HOME IS THE HUB
An Initiative to Accelerate Progress to Reduce Readmissions in Virginia

Webinar #3 – Post-Acute Care Readmissions
September 8, 2016
• Slides were sent this morning
• Webinar is being recorded
• Please use the “telephone” option
  • Audio pin prompt
• All participants are muted
• Raise your hand
• Ask a question
• Warm up
WELCOME AND OVERVIEW

Abraham Segres
VHHA
Vice President, Quality & Patient Safety
asegres@vhha.com
(804) 965-1214
VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

An association of 30 member health systems representing 107 community, psychiatric, rehabilitation and specialty hospitals throughout Virginia.

Vision

Through the power of collaboration, the association will be the recognized driving force behind making Virginia the healthiest state in the nation by 2020.

Mission

Working with our members and other stakeholders, the association will transform Virginia’s health care system to achieve top-tier performance in safety, quality, value, service and population health. The association’s leadership is focused on: principled, innovative and effective advocacy; promoting initiatives that improve health care safety, quality, value and service; and aligning forces among health care and business entities to advance health and economic opportunity for all Virginians.
VHHA 2015-2020 IMPROVEMENT PRIORITIES

1. Hospital readmissions
   1a. Hospital-wide
   1b. Post-acute transfers
   1c. Total hip/Total knee Replacement 30-day readmissions

2. Clostridium difficile – Healthcare-acquired Infections
3. Patient Experience – HCAHPS
4. Serious Safety Events
Statewide Learning & Action

- Statewide collaborative June 2016 to November 2018
  - **Focus** on PAC, HU, THR/TKR in parallel
  - Engage with partners in PAC
  - Engage with VHQC for **cross-continuum** work
  - Engage with AAAs for **community based** care/CTI
  - Provide, use, interpret **data** from VHHA & VHQC
Planned Activities for Learning & Action

June 16th* High Leverage Strategies
August 17th* Data/Measurement
September 8th* Reducing PAC Readmissions
October 20th* Improving Care for High Utilizers
November 15th In-Person Learning Event 9-3:30

*All webinars will be offered at 10am
A FEW OF OUR PARTNERS

- Virginia Healthcare Association (VHCA)
- Virginia Association of Home Care and Hospice
- LeadingAge Virginia
- VHQC
- Virginia Department of Aging & Rehabilitative Services (DARS)
REDUCING READMISSIONS FROM POST-ACUTE CARE

Amy Boutwell, MD, MPP
Collaborative Healthcare Strategies
President
amy@collaborativehealthcarestrategies.com
(617) 710-5785
AGENDA

• Readmissions from post-acute care in Virginia

• Identifying root causes of readmissions from post-acute care

• Developing a multi-faceted approach to reducing readmissions from post-acute care

• Specific action steps
OBJECTIVES

1. Describe common root causes of readmissions from post-acute care, and identify practical ways for hospitals and PAC providers to identify their own root causes;

2. Describe 3 effective strategies for reducing readmissions for patients discharged to post-acute care;

3. Discuss methods used to collaborate with post acute providers
Reduce All Cause All Payer Readmissions by 20% by 2020

- Reduce PAC Readmissions
- Reduce HU Readmissions
- Reduce Total Hip/Knee Replacement Readmissions
- Reduce Readmissions from Home

- Improve processes & practices for SNF patients
- Improve processes & practices for Home Health patients
- “Whole-person” care teams, care plans
- Improve pre-op, peri-op, post-op and rehab practices & processes
- Coaching and Linkage to Services (AAA/SIM)
READMISSIONS FROM POST ACUTE CARE IN VIRGINIA
READMISSIONS BY DISCHARGE DISPOSITION IN VIRGINIA

### Medicare FFS Readmission Rates, by Discharge Setting: Home, SNF, HH

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<td>18.5</td>
<td>18.7</td>
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Source: 2015 VA Medicare FFS data, courtesy of VHQC
KEY STATISTICS TO KNOW

Medicare

- ~275k Medicare discharges
- ~50k Medicare readmissions
- ~18% Medicare readmission rate

Medicare to PAC

- ~110k Medicare discharges to PAC
- ~22k readmissions “from” PAC
- ~20% readmission rate

~40% of discharges are to post acute care
A 20% reduction would avoid 4,400 readmissions per year in VA
Reducing PAC readmissions would reduce the state-wide rate from 18.2% to 16.6%

