RARE Reducing Avoidable Readmissions Effectively

Making Hospital Readmissions RARE in Minnesota

Minnesota Rural Health Conference
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www.RAREreadmissions.org





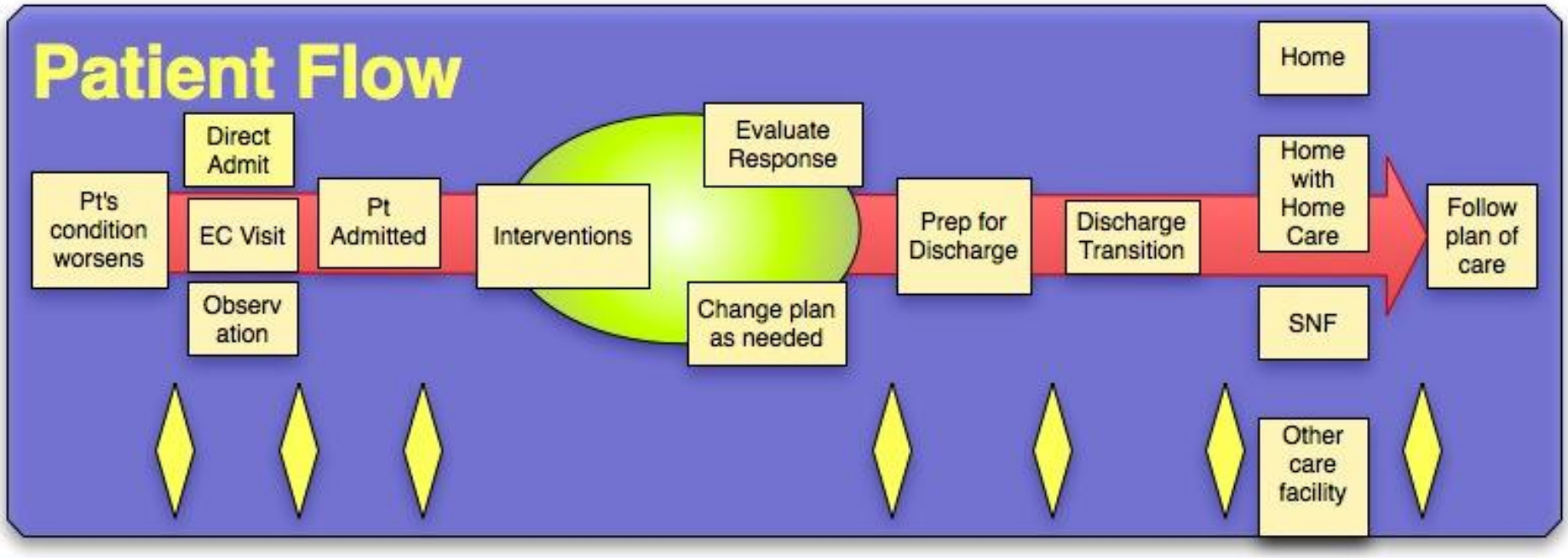


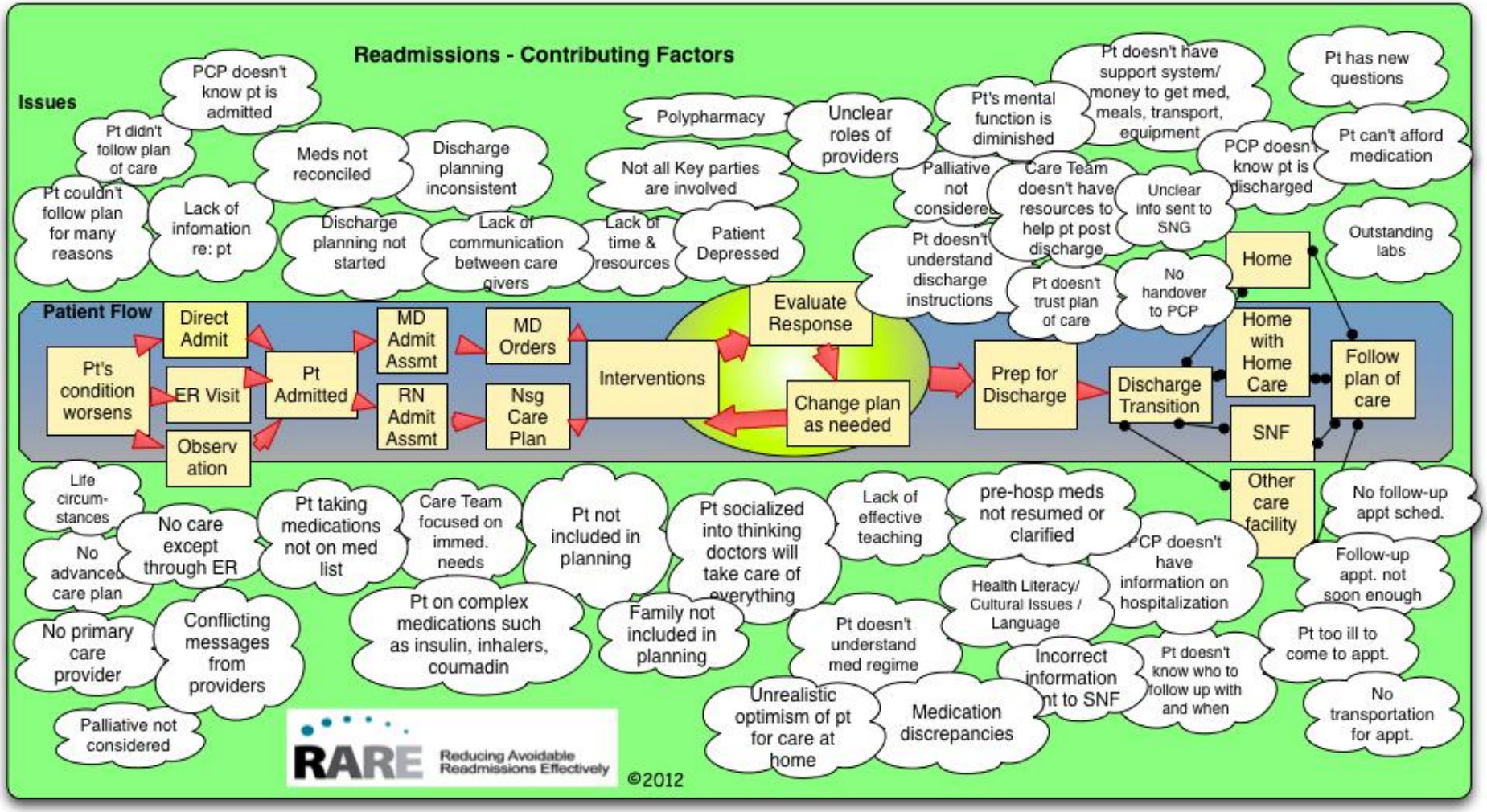







What is happening?




Readmissions - Contributing Factors
Issues
PCP doesn't know pt is admitted
Pt didn't follow plan of care
Meds not reconciled
Discharge planning inconsistent
Pt couldn't follow plan for many reasons
Lack of infomation re: pt
Discharge planning not started
Lack of communication between care givers
Lack of time & resources
Not all Key parties are involved
Polypharmacy
Unclear roles of providers
Patient Depressed
Pt's mental function is diminished
Pt doesn't have support system/ money to get med, meals, transport, equipment
Pt has new questions
Pt can't afford medication
PCP doesn't know pt is discharged
Palliative not considered
Care Team doesn't have resources to help pt post discharge
Unclear info sent to SNG
Pt doesn't understand discharge instructions
Pt doesn't trust plan of care
No handover to PCP
Outstanding labs
Patient Flow
Direct Admit
Pt's condition worsens
ER Visit
Observ ation
Pt Admitted
MD Admit Assmt
RN Admit Assmt
MD Orders
Nsg Care Plan
Interventions
Evaluate Response
Change plan as needed
Prep for Discharge
Discharge Transition
Home
Home with Home Care
SNF
Other care facility
Follow plan of care
Life circum-stances
No advanced care plan
No care except through ER
Pt taking medications not on med list
Care Team focused on immed. needs
Pt not included in planning
Pt socialized into thinking doctors will take care of everything
Lack of effective teaching
pre-hosp meds not resumed or clarified
PCP doesn't have information on hospitalization
Health Literacy/ Cultural Issues / Language
Incorrect information nt to SNF
Pt doesn't know who to follow up with and when
No follow-up appt sched.
Follow-up appt. not soon enough
Pt too ill to come to appt.
No transportation for appt.
No primary care provider
Conflicting messages from providers
Palliative not considered
Pt on complex medications such as insulin, inhalers, coumadin
Family not included in planning
Pt doesn't understand med regime
Unrealistic optimism of pt for care at home
Medication discrepancies
RARE
Reducing Avoidable Readmissions Effectively
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What is the RARE Campaign?

