NATIONAL QUALITY FORUM

Meeting Summary

Readmissions Action Team Public Web Meeting

The National Quality Forum (NQF) convened a public web meeting of the Readmissions Action Team on August 14, 2014. An online archive of the meeting is available by clicking here.

Action Team Member Attendance

Readmissions Action Team Members	
Name	**Organization**
Lois Cross (Chair)	*American Case Management Association*
Osman (Ozzy) Ahmed	*Magellan Complete Care*
Maria Basso Lipani	*Mount Sinai Hospital*
Sumita Bhatia	*Kaiser Permanente*
Sarah Callahan	*America's Essential Hospitals*
Pamela Carroll-Solomon	*CHE Trinity Health*
Maureen Dailey	*American Nurses Association*
Elizabeth Davis	*San Francisco General Hospital*
John Fastenau	*Janssen Pharmaceuticals*
Lisa Freeman	*Patient Advocacy of Connecticut*
Tejal Gandhi	*National Patient Safety Foundation*
Antony Grigonis	*Select Medical*
Sandy Markwood	*National Association of Area Agencies on Aging*
Diane Meier	*Center to Advance Palliative Care*
Amy Minnich	*Geisinger Health System*
Stacy Ochsenrider	*Bronson Methodist Hospital*
Ranjit Singh	*American Psychiatric Association*
Thomas Smith	*American Psychiatric Association*
Karen Southard	*The Carolina's Center for Medical Excellence*
Alissa Zerr	*Cerner Corporation*

Welcome and Meeting Objectives

Led by Lois Cross, American Case Management Association, Action Team Chair

Ms. Cross welcomed the group and reviewed the meeting objectives, which were to:

- Learn about initiatives that are successfully reducing avoidable admissions and readmissions for patients with psychosocial needs;
- Share and spread best practices, programs, and ideas to safely reduce readmissions; and
- Activate participants to bring lessons learned back to their organizations to examine their data, identify priority populations, and drive improvement.

Background & Project Overview

Led by Lois Cross

Ms. Cross provided a brief overview of the project which has focused on leveraging patient, provider, and community partnerships, and identifying and addressing patients with psychosocial needs. Ms. Cross described the strategies set forth by the Readmission Action Team to promote person-centered care for vulnerable populations to safely reduce avoidable readmissions which include the following:

Systems Improvement

- Share tools and resources to identify and assess individuals with psychosocial needs.
- Raise awareness of the interrelatedness of social, behavioral, and mental illness with medical issues among all team members' networks and constituent groups.

Collaboration

- Share resources for making the business case for collaborating and partnering.
- Promote patient and family workshops in the community and collaborate with other organizations to prevent readmissions.

Patient and Family Engagement

- Encourage widespread patient and family membership on hospital boards and committees.
- Share broadly, the value of partnership with patient and families and the importance of their input, preferences, and needs-both medical and psychosocial-during care planning.

The Preventable Admissions Care Team (PACT) Program

Presented by Maria Basso Lipani

Ms. Lipani provided an overview of Mount Sinai Hospital's PACT Program, which is an intensive, transitional care program utilizing social workers to target patients at high risk for a 30-day readmission. The program emphasizes early patient engagement to identify and address psychosocial strains that compound readmission risks, to provide seamless transitions to home, and to support the patient in successfully managing care in the community. Key messages from the presentation include:

- High utilizers are reachable and their readmission risk can be reduced;
- Reducing readmission requires an understanding of the psychosocial barriers to health for each patient and the latitude to address them;

- Authentic engagement of patients/their families and other supports to identify readmission drivers and subsequent interventions to address the drivers; and
- Sustaining risk reduction requires continued buy-in from the patient, a connection to trusted providers, and access to multidisciplinary care coordination.

Ms. Lipani noted that when all these factors are considered, patients are more willing to work with their care team leading to a uniquely crafted intervention that will positively impact the patient's circumstances. The results of the PACT program have been significant – a 43 percent reduction in admissions and 54 percent reduction in emergency department visits for patients who completed the PACT 5-week intervention.

