A Call to Action: Readmission Strategies from the Field

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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

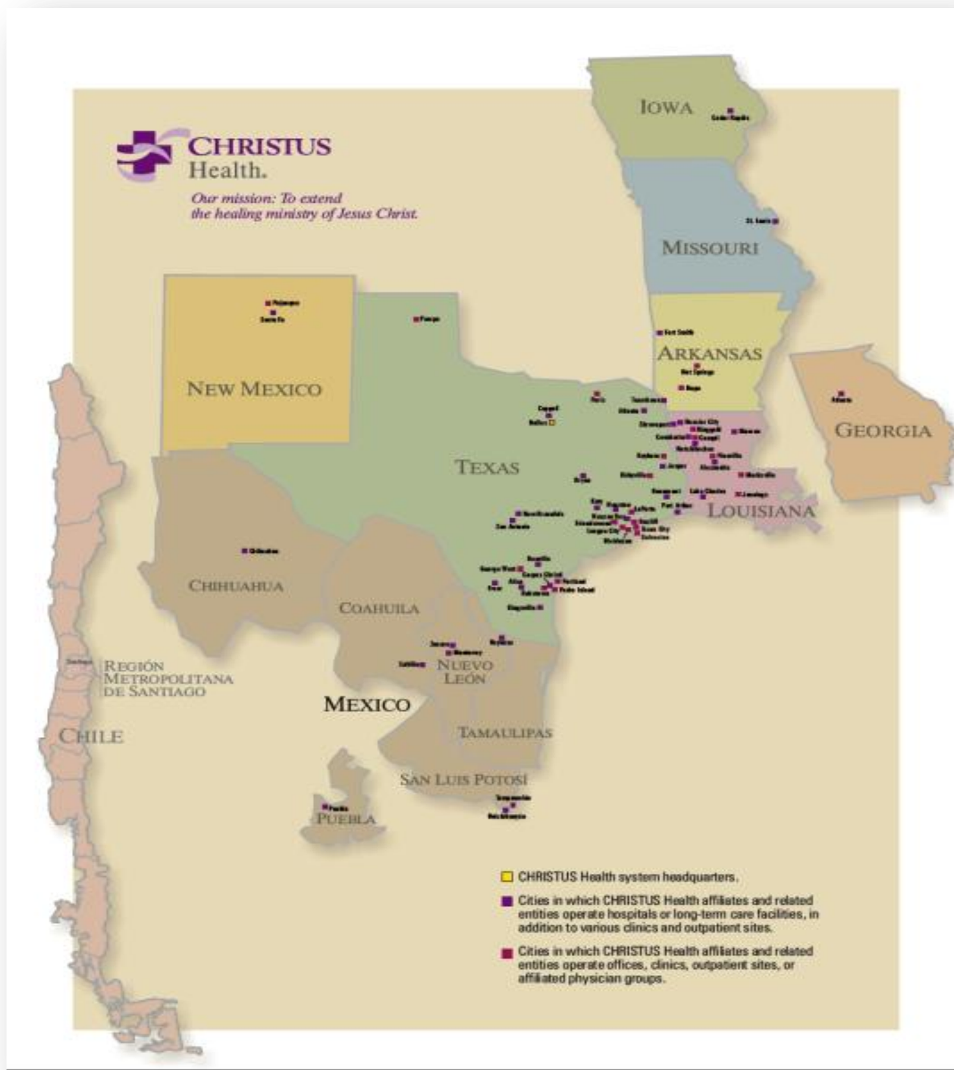
Midas+ Annual Symposium
Clinical & Application Effectiveness

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



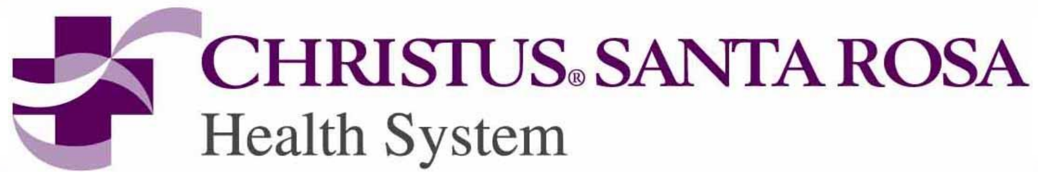
- An international Catholic, faith-based, not-for-profit health system comprised of almost 350 services and facilities, including more than 60 hospitals and long-term care facilities, 175 clinics and outpatient centers, and dozens of other health ministries and ventures.
- CHRISTUS services can be found in over 60 cities in Texas, Arkansas, Iowa, Louisiana, Missouri, Georgia, and New Mexico in the United States, and Mexico.

