Mission, Values and Promise

Our Mission

We extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and under-served.

Our Values

Compassion, Excellence, Human Dignity, Justice, Sacredness of Life and Service

Our Promise

To make lives better—mind, body and spirit.
To genuinely enjoy being of service.
To make healthcare easier.
Objectives

• Explain the components of a system approach to readmission reduction
• Describe specific examples of improvement interventions to reduce readmissions
Mercy Health
A Catholic healthcare ministry serving Ohio and Kentucky

➢ A legacy – founded by women religious 160 years ago
➢ A healing ministry – 5.9 million patient encounters a year
➢ A quality leader – Top quintile system rated by Truven Health Analytics
➢ A community benefit leader – Nearly $1 million a day
➢ A statewide leader – Largest health system in Ohio with $8.95 billion economic impact and nearly 500 points of care
➢ Network of 23 acute care hospitals, multiple ambulatory sites, long term care facilities, home health and hospice.
About the region: 
Mercy Health in Cincinnati

➢ Mercy Health is the largest of five competitive health systems in this region of 2.1 million people.
➢ We are among the largest employers with about 9,000 workers.
➢ We are led by Mike Garfield, president and CEO
➢ Recipient of Truven Top 15 Health Systems Award three out of past four years.
Our care delivery network in Cincinnati

5 Hospitals

- Mercy Health Anderson
- Mercy Health Clermont
- Mercy Health Fairfield
- Mercy Health West
- Jewish Hospital – Mercy Health

177 physician practices

4 wellness and fitness centers

4 free-standing Emergency Departments

17 outpatient rehab centers

Plus Tele-Health, lab sites, imaging centers and other ambulatory options
Background

• During 2015 and 2016, Mercy Health Cincinnati Region struggled to make traction on decreasing avoidable readmissions

• Improvement activities have not been regionally coordinated previously

• Our hospitals have received readmission penalties from CMS ranging from 0.5% to 2.6%
The Grant — Leveraging System Support

• The quality department applied for a Mercy Health Foundation Grant to support the kick off for the project.

• The grant covered a day long kick off collaborative
  • Guest lecture presenting on creative and innovative thinking
  • Collaborative Teams developed around diagnosis groups
  • Educational materials for the teams
  • Nourishment and meeting materials
  • Future follow-up region-wide collaborative
The Proposal

• To utilize the Institute for Healthcare Improvement model to develop and implement innovative evidence based process changes to decrease avoidable readmissions across all of Mercy Health.
• The region will institute diagnosis-specific teams composed of cross-sectional representation of diverse clinicians
• Each Cincinnati hospital will also develop a team of inpatient and ambulatory care providers, front line staff and leadership.
• To participate in a yearlong program charged with decreasing avoidable readmissions.
• The goals align around a clinical outcome – decreasing avoidable readmissions with an underlying emphasis on reliability and sustainability.
Driver Diagrams

• While there are many ways to depict a theory of change, one type of model that is particularly useful for working toward a specific aim is a “driver diagram.” A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers.

• Clearly defining an aim and its drivers enables a team to have a shared view of the theory of change in a system. A driver diagram represents the team members’ current theories of “cause and effect” in the system – what changes will likely cause the desired effects. It sets the stage for defining the “how” elements of a project – the specific changes or interventions that will lead to the desired outcome.
## Driver Diagram for Readmissions

### Aim
- **Reduce unplanned readmissions within 30 days of index admission for those conditions emphasized in value based purchasing (Acute MI, COPD, CADG, HF, PNU, Hip and Knee Total Joint Replacement)**

### Outcomes:
- 2017 Target: All regional clinical focus group targets reached by year end.
- 2017 Target: 5 of 6 regional clinical

### Primary Drivers
- **Improve Care at the transition out of the hospital**
- **Provide early post discharge services**
- **Patient engagement and education for self management**
- **Target high risk patients**
- **Disease Specific Drivers**

### Secondary Drivers
- **Complete discharge summaries within 24 hours of discharge**
- **Home tele monitoring**
- **Confirm that patients and families understand what they need to know**
- **Focus on patients with diseases with high likelihood of readmission**
- **Disease Specific Discharge Instruction**

- **Medication Reconciliation before discharge**
- **Provide patient with transition coach**
- **Proactive counseling and care planning for end of life patients**
- **Focus on patient with multiple diseases**
- **Identification of PCP and planned follow up**

