# WHAT'S WORKING?

*Strategies to reduce readmissions in safety net hospitals*

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
June 18, 2014

COLLABORATIVE
HEALTHCARE STRATEGIES

# Objectives

- What are hospitals with hospital-wide results doing?
- How does that differ from what we are doing?
- What are 5 practical ways to broaden our strategies?

# Hospitals with hospital-wide results

- Know their data –

  *Analyze, trend, track, display, share, post*

- Broad concept of “readmission risk”

  *Way beyond case finding for heart failure*

- Multifaceted strategy

  *Improve standard care, collaborate across settings, enhanced care*

- Use technology to make this better, quicker, automated

  *Automated notifications, implementation tracking, dashboards*

# Do you know these patients?

- 77F recently hospitalized for an infected dialysis catheter returns to the hospital 8 days following discharge with shortness of breath.
- 86M with cancer hospitalized for constipation and abdominal pain returns to the hospital 1 day after discharge with abdominal pain.
- 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.
- 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with pneumonia.
- 32M with every consequence of uncontrolled DM, released from prison, in 1 of 6 area hospitals 105 of the past 160 days.

# The Hospital is JB's Shelter of Choice

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 15-Sep | Prison | Prison | Prison | Prison | Prison | Released | |
| 22-Sep | | ED | DC | | | | |
| 29-Sep | | | | | | | |
| 6-Oct | | | ED | | ED | IN | IN |
| 13-Oct | IN | IN | DC | | | | |
| 20-Oct | | | | | ED | DC | |
| 27-Oct | | | | IN | ED | DC | ED |
| 3-Nov | IN | IN | IN | IN | IN | DC/ED | IN |
| 10-Nov | IN | IN | ED | IN | IN | IN | IN |
| 17-Nov | IN | IN | DC | ED | IN | IN | ED/DC |
| 24-Nov | IN | ED | | | ED | ED | IN |
| 1-Dec | ED | IN | DC | | | | ED |
| 8-Dec | IN | IN | IN | IN | IN | IN | IN |
| 15-Dec | IN | IN | DC | | | | |
| 22-Dec | | | | | | | |
| 29-Dec | | | | | | | |
| 5-Jan | | ED | | ED | IN | DC | ED |
| 12-Jan | | | | | | | ED |
| 19-Jan | ED | IN | IN | IN | IN | DC | ED |
| 26-Jan | DC | | | ED | | ED | IN |
| 2-Feb | IN | IN | IN | IN | IN | IN | IN |
| 9-Feb | IN | IN | IN | IN | IN | IN | IN |
| 16-Feb | IN | IN | IN | DC | IN | IN | IN |
| 23-Feb | IN | IN | ED (DC Brockton) | IN | ? | ED | |
| 2-Mar | | | | IN | IN | DC/ED | IN |
| 9-Mar | DC | ED | DC | ED | IN | IN | IN |
| 16-Mar | IN | IN | | | | | |

COLLABORATIVE HEALTHCARE STRATEGIES

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

AHRQ Agency for Healthcare Research and Quality

# STATISTICAL BRIEF #153

April 2013

## Readmissions to U.S. Hospitals by Diagnosis, 2010

*Anne Elixhauser, Ph.D. and Claudia Steiner, M.D., M.P.H.*

**Highlights**

- For several of the most frequently treated conditions in U.S. hospitals, at least one in five cases resulted in a readmission within 30 days:

- 18 states, 14 million discharges
- 45% of all hospitalizations in US

COLLABORATIVE HEALTHCARE STRATEGIES

# HCUP: Readmissions by Volume

| condition | Discharges | Readmissions | Rate |
|---|---|---|---|
| CHF | 847073 | 209017 | 25% |
| sepsis | 696122 | 145896 | 21% |
| pneumonia | 924160 | 144894 | 16% |
| mood disorder | 883245 | 131125 | 15% |
| COPD | 606186 | 126443 | 21% |
| complication of device | 596062 | 121036 | 20% |
| anemia | 705616 | 104607 | 15% |
| DM | 480958 | 97784 | 20% |
| schizophrenia | 397166 | 88629 | 22% |
| AMI | 520901 | 85932 | 16% |
| UTI | 522921 | 84858 | 16% |
| complications | 453266 | 81353 | 18% |
| fluid/lytes | 396551 | 73721 | 19% |
| CVA | 520793 | 71174 | 14% |
| ARF | 326586 | 70756 | 22% |
| cellulitis | 576902 | 64680 | 11% |
| chest pain | 601899 | 61465 | 10% |
| Gibleed | 320613 | 54154 | 17% |

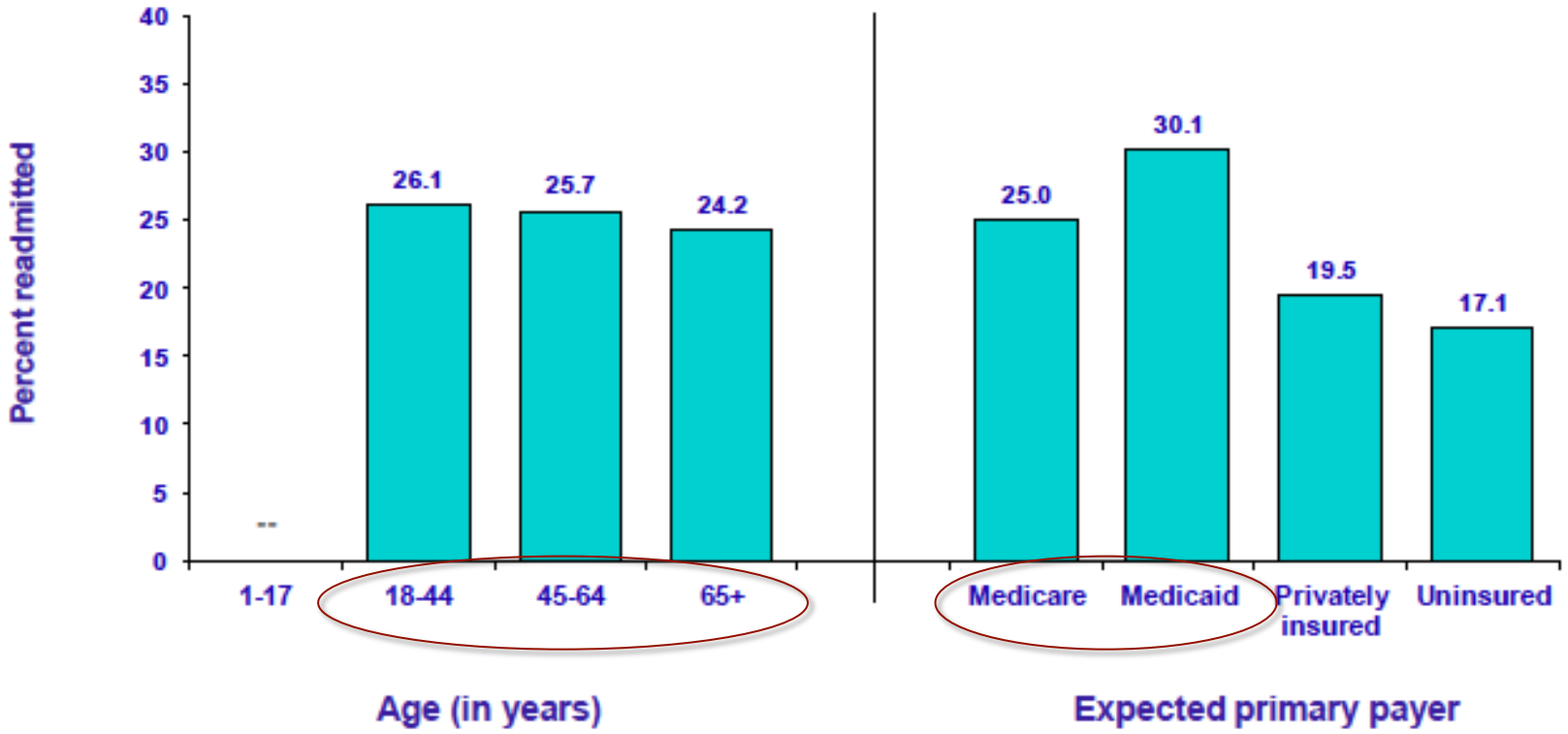
*The top 20 conditions account for ≈25% of readmissions*

# HCUP: Highest Rates

**Table 2. All-cause 30-day readmissions ranked by conditions with the highest readmission rates,* U.S. hospitals, 2010**

| Rank | Principal diagnosis for index hospital stay ** | Number of index stays | 30-day all-cause readmissions | |
|---|---|---|---|---|
| | | | Number of readmissions | Percent readmitted |
| 1 | Sickle cell anemia | 87,326 | 27,837 | 31.9 |
| 2 | Gangrene | 33,786 | 10,693 | 31.6 |
| 3 | Hepatitis | 37,480 | 11,593 | 30.9 |
| 4 | Disease of white blood cells | 54,861 | 16,771 | 30.6 |
| 5 | Chronic renal failure | 17,394 | 4,766 | 27.4 |
| 6 | Systemic lupus erythematosus and connective tissue disorders | 18,850 | 5,123 | 27.2 |
| 7 | Mycoses | 23,026 | 6,222 | 27.0 |
| 8 | HIV infection | 34,958 | 9,230 | 26.4 |
| 9 | Screening and history of mental health and substance abuse | 60,417 | 15,695 | 26.0 |
| 10 | Peritonitis and intestinal abscess | 25,219 | 6,315 | 25.0 |

# Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010




Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

-- Indicates too few cases to report.

