STRATEGIES TO REDUCE READMISSIONS

Delivering whole-person transitional care

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Co-Principal Investigator, Designing and Delivering Whole-Person Transitional Care
New York State Partnership for Patients HIIN Readmissions Launch Webinar
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Agenda

- The importance of effectively engaging patients and caregivers
  - Who?
  - Why?
  - How?

- Resources
Objectives

Being patient and caregiver-centered requires us to:

• Understand **who** is at risk of readmission

• Understand **why** patients return to the hospital

• Listen for **all** transitional care needs and readmission risks

• Be **helpful**: facilitate, advocate, connect
WHO

Who is at risk of readmission?
5. READMISSIONS BY PAYER TYPE

Figure 6: All-Payer Readmission Rates by Payer Type, July 2012 to June 2013

Readmission rates varied by payer type; patients with commercial payers had lower readmission rates than those with public payers.

- Commercial (12,749 readmissions)
- Medicare (50,973 readmissions)
- Medicaid (10,643 readmissions)

Payer Type

Statewide rate

Better
<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Medicare (% discharges to)</th>
<th>Medicaid (% discharges to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to Home</td>
<td>55%</td>
<td>84%</td>
</tr>
<tr>
<td>Discharge to SNF/IRF/LTAC</td>
<td>24%</td>
<td>5%</td>
</tr>
<tr>
<td>Discharge to Home with Home Health</td>
<td>14%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010


-- Indicates too few cases to report.
Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011

Anika L. Hines, Ph.D., M.P.H., Marguerite L. Barrett, M.S., H. Joanna Jiang, Ph.D., and Claudia A. Steiner, M.D., M.P.H.

Top 10 Medicaid Dx:
1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. Comp. of pregnancy
5. Alcohol-related
6. Early labor
7. CHF
8. Sepsis
9. COPD
10. Substance-use related

Top 10 Medicare Dx:
1. CHF
2. Sepsis
3. Pneumonia
4. COPD
5. Arrythmia
6. UTI
7. Acute renal failure
8. AMI
9. Complication of device
10. Stroke

Methods:
- Used CCS groupers
- Included OB
Readmission Rate: Any Behavioral Health Condition

Massachusetts Center for Health Information and Analysis, 2016.
Readmissions for Patients with High Utilization

- 4+ hospitalizations/year
- Readmission rate 40% v. 8%
- 74% of discharged to home
- Top Discharge Diagnoses:
  - Mood disorders
  - Schizophrenia
  - Diabetes
  - Chemotherapy
  - Sickle cell
  - Alcohol
  - Sepsis
  - Heart Failure
  - COPD

Massachusetts Center for Health Information and Analysis, 2016
Jiang et al. HCUP Statistical Brief #184 Nov 2014
Ask your patients "Why"

Elicit the personal/caregiver perspective; root causes
Take a "whole person" view of readmission risks, causes

• 41 woman with HIV; hospitalized for pneumonia, started on HIV medications and antibiotics and told to follow up with HIV and PCP providers. Readmitted 8 days later.

• 61 man with 8 hospitalizations this year for shortness of breath returns to the hospital after 10 days with shortness of breath.

• 86 man with recently diagnosed prostate cancer hospitalized initially for abdominal pain, readmitted 1 day after discharge for abdominal pain.

“Billing data aren’t going to tell you whether a patient needed a pharmacy intervention, needed a place to live, or couldn’t afford their medications.”
41 woman with HIV hospitalized with pneumonia

- **1st hospitalization:**
  - Longstanding HIV, never previously hospitalized
  - Diagnosed with pneumonia, found to have high HIV viral load
  - Lives with mother – unaware of her HIV

- **At discharge:**
  - Discharged on new anti-retroviral medications
  - Discharged on new antibiotics for the pneumonia
  - No infectious disease or primary care appointments made

- **Readmission:**
  - Returned 8 days later for persistent coughing
  - Returned because instructions said return if symptoms don’t improve
  - “It would have helped if they made the appointment for me”
61 man with 8 hospitalizations this year for SOB

- 1st hospitalization:
  - This really isn’t his “first” hospitalization, is it?
  - Intern H&P presents case as if new presentation to hospital
  - Discover he is marginally housed
  - Discover he has personality disorder issues
  - Refuses to work with physical therapy

- At discharge:
  - Patient can not be placed in facility due to a criminal history
  - Discharged to “home,” told to follow up with PCP (hasn’t been in > a year)

- Readmission:
  - Reports he gained 20 lbs in 8 days
  - “Oh honey, it always takes them about a week to tune me up”
  - Grabs remote, turns on TV and orders dinner
86 man with prostate cancer and abdominal pain

