SETMA Monthly Staff Training
March 28, 2012

Preventable Hospital Readmissions Policy, Problems, Processes

Preventable Hospital Readmissions Public Policy

HEALTHCARE REFORM: PENDING CHANGES TO REIMBURSEMENT FOR 30-DAY READMISSIONS (reference for slides 3-6)

AUGUST 2010

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Chief Scientist
Center for Healthcare Improvement

Preventable Hospital Readmissions Public Policy

High readmission rates have long been considered a marker of lower quality care. In its 2008 recommendation to Congress, the Medicare Payment Advisory Commission (MedPAC) reported that

- in 2005, 17.6 percent of admissions were readmitted within 30 days of discharge. That same year, readmissions accounted for $15 billion in Medicare spending, of which $12 billion was related to potentially preventable readmissions, equating to an average payment of about $7,000 per case.
- Congress has taken notice and acted. Lawmakers specifically addressed the issue in the healthcare reform legislation, the Patient Protection and Affordable Care Act, with the intent of holding care providers responsible and of managing healthcare spending.

Preventable Hospital Readmissions Public Policy

With regard to readmissions, areas of improvement are often focused around:

- Better quality care during hospitalizations — effective use of diagnosis-specific clinical decision support tools embedded into the workflow has demonstrated effectiveness.
- Improved communication among providers and with patients and caregivers — particularly between the inpatient and outpatient providers of care.

Preventable Hospital Readmissions Public Policy

- Care planning that begins with an assessment at admission — nurse care managers representing the insurer, the hospital, and the primary providers must collaborate.
- Clear discharge instructions with particular attention to medication management — incorporating the input of the inpatient and outpatient pharmacist has proven effective.
- Discharge to a proper setting of care — Hospital case management screenings should determine rehab/skilled nursing requirements before discharge to outpatient care.

Preventable Hospital Readmissions Public Policy

- Timely physician follow-up visits — with primary care provider and appropriate specialists; preferably the appointment should be scheduled prior to discharge.

- Appropriate use of palliative care and end-of-life planning should be built into the hospital discharge process. Palliative specialists and hospice expertise need to be integrated components of post-hospital planning.

SETMA's Hospital Discharges

	Total Discharges		Readmission Rate (Days)	
			30	60
• 2009	–	2995	--	--
• 2010	–	3001	16.5%	21.9%
• 2011	–	4194	17.4%	24.6%
• 2012 *	–	946	--	--
• Total	–	11055	--	--

*Jan, Feb 2012

CMS Fee For Service Medicare Study – Medical Homes vs. Benchmarks

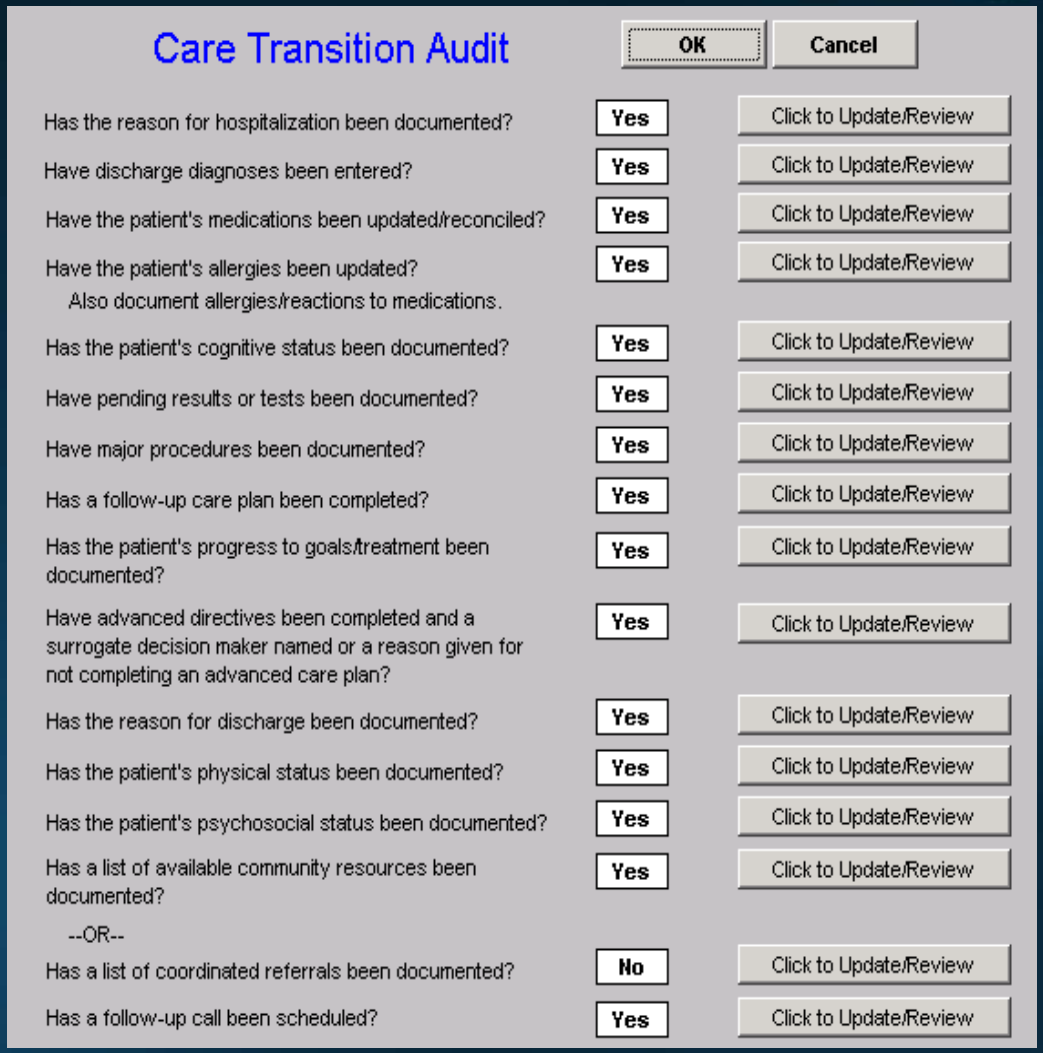
	30 Day Readmission (%)	Benchmark (%)		Two Week (%) Follow-Up	Benchmark (%)		Potentially Avoidable Inpatient Stays ($)	Benchmark ($)
SETMA 1	25.7	47.7		57.8	47.7		1766.00	3290.00
SETMA 2	17.5	30.9		56.5	40.4		962.00	2259.00
SETMA West	20.0	14.4		56.9	62.0		731.00	300.00

