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Title: Readmission Reduction

Areas of Focus: Quality Improvement and Patient Experience

Brief Statement

As the Vice President (VP) of Clinical Excellence, I support and commend innovative strategies that cultivate a commitment to our organization's strategic goal of Perfect Care. In the pursuit of Perfect Care, Performance Improvement (PI) opportunities were identified in the area of readmission reduction. Through the use of X-matrix strategic tool; priority health system initiatives are established which cascade to the executive leadership level then to the VP's team, whom are responsible for developing and deploying Perfect Care strategies. By leveraging the hospital resources, collaborating with Skilled Nursing Facility (SNF) leadership and the physician leadership, a strategy focusing on the continuum of care was developed.

Utilizing the X Matrix tool, St. Jude Medical Center identified the opportunity for improvement in reducing 30-day readmission rates. Incorporating our core values of Service, Dignity, Excellence, and Justice and our desire to treat the whole person, mind, body, and spirit we centralized our efforts on process improvement strategies related to reducing readmissions by creating an executive level Perfect Care Readmission Reduction Committee.

Simultaneous approaches were implemented within the hospital to identify potential readmissions. Utilization of the Institute for Healthcare Improvement (IHI) Readmission Failures Tool afforded the ability to improve the patient discharge process and design a partnership strategy with local Skilled Nursing Facility (SNF) providing support and resources to improve patient outcomes. These readmission reduction strategies can be replicated to obtain similar results.

Executive Summary

St. Jude Medical Center (SJMC) embarked on a journey to improve patient outcomes as evidenced by reduction in readmissions with a focus to improve the discharge planning process. Through the discovery of conflicting processes and flow of information, numerous PI

opportunities were identified. The formation of a Readmission Reduction Committee structure, inclusive of executive leadership, all frontline disciplines, physicians, and contracted SNF partners, enabled the identification of interventions to reduce readmissions.

The commitment of administrative leadership to the strategic goal of readmission reduction; continues to motivate the committee to make further improvements. The Perfect Care Readmission Reduction Committee has in attendance four executives: CNO, CMO, Medical Director of Care Management, and the VP of Clinical Excellence to support the team's efforts and remove any barriers that are assessed. Interventions that were developed by this team span the patients' admission, transfer, and discharge to the outpatient setting encompassing the entire continuum of care. Literature searches, attendance at conferences and openness to new innovative methods to communicate and process information have afforded the team success and vision to further achieve goals and improve patient outcomes. Refer to Figure 1 and 2.

Significance:

St. Jude Medical Center identified the opportunity to improve 30 day readmissions in FY 2011. Through data analysis of all cause readmissions the overall rate was 10.6%, and by Clinical Focus group populations it was determined that AMI all cause was 15%, Heart Failure all cause was 14% and Pneumonia all cause was 14%. These rates were above national averages and were identified as areas of opportunity.

St Jude Medical Center employs Lean methodology and uses the X-Matrix as a one-page visual tool depicting the alignment of our strategic initiatives and measures at multiple levels. The purpose of the tool is to develop and implement plans that are strategic, tactical, and coordinated across all stakeholders of the organization. It ensures there is ownership at all levels, encourages organizational learning, faster corrective action, and accountability.

The X-Matrix "South Box" contains the organization's mission, vision, and values along with the collective five-year strategic objectives. These objectives are categorized in dimensions aimed at addressing areas of opportunity faced in today's healthcare environment. Currently the categories of focus include: *engaged people, information sophistication, value, and network of care, physician partnership, population health, and essentiality*. As a cascade, the objectives set forth in the X-Matrix begin at the Health System (level zero), cascade to the Southern California Region (level one), which cascades to the hospital, St Jude Medical Center (level two). From the hospital level, cascading continues to the Vice-President or Division (level three). Some divisions also create an x-matrix for their Directors (level four), while others use the Vice-President's x-matrix for goal setting.

