Institute *for* Healthcare Improvement

This presenter has nothing to disclose

Setting the Stage

Eric Coleman

September 28, 2015

Session Objectives

After this session participants will be able to:

- Understand the context and common problems that contribute to patients being readmitted to the hospital within 30 days of discharge
- Describe IHI's approach to improving care transitions and reducing avoidable readmissions

The Major Challenges

- Potentially preventable rehospitalizations are prevalent, costly, burdensome for patients and families and frustrating for providers
- No one provider or patient can “just work harder” to address unplanned rehospitalization
- Our delivery system is highly fragmented - providers often act in isolation and patients are usually responsible for their own care coordination
- Most payment systems reward maximizing units of care delivered rather than quality care over time

The Chinese Symbol for Crisis

Danger

Opportunity

Opportunities

- Many re-hospitalizations are avoidable
- Nationally we are making progress
- Keys to reducing re-admissions include:
  - Not focusing on the hospital alone
  - Aligning financial incentives
  - Addressing systematic barriers
  - Fostering leadership at the multiple levels

What Can Be Done and How?

A growing number of approaches to reduce 30-day readmissions have been successful locally

Which are high leverage?

Which are scalable?

Success requires engaging clinicians, providers across organizational and service delivery types, patients, payers, and policy makers

How to align incentives?

How to catalyze coordinated effort?

Determinants of Preventable Readmissions

- Preventable readmissions have hallmark characteristics of healthcare events prime for intervention and reform
- Patients with generally worse health and greater frailty are more likely to be readmitted
- Identification of determinants does not provide a single intervention or clear direction for how to reduce their occurrence
- There is a need to:
  - Address the tremendous complexity of contributing variables
  - Identify modifiable risk factors (patient characteristics and health care system opportunities)

Determinants of preventable readmissions in United States: a systematic review. Implementation Science 2010, 5:88

The Bad News: There are No "Silver or Magic Bullets"!

….no straightforward solution perceived to have extreme effectiveness

Conclusion: "No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization."

Hansen, Lo, Young, RS, Keiki, h, Leung, A and William, MV, Interventions to Reduce 30-Day Rehospitalizations: A Systematic Review, *Ann Int Medicine 2011; 155:520-528.*

The Good News: There Are Promising Approaches to Reduce Rehospitalizations

- **Improved transitions out of the hospital**
  - Project RED
  - BOOST
  - IHI's Transforming Care at the Bedside and STAAR Initiative
  - Hospital to Home "H2H" (ACC/IHI)
- **Reliable, evidence-based care in all care settings**
  - PCMH, INTERACT, VNSNY Home Care Model
- **Supplemental transitional care after discharge from the hospital**
  - Care Transitions Intervention (Coleman)
  - Transitional Care Intervention (Naylor)
- **Alternative or intensive care management for high risk patients**
  - Proactive palliative care for patients with advanced illness
  - Evercare Model (APNs)
  - Heart failure clinics
  - PACE Program; programs for dual eligibles
  - Intensive care management from primary care or health plan

POPULATION HEALTH MANAGEMENT
Volume 0, Number 0, 2015

DOI: 10.1089/pop.2015.0005

Commentary

Cross-Continuum Collaboration in Health Care: Unleashing the Potential

Saranya Loehrer, MD, MPH,[1] Douglas McCarthy, MBA,[2,3] and Eric A. Coleman, MD, MPH,[4]
for the Cross-Continuum Study Panel[5]

Effective collaboration among health care providers requires:

- Trusted convener (individual or organization)
- Cultivation of trust (common goals)
- Shared understanding of the challenges faced by each participant (site visits and shadowing)
- Starting small and building on early progress
- Expand type of participants as needs arise
- Data to identify opportunities for improvement
- Focusing on patients' needs and experiences

Loehrer S, McCarthy D, Coleman, EA Population Health Management DOI: 10.1089/pop.2015.0005

