Reducing Readmissions: A Focused Quality Improvement Project for Patient Centered Medical Home & Health Home Practices

INTRODUCTORY WEBINAR

October 15, 2015
Host: Lisa L. Letourneau MD, MPH
Maine Quality Counts

For Audio, please call: 1.866.740.1260, Access Code: 2520060#

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Objectives

• The case for improving care transitions & reducing potentially avoidable readmissions
• Focused QI project overview
• Proposed project aim, measures & key changes
• Expectations & benefits of participating
• Q&A
Webinar Logistics:

To minimize background noise, all lines will be muted until the presentation begins

• To unmute your line, press *7
• To mute your line, press *6

To ask questions or share comments, use one of two ways:

1. Raise Your Hand button (press *7 to unmute your line)
2. Type in chat box on the lower left-hand side of the screen

Please state your name and organization before asking your question or sharing your comment.
Project Partners

• **Maine Quality Counts**: project leadership, QI coaching, PCMH expertise

• **State of Maine: State Innovation Model (SIM) Initiative**: project funding

• **Maine Department of Health and Human Services**, Office of MaineCare Services, Value Based Purchasing: Health Homes Initiative
Welcome & Introductions

• Practice & practice team member names attending call
• One thing that you would most like to learn from this call
Hospital Readmissions: The Facts

• For hospitalized Medicare patients*:
  – 20.3% readmitted within 30d, 35.1% within 90d
  – Within 1 year:
    • 68.9% medical, 53.0% surgical pts readmitted
    – Most frequent diagnoses for re-hospitalization:
      • HF, Pneumonia, COPD, Septicemia
• Readmissions assoc’d with quality, safety risks
• Many hosp’d pts had 1 or more previous ED visits
• At least 50% of patients readmitted had no claim for physician visit within previous 30 days

*Jencks et al, NEJM, 2009
The Case for Improving Transitions and Reducing Potentially Avoidable Readmissions

• In Maine, approximately 1 in 6 Medicare patients re-hospitalized within 30 days of discharge*

Project Aim: What are we trying to accomplish?

• Global Aim: Contribute to SIM triple aim goals
  – Improve quality of care
  – Improve patient experience
  – Decrease costs

• Contribute to SIM goal of reducing potentially avoidable readmissions by 13% (Oct 2016)
Project Aim: What are we trying to accomplish?

• QI Project Aim:
  – Work with up to 10 PCMH/HH practices in focused QI initiative
  – Decrease potentially avoidable 30-day hospital all-cause readmissions
  – Improve specific care processes in primary care practice related to care transitions
  – Build on prior work, Core Exp’s of PCMH/HH
  – Project duration: Nov 2015 - June 2016
PCMH/HH Practice Survey
Care Transition Processes of Care

• Conducted with PCMH & HH practices Aug-Sept 2015
• Queried on elements of Roadmap key changes for care transitions
• 75 practices responded
• Report 1-60 patients discharged/week; most ~2-3/wk
PCMH/HH Survey Results: Care Transition Processes of Care

• Participating practices report high levels of implementing care transition key changes

• Several areas of strength:
  – Notification of discharged pts (90%)
  – F/u call within 48hrs (93%)
  – F/u visit within 7d (74%)
  – Med reconciliation post-d/c (96%)
  – Assess social service needs (81%)

• And yet...
Opportunities for Improvement Remain

• MaineCare readmission rates (HH and overall MaineCare) increased steadily over past 3 yrs (30d readmit rate 11 → 15%)
• MaineCare readmit rates for BH conditions 21%!
• Early results from PCMH Pilot/MAPCP demo not showing decreases in 30d all-cause readmission rates (Pilot practices vs. comparison practices)
• Only 58% Maine patients "Strongly Agree" they understood their care when they left the hospital on patient experience surveys following hospitalization
Building Reliability into Care Processes

• Participating practices will focus on making care systems more reliable

• Aim for improving systems by asking...
  – Is there system or process in place?
  – If so, does it fail?
  – Do we catch failures?
  – Do we use information to improve or “fix” our systems?
Focus on Reliable Systems for 5 Key Changes

1. Timely notification for patients discharged from hospital
2. Phone outreach to all patients w/in 48 hours of discharge
3. Conduct meaningful medication review using standard protocols and schedule (48hr call)
4. Ensure all patients assessed for risk of readmission; identify patients at high risk for readmit
5. Ensure patients at high-risk for readmission are seen in office visit within 7 days of discharge
Primary Drivers

- Reliable Systems in Place to Support Transitions from Discharge to Being Seen in PCMH or HH

