

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

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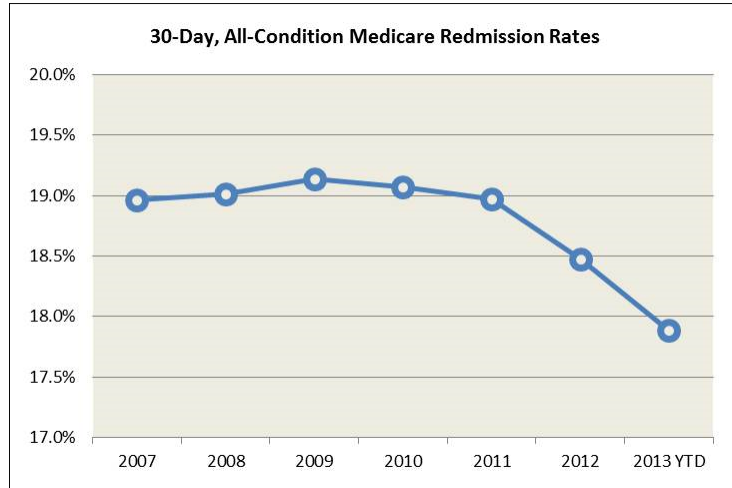
## The Problem

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.



## 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 Than U.S. National Rate (Adjusted Readmission Is Higher Than U.S. National Rate)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		X	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		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](http://www.PaymentReform.org)



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## 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



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## 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.

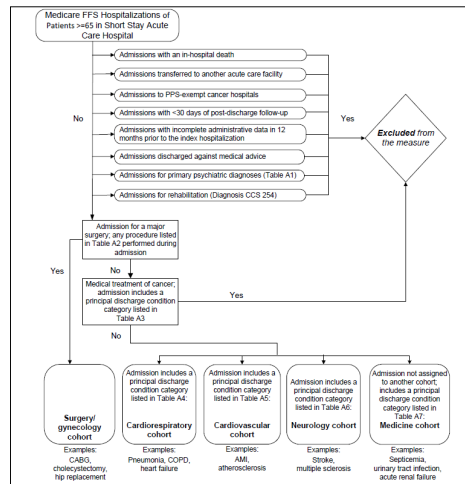
- This is claims-based, risk-adjusted measure for public reporting that reflects the quality of care for hospitalized patients.
- The HWR measure includes index admissions for patients:
  - Who are enrolled in Medicare fee-for-service (FFS);
  - Aged 65 years or over;
  - Discharged from non-federal 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



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## 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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## Referral from Discharge Planners

Revised By:	Gar,Josh	Assigned To:	Gar,Josh
Date:	1/26/2014	Location:	
Patient:	1301 East	Room:	1
OrderingPhysician:	1301 East	Type:	Discharge
Discharge/Referral Category:	1301 West	Discharge/Referral Category:	Discharge
Referral From:	1301 West	Referral From:	1301
Referral To:	1301 West	Referral To:	1301
Referral From HCN - Dis. Category:		Referral From HCN - Dis. Category:	

☒ Worksheet Definition: BAC - Referral from HCM by Diagnostic Category

Code:	Description:	Rule Type:	Worksheet:
0040	BAC - Referral from HCM by Diagnostic Category	Rule Type:	Worksheet

Title: Referral from HCM - Dis. Category

General Assignment

Review:	HCM CONCURRENT REVIEW	Sample Rate:	100	Active:	<input checked="" type="checkbox"/>
Ref. Code:	HCM CONCURRENT REVIEW	Review Date:		File/Print:	

Worksheet Instructions:
 

Conditions - F:
 

- HCM CONCURRENT Admit Review
- Has Major Targeted Feedback Presentation

HCM CONCURRENT Diagnostic Category
 

- Any
- Max Value: HCM PE
- Or: Heart Failure
- Or: T2MI Joint
- Or: Pneumonia
- Or: Chronic Obstructive Pulmonary Disease

Print

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

The screenshot displays the Epic EMR Patient Care interface for a patient named Joseph, James. The interface includes a top navigation bar with tabs for Assessment, Patient Care, Discharge Info, Comments, and User Paths. The Patient Care tab is currently selected. The patient's information is displayed at the top, including Name, Facility, Admitting Physician, Attending Physician, DOB, Account No., Location/Room, and Principal Payer. The Patient Care section contains several sub-sections: Referral Source, Involuntary/Cognitive Assessment, Existing Support System, Psychosocial Concerns, Advance Directives, and Identified Needs/Problem List. The Proposed Discharge Plan section is highlighted with a red circle.

