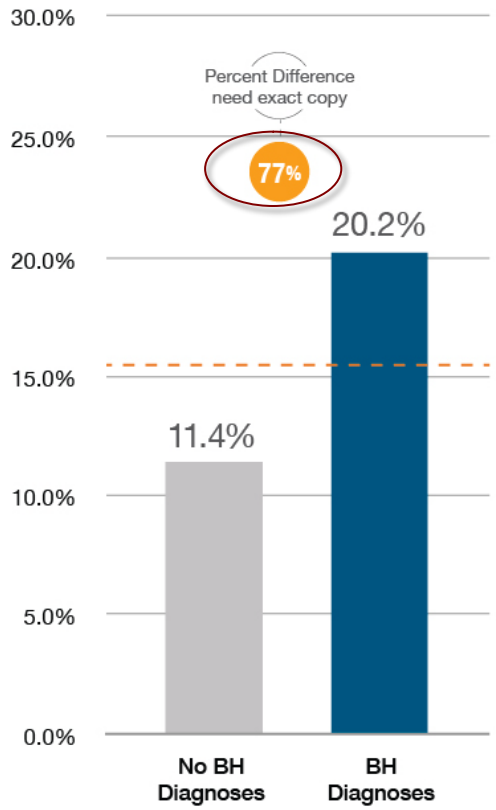
Medicare	Medicaid	Comm.	Unins.	Total
ARF (1384)	Sickle Cell (478)	Chemo (290)	Pancreatitis (187)	Sepsis (1859)
Sepsis (1366)	Sepsis (175)	CVA (276)	Chemo (157)	ARF (1800)
PNA (1336)	Chemo (175)	Arthritis (260)	DKA (136)	PNA (1750)
COPD (1211)	COPD (173)	Sepsis (222)	CVA (125)	CVA (1622)
CVA (1140)	DKA (156)	PNA (188)	COPD (109)	COPD (1608)
UTI (1038)	PNA (145)	ARF (182)	ARF (97)	UTI (1608)
Afib (851)	ARF (137)	CAD (181)	Sepsis (96)	HF (1115)
HF (822)	HF (129)	Pancreatitis (153)	PNA (81)	CAD (1092)
CAD (746)	Pancreatitis (127)	Afib (152)	ETOH w/d (76)	Afib (1092)

Source: Boutwell in collaboration with South Carolina Hospital Association



Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Readmission Rates for People with BH conditions

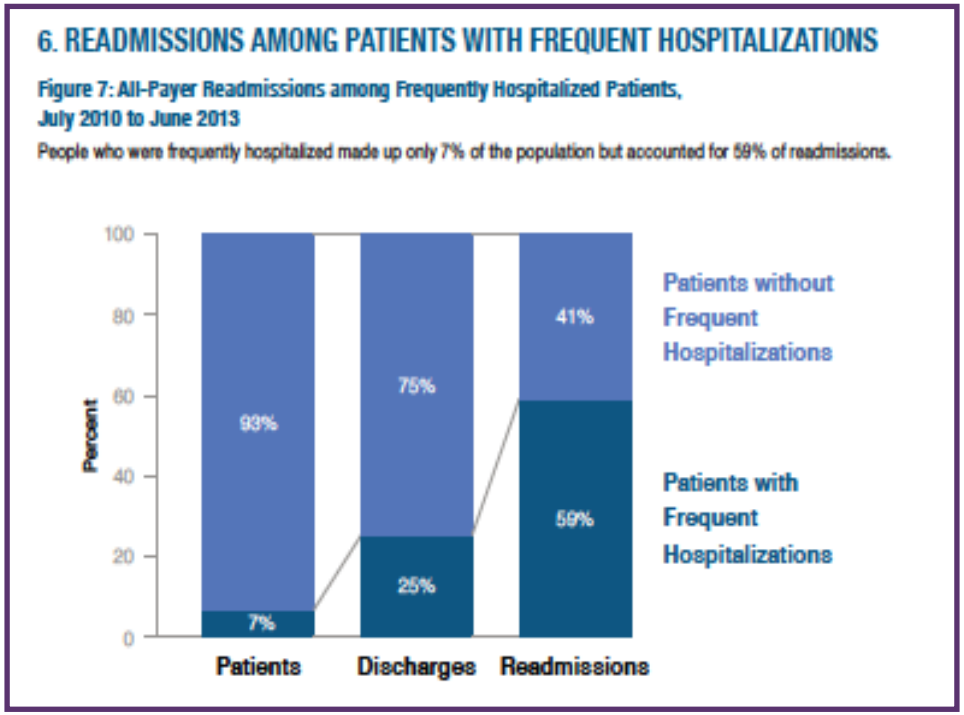


- **40%** of adult hospitalized patients had at least 1 behavioral health condition
- Patients with a BH condition had **77%** higher readmission rates

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Readmissions for Multi-Visit Patients

- 4+ hospitalizations/year
- 7% - 25%- 60%
- Hospitalizations: **6 v. 1.3**
- LOS: **6.1 days v. 4.5**
- Readmission rate **38% v. 8%**



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

Ask the question “who” is at risk of readmission?

