Trinity Health

The Roadmap to Success: Engaging Physicians in Avoiding Hospital Readmissions

Trinity Health

Trinity Health is one of the largest not-for-profit, faith-based health care systems in the nation. It is a family of **127,000 colleagues** and more than **38,300 physicians and clinicians** caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system **includes 93 hospitals, 107 continuing care locations, the second largest PACE program in the country, 142 urgent care locations and many other health and well-being services**. In fiscal year 2024, the Livonia, Michigan-based health system invested **$1.3 billion** in its communities in the form of charity care and other community benefit programs.

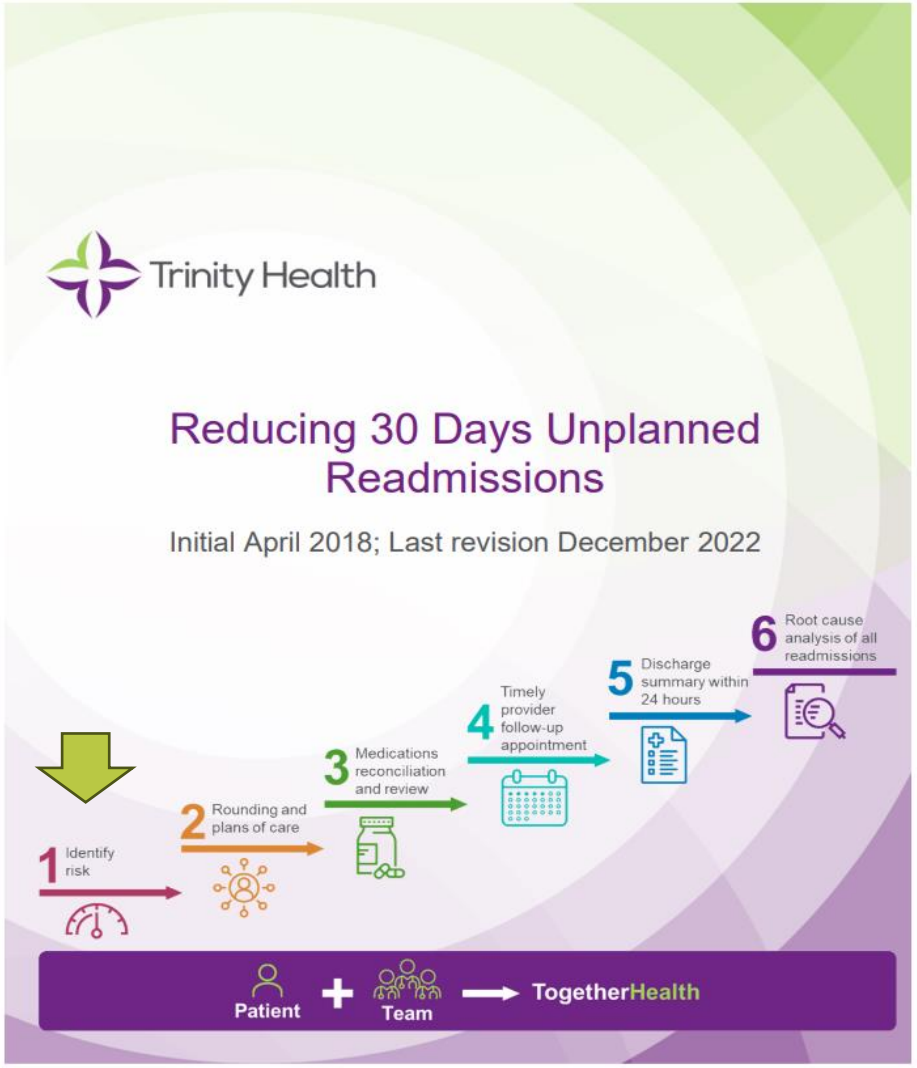
Hospital Readmissions

Over $600 Billion is spent on hospitalizations in the United States each year. Unfortunately, health care analysts estimate that 20 % of US hospitalizations are readmitted within 30 days of discharge, with ¾ of those readmissions determined as avoidable upon further study.

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing initiative developed by the Centers for Medicare & Medicaid Services (CMS) under the Affordable Care Act. HRRP was implemented on October 1, 2012, with the goal to improve healthcare quality by financially incentivizing hospitals to avoid and reduce preventable hospital readmissions.

For more information about HRRP please use the following link: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

TH Readmission Playbook: Key Strategies



The playbook details standard work for our RHMs to implement into their operations. Colleagues from across the system have come together to identify best practices, successful strategies, process improvements, measurable approaches and efficient integration of health services.