- A campaign across the continuum of care to reduce avoidable hospital readmissions across Minnesota and surrounding areas

- Regional approach, supported by hospitals, providers, health plans, other key stakeholders

- Campaign is engaging other care providers, acknowledging that readmissions are the result of a fragmented health care system

Triple Aim Goals

- Population health
  - Prevent 4,000 avoidable readmissions within 30 days of discharge, OR in other words,
  - Reduce overall readmissions rate by 20% from 2009 base by December 31, 2012
- Care experience
  - Recapture 16,000 nights of patients' sleep in their own beds instead of in the hospital
  - Improve by 5% on HCAHPS discharge survey questions
- Affordability of care
  - Save an estimated $30 million for commercially insured patients; additional savings for Medicare patients

Broad Community Support

- Operating Partners:
  - Institute for Clinical Systems Improvement (ICSI)
  - Minnesota Hospital Association (MHA)
  - Stratis Health

ICSI
INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Minnesota Hospital Association

StratisHealth®

Broad Community Support

- Supporting Partners:
  - Minnesota Medical Association
  - MN Community Measurement
  - VHA Upper Midwest

Broad Community Support

- Community Partners:
  - Endorse and actively support the campaign
    - A growing list of providers, health plans, state health agencies, home health agencies, nursing homes, patient advocacy groups, and other community organizations
    - Complete list on www.RAREreadmissions.org

Hospitals Participating in RARE Campaign

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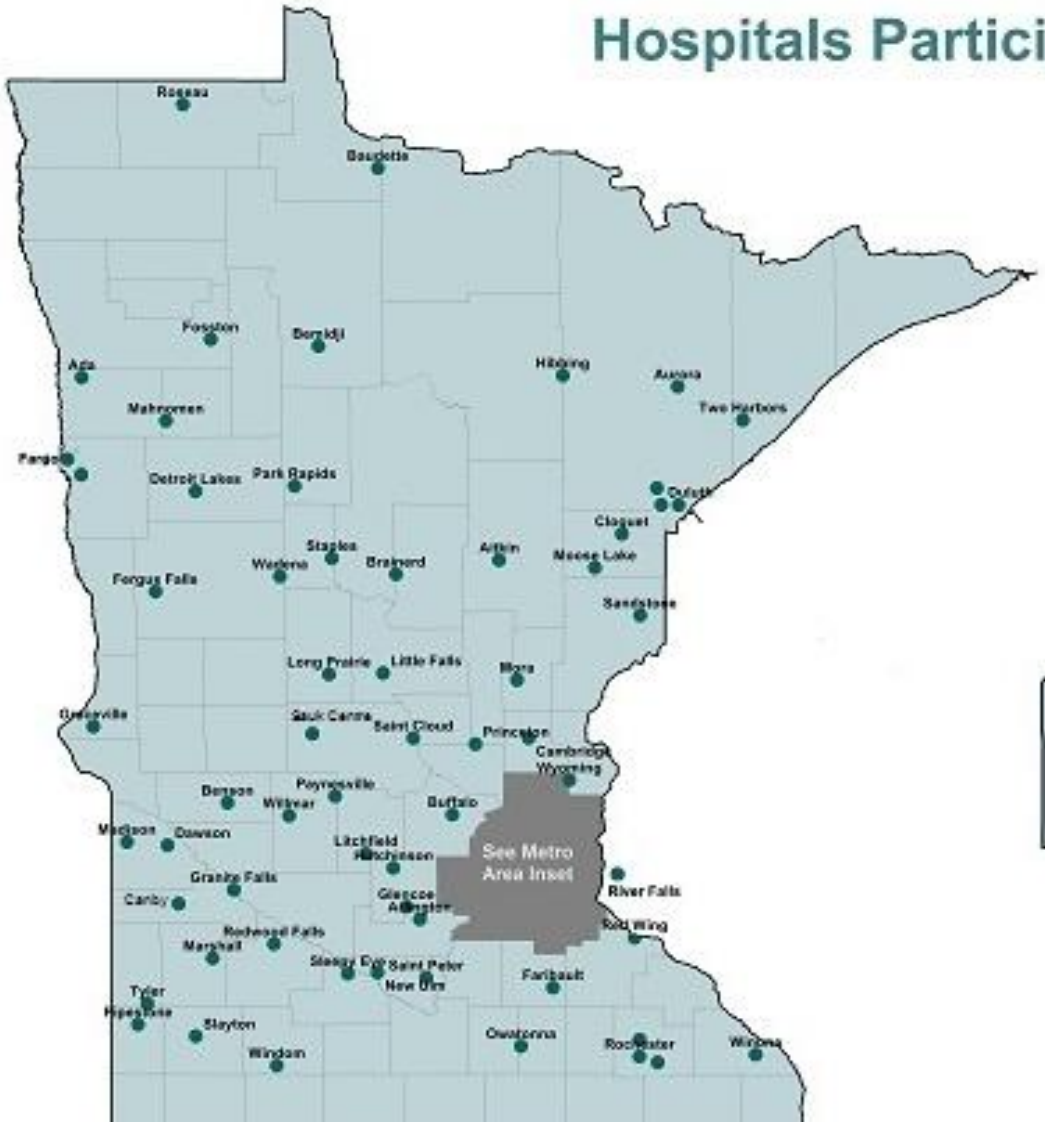
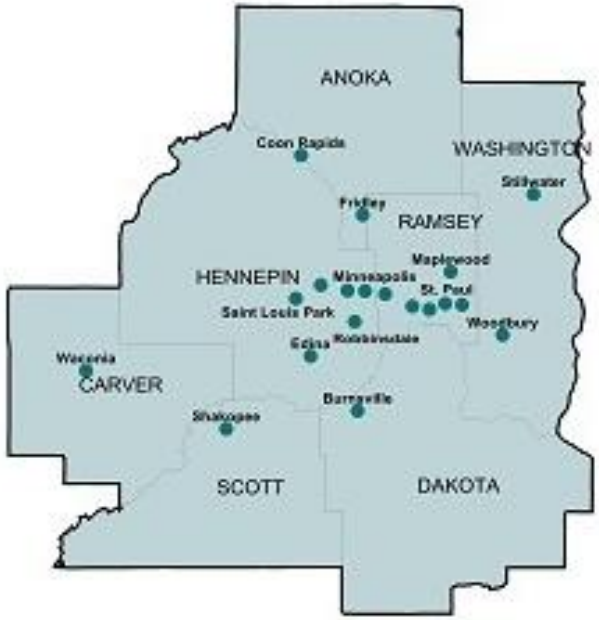