The organization's initiatives and metrics are further cascaded to frontline staff on a routine basis. This includes the publishing of results for the organization's strategic goals on a monthly basis for key value metrics (quality, patient experience, and affordability). This information is in graphical form illustrating current performance and fiscal year-to-date trend compared to threshold, target, and exceptional benchmarks. This information is posted in department visual management display cases where managers are able to discuss and share outcome information during team huddles with their staff. For the current fiscal year, our organization publishes routine performance outcome measures, including our Observed/Expected readmission rate (identified populations: AMI, HF, PN, COPD, H&K, CABG).

St. Jude Medical Center set targets to reduce overall readmissions using goals staggered over a three year period. Targets were based on exceeding Top Quartile outcomes from the baseline period. Using calendar year 2014 as a baseline, target goals were established for each successive year from FY16 to FY18: FY16 Target (1/3 between baseline and target), FY17 (2/3 between baseline and target), FY18 goal of meeting top quartile goal. Top quartiles were drawn from Premier, a healthcare data alliance warehouse that manages data from over 3,600 US hospitals.

Innovation:

The innovations undertaken were in two specific areas encompassing overall 30-day readmission reduction for all payors, with an emphasis on the reduction of readmissions from skilled nursing facilities (SNFs). Initial work included the formation of a performance improvement team where a process flow map was created. The map depicted the number of co-competing priorities for patients at admission and discharge. The team comprised of all of the process stakeholders, including physicians. The goal was to discover the current processes that were in place in each of the divisions, common duplications between departments, and to streamline the information to develop consistencies in practice.

The outcome of the review was a new design that allowed for improved communication between disciplines, a more focused review of patient needs prior to discharge, as well as identification of potential readmission triggers. Patients with insurance or social situations that would not be supportive of a successful discharge were identified and connected with services that could be integrated into their care, i.e., transportation arrangements, referral and scheduling at the transitional medical clinic, and medication payment assistance.

From that initial process map a number of interventions were identified; process changes that were needed and overall flow of information changes were required. One of the initial interventions was to produce a list of all readmissions from the previous day which is sent out to the hospitalists, care managers, nursing unit managers, infection prevention, and

pharmacy. The intent of this communication is to trigger conversation at the bedside in the consideration and development of an alternative discharge plan from the index discharge plan.

An executive-level committee with membership from hospital leadership, nursing, pharmacy, care management, medical group care management, ancillary disciplines and navigators was formed. The Perfect Care Readmission Reduction Steering Committee meets once a month to assess the compliance with processes, review all failures in discharge planning, and work on developing immediate action to mitigate any failures identified. This committee serves as an integrated platform with our outpatient partners. As new and improved outpatient programs are created the structure allow for integration across the continuum of care.

A readmission team was created to review all inpatient readmissions within 30 days. Members include representatives from nursing, dietary, palliative care, respiratory, quality, case management, home health, physician utilization, and a physician champion. This team meets weekly and analyzes the readmissions using an IHI readmission reason tool that provides the ability to track possible failures in the discharge process. The IHI tool provides criteria for review to determine if failures occurred. The failures are categorized by patient assessment, patient and family caregiver education, handoff communication, and discharge from hospital failures. Based on the aggregate data collected from these reviews, targeted interventions were put into place. A tracking tool for the interventions was implemented to improve the accountability of outcomes.

The Care Management staff complete an evidenced based readmission assessment on every patient readmitted from home. The utilization of the IHI evidence based tool allowed the team to identify potential reasons for avoidable readmissions. The assessment contains a list of questions including: medication understanding, availability of the medication, understanding of the discharge plans, contacting the physician's office, appointments at the physician's office or transitional Medical Clinic, language barrier issues and overall reason for readmission. Analysis of this data demonstrated that the largest opportunity was with the patient and caregiver's unrealistic expectation for care at home. This will allow the hospital to refocus efforts for care to the patient and caregiver training. Caregiver Training is being developed to include the patient and caregiver with hands-on training prior to discharge.

The important strategic approach was to include a focus on SNF readmissions and to create SNF group from the local area who were willing to partner with the hospital as active participants in readmission reduction. In May 2015 the initial collaborative of SNFs was convened with the purpose of building trust among the partners and to focus on patient outcomes. St. Jude Medical Center collaborated with six local SNFs and provided an avenue for the SNFs to initiate and discuss improvement of communication during patient handoff and

transfers. Individual SNF meetings were held to review and agree upon the metrics captured on the SNF dashboard that represented important SNF benchmarks for the hospital.

