Southeast Michigan “See You in 7” Hospital Collaborative:
Session 3 – Webinar

Tuesday, July 17 at 8 am
Agenda

Welcome and Introductions

Spectrum Health’s Experience Improving Early Follow-Up for Heart Failure Patients
David E. Langholz, MD, FACC
Spectrum Health

Gap Analysis Presentations
Simbiat Monsur, Physician Assistant
Henry Ford Macomb Hospital
Jill Dennis, JD, RHIA, Medical Staff Quality Specialist & Jacqueline S. Jones, MSN, APN-BC, CEN-CMC, Manager Cardiovascular NP/PA Services
Crittenton Hospital Medical Center

Closing
Next Assignments: Pre-Intervention Data Request and Plan for Improvement

Adjournment
Home to Office H2O

David Langholz, MD
July 17, 2012
Goals

- Have 100% of HF patients being cared for by WMH seen within five days of hospital discharge from Spectrum Health Hospitals, as recommended by the Institute of Healthcare Improvement (IHI). This recommendation is based on randomized controlled studies on provider follow-up and its impact on reducing hospital admissions, readmissions, and mortality.

- Improve communication and collaboration between inpatient and outpatient settings, so key information would be available for immediate provider follow-up.

- Put controls in place to maintain improvements.
Changes

- Developing a streamlined scheduling process for follow-up appointments, which involved coordination and collaboration between the schedulers at SH, the Clinic and the WMH RN.

- Developing care plans for HF patients that became part of the patient’s record and were made available to the next point of service. This allowed follow-up appointments to be a continuation of care.

- Redistributing tasks to free up clinic based mid level providers (MLPs) to see more HF patients

- Developing a coordinated system for rotating inpatient MLPs to the office setting on a weekly basis, increasing continuation of care as patients seen in the hospital would be followed by the same MLP in the office.
Changes Cont.

- Developing an expedited process for completing discharge summaries, available to the next point of service.

- Developing processes for following patients in Skilled Nursing Facilities (SNF)

- Developing a process for having patients who need immediate care to be seen in the HF Clinic for treatment (even if not a HF Clinic patient) in lieu of being seen in the Emergency Department, which leads to most certain hospital admission
Weekly Discharges

weekly discharged & mean days to f/u

kaizen start

Average days to f/u
total discharged
Days to Provider Follow-Up

Days to Provider Follow-up
H2O Initiative

Before Kaizen

Individual Value

0 10 20 30 40 50

08/03/09 09/07/09 10/05/09 10/26/09 11/23/09 01/04/10 02/15/10 03/15/10 03/29/10 04/12/10

week date

UCL=9.93
X̄=4.39
LCL=-1.15
What Makes This Project Creative

- It pulled together resources that had all functioned independently and had never truly pulled together to search for common solutions and maximize resource utilization.

- The team worked to find a solution that, prior to this initiative was seen as “impossible”.

- The team developed creative solutions (eg using the HF Clinic as way to avoid hospitalization)

- The team found ways to meet the needs of patients in SNFs

- They found ways to close the information gap between hospital and the next point of care

- The project was completed in a short period of time and the results have been sustainable.
See U in 7 – GAP ANALYSIS

Henry Ford Macomb Hospital

Presented by
Simbiat Monsur PA-C
Quality – Cardiovascular

Henry Ford Macomb Hospital, Clinton Township, Michigan
Selected Process Measures

- Identification of heart failure patients prior to discharge.
- Identifying and addressing barriers to keeping the follow up appointment.
Gap analysis

- Process measure 1
- Identifying heart failure patients prior to discharge
  - Defining heart failure patients
    - Attending physician
    - Cardiologist
    - Clinical documentation specialist
    - **Coding and Billing**
Patient Identification

- Currently
  - Cerner Power Chart “Visit Reason” column.
  - Diuretics and Inotropic agents list
  - Clinical documentation specialist notification.
    - Chart review**
    - Diagnosis made
Patient Identification

- Time consuming
- Number of charts reviewed far exceeds final coded heart failure cases.
- Accuracy not measured.
- After the fact diagnosis
Patient Identification

- Other possibilities
  - Hospitalist group rounds
  - Contacting Physicians
Goal

- Identify 95% of heart failure patients while in house and track them through hospitalization and discharge.
  - Core Measures
  - Focused/customized education
  - Perfect discharge

- Increase efficiency of identification system.
  - *number of charts reviewed versus number of patients diagnosed with heart failure.
Interventions

- Core measures cases*
- Monthly coding list
  - Match list with the 3 methods
  - Fine tune best match
- Increase physician engagement with Quality
Gap analysis

