MHA Massachusetts Hospital Association

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Readmission Summit Focused on Care across the Continuum & Patient and Family Engagement

MHA Conference Center

Thursday, November 6, 2014

MA HEN
MASSACHUSETTS HOSPITAL ENGAGEMENT NETWORK
CONNECTING TO IMPROVE CARE

Agenda

9 a.m. **Welcome and Opening Remarks**
- Lorraine Schoen MS, BSN, RN
  Director, Clinical Affairs, MHA
- Pat Noga, PhD, RN
  Vice President, Clinical Affairs, MHA

9:15 a.m. **The National State of Readmissions**
- Amy Boutwell, MD, MPP
  Collaborative Healthcare Strategies

10:30 a.m. **Transition to Morning Breakout Sessions**

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Agenda

10:40 a.m. **Morning Breakout Sessions**

A – The 'One Cape' Journey to Meet the Institute for Healthcare Improvement Triple Aim and Decrease Readmissions through Interdisciplinary Care Coordination
Board Room, 2nd Floor

B – The Improving Massachusetts Post-Acute Care Transfers (IMPACT) - Achievements and Lessons Learned
Café, 1st Floor

C – Partners Continuing Care - Collaboration to Prevent Readmissions after an Acute Care Episode
Conference Center, 1st Floor

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Agenda

11:55 a.m. – 1:00 p.m. Lunch

1 p.m. Patient-centered Care Transition Strategies
Todd J. Liu, JD, MHA, Assistant to the President
Griffin Hospital

2:15 p.m. Transition to Afternoon Breakout Sessions
Turn in evaluations and sign for CEUs/CMEs

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Agenda

2:25 p.m. Afternoon Breakout Sessions

D - Care Transitions Education Project (CTEP) – Equipping Nurses to Lead Patient-Centered Care Transitions
Board Room, 2nd Floor

E - MetroWest Medical Center's Experience in Fostering Cross Continuum Partnerships in Practice
Conference Center, 1st Floor

F - Leveraging Palliative Care - A Hospital and Home Based Approach
Café, 1st Floor

3:40 – 4:00 Turn in evaluations and sign for CEUs/CMEs

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CME/CE Accreditation Information

TEAMHealth INSTITUTE

- TEAMHealth Institute is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. This activity meets the criteria for a maximum of 3.0 AMA PRA Category 1 credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.
- TEAMHealth Institute is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. TEAMHealth Institute has designated this activity for 3.0 Nursing CE Hours.

ACCREDITED ORGANIZATION
CONTINUING NURSING EDUCATION

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Disclosures

TEAMHealth INSTITUTE

- **Patricia Noga and Lorraine Schoen**, the planners of this CME/CEU activity, have no conflicts of interest to disclose.
- **Amy Boutwell and Todd Liu** have no conflicts of interest to disclose.
- There is no commercial support to disclose for this CME/CEU activity.

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CME/CEU Reminders

TEAMHealth INSTITUTE

- 2 Evaluation forms must be completed (Team Health and HEN) for CEU/CME credit.
- Sign CEU/CME registration form for credit between 2:15 p.m. – 4:00 p.m. before you leave today.
- Credits will be mailed to your email address provided.

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- Rest rooms are located on the 1st floor to the left of the Café, around the corner, and on the 2nd floor by the Board Room.
- Coffee, tea and water located in the Café and outside the 2nd floor Boardroom

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Welcome and Opening Remarks

Pat Noga, PhD, RN
Vice President, Clinical Affairs

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MA Readmissions and Care Transitions Initiatives: 2008 to Present

- Care Transitions Forum
- State Strategic Plan for Care Transitions
- STAAR: State Action on Avoidable Rehospitalizations
- Division of Health Care Finance and Policy PPR Committee
- HCQCC Expert Panel on Performance Measurement
- **Care Transitions Steering Committee**
- Quality inspectors trained in elements of a good transition
- Universal Transfer Form Piloting between all settings of care
- IMPACT: Improving MA Post-Acute Care Transfers
- Hospital requirement to form Patient Family Advisory Councils
- Engaging Patients and Families in Improving Hospital Discharge
- ASAPs join cross continuum teams (Aging Service Access Points)
- Expert Panel on End Of Life Care
- MOLST Pilot (Medical Orders for Life Sustaining Treatment)
- PCMHI: Patient Centered Medical Home Initiative
- 3026 Community-based Care Transitions Program
- CMS Hospital Engagement Networks (HEN)

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THE COMMONWEALTH FUND

Institute for Healthcare Improvement

Statewide Performance Improvement Agenda
MHA Board-approved Quality & Safety Goals
Set January 2013

1. **Reduce** preventable readmissions by **20%** by 2015

2. **Reduce** preventable CAUTI, CLABSI and SSI by **40%** by 2015

Note: This is a statewide aggregate goal, focused primarily on acute care hospitals; there will be **no public reporting of individual hospital data** in the course of monitoring and reporting progress in achieving the goals. **Base year = FY or CY 2012**

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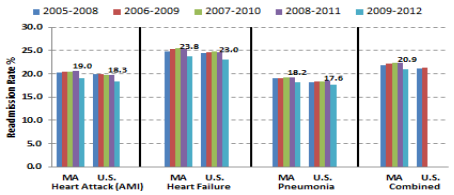
MHA Statewide Performance Improvement Agenda
Goal: Reduce preventable readmissions by 20% by 2015

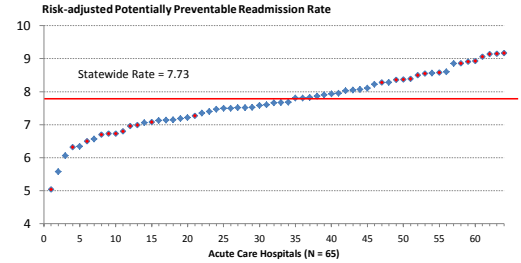
Figure 2.

30-day Post-Discharge Risk-Adjusted Readmission Rate, Selected Conditions
Massachusetts & United States Hospitals
Medicare Patients



Source: MHA and American Hospital Association (U.S. Combined conditions) analyses of Hospital Compare date files. 2010 through 2012 U.S combined analysis is not available.

MA Acute Care Hospitals Distribution of
Risk-adjusted Potentially Preventable Readmission Rates
OCT 2011 – SEP 2012



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Note: Red diamond markers signify statistically significant difference from state Rate (p>0.05)

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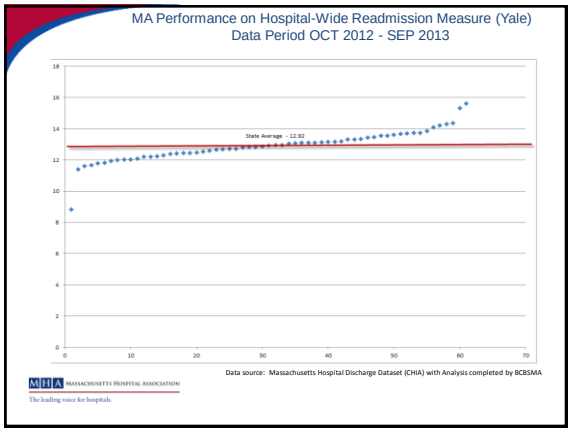
Source: 3M Health Information Systems analysis of MA hospital discharge database


MA Performance on Hospital-Wide Readmission Measure (Yale)
Data Period OCT 2012 - SEP 2013
State Average - 12.92
Data source: Massachusetts Hospital Discharge Dataset (CHIA) with Analysis completed by BCBSMA
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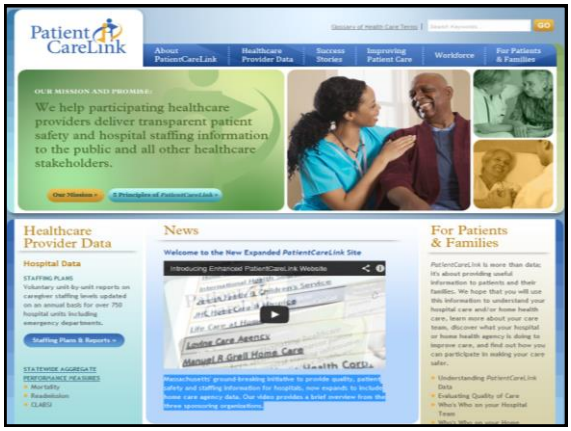

