A Call to Action: Readmission Strategies from the Field

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Brenda Pettyjohn, RN, CPHQ Solutions Advisor
Tina Esposito
Vice President, Center for Health Information Services
Advocate Health Care

- Responsible for system measurement and analytics in support of improved patient outcomes and organizational performance
- Responsibilities include data warehousing, HIM, and public data.
- Master in Business Administration
- Bachelor of Science degree in Health Information Management
- Certified Six Sigma Black Belt
Advocate Health Care

- Corporate offices in Downers Grove, Illinois
- More than 250 sites offering inpatient, outpatient services, home health services, hospice, counseling, physician services, and health care education programs
  - 12 hospitals, more than 3,300 beds
  - 11 acute care hospitals
  - 1 children’s hospital, with 2 campuses
- The state’s largest integrated children’s network
- The region’s largest medical group with more than 200 locations across metropolitan Chicago
Patty Toney RN, MSN
Vice President & Chief Nurse Executive
CHRISTUS Santa Rosa Health System

✓ Vice President and Chief Nurse Executive for a six hospital healthcare system in Santa Rosa, Texas
✓ Nursing Degree from Ball State
✓ Masters in Nursing Administration
✓ Former Chief Nursing Officer for McKenna Hospital in New Braunfels
✓ She has been a nurse for over 35 years and has practiced in Critical Care, Labor Delivery and as a House Supervisor for a large 500 bed teaching hospital in New Jersey.
Christus Health

- An international Catholic, faith-based, not-for-profit health system comprised of almost 350 services and facilities, including more than 60 hospitals and long-term care facilities, 175 clinics and outpatient centers, and dozens of other health ministries and ventures.

- CHRISTUS services can be found in over 60 cities in Texas, Arkansas, Iowa, Louisiana, Missouri, Georgia, and New Mexico in the United States, and Mexico.
Pamela Carroll-Solomon, MJ, RHIA, CPHQ, Director, Quality Services, Catholic Health East Trinity Health

- Director, Quality Services at CHE Trinity Health.
- Responsible for the MIDAS+ DataVision application since its implementation in 2009.
- Masters of Journalism
- Bachelors in Health Records Administration from Temple University
- CPHQ and Lean Six Sigma Black Belt
- Author of numerous publications on Quality and HIM related topics
- Member of NQF Readmission Action Team
- Just celebrated her 16th year at CHE
CHE Trinity Health

- Second-largest Catholic health care delivery system in the nation.
- Operate in 20 states from coast to coast with 82 hospitals, 88 continuing care facilities and home health and hospice programs that provide more than 2.3 million visits annually.
- Formed in May 2013, when Trinity Health and Catholic Health East completed their consolidation to strengthen their shared mission, increase excellence in care and advance transformative efforts with their unified voice.
NQF – Readmission Action Team

Promoting Person-Centered Care for Vulnerable Populations to Safely Reduce Avoidable (Re)admissions

**SYSTEMS IMPROVEMENT**
Share promising person-centered tools and resources

**COLLABORATION**
Leverage partnerships, networks, and relationships

**PATIENT AND FAMILY ENGAGEMENT**
Engage patients and families to catalyze change

**GOAL**
Reduce readmissions by 20 percent by:
- leveraging patient, provider, and community partnerships
- identifying and addressing psychosocial needs

Midas+ Annual Symposium
Clinical & Application Effectiveness

xerox®
## Advocate Care Model

<table>
<thead>
<tr>
<th>FROM...</th>
<th>TO...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silo care management</td>
<td>Population/enterprise care management</td>
</tr>
<tr>
<td>Episodes of care</td>
<td>Value-driven coordinated care</td>
</tr>
<tr>
<td>Discharges</td>
<td>Transitions</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Right care at the right place at the right time</td>
</tr>
<tr>
<td>Caring for the sick</td>
<td>Improving health status</td>
</tr>
<tr>
<td>Production (volume)</td>
<td>Performance (value/lower cost)</td>
</tr>
</tbody>
</table>
CHRISTUS Santa Rosa Care Transitions Program

- Trademarked program designed by Eric Coleman MD, MPH  www.caretransitions.org
- Started in 2009 at St. Michael's in Texarkana and then at SPOHN in Corpus Christi in 2010
- Santa Rosa implemented in October 2013 at one of three adult hospitals. Now have CTN in each adult hospital
- Focus on: AMI, HF and PN
- Goal: 10% reduction in re-admit by end of Year 1
In a Nutshell....

