HOME IS THE HUB
An Initiative to Accelerate Progress to Reduce Readmissions in Virginia
The Readmissions Reduction Playbook
February 28, 2017
OBJECTIVES:

1. Understand the need to continue efforts to reduce readmissions in Virginia.

2. Understand how to utilize the high-leverage strategies discussed in the Home is the Hub Readmissions Reduction Playbook to build on the “portfolio” of strategies at your hospital.

3. Identify at least one action to take in follow up to this presentation.
AGENDA

1. VHHA Statewide Strategic Improvement Priorities – Abraham Segres
2. Readmissions Reduction Case Study - Mr. Peter Mulkey
3. Readmissions Reduction Playbook – Dr. Amy Boutwell
4. Insights from HQI – Carla Thomas
5. Discussion/Questions - Audience
6. Closing Remarks - Abraham Segres
VHHA BOARD OF DIRECTORS’
2015-2020 QUALITY/SAFETY 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
VIRGINIA HOSPITAL-WIDE READMISSIONS RATE*

*All Payer, All-Cause, Non-Risk Adjusted
VIRGINIA POST-ACUTE TRANSFERS READMISSIONS RATE*

*All Payer, All-Cause, Non-Risk Adjusted
VIRGINIA TOTAL HIP/ TOTAL KNEE READMISSIONS RATE*

*All Payer, Non-Risk Adjusted
2018 Virginia Healthcare and Hospital Association

Peter Mulkey, CEO
Clinch Valley Medical Center
Richlands, VA
Patient Story

- BS is a 64 year old female with CAD, hepatitis C, cirrhosis, hypothyroidism, HTN, CHF/COPD and Type II diabetes. In reviewing her hospital stays in 2016 she had 11 inpatient stays in six months (June through December). She was referred to our Bridge Program where the following problems were identified. She:
  - Did not understand her many health issues and how it impacted her abilities/body and daily living
  - Was on 16 medications and was unable to afford medications
  - Needed continuous oxygen administration, 5 L/NC
  - Refused to utilize home BiPap machine
  - Needed assistance with all of her daily activities, and was severely deconditioned
Patient was placed into our Bridge Program - A partnership was developed with Appalachia Agency for Senior Citizens (AASC). AASC is the “eyes and ears” of the team in the home, they provide in hospital visits and home assessment within 48 hours of discharge.

The following assessments and interventions were made by Team:

- Because she was unable to place on the BiPap at night – a mirror was mounted to her bed facing down so she could place the mask on and remove it safely.
- Initially she was unable to cook her own meals and nutritious (within her diabetes guidelines) were delivered to her home. Logs were maintained regarding BP/BS/Weight and send to physician for in-home adjustments.
- To help with her deconditioning a home exercise program was developed by physical therapy.
- Her Medicare Part D plan were reevaluated to address the cost of medications.
- A primary care provider, who was closer to her home was established (this assisted with compliance).
- DME provider evaluated usage of machine daily with a report to the team.
- Home assessments were made by AASC, daily communication by the team and problems were addressed as they occurred.
Outcome

Since being in the program:

- ZERO hospitalizations in 2017
- Lost 70 LBS (contributing factors)
  - Use of BiPap
  - Meal Plan Program (from AASC)
  - Home Exercise Program
- Medications usage reduced by 50%
- 02 usage at 2 L/NC (from 5 L/NC)
- Daily compliance with BiPap usage
- New Medicare Part D plan which reduced patient copay by 83%
- Is independent in her daily living

She refers to herself as the Engine that could!!!
RESULTS

Hospital Wide 30 Day Readmits

- 2014: 11.8%
- 2015: 10.5%
- 2016: 8.7%
- 2017: 7.8%

Yearly vs. Target - 6.9%
THE READMISSIONS REDUCTION PLAYBOOK

Amy Boutwell, MD, MPP

President
Collaborative Healthcare Strategies
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Readmissions Reduction Playbook
High-Leverage Strategies for Virginia Hospitals and Health Systems

Content from 2016-2017
Inform work in 2018-2020

Dear Colleague:

During development of the Virginia Hospital Association's 2015-2020 Strategic Plan, the VHHA Board of Directors identified reducing statewide hospital readmission rates as one of its top priorities. As a result of staff and board leadership, the Board identified three key action areas to focus energy on:

- 20% by 2020
- Priority Areas:
  - All-cause
  - Post-acute care
  - Hip/knee

VHHA 2015-2020 Strategic Plan:
- 20% by 2020
- Priority Areas:
  - All-cause
  - Post-acute care
  - Hip/knee

About the Authors

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Director, Care Transitions, Virginia Quality Innovation

Dr. Scott is a nationally recognized thought leader in the field of reducing readmissions and improving care at the hospital level. Dr. Scott leads co-developed the Institute for Healthcare Improvement’s (IHI) model to the Virginia Hospital & Healthcare Association (VHHA). The Virginia Hospital & Healthcare Association is a member of the Blue Cross Blue Shield National Alliance, the largest coalition of statewide hospital associations in the United States. She is a frequent speaker at national and state conferences on strategies to improve care and reduce readmissions.

