Alaska Flex Readmission Reduction Collaborative (AKFlexR2)

Targeting Health Literacy & Social Determinants of Health

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Background & Aim

"Hospital readmissions are associated with unfavorable patient outcomes and high financial costs."[1] In the first six months of 2021, Alaska had over 600 unplanned 30-day readmissions with a rate of 12.81 per 1000 discharges and is projected to drop from 6th to 24th in national ranking.

	FFY 2021			FFY 2022		
	Est. Impact	% Impact	Rank	Est. Impact	% Impact	Rank
Alaska	($338,400)	-0.17%	6	($942,700)	-0.46%	24

Source: DataGen Healthcare Analytics

To reduce readmissions in Alaska, the Flex Team launched a readmission reduction collaborative based on ASPIRE, "Designing and Delivering Whole-Person Transitional Care," a framework developed by Dr. Amy Boutwell for the Agency for Healthcare Research and Quality (AHRQ).[2]

Goals:

- Recruit two hospitals in Alaska to engage in a readmission reduction collaborative by December 31, 2021.
- Have 100% of participating hospitals develop robust readmissions data, analyze readmission rates by provider category, and become familiar with the ASPIRE framework by June 30, 2022.
- Reduce the average Alaska critical access hospital (CAH) Medicare readmission rate by 3% for participating hospitals by December 31, 2022.
- Reduce the average Medicare readmission rate for all participating facilities by one point from 12.81 per 1000 discharges to 11.81 per 1000 discharges by December 2022 (12.81 baseline, Q1 & Q2 2021, slightly higher than the Hospital Quality Improvement Contractor (HQIC) Telligen network of 12.54 per 1000).

Measures:

- Numerator: Inpatients returning as an acute care inpatient within 30 days of an inpatient discharge, to any facility within the same state
- Denominator: All Medicare patients discharged from the hospital (excluding deaths or transfers)

Aim #1:

Tests of Change at Flex Program Level: Hospital engagement –
A. Participating in learning sessions and coaching calls;
B. Receiving technical assistance related to the project;
C. Attending in-person trainings and poster sessions; and
D. Creating culturally competent discharge instructions

Aim #2:

Test of Change at Hospital/Clinic Level: Reducing Medicare readmissions

Target Population:

Ten facilities participated in the project (two large hospitals, one medium-sized rural hospital, and seven critical access hospitals). Four collaborative members were tribal facilities.

Project Design & Methods

Design:

AKFlexR2 utilized a modified Institute for Healthcare Improvement (IHI) breakthrough series collaborative model,[3] along with the ASPIRE framework.[2]

Timeline/Learning Sessions:

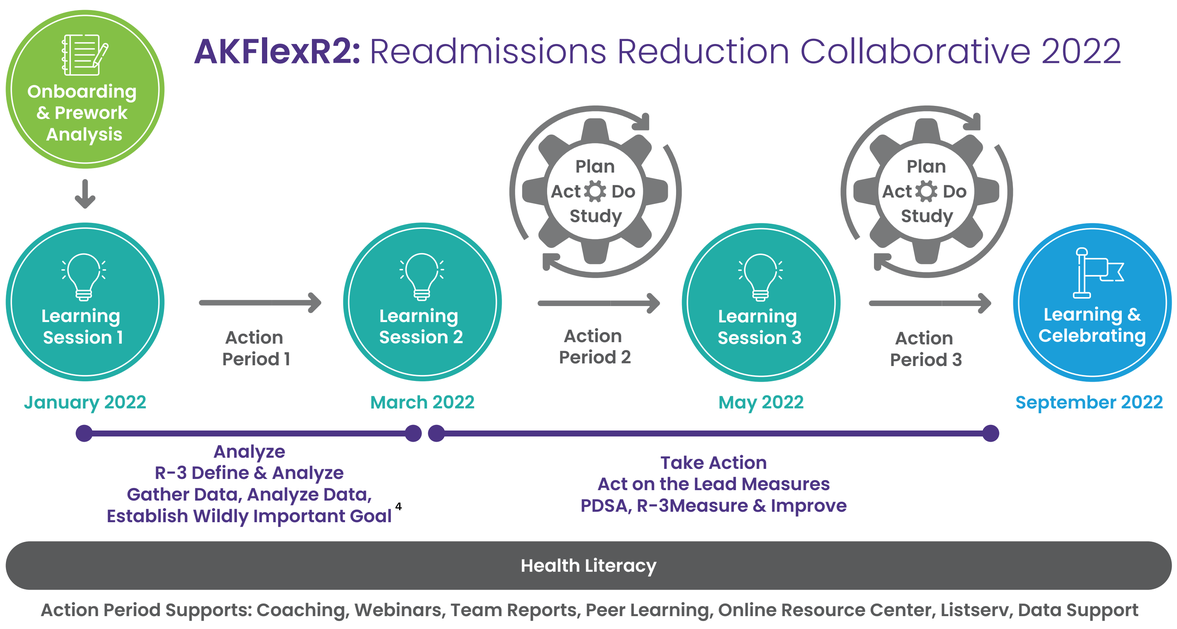
- December 2021 – Introduction to Health Literacy
- January 2022 – Process Improvement Strategies & Design - ASPIRE Reducing Readmissions
- April 2022 – Whole Person Transitions in Care
- May 2022 – Assessing Patient's Health Literacy

Coaching Calls:

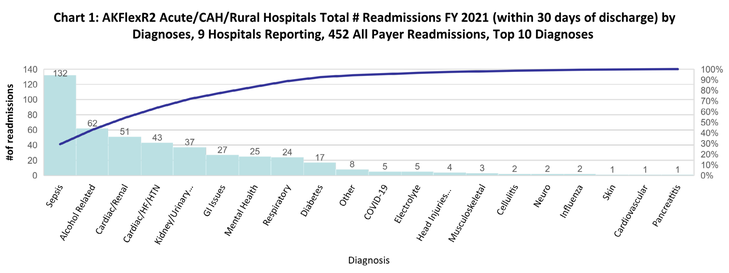
One-on-one coaching by subject matter expert Dr. Amy Boutwell provided each facility with a review and analysis of data, identification of opportunities, and recommendations for improving care.

Action Periods:

- Hospital team meetings: Between learning sessions, hospital teams engaged in action periods. The goals of the action periods were to support teams in their improvement work, build collaboration and shared learning, and assess progress on implementation.
- The hospital HUB team was formed to provide direction for the project and lead/facilitate collaborative sessions.
- Data reporting system: Alaska Hospital & Healthcare Association (AHHA) hosted a system to collect readmissions data from participating hospitals.
- AHHA developed and monitored an online communication platform for hospital teams to share resources and connect with each other and the Alaska Flex Team.



Analysis & Outcomes



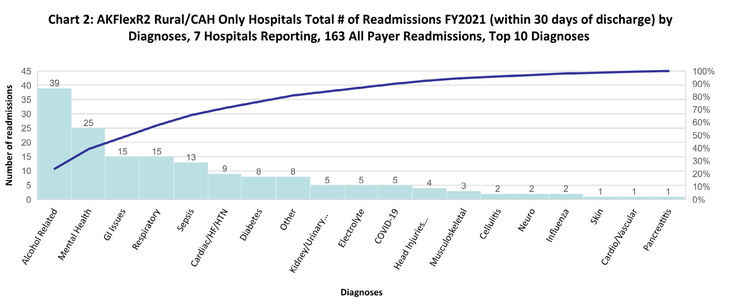


Table 2: Hospital Engagement & Outcomes

2022 FLEXR2 Hospital Engagement & Outcomes	Count & %
Hospitals participating in the collaborative	10
Critical access hospitals participating	7
Completed tool 1 - data analysis	100%
Hospitals received coaching calls with Dr. Boutwell	50%
% that received technical assistance	90%
Hospitals completing health literacy training	100%
Hospitals that completed posters	90%
Developed ideas for QI projects	90%
Hospitals that completed the project	90%
Hospitals that create culturally competent discharge instructions	In progress

