Chronic Disease Management Reduces Readmissions

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Learning Objectives

• Understand the strengths and limitations of transparent data in identifying opportunities for improvement.

• Identify how in-depth planning informed by analytics saves time in the long run and leads to better decisions that more effectively support evidence-based care for patients.

• Indicate the positive impact standardized, evidence-based order sets and protocols that support workflow have on patient outcomes.

• Recognize the strength of the interdisciplinary team in designing and successfully implementing redesigned care processes.
MultiCare wants to treat patients appropriately and do the best thing for them the first time, every time.
700,000 hospitalizations each year.

135,000 deaths annually making it the third leading cause of death.

1 in 5 readmitted within 30 days costing $9,000 to $12,000 per admission.
Poll Question #1

Reducing chronic obstructive pulmonary disorder (COPD) readmissions requires collaboration across the entire organization. How effective is your organization at collaborating across the continuum of care and engaging interdisciplinary teams?

1) Not effective
2) Somewhat effective
3) Effective
4) Very effective
5) Extremely effective
6) Unsure or not applicable
Long-standing Commitment to Quality of Care

A priority focus on 30-day, all-cause readmissions.

- Evidence-based measures that result in improvement of patient outcomes and a decreased rate of readmission for patients with COPD are largely lacking.

Many patients with COPD are managed by primary care providers (PCPs) rather than specialists, widening the number of providers who must have an adequate understanding of the most recent care guidelines for patients with COPD.

- Effective handoff to the outpatient setting is a priority, as a PCP could be managing up to 2,000 patients at any given point in time.
Costly COPD Readmissions Higher Than Expected

- When reviewing organizational performance for 30-day, all-cause readmissions, MultiCare identified that COPD was one of the top two readmission diagnosis, and the rate was higher than expected according to risk-adjusted benchmarks.

- Many of the patients being readmitted for heart failure (the number one readmission diagnosis) also had COPD.

*MultiCare needed an organizational strategy that would improve patient care processes and readmission rate for patients with COPD.*
Launching an improvement effort for COPD patients required:

• Strong leadership and a broad base of engaged participation with representation from many care locations and disciplines.

• Interdisciplinary collaboration.
  • At MultiCare, Clinical Collaboratives (permanent, interdisciplinary teams of clinicians, support staff, data analysts, and operational leaders) are responsible for improving patient care and outcomes by reducing variation.
MultiCare leadership tasked the existing Medicine Collaborative to form an interdisciplinary COPD workgroup to do the following:

- Improve care processes for patients with COPD.
- Reduce COPD readmission rate.
- Design and implement a COPD Best Practice Bundle.
- Reduce length of stay (LOS).
2017 Clinical Collaboratives

**Accountability**
- System Wide Anesthesia Committee (SWAC).
- QI contract deliverables.

**Strategic Partners**
- MultiCare Connected Care Network.
- MHS Quality Department.
- Medical/Clinical Informatics.
- Cardiovascular (CV) Institute.
- Clinical Quality Value Analysis (CQVA).

**Collaborative**

- **Critical Care Collaborative**
  - Early Mobility
  - ARDS
  - Sepsis
  - Respiratory Failure

- **Women’s Collaborative**
  - Preeclampsia
  - High BMI OB
  - Exclusive Breastfeeding
  - Gynecology
  - Note Standardization
  - Chemical Dependency

- **Surgery Collaborative**
  - IBD
  - Glycemic Control
  - Pre-Op Anemia
  - Total Joints
  - Colon

- **Medicine Collaborative**
  - Post Acute Strategy
  - COPD: Spirometry
  - COPD
  - Pneumonia

- **Pediatric Collaborative**
  - Neonatal Services
  - Ambulatory/CIN
  - Med/Surg Standardization
  - Regualtory/Core Measures
  - Culture of Safety

- **Primary Care Collaborative**
  - VBP Measures
  - Acute Back Pain

- **Emergency Services Collaborative**
  - Standardization of ED best practices across the system
Results

Reduction in readmission rate.

13% 89% 82%

Patients with COPD assessed for readmission risk. Increase in COPD order set utilization. PCP notification of patient discharge.
How MultiCare Achieved Results

- Best practice care guidelines.
- Interdisciplinary team learning from experience.
- Care bundles.
- Analytics and metrics.
Standardizing Care to Improve Outcomes

Care guidelines. Evidence-based practices for the management of COPD.

Guidelines standardize and improve appropriate delivery of pharmacologic treatment and non-pharmacologic treatment, including smoking cessation counseling, vaccinations, medications, oxygen, patient education materials and action plans, and pulmonary rehabilitation.

Best practices integrated into standard order sets for both admission and discharge.

Improves consistency and reliability of care.

To improve utilization of the orders sets, members of the Medicine Collaborative proactively sought feedback from ordering providers, asking how the order sets could be improved, and inquiring what changes could be made to increase usage.
NOREADMTS Bundle and Metrics
Key interventions to improve transitions of care and safe discharge from the hospital

**Notification.**
PCP inpatient discharge notification acknowledged within 14 days of discharge.

**Order set utilization.**
Condition-specific order set opened at least once during the encounter.

**Readmission risk assessment.**
Care managers assess and document each patient’s risk of readmission and align resources to mitigate risk factors.

**Education.**
Percent of discharges for which patient education or teach-back is completed.

**Advanced care planning.**
Percent of discharges for which advanced care planning completed and recorded.

**Specialist consult.**
Percent of discharges with a referral to specialist.

**Timely follow-up.**
Percent of patients with a follow-up appointment after discharge.

**Medication reconciliation.**
Percent of discharges for which medication reconciliation completed by a pharmacist.

**Discharge instructions.**
Percent of discharges for which RN provided specific discharge instructions.
Using Analytics to Promote Adoption

Integrating the NOREADMITS bundle elements into the analytics application supports monitoring and performance improvement.

- Analytics application supports visualization of bundle elements by discharging facility and by accountable department.

- Multiple views support quick, easy visualization of trends—including the ability to drill down into patient-level detail.
  - Eliminates need to perform burdensome chart reviews.
  - Enables and encourages review of performance.
Example

1. Filters to select population of interest.
2. NOREADMITS bundle element success rate.
Poll Question #2

How readily available is the data your clinical teams need to make sound decisions regarding evidence-based treatment of patients with chronic diseases?

a) We do not have all data available electronically
b) We have data available electronically, but it is in multiple systems and may not be up-to-date or it is difficult to access
c) We have data available electronically, and we have decision support, but it is cumbersome and in multiple systems
d) We have data and analytics tools that integrate data from multiple sources, providing sophisticated decision support
e) Unsure or not applicable
Key Takeaways and Lessons Learned

1. Apply lessons learned from other improvement efforts to enhance future results.
2. Use of an evidence-based care bundle at discharge standardizes care and improve outcomes.
3. Support from senior leadership and domain experts is key to success.
4. Use analytics to promote adoption.
Future Plans

- Implement a COPD Transition of Care Clinic to ensure patients have the opportunity to see a specialist that can stage their disease appropriately. Recommendations can then be provided to the PCP for ongoing management.

- Expand the use of the NOREADMITS bundle to improve care for other chronic diseases.

- Increase number of patients who receive all elements of the NOREADMITS bundle.
Thank You