Reducing Heart Failure Readmissions: It Takes a Village!

Kim Newlin, RN, CNS, NP-C
Cardiovascular Clinical Nurse Specialist
Heart Failure Program Manager
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Disclosures

• I have no disclosures.
Learning Objectives

• Understand the key role an NP can play in reducing Heart Failure (HF) Readmissions through work in a HF clinic, in the hospital and in the community.
• Identify barriers to a successful transition for patients with HF and other complex co-morbid conditions.
• Identify key partners within the hospital and community setting to help with successful transition planning and reducing readmissions.
• Understand the role of the care transition coordinator.
The Village Members: Cross Continuum Collaborative Team

- Sutter Care Coordination Program
- Telemanagement
- Sutter Care At Home: (HH/ AIM/ Hospice)
- Hospital Case Management
- Hospital Palliative Care Program

- SRMC Care Transitions Program
- Heart Failure Clinic
- Skilled Nursing Case Management
- Community Benefit Programs
Sutter Health - Regions

ใจ Central Valley Region
ใจ East Bay Region
ใจ Peninsula Coastal Region
ใจ Sacramento Sierra Region
ใจ West Bay Region
Sutter Health - Affiliates

- Alta Bates Summit Medical Center
- California Pacific Medical Center
- Eden Medical Center
- Kahi Mohala
- Memorial Hospital Los Banos
- Memorial Medical Center Modesto
- Mills-Peninsula Health Services
- Novato Community Hospital
- Palo Alto Medical Foundation
- Samuel Merritt University
- Sutter Amador Hospital
- Sutter Auburn Faith Hospital
- Sutter Care at Home
- Sutter Coast Hospital
- Sutter Davis Hospital
- Sutter Delta Medical Center
- Sutter East Bay Medical Foundation
- Sutter Gould Medical Foundation
- Sutter Health Plus
- Sutter Lakeside Hospital
- Sutter Medical Center of Santa Rosa
- Sutter Maternity & Surgery Center of Santa Cruz
- Sutter Medical Center Sacramento
- Sutter Medical Foundation
- Sutter Outpatient Services LLC
- Sutter Pacific Medical Foundation
- Sutter Physician Services
- Sutter Roseville Medical Center
- Sutter Solano Medical Center
- Sutter Tracy Community Hospital
Why We Chose to Focus on Readmissions

❤ By 2030, direct costs for hospitalizations related to cardiovascular disease will increase to ~$550 billion

❤ The Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Program

❤ Sutter Health Initiative – Sense of Urgency! Crisis!
Why is CMS Focusing on Readmissions?

♦ 30 Day Readmissions

♦ 19% readmission rate

♦ 2.5 million readmits

♦ $17.5 billion
Why is CMS Focusing on Readmissions?

- Indicator of the (or lack of) care coordination amongst providers and across the continuum of service.
- Stimulates hospitals to reach beyond their walls into the community and build collaborative relationships.
- Stimulates the development of integrated care systems.
- Is a precursor to **bundled payments and shared risk models of reimbursement**.
- Hospitals are a costly, and at times, even dangerous venue for care.
CMS Hospital Readmission Program

❤️ CMS Reduction in Payments
- 1% penalty yr/1 (2012)
- 2% penalty yr/2 (2013)
- 3% penalty yr/3 (2014)

❤️ Target Diagnoses
- 2013: AMI, HF, Pneumonia
- 2014: COPD, THA, TKA
- Future: Afib?!?! Sepsis?!?
Why Focus on Heart Failure (HF)?

- 5 million patients in US have HF
- > 500,000 new cases per year
- Cost exceeds treatment expenditures for all types of cancer combined
- Most common reason for Medicare hospital admission and readmission
- ~ 90% readmissions potentially avoidable
Prevalence of HF by Sex and Age

Hospital Discharges for HF by Sex

Readmission Causes

- Medication Reconciliation/Management Challenges
- Inadequate Transition Planning (e.g. No Home Health, SNF, Hospice)
- Delayed/Absent Follow Up with Primary Care
- Lack of Knowledge of Disease Process
- Lack of Follow up on Tests & Treatments
- Lack of Communication Between Providers and/or Family/Caregivers
Readmission Causes - Influencing Factors

