PIH HEALTH

Impacting Hospital Readmissions

PIH Health Cares Program

Intensive Outpatient Care Program

Ricki Stajer RN MA CPHQ

February 13, 2015

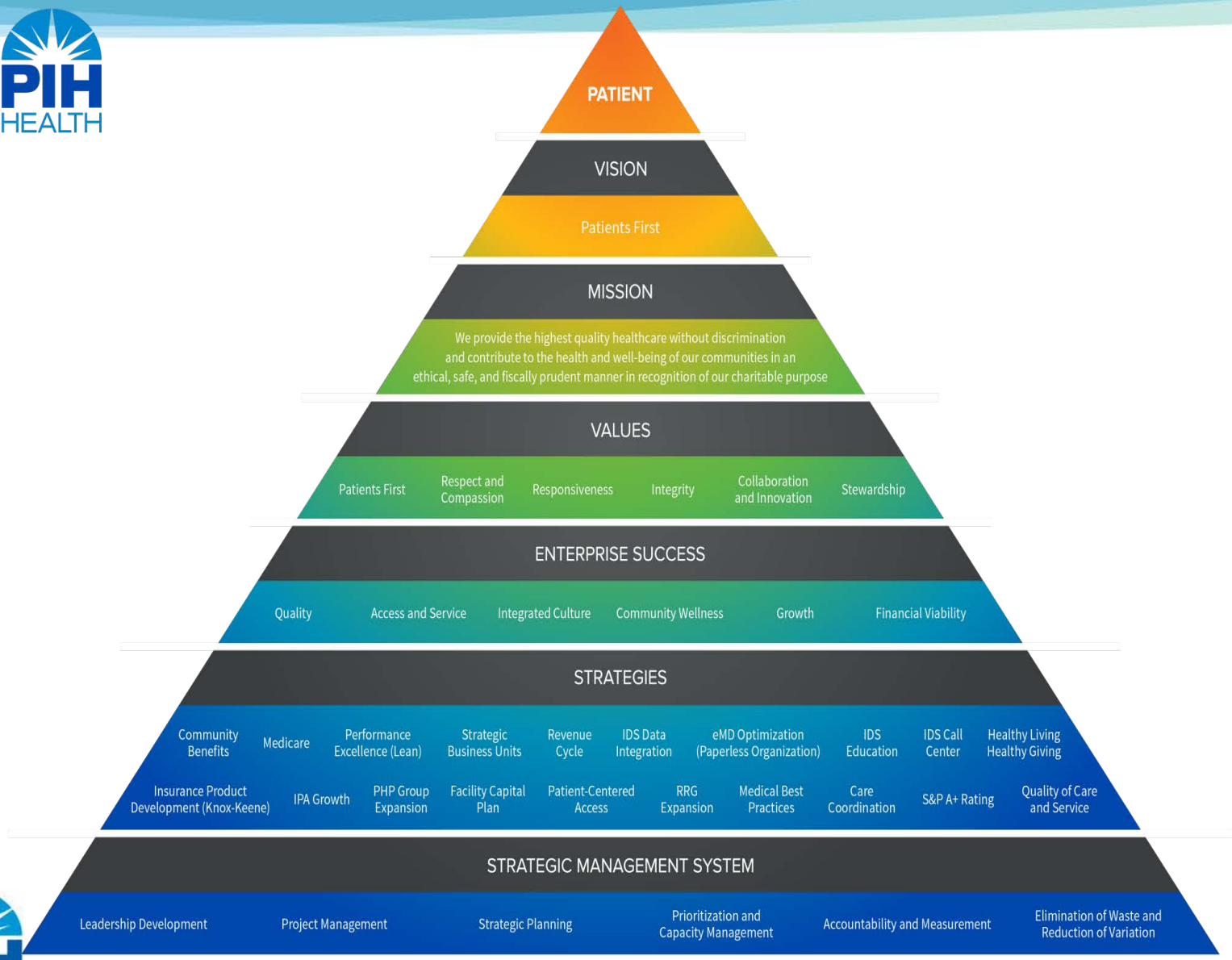
A Patients First System

Mission: We provide highest quality healthcare without discrimination and contribute to the health & well-being of the community…ethical, safe & fiscally prudent manner.