- 1\textsuperscript{st} hospitalization
  - Completed diagnosis and staging evaluation as outpatient
  - Started on oxycodone as needed for pain
  - Patient presented with constipation x 8 days
  - Resolved in ED; admitted anyway
- At discharge
  - Added bowel regimen
- Readmission
  - Daughter in NJ dropped everything to rush to dad’s side
  - Saw him at home and asked if he had any pain; he said yes
  - She brought him back to ED requesting admission to address pain
  - Patient did not want to be readmitted, but did not want to argue with loving daughter
Do not over-medicalize root causes of readmissions

- Kaiser Permanente team reviewed 523 readmissions across ~14 hospitals:
  - Found an average of 9 factors contributed to each readmission

- Philadelphia team interviewed patients who returned to ED after discharge:
  - Average age 43 (19-75)
  - Majority had a PCP; most reported no problem filling medications

- Found primary root cause for return: fear and uncertainty
- Patients need more reassurance during and after episodes of care
- Patients need access to advice between visits

Feigenbaum et al Medical Care 50(7): July 2012
HOW?

Adopt a data-informed, whole-person approach
What is a "Data-Informed" Approach?
Why Take A Data-Informed Approach?

- Many readmission reduction efforts have been launched in direct response to Medicare readmission penalties.

- The discharge diagnoses in the penalty program are not the top reasons for readmissions in the Medicare population.

- There are many high risk patients that go without improved transitional care when the focus is just on penalty conditions.

- **A data-informed approach is a more patient-centered approach.**
Data-Informed Approach

• Understand root causes of readmissions among your patients

• Design and implement readmission reduction efforts that are designed to address common root causes of readmissions

• Design and implement readmission reduction efforts that will effectively meet the transitional care needs of patients/caregivers

• Track implementation and outcome data to continuously improve processes to reach your goal

► A data-informed approach is responsive to root causes and is designed to better meet patient/caregiver transitional care needs
Why Take a "Whole-Person" Approach?
Whole-Person Approach

Analyses highlight the multi-factorial causes of readmissions

- Patient interviews
- Root cause analysis

Experience in the field has found success with transitional care models that address clinical, behavioral, and social needs

- Interdisciplinary, social work, social service models appear effective
- Several "clinical" approaches have been adapted to include social work, navigation, advocacy, resources to address basic needs
"Whole-Person" Adaptations to Transitional Care

- Navigating
- Hand-holding
- Arranging for…
- Providing with…
- Harm reduction
- Meet "where they are"
- Patient/caregiver priorities first
- Relationship-based
Whole-Person Approach

- Successful readmission reduction teams state:
  - "We look at the whole person, the big picture"
  - "We always address goals and ask what the patient wants"
  - "We meet the patient where they are"
  - "First and foremost it's about a trusting relationship"
  - "You can't talk to someone about their medications if there is no food in the fridge"
  - "We do whatever it takes"
Using Care Plans to Improve Care Over Time and Across Settings
Types of Care Plans: Observations from the Field

• **Longitudinal Care Plan**
  - A comprehensive plan to achieve health-promoting goals and objectives. Specific goals regarding clinical, behavioral, and/or functional status are often included, and are measured via serial assessments over time. Longer term; care management over time.

• **Transitional Care Plan**
  - Identifies post-hospital needs, patient priorities, and readmission risks and the plan to address those needs, priorities and mitigate risks in the 30 days post discharge. Focus on ensure linkage to providers and services within the 30 day transitional period.

• **ED Care Plan**
  - Summary information for the ED provider to inform safe, effective, and consistent care in the ED and facilitate discharge with team-based follow up, as appropriate.
RESOURCES

"Designing and Delivering Whole-Person Transitional Care: The AHRQ Hospital Guide to Reducing Medicaid Readmissions"
List of Tools

The guide comes with 13 customizable tools to be used in hospital teams' day-to-day operations.

1. Data Analysis
2. Readmission Review
3. Hospital Inventory
4. Community Inventory
5. Portfolio Design
6. Operational Dashboard
7. Portfolio Presentation
8. Conditions of Participation Handout
9. Whole-Person Transitional Care Planning
10. Discharge Process Checklist
11. Community Resource Guide
12. Cross Continuum Collaboration
13. ED Care Plan Examples

https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html
**Tool 1: Data Analysis Tool**

