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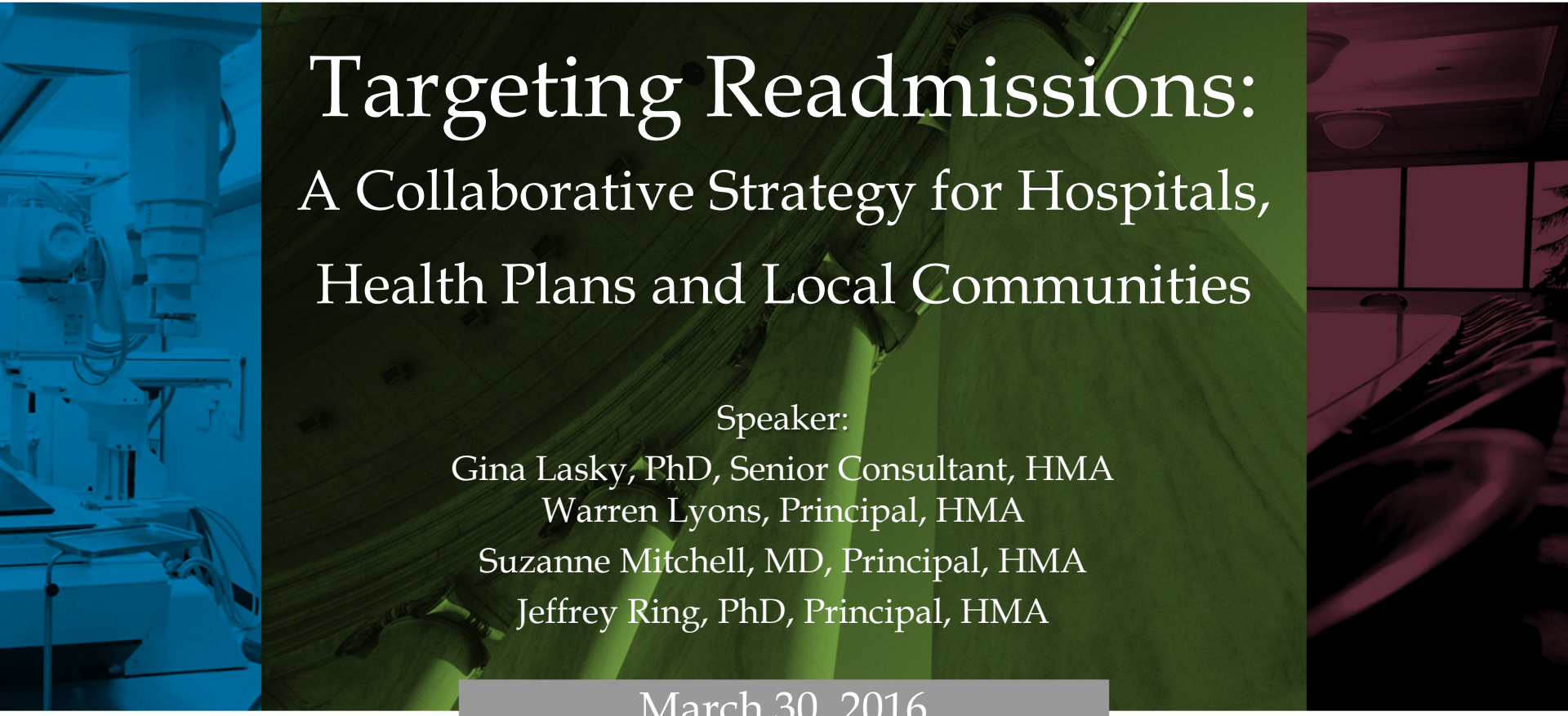


Targeting Readmissions:

A Collaborative Strategy for Hospitals, Health Plans and Local Communities

Speaker:

