Mary Rutan Hospital Readmission Project

Ohio Hospital Association

October 26, 2017

Mary Rutan Hospital
Readmission Project

- ***The Beginning***
- **Ohio STAAR Project 2010:**

  STate Action on Avoidable Rehospitalizations

  - **October 2010 initiative sponsored by OHA, Institute for Healthcare Improvement (IHI), and others encouraged Ohio hospitals to focus efforts on strategies to reduce/avoid 30 day readmissions.**
  - **Mary Rutan Hospital was one of 17 hospitals participating in this project.**
  - **The STAAR project served as the starting point for focus on changes in practice patterns to address this issue**
  - **Team approach was encouraged and utilized at Mary Rutan Hospital to focus on key components**

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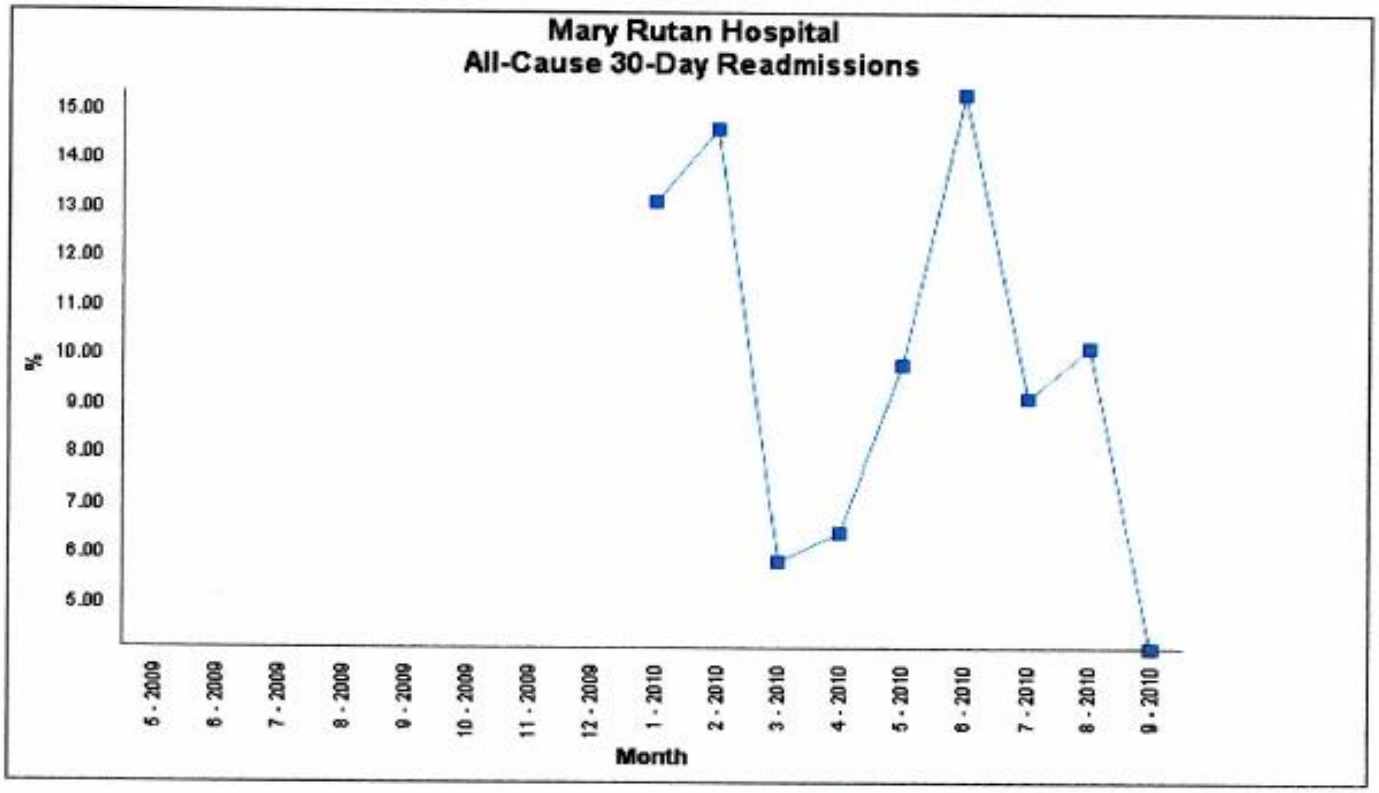
Readmission Project, 2

All-Cause 30-Day Readmissions (Percent of discharges with readmission for any cause within 30 days. Track hospital and pilot unit or pilot population data on separate series.)



