Kaiser Permanente: Transition Care Performance and Strategies

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care management | institute

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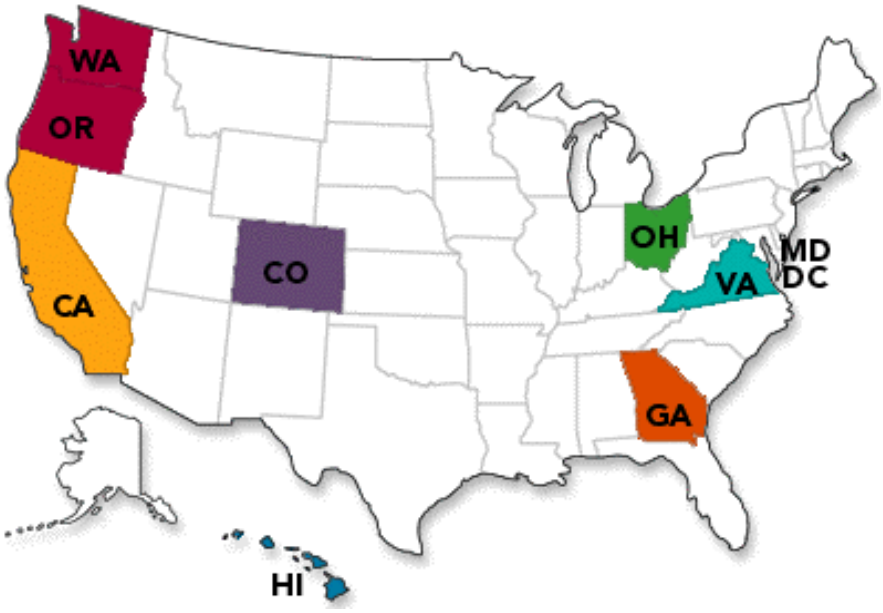
Agenda for today

- Kaiser Permanente Transitions Strategy
  - The Problem
  - The Approach
- NW Case Study
- Outcomes across KP
- Spread
- Questions/Discussion

Kaiser Permanente

- 8 regions serving 9 states and the District of Columbia
- 9+ million members
- 16,600 physicians
- 173,000 employees
- 37 medical centers (with hospitals)
- Nearly 600 medical offices (ambulatory care buildings)
- $47.0 billion operating revenue (2011)



About KP HealthConnect® and My Health Manager

- KP HealthConnect® is the largest civilian deployment of an electronic health record
  - As of March 2010, all Kaiser Permanente medical facilities are equipped with KP HealthConnect
  - Kaiser Permanente has received 36 Stage 7 Awards, more than any health system in the nation
- My Health Manager
  - KP's Personal Health Record linked to KP HealthConnect
  - More than 3.3 million users (as of Dec. 2012)
  - 2012 My Health Manager User Stats
    - Appointments scheduled online: 3.1M
    - Prescription refills: 11.8M
    - Secure email messages to doctors: 13.3M
    - Lab results viewed: 32.3M
    - KP mobile app downloads: 460,000

The problem

NW Transitions Improvement Kickoff
Arthur Hayward MD

It seems like members are catapulted out of the hospital

Transitions: Whose job is it?

Transitions Department?
Primary Care?
Specialty Care?
Hospitalists?
Continuing Care?
Quality Department?
Resource Stewardship?
UM Department?
The patient…..

KP Approach: Transition Care Journey

2008	2009	2010	2011	2012
•Interviewed Patient •Human Centered Transitions Redesign	•Kick-Off meeting •Readmission Diag. •Video Ethnography •Grants to Regions	•Transitions Bundle-Creation and Testing •Standard Measures	•Results •Bundle Spread •Transitions 101	•Contract Hosp. •SNF •Transitions 201

What Patients Need? → **Operational Change**

National Tools

- **Small grant $$' s**
- **Consultation/Support**
- **Transition Summit**
- **Readmit Diagnostic**
- **Measurement**
- **Transitions 101 series**
- **Transitions Wiki: 13,000 page views**