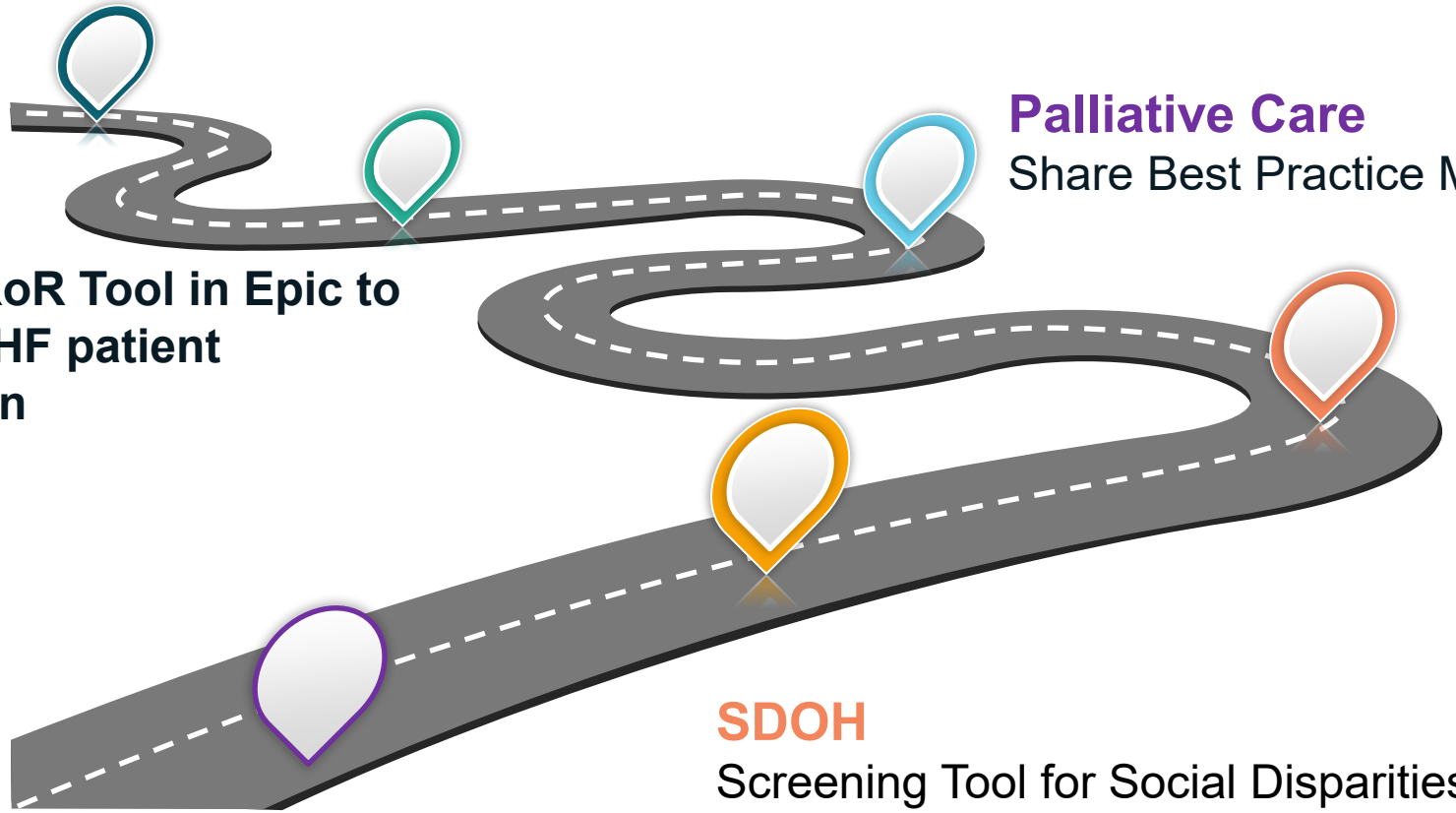
Conditions included are:

- AMI
- CHF
- COPD
- PN
- CABG
- THA/TKA

MI State Readmission Team: 2025 Focused Goals

Diagnosis
Performance monitoring with the focus on overall and DRG specific readmission rates

Discharge Optimization / F/Up Appointments
Extend one-click scheduling at all RHMs in MI



Palliative Care
Share Best Practice Models in Palliative Care

Tools
Utilize ERoR Tool in Epic to stratify CHF patient population

CHF Education
Automatic application of the heart failure education templet for Nursing in EPIC

SDOH
Screening Tool for Social Disparities in EPIC (SDOH Screening) .

Inpatient Risk of Unplanned Readmissions Model

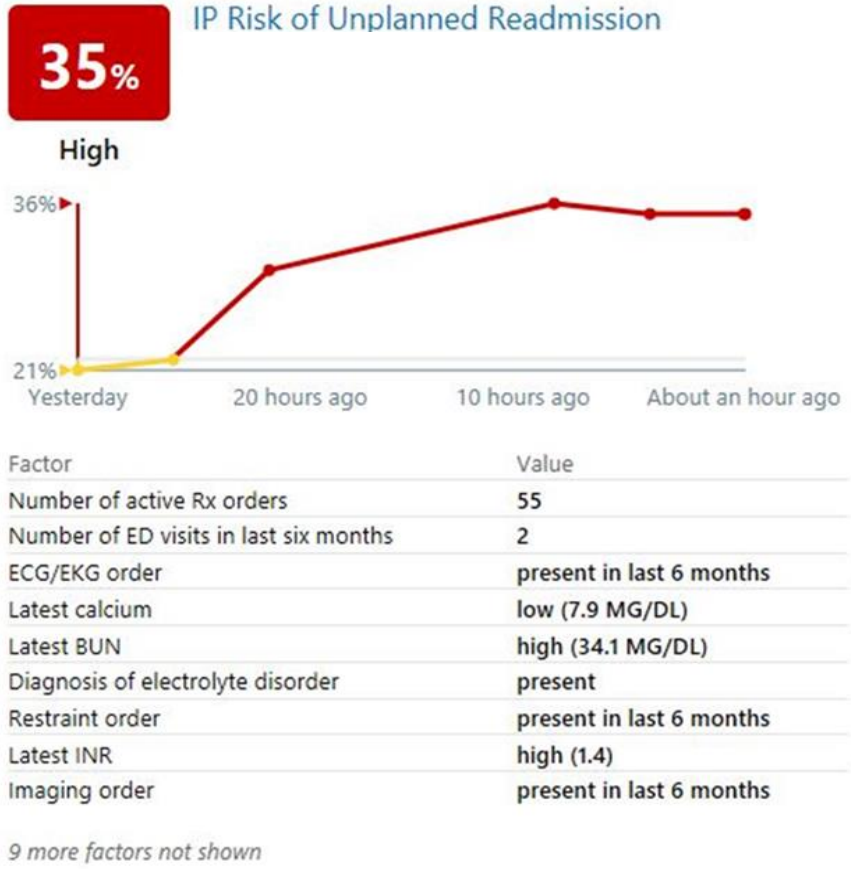
Model: A predictive analytics and risk assessment tool in EPIC to identify elderly patient population at risk for readmission, enable our physicians to be proactive in identifying high-risk patient profiles earlier and deploy targeted interventions including high-risk factors resulting in lowering readmission rates.