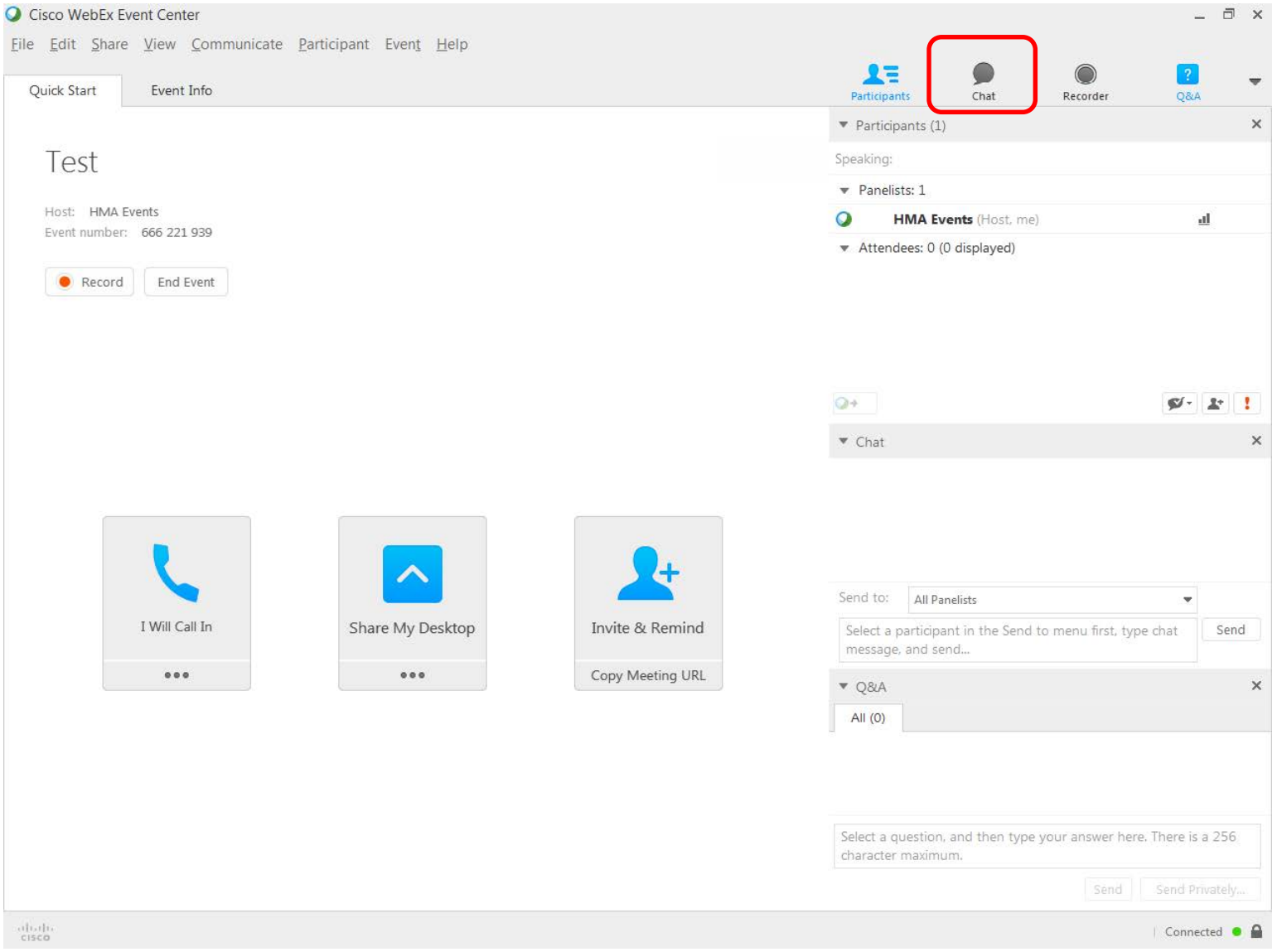
Gina Lasky, PhD, Senior Consultant, HMA

Warren Lyons, Principal, HMA

Suzanne Mitchell, MD, Principal, HMA

Jeffrey Ring, PhD, Principal, HMA

March 30, 2016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