Target Populations: Each Have Challenges

1. Medicare
2. Medicaid
3. Dual-eligibles
4. Commercial
5. Uninsured

Discharge Disposition: Medicare & Medicaid

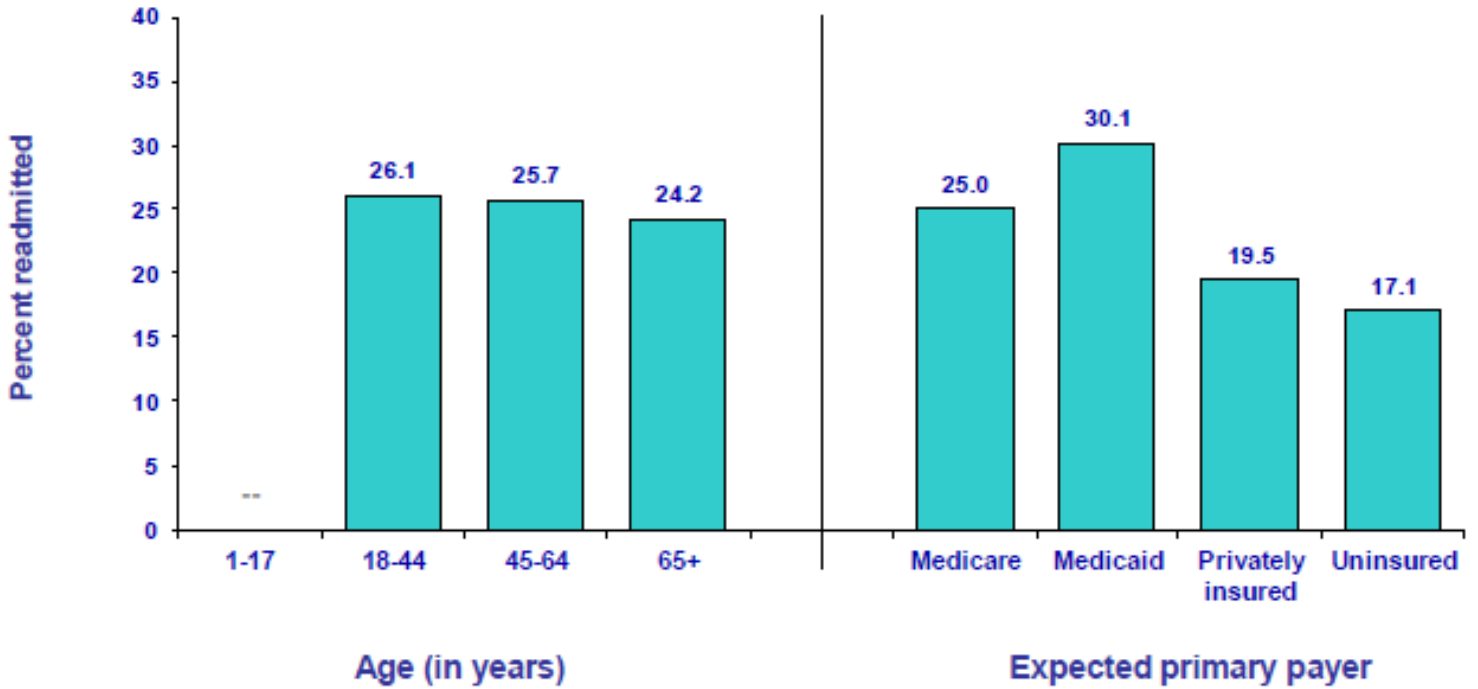
Disposition	Medicare	Medicaid
Discharge to home	55%	84%
Discharge to home with home health	14%	8%
Discharge to SNF, IRF, LTACH	24%	5%
Other	7%	3%

Medicare & Medicaid Top 10 Readmit Dx

Congestive heart failure; nonhypertensive
Septicemia (except in labor)
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)
Chronic obstructive pulmonary disease and bronchiectasis
Cardiac dysrhythmias
Urinary tract infections
Acute and unspecified renal failure
Acute myocardial infarction
Complication of device; implant or graft
Acute cerebrovascular disease

Mood disorders
Schizophrenia and other psychotic disorders
Diabetes mellitus with complications
Other complications of pregnancy
Alcohol-related disorders
Early or threatened labor
Congestive heart failure; nonhypertensive
Septicemia (except in labor)
Chronic obstructive pulmonary disease and bronchiectasis
Substance-related disorders

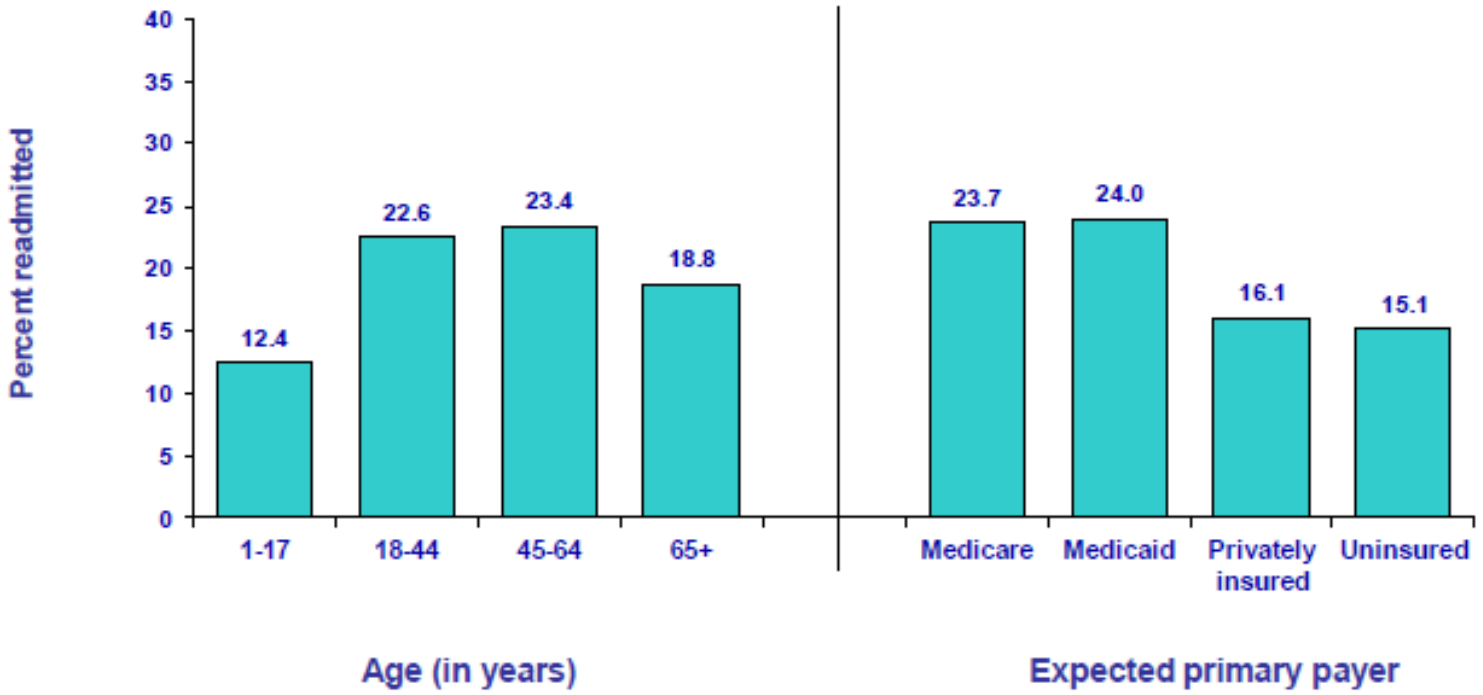
Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

