Readmission Reduction Project

JOHNSON MEMORIAL

A Hospital You Can Believe In

August 14, 2013

Johnson Memorial Hospital

- Johnson County Memorial Hospital opened in 1947 as a tribute to the men and women of Johnson County who have served in the military.
- Number of Beds: 125

Our Readmission Journey… Started with the Heart

- Formal focus on reduction of readmissions started in 2010.
- Lean Six Sigma Green Belt Team focused on Heart Failure patients.
  - Post-discharge call backs (continues to evolve and be refined)
  - Transitions of Care Coalition (TOCC)
  - Identification of patients at the time of admission (alert sent to case management, nutrition and pharmacy)
  - Follow-up appointments (continues to evolve and be refined)

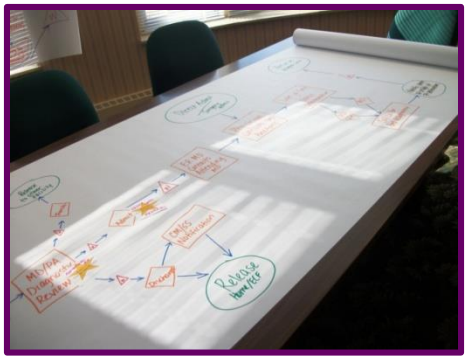
Our Readmission Journey… Started with the Heart

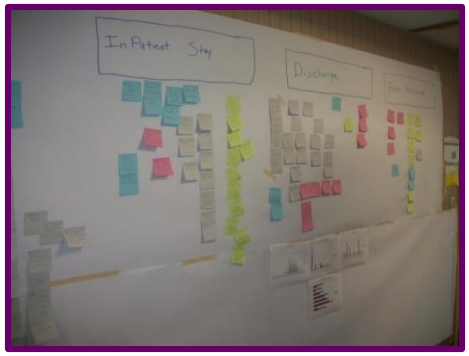
- Lean Six Sigma Green Belt Team focused on Heart Failure patients.
  - HF Magnet (zones)
  - HF patient education booklets
  - 2010-13.6% of readmissions were HF
  - 2012 -7.4% of readmissions are HF

2012-2013 Lean Six Sigma Readmissions Team

Goal

Decrease all-cause, all-payer 30-day Inpatient to Inpatient readmission rates by 20% by December 2013 over 2011 rates. (Decrease of 20% = Rate 5.2%)

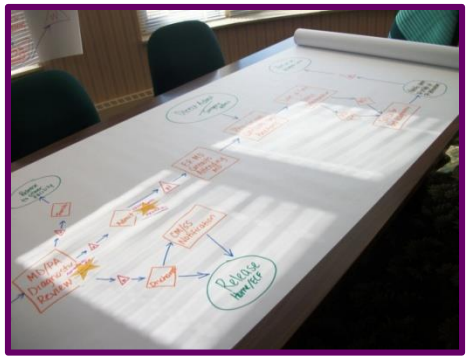


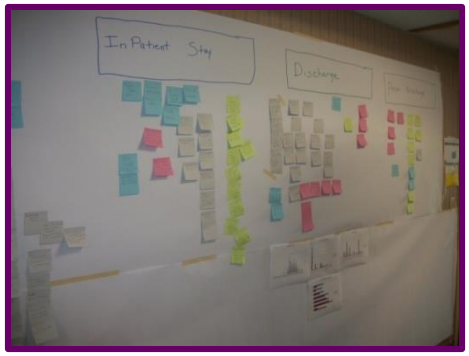


2012-2013 Lean Six Sigma Readmissions Team

Criteria

- Inpatient to Inpatient, all-cause, all-payer, all disposition
- Readmissions occurring less than 30 days from index discharge to readmission.
- Principle diagnosis used for index and readmission diagnosis.

