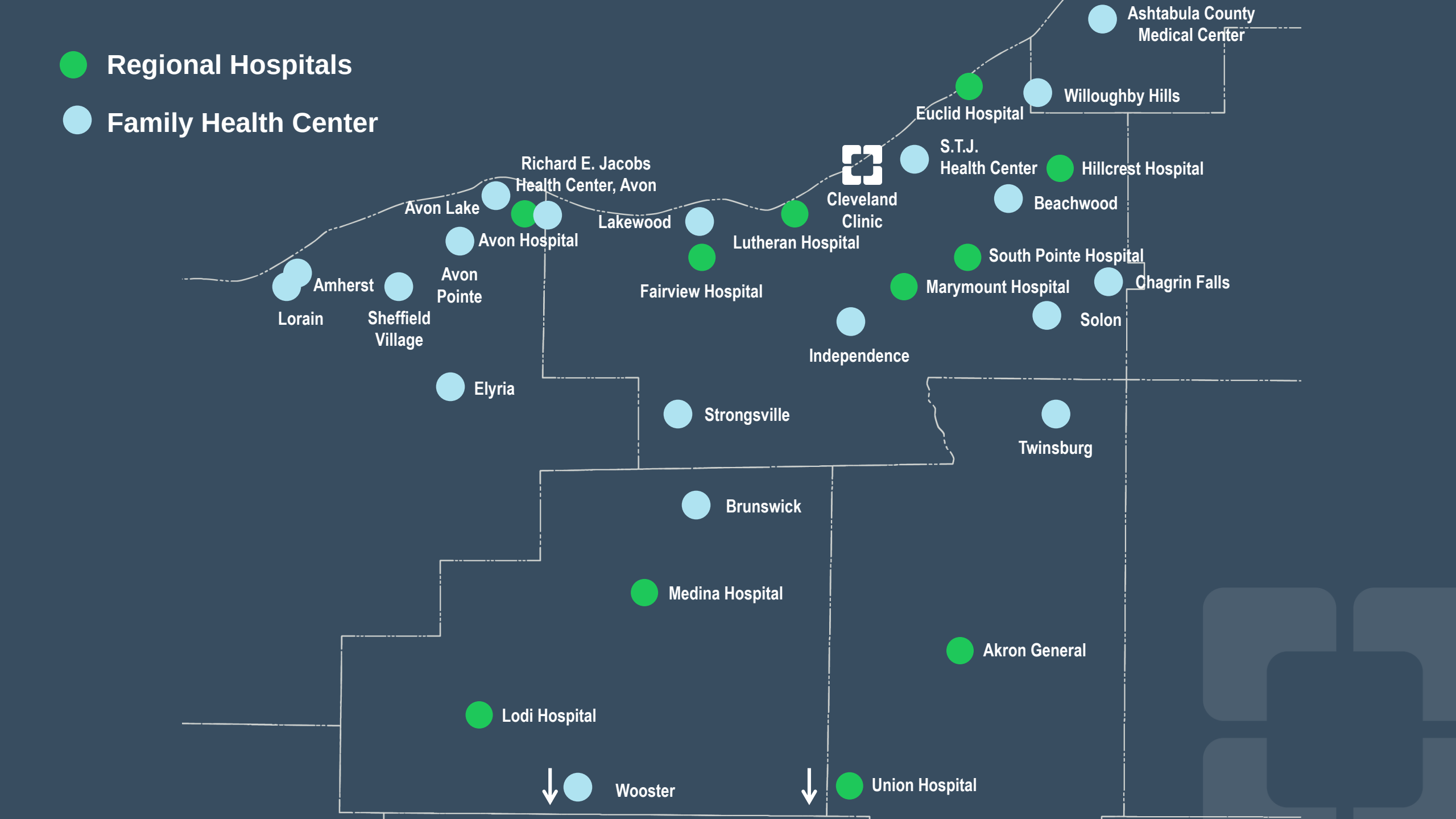
Readmission Reduction

Amy O’Linn DO FHM FACP
Physician Lead

- No financial disclosures

Cleveland Clinic Today

- 67,500 caregivers
- 10 million total visits
- 309,000 hospital admissions
- 4,500 physicians & scientists
- 1,974 residents & fellows


Regional Hospitals
Family Health Center
Ashtabula County Medical Center
Willoughby Hills
Euclid Hospital
S.T.J. Health Center
Hillcrest Hospital
Beachwood
Cleveland Clinic
Richard E. Jacobs Health Center, Avon
Avon Lake
Avon Hospital
Lakewood
Lutheran Hospital
Fairview Hospital
South Pointe Hospital
Marymount Hospital
Chagrin Falls
Solon
Amherst
Lorain
Sheffield Village
Avon Pointe
Independence
Elyria
Strongsville
Twinsburg
Brunswick
Medina Hospital
Akron General
Lodi Hospital
Wooster
Union Hospital

