HEN 2.0 READMISSIONS WEBINAR

# IMPLEMENTING PALLIATIVE CARE AND THE CMS DISCHARGE PLANNING CHECKLIST

June 2, 2016

11:00 a.m. – 12:00 p.m. CT



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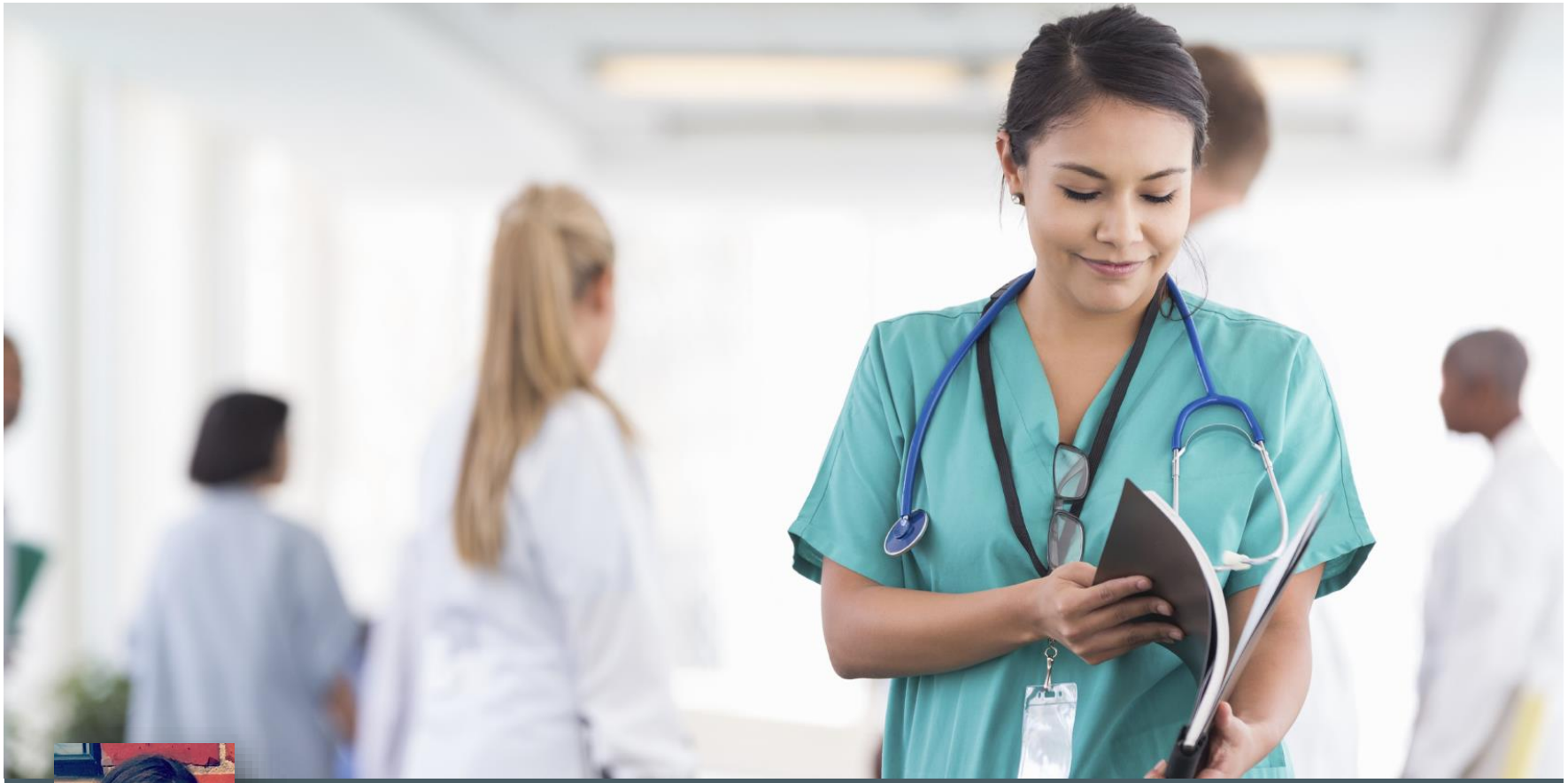

# WELCOME AND INTRODUCTIONS

Shereen Shojaat, Program Specialist, HRET | 11:00 – 11:05



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# SUMMARY DISCLOSURE & ACCREDITATION STATEMENT

**HRET HEN 2.0 – Implementing Palliative Care and the CMS Discharge Planning Checklist**
**Online Live Webinar – June 2, 2016**

The planners and faculty of the HRET HEN 2.0 "Reduce Readmissions through Integration of Palliative Care and Discharge Planning " webinar have indicated no relevant financial relationships to disclose in regard to the content of this presentation.

ABQAURP
American Board of Quality Assurance and Utilization Review Physicians

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical education through the joint providership of the American Board of Quality Assurance and Utilization Review Physicians, Inc. (ABQAURP) and Health Research & Education Trust (HRET). ABQAURP is accredited by the ACCME to provide continuing medical education for physicians.

The American Board of Quality Assurance and Utilization Review Physicians, Inc. designates this live activity for a maximum of ***1.0 AMA PRA Category 1 Credits™***. Physicians should only claim credit commensurate with the extent of their participation in the activity.

ABQAURP is approved to provide continuing education for nurses. This activity is designated for **1.0** Nursing Contact Hours through the Florida Board of Nursing, Provider # 50-94.



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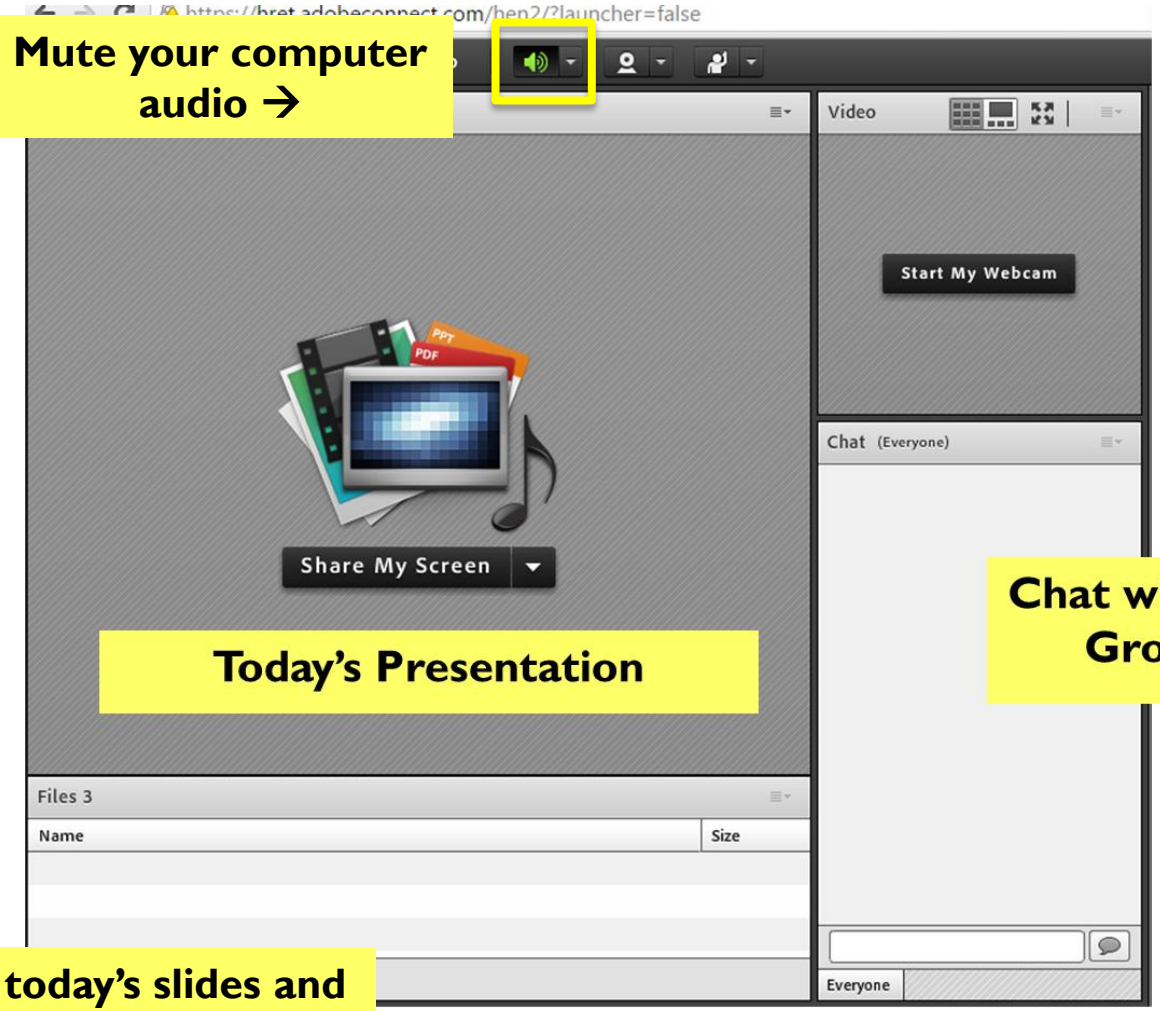
# WEBINAR PLATFORM QUICK REFERENCE



