Reducing Readmissions One-case-at-a-time Using Midas+ Community Case Management

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The Problem

Historically, up to 25% of patients discharged from an acute care hospital are readmitted within 30 days. Most of those readmissions could have been prevented. Readmissions have been one way that hospital costs have escalated.

- From 2007 through 2011, the national 30-day, all-cause, hospital readmission rate averaged 19 percent. During calendar year 2012, the readmission rate averaged 18.4 percent. *Centers for Medicare and Medicaid Services*
- Preliminary claims data shows the Medicare readmission rate averaged less than 18 percent over the first eight months of 2013. This translates into an estimated 130,000 fewer hospital readmissions between January 2012 and August 2013.

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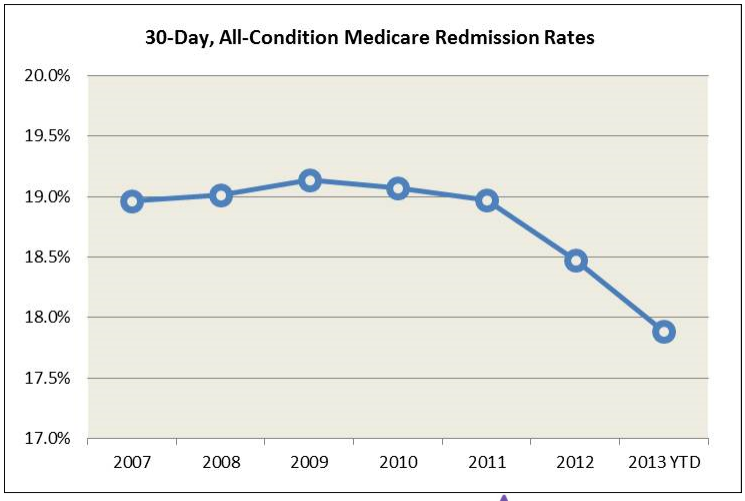
The Impetus to Continue



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Impact of the ACA

The Patient Protection Affordable Care Act of 2010 has created new incentives to reduce readmissions. Hospitals are beginning to partner with post-discharge providers in the community. Readmission rates for all hospitals can be found on Hospital Compare.

The rates displayed in this table were calculated from Medicare data on patients discharged between July 1, 2011 and June 30, 2012. They do not include people in Medicare Advantage (like an HMO or PPO) plans or people who do not have Medicare.

Rate of readmission after discharge from hospital (hospital-wide) shows a comparison between the 30-day readmission rates for the selected hospitals, and the U.S. national **rate of readmission after discharge from the hospital (hospital-wide)**. These comparisons take into account how sick patients were before they were admitted to the hospital and differences in readmission rates that might be due to chance.

Rate of readmission after discharge from hospital (hospital-wide) compared to the U.S. national rate.

U.S. national rate of readmission after discharge from hospital (hospital-wide) = 16.0%

Hospital Name	Better Than U.S. National Rate (Adjusted Readmission Is Lower Than U.S. National Rate)	No Different Than U.S. National Rate (Adjusted Readmission Is About The Same As U.S. National Rate Or Difference Is Uncertain)	Worse Thar U.S. Nation Rate (Adjus Readmissio Higher Thar U.S. Nation Rate)
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx			x
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx		x	
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx		x	

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Who gets readmitted?

Generally, 2/3 of all patients who are re-admitted within 30 days are thought to be preventable readmissions (other than planned readmissions)

Those preventable readmissions can be categorized in three ways:

1. Readmissions for complications or infections arising directly from the initial hospital stay
2. Readmissions because of poorly managed transitions during discharge
3. Readmissions because of a recurrence or exacerbation of a chronic condition that led to the initial hospitalization.

Source: "**Using Medical Homes to Reduce Readmissions**"; Center for Healthcare Quality and Payment Reform; www.PaymentReform.org

HRRP – Hospital Readmission Reduction Program

- Began in FY 2013 discharges 10/1/2012
  - Acute MI
  - Pneumonia
  - Heart Failure
  - Penalties up to 1% of Medicare Payments
- For FY 2015 CMS will add
  - Exacerbation of COPD
  - Total Hip Arthroplasty
  - Total Knee Arthroplasty
  - Penalties up to 3% of Medicare Payments

RSRR's

Risk-standardized 30-day Readmission Rates

CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF, and PN to calculate the excess readmission ratios, which includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty.