❤ Social Determinants of Health
- Behaviors
- Physical Environment
- Social & Economic
- Clinical Care

Noncompliance ≠ Provider Failure
Heart Failure Society of America: Recommended Components - Discharge

♥ Comprehensive education and counseling individualized to patient needs
♥ Promotion of self care, including self-adjustment of diuretic therapy in appropriate patients (or with family member/caregiver assistance)
♥ Emphasis on behavioral strategies to increase adherence

HFSA Guidelines 2010- Strength of Evidence = A, B, and C
Heart Failure Society of America: Recommended Components - Discharge

❤ Vigilant follow-up after hospital discharge or after periods of instability
❤ Optimization of medical therapy
❤ Increased access to providers
❤ Early attention to signs and symptoms of fluid overload
❤ Assistance with social and financial concerns

HFSA Guidelines 2010- Strength of Evidence = A, B, and C
20% HF readmission rate in 2009 (Sutter)

- Sutter Roseville ~ 19.5% in 2010

December 2007 to May 2008

- Team of Sutter Health doctors and administrators studied nine top-performing health care organizations

- Outstanding results in clinical quality, service quality, disease management and affordability
Developed “High Five” Recommendations

- Patient-focused compact
- Hospitalist programs integrated with ambulatory services
- Disease management for congestive heart failure, diabetes and end-of-life (palliative) care
- Leadership development supporting team accountability
- Patient-centered lean training
Focusing on HF Readmissions Meets Key Goals

- **Quality:** Medicare Hospital Readmission Program
- **Affordability:** Medicare Affordability
- **Patient centered care and a more integrated care system**
- **Data driven performance improvement for chronic disease care**
It’s the right thing to do!

- In 2009 only 47% of HF patients said “information about what to do about recovery at home was “very good”.

- Toolkit based on research
- Affiliates each had designated “lead”
- Patient Centered Care Delivery Map
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

Goal: Top level patient experience; High and reliable quality; Reduced heart failure readmission rate.

**ER**
- ER Patient
  - Schedule f/u appt with PC
  - Heart Failure ER/D/C instructions
  - Consider NH for eligible patients
  - Decision to admit patient
  - Identify PCP/Cardiologist/Care provider
  - HF Order Set (Initiate Pathway)

**Intake Process**

**Admit to 24 hours**
- Patient Identification: HF Core Measures Process and Chart Screen
  - Launch clinical Pathway
  - Start Interdisciplinary D/C Checklist
  - Enhanced assessment for post-discharge needs
  - Flag patient and enter data into registry
  - Assess Risk Of Readmission
  - Give patient pathway and discharge Checklist

**24 hours to day before discharge**
- Medical management according to ACC/AHA guidelines
- Core measures completed: Echo/LVEF documented, ACE/ARB LVEF <40%
- Beta blocker on discharge unless contraindicated
- Consider Device consult if patient meets eligibility criteria for resynchronization
- Arrange 48 hour f/u encounter (home health, AIM, care coordination/transition, MD office)

**Day of discharge to 2-day follow-up**
- Patient receives reconciled medication list
- Patient receives HF discharge instructions and transition record
- Moderate Risk: Phone contact within 2 days & doctor visit within 7 days
- High Risk: In person encounter within 2 days & doctor visit within 7 days
- Discharging MD hand off to next care provider; written discharge summary
- Next care provider receives key hand-off information
- Where available refer or “opt in” to transition or outpatient programs
- Complete Patient/Family/Caregiver HF literacy appropriate education with teach back to include red flags, med mgmt, f/u care

Can be accomplished by multiple entities including hospital, home health, HF program, MD office

World Class Cardiology - Local Zip Code
Assess for Risk within 24 hours of Admit
Appointment Within 7 days of Discharge
Inpatient Clinical Pathway
Patient Education – Teach Back
Medication Reconciliation
Implement Outpatient HF Management
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Sutter Health Blue Ribbon Team II: Assess for Risk Status

❤ Multiple Referral Systems (Push vs. Pull)

