Reducing Readmissions in Oregon Conference Summary
October 4, 2011

OREGON HEALTH CARE QUALITY CORPORATION
A nonprofit partnership for quality improvement

Morning Keynote Presentation
Harold Miller, Network for Regional Healthcare Improvement and Center for Healthcare Quality and Payment Reform

Harold Miller, in his keynote address, set the stage by examining recent efforts to reduce hospital readmissions for CHF and COPD patients. While acknowledging that there has been some limited success, Miller identified several key weaknesses shared by most of these initiatives.

- By narrowing their focus on a 30 day care transition window, and by largely limiting their attention to Medicare patients and senior citizens, programs could actually be missing over half of COPD readmissions.
- Programs that are not capturing and rigorously analyzing enough patient data are not prepared to catch the innumerable factors and variables that contribute to preventable readmissions
- Healthcare payment systems, while not through the fault of any individual parties, oftentimes stand at loggerheads with healthcare innovation.

Miller advocated for improved program coordination that spans the entire care continuum and extends to ALL care specialists, from pulmonologists to primary care practitioners, pharmacists to home-care nurses. A healthcare community that is properly communicating across all channels will be able to identify – or even prevent! - a mold-infested home nebulizer before its owner is twice readmitted to the hospital. Early interventions such as the "Asthma Lounge" at Alameda County Medical Center will be adopted nationwide as a successful patient resource to prevent hospital admissions in the first place.

Healthcare payment systems must be reformed now. Successful programs like the Pittsburgh Regional Health Initiative will continue to serve as exceptions to the rule until reductions in readmissions are adequately supported by a payment system that balances risk, accountability, incentives, and most of all trust.

Finally, Miller implored everyone to walk in their patients' shoes. Are they getting the information they need before discharge? Do they have a PCP? Do they understand how their medication schedule has changed? Have too many different specialists visited them in the past 24 hours? Do they know who they can call if they need self-management support? Go back and ask your patient if this is working for them.

Transitions in Care Survey Results
Steve Kinder, MHA, Oregon Health Care Quality Corporation

Steve Kinder led the participants through the results of a recent statewide survey of hospitals, medical groups, and long term care facilities. Some interesting trends from the survey responses:

- Most hospitals notify PCPs when patients are admitted and discharged, but there is very little communication beyond that.

- The majority of hospitals are participating in projects to reduce readmissions, but there hasn't been much effort to work together.

- Medical groups expressed the need for more information, including medication and discharge instructions, from hospitals.
- Long term care facilities struggle to validate patient discharge information, and PCPs do not respond when they are contacted.
- Patients often seem to not know what they are supposed to do after they have been discharged.

The survey results suggest a pronounced lack of communication and coordination between hospitals, medical groups, and care facilities. While there seems to be a fair amount of confusion and frustration, however, each of the three groups of respondents expressed the desire to be on the same page.

Leading with Data: Panel One

Diane Waldo of the Oregon Association of Hospitals and Health Systems provided attendees with a report on implementation of Apprise Health Insight's software package. Diane offered highlights of Insight's readmissions report, which utilizes Oregon inpatient discharge data for hospitals to analyze potentially preventable readmissions (PPR). Users will be able to track these PPRs across the state, however there currently not a method for tracking individual patients, and the data will be updated quarterly.

Stacy Moritz presented early results of Acumentra Health's (Acumentra is Medicare's Quality Improvement Organization for Oregon) efforts to measure and analyze readmission rates within 30 days at 33 acute-care hospitals from all corners of the state. Stacy observed that readmission rates varied widely within eligible hospitals (from roughly 7 to 24%), but also that the average remained fairly consistent across all different regions of the state, which might suggest that regional factors play a smaller role in readmissions.

