Reduce Readmissions by Leveraging BIG and little Data

July 17, 2017
WELCOME AND INTRODUCTIONS
Lisandra Cuadrado, MPH, Program Manager | HRET
Webinar Platform Quick Reference

- Mute computer audio
- Today’s presentation
- Download slides/resources
- Register for upcoming events
- Chat with participants

HRET HIIN VIRTUAL EVENT
Poll: How did you hear about this event?

How did you hear about today’s virtual event?

a. HRET HIIN flyer
b. HRET HIIN website
c. HRET LISTSERV
d. State hospital association
e. QIN-QIO
f. Your organization/colleague
g. Other, please specify
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
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<tbody>
<tr>
<td>1:00-1:05 p.m.</td>
<td>Welcome and Introductions</td>
<td>Lisandra Cuadrado, BS, MPH</td>
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<td>Program Manager, HRET</td>
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<tr>
<td>1:05 – 1:10 pm</td>
<td>Data and Framing</td>
<td>Julia Heitzer, MS</td>
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<td>Data Analyst, HRET</td>
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<td>HRET Pat Teske MHA, RN</td>
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<td>Improvement Advisor, Cynosure Health</td>
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<tr>
<td>1:10-1:25 p.m.</td>
<td>Using Readmissions Data to Focus Your Improvement Efforts</td>
<td>Pat Teske MHA, RN</td>
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<td>Improvement Advisor, Cynosure Health</td>
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<td>1:25 – 1:40 p.m.</td>
<td>Case Studies: Rural and CAH Hospitals in Action</td>
<td>Jaymie Heard</td>
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<td>Nurse Manager ICU/Med Surg, Kings Daughter Medical Center</td>
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<td>Nicole Thorell RN</td>
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<td>Chief Nursing Officer, Lexington Regional Health Center</td>
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<td>1:40 – 1:55 p.m.</td>
<td>Back to You: A Call to Action and Facilitated Discussion</td>
<td>Pat Teske MHA, RN</td>
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<td>Bruce Spurlock MD</td>
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<td>Cynosure Health</td>
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<td>1:55-2:00 p.m.</td>
<td>Bring it Home</td>
<td>Lisandra Cuadrado, BS, MPH</td>
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<td>Program Manager, HRET</td>
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HIIN READMISSIONS DATA REVIEW

Julia Heitzer, MS, Data Analyst | HRET
Readmissions Data Update

Data submitted to HRET as of: 6/30/2017
COMING SOON!

Excel-based tool for CAH/Rural hospitals to use to collect data for the HIIN measures

Displays measure-level data in run chart format

Calculates “day since last event”

State Partner can upload this data to CDS
Setting the Stage
Reduce Readmissions by Leveraging BIG and little Data

Pat Teske, RN, MHA
Cynosure Health
Featuring

Nicole Thorell MSN, CEN, RN
Lexington Regional Health Center, NE

Jaymie Heard DNP RN
Sarah Smith RN
Kings Daughter Medical Center, MS
The Executive Team at Lexington Regional Health Center

- Twenty-five bed critical access hospital in central Nebraska.
- The facility has expanded rehabilitation, outpatient and the radiology services to better serve the needs of our community.
- Opened an urgent care clinic in fall 2014.
- In July 2014, family medicine specialists opened a new clinic, providing general family medicine, sports medicine, prenatal care, weight management, physicals and disease management.
- In May 2016, the outpatient service center opened. The new center features 16 exam rooms, three new operating rooms, two endoscopy procedure rooms and nine pre and post-operation recovery rooms.
- October 2016, hospital renovations featured privatized patient rooms, a redesigned main entrance, updated mechanical and electrical systems, and a redesigned kitchen and dining room.
King’s Daughter Medical Center, Brookhaven, MS
Our mission is to provide quality health and wellness in a Christian environment. We are a non-profit community hospital established by a Christian ladies group “The Willing Hearts” in the late 1800s. We are strongly committed to our community and our mission.
Sample Instructional Video

https://youtu.be/0YgqUtW--wg
Reduce all cause 30-day readmissions by 12 percent by September 27, 2018.
Do You Operate Like This?

