Improving Patient Safety Across Michigan and Illinois

Readmissions Collaborative Kickoff

January 20, 2016
Agenda

• Readmissions Collaborative Structure and Overview

• Business case for readmissions

• Using data to identify high utilization population

• Presence St. Mary and Elizabeth Medical Center Vignette

• Q/A
Collaborative Aims

• Produce value-added webinars (11) and Grand Rounds (3)

• Foster a true peer to peer learning environment

• Develop and deliver a Reducing Readmissions Implementation Workbook by Fall 2016

• Conduct an in-person meeting in the Fall of 2016
# Structure

- **Objective:** Enhance Care Coordination and Reduce Avoidable Readmissions by 20%
- **Dual Tracks:** (1) The Four Walls & (2) The Continuum
- **Metrics:** (1) 30 day All-cause to same facility; (2) 30 Day All-cause across facility
- **Kickoff Meeting:** January 2016
- **Webinars:**
  - Readmissions Grand Rounds Webinar #1 (April)
  - Readmissions Grand Rounds Webinar #2 (June)
  - Readmissions Grand Rounds Webinar #3 (August)

<table>
<thead>
<tr>
<th>Defining Your Readmissions Approach (February)</th>
<th>Transition Points (March)</th>
<th>TBA (April)</th>
<th>TBA (May)</th>
<th>TBA (June)</th>
<th>TBA (July)</th>
<th>TBA (August)</th>
<th>TBA (September)</th>
</tr>
</thead>
</table>

- Three webinars will also be held which are characterized as “Readmissions Grand Rounds”. During these three webinars participants will be engaged in an interactive action-oriented discussion of implementation practices, barriers and strategies to overcome challenges.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, February 17</td>
<td>Defining Your Readmissions Approach</td>
<td>1 p.m. - 2 p.m. (CST)</td>
</tr>
<tr>
<td>Wednesday, March 15</td>
<td>Transition Points</td>
<td>1 p.m. - 2 p.m. (CST)</td>
</tr>
<tr>
<td>Wednesday, April 6</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative: Grand Rounds</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, April 20</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative</td>
<td>1 p.m. - 2 p.m. (CST)</td>
</tr>
<tr>
<td>Wednesday, May 18</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, June 8</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative: Grand Rounds</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, June 15</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, July 20</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, August 10</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative: Grand Rounds</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, August 17</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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<tr>
<td>Wednesday, September 21</td>
<td>IHA-MHA HEN 2.0 Readmissions Collaborative</td>
<td>1 p.m. - 2 p.m. (CST)</td>
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</table>
Readmissions Collaborative Website

Peer to Peer Learning Network Form coming soon...

https://www.alliance4ptsafety.org/HEN/Collaboratives/Readmissions.aspx
Readmissions Collaborative
Enrollment Form

To enroll your hospital in the institute's Readmissions Collaborative:

- Complete this brief form and
- Click submit button.

You will receive an email confirming our receipt of your form. We thank you for your commitment to this important initiative and look forward to working with you.

Hospital Name:
State:
Primary Readmissions Contact First Name:
Primary Readmissions Contact Last Name:
Title:
Phone Number:
Email Address:

1. Do you utilize IHA's Readmissions Activity Profile Report:
   ☐ Yes ☐ No ☐ Don't know

2. Have you established an internal readmissions team:
   ☐ Yes ☐ No ☐ Working on it ☐ Don't know

3. Have you established a cross-continuum readmissions team:
   ☐ Yes ☐ No ☐ Working on it ☐ Don't know

4. Do you review your readmissions data monthly:
   ☐ Yes ☐ No ☐ Don't know

5. Have you identified and targeted high utilizer populations:
   ☐ Yes ☐ No ☐ Working on it ☐ Don't know
Readmissions Collaborative Calendar