CARRA BRIER, MS, CCM, CMS
Director, Care Transitions, Virginia Quality Innovation

Cara Brier is a well-known partner and leader among Virginia’s care transitions initiatives. As Director of Care Transitions for the Virginia Quality Improvement Organization (VQIO) for the state’s BlueCross BlueShield, Cara oversees a team that supports community-based initiatives to reduce hospital readmissions. In addition, Cara is a Board-certified registered nurse who serves on the Virginia Hospital and Health Care Association’s (VHHA) Care Transitions Task Force. Cara is also a Certified Professional in Healthcare Quality (CPHQ) and currently leads the Virginia Hospital and Health Care Association’s (VHHA) Care Transitions Task Force.
The Playbook:
• 4 sections
• 18 pages
• 1 page per topic
• Skimmable
• Prompt discussion
• Use at meetings
• Refer to webinars as desired
Call to Action: Current State & High Leverage Strategies

The opportunity to accelerate efforts to reduce readmissions in Virginia is clear. In 2016:

- Virginia ranked #4 in US for average amount of readmission penalties per hospital
- 68 of 89 hospitals received a readmission penalty
- Virginia hospitals forfeited $1.6M in readmission penalties

In large part, the magnitude of the impact of readmission penalties in 2016 appears to be due to the expansion of the conditions included in the penalty program, specifically in that year the addition of COPD and hip/knee replacements. Each year that a new condition is added to the penalty program, the impact of the penalties would be expected to increase.

To date, many readmission reduction teams have been focused on targeting readmission reduction efforts only on patients with conditions directly penalized by the Medicare Hospital Readmission Reduction Program. This was a logical place to start. But as the market continues to evolve, it may be wise to identify “high-leverage” strategies that will reduce a broader set of readmissions - mitigating the impact of future changes to the readmission penalty program while building capability for success in future value-based payment arrangements.

What are “high-leverage” strategies? They are data informed and operationally and clinically meaningful, resulting in a plan that can be expected to achieve the VHHA Readmission Priorities of reducing all payer, all cause readmissions by 20% by 2020. Consider the following:

- The average Medicare readmission rate in Virginia is ~18%
- Heart failure readmissions account for only ~5% of all Medicare readmissions
- The 10 diagnoses leading to the most readmissions account for only ~55% of all readmissions
- The readmission rate for all Medicare patients discharged to post-acute care is ~20%
- The readmission rate for multi-visit patients is ~46%

In the VHHA Home is the Hub Initiative, we identified the following as high-leverage strategies:

- Hospital-wide readmissions, with a focus on multi-visit patients;
- Readmissions among patients discharged to post-acute care;
- Readmissions following hip or knee replacement surgery

For more Information:
- Home is the Hub webinar 1: June 2016

Call to Action
- High penalties ➔ call to action
- Be data-informed
- Be strategic
- Anticipate future market
- Build capability ➔ Value
High-Leverage Strategy: Hospital-Wide Readmissions

Key statistics
- The top 10 diagnoses leading to the most readmissions account for ~25% of all readmissions
- Heart failure readmissions account for ~5% of all readmissions
- Adult non-GI Medicaid readmission rates are often as high or higher than Medicare rates
- Readmission rates among patients with any behavioral health comorbidity are 27% higher than patients without a behavioral health comorbidity

Key concepts
- The VHHA Board established a goal of reducing all-cause readmissions by 20% by 2020
- Targeted and generalized efforts are needed to reduce hospital-wide readmission rates
- CMS has issued updated surveyor guidance and proposed changes to the Discharge Planning Conditions of Participation; these form a blueprint of improved transitional care
- Elements of improved transitional care for all patients include screen all patients for readmission risk and post-hospital support needs, directly link to local relief patients to needed post-hospital care, include behavioral Health as part of discharge plan
- Develop transitional care plans that can be realistically implemented by working with patients and their care partners or community resources to develop plans