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# AGENDA FOR TODAY

| | | |
|---|---|---|
| **11:00-11:05 AM** | **Welcome and Introductions** | |
| | Open and housekeeping information, including review of relevant HRET HEN resources, change packages and Listserv®. | **Shereen Shojaat, MS**<br>Program Specialist, HRET |
| **11:05-11:10 AM** | **HEN Data Update** | |
| | Readmissions data update – not limited to national percent reduction and percent reporting. | **Julia Heitzer, MS**<br>Data Analyst, HRET |
| **11:10-11:25 AM** | **Why and How of Palliative Care** | |
| | Using palliative care to augment your readmission reduction efforts | **Matthew Schreiber, MD**<br>Vice President, Hospital Quality and System Patient Safety, Spectrum Health |
| **11:25-11:40 AM** | **CMS Discharge Planning Checklist** | |
| | What's in it and why it should be implemented in your organization? | **Pat Teske, RN, MHA**<br>Cynosure Improvement Advisor |
| **11:40-11:50 AM** | **Hospital Story** | |
| | The "how tos" of implementing the CMS discharge planning checklist. | **Peggy Williams, RN**<br>Director of Quality and Joint Commission Coordinator, Summersville Regional Medical Center<br>**Dara Cook, BSN, MSN**<br>Director of Quality, Henry County Hospital |
| **11:50 AM-12:00 PM** | **Bring it Home** | |
| | Action items and tying together of didactic, hospital-level and improvement science information. | **Pat Teske, RN, MHA**<br>Cynosure Improvement Advisor |

# READMISSIONS CHANGE PACKAGE


- Readmissions driver diagrams and change ideas
- Example PDSA cycles
- Descriptions and guidance on how to use the change package effectively
- Referenced appendices



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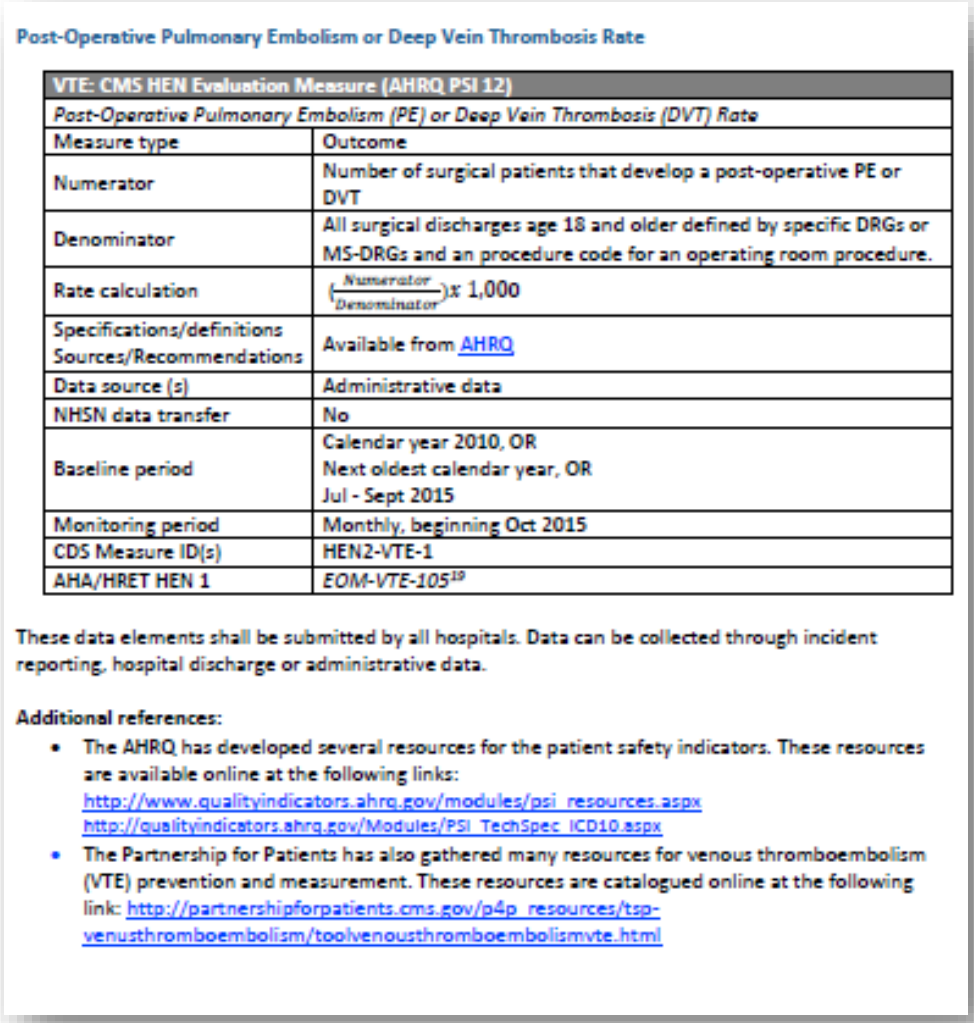
# ENCYCLOPEDIA OF MEASURES (EOM)

- Catalogued measure information available on the HRET HEN website
  - HEN Core Topics – (evaluation measures)
  - HEN Core Process Measures
  - HEN Additional Topics



**Post-Operative Pulmonary Embolism or Deep Vein Thrombosis Rate**

| VTE: CMS HEN Evaluation Measure (AHRQ PSI 12) | |
|---|---|
| *Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate* | |
| Measure type | Outcome |
| Numerator | Number of surgical patients that develop a post-operative PE or DVT |
| Denominator | All surgical discharges age 18 and older defined by specific DRGs or MS-DRGs and an procedure code for an operating room procedure. |
| Rate calculation | $(\frac{Numerator}{Denominator}) x\ 1{,}000$ |
| Specifications/definitions Sources/Recommendations | Available from AHRQ |
| Data source (s) | Administrative data |
| NHSN data transfer | No |
| Baseline period | Calendar year 2010, OR<br>Next oldest calendar year, OR<br>Jul - Sept 2015 |
| Monitoring period | Monthly, beginning Oct 2015 |
| CDS Measure ID(s) | HEN2-VTE-1 |
| AHA/HRET HEN 1 | *EOM-VTE-105*[19] |

These data elements shall be submitted by all hospitals. Data can be collected through incident reporting, hospital discharge or administrative data.