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HWR- Hospital-wide all cause Readmission Rate.

- This is claims-based, risk-adjusted measure for public reporting that reflects the quality of care for hospitalized patients.
- The HWR measure includes index admissions for patients:
  - Who are enrolled in Medicare fee-for-service (FFS);
  - Aged 65 years or over;
  - Discharged from non-federal acute care hospitals;
  - Without an in-hospital death; and
  - Who were not transferred to another acute care facility, because the measure evaluates hospitalizations for patients discharged to non-acute care settings

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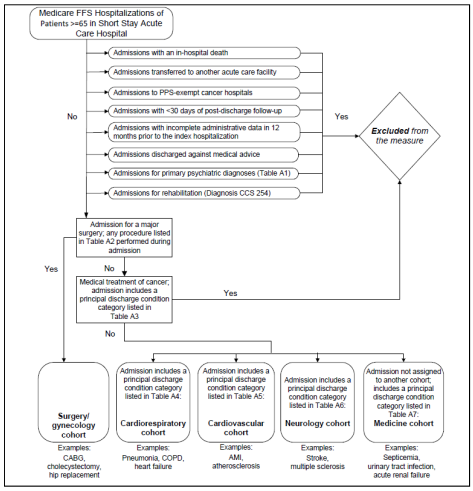
HWR – Inclusion and Exclusion Criteria



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Readmission Reduction Strategies

- Note: no single intervention alone was responsible for reductions in readmissions
  - Patient-centered Discharge Instructions
  - Follow-up telephone calls: including reminders about follow up appointments, symptoms management, medications, self-care
  - Include family, caregivers, and community providers in plan
  - Medication Reconciliation
  - Provide Real-time critical information to the next provider
  - Follow-up appointments with PCP in 2-5 days post-discharge.
  - Use “teach-back” techniques in hospital and during follow-up phone calls
  - Partnering with Home Care Agencies

- Sources:
- Health Research and Educational Trust (HRET) , affiliate of the American Hospital Association
- Mathematica Study of Evidence of Effective Care Coordination
- IHI STARR Programs (multiple states)
- Healthcare Finance News

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Readmission Reduction

These strategies have been associated with significantly lower RSRRs for patients with Heart Failure:

- Partnering with community physicians/physicians groups
- Partnering with local hospitals
- Having nurses responsible for Medication Reconciliation
- Arranging a follow-up appointment before discharge
- Having a process in place to send all discharge summaries directly to the patient's primary care provider
- Assigning staff to follow up on test results that return after the patient is discharged

Source:

Hospital Strategies Associated With 30-Day Readmission Rates for Patients With Heart Failure

Circulation: Cardiovascular Quality and Outcomes. **2013;** 6: **444-450**

Identifying Patients for Coaching

- Patient Pre-discharge
  - HCM Support Services
  - HCM Concurrent Review
  - HCM Discharge Planning
    - Boost Model Better Outcomes for Older Adults through Safe Transitions
    - State Action on Avoidable Rehospitalizations Initiative [STAAR])
    - the Hospital to Home [H2H] National Quality Improvement Initiative
  - Targeted Readmission Reduction Conditions

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Worklist Rules - Examples

- Receipt of Referral from HCM
- Concurrent Review
- Discharge Planning
- Support Services
- Discharge of pt. with targeted diagnosis (MDC)
  - AMI
  - CHF
  - Pneumonia
  - COPD
  - THA
  - TKA
- Based on ICD-10