Tool

- Determines a patient's risk of an unplanned readmission within 30 days of being discharged from an index admission
- Does not apply to ED patients
- Model can run at any time during a patient's stay vs. other readmission predictive models that can only be run at discharge: one sample at the time of admission, one sample 24 hours after admission and one sample at discharge

Scale

- **Low: 0-11%**
- **Medium: 12 -22 %**
- **High: =or > 23%**



EPIC Risk of Readmission (ERoR) Score

- Diagnosis: admission dx, problem list and ED DX including Charlson Comorbidity Index and the following diagnosis: Anemia, AMI, Cancer, PVD, AIDS/HIV, COPD, Liver disease, HF, Rheumatic Disease, Dementia, Drug Abuse, Diabetes, Renal Failure, Metastatic Solid Tumor, Fluid and Electrolyte Disorder.
- Demographics: Current Age
- Labs (72-hr lookback)

Blood Urea Nitrogen	Hemoglobin
Calcium	International Normalized Ratio
Creatinine	Phosphorus* *Any result for phosphorus contributes to the score.

- Medications

Number of Active Medications	On Corticosteroids
On Anticoagulants	On NSAIDs
On Antipsychotics	On Ulcer Medications

- Order Types (12 months lookback)

Had Electrocardiograph Orders	Had Restraint Orders
Had Imaging Orders	

- Utilization (12 months lookback, 6 months for ED visit)

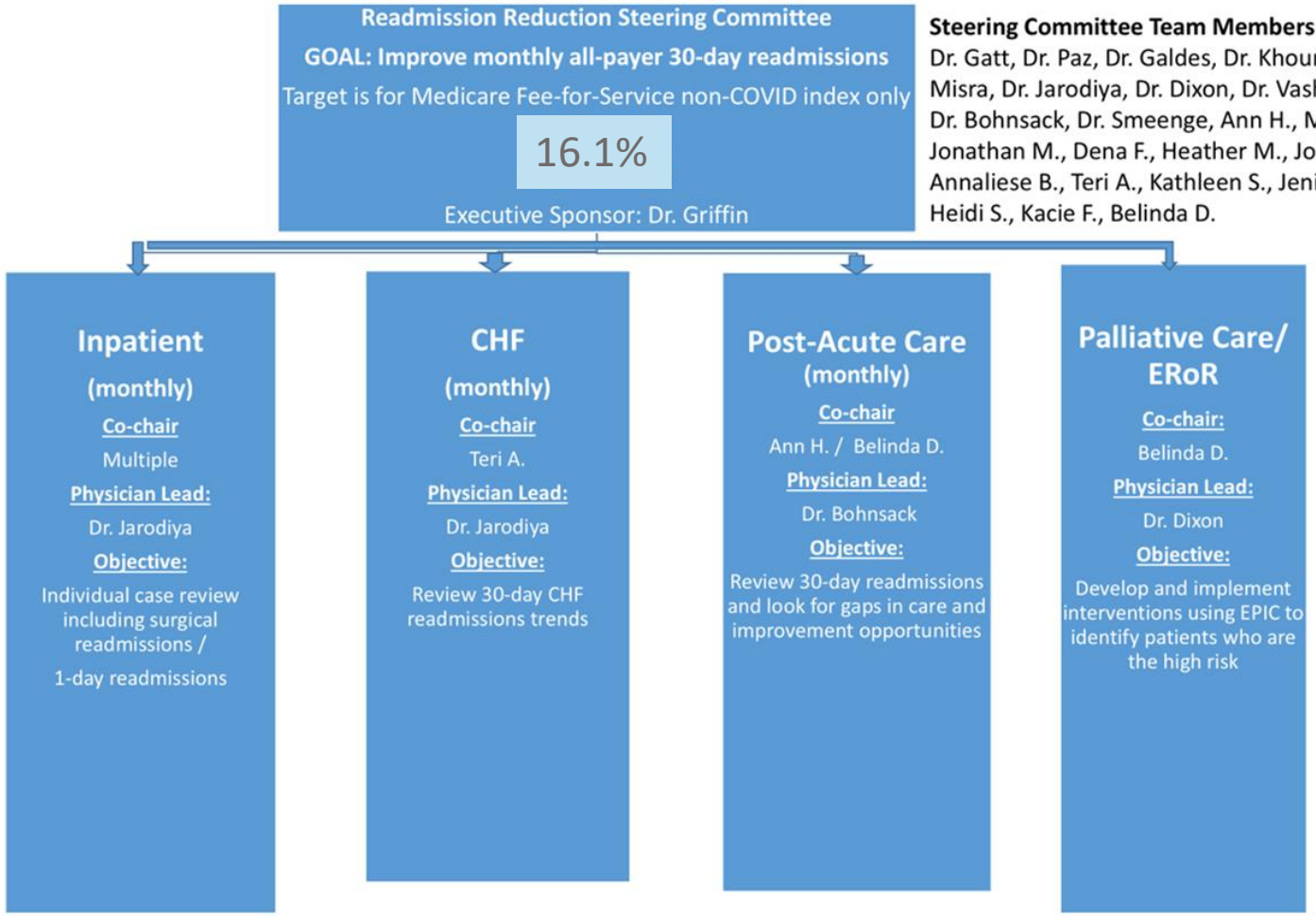
Current Length of Stay	Number of Past Hospitalizations
Has a Future Scheduled Appointment	Previous Length of Stay 10+ Days
Number of Past ED Visits	

Trinity Health (TH) Livonia

Trinity Health Livonia Hospital is a 304-bed community that was founded and opened by the Felician Sisters in 1959. We provide comprehensive and compassionate care to the Wayne County community. The facility features a 24-hour emergency department, Level II Trauma Center, inpatient and outpatient surgery, general medicine, imaging services, physical medicine and rehabilitation services, intensive care unit, cancer care, cardiovascular care, senior services and birthing and women's services.