*PAC = Home Health or SNF
CALCULATE THE IMPACT OF REDUCING PAC READMISSIONS ON YOUR HOSPITAL’S READMISSION RATE

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<thead>
<tr>
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<th>Formula</th>
<th>Example</th>
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<tr>
<td>Total hospital* discharges</td>
<td>A</td>
<td>1000</td>
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<tr>
<td>Total hospital readmissions</td>
<td>B</td>
<td>150</td>
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<tr>
<td>Hospital readmission rate</td>
<td>=B/A</td>
<td>15%</td>
</tr>
<tr>
<td>Total PAC** discharges (40% of total)</td>
<td>C = .4A</td>
<td>400</td>
</tr>
<tr>
<td>Total PAC readmissions (20% rate)</td>
<td>D = .2C</td>
<td>80</td>
</tr>
<tr>
<td>Goal: 20% reduction PAC readmissions</td>
<td>= .20 x D</td>
<td>16</td>
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<tr>
<td>New hospital readmissions</td>
<td>=B - (.2D) = E</td>
<td>150-16 = 134</td>
</tr>
<tr>
<td>New hospital readmission rate</td>
<td>=E/A</td>
<td>13.4%</td>
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*”hospital” = adult, non-OB

**PAC = Home Health or SNF

Calculate this for your hospital
EXAMINE ROOT CAUSES OF READMISSIONS FROM PAC
ROOT CAUSES OF READMISSIONS

• Incomplete information about clinical status
• Incomplete information about functional status
• Incomplete information about behavioral health or “sundowning”
• Missing hard copies of controlled substance prescriptions
• Missing documentation of placement of tubes or lines (eg picc lines)
• Delays in obtaining (rare, expensive) medications
• Change in clinical status requiring provider evaluation but not emergencies
• Patient/family dissatisfaction with the facility – seeking different placement
• Readmissions following discharge from SNF to home
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

Best practice: review all readmissions

READMISSION SPREADSHEET (2-3 min each)

The purpose of conducting a root cause analysis is to understand the reasons underlying patient readmissions in order to develop processes that can prevent readmissions. When analyzing each patient interview:

• Ask "why?" 5 times to elicit the "root causes" of readmissions.
  o As an example, an interview might reveal that a patient did not take her medication, which then contributed to her re-hospitalization. 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? I continue to ask until you have identified opportunities that your hospital team can address (e.g., bedside delivery of medication, (re)link medication reconciliation, such services may assist for some patients but not others, or may be delivered as available rather than consistently).
  o Try to avoid citing disease exacerbations or non-compliance 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 also pxx of the Hospital Guide to Reducing Medicaid Readmissions for an example of interview findings and root cause analysis.
READMISSIONS AFTER TRANSITION FROM SNF TO HOME

- 55,980 Medicare d/c from 694 SNFs
- 67% d/c to home care after SNF
- 12,350 (22%) returned to acute care <30d
  - 15% readmitted
  - ~50% of returns <30d occurred <10d!
- “indicates the need for interventions to improve transition from SNF to home”

Toles et al | JAGS 2014
BEST PRACTICES

• “Interview” (readmission review) patients while they are in the hospital
• Listen for “all” of the factors that contributed to a readmission
• Ask the person who sent the patient to the ED to provide their perspective
• View all readmissions as potentially avoidable by asking “5 whys”
• Readmission review and root cause analyses is most productive when conducted in the spirit of open inquiry and seeking opportunities to improve
• Use readmission reviews and root cause analysis as the basis for your collaborative work with post-acute providers
REDUCING READMISSIONS FROM PAC: BEST PRACTICES

Collaborate in managing care across settings and over time: not just a handoff
Warm RN-RN Handoff to SNF

Hospital calls back SNF 3-24h after d/c to ask 6 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?**

Source: Emily Skinner, Carolinas Healthcare System
PAC BEST PRACTICE #2
ACUTE CARE MANAGEMENT TEAM “WARM FOLLOW UP”

• ACO or Bundle clinical **coordinator**
  • Air traffic control (lists of patients, coordinates virtual co-management rounds)

• **Physical** rounds in SNF
  • Acute Care Team sends RN / NP to see patient, discuss plan with SNF staff
  • Respond to changes in clinical status to manage in setting

