Collaborating to Make Communities Healthier: 
*A Case Study in Community Coalitions*

AHA Leadership Summit 2017

Rusty Holman MD, CMO, LifePoint Health
Mike Patterson, CEO, Havasu Regional Medical Center
Aphreikah DuHaney-West, Former CNO, Havasu Regional Medical Center
LifePoint Health
“Making Communities Healthier”

- Founded in 1999
- More than $6.5 billion in revenues
- Fortune 500 (#374)
- 72 hospital campuses in 22 states; approximately 47,000 employees; and more than 6,300 physician relationships
- Leading healthcare provider in our communities
- Focused patient engagement and physician engagement models
- Committed to keeping healthcare local
- Proven partnership strategies
- Only investor-owned company awarded HEN 1.0 and 2.0 contracts from CMS; top performer in enhancing patient safety

Please note that the views expressed are those of the conference speakers and do not necessarily reflect the views of the American Hospital Association and Health Forum.
Culture that Supports Safety & Learning
- Environment that fosters speaking up & patient advocacy
- Engaging patients & their families

Process Improvement Methods
- Foundational tools
- Multidisciplinary team collaboration
- Evidence based clinical processes

Leadership
- Every level of the organization
- Accountability that is fair & expected
- Engagement of all stakeholders

Patient & Family Engagement
- At Moment of Care: Bedside Shift Report
- In Process Improvement: Initiatives Around Patient Safety and Patient Experience
- In Governance: Patient on Hospital Board or Patient Advisory Council

LP HEN Reliable Framework
Inpatient Harms
(HEN Harm Roll Up)

LifePoint Harm Rate for HEN Harms
(Includes all harm categories; excludes data for Central Carolina, Clark Memorial, Cemenaugh, Fleming, Frye, Providence, Nason, St. Francis)
Inpatient Harms
(HEN Harm Roll Up)

LifePoint Harm Rate for HEN Harms
(includes all harms categories; excludes data for Central Carolina, Conemaugh, Fleming, & Frye)

63% reduction April 2017 compared to 2010
Continuous, Measurable Improvement in Culture:
Teamwork/Safety Climate Index

LifePoint Hospitals TWSC Index
(Same Store Hospitals)

2012  50
2013  54
2014  59
2016  64

Index  Working goal  Performance goal

30% Statistically-significant improvement 2012 – 2016 (p<0.01)
LifePoint is Taking a National Lead in Establishing Coalitions With Community Resources

- LifePoint is in a privileged position to be the “convener” of resources across the care continuum AND throughout the community, in order to address difficult problems:
  - Readmissions and Complex Care Transitions
  - Chronic Disease Management
  - Wellness and Prevention
  - Primary Care Access and Affordability
  - Patient and Family Social Determinants of Health; how patients prioritize health decisions

- To address these challenges, LifePoint has taken a leadership position in creating Community Coalitions – collaborative efforts between LifePoint and a wide range of disparate community agencies and resources.
Havasu Story
The Problem

- Readmissions
- Patients not getting into their doctor post discharge
- Patients not getting Home Health Services
- Patients not knowing what meds to take
- Patients having no other option than to come back to the ED (and possibly get readmitted)
- The Hospital is not in control of all of the outside influences making it difficult to impact the patients behaviors
- Determinants of Health (Social, Economic, Environmental)
Engaging the Community

“Every system is perfectly designed to achieve exactly the results it gets.”
-Paul Batalden

Tell me if you see something other than an X, oval
Community Partners

• Fire Department, EMS, Police
• Hospice, Home Health, SNF
• QIO, Health Support Center
• Physicians from Primary Care, Hospitalist & Specialist
• Pharmacy
• Patient Family Advisory Council
• DME and Transportation Companies
• Veterans Administration, Social Services
• Places of Worship
• Hospitals and Clinics in Primary Service Area
• Health Department, Foundations, Community Services
Agenda for the Initial Kick Off Meeting

- Level set
- Speed dating
- Call to action
- Get feedback on the issues (POV)
- Select the top issues to address
- Identify chair and co-chair
- Identify leads for each subgroup
- Identify executive sponsor
Speed Dating

Round 1
ISSUES: What are the common failures or conditions that you see causing patients to be readmitted?

Round 2
ASKS: What are the barriers to improving or reducing readmissions?

Round 3
OFFERS: What current work do you do really well that this coalition could build on?
Emerging Themes for Improvement

1. Issues Related to Readmission Prevention

2. Asks

3. Offers
Coalition Framework

AIM

Reduce all-cause readmissions within 30 days at Havasu Regional Medical Center by 40%

Outcomes:
- Improve patient satisfaction ratings
- Avoid Medicare penalties for preventable readmission
- Build Community partnership

PRIMARY DRIVERS

Improve care at transition out of the hospital

Provide early post discharge services

Patient engagement and education for self-management

Target high-risk patients

SECONDARY DRIVERS

- Complete discharge summaries within 24 hours of discharge
- Medication review before d/c, disease specific education
- Provide 30-day supply of meds at discharge
- Home Health Engagement
  - Appointments 48 hours post d/c
  - PCP follow-up appointments (48 hrs) prior to discharge
- All high-risk patients discharge with post-acute plan
- Provide patient with a transition coach (RN)
- In home visits with 48hrs of d/c, Paramedicine Program
- Follow-up discharge calls

- Confirm that patients and families understand what they need to know and do, lay provider education
- Proactive counseling and care planning for end-of-life patients

- Focus on patient with diseases with high likelihood of readmission (COPD, heart failure, Sepsis, pneumonia)
- Focus on patients with multiple chronic diseases
- “Familiar Faces” Program for top 50 readmission patients
- Age 65 - 84
Three Teams From Framework

Discharge Appointments
- Identify unit to pilot
- Educate staff and physicians
- Complete rapid cycle test on one unit for 30 days

Patient Education
- Focusing on CHF education
- Reviewing quality and quantity of written discharge materials

Post Acute
- Develop post acute d/c plan for all patient with high risk for readmission
- Earlier identification of patients who qualify for Home Health
Outcomes
Coalition Metrics

Goals:
• 80% of high risk patients will have scheduled appointments prior to d/c
• 65% of patients will make it to their appointments.
• 90% of patients who qualify for Home Health will receive home health education/screening and 80% of those patients will receive service
• Paramedicine Program will have less than 7% readmission rate

Results:
• 100% of high risk patients had appointments scheduled (70% improvement)
• 85% of patients made it to their appointments (80% improvement)
• 100% of patients screened for HH and 86% of those patients received services.
• Last validation: 100% of high risk patients had appointments scheduled (70% improvement) and 85% of patients made it to their appointments (80% improvement)
• Paramedicine Program readmission rate is 5%
Results for all Patients Seen

30-Day Readmit Results
Havasu’s Readmissions Rate Trends
## Change in Practices as a Result of Our Journey

### Volume
- A 10% increase in referrals to Home Health
- 84% of patients seen in house qualified for HH services
- Increase in revenue
- Transition nurse or paramedics see patients waiting for payer authorization

### Coordination
- Patients identified in daily IDT and assessed that day by SME for Home Health
- Patients with high risk for readmission who fall off HH service due to payer are referred to transition of care nurse and paramedicine program

### Physician Involvement
- Several meetings with PCP to get buy in when paramedics send referral form
- Using “no doc” list from the ED to complete assessment while patient is in the ED to avoid readmission. Accomplished by team meeting with docs on the list.
CEO Perspective

Priority

Team

BeVisible

There is no final destination on your improvement journey.
Questions