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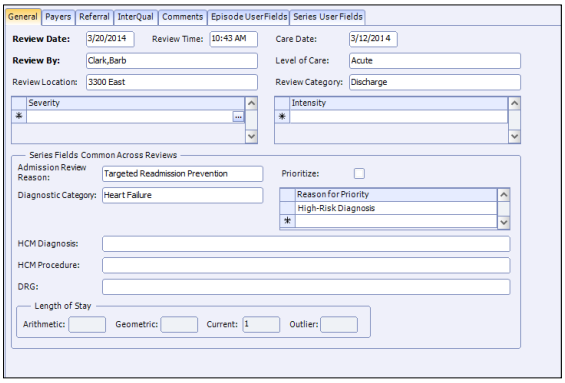
Identification through the use of SmarTrack Worklists

Leverage the Diagnostic Category field within Concurrent Review



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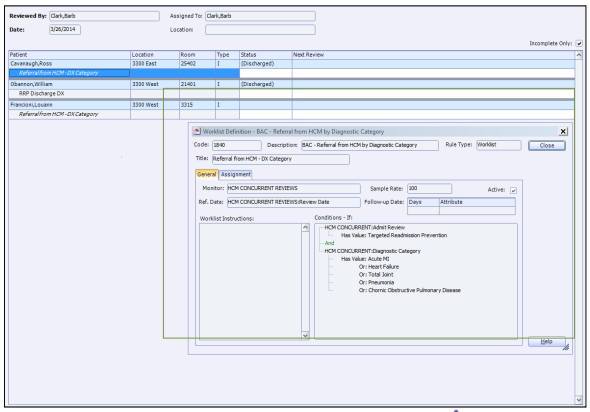
Identification through the use of SmarTrack Worklists

Referral from Discharge Planners



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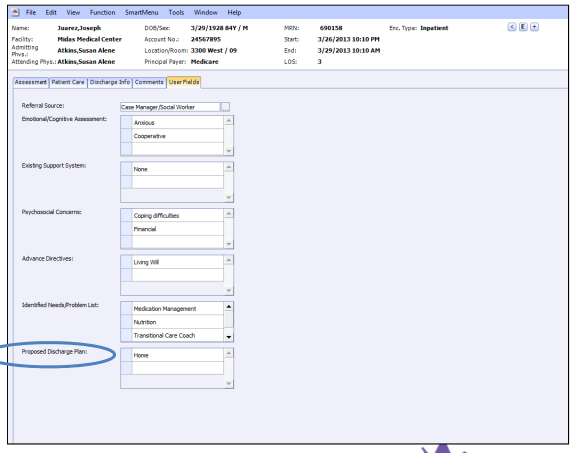
Build a Worklist Rule Based on HCM Discharge Planning Referral in User Fields



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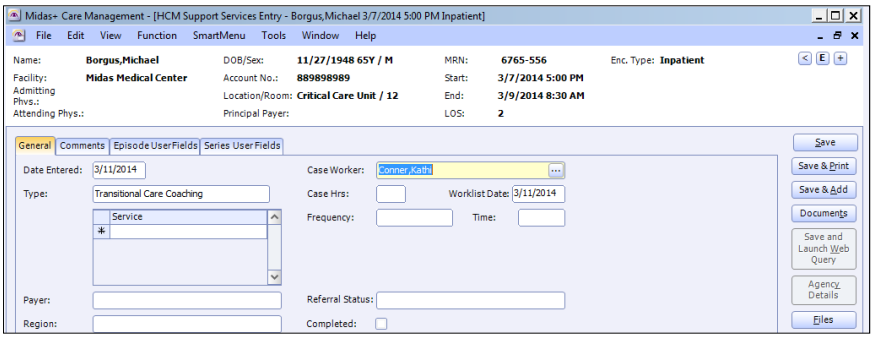
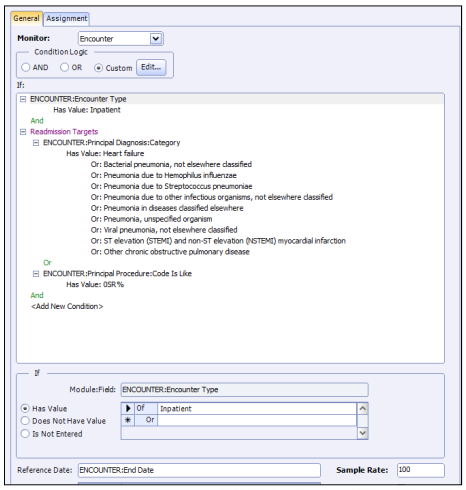
HCM Support Services Direct Referral