TOOL 1

COLLABORATIVE HEALTHCARE STRATEGIES JSI

# Readmission Data Analysis

Use the most recent 12 months of data available, calendar or fiscal year. Count readmissions as any return to the inpatient setting for any reason within 30 days of discharge from the inpatient setting. This analysis is for non-OB, non-pediatric, adult medical/surgical/behavioral health patients. Exclude discharges that are coded as deaths or transfers to another acute care hospital.

| Data Element | Medicare | Medicaid | Uninsured | All-Payer |
|---|---|---|---|---|
| 1. Total number of discharges alive (exclude transfers, deceased, <18yrs, OB) | | | | |
| 2. Total number of individual patients | | | | |
| 3. Total number of 30-day readmissions | | | | |
| 4. Overall readmission rate (#3/#2) | | | | |
| 5. Discharge disposition (from #2):<br>a. Home (no home health) (#, %)<br>b. Home with Home Health (#, %)<br>c. SNF (#, %) | | | | |
| 6. Number of days between discharge and readmission for all readmissions, days 0-30 | | | | |
| 7. Top 10 discharge diagnoses resulting in readmission (based on index diagnosis)<br>a. list top 10 diagnoses<br>b. report number of readmissions per diagnosis<br>c. report readmission rate per diagnosis | | | | |
| 8. Top 10 readmission discharge diagnoses (based on readmission discharge diagnosis) | | | | |
| 9. Calculate the proportion of top 10 readmission diagnoses as a percent of all readmissions (#7/#3) | | | | |
| 10. High-utilizing population (H.U.)<br>a. Number of people hospitalized three or more times in past 12 months (H.U.)<br>b. Number of hospitalizations among H.U.<br>c. Discharge disposition of H.U. (home, HH, SNF)<br>d. Top 10 discharge diagnoses among H.U.<br>e. 30-day readmission rate among H.U. | | | | |

# Patients' Voices

- "I couldn't get….."
- "I didn't understand….."
- "I didn't know….."
- "The doctor/nurse  told me to go to the ED…."
- "I knew I should come right back with {symptoms}"
- "I thought I would wait to…until I saw my own doctor"

# There is Never One Reason for Readmission…..

- KP team reviewed 523 readmissions across ~14 hospitals:
  - 250 (47%) deemed potentially preventable
  - Found an average ***of 9 factors*** contributed to each readmission

- Assessed factors related to 5 domains:
  - 73% - care transitions planning & care coordination
  - 80% - clinical care
  - 49% - logistics of follow up care
  - 41% - advanced care planning & end of life
  - 28% - medications

- 250 readmissions identified 1,867 factors!

COLLABORATIVE HEALTHCARE STRATEGIES

Feingenbaum et al Medical Care 50(7): July 2012

# Who is "High Risk" of Readmission?

- New diagnosis – needs teaching, clear instructions
- New medications – need medication review, instructions
- Complex medical – needs continued active management
- Complex social – isolated, unstable housing, poverty
- Behavioral health – substance use, depression, anxiety, SMI
- Frailty/convalescence – weakened, less able to manage
- Skilled care needs- nursing, therapy, medication management
- Personal care needs- ADL limitations, caregiver, meals, respite
- Access to care needs- no PCP, financial, transportation
- Navigating – low health literacy, language, cultural barriers
- Advocacy – direct assistance in accessing resources/support
- Care seeking patterns- accustomed to using ED for care
- Chronic recurrent symptoms- pain, need palliative care & care plan
- End of life – goals of care decision making

# 6 Very Important Messages from CMS

- Readmissions will cause financial loss – at least to some extent
- Hospitals must have updated processes in place
- Reducing readmissions is a cross-continuum effort
- Attend to non-clinical needs for supports & services
- We will flood the market with all best ideas on our dime
- Reducing readmissions requires better data

# HOWEVER….

*Powerful messages from powerful agencies can create blinders*

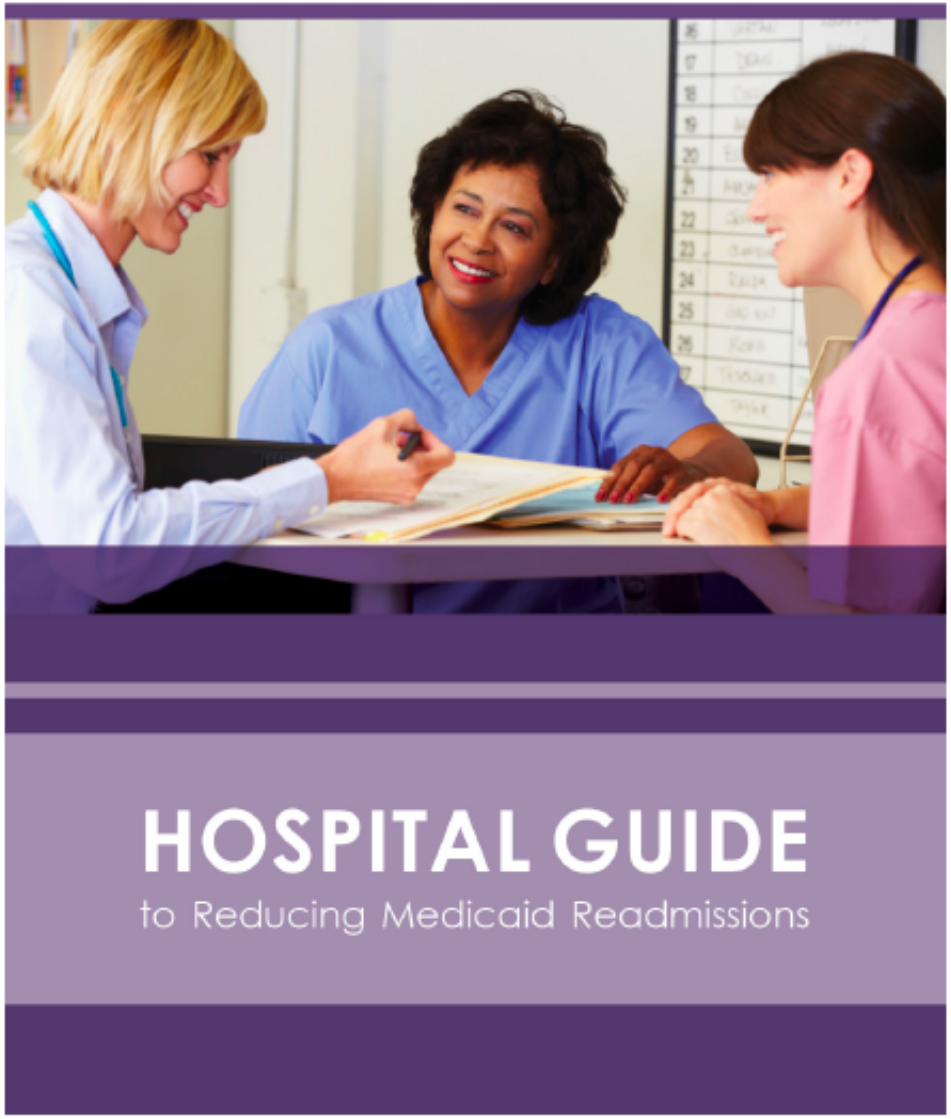
# Inadvertent Blinders….

