HealthLeaders Media LIVE From Memorial Hermann

The Readmissions Master Plan
Slash Preventable Readmissions by Closing Care Continuum Gaps

Featuring a live event on December 3, 2013
12-3 p.m. ET (9 a.m.-12 p.m. PT)
Memorial Hermann | Houston

2 Analysis
An Evolved Readmissions Strategy

4 Case Studies
4 Lesson 1: Accountable Focus to Eliminate Care and Communication Gaps
9 Lesson 2: An Ambulatory-Based Care Management Team
12 Lesson 3: Targeted, Enhanced Programs for High-Risk Populations

15 Resource Guide
Additional Resources From HealthLeaders Media
Many health systems knew years ago that readmissions were a problem. Patients would return to the hospital, often for preventable reasons, and be readmitted as a matter of course. It did not help that the reimbursement structure mostly rewarded looking the other way.

With 12 hospitals and 10 emergency departments across Houston, Memorial Hermann Health System found more than a decade ago that it had an incentive to do something about readmissions. Houston consistently ranks at or near the top of American cities with the highest proportion of uninsured, and many of those uninsured were coming back into the hospital with preventable readmissions.

So Memorial Hermann’s team began with a few of the most glaring deficiencies; first was simply to identify those who were at higher risk for readmission, especially those who had been readmitted before. Over a few short years, that risk-stratification process evolved and now the team uses a software program running behind an electronic health record that scans the daily patient census and flags patients who may be at higher risk.

Identifying those at higher risk for readmission and actually doing something to prevent that readmission are two different things. Memorial Hermann knew that it needed to close the circle with often complex patients who have diverse social and medical needs to be able to make a real dent in readmissions.

The case management team across the health system took on the active role of working readmissions into the daily workflow, taking on the responsibility to develop a plan that was realistic in terms of the patients’ needs but also maximized the likelihood that the patient would stay out of the hospital unless there was a change in condition that necessitated a readmission. The tactics themselves are fairly well known—better team communication with physicians and nurses, enhanced patient education, and a follow-up care plan. What Memorial Hermann succeeded in doing where others often fail was...
to integrate the readmissions plan into the care plan with the same depth and precision as any other patient safety or quality program, with the resources and staff to back it up.

Many readmissions occur because patients miss or skip the follow-up visits with their primary care physician or specialists. So Memorial Hermann has developed and grown a care management team embedded not in the hospital, but in its ambulatory network. Moving the accountability for follow-up care outside the walls of the hospital recognizes one patient behavior axiom: Patients are more comfortable and likely to follow up with their own physician and nurse over others in the health system.

While ahead of many health systems in an evolved readmission strategy, Memorial Hermann still has some key hurdles to overcome, most notably continuing to prove the value proposition of the additional staff based on lower utilization and readmissions. Development so far has been positive, and if eventually successful, Memorial Hermann’s readmissions program could prove to be a model for integrated delivery systems.
Memorial Hermann in Houston is fortunate in some ways that it had a preview of the pain of readmissions almost a decade ago and decided to do something about it. Years before the Centers for Medicare & Medicaid Services started to penalize hospitals for preventable readmissions, Memorial Hermann had pain of its own: hundreds of millions of dollars in annual uncompensated care for a population that reached as high as 33% uninsured.

“We see a tremendous number of uninsured patients,” says Memorial Hermann Chief Medical Officer Michael Shabot, MD. “We run 10 emergency departments, seeing over a half million patients a year, and we take care of everybody without regard to ability to pay. But what we found was that those individuals who weren’t insured had a very high rate of readmission to the hospital or to our EDs or to observation. So we were actually paying for their admission and for every readmission. I mean literally just the hospital was paying for it.”

It was decided that the right thing to do—as well as the most cost-effective—would be to undertake a comprehensive program to better manage high-risk patients. This program would close gaps in the care continuum that historically have led to readmissions: poor communication among disjointed or unaligned providers, a lack of systemic accountability and follow through, and inadequate human and IT resources.

The first step was to understand which patients were at higher risk for readmission. When the program began, risk stratification was based simply on a patient’s number of previous hospital admissions. The team began to use a software program in conjunction with the Cerner-based electronic health record that scans the daily patient census and uses an
algorithm to flag patients who may be at higher risk—based on their disease type or condition, as well as other demographic or clinical data. Those patients are added to a list that case management contacts for more follow-up.

