Objectives for the Day

• Review the rationale for focusing on preventable readmissions
• Explore strategies and resources that have worked for others
  – Focusing on the “Magnificent Seven” BOOST Readmissions Reduction Collaborative in CA
• Describe the key steps to any readmissions reduction program
• Identify sites with additional resources
Readmissions Reduction - The Why

Reduce avoidable readmissions by 20 percent by June 2013.
Number of Medicare FFS Patients Readmitted within...

- 0-7 Days: 35.5%
- 8-14 Days: 25.3%
- 15-21 Days: 19.7%
- 22-30 Days: 19.5%
The Readmissions Goal

- Q4 2010 to Q1 2011 Readmissions Data
  - 3,429,614 total Medicare FFS beneficiaries
  - 403,880 (12%) were discharged from an acute stay
  - 78,397 (19.4%) were readmitted within 30 days

- California's Goal:
  - Reduce overall readmission rate by 20 percent
  - Prevent 15,000 avoidable readmissions
Average readmission costs $8,000-$13,000

+ California prevents 15,000 readmissions

= $120 - $195 million saved
How about Cost to the Hospital?

- Readmission rates effect Medicare Reimbursement
- Some adverse events are on the CMS “no pay” list
- All payer programs follow Medicare
- Healthcare Reform and the ACA
What about Cost to Patients?

- Health
- Time
- Co-pays
- Adverse Events
  - And the corresponding hospital liability
Project BOOST sites as of 3/2012
About the Program

• What is BOOST?
  – Evidence-based clinical interventional
  – Structured process for system-level analysis & change
  – Year long mentored implementation process to tailor interventions and support sites
  – Participation in a National Community to share ideas
  – Performance and Data tracking Center
  – Wealth of educational resources for the entire clinical team
• Additional Resources:
  – HASC QI expert supports and visits participating sites
  – HASC QI expert advises BOOST faculty on additional educational resources required for regional sites
  – Regional meetings support expanded collaboration across sites

This project is funded in part by L.A. Care Health Plan and will benefit low-income and uninsured residents of Los Angeles County
Advisory Board

Chair: Eric Coleman, MD, MPH
Co-Chair: Mark Williams, MD

with organizational representatives from:

- Social work
- Case management
- Clinical pharmacy
- Geriatric medicine
- Geriatric nursing
- Health IT
- Blue Cross/Blue Shield
- United Health
- Health systems
- NQF
- AHRQ
- TJC
- CMS
- National Consumer’s League
- Other content experts
Eric Coleman, MD, MPH

• Director, Care Transitions Program
  University of Colorado Denver

• Reducing readmissions “jumps off the page as an area where we could see enormous savings in national health expenditures.”

• “We’re pretty good at identifying who’s at risk of readmission, but it’s harder to say who’s at modifiable risk.”
“Change Package” Program Resources

- Assessment – Problem Analysis
- Tools and Interventions – For the Continuum
- Collaborative Exchange – Peer to Peer
- Implementation – The QI Model
The Four Pillars

- Patient-family activation
- Medication management
- Follow-up with PCP/Specialist
- Knowledge of “Red Flags” or warning signs/symptoms and how to respond

—But wait, there’s more!
Tools and Interventions…

…For the Continuum!

- Patient Risk Stratification
- Patient and Family Education
- Effective Discharge Plan
- Follow up Appointment with MD
- Visit/contact within 72 hours
- Networking with Post-Acute Partners
Tools and Interventions

Patient Risk Stratification

• BOOST Target Tool
  – The 8 Ps

• GAP Analysis
  – General Assessment of Preparedness
TARGET: Tool for Adjusting Risk: A Geriatric Evaluation for Transitions

- 8P Risk Scale
  - Prior hospitalization
  - Problem medications
  - Psychological (depression)
  - Principal diagnosis
  - Polypharmacy
  - Poor health literacy
  - Patient support
  - Palliative Care

Each associated with risk specific interventions
The General Assessment of Preparedness: The GAP

