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Bundled Payments for Care Improvement Initiative

Accelerated Development Learning Session # 3

Data-Driven Continuous Quality and Efficiency Improvement

Weslie Kary, Moderator

February 21, 2012

You Should Know

- Where to find the slides: http://cmmi.airprojects.org/BPCI.aspx
- The views expressed in these presentations are the views of each speaker and do not necessarily reflect the views or policies of the Centers for Medicare and Medicaid Services. The materials provided are intended for educational use and the information contained within has no bearing on participation in any CMS program.

Objectives for Accelerated Development Learning Sessions

- Support practitioners in their efforts to successfully implement bundled payment in support of the three-part aim.
- Share expert knowledge and lessons learned by early adopters.
- Set stage for continued collaborative learning during implementation.

Objectives for Care Design and Coordination Sessions

Today's session second of two in domain of care design and coordination.

- ***Data-Driven Continuous Quality and Efficiency Improvement***
- *Transform Care Today: Strategies and Tactics Across the Continuum (ADLS #2, February 14)*

Goal for both sessions is to support your efforts to achieve the three-part aim: better health, better care, and lower costs through improvement for all Americans

Agenda

- **Presentation:** *Data Considerations for Sustained Engagement,* Sid Thornton, PhD
- **Q & A** for Dr. Thornton
- **Presentation:** *Episodes of Care: Measuring and Sharing Clinical Data,* Richard G. Popiel MD, MBA
- **Presentation:** *Improving Transitions and Reducing Avoidable Rehospitalizations,* Peg M. Bradke, RN, MA
- **Q&A** for Dr. Popiel and Ms. Bradke

Presenters

Sid Thornton, PhD is a Senior Medical Informaticist with the Homer Warner Center for Informatics Research at Intermountain Healthcare in Salt Lake City, Utah. His responsibilities include interoperability among clinical and administrative systems including patient and provider registries and health information exchange. He serves as adjunct faculty to the University of Utah School of Medicine Department of Bioinformatics with research focus areas in perinatal information systems and activity-based encounter management. In 2002, he was awarded the Homer R. Warner Award from AMIA for his work in activity-based cost capture.

AIR®

Presenters

Richard G. Popiel, MD, MBA is President and COO of Horizon Healthcare Innovations, a company whose purpose is to launch new models of reimbursement and care delivery with network providers. He continues to serve as a member of the Board of Directors of Horizon Healthcare of New Jersey. Dr. Popiel has chaired both the National Council of Physician Pharmacy Executives at the Blue Cross Blue Shield Association and for the Chief Medical Officer Leadership Group at American Association of Healthplans (AHIP). He was also a member of AHIP's Board of Directors.

Dr. Popiel earned his Bachelor of Science and Doctor of Medicine degrees from George Washington University and his Masters in Business Administration from Northwestern University Kellogg School of Management in Chicago. He is Board Certified in Internal Medicine.

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Presenters

Peg M. Bradke, RN, MA, is Director of Heart Care Services at St. Luke's Hospital in Cedar Rapids, Iowa. She received her Bachelor's Degree in Nursing from Mount Mercy College and her Master's Degree in Nursing Administration from the University of Iowa College of Nursing. In her 25-year career, she has had various administrative roles in cardiac care. She currently coordinates the Heart and Vascular Service Line, including two intensive care units, two step-down telemetry units, the Cardiac Cath Lab, Electrophysiology Lab, Diagnostic Cardiology, Vascular and Interventional Lab, Respiratory Care, Cardiopulmonary Rehabilitation and the Heart Failure Clinic. Peg also serves as faculty with the Institute for Health Care Improvement (IHI) on the Transforming Care at the Bedside (TCAB) Initiative and STAAR (State Action on Avoidable Rehospitalizations Initiative).

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Data considerations for sustained engagement

Sid Thornton, PhD

Intermountain Healthcare

Homer Warner Center for Informatics Research

February 21, 2012

Having a goal of engaging providers and encouraging sustainable change…

What should I ask of my data and information services?

Thoughtful data strategies can help engage participants

Quality care translates into cost effective care

Personalized performance metrics effect change

Data and information systems can facilitate multiple QI or decision support processes

Acknowledgments

Brent James, MD

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Peter Haug, MD

Homer Warner Center for Informatics Research

Stan Huff, MD

Intermountain Healthcare, Salt Lake City, UT

Where possible, rally around the common purpose of improved care delivery

- Financial measures alone can be divisive
- Compliance drivers can be seen as top heavy

Can my care process models have both clinical, financial, and compliance variance views?

What feedback can be available in real time at the point of service?

How can it be easier to do the right thing?

- Can I give providers comparative effectiveness and projected cost when ordering?
- Can providers see patient-specific variance details when making decisions?
- Can the patient's current condition and progression be visible within modeled care process?
- Can the patient's historical compliance inform the point of service decision?

Can accountability be effectively distributed across episodes?

How does this specific encounter factor into the broader episodic goals?

Can my community establish baselines independent of organizational boundaries?

Can my community of providers agree to common benchmarks?

Can patient-provider relationships be resolved within episodes?

How can I participate in the development of performance metrics?

For example, can I create different views based on adjustment criteria?

How are outliers fairly managed?

Can my progress by tracked well in advance of action points?

Does my review and appeal have any effect?

Exceptions happen. Do I have safe and realistic bypass mechanisms

For example, I can divert novel coding scenarios to in-line terminology workflows without corrupting or distorting existing concepts.

I can mark known excursions from processes for retrospective analysis without impacting my workflow

I can document by exception.

Can I dive into the details comprising my variance?

Are my assisted computations transparent and indisputable?

For example, can I pinpoint the documented service or observation that rolls my patient into a higher acuity?

Can I see the detailed diagnostic codes of my comparison cases?

Can I forecast variance in an exploration sandbox?

Have I achieved balance between investment and empowerment?

For example, can I avoid alert fatigue?

Are my expectations realistic?

Can I expect meaningful critique and feedback?

Have I provided reasonable escape processes?

Thank you

Sid.thornton@imail.org

Horizon Healthcare Innovations
a new shade of Blue

Episodes of Care Measuring and Sharing Clinical Data

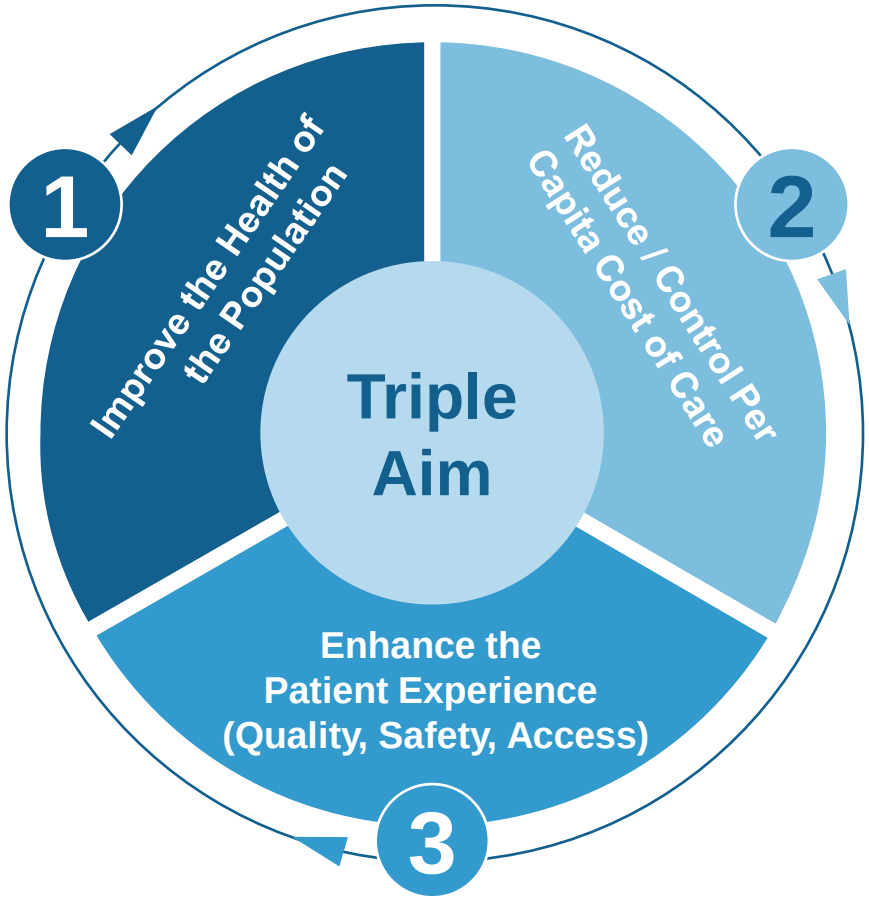
Richard G. Popiel, M.D., M.B.A
President and Chief Operating Officer
Horizon Healthcare Innovations
Tuesday, February 21, 2012

HHI Mission / Achieving the Triple Aim

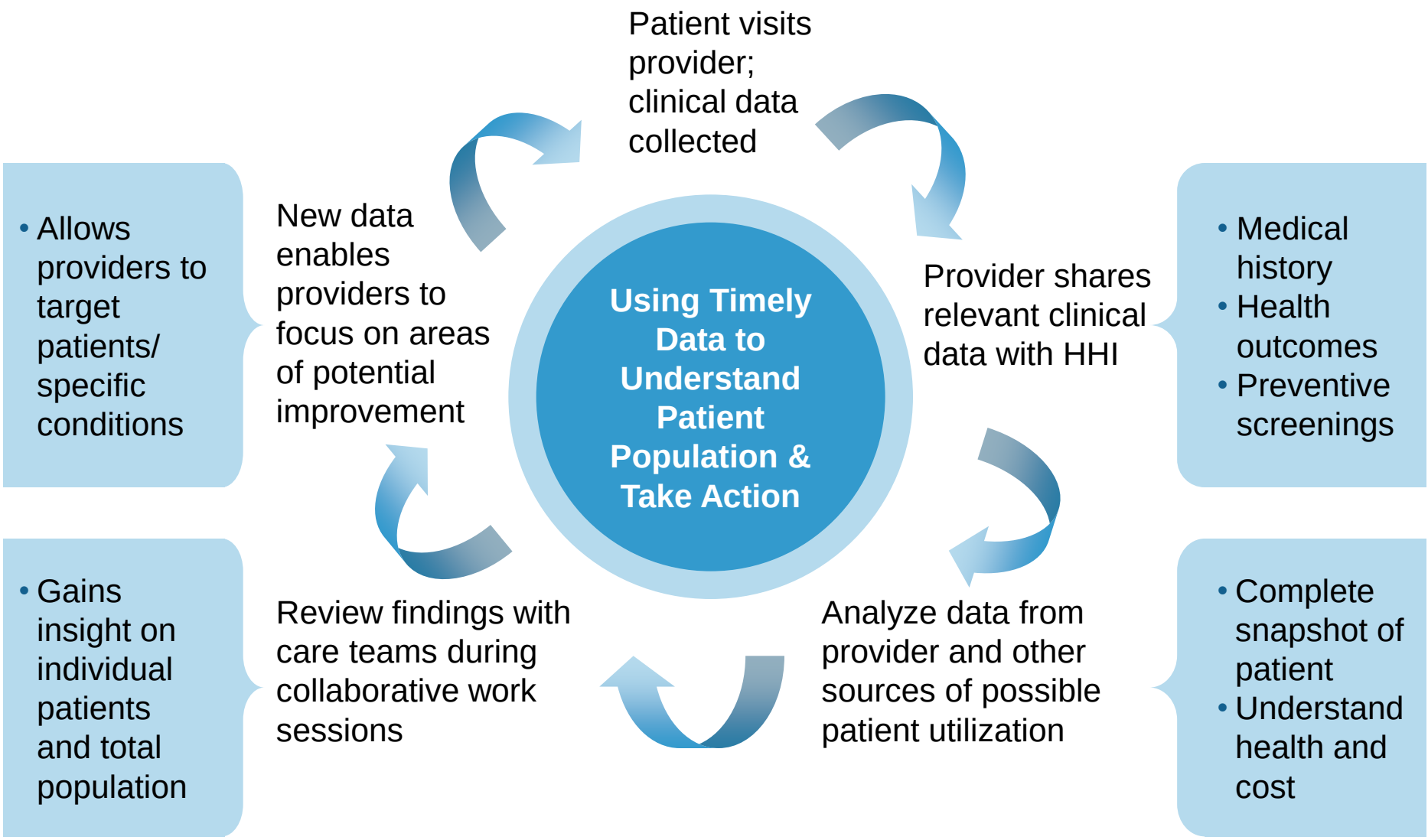
- **Horizon Healthcare Innovations -** Through **collaboration**, we are helping to create an **effective, efficient and affordable** health care system