Section	Item	Value
Patient Information	Name	Joseph, James
Patient Information	Facility	Holmes Medical Center
Patient Information	Admitting Physician	Atkins, Susan Alene
Patient Information	Attending Physician	Atkins, Susan Alene
Patient Information	DOB	3/29/1958 847 / M
Patient Information	Account No.	24657995
Patient Information	Location/Room	3300 West / 09
Patient Information	Principal Payer	Medicare
Patient Information	MRN	000128
Patient Information	Enr. Type	Inpatient
Patient Information	Start	3/24/2013 10:10 PM
Patient Information	End	3/29/2013 10:10 AM
Patient Information	LGS	3
Referral Source	Case Manager/Goal Worker	
Involuntary/Cognitive Assessment	Anxious	
Involuntary/Cognitive Assessment	Cooperative	
Existing Support System	Name	
Psychosocial Concerns	Coping difficulties	
Psychosocial Concerns	Personal	
Advance Directives	Living Will	
Identified Needs/Problem List	Medication Management	
Identified Needs/Problem List	Nutrition	
Identified Needs/Problem List	Transitional Care Coach	
Proposed Discharge Plan	Name	



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## HCM Support Services Direct Referral

Midas+ Care Management - [HCM Support Services Entry - Borgus, Michael 3/7/2014 5:00 PM Inpatient]

File Edit View Function SmartMenu Tools Window Help

Name: **Borgus, Michael** DOB/Sec: **11/27/1948 65Y / M** MRN: **6765-556** Enc. Type: **Inpatient**

Facility: **Midas Medical Center** Account No.: **889898989** Start: **3/7/2014 5:00 PM**

Phys.: **Critical Care Unit / 12** End: **3/9/2014 8:30 AM**

Attending Phys.: **Principal Payer:** LOS: **2**

General Comments Episode User Fields Series User Fields

Date Entered: 3/11/2014 Case Worker: **Conner, Kaiti**

Type: **Transitional Care Coaching** Case Hrs:  Worklist Date: 3/11/2014

Service:  Frequency:  Time:

Payer:  Referral Status:

Region:  Completed: ☐

Save Save & Print Save & Add Documents Save and Launch Web Query Agency Details Files



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## Worklist Rule Identifying Targeted Readmission Diagnoses with ICD-10

General Assignment

Monitor: **Encounter**

Condition Logic: ☐ AND ☐ OR ☒ Custom **Edit...**

If:

- ☒ ENCOUNTER:Encounter Type  
Has Value: Inpatient
- And
- ☒ Readmission Targets
- ☒ ENCOUNTER:Principal Diagnosis:Category  
Has Value: Heart failure  
Or: Bacterial pneumonia, not elsewhere classified  
Or: Pneumonia due to Hemophilus influenzae  
Or: Pneumonia due to Streptococcus pneumoniae  
Or: Pneumonia due to other infectious organisms, not elsewhere classified  
Or: Pneumonia in diseases classified elsewhere  
Or: Pneumonia, unspecified organism  
Or: Viral pneumonia, not elsewhere classified  
Or: ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction  
Or: Other chronic obstructive pulmonary disease
- Or
- ☒ ENCOUNTER:Principal Procedure:Code Is Like  
Has Value: ICDR%
- And
- <Add New Condition>

If:

Module:Field: **ENCOUNTER:Encounter Type**

☒ Has Value ☐ Does Not Have Value ☐ Is Not Entered

☒ Of ☐ Or

Reference Date: **ENCOUNTER:End Date** Sample Rate: **100**



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## Beginning of CCM Use

Now that we have identified our patients

### 1. Perform Assessment using Midas+ CCM

Case No.:	14-3	Start Date:	3/11/2014	End Date:	
Episode:	CHF				
Assessment:	CHF READMISSION PREVENTION	Date:	3/11/2014	ID:	14-6
Item	Response				
Which Assessment of the Series is this?:	Initial	Move to Problem List:	<input type="checkbox"/>		
Who is the patients Primary Care Physician?:	Jones, Hilary Kathleen	Move to Problem List:	<input type="checkbox"/>		
Date of Next PCP Appointment:	3/14/2014	Move to Problem List:	<input type="checkbox"/>		
Date of Next Assessment:	3/14/2014	Move to Problem List:	<input type="checkbox"/>		
Increasing Shortness of Breath?:	No	Move to Problem List:	<input type="checkbox"/>		
Increasing weakness or tiredness?:	Yes	Move to Problem List:	<input checked="" type="checkbox"/>		
Increased swelling of the ankles?:	Yes	Move to Problem List:	<input checked="" type="checkbox"/>		
Can they sleep lying down or do they need to be propped on 2 or more pillows?:	Lying Down	Move to Problem List:	<input type="checkbox"/>		
Do they wake up at night short of breath?:	Yes	Move to Problem List:	<input checked="" type="checkbox"/>		
How many times do they wake up to urinate during the night?:	3	Move to Problem List:	<input type="checkbox"/>		
Have they had dizzy spells?:	No	Move to Problem List:	<input type="checkbox"/>		



