AMERICA'S ESSENTIAL HOSPITALS

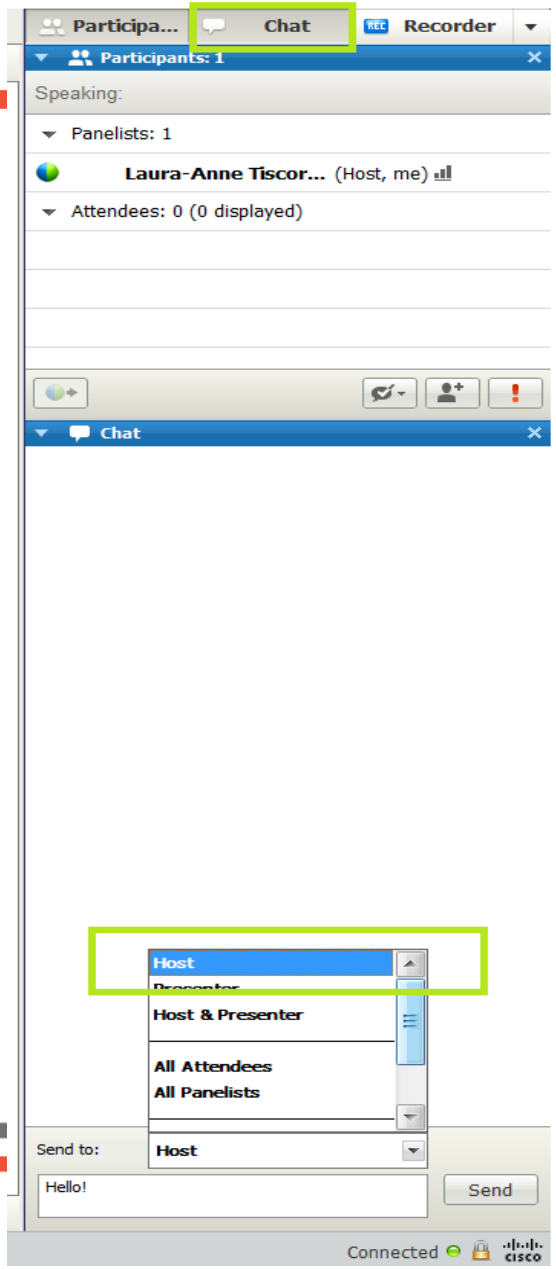
How to Refine Care Transitions to Reduce Readmissions

Essential Hospitals Engagement Network

February 27, 2014

CHAT FEATURE

The chat tool is available to ask questions or comments at any time during this event.



RAISE YOUR HAND

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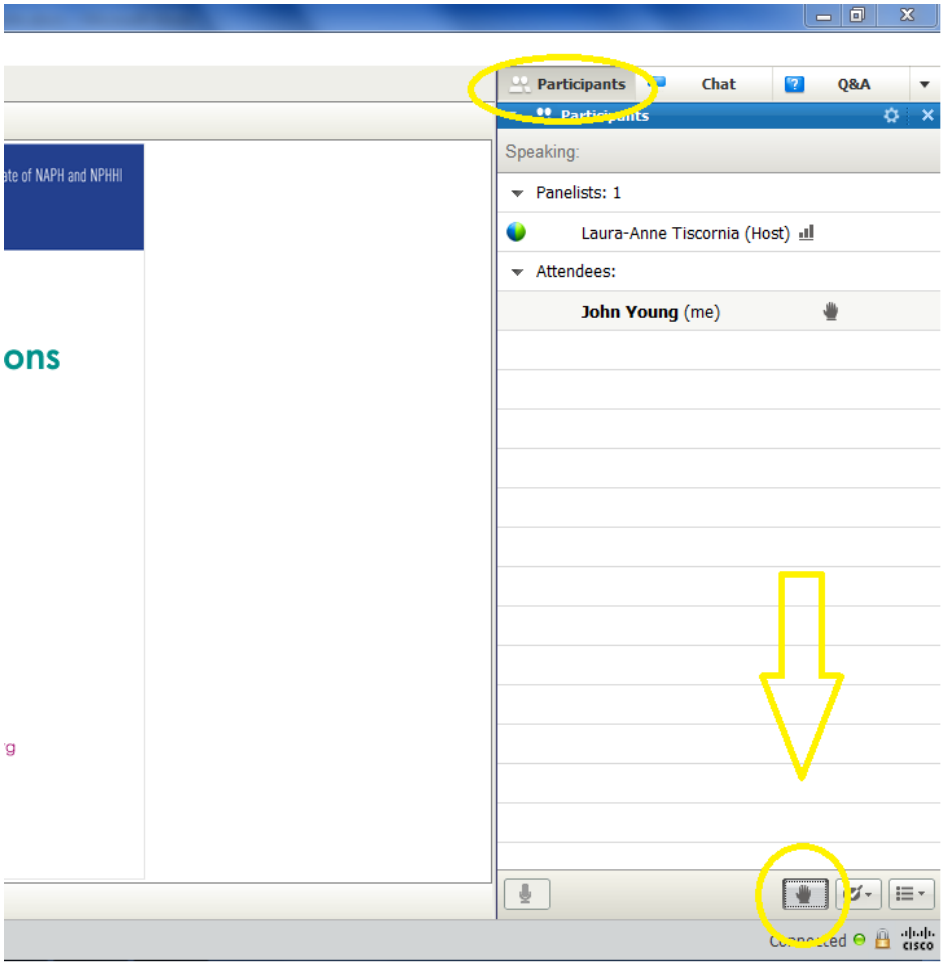
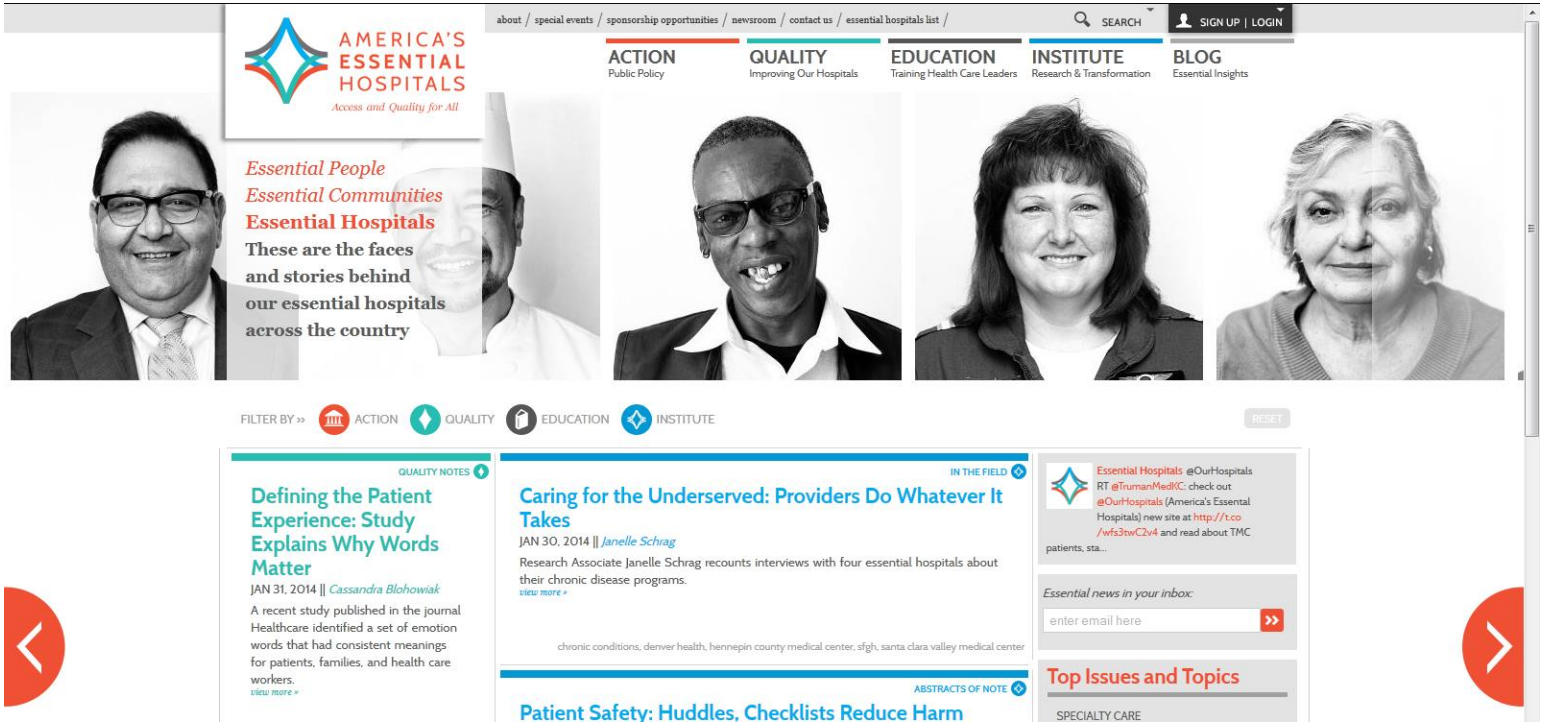


ENGAGE AT OUR NEW WEBSITE!



