PIH HEALTH

Impacting Hospital Readmissions
PIH Health Cares Program
Intensive Outpatient Care Program

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February 13, 2015
Mission: We provide highest quality healthcare without discrimination and contribute to the health & well-being of the community...ethical, safe & fiscally prudent manner.

Values: patients first, respect & compassion, responsiveness, integrity, collaboration & innovation, stewardship
A Patients First System

MISSION
We provide the highest quality healthcare without discrimination and contribute to the health and well-being of our communities in an ethical, safe, and fiscally prudent manner in recognition of our charitable purpose.

VALUES
- Patients First
- Respect and Compassion
- Responsiveness
- Integrity
- Collaboration and Innovation
- Stewardship

ENTERPRISE SUCCESS
- Quality
- Access and Service
- Integrated Culture
- Community Wellness
- Growth
- Financial Viability

STRATEGIES
- Community Benefits
- Medicare
- Performance Excellence (Lean)
- Strategic Business Units
- Revenue Cycle
- IDS Data Integration
- eMD Optimization (Paperless Organization)
- IDS Education
- IDS Call Center
- Healthy Living
- Healthy Giving
- IPA Growth
- PHF Group Expansion
- Facility Capital Plan
- Patient-Centered Access
- RRG Expansion
- Medical Best Practices
- Care Coordination
- S&P A+ Rating
- Quality of Care and Service

STRATEGIC MANAGEMENT SYSTEM
- Leadership Development
- Project Management
- Strategic Planning
- Prioritization and Capacity Management
- Accountability and Measurement
- Elimination of Waste and Reduction of Variation

February 2014
**Integrated Delivery System**

**CARE TRANSITION ACTIVITIES**
Managed by Nurse and Social Worker Case Managers

- Referral & Authorization Services
- Post-Hospital Discharge Appointments*
- Home Health CHF Program
- Chronic Disease Management
- Complex Case Management

**CARE COORDINATION SERVICES**

**PIH Health CARES**

- Intensive Outpatient Care Program

**PIH Health Healthcare System Care Coordination Structure**

Case Management/Social Service

- PIH Health Hospital - Downey
- PIH Health Physicians
- PIH Health Hospital - Whittier

- CARE COORDINATION SERVICES
  - Referral & Authorization Services
  - Post-Hospital Discharge Appointments*
  - Home Health CHF Program
  - Chronic Disease Management
  - Complex Case Management

- PIH Health CARES

- IPA

- Physician Group *
Strategies to Reducing Readmissions Over the Last 5 Years

• **Post Hospital Discharge Clinic**
  – Run by Nurse Practitioners
    • Reduced 30 day readmissions by 40%
    • Small patient volumes – disbanded in 2014

• **CHF Home Health Program**
  – All CHF discharged patients received HH services for 6 weeks
    • Reduced 30 readmissions by 20%
    • Ongoing
We Are Very Proud of our Chronic Disease Management Program
PIH Health CARES Program

PIH Health CARES Program is:

- Coordinated & Centered on our patients
- Accessible & Accountable
- Respectful & Relational
- Empathetic & Empowering
- Secure & Supportive

for the patients who need us most!

Phone number: 562-967-CARES
Email: pihhealthcares@pihhealth.org
PIH Health Cares is Made Up of 3 Major Components

- Palliative Care Team
- IOCP Team
- Case Management Team
• Persistently complex, chronic conditions
• Often with poor social conditions
• Often with behavioral health co-morbidities
• Evidence-based model
• Referrals from MDs, case managers, mid-level providers

Approach:
• Targeted population – predicted highest cost (10-15%)
• Patients with persistent and actionable issues
• Provide team based care
  • RN Case Manager – assessments, triage, communication w MDs
  • Health Coach (MA) – follow-up phone calls, forms, communication
  • LCSW – psychosocial support, palliative care, community resources
  • PCPs, Nurse Practitioners, Specialists, MD office nurses
## Total Number of Patients (80) Based on Clinical Activity

(Patients can fall into more than one category)

<table>
<thead>
<tr>
<th>Clinical Activity</th>
<th># of Patients</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>CHF</td>
<td>32</td>
<td>40%</td>
</tr>
<tr>
<td>HTN</td>
<td>65</td>
<td>82%</td>
</tr>
<tr>
<td>CKD</td>
<td>39</td>
<td>48%</td>
</tr>
<tr>
<td>COPD</td>
<td>23</td>
<td>28%</td>
</tr>
<tr>
<td>DM</td>
<td>39</td>
<td>49%</td>
</tr>
<tr>
<td>Depression</td>
<td>31</td>
<td>38%</td>
</tr>
<tr>
<td>Required Social Services</td>
<td>50</td>
<td>61%</td>
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</table>
### Clinical Activity by Category

(Patients can fall into more than one category)

