The Preventable Readmissions Challenge: Pay Now or Pay Later

November 21, 2014
Webinar Agenda

• Welcome & Introductions
  – Colleen O’Brien, Patient Safety/Quality Advisor, IHA
• The Hospital Readmission Reduction Program (HRRP)
  • Kathy Wallace, Dir. of Performance Improvement, IHA
• Parkview’s successful campaign to reduce hospital readmissions
  – Susan McAlister, Dir. of Clinical Effectiveness, Parkview RMC
• Your hospital’s foundation as a readmissions funding source
  – Julia Abedian, President, Columbus Regional Health Foundation
• Wrap-up/Questions
Pay for Performance: Hospital Readmission Reduction Program (HRRP)
Readmission Reduction FY 2015

- Date Range included in HRRP: July 1, 2010 - June 30, 2013
- Included Populations
  - AMI
  - HF
  - Pneumonia
  - COPD
  - Total Hip Arthroplasty / Total Knee Arthroplasty
  - CABG (beginning FY 2017)

- Hospital must have at least 25 cases in a population over the three years for it to be considered in the program
- Penalty increases to 3% maximum beginning FY 2015, Oct. 1, 2014
- No opportunity for financial gain with this program
Observed to Expected Ratio (O/E)

• O/E less than 1 =
  – Lower than expected readmission rate
  – Better quality

• O/E greater than 1 =
  – Higher than expected readmission rate
  – Lower quality
Financial penalties for readmissions are increasing across the country

• Fiscal Year 2013 (1% maximum penalty)
  – $280 million in hospital penalties

• Fiscal Year 2014 (2% maximum penalty with additional exclusions)
  – $227 million in hospital penalties

• Anticipated Fiscal Year 2015 (3% maximum penalty and increase from three to five conditions)
  – 2,623 hospitals will be penalized
  – $424 million in hospital penalties
The HRRP Experience in Indiana Hospitals Over Time

FY 2013 and FY 2014 are actual.
FY 2015 is data analysis from FY 2015 IPPS Final Rule.
The Indiana Experience – FY 2015

• 23 hospitals with no loss
• 68 hospitals with projected losses year three
  – Eighteen hospitals with a 1.0% loss or greater
  – Six hospitals between 0.76-0.99% loss
  – Seven hospitals between 0.51-0.75% loss
  – Twelve hospitals between 0.26-0.50% loss
  – Fifteen hospitals between 0.1-0.25% loss
  – Ten hospitals with less than 0.1% loss
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>
What drove the losses?

<table>
<thead>
<tr>
<th>Excess%</th>
<th>PNEU</th>
<th>HF</th>
<th>MI</th>
<th>COPD</th>
<th>Hip&amp;Knee</th>
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</thead>
<tbody>
<tr>
<td>&gt;20%</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
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<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>
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<tr>
<td>&lt;1%</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>0</td>
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</table>
Readmission Policy Issues

• Measures do not exclude readmissions unrelated to the reason for initial admission in spite of the ACA statutory requirement

• 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
January – July 2014 Re-admission Focus

System-All Physicians

% 30 Day Readmissions (Any APR-DRG)
- 8.94%
- 10.49%
- 1976 / 22097 cases

Clinical Team Focus

Discharge Disposition

<table>
<thead>
<tr>
<th>DISPOSITION</th>
<th>VALUE</th>
<th>STD DEV</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to Home of Self Care with Inpatient Readmission</td>
<td>40.00%</td>
<td>1.63</td>
<td>2 / 5</td>
</tr>
<tr>
<td>Discharge/Transfer to Home Health</td>
<td>20.78%</td>
<td>1.38</td>
<td>277 / 1333</td>
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<tr>
<td>Left Against Medical Advice</td>
<td>20.24%</td>
<td>1.29</td>
<td>17 / 84</td>
</tr>
<tr>
<td>Discharge/Transfer to ICF</td>
<td>21.43%</td>
<td>1.15</td>
<td>24 / 112</td>
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<tr>
<td>Discharge/Transfer to SNF</td>
<td>17.60%</td>
<td>0.50</td>
<td>315 / 1790</td>
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</table>

