Readmissions Action Team Public Web Meeting

August 14, 2014
2:00-3:30 pm ET

NATIONAL QUALITY FORUM

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Meeting Objectives

- Learn about initiatives that are successfully reducing avoidable admissions and readmissions for patients with psychosocial needs;
- Share and spread best practices, programs, and ideas to safety reduce readmissions; and
- Activate participants to bring lessons learned back to their organizations to examine their data, identify priority populations, and drive improvement.

Background & Project Overview

Who is the NQF Readmissions Action Team?

Lois Cross RN, BSN, ACM (Chair) American Case Management Association	Antony Grigonis, PhD Select Medical
Osman (Ozzy) Ahmed, MD, DrPH Magellan Complete Care	Sandy Markwood National Association of Area Agencies on Aging
May-Lynn Andresen, RN Quality in Healthcare Advisory Group, LLC	Debra McGill, RN Maine Medical Partners
Maria Basso Lipani, LCSW Mount Sinai Hospital	Diane Meier, MD Center to Advance Palliative Care
Sumita Bhatia, MPH, MS Kaiser Permanente	Amy Minnich, RN, MHSA Geisinger Health System
Sarah Callahan, MHSA America's Essential Hospitals	Armando Nahum Safe Care Campaign
Pamela Carroll-Solomon, MJ, RHIA, CPHQ CHE Trinity Health	Stacy Ochsenrider, MSN, ANP-BC Bronson Methodist Hospital
Maureen Dailey, PhD, RN, CWOCN American Nurses Association	Ranjit Singh, MA, MBBChir, MBA American Board of Family Medicine
Elizabeth Davis, MD San Francisco General Hospital	Thomas Smith, MD, FAPA American Psychiatric Association
John Fastenau, MPH, RPh Janssen Pharmaceuticals	Karen Southard, MHA, RN The Carolina's Center for Medical Excellence
Lisa Freeman Patient Advocacy of Connecticut	Alissa Zerr, RN, BSN, MPH Cerner Corporation
Tejal Gandhi, MD, MPH, CPPS National Patient Safety Foundation	

Readmissions Action Team Pathway

Promoting Person-Centered Care for Vulnerable Populations to Safely Reduce Avoidable (Re)admissions

The Preventable Admissions Care Team (PACT) Program

Maria Basso Lipani, Mount Sinai Hospital

The PACT (Preventable Admissions Care Team) Program

Maria Basso Lipani, LCSW
Director, PACT

August 14, 2014

Mount Sinai

The Mount Sinai Hospital

Founded in 1852

- 1,171-bed tertiary-care teaching and research Hospital
- 183 Hospital based practices
- 3,500 Physicians, residents, and fellows
- 2000 Nurses
- 200 Social Workers
- 58,000 Discharges
- 95,000 ED visits
- One million ambulatory visits in hospital clinics and
- Family Practice Associates

Our Community:
Cultural, socio-economic, ethnic and religious diversity

East Harlem: Lower than median household incomes; documented health disparities exist among the predominantly Latino/Hispanic and African American populations

Upper East Side: One of the nation's most affluent communities

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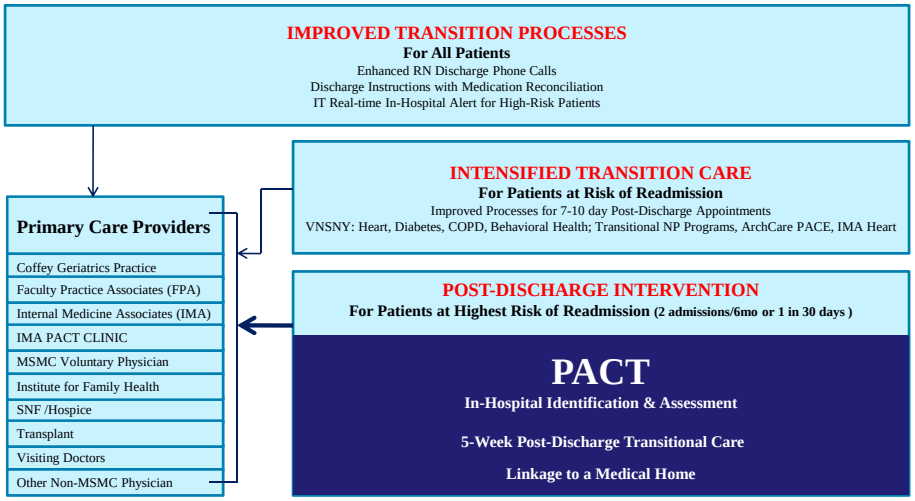
Mount Sinai Medical Center Transition/Readmission Initiatives

Objective: Reduce 30-Day Readmissions of All Adult Patients



Program Overview

PACT is an intensive, transitional care program utilizing social workers to target patients at high risk for a 30-day readmission

- Emphasis is on engagement at hospital bedside to identify for each patient the areas of psychosocial strain that compound readmission risk
- 35-day post discharge intervention is titrated to address each psychosocial driver; delivered through phone calls, accompaniments and home visits when necessary
- No exclusions for: homeless; non-English speaking; substance abuse; mental illness; dialysis; dementia
- Three funding sources enable application of the PACT Model to different populations (Funding: CMS as part of CCTP; a NY-based managed care company; MSH)
- Integration & coordination w/other CMS-funded initiatives at Mount Sinai

PACT Principles

- **High utilizers are reachable; their readmission risk can be reduced**
- **Reducing readmission risk is about more than disease management. It requires…**
  - an understanding of the psychosocial barriers to health for each patient

  and
  - the latitude (time/resources) to address them
- **Authentic engagement – of patients/their families and other supports – is critical to…**
  - identifying readmission drivers *and*
  - any subsequent interventions to address the drivers
- **Sustaining risk reduction requires…**
  - continued buy-in of the patient
  - connection to trusted providers
  - access to multidisciplinary care coordination

PACT Assessment

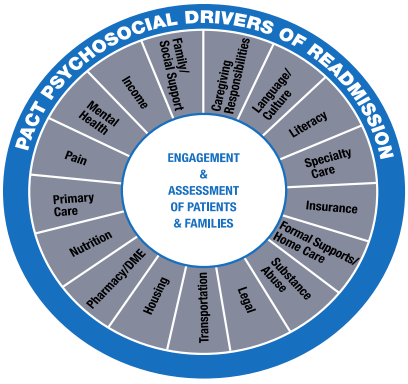
Engaging patients & families through a person-centered tool

Toward understanding the areas of psychosocial strain compounding risk…

What circumstances increase the risk for readmission?