1. HF, AMI, PNA….[COPD, hip/knee replacement]
   - NOT the 3-6 most frequent causes of readmissions, even in Medicare FFS
   - Many other very important targets, including high utilization & PAC

2. Driven a Medicare focus in the field
   - Medicaid adults have as high or HIGHER readmission rates than Medicare FFS

3. Driven a case-finding approach
   - Rather than emphasizing reliable redesign of transitional care for all

4. Preferred first move: hire a transitional care FTE
   - Driven a capacity limited perspective on scale




- Introduction
- Why focus on Medicaid Readmissions?
- How to Use This Guide
- Overview of Guide Content
- Roadmap of Tools
- Know Your Data
- Inventory Readmission Efforts
- Develop a Portfolio of Strategies
- Improve Hospital-based Transitional Care
- Collaborate with Cross Setting Partners
- Provide Enhanced Services
- Tools

# DESIGN A PORTFOLIO OF STRATEGIES

*Expand beyond singular effort to a multi-faceted approach*

# Develop Portfolio Strategy

## Improve hospital-based transitional care processes for Medicaid patients

1. Flag discharge <30d in chart
2. ED-based efforts to treat & return
3. Broaden view of readmission risks; assess “whole-person” needs
4. Develop transitional care plans that consider needs over 30 days
5. Ask patients & support persons why they returned, if readmitted
6. Ask patient & support persons what help they need; share with them their needs/risk assessment
7. Use teach-back, target the appropriate “learner”
8. Customize information
9. Arrange for post-hospital follow up
10. Use a check-list for all patients

## Collaborate with cross-setting partners

1. Use ADT notifications with medical and behavioral health providers
2. Ask community providers what they need and how they want to receive it
3. Collaborate to arrange timely follow up
4. Perform “warm” handoffs, and opportunity for clarification
5. Form a cross-continuum team that can access resources your staff are unaware of
6. Constantly refresh your awareness of social and behavioral health resources
7. Broaden partners to include Medicaid health plans and their care managers
8. Identify community partners with social work and behavioral health competencies

## Provide enhanced services for high risk

1. Segment “high risk” – varying types of service & levels of intensity
2. Strategy for high utilizers
3. Strategy for navigating care
4. Strategy for accessing resources
5. Strategy for self-management
6. Strategy for frailty/medically complex
7. Strategy for end-of-life trajectory
8. Strategy for recurrent stable symptoms, etc individual care plans

# 46-study Meta-Analysis: What Works?

**Preventing 30-Day Hospital Readmissions**

*A Systematic Review and Meta-analysis of Randomized Trials*

Leppin et al; JAMA Internal Medicine (online first) May 12 2014

- Review of 42 published studies of discharge interventions
- Found that multi-faceted interventions were 1.4 times more effective
  - Many components
  - More people
  - Support patient self-care
- Interventions published more recently had fewer components are were found to be less effective

# Standardize your Processes

**CMS Issued New Discharge Planning Conditions of Participation May 2013 that require hospitals demonstrate the following:**

1. **Have a process**
2. **Know your data;** track rates & review readmissions
3. **Assess & reassess** patients for post-hospital needs
4. **Engage patients and caregivers**
5. **Teach** self-care to patients & caregivers
6. **Provide** a written discharge plan for all inpatients
7. **Communicate** effectively with “receiving” providers
8. **Know** the capabilities of area providers, including support services
9. **Arrange** for post-acute services, including support services

# COPs Apply to Medicaid, Too

- *Similarly, for Medicaid, they should know coverage options for home health, attendant care, and long term care services or have contacts at the State Medicaid agency that can assist with these issues. As noted above, hospitals are also expected to have* ***knowledge of community resources to assist in arranging*** *services.*
    - These are different partners – different services……

# Know Your Cross-Continuum Partners

- *While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care **capabilities** of **area long term care facilities** and to factor this knowledge into the discharge planning evaluation.*

- *Hospitals are expected to have knowledge of the **capabilities** and capacities of not only of long term care facilities, but also of **the various types of service providers** in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented.*

- *This includes knowledge of **community services**, as well as familiarity with available Medicaid home and community- based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients.*

# Deliver enhanced services

- Shorter term, lower intensity
  - BRIDGE social work care transition
- Short term, higher intensity
  - Multi-disciplinary care team
- Longer term, lower intensity
  - Community Health Worker
- Longer term, high intensity/investment
  - Eg Sickle Cell Clinic, High Risk High Cost Care Team

# Community Health Workers/ Navigators

**Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes**

***A Randomized Clinical Trial**; Kangovi et al*

JAMA Internal Medicine April 2014

- Target population: 683 low income, uninsured, Medicaid patients
  - 237 (35%) declined to participate
  - 446 were randomized to standard care or intervention (CHW)
- CHW intervention
  - Engaged w/ patients during hospitalization
  - Developed personalized action plans
  - Worked with patients at least 2 weeks
- Results:
  - Reduced recurrent 30-day readmissions (2.3% v. 5.5%)
  - Among 63 pts, recurrent readmissions 40% v. 15% for CHW

# "High Risk Care Teams"

- In safety net – use a multi-disciplinary team
  - Navigator, behavioral health, social work, pharmacist
- Address full complement of medical, social, logistical needs
  - Affordable medications; waiving office visit copayments
  - Transportation
  - Stable housing
  - Navigating the healthcare system, asking questions, making appointments
- Identify using combination of clinical and non-clinical criteria
  - History of high utilization, no PCP, numerous prescribers, numerous meds, behavioral health comorbidities, homeless….not "just" chronic disease
- Don't over medicalize – whole person, psychosocial
  - Start with the person's priorities

# New York Delivery System Reform Incentive Payment Program

New York State

Delivery System Reform Ince

Program

Project Toolkit



MRT DSRIP – Pathway t

Section 1: a. DSRIP Projects List

| Project Numbers | DESCRIPTION |
|---|---|
| | **Domain 2: System Transformation Projects** |
| A. | Create Integrated Delivery System |
| 2.a.i | Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management |
| 2.a.ii | Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP)) |
| 2.a.iii | Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services |
| 2.a.iv | Create a medical village using existing hospital infrastructure |
| 2.a.v | Create a medical village/alternative housing using existing nursing home infrastructure |
| B. | Implementation of Care Coordination and Transitional Care Programs |
| 2.b.i | Ambulatory ICUs |
| 2.b.ii | Development of co-located primary care services in the emergency department (ED) |
| 2.b.iii | ED care triage for at-risk populations |
| 2.b.iv | Care transitions intervention model to reduce 30 day readmissions for chronic health conditions |
| 2.b.v | Care transitions intervention for skilled nursing facility residents |
| 2.b.vi | Transitional supportive housing services |
| 2.b.vii | Implementing the INTERACT project (inpatient transfer avoidance program for SNF) |
| 2.b.viii | Hospital-Home Care Collaboration Solutions |
| 2.b.ix | Implementation of observational programs in hospitals |
| C. | Connecting Settings |
| 2.c.i | Development of community-based health navigation services |
| 2.c.ii | Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services |
| | **Domain 3: Clinical Improvement Projects** |
| A. | Behavioral Health |
| 3.a.i | Integration of primary care and behavioral health services |
| 3.a.ii | Behavioral health community crisis stabilization services |
| 3.a.iii | Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance |
| 3.a.iv | Development of withdrawal management (ambulatory detoxification)capabilities within communities |
| 3.a.v | Behavioral Interventions Paradigm in Nursing Homes (BIPNH) |

MRT DSRIP – Pathway to Achieving the Triple Aim | 4

| | |
|---|---|
| B. | Cardiovascular Health—Implementation of Million Hearts Campaign |
| 3.b.i | Evidence based strategies for disease management in high risk/affected populations (adult only) |
| 3.b.ii | Implementation of Evidence-based strategies in the community to address chronic disease – primary and secondary prevention strategies (adult only) |
| C | Diabetes Care |
| 3.c.i | Evidence based strategies for disease management in high risk/affected populations (adults only) |
| 3.c.ii | Implementation of evidence-based strategies to address chronic disease – primary and secondary prevention strategies (adults only) |
| D. | Asthma |
| 3.d.i | Development of evidence-based medication adherence programs (MAP)– asthma medication |
| 3.d.ii | Expansion of asthma home-based self-management program |
| 3.d.iii | Evidence based medicine strategies for asthma management |
| E. | HIV/AIDS |
| 3.e.i | Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for Management of HIV/AIDS |
| F. | Perinatal Care |
| 3.f.i | Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership) |
| G. | Palliative Care |
| 3.g.i | IHI "Conversation Ready" model |
| 3.g.ii | Integration of palliative care into medical homes |
| 3.g.iii | Integration of palliative care into nursing homes |
| H. | Renal Care |
| 3.h.i | Specialized Medical Home for Chronic Renal Failure |
| | **Domain 4: Population-wide Projects: New York's Prevention Agenda** |
| A. | Promote Mental Health and Prevent Substance Abuse |
| 4.a.i | Promote mental, emotional and behavioral (MEB) well-being in communities |
| 4.a.ii | Prevent Substance Abuse and other Mental Emotional Behavioral Disorders |
| 4.a.iii | Strengthen Mental Health and Substance Abuse Infrastructure across Systems |
| B. | Prevent Chronic Disease |
| 4.b.i. | Promote tobacco use cessation, especially among low SES populations and those with poor mental health. (Focus Area 2; Goal #2.2) |
| 4.b.ii | Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This strategy targets chronic diseases that are not included in domain 3.b., such as cancer) |
| C. | Prevent HIV and STDS |
| 4.c.i | Decrease HIV morbidity |
| 4.c.ii | Increase early access to, and retention in, HIV care |
| 4.c.iii | Decrease STD morbidity |
| 4.c.iv | Decrease HIV and STD disparities |
| D. | Promote Healthy Women, Infants and Children |
| 4.d.i | Reduce premature births in New York State |

