

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Jennifer Markley:

Good morning. I'm Jennifer Markley. I'm going to be talking about a project that we did in south Texas, it was one of the 14 care transition projects that were done around the country in the last contract. So, we began the project in August of 2008. There were 14 communities, as I said. Our goal was to reduce hospital readmissions through improved quality at the patient transitions, and to do that in a community-wide setting.

So, our goal was a minimum of 2 percent reduction. Twenty-eighth month of the project, which was November 2010, that was only 18 months of work. We have to keep that in mind, we've got data lags involved.

Comprehensive community-wide cross-setting effort and to yield sustainable and replicable strategies, and that's hopefully what I'm going to help you see today, is how to replicate the improvement that we saw in the project.

So here are the 14 communities. And we are the one that is very, very southernmost tip of Texas. We're about – in Brownsville, where my partner hospital is located,

we're about a mile from the Mexican border. This area is often studied because of the demographics, the poverty and the barriers to care. One of the things that really helped us engage the community down in south Texas was that when we came, we said, "We are not here to study. We are here to implement and we're here to make change."

And they were on board with that. They were tired of being studied and they wanted to try and make real change. So, this area down here is the hospital referral region. The Harlingen Hospital Referral Region, it is 35 ZIP codes. It encompasses the cities of Weslaco, Harlingen, and Brownsville. Brownsville is the one that's about a mile from the Mexican border.

And it was a great community to work with. They had a lot of pride in their community. They want to provide excellent care. And they were very easy to engage. They came at the project wholeheartedly and gave it everything they had during the course of the project. It was a wonderful community.

This is a sample of the data that we gave the

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providers quarterly so that they can look at their data and see both how the region was doing and also how the hospital itself was doing in terms of readmissions. And so we broke it down, and one of the things that I want to be sure and draw out here is that the hospital readmission rate is not solely the responsibility of the hospital. It is the responsibility of the community. Downstream providers play a role in terms of the quality of care. And then the communication that happens between the hospital and those downstream providers is a dual responsibility that everybody should participate in.

And when you look at this data, you can see how the downstream providers contribute to the readmissions within the region. And I want to draw out a couple of things here for you. On the top, second to the top line, you can see that within the region, looking at the top boxes, 2736 patients were discharged from the hospital to the home with self care and physician follow-up, no other provider, that's 55.7 percent of the patients in that community are being discharged home. Six hundred and forty-eight of those that were discharged home were

readmitted, which was a 23.7 percent readmission rate.

The readmission rate for the home health providers was 15.6; for the in-patient rehabilitation facilities, 16; long term acute care centers were sending 16.1 percent back. And look at our SNF. Our skilled nursing facilities were 12.3 percent of the referrals, but of those 31.3 percent were coming back within 30 days. This is the community data that you'll all need to be aware of. And it's why it's so important within this care transitions project that we work across the community setting.

And then looking at the bottom boxes, this is the actual facility that we're going to be highlighting today. And you could see that their numbers were pretty similar. They were actually higher in terms of their home, 26.9 percent of their patients discharged home were coming back, 32.9 from their SNF. And, overall, you can see in the gray box – or the orange box on your screen – 22.1 was the readmission rate within the Harlingen Hospital Referral Region and 23.3 for our hospital.

So how are we going to... oops, skipped a slide. Oh, I don't have it. I've got one that you don't have. And it's an

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important one. I apologize. One of those is how are we going to do it. And way that we approached it was we offered the hospitals and the providers within the community options in terms of evidence-based practice that they could implement and that we knew from research that they could be effective if they were implemented well. And so one of the things that we offered was the reengineering discharged. And that involves a research study that was done with the Boston Medical Center.

It was funded by AHRQ. RED stands for Re-Engineering Discharge. And again it was Boston Medical Center. Dr. Brian Jack was the lead on the study. And they came up through their research with 11 mutually reinforcing components – follow-up appointments with the physician, outstanding tests and studies were resolved and taken care of prior to discharge, post-discharge services were arranged. The patient was educated. They knew what they needed to look for and they were prepared for self care, keeping in mind that about half of them in this community were going home to

self care, so how well were they prepared to be that once they were released from the hospital.

