Care Transitions:
Making the Programmatic Case

February 9, 2011

Agenda

- Introductions/housekeeping
- The Care Transitions Theme
  - Jane Brock, Chief Medical Officer, Colorado Foundation for Medical Care (CFMC)
  - Alicia Goroski, Care Transitions Project Director, CFMC
- The Atlanta Care Transition Initiative
  - Cathie Berger, Director, Atlanta Regional Commission Area Agency on Aging
- Data Sources to Target your Efforts
  - Abigail Morgan, Social Science Analyst, Office of Policy Analysis and Development, Administration on Aging
- Questions & Answers

The Care Transitions Theme:

Experiences from Community-Based Hospital Readmission Reduction Initiatives

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http://www.cfmc.org/caretransitions

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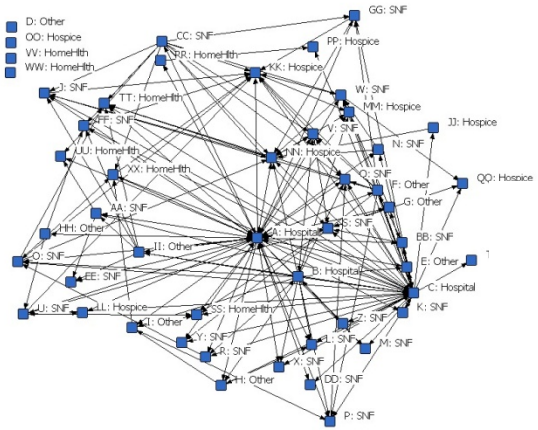
The Care Transitions Theme

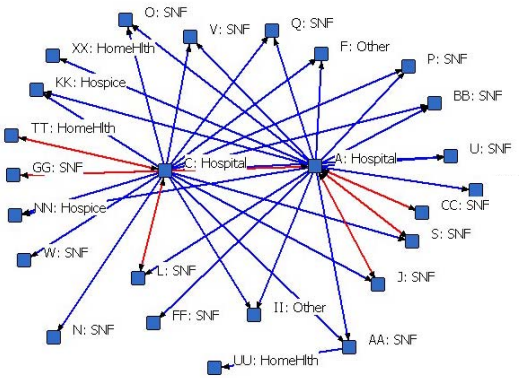
- Define a community
- Identify service patterns associated with readmission
- Recruit and convene providers/partners
- To reduce unplanned 30 day hospital readmissions for the *community*
- Using evidence-based interventions and tools

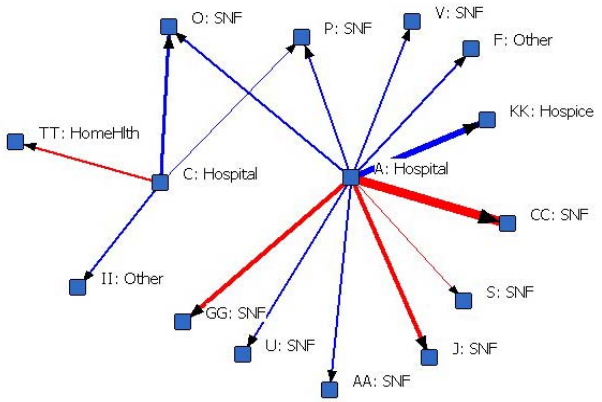
CMS Claims Data

- Regional readmission rates and care patterns
  - Very helpful for recruitment
  - Common target
  - Common language
- Other types of data
  - Root cause analyses
  - Medical records reviews
- Use of single stories
  - Motivational

Social Network Analysis







Root Cause Analyses

1) Medical record review
   - First hospitalization discharge
   - Other services provided
   - Readmission admission

Readmission Case Review Tool

Draft as of 10/09/09
Care Transitions Record Review Template
Work in progress/exploratory in nature/ Has NOT been tested for reliability/validity

Circle the correct response or fill in the blank, as indicated:

Date of this record review: _____
Code name/number of hospital: _____

Is this record the: Initial Admission OR Readmission

If this is a readmission,

Is there a notation that this is a readmission? YES NO

What is the stated reason for readmission?
_____
_____

Is the date of the last admission recorded? YES NO

If YES, what is the time interval between the date of discharge for the last admission and the current readmission? _____days

Admitted from: _____ (Possible answers include: HOME, SNF, NH, ALF, etc.)

Admitted to hospitalist/hospitalist group (includes a critical care group)? YES NO

Root Cause Analyses

1) Medical record review
   - First hospitalization discharge
   - Other services provided
   - Readmission admission
2) Readmission - Admission process assessment
   - Direct observation
   - Process owner interviews