Patient CareLink
About PatientCareLink
Healthcare Provider Data
Success Stories
Improving Patient Care
Workforce
For Patients & Families
OUR MISSION AND PROMISE:
We help participating healthcare providers deliver transparent patient safety and hospital staffing information to the public and all other healthcare stakeholders.
Healthcare Provider Data
Hospital Data
News
Welcome to the New Expanded PatientCareLink Site
Introducing Enhanced PatientCareLink Website
For Patients & Families

REDUCING READMISSIONS - 2014

Expanding efforts to drive to hospital-wide results

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
November 2014

COLLABORATIVE HEALTHCARE STRATEGIES

Objectives

- What are hospitals with hospital-wide results doing?
- How does that differ from what we are doing?
- What are 3 practical ways to expand our strategies?
  - *Medicaid adults have high readmission rates and need to be specifically included in all efforts*

COLLABORATIVE HEALTHCARE STRATEGIES

THANK YOU CMS

6 game-changing messages from CMS policies……..

COLLABORATIVE HEALTHCARE STRATEGIES

6 Very Important Messages from CMS

1. Readmission reduction pays – inaction hurts
2. Hospitals must update & standardize transitional care processes
3. Reducing readmissions is a cross-continuum effort
4. Attend to non-clinical needs for post-hospital supports & services
5. We will flood the market with all best ideas on our dime
1. Reducing readmissions requires better data

COLLABORATIVE HEALTHCARE STRATEGIES

HOWEVER….

Powerful messages from powerful agencies can create blinders

COLLABORATIVE HEALTHCARE STRATEGIES

CMS' Medicare Focus Has Created Blinders

1. HF, AMI, PNA…COPD, hip/knee replacement
   - NOT the 5 most frequent diagnoses leading to readmissions
   - CMS' discharge diagnosis-specific penalty obscured other meaningful categorizations s/a frequent utilizer, social complexity, BH, functional status
2. Driven a Medicare focus to the exclusion of other high risk patient groups
   - Medicaid adults have higher readmission rates than Medicare FFS
3. Driven a case-finding approach
   - Interventions often limited to Medicare FFS with certain diagnosis
   - Created a 2- tiered discharge process - at odds with principles of quality
4. Preferred first move among hospitals: hire a Transitional Care FTE
   - Lost the focus on reliable redesign on transitional care for all patients
   - Hire dedicated staff to focus only on "penalty condition" patients

COLLABORATIVE HEALTHCARE STRATEGIES

Medicare Readmission Penalties

- October 1 2014- September 30 2015
- Up to 3% reduction in all Medicare payments for hospitals with high 30-day readmissions for AMI, HF, PNA, COPD and hip/knee replacement
- Average penalty **DOUBLED** this year
- 2,160 hospitals penalized; **$480 MILLION**
- In MA, **80%** of all hospitals penalized = 55 hospitals
  - the average penalty in MA is 0.78%
  - 19 hospitals with >1% penalty this year
  - MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT tied with NY

COLLABORATIVE HEALTHCARE STRATEGIES

Name	Provider ID	City	State	ZIP Code	County	FY2013 Readmission Penalty	FY2014 Readmission Penalty	FY2015 Readmission Penalty
The Neuromedical Center Hospital	190246	Baton Rouge	LA	70810	East Baton Rouge	0.00%	0.00%	0.00%
The Regional Medical Center Of Acadiana	190205	Lafayette	LA	70506	Lafayette	0.41%	0.23%	0.18%
Thibodaux Regional Medical Center	190004	Thibodaux	LA	70301	Lafourche	0.67%	0.63%	1.06%
Touro Infirmary	190046	New Orleans	LA	70115	Orleans	0.00%	0.00%	0.01%
Tulane Medical Center	190176	New Orleans	LA	70112	Orleans	0.00%	0.04%	0.25%
University Hospital & Clinics	190006	Lafayette	LA	70508	Lafayette	0.20%	0.18%	0.00%
Villa Feliciana Medical Complex	190199	Jackson	LA	70748	East Feliciana	0.00%	0.00%	0.00%
Washington St Tammany Regional Medical Center	190001	Bogalusa	LA	70427	Washington	0.00%	0.00%	0.34%
West Calcasieu Cameron Hospital	190013	Sulphur	LA	70663	Calcasieu	0.00%	0.00%	0.00%
West Carroll Memorial Hospital	190051	Oak Grove	LA	71263	West Carroll	0.87%	0.91%	0.68%
West Jefferson Medical Center	190039	Marrero	LA	70072	Jefferson	0.19%	0.02%	0.22%
Willis Knighton Bossier Health Center	190134	Bossier City	LA	71111	Bossier	0.00%	0.14%	0.42%
Willis Knighton Medical Center	190111	Shreveport	LA	71108	Caddo	0.00%	0.00%	0.05%
Winn Parish Medical Center	190090	Winnfield	LA	71483	Winn	0.92%	0.51%	0.40%
Women'S Hospital	190128	Baton Rouge	LA	70817	East Baton Rouge	0.00%	0.00%	0.00%
Adcare Hospital Of Worcester Inc	220082	Worcester	MA	1605	Worcester	0.00%	0.00%	0.00%
Anna Jaques Hospital	220029	Newburyport	MA	1950	Essex	0.24%	0.34%	1.36%
Baystate Franklin Medical Center	220016	Greenfield	MA	1301	Franklin	0.05%	0.14%	0.08%
Baystate Mary Lane Hospital	220050	Ware	MA	1083	Hampshire	0.00%	0.00%	0.00%
Baystate Medical Center	220077	Springfield	MA	1199	Hampden	0.00%	0.00%	0.00%
Berkshire Medical Center Inc	220046	Pittsfield	MA	1201	Berkshire	0.05%	0.04%	0.05%
Beth Israel Deaconess Hospital - Needham	220083	Needham	MA	2494	Norfolk	0.34%	0.05%	0.71%
Beth Israel Deaconess Hospital-Milton Inc	220108	Milton	MA	2186	Norfolk	0.23%	0.69%	1.41%
Beth Israel Deaconess Medical Center	220096	Boston	MA	2215	Suffolk	1.00%	0.69%	0.64%
Beverly Hospital Corporation	220018	Beverly	MA	1915	Essex	0.17%	0.09%	1.17%
Boston Medical Center Corporation	220031	Boston	MA	2118	Suffolk	1.00%	0.79%	0.56%
Brigham And Women'S Faulkner Hospital	220119	Boston	MA	2130	Suffolk	0.81%	0.85%	0.78%
Brigham And Women'S Hospital	220110	Boston	MA	2115	Suffolk	0.33%	0.30%	0.27%
Cambridge Health Alliance	220011	Cambridge	MA	2139	Middlesex	0.94%	0.32%	0.88%
Cape Cod Hospital	220012	Hyannis	MA	2601	Barnstable	0.17%	0.24%	0.05%
Carney Hospital	220017	Boston	MA	2124	Suffolk	0.11%	0.46%	0.71%
Clinton Hospital Association	220070	Clinton	MA	1510	Worcester	0.56%	0.48%	1.28%
Cooley Dickinson Hospital Inc The	220015	Northampton	MA	1060	Hampshire	0.19%	0.12%	0.46%
Emerson Hospital	220094	W Concord	MA	1742	Middlesex	0.00%	0.00%	0.01%
Falmouth Hospital	220135	Falmouth	MA	2540	Barnstable	0.00%	0.04%	0.16%
Good Samaritan Medical Center	220111	Brockton	MA	2301	Plymouth	0.94%	0.73%	1.18%
Helmark Health System	220070	Melrose	MA	2176	Middlesex	0.04%	0.24%	1.35%
Herrington Memorial Hospital	220019	Southbridge	MA	1550	Worcester	0.65%	0.64%	1.21%