- Subsidiary of Horizon Blue Cross Blue Shield of New Jersey

- Achieving the **Triple Aim**



Sharing Data to Improve Quality, Lower Costs



How do we measure results?

Methodology

- Cross-sectional comparison between Horizon BCBSNJ members who were, and were not, attributed to PCMH practices

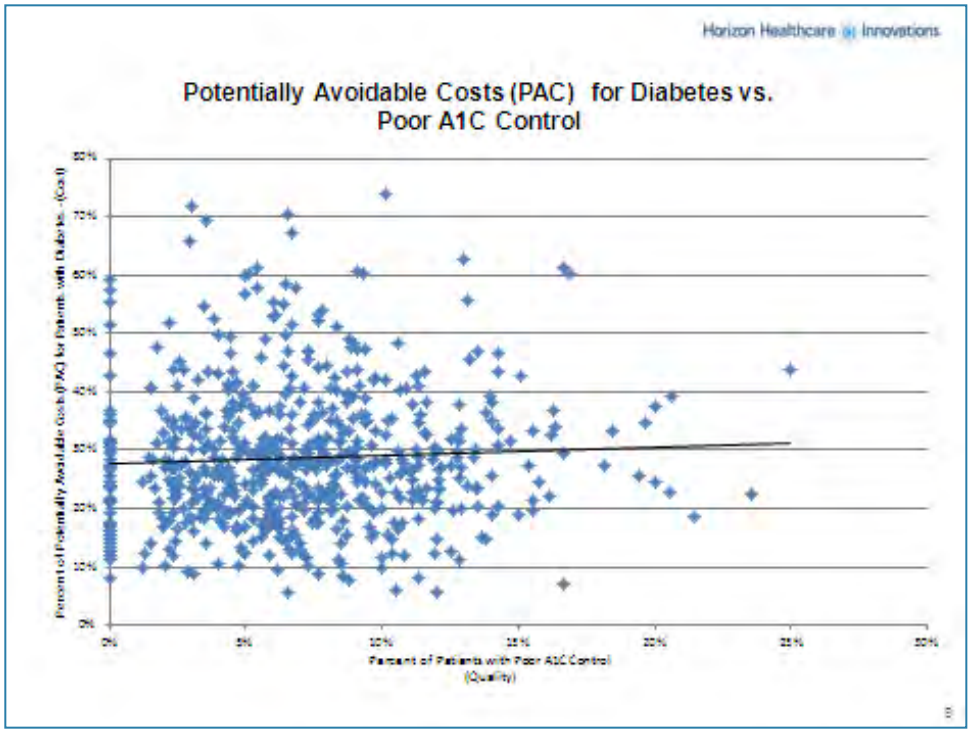
- Pre-post comparison in which pre-post changes over time among populations attributed to PCMH practices are compared with similar changes among populations who were not attributed to PCMH

- Compare actual results in the initiative against the budget for the intended population and time period

  - Statistical
  - Econometric

Statistical Measurement

- **Methodology Details**
  - We can evaluate our programs using a regression framework (which allows us to add regression controls, as needed)
  - We can also use a “difference-in-difference” framework. The coefficient on the interaction term gives us the difference-in-differences estimate of the effect



HHI Episode of Care Model Summary

Initial episodic pilot: Major joint replacements

- Partnering with orthopedic groups in New Jersey on Hip and Knee replacement episodes
- Created a Collaborative Clinical Advisory Panel (CAP)
- Phased-in reimbursement approach
- Collaboratively align on quality metrics, methods and data sharing/data validity with CAP and HCI3 (Prometheus)
- Grouper Technology
- Web-based tool to collect data
- Patient Experience Survey

Most Valuable, Most Unique Tools

Clinical Advisory Panel (CAP):

- Provided regular input into pilot design
- Variation of practices was evident
- Developed and agreed upon clinical metrics
- Encouraged idea sharing and development (e.g. same day knee replacements, complicated cases)

Web-Based Tool:

- Claims data alone is not sufficient
- Tool allows us to capture entire picture of episode
  - Data by segments (pre-surgery, surgery, and post-op)
- Since care is fragmented, tool can capture all encounters, increasing the likelihood of care coordination.

Clinical Data Reporting

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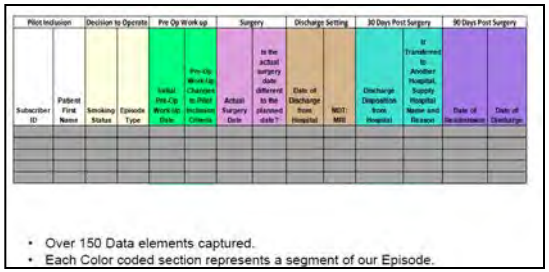
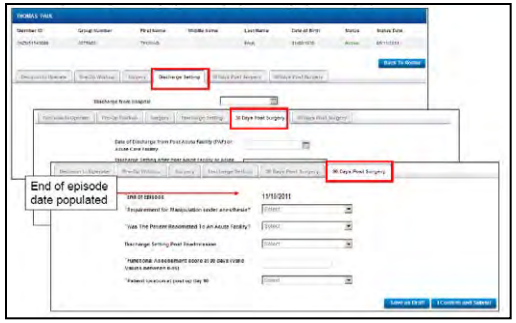
Initial Data Capture Tool

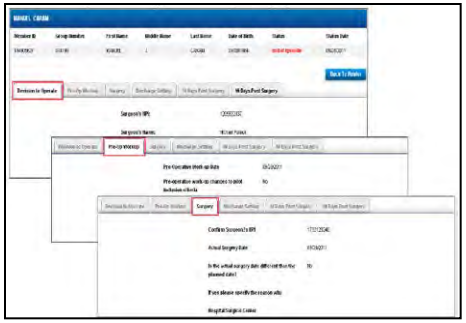


Entering Clinical Data

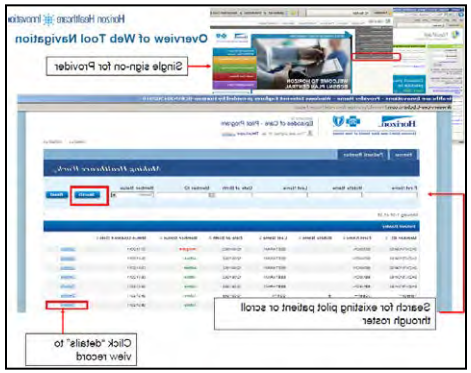
Discharge Setting- 30 days Post Surgery/90 days Post Surgery



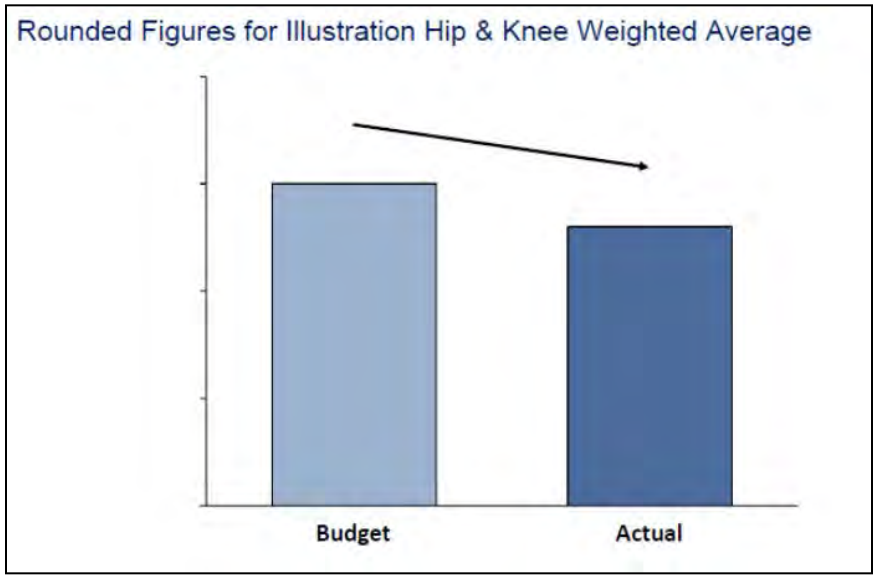
Decision to Operate-Pre-Operative Workup-Surgery



