SETMA's Initiative to Reduce Preventable Readmissions

Readmission Web Summit
August 23, 2012

Dr. James L. Holly, CEO
Southeast Texas Medical Associates, LLP
Adjunct Professor, Family/Community Medicine
University of Texas Health Science Center
San Antonio, School of Medicine

National Priorities Partnership

Addressing the fourth NPP goal, the NQF report to HHS stated that in regard to care coordination*:*

"Healthcare should guide patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships among patients and the healthcare professionals accountable for their care…."

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.

Care Transitions

SETMA's Care Transition involves:

1. Evaluation at admission -- transition issues: "lives alone," barriers, DME, residential care, medication reconciliation, or other needs
2. Fulfillment of Care Transitions Quality Metric Set
3. Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan at discharge
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 – the last and critical step in Care Transitions

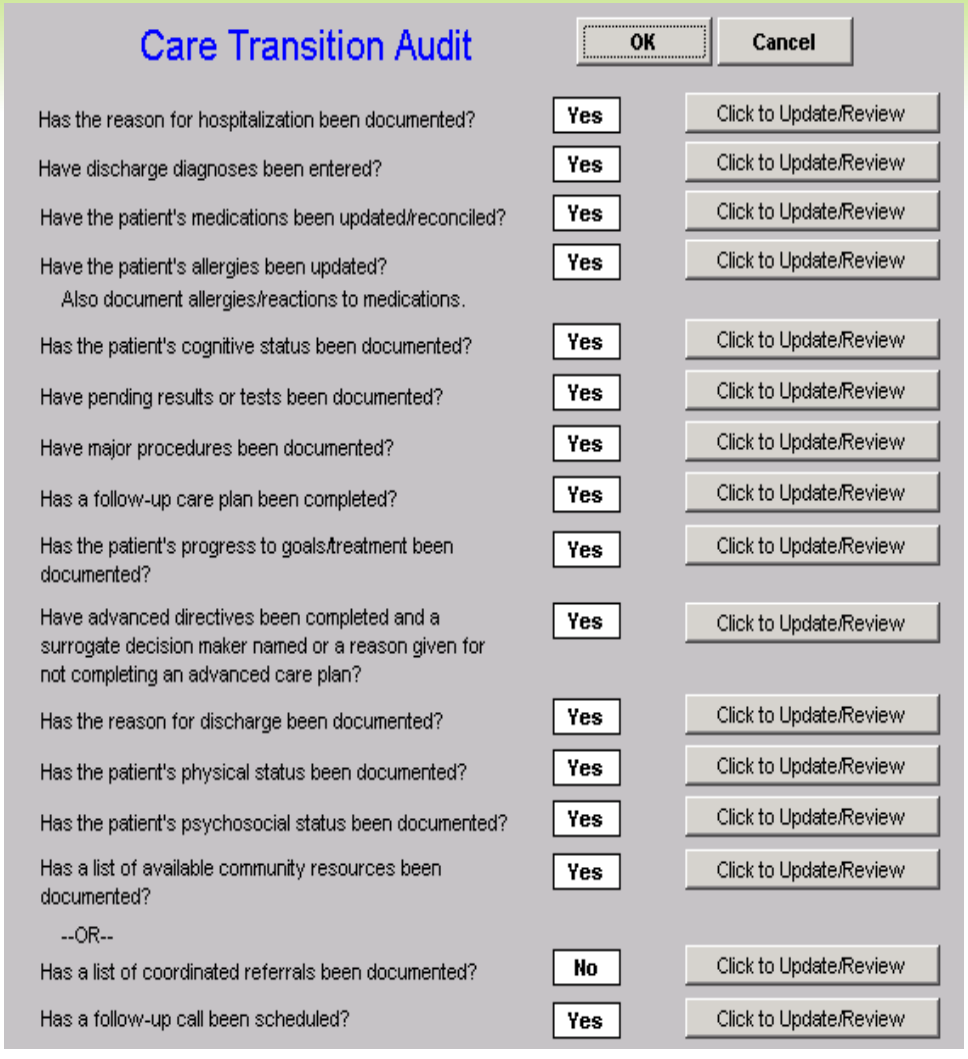
1. Evaluation At Admission

- Barriers to Care including support requirements – **does the patient live alone**
- Activities of Daily Living
- **Hospital Plan of Care** given to patient/family -- includes potential for re-hospitalization, estimated length of stay, why hospitalized, expected length of hospitalization, procedures and tests planned, contact information for how to call hospital-team members.
- Establishes communication with all who are involved in patient's care

2. Fulfillment of Quality Metric Sets

- June 2009, PCPI published Transitions of Care Quality Metric Set (14-4)
- SETMA has completed “Discharge Summaries “ in ambulatory EMR since the year 2000.
- Adopted Measurement set immediately