Inpatient Medical Record Census Home

Search for Patients

Incomplete | Complete - 6 months only | Complete more than 6 months

Last Name	First Name	DOB	Hospital	Adm Date	Dis Date	Provider	HP Date	DS Date	CBO
[redacted]	Eva	[redacted]	Baptist	12/06/2011		Holly	12/07/2011		
	Billy		Baptist	12/06/2011		Deiparine	12/07/2011		
	Michael		Baptist	12/06/2011		Qureshi	12/07/2011		
	Robert		Baptist	12/06/2011		Holly	12/07/2011		
	James		Baptist	12/06/2011		Holly	12/07/2011		
	Betty		Baptist	12/06/2011		Holly			
	Elizabeth		Baptist	12/06/2011		Holly	12/07/2011		
	Elfunzell		Baptist	12/06/2011		Holly	12/07/2011		
	Billie		Christus	12/06/2011		Murphy	12/07/2011		
	John		The Medical Center	12/06/2011		Thomas	12/07/2011		
	Jesse		Baptist	12/06/2011		Holly	12/06/2011		
	Jackson		The Medical Center	12/05/2011		Thomas	12/06/2011		
	Lorine		The Medical Center	12/05/2011		Thomas	12/06/2011		
	Bettye		Baptist	12/05/2011		Holly	12/05/2011		
	Christopher		Christus	12/05/2011		Palang	12/06/2011		
	Georgia		Baptist	12/05/2011		Holly	12/06/2011		
	Ruby		Baptist	12/05/2011		Holly	12/06/2011		
	Harry		Baptist	12/05/2011		Anwar	12/06/2011		
	Marion		Baptist	12/05/2011		Deiparine	12/06/2011		
	Geraldine		Baptist	12/05/2011		Holly	12/06/2011		
	John		Baptist	12/05/2011		Holly	12/06/2011		


Care Transition Audit
OK
Cancel
Has the reason for hospitalization been documented?
Yes
Click to Update/Review
Have discharge diagnoses been entered?
Yes
Click to Update/Review
Have the patient's medications been updated/reconciled?
Yes
Click to Update/Review
Have the patient's allergies been updated?
Also document allergies/reactions to medications.
Yes
Click to Update/Review
Has the patient's cognitive status been documented?
Yes
Click to Update/Review
Have pending results or tests been documented?
Yes
Click to Update/Review
Have major procedures been documented?
Yes
Click to Update/Review
Has a follow-up care plan been completed?
Yes
Click to Update/Review
Has the patient's progress to goals/treatment been documented?
Yes
Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?
Yes
Click to Update/Review
Has the reason for discharge been documented?
Yes
Click to Update/Review
Has the patient's physical status been documented?
Yes
Click to Update/Review
Has the patient's psychosocial status been documented?
Yes
Click to Update/Review
Has a list of available community resources been documented?
Yes
Click to Update/Review
--OR--
Has a list of coordinated referrals been documented?
No
Click to Update/Review
Has a follow-up call been scheduled?
Yes
Click to Update/Review
Has the current/reconciled medication list been discussed with the patient/family/caregiver?
Yes
No
Brandon Sheehan
11/23/2011
10:05 AM
Have the discharge orders been discussed with the patient/family/caregiver?
Yes
No
Brandon Sheehan
11/23/2011
10:05 AM
Have the follow-up instructions been discussed with the patient/family/caregiver?
Yes
No
Brandon Sheehan
11/23/2011
10:05 AM
Have the discharge materials been printed and given to the patient/family/caregiver?
Yes
No
Brandon Sheehan
11/23/2011
10:05 AM

Care Transition Audit

- Quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "**Public Reporting**," along with over 200 other quality metrics which we track routinely.

- The following is the care transition audit results by provider name for 2011.

Care Transition Audit

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2011 through 10/31/2011

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Anwar	98.5%	100.0%	93.9%	97.0%	98.5%	99.2%	100.0%	99.2%	98.5%
Aziz	99.6%	100.0%	97.7%	99.2%	98.1%	99.6%	98.5%	99.2%	98.9%
Curry	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%
Deiparine	97.7%	100.0%	96.1%	98.8%	98.8%	97.7%	98.8%	97.7%	97.7%
Halbert	100.0%	100.0%	100.0%	98.9%	98.9%	100.0%	98.9%	100.0%	98.9%
Holly	97.9%	100.0%	95.7%	98.9%	98.9%	97.9%	97.3%	96.8%	97.9%
Leifeste	98.8%	100.0%	96.3%	98.0%	98.4%	98.0%	98.8%	98.0%	98.4%
Murphy	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	100.0%	99.0%	99.0%
Palang	98.3%	100.0%	98.3%	99.1%	99.1%	98.3%	98.3%	98.3%	97.4%
Qureshi	96.8%	100.0%	93.0%	98.9%	98.9%	96.8%	98.9%	96.8%	96.8%
Satterwhite	97.6%	97.6%	100.0%	95.1%	97.6%	97.6%	95.1%	95.1%	95.1%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	98.4%	100.0%	93.0%	98.9%	97.8%	98.4%	96.2%	97.3%	98.4%
Vardiman	97.8%	100.0%	93.3%	100.0%	100.0%	97.8%	97.8%	97.8%	97.8%
SETMA Totals :	98.5%	99.9%	96.2%	98.7%	98.6%	98.4%	98.4%	98.0%	98.1%