### Hospital-wide All Condition, All-Payer, and Payer-Specific Readmission Analysis (adults, non-Ob)

<table>
<thead>
<tr>
<th>Total Readmission Rate</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># of readmissions</td>
<td>1500</td>
<td>1500</td>
<td>1500</td>
<td>4500</td>
</tr>
<tr>
<td># of discharges</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>3000</td>
</tr>
<tr>
<td>% of readmissions on day 0</td>
<td>30.0%</td>
<td>30.0%</td>
<td>30.0%</td>
<td>30.0%</td>
</tr>
</tbody>
</table>

### Top 10 Discharge Diagnoses Leading to Highest Number of Readmissions

<table>
<thead>
<tr>
<th>Diagnosis Category</th>
<th># of Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>100</td>
</tr>
<tr>
<td>Nephritis</td>
<td>50</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>25</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>20</td>
</tr>
<tr>
<td>Acute Rheumatic</td>
<td>15</td>
</tr>
<tr>
<td>Cerebrovascular</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>300</td>
</tr>
</tbody>
</table>

### Days between Discharge and Readmission (patient, non-Ob)

- % of readmissions on day 0: 30.0%
- % of readmissions in 1-4 days: 20.0%
- % of readmissions in 5-14 days: 10.0%

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**Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions**

Collaborative Healthcare Strategies
Tool 2: 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 during planning
- Review all readmissions
IMPROVING TRANSITIONAL CARE FOR ALL PATIENTS

CMS has recommended that hospitals should do the following to improve discharge planning - now referred to as “transitional care.” These expectations apply to Medicare and Medicaid patients:

- Have a documented discharge planning process, approved by the hospital’s governing board;
- Provide discharge planning for all inpatients, observation patients, and certain ED patients;
- Analyze and track readmission rates;
- Review readmissions to look for patterns;

- Conduct root cause analyses on readmissions to assess whether the discharge planning process meets patients’ needs;
- Craft a discharge plan that can be realistically implemented;
- Actively solicit the input of the patient and family/friends/support persons;
- Address behavioral health follow up as part of the discharge plan;
- Provide customized education to patients and their caregivers;
- Provide verbalized instructions using the teach-back technique;
- Arrange for (not just refer to) post-hospital services;
- Know the capabilities of post-acute and community-based providers, including Medicaid home-and community-based services;
- Provide patients data to help inform their choice of high quality post-acute providers;
- Know options for Medicaid long-term services and supports, or have a contact at the State Medicaid agency that can assist with these issues; and
- Follow up with high risk patients after discharge.

[Our hospital] is working to meet these expectations – and we need your help! Please contact your manager or supervisor if you have feedback or ideas to improve how we deliver safe and high quality transitional care to all of our patients. For more information, contact [Readmission Champion].

DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE: THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS
Tool 9: Whole-Person Transitional Care Planning

WHOLE-PERSON CARE TRANSITIONAL PLANNING TOOL

Readmission Risks and/or Post-Hospital Needs
Uncover patient’s nonclinical issues and challenges in accessing post-hospital care to prevent avoidable hospitalizations in the future.

ACCESS TO AMBULATORY CARE
- No regular source of care
- Difficulty with transportation to medical care
- Work/family responsibilities pose barrier to appointments
- Regular use of emergency room for care

ACCESS TO BEHAVIORAL HEALTH CARE
- History of receiving behavioral health services
- Concern about emotional or mental health
- Alcohol or drugs affecting health and wellness
- Needs linkage to behavioral health services

FUNCTIONAL STATUS
- Functional limitations
- Cognitive limitations, including executive function
- Low self-activation or self-efficacy
- Disabled, may qualify for ADRC or other services

UNSTABLE/INADEQUATE HOUSING
- Lack of stable housing
- Lack of heat or cooling
- Environmental hazards affecting health (mold, etc.)
- Lack of safety and security within or outside the home

FINANCIAL INSECURITY
- Difficulty paying for basic survival needs (clothing, food)
- Difficulty paying medical-related costs (copays, supplies)
- Must prioritize survival versus medical needs

FOOD INSECURITY / ACCESS
- Lacks access to adequate amounts of food
- Lacks access to nutritious or medically appropriate diet

SOCIAL CONNECTION/ISOLATION
- Lives alone
- Lacks friends/family/connections

LEGAL ISSUES
- Barriers due to coverage, utilities, pending eviction
- Recent or repeated incarceration or detention

LANGUAGE OR LITERACY ISSUES
- Low literacy, low numeracy
- Low health literacy—diagnoses, medications, care plan
- Low or no ability to speak English

Actions to Take Prior to Discharge
Use the improvement motto, “See a problem, fix a problem.” This list represents possible interventions you may identify for a patient. Modify it to meet the most common needs for your patient population.

