Coalition for Care
IHA's Hospital Engagement Network

Indiana Hospital Association
INDIANA PATIENT SAFETY CENTER

The Preventable Readmissions Challenge: Pay Now or Pay Later

November 21, 2014

Indiana Hospital Association

Indiana Hospital Association

Webinar Agenda

- Welcome & Introductions
  - Colleen O'Brien, Patient Safety/Quality Advisor, IHA
- The Hospital Readmission Reduction Program (HRRP)
  - Kathy Wallace, Dir. of Performance Improvement, IHA
- Parkview's successful campaign to reduce hospital readmissions
  - Susan McAlister, Dir. of Clinical Effectiveness, Parkview RMC
- Your hospital's foundation as a readmissions funding source
  - Julia Abedian, President, Columbus Regional Health Foundation
- Wrap-up/Questions

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Pay for Performance:
Hospital Readmission Reduction Program
(HRRP)

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Readmission Reduction FY 2015

- Date Range included in HRRP: July 1, 2010- June 30, 2013
- Included Populations
  - AMI
  - HF
  - Pneumonia
  - COPD
  - Total Hip Arthroplasty /Total Knee Arthroplasty
  - CABG (beginning FY 2017)

- Hospital must have at least 25 cases in a population over the three years for it to be considered in the program
- Penalty increases to 3% maximum beginning FY 2015, Oct. 1, 2014
- No opportunity for financial gain with this program

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Observed to Expected Ratio (O/E)

- O/E less than 1= 
  - Lower than expected readmission rate
  - Better quality
- O/E greater than 1= 
  - Higher than expected readmission rate
  - Lower quality

National Financial Impact HRRP FY 2015

Financial penalties for readmissions are increasing across the country

- Fiscal Year 2013 (1% maximum penalty)
  - **$280 million in hospital penalties**
- Fiscal Year 2014 (2% maximum penalty with additional exclusions)
  - **$227 million in hospital penalties**
- Anticipated Fiscal Year 2015 (3% maximum penalty and increase from three to five conditions)
  - 2,623 hospitals will be penalized
  - **$424 million in hospital penalties**

The HRRP Experience in Indiana Hospitals Over Time

FY 2013 and FY 2014 are actual.
FY 2015 is data analysis from FY 2015 IPPS Final Rule .

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The Indiana Experience – FY 2015

- 23 hospitals with no loss
- 68 hospitals with projected losses year three
  - Eighteen hospitals with a **1.0%** loss or greater
  - Six hospitals between **0.76-0.99%** loss
  - Seven hospitals between **0.51-0.75%** loss
  - Twelve hospitals between **0.26-0.50%** loss
  - Fifteen hospitals between **0.1-0.25%** loss
  - Ten hospitals with less than **0.1%** loss

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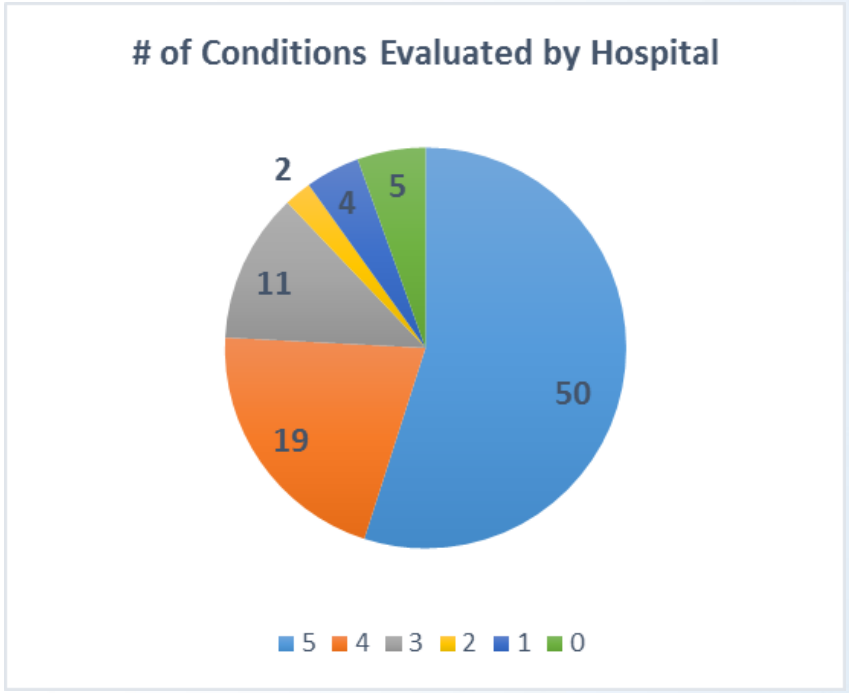
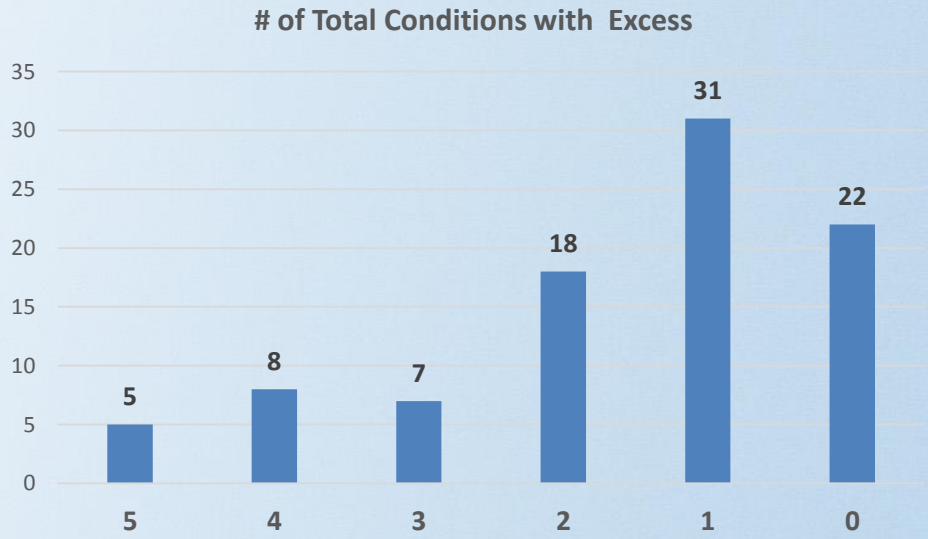
What drove the losses?



Cond.	# Hospitals	# Penalized	% Penalized
PNEU	80	25	31%
HF	81	31	38%
MI	57	26	46%
COPD	80	32	40%
Hip&Knee	70	31	44%



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What drove the losses?

Excess%	PNEU	HF	MI	COPD	Hip&Knee
>20%	1	1	0	0	8
10 -19.9%	4	3	3	5	11
5 - 9.9%	6	12	10	12	5
1- 4.9%	11	12	8	12	7
<1%	3	3	5	3	0

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Readmission Policy Issues

- Measures do not exclude readmissions unrelated to the reason for initial admission in spite of the ACA statutory requirement
- No exclusions for patients with conditions requiring frequent inpatient hospitalizations (e.g.—burns, psychosis, ESRD, substance abuse)
- Poor measure reliability (i.e.—inadequate minimum case threshold to produce accurate measure results)
- **No adjustments for socioeconomic factors beyond hospital control**

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Parkview Health Readmission Journey

Susan McAlister DNP,RN, CPHQ

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January – July 2014 Re-admission Focus

System-All Physicians

Group | Overview | **Quality** | Utilization | Charg

% 30 Day Readmissions (Any APR-DRG)

Details ›

8.94%

10.49%

1976 / 22097 cases

-1.0σ 1.0σ -0.67

Data: Large Non-Teachi…Severity, Hospital-type

Clinical Team Focus

MS-/APR-DRG (Readmission)

MS-DRG	VALUE	CASES
Septicemia Or Severe Sepsis W/O Mv 96+ Hours W Mcc (871)	4.07%	64
Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (392)	3.37%	53
Heart Failure & Shock W Cc (292)	3.05%	48
Renal Failure W Cc (683)	2.86%	45
Heart Failure & Shock W Mcc (291)	2.60%	41

Discharge Disposition

DISPOSITION	VALUE	STD DEV (σ)	CASES
Discharged to Home of Self Care with a Planned Acute Care Hospital Inpatient Readmission	40.00%	1.63	2 / 5
Discharge/Transfer to Home Health	20.78%	1.38	277 / 1333
Left Against Medical Advice	20.24%	1.29	17 / 84
Discharge/Transfer to ICF	21.43%	1.15	24 / 112
Discharge/Transfer to SNF	17.60%	0.50	315 / 1790