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## Beginning of CCM Use

Now that we have identified our patients

### 2. Create an Episode from the Assessment

Case No.:		Start Date:		End Date:		Save
Episode:						Save & Print
Assessment:	TRANSITIONAL CARE COACHING	Date:		ID:		Save & Create New CCM Episode
Item	Response					Cancel
Name of Coach:		Move to Problem List:	<input type="checkbox"/>			
Coaching assessment type:		Move to Problem List:	<input type="checkbox"/>			
Target of coaching assessment:	*	Move to Problem List:	<input type="checkbox"/>			
Name of person(s) receiving coaching if other than patient:	Word Processing Field	Move to Problem List:	<input type="checkbox"/>			
PILLAR #1 - Medication Management (MM):		Move to Problem List:	<input type="checkbox"/>			
MM Score 1 - Demonstrates effective use of MM approach:		Move to Problem List:	<input type="checkbox"/>			
MM Score 2 - For each med, understands purpose, when and how to take:		Move to Problem List:	<input type="checkbox"/>			
Comments:						
		Completed:	<input type="checkbox"/>			Navigate
						Help



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# Beginning of CCM Use

## The Episode



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## 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

Assessment Date	Issue	Problem	Start Date	Status	Files
3/11/2014	Inadequate Financial Support	Inadequate Financial Resources	3/11/2014	Open	
3/11/2014	Drug / ETOH Abuse	Substance Abuse, Active	3/11/2014	Open	
3/11/2014	Finances	Inadequate, Financial Resources	3/11/2014	Open	
3/11/2014	Increasing weakness or tiredness	Chronic Condition	3/11/2014	Open	

Details for Inadequate, Financial Resources

Problem Goals

Category: Financial

Comments:

Addressed By:

End Date:



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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

Case No.: 14-3 Manager: Conner, Kathi Episode: CHF  
 Problem: Non-Compliance, Medications Category: Status: Open

Save Save & Print Documents Agency Details Cancel

Date	Time	Type	Case Worker	Files
3/11/2014	11:00 AM	Home Health Agency	Conner, Kathi	

\* Details for 3/11/2014 Home Health Agency

Services	Frequency	Payer
Medication Setup/Monitoring	daily x 4	Medicare
Education & Counseling - HF	weekly	

Region: Agency: Visiting Nurse Service Special Lookup: Change Parameters

Acuity: Case Hours: Completed: ☒

Comments: Patient is non-compliant with medication regime and diet. Orders for daily HH RN visits X4; then weekly for 6 weeks to monitor progress and continue teaching.

Navigate Help



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## Follow-up within 48 Hours

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

Case No.: 14-3 Start Date: 3/11/2014 End Date: Episode: CHF  
 Assessment: CHF READMISSION PREVENTION Date: 3/14/2014 ID: 14-15

Item	Response	Move to Problem List
Which Assessment of the Series is this?:	Week 1	<input type="checkbox"/>
Who is the patients Primary Care Physician?:	Jones, Hilary Kathleen	<input type="checkbox"/>
Date of Next PCP Appointment:	3/21/2014	<input type="checkbox"/>
Date of Next Assessment:	3/20/2014	<input type="checkbox"/>
Increasing Shortness of Breath?:	<input type="checkbox"/>	<input type="checkbox"/>
Increasing weakness or tiredness?:	<input type="checkbox"/>	<input type="checkbox"/>
Increased swelling of the ankles?:	<input type="checkbox"/>	<input type="checkbox"/>



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## Follow-up within 48 Hours

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

The screenshot shows the 'Midas+ Case Management - [CCM Episode Entry - Borgus, Michael]' window. The 'Case No.' is 001, 'Start Date' is 03/10/2014, and 'End Date' is 03/10/2014. The 'Episode' is 01. The 'Manager' is Conner, J. The 'Problem List' section has a table with columns for 'Problem', 'Status', and 'Action'. The table contains two rows: 'Risk Factor' and 'Self-Care Barrier'. The 'Risk Factor' row has a status of 'Active' and an action of 'Move to Problem List'. The 'Self-Care Barrier' row has a status of 'Active' and an action of 'Move to Problem List'.