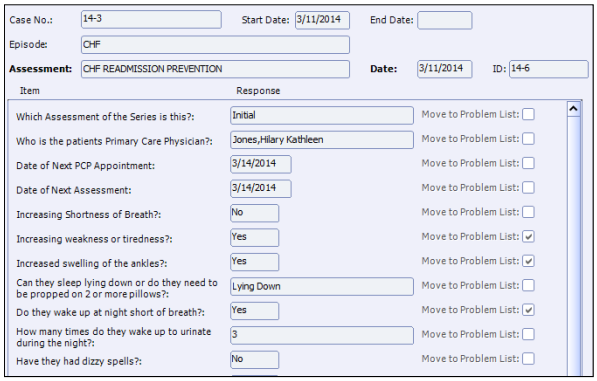
Worklist Rule Identifying Targeted Readmission Diagnoses with ICD-10



Beginning of CCM Use

Now that we have identified our patients

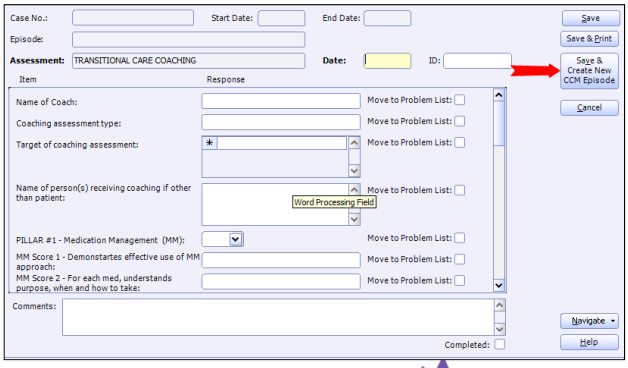
1. Perform Assessment using Midas+ CCM



Beginning of CCM Use

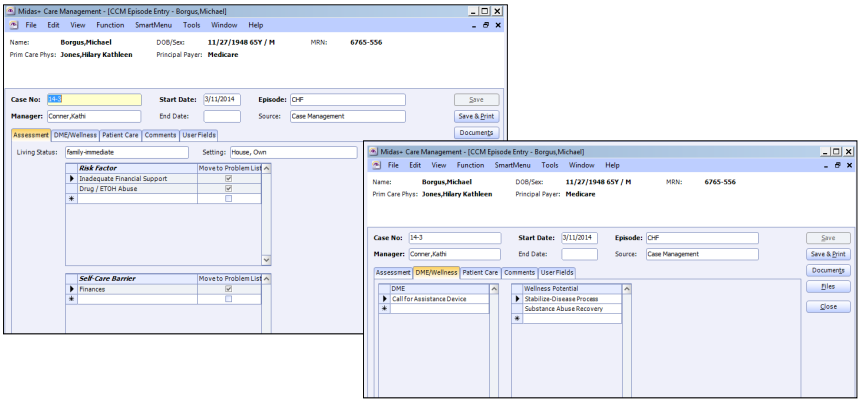
Now that we have identified our patients

2. Create an Episode from the Assessment



Beginning of CCM Use

The Episode



Information Flow from Discharge Planning to CCM Episode

- Site Parameter
  - Transfers data from HCM Discharge Planning
    - Assessment Tab
    - DME Tab
    - Patient Care Tab

CCM	**CMGE-LOAD UR DISCHARGE DATA**	Y or N	N		Choose Y to allow HCM Discharge Planning data from an Encounter to populate the CCM Episode Entry form.