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Readmission Project, 3

- ***Potentially avoidable***
  - 76% of Medicare readmissions were "**potentially preventable**" based on 3M definition
  - 14-46% in general hospital populations in retrospective clinician reviews
- ***Actionable for improvement***
  - Individual delivery systems and health services researchers have demonstrated dramatic (30-90%) reduction of 30-day readmission rates for certain patient populations (such as patients with HF)
  - Since **2010**, 565,000 readmissions were avoided due to threat of penalties and individual hospital intervention programs
  - CMS reviews 6 diagnosis for readmission: MI, CHF, Pneumonia, COPD, Hip/Knee Surgery and CABG

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Readmission Project, 4

- ***First Steps:***
  - Development of Universal Screening of Admission/Observation patients for Readmission Risk
    - Utilized screening template developed by Dr. Eric Coleman, IHI Consultant for STAAR Project
    - Modified screening template based on:
      - Mary Rutan Hospital patient population
      - Medical Staff scope of services
      - Historical readmission review
  - Case Managers initial assessment includes Screening for High Risk for Readmission
  - Daily High Risk list from the assessment is “pushed” to various providers and clinical departments through EMR
  - Hospital Department Teams focused on interventions to address this population

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Readmission Project, 5

Readmission Risk Screen

Last Hospital:	
From Date:	
Thru Date:	
Readmission Risk Screen	☐ No Risk Identified ☐ Inpatient Admission Within the Last 30 Days ☐ Readmit in Last 12 Mon. In the past 12 months, 2 stays less than 30 days apart, that occurred more than 30 days from this stay. ☐ More Than 2 ED Visits in the Last 6 Months ☐ Hx Complex DC Planning ☐ Inadequate Social Support ☐ Previous Readmission Risk
Comment:	
Patient is a Risk for Readmission Within 30 Days:	○ Yes ○ No Comment:

- ***Where did we start?***
  - Based on IHI leadership, hospitals were encouraged to focus on rapid, small steps to make improvements
  - Hospital Departments/Teams educated regarding Readmission issues and developed targeted interventions
  - Mary Rutan Hospital started working with community partners to increase awareness and to engage them
  - Integration of many primary care and specialist practices was occurring at the same time, so as the practices joined the hospital corporation, readmissions became a focus
  - Improving our EMR to assure clinical data was shared became the next challenge
  - Scheduling follow-up visits with primary care for high risk patients within *3 to 5 days post discharge* became one of our primary interventions

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Readmission Project, 7

Interventions

MUST MAKE FOLLOW-UP APPOINTMENT DIS... I ✔

Assessments

PATIENT IDENTIFIED AS READMISSION RISK ✔

FOLLOW-UP APPOINTMENT MUST BE WITHIN 3-5 DAYS OF DISCHARGE

Follow-Up Appointment Information

*Follow Up Appointment:	
Location of Appointment:	
Additional Information:	

*PLEASE ENTER THIS INFORMATION ON THE DISCHARGE PLANS SCREEN

Appointment Outlier Information

Reason for Outlier Appointment:	☐ Physician Office Closed/Physician Out of Office during 3-5 Day F-Up ☐ First Available Appointment Offered by Physician Office ☐ Physician Decision Physician is aware that patient is a High Risk for Readmission and does not want follow-up appointment within 3-5 days. ☐ Patient Declines Appt ☐ ECF Placment/Return ☐ Outpatient Follow-Up Testing within 3-5 Days, then to see PCP ☐ Reassessment of Case Reveals Pt. Does NOT Meet Readmit Risk Criteria
Other Reason for Outlier Appointment:	

- ***Sharing Interventions, Barriers and Outcomes***
  - The Readmission Project was placed under the Med/Surg Division to allow for project data to flow to department clinical leaders and Medical Staff
  - Goal of 10% “All Cause” readmissions set initially in 2010, was lowered to 7% in early 2014 based on results
  - Monthly reporting to hospital wide Quality Council engaged Administration, Medical Staff, Board of Directors and Department leaders
  - Engaging our Patient Centered Medical Home projects also allowed for increased focus and interventions beyond the hospital walls
  - Continuing to engage with our community partners to assess interventions and to determine what works and possible alternative options