Regional Outcomes

Patient Centered Transition Bundle
Created
Tested
Implemented
Spread

Deep Dive Readmission Diagnostic

REVIEWS

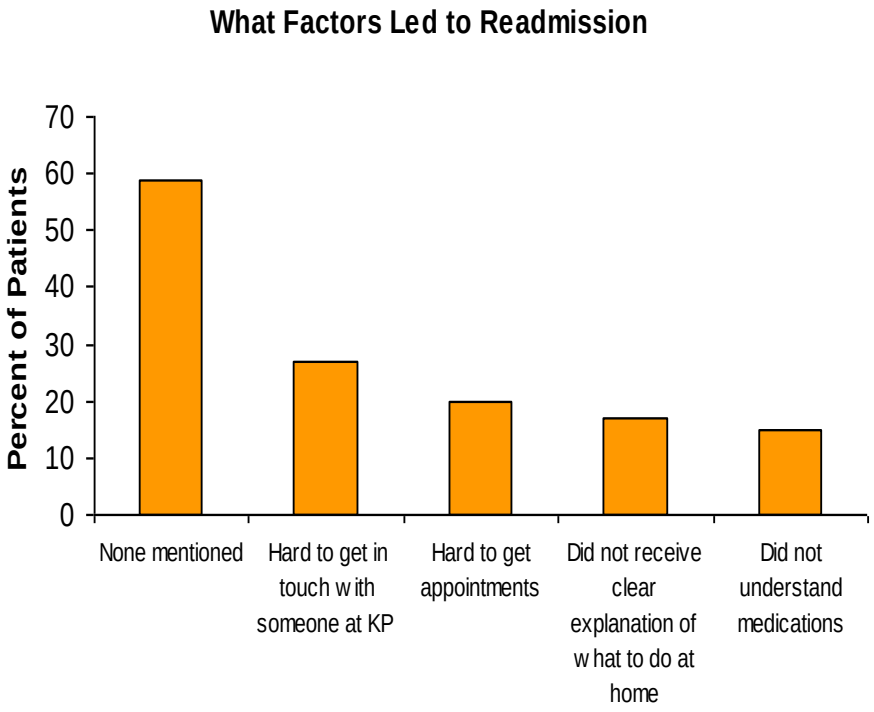
MD INTERVIEWS

PATIENT OR CAREGIVER INTERVIEWS

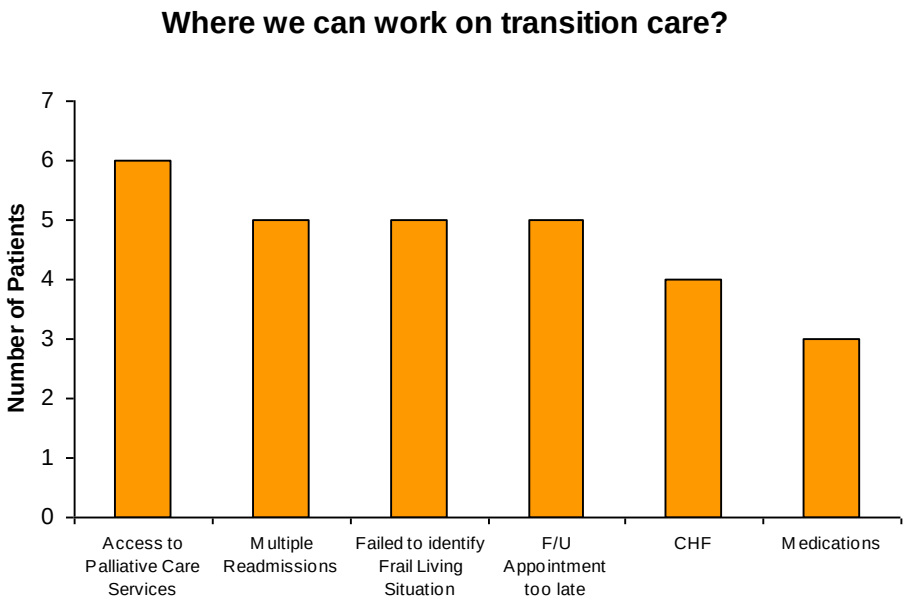
RN/ MD Team FINAL ASSESSMENTS Synthesis of 3 different data sources

Diagnostic Results

Patient Perspective



System Perspective



* From Patient Interview, n=115

Member's perspective….

There were too many new meds and I didn't understand the changes.

My primary care provider did not know I was in the hospital.

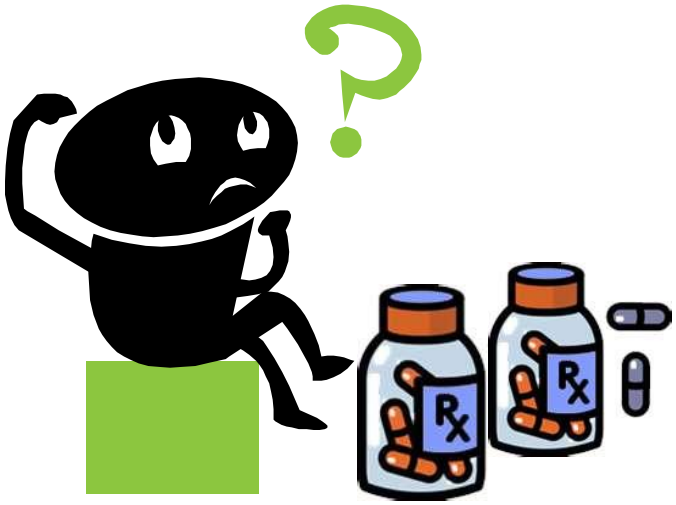
The main thing was not knowing who to call…so I called 911.

