UCSF Medical Center

UCSF Benioff Children's Hospital

True North Metric Update: Reducing Readmissions

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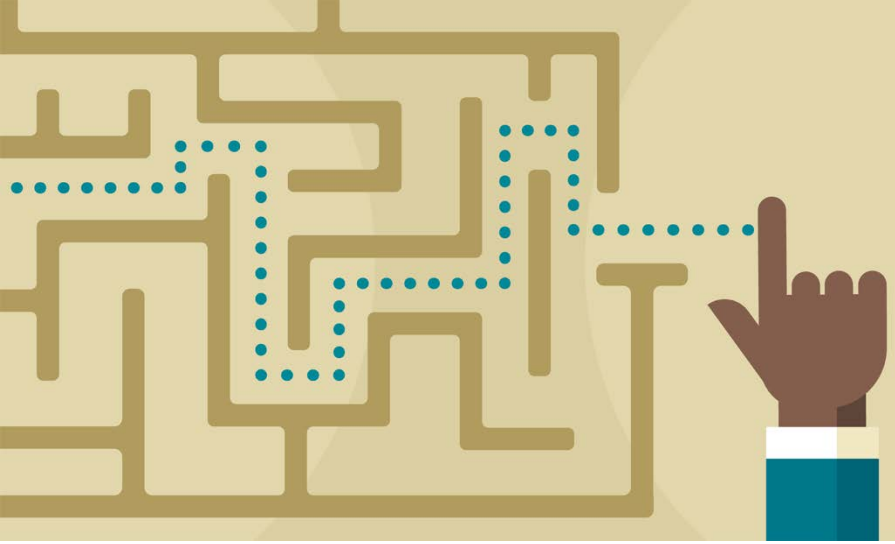
Naming the Problem

A readmission likely represents an opportunity to improve quality, access and timeliness of care for our patients.

Current State

- Readmission rates have fallen over the last 12 months to a new consistent benchmark of ~11%

