Reducing ADEs and Readmissions

October 16, 2015
Agenda

► Welcome and Introductions
► Today’s Objectives
► Indiana Statewide Harm Focus Areas
► Eliminating ADEs
► Enhancing Care Transitions and Reducing Readmissions
► Next Steps
Today’s Objectives

• List suggested Indiana measure definitions for ADEs related to warfarin, insulin and naloxone

• Describe three recommendations to address key factors contributing to ADEs related to warfarin, insulin and opioids

• Identify three strategies for enhancing care transitions and preventing readmissions for patients being discharged home or to another care facility

• Evaluate adherence to recommended, evidence-based “best practices” in your organization
Indiana’s Bold Aim

To make Indiana the safest place to receive health care in the United States... if not the world

Inaugural Indiana Patient Safety Summit – March 2010
National Quality Strategy
Aims and Priorities

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person & family are engaged as partners in their care
3. Promoting effective communication & care coordination
4. Prevention & treatment of leading causes of mortality
5. Working with communities to promote wide use of best practices to enable healthy living
6. Making quality care more affordable for individuals, families, employers, & governments by developing & spreading new health care delivery models
**Indiana Regional Patient Safety Coalitions**

Members agree not to compete on patient safety

**Collaborative model** of regional coalitions and affinity groups supports transformation, learning and spread

**Benefits:**
- Innovate at the front lines
- Align with state and national efforts, and standardize when beneficial
- Build local and hospital-specific capacity for improvement and innovation
- Encourage safety leadership at all levels across multiple professions
Indiana Patient Safety Center

2015 Statewide Focus Areas

• Adverse Drug Events
• Care Transitions and Readmissions
• Catheter-Associated Urinary Tract Infections
• Prevention of Injurious Falls
• Sepsis
Why These Five Topics?

- **National Focus**
  - National call to eliminate healthcare-related harm; *Partnership for Patients* focus areas

- **Pay for Performance**
  - Various healthcare-acquired conditions place hospitals at risk for financial loss

- **Financial Penalties**
  - Data support the need to reduce preventable readmissions in Indiana

- **Data**
Background

IPSC’s Approach to Impact Areas of Focus

- Collaborate with a statewide faculty from various disciplines
  - Review national and statewide trends
  - Develop consensus around best practices
  - Identify methods for practical application across the continuum

- Harvest innovative ideas

- Recommend practices to reduce harm throughout Indiana
What Can a Focus on ADEs Impact?

- Complications
- Absenteeism
- Cost of Care
- Patient & Family Engagement
- Quality of Life
- Readmissions
- Length of Life
ADEs

ADEs related to warfarin, insulin and opioids account for significant patient harm and preventable readmissions

Consider: 13,227 Adverse Drug Events in just three drug categories in a 12 month period in 80 Indiana hospitals

• Tip of the iceberg
• Measurement inconsistencies
• Effective interventions needed
## Indiana Harm Snapshot
*(from HRET HEN 1.0 data)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Indiana Harms (9/2013 – 8/2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADE</strong></td>
<td></td>
</tr>
<tr>
<td>Warfarin</td>
<td>1640</td>
</tr>
<tr>
<td>Insulin (Hypoglycemia)</td>
<td>7455</td>
</tr>
<tr>
<td>Opioids</td>
<td>4132</td>
</tr>
<tr>
<td><strong>CAUTI Rate - All Tracked Units</strong></td>
<td>448</td>
</tr>
<tr>
<td><strong>Falls with Injury</strong></td>
<td>1381</td>
</tr>
<tr>
<td><strong>Readmissions (All Cause)</strong></td>
<td>43,707</td>
</tr>
<tr>
<td>Sepsis Mortality</td>
<td>1076</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>59,839</td>
</tr>
</tbody>
</table>

- 13,227 ADEs across three drug categories
- 43,707 Readmissions
“Top Ten” Checklist* - ADEs

Specific Recommendations

Anticoagulants
✓ Implement pharmacist-driven warfarin management

Insulin
✓ Reduce sliding scale variation for insulin (or eliminate sliding scales)
✓ Coordinate insulin and meal times

Opioids
✓ Use alerts to avoid multiple prescriptions of opioids and sedatives
✓ Use effective tools to reduce over-sedation from opioids (assess risk/sedation)

*Source: HRET Change Package 2014 Update
“Top Ten” Checklist* - ADEs

General Recommendations

✓ Standardize concentrations and minimize dosing options, where feasible
✓ Minimize or eliminate pharmacist or nurse distraction during medication fulfillment or administration process
✓ Identify “look alike, sound alike” medications & create mechanism to reduce errors
✓ Use data/information from alerts and overrides to redesign standardized processes
✓ Set dosing limits for insulin and opioids

¿ Question: DO YOU HAVE SPECIFIC PRESCRIBING GUIDELINES FOR OPIOIDS?