<table>
<thead>
<tr>
<th>Clinical Activity</th>
<th><strong>Green</strong></th>
<th></th>
<th><strong>Yellow</strong></th>
<th></th>
<th><strong>Red</strong></th>
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<tbody>
<tr>
<td></td>
<td># of</td>
<td>%</td>
<td># of</td>
<td>%</td>
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<tr>
<td></td>
<td>Patients</td>
<td>Patients (Least intensive &amp;</td>
<td>Patients</td>
<td>Patients (Mid-level intensive</td>
<td>Patients</td>
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<td></td>
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<td>frequent interventions)</td>
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<td>&amp; frequent interventions)</td>
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<td></td>
</tr>
<tr>
<td>CHF</td>
<td>3</td>
<td>20%</td>
<td>19</td>
<td>41%</td>
<td>10</td>
</tr>
<tr>
<td>HTN</td>
<td>12</td>
<td>80%</td>
<td>37</td>
<td>80%</td>
<td>16</td>
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<tr>
<td>CKD</td>
<td>4</td>
<td>27%</td>
<td>24</td>
<td>52%</td>
<td>11</td>
</tr>
<tr>
<td>COPD</td>
<td>3</td>
<td>20%</td>
<td>11</td>
<td>24%</td>
<td>9</td>
</tr>
<tr>
<td>DM</td>
<td>5</td>
<td>33%</td>
<td>22</td>
<td>48%</td>
<td>12</td>
</tr>
<tr>
<td>Depression</td>
<td>7</td>
<td>47%</td>
<td>12</td>
<td>26%</td>
<td>12</td>
</tr>
<tr>
<td>Required Social Services</td>
<td>9</td>
<td>60%</td>
<td>24</td>
<td>52%</td>
<td>15</td>
</tr>
</tbody>
</table>

- **Green**: 15 patients (Least intensive & frequent interventions)
- **Yellow**: 46 patients (Mid-level intensive & frequent interventions)
- **Red**: 19 patients (Most intensive & frequent interventions)
# Age Range of Patients

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>Green (15 patients, Least intensive &amp; frequent interventions)</th>
<th>Yellow (46 patients, Mid-level intensive &amp; frequent interventions)</th>
<th>Red (19 patients, Most intensive &amp; frequent interventions)</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td># of Patients</td>
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<tr>
<td>61 – 64</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
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<tr>
<td>65 – 70</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>16</td>
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<td>71 – 80</td>
<td>3</td>
<td>12</td>
<td>4</td>
<td>19</td>
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<tr>
<td>81 – 90</td>
<td>6</td>
<td>22</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>&gt; 90</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>
What Have We Accomplished to Date?

• Enrollment is active
  – 19 patients enrolled as of 3/15/14; 126 patients as of 12/2014
    • 90 active as of 01/15/15

What barriers did we hit?

• Capacity became our #1 issue
  – No additional FTEs available

• Patient selection was our 2nd issue
  – Too much data – overwhelmed patient identification
  – Lots of referrals of patients who needed palliative care services
Plan

1. Change the model of the Post Hospital Discharge Clinic into the CMS Transitional Care Management Model of PCP appointments within specific time frames post discharge

2. Develop a distributive model by involving the RNs who work in our PCP offices
Struggles

• **Collaboration**
  – “buy-in” to get appointments made prior to discharge
  – “buy-in” to complete IOCP documents at the PCP offices
  – “buy-in” strategically: Volume versus Value!

• **Technology**
  – building monitoring reports from 2 systems
  – drilling down through complicated data
  – IPA offices not on an EHR
Successes Over the Years

- Decrease in readmissions & ED visits
- Collaboration between hospital case managers, MD office nurses & ambulatory case managers
- Recognition that disease management, chronic disease management, complex case management & palliative care are all part of the same rainbow
- Support of patient centered outcomes
Case Study – Who are we trying to keep out of the Emergency Department (ED) and the Hospital?

• **Patient**
  – Blue Shield 65+ health plan
  – 67 y/o female, with multiple co-morbidities
  – Hypertension, diabetes, chronic kidney disease/failure
  – Patient attempting to delay going on dialysis
  – Previous spinal stimulator implant with infection & removal (2012)
    • Two same day surgeries, two inpatient stays, one TCU stay, home health services
  – Patient missed her last four office visits by either cancelling or not showing up
  – Four falls in the last month
  – Three ED visits since May 2014
• **Social Situation**
  - Lives at home with her husband
  - Caretaker for her husband who has chronic lung cancer and is receiving chemotherapy twice a week at PIH Health Hospital - Whittier

• **PIH Health Care Interventions**
  - Assessment
    • Doesn’t take medications properly; two ED visits in May due to edema and renal insufficiency
      - Finding: Not taking kidney medications at all (found six weeks of pills during home visit)
    • Doesn’t understand new blood pressure medication – one ED visit in July two days after being prescribed new medication
Case Study (cont’d)

• PIH Health Care Interventions (cont’d)
  – Shared Action Plan: Patient - “I want to stay out of the hospital.”
  – Case Manager’s Actions:
    • Called renal physician to notify about ED visit and ask for medication change
    • Called PCP to notify about ED and new HTN medication
    • Shared information between PCP and Specialist
    • Connected with Diabetic Management Team
    • Calls patient twice per week at minimum to check in about blood pressure monitoring and medication compliance
      – Patient needs continuous reminders
    • Took social worker to patient’s home and found the kidney medication wasn’t being taken
    • Set up social worker services support to help patient and husband cope with clinical and social situations
    • Continuously educating patient to call case manager and PIH Health CARES team when any issues arise before going to the ED
Thank you!

Questions?