What psychosocial factors are at the root of each problem?

In what areas is the patient open to receiving support?



PACT Intervention

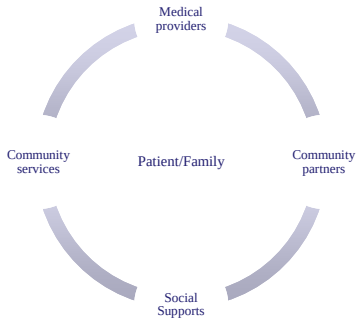
Leveraging community partnerships, networks, relationships

Toward connecting a care team for long-term sustainability…

What services are needed to stabilize - then sustain - the patient?

What tasks must be done to ensure access to the needed services?

Who must PACT partner with to ensure expedition and quality?



Who does PACT reach?

PACT targets patients at high risk for a 30-day readmission

Patient identification methods:

2010-2011: Utilization history at same hospital

2012: Modified HCC score*

2013: Risk flags embedded in EMR, driven by score + utilization history to same or other hospital

2014: Same as 2013; PEP Score testing underway**

PACT patient characteristics:

- 7829 patients enrolled 10/12 – 7/14 (all payors)
- 55% female; 45% male
- 48% African American/Hispanic/Other; 43% Caucasian; 9% Not reported
- Ages 21-107
- Majority have 3+ comorbidities; high incidence of diabetes; dialysis; documented mental illness
- 75% require a HIGH intervention vs. 25% MODERATE

*Modified HCC Score was created by Mount Sinai's Department of Health Evidence & Policy using 2010 Medicare claims data

** PEP score (Predicted Effect of PACT)was created by Mount Sinai's Department of Health Evidence & Policy and is derived from monthly data analysis of PACT outcomes

Examples of PACT

PACT work requires strong engagement, assessment & advocacy skills; creativity, collaboration & perseverance - *"Anything & Everything"*

Standardized approach is individualized for each patient VERY HIGH; HIGH; MODERATE

- **Jeffrey:** 55**;** African American male; ESRD on hemodialysis; COPD; DM; HTN; HLD; PAD; Cough Syncope Syndrome; Schizoaffective Disorder - Depressive Type
  - Six month-Pre-PACT utilization: 2 MSH admissions in 6 months prior + 5 ED visits
  - 30-day Readmission Risk: Very HIGH
  - PACT Intervention Type: Very HIGH
  - Areas of psychosocial strain addressed: Primary Care; Specialty Care; Literacy; Nutrition; Transportation; Formal Support; Social Support; Caregiver Experience; Pain; Substance Abuse; Mental Health; Housing; Pharmacy/DME
  - Six month-Post-PACT utilization: 1 MSH admission + 2 ED visits
- **Joe**: 76; Caucasian male; venous stasis ulcers of lower extremity, weakness, HTN, chest pain, HLD, CAD umbilical hernia, and "social problem"
  - Six month-Pre-PACT utilization: 1 MSH admission in 6 months prior + 3 ED visits/week, multiple weeks
  - 30-day Readmission Risk: HIGH
  - PACT Intervention Type: HIGH
  - Areas of psychosocial strain addressed: Housing; Primary Care; Formal Supports; Insurance
  - Six month-Post-PACT utilization: None

The Impact of PACT

The blended risk of a 30-day readmission for all PACT patients is 29.2%

Most have a 39% risk of a readmission within 30 days

Condition or Characteristic	Coefficient	Odds Ratio	95% CL for OR		Risk Score
Chronic Kidney Disease	0.3869	1.5	1.199	1.809	2
HF	0.2569	1.3	1.058	1.580	1
Osteoporosis	0.3374	1.4	1.040	1.888	1
COPD	0.6851	2.0	1.485	2.651	3
Depression	0.5553	1.7	1.277	2.377	2
Stroke	0.9292	2.5	1.590	4.035	4
AMI	0.8912	2.4	1.639	3.628	3
HIP Fracture	1.055	2.9	1.306	6.316	4
Alcohol Abuse	0.7603	2.1	1.100	4.160	3
Breast Ca	0.8597	2.4	1.124	4.967	3
Dual Eligible	0.279	1.3	1.104	1.583	1
Black	0.4201	1.5	1.228	1.887	2
Hispanic	0.2914	1.3	1.078	1.661	1
CKD & AFIB	1.1159	3.052	1.756	5.305	4
CMD (<65 yrs)	0.5437	1.722	1.220	2.431	2

Score	Patients at Each Score	Patients/ Group	Avg Risk/Group	Blended Risk
2	1717	2883	20.6%	29.2%
3	1166			
4	809	2509	39.0%	
5	572			
6	535			
7	281			
8	146			
9	67			
10	56			
11	21			
12	17			
13	3			
14	2			

Source: Mount Sinai's Department of Health Evidence and Policy. Based on analysis of 2010 claims data.

PACT Pilot Hospital Utilization & Readmissions

All Payors ***(These results have been replicated across 6045 patients enrolled 10/1/12 – 3/31/14)***

Hospital Utilization*
For Patients Who Completed PACT 5-Week Intervention (N=615)
(September 2010 – August 2012)

	Pre	Post	Reduction
Admissions excludes index admission	952	546	43%
ED Visits	1707	789	54%

Patients with no Readmissions at Mount Sinai at 30, 60, 90 days (N=615)**

# of days from Index Admission	# of patients	# of patients with hospitalizations	# of patients with none	30-day readmission rate (%)
30	615	106	509	17%
60	499	73	426	28%
90	472	104	368	34%

Source: TSI (Mount Sinai's cost accounting system) 9/1/10-8/31/12
*All patients are their own controls. The "Pre" time period has been adjusted to match the "Post" period on a per patient basis.
** Excludes patients who died post-discharge or were lost to follow-up.

Feedback about PACT

(Via text) "My hat's off for you…this wouldn't have happened without you…thank you for what you've done ☺" *(on expediting the clearance needed for hip surgery and ensuring he had pain medication).* Later (over the phone), "I know how hard you're working and I'm with you. I'll do whatever it takes."

"I know I'm a difficult person to work with, and no one has ever been this patient with me. Thank you for taking the time to show that you care, and for instilling hope".

