Today’s Agenda

• Welcome and Overview
• EDie Overview
• Orlando Health’s SNF to ED Handoff Tool
• Questions/Sharing
HELP FLORIDA'S HOSPITAL HEROES

DONATE TO THE FHA HOSPITAL EMPLOYEE ASSISTANCE FUND AT FHA.ORG/DONATE
# CMS Readmissions Penalties

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals receiving no penalty</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Hospitals receiving max penalty</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Hospitals receiving a penalty</td>
<td>155</td>
<td>156</td>
</tr>
<tr>
<td>Percent of hospitals receiving a penalty</td>
<td>92.8%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Average Penalty</td>
<td>.94%</td>
<td>.90%</td>
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</tbody>
</table>

Florida had 5th highest percentage of hospitals penalized.
<table>
<thead>
<tr>
<th>State</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>0.94</td>
<td>1.17</td>
</tr>
<tr>
<td>Nevada</td>
<td>0.84</td>
<td>1.00</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.10</td>
<td>0.98</td>
</tr>
<tr>
<td>Idaho</td>
<td>1.10</td>
<td>0.97</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>0.92</td>
<td>0.96</td>
</tr>
<tr>
<td>New York</td>
<td>0.99</td>
<td>0.94</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1.07</td>
<td>0.91</td>
</tr>
<tr>
<td>New Jersey</td>
<td>0.99</td>
<td>0.91</td>
</tr>
<tr>
<td>West Virginia</td>
<td>0.93</td>
<td>0.91</td>
</tr>
<tr>
<td>Wyoming</td>
<td>0.84</td>
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<td>Florida</td>
<td>0.94</td>
<td>0.90</td>
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</tbody>
</table>
Source: HRET Comprehensive Data System, October 17, 2018
Readmissions - Medicare

Source: HRET Comprehensive Data System, October 17, 2018
Readmission Strategy Resources

www.fha.org
www.hret-hiin.org
Emergency Department Information Exchange (EDie) Overview

Andrew Reeve and Alyn Ford,
Collective Medical
The Collective Platform

FHA Readmission Webinar

October 17, 2018

Alyn Ford
Alyn.Ford@collectivemedical.com
SVP, Network Development
Complex Patients: The Elephant in the Room

With only a partial view into a patient’s situations, it’s easy to draw incorrect conclusions.

Collective Medical resolves this problem by creating a collaborative communication environment in which ALL members of the patient’s care team contribute.

This aggregate data provides a complete picture of the patient, enabling better care and avoiding the misdiagnoses or complications that can arise from a lack of information.
The Opportunity

**ED as an Island**

ED is focused primarily on efficiency and is only concerned with acute care episode.

ED and hospital at large view as separate from the larger care continuum.

**ED as a Bridge**

ED is intrinsically connected to entire healthcare enterprise and is focused on items beyond efficiency.

ED collaborates to help prevent readmissions, avoid preventable admissions, and promote care coordination.
Collective EDie delivers intelligent, real-time care collaboration for complex patients in the ED

**FOCUS**

Ingest a thin slice of data independent of—and across—facility, system, EMR, or/and payer class

and

Real-time analytics: What complexities just walked in the front door of my health system?

**ENGAGE**

Configurable risk-based notifications...

...pushed to the right stakeholders, directly into their workflows...

...presented as consumable, relevant patient insights results in...

high engagement, no alert fatigue, and consistent care

**COLLABORATE**

With ‘blindfolds’ removed, stakeholders collaborate across:

- organizations
- IT systems
- care settings

on shared, patient-specific care guidelines with the patient’s complexity in full context
CMS will reduce reimbursements for 2,573 hospitals in FY 2018 for excessive readmissions and withhold $564 million in payments over the next year.
Collective, as the technical backbone to a hospital’s readmissions program, has been proven to support drastic reductions in avoidable hospital readmissions.
Patient Scenario: SNF 30-Day Readmission Alert

1. Transfer from hospital

2. 20-day stay; patient discharged from SNF to home

3. Unexpected ED encounter

4. Direct SNF readmission

 Upon registration, SNF receives care guidelines from hospital

PCP notification regarding hospital discharge, SNF transfer, and SNF readmit

Upon ED registration a notification is sent to the ED, hospital, PCP, and SNF within 30-day window
Meet "Jack"

- **About Jack**: 76 year old male; active lifestyle (tennis) lives in Des Moines, IA

- **Primary insurance**: Wellmark BCBS Medicare Advantage

- **Conditions include**:  
  - Chronic obstructive pulmonary disease (COPD)  
  - Osteoarthritis; requires knee replacement

- **Currently taking the following meds** (among others):  
  - albuterol/ipratropium (Combivent); oral prednisone (PRN)

- Has a primary care + pulmonologist friend, but in different health systems
## Event Timeline

<table>
<thead>
<tr>
<th>Step</th>
<th>Context</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Pre-Surgery</td>
<td>Knee replacement, scheduled in advance</td>
</tr>
<tr>
<td>1</td>
<td>IP Surgery</td>
<td>Paper charge strapped to patient chest during EMS ride from IP to SNF --- IP discharge planner faxes / calls SNF to coordinate verbally with overloaded SNF staff</td>
</tr>
<tr>
<td>2</td>
<td>Discharged to SNF (Target LOS: 10 days)</td>
<td>Complication occurs; severe shortness of breath as a result of COPD and aggressive prednisone tapering because notes not transferred to SNF</td>
</tr>
<tr>
<td>3</td>
<td>Discharged from SNF to ED</td>
<td>ED docs stabilize with appropriate med dosing --- Regulations require IP stay before being discharged to SNF again</td>
</tr>
<tr>
<td>4</td>
<td>Readmitted to IP from ED</td>
<td>Meds are normalized --- Knee surgery healing occurs --- But, handoff was from hospital only, with no view by SNF team of patient’s broader care team</td>
</tr>
<tr>
<td>5</td>
<td>Discharged back to SNF</td>
<td>Patient sent home --- Ambulatory and IP care team unaware of discharge</td>
</tr>
<tr>
<td>6</td>
<td>Discharged to Home</td>
<td>Meds for hospital/SNF stay, not home, so SOB continues --- Patient returns to ED for proper dosing --- Potential 2nd IP readmit out of abundance of caution</td>
</tr>
<tr>
<td>7</td>
<td>Subsequent ED / IP visit</td>
<td></td>
</tr>
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</table>
How it can be

