Readmissions Reboot

Webinar #3
January 16, 2020
A new focus on an old issue
What Drives Improvement in Readmissions?
Drivers for Improvement in Readmissions

Reduce Readmissions

- Use data to inform improvement activities
- Improve standard hospital transitions of care
- Deliver enhanced services based on need
- Collaborate with providers and services across the continuum

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Driver #3: Deliver Enhanced Services Based on Needs

Deliver enhanced services based on assessed needs of the patient

- Palliative care
- Condition specific programs
- Pharmacy interventions
- Complex care management
- Emergency Department pause
What are Enhanced Services?

• Additional services and supports in the time following care in your organization.
• Services not provided to all patients as part of routine care.
• Offered to subgroups identified as "high risk" of readmission.
• Delivered prior to and after discharge, often for 30 days.
• Deployed at provider expense to reduce readmissions.
• Delivered by hospital staff or by contracted staff from other entities.
Match needs with resources

• Which patients will probably do well with “normal discharge”?

• Which patients need something more?

• Which patients need far more?

• How do you know?

• What do you do?
How do we know which patients need enhanced services?
Your Turn: How Have You Utilized Both Big and Little Data to Identify High Risk Patients?

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Bright Spots in the Room

How are you approaching certain higher need populations in your organization?

How did you find out this population needed assistance/focus?
What Services Exist That I Am Not Aware Of?

• Community based elder care services:
  • Area Agency on Aging
  • Senior Centers
• Behavioral Health Services
  • Clinics, Drop in Centers
  • Referral Lines, NAMI
• Social Services
  • YMCA
  • Shelters
  • Food, Transportation, Utilities Assistance, 2-1-1
# Inventory Community Resources

<table>
<thead>
<tr>
<th>Provider or Agency</th>
<th>Transitional Care Services (Examples)</th>
<th>Use?</th>
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<tbody>
<tr>
<td>Clinical and Behavioral Health Providers</td>
<td></td>
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<tr>
<td>Community health centers, federally qualified health centers</td>
<td>ability to accept new patients, timely posthospital follow-up, co-located social visit, nutritional, pharmacy services, etc.</td>
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<tr>
<td>Accountable care organization with care management or transition care</td>
<td>high-risk care management, transitional care to reduce readmissions, etc.</td>
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<tr>
<td>Medicaid managed care organizations</td>
<td>high-risk care management, social work, wraparound services, etc.</td>
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<tr>
<td>Program of All-Inclusive Care for the Elder (PACE), Denver Care Options</td>
<td>frailty or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs</td>
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<tr>
<td>Medicaid homes</td>
<td>engagement, outreach, Tiered care management, eligibility based on chronic and behavioral health conditions</td>
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<tr>
<td>Muiltiservice behavioral health centers, including behavioral health homes</td>
<td>quantified posthospital follow-up availability for new patients, co-located support services, etc.</td>
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<tr>
<td>Behavioral health providers</td>
<td>accepting new patients, prioritizing posthospital follow-up</td>
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<tr>
<td>Substance use disorder treatment providers</td>
<td>effective processes for linking patients from acute care to substance use disorder treatment</td>
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<tr>
<td>Heart failure, chronic obstructive pulmonary disease (COPD), HIV, diabetes, or cancer center clinics</td>
<td>urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.</td>
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<tr>
<td>Pain management or palliative care</td>
<td>symptom management over time, often with behavioral health specialists and social workers, education, etc.</td>
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<tr>
<td>Physician/provider home visit service</td>
<td>timely post-discharge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.</td>
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<tr>
<td>Skilled nursing facilities</td>
<td>insole providers, warm handoffs, joint readmission review, INTERACT (Interventions To Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.</td>
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<tr>
<td>Home health agencies</td>
<td>warm handoffs, joint readmission review, front-loaded home visits, behavioral health clinical expertise, etc.</td>
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<tr>
<td>Hospice</td>
<td>warm handoffs, joint readmission review, same-day home visits, etc.</td>
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<tr>
<td>Adult day health</td>
<td>daily clinical, nutritional, medication management, socialization, etc.</td>
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<tr>
<td>Public health nurses</td>
<td>home visits, outreach, education, clinical coordination, etc.</td>
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<tr>
<td>Pharmacies</td>
<td>website delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.</td>
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<tr>
<td>Durable medical equipment</td>
<td>same-day delivery, 30-day transitional care monitoring, education services, etc.</td>
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</tbody>
</table>

**Aunt Bertha** | Connecting People and Programs

Search for free or reduced cost services like medical care, food, job training, and more.

[Search](#)

- Zip: 080210
- [Search](#)
Finding the Bright Spots
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Palliative Care

• What are the challenges?
• Bright spots?
Emergency Department Efforts

• Process to inform ED staff that this person had a prior admission

• Pause to interact in-person or on the phone with a care transitions team member

• Decision
  • Admit
  • Observation
  • Home with follow up

What are you doing in your ED?
Lessons from the Field
Many Resources Available to Guide Improvement
Readmissions Resources

- Readmissions Change Package
- ASPIRE Guide
- Trail Guide
- Readmissions Top Ten Checklist
- Readmissions Whiteboard Video Series
- HRET-HIIN Hospital Wide Topics LISTSERV
- Huddle for Care Discussion Forum
- IHI Improving Transitions How To Guide
- BOOST – Better Outcomes by Optimizing Safe Transitions
- LACE – Risk Assessment for Readmissions


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Thank You!

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