"Where were you in 2005? If you'd have been in my life, I may not have needed triple bypass surgery."

"I feel so much better about this whole process. I feel like you know more about me and my dad than my own wife!"

"You know the old me better than I do but now I know me better than anyone knows me…and thanks for helping me get to this place in my life by the way!"

"Do you want to see pictures of my gran? You're family now." *(After a patient returned from an out-of-state trip to his grandmother's memorial services.)*

"Y'all have taken such good care of me, I feel like I should take care of me."

"Today is our last day I know, but I don't want to graduate, what do I do to get left back? Thank you so much for what you've done for me."

(Her PCP after the intervention ended) "It's going to take her some time to get things back together but I truly believe what you have done for her will be the foundation she is able to build off. Without having to worry about these things, she can start to focus on her medical problems and getting better."

"A lot of luck came my way when I met you."

Next Steps for PACT:

1. **1 year renewal of CCTP-funding with option to expand program into Mount Sinai Health System ("shovel-ready" Oct. 1, 2014)**

   Four social workers in 2010 to 64 in 2014; 600 patients to 12K

   Year 3 goals: 1) Maximize quality, effectiveness & efficiency; 2) Contribute meaningful data to the discussion of psychosocial factors driving readmission and intervention dose required to reduce risk

2. **Publication**

   Submission to JAMA Internal Medicine this month; Academy of Health poster at conference (6/14)

   Design: Retrospective cohort study using case control approach

   Conclusions: ***PACT reduced readmission rates and cost compared to matched controls****

   Utilization:

   - 30-day readmission rate reduced by 31% (p=0.003),
   - 60-day hospitalization rate reduced by 25% (p=0.001);
   - 90-day hospitalization rate reduced by 22% (p=0.001),

   Total inpatient costs 30 days post-index:

   - $2.7 million for PACT patients
   - $4.1 million for controls

* The effect of the program on readmission rates was not significant at 180 days after index admission. Additionally, the cost savings were not sustained at 180 days after index, and the median cost per patient did not differ significantly between the two groups

Mount Sinai Health System at a Glance

1. Beth Israel Medical Center
280 First Avenue
New York, NY 10003
856-beds

2. Beth Israel Brooklyn
3201 Kings Highway
Brooklyn, NY 11234
212-beds

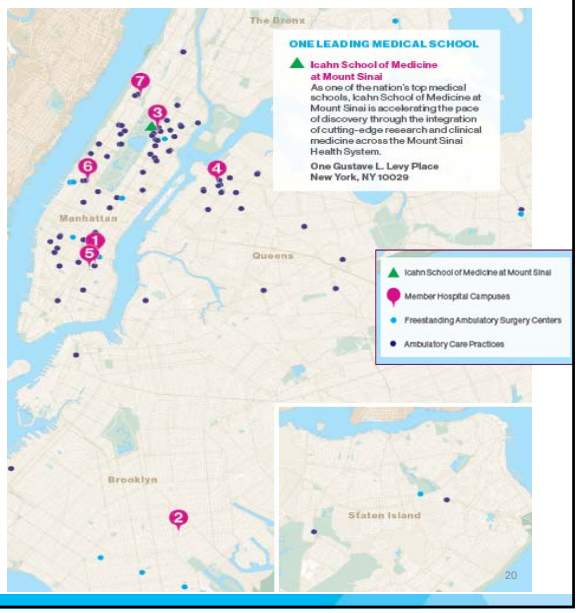
3. The Mount Sinai Hospital
One Gustave L. Levy Place
New York, NY 10029
1,171-beds

4. Mount Sinai Queens
25-10 30th Avenue
Long Island City, NY 11102
235-beds

5. New York Eye and Ear Infirmary
310 East 14th Street
New York, NY 10003
69-beds

6. Roosevelt Hospital (St. Luke's-Roosevelt Hospital Center)
1000 Tenth Avenue
New York, NY 10019
505-beds

7. St. Luke's Hospital (St. Luke's-Roosevelt Hospital Center)
1111 Amsterdam Avenue
New York, NY 10025
523-beds



Public Comment and Questions

The Reducing Avoidable Readmissions Effectively (RARE) Campaign

Kathy Cummings, Institute for Clinical Systems Improvement
Kim McCoy, Stratis Health
Kattie Bear Pfaffendorf, Minnesota Hospital Association

RARE Campaign: Maintaining patient health after a hospital stay…

What is the RARE Campaign?

- A campaign across the continuum of care to reduce avoidable hospital readmissions across Minnesota and surrounding areas
- Regional approach, supported by hospitals, providers, health plans, other key stakeholders
- Campaign is engaging other care providers, acknowledging that readmissions are the result of a fragmented health care system

Broad Community Support

- Operating Partners:
  - Institute for Clinical Systems Improvement (ICSI)
  - Minnesota Hospital Association (MHA)
  - Stratis Health

Broad Community Support

- Supporting Partners:
  - MN Community Measurement
  - MN Medical Association
  - VHA Upper Midwest
- 100+ Community Partners
- Advisory Committee and subject-matter specific workgroups

Triple Aim Goals

- Population health
  - Prevent 6,000 avoidable readmissions within 30 days of discharge by the end of 2013
  - Reduce overall readmissions rate by 20% from the 2009 and maintain that reduction through 12/13/13.
- Care experience
  - Recapture 24,000 nights of patients' sleep in their own beds instead of in the hospital
- Affordability of care
  - Save millions of dollars in health care expenses

