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

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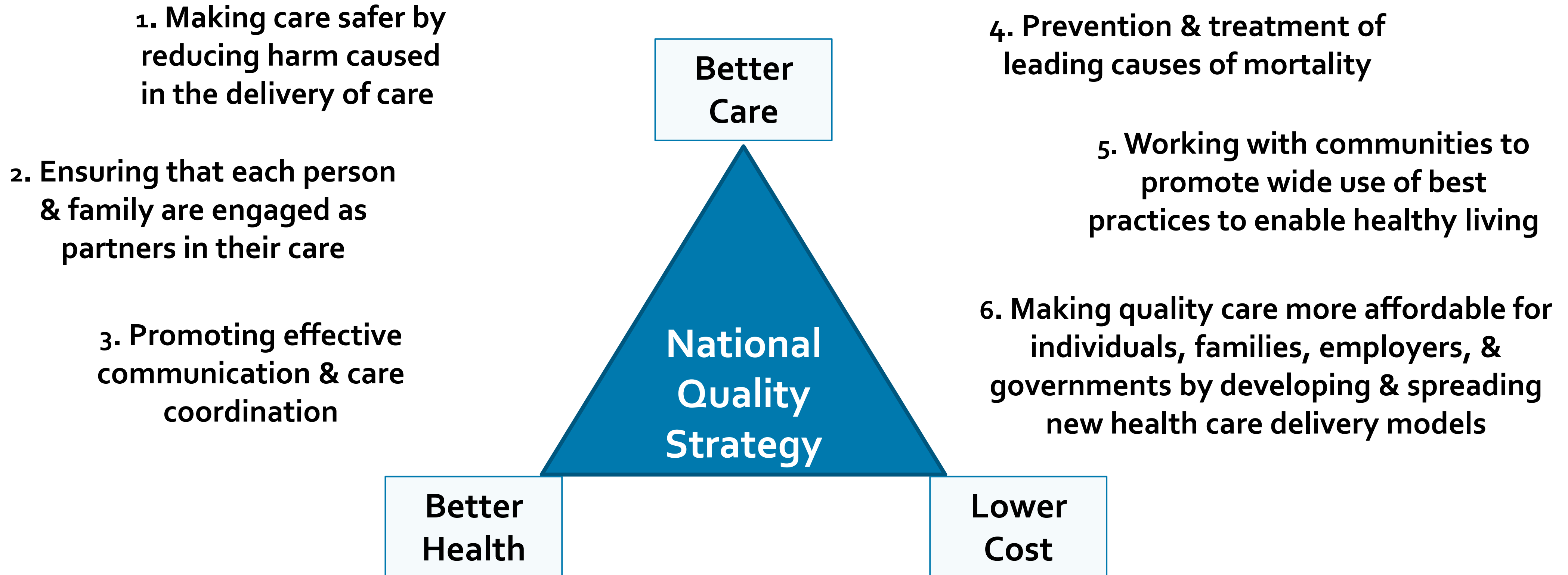
National Quality Strategy Aims and Priorities



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

11 Regional Patient Safety Coalitions

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2015 Statewide Focus Areas

- **Adverse Drug Events**
- **Care Transitions and Readmissions**
- Catheter-Associated Urinary Tract Infections
- Prevention of Injurious Falls
- Sepsis