*Source: HRET Change Package 2014 Update
## Proposed Measure Definitions For Indiana

<table>
<thead>
<tr>
<th>Target Drug Categories</th>
<th>Measure Definitions</th>
<th>Inclusions</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants (Warfarin)</td>
<td>Excessive anticoagulation INR &gt;6</td>
<td>Inpatients who have received a dose of warfarin after admission</td>
<td>ED patients (however, may want to track to determine need for/efficacy of an anticoagulation clinic)</td>
</tr>
<tr>
<td>Hypoglycemics (Insulin)</td>
<td>Hypoglycemia Blood glucose ≤50mg/dl</td>
<td>Inpatients who have received a dose of insulin after admission</td>
<td>ED patients</td>
</tr>
<tr>
<td>Opioids (Narcan use as proxy for oversedation)</td>
<td>Excessive sedation in patients receiving an opioid that results in naloxone administration</td>
<td>Inpatients and outpatients who have received an opioid and naloxone as reversal agent</td>
<td>ED patients and patients receiving IV naloxone for pruritis or nausea</td>
</tr>
</tbody>
</table>
ADE Faculty Recommendations

Warfarin
- Expand pharmacist role to include dosing (active or passive) and bedside interview for accurate history
- Provide anticoagulation clinic for patients on warfarin

Insulin
- Consider eliminating bedtime dosing and use of sliding scales
- Avoid ‘continue home regimen’ orders (inpatients are not “the same”)

Opioids
- Avoid routine (non-emergent) reversals
- Perform routine assessment (Passero, RASS) and monitoring (capnography, oximetry)

Overarching Recommendations
- Definitions were clarified for consistent use in Indiana
- Perform accurate Medication Reconciliation on admission, at discharge, and “x” days post discharge
- Ensure patients have a PCP for follow up, and collaborate routinely and actively with post-acute providers
- Patient-centered care model: Involve “two other people” who can support the patient’s compliance with the Discharge Plan – and include pharmacist as one of them
Readmissions

Readmissions place a significant burden on patients and their families and on the healthcare system

Consider: 43,707 Readmissions in a 12 month period among 90 Indiana hospitals

• All cause, adults
**Indiana 30-day All-Cause Readmissions**

At current rate, it would take 3.5 more years to reach 20% reduction goal.

Source: IHA’s Inpatient Discharge Study (IDS)
Hospital Readmissions Reduction Program (HRRP)

Mandated by the Affordable Care Act

Imposes financial penalties for hospitals with higher than expected readmission rates

Includes all acute care PPS hospitals

Excludes Critical Access Hospitals and specialty hospitals such as psychiatric, rehabilitation, long-term care and veterans, MD and PR

Hospitals must have 25 discharges within a disease category over the 3 year reporting period for public reporting via Hospital Compare
The HRRP Experience in Indiana Hospitals Over Time

Readmission Penalty

<table>
<thead>
<tr>
<th>Year</th>
<th>No Loss</th>
<th>Loss</th>
<th>Total Included</th>
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<tr>
<td>FY 2013</td>
<td>48</td>
<td>42</td>
<td>90</td>
</tr>
<tr>
<td>FY 2014</td>
<td>47</td>
<td>42</td>
<td>89</td>
</tr>
<tr>
<td>FY 2015</td>
<td>23</td>
<td>68</td>
<td>91</td>
</tr>
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</table>
What drove the losses?

<table>
<thead>
<tr>
<th>Cond.</th>
<th># Hospitals</th>
<th># Penalized</th>
<th>% Penalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNEU</td>
<td>80</td>
<td>25</td>
<td>31%</td>
</tr>
<tr>
<td>HF</td>
<td>81</td>
<td>31</td>
<td>38%</td>
</tr>
<tr>
<td>MI</td>
<td>57</td>
<td>26</td>
<td>46%</td>
</tr>
<tr>
<td>COPD</td>
<td>80</td>
<td>32</td>
<td>40%</td>
</tr>
<tr>
<td>Hip&amp;Knee</td>
<td>70</td>
<td>31</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excess%</th>
<th>PNEU</th>
<th>HF</th>
<th>MI</th>
<th>COPD</th>
<th>Hip&amp;Knee</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;20%</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>10 -19.9%</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>5 - 9.9%</td>
<td>6</td>
<td>12</td>
<td>10</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>1 - 4.9%</td>
<td>11</td>
<td>12</td>
<td>8</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>&lt;1%</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: CABG will be added in FY 2017)
HRRP - Readmission Policy Issues

- Measures do not exclude readmissions unrelated to the reason for initial admission
- No exclusions for patients with conditions requiring frequent inpatient hospitalizations (e.g.—burns, psychosis, ESRD, substance abuse)
- Poor measure reliability (i.e.—inadequate minimum case threshold to produce accurate measure results)
- No adjustments for socioeconomic factors beyond hospital control
“Top Ten” Checklist*