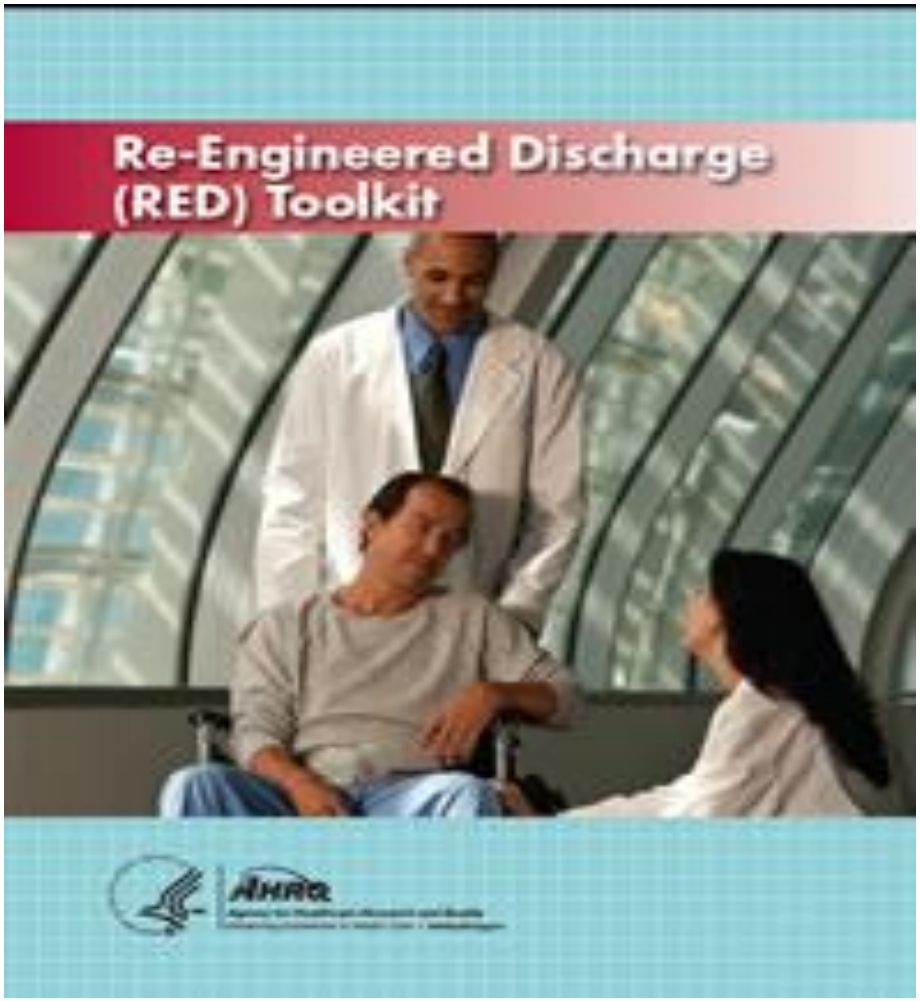
-- Indicates too few cases to report.

Figure 2. All-cause 30-day readmission rates for schizophrenia and other psychotic conditions by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

PROJECT RED
Re-Engineered Discharge

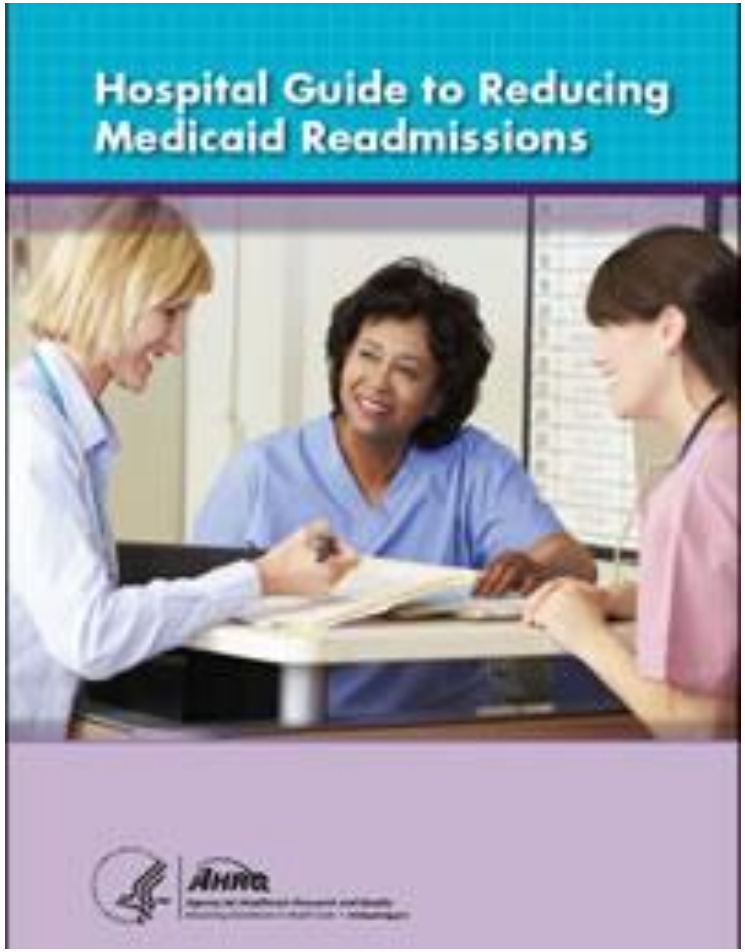


Project RED Safe Discharge Toolkit

Eleven Steps To Implement Project RED

Step 1: Make a Clear and Decisive Statement
Step 2: Identify Your Implementation Leadership
Step 3: Analyze Readmit Rates/Determine Your Goal
Step 4: Identify Which Patients Should Receive the RED
Step 5: Create Your Process Map
Step 6: Revise Workflow to Eliminate Duplication
Step 7: Assign Responsibility for RED Components
Step 8: Train Discharge Educators and Telephone Callers
Step 9: Decide How To Generate the After Care Plan
Step 10: Provide the RED for Diverse Populations
Step 11: Measure the Progress of RED Implementation