PIH HEALTH

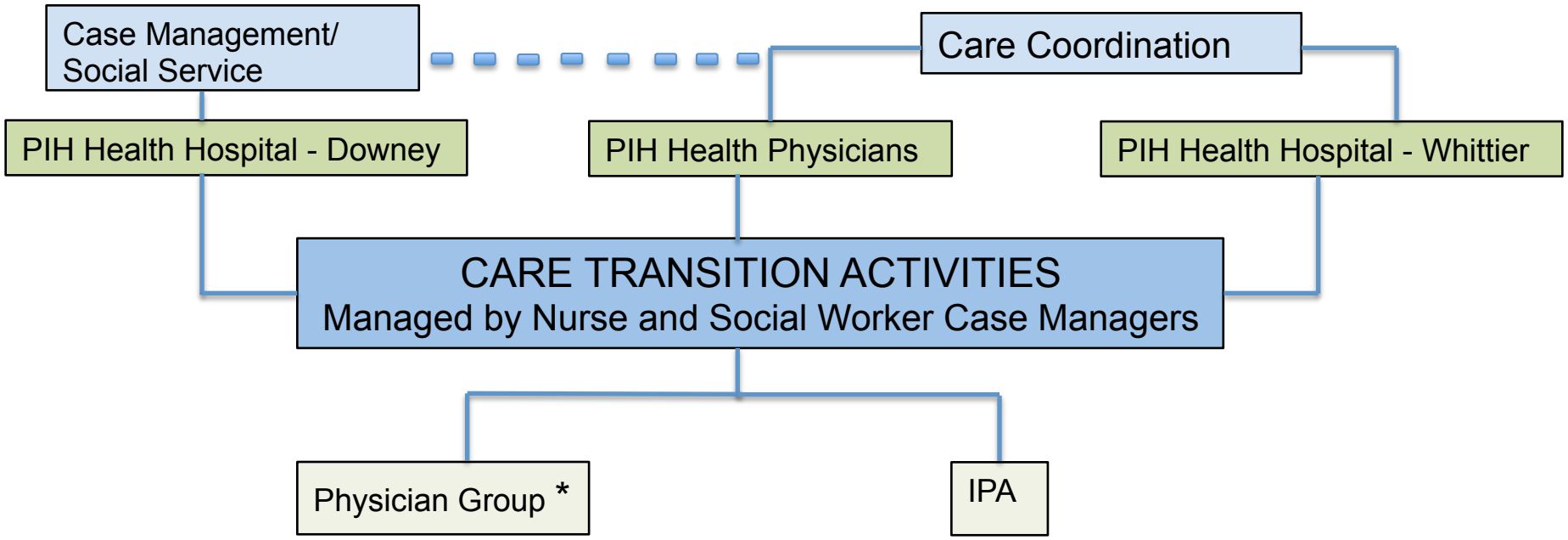
Values: patients first, respect & compassion, responsiveness, integrity, collaboration & innovation, stewardship

A Patients First System



PIH Health Healthcare System Care Coordination Structure

Integrated Delivery System



CARE COORDINATION SERVICES

- Referral & Authorization Services
- Post-Hospital Discharge Appointments*
- Home Health CHF Program
- Chronic Disease Management
- Complex Case Management

Intensive Outpatient Care Program

PIH Health CARES

Strategies to Reducing Readmissions Over the Last 5 Years

- Post Hospital Discharge Clinic
  - Run by Nurse Practitioners
    - Reduced 30 day readmissions by 40%
    - Small patient volumes – disbanded in 2014
- CHF Home Health Program
  - All CHF discharged patients received HH services for 6 weeks
    - Reduced 30 readmissions by 20%
    - Ongoing

PIH HEALTH

PIH Health *CARES* Program is:

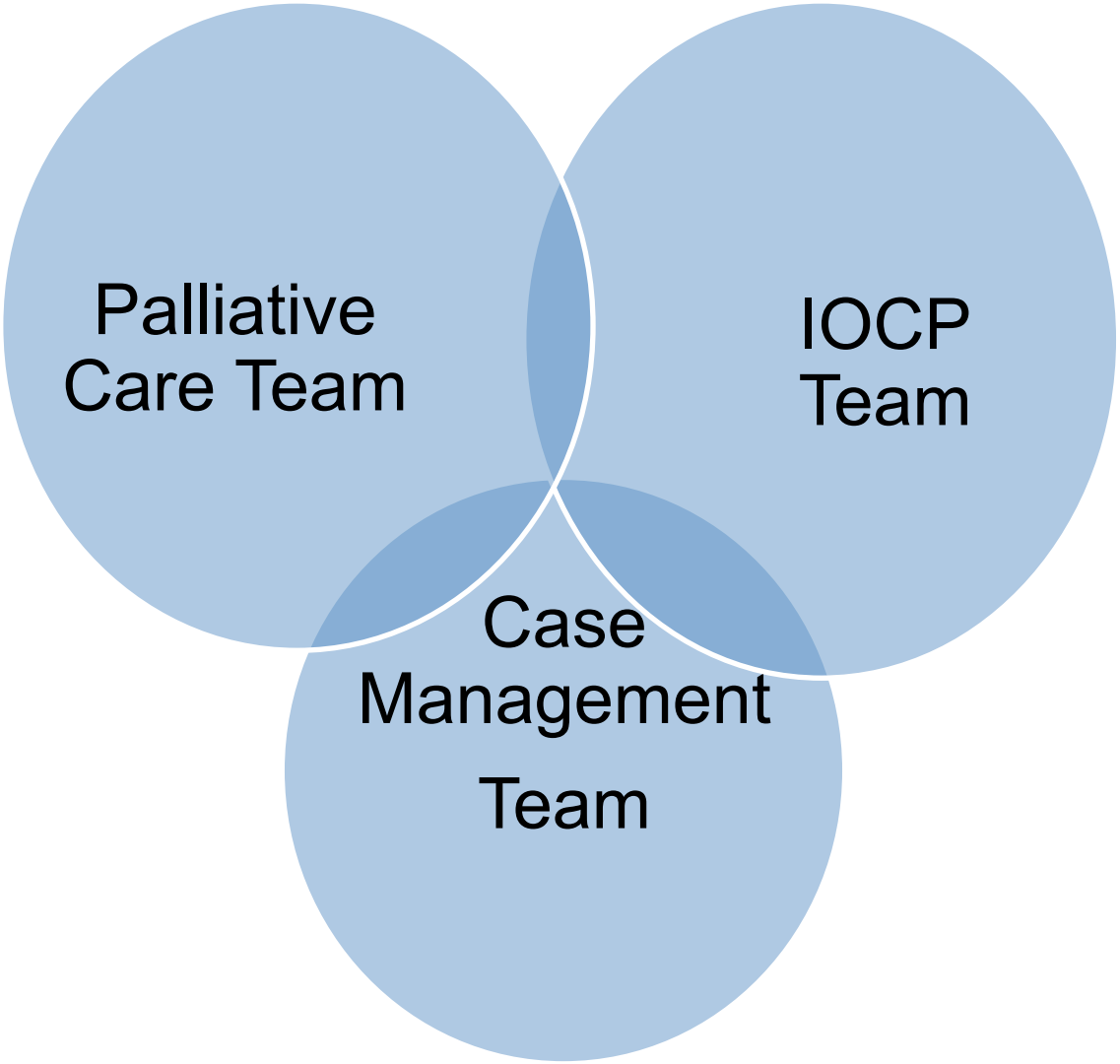
- Coordinated & Centered on our patients
- Accessible & Accountable
- Respectful & Relational
- Empathetic & Empowering
- Secure & Supportive

for the patients who need us most!

Phone number: 562-967-CARES
Email: pihhealthcares@pihhealth.org

PIH HEALTH

PIH Health Cares is Made Up of 3 Major Components



Patients with Most Need – Disease Burden & Complicated Life

- Persistently complex, chronic conditions
- Often with poor social conditions
- Often with behavioral health co-morbidities
- Evidence-based model
- Referrals from MDs, case managers, mid-level providers

Approach:

- Targeted population – predicted highest cost (10-15%)
- Patients with persistent and actionable issues
- Provide team based care
  - RN Case Manager – assessments, triage, communication w MDs
  - Health Coach (MA) – follow-up phone calls, forms, communication
  - LCSW – psychosocial support, palliative care, community resources
  - PCPs, Nurse Practitioners, Specialists, MD office nurses

PIH HEALTH

Clinical Activity

Total Number of Patients (80) Based on Clinical Activity (Patients can fall into more than one category)		
Clinical Activity	# of Patients	Percentage
CHF	32	40%
HTN	65	82%
CKD	39	48%
COPD	23	28%
DM	39	49%
Depression	31	38%
Required Social Services	50	61%

