VPQHC
Vermont Program for Quality in Health Care, Inc.

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**Avoidable Hospital Readmission over Five Years (2010 – 2015)**

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## Introduction

CMS reported progress across the nation in reducing 30 day all-cause hospital readmission rates among Medicare patients in 49 states and Washington D.C.[1]. According to their analysis, Vermont's readmission rate was virtually unchanged over the five year period. These findings were reported to the public via news cycles and other open reports with little explanation. This testimony will attempt to put these data into context, and highlight some opportunities that may support future reductions in readmission rates across Vermont hospitals.

## Interpretation of Vermont's data

When interpreting these data, we suggest the following considerations:

1. Very small numbers determined Vermont's performance. For example, the difference in Vermont's performance in 2010 of 15.3% to 2015 to 15.4% is ***21 readmissions*** across the state.
2. Based on 2015 data available through Hospital Compare, each Vermont hospitals' readmission rate is not statistically significantly different than the national rate.[2] Vermont has consistently demonstrated a relatively low, carefully managed avoidable readmission rate compared to other states, by applying progressive, proactive initiatives.
3. While 49 other states showed a decline in their readmissions rate, whether or not that difference was statistically significant was not noted, and in some cases the change in other states may also not have been statistically significant.
4. While theoretically possible, it is not practical or in patients' best interest to get down to 0% readmissions due to the nature of health and prevalence of disease. Even with excellent care during their primary admission, patients may need to be readmitted to the hospital within 30 days. Caution is necessary when discussing "avoidable" readmissions when the need for care is appropriately provided through hospital-based services.
5. Continuing concerted efforts can support appropriate care in community-based settings to address potential inappropriate use of hospital inpatient based services.

## How Hospitals are Addressing Avoidable Readmissions

All Vermont hospitals in collaboration with VPQHC through funding from the State Office of Rural Health implemented the Transitions of Care initiative between 2011 and 2015. Vermont began addressing this important issue in 2011 by implementing successful and effective discharge transitions with the goal of reducing avoidable readmissions. Hospitals completed internal needs assessments to identify specific processes and systems opportunities, and designed improvement projects based on the IHI roadmap. These interventions addressed the needs of the elderly and super-utilizers while also focusing particular

[1] CMSBlog – https://blog.cms.gov/2016/09/13/new-data-49-states-plus-dc-reduce-avoidable-hospital-readmissions/ accessed 10/21/16
[2] https://www.medicare.gov/hospitalcompare/results.html#dist=25&state=VT&lat=0&lng=0 accessed 10/21/16

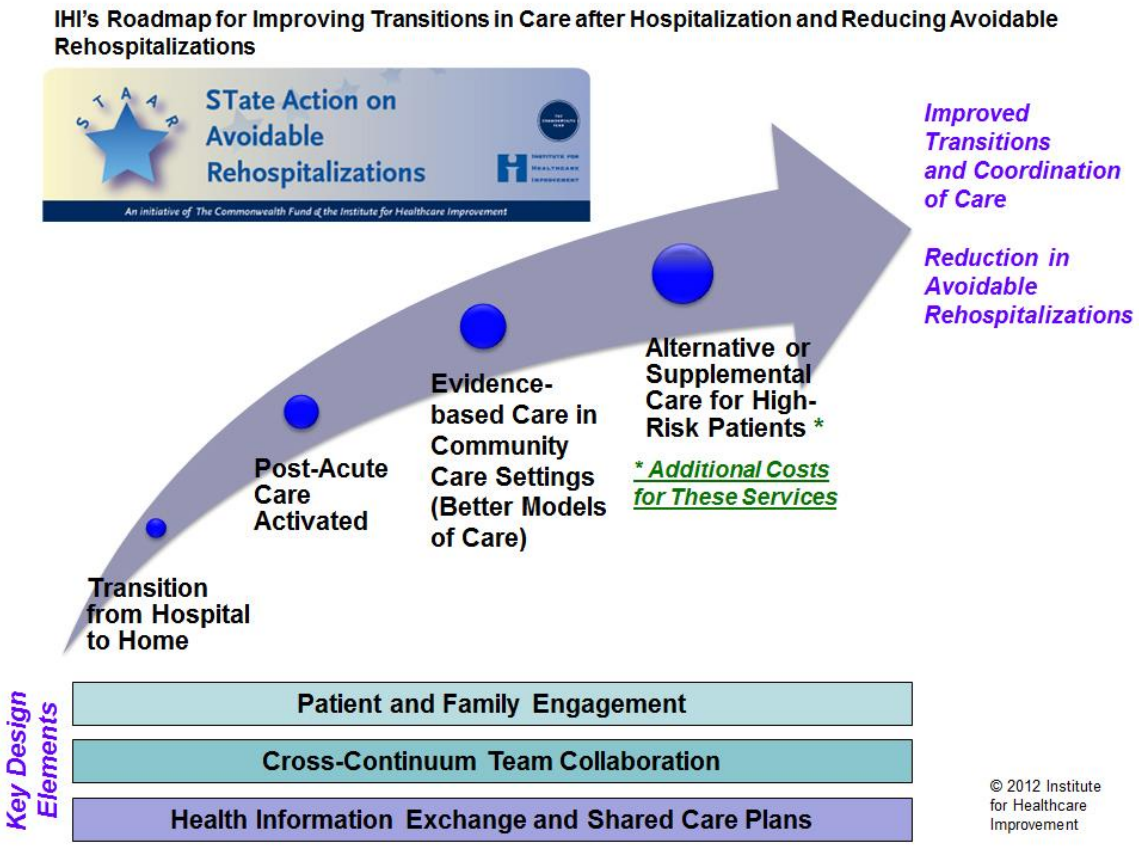
efforts and improvement around the discharge planning process. Several of the interventions that were implemented through this work include:

- Enhanced admission assessment of post-hospital needs
- Medication reconciliation across all health care settings
- Effective teaching and learning through "teach back" about conditions, medications, symptom management and discharge care
- Creation of real-time handover communications with patient, family and community partner input
- Established plan for follow-up care appointments
- Establishment of baseline data collection and tracking capability
- Ongoing management and monitoring of high-risk patients
- Enhanced post-hospital follow-up care coordination – "The Medical Neighborhood"
    - Medical Home Care Coordinators
    - Chronic Care Coordinators
    - Primary Care Providers
    - Case Managers
    - Discharge Planners
    - Home Health and Hospice Agencies
    - Rehabilitation and Long-term Care Facilities
    - Area Agencies on Aging
    - Elder Support and Services at Home
- Expanded end of life care education regarding Clinical Order for Life Sustaining Treatment form (DNR/COLST) and Hospice for providers, patients and families
- Establishment of baseline data collection and tracking capability
- Continuous improvement of Electronic Health Record integration
    - universal medication lists
    - shared care plans
    - customized education documents
    - discharge instructions
    - communication with primary care providers
    - continuing care documents

Hospitals worked on individual projects aimed at addressing common readmissions within their community and recognized substantial gains at the local level. The building blocks put in place through this project allowed for hospitals to move to the next level within their communities and resulted in:

- SVMC's Transitional Care Nurse Program
- BMH creating a triage process for post-discharge PCP appointments
- Porter working more closely with their nursing home to improve care transitions between facilities
- Enhanced partnerships with community resources such as Home Health, the Blueprint for Health, SASH, etc.

Hospitals found these interventions essential in maintaining their already low readmissions rates.




Additional interventions that have been implemented in Vermont or other states, known to have a significant impact on readmissions include:

- Vermont's Statewide Surgical Services Collaborative's (VSSSC) use of the American College of Surgeons – National Surgical Quality Improvement Program (ACS-NSQIP) database to track detailed data and information regarding surgical complications. Funding for this effort came from the VHCIP Provider Sub-Grant program. Data from ACS-NSQIP is used to identify areas for improvement and design targeted and highly effective interventions.
- The Integrated Communities Care Management Learning Collaborative supported the development of Shared Care Plans across interdisciplinary providers to coordinate community-based care services for high utilizers of Emergency Department and hospital services. Funding for this effort also came from the VHCIP.
- Ongoing education concerning implementation of the POLST and DNR forms to direct patient and wishes concerning end-of-life care.
- Increase utilization of hospice and palliative care programs statewide.

**Ways VPQHC is continuing to support hospitals in effective care transitions**

The following activities demonstrate our commitment to ensuring appropriate and effective care transitions and reducing avoidable readmissions.

- VPQHC meets on a quarterly basis with hospital Quality Directors. These meetings support the sharing of information and best practices between hospitals, often focused on ways to improve care transitions.
- VPQHC has met with hospital Case/Care Managers in an effort to show support and provide networking opportunities to address discharge planning practices.

**How Vermont is Monitoring Readmissions**

- Hospital-Wide All Cause Readmission has been included in the Inpatient Quality Reporting Program for community hospitals since 2014, with hospital performance posted publically on HospitalCompare.
- All Cause Readmission is a metric that is included in the current ACO Shared Savings program Payment measures set.
- All Cause Readmission is a performance metric included in the CMS measure set for All Payer model performance evaluation. [3]

**Conclusion**

Vermont's hospitals have many excellent structures and processes already in place to track and monitor performance on avoidable hospital readmissions, and has consistently been a "leader of the pack" in addressing avoidable readmissions. Hospitals continue to innovate creative programs to keep their eye on this metric, in many cases moving to intensive new services to effectively manage challenging high need populations. VPQHC looks forward to continuing to support Vermont hospitals implementation of best practice. We are happy to continue to share updates and additional detail on any of the programs and activities that underway currently that not only monitor but strive to move the needle to improve performance.

[3] http://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/DRAFT_APM_Agreement_UNDER_LEGAL_REVIEW.pdf (page 40)