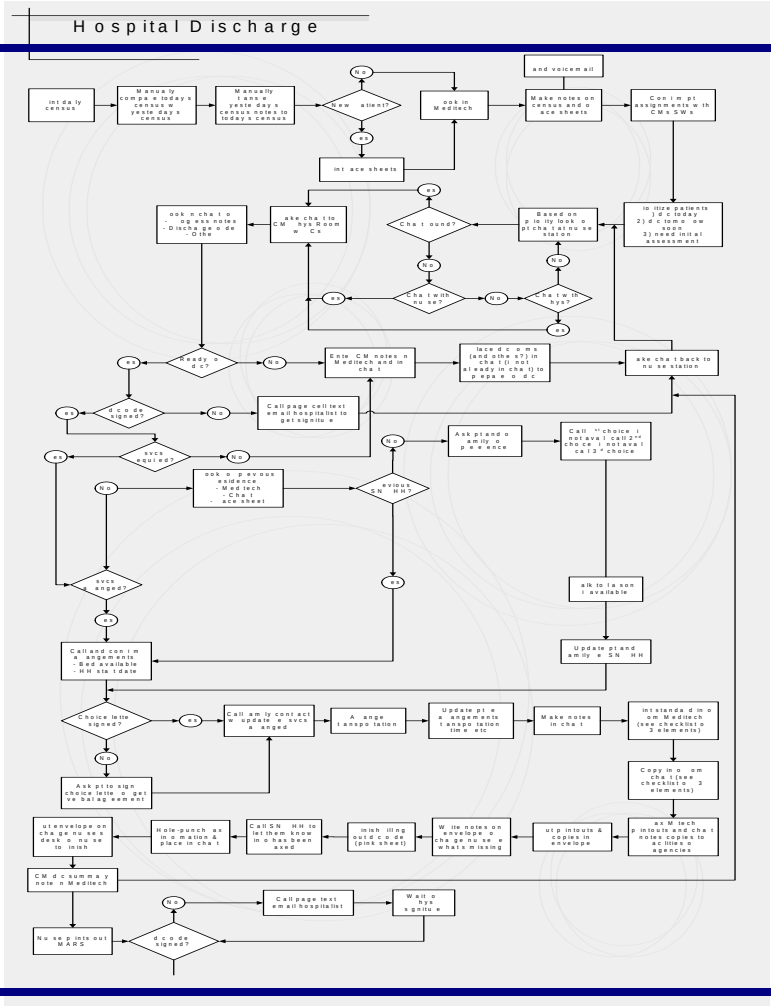
Value Stream Mapping

Current State Map

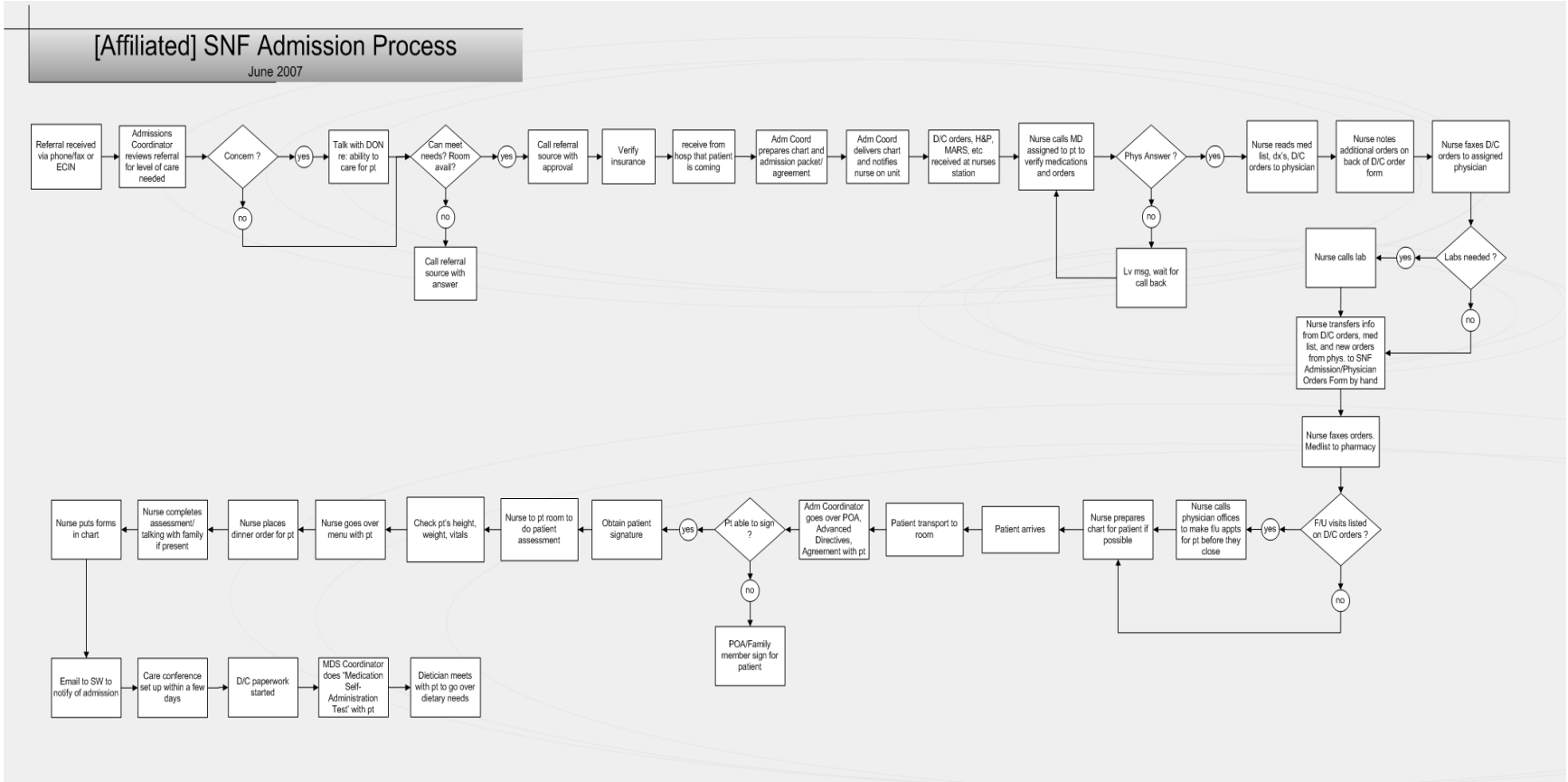
Future State Map

Process Mapping

Hospital discharge process



Skilled Nursing Facility Admission Process



Root Cause Analyses

1) Medical record review
   - First hospitalization discharge
   - Other services provided
   - Readmission admission
2) Process assessment
   - Direct observation
   - Process owner interviews
3) Group discussion
   - Focus groups
   - Appreciative inquiry-style interviews