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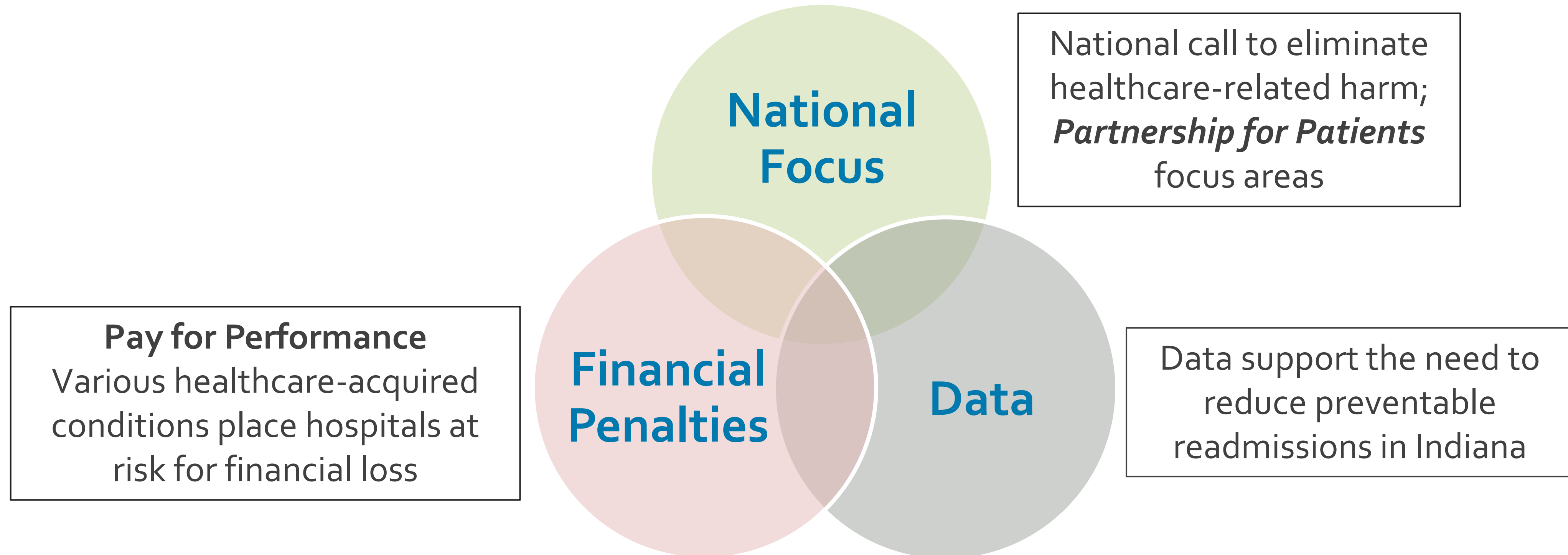
Why These Five Topics?



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

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What Can a Focus on ADEs Impact ?

Complications

Absenteeism

Cost of Care

Quality of Life

Readmissions

Length of Life

Patient & Family Engagement

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

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Indiana Harm Snapshot
(from HRET HEN 1.0 data)

		Indiana Harms (9/2013 – 8/2014)
ADE	Warfarin	**1640**
	Insulin (Hypoglycemia)	**7455**
	Opioids	**4132**
CAUTI Rate - All Tracked Units		448
Falls with Injury		1381
Readmissions (All Cause)		**43,707**
Sepsis Mortality		1076
Total		59,839

13,227 ADEs across three drug categories
43,707 Readmissions

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"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

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Proposed Measure Definitions For Indiana

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

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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