Post acute Focus

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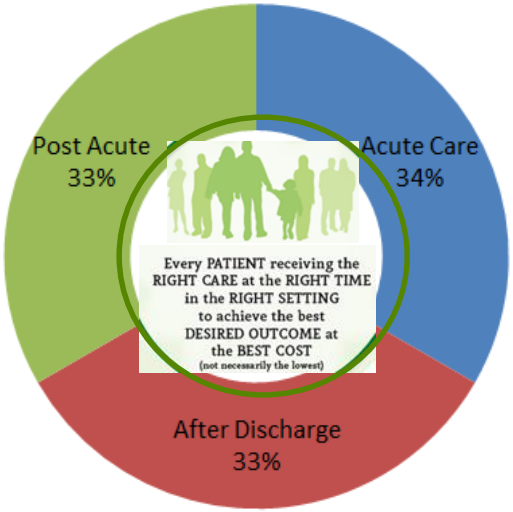
30 Day Re-admission work

- Long Term Care Collaborative
- Long Term Care Pilots
  - Sepsis identification and treatment
  - Rapid Response
  - Transitional Care Unit
- Post SNF discharge calls and visits
- Senior Care

Components of Re-admission Work



- Emergency Department "Hot Spotters"
  - Clinical Decision Unit
- Case management focus on Rankin's ≥ 10
- Collaborative rounding
- Transition Care Nurses
  - Re-admissions
  - High Rankin's
- Service Line focus
- Palliative Care

- Home Health Care
  - Tele-health
- Hospice
- Aging and In Home Services
- Palliative care Clinic
- Wound Clinic
- 30 days Transitional Care NP visits

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Acute Care

- Emergency Department “Hot Spotters”
  - Clinical Decision Unit
- EPIC Notification of re-admission
- Case management focus on Rankin's ≥ 10
- Collaborative rounding
- Transition Care Nurses
  - Second Re-admissions
  - High Rankin's
- Service Line focus
- Palliative Care

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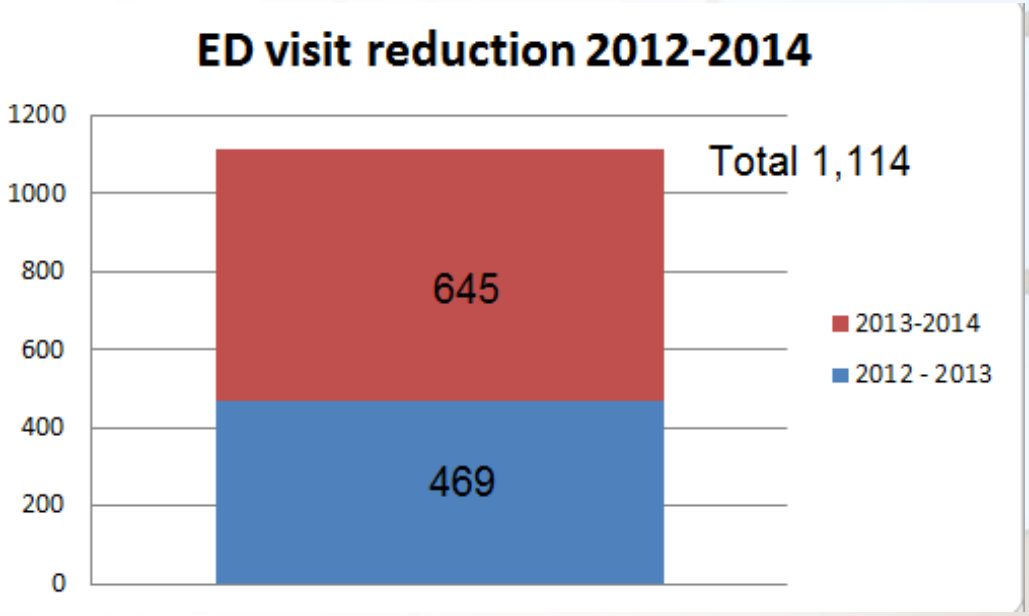
ED “Hot Spotters” Pattern Reductions

- Case Management driven
- Identify frequent visits to Emergency
- Determine needs
- ED Physician develops Plan of Care
- EMR alert to Plan of Care
- Measure progress



154 active patients

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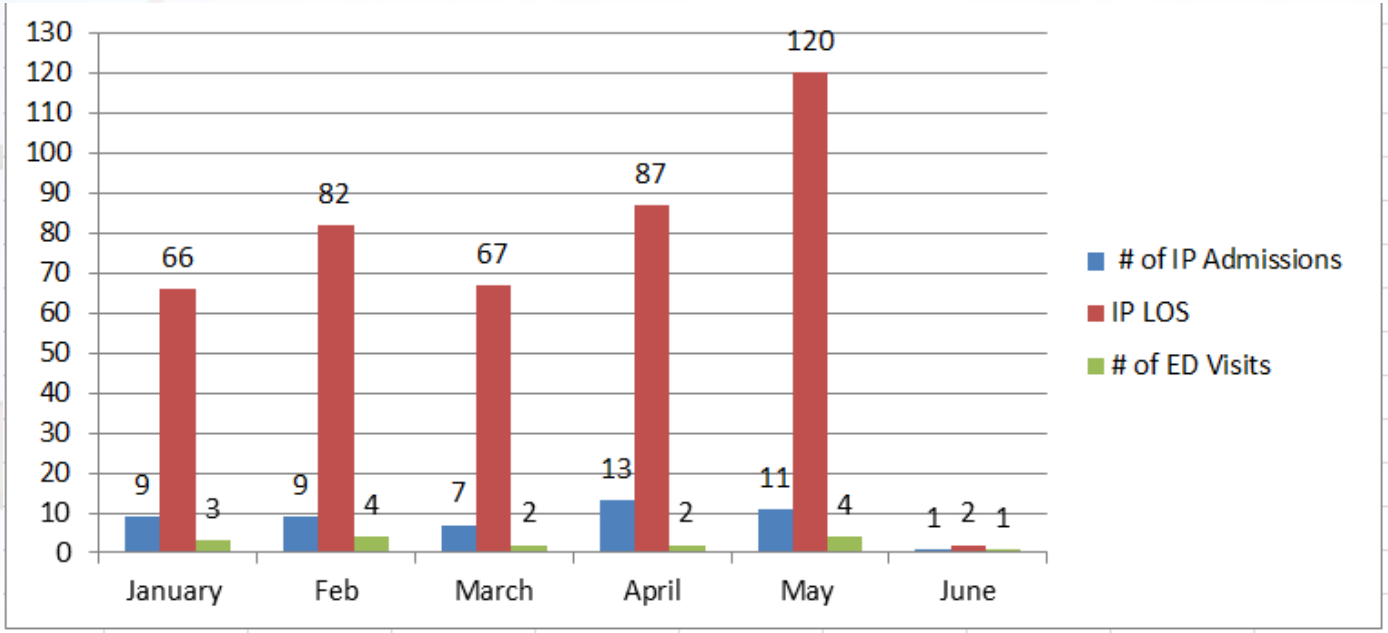
Multiple – Readmissions/Admissions/ ED visits

Goal: To Break patterns of resource use
Individual Care Plan Development



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Clinical Decision Unit Criteria

- Directed by Emergency Department - managed by NP with hospitalist group
  - LOS - Estimated12 hrs. < 24 hours
  - Protocol/symptom driven care
  - Discharge to Home
  - Stable Vital Signs
  - Interventions:
    - IV hydration
    - Diagnostic test
    - Medication management
    - Pain management

Clinical Decision Unit
January 2013 – August 2013

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- Volume = 1,505
- 84 potential diverted re-admissions
  - Inpatient admission followed by CDU visit in 30 days
    - Change in discharge disposition:
      - SNF 8, Rehab 2
    - Home Health Care referrals = 15

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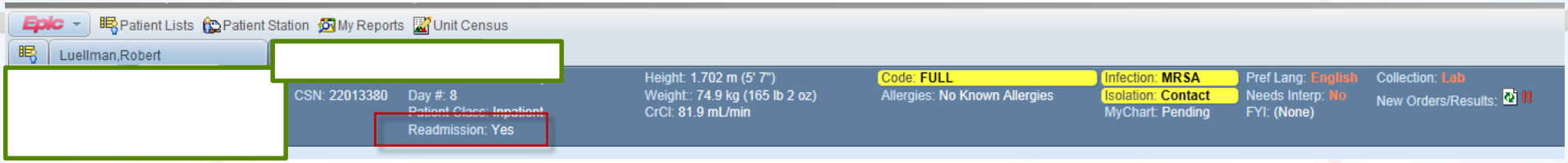
Re-admission on Banner in EPIC



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Early Screen for Discharge Planning (ESDP)

ESDP Components

- 4 item screen completed on admission
  - Age
  - Lives alone
  - Walking limitation
  - Disability
- Score of 10 or more considered at risk for complicated discharge plans
- Sensitive and specific (AUC= .82 - .84)

Holland DE, Harris MR, Leibson CL, Pankratz VS, Krichbaum KE (2006)