Consumer Focus Group

Community Engagement

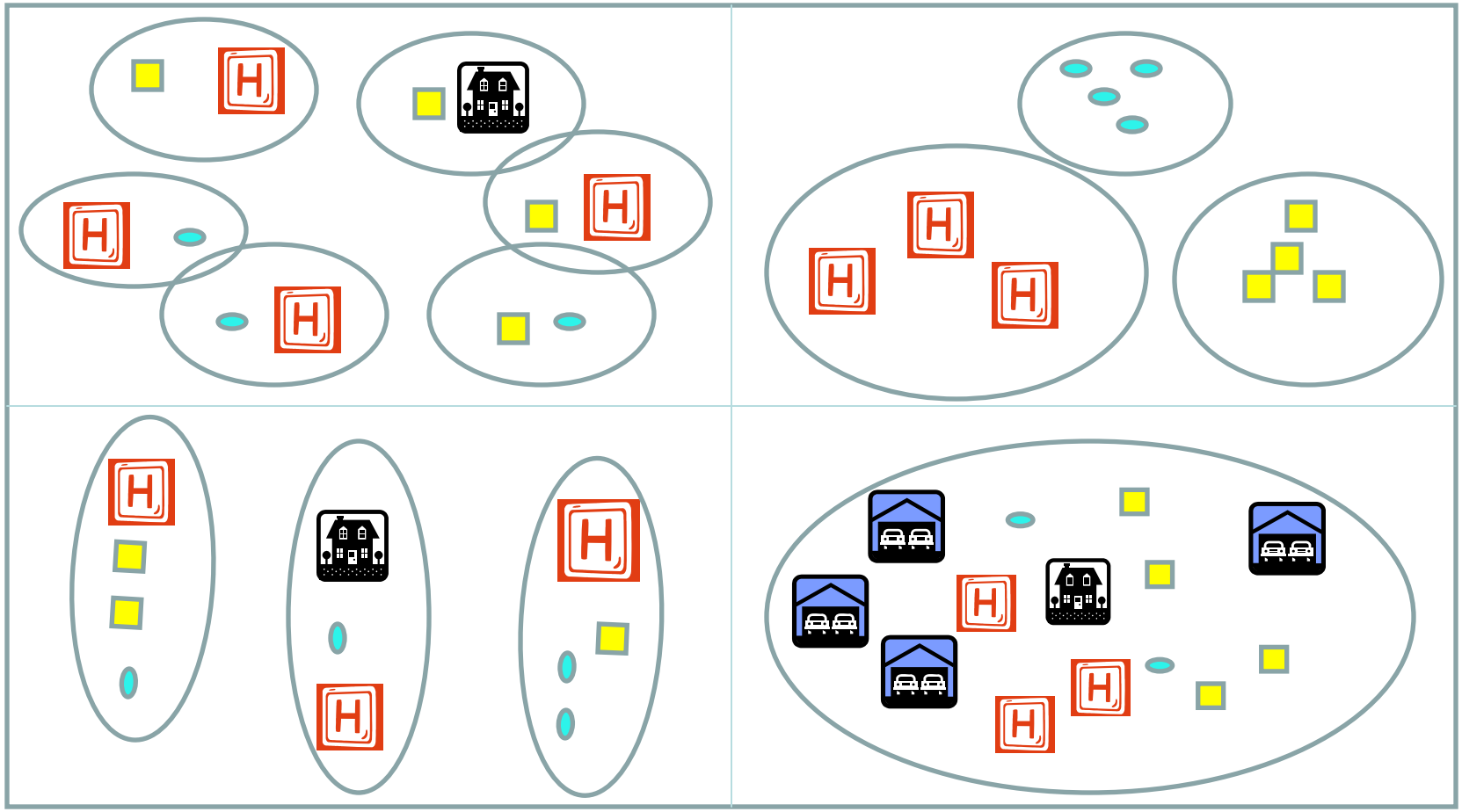
Handing Over Medical Responsibility

- *Real time communication to Primary Care Physicians (PCPs)*
  - <20% at time of discharge
  - 33% unaware of discharge
- *Communication to Home Health Agencies*
  - No direct conversation
  - Need signature from PCP
- *SNF needs functional status information*
  - High refusal rates
  - 3-day stay rule
- *Discharge summaries*
  - 86% in 48 hrs
  - 33% by the time of the follow-up visit

CMS Table of Interventions

http://www.cfmc.org/caretransitions/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf

Ways of organizing a community effort



Where a Motivated Community Could Start

- Identify your community
- Call/visit your QIO to see what they can do for you
- Value/promote informal social networking
- Figure out who shares patients in your community
- Forum for routine information exchange/discussion
- Routine discussion of readmission cases among all involved providers
- Review hospice/palliative care providers/utilization/referral processes
- Map/create handover management processes among providers

For more information:

Visit our website: http://www.cfmc.org/caretransitions

Join our Care Transitions Learning Sessions:

http://www.cfmc.org/caretransitions/learning_sessions.htm

Contact Us:

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Alicia Goroski – agoroski@cfmc.org

