Engaging the Medical Neighborhood to Prevent Avoidable Hospital Readmissions

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A Problem: The Revolving Door

- In Maine, **~1 in 6** Medicare patients **rehospitalized** within 30 days of discharge
- Unplanned readmissions estimated to cost Medicare (us!) approximately **$17.4B annually**
- "Every patient's story about…hospital readmission…is hard to characterize. Yet there are **common traits across the stories**."
  - Break-downs in communication
  - Gaps in care
  - Lack of patient understanding of conditions, meds

Problem: Missing Links to Primary Care Solution = Collaboration!

"**Readmission rates stubborn**, even among best hospitals" - per recent study…

- **Only 36.6% of hospitals** had **process** in place to ensure that **primary care physician was notified** within 48 hours of their discharge (vs. to 38% in 2012)
- **Only 23.8% of hospitals** reported having process in place to **send d/c summary directly to primary care practice** "all" of time
- **"Collaboration** between hospitals and caregivers in local community is **critically important**… people don't have support outside the hospital"

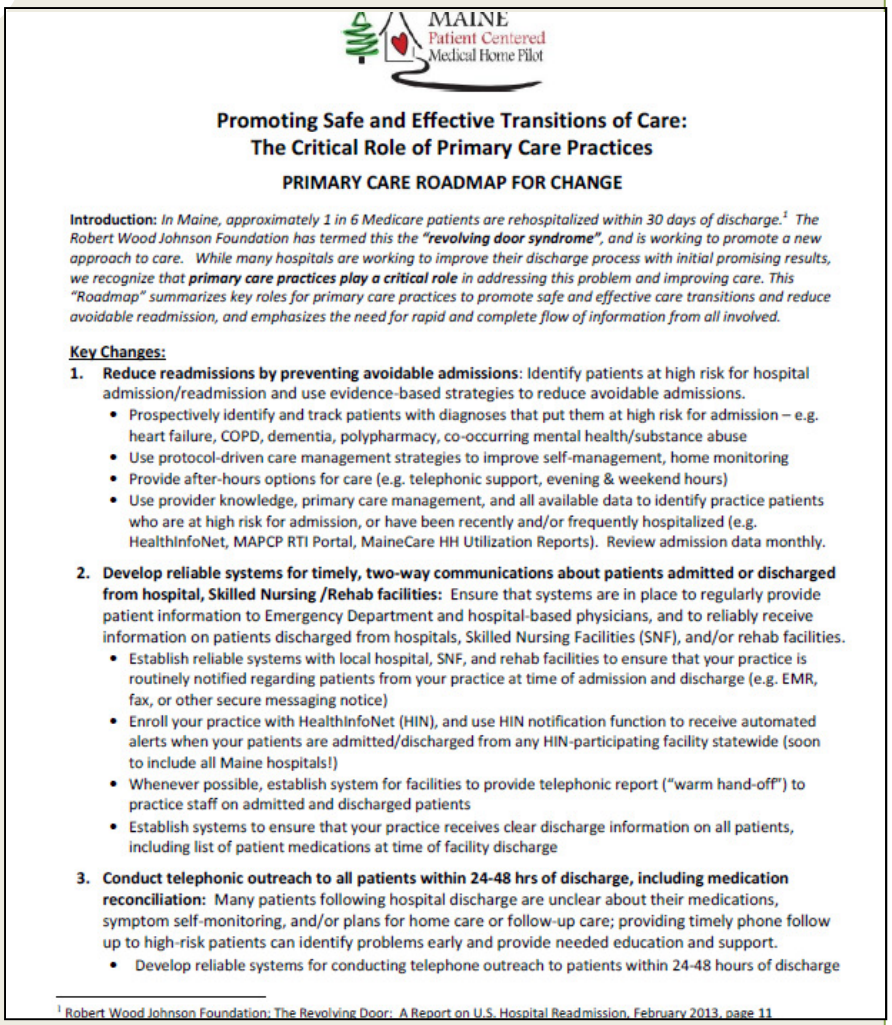
E. H. Bradley, H. Sipsma, L. I. Horwitz et al., "Contemporary Data About Hospital Strategies to Reduce Unplanned Readmissions: What Has Changed?" JAMA Internal Medicine, Oct. 21, 2013

Why Now? Time for Action!

- BUT…
  - "Our hospital is already doing this…"
  - "Readmission rates in our [state/community] are already lower than others
  - "We've been trying…"
- NOW is time to ramp up efforts!
  - Quality issue – patient/family impact
  - Opportunity to rapidly impact costs/decrease waste
  - CMS Value Based Purchasing – hospital incentives & penalties - coming soon to SNFs?