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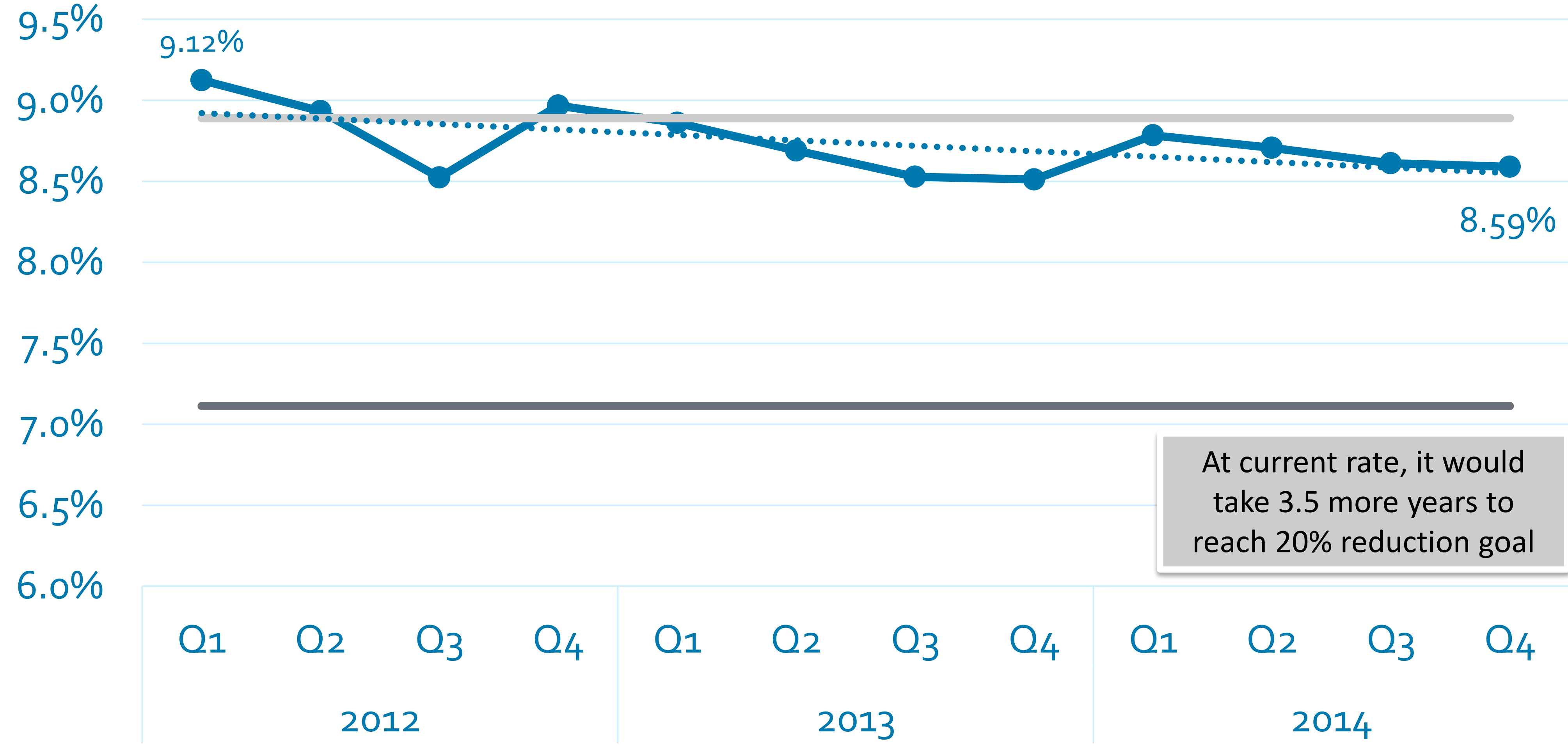
Indiana 30-day All-Cause Readmissions