Should You Continue?
This is NOT the Answer
What Would Be Better?
Readmission Reduction Drivers

- 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
<table>
<thead>
<tr>
<th>Use Data and Root Cause Analysis to Drive Continuous Improvement</th>
<th>Change Idea</th>
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</thead>
<tbody>
<tr>
<td>Analyze data to inform your targeting approach</td>
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<tr>
<td>Understand root causes of readmissions; elicit the patient, caregiver, and provider perspectives</td>
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<td>Periodically update approach based on findings; articulate your readmission reduction strategies</td>
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<td>Develop a performance measurement dashboard to use data to drive continuous improvement</td>
<td>Change Idea</td>
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Big DATA + Little DATA = A better approach

BIG Data

• The entire readmissions population
• Dice and slice by payer, REaL, etc.
• Learn which groups are readmitted at a higher rate
• These are the groups you will TARGET with special effort

Little Data

• What you are learning on a day-to-day basis
• From patients, providers, case review
• Help you understand where the gaps are in your current processes and program
• Helps you decide WHAT to prioritize from a PI perspective
Data Drill Down Tool

• **Tool**
• A data analyst friend
• Several hours

Process
  – Run the data
  – Populate the tool
  – Answer the questions with your team
    • What assumptions did your data confirm?
    • What surprised you?

• **Tabs**
  – Instructions
    • ICD 10: F0-F9 often used to capture behavioral health
  – Data entry
  – Data dashboard
  – Data entry example
  – Data dashboard example
Polling Question

In the past 6 months which big data reports have you used?

a. We’ve used the HRET HIIN data drill down tool
b. We’ve used Medicare FFS reports from our QIN-QIO
c. We’ve used both
d. We’ve used neither
e. Not sure
If This Was Your Data?

Readmissions by Initial Discharge Disposition

Where Would You Focus?
What Is This Data Telling Us?

Readmissions by Days Between Discharge and Readmission

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<tr>
<th>Days</th>
<th>Readmissions</th>
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<tr>
<td>1-5 DAYS</td>
<td>8</td>
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<tr>
<td>6-10 DAYS</td>
<td>8</td>
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<tr>
<td>11-15 DAYS</td>
<td>4</td>
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<td>16-20 DAYS</td>
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<td>21-25 DAYS</td>
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<tr>
<td>26-30 DAYS</td>
<td>4</td>
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What would you do?
What Is This Data Telling Us?

Figure 4. Discharge Disposition by Payer (adult, non-OB)

- % of discharges discharged to SNF
- % of discharges discharged with home health
- % of discharges discharged to home (without home health)
What Is This Data Telling Us?

30-Day Potentially Preventable Readmission (PPR) Rates by Race and Ethnicity
Major Respiratory Infections & Inflammations for New Jersey Hospitals, 2012

- Hispanic Black: 50.0%
- Hispanic Other: 10.6%
- Hispanic White: 13.3%
- Other Race: 9.6%
- Asian: 13.9%
- Black or African American: 13.4%
- White: 13.7%
- Major Respiratory Infec & Inflam combined: 13.3%
Some Key Questions

• How many readmissions would be reduced if this hospital reduced readmissions by 12 percent; how many per year and per month?
• Which groups of patients have higher than average readmission rates? Which group experiences the most readmissions? Are there any high-risk diagnoses to consider?
• What percentage of readmissions occurs within four days of discharge? Within ten days?
• How many patients were hospitalized four or more times in the past year (also known as “high utilizers”)? What is the readmission rate for this group?
Let’s Chat With Our Hospitals

• What have you learned from your BIG data analysis?
• What have you done differently as a result of drilling down into your data?
• What advice do you have for today’s listeners?
Little Data Provide A Different Perspective

• Why ask the patients and providers?
  – Gain their perspectives
  – Understand reasons
  – Identify gaps
  – Develop a better plan for the specific patient
  – Design a more effective program

• Why do case reviews (focus on quick returns)?
  – Determine care gaps
  – Look at plans overtime
  – Prioritize repeated issues
The Story Behind The Story

- Identify patients in the hospital who have been readmitted.
- Ask the patients/caregivers if they are willing to have a 5- to 10-minute discussion about their recent hospitalizations.
- Capture patient/caregiver responses.
- Analyze responses for new insight regarding “why” patients returned to the hospital soon after being discharged.
What’s your process for understanding the reasons for readmission?

a. Routinely interview readmitted patients to determine from them why they believe they were readmitted and what they think needs to be done differently when they go home this time.

b. Interview patients and aggregate the reasons for readmission

c. Haven’t started yet but plan to

d. Not sure
51 year-old male with three acute care admissions and two ED visits in the past 180 days.
When asked why he thought he was readmitted said...