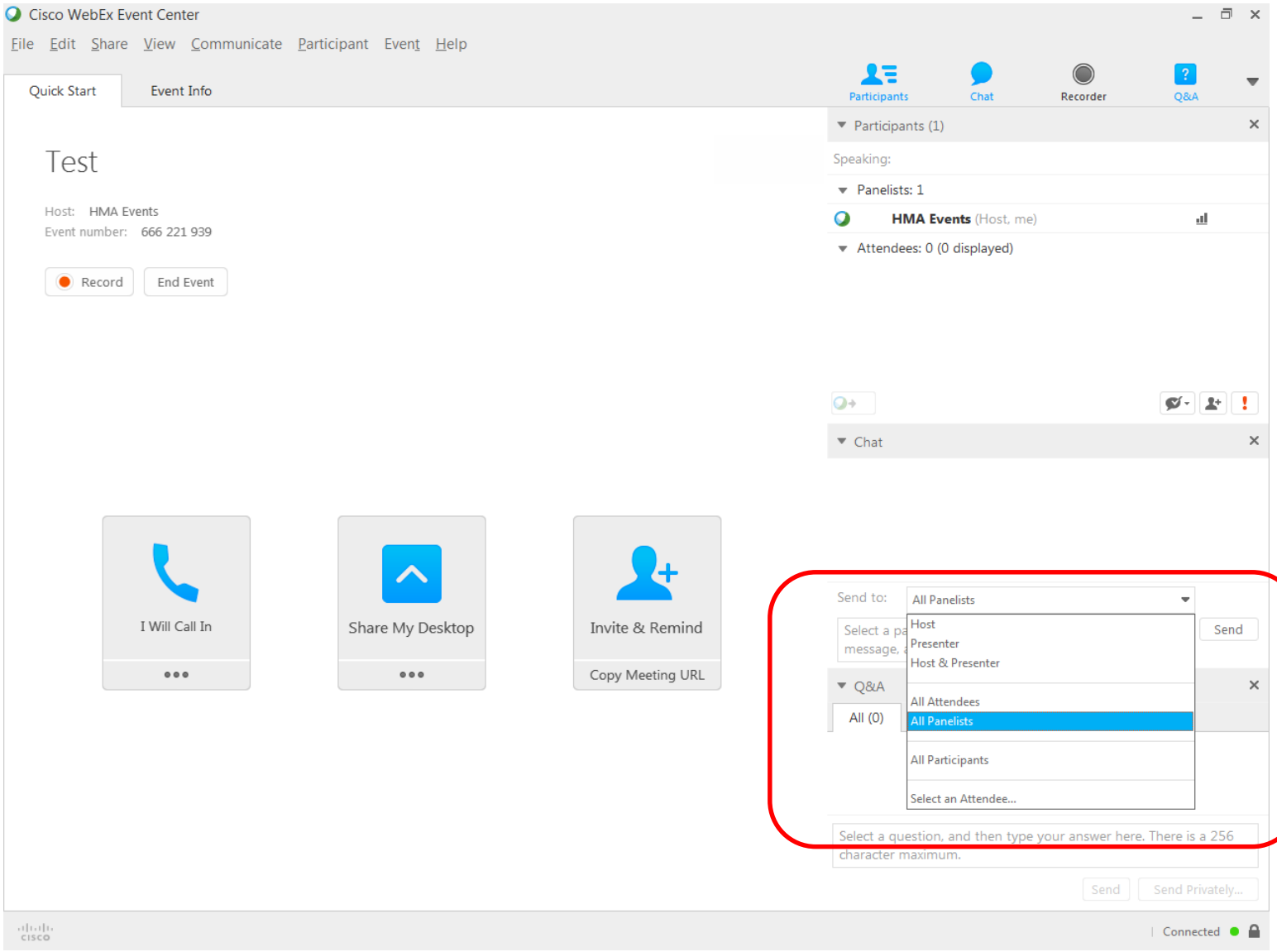
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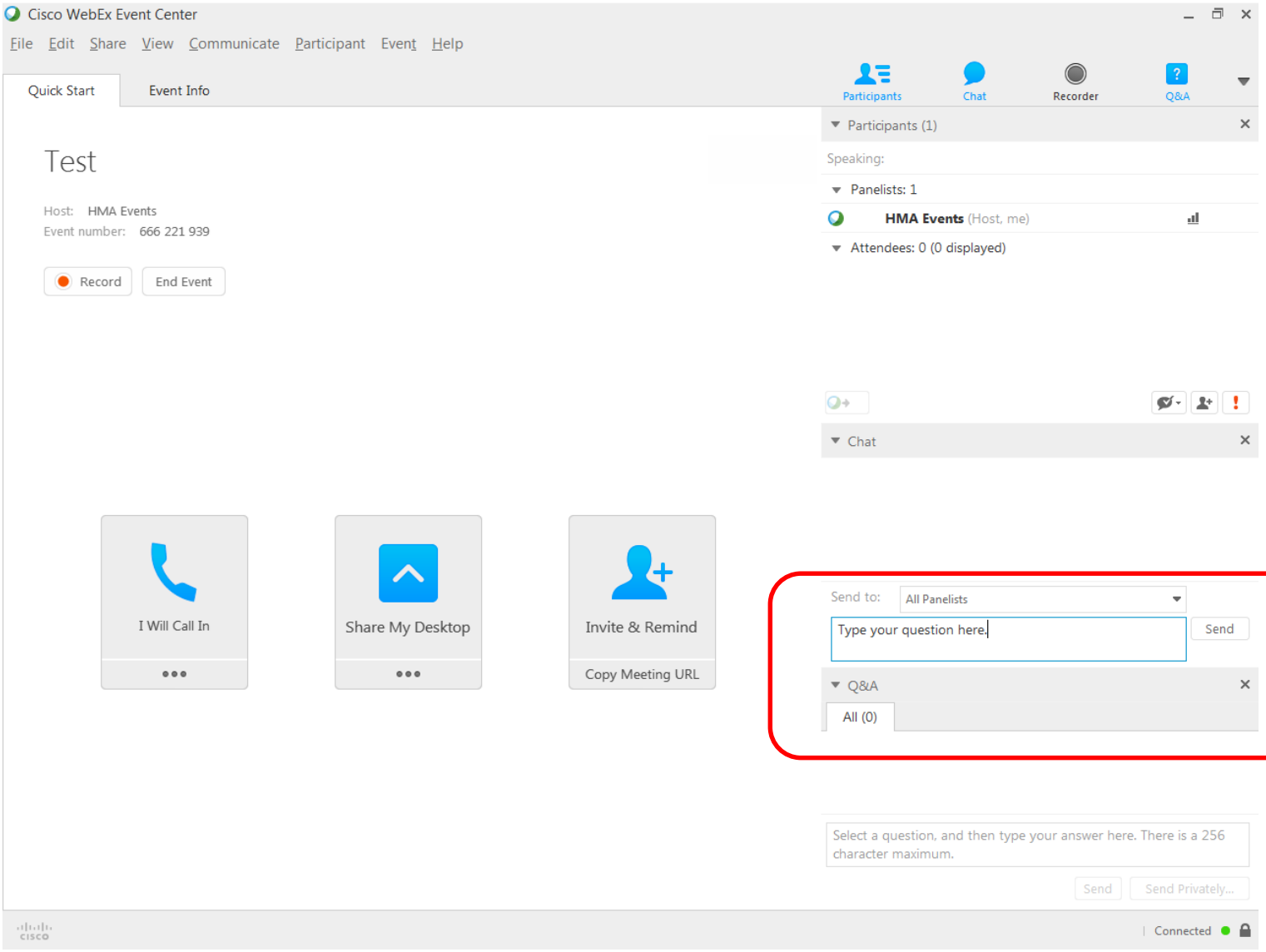
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Introduction and Overview

