Reducing Readmissions Through Timely Post-Discharge Follow-Up: 

*Best Practices from the Field*

March 18, 2015

Guest Presenters:

**JENNIFER DURST**, Quality Assurance and Improvement Manager, Marin Community Clinics  
**ALEXIS RILEY**, MA, RHIT, CPC. Director of HIS, Shasta Community Health Centers  
**JEAN LUDWIGSEN**, RN. Care Transition Manager, Mountain Valleys Health Centers
To avoid echoes and feedback, we request that you **use the telephone** instead of your computer microphone for listening/talking during the webinar.
All participants have been muted to eliminate any possible noise interference/distraction.

If you have a question or would like to share your comments during the webinar, **please type your question in the “question” box.**
Evaluation

• Evaluations are important to improving the Partnership Improvement Academy and our services.

• A short evaluation will appear at the end of the session. Please **take time to respond**.
Agenda

1. Introduction
2. Best practices from the field to improve timely follow-up post-discharge
3. PHC’s Patients in Acute Hospital list
4. QIP All-Cause Readmissions measure
PHC: The Strategic Importance of Readmissions

2011 - 2012:
- DHCS declared readmissions a statewide Quality Improvement Project
- PHC launched Readmissions Committee

2014-2015:
- PHC focused activities on:
  - Care Transitions/Coordination
  - Internal Data Systems
  - CHF
  - Hospital-PCP partnerships

Drivers of reduced readmissions risk among PHC’s 518,000 members include:
- High-quality discharge processes
- High-quality care transitions services
- Timely PCP post-discharge follow-up
Best Practices: Jennifer Durst, MCC
Strategies for Improved Hospital Follow-up at Marin Community Clinics

Partnership HealthPlan of California
Readmissions Webinar
March 18th, 2015

Jennifer Durst, Marin Community Clinics
Quality Assurance & Improvement Manager
Marin Community Clinics

- 4 Primary Care Sites
  - 34 Primary Care Providers
  - 3 Family Practice, 1 Adult Med
  - 2 OB Clinics
  - 2 Dental Clinics
  - 2 Optometry Clinics
  - Many other Specialty Services
    (Podiatry, Neurology, Chiropractic, etc.)

- Serves approx. 34,000 patients/year
- PCMH (level 3) Recognized Practice
- EHR: NextGen
Partner Hospitals

• 2 Major Community Hospitals in Marin County:
  
  **Novato Community Hospital (Novato)**
  - 4 minute drive to MCC Novato

  **Marin General Hospital (Greenbrae)**
  - 7 min walk or 1 min drive to MCC Larkspur
Strategies for Hospital Follow-up

• Improve avenues of communication & partnership between clinics and hospitals

• Stored “my phrases” to aid in documentation and follow-up

• Shared responsibility among multiple staff levels for documenting hospitalization
Partnering with Hospitals

• Novato Community Hospital

Meetings:
  • MCC’s Clinical Quality Lead Clinician, Dr. Elizabeth Shaw, held initial meetings with NCH’s Medical Director of Emergency Services & Lead Hospitalist to set mutual goals for patient follow-ups
  • Ongoing meetings with Case Managers to discuss discharge planning

Benefits:
  • Demonstrated that the clinic was a willing partner with the hospital in improving patient care
  • Shared contact info between Hospitalists and MCC providers: Hospital now sends coverage schedule to Dr. Shaw every month, so MCC has contact info when we send a patient to the hospital or have a question about a discharge.
Partnering with Hospitals

• Marin General Hospital

Meetings:
• Ongoing meetings with MGH ER Medical director, Hospitalists, and Case Managers

Previous Strategies:
• Care Book (messaging device that allowed MGH to alert MCC clinicians when a patient was hospitalized)
• MCC provided support staff to meet with patients who were in the hospital to aid in their transition and attempt to decrease the no-show rate at scheduled Hospital Follow-up visits.

Benefits:
• Demonstrated that the clinic was a willing partner with the hospital in improving patient care
• Recently, it was discovered through a meeting with the ER Medical Director that a functionality within the Hospital’s EHR had been turned off that would allow ED reports & dictations to automatically fax to MCC. This was fixed and we are receiving an increase in reports.
Strategies for Hospital Follow-up

• Improve avenues of communication & partnership between clinics and hospitals

• Stored “my phrases” to aid in documentation and follow-up

• Shared responsibility among multiple staff levels for documenting hospitalization
## Stored “My Phrases”