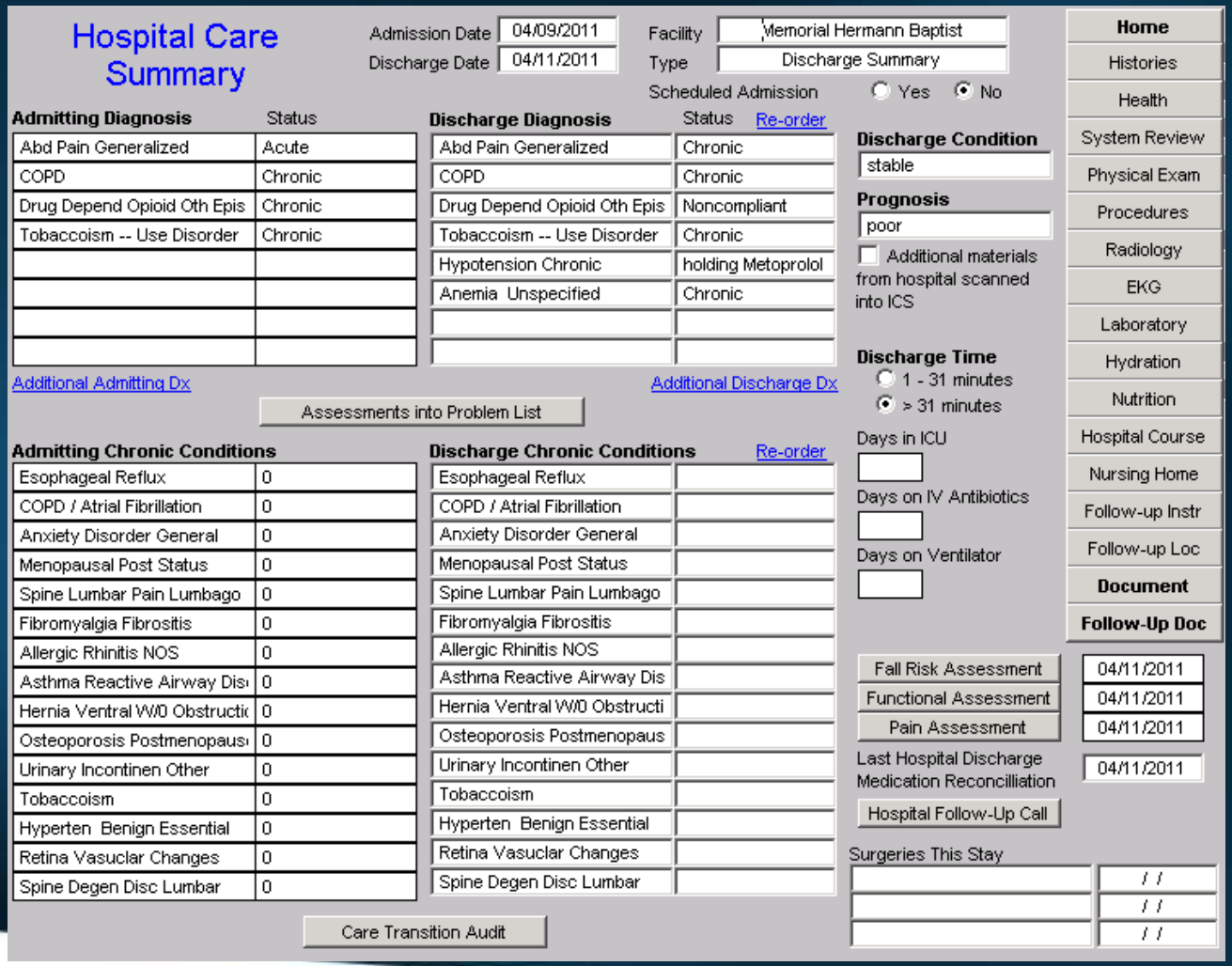
Care Transition Audit

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2011 through 10/31/2011

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	93.9%	98.5%	98.5%	97.7%	93.9%	92.4%	92.4%	92.4%	92.4%
Aziz	96.6%	98.9%	98.1%	98.9%	93.5%	97.3%	97.3%	96.6%	93.9%
Curry	91.7%	100.0%	100.0%	100.0%	89.6%	97.9%	97.9%	97.9%	97.9%
Deiparine	95.3%	97.3%	99.6%	98.1%	94.6%	93.4%	93.4%	93.4%	93.4%
Halbert	100.0%	100.0%	98.9%	100.0%	95.7%	97.9%	97.9%	97.9%	97.9%
Holly	94.1%	97.3%	98.9%	97.9%	94.1%	91.4%	91.4%	91.4%	91.4%
Leifeste	95.1%	98.4%	98.4%	98.4%	94.7%	93.0%	93.0%	93.0%	93.0%
Murphy	100.0%	100.0%	99.0%	100.0%	93.1%	98.0%	98.0%	98.0%	97.1%
Palang	96.6%	98.3%	99.1%	99.1%	91.5%	95.7%	95.7%	95.7%	95.7%
Qureshi	89.8%	96.8%	100.0%	96.8%	91.4%	88.2%	88.2%	87.7%	88.2%
Satterwhite	97.6%	95.1%	97.6%	100.0%	92.7%	92.7%	95.1%	95.1%	95.1%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	93.0%	97.8%	99.5%	95.7%	94.1%	87.0%	87.0%	87.0%	86.5%
Vardiman	93.3%	97.8%	100.0%	95.6%	91.1%	91.1%	91.1%	91.1%	91.1%
SETMA Totals :	95.0%	98.1%	99.0%	98.1%	93.5%	93.2%	93.2%	93.1%	92.6%

Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan



Hospital Care Summary

Admission Date 04/09/2011
Discharge Date 04/11/2011
Facility Memorial Hermann Baptist
Type Discharge Summary
Scheduled Admission ○ Yes ◉ No

Admitting Diagnosis	Status
Abd Pain Generalized	Acute
COPD	Chronic
Drug Depend Opioid Oth Epis	Chronic
Tobaccoism -- Use Disorder	Chronic

Discharge Diagnosis	Status (Re-order)
Abd Pain Generalized	Chronic
COPD	Chronic
Drug Depend Opioid Oth Epis	Noncompliant
Tobaccoism -- Use Disorder	Chronic
Hypotension Chronic	holding Metoprolol
Anemia Unspecified	Chronic