- **Provide 30 days supply of meds at discharge**
- **Multidisciplinary home visits**
- **Post Discharge Plan of Care**
- **Special Care for homeless patients**
- **Provide Transition for patients with limited English Proficiency**

- **Timely and effective communication among all care team members (pre and post discharge)**
- **Follow up calls**
- **Exercise Plan of Care**
- **Provide Hygiene Bundle to address hand hygiene, dressing changes, Bowel and Bladder, mouth care**

- **Schedule PCP follow up appointments before discharge**
- **Discharge Follow up for patient without a PCP**
- **Exercise Plan of Care**
- **Provide Hygiene Bundle to address hand hygiene, dressing changes, Bowel and Bladder, mouth care**
Driver Diagrams, 3

Readmission Driver Diagram

**AIM**
- Reduce unplanned readmissions within 30 days of index admission for those conditions emphasized in value-based purchasing (Acute MI, COPD, CABG, HF, PNI, Hip and Knee Total Joint Replacement)
- Outcomes:
  - 2017 Target: 46 regional clinical focus group targets reached by year end.
  - 2017 Target: 56 regional clinical

**Primary Drivers**

**Disease Specific Drivers**

**Secondary Drivers**
- AMI
- COPD
- CABG
- HF
- Pneumonia
- Hip and Knee Total Replacement

- Cardiac Rehab
- Inhaler Use Competency
- Infection Prevention Shower and/or 4% CHG wipes
- HF Rehab
- Swallow Evaluation
- Outpatient PT

- Identification of PCP and follow up
- Home oxygen monitoring
- Depression screening and follow up
- Group Visits
- End of life planning
- Vaccines

- COPD Rehab
- Stop Smoking Support
- End of life planning
Teams

• Acute Myocardial Infarction
• Chronic Obstructive Pulmonary Disease
• Coronary Artery Bypass Graf
• Heart Failure
• Pneumonia
• Total Hip and Knee
Teams

• Lead by a dyad of a physician and an operational leader
• Include members at all sites
• Across both acute care and ambulatory sites
Projects – Post Acute

S4 Model - Ordering the Appropriate Level of Care in Home Health Referral

- Project in conjunction with Sound Hospitalist and American-Mercy Home Care
- Goal is to assure that the patient receives the appropriate intensity of care at home
- Guidelines created to help determine the appropriate level of post-acute care required by patients upon discharge.
- PT recommends level, physician orders
S4 MODEL

LEVEL 1 - STANDARD

• Initial home health evaluation to occur within 24-48 hours, in patient home
• Home health agency to establish plan of care for patient over 60 day period
• Medication Reconciliation
• PCP Visit scheduled within seven days of discharge
• PT/OT to evaluate with goal of regaining prior level of functioning
• OT to evaluate if patient has Home Health Aide needs for personal care

LEVEL 2 - SOCIAL

• All bullets in Level 1, plus
• Social Worker evaluation within 24-48 hours, includes evaluation of resources and insurance to determine AL/IL/LTC/Medicaid options
• Council on Aging Referral
• Dietician evaluation within five days of discharge
• Family/POA Care Conference to discuss home support and care needs post discharge. This care conference will occur within two weeks of discharge
LEVEL 3 - SAFETY

- First 3 bullets of Level 1, plus
- PT/OT/Speech evaluations in home within 24-48 hours of discharge; including DME and home safety
- Frontload therapy 5 days, then 3x a week
- OT to evaluate if patient has Home Health Aide needs for personal care
- Social Worker evaluation within 24-48 hours, includes evaluation of resources and insurance to determine AL, IL, LTC, and Medicaid options
- PCP Visit scheduled within three to seven days of discharge

LEVEL 4 - SICK

- First 4 bullets of Level 3, plus
- Frontload nursing visits daily, then qod with progression as warranted; establish plan for 60-day period
- Nursing to perform telephone visit on the days that a visit is not being made in person for the first 30 days
- Palliative Care referral
- Dietician evaluation within five days of discharge
- PCP visit within three days of discharge, followed by visit at 10 days, and 21 days
- Social Worker evaluation within 24-48 hours, includes evaluation of resources and insurance to determine AL, IL, LTC, and Medicaid options
### Sound Hospitalist/AMHC Project

#### S4 Pilot Project

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<th>Feb</th>
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<th>April</th>
<th>May</th>
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<td>13</td>
<td>7</td>
<td>56</td>
<td>53</td>
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<td>length of services/days</td>
<td>38</td>
<td>31</td>
<td>47</td>
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**Chart:**
- **Y-axis:** Number of patients and length of services/days.
- **X-axis:** Months (Feb, March, April, May).
- Bars represent patients and length of services/days for each month.
Readmission Rates