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AGENDA

- Partnership for Patients and 2014
- Care Transitions Taskforce – Improvement Work at SFGH
  - » Michelle Schneidermann, MD, San Francisco General Hospital
- Prevent Readmissions Optimize Ambulatory Care Transitions (PROACT)
  - » Sara Levin, MD, Contra Costa Regional Medical Center, Martinez, Calif.
- Transition of Care Program at Santa Clara Valley Medical Center
  - » Thomas Ormiston, MD, and Linda Panofsky, PharmD, Santa Clara Valley Medical Center, San Jose, Calif.
- Q & A
- Upcoming events

2014 PARTNERSHIP FOR PATIENTS

Partnership for Patients (PfP)

- CMS-funded
- Reduce nine hospital-acquired conditions by 40 percent
- Reduce readmissions by 20 percent

Hospital Engagement Networks (HENs)

- 27 contracted organizations
- 3,700 U.S. hospitals

Essential Hospitals Engagement Network (EHEN)

- 22 hospitals nationwide
- Only essential hospital-focused HEN
- Special focus on health equity

SPEAKER INFORMATION

Michelle Schneidermann, MD
Associate Clinical Professor of Medicine, Division of Hospital Medicine, UCSF/SFGH
Medical Director, SFDPH Medical Respite & Sobering Center

Sara Levin, MD
Staff Physician, Internal Medicine
PROACT (Preventing Readmissions – Optimizing Ambulatory Care Transitions) Physician Lead
Contra Costa Regional Medical Center

SPEAKER INFORMATION

Thomas Ormiston, MD, FACP
Hospitalist, Santa Clara Valley Medical Center
Clinical Associate Professor of Medicine (Affiliated)
Stanford School of Medicine

Linda Panofsky, PharmD
Clinical Pharmacist, Transition of Care Program
Santa Clara Valley Medical Center
Assistant Professor of Pharmacy Practice/APPE Coordinator
University of the Pacific

CARE TRANSITIONS TASKFORCE – IMPROVEMENT WORK AT SFGH

Michelle Schneidermann, MD

Contact: mschneiderman@medsfgh.ucsf.edu

Associate Clinical Professor of Medicine, UCSF/SFGH

SFGH and DPH enterprise

- SFGH – academic, public, safety net hospital
  - About 16,000 patients admitted/year
  - Diverse patients; staff provide services in >20 languages
  - Young patients : 45% <45 yo, 35% 45-64 yo
  - Payer mix: 30% uninsured, 40% Medi-Cal, 20% Medicare, 10% commercial
  - 8-10% of patients homeless
- Other DPH clinical operations:
  - Laguna Honda Hospital & Rehab: skilled nursing, rehab, and hospice care
  - Home health program
  - Network of primary care clinics
  - Respite care for homeless
  - Substance abuse and mental health services

Readmissions at SFGH

- SFGH's Medicare data 2011-12:
  - 20% All-Cause 30 day Readmission Rate
  - 2/3 within 14 days of discharge
  - 50% after a length of stay $\leq$3 days
  - Top five DRG's: heart failure, alcohol/drug abuse, COPD, Diabetes, and Renal Failure
  - The 30 day readmission rate for core measures
    - 20% for AMI
    - 32% for CHF
    - 19% for Pneumonia

Care Transitions Taskforce

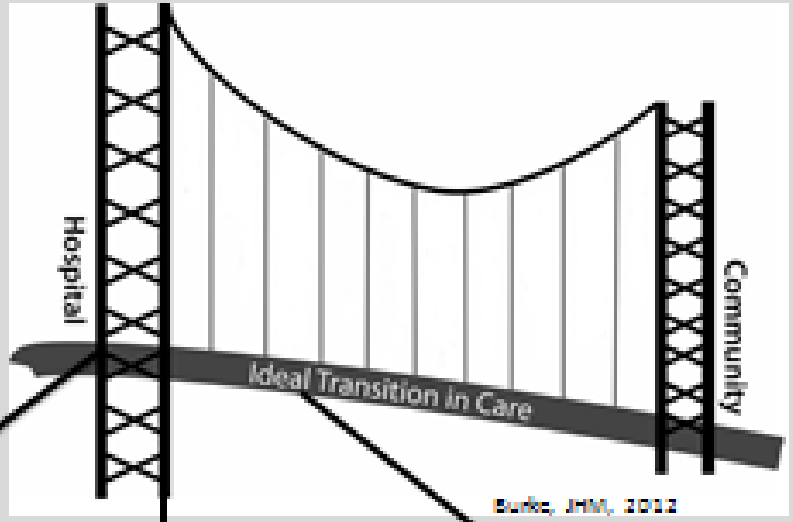
- Multidisciplinary, inpatient/outpatient
- Objectives:
  - Promote transitional care best practices and **reduce readmissions by 15%** by 2014
  - Create a data dashboard
  - Identify high risk patients & deploy interventions to mitigate risk
  - Partner with primary care
    - build capacity and best practices for post-discharge f/u
    - ensure timely follow-up and safe hand-offs

SFGH Care Transitions Taskforce: vision

Define the Problem

- **Multidisciplinary task force** convened to describe what we have and where we need to go.
- **Data Dashboard** created to track readmissions and care transitions process measures starting fall 2013

Develop Solutions



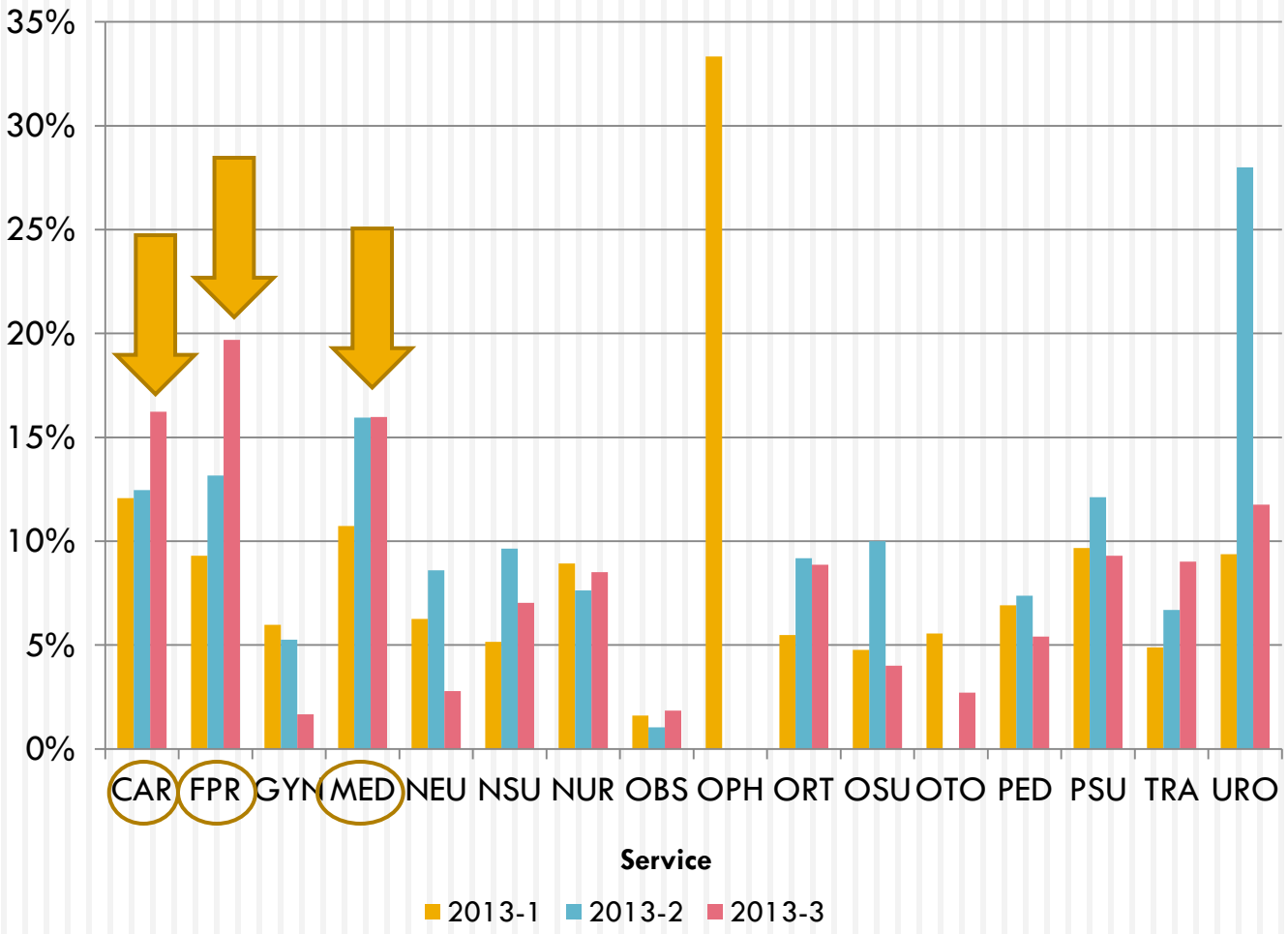
High Risk **Inpatient** **Outpatient**

Care Transitions Taskforce: work to date

- Convened stakeholders
  - Developed aim statement, charter, found executive sponsor, narrowed scope
  - Meet bimonthly, >20 active participants
  - Several subgroups have emerged, including primary care subgroup and pharmacy subgroup
- Received grant from the Moore Foundation to hire data analyst
- Created data dashboard (in process)

Dashboard: 30d readmission rate by service

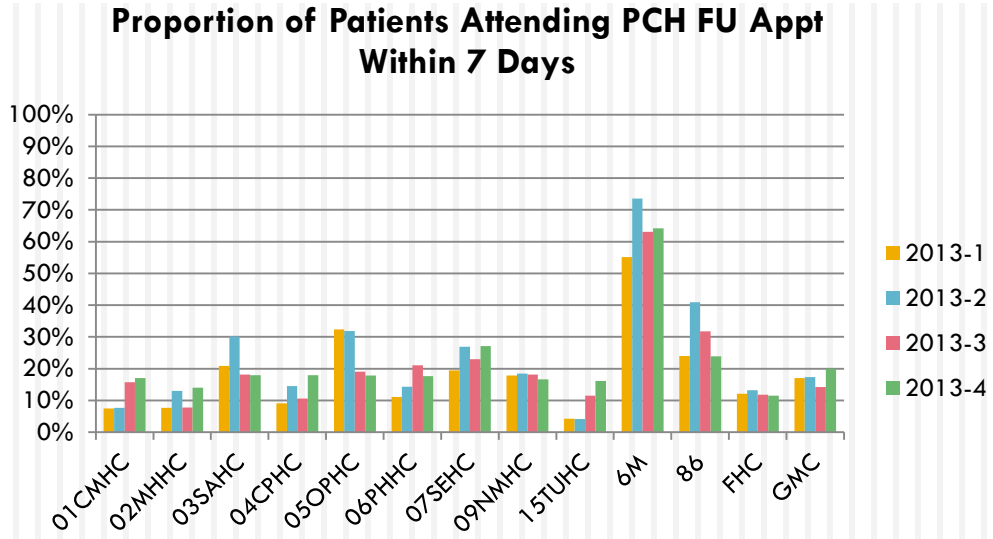
- 2013 median rate for all services: 7% (Q1), 9% (Q2), 8% (Q3)