Trinity Health Livonia Hospital

TH Livonia Readmission Reduction Committee

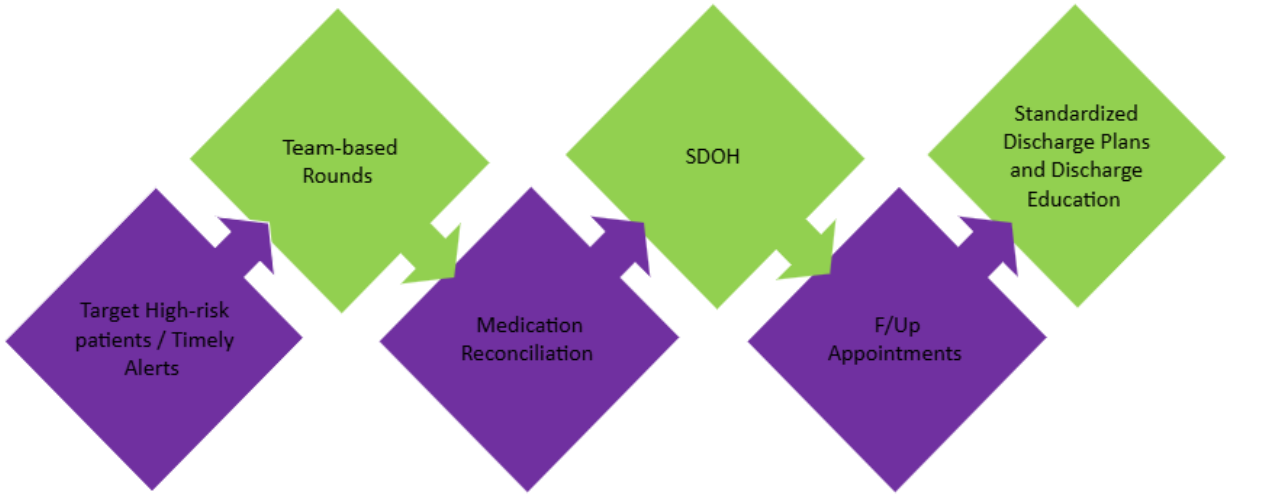


Steering Committee Team Members:
Dr. Gatt, Dr. Paz, Dr. Galdes, Dr. Khoury, Dr. Misra, Dr. Jarodiya, Dr. Dixon, Dr. Vashishta., Dr. Bohnsack, Dr. Smeenge, Ann H., Maria F., Jonathan M., Dena F., Heather M., John H., Annaliese B., Teri A., Kathleen S., Jeni H., Heidi S., Kacie F., Belinda D.

Updated 03/17/2025

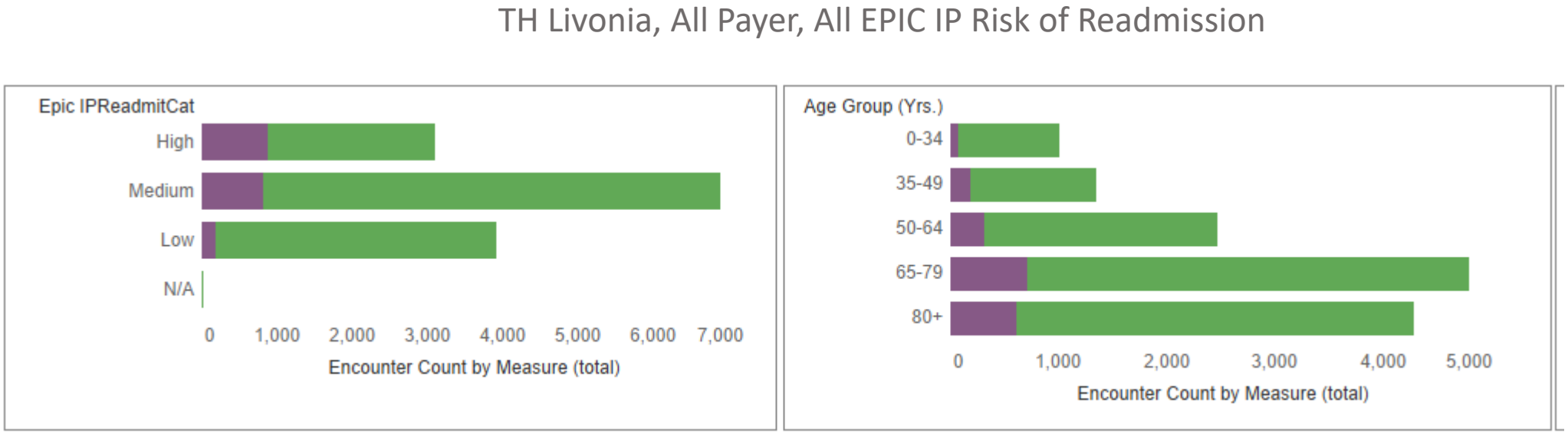
Physician Engagement

- Dr. Kevin Bohnsack, CIN Executive Director
- Dr. Michael Gatt. Director of Quality
- Dr. Babu Jarodiya, Internal Medicine
- Dr. Gaurav Vashishta, Internal Medicine
- Dr. Jospeh Dixon, Palliative Care
- Dr. Preeti Misra, Internal medicine
- Dr. Kuldeep Sidhu, Internal Medicine
- Dr. Roy Misirliyan, Cardiologist
- Dr. Paul Nona, Cardiologist

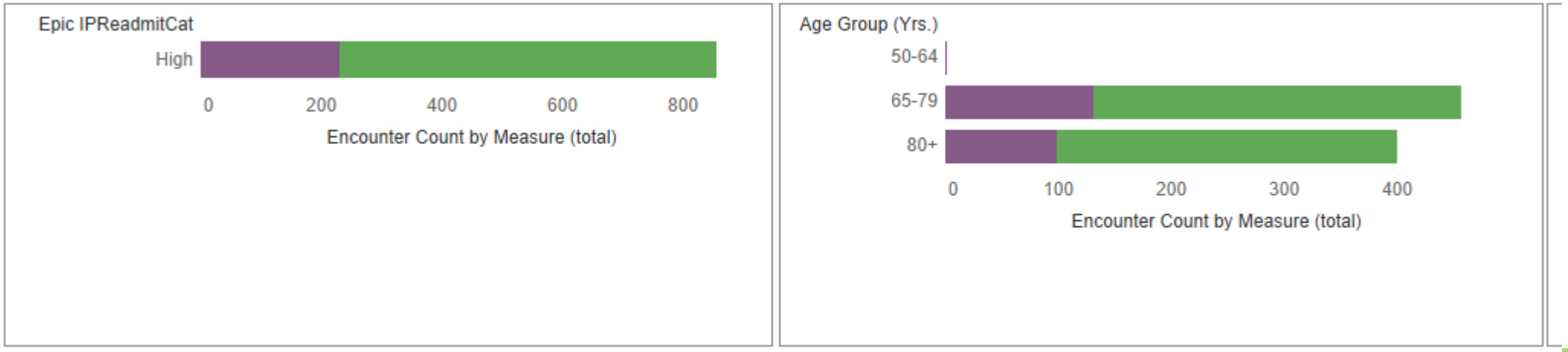


Patient Population and Risk Score (Aug 24-Jul 25)

