Facey Medical
FOUNDATION + GROUP

Care Transitions Grant
Readmission Root Cause Analysis
June 2013

Facey Medical Group , Mission Hills, CA Clinic – Opened September 2012

Agenda

- Care Transition Grant Goals
- RRCA Project Purpose
- RRCA Study Population
- Methodology
- RRCA Findings
- Opportunity

Care Transition Grant Goals

- **Expand Care Transitions capabilities and resources at Providence Holy Cross (PHCMC).**
- **Conduct weekly inpatient readmission reviews.**
- **Increase home visits.**
- **Review and implement a software application with identification of at-risk patients, care plan documentation, Care Team review and NCQA/health plan reporting.**
- **ER admit rate review; implement plan for safe ER diversion to alternate site of care.**

Project Purpose

- Gather subjective evidence from patients, caregivers and our medical team.
- Assess opportunities to close gaps in care.
- Improve transition communication, increase efficiency and HIPAA compliance.
- Develop safe, effective and funded care alternatives to ER and hospital.
- Trend subjective, demographic and utilization data.
- Implement process improvement plans.

Study Population Oct 2011-Feb 2013

- 1047 HMO patients were readmitted in this period in any facility
- 484 patients were readmitted at PHCMC
- 266 participants completed survey at PHCMC

Methodology

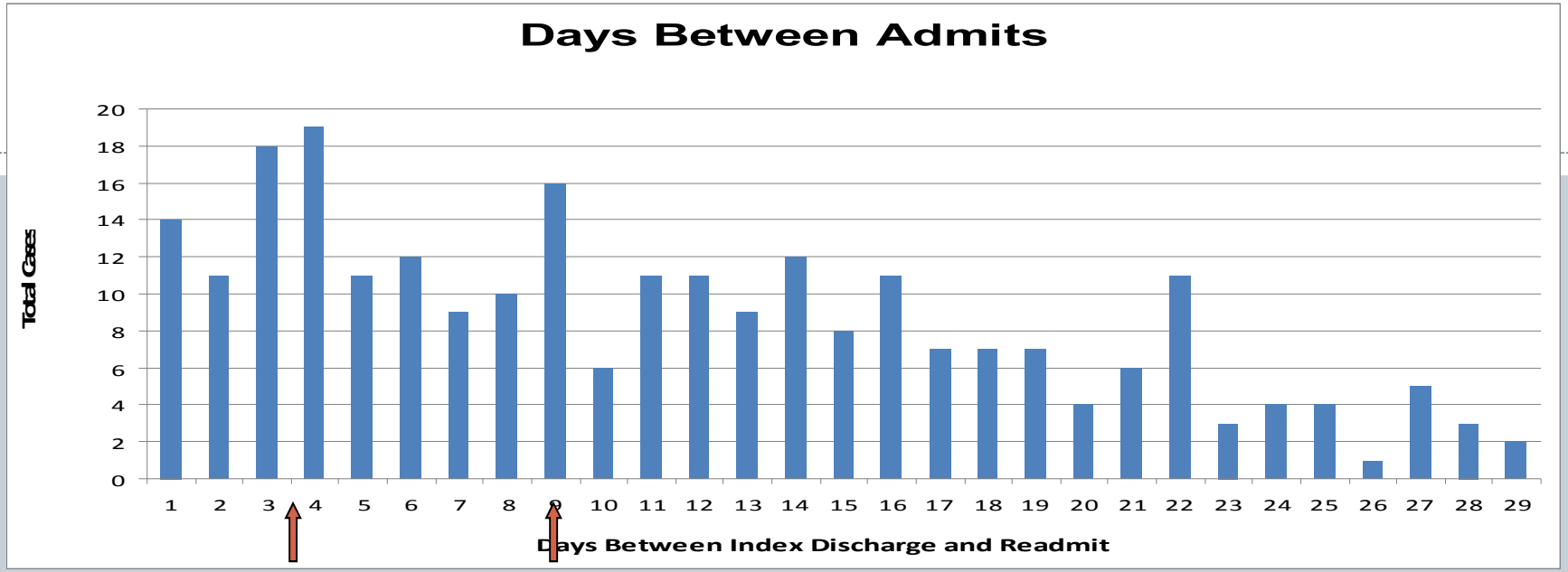
- Designed Interview Templates
  - Patient/Caregiver
  - PCP and Discharging Hospitalist
  - Case Manager
- Developed DSRA secure database
- Designed FTP flat file elements and transmit to Facey monthly
- Designed Decision Support queries with demographic, utilization and subjective data
- Interdisciplinary team reviewed cases and data weekly
- Team shared feedback to PCP, CM team, Provider and staff Committees at Facey and Providence Holy Cross
- Team implemented High Risk case conference calls/interventions and measured change