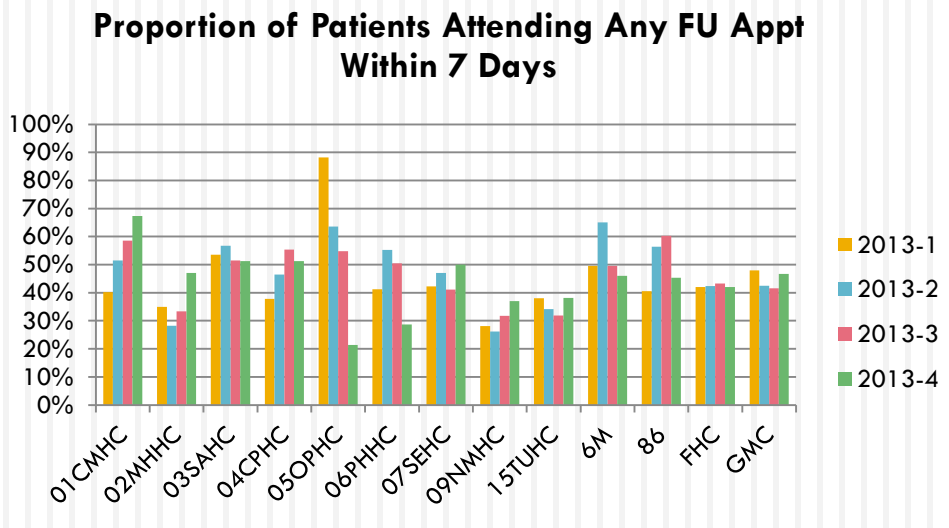
# of Readmissions by Service:

Service	2013-1	2013-2	2013-3
CAR	39	42	49
FPR	29	42	65
GYN	4	3	1
MED	124	166	174
NEU	6	11	3
NSU	10	16	13
NUR	24	20	24
OBS	5	3	6
OPH	1	0	0
ORT	9	19	21
OSU	1	1	1
OTO	2	0	1
PED	13	9	8
PSU	3	4	4
TRA	20	30	45
URO	3	7	4

Dashboard: post discharge follow-up



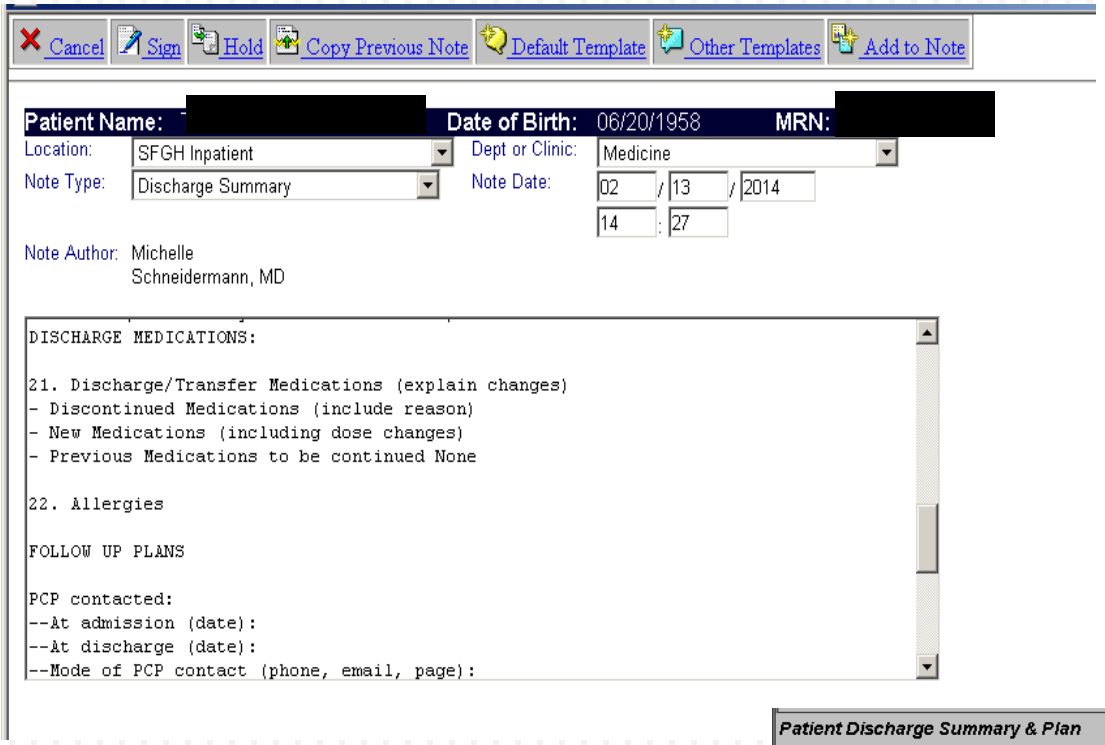
Definition: # patients discharged from SFGH who attend any PCP, RN, or pharmacy appointment at PCH within 7 days/# patients discharged from SFGH who have CHN/COPC providers; excludes patients with providers outside of CHN/COPC and patients unassigned to PCP. Stratified by clinic.



Definition: # patients discharged from SFGH who attend any appointment (primary care or specialty) within 7 days/# patients discharged from SFGH; excludes patients with providers outside of CHN/COPC and W82 Urgent Care. Includes patients without PCP. Stratified by clinic.

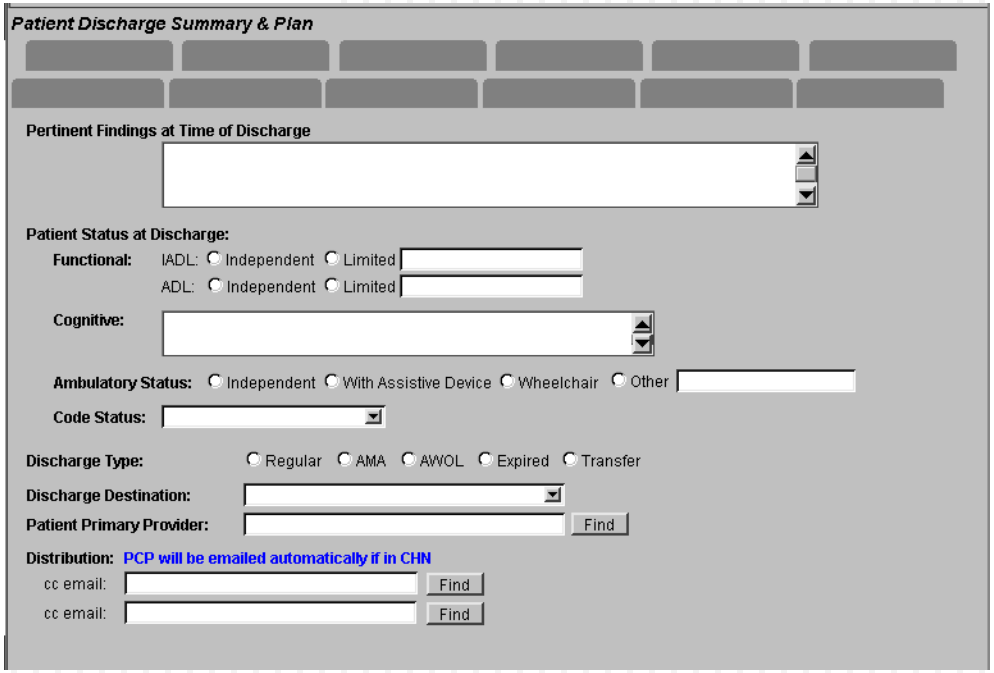
Care Transitions Taskforce: work to date

- INPATIENT improvement work
  - Creating medical student and housestaff curriculum
  - Promoting coordination and process improvement among existing transitional care programs
    - Post-discharge "Bridge" Clinic
    - Medical Respite program for homeless patients
    - SFGH Transitional Care Nursing Program
  - Partnering with IT to build discharge templates into EMR



CURRENTLY: medicine dept has excellent d/c summary template based on best practices.

Problems: not user friendly, can choose whether or not to complete as prompted, not used by services other than medicine.



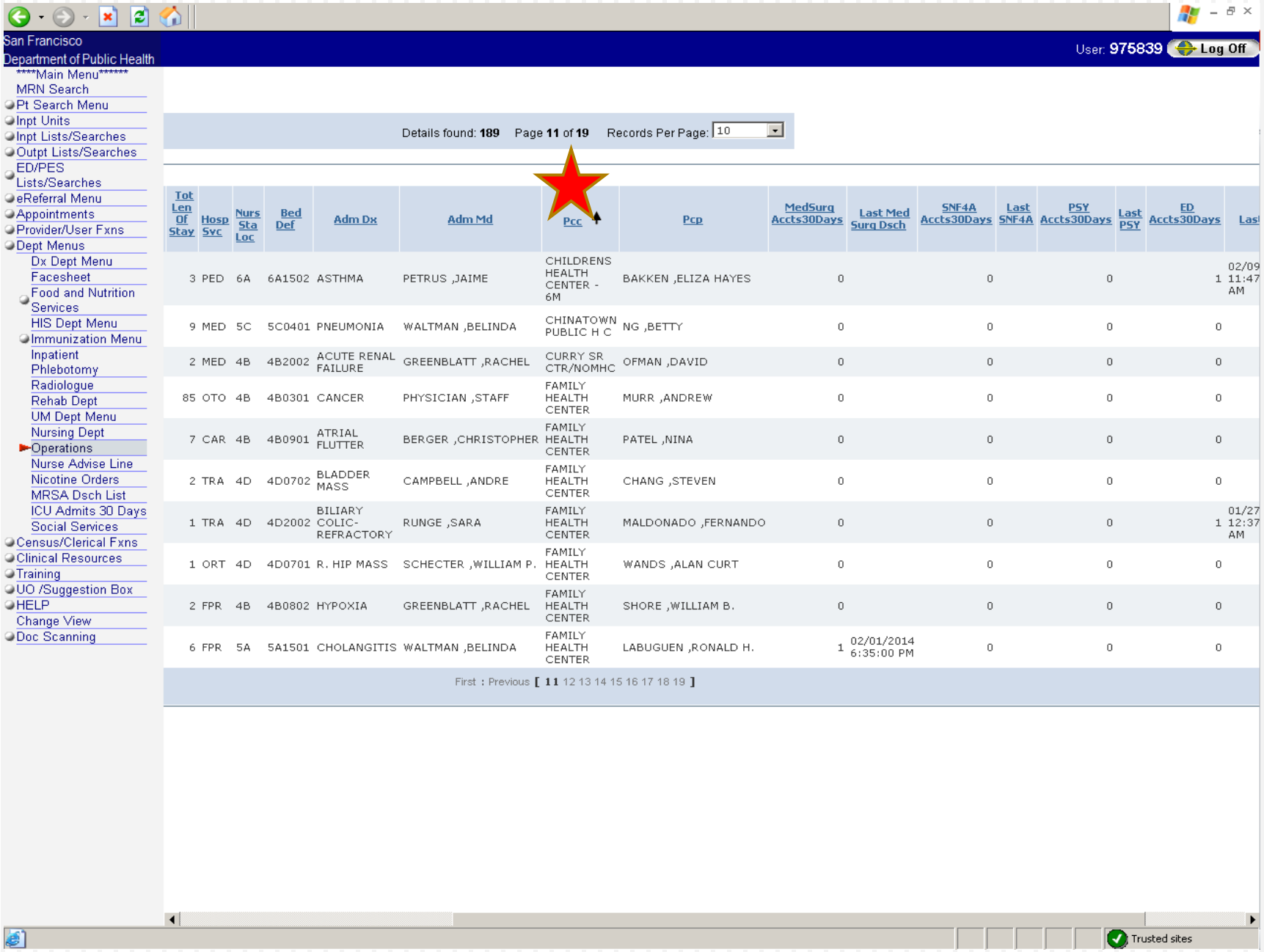
GOAL: build standardized template based on consensus guidelines directly into EMR.

