Doctors, we have a problem...

THE RENAISSANCE DIFFERENCE

Robert D. Martinez, MD
Chief Medical Officer and Chief Physician Executive
History of Doctors Hospital at Renaissance

- Started as an Endoscopy Center by several GI physicians in 1997 with 2 rooms and 5 employees.
- Today is a Physician owned General Acute Care Hospital with almost all medical specialties represented on staff.
- 530 Acute Care beds, over 700 hundred physicians on staff and over 1100 nurses and 3800 employees.
- Operate the ONLY exclusive Women’s Hospital in South Texas, have an 88 bed IP Psychiatric Hospital, 48 bed Rehabilitation Hospital and a Level III B Neonatal ICU where we average 850-900 deliveries a month.
In early 2010, leadership at Doctors Hospital at Renaissance began to recognize a looming and potential disaster.

- As the idea of VBP picked up steam, leadership at DHR really started to examine future plans to establish itself as the premier health care provider in South Texas as well as identify potential roadblocks. Panic set in. The social/economic challenges that face the RGV are significant. The idea of being penalized for all cause hospital readmissions was horrific! For perspective on the challenge, I offer the following statistics:

- When looking at health factors affecting the population of Texas where the rank of 1 is the best and 232 is the worst, in Hidalgo County where DHR is located, the rank was **228/232**. Neighboring Starr County ranked dead last at 232.

- **Health factors** include levels of obesity, smoking, physical inactivity, teen birth rates, uninsured patients, lack of primary care physicians, preventable hospital stays, lack of basic education, poverty levels, lack of social support, unemployment rates and several others.
<table>
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<tr>
<th>Health Indicator</th>
<th>RGV</th>
<th>US 90th %</th>
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<tbody>
<tr>
<td>Obesity</td>
<td>35-40%</td>
<td>20-25%</td>
</tr>
<tr>
<td>Teen birth</td>
<td>87</td>
<td>21</td>
</tr>
<tr>
<td>Uninsured</td>
<td>38%</td>
<td>11%</td>
</tr>
<tr>
<td>PCPs</td>
<td>2,235:1</td>
<td>1,067:1</td>
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<tr>
<td>Unemployment</td>
<td>12%</td>
<td>5%</td>
</tr>
<tr>
<td>Children in poverty</td>
<td>48%</td>
<td>14%</td>
</tr>
<tr>
<td>Fast food Restaurants</td>
<td>49%</td>
<td>27%</td>
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These numbers highlighted the need for our newly created TCM Team to get working.....fast...

We quickly assembled a team to start exploring the data and the problem areas in order to better understand the scope of issues. I do not need to tell you that there were many.....To begin with were all of those things I mentioned earlier as health factors.

Worse yet was that many of those factors DHR could not control as a hospital much less a community.
At about this time the administrative physician leadership team at DHR was just starting... I was the new Chief of Staff with no real administrative authority.

Being Chief of Staff however gave me access to over 500 physicians who could, if convinced, change significantly the patterns of behaviors that were problematic.

We needed to show our doctors that for the sake of our patients, we needed to do better.

Regularly bringing these physicians together and teaching/showing them what VBP was and how patients, physicians and hospitals were going to be affected, was where it all started.
One of our nurses, relatively versed in utilization data, was given multiple specific tasks and given some direction. Otherwise, I let her run with several ideas based on her patient experiences and interactions over the years. The questions we asked were:

- 1. How would we identify at risk patients?
- 2. Who would do it and how often?
- 3. What departments would be targeted?
- 4. What resources would be needed and how would those resources be funded?
- 5. Would physicians think we were “stealing” their patients?

As one could imagine, as we proceed to obtain resources, which were not free, there was pushback. Providing patients with scales, pillboxes?? Cap Ex Committee was not amused. You need how many ??
And so It was Born…

• At that point, I was officially made responsible for this effort and was asked to bring back an ROI and cold hard data and facts.

• The Transitional Care Management Team (TCM) was born and initially one LVN and one CNA were allocated to this project. The initial staff volunteered for this project because they saw this as a huge challenge with significant potential for positive change.

• The planning, ideas and problem solving were kicked into overdrive and we began to embark on a journey not knowing what we didn’t know.
The Challenge

- As we soon found out, things were easier said than done. At that time we were collecting the necessary data manually...that’s right manually! We had not yet purchased any software that could tie in all providers to secure meaningful data so manual data collection was the rule of the day.