PIH HEALTH

Clinical Activity by Category (Patients can fall into more than one category)

Clinical Activity	Green 15 patients (Least intensive & frequent interventions)		Yellow 46 patients (Mid-level intensive & frequent interventions)		Red 19 patients (Most intensive & frequent interventions)	
	# of Patients	%	# of Patients	%	# of Patients	%
CHF	3	20%	19	41%	10	53%
HTN	12	80%	37	80%	16	85%
CKD	4	27%	24	52%	11	58%
COPD	3	20%	11	24%	9	48%
DM	5	33%	22	48%	12	64%
Depression	7	47%	12	26%	12	64%
Required Social Services	9	60%	24	52%	15	79%

PIH HEALTH

Age Range of Patients

Years of Age	Green 15 patients (Least intensive & frequent interventions)	Yellow 46 patients (Mid-level intensive & frequent interventions)	Red 19 patients (Most intensive & frequent interventions)	Total	
	# of Patients	# of Patients	# of Patients	# of Patients	% of Total # of Patients
61 – 64	1	1	2	4	5%
65 – 70	2	8	6	16	20%
71 – 80	3	12	4	19	24%
81 – 90	6	22	6	34	42%
> 90	3	3	1	7	9%

PIH HEALTH

What Have We Accomplished to Date?

- Enrollment is active
  - 19 patients enrolled as of 3/15/14; 126 patients as of 12/2014
    - 90 active as of 01/15/15

What barriers did we hit?

- Capacity became our #1 issue
  - No additional FTEs available

- Patient selection was our 2nd issue
  - Too much data – overwhelmed patient identification
  - Lots of referrals of patients who needed palliative care services

PIH HEALTH

This Called for a Strategy Change!

Plan

1. Change the model of the Post Hospital Discharge Clinic into the CMS Transitional Care Management Model of PCP appointments within specific time frames post discharge

2. Develop a distributive model by involving the RNs who work in our PCP offices

PIH HEALTH

Struggles

- **Collaboration**
  - "buy-in" to get appointments made prior to discharge
  - "buy-in" to complete IOCP documents at the PCP offices
  - "buy-in" strategically : Volume versus Value!
- **Technology**
  - building monitoring reports from 2 systems
  - drilling down through complicated data
  - IPA offices not on an EHR