I just wanted to go home, I didn't pay as much attention as I should have to the nurse.

Physician's perspective….

Outpatient physicians were not always getting timely information from both the hospitals and SNF's

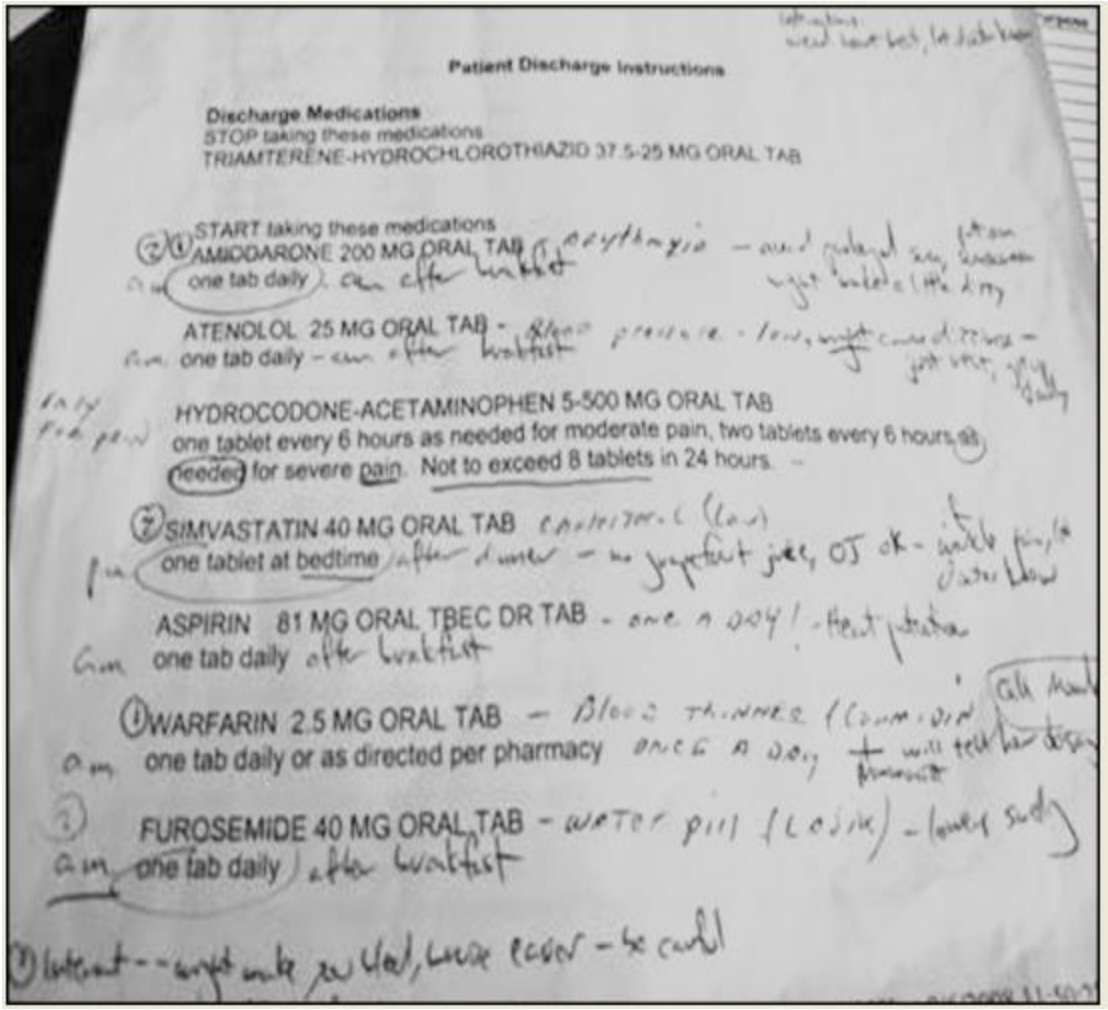
Chart Review….



- The medication lists were not always accurate or in understandable language.
- The hospital medication list matched what the patient was actually taking 57% of the time.

