KP Transition Bundle

Washington Patient Safety Coalition
Seattle
May 14, 2012

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Kaiser Permanente
Executive Consultant Strategic Programs

care management institute
Session Objectives

Participants will be able to...

- describe the essential components to a patient centered transitions approach
- understand key drivers of unnecessary readmissions
- identify key interventions that contribute to improved transitions and a decrease in unnecessary readmissions
Kaiser Permanente

- 8.7 million members
- 9 states + Washington, DC
- 32 hospitals
- 420 medical offices
- 14,000 physicians
- 160,000 employees
- KPHealthConnect
Today

- Voices of our Members Video
- Readmission Diagnostic Evaluation Results
- KP Transition Bundle
- Results
Voices of Our Members: Video
What do we know about readmissions?

- **Readmissions are Frequent**
  - 1 out of every 5 Medicare beneficiaries had an unplanned readmission within 30 days (NEJM, April 2009)

- **Readmissions are Costly**
  - Total cost of unplanned readmissions for Medicare population estimated to be $17.4 billion in 2004 alone (NEJM, April 2009)
  - CMS reimbursement is changing – there are new incentives to reduce unplanned readmissions

- **Readmissions are sometimes preventable**
  - Nationwide, between 9% and 48% of readmitted patients receive substandard care during or following the index hospitalization (Archives Internal Medicine 2000)
We used evidence to guide our approach

- **Brian Jack**: Project RED:
  - Medication reconciliation
  - Standardized DC plan
  - Follow-up appointments
  - Outstanding tests
  - Post-discharge services
  - Written discharge plan for patient
  - Telephone reinforcement

- **Mary Naylor**: Multi-disciplinary care team
  - Advance Practice Nurse Transitional Care
  - Home visits
  - Telephone Follow-Up

- **Eric Coleman**: Four Pillars:
  - Medication self-management
  - Personal health record
  - Timely MD Follow-Up
  - Understanding “red flags”
The discharge-readmission cycle

It seems like members are catapulted out of the hospital

NW Transitions Improvement Kickoff, March, 2009
Arthur Hayward MD
Transitions: Whose job is it?

Transitions Department?
Primary Care?
Specialty Care?
Hospitalists?
Continuing Care?
Quality Department?
Resource Stewardship?
UM Department?
The patient.....
"Care transitions is a team sport, yet all too often we don’t know who our teammates are, or how they can help."

Eric A. Coleman, MD, MPH
KP Transition Journey

What Patients Need?

Transitions Bundle Redesign and Spread

<table>
<thead>
<tr>
<th>What does the patient and family need?</th>
<th>Transition bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will have what I need when I return home</td>
<td>Risk Stratification with tailored care</td>
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<td>Standardized RN/CC Needs Assessment</td>
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<td>My regular doctor will know what happened to me in the hospital</td>
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<td>RN follow up Call within 48 hours.</td>
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</tr>
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</table>
Our Patients Are Our Strongest Tool in Helping Get Us Where We Want To Go
Many ways of bringing patients into improvement

- Surveys
- Focus groups
- Video ethnography
- Readmission diagnostics case review
- Patient councils
- Patients on the QI team

More people ➔ More compelling
Ethnography, also called “field work”, is a qualitative method developed by social scientists involving in-depth interviews and observation to understand, describe, and interpret experience, systems, organizations and cultures.

Video Ethnography combines ethnography with video to capture data from interviews and observation for rapid analysis and communication to different audiences to inform and motivate decision-making and improvement.
Voices of our Members Library

- 50 videos created on a wide range of topics
- Videos shared across the organization for education, training, and improvement with front line teams, nurses, physicians, and leadership
- Videos shared outside the organization for educational purposes with purchasers, policy makers, and others

“Tool Kit on Video Ethnography” just created, now available to you
“Seeing with New Eyes”

"The real act of discovery consists not in finding new lands but in seeing with new eyes.”