Five Focus Areas

Patient and Family Engagement

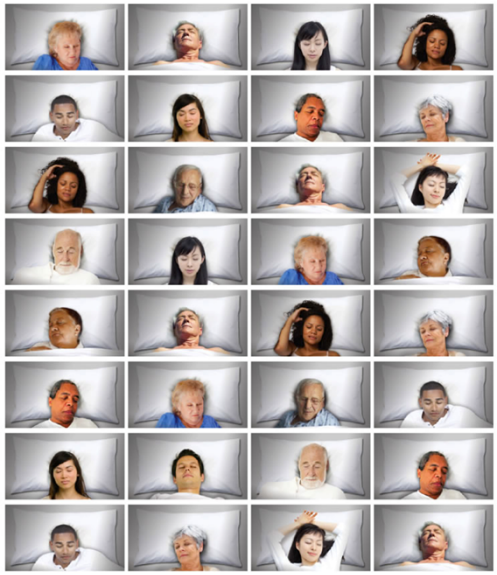
Comprehensive Discharge Plan

Transition Communication

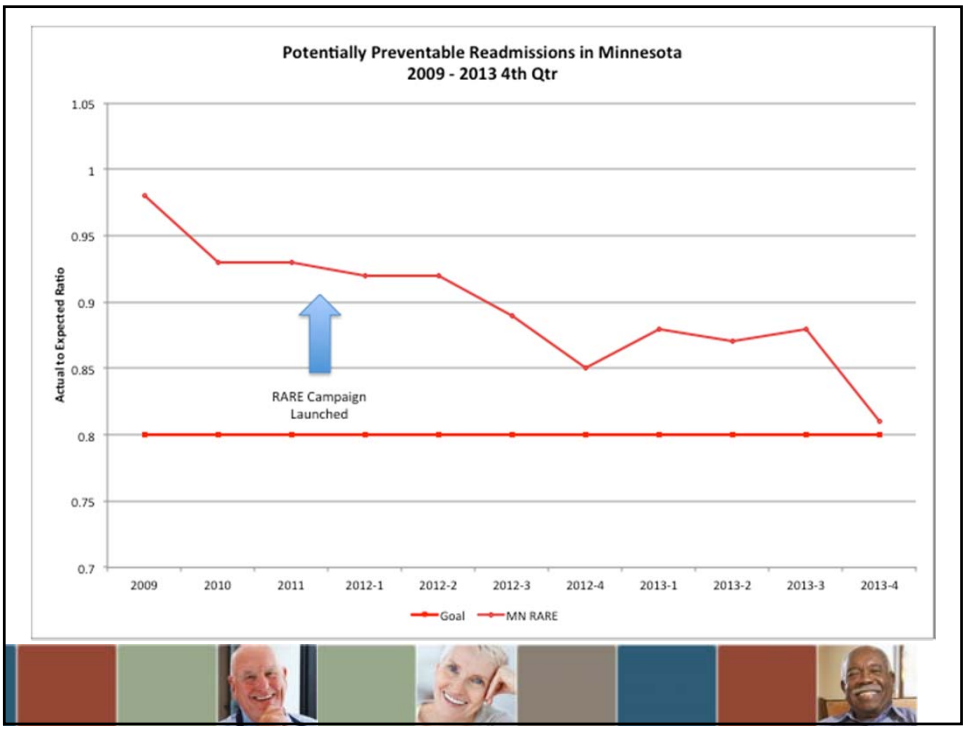
Medication Management

Transition Support

RARE Campaign: 7,975 Readmissions Prevented



Each person represents 250 prevented readmissions, and 1,000 more nights of sleep in their own beds for Minnesotans



JOHN M. EISENBERG
PATIENT SAFETY & QUALITY AWARDS

What a Difference a Community Makes!

www.RAREreadmissions.org

Kathy Cummings
kcummings@icsi.org
Kim McCoy
KMCCOY@stratishealth.org
Kattie Bear Pfaffendorf
kbear-pfaffendorf@mnhospitals.org

Public Comment and Questions

Maximizing Community Benefit Programs to Improve Outcomes

Holly Harper, Sutter Health

Sutter Health
We Plus You

The Impact of Collaborative Partnerships

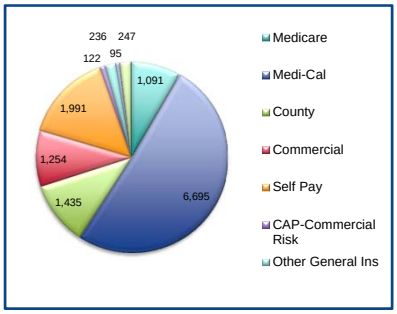
Presented By:
Holly Harper, MPA, Regional Manager, Community Benefit, Sutter Health Sacramento Sierra Region

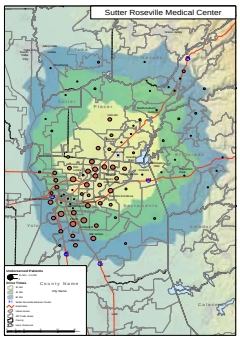
NQF Readmissions Action Team, Public Web Meeting
Thursday, August 14th

Unique Community Needs

Identifying The Need:

- » Community Health Needs Assessment
- » Emergency Department Data
- » Capacity Study





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Regional Challenges

Limited or lack of access to primary, mental & preventive health care.

Too few options for care leads to a serious impact on the ED & poor use of healthcare dollar.

This is bad for the patient, the hospital and the community.

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Smart Partnerships

The Affordable Care Act has challenged us to look at things differently and determine how we can partner with other organizations to create change.

- **What do we do well?**
- **What do our community partners do well?**
- **How do we collaborate to improve whole health stability?**

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Putting it all Together

Sutter Health Sacramento Sierra Region and WellSpace Health, a local Federally Qualified Health Center (FQHC), have served as close partners for nearly 10 years.

This collaboration works to successfully design and implement innovative programs, aimed to meet the needs of the most vulnerable populations in our region.

As a result of strategic investments in WellSpace, we ensure that the underserved have access to primary care, mental health services and a medical home.

Through this partnership, we help connect people to the right care, at the right place, at the right time.

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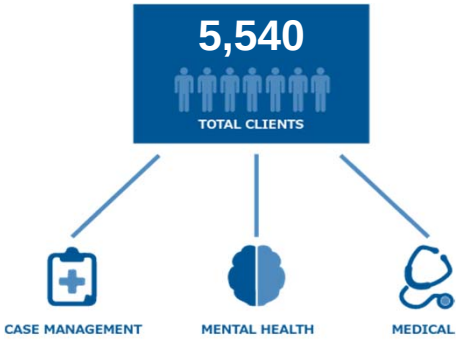
The Impact of Partnership

Through innovative and collaborative Community Benefit programming, Sutter Health and WellSpace Health have helped more than 5,540 clients.



ED Navigator | Triage, Transport, Treat | Interim Care Program | T3+

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Tangible Outcomes

Expanding Access to Care:

Investment in WellSpace Health Clinics:

- Strategic investments have allowed WellSpace Health to expand across the greater Sacramento Region.
- The CHNA was able to show need for health clinics in our region, even in affluent areas like Placer County.
- WellSpace Health is on track to see 30,000 – 32,000 patients in 2014. This is approximately an 84% increase in patients served since 2011.
- Ground breaking efforts like Open Access Clinic Hours have emerged as a result of our partnership with the WellSpace Health clinics.