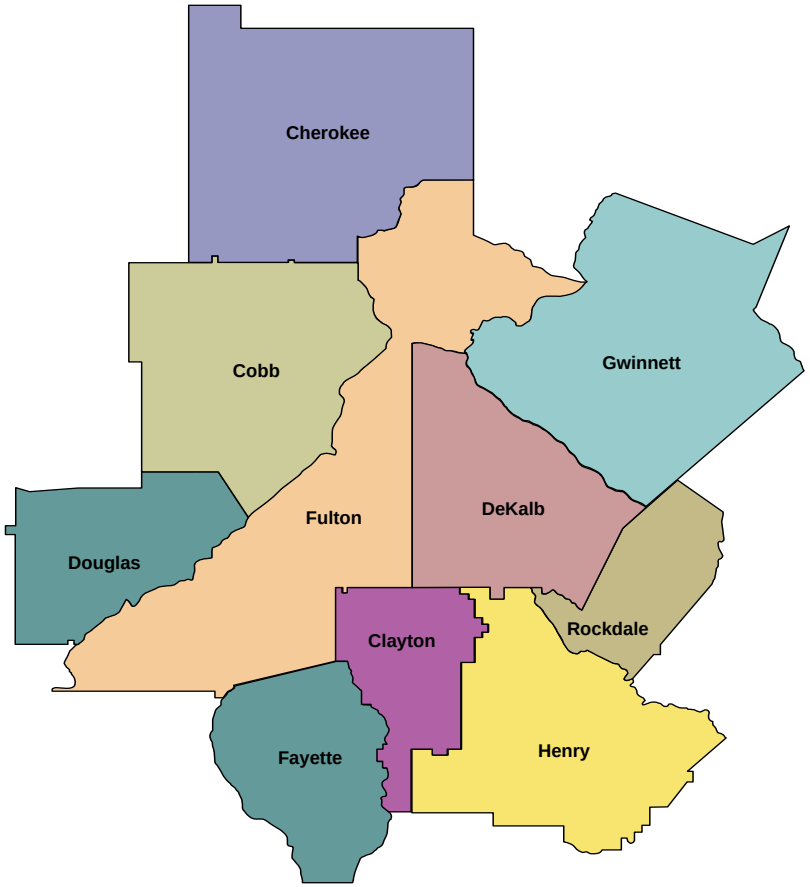
Atlanta Care Transition Initiative

Cathie Berger
Area Agency on Aging
Atlanta Regional Commission
Atlanta, GA

Atlanta Care Transitions Workgroup

- Build linkages and partnerships
- Share best practices and results
- Educate the medical and social service networks
- Educate consumers and families
- Promote common understanding

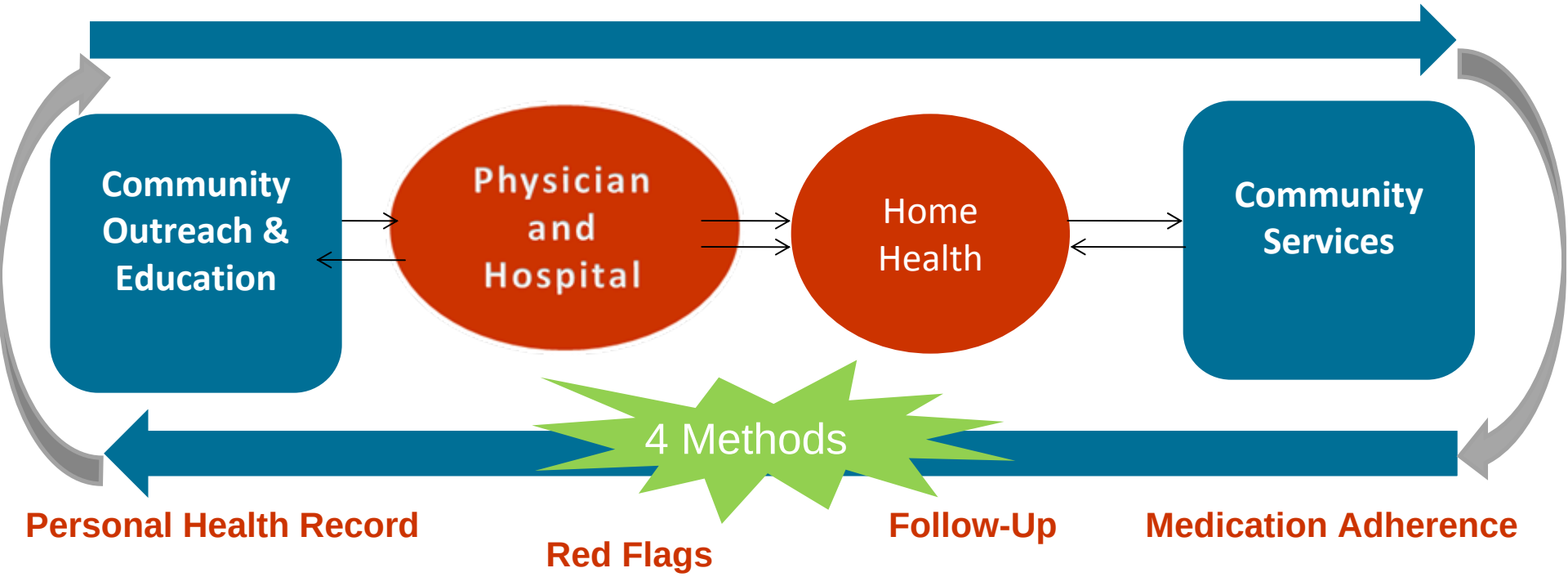
"….to plan and guide a regional approach to care transitions with a focus on how to collectively and individually implement the key principles of transitions care into our daily work processes."



Why Is This Important to the Aging Network?

- Share the goal of safe transitions
  - —Prevent experience and trauma of readmission
- Limited resources
  - —Ensure right supports at the right time in most efficient manner
- Opportunity to bridge the gap
  - —Between acute care and long-term care
- Reduce healthcare cost

Atlanta Care Transitions Framework



Linkage to Support Services

Coleman Approach: Key Activities

- Medication Self Management
- Use of a Personal Health Record
- Knowledge of warning signs and symptoms
- Follow-up visit with physician scheduled

Clear communication – Teach Back

Participation: The Aging Network

- Beginning when older adults and their families first call for information and resources
- Providing assistance in managing their care
- Delivering services
- Ensuring that clients and their families know what to expect

I. Information Services -- ADRC

- Incorporating care transitions protocols into options counseling
  - Asking the right questions
  - Providing options for support services
  - Providing educational materials
  - Providing follow up
  - Tracking calls

Responding to 70,000 calls per year

Care Transitions Information Counselor Protocols

1. Tell me what caused your hospitalization.
2. Tell me what you understand about your discharge plan.
    a) If the client is still in the hospital: Are you working with a discharge planner?
3. Do you have a follow up appointment scheduled with your primary care doctor? (should be 7-10 days following discharge)
    a) If the client is already home: Did you go to your follow up appointment?
4. Do you understand how to take your medications and what side effects to watch for and report?
    a) Is paying for them a problem?
    b) If the client is already home: Did you get your medications yet?
5. Do you know what the warning signs (or red flags) are for your condition?
    a) Tell me what you were told to watch for and report