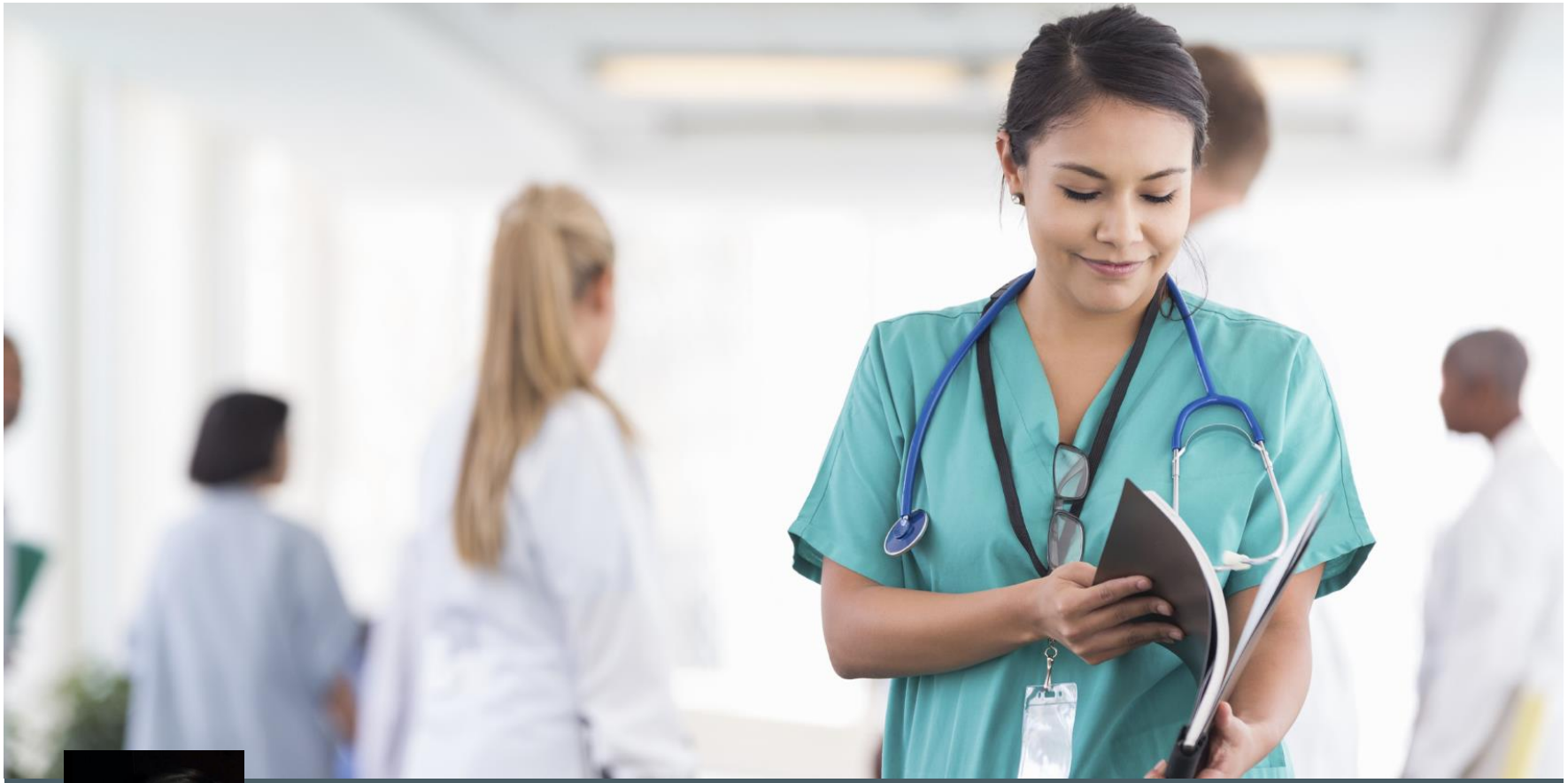
**Additional references:**

- The AHRQ has developed several resources for the patient safety indicators. These resources are available online at the following links:
  http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx
  http://qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx
- The Partnership for Patients has also gathered many resources for venous thromboembolism (VTE) prevention and measurement. These resources are catalogued online at the following link: http://partnershipforpatients.cms.gov/p4p_resources/tsp-venousthromboembolism/toolvenousthromboembolismvte.html

# SIGN UP TODAY: READMISSIONS LISTSERV®

- Readmissions Analytics Listserv® is available for:
  - Sharing of:
    - HRET Resources
    - Publicly Available Resources
    - Best Practices
    - Learnings from Subject Matter Experts
  - Troubleshooting for Data Reporting and Analysis

Sign Up Here



# HEN DATA UPDATE

Julia Heitzer, Data Analyst, HRET | 11:05 – 11:10



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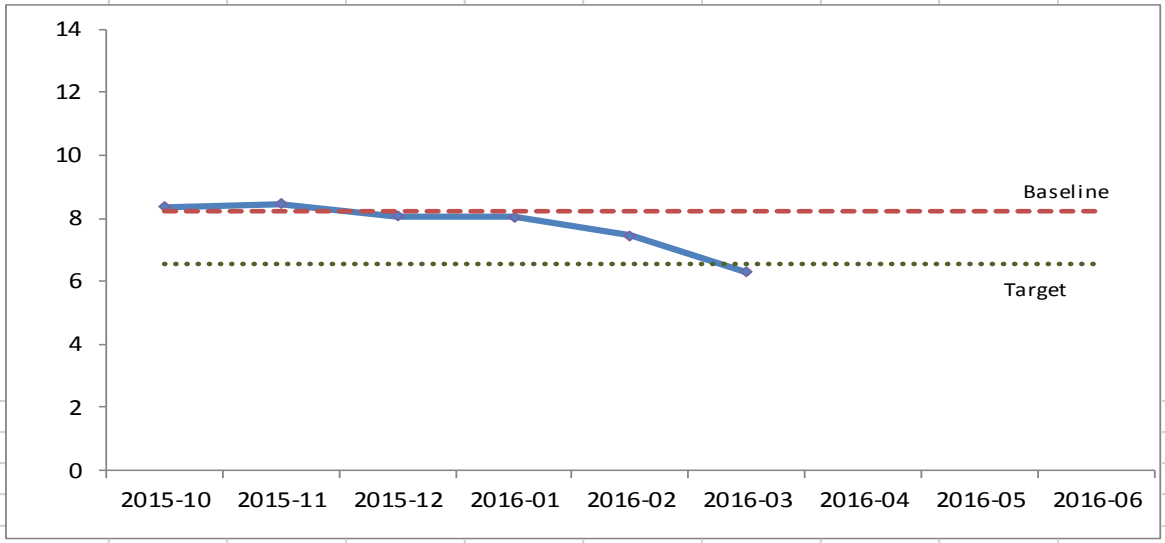
# HEN DATA UPDATE

## All-Cause 30-Day Readmission - Data submitted to AHA/HRET as of: 5/2/2016

*This measure requires monitoring for 30 days post-discharge, therefore, February 2016 data is not complete nor expected at the end of March 2016.*




| | Baseline | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | Relative reduction from baseline, most recent quarter (Dec 2015, Jan & Feb 2016) |
|---|---|---|---|---|---|---|---|---|
| Readmissions within 30 Days (All Cause) | 8.21 | 8.36 | 8.46 | 8.07 | 8.04 | 7.46 | 6.30 | -3% |
| Number (%) of hospitals reporting | 1176 (91%) | 1112 (86%) | 1102 (85%) | 1037 (80%) | 933 (72%) | 688 (53%) | 346 (27%) | -- |

Results for months in which data submission was less than 50% should be interpreted cautiously, as the data on which the results are based is not yet complete.



