HDM KLASroom



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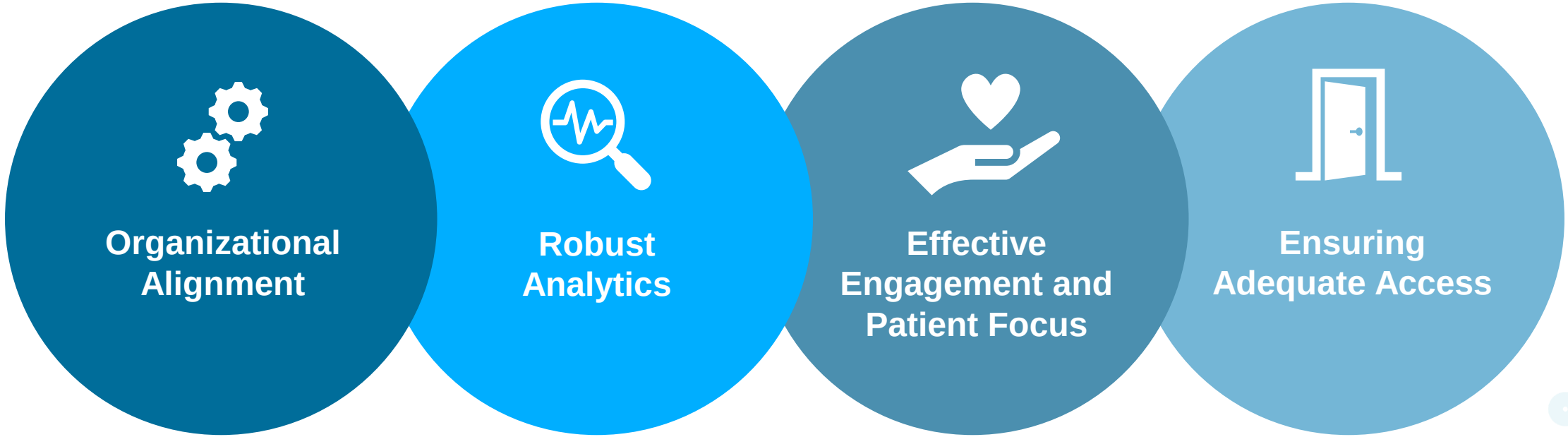
In association with

HealthCatalyst®

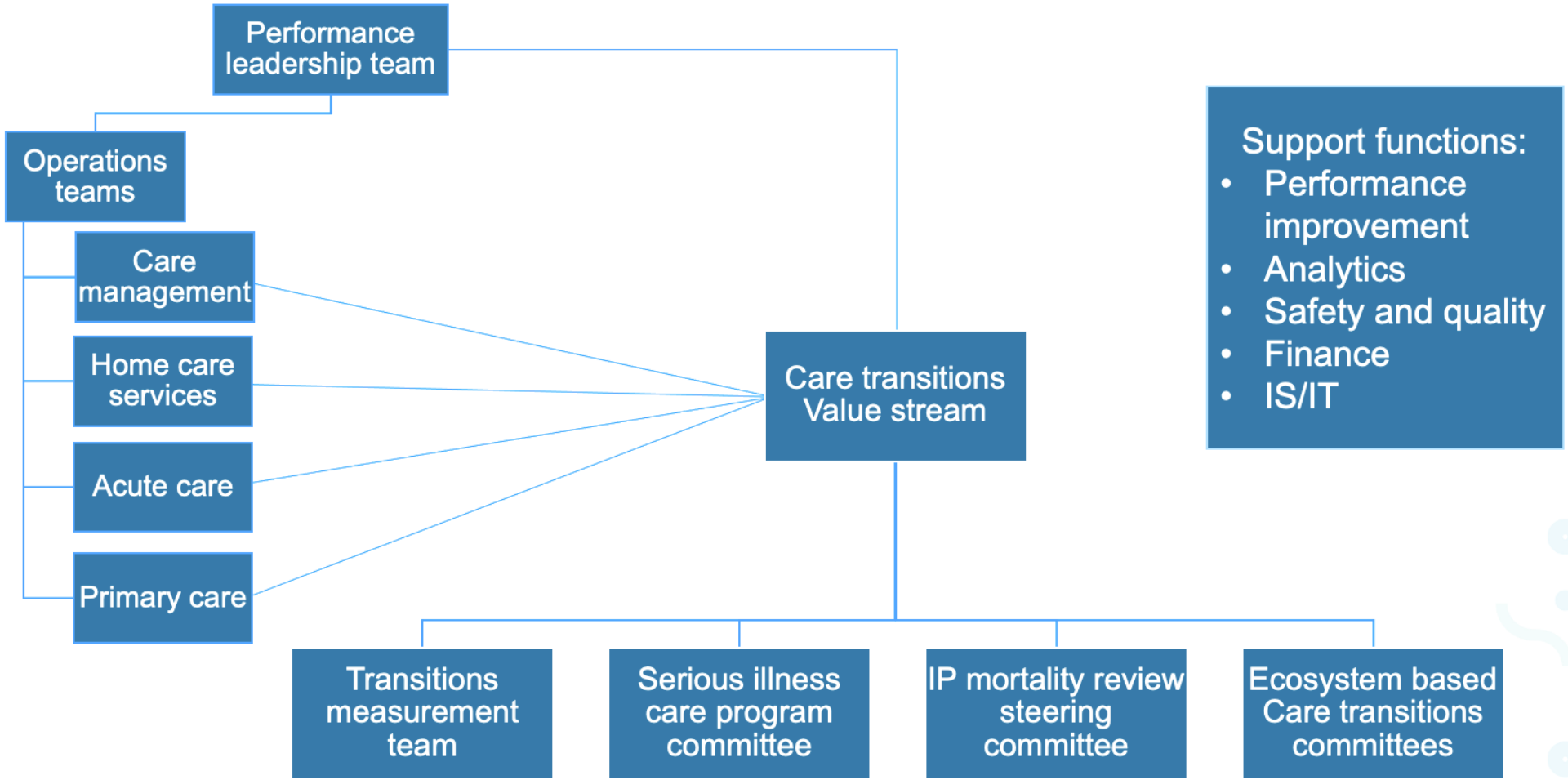
**Topic:** Innovative approaches to improving outcomes through care transitions from a **Large Health System**