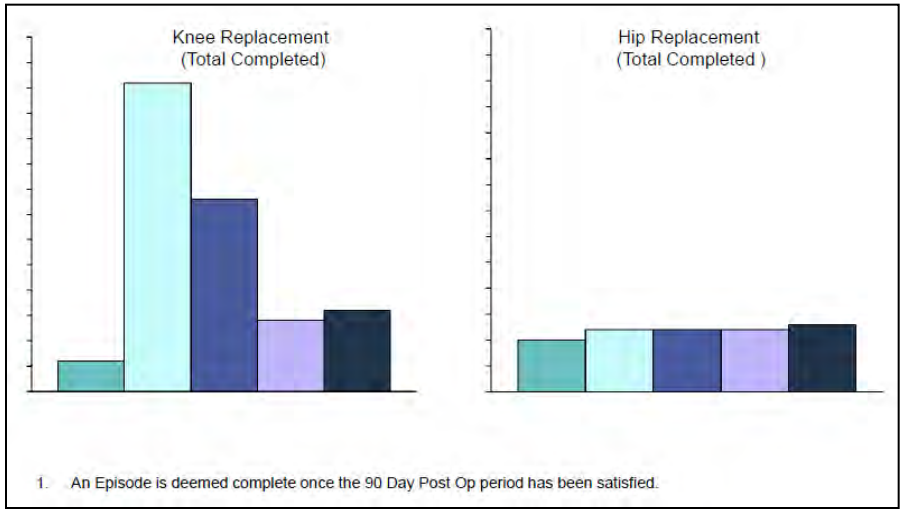
Overview of Web Tool Navigation



Preliminary Episodic Savings



Tracking Complete Episodes



Source: HHI Informatics

Monitoring EOC Clinical Data Captured

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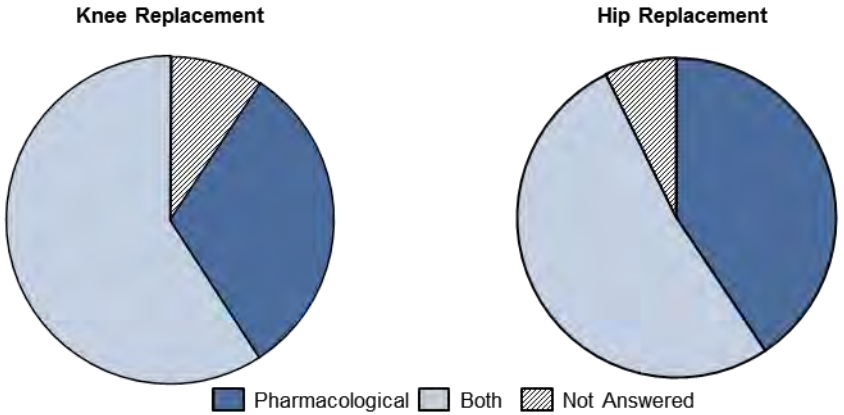
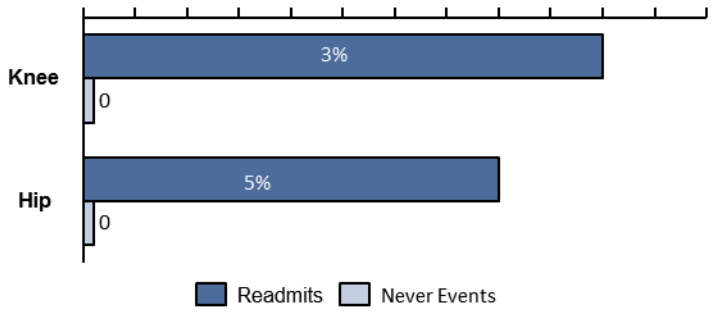
VTE Prophylaxis Rate by Surgery Type



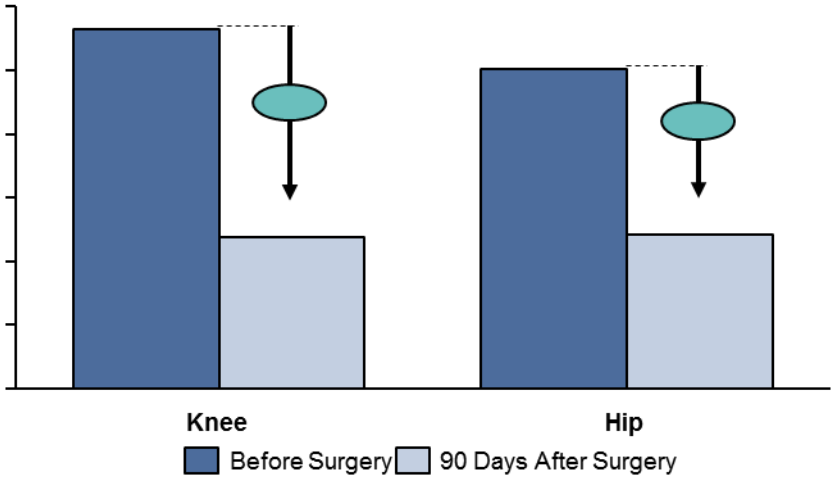
VTE prophylaxis is a clinical measure that requires 100% compliance. The measure is captured during our clinical data collection process.

Quality Measures



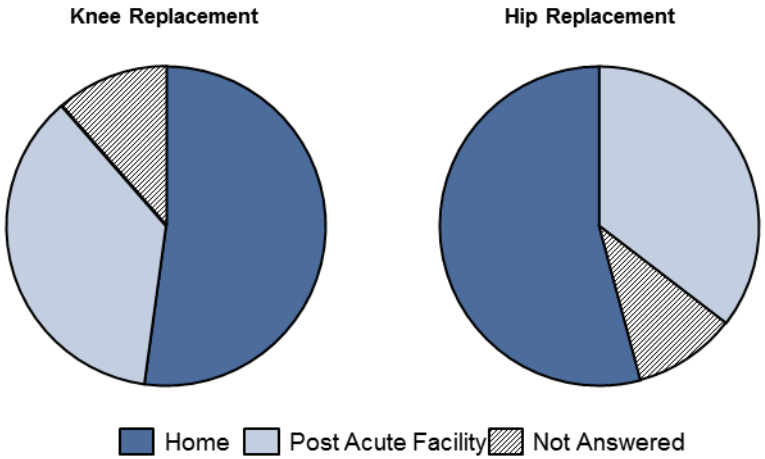
1. Claims for Surgeries with 30 Post-Op Days
2. 8 readmissions (4 Hip and 4 Knee) out of 9 are related to wound infections.

Average Change in Functional Status Score



1. Observed difference between pre-surgery and 90 days after surgery for both hip and knee are significant at p<0.0001.
2. Reduction in score indicates less pain and difficulty with activity and is desirable.
3. 80 Patients out of 279 have not reached 90 days post operation period.

Discharge Settings



Source: HHI Informatics

Actual Spend vs. Severity Adjusted Budget

ILLUSTRATIVE

Historical Average by Stage Knee					
Incurred April 2009 - March 2011					
KNEE	Pre-Operation	Surgical Stay	Post 30 Days	Post 31-90 Days	Total
n=XXX	$ 300	$ 14,200	$ 3,000	$ 2,000	$ 19,500
Percentage (Hist Avg)	1.5%	72.8%	15.4%	10.3%	100%

Under Historical Avg/Budget
Above Historical Avg/Budget

Phase I Vs History Average (KNEE n=XX)						
	Pre-Operation	Surgical Stay	Post 30 Days	Post 31-90 Days	Total	Budget
Patient A	**$ 250**	**$ 19,000**	**$ 2,300**	**$ 800**	**$ 22,350**	**$ 23,000**
% Episode Spend	1.1%	85.0%	10.3%	3.6%	100.0%	
? Historical Avg %	-16.7%	33.8%	-23.3%	-60.0%		
? Historical Avg	$ 50	$ (4,800)	$ 700	$ 1,200		$ 650
Patient B	**$ 100**	**$ 13,500**	**$ 2,000**	**$ 1,000**	**$ 16,600**	**$ 22,500**
% Episode Spend	0.6%	81.3%	12.1%	6.0%	100.0%	
? Historical Avg %	-66.7%	-4.9%	-33.3%	-50.0%		
? Historical Avg	$ 200	$ 700	$ 1,000	$ 1,000		$ 5,900
Patient C	**$ 400**	**$ 22,500**	**$ 1,500**	**$ 1,500**	**$ 25,900**	**$ 23,500**
% Episode Spend	1.5%	86.9%	5.8%	5.8%	100.0%	
? Historical Avg %	33.3%	58.5%	-50.0%	-25.0%		
? Historical Avg	$ (100)	$ (8,300)	$ 1,500	$ 500		$ (2,400)

Wave 1 – Phase I Average Implant Cost and Model Selection by HSP and Providers

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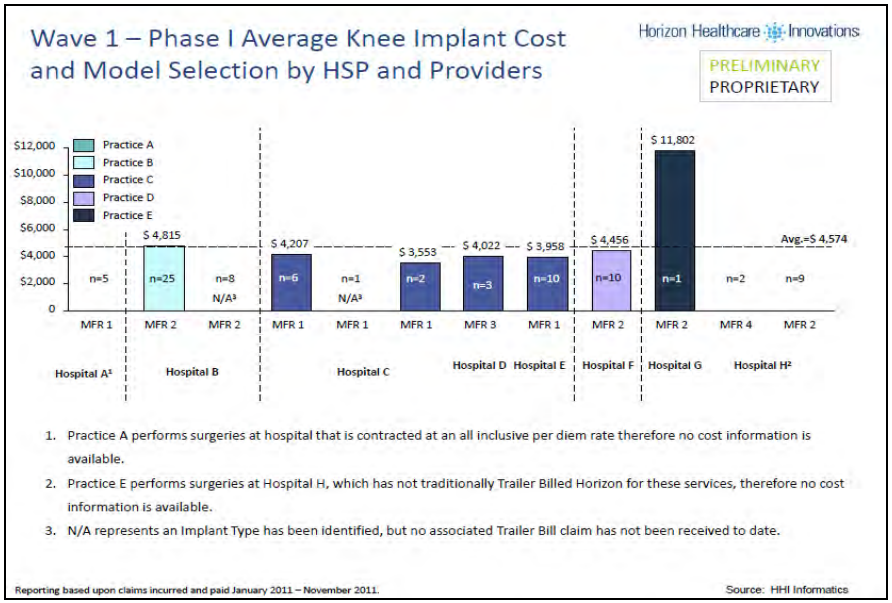
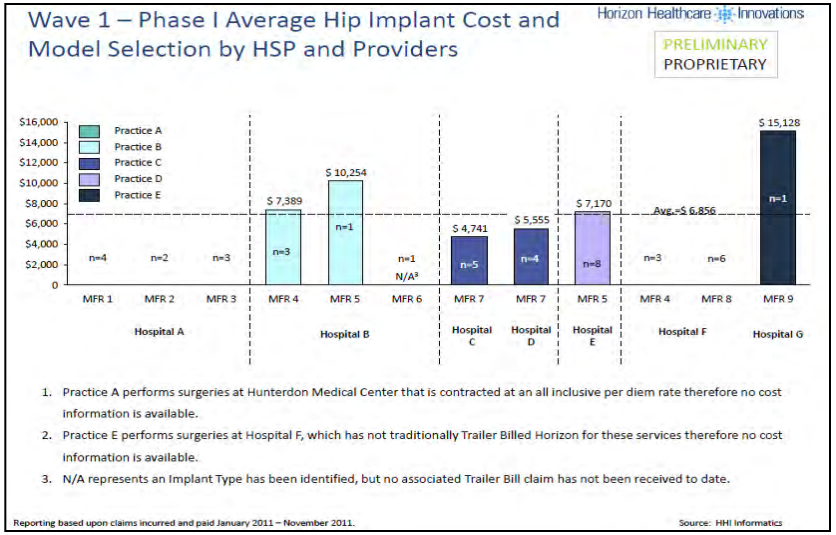


1. Practice A performs surgeries at hospital that is contracted at an all inclusive per diem rate therefore no cost information is available.
2. Practice E performs surgeries at Hospital H, which has not traditionally Trailer Billed Horizon for these services, therefore no cost information is available.
3. N/A represents an Implant Type has been identified, but no associated Trailer Bill claim has not been received to date.

Reporting based upon claims incurred and paid January 2011 – November 2011. Source: HHI Informatics



1. Practice A performs surgeries at Hunterdon Medical Center that is contracted at an all inclusive per diem rate therefore no cost information is available.
2. Practice E performs surgeries at Hospital F, which has not traditionally Trailer Billed Horizon for these services therefore no cost information is available.
3. N/A represents an Implant Type has been identified, but no associated Trailer Bill claim has not been received to date.