FY2015	FY2016	FY2017	FY2018	FY2019 YTD
11.9%	11.6%	11.4%	11.4%	10.7%

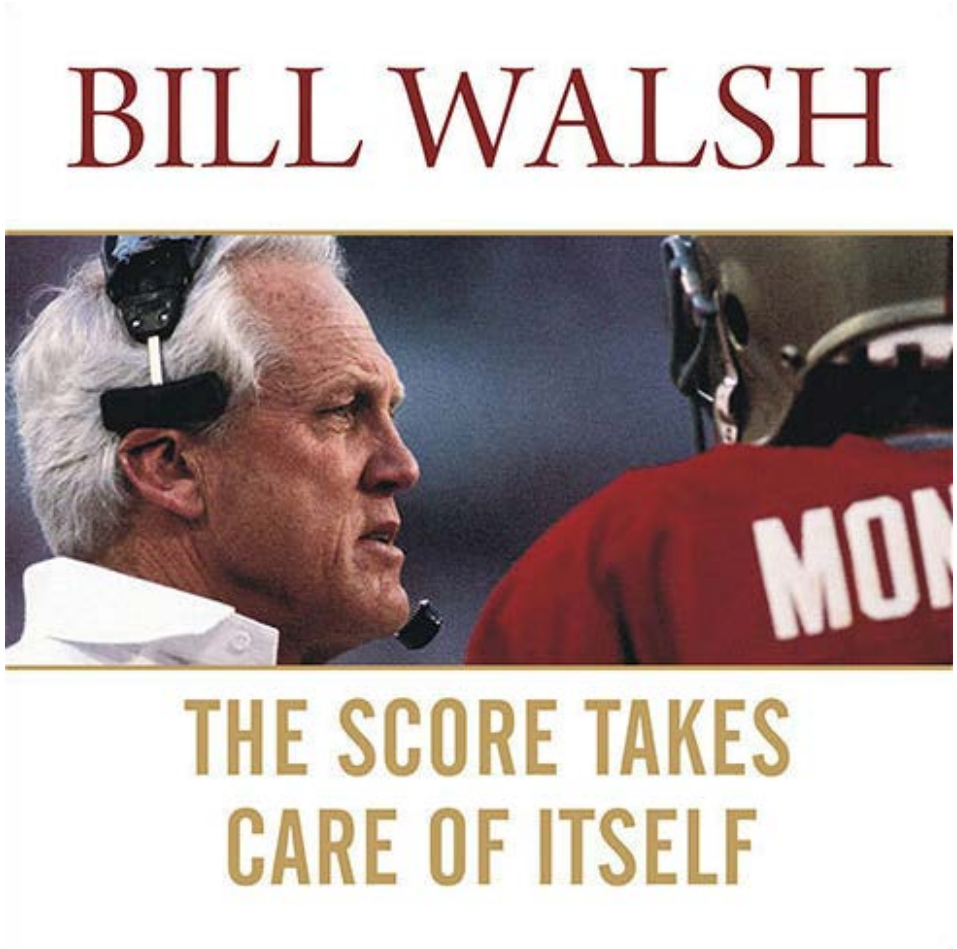


- **Future State:**
  - Better understanding of where readmissions represent a problem with quality, access, timeliness, and equity.
  - Data-driven approach to resource use to drive improvements in those areas.

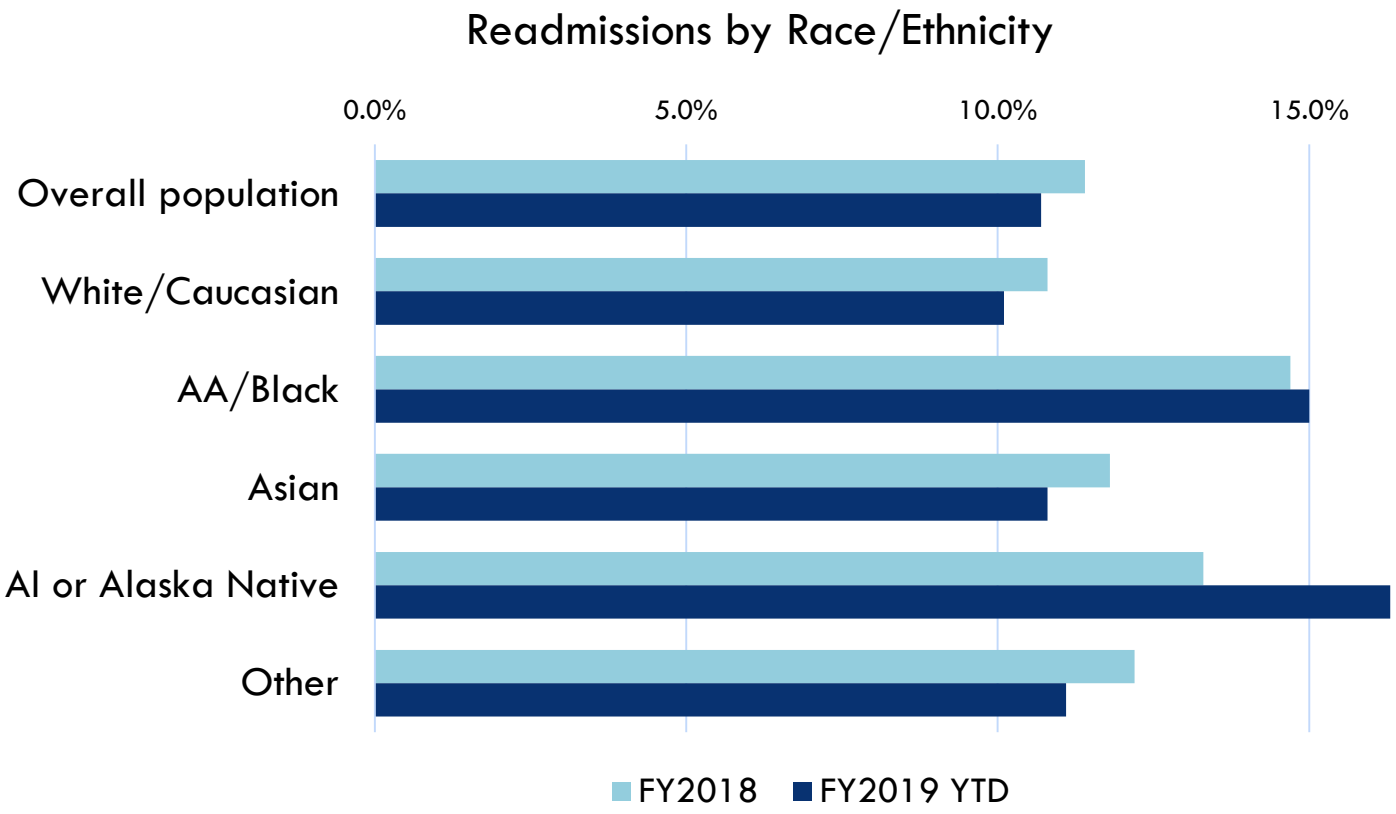
Where are things going well?