The Readmissions Collaborative webinar series will take place approximately monthly on **Wednesday afternoons**. Registration links will be provided as we approach each event. Resource links will be provided shortly after each event occurs.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Time</th>
<th>Registration/Resources</th>
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</thead>
<tbody>
<tr>
<td>Jan. 20</td>
<td>Readmissions Collaborative Kickoff</td>
<td>3 pm - 4 pm CT</td>
<td>Register/Slides/Recording</td>
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<td>4 pm - 5 pm ET</td>
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<tr>
<td>Feb. 17</td>
<td>Readmissions Content Call</td>
<td>1 pm - 2 pm CT</td>
<td>Register/Slides/Recording</td>
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<td>2 pm - 3 pm ET</td>
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<tr>
<td>Mar. 16</td>
<td>Readmissions Content Call</td>
<td>1 pm - 2 pm CT</td>
<td>Register/Slides/Recording</td>
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<td>2 pm - 3 pm ET</td>
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<tr>
<td>Apr. 6</td>
<td>Grand Rounds- Best Practice Sharing</td>
<td>1 pm - 2 pm CT</td>
<td>Register/Slides/Recording</td>
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<td>2 pm - 3 pm ET</td>
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<tr>
<td>Apr. 20</td>
<td>Readmissions Content Call</td>
<td>1 pm - 2 pm CT</td>
<td>Register/Slides/Recording</td>
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<td>2 pm - 3 pm ET</td>
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<tr>
<td>May 18</td>
<td>Readmissions Content Call</td>
<td>1 pm - 2 pm CT</td>
<td>Register/Slides/Recording</td>
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<td>2 pm - 3 pm ET</td>
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<tr>
<td>Jun. 8</td>
<td>Grand Rounds- Best Practice Sharing</td>
<td>1 pm - 2 pm CT</td>
<td>Register/Slides/Recording</td>
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MHA
Keystone Center
Hospital Engagement Network
MICHIGAN | ILLINOIS

IHA
Illinois Hospital Association
Readmissions Collaborative Resources

These curated resources reflect best practices across the country from government agencies, national and state associations for reducing hospital readmissions.

Implementation Resources
- AHRQ Readmission Resource Page
- AHRQ Hospital Guide to Reducing Medicaid Readmissions Toolbox
- AHRQ Hospital Guide to Reducing Medicaid Readmissions - Editable Tools 1-3
- AHRQ Hospital Guide to Reducing Medicaid Readmissions - Editable Tools 4, 5, 12, 13
- AHRQ Hospital Guide to Reducing Medicaid Readmissions - Editable Tool 7
- AHRQ Hospital Guide to Reducing Medicaid Readmissions - Editable Tool 8
- Huddle for Care
- IHI Readmissions Resource Page
- National Readmission Prevention Collaborative

Readmission Reports for Illinois Hospitals
- Readmissions Activity Profile
  - Step-by-Step Download Guide
  - Login COMPdata Specialty Reports
  - Readmissions Profile FAQ
  - Request Office Hours
  - COMPdata Help
## Enrollment Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>Don't Know</th>
<th>Working on it</th>
<th>Total</th>
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<tbody>
<tr>
<td>1. Do you utilize IHA’s Readmissions Activity Profile Report?</td>
<td>21</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>58</td>
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<tr>
<td>2. Have you established an internal readmissions team?</td>
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<td>3. Have you established a cross-continuum readmissions team?</td>
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<td>4. Do you review your readmissions data monthly?</td>
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<td>5. Have you identified and targeted high utilizer populations?</td>
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<td>6. Do you conduct an enhanced admission assessment of discharge needs?</td>
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<td>7. Do you have a formal readmissions risk assessment administered upon admission?</td>
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<td>8. Do you perform accurate medication reconciliation at admission?</td>
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<td>9. Do you ensure that patient education is culturally sensitive and incorporates health literacy concepts?</td>
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<td>10. Do you identify the primary caregiver (if not the patient) and include them in education and discharge planning?</td>
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<td>11. Do you use teach-back to validate patient and care giver understanding?</td>
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<td>12. Do you send the discharge summary to the PCP within 24-48 hours?</td>
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<td>13. Do you schedule follow-up medical appointments and post-discharge tests/labs prior to discharge?</td>
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<td>14. Do you conduct post-discharge follow-up phone calls within 48 hours of discharge for high risk populations?</td>
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<td>15. Do you currently have a partnership established with another entity across the continuum that focuses on readmissions reduction?</td>
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<td>16. Does your organization use community health workers or nurse navigators?</td>
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<td>17. Have you incorporated social determinants of health factors (i.e. food, housing, transportation, etc.) in your readmissions work?</td>
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### Survey Results