- ***Team Clinical Interventions***
  - ***Nursing Department:***
    - "Teach Back" technique introduced and integrated into standard practice, particularly focused on discharge instructions
    - Nursing "call backs" to all patients with increased focus on readmission risk patients
  - **Clinical Pharmacy Department:**
    - Medication reconciliation and teaching became focus for Clinical Pharmacy staff, particularly to High Risk population
    - Pharmacy has utilized Pharm D. residents to assist with more in-depth teaching and assistance with Manufacturer Indigent Programs to improve medication compliance and access

- ***Team Clinical Interventions con't***
  - ***Care Coordination Department:***
  - Daily reports to Primary Care offices with list of their patients who were in ED, and another list of any that are in hospital. Information shared includes reason for admission, high risk status, follow up appointments and discharge planning interventions
  - Close work with 3 Patient Centered Medical Home programs in Logan County to coordinate efforts and share resources for high risk patients
  - Enhanced Discharge Planning interventions integrated into Case Managers daily practice,
    - engaging family to focus on options for care
    - encouraging utilization of community services
      - Home Health Care Agencies
      - Skilled Nursing Facilities
      - Assisted Living Providers

- ***Team Clinical Interventions con't***
  - ***Cardiovascular Services:***
  - CHF Clinic has existed for 15 years, but we are now looking at options to expand with focus on high risk for readmission patients
  - **Respiratory Care Department:**
  - "Teach Back" methods incorporated into daily practice
  - COPD Clinic started in 2017 to address this group of high risk patients
  - **Education Department**
  - Diabetic Education program has also been focused on the high risk for readmission patients and is trying to connect them to available community resources

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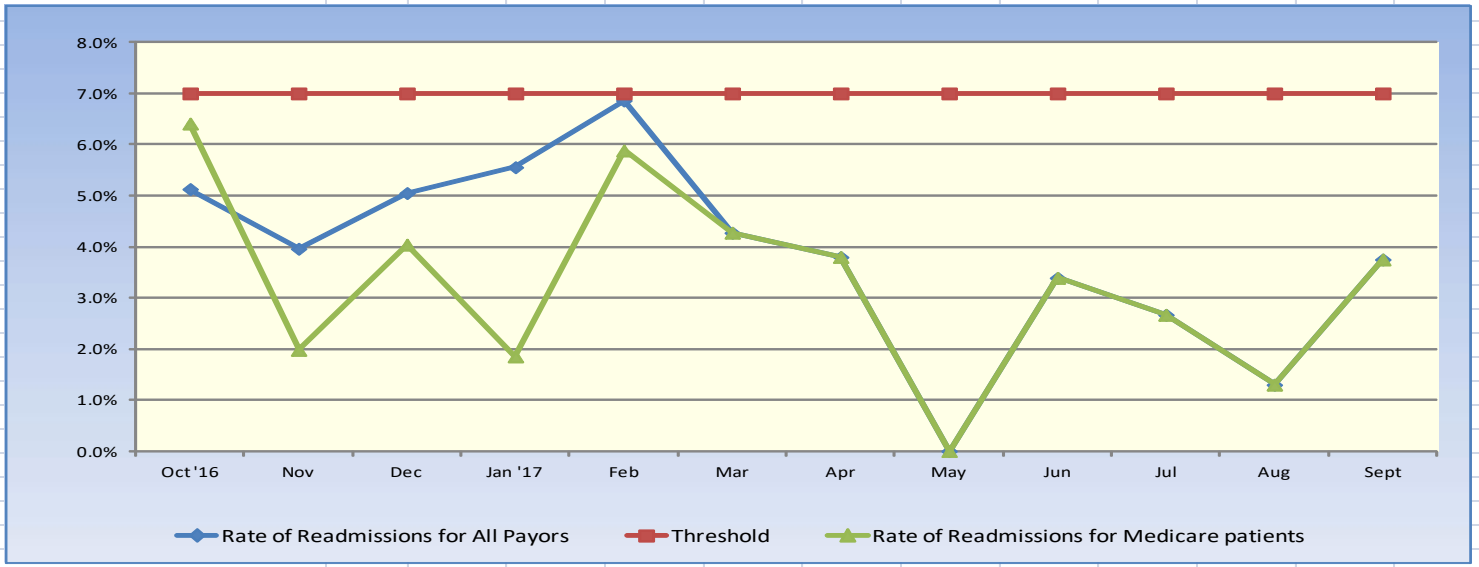
Readmission Project, 12