- Even the system used in the ER was different. As you can imagine, the ER was the major traffic area for any program dealing with readmissions reduction.

- We set up shop collecting data on a daily basis, from the ER, IP Admissions, Bedboard and anywhere else we thought admissions would be coming in. Our team collected data from each area 3-4 times daily, using logs we had made with necessary information that staff would fill out on each and every patient.
The LACE tool was chosen by the DHR Transitional Care Management team (TCM), which was tasked with following high-risk patients throughout their hospital stay and during the 30 days post-discharge.

Using the LACE scoring methodology, each day the TCM Nurse Navigators review the census, coded list, and concurrent ER visits to identify high risk patients.
**Method**

**Survey, Chart Review, Patient Intervention**

- In-hospital intervention (multi-visits)
  - Discuss hospitalization
  - Assessment
  - Discuss medications
  - Discuss physician health record
  - Identify red flags
  - Discuss Care Transition to home
  - If identified as readmission, will conduct a readmission analysis questionnaire
  - Assess barriers to compliance to medications, appointments, treatments, etc
  - Provide available medication and diagnosis education handouts in preparation for discharge and confirm with Teach Back process
  - Work with case management to coordinate discharge needs

**Enroll in Transitional Care Program and endorse to CTI coach**

- HOME: Follow phone within 24 – 48 hours post discharge
- PAC: Transmit discharge documentation downstream providers
- Coach conducts home visits within 3 – 7 days post discharge
- Follow up phone calls weekly and additional home visits as needed

**Patient is screened and identify as high risk upon admission using the LACE assessment tool**

- Yes
  - TCM and CTI coach eligible for enrollment

- No: Follow hospital intervention

**Surveys and Chart Reviews, Patient intervention toward discharge**

- Follow up patient for discharge
  - Patient discharge surveys
  - Introduction to Transitional Care Program
  - Discuss the discharge checklist
  - Review with patient/caregiver to ensure understanding of the discharge instructions, follow up appointments, medications, activities, medical problems, signs and symptoms and plan of care
  - Ensure important and correct telephone numbers are listed in patients discharge summary
  - Discharge survey,
  - Schedule calls/visits

**Score: 10 or Less**

**Score: 11 or Greater**

**Notify Interdisciplinary team of High Risk patient**

**Conduct Root Cause Analysis; review strength and weakness, trending and opportunity for improvement Interdisciplinary Team process improvement initiative and implementation**
Method

- Essentially, Nurse Navigators review the daily census, coded lists, and concurrent ER visits to identify high risk patients.

- Identified patients/caregivers are provided in-person education and printed collaterals, in their native languages, about their conditions/plans of care/medications/follow up appointments. Education is confirmed via the Teach Back process.

- Education is documented in our EMR and a hard copy, along with appointment cards for follow up visits, are given to patients/caregivers before or at discharge.
DISCHARGE LACE TOTAL
- % of 11 and above: 69%
- % of 10 and below: 31%

READMISSION LACE TOTAL
- % of 11 and above: 86%
- % of 10 and below: 14%
Since the beginning of these initiatives, our outcomes have been very positive. We have since expanded the population looked at by Doctors Hospital at Renaissance. DHR has seen a steady reduction in readmission rates for high risk patients with Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN) as well as our newer added diagnoses.

The Transitional Care Management initiative was implemented in September 2010, at which time the readmission rate for AMI was 19.2%, HF was 28% and PN was 19.5%.

Doctors Hospital at Renaissance is proud to say that the current readmission rates as of last quarter for AMI are 10.7%, HF is 15% and PN is 5.2%.
Because of our great success at Doctors Hospital at Renaissance Health System, in reducing readmissions in our community, we have been recognized by THA, in JAMA with the TMF and CMS for leading the way when it comes to reducing readmissions.

In some instances we were noted to reduce those readmissions at twice the rate of other similar communities in Texas and the US as per a 2013 JAMA report.

In Early 2014, with a new name and a significantly expanded target group, we quickly added essentially all payers and all patient re-admissions at our hospital.

The DHR Care Link Clinics were born and expanded to what is now 6 different sites in our community: These sites include dieticians, pharmacist/pharmacy techs, social workers and of course our nurses.
DHR Care Link Clinics and its providers target the obvious readmission targets:

1. AMI
2. CHF
3. Pneumonia
4. COPD/Asthma
5. Total Knees/Total Hips
6. ESRD

Last year we began to include Diabetes Mellitus related readmits and the early data looks as promising as our other better studied diagnoses.