EMERGENCY CENTER
CHRISTUS
SANTA ROSA
EMERGENCY

CHRISTUS
SANTA ROSA

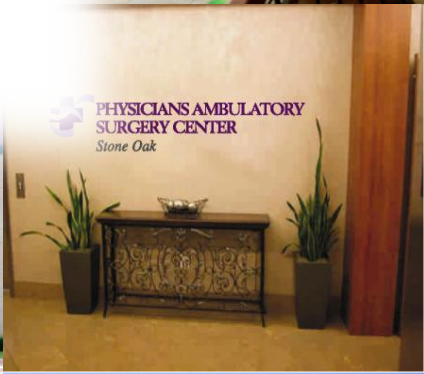
CHRISTUS SANTA ROSA
Physicians Ambulatory Surgery Center - Ewing Halsell

CHRISTUS SANTA ROSA
Physicians Ambulatory Surgery Center - Alamo Heights II


CHRISTUS® SANTA ROSA
Health System

CHRISTUS SANTA ROSA

CHRISTUS SANTA ROSA


PHYSICIANS AMBULATORY
SURGERY CENTER
Stone Oak

CHRISTUS
SANTA ROSA
Hospital
New Braunfels

CHRISTUS Santa Rosa

CHRISTUS SANTA ROSA
Hospital-Alamo Heights

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

Advocate Care Model

FROM...	TO...
Silo care management	Population/enterprise care management
Episodes of care	Value-driven coordinated care
Discharges	Transitions
Utilization Management	Right care at the right place at the right time
Caring for the sick	Improving health status
Production (volume)	Performance (value/lower cost)

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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CHE Readmission Penalty Projections

FY15 MIDAS data (rate)	FY14 QNet data (rate)	FY14 CMS Penalty Factor	FY14 Penalty (1-factor)	FY15 Estimated Penalty Factor	FY15 Estimated Penalty Factor	Adjusted DRG Payment	FY12 Cost Report DRG Payments	Adjusted DRG Payments	FY15 Potential Readmission Impact
Standard indicators for CMS readmissions reduction program for timeframe of penalty year Calculation: (sum of nums)/ (sum of denoms) * 100	Obtain preview reports, specifically rate data Calculation: (sum of nums)/ (sum of denoms) * 100	From most recent IPPS final rule	Calculation: 1 – actual penalty factor (from prior year)	Calculation: (Projected FY Midas data) x (Prior FY penalty factor)/(prior FY Qnet data)	Calculation: 1 – FY15 estimated penalty factor	From most recent IPPS final rule	From most recent IPPS final rule	Calculation: (projection FY estimated penalty factor) x (Most current FY cost report DRG payments)	Calculation: (Adjusted DRG payments) – (Most current FY cost report DRG payments)

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Observational Care Units & Retail Health Clinics

Leveraging EMR Technology

Readmission Model Framework

Readmission Risk Factors Analyzed > 700

Medications
e.g.,
Past & Present Medications, Polypharmacy

Conditions
e.g.,
Past & Present Conditions (ICD-9-CM)

History & Physical Exam
e.g.,
Vitals, Body Mass Index, etc.

Procedures
e.g.,
Past & Present Procedures (ICD-9-CM)

Utilization
e.g.,
Number of visits past 6 & 12 months, etc.

Lab Tests
e.g.,
Past & Present Lab Results

Demographics & Social
e.g.,
Age, Gender, Race, etc.

Exploratory
e.g.,
Environmental, Interactions, etc.

30-Day Readmissions

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.