Exploring Solutions: The Primary Care Roadmap for Change

- Summarizes key roles for primary care practices to promote effective care transitions
- Developed by ME PCMH Pilot from review of best practices, expert opinion, consensus



MAINE Patient Centered Medical Home Pilot

Promoting Safe and Effective Transitions of Care:
The Critical Role of Primary Care Practices

PRIMARY CARE ROADMAP FOR CHANGE

Introduction: *In Maine, approximately 1 in 6 Medicare patients are rehospitalized within 30 days of discharge.[1] The Robert Wood Johnson Foundation has termed this the* ***"revolving door syndrome"****, and is working to promote a new approach to care. While many hospitals are working to improve their discharge process with initial promising results, we recognize that* ***primary care practices play a critical role*** *in addressing this problem and improving care. This "Roadmap" summarizes key roles for primary care practices to promote safe and effective care transitions and reduce avoidable readmission, and emphasizes the need for rapid and complete flow of information from all involved.*

Key Changes:

1. **Reduce readmissions by preventing avoidable admissions**: Identify patients at high risk for hospital admission/readmission and use evidence-based strategies to reduce avoidable admissions.
   - Prospectively identify and track patients with diagnoses that put them at high risk for admission – e.g. heart failure, COPD, dementia, polypharmacy, co-occurring mental health/substance abuse
   - Use protocol-driven care management strategies to improve self-management, home monitoring
   - Provide after-hours options for care (e.g. telephonic support, evening & weekend hours)
   - Use provider knowledge, primary care management, and all available data to identify practice patients who are at high risk for admission, or have been recently and/or frequently hospitalized (e.g. HealthInfoNet, MAPCP RTI Portal, MaineCare HH Utilization Reports). Review admission data monthly.
2. **Develop reliable systems for timely, two-way communications about patients admitted or discharged from hospital, Skilled Nursing /Rehab facilities:** Ensure that systems are in place to regularly provide patient information to Emergency Department and hospital-based physicians, and to reliably receive information on patients discharged from hospitals, Skilled Nursing Facilities (SNF), and/or rehab facilities.
   - Establish reliable systems with local hospital, SNF, and rehab facilities to ensure that your practice is routinely notified regarding patients from your practice at time of admission and discharge (e.g. EMR, fax, or other secure messaging notice)
   - Enroll your practice with HealthInfoNet (HIN), and use HIN notification function to receive automated alerts when your patients are admitted/discharged from any HIN-participating facility statewide (soon to include all Maine hospitals!)
   - Whenever possible, establish system for facilities to provide telephonic report ("warm hand-off") to practice staff on admitted and discharged patients
   - Establish systems to ensure that your practice receives clear discharge information on all patients, including list of patient medications at time of facility discharge
3. **Conduct telephonic outreach to all patients within 24-48 hrs of discharge, including medication reconciliation:** Many patients following hospital discharge are unclear about their medications, symptom self-monitoring, and/or plans for home care or follow-up care; providing timely phone follow up to high-risk patients can identify problems early and provide needed education and support.
   - Develop reliable systems for conducting telephone outreach to patients within 24-48 hours of discharge

[1] Robert Wood Johnson Foundation; The Revolving Door: A Report on U.S. Hospital Readmission, February 2013, page 11

Primary Care Roadmap: 7 Key Changes

1. Reduce readmissions by preventing avoidable admissions, with focus on high-risk conditions
2. Develop systems for timely, two-way communication re: patients admitted/ discharged from hospital, SNF/Rehab
3. Conduct telephonic outreach within 24-48 hrs of discharge, including medication reconciliation

Primary Care Roadmap: 7 Key Changes

4. Provide patient-centered, timely access to follow-up care (i.e. office visit within 3-7 days)
5. Connect with community resources to optimize patient & family/caregiver supports
6. Facilitate patient and family-centered discussions regarding end of life care
7. Build personal relationships across your medical neighborhood!

Let's Get Started!