MS-/APR-DRG (Readmission)

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>VALUE</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Septicemia Or Severe Sepsis W/O Mv 96+ Hours W Mcc (871)</td>
<td>4.07%</td>
<td>64</td>
</tr>
<tr>
<td>Esophagitis, Gastroent &amp; Misc Digest Disorders W/O Mcc (392)</td>
<td>3.37%</td>
<td>53</td>
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<tr>
<td>Heart Failure &amp; Shock W Cc (292)</td>
<td>3.05%</td>
<td>48</td>
</tr>
<tr>
<td>Renal Failure W Cc (683)</td>
<td>2.86%</td>
<td>45</td>
</tr>
<tr>
<td>Heart Failure &amp; Shock W Mcc (291)</td>
<td>2.60%</td>
<td>41</td>
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</tbody>
</table>

Post acute Focus
30 Day Re-admission work

Components of Re-admission Work

- Long Term Care Collaborative
- Long Term Care Pilots
  - Sepsis identification and treatment
  - Rapid Response
  - Transitional Care Unit
- Post SNF discharge calls and visits
- Senior Care

- Emergency Department “Hot Spotters”
  - Clinical Decision Unit
- Case management focus on Rankin's ≥ 10
- Collaborative rounding
- Transition Care Nurses
  - Re-admissions
  - High Rankin's
- Service Line focus
- Palliative Care

- Home Health Care
  - Tele-health
- Hospice
- Aging and In Home Services
- Palliative care Clinic
- Wound Clinic
- 30 days Transitional Care NP visits
Acute Care

- Emergency Department “Hot Spotters”
  - Clinical Decision Unit
- EPIC Notification of re-admission
- Case management focus on Rankin's ≥ 10
- Collaborative rounding
- Transition Care Nurses
  - Second Re-admissions
  - High Rankin's
- Service Line focus
- Palliative Care
ED “Hot Spotters” Pattern Reductions

- Case Management driven
- Identify frequent visits to Emergency
- Determine needs
- ED Physician develops Plan of Care
- EMR alert to Plan of Care
- Measure progress

154 active patients

ED visit reduction 2012-2014

Total 1,114

645

469

2013-2014

2012 - 2013
Multiple – Readmissions/Admissions/ED visits

Goal: To Break patterns of resource use
Individual Care Plan Development
Clinical Decision Unit Criteria

- Directed by Emergency Department - managed by NP with hospitalist group
  - LOS - Estimated 12 hrs. < 24 hours
  - Protocol/symptom driven care
  - Discharge to Home
  - Stable Vital Signs
- Interventions:
  - IV hydration
  - Diagnostic test
  - Medication management
  - Pain management
Clinical Decision Unit
January 2013 – August 2013

• Volume = 1,505

• 84 potential diverted re-admissions
  • Inpatient admission followed by CDU visit in 30 days
    • Change in discharge disposition:
      • SNF 8, Rehab 2
    • Home Health Care referrals = 15
Re-admission on Banner in EPIC
Early Screen for Discharge Planning (ESDP)

ESDP Components

- 4 item screen completed on admission
  - Age
  - Lives alone
  - Walking limitation
  - Disability

- Score of 10 or more considered at risk for complicated discharge plans

- Sensitive and specific (AUC = .82 - .84)

Collaborative Care Rounding

Huddle Team members:
- Hospitalist
- Case Manager
- RN
- Pharmacy

Rounding Prioritization:
- Day of discharge patients
  - Discharge Needs
- Rankin >10
  - Physical Therapy evaluations
Transitional Care Nurses

All Cause Re-admission Rate
Parkview Health - 2013

Transitional Care January – March 2013
Very High Risk Second Readmissions N = 204
9% rate
Second Re-admission

Goal = 3-5 days post discharge

Physician Access

Number of Days between Discharge and Second Readmit

- 0-3 Days: 15%
- 4-9 Days: 39%
- 10-15 Days: 57%
- 16-21 Days: 77%
- 22-30 Days: 100%
Service Line Focus

Aim Statement

2013 Readmission rate: 10.24%

AIM: To reduce Acute Care Readmission Rate to 9.38% by 12/31/2014

Why is this project important?

