Santa Clara Care Coordination Collaborative Meeting

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Corporate Advisor
Health Services Advisory Group (HSAG)
December 14, 2018

You Are Here!

- Improving care coordination together with your peer providers
- Enriched with new learning
- Empowered with new resources
- Improving quality of care for our patients!

Thank you for your support

CALIFORNIA ASSOCIATION CAHF OF HEALTH FACILITIES

SANTA CLARA COUNTY SEPSIS COLLABORATIVE

CALTCM

SANTA CLARA VALLEY MEDICAL CENTER Hospital & Clinics

Santa Clara Family Health Plan

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Santa Clara Care Coordination Collaborative 2018 Community Quarterly Meeting Schedule

WHEN	WHERE	REGISTRATION REQUIRED
Friday December 14, 2018	Della Maggiore Building, 2nd Floor *(Near Santa Clara Valley Medical Ctr.)* 2300 Coverdale Dr., Marin Classroom San Jose, CA 95128	COMPLETED TODAY
Friday March 1, 2019 8:00 a.m.–12 noon	El Camino Hospital Basement Conference Rooms E, F, G 2500 Grant Road Mountain View, CA 94040	Register now at: www.hsag.com/events or http://bit.ly/2FyBsMB
Friday June 7, 2019 8:00 a.m.–12 noon	El Camino Hospital Basement Conference Rooms E, F, G 2500 Grant Road Mountain View, CA 94040	COMING SOON
Friday September 9, 2019 8:00 a.m.–12 noon	El Camino Hospital Basement Conference Rooms E, F, G 2500 Grant Road Mountain View, CA 94040	COMING SOON

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Objectives

- Review Santa Clara Community readmission data.
- Listen to panel discussion about various readmission interventions to reduce 7-day and 30-day readmissions.
- Vote on a community initiative for 2019.
- Learn the teach-back method or "show me" method used by healthcare providers to confirm whether a patient understands what is being explained to them.

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Today's Agenda

- Welcome and introductions
- Santa Clara readmission and high-risk medication (HRM) data update
- Panel discussion on various best practices
- Readmission topic focus and group activity
- Teach-back method
- Meeting summary, evaluation, and next steps

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Community Introductions—Who Is In The Room?

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Santa Clara Community Data

Santa Clara Community All-Cause Readmission Rates by Setting Q3 2017–Q2 2018

Setting Discharged To	Discharges	Readmits Within 30 Days	30-Day Readmission Rate
Home	11,412	1,689	14.8%
Skilled Nursing Facility (SNF)	6,915	1,394	20.2%
Home Health Agency (HHA)	5,334	954	17.9%
Hospice	755	30	4.0%
Other*	1,137	225	19.8%
Your Total	25,533	4,292	16.8%
State Total	746,385	134,175	18.0%

*Other includes discharges to settings that include psychiatric, long-term care, rehab, federal healthcare facility, left against medical advice, other institutions, etc.

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Data files provided to Health Services Advisory Group (HSAG) by the Centers for Medicare & Medicaid Services (CMS) were used for analysis in this report. The data files include Part-A claims for Medicare Fee-for-Service beneficiaries.

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Santa Clara Community All-Cause 30-Day Readmission Rates by Quarter Q3 2017–Q2 2018

Quarter	30-Day Readmit Rate	Discharges	Readmits Within 30 Days	30-Day Readmits to Same Hospital		30-Day Readmits to Different Hospital	
				N	%	N	%
Q3 2017	17.2%	6,236	1,073	835	77.8%	238	22.2%
Q4 2017	17.2%	6,337	1,089	829	76.1%	260	23.9%
Q1 2018	16.1%	6,896	1,110	838	75.5%	272	24.5%
Q2 2018	16.8%	6,084	1,020	795	77.9%	225	22.1%
Total	16.8%	25,553	4,292	3,297	76.8%	995	23.2%

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Santa Clara Community Readmission Rates by Condition Q3 2017–Q2 2018

Community	Condition	30-Day Readmission Rate	30-Day Volume	
			Discharges	Readmissions
Santa Clara Community	AMI[1]	14.0%	484	68
	HF[2]	22.5%	1,600	360
	PNE[3]	17.8%	1,761	313
	COPD[4]	21.6%	499	108
	CABG[5]	8.7%	126	11
	THA/TKA[6]	2.5%	1,139	28

1. Acute Myocardial Infarction=AMI
2. Heart Failure=HF
3. Pneumonia=PNE
4. Chronic Obstructive Pulmonary Disease=COPD
5. Coronary Artery Bypass Graft=CABG
6. Total Hip/Total Knee Arthroplasty=THA/TKA

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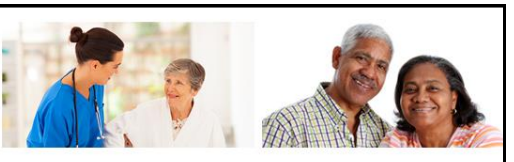

We Cannot Forget About 7-Day Readmissions

Santa Clara All-Cause 7-Day Readmission Rate by Setting Q3 2017–Q2 2018

Setting Discharged To	30 Day Readmissions	Readmits Within 7-Days	7-Day Readmission Rate
Home	1,689	608	36.0%
SNF	1,394	456	32.7%
HHA	954	368	38.6%
Hospice	30	16	53.3%
Other	225	100	44.4%
Your Total	4,292	1,548	36.0%
State	134,175	49,188	36.7%