AHRQ Guide to Reducing Medicaid Readmissions



Contents

Tools

Tool 1: Data Analysis Tool
Tool 2: Readmission Review Tool
Tool 3: Data Analysis Synthesis Tool
Tool 4: Hospital Inventory Tool
Tool 5: Cross-Continuum Team Inventory Tool
Tool 6: Conditions of Participation Checklist Tool
Tool 7: Portfolio Design Tool
Tool 8: Readmission Reduction Impact/Financial Analysis Tool
Tool 9: Readmission Risk Tool
Tool 10: Whole-Person Assessment Tool
Tool 11: Discharge Information Checklist
Tool 12: Cross-Continuum Team How To Tool
Tool 13: Community Resource Guide Tool

Minnesota RARE Campaign
Mental Health Collaborative

RARE
Reducing Avoidable
Readmissions Effectively

Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders

Journal of Addictive Diseases, 33:340–353, 2014

ISSN: 1055-0887 print / 1545-0848 online
DOI: 10.1080/10550887.2014.969602

Routledge
Taylor & Francis Gro

ENHANCING TRANSITIONS FROM ADDICTION TREATMENT TO PRIMARY CARE

Michael A. Cucciare, PhD[1,2,3], Eric A. Coleman, MD, MPH[4], Richard Saitz, MD, MPH[5,6], Christine Timko, PhD[7,8]

Primary Health Care Research & Development 2014; **00**: 1–14
doi:10.1017/S1463423614000164

RESEARCH

A conceptual model to facilitate transitions from primary care to specialty substance use disorder care: a review of the literature

Michael A. Cucciare[1,2], **Eric Coleman**[3] and **Christine Timko**[4,5]