Additional Admitting Dx | Additional Discharge Dx

Assessments into Problem List

Admitting Chronic Conditions	
Esophageal Reflux	0
COPD / Atrial Fibrillation	0
Anxiety Disorder General	0
Menopausal Post Status	0
Spine Lumbar Pain Lumbago	0
Fibromyalgia Fibrositis	0
Allergic Rhinitis NOS	0
Asthma Reactive Airway Dis	0
Hernia Ventral W/0 Obstructi	0
Osteoporosis Postmenopaus	0
Urinary Incontinen Other	0
Tobaccoism	0
Hyperten Benign Essential	0
Retina Vasuclar Changes	0
Spine Degen Disc Lumbar	0

Discharge Chronic Conditions (Re-order)	
Esophageal Reflux	
COPD / Atrial Fibrillation	
Anxiety Disorder General	
Menopausal Post Status	
Spine Lumbar Pain Lumbago	
Fibromyalgia Fibrositis	
Allergic Rhinitis NOS	
Asthma Reactive Airway Dis	
Hernia Ventral W/0 Obstructi	
Osteoporosis Postmenopaus	
Urinary Incontinen Other	
Tobaccoism	
Hyperten Benign Essential	
Retina Vasuclar Changes	
Spine Degen Disc Lumbar	

Care Transition Audit

Discharge Condition: stable

Prognosis: poor

☐ Additional materials from hospital scanned into ICS

Discharge Time
○ 1 - 31 minutes
◉ > 31 minutes

Days in ICU
Days on IV Antibiotics
Days on Ventilator

Fall Risk Assessment	04/11/2011
Functional Assessment	04/11/2011
Pain Assessment	04/11/2011
Last Hospital Discharge Medication Reconcilliation	04/11/2011
Hospital Follow-Up Call	

Surgeries This Stay

	/ /
	/ /
	/ /

Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan

Hospital Care Summary completed at the time the patient is discharged from the hospital:

Year	Completion (%)
2010	98.8
2011	97.7
2012 (to date)	92.1
Cumulative	97.7

* January 1, 2010 to date

Hospital Discharge Analysis

Section I - Admissions and Follow-ups

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	Selection Group 1	Selection Group 2
Readmission		
Average Days:	11.81	
Mode:	1.00	
Previous Hospitilization		
Average Days:	9.39	10.24
Mode:	2.00	2.00
Follow-up (Clinic Visit)		
Average Days:	6.65	18.14
Follow-up Visit (%):	37.85%	68.04%
Follow-up (Call)		
Call Completed (%):	74.67%	77.53%
Unable to Complete (%):	6.48%	6.91%

Hospital Discharge Analysis

Section II - Patient Measures

Prompt Selections	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

	Selection Group 1	Selection Group 2
Ancillary Services		
Hospice:	1.62%	1.36%
Home Health:	4.27%	2.82%
Physical Therapy:	0.15%	0.25%
Case Management:	0.00%	0.00%
Assisted Living:	0.44%	0.37%
Nursing Home:	21.35%	16.24%
Living Alone		
Patient Lives Alone:	1.62%	2.39%
Barriers to Care		
Financial Barriers:	5.60%	4.90%
Social Barriers:	5.30%	6.54%
Assistive Device:	12.96%	9.02%
Habits		
Tobacco Use:	21.35%	23.47%
Alcohol Use:	10.16%	12.24%
Illicit Drug Use:	2.50%	1.64%
Disease - Not in Compliance		
Diabetic:	40.95%	39.20%
Hyperlipidemia:	23.60%	28.43%
Hypertension:	23.77%	22.72%
CHF:	89.45%	88.51%
Care Transition Audit		
Transition Audit Completed:	94.85%	94.17%

Hospital Discharge Analysis

Section III - Patient BMI and Changes Made

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

Body Mass Index	Selection Group 1	Selection Group 2
Less than 18.5:	6.04%	6.82%
Between 18.5 and 25:	24.59%	23.93%
Between 25 and 30:	28.13%	25.26%
Between 30 and 35:	15.46%	18.07%
Between 35 and 40:	9.43%	8.18%
Greater than 40:	7.81%	8.65%

Hospital Discharge Analysis

Section IV - Readmission Diagnoses

Prompt Selections

	Selection Group 1	Selection Group 2
Beginning Discharge Date:	Jan 1, 2011	Jan 1, 2011
Ending Discharge Date:	Dec 31, 2011	Dec 31, 2011
Include Readmits:	Within 30 days	Not Within 30 days
Ethnicity:	All	All
Financial Class:	All	All
Zip Code:	All	All
Age:	All	All
Gender:	Both	Both
Living Arrangement:	None Selected	None Selected
Encounters for this Selection:	679	3226

Selection Group 1

Top 5 Principle Diagnoses of Readmission

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	486	Pneumonia organism NOS
4	78097	Altered Mental Status
5	5789	Hem gi tract