Warren Lyons, MPH, MBA
Principal

Focus of Presentation

Vulnerable Populations/Safety Net

Learning Objectives

- Understand community factors and strategies
- Identify the elements of successful partnerships
- Appreciate the training challenges in providing culturally responsive care management

- Understand the economic and business rationale for hospitals to develop strong collaborative efforts to address readmissions.

Rationale for Attention

- The Readmissions Problem
- Goals for Improved Health Status
- Community Collaboration Strategies
- The Value Based Payment Vision
- Urgency: The Time is Now

Disparities and Readmissions

- Medicaid > Private insurance, especially men
- African American >White Medicare
  - 30 day readmissions for CHF, AMI, CAP
  - Especially in Minority-Serving Hospitals
- Low Health Literacy (Ask me 3)
  - have 1.5 higher rate of 30d readmission
  - Can be marker for racial disparities

Johnstone MJ, Kanitsaki O. Culture, language and patient safety: Making the link. Intern J Quality in Healthcare. 2006;18(5):383-388.
Joynt, Orav, Jha. JAMA 2011;305(7):675-681.
http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Disparities and Readmissions

- Language Barriers
  - Karliner et al, 2010….
    - Non-English speakers more likely to be readmitted (OR1.5-1.7)
  - Divi et al, 2007…
    - Non-English/LEP speakers are more likely to experience physical harm from AE due to communication error.
  - Lindholm et al 2012…
    - Patients NOT receiving interpreter services had longer LOS of between 0.75 and 1.47 days, ($P < 0.02$).
    - Patients receiving interpretation at admission and/or discharge were less likely than patients receiving no interpretation to be readmitted with 30 days.

