REDUCING AVOIDABLE HOSPITAL UTILIZATION

Best practices and promising strategies for Medicaid patients

Amy E. Boutwell, MD, MPP
New York DSRIP Learning Symposium
September 18, 2015
Agenda

• This can be done
• What are hospitals with hospital-wide results doing?
• Key Messages
Key Messages

• Medicaid adults have high readmission rates

• Medicaid patients need to be specifically identified as high-risk of readmission

• Readmission reduction efforts must include the ED

• Don’t over-medicalize
All Cause 30-day Readmissions
AHRQ Reducing Medicaid Readmissions Project

- Identify the similarities & differences in readmission patterns for Medicare v. Medicaid patients
- Explore whether the “best practices” to reduce readmissions apply to the Medicaid population as well
- Create a guide for hospitals to increase awareness of the unique issues in reducing Medicaid readmissions
CONTENTS:

• Why focus on Medicaid Readmissions?
• Know Your Data
• Inventory Readmission Efforts
• Develop a Portfolio of Strategies
• Improve Hospital-based Transitional Care
• Collaborate with Cross Setting Partners
• Provide Enhanced Services
• 13 new Tools

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Tools

1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Key Actions

1. *Know* your data
2. *Ask* your patients, their caregivers and providers, “why”
3. *Develop* a portfolio of strategies
4. *Improve* hospital-based transitional care for all
5. *Collaborate* with cross setting providers & payers
6. *Provide* enhanced services for high risk patients
Hospitals with hospital-wide results

- Know their data –
  Analyze, trend, track, display, share, post

- Broad concept of “readmission risk”
  Way beyond case finding for diagnoses

- Multifaceted strategy
  Improve standard care, collaborate across settings, enhanced care

- Use technology to make this better, quicker, automated
  Automated notifications, implementation tracking, dashboards
KNOW YOUR (OWN) DATA

Analyze, track, trend, raw unadjusted data to identify opportunities
Medicaid can be used as a singular risk factor for readmissions. The image shows that 37% of readmissions occurred within 7 days.
Table 1: All-Payer Readmissions by Discharge Setting, July 2012 to June 2013

<table>
<thead>
<tr>
<th>Discharge Setting</th>
<th>Number of Discharges</th>
<th>Percentage of Discharges</th>
<th>Number of Readmissions</th>
<th>Percentage of Readmissions</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>258,860</td>
<td>50.9%</td>
<td>30,541</td>
<td>39.9%</td>
<td>11.8%</td>
</tr>
<tr>
<td>SNF</td>
<td>90,346</td>
<td>19.5%</td>
<td>18,335</td>
<td>24.0%</td>
<td>18.5%</td>
</tr>
<tr>
<td>HHA</td>
<td>110,419</td>
<td>21.7%</td>
<td>19,946</td>
<td>26.1%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Hospice</td>
<td>3,661</td>
<td>0.8%</td>
<td>429</td>
<td>0.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Rehab</td>
<td>22,968</td>
<td>4.5%</td>
<td>4,273</td>
<td>5.6%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Total</td>
<td>508,364</td>
<td>100.0%</td>
<td>76,481</td>
<td>100.0%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

Note: Figures do not sum to those in the total row because the table excludes “other” discharge settings and missing values.

Data source: Massachusetts Hospital Inpatient Discharge Database, July 2012 – June 2013.
Top 10 Medicaid Dx:

1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. Comp. of pregnancy
5. Alcohol-related
6. Early labor
7. CHF
8. Sepsis
9. COPD
10. Substance-use related

Top 10 Medicare Dx:

1. CHF
2. Sepsis
3. Pneumonia
4. COPD
5. Arrhythmia
6. UTI
7. Acute renal failure
8. AMI
9. Complication of device
10. Stroke

Methods:
- Used CCS groupers
- Included OB
Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010


-- Indicates too few cases to report.
HU Readmission Rate = 40%
Non-HU Readmission Rate = 8%
High Utilizers