Top 5 Supporting Diagnoses of Readmission

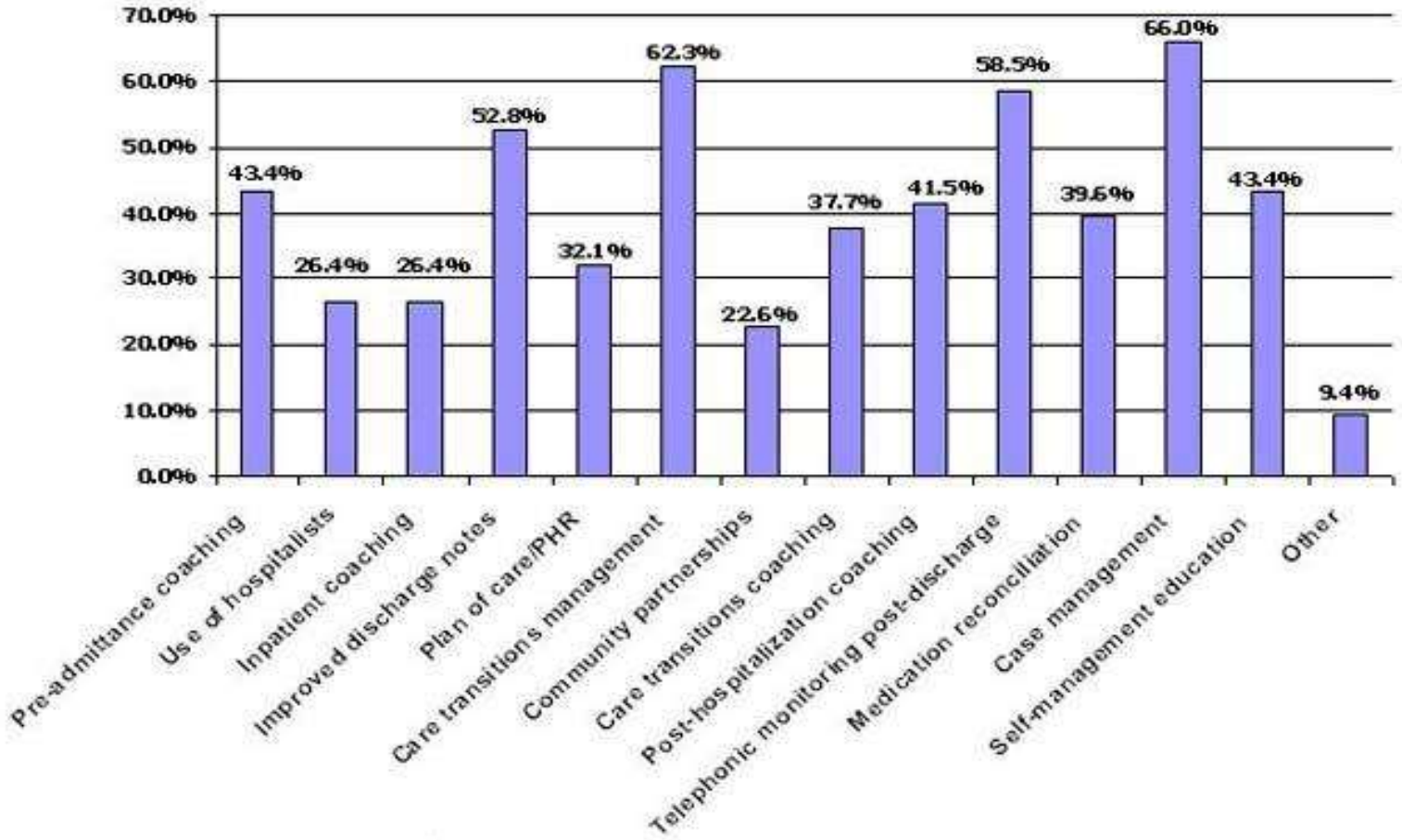
Rank	Readmission Diagnoses	Description
1	4011	Essential hypertension benig
2	4019	Essential hypertension unsp
3	496	Chronic airway obstruction NEC
4	2859	Anemia unsp
5	25040	Diab mellitus ren manif typ II

Selection Group 2

Rank	Readmission Diagnoses	Description
1	78650	Symp resp unsp chest pain
2	78605	Shortness Of Breath
3	7802	Gen symp syncope/collapse
4	2859	Anemia unsp
5	486	Pneumonia organism NOS

Rank	Readmission Diagnoses	Description
1	4019	Essential hypertension unsp
2	4011	Essential hypertension benig
3	25040	Diab mellitus ren manif typ II
4	2859	Anemia unsp
5	41400	Coron athero unsp typ ves nati

13 Strategies to Help Prevent Hospital Readmissions



Source: HIN Reducing Readmissions Survey
November, 2009

HIN © 2010

All Readmissions Are Not Preventable

"Critical to the analysis of readmissions is appropriateness. Some readmissions may be unavoidable. Other readmissions may be avoidable, but nevertheless occur, due to a *lack* of follow-up care coordination or some other problem. Obtaining a readmissions rate of zero is not feasible and may even indicate poor quality care, as many readmissions are medically appropriate due to an unavoidable change in condition or a new condition. For example, physicians may provide patient centered care by discussing early discharge with patients, with the mutual understanding that readmission may be necessary."

All Readmissions Are Not Preventable

- “Behavioral choices, such as non-compliance with dietary recommendations, may also trigger an avoidable readmission despite proper outpatient care coordination.”

- “Other readmissions may occur as a result of a medical error or adverse event that occurred during the initial hospitalization or as a result of a lack of social support, follow up care, understanding of discharge instructions, or communication following discharge. These avoidable readmissions that occur as a result of a breakdown along the care continuum were the focus of meeting discussion and of this brief.”

Strategies For Reducing Readmissions

- Provide better, safer care during the inpatient stay. According to one study, hospital readmission rates doubled—from 14 percent to 28 percent—when initial hospitalizations involved adverse patient safety events, such as anesthesia complications and infections. Evidence-based care practices—such as giving blood thinners after joint replacement surgery—can also reduce complications that tend to occur after discharge, resulting in readmission.

Source: 2007 Report to Congress: Reforming the Delivery System, Medicare Payment Advisory Committee, 2008. (Available at www.medpac.gov.)

Strategies For Reducing Readmissions

- *Attend to a patient's medication needs at discharge.* Sixty-six percent of the patients who experienced an adverse event within three weeks of hospital discharge suffered an adverse drug event. Physicians and nurses at one hospital improved the appropriate use of medications—and reduced readmissions—for cardiovascular patients by using a checklist of indications and contraindications for five life-saving medications, including beta blockers and warfarin.

Source: 2007 Report to Congress: Reforming the Delivery System, Medicare Payment Advisory Committee, 2008. (Available at www.medpac.gov.)

Strategies For Reducing Readmissions

- *Improve communication with patients before and after discharge.* Philadelphia hospitals reduced readmissions by 45 percent by having nurses meet frequently with high-risk patients both in the hospital and after discharge to discuss medication management, diet, symptom management, etc. Even ensuring that all patients receive complete instructions about how to take care of themselves after discharge has been shown to reduce readmissions.

Source: 2007 Report to Congress: Reforming the Delivery System, Medicare Payment Advisory Committee, 2008. (Available at www.medpac.gov.)