Recommendations
- Have a process to track and trend all cause and target population specific readmission rates
- Regularly review readmissions to identify root causes and continuously improve strategies
- Identify a caregiver for all hospitalized patients; write the name/number on the whiteboard
- Screen all patients for readmission risk; address disreadmission risks in the discharge plan
- Make appointments; link to clinical, behavioral, social and supportive services

For more information:
- Home is the Hub webinar 1, June 2016
- ASPIRE Guide, Chapter 4 and Tools 8 and 9
- AHA/HRH/HIN Readmission Reduction Whiteboard videos 4, 5, and 6

Hospital-wide Readmissions
- Consider current strategy
- Run your own data
- Do the math
- Is it high-leverage?
- Improve standard care
- Identify & address risks for all
- Review readmissions to learn
Post-Acute Care Readmissions

- 40% all Medicare discharges
- Readmission rate: 20%
- This is high-leverage
- New SNF readmission penalty
- Aligned incentives
- Co-produced outcome
- Takes time to collaborate
Hip/Knee Readmissions

- Top cause of penalties
- Readmissions for medical issues
- 30% readmissions < 5 days
- Provide more guidance
- Who to call
- Dedicated navigator
- Dedicated team
Multi-Visit Patients

• 4 +/- 12 months
• Symptom of unmet need
• Identify the “DOU”
• Address the “DOU”
• Don’t over-medicalize
• Proactive, persistent
• New tool: ED Care Plans
Work in the Emergency Department

- Flag returning patients <30 days
- Last opportunity to avoid readmit
- Notify care team
- Facilitate discharge from ED
- Facilitate return to SNF
- Use ED Care Plans
Special Topic: Working with Payers

Key statistics
- Hospitalizations account for one-third of the $2 trillion spent on healthcare in the US
- Anthem data shows that >40% of readmissions occurred within 7 days of discharge
- Anthem data shows that <2% of their members have 5+ admissions in a 12-month period

Key concepts
- Payers seek to achieve the triple aim: improve care, patient experience and reduce costs
- Payers seek to reduce avoidable hospital use; meet needs in most appropriate care setting
- Payers review daily census tracker which includes: DRG, total admits, total ED visits, readmits, most recent office visit. This information helps them understand hospital team
- Review of daily census may trigger interdisciplinary rounds presentation. Medical Director consultation, case management referral, review eligibility for special services
- Payers seek to know about socio-economic needs, behavioral health, comorbidities and inadequate or lack of caregiver support; recognizing these are readmission risks
- Effective strategies from data and Medicaid programs include: interdisciplinary care, house calls, treat-in-SNF, advanced illness support, navigation, support, 24/7 availability
- Establishing contact prior to discharge increases effectiveness of post-hospital services

Recommendations
- Know what payers are doing to reduce readmissions; meet with them
- Identify a single point of contact of the plan and of the hospital to facilitate collaboration
- Develop and test strategies for collaborating on self-assessment, the transitional care plan, and post-discharge support; test, gather feedback, meet, iterate and improve
- Allow care managers to meet with patients prior to discharge

Working with Payers
- Triple Aim
- Aligned incentives
- Total utilization data
- BH, SDH, isolation important
- Team approach
- Mobilize services
Community Health Workers

- Effective in various programs
- State-wide advisory group
- Whole-person approach
- Don’t over-medicalize
- Effectively engage
- Trusting, helpful relationship
Recommended Action: Know Your Data and Root Causes

Many readmission reduction teams focus their readmission reduction efforts on the "Medicare penalty" conditions – and with good reason. However, hospitals that aim to reduce hospital-wide readmissions will find value in conducting an all cause all payer readmission analysis.

- Which patients are high risk of readmission at your hospital?
  - Do you know your hospital-wide all cause (adult, non-OB) readmission rate?
  - Do you know your all cause readmission rate by payer (Medicare, Medicaid, commercial)?
  - What are the top 10 discharge diagnoses leading to the most readmissions?
    - Any surprises?
  - Do you know your readmission rate for discharges to post-acute care?
  - Do you know how many multi-visit patients you have?
  - What’s the readmission rate for your high-risk target population(s)?

The best data analysis will only ever provide part of the information needed to reduce readmissions. Seek to understand root causes through a patient, caregiver and provider lens:

- Do you know why your patients return to the hospital soon after discharge? Have you asked your readmitted patients and/or their caregivers to describe the events and issues that arose between the day of discharge and the day of readmission?
- Do you seek to identify all of the factors – clinical, non-clinical, social, behavioral, and logistical – that contribute readmission among your patients?