- Caregivers and social support circle for patient
- Functional status evaluation completed
- Cognitive status assessed
- Abuse/neglect
- Substance abuse
- Advanced care planning addressed and documented

On Admission
- Functional status
- Cognitive status
- Access to meds
- Responsible party for ensuring med adherence prepared
- Home preparation for patient’s arrival
- Financial resources for care needs
- Transportation home
- Access (e.g. keys) to home

Nearing Discharge
- Understanding of dx, treatment, prognosis, follow-up and post-discharge warning S/S (using Teach Back)
- Transportation to initial follow-up

At Discharge
Patient and Family Education

• BOOST Teach-back Tool
  – Not just at Discharge

• Diagnosis and Patient Specific Education
  – Brief and Customized
NEW CONCEPT
Health information, advice, instructions, or change in management

The Teach Back Method

Assess patient comprehension / Ask patient to demonstrate

Clarify and tailor explanation

Re-assess recall and comprehension / Ask patient to demonstrate

Patient recalls and comprehends / Demonstrates skill mastery

Explain new concept / Demonstrate new skill

Adherence / Error reduction

Tools and Interventions

Effective Discharge Plan

• Project RED
  – The personalized AHCP lists medications and upcoming appointments and tests

• Follow Through with Rx and DME
  – Accountability for reconciling and dispensing
BOOST’s Discharge Plan: The Patient PASS

• Patient-centered
• Simple
• Problem focused
• Low literacy
• To be supplemented by a patient-centered medication list
  – New meds
  – Stopped meds
  – Changed meds

• Why was I in the hospital?
• What do I do if I run into problems?
• When do I follow-up?
• How do I reach key people?
• What should I talk to my doctor about?
**Patient PASS**

Patient Preparation to Address Situations (after discharge) Successfully

<table>
<thead>
<tr>
<th>I was in the hospital because</th>
<th>If I have the following problems ...</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td>1.</td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td>2.</td>
<td>(__) ______________________</td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td>3.</td>
<td>(__) ______________________</td>
</tr>
<tr>
<td></td>
<td>4.</td>
<td>4.</td>
<td>(__) ______________________</td>
</tr>
<tr>
<td></td>
<td>5.</td>
<td>5.</td>
<td>(__) ______________________</td>
</tr>
</tbody>
</table>

| My appointments:             | Tests and issues I need to talk with | Other:       |
|------------------------------| my doctor(s) about at my clinic visit:|--------------|
| 1.                          | 1.                                  | (__)  ______ |
| On:__/__/ at __:__ am/pm    | 2.                                  | ______       |
| For: ______                  | 3.                                  | ______       |
| 2.                          | 4.                                  | ______       |
| On:__/__/ at __:__ am/pm    | 5.                                  | ______       |
| For: ______                  | Other:                              | ______       |

| On:__/__/ at __:__ am/pm    | Other:                              | ______       |
| For: ______                  | Other:                              | ______       |

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

| 1.                          | 2.                                  |
| __________________________ | __________________________         |
| 1.                          | 2.                                  |
| __________________________ | __________________________         |
| 3.                          | 4.                                  |
| __________________________ | __________________________         |
| 5.                          |                                     |
| __________________________ |                                     |

I understand my treatment plan. I feel able and willing to participate actively in my care:

______________________________
Patient/Caregiver Signature

___/___/____
Date

Provider Signature
Follow Up Appointment with MD

• Make the appointment before discharge
• Assure patient can make that appointment
  – Arrange transport services
Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

- 1 in 5 Medicare patients rehospitalized in 30 days
- Half never saw outpatient doc
- 70% of surgical readmissions—chronic medical conditions
- Costs $17.4 billion
Tools and Interventions

Visit/Contact within 72 hours

• Pharmacist call and Med Reconciliation
• (1) HHA visit is indicated for most patients
• Case Management Follow up call
• Nursing Unit follow up call
• HCAHPS call expanded
• Patient visit to Community Clinic
• Senior Day Care Plus
Tools and Interventions

