REDUCING READMISSIONS - 2015

Focus on Medicaid, the Emergency Department and Behavioral Health

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Collaborative Healthcare Strategies
February 13 2015
Objectives

• What are hospitals with hospital-wide results doing?

• How does that differ from what we are doing?

• What are 3 practical ways to expand our strategies?
Key Messages

• Medicaid adults have high readmission rates

• Medicaid patients need to be specifically identified as high-risk of readmission

• Readmission reduction efforts must include the ED

• High risk targeting should include presence of BH comorbidities and High Utilizers with any diagnoses
THANK YOU CMS

6 game-changing messages from CMS policies……..
6 Very Important Messages from CMS

- Readmission reduction pays – inaction hurts
- Hospitals must update & standardize transitional care processes
- Reducing readmissions is a cross-continuum effort
- Attend to non-clinical needs for post-hospital supports & services
- We will flood the market with all best ideas on our dime
- Reducing readmissions requires better data
HOWEVER....

*Powerful messages from powerful agencies can create blinders*
CMS’ Medicare Focus Has Created Blinders

1. HF, AMI, PNA…COPD, hip/knee replacement
   • NOT the 5 most frequent diagnoses leading to readmissions
   • CMS’ discharge diagnosis-specific penalty obscured other meaningful categorizations s/a frequent utilizer, social complexity, BH, functional status

2. Driven a Medicare focus to the exclusion of other high risk patient groups
   • Medicaid adults have higher readmission rates than Medicare FFS

3. Driven a case-finding approach
   • Interventions often limited to Medicare FFS with certain diagnosis
   • Created a 2-tiered discharge process - at odds with principles of quality

4. Preferred first move among hospitals: hire a Transitional Care FTE
   • Lost the focus on reliable redesign on transitional care for all patients
   • Hire dedicated staff to focus only on “penalty condition” patients
Medicare Readmission Penalties

- October 1 2014- September 30 2015
- Up to 3% reduction in all Medicare payments for hospitals
- 6 Dx: AMI, HF, PNA, COPD and hip and knee replacement
- Average penalty **DOUBLED** this year
- 2,160 hospitals penalized; **$480 MILLION**
CRUNCHING THE NUMBERS

Will your current strategy get you to your goal?
Let’s Run the Numbers:  
*One Strategy Won’t Get Us There*

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<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Medicare admits/year</td>
<td>5,000 admissions</td>
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<tr>
<td>Medicare RA rate</td>
<td></td>
<td>18%</td>
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<tr>
<td># Medicare RA/year</td>
<td>900 readmissions</td>
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<tr>
<td>Pilot project</td>
<td>200 high risk patients</td>
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<tr>
<td>Pilot group RA rate</td>
<td></td>
<td>25%</td>
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<tr>
<td>Expected # RA pilot</td>
<td>50</td>
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<tr>
<td>Expected effect of pilot</td>
<td></td>
<td>20%</td>
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<tr>
<td># RA reduced by pilot</td>
<td>10</td>
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<tr>
<td># Medicare RA/year</td>
<td>=900 – 10 = 890</td>
<td>1%</td>
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</table>

*Collaborative Healthcare Strategies*
Hospitals with hospital-wide results

- Know their data –
  Analyze, trend, track, display, share, post

- Broad concept of “readmission risk”
  Way beyond case finding for diagnoses

- Multifaceted strategy
  Improve standard care, collaborate across settings, enhanced care

- Use technology to make this better, quicker, automated
  Automated notifications, implementation tracking, dashboards
EXPAND EFFORTS FOR IMPACT

Broad concept of risk, broad understanding of patient needs
Next Frontier: Medicaid Readmissions

What is different? What is similar?