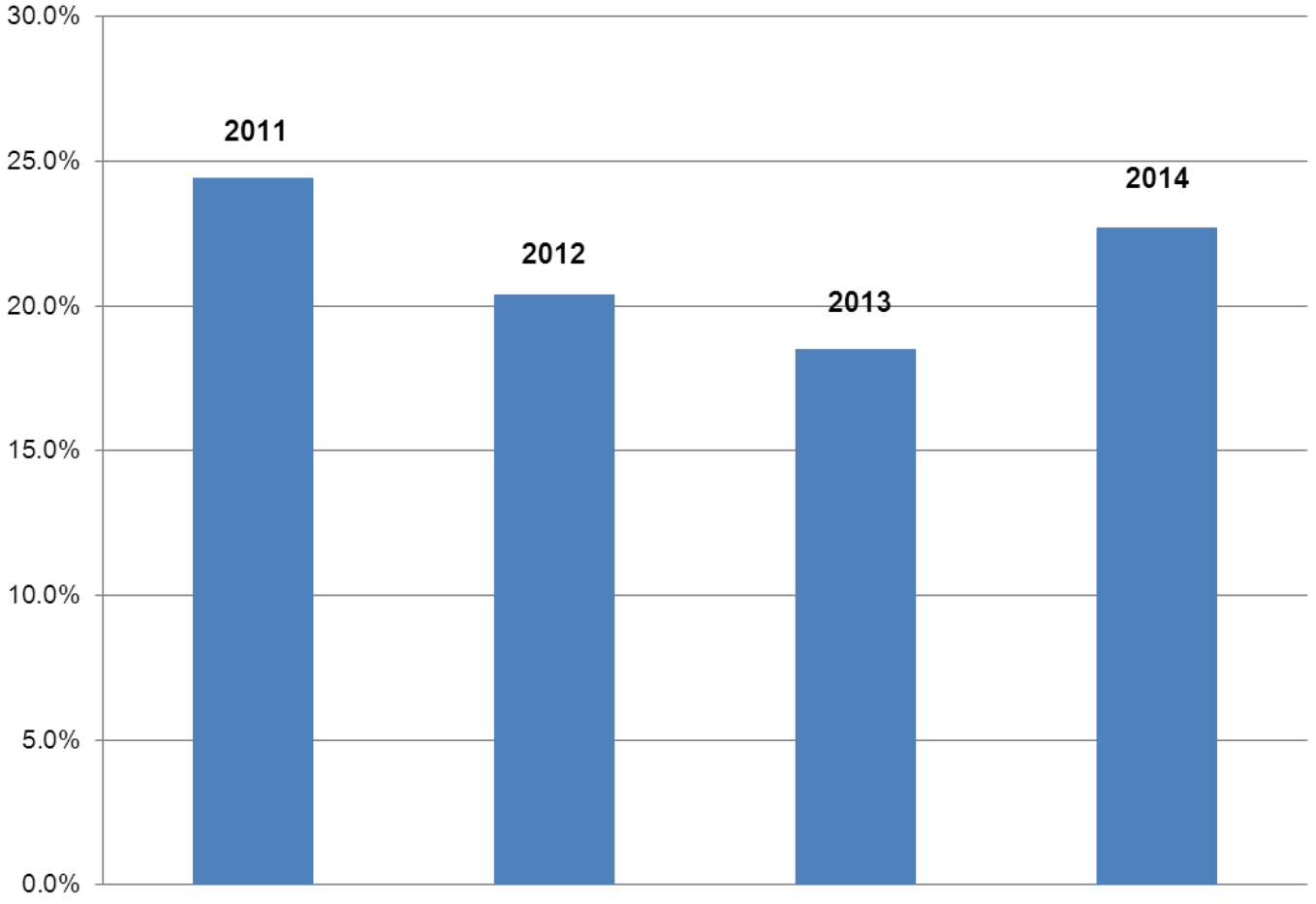
PIH HEALTH

Successes Over the Years

- Decrease in readmissions & ED visits
- Collaboration between hospital case managers, MD office nurses & ambulatory case managers
- Recognition that disease management, chronic disease management, complex case management & palliative care are all part of the same rainbow
- Support of patient centered outcomes

PIH HEALTH

CHF Readmissions 2011 - 2014



PIH HEALTH

Case Study – Who are we trying to keep out of the Emergency Department (ED) and the Hospital?

- Patient
  - Blue Shield 65+ health plan
  - 67 y/o female, with multiple co-morbidities
  - Hypertension, diabetes, chronic kidney disease/failure
  - Patient attempting to delay going on dialysis
  - Previous spinal stimulator implant with infection & removal (2012)
    - Two same day surgeries, two inpatient stays, one TCU stay, home health services
  - Patient missed her last four office visits by either cancelling or not showing up
  - Four falls in the last month
  - Three ED visits since May 2014

PIH HEALTH

Case Study (cont'd)

- Social Situation
  - Lives at home with her husband
  - Caretaker for her husband who has chronic lung cancer and is receiving chemotherapy twice a week at PIH Health Hospital - Whittier
- PIH Health Care Interventions
  - Assessment
    - Doesn't take medications properly; two ED visits in May due to edema and renal insufficiency
      - Finding: Not taking kidney medications at all (found six weeks of pills during home visit)
    - Doesn't understand new blood pressure medication – one ED visit in July two days after being prescribed new medication

PIH HEALTH

Case Study (cont'd)

- PIH Health Care Interventions (cont'd)
  - Shared Action Plan: Patient - "I want to stay out of the hospital."
  - Case Manager's Actions:
    - Called renal physician to notify about ED visit and ask for medication change
    - Called PCP to notify about ED and new HTN medication
    - Shared information between PCP and Specialist
    - Connected with Diabetic Management Team
    - Calls patient twice per week at minimum to check in about blood pressure monitoring and medication compliance
      - Patient needs continuous reminders
    - Took social worker to patient's home and found the kidney medication wasn't being taken
    - Set up social worker services support to help patient and husband cope with clinical and social situations
    - Continuously educating patient to call case manager and PIH Health CARES team when any issues arise before going to the ED

PIH HEALTH

Thank you!

Questions?