Strategies For Reducing Readmissions

- *Improve communication with other providers.* For example, California-based Healthcare Partners has established the goal of getting discharge summaries to primary care physicians within one business day of their patients' discharges.
- *Review practice patterns.* Some practice patterns may influence the likelihood of readmission. Examples include keeping patients an extra day in the hospital and providing physicians with comparative data on their readmission rates.

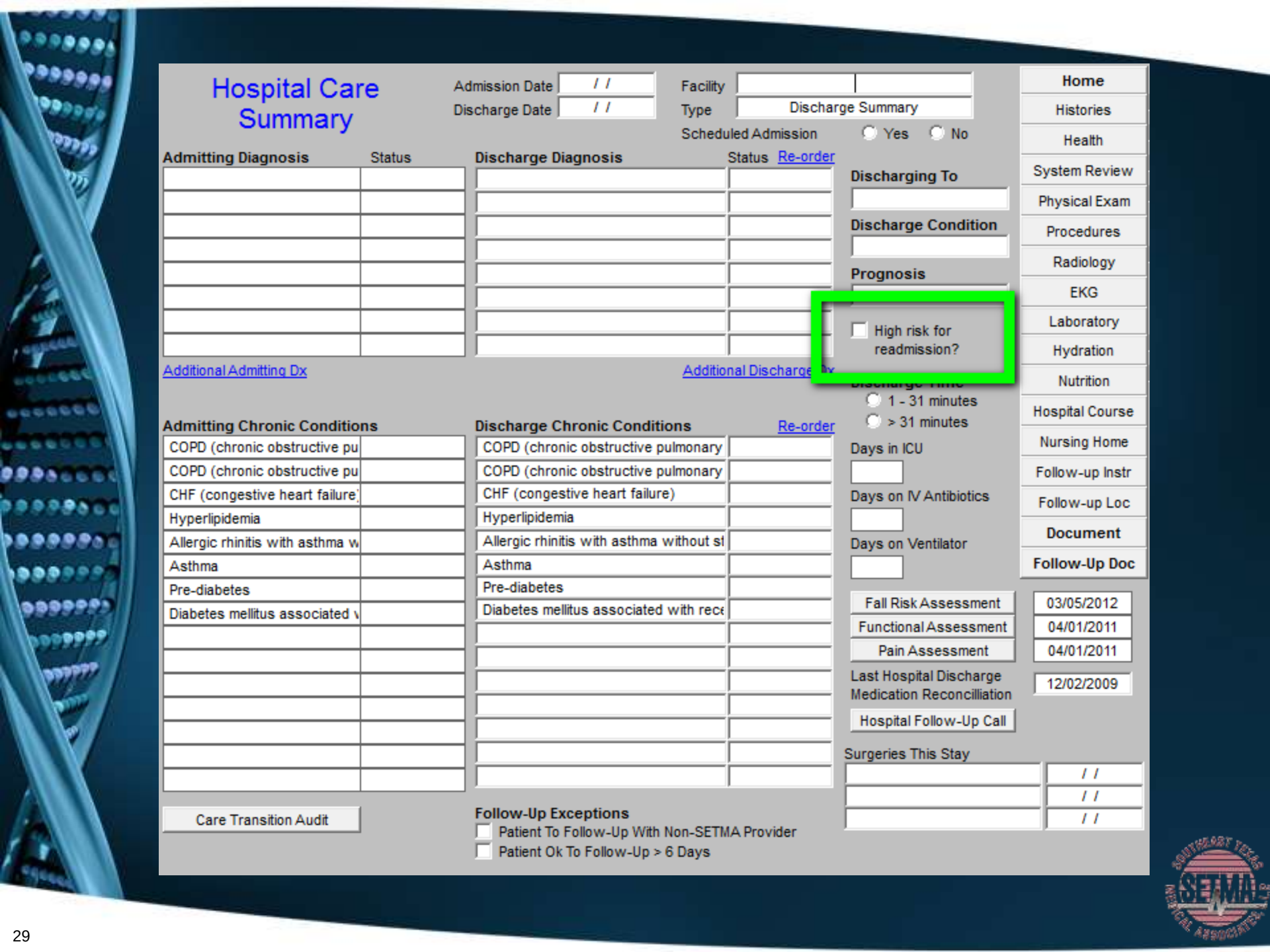
Source: 2007 Report to Congress: Reforming the Delivery System, Medicare Payment Advisory Committee, 2008. (Available at www.medpac.gov.)

Risk of Readmissions

- Recent studies continue to suggest the risk of readmission can be quantified based on a patient's risk factors and therefore are an important tool in establishing evidence-based best practices.

Risk of Readmissions

- The *Journal of Hospital Medicine* recently published a pair of studies in which researchers analyzed data from California and Austria to determine the risk factors of hospital readmission.
    - Medicare
    - Medicaid
    - Black Race
    - Inpatient use of narcotics
    - Inpatient use of corticosteroids
    - Cancer with and without metastasis
    - Renal Failure
    - Congestive Heart Failure
    - Weight loss


Hospital Care Summary
Admission Date / /
Discharge Date / /
Facility
Type Discharge Summary
Scheduled Admission Yes No
Admitting Diagnosis Status
Discharge Diagnosis Status Re-order
Additional Admitting Dx
Additional Discharge Dx
Discharging To
Discharge Condition
Prognosis
High risk for readmission?
1 - 31 minutes
> 31 minutes
Admitting Chronic Conditions
COPD (chronic obstructive pu
COPD (chronic obstructive pu
CHF (congestive heart failure
Hyperlipidemia
Allergic rhinitis with asthma w
Asthma
Pre-diabetes
Diabetes mellitus associated v
Discharge Chronic Conditions Re-order
COPD (chronic obstructive pulmonary
COPD (chronic obstructive pulmonary
CHF (congestive heart failure)
Hyperlipidemia
Allergic rhinitis with asthma without sl
Asthma
Pre-diabetes
Diabetes mellitus associated with rece
Days in ICU
Days on IV Antibiotics
Days on Ventilator
Fall Risk Assessment 03/05/2012
Functional Assessment 04/01/2011
Pain Assessment 04/01/2011
Last Hospital Discharge Medication Reconcilliation 12/02/2009
Hospital Follow-Up Call
Surgeries This Stay
/ /
/ /
/ /
Care Transition Audit
Follow-Up Exceptions
Patient To Follow-Up With Non-SETMA Provider
Patient Ok To Follow-Up > 6 Days
Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Managing High Risk Patients

When a person is identified as a high risk for readmissions, SETMA's Department of Care Coordination is alerted. The following ten steps are then instituted:

1.Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan is given to patient, care giver or family member.

