Chronic Heart Failure Disease Management
AMGA Heart Failure Collaborative August Webinar

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Sutter Health
Presentation Goals

• Introduction to Sutter Health
• Sutter Health’s Approach to Care Management
• Heart Failure Management at Sutter Medical Center Sacramento
• Sutter Medical Center Sacramento Lessons Learned and Outcomes
• Questions
Our mission and vision

Our Mission

We enhance the **well-being of people in the communities** we serve through a not-for-profit commitment to **compassion and excellence** in health care services.

Our Vision

Sutter Health leads the transformation of health care to achieve the highest levels of **quality, access and affordability**.

Community impact, national leadership
Sutter is Nationally Significant

**Broad Reach**
Largest contiguous not-for-profit health system in the US

**Diverse Patients**
100+ languages
Serving some of the richest and poorest areas in the nation

**National Health Impact**
1 in 100 Americans receives care at Sutter

**Economic Contributor**
Among the largest US employers

**Community impact**
$3M of charity care provided every week
Sutter Health

**Hospitals**
- 24 Hospitals NorCal
- 59,000 Employees
- 33 Outpatient Surgery Centers
- 9 Cancer Centers
- 6 Cardiac Centers
- 5 Acute Rehab
- 6 Behavioral Health
- 5 Trauma Centers
- 4,321 Acute Care Beds
- 35,000 Births
- 190,000 Discharges

**Physicians**
- 5000 Physicians
- 5 Medical Foundations
- 84 Care Centers
- 3.9 Million Patients
- 700 Aligned Physician in Medical Group/Foundation
- 550 Independent Physicians
- 100 Communities

**Operating Areas**
- Bay and Valley
Valley Area

- Counties: 12
- Population: 4.6M
- Square Miles: 14k
- Employees: 17k
- Medical Group Physicians: 1,060
- Independent Physicians: 890
- Acute Campuses: 11
- Beds: 1,700
- ASCs: 13
- Care Centers: 115
- Acute Inpatient Discharges: 87k
- Medical Foundation Active Patients: 1.4M
- Net Operating Rev: $4.1B
- Operating Expense: $4.0B
- Operating Income: $102M | 2.5%
- EBITDA: $334M | 8.2%
Strategic Direction -- Our Path Forward
breakthrough initiatives
“Our Path Forward”

Total Care Accountability
- Care Coordination Across the Continuum
- Sutter Health Plan
- Regional value payment transitions
- Value-based network approaches
- PSA alignment
- Aligned Payment Systems
- Transformational Quality & Efficiency Gains
- Eliminate preventable harm
- In and outpatient OR’s
- Patient care staffing
- Foundation medical practices
- Care of observation patients
- Support function transformation

Customer Experience
- Best-in-Class Retail Practices
- Tools, technology and personalized practices that create an unmatched customer experience

Innovation & Partnership
- Delivery System Innovation
- Rapid implementation and dissemination of great ideas

Research, Education & Philanthropy
- Enterprise research model
- Enhanced physician graduate education & retention
- Best practice approach: Philanthropy

Breakthrough Initiatives and Their Component Programs and Projects

Total care accountability. Implement systems and adopt efficiencies to deliver high-value care—a powerful combination of high clinical quality, exceptional service, and lower overall costs—to our communities.
Care Coordination

Care Coordination and Population Risk Complexity

Patient Populations With Complementary Care Models

- **High Risk**
  - 10% of population
  - End of Life
  - Advanced Illness Management (AIM), Hospice, Inpatient Palliative Care
  - Complex Care Management
  - ICCP SCCR, Champion, PACE, PCOR
  - Partnerships

- **Rising Risk**
  - 20% of population

- **Low Risk**
  - 70% of population
  - Wellness
  - Screening, Coaching, & Prevention

- **High Risk**
  - 10% of population

- **Rising Risk**
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Care Coordination Model

Patient Engagement
- Motivational Interviewing
- Shared goal setting
- Create shared action plan in collaboration with patient and family/support system
- Identify patient’s life goals and how treatment may support attaining them
- Coaching