- Process measure 4
- Identifying and addressing barriers to keeping the appointment.
  - Contact during admission
    - Reinforce need for 3-5 day follow up
    - Identify home bound patients and refer to visiting physicians
    - Resident Clinic
    - Neighbours to neighbours
Barriers to appointment

- Currently
  - Readmission interview
    - Dependent on proper identification
  - ECIN readmission pull
  - Skilled Nursing Facilities**
    - Average less than 48 hours
  - Assisted Living Facilities
Goals

- Recognizing barriers to any missed follow up assessments.
- Develop process to prevent recurrence of identified barrier within 60 days of new discharge.
Interventions

- Before discharge
  - Coordinate discharge planning to resolve barriers to keeping follow up appointment.
  - Appointment committee*.
Thank you!
Crittenton Hospital Medical Center
“See You in 7” Gap Analysis

Jill Dennis, JD, RHIA, Medical Staff Quality Specialist
Jacqueline S. Jones, MSN, APN-BC, CEN-CMC, Manager
Cardiovascular NP/PA Services
# Gap Analysis: Crittenton

<table>
<thead>
<tr>
<th>Selected Process Measure</th>
<th>Where is your hospital in terms of achieving this process measure?</th>
<th>Where should your hospital be in terms of achieving this process measure?</th>
<th>What interventions will your hospital implement in order to reach these aims?</th>
</tr>
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<tbody>
<tr>
<td>Identifying and addressing barriers to keeping the appointment</td>
<td>Have not addressed this systematically; have received anecdotal reports of difficulties in follow-up.</td>
<td>Having early notice of possible barriers (prior to discharge) so that we can address them where possible</td>
<td>We are planning a brief survey of physician offices involved in the follow-up care of this patient population to identify the barriers they perceive, and their ability to see patients within the 7-day time frame.</td>
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<tr>
<td>Working to ensure that the patient arrives at the appointment within 7 days of discharge</td>
<td>Need to determine what options we have for facilitating patient compliance with appointments; also need to determine whether appointments are being appropriately scheduled (timely).</td>
<td>Measure to determine compliance with appointment and identify barriers to compliance</td>
<td>Interventions will be planned once we have a fuller understanding of the reasons patients are not following up timely. We’re asking the offices to report the reasons they are hearing from patients, but we may also need to do some follow-up calls to patients directly.</td>
</tr>
<tr>
<td>Making the discharge summary available to the follow-up health care provider</td>
<td>Not yet sure that all physicians following patient post-discharge receive copy of transcribed discharge summary. Issues with timely dictation of discharge summary for some physicians. Medications are not listed routinely in the discharge summary, but patients are asked to bring their meds list to the appointment.</td>
<td>Discharge summaries should be clear, timely, including all relevant follow-up information, and should facilitate the “handoff” between inpatient and outpatient care. We need to determine whether patients are bringing their meds list to the appointment, or whether this is the best method of sharing info on medications at discharge.</td>
<td>One of the questions we are asking in the survey of physician offices is whether they are getting the discharge summary, and receiving it in a timely fashion to facilitate coordination. We also have included a question on our survey about whether patients bring their discharge meds list with them to their first follow-up appointment.</td>
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Crittenton Hospital Medical Center is a participant in a quality collaborative, "See You in 7", that seeks to reduce hospital readmissions among heart failure and Acute MI patients. Prompt and high quality follow-up care is an important contributor to reducing readmissions, so we're working to **identify potential barriers that prevent patients from being seen by their primary care physician and/or specialist within 7 days of discharge**.

Your opinions on the questions below would be very valuable to us in designing a smoother, more productive transition between inpatient and outpatient care. Please discuss these questions with others in your practice, including your physician(s) and complete this survey. Any additional comments are also welcome.

If you have questions about the survey, call Jill Dennis in the Quality & Outcomes Management Department at 248-601-4278. Please return your response in the envelope provided by **August 1, 2012**. Thank you!

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**Questions**

1. **On average**, how soon after hospital discharge do you typically see heart failure/AMI patients for their follow-up appointments? (Check the best answer)
   - ≤ five days after discharge
   - Between five - seven days after discharge
   - One - two weeks after discharge
   - More than two weeks after discharge

2. **Could** your appointment schedule accommodate follow-up visits for heart failure/AMI patients **within** seven days of discharge? (Check the best answer)
   - Yes, all of the time
   - Most of the time
   - About half of the time
   - Less than half of the time

3. When heart failure/AMI patients **cancel or fail** to keep appointments, what are the reasons you are given? (Check all that apply, and estimate the percentage of cancellations citing that reason)
   - Cannot afford to come
   - Feeling too ill to come
   - No one to accompany them
   - Transportation problem
   - Feeling better now
   - Other: (please write in):

