Indiana University Health

Indiana Hospital Association Coalition for Care Regional Meeting
August 13, 2013

Introduction
Transition of Care – Case Management

- Debbie Hostetler RN, CCM
  - *Transition of Care Case Manager*

- Nicole Molter RN, MSN, CCM
  - *Supervisor, Care Management*

Care Management Program

- Hospitalist Group
- Unit Based Case Management
- Unit Based Social Work
- Utilization Review/Medical Necessity
- Report Structure/Support

Transition of Care Case Management

- Focus – High Risk Population
  - Risk Stratification
    - LACE
    - Frequent Readmissions
  - Case Management
    - Patient Centered Approach
    - Motivational Interviewing/Shared Decision Making
    - Improved Transition to Outpatient Management
    - Follow-Up

LACE

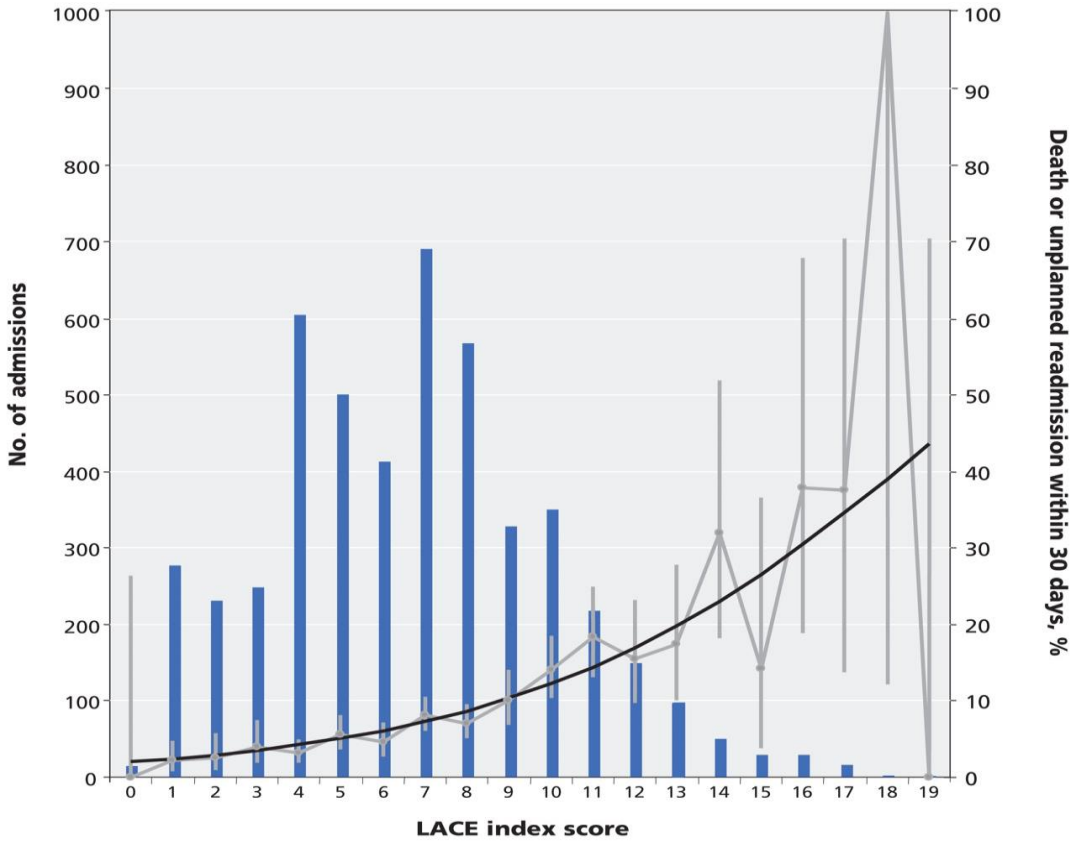
- The LACE tool predicts readmissions based on the following:
  - Length of Stay
  - Acute admission
    - Inpatient v/s Observation
  - Co-morbidities (Charleston Co-Morbid Index)
  - Emergency Room Visits/Inpatient admissions over the past 6 months

- ***According to the Clinical Advisory Board (2010) both the PARR Tool and LACE Index have a moderate level of success based on evidence compared to the remaining two which are ranked as low.***

Tool Selection & Process

Figure 1: Calibration curve for the LACE index, based on data representing patients in the derivation and internal validation groups.