Lindholm M, Hargraves JL et al. J Gen Intern Med. 2012 Apr 18.
Divi C, et al. Internatl J for Qual Health Care 2007;19(2).
Karliner LS et al. J Hosp Med. 2010;

Catalysts for Hospital Action

- CMC Office of Minority Health
  - CMS Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries
  - CMS Equity Plan for Improving Quality in Medicare
- Medicare/Medicaid Rewards/Fines to Hospitals
- MACRA/MIPS Incentive Payments to Providers

Cultural and Care Management Approaches

Jeffrey M. Ring, Ph.D.
Principal

CMS Key Issues Summary

Betancourt et al. (2015)

- Care Transitions
- Primary Care Linkages
- Language Barriers
- Health Literacy
- Culturally Competent Patient Education
- Social Determinants
- Mental Health
- Co-Morbidities

Culturally Responsive Health Care

- Providing care consistent with the patient's world view
- Addressing patient's cultural and linguistic needs
- Patient-centered care

CLAS STANDARDS

(Culturally and Linguistically Appropriate Services)

- Published by OMH in 2000
- Enhanced Standards published in 2013
- Emphasize opportunities to address disparities at every point of contact along health care services continuum
- Emphasis on health care organizations
- Legal consequences

CLAS Principal Standard

"Provide effective, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practice, preferred languages, health literacy and other communication needs."

C.L.A.S.

Culturally & Linguistically Appropriate Services

CLAS Standards

- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement and Accountability

Discharge Care Management Training

- A Patient-Centered Approach
- Foundations of Listening and Empathic Communication
- Patient Activation and Engagement
- Motivational Interviewing
- Shared Decision Making and Negotiating Care
- Navigating Language and Culture
- Attending to Social Determinants and Context
- Equipoise

A Planful Approach: Project Red

Suzanne Mitchell, M.D.
Principal

Project RED: The Re-Engineered Discharge

Managing Patient Care Transitions

PROJECT RED
Re-Engineered Discharge

A standardized discharge process that is tailored to the patient's unique needs.

Checklist

Twelve mutually reinforcing components:

- Medication reconciliation
- Reconcile dc plan with National Guidelines
- Follow-up appointments
- Outstanding tests
- Post-discharge services
- Written discharge plan
- What to do if problem arises
- Patient education
- Assess patient understanding
- Dc summary to PCP
- Telephone Reinforcement
- Assess Cultural and Language Service Needs

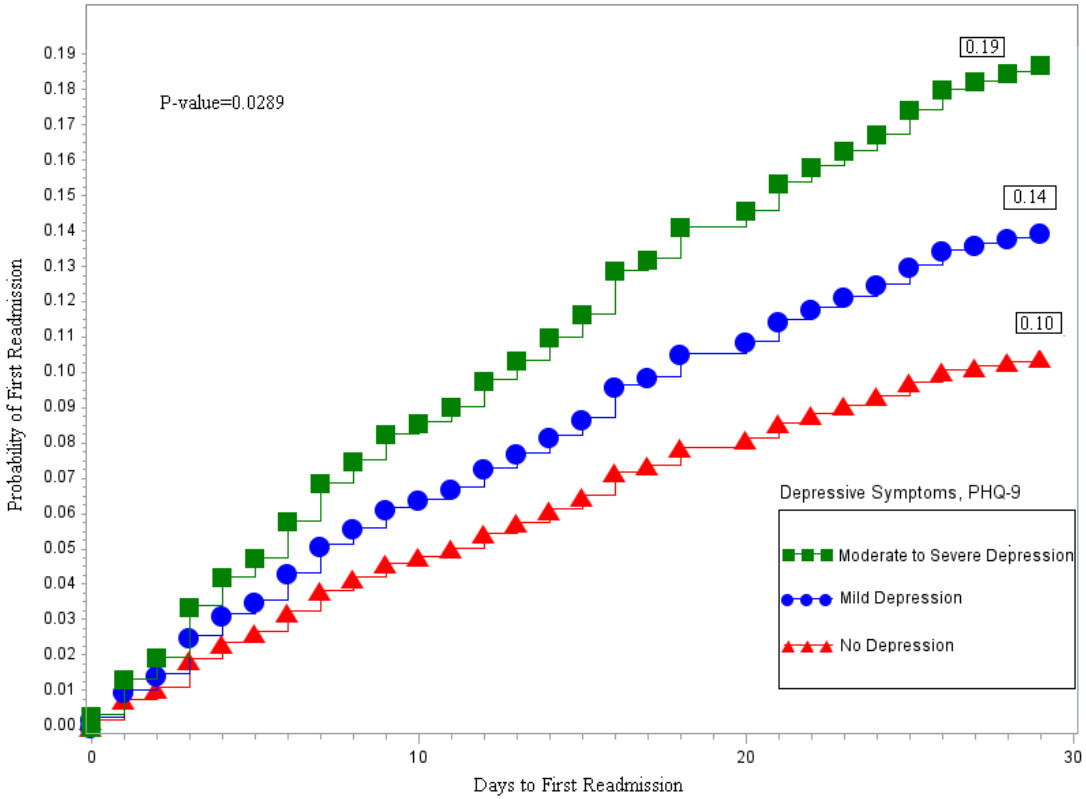
RCT Finding: RED reduced 30-day readmissions and ED visits by 30% in safety net setting. NNT = 7.3