Event Timeline

<p>| | | | | | |</p>
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</tr>
<tr>
<td>Patient flagged as high risk based on COPD condition</td>
<td>Knee replacement, scheduled in advance</td>
<td>Discharge summary + care plan transferred automatically to Intaking SNF</td>
<td>Complication still occurs, but SNF is empowered by additional information, including care team members (such as Jack’s pulmonologist friend)</td>
<td>SNF visit concludes as anticipated</td>
<td>Care team + care manager immediately notified as patient departs SNF</td>
</tr>
<tr>
<td>Patient carefully followed by care management, coordinating care across EMRs, network nodes, asynchronously (as emergencies happen at 2am)</td>
<td>Care team + IP discharge planner notified when patient admits to SNF</td>
<td>SOB complication but good data flow to EMS, ED</td>
<td>Recurring patient assessment reports automatically sent to IP discharge planner + PCP to track progress, target LOS</td>
<td>Care plan transferred to ambulatory care team</td>
<td>Home health alerted of same, dispatched to home care automatically</td>
</tr>
</tbody>
</table>
Results
Opened in 2005, Legacy Salmon Creek Medical Center is a part of Legacy Health, a local, nonprofit health system with six hospitals. Legacy also includes more than 70 primary care, specialty and urgent care clinics, as well as almost 3,000 providers who are either employed, on the medical staff or part of Legacy Health Partners. Legacy Salmon Creek has a high-volume ED, seeing 200 patients per day on average.

After joining the Collective network, Legacy Salmon Creek saw:

- 24.9% reduction in all-cause 30-day readmission rates (equating to 178 readmissions avoided)
- 81% reduction in the ED visit rate by high utilizers
- A reduction in ED visits by high ED utilizers from 3,081 per year to 573
CHI St. Anthony Hospital | Pendleton, Oregon

CHI St. Anthony Hospital (St. Anthony) is a rural hospital serving Pendleton, Oregon. The 25-bed critical access hospital is part of the Catholic Health Initiatives (CHI) family. The hospital needed to implement a strategy to reduce readmissions. Starting in 2015, with an all-cause readmissions rate of 8%, St. Anthony structured a program around Collective’s EDie application. It saw significant results:

- By January 2017, the hospital had reduced all-cause readmissions rates to 3%.
- By June 2018, the hospital had reduced all-cause readmissions rates to 1.72%.
- This represents a 78% reduction in all-cause 30-day readmissions achieved in less than three years.
THANK YOU
Orlando Health’s
SNF to ED Handoff Tool

Julie Haile, Director of Transition Services
## Orlando Health

### 30-Day Re-hospitalization Alert

**SNF to ED TRANSFER HANDOFF**

<table>
<thead>
<tr>
<th>Facility:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Information:</td>
<td>Date: Time:</td>
</tr>
</tbody>
</table>

**Name/Title of Person Receiving Report:**

**Transferring Facility Name:**

**Patient Name:**

**Age/DOB**

**Reason for resident transfer and any input from the sending Physician/Practioner:**

**Current Vital Signs:**

- **T:**
- **P:**
- **R:**
- **B/P:**
- **Blood Glucose:**
- **Long Term Resident:**
- **Blood Pressure:**

**Physician/Provider Ordering Transfer to ED:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact Number:</th>
</tr>
</thead>
</table>

**Who to Call at Facility for additional information:**

<table>
<thead>
<tr>
<th>Name/Title:</th>
<th>Contact Number:</th>
</tr>
</thead>
</table>

**Current Mental Status:**

- **Orientation:**
- **Confusion:**
- **Varies:**
- **Agnescia:**
- **Agitated:**

**Disability:**

- **Handicap:**
- **Blind: L/R:**
- **Paralysis:**
- **Upper/Lower:**
- **Speech:**
- **Language:**

**Advance Directive Status:**

- **Health Care Surrogate-POA:**
- **Living Will:**
- **Guardian:**

**HCPOA/Guardian Name:**

<table>
<thead>
<tr>
<th>Relationship to Patient:</th>
<th>Contact Number:</th>
</tr>
</thead>
</table>

**Family Contact Aware of Transfer to ED:**

- **Yes**
- **No**
- **Attempted**
- **Uncertain**

**High Risk Medications:**

- **Diabetic Agent:**
- **Anticoagulant:**
- **Opioid:**
- **Antibiotic:**

**Recent Labs:**

- **Blood Sugar:**
- **Creatinine:**
- **BUN:**
- **Sodium:**
- **Potassium:**
- **Creatinine:**

**Required Attachments:**

- Face Sheet
- Medication Record
- DNR (if applicable)

**SNF CAPABILITIES LIST ON BACK**

**Community Version:** July 30, 2017

**Patient Label**
Questions / Sharing
Next Quarterly Virtual Meeting

• Readmissions Stakeholder Virtual Meeting #5
  • January 17, 2019 @ 12-1pm ET
  • Email HIIN@fha.org to request a topic for discussion
Contact Us

We are here to help!

HIIIN@fha.org
407-841-6230