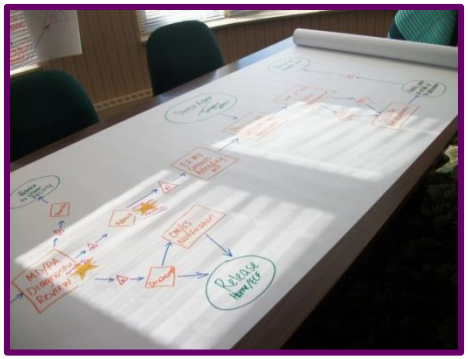


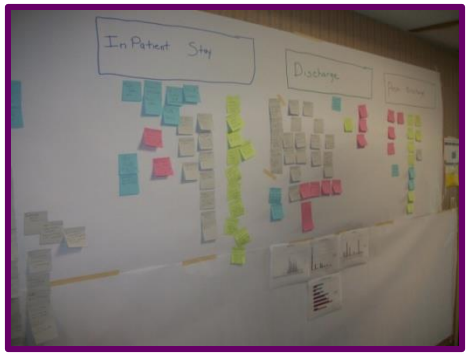


2012-2013 Lean Six Sigma Readmissions Team

Excluded

- Patients readmitted for elective surgeries
- Labor patients

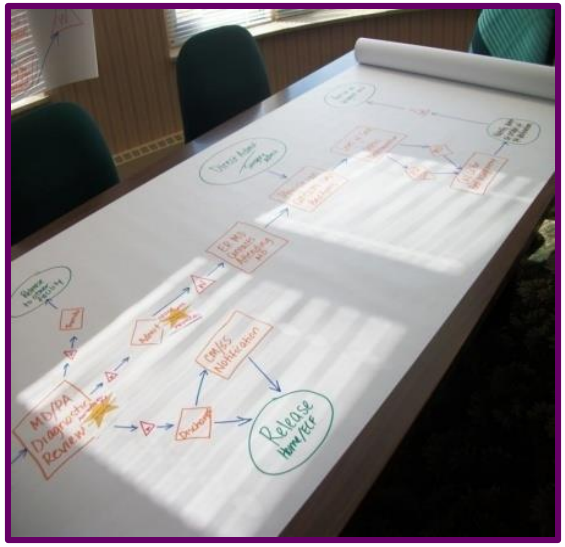




Tools Used To Gather Data

- Voice of the Customer (VOC) / S.W.O.T. analysis
- Bar and pie graphs
- Flowcharts
- Fish bone diagram
- SIPOC – Broke into 4 categories: Admission, Inpatient stay, Discharge, and Post-discharge.

Data Collection



Data Collection determined…

Time and day of week

12:30 pm to 10:00 pm were the peak times when patients were readmitted. However, those times correlate with peak admission times for the hospital in general so no significant effect/impact was determined. Tuesdays were the days with the highest readmissions.

Data Collection determined…

By physician

- Physicians who had the highest readmission rates were identified.
- They were also the highest admitters to the hospital.

Data Collection determined…

Disposition

- 46% of patients were discharged home without additional resources on index discharge (Home health, etc.)
- 50% of the readmission discharges received a higher level of care (Home health, etc.)

Data Collection determined…

Diagnosis:

- Top readmission diagnoses determined.

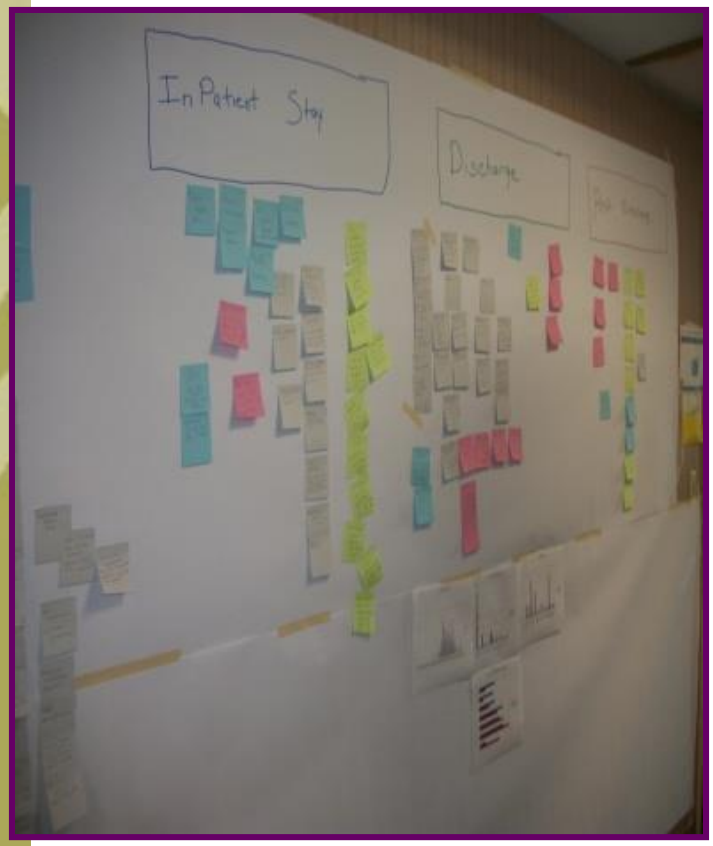
2012 Readmission Data

Diagnoses	# of cases	Percent
Sepsis/Septicemia	19	15.7%
CHF	9	7.4%
ARF	8	6.6%
COPD	8	6.6%
Resp infect/failure	7	5.8%
Pneumonia	7	5.7%
Bowel obstruction	5	4.1%
Hip/Femur Fx	5	4.1%
Cellulitis	4	3.3%
Diverticulitis	4	3.3%
Post-op infections	3	2.5%
Cancer related	3	2.5%

Run Chart


(Preventable Readmissions) Readmission within 30 days (All Cause)
Rate
12
10
8
6
4
2
0
01/01/11-12/31/11 Baseline
Feb 2012
Apr 2012
Jun 2012
Aug 2012
Oct 2012
Dec 2012
Feb 2013
Apr 2013
Jun 2013
Johnson Memorial Hospital
All State Organizations
All Project Organizations

As a Result of the LSS Readmissions Team



As a Result of the LSS Readmissions Team

- LACE Tool and call back modifications.
- Quarterly Physician Report on all readmissions meeting criteria.
- Sepsis added to the call back/LACE Tool.
- Sepsis Committee was formed and will meet monthly for six months then switch to quarterly.
- Medication reconciliation Six Sigma Team.

