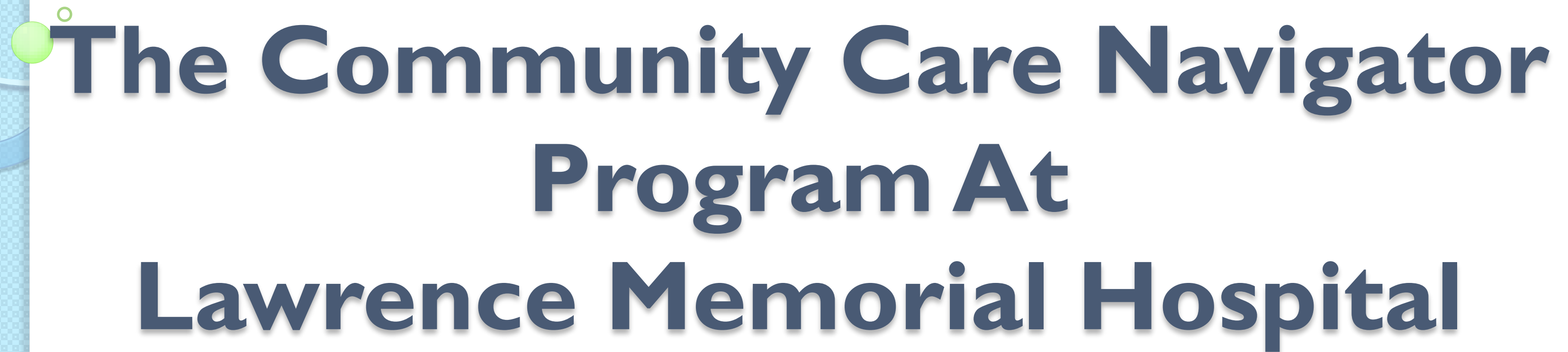

Presented By:
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Director of Care Coordination

October 21, 2011

Learning Objectives:

- 1. Describe the vision and goals of a Community Care Navigator program.
- 2. Identify the most vulnerable and high risk patients to assist post discharge.
- 3. Analyze and interpret the patient responses and outcomes data.
- 4. Develop and implement a Community Care Navigator Program at your hospital.

Background:

- One in five hospitalizations (18-20%) is complicated by post-discharge adverse events, some which may lead to preventable emergency department visits or readmissions.
- The Centers for Medicare and Medicaid Services is targeting readmissions within 30 days and plan to hold hospitals accountable for the patient's post discharge follow-up care.

Health Reform: Section 3025 Reducing Hospital Readmissions

- Starting October 1, 2011, CMS will track hospitals potential overpayment or reimbursement risk based on excess 30-day readmission rate for **heart attack, heart failure and pneumonia**
- **Data period for FY 2013 penalties is July 2008 -June 2011** (Data will not be posted on hospital compare until Aug. 2012)
- **Not limited to preventable, avoidable readmissions**
- Applies even if readmitted to another hospital
- Hospital EXPECTED readmission rates for certain conditions have yet to be determined based on "probability of readmission"

Penalty for Excess Hospital Readmissions

- Poor performing hospitals will have all Medicare payments reduced by an amount equal to value of payments for excess readmission.

- **Penalty Calculation=**
  (Base Operating DRG Revenue) x (Adjustment Factor)

Adjustment Factor is the greater of:

- **Ratio: (**Actual Readmit Rate / Expected Readmit Rate)
- **A Floor Adjustment Factor:**
  - **FY2013: up to1%**
  - **FY2014: up to2%**
  - **FY2015: up to 3%**

Calculation of Actual Readmissions

Mathematically, the numerator equation can be expressed as:

Numerator: Adjusted Actual Readmissions

Step 1:

Calculate each patient's predicted probability of readmission = $\frac{1}{1 + e^{-Z_a}}$

Z_a = hospital-specific effect + Xβ

Step 2:

To get the numerator result, add all patients' predicted probabilities of readmission

Calculation of Expected Readmissions

This can be expressed mathematically as:

Denominator: Expected Readmissions

<u>Step 1:</u>

Calculate each patient's expected probability of readmission = $\frac{1}{1 + e^{-Z_e}}$

$Z_e = X\beta$

intercept + risk-adjustment coefficients

<u>Step 2:</u>

To get the denominator result, add all patients' expected probabilities of readmission

Community Care Navigator Program Started March 2010

- Organizations that make discharge phone calls reduce non-reimbursable readmissions between 20-30%.
- Research shows that patient/family likelihood to recommend a hospital is above the 90th percentile when they receive a discharge call.
- Primary Physician follow-up visit compliance increases with discharge call.