- Public reporting by provider name at www.jameslhollymd.com of performance on quality metric sets for 2009, 2010, 2011 and 2012.
- In 2011 completed research project with AMA to determine if SETMA fulfilling measures.

Care Transition Audit



Care Transition Audit

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

3. Hospital Care Summary & Post-Hospital Plan of Care and Treatment Plan

- Changed name of "discharge summary," September, 2010
- Includes follow-up appointments, reconciled medication lists (4 reconciliations: admission, discharge, care coaching call, follow-up appointment.)
- Over 14,000 discharges since June 2009; 98.7% of time, document given to patient at time of discharge.
- This is the tool – **the Baton** – transferring care to patient.

Care Transition Audit

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2012 through 06/30/2012

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	97.5%	99.6%	94.9%	98.3%	98.3%	97.5%	97.5%	96.6%	97.0%
Aziz	99.1%	100.0%	98.0%	99.7%	99.4%	99.4%	99.1%	98.5%	99.4%
Curry	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine	98.1%	99.2%	95.3%	97.1%	98.4%	98.4%	98.1%	96.9%	98.1%
Halbert	99.3%	100.0%	98.6%	99.3%	100.0%	99.3%	98.6%	99.3%	98.6%
Holly	97.1%	99.1%	96.0%	98.0%	98.3%	97.4%	96.8%	96.2%	97.4%
Leifeste	99.7%	99.7%	98.8%	98.8%	99.4%	100.0%	98.8%	98.8%	99.4%
Murphy	100.0%	100.0%	98.5%	99.2%	100.0%	100.0%	100.0%	99.2%	100.0%
Palang	99.4%	100.0%	100.0%	100.0%	99.4%	100.0%	98.8%	99.4%	99.4%
Qureshi	98.1%	100.0%	94.8%	97.8%	97.8%	98.1%	98.1%	96.3%	98.1%
Shepherd	97.8%	97.8%	100.0%	100.0%	100.0%	97.8%	97.8%	97.8%	97.8%
Thomas	97.7%	100.0%	95.3%	99.5%	99.5%	97.7%	97.9%	97.2%	97.7%
Vardiman	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
SETMA Totals :	98.4%	99.6%	96.7%	98.7%	99.0%	98.6%	98.3%	97.6%	98.4%