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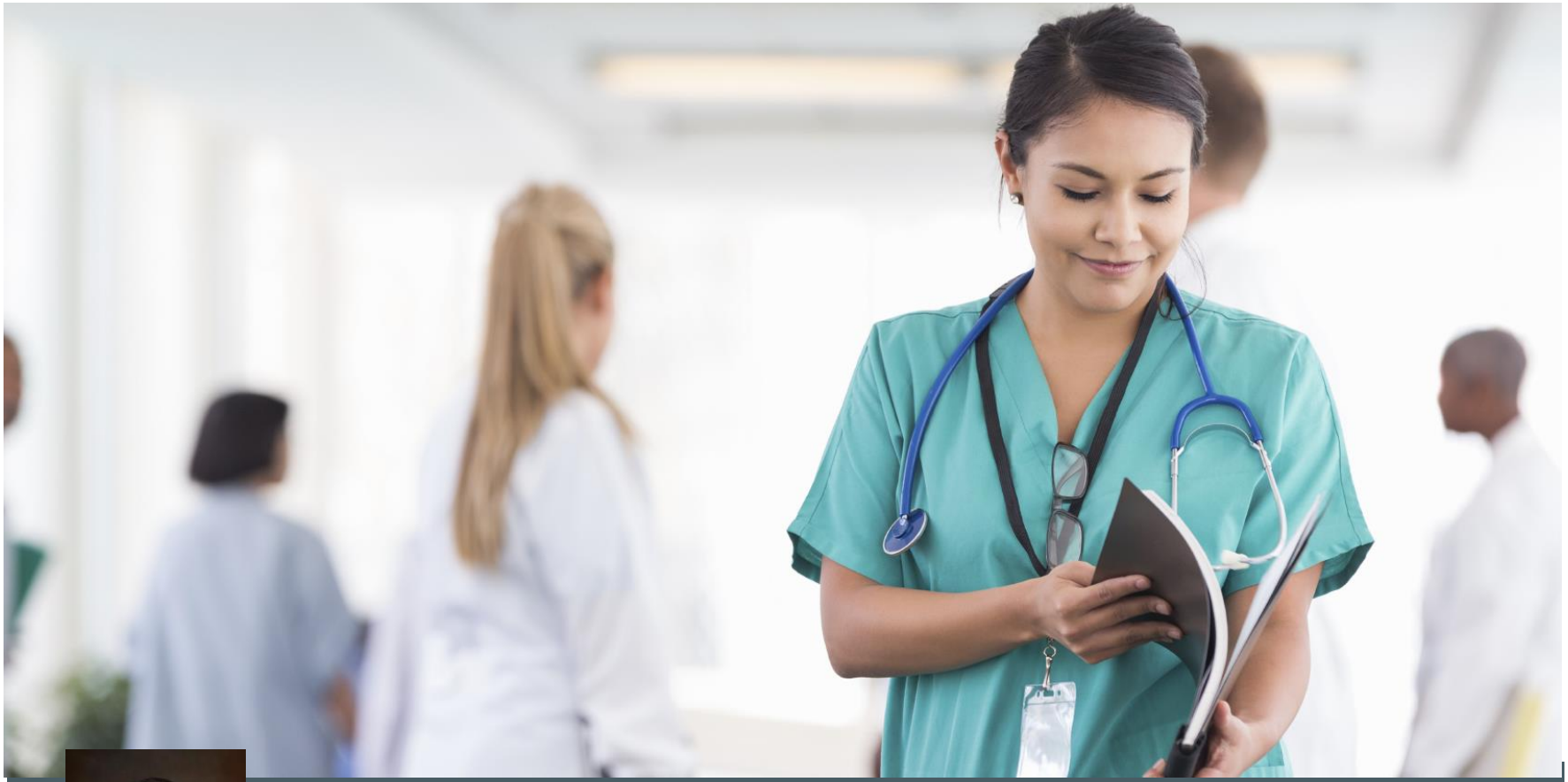

# WHY AND HOW OF PALLIATIVE CARE

Matthew Schreiber, MD, VP Spectrum Health Quality & System Patient Safety| 11:10 – 11:25

# Top three causes of death

| 2000 | 1900 |
| --- | --- |
| 1. Heart Disease | 1. Influenza |
| 2. Cancer | 2. Tuberculosis |
| 3. Stroke | 3. Diphtheria |

Most people (80%) are diagnosed with a chronic degenerative illness in their 50s and spend the next 20 years managing the illness. They eventually die of the illness or a complication of.

# CONSIDER THE FACTS

- There are huge differences between what we say and what we do!

**One conversation can make all the difference.**

*Source: Survey of Californians by the California Health Care Foundation (2012)*

# Talking to your family

- **60%** of people say that making sure their family is not burdened by tough decisions is “extremely important.”
- **56%** have not communicated their end-of-life wishes.

# Talking to your doctor

- **80%** of people say that if seriously ill, they would want to talk to their doctor about end-of-life care.
- **7%** report having had an end-of-life conversation with their doctor.

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U.S. Department of Health & Human Services Partnership for Patients HealthCare.gov

# Writing down your wishes

- **82%** of people say it's important to put their wishes in writing.
- **23%** have actually done it.

# PALLIATIVE CARE

- What Patients Want:
    - Majority of Americans prefer to die at home

    (Hays et al., 2001; Gallup, 2000)
    - Pain-Free Passing
- What Patients Get:
    - 33.5% die at home

    (Teno et al., 2013)
    - Patients continue to die in pain

    (Meier, 2006)
    - 46% of Do Not Resuscitate orders written within 2 days of death

# PALLIATIVE CARE IS ALL ABOUT DOING THE RIGHT THING

- Provide people with the care they want.
- Don’t provide people with the care they don’t want.
- Help others make difficult decisions; don’t make decisions difficult.
- When you do the right thing, you generate significant value.

# PALLIATIVE CARE: THE VALUE PROPOSITION

The inpatient value proposition

- Reduced total hospital LOS
- Reduced ICU LOS
- Reduced ICU cost per case [CRRT, vent, drips]

Reduced readmission rates

- Enguidanos, Vesper & Lorenz. (2012). 30-day readmissions among seriously ill older adults. *Journal of Palliative Medicine*.