COLLABORATIVE HEALTHCARE STRATEGIES

Name	Provider ID	City	State	ZIP Code	County	FY2013 Readmission Penalty	FY2014 Readmission Penalty	FY2015 Readmission Penalty
Healthalliance Hospitals, Inc	220001	Leominster	MA	1453	Worcester	0.22%	0.43%	0.72%
Heywood Hospital	220095	Gardner	MA	1440	Worcester	0.76%	0.52%	0.40%
Holy Family Hospital	220080	Methuen	MA	1844	Essex	0.85%	0.69%	1.29%
Holyoke Medical Center	220010	Holyoke	MA	1040	Hampden	0.20%	0.63%	0.77%
Jordan Hospital Inc	220060	Plymouth	MA	2360	Plymouth	1.00%	1.04%	0.32%
Lahey Hospital & Medical Center, Burlington	220171	Burlington	MA	1803	Middlesex	0.88%	0.54%	0.91%
Lawrence General Hospital	220010	Lawrence	MA	1841	Essex	0.24%	0.34%	0.86%
Lowell General Hospital	220063	Lowell	MA	1854	Middlesex	0.19%	0.26%	0.42%
Marlborough Hospital	220049	Marlborough	MA	1752	Middlesex	0.94%	0.86%	0.28%
Massachusetts Eye And Ear Infirmary	220075	Boston	MA	2114	Suffolk	0.00%	0.00%	0.00%
Massachusetts General Hospital	220071	Boston	MA	2114	Suffolk	0.51%	0.25%	0.24%
Mercy Medical Center	220068	Springfield	MA	1104	Hampden	0.02%	0.00%	0.31%
Merrimack Valley Hospital	220174	Haverhill	MA	1830	Essex	0.13%	0.00%	0.35%
Metrowest Medical Center	220175	Framingham	MA	1701	Middlesex	1.00%	0.95%	0.14%
Milford Regional Medical Center	220090	Milford	MA	1757	Worcester	0.42%	0.68%	1.39%
Morton Hospital	220075	Taunton	MA	2780	Bristol	0.66%	0.95%	1.81%
Mount Auburn Hospital	220010	Cambridge	MA	2138	Middlesex	0.60%	0.14%	0.88%
Nantucket Cottage Hospital	220177	Nantucket	MA	2554	Nantucket	0.45%	0.15%	0.00%
Nashoba Valley Medical Center	220070	Ayer	MA	1432	Middlesex	0.33%	0.11%	0.48%
New England Baptist Hospital	220088	Boston	MA	2120	Suffolk	0.02%	0.01%	0.00%
Newton-Wellesley Hospital	220101	Newton	MA	2462	Middlesex	0.07%	0.23%	0.17%
Noble Hospital	220065	Westfield	MA	1085	Hampden	0.02%	0.00%	0.37%
North Adams Regional Hospital	220051	North Adams	MA	1247	Berkshire	0.36%	0.16%	0.92%
North Shore Medical Center	220035	Salem	MA	1970	Essex	0.00%	0.00%	0.00%
Norwood Hospital	220126	Norwood	MA	2062	Norfolk	0.41%	0.45%	1.06%
Quincy Medical Center	220087	Quincy	MA	2169	Norfolk	0.43%	0.63%	1.44%
Saint Anne'S Hospital	220010	Fall River	MA	2721	Bristol	1.00%	0.79%	1.08%
Saints Medical Center Inc	220082	Lowell	MA	1852	Middlesex	0.12%	0.21%	1.33%
Signature Healthcare Brockton Hospital	220053	Brockton	MA	2302	Plymouth	0.24%	0.27%	0.46%
South Shore Hospital	220100	South Weymouth	MA	2190	Norfolk	0.48%	0.28%	0.45%
Southcoast Hospital Group, Inc	220074	Fall River	MA	2720	Bristol	1.00%	0.83%	1.40%
St Elizabeth'S Medical Center	220038	Brighton	MA	2135	Suffolk	1.00%	0.79%	1.12%
St Vincent Hospital	220178	Worcester	MA	1608	Worcester	0.32%	0.30%	0.48%
Sturdy Memorial Hospital	220008	Attleboro	MA	2703	Bristol	0.01%	0.28%	0.45%
Tufts Medical Center	220116	Boston	MA	2111	Suffolk	1.00%	0.85%	1.38%
Umass Memorial Medical Center Inc	220183	Worcester	MA	1655	Worcester	0.96%	0.73%	1.37%
Winchester Hospital	220107	Winchester	MA	1890	Middlesex	0.25%	0.41%	1.08%
Wing Memorial Hospital And Medical Center	220030	Palmer	MA	1069	Hampden	0.91%	1.38%	1.45%

COLLABORATIVE HEALTHCARE STRATEGIES

CRUNCHING THE NUMBERS

Will your current strategy get you to your goal?

COLLABORATIVE HEALTHCARE STRATEGIES

Let's Run the Numbers: *One Strategy Won't Get Us There*

	Number	Rate
Medicare admits/year	5,000 admissions	
Medicare RA rate		20%
# Medicare RA /year	**1,000** readmissions	
Pilot project	200 high risk patients	
Pilot group RA rate		25%
Expected # RA pilot	50	
Expected effect of pilot		20%
# RA reduced by pilot	**10**	
# Medicare RA/year	=1000 – 10 = **990**	**1%**

COLLABORATIVE HEALTHCARE STRATEGIES

Hospitals with hospital-wide results

- Know their data –
  Analyze, trend, track, display, share, post
- Broad concept of "readmission risk"
  Way beyond case finding for diagnoses
- Multifaceted strategy
  Improve standard care, collaborate across settings, enhanced care
- Use technology to make this better, quicker, automated
  Automated notifications, implementation tracking, dashboards

COLLABORATIVE HEALTHCARE STRATEGIES

EXPAND EFFORTS FOR IMPACT

Broad concept of risk, broad understanding of patient needs

COLLABORATIVE HEALTHCARE STRATEGIES

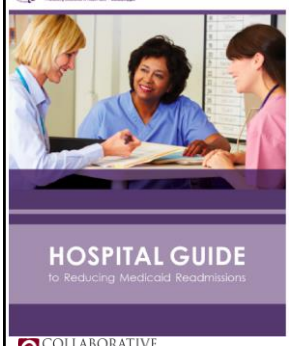
Next Frontier: Medicaid Readmissions

What is different? What is similar?

- Population analyses of Medicaid readmission rates are low
  - Because they include high-volume deliveries (OB) and pediatric discharges
  - Readmission rates appear low and providers think there is no "problem" in Medicaid
- Emerging experience suggests that social, financial, behavioral health factors greatly influence risk of readmission
- Adult Medicaid patients would be expected to have a high prevalence of social, financial and behavioral health issues
- Little has been described about readmission rates and the factors that contribute to readmissions among the younger adult population

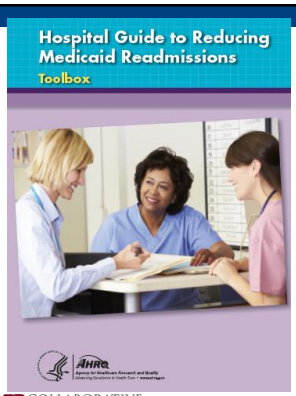
COLLABORATIVE HEALTHCARE STRATEGIES

AHRQ



- Introduction
- Why focus on Medicaid Readmissions?
- How to Use This Guide
- Roadmap of Tools
- Know Your Data
- Inventory Readmission Efforts
- Develop a Portfolio of Strategies
- Improve Hospital-based Transitional Care
- Collaborate with Cross Setting Partners
- Provide Enhanced Services
- 13 new Tools