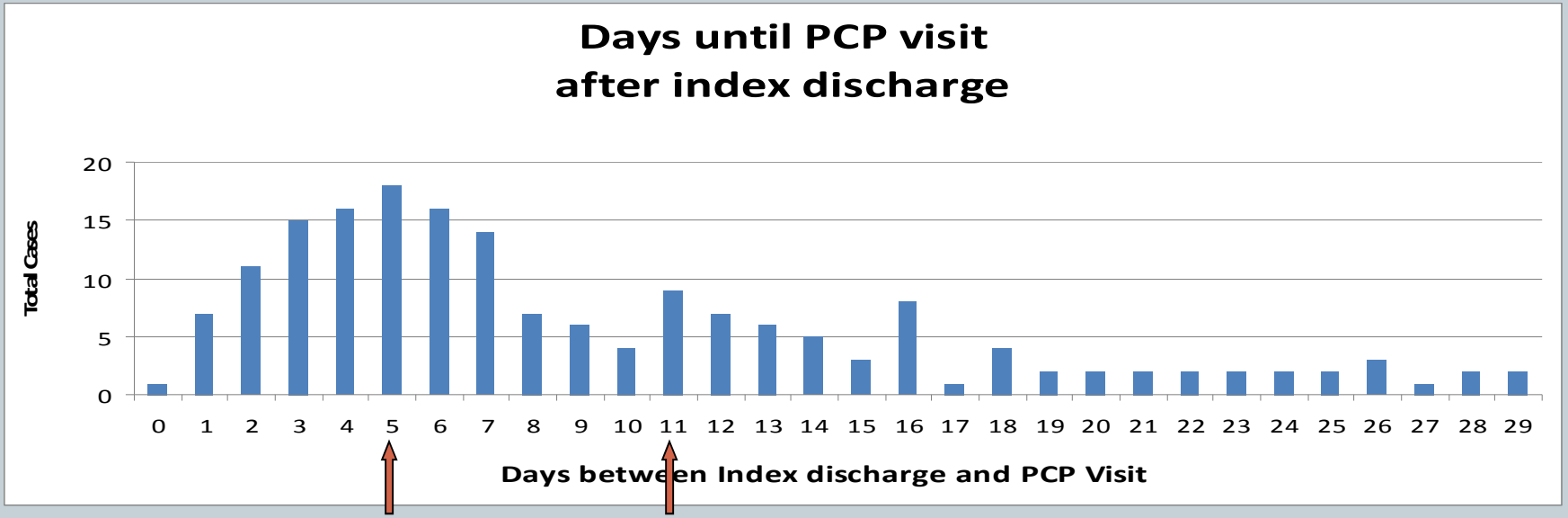
Findings

Readmissions- HMO Only					
Commercial		**2011**	**2012**		**GOAL**
Readmits	Total	332	357		
	% of Admits	8%	**8%**		**7%**
PHC Readmits	Total	132	182		
	% of Admits	9%	10%		--
Seniors		**2011**	**2012**		**GOAL**
Readmits	Total	469	481		
	% of Admits	16%	**14%**		**15%**
PHC Readmits	Total	171	198		
	% of Admits	15%	14%		--

Findings

Readmit Cases- Post Discharge Visits- HMO Only Appointments with NP or PCP Only					
Year	**Sum of Readmits**	**% w/scheduled PCP/NP 7 days post readmit discharge**	**% 7-dayPCP/NP arrived of scheduled**		**Goal for % Arrived of Scheduled**
Commercial					
2011	332	**42%**	**65%**		**85%**
2012	357	**40%**	**65%**		
2013 YTD	66	**53%**	**63%**		
Seniors					
2011	469	**50%**	**63%**		
2012	481	**50%**	**58%**		**85%**
2013 YTD	87	**51%**	**55%**		


Days Between Admits
Total Cases
0
2
4
6
8
10
12
14
16
18
20
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Days Between Index Discharge and Readmit


Days until PCP visit
after index discharge
Total Cases
0
5
10
15
20
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29
Days between Index discharge and PCP Visit

Advance Directive

Advance Directive *RRCA Patients with Advance Directive or POLST on file with Facey*	
Total with Advance Directive/POLST	37
Total unique patients	266
Percent with Advance Directive/POLST	14%

Urgent Care / ER Visits

Urgent Care Visits ***Provider Specialty is Urgent Care Only (BAR); Visits on day of admission included***	
Total cases	**266**
Total number with Urgent Care visit within 7 days prior to readmission	**22**
% with Urgent Care visit within 7 days prior to readmission	8%
14 patients saw both PCP and Urgent Care within 7 days prior to readmit	
ER Visits ***Visits to place of service 23; codes 99281-99285 and 99291 only***	
Total cases	**266**
Total number with ER visit within 7 days prior to readmission	**50**
% with ER visit within 7 days prior to readmission	19%

ER date before readmission date but not before index discharge date

Patient/Provider Perception

Reason for Readmission - as answered by PROVIDER

(Can have multiple reasons for one patient)

	Total Cases	Non-Compliant	Inability to See Provider	Discharged too Soon	Social Factors	Disease State	Discharge Instructions	Other*
Number	266	11	2	16	16	115	6	115
Percent	106%	4%	1%	6%	6%	43%	2%	43%

Reason for Readmission - as answered by PATIENT

(Can have multiple reasons for one patient)

	Total Cases	Non-Compliant	Inability to See Provider	Discharged too Soon	Social Factors	Disease State	Discharge Instructions	Other*
Number	266	17	1	4	18	123	1	84
Percent	93%	6%	0%	2%	7%	46%	0%	32%

*too much fluid, not enough fluid, drank too much, ate too much, took a cruise, ate KFC, could not get out of bed, did not know who to contact/call.

Care Innovations During Study

- Home Visits increased by >100% from baseline.
- Post discharge home visits on senior discharges for Annual Wellness Visits began for 100% of senior discharges by selected health plans.
- Discharge Checklist at time of admission in use at all network hospitals.
- A Patient Alert was instituted in EHR to identify Hospice/Hospice diagnosis, Advance Directive, POLST.
- CM discuss advance care planning and document POLST on all seniors prior to discharge. Multiple training activities.
- CM uses teach back to share condition specific red flag teaching
- CM and Hospitalists attend 2 CMEs on increasing patient engagement and use of teach back method.

Methods and Opportunities

Open Discussion
and Questions