Sutter Health
Sutter Heart & Vascular Institute

Reducing Heart Failure Readmissions: It Takes a Village!

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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

- Central Valley Region
- East Bay Region
- Peninsula Coastal Region
- **Sacramento Sierra Region**
- 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!

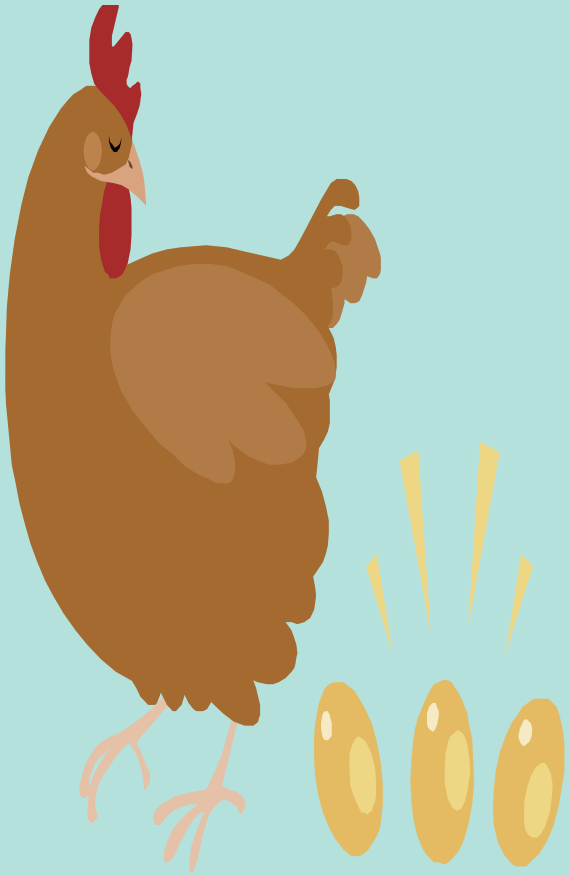
Why is CMS Focusing on Readmissions?

- 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



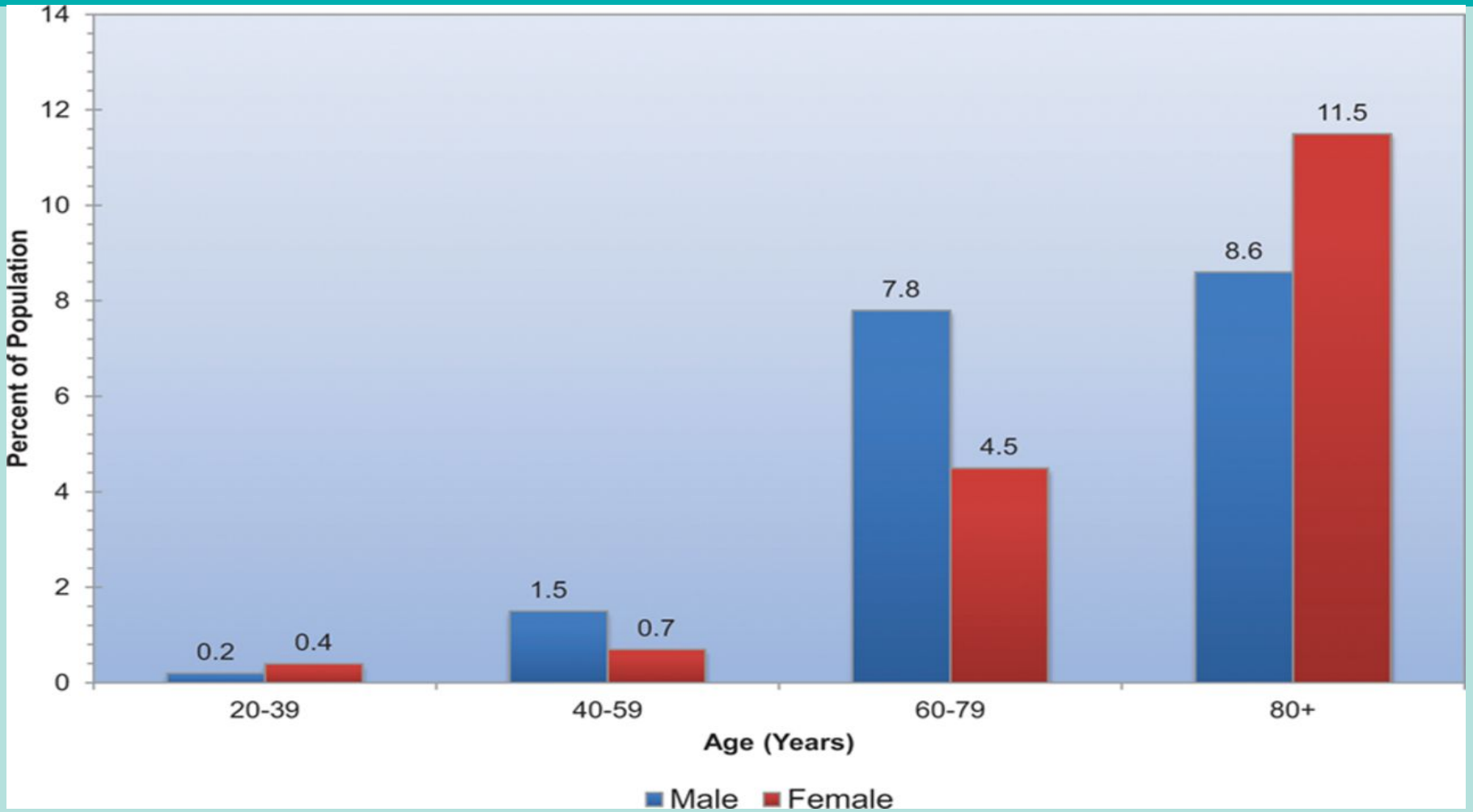
- **CMS Reduction in Payments**
  - 1% penalty yr/1 (2012)
  - 2% penalty yr/2 (2013)
  - 3% penalty yr/3 (2014)