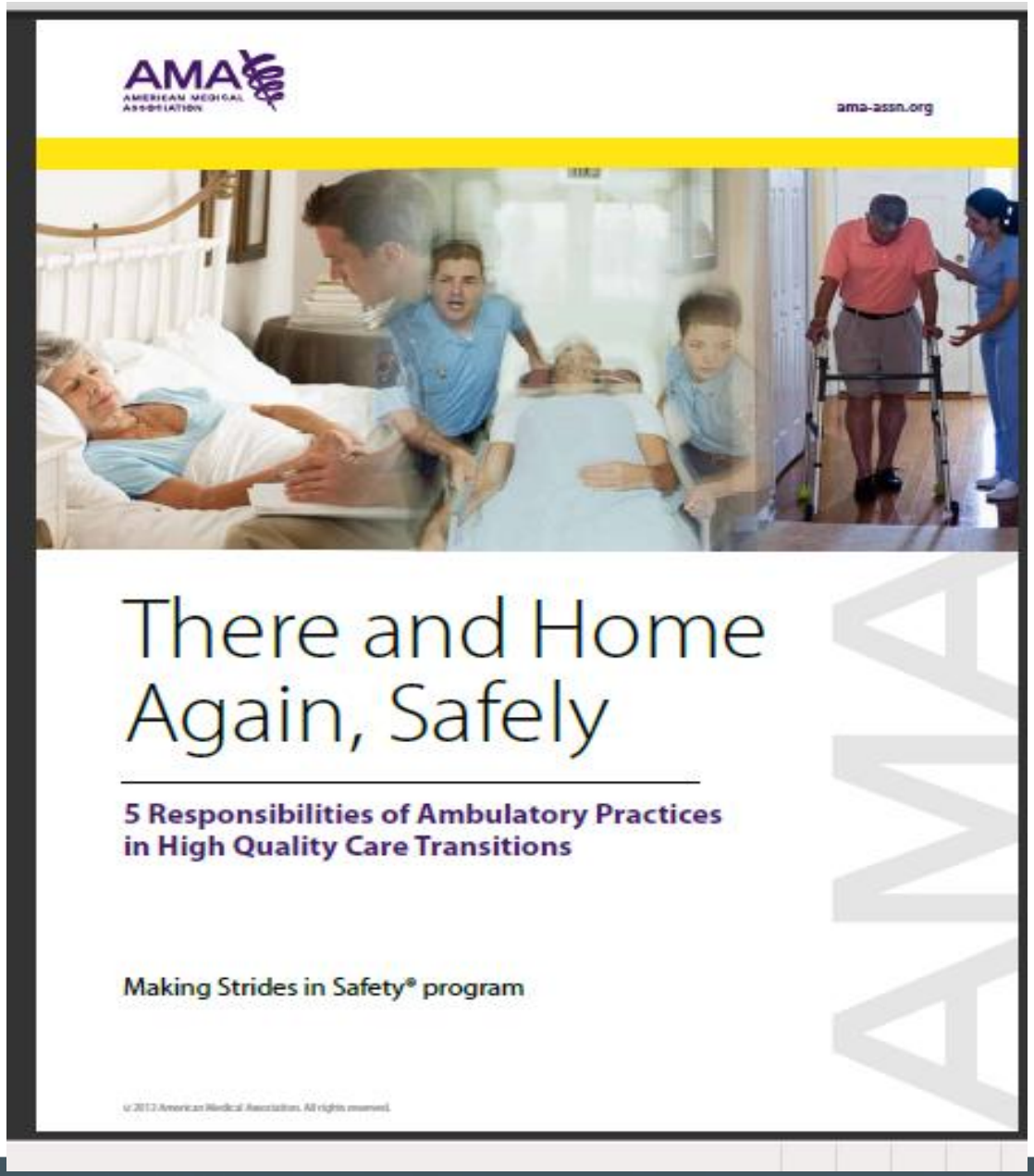
ERIC A. COLEMAN, MD, MPH, NANCY A. WHITELAW, PHD, AND ROBERT SCHREIBER, MD

Caring for Seniors:

How Community-Based Organizations Can Help

PARTNERING WITH LOCAL GROUPS THAT WORK WITH SENIORS CAN HELP YOU MEET THE SPECIAL NEEDS OF OLDER PATIENTS.

Family Practice Management September/October 2014 13-17 | www.aafp.org/fpm



https://npsf.site-ym.com/resource/resmgr/PDF/There-and-Home-Again_AMArepo.pdf

Confluence of National Attention

Medicare Payment Advisory Commission (MedPAC)

Three policies to align incentives to reduce readmissions:

1) Public disclosure of hospital 30-day (risk-adjusted) readmission rates www.hospitalcompare.hhs.gov

2) Adjust payment based on performance (i.e., penalties)

3) Bundling payment across hospitals and physicians

Readmission Penalties

Beginning FY 2013:

- Heart failure
- AMI
- Pneumonia

Beginning FY 2015:

- COPD
- Knee and Hip Joint Replacement

Readmission Penalties Have Helped Hospitals Understand

- The wide range of contributors to readmissions
- Many, if not most, are out of the traditional reach of the hospital—making the case for cross setting collaboration

Transitional Care Management Codes

- Designed to promote greater support through both face-to-face and non face-to-face encounters
- New CPT codes (99495 and 99496) to pay physicians (and NPs & PAs) for post-hospital discharge (30 days) care coordination provided to FFS Medicare beneficiaries
- $163.88 or $230.86, for combined face-to-face and non face-to-face (depending on E&M level 3 or 4 and whether face-to-face visit is <14 days or <7 days)

Complex Care Code for Ambulatory Care

- Compensates physicians for non-face-to-face time:
  - regular development and revision of a plan of care
  - communication with other treating health professionals
  - medication management (total 20 minutes over 30 days)
- Medicare patients with 2+ significant chronic conditions
- Proposed amount = $41.92 per month
- *For 20 Medicare patients, this translates to $10K/year*

Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)

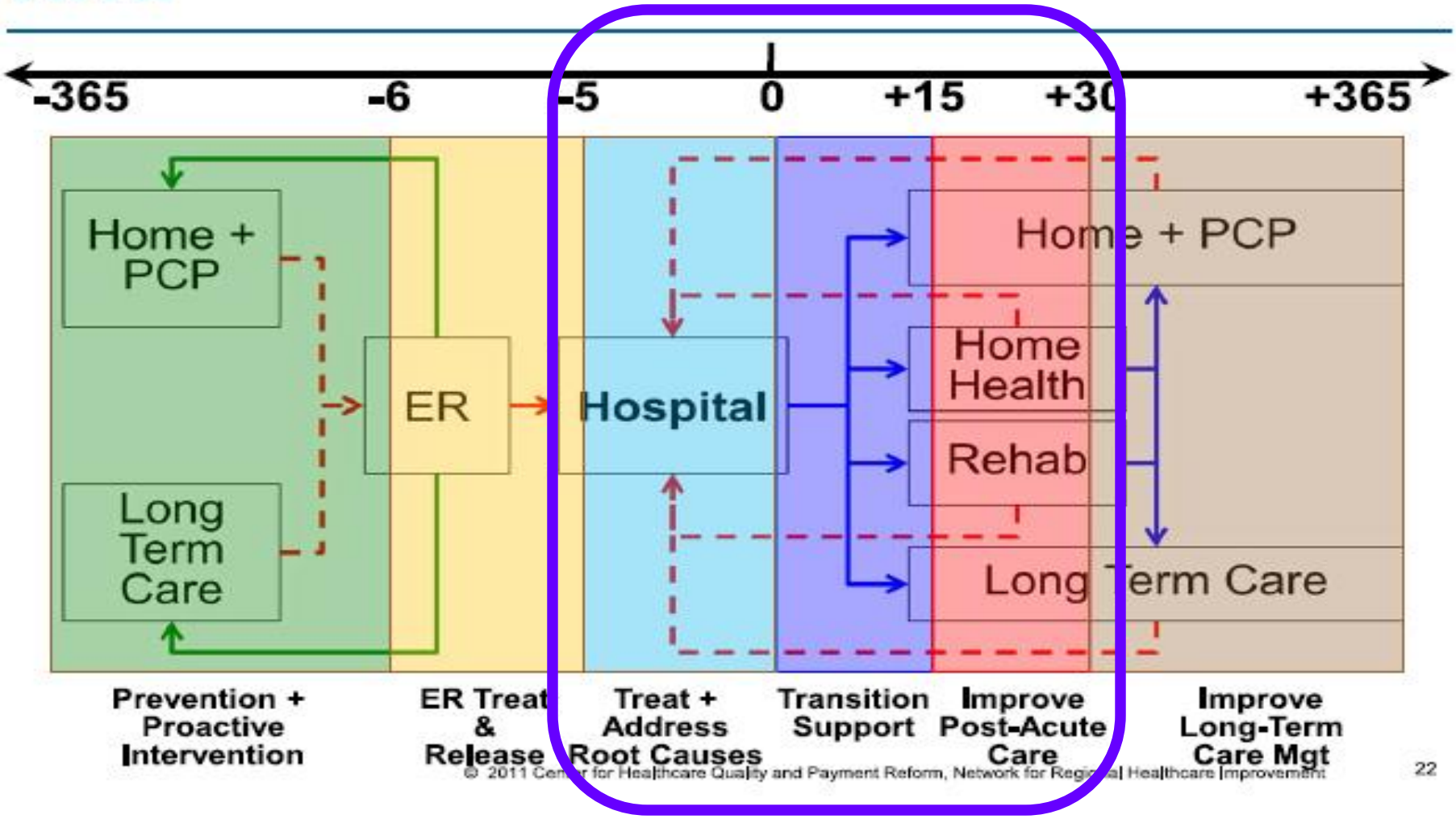
- Signed into law October 6, 2014
- By 2022, payment rates will be tied to “individual characteristics instead of settings where the patient is treated
- Intended to streamline PAC sector by standardizing assessments - Continuity Assessment Record and Evaluation Item Set (CARE)
- Affects skilled nursing facilities (SNF), home health agencies, inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH).
- Financial penalties for failing to report quality measures beginning 2019.