Health Literacy
- Patient education with "teach back" to assure comprehension of medication and treatment plan
- Culturally relevant education
- Assist patient with "red flag" management

Advance Care Planning
- Education about trajectory of illness, treatment options and decisions
- End of Life Discussions and planning
- Durable power of attorney
- Family conferencing
- POLST

Transition Planning
- Medication reconciliation at transitions of care
- Whole person assessment of patient’s “burden of care” and resources to meet them
- Patient reminders
- Augment patient’s resources to assist them in meeting burden of care
- Provide longitudinal coordination including acute and post acute

Community Resources
- Connect patients with personalized resources
- Transportation
- Mental health
- Referral to palliative care
- Integrate and/or increase access to Mental Health/ Substance Abuse resources
- Referral to additional resources
- Meals on Wheels
- Governmental and non-profit services

Sutter Health Care Coordination Management Operating Model
- Coordinated care transitions
- Centralized operations functions
- Standard use of technology
- System & Region Case Management leadership
- Standard processes, policies, procedures
- Standard job descriptions, roles, & responsibilities
- Standard metrics & variance management
- Standard reporting
- Optimized staffing model
- Orientation & ongoing training

Sutter Care Coordination
Care Coordination: Continuum of Care Strategy

- Admission Prevention
- Admission Management
- Transition
- Inpatient Status
- Observation Status: Specialized Care Unit
- SCAH
- SCCP
- HOSPICE
- AIM
- Robust Services & Support
- SNF Care Coord.
- Rigorous Management
- Physician Leadership and Communication

01/15/15 RPC Meeting Packet
Care Coordination helps improve quality of care across the care continuum through medical offices, hospitals, home health services, skilled nursing facilities and the community.

Responsibilities and Accountabilities:
- Assesses patients’ post-discharge needs and develops a plan to meet them.
- Partners with patients, their families and the treatment team to establish a patient-centered plan of care to encourage optimal outcomes.
- Communicates with insurers about patient status, care plan and discharge needs.
- Manages and reduces denials of payment from governmental and commercial payers.

• MICHAEL AVRIETTE
  Vice President

Operating Units
- Administers case management in affiliates
- Helps patients find care and services across the system
- Uses standardized criteria to conduct utilization review for verifying medical necessity of claims and communicates findings to payers
- Helps patients access community resources

Operations
- Manages the operations needed for successful case management; establishes standardized work processes; provides ongoing education and training; handles reporting and analysis and payer communication; and helps manage clinical denials.
- Monitors the effectiveness and efficiency of case management processes.

Telephonic Disease Management (TDM)
- Helps patients manage chronic conditions through telephone support.
- Addresses potential care plan changes with patients and physicians as those changes occur.
- Educates patients about the course and management of their disease.
- Helps patients improve their health through medication, diet and exercise.
SCCP Background & Purpose:
Prior State

Doctor

RN Case Manager

SW Case Manager

Health Care Coord.

Patient

Reactive
Non Targeted
Diffuse
Loose Team Work
Passive Pt

70%
Episodic Care

30%
Longitudinal Care

01/15/15 RPC Meeting Packet

Sutter Health
We Care For You
Sutter Medical Center Sacramento (SMCS)

- 524 beds Tertiary Facility
- 33,000 Discharges
- >280,000 births
- 100,000 OPT visits
- SMF Diagnostic Partner
- 93,000 ER visits
- 3500 employees/600 physicians
- 73 Bed Psychiatric Hospital

- Adult Comprehensive Heart (1959)
- Added Heart Transplant
- Pediatric Heart Program (1963)
- Truven Top 100 – Everest (5)
- Truven Top 50 Cardiovascular Hospital (4)
- Completed $800 M campus consolidation + EPIC implementation Aug 2015
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Sutter Medical Foundation

Serving more than 100 Northern California Communities

Over 1,000,000 Patients
3,300 Employees
1,200 Clinicians
$37 million in Community Benefit and Charity Care
Integrating across the continuum and into the community

Through an integrated approach, we provide the highest levels of quality, access and affordability.