Assemblyman Roger Dickson, Sacramento County Supervisor Phil Serna, Congresswoman Doris Matsui and WellSpace Health CEO, Jonathan Porteus, PhD at ribbon cutting for a WellSpace Health Clinic.

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The Specifics

Emergency Utilization Programs:

ED Navigator Program: ED Navigators connect with patients in the ED to link them to primary and metal health care, community resources, transportation and other vital services.

- Collectively, the WellSpace ED Navigators have connected with 416 people year to date
- In the same time period, ED Navigators provided nearly 1,620 referrals, for an average of 3.9 referrals per patient
- 174 of those patients were enrolled in our T3 program

ED Navigator Referrals Include:
Insurance
Primary Care
Mental Health
Housing
Transportation
General Assistance
Food Banks
Other

Triage, Transport, Treat (T3): T3 serves those seeking ED treatment for non-urgent issues and need ongoing case management.

- Collectively, the SHSSR T3 programs have nearly 400 active patients
- Patients show an 83%-85% reduction in overall hospital usage, post-T3
- Following T3 intervention, patients show an 85-87% decrease in ED usage

More than 1,000 patients have been served by T3

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The Specifics Continued

Outpatient Program:

Interim Care Program (ICP): ICP gives homeless patients a place to heal, while wrapping them with services.

- Nearly 35 patients have been served by the ICP year to date
- Of the patients that did return to the hospital, they are healthier with fewer instances of chronic conditions and major health issues.
- Patients show a 66% reduction in overall hospital usage, post ICP

More than 1,050 patients served since inception

Inpatient Program:

T3+: Is an extension of T3 that provides more intensive and ongoing case management services for inpatients (rather than those using the ED) whom have a high risk of readmission.

- 35 patients have been served year to date
- Patients show a 55% reduction in inpatient visits post T3+ intervention

Patients show a 62% reduction in inpatient bed days post-T3+

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Questions?

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Integrating Risk Stratification to Reduce Readmissions

Ramesh Sairamesh (Jakka), Advisory Board Company

The Advisory Board Company | Crimson Real Time

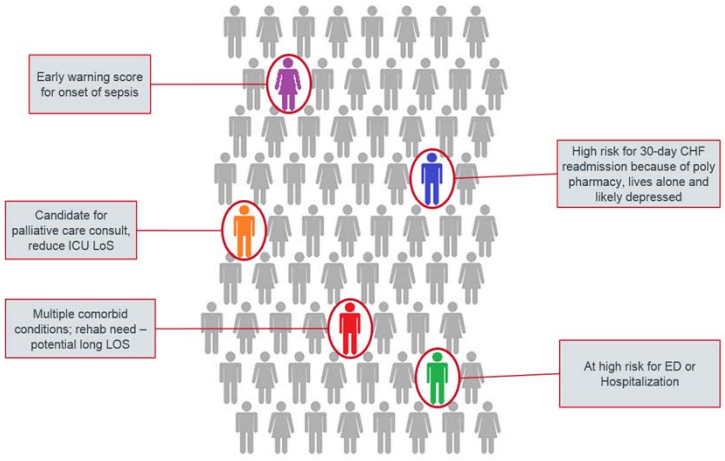
Crimson Real Time

Leveraging Predictive Analytics to Reduce Readmission Rates, Clinical Costs and Improve Outcomes

Find the Patients Who May be Trending Toward Avoidable 30-day Readmissions, ED and Hospitalization Costs

Reducing Costs, Improving Quality Through Population Health Within and Across the Four Walls

Goal is Early Identification to Match Resources to Risk



Automated Chart Review To Glean Psychosocial & Mental Health Factors for Stratifying Patients at-Risk for Readmissions

Disproportionate Value Embedded in Clinician Notes, Unstructured Text

HISTORY OF PRESENT ILLNESS: The patient is a 41-year-old previously well known to me. He presents with dyspnea, weakness, and confusion. He has a history of aortic valve disease, status post aortic valve replacement on 99/99/9999, for which he has been on chronic anticoagulation. There is a previous history of paroxysmal atrial fibrillation and congestive heart failure, which has been rather unstable prior to this admission. He has a previous history of transient ischemic attack with no residual neurologic deficits.

The patient has undergone surgery by Dr. X for attempted nephrolithotomy. The patient has experienced significant postoperative bleeding, for which it has been necessary to discontinue all anticoagulation. The patient is presently seen at the request of Dr. X for management of anticoagulation and his above heart disease.

FAMILY HISTORY: There are no family members with coronary artery disease. His mother has congestive heart failure.

SOCIAL HISTORY: The patient is widowed, living alone. He has "a friend" who helps with care once in a while. He is employed as a barber. He does not use alcohol, tobacco, or illicit drugs.

MEDICATIONS PRIOR TO ADMISSION:

1. Clonidine 0.3 mg b.i.d.
2. Atenolol 50 mg daily.
3. Simvastatin 80 mg daily.
4. Furosemide 40 mg daily.
5. Metformin 1000 mg b.i.d.
6. Hydralazine 25 mg t.i.d.
7. Diovan 320 mg daily.
8. Lisinopril 40 mg daily.
9. Amlodipine 10 mg daily.
10. Lantus insulin 50 units q.p.m.
11. KCl 20 mEq daily.
12. NovoLog sliding scale insulin coverage.
13. Warfarin 7.5 mg daily.
14. Levothyroxine 0.2 mg daily.
15. Folic acid 1 mg daily.

ELECTROCARDIOGRAM: Normal sinus rhythm. Right bundle-branch block. Findings compatible with old anteroseptal and lateral wall myocardial infarction. Nonspecific ST-T abnormality.

HEART FAILURE is **UNSTABLE**. Risk factor for 30-day readmission.

Potential **COMPLICATIONS** (TIAs)

LITTLE OR NO SUPPORT: strong risk factor for noncompliance & 30-day readmission

LIVES ALONE: strong risk factor for noncompliance

SOCIOECNOMIC RISK: can't afford care, afford transportation to come to clinic visits, etc.