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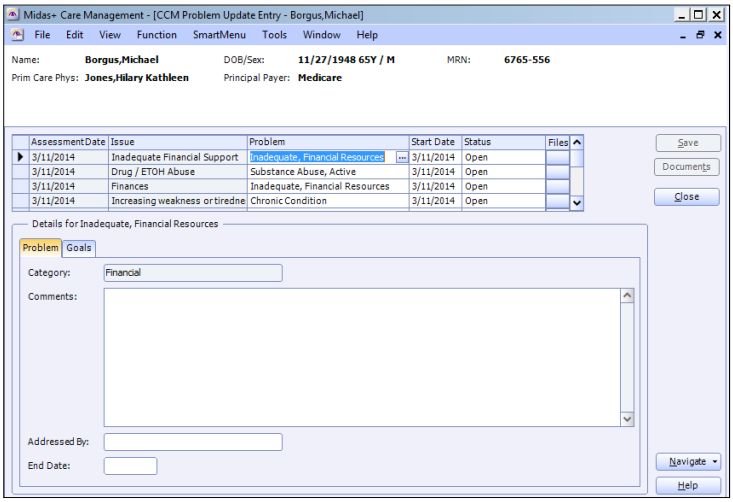
Problem List



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Problem List

- Allow Problem List and Goals to Drive Referrals and Interventions
  - Based on the problem, is there an intervention that can be set up to assist in meeting a goal?

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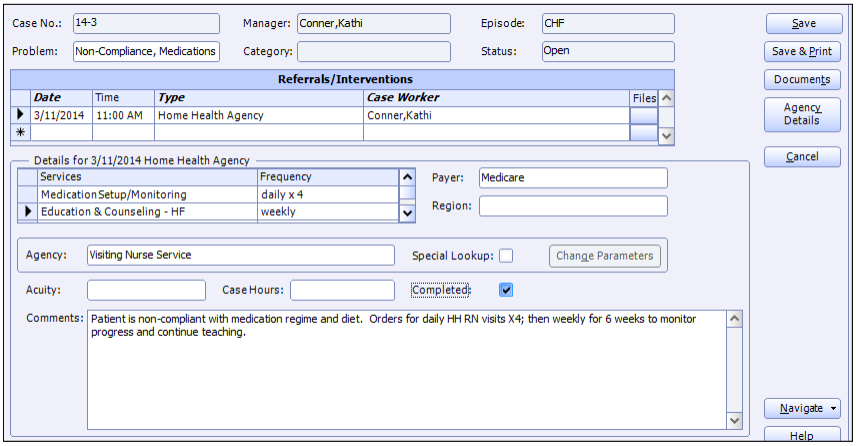
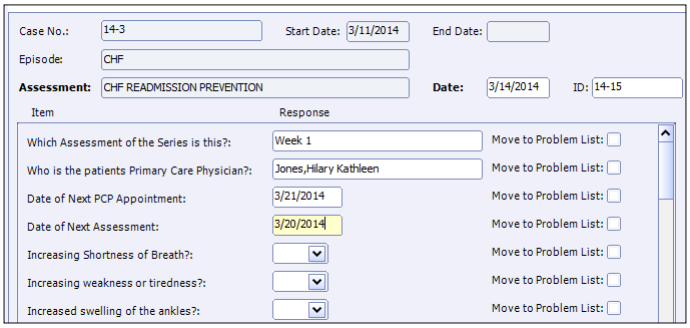
Referrals and Interventions



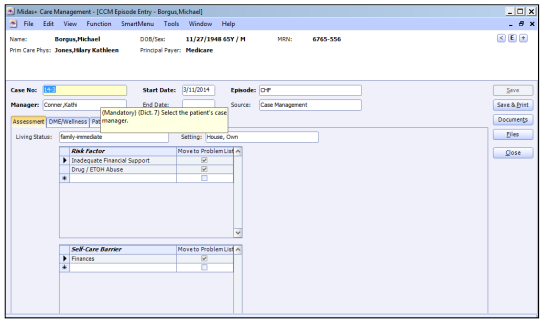
Follow-up within 48 Hours

- Re-Assess Patient
  - CCM Assessment
    - Add additional items to Problem List



Follow-up within 48 Hours

- Re-Assess Patient
  - CCM Episode
    - Add items to Problem List



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ReporTrack Document to PCP

Midas+ Medical Center

3/26/2014

Dear Dr. Jones,

I have been following your patient, Michael Borgus, since discharge from Midas Medical Center on 03/09/2014. My most recent telephone assessment of this patient on 03/11/2014 revealed the following:

Assessment Type: Initial

The patient reports:

Increasing shortness of breath? N

Increasing weakness or tiredness? Y

Increased swelling of the ankles? Y

Sleep position? Lying Down

Number of times up to urinate during the night = 4

Weight gain of more than 2 lbs per day or 5 lbs per week? The patient has not been weighing himself.

