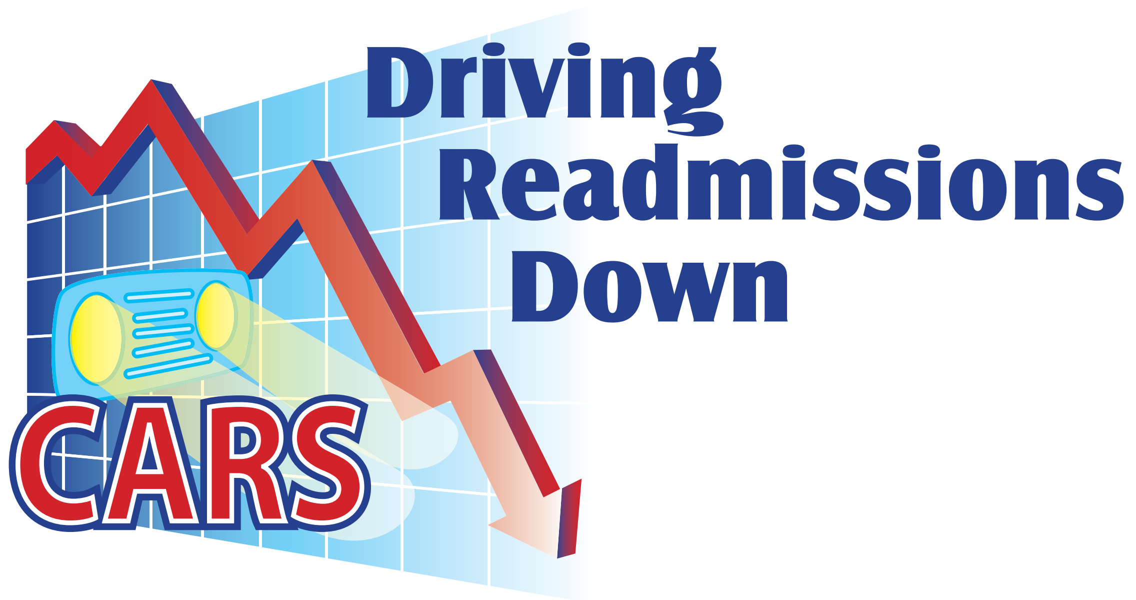
California Readmission Summit



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Underwritten by the Gordon and Betty Moore Foundation and hosted by ARC in partnership with Cynosure Health, the California Hospital Engagement Network (CHA HEN) and the Health Services Advisory Group (HSAG).

Presenting Sponsors

Avoid Readmissions Through Collaboration (ARC)

Avoid Readmissions Through Collaboration (ARC) is a partnership between Cynosure Health and the California Quality Collaborative (CQC) and funded by the Gordon and Betty Moore Foundation. ARC's goal is to reduce 30 and 90 day all cause readmission rates by 30% by 2013. Simply put: 30/30/13. The ARC program includes a learning community where hospitals and their partner organizations (e.g. medical groups/ IPAs, home health, long term care and health plans) can participate in learning sessions as well as an Action Network of organizations who are fully engaged in readmission improvement work.

California Health Engagement Network (CALHEN)

The California Health Engagement Network (CALHEN) is part of the Partnership for Patients effort that includes a collaboration of hospitals across the state focused on making hospital care safer, more reliable, and less costly. The CALHEN goals include reducing patient harm by 40 percent and readmissions by 20 percent by the end of 2013.

California Quality Collaborative

California Quality Collaborative (CQC) is improving transitions of care through two separate collaboratives focusing on both inpatient and outpatient care systems. Avoid Readmissions through Collaboration (ARC) is a program through which hospitals implement processes known to reduce readmissions. Take Accountability through Ambulatory Care Transitions (TAACT) is a program that enables medical groups, IPAs, hospitals, and health plans to develop post-discharge, team-based care strategies to address the outpatient medical and social issues which lead to readmissions.

Cynosure Health

Cynosure Health is a not-for-profit organization dedicated to improving healthcare at the local, regional and national level. We work collaboratively with hospitals, hospital associations, and others who seek expertise and support as they work toward improving quality and reducing patient harm. Cynosure Health partners with the California Quality Collaborative and the Gordon and Betty Moore Foundation to support the Avoid Readmissions though Collaboration (ARC) program focused on reducing unnecessary hospital readmissions in and around the San Francisco Bay Area.

Gordon and Betty Moore Foundation

The Gordon and Betty Moore Foundation (GBMF) is working to improve patients' transitions from the hospital to the next care setting by helping San Francisco Bay Area hospitals implement innovative care models proven to reduce unnecessary readmissions. GBMF supports the Avoid Readmissions Through Collaboration (ARC) program in partnership with Cynosure Health and the California Quality Collaborative (CQC).