Adopted by NQF as one of 30 "Safe Practices" in Care Transitions (SP-11)

RED: Culturally Responsive Approaches

- Assess patient's concerns (medication, discharge plan)
- Use qualified interpreters inpatient and outpatient
- Assess dietary patterns, CAM, Spirituality for safety risks and concordance with transition care plan
- Identify key family members
  - discuss disclosure issues early
  - identify family caregivers and their roles
- Create an AHCP in the patient's preferred language
- Use Universal Precautions for Health Literacy Barriers

Hazard of Hospital Readmission 30 days Post-Discharge Among Hospital Patients with Depressive Symptoms



Linking Community-based Services During Care Transitions RED-D

- RED Discharge + CBT via telephone
  - Master's level counselor
  - 12 weeks CBT post-discharge
  - Collaborative Care Model
  - Navigation support
  - Self-management Education

Community Partnership Essentials

Gina Lasky, Ph.D.
Senior Consultant

Why Community Matters

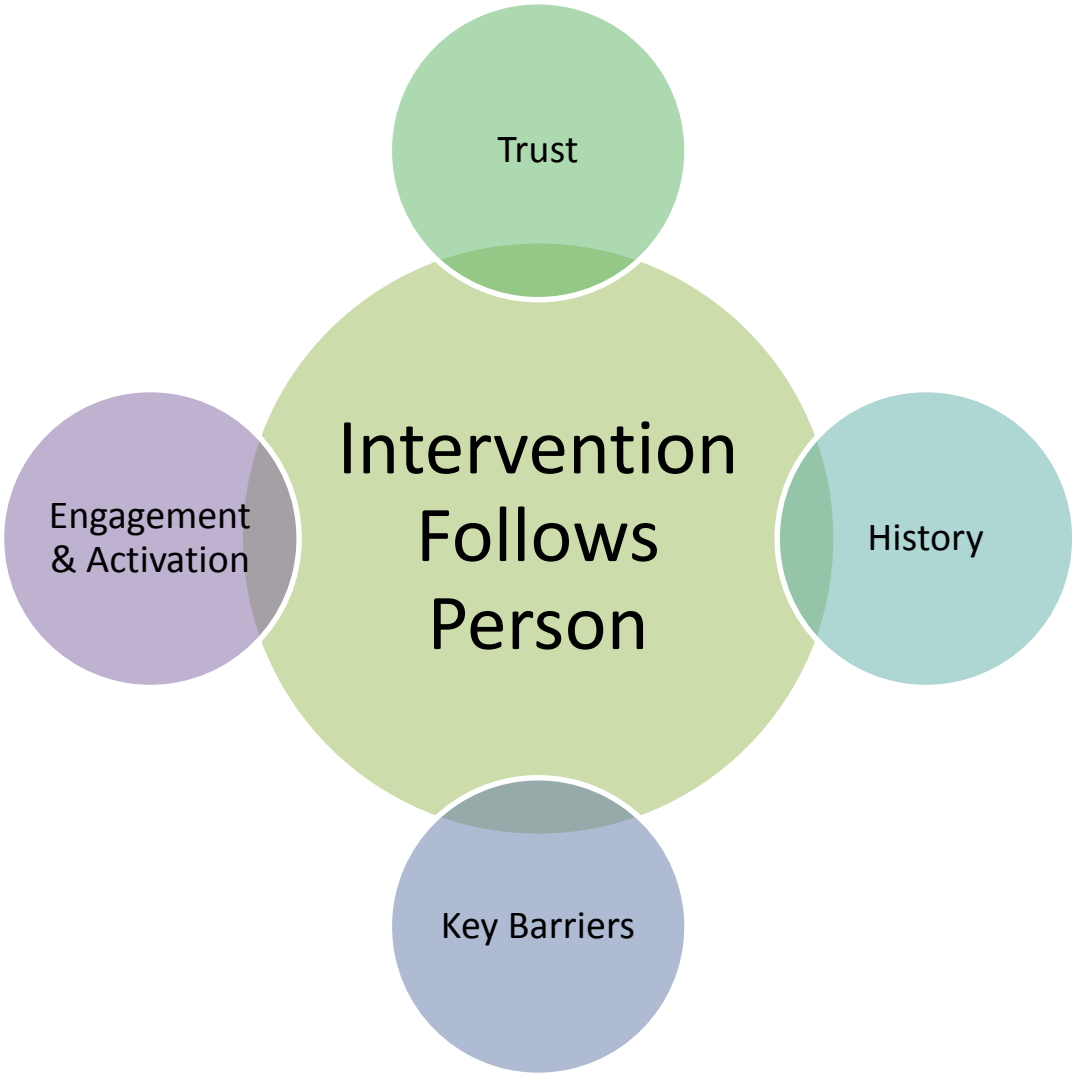
Intervention Follows Person

Social Determinants of Health

Proximity of Services

Hospital Quality Discharge and Partnerships

Role of Community Based Partners



Community Program Examples

Emergency Services Pilots

- In Home
- Extension of Medical Expert

Faith Based Organizations

- Trusting Relationship
- Connecting Health to Community

Integrated Behavioral Health in PC

- Engagement
- Behavioral Health Co-Occurring

Financial and Policy Considerations

Warren Lyons, MPH, MBA
