HOUSEKEEPING ITEMS

- Please enter your AUDIO PIN
- To communicate with speakers, please use the “chat” function;
- Ask questions at any time.
- Webcast will be recorded.
TODAY’S AGENDA

- Preventing Readmissions
  Jamie Grebosky, MD - VPMA Asante Rogue Regional Medical Center

- Hospital Case Studies

- Resources
  - PPR Data Base – Mark Christman
  - Other Resources – AHRQ, IHI, Hospital Associations, HRET, etc.
Readmissions: One Hospital’s Journey So Far

Jamie Grebosky, MD

OAHHS Presentation

July 29, 2015
What We Will Cover

The problem(s)
Getting started
Resources needed
Pearls/Pitfalls
30-day Readmissions to Same Hospital or Elsewhere

- Hospital
- National: 80th Percentile
- Jurisdiction: 80th Percentile
- State: 80th Percentile
# The Problem(s)

## Hospital Readmission Reduction Program

<table>
<thead>
<tr>
<th>VBP Year</th>
<th>% Hospital Penalized</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>64%</td>
<td>$227 Million</td>
</tr>
<tr>
<td>14</td>
<td>66%</td>
<td>$290 Million</td>
</tr>
<tr>
<td>15</td>
<td>78%</td>
<td>$428 Million</td>
</tr>
</tbody>
</table>
Pearls/Pitfalls

• Multidisciplinary Team
• Case reviews
• Transitions of care visit
• Post DC case management
  – Follow up management
    • PCP/specialist appts
    • DC summary in PCP / specialist hands
    • Lab/Rads/Med reconciliation
    • Teach Back/education
    • Patient experience calls
    • In house CM
    • Ambulatory CM

Measure Name: 30 Day Readmissions - Heart Failure (HF)

Formula: (Note exclusions: readmissions for planned procedures)

Numerator: Number of 30 day readmissions each category
Denominator: Total number of discharges with HF primary diagnosis/procedure codes

Historical Results: Roll-up View (Final Sep-13 to Aug-14 Performance)

30-Day Readmission Rate for HF

Weight Factor 23%

<table>
<thead>
<tr>
<th>Month</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-13</td>
<td>2.111111111</td>
</tr>
<tr>
<td>Oct-13</td>
<td>1.119047619</td>
</tr>
<tr>
<td>Nov-13</td>
<td>0.161290323</td>
</tr>
<tr>
<td>Dec-13</td>
<td>0.125</td>
</tr>
<tr>
<td>Jan-14</td>
<td>0.133135135</td>
</tr>
<tr>
<td>Feb-14</td>
<td>0.06895517</td>
</tr>
<tr>
<td>Mar-14</td>
<td>0.127659574</td>
</tr>
<tr>
<td>Apr-14</td>
<td>0.127725857</td>
</tr>
<tr>
<td>May-14</td>
<td>0.222222222</td>
</tr>
<tr>
<td>Average</td>
<td>0.127725857</td>
</tr>
</tbody>
</table>

Benchmark Source: Premier Top Quartile/Top Decile

Target: FY14

Analysis of Data: HF readmissions for FY14 through May (n=321) are above the ≤11.76% target at 12.8%. Readmission rates increased from 12.8% in April (n=47) to 22.2% in May (n=27). Subcommittees are performing case reviews to identify and follow trends. Analysis revealed an association between heart failure readmissions and high risk patients not receiving condition appropriate care, the absence of a follow-up appointment prior to discharge, and the absence of follow-up within 3 days of discharge. Action plans in place and trends continue to be followed.

Action Plans

- Focus efforts on making follow up appointments prior to discharge
  - DC Units: Dec-13 - Follow up with unit secretaries/staff on scheduling and documenting follow up appointment

- Discuss outcomes with Cardiologists at section meetings

- Implement Risk Assessment Tool
  - J. Grebrosky, Abrams, R. Schaefer: Apr-14 - Refine tool for Cardiac Educators to use

- Modify stoplight teaching tool for discharge instructions. Patient education for zones and calendar for daily weights.
  - Abrams, R. Schaefer: Apr-14 - Refine existing tool

- Utilize Lincare follow up option
  - J. Grebrosky, D. Wipf: Dec-13 - Following high risk population for continued follow up at home. Proactive approach to assess needs and provide care following discharge

Asante Reporting Template

Protected as peer review data under ORG 41.675; not to be disclosed voluntarily or involuntarily
Pearls/Pitfalls

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Case Reviews

Here is today’s list: 19

Number of re-admits within 30 days: 3

Potential goals of care discussions: 11
Potential pulmonary services: 2
Potential telehealth services: 6

