Improving Care Transitions

Laura Cole, RN
South Carolina Partnership for Health
PART: Preventing Avoidable Readmissions Together

SPECIFIC QUESTIONS WE WILL EXPLORE TODAY:

• Why the focus on care transitions?
• What strategies are affective to improve Care transitions?
• What are some examples of successful care transitions initiatives in SC?
CARE TRANSITIONS DEFINITION

Refers to the patients moving between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness*

(*Source: Care Transitions Program, University of Colorado).

http://www.caretransitions.org
Do you want to be the driver or the passenger
Measures affected by Care Transitions

- Value Based Purchasing
- HCAHPS
- Mortality
- Core Measure
- Meaningful use
- Readmissions
- BlueCross/BlueShield Rewarding Excellence Program

PART: Preventing Avoidable Readmissions Together
3 CMS programs....Accumulating risk over time

<table>
<thead>
<tr>
<th>Program</th>
<th>FFY13</th>
<th>FFY14</th>
<th>FFY15</th>
<th>FFY16</th>
<th>FFY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBP</td>
<td>1%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>HAC</td>
<td>-</td>
<td>-</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Total Risk</td>
<td>2%</td>
<td>3.25%</td>
<td>5.5%</td>
<td>5.75%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Hospital Readmission Reduction Program

- FY 2013 1% reduction
  July 2008-June 2011
  AMI, HF, Pneumonia

- FY 2014 2% reduction
  July 2009-June 2012
  AMI, HF, Pneumonia

- FY 2015 3% reduction
  July 2010-June 2013
  AMI, HF, Pneumonia, COPD, Total Hip and Knee Arthroplasty

- FY 2016 3% reduction
  July 2011- June 2014
  Proposed AMI, HF, Pneumonia, COPD Total Hip and Knee Arthroplasty
  Ischemic stroke, and All cause
GOAL: To compensate hospitals for the quality of care provided to patients, not just the quantity of procedures performed.

Quality measures include key safety and efficiency measures, as well as patient experience.

Rewards top-performing hospitals with increased payments for the quality of care they provide.
PART: Preventing Avoidable Readmissions Together

Know where you are, then decide where you are going?
Have you looked at your care transitions processes?

Has your team performed a hospital specific Root Cause Analysis to better understand your needed areas for quality improvement? (i.e. Process mapping, SWOT analysis, fishbone, etc)

Yes
No
PART: Preventing Avoidable Readmissions Together

Your Magic Pill
Care Transitions Coach

Does your facility use personnel dedicated as Transitions Coaches?

- Fully integrated
- In Process
- Implemented in sub populations
- Not a current focus
PART: Preventing Avoidable Readmissions Together

Inpatient  Outpatient
Outpatient

Where is the patient discharged too?
What is that provider able to provide for the patient?
How are post acute care appointment scheduled?
What information is shared with the facility/PCP?
When is it Shared?
What resources does your patient have after discharge if they have a question or concern?
Do community organizations know about your effort? What can they provide?
Community Meetings

Within the last year how often has your team met with community members regarding care transitions?

- weekly
- monthly
- quarterly
- yearly
- as needed
- never
Hospital Specific

- Are you screening patients for risk factors associated with higher readmission rates? If so what are you doing to mitigate those factors?
- What information are you providing to patients?
- Are patients active participants in the decision making in the hospital and at discharge?
- Are you having multidisciplinary rounds? How affective are they?
Risk Assessment

Has your facility implemented a tool for readmission risk assessment (e.g. Target tool, LACE, other)?

- Fully integrated
- In process
- Implemented in sub populations
- Not a current focus
Multidisciplinary Rounds

Does your facility have a multidisciplinary rounds to address care transitions needs?

- Fully integrated
- In Process
- Implemented in sub populations
- Not a current focus
TeachBack

Has your facility implemented Teach Back?

- Fully integrated
- In process
- Implemented in sub populations
- Not a current focus
Discharge Instructions

Has your facility implemented a transition record (i.e. discharge instructions) that addresses the 10 elements from National Quality Forum? (see list in next question)

- Fully integrated
- In process
- Implemented in sub populations
- Not a current focus
The in-between

Who calls the patient?
What questions does the team ask?
Is there a way to close the loop on discharge summaries
Follow up phone calls

Has your facility implemented followup phone calls?

- Fully integrated
- In process
- Implemented in sub populations
- Not a current focus
Discharge Summaries

Has your facility implemented strategies to improve discharge summaries?

- Fully integrated
- In process
- Implemented in sub populations
- Not a current focus
Follow up appointments

Has your facility implemented a strategy for timely followup appointments?

- Fully integrated
- In process
- Implemented in sub populations
- Not a current focus
Where to start???

- Remember you will not change readmissions rates in a day
- Start small
- Make it a priority: create a budget
- In cooperate things you are already doing
- Remember the multidisciplinary team-assignments
- Your communities want to help
### 30 day readmission relative rate improvement CY 2012 vs. 2011

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Prevented Readmissions</th>
<th>Relative Rate Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cause</td>
<td>3322</td>
<td>5.48%</td>
</tr>
<tr>
<td>AMI</td>
<td>147</td>
<td>13.16%</td>
</tr>
<tr>
<td>COPD</td>
<td>278</td>
<td>12.27%</td>
</tr>
<tr>
<td>HEART FAILURE</td>
<td>380</td>
<td>10.78%</td>
</tr>
<tr>
<td>PNEUMONIA</td>
<td>204</td>
<td>9.27%</td>
</tr>
</tbody>
</table>

*All payers*