“ I RAN OUT OF LASIX ”
### Aggregate and Prioritize

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<td>Discharge Instructions</td>
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<td>Pt/hosp did their best</td>
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### Readmission Reduction Priorities

- **Palliative care...**
- **Medication...**
- **Care...**
- **MD f/u**
- **Psychosocial...**
- **Pt/hosp did their...**
- **Other**
- **Discharge...**

![Bar chart showing readmission reduction priorities](chart.png)
Other Data To Consider

• Inventory your efforts
  – Across departments
  – Coordination of activities
  – Check for duplication
  – Look for gaps

• Inventory community resources
  – Clinical
  – Non-clinical
Let’s Chat With Our Hospitals

• What have you learned from your LITTLE data?
• What have you done differently as a result of these learnings?
• What advice do you have for today’s listeners?
Ongoing Monitoring Data

- Monitor what matters
- If you aren’t where you need to be - adjust

My Favorite Medical Center
Readmission Reduction Team Report 2017

Follow-up appt.
% of Pts who attend fu appt

AHCP
% of Pts who receive AHCP
% AHCP complete

PCP
% got DC summary in 48hrs

Teach back
% Pts who can teach back

Meds
% completed Med Rec
% plan to obtain Meds

F/U Call post-DC
% call compl. in 72 hrs

Download the tool here:
Polling Question

What best describes your approach to monitoring your processes?

a. We have a dashboard that our team reviews monthly which contains all of our key processes: appointments scheduled and made, post discharge phone calls, discharge instructions and teach back, etc.

b. We monitor only readmission rates, not specific processes.

c. We are planning to develop a dashboard.

d. Not sure.
Let’s Chat With Our Hospitals

• How do you share readmission data within your organization?
• What processes are you monitoring?
• What advice do you have for today’s listeners?
### Preventable Readmissions Top Ten Checklist

1. Develop a data-informed targeting strategy to identify target populations with higher than average rates of readmissions. Deliver enhanced readmission reduction strategies to these "target population" patients.

2. Identify root causes of readmissions based on interviewing patients, caregivers and providers. Prioritize your improvement strategies based on those that will address the root causes of readmissions among your patients.

3. Improve care transition processes for all patients, regardless of readmission risk. Refer to the proposed practices articulated in the proposed CMS Conditions of Participation for Discharge Planning.

4. Provide a customized transitional care plan for all patients.

5. Effectively communicate with patients and caregivers. Use translation services, teach-back, motivational interviewing and materials written in plain language.

6. Deliver enhanced readmission reduction services for your target populations based on their root causes of readmissions.

7. Design a high utilizer approach for patients with four or more admissions per year. Identify their "driver of utilization," and use care plans to improve care across settings.

8. Engage the emergency department as a new site of readmission reduction activities.

9. Collaborate with clinical, behavioral, and social service providers to improve cross-setting care processes for shared patient populations. Ensure you are aware of the services and supports that are available from other providers and agencies in your community.

10. Measure what you implement, driving to reliable delivery of improved processes.

Next Steps!

- Download the 2017 readmissions reductions change package and top 10 checklist
- Ask what changes are needed?
  - Your approach?
  - The team(s)?
- Test your new ideas
- Interview five patients
Any questions?
Pat Teske, RN, MHA
Implementation Officer
Cynosure Health
pteske@cynosurehealth.org
• Join the **LISTSERV®**
  – Ask questions
  – Share best practices, tools and resources
  – Learn from subject matter experts
  – Receive follow up from this event and notice of future events

Thank You!

Find more information on our website: www.hret-hiin.org

Questions or Comments: HIIN@aha.org