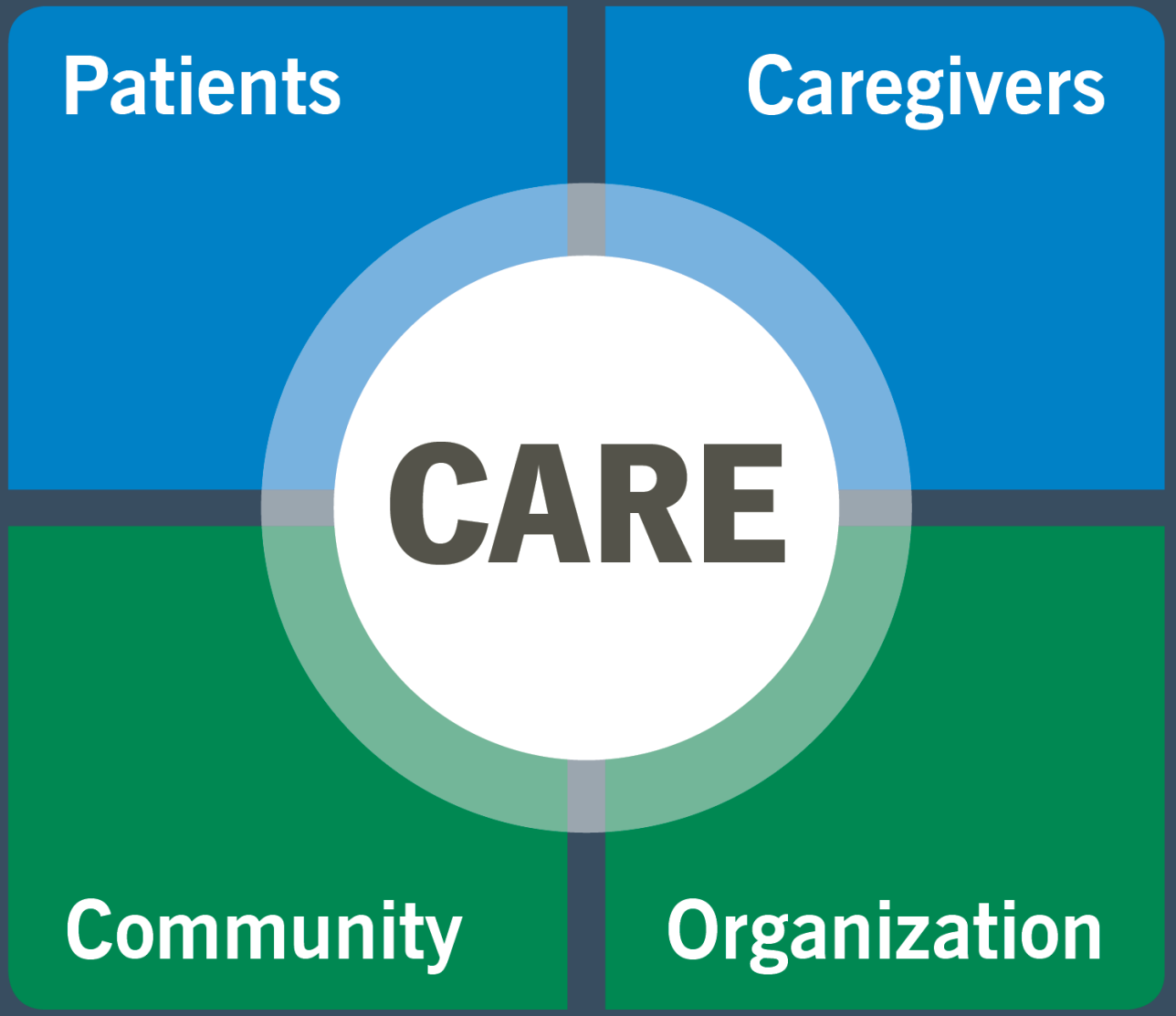
Cleveland Clinic Locations

Mission

Care for the Sick

Investigate their Problems

Educate those who Serve


Patients
Caregivers
CARE
Community
Organization

Polling Question #1

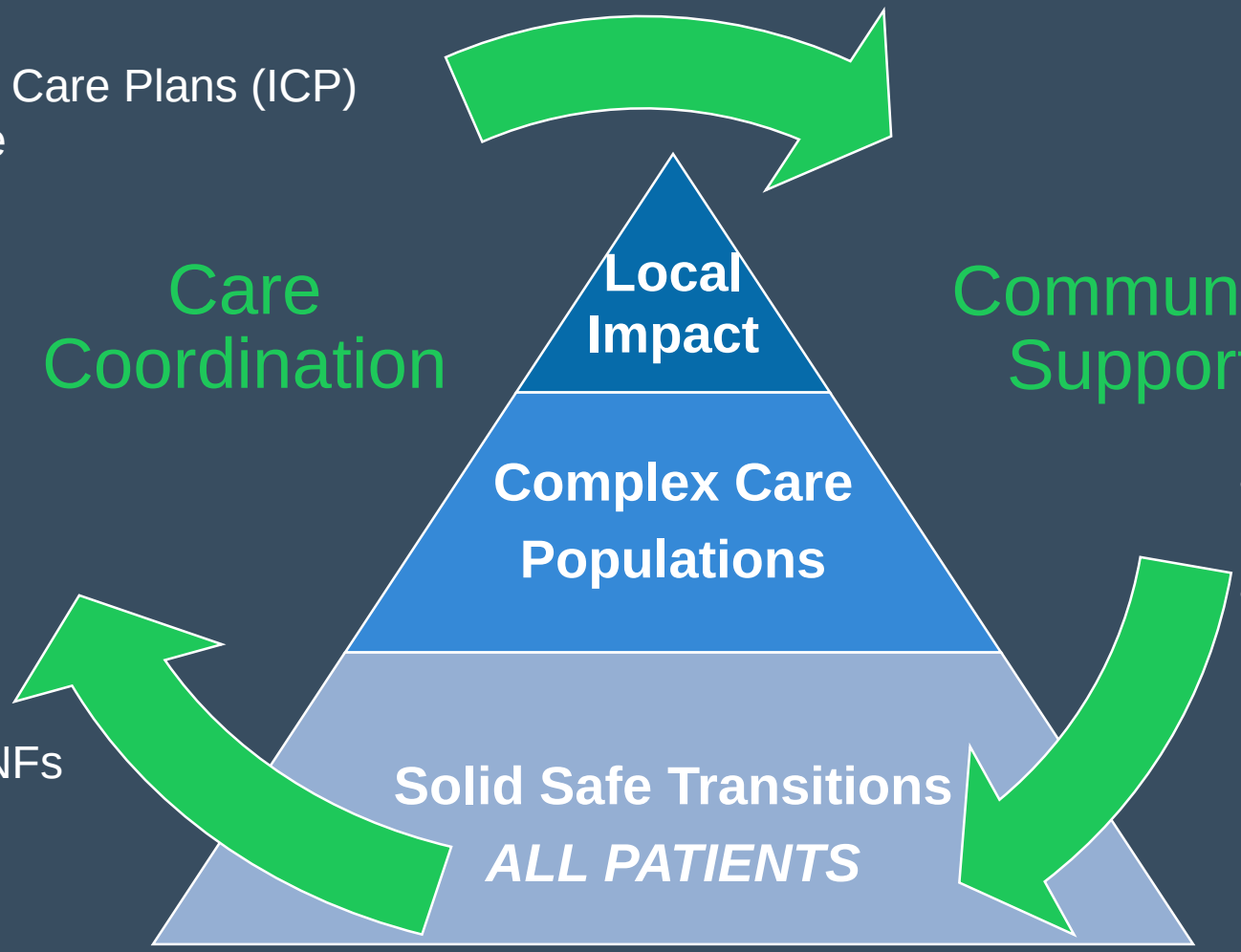
Who's most able to reduce 30-day hospital readmissions?

1) Hospital-based Providers/teams
2) Primary Care Providers/teams
3) Patient
4) Everyone involved in the patient's care

Overall Strategy

Readmission Reduction Strategy

- Individualized Care Plans (ICP)
- Tiered Huddle



- Technology supports patients (MyChart Care Companion)
- Connecting local community resources to address SDOH

- DrConnect for SNFs

Solid Safe Transitions

- Medication List Perfection
  - Admission Medication Reconciliation
  - Discharge Medication Reconciliation
- Medication Access
- Correct Disposition & Follow up
  - Home, Home Health, SNF, LTAC, Acute Rehab
- Communication

Polling Question #2

Did you know you can access your patient's Cleveland Clinic records from anywhere in the world (if you're the PCP)?

1) Yes, I knew!
2) This is news to me!

CORONAVIRUS: DELAYS FOR ROUTINE SURGERIES, VISITOR RESTRICTIONS + COVID-19 TESTING. >

DrConnect

Provides referring physicians secure online access to real-time information about their patients' treatment progress while at Cleveland Clinic.

Call 877.224.7367

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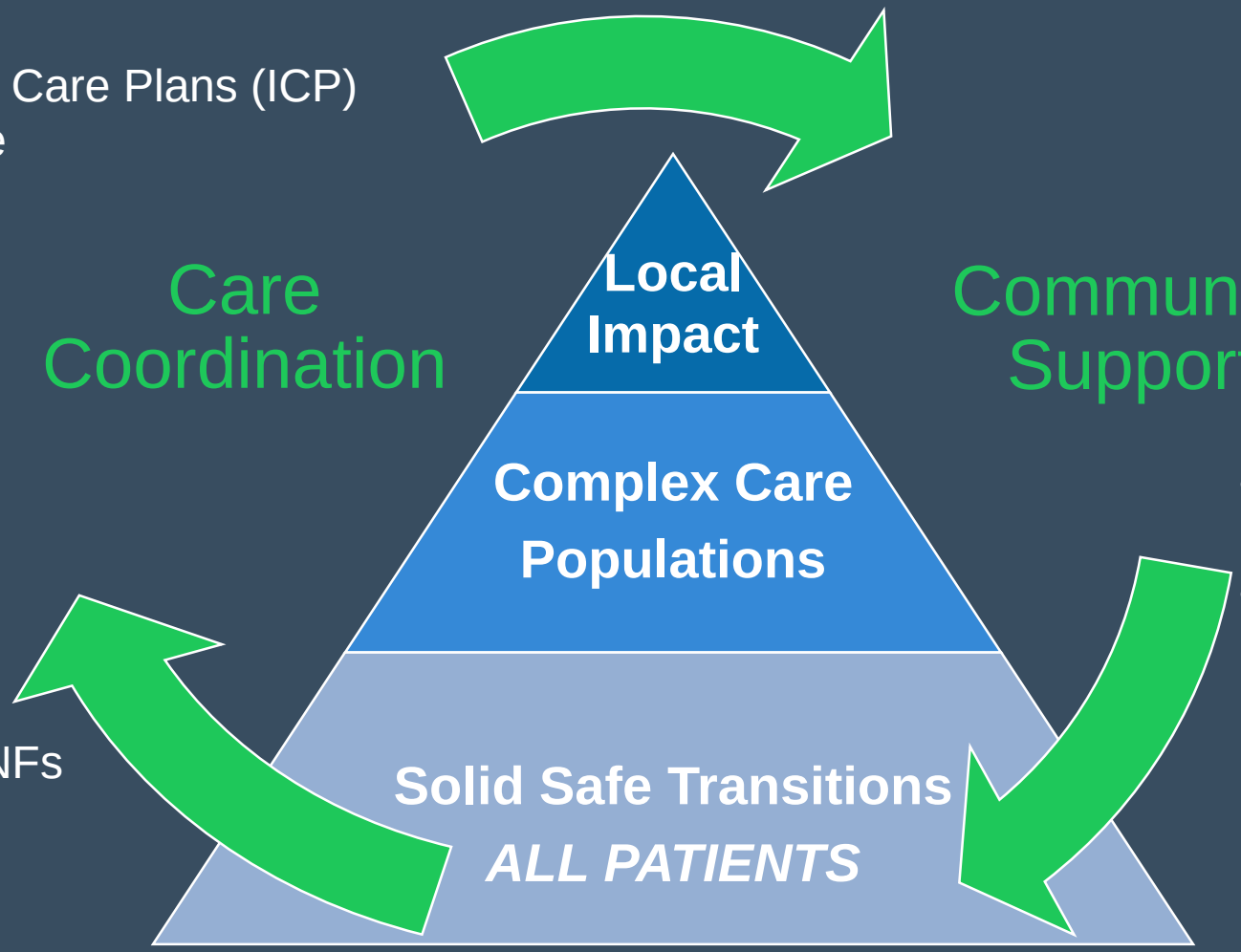
FAQs | Watch How DrConnect Works | Subscribe to eRounds | Contact DrConnect