Health Service Advisory Group (HSAG)

Health Services Advisory Group of California (HSAG-CA) is the state's contracted Medicare Quality Improvement Organization (QIO). QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), are collaborating with partners to assist communities and providers with reducing avoidable hospital readmissions.

www.avoidreadmissions.com
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California Readmission Summit: Driving Readmissions Down

Introduction

From one end of California to the other, healthcare providers have been coming together for several years to find creative ways to reduce the rate of 30-day hospital readmissions. While the overall state statistics for all adult, all-payor readmissions have remained stubbornly in the 12 percent range, pockets of success have grown up in areas that have active collaboratives working on a wide variety of innovative initiatives.

To leverage that success, the California Readmission Summit was convened in October 2013. Drawing about 400 attendees from across the state, the Summit provided an overview of state and national efforts to reduce readmissions during a morning general session. In addition, the Summit offered 15 breakout sessions that gave participants the opportunity to explore specific initiatives that could be adapted to meet their local needs. The Summit wrapped up with an inspirational presentation on how to bring innovation into the culture of organizations.

The goals of the Summit were to enable attendees to:

- Select practical strategies to reduce avoidable hospital readmissions in their communities.
- Examine strategies to build cross-setting partnerships between hospitals, nursing homes, home health agencies, and other community partners.
- Compare methods to reduce readmission rates by implementing quality improvement interventions.
- Formulate ways to reduce avoidable hospital readmissions through best practice sharing from successful care transition programs.

As part of a strategy to widely share information, inspiration and success stories, the major presentations offered during the Summit have been summarized in this report. The report begins with a paraphrased recap of a panel discussion of four questions that are at the core of readmission issues today. This is followed by paraphrased summaries of the keynote address and the endnote address. Also included are descriptions of breakout sessions.

"Readmissions Panel Discussion: State of the State"

Panel Participants: Bruce Spurlock, MD; Julie Morath, RN, MS; Diane Stewart, MBA; and Mary Fermazin, MD, MPA

Bruce Spurlock

Julie Morath

Diane Stewart

Mary Fermazin

1. What can each of us do to make measurement more effective?

Julie Morath: Measurement is a serious topic that deserves discussion, but one of the things I've found is that it can be a barrier to getting on with the work. Don't wait for the government to define it; just understand it in your own environment. The real issue is to break through the noise and get to the signal. You can continue to work for a more precise and meaningful measure, but what is important is really understanding what is going on with people who are readmitted.

Diane Stewart: One of the lessons I've learned is that you have to start with what the measurement is going to be used for and work back from that.

Mary Fermazin: There are so many different kinds of readmissions measures – and all of them are confusing to people. I know at the federal level they are diligently working on aligning and harmonizing measurements to decrease "noise," and make measurement less of a burden and more understandable for everyone. There is no such thing as a perfect measure, but there is hope in finding one that can be applied to everybody so that all health care providers can be held accountable.

Bruce Spurlock: We like to benchmark measurements, for example with the 12-month snapshots that come out every quarter. But we need to start thinking about dynamic benchmarking – not just how much we improved, but how much we improved compared to others. If we have improved and are at 10, but everyone else is at 20, then we are behind. So rather than where we rank, we should be looking at how we are doing compared to others.

2. Do you think it is fair to penalize readmissions across the board? Should hospitals bear the burden of all the factors that influence readmissions?

Julie Morath: Everyone has been waiting for the future, but the future is here and we are experiencing penalties – 1 percent reduction in reimbursement this year, 2 percent next year, and 3 percent in 2015 and beyond. This issue is coming at a time when the industry is under barrage in terms of cost constraint and reducing spending. The question is can we afford to make the investments we need to make to reduce readmissions at a time when healthcare providers are being asked to reduce overall costs. The incentives are serving as

a vehicle to accelerate our traditional commitment to patients, and it is a good thing for us to look beyond our walls and collaborate.

Bruce Spurlock: Wouldn't it be great to work with patients in an environment where cost wasn't a concern and you could just do what is right for the patient? That's what I'm committed to, but the reality of the world is that we cannot. The current system for how we finance healthcare is broken – maybe we are moving to a system that isn't broken, but right now it is. The fact is that hospitals lose money when they reduce readmissions. We have to get back to the patient, and having dollars flow to the patient. I don't have the answer other than "Do the right thing for the patient."

Diane Stewart: The insurers who buy healthcare for two million Californians are a voice that is not often in the room, but I can tell you a little about how they see the issue. They know they are shouldering the cost shift from Medicaid and Medicare, and they know that cost and quality are tied. They see the price going up, but they can't really tell about quality. They see Medicare moving to value-based purchasing and that works for them. They are used to doing that on everything else they buy. They are willing to pay more for quality but they can't tell where to find it right now. The good news is they are willing to be collaborative; they want to be there to figure out how to work with this transition as we move from one kind of healthcare delivery system to another.

