Readmission Summit
Focused on Care across the Continuum & Patient and Family Engagement

MHA Conference Center
Thursday, November 6, 2014

Agenda

9 a.m. Welcome and Opening Remarks
Lorraine Schoen MS, BSN, RN
Director, Clinical Affairs, MHA
Pat Noga, PhD, RN
Vice President, Clinical Affairs, MHA

9:15 a.m. The National State of Readmissions
Amy Boutwell, MD, MPP
Collaborative Healthcare Strategies

10:30 a.m. Transition to Morning Breakout Sessions

10:40 a.m. Morning Breakout Sessions
A – The ‘One Cape’ Journey to Meet the Institute for Healthcare Improvement Triple Aim and Decrease Readmissions through Interdisciplinary Care Coordination
Board Room, 2nd Floor

B – The Improving Massachusetts Post-Acute Care Transfers (IMPACT) - Achievements and Lessons Learned
Café, 1st Floor

C – Partners Continuing Care - Collaboration to Prevent Readmissions after an Acute Care Episode
Conference Center, 1st Floor
Agenda

11:55 a.m. – 1:00 p.m. Lunch

1 p.m. Patient-centered Care Transition Strategies
Todd J. Liu, JD, MHA, Assistant to the President
Griffin Hospital

2:15 p.m. Transition to Afternoon Breakout Sessions
Turn in evaluations and sign for CEUs/CMEs

Agenda

2:25 p.m. Afternoon Breakout Sessions

D - Care Transitions Education Project (CTEP) – Equipping Nurses to Lead Patient-Centered Care Transitions
Board Room, 2nd Floor

E - MetroWest Medical Center’s Experience in Fostering Cross Continuum Partnerships in Practice
Conference Center, 1st Floor

F - Leveraging Palliative Care - A Hospital and Home Based Approach
Café, 1st Floor

3:40 – 4:00 Turn in evaluations and sign for CEUs/CMEs

CME/CE Accreditation Information

• TEAMHealth Institute is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. This activity meets the criteria for a maximum of 3.0 AMA PRA Category 1 credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

• TEAMHealth Institute is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. TEAMHealth Institute has designated this activity for 3.0 Nursing CE Hours.
Disclosures

- Patricia Noga and Lorraine Schoen, the planners of this CME/CEU activity, have no conflicts of interest to disclose.
- Amy Boutwell and Todd Liu have no conflicts of interest to disclose.
- There is no commercial support to disclose for this CME/CEU activity.

CME/CEU Reminders

- 2 Evaluation forms must be completed (Team Health and HEN) for CEU/CME credit.
- Sign CEU/CME registration form for credit between 2:15 p.m. – 4:00 p.m. before you leave today.
- Credits will be mailed to your email address provided.

- Rest rooms are located on the 1st floor to the left of the Café, around the corner, and on the 2nd floor by the Board Room.
- Coffee, tea and water located in the Café and outside the 2nd floor Boardroom.
Welcome and Opening Remarks

Pat Noga, PhD, RN
Vice President, Clinical Affairs

MA Readmissions and Care Transitions Initiatives: 2008 to Present

- Care Transitions Forum
- State Strategic Plan for Care Transitions
- STAAR: State Action on Avoidable Rehospitalizations
- Division of Health Care Finance and Policy PPR Committee
- HCQCC Expert Panel on Performance Measurement
- Care Transitions Steering Committee
- Quality inspectors trained in elements of a good transition
- Universal Transfer Form piloting between all settings of care
- IMPACT: Improving MA Post-Acute Care Transfers
- Hospital requirement to form Patient Family Advisory Councils
- Engaging Patients and Families in Improving Hospital Discharge
- ASAPs join cross continuum teams (Aging Service Access Points)
- Expert Panel on End Of Life Care
- MOLST Pilot (Medical Orders for Life Sustaining Treatment)
- PCMHI: Patient Centered Medical Home Initiative
- 3026 Community-based Care Transitions Program
- CMS Hospital Engagement Networks (HEN)
1. Reduce preventable readmissions by 20% by 2015

