Readmissions Action Team Action Pathway: Reducing Avoidable Admissions and Readmissions

July 31, 2014

In 2014, the National Quality Forum convened a multistakeholder action team to focus on reducing readmissions across care settings through a model of sharing best practices and aligning public- and private-sector patient safety efforts. In support of the Partnership for Patients initiative, this action team brings together critical thought leaders to identify aspirational goals and key strategies to drive system-level change. The results of this work will contribute to a broader national effort to achieve a significant and sustainable reduction in avoidable admissions and readmissions.

Background

In March 2011, the Department of Health and Human Services (HHS) released the National Quality Strategy (NQS), which established six priorities to achieve the overarching aims of healthy people and communities, better care, and affordable care. In support of the NQS, HHS launched the Partnership for Patients initiative as a major effort to advance the priority areas of safety, care coordination, and patient and family engagement, and to achieve two important goals:

1. Decrease preventable hospital-acquired conditions by 40 percent compared to 2010.
2. Decrease preventable hospital readmissions by 20 percent compared to 2010.

To achieve broad stakeholder engagement and action around these goals, HHS requested the National Quality Forum (NQF) to convene critical thought leaders and organizations to focus on further reducing avoidable admissions and readmissions by leveraging NQF's action catalyst role in support of the Partnership for Patients. In 2012, NQF convened the first readmissions action team, which focused on safely reducing avoidable readmissions across care settings—particularly in long-term and post-acute care—by emphasizing and spreading the implementation of patient-centered models of care such as the INTERACT[1] program.

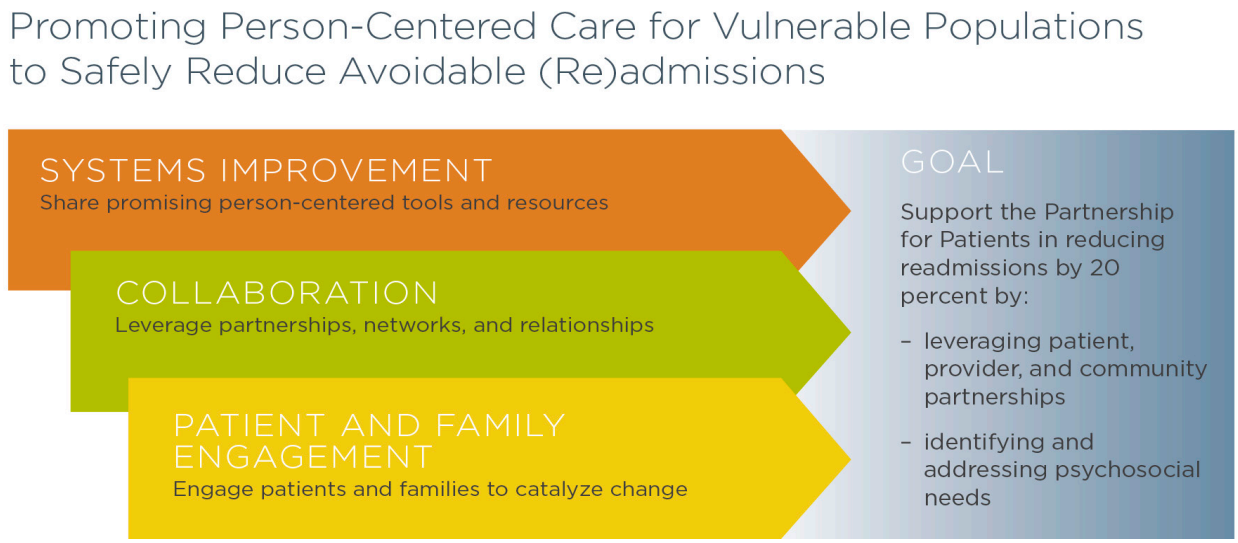
There is strong evidence to support the continued reduction of avoidable admissions and readmissions as a necessary step in improving patient safety and lowering healthcare costs. A 2009 study revealed that almost one in five Medicare patients discharged from the hospital is readmitted within 30 days, putting patients at increased risk of complications or infections and accounting for approximately $15 billion of excess Medicare spending each year.[2] [3] [4] Although readmissions is finally on the decline, attention has recently focused on the challenges of adequately treating patients with behavioral and mental health issues, and of addressing psychosocial factors that are barriers to health, wellness, and recovery. Both require actions that extend beyond the healthcare delivery system that through partnership bridge hospitals and healthcare providers with the communities they serve.