• Care Transitions Nurse (CTN) reviews census each morning for AMI, HF or PN diagnosis or related symptoms.

• Visits patient and family, explains program, obtains consent to enroll.

• Works w patient and family while in hospital to prepare for discharge

• Makes 1 home visit within 48 hrs of discharge

• Makes two F/U telephone calls for total program length of 30 days

• “Hands off” patient to primary care provider at end of 30 days
Patient Engagement
## CHE’s Approach – Readmissions Task Force

### Use of data to drive improvements
- In-depth analysis (DataVision Toolpack)
- Readmission penalty projection calculations
- Kept abreast of HEN activities, public release of data
- Use various MIDAS reports (DV Toolpack, APRDRG reports, new readmission reduction metrics)
- Inpatient satisfaction with discharge information received

### Cross-continuum collaboration
- **SNF**
  - Use of Interact tool
  - Partnering with hospitals to improve care transitions
  - Residents/Family Teaching on resources at facility level
  - CMMI grant on care transitions
- **Home Care**
  - Front-loading of visits
  - Partnering with other providers to improve care transitions
  - Use of telemedicine

### Person-centered care
- Integrate hospitalists and residents into daily operations related to readmissions
- Importance of palliative care referrals
- Teach back
- Partnering with community pharmacies for delivery of home meds prior to discharge

### Leveraging technology
- Created reports to assist/automate medication reconciliation
- Monitor recording of discharge instructions
- Use telemonitoring

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*Image with flowchart and bullet points representing the approach to readmissions.*
<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard indicators for CMS readmissions reduction program for timeframe of penalty year</td>
<td>Obtain preview reports, specifically rate data</td>
<td>From most recent IPPS final rule</td>
<td>Calculation: 1 – actual penalty factor (from prior year)</td>
<td>Calculation: ( \frac{\text{Projected FY Midas data}}{\text{Prior FY penalty factor}} )</td>
<td>From most recent IPPS final rule</td>
<td>From most recent IPPS final rule</td>
<td>Calculation: ( \frac{\text{projection FY estimated penalty factor}}{\text{Most current FY cost report DRG payments}} )</td>
<td>Calculation: (Adjusted DRG payments) – (Most current FY cost report DRG payments)</td>
</tr>
<tr>
<td>Calculation: ( \frac{\text{sum of nums}}{\text{sum of denoms}} ) * 100</td>
<td>Calculation: ( \frac{\text{sum of nums}}{\text{sum of denoms}} )</td>
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**CHE Readmission Penalty Projections**
Observational Care Units
& Retail Health Clinics
Leveraging EMR Technology
Cohort description:

- 192 K people with hospitals encounters
- 8 hospitals in Chicago-land area
- Analyzed observation, medical, and surgical patients
- Considered all conditions except mental health

Please Note: The examples provided are intended to show a representation of the many variables analyzed in the model which is still under development and should not be interpreted as statistically significant predictors for a readmission.
Readmission Solution Workflow

- Identify
- Notify
- Assess
- Intervene

MPage
Discern Alerts
PowerForms
Readmission Plan of Care
Discharge Checklist

Orders for Signature
- Plans
  - Nursing
    - Readmission Prevention Adult IPIC (Initiated)
- Suggested Plans (3)
  - Nursing
    - Fall Prevention and Management: EBN Adult PowerPlan (05)
    - Readmission Prevention Adult IPIC
      - Plan Suggestion: Readmission Prevention Adult IPIC
        - Suggested On: 05/13/2014 02:51

Interventions
- Education AMI
- Education Heart Failure
- Education Pneumonia
- Education COPD
- Education Readmission Prevention

Scheduled Patient Care

<table>
<thead>
<tr>
<th>Scheduled Date and Time</th>
<th>Task Status</th>
<th>Task Description</th>
<th>Mnemonic</th>
<th>Order Details</th>
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<tbody>
<tr>
<td>05/13/2014 8:41</td>
<td>Pending</td>
<td>Education Heart Failure</td>
<td></td>
<td>05/13/14 8:41:00</td>
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<tr>
<td>05/13/2014 8:41</td>
<td>Pending</td>
<td>Education Readmission Prevention</td>
<td></td>
<td>05/13/14 8:41:00</td>
</tr>
<tr>
<td>05/13/2014 12:35</td>
<td>Pending</td>
<td>PRN Response</td>
<td></td>
<td>05/13/14 21:47:00, Routine, Tab CAUTION: Look sound elite med.</td>
</tr>
<tr>
<td>05/13/2014 16:00</td>
<td>Pending</td>
<td>Confusion Assessment Method (CAM)</td>
<td></td>
<td>05/13/14 16:00:00</td>
</tr>
</tbody>
</table>
How to Manage High-Risk Patients
A Qualitative Analysis Example