St. Jude Medical Center continued to pursue a stronger collaboration by introducing and incorporating an evidence-based quality improvement program called INTERACT (Interventions to Reduce Acute Care Transfers). On July 30, 2015, CALTCM (California Association of Long Term Care Medicine) did a one day training at St. Jude Medical Center with a goal to “Train the Trainers” on the INTERACT tools and processes for daily use at the SNFs. The attendees present were physicians, directors of nursing, and directors of staff development, administrators, and hospital representatives. The forum allowed the attendees from each skilled nursing facility to ask questions, identify their facility’s skilled capabilities, and develop an individualized skilled nursing facility action plan to implement all, or some portions, of the INTERACT program with the guidance of CALTCM.

In conjunction with this process, a St. Jude Medical Center SNF Liaison was hired to provide oversight of the INTERACT program at the partnered SNFs. In addition, the SNF Liaison provides a valuable review of hospital readmissions from the SNF to the weekly Readmission group. The review is focused on what we could have done better from the hospital perspective and whether the SNF required added resources to improve processes.

The SNF collaborative meetings expanded to include hospital leaders in specific areas of Infection Prevention, Respiratory Therapy, Wound Care, Orthopedic services and nursing staff working on Clinical III projects to improve patient outcomes. The focus of these leaders is to provide the six partnered SNFs with real-time education to mirror hospital processes and share any newly discovered best practices within their scopes. This is an ongoing effort to reduce patient harm, improve patient safety and quality outcomes.

Integration:

St. Jude Medical Center has incorporated into the Perfect Care Readmission Reduction Steering Committee the interventions discovered through the performance improvement work for both inpatient readmission reduction and the SNF Steering committee. This steering committee expanded the focus from inpatient readmissions from home and SNF to include the medical group outpatient case management process, Transitional Medical Care, the Care Connect team, home health, hospice, St. Jude Medical Center palliative care program, outpatient palliative care program, and the nurse advice line. A performance improvement tracker was developed to collect the number of new and current interventions being tested. The tracker is reviewed monthly at the steering committee.

The hospital SNF Liaison has afforded the opportunity to obtain much needed information at the SNF sites to improve the hospital discharge process. The addition of this role

brings the effect of what the hospital discharge process documentation contains and the communication of information to the partnership to reduce the patient from being readmitted to the forefront. This integration of the SNF Liaison into the SNF and Hospital process has led to improvements in the discharge information that is provided, more concise and better packaged information to the SNFs.

An analysis was performed of each of the SNF readmissions with identified potential interventions. These identified interventions provided to the SNF partners include: a) the infection preventionist consultation on hand hygiene that allowed the SNF to identify the need for increases hand hygiene stations; b) decrease turnaround times for lab test by providing the SNFs with lab draws at the SNF and processing at the hospital; c) heart failure education to the SNF staff to identify exacerbation of Heart Failure; d) early identification of sepsis in the SNF with beginning treatment; e) a collaborative of SNF physicians performing medical record review to identify opportunities.

Every day the readmissions from the most recent 30 day period are reviewed by the data analyst, placed on a list then sent out to the Readmission Core Team to review and develop changes in discharge plans. This Core Team consist of front line staff, Care Managers and physicians has daily rounds and develop discharge plans that encompass the patient's needs, caregiver education for realistic expectations and once discharged the outpatient staff calls each patient to ensure the discharge plans are executed. The weekly review of all previous weeks' readmissions has resulted in changes to interventions, and identification of discharge processes that are not meeting the overall patient needs.

The integration of these efforts focused on patient safety. Through the inclusion of multiple disciplines: pharmacy, nursing, care management, outpatient services through physicians' offices, outpatient care management and palliative-Hospice care has allowed for a robust developed readmission and discharge process. The focus of doing the "right thing" for patient safety and not just focusing on the outcome of satisfaction metric allowed the teams to make needed changes to the discharge process.

