HRET HIIN READMISSIONS VIRTUAL EVENT: BRIGHT SPOTS & BIG OPPORTUNITIES

November 10, 2016
11:00a.m. – 12:00p.m. CST

Register for Upcoming Events:
November 15, 11:00 am CT: Data
November 17, 11:00 am CT: ADE
November 29, 1:00 pm CT: Sepsis
November 30, 11:00 am CT: QI Fellowship Informational Session
WELCOME AND INTRODUCTIONS

Shereen Shojaat, MS, Program Manager | HRET | 11:00 – 11:10 a.m.
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter(s)</th>
</tr>
</thead>
</table>
| 11:00-11:10 a.m. | Welcome and Introductions                | Shereen Shojaat, MS  
Program Manager, HRET |
|            | Opening and housekeeping information, including an introduction to the HIIN team and how readmissions will be supported during HIIN. |                                  |
| 11:10-11:15 a.m. | Readmissions Measurement Plan            | Julia Heitzer, MS  
Data Analyst, HRET |
|            | Review the readmissions measure specifics - definition, inclusion, exclusion baseline periods, etc. |                                  |
| 11:15-11:30 a.m. | The Big Opportunities                    | Pat Teske, BSN, MHA  
Improvement Advisor, Cynosure Health |
|            | Key opportunities and new approaches to reduce readmissions in your facility. |                                  |
| 11:30-11:50 a.m. | Bright Spots                              | Nicole Thorell  
CNO, Lexington Regional Health Center |
|            | A facilitated discussion with some of our bright spot organizations regarding their readmission reduction efforts with a focus on key opportunity areas. |                                  |
| 11:50-11:55 a.m. | To Do’s By The End Of 2016!              | Pat Teske, BSN, MHA  
Improvement Advisor, Cynosure Health |
|            | Leaving in action. What will you do by the end of this year? |                                  |
| 11:55 a.m.-12:00 p.m. | Bring It Home                            | Shereen Shojaat, MS  
Program Manager, HRET |
|            | Review of relevant HRET HIIN resources.  |                                  |
|            | Summary of next steps.                   |                                  |
Readmissions Measurement Plan

Julia Heitzer, MS, Data Analyst | HRET | 11:10 – 11:15 a.m.
# Readmission Within 30 Days (All Cause) Rate

<table>
<thead>
<tr>
<th>Readmission: CMS Evaluation Measure</th>
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</thead>
<tbody>
<tr>
<td>Readmission within 30 Days (All Cause)</td>
<td></td>
</tr>
<tr>
<td>Measure type</td>
<td>Outcome</td>
</tr>
<tr>
<td>Numerator</td>
<td>Inpatients returning as an acute care inpatient to the same facility within 30 days of date of discharge</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total inpatient discharges (excluding discharges due to death)</td>
</tr>
</tbody>
</table>
| Rate calculation | \[
\left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 100
\] |
| Specifications/definitions Sources/Recommendations | Facilities should follow the CMS definition of a readmission. This definition is explained in the “Frequently asked questions about readmissions” chapter, available on [Quality Net](http://example.com). “Chapter 3 – Readmissions Measures,” section “Defining readmissions” beginning on page 7 |
| Data source(s) | Administrative data or billing systems or other tracking systems |
Note: This measure is a subset of the “Readmission within 30 Days (All Cause) Rate” measure (HIIN-READ-1). The only difference between this measure and the “Readmission within 30 Days (All Cause) Rate” is that this measure is limited to Medicare patients.
The Big Opportunities

Pat Teske, RN, MHA, Improvement Advisor | Cynosure Health | 11:15 – 11:30 a.m.
OUR BIG OPPORTUNITIES

1. Develop a learning loop.

2. Partnering with patients and their caregivers.

3. Focus on high leverage strategies including: ED pause, community collaboration and a highest utilizer approach.
Develop your learning loop
BIG DATA

• Take 12 months of readmission data and learn from it. For example:
   Sort readmissions by major payer type and REaL. For each sub-category find:
    • Total number of discharges
    • Total number of readmissions
    • Rate = readmissions/discharges
    • Discharge disposition
    • Number home
    • Number home with home health
    • Number SNF
   Ask – Are all of my payors the same?
   Ask – Do I see differences based on race, ethnicity or language?
ADDITIONAL DATA QUESTIONS

• Number and types of coded behavioral health diagnoses
• Number and/or percentage of readmissions occurring within 7 days of discharge
• Number of patients with ≥4 hospitalizations in past year
  – Total number of discharges in >4 group
  – Total number of 30-day readmissions among them
• Top DRGs
• Ask – How are behavioral health diagnoses impacting our readmissions?
• Ask – When are our patients returning? Sooner vs later?
• Ask – Who are our highest utilizers?
• Ask – What portion of our readmissions are in the top 10?
IF THESE WERE YOUR DATA
IF THESE WERE YOUR DATA