We navigate an intricate network of care and services for our patients, so they don’t have to. We are solving a dilemma for our communities.
DECREASING 30 DAY HEART FAILURE READMISSIONS

Presented by
Larry Chavez, Kelly Guerrero, Julie Speck
Management and Clinical Excellence XXVIII
July-November 2013
REDUCING HOSPITAL READMISSION RATES IS A NATIONAL PRIORITY

- The national average of 30 day Heart Failure (HF) readmissions is 24% with a cost exceeding $17 billion. (www.ahajournals.org)

- SMCS’ HF readmission rate averages 20%

- SMCS’ HF Clinic patients’ 30 day readmission rate = < 2%
We will decrease the current rate of 30 day readmissions for HF patients to less than 10% for SMCS patients by the end of December, 2013.
STRATEGIC LINK

Total Care Accountability
- Care Coordination
- Aligned Payment
- Transformational Quality & Efficiency
- Individualized care & Personal Attention

Best-in-Class Customer Experience
- Preference-based care
- Simpler navigation
- Open sharing of information

Innovation & Partnerships
- New alliances
- New technologies and care models
- Enhanced research and education
Engaged and enthusiastic!

“Client” perception when initially diagnosed with heart failure:

- “I’m dying”
- Depressed
- In denial
- Do not want to change lifestyle

How to successfully reach client:

- Face to face meeting in hospital
- Engage support system
- Identify barriers to care
- Ongoing communication after discharge
1. Considered referrals of HF patients to Cardiac Rehab for 30 day follow up post discharge

2. Considered Social Worker involvement for all high risk HF patients prior to discharge to assess and address barriers

3. Created the Transition Care Coordinator (TCC) role
DATA COLLECTION

Initiation of Pilot Study

- August 20 – September 20

- 30 day follow up post DC through October 21st

Identification of high risk HF patients by TCC
MEASURES

**Outcome Measures**
- Percentage of 30 day readmissions of all pilot study HF patients.

**Process Measures**
- Percentage of pilot study patients that have a HF Clinic referral at time of discharge
- Percentage of pilot patients seen in the HF clinic within 48 hours
- Mean time for all pilot patients scheduled and seen for follow up appointment at time of discharge
- Number of high risk pilot patients that maintained contact with TCC 30 days post discharge

**Balance Measures**
- Percentage of High risk patients in HF Clinic will have their PCP or Cardiologist contacted prior to discharge
MEASURES

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RESULTS DATA

Aug/Sept/Oct 2013, 30 day HF Readmissions for SMCS Pilot Study Patients (SMH only)
MEASURE RESULTS

Outcome Measures:
- Percentage of 30 day readmissions of all pilot study HF patients = 0%

Process Measures:
- Percentage of pilot study patients that have a HF Clinic referral at time of discharge = 100%
- Percentage of pilot patients seen in the HF clinic as scheduled = 50%
- Mean time for all pilot patients scheduled and seen for follow up appointment at time of discharge = 2 days
- Percentage of high risk pilot patients that maintained contact with TCC 30 days post discharge = 92%

Balance Measures:
- Percentage of High risk patients in HF Clinic will have their PCP or Cardiologist contacted prior to discharge = 100%
COST AVOIDANCE AND ROI

- **SMCS COST PER 30 DAY READMISSION = $9k**
- **EST. 225 YEARLY READMISSIONS = $2.025 M**

**OPERATIONAL EXPENSES**
- **INCREASE HF CLINIC HOURS FROM 15 TO 35 HRS/WEEK**
- **ADDITIONAL RESOURCES NEEDED**
  - $740K

- **$1.285 M EST. COST AVOIDANCE ANNUALLY**
- **TIME TO BREAK EVEN: 17 weeks**
- **ANNUAL RETURN ON INVESTMENT (ROI) = 173%**
HUMAN SIDE OF CHANGE….
...example of success!