- Marcel Proust
Readmission Diagnostic Work

600 CHART REVIEWS

538 MD INTERVIEWS
PCP 234
HBS 166
Specialist 111
SNF MD 14
Other 13

600 RN/MD Team FINAL ASSESSMENTS
Synthesis of 3 different data sources

433 PATIENT OR CAREGIVER INTERVIEWS
Patient 255
Caregiver 178

Slide 17
Some cases were potentially preventable

<table>
<thead>
<tr>
<th>Who We Asked</th>
<th>Not Likely</th>
<th>Slightly or Moderately Likely</th>
<th>Very or Completely Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD (n=445)</td>
<td>67%</td>
<td>30%</td>
<td>3%</td>
</tr>
<tr>
<td>Patient (n=368)</td>
<td>67%</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td>RN/MD Final Assessment Team (n=537)</td>
<td>53%</td>
<td>36%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Five areas of opportunity were identified

- For each case, RN/MD assessment teams identified missed opportunities from a list of 42 possibilities. We clustered related missed opportunities into five categories.
- Potentially preventable cases contained an average of 6.6 missed opportunities each.
There was a relationship between the index hospitalization and the readmission

➢ 71% of patients came back for a problem related to index hospital stay.

• Reviewers frequently noted that better managing and monitoring of the condition from index hospitalization might have prevented many of these readmissions

• One fifth of physicians reported that the care at readmission might have been provided in an outpatient setting.
Many patients used the Emergency Room for follow up care

- When their conditions worsened, most patients went to the ED instead of contacting someone at Kaiser Permanente.

  - Two thirds of patients did not contact KP before coming to the Emergency Department.

  - 61% of outpatient physicians reported they were not aware of the patient’s worsening condition prior to readmission.
Risk Assessment

- Patients did not always have their risk fully assessed at discharge.

**Physician Opinion:**
- 41% of providers interviewed reported that they could have predicted the readmission.

**Previous Utilization:**
- Over half of patients had prior hospitalizations and/or ED visits in the last 6 months.

**Functional Status:**
- 60% of patients were somewhat or fully dependent for activities of daily living (ADLs).
Referrals

Patients did not always receive referrals that might have been beneficial.

40% of patients might have benefited from additional referrals:

<table>
<thead>
<tr>
<th>Referral</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Palliative</td>
<td>65</td>
</tr>
<tr>
<td>Outpatient Palliative</td>
<td>49</td>
</tr>
<tr>
<td>Chronic Conditions Management</td>
<td>49</td>
</tr>
<tr>
<td>Home Health</td>
<td>40</td>
</tr>
<tr>
<td>Social Work</td>
<td>36</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>16</td>
</tr>
<tr>
<td>Hospice</td>
<td>16</td>
</tr>
<tr>
<td>Specialist</td>
<td>12</td>
</tr>
</tbody>
</table>
Patient Discharge Instructions

➢ Over half of discharge instructions did not specify who to call at Kaiser Permanente if patients needed help.

911 is often the only phone number given

Sometimes... many phone numbers are given
Follow Up Care Inconsistent

MANY PATIENTS RECEIVED FOLLOW-UP

- **59%** of patients attended a physician visit between hospitalizations
- **45%** of patients received a follow-up phone call between hospitalizations

FOLLOW-UP PROTOCOL NOT SYSTEMATIC

- In **10%** of cases, MD/RN team reviewers reported that the readmission might have been prevented if the patient had received a follow-up visit
- Individual medical centers **did not always follow a uniform method** of delivering follow-up

### Range of Follow-up Across Medical Centers

<table>
<thead>
<tr>
<th>Follow-up Type</th>
<th>Least</th>
<th>Most</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach phone call post-discharge</td>
<td>20%</td>
<td>63%</td>
</tr>
<tr>
<td>Follow-up appointment made in the hospital</td>
<td>23%</td>
<td>76%</td>
</tr>
<tr>
<td>Follow-up Physician Visit within 5 days</td>
<td>17%</td>
<td>63%</td>
</tr>
</tbody>
</table>
Providers did not leverage programs for patients with advance care needs.