Benefits: User friendly, required by all services, force function to promote completeness.

Care Transitions Taskforce: work to date

- OUTPATIENT improvement work
  - CA Quality Collaborative's "Taking Accountability for Ambulatory Care Transitions" (TAACT) Collaborative
    - Standard work for post-discharge follow-up
    - Small tests of change utilizing health workers and nurses
  - Developed EMR-based admission list, sortable by clinic
  - Convened primary care working group to focus on standardizing:
    - Post-discharge follow-up appointment scheduling
    - Content of post-discharge follow-up appointments
    - Use of non-physician personnel to provide f/u

Admission List, Sortable by PCC or PCP



San Francisco Department of Public Health

User: 975839 Log Off

- ****Main Menu******
- MRN Search
- Pt Search Menu
- Inpt Units
- Inpt Lists/Searches
- Outpt Lists/Searches
- ED/PES Lists/Searches
- eReferral Menu
- Appointments
- Provider/User Fxns
- Dept Menus
  - Dx Dept Menu
  - Facesheet
  - Food and Nutrition Services
  - HIS Dept Menu
  - Immunization Menu
  - Inpatient Phlebotomy
  - Radiologue
  - Rehab Dept
  - UM Dept Menu
  - Nursing Dept
  - Operations
  - Nurse Advise Line
  - Nicotine Orders
  - MRSA Dsch List
  - ICU Admits 30 Days
  - Social Services
- Census/Clerical Fxns
- Clinical Resources
- Training
- UO /Suggestion Box
- HELP
- Change View
- Doc Scanning

Details found: **189** Page **11** of **19** Records Per Page: 10

Tot Len Of Stay	Hosp Svc	Nurs Sta Loc	Bed Def	Adm Dx	Adm Md	Pcc	Pcp	MedSurg Accts30Days	Last Med Surg Dsch	SNF4A Accts30Days	Last SNF4A	PSY Accts30Days	Last PSY	ED Accts30Days	Last
3	PED	6A	6A1502	ASTHMA	PETRUS ,JAIME	CHILDRENS HEALTH CENTER - 6M	BAKKEN ,ELIZA HAYES	0		0		0		1	02/09 11:47 AM
9	MED	5C	5C0401	PNEUMONIA	WALTMAN ,BELINDA	CHINATOWN PUBLIC H C	NG ,BETTY	0		0		0		0	
2	MED	4B	4B2002	ACUTE RENAL FAILURE	GREENBLATT ,RACHEL	CURRY SR CTR/NOMHC	OFMAN ,DAVID	0		0		0		0	
85	OTO	4B	4B0301	CANCER	PHYSICIAN ,STAFF	FAMILY HEALTH CENTER	MURR ,ANDREW	0		0		0		0	
7	CAR	4B	4B0901	ATRIAL FLUTTER	BERGER ,CHRISTOPHER	FAMILY HEALTH CENTER	PATEL ,NINA	0		0		0		0	
2	TRA	4D	4D0702	BLADDER MASS	CAMPBELL ,ANDRE	FAMILY HEALTH CENTER	CHANG ,STEVEN	0		0		0		0	
1	TRA	4D	4D2002	BILIARY COLIC-REFRACTORY	RUNGE ,SARA	FAMILY HEALTH CENTER	MALDONADO ,FERNANDO	0		0		0		1	01/27 12:37 AM
1	ORT	4D	4D0701	R. HIP MASS	SCHECTER ,WILLIAM P.	FAMILY HEALTH CENTER	WANDS ,ALAN CURT	0		0		0		0	
2	FPR	4B	4B0802	HYPOXIA	GREENBLATT ,RACHEL	FAMILY HEALTH CENTER	SHORE ,WILLIAM B.	0		0		0		0	
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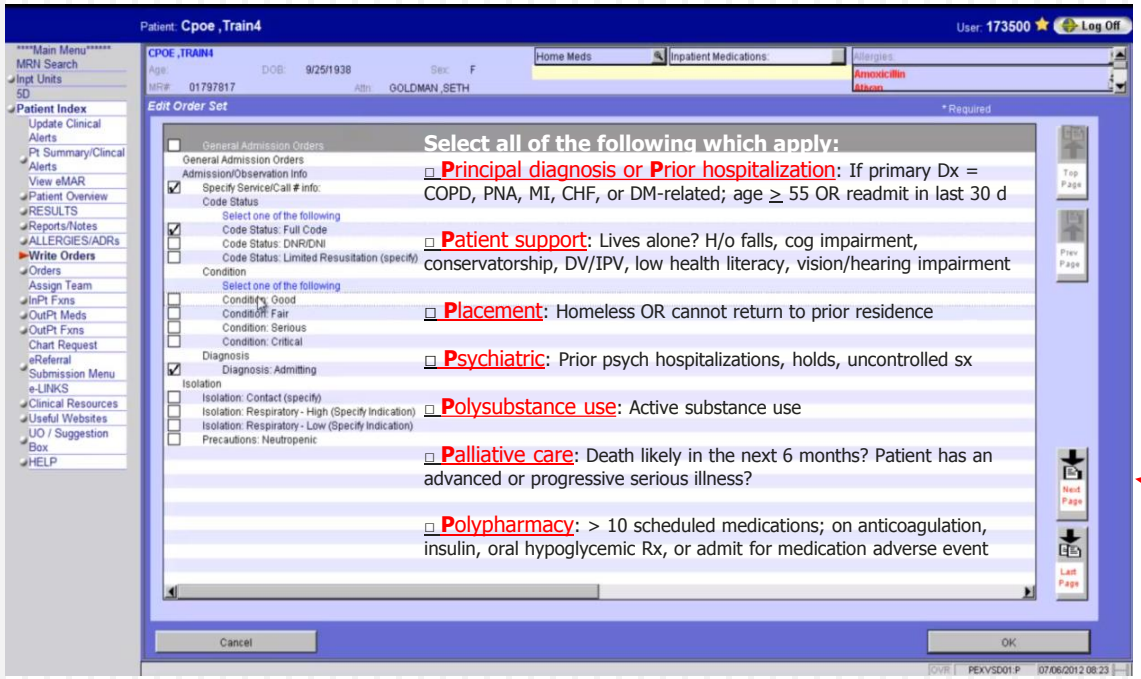
First : Previous [**11** 12 13 14 15 16 17 18 19]

Trusted sites

Care Transitions Taskforce: work to date

- HIGH RISK PATIENTS improvement work
  - Risk prediction tools
    - Developed a modified BOOST 7P's tool
    - Partnering w/IS to build LACE index into EMR
    - Developing SFGH-specific risk prediction tool
  - SFGH Transitional Care Nursing Program
    - Bedside teaching/coaching and post-d/c phone calls for 30d
    - CHF focus: low literacy teaching tools, pharmacist
    - Piloting "Meducation" software
  - Partnering w/SF Community Care Transitions program
    - High risk Medicare patients