Changing Paradigms

Traditional Focus	Transformational Focus
Immediate clinical needs	Whole person needs
Patients	Patient & family members
LOS & timely discharge	Post-acute care plan for comprehensive needs
Handoffs	Co-design of “handovers”
Clinician teaching	Patient & family learning
Location teams	Cross-continuum team

“We can’t solve problems by using the same kind of thinking we used when we created them.” - Albert Einstein

A Truly Comprehensive Solution



Harold D. Miller, President and CEO, Network for Regional Healthcare Improvement and Executive Director, Center for Healthcare Quality and Payment Reform.

Systems of Care

"The quality of patients' experience is the "north star" for systems of care." –Don Berwick

What Experience of Care Is the "North Star" Vision for Your System of Care?

What Can Rebecca Teach Us?

Rebecca's Story

Rebecca Bryson lives in Whatcom County, WA and she suffers from diabetes, cardiomyopathy, congestive heart failure, and a number of other significant complications; during the worst of her health crises, she saw 14 doctors and took 42 medications. In addition to the challenges of understanding her conditions and the treatments they required, she was burdened by the job of coordinating communication among all her providers, passing information to each one after every admission, appointment, and medication change.

Rebecca's Story

Rebecca said if she were to dream up a tool that would be truly helpful, it would be something that would help her keep her care team all on the same page. Bryson described typical medical records as being "location or process centered, not patient-centered." She also describes how difficult it can be for patients to navigate a large health care system. Rebecca summarizes her experience in this way – "Patients are in the worst kind of maze, one filled with hazards, barriers, and burdens."

IHI's approach to reducing avoidable readmissions

IHI Four Key Changes

1. Perform an Enhanced Assessment of Post-Hospital Needs
2. Provide Effective Teaching and Facilitate Enhanced Learning
3. Ensure Post-Hospital Care Follow-up
4. Provide Real-Time Handover Communications

Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Achieving Desired Results

IHI's Framework: Improving Care Transitions

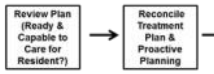
Transition from Hospital to Home or other Care Setting

Hospital

Transition to Community Care Settings and Better Models of Care

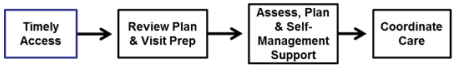
INTERACT II

Skilled Nursing Care Centers



NCQA

Primary & Specialty Care



VISITING NURSE SERVICE OF NEW YORK

Home Health Care

Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)

The Care Transitions Program

Center to Advance Palliative Care

Evercare®

GRACE Team Care

Commonwealth Care alliance

National PACE Association

n4a

Advocacy. Action. Answers on Aging.

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

Key Design Elements

- Patient and Family Engagement
- Cross-Continuum Team Collaboration
- Health Information Exchange and Shared Care Plans

Improving Transitions Processes

Skilled Nursing Care Centers

Review Plan (Ready & Capable to Care for Resident?) → Reconcile Treatment Plan & Proactive Planning → Plan for Timely Consultation when Status Changes → LTC or Home ? → Assessment of Needs / Teaching & Learning → Plan post-acute FU Care → Handover Communications

Hospital

Assessment of Needs / Teaching & Learning → Plan post-acute FU Care → Handover Communications

Cross-continuum Teams are Core to the Work

Primary & Specialty Care

Timely Access → Review Plan & Visit Prep → Assess, Plan & Self-Management Support → Coordinate Care