• **Virtual** care management rounds with SNF
  • Weekly telephonic rounds ACO/bundle coordinator and SNF
  • LOS, progress toward discharge goals, discharge planning

• **Tele-medicine** consults in SNF

• **Direct admit** to SNF from home if need escalated care
LESSONS FROM ACOS AND BUNDLES

Key lessons:

• Took time to develop a collaborative rapport vs. “hospital in-charge”

• No substitute for verbal communication and problem solving

• Active co-management and care management gets results
PAC BEST PRACTICE #3

HALLMARK HEALTH SYSTEM TREAT-AND-RETURN TO SNF

- Hallmark Health System
  - 2 hospital system, 20 ED docs, 17 PAs
  - “Why are almost all SNF patients admitted?”
  - “Patients only seen once a month”; “can’t do IVs”, etc
  - “If they send them here they can’t take care of them”

- Actions:
  - Asked ED clinicians “5 whys”
  - Education: posted INTERACT SNF capacity sheets in ED
  - Simplicity: establish contacts, standard transfer information

- Results: increase in number of patients transferred from ED to SNF

Source: Dr Steven Sbardella, CMO and Chief of ED
Hallmark Health System Melrose, MA
PAC BEST PRACTICE #4
SNF TRANSITION TO HOME PROGRAM

• “Home and Healthy Program”
• Comprehensive discharge planning: appointments, services made
• Reviews all information with resident, family, caregiver
• Direct contact after SNF discharge
  • Phone call next day
  • Once a week for a month
  • Once a month for 3 months

Courtesy of Keswick Multi-Care, Maryland
INTERACT TOOLS TO REDUCE POST-ACUTE HOSPITALIZATIONS

Hospitals need to know these tools in order to more effectively collaborate.
INTERACT
(INTerventions to Reduce Acute Care Transfers)

- Customized Guides for SNF, Home Health and Assisted Living Facilities
- Implementation Guide
- Measurement and Root Cause Analyses Tools
- Changes in Clinical Status Tools
- Hospital Communication Tools
- Patient / Family Communication Tools
- All available for free to download at www.interact2.net
Stop and Watch
Early Warning Tool

If you have identified a change while caring for or visiting a patient, please circle the change and notify a nurse or supervisor.

STOP

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities

Ate less
No bowel movement in 3 days; or diarrhea
Drank less

WATCH

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Check here if no change noted while monitoring high risk patient

Patient

Your Name:

Observation Reported to

Date and Time (am/pm)

Nurse/Supervisor Response

Date and Time (am/pm)

Nurse/Supervisor Name

Available at: www.interact2.net
## Nursing Home to Hospital Transfer Form

### General Information
- **Resident Name:**
- **Date of Birth:**
- **Gender:**
- **Resident ID:**
- **Social Security Number:**
- **Resident Address:**
- **Resident Phone:**
- **Resident Email:**
- **Next of Kin:**
- **Next of Kin Phone:**
- **Next of Kin Email:**

### Admission Information
- **Date of Admission:**
- **Reason for Admission:**
- **Primary Diagnosis:**
- **Secondary Diagnosis:**
- **Discharge Diagnosis:**
- **Discharge Date:**

### Contact Information
- **Primary Nurse:**
- **Primary Nurse Phone:**
- **Primary Nurse Email:**
- **Social Worker:**
- **Social Worker Phone:**
- **Social Worker Email:**

### Key Clinical Information
- **Medications:**
- **Allergies:**
- **Immunizations:**
- **Diet:**
- **Special Needs:**
- **Treatment Plans:**
- **Physical Therapy:**
- **Occupational Therapy:**
- **Speech Therapy:**
- **Respite Care:**
- **Behavioral Issues:**
- **Emergency Contact:**

### Social History
- **Family History:**
- **Financial Support:**
- **Legal Status:**
- **Disability:**
- **Religious Affiliation:**
- **Cultural Background:**

### Additional Information
- **Medical History:**
- **Surgical History:**
- **Trauma History:**
- **Hypertension History:**
- **Diabetes History:**
- **Chronic Obstructive Pulmonary Disease:**
- **Cardiovascular Disease:**
- **Cancer History:**
- **Mental Health History:**
- **Drug History:**
- **Alcohol History:**
- **Smoking History:**
- **HIV/AIDS:**
- **CVA/TIA History:**
- **Renal History:**
- **Liver History:**
- **Endocrine History:**