RARE Campaign Implementation Overview 2011-2012

RARE Reducing Avoidable Readmissions Effectively

Hospitals commit to the RARE campaign

Hospitals complete Getting Started Tasks and Organizational Assessment

Hospitals with Community Partners focus improvement in one of Five Key Areas:
- Medication Management
- Transition Care Support
- Patient and Family Engagement
- Comprehensive Discharge Planning
- Transition Communication

Options for Collaborative Support
- Care Transitions
- Project Red
- SAFE Transitions

Exploring Innovative Strategies - TBD

Support for each RARE organization

Individual support and assistance from RARE Resource Consultants

Quarterly PPR data reports starting in October 2011

Triple Aim Goals:
1. Prevent 4,000 avoidable readmissions with in 30 days of discharge by December 31,2012
2. Patients and their families will spend 16,000 nights of sleep in their own beds and improve HCAHPS discharge preparation scores by 5%
3. Decrease health care costs by avoiding 4000 readmissions.

9/11

Five Focus Areas

Patient and Family Engagement

Comprehensive Discharge Plan

Transition Communication

Medication Management

Transition Support

Patient Family Engagement and Activation

1. Use Teach Back to assess patient's understanding of any instructions
2. Ensure caregivers are engaged in developing the plan of care
3. Use health literacy standards such as AHRQ Health Literacy Universal Precautions

Comprehensive Discharge Planning

A written patient centered plan must include:

1. Reason for hospitalization, including information on disease in terms patient can understand
2. Medications to be taken post transition: Purpose, dosage, when and how to take, and how to obtain refills
3. Self-care activities
4. Durable medical equipment
5. Symptom recognition and management
6. Coordination and planning for follow-up appointments

Medication Management

1. Medication reconciliation at each patient transition with date
2. Medication list should contain purpose for each medication
3. Pre/post hospital medication changes should be made clear to the patient
4. Medication discrepancies must be evaluated and acted upon
5. Use Teach Back when instructing patients on medication use

Care Transition Support

1. Follow-up appointment within 5 business days
2. Available appointment slots
3. Follow-up arranged with ancillary services, such as PT, OT, RT
4. Within 72 hours a purpose contact is made with patient by a care team member

Follow-up visit should focus on:

1. Patient's goals for the visit
2. Patient's needs for medication adjustment, test results, advance directives
3. Instruction on self management
4. Explanation of warning signs and how to respond
5. Instructions for seeking emergency and non-emergency after hours care

Transition Communication

1. PCP notified when patient is admitted or discharged
2. Patients know who is responsible for care and how to contact them
3. Concise transfer forms with key elements must be sent with the patient in every transfer
4. Direct reports between nursing staff
5. Complete discharge summaries should be received by the accepting facilities within 3 business days