Most providers suspected their patients were at the end of life:
- 65% of providers reported that they would not have been surprised if their patient died in the next year.

But many did not perceive a benefit for referring to an advance care program:
- 66% did not think their patient would benefit from palliative care or hospice.

Others did identify a benefit but did not make the referral:
- Almost half of physicians who reported that their patient would benefit from an advance care program had not referred their patient to a program.
Advance Care Planning

- Physicians explained why they did not discuss advance care planning with their patients.

IT WOULD NOT BE WELL RECEIVED
- “I know she is not open to or ready for that type of discussion.”
- “I felt he was not ready emotionally.”

IT’S SOMEONE ELSE’S JOB
- “I am only one of many physicians treating the patient.”
- “It was more appropriate for the Oncologist to have that conversation.”
- “Surgeon should bring it up.”

NO TIME
- “Every visit is so complicated and I didn’t have time to get to it.”
- “So many issues, I don't have the time to have the conversation in clinic.”

IT DIDN’T OCCUR TO THEM
- “I did not think about palliative care, do you think I should refer?”
- “I didn't think of it. It is probably a good idea.”
What did our members tell us

- Patients would have liked to know more about their health, prognosis, and treatment.
  - 31% reported we could have explained their prognosis more clearly.
  - 30% reported we could have explained things more clearly in general.
  - 24% reported we could have talked to them more about their medications and why they take them.
Implications

This method of review uncovers important information that administrative data alone does not provide.

The four step process of chart review, patient and family caregiver interview, provider interview, and final assessment by an RN and MD team allowed certain themes to emerge that would have been difficult to detect with administrative data alone:

- Many readmitted patients are nearing the end of life
- Outpatient providers are usually unaware of their patient’s worsening condition prior to readmission
- Patients generally go to the emergency department rather than contacting their primary providers

Other quality improvement projects could apply this methodology to uncover valuable information to inform, guide, and motivate improvement.
Factors Contributing to All-cause 30-day Readmissions: A Structured Case Series Across 18 Hospitals

Feigenbaum, Paul; Neuwirth, Estee; Trowbridge, Linda; Teplitsky, Serge; Barnes, Carol Ann; Fireman, Emily; Dorman, Jann; Bellows, Jim

Abstract:

Objective: To understand factors leading to all-cause 30-day readmissions in a community hospital population.

Research Design: Structured case series of 537 readmissions using chart reviews, interviews with treating physicians, patients and family caregivers, and overall case assessment by a nurse-physician team.

Setting: Eighteen Kaiser Permanente Northern California hospitals.

Results: Forty-seven percent (250) of readmissions were assessed as potentially preventable; 11% (55) were assessed as very or completely preventable; and 36% (195) as slightly or moderately preventable. On average, 8.7 factors contributed to each potentially preventable readmission. Factors were related to care during the index stay (in 143 cases, 57% of potentially preventable readmissions), the discharge process (168, 67%), and follow-up care (197, 79%). Missed opportunities to prevent readmissions were also related to quality improvement focus areas: transitions care planning and care coordination, clinical care, logistics of follow-up care, advance care planning and end-of-life care, and medication management.

Conclusions: Multiple factors contributed to potentially preventable readmissions in an integrated health care system with low baseline readmission rates. Reducing all-cause 30-day readmissions may require a comprehensive approach addressing these areas. Future quality improvement efforts and research should identify existing and new tactics that can best prevent readmissions by addressing missed opportunities we identified.
Transition Bundle Development

Old way of thinking

New way of thinking
Transition Bundle Development

**AIM**
Create an integrated end to end transitions process for KPNW members to keep them safely at home (or at a care facility) after a hospitalization.