The Reducing Avoidable Readmissions Effectively (RARE) Campaign

Presented by Kathy Cummings, Kim McCoy, and Kattie Bear Pfaffendorf

Ms. Pfaffendorf began the presentation by describing RARE as a campaign across the continuum of care to reduce avoidable hospital readmissions across Minnesota and surrounding areas. The campaign was designed as a regional approach and is supported by hospitals, providers, health plans, and has engaged other care providers, acknowledging that readmissions are the result of a fragmented healthcare system. The campaign sought community support by partnering with many stakeholders including more than 100 community partners. Ms. Pfaffendorf explained that the campaign was designed with the triple aim goals in mind which included preventing 6,000 avoidable readmissions by the end of 2013 and reducing overall readmissions rate by 20%; recapturing 24,000 nights of patients' sleep in their own beds instead of in the hospital; and saving millions of dollars in healthcare expenses. She introduced five focus areas that participating hospitals can choose to reduce readmissions including: patient and family engagement, medication management, comprehensive discharge planning, transition communication, and transition support. While the initial goal was set on 6,000, nearly 8,000 readmissions have been prevented by Minnesota hospitals since the start of the campaign.

Next Ms. Cummings provided examples of innovative interventions that were used to reduce readmissions which included evidence-base practices as well as promising practices such as utilizing EMS and fire department staff to do post-discharge home visits. In their visits these professionals can identify potential issues that may increase the risk of readmission (e.g., not eating properly or not taking their medication) and subsequently can connect at risk individuals with appropriate community support and services.

Maximizing Community Benefit Programs to Improve Outcomes

Presented by Holly Harper

Ms. Holly Harper presented on the Community Benefit programs established by Sutter Health based in Sacramento, CA. These programs are funded by hospitals through their net patient revenue to reduce readmissions and improve outcomes. This is accomplished by identifying social determinants of health and community needs, which entails conducting community health needs assessment, reviewing emergency department data, and conducting capacity studies. Through innovative and collaborative Community Benefit programming, Sutter Health and WellSpace Health have helped more than 5,500

clients. Ms. Harper stated that specific programs aim to meet the needs of the most vulnerable populations in the region and help connect people to the right care (e.g., primary care, mental health services), at the right place, and at the right time. Some of the tangible outcomes of this effort include expanding access to care across the greater Sacramento region; being on track to see 30,000-32,000 patients in 2014 which is approximately an 84 percent increase in patients served since 2011; and establishing programs such as Open Access Clinic Hours which allows patients to be seen without appointments.

Integrating Risk Stratification to Reduce Readmissions

Presented by Ramesh Sairamesh (Jakka)

Mr. Sairamesh provided a synopsis of the work that he and his team are doing to identify patients who maybe trending toward avoidable 30-day readmissions. The overarching goal of the program is early identification of risk factors, which helps match appropriate resources and interventions to improve patient care during hospitalization as well as when they leave the hospital. All patients are screened upon their admission into an inpatient setting in terms of their medical condition and other health determinants such as behavioral and social factors. Mr. Sairamesh pointed out that combining psychosocial factors, mental factors, and socioeconomic conditions with patients' clinical information done in a real-time basis has yielded great results.

Wrap Up and Next Steps

Led by Wendy Prins

Ms. Wendy Prins thanked everyone for their participation in the webinar and asked everyone to continue the conversation by sharing the work they are doing to reduce readmissions for people with psychosocial needs which will be highlighted in the Action Teams quarterly impact report. As an immediate follow-up, she said that an email will be sent to everyone seeking their input regarding the three following questions:

- What specific things can you do to model, build on, or help to spread what you have heard today?
- What work are you doing that others can model, build on, or spread?
- What tools and resources exist that assess individuals with psychosocial needs?

Lastly, Ms. Prins informed everyone of the submission dates for the NQF 2014 John M.Eisenberg Patient Safety & Quality awards which is open now until September 30, 2014.