Reducing Preventable Readmissions: Fairview’s Work

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Fairview Overview

• Not-for-profit established in 1906
• Partnership with University of Minnesota since 1997
• 21,000+ employees
• 2,300 aligned physicians
  – Employed, faculty, independent
• 7 hospitals/medical centers (1,475 staffed beds)
• 40+ primary care clinics
• 55+ specialty care clinics
• 53 senior housing locations
• 30+ retail pharmacies

2013 data
• 5.9 million outpatient encounters
• 1.5 million clinic visits
• 72,291 inpatient admissions
• 320,00 attributed lives
• $524 million community contributions
• 3 billion total assets
• $3.4 billion total revenue
Taking partnership with U of M to the next level

Creating University of Minnesota Health

Co-managed facilities and services include:

- University of Minnesota Medical Center (UMMC) and Children’s Hospital
- University of Minnesota Physicians services at UMMC
- UMP physician activity at other Fairview sites (e.g. NICU, ICU, Hospitalists, specialty outreach)
- University-branded services at Fairview sites
- Associated services and tests provided at UMMC
- Fairview Maple Grove ACC specialty activity
- University ACC Joint Venture

Overarching Goal:

Do the right thing for our patients

- Improve the quality of care
- Improve the patient and family experience
- Reduce the cost of care
One Strategy: Reduce Hospital Readmissions

Why focus here? The numbers tell the tale...

Medicare patients discharged from the hospital readmitted within 30 days*

1 in 5

30-day readmissions that could be prevented out of 7 million annually**

836,000

Estimated cost of preventable readmissions to the U.S. health system annually***

$25 billion

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*Jencks, SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. New England Journal of Medicine, 2009;360(14):1418-1428

**National Priorities Partnership, Nov. 2010


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What Fairview is Doing

Testing ideas, putting them into action

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<tr>
<th>Targeting Populations</th>
<th>Addressing Causes</th>
<th>Testing Solutions</th>
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<td>Focus on populations of patients with the highest rates and risk for readmission, such as: • Heart failure • Heart attack • Pneumonia • Chronic obstructive pulmonary disease • Psychoses • Intestinal problems</td>
<td>• Inadequate discharge planning and follow up • Inadequate or ineffective patient and family engagement • Lack of transition support and communication</td>
<td>• Risk stratification to identify high-risk patients in real time and connect to resources • Follow-up appointments • Teach-back • After-visit summary improvements • One plan of care in electronic medical record</td>
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Meet Veronica

88 years old, chronic heart failure

Veronica was in the hospital for her heart condition
She was ready to go home on a Sunday
• Discharge instructions weren’t very clear
• Left the hospital not certain of who to call with questions
• No scheduled follow-up appointment at her primary care clinic
• Managing multiple medications

Veronica was readmitted the next month for the same issues

What Did We Do?

Developed a patient-centered disease management program

As part of our Chronic Heart Failure program, we created the Cardiomyopathy Optimization Rehabilitation and Education (C.O.R.E.) Clinic in 2003

Goal is to help patients:
– Better understand their condition, treatment and the importance of follow-up care and lifestyle choices
– Improve the length and quality of their lives (slow the progression with guidelines-based medicine)
– Detect future heart problems before they become life-threatening
– Avoid hospital admissions and readmissions
Where Do We Provide This Care?

*University of Minnesota Heart*

5 locations
- Fairview Northland Medical Center
- Fairview Ridges Hospital
- Fairview Southdale Hospital
- University of Minnesota Medical Center
- Fairview Clinics – Fridley

Clinic staffed by
- University of Minnesota Heart cardiologists
- Nurse practitioners
- Physicians assistants
- Currently have 800 C.O.R.E. patients

Why it Works

*Little details matter for people with heart failure*

- Follow-up visit within 3 days of hospital discharge
- Nurse practitioners and physicians tailor care around patient’s lifestyle
- Focus on patient engagement: diet, exercise patterns and medications
- High-risk patients:
  - Transition to an appropriate 24-hour care setting or
  - Participate in tele-management program
- Enrollment: Physician, cardiologist or self-referral
What Are The Results?
*At one hospital, we were able to...*

Based on 2011 data, C.O.R.E. Clinic patients experienced:

- 67% lower rate of readmissions for a primary diagnosis of heart failure compared to patients not in the clinic
- 85% lower rate of readmissions for all causes compared to patients not in the clinic

The impact on patients

*Veronica’s story*

After landing back in the hospital in January 2013, Veronica’s physician referred her to the C.O.R.E. Clinic

- Enrolled into the tele-management program.
- Treated her hypertension and sleep apnea.
- Veronica has been seen monthly and has stayed out of the hospital.
Questions?