> *"While we are sitting here today, 288 will be readmitted to hospitals in California."*
>
> Bruce Spurlock, MD

Mary Fermazin: The Affordable Care Act has many payment reforms, and care coordination underlies them all. The other thing is that outcome measurement is coming, and everyone will be held accountable for outcomes, not just processes. With these implications, you can see that a lot of integration is going on, with the need to coordinate care not just within but also outside of each organization. For our patients, care coordination is the most important thing. But economists are warning that more integration and coordination will lessen competition. So we don't know what will happen in the next few years in terms of how the market will shake out.

3. What are the best innovative practices that you have come across?

Diane Stewart: When people become innovative, they start within their own walls, whether they are a hospital or a medical group or some other provider. Then they go out to community partners and really focus on how to engage patients.

Julie Morath: I'm going to be very concrete. There are three that are making a real difference in the stability of patients. 1) MyHealth at Vanderbilt, where patients have access to their chart and can email their physician or other provider about changes in their health condition and seek advice in real time. Engagement of the patient is really a core part of the system; they are not passive recipients. 2) Breaking away from traditional boundaries by involving partners is important. One example is pharmacists, who are in a position to teach patients and play a valuable role in the success of care transition. 3) Predictive models are causing a lot of debate, but they give you the ability to look at the patients within your setting and mobilize resources around those at the highest risk.

Bruce Spurlock: Unlike Julie, I'm going to be abstract. I think the most innovative practice is the concept of creativity. When you travel across the country, the solutions that work in Mississippi are different than those that work in Nebraska. What we do is really a local phenomenon. Two examples: There is a program in Memphis where hospitals got together and engaged the faith community, getting pastors to go along on home visits. This helped in neighborhoods where nurses had felt nervous about their safety and patients had been reluctant to open the door and let the nurses in. The involvement of pastors changed the dynamic for both the nurses and the patients. Readmissions dropped dramatically; this was a local solution that really worked. The second example is from West Virginia hospital that was working on heart failure readmissions. At first, they sent scales home so patients could see if their weight was fluctuating. But patients were having difficulty reading their home scales correctly. So instead, they had them try on their Sunday leather shoes every week – and if the patient did not have a pair, the hospital gave shoes to them. Patients were asked to report when the shoes felt comfortable and when they were tight. If the shoes didn't fit well, it was a sign of edema and the need for further treatment. So the most promising innovation I see is the creative energy and the neat ideas about how to adapt common solutions for local conditions.

> *"Language creates consciousness and culture. I would love to see us lose the word 'hand-off' – you can throw something over the transom and that's a hand-off. 'Hand over' means that the responsibility is accepted by the other side. I'd also like to get rid of 'noncompliant' as a way to describe patients. Blaming the patient just gets in our way and creates a barrier to understanding what is going on with the patient. And finally, 'discharge' is an unattractive word if you look it up in a dictionary. We should be in the business of continual transitions and making those transitions as smooth as possible."*
>
> Julie Morath, RN, MS

4. How are institutions engaging patients in their own care?

Diane Stewart: At Avoid Readmissions through Collaboration (ARC), we've put together a patient advisory council and we've learned a great deal from them. There was the young man with cancer who saw the discharge process as "a lot of paperwork and not a lot of talk." Another member, the mother and caretaker of the young man with cancer, found all of the medical jargon baffling and felt people should be able to get answers in real time. A third patient, a man with cardiac problems, sees cross-discipline communication issues that he felt should be resolved within the hospital. He didn't believe that coordination of care should fall to the patient. So bringing patients into our work and understanding their perspective is very important.

Mary Fermazin: It is not easy to get patients involved – it's one step at a time. You have to interview them and understand where they are coming from, and then ask if they would like to participate. But it is important because even our own well-educated family members and friends are telling us that they can't understand what the physician is saying and they feel burdened by having to pass information that the hospital tells them on to the nursing home. We need to solve that.

Bruce Spurlock: Healthcare is local; healthcare is individual. When you've seen one patient – you've seen one patient. You can use principles, and concepts, and averages, but you cannot generalize too much or you will miss what is happening with a specific patient. So the notion of engaging patient is important but is something that we are not doing enough of yet.

Julie Morath: We came up with daily rounds to talk about transitions – from the ICU to a ward, or the transition to home or to a different level of care at a nursing home. What we designed was a screen that had a language map every day that projected the patient's own words about their experience. Every provider and every caregiver could see what was on the patient's mind and interventions could be made accordingly. So harnessing technology is one way to engage patients.

Reducing Readmission Risk through High-Quality Transitions

Keynote address by Jane Brock, MD, MSPH,
Chief Medical Officer for Community Action, CFMC

One of the hottest topics in healthcare reform today is the hospital readmission rate – yet this is not a new concern. When we look back at calls for reform over time, we see as early as 1949 that policy makers were concerned that healthcare in the United States was too hospital-centric. In 1980, hospital costs were labeled unsustainable. And in 1984, the Health Care Financing Administration was being urged to engage subcontractors to work on preventing readmissions.