MRT DSRIP – Pathway to Achieving the Triple Aim | 5

COLLABORATIVE HEALTHCARE STRATEGIES

http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

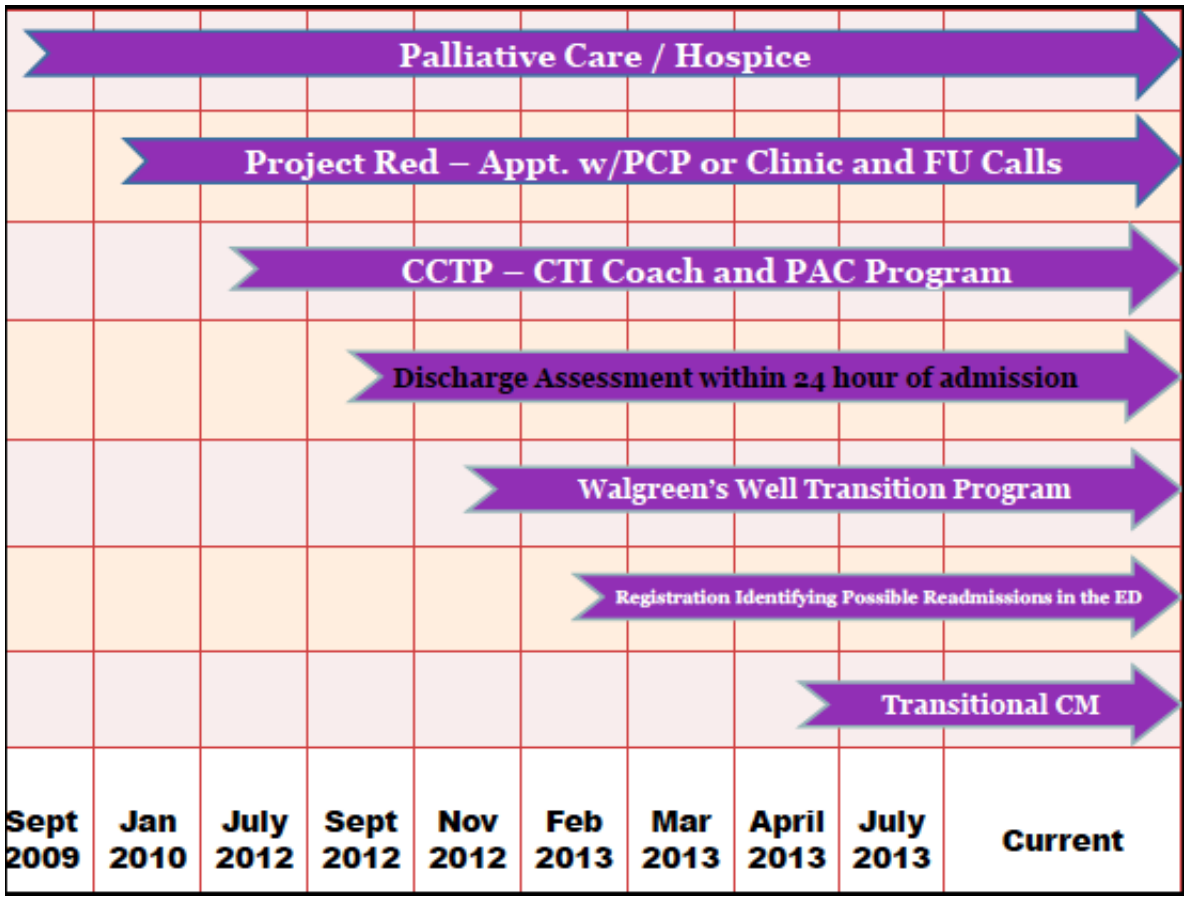
# 2 HOSPITALS' PORTFOLIO STRATEGIES

*Valley Baptist Medical Center, Harlingen TX*

*Frederick Memorial Hospital, Frederick MD*

COLLABORATIVE
HEALTHCARE STRATEGIES

# Valley Baptist Medical Center's Portfolio of Strategies




COLLABORATIVE HEALTHCARE STRATEGIES

Courtesy of Angela Blackford, VBMC

## VBHS Transitional Case Management

-Visit Patient during admission
-Get consent before discharge
-Collaborate with SW/CM the Discharge Plan
-Visit and Call Patient, intervening as necessary for 30 days after discharge

## CCTP Coalition of Hospitals

-CCTP and Governing Board
**-Goals:**
- •Improve care transitions through targeted interventions
- •Reduce Medicare FFS 30-day readmissions by 20%
- •Continuously improve program through systematic review process

## Care Transitions Intervention (CTI) Coaches

-Refer high risk Medicare patients

## Valley Health Baptist System

-Project "Red"
-Medication Reconciliation
-Proper discharge plan arrangements
-Equipment services arrangement
-Teach Back
-MD appointment
-Internal CHF Clinic
-Follow-up Calls

## Community Resources

-Churches
-Clinics
-Support groups
-Wesley nurses
-Senior companions
-Promotoras

## PAC Providers CCTP

-Rehab Facility
-Hospice/Palliative Care
-Home Health -BIPIP
-Skilled Nursing Facility - Interact
-Long Term Acute Care

## MD's Office and Clinics

-Calls for appropriate follow up appointments
-Follow up appointments within 7 days
-Readmission Education