- Core Measure Manager Program*
- ER Entry Program Alert
- HF Admission Orders
- Physician Order
- Rounding
- Palliative Care Meeting
- Nurse/Case Manager Request

Sutter Health Blue Ribbon Team II: Assess for Risk Status

❤ HIGH RISK FOR READMISSION

• 2+ hospitalizations within the last year
• Poor health literacy: inability to teach back
• In Person Appointment within 48 hours
  – Home Health/Hospice
  – SNF
  – Medical Appointment
Sutter Health Blue Ribbon Team II: Assess for Risk Status

❤️MODERATE RISK FOR READMISSION

• 1 hospitalization within the last year
• New prescription for a “problem medication”: (anticoagulant, insulin, aspirin and clopidogrel dual therapy, digoxin, narcotics)
• Discharged on 5+ medications
• Absence of caregiver at discharge for home care
• Phone call follow up within 48 hours
Care Transition Coordinator

- Pilot Program started 12/2012
- 7 days/week coverage
- Addressing AMI and HF, readmissions + Core measures
- Two individuals, each .5 FTE (RN + MPH/EP/RCP)
- 6 months to show it worked......
- Approval within 5 months for full implementation
- Increased to two .7 FTE positions (MPH/EP/RCP + LCSW)

Case Managers enter risk into system
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

- Assess for Risk within 24 hours of Admit
- Appointment Within 7 days of Discharge
- Inpatient Clinical Pathway
- Patient Education – Teach Back
- Medication Reconciliation
- Implement Outpatient HF Management
Sutter Health Blue Ribbon Team II: Appointment Within 7 days

❤️ Initiative set for ALL patients within 14 days
❤️ IHI Best Practice
❤️ Attempt to make within 7-10 days for HF
  • PCP, Cardiologist, HF Clinic
❤️ If no PCP, attempt to help find one or set up with community clinic
  • Relationship building with WellSpace clinics
  • Working with Sutter Medical Group for certain patients
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

❤ Assess for Risk within 24 hours of Admit
❤ Appointment Within 7 days of Discharge
❤ Inpatient Clinical Pathway
❤ Patient Education – Teach Back
❤ Medication Reconciliation
❤ Implement Outpatient HF Management
Sutter Health Blue Ribbon Team II
Inpatient Clinical Pathway

- HF Admission Orders
- Pathway
- Patient Education-Material Selection
- Staff Education: RN, MD, RD, CM, RCP
- Palliative Care
- Low Sodium Diet
- Daily Weights
- Core Measures
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

♥ Assess for Risk within 24 hours of Admit
♥ Appointment Within 7 days of Discharge
♥ Inpatient Clinical Pathway
♥ Patient Education – Teach Back
♥ Medication Reconciliation
♥ Implement Outpatient HF Management
Sutter Health Blue Ribbon Team II: Patient Education - Teach Back Process

❤ Standardized Teach Back education slides
❤ Role Play
❤ Multiple disciplines: RN, Nursing Assistant, Dietary, RCP, PT/OT
❤ Incorporate concept into all classes taught
❤ New hire training
❤ Documentation “Teach Back”
Sutter Health Blue Ribbon Team II: Patient Education - Teach Back Process

Dean Schillinger, MD, Associate Professor of Clinical Medicine
University of California, San Francisco + San Francisco General Hospital
Sutter Health Blue Ribbon Team II: Patient Education - Teach Back Process

**Step 1:** Use simple lay language to explain concept/demonstrate

**Step 2:** Ask the patient/caregiver to repeat in own words or demonstrate how understands concept.

**Step 3:** Identify and correct misunderstandings of or incorrect procedures by patient/caregiver

**Step 4:** Ask patient/caregiver to demonstrate understanding or procedural ability again to ensure misunderstandings corrected

**Step 5:** Repeat Steps 4 and 5 until convinced the comprehension of the patient/caregiver is accurate and safe
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

- Assess for Risk within 24 hours of Admit
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“Poor or nonexistent communication about medication information at key 'transition points' — admission, transfer between care settings, and discharge — is responsible for as many as 50% of all medication errors and up to 20% of adverse drug events (ADEs) in hospitals” (IHI, 2006).