**Objectives**
- Reduce 30-day readmission rates from 12.1% to 10% for members receiving the intervention
- Improve patient satisfaction with their care experience
- Increase % of patients that get a PCP appointment in 5 days
Transitions takes a Village!

- Patient
- Hospitals
- Clinics
- Home Health
- Hospitalists
- PCPs
- SNF
- Care coordination
- Utilization Management
- Medical Home
- Pharmacy
- Quality
- Service
- Nursing
- Physical Therapy
- Leaders
- EMR
- IT
- Others!
### Patient Centered Transition Bundle

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<thead>
<tr>
<th>What does the patient need?</th>
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<td>➢ Risk Stratification with tailored care</td>
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<td>I know when I should call and what number to use when I need help</td>
<td>➢ Specialized phone number on DC Instructions</td>
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<td>My regular doctor will know what happened to me in the hospital</td>
<td>➢ Standardized Same Day Discharge Summary</td>
</tr>
<tr>
<td>I understand my medications, how to take them, and why I need them</td>
<td>➢ Pharmacist reviewing medications in hospital and follow phone call at home for high risk patients</td>
</tr>
<tr>
<td>I know someone will check on me when I am home.</td>
<td>➢ MD appointments made in hospital within 5 (high risk) to 10 days.</td>
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<td>➢ RN case mgmt 30 days (high risk)</td>
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Transitions Bundle Element #1: Risk Stratification and Tailored Care

Which patients are at high risk for readmission?

- Physician or RN believes the patient may be at risk for readmission
  OR
- Heart Failure Diagnosis
  OR
- Prior hospitalization in last 30 days
Transition Bundle Element #2: Special Transitions Phone number

Patients now can quickly access KP after leaving the hospital and get their questions answered.

- Special Phone number on DC instructions for use between leaving the hospital and seeing PCP
- Calls are answered 24/7; triaged by an advice RN answered within 17 seconds
- RN can manage 50% of calls/pages hospitalist for other issues

Pilot Call Types

- Vomiting: 4%
- Pain: 4%
- Fever: 4%
- Emergent Symptoms: 13%
- Routine Symptoms: 42%
- Incision Issue: 4%
- Medications: 29%

Diagram: Pilot Call Types
Transition Bundle Element #3: Standardized DC Summary

Hospitalists and PCPs collaborated on a simple DC summary, completed day patient leaves the hospital, that everyone LOVES
Bundle Element #3: Standardized DC Summary

HOSPITALIST DISCHARGE SUMMARY
10/13/2011

Pharmacy Test
9876-54-32
PCP: Christopher A. Calawa, MD

Date Of Admission: 10/1/2011
Date Of Discharge: 10/13/2011
Disposition: Home

Readmission Risk Assessment: Medium (follow-up 10 days or less)

Pending Study Results At Discharge
1. Blood cultures still in progress; no growth so far
2. HgA1C is still pending

Issues To Be Addressed In Follow-Up
1. Has cellulitis resolved?
2. Are BG’s better on adjusted insulin
3. Routine wound care (had I&D of abscess on RLE)

Primary Discharge Diagnoses
*CELLULITIS - WITH ABSCESS SKIN OR SUBQ TISSUE, ACUTE
SYSTOLIC HEART FAILURE, ACUTE ON CHRONIC DIABETES, UNCONTROLLED
CHRONIC KIDNEY DISEASE, STAGE 4, SEVERELY DECREASED GFR

Other Diagnoses
PANCREATITIS, CHRONIC OSTEOPOROSIS

The PCP’s and CCCM nurses love this section.
Did I say the PCP’s and CCCM nurses love this section too?
Bundle Element #3 – Standardized DC Summary

Post Hospital Care Instructions

Diet
Diabetic, Low Cholesterol

Activity
As tolerated

Notify the Physician or Nurse If You Have Any of the Following Symptoms/Problems
Recurrent fever or redness in your leg