- Assess discharge needs at admission and begin discharge planning
- Conduct Med Rec at admission, change in condition/level of care and discharge
- Provide culturally sensitive patient education
- Identify caregiver, if not patient, and include in education and discharge planning
- Use teach-back to validate both patient’s and caregiver’s understanding
- Assess risk of readmission & align interventions accordingly
- Schedule follow up appointments before discharge
- Communicate with post discharge care providers
- Send discharge summary and after-hospital care plan to PCP in 24-48 hours
- Conduct post discharge call in <48 hours

*Source: HRET Change Package 2014 Update
Common Challenges

▶ Adherence to evidence-based best practices and policies

▶ Assessment/reassessment of risk factors and timely action on findings

▶ Communication across multidisciplinary teams within and between care settings

▶ Patient/family factors affecting compliance
Driving Down Readmissions

Indiana Patient Safety Summit 2015
Steven C. Tremain, MD, FACHE
Physician Advisor for Cynosure Health

Conclusions:

• There is no silver bullet
• All patients are not at equal risk (Cumulative complexity model)
• Requires a portfolio approach
• Almost everything helps a little

• Consider the 5:2:1 approach
  • Do 5 things well for EVERY patient, EVERY time
  • Involve at least 2 people besides the patient as “owners” of the discharge plan
  • Increase the patient's capacity for self care
Recommended Strategies

- Identify patients at high risk for readmission
- Educate patient/caregiver, including self management skills
- Facilitate effective Care Transitions across the continuum
- Provide access to resources for follow up and referral to community resources
CT & R Faculty Recommendations

• Engage and educate patients and their caregivers
• Consider the continuum of care, including end of life wishes
• Provide for accurate medication management
• Know your data and your patients

Question: HAVE YOU CONSIDERED DISPARITIES WHEN EVALUATING READMISSIONS?
## From Strategy to Action

<table>
<thead>
<tr>
<th>Key Strategies</th>
<th>Considerations</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know your data ...and your patients</td>
<td>Super-utilizers (Medicare patients admitted &gt;3x/year)</td>
<td>Prioritize opportunities for improvement</td>
</tr>
<tr>
<td></td>
<td>Disease populations</td>
<td>Implement a plan (&quot;do 5 things well, every patient, every time&quot;)</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>Monitor progress</td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SES, REAL - Disparities</td>
<td></td>
</tr>
<tr>
<td>Engage and educate patients and their</td>
<td>Complexity of disease and of discharge plan</td>
<td>Assess for risk of readmission on admission</td>
</tr>
<tr>
<td>caregivers</td>
<td>Teachable moments</td>
<td>Educate with teach back (for both patients and caregivers)</td>
</tr>
<tr>
<td>Recommendation of having 2 people</td>
<td>Caregiver Act (effective Jan. 1, 2016)</td>
<td>Implement policy to comply with Caregiver Act (HB 1265)</td>
</tr>
<tr>
<td>other than the patient to share</td>
<td>SES</td>
<td>Consider sharing educational resources with LTCs, etc., to enhance</td>
</tr>
<tr>
<td>accountability for carrying out</td>
<td></td>
<td>their skill &amp; comfort level</td>
</tr>
<tr>
<td>discharge plan!</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide accurate medication management</td>
<td>Assess compliance for prompt intervention</td>
<td>Perform accurate rec along the continuum (in the ED, at admission and</td>
</tr>
<tr>
<td></td>
<td>Partner with EMS, home care or other resource to monitor</td>
<td>at discharge and post discharge)</td>
</tr>
<tr>
<td></td>
<td>SES</td>
<td>Consider use of med techs in ED and EMTs in the home</td>
</tr>
<tr>
<td>Consider the continuum of care...</td>
<td>Physician engagement</td>
<td>Schedule MD appointments before discharge</td>
</tr>
<tr>
<td>including end of life wishes and care</td>
<td>Home visits (home health care, other resources)</td>
<td>Establish relationships with post-acute care providers</td>
</tr>
<tr>
<td></td>
<td>Negotiate minimum expectations (e.g. CHF)</td>
<td>Ensure secure hand-offs</td>
</tr>
<tr>
<td></td>
<td>POST and Advance Directives</td>
<td>Know your community resources/networks</td>
</tr>
</tbody>
</table>
National Quality Strategy
Aims and Priorities

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person & family are engaged as partners in their care
3. Promoting effective communication & care coordination
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5. Working with communities to promote wide use of best practices to enable healthy living
6. Making quality care more affordable for individuals, families, employers, & governments by developing & spreading new health care delivery models
Food for Thought…Next Steps

- Participate in HEN 2.0
- Make the 123forEquity Pledge
- Consider joining Huddle for Care at www.huddleforcare.org
- Utilize EHRs to the fullest to enhance care transitions
- Watch the IPSC News for upcoming events
- Collaborate to spread improvement!
Together, we can achieve Better Health and Outcomes For ALL Hoosiers!
Thank you!
from your IPSC Team

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