## PAC Providers Non-CCTP

-Encourage to join CCTP to implement readmit decreased measures

## Walgreens Well Transition Program

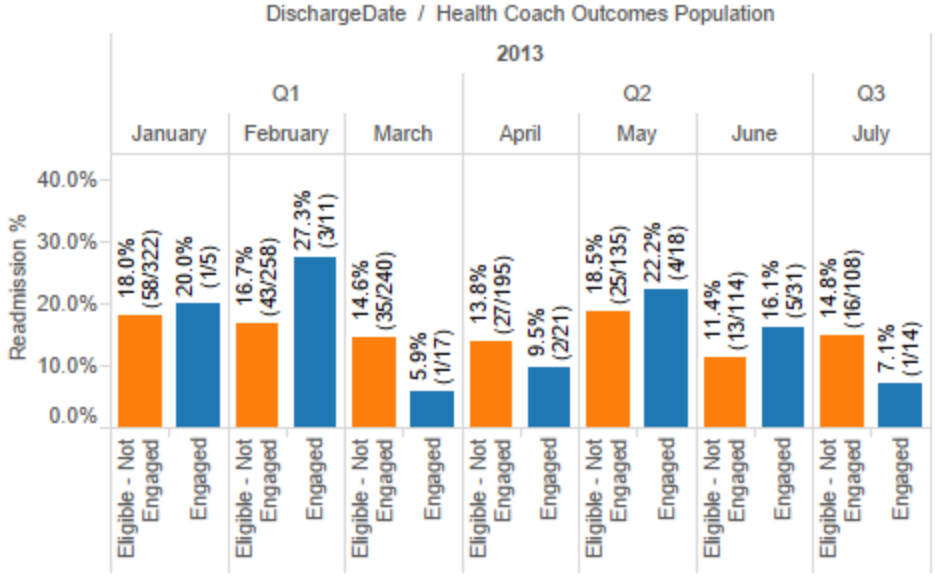
-Medication Reconciliation

# Health Coach Outcomes Scorecard

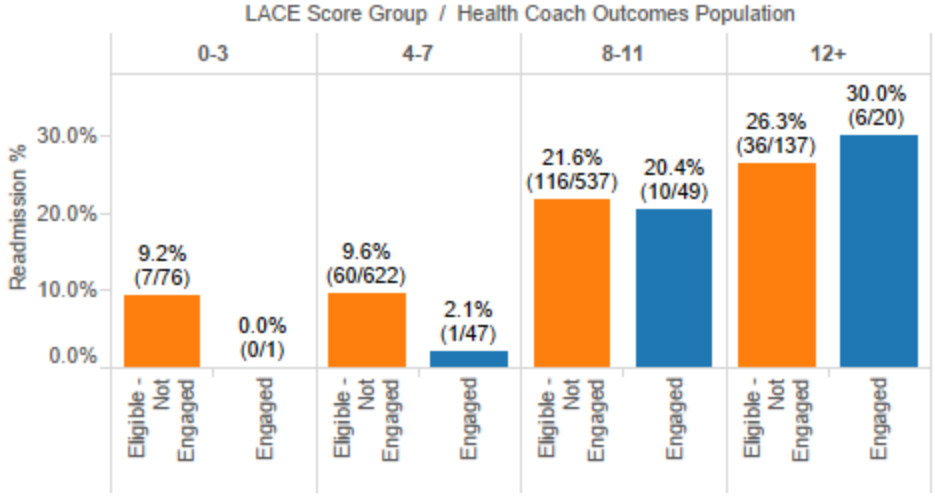
Hospital: VB-H

LOOPBACK ANALYTICS

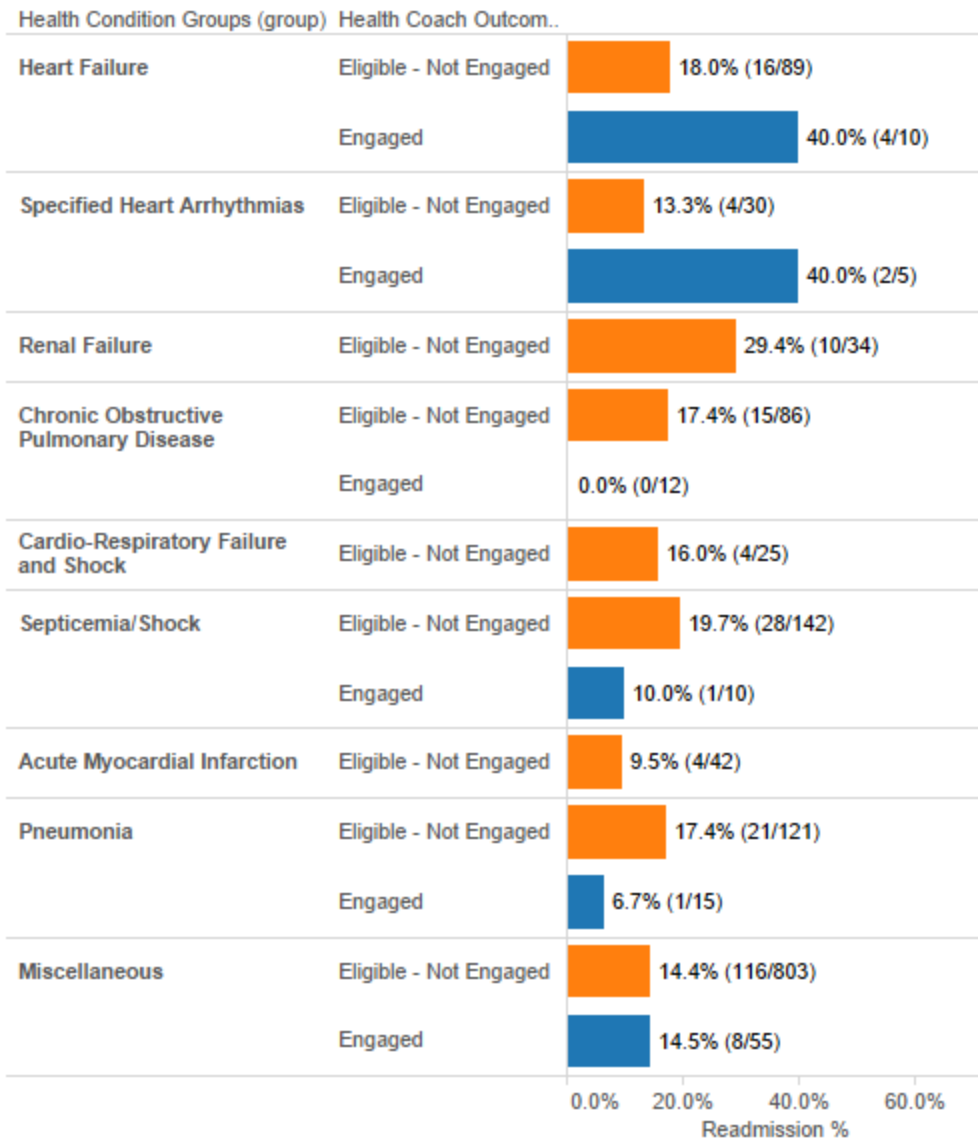
## Readmission Rate by Time



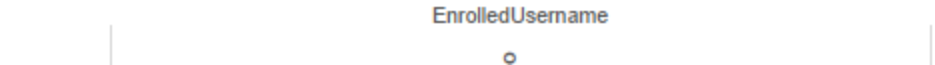

## Readmission Rate by LACE Score



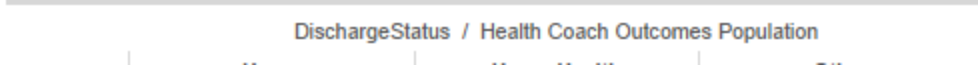

## Readmission Rate by Health Condition




## Readmission Rate by Coach




## Readmission Rate by Discharge Location

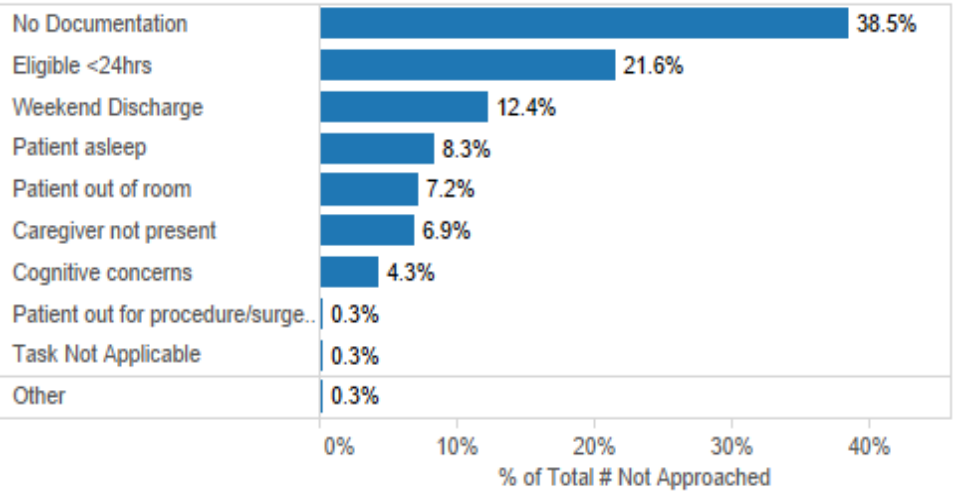


# WellTransitions® Administrator Scorecard #2

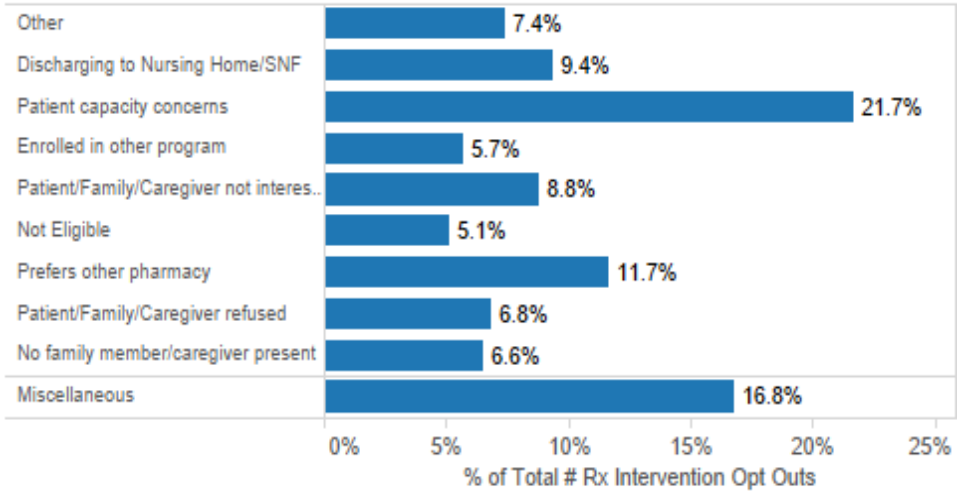
| | |
|---|---|
| Hospital: | VB-B |
| Time Frame: | Last 4 Months |
| Report Date Range: | 6/1/13 - 9/23/13 |