Collaborative Care Rounding

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Huddle Team members:

- Hospitalist
- Case Manager
- RN
- Pharmacy

Rounding Prioritization:

- Day of discharge patients
  - Discharge Needs
- Rankin >10
  - Physical Therapy evaluations

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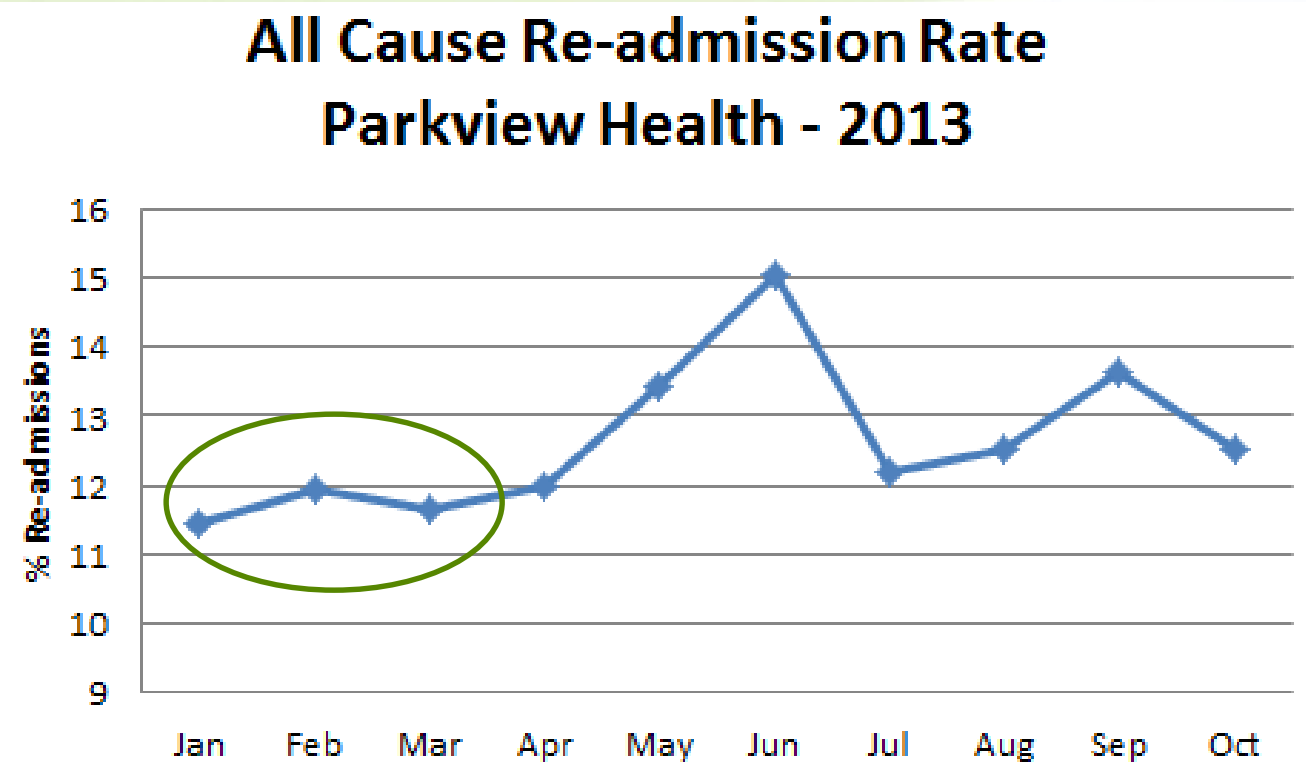
Transitional Care Nurses



Transitional Care January – March 2013

Very High Risk Second Readmissions N = 204

9% rate

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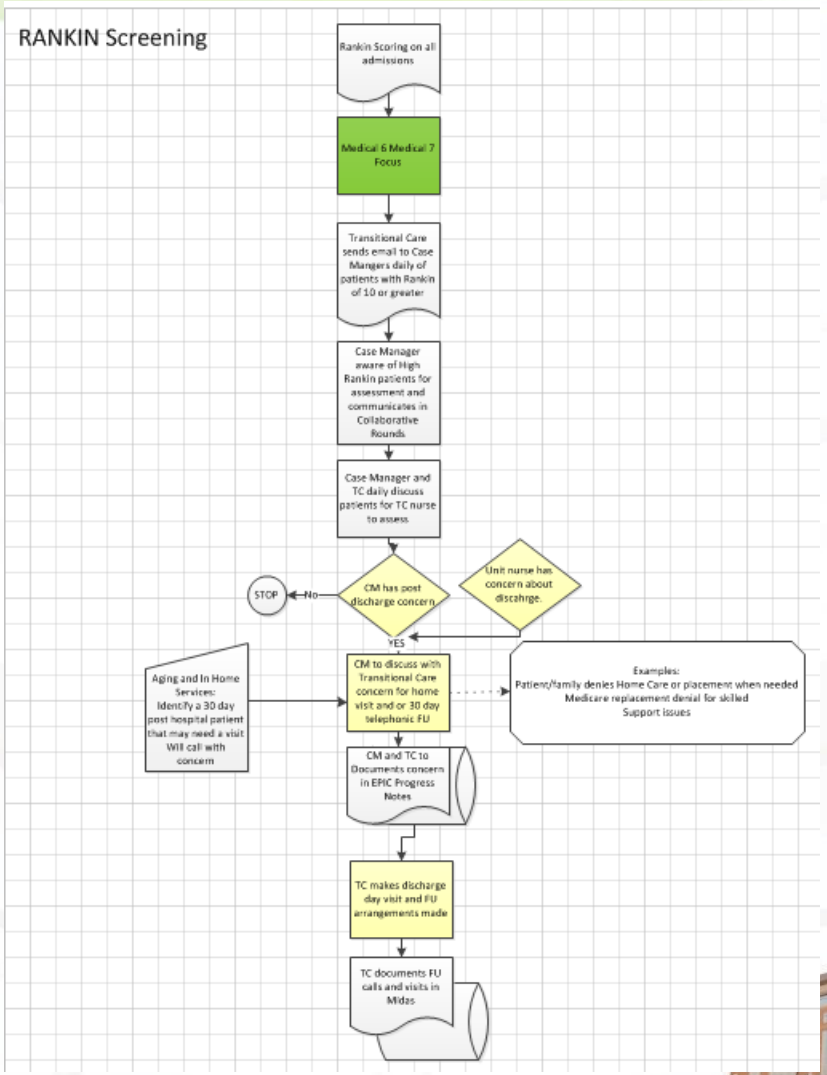
Transitional Care Nurse Flow



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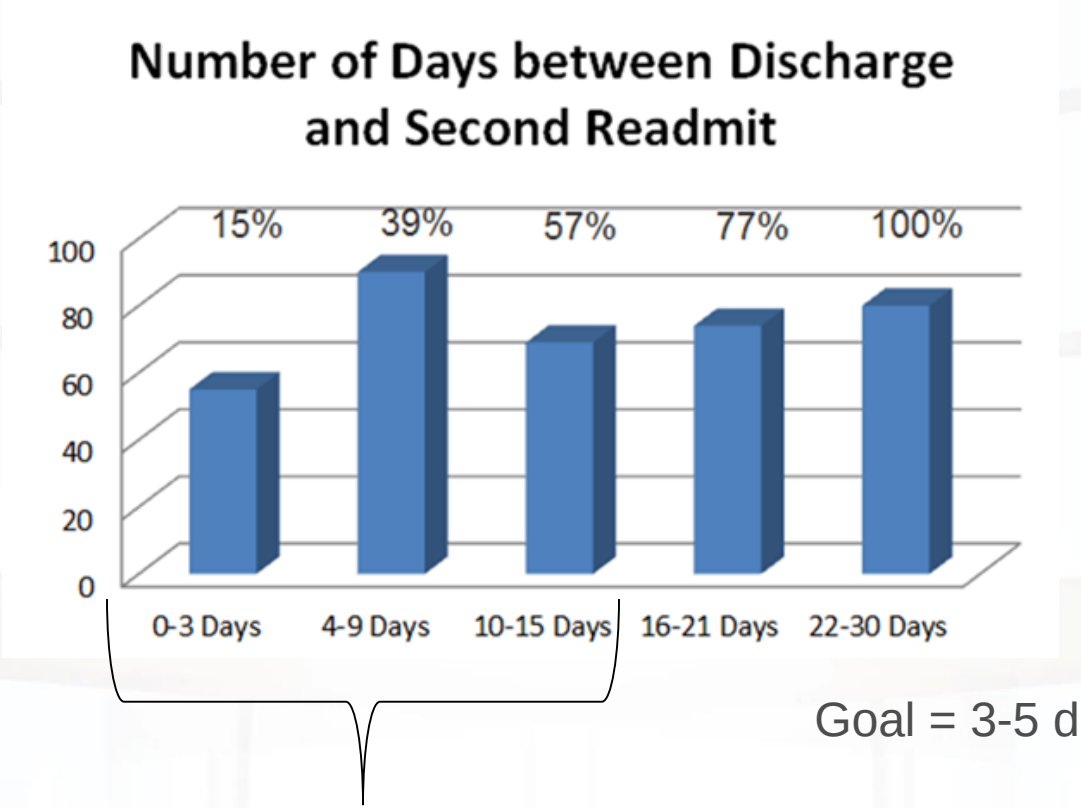
Second Re-admission



Goal = 3-5 days post discharge

Physician Access

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Service Line Focus

Aim Statement

2013 Readmission rate: 10.24%

AIM: To reduce Acute Care Readmission Rate to 9.38% by 12/31/2014

Why is this project Important?
Improved patient care & safety, outcomes, financial responsibility &

Changes being Tested, Implemented or Spread

I-Identify and mitigate failures or problems for discharge planning of patients to PPG physicians.

