Ideas to Consider to Move the Readmissions “Needle”

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Health Services Advisory Group of California, Inc.
(HSAG-California)
HSAG-California: Your Partner in Health Care Quality

- HSAG-California is the Medicare Quality Improvement Organization (QIO) for California.
- The QIO Program is the largest federal program dedicated to improving health quality at the community level.
- QIOs are a major force and trustworthy partner for improvement.
- QIOs in every state and territory are united in a network administered by the Centers for Medicare & Medicaid Services (CMS).
Readmission Resources
www.noplacelikehomeca.com

No Place Like Home
CAMPAIGN
... reducing hospital readmissions because there really is no place like home.

Get Readmission Data Here!

California Providers are Committed to Reducing Readmissions

The Centers for Medicare & Medicaid Services (CMS) has tasked Health Services Advisory Group of California, Inc. (HSAG-CA), California’s Medicare Quality Improvement Organization (QIO), to work with partners throughout the state to assist communities with reducing avoidable hospital readmissions.

Following a hospital stay, 18.9 percent of Medicare beneficiaries in California are rehospitalized within 30 days of discharge. The No Place Like Home Campaign brings together hospitals, rehabilitation and skilled nursing facilities, hospices, home health, pharmacies, clinicians, community-based organizations, and other care providers in a robust, intense effort to reduce hospital readmissions. It takes a community to coordinate care for Californians!

Join California’s Efforts to Reduce Hospital Readmissions NOW!

California Readmission Goals

1. Prevent 30,000 avoidable 30-day hospital readmissions by July 2014.

2. Reduce the overall readmission rate for Medicare beneficiaries by 20 percent (based on claims data from Medicare 2010).


Highlights

The Medicare Quality Improvement Organization for California
HSAG-CA provides information regarding California’s 30-day readmissions by region for Medicare Fee-for-Service beneficiaries. Hover over the region of interest on the map to view the region’s readmission rate. Click on the region number to download the 17-page regional readmission report reflecting data from October 1, 2011 through September 30, 2012. Updated reports reflecting calendar year 2012 are scheduled to be posted July 2013.
# 2013 Events Calendar

www.noplacelikehomeca.com

## August

<table>
<thead>
<tr>
<th>County</th>
<th>Date</th>
<th>Type of Event</th>
<th>Event</th>
<th>Time</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>8/1/2013</td>
<td>Webinar</td>
<td>Advancing Excellence Webinar: Getting started with the AE Hospitalization Goal - Time to Act</td>
<td>11 a.m. – 12 p.m. PST</td>
<td>Register</td>
</tr>
<tr>
<td>N/A</td>
<td>8/8/2013</td>
<td>Webinar</td>
<td>Shining Stars Webinar: ARC - Avoiding Readmissions through Collaboration, California</td>
<td>12 – 1 p.m. PST</td>
<td>1-866-639-0744 <a href="https://qualitynet.webex.com">https://qualitynet.webex.com</a> password: community</td>
</tr>
<tr>
<td>N/A</td>
<td>8/14/2013</td>
<td>Webinar</td>
<td>LAN Discovery Learning Series: Showing Improvement</td>
<td>12 – 1 p.m. PST</td>
<td>1-877-691-6020 <a href="https://qualitynet.webex.com">https://qualitynet.webex.com</a> password: improvement</td>
</tr>
<tr>
<td>Fresno</td>
<td>8/15/2013</td>
<td>Community Meeting</td>
<td>Fresno Quarterly Care Transition Collaborative Meeting</td>
<td>9 a.m. – 11:30 a.m. PST</td>
<td>Registration Link</td>
</tr>
<tr>
<td>Kern</td>
<td>8/21/2013</td>
<td>Community Meeting</td>
<td>Kern County Quarterly Care Transition Collaborative Meeting</td>
<td>9 – 11:30 a.m. PST</td>
<td>Registration Link</td>
</tr>
<tr>
<td>Riverside</td>
<td>8/22/2013</td>
<td>Work Group</td>
<td>Inland Empire Readmissions Workgroup</td>
<td>2 – 3:30 p.m. PST</td>
<td>For more information, please contact Lindsay Holland.</td>
</tr>
<tr>
<td>N/A</td>
<td>8/27/2013</td>
<td>Webinar</td>
<td>Transformational Event: Getting in the Mindset</td>
<td>12 – 2 p.m. PST</td>
<td>1-877-691-6020 <a href="https://qualitynet.webex.com">https://qualitynet.webex.com</a> password: improvement</td>
</tr>
<tr>
<td>Orange</td>
<td>8/28 – 29/2013</td>
<td>Symposium</td>
<td>CAHF Quality Symposium</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Ideas to Consider: Hand-Off/Transfer Communication