2014 Readmissions Action Pathway Goals and Strategies

To complement the Partnership for Patients goal of reducing hospital readmissions and the many efforts focused on improving care transitions from the hospital setting, NQF has formed a multistakeholder action team (Appendix A). This team, led by Lois Cross, System Case Management Consultant, Sutter Health, developed an action pathway with a primary aim of promoting person-centered care for vulnerable populations to safely reduce avoidable admissions and readmissions (Figure 1).

To achieve the aspirational goals set forth by the Partnership for Patients, the action team is focused on identifying high-risk patients with psychosocial needs, and on leveraging patient, provider, and community partnerships to address those needs. The strategies it is advancing include working together across stakeholder groups to enhance systems improvement, collaboration, and patient and family engagement. The group is sharing and spreading best practices and approaches to improving the quality of care aligned with these strategies that serve as a driver in fostering both individual and collective efforts to further progress.

Figure 1: (Re)admissions Action Pathway



Systems Improvement

The action team is contributing to widespread sharing and implementation of person-centered models of care with demonstrated success in reducing avoidable admissions and readmissions in complex patient populations. The models emphasize person-centered approaches to care that honor patient, family, and caregiver preferences, and that promote shared accountability across care settings and providers and into the community. As part of its goal and focus on patient centeredness, the team has emphasized the importance of identifying patients at highest risk of being readmitted—particularly from a psychosocial lens—as an opportunity to reduce avoidable readmissions. High-risk patients often require care beyond the medical model, and this team is well positioned to identify and spread best practices, programs, or models that address this population's specific health and wellness needs. The team is promoting these models within their respective spheres of influence and stakeholder groups.

As a start, the team has identified promising examples of how to improve systems of care, including social worker-driven models that focus on psychosocial strains as risk factors for readmissions and supporting patients in successfully managing their care in the community. Other programs focus on care transitions coaching led by nurse practitioners for high-risk patients while emphasizing interdisciplinary collaboration to ensure a safe, seamless transition across the continuum of care. In addition to these models, the team has a number of representatives with a track record of success in reducing readmissions who are sharing their successes with one another.

Members of the action team have committed to raising awareness among their member networks and constituencies about the interrelatedness of social, behavioral, mental, and medical issues and their relation to readmissions. Opportunities for exploration and spread by the team include drawing on their own resources to share best practices from the fields of developmental disabilities and integrative

health; understanding and capitalizing on trends and strategies in health information technology; and utilizing best practices from leading health systems and safety net hospitals.

Collaboration

The action team views partnership and collaboration—particularly between health systems and communitites—as critical to reducing hospital admissions and readmissions. Unplanned readmissions often reflect medical and social complexities that cannot be addressed by hospitals or healthcare systems in isolation. Rather, the healthcare system and the communities within which they operate need to partner to understand the unique needs of their patients, families, and caregivers and to determine how to best meet their needs. The action team is emphasizing the importance of fully address the psychosocial issues of patients, which necessitates collaboration among a wide variety of groups beyond the medical community. This collaboration needs to occur at multiple levels—national, state, and community—as well as within and across organizations involved in providing health or social services to individuals at the local level.

Through its forum for sharing best practices, the team is identifying opportunities to strengthen partnerships and is committed to fostering relationships that will facilitate continued reductions in readmissions. Through its own membership—which includes a Quality Improvement Organization (QIO), a Community-based Care Transitions Program (CCTP), and Hospital Engagement Networks (HEN)—the team has expertise in community coalition building and other community-based care models that can serve as informative models of partnerships and opportunities for collaboration. Additional members have expertise in behavioral health, safety net populations, and community-based services that can augment the medical perspectives. Many action team members have broad networks that can further enhance collaboration and the dissemination of goals, strategies, and tactics through webinars, membership groups, and other actions and activities. The team is specifically considering the need for a simple roadmap to community collaboration and a resource that outlines the business case for collaboration and partnership, recognizing that there is still a lack of “buy-in” that it is indeed important.

Patient and Family Engagement

Throughout the development of the team’s goal, the importance of patient and family engagement has been at the forefront. Authentically engaging patients in their care requires an understanding of their preferences, values, and goals; addressing complex psychosocial issues necessitates an even deeper understanding of their specific needs and risks. Engaging patients and families who have challenging needs can be particularly difficult, and special attention is necessary to consider the barriers to connecting patients with services that will benefit, support, and sustain them over time. The action team is committed to promoting engagement with patients and families, and to identifying and sharing successful strategies and tools to accomplish this more broadly.