Inpatient Readmission Report														
	Goal	Oct '16	Nov	Dec	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Total
Number of Discharges		78	101	99	108	102	117	79	72	59	75	77	80	1047
Number of readmissions for "All Cause, All Payors"		4	4	5	6	7	5	3	0	2	2	1	3	42
Rate of Readmissions for All Payors	<7%	5.1%	4.0%	5.1%	5.6%	6.9%	4.3%	3.8%	0.0%	3.4%	2.7%	1.3%	3.8%	4.0%
Medicare patients readmitted for "All Cause"		5	2	4	2	6	5	3	0	2	2	1	3	35
Rate of Readmissions for Medicare patients		6.4%	2.0%	4.0%	1.9%	5.9%	4.3%	3.8%	0.0%	3.4%	2.7%	1.3%	3.8%	3.3%
Threshold	<7%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%



**The national average readmission threshold is 10%.

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Readmission Project, 13

Readmissions for AMI, CHF, PN, Stroke, COPD, Hip Fx

AMI (DRG 280, 281,282)	Threshold	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MC pts readmitted w/these DRG		0	0	0	0	0	0	0	1	0				1
MC pts discharged w/these DRG		0	1	1	0	2	1	0	1	1				7
Readmission rate	**17.8%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%				14.3%
Physician									Payind					

Heart Failure (DRG 291, 292, 293)	Threshold	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MC pts readmitted w/these DRG		2	1	1	1	0	1	2	0	2				10
MC pts discharged w/these DRG		7	6	4	3	3	3	7	9	4				46
Readmission rate	**22.7%**	**28.6%**	16.7%	**25.0%**	**33.3%**	0.0%	**33.3%**	**28.6%**	0.0%	**50.0%**				**21.7%**
Physician		Fulmer	Fulmer	Bang	Rethman		Fulmer	Fulmer		Fulmer				
		Bang						Bang						

Pneumonia (DRG 193, 194, 195)	Threshold	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MC pts readmitted w/these DRG		1	0	0	0	0	0	0	0	0				1
MC pts discharged w/these DRG		5	4	5	2	1	5	0	0	3				25
Readmission rate	**22.7%**	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				4.0%
Physician		Fulmer												

Stroke (DRG 064, 065, 066)	Threshold	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MC pts readmitted w/these DRG		0	0	0	0	0	0	0	0	0				0
MC pts discharged w/these DRG		1	1	1	2	0	1	1	0	1				8
Readmission rate	**13.3%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				0.0%
Physician														

COPD (DRG 190, 191, 192)	Threshold	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MC pts readmitted w/these DRG		0	1	1	0	0	0	0	0	1				3
MC pts discharged w/these DRG		9	7	8	6	2	4	2	6	10				54
Readmission rate	**20.7%**	0.0%	14.3%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%				5.6%
Physician			Bang	Payind						Costin, S				

Total Hip and Knee Replacement (DRG 469, 470)	Threshold	Jan '17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MC pts readmitted w/these DRG		0	0	0	0	0	0	0	0	0				0
MC pts discharged w/these DRG		3	5	5	7	2	4	3	4	4				37
Readmission rate	**5.2%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				0.0%
Physician														

Follow up appointment interventions:

2016	
Total Readmission Risk Patients	20% of total patients
Follow Up Appointments Scheduled	95%
3 – 5 day Follow Up Appointment Scheduled	67%
Attended Follow Up Appointment	60%

1st Quarter 2017	
Total Readmission Risk Patients	25% of total patients
Follow Up Appointments Scheduled	96%
3 – 5 day Follow Up Appointment Scheduled	58%
Attended Follow Up Appointment	63%

- ***Future Issues***
  - For the 2017 fiscal year, **2582** US hospitals face potential reimbursement cuts due to Readmissions
  - More than **half** of US hospitals were penalized in 2015, with a total of $528 million dollars withheld
  - Beginning 2018, CMS will base penalties on hospital outcomes relative to other hospitals with comparable numbers of dual-eligible patients
  - Focus on community partnerships will be important for all hospitals to address the ongoing readmission dilemma
  - Hospitals may need to consider utilizing Case Managers to follow high risk patients for 31 days post discharge to assure maximal efforts aimed at avoiding hospitalization

Questions?

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