- 4+ hospitalizations/year
- 6 hospitalizations /year v. 1.3
- LOS 6.1 days v. 4.5
- $11,600 v. $9,000
- Readmission rate 52% v. 8%
- 74% of high utilizers d/c to home
- Top Dx: mood disorders, schizophrenia, DM, chemo, sickle cell, ETOH, sepsis, CHF, COPD

Jiang et al. HCUP Statistical Brief #184 Nov 2014
ASK YOUR PATIENTS “WHY”

*Patient-centered assessment to get the story behind the “cc”*
Understand the “story behind the chief complaint”

• 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.

• 32M with uncontrolled DM, cognitive limitations, bipolar disorder, active substance use, homeless presents with flank pain to one hospital, readmitted with chest pain to another hospital

*Chart reviews and checklists will NOT reveal what we need to know: we must talk to patients, their families and caregivers & providers*
Root Cause of Chest Pain Admission: Shelter

“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don't do that and they kick you out every morning. I need a stable residence and no one is able to help with that.”

Acute Care Utilization over 180 days of freedom
## Interview Findings and Lessons Learned

1. Nearly all the patients interviewed currently are **receiving services** through the Department of Mental Health, Community Based Flexible Services (CBFS), outpatient community mental health services, supportive housing services, etc. Through increased care navigation our program will ensure collaboration and communication with these programs so as not to duplicate referrals and to come to some agreement with the patient on what would be the best approach to care.

2. Lack of healthy **daily structure** appears to be a common theme. Patients often report not having enough to keep them busy, feeling lonely, unsupported, and a general sense of disconnection. Increased rapid access to day treatment programs, partial hospitalization programs, peer-based support programs, etc. will be an importance component of our program.

3. Sometimes **referrals to appropriate services are not enough**, especially for the patient with substance abuse concerns. **Intensive follow-up is needed** to ensure that patients stay consistent with their goals of treatment and continue to be engaged throughout the treatment process. Often the treatment system **navigation requires the assistance of a skilled clinician**, because the system can be too confusing for patients to manage on their own.
There is Never One Reason for Readmission.....

• KP team reviewed 523 readmissions across ~14 hospitals:
  • 250 (47%) deemed potentially preventable
  • Found an average of 9 factors contributed to each readmission

• Assessed factors related to 5 domains:
  • 73% - care transitions planning & care coordination
  • 80% - clinical care
  • 49% - logistics of follow up care
  • 41% - advanced care planning & end of life
  • 28% - medications

• 250 readmissions identified 1,867 factors!
Interviewed 60 patients who returned to ED after d/c from ED <9days
  - Average age 43 (19-75)
  - Majority had a PCP,
  - Preferred the ED: more tests, quicker answers, ED more likely to treat symptoms
  - Most reported no problem filling medications
  - 19//60 thought they didn’t get prescribed the medications they needed (pain)
  - 24/60 expressed concerns about clinical evaluation and diagnosis

Primary reason for returning: **fear and uncertainty about their condition**

Patients need more reassurance during and after episodes of care
Patients need access to advice between visits
NY Hospitalist-Generated Ideas:

1. Flag 30-day returns in the ED record
2. Promote collaboration between Emergency Medicine and Hospital Medicine on the decision to admit
3. Encourage Hospital Medicine to see the patient in the ED
4. Collaborate with referring providers, especially SNFs
5. Capture the “story behind the story”
6. Form a joint quality review committee of EM and Hospital Medicine to review low-acuity admissions and readmissions

Boutwell et al, New York State Partnership for Patients 2014
DESIGN A PORTFOLIO OF STRATEGIES

(Re)admission reduction = System transformation
Develop A Multifaceted Portfolio of Efforts