II. Care Management

- Incorporating care transitions protocols into care management
  - Ensuring the client and caregiver(s) understand the transition plan
  - Using the Coleman coaching approach
  - Complementing the transition plan with HCBS care plan
  - Facilitating communication among all concerned
  - Tracking hospitalizations

VNHS/CCSP Transition Process - The Eric Coleman 4 Pillars Method

Administrative Process

PA
- Receives CCNF informing of Client Hospitalization/ER visit

OR
- SW/RN informs PA of Client Hospitalization via email w/ cc: to SW/RN partner

- Sends email Alert SW & RN requesting updated/completed information regarding ADMT, HOSP, Dx, D/c, FU
- Returns original CCNF to SW w/ initials/date in red
- Within 5 days RN will update PA via email RE:ADMT, HOSP, Dx, D/c date & FU

Interventions Within 48 hours of Notification

RN
- Contacts client and/or family to determine admission date, reason for hospitalization/ER visit, & expected discharge date
- May contact Hospital Discharge planner when appropriate.
- Document in CHAT as "Hospitalization"
- Determine & DOCUMENT IN CHAT REASON REASSESSMENT NOT PERFORMED
- Determine if Incident report is needed
- Determine if HH is in place & Communicate/Coordinate with HH RN
- Document in Chart & notify SW of any changes in the service order changes
- RN will consult w/ SW

RN
- Contact Client and/or Family with a common focus on The 4 Pillars Goals and Interventions
- Communication will continue for up to 6 weeks or until all 4 Pillar Goals are met

SW
- Contact the Provider for updated information, adjust the SAF &/or create interim service order
- De-authorize SAF for hospitalizations > than 5 days
- Assess Client for contributing psycho-social issues
- Document in CHAT as "Hospitalization"
- SW will consult w/ RN

ERIC COLEMAN CARE TRANSITIONS – FOUR PILLARS

Medication Review
- Identify/teach all Med changes
- Determine if Client has Meds

Confirm MD Follow-up w/ PCP/Specialist
- PCP is informed if Specialist to be seen 1st
- Discuss/Role Play one question Client will ask during MD visit

Red Flags
- Teach warning signs that condition is getting worse & appropriate interventions.
- Determine Client/CG understanding of reasons for Hospitalization
- Determine if Client would benefit from Disease Management
- Frequent Flyers(>2 acute visits in 6 months)will be followed for up to 6 weeks

Personal Health Record
- Provide a Personal Health Record for Clients receiving DM & Frequent Flyers when RN deems appropriate

2/10/2010

VNHS Care Management Readmission Data

Medicaid Waiver CCSP FY 2010 July 1, 2009 – June 30,2010		
Total Clients	2,622	
Clients hospitalized	823	31%
Clients hospitalized more than 1x	683	26%
Clients readmitted w/in 30 days	184	22%

III. Service Delivery System

- Support services provided under Older Americans Act, State and Local funding:
  - Home delivered meals, in-home, caregiver support, transportation, adult daycare
- Services provided under the Medicaid Waiver Programs:
  - Adult day health, skilled nursing, personal support services, home delivered meals, emergency response, alternative living

Service Delivery System: DeKalb Pilot Project

- Seven day pre-arranged support package
  - Home delivered meals _ 7 days
  - In-home support services - 6 hours
  - Transportation - 4 One way trips
  - Case management/coaching - 30 days
- 5 Hospitals
- Average cost: $500.00
- Readmission rate: 16%
- Replicated in 4 additional counties

Expanding to other counties

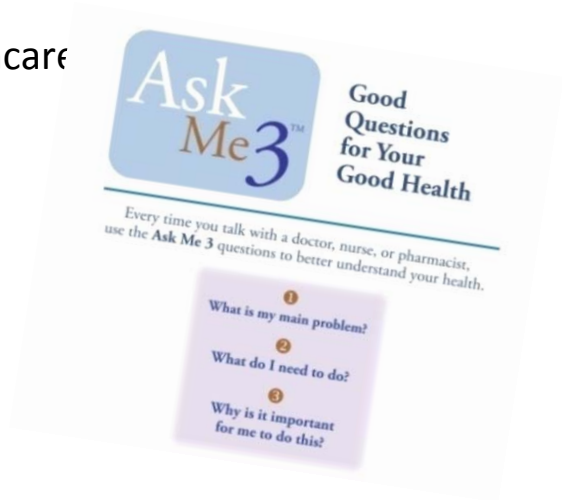
DeKalb Preliminary Results
April 1 – June 30, 2010

- Number of clients served
  - Meals and homemaker: 14
  - Meals only: 30
  - Transportation: 9
  - Transportation and escort: 2

Service	Units	Without Escort	With Escort
Transportation	4 one way trips	$ 55.00	$110.00
In-Home	6 hours	$139.00	$139.00
Meals	7 meals/14 meals	$ 51.00	$102.00
Coaching		$143.00	$143.00
Subtotal		$388.00	$494.00
20% overhead		$ 77.60	$ 98.80
Total		**$465.60**	**$592.80**

IV. Consumer Education

- Incorporating care transitions into the AAA Volunteer Outreach/Community Education
  - Retired Professionals
  - *How to Navigate the Health Care System*
    - How to prepare for a hospital stay and discharge
    - Importance of maintaining a Personal Health Record
    - Why complete a Georgia Advance Directive for Healthcare
    - Medication Management
    - Information about Medicare and related benefits
  - Materials for Distribution
- In past year
  - 40 trained volunteers
  - 77 presentations



For more information:

Contact:

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Data Sources to Target Your Efforts

Abigail Morgan

Office of Policy Analysis and Development

Administration on Aging

Definitions for Partnership

- Hospitals
  - High readmission rates
- Community-based organizations
  - Providing care transition services
  - Representative governing body

Learning More About Local Hospitals

- Hospital Compare
  - http://www.hospitalcompare.hhs.gov

- Medicare.gov Database Download
  - http://www.medicare.gov/Download/DownloadDB.asp

Medicare Hospital Compare Quality of Care - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Search Favorites

Address http://www.hospitalcompare.hhs.gov/

U.S. Department of Health & Human Services

HHS.gov

Sign In to MyMedicare.gov

Search Medicare.gov Search FAQ

Email | Print | Bookmark & Share | RSS | Español (Spanish) | A A A

Medicare.gov | Manage Your Health | Medicare Basics | Resource Locator | Help & Support

? Help | For Consumers | For Professionals

Medicare.gov › Hospital Compare Home

Hospital Compare

Where do you want to find a hospital?