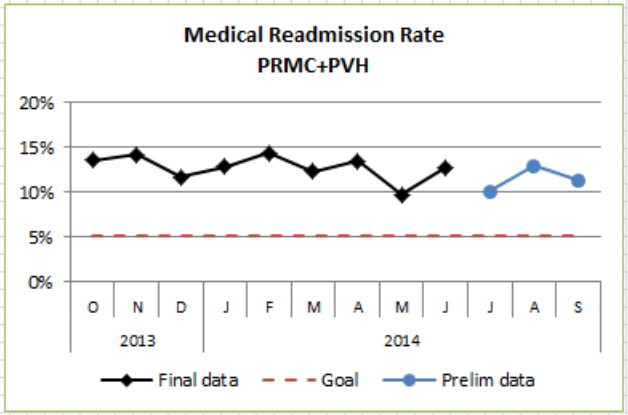
I-Identify and mitigate opportunities for Palliative Care to consult patients.

I-Identify and mitigate failures or problems about collaboration with ED, physicains, and SNF.

I- Identify and mitigate opportunities for patient education for COPD.

Readmission Rate Reduction Dashboard
Medical Svc Line, PRMC+PVH
Month Ending September 2014

Run Charts



Top 10 Medical Readmit DRG's for Last 12 Months (PRMC+PVH)

Index DRG	Desc	Count
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+HOURS W MCC	78
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	59
194	SIMPLE PNEUMONIA & PLEURISY W CC	53
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	52
683	RENAL FAILURE W CC	47
191	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	44
378	G.I. HEMORRHAGE W CC	39
682	RENAL FAILURE W MCC	37
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	36
189	PULMONARY EDEMA & RESPIRATORY FAILURE	33

Lessons Learned

-Physician collaboration teams to understand the complexity of post discharged patients to decrease RA

-Need to develope triggers in EPIC for Palliative Care consults

-Ongoing education with LTC for early signs of sepsis

- Respiratory team to collaborate and deliver patient education for

Recommendations and Next Steps

-Patient's hospital plan of care sent to PPG Primary Care physician for continuity of care
-PPG working on holding 2 appointments open for earlier access to primary physician
-Educate physicians what the Palliative Care program has to offer patients with a chronic diagnosis (Nov 12th)
-Ashton Creek transitional care unit pilot for high risk RA patients
- COPD care plan in approval phase with PPG quality team
-RT using the 5 easy things concept for patient education
-Multiple admission renal patients with collaborative care plan and NP visits

Team Members

Carma Shoemaker,Craig Traxler, Deb Highland, Daine Barnes, Jackie Meyers, Joni Hissong, Juila Walker, Karen Bartom, Kristine Taylor, Laura kaplanis,Lindsey Daniel,Margie Costis, Mathew McAllsiter,Munyaradzi Chakabva, Paula Bostwick,Petra Smith,Rhonda Allen, Susan Mcalister,Tammy Cooper,Tammy

Palliative Care

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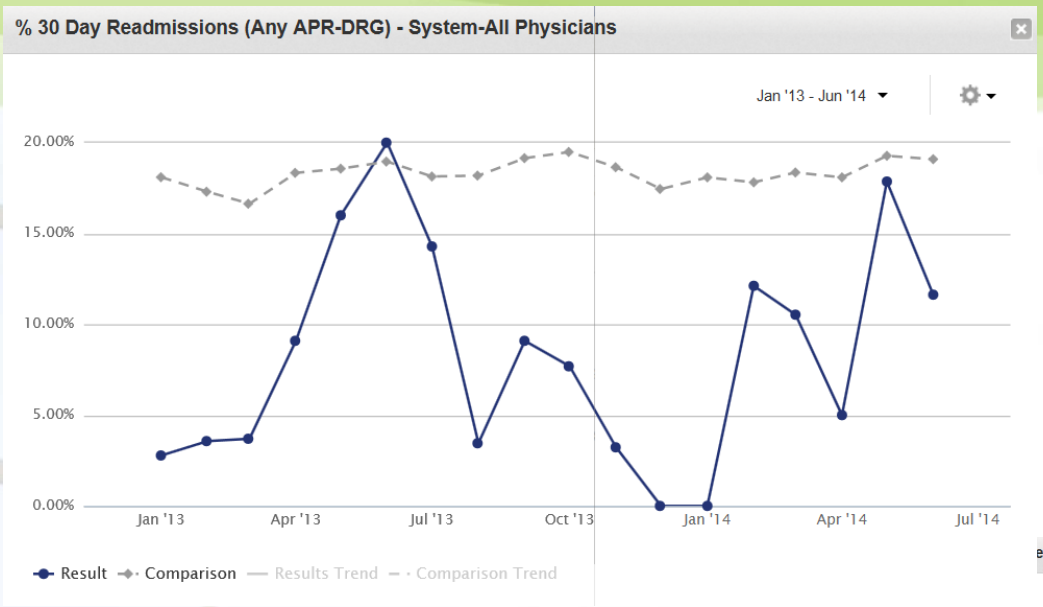
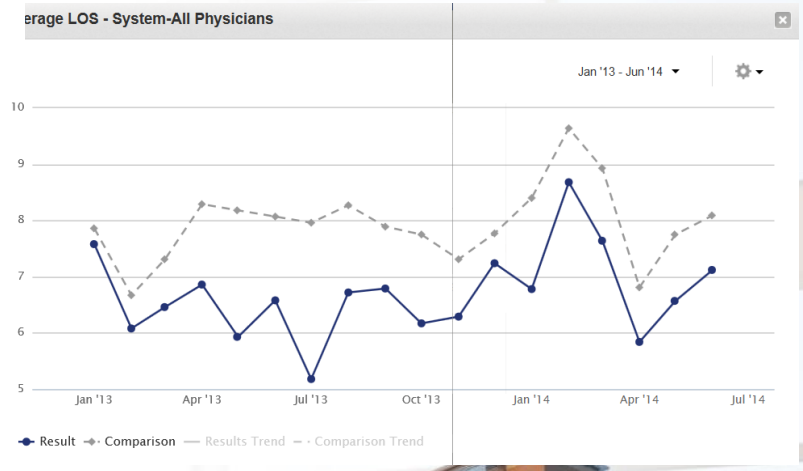


Palliative Care Triggers

Palliative Care Clinic



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After Discharge

- Home Health Care
  - Tele-health
- Hospice
- Aging and In Home Services
- Palliative Care Clinic
- Wound Clinic
- 30 days Transitional Care NP visits

January – July 2014
Parkview Home Health

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- Patient Volume 22,501
- Home Health Discharges 1,850 (8.2%)
  - Benchmark 16%
- 45 % of Home Care referrals outside of Parkview Home Care

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Parkview Home Health Care Readmissions
January – July 2014

- All Cause Re-admission 8.94%
  - Large Non-Teaching hospital benchmark 10.49
- Home Health Re-admissions 18.86% (349)
  - 1.06 Standard deviations above mean

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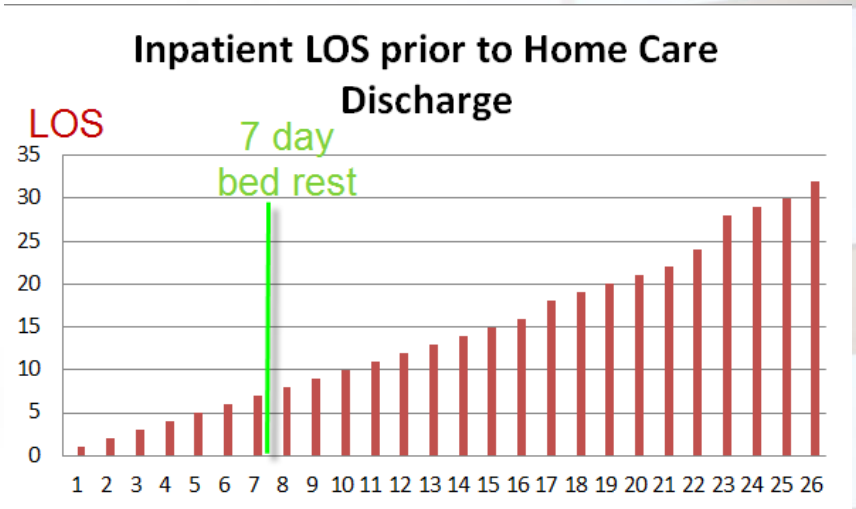
Home Health Care Re-admissions