2. Reduce preventable CAUTI, CLABSI and SSI by 40% by 2015

Note: This is a statewide aggregate goal, focused primarily on acute care hospitals; there will be no public reporting of individual hospital data in the course of monitoring and reporting progress in achieving the goals. Base year = FY or CY 2012
MA Performance on Hospital-Wide Readmission Measure (Yale)
Data Period OCT 2012 - SEP 2013

Data source: Massachusetts Hospital Discharge Dataset (CHIA) with Analysis completed by BCBSMA.
REDUCING READMISSIONS - 2014
Expanding efforts to drive to hospital-wide results

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
November 2014

Objectives

• What are hospitals with hospital-wide results doing?
• How does that differ from what we are doing?
• What are 3 practical ways to expand our strategies?

➢ Medicaid adults have high readmission rates and need to be specifically included in all efforts

THANK YOU CMS
6 game-changing messages from CMS policies…….
6 Very Important Messages from CMS

1. Readmission reduction pays – inaction hurts
2. Hospitals must update & standardize transitional care processes
3. Reducing readmissions is a cross-continuum effort
4. Attend to non-clinical needs for post-hospital supports & services
5. We will flood the market with all best ideas on our dime
6. Reducing readmissions requires better data

HOWEVER…

Powerful messages from powerful agencies can create blinders

CMS’ Medicare Focus Has Created Blinders

1. HF, AMI, PNA…COPD, hip/knee replacement
   - NOT the 5 most frequent diagnoses leading to readmissions
   - CMS’ discharge diagnosis-specific penalty obscured other meaningful categorizations s/a frequent utilizer, social complexity, BH, functional status
2. Driven a Medicare focus to the exclusion of other high-risk patient groups
   - Medicaid adults have higher readmission rates than Medicare FFS
3. Driven a case-finding approach
   - Interventions often limited to Medicare FFS with certain diagnosis
   - Created a 2-tiered discharge process – at odds with principles of quality
4. Preferred first move among hospitals: hire a Transitional Care FTE
   - Lost the focus on reliable redesign on transitional care for all patients
   - Hire dedicated staff to focus only on “penalty condition” patients
Medicare Readmission Penalties

- October 1 2014 - September 30 2015
- Up to 3% reduction in all Medicare payments for hospitals with high 30-day readmissions for AMI, HF, PNA, COPD and hip/knee replacement
- Average penalty **DOUBLED** this year
- 2,160 hospitals penalized; **$480 MILLION**
- In MA, 80% of all hospitals penalized = 55 hospitals
  - The average penalty in MA is 0.78%
  - 19 hospitals with >1% penalty this year
  - MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT tied with NY
CRUNCHING THE NUMBERS

Will your current strategy get you to your goal?

Let’s Run the Numbers:  
One Strategy Won’t Get Us There

<table>
<thead>
<tr>
<th>Number</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare admits/year</td>
<td>5,000 admissions</td>
</tr>
<tr>
<td>Medicare RA rate</td>
<td>20%</td>
</tr>
<tr>
<td># Medicare RA/year</td>
<td>1,000 readmissions</td>
</tr>
<tr>
<td>Pilot project</td>
<td>200 high risk patients</td>
</tr>
<tr>
<td>Pilot group RA rate</td>
<td>25%</td>
</tr>
<tr>
<td>Expected # RA pilot</td>
<td>50</td>
</tr>
<tr>
<td>Expected effect of pilot</td>
<td>20%</td>
</tr>
<tr>
<td># RA reduced by pilot</td>
<td>10</td>
</tr>
<tr>
<td># Medicare RA/year</td>
<td>=1000 – 10 = 990 1%</td>
</tr>
</tbody>
</table>

Hospitals with hospital-wide results

- Know their data –  
  Analyze, trend, track, display, share, post
- Broad concept of “readmission risk”  
  Way beyond case finding for diagnoses
- Multifaceted strategy  
  Improve standard care, collaborate across settings, enhanced care
- Use technology to make this better, quicker, automated  
  Automated notifications, implementation tracking, dashboards
EXPAND EFFORTS FOR IMPACT

Broad concept of risk, broad understanding of patient needs

Next Frontier: Medicaid Readmissions
What is different? What is similar?