Quarterly Physician Report

Quarterly Physician Report Less Than 30 Day Readmissions									
MR#	Index Admission Attending	Index Admission Attending #	Index Admission Principle DX	Initial D/C Dispo	Days between	Principle DX 2nd visit (Readmit)	Readmit Attending	Readmit Attending #	Readmit D/C Dispo
Q3 2013									
Q4 2013									

Barriers

- Inconsistent Hospitalists
- Variation in Practice
- Patient/Family Non-Compliance
- Patient/Family Lack of Resources

Case Management Interventions

- Case Managers change from Utilization Review to Case Management
- Screening of Patients within 48 hours of admission
- Modified Lace Tool
- Change in Call Back Process
- Partnerships with Providers
- Palliative Care Team

Case Management Interventions
RN Case Manager Changes

- Case Managers prior priority was for Utilization Review versus true Case Management
- Secretarial Support
  - 40 hours per pay period
- LCSW
  - 40 hours per pay period

Case Management Interventions
Patient Screening

- Screening of patients within 48 hours of admission
  - Identify baseline
  - Identify needs early
  - Link patient with financial resources
    - Claim-Aid
    - Disability (Allsup)

Case Management Interventions Modified Lace Tool

- HRET recommended using a tool to identify high risk patients for readmission.
  - Modified Lace Tool
  - www.raadplan.com

Case Management Interventions LACE

- Length of Stay
- Acuity of Admission
- Comorbidities
- Emergency Room Visits in Past 6 Months

Case Management Interventions
LACE TOOL

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0		
	1 day	1		
	2 days	2		
	3 days	3		
	4-6 days	4		
	7-13 days	5		
	14 or more days	6		
Acute admission	Inpatient	3		
	Observation	0		
Comorbidity: (Comorbidity points are cumulative to maximum of 6 points)	No prior history	0		
	DM no complications, Cerebrovascular disease, Hx of MI, PVD, PUD,	1		
	Mild liver disease, DM with end organ damage, CHF, COPD, Cancer, Leukemia, lymphoma, any tumor, cancer, moderate to severe renal dz	2		
	Dementia or connective tissue disease	3		
	Moderate or severe liver disease or HIV infection	4		
	Metastatic cancer	6		
Emergency Room visits during previous 6 months	0 visits	0		
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
	Take the sum of the points and enter the total ➔			

Case Management Interventions Lace Score

- Study recommended using LACE score of 11
- Reviewed readmissions for our population and found that a LACE score of 10 would be more effective for our area
- Plan to monitor and reassess to see if lowering LACE score would be more beneficial

Case Management Interventions Communicating Lace Scores

- Nurse Case Managers review discharges to home and calculate LACE score using I-PAD
- Score is entered into Meditech Interventions
- Scores are printed to Discharge Call RN printer for review

Case Management Interventions Discharge Call Nurse

- Prior practice was to call all patients
- Changed focus to call high risk patients
- Changed from single call to serial calls
- Single call for
  - Patients that did not follow discharge recommendations
  - Pediatrics
  - Any patients identified by CM/SW

Case Management Interventions Discharge Calls

- Serial Calls (Discharge to Home only)
  - Modified Lace Score of 10 or greater
  - Discharge Diagnosis
    - Pneumonia
    - COPD
    - CHF
    - Sepsis
    - MI

Case Management Interventions
Discharge Call Success

- Call Success Rate:
  - First Call - 60%
  - Second Call – 44%
  - Third Call – 48%
  - Fourth Call – 53%
  - Fifth Call – 38%
  - Total – 50%

Case Management Interventions
Discharge Call Interventions

- Problems identified by Discharge Call RN
  - Brought to CM Manager for intervention
    - Contact patient or family
    - Contact physician or physician office
    - Initiate higher level of care
      - HHC, SNF, LTAC
    - Medications
      - Last Resort Fund
    - Transportation
      - Access Johnson County

Case Management Interventions Partnerships/ Resources

- Partnerships
  - St. Thomas Clinic
    - Follow-Up Appointments
  - Kindred LTAC
    - Screenings
- Resources
  - Last Resort Fund
  - AHN ACO Case Managers
  - Transitions of Care Coalition

Lessons Learned

- The reduction of readmission is **NOT** resolved with one silver bullet!
- Multidisciplinary approach is needed.
- Data collection was time consuming but worth it!
- Patient centered approach.

Questions?

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