Medication reconciliation key, especially reconciliation between the home medications and the hospital medications. The patient needs to understand very clearly what's changed, what's new, what's been discontinued at the point where they're going home to self care. Getting the discharge summary to the primary care physician in a timely and efficient way so that when that patient comes for the follow-up physician appointment that there is a discharge summary available and the primary care physician knows what happened during that course of hospitalization.

The patient needs to know what to do if problems arise, what are the red flags, what are the things that they should be looking for in terms of changes in their condition and what should they do about them and who should they call and how soon should they call once they get home. Assessing the patient's understanding, making sure that the patient truly understands by doing teach-back, by asking the patient to explain in his own words

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what he's heard the educator tell him. A written discharge plan for the patient that's easy to read and that the patient can understand, that is large font, that is appropriate health care literacy, not a printout from the EHR.

Reconcile the plan with the National Guidelines for Quality and provide telephone reinforcement for the patient after discharge. Part of the RED was making one follow-up phone call two to three days after discharge to make sure that the patient would keep their appointment, that they understood their red flags. If they had any questions about their medications, any questions about the follow-up services, that was an opportunity to resolve those, reinforce the teaching, reinforce the follow-up so that the patient would understand the importance of the discharge plan.

And, now, I'm going to pass it over Robin Jones who is going to share about the hospital in south Texas.

Robin Jones:

Hi. My name is Robin Jones, I'm the Quality Care Coordinator at Valley Baptist Medical Center Brownsville.

Valley Baptist Medical Center Brownsville is a 280 bed licensed acute care hospital. We are a faith-based organization and we're not for profit. This doesn't include a separate 37 bed psychiatric facility that we also have. We're a level 3 trauma designated center. We're also joint commission accredited for our hospital and lab; and we're stroke-certified. Again, we're located in the southernmost tip of Texas on the border of Mexico.

When we began the care transition project, our baseline rate was 23.3 percent for all cause 30-day readmission rates. Our hospital compare heart failure readmission rate was 28.1 percent based on the hospital compare data from 2006 to 2009.

We began with the implementation of Project RED, our initial focus began on the heart failure patients in our telemetry unit. The reason that we decided to start with those patients was because three of our top five DRG readmissions were for heart failure related diagnosis.

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And we decided that would make the most impact in our facility.

In May of 2010, we decided to expand to all diagnoses in the telemetry unit. We partnered community-wide with our downstream providers and we implemented the use of electronic health record in 2008 to improve our hand-off communications. We worked with our corporate compliance department in order to give our physicians and our physicians' offices access to our electronic medical record to have this information available to them.

We're also actively involved in regional workgroup meetings with the entire lower Rio Grande Valley to find out what other acute care hospitals and issues they're having in their communities. We also educated our medical staff, including our physicians, on medication reconciliation, health literacy, patient safety, and CKD. Our population, our demographic area, we have a very high incidence of diabetes, heart failure, and kidney disease.

All the components of Project RED were implemented

and monitored in our 30-bed telemetry unit. We had a team approach to administering all 11 components and incorporating them into our hospital processes. This included working with the nursing, care management, pharmacy, and the core measures team who all contributed to this process.

In working with the nursing and care management, we educated the patient about his or her diagnosis throughout the hospital stay. We started this with every patient that comes in has a learning needs assessment along with daily teaching of their diagnosis and what's going on with them and their care for the day.

We also discussed with the patient any tests and studies that have been completed in the hospital and also the tests that are pending once they leave, if there are any. We review the next steps for what the patient is to do if a problem arises and this information and a contact number is provided on the discharge instructions.

Nursing provides a follow-up telephone call reinforcement two to three days after the patient has gone home. Before the patient is discharged, we actually

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make the appointments for the patient and make sure that they understand when the appointment is and then coordinate it with the patients and the families so that they are able to make that important post discharge appointment. We also make sure that we provide them with a written discharge plan that is the appropriate language for the patient and we assess their degree of understanding with teach-back.

Care management organizes the post-discharge services that the patient is going to need when they leave. They start this on the admission with the patient. They also expedite the transmission of the discharge instructions to the downstream providers, making sure that they have that information before the patient leaves.