Community Care Navigator Vision:

- To achieve a continuum of care and optimal health for vulnerable populations by linking hospital care, primary care, specialty care, and community resources in a coordinated effort.

Purpose of Follow-Up:

- Discharge calls produce better clinical outcomes and are the right thing to do for patients and families.
- It’s a great way to verify that patients understand post-care instructions, which reduces preventable readmissions.
- Most importantly, lives are enhanced and saved.

Goals of Program:

- To extend health and wellness services beyond the hospital walls to vulnerable patients.
- To improve the continuum of care for underserved and uninsured patients suffering from complex medical and social conditions.
- To improve transitional care and home-based care to produce quality health outcomes.
- To achieve the Institute of Medicine's goals of safe, timely, effective, equitable, efficient, and patient-centered care.
- To promote health equity by increasing access to care despite financial resources.
- To decrease inappropriate utilization of hospital and Medicare/Medicaid resources.

Process:

- Social Workers and RN Case Managers identify high-risk patients while in Emergency Department and/or hospital, and assess needs.
- Immediate needs are addressed and appropriate resource referrals are made by Social Worker or Case Manager before discharge.
- High-risk patients, Medicaid, and uninsured are referred to Community Care Navigator.

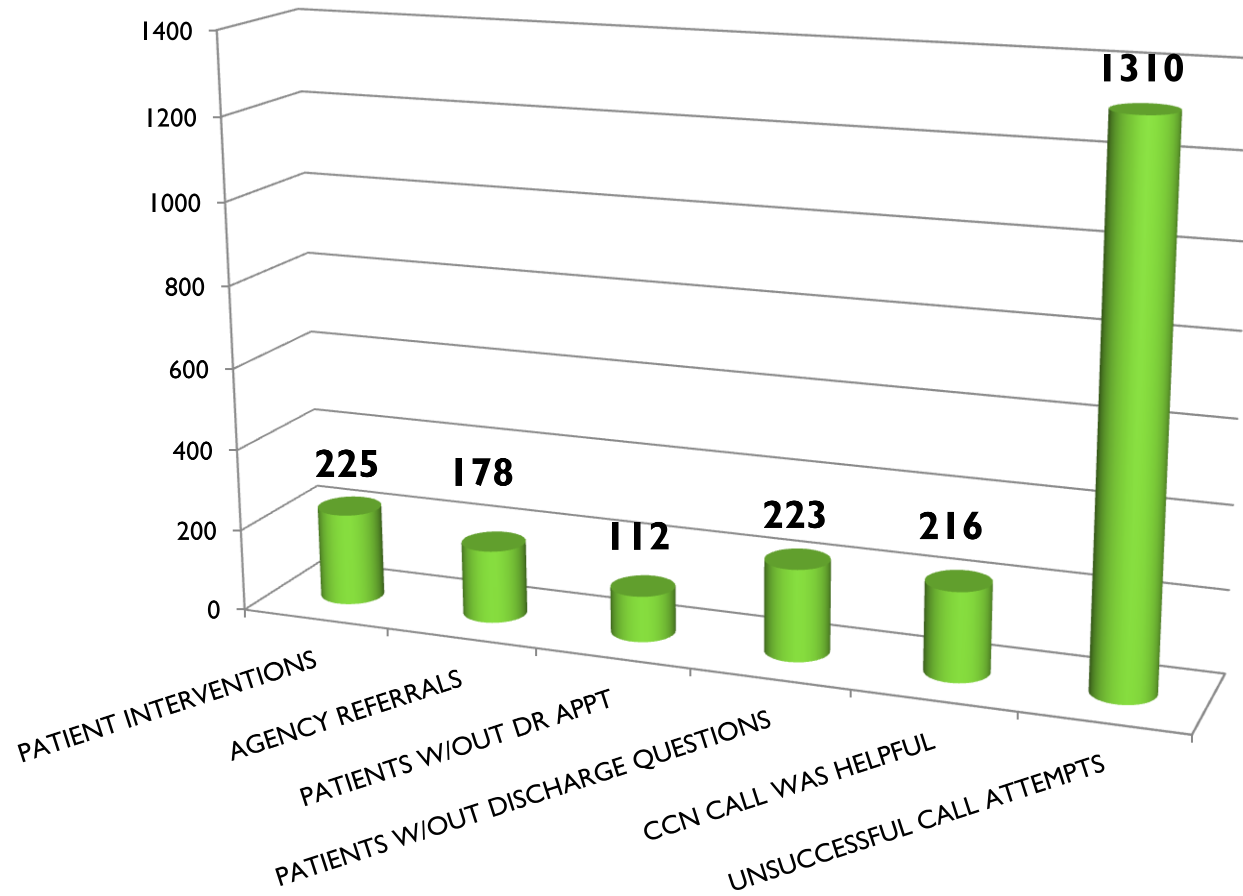
Process Cont.

