Reducing Readmissions in Wisconsin
All Hands on Deck!

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Objectives
During this presentation you will learn:
1. The impact of federal programs to speed the improvement in readmissions and care transitions.
2. How the many drivers of readmissions are addressed to achieve improvement.
3. The role of long-term care and other providers in partnering with hospitals to reduce readmissions.

Readmissions - A national imperative

RWJ Foundation, 2010
Converging Forces
putting a spotlight on readmissions

Is a Preventable Readmission a Patient Harm?

All Cause Readmission Focus
Recommend that providers approach to reducing readmissions is ‘universal’
and
Target specific patient populations to address particular needs
### CMS Readmission Reduction Penalty

- 1st payment adjustment was Oct. 1, 2012 (FFY 2013)
- Penalizes hospitals for exceeding expected readmissions based on national performance levels
- Program expands over time by adding new conditions
- Capped penalty increases each year
  - 1% in FFY 2013;
  - 2% in FFY 2014;
  - 3% in FFY 2015+

### CMS Readmission Penalty Program

[Diagram showing savings to the healthcare system]
How Readmissions Happen

An Interconnected System...

PRIMARY CARE ➔ HOSPITAL ➔ HOME

COMMUNITY ORGS ➔ HOME HEALTH

REHAB or LONG TERM CARE

HOME HEALTH ➔ PRIMARY CARE

COMMUNITY ORGS

HOME CARE
What could go wrong?

Ideally, this system should work really well for those in our community...

But we know it doesn’t always work as it should...
A problem of heterarchy

Understanding Local Care System

What is your local “systems” story?

• Who are the providers in your patients’/residents’/consumers’ care continuum?
• What does that “system” look like?
• Who are the care giving entities?
• How do they connect?
• What is working & what’s not working
Understanding Local Care System

From the patient’s perspective

Who is responsible?
Control or Influence?

- No control or Influence
- Influence
  - Where you work with others to create change.
  - What is within your power to change.
- Control
  - What is within your power to change.

No control or Influence

- PRIMARY CARE Physician Communication
- LTC/SNF Monitor Early Warning Signs
- HOSPITAL Discharge Instructions

Where you work with others to create change.

The Improvement Challenge
It's not easy

Complex and interconnected causes

One size doesn’t fit all → patient-centered

We are improving a “system of systems”

Hospital Improvement

1 Outcome Measure

All Cause 30 day Readmission Rate

11 Process Measures

24+ Interventions to implement

(focus is determined by organization’s Root Cause Analysis)

Driver Diagram

AIM

Reducing Readmissions by 20% by 12/13/2016

Primary Drivers

Interventions

- Risk for Readmission Assessment
- Risk Stratification by Patient Type
- Patient/Caregiver Knowledge of Inpatient and Outpatient Care
- Use of Teach Back to Validate Understanding
- Create a Patient Centered Record
- Communication to Care Team/Outside the Hospital
- Readmission, Discharge
- Discharge Transfers
- Post-Discharge Calls and Visits
- Outside Primary Care / Medical Home Access
- Assess Patient and Family Capability for Care
- Connect Patient with Community Resources
Key Processes

Reduce Preventable Readmissions by 20%

Determine Root Causes of Readmissions
- Conduct chart audit of recent readmissions
- Interview recently readmitted patients and family members
- Stratify readmission data

Begin discharge at admission
- Screen patient for risk of readmission
- Reconcile medications
- Determine patients/family understanding of their condition
- Determine patients level of activation

Prepare patient and family for discharge home
- Connect patient to resources prior to d/c
- Ensure patient understands post-d/c inst. Teach Back
- Ensure patient knows warning signs & who to call

Prepare patient for transfer to next site of care
- Obtain follow-up app'ts prior to discharge
- Prepare patient and family for follow-up call post-d/c
- Ensure documentation is received at next site of care

Ensure follow-up is carried out
- Telephone follow-up to ensure care plan is in place
- Connect patients with community resources
- Track if patients with follow-up app'ts were seen

Work across the care continuum
- Establish Transitions of Care Coalition
- Connect with local retail pharmacy (WPQC)
- Assess if high risk patients return to the ED
- Assess primary care “No show” rate
All Hands on Deck

Unnecessary readmissions are a problem of the fragmented system of care we have

No one type of provider can fix this type of problem

Working Collaboratively

Macro & Micro Approach

MACRO Strategy
Statewide Transitions of Care Coordinating Committee

Poor Health Literacy
Last Minute Teaching
Failure to Detect Change in Condition
Not Knowing “Who to call?”
Difficult Access to Primary Care F/u
Chronic Condition

MICRO Strategy
Engaging Patient, Family and Other Care Givers in the Process

Challenged with Self-Care
Lack of Transportation
Adverse Med Reaction
Lack Access to Local Resources
Transfer to Skilled Nursing
Difficult Access to Primary Care F/u
Chronic Condition

Difficulty Paying for Meds
The Wisconsin Model

Key: Consistent messaging from all these organizations about the importance of community engagement to improve transitions in care

Collaboration in Action

- Convened Readmissions stakeholder organizations with a statewide presence.
- Meet 6-8 times annually
- Leverage funding resources to launch workshops around the state
- Hold best practice sharing events & coaching calls
Transitions of Care Coalitions

- Hospitals (Care Coordinators, D/c Planners, Social Work)
- Skilled Nursing and Long-term Care organizations
- Aging and Disability Resource Centers
- County Health Departments
- Home Health Agencies
- Home Care Organizations
- Retail Pharmacies
- Primary Care
- Other Community Organizations (churches, non-profits)
- EMTs (newer)

Wisconsin has 27 active Transitions of Care Coalitions

Information provided by MetaStar, which represents Wisconsin in the Lake Superior Quality Innovation Network.

Questions?

Hospital Transitions of Care

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