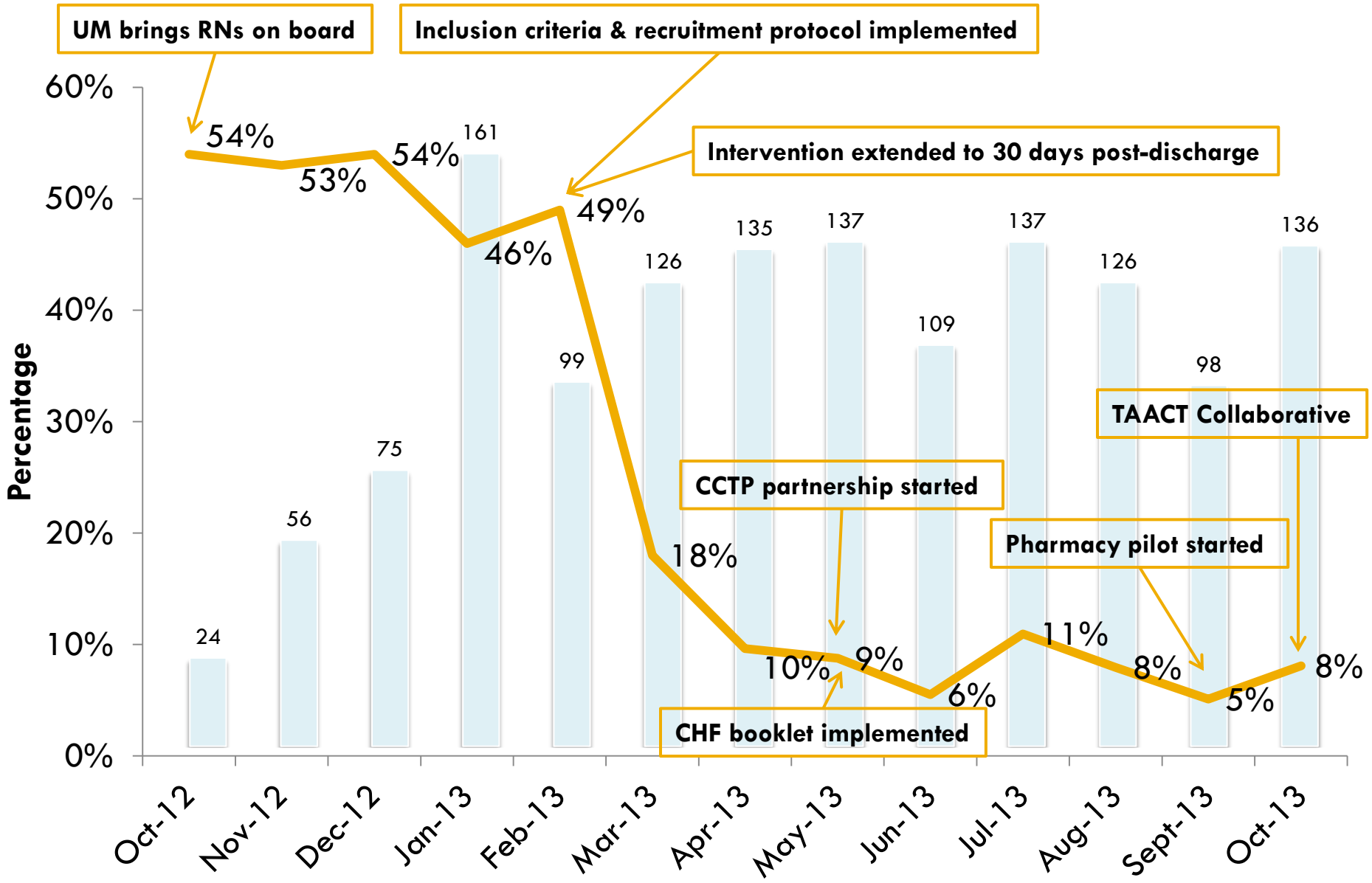
Modified 7P's



Standard Orders

	MD	SW	UM	RN
☐ **Principal diagnosis and Prior hospitalization** **High priority: ≥ 55 yo +/- readmit in 30 days with primary diagnosis of COPD, PNA, MI, CHF, or DM-related complication.**	☐ Action plan review with pt/caregiver(s) for "red flag" sx ☐ Determine/contact PCP, ask UM/PCC to assist in arranging f/u appt within 1 wk of discharge. PCP Info: _____ _____ __ ☐Discuss Plan of Care at rounds ☐If surgery planned during admission, what is the OR date: _____	☐ Eligible for SF Transitional Care Program (outpt)? Referred Date: _____ ☐ Specialty SW involvement and plan (briefly):	☐ Level of Care per InterQual Criteria • ICU – Date: _____ • Acute – Date: _____ • LLOC(circle): ○ SNF ○ SNF-Rehab ○ Custodial ○ Behavioral • Date of LLOC: _____ ☐Insurance? if no coverage, refer to eligibility. ☐Transfer needed? D/w team. ☐ Eligible for SFGH (inpt) Transitional Care Nursing? ☐Assist in arranging f/u appts.	☐ Consider CNS for specific conditions (DM, wounds, etc.). ☐ Disease-specific education using teach back with patient/caregiver Patient Education Items: ○ _____ _____ ○ _____ _____ ○ _____ _____ ○ _____ _____

SFGH Transitional Care RN Readmission Rates & Timeline



Lessons Learned

- A “sanctioned” taskforce with executive sponsorship can bring structure, legitimacy & potentially resources to an otherwise organic process
- Data is key to engaging partners, making decisions in a resource limited setting, and understanding the impact of an intervention
- Relationship building across the continuum of care should be prioritized in transitions work
- There is no “plug and play” solution for care transitions
  - Risk stratification/prediction tools and interventions should be adapted to each system and its population

SPEAKER

Sara Levin, MD

Staff Physician, Internal Medicine
PROACT (Preventing Readmissions – Optimizing Ambulatory Care Transitions) Physician Lead
Contra Costa Regional Medical Center

LET'S GET PROACTIVE!!

PREVENT READMISSIONS
OPTIMIZE AMBULATORY CARE TRANSITIONS (PROACT)

Reducing Readmissions Team
Contra Costa Health Services
Presenter: Sara Levin, MD
slevin@hsd.cccounty.us
America's Essential Hospitals
Webinar – February 27, 2014

Contra Costa Health Services

Our mission is to care for and improve the health of all people in Contra Costa County <u>with special attention to those who are most vulnerable to health problems.</u>

CONTRA COSTA
HEALTH SERVICES

"Improve the health…of those most vulnerable to health problems"

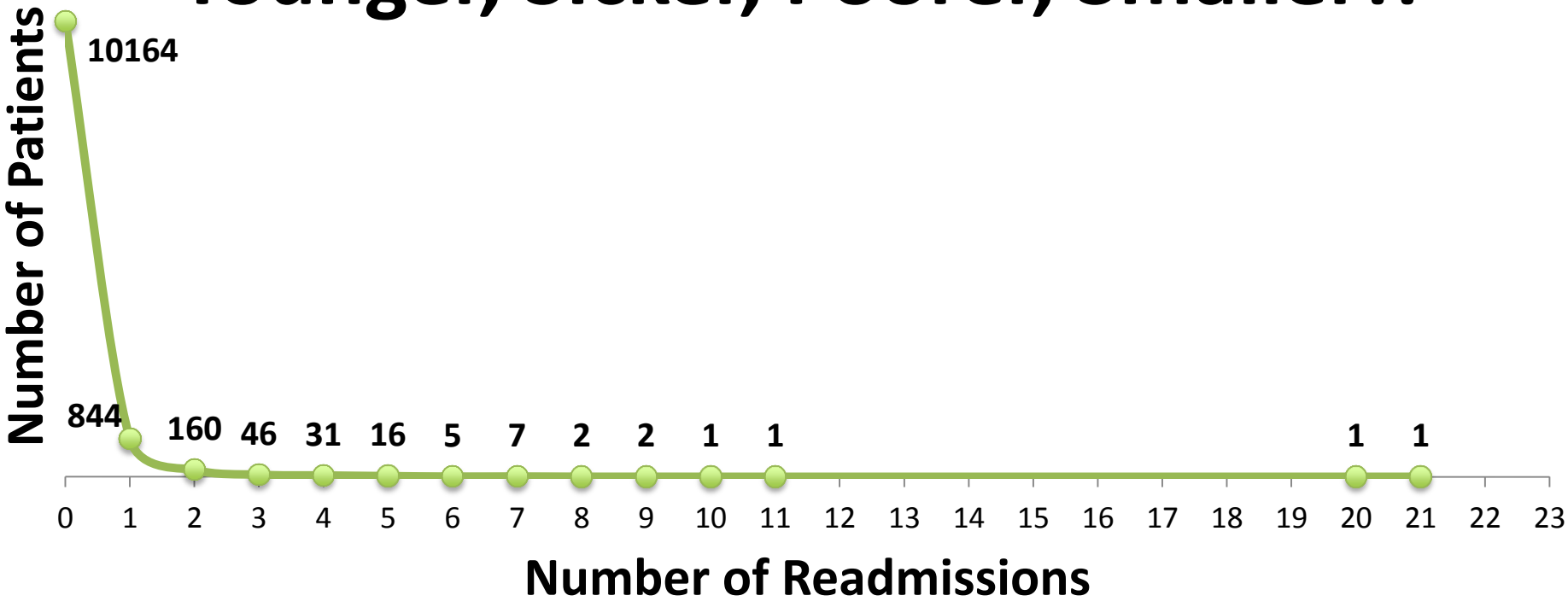
PROBLEM:

- **Delivery system integrated but not aligned**
- **Disease-focused instead of patient-centered**
- **Identifying need - which patient? which problems?**
- **Addressing Social Determinants**

PROACT

MIND THE GAP

The Safety-Net Readmit Population: Younger, Sicker, Poorer, Smaller!!



2008-2011:

- 1% of hospitalized patients readmitted more than 2 times within 30 days of discharge
- 2.5% of hospitalized patients account for 50% of 30-day readmission visits

PROACT

GOALS

- Improve the quality and experience of care during transition period between hospitalization and (re)establishment of primary care
- Reduce morbidity that leads to repeated unplanned hospitalization
- Improve delivery system between venues

PROACT

PROACT Team:
Patient Touchstone

PROACT TEAM: Inpatient teams; Home Visit MDs; PROACT RN; Clinical Pharmacist; Case Mgmt Coaching (CTI); SNF FNP

