Realtime Readmissions Feedback at Penn Medicine — Making the Data “Actionable”

University of Pennsylvania Health System
September 29, 2010

University HealthSystem Consortium
San Diego, California
Who we are

PJ Brennan, MD
Chief Medical Officer & Senior Vice President
University of Pennsylvania Health System

Victoria Rich, PhD, FAAN, RN
Chief Nursing Executive, University of Pennsylvania Medical Center
Associate Professor, University of Pennsylvania School of Nursing

Joan Doyle, MBA, MSN, RN
Executive Director, Penn Home Care and Hospice Services
University of Pennsylvania Health System
Assistant Dean for Clinical Practice, University of Pennsylvania School of Nursing

Linda May, PhD
Principal
CFAR
Penn Medicine — Philadelphia, PA

School of Medicine

University of Pennsylvania Health System

- Hospital of the University of Pennsylvania
- Pennsylvania Hospital
- Penn Presbyterian Medical Center
- Penn Home Care & Hospice Services

#9 US News Magnet

Adult admissions — 77,500
Employees — 12,700

Admissions — 18,000
Employees — 450
Penn Medicine is working to improve Transitions-in-Care from hospital to home — and prevent readmissions

The aim is to keep patients safe and stable and give them a safe “medical landing”

- Preadmission
- Hospital Stay
- Post-acute Care
- Admission
- Discharge
- “Medical Landing”

It’s the **right thing to do for our patients** — **AND** we’re trying to get ahead of the curve for the new world of healthcare

What we’re learning will give us a head start in a new healthcare environment of **ACOs and bundled payments.**
Realtime readmissions feedback is at the heart of our model for Transitions-in-Care

**UPHS Transitions Model — Seven “Levers”**

- Screen for patients at greatest risk
- Real-time readmissions feedback to actively manage patients
- Interdisciplinary care planning
- Links to post-acute follow-up services
- Primary care follow up
- Med mgmt across the continuum
- Education & red flag mgmt
It starts with the daily readmissions report — but the report is the “least” of it

### Daily Readmissions Report

<table>
<thead>
<tr>
<th>Readmitted patients (across all three hospitals) — with chief complaint, facility, unit, service, attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed history of previous admissions</td>
</tr>
</tbody>
</table>

**Full report** is distributed each morning to Discharge Planners, Homecare and others.

**Each hospital unit gets a tailored version,** with just its own patients.

**But ...**

It’s the organizational “machinery” that makes the data actionable.
Today’s talk about making the realtime readmissions data actionable has three parts

1. “Changing the way we work”
   - The story of frontline leadership

2. “Speaking with a united clinical voice”
   - The story of the CMO/CNO Alliance

3. “Mobilizing other people’s energies”
   - The story of the Transitions Steering Group
1 Changing the way we work
In-the-moment and long term

**Daily Troubleshooting**
Readmissions data are available in time to take action on specific cases

**Long-term Changes to Clinical Practice**
Tools, standards, education, faster turnaround, tighter feedback loops — based on opportunities we see in the data

- Screen for patients at risk
- Real-time readmissions feedback
- Interdisciplinary care planning
- Links to post-acute follow-up services
- Primary care follow-up
- Med mgmt across the continuum
- Education & red flag mgmt

**UPHS Transitions Model — Seven “Levers”**
“Findings with feet ...”

— Executive Administrator
**Daily troubleshooting**

**At the System Level**

- **Discharge Planners** review every UPHS readmission, every day.

- **Homecare/Hospice** review every one of their readmissions, every day.

- **On the phone with each other daily** to troubleshoot specific patients.

- **Hospice** dispatches a team to investigate its patients, along with the inpatient medical team.

- **Discharge Planners** interview readmitted UPHS patients.

  They’re learning that most patients don’t see the link between readmission and things like not taking their meds. This is a teaching opportunity.

**On the Individual Hospital Units**

For example, a general medicine/telemetry unit started **interviewing each of its readmitted patients** to learn why the patients themselves thought they came back into the hospital.

**This got picked up at the system level**.
Long-term changes to clinical practice

For example, here’s how Hospice is changing the way it works ...

Hospice conducts regular **case conferences** to understand why their patients are readmitted.

They’ve learned that many are coming back because of **pain or dehydration**.

Hospice has developed a **tool to identify their patients at greatest risk** for readmission.

Hospice is building in **new practices** for those high-risk patients:

- Frontloading visits
- Proactive phone calls
- Educating staff
- Tighter feedback loops

And they’ve developed a tool for patients to **help them know when to call** if their symptoms are getting out of control.
What’s next? Two things on our plate ...

Building out the Daily Review Process on the Hospital Units

? Who’s responsible? If the daily readmissions report goes to “everyone,” it might as well go to “no one.”

? What actions are “automatically” taken for a readmitted patient?