- **Age:** Largest fall in the very old and very young, but all ages show a decrease.
- **Payor:** Largest fall in Medicare patients, but seen across all payors.
- **Service:** Stand out performance by CT surgery, General Surgery, Hospital Medicine, Newborn Nursery, Pediatric Specialties

Readmissions: My philosophy?



Addressing Health Inequities in Readmissions



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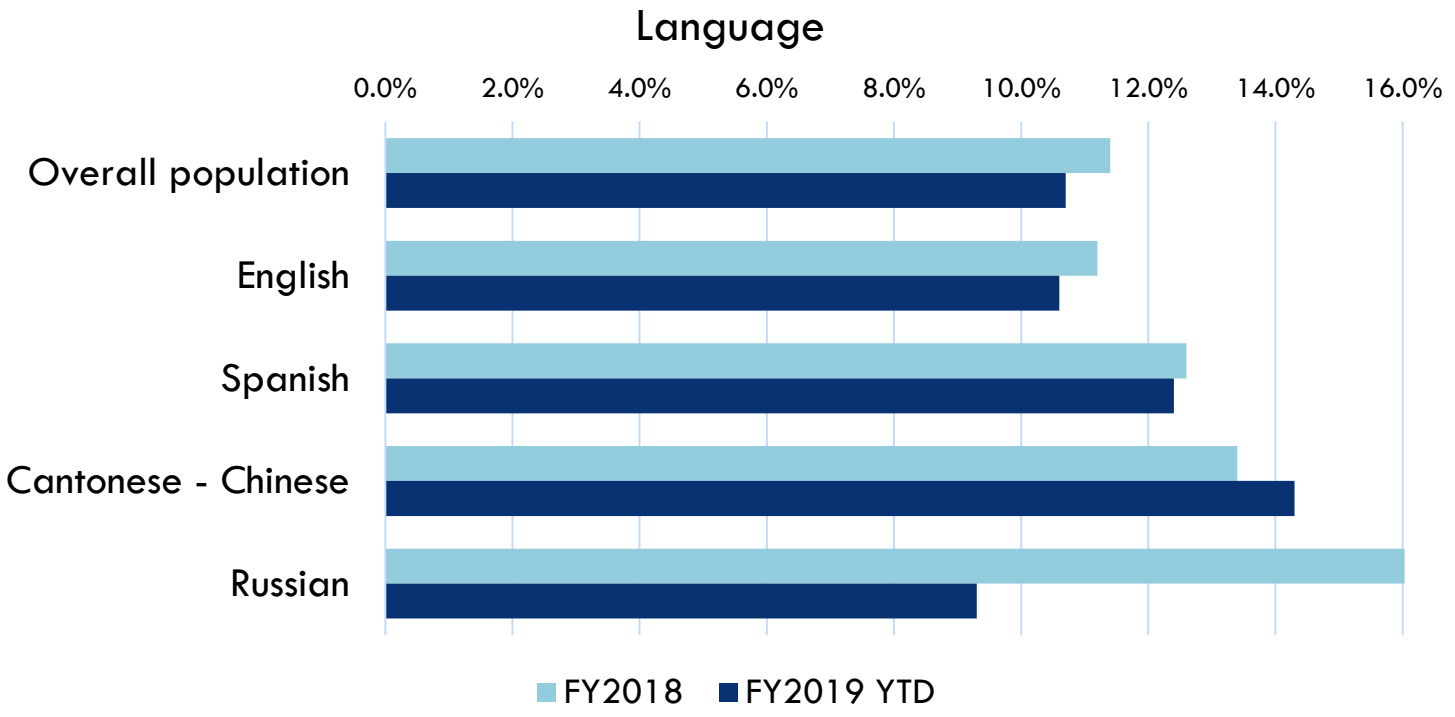
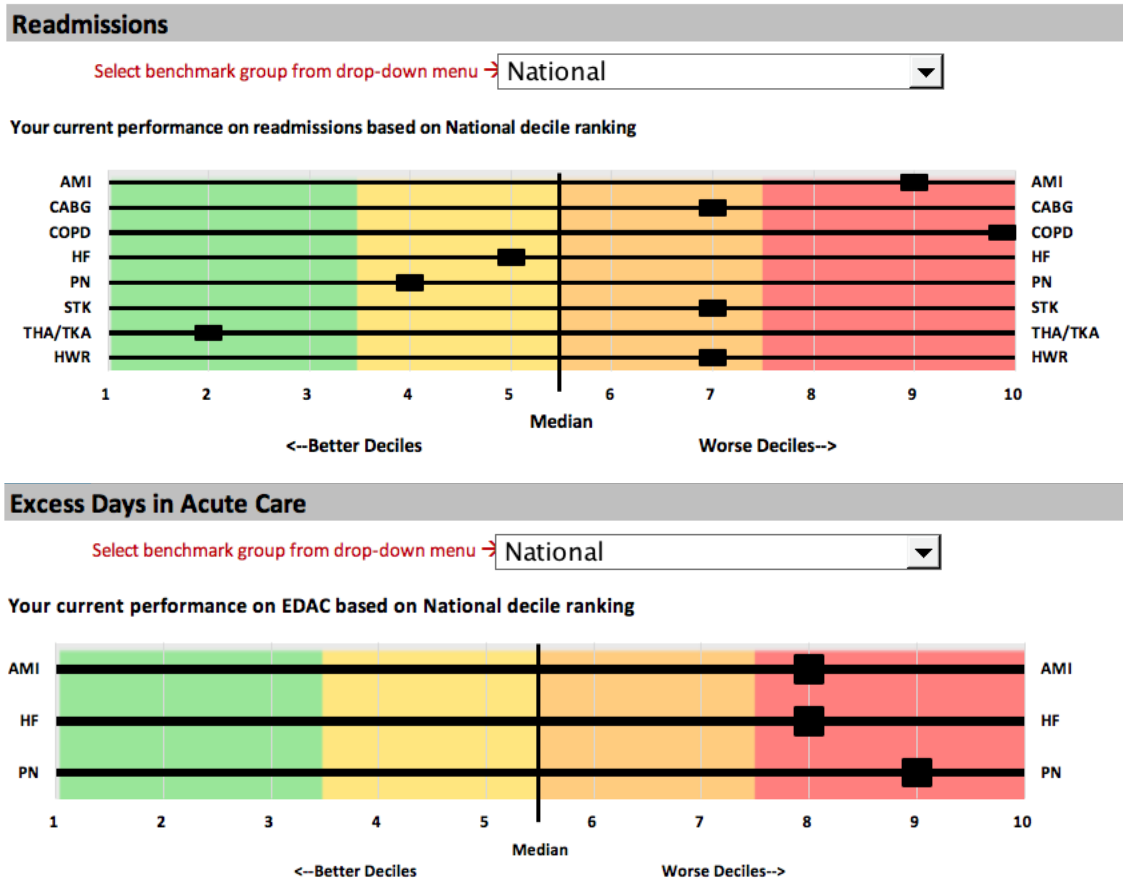


CMS Comparison to National Performance



- No risk adjustment
- Data is from CY2018 which is largely prior to our recent improvement in some of these measures.

CMS Readmissions: Financial Penalties

Year	Payment Adjustment Factor	Number of Eligible Discharges for AMI	Excess Readmissions Rate AMI	Number of Eligible Discharges for COPD	Excess Readmissions Rate COPD	Number of Eligible Discharges for HF	Excess Readmissions Rate HF	Number of Eligible Discharges for Pneumonia	Excess Readmissions Rate Pneumonia	Number of Eligible Discharges for CABG	Excess Readmissions Rate CABG	Number of Eligible Discharges for THA/TKA	Excess Readmissions Rate THA/TKA
FY2018	**0.9988**	131	1.0167	147	1.1207	385	1.0165	559	1.0303	64	1.0740	389	0.9631
FY2019	**0.9993**	120	1.0626	145	1.1040	393	1.0032	612	0.9818	68	1.0486	473	0.9100