COLLABORATIVE HEALTHCARE STRATEGIES



Tools

1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide

COLLABORATIVE HEALTHCARE STRATEGIES

Key Actions

1. Know your data
2. Ask your patients, their caregivers and providers, "why"
3. Develop a portfolio of strategies
4. Improve hospital-based transitional care for all
5. Collaborate with community based providers & services
6. Provide enhanced services for high risk patients

…do so leveraging technology to incorporate changes into workflow, enable implementation analytics and continually improve to achieve measurable results

COLLABORATIVE HEALTHCARE STRATEGIES

1. KNOW YOUR DATA

Analyze, track, trend, raw unadjusted data to identify opportunities

COLLABORATIVE HEALTHCARE STRATEGIES

HCUP: All Payer Readmissions

condition	Discharges	Readmissions	Rate
CHF	847073	209017	25%
sepsis	696122	145896	21%
pneumonia	924160	144894	16%
mood disorder	883245	131125	15%
COPD	606186	126443	21%
complication of device	596062	121036	20%
arrythmia	[illegible]	[illegible]	15%
DM	480958	97784	20%
schizophrenia	397166	88629	22%
AMI	520901	85932	16%
UTI	522921	84858	16%
complications	453266	81353	18%
fluid/lytes	396551	73721	19%
CVA	520793	71174	14%
ARF	326586	70756	22%
cellulitis	576902	64680	11%
chest pain	601899	61465	10%
Gibleed	320613	54154	17%

The top 20 conditions account for ~25% of readmissions –and doesn't account for comorbid BH, social issues

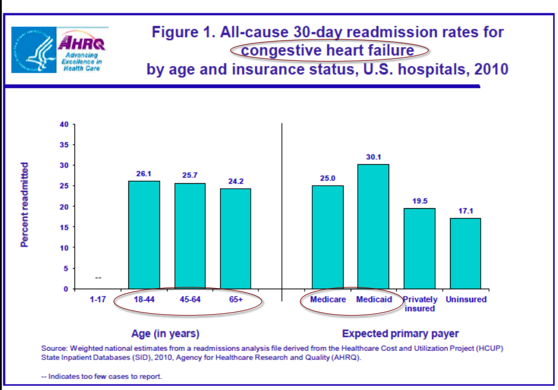
HCUP: All Payer Highest Rates

Table 2. All-cause 30-day readmissions ranked by conditions with the highest readmission rates,* U.S. hospitals, 2010

Rank	Principal diagnosis for index hospital stay **	Number of index stays	30-day all-cause readmissions: Number of readmissions	30-day all-cause readmissions: Percent readmitted
1	Sickle cell anemia	87,326	27,837	31.9
2	Gangrene	33,786	10,693	31.6
3	Hepatitis	37,480	11,593	30.9
4	Disease of white blood cells	54,861	16,771	30.6
5	Chronic renal failure	17,394	4,766	27.4
6	Systemic lupus erythematosus and connective tissue disorders	18,850	5,123	27.2
7	Mycoses	23,026	6,222	27.0
8	HIV infection	34,958	9,230	26.4
9	Screening and history of mental health and substance abuse	60,417	15,695	26.0
10	Peritonitis and intestinal abscess	25,219	6,315	25.0

COLLABORATIVE HEALTHCARE STRATEGIES

HCUP April 2013



H-CUP HEALTHCARE COST AND UTILIZATION PROJECT

AHRQ Agency for Healthcare Research and Quality

STATISTICAL BRIEF #172

April 2014

Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011

Anika L. Hines, Ph.D., M.P.H., Marguerite L. Barrett, M.S., H. Joanna Jiang, Ph.D., and Claudia A. Steiner, M.D., M.P.H.

Methods:
- Used CCS groupers
- Included OB

Top 10 Medicaid Dx:

1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. Comp. of pregnancy
5. Alcohol-related
6. Early labor
7. CHF
8. Sepsis
9. COPD
10. Substance-use related

Top 10 Medicare Dx:

1. CHF
2. Sepsis
3. Pneumonia
4. COPD
5. Arrythmia
6. UTI
7. Acute renal failure
8. AMI
9. Complication of device
10. Stroke

COLLABORATIVE HEALTHCARE STRATEGIES

State All-Payer by Payer Readmission Analysis

Medicare	Medicaid	Comm.	Unins.	Total
ARF (1384)	Sickle Cell (478)	Chemo (290)	Pancreatitis (187)	Sepsis (1859)
Sepsis (1366)	Sepsis (175)	CVA (276)	Chemo (157)	ARF (1800)
PNA (1336)	Chemo (175)	Arthritis (260)	DKA (136)	PNA (1750)
COPD (1211)	COPD (173)	Sepsis (222)	CVA (125)	CVA (1622)
CVA (1140)	DKA (156)	PNA (188)	COPD (109)	COPD (1608)
UTI (1038)	PNA (145)	ARF (182)	ARF (97)	UTI (1608)
Afib (851)	ARF (137)	CAD (181)	Sepsis (96)	HF (1115)
HF (822)	HF (129)	Pancreatitis (153)	PNA (81)	CAD (1092)
CAD (746)	Pancreatitis (127)	Afib (152)	ETOH w/d (76)	Afib (1092)

COLLABORATIVE HEALTHCARE STRATEGIES

Method: DRG, age>18, exclude OB

Medicaid Readmissions at a Community Hospital

- COPD 29%
- Alcohol withdrawal 21%
- Pneumonia 18%
- Pancreatitis 24%
- Poisoning 24%
- Major Depression 29%
- Acute Resp.Failure 67%
- Acute Renal Failure 27%
- Arrhythmias 43%
- Cirrhosis 25%

COLLABORATIVE HEALTHCARE STRATEGIES

County Hospital Readmission Stats

Measure	#	%
Total Discharges	11,850	
Total Medicare Discharges	967	8% total
Total (adult non-ob) Medicaid Discharges	4,288	36% total
Total 30-day Readmissions	1,631	14% RA rate
Total Medicare Readmissions	154, 9% total	16% RA rate
Total (adult-non-ob) Medicaid Readmissions	823, 50% total	19% RA rate

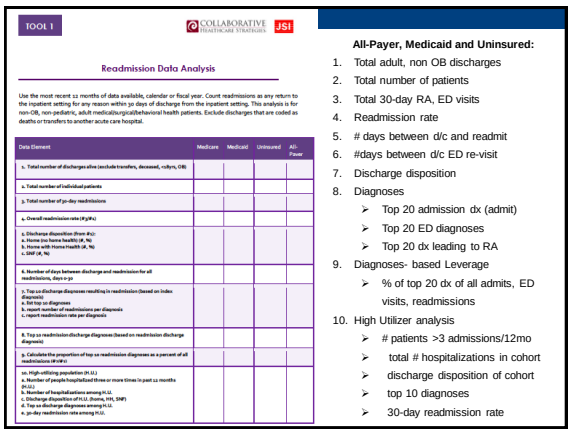
Medicaid RA are 35% higher than all-payer RA
Medicaid RA account for 50% of ALL Readmissions

COLLABORATIVE HEALTHCARE STRATEGIES

Medicare v. Medicaid –Discharge Disposition

Measure	Medicare	Medicaid
Discharge to Home	55%	84%
Discharge to SNF/IRF/LTAC	24%	5%
Discharge to Home with Home Health	14%	8%
Other	7%	3%

COLLABORATIVE HEALTHCARE STRATEGIES


TOOL 1

COLLABORATIVE HEALTHCARE STRATEGIES JSI

Readmission Data Analysis

Use the most recent 12 months of data available, calendar or fiscal year. Count readmissions as any return to the inpatient setting for any reason within 30 days of discharge from the inpatient setting. This analysis is for non-OB, non-pediatric, adult medical/surgical/behavioral health patients. Exclude discharges that are coded as deaths or transfers to another acute care hospital.