Reporting based upon claims incurred and paid January 2011 – November 2011. Source: HHI Informatics

Outcomes Based Payment Model

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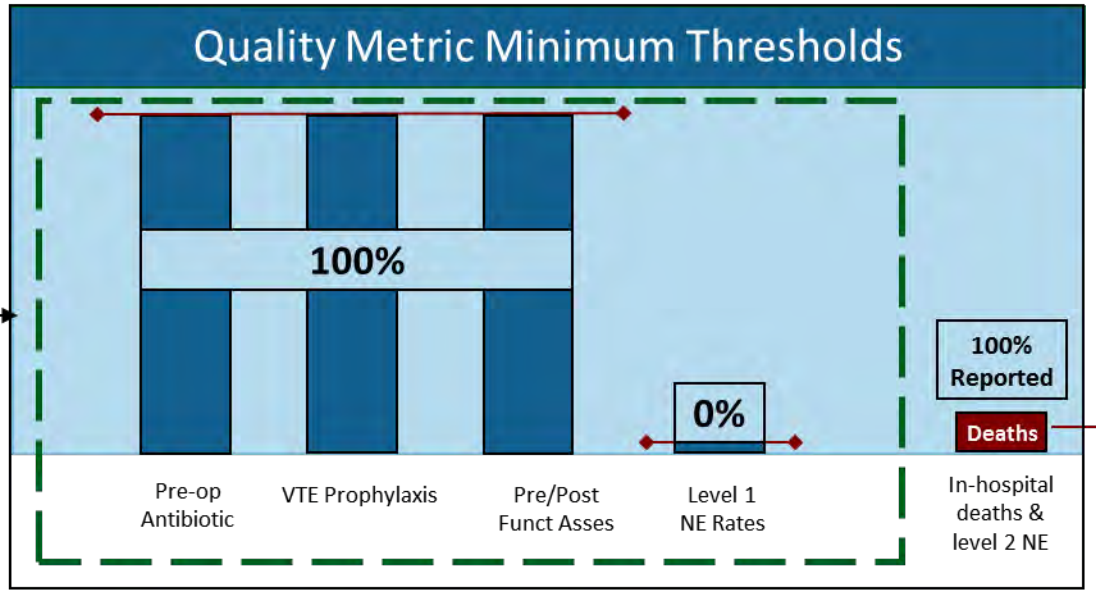
PROPRIETARY

100% Completion Data Research Submission[1]

Quality Metric Minimum Thresholds



= Target

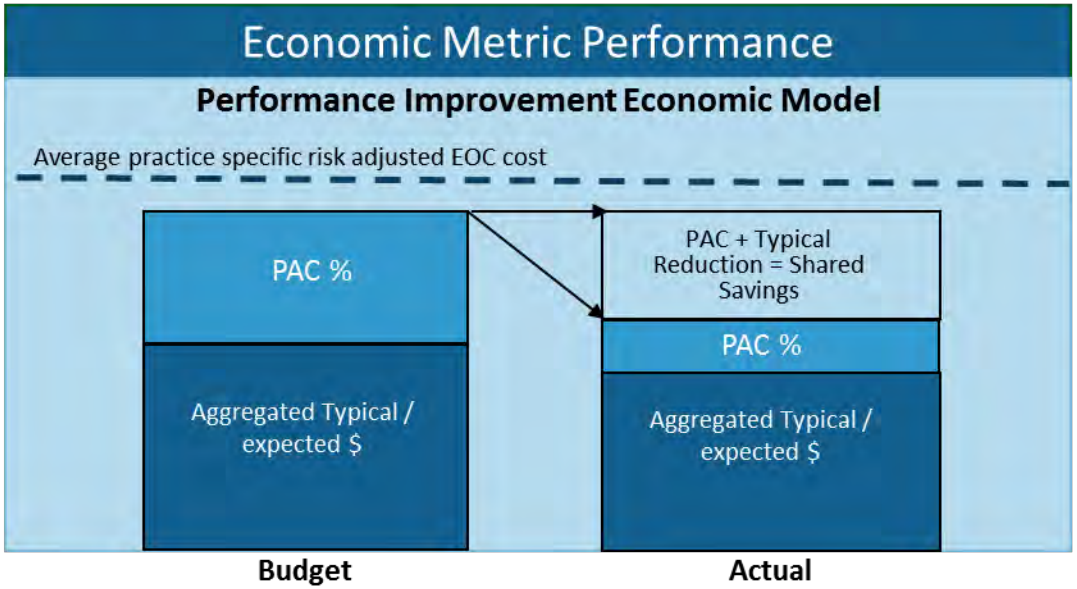
= Actual practice performance

Reviewed by Quality Committee to determine locus of control

EOC outcomes $$ payment =
(Both quality & cost targets must be met or exceeded – Hip and Knee EOC evaluated separately

Economic Metric Performance

Performance Improvement Economic Model



- Total EOC cost reduction relative to baseline EOC risk adj. total cost
- Total Cost reduction = shared savings
- Payment reconciliation conducted every 6 months
- No downside risk in phase 2

1. Practice self-reported. Additional data derived from administrative claims data

Thank You

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Improving Transitions and Reducing Avoidable Rehospitalizations

Webinar February 21, 2012

Peg M. Bradke, RN, MA

St. Luke's Hospital, Cedar Rapids, Iowa

Heart Failure Team

- Formed in 2001
- In February 2006, St. Luke's joined the RWJF/IHI TCAB Collaborative with a focus on improving discharge processes and reducing avoidable rehospitalizations.
- Initial focus was on the heart failure population with the goal of creating an "ideal" transition to home".
- In 2010, changed focus to all Core Measure patients to develop reliable processes to ensure smooth transitions and compliance with CMS Core Measures.
- Serve on faculty with State Action on Avoidable Rehospitalizations (STAAR).

Why is Reducing Avoidable Rehospitalizations Strategic for St. Luke's Hospital?

- It is part of our mission: "To give the care we would like our loved ones to receive".
- It emphasizes care must not only be "better" but "demonstrably better" in a way that is noticeable and meaningful to the patients and families.
- The work is very patient/family-centered.
- Quality is measured in two domains: clinical outcomes and patient and family experience with care.
- It represents goals that are aligned with health care reform: providing better value for decreased costs.

Need for a Paradigm Shift

Past Focus	Focus Going Forward
Traditional focus on discharging patients – a handoff *D/C to home*	Facilitating transitions in care with a shift to handover (senders and receivers co-design the process) *Admission to Home (30-day LOS)*
Hospital problem	Continuum issue
Focus is on what clinicians are teaching	Focus on what the patient is learning
Patient is the recipient of the care	Patient and defined family are essential members of the care team. Initiating a post acute plan to meet the comprehensive needs of the patient.
Immediate focus on clinical needs	Focus on the whole person and their needs within social situation over time
Focus on patient care needs in each setting	Focus on the patient's experience over time

Critical Capabilities for Care Redesign Include:

- Cross-continuum participation and alignment
- The development and use of standardized tools and compatible information infrastructure
- Horizontal Leaderships and executive sponsorship; and
- Effective external and internal learnings

Cross Continuum Team Membership

- Day-to-day Leader
- Patients and family members
- Hospital clinicians and staff
  - Pilot units frontline, managers and case managers
  - Emergency Department
  - Palliative Care
  - Pharmacy
  - Cardio-Pulmonary Rehab
  - Hospitalists/PCPs
- Supporting staff (QI, IT, Finance, etc.)
- Clinical and administrative staff and/or leaders from the community
  - Skilled/long-term care nursing facilities
  - Office practice settings
  - Home health
  - Community or Public Health Services

Cross-Continuum Team

- Meets every other week to assess causes and opportunities for improvement.
- By including participants across the continuum of care and breaking down barriers to honest and candid communication, the team begins to construct a comprehensive picture of how and why readmissions occurred.
- Reviews process and outcome measures.
- Continually makes improvements, aggregating the experiences of patients, families and caregivers.
- Work gains executive sponsorship and support.

Cross-Continuum Teams

- One of the most transformational changes in the STAAR Collaborative
- Reinforces that readmissions are not solely a hospital problem
- Need for involvement at two levels:
  1. At the executive level to remove barriers and develop overall strategies for ensuring care coordination
  2. At the front-lines - power of "senders" and "receivers" co-redesigning processes to improve transitions of care
- New competencies in partnering across care settings will be a great foundation for integrated care delivery models. Secondary objectives come into focus: develop data analytics, performance improvement, clinical integration, and other competencies critical for additional value-based reforms.

Diagnostic Reviews

- Recommend that teams complete a formal review of the last five readmissions every six months (chart review and interviews).
- Members from the cross continuum team hear first-hand about the transitional care problems “through the patient’s eyes”.
- Engages the “hearts and minds” of clinicians and catalyzes action toward problem-solving.
- Opportunities for learning from reviewing a small sampling of patient experiences are innumerable.

Diagnostic Review Questions

Patients and Family Caregivers:

- *What do you think caused you to be readmitted to the hospital?*
- *Did you see a physician in his/her office before you came back to the hospital? If not, why not?*
- *Has anything gotten in the way of your taking your medicines?*
- *How do you take your medicines and set up your pills each day?*
- *Describe your typical meals since you got home.*

Care Team Providers in the Community:

- *What do you think caused this patient to be readmitted?*

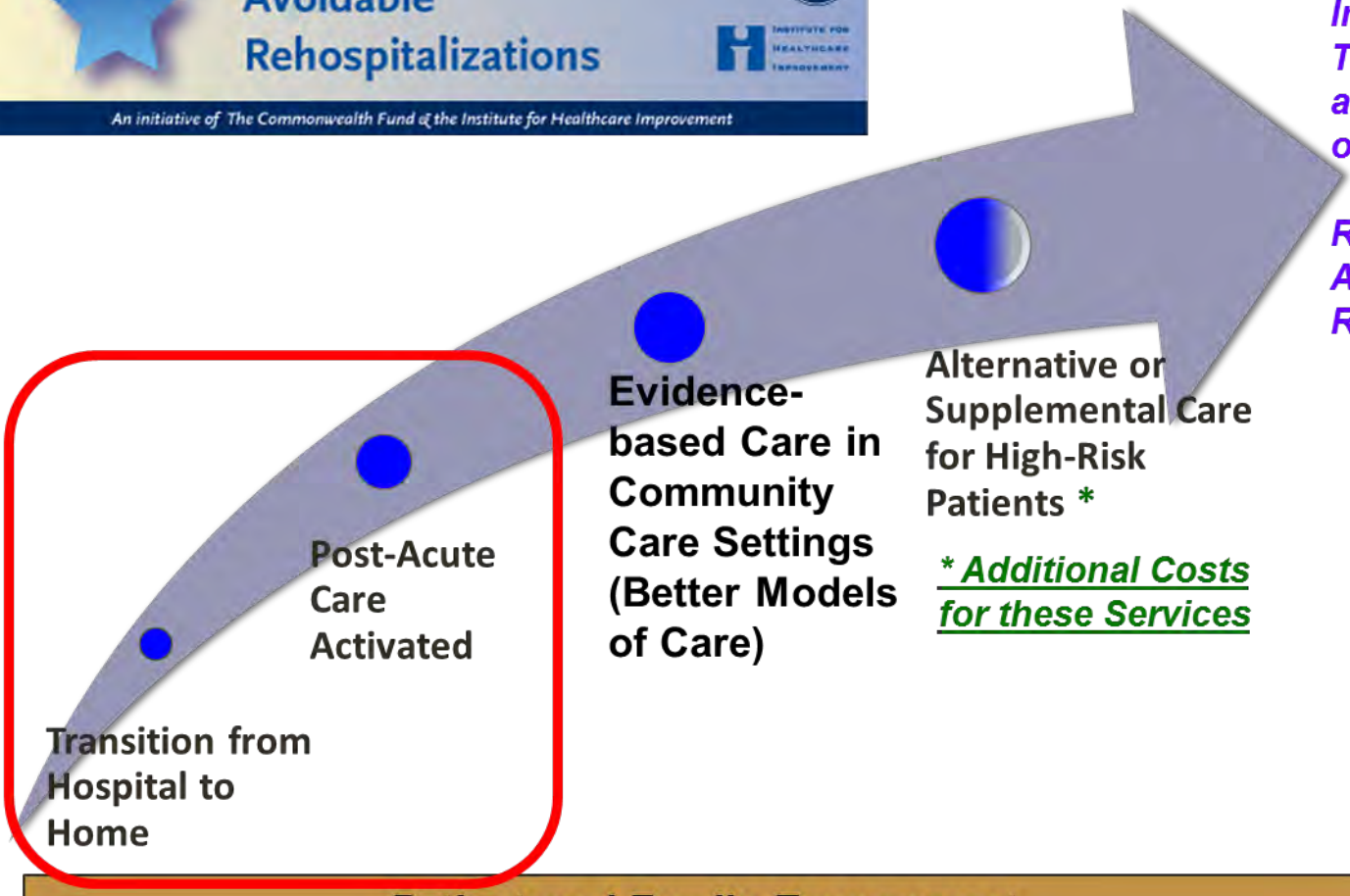
State Action on Avoidable Rehospitalizations (STAAR) Initiative