TRAVERSING THE CARE CONTINUUM | HealthData Management | KLAS

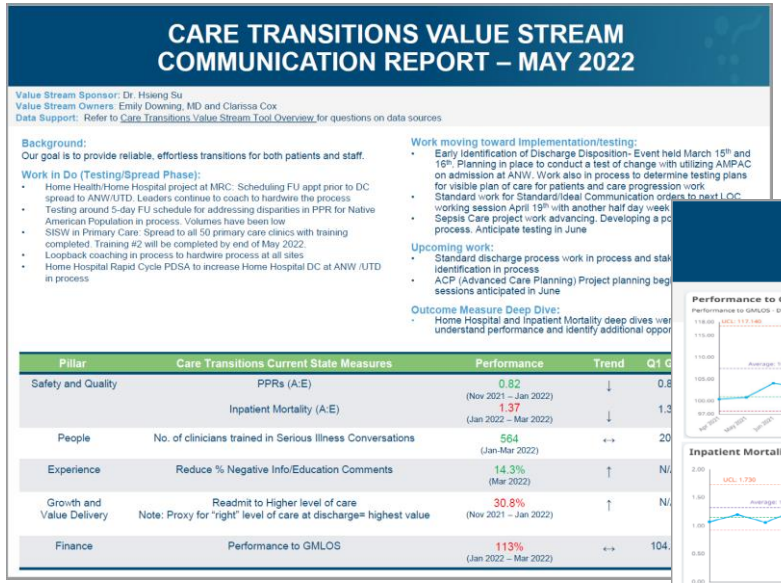
# KEY SUCCESS ELEMENTS



# PERFORMANCE IMPROVEMENT STRUCTURE



# PERFORMANCE IMPROVEMENT REPORTING



## CARE TRANSITIONS VALUE STREAM COMMUNICATION REPORT – MAY 2022

**Value Stream Sponsor:** Dr. Hsieng Su
**Value Stream Owners:** Emily Downing, MD and Clarissa Cox
**Data Support:** Refer to Care Transitions Value Stream Tool Overview for questions on data sources

**Background:**
Our goal is to provide reliable, effortless transitions for both patients and staff.

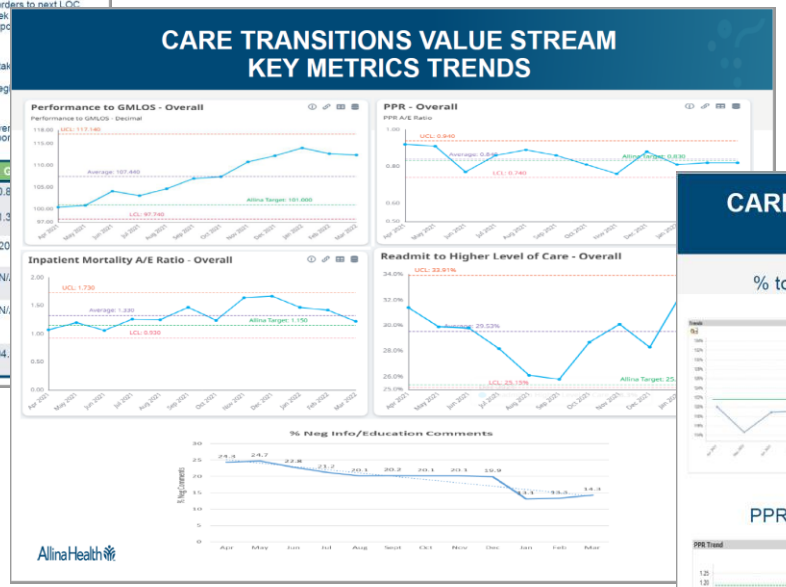
**Work in Do (Testing/Spread Phase):**
- Home Health/Home Hospital project at MRC: Scheduling FU appt prior to DC spread to ANW/UTD. Leaders continue to coach to hardwire the process
- Testing around 5-day FU schedule for addressing disparities in PPR for Native American Population in process. Volumes have been low
- SISW in Primary Care: Spread to all 50 primary care clinics with training completed. Training #2 will be completed by end of May 2022.
- Loopback coaching in process to hardwire process at all sites
- Home Hospital Rapid Cycle PDSA to increase Home Hospital DC at ANW /UTD in process