- **Total Respondents:** 57
- **No:** 27
- **Yes:** 30
- **Don't Know:** 0
- **Working on it:** 0

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**MHA Keystone Center**
**Hospital Engagement Network**
**Michigan | Illinois**

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**IHA Illinois Hospital Association**
Readmissions Activity Profile

| 1. Do you utilize IHA’s Readmissions Activity Profile Report |
|------------------|-----------------|
| No               | 21              |
| Yes              | 20              |
| Don't Know       | 17              |
| Working on it    | 0               |
| Total            | 58              |

https://www.compdatainfo.com/subscriber-services/specialty-reports.aspx
Enhanced knowledge or best practices to decrease the frequent utilizers to the hospital...

Make better use of our data for improvements and increase the use of best practices to reduce our readmissions...

Best practices in reducing readmissions...

We are a small hospital. Our readmissions seem to be non-compliant patients. Would like to collaborate with other hospitals to see how we can overcome this obstacle...

Create a work plan to have specific impact on readmissions with the Medicaid population

We hope to identify processes that will decrease readmission in high risk populations...

**We are always open to feedback-help our PDSA process by emailing IllinoisHEN@ihastaff.org with your thoughts throughout the collaborative**
Readmissions Kick Off

Pat Teske, RN, MHA
pteske@cynosurehealth.org
Let’s Talk About...

• Why reduce readmissions?
  – It’s the right thing to do
  – The business case to reduce readmissions
• How to reduce readmissions
• Using data to target for maximum results
• The Models
• Picking your strategies
• Developing a learning loop
Why should we do this?
Two Reasons
How was your hospital paid?

- Medicare FFS
  - DRG based
    - Coding dependent
    - No prior authorizations

- Medical per diem
  - Payment per approved day

- Private insurance
  - Per contract

- Private pay
  - Based on charges
Themes across payors

- More means more
- Related directly or indirectly to charges
- Not based on quality or satisfaction with experience
- Hospital only

![Payor Mix Chart]

- Medicare: 25%
- Medical: 50%
- Private Insurance: 20%
- Private Pay: 5%
Heads in beds?
How will your hospital be paid?

Sylvia Mathews Burwell
The 22nd Secretary of Health & Human Services (HHS)
Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- **All Medicare FFS (Categories 1-4)**
- **FFS linked to quality (Categories 2-4)**
- **Alternative payment models (Categories 3-4)**

**2016**
- All Medicare FFS: 85%
- FFS linked to quality: 30%
- Alternative payment models: 5%

**2018**
- All Medicare FFS: 90%
- FFS linked to quality: 50%
- Alternative payment models: 10%
• Hospital readmission reduction program
• Hospital value based purchasing program (VBP)
• Medicare spending per beneficiary
• Hospital-acquired condition (HAC) reduction program
Hospital readmission reduction program

• History
  – Began in 2012
    • PN, HF, AMI - Up to 1%
  – Now, also includes:
    • COPD, Total Hips & Total Knees - Up to 3%
  – What’s next?
    • All cause? - Up to ?%

• How it works
  – Excess readmissions are measured by a ratio, of “predicted”/“expected” based on an average hospital with similar patients
  – Takes into consideration readmissions to any acute care hospital
  – Three years of discharge data and the use of a minimum of 25 cases to calculate a hospital’s excess readmission ratio
  – A ratio greater than 1 indicates excess readmissions (penalty)
  – If you received a penalty it is applied to ALL Medicare cases
Your States