Know Data, Root Causes

- High readmission rates
- High readmission volume
- # readmissions / month
- # readmissions / target pop
- Why do your patients return?

For more information:
- Home is the Hub learning session, November 2016
- ASPIRE Guide Chapter 1, Tools 1 and 2, and webinar 2
- AHA/IMNet HIMN Readmission Reduction Whiteboard video 2, 3
Articulate Your Strategy

• What is happening?
• For which patients?
• How reliably?
• What results do you expect?
• Who are you working with?
• What gaps need to be filled?

Recommended Action: Articulate Your Portfolio of Strategies

Many hospitals have several readmission reduction related efforts underway. Without clear articulation, these efforts have proliferated over time, across departments, service lines, disease-specific programs, accountable care organizations, bundled payment programs. et al. All of these efforts contribute to your goal of reducing hospital-wide readmissions – and can do so even more effectively if you coordinate and align these related efforts as a “portfolio of strategies.”

• Are you aware of all readmission reduction-related efforts at your hospital?
• Are you aware of the readmission reduction resources or efforts across the continuum?
• Do you know which efforts are intended to help which target population?
• Do you have resources in place to track readmission data and identify root causes?
• Do you have efforts in place to improve transitional care for all patients?
• Do you have efforts in place to identify “whole person” transitional care needs?
• Do you have disease-specific programs in place for which conditions?
• Do you have programs in place to address patients with social or behavioral health needs?
• Do you have efforts in place to better collaborate with post-acute care providers?
• Are there gaps that should be addressed to strengthen your portfolio of strategies?

For more Information
- Home is the Hub webinar 6, December 2016
- ASPIRE Guide Chapters 2 and 3 and webinar 3
- ASPIRE tools 3, 4, 6, and 7

Recommendations
- Survey the readmission reduction related efforts within your hospital; use ASPIRE Tool 3
- Survey the readmission reduction related efforts across the continuum; use ASPIRE Tool 4
- Analyze what resources and efforts are in place; articulate your current portfolio of strategies
- Use the survey result and current driver diagram to consider whether there are gaps to fill or opportunities to improve the implementation of existing efforts
- Design a data-informed strategy that is designed to get the results you want to achieve

Readmissions Reduction Playbook / High Leverage Strategies for Virginia Hospitals and Health Systems
Collaborate Across the Continuum

- Skilled nursing facilities
- Home health agencies
- Area agencies on aging
- Behavioral health providers
- Social service agencies
- Payers
- Take the “receivers” perspective
- Is it as easy as it needs to be?
Measure Implementation

• Operational dashboard
• # discharges
• # discharges in target pop
• #/% target pop "served"
• Close the gap
• Track, trend, display
• Use data as a tool for change
Readmission Interview

- Highly recommended
- At least 10
- High-performers → 100%
- Listen to patient, caregiver
- Observe
- Do not over-medicalize
- Part of standard care
Hospital-SNF Collaboration

• Questions for hospitals
• Questions for SNF
• Questions for both
• Identify opportunities
• Action steps

Resource
Hospital to Skilled Nursing Facility Planning Worksheet

This worksheet is a suggested discussion guide to help you identify opportunities for improvement.

1. Know your data and review readmission events
   • Hospitals: Do you track readmissions from SNF's/junior other facilities by facility?
   • SNF Facility: Do you track admissions to the hospital?
   • SNF Facility: Describe how your facility monitors post-hospitalization.
   • Both: Do you review readmissions from SNF? Together?
   • Both: Do you use a closed loop process to involve both hospital and SNF Patient/Families?

2. Identify opportunities for improvement
   • Hospitals: What improvement efforts do you have in place to improve readmission?
   • SNF Facility: What improvement efforts do you have in place to improve readmission?
   • Both: Do you work together to improve readmission?
   • Both: Do you discuss potential partnerships or opportunities for collaboration?
   • Both: Have you considered a one-page tool?
   • Hospitals: Have you considered providing contact information at discharge?
   • Hospitals: Do all SNF patient leave with documented goals of care?
   • Both: Do you jointly review medications to identify any that may be difficult to attain?
   • SNF Facility: Do you use the INR/ACT tools? Which ones?
   • Hospital: If you received here, you trained your ED staff to use INR/ACT tools?

Specific ACTION STEPS we will take to improve our hospital to SNF transitions:

1.
2.
3.
4.
5.
Other Resources

Virginia Hospital & Healthcare Association (VHHA):

Please see the VHHA home in the hot words to access the full curriculum of recorded webinars and presessional webcasts.

