



---

# Improving Safe Transitions Across the Continuum of Care

November 28<sup>th</sup> , 2012, 0900-1000

**Suneela Nayak MS RN**

Clinical Quality Improvement Specialist MaineHealth  
Center for Quality and Safety

MaineHealth

# Learning Points

---

- Why focus on Care Transitions?
- What are Best Practices for Improved Transitions?
- What is the MaineHealth Transitions of Care Program?
- What lessons have we learned?

# Victor's Story

- **72 year old male with extensive medical history**
- **Well known to the hospital staff**
- **13 medical problems and 19 daily medications**
- **In the past year :**
  - Admitted 5 times for pneumonia, weakness, hypoglycemia, fall
  - Presents to ED with syncope

# Past Medical History

## Diagnoses

- **Benign prostatic hyperplasia (BPH )**
- **Hypertension (HTN )**
- **Hyperlipidemia (HLD )**
- **Coronary Artery Disease (CAD )**
- **Gastroesophageal reflux disease (GERD)**
- **Diabetes Type 2**
- **Depression**
- **Insomnia**
- **Chronic back pain**
- **Chronic fatigue**
- **Recent forgetfulness, not been fully worked up**

# Victor's Health Goals

---

- Wishes to stop being so forgetful
- Would like to decrease the amount of daily medications he takes
- Would like to have more energy and motivation to play with his grandchildren during the day,
- Would like to get adequate rest at night

# CURRENT:

## 19 Medications: 3-4 times/day

- Acetaminophen PM 500mg/25mg qhs
- Furosemide 40mg qam
- Acetaminophen 650mg tid
- Glyburide 10mg bid
- Amitriptyline 25mg qhs
- Metformin 500mg bid
- Amlodipine 5mg qam
- Methylphenidate 10mg qam and qnoon
- Aspirin EC 81mg qam
- Omeprazole 20mg qam
- Bupropion SR 300mg qhs
- Pregabalin 50mg tid
- Carvedilol 12.5mg q12h
- Simvastatin 40mg qhs
- Captopril 12.5mg tid
- Terazosin 10mg qam
- Cyclobenzaprine 10mg tid
- Trazodone 50mg qhs
- Digoxin 0.25mg qam

“Doc, if you think I need it, I’ll take it - but it sure does feels like I take handfuls of medications every single day.”

Victor

# Victor's Hospital Course

---

- Cardiac monitoring and diagnostic testing
- Developed urinary retention and UTI
  - Urology consultation
  - Urologic procedure performed
- Discharged on coumadin, new antibiotic, with urinary catheter



# One week later...

---

- Developed hematuria, urinary retention
- ED Visit
  - Dramatic hematuria with catheter obstruction
  - INR 9.6 (ideal range 2 –3)
  - More urological intervention
- Readmitted
  - Reversal of anticoagulation
- Transfused 6 units of blood

# Questions to Consider

---

- Was this readmission predictable?
- Was this readmission preventable?
- What went wrong with the transitions of care?
- How can we do better?

# Why focus on Care Transitions?

---

- Frequent & costly
- Issue of quality of care and patient safety
- Source of patient & provider dissatisfaction
- Waste increasingly scarce clinical resources

# 2007 MedPac Report

- Medicare Payment Advisory Committee
- Readmissions
  - “sometimes indicators of poor care or missed opportunities to better coordinate care”
  - 17.6% of Medicare patients readmitted within 30 days
  - \$15 billion in annual spending
  - 76% of readmissions potentially avoidable
- Recommended public reporting, payment reform



# The NEW ENGLAND JOURNAL of MEDICINE

[HOME](#)[ARTICLES ▾](#)[ISSUES ▾](#)[SPECIALTIES & TOPICS ▾](#)[FOR AUTHORS ▾](#)

## SPECIAL ARTICLE

### Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D. and Eric A. Coleman, M.D., M.P.H.

N Engl J Med 2009; 360:1418-1428 | April 2, 2009

[Abstract](#)[Article](#)[References](#)[Citing Articles \(44\)](#)[Letters](#)