- 55 % of Home Care referrals to Parkview Home Care
- 19% of readmissions less than 48 hours and potentially not seen by Home Health
- 40% of readmissions 7 days or less
  - CHF patients visited 3-4/week the first 7 days
  - CHF home care pathway implemented

LOS and Bed rest
7 days

- Loss up to 10% plasma volume
  - VTE risk
  - Shrinking skeletal muscles – lowers O2 levels
  - < oxygen – skin integrity
- Strength and muscle mass
- GI tract slows
  - Dysphagia



Aging and In-home Services Medicare Traditional - 2014

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Services:

- Palliative Care Clinic
- CHF Clinic
- Wound Clinic
- Outpatient Infusion
- NP Transitional Care Visits
  - Within 14 days of discharge

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Post Acute Care

- Long Term Care Collaborative
- Long Term Care Pilots
  - Sepsis identification and treatment
  - Rapid Response
  - Transitional Care Unit
- Post SNF discharge calls and visits
- Senior Care

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Parkview LTC Collaborative

- Care Transition/Readmission Focus
- Began - January 2013
- Quarterly Meetings
  - Multidisciplinary Members: Administrators, DONs, Case Management, Hospital Leaders
- Yearly Collaborative Needs Assessment

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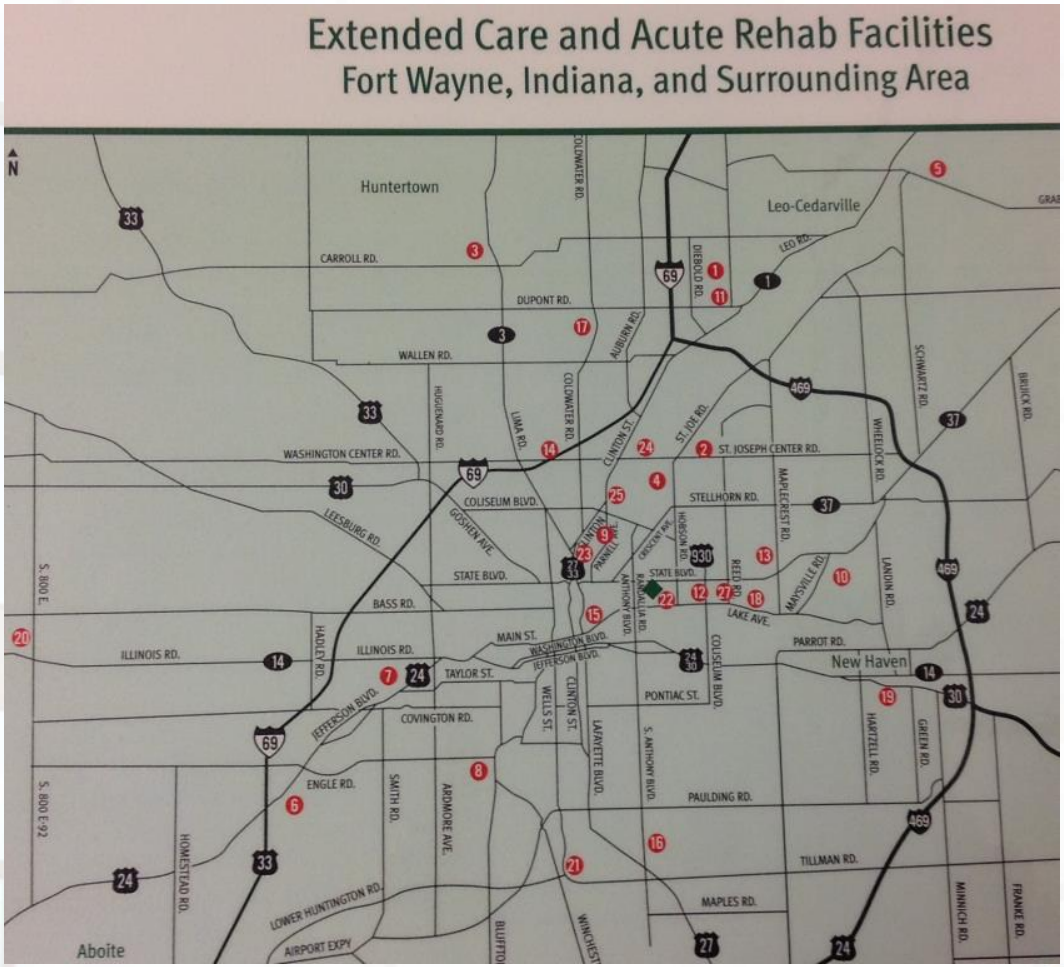
Post Acute Facilities = 27



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LTC Dashboard 2014

STATUS UPDATE

Top 5 Issues Identified 1-29-14	1Q14	2Q14	3Q14	4Q14
SNF Competency Skills/Critical Thinking				Sepsis Pilot
Clinical Education/Quarterly Sessions	CHF	Hydration	Sepsis	Sepsis simulation
Hospital Hand "Over"/Communication				
Care Navigators/Seamless Transition				
IV Fluids/Hydration/ATB				
Care Pathways			Sepsis	Sepsis KPI

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Data Comparisons 2013/2014

- Readmission Rate Ranges
- 4Q13 0 – 92%
- 1Q14 0 – 83%
- 2Q14 0 – 19%
- 3Q14 0 – 26%

Ranges based on new admission volumes

3Q14 Re-admission n = 12 facilities

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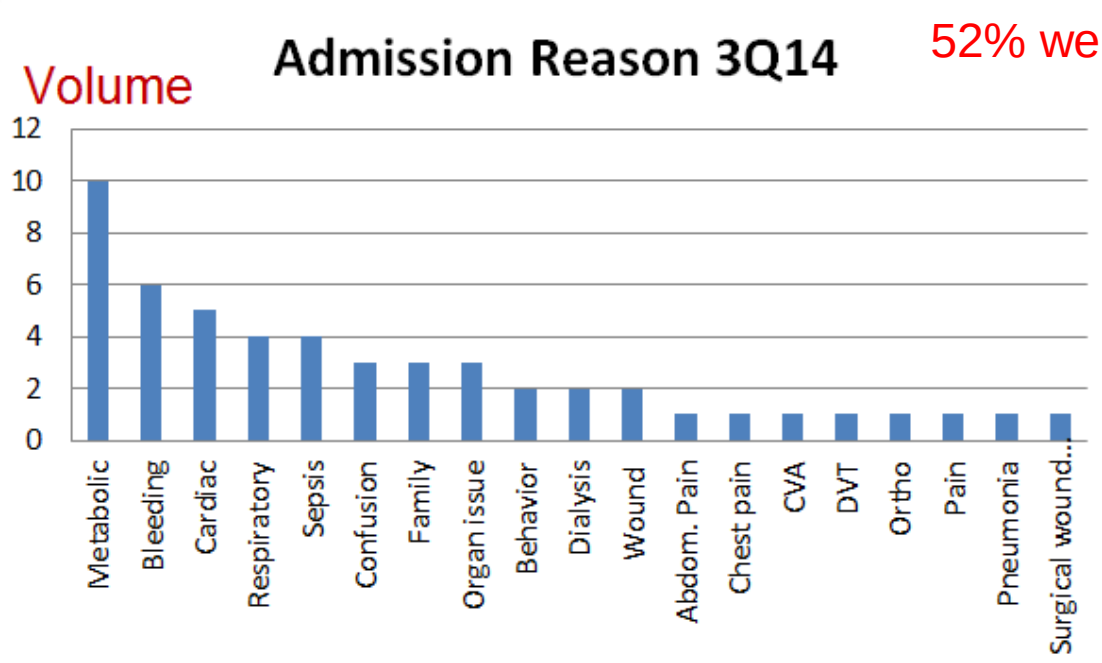
53 patients
28% family request (15 residents)
64% No Code (34 residents)