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June 8 Meeting Poll

A. Poor patient self-management skills
B. Low health literacy
C. Neglecting chronic comorbid conditions
D. Inaccurate medication history/medication reconciliation
E. Unrecognized social determinants of health
F. Higher patient acuity management in the post-acute setting
G. Lack of timely follow-up calls and appointments after discharge
H. Lack of standardized discharge processes
I. Physician communication
J. Patient/Family Expectations

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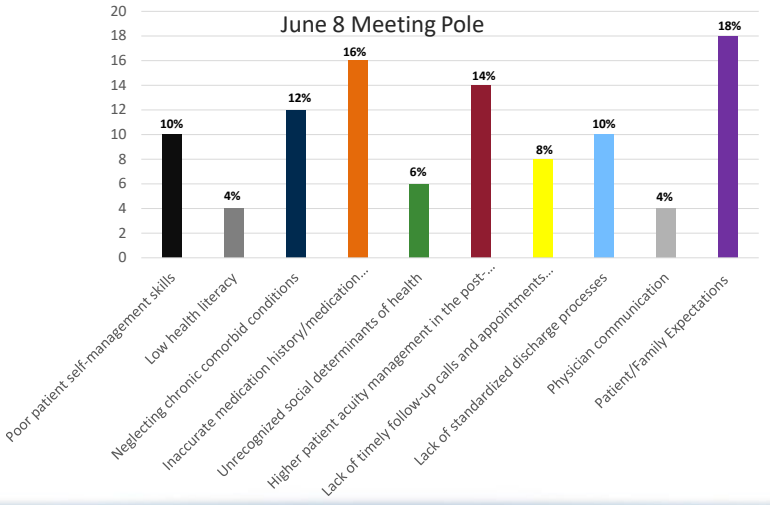
Results



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Shared Best Practices 2018

- Heart Failure
- Identification of high-risk patient
- Interact Tools
- Medication Reconciliation
- Opioids
- Palliative Care
- Reducing Readmission Preparation Program
- Role of Medical Director in long-term care (LTC)
- Sepsis
- Standardized Discharge Form
- Transition Handoff (getting the right information to the right person)
- Using physicians/hospitalists to follow patient after discharge

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Community Panelists

Facilitator—Ettie Lande

- Sunny Rutter—Hospital
- Gary Steinke, MD—Nursing Home
- Drs. Chan/Nyu—Post Discharge Follow up
- Man Deep Dhee—Hospice
- Kim-Yen Nguyen—Pharmacist
- Judy Chu—Clinical Heart Specialist

Vote for Community Initiative 2019

1. Standardized discharge form
2. Heart Failure
3. Medication Reconciliation
4. Post Discharge Follow Up
5. Physician Post-Acute Education
6. Patient/Family Education
7. Advanced Care Planning/Palliative Care

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Group Activity
Teach-Back

Bertha Sandoval
HSAG Project Coordinator

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Words to Remember

Doing things the same way…

…will NOT reduce readmissions.

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Meeting Summary and Evaluations

Our Next Meeting

March 2019 Meeting

Planning Committee—Volunteers
Present Action Plan

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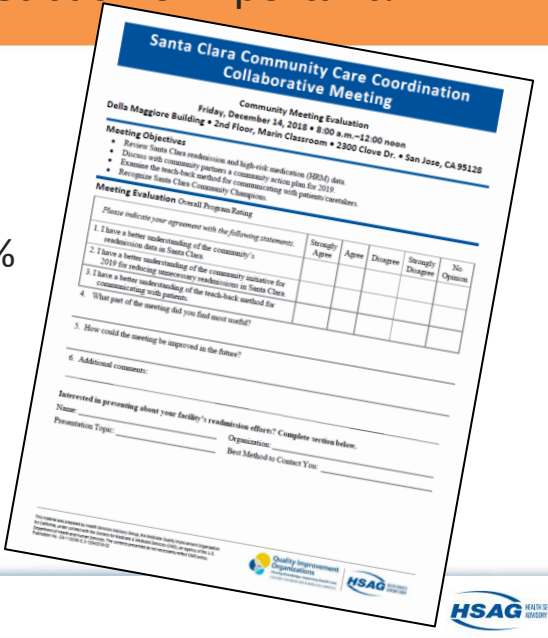
Meeting Summary

Connecting all the moving pieces

Your Meeting Feedback Is Important!

Please help us exceed the 85% target!



Santa Clara Community Care Coordination
Collaborative Meeting

Community Meeting Evaluation
Friday, December 14, 2018 • 8:00 a.m.–12:00 noon
Della Maggiore Building • 2nd Floor, Marin Classroom • 2300 Clove Dr. • San Jose, CA 95128

Meeting Objectives
- Review Santa Clara readmission and high-risk medication (HRM) data.
- Discuss with community partners a community action plan for 2019.
- Examine the teach-back method for communicating with patients/caretakers.
- Recognize Santa Clara Community Champions.

Meeting Evaluation Overall Program Rating

Please indicate your agreement with the following statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion
1. I have a better understanding of the community's readmission data in Santa Clara.					
2. I have a better understanding of the community initiative for 2019 for reducing unnecessary readmissions in Santa Clara.					
3. I have a better understanding of the teach-back method for communicating with patients.					

4. What part of the meeting did you find most useful?

5. How could the meeting be improved in the future?

6. Additional comments:

Interested in presenting about your facility's readmission efforts? Complete section below.
Name: Organization:
Presentation Topic: Best Method to Contact You:

Questions?

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Thank You!

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