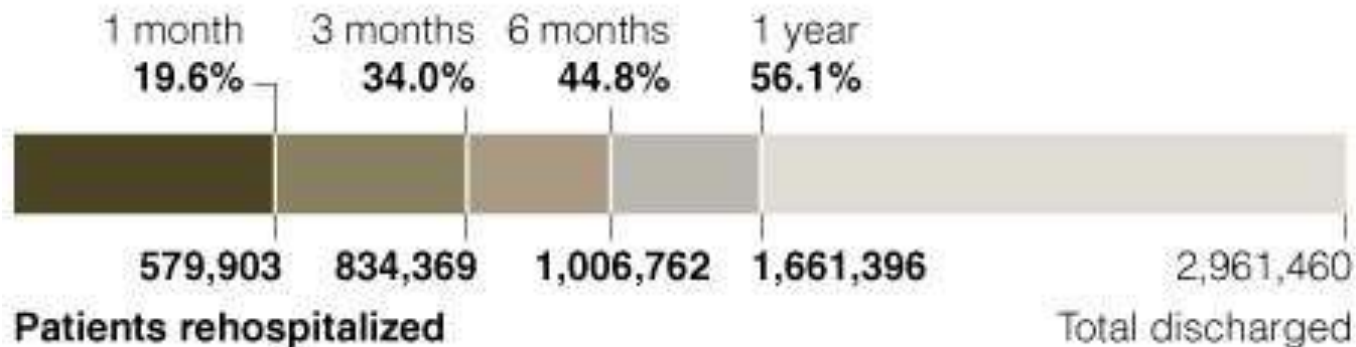
Medicare currently pays for all rehospitalizations, except those in which patients are rehospitalized within 24 hours after discharge for the same condition for which they had initially been hospitalized. Recent policy proposals would alter this approach and create payment incentives to reduce the rates of rehospitalization. The Medicare Payment Advisory Commission (MedPAC) recommended to Congress in its report in June 2008 that hospitals receive from the Centers for Medicare and Medicaid Services (CMS) a confidential report of their risk-adjusted rehospitalization rates and that after 2 years, rates should be published. MedPAC also recommended complementary changes in payment rates, so that hospitals with high risk-adjusted rates of rehospitalization receive lower average per case payments. The commission reported that Medicare expenditures for potentially preventable rehospitalizations may be as high as \$12 billion a year.<sup>1</sup> In July 2008, the National Quality Forum adopted two measures of hospital performance based on the rate of rehospitalization,<sup>2</sup> and the CMS indicated an interest in making the rehospitalization rate a measure for value-based hospital payment.<sup>3</sup> Reducing rehospitalization is an important element of President Barack Obama's February 2009 proposal for financing health care reform.<sup>4</sup> Such proposals would radically change the accountability of hospitals for patients' outcomes after discharge.

## Back to the Hospital

A study of Medicare patients found that nearly a fifth were back in the hospital within a month of being discharged, and more than half within a year. The study looked at almost three million patients discharged from October through December 2003.

