It Takes a Village: A Collaborative Approach to Improving Care Coordination

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Objectives

Participants will:
• Learn about the healthcare landscape in Detroit
• Review the readmission journey for Henry Ford Health System (HFHS)
• Understand the background and development of the Tri-County SNF Collaborative
• Discuss quality metrics, barriers and lessons learned

Henry Ford Health System

• Not-for-profit, integrated health system founded in 1915
• 6 acute care hospitals, 26 medical centers, and a center for chemical dependency treatment
• Henry Ford Medical Group (HFMG)
  - 1200 employed physicians and researchers
  - 40 specialties
• Henry Ford Physician Network (HFPN) – 500 private practice physicians
• Community Care Services
  - Home care and hospice
  - Medical equipment
  - Outpatient pharmacies and dialysis centers
• Health-Alliance Plan: Nonprofit health plan with 670,000 members
• Research and Education: Affiliated with Wayne State University
  - $70 million in research funding annually
The Detroit Landscape
- Detroit has a diverse and culturally-rich history
- The hub of automation and locomotion with a booming economy through the 1960’s
- The Motor City – home of the “Big 3” automakers
  - 2009 – GM and Chrysler filed for Chapter 9 bankruptcy
    - Led to massive plant closures and job losses
    - Major impact to the entire metro Detroit area
- Detroit filed for bankruptcy in 2013
- Negative impact on city services
  - Transportation
  - Community programs
  - School funding

MIPPO: Squire Report to CMS, June 2017, Improving Care Coordination Through a Post-Acute Skilled Nursing Facility Collaborative
The Detroit Landscape and Healthcare

- Fivefold increase in number of extremely poor
  - Those who could afford to, moved out of the city
  - Left behind low income workers
  - Highest concentration and rate of poverty out of the top 25 cities in the nation – 32% (National Average – 13.5%)
- Largest population eligible for Medicare and Medicaid in the state
- Highest Medicare readmission rate
- Low income patients are a vulnerable population
  - Increased likelihood of homelessness
  - Low health literacy
  - Inability to access healthcare

CNP Care Wagner by CMS, June 2017, Improving Care Coordination Through a Post-Acute Skilled Nursing Facility Collaborative
Readmission Penalties

- Research has shown:
  - Majority of hospitals receiving readmission penalties are large, teaching, safety net hospitals
    - Strong correlation with medical complexity and socioeconomic case mix
  - Hospitals in metro Detroit:
    - Drive the statewide readmission rate
    - Suffer a disproportionate share of readmission penalties in the state and nationally
      - All 5 hospitals within the city received a penalty
      - 12 hospitals within the surrounding community received a penalty
      - Only 37 of 75 hospitals in the rest of the state received a penalty

MIPRO Squire Report to CMS, June 2017, Improving Care Coordination Through a Post-Acute Skilled Nursing Facility Collaborative
Readmission Study - HFH
Socioeconomic Status and Readmissions: Evidence from an Urban Teaching Hospital *

- Retrospective cohort study using data from Henry Ford Hospital:
  - All Medicare fee-for-service beneficiaries discharged from an inpatient stay in 2010
  - 65 years of age and older
  - Key variables from census data related to neighborhood socioeconomic status:
    - Poverty
    - Education
    - Median household income

*Hu, J., Gonsahn, M., and Nerenz, D., Health Affairs 33, No. 5, 2014: 778-785

Readmission Study - HFH

- Findings:
  - Significant association found between socioeconomic variables and 30 day readmissions.
  - Higher rates for patients:
    - Living in high poverty neighborhoods
    - With low education levels
    - With low household incomes
    - Who live alone

*Hu, J., Gonsahn, M., and Nerenz, D., Health Affairs 33, No. 5, 2014: 778-785

Readmissions at Henry Ford Hospital

- First release of penalties in October 2012:
  - Henry Ford Hospital in Detroit identified by CMS as 1 of only 8 hospitals in the country with worse than expected readmissions in all 3 conditions
  - Full 1% penalty applied
- Deep dive into readmission data
  - Many areas of opportunities
  - Condition specific interventions
- Identified readmissions from skilled nursing facilities (SNF) as the top priority

4/26/2018
SNF Initiative began: January 2013

• Goal – Reduce Readmissions from SNF by:
  – Improving the transition of care from hospital to SNF
  – Identifying process improvement opportunities
  – Creating a post acute network