According to a study conducted by Walraven, Dhalla, Bell, Etchells, Stiell, Zarnke, Austin, and Forster (2010) the LACE tool was discriminative and moderately successful at predicting the risk of early death or unplanned readmission.



http://www.cmaj.ca/content/182/6/551.full.pdf+html

van Walraven C et al. CMAJ 2010;182:551-557

CMAJ·JAMC

Connect to Purpose

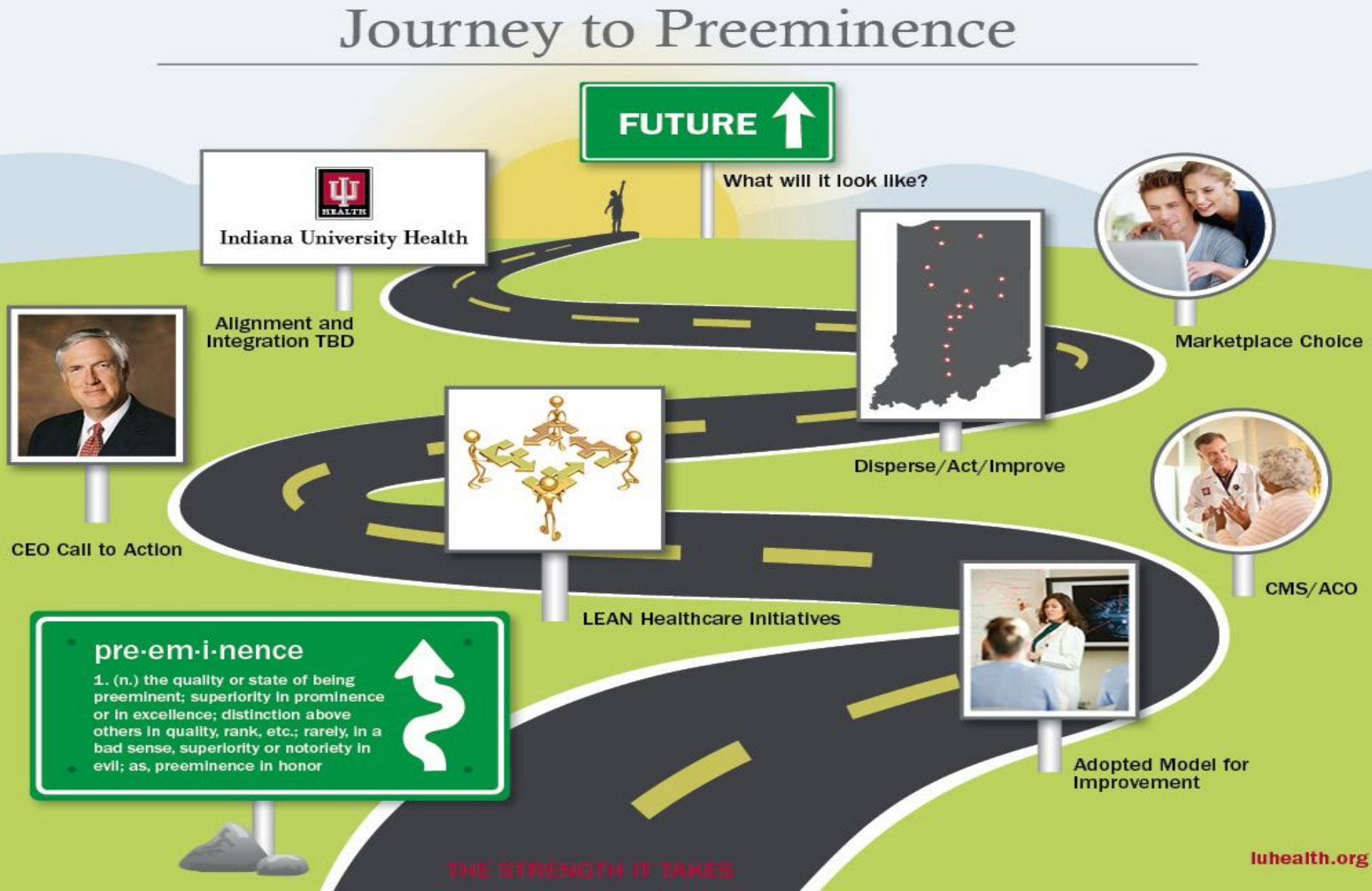
Improving Patient Outcomes

- Focusing on Complex/High Risk – Chronic Disease
  - Condition Specific (COPD)
  - Individualized Plans of Care
  - Multi-Disciplinary Rounding
  - Socioeconomic Status/Barriers to Resources
- ECF Hand-Offs
  - Improving Communication/Care

Introductions: Extended Care Facilities Readmissions Lean Project

- Jeannine Malone, MS, HSA, PMP
  - *Facility Based Project Manager & Lean Six Sigma Black Belt, Office of Lean Transformation*
- Anthony Hansen, B.S., CPhT
  - Pharmacy Project Coordinator & Lean Six Sigma Green Belt

IU Health Arnett Office of Lean Transformation



ECF Project Charter & Team Selection

- Project Charter
  - **Problem Statement**: Readmissions have a negative impact on reimbursement rates, patient safety & satisfaction, quality of care, length of stay and bed availability. Currently, the readmission rate for patients discharged from IU Health Arnett to an Extended Care Facility is 20%.
  - Goals/Metrics

Metric Name	Baseline	Goal
IU Arnett Overall Readmission Rate	10.88% (through November 2012)	6.74% (IU Health System Quality Aggregate Goal)
Readmission Rate for patients discharged from IU Arnett to an Extended Care Facility	20% (through June 2012)	16%

- Team Members
  - Jeannine Malone, Lean Six Sigma Black Belt
  - Anthony Hansen, Lean Six Sigma Green Belt
  - Doug Jackson, Lean Six Sigma Green Belt
  - Star Meyer, Lean Green Belt