How to Contact A Nurse or Physician After You Leave the Hospital
a. WE ARE GOING TO CALL YOU AT HOME IN THE NEXT FEW DAYS TO CHECK ON YOU: Many patients find they have questions once they arrive home after a hospitalization. Therefore, Kaiser Permanente will have a nurse from your Primary Care Clinician’s office contact you within the next three days to go over your medications and follow-up care.

b. FOR URGENT MEDICAL QUESTIONS DURING THE NEXT 48 HOURS CALL 1-888-574-3556: Tell the receptionist, “I was discharged from Kaiser Sunnyside within the past 48 hours by the hospitalist, Andrew H. Felcher, MD. An advice nurse is available to address your concerns 24 hours per day and, if necessary, they will contact your doctor, if available, or the doctor on call.

c. FOR ROUTINE QUESTIONS AND MEDICAL ISSUES THAT COME UP MORE THAN 48 HOURS AFTER YOU LEAVE THE HOSPITAL: Contact your own Primary Care Clinician, Christopher A. Calawa, MD, or if after hours, call the Regional Advice Nurse at 1-800-813-2000.

Additional Instructions
Please try to be nicer to your middle child - he misses you.

Follow-up Labs and Tests
Please go to any KPNW LAB and get a blood test (CBC) on November 1

Follow-Up Appointments Currently Scheduled
I have requested the following appointment(s) be made for you. If the specific appointment details are not listed below in “Upcoming Appointments”, you will be contacted by phone with this appointment. If you have not heard from us within five days, please call the Advice and Appointment Center at (503) 813-2000 to schedule your appointment(s). An appointment with your primary care clinician will be made for you within 10 days.

“I can definitely help you, what seems to be the problem?”

“Wow, thanks for calling. I wasn’t sure about…”

Individual departments have their own specific contacts
Transition Bundle Element #4: Medications

Medication lists were not always accurate or in understandable language

List in hospital matched what patient was taking 57% of time

Image of a discharge instruction sheet with medications listed.
Medication management must happen across settings to make sure list is accurate and to support patient understanding and adherence.

- **Hospital**
  - MD reconciles home/hospital
  - RN teaching/teach back
  - Pharmacist review of meds (high risk)

- **Home**
  - RN f/u call/review
  - Pharmacist calls patients once home (high risk)
  - PCP

- **SNF**
  - Pharmacist reviews meds for all patients going to SNF
Bundle Element #4 - Medications

Skin infection with a large boil that needed incised and drained

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**NEW MEDICATIONS**

| Medication | Dose | Administration
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clindamycin HCl (CLEOCIN)</td>
<td>300 mg Oral Cap</td>
<td>1 TAB BY MOUTH FOUR TIMES A DAY x 7 MORE DAYS</td>
</tr>
</tbody>
</table>

**UNCHANGED MEDICATIONS**

| Medication | Dose | Administration
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FLUoxetine (PROZAC)</td>
<td>10 mg Oral Cap</td>
<td>1C PO QAM</td>
</tr>
<tr>
<td>gliclAZIDE (GLUCOTROL)</td>
<td>10 mg Oral Tab</td>
<td>0 ST PO QAM</td>
</tr>
<tr>
<td>Simvastatin (ZOCOR)</td>
<td>80 mg Oral Tab</td>
<td>TAKE ONE TABLET BY MOUTH ONCE DAILY</td>
</tr>
<tr>
<td>Aspirin (ECOTRIN LOW STRENGTH)</td>
<td>81 mg Oral TBEC DR Tab</td>
<td>TAKE ONE TABLET BY MOUTH ONCE DAILY</td>
</tr>
</tbody>
</table>

**MEDICATIONS YOU WERE TAKING THAT HAVE BEEN STOPPED**

Please stop taking your atenolol – it caused your heart to go so slow you fainted.

If you are taking medications not listed above, please discuss them with your healthcare team.