Search Information

Location - ZIP Code or City, State

e.g. 10009 or New York, NY

Search type[?]

- (•) General
- ( ) Medical Conditions
- ( ) Surgical Procedures

Find Hospitals >

Hospital Spotlight

There's new information about the quality of surgical care for hospitals in your area. **A complete list of Surgical Care Measures is available in the Technical Appendix.**

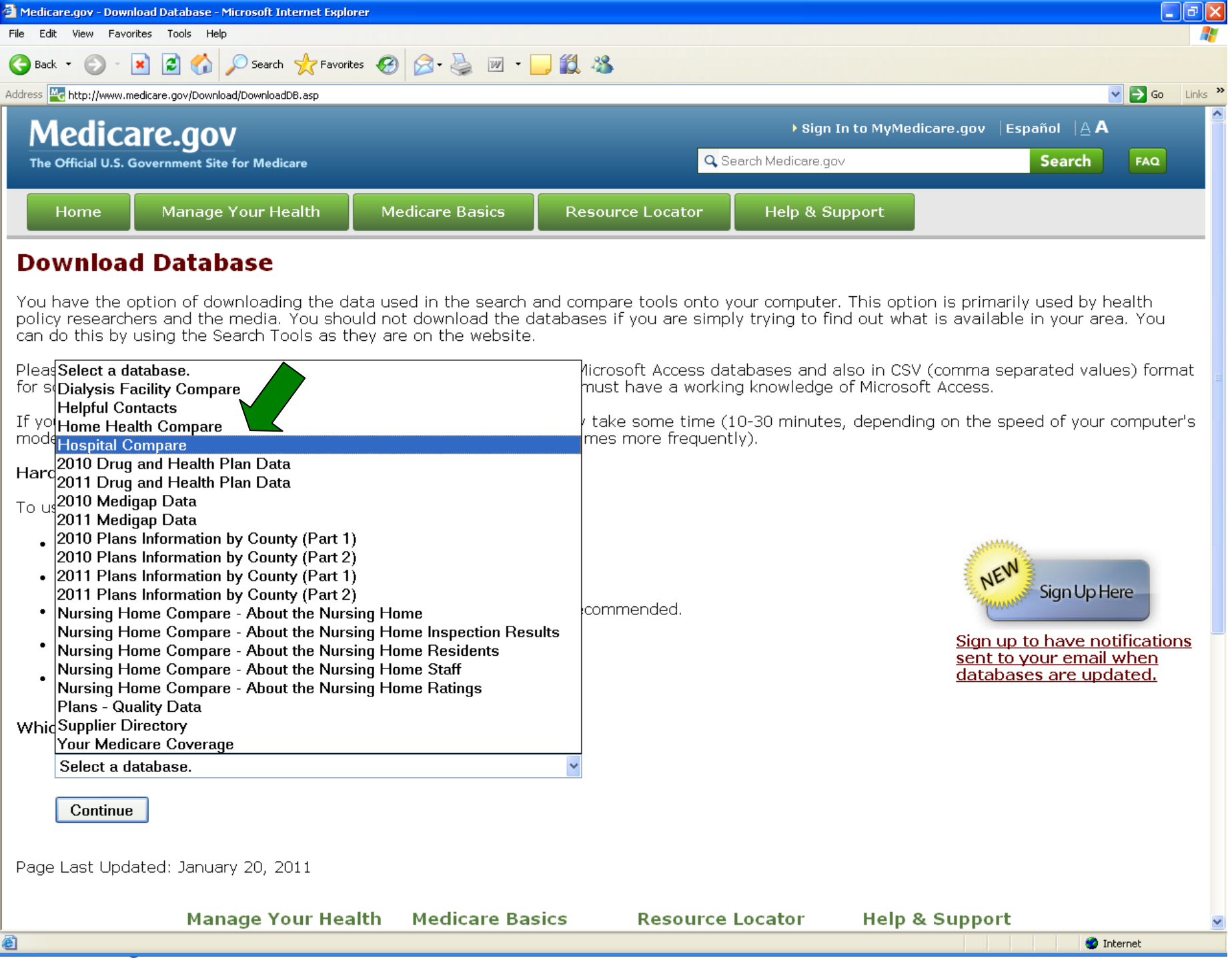
NEW Hospital Profile Page!

Each hospital's information and measures all in one place! Simply click on the hospital name.

