Project RED: A True Collaborative Effort
Special Innovation Project Outcomes Congress

Thursday August 22nd
10:00 AM – 12:00 PM
Massachusetts Senior Care Association

Summary Notes

With over 30 individuals in attendance from organizations across the care continuum, Healthcentric Advisors, in partnership with the Massachusetts Senior Care Association, held an Outcomes Congress to recognize and spread outcomes, tools, and learnings from a Special Innovation Project focused on reducing readmissions through an adaptation of Project RED, focused on the transition from skilled nursing facility to the community.

Attendees were prompted to reflect briefly on their goals for the session, grouped below:

- Gain understanding:
  - What is Project RED? Successes/challenges? "the secret sauce!"
  - Strategies for successful patient discharges and transitions
  - Process (overall) of discharge from the nursing facility
  - Resource management
- Gain tools/resources:
  - Best practices regarding care transitions (a high risk area), disease-specific areas
  - Tools & resources to improve care transitions
- Questions for exploration:
  - What/how other hospital settings are managing and facilitating the discharge plan and process? Does anyone use dedicated discharge planners?
  - Is Project RED a FTE-neutral program?
  - How to include care transitions in Serious Illness Care and new MOLST form?
  - How can home health providers better operate outside of our silo? How do other home health providers become part of these projects?
  - New ideas to improve transition from SNF to home, reduce readmissions to the hospital

We acknowledged all of the participants in the Special Innovation Project, including both those who were part of the effort when it began 3 years ago, as well as additional partners who joined last fall when we were granted an extension due to the promising early outcomes.

Grace Dotson, Executive Director of Clinical Integrated Care Services at Southcoast Health and a champion of this project from the beginning, spoke about the challenges of the current environment, with emphasis on the chasm that threatens our most vulnerable patients. She stressed that big problems require big solutions, and a focus on system transformation – and why Project RED is an important, big solution. She detailed the key elements of Project RED, and also noted the importance of alignment within a system and between partners, to set up for success.

Tara Gregorio, President of the Massachusetts Senior Care Association, partner/host of this event, provided larger context for the regulatory and payment pressures faced by skilled nursing facilities, identifying key drivers that impact length of stay. A significant amount of time has elapsed without any cost adjustment increases associated with Medicaid beneficiaries. As a result, many facilities are running deficits, creating stress. Tara shared some data associated with length of stay and its effect on readmission rates, and referred to an upcoming report that is being published soon. She also touched on the variety of obstacles to a safe discharge home, the importance of staying engaged, and utilizing best practices (such as Project RED) to leverage/disseminate as we approach these challenges.

Video: The Project RED Experience: Voices from the Field (link)

Joshua Clodius from the Healthcentric Advisors team presented the data showing outcomes and impact. He noted reasons behind some differences we see between the pilot and expansion groups' measures, alignment with ACO measures and payment programs, and other variables. The project showed a reduction in readmission sustained at 30, 60, and 90 days post-discharge from the skilled nursing facility, as well as meaningful relative improvement for both pilot and expansion groups at 30 days post-discharge from the hospital. This is raw Medicare FFS claims data, not risk-adjusted. (See Assessing Outcomes and Impact slides)

A panel discussion followed, featuring representatives from all settings involved in the project, both pilot and expansion. Panelists spoke of their challenges (staff turnover, staff buy-in, paper records/access to info, duplication, closing the loop), their "aha" moments (importance of ASAP knowledge and link, focus on connecting/convening/talking/probing questions, importance of tying back to patient-centered, patient-driven care, data-driven "it's working"). Sustainability was also a key topic, often hindered by staff turnover, but assisted by hard-wiring within facility process through integration with EMR and also embedding within facility culture. The group discussed how changes in payment are also forcing the change, a need to think forward, rethinking, transforming.

Joshua closed the session by prompting attendees to leave in action, and note something they could do that day:

- Takeaways and Action Steps:
    - Strategies for improving transitions of care, strategies for reducing hospital readmissions, ways to improve Goals of Care Discussions, tool for examining root cause of readmissions
    - Connect with PCPs in communities
    - Reach out to hospitals and SNFs to starts discharge planning immediately
    - Explore ASAPs! Bring ASAP into acute care for pre-d/c family meetings/complex cases
    - Enhance discharge assessments/plans in EHR
    - Broaden my professional network, share our journey and goals/how to get to success