Readmissions by Days Between Discharge and Readmission

<table>
<thead>
<tr>
<th>Days</th>
<th>Count</th>
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<tbody>
<tr>
<td>1-5 DAYS</td>
<td>8</td>
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<tr>
<td>6-10 DAYS</td>
<td>8</td>
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<tr>
<td>11-15 DAYS</td>
<td>4</td>
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<tr>
<td>16-20 DAYS</td>
<td>2</td>
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<tr>
<td>21-25 DAYS</td>
<td>2</td>
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<tr>
<td>26-30 DAYS</td>
<td>4</td>
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</table>
LITTLE DATA

• Why are your patients returning?
  ❑ Create a list of reasons. You can modify it as you learn. Focus on the first 7 days. Sample below.
    ○ Medication management
    ○ Discharge instructions
    ○ Palliative care/hospice
    ○ Care coordination
    ○ MD follow-up
    ○ Psychosocial/family dynamics
    ○ Transportation
    ○ Patient/hospital did their best
    ○ Other
AGGREGATE CASE REVIEW RESULTS

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<th>Pillar</th>
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<th>4</th>
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<th>6</th>
<th>7</th>
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<th>9</th>
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Readmission Pillars:
1. Medication Management
2. Discharge Instructions
3. Palliative Care/Hospice
4. Care Coordination
5. MD follow up
6. Home Health & DME
7. Psychosocial/Family Dynamics
8. Post op readmission
9. PO Progression
10. Medically not stable for DC
12. Pt. and hospital did their BEST

Palliative care is the biggest opportunity
Patient and Family Engagement (PFE)

• Optimize PFE
  – Use CMS discharge checklist
  – Ask patients why they believe they were readmitted and what should be done differently?
  – Consider activation
    • Patient Activation Measure (PAM)
    • Motivational interviewing
PFE Question

• Prior to admission, do hospital staff discuss a planning checklist that is similar to CMS’s Discharge Planning Checklist with every patient that has a scheduled admission – allowing for questions and comments from the patient or family?

• HEN 2.0 hospitals responded
  • 39% YES
  • 71% NO

CMS Discharge Planning Checklist

For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting.
**SOME OF THE CMS CHECKLIST QUESTIONS**

- Ask where you’ll get care after you leave (after you’re discharged). Do you have options (like home health)? Be sure to tell the staff what you prefer.

- Ask the staff about your health condition and what you can do to get better.

- Ask if you’ll need medical equipment (like a walker). Who will arrange for this? Write down a name and a phone number of a person you can call if you have questions about equipment.
BIG LEVERS

1. ED pause
2. Community collaboration
3. Highest utilizer strategy
1. Process to inform ED staff that this person had a prior admission
2. Pause to interact in-person or on the phone with a care transitions team member
3. Decision
   a) Admit
   b) Observation
   c) Home with follow-up
PARTNERING IN OUR COMMUNITIES

• Get people in the same room
• Learn what everyone has to offer
• Learn what everyone's frustrations are
• Start with one issue and go from there

http://interact2.net/tools.html
Identify highest utilizers
Learn what drives their utilization
Meet the needs
BRIGHT SPOT HOSPITALS- 11:30-11:50 A.M.

Russell Regional Hospital
Russell, Kansas

Left to Right: Diane Kilian, Mary Ulrich, Stacey Keller

Lexington Regional Health Center
Lexington, Nebraska

Nicole Thorell
LEAVING IN ACTION
Pat Teske, RN, MHA, Improvement Advisor | Cynosure Health | 11:50–11:55 a.m.
What do you think?

Virtual learning events
Technical assistance
Huddle discussion board
Quick start guide
Whiteboard videos
Podcasts
Harvesting bright spots
Fishbowl series
State readmission leader calls
WHAT’S YOUR PLAN?

2016
BRING IT HOME

Shereen Shojaat, MS  Program Manager | HRET | 11:55 a.m. –12:00 p.m.
READMISSIONS CHANGE PACKAGE

• *Readmissions* driver diagrams and change ideas
• Example PDSA cycles
• Description and guidance on how to use change package effectively
• Referenced appendices

http://www.hret-hen.org/topics/readmissions/HRET Henri Readmissions.pdf
ENCyclopedia of Measures (EOM)

- Catalogued measure information available at the HRET HIIN website
- HIIN core topics (evaluation measures)
  - HIIN core process measures
  - HIIN additional topics
UPCOMING EVENTS

• November 15, 11:00 am CT: Data
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• November 30, 11:00 am CT: Quality Improvement Fellowship Informational Session
THANK YOU!

Find more information on our website: http://www.hret-hiin.org/

Questions/Comments: HIIN@aha.org