- Population analyses of Medicaid readmission rates are low
  - Because they include high-volume deliveries (OB) and pediatric discharges
  - Readmission rates appear low and providers think there is no “problem” in Medicaid

- Emerging experience suggests that social, financial, behavioral health factors greatly influence risk of readmission

- Adult Medicaid patients would be expected to have a high prevalence of social, financial and behavioral health issues

- Little has been described about readmission rates and the factors that contribute to readmissions among the younger adult population

HOSPITAL GUIDE to Reducing Medicaid Readmissions

- Introduction
- Why focus on Medicaid Readmissions?
- How to Use This Guide
- 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
- 13 new Tools
Tools
1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide

Key Actions
1. Know your data
2. Ask your patients, their caregivers and providers, “why”
3. Develop a portfolio of strategies
4. Improve hospital-based transitional care for all
5. Collaborate with community based providers & services
6. Provide enhanced services for high risk patients

...do so leveraging technology to incorporate changes into workflow, enable implementation analytics and continually improve to achieve measurable results

1. KNOW YOUR DATA

Analyze, track, trend, raw unadjusted data to identify opportunities
The top 20 conditions account for ~25% of readmissions and doesn’t account for comorbid BH, Social issues.
### Medicaid Readmissions at a Community Hospital

- COPD: 29%
- Alcohol withdrawal: 21%
- Pneumonia: 18%
- Pancreatitis: 24%
- Poisoning: 24%
- Major Depression: 29%
- Acute Resp. Failure: 67%
- Acute Renal Failure: 27%
- Arrhythmias: 43%
- Cirrhosis: 25%

### State All-Payer by Payer Readmission Analysis

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Comm.</th>
<th>Unins.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARF (1344)</td>
<td>Sickle Cell (476)</td>
<td>Chemo (230)</td>
<td>Pancreatitis (187)</td>
<td>Sepsis (1850)</td>
</tr>
<tr>
<td>Sepsis (1366)</td>
<td>Sepsis (175)</td>
<td>CVI (279)</td>
<td>Chemo (157)</td>
<td>ARF (1500)</td>
</tr>
<tr>
<td>PNA (1336)</td>
<td>Chemo (175)</td>
<td>Asthma (260)</td>
<td>DKA (136)</td>
<td>PNA (1750)</td>
</tr>
<tr>
<td>COPD (1211)</td>
<td>COPD (173)</td>
<td>Sepsis (222)</td>
<td>CVI (125)</td>
<td>CVI (1622)</td>
</tr>
<tr>
<td>CVI (1140)</td>
<td>DKA (156)</td>
<td>PNA (148)</td>
<td>COPD (109)</td>
<td>COPD (1600)</td>
</tr>
<tr>
<td>UTI (1039)</td>
<td>PNA (145)</td>
<td>ARF (182)</td>
<td>ARF (97)</td>
<td>UTI (1608)</td>
</tr>
<tr>
<td>All (961)</td>
<td>ARF (137)</td>
<td>CAD (181)</td>
<td>Sepsis (56)</td>
<td>HF (1115)</td>
</tr>
<tr>
<td>HF (822)</td>
<td>HF (128)</td>
<td>Pancreatitis (153)</td>
<td>PNA (81)</td>
<td>CAD (1092)</td>
</tr>
<tr>
<td>CAD (146)</td>
<td>Pancreatitis (127)</td>
<td>AHI (152)</td>
<td>ETOH w/ (76)</td>
<td>AHI (1092)</td>
</tr>
</tbody>
</table>

Method: DRG, age>18, exclude OB
County Hospital Readmission Stats

<table>
<thead>
<tr>
<th>Measure</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Discharges</td>
<td>11,850</td>
<td></td>
</tr>
<tr>
<td>Total Medicare Discharges</td>
<td>967</td>
<td>8% total</td>
</tr>
<tr>
<td>Total (adult non-ob) Medicaid Discharges</td>
<td>4,288</td>
<td>36% total</td>
</tr>
<tr>
<td>Total 30-day Readmissions</td>
<td>1,631</td>
<td>14% RA rate</td>
</tr>
<tr>
<td>Total Medicare Readmissions</td>
<td>154</td>
<td>9% total 16% RA rate</td>
</tr>
<tr>
<td>Total (adult-non-ob) Medicaid Readmissions</td>
<td>823</td>
<td>50% total 19% RA rate</td>
</tr>
</tbody>
</table>