<table>
<thead>
<tr>
<th>My Phrase Type</th>
<th>My Phrase Summary</th>
<th>My Phrase</th>
</tr>
</thead>
</table>
| Plan           | ER Visit Follow-up| ER Facility:  
|                |                   | Visit Date:  
|                |                   | Primary Diagnosis:  
|                |                   | Full ER visit note received: (task to MR to request if needed)  
|                |                   | Needs Follow-up: Yes / No  |
| Plan           | Hospital Follow-up| Hospital:   
|                |                   | Discharge Date:  
|                |                   | Primary Diagnosis:  
|                |                   | Hosp fu appt date/time/provider:  
|                |                   | 4 day phone call made (caller/date/comments):  
|                |                   | Medication Reconciliation Discussed: Y/N  
|                |                   | Records received and to provider:  
|                |                   | Other Actions/Comments:  
|                |                   | Referrals made/needed:  
|                |                   | **Consider referral to Project Independence if appropriate** |
Communication using *my phrases*

The highlighted portions are a stored phrase that all staff can use to document any piece of information that they have about a patient’s hospitalization.
Strategies for Hospital Follow-up

• Improve avenues of communication & partnership between clinics and hospitals

• Stored “my phrases” to aid in documentation and follow-up

• Shared responsibility among multiple staff levels for documenting hospitalization
Shared Responsibilities

Any staff (Front Office, Call Center, Medical Records, Referrals, Medical Assistant, Clinician, etc.) who receives notification of a Hospital or ER discharge will:

1. Open a communication template
2. Label the template with “Hospital Follow-up Call” (dropdown)
3. Load the “my phrase” for the particular type of discharge
4. Fill in any and all information that they can
5. Task the communication to the Pod RN (Team Nurse) to follow up with gathering any missing data and calling the patient

**The RN will task any department or staff member needed in order to gather all necessary info (graphic on following slide)**
Shared Responsibilities

**Pod RN**
1. Reviews case and tasks team members to prepare for Hospital Follow-up visit
2. Calls patient WITHIN 4 DAYS of discharge to discuss and document the following:
   - Hosp fu appt time
   - Med reconciliation
   - Patient’s status and ?s
   - Any additional issues
3. Makes referral to Project Independence if appropriate or requested by patient or provider

**Medical Records**
- Obtain discharge summary and any additional hospital records as requested

**Schedulers/Front Office**
- Schedule hospital follow-up appointment with PCP and notify patient

**Medical Assistants**
- Review and help complete Hospital Follow-up communication template during pre-visit preparation

**PCP**
- Works with RN to address questions/issues and to order necessary referrals/studies

**Referral Coordinators**
- Process and document referrals to Project Independence or other specialists

*All tasking & documentation is done within the Hospital Follow-up Call communication template*
Project Independence

• A county HHS program, utilizing well-trained volunteers to partner with patients upon discharge from the hospital

• Volunteers serve as supportive, caring companions to patients transitioning from hospital to home

• MCC refers qualified patients to project independence as part of our care transition follow-up
Questions?

THANK YOU!
Best Practices: Alexis Riley, SCHC
Tools to Assist in Continuity of Care and Reducing Readmissions

Shasta Community Health Center
Alexis Riley, MA, RHIT, CPC
Director, Health Information Services
Privacy Officer
530-246-5735
Who We Are

Shasta Community Health Center (FQHC)

- Located in Redding, California (3 hours north of Sacramento)
- We offer Primary Care, Neuropsychiatry and Specialty Care with 29 specialists, which includes 15 different specialties
- Patients are primarily seen at 3 local hospitals and many times are sent to UC Davis and other hospitals in the Bay Area for more specialized care
- We serve 33,000 patients per year, around 75% of those are Partnership Health Plan members
What We Use

• Partnership HealthPlan makes a list available each day, which includes:
  ➢ All member Emergency Room visits
  ➢ Member In-Patient Admissions
• List downloaded into a .csv format
Scrubbing the List

• List is downloaded from the Provider Online Services section of the PHC site.

• This information is copied into a master Excel list.  
  *This has helped us identify patients that are assigned, but have not been seen and need to have their care transferred to SCHC.*

• HIS staff opens the hospital portal (if available) and retrieves records; if no portal, records are retrieved through fax or telephone calls.
Next Steps

• HIS team then tasks the PCP alerting them that their patient has been in the ED or admitted, and records are available for review.

• HIS team also enters information into Interim History, saving clinical teams’ time.
  
  • **Challenge:** Records can take some time to be completed (particularly for in-patients).
  
  • **Challenge:** Staff have to check back periodically to ensure they retrieve the records.