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

Advocate Health Care

Readmission Solution Workflow

Identify → Notify → Assess → Intervene

MPage → Discern Alerts → PowerForms → Readmission Plan of Care

Discharge Checklist

View
- Orders for Signature
- Plans
  - Nursing
    - **Readmission Prevention Adult IPOC (Initiated)**
- **Suggested Plans (3)**
  - Nursing
    - Fall Prevention and Management EBN Adult PowerPlan (05/
    - Readmission
    - VTE Prevent

Plan Suggestion: Readmission Prevention Adult IPOC
Suggested On: 05/13/2014 02:51

Initiate Accept Reject

	$		Component	Status	Dose ...	Details
Readmission Prevention Adult IPOC Suggested On: 05/13/2014 02:51						
Outcomes						
☑			Readmission Risks Addressed			By Phase End
Interventions						
☐			Education AMI			
			Education Heart Failure			
			Education Pneumonia			
			Education COPD			
☑			Education Readmission Prevention			

Scheduled Patient Care | Continuous Tasks | PRN Tasks

Task retrieval completed

Scheduled Date and Time	Task Status	Task Description	Mnemonic	Order Details
05/13/2014 8:41	Pending	Education Heart Failure	Education Heart Failure	05/13/14 8:41:00
05/13/2014 8:41	Pending	Education Readmission Prevention	Education Readmission Prevention	05/13/14 8:41:00
05/13/2014 12:35	Pending	PRN Response	morphine (morphine oral 15 mg tablet (MSIR)) (Morphine 15 mg IR tab)	15 mg = 1 tab, Oral, Q4hr, PRN pain, 05/12/14 21:47:00, Routine, Tab CAUTION: Look/sound-alike med.
05/13/2014 16:00	Pending	Confusion Assessment Method (CAM)	Confusion Assessment Method (CAM)	05/13/14 16:00:00

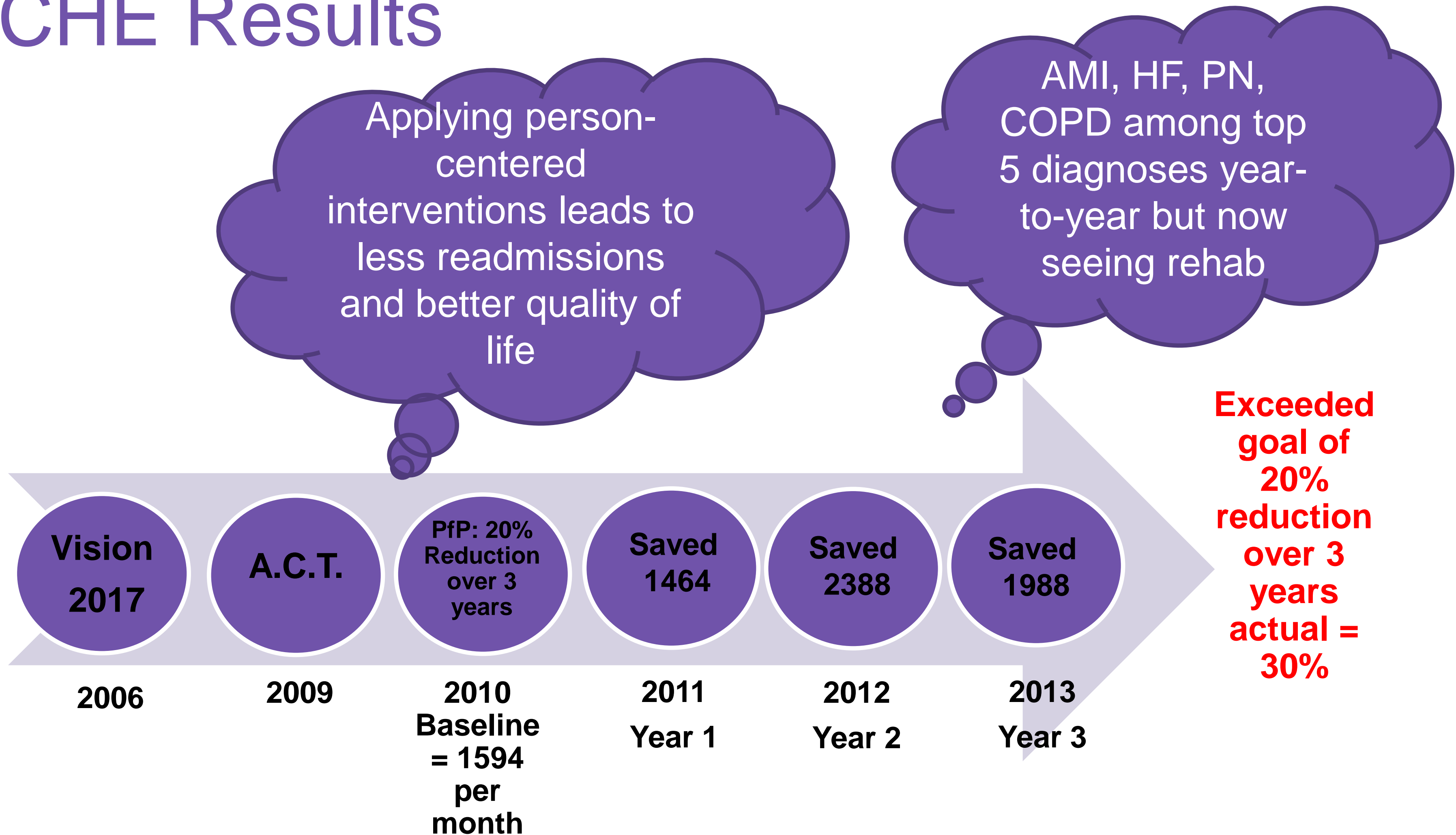
How to Manage High-Risk Patients A Qualitative Analysis Example