POLYPHARMACY, DOSAGE VARIATION / FREQUENCY, DRUG COST: risk factors for noncompliance, 30-day readmission, adverse events

Curating Clinician Notes to Drive Insights

"Until now, most of the benefit of EMRs have come from clinical decision support – avoiding two drugs with serious drug-drug interactions. Yet, there is so much more that they could do….Much of the value resides in unstructured clinician notes rich in detail about signs and symptoms, patients response to treatment, and other details key to understanding the patient's condition."

JAMA, 2012

Demonstrated Success at a Progressive Health System

About the Organization

- Multi-hospital, not-for-profit health system

Challenge

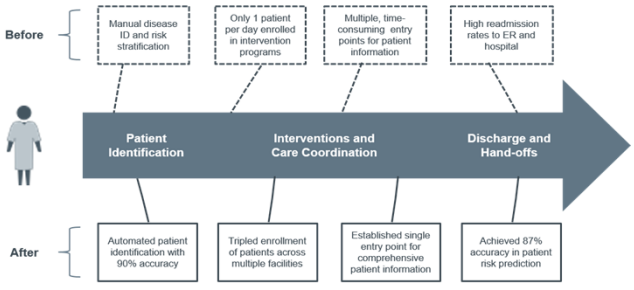
- Needed to replace manual process for identifying patients for disease-based risk assessment
- Wanted to improve accuracy of 30-day readmission risk stratification
- Needed to boost enrollment in intervention programs
- Looked to enable an automated clinical and psychosocial care plan summary

Impact

- Reduced chart review time by 15 minutes per patient
- Enabled a single entry point for access to patient risk and care plan summaries
- Tripled enrollment of patients in intervention programs
- Achieved 30% time savings in hand-offs and care coordination
- Reduced Readmission rates by 15% over short time period.

Reduce 30-day Readmissions through Accurate Identification and Targeted Interventions

Reduce Inefficiencies by Streamlining Analytics



87% Accuracy with 0.76 in PPV for 30-day readmissions

3x Enrollment of high risk patients in targeted intervention programs

Q&A

Contact: Sairamer@advisory.com
Ramesh Sairamesh (Jakka)

Discussion: Sharing Resources and Strategies to Reach our Goal

Goal: Promoting Person-Centered Care for Vulnerable Populations to Safely Reduce Avoidable (Re)admissions

- What specific things can you do to model, build on, or help to spread what you have heard today?
- What work are you doing that others can model, build on, or spread?
- What tools and resources exist that assess individuals with psychosocial needs?

2014

JOHN M. EISENBERG
PATIENT SAFETY & QUALITY AWARDS

Submissions will be accepted
August 1, 2014 – September 30, 2014

EisenbergAwards@qualityforum.org

Thank you!

If you have additional feedback we'd love to hear from you.

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Supplemental Materials

Improving Care Transitions

Kaiser Permanente

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Improving Care Transitions

- Background
- Solution
- Components
- Results
- Learn More

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KP Values & Commitment to Quality

KP Value Compass

KP Mission

Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Triple Aim

- We achieve the KP Mission and the Triple Aim through our unyielding focus on delivering high-quality care and following the principle of doing no harm. We recognize an ethical responsibility to remain good stewards of our member's resources so that we are able to bring our high quality, coordinated care to more people within our communities.
- At Kaiser Permanente, medical decisions are made by physicians in partnership with their patients. We support conversations between physicians and patients to discuss appropriate medical options and reach decisions that are supported by sound medical judgment; including evidence-based practices while maintaining our commitment to quality care and affordability.

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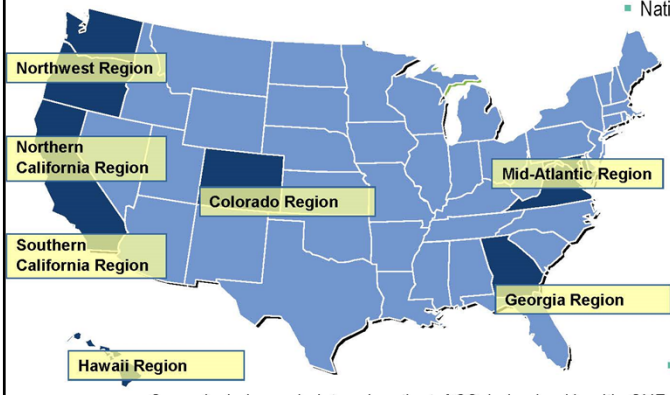
About Kaiser Permanente



- Nation's largest non-profit health plan
- Integrated health care delivery system
- 9.5 million members
- 16,000+ physicians
- 174,000+ employees (including 48,000+ nurses)
- Serving 8 states and the District of Columbia
- 38 hospitals
- More than 600 medical offices
- $53.1 billion operating revenue*
- Scope includes ambulatory, inpatient, ACS, behavioral health, SNF, home health, hospice, pharmacy, imaging, laboratory, optical, dental, and insurance

*Kaiser Permanente 2013 Press Release

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Background

Addressing Unnecessary Readmissions

- We know from the literature that one in every five Medicare beneficiaries had unplanned readmissions within 30 days of hospital discharge (NEJM, April 2009).
  - For 50% of these cases, there was not a bill for the visit to a physician's office between the time of discharge and readmission.
  - Total cost of unplanned readmissions for Medicare population estimated to be 17.4 billion in 2004 alone (NEJM, April 2009).
- **Solution:** Improve the end-to-end care experience for patients leaving the hospital by spreading the Transition Bundle across Kaiser Permanente regions and creating reliable systems that improve the ability of our members to stay safely at home after hospitalization.

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Kaiser Permanente Approach & Perspectives

Transitions: Whose Job Is It? How to Designate Roles?

- Transitions Department?
- Primary Care?
- Specialty Care?
- Hospitalists?
- Continuing Care?
- Quality Department?
- Resource Stewardship?
- Utilization Management?
- The Patient…..

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KP Approach: Transition Care Journey

2008	2009	2010	2011	2012
•Interviewed Patient •Human Centered •Transitions Redesign	•Kick-Off meeting •Readmission Diag. •Video Ethnography •Grants to Regions	•Transitions Bundle-Creation and Testing •Standard Measures	•Results •Bundle Spread •Transitions 101	•Contract Hosp. •Skilled Nursing Facilities •Transitions 201

What Patients Need? → **Operational Change**

National Tools
- **Small grant $$'s**
- **Consultation/ Support**
- **Transition Summit**
- **Readmit Diagnostic**
- **Measurement**
- **Transitions 101 Series**
- **Transitions Wiki Site**

Regional Outcomes
- **Patient Centered**
- **Transition Bundle**
- **Created**
- **Tested**
- **Implemented**
- **Spread**

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Deep Dive: Developing the KP Readmission Diagnostic

Recommended by the Institute for Healthcare Improvement, the KP methodology combines chart review with patient and provider interviews to determine why readmissions occur. This information was used for test of change to eliminate failures in transitions in care from the hospital to the home.

