Partnership for Patients: Reducing Readmissions

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Partnership for Patients

US Department of Health & Human Services and Centers for Medicare & Medicaid Services

New York State Partnership for Patients  
Webinar

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Breakthrough Aims of the Partnership for Patients

40% Reduction in Preventable Hospital Acquired Conditions
– 1.8 Million Fewer Injuries
– 60,000 Lives Saved

20% Reduction in 30-Day Readmissions
– 1.6 Million Patients Recover Without Readmission

Up to $35 Billion Dollars Saved
Questions to Run On

• What is my hospital’s game plan to reduce readmissions by 20% and what is working?
• What is my 2010 baseline for 30-day readmissions my 2013 target for a 20% reduction?
• What activities/successes in New York can I partner with and learn from?
• What action(s) will I take based on these presentations to strengthen my game plan and accelerate progress towards the aim?
1. CMS Innovation Center Investments, up to $1 billion
   - Technical Assistance to Hospitals (Hospital Engagement Networks, like NYSPFP)
   - Community Based Care Transitions Program

2. Programs and platforms of the Department of Health & Human Services – AHRQ, CDC, ACL, HRSA, CMS, ONC, OASH, IHS – VA and DoD

3. Programs and platforms of Partners: AMA, ABMS, AFL-CIO, AHA, NAPH, ANA, N4A, many more
## 2010 Readmission Rates by Payer

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payer-Specific Rate</th>
<th>Total Index Admissions (2009 for Medicaid; 2010 for all others)</th>
<th>Total Readmissions</th>
<th>Number of Readmissions to Prevent to Reach 20% Reduction, Based on 32.85 Million Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>18.7%</td>
<td>14,672,303</td>
<td>2,742,187</td>
<td>548,437</td>
</tr>
<tr>
<td>Medicaid</td>
<td>14.0%</td>
<td>6,004,407</td>
<td>838,412</td>
<td>167,682</td>
</tr>
<tr>
<td>Private Insurers</td>
<td>8.6%</td>
<td>8,527,941</td>
<td>731,101</td>
<td>146,220</td>
</tr>
<tr>
<td>Uninsured Population</td>
<td>10.3%</td>
<td>1,650,410</td>
<td>170,518</td>
<td>34,104</td>
</tr>
<tr>
<td>All Other</td>
<td>12.7%</td>
<td>1,996,018</td>
<td>253,315</td>
<td>50,663</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14.4%</strong></td>
<td><strong>32,851,079</strong></td>
<td><strong>4,735,532</strong></td>
<td><strong>947,106</strong></td>
</tr>
</tbody>
</table>
The Community-Based Care Transitions Program (CCTP, ACA Section 3026)

GOALS:

• Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings

• Improve quality of care

• Reduce readmissions for high risk beneficiaries

• Document measureable savings to the Medicare program

For more information, visit:
http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP
The Community-Based Care Transitions Program Map (CCTP, ACA Section 3026)

Now 47 Sites: CBOs with 200+ hospitals serving 185,500 beneficiaries in 21 states
PfP Readmissions Aim: A Network of Networks for Nationwide Results

QIO-Recruited Communities, CCTP Sites, & ADRC Option D Grantees (as of July 31, 2012)

CCTP Partners with ZIPs (N=32)
CCTP Partners without ZIPs (N=15)
Formal QIO Communities with ZIPs (N=169)
Formal QIO Communities without ZIPs (N=1)
ADRC Option D Communities (N=21)
ZIPs with <= 10 Beneficiaries
CCTP Sites, QIO-Recruited Communities, ADRC Grantees
ZIP Code Level Readmissions per 1000 Medicare Beneficiaries
(January 1, 2011 – December 31, 2011)
HANYS and GNYHA’s Commitment to Reducing 30 Day Readmissions, Thank You!

- **164** Hospitals (CCN’s) Enrolled in the Network
- **138** Hospitals (CCNs) Enrolled in Reducing 30-Day Readmissions
- **31** Hospitals in the **8** CCTP Partnerships in New York State
- Implementation of Continuous Improvement Efforts
  - Conduct chart analysis on readmitted patients
  - Interview patients who have been readmitted and/or their family caregivers
  - Discuss discharge planning and readmissions with community-based providers and other post-hospital care providers
  - Provide hospitals with educational tools such as the Preventable Readmissions analytic reports, Webinars, support from dedicated Project Managers and many more
CMS & HENs are Making Progress in Getting Hospitals to Voluntarily Commit, Report Data and Generate Improvement

<table>
<thead>
<tr>
<th>Hospitals' Stage of Engagement and Results, by PfP Adverse Event Area</th>
<th>Not participating</th>
<th>Engaged, not submitting data</th>
<th>Engaged and submitting data</th>
<th>Outstanding improvement or high performance</th>
<th>Potential mentor hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE</td>
<td>42%</td>
<td>31%</td>
<td>26%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAUTI</td>
<td>29%</td>
<td>20%</td>
<td>47%</td>
<td></td>
<td></td>
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<tr>
<td>CLABSI</td>
<td>34%</td>
<td>22%</td>
<td>38%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>30%</td>
<td>22%</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB-EED</td>
<td>49%</td>
<td>24%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB-Other</td>
<td>58%</td>
<td>21%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PrU</td>
<td>39%</td>
<td>25%</td>
<td>33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readm</td>
<td>24%</td>
<td>21%</td>
<td>54%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>38%</td>
<td>21%</td>
<td>39%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAP</td>
<td>44%</td>
<td>21%</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VTE</td>
<td>45%</td>
<td>22%</td>
<td>32%</td>
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<td></td>
</tr>
</tbody>
</table>
8 CCTP Communities – including 32 Hospital Partners in NY State!