The Commonwealth Fund-supported initiative to reduce avoidable 30-day rehospitalizations, taking states as unit of intervention.

- May 2009 - launch of the anticipated four-year initiative
- Institute for Healthcare Improvement providing technical assistance and facilitating a learning system
- Multi-stakeholder coalitions in three states selected as partners in this initiative (Massachusetts, Michigan, Washington); Ohio is a self-funded participant
- Approximately 150 hospitals in partnership with more than 500 community-based organizations are engaged in STAAR

STate Action on Avoidable Rehospitalizations

An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement



Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans

Heart Failure Continuum of Care

- Standardized care through order sets
- Patients identified via BNP and IV diureutic daily reports
- Teaching
  - Utilizing Universal Health Literacy Concepts
  - Enhanced teaching materials
  - Teach Back
- Touch points
  - Home Care: Care coordination visit 24 to 48 hours post discharge
  - Hospital-based Heart Failure Clinic visit in 3-5 days with subsequent visits established with clinic and PCP based on needs of each individual
  - Follow-up phone call on post discharge at 5-9 days
  - Outpatient Heart Failure class

Co-designing Processes to Improve Transitions

Hospitals

- Perform an enhanced assessment of post-hospital needs
- Provide effective teaching and facilitate enhanced learning
- Ensure post-hospital care follow-up
- Provide real-time handover communications

Office Practices

- Provide timely access to care following a hospitalization
- Prior to the visit: prepare patient and clinical team
- During the visit: assess patient and initiate new care plan or revise existing plan
- At the conclusion of the visit: communicate and coordinate ongoing care plan

Home Care

- Meet the patient, family caregiver(s), and inpatient caregiver(s) in the hospital and review transition home plan
- Assess the patient, initiate plan of care, and reinforce patient self-management at first post-discharge home care visit
- Engage, coordinate, and communicate with the entire clinical team

Skilled Nursing Facilities

- Ensure that SNF staff are ready and capable to care for the resident patient's needs
- Reconcile the Treatment Plan and Medication List
- Engage the resident and their family or caregiver in a partnership to create an overall place of care
- Obtain a timely consultation when the resident's condition changes

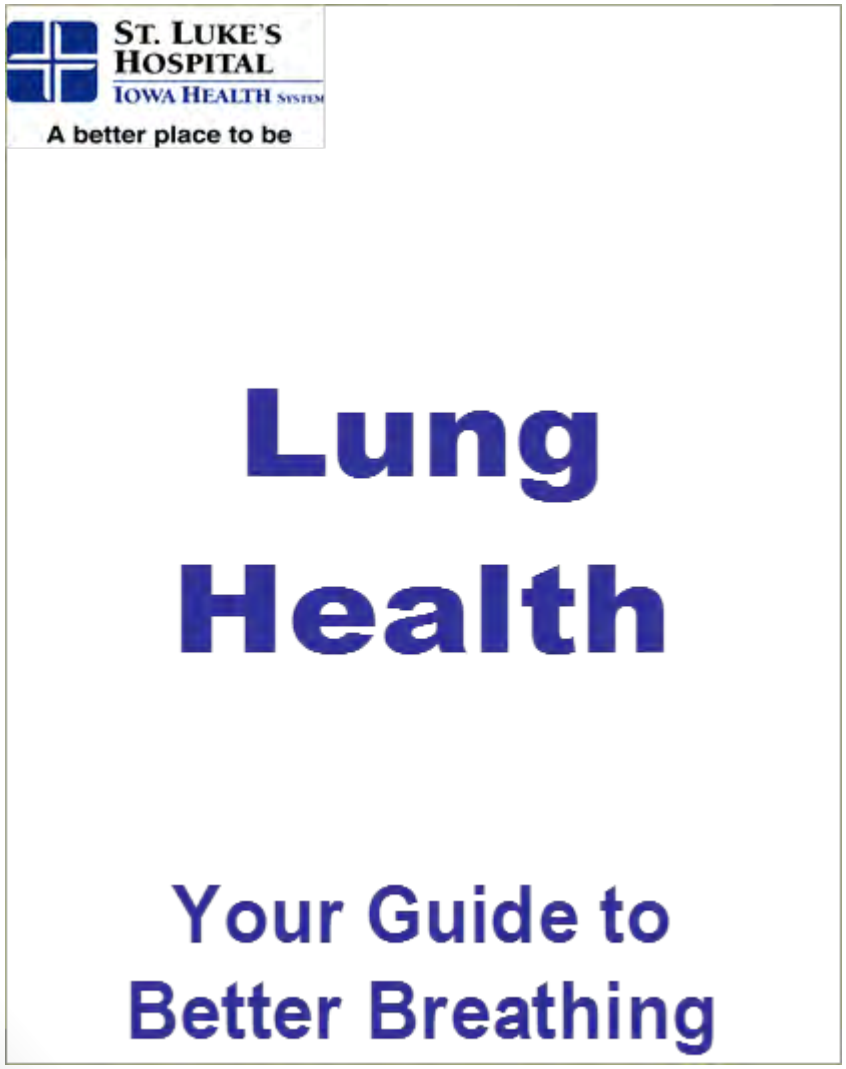
Enhanced Admission Assessment

- During Admission Assessment, the patient and family are asked, “Who would you like to have present when we provide your discharge information?”
- Medication Reconciliation: At times, the pharmacy or physician offices need to be called to get additional information. If the patient is a home care patient, the home care agency is called to get the current list of medications.
- Completing a comprehensive assessment requires additional time and care coordination (roles and responsibilities need to be designated, and standard work processes need to be developed)
- Role of Palliative Care

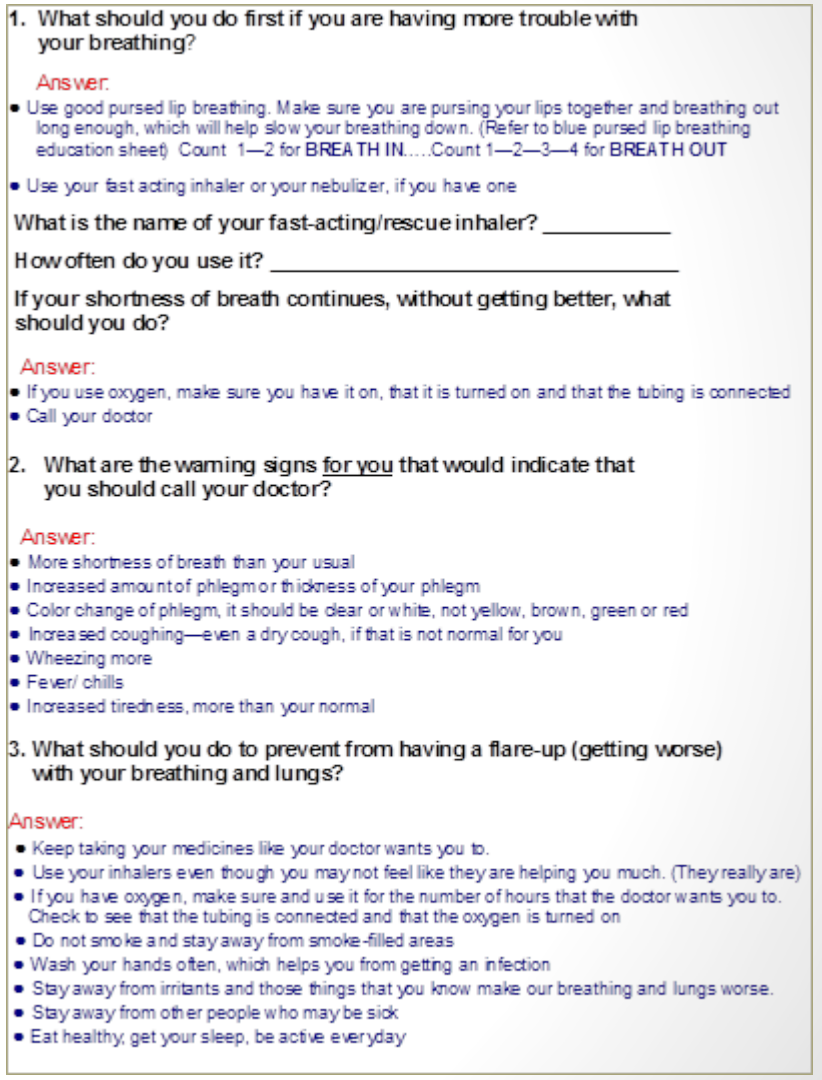
Enhanced Teaching and Learning

- The patient education materials facilitate the use of teachback, and the same materials are used across the continuum: in the hospital, with home care, long-term care settings and the clinic.
- Teachback - the process of asking patients to recall and restate in their own words what they have been taught - was incorporated at the patient's bedside during the 24-48 hour post-discharge follow-up visit by Home Health and in the seventh day post-discharge phone call to the patient.
- Teachback question part of packet for staff and patient reference
- Patients and families are given a 12-month calendar for Heart Failure

Lung Packet Contents



Cover page



1. What should you do first if you are having more trouble with your breathing?

Answer:

- Use good pursed lip breathing. Make sure you are pursing your lips together and breathing out long enough, which will help slow your breathing down. (Refer to blue pursed lip breathing education sheet) Count 1—2 for BREATH IN.....Count 1—2—3—4 for BREATH OUT
- Use your fast acting inhaler or your nebulizer, if you have one

What is the name of your fast-acting/rescue inhaler? _____

How often do you use it? _____

If your shortness of breath continues, without getting better, what should you do?