Transitional Care Management

- RN
- Network Navigators
- Pharmacists
- Teams

Readmission Reduction Strategy

- Individualized Care Plans (ICP)
- Tiered Huddle



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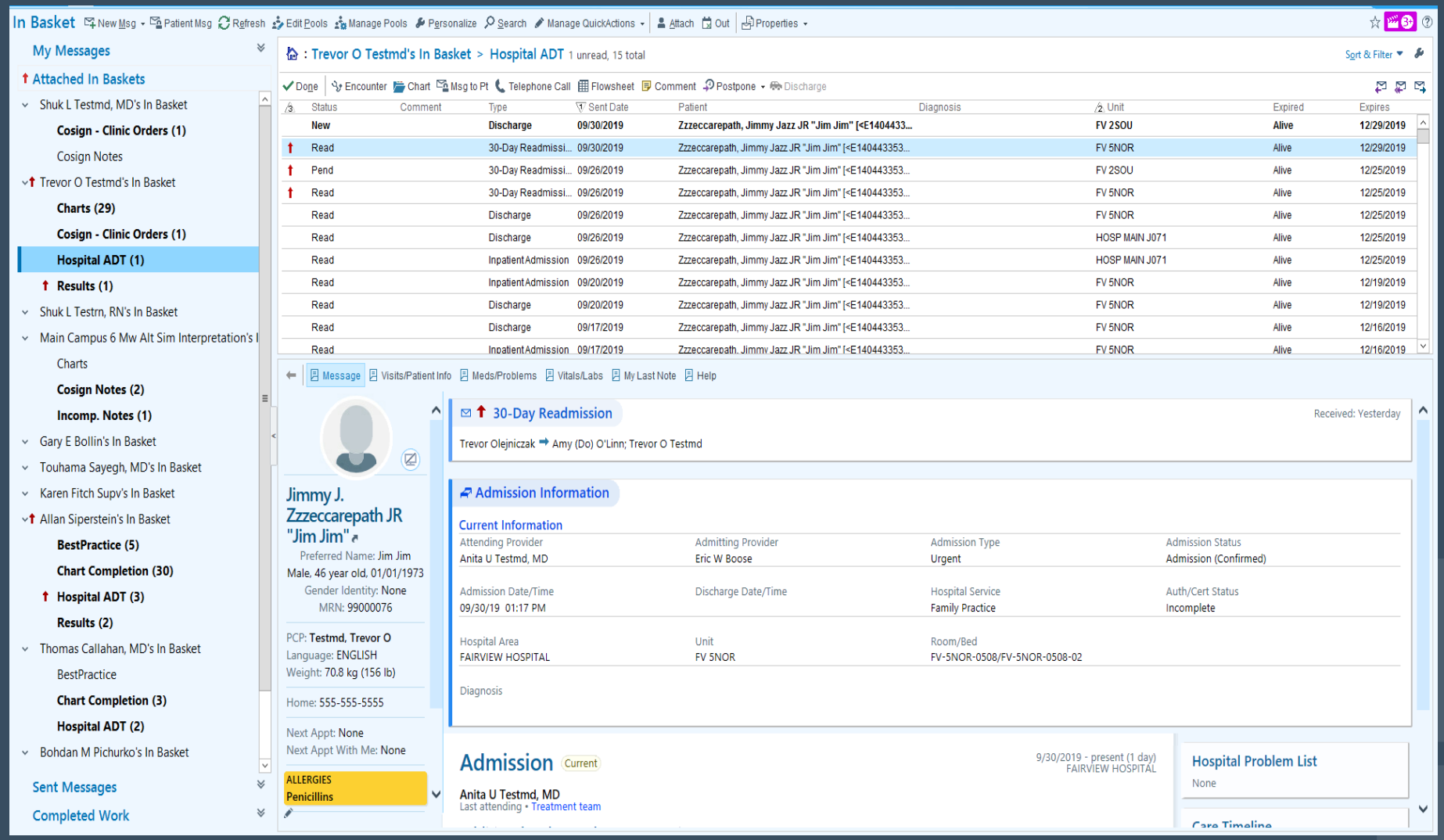
EHR Tools to Help

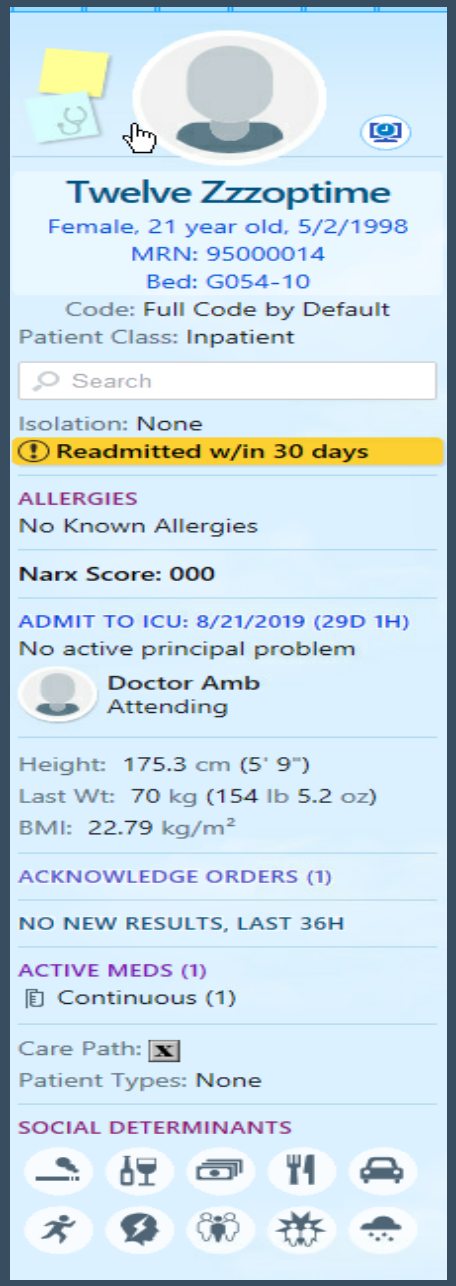
Polling Question #3

Have you ever had a patient get admitted or readmitted to a hospital and you didn’t know the patient was readmitted?