### Contact Person
- **Name:**
- **Relationship:**
- **Phone:**
- **Email:**

### Additional Information
- **Additional Information:**
- **Other:**

### Additional Relevant Information
- **Signatures:**

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Available at: [www.interact2.net](http://www.interact2.net)
### Nursing Home Capabilities List

This list is for hospital emergency rooms, hospitals, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

<table>
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<th>Facility</th>
<th>Address</th>
<th>Key Contact</th>
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**Capabilities**

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<th>Year</th>
<th>No</th>
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<tbody>
<tr>
<td>Y</td>
<td>N</td>
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**Primary Care/Outpatient Services**

- At least one physician, NP, or PA
- At least one physician, NP, or PA per 100 beds
- At least one physician, NP, or PA per 100 beds in the facility

**Diagnostic Testing**

- Ultrasound
- CT

**Interventions**

- IV therapy
- Infusion therapy

**Consultations**

- Physical therapy
- Occupational therapy

**Therapies on Site**

- Physical therapy
- Occupational therapy

**Emergency Services**

- Hospital-based emergency room
- Ambulance service

**Other Specialized Services (if any)**

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<tr>
<th>Year</th>
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### Home Health Capabilities List

This list is for hospital emergency rooms, hospitals, and case managers; and for physicians, NPs, and PAs who take calls for the Home Health agency to assist with decisions about hospital admission or return to home health.

<table>
<thead>
<tr>
<th>Home Health</th>
<th>Address</th>
<th>Key Contact</th>
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<tbody>
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</tbody>
</table>

**Nursing Services**

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech-language therapy
- Medical/surgical therapy
- Home health aide

**Diagnostic Testing**

- Lab tests
- X-ray
- EKG

**Interventions**

- IV therapy
- Infusion therapy

**Consultations**

- Physical therapy
- Occupational therapy

**Therapies on Site**

- Physical therapy
- Occupational therapy

**Emergency Services**

- Hospital-based emergency room
- Ambulance service

**Other Specialized Services (if any)**

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</table>

Available at: [www.interact2.net](http://www.interact2.net)
**Hospital to Post-Acute Care Transfer Form**

**A. Patient Information**
- Name:
- Address:
- Phone:
- Date of Birth:
- Social Security Number:
- Medicare Number:
- Insurance Provider:
- Plan:
- Policy Number:
- Primary Care Provider:
- Physician:
- Cell Phone:
- E-mail:
- Emergency Contact:
- Relationship:
- Phone:
- Address:

**B. Family/Caregiver/Proxy Information**
- Name:
- Relationship:
- Phone:
- Address:

**C. Advance Directives/Goals of Care**
- Yes
- No
- Not Applicable

**D. Transferring Hospital Information**
- Hospital Name:
- Address:
- Phone:
- Hospital:
- Triage:
- Transport Provider:
- Transport Agency:
- Treatment:
- Length of Stay:
- Date Admitted:
- Date Discharged:
- Date Transferred:
- Date of Admission:

**E. Transferring Information**
- Transferred From:
- Transferred To:
- Transferred By:
- Date Transferred:

**F. Hospital/Patient Care Team Information**
- Primary Physician:
- Specialty:
- Specialty:
- Other Providers:

**G. Key Clinical Information**
- Date of Birth:
- Address:
- Phone:
- E-mail:
- Medical History:
- Diagnosis:
- Discharge Diagnosis:
- Primary Diagnosis:
- Admitting Diagnosis:
- Other Diagnoses:
- Primary Provider:
- Specialty:
- Specialty:
- Other Providers:
- Date of Admission:
- Date of Discharge:
- Length of Stay:
- Date of Transfer:
- Date of Admission to Transfer:
- Date of Discharge from Transfer:

**H. High-Risk Conditions/Interventions Information (check all that apply)**
- Diabetic:
- Hypertension:
- Heart Disease:
- Pulmonary Disease:
- Renal Disease:
- Cancer:
- Stroke:
- HIV/AIDS:
- Other:

**I. Controlling Conditions, Risk Factors, and Interventions (check all that apply)**
- Medications:
- Allergies:
- Interventions:
- Risk Factors:
- Other:

**M. Attached Document(s) Not Affected**
- Signed Consent:
- Referral:
- Discharge Planning:
- Home Health:
- Transportation:
- Other:

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**Available at:** [www.interact2.net](http://www.interact2.net)
Available at: www.interact2.net
Advance Care Planning Communication Guide: Overview

The INTERACT Advance Care Planning Communication Guide is designed to help healthcare professionals who work in home health to initiate and carry out conversations with patients and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health.