2.The post hospital, care coaching call, which is done the day after discharge, goes to the top of the queue for the call – made the day after discharge by SETMA's Care Coordination Department. It is a 12-30 minute call.

Managing High Risk Patients

3. Medication reconciliation is done at the time of discharge, is repeated in the care coordination call the day after discharge and is repeated at the follow-up visit in the clinic.

4. MSW makes a home visit for need evaluation, including barriers and social needs for those who are socially isolated.

5. A clinic follow-up visit within three days for those at high risk for readmission.

Managing High Risk Patients

6. A second care coordination call in four days.

7. Plan of care and treatment plan discussed with patient, family and/or care giver at EVERY visit and a written copy with the patient's reconciled medication list, follow-up instructions, state of health, and how to access further care needs.

8. MSW documents barriers to care and care coordination department designs a solution for each.

Managing High Risk Patients

9. The patient's end of life choices and code status are discussed and when appropriate hospice is recommended.

10. Referral to disease management is done when appropriate, along with tetehealth monitoring measures.

Managing High Risk Patients

- Currently, SETMA's determination of whether patients are high risk for readmissions is intuitively determined, i.e., at discharged based on experience and judgment, a patient is designated as potentially high risk for readmission. SETMA is designing a "predictive model" for identifying patients at high risk for readmissions and instituting the above plan for interdicting a readmission. This is an attempt to quantify the most effective opportunities for decreasing preventable readmissions.

Managing High Risk Patients

- There is a significant body of science associated with "**predictive modeling**." It is clear that tradition models of care delivery will not "work" in a sustainable program for decreasing readmissions. Traditional disease management will not result in changing the patterns of care. In a January/February, 2012 *Professional Care Management* Journal article, the following abstract addressed changes needed to affect a decrease in preventable readmissions:

Managing High Risk Patients

- "**Purpose/Objectives**: The move to the Accountable Care Organization model of care calls for broad-sweeping structural, operational, and cultural changes in our health care systems. The use of predictive modeling as part of the discharge process is used as a way to highlight just one of the common processes that will need to be transformed to maximize reimbursement under the Accountable Care Organization model. The purpose of this article is to summarize what has been learned about predictive modeling from the population health management industry perspective, to discuss how that knowledge might be applied to discharge planning in the Accountable Care Organization model of patient care, and then to outline how the Accountable Care Organization environment presents various challenges, opportunities, and implications for the case management role."

Managing High Risk Patients

- "**Findings/Conclusions**: The development of predictive models to identify patients at risk for readmission and can positively impact the discharge planning process by lowering readmission rates. Examples of the structural, operational, cultural, and case management role changes necessary to maximize the benefits of an Accountable Care Organization are critical."

- "**Implications for Case Management Practice**: There is a growing need for advanced practice nurses to fill the leadership, resource management, analytical, informatics-based, and organizational development roles that are sorely needed to advance the Accountable Care Organization model of care. Case managers are well-positioned to lend their expertise to the development efforts, but they will need to be educationally prepared for the many advanced practice roles that will emerge as our nation evolves this new system of health care delivery."

Care Transitions

In SETMA's Model of Care -- Care Transition involves:

1. Evaluation at admission -- transition issues: "lives alone," barriers, DME, residential care, or other needs
2. Fulfillment of PCPI Transitions of Care Quality Metric Set
3. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan
4. Post Hospital Follow-up Coaching -- a 12-30 minute call made by members of SETMA's Care Coordination Department and additional support
5. Follow-up visit with primary provider

National Priorities Partnership

Focus in care coordination by NPP are the links between:

- **Care Transitions -** …continually strive to improve care by … considering feedback from all patients and their families… regarding coordination of their care during transitions between healthcare systems and services, and…communities.
- **Preventable Readmissions -** …work collaboratively with patients to reduce preventable 30-day readmission rates.

Hospital Care Summary

- Once the **Care Transition** issues are completed, The **Hospital Care-Summary-and-Post- Hospital-Plan-of Care-and Treatment-Plan** document is generated and printed. It is given to the patient and/or to the patient's family and to the hospital.

The Baton

The following picture is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race.

The Baton

"The Baton" is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

Firmly in the provider's hand --The baton -- the care and treatment plan Must be confidently and securely grasped by the patient, If change is to make a difference 8,760 hours a year.

The Baton

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the “baton,” is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the “baton,” which has been developed by the healthcare team, is a coordinated effort between the provider and the patient.

The Baton

4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan – the "baton" – is that it must be transferred from the provider to the patient, **if change in the life of the patient is going to make a difference in the patient's health.**

