Our goal
12% reduction
Updated HIIN data
Updated KY data
Let’s Play Readmissions Jeopardy
1 in _____ Medicare patients are rehospitalized within 30 days of discharge.
What is 5?

The estimated annual cost of Medicare readmissions.
What is $12 billion?

2008 Medicare Payment Advisory Commission
The % of readmitted patients who visited a doctor prior to readmission
What is 50%?

According to the Harvard Business Review, ___________ has the biggest impact on hospital readmission rates.
What is COMMUNICATION?
Discharge Instructions

What did that mean?

“No”

Do you have any ‘s

Project ACHIEVE - This work was supported through a Patient-Centered Outcomes Research Institute (PCORI) award (Contract #TC-1403-14049).
A 2016 Centers for Medicare & Medicaid Services (CMS) blogpost released new data on states efforts to reduce avoidable hospital readmissions. The data shows that in the 50 states and the District of Columbia between 2010 and 2015, readmission rates fell by 8%. Since 2010:

- All but one state have seen Medicare 30-day readmission rates fall;
- In 43 states, readmission rates fell by more than 5%.
- In 11 states, readmission rates fell by more than 10%.

KY showed a 9.1% decrease in readmissions between 2010 and 2015.

But there is still a long road ahead...
How can we close this gap?
What are your bright spots?
What are your barriers?
12% reduction

We need.....

• More
• Less
• Different

.green-circle Keep doing
.red-circle Stop
No More Non-Compliance
Pay more attention to the 4 Ms

1. What matters?
2. Medications
3. Mentation
4. Mobility
Why are your patients being readmitted?

What should you be doing differently?
Time for table talk

• What does the gap look like in your organization?
• Describe what it would take for your patients to truly understand their care when they left the hospital?
Readmission reduction drivers

Reduce Readmissions

- Use data and RCA to drive cont. improvement
- Improve standard hosp.-based transitional care processes
- Deliver enhanced services based on need
- Collaborate with providers and agencies across the continuum

HRET HIIN Readmissions Change Package Driver Diagram

CP
Driver #1

Use data and RCA to drive continuous improvement
What are your bright spots & opportunities?

<table>
<thead>
<tr>
<th>USE DATA AND ROOT CAUSE ANALYSIS TO DRIVE CONTINUOUS IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANALYZE DATA TO INFORM YOUR TARGETING APPROACH</strong></td>
</tr>
<tr>
<td><strong>UNDERSTAND ROOT CAUSES OF READMISSIONS; ELICIT THE PATIENT, CAREGIVER AND PROVIDER PERSPECTIVES</strong></td>
</tr>
<tr>
<td><strong>PERIODICALLY UPDATE APPROACH BASED ON FINDINGS; ARTICULATE YOUR READMISSION REDUCTION STRATEGIES</strong></td>
</tr>
<tr>
<td><strong>DEVELOP A PERFORMANCE MEASUREMENT DASHBOARD TO USE DATA TO DRIVE CONTINUOUS IMPROVEMENT</strong></td>
</tr>
</tbody>
</table>

American Hospital Association
Advancing Health in America
What we see across the country

Use of data to select target populations and priorities

Learning from and engaging with patients
Driver #2

Improve standard hospital based care transitions practices for all
<table>
<thead>
<tr>
<th>IMPROVE STANDARD HOSPITAL-BASED TRANSITIONAL CARE PROCESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENGAGE PATIENTS AND THEIR CAREGIVERS TO IDENTIFY THE “LEARNER,” UNDERSTAND CARE PREFERENCES AND ASSESS READMISSION RISK FACTORS</strong></td>
</tr>
<tr>
<td><strong>FACILITATE INTERDISCIPLINARY COLLABORATION ON READMISSION RISKS AND MITIGATION STRATEGIES</strong></td>
</tr>
<tr>
<td><strong>DEVELOP A CUSTOMIZED CARE TRANSITIONS PLAN, TAKING INTO ACCOUNT PATIENT PREFERENCES AND ADDRESSING READMISSION RISK FACTORS AND POST-HOSPITAL CONTACT NAMES AND NUMBERS</strong></td>
</tr>
<tr>
<td><strong>USE TEACH BACK TO VALIDATE PATIENT UNDERSTANDING; USE LOW HEALTH LITERACY TECHNIQUES AND/OR PROFESSIONAL TRANSLATION SERVICES TO OPTIMIZE UNDERSTANDING AND TEACH BACK</strong></td>
</tr>
<tr>
<td><strong>MAKE TIMELY POST-DISCHARGE FOLLOW UP PHONE CALLS TO FOLLOW UP ON SYMPTOMS AND REVIEW THE CARE TRANSITIONS PLAN</strong></td>
</tr>
</tbody>
</table>
What we see across the country

**Bright Spots**
- Interdisciplinary collaboration
- Improved educational materials

**Opportunities**
- Learning what matters most
- Validating understanding
Driver #3
Deliver enhanced services based on needs
What are your bright spots & opportunities?

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>PALLIATIVE CARE</td>
<td>Change Idea</td>
</tr>
<tr>
<td>CONDITION SPECIFIC PROGRAMS</td>
<td>Change Idea</td>
</tr>
<tr>
<td>PHARMACY INTERVENTION</td>
<td>Change Idea</td>
</tr>
<tr>
<td>COMPLEX CARE MANAGEMENT</td>
<td>Change Idea</td>
</tr>
<tr>
<td>ED PAUSE</td>
<td>Change Idea</td>
</tr>
</tbody>
</table>
What we see across the country

Bright Spots

- Condition specific programs
- Complex care management
- Pharmacy involvement

Opportunities

- ED Pause
- Palliative Care
Driver #4

Collaborate with providers and agencies across the continuum
What are your bright spots & opportunities?

<table>
<thead>
<tr>
<th>COLLABORATE WITH PROVIDERS AND AGENCIES ACROSS THE CONTINUUM</th>
<th>IDENTIFY THE CLINICAL, BEHAVIORAL, SOCIAL AND COMMUNITY BASED SUPPORTS THAT SHARE THE CARE OF YOUR HIGH RISK PATIENTS</th>
<th>Change Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CONVENE A CROSS-CONTINUUM TEAM OF PROVIDERS AND AGENCIES THAT SHARE THE CARE OF YOUR HIGH RISK PATIENT POPULATIONS</td>
<td>Change Idea</td>
</tr>
<tr>
<td></td>
<td>IMPROVE REFERRAL PROCESSES TO MAKE LINKING TO BEHAVIORAL, SOCIAL AND COMMUNITY BASED SERVICES MORE EFFECTIVE AND EFFICIENT</td>
<td>Change Idea</td>
</tr>
</tbody>
</table>
What we see across the country

Bright Spots

Strong collaboration with SNF & HH

Opportunities

Identification and collaboration with: SU, BH & non-clinical community resources
Numbers matter - You need to impact enough patients to lower your rate.
It’s about the connections
Get into the weeds
Celebrate successes
Let’s chat with our panel
Commitments

• What ideas did you like?
• What idea will you test in your organization?
  • Who?
  • By when?
Readmissions Resources

- Readmissions Change Package Link
- Trail Guide
- Readmissions Top Ten Checklist Link
- Readmissions Whiteboard Video Series Link
- Join the LISTSERV®
- Huddle for Care Discussion Forum https://www.huddleforcare.org/
- Podcasts Coming Soon
Thanks for joining the journey