TH Livonia, All Payer, All EPIC IP Risk of Readmission

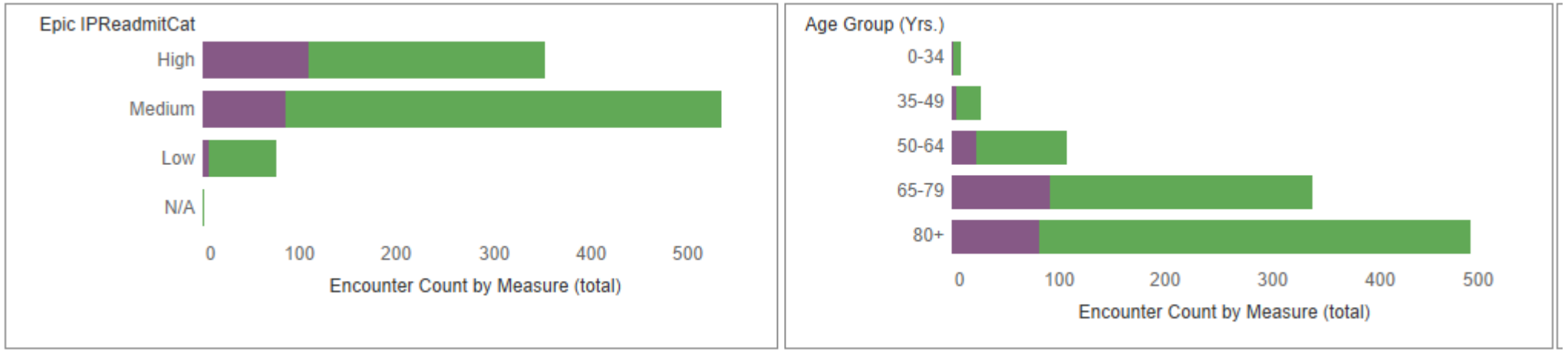


TH Livonia, 65/+, High EPIC IP Risk of Readmission

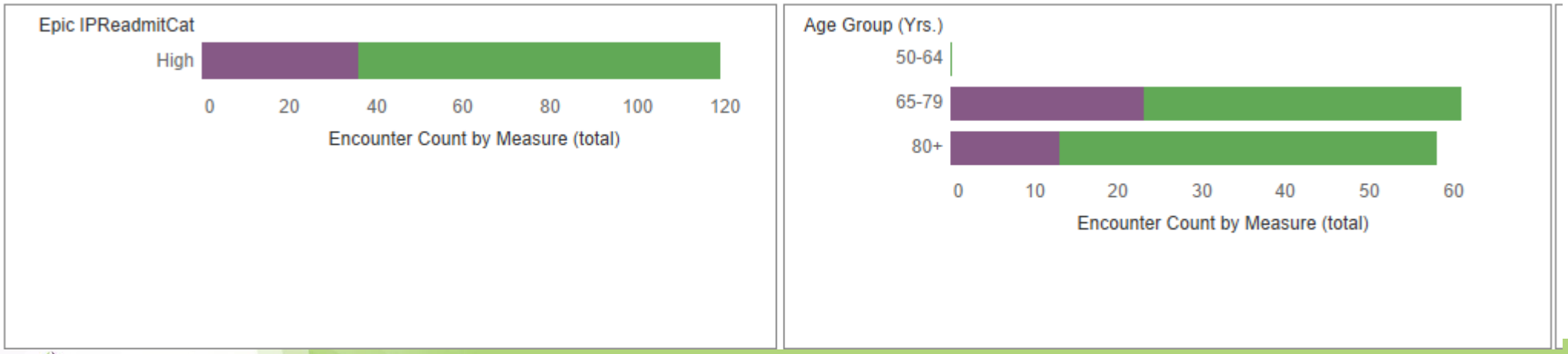


CHF Population and Risk Score (Aug 24-Jul 25)

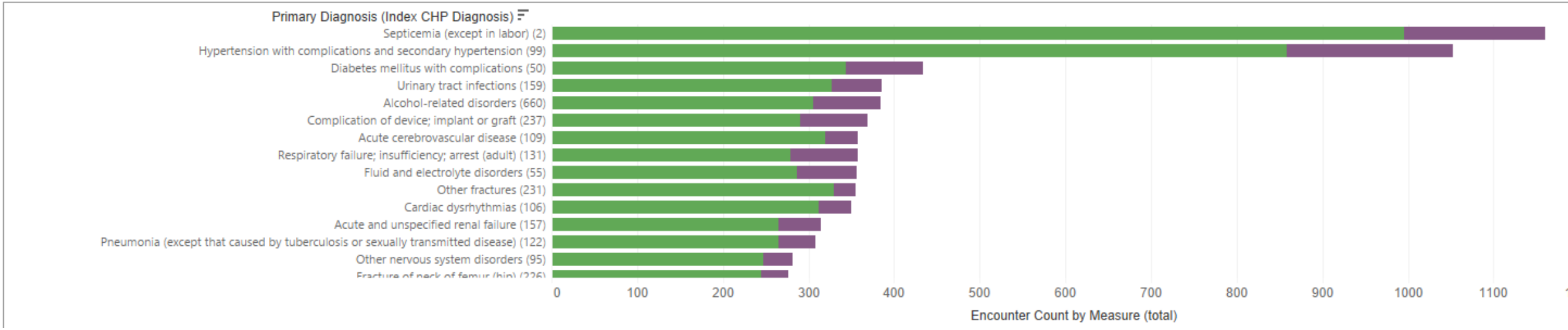
TH Livonia, All Payer, All EPIC IP Risk of Readmission