• Population analyses of Medicaid readmission rates are low
  • Because they include high-volume deliveries (OB) and pediatric discharges
  • Readmission rates appear low and providers think there is no “problem” in Medicaid

• Emerging experience suggests that social, financial, behavioral health factors greatly influence risk of readmission

• Adult Medicaid patients would be expected to have a high prevalence of social, financial and behavioral health issues

• Little has been described about readmission rates and the factors that contribute to readmissions among the younger adult population
1. Know Your Data
2. Inventory Readmission Efforts
3. Develop a Portfolio of Strategies
4. Improve Hospital-based Transitional Care
5. Collaborate with Cross Setting Partners
6. Provide Enhanced Services
   • 13 new Tools
Tools

1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide
KNOW YOUR (OWN) DATA

Analyze, track, trend, raw unadjusted data to identify opportunities
Readmission Analysis

Use the most recent 12 months of data available. Using all hospital discharge data, exclude patients <18, all OB (DRG 630-679), discharges dead, or transfers to another acute care hospital. Define a readmission as any return to inpatient status within 30-days of discharge from inpatient status.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Private</th>
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<tbody>
<tr>
<td>A. Total Discharges</td>
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<tr>
<td>B. Total Readmissions</td>
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<tr>
<td>C. Readmission Rate (B/A)</td>
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<tr>
<td>D. Total Discharges to Home</td>
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<tr>
<td>E. Total Discharges to SNF</td>
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<tr>
<td>F. Total Discharges to Home Health Care</td>
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<tr>
<td>G. Total Discharges with any coded Behavioral Health Diagnosis (290-319)</td>
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<tr>
<td>H. Total Readmissions with any coded Behavioral Health Diagnosis</td>
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<tr>
<td>I. Number / % of readmissions occurring within 7 days of d/c</td>
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<tr>
<td>J. Number of patients with ≥4 hospitalizations in past year</td>
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<tr>
<td>K. Total number of discharges among [J]</td>
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<tr>
<td>L. Total Number of 30-day readmissions among [J]</td>
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<tr>
<td><strong>M. Top 10 Discharge Diagnoses Resulting in Readmission, by Payer</strong></td>
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<table>
<thead>
<tr>
<th>All Payer</th>
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<th>Medicaid</th>
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<td>9</td>
<td></td>
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<tr>
<td>10</td>
<td></td>
<td></td>
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<tr>
<td><strong>N. Proportion of all readmissions represented by top 10 discharge diagnoses</strong></td>
<td>X%</td>
<td>Y%</td>
</tr>
</tbody>
</table>

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### Readmission Analysis

Use the most recent 12 months of data available. Using all hospital discharge data, exclude patients <18, all OB (DRG 630-679), discharges dead, or transfers to another acute care hospital. Define a readmission as any return to inpatient status within 30-days of discharge from inpatient status.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Total Discharges</td>
<td>12324</td>
<td>2222</td>
<td>5753</td>
<td>834 (7%)</td>
</tr>
<tr>
<td>B. Total Readmissions</td>
<td>1609</td>
<td>313</td>
<td>1031 (64%)</td>
<td>77</td>
</tr>
<tr>
<td>C. Readmission Rate (B/A)</td>
<td>13.1%</td>
<td>14.1%</td>
<td>17.9%</td>
<td>9.2%</td>
</tr>
<tr>
<td>D. Total Discharges to Home (Routine Discharge)</td>
<td>9136</td>
<td>1101 (50%)</td>
<td>4460 (77%)</td>
<td>731</td>
</tr>
<tr>
<td>E. Total Discharges to SNF</td>
<td>703</td>
<td>560 (25%)</td>
<td>229</td>
<td>13</td>
</tr>
<tr>
<td>F. Total Discharges to Home Health Care</td>
<td>505</td>
<td>555 (25%)</td>
<td>244</td>
<td>13</td>
</tr>
<tr>
<td>G. Total Discharges with any coded Behavioral Health Diagnosis)</td>
<td>7456 (60%)</td>
<td>1279</td>
<td>3992</td>
<td>603</td>
</tr>
<tr>
<td>H. Total Readmissions with any coded Behavioral Health Diagnosis)</td>
<td>1320 (82%)</td>
<td>291</td>
<td>1272</td>
<td>55</td>
</tr>
<tr>
<td>I. Number of readmissions occurring within 7 days of d/c</td>
<td>578 (36%)</td>
<td>111</td>
<td>366</td>
<td>24</td>
</tr>
<tr>
<td>J. Number of patients with ≥4 hospitalizations in past year</td>
<td>326</td>
<td>73</td>
<td>221</td>
<td>10</td>
</tr>
<tr>
<td>K. Total number of discharges among [J]</td>
<td>1734 (14%)</td>
<td>371</td>
<td>1201 (21%)</td>
<td>55</td>
</tr>
<tr>
<td>L. Total Number of 30-day readmissions among [J]</td>
<td>563 (35%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Proportion of All Readmissions Accounted for by top 10 Diagnoses</td>
<td>28%</td>
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</tbody>
</table>
## All-Payer by Payer Readmission Analysis