? What interventions are triggered — Homecare referral? Patient education? Discharge safety check? Followup call?

Making Common Cause with the Cardiac and Oncology Service Lines

? How can we share their readmissions data so it’s “hearable” and “actionable”?

? How can we tap into what the service lines are already planning to do?

? How can we shape what they’re doing?
A funny thing is happening along the way — we’re breaking down our silos and collaborating in new ways.

From

To

Service Lines

Discharge Planners

Unit Leadership Trios

Homecare/Hospice
So, what does it take to make the readmissions data “actionable”?

1. **Changing the way we work**
   - **Daily troubleshooting** to take action on specific cases
   - **Tracking and trending the readmissions data** to identify longer-term interventions
   - **Making changes to clinical practice** — tools, standards, education, faster turnaround, tighter feedback loops
   - **Along the way**, breaking down our silos and **collaborating in new ways**

Realtime readmissions data — the report is the “least” of it
Collaboration at the local level didn’t happen overnight. One day at a time, we earned new reputations for what each other could bring.

We focused on the work — which led to new ways of thinking about each other.

It’s not just about “educating” each other. The best way to collaborate was to work together on common problems — and bring our clinical expertise to bear.

It’s easier to “act your way to new thinking” than to think your way to new actions.
But frontline actions by themselves aren’t enough ...
2 Speaking with a united clinical voice
The CMOs and CNOs have banded together across the continuum of care

The CMO/CNO Alliance spans the care continuum:

- All three hospitals
- Penn’s homecare and hospice services
- Penn’s rehab facilities
- Physician practices
The CMOs and CNOs set clinical direction for UPHS — with Transitions-in-Care as a major element

### UPHS Blueprint for Quality and Patient Safety

<table>
<thead>
<tr>
<th>Four Imperatives</th>
<th>Priority Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transitions in care</strong></td>
<td>◆ Transition planning</td>
</tr>
<tr>
<td></td>
<td>◆ Med management</td>
</tr>
<tr>
<td>Reduce variations in practice</td>
<td>◆ Reduce hospital-acquired infections</td>
</tr>
<tr>
<td></td>
<td>◆ Reduce medication errors</td>
</tr>
<tr>
<td>Care coordination</td>
<td>◆ Interdisciplinary rounding</td>
</tr>
<tr>
<td>Accountability</td>
<td>◆ Unit clinical leadership</td>
</tr>
</tbody>
</table>

Reduce mortality and reduce 30-day readmissions
To bring clinical strategy to the frontline, we’ve established “local leadership” on each hospital unit.

Leadership Trio on Each Hospital Unit

We call these trios “UBCLs,” for “Unit Based Clinical Leadership”

We needed a multi-purpose solution on the units to handle almost any Quality problem.

“This isn’t a project, it’s a way of doing things. You can bolt different strategies onto it.”

—UPHS CFO
We started modestly on purpose so the leadership trios could learn to work with each other

13 pilot units in 2007

The job in 2007 — not “too much,” not “too little”:

- Weekly operations meeting of the Physician Leader, Nurse Leader, Project Mgr. for Quality
- Interdisciplinary rounding
- Orienting house staff
- Two improvement projects
Today we’ve covered the house and the trios are ready to take on Transitions, a major system-wide initiative.

Today it’s 34 “official” units — and another dozen who are “operating as.”

The job today: The trios manage Quality on the unit, drawing in others as needed.

UBCLs are ready this year to shoulder Transitions-in-Care, a major system-wide initiative.
“Choice within a framework” — each year we develop targets and work with the hospital units to pick theirs.

### UPHS Blueprint for Quality and Patient Safety

**Reduce mortality and reduce 30-day readmissions**

<table>
<thead>
<tr>
<th>Four Imperatives</th>
<th>Priority Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions in care</td>
<td>- Transition planning</td>
</tr>
<tr>
<td></td>
<td>- Med management</td>
</tr>
<tr>
<td>Reduce variations in practice</td>
<td>- Reduce hospital-acquired infections</td>
</tr>
<tr>
<td></td>
<td>- Reduce med errors</td>
</tr>
<tr>
<td>Care coordination</td>
<td>- Interdisciplinary rounding</td>
</tr>
<tr>
<td>Accountability</td>
<td>- Unit clinical leadership</td>
</tr>
</tbody>
</table>

#### Transitions in Care — FY’11 Targets

- **Risk stratification** — screening tool and daily review of realtime readmissions
- **Discharge safety check**
- **Discharge communication**
- **Med rec** on discharge
- **HCAHPS** medication domain
“Focusing attention” — we negotiated a Transitions metric in every senior leader’s incentive plan

METRIC: Increase referrals to post-acute services (homecare, hospice, rehab, SNF, infusion, LTAC)

The entire system ended the year at high performance.