Medication List

An actual discharge medication list



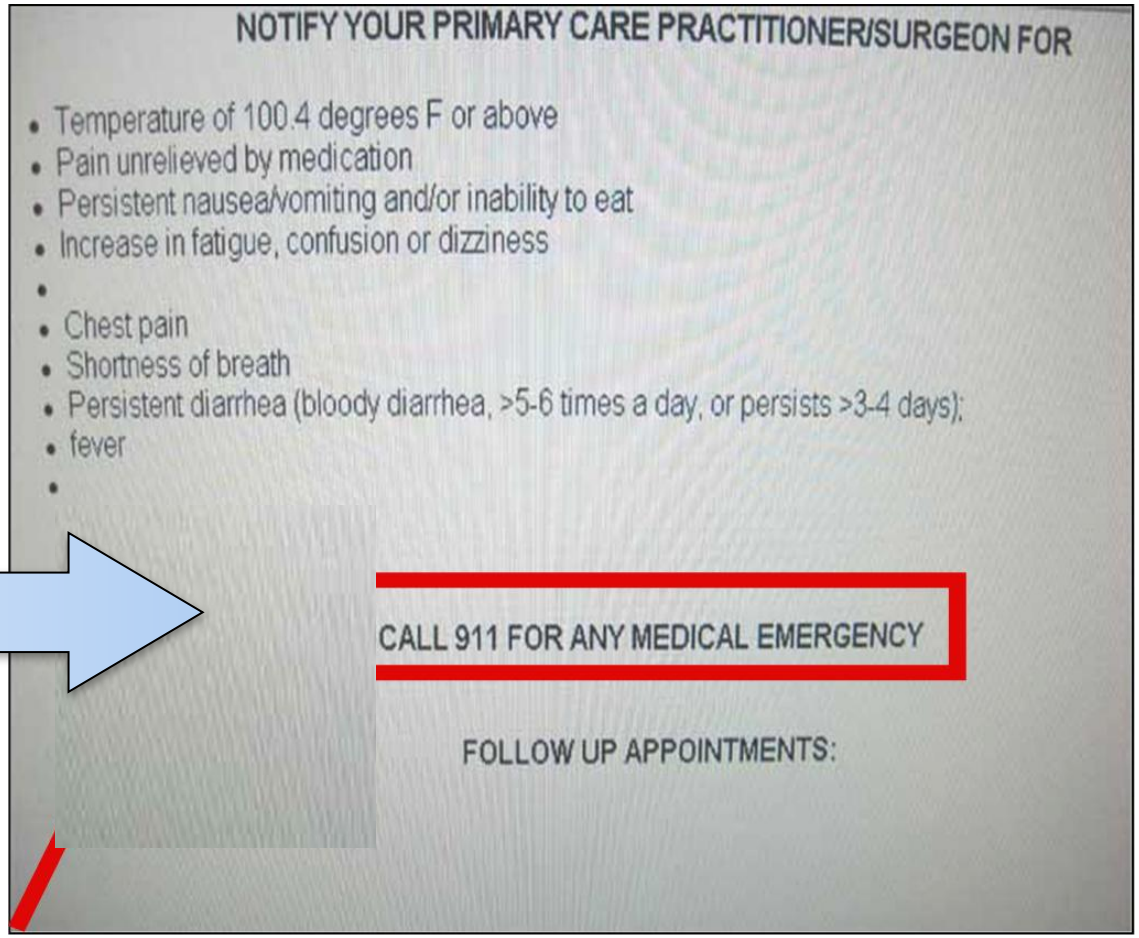
Patient Discharge Instructions

Discharge Medications
STOP taking these medications
TRIAMTERENE-HYDROCHLOROTHIAZID 37.5-25 MG ORAL TAB

START taking these medications
AMIODARONE 200 MG ORAL TAB
one tab daily
ATENOLOL 25 MG ORAL TAB
one tab daily
HYDROCODONE-ACETAMINOPHEN 5-500 MG ORAL TAB
one tablet every 6 hours as needed for moderate pain, two tablets every 6 hours as needed for severe pain. Not to exceed 8 tablets in 24 hours.
SIMVASTATIN 40 MG ORAL TAB
one tablet at bedtime
ASPIRIN 81 MG ORAL TBEC DR TAB
one tab daily
WARFARIN 2.5 MG ORAL TAB
one tab daily or as directed per pharmacy
FUROSEMIDE 40 MG ORAL TAB
one tab daily

Who are you going to call?

Over half of the time, 911 was only phone number listed



Setting the AIM

- **AIM**
  - Create an integrated end to end transitions process for ALL KPNW members to keep them safely at home (or at a care facility) after a hospitalization.