Care Transition Audit

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2012 through 06/30/2012

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Anwar	94.9%	97.5%	98.3%	98.3%	95.8%	94.1%	93.6%	94.1%	94.1%
Aziz	98.0%	99.1%	99.7%	99.1%	96.5%	97.4%	97.4%	97.4%	95.6%
Curry	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Deiparine	95.3%	98.4%	98.8%	97.5%	94.7%	93.8%	93.8%	93.6%	92.8%
Halbert	98.6%	98.6%	100.0%	99.3%	97.3%	98.6%	98.0%	97.3%	95.9%
Holly	95.1%	97.7%	98.6%	97.1%	94.8%	94.2%	94.2%	94.2%	94.2%
Leifeste	98.5%	99.7%	99.1%	99.4%	97.0%	98.5%	98.5%	98.5%	98.2%
Murphy	98.5%	100.0%	100.0%	100.0%	96.9%	98.5%	98.5%	97.7%	96.9%
Palang	100.0%	100.0%	99.4%	100.0%	98.2%	100.0%	100.0%	99.4%	99.4%
Qureshi	94.8%	98.1%	97.8%	97.8%	94.8%	92.9%	92.9%	92.9%	92.9%
Shepherd	97.8%	97.8%	100.0%	100.0%	97.8%	97.8%	97.8%	95.7%	93.5%
Thomas	94.6%	97.2%	99.5%	99.1%	96.7%	94.6%	94.6%	94.4%	93.0%
Vardiman	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%
SETMA Totals :	96.5%	98.5%	99.1%	98.6%	96.1%	95.8%	95.8%	95.6%	94.9%

