Expedition Coordinator

Kayla DeVincenitis, CHES, Project Coordinator, Institute for Healthcare Improvement, currently manages web-based Expeditions and the Executive Quality Leaders Network. She began her career at IHI in the event planning department and has since contributed to the State Action on Avoidable Rehospitalizations (STAAR) Initiative, the Summer Immersion Program, and IHI’s efforts for Medicare-Medicaid enrollees. Kayla leads IHI’s Wellness Initiative and has designed numerous activities, challenges, and educational opportunities to improve the health of her fellow staff members. In addition to implementing the organization’s first employee health risk assessment, Kayla is certified in health education and program planning. Kayla is a graduate of Northeastern University in Boston, MA, where she obtained her Bachelors of Science in Health Science with a concentration in Business Administration.
WebEx Quick Reference

- Welcome to today’s session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…

Please send your message to All Participants
Expedition Director

Saranya Loehrer, MD, MPH, Director, Institute for Healthcare Improvement (IHI), aligns care transitions related programming within IHI and provides coaching and facilitation to teams within the STAAR initiative. She also contributes to IHI’s efforts to adapt promising practices to better care for Medicare-Medicaid beneficiaries and serves as one of IHI’s “content curators” to ensure IHI’s publications and resources are reflective of the most recent innovations and best practices in the field. Saranya received her medical degree from Loyola University Chicago’s Stritch School of Medicine and her Master of Public Health degree from the Harvard School of Public Health, where she served as a Zuckerman Fellow.

Today’s Agenda

- Action Period Report Out
- Content: Assess for Success
- Content In Action
  - Virginia Mason Medical Center
- Action Period Assignment
Overall Program Aim

The aim of this Expedition is to share strategies for hospitals and their cross-continuum partners to co-design care processes to improve the transition of patients from the hospitals to the next care setting.

Expedition Objectives

At the end of the Expedition each participant will be able to:

- Assess current challenges in reducing avoidable rehospitalizations and identify opportunities for improvement.
- Explain how to build an effective improvement team including patients and families as well as acute, post-acute and community care providers.
- Describe how to use the patient story to build an individualized plan of care.
- Use appreciative inquiry and Teach Back to better understand a patient’s post-acute care needs and capabilities.
- Develop processes with post-acute care providers and community partners to ensure the timely transfer of critical information during patient transitions.
Schedule of Calls

Session 1 – Building the Team You Need to Reduce Readmissions
Date: Thursday, June 6, 12:00-1:30 PM ET

Session 2 – Capturing the Patient Story
Date: Thursday, June 20, 12:00-1:00 PM ET

Session 3 – Assess for Success: Appropriate Post-Acute Follow-up
Date: Thursday, July 11, 12:00-1:00 PM ET

Session 4 – Passing the Baton: The Handover of Critical Information
Date: Thursday, July 25, 12:00-1:00 PM ET

Session 5 – Putting it All Together: Orchestrated Testing and Implementation
Date: Thursday, August 8, 12:00-1:30 PM ET

Faculty

Peg M. Bradke, RN, MA, is Director of Heart Care Services at St. Luke’s Hospital in Cedar Rapids, Iowa. She received her Bachelor’s Degree in Nursing from Mount Mercy College and her Master’s Degree in Nursing Administration from the University of Iowa, College of Nursing. In her 25-year career, she has had various administrative roles in the cardiac care areas. She currently coordinates the Heart and Vascular Service line which includes two intensive care units, two step-down telemetry units, the Cardiac Cath Lab, Electrophysiology Lab, Diagnostic Cardiology, Vascular and Interventional Lab, Respiratory Care, Cardiopulmonary Rehabilitation and Heart Failure and Coumadin Clinics. In addition, Peg is serving as faculty with the Institute for Healthcare Improvement (IHI) on the Transforming Care At the Bedside (TCAB) Initiative and STAAR (STate Action on Avoidable Rehospitalizations Initiative).
Action Period Report Out

- Observe rounds/huddles where patient transitions are discussed and think about the following:
  - Who attends them?
  - How are the patient’s post-discharge needs surfaced and discussed?
  - How are the perspectives of the clinical team solicited and incorporated?
  - How are the patient’s post-discharge needs addressed?