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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)

## ReporTrack Document to PCP



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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:

Assigned To:

Date:

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

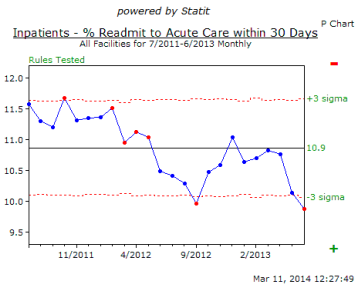
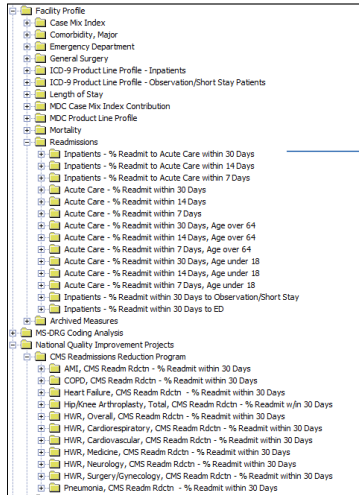
Indicator	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Total
<b>General Information</b>							
Total Inpatient Discharges	356	380	402	411	408	397	2354
Inpatient Readmission within 30 days of Inpatient Discharge	37	35	42	50	54	48	266
% Inpatient Readmissions within 30 Days	10 %	9 %	10 %	12 %	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 %
<b>Readmission Targets</b>							
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 %
<b>HCM Data</b>							
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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Midas+ Care Management - [Compile Standard Reports]

File Edit View Function SmartMenu Tools Window Help

Report: DATAVISION READMISSION TOOLPACK

Report Type: Text

Output Device: File

Selection Criteria: DATAVISION READMISSION TOOLPACK - For DataVision Populations

Facility: Sparrow Memorial

Population for analysis: 140 Chronic obstructive pulmonary disease, Inpatient

Month range: From: 7/2011 To: 6/2013

Max. # of days in the readmission period (0-365): 90

INITIAL ENCOUNTERS

To exclude initial encounters with a discharge disposition equivalent to Death, mark the following checkbox:

Exclude death ☐

READMISSION ENCOUNTERS

Selections in this section override the measure definition for the readmission encounters included in the numerator population. For example, if you select an acute care measure for the Population for Analysis, such as All Acute Care Inpatients, and you mark Non-acute care readmissions, the numerator includes acute care and non-acute care readmissions. Mark at least one checkbox to specify the type of readmission encounters to be included.

Include encounter types:

Inpatient acute care ☒

Inpatient non-acute care ☐

Observation/short stay ☐

Emergency Department ☐

To exclude readmission encounters that have an admit status of Elective, mark the following checkbox:

Exclude elective readmissions ☒

If your Midas+ server has multiple facilities and you want to limit the readmission population to encounters returned to the same facility from which the initial encounter was discharged, mark the following checkbox:

Include readmissions only to the same facility ☒

To limit the readmission population to encounters that qualify for the same inclusion and exclusion criteria as the initial population, mark the following checkbox. To use this option, the selected indicator population must be defined by ICD-9 or DRG codes.

Include readmissions only with the same clinical condition ☒

## DV Readmission ToolPack



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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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## References

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- **How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations**. <http://www.noplacelikehomeaz.com/toolkit.html>
- H2H - <http://cvquality.acc.org/Initiatives/H2H.aspx>
- CMS Medicare Hospital Quality **Chartbook** September 2013
- Craig, C, Eby, D, Whittington J. **Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs**. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011
- **Hospital Strategies Associated With 30-Day Readmission Rates for Patients With Heart Failure** Circulation: Cardiovascular Quality and Outcomes. 2013; 6: 444-450
- **Fiscal Year 2013 Hospital Readmissions Reduction Program: Measure Methodology Report** Developed By Yale New Haven Health Services Corporation/ Center for Outcomes Research & Evaluation Prepared For: Centers for Medicare & Medicaid Services June 18, 2012
- **"Using Medical Homes to Reduce Readmissions"**; Center for Healthcare Quality and Payment Reform; [www.PaymentReform.org](http://www.PaymentReform.org)



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# Thanks for attending. Are there any questions?

John Playford, Senior Solutions Advisor  
Barb Craig, SaaS Advisor



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