Networking with Post-Acute Providers

- Nursing Homes
  - INTERACT Tool
- Home Health Agencies (HHA)
- Community Clinics
- Senior Day Care Plus
Readmissions Reduction-The HOW

• Explore the Problem/Process in need of Change
  – Process Mapping, Fishboning

• PDSA SToC – “Rapid Cycle”
  – Measurement
  – Adjust and Implement the change
  – Continue to Learn and Spread
Assessment and Analysis

- Process Mapping
- Case Review and Root Cause Analysis (RCA)
- Cause & Effect Ishikawa/Slininger (Fishbone)
- Internal Multidisciplinary Team
I. Explore the Problem Through Cause and Effect Analysis
II. Initiate an Action Plan Using a Nominal Group Technique

1. Fishbone
   - People:
     - MD with other pts
   - Materials:
     - Cardio “on call”
     - Chart not available
   - Environment:
     - ER full
   - Current Process:
     - Triage full
     - Other dx tests same time
     - MD must order
   - EKG machine in ER (not triage)
   - Delayed EKG

Effect
PDSA – SToC
Small Test of Change

Changes that Result in Improvement

Cycle #1
Cycle #2
Cycle #3
Cycle #4

Ideas, Theories, Hunches

DATA

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The Magnificent Seven!

– Garfield Medical Center
– Olympia Medical Center
– Pomona Valley Hospital Medical Center
– Harbor UCLA Medical Center
– Valley Presbyterian Medical Center
– Antelope Valley Hospital
– St. Francis Medical Center
Preliminary Findings

• Common reasons for readmission
  – PMD says “go to ER” or ER is used like PMD
  – Nursing home sends to ER for MD evaluation

• Process mapping discovery
  – DME procurement delays
  – Medication Reconciliation and Rx Acquisition

• Initial intervention priorities
  – Better plan/options for first several days post acute
  – Teachback method for patient/family education
Qualitative Outcomes

- __7__ Redesigned effective patient education during the stay and at discharge
- __7__ Worked with physicians in planning for discharge and securing that critical 1\textsuperscript{st} appointment
- __5__ Began a new partnership with Nursing Homes, Home Health Agencies, and other providers
- __6__ Established a mechanism for post-discharge follow-up via a visit or phone call
- __2__ Created a post-acute clinics that or revitalized existing ones to see patients after DC
Quantitative Outcomes

Four Hospitals demonstrated significant results on their BOOST Units!

- 24% reduction (a 2.9 point decrease) – 12.3% to 9.4%
  at St. Francis Medical Center
- 34% reduction (a 5.5 point decrease) – 16.2% to 10.7%
  at Harbor UCLA Medical Center
- 37% reduction (a 3.6 point decrease) – 9.9% to 6.3%
  at Pomona Valley Hospital Medical Center
- 52% reduction (a 13 point decrease) – 25% to 12%
  at Olympia Medical Center

And the other 3 improved, but are refining their data!
Your Next Steps…

Conduct your analysis, then select your initial intervention for SToC

- Patient Risk Stratification
- Patient and Family Education
- Effective Discharge Plan
- Follow up Appointment with MD
- Visit/contact within 72 hours
- Networking with Post-Acute Partners
Should you Focus on the Destination or the Journey?

• If you’ve seen one BOOST site….
  – You’ve seen one BOOST site!

• Interventions evidence Creativity
  – Based on each hospital’s assessment, capacity, and special population

• New partnerships in the continuum
  – Internally (among Case Managers and MDs)
  – Externally (Post acute provider organizations)
Web resources

- www.hospitalmedicine.org/boost
- http://www.noplacelikehomeca.com/
- cfmc.org/integratingcare/toolkit.htm
- cfmc.org/integratingcare/toolkit_interventions.htm
- ahrq.gov/news/kt/red/
- ihi.org/STAAR
  - (State Action on Avoidable Readmissions)
- healthcare.gov/compare/partnership-for-patients/safety/transitions.html
We Cannot Reach Our Goal Without

Shared Accountability Throughout the Community.