**Issue:** How to address a “highly satisfied patient”

**Response:**
- Aligned with philosophy of doing the right thing for the patient at the right time
- Worked with patient to assign a primary care team in ED
- Cut visits from 30 ED visits, 31 admissions, 24 readmits/year to 5 admissions, 1 readmission, no ED visits in next year!!
CHE Results

Applying person-centered interventions leads to less readmissions and better quality of life.

Exceeded goal of 20% reduction over 3 years but now seeing rehab.

Vision 2017

A.C.T.

PfP: 20% Reduction over 3 years

Saved 1464

Saved 2388

Saved 1988

2006 2009 2010 Baseline = 1594 per month 2011 Year 1 2012 Year 2 2013 Year 3

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Outcomes

• Leading the industry
  • ~ 20% better than industry (Yale, LACE, etc.)
  • Solution purchased by 120 non-Advocate Cerner clients

• Gaining efficiency
  • ~ 3.5 FTE productivity savings across system
  • Automated continuous calculation of risk score in EMR

• Reducing readmissions
  • 20% reduction in readmission rates (for high risk patients that received interventions)
  • Statistically significant reductions observed for sub-populations (e.g., COPD and HF)
Readmission Penalty Trend

Dollars (millions)

$ Lost  $ Earned Back  $ at Risk  Readmission Rate

2009: 12.4  0  0  12.4
2010: 11.8  0  0  11.8
2011: 11.3  0  0  11.3
2012: 10.4  0  0  10.4
2013*: 10.1  0  0  10.1
2014: $17.0  0  0  17.0

$ at Risk

2009: $1.8  0  0  1.8
2010: $2.9  0  0  2.9
2011: $2.1  0  0  2.1
2012: $9.4  0  0  9.4
2013*: $10.1  0  0  10.1
2014: $17.0  0  0  17.0

Readmission Rate (%)
CHRISTUS Observations from the field…

• Medication reconciliation and polypharmacy is single biggest problem/challenge
• Linking patient to pc provider before discharge from hospital is high priority
• Visit to the home is invaluable for identifying socio-economic issues
• That said, single biggest reason for refusal to participate is the home visit – telemonitoring option needed!
• CTN works closely with CM to identify potential program candidates
CHRISTUS Santa Rosa - New Braunfels
AMI Readmission Rates FY2014
(Any Payer, Any Diagnosis)
CHRISTUS Santa Rosa - New Braunfels
Heart Failure Readmission Rates FY2014
(Any Payer, Any Diagnosis)

New Braunfels
Linear (New Braunfels)
CHRISTUS Santa Rosa - New Braunfels
Pneumonia Readmission Rates FY2014
(Any Payer, Any Diagnosis)

- New Braunfels
- Linear (New Braunfels)
Next steps at CHRISTUS….

• Using Midas+ to automate data collection and drill down into demographics, medical history etc. for risk stratification and improved analytics

• Introduce telemonitoring as an intervention option

• Create screening criteria for applying right intervention, at the right time, for the best outcome

• Expand scope of program to include other at risk for re-admit populations such as COPD and diabetes

• Expand program to include post acute facilities - SNF’s, nursing homes, etc.

• Incorporate Care Transitions program into clinically integrated network of medical homes to build a true coordinated model of care
Socioeconomic Variables

- General socioeconomic, cultural and environmental conditions
- Living and working conditions
- Social and community networks
- Individual lifestyle factors
  - Age, Sex and hereditary factors

- Education
- Agriculture and food production
- Work environment
- Unemployment
- Water and sanitation
- Health care services
- Housing
Questions and Shared Learning
We Wish to Thank All Our Midas Clients For Their Support!

See You Tonight at the Party!!

Vicky Mahn-DiNicola, VP Research & Market Insights, Midas+

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