Medicaid RA are 35% higher than all payer RA
Medicaid RA account for 50% of ALL Readmissions

Medicare v. Medicaid –Discharge Disposition

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to Home</td>
<td>50%</td>
<td>84%</td>
</tr>
<tr>
<td>Discharge to SNF/IRF/LTAC</td>
<td>24%</td>
<td>5%</td>
</tr>
<tr>
<td>Discharge to Home with Home Health</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

All-Payer, Medicaid and Uninsured:
1. Total adult, non OB discharges
2. Total number of patients
3. Total 30-day RA, ED visits
4. Readmission rate
5. # days between d/c and readmit
6. #days between d/c ED re-visit
7. Discharge disposition
8. Diagnoses
   - Top 20 admission dx (admit)
   - Top 20 ED diagnoses
   - Top 20 dx leading to RA
9. Diagnoses- based Leverage
   - % of top 20 dx of all admits, ED visits, readmissions
10. High Utilizer analysis
    - # patients >3 admissions/12mos
    - total # hospitalizations in cohort
    - discharge disposition of cohort
    - top 10 diagnoses
    - 30-day readmission rate
ASK YOUR PATIENTS “WHY”

Interview patients, caregivers for the “story behind the chief complaint”

Understand the “story behind the chief complaint”

- 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 uncontrolled DM, cognitive limitations, bipolar disorder, active substance use, homeless presents with flank pain to one hospital, readmitted with chest pain to another hospital

Chart reviews and administrative analyses will NOT reveal what you need to know: you must talk to your patients, their families and caregivers, providers

Root Cause of Chest Pain Admission: Shelter

“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don’t do that and they kick you out every morning. I need a stable residence and no one is able to help with that.”

Acute Care Utilization over 180 days of freedom
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!

There is Never One Reason for Readmission

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

Return Visits to the Emergency Department:
The Patient Perspective

- Interviewed 60 patients who returned to ED after d/c from ED <9days
  - Average age 43 (19-75)
  - Majority had a PCP, but cited ED gave more tests, quicker answers, single site and ED more likely to treat the symptoms
  - Most reported no problem filling medications
  - 19/60 thought they didn’t get prescribed the medications they needed (pain)
  - 24/60 expressed concerns about clinical evaluation and diagnosis
  - Primary reason for returning: fear and uncertainty about their condition
- Patients need more reassurance during and after episodes of care
- Patients need access to advice between visits

Annals of Emergency Medicine

DESIGN A PORTFOLIO OF STRATEGIES

There is no single bullet; we are engaged in system transformation
Develop A Multifaceted Portfolio of Efforts

Improve hospital-based care processes for all patients, including ED

- Collaborate with cross-setting partners, including payers

Provide enhanced services

Use data, analytics, flags, workflow prompts, automation, dashboards to support continuous improvement, ensure reliability, drive to results

Develop Portfolio Strategy

Improve hospital-based transitional care processes for ALL 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

- Use ADT notifications with medical and behavioral health providers
- Ask community providers what they need and how they want to receive it
- Collaborate to arrange timely follow up
- Perform “warm” handoffs, and opportunity for clarification
- Form a cross-continuum team that can access resources your staff are unaware of
- Constantly refresh your awareness of social and behavioral health resources
- Identify community partners with social work and behavioral health competencies

Provide enhanced services for high-risk

- Develop high needs EPSDT approach
- Develop high needs Neonatal approach
- Strategy for engaging care
- Strategy for enhancing resources
- Strategy for high needs Neonatal
- Strategy for end-of-life transition
- Strategy for transition services, systematic, or individual care plans

1. IMPROVE STANDARD CARE FOR ALL

All patients, not just high risk patients
Improve Standard Hospital-Based Processes

CMS Issued Updated 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

2. COLLABORATE ACROSS SETTINGS

Hospitals don’t need to provide everything…

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.