Available at: www.interact2.net

Advance Care Planning Communication Guide
Part 1: Tips for Starting & Conducting the Conversation

Set the Stage

1. Get the facts – understand the patient’s conditions and prognosis.
2. Choose a private environment.
3. Determine an agenda for the meeting and who should be present.
4. Allow adequate time – usually these discussions take at least 60 minutes.
5. Turn cell phone or pager to vibrate to avoid interruptions and demonstrate full attention.
6. If the patient is involved, sit at eye level with him or her.
7. Have tissues available.

Initiate the Discussion

1. Describe the purpose of the meeting.
2. Identify whether the patient wants or already has a spokesperson and who it is.
3. Ask what the patient and/or family understand about advance care planning.
4. Ask about their goals for care.
5. Most home health patients and their families are concerned about comfort and life prolongation. This opens the door to discuss palliative care and comfort care plans.
6. Attempt to understand underlying rationales for the goals (i.e. “I’ve lived long enough, now I’m ready to meet God,” or “I want to keep on living until my granddaughter graduates next spring”). This provides insight into specific decisions that are made.

Initiate the Discussion

1. Use simple language.
2. Briefly discuss:
   - Cardiopulmonary arrest and CPR
   - Artificial Hydration/Nutrition (tube feeding)
   - Palliative care, comfort care orders
3. Understand for goals if appropriate.

Cardiopulmonary Arrest and CPR

1. Initiate discussion of Cardiopulmonary Resuscitation (CPR).
2. Sometimes when people hear the word “CPR,” they think of someone who has stopped breathing and someone trying to pump the heart.
3. Not all deaths should involve CPR.
4. The possibility of surviving CPR in a home health is very low and CPR often results in the need for a respirator (breathing machine) in an intensive care unit.
5. A request to not perform CPR (a Do Not Resuscitate (DNR) Order) does not mean that CPR will not be performed if there is a heart attack or other serious accident.

Advance Care Planning Communication Guide
Part 2: Communication Tips

Tips | Examples
--- | ---
Establish Trust | “Tell me what you understand about your illness.”
| “Help me get to know you better. — Tell me about your life before you came to the Home Health.”
Recognize patient and family concerns, but do not push other health care providers | “I understand that you didn’t feel heard by other doctors/nurses. I’ll do my best to make sure you have a chance to voice your concerns.”
| “If you had the Dr. X you would be very happy because I’m sure he really cares for you, and would have been wonderful if there would have been someone as the other.”
Be honest | “If you are really not sure about what you have been prescribed, it’s clear that is not right for you.”
Demonstrate respect | “I am so impressed by how involved you have been with your treatment throughout this illness. I see how much you love her/him.”
Don’t force decisions | “We’ve just had a very difficult conversation, and you are your family have a lot to think about. Let’s schedule another meeting and see how you feel about things then.”

Attend to Emotions

| Attune to the emotion | “I think about the issues you’re facing.”
| Identiﬁcation | “I bet it’s hard to imagine life without your relative…”
| Logistic | “It’s common for someone in your situation to have hard time making these decisions…”
| Explore | “You’re young. You’ve never faced what you’re now facing.”
| Cope | “No matter what the road holds ahead, I’m going to help you with it.”

Communicate Hope

Hope for the best, but prepare for the worst
| “Have you thought about what might happen if things don’t go as you wish? Sometimes having explicit discussion for the worst makes it easier to focus on what you hope for most.”
| “I know that your illness will improve. Are there other goals you want to focus on?”

Reframe hope
| “Some treatments are really not going to help and may make you feel worse or uncomfortable.”
| “What sorts of things are you really worried about? Let’s focus on those.”

Focus on the positive
| “I know that your illness will improve. Are there other goals you want to focus on?”
| “Some techniques are really not going to help and may make you feel worse.”

