Innovative Tools to Prevent Avoidable Readmissions

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Timeless values delivered with humankindness

“Unleash the Healing Power of Humanity”
Family of more than 55,000 care givers and staff

Diverse communities in Arizona, California and Nevada

Founded in 1986 and headquartered in San Francisco

5th Largest hospital provider nationwide

Largest Hospital System in California

1 of 5 health systems and 1 of 26 networks awarded two year Hospital Engagement Network (HEN) and CMS partnership (PfP) (Granted 3rd year)
No Harm Campaign (HEN)
Better care, lower costs
Unprecedented National Decreases
Medicare Fee-for-Service 30-day All-Cause Readmissions
(February 4, 2014)
Reduction in Medicare FFS 30-Day All-Cause Readmission Rates by HEN, 2010 vs. Dec 2012 – Feb 2013*

* Dec 2012 – Feb 2013 Readmission Rates are estimates projected from early data
Managing The Magic Circle of Readmissions

Penalties for Excess Readmissions

“Whole” Patient Focus

Transition Management

X Factor

Payer

Inpatient Volume

Outpatient volume

Community Resources

Readmissions Clinical and Behavioral Risk
What is Innovation, Really?

- **You don’t have to be Steve Jobs to innovate:**
  - Look around see what’s barely working and tweak it!
- The Asthmapolis Sensor—GPS for inhaler
- John C. Lincoln Health Network’s Transition Coach Program
  - Tackles two unmet needs in Arizona
    - Increased number of unemployed, highly-trained military medics
    - Lack of dedicated staff for frail, elderly patients –combat re-hospitalizations
- Combination Therapy
  - Readmission Risk Assessment Tool (clinical) and Psychosocial Assessment Tool
- CareMore Model
  - New model for most at risk (chronic, acute care mgmt+predictive modeling and early intervention)
- **Innovations Lie in each of You!**
  - Seeds of change to advance our work…is in this room.
Readmissions Improvement
Mercy Hospitals Bakersfield

Erica Mares
Director, Care Management
Kern County...

- Population 864,124
- Language other than English spoken in home 41.6%
- Below poverty level 21.5%
- Ranks 58/58 CA counties in incidence of heart disease
- Ranks 57/58 CA counties in incidence of diabetes
Mercy Hospitals Bakersfield

Mercy Downtown 144 beds

Mercy Southwest 78 beds
Early Reduction Efforts

CHAMP® (Congestive Heart Active Management Program)

- Cardiologists
- Primary care physicians
- Registered nurses
- Exercise physiologists
- Pharmacists
- Dietitians
- Nutritionists

Community Outreach Grant funded CHAMP Liaison
Department Structure

Grant Funded position

Permanent FTE allotted specifically to Readmission Reduction

Case Manager
- Utilization Review
- Discharge Planning
- Referral base for

Chronic Care/Disease Management Nurse
- Post Discharge Needs
- Patient/Family Resource

Separate and Distinct Roles
Role of the Chronic Care Management Nurse

- Dignity Health Standardized Risk Assessment Tool
- Open referrals
- Telephonic contact within 48h of discharge
- Assessment of patient condition
- Monitoring x 30 days
- Follow-up appointments
- Troubleshoot any issues
Role of the Chronic Care Management Nurse

Chronic Care Nurse

Patient/Caregiver

Insurance

PCP and Consultants

CCTP Coach

DME

Medications

SNF/Acute Rehab/ Home Health

Community Outreach

Inpatient Case Managers

Inpatient Case Managers

Community Outreach

SNF/Acute Rehab/Home Health

Medications

DME

CCTP Coach

PCP and Consultants

Insurance

Patient/Caregiver

Chronic Care Nurse
Mercy Hospital Bakersfield
All Cause Overall Readmission Rate

Baseline (Fiscal Year 2011)

6.86%

February 2014

4.99%
“What if we don’t change at all ... and something magical just happens?”
Going Forward...

- CCTP Partners in Care Coach onsite
- Palliative Care
- Home Health
- Friends of Mercy Foundation
- Community Clinic Negotiations
- Community Wellness Programs
- Ongoing Community Involvement
Our Future Hierarchy of Discharges Home

Home Health vs. Home Health with Palliative Care

- **Patient Navigator**
  - Small case load/most complex patients
  - In-home visits + telephonic assessment and intervention x 30 days

- **Chronic Care/Disease Management**
  - 30-40 case load/moderate – high risk
  - Telephonic assessment and intervention x 30 days

- **CCTP Coach**
  - Moderate risk
  - Telephonic empowerment x 30 days
St. John’s Hospitals

Regional Medical Center
-Oxnard-265 Beds
  Acute Rehab
  NICU
  Cardiology
  Orthopedics

Pleasant Valley Hospital
-Camarillo-180 Beds
  Sub-Acute Care
  Pulmonary
  Urology
Discharge Planning is Everyone’s Job!
Collaborative Approach to identifying patients at greatest risk for readmission

Education is shared throughout the hospital stay by all disciplines

Notify the patient and family they can request a discharge assessment and plan.

Assure the patient is aware of Community Resources

Provide one Location for resources
Focus the Patient and Family to a Single Location for References and Resources!

Each Discipline will:

- Need to define their role in the process of using a discharge folder
- Make it real for the patient and a part of our employee’s jobs.
Discharge Planning ~ Coordination of Activities

Starting at the beginning:

**Discharge Folder**

For:

**Everyone to Use!**

Dignity Health
Show Discharge Folder

• Video
Discharge Folder – Roll-out Plan

- Education Plan to Admitting, Case Management, Nursing and Ancillary Services
  - Everyone is empowered
- Give the effort needed for success!
  - Policy for Use and reorder plan
  - Method for stuffing with some information by volunteers
  - Measurement of use included in patient rounding
  - Control the Content to be patient specific
Preparing a Patient for Discharge is an Entire Process

- Readmission Risk Assessment
- Focused timing for Discharge Assessment
- Coordination of Discharge with next level of care
- Individualizing for the Patient
- Key Words and key times for all disciplines for discharge assistance

Recommendation: **Readmission & Discharge Team**
Collaboration of Care
Exposition

Start the Conversation

Review the Similarities of purpose of all providers

Remember to put the patient in the Center of all efforts
This is a journey without end.....

Keeping the Team excited and involved is key!
Focus your efforts on specific areas for improvement

- Disease Specific
- Pharmacy Needs
- Second Care provider groups
Measure your efforts!

Recognize departments that make a difference in patient discharges!

Share your program’s success!
Our Program recognizes:

♦ Healthcare is changing...
♦ Healthcare needs to empower the patient
♦ We need to own the change and celebrate the transition of healthcare to a focus on developing healthier lifestyles.
Thank you