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Comm.</th>
<th>Unins.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARF (1384)</td>
<td>Sickle Cell (478)</td>
<td>Chemo (290)</td>
<td>Pancreatitis (187)</td>
<td>Sepsis (1859)</td>
</tr>
<tr>
<td>Sepsis (1366)</td>
<td>Sepsis (175)</td>
<td>CVA (276)</td>
<td>Chemo (157)</td>
<td>ARF (1800)</td>
</tr>
<tr>
<td>PNA (1336)</td>
<td>Chemo (175)</td>
<td>Arthritis (260)</td>
<td>DKA (136)</td>
<td>PNA (1750)</td>
</tr>
<tr>
<td>COPD (1211)</td>
<td>COPD (173)</td>
<td>Sepsis (222)</td>
<td>CVA (125)</td>
<td>CVA (1622)</td>
</tr>
<tr>
<td>CVA (1140)</td>
<td>DKA (156)</td>
<td>PNA (188)</td>
<td>COPD (109)</td>
<td>COPD (1608)</td>
</tr>
<tr>
<td>UTI (1038)</td>
<td>PNA (145)</td>
<td>ARF (182)</td>
<td>ARF (97)</td>
<td>UTI (1608)</td>
</tr>
<tr>
<td>Afib (851)</td>
<td>ARF (137)</td>
<td>CAD (181)</td>
<td>Sepsis (96)</td>
<td>HF (1115)</td>
</tr>
<tr>
<td>HF (822)</td>
<td>HF (129)</td>
<td>Pancreatitis (153)</td>
<td>PNA (81)</td>
<td>CAD (1092)</td>
</tr>
<tr>
<td>CAD (746)</td>
<td>Pancreatitis (127)</td>
<td>Afib (152)</td>
<td>ETOH w/d (76)</td>
<td>Afib (1092)</td>
</tr>
</tbody>
</table>

*Method: DRG, age>18, exclude OB*
Top 10 Medicaid Dx:
1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. Comp. of pregnancy
5. Alcohol-related
6. Early labor
7. CHF
8. Sepsis
9. COPD
10. Substance-use related

Top 10 Medicare Dx:
1. CHF
2. Sepsis
3. Pneumonia
4. COPD
5. Arrythmia
6. UTI
7. Acute renal failure
8. AMI
9. Complication of device
10. Stroke

Methods:
- Used CCS groupers
- Included OB
Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010


-- Indicates too few cases to report.
## County Hospital Readmission Stats

<table>
<thead>
<tr>
<th>Measure</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Discharges</td>
<td>11,850</td>
<td></td>
</tr>
<tr>
<td>Total Medicare Discharges</td>
<td>967</td>
<td>8% total</td>
</tr>
<tr>
<td>Total (adult non-ob) Medicaid Discharges</td>
<td>4,288</td>
<td>36% total</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 30-day Readmissions</td>
<td>1,631</td>
<td>14% RA rate</td>
</tr>
<tr>
<td>Total Medicare Readmissions</td>
<td>154</td>
<td>9% total</td>
</tr>
<tr>
<td>Total (adult-non-ob) Medicaid Readmissions</td>
<td>823</td>
<td>50% total</td>
</tr>
</tbody>
</table>

**Medicaid RA are 35% higher than all-payer RA**

**Medicaid RA account for 50% of ALL Readmissions**
## Medicare v. Medicaid – Discharge Disposition

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to Home</td>
<td>55%</td>
<td>84%</td>
</tr>
<tr>
<td>Discharge to SNF/IRF/LTAC</td>
<td>24%</td>
<td>5%</td>
</tr>
<tr>
<td>Discharge to Home with Home Health</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Medicaid High Utilizers - AHRQ