1) Yes
2) No

Help to Providers



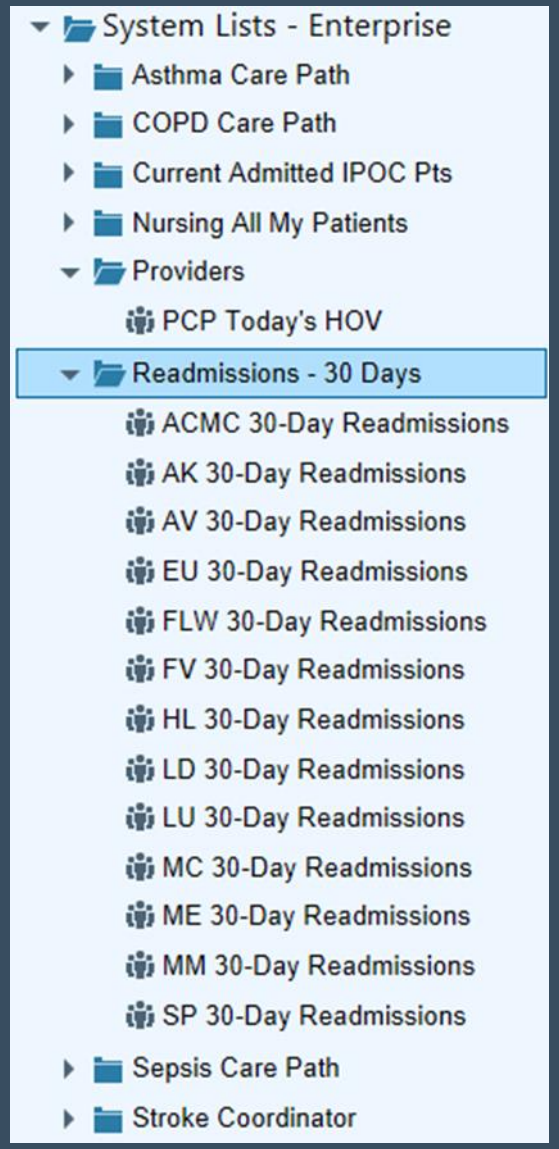


Help to Providers

- The Storyboard banner
- EHR Columns

Readmitted within 30 Days?	Readmission Information	Readmission Review Notes
Yes	Readmitted 6 days from FV3SOU	Will have Care Management follow up on…
Yes	Readmitted 4 days from FV3L+D	—

System Lists



- Tiered Huddles

Polling Question #4

Do you think that was enough to reduce readmissions for Cleveland Clinic?

1) Yes
2) No

We needed more…

The development of Patient-Centered Individualized Care Plans

Special Populations

- CHF
- COPD

INDIVIDUALIZED CARE PLAN

The intent of this plan is to provide guidance to any member of this patient's care team to prevent avoidable readmissions to the acute care hospital environment.

PLAN IMPLEMENTATION DATE: ***

REASON(S) FOR ICP: ***

RELEVANT MEDICAL ISSUES: ***

RECENT HOSPITAL ENCOUNTERS:
***

PATIENT'S TEAM:

- PCP:
- Subspecialists:
- Care Coordinators:

Relevant Social background: ***

ICP RECOMMENDATIONS:
To avoid readmission/ED visit from the outpatient arena:

1. ***

If the patient presents to the ED, please consider the following prior to decision to hospitalize:

1. ***

If care in the acute care environment is medically necessary:

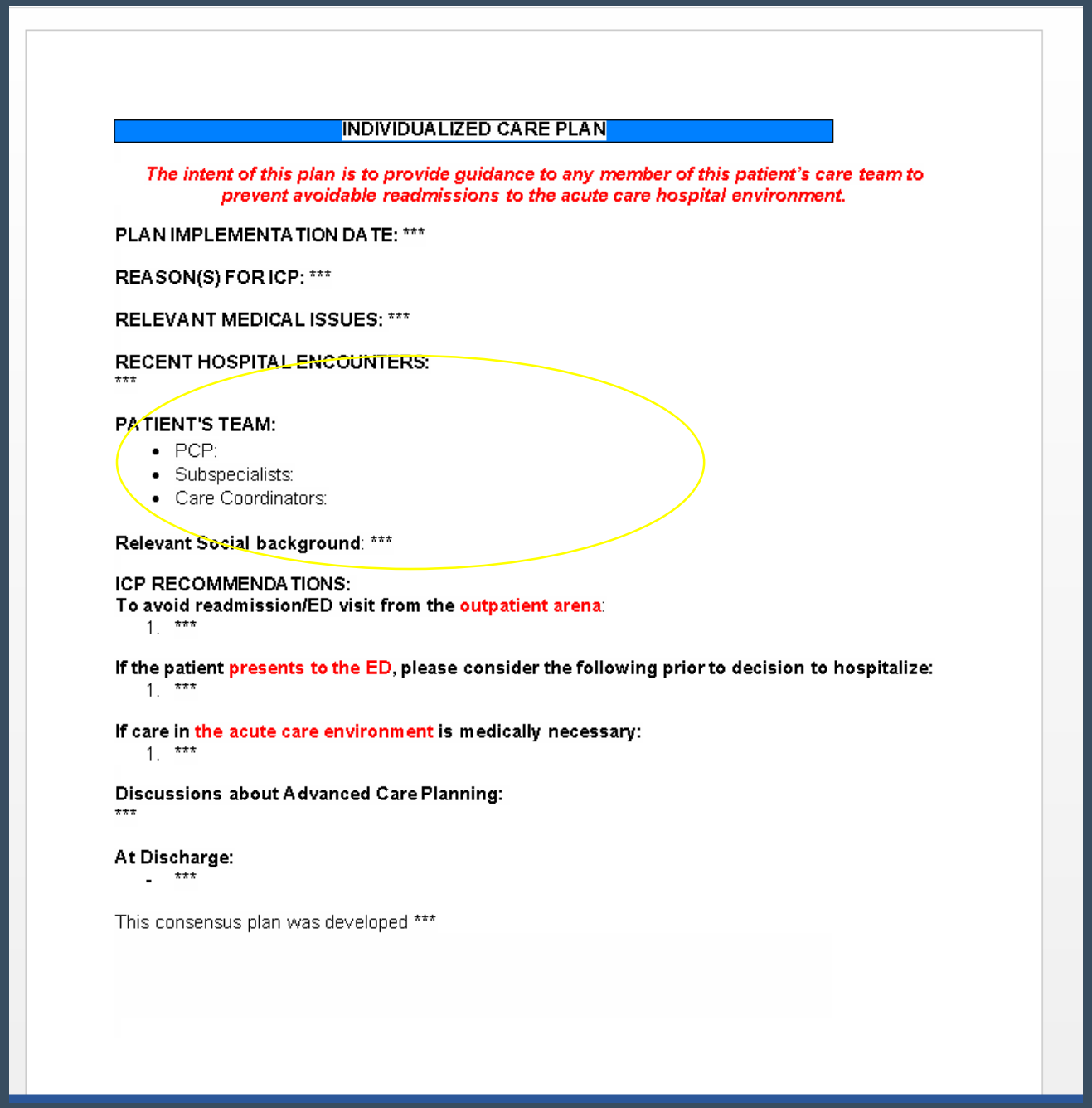
1. ***

Discussions about Advanced Care Planning:
***

At Discharge:

- ***

This consensus plan was developed ***



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1. ***

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***

At Discharge:
- ***

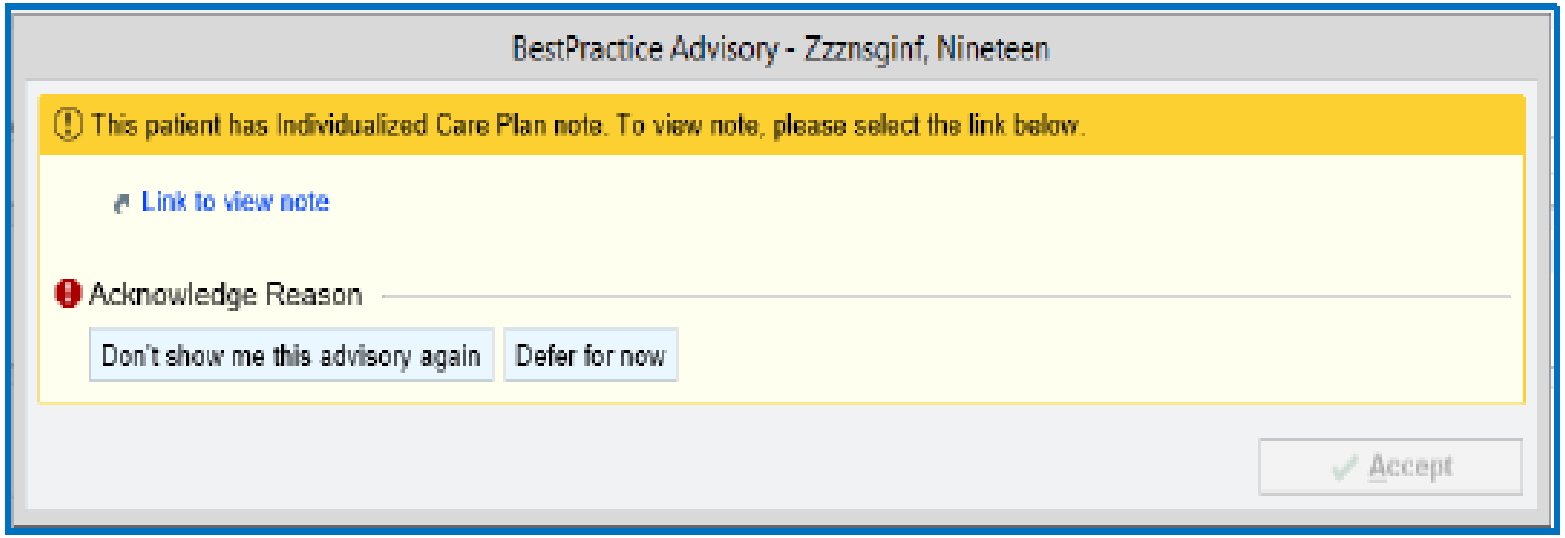
This consensus plan was developed ***

Key Stakeholders:

- Patient
- PCP
- Subspecialists
- Social Work
- Palliative Medicine
- Post-Discharge teams

Individualized Care Plan Note BPA

1. If an **Individualized Care Plan** note has been documented or updated within the past 365 days, a BPA will appear upon opening an **Ambulatory Office Visit** or **Admitted** patient's chart. The alert will display for all Ambulatory and Inpatient caregivers involved in the patient's care, to ensure our work is coordinated.



2. The following acknowledge reason options are available to satisfy the BPA:
   - **Don't show me this advisory again** locks out the BPA for the rest of the encounter. It is user-specific, so it will fire for each provider type until satisfied.
   - **Defer for now** locks out the BPA for the next one hour of the Encounter.

ICP Best Practice Alert

Encounter Type	
Anticoagulation Visit	PAT
Connected Care	Patient Outreach
Distance Health	Patient Update
Distance Health (Visit Summary)	Patient Update AC
Distance Health ED/IP	Patient Update CP
Distance Health Patient Outreach	Pharmaceutical Care Clinic
Home Care Visit	Pharmaceutical Care Clinic AC
EHP Outreach	Pharmaceutical Care Clinic CP
Mobile visit	Procedure
MyChart Video	Procedure AC
Nurse Triage	Procedure CP
Nurse Visit	Refill
Nurse Visit AC	Refill AC
Nurse Visit CP	Refill CP
Office Visit	Remote Patient Monitoring
Office Visit AC	Social Work
Office Visit CP	Social Work Secure
Office Visit OPHT	Telephone
Office Visit OPHT AC	Telephone AC
Office Visit OPHT CP	Telephone CP
Orders Only	Telephone Note
Orders Only AC	Treatment Team
Orders Only CP	Visit (SP) Office
OT/PT/Speech Visit	Visit (SP) Office AC

Provider Type
Physician
Physician Assistant
Nurse Practitioner
Resident
Fellow
Social Worker
Registered Nurse
Therapist
Certified Pediatric Nurse Practitioner
Counselor
Pharmacist
Clinical Nurse Specialist
Licensed Nurse

Case 1 (Average Score 4.17, Range 3-5)

REASON(S) FOR ICP: Multiple Hospital readmissions between January and April 2020, challenges adhering to the medical plan of care, and moderate risk factors in Social Determinates of Health.

COMMON COMPLAINTS AND PRIOR EVALUATIONS:

Primary Spanish speaking female presents to the ED with persistent SOB, cough, sputum production, feeling like holding water, and weakness.

COPD Exacerbation; per pulmonary provider, emphysema; spirometry normal in 2016, needs f/u testing(scheduled 8/31/20), questionable smoking cessation status.
CHF: VHD (2+ MR and 3+ TR-- 2-D ECHO in January 2020)
Atrial Fibrillation with RVR: Started on Tikosyn April 2020 with improvement in rate control

RELEVANT PAST MEDICAL HISTORY: In addition to the above:

Anxiety
History of bariatric surgery
HTN
Vertigo
Gastric ulcer
Alcohol/tobacco abuse

ICP RECOMMENDATIONS:

To avoid readmission/ED visit from the outpatient arena:

1. Ensure follow up appointments are scheduled when patient has transportation, currently prefers Friday when her son is available. Otherwise relies on public transit.
2. Arrange Spanish translator, especially if family not available.
3. Continue ambulatory Care Management and Social Work interventions through Primary Care service. Patient is underinsured.
4. Consider referral for outpatient BH follow up

If the patient presents to the ED, please consider the following prior to decision to hospitalize:

1. Consult Social Work/Care Manager if available. Reach out to St. Vincent HHC Agency RN for hand in.
2. Use translator line, especially if family not present.
3. If medially stable for treat and release, ensure follow up appointment arranged with PCP, and/or Cardiology/pulmonary service as indicated by patient presenting complaints and findings

If care in the acute care environment is medically necessary:

1. Use Spanish Interpreter service
2. Arrange family meeting
3. Continue to address smoking cessation, and set up specific plan prior to discharge
4. Consult COPD/CHF Care Coordinator to follow up on prior education understanding and further reinforcement
5. Minimize medication changes, if possible

Discussions about Advanced Care Planning:

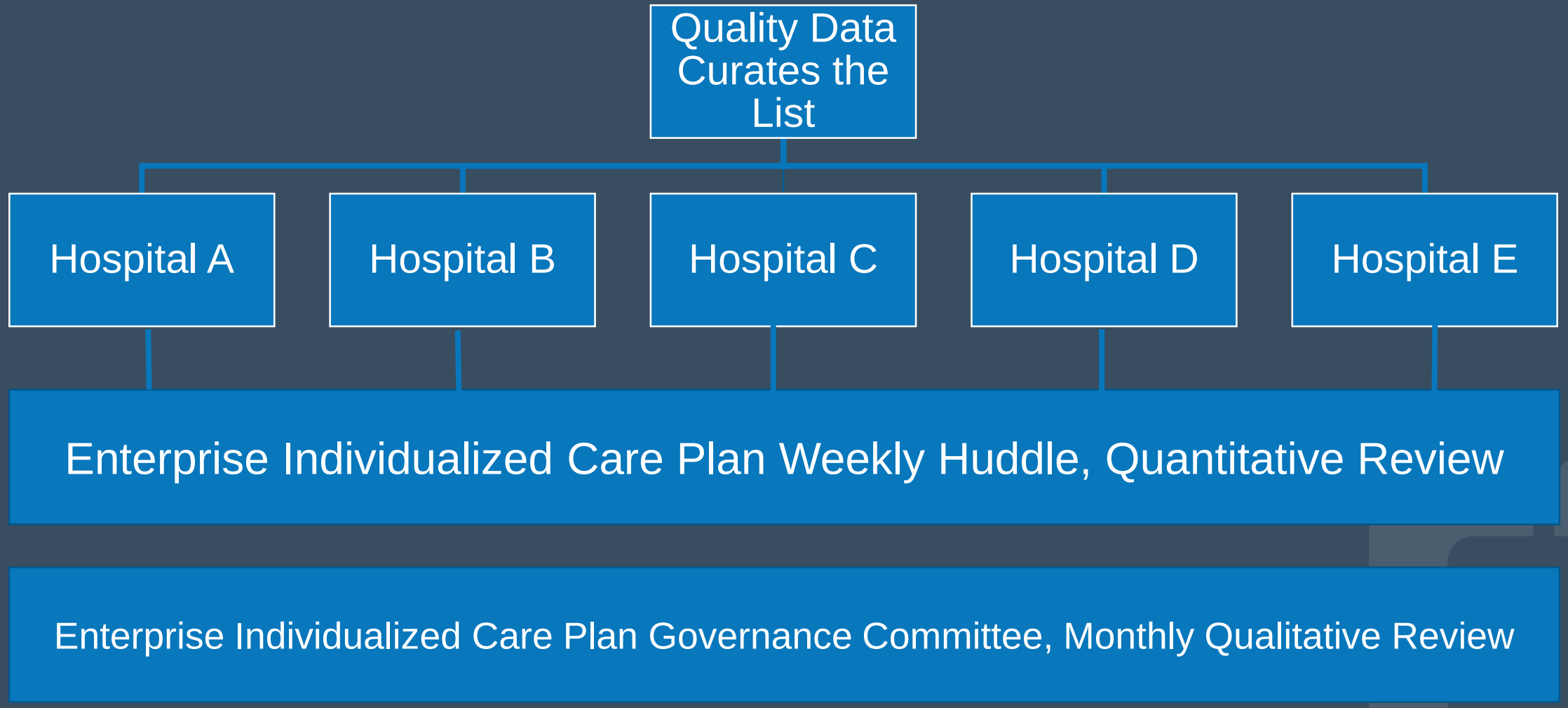
Completing Advance Directives and Palliative Care referral has been discussed during recent hospitalization, and patient had declined both. Continue to address at each outpatient appointment as appropriate and during each hospitalization.

At Discharge

1. Ensure AVS is thorough and printed in Spanish Instructions. Provide instructions to family too, if possible.
2. Providers and Care Manager provide warm handover to Ambulatory and HHC providers

Limited Usefulness	Needs Improvement	Meets Most	Fully Meets	Exceeds Expectations
1	2	3	4	5

Workflow


Quality Data Curates the List
Hospital A
Hospital B
Hospital C
Hospital D
Hospital E
Enterprise Individualized Care Plan Weekly Huddle, Quantitative Review
Enterprise Individualized Care Plan Governance Committee, Monthly Qualitative Review

ICP Patients

ICP Exists?	Average Age	Average Readmission Risk Score	0 Readmits Before	1 Readmit Before	2+ Readmits Before	Total
Yes	79	29	137	40	20	197
No	79	23	1391	148	32	1571

Internal data sources, excludes CCHS Florida hospitals
Data demonstrates equal months prior to and after ICP
Data ends 9/30 to allow for at least one 30 day readmission post ICP
Excludes known deceased

ICP Impact, 0-1 Readmits before ICP

ICP Exists?	Avg. Age	Average Readmit Risk Score	0 Readmits Before	30 Day Readmission Rate	1 Readmit Before	30 Day Readmit Rate	2+ Readmits Before	Total
Yes	79	29	137	**2%**	40	**7.5%**	20	197
No	79	23	1391	**4%**	148	**11.5%**	32	1571

Internal data sources, excludes CCHS Florida and Union hospitals
Readmission Data demonstrates equal months prior to and after ICP
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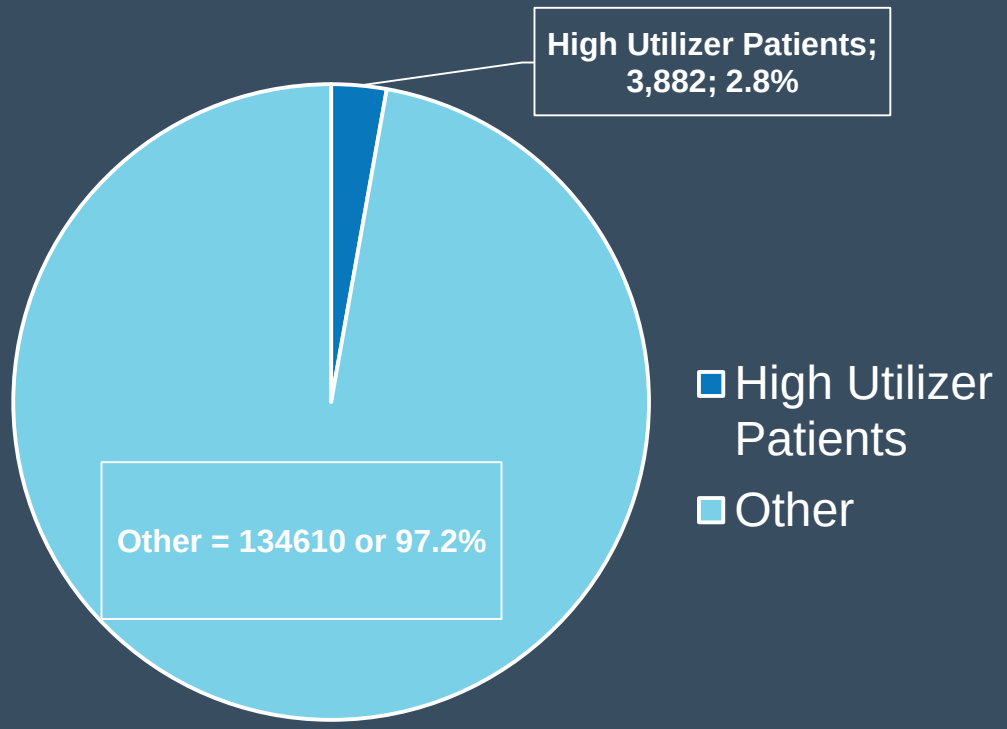
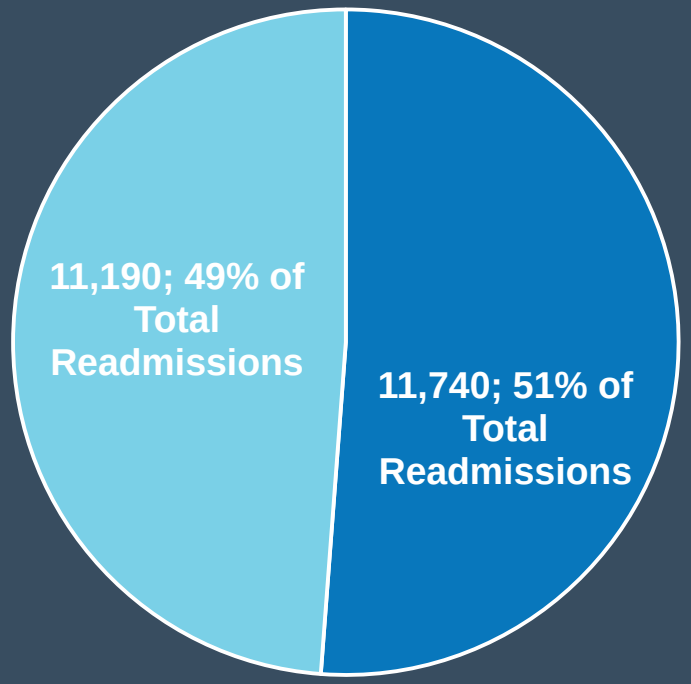
How many of our All-cause Readmissions are from “High Utilizer” patients in 2019?