We’re setting the stage for a more ambitious “readmissions” metric next year.
Quality outcomes are moving in the right direction — including the ones focused on Transitions-in-Care.

- Mortality
- Infections
- Length of stay

- Peer recognition
- Patient and staff satisfaction
- Referrals to post-acute care
- Pay for performance is on track
We’re getting out ahead of the budget cycle and negotiating with a united clinical voice

<table>
<thead>
<tr>
<th>The old way</th>
<th>The new way</th>
</tr>
</thead>
<tbody>
<tr>
<td>First step — set margins for each hospital. Hospitals are locked in.</td>
<td>Discussion of system-wide quality initiatives before margins are set.</td>
</tr>
<tr>
<td>Hospitals (separately) submit budgets.</td>
<td>CMOs and CNOs submit a joint budget for system-wide quality initiatives they all agree on.</td>
</tr>
<tr>
<td>Negotiation — across hospitals and with Finance — occurs after budgets are submitted.</td>
<td>Negotiation occurs before budgets are submitted.</td>
</tr>
</tbody>
</table>

We’re making our job **AND** the CFO’s job easier.
We’re bringing payers to the table

Paying for the Naylor Transitional Care Program

A major insurance company pays Penn to provide the “Transitional Care” (Naylor model) follow-up program to its patients.

In this program, the same advanced practice nurse follows patients before and after discharge.

Sharing the gains

Penn has also negotiated an agreement with the insurance company to share the savings when patients are able to stay out of the hospital.
So, how are we speaking with a united clinical voice to make the readmissions data “actionable”?

2 Speaking with a united clinical voice

- CMO/CNO Alliance across the continuum of care
- Local leadership on each hospital unit — Physician Leader, Quality Project Manager
- Clinical strategy — with Transitions-in-Care as a major element
- Realtime readmissions data — the report is the “least” of it
- Metrics as feedback — each hospital unit and each senior leader know where they stand

- Negotiating the budget with a united clinical voice
- Bringing the payers to the table
- Aligning quality metrics across the system, including senior leaders’ incentive targets

- Quality redesign to dedicate a Quality Project Manager to each hospital unit

- Clinical strategy — with Transitions-in-Care as a major element
To paraphrase James Carville:

“It’s the work, stupid.”

A united clinical voice is based on actions, not just words.

We started with the work — developing the Blueprint, establishing the unit teams, setting the metrics, negotiating the budget.

Succeeding at the work is what turned the CMOs and CNOs into a real leadership team that could speak with a united voice.

That’s very different from trying to do it the other way around.
But leadership at the top isn’t enough to make the readmissions data “actionable” ...
Mobilizing other people’s energies and keeping the moving parts aligned
The Transitions Steering Group is in the integration business

This interdisciplinary group of senior leaders:

• **Sets direction** for Transitions-in-Care
• **Integrates** the moving parts
• **Opens doors** at the system level
• **Troubleshoots** to keep things on track
We’re working with “other people’s energies.” Our biggest job is keeping them aligned.

**INTERNAL**

- CMO/CNO Alliance across the continuum of care
- Penn Medicine Leadership Forum “action learning” Transitions projects
- Knowledge-Based Charting (EHR protocols & tools) under development
- Transitions Collaborative — active operational arm
- Unit-based Pharmacists
- Med Mgmt redesign

**EXTERNAL**

- CMS penalties for readmissions will begin in 2012
- Pay-for-performance contracts
- Bundled payments and ACOs are on the horizon
- Payers willing to fund follow-up programs and negotiate gain-sharing arrangements
- Public reporting influences patient choice

**TRANSITIONS IN CARE**

for better patient outcomes & fewer readmissions
For example — We took advantage of Penn’s flagship leadership development program

Penn Medicine Leadership Forum

Curriculum of leadership concepts and skills ...

• Innovation
• Strategic orientation
• Execution
• Relationship mgmt

“Action Learning”

... applied to real-life projects

This year the Penn Medicine Leadership Forum is targeted to the unit-based leadership teams — along with homecare and other partners

This year the projects are focused on a strategic system-wide initiative — Transitions-in-Care
“Testbeds” — each team tried out a small part of the Transitions Model. All over the place, but look at the energy!

<table>
<thead>
<tr>
<th>Penn Medicine Leadership Forum — Transitions Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Real-time readmissions analysis and intervention</strong></td>
</tr>
<tr>
<td><strong>End-of-life goals of care</strong></td>
</tr>
<tr>
<td><strong>Screening tool for post-acute referrals</strong></td>
</tr>
<tr>
<td><strong>New approaches to interdisciplinary care planning</strong></td>
</tr>
<tr>
<td><strong>Post-discharge phone calls</strong></td>
</tr>
<tr>
<td><strong>Med management across continuum</strong></td>
</tr>
<tr>
<td><strong>House staff awareness of homecare &amp; hospice services</strong></td>
</tr>
<tr>
<td><strong>Discharge Team-based safety check</strong></td>
</tr>
<tr>
<td><strong>Patient &amp; family education, with emphasis on self management</strong></td>
</tr>
<tr>
<td><strong>“Opt-out” for homecare referral</strong></td>
</tr>
<tr>
<td><strong>Improve internal Transitions</strong></td>
</tr>
<tr>
<td><strong>Discharge Summary follows patient to post-acute services</strong></td>
</tr>
</tbody>
</table>
To pull it all together, we turned the teams’ work into an integrated Transitions Process for the health system

Work as far “upstream” as possible — prior to admission where that makes sense.