♥ TJC National Patient Safety Goal #8
♥ Upon admission and discharge from acute care
♥ Update in EPIC for SMG patients by discharging MD
♥ HF Clinic request bring ALL medication bottles, expired and new, to every appointment
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

❤️Assess for Risk within 24 hours of Admit
❤️Appointment Within 7 days of Discharge
❤️Inpatient Clinical Pathway
❤️Patient Education – Teach Back
❤️Medication Reconciliation
❤️Implement Outpatient HF Management
Medication Management

- Compare home medications with meds on discharge list
- Identify medications that were prescribed but not obtained
- Identify medication discrepancies and develop a plan to resolve discrepancies
- Answer questions about medications
- Alert patient to potential adverse drug reaction(s), interactions
- Encourage use of patient's medication management "system"
- Identify medications needing refills and/or barriers to refill
Outpatient HF Management: Key Elements - 48 Hours Post Discharge

Primary Care /Specialist Follow Up

- Facilitate follow-up appointments
- Discuss transportation
- Discuss questions with patient for PCP/specialist visit
- Clarify whether patient will need to obtain follow-up tests and/or results prior to visit and facilitate as appropriate
- Review outstanding lab results at follow-up visit
Red Flags and Symptom Management

- Assess patient’s knowledge of disease process and self management of condition
- Discuss symptoms to monitor and what to do should they arise
- Discuss when PCP or physician managing care should be called
- Consistent teaching tool: Stoplight
Advance Care Planning

- Discuss patient's personal goal and possible steps for achieving
- Discuss Patients end of life planning and Advance Directive and physician ordered life sustaining treatment (POLST)
- Determine adequacy of support system and need for ongoing case management
- Connect patient to necessary community resources
Sutter Health Blue Ribbon Team II: Outpatient HF Management

♥ Disease Telemanagement Program

• Already in place throughout SHSSR
• Call MOD risk HF patients within 48 hours
• Call HIGH risk HF patients who are on HH at 2 weeks out
• Extend beyond 30 days if SMG patient
• Communication with MD + HF Clinic
• Review Key Elements
Sutter Health Blue Ribbon Team II: Outpatient HF Management

❤ Home Health

- Education
- Case Study Review
- Same Materials
- Access to documentation system
- Escalate to Advanced Illness Management (AIM) program or Hospice
- Open line of communication – email, text, phone
Skilled Nursing Facilities

- Consultation and Education
  - Select 1-2 SNFs in community first
  - Case Study Review
- Protocol development
- HF SNF Order Set developed
- Expanded to Community SNF Forum Quarterly
- Open line of communication – email, text, phone
Sutter Health Blue Ribbon Team II: Outpatient HF Management

❤️ Cardiologists
  • Education/Awareness of HF Clinic
  • Communication between disciplines

❤️ Primary Care Doctors
  • Staff meetings- introduce program and reasons
  • Promote benefits of clinic
  • Discuss key components of transition
**Heart Failure Clinic: 9/11/11**

- Outpatient, hospital based NP run clinic
  - Share space with other NP/nurse clinics
- Primary Focus is Post-Hospitalization
- Medical Director + Nurse Practitioner
  - NP at .2 FTE for position
  - Added second NP 12/2012
- Standardized Procedures + Formulary + Privileges
- Facility Fee
Transitional Care Management Services

❤️ CPT codes 99495 and 99496

❤️ TCM “includes services provided to the patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during the 30 days after discharge and transition from hospital, SNF, observation, or partial hospitalization to the patient’s community setting.”

## Transitional Care Management Services - Required Elements

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99495</td>
<td>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (If 2 attempts made, qualifies)</td>
<td>99496</td>
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<tr>
<td></td>
<td>Medical decision making of at least <strong>moderate complexity</strong> during the service period</td>
<td></td>
<td>Medical decision making of <strong>high complexity</strong> during the service period</td>
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<tr>
<td></td>
<td>Face-to-face visit within <strong>14</strong> calendar days of discharge</td>
<td></td>
<td>Face-to-face visit within <strong>7</strong> calendar days of discharge</td>
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<tr>
<td></td>
<td>$164 (office) / $132 (facility)</td>
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<td>$231 (office) / $198 (facility)</td>
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World Class Cardiology - Local Zip Code
Transitional Care Management Services - Non Face-to-Face - MD/NP/PA