Available at: www.interact2.net
COLLABORATING WITH PAC PROVIDERS TO REDUCE READMISSIONS
Section 5: Collaborate With Cross-Setting Partners

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

Improving hospital-based transitional care processes is essential. However, the best transition out of the hospital is only as good as the reception it receives at the next setting of care. Forming partnerships with “receiving” providers—physicians, community-based, primary care, and social service—can only be made efficient and effective by ensuring that the critical and transitional care provided by hospitals is more likely to succeed in the posthospital setting, but also sustainably create and draw the resources and services available to patients.

Over the past several years, forming cross-setting partnerships has emerged as a core component of effectively delivering care across settings and over time. The SHIAR Initiative emphasized the benefits of forming a “cross-continuum team,” the Care Transitions Aim of the CMS QIO program provided technical assistance and support to “community coalitions,” and the CMS Community-Based Care Transitions Program requires cross-setting partnerships between hospital and community-based organizations to provide efficient and effective transitional care services in the posthospital period. Accountable Care Organizations (ACOs) and Bundled Payments for Care Improvement (BPCI) teams are focusing on developing strategies to improve care across settings when all care settings are part of the same organization.

Whatever they are called, cross-continuum teams are much more than just coffee talks and networking events. Providers with effective cross-setting partnerships see the true, transparency, shared goals, real-time problem solving, shared operational strategies, and clinical management pathways as foundational to their success in transitioning to value-based delivery systems.

There are several specific reasons and practical benefits to forming a cross-continuum team, including the opportunity to:

- Decline your hospital’s readmission reduction goals to referral partners;
- Identify common patient and community-based providers and agencies;
- Streamline efforts to improve posthospital care and reduce readmissions;
- Obtain “real” feedback from “receiving” providers;
- Learn what information “receiving” provider need to effectively assume care;
- Decide how to efficiently allocate patients to community-based services and support.

Form a Cross-Continuum Team

"Who’s not our partner at this point? There’s too much out there."

Forming a cross-continuum team does not need to represent a major new strategic business decision. Cross-continuum teams should begin with a “coalition of the willing”—that is, partners who are eager to collaborate and work toward a shared aim of reduced readmissions. Begin with physicians, agencies, and Medicaid health plans with whom you currently share patients. Expand the network of engaged stakeholders as challenging posthospital care needs are identified through your efforts, data, and patient interviews.

To date, cross-continuum teams have developed primarily to meet the posthospital needs of the Medicare patient. As a result, we observe that hospitals’ cross-setting partnerships most commonly consist of providers and agencies most suited to meet the needs of the older adult skill-diminishing facilities, home health and hospice agencies, and agencies on aging.

Hospitals can readily expand their cross-setting partnerships to include providers and health plans who serve a high volume of Medicaid patients, such as:

- Medicaid health plans;
- Medicaid behavioral health carve-out plans;
- Federally qualified health centers;
- Community health centers;
- Behavioral clinics;
- Behavioral health centers;
- Adult care centers;
- Substance use treatment facilities;
- Medical interpreters;
- Translators.

Cross-Continuum Team How To Tool (Tool 12)

Purpose: To advise and assist with the formation of a cross-continuum team.

Description: This tool explains how to form a cross-continuum team and offers a template for inviting partners to join it.

Staff: Quality improvement leadership, cross-continuum teams.

Time required: 1-2 hours (for informing how to convene this team).
Community Partnership Meeting
[Your Organization Here] Readmission Reduction Project

Dear Colleagues,

[Your Organization] invites you to join us at the to improve worst practices and reduce avoidable [Your Organization] is committed to high-quality care settings. [Your Organization] has embraced and has recently made encouraging avoidable readmissions. Our aim is to reduce readmissions by [Goal].

We know that a culture on strong partners share the care of patients in the greater [city].

To that end, we are hosting an open "cross continuum" to create a culture of shared learning, improvement, and accountability.

Please join us. We will be [setting] during the meeting. If you are not able to attend, we welcome you to participate in the discussions.

[Your organization name] - the readmission reduction champion at your site.

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Example Cross-Continuum Team Workplan
Collaborating with cross-continuum providers is a specific and action-oriented strategy to improve transitions in care. Productive cross-continuum collaboration requires forming a team culture of engagement, commitment to shared goals, transparency, and shared accountability.