The crux of Memorial Hermann's initial work in preventing readmissions has been in the expanded role of case management, which has evolved over the past seven years from a traditional inpatient episode role to one that takes a broad, continuum-spanning view of a patient's care. Pat Metzger, RN, chief of care management at Memorial Hermann, says the staff case managers at the system's 12 hospitals follow up daily once the system has identified patients as a risk for readmission.

"At each of the campuses, the case management staff has what they call one-minute rounds," Metzger says. "They go up on the units each morning and they meet with the nursing staff to ask, 'Who have we got today that we need to consider as high risk for readmission when discharged? Who was the new admission? What are their care needs that are driving this hospitalization? Who do we have that we're planning on sending home today? Have they met all their milestones?'"

The case manager makes certain that every discharged patient has a plan that maximizes the ability to avoid a readmission, Metzger says.

"No. 1, our case managers in the hospitals are focused on making sure that we're putting together a discharge plan that is the most cost-effective, but the least restrictive for the patients," Metzger says. For example, the case managers will review options for home health and other postacute providers that "we know we can trust to try to manage that patient in the ambulatory setting."

The staff case managers are "making every effort to get patients connected to the services that they're going to need back in the community before the patient leaves the hospital," Metzger says. Case managers will make the necessary doctor appointments for them, either within the Memorial Hermann physician staff or at area clinics. The case managers also coordinate with Memorial Hermann's ambulatory case managers to share care plans and to ensure there...
are no gaps in the care transition.

Case managers coordinate the discharge planning efforts, which are communicated via the health system’s EHR platform.

“Our case managers do their discharge planning documentation right in ... our electronic health record so that all the team members have access,” Metzger says. “There’s a particular folder in which they document interventions, such as who’s going to be handling the patient, what arrangements have been made, or who the providers are so that anybody who accesses that patient’s records can know where we are in the planning process and who’s going to be the providers of services. The [time spent on] handoffs seems to get minimized because of the accessibility of the electronic data.”

The organization is working to extend the accessibility of that data. Memorial Hermann owns many key pieces of the care continuum, including TIRR Memorial Hermann, one of the nation’s leading rehabilitation hospitals, and its own home health agency. But for its readmissions program to be successful, the system had to find a way to work with a variety of community partners, says Carl Josehart, CEO of TIRR Memorial Hermann and System Rehabilitation Services.

“We’re willing to share our data with them,” Josehart says. “It’s really being open about not only what we think they can improve, but also asking them if there was anything we did in our care that made it harder for them to receive our patient. We realized there are agencies in the community [for which] we may not share ownership, but when we share our patients, we are really working together in partnership to close the gaps in care.”

In addition to discharge planning, the case managers also make certain that discharge education is tailored for the patient’s situation, both clinically and at home. Nurses and nurse educators provide the instruction to the patient, while the case managers follow progress to make sure the education happens when it should and involves the right people, Metzger says.

“They’re communicating with the families about what the plan is,” Metzger says. “The case managers work with patients and their families to decide whether they have the resources, skill, or the desire to help manage the process once they leave the hospital. Is it the family member we have to teach? Is it
the patient we have to teach? Do we need to look at a postacute provider as an interim step for this patient? So they're doing a lot of assessment about the readiness of the patient, the family, or significant others to assume responsibility post hospitalization for care, and then they'll involve the right people in that.”

Enhancing case management, sharing data, and linking to community partners are some of the organizational improvements Memorial Hermann has made, but some of the largest gains involved closing the more practical gaps that can trigger readmission, such as those related to:

**Durable medical equipment:** Some patients with a catastrophic illness or injury may require a substantial number of durable medical devices, often for the first time. The team found that patients would frequently be sent home before the DME was ready, says Josehart—so rather than just making a DME referral, the staff now manages the transition. “Our standard is that all the equipment needed to care for a patient in the home is in the home 24 hours prior to discharge so the family has a chance to make sure that it’s there, that it’s working, to test it, and if it’s different from what they expected, to resolve that issue prior to the patient going home. That’s something that we track in our internal quality metrics. Although it’s a home thing, we see that as part of our commitment to making sure that we’re handing off to a safe environment,” Josehart says.

**Medication reconciliation:** Even before discharge, the nurses and case managers work to ensure that the patient and family understand their medication, even something as seemingly simple as recognizing changes in shape or color of a medication, Metzger says. Whenever there is a question, a staff pharmacist is brought in to explain the new medications and any potential interactions. The team also makes sure the patients have enough medication to take home with them so they don’t have to rush out in those first few days to get a refill. “We have a relationship with Walgreens so that when we have patients we know will be leaving the hospital with a new prescription, they can opt to have a Walgreens that is located on our campus bring those prescriptions directly to their room so that in fact they don’t have to try to stop at the pharmacy or have something delivered to their home,” Metzger says.