- >3 hospitalizations/year
- 85% are over age 21
- Average ~6 hospitalizations/year v. 1.3 for non-high utilizers
- Average LOS 6.1 days v. 4.5 for non-high utilizers
- Average cost per hospitalization $11,600 v. $9,000 for non high-utilizers
- Readmission rate 52% v. 8% for non high-utilizers
- 74% of high utilizers are discharged to home
- Top Dx: mood disorders, schizophrenia, DM, chemo, sickle cell, ETOH, sepsis, CHF, COPD

Jiang et al. HCUP Statistical Brief #184 Nov 2014
ASK YOUR PATIENTS “WHY”

*Interview patients, caregivers for the “story behind the chief complaint”*
Understand the “story behind the chief complaint”

• 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.

• 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with pneumonia.

• 32M with uncontrolled DM, cognitive limitations, bipolar disorder, active substance use, homeless presents with flank pain to one hospital, readmitted with chest pain to another hospital.

*Chart reviews and administrative analyses will NOT reveal what you need to know: you must talk to your patients, their families and caregivers, providers.*
“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don't do that and they kick you out every morning. I need a stable residence and no one is able to help with that.”
There is Never One Reason for Readmission.....

- KP team reviewed 523 readmissions across ~14 hospitals:
  - 250 (47%) deemed potentially preventable
  - Found an average of 9 factors contributed to each readmission

- Assessed factors related to 5 domains:
  - 73% - care transitions planning & care coordination
  - 80% - clinical care
  - 49% - logistics of follow up care
  - 41% - advanced care planning & end of life
  - 28% - medications

- 250 readmissions identified 1,867 factors!

Feingenbaum et al Medical Care 50(7): July 2012
Interviewed 60 patients who returned to ED after d/c from ED <9days

- Average age 43 (19-75)
- Majority had a PCP, but cited ED gave more tests, quicker answers, single site and ED more likely to treat the symptoms
- Most reported no problem filling medications
- 19/60 thought they didn’t get prescribed the medications they needed (pain)
- 24/60 expressed concerns about clinical evaluation and diagnosis

Primary reason for returning: *fear and uncertainty about their condition*

- Patients need more reassurance during and after episodes of care
- Patients need access to advice between visits
DESIGN A PORTFOLIO OF STRATEGIES

Readmission reduction = System transformation
Develop A Multifaceted Portfolio of Efforts

Improve hospital-based care processes for all patients, including ED

Collaborate with cross-setting partners, including payers, BH, Social Services, EMS, public health, SUD

Provide enhanced services

Use data, analytics, flags, workflow prompts, automation, dashboards to support continuous improvement, ensure reliability, drive to results
EXPANDING EFFORTS TO DRIVE IMPACT

Adding ED, BH, social stabilization to your portfolio
2 Hospitals’ Multifaceted Portfolios

Valley Baptist (TX)

- Improve Standard Hospital-based Processes
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8P to “behavioral interview”

- Collaborate with Providers
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly “co-management” virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed

- Provide Enhanced Services to High Risk
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team “works the case” x 30+ days
  - Cardiology NP “Heart Bridge Clinic”

Frederick Memorial (MD)

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Courtesy of Angela Blackford and Heather Kirby
Hospital-wide Results

Valley Baptist (TX)

All Cause Readmission Rate:
- FY 2011: 28%
- FY 2013: 21%
- FY 2014: 14%

CMS Penalty:
Year 1: 0.8% (of possible 1%)
Year 2: 0.2% (of possible 2%)
Year 3: 0.04% (of possible 3%)

Frederick Memorial (MD)

FY 12: 10.6%
FY 13: 9%
FY 14: 7.8%

Courtesy of Angela Blackford and Heather Kirby
Interventions Led by the ED

• Hallmark Health System
  • 2 hospital system, 20 ED docs, 17 PAs
  • “Why are almost all SNF patients admitted?”
  • “Patients only seen once a month”; “can’t do IVs”, etc
  • “If they send them here they can’t take care of them”