2019 CCHS Patient Population



N = 138,492 Unique Patients

High Utilizer Readmissions



N = 22,930 Total Readmissions

High Utilizer patient = patient who has undergone at least two 30-day readmissions within a 90 days. Put another way, these patients have had at least 3 inpatient hospital stays within a 90 days, 2 of which were 30-day inpatient readmissions.

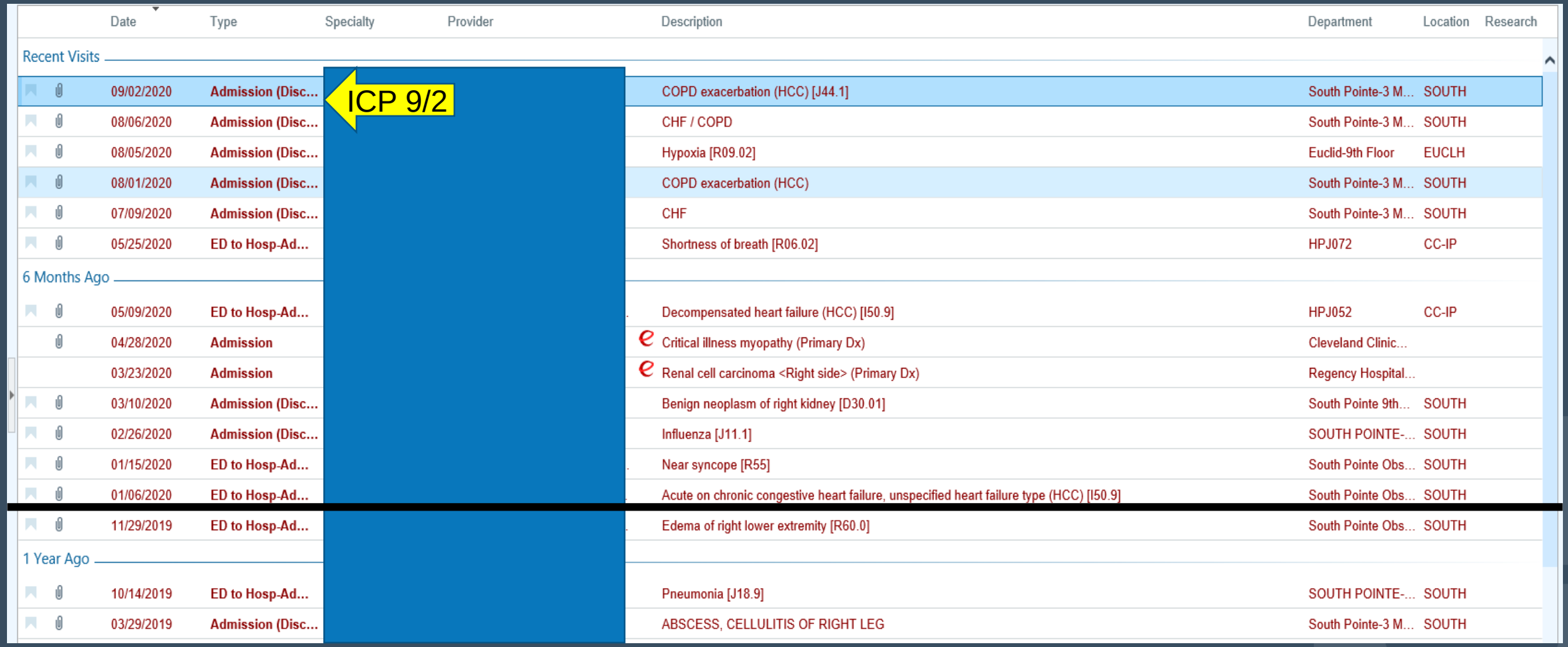
ICP Impact, 2 + Readmits before ICP

- Patients with a least 2 readmissions prior to ICP with equal time period before and after ICP creation

Number of patients	Number of Readmissions Before	Number of Readmissions After	Variance	Variance %
20	52	17	-35	-65%

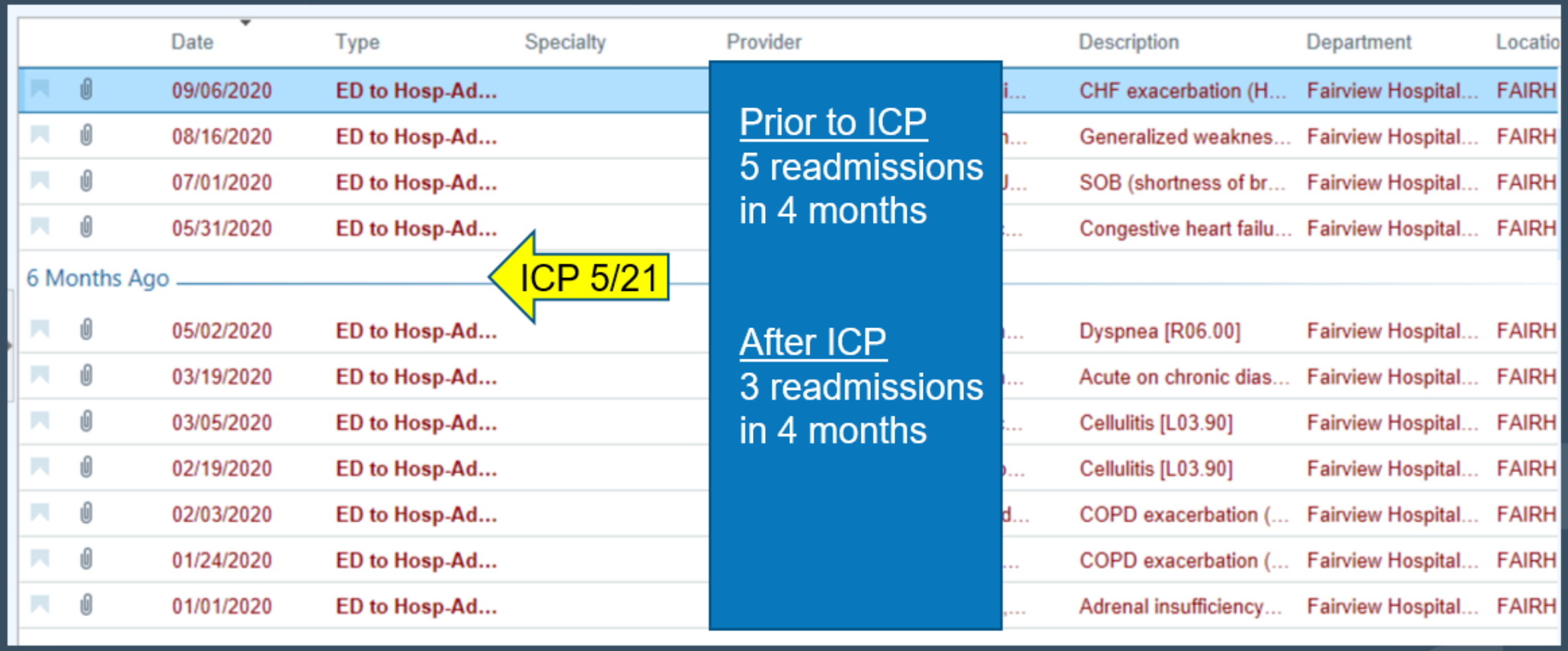
*Over 10 months, the average number of hospitalizations before ICP was 5.7