Results:

Strategic focus for Readmission Reduction has been on the clinical areas of Heart Failure, Pneumonia, COPD, AMI, Hip and Knee replacement surgery. In fiscal year 2016, the monthly overall readmission rates met the top quartile goal 5 of the 8 months measured with our fiscal year to date (0.79) at target. SJMC is currently outperforming the FY 2018 top quartile National Benchmark for Readmission Reduction.

Figure 1: Observed/Expected Readmission Ratio

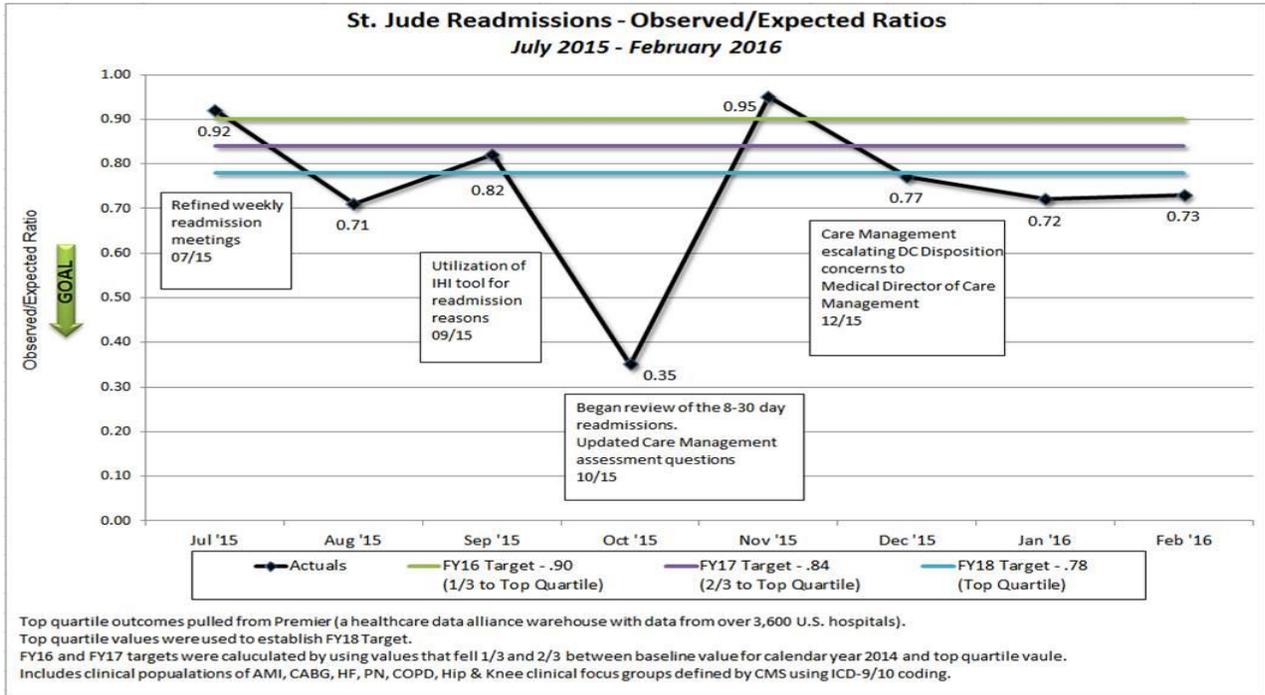
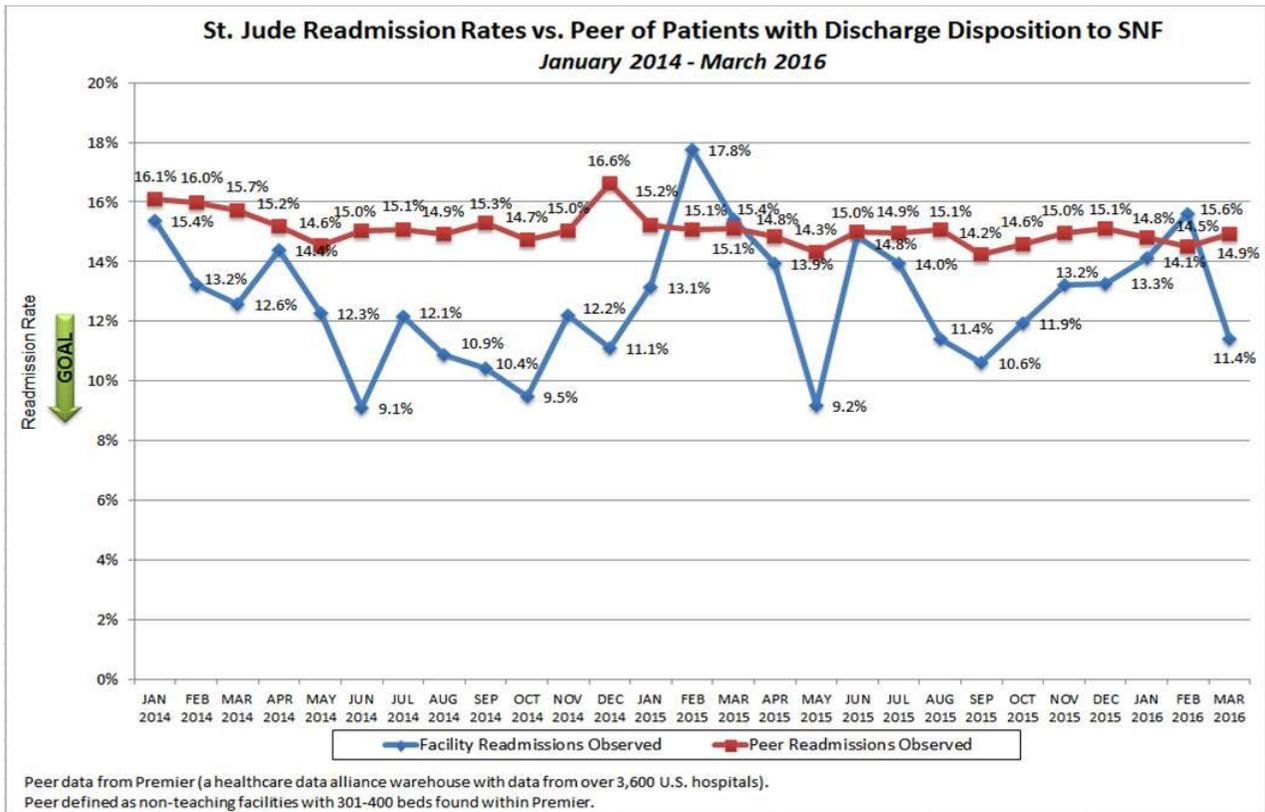