From CMS Conditions of Participation May 2013
ED – Health Center – Community Mental Health Center

• ED based Behavioral Health “Navigator” position to:
  - Intensively coordinate & improve access to outpatient care
  - Re-design ED workflows for referrals between all 3 entities
  - Design standing orders for frequent BH ED users
  - Establish individualized care plans

• Impact: successful linkage to care for frequent users
  - 1 patient who had 26 ED visits in March has had no ED visits since May!

• Time to implement: 10 weeks.

ED - SNFs: Treat-and-Return

• Hallmark Health System
  - 2 hospital system, 70% admits via ED, hospitalists
  - 20 ED docs, 17 PAs
  - ED Chief and Champion of this work explored myths of SNFs/EDs
    • Patients only seen once a month; can’t do IVs, etc
    • “ED admits everyone”
  - Actions:
    - Discussion “why”
    - Education: our capacity/their capacity
    - Simplicity : establish contacts, standard transfer information
    - Feedback
  - Results: increase in number of patients transferred from ED to SNF

3. PROVIDE ENHANCED SERVICES

Best “transition out” of the hospital will not suffice for some patients
Enhanced Care: Social Workers

• BRIDGE – Social work-based transitional care model
  • Assess “person in context”
  • Make contact in hospital; reassess at 24-48h after going home, as needs change/emerge; reassess periodically over 30d
  • Observation: Don’t require / use additional “slush funds” for transitional care – they are adept at getting patient linked to existing services (Medicaid waiver, AAA, ADRC, etc)
  • Observation: Don’t medicalize social complexity – “work the case” and refer for services, follow up, advocate for the patient, but don’t “escalate” care medically when they encounter barriers

“High Risk Care Teams”

• Multidisciplinary team
  • NP / MD (who can facilitate urgent clinical eval if needed)
  • Care manager (RN)
  • Social Work
  • Pharmacist
  • Navigators, coordinators

• Address full complement of medical, social, logistical needs
  •Navigating the healthcare system, asking questions, making appointments
  • Focus on psychosocial issues
  • Coordinating among clinicians, service providers, between settings

• 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

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 and were found to be less effective

2 HOSPITALS’ PORTFOLIO STRATEGIES

Valley Baptist Medical Center, Harlingen TX
Frederick Memorial Hospital, Frederick MD

Valley Baptist Medical Center’s Portfolio of Strategies

[Diagram showing various strategies]

Health Coach Outcomes Scorecard

[Data chart showing readmission rates by various factors]
Valley Baptist Medical Center - Results

<table>
<thead>
<tr>
<th>All-cause readmissions</th>
<th>Medicare Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2011: 28%</td>
<td></td>
</tr>
<tr>
<td>FY 2013: 21%</td>
<td>0.8% (of possible 1%)</td>
</tr>
<tr>
<td>FY 2014: 14%</td>
<td>0.2% (of possible 2%)</td>
</tr>
<tr>
<td>FY 2014:</td>
<td>0.04% (of possible 3%)</td>
</tr>
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BY THE WAY, THAT’S A 50% REDUCTION!!!
3-year results, Frederick Memorial

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 12</td>
<td>10.6%</td>
</tr>
<tr>
<td>FY 13</td>
<td>9%</td>
</tr>
<tr>
<td>FY 14</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Recommendations

- Know your data and your patients
- Adopt a broad concept of readmission risk
  - Capture all reasons, whole-person approach
- Develop a multifaceted strategy
  - Improve standard hospital-based care for ALL patients
  - Start in ED
  - Collaborate across settings with multi-sector partners
  - Provide enhanced services
- Use technologies to make work better, quicker, automated

THANK YOU

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
Lexington, Massachusetts
Patient Centered Care Transition Strategies

Is it me… or has health care delivery gotten harder?
More than **24.7%** of Medicare patients are readmitted within **30 days** of discharge.

Medicare currently spending **$17 billion** per year on readmissions.