Additional Information

- View a list of Hospital Compare Contacts
- Download the Hospital Compare Database (Data Last Updated: December 11, 2010)

Back to Top


Medicare.gov - Download Database - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://www.medicare.gov/Download/DownloadDB.asp
Go Links
Medicare.gov
The Official U.S. Government Site for Medicare
Sign In to MyMedicare.gov
Español
A A
Search Medicare.gov
Search
FAQ
Home
Manage Your Health
Medicare Basics
Resource Locator
Help & Support
Download Database
You have the option of downloading the data used in the search and compare tools onto your computer. This option is primarily used by health policy researchers and the media. You should not download the databases if you are simply trying to find out what is available in your area. You can do this by using the Search Tools as they are on the website.
Pleas
Microsoft Access databases and also in CSV (comma separated values) format
for s
must have a working knowledge of Microsoft Access.
If yo
take some time (10-30 minutes, depending on the speed of your computer's
mode
mes more frequently).
Harc
To us
ecommended.
Whic
Select a database.
Dialysis Facility Compare
Helpful Contacts
Home Health Compare
Hospital Compare
2010 Drug and Health Plan Data
2011 Drug and Health Plan Data
2010 Medigap Data
2011 Medigap Data
2010 Plans Information by County (Part 1)
2010 Plans Information by County (Part 2)
2011 Plans Information by County (Part 1)
2011 Plans Information by County (Part 2)
Nursing Home Compare - About the Nursing Home
Nursing Home Compare - About the Nursing Home Inspection Results
Nursing Home Compare - About the Nursing Home Residents
Nursing Home Compare - About the Nursing Home Staff
Nursing Home Compare - About the Nursing Home Ratings
Plans - Quality Data
Supplier Directory
Your Medicare Coverage
Select a database.
Continue
NEW
Sign Up Here
Sign up to have notifications sent to your email when databases are updated.
Page Last Updated: January 20, 2011
Manage Your Health
Medicare Basics
Resource Locator
Help & Support
Internet

Medicare.gov - Download Database - Microsoft Internet Explorer

File Edit View Favorites Tools Help

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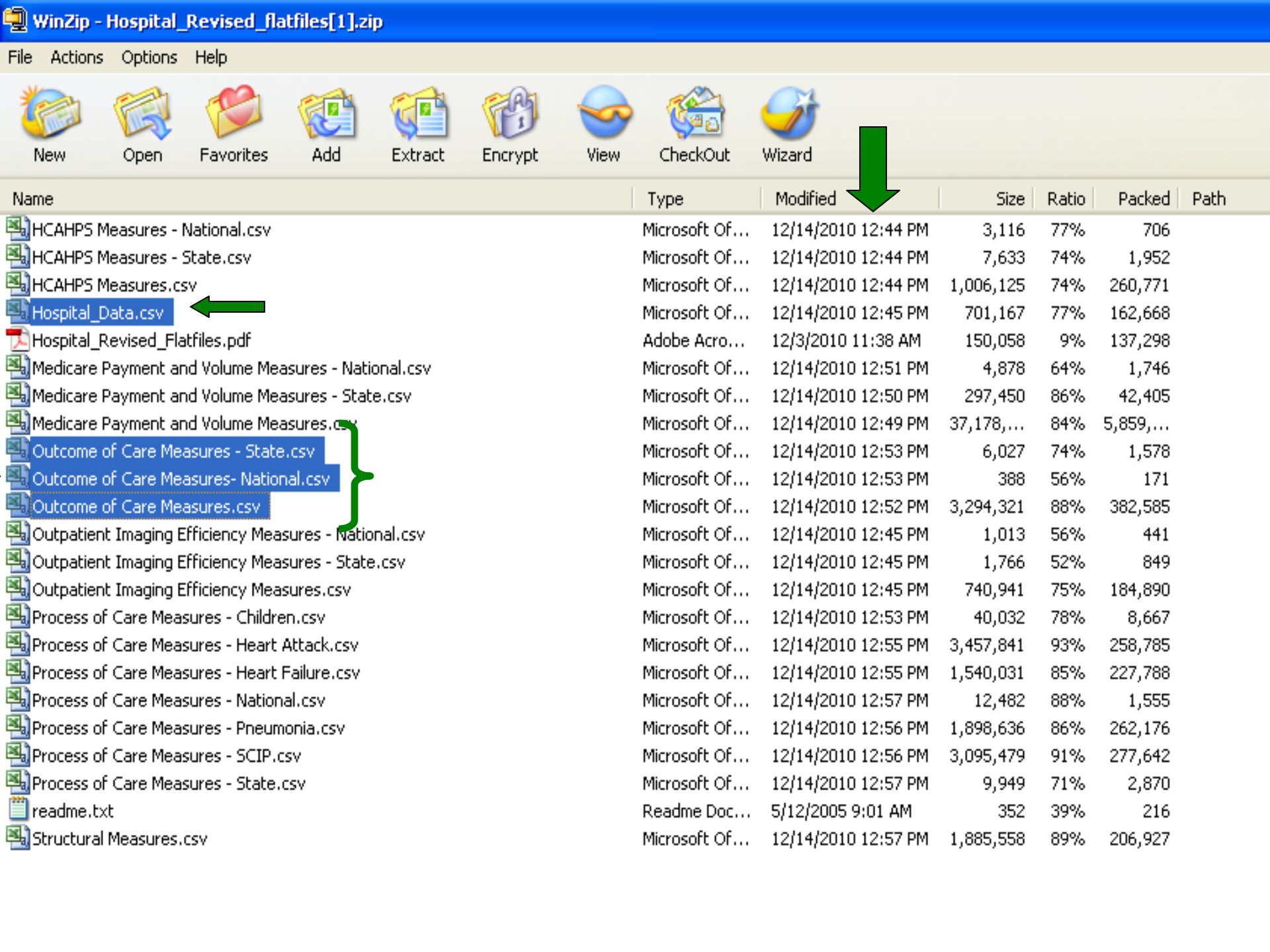
Address http://www.medicare.gov/Download/DownloaddbInterim.asp Go Links

You have the option of downloading the Hospital Compare data as a Microsoft Access 2000 database or as .csv file.