• Actions:
  • Asked ED clinicians “5 whys”
  • Education: posted INTERACT SNF capacity sheets in ED
  • Simplicity : establish contacts, standard transfer information

• Results: increase in number of patients transferred from ED to SNF
Interventions Led by the ED

ED- Community BH Services

- Health Alliance Hospital
- High ED boarding
- Data showed 75% d/c to home
- Identified linkage to care as need
- ED didn’t know BH center
- Called meeting; weekly x 10 weeks
- Reassigned ED RN to be BH ED navigator
- Redesigned triage / flow
- Effectively link to BH care
- BH deployed existing case workers
- Reduced high-user ED BH visits

ED – County DPH

- Carroll County, Maryland
- County- peer recovery navigators
- Were underutilized
- Reached out to ED
- Co-located peer navigators in ED
- Connected and followed after ED
- 30% reduction high-user ED BH
Transitional Care: Actively Address Social Complexity

Social Work Transitional Care
- Assess “person in context”
- Employ motivational interviewing
- Connect, assess, reassess
- Needs change over time
- Navigate clinical follow up
- Ensure linkage to services
- Don’t over medicalize complexity

Multi-Disciplinary Care Teams
- NP, RN, SW, Pharm, Navigator
- Address full complement of medical, social, logistical needs
- Navigator position particularly valuable for outreach, relationships
- Highland Hospital: team actively inquires about SUD, links to care, harm reduction approach

www.transitionalcare.org

Courtesy of Maia White, Highland Hospital
No Shortage of Great Practices to Emulate!

1. INTERACT SNF-ED-SNF
2. County DPH peer recovery workers in ED to connect and navigate
3. ED – Community Mental Health and CHC effective linkage to post-ED follow up
4. ED-based High Utilizer Care Team, using ED to identify, connect, follow
5. Automated flag in ED Record to indicate 30-day return
6. MGH High Cost Beneficiary Demo – page care team from ED to avert admission
7. Payer (MCO) – deployed transitional care staff colocated in hospital
8. Payer (MCO) – supported CHW navigator programs
9. Payer (MCO) – supported sickle cell urgent care clinic
10. County workforce development program – CHW training
11. County-EMS home visit program
12. “Reverse co-location” – medical providers (NP) co-located in community BH centers
13. Housing with services – multi-disciplinary team co-located at housing sites
14. Warm handoffs hospital-SNF with call-back
15. Virtual rounding hospital-SNF to co-manage over numerous transitions
Let’s Run the Numbers:  
*Three-part strategy*

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<tr>
<td><strong>1. Improve standard care</strong></td>
<td>5,000 admissions</td>
<td>(20% RA rate)</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Expected # RA reduction</td>
<td><strong>100 RA avoided</strong></td>
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</tr>
<tr>
<td><strong>2. Collaborate with receivers</strong></td>
<td>1650 admissions (1/3 total)</td>
<td>(30% RA rate)</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Expected # RA reduction</td>
<td><strong>99 RA avoided</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3. Enhanced Service for Pilot</strong></td>
<td>200 admissions</td>
<td>(25% RA rate)</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Expected # RA reduction</td>
<td><strong>10 RA avoided</strong></td>
<td></td>
</tr>
<tr>
<td>*<em>Total (<em>illustrative)</em></em></td>
<td><strong>209 RA avoided</strong></td>
<td>209/1000 = 20% overall*</td>
</tr>
</tbody>
</table>

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46-study Meta-Analysis: What Works?

Preventing 30-Day Hospital Readmissions
A Systematic Review and Meta-analysis of Randomized Trials
Leppin et al; JAMA Internal Medicine (online first) May 12 2014

- Review of 42 published studies of discharge interventions
- Found that multi-faceted interventions were 1.4 times more effective
  - Many components
  - More people
  - Support patient self-care
- Interventions published more recently had fewer components and were found to be less effective

Recommendations

- Know your data and your patients

- Adopt a broad concept of readmission risk
  - Capture all reasons, whole-person approach

- Develop a multifaceted strategy
  - Start in ED
  - Expand partners, include agencies, payers
  - Provide enhanced services

- Use technologies to make work better, quicker, automated
THANK YOU

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