Goal	Rate Achieved	Change	% Achieved
Goal: Reduce Alaska Medicare Readmissions rate by one point from 12.81 to 11.81 (baseline Q1 & Q2 2021 as compared to 1/1/2022 - 8/30/2022)	11.41	1.40	11%
Goal: Reduce Medicare Readmissions CAHs by 3% from 14.25 to 11.25 (baseline Q1 & Q2 2021 as compared to 1/1/2022 - 8/30/2022)	8.31	5.94	42%

Source: Telligen CDS Data All State Org, All Project Org, 12/8/2022 & 2/1/2023

Table 3: Collaborative Readmission Rate & FY2021 All Payer Analysis

Readmission Rate	All Discharges	All Readmissions	Readmission Rate	Medicare Readmissions	Medicaid Readmissions	Commercial Readmissions	Uninsured Readmissions
Total of Hospitals in the AkFlexR2 Collaborative	18,691	1582	8%	10%	10%	5%	7%

References & Acknowledgements:

1. McIlvennan, Colleen K et al. "Hospital readmissions reduction program." Circulation vol. 131,20 (2015): 1796-803. doi:10.1161/CIRCULATIONAHA.114.010270
2. Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. Accessed 11/20/2021. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html
3. IHI Breakthrough series College. Institute for Healthcare Improvement. Accessed 11/30/2021. http://www.ihi.org/education/InPersonTraining/breakthrough-series-college/Pages/default.aspx1.
4. McChesney, C., Covey, S., Huling J. The 4 disciplines of execution: Achieving your wildly important goals Washington D.C.: Free Press; 2012:35

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Lessons Learned

Barriers:

- Using Medicare-only data for outcomes
- Getting reports from electronic medical records (EMRs) to complete the readmission analysis (inability to striate data and extract social drivers of health)
- Conducting the patient interviews (held up at some facilities)
- Experiencing limited staffing/turnover/competing priorities/difficulty getting staff engaged
- Having a timeframe that was too short (need another year to work on the project)
- Having readmits who could not be interviewed because of mental health
- Having few readmits, low census, skewed readmission rates
- Having minimal community options at discharge (no home health services)

Benefits:

- The ASPIRE framework analyzed all payer readmissions/striation of data.
- Hospitals were engaged in the meetings and worked collaboratively.
- It was an opportunity to learn together and work with peers in a supportive environment.
- It allowed hospital staff to discover what was happening in the hospital and community.
- The interventions were data-driven.
- There were educational opportunities to inform about the issue.
- There were resources to address and improve patient outcomes.
- It allowed staff to focus on transition of care, which provides benefits beyond this project.
- It increased readmission awareness (recognition of high emergency department (ED) utilizers and multi-visit patients).

Conclusions:

- Alcohol-related diagnoses are the prominent reason for readmission for rural and CAH hospitals (24% of all readmissions).
- Alcohol and mental health diagnoses combined equate to 47% of readmissions in Alaska's rural/CAHs.
- Further research is indicated to assess alcohol as a potential contributing factor related to acute care top diagnoses for readmissions, sepsis and heart failure in Alaska's acute care facilities.

Next Steps:

- AHHA is extending the project for another year for all nine facilities with an additional focus on health equity/social drivers of health.
- Pilot project: A patient-focused alcohol education resource/toolkit was developed and will be piloted in four facilities, beginning January 2023.
- Explore discharge challenges and interventions, including potential contribution of ETOH, in patients diagnosed with sepsis within Alaska's acute care facilities.
- Continue to support facilities to address health literacy and assess materials for accessibility and potential improvement in Alaska's HCAHPS scores in the domains of doctor and nurse communications.

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