# Facey Medical Group
# Care Transitions Project: Readmission Root Cause Analysis
# June 20, 2013

## Project Description:

### October 2011 – January 31, 2013 Study Period

Readmission Root Cause Analysis (RRCA) is one activity within Facey's Care Transitions project. Facey Medical Foundation (FMF) and Facey Medical Group (FMG) designed and launched in-person interviews for all readmissions to Providence Holy Cross Medical Center (PHCMC), a primary network hospital with our highest daily census. Readmission interviews for patients/caregivers were administered by a Nurse Practitioner. A readmit chart record review was conducted by the nurse case manager and a PCP/Hospitalist/hospital case manager complete a readmission interview tool. All results were entered into a web-based secure data base designed by Facey and a consultant. An interdisciplinary RRCA Committee consisting of Medical Director, UM Medical Director, Assistant Medical Director, Admin Director of Managed Care, UM RN Director and Complex Case Management RN Supervisor met biweekly to conduct case reviews and detailed analysis.

The purpose of such activity was to gather subjective evidence from patients, caregivers and our medical team to assess opportunities for Facey Medical Group to close care gaps, improve transitions communication, develop safe and effective care alternatives to ER and hospital as a result of looking at trends in these data, in conjunction with demographic and utilization data in our HMO population.

## The Population:

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

## Results:

- 14% of Senior patients were readmitted. Goal <15%.
- 10% of Commercial patients readmitted. Goal <7%.

## Summary of Findings:

- All Readmitted patients post hospital appointments with Primary Care Physician
  - Commercial - 40% of the readmitted patients scheduled within 7 days of index discharge.
  - Senior – 50% of patients scheduled within 7 days.
  - 65% of commercial patients arrived as scheduled.
  - 58% of senior patients arrived as scheduled.
- Visits to specialists were excluded; cardiology, surgery, OB.

## Profile of PHC Readmissions Taking Part in RRCA Survey Tool (Study population):

- 8% of patients had been to urgent care in week prior to readmit.
- 19% of patients had been to ER in week prior to readmit.

- 19% of readmitted patients had advance directives at the time they were readmitted, % increased as study evolved (for Facey Medical Group overall this rate is 6.6%).

- 80% of patients reported self-directing to ER upon readmission, not 911 or directed by MD.

- 10% of readmitted patients came from a SNF, but the SNF readmission rate (14%) was similar to the readmission rate from all other sources, and readmission rate in total.

- 49% of patients described themselves as needing some level of assistance at home.

- GAP: Of 35% that had Home Health orders, 60% had RNs in home within 1 day of discharge, as patient reported.

- 52% of patients in the study had no physician orders for post hospital DME/HH.

- Over the 16-month period, 54% of patients had a completed post hospital call. (This is underreported due to coding at onset.) Last six months of program increased to 85%.

## Provider and Patient Perspective:

- Providers (Hospitalist/PCP) stated that 43% of these cases were readmitted due to a decline in disease state/condition.

- Patients agreed with this, as 46% attribute their readmission to a decline in their disease state.

- Both patients and providers agreed on social factors contributing (7%) and non-compliance (6%) of their reasons for readmission.

- Providers reported 6% of patients discharged too soon and patients, 2%.

## RRCA Committee:

Medical Director
Assistant Medical Director (Hospitalist)
UM Medical Director
Administrative Director, Managed Care
UM RN Director
RN Supervisor, Complex Case Management

## Innovations in care during and after RRCA analysis:

1. Discharge Checklist in use at all network hospitals.
2. Case Managers complete red flag teaching to patients with approved tools with teach back.
3. Case Managers discuss advance care planning and attempt to document POLST on all seniors prior to discharge.
4. PCHMC is evaluating an Observation Care Unit.
5. Non-emergent blood transfusions are ambulatory services at 3 network facilities.
6. Preferred vendor for MD /NP home visit has Facey cell phones and Facey secure email for ease of coordination of care needs.
7. PHCMC is evaluating Unit-based Pharm Techs or Pharmacists to complete medication reconciliation at time of admission as a pilot.
8. Case Managers and Hospitalists/Nocturnists completed 2 trainings on increasing patient encouragement and use of teach back.
9. High Risk Case Conferences began with multiple providers, including specialists (internal and external) and involved staff. Treatment plans are developed and monthly check in calls scheduled with utilization reported to group. High-risk patients entered into a CCM and Home Visit by MD/NP program. Significant success on a small scale with our highest risk frequent flyers.
10. Post-discharge home visits on senior discharges for Annual Wellness Visits and home visits began for 100% of discharges for selected senior health plans.
11. Case Managers/Discharge Planners/Hospitalists/Nocturnists/PCPs/Specialists attended Palliative Care workshops to design needed home services for our Facey patients.
12. RRCA Committee met with Providence Home Care to describe needed efficiency for home health documentation and brainstorm innovation of services.
13. PCMH staff and Nurse Practitioners orient at PHCMC, in UM Committee and UM Department for a day to experience patient coordination of care process.
14. A designated patient alert was developed for Hospice/Hospice diagnosis in Allscipts.
15. A banner in Allscripts now denotes if Advance Directive or POLST is on file in Allscripts.
16. Hospital CM, SNF or community obtained POLST is scanned to medical records and Allscripts by FMF Discharge Planners and GeriNet providers in community and SNF. AD or POLST on file at PHC is not sent to FMG as yet.
17. Home visits overall increased by >100% from baseline during the 16 month study.
18. Pharm Tech support for Hospitalists was implemented where H.P. prior authorization of discharge medication was required.