Despite this historical focus on hospital readmission rates, little has changed. In 1984, the 30-day readmission rate was 19.6 percent. Thirty years later, we have pretty much the same rate.

Increasingly there is the recognition that reducing readmissions is not simply a matter of putting pressure on hospitals. In fact, an April 2012 New England Journal of Medicine article found that "much of what drives hospital readmission rates are patient- and community-level factors that are well outside the hospital's control."

> *"If other prices had grown as quickly as healthcare costs since 1945, a dozen eggs would cost $55, a gallon of milk would cost $48 and a dozen oranges would cost $134."*
>
> Jane Brock, MD, MSPH

So what should be the role of hospitals in reducing readmission rates? In Colorado, where we started with a three-community pilot in 2006 that was expanded to 14 communities nationally from 2008 to 2011, we learned that when people leave hospitals, they simply don't do a good job of managing their condition. We found that three things go wrong with the provider-patient interface that leads to readmission: 1) their unmanaged condition worsens, 2) they use suboptimal medication regimes, and 3) they return to an emergency department where hospitals lack intervention options that would keep them from being readmitted.

Why does this happen? The immediate answer is that the support system for care transition is unreliable. There is a lack of standard processes for transitioning a patient's care, the information transfer from the hospital to the next care provider is often unreliable, and patient activation is not supported during the transfer.

Patients need to know what to do and how to do it, and have the confidence that they can handle what they are being asked to do. People need to be supported when they arrive at the next care setting, but that too often is not the case.

These concepts are not new, yet hospitals have not been able to solve the problem of readmissions. What we found is that there is no community infrastructure for achieving the common goals of a successful care transition. In the end, this is a local management problem. You have to know who the local partners are and bring them together to strengthen the care transition model.

Based on a series of papers out of Stanford University about the way to create an effective community-based effort, the 14-community project used a convening and collaborative approach. It was critical to have the right experts in the room – for example, you need home healthcare providers in the room if you are designing a home healthcare process.

"Before the telephone was introduced at the 1876 World's Fair in Philadelphia, people wrote notes to each other and the mail was delivered four times a day in urban areas. When the 'speaking machine' was introduced, people understood that it was a transformation for communications. By the 1960s and 70s, everyone had at least one telephone at home and futurists were saying the next improvement in communications would be the video phone. Instead the huge innovation was the digitalization of information – so now we have smart phones, everyone is texting, and we're back to written communications, but in real time and without the mailman. So when we apply the word transformation to healthcare, we need to be much broader in our thinking about what that can mean."

Jane Brock, MD, MSPH

When these 14 communities leveraged existing interventions together, as well as created new ones, they began to see readmissions drop. In communities without the project, rates dropped as well, but in the participating communities readmissions improvements were three times greater, dropping 5.7 percent. Bringing people together accelerated the reduction in readmissions.

Based on this success, beginning in 2011 the federal government funded collaboration in 375 communities covering 35 percent of the Medicare population. The Integrating Care for Populations and Communities has the goal of reducing the 30-day readmission rate by 20 percent through improving the quality of transitional care. Communities work together, using tools like root cause analysis, social network analysis diagrams and hot-spotting maps. Results are tracked and driven by data.

The early progress report from this initiative is very good – by the end of the third quarter of 2012, readmissions per 1,000 patients were down 9.1 percent.

So how did these communities make this kind of progress? At the patient level, there are interventions to make sure patients have the appropriate level of support they need to manage their own care.

At the institution level, care providers standardized transfer processes, standardized the transfer of information, understood the capabilities of the care-providing partners involved, and tracked data.

And at the coalition level, success came from having a common agenda, a standard measurement system, mutually reinforcing activities, continuous communication and organizations to provide backbone support.

In the real world, this ideal structure is difficult to achieve. But what we found is that even meeting and discussing issues makes a difference. Agreeing on a common metric to measure results…discussing actual cases…having accountability to a broader constituency. All of these things are valuable, but simply having a regularly schedule forum for social interaction and discussion is very powerful.

At the same time we are seeing progress across the country on readmissions, challenges remain and changes are coming. Among these are:

- ❖ Debate about what to measure and how to make sure penalties are aligned with what we want to improve. The Affordable Care Act penalizes hospitals based on readmissions compared to discharges, but our pilot projects were allowed to track improvements based on readmissions per thousand population, a much more meaningful statistic.
- ❖ Increases in hospital penalties (now 2 percent and headed for 3 percent), as well as additional conditions that will be monitored for readmission rates (CABG and COPD).
- ❖ The issue of how observation stays impact patients and are tied to hospital efforts to reduce readmissions.
- ❖ Risk stratification tools that help identify patients most likely to be readmitted. There are a huge number of risk models, and no one tool is perfect. Even the best typically fail to identify a third of those who will be coming back. Risk stratification works better when it takes into account mental health diagnosis, substance abuse status, functional capability, and patient preparation/confidence.
- ❖ The link between socio-economic status (SES) and admissions. There is a lot of contention around this issue, and not much agreement on the best way to measure SES. However, it appears to make only a 3 to 4 percent difference in risk stratification modeling.