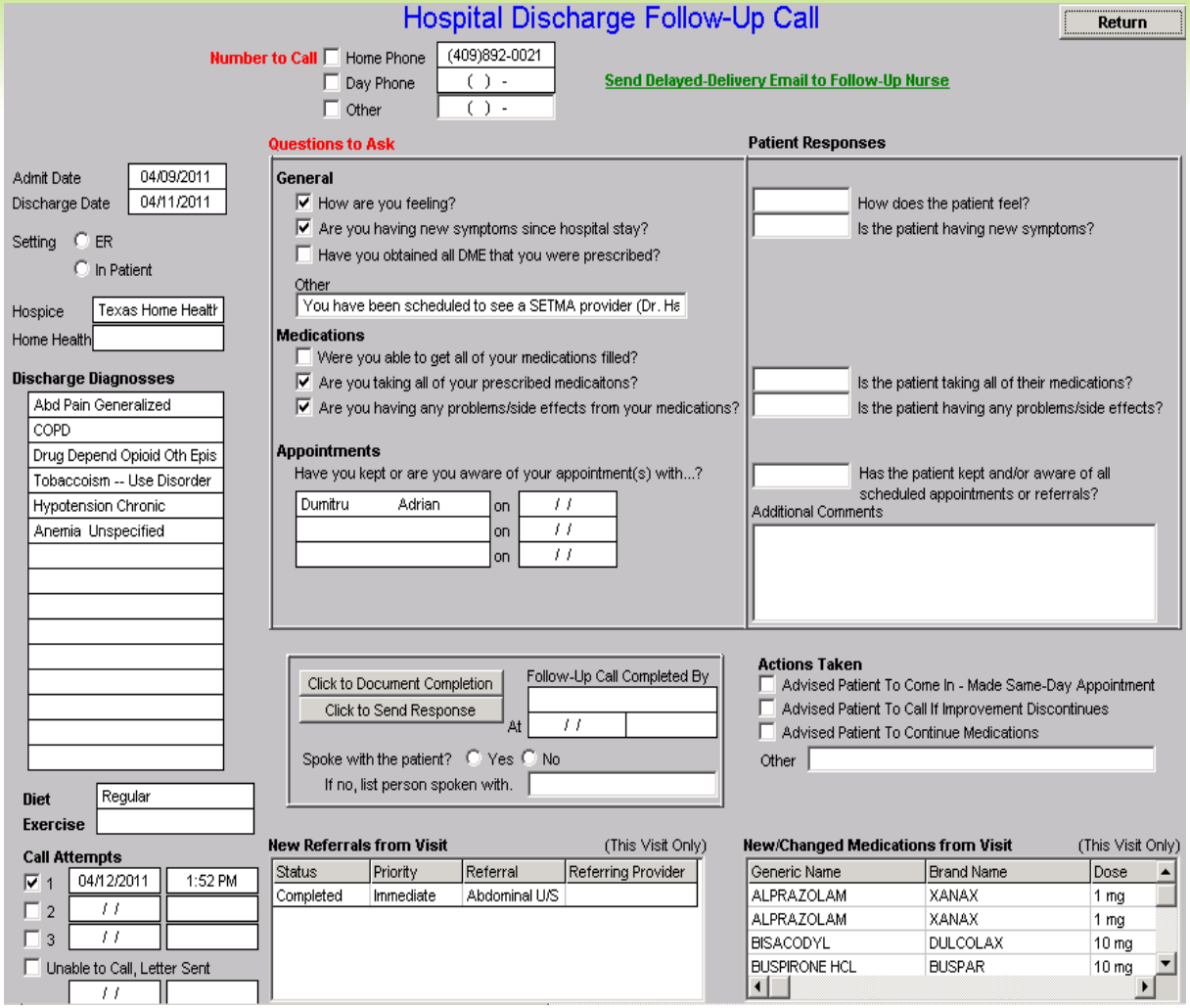
4. Hospital Follow-Up Call

A 12-30 minute call made by members of SETMA's Care Coordination Department the day after discharge

- If after three telephone attempts, contact is not made a letter is automatically generated for mailing to the patient.
- Additional phone calls, or other interventions can be scheduled by care coordination department
- Results of the follow-up phone call are sent back to the healthcare provider.
- If problems are discovered, immediate appointment is given.

Hospital Follow-Up Call

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



5. Follow-Up Visit with Primary Care Provider

- Care Transition is not complete until patient seen by primary care physician within 3-6 days
- If patient misses the appointment they are immediately contacted by Care Coordination.
- Two things appear to contribute to improvement in re-hospitalization rates: coaching call and timely follow-up visit.
- If patient is vulnerable and anxious a call from the primary care physician can be made before the first visit.

IHI Reference

- Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. ***How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Re-hospitalizations***. Cambridge, MA: Institute for Healthcare Improvement; June 2012.

  Available at www.IHI.org

Improved Transition & Reception

Institute for Healthcare Improvement

- An improved transition out of the hospital (and from post-acute care and rehabilitation facilities) as well as
- An **activated and reliable reception** into the next setting of care such as a primary care practice, home health care agency, or a skilled nursing facility.

Activated Receivers

Institute for Healthcare Improvement

- An **example of an activated receiver is a physician's office** with a specified process for scheduling post-hospital follow-up visits within 2 to 4 days of discharge.
- Although the care that prevents re-hospitalization occurs largely outside of the hospital, it starts in the hospital.

Key Changes to Improve Transitions

Institute for Healthcare Improvement

Perform an Enhanced Assessment of Post-Hospital Needs

A. Involve the patient, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient's home-going needs.

B. Reconcile medications upon admission.

C. Create a customized discharge plan based on the assessment.

Key Changes to Improve Transitions

Institute for Healthcare Improvement

Ensure Post-Hospital Care Follow-Up

A. Assess the patient‘s medical and social risk for readmission and finalize the customized discharge plan.

B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the assessment of post-hospital needs and the capabilities of patients and family caregivers.