Improve hospital-based transitional care processes for ALL patients

1. Flag discharge <30d in chart
2. ED-based efforts to treat & return
3. Broaden view of readmission risks; assess “whole-person” needs
4. Develop transitional care plans that consider needs over 30 days
5. Ask patients & support persons why they returned, if readmitted
6. Ask patient & support persons what help they need; share with them their needs/risk assessment
7. Use teach-back, target the appropriate “learner”
8. Customize information
9. Arrange for post-hospital follow up
10. Use a check-list for all patients

Collaborate with cross-setting partners

1. Use ADT notifications with medical and behavioral health providers
2. Ask community providers what they need and how they want to receive it
3. Collaborate to arrange timely follow up
4. Perform “warm” handoffs, and opportunity for clarification
5. Form a cross-continuum team that can access resources your staff are unaware of
6. Constantly refresh your awareness of social and behavioral health resources
7. Broaden partners to include Medicaid health plans and their care managers
8. Identify community partners with social work and behavioral health competencies

Provide enhanced services for high risk

1. Segment “high risk” – varying types of service & levels of intensity
2. Strategy for high utilizers
3. Strategy for navigating care
4. Strategy for accessing resources
5. Strategy for self-management
6. Strategy for frailty/medically complex
7. Strategy for end-of-life trajectory
8. Strategy for recurrent stable symptoms, etc individual care plans

Use data, analytics, flags, workflow prompts, automation, dashboards to support continuous improvement, ensure reliability, drive to results
Reduce Readmissions by 25% for all patients

- Screen ED high risk patients** for alternatives to admission (ED case management)
- Secure medications, transportation as needed
- Ensure all unassigned (ED) patients have PCP, ensure all BH patients have PCP and psych f/u
- Offer post-discharge clinic to facilitate early follow up for any patient who can’t get appointment <10d

- Improve Standard “Transition” Services for all, based on needs
  - Provide enhanced transitional care for patients who have been RA <30d
  - Navigator ensures comprehensive plan in place prior to discharge
  - Navigator provides telephonic follow up to ensure linkage to care & services
  - Use HIE to identify cross-hospital RA
  - Navigator led proactive outreach to inpatient team at other hospital to collaborate on plan
  - Collaborate with area SNFs to improve SNF-ED transitions and possible returns

- Proactively coordinate with other hospitals & SNFs
  - Use internal data to identify top HU
  - Develop efficient process for developing care plans
  - Engage ED & inpatient clinicians in using plans
  - Engage/inform patient about purpose of care plan

- Develop & Utilize Care Plans for HU
2 Hospitals’ Multifaceted Portfolios

Valley Baptist (TX)

- Improve Standard Hospital-based Processes
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8P to “behavioral interview”

- Collaborate with Providers
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly “co-management” virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed

- Provide Enhanced Services to High Risk
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team “works the case” x 30+ days
  - Cardiology NP “Heart Bridge Clinic”

Frederick Memorial (MD)

- Improve Standard Hospital-based Processes
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8P to “behavioral interview”

- Collaborate with Providers
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly “co-management” virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed

- Provide Enhanced Services to High Risk
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team “works the case” x 30+ days
  - Cardiology NP “Heart Bridge Clinic”

Courtesy of Angela Blackford and Heather Kirby
Hospital-wide Results

Valley Baptist (TX)

All Cause Readmission Rate:
• FY 2011: 28%
• FY 2013: 21%
• FY 2014: 14%

CMS Penalty:
Year 1: 0.8% (of possible 1%)
Year 2: 0.2% (of possible 2%)
Year 3 0.04% (of possible 3%)

Frederick Memorial (MD)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 12</td>
<td>10.6%</td>
</tr>
<tr>
<td>FY 13</td>
<td>9%</td>
</tr>
<tr>
<td>FY 14</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Courtesy of Angela Blackford and Heather Kirby
46-study Meta-Analysis: What Works?