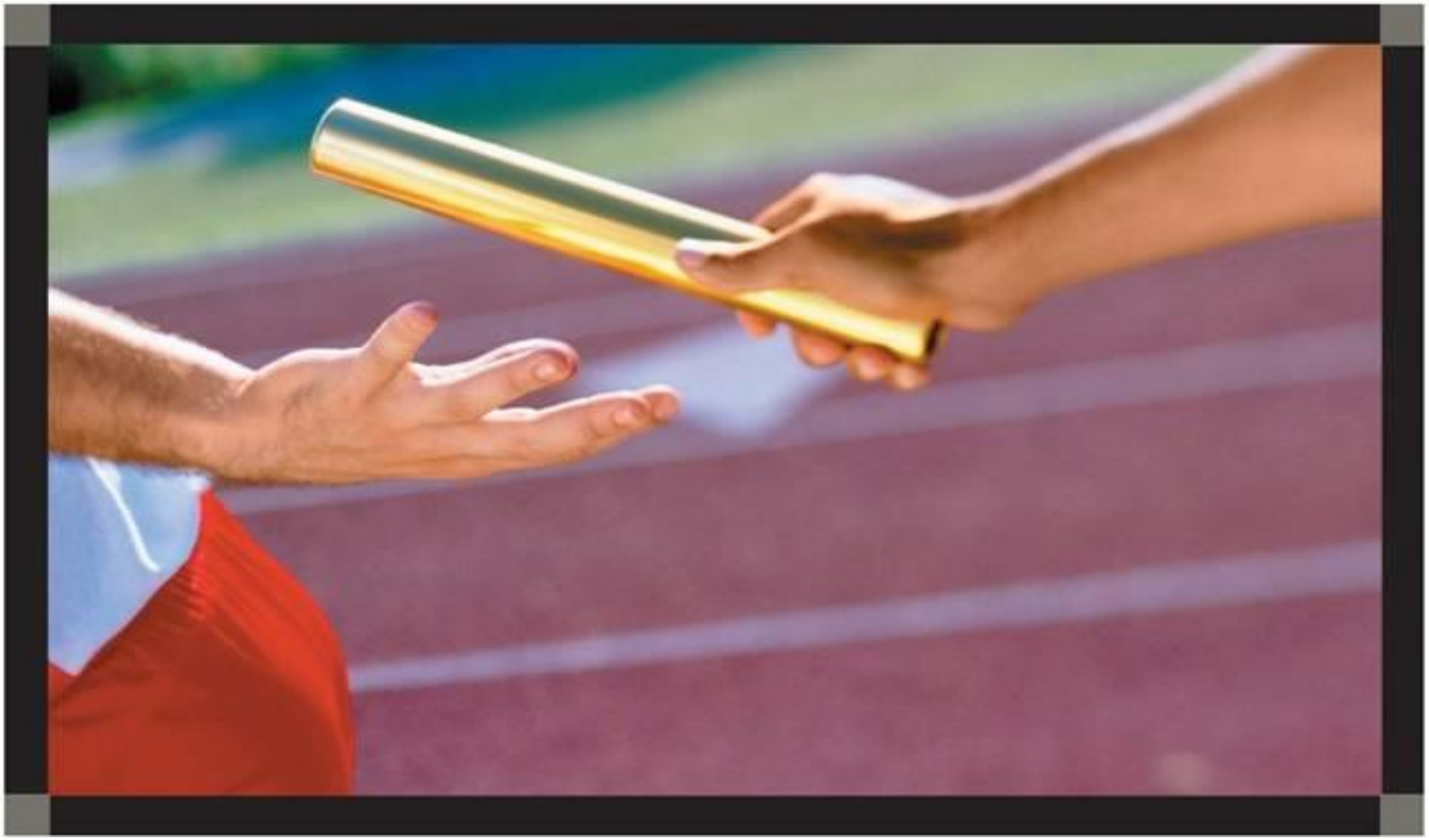
Home (Patient & Family Caregivers)

Home Health Care

Review Home Care Plan → Assess, Plan & Self-Management Support → Coordinate Care

Core Processes

Co-Design of Handover Communications



Lessons Learned

- Cross-continuum team partnerships transform care processes together
- “Senders” and “receivers” partnerships agree upon and design the needed local changes
  - Vital few critical elements of patient information that should be available at the time of discharge to community providers
  - Written handover communication for high risk patients is insufficient; direct verbal communication allows for inquiry and clarification

Cross Continuum Teams

A team of hospital and community-based clinicians along with patients and family members:

- Provide oversight and guidance
- Help to connect improvement efforts across all care settings
  - Identify improvement opportunities
  - Facilitate collaboration to test changes
  - Facilitate learning across care settings
- Provide oversight for the initial pilot unit work and establish a dissemination and scale-up strategy

Cross Continuum Teams

CCTs:

- Are one of the most transformational changes in IHI's work to improve care transitions
- Reinforce the idea that readmissions are not solely a hospital problem
- Need engagement at two levels:
  1) Executives remove barriers and develop overall strategies for ensuring care coordination
  2) Front-line leverages the power of "senders" and "receivers" co-designing processes to improve transitions of care

Collaboration across care settings is a great foundation for integrated care delivery models (e.g. bundled payment models, ACOs)

Lessons Learned

- Reducing readmissions is dependent on highly functional cross-continuum teams and a focus on the patient's journey over time
- Providing intensive care management services for targeted high risk patients is critical
- Reliable implementation of changes in pilot units or pilot populations require 18 to 24 months

Diagnostic Case Reviews

- Provide opportunities for learning from reviewing a small sampling of patient experiences
- Engage the “hearts and minds” of clinicians and catalyze action toward problem-solving:
  - Teams complete a formal review of the last five readmissions every 6 months (chart review and interviews)
  - Members from the cross-continuum team hear first-hand about the transitional care problems “through the patients’ eyes”