Last Reported Blood Pressure: 144/88

Have they missed any prescribed medications? Y

Comments:

Patient is cooperative and happy to be at home.

The patient reports a next follow up visit with you on: 03/14/2014

I plan on conducting another telephone assessment of this patient on: 03/17/2014

Please do not hesitate to call me if I can be of assistance in our shared responsibility of keeping this patient healthy and out of the hospital.

Sincerely,

Kathy Conner
Transitional Case Manager
600-777-8888 (cell phone)

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Worklist Rules to Support CCM Follow-Up

- System-generated Worklist Rules
  - Referrals and Interventions (Incomplete Tasks)
  - New Encounter for open CCM patient to facility based on site parameter (Re-Entry Rule)
- Custom Worklist Rules
  - Problem list
  - Assessment Follow-up
  - Follow-up appointments kept
  - Lab follow up (for those clients with a lab Clinical Data Interface)

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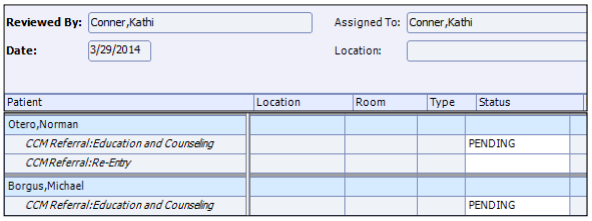
The Mysterious Service Type

Re-Entry – A distributed term within the Service Type Dictionary.



Reviewed By: Conner,Kathi **Assigned To:** Conner,Kathi
Date: 3/29/2014 **Location:**

Patient	Location	Room	Type	Status
Otero,Norman				
CCM Referral:Education and Counseling				PENDING
CCM Referral:Re-Entry				
Borgus,Michael				
CCM Referral:Education and Counseling				PENDING

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Re-Entry Site Parameter

This parameter is used to determine which Encounter Type:type(s) will flag a re-entry.

#	Midas+ Site Parameter	Options	Default	Choice	Comments
2.3	**CMGRE-REENTRY ENCOUNTER TYPES**	I, O, E, S or N	blank		Choose one or more Encounter Type:Types (I, O, E, S) that will generate a re-entry on the Worklist. Choose N to have no Encounter Type:Types generate re-entry supports. Choose "blank" to have all Encounter Types generate re-entry Supports.

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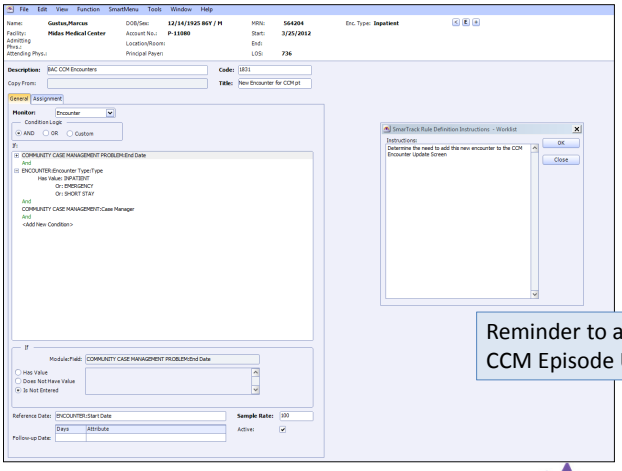
Worklist Rules to Support CCM Follow-Up