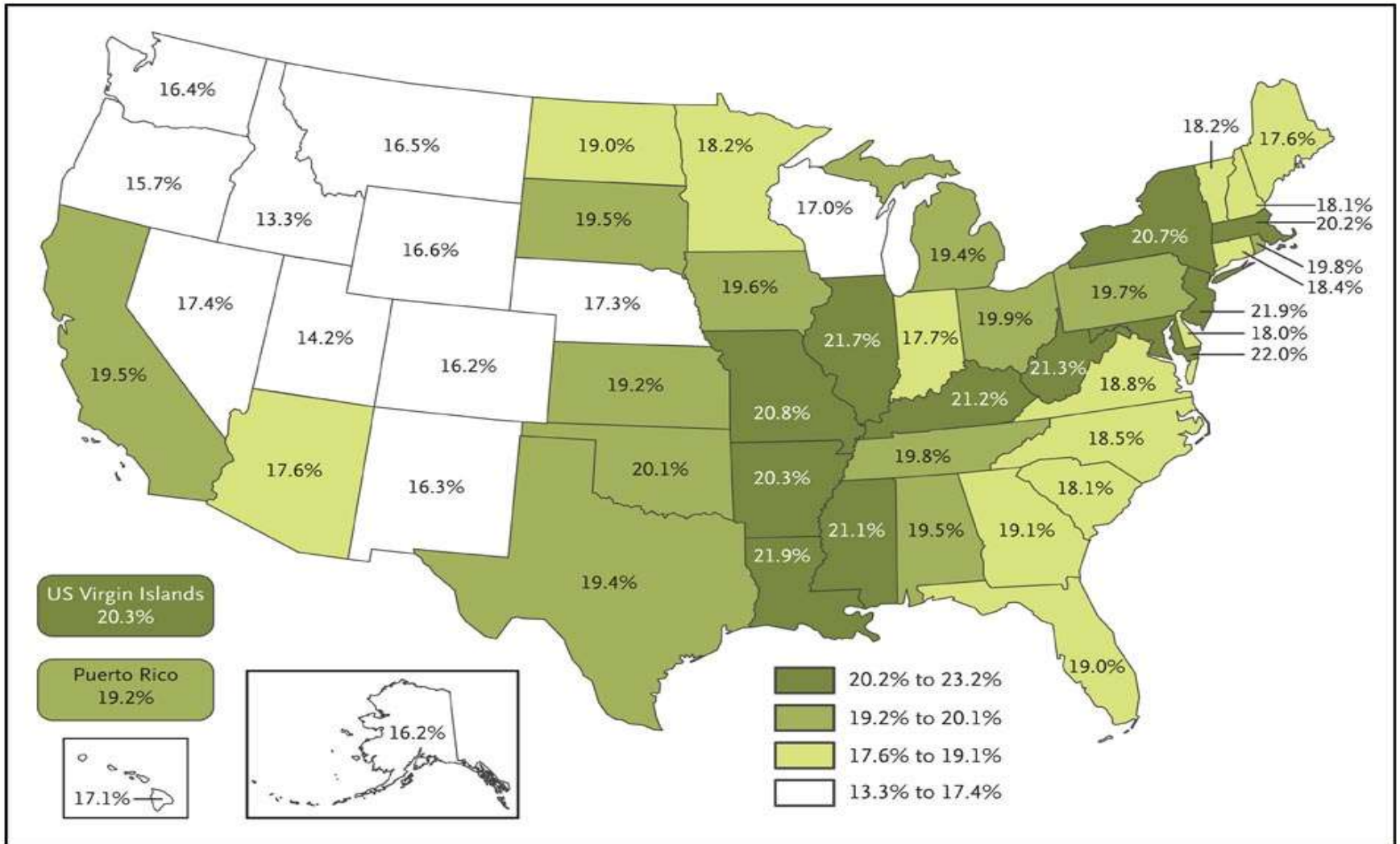
### MEDICARE REHOSPITALIZATION RATE

Cumulative percentage of patients rehospitalized after:



Source: *New England Journal of Medicine*

THE NEW YORK TIMES



# Health Care Reform: Hospitals

---

- Reduce reimbursement for hospitals with high risk-adjusted rates of readmission by 1% a year beginning in 2012 (up to 5% total)
  - 2012 : CHF, pneumonia, AMI
  - 2013: Add COPD, CABG, PTCA, Other vascular procedures, potentially global readmission rate
- Reduce reimbursement to SNF, Home Health when patient under their care readmitted



# Health Care Reform: Physicians

---

- Create new payment code for patient visit within one week of discharge
- Apply payment reductions for physicians who treat a patient during an admission that results in a readmission

# Payment Reform: MaineCare

---

- Reimburse for only one hospitalization when MaineCare patient readmitted to same hospital within 72 hours for the same diagnosis.



# Where to start?

Lots of Data, Best Practice, and  
Tools  
at your fingertips



### Program for Evaluating Payment Patterns Electronic Report

Tuesday, March 15, 2011 Options

- HOME
- PEPPER
- TRAINING & RESOURCES
- DATA
- TOOLS
- FAQ
- TESTIMONIALS
- HELP/CONTACT US
- CMS/MAC/FI
- PEPPER IN THE NEWS

Home

Web Site Search



*"Our hospital uses its PEPPER to identify trends, potential outliers and any significant changes from one quarter to the next."*

Join our e-mail list to receive updates on training and PEPPER distribution.

### Welcome to PEPPER Resources

PEPPERresources.org is the official site for information, training and support related to the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments.

#### Short-term Acute Care Hospitals

- User's Guide (PDF)
- Training & Resources
- Distribution Schedule

#### Long-term Acute Care Hospitals

- User's Guide (PDF)
- Training & Resources
- Distribution Schedule

#### Critical Access Hospitals

- User's Guide
- Training & Resources
- Distribution Schedule

#### Inpatient Psychiatric Facilities

- User's Guide
- Training & Resources
- Distribution Schedule

#### Inpatient Rehabilitation Facilities

- User's Guide
- Training & Resources
- Distribution Schedule

View a demonstration PEPPER (Excel) for short-term acute care hospitals, as well as the expanded list of ST PEPPER target areas (PDF).

View a sample of the new PEPPER (PDF) for long-term acute care hospitals, critical access hospitals, inpatient psychiatric facilities and inpatient rehabilitation facilities. Note: This example shows an LT PEPPER. PEPPERS for CAHs, IPFs and IRFs will follow the same format, but the target areas will be specialized for each setting.

This website is developed and maintained by TMF Health Quality Institute, under contract with the Centers for Medicare & Medicaid Services to provide comparative data reports to hospitals and to Medicare Administrative Contractors/Fiscal Intermediaries in support of efforts to reduce Medicare fee-for-service improper payments. PEPPER was previously distributed to hospitals by their state Medicare Quality Improvement Organization (QIO) in support of the Hospital Payment Monitoring Program. QIOs are no longer involved in providing these reports.



A Research Group at  
Boston University Medical Center



Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality & National Heart, Lung and Blood Institute

- [Home](#)
- [Development of the RED](#)
- [Components of the RED](#)
- [Implementing Project RED](#)
- [Meet Louise...](#)
- [Toolkit](#)
- [Our Team](#)
- [Recognitions](#)
- [Newsroom](#)
- [Presentations](#)
- [Publications & Abstracts](#)
- [Funding](#)
- [Links](#)
- [Receive Updates](#)
- [Contact Us](#)

## Project RED (Re-Engineered Discharge)

Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction. Virtual patient advocates are currently being tested in conjunction with the RED. In addition, Project RED has started to implement the re-engineered discharge at other hospitals serving diverse patient populations.