Secondary Drivers

- Timely notification about patients discharged from the hospital
- Ensure patient assessed for risk of readmission and results shared with PCMH or HH
- Phone calls within 48 hours to all patients discharged from hospital
- Initial meaningful review of patient’s medications completed
- Ensure that patients identified as high risk are scheduled for an office visit with PCMH or HH w/in 7 days of discharge

Aim

Improved primary care processes resulting in increased numbers of potentially avoidable hospital readmissions by June 30, 2016

Patient-Centered Visit with PCMH or HH and Follow-up to Support Patients/Families/Caregivers

- Set up patient-specific risk mitigation co-coordinated care plans
- Ensure patient and family are optimally involved in care planning
- Perform medication reconciliation & social needs assessment and provide information to patients
- Ensure patients are connected to appropriate resources in the community
- Coordinate care with community partners as necessary
Measures: How to Know Changes are Resulting in Improvement?

• Pre and post Office Systems Survey
• Review up to 10 charts/month of practice patients discharged from hospital assessing performance on 5 key changes
• Conduct “root cause analysis” for up to 3 patients readmitted during measurement month
Process Measure Goals

• Office systems supporting care transitions: 100% of participating practices see improvement from pre to post-project survey

• Reach targets for key change processes (via chart review):
  – 100% notification of discharged patients
  – 90% d/cd patients receive phone call w/in 48 hours of d/c
  – 90% have medication review documented
  – 100% have assessed for readmission risk
  – 100% high risk pts have f/u appointment w/in 7 days scheduled
  – 90% high risk pts are seen for follow up w/in 7 days

• At least 1 process change tested using PDSA cycle using findings from root cause analysis of readmission
Measurement Strategy

• Baseline data by November 15, 2015
  – Develop aim for work in your practice
  – Complete chart review on up to 10 charts/month per practice discharged from hospital in measurement month
  – Enter data into QI Teamspace (web based platform)
  – Complete pre-project office systems survey

• Beginning December 15, 2015
  – Submit PDSA cycle
  – Submit qualitative data on lessons learned from root cause analysis
## Three Faces of Measurement

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Clinical Research</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim:</strong></td>
<td>Improvement of care</td>
<td>Comparison, choice, reassurance, spur for change</td>
<td>New knowledge</td>
</tr>
<tr>
<td><strong>Methods:</strong></td>
<td>Test observable</td>
<td>No test, evaluate current performance</td>
<td>Test blinded</td>
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<tr>
<td>Test observability</td>
<td>Test observable</td>
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<tr>
<td>Bias</td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td>Sample size</td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant, data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td>Flexibility of hypothesis</td>
<td>Hypothesis flexible, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis</td>
</tr>
<tr>
<td>Testing strategy</td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
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<tr>
<td>Confidentiality of data</td>
<td>Data used only by those involved in the improvement</td>
<td>Data available for public consumption</td>
<td>Research subjects’ identities protected</td>
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We are here....

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Deeper Dive: Monthly Root Cause Analysis

Identify process variables that contribute to patient(s) admission or re-admission.
Root Cause Analysis

Methods

Materials

People

Equipment

Environment

Use what you learn to inform improvement and testing.

Patient
Admitted or
Re-Admitted
Expectations for Practices

1. Identify Leadership Team: Lead Provider, Practice Administrator & Clinical Staff Member (e.g., RN, MA, other)

2. Complete Memorandum of Agreement & Business Associate Agreement

3. Complete pre and post paperwork for Maintenance of Certification

4. Complete on-line office systems assessment before & after project

5. Identify point person for collecting and reporting monthly data
Expectations for Practices

6. Attend PCMH/HH monthly webinars and PCMH/HH Learning Session (February 5, 2016)

7. Work collaboratively with other participating practices and QC staff to test and implement key changes during 8-month project period

8. Participate in evaluation call at close of project
Benefits of Participating

• Improve quality & safety of care for patients experiencing care transitions!
• Learn from peers, community partners, and experts about how to improve care processes
• Receive credit toward Maintenance of Certification (MOC) for interested physicians
• Contribute to improving hospital performance on readmission rates
Mark the Dates!

- Complete Pre-Office Systems Survey **by Nov 15th**
- Submit baseline data on monthly chart review **by Nov 15th**
- PCMH/HH Webinar: Establishing Timely, Two-Way Communication About Admitted and Discharged Patients **Wed, Nov 18th (7:30– 8:15 am)**
- PCMH Learning Session: **Feb 5, 2016** (Cross Insurance Center, Bangor)
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