- **Target Diagnoses**
  - 2013: AMI, HF, Pneumonia
  - 2014: COPD, THA ,TKA
  - Future: Afib?!?! Sepsis?!?

Why Focus on Heart Failure (HF)?

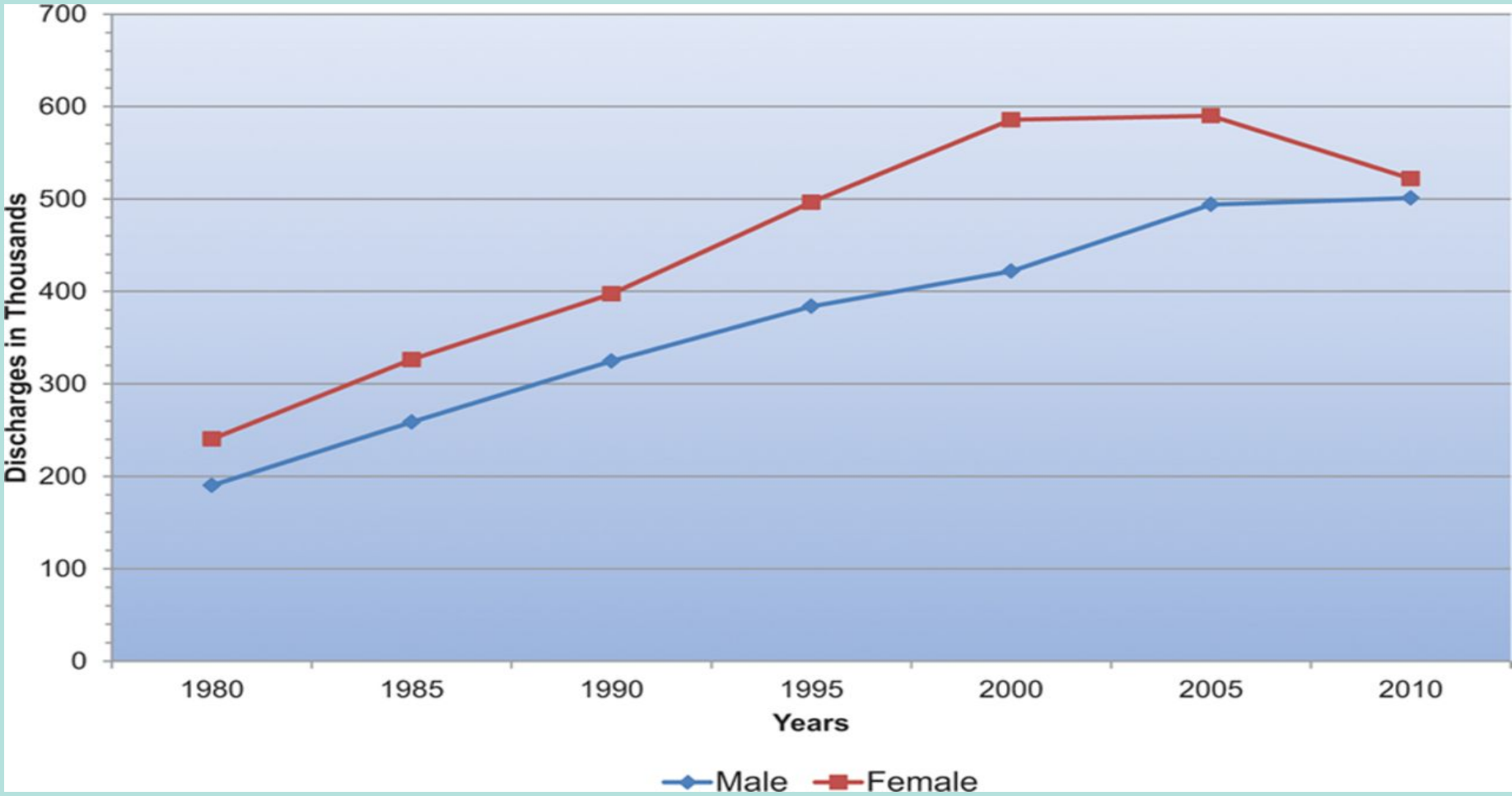
- 5 million patients in US have HF
- > 500,000 new cases per year
- Cost exceeds treatment expenditures for all types of cancer combined
- Most common reason for Medicare hospital admission and readmission
- ~ 90% readmissions potentially avoidable

