Parkland Health & Hospital System
Readmission Rates

August 30, 2016
Determinants of Readmission

- Appropriate Care screening
- Outpatient Access
- Navigation assistance
- Rx Understanding and access
- Dietary counseling

Kangovi and Grande, JAMA, 2011
• Reduction by Proportion payer groups/MLIU greater for Medicaid than self Pay or charity patient
“Case management begins in the ED”

- Inpatient appropriate level of care screening with Milliman/InterQual
- Social work screening for patients with prior hospitalization to identify opportunities for reducing readmission
- Drug and Alcohol counseling
- IMPACTS: Reduction in inpatient observation stay ratio, one day stays and provider liable inpatient accounts
Risk Score Workflow

1. List of high and medium risk patients generated in Epic.
2. EHR Review for eligibility
4. Documentation and Navigation assistance
<table>
<thead>
<tr>
<th>Interventions*</th>
<th>Risk Classifications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High-Risk</td>
</tr>
<tr>
<td>24-hour inpatient transitional care unit (TCU) consult</td>
<td>✓</td>
</tr>
<tr>
<td>Floor case manager / social worker consult</td>
<td></td>
</tr>
<tr>
<td>Pharmacy pre-screen / discharge consult</td>
<td>✓</td>
</tr>
<tr>
<td>24 – 72 hour (post-discharge) TCU or care coordination assistant follow up phone call</td>
<td>✓</td>
</tr>
<tr>
<td>30 day (post-discharge) PCP follow up appointment</td>
<td>✓</td>
</tr>
<tr>
<td>7 – 10 day (post-discharge) destination (specialty) follow up appointment as appropriate</td>
<td>✓</td>
</tr>
<tr>
<td>Additional patient disease-based intervention assessment**</td>
<td>✓</td>
</tr>
</tbody>
</table>

* Interventions are those deployed for all cause readmission

** Includes enrollment in pilot intervention programs, based on adverse event/disease classification

Pieces™ Facilitates Efficient and Effective Resource Allocation Based on Risk Classification
FU Capacity: Acute Response Clinics (ARC)

- Appropriate Care: Alternate ED destination for diagnostic follow/observation
- Post Discharge Follow Up destination for primary care coupled with capacity investments in specialty clinics as well
High risk groups

- Chronic Disease Management plans through registry
  - **Diabetes** - registry and global diabetes program
    - Focus on OPAT and diabetic foot infections
    - DM registry to improve glycemic control and lipid management

- **HIV**
  - HIV registry

- **CHF/CKD**
  - Registry: management of ACEi-ARB
  - Specialist Expansion

- **Palliative Care**
Risk screening for medication reconciliation

- Use Pharmacy resources to perform complex medication reconciliation
- Pharmacy MTM visits in COPC to address compliance and titration issues for chronic disease

Scoring to queue a pharmacy team to do a med history:

- On PTA med list - Warfarin - 5 points
- Insulin - 5 points
- Phenytoin - 5 points
- Fentanyl Patches - 5 points
- Greater than 8-10 meds on list - 5 points
- PTA meds missing dose or sig field - 10 points

- Certain Disease states - DM - 2 points
- Chronic Lung Disease - 2 points
- Heart Failure - 2 points
- Renal Failure - 2 points
- Liver Disease - 2 points
- Age > 65 years - 5 points

- Other
  - No of prescribers - 5 points
  - No of patients with >= 1 hospitalization - 5 points
  - No of patients with >= 1 ED visit - 5 points
  - Potentially high dose alert went off on ordering - 5 points
  - Duplicate therapy from previous AVS - 10 points
  - No funding showing - 10 points