FY2018 penalties

Translated into 0.18% of our total Medicare Revenue

0.0018 x 150 M = 270 K

FY2019 penalties

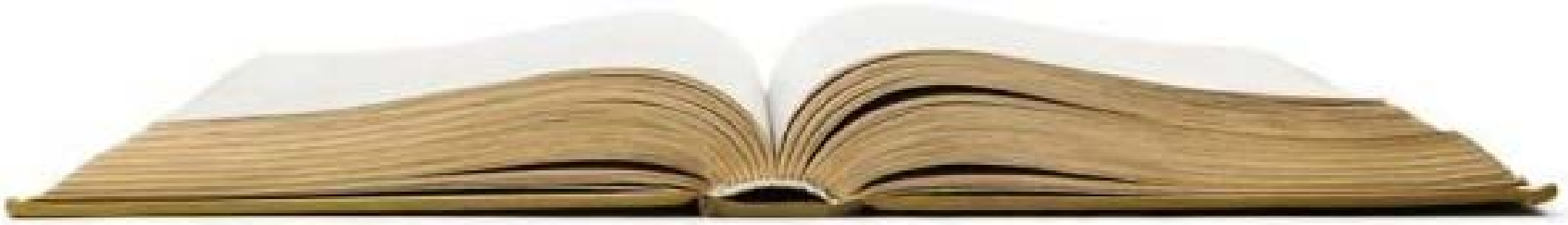
Will translated into 0.07% of our total Medicare Revenue