Warm Hand-offs/ active management

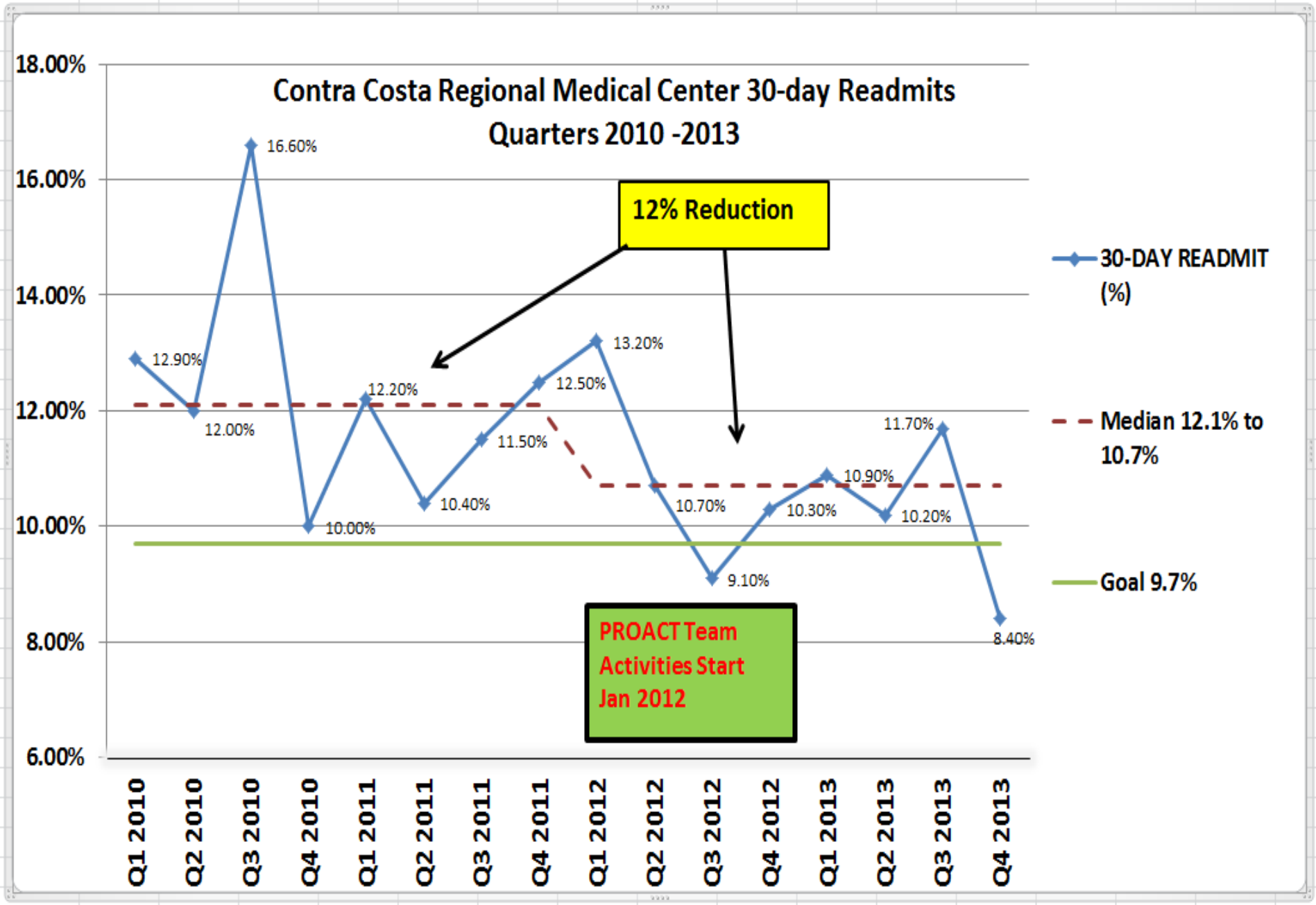
Primary Care Health Home

Based on risk level:

- Phone Visit<72hrs
- PROACT Clinical Pharmacist
- Coaching/Case mgmt.
- Home Health referral
- Home Visit MD
- High Intensity Health Home(?)

Connect to services:

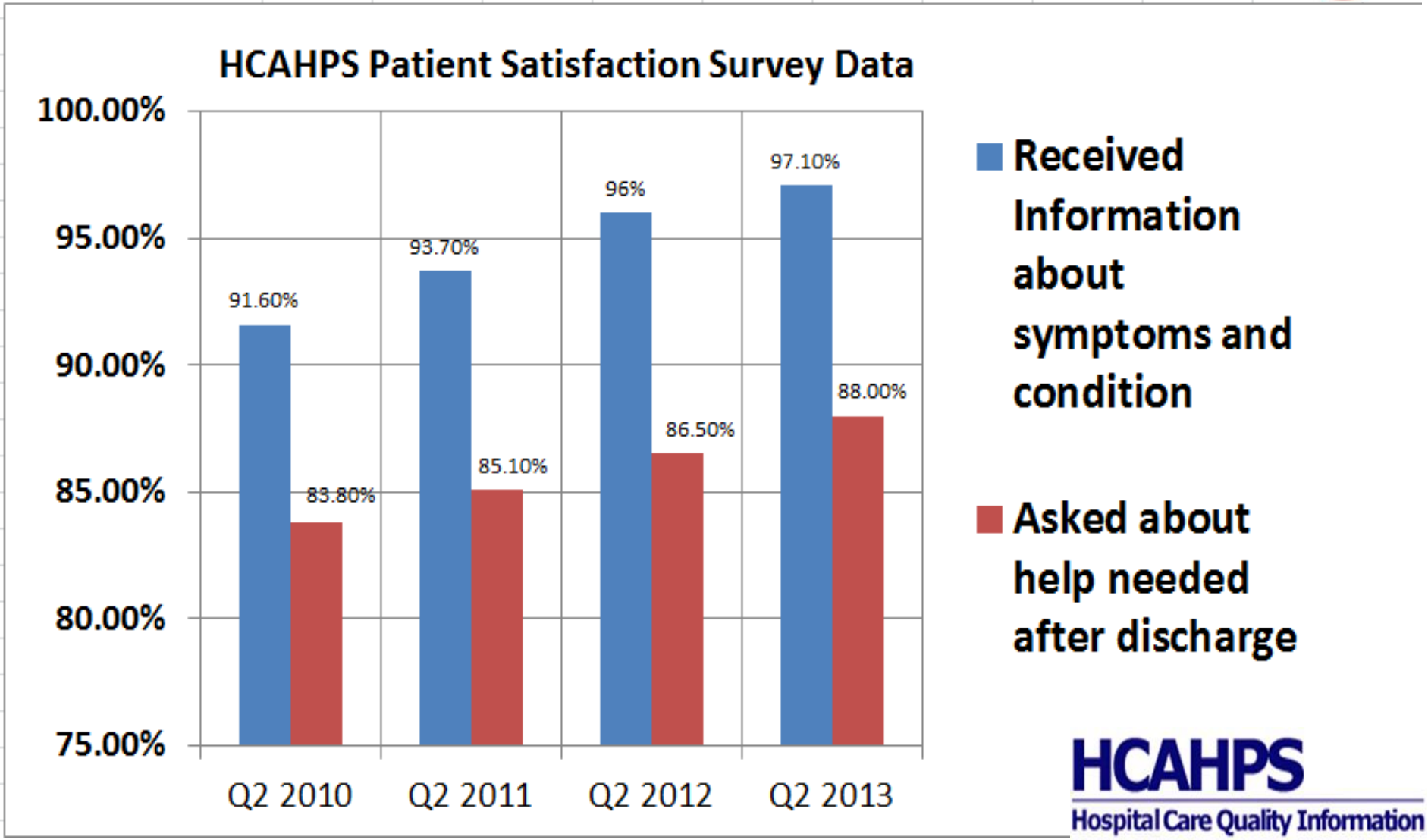
- mental health
- specialty care
- addiction treatment
- hospice
- community support


Contra Costa Regional Medical Center 30-day Readmits
Quarters 2010 -2013
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
12% Reduction
PROACT Team Activities Start Jan 2012
16.60%
12.90%
12.00%
10.00%
12.20%
10.40%
11.50%
12.50%
13.20%
10.70%
9.10%
10.30%
10.90%
10.20%
11.70%
8.40%
Q1 2010
Q2 2010
Q3 2010
Q4 2010
Q1 2011
Q2 2011
Q3 2011
Q4 2011
Q1 2012
Q2 2012
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q4 2013
30-DAY READMIT (%)
Median 12.1% to 10.7%
Goal 9.7%

STEADY RISE IN PATIENT SATISFACTION (Goal? Not Yet!)

PROACT

MIND THE GAP



HCAHPS

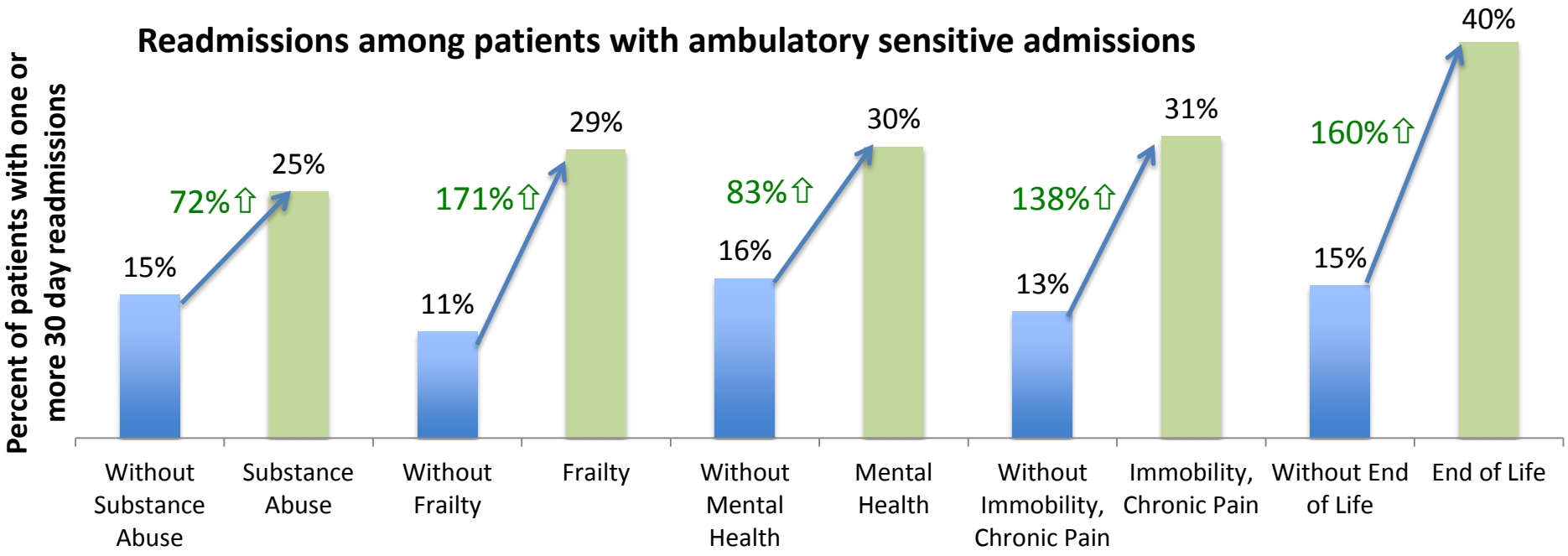
Hospital Care Quality Information from the Consumer Perspective

PROACT

Projected Savings from Readmissions Reductions

- $196K/Mo now! (12% reduction 30-day readmits)
- $327K/Mo when we reach goal of 20%
- $3.9 Mil/Yr

Conditions of Vulnerability Drive Readmissions in Patients with Ambulatory-Sensitive Admissions



- Conclusion: Among patients with ambulatory sensitive admissions, a presence of a condition of vulnerability MARKEDLY increases risk of readmission for patient

PROACT

Current Successes & Challenges

- INPATIENT VS. POST-DISCHARGE FOCUS
- IMPROVING INPATIENT EXPERIENCE WITH ENHANCED TEACHING/TEACH BACK AND DISCHARGE PLANNING
- IMPROVING THE POST-DISCHARGE COORDINATION
- IMPORTANCE OF ASSESSING THE CAPACITY OF THE AMBULATORY SYSTEM TO ADDRESS THE SUPER-UTILIZER POPULATION
- TEAM DEVELOPMENT – IMPORTANCE OF EACH DISCIPLINE DEVELOPING THEIR ROLE WITHIN THE LARGER SCOPE
- ULTIMATELY, HOW DO WE ADDRESS THIS VERY COMPLEX SITUATION WITHOUT ADDRESSING THE FUNDAMENTAL BASIC NEEDS – HOUSING; FOOD; LITERACY?