Prevalence of HF by Sex and Age



Go A S et al. *Circulation*. 2014;129:e28-e292

Hospital Discharges for HF by Sex



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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

Sutter Health Blue Ribbon Team II

- 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

Sutter Health Blue Ribbon Team II

- 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

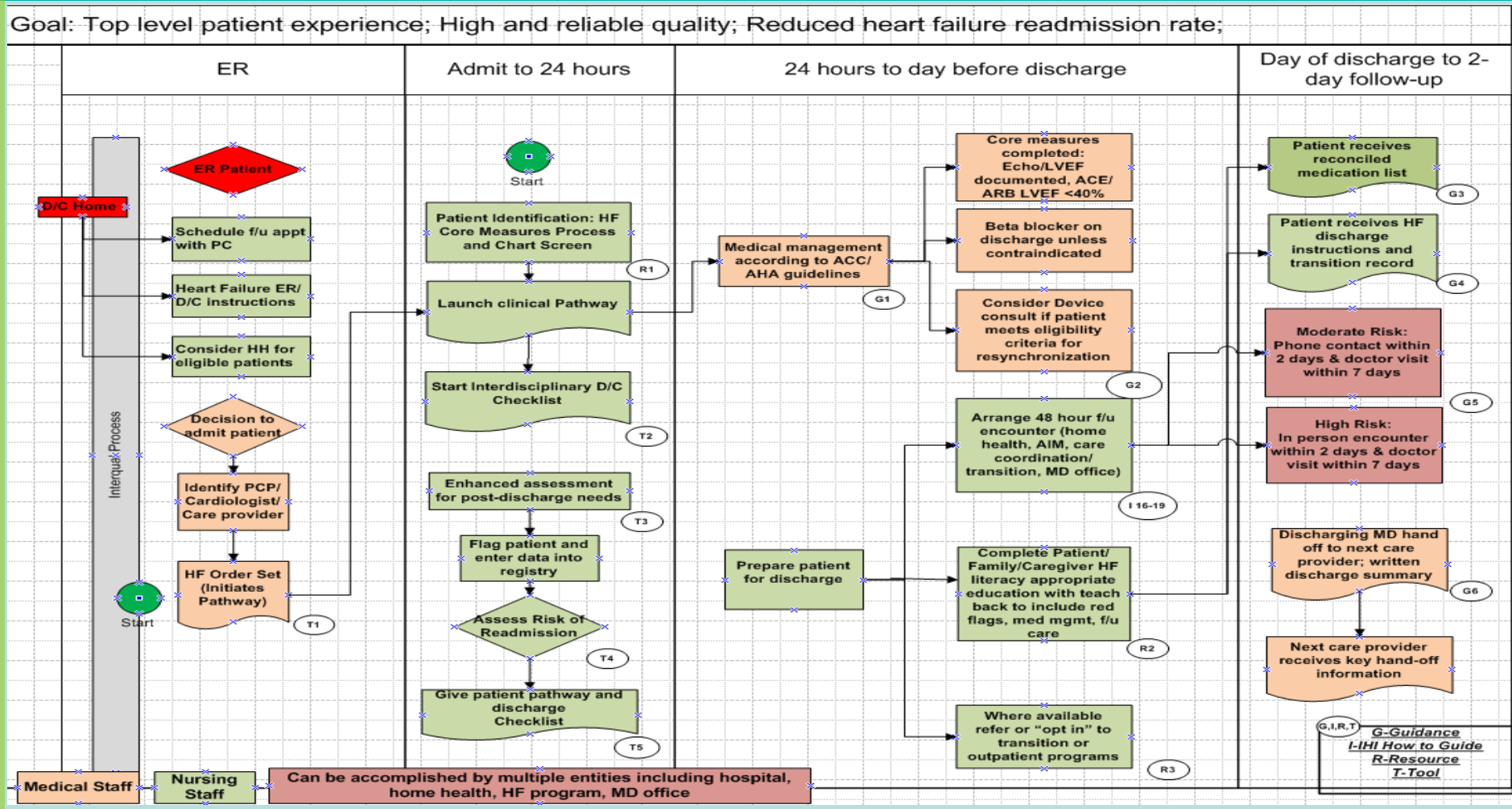
Sutter Health Blue Ribbon Team II

- **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**

Sutter Health Blue Ribbon Team II

- **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



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 Centered Care Delivery Map

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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

* Niemi, Am J Health-Syst Pharm. 2009; 66:389-97

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**

Sutter Health Blue Ribbon Team II: Assess for Risk Status – Who Does This?

- **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

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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

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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