- Improved patient care & safety, outcomes, financial responsibility &

Changes being Tested, Implemented or Spread

- Identify and mitigate failures or problems for discharge planning of patients to PPG physicians.
- Identify and mitigate opportunities for Palliative Care to consult patients.
- Identify and mitigate failures or problems about collaboration with ED, physicians, and SNF.
- Identify and mitigate opportunities for patient education for COPD.

Lessons Learned

- Physician collaboration teams to understand the complexity of post discharged patients to decrease RA
- Need to develop triggers in EPIC for Palliative Care consults
- Ongoing education with LTC for early signs of sepsis
- Respiratory team to collaborate and deliver patient education for

Recommendations and Next Steps

- Patient's hospital plan of care sent to PPG Primary Care physician for continuity of care
- PPG working on holding 2 appointments open for earlier access to primary physician
- Educate physicians what the Palliative Care program has to offer patients with a chronic diagnosis (Nov 12th)
- Ashton Creek transitional care unit pilot for high risk RA patients
- COPD care plan in approval phase with PPG quality team
- RT using the 5 easy things concept for patient education
- Multiple admission renal patients with collaborative care plan and NP visits

Team Members

- Carma Shoemaker
- Craig Traylor
- Deb Highland
- Deine Barnes
- Jessica Meyers
- Jeni Hasong
- Julie Walker
- Karen Bantum
- Kristine Taylor
- Laura Implants
- Lindsey Daniel
- Margie Ceklosi
- Matthew McKnight
- Munyaradzi Chakalava
- Paula Rostick
- Parra Smith
- Rhonda Allen
- Susan McElister
- Tammy Cooper
- Tammy
Palliative Care

% 30 Day Readmissions (Any APR-DRG) - System-All Physicians

Palliative Care Clinic

Palliative Care Triggers
After Discharge

• Home Health Care
  • Tele-health
• Hospice
• Aging and In Home Services
• Palliative Care Clinic
• Wound Clinic
• 30 days Transitional Care NP visits
January – July 2014
Parkview Home Health

- Patient Volume: 22,501
- Home Health Discharges: 1,850 (8.2%)
  - Benchmark 16%
- 45% of Home Care referrals outside of Parkview Home Care
Parkview Home Health Care Readmissions
January – July 2014

• All Cause Re-admission 8.94%
  • Large Non-Teaching hospital benchmark 10.49

• Home Health Re-admissions 18.86%
  (349)
  • 1.06 Standard deviations above mean
Home Health Care Re-admissions

- **55%** of Home Care referrals to Parkview Home Care
- **19%** of readmissions less than 48 hours and potentially not seen by Home Health
- **40%** of readmissions 7 days or less
  - CHF patients visited 3-4/week the first 7 days
  - CHF home care pathway implemented
LOS and Bed rest
7 days

- Loss up to 10% plasma volume
  - VTE risk
  - Shrinking skeletal muscles – lowers O2 levels
- < oxygen – skin integrity
- Strength and muscle mass
- GI tract slows
- Dysphagia
Aging and In-home Services
Medicare Traditional - 2014

[Diagram showing volume and percentage of re-admits for each month from January to September.]
Services:

- Palliative Care Clinic
- CHF Clinic
- Wound Clinic
- Outpatient Infusion
- NP Transitional Care Visits
  - Within 14 days of discharge
Post Acute Care

- Long Term Care Collaborative
- Long Term Care Pilots
  - Sepsis identification and treatment
  - Rapid Response
  - Transitional Care Unit
- Post SNF discharge calls and visits
- Senior Care
Parkview LTC Collaborative