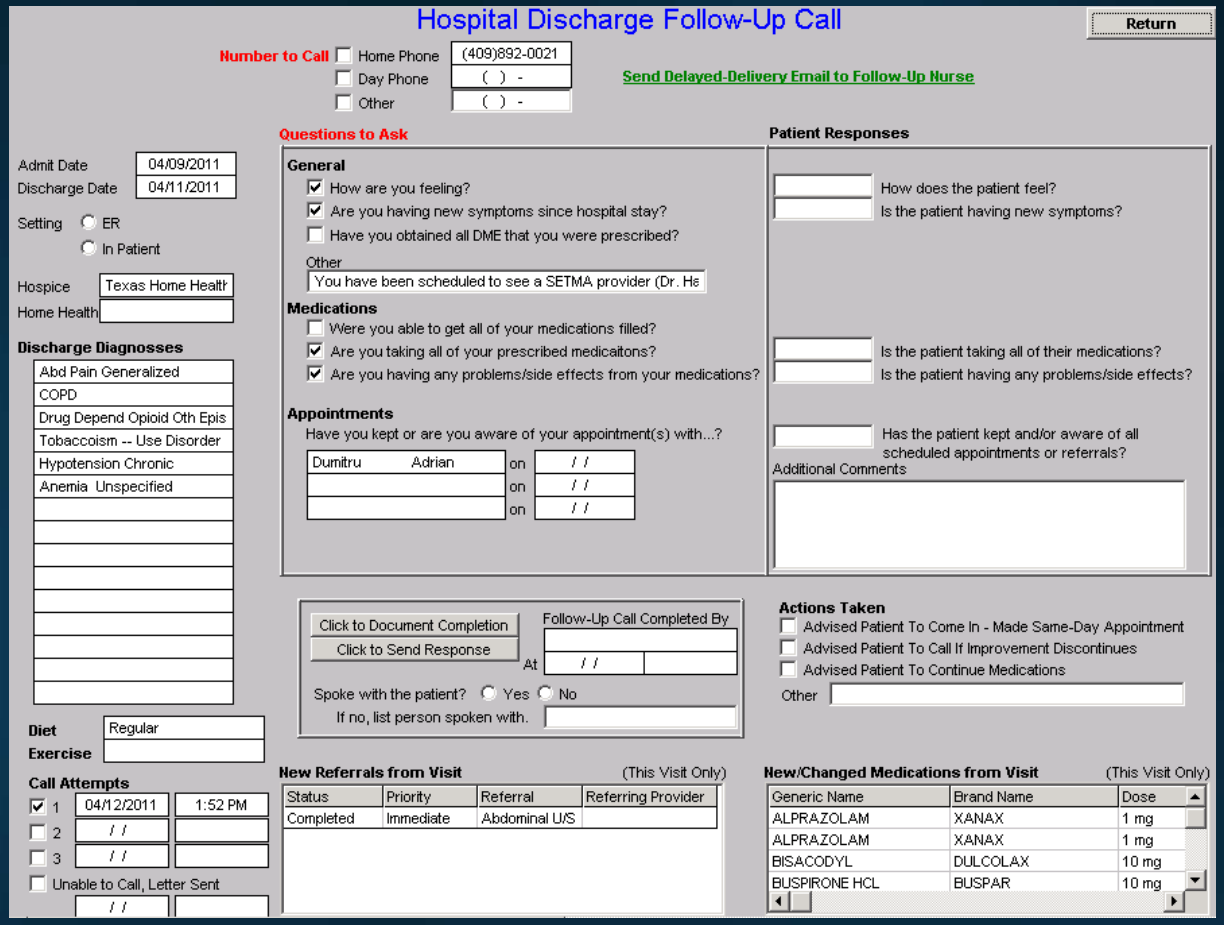
The Baton

6. That this transfer requires that the patient “grasps” the “baton,” i.e., that the patient **accepts**, **receives**, **understands** and **comprehends** the plan, and that the patient is equipped and empowered to carry out the plan successfully.

7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for “carrying the baton,” longer and better than any other member of the healthcare team.

Hospital Follow-Up Call

After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:



Hospital Discharge Follow-Up Call

Return

Number to Call: Home Phone (409)892-0021; Day Phone ( ) -; Other ( ) -

Send Delayed-Delivery Email to Follow-Up Nurse

Admit Date 04/09/2011
Discharge Date 04/11/2011

Setting: ER / In Patient

Hospice: Texas Home Healt
Home Health:

Discharge Diagnoses:
- Abd Pain Generalized
- COPD
- Drug Depend Opioid Oth Epis
- Tobaccoism -- Use Disorder
- Hypotension Chronic
- Anemia Unspecified

Diet: Regular
Exercise:

Call Attempts
- 1 04/12/2011 1:52 PM
- 2 / /
- 3 / /
- Unable to Call, Letter Sent / /

Questions to Ask

General
- How are you feeling?
- Are you having new symptoms since hospital stay?
- Have you obtained all DME that you were prescribed?

Other: You have been scheduled to see a SETMA provider (Dr. He

Medications
- Were you able to get all of your medications filled?
- Are you taking all of your prescribed medicaitons?
- Are you having any problems/side effects from your medications?

Appointments
Have you kept or are you aware of your appointment(s) with...?
- Dumitru Adrian on / /
- on / /
- on / /

Patient Responses
- How does the patient feel?
- Is the patient having new symptoms?
- Is the patient taking all of their medications?
- Is the patient having any problems/side effects?
- Has the patient kept and/or aware of all scheduled appointments or referrals?

Additional Comments

Click to Document Completion
Click to Send Response
Follow-Up Call Completed By
At / /
Spoke with the patient? Yes No
If no, list person spoken with.

Actions Taken
- Advised Patient To Come In - Made Same-Day Appointment
- Advised Patient To Call If Improvement Discontinues
- Advised Patient To Continue Medications

Other

New Referrals from Visit (This Visit Only)

Status	Priority	Referral	Referring Provider
Completed	Immediate	Abdominal U/S	

New/Changed Medications from Visit (This Visit Only)

Generic Name	Brand Name	Dose
ALPRAZOLAM	XANAX	1 mg
ALPRAZOLAM	XANAX	1 mg
BISACODYL	DULCOLAX	10 mg
BUSPIRONE HCL	BUSPAR	10 mg

Follow-Up Call

- During that preparation of the “baton,” the provider checks off the questions which are to be asked the patient in the follow-up call.
- The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called.
- The call is the beginning of the “**coaching**” of the patient to help make them successful in the transition from the inpatient setting.

Conclusions

1. The problem of readmissions will not be solved by more care: more medicines, more tests, more visits, etc.

2. The problem will be solved by redirecting the patient's attention for a safety net away from the emergency department.

3. The problem will be solved by our having more proactive contact with the patient.

Conclusions

4. The problem will be solved by more contact with the patient and/or care giver in the home: home health, social worker, provider house calls.

5. The problem will be solved by the patient and/or care giver having more contact electronically (telephone, e-mail, web portal, cell phone) with the patient giving immediate if not instantaneous access.

Keys to Success

Seamless Collaboration Between:

- Hospital Care Team
- Care Coordination Department
- I-Care (Nursing Home) Team
- Healthcare Providers
- Clinic Staff