Key Changes to Improve Transitions

Provide Real-Time Handover Communications

A. Give patient and family members a patient-friendly post-hospital care plan that includes a clear medication list.

B. Provide customized, real-time critical information to the next clinical care provider(s).

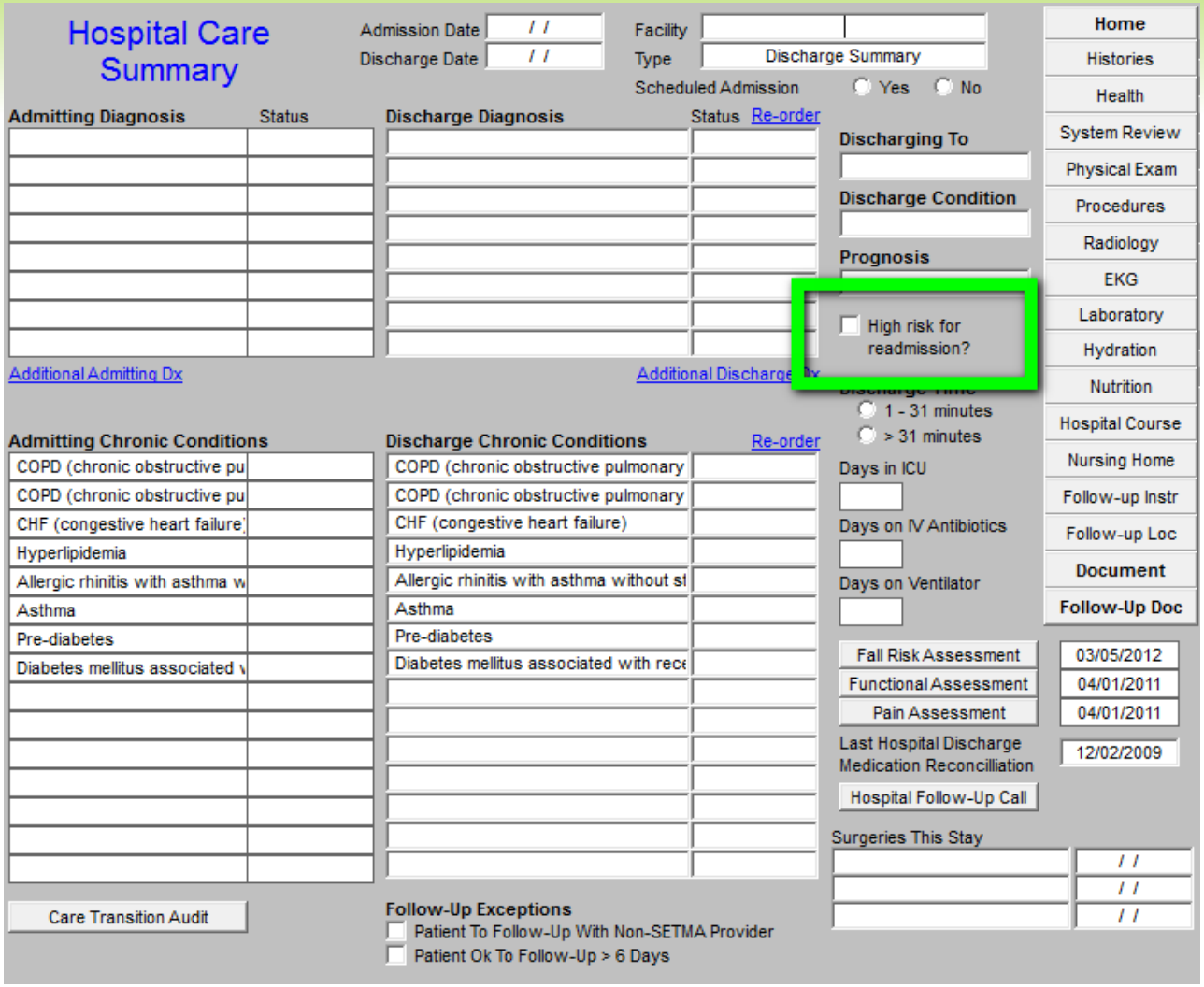
C. For high-risk patients, a clinician calls the individual(s) listed as the patient‘s next clinical care provider(s) to discuss the patient‘s status and plan of care.

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
- African American Race
- Inpatient use of narcotics
- Inpatient use of corticosteroids
- Cancer with and without metastasis
- Renal Failure
- Congestive Heart Failure
- Weight loss

Hospital Care Summary



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 telehealth monitoring measures.

Managing High Risk Patients

Currently, SETMA's determination of whether patients are high risk for readmissions is based on an algorithm published by IHI, which is principally based on frequency of admissions.