- Navigator meets patient while hospitalized and then contacts patient at home within 72 hours after discharge and further assesses any additional needs.
- Navigator identifies appropriate community resources and refers patient according to their choice and with their consent.
- Navigator follows-up with patient and community agencies to assess any additional needs or issues after services are in place.

Questions asked on calls

- Do you have questions about your Discharge Instructions?
- Do you have your f/u appointment? PCP?
- Do you have transportation to appt.?
- Do you have new medications and questions about how to take them?
- Are there needs that are preventing your wellness?

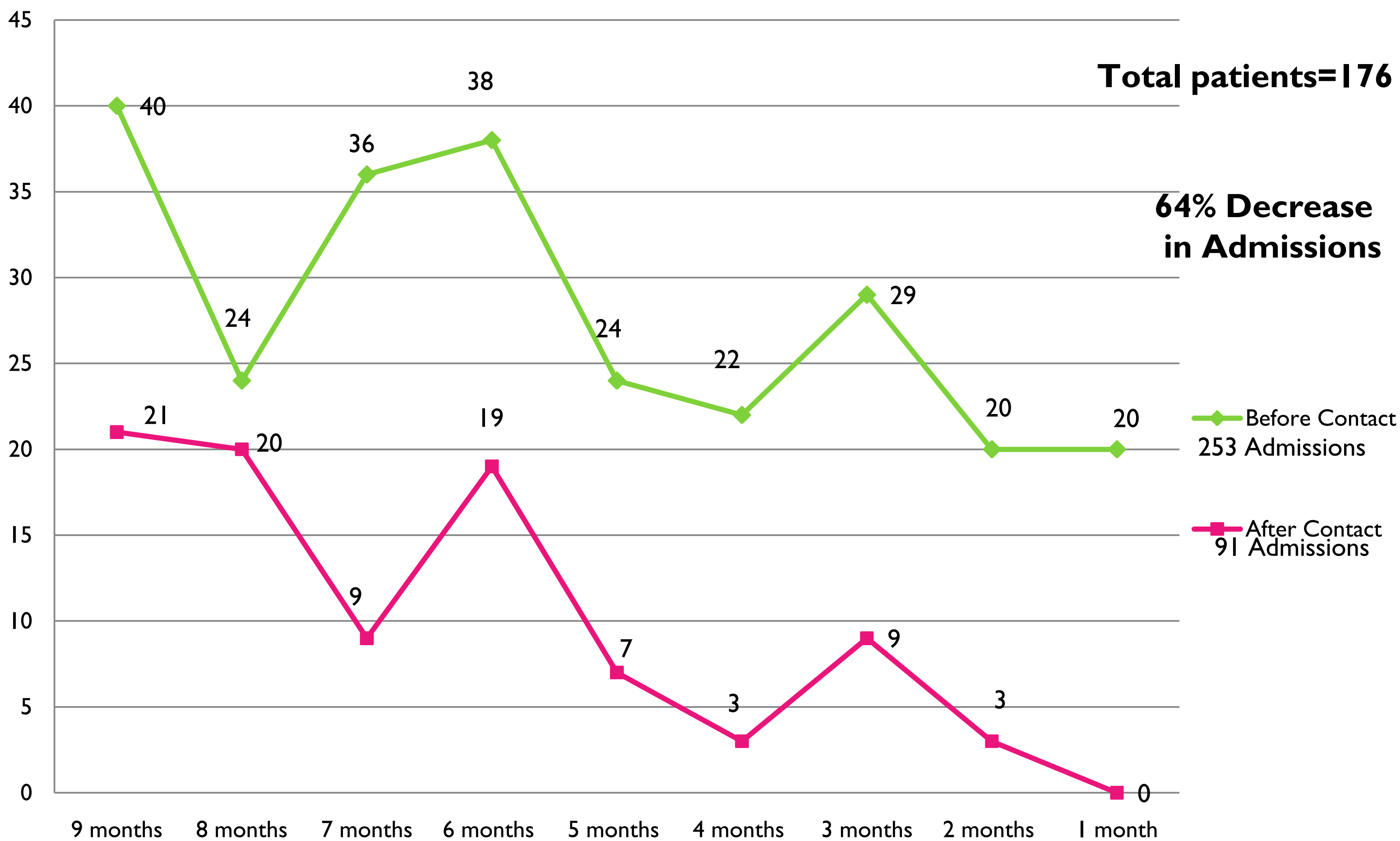
Summary of Calls: March-Dec. 2010



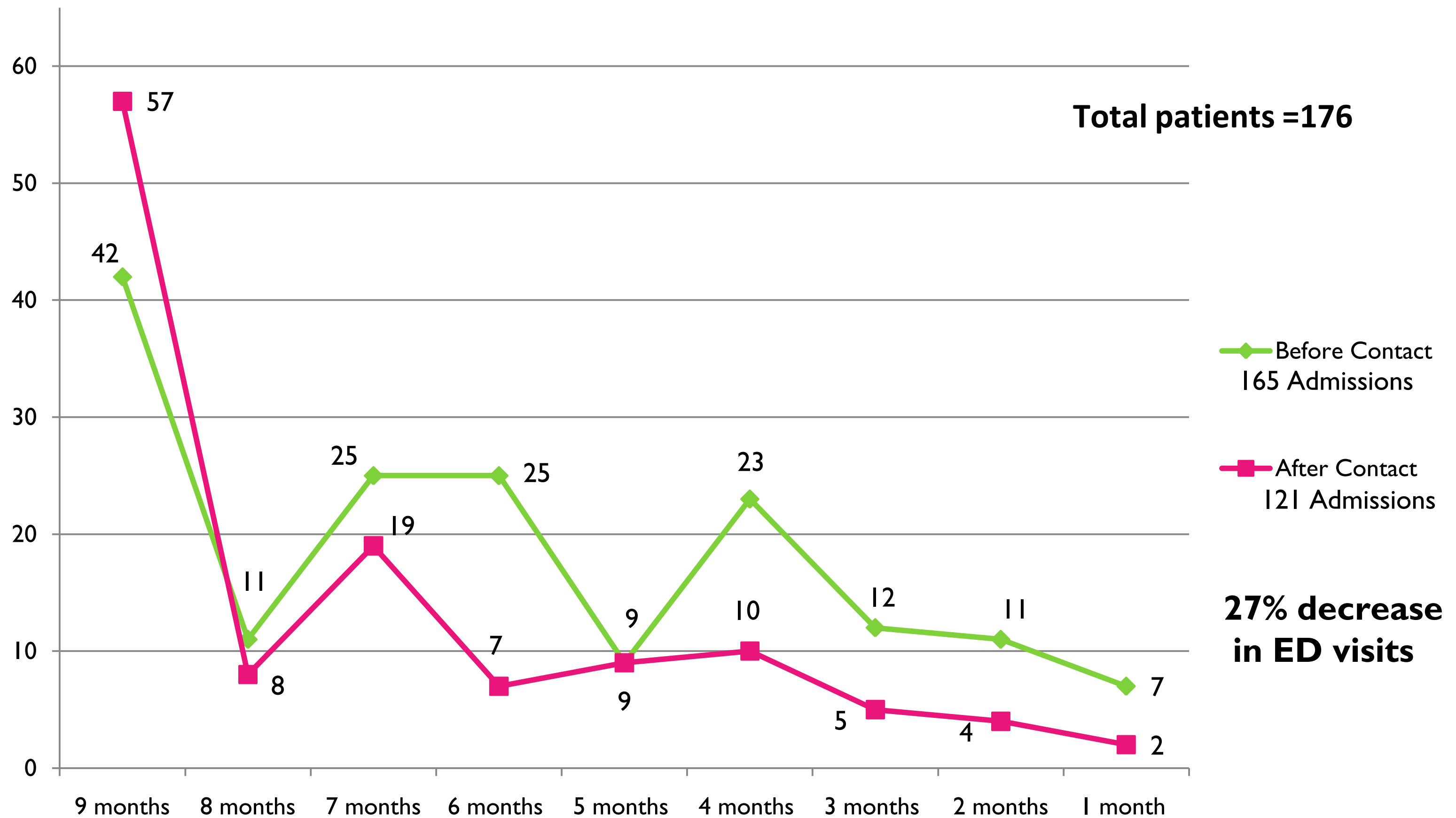
Agencies Referred To:

- HealthCare Access & Heartland Clinic
- Transportation
- Connect Care for Primary Care Physician
- Meals on Wheels
- Independence, Inc.
- In-Home Care
- Midland Group for Medicaid
- Project Lively Senior Services
- Social Security Administration
- Home Health
- Friendly Visitors Program
- Housing Authority
- Dental Clinic

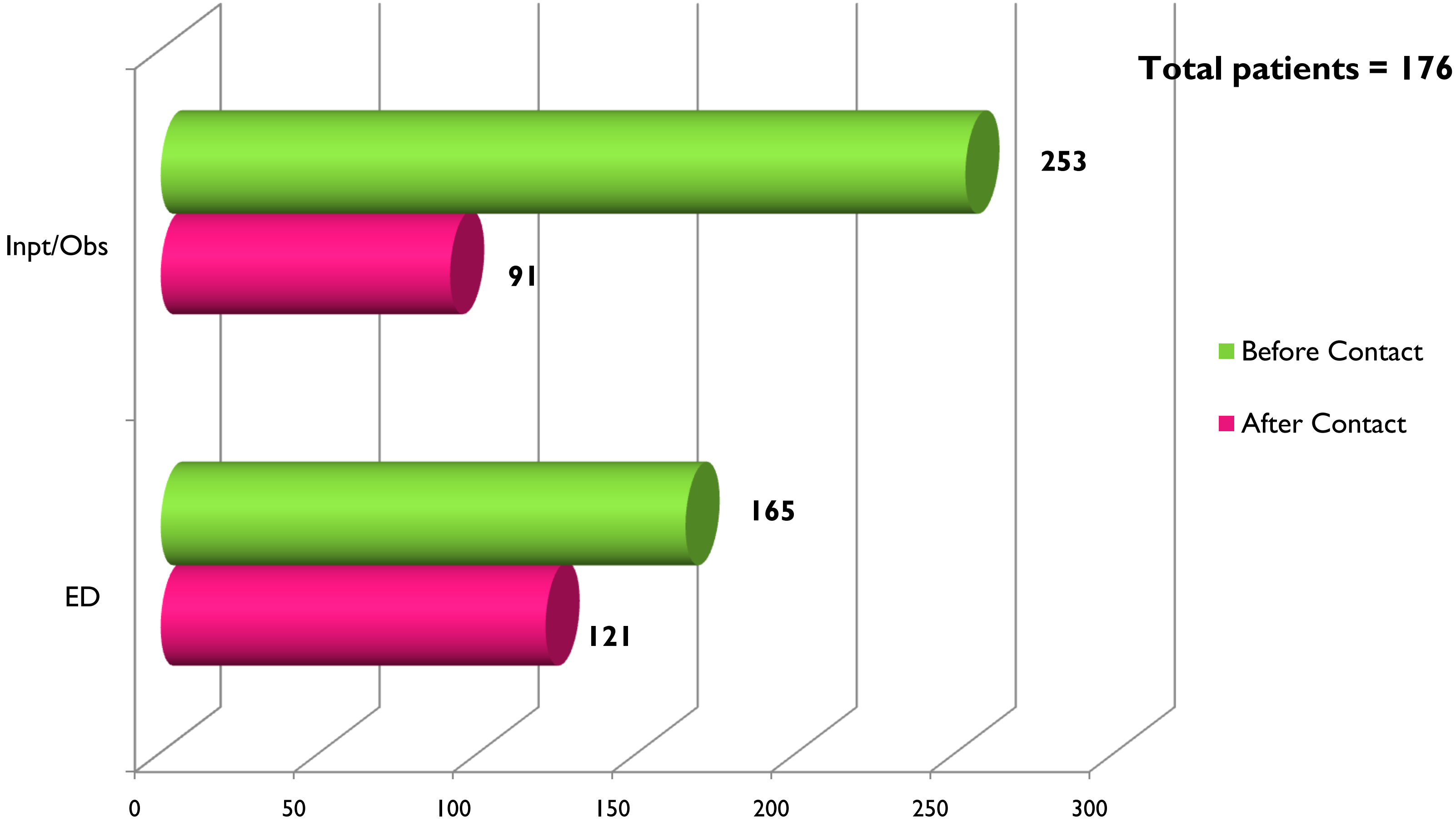
Admissions for Inpatient or Observation Before and After Care Navigator Contact