In the end, what may make the most difference in the health of people in the United States is adopting a much broader notion of "bundling" – bringing social service and health spending together so there is a greater safety net of services that is capable of supporting people in their communities. The goal should be to focus on better health, and not medicalizing every issue, so that more services can be provided affordably.

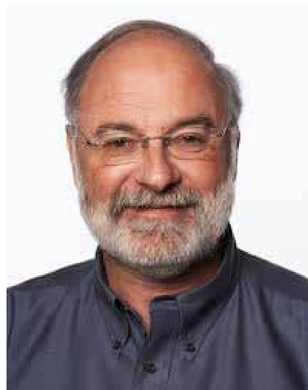
When we reach that stage, the question we will focus on in each community is "who lives here?" "what do they want/need?" Each of us will know what our role is and how we will be held accountable for fulfilling that role. The result will be better health for the population.

"There are three basics of intervention. If you want people to cross a bridge, you have to make sure they are capable of crossing it – but you also need to build a better bridge, plus you need to give them a map so they know how to cross it. Each of these calls for a different type of intervention. To help people be capable of crossing the bridge, you need coaches; some people may need a navigator or care coordinator to hold their hand while they cross; and others may need a transitional care nurse to carry them over the bridge."

Jane Brock, MD, MSPH

“Innovation is No Longer Optional”

Endnote Address by Doug Solomon, PhD, MPH, Innovation Consultant and IDEO Fellow



In the past, many organizations felt that if things weren’t broken, they could keep them the way they are. But given the path of change and the pace of change, today innovation is no longer optional for any organization. My goal today is to share some frameworks around how to understand innovation.

We can begin with the concept of “design thinking” – a thought practice that came out of industrial design over the past 60 years. It has been used to develop physical products, but we have found that it is applicable to non-physical things, such as strategies and experiences. It really borrows heavily from anthropology, sociology and psychology.

> *“Innovation is kind of like quality. It sounds good; you can’t argue with it, but most people don’t know what to make of it. When people were concerned that the Japanese were going to take over sales to consumers with well-made goods, companies put up posters that said ‘Quality is our No. 1 job.’ It didn’t change anyone’s behavior. Most organizations put up signs, but signs don’t work. They just are not powerful enough to change behavior.”*
>
> Doug Solomon, PhD, MPH

Design thinking starts and ends with the people you are trying to design for. You deeply look at it from the point of view of the people you are designing for: understand their behaviors and infer their motivations. You need to understand people within the cultural context they live in – and that helps us understand the way they think and act.

What are the key advantages of design thinking and why should you care? First, because design thinking is focused on the end user and key influencers in any process, you should end up with a much better solution for the people involved.

Second, by using design thinking, you build tangibility into the process – and tangibility provides impetus for moving projects forward.

And third, design thinking reduces risk in projects. Generally, we don’t prototype ideas at the beginning of a project; instead we do it later, and then it is often too late to change. But with design thinking, we believe in prototyping and failing early to succeed sooner. If the prototype doesn’t work, throw it away and start over again.

So innovation is not just about what we do, but also how we do it. Design thinking results in innovation because it is empathetic, insight-driven, integrative, experiential, intuitive and optimistic.

How do we build a culture of innovation? There are five recommendations:

1. ***Find out what people care about.*** You may say that you know what patients want because you talk to them every day. But we actually don’t know what they want until we try to find out directly from them what they really care about.

2. ***Start small but start now.*** Often at the beginning of a project, we think too much and act too little. We put off acting and miss opportunities. In addition, we can build on what is already working; we don't have to do something entirely new. And by taking action, we can become more certain about what works and what does not.

3. ***Experiment to learn.*** Sometimes we set things in stone. We roll out a big new program and don't want to change it. But if we "embrace the beta," we can implement innovations, make sure people are comfortable with it, and then change as we continually learn about what works.

4. ***Bring in the outside world.*** Engage other perspectives. Bring in people to find out what moves them and what their concerns are. Design with, and not just for, the people involved.

5. ***Model the behaviors you desire.*** You have to adopt the behaviors you want other people to engage in. If you don't model it, then they will catch on that you don't care and are just imposing a solution on them.

Two examples of how innovation works in the healthcare world have inspired me. One is the senior engineer and designer for MRI and CAT scanners who visited a hospital one day and discovered that children are frightened of these machines. He had been working on them for 30 years and thought of them as great products – but now he was devastated to discover that 80 percent of children needed to be sedated at this hospital for scans. He went to design school at Stanford and learned about design thinking. The result was turning the MRI into a pirate ship or a submarine under the sea. The idea was to kneel down and look at what was happening from the perspective of a child.