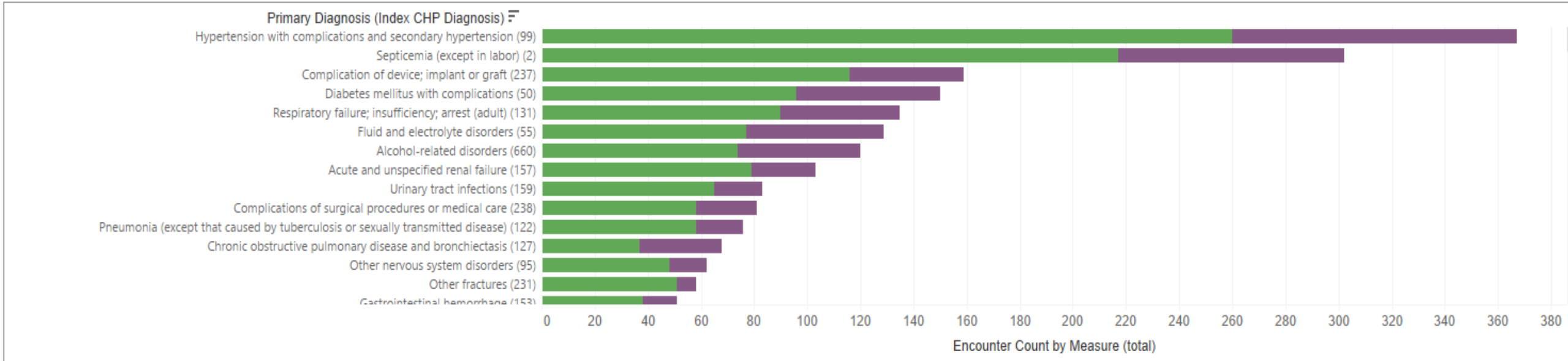


TH Livonia, 65/+, High EPIC IP Risk of Readmission

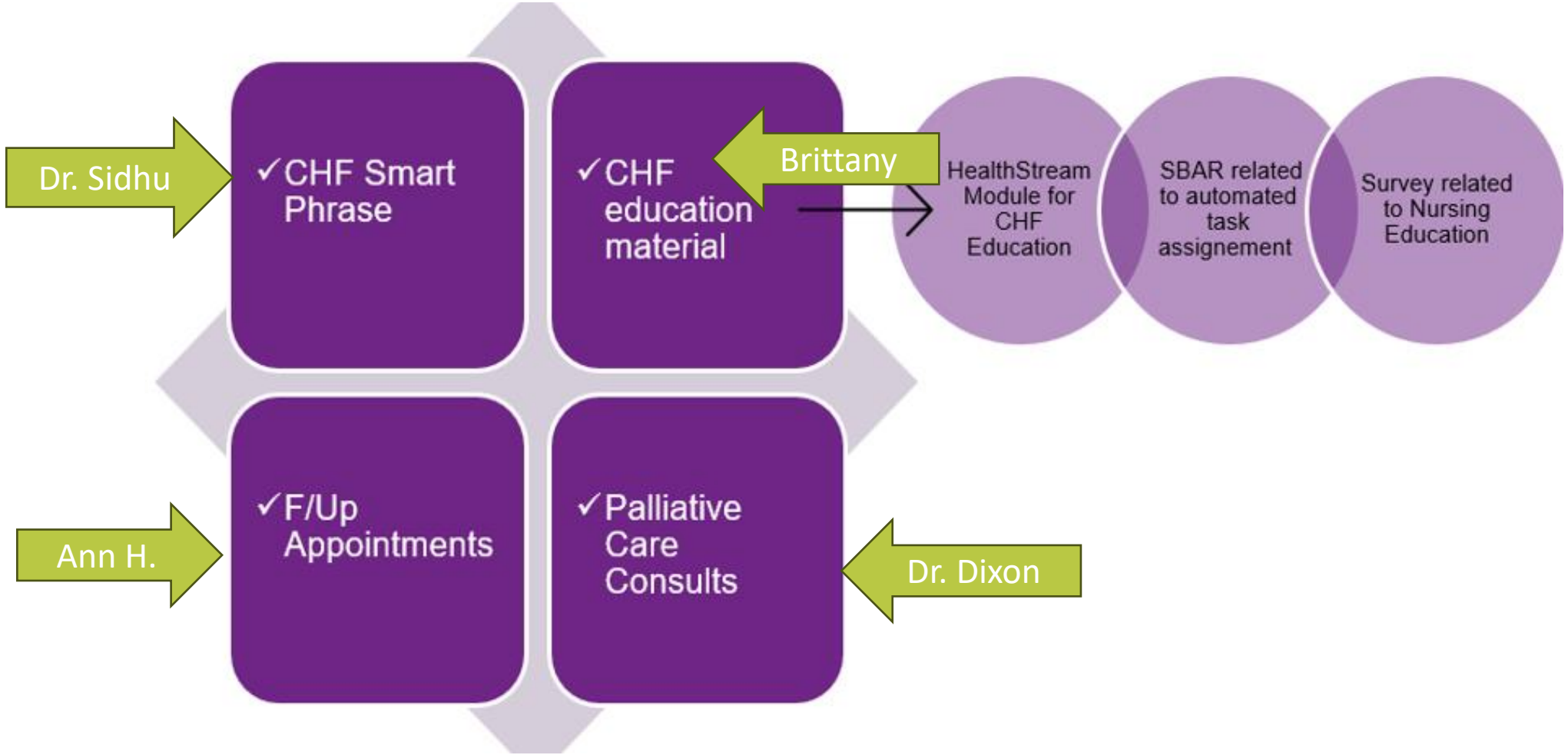


Primary Diagnosis and Risk Score