Emergency Visits Before and After Care Navigator Contact



ED Visits and Admissions Before and After Care Navigator Contact



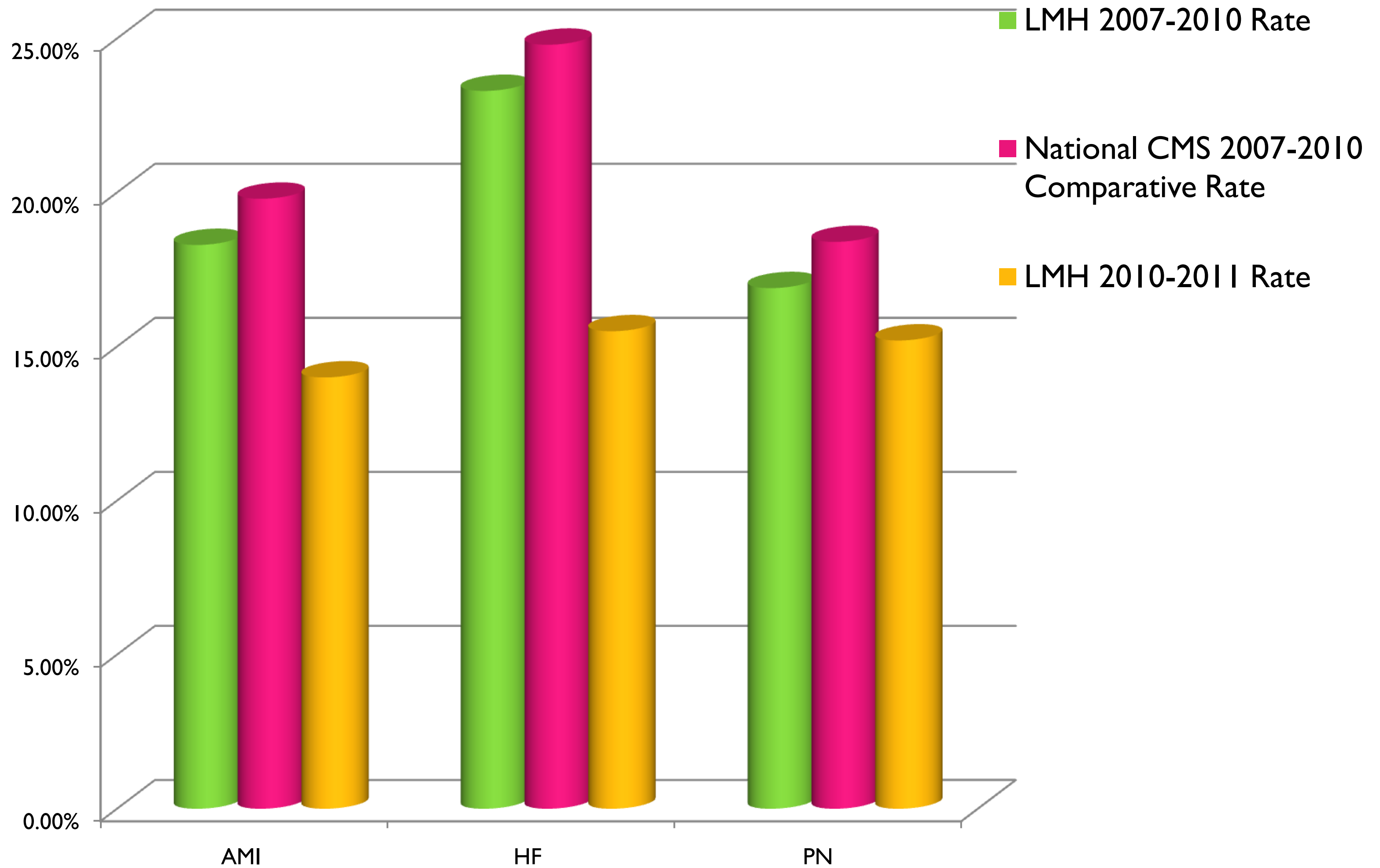
Readmissions

- Only 10 patients out of 176 patients contacted between March-Dec. 2010 had readmissions within 30 days
- That's only a 6% readmission rate within 30 days for our most vulnerable patients
- It's working!

Discharge Follow-Up Calls for HF & PN

- 41 Inpatient Medicare with above conditions from May 2010 – Dec 2010:
  - 20 post discharge calls for d/c to home
  - 16 excluded d/t Nursing Home after d/c
  - 2 readmitted within 2 days before call made
  - 2 no phone
  - 1 expired
- Main need identified on calls was smoking cessation and exercise program coaching

Medicare 30 day Readmits for Acute Myocardial Infarction, Heart Failure & Pneumonia



What we Learned:

- Send letters/brochures to higher risk patients that we're unable to make contact with
- Collaboration with Homeless Programs
- Expand F/U calls to Medicare patients
  - Chronic Obstructive Pulmonary Disease
  - AMI
- Assess readmits within 30 days on readmission
- Need to improve collaboration with nursing homes for discharge plan of care
- Need to expand to a full time RN in 2011

Assessments of Readmissions

Started January 2011

- Social Work completed an Assessment with all patients readmitted within 30 days.
- Majority of patients had new medications on their previous discharge and weren't really taking them correctly.
- Found that the majority of patients readmitted without seeing their Primary Care Physician.

New Initiatives

- Hired RN as Navigator in June 2011 to expand Disease Management Coaching
- Contacting HF, PN, AMI pts. weekly after d/c
- Schedule f/u appt with PCP before d/c
- Schedule highest-risk patient appts. within 3 days after discharge
- Transitions of Care Forum quarterly with Community Agencies
- Cardiology Consults, Heart Failure Clinic and Pulmonary Rehab

Opportunity for Medical Homes

- Care Coordination and Care Management in the Medical Home is the quickest way to make a cost and quality impact.
- Care Coordinator deals with the external care of a patient and helps them navigate thru transitions of care.
- Care Management assists with coaching the patient on their chronic diseases so they can self manage their care.

Tools for Implementation

- Proposal and ROI
- Job Description
- Automated Worklists
  - Chronic DRGs, Payers, Readmits, Referrals
- Focus Study Templates for Calls
- Data Capture
- Transitions of Care Programs
  - Project RED, BOOST, Eric Coleman, IHI, Vulnerable Patient Network

Questions?

Thank You!!

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