- Identify partners that will help your hospital achieve quality, satisfaction, and/or efficiency.
- Form and strengthen interprofessional relationships among providers who share common patients.
- Create an open "cross-continuum" team to identify and reduce avoidable readmissions.
- Share best practices and strategies.

Community Resources and Capabilities
- Aligned with your facility's complete PHRAC "Network Readmission Reduction" data
- All providers fill out their part of the "cross-continuum team inventory" within a month
- Group education on best practices
- PHRAC "Network Readmission Reduction" data

Time and Date
- Network meeting
- June 30th, 2023, 10:00 AM
- Location: [Meeting Room]

Additional Resources
- [Website]
- [Contact Information]
Engaging Hospitals in Your Program

Keys to Engaging Your Local Hospitals

1. Transitions in care are critical to patients. Although there are numerous process improvements that INTERACT hospitals can implement to improve care and reduce acute care transfers, safety and effectively sending patient (hospital and receiving hospitals from the provider) is fundamental to improving transitional care. Hospital discharge post-acute care (PAC) is very important and high risk transitions in care setting by definition, effective transition planning and communication is the critical component of both assessing provider and a supervisory tool.

2. The best "landing" in the acute care setting is the meaningful relationship the patient has with his/her health care providers in acute care settings. The INTERACT Version 1.2 Tools include a sample HIP Hospital Transfer Form and a Transfer Document Checklist that can be printed on as an addendum to help guide acute care practices and improve in-patient acute care transitions. INTERACT home health agencies should work with their providers to ensure that high quality information is transferred to the hospital. You will want to establish a relationship with hospital leadership to ensure that information you send is used and improves care quality.

3. INTERACT home health agencies should stand ready to accept the patient back to the home health agency an avoid hospitalizations, if safe and appropriate. On occasion, a skilled nurse will transfer a patient for tests and work but the division and the HHVY should be willing to accept the patient back following the evaluation when safe and appropriate. This represents a significant change for many hospitals and Emergency Rooms (ER). Specific dialog about your home health agency will benefit your discharge. In addition, HHVY should be encouraged to keep INTERACT version 1 HH Capable. Est readily available at these facilities.

4. INTERACT home health agencies can influence improved methods of communication and transitioning patients from hospital to home. HHVY home health agencies, in most states, when using the INTERACT Version 1.2 Quality Improvement Improvement Tool review of acute care transfers that safely return to acute care can often be a result of good hand-off of information regarding the hospital clinical care. Hospital HHVY partnerships to improve information and handoffs will benefit patients, hospitals, and post-acute care home health agencies. INTERACT Version 1.2 tools include Hospital Post-Acute Care Data Last and Sample Form to achieve this goal.

5. INTERACT home health agencies will demonstrate their value added in an increasingly competitive post-acute care business environment. Improving care and reducing re-admissions and preventable hospital transfers will only benefit your patients and your home health agency's 30-day readmission rate, but will also provide valuable information to your referral base. Partnerships with hospitals around preventable hospital utilization and other pricing of services, high quality care embodied in the INTERACT program will be increasingly relevant in a value-based care payment environment. The INTERACT Version 1.2 Hospital Transfer Tracking Tool, used in other similar context, can provide a defined and easy-to-read means in various measures that will help improve partnerships.

Engaging Hospitals in Your Program

Engaging Hospitals Checklist

1. Create a list of all hospitals your home health agency sends patients to receive patients from.

2. Identify the "readmission" chart for each hospital. You cannot easily discover who is leading the effort locally by reaching out to the leaders listed below. Who will know if there is something for readmission for instance, the
   - Chief Quality Officer
   - Chief Medical Officer
   - Chief Nursing Officer
   - Director of Care Management
   - Director of Quality

3. Meet or join a "Care continuum" or Community Care Transitions Working Group or Coalition. Start by inviting key people in these groups to understand your capabilities. Also, attend cross-hospital meetings held by the hospital. It is important to be in person to form and strengthen relationships, but in one phone call preferred.

4. State your HHVY's goals to reduce avoidable hospital transfers, admissions, and readmissions, and link the goals in reduction reduction. Lead with a brief list of numbers.
   - The average number of patients you see from the hospital each month.
   - The current 30-day readmission rate among these patients.
   - Your HHVY's goals to decrease preventable and unnecessary hospital transfers.