**Questions continue on other side**
4. By the time of the follow-up visit, have you received a copy of the dictated discharge summary from Crittenton? (Check the best answer)

- Almost all the time
- Usually
- About half the time
- Rarely
- Never

5. Is the content of the discharge summary generally useful to you in providing follow-up care?

- Yes
- Yes, but we’d like more information about: ____________________________
- No, because: ____________________________

6. When patients arrive for their appointment, do they bring a copy of their hospital discharge instructions and medication list with them? (Check the best answer)

- Yes, almost all the time
- Yes, more than half the time
- No, less than half the time
- No, almost never

If you have suggestions for us on ways to improve the transition from inpatient care to outpatient care, or suggestions on how we can better coordinate follow-up care with you, please note them below:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

If you would like to identify your practice, feel free to do so in the space below (not mandatory for participation).

____________________________________________________________________

Thank you so much for sharing your views. Please return the survey in the enclosed envelope by August 1, 2012.
“See You in 7” Hospital to Home Initiative

When discharging patients from the hospital please:

1. Check to ensure an appointment was made by the Unit Secretary within 7 days.
2. If no appointment was made, please have the Unit Secretary complete this task.

After the appointment is made, please ask the patient the following questions:

1. Will you be able to keep your doctor's appointment within 7 days?
   a. Yes
   b. No

2. If the answer was “No” to the above question, please select from the options below that may prevent the patient from keeping the appointment.
   a. Transportation issues.
   b. Feeling too ill.
   c. No one to go along with the patient.
   d. Not able to afford the office visit.
   e. Patient may be feeling better.
   f. Other ________________________________

Comments:

Signature: ___________________________ Date: ________________ Time: __________
<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Metric</th>
<th>May - July (Pre-Intervention)</th>
<th>Feb. - April (Post-Intervention)</th>
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<tbody>
<tr>
<td>Identify all heart failure patients prior to discharge</td>
<td># of heart failure patients identified prior to discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduling and documenting a follow-up visit with a cardiologist or primary care practitioner that takes place within 7 days</td>
<td>Prior to discharge, # of heart failure patients with a scheduled follow-up visit with a cardiologist or PCP. This visit must be scheduled to take place within 7 days of discharge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing patient with documentation of the scheduled appointment</td>
<td># of heart failure patients given documentation of the scheduled appointment prior to discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying and addressing barriers to keeping the appointment</td>
<td># of patients with which any potential barriers to keeping the follow-up appointment were identified and addressed prior to discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working to ensure that patient arrives at appointment within 7 days of discharge</td>
<td># of patients who arrived at appointment within 7 days of discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making the discharge summary available to the follow-up health care provider</td>
<td># of patients whose discharge summary was available to the follow-up health care provider within 48 hours</td>
<td></td>
<td></td>
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<td></td>
<td>30-day all cause readmissions for patients discharged with heart failure</td>
<td></td>
<td>Hospitals will receive Medicare data from MPRO may share with GDAHC as part of Collaborative</td>
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<td></td>
<td>Rates of outpatient follow-up for heart failure patients within 7 days (Initial data provided will be within 30 days)</td>
<td>Hospitals will receive Medicare data from MPRO may share with GDAHC as part of Collaborative</td>
<td>Hospitals will receive Medicare data from MPRO may share with GDAHC as part of Collaborative</td>
</tr>
</tbody>
</table>

*The sample of patients should be randomly selected from the Medicare population.  
*This data request may apply to all Medicare heart failure patients in a hospital or to a unit within the hospital. This will be determined by each participating hospital as part of the collaborative.
### Process Measure #1

| Identify heart failure patients prior to discharge |

### Strategies

**Example:** 1 to 2 dedicated staff review patients' charts daily for any “triggers” and flag the chart (triggers: admission diagnosis codes for HF, shortness of breath, swelling, edema, fluid overload; Secondary diagnosis codes for HF, shortness of breath; history of HF; Abnormal BNP or NT-proBNP levels; treatment with IV diuretics within the last 24 hours; chest X-ray showing HF or pulmonary edema)

### Action steps

**Example:** Project lead meets with dedicated staff for initial meeting to discuss project and strategies on identifying heart failure patients prior to discharge followed by monthly meetings to discuss progress/results/barriers

### Target Date

**Example:** 8/27/2012

### Responsible Person

**Example:** Cec Montoye, System Performance Improvement Leader, “See You in 7” Project Lead
Thank you!

Next Session:
Session 4 – In-Person at AIAG Offices
Wednesday, Aug. 22 at 8:00 am

Plan for Improvement & Pre-Intervention Data Request Due
Aug. 10