- **Objectives**
  - Reduce 30-day readmission rates from 12.1% to 10% for members receiving the intervention
  - HCAHPS in 90th percentile
  - Increase % of patients that get a PCP appointment in 5 days

The NW Transition Care Bundle

What does the patient need?	Transition Bundle Elements
I will have what I need when I return home.	1. Risk Stratification with tailored care
I know when I should call and what number to use when I need help.	2. Specialized phone number on DC Instructions
My regular doctor will know what happened to me in the hospital.	3. Standardized Same Day Discharge Summary
I understand my medications, how to take them, and why I need them.	4. Pharmacist reviewing medications in hospital (Hi risk PharmD phone call)
I will see my doctor soon after my hospitalization. I know someone will check on me when I am home.	5. Follow Up ▪ MD appointments made in hospital within 5 (high risk) to 10 days. ▪ RN follow up Call within 72 hours. ▪ RN case management 30 days (high risk)

Bundle Element #1 - Risk Stratification

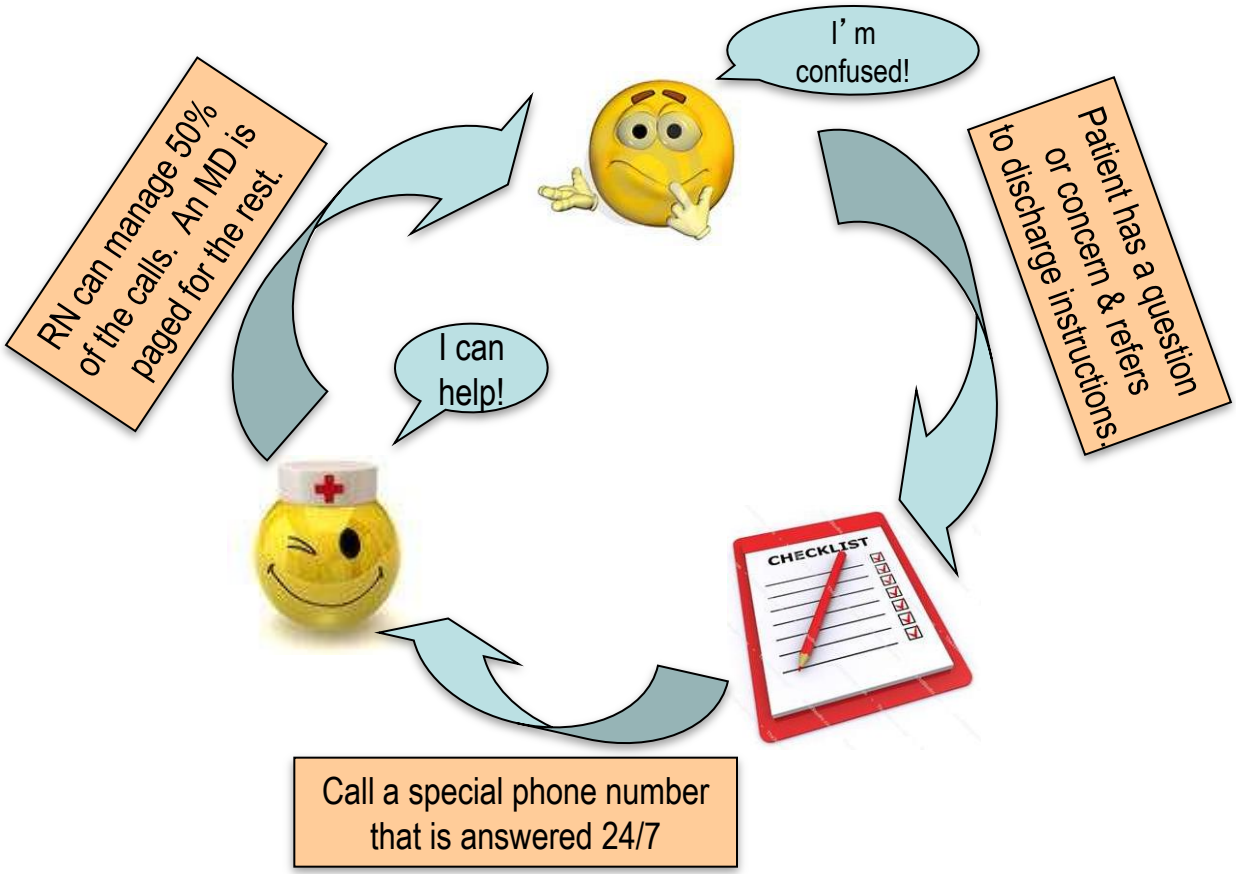
Which patients are at high risk for readmission?