  1. Accrediting Hospitals to Reduce Readmissions in Virginia ........... June 2016
  2. Data and Analytics to Support Risk Management Reduction Initiatives August 2016
  3. Post-Acute Care: Building a Community Lifestyle Model September 2016
  4. Improving Care for High-Utilizers (Multi-Valued Learning) .................. October 2016
  5. In-Process Loaner Lenses .................................................. November 2016
  7. ED Based Strategies .......................................................... January 2017
  8. Physician Strategies ............................................................ February 2017
  9. Community Health Workers .................................................. April 2017
  10. Deep Dive Post-Acute Care Strategies .................................... May 2017

VHHA Data and Analytics Services

VHHA supports members to address healthcare as a resource. Each quarter, all hospitals are electronically reporting their inpatient, observation, and emergency department cost per day, revenue, and revenue per discharge. In addition, hospitals contribute data daily on their readmission rates and outcomes. Data, including hospital-level results, access to tools, and useful information on improving patient care, can be found in the Data and Analytics section on the VHHA website. Data and analytics are available at no cost for the users of the system. For additional reporting, please contact contactus@vhha.org or visit the website at vhha.com for useful information and resources. For more information on how to use VHHA Analytics, please visit the user guides available on the VHA Analytics website. For more information on how to use these tools, please contact contactus@vhha.org or visit the website at vhha.com.

- http://www.vhha.com/research/

Health Quality Innovators (HQI)

Please see the Health Quality Innovators (HQI) website to access the resource to access resources, strategies, and tools for health care providers. In a variety of settings, expand their capacity for quality improvement.

- http://www.hqiresources.com/

Agency for Healthcare Research & Quality (AHRQ)

Please see the AHRQ website to access the full curriculum of the ASPRE Guide (Designing and Delivering White Paper Translation Guide: The Hospital Guide to Reducing Hospital Readmissions)

  - ASPRE: Guide
  - ASPRE: Toolkit
  - ASPRE: Webcasts
  1. Introduction & Overview
  2. Analyze Data and Compare Performance
  3. Review & Update Readmission Reduction Efforts
  4. Implement Whole-System Transitional Care for All
  5. Debrief Outcomes Collaboratively with Partners: Aiming for Setbacks
  6. Enhance Services for High-Risk Patients

American Hospital Association’s Health Research & Education Trust (AHA HRET)

Please see the American Hospital Association’s Health Research & Education Trust Hospital Improvement Innovation Network (HIIN) website to access the “Recommendation-Based Webcast Video Series”

  - Introduction
  2. Know Your Data
  3. Understand the Risk Factors
  4. Improve Interventions for All Patients
  5. Develop a Customized Treatment Plan for All Patients
  6. Effectively Communicate with Patients and Their Caregivers
  7. Engaging for Feedback Reduction Readmissions
  8. Deliver Enhanced Services as Needed
  9. Improving Care for High Utilizers
  10. Collaborating with Clinical and Non-Clinical Community Providers and Services
  11. Measure What Has Been Improved

Fiscal and Clinical Excellence Strategies for Virginia Hospitals and Health Systems
QUESTIONS & DISCUSSION

Utilizing the Readmissions Reduction Playbook
INSIGHTS & RESOURCES FROM HEALTH QUALITY INNOVATORS (HQI)

Carla Thomas, MS, CTRS, CPHQ

Director, Care Transitions
Health Quality Innovators
Supporting Your 2018 “Home is the Hub” Activities

February 28, 2018
Action Across Virginia

HQI Virginia Communities:
2014-16 Recruited and In Conversation
Supporting Your Action

Hospital Medicare Readmissions

• Uploaded to Quality Net Exchange
  • Check with your Quality Department

Multiple Interventions

• Data to identify how your improvements can impact larger goals

Partnerships

• Implementing successful post-acute strategies
  • Processes, resources, and measurement
Numerous Hospitals adopting Circle Back with partner SNFs!


Contact HQI

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CLOSING REMARKS
VHHA 2018 READMISSIONS FOCUS AREAS

1. **Execution**: Encourage hospitals and their partners to use Playbook as a guide for utilizing the “Home is the Hub” high-leverage strategies.

2. **Post-Acute**: Pursue standardization of hospital-post-acute transfer communications.

3. **Sepsis**: Provide resources to assist hospitals and their partners with this high-risk readmissions diagnosis.

4. **Disparities**: Provide resources to assist hospitals identify key issues and strategies impacting readmissions for diverse populations.
THANK YOU FOR YOUR COMMITMENT TO IMPROVING CARE!