- Adult, Medicaid
- Discharged to post-acute care
- Any behavioral health comorbidity
- CHF of any age, any payer
- Sickle cell, sepsis, renal failure, UTI, etc…

Ask your patients "Why"

Elicit the story behind the chief complaint; identify root causes

Understand the “story behind the chief complaint”

- 86M with cancer hospitalized for abdominal pain returns to the hospital 1 day after discharge with pain.
- 77F discharged following sepsis returns to the hospital 8 days later 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.
- 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with cough.

Chart reviews and administrative analyses will NOT reveal what you need to know: you must talk to your patients, their families, care partners, providers

Return Visits to the Emergency Department: The Patient Perspective

Kristin L. Rising, MD, MS*; Kevin A. Padrez, BA; Meghan O'Brien, MD, MBE; Judd E. Hollander, MD; Brendan G. Carr, MD, MA; Judy A. Shea, PhD

- Interviewed 60 patients who returned to ED <9days of visit
  - Average age 43 (19-75)
  - Majority had a PCP,
  - Preferred the ED: more tests, quicker answers, ED more likely to treat symptoms
  - Most reported no problem filling medications
  - 19//60 thought they didn't get prescribed the medications they needed (pain)
  - 24/60 expressed concerns about clinical evaluation and diagnosis

- Primary reason: ***fear and uncerta****inty about their condition*
- Patients need *more* ***reassurance*** *during and after* episodes of care
- Patients need access to ***advice between*** visits

Annals of Emergency Medicine

Take a Data-Informed Approach

1. What is our aim?
2. What does our data show?
3. Who should we focus on?

Many teams start in the ***reverse*** order!

Example: Data-Informed Design

Goal: reduce hospital-wide readmissions

Based on data, target:

- Adult, non-OB Medicaid patients
- Medicare <65
- Substance use disorder
- High utilization (4+ admissions/12 months)

- Hospital-wide readmission rate: **13%**
- Target population readmission rate: **37%** (3x hospital average)

Data-Informed Design – Do the Math

What does success look like?

- If we reduce readmissions for the **target population by 20%,** what is the impact on hospital-wide readmissions?

Hospital-Wide	
# Adult discharges	10,000
Readmission rate	10%
# readmissions	1,000

Program A	
# discharges served	200
Readmission rate	25%
# readmissions	=0.25*200 = 50
Goal: reduce 20%	=0.20*50 = 10
Impact on Hospital	10/1000=1%

Data-Informed Design – Do the Math

What does success look like?

- If we reduce readmissions for the **target population by 20%,** what is the impact on hospital-wide readmissions?

Hospital-Wide	
# Adult discharges	10,000
Readmission rate	10%
# readmissions	1,000

High Risk Target	
# discharges	2,500
Readmission rate	37%
# readmissions	=0.37*2500 = 925
Goal: reduce 20%	=0.20*925 = 185
Impact on Hospital	185/1000=18.5%