Figure 2: SNF Readmission Rate



Overall results compared to the peer group demonstrate a strong trend of decreased readmission. The trends for the SNF Readmission identified special cause variation through analysis of individual cases with opportunity in the case mix Severity of Illness (SOI), and Sepsis areas.

Sustainability:

The readmission review process, committee structure and SNF Liaison role was developed to support the readmission reduction goals has now been in place for four years. The continuous improvement in the structure allowed new membership with fresh eyes and innovative ideas to contribute to the readmission reduction effort. In addition, the commitment of the hospital leadership to the project and dedication of resources elevated and supported the importance of this work.

The evolution of the SNF partnership process 18 months ago has created a generated new passion by both the partnered SNFs and hospital leadership. The focus on collaboration between the two types of facilities has identified the need for knowledge and resources by both entities. Incorporation of the SNF processes into the Perfect Care Committee added to the success of overall readmission reduction. The grant for the original SNF Liaison role was extended for another two years as a direct result of the successful partnership and outcomes to patients.

Scalability:

St. Jude Medical Center has been identified as a best practice for the readmission reduction process within the St. Joseph Health System. These processes, committee structure, and the work completed by the SNF partnership have been adopted by the other St. Joseph Health hospitals and will continue to be a strategic goal.

The value of this endeavor is realized by the support provided by the Executive Leadership team, finance and frontline staff, as well as the Readmission Reduction interdisciplinary team. The performance improvement activities and overall committee structure that provides oversight for the development and implementation of the SNF partnership and hospital readmission goals are linked to the overall hospital strategic goals.

Replication of the interventions, accountability structure, discharge planning, readmission identification, and SNF partnership, will support other organizations to achieve similar results.