Answer:

- If you use oxygen, make sure you have it on, that it is turned on and that the tubing is connected
- Call your doctor

2. What are the warning signs for you that would indicate that you should call your doctor?

Answer:

- More shortness of breath than your usual
- Increased amount of phlegm or thickness of your phlegm
- Color change of phlegm, it should be clear or white, not yellow, brown, green or red
- Increased coughing—even a dry cough, if that is not normal for you
- Wheezing more
- Fever/ chills
- Increased tiredness, more than your normal

3. What should you do to prevent from having a flare-up (getting worse) with your breathing and lungs?

Answer:

- Keep taking your medicines like your doctor wants you to.
- Use your inhalers even though you may not feel like they are helping you much. (They really are)
- If you have oxygen, make sure and use it for the number of hours that the doctor wants you to. Check to see that the tubing is connected and that the oxygen is turned on
- Do not smoke and stay away from smoke-filled areas
- Wash your hands often, which helps you from getting an infection
- Stay away from irritants and those things that you know make our breathing and lungs worse.
- Stay away from other people who may be sick
- Eat healthy, get your sleep, be active everyday

Inside

Heart Failure Magnet

Heart Failure Zones

EVERY DAY	**Every day**: • Weigh yourself in the morning before breakfast and write it down. • Take your medicine the way you should. • Check for swelling in your feet, ankles, legs and stomach • Eat low salt food • Balance activity and rest periods **Which Heart Failure Zone are you today? Green, Yellow or Red**
GREEN ZONE	**All Clear** **This zone is your goal** Your symptoms are under control You have: • No shortness of breath • No weight gain more than 2 pounds (it may change 1 or 2 pounds some days) • No swelling of your feet, ankles, legs or stomach • No chest pain
YELLOW ZONE	**Caution** **This zone is a warning** Call your doctor's office if: • You have a weight gain of 3 pounds in 1 day or a weight gain of 5 pounds or more in 1 week • More shortness of breath • More swelling of your feet, ankles, legs, or stomach • Feeling more tired. No energy • Dry hacky cough • Dizziness • Feeling uneasy, you know something is not right • It is harder for you to breathe when lying down. You are needing to sleep sitting up in a chair
RED ZONE	**EMERGENCY** **Go to the emergency room or call 911 if you have any of the following:** • Struggling to breathe. Unrelieved shortness of breath while sitting still • Have chest pain • Have confusion or can't think clearly

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COPD Action Plan

Which zone are you in today? Green, Yellow or Red		For You to Do
Green Zone	**All Clear - You are feeling well** ▪ Your breathing is normal for you ▪ The color of your phlegm is clear or white ▪ You can do your normal activities without unusual tiredness or shortness of breath ▪ Your appetite is good ▪ You are sleeping like you normally do ▪ You can think clearly	▪ Take your daily medicines as prescribed by your doctor, even if you are feeling good ▪ Eat healthy foods. ▪ Be active every day (get up and do things) Include some exercise, like walking, in your daily routine ▪ Balance your activity with some rest periods ▪ **Use Pursed Lip Breathing** ▪ Do not smoke. Make your home and car smoke free. Stay away from smoke areas.
Yellow Zone	**Caution - You are feeling worse** ▪ You are more short of breath. You are wheezing or coughing more than usual ▪ You have unexplained changes in your weight ▪ You have more swelling in your feet, legs or ankles ▪ You notice changes in your phlegm (thicker, color, amount) ▪ You are using your rescue inhaler(the fast acting one) or your nebulizer more often than usual ▪ You are more tired and can not do your usual activities ▪ You have a fever and chills ▪ You are sleeping poorly. Your symptoms wake you up.	▪ Limit your activities ▪ Check your oxygen system to make sure it is working correctly ▪ Make sure you have been taking your medicines Have you forgotten any today? ▪ **Use Pursed Lip Breathing** ▪ Call your doctor if your weight gain is 3 pounds in one day OR if you have a weight gain of 5 pounds or more in 1 week. ▪ Eat smaller meals more often during the day rather than 3 big meals in a day. ▪ Use your nebulizer or rescue inhaler (fast acting one), as prescribed by your doctor. ▪ **Call your doctor if your symptoms don't improve. Don't wait longer than 2 days**
Red Zone	**Emergency - You feel you are in danger** ▪ You have severe shortness of breath (You feel like you cannot breathe or catch your breath while resting) ▪ You have chest pain ▪ You feel faint ▪ You are more sleepy and have difficulty staying awake ▪ You feel confused or are very drowsy. ▪ Your speech is slurred ▪ You have bluish color to your lips or fingernails.	**Call 911 or go the hospital Emergency Room**

Low Sodium Eating Plan

2000mg Sodium

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Low Sodium Eating Plan

2,000mg Sodium

Salt is also called "sodium" and is found in most foods you eat.

Why do you need to limit sodium in your diet?

Sodium acts like a sponge and makes your body hold onto water. Eating too much sodium can cause you to gain weight, make your legs swell, and cause water to collect in your lungs.

How much sodium can you have each day?

Doctors recommend that you eat less than 2000mg of sodium each day. This means taking the salt shaker off of your table and paying attention to the types of foods you eat.

The First Steps…

1. Do not add salt to foods when you cook or at the table
2. Use herbs and seasonings like Mrs. Dash that are sodium free
3. Start with fresh foods
4. Do not use instant foods that come in a can, bag, or box

Eat Less Added Salt

Choose this:

Mrs. Dash
Spices
Herbs
Lemon Juice
Hot Sauce
Fresh Garlic, Onion, Green Pepper
Ketchup labeled "**No Salt Added**"
Onion Powder
Garlic Powder
Oil and Vinegar
Pepper

Do not choose this:

Salt
Seasoning Salts
Meat tenderizer
Soy Sauce
Garlic Salt
Bottled Salad Dressing
Olives
Relishes
Cheese Sauce
Sea Salt
Mustard
Ketchup
BBQ Sauce
Onion Salt
Bouillon
Sauerkraut
Pickles
Onion Soup Mix

Weigh yourself everyday.
Compare to the day before .
Have you gained weight?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 My Weight	2 My Weight	3 My Weight	4 My Weight	5 My Weight
6 My Weight	8 My Weight	8 My Weight	9 My Weight	10 My Weight	11 My Weight	12 My Weight
13 My Weight	14 My Weight	15 My Weight	16 My Weight	17 My Weight	18 My Weight	19 My Weight
20 My Weight	21 My Weight	22 My Weight	23 My Weight	24 My Weight	25 My Weight	26 My Weight
27 My Weight	28 My Weight	29 My Weight	30 My Weight	31 My Weight		

- **Always carry a list of your medications.**
- **Keep the list up to date.**
- **Don't run out of medicine.**
- **Keep them refilled.**

Strengthen your arms by lifting 2 or 3 pound hand weights while watching TV!

If you don't have hand weights, you can use cans of soup, a bag of dried beans or an empty milk jug filled with some sand.

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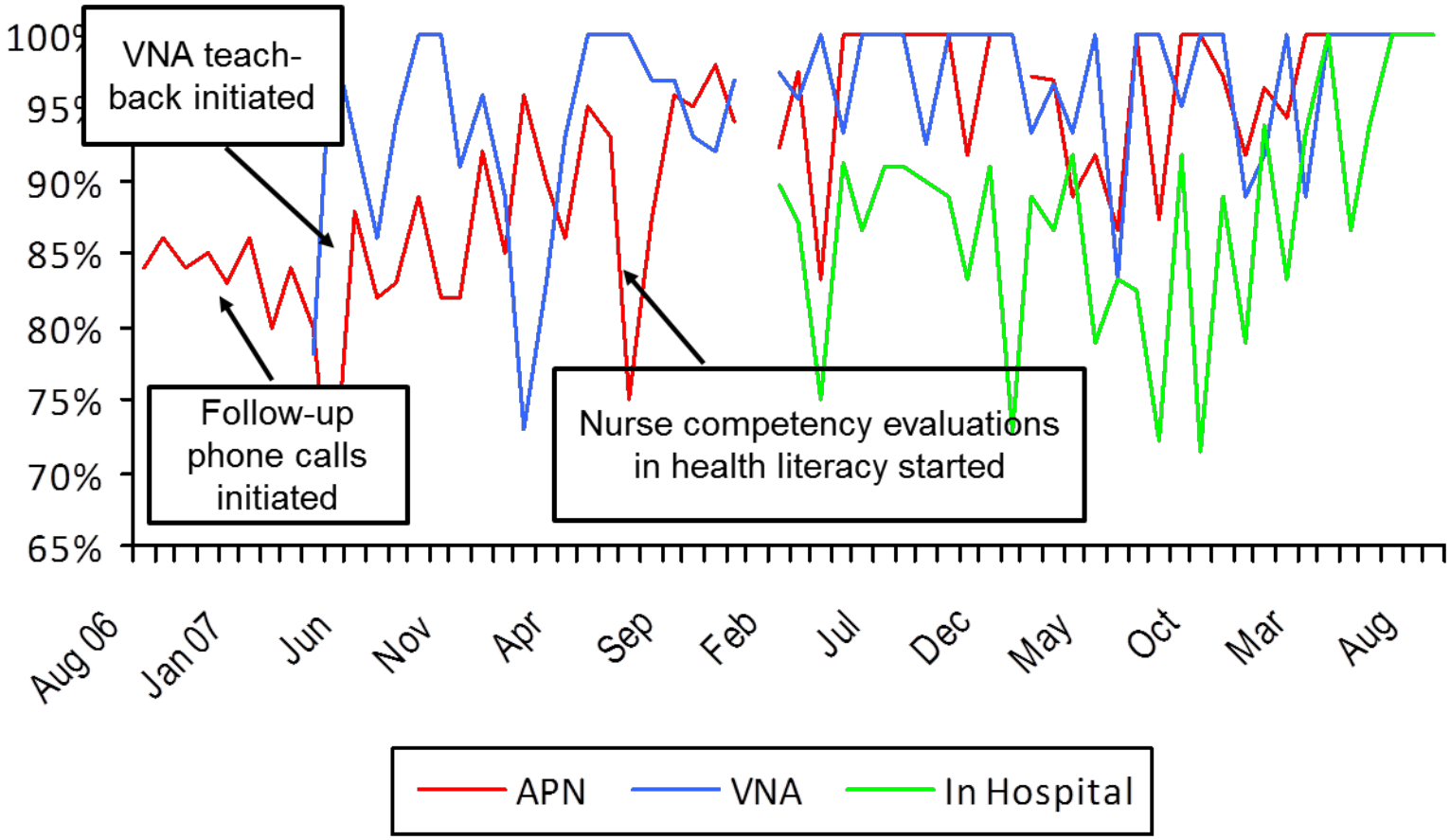
Teachback with Discharge Instructions

- Can you show me on these instructions:
  - How you find your doctors' office appointment?
  - What other tests you have scheduled and when?
- Is there anything on these instructions that could be difficult for you to do?
- Have we missed anything?