Reduced daily cost per case on palliative care status in hospital

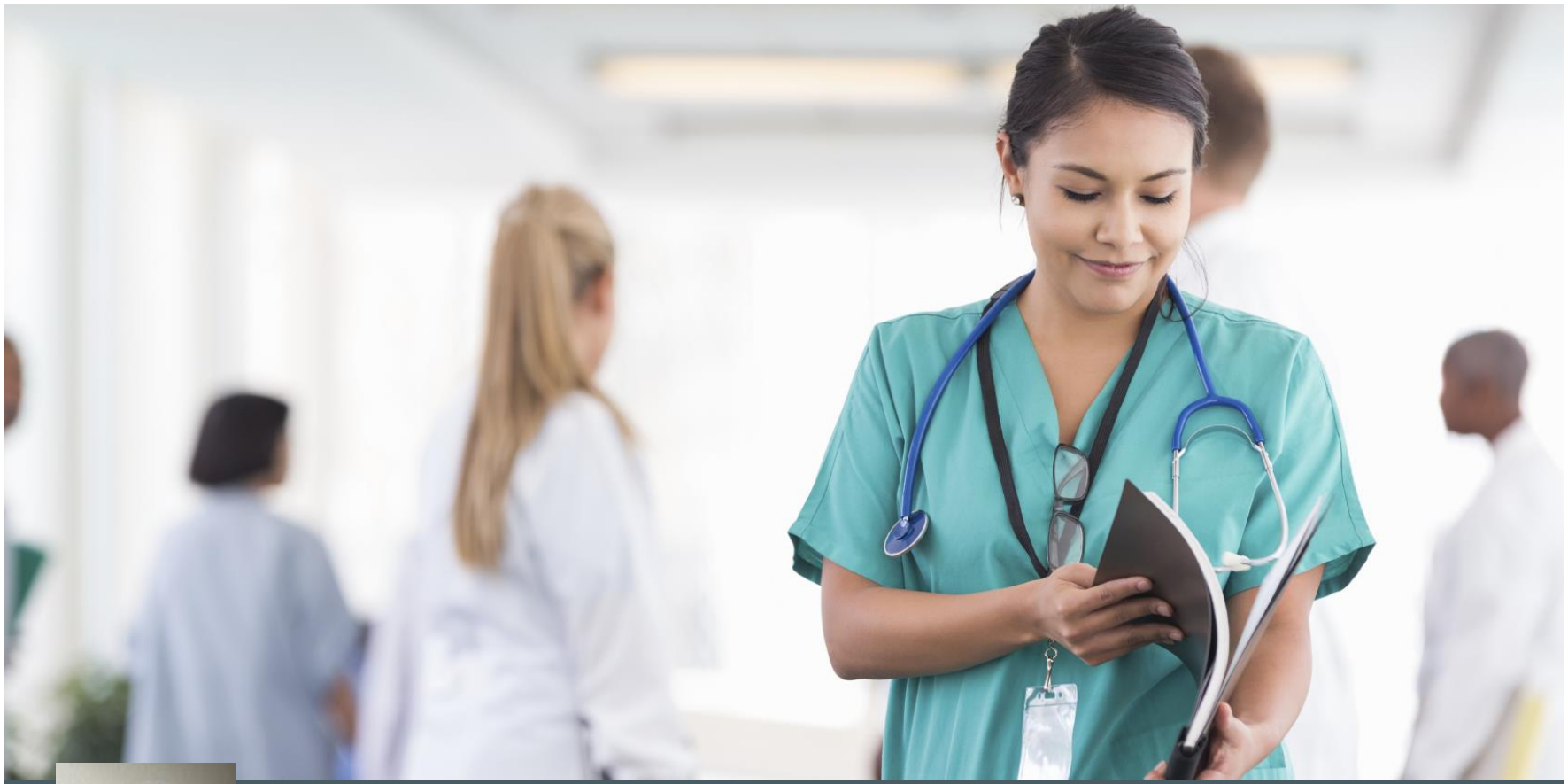
- Ciemins, Blum, Nunley, Lasher, Newman. (2007). *Journal of Palliative Medicine*.

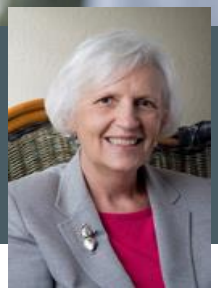
Improved satisfaction—palliative care patients more likely to die at home

- Townsend, Frank, Fermont, et al., 1990; Karlsen & Addington-Hall, 1998; Hays et al., 2001.

# PALLIATIVE CARE PEARLS

- Deciding how someone will spend the time they have left is not our decision to make.
- Palliative care is the difference between asking “what’s the matter” and asking “what matters most.”
- Palliative care is a matter for the entire care continuum to address.
- Palliative care often translates to providing skilled service cost at hospice pay rates.
- Do not attempt to change the entire culture—compartmentalize into something practical for slow, steady change.





# THE CMS DISCHARGE PLANNING CHECKLIST

Pat Teske, Improvement Advisor, Cynosure Health | 11:25 – 11:40



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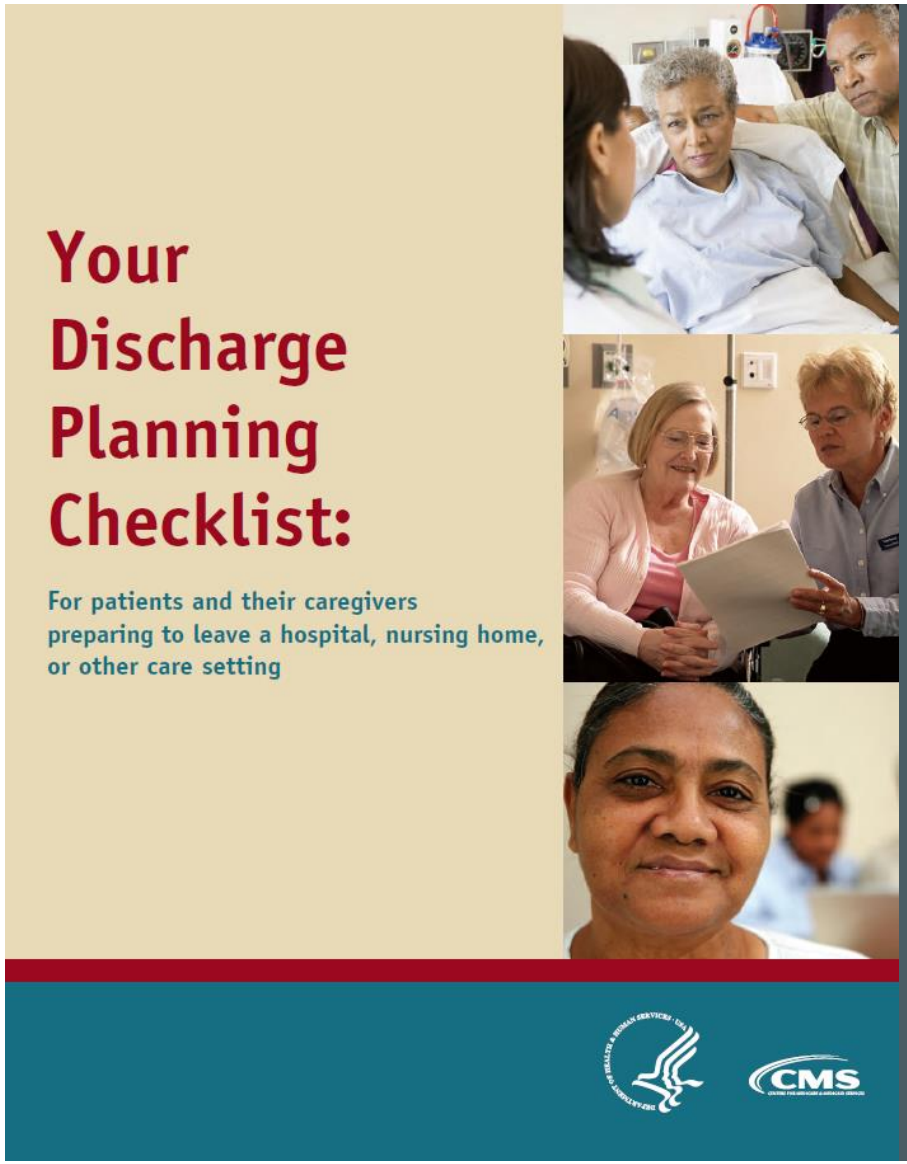


# CMS Discharge Planning Checklist

PFE Measure

- Prior to admission, do hospital staff discuss a planning checklist that is similar to CMS's Discharge Planning Checklist with every patient that has a scheduled admission – allowing for questions and comments from the patient or family?
- **34%** of HRET hospitals responded YES
- **66%** of HRET hospitals responded NO

https://www.medicare.gov/Pubs/pdf/11376.pdf

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# Who is it for?