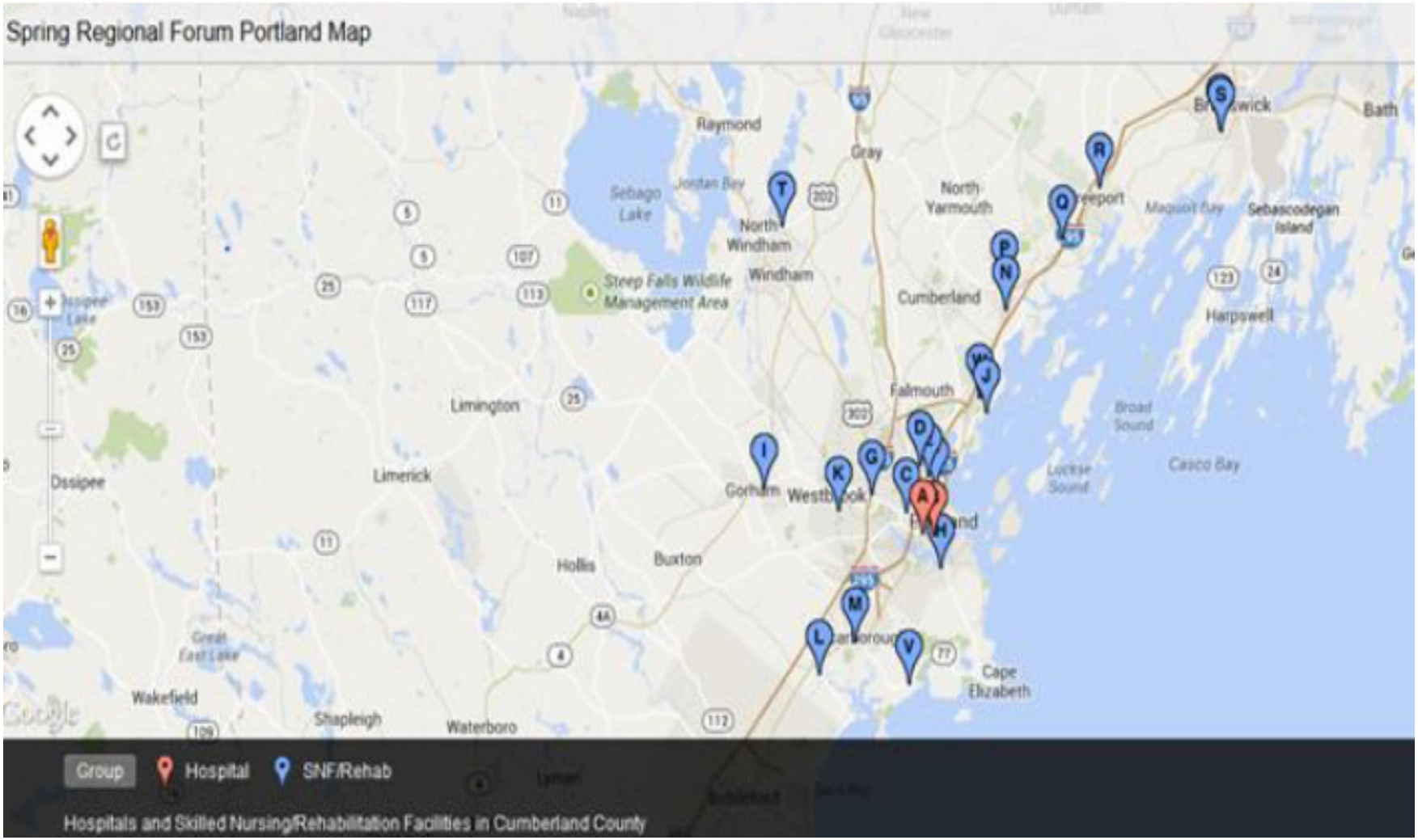
Bridging the Medical Neighborhood: Community Discussions!

- Regional Forums bring together colleagues from medical neighborhood to make & strengthen local relationships – e.g.
  - Hospital staff, care managers
  - AAAs
  - SNFs/Rehabs
  - Home care
- Introduce PCMH "Roadmap for Change"
- Encourage PCMH practices to build connections, identify new change ideas for improving care transitions in local community

Regional Forum Agenda

- Reactor Panel
  - What's working in our medical neighborhood
  - Opportunities for further improvements
  - Additional roles for primary care?
- World Café - Roundtable Discussions
  - Build relationships
  - Explore current challenges, opp's for improvement
  - Craft action plan together

Mapping Your Medical Neighborhood



The Strength of Relationships

Primary Care in isolation vs. Connected medical neighborhoods!

Consider the important relationships you want to strengthen in your medical neighborhood – make a new connection tonight!

Maine Quality Counts
Better Health Care. Better Health.

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Maine Patient Centered Medical Home Pilot (ME PCMH Pilot)

Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition are working together to lead the Maine Patient Centered Medical Home Pilot. The ultimate goal is to sustain and revitalize primary care both to improve health outcomes for all Maine people and to reduce overall healthcare costs.

Maine Patient Centered Medical Home Pilot

What is a Patient Centered Medical Home (PCMH)?

A patient centered "medical home" is an approach to providing primary care to people of all ages. It is not a building or place, but a team of health professionals who work together to provide a central point for coordinating care to help people become as healthy as possible. **For more information and to download the PCMH brochure, click HERE.**

Maine PCMH

More about PCMH

- Maine PCMH Pilot Information
- MaineCare Health Homes Initiative
- Maine PCMH and Health Homes Learning Collaborative
- Maine PCMH Transformation Tools & Reporting Resources
- Care Transitions Tools & Resources

QC Programs

- Aligning Forces for Quality (AF4Q)
- AF4Q: Maine Race, Ethnicity and

Contact Info / Questions

- Maine Quality Counts
  - www.mainequalitycounts.org
- Maine PCMH Pilot
  - (See "Major Programs" → "PCMH Pilot")
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