Illinois
- Number of penalized hospitals = 113
- % of penalized hospitals = 62%
- Average hospital penalty % = 0.72

Michigan
- Number of penalized hospitals = 69
- % of penalized hospitals = 50%
- Average hospital penalty % = 0.64

vs. National
- 54% of hospitals
- Average penalty = 0.61

Kaiser Health News – Year Four Report
<table>
<thead>
<tr>
<th>Then and Now</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Then</strong></td>
</tr>
<tr>
<td>• Do more get paid more</td>
</tr>
<tr>
<td>• Hospital only</td>
</tr>
<tr>
<td>• Today focused</td>
</tr>
<tr>
<td>• Narrow focus</td>
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</tbody>
</table>
A Strategy to Reduce Heart Failure Readmissions and Inpatient Costs

Jill Howie-Esquivel, Maureen Carroll, Eileen Brinker, Helen Kao, Steven Pantilat, Karen Rago, Teresa De Marco

Results: Group baseline characteristics were similar with 30-day readmission rates significantly different (19% usual care vs. 12% for the intervention respectively (P = 0.003)). Patients in the usual care group were 1.5 times more likely to be hospitalized (95% CI: 1.2 - 1.9; P = 0.001) compared to the intervention group. A savings of 641 bed days with potential revenue of $640,000 occurred after TEACH-HF.

Conclusions: The TEACH-HF intervention was associated with significantly fewer hospital readmissions and savings in bed days.
Medicare Payment

• $9,600 per Readmission Prevented (Avg. payment)

• Tiongson J. "Solicitation for Applications Community-based Care Transitions Program." Centers for Medicare & Medicaid Services, Web. 4 Dec 2012.

How to reduce readmissions

1. Partnering with other hospitals in the local area to reduce readmissions
2. Tracking % of patients discharged with a follow-up appointment already scheduled within 7 days
3. Tracking % of patients readmitted to another hospital
4. Estimating risk of readmission in a formal way and using it to guide clinical care during hospitalization
5. Having electronic medical record or web-based forms in place to facilitate medication reconciliation
6. Using teach-back techniques for patient and family education
7. At discharge, providing patients with heart failure written action plans for managing changes
8. Regularly calling patients after discharge to follow up on post-discharge needs
9. Discharging patients with an outpatient follow-up appointment already scheduled
Result Highlights

- Hospitals that took up any 3 or more strategies had significantly greater reductions in RSRR compared with hospitals that took up only 0-2 strategies.
- 93 different combinations of strategies
- High and low performing groups both used recommended clinical practices.
- Four specific approaches distinguished high performers
  - Collaboration across departments/ disciplines
  - Working with post-hospital providers
  - Learning and problem solving
  - Senior leadership support
Key Steps

- Understand your readmissions
- Select a portfolio of strategies and target population(s) for each
- Evaluate the effectiveness of your portfolio
- Adjust as needed to reach your goal
Understanding your readmissions

• Perform an analysis of your readmitted patients
  – Use your data in aggregate
    • IL readmission rate report
    • Other available data sources
  – Patient interviews
  – Provider interviews
  – Process reviews
• Review charts
• Admission
• Teaching/Coaching
• Hand Over
• Acute Care Follow Up
• Post-Acute care support

• Admission Rates
• To – From
• Diagnoses
• Risk Groups

• Do 5 structured interviews

• Review 5 charts

• Review Your data

• Review Your Processes

• Review MRs

• Talk to your patients & providers
What are the data saying?

• By major payer type:
  – Total number of discharges
  – Total number of readmissions
  – Rate = readmissions/discharges
  – Discharge disposition
    • Number home
    • Number home with home health
    • Number SNF
More data questions

• With any coded behavioral health diagnosis
  – Discharges
  – Readmissions

• Number and/or percentage of readmissions occurring within 7 days of discharge

• Number of patients with ≥4 hospitalizations in past year
  – Total number of discharges in >4 group
  – Total number of 30-day readmissions among them

• Top 10 DRGs
  – What are they?
  – Do they differ between payers?
  – What percentage of readmissions do the top ten DRGs account for?
    • Usually less than 28%
What are your patients saying?