  - James Bien, MD Lean Yellow Belt
  - Katrina Boes, Lean Yellow Belt
  - Norma Gilbert, Lean Yellow Belt
  - Debbie Hostetler, Lean Yellow Belt
  - Nicole Molter, Lean Yellow Belt
  - Mandy Ovalle, Lean Yellow Belt

A3 – Project Story Board

- Define Phase
  - Reducing readmissions from ECFs by 20%
  - ECFs focus was based upon analysis of total readmissions
- Measure Phase
  - Mapped the process of a patient discharged to an ECF and readmitted in 30 days
  - Identified value, non-value, non-value but necessary process steps

A3 – Project Story Board

- Analyze
  - Gemba Voice of the Customer/Stakeholder
  - Analysis of data reveled that there was not a common cause variation
  - Main Tools used by team to identify areas of focus included brainstorming, affinity diagram, X-Y matrix and root cause analysis
  - Root causes
    - Time of day for discharge
    - Lack of standardize discharge packet

A3 – Project Story Board

- Improve Phase
  - Recommendations
    - Developed standardized discharge packet and process
    - Discharge patient no later than 3pm to ensure patient arrival by 4pm
- Control Phase
  - Initial small test of change demonstrated improvement therefore process changes are currently being spread to all floors of the hospital
  - Thru collaboration with the process owner created ongoing Control Plan for monitoring impact of changes

Spread and Outcomes Data

- New process has been spread house wide at the Hospital (2nd, 4th, 5th and 6th).
- Control plan is in place and monitoring of the defined metrics is on-going.
- To date, no major barriers have been identified with the implementation of our standardized processes.
- Review of Outcomes Data – to early in the process to determine impact given final roll-out completed in July 2013.

Questions and Answers?