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

SETMA has deployed a business intelligence software program to contrast and compare patients who are readmitted with those who are not for:

- Age
- Gender
- Diagnoses and co morbidities
- Socio-economic circumstances
- Ethnicity
- Follow-up visit within six days or not
- Care Coaching call completed, etc.

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.**

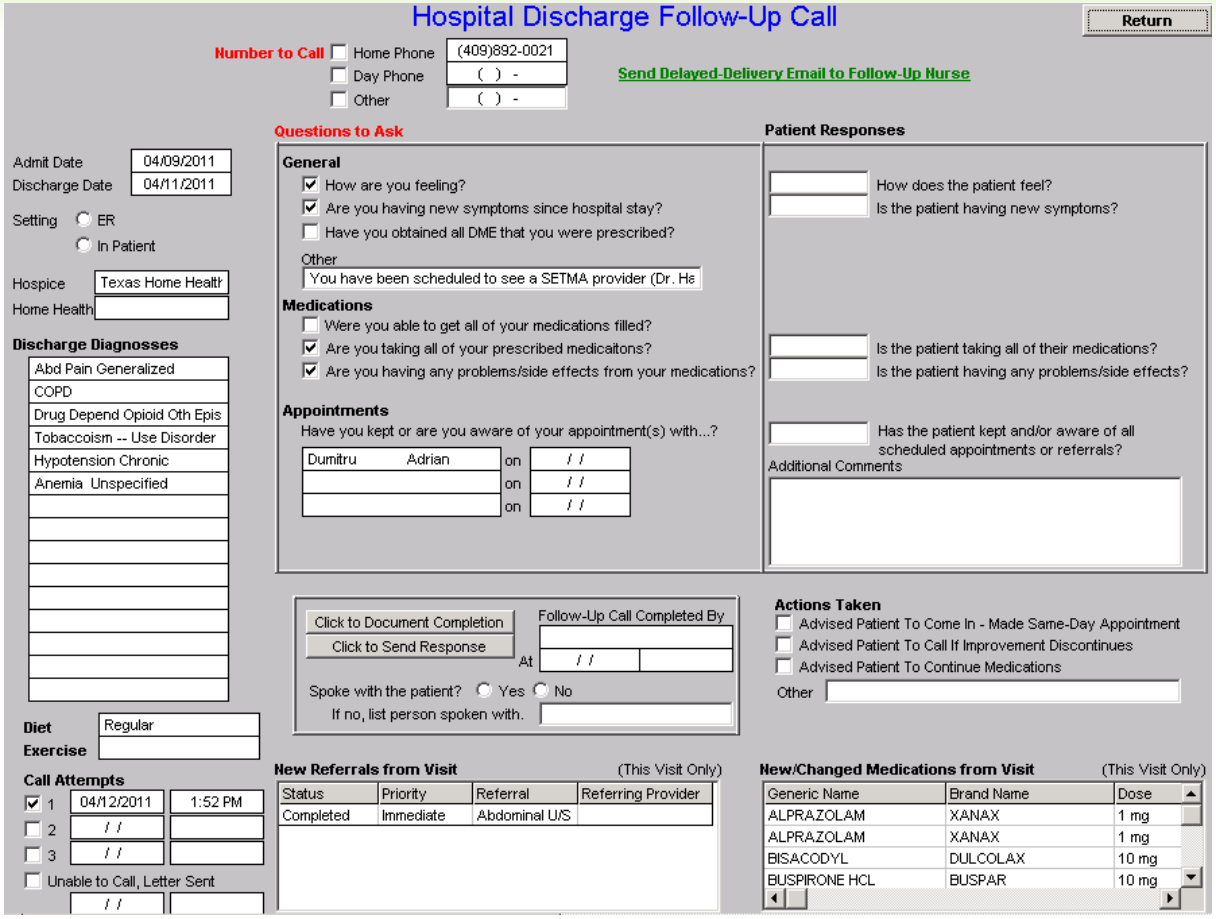
The Baton

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 template.



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
- Hospital In-Patient Staff