Project RED is supported by grants from the **Agency for Healthcare Research and Quality** (AHRQ) and the **National Institutes of Health (NIH)-National Heart, Lung and Blood Institute** (NHBLI). The contents of this website are solely the responsibility of Brian Jack, MD and Boston Medical Center and do not necessarily represent the official view of or imply endorsement by AHRQ, the U.S. Department of Health and Human Services, the NIH or NHBLI.

### Latest Project RED News

**Reducing Hospital Readmissions With Enhanced Patient Education (PDF)**  
*Krames Patient Education*  
December 2010

**Change You Should Believe In**  
*The Hospitalist*  
Larry Beresford  
July 2010

**Re-engineering the discharge process to reduce readmissions**  
*Press Ganey*  
Barbara Kirchheimer  
June 22, 2010

**Back in the hospital again**

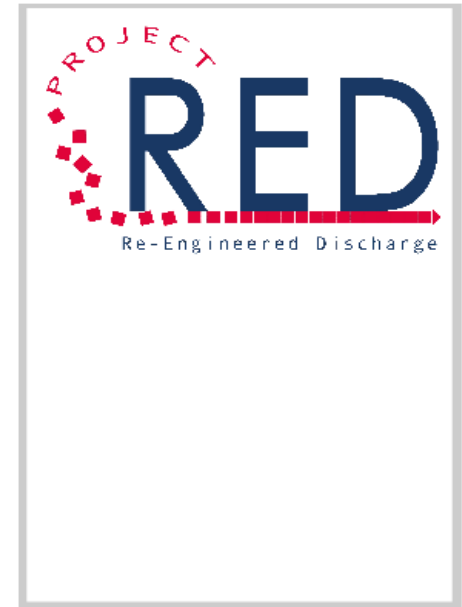


Photo: Glenn Kulbako





- About SHM
- Membership
- Education
- Quality Initiatives
  - > QI Current Initiatives and Training Opportunities
  - > QI Basics
  - > QI Clinical Tools
  - > QI Resource Rooms
  - > Clinical Blog: Hospital Medicine Quick Hits
- Practice Resources
- Advocacy
- Events
- Publications
- News, Media & Blogs

## QUALITY INITIATIVES



# BOOSTing Care Transitions *Resource Room*

Home | Project Team

Professional Development  
Implementation Guide  
Exchange Information

- How to Use
- First Steps
- Best Practices
- Analyze Care Delivery
- Track Performance
- The BOOST Intervention
- Continue to Improve
- Education Resources
- Clinical Tools
- QI Basics



### How Do I Become A BOOST Site?

Steps to apply:





# Reducing Avoidable Readmissions: A Paradigm Shift?

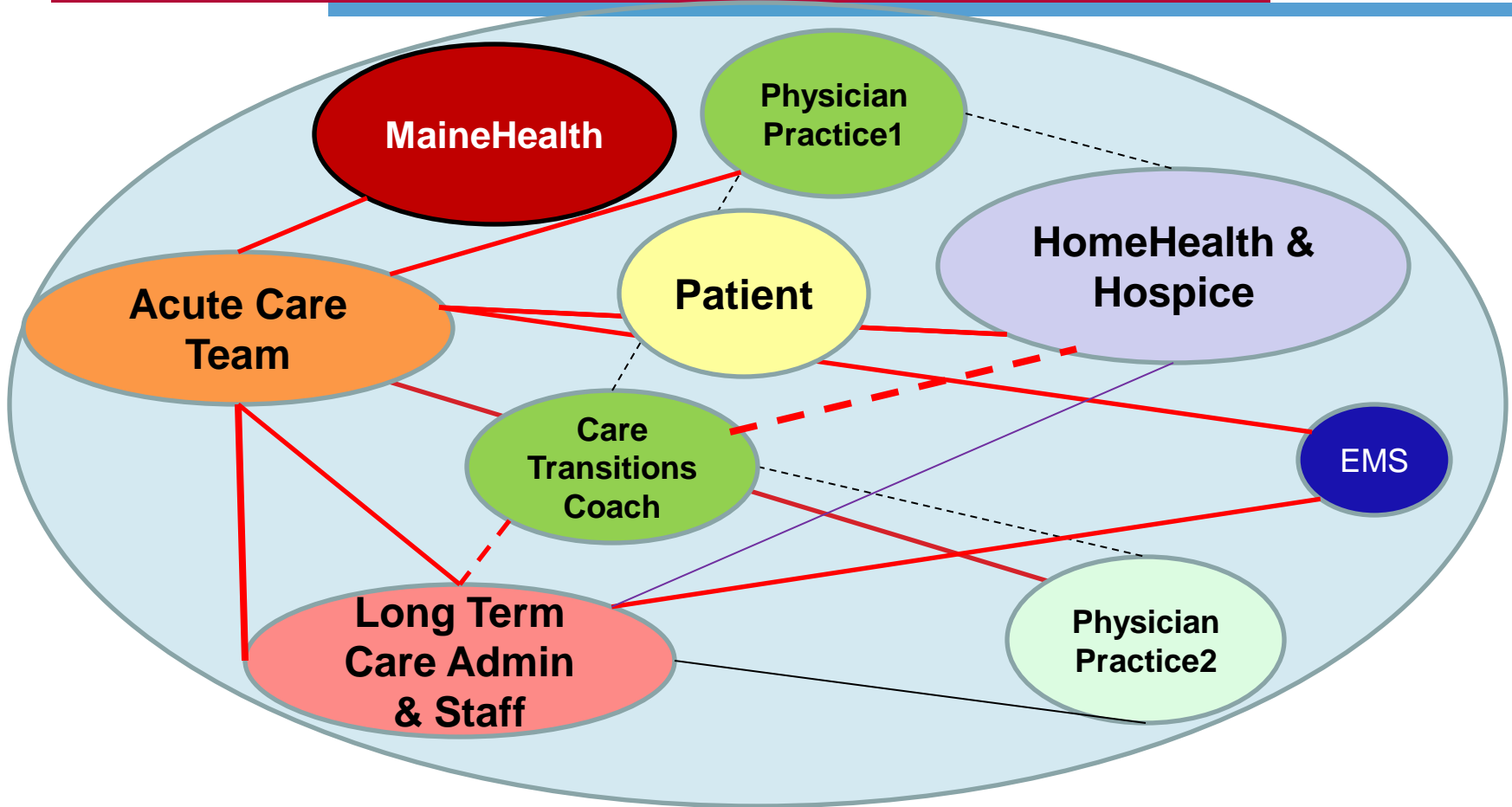
Past Focus	Focus Going Forward
Traditional focus on discharging patients  <i>D/C to home</i>	Facilitating transitions in care with a shift to handoffs (senders and receivers design the process)  <i>Admission to Home (30-day LOS)</i>
Hospital problem	Continuum issue
Focus is on what clinicians are teaching	Focus on what the patient is learning
Patient is the focus of the care team	Patient and defined family are essential members of the care team
Immediate focus on clinical needs	Focus on the whole person and their social situation over time
Focus on patient care needs in various settings	Focus on the patient's experience over time

# MaineHealth Transitions of Care Program Highlights

1. Care Transitions Pilot - Care Transitions Intervention Training, Eric Coleman – **Sept 2006**
2. Readmission Baseline established **2008**
3. Sr. Leadership support for program **2009**
4. Cardinal Grant funding; Establish pilots **2009-10**
5. Transitions of Care Program established **2010**
6. Development of Transitions of Care Bundle **2010**
7. Cross Continuum teams established at each MH hospital **2011**
8. TOC Workgroup convenes first monthly meeting **2011**
9. Multiple collaborative learning sessions and symposia **2009-present**
10. Achieved FY 2012 target of 15.1% - **March 2012**
11. Focus on patients at highest risk, medication safety: **2012-13**



# Cross Continuum Networks



# MaineHealth

## Transitions of Care Bundle

---

1. Risk stratification for readmission
2. Transition Checklist
3. Medication reconciliation
4. Patient/family health education
5. Timely communication among hospital and post-hospital providers
6. Timely follow-up of patients