Principal

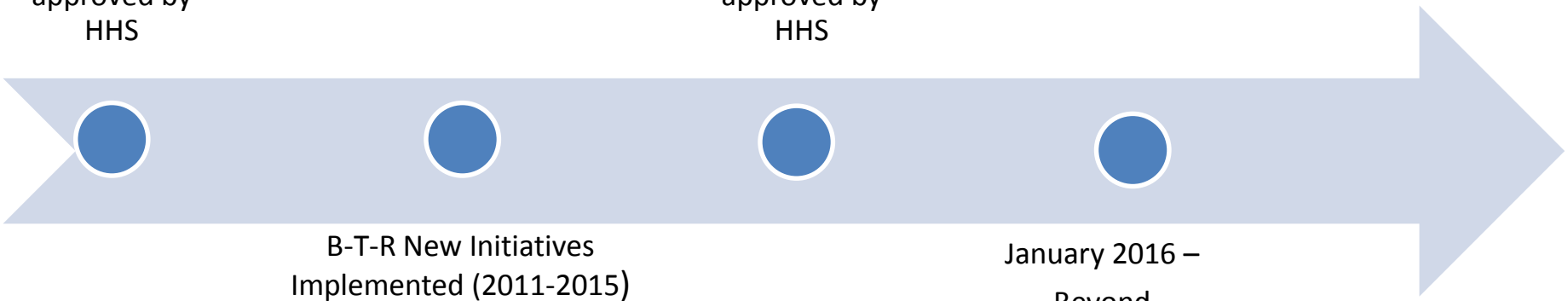
Building a Business Case
The California Experience

- Accelerating Catalysts for Action
- Nominal hospital readmission/other penalties: false barrier to collaboration development, human and infrastructure investments
- Similar Medicaid initiatives and pilots occurring in other states

Medi-Cal Timeline

November 2010, Bridge to Reform Waiver approved by HHS

December 2015, Medi-Cal 2020 Waiver approved by HHS



B-T-R New Initiatives Implemented (2011-2015)

Seniors Persons with Disabilities

Low-Income Health Program

Community Based Adult Services

Medicaid Expansion

Coordinated Care Initiative

January 2016 – Beyond

Implementation of PRIME

Global Payment Program

Whole Person Pilots

Dental Transformation Initiative

Catalysts for Changes

- Medicaid Waivers in California
  - Whole Person Care-high risk/high use
  - PRIME-public hospital delivery/payment redesign
  - Global Payment Program –uninsured care
  - Dental Transformation Initiative
- Health Home: Community Based-Case Management Entities-high risk/high use
- Alternative Payment Methodologies
    - Health Plans/Hospitals/FQHCs
- Health Care Payment and Learning Network[HCLAN]

Medi-Cal Whole Person Care Waiver

- 5 year, $1.5B pilot to test county-based coordination initiatives for vulnerable, high users of multiple systems with poor outcomes
- Public/municipal hospitals can be lead agencies
- Can include housing supports, tenancy-based care management; NOT housing units or rent payments