LOOPBACK ANALYTICS

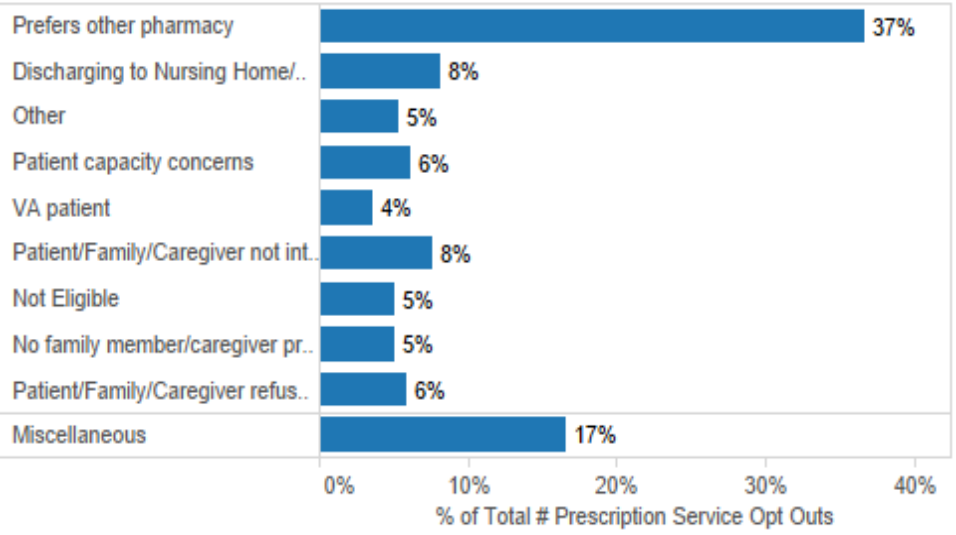
## Not Approached Reasons



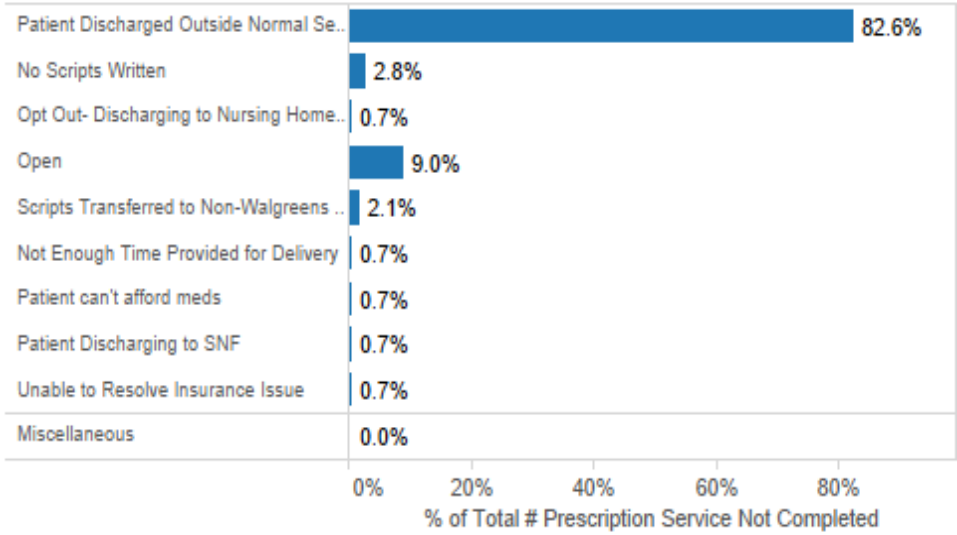

## Rx Intervention Opt Out Reasons




## Prescription Service Opt Out Reasons

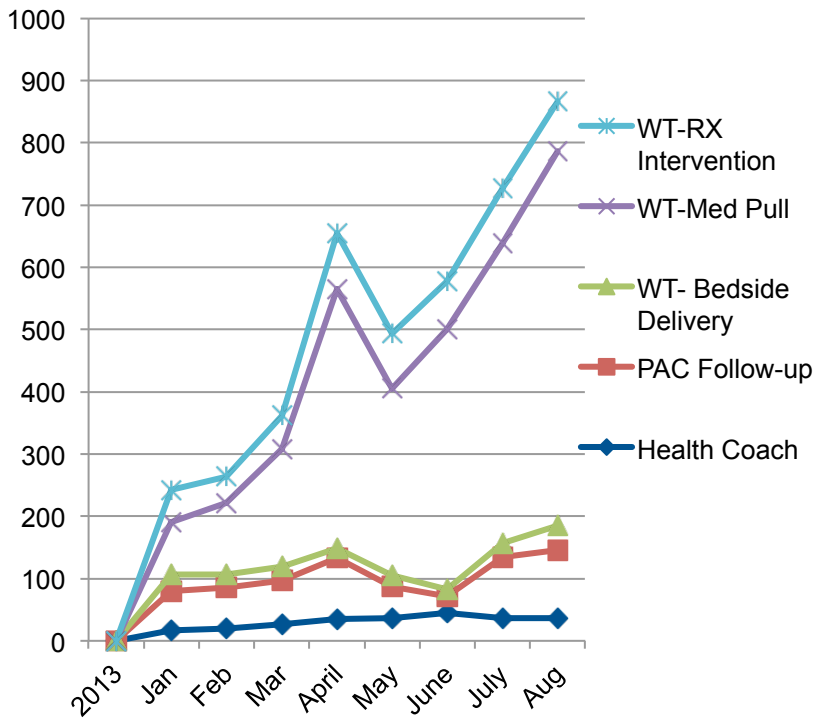



## Prescription Service Not Completed Reasons

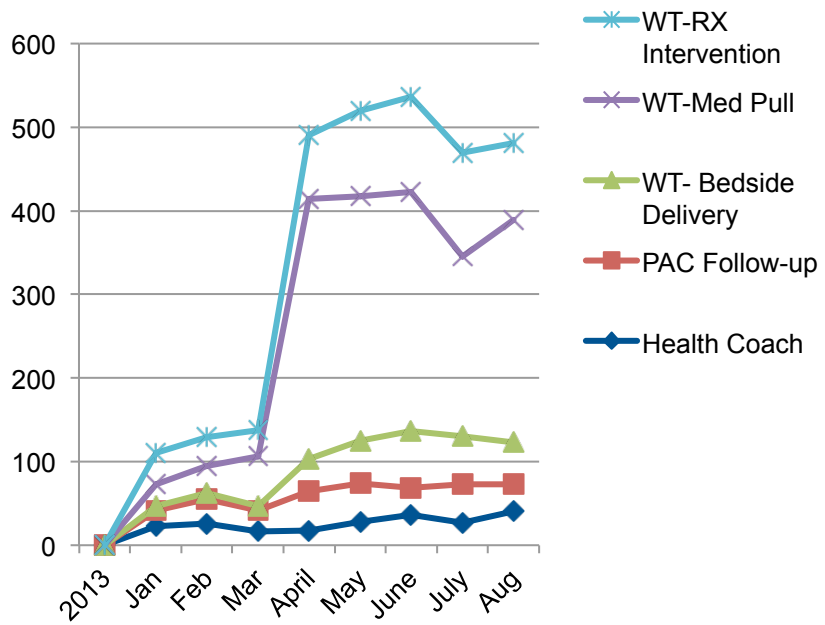


# Tracking Spread

## Harlingen




## Brownsville




COLLABORATIVE HEALTHCARE STRATEGIES

# Valley Baptist Medical Center - Results

| All-cause readmissions | Medicare Penalty |
| --- | --- |
| • FY 2011: 28% | |
| • FY 2012: 21% | 0.8%, 0.6% (of possible 1%) |
| • FY2013: 14% | 0.2%, 0.1% (of possible 2%) |

# Frederick Memorial Hospital - Portfolio

- **Improve Standard Hospital-based Processes**
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8B to “behavioral interview”

- **Collaborate with Providers**
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly “co-management” virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed

- **Provide Enhanced Services to High Risk**
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team “works the case” x 30+ days
  - Cardiology NP “Heart Bridge Clinic”