52% were pre septic or septic

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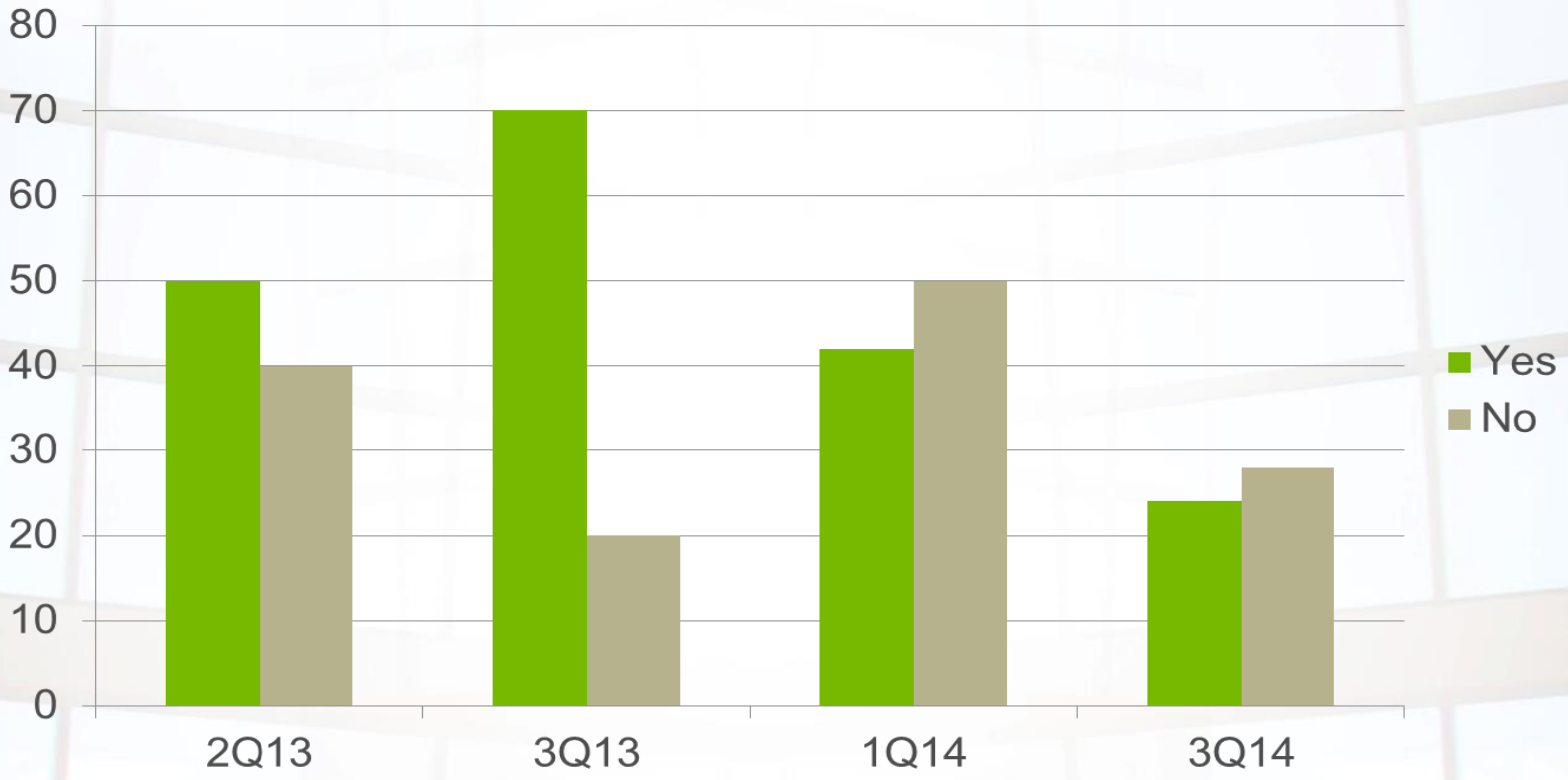
Resident seen by NP or MD prior to transfer



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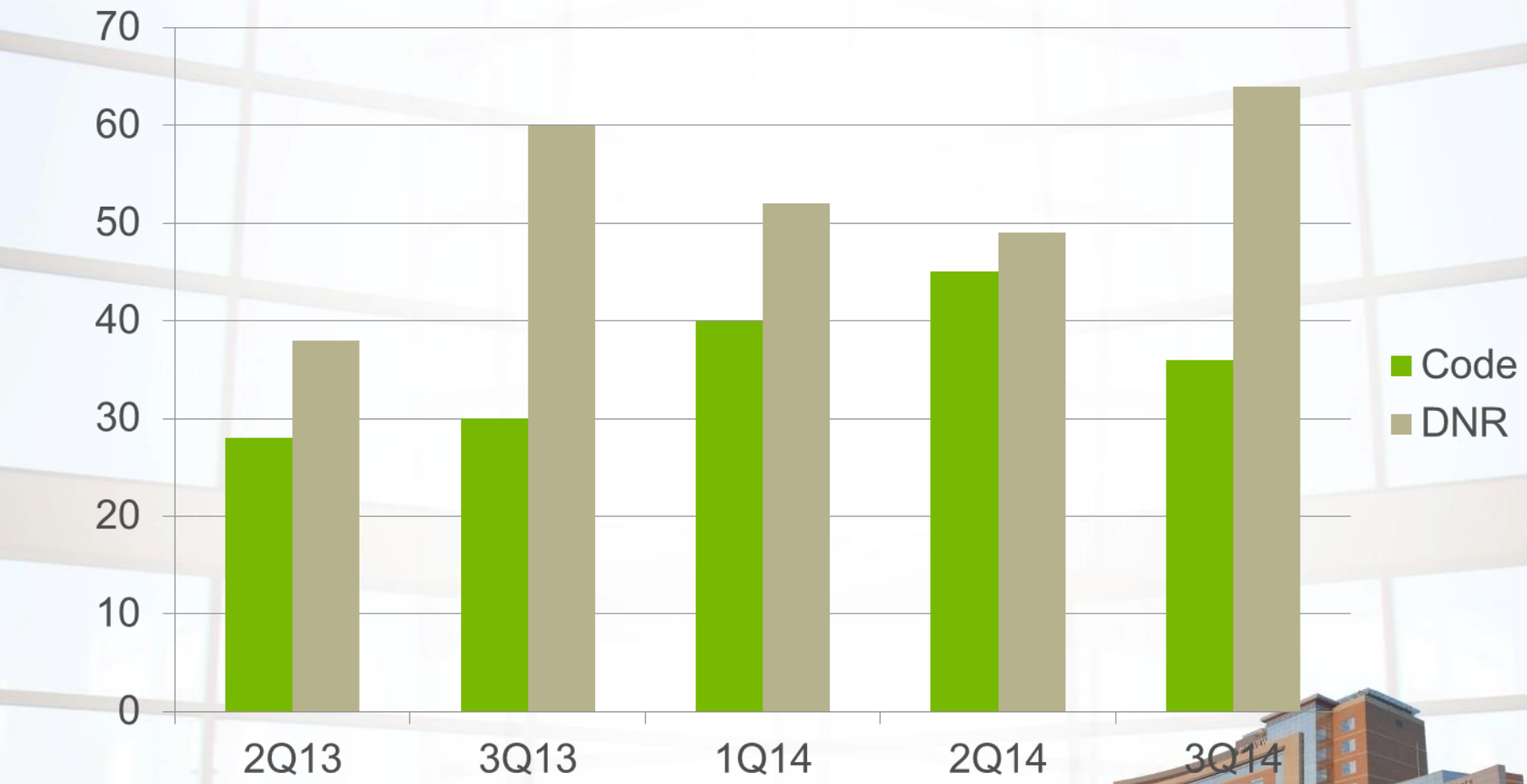
DNR Trends 2Q13 to 3Q14