Reminder to add related encounters to CCM Episode Update

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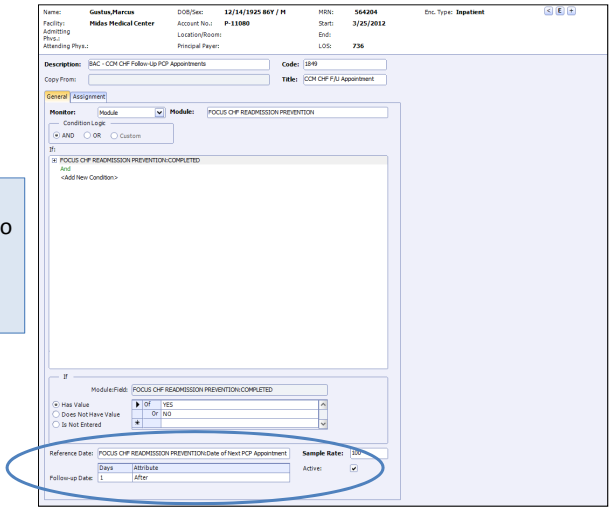
Worklist Rules to Support CCM follow-up

Reminder to CCM/Transitional Coach to follow up on whether or not follow-up appointment was kept



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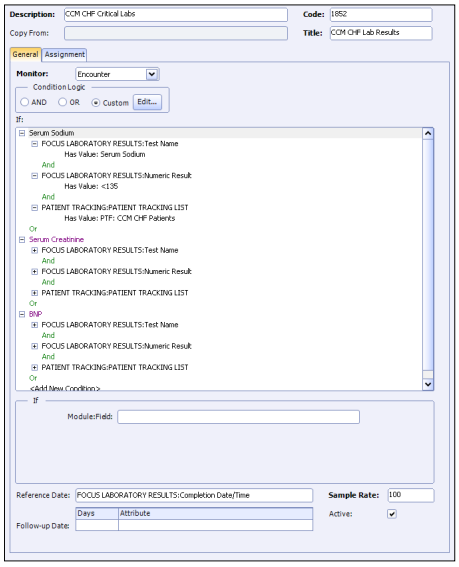
Worklist Rules to Support CCM follow-up



If you have Clinical Data Interfaces, you can capitalize on the results via worklist rule.

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What processes are in place within your organization pre-discharge to identify patients with a high potential for readmission?

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SmarTrack Profile Example

Indicator	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Total
General Information							
Total Inpatient Discharges	356	380	402	411	408	397	2354
Inpatient Readmission within 30 days of Inpatient Discharge	37	35	42	50	54	48	266
% Inpatient Readmissions within 30 Days	10 %	9 %	10 %	12 %	13 %	12 %	11 %
Readmission within 30 days from sub-acute facility	8	7	8	9	12	10	54
HWR - Hospital-wide Medicare Readmission Rate	17.1 %	14.6 %	13.5 %	14.4 %	24.1 %	20.6 %	17.1 %
Readmission Targets							
Discharges with Targeted Readmission Diagnoses	48	46	53	51	70	62	330
Readmissions with Targeted Diagnosis	12	10	8	11	14	13	68
% Pts. with Targeted Diagnoses Readmitted in <30 Days	25 %	22 %	15 %	22 %	20 %	21 %	21 %
Patients with targeted readmission dx referred to CCM	12	18	24	32	33	34	153
% Pts. with Targeted Dx referred to CCM Readmitted <30 Days	25 %	39 %	45 %	63 %	47 %	55 %	46 %
HCM Data							
Referrals to Transitional Coach from Inpatient Case Manager	20	20	18	28	30	31	147