Preventing 30-Day Hospital Readmissions

A Systematic Review and Meta-analysis of Randomized Trials
Leppin et al; JAMA Internal Medicine (online first) May 12 2014

• Review of 42 published studies of discharge interventions

• Found that multi-faceted interventions were 1.4 times more effective
  • Many components
  • More people
  • Support patient self-care

• Interventions published more recently had fewer components are were found to be less effective

COLLABORATE ACROSS SETTINGS

Not just a handoff; a purposeful, measured, managed collaboration
START IN THE EMERGENCY DEPARTMENT

_Ed is the hub of many effective strategies_
Emergency Department Visits After Hospital Discharge: A Missing Part of the Equation

Kristin L. Rising, MD; Laura F. White, PhD; William G. Fernandez, MD, MPH; Amy E. Boutwell, MD, MPP

- Inpatient discharge - ED revisit
- 24% of inpatient discharges returned to ED <30days
- 46% of revisits were readmitted
- 54% of revisits were d/c

Annals of Emergency Medicine 2013
## Top 10 Discharge Diagnoses Leading to ED Return

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Post d/c ED Revisit</th>
<th>Post d/c ED - Readmit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>115/362 = 32%</td>
<td>95/115 = 83%</td>
</tr>
<tr>
<td>DM with complications</td>
<td>97/315 = 31%</td>
<td>67/97 = 69%</td>
</tr>
<tr>
<td>Complications of device</td>
<td>91/316 = 29%</td>
<td>66/91 = 73%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>89/406 = 22%</td>
<td>52/89 = 58%</td>
</tr>
<tr>
<td>Sickle cell anemia</td>
<td>82/399 = 21%</td>
<td>58/82 = 71%</td>
</tr>
<tr>
<td>Nonspecific chest pain</td>
<td>184/984 = 19%</td>
<td>109/184 = 59%</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>79/432 = 18%</td>
<td>37/79 = 47%</td>
</tr>
<tr>
<td>Asthma</td>
<td>80/536 = 15%</td>
<td>47/80 = 59%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>73/550 = 13%</td>
<td>51/73 = 70%</td>
</tr>
<tr>
<td>Live-born</td>
<td>102/929 = 11%</td>
<td>39/102 = 38%</td>
</tr>
</tbody>
</table>

Experience from state-wide SNF-ED efforts

“The biggest barrier was engaging the EDs. We sent them more focused, standardized information. We gave them contact information to call us. We let them know what our facility can do and indicated we would be willing to take the patient back. It turns out the packets we sent ended up in the recycling bin and never really looked at.”

- Leader of a 300+ site avoidable admission from SNF effort
Hallmark Health System Treat-and-Return to SNF

- Hallmark Health System
  - 2 hospital system, 20 ED docs, 17 PAs
  - “Why are almost all SNF patients admitted?”
  - “Patients only seen once a month”; “can’t do IVs”, etc
  - “If they send them here they can’t take care of them”

- Actions:
  - Asked ED clinicians “5 whys”
  - Education: posted INTERACT SNF capacity sheets in ED
  - Simplicity: establish contacts, standard transfer information

- Results: increase in number of patients transferred from ED to SNF

Source: Dr Steven Sbardella, CMO and Chief of ED
Hallmark Health System Melrose, MA
9-month results: Treat-and-Return to SNF

January through September

Courtesy of Dr Steven Sbardella, Hallmark Health
Sinai Hospital of Baltimore-Social Service Agency

• Looked at data, identified frequent users of the ED
• Needs of frequent users were not well met in ED
• Really needed connection to other resources
• Partnered with community agency- HealthCare Access Maryland
• Identify patients with >4 visits in 4 months – automated flag
• Conducted weekly in-service sessions to engage / education ED staff
• 3 care coordinators in the ED – contracted staff, have access to EMR
• Home visits <1 week of ED visit; follow for 90days
• Comprehensive whole person needs assessment
• Link patients to medical homes and other resources
• Educate patient re: when to call PCP rather than go to ED
• “We partner with many mental health organizations in the city”
• Addresses housing needs
• 80% reduction in ED visits!