- Based on what you learned, what might you test to improve your process?

Action Period Report Out

What did you do?

What surprised you?

What will you do next as a result?
Assess for Success

Appropriate Post-Acute Care Follow-Up

Peg Bradke, RN, MA

How-to Guide:
Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

Support for this How-to Guide provided by a grant from The Commonwealth Fund.
How Might We…

“….develop a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers?”
Post-Hospital Care Follow-Up

Typical Failures:
- Discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy
- Lack of scheduled follow-up appointment with appropriate care providers, including specialists
- Follow-up visit too long after hospitalization
- Follow-up visit made the sole responsibility of the patient

Post-Hospital Care Follow-Up

Typical Failures (cont):
- Inability of patient to keep follow-up appointments because of illness or transportation issues
- Multiple care providers resulting in patient confusion about which provider is in charge
- Lack of patient social support and community-based services for patients
- Inconsistent information being given by various clinical providers (including medication discrepancies)
Assess Risk for Readmission

- Risk assessments are needed to help teams to appropriate transitional care resources
- Variety of risk-assessment tools are reported in the literature (BOOST, LACE, Transitional Care Model (TCM), etc.)
- Inconsistencies regarding which characteristics and/or variables are most predictive of patients who are at risk for readmissions

Identification of Patients at High-Risk for Readmission

- Ideally a risk tool would not only identify those at high-risk for readmission but more precisely those who have modifyable risk
  - In other words, risk tools should be aligned with what we understand about how our interventions work and for which patients our interventions work best
- In the case of heart failure, we should be careful to not assume that the primary readmission for heart failure is after all...the heart
  - Low health literacy, cognitive impairment, change in health status for a family caregiver, and more may be greater contributors than left ventricular ejection fraction

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Identification of Patients at High-Risk for Readmission (cont.)

- Asking the patient directly to describe in her or his own words the factors that led to the hospitalization and where they need our support may provide greater insight into risk for return
- The data elements or variables in risk tools available are largely similar
  - Some require more advanced data capabilities than others
- There are inconsistencies regarding which characteristics are most predictive
  - One possible explanation is that non-patient factors may have a larger role in readmission rates, such as the health care system and access

What Are We Learning About Risk Assessments?

- There are no universally agreed-upon risk assessment tools
  - Use practical methods to identify modifiable risks
- Criteria may result in almost all who are screened being high risk
- The tool might help you identify who is at risk but not what to do about it!
- It may be difficult to mitigate some medical and social risks
- Importance of Teach Back in assessing patient and family caregivers understanding and capability to provide self-care and administer medications
- Importance of leveraging patient care rounds to create follow-up care plans that take the patient’s comprehensive needs and capabilities into consideration
IHI’s Approach: Assess the Patient’s Medical and Social Risk for Readmission

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Patient has been admitted two or more times in the past year</td>
<td>● Patient has been admitted once in the past year</td>
<td>● Patient has had no other hospital admission in the past year</td>
</tr>
<tr>
<td>● Patient or family caregiver is unable to Teach Back, or the patient or</td>
<td>● Patient or family caregiver is able to Teach Back most of discharge information and</td>
<td>● Patient or family caregiver has a high degree of confidence and can Teach Back</td>
</tr>
<tr>
<td>family caregiver has a low degree of confidence to carry out self-care at home</td>
<td>has a moderate degree of confidence to carry out self-care at home</td>
<td>how to carry out self-care at home</td>
</tr>
</tbody>
</table>


IHI’s Suggested Follow-Up

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to discharge:</td>
<td></td>
<td>Prior to discharge:</td>
</tr>
<tr>
<td>● Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or home health care is the best option for the patient.</td>
<td>● Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit within 5 to 7 days.</td>
<td>● Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit as ordered by the attending physician.</td>
</tr>
<tr>
<td>● If a home health care visit is initiated in the first 48 hours, also schedule a physician office visit within 5 days.</td>
<td>● Initiate home health care services (e.g., transition coaches) as needed.</td>
<td>● Provide 24/7 phone number for advice about questions and concerns.</td>
</tr>
<tr>
<td>● Initiate intensive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g., heart failure clinics and patient-centered medical homes).</td>
<td>● Provide 24/7 phone number for advice about questions and concerns.</td>
<td>● Initiate a referral to social services and resources as needed.</td>
</tr>
<tr>
<td>● Provide 24/7 phone number for advice about questions and concerns.</td>
<td>● Initiate a referral to social services and community resources as needed.</td>
<td></td>
</tr>
</tbody>
</table>
Physician Follow-Up Care