The second example was of a challenge to design an extremely affordable incubator that didn't require electrical power and that could be used in developing countries. The students that took on the challenge went to Nepal and discovered that 20 million children are born each year in the rural areas, and that at least one quarter die within the first month. Several gave up jobs and moved to India to create Embrace, sleeping bags with a pocket for a heated insert made out of plastic. It was really a brilliant innovation that began with design thinking – a complete focus on the needs of the end users.

> *"Ready, fire, aim – that's what most organizations do. What we suggest is to go more abstract. Try to synthesize insights and create a conceptual framework of where we are and where we would like to go. And then create a strategy."*
>
> Doug Solomon, PhD, MPH

CARS Breakout Sessions

The following is a brief summary of the breakout sessions that were available to Summit participants.

It Takes a Village: How One ACO Has Partnered with Hospitals and Community Pharmacists to Improve Care Transitions

This session provided an overview of Heritage California ACO's fundamental goals: Focus on providing good care and good patient experiences that align with quality measures and costs. Dr. Brian Hodgkins described how Heritage ACO's model optimizes care by focusing on the whole patient, not just on the primary admission diagnosis. Desert Regional Medical Center has partnered with Heritage ACO where the intervention starts on day 1 of the patient stay; this is when Care Managers go to the hospital to meet with the patient.

Dr. Tim Perlick talked about the primary roles of pharmacists in an ACO model related to admissions and discharges. Speakers identified opportunities for pharmacists to collaborate with ACOs as an expansion of both delivery sites and scope of practice. They also demonstrated how transitional care gaps could be filled by collaboration between hospitals and community pharmacies.

Patient Engagement Through Empowerment: Julia Hallisy and the ARC Patient/Caregiver Panel

This session focused on the topics of patient engagement, provider-patient communication, and patient challenges with navigating the healthcare system. Dr. Julia Hallisy shared her personal story with frequent hospital readmissions while she cared for her daughter who was diagnosed with retinoblastoma at an early age and subsequently succumbed to the illness at age 11.

This experience prompted Dr. Hallisy to create 'The Empowered Patient Coalition (EPC), which is a consumer and advocate-led non-profit that works to inform, engage and empower patients, family members, and providers. The EPC provides tools, resources, and support to organizations and patients to help bridge the communication gaps that occur during the care transition process.

The EPC especially focuses on patients/caregivers taking charge of their own healthcare and partnering with hospital and community providers to make the care transition process as seamless as possible. Four members of the ARC Patient Advisory Council participated on a panel during this session and answered questions focused on what they felt the most important areas of needs are for patients when making the transition from hospital to home. Patient education, mental health support, and preparing the patient for discharge at an earlier time were identified as key issues to prevent a trip back to the hospital.

Supporting Providers through Patient-Centered, Interdisciplinary Palliative Care

Dr. Suzanna Makowski talked about the changing perspectives on Palliative Care (PC) including building the primary palliative care model and shifting PC from problem-based care to goal-based care. The focus is on how to provide the best care while keeping the patients' goals the main priority. Dr. Makowski discussed UMASS Memorial's Palliative Care Program and its current focus on preventing readmissions, enhancing coordination of care across the continuum, and follow-up on medication education, goals of care, and symptom management. She also talked about the Lois Green Learning Community, which is an online palliative care learning resource.

Dr. Sangeeta Kopradekar shared her efforts with the Palo Alto Medical Foundation's Outpatient Palliative Care Program. The Outpatient Palliative Care team consists of two doctors, a Nurse Practitioner, a Social Worker, an RN Liaison, and a Care Coordinator. Major takeaways were to engage the patient/caregivers from the start because if the caregiver system fails, the patient fails; addressing caregiver burnout; assessing for function (marker of prognosis and identification of needed support); and the importance of having a team-based PC program. The team at Camino has been operational for about 10 months. Preliminary data shows a reduction in readmissions to the hospital by 84 percent.

Many Roads Lead to the Top of the Mountain: Three Different Approaches to Reduce Readmissions

In this breakout session, Shogofa Zamon, Project RED Coordinator at St. Rose Hospital, Valerie Cronin the Director Utilization Management at Lodi Health, and Eileen Brinker, Heart Failure Program Coordinator at UCSF Medical Center, discussed the different approaches they have taken to reduce readmissions.

Shogofa shared that the key levers for St. Rose are their Project Red team members. Unlike other hospitals, they are staffed for the most part with non-clinical team members who are doing a fantastic job listening to the patients, making post-discharge phone calls. One reason for their success is the support they receive from the nursing staff, who view their roles as very important support for patients. The Project RED team has reduced their 30-day readmissions by 29 percent and they are still going strong. Another key success factor is seeing enough patients. You can have the greatest intervention in the world but if you don't see enough patients you will not be able to impact your readmission rate.