- Obtaining and reviewing the discharge information
- Order or follow up with diagnostic tests and treatments
- Interaction with other health care professionals and specialists
- Education of patient, family, guardian, and/or caregiver
- Establishment or reestablishment of referrals and arrangement of needed community resources
- Assistance in scheduling any required follow-up with community providers and services
Transitional Care Management Services - Non Face-to-Face - Clinical Staff

- Communication (direct contact, telephone, electronic) with patient and/or caregiver within 2 business days of discharge
- Communication with HH agencies and community services
- Patient and/or family/caretaker education to support self-management, independent living, and ADLs
- Assessment /support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care/services needed by patient and/or family
Sutter Health Blue Ribbon Team II: Patient Centered Care Delivery Map

♥ Assess for Risk within 24 hours of Admit
♥ Appointment Within 7 days of Discharge
♥ Inpatient Clinical Pathway
♥ Patient Education – Teach Back
♥ Medication Reconciliation
♥ Implement Outpatient HF Management
♥ Outside the Box..... Beyond BRT II
SRMC Foundation Grants
• October, 2011 and June, 2012
• Funding for Scales, BP cuffs, Pill Boxes
• Provide as transition home or in HF clinic

Volunteer/Navigator Program
• May, 2013
• Focus is Caregiver
• 2 Volunteers, expanding
Outside the Box... Beyond The Sutter Health Blue Ribbon Team II

❤ Heart Health Living Support Group

- Started August, 2013
- Monthly 2 hour meeting
- Changes in January, 2014
  - Name from HF Support Group
  - 6 month series of educational programs offered twice each year
  - 90 minutes long
  - Diploma when complete all classes!
Heart Failure Program – Success!

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
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<tbody>
<tr>
<td>HF Admissions</td>
<td>354</td>
<td>333</td>
<td>292</td>
</tr>
<tr>
<td># Readmissions</td>
<td>62</td>
<td>63</td>
<td>38</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>17.5%</td>
<td>18.9%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>3.69</td>
<td>3.88</td>
<td>3.80</td>
</tr>
<tr>
<td>HF Clinic Visits</td>
<td>43</td>
<td>112</td>
<td>314</td>
</tr>
</tbody>
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Leadership and Messaging

❤️ Rehospitalization is not a data error but a danger to patients and viability of health care.

❤️ “Most of us – payers, purchasers, hospitals, practitioners, other providers – have helped to create this problem by using and abusing fee for-service, building silos around what we do and maintaining ignorance of things we don’t want to know.”

❤️ It is not someone else’s problem: it is ours!

Culture Issues in Hospitals

♥ “We have too many noncompliant patients.”
♥ “We can’t control what care patients get after they leave.”
♥ “Nursing homes and home health agencies just send the patient to the emergency room because they don’t want to do the hard work.”
♥ These are issues of knowledge, imagination, and will.

Success is a step toward reducing the fragmentation of care!
Initiatives are largely collaborative – and less politically charged
If we fall short = not so good
If we succeed we have created a precedent for changing health care that will hold promise for helping to save it.

This is a big, expensive issue!
There are effective interventions
Do it right = improve care while saving $$
Already momentum for change
NPs are in the perfect position to lead this change on multiple fronts!

“When written in Chinese, the word 'crisis' is composed of two characters. One represents danger and the other represents opportunity.”

John F. Kennedy
Special Thanks.........

- Cardiology Care Transition Coordinators: Kristen Wolber, Jennifer Hanson, and Frances Patmon
- Case Management: Martha Koen, Deborah Wafer, Carol Shaneen, Tory Starr + Team
- HF Disease Telemanagement: Jan Van Der Mei, Tom Leonard, + Team
- Home Health: Mark Provan, Lisa Gaza + Team
- Skilled Nursing Facilities: Plum Healthcare
- Cardiology: Roseville Cardiology, Advanced Heart Therapies Clinics (SMCS Staff- Julie Chester-Wood)
- Administration: Dionne Miller, Pat Brady, Barbara Nelson