Source: ED Management October 2014
ED Collaboration with County Public Health

- Carroll County, Maryland
- County and Hospital have a **formal partnership** arrangement
- Health Department deployed **BH peer navigators** in ED
- Navigators **directly connected with** & followed patients
- **~30% reduction** in utilization for high utilizing BH patients
MGH High Cost Beneficiary Demo

• Target population: 2500 most expensive Medicare pts at MGH ($68M)

• Opportunity: **Identify** in ED, **intervene** to avoid hospitalization

• Intervention: **Flag** in record to identify patient by registration in ED
  • Patients’ full care team (SW, PCP, specialists) paged
  • Expectation clinicians will “reach in” to ED and avert admission

• Impact: 20% reduction in hospitalization, 13% reduction in ED visits
  • 12% gross, 7% net savings: for every $1 spend, $2.65 saved

• Lessons learned:
  • May not stop patients from behavior of going to ED
  • These patients always “look bad” (physically, or labs)
  • Clinicians who know the patient know what baseline is
  • Partner with ED doc to reassure no substantial change is present and to assure that close follow up will occur

http://www.massgeneral.org/News/assets/pdf/CMS_project_phase1FactSheet.pdf
Promote ED – Hospitalist Collaboration

State-wide focus group, part of NY Partnership for Patients:

1. Flag 30-day returns in the ED record
2. Promote collaboration between Emergency Medicine and Hospital Medicine on the decision to admit
3. Encourage Hospital Medicine see the patient in the ED
4. Collaborate with referring providers, especially SNFs
5. Capture the “story behind the story”
6. Form a joint quality review committee of EM and Hospital Medicine to review low-acuity admissions and readmissions
PROVIDE ENHANCED SERVICES

*Best “transition out” of the hospital will not suffice for some patients*
“There’s always going to be a group of folks that’s going to need somebody to help them. That’s never going to change.”

~ Social Worker, North Philadelphia
“It’s always been about social work fundamentals: meeting the patient where they are, counseling, teaching, educating. To expect people who are already working and living at a deficit to be able to readily navigate these systems is just unrealistic.”

~ Care Transitions Program Manager
Transitional Care: Actively Address Social Complexity

Social Work Transitional Care

- Assess “person in context”
- Employ motivational interviewing
- Connect, assess, reassess
- Needs change over time
- Navigate clinical follow up
- Ensure linkage to services
- Don’t over medicalize complexity

Multi-Disciplinary Care Teams

- NP, RN, SW, Pharm, Navigator
- Address full complement of medical, social, logistical needs
- Navigator position particularly valuable for outreach, relationships
- Fluid teamwork – problem solving

www.transitionalcare.org

Courtesy of Maia White, Highland Hospital
Alameda Health System, Oakland CA

- 8 FTE -member transitional care team
- Pharmacist, CHF RN, COPD RN, Social Worker, 2 community health outreach workers (CHOW)
- **CHOW came from background of detox center workers**
- Program manager, data analyst
- CHOW screen inpatient units for patients with HF, COPD, HIV
- Establish rapport in-house, arrange for follow up quickly
- “Acknowledge reality” of marginal housing, poverty, instability
- **Specifically inquire about and discuss substance use**
- Accompany, support, touch base, follow up
- RN hold “group visits” as “drop in” in outpatient conference room
- **All members of team do home visits**

Courtesy of Maia White, Highland Hospital
St Agnes Hospital, Baltimore MD

- 11-member transitional care staff
- ED-based team
  - 2 RN, 2 SW
  - Staffed 16 hours daily
- Inpatient-based team
  - 4 RN + 1 SW “navigators + pharmacist + LPN educator
  - Adjunct to floor nurses, case managers
  - Enhanced comprehensive care planning and follow-up
  - Bedside delivery of medicines
  - Establish relationship in inpatient setting sets stage for telephonic follow up
  - Telephonic follow up for at least 30 days, sometimes more
  - Flexible, proactive, persistent, address all needs
  - “Incredible interpersonal skills”
- Navigators get HIE alerts when patients admitted to other hospitals
  - Navigators call the floors of the other hospitals to share care plans
  - Called a meeting to develop template for care plans to share on the HIE
NEWEST TOOL: INDIVIDUAL CARE PLANS