SPEAKER INFORMATION

Thomas Ormiston, MD, FACP
Hospitalist, Santa Clara Valley Medical Center
Clinical Associate Professor of Medicine (Affiliated)
Stanford School of Medicine

Linda Panofsky, PharmD
Clinical Pharmacist, Transition of Care Program
Santa Clara Valley Medical Center
Assistant Professor of Pharmacy Practice/APPE Coordinator
University of the Pacific

SANTA CLARA VALLEY MEDICAL CENTER

SCVMC Transition of Care Program

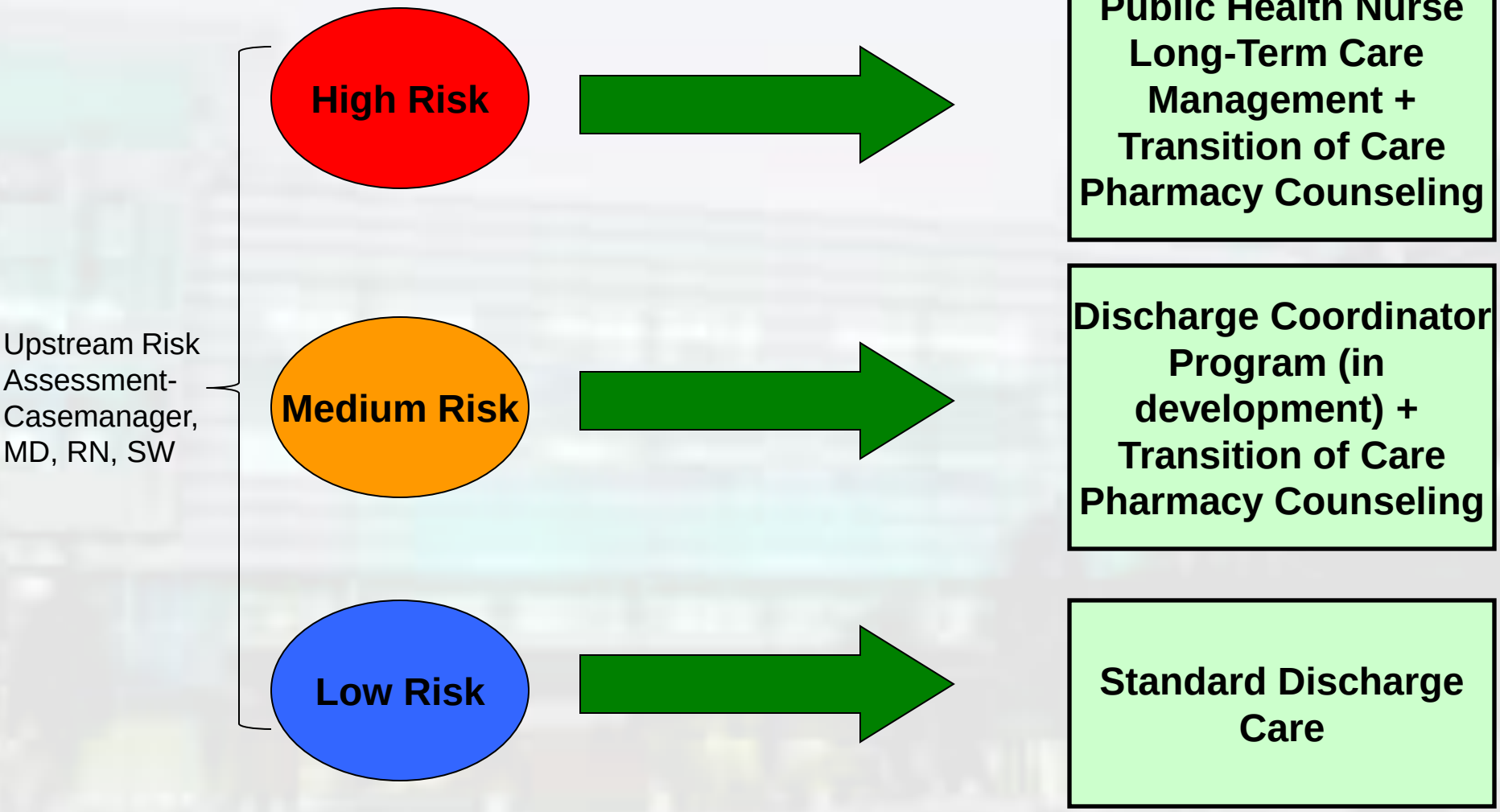
Thomas Ormiston, M.D.
Linda Panofsky, Pharm.D.

Program Goals and Objectives

- Identify high risk patients
- Proactive approach to daily discharges
- Timely receipt of discharge prescriptions
- Discharge counseling for patients
- Identify problems at follow-up
- Improve 30-day readmission rates

SCVMC Overview

- Owned by Santa Clara County
- 574-bed, teaching institution
- Provides care to 25% of residents
- Level 1 Trauma Center
- 500,000 patients per year
- Affiliated with Stanford School of Medicine


Upstream Risk Assessment- Casemanager, MD, RN, SW
High Risk
Medium Risk
Low Risk
Public Health Nurse Long-Term Care Management + Transition of Care Pharmacy Counseling
Discharge Coordinator Program (in development) + Transition of Care Pharmacy Counseling
Standard Discharge Care

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Target Patients

- Recurrent admissions
- Age > 65 years
- > Five medications or Hx of non-adherence
- ≥ 2 co-morbidities or core measure disease
- Heart Failure, Pneumonia, Diabetes, COPD, Asthma, AFib, DVT/PE

SANTA CLARA VALLEY MEDICAL CENTER

Summary

- 13 months (analysis ongoing)
- 864 encounters, 794 patients
- Inclusion: received bedside education by pharmacist; discharge to a home/self care
- Factors (subgroups)
  - Demographics (Dx, age, homeless status, insurance)
  - Received Meds at Bedside
  - Received Follow-up phone call

Demographics

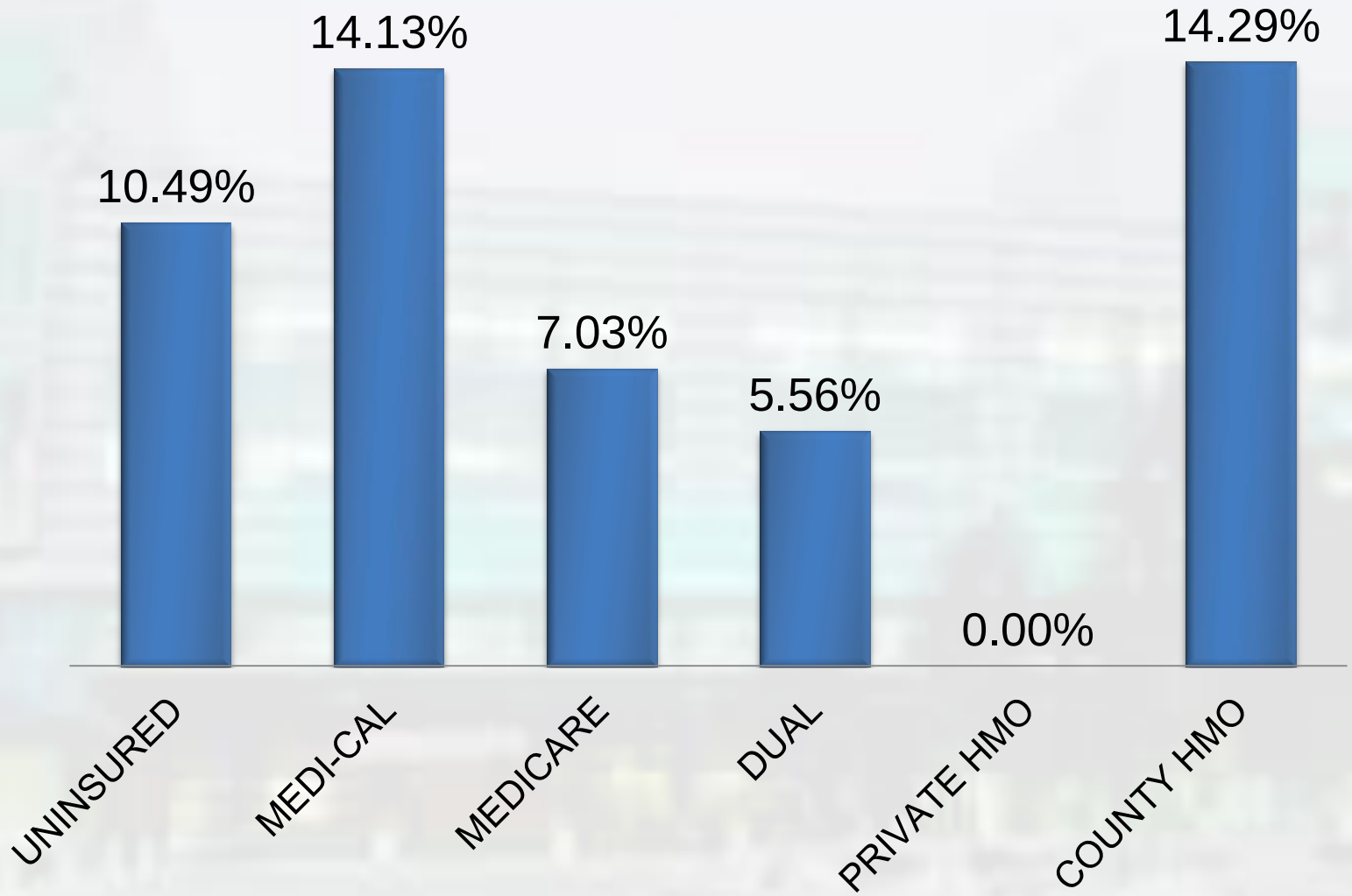
- Language: 79% English, 15% Spanish, 2% Vietnamese
- Gender/Age: 61% male, 81% <65 years old
- Homeless status: 11% homeless
- Insurance: 49% Uninsured, 23% Medicaid,16% Medicare, 9% HMO, 2% Dual
- Total medications: 5 +/- 4.38
- 90% of patient Rxs filled internally (714)
  - 76% received meds at bedside (607)
- 40% of patients were able to be reached for follow up call