0.0007 x 180 M = 126 K

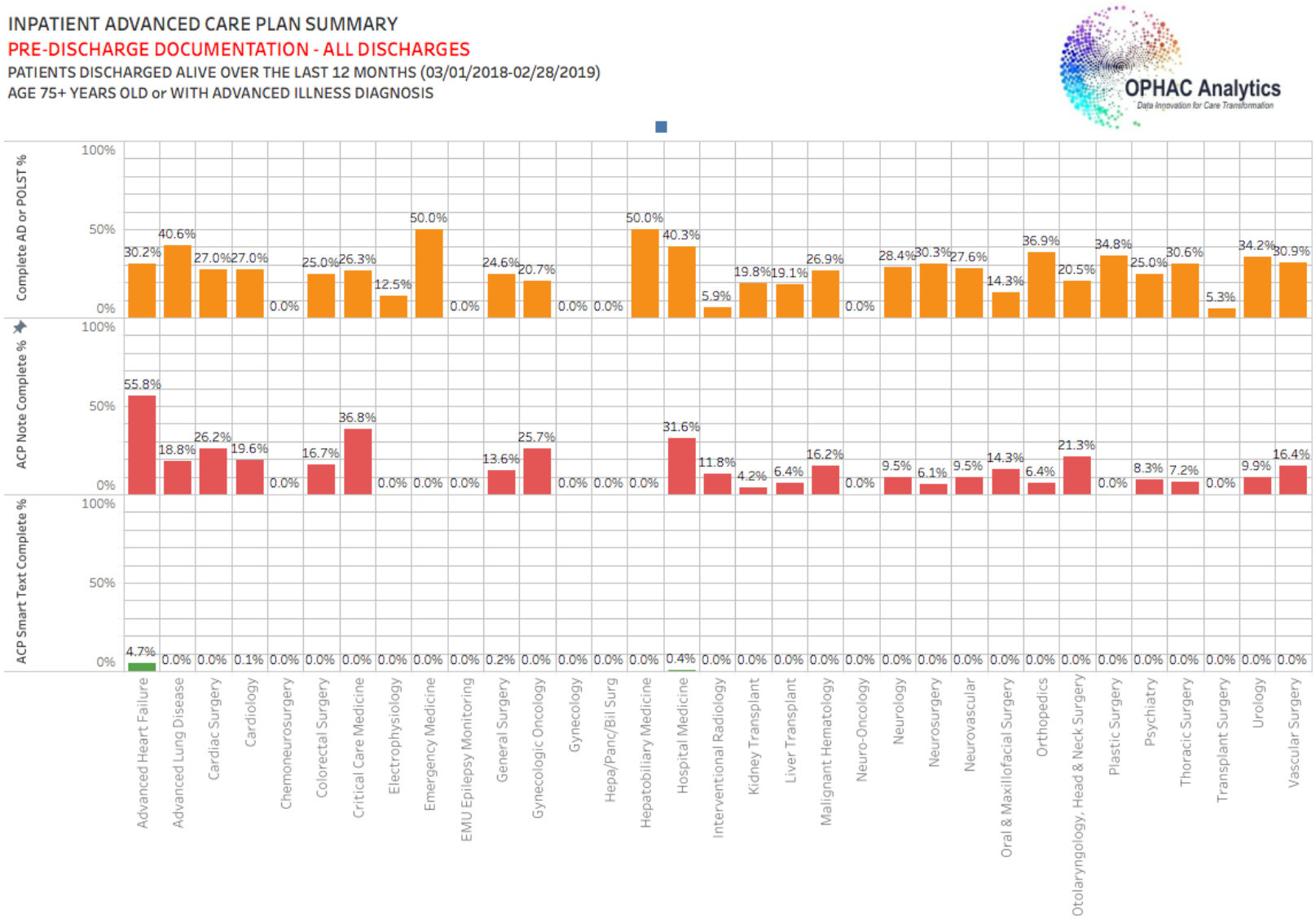
Readmissions: Key Interventions

- **Discharge Core Measures**
  - Dedicated service contact number in AVS: **100%**
  - AVS Service Specific Discharge Instructions: **91%**
  - Follow Up Appointments w UCSF PCP w/in 14d: **50%***
  - Discharge Summary Timeliness – 24hr resident/48 hr attending **(93%/70%)**
  - Advanced Care Planning: Intervention Underway

** All PCPs - Medicare rate 59.4%, compared to 19% National Average*



Advanced Care Planning: Metric Dev



Readmissions: Key Interventions

- **Disease Specific Interventions**
  - Heart Failure: Transitional Care nurses, call program
  - AMI: Post-discharge COR Clinic
  - COPD: Inpatient RT + Outpatient HCN
  - CABG: Inpatient patient educator
  - Ortho and Major Bowel Bundles: SNF Pathways

✓ *Engaging with OPHAC on pursuing bundled payments*
✓ *Engaging New Non-Oncology Palliative Care RN and MD*

Key Interventions: COPD

- Brief COPD Education
- Quality of Life Assessment
- PIFR Measurement

- Detailed COPD Education + COPD action plan
- Quality of Life Assessment
- MDI/DPI teaching
- PIFR and Bedside spirometry
- Pulmonary Rehab evaluation
- Smoking Cessation
- Suggestions for PT
- Palliative Care consult if needed
- Pulmonary Consult
- Suggestions for Outpatient Referrals

- Weekly phone calls to emphasize COPD action plan
- Follow through with all referrals
- Reminder calls before appointments

Spotlight on the COPD Population

- Medicare FFS COPD Discharges **16.7% to 9.4%**
- Medicare ACO COPD Discharges **18.5% to 16.7%**

Key Interventions: MSSP

- Two Inpatient transitions nurses review high risk MSSP patients and discuss enrollment in population health based programs in a daily huddle
  - Care at Home
  - Care Support
  - **Virtual High Risk Transitions program**
  - **SNF NP and Navigator post-acute support**
- Patients are introduced to these programs with a warm handoff while hospitalized