- Use a community universal transfer form.
- Establish communication expectations.
- Share provider contact information.
- When a readmission occurs, have the post-acute provider call the hospital to discuss the case.
- Consider INTERACT (Interventions to Reduce Acute Care Transfers).
  - Nursing home capabilities list
  - Talk to physicians using SBAR
  - Track process and outcomes data
Advancing Excellence Campaign
www.nhqualitycampaign.org

## Hospitalizations

<table>
<thead>
<tr>
<th>Explore Goal</th>
<th>Identify Baseline</th>
<th>Examine Process</th>
<th>Improve</th>
<th>Leadership</th>
<th>Monitor &amp; Sustain</th>
<th>Celebrate</th>
</tr>
</thead>
</table>

Now that you know what you want to improve, it's important to identify your starting point or baseline. Download the data tracking tool and collect data for a month or so to determine your starting point.

**Safely Reduce Hospitalizations Tracking Tool**

This tool calculates rates for 30-day Readmission, Hospital Admissions, Transfers to Emergency Only, and Transfers Resulting in Observation Stay. This tool also has features that allow you to track patterns and processes affecting your hospital transfers.

[AE_SafelyReduceHospitalizationsTrackingTool_v3.0_6-19-13.xls](AE_SafelyReduceHospitalizationsTrackingTool_v3.0_6-19-13.xls)
# 30-Day Readmission Outcomes Calculated

## January 2013

### Status at Time of Admission from Hospital

<table>
<thead>
<tr>
<th></th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care (non-Medicare)</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Residents with Date of Discharge from Hospital in This Month</td>
<td>12</td>
<td>46</td>
<td>58</td>
</tr>
<tr>
<td>30-Day Readmission Rate percent of those readmitted to hospital within 30 days of the date of discharge from hospital</td>
<td>41.7%</td>
<td>30.4%</td>
<td>32.8%</td>
</tr>
</tbody>
</table>

### Purpose of Stay at Time of Transfer to Hospital

<table>
<thead>
<tr>
<th></th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Days This Month Your ADC x the number of days in the month</td>
<td>1147</td>
<td>3472</td>
<td>4619</td>
</tr>
<tr>
<td>Hospital Admission Rate per 1000 resident days</td>
<td>6.1</td>
<td>4.9</td>
<td>5.2</td>
</tr>
<tr>
<td>Rate of Transfers to Emergency Department Only per 1000 resident days</td>
<td>2.6</td>
<td>2.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Rate of Transfers Resulting in Observation Stay per 1000 resident days</td>
<td>2.6</td>
<td>2.3</td>
<td>2.4</td>
</tr>
</tbody>
</table>
Track Patterns

- Admissions by day of week
- Transfers by time of day
- Transfers by clinician
  - Five clinicians who order the most transfers
- Transfers by reason
- Hospitals admitting
Track Patterns (cont’d)

Transfers by Time of Day

Transfers by Clinician
for the 5 doctors who order the most transfers
Ideas to Consider: Education

- Patient and Family Education
  - San Diego patient/family education brochure
  - INTERACT family education handout “Deciding About Going to the Hospital” (benefits and risks of going back to the hospital)

- Provider Education—Shared Accountability
  - Antelope Valley Physician Orders for Life-Sustaining Treatment (POLST) education
Enhanced Home Health Program

A minimum of seven touch points to occur within the first two weeks of discharge.

Week 1

1. In-Patient: Introduction phone call or hospital visit
   - 24 – 48 hours prior to discharge

2. Home Visit #1: Includes medication reconciliation, assessment, education, and involving other disciplines
   - Day after discharge

3. Tuck-in Phone Call #1: Identify red flags and schedule next home visit
   - 1st Friday patient is at home

4. Home Visit #2: Includes medication compliance, vitals, assessment, and scheduling next home visit
   - 1st weekend patient is at home

Week 2

5. Home Visit #3: Includes medication compliance, vitals, and well-being assessment
   - Monday – Thursday Minimum of one home visit

6. Tuck-in Phone Call #2: Address questions and schedule next home visit
   - 2nd Friday patient is at home

7. Home Visit #4: Includes medication compliance, vitals, and well-being assessment
   - 2nd weekend patient is at home

Schedule additional home health visits as needed
Expensive But Effective Interventions

- Care Transitions Intervention (CTI) coaching model.
- Nurse practitioners seeing patients in nursing homes.
- Who can pay for these services?
We cannot reach our goal without shared accountability throughout the community.
Thank You!

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818-409-9229
We convene providers, practitioners, and patients to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care; increases in population health; and decreases in healthcare costs for all Americans.

www.hsag.com

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