# 8P Risk for Readmission

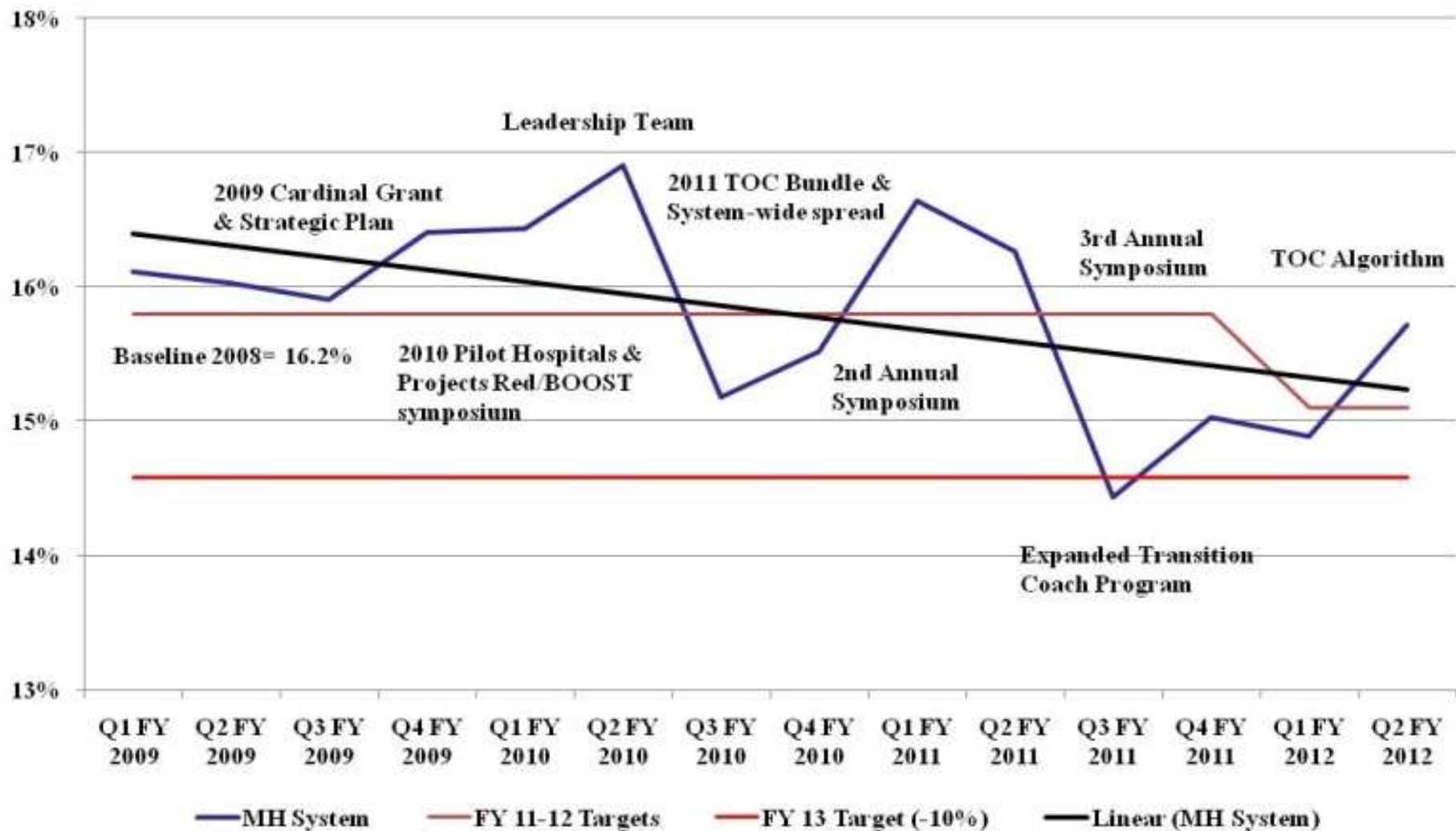
---

1. Prior hospitalization
2. Problem medications
3. Polypharmacy
4. Principal diagnosis
5. Psychological
6. Poor health literacy
7. Patient support
8. Palliative care