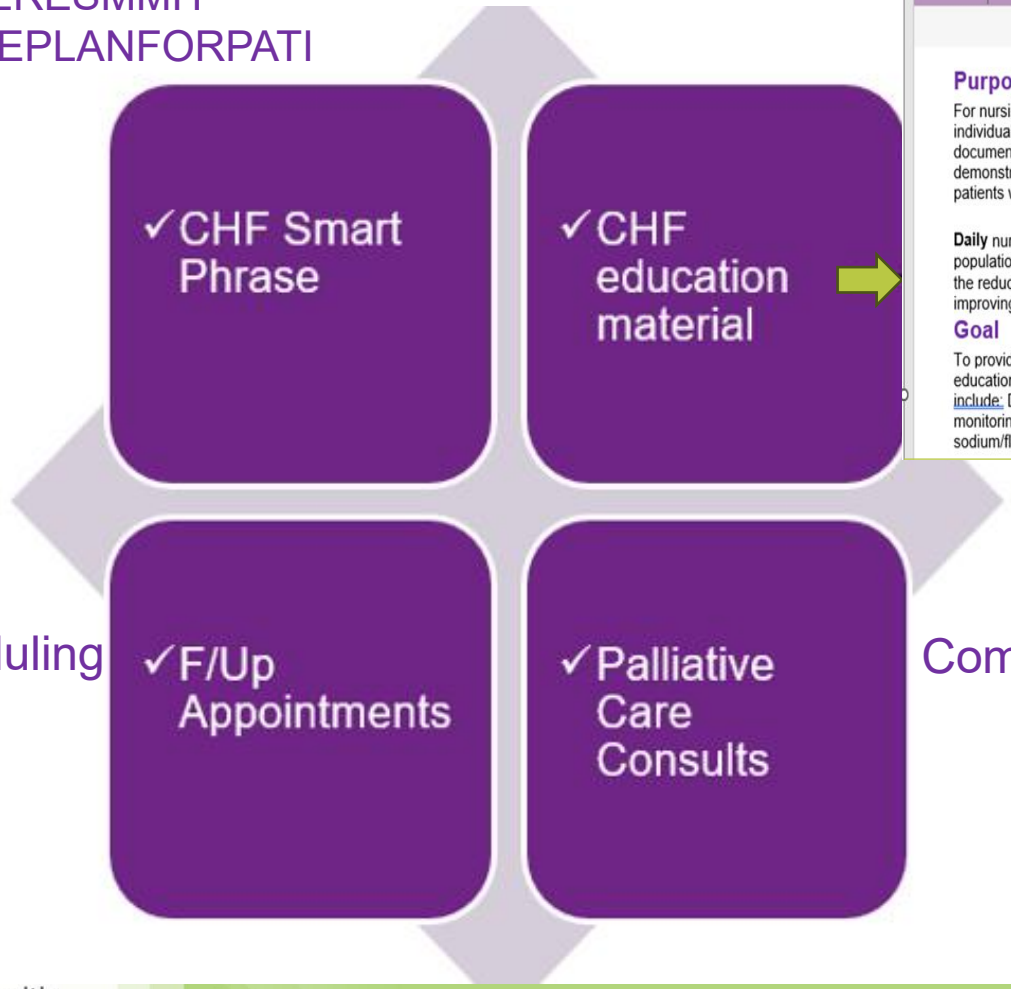


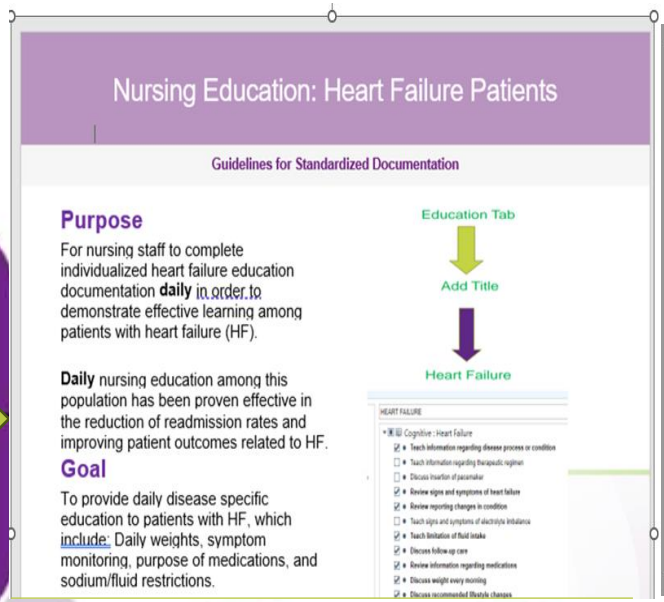
Targeted Interventions

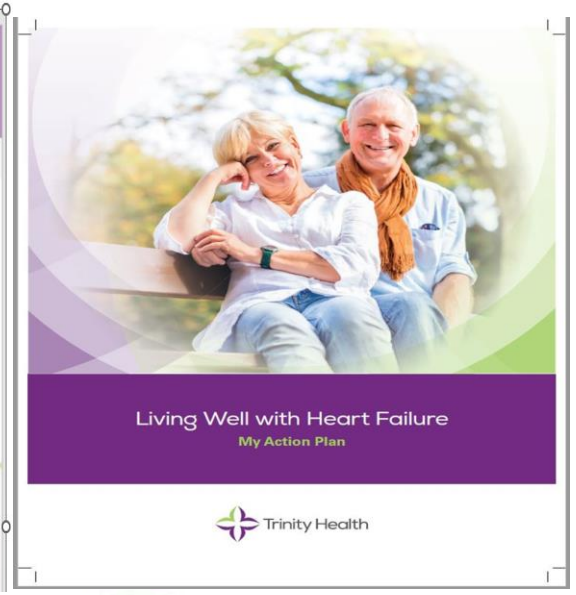


Targeted Interventions cont.