**Discharge packets:** One of the gaps that physician leaders noted in medication reconciliation failures was that patients did not understand their discharge instructions. That’s no surprise, considering the volume and complexity of the
material given to them, says Keith Fernandez, MD, president of MHMD Memorial Hermann Physician Network. “Historically our patients might go home with 30 pieces of paper,” he says. “It was hard for the patient to determine which piece of paper was the most important. And even the important ones were hard to read and in language that the average patient could not understand.” A physician-led team spent a year organizing and editing down discharge instructions to a critical few and embedded those into the EHR. Now, discharge instructions are distributed consistently to every patient based on that patient’s specific condition. “The group came up with a very streamlined process for discharges,” Fernandez says. “In fact, the discharge process probably would qualify for a discharge summary as well. So when the patient leaves, they take home a relatively clean sheet of information that has everything critical in that process for the patient to know—and only that.”

The secret, if there is one, is in effort and attention, Metzger says. “There is no magic to this,” she says. “It’s paying attention to the details and it’s making sure that the patient and the family always understand where they are in a trajectory. It is constant, precise execution on those kinds of things every single day.”

**TAKEAWAYS: WHAT MAKES IT WORK?**

**DO THE BASICS BETTER THAN EVER** Hospital leaders have seen the evidence in journals and in their own health systems that proves some common problems drive readmissions. For example, a leading driver of readmissions is patients not understanding their medication or its side effects. What Memorial Hermann did was to attack that one nagging problem from a number of directions: bringing in pharmacists to talk to patients, if need be; greatly simplifying the discharge instructions; and even having a nearby pharmacy bring that medication to the patient before he or she leaves the hospital. Some hospital leaders might look for a single solution or a less labor-intensive one. Memorial Hermann’s success so far has been in focused intensity.
Just a few years into the system-wide work on readmissions, Memorial Hermann did a service gap analysis and found that working on handoffs could only go so far when there was no real support on the physician practice side. Essentially, there was no one to hand off to.

So MHMD—Memorial Hermann's physician network of more than 2,000 clinically integrated (but not system-employed) physicians—created an ambulatory care management team that is imbedded into the practices. Mary Folladori, RN, MSN, system director of care management, says the program was based on learning from the Project RED (Re-Engineered Discharge) program out of Boston University.

A care management team was created in MHMD that now includes a tiered level of skill sets, including RN care coordinators, care coordination assistants, and skilled personnel such as licensed vocational nurses and respiratory therapists. The team also includes health coaches and social workers, with plans to add pharmacists who will work with complex medications and medication reconciliations, she says.

Currently some 25 FTEs are spread across the system sites, with plans to add another 15–20 FTEs next year, she says.

All members of the team share a common mission, which is to be a connecting point, she says.

“We really focus on coordinating care,” Folladori says. “We're not necessarily here to replace or reinvent something that's already within our system. But because so many people don't know all of the details of the services, that's really where we have found our niche: It's helping our physicians get their patients into services that are already here.”

After patients are identified in the hospital or ED, the inpatient case
manager makes the electronic handoff to the physician practice or community case manager. In some complex cases the community case managers may even come to the hospital to confer with the patient and family prior to discharge, she says. But for the most part the goal is to reach patients on the phone right in the critical days after discharge.

“That first phone call is always within 24 to 48 hours,” Folladori says. “We cover those things like medication reconciliation, symptom recognition, getting to appointments in a timely manner, all those standard things that could trigger a readmission. Then the frequency of those calls varies dependent on the patient’s needs. We don’t call them beyond a 30-day period, because then they obviously need longer-term care management. The information that we gather is shared with their primary care physician so that the PCP is aware of what’s going on when they see them for that first follow-up visit.”

One of the challenges health systems face is that patient engagement programs often fail when patients believe their nurse or care coordinator is working for the payer, or to save the system time or money. A big part of the success of the MHMD care management program has been that the connection has been to the patient’s physician.

“They really see our team as being part of their physician’s practice,” Folladori says. “We work with their physicians. Every service that we do is driven from our physicians and built upon our clinical practice committee and our evidence-based guidelines. When it’s put in front of a patient or family member, it’s amazing the difference in how they respond to you. This isn’t a call from some random person. We know about their history. We’ve been able to follow them and what happened to them in the hospital. We know what their doctor’s treatment plan was before and after they were in the hospital.”