David Shute of Q-Corp shared data from the Dartmouth Atlas Report on Post-Acute Care, the first report to look at nationwide readmission rates for Medicare patients with chronic illness – a massive data set. In addition to readmission data, the report measured rates of Medicare patients seeing a PCP within 14 days of discharge, patients having an ER visit within 30 days of discharge, and those having an ambulatory visit within 14 days of discharge. David compared Oregon to national rates, as well as comparing Oregon's 5 Hospital Referral Regions. Among the findings, Oregon readmission rates are lower than national rates, but little overall progress had been made in reducing those rates between 2004 and 2009. Roughly half of medical patients in Oregon visited a PCP within 14 days of discharge, while over 63% had at least one ambulatory visit. Finally, variability exists between Oregon's 5 HHRs, with Salem leading the nation for 30 day ED use following medical discharge.

Devan Kansagara approached readmission data from a higher scale, reviewing over 300 readmission risk prediction models. Devan found that most models performed poorly, getting their predictions wrong 30 – 40% of the time. All 3 CMS models underperformed; in fact only one model explicitly defined and examined PPRs. Furthermore, few models examined informative variables such as housing status, access to care, health literacy or substance abuse. In short, users need to be very careful when choosing and adapting risk assessment tools. They should only use tools that match their intended use and local environment, and they should be simple enough for people to easily use in real-time.

The Leading with Data panel shined a spotlight on the fact that that there are numerous tools and reports

available to assist in measuring and predicting readmission rates for chronic illness patients. People should recognize, however, that no single tool can completely close the gap in our understanding of readmissions, and that "perfect does not have to be the enemy of the good."

Oregon Projects: Panel Two

The second afternoon panel profiled a number of local projects, both current and in-development, that may serve as "best practice" models both for reducing readmission rates and empowering patients to take a more active role in their overall health.

Honora Englander, MD, presented OHSU's Care Transitions Innovation (C-TraIn) program for disadvantaged populations, which focuses on improving patients' transition from inpatient to outpatient care. The program operates within four components:

- Early Needs Assessment – A transitional care nurse meets with patients early on, in the hospital and at home, to assess their particular needs.
- Knowledge – Expanding the patients' understanding of their risk factors and early warning signs.
- Personal Health Record – Patients work with their care transition nurse and pharmacy team to produce – in their own words – a medical autobiography.
- Medication support at discharge to ensure that prescriptions match up with Medicare benefits.

Rebecca Ramsay, RN, spoke about CareOregon's Transitions Initiatives, spotlighting a project (based on Dr. Coleman's model) for telephonic transitional care intervention. This is a robust telephonic model, given the resources available, that includes medication reconciliation, red flag education, teaching and support, making sure DMEs have been ordered, and many more specific interventions.

CareOregon is also working on a "Hot Spot" program that has members working with clinical outreach teams to identify the people who need additional help with a self-care plan. Finally, CareOregon is facilitating conversations with hospitals and PCPs on a standard transitional care process map.

Jayne Mitchell, ANP, described her efforts at OHSU to improve patient transitions by shadowing seven hospital patients from discharge and identifying missed opportunities for effective patient education and self-empowerment. Jayne developed a 90 day action plan for staff and providers that asks questions like "Have you given your patient a scale? Have you talked about heart failure? Are your materials written for a sixth grade reading level?" This program also emphasizes working with the patient's family so that loved ones know what the plan is and how they can play a role in the patient's recovery.

Kathy LeVee of Marquis Companies (a long term care provider with 27 facilities in 5 NW states) shared their strategies for reducing hospital readmissions. Marquis took all hospital readmissions from their settings and looked at 23 different levers (ie. What where the top three diagnoses? What was the time of day? Who was the doctor or nurse on duty? What is the patient's family dynamic? etc). Kathy noted that long term care nurses are seeing more and more tough post-acute issues such as CHF. Best practices were established and LTC staff trained for improved transition communication and more proactive responses to patient data.

Dan Reece, LCSW presented on Lane Transitions of Care Collaborative, which developed a standardized Personal Health Record for patients to use with all of their care providers. A pilot project, working with COPD patients in Colorado, met with community debate over e-health records. The hard copy record has been moderately successful, but it has been difficult to get all care providers on board using it.

Continuing what had already become a recurring theme all day, the biggest challenge shared by all panelists was a lack of transparency and a feeling of competition that has kept many parties working in silos. Collaboration takes time and effort, but there was agreement among everyone that this is essential.