Thanks!
Betty
Pearls/Pitfalls

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AAFP Frequently Asked Questions
Transitional Care Management

Pearls/Pitfalls

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Discharge Phone Calls
Pearls/Pitfalls

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## Teach-Back in Heart Failure Patient Education

<table>
<thead>
<tr>
<th>Cycle 1</th>
<th><strong>Teach-Back in Heart Failure Patient Education</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>EPIC</td>
<td><strong>Document</strong> the learner’s responses as a progress note.</td>
</tr>
<tr>
<td><strong>ID Key Learner</strong></td>
<td><strong>Identify the key learner.</strong> The learner may be the patient, if not ask if they can be present for education.</td>
</tr>
<tr>
<td></td>
<td>• Who assists you with your medications at home?</td>
</tr>
<tr>
<td></td>
<td>• Who accompanies you to doctor appointments?</td>
</tr>
<tr>
<td></td>
<td>• Who should be present to listen to your discharge instructions?</td>
</tr>
<tr>
<td><strong>Pre-Test</strong></td>
<td><strong>Prior to providing education, assess baseline knowledge:</strong></td>
</tr>
<tr>
<td></td>
<td>• What is heart failure?</td>
</tr>
<tr>
<td></td>
<td>• What will make your heart failure worse?</td>
</tr>
<tr>
<td></td>
<td>• Why is it important to take your medications?</td>
</tr>
<tr>
<td><strong>Educate</strong></td>
<td><strong>Using the Heart Failure Portfolio, discuss the nine points of “Living Well with Heart Failure” emphasizing:</strong></td>
</tr>
<tr>
<td></td>
<td>• How to weigh daily and document on the calendar.</td>
</tr>
<tr>
<td></td>
<td>• Sodium restricted diet.</td>
</tr>
<tr>
<td></td>
<td>• Symptom and zone identification.</td>
</tr>
<tr>
<td></td>
<td>• Calling their physician with <strong>any</strong> “yellow zone” sign or symptom.</td>
</tr>
<tr>
<td></td>
<td>• Bringing the calendar to follow-up appointments.</td>
</tr>
</tbody>
</table>
| Day 1 | **Assess post-education knowledge** and clarify as needed.  
*What:*  
- Is the name of your diuretic/water pill?  
- Amount of weight gain should you call the doctor about?  
- Foods will you need to avoid or limit because of your heart failure?  
- Symptoms you have with heart failure?  
- What does it mean when you are in the “yellow zone”? |
| Day 2 | **Assess the learner’s attitude** about self-management and promote self-efficacy.  
**Why is it important for you to:**  
- Take your diuretic/water pill?  
- Weigh yourself every day?  
- Eat a low sodium diet?  
- Check for symptoms of heart failure?  
- Call your doctor if you are in the “yellow zone”? |
| Day 3 | **Assess and support the learner’s plans to make behavioral changes.**  
**How will you:**  
- Remember to take your medications?  
- Remember to weigh daily?  
- Maintain a low sodium diet?  
- Check for symptoms of heart failure?  
- Show your doctor that you are taking good care of yourself? |
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What I Hope We Covered

The problem(s)
Getting started
Resources needed
Pearls/Pitfalls
PREVENTING READMISSIONS

Hospital Presentations

• Sky Lakes Medical Center
  » Molly Jespersen, Director of Care Management and NonEmergent Medical Transportation
  » Eric Weathersbee, Director of Home Health
  » Laurie Gurske, Director of Quality Management

• Salem Hospital
  » Erin Redling, Kaizen Clinical Nurse Consultant
  » Adam Sanchez, Supervisor Care Management
Collaboration and communication

Data

Pre-discharge

Post-discharge
Pre-Discharge
- Communicate estimated discharge date
- Daily communication between Case Management and Home Health

Post-Discharge
- Discharge summary dictated and transcribed within 24 hours
- Hospitalist attempts to contact PCP
- Hospitalists seeing selected patients within 5 days of discharge
- Connect calls
- Case Management contacts high risk patients to review discharge instructions
- Family Medicine Residency Clinic contacting their patients within 72 hours
- Community Case Management for selected high risk patients
- Non-Emergency Medical Transportation
Challenges

- Primary care appointments

Future plans

- Expand Community Case Management services
- Improve discharge instructions
Thoughts and ideas

- Senior Management support
- Community and internal resources
- Paradigm shift
SALEM HOSPITAL

Readmissions
- Readmission assessment (patient’s perspective)
- Palliative Care Test Of Change (TOC)
- Transitional Care group (SNF partnership)