**Griffin’s Cost of Readmissions 2013**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Grade National Rate</th>
<th>Excess Risk $</th>
<th>Eligible Volumes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infection</td>
<td>16.7%</td>
<td>1.11</td>
<td>116</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>24.7%</td>
<td>1.12</td>
<td>300</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>16.0%</td>
<td>0.60</td>
<td>273</td>
</tr>
</tbody>
</table>
Houston… We have a problem

We Need to Meet Patients at Their Level

The Vicious Cycle of Chronic Disease Readmission

- Patients discharged without adequate education
- Lack of coordination among disciplines in hospital
- Failure to set up appointment with cardiologist or primary care physician
- Patients do not keep follow-up physician appointments
- SNFs allow delay in physician evaluation after discharge, delay in medication administration and poor adherence to diet
- Patient discharged without adequate education
- Failure to set up appointment with cardiologist or primary care physician
- Inconsistency in tracking outcomes and practice among providers
We’ve got to stop labeling patients “Non-compliant”

Why do our medical “Frequent Flyers” keep returning?

Pop Quiz

What is a stronger predictor of a person’s health than age, income, employment status, educational level, and race?
Pop (Compliance) Quiz

Who here has been “compliant” each day, every day with:

- Eating a 2,000 calorie diet…
- … including 9 servings of fruits and vegetables (4 ½ cups)
- Getting 30 minutes of exercise
- Flossing daily
- Getting 8 hours of sleep
- Wearing your seatbelt
- Observing the speed limit

Assessing the ROI

But for our patients, there’s more to it…

How Much Do Patients Really Understand?

- 71% of older adults have difficulty using print materials
- 80% have difficulty using documents such as forms or charts
- 68% have difficulty interpreting numbers
- 2/3 are unable to understand information given to them about their prescriptions
- 90 million people – nearly half the US adult population – lack health literacy skills needed to understand and act on health information
What Patients Hear…

Am I taking the patient/family preferences into account in deciding needs after discharge?

Does the patient have a good understanding of responsibilities for managing own health?

Does the patient understand the purpose for taking each medication?

HCAHPS
Being Mindful of Transitions of Care Questions

Addition of Two Software Modalities

Project RED

Transitions Advantage

vree health Transition Advantage
Patient Education for Diagnosis

Nursing Alerts for Patient Understanding

Comprehensive Patient Centered After Hospital Care Plan (AHCP)
- Medication reconciliation
- Follow-up appointments
- Outstanding tests
- Post-discharge services
- What to do if a problem arises
- Discharge summary sent to PCP
- Telephone reinforcement

Project RED (Re-Engineered Discharge)

After Hospital Care Plan

My Medicine

Bring all of your medications (in their bottles) to your doctor’s appointments.
Testimonial

Innovative Digital Communications
- Dashboards with charts, graphs, and alerts
- Web, IVR, and mobile applications

Connectivity Across Extended Care Team
- Electronic Patient Profile (EPP)
- Daily Health Check

Innovative Digital Communications
- Dashboards with charts, graphs, and alerts
- Web, IVR, and mobile applications

Transition Advantage™ Service:
A Solution for Primary Causes of Preventable Readmissions

Transition Liaison
- Daily check-in
- Medication management services
- Family caregiver communication engagement
- Customer service coordination
- Transportation arrangements
24/7 Access to Advice
- Nurse Hotline

The Transition Advantage™ Cloud-based Technology
Enables connectivity across people, services, and information

People
- Patient
- Family Caregiver
- Hospital Staff

Services
- Transition Liaison
- 24/7 Nurse Hotline
- Web, IVR, Mobile

Future
- Remote monitoring
- Third-party labs
- Third-party pharmacies
How Accountable Care Is Redefining the Role of Hospitals

Beyond Penalties, the "shared savings" imperative

- 52% of the US population is living in a primary care service area with an ACO
- 14% of the US population is treated by an ACO
- 5.5M Medicare FFS beneficiaries are treated by an ACO
To Be Effective in an Accountable Care Environment Hospitals Must Take on New Roles

Valley Gateway to Health Solutions

Valley Gateway to Health
30-day readmission rates for CHF by SNF
October 2007 – March 2009

<table>
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<tr>
<th>Area Skilled Nursing Facilities</th>
<th>Patients Readmitted</th>
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<tr>
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VG2H Mission

To partner with the patient, care partner, his/her physicians, home care agencies and skilled facilities to improve the transition to post hospital care by providing “same page” care to patients across the continuum, focusing on medication compliance, dietary restrictions, weight monitoring and exercise with the goal of improving the quality of life for those we serve and to help them avoid preventable readmissions.