Nursing, pharmacy, and care management confirm the medication plan. I was also very fortunate to also be the medication reconciliation owner for the process at our facility and understanding the strengths and weaknesses that we have with our medication reconciliation process. Nursing and core measures also work together in reconciling the discharge plan with the national

guidelines for the core measures.

In monitoring for effectiveness with the patients, the patients are given surveys before they leave. And the patients are able to tell us what their knowledge and their understanding of our discharge process is. The questions that we ask on the discharge survey for the patients... They're both given to the patient in English and Spanish, and the patient is the one who fills this information out. We do have assistance if they have difficulty in being able to sign these surveys.

We want to make sure that they were taught about their diagnosis throughout their stay. We want to make sure that they have appointments with their physicians made for them prior to them leaving. We want to make sure that any tests or studies, medical equipment or services are also explained to them before they leave.

We want to make sure that they know who to call if a problem arises. We want to make sure that they receive a copy of the written discharge plan and that is easy for them to understand and read. We want to make sure they have an understanding of the discharge plan and

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the information they need to take care of themselves once they have returned to their home, make sure that they have a list of the medications that they are to be taking once they're discharged and any new medication or any exchange medications. And we want to make sure that they understood the teaching and they're asked to teach back.

The process that we give them includes having a case manager runner that gives out a daily length of stay report. That report is given to case managers, the telemetry supervisors, charge nurses as well as quality. The floor staff is responsible for completing all the components of the RED prior to discharge. The case management runner delivers and retrieves these surveys that we give to the patients and forwards the completed surveys to me. And then two to three days after discharge, I call the patients and make sure that they understood their discharge instructions and are able to troubleshoot any problems that they do have.

We do track our patients' survey results to make sure that we understand where our problems lie. Ninety-three

percent of our patients surveyed said that they received the information about their diagnosis. They also understood the follow-up appointments on 94 percent of the cases. Eighty-eight percent of these patients had a follow-up appointment scheduled within a week after their discharge from the hospital and 99 percent of our patients surveyed said that their written discharge plan had information needed for their self-care management and that was really easy for them to read and understand.

As you can see, these are our patients that we actually surveyed, and we tracked them within 30 days of discharge to see which ones surveyed actually came back. And we see in March and April, we were about 23 percent and then in May we saw all of our interventions, our education come together. And since May, our readmissions for this survey group have been less than 10 percent in almost all of the months. We continue to see that downward trend for the latter part of this year.

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Jennifer Markley:

I'm just going to pick it up and do some closing data real quick. This is looking at the remeasurement period. The one thing that I want to point here and I'll show you this, it's not very helpful in this format, but I'll show it to you in graphs in just a second. But we not only had a reduction in readmissions, 30-day readmissions. We had a reduction in admissions in the community. And so if you look at the numbers and compare them to the first chart, you'll see we had 342 less discharges, or less admissions to the hospital, and that's a 14 percent decrease.

This is looking at the Harlingen Hospital Referral Region by the different downstream providers. And this is looking at the hospital compared to the Harlingen Hospital Referral Region. And what you'll see if you do the math here, is that home health agencies decreased by 2.7 percent. That's a 28 percent relative improvement. Patients discharged to home decreased by 5.9 percent on their 30-day readmission. That's a 22 percent relative improvement.

IRFs, the inpatient rehabilitation facility in this community was not working with us. The LTAC had a 1.5 percent decrease in 30-day readmissions, 6-percent relative improvement. Look at our SNF, 19.9 percent reduction in 30-day readmissions. That's 60 percent relative improvement. They did a terrific job.

And then, overall, 4.6 percent, 20 percent relative improvement. And this is over 18 months, moving very quickly. This is showing, again, keep in mind that we started quarter 3 2008 so that the data prior to that, we were not working. And then we're starting to see this drop off here. Their data continues to fall through 2010, 4.7 percent – 20.34 percent relative improvement is what they're showing.

Looking at their HCAHPS, what I want to tell you that in May and October of 2010, May and October 2010, which is not on this chart, their medication management patient satisfaction is 94 percent. The discharge planning satisfaction is 93.8 and 93.1, and appointments to the physician, 93 percent in their target population.

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This is information on RED where you can go to contact RED. And there's my contact information if you want to contact us with any questions on the data or the project. Thank you.