• Ask a patient who was readmitted today.

• Tell me in your own words how you think you became sick enough to come back to the hospital?

• What needs to happen for you to be safe at home?

• Track results
What are your providers saying?

- Were you aware your patient was hospitalized?
- Did you receive timely information?
- What do you think needs to happen for your patient to be able to stay healthy enough to stay out of the hospital?
What do the records say?

- Review medical records for the patient for the past 180 days
- Note condition, disposition, instructions
- Was the same discharge plan repeated?
Don’t forget the processes

• Review key processes
e.g. patient education
  – Documents and tools
  – Training
  – Observation on practice
  – Monitoring

• What changes are needed?
What did you learn?

• What did your data say?
• What did your patients say?
• What did your providers say?
• What did the records say?
• How reliable are your processes?
Design your portfolio

Risk

Community
Health Navigator

Disease
Specific
Program

Clinic/PCP Care

Palliative Care

Continuum

http://caretransitions.org/
Continue to ask why they’re back
If your rate is not reducing, did you?

- Impact enough patients
- Select the correct strategies
- Implement them reliably
Go it alone
Skill building assignment

- If you haven’t already done so, perform an analysis of your readmitted patients
- Bring that understanding to next month’s webinar when we will discuss the evidence based models to reduce readmissions
Pat Teske, RN, MHA
Implementation Officer
Cynosure Health
pteske@cynosurehealth.org
Presence Saints Mary and Elizabeth Medical Center

Saint Mary of Nazareth Hospital (387 beds)
+ 186 Medical / Surgical
+ 120 Behavioral Health
+ 32 Critical Care
+ 20 Obstetrics
+ 15 Rehabilitation
+ 14 Pediatrics
+ Comprehensive Emergency Department

Saint Elizabeth Hospital (108 beds)
+ 40 Child / Adolescent Behavioral Health
+ 40 Substance Abuse
+ 28 Skilled Nursing
+ Stand-by Emergency Department

Our mission and values
Inspired by the healing ministry of Jesus Christ, we Presence Health, a Catholic health system provide compassionate, holistic care with a spirit of healing and hope in the communities we serve.

Honesty  Oneness  People  Excellence
PSMSEMC Readmission Reduction Driver Diagram
Version 2.0 9/1/15

Reduce readmissions for priority target populations

Enhance Hospital-based Behavioral Health Care
- SW evaluate all ED BH patients
- Psychiatrist eval of BH patients in ED
- APRN support to inpatient psych service
- CHF NP
- DM APN, DM Educator
- SW-based care planning for med/surg patients
- Pharmacist consult for high risk, polypharmacy
- Directly provide 30-day medications, transportation as needed
- Establish care plans
- Collaboration with community providers

Enhance services for medical and social needs

Focus on patients with high utilization

MHA
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Hospital Engagement Network
MICHIGAN | ILLINOIS

IHA
Illinois Hospital Association
Improving Hospital-Based Behavioral Health Care

• Identify BH patients upon presentation to the ED
• Identify 30-day returns in real-time in the ED
• Streamline medical clearance/evaluation of BH ED patients
• Assess: based on staffing is it possible for all ED BH patients to be assessed by the SW? If not, create triage/prioritization rule
• Collaborate with community crisis team
• Identify community BH partners who can perform post ED outreach
• Identify community BH partners who can offer urgent post-ED follow up
Next Steps

• Perform an analysis of your readmitted patients - AHRQ Data Analysis Tools: https://www.alliance4ptsafety.org/HEN/Resources/Readmissions.aspx

• Bring that understanding to next month’s webinar when we will discuss the evidence based models to reduce readmissions
Email: IllinoisHEN@IHAstaff.org

February 17th - Defining Your Readmissions Approach