Post-acute Follow-up Care: Prior to Discharge

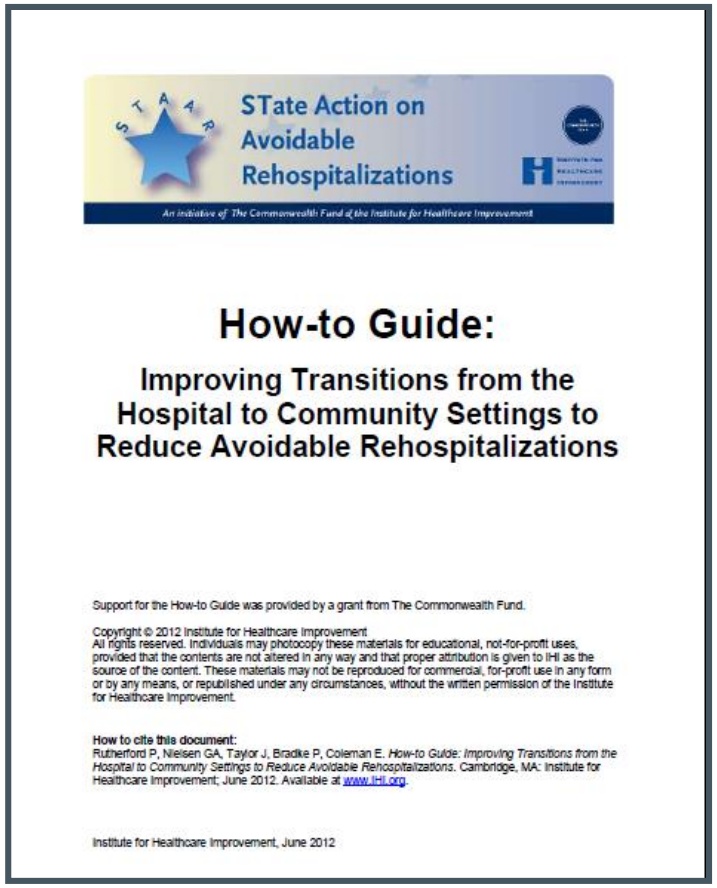
High-Risk	Moderate-Risk	Low-Risk
• Schedule a face-to-face follow-up visit within 48 hours of discharge. Assess whether an office or home health care is the best option for the patient. • If a home care visit in 48 hours, also schedule a physician office within 5 days. • Initiate intensive care management as indicated (if not provided in primary care or in outpatient specialty clinics • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and a physician office visit within 5 to 7 days. • Initiate home health care services (e.g. transition coaches) as needed. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule follow-up phone call within 48 hours of discharge and a physician office visit as ordered by the attending physician. • Provide 24/7 phone number for advice about questions and concerns. • Initiate referral to social services and community resources as needed.

IHI: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. June 2013

Lessons Learned

- There are no universally agreed upon risk assessment tools
  - We need a much deeper understanding of how best to meet the needs of high-risk patients
  - Use practical methods to identify modifiable risks
- Providing intensive care management services for targeted high-risk patients is critical
- Written handover communication for high-risk patients is insufficient

Four Guides on Transitions


STate Action on Avoidable Rehospitalizations

An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement

How-to Guide:

Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

How to cite this document:
Rutherford P, Nielsen GA, Taylor J, Bradike P, Coleman E. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012. Available at www.IHI.org.

Institute for Healthcare Improvement, June 2012

- Senders:
  - From Hospital to SNF or Home
- Receivers:
  - Office Practice
  - Home Care
  - Skilled Nursing Care Facilities
- How-to Methods

http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionstoReduceAvoidableRehospitalizations.aspx

CHALLENGES FOR HOSPITALS

By Amy E. Boutwell, Marian Bihrle Johnson, Patricia Rutherford, Sam R. Watson, Nancy Vecchioni, Bruce S. Auerbach, Paula Griswold, Patricia Noga, and Carol Wagner

DOI: 10.1377/hlthaff.2011.0111
HEALTH AFFAIRS 30,
NO. 7 (2011): 1272–1280

An Early Look At A Four-State Initiative To Reduce Avoidable Hospital Readmissions

Amy E. Boutwell (amy@collaborativehealthcarestrategies.com) is president of Collaborative Healthcare Strategies, in Lexington, Massachusetts.

Marian Bihrle Johnson is a senior research associate at the Institute for Healthcare Improvement, in Cambridge, Massachusetts.

Patricia Rutherford is a vice president at the Institute for Healthcare Improvement.

Sam R. Watson is senior vice president, Patient Safety and Quality, at the Michigan Health and Hospital Association, in Lansing.

ABSTRACT Launched in 2009, the State Action on Avoidable Rehospitalizations initiative, known as STAAR, aims to reduce rates of avoidable rehospitalization in Massachusetts, Michigan, Ohio, and Washington by mobilizing state-level leadership to improve care transitions. With the program two years into its four-year cycle, 148 hospitals are working in partnership with more than 500 cross-continuum team partners. Although there are no publicly available data on whether the project is achieving its primary goal of reducing avoidable rehospitalizations, the effort has so far been successful in aligning numerous complementary initiatives within a state, developing statewide rehospitalization data reports, and mobilizing a sizable number of hospitals to work on reducing rehospitalizations. More than 90 percent of participating hospitals have formed teams to routinely review rehospitalizations with their community-based colleagues.

An Early Look at a Four-State Initiative to Reduce Avoidable Readmissions. Boutwell, A,, Bihrle Johnson, M, Rutherford, P, et. al. Health Affairs, July 7,2011

Summary

- Rehospitalizations are frequent, costly, and actionable for improvement
- The IHI approach acts on multiple levels – engaging hospitals and community providers, communities, and state leaders in pursuit of a common aim to reduce avoidable rehospitalizations
- Working to reduce rehospitalizations focuses on improved communication and coordination over time and across settings
  - With patients and family caregivers;
  - Between clinical providers;
  - Between the medical and social services (e.g. aging services, etc.)
- Working to reduce rehospitalizations is one part of a comprehensive strategy to promote patient-centered care and appropriate utilization of health care resources