Physician or RN believes the patient may be at risk for readmission
OR
Heart Failure diagnosis
OR
Prior hospitalization within the last 30 days?

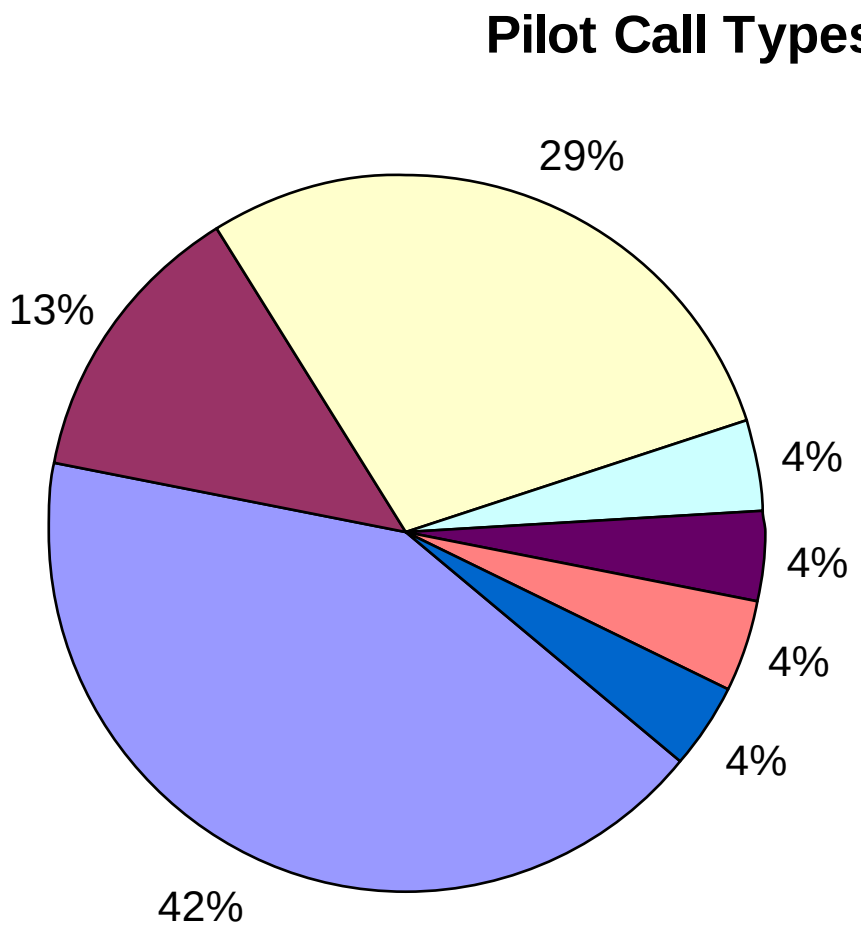
Bundle Element #2 – Special Transitions phone number

"I know when to call and what phone number to call if I need help"

- ☑Special phone number on DC instructions for use between discharge and seeing PCP
- ☑Calls are answered within 17 seconds 24/7 and triaged by an advice nurse
- ☑RN can manage 50% of the calls. The hospitalist or specialist on call are paged for the others.



Bundle element #2: Special Transitions phone number



Bundle Element #3 – Standardized D/C Summary

Hospitalists, PCP's and Specialists collaborated to create a simple DC Summary completed the day the patient leaves the hospital, that everyone loves.

My regular doctor will know what happened to me in the hospital

Bundle Element #3 Standardized Discharge Summary

HOSPITALIST DISCHARGE SUMMARY
10/13/2011

Pharmacy Test Kpnwrx
9876-54-32
PCP: Christopher A. Calawa, MD

Date Of Admission: 10/1/2011
Date Of Discharge: 10/13/2011
Disposition: Home

Readmission Risk Assessment: Medium (follow-up 10 days or less)

Pending Study Results At Discharge
1. Blood cultures still in progress; no growth so far
2. HgA1C is still pending

Issues To Be Addressed In Follow-Up
1. Has cellulitis resolved?
2. Are BG's better on adjusted insulin
3. Routine wound care (had I&D of abscess on RLE)

Primary Discharge Diagnoses
*CELLULITIS - WITH ABSCESS SKIN OR SUBQ TISSUE, ACUTE
SYSTOLIC HEART FAILURE, ACUTE ON CHRONIC
DIABETES, UNCONTROLLED
CHRONIC KIDNEY DISEASE, STAGE 4, SEVERELY DECREASED GFR

Other Diagnoses
PANCREATITIS, CHRONIC
OSTEOPOROSIS

Bundle Element #4 - Medications

I understand my medications, how to take them and why I need them.