Currently we have not found a good way to deal with these issues...
Ideal Process – Perfect World

• SCHC Team which would include a PA who will work with the hospital Case Manager.
• SCHC could round with CM on the SCHC-identified patients and do a face to face hand off.
• SCHC would have a dedicated “discharge schedule” for their patient.
• Patient would return to SCHC for scheduled appointment w/PCP’s or home visits.
• Records handled between the hospital case manager and HIS who would alert SCHC Triage Nurse.
Ideal Process – Perfect World

• Since no funding was available for the “Perfect World” scenario:

  We suggested tackling a small piece: Setting up some kind of communication and records transfer until funding could be arranged.
Realistic Idea

- Developed a plan with both local hospitals over a period of four months:
  - Educated hospitals on SCHC’s process.
  - In-depth discussions about how to facilitate improved continuity of care and subsequently, reduce readmissions.

- Issues we encounter:
  - After hours Emergency Room case managers need to fax face sheets for patients that were not admitted
  - Emergency Room physicians want one point of contact
  - Because of the need to obtain and get records to PCP, HIS became a good option for these tasks
Instruction Sheet

SCHC Coordination of Care Instructions
Partnership Health Patients (PHC)

(All other patients will be handled the same except item #1.)

1. Call Partnership Health Provider Relations at 707-863-4140 to verify that patient is assigned to SCHC. If not, contact the appropriate provider which the patient has been assigned.

2. After confirmation of patient’s assignment, fax H&P, Med List, and latest progress note to 245-0863 (HIS Fax) with instructional cover sheet.

3. The HIS Department at SCHC will receive the documentation; scanning and indexing the documentation into the patient’s EHR file.

4. HIS at SCHC will then immediately notify by phone and task the PCP’s appropriate triage nurse to give them the discharge planner’s contact number.

5. Triage nurse will then contact the Case Manager whose phone number appears on the cover sheet.

6. The SCHC triage nurse and the SRMC Case Manager will then coordinate care for the discharge.

7. If problems arise, call 246-5888 and ask for Paul Senn or Barbara Martin (if not available ask that they be paged).
What Actually Happened

At first......crickets

• Lately we have seen a small up-tick in calls from one of the hospital case management team

**Challenge:** Sometimes the calls come in before the paperwork is complete, which leaves our triage nurse with nothing to refer to in scheduling the patient

• The increase in communication is recent, so has not been measured
Questions?
Best Practices, Jean Ludwigsen, Mountain Valleys Health Ctrs

• Funded by Blue Shield of California Foundation
  GOAL: advance care coordination and integration between CHC’s and hospitals to achieve the Triple Aim
• Developed best practices, including tactics to promote hospital-PCP communication:
  1. Create a document on letterhead that lists:
     a. Primary contact (i.e. Transition of Care Nurse) and Medical Director
     b. Clinic address, phone number and fax line
     c. Provider NPIs, license numbers, and clinic addresses of all providers at practice
  2. Go in-person to each of your local hospitals, and visit the Medical Staff Department and Transcription Department.
     a. Provide them with the list of providers and clinic contact information (mentioned in bullet 1), and your business card.
  3. Sign up for the local HIE in your region: i.e. the HIE associated with Dignity Health. Identify at least one doctor at your practice who will have administrator access to the HIE. Admissions will appear in the HIE by PCP (and affiliated practice site).
  4. Review PHC’s Patients in Acute Hospital List on Provider Online Services to identify admissions at any hospital.

Once admissions are identified and records are obtained, review care plan and call patient to establish the f/u visit.
When a PHC member is admitted to acute care, information from the inpatient TAR is extracted and reported to the assigned PCP via our Online Services platform.

If you need access to PHC Online Services or training on the Patients in Acute Hospital report, contact your assigned Provider Relations Representative. If you don’t know who your assigned Rep is, call the Provider Relations Department at (707) 863-4100. We will connect you.
### PHC: Patients in Acute Hospital Report

**Partnership HealthPlan of California**

**PCP Name:** Cali Community Clinic

**Report Name:** Patients in Acute Hospital

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>CIN</th>
<th>SSN</th>
<th>DOB</th>
<th>Gender</th>
<th>Hospital Details</th>
<th>Admission Date</th>
<th>Diagnosis</th>
<th>Service Provider</th>
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<tr>
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<td>1</td>
<td>1</td>
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<td>9</td>
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<td>1</td>
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<td>Medical Center Northbay Po Box 39000 Dept 05221 San Francisco, CA - 94139 Phone: 707-646-5000</td>
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<td>Prem Rupt Membran-Unspec</td>
<td>1300 0001</td>
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<td>Uc Davis Medical Center Po Box 742769 Los Angeles, CA - 90074 Phone: 916-734-9200</td>
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<td>Female</td>
<td>Medical Center Northbay Po Box 39000 Dept 05221 San Francisco, CA - 94139 Phone: 707-646-5000</td>
<td>3/11/2015</td>
<td>Other Specified Disorders Of Female Genital Organs</td>
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</table>
Why should I check the Patients in Acute Hospital list?