The Hospital Focus

- Better Discharge Planning
  - Shared Teaching Tool utilizing 4th grade literacy
  - “Teach Back” by patients
  - Adding patient’s dry weight to the W-10
  - Core Measures Checklist
  - Provide copy of H&P to Home Care Agencies
  - Follow-up M.D. appointments made before discharge
The Hospital Focus

- HF protocol included in discharge packet for next provider
- Scales provided for home care patients
- Nurse to nurse hand-off report via telephone
- M.D. to M.D. telephone report for high risk patients
- Shared teaching tool "Managing Your Health with Heart Failure"
- Follow-up phone calls 48 hours post discharge and weekly x4

Managing Your Health with Heart Failure

Heart Success Protocol
The Skilled Facility

- Stock frequently used medications for CHF
- Shared teaching tool “Managing your Health with Heart Failure”
- Utilize “Teach Back” methodology
- Reinforce salt restriction and daily weights
- Assessment by physician within 48 hours
- Hand off Report to Home Care Agency upon discharge
- Provision of prescriptions to patient on discharge
- Follow-up appointment made with physician prior to discharge. Utilize “Heart Success Protocol”

The Home Care Agency

- Coordination of transportation to follow-up appointments
- Shared teaching tool “Managing Your Health with Heart Failure”
- Ensure that patient has enough medications to last until MD appointment
- Provide patient with scale if indicated and monitor weights
- Refer end of life care to hospice as indicated
- Utilize Heart Success Protocol
- Provide on-site visits as requested

Current State of Collaborative

- Shared Best Practices
- Expansion of shared teaching tool and protocols for diagnoses of AMI, Pneumonia and COPD
- Monthly collaborative review of readmissions
- Enrollment in Griffin’s Heart Wellness Clinic and Transition Advantage
- Sharing readmission rates and publically reported outcomes
- Increased education for Advanced Directives
Griffin Hospital Readmission Rates for Heart Failure (HF) Within 30 days

Future State of Collaborative

• Expansion of focus to other chronic diseases
• Creating preferred community partnerships with shared pathways
• Creation of physician rounding in skilled facility

Overall goal: Create a smooth seamless transition from

“HERE TO HOME”

Transitioning to a “Preferred Partner” Model

Remaining High Quality/Low Cost will require change

New ACO model requires community resources to work together

Strong partnerships required with patient at the center of all care transitions

Shared accountability for care outcomes
From this…

To This…

Highlighting our Preferred Partners in Care

Preferred Partners
Objective criteria for designation: commitment to develop collaborative care pathways and meet quality goals

Facility-level data, including:
Overall Quality Rating (nursinghomecompare.gov)
All-Cause Readmission Rate
What's Next?

Patient Preference Passport

Planetree Passport Version 1.0 based on the National Quality Forum Version 1.0 created in partnership with the Patient and Family Engagement Action Team convened by National Quality Forum.

Dr. Peter Pronovost
Sr. VP for Patient Safety and Quality, Johns Hopkins Dir of the Armstrong Institute for Patient Safety Quality

Dr. Adil Haider
Associate Professor, Director, Center for Surgery and Public Health Brigham and Women’s Hospital Center Formerly with Johns Hopkins

“If a new drug were as effective at saving lives as Peter Pronovost’s checklist, there would be a nationwide marketing campaign.”

Dr. Atul Gawande, Professor of Surgery at Harvard, author of best-selling book Checklist Manifesto
Technology to Support Patient Engagement with Care Providers

Digitizing the Patient Passport

[Image of a digital patient passport interface]
Questions???

Thank You

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