To Act as a Unit



	Date	Type	Specialty	Provider	Description	Department	Location	Research
Recent Visits								
	09/02/2020	Admission (Disc...			COPD exacerbation (HCC) [J44.1]	South Pointe-3 M...	SOUTH	
	08/06/2020	Admission (Disc...			CHF / COPD	South Pointe-3 M...	SOUTH	
	08/05/2020	Admission (Disc...			Hypoxia [R09.02]	Euclid-9th Floor	EUCLH	
	08/01/2020	Admission (Disc...			COPD exacerbation (HCC)	South Pointe-3 M...	SOUTH	
	07/09/2020	Admission (Disc...			CHF	South Pointe-3 M...	SOUTH	
	05/25/2020	ED to Hosp-Ad...			Shortness of breath [R06.02]	HPJ072	CC-IP	
6 Months Ago								
	05/09/2020	ED to Hosp-Ad...			Decompensated heart failure (HCC) [I50.9]	HPJ052	CC-IP	
	04/28/2020	Admission			Critical illness myopathy (Primary Dx)	Cleveland Clinic...		
	03/23/2020	Admission			Renal cell carcinoma <Right side> (Primary Dx)	Regency Hospital...		
	03/10/2020	Admission (Disc...			Benign neoplasm of right kidney [D30.01]	South Pointe 9th...	SOUTH	
	02/26/2020	Admission (Disc...			Influenza [J11.1]	SOUTH POINTE-...	SOUTH	
	01/15/2020	ED to Hosp-Ad...			Near syncope [R55]	South Pointe Obs...	SOUTH	
	01/06/2020	ED to Hosp-Ad...			Acute on chronic congestive heart failure, unspecified heart failure type (HCC) [I50.9]	South Pointe Obs...	SOUTH	
	11/29/2019	ED to Hosp-Ad...			Edema of right lower extremity [R60.0]	South Pointe Obs...	SOUTH	
1 Year Ago								
	10/14/2019	ED to Hosp-Ad...			Pneumonia [J18.9]	SOUTH POINTE-...	SOUTH	
	03/29/2019	Admission (Disc...			ABSCESS, CELLULITIS OF RIGHT LEG	South Pointe-3 M...	SOUTH	

Customized Care



	Date	Type	Specialty	Provider	Description	Department	Locatio
	09/06/2020	ED to Hosp-Ad...			CHF exacerbation (H...	Fairview Hospital...	FAIRH
	08/16/2020	ED to Hosp-Ad...			Generalized weaknes...	Fairview Hospital...	FAIRH
	07/01/2020	ED to Hosp-Ad...			SOB (shortness of br...	Fairview Hospital...	FAIRH
	05/31/2020	ED to Hosp-Ad...			Congestive heart failu...	Fairview Hospital...	FAIRH
6 Months Ago							
	05/02/2020	ED to Hosp-Ad...			Dyspnea [R06.00]	Fairview Hospital...	FAIRH
	03/19/2020	ED to Hosp-Ad...			Acute on chronic dias...	Fairview Hospital...	FAIRH
	03/05/2020	ED to Hosp-Ad...			Cellulitis [L03.90]	Fairview Hospital...	FAIRH
	02/19/2020	ED to Hosp-Ad...			Cellulitis [L03.90]	Fairview Hospital...	FAIRH
	02/03/2020	ED to Hosp-Ad...			COPD exacerbation (...	Fairview Hospital...	FAIRH
	01/24/2020	ED to Hosp-Ad...			COPD exacerbation (...	Fairview Hospital...	FAIRH
	01/01/2020	ED to Hosp-Ad...			Adrenal insufficiency...	Fairview Hospital...	FAIRH

ICP 5/21

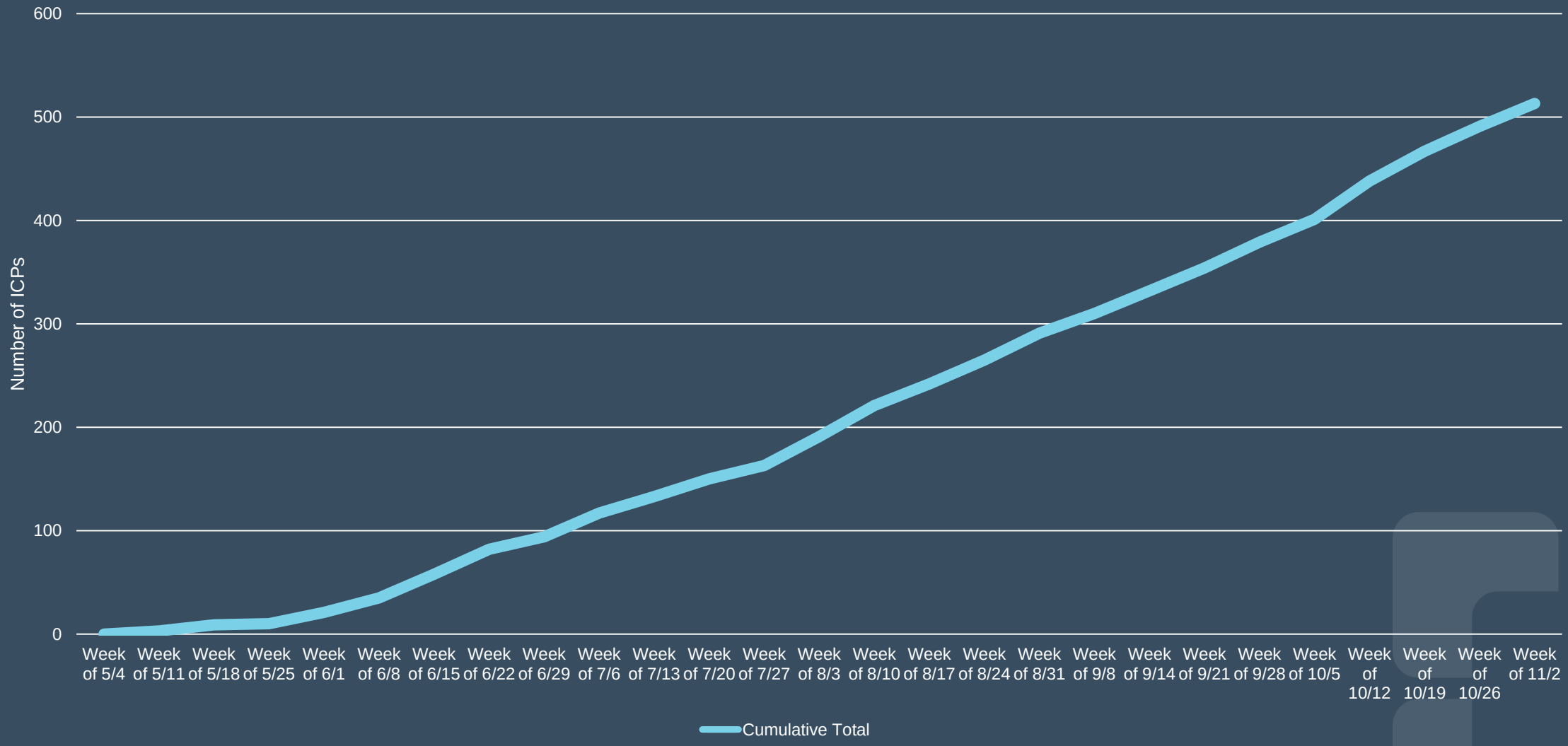
Prior to ICP
5 readmissions
in 4 months

After ICP
3 readmissions
in 4 months

Qualitative Impact

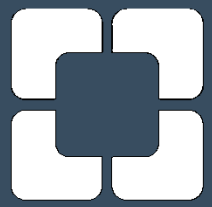
- All programs improving with volume, efficiency, workflow
- Addressing vital patient-centered issues
  - SDOH
  - Palliative conversations
  - Resource referrals (SMA, Chronic Care Clinic)
- Enhancing teamwork between geographic silos and patients feel the difference

Total Number CCHS ICPs



Key Takeaways

- Readmission Reduction requires a Team of Teams
- Individualized Care Plans and EHR tools can help



Cleveland Clinic

Every life deserves world class care.