Put diagnosis(es) in lay language…figure that it will be your high school English teacher reading it.
Follow-up Appointments
- Made upon discharge
- High risk patients in 5 days
- Medium risk patients in 10 days

Follow-up Calls
- RN follow up within 48 hours
- RN case management within 30 days (high risk)
Bundle Element #5 – Follow Up

Post Hospital Care Instructions

Diet
Diabetic, Low Cholesterol

Activity
As tolerated

Notify the Physician or Nurse If You Have Any of the Following Symptoms/Problems
Recurrent fever or redness in your leg

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“Wow, thanks for calling. I wasn’t sure about…”

“I can definitely help you, what seems to be the problem?”

Individual departments have their own specific contacts
**“My Concerns” Form Used for Discharge Planning**

<table>
<thead>
<tr>
<th>My Concerns</th>
<th>Check up to 5 concerns and talk to your provider about them today.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>About My Diagnosis</strong></td>
<td></td>
</tr>
<tr>
<td>- I want to understand the medical terms.</td>
<td></td>
</tr>
<tr>
<td>- How long will I be sick?</td>
<td></td>
</tr>
<tr>
<td>- Will this disease go away?</td>
<td></td>
</tr>
<tr>
<td>- How will my lifestyle change?</td>
<td></td>
</tr>
<tr>
<td>- What help will I need at home?</td>
<td></td>
</tr>
<tr>
<td>- What should I be most concerned about?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>About My Medications</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- I don't want to take so many medications.</td>
<td></td>
</tr>
<tr>
<td>- I want to understand what my medications are for.</td>
<td></td>
</tr>
<tr>
<td>- I am concerned about the cost of medications.</td>
<td></td>
</tr>
<tr>
<td>- I need an easier way to organize all of my medications.</td>
<td></td>
</tr>
<tr>
<td>- Can I take medications instead of changing my diet?</td>
<td></td>
</tr>
<tr>
<td>- Will these medicines make me feel better?</td>
<td></td>
</tr>
<tr>
<td>- When will I know the medicine is working?</td>
<td></td>
</tr>
<tr>
<td>- What happens if I don't take my medicine?</td>
<td></td>
</tr>
<tr>
<td>- Which medicines do I have to take with food? Which do I take without food?</td>
<td></td>
</tr>
<tr>
<td>- What effects will this medicine have on my mood?</td>
<td></td>
</tr>
<tr>
<td>- I don't like some of my medications.</td>
<td></td>
</tr>
<tr>
<td>- When do I take each medicine?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>About My Diet</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- I am concerned about being able to prepare my meals.</td>
<td></td>
</tr>
<tr>
<td>- I don't like the foods that are being recommended.</td>
<td></td>
</tr>
<tr>
<td>- Where can I learn more about more healthy eating choices?</td>
<td></td>
</tr>
<tr>
<td>- The recommended foods sound expensive.</td>
<td></td>
</tr>
<tr>
<td>- How can I make my favorite foods more healthy?</td>
<td></td>
</tr>
<tr>
<td>- If I eat something I'm not supposed to, what happens?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>About My Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- I'm not sure what types of activity I can do.</td>
<td></td>
</tr>
<tr>
<td>- I am concerned about the stairs where I live.</td>
<td></td>
</tr>
<tr>
<td>- Using a walker is going to be hard for me.</td>
<td></td>
</tr>
<tr>
<td>- How do I get to the clinic if I cannot drive?</td>
<td></td>
</tr>
<tr>
<td>- I don't think I have enough help at home.</td>
<td></td>
</tr>
<tr>
<td>- I'm concerned about how I will keep up with my house chores.</td>
<td></td>
</tr>
<tr>
<td>- How will I dress myself?</td>
<td></td>
</tr>
<tr>
<td>- Getting to the bathroom is hard.</td>
<td></td>
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<tr>
<td>- When can I drive?</td>
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</table>

<table>
<thead>
<tr>
<th>About My Other Concerns</th>
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_ care management institute_
151 patients were readmitted within 30 days of index hospitalization.
7 of these readmissions (5%) were deemed likely preventable readmissions.
32/151 (22%) had a diagnosis of CHF.
20/151 (13%) were discharged to a SNF following index admit.
65/151 (43%) received a transition pharmacist review at index discharge.
135/151 (89%) discharge summary/instruction templates used index admit.
137/151 (91%) had a care coordinator note/evaluation during index admit.