• Care Transition/Readmission Focus
• Began - January 2013
• Quarterly Meetings
  • Multidisciplinary Members: Administrators, DONs, Case Management, Hospital Leaders
• Yearly Collaborative Needs Assessment
Post Acute Facilities = 27
<table>
<thead>
<tr>
<th>Top 5 Issues Identified 1-29-14</th>
<th>1Q14</th>
<th>2Q14</th>
<th>3Q14</th>
<th>4Q14</th>
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</thead>
<tbody>
<tr>
<td>SNF Competency Skills/Critical Thinking</td>
<td></td>
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<td></td>
<td>Sepsis Pilot</td>
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<tr>
<td>Clinical Education/Quarterly Sessions</td>
<td>CHF</td>
<td>Hydration</td>
<td>Sepsis</td>
<td>Sepsis simulation</td>
</tr>
<tr>
<td>Hospital Hand &quot;Over&quot;/Communication</td>
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<tr>
<td>Care Navigators/Seamless Transition</td>
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<tr>
<td>IV Fluids/Hydration/ATB</td>
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<td></td>
<td>Sepsis</td>
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<tr>
<td>Care Pathways</td>
<td></td>
<td></td>
<td>Sepsis</td>
<td>Sepsis KPI</td>
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</tbody>
</table>
Data Comparisons 2013/2014

- Readmission Rate Ranges
  - 4Q13: 0 – 92%
  - 1Q14: 0 – 83%
  - 2Q14: 0 – 19%
  - 3Q14: 0 – 26%

Ranges based on new admission volumes
3Q14 Re-admission
n = 12 facilities

53 patients
28% family request (15 residents)
64% No Code (34 residents)

52% were pre septic or septic
Resident seen by NP or MD prior to transfer
Transitional Care Pilot

To provide patients with high acuity and multiple co-morbidities a smooth transition to Skilled nursing care

- The transitional will be accomplished with remote monitoring assistance from Parkview eAcute unit.
- Dedicated staff and unit at Ashton Creek.
Determination of Need

2013 LOS Spread

N = 38,206

- Parkview LOS: 4.23
- Indiana: 3.92
- Crimson top 10%: 3.40

Number of Days between Discharge and Second Readmit

- 0-3 Days: 15%
- 4-9 Days: 39%
- 10-15 Days: 57%
- 16-21 Days: 77%
- 22-30 Days: 100%
Risk Identifiers

<table>
<thead>
<tr>
<th>Rankin Range</th>
<th>Days out before return</th>
</tr>
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<tbody>
<tr>
<td>10&lt;</td>
<td>21 days</td>
</tr>
<tr>
<td>11 to 17</td>
<td>15.5 days</td>
</tr>
<tr>
<td>18&gt;</td>
<td>12 days</td>
</tr>
</tbody>
</table>

Rankin Percentages

- <10: 34%
- 11 to 17: 46%
- 18+: 20%
Implement a non-emergency pilot “Rapid Response” program in Noble and Huntington counties between the Parkview EMS and select community based LTC facilities.

**Scope of Project:**

**Who:**
- EMS: Huntington and Noble
- LTC facilities: Scared Heart - Avilla
- Norwood - Huntington

**Target start date:** January 5, 2015

**Pilot duration** – 6 months - July 4, 2015
For Allen County, the time of day for presentation to the ED and then progression to inpatient care is from 1000 – 1600. This data appears to be similar in the community hospitals.
Rapid Response/Skills

- SBAR notification
- EMS Assessment
- Task specific
- Clinical interventions
- Immediate labs – istats
- MD/NP communication
- Calming effect to critical situation
- Team decision on making the transfer call

- IV, fluids start
- Drawing of labs
- ISTAT labs – Chem 6, H/H, Troponin, Venous Blood Gas, Lactic, Lactic acid analysis for sepsis
- Blood cultures
- Urinary catheterization
- IV push of Meds (Lasix)
- Parenteral pain medications (IM or IV)
LTC Sepsis Detection and Intervention