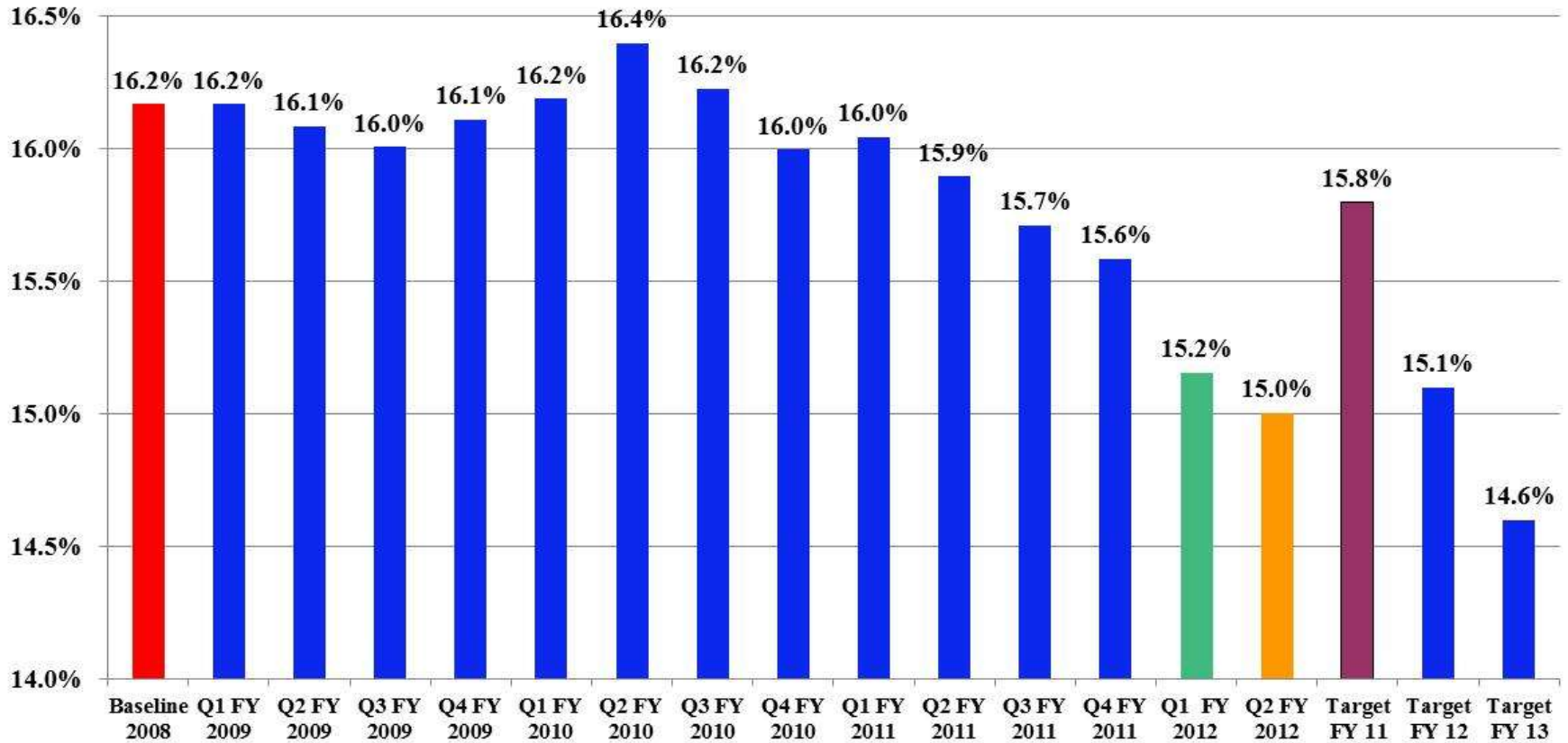


# Outcomes?

## MaineHealth Medicare 30 Day Readmission Rates Q1 FY 2008 - Q1 FY 2012



## MaineHealth Rolling 4 Quarter Medicare 30 Day Readmission Rate



NOTE: CAH data excluded in calculations of system performance

# Victor revisited

(admitted for evaluation of syncopal episode )

## Hospital Course:

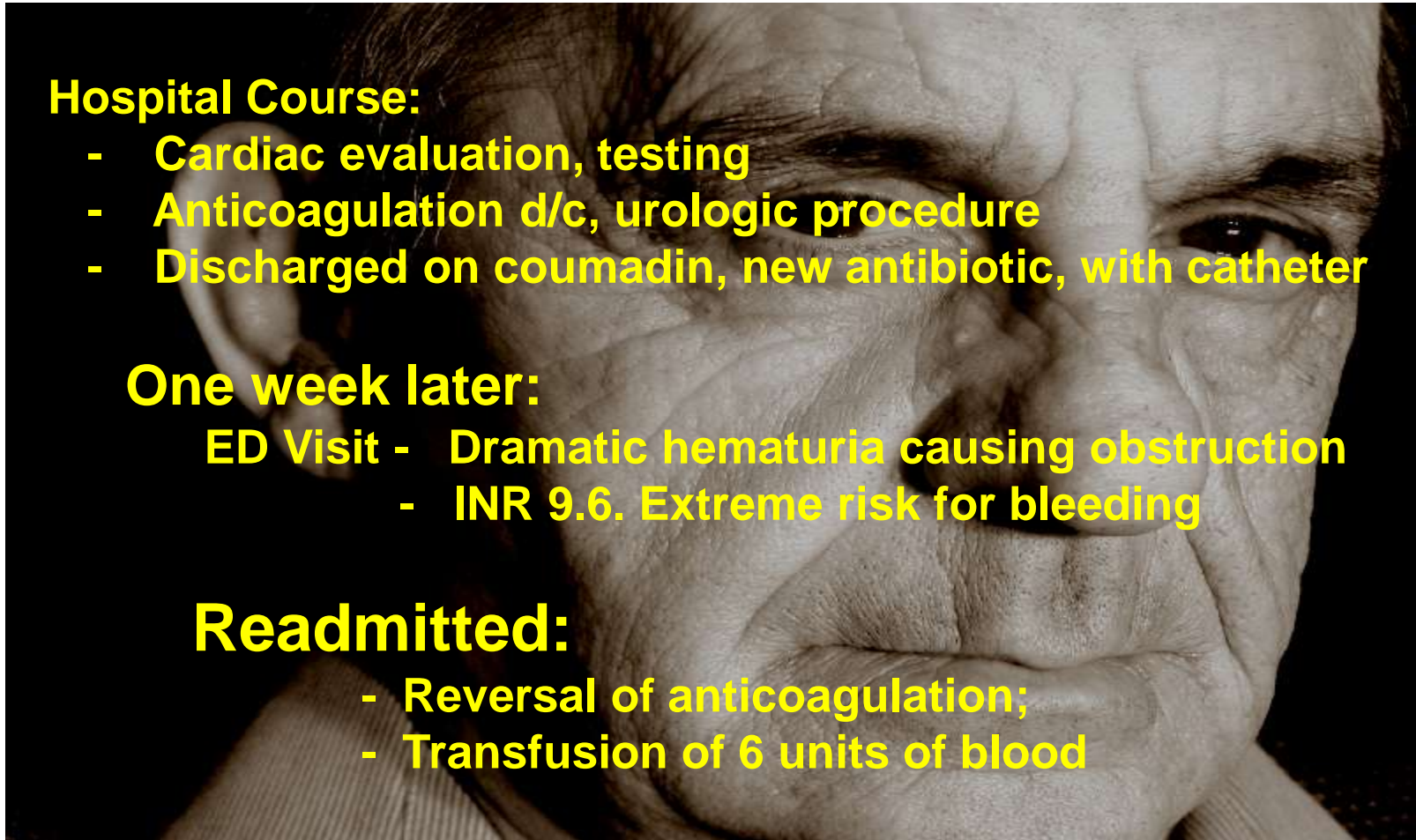
- Cardiac evaluation, testing
- Anticoagulation d/c, urologic procedure
- Discharged on coumadin, new antibiotic, with catheter