Data Element	Medicare	Medicaid	Uninsured	All-Payer
1. Total number of discharges alive (exclude transfers, deceased, <18yrs, OB)				
a. Total number of individual patients				
3. Total number of 30-day readmissions				
4. Overall readmission rate (#3/#1)				
5. Discharge disposition (from #1): a. Home (no home health) (#, %) b. Home with Home Health (#, %) c. SNF (#, %)				
6. Number of days between discharge and readmission for all readmissions, days in yr				
7. Top 10 discharge diagnoses resulting in readmission (based on index discharge): a. list top 10 diagnoses b. report number of readmissions per diagnosis c. report readmission rate per diagnosis				
8. Top 10 readmission discharge diagnoses (based on readmission discharge diagnosis)				
9. Calculate the proportion of top 10 readmission diagnoses as a percent of all readmissions (#10/#1)				
10. High-utilizing population (H.U.) a. Number of people hospitalized three or more times in past 12 months (H.U.) b. Number of hospitalizations among H.U. c. Discharge disposition of H.U. (home, HH, SNF) d. Top 10 discharge diagnoses among H.U. e. 30-day readmission rate among H.U.				

All-Payer, Medicaid and Uninsured:

1. Total adult, non OB discharges
2. Total number of patients
3. Total 30-day RA, ED visits
4. Readmission rate
5. # days between d/c and readmit
6. #days between d/c ED re-visit
7. Discharge disposition
8. Diagnoses
   - Top 20 admission dx (admit)
   - Top 20 ED diagnoses
   - Top 20 dx leading to RA
9. Diagnoses- based Leverage
   - % of top 20 dx of all admits, ED visits, readmissions
10. High Utilizer analysis
    - # patients >3 admissions/12mo
    - total # hospitalizations in cohort
    - discharge disposition of cohort
    - top 10 diagnoses
    - 30-day readmission rate

ASK YOUR PATIENTS "WHY"

Interview patients, caregivers for the "story behind the chief complaint"

COLLABORATIVE HEALTHCARE STRATEGIES

Understand the "story behind the chief complaint"

- 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.
- 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with pneumonia.
- 32M with uncontrolled DM, cognitive limitations, bipolar disorder, active substance use, homeless presents with flank pain to one hospital, readmitted with chest pain to another hospital

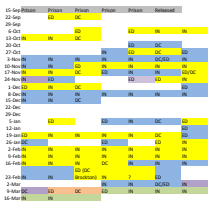
Chart reviews and administrative analyses will NOT reveal what you need to know: you must talk to your patients, their families and caregivers, providers

COLLABORATIVE HEALTHCARE STRATEGIES

Root Cause of Chest Pain Admission: Shelter

"I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don't do that and they kick you out every morning. I need a stable residence and no one is able to help with that."

Acute Care Utilization over 180 days of freedom



COLLABORATIVE HEALTHCARE STRATEGIES

There is Never One Reason for Readmission…..

- KP team reviewed 523 readmissions across ~14 hospitals:
  - 250 (47%) deemed potentially preventable
  - Found an average ***of 9 factors*** contributed to each readmission
- Assessed factors related to 5 domains:
  - 73% - care transitions planning & care coordination
  - 80% - clinical care
  - 49% - logistics of follow up care
  - 41% - advanced care planning & end of life
  - 28% - medications
- 250 readmissions identified 1,867 factors!

COLLABORATIVE HEALTHCARE STRATEGIES

Feingenbaum et al Medical Care 50(7): July 2012

Return Visits to the Emergency Department: The Patient Perspective

Kristin L. Rising, MD, MS[a]; Kevin A. Padrez, BA; Meghan O'Brien, MD, MBE; Judd E. Hollander, MD; Brendan G. Carr, MD, MA; Judy A. Shea, PhD

- Interviewed 60 patients who returned to ED after d/c from ED <9days
  - Average age 43 (19-75)
  - Majority had a PCP, but cited ED gave more tests, quicker answers, single site and ED more likely to treat the symptoms
  - Most reported no problem filling medications
  - 19//60 thought they didn't get prescribed the medications they needed (pain)
  - 24/60 expressed concerns about clinical evaluation and diagnosis
- Primary reason for returning:

  fear and uncertainty about their condition

- Patients need more reassurance during and after episodes of care
- Patients need access to advice between visits

COLLABORATIVE HEALTHCARE STRATEGIES

Annals of Emergency Medicine

DESIGN A PORTFOLIO OF STRATEGIES

There is no single bullet; we are engaged in system transformation

COLLABORATIVE HEALTHCARE STRATEGIES

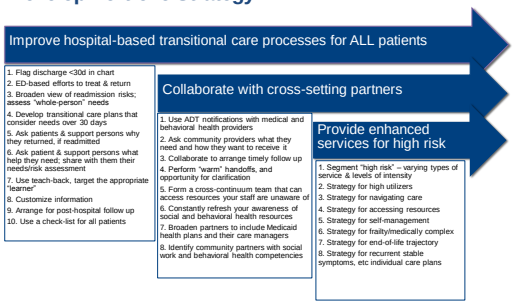
Develop A Multifaceted Portfolio of Efforts

- Improve hospital-based care processes for all patients, including ED
- Collaborate with cross-setting partners, including payers
- Provide enhanced services

Use data, analytics, flags, workflow prompts, automation, dashboards to support continuous improvement, ensure reliability, drive to results

COLLABORATIVE HEALTHCARE STRATEGIES

Develop Portfolio Strategy



COLLABORATIVE HEALTHCARE STRATEGIES

1. IMPROVE STANDARD CARE FOR ALL

All patients, not just high risk patients

COLLABORATIVE HEALTHCARE STRATEGIES

Improve Standard Hospital-Based Processes

CMS Issued Updated Discharge Planning Conditions of Participation May 2013 that require hospitals demonstrate the following:

1. **Have a process**
2. **Know your data;** track rates & review readmissions
3. **Assess & reassess** patients for post-hospital needs
4. **Engage patients and caregivers**
5. **Teach** self-care to patients & caregivers
6. **Provide** a written discharge plan for all inpatients
7. **Communicate** effectively with "receiving" providers
8. **Know** the capabilities of area providers, including support services
9. **Arrange** for post-acute services, including support services

COLLABORATIVE HEALTHCARE STRATEGIES

2. COLLABORATE ACROSS SETTINGS

Hospitals don't need to provide everything…

COLLABORATIVE HEALTHCARE STRATEGIES

Know Your Cross-Continuum Partners

- *While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care **capabilities** of **area long term care facilities** and to factor this knowledge into the discharge planning evaluation.*
- *Hospitals are expected to have knowledge of the **capabilities** and capacities of not only of long term care facilities, but also of **the various types of service providers** in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented.*
- *This includes knowledge of **community services**, as well as familiarity with available Medicaid home and community- based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients.*

COLLABORATIVE HEALTHCARE STRATEGIES

From CMS Conditions of Participation May 2013

ED –Health Center – Community Mental Health Center

- ED based Behavioral Health "Navigator" position to:
  - Intensively coordinate & improve access to outpatient care
  - Re-design ED workflows for referrals between all 3 entities
  - Design standing orders for frequent BH ED users
  - Establish individualized care plans
- Impact: successful linkage to care for frequent users
  - 1 patient who had 26 ED visits in March has had no ED visits since May!
- Time to implement: 10 weeks.