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!!

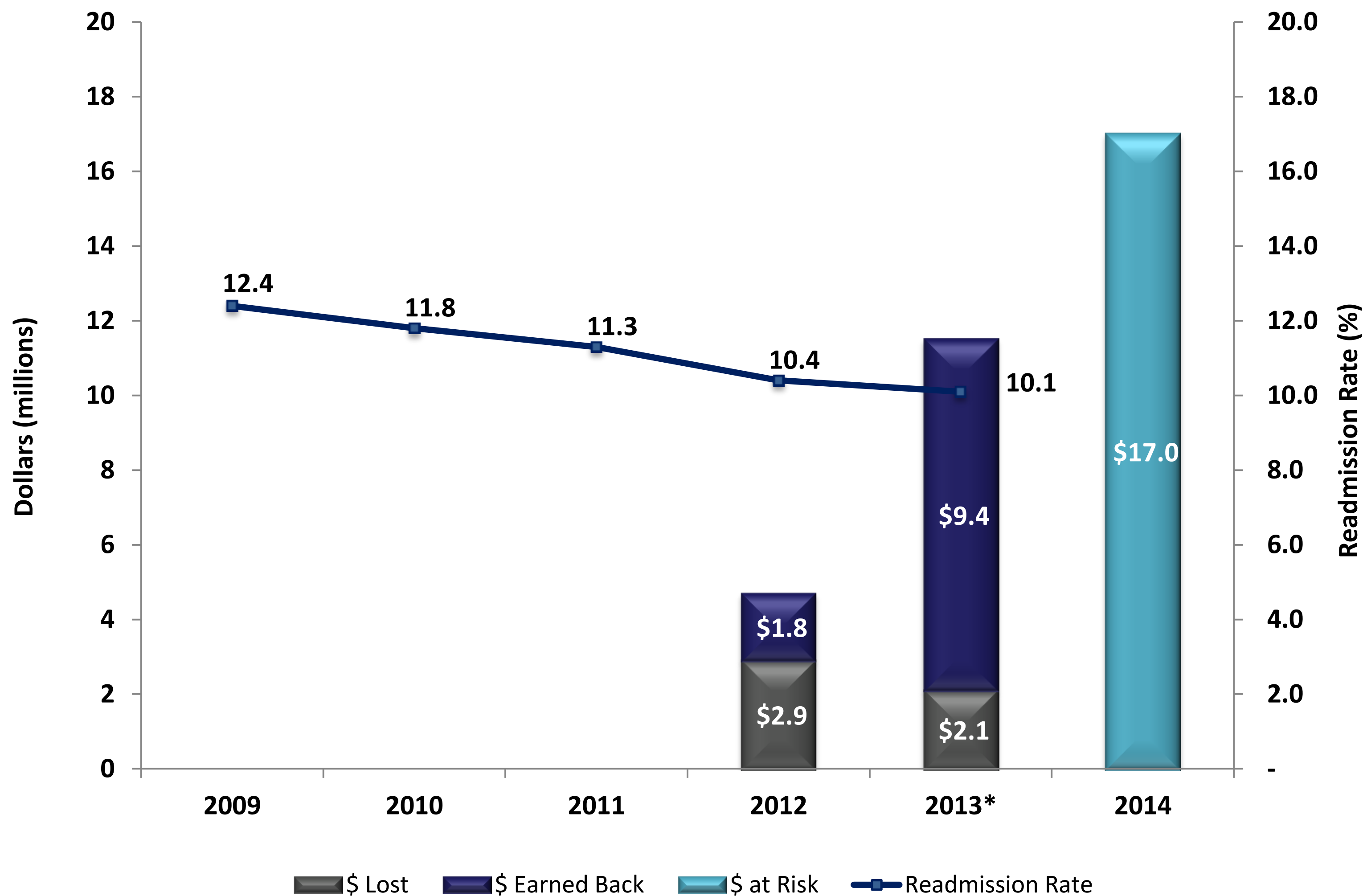
CHE Results



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



Advocate Health Care