- **Significant barriers**

- **What is working**
  - “I feel like I can call the clinic anytime and they always get me in when it’s convenient for me”
  - “They reassure me and help relieve my anxiety when I’m worried something is wrong”

- **Accomplishments**
NEXT STEPS

1. Present MCE project findings to SMCS Administration

2. Obtain Administrative approval for the following:
   - Implementation of Transition Care Coordinators for continued optimal management of high risk HF pts
   - Expand HF clinics and increase resources (staff and hours) to accommodate increased referrals from TCC
   - Initiate after hours on-call for HF clinic midlevel practitioners to further reduce 30 day readmissions

3. For evidence of success, ongoing monitoring is needed for:
   - Incidence of 30 day readmissions
   - Positive patient satisfaction results
   - On-going contact with patient advisor as program is developed
Special recognition to Gretchen Trowbridge, RN, BSN, for her time, expertise and dedication to this pilot study. Her passion and follow through as the TCC was instrumental in the success of eliminating 30 day readmissions among all of the high risk HF patients identified for this project.


Lainscak, M., Kadivec, S., Kosnik, M., Benedik, B., Bratkovic, M., Jakhel, T., & ... Farkas, J. (2013). Discharge Coordinator Intervention Prevents Hospitalizations in Patients With COPD: A Randomized Controlled Trial. *Journal Of The American Medical Directors Association, 14*(6), 450.e1-6. doi:10.1016/j.jamda.2013.03.003


www.innovations.ahrq.gov

www.connect.curaspan.com
Cardiovascular Services Model to Integrate Care

Admission
- Transfer
- SMG
- PCP
- Card
- SIP
- PCP
- Card
- Transfer
- ER

Inpatient
- Medical Hospitalist Admit
- Cardiac Hospitalist Consult
- Consult Heart Failure Team
- Get with the Guidelines
- Risk Stratification
- Moderate
- High Risk
- RN Screening
- Case Management
- Transitional Care Coordinator
- Other Consult Specialities as needed
- Financial Counselor

Post Discharge
- Post Discharge Readmit Prevention
- Heart Failure Clinic - TCC
  - Moderate - visit W/1 7 days
  - High - W/1 48 hours
  - Face2Face + W/1 7 days with provider
- SMG Care Coordination

Community
- TCC
  - SNF
  - Infusion
  - Diet
  - WT
  - I/O
  - HF Clinic b/4 D/C to HH
  - HF Clinic
  - Home Health
  - AIM
  - Telehealth
  - Hospice
  - Interim Care
  - Wellspace - FQHC
  - Salvation Army

Relationships
- TCC
  - Community Pharm - 30 d Meds
  - Education
  - Transportation/Taxi
  - Self-Assessment
  - Medical Notebook
  - Blood Pressure Cuff
  - Scales
  - Pill Box
  - Financial Coordinator
  - Drug Treatment
  - Insurance Exception for unaffiliated plans
  - Sac Medical Clinic
  - Social Work/Nursing Ed - SNF Education
SMCS Heart Failure Readmissions 2012-2015

Implementation in progress of HF Blue Ribbon II initiatives

SNF HF Orders
1/2013

TCC Program
6/2014
M-F

TCC Program
8/2015
M-S

High and Moderate risk post dc appt

Sutter Medical Center - Sacramento

Observed/Expected Ratio

p = 0.033
1. Engage staff close to the problem.
3. From passive to active patient identification.
5. Include all disciples, primary nurse, physician, HOSPITALIST, social work, case management.
6. Establish follow-up plan for patient before discharge, within 3 or 7 days
7. Off hours access to mid-level for clinic patients.
8. Calling the on-call physicians leads to ER visit and readmission.
9. Analyze your readmission data, month to month. Care Coordination
   – Remove the barriers to successful management
10. Analyze the individual patient who frequently readmit. Care Coordination
    – Plan for social related issues, BP cuffs, scales, transportation, READING glasses