Some health systems may try to manage readmissions only from the hospital case management side, but the key is to have both sides of the bridge.
supported, says Keith Fernandez, MD, president of MHMD Memorial Hermann Physician Network.

Technically the care management team is employed and paid by the MHMD network, not by the individual PCPs or their practices. But that background distinction is invisible to the patient.

“Our pickup rate for this is better than the average insurance company’s by a long shot because our care management nurses are identified with our primary care doctors,” Fernandez says. “When they call, they call as the nurse of our doctors, even though they’re employed by us, not by the physician. So we get a lot more buy-in.”

**TAKEAWAYS: WHAT MAKES IT WORK?**

**PASS OR FAIL ON PATIENT TRUST** Patients are notoriously and somewhat understandably skeptical of anyone who calls them on the phone from a healthcare organization. They will quickly make a decision whether that nurse or care manager on the other end has their best interests in mind. Hospital and medical group leaders have had ample evidence that patients are more likely to trust that voice on the line if it belongs to their own physician or nurse. But at the same time, medical groups have been trying to keep their staffs lean. As a health system with broader goals in mind, Memorial Hermann could bridge both the engagement side and the financial side by embedding the care managers in the ambulatory setting but with the investment borne by the system.
Case Study // LESSON 3

Targeted, Enhanced Programs for High-Risk Populations

Alongside building robust care management teams on the inpatient and ambulatory side, Memorial Hermann leaders recognized that to really tackle readmissions, they had to target those populations at higher risk due to their disease, age, ability, or support.

Working through its owned home health agency, Memorial Hermann began by creating support resources around chronic cardiovascular care, particularly acute myocardial infarction and congestive heart failure. The Cardiac Life program combines home health nursing, coordination with the primary and specialty care teams, and telemonitoring technology, with the goal of keeping patients able to care for themselves far beyond the 30-day threshold that CMS sets for readmissions, says Susan Markland, director of patient care for Memorial Hermann Home Health.

“We took our home health model and separated it into specialty teams like you would see in the hospital,” Markland says. “Where on different floors you have different specialties, we have different home health teams that see different patients.”

Not every cardiac patient is put into the program, but those who “are long-term, chronically ill patients who may come in and out of our home health program as they have symptom exacerbation, or they’re returning from different hospitalizations,” Markland says. Patients are assigned to a particular home health branch associated with a Memorial Hermann hospital campus. There are usually between 25–30 patients cardiac patients assigned to a team, and that team will include a variety of clinicians in addition to home health nurses, Markland says.

“We also have nurse practitioners who can be involved and able to do home visits with the nurse,” Markland says. “That is not quite like having a physician, of course, but it’s that higher level that can become involved. And so when the patient discharges
from the hospital or comes to us from the physician’s office, they know that there’s going to be a nurse practitioner who can also see them. And they’re okay with that.”

That same team model is replicated in other home health programs. The Palliative Life program is for patients who have chronic, life-limiting, or life-threatening illnesses, but may not be ready for a palliative care clinic or hospice, Markland says. The Home Sight program for low-vision patients uses occupational therapists in the home to look at whether something as simple as larger knobs on the stove would allow the patient to keep cooking for themselves, Markland says.

Even with the variety of disease-specific programs introduced, leaders noticed there were still gaps for patients who had a higher risk for readmission but didn’t fit into traditional definitions. So the Care Transitions program was designed “for patients who do not have a traditional home skilled need, or they’re not homebound, but we have determined during their hospitalization they are at a greater than 15% risk of being readmitted to the hospital,” Markland says. “These are patients who we feel like we just need to follow somehow, or they are going to be right back in.”

For 30 days post hospitalization, the care transitions team does at least one home visit and makes at least three phone calls. The nurses work on the usual readmission triggers: medication reconciliation and education, making follow-up appointments, and making sure the patient has support in place to feed and take care of themselves.

All of this coordination comes at a cost. Memorial Hermann is participating in a Medicare Shared Savings ACO, and has its own health plan and other risk-sharing pilots, but still a sizable portion of the care transitions work is uncompensated.