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

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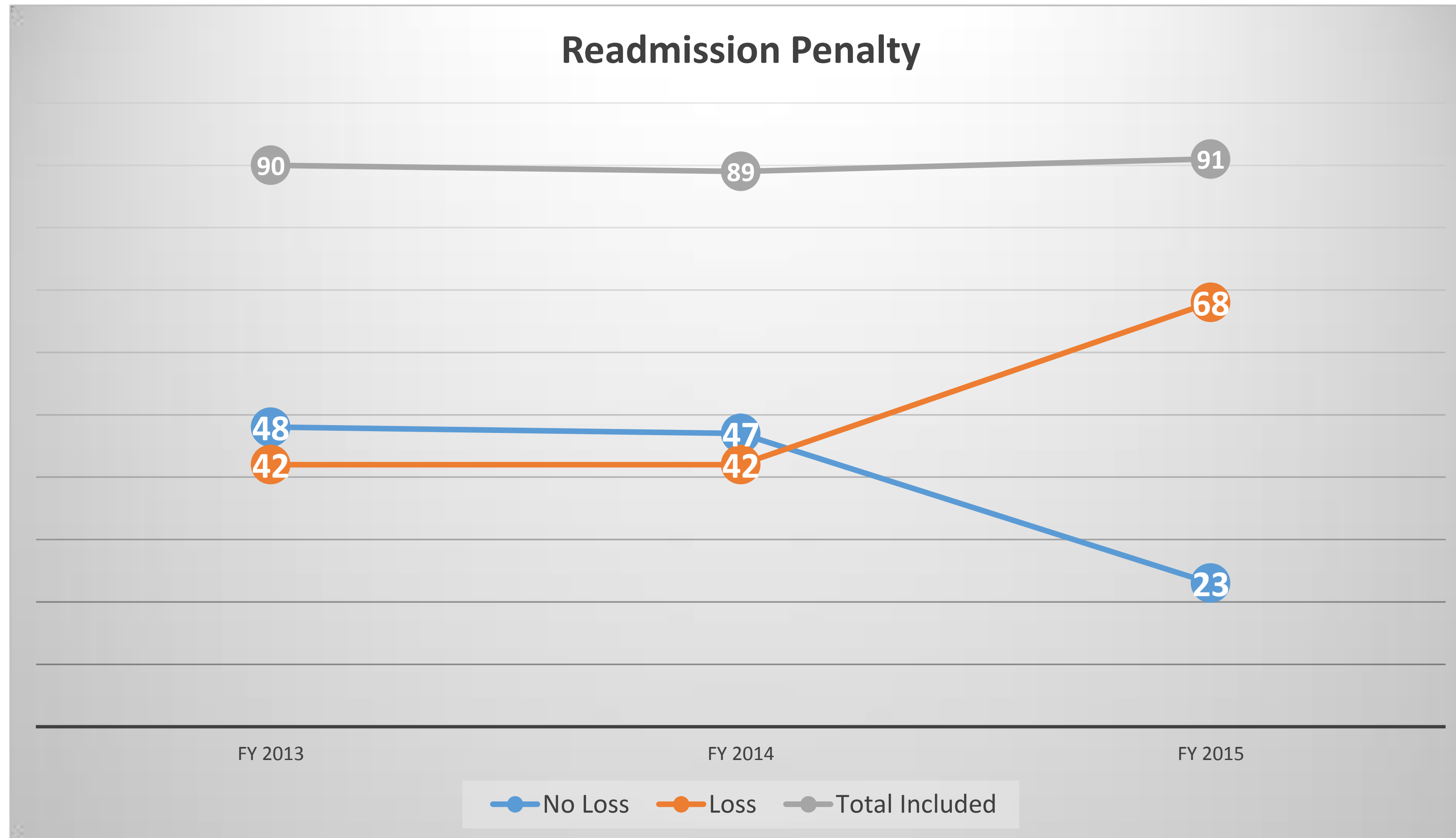
The HRRP Experience in Indiana Hospitals Over Time



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What drove the losses?

Cond.	# Hospitals	# Penalized	% Penalized
PNEU	80	25	31%
HF	81	31	38%
MI	57	26	46%
COPD	80	32	40%
Hip&Knee	70	31	44%

Excess%	PNEU	HF	MI	COPD	Hip&Knee
>20%	1	1	0	0	8
10 -19.9%	4	3	3	5	11
5 - 9.9%	6	12	10	12	5
1- 4.9%	11	12	8	12	7
<1%	3	3	5	3	0

Note: CABG will be added in FY 2017)

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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**

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"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 patent's capacity for self care

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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

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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?