*Help us help you….make your all your work readily accessible!*
Individual Care Plans

• ED- or “Acute” care plans

• Individual, or “Comprehensive” care plans
# ED or “Acute” Care Plan

## What is it useful for?
- Written to influence decisions in ED
- Common symptomatic presentations
- Guide ED-based treatment (avoidance – meds, scans)
- Promotes consistency across providers
- Creates “institutional memory”

## What’s in it?
- Summary of relevant active Issues (not comprehensive history)
- Pattern of utilization (x visits in past y months)
- De-escalation plan
- Symptom or pain management plan
- Behavioral management plan
- Medical clearance plan
- Care Team with contact information
Baltimore Hospitals
- Multiple hospitals collaborating
- Develop 1 page Summary
- Background
- Challenge
- Recommendations – staff, MDs
- Recent studies
- Care Management contact
Comprehensive Care Plan

• Intended to facilitate care management
• Across settings (hospital, SNF, HH, ambulatory care)
• Over time
• Across clinical and non-clinical entities (medical – social – familial)
• Transparent and/or shared by patient & family/caregiver
• Lives in shared care management platform, medical record, other
• Shared broadly for care coordination
BI-Plymouth Example

- Community Care Plan
- Focus on BH patients
- 4 pages

---

**Draft Version 3.10 June 2015**

**BID-Plymouth Community Case Management Individualized Patient Care Plan**

**Team Members:**
- Agency/ Formal Support
- Primary V
- BID-F Community Case Manager
- BID-F Community Case Worker
- BID-F Community NP
- BAYADA Home Health Care VNA
- Long-Term Care
- Hospice
- Home Health Care VNA
- Other

**Select the PCP Team**
- [ ] Plymouth Medical Group (PMG)
- [ ] Affiliated Physicians Group (APG)
- [ ] Physicians by Medical Associates (PBMA)
- [ ] Affiliates

**Health care proxy**
- [ ] Yes
- [ ] No

**Health care proxy:**
- Name:
- Relationship:
- Contact Information:

**Social history**
- [ ] Yes
- [ ] No

**Recent/past medical information/history:**
- [ ] Yes
- [ ] No

**Interventions:**
- [ ] Coordinate non-face-to-face follow-up appointments
- [ ] Initiate VHA referrals to provider
- [ ] Initiate VNA referrals
- [ ] Identify: medication changes, transportation, etc.

**Exclusions:**
- [ ] Yes
- [ ] No

**Function notes:**
- [ ] Yes
- [ ] No

**Prevent Community Case Management Information:**

---

**Draft Version 3.10 June 2015**

**Individual Patient Care Plan**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Additional Details/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

**Goal:**
- [ ] Access/availability to care team
- [ ] Secure VHA support
- [ ] Secure VNA Falls Program
- [ ] Secure medication therapy management
- [ ] Secure mental health interventions
- [ ] Continue best communication modality

---

**CVD: Draft Healthcare Strategies**
Summary

- Know your data – use it as a powerful tool
- Constantly work to understand why patients return to the hospital
- Successful efforts include multiple efforts: In the ED, Improved Standard Care, Purposeful Collaboration, Delivering New Services
- Deploy care teams that actively “do for” – navigate, advocate, support
- Don’t over-medicalize utilization: view through social / behavioral lens
- Leverage the ED as a valuable setting for engagement & linkage
THANK YOU

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Co-Principal Investigator, AHRQ Reducing Medicaid Readmissions Project
Strategic Advisor, Massachusetts Health Policy Commission CHART Program
Amy@CollaborativeHealthcareStrategies.com
617-710-5785