By targeting 25% of discharges, reduce hospital-wide readmissions by 18.5%

Deliver a Multi-Faceted Portfolio of Strategies

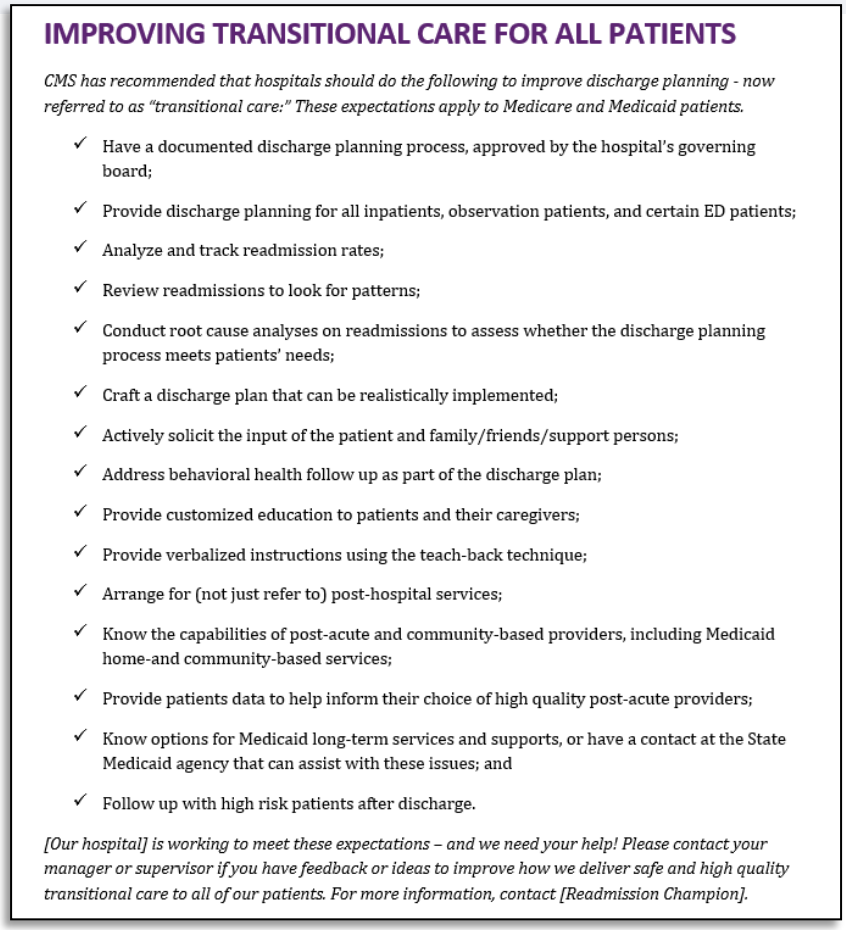
Adapt, collaborate, implement at scale

Portfolio of Strategies

Implement a ***"portfolio of strategies"***

- ✓ ***Improve*** standard care for all
- ✓ Actively ***collaborate*** with "receivers"
- ✓ ***Deliver*** enhanced transitional care services for high risk

Improve Standard Care for All



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].

- Identify all patients at high-risk of readmission
- Assess patients for clinical, behavioral and social needs
- Communicate with patients simply and effectively
- Link patients to follow-up and post-hospital services
- Provide real-time information to receiving providers
- Ensure timely post-discharge contact

AND

- Have a process
- Track, trend and review readmissions
- Continuously improve the process to meet needs

ASPIRE Tool 8

https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

Collaborate with "Receivers"

- ✓ SNF
- ✓ Visiting Nurse Agencies
- Patient Centered Medical Homes
- Adult Day Care Centers
- Behavioral Health Centers
- Medicaid Managed Care Plans
- Health Homes
- Group Homes
- Housing Authority
- Transportation Providers
- County Health Departments
- Food Assistance
- Legal Advocacy Assistance
- Peer Support

"We would be thrilled if someone from the hospital called us"

New Frontier of Collaboration: the ED

1. Create a 30-day return **flag** on the ED Tracker Board
2. Use the 30-day return flag to **notify** the high risk care team
3. Use ***ED care alerts*** to inform treating providers; connect with care team
4. Develop ***"treat and return"*** pathways

"In previous times, the path would've been to simply admit the patient, and we'll sort it out later. We're becoming more accustomed to working in ER to help discharge patients from the ED. That's a culture change."

Deliver Enhanced Services to High Risk

Successful readmission reduction teams state:

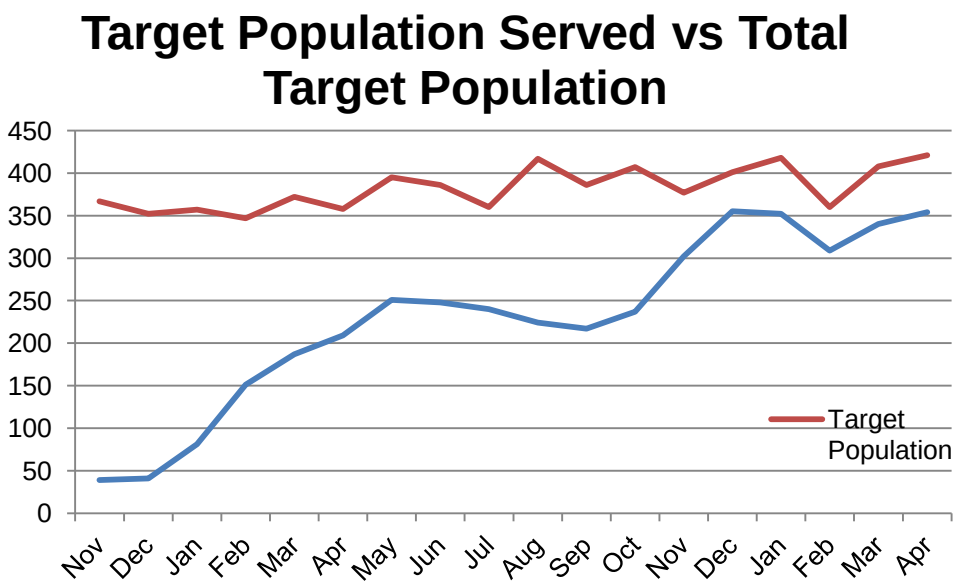
- "We look at the whole person, the big picture"
- "We always address goals and ask what the patient wants"
- "We meet the patient where they are"
- "First and foremost it's about a trusting relationship"
- "You can't talk to someone about their medications if there is no food in the fridge"
- "We do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