COLLABORATIVE HEALTHCARE STRATEGIES

ED - SNFs: Treat-and-Return

- Hallmark Health System
  - 2 hospital system, 70% admits via ED, hospitalists
  - 20 ED docs, 17 PAs
- ED Chief and Champion of this work explored myths of SNFs/EDs
  - Patients only seen once a month; can't do IVs, etc
  - "ED admits everyone"
- Actions:
  - Discussion "why"
  - Education: our capacity/their capacity
  - Simplicity : establish contacts, standard transfer information
  - Feedback
- Results: increase in number of patients transferred from ED to SNF

COLLABORATIVE HEALTHCARE STRATEGIES

Source: Dr Steven Sbardella, CMO and Chief of ED Hallmark Health System Melrose, MA

3. PROVIDE ENHANCED SERVICES

Best "transition out" of the hospital will not suffice for some patients

COLLABORATIVE HEALTHCARE STRATEGIES

Enhanced Care: Social Workers

- BRIDGE – Social work-based transitional care model
  - Assess "person in context"
  - Make contact in hospital; reassess at 24-48h after going home, as needs change/emerge; reassess periodically over 30d
  - Observation: Don't require / use additional "slush funds" for transitional care – they are adept at getting patient linked to existing services (Medicaid waiver, AAA, ADRC, etc)
  - Observation: Don't medicalize social complexity – "work the case" and refer for services, follow up, advocate for the patient, but don't "escalate" care medically when they encounter barriers

COLLABORATIVE HEALTHCARE STRATEGIES

"High Risk Care Teams"

- Multidisciplinary team
  - NP / MD (who can facilitate urgent clinical eval if needed)
  - Care manager (RN)
  - Social Work
  - Pharmacist
  - Navigators, coordinators
- Address full complement of medical, social, logistical needs
  - Navigating the healthcare system, asking questions, making appointments
  - Focus on psychosocial issues
  - Coordinating among clinicians, service providers, between settings
- Identify using combination of clinical and non-clinical criteria
  - History of high utilization, no PCP, numerous prescribers, numerous meds, behavioral health comorbidities, homeless….not "just" chronic disease

COLLABORATIVE HEALTHCARE STRATEGIES

46-study Meta-Analysis: What Works?

Preventing 30-Day Hospital Readmissions
A Systematic Review and Meta-analysis of Randomized Trials
Leppin et al; JAMA Internal Medicine (online first) May 12 2014

- Review of 42 published studies of discharge interventions
- Found that multi-faceted interventions were 1.4 times more effective
  - Many components
  - More people
  - Support patient self-care
- Interventions published more recently had fewer components are were found to be less effective

http://archinte.jamanetwork.com/article.aspx?articleid=1868538

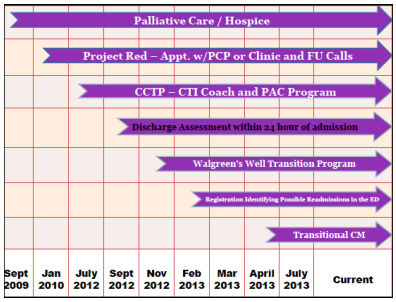
COLLABORATIVE HEALTHCARE STRATEGIES

2 HOSPITALS' PORTFOLIO STRATEGIES

Valley Baptist Medical Center, Harlingen TX
Frederick Memorial Hospital, Frederick MD

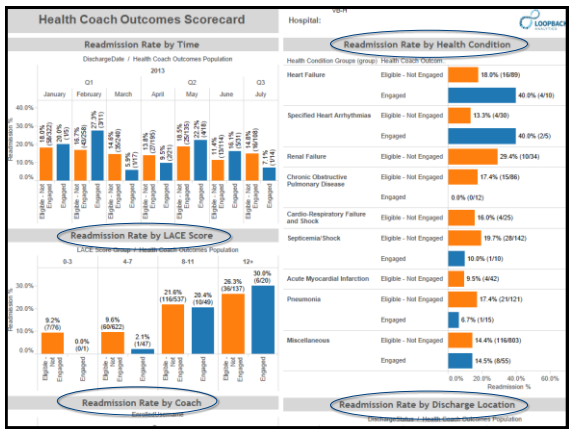
COLLABORATIVE HEALTHCARE STRATEGIES

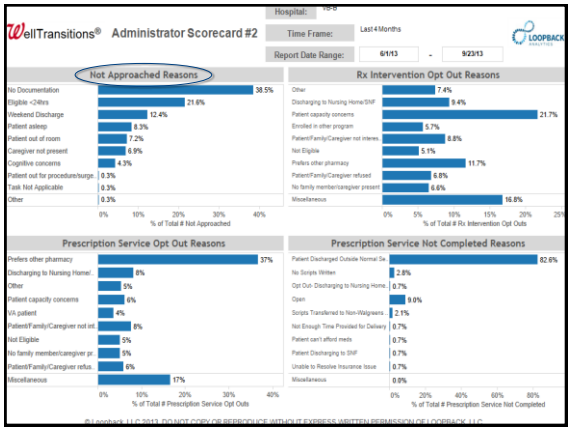
Valley Baptist Medical Center's Portfolio of Strategies



COLLABORATIVE HEALTHCARE STRATEGIES

Courtesy of Angela Blackford, VBMC





Valley Baptist Medical Center - Results

All-cause readmissions	Medicare Penalty
• FY 2011: 28%	
• FY 2013: 21%	0.8% (of possible 1%)
• FY2014: 14%	0.2% (of possible 2%)
• FY 2014:	0.04% (of possible 3%)

BY THE WAY, THAT'S A 50% REDUCTION!!!

COLLABORATIVE HEALTHCARE STRATEGIES

Frederick Memorial Hospital - Portfolio

- **Improve Standard Hospital-based Processes**
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8B to "behavioral interview"
- **Collaborate with Providers**
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly "co-management" virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed
- **Provide Enhanced Services to High Risk**
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team "works the case" x 30+ days
  - Cardiology NP "Heart Bridge Clinic"

COLLABORATIVE HEALTHCARE STRATEGIES

Frederick Memorial Dashboard

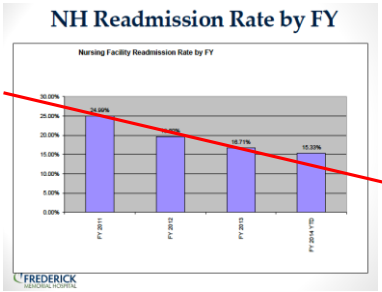
CARE TRANSITIONS PERFORMANCE DASHBOARD

COLLABORATIVE HEALTHCARE STRATEGIES

Frederick Memorial Dashboard-2

COLLABORATIVE HEALTHCARE STRATEGIES

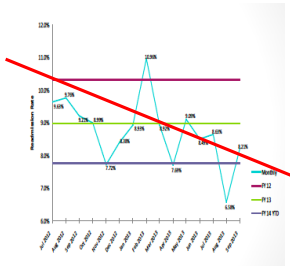
SNF Readmissions, Frederick Memorial



COLLABORATIVE HEALTHCARE STRATEGIES

Courtesy of Heather Kirby

3-year results, Frederick Memorial



All-payer all cause readmissions

FY 12 10.6%

FY 13 9%

FY 14 7.8%

COLLABORATIVE HEALTHCARE STRATEGIES

Recommendations

- Know your data and your patients
- Adopt a broad concept of readmission risk
  - Capture all reasons, whole-person approach
- Develop a multifaceted strategy
  - Improve standard hospital-based care for ALL patients
  - Start in ED
  - Collaborate across settings with multi-sector partners
  - Provide enhanced services
- Use technologies to make work better, quicker, automated

COLLABORATIVE HEALTHCARE STRATEGIES

THANK YOU

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
Lexington, Massachusetts

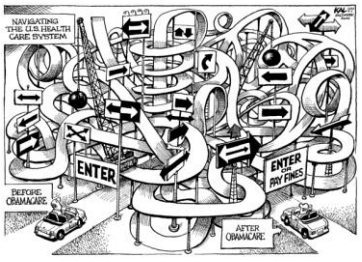
COLLABORATIVE HEALTHCARE STRATEGIES

Patient Centered Care Transition Strategies

H2H Here to Home

Griffin Health Services Corporation
Griffin Hospital

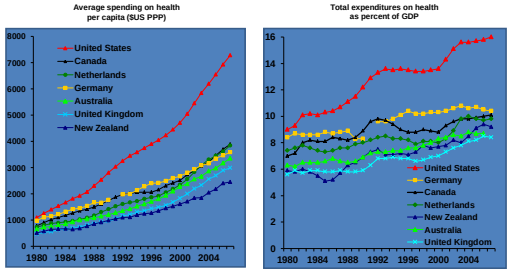
Is it me…
or has health care delivery gotten harder?