5. Describe the suite of quality improvements underway in your home health agency through INTERACT and how you are engaged in making a difference in your community.

6. Ask the hospital to take an active partner in your INTERACT project.
   - Post the INTERACT Version 1.2 Capabilities list in the ER and on the floor case management workstations.
   - Educate ER staff and patient educators about relevant INTERACT forms and tools.
   - Encourage ER physicians to review your transfer forms and consider returning the patient to HHVY if appropriate based on the HHVY Capabilities Checklist.

7. Develop a process to ensure INTERACT forms are sent from HHVY to the hospital care team.
   - Improve hand-off communication between hospital and HHVY using "Warn Rand-ORS" in-patient care.
   - Engage in regular readmission reviews to identify improvement opportunities.

How INTERACT Can Help Your Hospital

As a leader in quality and safety at your hospital, you may be responsible for ensuring that your staff executes safe transitions in care, and that your hospital's readmission rates are not higher than expected. As you know, CMS now penalizes hospitals for higher than expected all-cause 30-day readmission rates for certain conditions. Within 24 months, 535 hospitals will be penalized for higher than expected readmission rates. Penalties for hospitals that are implementing the INTERACT quality improvement program will contribute to reducing preventable admission and readmission rates among this high-risk population.

What INTERACT Home Health Agencies Offer to Hospitals

INTERACT home health agencies are committed to implementing a set of strategies, tools, care process improvements, and related staff education aimed at identifying acute changes in patient care variation and early initiating evaluation and management of these clinical conditions within the home health agency, and preventing hospital transfers when safe and feasible. INTERACT home health agencies will:

- Send an organized and comprehensive set of transitional care information to your ER.
- Participate as a lead of the INTERACT project and capabilities to support providers in developing their decisions whether or not to admit or return to the patient to the home health agency.
- Engage in improving hand-off from hospital to home health agency—through accepting "Warn Rand-ORS", participating in post-discharge follow-up phone calls, regular process improvement meetings, etc.
- Actively engage in a strategic planning in support of the clinical health agency's patients and their families to identify goals.

What INTERACTFacilities Request of Hospitals

- Include INTERACT as part of your hospital's strategy for reducing readmissions
- Provide your ER staff with information about INTERACT
- Encourage your ER staff to learn about and use the INTERACT tools and forms
- When appropriate, consider whether the patient can return to the HHVY forEvaluation
- Develop a scalable process to assess the INTERACT Form from the appropriate team
- Encourage inpatient teams to provide "Warn Rand-ORS" to patients and in-patient care teams
- Engage in regular patient review to identify improvement opportunities

Available at: www.interact2.net
BEST PRACTICES OF CROSS SETTING COLLABORATION

• Shared understanding of (best-available) data
• Shared understanding of patients and caregivers’ perspective
• Shared understanding of “receivers” perspective
• Clear articulation of specific, feasible opportunities for improvement
• Improvements are made & “hardwired” into new standard processes
• Regular meetings, active collaboration and joint problem-solving
OPPORTUNITIES AND RECOMMENDATIONS
VHQC CAN SUPPORT YOUR EFFORTS TO WORK WITH PAC PROVIDERS

Contact Carla Thomas: cthomas@vhqc.org
ADDITIONAL WEBINAR THIS WEEK

• Attend the national launch webinar for the Agency for Healthcare Research and Quality’s Hospital Guide to Reducing Medicaid Readmissions

• This new guide supports hospitals in developing a data-informed and whole-person approach to reducing readmissions, using the “ASPIRE Framework”
  • Tomorrow: Friday September 9 from 3-4:30
  • No cost to attend

• Registration link can be found on Amy Boutwell’s LinkedIn page
RECOMMENDATIONS

1. Know your data: how many discharges and readmissions from PAC?
2. Review 5 readmissions from post-acute care settings
3. Convene a meeting with a group of post acute providers
4. Identify 3 ways the hospital can improve the transition from hospital to PAC
5. Identify 3 ways the PAC provider(s) can reduce acute care transfers
QUESTIONS?
THANK YOU FOR YOUR COMMITMENT TO REDUCING READMISSIONS

Amy E. Boutwell, MD, MPP
Advisor, VHHA Center for Healthcare Excellence
President, Collaborative Healthcare Strategies
amy@collaborativehealthcarestrategies.com