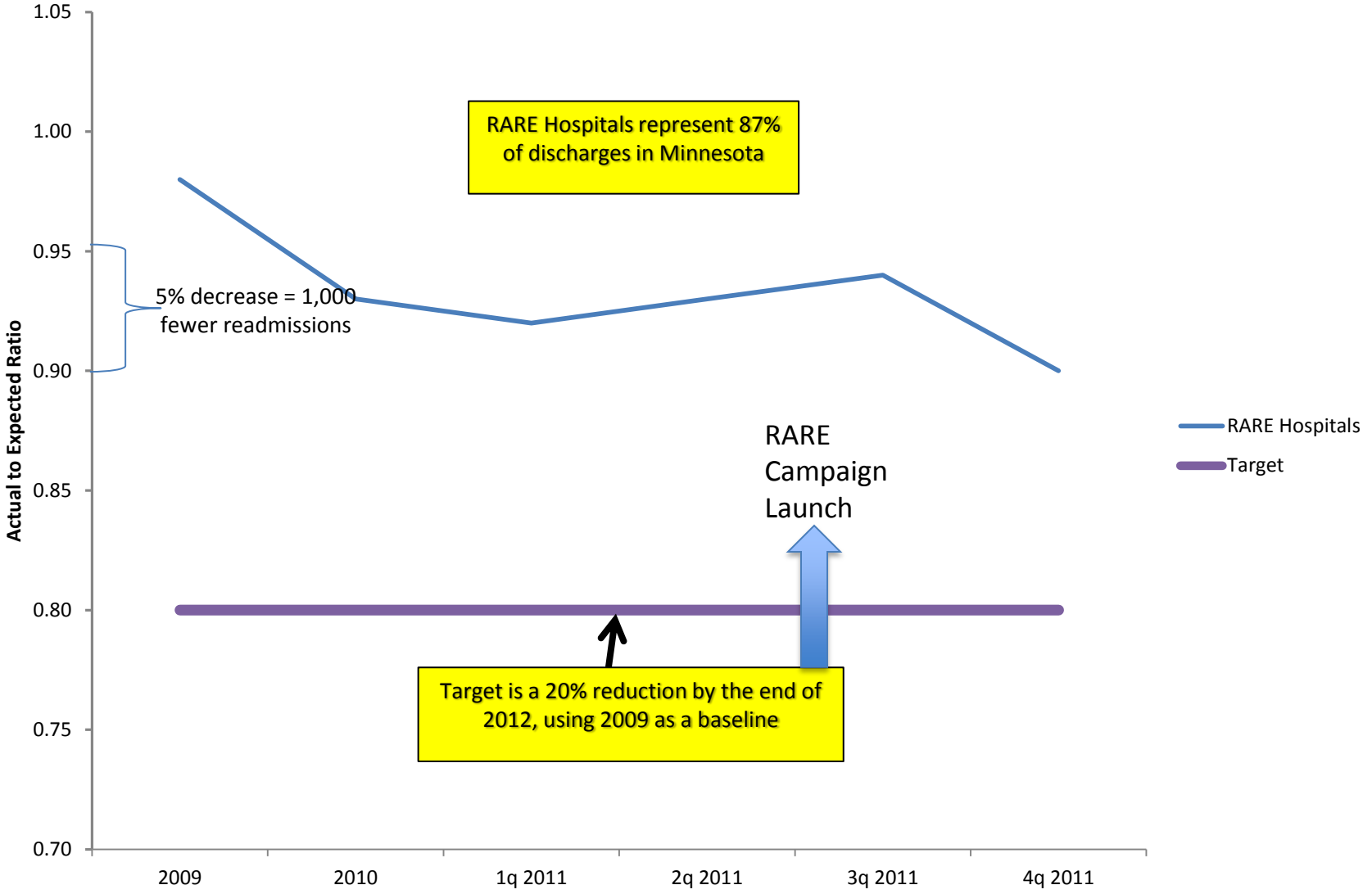
Supporting Work Groups

- Medication Management
- Mental Health
- Epic Users
- Measurement
- Long Term Care

“Potentially Preventable Readmissions”

- Data source – Minnesota Hospital Association database
  - All-payer inpatient claims for all Minnesota hospitals
    - But, can only look at readmit to same facility
      - 22% readmits to different facility
- Software – 3M Potentially Preventable Readmissions
    - 3M’s clinical experts developed methodology
    - Each record designated as admission or readmission
    - Calculates severity-adjusted PPR rates by condition and by hospital

Potentially Preventable Readmissions in Minnesota, 2009 - 2011



16,000 Nights At Home Will Make Our Day.

Thank You For Helping Everyone Sleep More Peacefully.

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