- Patients and caregivers

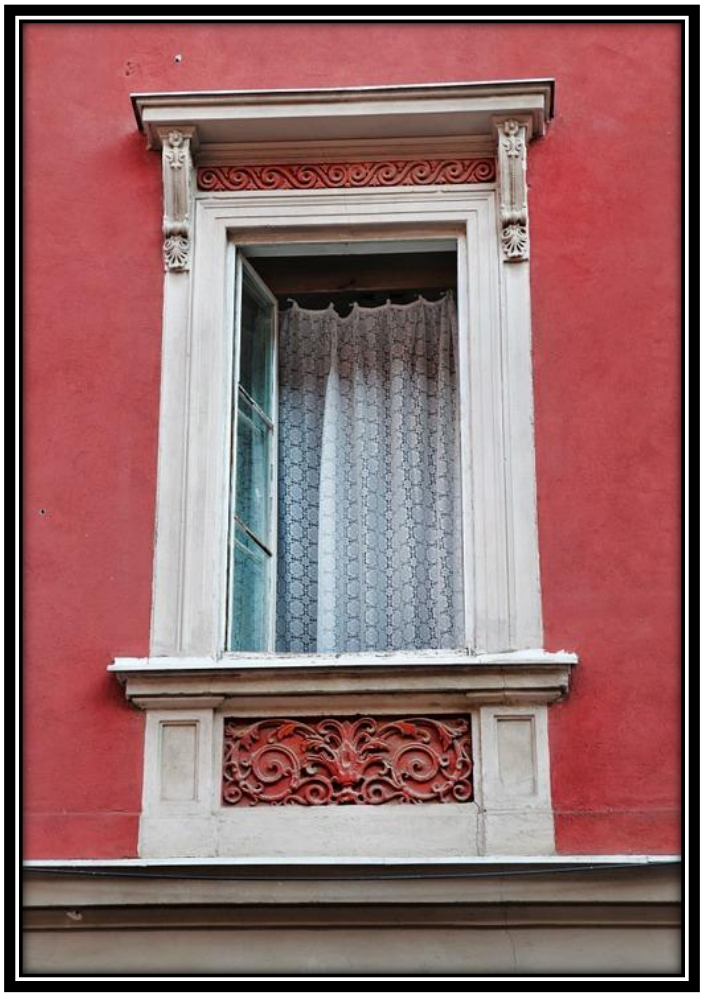
Name: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (a family member or friend who may be helping you) are important members of the planning team. You and your caregiver can use this checklist to prepare for your discharge.

# What's in it?

- Instructions
- Key topics:
  - What's ahead?
  - Your health
  - Recovery and support
  - For the caregiver
- Information for Medicare patients
- My drug list
- My appointments
- Resources



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U.S. Department of Health & Human Services — Partnership for Patients — HealthCare.gov

# INSTRUCTIONS

## Instructions:

- Use this checklist early and often during your stay.
- Talk to your doctor and the staff (like a discharge planner, social worker, or nurse) about the items on this checklist.
- Check the box next to each item when you and your caregiver complete it. 
- Use the notes column to write down important information (like names and phone numbers).
- Skip any items that don't apply to you.

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# PATIENT/CAREGIVER ACTION ITEMS

| Action items | Notes |
|---|---|
| **What's ahead?** | |
| ☐ Ask where you'll get care after you leave (after you're discharged). Do you have options (like home health care)? Be sure you tell the staff what you prefer. | |
| ☐ If a caregiver will be helping you after discharge, write down their name and phone number. | |
| **Your health** | |
| ☐ Ask the staff about your health condition and what you can do to help yourself get better. | |
| ☐ Ask about problems to watch for and what to do about them. Write down a name and phone number of a person to call if you have problems. | |

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# PATIENT/CAREGIVER ACTION ITEMS

- ☐ Use "My drug list"on page 5 to write down your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.
  - ☐ Review the list with the staff.
  - ☐ Tell the staff what drugs, vitamins, or supplements you took before you were admitted. Ask if you should still take these after you leave.
  - ☐ Write down a name and phone number of a person to call if you have questions.

## Recovery & support

- ☐ Ask if you'll need medical equipment (like a walker). Who will arrange for this? Write down a name and phone number of a person you can call if you have questions about equipment.
- ☐ Ask if you're ready to do the activities below. Circle the ones you need help with, and tell the staff:
  - Bathing, dressing, using the bathroom, climbing stairs
  - Cooking, food shopping, house cleaning, paying bills
  - Getting to doctors' appointments, picking up prescription drugs

# PATIENT/CAREGIVER ACTION ITEMS

- ☐ Make sure you have support (like a caregiver) in place that can help you. See "Resources" on page 6 for more information.
- ☐ Ask the staff to show you and your caregiver any other tasks that require special skills (like changing a bandage or giving a shot). Then, show them you can do these tasks. Write down a name and phone number of a person you can call if you need help.
- ☐ Ask to speak to a social worker if you're concerned about how you and your family are coping with your illness. Write down information about support groups and other resources.
- ☐ Talk to a social worker or your health plan if you have questions about what your insurance will cover, and how much you'll have to pay. Ask about possible ways to get help with your costs.

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# PATIENT/CAREGIVER ACTION ITEMS

- ☐ Ask for written discharge instructions (that you can read and understand) and a summary of your current health status. Bring this information and your completed "My drug list" to your follow-up appointments.
- ☐ Use "My appointments" on page 5 to write down any appointments and tests you'll need in the next several weeks.

## For the caregiver

- ☐ Do you have any questions about the items on this checklist or on the discharge instructions? Write them down, and discuss them with the staff.
- ☐ Can you give the patient the help he or she needs?
  - ☐ What tasks do you need help with?
  - ☐ Do you need any education or training?
  - ☐ Talk to the staff about getting the help you need before discharge.
  - ☐ Write down a name and phone number of a person you can call if you have questions.
- ☐ Get prescriptions and any special diet instructions early, so you won't have to make extra trips after discharge.

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# MEDICARE INFORMATION

## More information for people with Medicare

**If you need help choosing a home health agency or nursing home:**

- Talk to the staff.
- Visit **Medicare.gov** to compare the quality of home health agencies, nursing homes, dialysis facilities, and hospitals in your area.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

**If you think you're being asked to leave a hospital or other health care setting (discharged) too soon:**
You may have the right to ask for a review of the discharge decision by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) before you leave. A BFCC-QIO is a type of quality improvement organization (a group of doctors and other health care experts under contract with Medicare) that reviews complaints and quality of care for people with Medicare. To get the phone number for your BFCC-QIO, visit **Medicare.gov/contacts**, or call **1-800-MEDICARE**. You can also ask the staff for this information. If you're in a hospital, the staff should give you a notice called "Important Message from Medicare," which contains information on your BFCC-QIO. If you don't get this notice, ask for it.

For more information on your right to appeal, visit **Medicare.gov/appeals**, or visit **Medicare.gov/publications** to view the booklet "Medicare Appeals."

# MEDICATION LIST

## My drug list

**Filled out on:** _____

Fill out this list with all prescription drugs, over-the-counter drugs, vitamins, and herbal supplements you take. Review this list with the staff.

If you have Medicare and limited income and resources, you may qualify for Extra Help to pay for your Medicare prescription drug coverage. For more information about Extra Help, visit **Medicare.gov/publications** to view the booklet "Your Guide to Medicare Prescription Drug Coverage."

| Drug name | What it does | Dose | How to take it | When to take it | Notes |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

# APPOINTMENTS

## My appointments

| Appointments and tests | Date | Phone number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Resources

## Resources

**The agencies listed here have information on community services, (like home-delivered meals and rides to appointments). You can also get help making long-term care decisions. Ask the staff in your health care setting for more information.**

**Area Agencies on Aging (AAAs) and Aging and Disability Resource Centers (ADRCs):** Help older adults, people with disabilities, and their caregivers. To find the AAA or ADRC in your area, visit the Eldercare Locator at **eldercare.gov**, or call 1-800-677-1116.

**Medicare:** Provides information and support to caregivers of people with Medicare. Visit **Medicare.gov**.

**Long-Term Care (LTC) Ombudsman Program:** Advocate for and promote the rights of residents in LTC facilities. Visit **ltcombudsman.org**.

**Senior Medicare Patrol (SMP) Programs:** Work with seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error, and abuse. To find a local SMP program, visit **smpresource.org**.

**Centers for Independent Living (CILs):** Help people with disabilities live independently. For a state-by-state directory of CILs, visit **ilru.org/html/publications/directory/index.html**.

**State Technology Assistance Project:** Has information on medical equipment and other assistive technology. Visit **resna.org**, or call 1-703-524-6686 to get the contact information in your state.