“A lot of what we’re doing in things like telemonitoring and the care
transitions program are not reimbursable services at this point, but the system has chosen to take on some of that expense,” Markland says. “From a budgetary aspect, I have to be able to show cost avoidance. I have to be able to say it’s because we took 16 care transitions patients that we did 23 visits on them. And even if it’s anecdotally, I can say we kept X numbers of patients from readmitting to the hospital because we responded or we caught this problem or that problem.”
For Further Study

Leadership at Memorial Hermann has cut through readmission through better communication, systemic accountability, and improved care for high-risk patients. For further study, consider the following resources:

**Readmissions: The Big Picture**

*This piece by Philip Betbeze is adapted from the October 2013 issue of HealthLeaders magazine.*

Hospital leaders have long known that they would be at risk for penalties from the Centers for Medicare & Medicaid Services based on how well they prevent 30-day readmissions for three targeted diagnoses. But that amount of lead time may not have been enough: More than 2,000 hospitals faced penalties in the 2013 fiscal year based on discharges between July 1, 2008, and June 30, 2011.

Still, no matter how badly they missed, hospital penalties for FY 2013 were capped at 1% of Medicare reimbursements. But that cap ratcheted up to 2% for FY 2014 and 3% for FY 2015. Besides that, the number of conditions and diagnoses at risk also are likely to increase dramatically.

**Coordination and Readmission**

*Q:* Regarding clinical quality improvement, which of the following areas represents the single greatest challenge for your organization?

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination, continuum of care</td>
<td>24%</td>
</tr>
<tr>
<td>Population health management</td>
<td>14%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>14%</td>
</tr>
<tr>
<td>Care episode payment bundling</td>
<td>12%</td>
</tr>
<tr>
<td>Clinical quality metrics</td>
<td>11%</td>
</tr>
<tr>
<td>Staff buy-in</td>
<td>10%</td>
</tr>
<tr>
<td>Patient experience</td>
<td>8%</td>
</tr>
<tr>
<td>Medical home</td>
<td>4%</td>
</tr>
<tr>
<td>Patient safety</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

Strategic Solutions for the Readmissions Challenge

This piece by Jim Molpus is adapted from the June 2012 HealthLeaders Media Breakthroughs Report, Strategic Solutions for the Readmissions Challenge.

The focus of the past few decades of American hospital medicine has been to get patients out of the hospital to reduce the length of stay and the associated costs. But that drive had a harmful side effect: Patients were sicker when they left, and often ended up back in the hospital for the same condition. To successfully prevent readmissions requires many players to fill the gaps in the care continuum that have developed among hospitals, physician practices, community health resources, skilled nursing, and even patients themselves. We’ll examine how four leading health systems are moving the needle, and keeping patients out of the hospital if they don’t really need to be back there.

In this HealthLeaders Media Breakthroughs report, leading hospital systems—Griffin Hospital, Parkview Health, Sarasota Memorial Health Care System, and UPMC Hamot—share insights and lessons learned that will help you:

• Improve communication and care coordination beyond the walls of your organization
• Enhance patient education and engagement
• Target disease-specific opportunities to advance the care protocol regimen
• Develop technology solutions to upgrade coordinated care efforts

About the Host

At Memorial Hermann, our 5,500 affiliated physicians and 21,000 employees practice evidence-based medicine with a relentless focus on quality and patient safety. Our efforts continue to result in national awards and recognition, including being ranked one of the nation’s Top 5 large health systems by Truven Health for patient safety and quality.

The not-for-profit health system has 12 hospitals and numerous specialty programs and services throughout the Greater Houston area. Memorial Hermann-Texas Medical Center is one of the nation’s busiest Level I trauma centers and the primary teaching hospital for The University of Texas Health Science Center at Houston Medical School.

Our Memorial Hermann Physician Network, MHMD, comprises physicians from Memorial Hermann Medical Group, UTHealth, and private physicians and specialists. Memorial Hermann’s MHMD subsidiaries offer comprehensive, integrated health solutions that deliver quality benefits while helping to contain costs. We’ve proudly served this community for more than 105 years, and contribute some $300 million annually through school-based health centers and other programs.

About Us

HealthLeaders Media is a leading multi-platform media company dedicated to meeting the business information needs of healthcare executives and professionals. To keep up with the latest on trends in physician alignment and other critical issues facing healthcare senior leaders, go to www.healthleadersmedia.com.

Sponsorship

For information regarding underwriting opportunities for HealthLeaders Media LIVE, contact Sales@healthleadersmedia.com or 800-753-0131.

Copyright ©2013 HealthLeaders Media, 515 Maryland Way, Brentwood, TN 37027 • Opinions expressed are not necessarily those of HealthLeaders Media. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.