Readmission Rates for Pilot Population

<table>
<thead>
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<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
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<tr>
<td>Rates</td>
<td>11%</td>
<td>7%</td>
<td>12%</td>
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Care Transition Collaborative

- Created a network of preferred providers for SNF and Home Health Agencies along with quality metrics
- Provided CHF teaching at individual nursing homes
- Offered CHF classes at West
- Established monthly readmission touch base call to do RCA with some skilled facilities – planning on expanding
- Provided CARE- LINK access
- Share Best Practices
- Provide education on an ongoing bases
  - Webinars – second in a series – July 6th r/t to readmission
  - Molst Forms, Alzheimer
  - Individualized education to SNF i.e Resp and Cardiac Assessments
Projects - Acute

Heart Failure Team

• Trial collaboration between cardiology and ED to identify appointment times for patients to be seen the day after an ED visit

• Survey Monkey

Pneumonia

• Meds to Beds complimentary supply of antibiotics for all discharged pneumonia patients
Projects – Acute, cont’d

COPD Team

• Discharge checklist specific to COPD
• COPD Kit (pulse ox, nebulizer, spacer, daily routine checklist)
• Survey Monkey

CABG Team

• Protocol developed between the ED physicians and CVT surgeons so that a call is placed to the surgeon prior to admission

Hip & Knee Team

• PO Day 0 PT visit
**ED Discharge Pull Process**

**Before**

- **Patient Treated**
  - Severity of patient symptoms do not dictate admission

- **Care Plan Created**
  - ED Physician provides patient information based on treated diagnosis

- **Discharged**
  - Patient leaves ED with general follow up with physician instructions on AVS

**After**

- **Patient Treated**
  - Severity of patient symptoms do not dictate admission

- **Care Plan Created**
  - Physician provides patient information based on treated diagnosis.
  - Outpatient Discharge Order entered

- **Discharged**
  - Patient leaves ED with instructions on AVS including information for Mercy Health Physicians
  - Physician office contacts patient for follow up
You have been diagnosed as having a flare up of COPD (Chronic Obstructive pulmonary Disease). You are being discharged with the following instructions:

Visit your family doctor within 1 week of leaving the hospital and bring this sheet with you. Discuss getting an Action Plan to prevent future hospital visits.

- □ Take your inhaler(s) as indicated until you see your family doctor or specialist:
  - □ Albuterol (ProAir, Ventolin, Proventil)
  - □ Ipratropium (Atrovent)
  - □ Albuterol + Ipratropium (Combivent, DuoNeb)
  - □ Levalbuterol (Xopenex)
  - □ Formoterol (Foradil)
  - □ Tiotropium (Spiriva)
  - □ Budesonide + Formoterol (Symbicort)
  - □ Mometasone + Formoterol (Dulera)
  - □ Fluticasone + Salmeterol (Advair)
  - □ Other ____________

- □ You have been given a prescription for:
  - □ An ANTIBIOTIC: ____________
  - □ PREDNISONE
  - □ Other ____________
  - □ Are you interested in getting your medication prescriptions filled prior to leaving the hospital

- □ Please have prescriptions filled at a pharmacy as soon as possible and take as directed.

- □ A follow up appointment is scheduled with the PCP or Pulmonologist within 7 days of the discharge. The provider, location, date and time are noted.

- □ The COPD care-plan has been completed.

- □ COPD education completed.

- □ 60 minutes of COPD education has been documented.

- □ The six Elements of COPD education has been documented on the education flow sheet:
  - □ Activity
  - □ Signs/ symptoms of COPD
  - □ Diet
  - □ Smoking Cessation
  - □ Education on proper use of Inhaler
  - □ Follow up appointment

- □ Respiratory assessment for oxygen completed.

- □ Home care and oxygen set up prior to discharge.
Survey Monkey
Survey Monkey - COPD

Where do your pets sleep?

Answered: 28  Skipped: 15

- With you: 39.29% (11 responses)
- In the same room (but not with you): 3.67% (1 response)
- In another room: 21.43% (6 responses)
- Other (please specify): 35.71% (10 responses)
Heart Failure

Goal: ≤1.0 O/E
COPD

Goal: ≤1.0 O/E
Pneumonia

Goal: ≤1.0 O/E
Hip and Knee

Goal: ≤1.0 O/E