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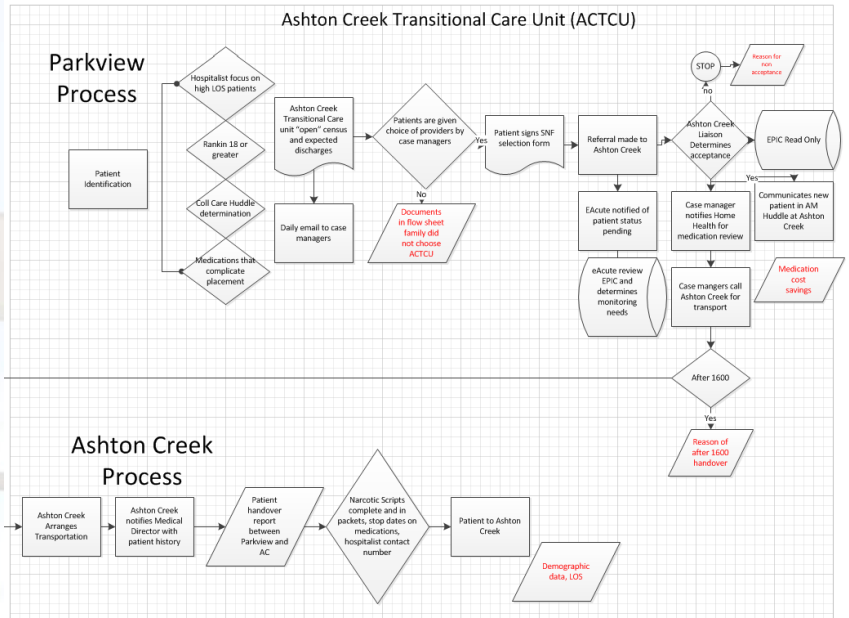
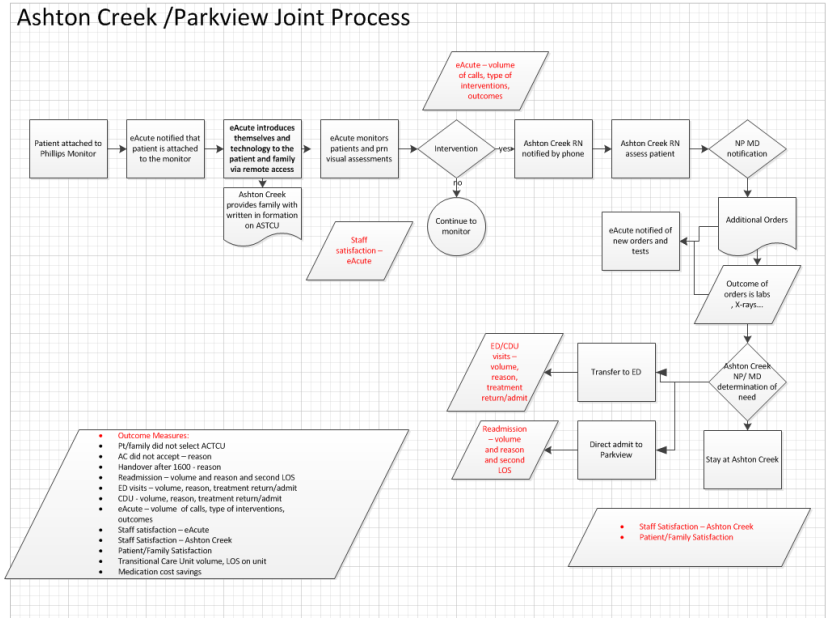
Transitional Care Pilot

To provide patients with high acuity and multiple co- morbidities a smooth transition to Skilled nursing care

- The transitional will be accomplished with remote monitoring assistance from Parkview eAcute unit.
- Dedicated staff and unit at Ashton Creek.





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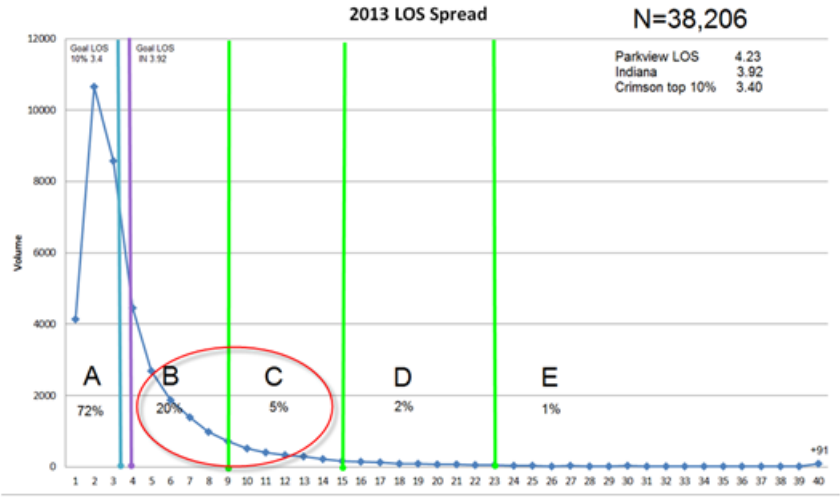
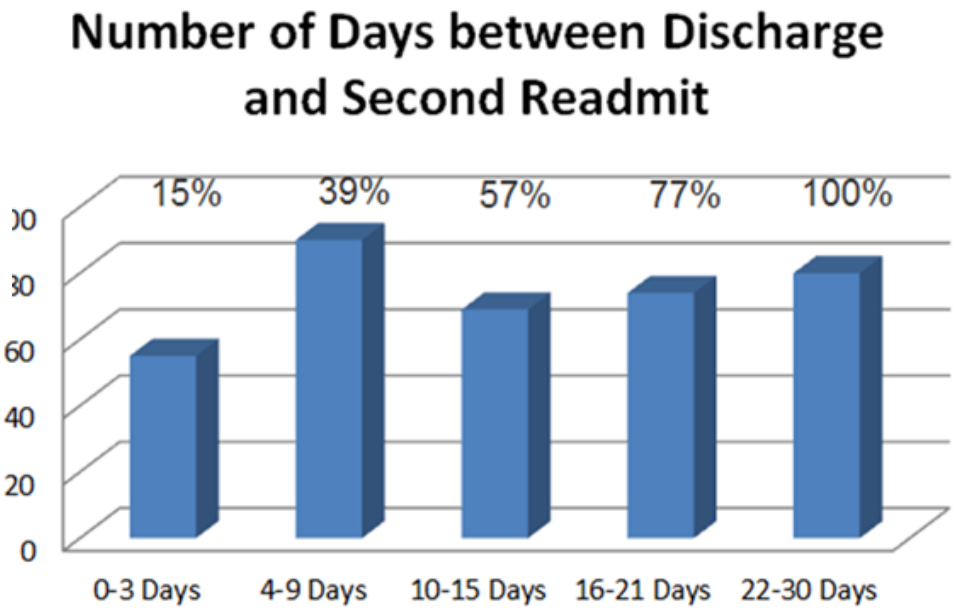
Determination of Need





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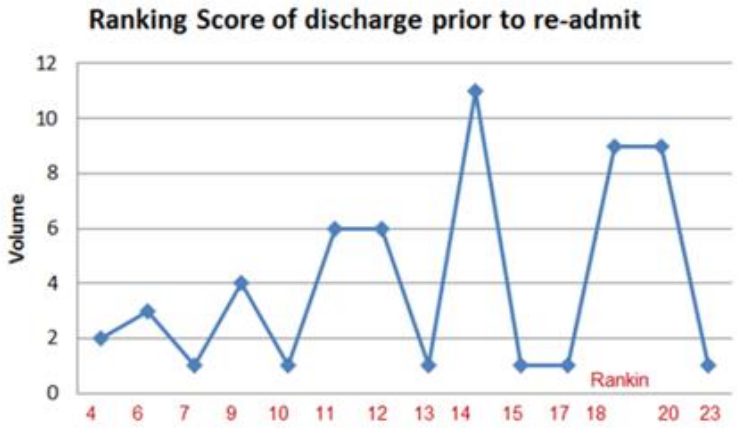
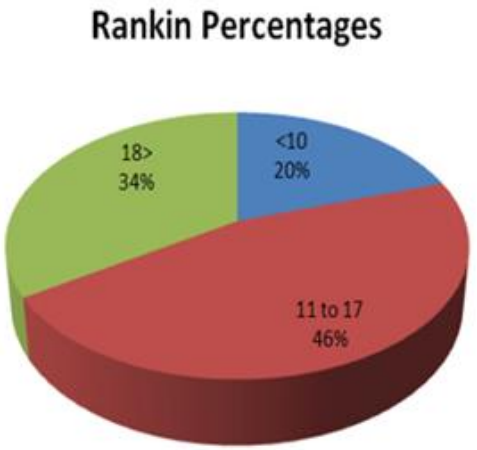
Risk Identifiers



Rankin Range	Days out before return
10<	21 days
11 to 17	15.5 days
18>	12 days



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LTC/ EMS Pilot in Rural setting

Implement a non-emergency pilot “Rapid Response” program in Noble and Huntington counties between the Parkview EMS and select community based LTC facilities.

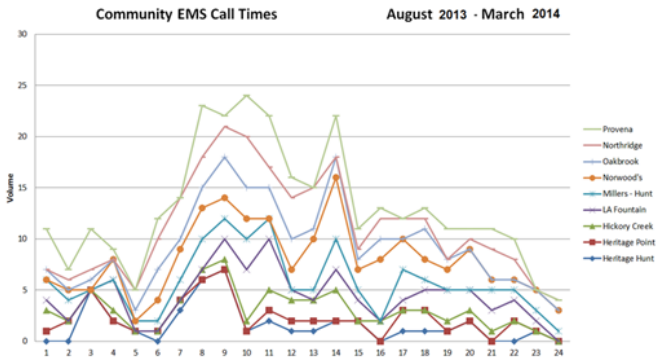
Scope of Project:

Who: EMS: Huntington and Noble

LTC facilities: Scared Heart - Avilla Norwood - Huntington

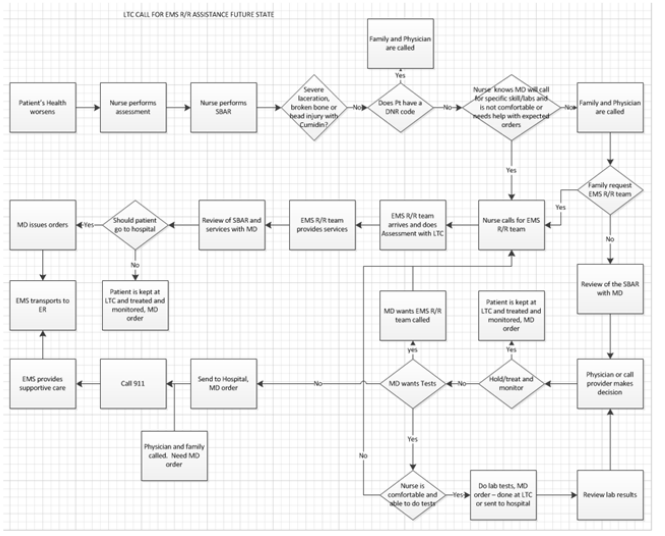
Target start date: January 5, 2015

Pilot duration – 6 months - July 4, 2015



For Allen County, the time of day for presentation to the ED and then progression to inpatient care is from 1000 – 1600. This data appears to be similar in the community hospitals.