Successful Teachback Rate
Aug 06 – Sep 11



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Real-time Handover Communications

- St. Luke's partnered with the hospital's home care agency (VNA) and two long-term care facilities to standardize and enhance the quality of the handoff communication process. Warm handover with those patients with complex issues.
- Provided education for home care and long-term and skilled care RNs and CNAs on HF and continuity process. CNAs often observe symptoms.
- Provided the receiving nursing home facilities with the patient education packet.
- Designed standardized handover forms ("senders" and "receivers" agree upon the information and design reliable processes)

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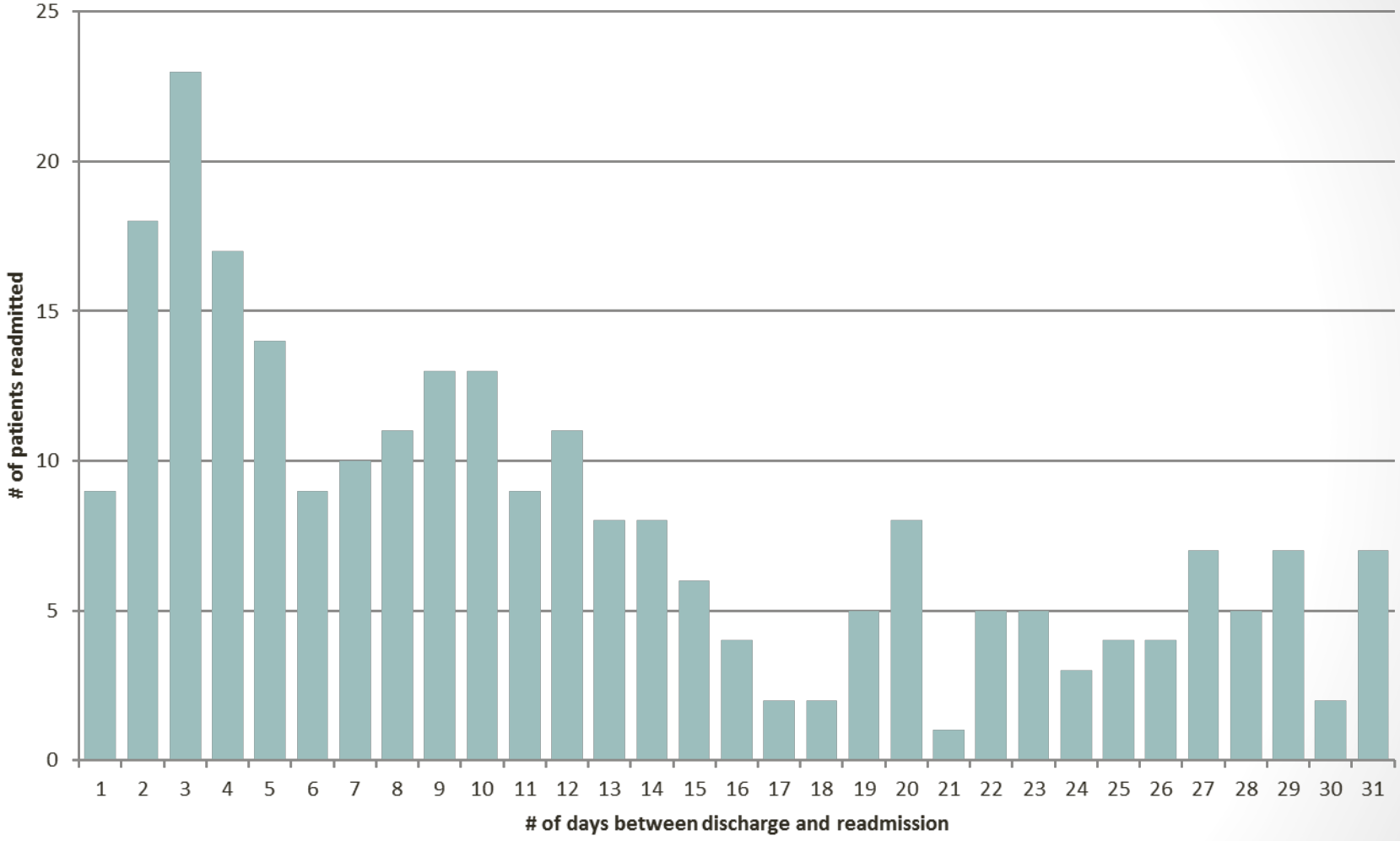
Post-Acute Care Follow-Up

- Home Care Visit set up for 24-48 hours after discharge. Home Care liaison in-house.
- Follow-up phone calls designated and share based on service. Same teachback questions utilized in hospital also used in calls to determine the patient and/or caregiver understanding of critical self-care management.
- Partnership with physicians' offices resulted in redesign of scheduling HF visits to allow office visits within 3 to 5 days for all patients with HF in HF Clinic. HF Clinic also provides visits in the nursing facilities. Subsequent appointments established with Clinic, PCP or specialist based on patient's assessment and need.

Number of Days after Discharge Patients are Readmitted



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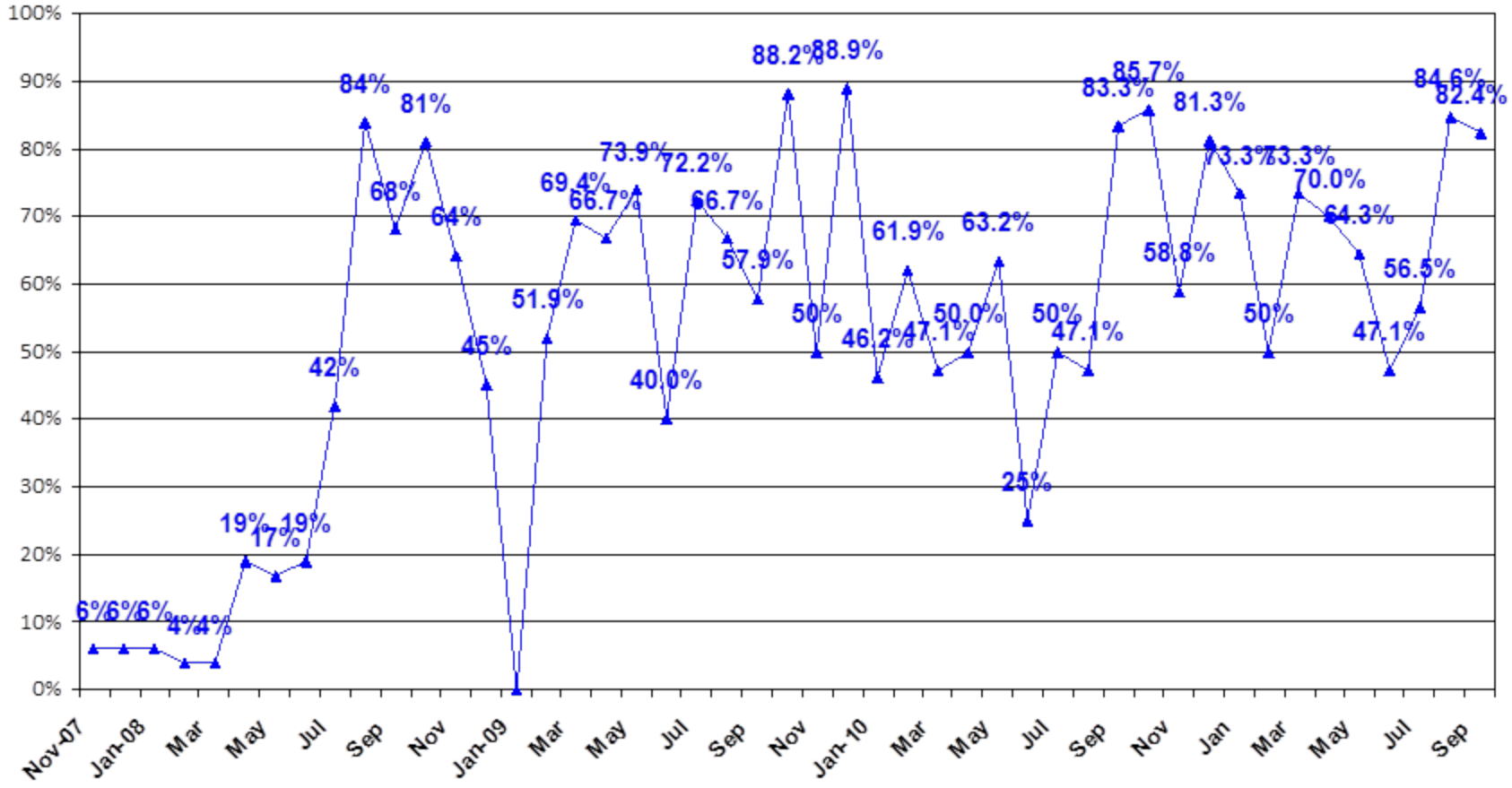
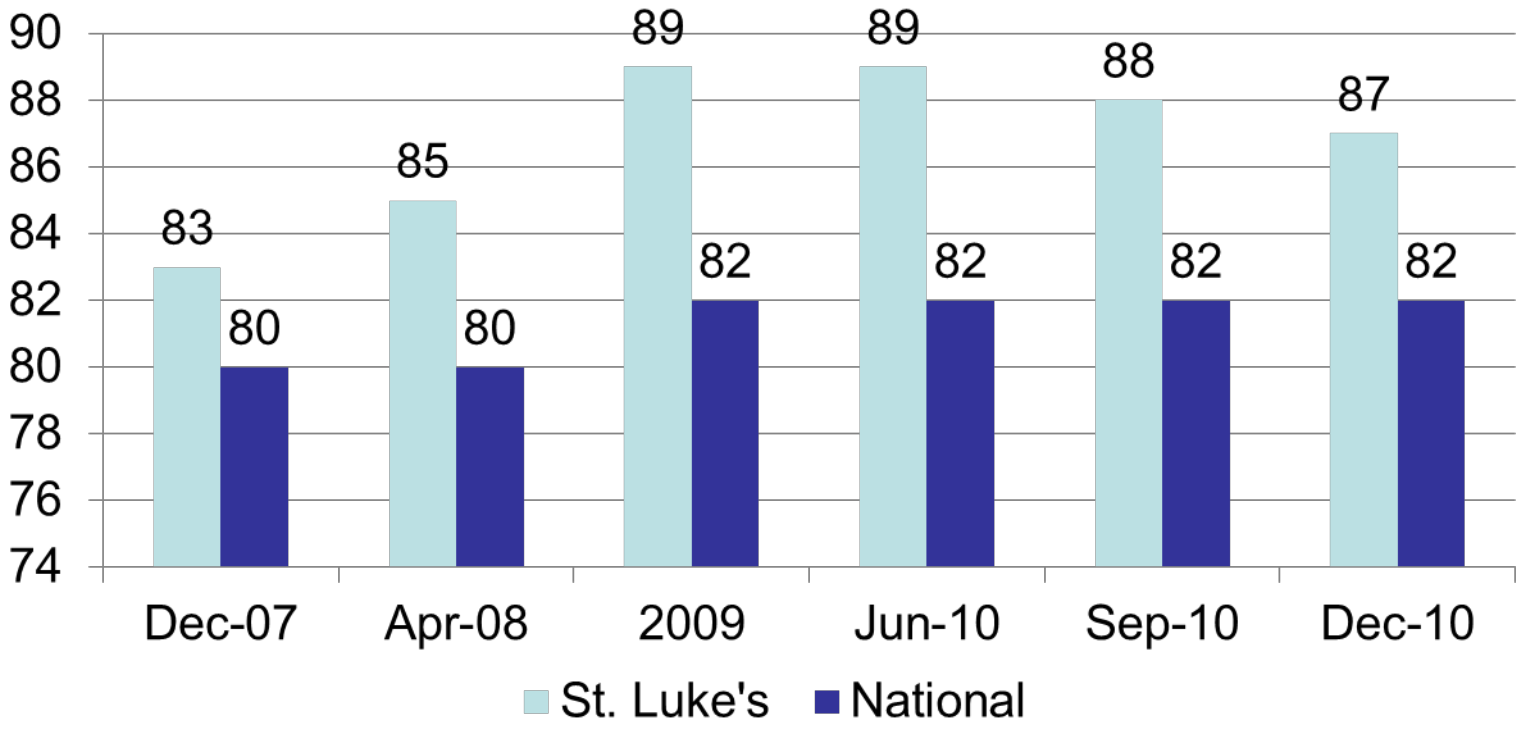
Three to Five-Day Follow-up (Nov 07 – Sep 11)