CHART REVIEWS

MD INTERVIEWS

PATIENT/ CAREGIVER INTERVIEWS

RN/ MD Team FINAL ASSESSMENTS Synthesis of 3 different data sources

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What We Learned

Transitions Care Planning and Care Coordination

Patients would have liked to know more about their health, prognosis, and treatment.

- 31% of patients reported we could have explained their prognosis more clearly.
- 24% of patients reported we could have talked to them more about their medications and why they take them.
- Some patients had social, financial, or behavioral needs that needed addressing

Source: Data from 600 patient charts reviewed as part of readmission diagnostic in Kaiser Permanente.

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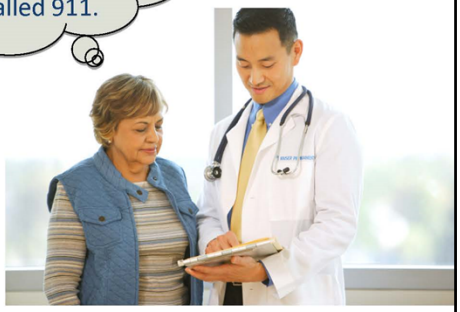
Patient's Perspective....

There were too many new meds and I didn't understand the changes.

My primary care provider did not know I was in the hospital.

The main thing was not knowing who to call...so I called 911.

I just wanted to go home, I didn't pay as much attention as I should have to the nurse.



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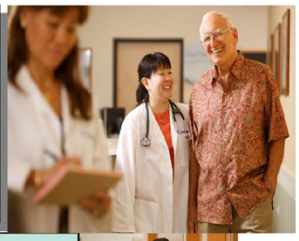
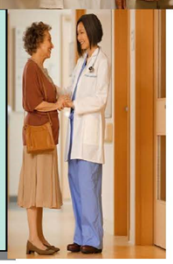
Perspectives: Physician

Primary care physicians were not always getting timely information from both the hospitals and Skilled Nursing Facilities.



In 25% of the readmissions, care could have been delivered in primary care versus hospital.



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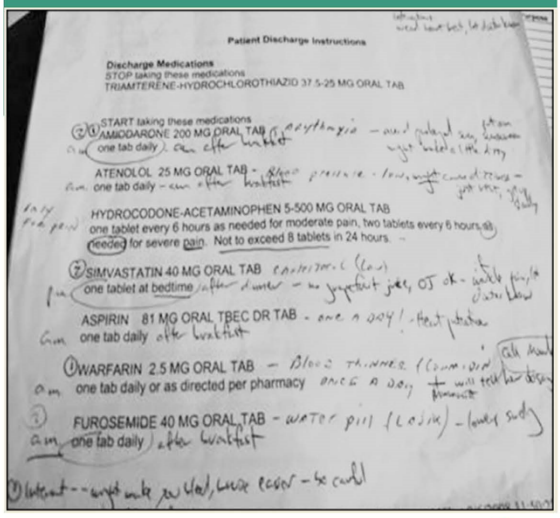
Medication List

Actual Discharge Medication List



Patient Discharge Instructions

Discharge Medications
STOP taking these medications
TRIAMTERENE-HYDROCHLOROTHIAZID 37.5-25 MG ORAL TAB

START taking these medications
AMIODARONE 200 MG ORAL TAB
one tab daily
ATENOLOL 25 MG ORAL TAB
one tab daily
HYDROCODONE-ACETAMINOPHEN 5-500 MG ORAL TAB
one tablet every 6 hours as needed for moderate pain, two tablets every 6 hours as needed for severe pain. Not to exceed 8 tablets in 24 hours.
SIMVASTATIN 40 MG ORAL TAB
one tablet at bedtime
ASPIRIN 81 MG ORAL TBEC DR TAB
one tab daily
WARFARIN 2.5 MG ORAL TAB
one tab daily or as directed per pharmacy
FUROSEMIDE 40 MG ORAL TAB
one tab daily

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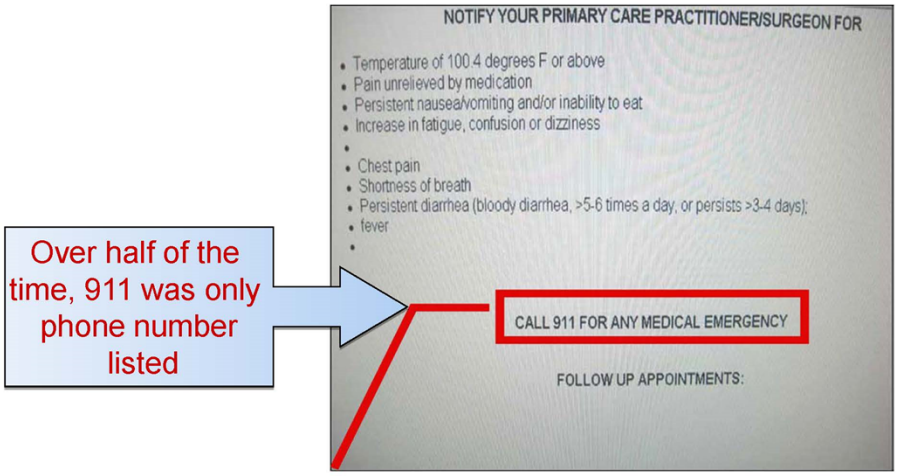
Who Do You Call?