• Interventions:
  – Implemented SNF collaboratives led by case management at each hospital
  – Created a System Post-Acute Care Value Council:
    • Function as a steering committee for local collaboratives
    • Establish performance targets
    • Agree to and spread best practices
  – Developed a SNF dashboard with readmission rates and process measures
    • Included HFHS data and SNF self reported data
  – Engaged SNF physicians

Process Improvement

Hospital process changes:

- 1st Fill program: Provide a 3-day supply of discharge medications to contracted SNFs
- Outpatient process for scheduling of procedures
- Outpatient process for transfusions
- Nurse to nurse handoff

SNF requirements:

- Access to Epic Care Link
- Attendance at collaborative meetings
- Root cause analysis of readmitted patients

Achieved an 18% readmission reduction over the following 2 years.

Other Detroit Health Systems

• Several other Detroit Hospitals also received the full 1% readmission penalty
• Learned from SNF partners that they had also launched SNF collaboratives
• MPRO (Michigan’s Quality Improvement Organization) provided data showing 30% of the Medicare patient population was shared between the three systems:
  – Detroit Medical Center
  – Henry Ford Health System
  – St. John/Providence Health System
Beginning Stages

- Recognized that this was a community problem and not an individual hospital problem
- Recognized that we needed to address the changing landscape of health care together
- Although this is an intensely competitive market, the “people” involved had similar roles in their organization, had little risk to working together and the organizations had a lot in common
- Reviewed each hospital’s SNF initiative and identified many similarities
- Discovered each was working with most of the same SNFs

What happened next?

- Quality/care transition leaders from each health system:
  - Attended multiple common meetings and eventually met
  - Learned that:
    - Each was partnering with SNFs to improve quality and reduce readmissions
    - Each was requiring the submission of data by participating SNFs that was similar but not the same creating a burden for the SNFs
    - Shared the same patient population

Social Networking Map
Establishing the vision

• Created a partnership of cooperation and transparency
• Identified common metrics used by all three health systems
• Developed agreed upon operational definitions for each metric
• Engaged MPRO as an objective convener
• Reached out to each system’s SNF partners
• Created a charter to solidify cooperation and collaboration

History in the Making

Tri-County SNF Collaborative first came together in 2014 to:
• Align hospital and post-acute care provider goals
• Reduce duplication of efforts
• Improve quality of healthcare in Oakland, Macomb and Wayne counties

Vision: Develop and implement best practices for improving care transitions and eliminate avoidable re-hospitalizations.

Challenges

• Lack of trust between all involved
• Competition between all organizations, hospitals and SNFs
• Lack of transparency between hospitals and SNFs
• No means to collect the data in a standard way
• No objective and reliable data for verification of self-reported information
• Recognized:
  • NEEDED DATA for any hope of progress
  • Needed agreement by SNFs to submit data
Data Use Agreement

Metrics

Evolution of Metrics

Year 1 - 2015
- 2 Acuity
- 8 Transition
- 5 Quality
- 5 Readmission

Year 2 & 3 - 2016 & 2017
- 2 Acuity
- 7 Transition
- 4 Quality
- 2 Readmission

Year 4 - 2018
- 2 Acuity
- 5 Transition
- 8 Quality
- 2 Readmission

Shifting more to claims data and not self-reported
Where we are today

- Quarterly meetings with more than 130 SNFs
- Standardization of reported metrics through single portal created by MPRO
- Identification and sharing of best practices across all partners to improve care to the community we serve
- Ability to benchmark and compare quality across facilities
- Focused interventions on opportunities common to all:
  - Readmissions
  - Sepsis
  - Disease specific conditions impacted by bundling

More Partners

- All eight health systems in the metro Detroit area have recently joined
- Monthly leadership meetings for strategic planning in the region
- Beginning to attempt standardization across southeast Michigan
- Sepsis guidelines and education in SNFs
  - Standard content of education – 5 sessions
  - Weekly coaching calls
  - Metrics added to dashboard following program completion
- Universal transfer form from SNF to ED
- Expand reach of 1st Fill programs
  - Currently more than 80 SNFs participating

Lessons learned

- Difficult and heavy lift
- Challenges with data reporting from SNFs
  - Self reported data needs to be validated with paid claims
  - Sharing of data must be transparent
- Understanding different levels of care both from hospitals and SNFs
- Challenges with the alignment of goals between SNFs and hospitals:
  - Example: Low sodium diet in SNF – not required
  - Sharing of internal best practices processes with competitors
- Need for coordination of efforts across all post-acute care for condition specific interventions