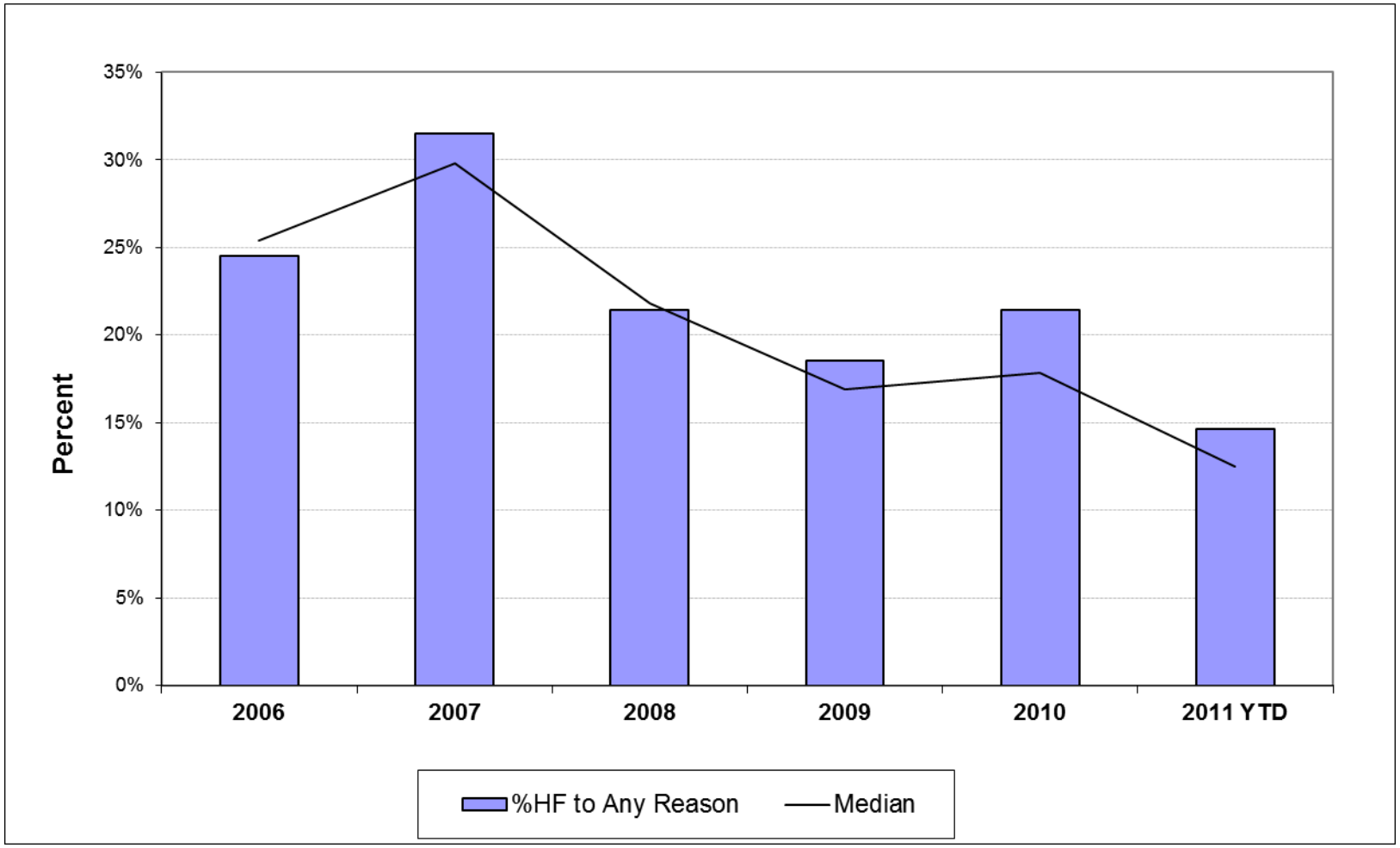


HCAHPS RESULTS
DISCHARGE INFORMATION (% Yes)



#19 During hospital stay, did doctors, nurses or other hospital staff talk about whether you would have the help you needed when you left the hospital?
#20 During the hospital stay, did you get the information in writing about what symptoms or health problems to look out for after you left the hospital?

Heart Failure Readmissions (for Any Cause) within 30 Days



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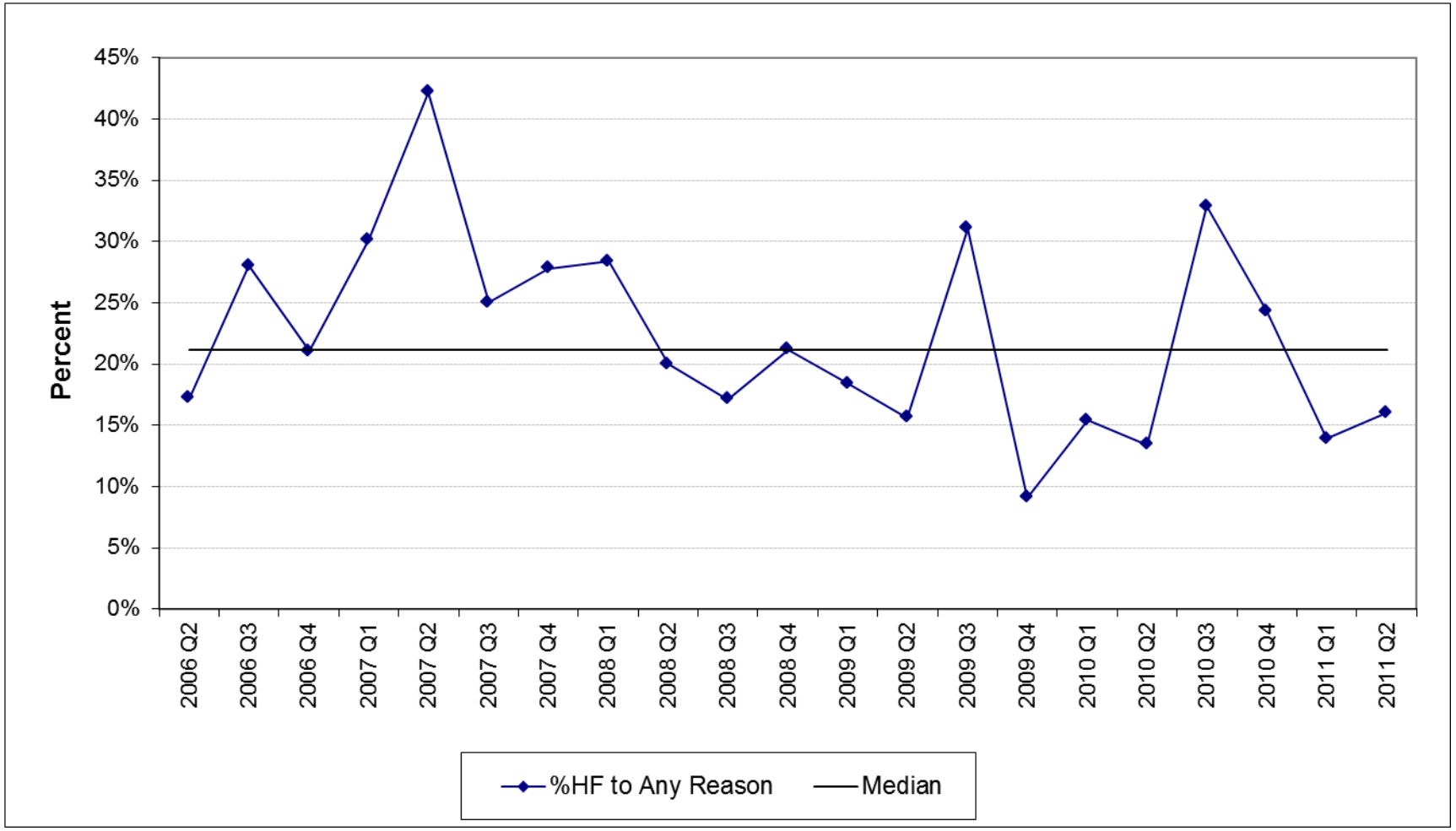
Heart Failure Readmissions (for Any Cause) within 30 Days



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Analysis of Results to Date

- Reducing readmissions is dependent on highly functional cross-continuum teams and a focus on the patient's journey over time.
- Explicit focus on patient and family-centered work.
- Importance of engaged Executive Leadership and Physician Leadership.
- Improving transitions in care requires co-design of transitional care processes among "senders and receivers". Frontline clinicians and staff involvement in developing the process improvements.
- Stories are as important as data.
- Providing intensive care management services for targeted high-risk patients is critical.
- Reliable implementation of changes in pilot units or pilot populations requires 18 to 24 months.
- Information Technology design is part of the work.

Barriers to Improving Care Transitions and Reducing Rehospitalizations

- Cost of copayments for medications and follow-up visits.
- Lack of coverage for home health services if patients did not meet Medicare's "home-bound" requirements.
- Lack of reimbursement for transitional care services such as post-discharge phone calls, coaches and dedicated clinicians to provide extra support for patients and family caregivers.
- Limitations of the electronic medical record to capture and transmit information.
- Access to physician offices for follow-up visits.
- Complexity of patients with multiple co-morbidities.
- Challenges to completing reliable medication reconciliation.

Opportunities

- Rehospitalizations are ***frequent, costly and many are avoidable;***
- Successful pilots, local programs and research studies demonstrate that rehospitalization rates ***can be reduced;***
- Individual successes exist ***where financial incentives are aligned;***
- Improving transitions state-wide requires ***action beyond the level of the individual provider; systemic barriers*** must be addressed;
- ***Leadership at the provider, association, community and state levels are essential assets*** in a state-wide effort to improve care coordination across settings and over time.

Questions for Presenters

1. Ask a question of one of today's speakers by using the chat function.
2. Direct a question about CMS Innovation Center Bundled Payment for Care Improvement Initiative to: BundledPayments@cms.hhs.gov.

What's Next—Upcoming Sessions

- March 13, 12:00 to 1:15 pm ET: Episode Definition for Care Improvement
- Announcements, slides and transcripts: http://cmmi.airprojects.org/bpci.aspx

Remember

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