- Implement a Pre-Sepsis detection program for earlier identification of infection
- Slow the progression of Sepsis to Septic Shock with LTC intervention
- Decrease the mortality rate at Parkview by patients presenting to the ED with infection vs. advanced stages of Sepsis.
# Sepsis Determination of Need

## July 2013 – June 2014

<table>
<thead>
<tr>
<th>Sepsis</th>
<th>ICD9</th>
<th>All patients</th>
<th>SNF discharges (% of discharges)</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>995.91</td>
<td>584</td>
<td>144 (25%)</td>
<td>43</td>
</tr>
<tr>
<td>Severe Sepsis</td>
<td>995.92</td>
<td>595</td>
<td>160 (27%)</td>
<td>146</td>
</tr>
<tr>
<td>Septic Shock</td>
<td>785.52</td>
<td>328</td>
<td>85 (26%)</td>
<td>106</td>
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</table>
### Resident Data Log

<table>
<thead>
<tr>
<th>Task</th>
<th>Example</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Facility</td>
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<tr>
<td>Patient Identifier</td>
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<tr>
<td>Date</td>
<td>11/5/2014</td>
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<tr>
<td>NP/MD notified with SBAR (Time)</td>
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<tr>
<td>NP/MD responded to SBAR in 30 minutes (Yes/no)</td>
<td>Yes</td>
<td></td>
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<tr>
<td>NP/MD orders -(Time)</td>
<td>900</td>
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<td>Chest X ray performed (Time)</td>
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<td>Chest X ray results (Time)</td>
<td>1100</td>
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<td>Labs drawn (Time)</td>
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<tr>
<td>Lab results - (Time)</td>
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<tr>
<td>Blood culture before Antibiotic started (Yes/no)</td>
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<td>IV placed (Time)</td>
<td>1200</td>
<td></td>
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<td>IV fluids started (Time)</td>
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<tr>
<td>IV antibiotics started (Time)</td>
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<tr>
<td>STOP and Watch altered RN (Yes/No/Other)</td>
<td>Yes</td>
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<tr>
<td>If yes....STOP and Watch received (Time)</td>
<td>830</td>
<td></td>
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<tr>
<td>RN assessment of resident (Time)</td>
<td>840</td>
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</tbody>
</table>

Send completed data log to Susan McAlister DNP,RN, CPHQ @ susan.mcalister@parkview.com
Send each month by the 10th of the month
30 Day Re-admission work

Components of Re-admission Work

- Long Term Care Collaborative
- Long Term Care Pilots
  - Sepsis identification and treatment
  - Rapid Response
  - Transitional Care Unit
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- Senior Care

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- Home Health Care
  - Tele-health
- Hospice
- Aging and In Home Services
- Palliative care Clinic
- Wound Clinic
- 30 days Transitional Care NP visits
Questions
Potential of Philanthropy to Accelerate Strategic Innovations in Your Hospital System.

Julie Abedian
President, Columbus Regional Health Foundation
Your Foundation can provide resources in a variety of ways.
Source of Traditional Philanthropic Resources:

- Grants
- Gifts from donors who believe in your hospital and its leadership
Your Foundation can be a neutral convener.

- At the intersections of the hospital and the community
- Between clinical professionals & public health experts
Your Foundation can incubate innovative solutions until they can be proven and brought to scale.

- Fund pilots
- Fund “FDEs”
Your Foundation can provide “risk capital.”

• Especially for work that may be reimbursed in the future.
Your Foundation already has many priorities.

Your Foundation is always aligned with your executive leadership’s priorities.
Evaluation & Follow-up

- Webinar funded by CMS through the *Partnership for Patients*
- CMS reviews results and wants 80% of participants to evaluate educational sessions
- Please complete the simple three question evaluation by Dec. 1, 2014:
- Link to evaluation and webinar recording will be distributed to participants within one week

THANK YOU FOR YOUR PARTICIPATION!
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