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From Strategy to Action

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

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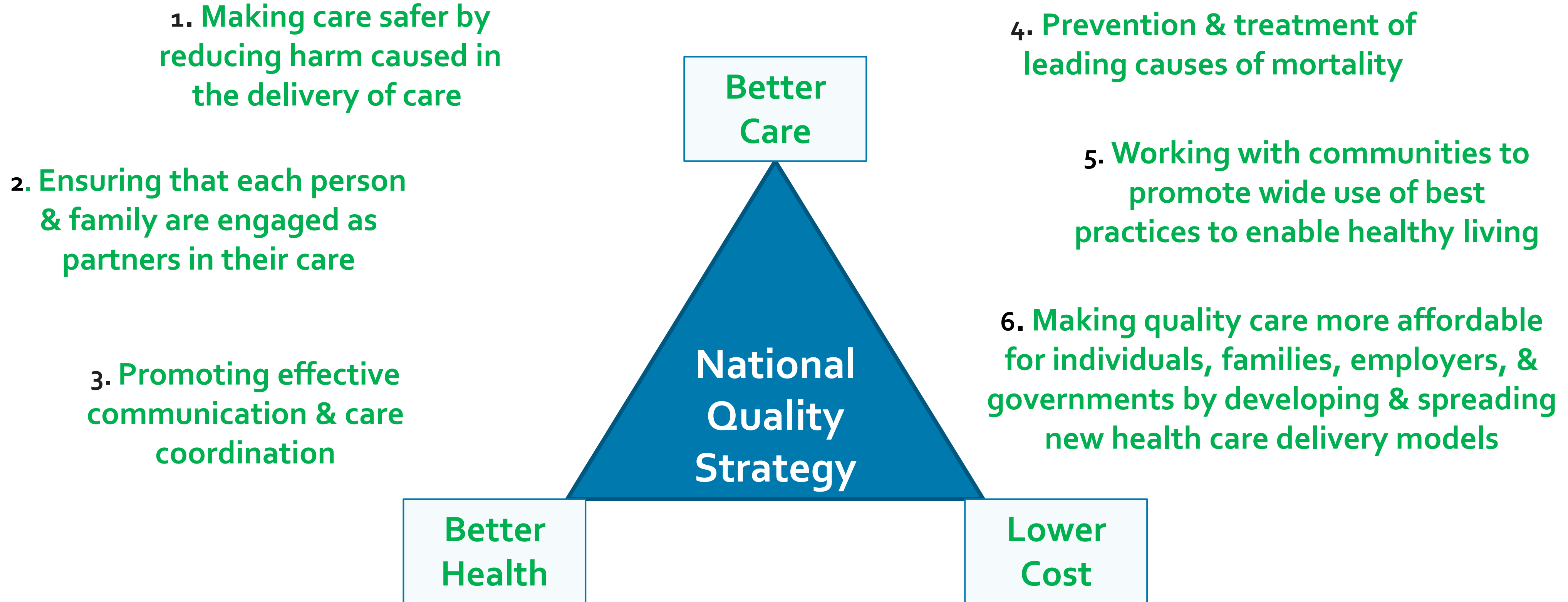
National Quality Strategy Aims and Priorities



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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!

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Together, we can achieve Better Health and Outcomes For ALL Hoosiers!

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Thank you! from your IPSC Team

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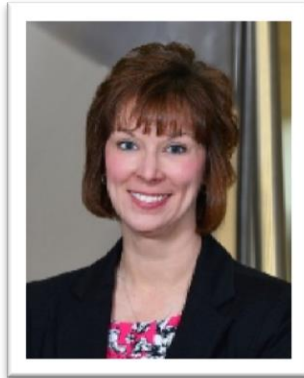

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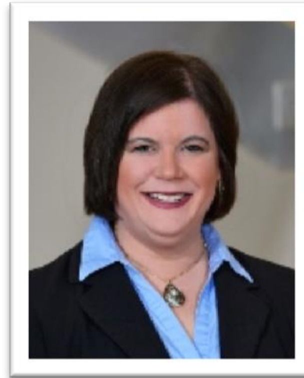

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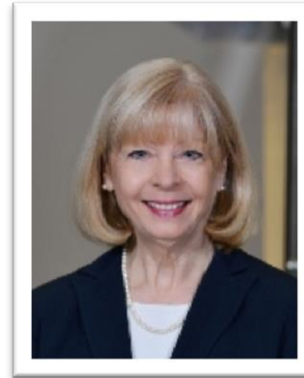

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