- Rochester General
- Unity Hospital
- Strong Memorial Hospital
- Fingerlakes Health Systems Agency
- Lifespan of Greater Rochester, Inc.
- Visiting Nurse Service
- Adirondack Medical Center
- Champlain Valley Physicians Hospital Med Center
- Ellis Hospital 6 CBOs
- Alice Hyde Medical Center
- Nathan Littauer Hospital
- Columbia Rural Health Consortium
- Green Co. LTC Council
- Seton Health

- The Dale Association
- Allegany County Aging Office
- Brooks Memorial
- WCA Hospital
- Genesee Co. Aging Office
- Chautauqua Co. Aging Office
- Jones Memorial
- Lifetime Care
- Cattaraugus Co. Dept of Aging
- Olean General Hospital
- Orleans Co. Aging Office
- Orleans Community Hospital

- TLC Health Network Lake Shore Health Care Center
- Cattaraugus Co. Dept of Aging

- P2 Collaborative of Western NY

- Institute for Family Health (FQHC)
- Mt. Sinai Hospital
- Mt. Sinai Hospital Queens

- Westfield Memorial
- United Memorial Med Center
- Wyoming Community Hospital
- Wyoming Co. Aging Office
- Community Concern of WNY, Inc.

- 2 home health agencies

- Heights and Hills of Brooklyn

- New York Methodist Hospital
- Brooklyn Housecall Program
- ILS, Inc.
- The Brooklyn Hospital Center
- Interfaith Medical Center

- 5 skilled nursing facilities

- Cobble Hill Health Center
- Albany Memorial Hospital
- St. Peter’s Hospital
- Samaritan Hospital

- EG Visiting Nurse Association
- 4 local Offices for the Aging
Partnership for Patients is About All of Us Doing Things Differently.

We have unprecedented Federal action and coordination.

We have an unprecedented CMMI Investment in taking proven practices to scale.

We are calling for continued unprecedented action and alignment by community-based organizations, hospitals, clinicians, private partners and others.
CCTP and QIO Care Transitions: The Approach

- Convene community partners to improve transitions across the continuum, including social/HCBS providers, hospitals, pharmacy, SNFs, home health, primary care, other post-acute care providers
- Identify major drivers of readmissions and ideal target population through community-specific Root Cause Analysis
- Select interventions best suited to address those drivers and implement for target population identified as at high risk of readmission (in CCTP, with monthly payment for services)
- Use PDSA, rapid-cycle measurement for improvement (e.g., run charts), learning collaboratives and change packages to share successful practices, other continuous improvement tools to adjust target population and/or intervention strategy and improve along the way
- Partner with multiple payers if possible, to serve more patients and reduce more readmissions
Readmissions Reduction
Some Keys to Success

• Build on and spread success within and across networks, including CCTP, QIO, HEN, private efforts, and so on
• Hospitals team with the larger community
• Work closely with QIOs and align with state/local efforts
• Target patient-level interventions to highest risk patients
• Conduct a thorough Root Cause Analysis (RCA) to determine major readmissions drivers, not just top diagnoses
• Make greater patient engagement and enhanced role of family caregivers a core focus
• Choose your interventions based RCA findings
Other Activities in NYS

- 8 Communities formally working with the QIO, IPRO, to improve care transitions and reduce readmissions (202 Nationwide including 661 Hospitals, 1584 SNFs, 532 HHAs, 118 Dialysis, 273 Hospices)
- United Hospital Fund Next Step In Care Transitional Care Quality Improvement Collaborative
- 13 CMMI Health Care Innovation Awards
- Comprehensive Primary Care Initiative
- Multiple Accountable Care Organizations (ACOs), including 1 Pioneer ACO
- Health IT: Strong Regional Extension Centers (RECs), Health Information Exchange (HIE)
- Aligning Forces for Quality (AF4Q)
- AHRQ Chartered Value Exchange
- Others??
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Resources

• CMS Innovation Center Initiatives: http://www.innovations.cms.gov

• Join the PfP Community of Practice: http://healthcarecommunities.org

• NYS Partnership for Patients: https://www.nyspfp.org/

• Free Care Transitions Toolkit and Learning Sessions: http://cfmc.org/integratingcare

• Your Care Transitions Contact at IPRO: Sara Butterfield, RN, BSN, CPHQ: (518) 426-3300, Ext. 104 / sbutterfield@nyqio.sdps.org