**Work moving toward Implementation/testing:**
- Early Identification of Discharge Disposition- Event held March 15th and 16th. Planning in place to conduct a test of change with utilizing AMPAC on admission at ANW. Work also in process to determine testing plans for visible plan of care for patients and care progression work
- Standard work for Standard/Ideal Communication orders to next LOC working session April 19th with another half day week
- Sepsis Care project work advancing. Developing a pc process. Anticipate testing in June

**Upcoming work:**
- Standard discharge process work in process and stak identification in process
- ACP (Advanced Care Planning) Project planning beg sessions anticipated in June

**Outcome Measure Deep Dive:**
- Home Hospital and Inpatient Mortality deep dives wer understand performance and identify additional oppor

| Pillar | Care Transitions Current State Measures | Performance | Trend | Q1 G |
|---|---|---|---|---|
| Safety and Quality | PPRs (A:E) | 0.82 (Nov 2021 – Jan 2022) | ↓ | 0.8 |
| | Inpatient Mortality (A:E) | 1.37 (Jan 2022 – Mar 2022) | ↓ | 1.3 |
| People | No. of clinicians trained in Serious Illness Conversations | 564 (Jan-Mar 2022) | ↔ | 20 |
| Experience | Reduce % Negative Info/Education Comments | 14.3% (Mar 2022) | ↑ | N/ |
| Growth and Value Delivery | Readmit to Higher level of care Note: Proxy for "right" level of care at discharge= highest value | 30.8% (Nov 2021 – Jan 2022) | ↑ | N/ |
| Finance | Performance to GMLOS | 113% (Jan 2022 – Mar 2022) | ↔ | 104. |



## CARE TRANSITIONS VALUE STREAM KEY METRICS TRENDS

Performance to GMLOS - Overall

PPR - Overall

Inpatient Mortality A/E Ratio - Overall

Readmit to Higher Level of Care - Overall

% Neg Info/Education Comments

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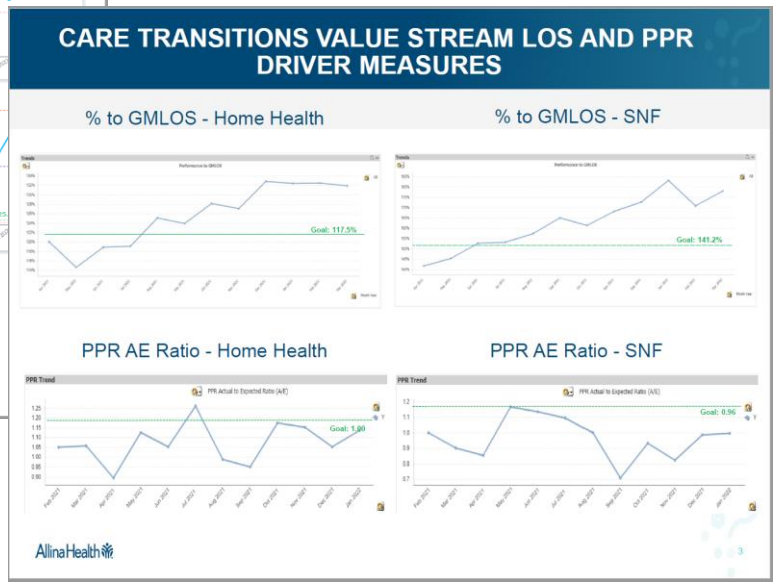

## CARE TRANSITIONS VALUE STREAM LOS AND PPR DRIVER MEASURES

% to GMLOS - Home Health

% to GMLOS - SNF

PPR AE Ratio - Home Health

PPR AE Ratio - SNF

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# RESULTS

## 1 Serious Illness Care

- Five percentage point increase in serious illness interventions for patients rated as category 5

## 2 Inpatient Mortality

- Stability in serious illness category 5 patient IP mortality compared to increasing mortality in other populations

## 3 Length of Stay

- 17% increase over 2019 in ALOS; 6.4% increase in median LOS*

* LOS performance in 2021-2022 significantly impacted by COVID and by post-acute access

## 4 Discharge Disposition

- 1.8% decrease in SNF discharges decreased pre to post-Covid19
- 2% of all discharges to home hospital

## 5 Readmissions

- 3.3% improved PPR A/E ratio year over year