- Identify members assigned to your practice who have been admitted to acute care
- Capture data from out-of-area hospitals
- Ensure timely post-discharge follow-up

What factors impact the quality of the Patients in Acute Hospital data?

- Special Member or other insurance status
- Timeliness of hospital notification to PHC of inpatient admission (TAR)
- Duration of inpatient stay
- TAR volume, holidays and weekends
## June 2015 Enhancements

1. Export capability

2. Enhanced sorting functionality

3. Historical record: ability to identify “frequent fliers”
   - ☑ 30-day view
   - ☑ 3 month view
   - ☑ 6 month view
PHC: QIP Readmissions Measure Specs

Readmission Rate or Follow-Up Post Discharge, Family & Internal Med

Measure Description
Ratio of Acute hospital admissions that are within 30 days of a discharge to total number of inpatient stays. Medi-Cal capitated members only.

Targets: Plan mean by practice type
- Full points (10 points): 110% or less than target
- Half points (5 points): 111-119% of target

*Back-up measure: If Bed Days per 1000 threshold /or Readmission rate threshold is not met, providers may earn points based on performance on a back-up measure: Follow up visit within 4 days of discharge
Follow Up Post Discharge

Measure Description

– Follow-up Post Discharge can be the back up measure for rather Acute Bed Days/1000 or Readmission Rate.
– Follow-up visits include both primary care specialty care visits and excludes follow-up visits to the hospital.
– A telephonic encounter may count if it is made by the clinician or a licensed staff member.
– PHC will collect preliminary inpatient stay data 30 days after the conclusion of the measurement year (June 30, 2015) and identify stays with no associated office visit claims with a date of service within 4 calendar days of discharge.
– QIP team will distribute to practice sites a list of patients hospitalizations in August 2015.
– Practice sites will return the list to QIP team indicating the date a telephonic encounter or office visit occurred if applicable.
PHC: QIP Monthly Non-Clinical Reports

### Partnership HealthPlan of California
Quality Improvement Program (QIP) FY 2012-2013 Report: Summary and Ranking
Non-Clinical Measures
For Period: July 1, 2012 - September 30, 2012

<table>
<thead>
<tr>
<th>Practice Type: Family Practice</th>
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<tbody>
<tr>
<td>Total Member Months: 2,691</td>
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</table>

<table>
<thead>
<tr>
<th>Measures</th>
<th>Your Results</th>
<th>Target</th>
<th>Desired Position</th>
<th>Points Earned to Date</th>
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</thead>
<tbody>
<tr>
<td>Appropriate Use of Resources</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Readmission Rate</td>
<td>169</td>
<td>236</td>
<td>Below Below</td>
<td>10.00</td>
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<tr>
<td>Generic Rate</td>
<td>12.0%</td>
<td>85%</td>
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<tr>
<td>Specialty Costs PMPM</td>
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<td>Avoidable ED Visits PMPY</td>
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<td>PCP Office Visits PMFY</td>
<td>1.00</td>
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<td># of quarters open to new patients</td>
<td>1.00</td>
<td>5.00</td>
<td>Above Above Above</td>
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<tr>
<td>3rd Next Avail Appt + 1 AdF Operations Measure</td>
<td>1.00</td>
<td>4.00</td>
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<td>Patient Experience</td>
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*Patient Experience results and points will be available at year-end report.

### Comparative Data

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<thead>
<tr>
<th>Measures</th>
<th>IP Days/1000</th>
<th>Readmission Rate</th>
<th>Generic Rate</th>
<th>Rx Formulary Rate</th>
<th>Specialty Costs PMPM</th>
<th>Avoidable ED Visits PMPY</th>
<th>PCP Office Visits PMFY</th>
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<td>Minimum</td>
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<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>$0.00</td>
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<td>100.00%</td>
<td>$233.55</td>
<td>$124.83</td>
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Lower rate is favorable.

Results for All Family Practice sites with: 750-1,549 members

<table>
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<th>Results for All Family Practice sites with: 750-1,549 members</th>
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<td>Your results</td>
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<td>PCP Site 11: 148</td>
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</tbody>
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Q&A
Clinical Presenter Contact Information

Alexis Riley, Shasta Community Health Center: aparsons@shastahealth.org

Jennifer Durst, Marin Community Clinics: jdurst@marinclinic.org

Jean Ludwigsen, Mountain Valleys Health Centers: jjudgwigsen@mtnvalleyhc.org

Provider Relations Department (to learn more about Patients in Acute Hospital report): Contact your Provider Relations representative, or call (707) 863-4100

QIP, Partnership HealthPlan of California: qip@partnershipphp.org

Any other questions about this webinar: ImprovementAcademy@partnershipphp.org