- **Hospital**
  - ONE process MD/RN on admissions
  - RN teaching/teach back
  - Pharmacist reviews (high risk)
  - Patient friendly language
- **Home**
  - RN follow-up call/review
  - Pharmacist calls patients at home (high risk)
  - PCP
- **SNF**
  - Transition Pharmacist reviews meds for 100% of patients going to SNF

Bundle Element #5 – Follow Up

- **Follow-up Appointments**
  - Made upon discharge
  - High risk patients in 5 days
  - Medium risk patients in 10 days
- **Follow-up Calls**
  - RN follow up within 72 hours
  - RN case management within 30 days (high risk)

NW Ongoing Readmission Review

MD reviews every readmission

Sends cases to quality chiefs = Improved quality

Examples of Findings

- **10% preventable**
- **ID patients that did not get call**
- **Reduced readmit for constipation**
- **Identified cluster infections**
- **Improved Palliative Care connect**
- **Medication errors**
- **HF patients need additional f/u**

Results

- **Readmission Rate (Sunnyside Hospital):**
  - Overall the readmission rate is 9.1%
  - Both commercial and Medicare readmission rates are 7.1% and 11.5% respectively, the lowest of all KP regions
  - In HEDIS 90th percentile

- **Discharge medication list errors:**
  - Down from 57% to 19% overall – most are fixed before discharge by a Transition pharmacist

- **Discharge templates:**
  - Medicine, Specialty Care and SNF have a standardized template which is used over 90% of the time

Results

- **Follow up**
  - The average time to follow up with their PCP has gone from 9.7 days to 6.9 days

- **Physician Review**
  - Monthly single MD reviewer of all readmissions. Feedback provided on those readmissions which may have been preventable. This has resulted in improvements in communication and processes within the Medicine and Specialty Care Departments.

- **Satisfaction**
  - HCAHPS scores are continuing to improve
  - Discharge Composite in HEDIS 90th percentile

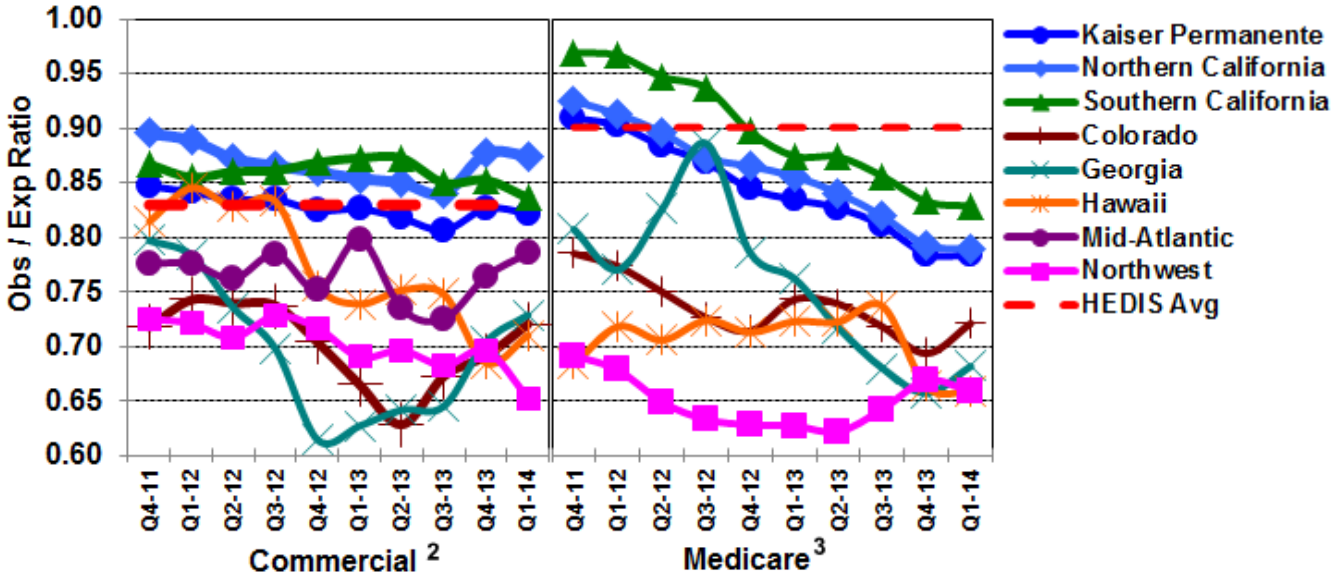
Success factor: Ongoing Governance

- Transitions leadership team
  - Cross settings
  - Cross disciplines
  - Patient is part of team
  - Twice monthly 30 minute meeting
    - Hot Topics
    - Ad hoc
  - 60 minute meeting
    - Review data
      - Readmission Rate Report
      - Patent Readmission Feedback
      - Readmission Review
      - Dashboard (when in production)