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

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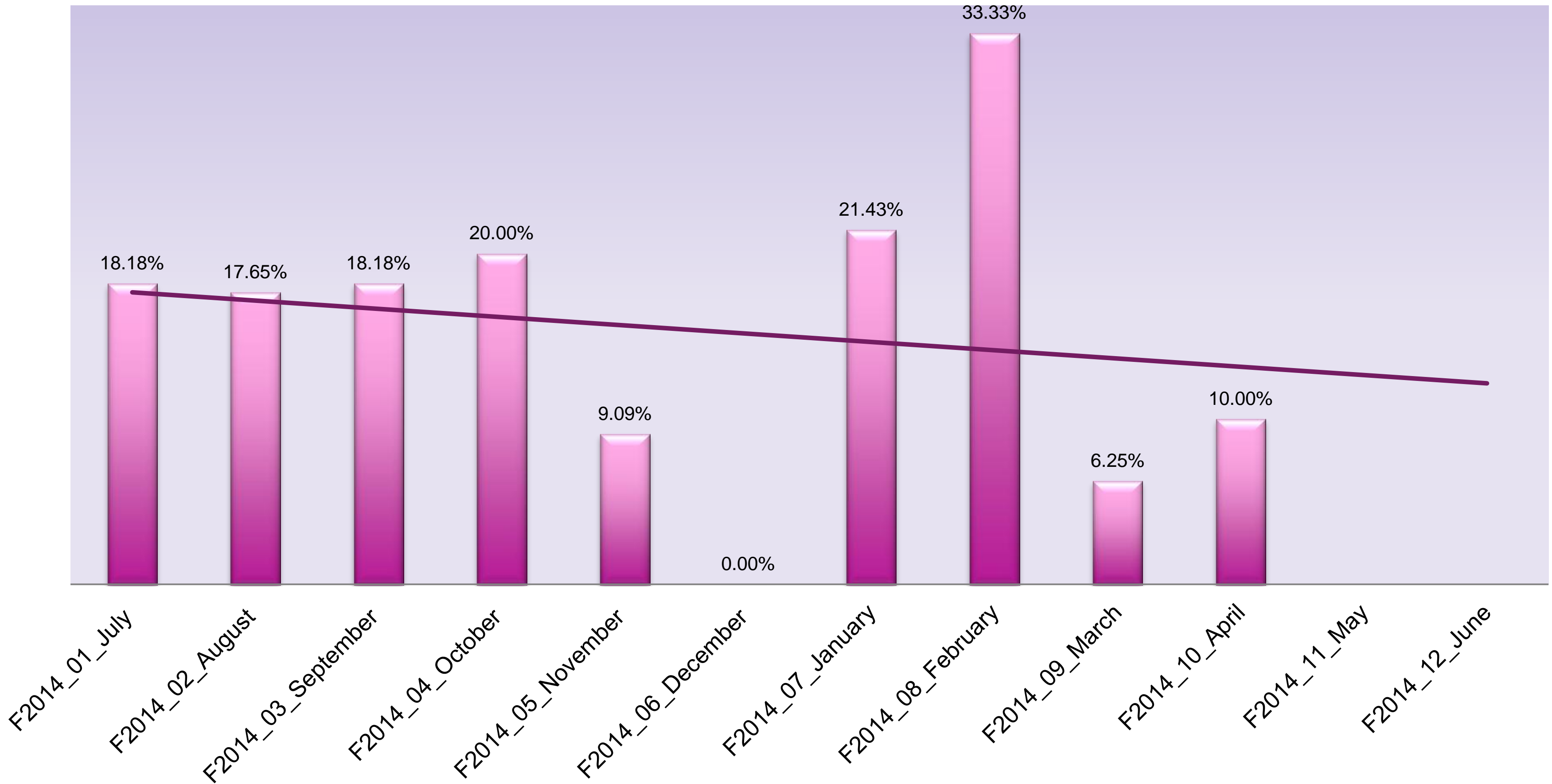
CHRISTUS Santa Rosa - New Braunfels
AMI Readmission Rates FY2014
(Any Payer, Any Diagnosis)