"Our [navigators] are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills."

Use data to drive implementation to drive outcomes

3 Process Measures to Drive Successful Implementation

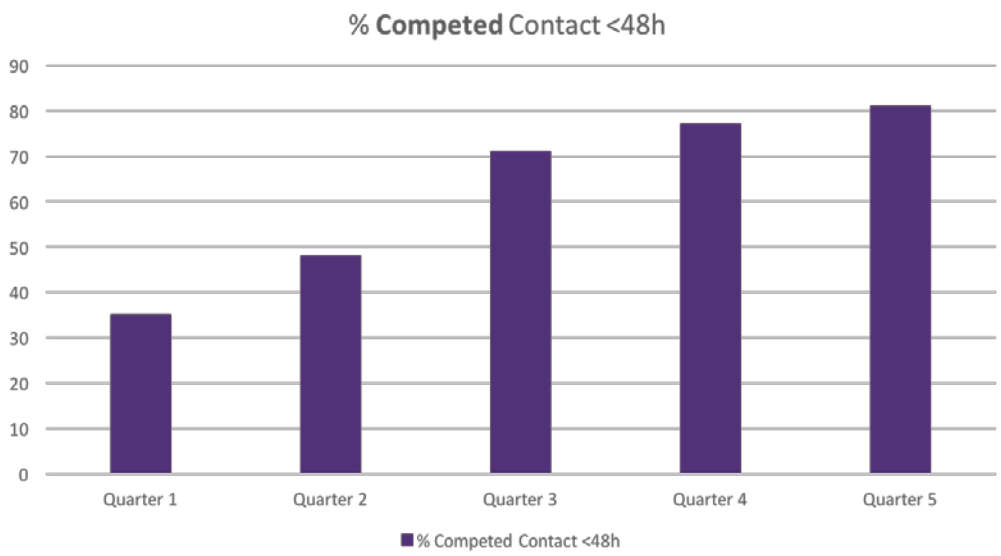
Percent of Target Population Patients Served



Key lessons:

- Reliably identify target pop
- Face to face in-hospital
- Opt-out approach
- Continuation of your care
- Avoid “special program”

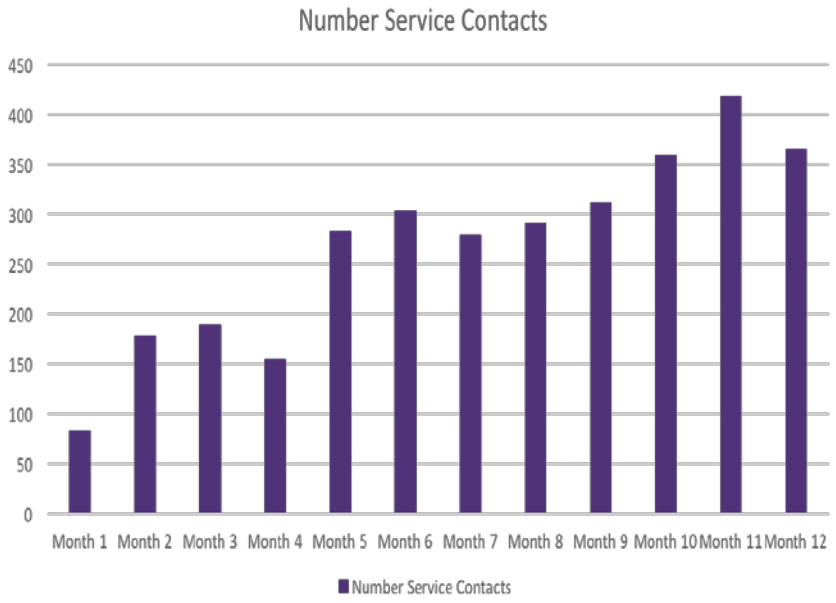
Timely Contact Post-Discharge



Key lessons:

- "It's my job to check on you once you go home"
- Use texting
- Any relevant contact
- Call their cell prior to discharge to confirm #

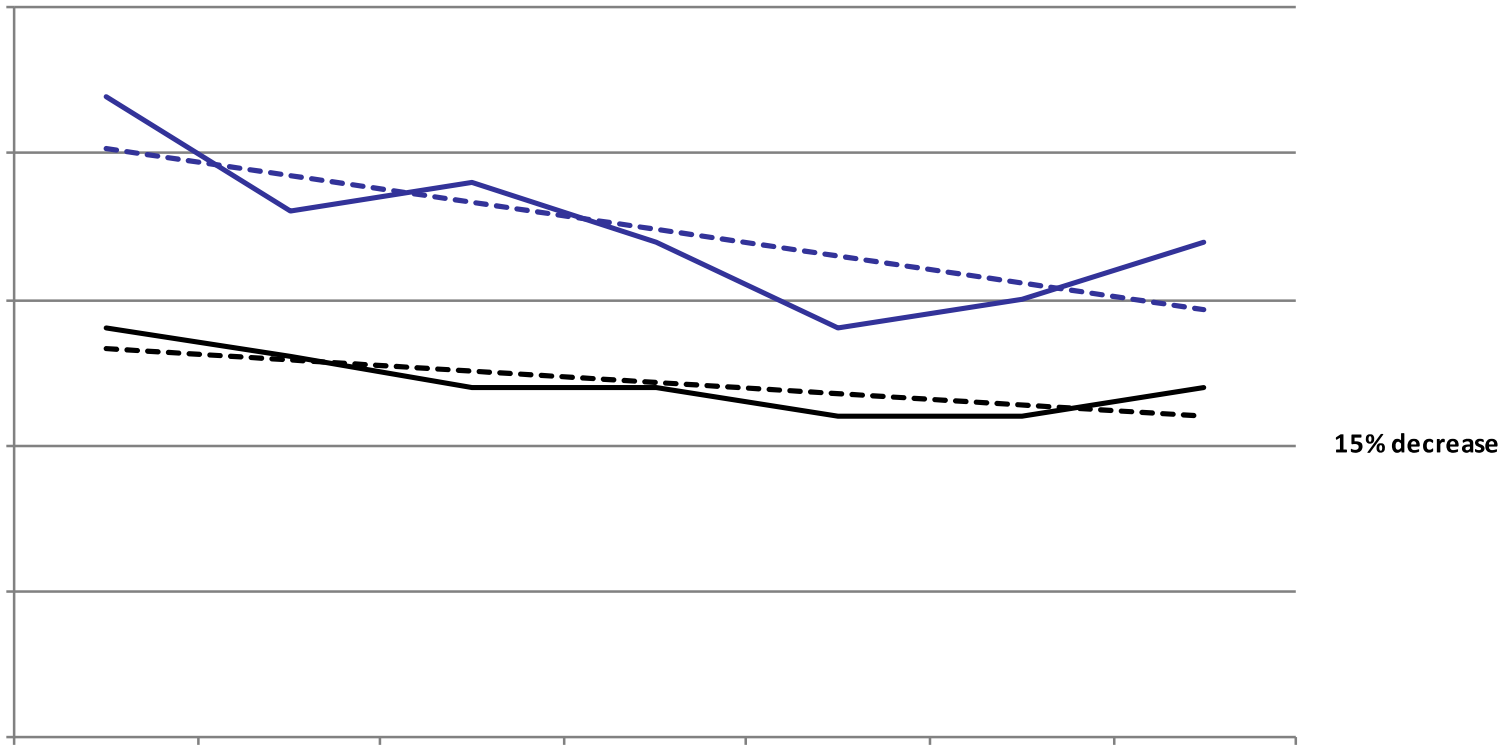
Intensive Service Delivery



Key lessons:

- Brief in-hospital visit
- Prioritize community visits
- Batch SNF visits
- Batch home visits
- Batch documentation

All Cause All Payer 30-day Readmissions
ASPIRE Implementation Hospital



Summary

- ***Expand*** readmission reduction efforts to all patients
- Employ a ***data-informed approach*** to designing efforts
- Design efforts targeted at ***root causes*** of readmissions
- Develop a ***portfolio of strategies*** to achieve hospital-wide results
- ***Adapt*** strategies to serve whole-person needs
- ***Deliver interventions*** to a high percentage of the target population
- ***Measure implementation*** to drive to higher levels of performance

Thank you for your commitment to reducing readmissions

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