- HFDISCHARGERESMMH
  HEARTFAILUREPLANFORPATI
  ENTSMMH



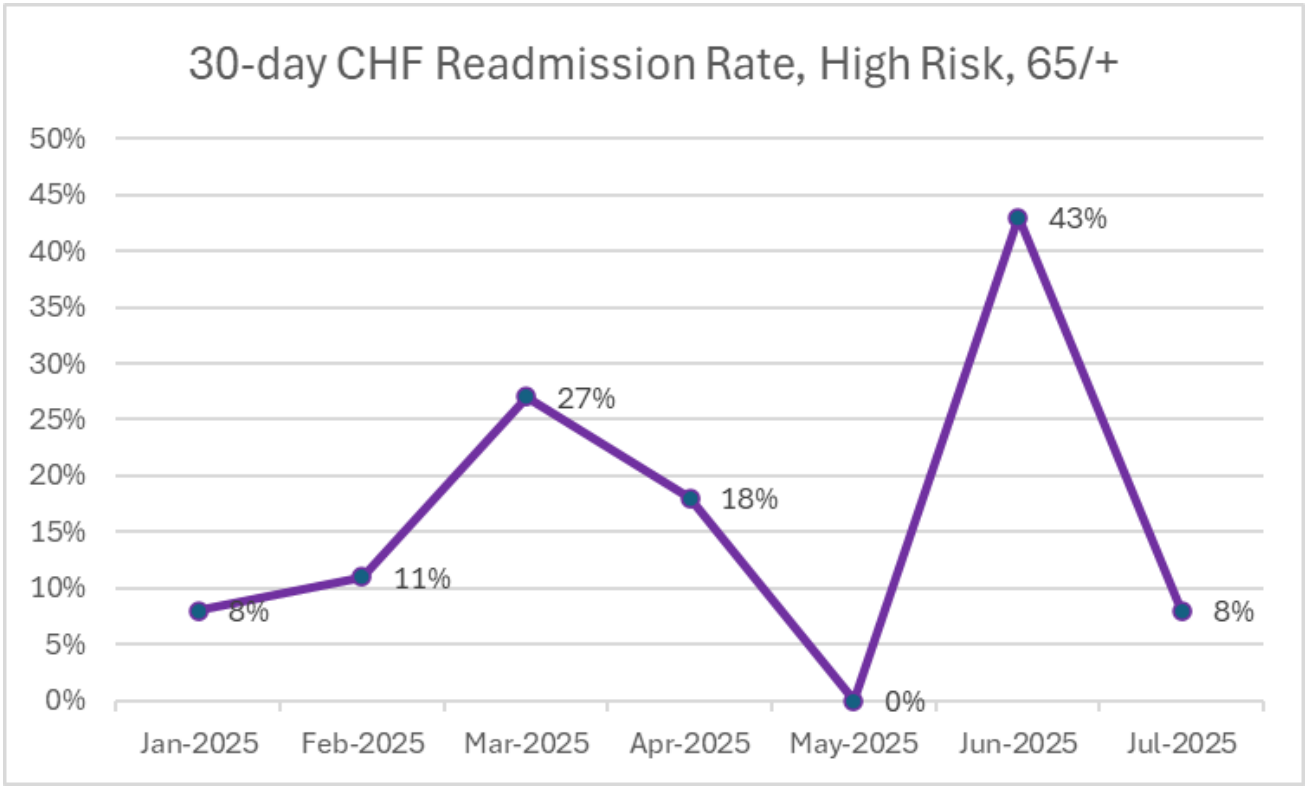




One Click scheduling

Comprehensive palliative care curriculum for residents

30-day CHF Readmission Rate, High Risk, 65/+



On-going strategies to prevent readmissions

- One-click Scheduling
- Medical Record Review for a specific diagnosis (AMI, COPD, CHF and PN)
- Interdisciplinary Rounds (IDRs)
- Palliative Care Education and OP Palliative Care Clinic
- Bedside Education for patients with CHF (Diagnosis, Med Adherence, Fluid Management and Healthy Habits)
  - iPads: URL Link: Patient Education | Trinity Health Michigan
- Root cause analysis of hospital readmissions from Skilled Nursing Facilities
- Root cause analysis of hospital readmissions during Home Care
- Transition of Care Clinic (TCC)

Common Root Cause Categories

Hospital

1. Flare of index Disease/Condition (optimized in hospital)
2. Flare of co-morbidity not related to index Admission /
3. Lack of palliative care or hospice involvement when appropriate

Skilled Nursing Facility

1. Lack of palliative care or hospice involvement when appropriate
2. Flare of index Disease/Condition (optimized in hospital)
3. Premature Discharge

Home Health Agency

1. Flare of index Disease/Condition (optimized in hospital)
2. Lack of palliative care or hospice involvement when appropriate
3. Inadequate Discharge Planning

References

- Boutwell, A., Bourgoin, A., Maxwell, J., DeAngelis, K., Genetti, S., Savuto, M., & Snow, J. (2016, September). Designing and delivering whole-person transitional care: The hospital guide to reducing Medicaid readmissions. Retrieved from Agency for Healthcare Research and Quality: https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html
- Donzé, J., Aujesky, D., Williams, D., & Schnipper, J. L. (2013). Potentially avoidable 30-day hospital readmissions in medical patients: derivation and validation of a prediction model. JAMA Internal Medicine, 173(8), 632-638. doi:10.1001/jamainternmed.2013.3023
- Kripalani, S., Theobald, C. N., Anctil, B., & Vasilevskis, E. E. (2014). Reducing hospital readmission rates: Current strategies and future directions. Annual Review of Medicine, 65, 471-485. doi: 10.1146/annurev-med-022613-090415
- Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., ... & Ting, H. H. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. JAMA Internal Medicine, 174(7), 1095-1107. doi:10.1001/jamainternmed.2014.1608
- Zuckerman, R. B., Sheingold, S. H., Orav, E. J., Ruhter, J., & Epstein, A. M. (2016). Readmissions, observation, and the hospital readmissions reduction program. New England Journal of Medicine, 374(16), 1543-1551. doi: 10.1056/NEJMsa1513024
- EPIC document (2020). Cognitive Computing Model Brief: Risk of Unplanned Readmissions

Questions?