**National Long-Term Care Clearinghouse:** Provides information and resources to plan for your long-term care needs. Visit **longtermcare.gov**.

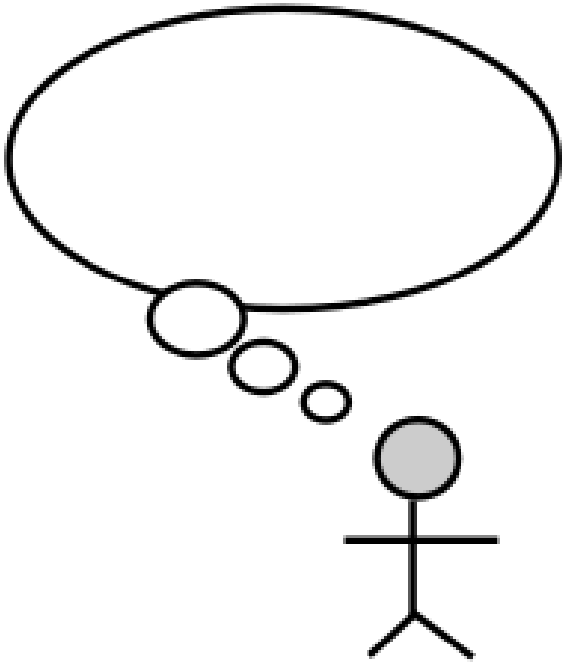
**National Council on Aging:** Provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Visit **benefitscheckup.org**.

**State Health Insurance Assistance Programs (SHIPs):** Offer counseling on health insurance and programs for people with limited income. Also help with claims, billing, and appeals. Visit **shiptacenter.org**, or call 1-800-MEDICARE (1-800-633-4227) to get your SHIP's phone number. TTY users should call 1-877-486-2048.

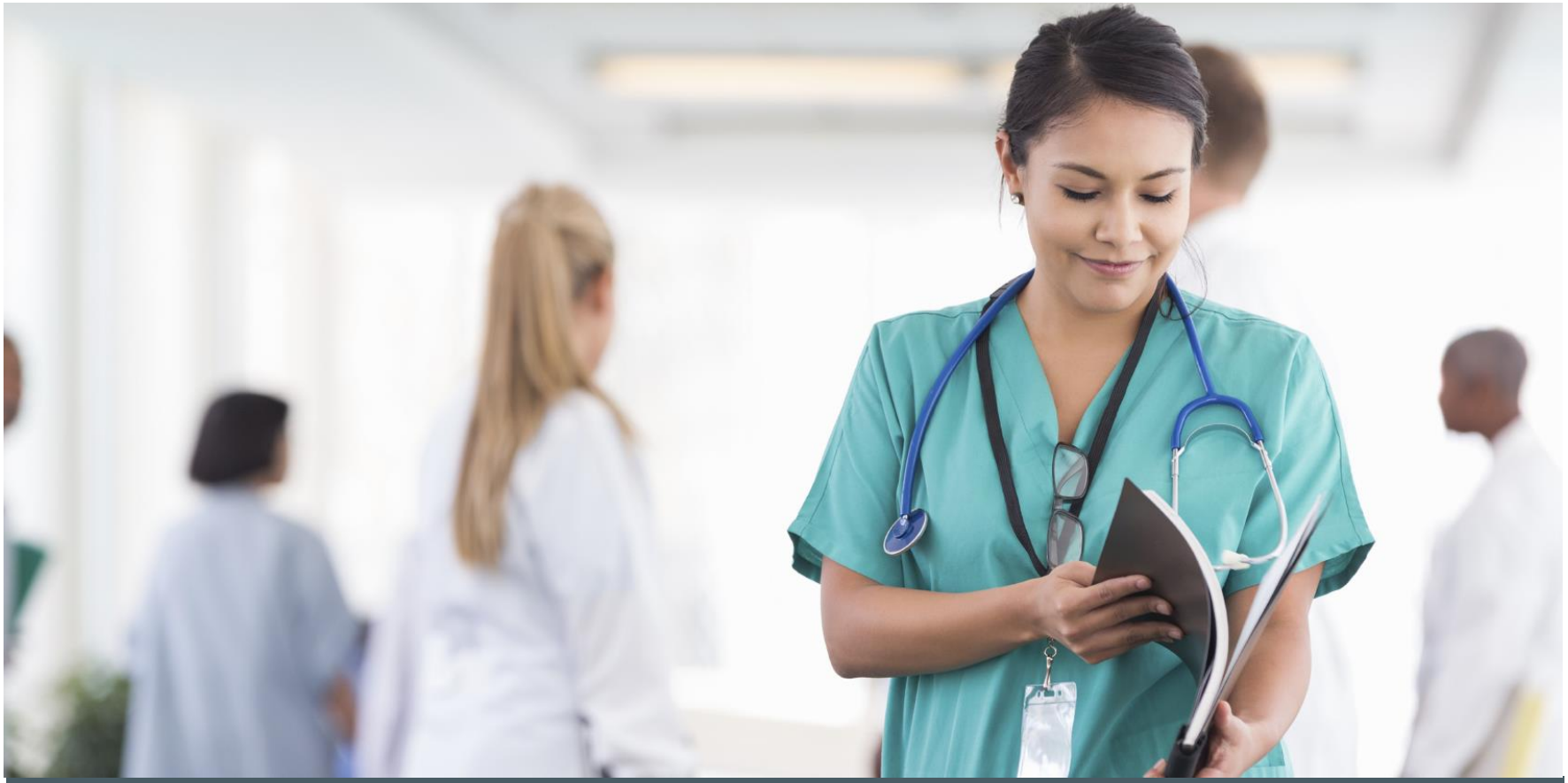
**Medicaid:** Helps with medical costs for some people with limited income and resources. To find your local office, visit **Medicare.gov/contacts**, or call 1-800-MEDICARE.