**Risk stratification**

1. **Screening** on admission
2. Daily review of **realtime readmissions report**

**Interdisciplinary rounds**

3. **Plan of care** looks ahead to post-discharge
4. **Referral to post-acute care** as early as feasible

**Patient and family education**

5. **Education** for post-discharge care and meds, with emphasis on self management
6. **Med reconciliation** on discharge

**Discharge communication**

7. **Discharge safety check** (for high-risk patients)
8. **Discharge summary handoff** to primary & post-acute
9. **Schedule appointment** with primary (for high-risk patients)
10. **Follow-up phone calls** (for high-risk patients)
To build out the Transitions Process part-by-part, we’re “respectfully hijacking” other people’s projects and efforts.
We know we can’t focus all our interventions on all 80,000 patients — so where to start?

The readmissions data helped us decide where to focus first:

- **Readmits and the top 10-20% at greatest risk for readmission**
- **The “big three” diagnoses** that will affect CMS payments for readmissions in 2012 — **Heart Failure, Heart Attack, Pneumonia**
- **Two service lines** with the biggest impact on those three diagnoses — **Cardiac and Oncology**

**Why Oncology?** Analysis of our Pneumonia readmits shows that almost a third are on the Oncology service.

And 30% of our overall readmits are Oncology.
It’s a “build out,” not a “roll out”

Some parts of the Transitions Process will start before others. Not everything needs to develop at the same speed.

We think the process will be stronger for growing organically.

But we have to keep it moving and keep it integrated.
So, how are we using other people’s energies to make the readmissions data “actionable”?

3 Mobilizing other people’s energies

- **Transitions Process as a framework** — so people know what to do on a daily basis
- **Tapping into other people’s projects and efforts** — to build out the Transitions Process part by part
- **Tracking and trending the readmissions data** to **figure out where to focus first**
- **Keeping the moving parts aligned** — and opening doors for the people doing the work

Realtime readmissions data — the report is the “least” of it
Mobilizing energies — lessons learned

By tapping into other people’s efforts and projects, you can **create results and critical mass** as you go.

You get **change that sticks**, because people are creating it themselves.

You **don’t have to do all the work yourself**.

**Your job is to align** what might otherwise work at cross purposes.

Tapping into other people’s energies and momentum **creates “pull” for the changes you want to make.** Other people pull the changes along.
There’s good social science behind what we’re doing
"Pull" is stronger than "push"

If you create pull, others will do the work of change for you.

New behaviors can’t be legislated. They begin to show up when an organization knows how to create pull for them.

The UPHS campaign created pull for change.
Your organization’s culture is a renewable resource

A useful definition of culture: “The way we do things around here.”

New behaviors are the building blocks of an organization’s culture. Each behavior by itself may be small, but together they can move the organization’s culture.

The raw material for a culture change is almost always already emerging in your organization.
Leadership can be top down AND bottom up

Top down, by itself, lacks the **resilience and creativity of grassroots efforts.**

Bottom up, by itself, lacks **focus, alignment and the commitment of mainstream leaders who can give resources.**

The UPHS campaign tapped into the creativity and commitment of the **whole system.**
The leadership skills you’ll need may seem counterintuitive

<table>
<thead>
<tr>
<th>NOT ...</th>
<th>INSTEAD ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling and selling</td>
<td>Listening and amplifying</td>
</tr>
<tr>
<td>Pushing people to change</td>
<td><strong>Creating pull</strong> for the changes</td>
</tr>
<tr>
<td>Trying to “motivate” or “empower” others</td>
<td>Discovering and <strong>freeing up energy</strong> and passion</td>
</tr>
<tr>
<td>Thinking your way to new actions</td>
<td><strong>Acting your way to new thinking</strong></td>
</tr>
</tbody>
</table>

Q&A — We welcome your questions, thoughts, & experiences
To be in touch

PJ Brennan, MD
PJ.Brennan@uphs.upenn.edu

Victoria Rich, PhD, FAAN, RN
Victoria.Rich@uphs.upenn.edu

Joan Doyle, MBA, MSN, RN
Joan.D Doyle@uphs.upenn.edu

Linda May, PhD
LMay@cfar.com