CHRISTUS Santa Rosa - New Braunfels
Heart Failure Readmission Rates FY2014
(Any Payer, Any Diagnosis)



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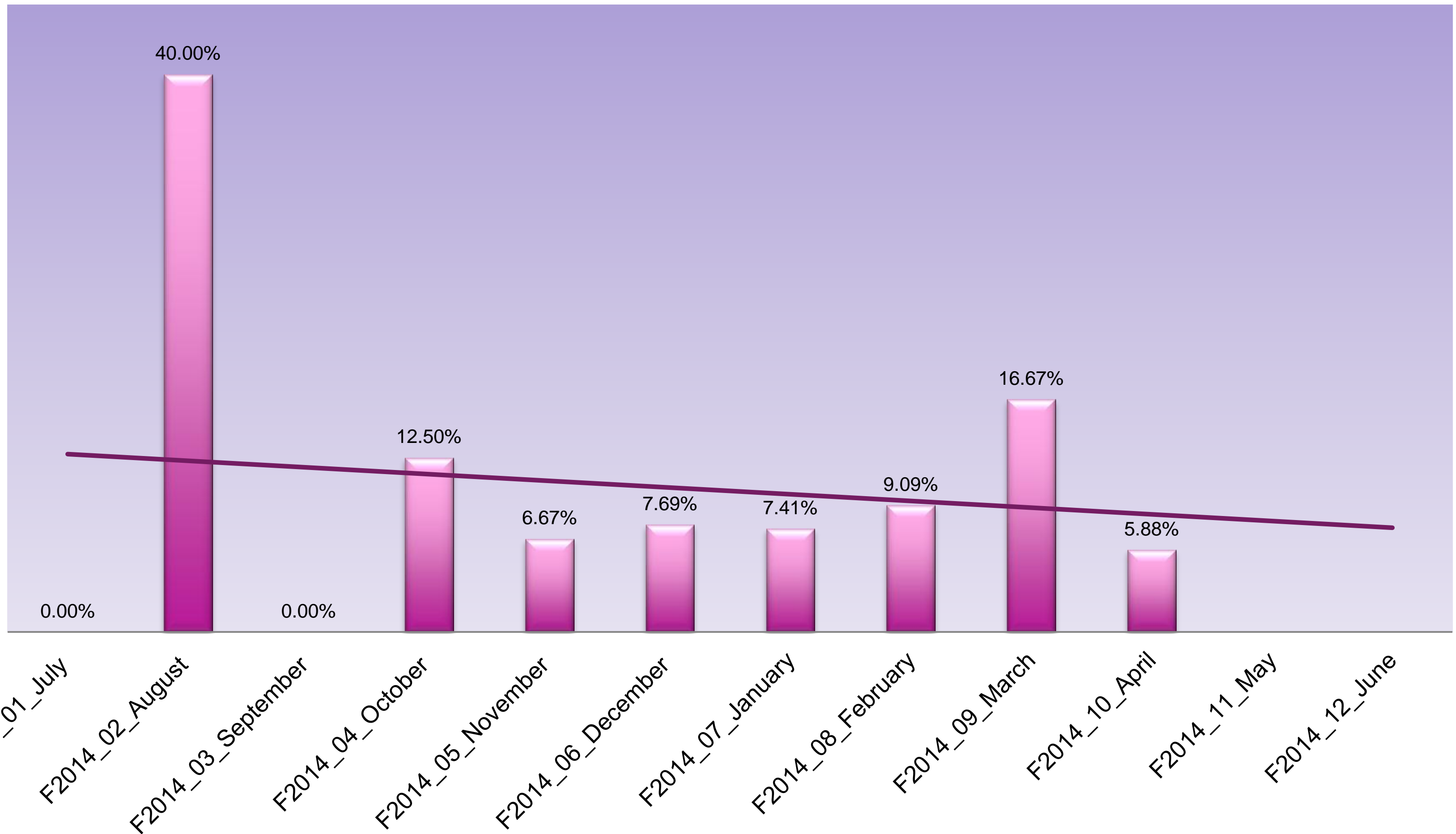
CHRISTUS Santa Rosa - New Braunfels Pneumonia Readmission Rates FY2014
(Any Payer, Any Diagnosis)