# Frederick Memorial Dashboard

## CARE TRANSITIONS PERFORMANCE DASHBOARD

| Metric Description: | FY 11 | FY 12 | Goal | July | August | September | October | November | December | January | February | March | April | May | June | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FMH HSCRC All Patient Readmission Rate: | 13.90% | 10.30% | 9.90% | 10.11% | 9.78% | 9.29% | 9.02% | 7.98% | 8.44% | 8.98% | 11.00% | 8.69% | 7.89% | 8.62% | 8.87% | 9.00% |
| Readmission Rate for patients in FMH Care Transitions program | New Program | New Program | Undetermined | | | | | | | | | | | | | |
| Statewide Readmission Rate CY 2011: | 9.70% | CY 2011: 9.70% | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| # Patients seen in ED within 30 days of DC: | | | No Goal | | | | | | | | | | | | | |
| # Prevented RA's in ED | | 31 (J-M) | No Goal | 4 | 5 | 7 | 8 | 5 | 6 | 9 | 6 | 6 | 3 | 6 | | 65 |
| % of Prevented RA's | | | No Goal | | | | | | | | | | | | | |
| Diverted Admissions in ED | | | | 17 | 34 | 33 | 27 | 25 | 26 | 26 | 15 | 23 | 13 | 33 | | 352 |
| | | | | | | | | | | | | | | | | |
| HCAHPS Discharge domain (Rolling 366 day) | | 80 | 84 | 85 | 84 | 84 | 84 | 84 | 85 | 85 | 86 | 85 | 86 | 86 | 87 | 86 |
| | | | | | | | | | | | | | | | | |
| # Patient admitted - Med/Surg + ICU | | New Program | No Goal | | | | 1226 | 1186 | 1192 | 1296 | 1130 | 1225 | 1139 | 1140 | | 9467 |
| # Patient screened for risk of readmission | | New Program | No Goal | | | | 1092 | 972 | 835 | 1124 | 845 | 1069 | 923 | 969 | | 7799 |
| % Patients screen for risk of readmission | | New Program | | | | | 89.15% | 76.12% | 70.08% | 87.02% | 75.91% | 86.96% | 83.23% | 84.12% | | 82.03% |
| | | | | | | | | | | | | | | | | |
| # Patients referred to Care Transitions Program | | New Program | No Goal | | | 384 | 415 | 389 | 450 | 490 | 405 | 490 | 466 | 433 | | 3922 |
| # Patients followed by CT Guide | | | | | | | 173 | 177 | 208 | 248 | 208 | 250 | 235 | 228 | | 1729 |
| % followed by CT Guide | | New Program | | | | 27.76% | 41.69% | 45.50% | 46.22% | 50.61% | 51.36% | 53.06% | 50.75% | 52.66% | | 44.54% |
| % followed by CM | | New Program | No Goal | | | 72.25% | 58.41% | 54.50% | 53.78% | 49.39% | 48.64% | 46.94% | 49.25% | 47.34% | | 55.46% |
| # Patients followed by CT Pharmacist | | | | | | | 52 | 58 | 52 | 61 | 52 | 78 | 65 | 64 | | 470 |
| % of patients with a pharmacist completed med history | | | | | | | 12.50% | 14.91% | 11.56% | 12.45% | 12.84% | 15.51% | 13.98% | 12.47% | | 12.08% |
| | | New Program | | | | | | | | | | | | | | |
| % of Care Transitions Patients d/c'ed with post acute services: | | | | | | | | | | | | | | | | |
| Home self care | | | | | | 11.89% | 35.84% | 37.85% | 39.90% | 34.08% | 45.40% | 41.62% | 46.70% | 44.90% | | 40.32% |
| HHC: | | | | | | | | | | | | | | | | |
| FMH HHC | | | | | | 22.77% | 23.70% | 27.56% | 25.96% | 30.54% | 35.15% | 36.40% | 18.78% | 28.06% | | 25.76% |
| Non-FMH HHC | | | | | | 2.97% | 5.30% | 6.21% | 7.69% | 7.96% | 3.07% | 6.59% | 6.65% | 4.98% | | 5.69% |
| Hospice/Palliative Care | | | | | | 4.96% | 1.73% | 0.00% | 0.48% | 0.00% | 1.23% | 0.51% | 0.51% | 0.51% | | 0.65% |
| SNF | | | | | | 17.82% | 13.87% | 12.43% | 9.62% | 12.38% | 12.27% | 11.68% | 12.18% | 10.71% | | 11.72% |
| Other Post acute svc: | | | | | | | | | | | | | | | | |
| Assisted Living/Group Home | | | | | | 3.96% | 1.73% | 0.56% | 0.96% | 0.00% | 1.84% | 1.02% | 0.51% | 0.51% | | 0.84% |
| Acute Facility | | | | | | 3.96% | 3.47% | 3.39% | 1.92% | 3.10% | 1.84% | 0.51% | 1.52% | 1.53% | | 2.14% |
| Acute Rehab | | | | | | | | | | | | 1.02% | 0.00% | 0.51% | | 0.19% |
| Clinic | | | | | | 2.97% | 1.73% | 0.56% | 0.48% | 0.44% | 1.23% | 0.51% | 3.55% | 2.55% | | 1.35% |
| Patient Expired | | | | | | 3.96% | 0.56% | 0.56% | 2.88% | 0.88% | 0.00% | 2.54% | 1.02% | 1.02% | | 1.33% |
| Patient Left AMA | | | | | | | 0.00% | 0.56% | 0.48% | 0.00% | 0.61% | 0.00% | 0.00% | 0.51% | | 0.32% |
| Patient / Caregiver refused | | | | | | 34.75% | 12.14% | 14.12% | 7.21% | 10.62% | 5.52% | 6.09% | 8.63% | 5.10% | | 8.61% |
| Patient still at FMH at end of month | | | | | | | | 1.69% | 1.92% | 0.00% | 0.61% | 1.02% | 0.00% | 0.00% | | 0.65% |
| Other services | | | | | | | | | | | | 1.02% | 0.00% | 0.00% | | 0.32% |
| | | | | | | | | | | | | | | | | |
| Follow up MD visit | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Readmission Interview/Reason for return visit: | | TOTAL | 100% | | | | | | | | | | | | | |
| Unavoidable Medical Issue | | New Program | | | | | | | | | | | | | | |
| Lack of understanding/disease | | New Program | | | | | | | | | | | | | | |
| Medication/Prescription | | New Program | | | | | | | | | | | | | | |
| Lack of support network | | New Program | | | | | | | | | | | | | | |
| Lack of MD follow up visit | | New Program | | | | | | | | | | | | | | |
| Patient non-compliance w/plan | | New Program | | | | | | | | | | | | | | |
| | | New Program | | | | | | | | | | | | | | |
| | | New Program | | | | | | | | | | | | | | |
| | | New Program | | | | | | | | | | | | | | |