The team has identified examples of person-centered tools to promote patient engagement. These include resources supported by the National Patient Safety Foundation; dissemination of patient educational information on patient and caregiver engagement to prevent readmissions through the network of Area Agencies on Aging: Title VI Tribal Aging programs which reach over 12 million older adults; and action team knowledge and experience with person-centered approaches and strategies for

screening, assessing, and referring for behavioral health conditions. The team will continue to identify opportunities to promote patient and family engagement, particularly those most relevant to the complex issue of readmissions. Additionally, the group fully supports and is committed to promoting the Partnership for Patients goals for patient and family engagement, particularly those focused on patient and family representation on committees and hospital boards.

The Path Forward—Driving Momentum and Sustainability

The action team is actively collaborating with stakeholder groups in the public and private sectors to achieve the goals of the Partnership for Patients, and is working with the National Content Developer, consumer advocates, and the NQF membership to spread promising practices and resources. The action team is holding monthly calls, in-person meetings, and two open forums to engage a broad array of stakeholders in dialogue. These activities are organized to foster the identification of opportunities to augment, amplify, and accelerate the strategies as well as other readmissions-focused efforts in the field. Team members are providing updates on actions related to progress on the pathway, and identifying the opportunities and activities that will spread best practices, programs, and ideas for safely reducing readmissions. Additionally, the team and many others are actively using LinkedIn to share and spread best practices, programs, and ideas, and to more broadly communicate to the community at large on a real-time basis. This will continue to provide an open forum for networking and collaboration in the joint effort to reduce readmissions.

Updates on the activities and accomplishments of the action team members are highlighted in NQF's Quarterly Impact Reports, and through in-person meeting and webinar summaries posted to the NQF website. The final Quarterly Impact Report (due October 15, 2014) will include a summary of the action team's activities and results over the course of the project.

Endnotes

[1] Interventions to Reduce Acute Care Transfers (INTERACT). Available at: http://interact2.net.

[2] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New Engl J Med*. 2009;360(14):1420-1421.

[3] Pennsylvania Patient Safety Advisory. Leveraging healthcare policy changes to decrease hospital 30-day readmission rates. *Pa Patient Saf Advis*. 2010 March;7(1):1-8).

[4] Medicare Payment Advisory Commission. Report to Congress: Promoting Greater Efficiency in Medicare. Washington, DC:103-199;June 2007.

Appendix A: Patient Safety Collaboration: Readmissions Action Team

Lois Cross RN, BSN, ACM (Chair)
American Case Management Association, Dixon, CA

Osman (Ozzy) Ahmed, MD, DrPH
Magellan Complete Care, Miami, FL

May-Lynn Andresen, RN
Quality in Healthcare Advisory Group, LLC, Cold Spring Harbor, NY

Maria Basso Lipani, LCSW
Mount Sinai Hospital, New York, NY

Sumita Bhatia, MPH, MS
Kaiser Permanente, Oakland, CA

Sarah Callahan, MHSA
America's Essential Hospitals, Washington, DC

Pamela Carroll-Solomon, MJ, RHIA, CPHQ
CHE Trinity Health, Wilmington, DE

Maureen Dailey, PhD, RN, CWOCN
American Nurses Association, Silver Spring, MD

Elizabeth Davis, MD
San Francisco General Hospital, San Francisco, CA

John Fastenau, MPH, RPh
Janssen Pharmaceuticals, Titusville, NJ

Lisa Freeman
Patient Advocacy of Connecticut, Fairfield, CT

Tejal Gandhi, MD, MPH, CPPS
National Patient Safety Foundation, Boston, MA

Antony Grigonis, PhD
Select Medical, Mechanicsburg, PA

Sandy Markwood
National Association of Area Agencies on Aging, Washington, DC

Debra McGill, RN
Maine Medical Partners, South Portland, ME

Diane Meier, MD
Center to Advance Palliative Care, Washington, DC

Amy Minnich, RN, MHSA
Geisinger Health System, Danville, PA

Armando Nahum
Safe Care Campaign, Atlanta , GA

Stacy Ochsenrider, MSN, ANP-BC
Bronson Methodist Hospital, Kalamazoo, MI

Ranjit Singh, MA, MBBChir, MBA
American Board of Family Medicine, Buffalo, NY

Thomas Smith, MD, FAPA
American Psychiatric Association, New York, NY

Karen Southard, MHA, RN
The Carolina's Center for Medical Excellence, Cary, NC

Alissa Zerr, RN, BSN, MPH
Cerner Corporation, Overland Park, KS