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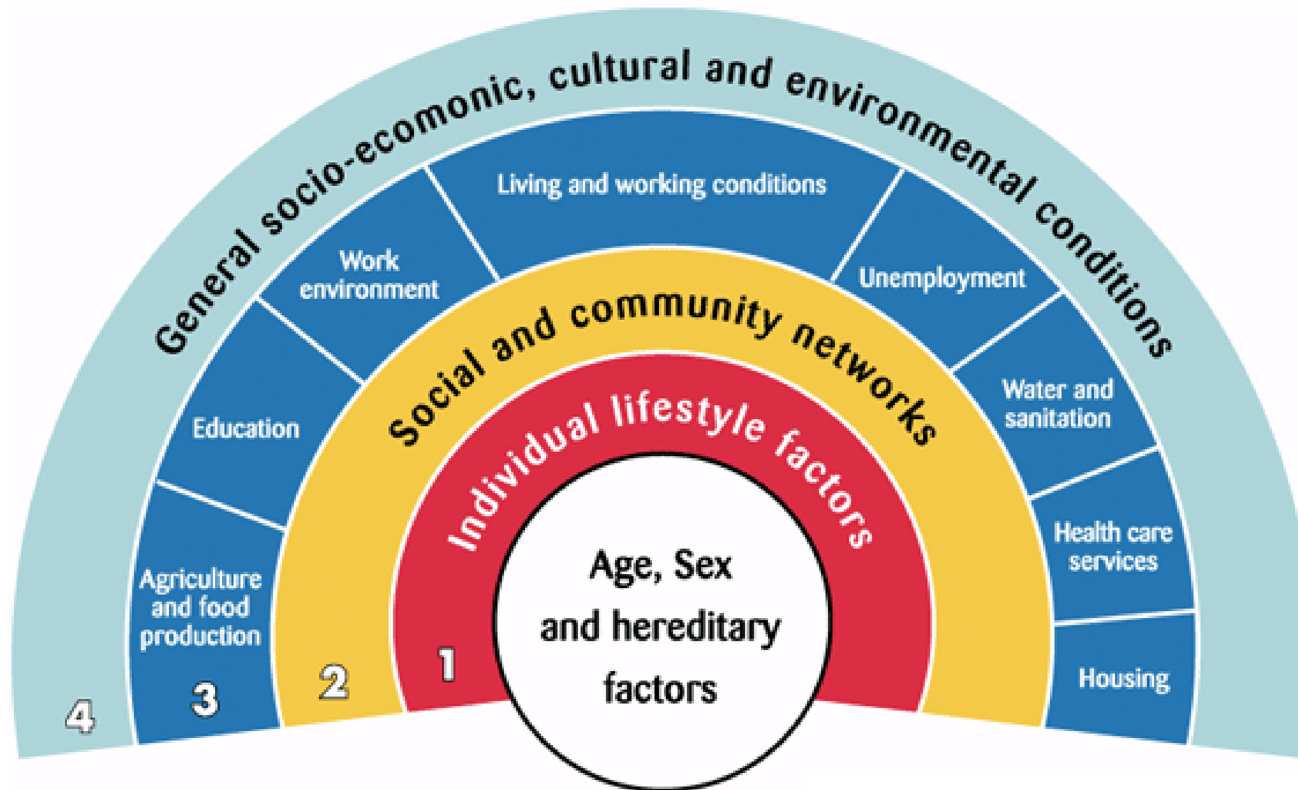
Next steps at CHRISTUS….

- 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



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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+

Brenda Pettyjohn, Solutions Advisor, Midas+

Tina Esposito, VP Center for Health Information Services, Advocate Health Care