Key Interventions: ***Virtual*** High Risk Transitions

Gap in the OPH Clinical Programs

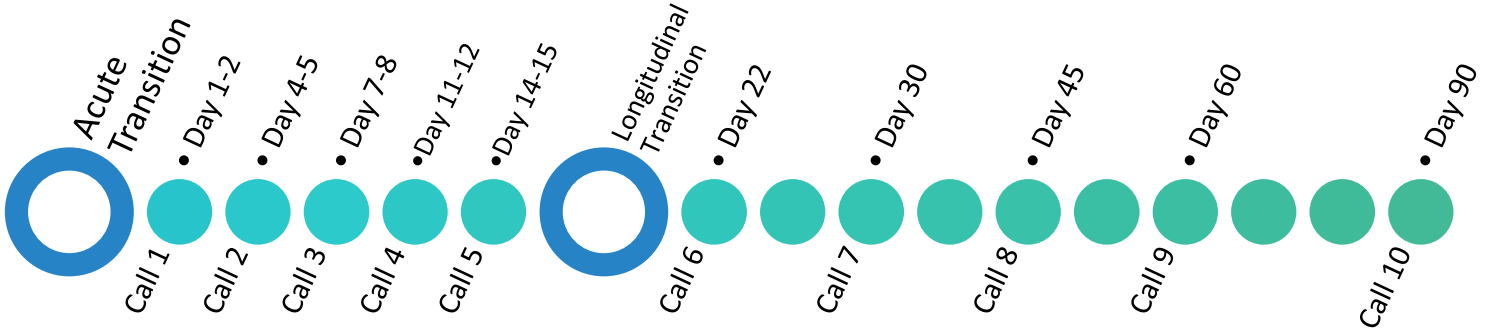
- Home-based primary and palliative care
  - Yet no home-based transitions team
- Care Transitions Outreach Program (CTOP)
  - Calls all patients 2-3 days after discharge home
  - Primarily just one call

Create a High Risk Transitions Program – Make it Virtual

- High risk patients identified in the hospital, warm handoff to RN who will follow them after discharge

Key Interventions: Virtual High Risk Transitions

1. Adapting Standardized Clinical Assessment Tools
   - Maintaining core components
2. Identifying patients for the intervention
   - Inclusion criteria for high risk patients
     - MSSP
     - LACE ≥ 9
     - UCSF PCP
     - ≥ 2 IP or Obs in last 12 mo.
   - Baseline measures from APeX
     - Post-hospitalization syndrome indicators
3. Three avenues for enrollment
   - 2 while in the hospital, 1 after discharge
4. Engaging Primary Care
   - Via APeX note routing



Key Interventions: Virtual High Risk Transitions

Outcomes Metrics

- Change over time in key domains
- Program satisfaction (patients, providers, & staff)
- Positive impact on utilization
  - Decreased ED visits & unplanned hospitalization
  - Increased use of MyChart & PCP clinic
  - Decreased no-shows

On the Horizon

- Video Visits via Zoom
- Phase 2 Naylor domains
  - Mood/Emotional status
  - Nutrition
  - Self-monitoring
  - Caregiver burden/Social support
  - QOL

Domain	Standardized Tool / Item	Data Source(s)	Completed By:	Completed When: (Intensive Phase)				
				ad	30d	d/c	6m	9m
Nutrition	Unexplained weight loss of ≥ 10 pounds, or ≥ 5% of body weight or persistent weight loss	Patient EHR Family CG Hospital/SNF/HA Staff	TCM Team	√	√	√	√	√
	Mini Nutrition Assessment (MNA)	Patient EHR Family CG Hospital/SNF/HA Staff	TCM Team	√		√		
Skin Integrity	Braden Scale for Predicting Pressure Sore Risk	Patient Family CG Hospital/SNF/HA Staff	TCN	√		√		
Caregiver Needs	Next Step in Care Assessment - Availability - Training Needs - Worries	Family CG	TCN	√		√		

Spotlight on the Medicare ACO population

- All Cause Readmissions: **18.2% to 13.7%**
- Readmissions from Skilled Nursing Facilities **20.5% to 13.9%**

Where can we improve?

- Increase in SNF Readmission Rates 14.6 → 16%
- Rates by service (select services that have seen a significant increased)
- Examined causes and challenges are around
  1. Communication of care plans (medication lists, order set improvement)
  2. Contingency planning (abnormal labs, lines/drains, urgent follow up, failure to progress)

Readmissions: Key Interventions

- **HH & SNF Collaboratives**
  - GOALS :

- Improve handoffs and communication
- Standardize care quality in treatment of chronic conditions

- Develop and work towards shared quality goals

- Maintain relationships that increase accountability for high quality post acute care

Collaborative Continuous Process Improvement

QUALITY AND SAFETY

TRUE NORTH GOALS

To reduce readmissions of UCSF patients from SNF → hospital and SNF → HH → hospital