**CMS Product No. 11376**
**Revised June 2015**

# How About You?



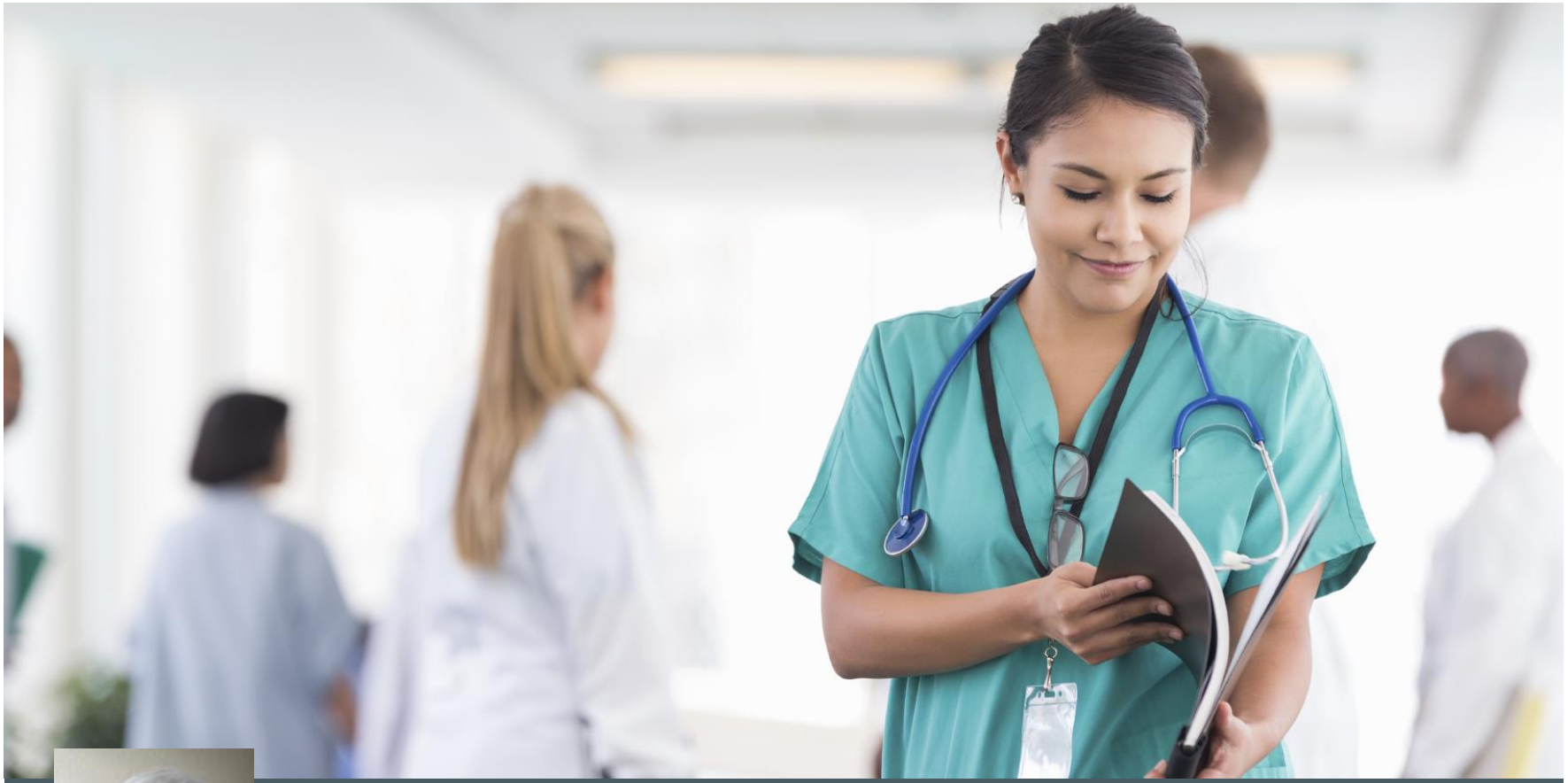
- What's your answer now?
- Prior to admission, do hospital staff discuss a planning checklist that is similar to CMS's Discharge Planning Checklist with every patient that has a scheduled admission – allowing for questions and comments from the patient or family?



## HOSPITAL STORY: IMPLEMENTING THE CMS DISCHARGE PLANNING CHECKLIST

Peggy Williams, Director of Quality and Joint Commission Coordinator, Summersville Regional Medical Center

Dara Cook, Director of Quality, Henry County Hospital| 11:40 – 11:50



# BRING IT HOME

Pat Teske, Improvement Advisor, Cynosure Health| 11:50 – 12:00



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# PHYSICIAN LEADER ACTION ITEMS

**What are you going to do by next Tuesday?**

- ❑ Review the palliative care practices at your organization.
- ❑ Select one step you can take to start or enhance your program.

**What are you going to do in the next month?**

- ❑ Continue to grow your program.
- ❑ Work with clinicians to reach consensus about when to refer patients for palliative care services.

# UNIT-BASED TEAM ACTION ITEMS

**What are you going to do by next Tuesday?**

- ❑ Download the CMS discharge planning checklist.
- ❑ Review the checklist items against your current practice.

**What are you going to do in the next month?**

- ❑ Incorporate any missing elements from the CMS checklist into practice.
- ❑ Develop scripts for staff.

# HOSPITAL LEADERS ACTION ITEMS

**What are you going to do by next Tuesday?**

- ❑ Find out what is happening in your organization regarding palliative care.
- ❑ Find out what is happening in your organization regarding the CMS discharge planning checklist.

**What are you going to do in the next month?**

- ❑ Support the start/growth of your palliative care program.
- ❑ Set a deadline for implementation of all elements of the CMS discharge planning checklist.
- ❑ Review stories on Huddle for Care for further programmatic ideas. (www.huddleforcare.org)

# PFE LEADS ACTION ITEMS

**What are you going to do by next Tuesday?**

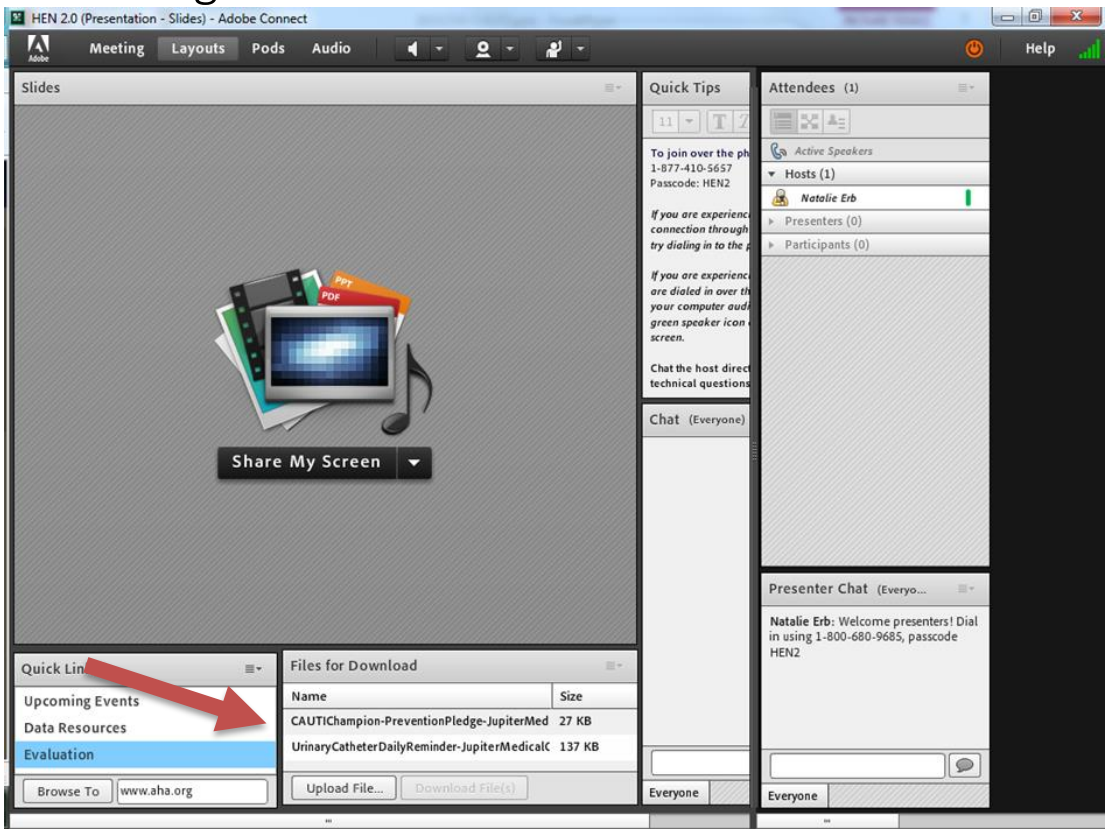
- ❑ Ask to see the CMS discharge planning checklist.
- ❑ Ask about the palliative care services that are available in the hospital.

**What are you going to do in the next month?**

- ❑ Provide guidance on the implementation of the CMS discharge planning checklist.
- ❑ Provide guidance on the implementation or spread of the palliative care program.

# CONTINUING EDUCATION CREDITS

- Launch the evaluation link in the bottom left-hand corner of your screen.
- If **viewing as a group**, each viewer will need to submit separately through the CE link



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# QUESTIONS?

# UPCOMING WEBINARS

HRET/HEN 2.0 Early Elective Deliveries (EED) Webinar

June 7| 11:00 – 12:00 p.m. CT

HRET/HEN 2.0 SOAP UP Webinar

June 9 | 11:00 – 12:00 p.m. CT

# THANK YOU!

Find more information on our website: www.hret-hen.org

Questions/Comments: hen@aha.org