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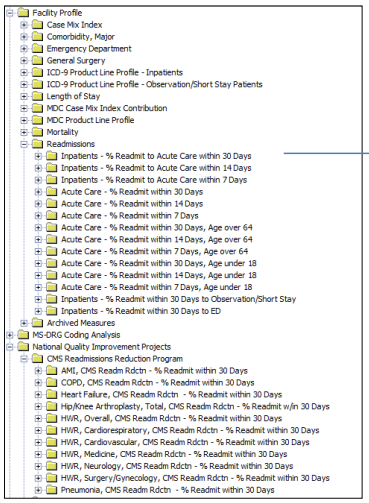
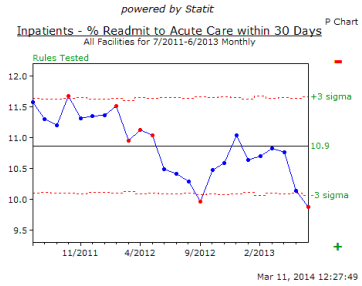
Readmission Metrics Available in DataVision





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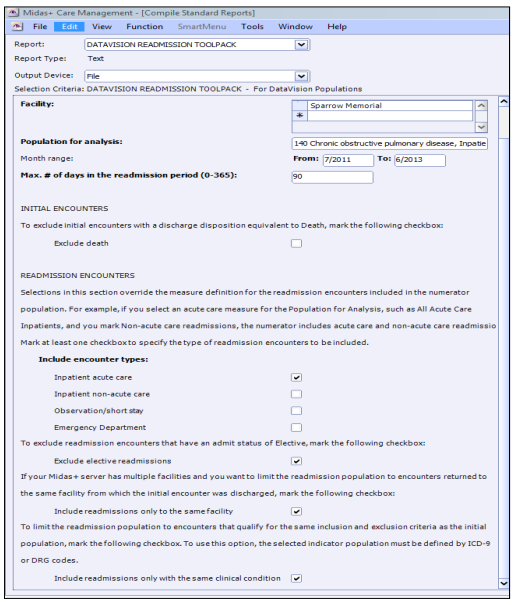

DV Readmission ToolPack

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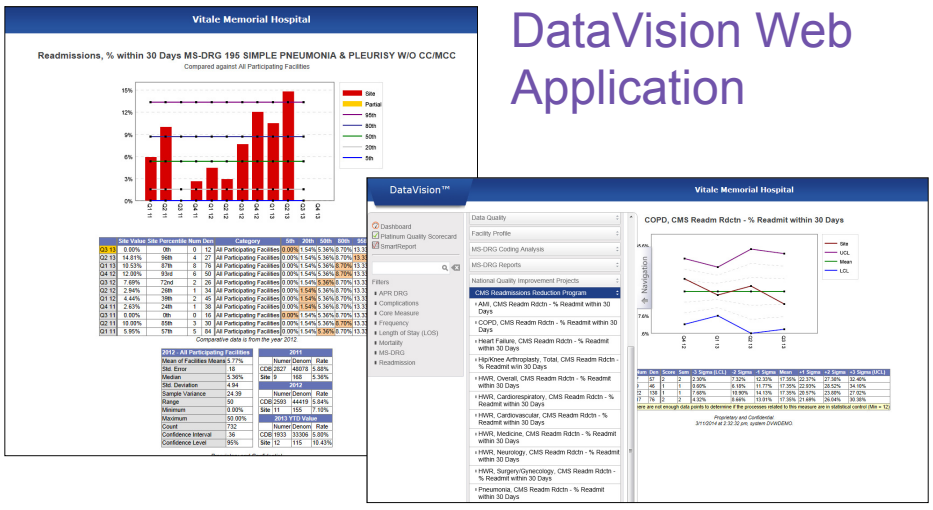

DataVision Web Application

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How can Midas+ CCM help to support Readmission Reduction Strategies?

- Follow-up telephone calls: including reminders about follow up appointments, symptoms management, medications, self-care
- Provide Real-time critical information to the next provider
- Follow-up appointments with PCP in 2-5 days post discharge
- Use “teach-back” techniques in hospital and during follow-up phone calls
- Assigning staff to follow up on test results that return after the patient is discharged

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What is the answer to reducing readmissions?

- Hospitals must do everything in their power to prepare a patient for self-care after discharge.
- Patients must have adequate options for primary care that do not require an ED visit after 5pm and on weekends
- We need to resolve and reduce poverty, social isolation, and mental health issues

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Thanks for attending.
Are there any questions?
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Barb Craig, SaaS Advisor
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