CURRENT STATE

SNF 1	SNF 2	SNF 3	SNF 4	SNF 5	SNF 6	SNF 7	SNF 8
6% /21%	17%/24%	25%/24%	19%/15%	7 %/21%	8%/25%	18%/20%	33%/30%

PROPOSED TARGET

Decrease readmission rates from each Skilled Nursing Facility by 10%

PROBLEM SOLVING

SNFs and HH do not have reliable / consistent UCSF provider to engage with them in problem solving

TACTIC

- Create triage protocols for common SNF concerns
- Weekly virtual huddle at all SNFs to triage concerns
- Create workflow for post-acute healthcare navigator to help with urgent follow-up appointments, outreach to PCPs
- Engage SNF NP in visiting high volume SNFs and assessing patients at risk for readmission
- Engage SNF NP & SW in GOC discussions at SNF (starting with MSSP patients)
- Pilot SNF NP presence as a UCSF representative at SNF Care Conference
- Create 24/7 or 2-hour return call line for SNF/HH providers to urgently reach UCSF provider
- Ensure all providers & staff have MDLink access (enables InBasket messaging function to all UCSF providers)
- Explore HIPAA-compliant texting

IN PROCESS

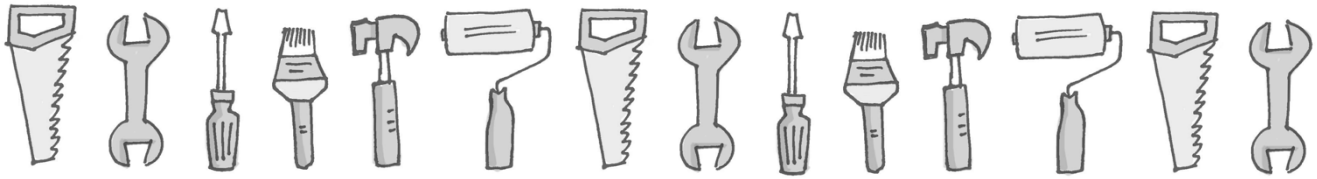
- Gain consensus on most common SNF concerns that would be amenable to triage protocol
- Continue to assess reason for readmission flagging “preventable” readmissions back into triage protocol to try to address them
- Hold weekly huddles at all SNF with >10 short-term UCSF patients
- Hire healthcare navigator and SNF NP
- Provide SNFs with MDLink how-to sheet

Readmissions: Key Interventions

- Post-Acute SNF Support: Grant (HCN) & Jay (NP)
  - GOALS :
    1. To ensure continuity of care plan and safety in the transition for UCSF patients going to SNF
    2. To improve communication with families and members of the their UCSF care team.
    3. To help reduce unnecessary ER transfers and prevent preventable hospital readmission
    4. Help promote shorter and safe SNF LOS & safe discharges from SNF

Readmissions: Key Interventions

- Post-Acute SNF Support: Grant (HCN) & Jay (NP)
  - Tactics
    - Participate in the admission of all MSSP admissions to SNF (med rec, care plan clarification, understanding of goals)
    - Round on MSSP patients and families while at SNF, evaluate progression with goals
    - Participate in discharge planning for all MSSP patient (med rec, transmission of care plan in APeX)
    - See ALL patient with urgent concerns raised at SNF
    - Escalate any concerns/needs for ALL patient to UCSF team



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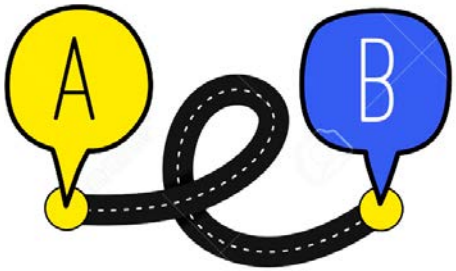

  - In Process Measures
    - Developing pathways for urgent consultation: Cardiology, Geriatrics, Palliative Care, Urgent Care
    - Developing mechanisms for more timely diagnostics in SNF: urgent labs, radiology
    - Creating pathways for common problems: Aspiration, New respiratory symptoms, Tube/drain concerns, Transfusion/infusion needs

Readmissions: Opportunities

- **Medication Reconciliation**
  - Poor gathering of admission medication information leads to incorrect medication list on discharge
  - Discharge medication list includes duplicates, old medications and meds requiring prior authorization

- Proposal approved for new pharmacy tech funding to address new pharmacy legislation around med rec.

Questions/Comments/Discussion?

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