HEDIS All Cause 30-Day Hospital Readmissions Ratio – By Region & Hospital

Population = Commercial & Medicare, HEDIS Measurement Period[1]

- **Q4-2013 and Q1-2014 results are based on 2014 HEDIS PCR Specifications which include the following updates: (1) exclusion of Medicare Hospice Members from the denominator (2) inclusion of same day admission/discharges from the denominator. For Q4-13, there was on average about a 3.7% increase for the Commercial O/E ratio and 2.5% increase for the Medicare O/E ratio which may be attributable to the specification changes.**
- **The average Observed/Expected Readmissions ratio for all Plans for performance year 2013 will not be released by NCQA until later this year.**
- **The all-Plan Commercial average (PY 2012) was 0.83. All Regions except Northern and Southern California performed better than the 2012 average for the rolling year ending in Q1 2014.**
- **The all-Plan Medicare average (PY 2012) was 0.90. All Regions performed better than 2012 average for the rolling year ending in Q1 2014.**



Kaiser Hospitals for rolling year ending in Q1 2014

	Commercial		Medicare
South SF	0.70	Fresno	0.61
Antioch	0.71	Moanalua	0.65
Sunnyside	0.71	Sunnyside	0.69
Moanalua	0.73	Manteca	0.69
Manteca	0.76	Vacaville	0.69
West LA	0.77	Santa Rosa	0.70
Richmond	0.78	Roseville	0.71
Irvine	0.78	San Rafael	0.71
Vacaville	0.78	Sacramento	0.73
San Rafael	0.80	South SF	0.74
Woodland Hills	0.80	San Francisco	0.75
Fremont	0.81	Moreno Valley	0.76
Santa Clara	0.82	Woodland Hills	0.76
Kaiser Permanente	0.82	Panorama City	0.77
HEDIS MY 2012 Average	0.83	Vallejo	0.78
Southern California	0.84	Modesto	0.78
Vallejo	0.84	Kaiser Permanente	0.78
Fresno	0.85	Northern California	0.79
San Francisco	0.86	Fremont	0.79
Fontana	0.86	Santa Clara	0.80
Oakland	0.86	Riverside	0.80
South Sacramento	0.87	Baldwin Park	0.81
Panorama City	0.87	Anaheim	0.82
Northern California	0.87	Southern California	0.83
Anaheim	0.88	Irvine	0.83
Santa Rosa	0.89	Richmond	0.83
Roseville	0.91	Downey	0.83
Baldwin Park	0.93	Redwood City	0.85
Downey	0.93	Walnut Creek	0.85
Modesto	0.94	South Bay	0.85
San Jose	0.94	Hayward	0.86
Moreno Valley	0.95	Los Angeles	0.86
Los Angeles	0.95	South Sacramento	0.86
San Diego	0.96	San Diego	0.86
Riverside	0.97	West LA	0.88
Ontario	0.97	San Jose	0.88
Walnut Creek	0.98	Antioch	0.89
Redwood City	0.99	Oakland	0.90
Sacramento	1.03	HEDIS MY 2012 Average	0.90
Hayward	1.05	Fontana	0.93
South Bay	1.05	Ontario	0.93

[1] Data sources vary across regions: MIA (CA), DSS (HI), & Regional sources (CO, G
NW Westside results are included in the NW Region results since Q
Hawaii's decrease in O/E between 2013Q3 and 2013Q4 can be attributed to a change
(per NCQA specification clarification) that increased the risk adjustment for expec

[2] Beginning with Q4-12 data, Georgia is using a different data system (Verisk) than what was utilized for prior measurement periods.

[3] O/E Ratios for Medicare is not being reported for MAS and therefore the overall KP Medicare total excludes MAS; MAS was not required to report Medicare readmissions for HEDIS.

NW Transitions Bundle Spread

- All regions have adopted the Transition Bundle
- 44% increase in bundle elements at strong implementation in one year

Transition Bundle Elements	NW	CO	SC	MA	OH	GA	NC	HI
Risk stratification-tailored care	★			★	★			
Follow-up call 48 hours	★	★			★			
Timely physician follow-up appointments scheduled in hospital	★		★		★			
Medication reconciliation redundancies across settings		★						
Standardized same-day DC summary	★	★						
Special transition phone number on DC instructions (24/7 expedited; immediate access to RN/physician)	★							P

★ Strong Implementation | Implementation Phase | Testing Phase | P Planning Phase | No activity yet

Thank you: Questions?