"May you live in interesting times"

危机

What's driving the change?



The response has been (unsurprisingly) predicable

More than **24.7%** of Medicare patients are readmitted within **30 days** of discharge.

Medicare currently spending **$17 billion** per year on readmissions

Griffin's Cost of Readmissions 2013

SUMMARY ANALYSIS

Estimated Penalty Percentage: 1%

Estimated Net Revenue Change: - $ 277,540

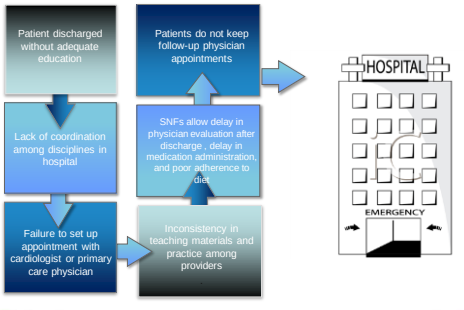
Condition	Crude National Rate	Excess Ratio*	Eligible Volumes
Acute Myocardial Infarction	19.7%	1.11	118
Heart Failure	24.7%	1.13	385
Pneumonia	18.5%	0.95	273

Houston… We have a problem

INSERT YOUR CFO HERE

We Need to Meet Patients at Their Level

The Vicious Cycle of Chronic Disease Readmission



We've got to stop labeling patients

"Non-compliant"

Why do our medical "Frequent Flyers" keep returning?

Pop Quiz

What is a stronger predictor of a person's health than age, income, employment status, educational level, and race?

Pop (Compliance) Quiz

Who here has been "compliant" each day, every day with:

- Eating a 2,000 calorie diet…
- … including 9 servings of fruits and vegetables (4 ½ cups)
- Getting 30 minutes of exercise
- Flossing daily
- Getting 8 hours of sleep
- Wearing your seatbelt
- Observing the speed limit

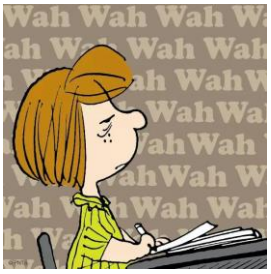
Assessing the ROI

But for our patients, there's more to it…

How Much Do Patients Really Understand?

- 71% of older adults have difficulty using print materials
- 80% have difficulty using documents such as forms or charts
- 68% have difficulty interpreting numbers
- 2/3 are unable to understand information given to them about their prescriptions
- 90 million people – nearly half the US adult population – lack health literacy skills needed to understand and act on health information

What Patients Hear…



HCAHPS

Being Mindful of Transitions of Care Questions

Addition of Two Software Modalities

Project RED

Transitions Advantage

Project RED

(Re-Engineered Discharge)

Patient Education for 4 Diagnosis

Nursing Alerts for Patient Understanding

Comprehensive Patient Centered After Hospital Care Plan (AHCP)

- Medication reconciliation
- Follow-up appointments
- Outstanding tests
- Post-discharge services
- What to do if a problem arises
- Discharge summary sent to PCP
- Telephone reinforcement

RED

After Hospital Care Plan

JOHN SMITH

Griffin Hospital's 'Here to Home' Program

LEFT HOSPITAL: 2/18/2013

Griffin Health Services Corporation
Griffin Hospital

URGENT HEALTH CONCERN?
CALL YOUR DOCTOR:
Dr. Christian Jones, M.D.
(206) 555-6678

MEDS TO GO:
Griffin Pharmacy & Gifts
(203) 732-1490

CARE PLAN QUESTIONS?
CALL (203) 732-7150
UNIT 1NO

BRING THIS PLAN TO ALL MEDICAL APPOINTMENTS

My Medicine

Bring all of your medicines (in their bottles) to your doctors' appointments

What do I need to take?	Why am I taking this?	How do I take this?	How much do I take?	When do I take this?
NEW CARVEDILOL (COREG)	BLOOD PRECURE	BY MOUTH LAST DOSE: 10/3/2013 10:00 AM	12.5 MG	2 TIMES A DAY
AMLODIPINE (NORVASC)	BLOOD PRECURE	BY MOUTH LAST DOSE: 10/2/2013 3:52 PM	10 MG	ONCE A DAY
ASCORBIC ACID (VITAMIN C)	VITAMIN	BY MOUTH LAST DOSE: 10/3/2013 10:00 AM	500 MG	ONCE A DAY
ASPIRIN (BABY ASPIRIN CHEW TABLET)	BLOOD THINNER	BY MOUTH LAST DOSE: 10/3/2013 10:00 AM	81 MG	ONCE A DAY
CHOLECALCIFEROL (VITAMIN D)	BONE STRENGTH	BY MOUTH	1000 UNITS	ONCE A DAY

My Appointments

Important information about my appointments

PRIMARY CARE PHYSICIAN	HOME VISIT	
CALL TO SCHEDULE	CALL TO SCHEDULE	CALL TO SCHEDULE
Roger Rabbit, MD	Beck'n Call Home Care	Peter Pan, MD
To follow-up with your doctor	To make sure your health is getting better	To make sure your health is getting better
	800-999-9999	888-888-8888
CALL TO SCHEDULE	Monday, September 30, 2013 12:30 PM	
Robin Hood, MD	Robin Hood, MD	
To make sure your health is getting better	To make sure your health is getting better	
(777)777-7777	(777)777-7777	

Meet Louise

Project RED Discharge Education

Testimonial

TransitionAdvantage™ Service: A Solution for Primary Causes of Preventable Readmissions

Connectivity Across Extended Care Team
- Electronic Patient Profile (EPP)
- Daily Health Check

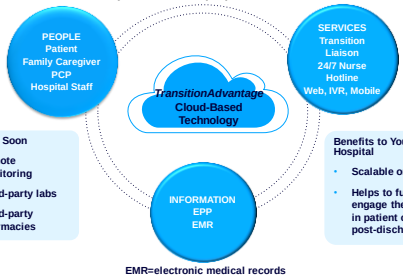
Innovative Digital Communications
- Dashboards with charts, graphs, and alerts
- Web, IVR, and mobile applications

Transition Liaison
- Daily check-in
- Medication management services
- Family caregiver communication/engagement
- Customer service coordination
- Transportation arrangements

24/7 Access to Advice
- Nurse Hotline

The TransitionAdvantage™ Cloud-based Technology

Enables connectivity across critical people, services, and information



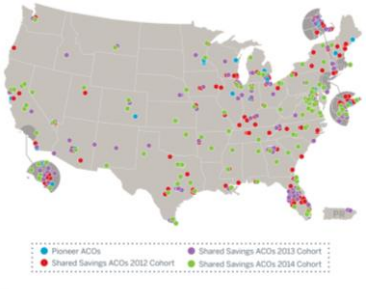
Coming Soon
- Remote monitoring
- Third-party labs
- Third-party pharmacies

Benefits to Your Hospital
- Scalable on demand
- Helps to further engage the PCP in patient care post-discharge

EMR=electronic medical records
EPP=electronic patient profile
IVR=interactive voice response (automated phone call for information capture)
PCP=primary care physician

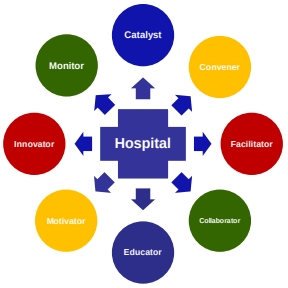
How Accountable Care Is Redefining the Role of Hospitals