An evaluation of the likely preventable readmissions reveals:
0/7 none had a diagnosis of CHF.
3/7 (43%) were discharged to a SNF following the index admit.
4/7 (57%) received a transition pharmacist review at index discharge.
7/7 (100%) had discharge summary/instruction templates used index admit.
7/7 (100%) had a care coordinator note/evaluation during index admit.
3/7 (43%) were readmitted within one day of discharge.
2/3 (67%) not in a SNF or on Hospice received a transition follow up call.
4/7 (57%) of the patients were high risk for readmission but only 1 (14%) was categorized as high risk for readmission by the physician at discharge.
1/3 (33%) not in a SNF or on Hospice had follow up within 5 days of discharge.
100% contacted Kaiser prior to readmission.
Results: NW Readmission Rates
(Sunnyside Hospital)

30 day readmission rates trending down – lowest in KP

- Medicare
- Medicaid
- Overall
- Commercial

- 2009: 10.9%
- 2010: 10.3%
- 2011: Target is 9.9%
Results: Access to MD

% of patients with MD visit in 5 days improving
Results: Access to PCP

Patients seeing PCP sooner

<table>
<thead>
<tr>
<th>Average # of Days Between Discharge and PC/SC Visit</th>
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<tr>
<td>Days to PCP appointment</td>
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<td>6.0</td>
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</table>
Results: Patient Satisfaction

HCAHPS scores are improving

HCAHPS - Pt. Received Written Information

- Jun 09: 82%
- Aug 09: 84%
- Oct 09: 86%
- Dec 09: 88%
- Feb 10: 90%
- Apr 10: 92%
- Jun 10: 94%
- Aug 10: 96%
Results: Increased Access to Palliative Care Services

Patients have increased access to Palliative Care Services

Number of Weekly IPC Consults at KPNW Sunnyside Hospital

- UCL: 23.55
- Mean: 10.73
<table>
<thead>
<tr>
<th>Transition Bundle</th>
<th>NW</th>
<th>CO</th>
<th>SC</th>
<th>MA</th>
<th>OH</th>
<th>GA</th>
<th>NC</th>
<th>HI</th>
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<tbody>
<tr>
<td>Risk Stratification-Tailored care</td>
<td>★</td>
<td>⬠</td>
<td>P</td>
<td>★</td>
<td>P</td>
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<tr>
<td>Follow-up call 48 hours</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Timely MD follow up appointments scheduled in hospital</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Medication Reconciliation redundancies Across settings</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td></td>
<td>P</td>
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<tr>
<td>Standardized same day DC summary</td>
<td>★</td>
<td>★</td>
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<td>P</td>
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<tr>
<td>Special Transition phone # on DC instructions (24/7 expedited, immediate access to RN/MD)</td>
<td>★</td>
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</table>

- **Strong Implementation**
- **Implementation Phase**
- **Testing Phase**
- **Planning Phase**
- **No activity yet**
NCQA has released preliminary information about the average Observed/Expected Readmissions ratio for all Plans (performance year 2010).
HCAHPS – Discharge Information through Dec.2011

Monthly Trend Report - HCAHPS Dimension - Discharge information Program - All IP Combined

- Northwest Region
- Program Wide
- Southern California Region
- Hawaii Region
- Northern California Region

Benchmark is CMS National Benchmark Based on Reporting Period 2010 Q1 - 2010 Q4.
† means significant improvement over last month, ‡ means significant regression from last month.
Thank you: Questions?
Appendix: References