INTERDISCIPLINARY CARE PLANNING AND COORDINATION
- Obtain high risk readmission team consult
- Contact an MCO, ACO, FQHC, Health Home care manager, as applicable
- Contact community clinical, behavioral and social service providers
- Obtain pharmacist consult
- Obtain social work consult
- Obtain pain management or palliative care consult, as applicable
- Obtain psychiatry consult, as applicable
- Develop individualized transitional care plan
- Share plan with ED, patient providers, community service providers

PROVIDE SERVICES
- Identify whether eligible for (Medicaid) health home and contact health home to initiate screening and enrollment process
- Contact MCO, ACP, FQHC, Health Home medical director if high risk patient is not currently in care management to advocate for enhanced services
- Arrange for bedside delivery of medications
- Discuss cost of medications, how will obtain, and modify as needed
- Discuss transportation and arrange as needed
- Offer to provide transitional care follow up services (if available)

ARRANGE FOR NEXT STEPS
- Ensure all patients have a PCP or temporary provider (“bridge” clinic)
- Schedule follow up with primary care provider
- Schedule follow up with relevant specialists
- Schedule follow up with behavioral health provider
- Initiate initial eligibility screen for services (health home, adult day, etc) or allow social/support service entity to screen patient prior to discharge
- Ask for best contact number for purposes of post-discharge follow up call

LINK TO POST-HOSPITAL SUPPORTS AND SERVICES
- Link to transitional care navigating and support services for 30 days
- Link to community behavioral health services
- Link to community health worker or navigator programs
- Link to housing with services agency
- Link to food program
- Link to county health department provided services
- Link to community/family-based or volunteer services
- Link to Medical Legal Partnership
- Link to Adult Day Health
- Link to language concierge navigation or advocacy services
# TOOL 10: DISCHARGE CHECKLIST

This checklist is a tool to promote optimal adherence to the processes and practices outlined as guidance and/or proposed updates to the CMS Discharge Planning Conditions of Participation. Review your current processes to identify the extent to which you current processes – including written discharge information and documentation – adhere to the intent of these discharge process elements. In addition, hospitals should have a written discharge process; regularly review readmissions to identify root causes of readmissions; use those insights to continually improve the discharge process.

<table>
<thead>
<tr>
<th>Hospitals Must Provide the Following...</th>
<th>Details Per the CMS 2013 Surveyor Guidance and 2015 Proposed Rule Documents</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A discharge plan for all inpatients and observation patients</td>
<td>As specified in the November 2015 proposed Discharge Planning COPs*</td>
<td></td>
</tr>
<tr>
<td>2. A brief reason for hospitalization and principal diagnosis</td>
<td>Many patients do not know why they were in the hospital.</td>
<td></td>
</tr>
<tr>
<td>3. A brief description of hospital course of treatment</td>
<td>Many patients do not know what was done for them in the hospital.</td>
<td></td>
</tr>
<tr>
<td>4. The patient's condition at discharge</td>
<td>Include cognitive function* Include functional status* Include social support structure*</td>
<td></td>
</tr>
<tr>
<td>5. Specifically address comorbid behavioral health conditions</td>
<td>Include plan for follow up care for behavioral health conditions*</td>
<td></td>
</tr>
<tr>
<td>6. A medication list – an actual list of medications, not a referral to the list in the medical record*</td>
<td>Identify changes made during the patient's hospitalization*</td>
<td></td>
</tr>
<tr>
<td>7. A list of allergies</td>
<td>Food allergies* Drug allergies and drug intolerances*</td>
<td></td>
</tr>
<tr>
<td>8. Pending test results</td>
<td>When the results are expected* How to obtain the test results*</td>
<td></td>
</tr>
<tr>
<td>9. A copy of the patient's advance directive</td>
<td>Applicable when the patient is being transferred to another facility*</td>
<td></td>
</tr>
<tr>
<td>10. A brief description of care instructions</td>
<td>Customized instructions for self-care* Consistent with the training provided to patient and caregiver*</td>
<td></td>
</tr>
<tr>
<td>11. Effectively link patients to post-hospital clinical, behavioral and social services</td>
<td>The hospital must demonstrate knowledge of capabilities of the hospital, and community providers, including Medicaid providers, and social services providers*</td>
<td></td>
</tr>
</tbody>
</table>
THANK YOU FOR YOUR COMMITMENT TO REDUCING READMISSIONS

Amy E. Boutwell, MD, MPP  
President, Collaborative Healthcare Strategies  
Co-Principal Investigator, AHRQ Reducing Medicaid Readmissions Project  
Expert Advisor, New York State DSRIP Super Utilizer Collaborative  
Amy@CollaborativeHealthcareStrategies.com  
617-710-5785