RA = Readmission

- at or above goal
- < 10% below the goal
- > 10 % below the goal

COLLABORATIVE HEALTHCARE STRATEGIES

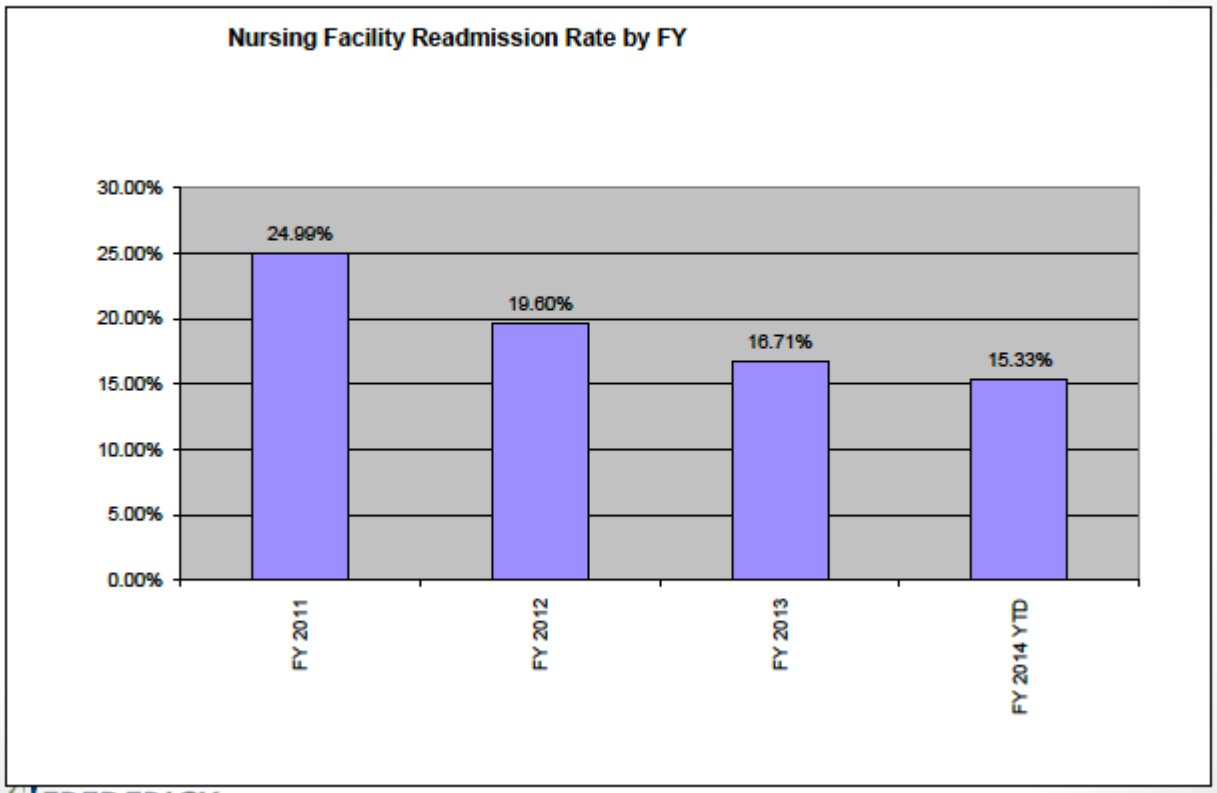
# Frederick Memorial Dashboard-2

| Source | FY 2012 | Goal | July | August | September | October | November | December | January | February | March | April | May |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Volume of Observation Patients | | | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 |
| | | | | | | | | | | | | | |
| # Patients RA'ed FY 2011 | 1719 | | | | | | | | | | | | |
| # Patients RA | 1688 | | | | | | | | | | | | |
| % of Patients RA | 10.27% | 9.60% | 8.63% | 9.76% | 8.20% | 8.02% | 7.68% | 8.44% | 8.88% | 11.00% | 8.86% | 7.88% | 8.62% |
| Average # of days from DC to RA | 14.2 | | 14.6 | 13.4 | 12.0 | 13.2 | 12.8 | 13.2 | 13.8 | 13.7 | 14.0 | 13.4 | |
| | | | | | | | | | | | | | |
| All Patient RA Rate: | | | | | | | | | | | | | |
| BRG Payer Source: | | | | | | | | | | | | | |
| All Patients: | 10.27% | 9.60% | 8.63% | 9.76% | 8.20% | 8.02% | 7.68% | 8.44% | 8.88% | 11.00% | 8.86% | 7.88% | 8.62% |
| MC/MC HMO: | 16.73% | | 14.20% | 14.78% | 15.84% | 14.96% | 13.60% | 11.41% | 13.56% | 17.44% | 12.96% | 14.58% | 12.48% |
| MA/MA HMO: | 6.87% | | 13.30% | 9.76% | 6.33% | 10.27% | 7.62% | 9.16% | 8.00% | 10.44% | 12.20% | 9.09% | 9.24% |
| Self Pay/No Charge | 9.96% | | 4.26% | 10.94% | 9.80% | 4.55% | 2.17% | 12.24% | 5.36% | 6.82% | 8.70% | 1.23% | 8.20% |
| Commercial/Other: | 6.83% | | 4.55% | 5.30% | 4.59% | 3.52% | 2.81% | 5.34% | 4.21% | 5.21% | 3.62% | 1.89% | 4.88% |
| BRG Diagnosis: | | State | | | | | | | | | | | |
| HF DRG 194: | 25.00% | 22.30% | 20.83% | 16.00% | 11.11% | 18.18% | 15.38% | 24.00% | 16.67% | 40.91% | 11.43% | 18.18% | 25.93% |
| COPD DRG 140: | 22.70% | 14.10% | 22.86% | 16.28% | 32.43% | 24.39% | 22.58% | 10.20% | 22.97% | 38.71% | 16.67% | 31.11% | 25.81% |
| Sepsis DRG 720: | 17.12% | 17.20% | 14.58% | 22.58% | 14.00% | 8.89% | 11.11% | 16.67% | 11.29% | 20.51% | 18.42% | 6.38% | 12.73% |
| Diabetes DRG 420: | 31.11% | 13.30% | 9.09% | 33.33% | 60.00% | 20.00% | 25.00% | 10.00% | 16.67% | 50.00% | 16.67% | 0.00% | 10.00% |
| Renal Failure DRG 460: | 18.48% | 18.90% | 10.00% | 3.45% | 13.04% | 13.64% | 0.00% | 15.00% | 4.17% | 17.86% | 7.50% | 3.57% | 21.74% |
| BH: Bipolar DRG 763/783: | 8.26% | 10.10% | 20.69% | 10.81% | 8.33% | 12.50% | 6.25% | 0.00% | 7.14% | 4.76% | 3.85% | 2.63% | 7.89% |
| BH: All Other | 8.88% | 8.88% | 15.19% | 7.53% | 12.99% | 7.23% | 7.41% | 4.94% | 6.06% | 6.35% | 7.79% | 9.09% | 11.25% |
| | | | | | | | | | | | | | |
| Physician RA all Patients: | | | | | | | | | | | | | |
| BRG | | | | | | | | | | | | | |
| Dr. Praveen Bolarum | 27.40% | 18.32% | | | | | | | | | | | |
| Dr. Hiren Shah | 19.83% | 15.98% | | | | | | | | | | | |
| Dr. Ronald Miller | 21.15% | 15.98% | | | | | | | | | | | |
| Dr. Austin Pearre | 17.60% | 15.88% | | | | | | | | | | | |

COLLABORATIVE HEALTHCARE STRATEGIES

# SNF Readmissions, Frederick Memorial

## NH Readmission Rate by FY

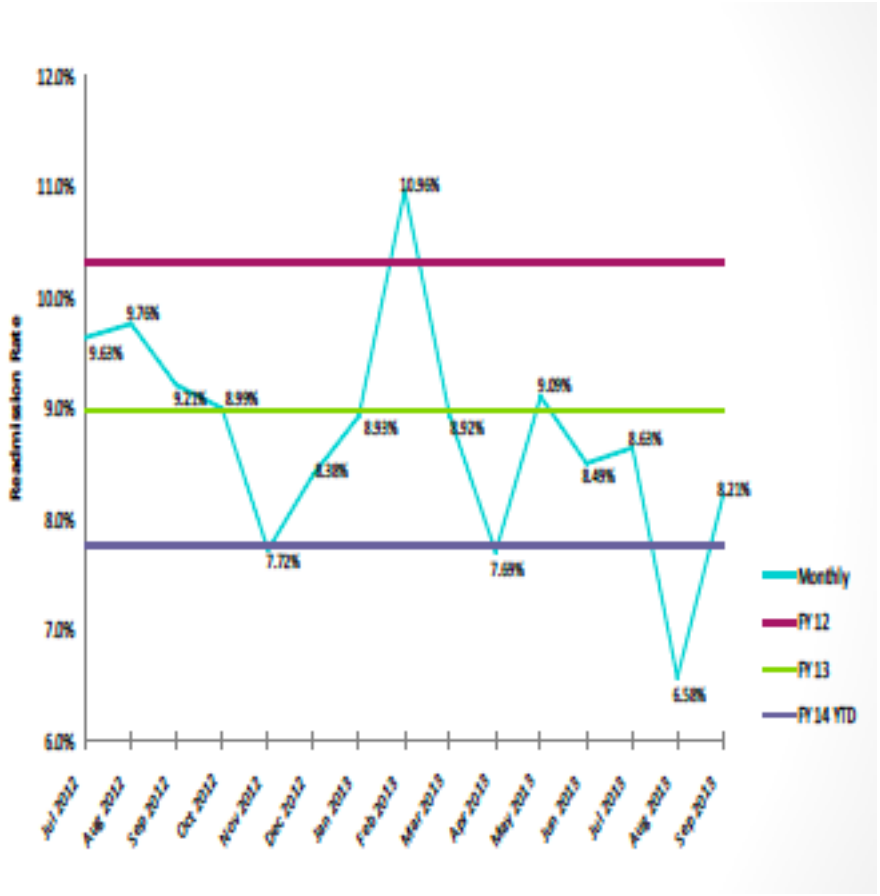



FREDERICK MEMORIAL HOSPITAL

COLLABORATIVE HEALTHCARE STRATEGIES

Courtesy of Heather Kirby

# 3-year results, Frederick Memorial




**All-payer all cause readmissions**

**FY 12 10.6%**

**FY 13 9%**

**FY 14 7.8%**

COLLABORATIVE HEALTHCARE STRATEGIES

# Recommendations

- Know your data
  - Not just chronic illness, not just AMI/PNA/HF; run your own
- Adopt a broad concept of readmission risk
  - Capture all reasons, whole-person approach
- Develop a multifaceted strategy
  - Improve standard transitional care for ALL patients
  - Collaborate across settings with multi-sector partners
  - Provide enhanced services
- Use technologies to make work better, quicker, automated
  - ADT notifications - Patient Ping, geomapping (CRISP)
  - Patient-reminders, scheduling –Axial Exchange
  - Clinician-Clinician Communication – OnService MD
  - Cross-setting portfolio implementation tracking – Loopback Analytics

*Thank you*

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COLLABORATIVE
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