Medi-Cal 2020: WPC Pilot

- Local partnerships to integrate and coordinate otherwise siloed services to improve health outcomes:
  - Reduce inappropriate ER and I/P utilization
  - Reduce unnecessary readmissions
  - Improve inter-provider data collection and sharing
  - Improve health status and triple aim metrics
  - Increase access to housing and supportive services

Medi-Cal 2020: WPC Pilot

Participating agencies

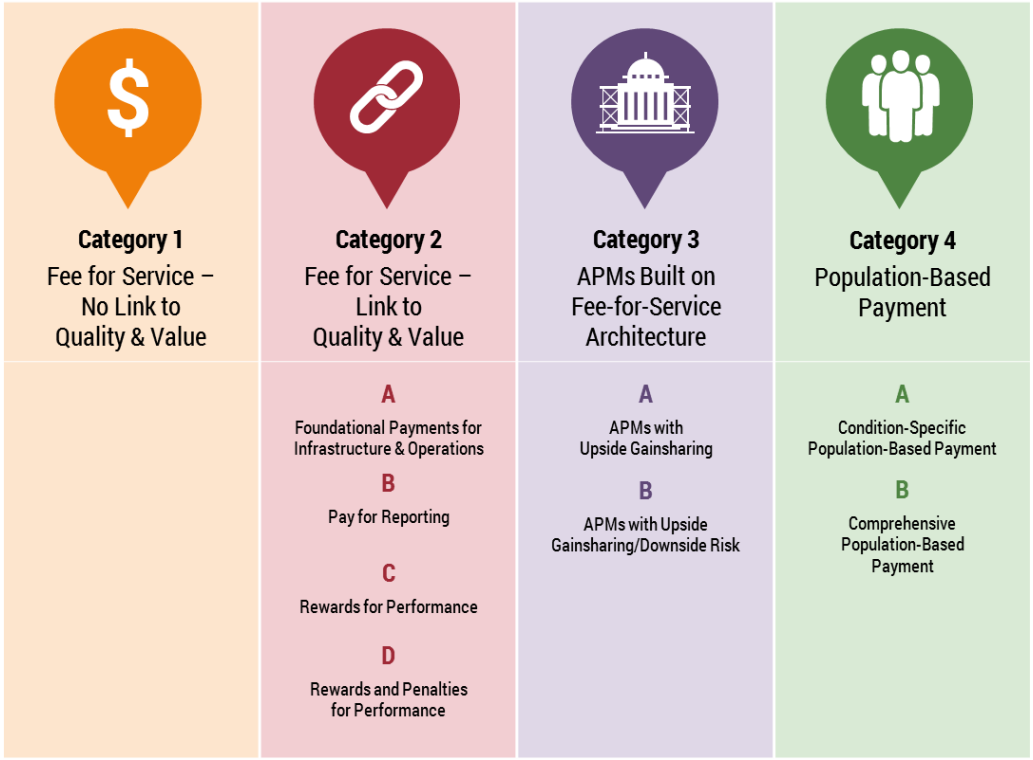
- Managed care plan - at least 1 per service area
- Must include:
  - County Health Services and Specialty Mental Health Services or Department
  - At least one other public agency or department
- Must also include at least 2 other key community partners serving this population, such as:
  - Physician groups
  - Clinics
  - Hospitals
  - Community-Based Organizations (CBOs)

California Medi-Cal Health Home

- Network of providers to integrate and coordinate primary, acute and behavioral health services for highest risk members
- Health plan organizes services/payments
- Plans must certify and contract with Community-Based Care Management Entities [CB-CMEs]: hospitals, clinics, physicians, community mental health/substance use disorder providers, county agencies

HCP LAN
Health Care Payment Learning & Action Network

Figure 1. APM Framework (At-A-Glance)



Covered California-Exchange Plans

- Draft proposal adopts national triple aim standards: MACRA, MIPS, VBP,HC-LAN
- Hospitals and providers are scored against standards
- Persistent underperforming "outliers" are excluded from participation in exchange planes
- Identify hospital "outliers" on cost and quality starting in 2018. Medical groups and providers would be rated after that.

Summary

- Many reasons to reduce readmissions
- Community partnerships are essential
- Emerging models are promising
- Key roles for training in culturally responsive patient-centered care management
- Health care policy change is moving quickly

HEALTH MANAGEMENT ASSOCIATES

Q & A

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