SANTA CLARA VALLEY MEDICAL CENTER

Results Conclusion

- Hospital baseline same Dx, all cause readmission rate = 15%
- Total study readmission rate = 10.7%
- Absolute Risk Reduction = 4.29%
- No. Needed to Treat = 23
- 34 readmissions prevented in 794 patients
- Estimated Cost Savings = $314,000
- 367 pharmacist interventions

Readmission Rate by Insurance Type



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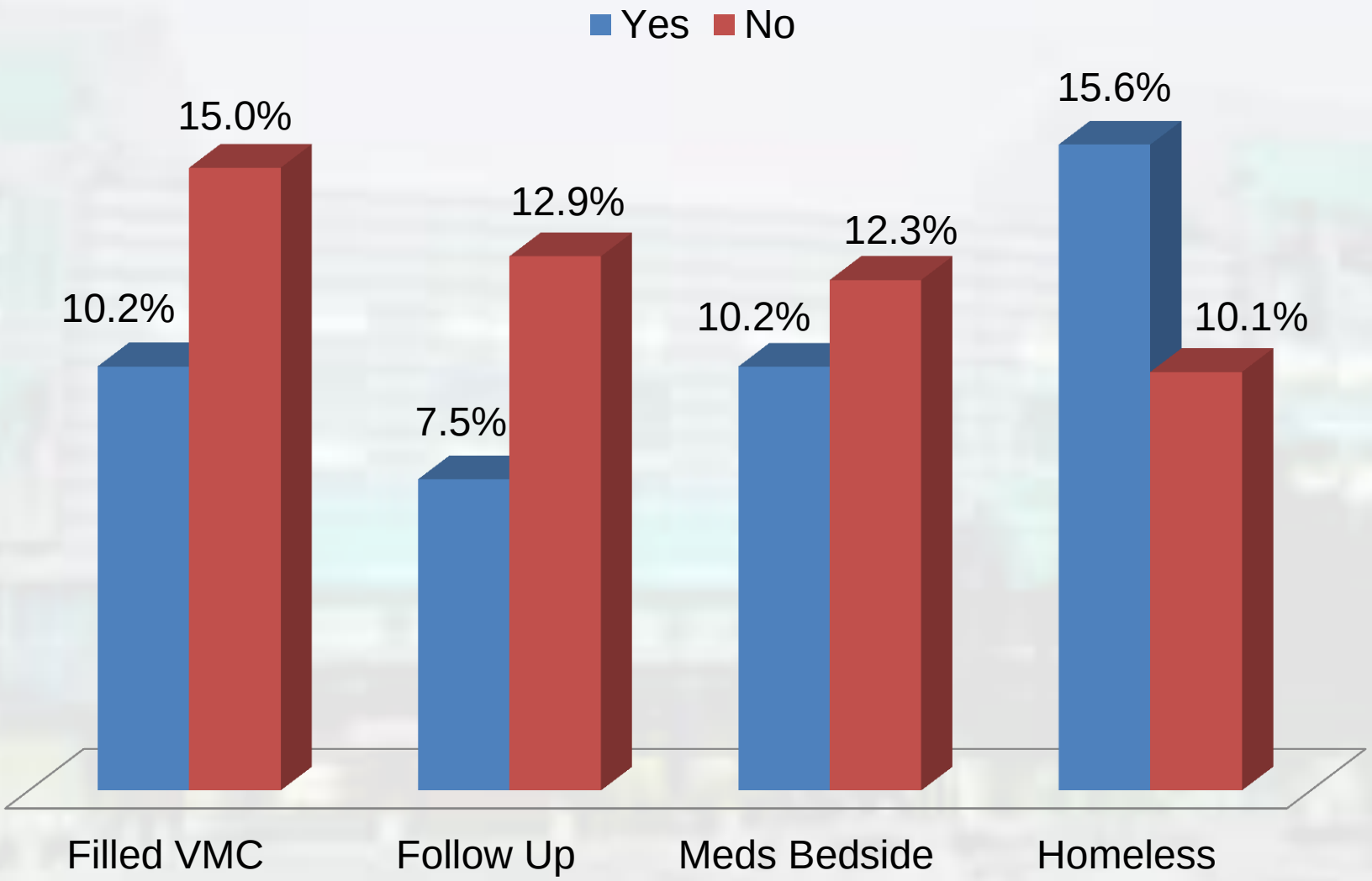
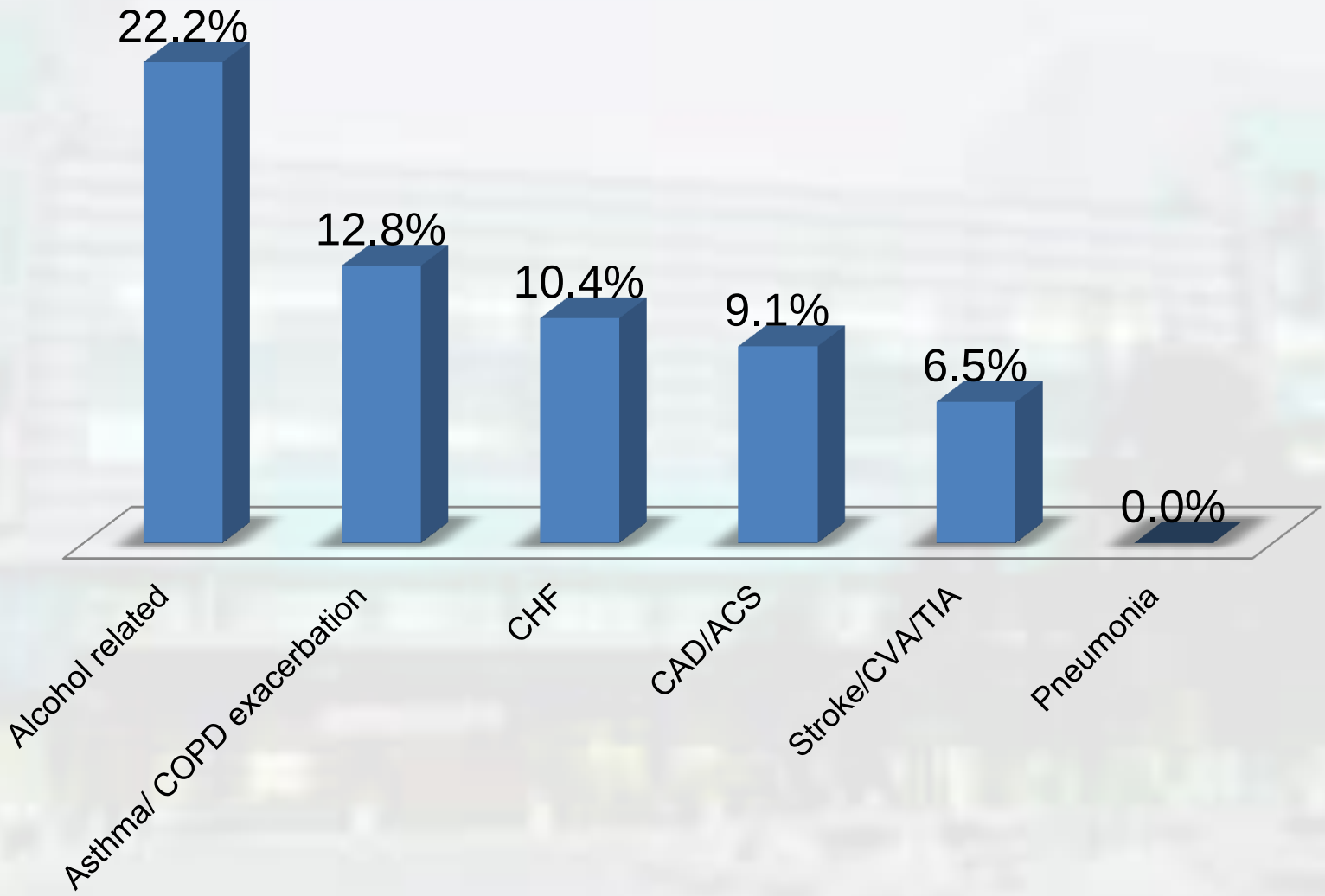
Readmission Rate by Subgroup



High Risk Diagnosis Readmission Rate



SANTA CLARA VALLEY MEDICAL CENTER

Future Goals

- Improve medication adherence
  - Optimize affordability of medications
  - Prevent adverse events post discharge
- Improve 30-day readmission rates
- Decentralized pharmacists
- Expanding program to other units and teams
- Connect program to other hospital initiatives

Q & A

UPCOMING EVENTS

- **Patient and Family Engagement Series IV – Patient and Family Centered Care at the Bedside**

  March 6, 2-3 pm ET

- **Save the Date**

  Patient Harm Series II – Focus on CAUTI

  April 16, 2-3 pm ET

THANK YOU FOR ATTENDING

- **Evaluation:** When you close out of WebEx following the webinar a evaluation will open in your browser. Please take a moment to complete. We greatly appreciate your feedback!

- **Check out the NEW Essential Hospitals Engagement Network website:** http://essentialhospitals.org/groups/ehen/