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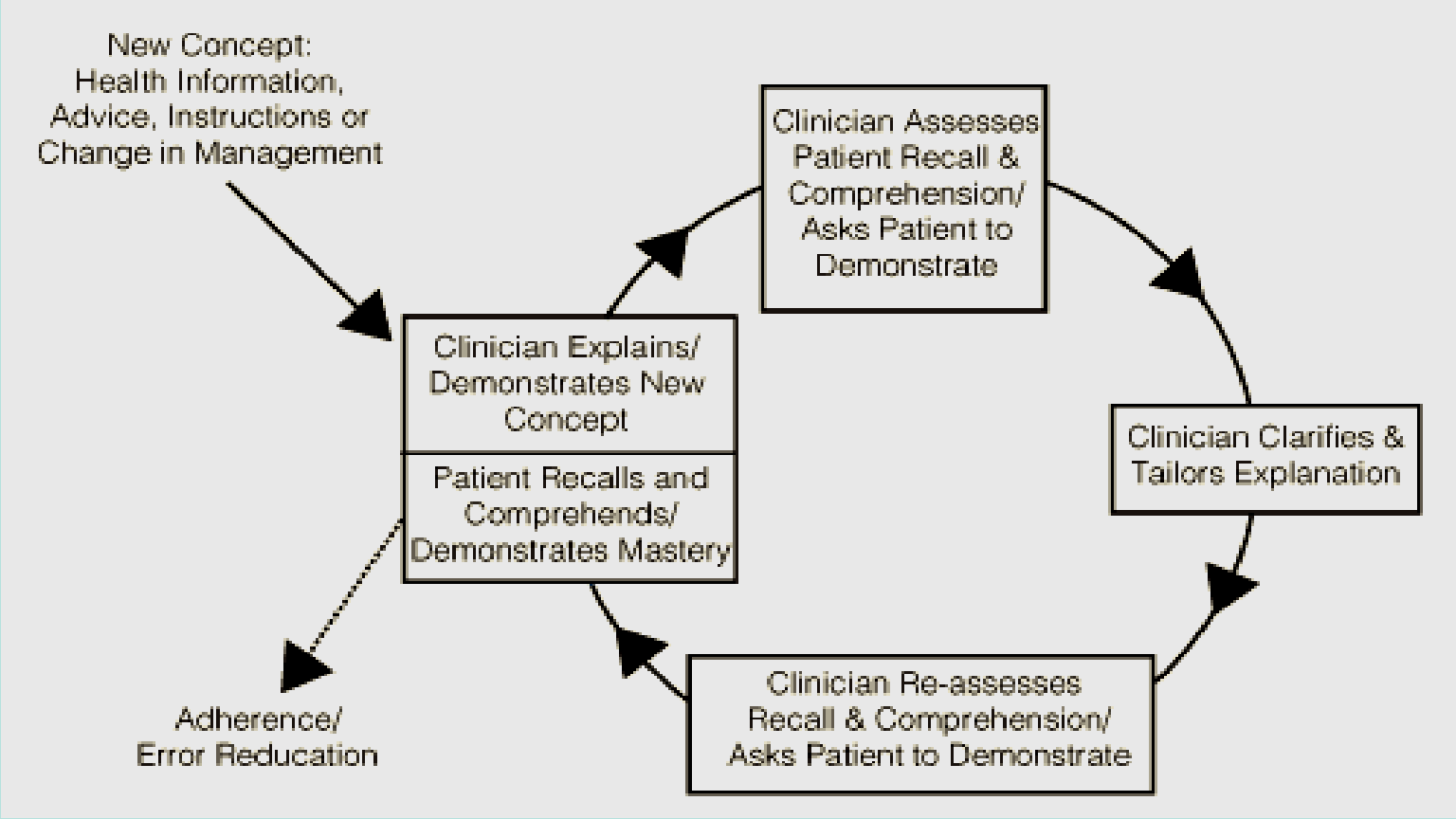
Sutter Health Blue Ribbon Team II: Patient Education - Teach Back Process

- 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



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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

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- **Medication Reconciliation**
- Implement Outpatient HF Management

Sutter Health Blue Ribbon Team II: Medication Reconciliation

"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

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- **Implement Outpatient HF Management**

Outpatient HF Management: Key Elements - 48 Hours Post Discharge

♥ 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

Outpatient HF Management: Key Elements - 48 Hours Post Discharge

- **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

Outpatient HF Management: Key Elements - 48 Hours Post Discharge

- **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

Sutter Health Blue Ribbon Team II: Outpatient HF Management

♥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

Sutter Health Blue Ribbon Team II: Outpatient HF Management - Clinic

- **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."
- http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCMFAQ.pdf

Transitional Care Management Services- Required Elements

99495	99496
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (If 2 attempts made, qualifies)	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge (If 2 attempts made, qualifies)
Medical decision making of at least **moderate complexity** during the service period	Medical decision making of **high complexity** during the service period
Face-to-face visit within **14** calendar days of discharge	Face-to-face visit within **7** calendar days of discharge
$164 (office) / $132 (facility)	$231 (office) / $198 (facility)

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
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- **Outside the Box….. Beyond BRT II**

Outside the Box… Beyond The Sutter Health Blue Ribbon Team 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!

Measure	2011	2012	2013
HF Admissions	354	333	292
# Readmissions	62	63	38
Readmission Rate	17.5%	18.9%	13.0%
Length of Stay	3.69	3.88	3.80
HF Clinic Visits	43	112	314

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!**

http://www.iha.org/pdfs_documents/resource_library/Stephen%20Jencks.pdf

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.**

http://www.iha.org/pdfs_documents/resource_library/Stephen%20Jencks.pdf

Rehospitalization- A Perfect Crisis

- 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.

http://www.iha.org/pdfs_documents/resource_library/Stephen%20Jencks.pdf

Rehospitalization- A Perfect Crisis

- 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!**

http://www.iha.org/pdfs_documents/resource_library/Stephen%20Jencks.pdf

Crisis = Opportunity

"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