Over half of the time, 911 was only phone number listed

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Transition Bundle Components

Core Components

- Risk Stratification with Tailored Care
- Discharge Hotline
- Standardized Same Day Discharge Summary
- Medication Management
- Timely Follow Up

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Transition Care Bundle

What Does the Patient Need?	Transition Bundle Elements
I will understand the risk and have what I need when I return home.	1. Risk Stratification with Tailored care
I know when I should call and what number to use when I need help.	2. Discharge Hotline
My regular doctor will know what happened to me in the hospital.	3. Standardized Same Day Discharge Summary
I understand my medications, how to take them, and why I need them.	4. Medication Management
I will see my doctor soon after my hospitalization. I know someone will check on me When I am home.	5. Follow Up ▪ MD appointments made in hospital within 5 (high risk) to 10 days. ▪ RN follow up Call within 72 hours. ▪ RN case management 30 days (high risk)

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Bundle Element #1: Risk Stratification

Which patients are at high risk for readmission?
Physician or RN believes the patient may be at risk for readmission
OR
Heart Failure diagnosis
OR
Prior hospitalization within the last 30 days?
OR
LACE score >11

LACE is the Risk Stratification Tool: LACE Index - L= Length of Stay, A=Acuity of admission, C=Charlson Comorbidity Index, E= Number ER visits in prior 6 months

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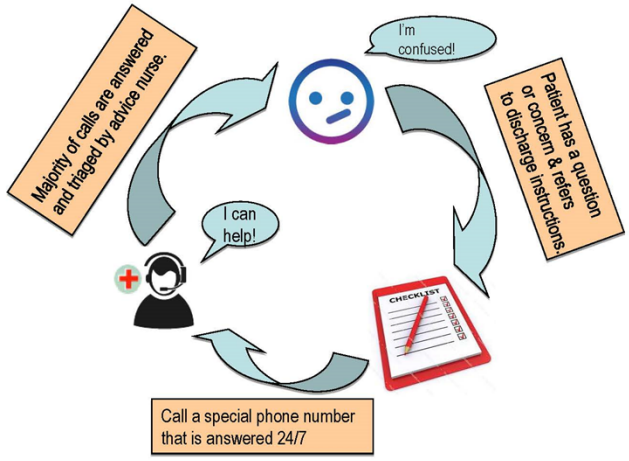
Bundle Element #2: Discharge Hotline

"I know when to call and what phone number to call if I need help"



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Bundle Element #3: Standardized Discharge Summary

Hospitalists, primary care physicians and specialists collaborated to create a simple discharge summary completed the day the patient leaves the hospital.

My regular doctor will know what happened to me in the hospital

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Bundle Element #3: Standardized Discharge Summary

HOSPITALIST DISCHARGE SUMMARY
10/13/2011

Pharmacy Test Knowrx

Date Of Admission: 10/1/2011
Date Of Discharge: 10/13/2011
Disposition: Home

Readmission Risk Assessment: Medium (follow-up 10 days or less)

Pending Study Results At Discharge
1. Blood cultures still in progress; no growth so far
2. HgA1C is still pending

Issues To Be Addressed In Follow-Up
1. Has cellulitis resolved?
2. Are BG's better on adjusted insulin
3. Routine wound care (had I&D of abscess on RLE)

Primary Discharge Diagnoses
*CELLULITIS - WITH ABSCESS SKIN OR SUBQ TISSUE, ACUTE
SYSTOLIC HEART FAILURE, ACUTE ON CHRONIC
DIABETES, UNCONTROLLED
CHRONIC KIDNEY DISEASE, STAGE 4, SEVERELY DECREASED GFR

Other Diagnoses
PANCREATITIS, CHRONIC
OSTEOPOROSIS

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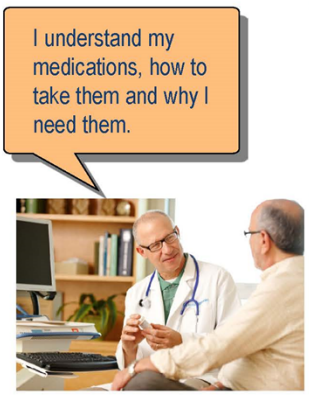
Bundle Element #4: Medications



- Hospital
  - ✓ Medication reconciliation by MD/RN on admission
  - ✓ RN teaching/teach back
  - ✓ Pharmacist reviews (high risk)
  - ✓ Patient-friendly language
- Home
  - ✓ RN follow-up call/review
  - ✓ Pharmacist calls patients at home
  - ✓ (high risk)
- Skilled Nursing Facility
  - ✓ Transition pharmacist reviews medications for 100% of patients admitted to a skilled nursing facility

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Bundle Element #5: Follow Up

- Follow-up Appointments
  - ✓ Made upon discharge
  - ✓ High risk patients in 5 days
  - ✓ Medium risk patients in 10 days
- Follow-up Calls
  - ✓ RN follow up within 72 hours
  - ✓ RN case management over 30 days (high risk)

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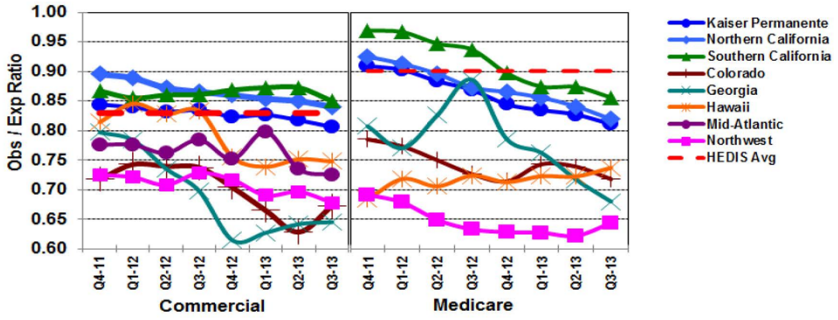
Majority of Regions Trending Down

HEDIS All Cause 30-Day Hospital Readmissions Ratio (Population = Commercial & Medicare)

- For the Commercial population all Regions except Northern and Southern California performed better than the HEDIS average (0.83) for the rolling year ending in Q3 2013.
- For the Medicare population all Regions performed better than the HEDIS average (0.90) for the rolling year ending in Q3 2013.



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Transitions Bundle Spread: Where We Are Today

All Kaiser Permanente regions have adopted the Transition Bundle

Transition Bundle Elements	1	2	3	4	5	6	7
Risk stratification-tailored care	★	★	★	★		★	★
Follow-up call 48 hours	★	★	★	★	★	★	★
Timely physician follow-up appointments scheduled in hospital	★	★	★	★		★	★
Medication reconciliation redundancies across settings	★				★	★	★
Standardized same-day DC summary	★	★	★	★	★	★	★
Special transition phone number on DC instructions (24/7 expedited; immediate access to RN/physician)	★	★	★			P	★

★ Strong Implementation | Implementation Phase | Testing Phase | P Planning Phase | No activity yet

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