National Medicare analysis found 50% of patients who were rehospitalized within 30 days did not have an intervening physician visit between the date of discharge and readmission to the hospital.


Ensure Post-Acute Care Follow-Up

- Review daily the patient’s medical and social risk for readmission and finalize the customized post-hospital follow-up plan.

- Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the identified post-hospital needs and the capabilities of patients and family.
Scheduling MD Follow-Up Care

- There is much debate about when to schedule the follow-up appointments with an MD after patients are discharged
  - Look at your own patterns, see when patients are readmitted
- Teams have succeeded in successfully scheduling appointments prior to the patient leaving the hospital by partnering with providers to create a simplified process for scheduling
- Front-loading clinical and support services in the immediate post-hospital period has proven to be effective
- Hospital staff should collaborate with physician practices to create processes for assigning patients to a primary care provider and ensuring the patient knows who to call when multiple providers are involved

Frequency of Readmissions by Number of Days Between Discharge and Readmission
Days between Admission for HF
Comparison of 2009 to 2012

Follow-Up in Specialty Clinics

- 30-45 minute visits
- Reinforce Teach Back
- Medication reconciliation
- Assess self-management capabilities
- Referrals to interdisciplinary team as needed
- Telephone follow individualized based on need
- Follow-up assessment sent to PCP after each encounter
What Are We Learning About Post-Hospital Follow-Up Care?

- The post-hospital visits should be scheduled prior to the patient leaving the hospital
- Appropriate and timely follow-up care is dependent on availability and payment for services
- Executive Sponsors and cross-continuum teams bring together providers, payers and social service agencies to jointly plan how best to meet the post-acute care needs of high-risk patients

Care Coordination Benefit

CMS 2013 Physician Fee Schedule includes two new CPT codes for Transitions Care Management (99495 and 99496)

- **99495 Transitional Care Management Services (Moderate Complexity):**
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge.
  - Medical decision making of at least moderate complexity during the service period.
  - Face-to-face visit, within 14 calendar days post-discharge.

- **99496 Transitional Care Management Services (High Complexity):**
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge.
  - Medical decision making of high complexity during the service period.
  - Face-to-face visit, within 7 calendar days post-discharge.

Content in Action: Virginia Mason Medical Center

Virginia Mason Medical Center

- What were some of the reasons that led to your team to realize you needed/wanted to tackle this issue?
- How did you go about tackling it?
- What were some of your challenges and how did you overcome them?
- How were you able to convince PCP’s of the important of securing timely follow-up appointments?
- How were you able to motivate staff on both the hospital and the ambulatory side to ensure there was timely communication?
- What are you most excited about/proud of related to your work together?
- What advice would you have for others?
Action Period Assignment (choose 2!)

- During rounds/huddles, ask “what is the likelihood that this patient will be readmitted in the next 30 days?”

- Observe 1-2 patient transitions for the following:
  - Were follow-up appointments made prior to the patient leaving?
  - Were resources set up based on the post-hospital needs and capabilities of patients and caregivers?
  - Was the key learner/caregiver present for the discharge instructions?
  - Was Teach Back used to assess patient and caregiver understanding of the discharge instructions?

- Make your own histogram for days between admissions.
  - What did you learn from your data? What are your opportunities there?

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Chat Time!

Chat in one thing you learned during today’s session.
Expedition Communications

- Listserv for session communications: 
  ReadmissionsExpedition@ls.ihi.org

- To add colleagues, email us at info@ihi.org

- Pose questions, share resources, discuss barriers or successes

Next Session

Thursday, July 25, 12:00 PM – 1:00 PM ET
Session 4 – Passing the Baton: The Handover of Critical Information