Valerie discussed the long and layered journey that Lodi has taken to reduce their readmission rates. Their key to success is the implementation of BOOST throughout the medical center. They are now reaching out into their community to advance their work. Lodi also hired a program coordinator to make sure all aspects of the work are in place.

Eileen shared the five-year journey that UCSF has been on to reduce heart failure readmissions. They implemented the IHI model and worked to greatly improve and deliver education to their patients. Without a doubt improvements in communication to the patients, their caregivers and among the team have been key drivers of their successes, as have the rigorous deployment of teach back and the incorporation of palliative care. Since they started this work, the heart failure readmission rate at UCSF has been cut in half.

Good to Go: Using Technology to Improve Care Transitions

In this breakout session, Cheryl Bailey, Chief Nursing Officer and VP of Patient Care Services at Cullman Regional Medical Center, shared the very innovative technology they are using to record discharge instructions so their patients can listen to them over and over again after discharge. Using a software platform developed by ExperiaHealth, staff nurses are able to record patient teaching instructions at the bedside using a hand-held Apple device. Once home, patients and their families are able to access these recordings along with a personalized library of teaching programs. The results are in and the organization increased their HCAHPS scores by over 60 percent, patients love it and staff love it.

A Way to Approach Addiction in Your Readmission Reduction Efforts

In this session Mark Stanford, Santa Clara Valley Medical Center Department of Alcohol & Drug Services, described the approach SCVMC is taking. Dr. Stanford shared the neurophysiology of addiction and informed the audience that almost 90 percent of substance abusers go undetected yet their substance abuse often leads to poor healthcare choices and chronic diseases that drive up healthcare costs. At SCVMC, a structured approach called SBRIT is used. It stands for Screening, Brief Intervention and Referral to Treatment. They use the CAGE-AID tool for screening and act upon the results. Although the program is new, Dr. Stanford and his team expect to impact the heart failure readmission rates at SCVMC.

New Approaches to Community Pharmacist Interaction

In this session, Kevin Rhodondi and Marilyn Stebbins, both of whom are pharmacist with UCSF, discussed the partnership they are developing with their community Walgreens pharmacy. Their approach is to identify heart failure patients who are at a high risk of readmission, provide these patients with an accurate medications list, and bring to their hospital beds a medication supply. The patients are then connected to their community pharmacist through a specific hand-over process.

Getting on the Same Page: Hospital, Community, Caregiver Alliance

Carole Levine from the United Hospital Fund spoke about the ground-breaking work she has led in New York City to integrate family caregivers into the support and management of patients recovering from illness. Excellent checklists and guides for caregivers and providers are available on the website: www.nextstepincare.org. The tools are available in four languages, English, Spanish, Chinese and Russian.

Collaborating with Community Pharmacies to Reduce Readmissions

Representatives from three major chains, Walgreens, Ralphs and Safeway, described their partnerships with hospitals, doctor groups and patients to provide medication management services on location at the hospital, the patient's home or at the pharmacy.

Together We're Better: Extending Patient Care Outside the Hospital Walls

Nancy Seck and June Simmons discussed the history of the community collaborative efforts in the California city of Glendale and their partnerships with community based organizations, skilled nursing facilities, and home health agencies. They shared the tools that have been created in the collaborative environment and how to replicate the effort in other communities.

The speakers went on to reinforce the need for community based organizations to be involved in the care of patients

and how the community based organizations can enhance the efforts of the healthcare delivery system.

Successful Strategies to Increase Patient Activation

Cheri Lattimer discussed two key strategies for increasing patient activation: 1) the role of providers in patient engagement and 2) how to engage patients to manage their own needs and preferences to prevent and manage their condition.

Implementing the Bridge Model to Reduce Readmissions at a Major Medical Center

This session provided a general discussion of the Bridge Model, its results in reducing avoidable readmissions and the scalability of the intervention. Bridge is a telephonic intervention that consists of a social worker-led interdisciplinary team. Walter Rosenberg also stressed the importance of communication between hospitals and community providers being facilitated by the care coordinator, ultimately reinforcing the team-based approach to care transitions.

Cedars-Sinai Health System: Partnering with Home Health Agencies and Nursing Homes to Prevent Hospital Readmissions

Katie Gurvitz, Kelley Hart and Michelle Hoffhine discussed two successful programs to reduce readmissions: 1) the Enhanced Home Health Program, which involves offering more rigorous home health services to patients in the first two weeks post discharge; and 2) the Enhanced Care Program, which involves the hospital deploying nurse practitioners into the nursing home to follow patients for a month after a hospitalization. Both programs successfully reduced readmissions by over 50 percent.