Future State Process:



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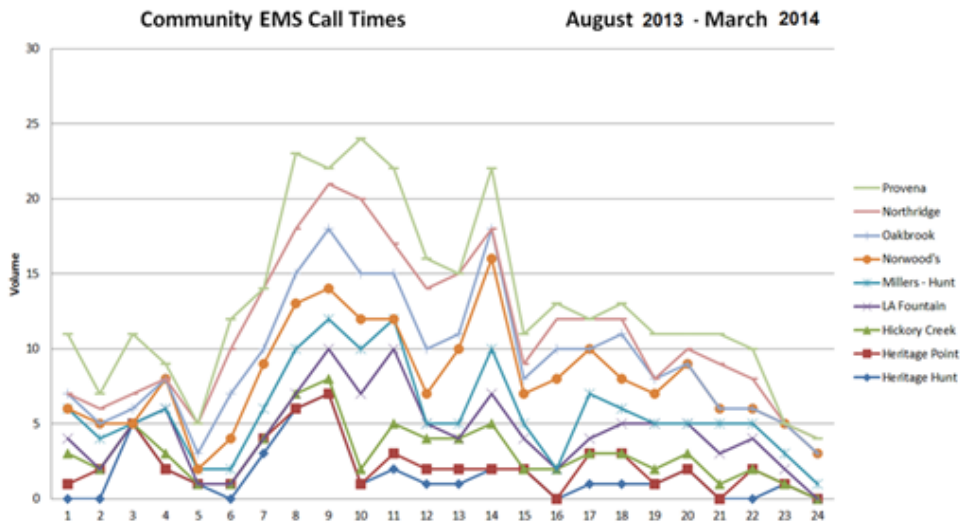
Determination of Need



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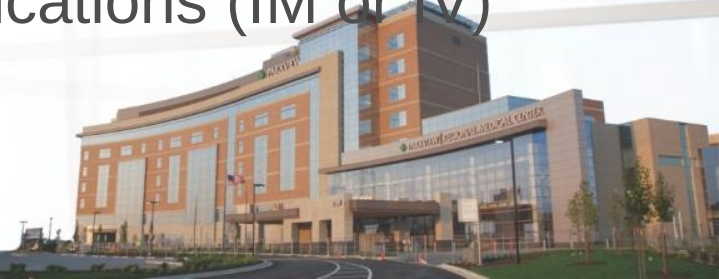
Rapid Response/Skills

- SBAR notification
- EMS Assessment
- Task specific
- Clinical interventions
- Immediate labs – istats
- MD/NP communication
- Calming effect to critical situation
- Team decision on making the transfer call
- IV, fluids start
- Drawing of labs
- ISTAT labs – Chem 6, H/H, Troponin, Venous Blood Gas, Lactic, Lactic acid analysis for sepsis
- Blood cultures
- Urinary catheterization
- IV push of Meds (Lasix)
- Parenteral pain medications (IM or IV)



LTC Sepsis Detection and Intervention

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- Implement a Pre-Sepsis detection program for earlier identification of infection
- Slow the progression of Sepsis to Septic Shock with LTC intervention
- Decrease the mortality rate at Parkview by patients presenting to the ED with infection vs. advanced stages of Sepsis.

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Sepsis Determination of Need

July 2013 – June 2014

Sepsis	ICD9	All patients	SNF discharges (% of discharges)	Deaths
Sepsis	995.91	584	144 (25%)	43
Severe Sepsis	995.92	595	160 (27%)	146
Septic Shock	785.52	328	85 (26%)	106

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Resident Data Log

Task	Example	1	2	3	4	5	6	7	8	9	10
Facility	Home Away										
Patient Identifier	23415										
Date	11/5/2014										
NP/MD notified with SBAR (Time)	4/29/1902										
NP/MD responded to SBAR in 30 minutes (Yes/no)	Yes										
NP/MD orders -(Time)	900										
Chest X ray performed (Time)	1000										
Chest X ray results (Time)	1100										
Labs drawn (Time)	1000										
Lab results - (Time)	1200										
Blood culture before Antibiotic started (Yes/no)	Yes										
IV placed (Time)	1200										
IV fluids started (Time)	1210										
IV antibiotics started (Time)	1300										
STOP and Watch altered RN (Yes/No/Other)	Yes										
if yes....STOP and Watch received (Time)	830										
RN assessment of resident (Time)	840										

Send completed data log to Susan McAlister DNP,RN, CPHQ @ susan.mcalister@parkview.com
Send each month by the 10th of the month

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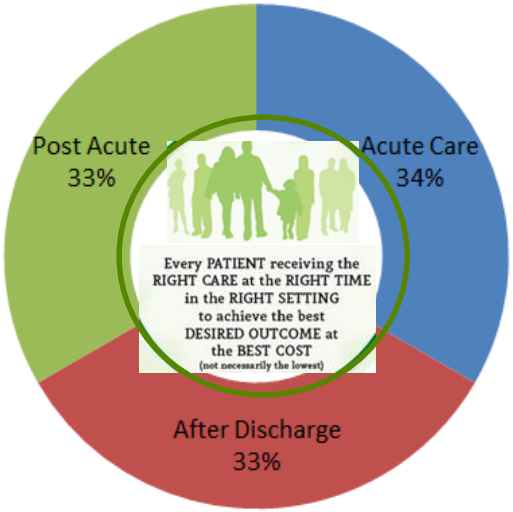
30 Day Re-admission work

- Long Term Care Collaborative
- Long Term Care Pilots
  - Sepsis identification and treatment
  - Rapid Response
  - Transitional Care Unit
- Post SNF discharge calls and visits
- Senior Care

Components of Re-admission Work



- Emergency Department "Hot Spotters"
  - Clinical Decision Unit
- Case management focus on Rankin's ≥ 10
- Collaborative rounding
- Transition Care Nurses
  - Re-admissions
  - High Rankin's
- Service Line focus
- Palliative Care

- Home Health Care
  - Tele-health
- Hospice
- Aging and In Home Services
- Palliative care Clinic
- Wound Clinic
- 30 days Transitional Care NP visits

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Questions

thinking innovation

COLUMBUS REGIONAL HEALTH
thinking beyond

Potential of Philanthropy to Accelerate Strategic Innovations in Your Hospital System.

Julie Abedian
President, Columbus Regional Health Foundation

COLUMBUS REGIONAL HEALTH
thinking beyond

Your Foundation can provide resources in a variety of ways.

Columbus Regional Health
thinking beyond

Source of Traditional Philanthropic Resources:

- Grants
- Gifts from donors who believe in your hospital and its leadership

COLUMBUS REGIONAL HEALTH
thinking beyond

Your Foundation can be a neutral convener.

- **At the intersections of the hospital and the community**
- **Between clinical professionals & public health experts**

COLUMBUS REGIONAL HEALTH
thinking beyond

Your Foundation can incubate innovative solutions until they can be proven and brought to scale.

- **Fund pilots**
- **Fund "FDEs"**

COLUMBUS REGIONAL HEALTH
thinking beyond

Your Foundation can provide "risk capital."

- **Especially for work that may be reimbursed in the future.**

COLUMBUS REGIONAL HEALTH
thinking beyond

Your Foundation already has many priorities.

Your Foundation is always aligned with your executive leadership's priorities.

Indiana Hospital Association

Evaluation & Follow-up

- Webinar funded by CMS through the *Partnership for Patients*
- CMS reviews results and wants 80% of participants to evaluate educational sessions
- Please complete the simple three question evaluation by Dec. 1, 2014:
  - https://www.surveymonkey.com/s/2014_11_21_ReadmissionsWebinar
- Link to evaluation and webinar recording will be distributed to participants within one week

THANK YOU FOR YOUR PARTICIPATION!

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