Tools used
- Kaizen Promotion Office (KPO) support
  - Lean methodology
- Business Intelligence (BI) support
  - Rapid Improvement Event (RIE)
  - Reporting from EMR
SALEM HOSPITAL

What went well:

• Team collaboration and participation (BI, KPO, MD, Care Management, Nursing, Leaders etc.)
• New data source for root cause of readmissions

Opportunities for improvement

• Refinement of root cause analysis (true gaps)
• Early assessment of workload capacity within Test Of Changes
• Early identification of data support needs/analysis
SALEM HOSPITAL

- Discussion of, or plans for, collaborative work with your community
  - Continued collaborative relationship with SNFs
  - Community PCP collaborative efforts
  - Formed relationships with HH agencies
  - Formulation of Transitional Care clinic
SALEM HOSPITAL

Key learning and ideas for others to consider:

- Continued/formalized partnerships with community (continuum of care)
- Get patient’s/families/care giver perspective and use concurrently in plan of care
- No single solution to readmissions work. Multi-disciplinary, ongoing, shared responsibility.
RESOURCES: APPRISE READMISSIONS TOOL

Apprise Readmissions Tool

- Tool to be provided to all DRG hospitals for internal use to reduce readmissions.
- Contains PHI – patient names and other confidential data - please do not release outside your organization.
RESOURCES: APPRISE READMISSIONS TOOL

- Quarterly report from hospital discharge data
- Potentially Preventable Readmissions
- Includes readmissions to other hospitals
RESOURCES: APPRISE READMISSIONS TOOL

- Readmission chains
- Relative comparison groups
- Drilled down to claims level data

For questions about the tool, please contact Mark Christman at 503-479-6017 or email mark.christman@apprisehealthinsights.com
OTHER READMISSION RESOURCES

AHRQ:

  Thirty-day all-cause hospital readmissions at the Department of Veterans Affairs Palo Alto (CA) Health Care System dropped 30 percent after administrators and clinicians implemented AHRQ's Re-Engineered Discharge (RED) Toolkit. Readmission rates fell to less than 9 percent after ranging between 14 and 16 percent before the toolkit was adopted.*****

OTHER READMISSION RESOURCES

IHI


• IHI: [http://www.ihi.org/Topics/Readmissions/Pages/default.aspx](http://www.ihi.org/Topics/Readmissions/Pages/default.aspx)

• IHI Initiative: [http://www.ihi.org/Engage/Initiatives/Completed/STAAR/Pages/default.aspx](http://www.ihi.org/Engage/Initiatives/Completed/STAAR/Pages/default.aspx)

• IHI – 11 resources with star ratings: [http://www.ihi.org/resources/pages/ViewAll.aspx?FilterField1=IHI_x0020_Content_x0020_Type&FilterValue1=038f90e0-a18e-4460-a5ea-d29ae9817b3b&Filter1ChainingOperator=Or&FilterField2=IHI_x0020_Topic&FilterValue2=4d236ba3-cab6-4dd5-a1fc-0f593e0675b9&Filter2ChainingOperator=Or&TargetWebPath=/resources](http://www.ihi.org/resources/pages/ViewAll.aspx?FilterField1=IHI_x0020_Content_x0020_Type&FilterValue1=038f90e0-a18e-4460-a5ea-d29ae9817b3b&Filter1ChainingOperator=Or&FilterField2=IHI_x0020_Topic&FilterValue2=4d236ba3-cab6-4dd5-a1fc-0f593e0675b9&Filter2ChainingOperator=Or&TargetWebPath=/resources)

• Health Leaders Media (link from IHI website): [http://www.healthleadersmedia.com/page-1/QUA-260658/12-Ways-to-Reduce-Hospital-Readmissions](http://www.healthleadersmedia.com/page-1/QUA-260658/12-Ways-to-Reduce-Hospital-Readmissions)
OTHER READMISSION RESOURCES

- Oregon and Washington hospital associations
  - OAHHS: [http://www.oahhs.org/readmissions](http://www.oahhs.org/readmissions)
  - Washington State Hospital Association Readmissions toolkit (created for their HEN for Partnership for Patients)
OTHER READMISSION RESOURCES

➢ HRET-HEN


OTHER READMISSION RESOURCES

Other sources


• National Readmissions Certification website (shared by one of our hospital who recently attended a seminar): http://www.readmissionscertified.com/
OTHER READMISSION RESOURCES –
FROM AHRQ INNOVATIONS EXCHANGE


QUESTIONS?
THANK YOU

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