Beyond Penalties, the “shared savings” imperative

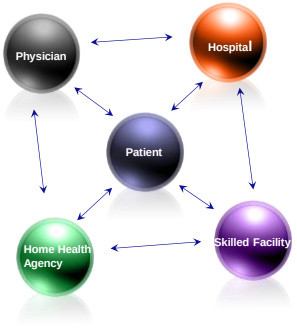


- 52% of the US Population is living in a primary care service area with an ACO
- 14% of the US population is treated by an ACO
- 5.5M Medicare FFS beneficiaries are treated by an ACO

To Be Effective in an Accountable Care Environment Hospitals Must Take on New Roles



Valley Gateway to Health Solutions

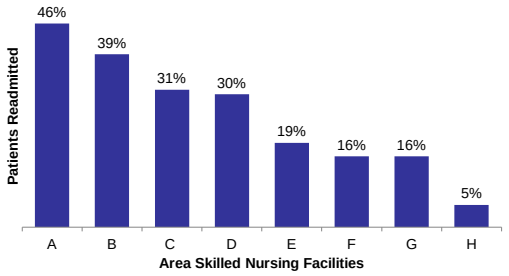


Valley Gateway to Health

VG2H

- Skilled facilities with the highest readmission rates/volume for HF were invited to join Griffin in a coalition to reduce preventable readmissions in December 2009
- In February 2010, Home Health Agencies with the highest readmission rates/volume were invited into the collaborative
- In May, 2010 Griffin joined forces with the CT QIO and hospital association in a state wide collaborative to reduce readmissions for HF state wide

30-day readmission rates for CHF by SNF October 2007 – March 2009



VG2H Mission

To partner with the patient, care partner, his/her physicians, home care agencies and skilled facilities to improve the transition to post hospital care by providing "same page" care to patients across the continuum, focusing on medication compliance, dietary restrictions, weight monitoring and exercise with the goal of improving the quality of life for those we serve and to help them avoid preventable readmissions.

The Hospital Focus

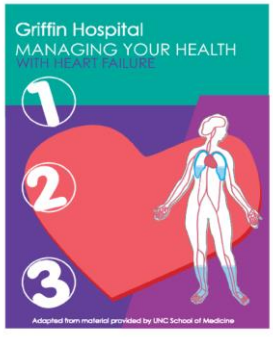
- Better Discharge Planning
  - Shared Teaching Tool utilizing 4th grade literacy
  - "Teach Back" by patients
  - Adding patient's dry weight to the W-10
  - Core Measures Checklist
  - Provide copy of H&P to Home Care Agencies
  - Follow-up M.D. appointments made before discharge

The Hospital Focus

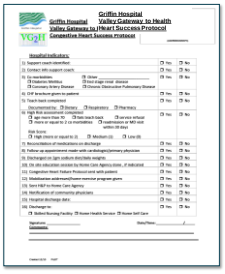
- HF protocol included in discharge packet for next provider
- Scales provided for home care patients
- Nurse to nurse hand-off report via telephone
- M.D. to M.D. telephone report for high risk patients
- Shared teaching tool “Managing Your Health with Heart Failure”
- Follow-up phone calls 48 hours post discharge and weekly x4

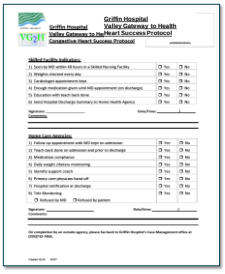
VG2H

Managing Your Health with Heart Failure



Heart Success Protocol





The Skilled Facility

- Stock frequently used medications for CHF
- Shared teaching tool “Managing your Health with Heart Failure”
- Utilize “Teach Back” methodology
- Reinforce salt restriction and daily weights
- Assessment by physician within 48 hours
- Hand off Report to Home Care Agency upon discharge
- Provision of prescriptions to patient on discharge
- Follow-up appointment made with physician prior to discharge. Utilize “Heart Success Protocol”

VG2H

The Home Care Agency

- Coordination of transportation to follow-up appointments
- Shared teaching tool “Managing Your Health with Heart Failure”
- Ensure that patient has enough medications to last until MD appointment
- Provide patient with scale if indicated and monitor weights
- Refer end of life care to hospice as indicated
- Utilize Heart Success Protocol
- Provide on-site visits as requested

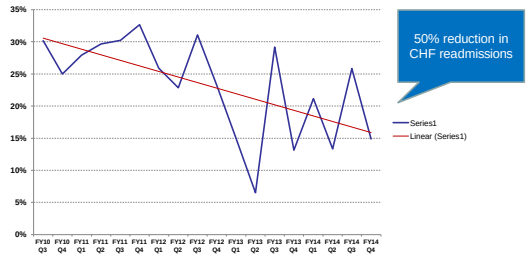
VG2H

Current State of Collaborative

- Shared Best Practices
- Expansion of shared teaching tool and protocols for diagnoses of AMI, Pneumonia and COPD
- Monthly collaborative review of readmissions
- Enrollment in Griffin’s Heart Wellness Clinic and Transition Advantage
- Sharing readmission rates and publically reported outcomes
- Increased education for Advanced Directives

VG2H

Griffin Hospital Readmission Rates for Heart Failure (HF) Within 30 days



Future State of Collaborative

- Expansion of focus to other chronic diseases
- Creating preferred community partnerships with shared pathways
- Creation of physician rounding in skilled facility

Overall goal: Create a smooth seamless transition from

"HERE TO HOME"

H2H Here to Home

Transitioning to a "Preferred Partner" Model

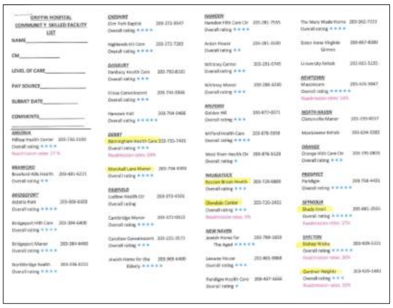
Remaining High Quality/Low Cost will require change

New ACO model requires community resources to work together

Strong partnerships required with patient at the center of all care transitions

Shared accountability for care outcomes

From this…



To This…

Highlighting our Preferred Partners in Care

Preferred Partners

Objective criteria for designation; commitment to develop collaborative care pathways and meet quality goals

Facility-level data, including:

Overall Quality Rating (nursinghomecompare.gov)

All-Cause Readmission Rate

What's Next?

Patient Preference Passport

NATIONAL QUALITY FORUM

Planetree Passport Verison1.0 based on the National Quality Forum Version 1.0 created in partnership with the Patient and Family Engagement Action Team convened by National Quality Forum.

Doctella

Partners on Your Road to Recovery

Dr. Peter Pronovost
Dr. VP for Patient Safety and Quality, Johns Hopkins
Dir of the Armstrong Institute for Patient Safety Quality

JOHNS HOPKINS MEDICINE

BWH

Dr. Adil Haider
Associate Professor
Director, Center for Surgery and Public Health
Brigham and Women's Hospital Center
Formerly with Johns Hopkins

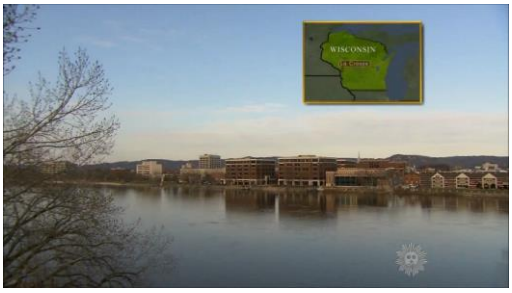
JAMA Media Briefing:
Theme Issue on
Comparative Effectiveness Research

"If a new drug were as effective at saving lives as Peter Pronovost's checklist, there would be a nationwide marketing campaign."

Dr. Atul Gawande, Professor of Surgery at Harvard, author of best-selling book Checklist Manifesto

Technology to Support Patient Engagement with Care Providers

Digitizing the Patient Passport



Thank You

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H2 Here to Home™