Road Trip

The Summit also featured a road trip session where participants were able to spend time with experts and ask them about:

An in-hospital simulation program that allows patients to practice weighing themselves, planning a meal and managing their medications.

Health literacy and how healthcare providers can improve their patient communications.

Setting up or enhancing a Patient Advisory Council.

FEATURED SPEAKERS

Jane Brock, MD, MSPH
Chief Medical Officer for Community Action
Colorado Foundation for Medical Care

Dr. Brock is the Chief Medical Officer for Community Action at the Colorado Foundation for Medical Care (CFMC), the Medicare Quality Improvement Organization (QIO) for Colorado. Dr. Brock received her MD from The University of Kansas and her MSPH and Preventive Medicine training from The University of Colorado, and spent 23 years in clinical practice. Her work focuses on reducing unwanted readmissions for Medicare beneficiaries, and supporting communities to develop coalition-based approaches for achieving better health for community residents. She currently serves as a member of the National Coordinating Center for the QIOs' Aim to Integrate Care for Communities & Populations, and leads several projects designing data streams and other tools for community stakeholders to use for improvement.

Julie Morath, RN, MS
President and CEO
Hospital Quality Institute (HQI)

Julianne Morath, RN, MS, is a recognized expert in health care quality and patient safety. She serves as President and CEO of the Hospital Quality Institute (HQI), a collaboration of the California Hospital Association and the three Regional Associations. Prior to joining HQI, Ms. Morath served as Chief Quality and Patient Safety Officer for Vanderbilt University Medical Center. She is a founding and current member of the Lucian Leape Institute of the National Patient Safety Foundation and serves on the Board of Commissioners of The Joint Commission and the Board of the Virginia Mason Medical Center and Health System. Ms. Morath is a distinguished advisor to the National Patient Safety Foundation, past member of the National Quality Forum Best Practices Committee, and member of the Advisory Board to the Association of the Advancement of Medical Instrumentation.

Bruce Spurlock, MD
Executive Director
Cynosure Health

Dr. Spurlock is the Executive Director of Cynosure Health where he directs and facilitates multi-participant healthcare quality collaboratives designed to accelerate the dissemination of evidence-based clinical practices. Dr. Spurlock is currently Chair of the CHART Board and Adjunct Associate Professor for Stanford University. Prior to establishing Cynosure Health, Dr. Spurlock was the Executive Director of BEACON, the Executive VP for the California Healthcare Association (CHA), and practiced internal medicine as a senior physician with The Permanente Medical Group, Inc. Dr. Spurlock earned his MD degree from the University of California, Davis and completed his internal medical residency, chief residence and general medicine fellowship at Kaiser Foundation Hospital in Santa Clara, CA.

Doug Solomon, PhD, MPH
Innovation Consultant and IDEO Fellow

Doug Solomon is an IDEO Fellow and innovation consultant. For the past five years, Doug was Chief Technology Officer at IDEO, working with clients to leverage technologies that create both business and social value. With more than 30 years of leadership experience at the intersection of health, technology and people, Doug has a particular interest in collaborative approaches that enable people to innovate in ways they never before thought possible.

Mary Fermazin, MD, MPA
Chief Medical Officer
Health Services Advisory Group of California, Inc.
Vice President, Health Policy & Quality Measurement
Health Services Advisory Group, Inc.

Dr. Fermazin provides strategic medical and quality improvement leadership in all work undertaken by the Medicare Quality Improvement Program in California. She has strong interest in improving care coordination and care transitions and has extensive experience in building provider coalitions to more effectively and efficiently achieve common goals of health care improvements. Dr. Fermazin also has extensive expertise in quality measurement and leads the CMS Measures Management Special Innovation Project. She has over 25 years of health care industry experience as a physician, medical quality consultant, and quality improvement and measurement expert. Prior to her work at Health Services Advisory Group, Inc., she had served as the Chief of the state's Office of Clinical Standards and Quality at the California Department of Health Services. Dr. Fermazin is a general internist with a Master's Degree in Public Administration.

Diane Stewart, MBA
Senior Director
Pacific Business Group on Health (PBGH)

Ms. Stewart directs PBGH's health care improvement initiative, California Quality Collaborative, a statewide collaborative program to re-engineer care in the outpatient setting in partnership with health plans, medical groups, and employers. She developed the California Improvement Network, a program funded by the California HealthCare Foundation to foster practice improvement across all public and private delivery systems in California. Previously, she led the technical development team for the Integrated Healthcare Association's Pay for Performance. Prior to joining PBGH, Ms. Stewart was Director of Quality and Planning at the Palo Alto Medical Foundation, where she initiated the quality program driving improved outcomes in patient satisfaction, clinical performance, financial performance, and staff satisfaction. Ms. Stewart has also held management positions at Harvard Community Health Plan as well as other IPAs and medical groups on the east coast. Ms. Stewart received a BA in Biology from Dartmouth College and an MBA from the Yale School of Management.

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