## One week later:

- ED Visit - Dramatic hematuria causing obstruction
- INR 9.6. Extreme risk for bleeding

## Readmitted:

- Reversal of anticoagulation;
- Transfusion of 6 units of blood



# MaineHealth

## Transitions of Care Bundle:

---

- ✓ 1. Risk stratification for readmission (8P)
- 2. Transition Checklist
- ✓ 3. Medication Reconciliation
- ✓ 4. Patient/family health education
- ✓ 5. Timely communication among hospital and post-hospital providers (including Victor's meds)
- ✓ 6. Timely follow-up of patients





# Victor's Risk for Readmission (**8P's**)

- ✓ **Prior hospitalization:** in last 6 months
- ✓ **Problem medications:** anticoagulants
- ✓ **Polypharmacy:**  $\geq 5$  routine medications
- ✓ **Principal diagnosis:** heart failure
- **Psychological:**
- **Poor health literacy:**
- ✓ **Patient support:** absence of caregiver to assist
- **Palliative care:** advanced or progressive illness

## Victor's Medication Schedule

	Morning	Noon	Afternoon/ Evening	Bedtime
Acetaminophen PM 500mg/525mg				X
Furosemide 40mg	X			
Acetaminophen 650mg	X	X	X	
Glyburide 10mg	X		X	
Amitriptyline 25mg				X
Metformin 500mg	X		X	
Amlodipine 5mg	X			
Methylphenidate 10mg	X	X		
Aspirin EC 81mg	X			
Omeprazole 20mg	X			
Bupropion SR 300mg				X
Pregabalin 50mg	X	X	X	
Carvedilol 12.5mg	X		X	
Simvastatin 40mg				X
Captopril 12.5mg	X	X	X	
Terazosin 10mg	X			
Cyclobenzaprine 10mg	X	X	X	
Trazodone 50mg				X
Digoxin 0.25mg		X		

## Victor's Medication Schedule – After Pharmacy Review

	Morning	Evening/Bedtime
<b>furosemide 40mg</b>	X	
<b>acetaminophen 1000mg</b>	X	X
<b>glipizide 15mg</b>	X	
<b>duloxetine 60mg</b>	X	
<b>metformin 500mg</b>	X	X
<b>amlodipine 5mg</b>	X	
<b>aspirin EC 81mg</b>	X	
<b>omeprazole 20mg</b>	X	
<b>carvedilol 12.5mg</b>	X	X
<b>atorvastatin 20mg</b>		X
<b>lisinopril 40mg</b>	X	
<b>tamsulosin 0.8mg</b>		X
<b>trazodone 50mg</b>		X
<b>digoxin 0.25mg</b>	X	

# Case Study:

## Victor's New Post Hospital Scenario

- Home support services
    - Monitoring of anticoagulant status
  - Follow-up phone call
  - Office visit within 5 to 7 days
- \* No ED visit
  - \* No readmission
  - \* Decreased morbidity
  - \* Decreased cost
  - \* Increased patient satisfaction

# Lessons Learned

---

- Community partnerships key to improving quality through strengthened communication/collaboration
- System wide collaborative learning sessions accelerated progress
- Leadership support key to gaining buy-in for improvement at the local level.

# Learning Points

---

- Focus on Care Transitions.
- Best Practices for Improved Transitions.
- MaineHealth Transitions of Care Program.
- Lessons learned



Questions?

THANK-YOU