Interactive Database The data can now be accessed online in an interactive database using the new Medicare data website.	http://data.medicare.gov
Microsoft Access Database (Size: 14 MB) This data can be downloaded as a Microsoft Access 2000 database contained within a compressed, or "zipped" file. To use this data you will need Microsoft Access 2000 or later, or download Microsoft Access Viewer below. The database file can be extracted from the compressed file using either the WinZip or PKUNZIP utility. In the former case, open the compressed file using WinZip, select the file with the .MDB extension from the list of files displayed, choose the Extract command from the Actions menu, and then specify the directory where the extracted file is to be saved. In the latter case, open an MS-DOS window, go to the directory where the compressed file is saved, and execute the command PKUNZIP "compressed name file" *.zip where "compressed name file" is the name of the compressed file saved on your disk drive. This case assumes that the executable PKUNZIP.exe is in a directory in your PATH statement.	Download
CSV Flat Files (Size: 5 MB) This data can be downloaded as a set of CSV (Comma Separated Values) files contained within a compressed, or "zipped" file. These files are viewable by most text editors, spreadsheet and database programs. The file can be extracted from the compressed file using either the WinZip or PKUNZIP utility. In the former case, open the compressed file using WinZip, select the file with the .MDB extension from the list of files displayed, choose the Extract command from the Actions menu, and then specify the directory where the extracted file is to be saved. In the latter case, open an MS-DOS window, go to the directory where the compressed file is saved, and execute the command PKUNZIP "compressed name file" *.zip where "compressed name file" is the name of th ompressed file saved on your disk drive. This case assumes that the executable PKUNZIP.exe is directory in your PATH statement.	Download
CSV Flat Files - Revised Format (Size: 8 MB) The CSV Flat Files - Revised Format contains the same data as the original CSV Flat File and Access database but in a revised format where any numerical codes (i.e., footnote codes, value codes, message codes) are replaced with their text equivalent. In the original CSV Flat File format, a PDF document accompanied the flat files that explained the numerical codes. However, this Revised Format integrates the text equivalent directly into the CSV flat file. This Revised Format may be more useful for some users.	Download

Done Internet


WinZip - Hospital_Revised_flatfiles[1].zip
File Actions Options Help
New Open Favorites Add Extract Encrypt View CheckOut Wizard
Name Type Modified Size Ratio Packed Path
HCAHPS Measures - National.csv Microsoft Of... 12/14/2010 12:44 PM 3,116 77% 706
HCAHPS Measures - State.csv Microsoft Of... 12/14/2010 12:44 PM 7,633 74% 1,952
HCAHPS Measures.csv Microsoft Of... 12/14/2010 12:44 PM 1,006,125 74% 260,771
Hospital_Data.csv Microsoft Of... 12/14/2010 12:45 PM 701,167 77% 162,668
Hospital_Revised_Flatfiles.pdf Adobe Acro... 12/3/2010 11:38 AM 150,058 9% 137,298
Medicare Payment and Volume Measures - National.csv Microsoft Of... 12/14/2010 12:51 PM 4,878 64% 1,746
Medicare Payment and Volume Measures - State.csv Microsoft Of... 12/14/2010 12:50 PM 297,450 86% 42,405
Medicare Payment and Volume Measures.csv Microsoft Of... 12/14/2010 12:49 PM 37,178,... 84% 5,859,...
Outcome of Care Measures - State.csv Microsoft Of... 12/14/2010 12:53 PM 6,027 74% 1,578
Outcome of Care Measures- National.csv Microsoft Of... 12/14/2010 12:53 PM 388 56% 171
Outcome of Care Measures.csv Microsoft Of... 12/14/2010 12:52 PM 3,294,321 88% 382,585
Outpatient Imaging Efficiency Measures - National.csv Microsoft Of... 12/14/2010 12:45 PM 1,013 56% 441
Outpatient Imaging Efficiency Measures - State.csv Microsoft Of... 12/14/2010 12:45 PM 1,766 52% 849
Outpatient Imaging Efficiency Measures.csv Microsoft Of... 12/14/2010 12:45 PM 740,941 75% 184,890
Process of Care Measures - Children.csv Microsoft Of... 12/14/2010 12:53 PM 40,032 78% 8,667
Process of Care Measures - Heart Attack.csv Microsoft Of... 12/14/2010 12:55 PM 3,457,841 93% 258,785
Process of Care Measures - Heart Failure.csv Microsoft Of... 12/14/2010 12:55 PM 1,540,031 85% 227,788
Process of Care Measures - National.csv Microsoft Of... 12/14/2010 12:57 PM 12,482 88% 1,555
Process of Care Measures - Pneumonia.csv Microsoft Of... 12/14/2010 12:56 PM 1,898,636 86% 262,176
Process of Care Measures - SCIP.csv Microsoft Of... 12/14/2010 12:56 PM 3,095,479 91% 277,642
Process of Care Measures - State.csv Microsoft Of... 12/14/2010 12:57 PM 9,949 71% 2,870
readme.txt Readme Doc... 5/12/2005 9:01 AM 352 39% 216
Structural Measures.csv Microsoft Of... 12/14/2010 12:57 PM 1,885,558 89% 206,927

Summary: Downloading Hospital Compare

- Use Hospital Compare CSV Flat Files—Revised Format
- Target five files
  - Hospital_Revised_Flatfiles.pdf
  - Hospital_Data.csv
  - Outcome of Care Measures.csv (three files)

Summary: Outcome of Care Measures

- National, State and local files
  - 30 Day Mortality and Readmission Rates
  - Heart Attack, Heart Failure, Pneumonia
- Sort by state, city and county

Resources: For Hospitals

- Eldercare Locator
  - Public service of US Administration on Aging
  - Listings for local Area Agencies on Aging, Aging and Disability Resource Centers (ADRC), local aging service providers and programs
  - http://www.eldercare.gov

Resources: Care Transitions

- http://www.cfmc.org/caretransitions/Default.htm (Care Transitions Quality Improvement Organization Support Center)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers and care transitions)

Resources: Data Sources

- http://www.hospitalcompare.hhs.gov (U.S. Department of Health & Human Services' consumer-oriented website that provides information on how well hospitals provide recommended care to their patients)
  - For Professionals: http://www.hospitalcompare.hhs.gov/staticpages/for-professionals/poc/data-collection.aspx
- http://www.medicare.gov/Download/DownloadDB.asp (Medicare's downloadable databases)
- https://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf (Data by state on high readmission rate hospitals)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)

Next Training

- *Care Transitions: Making the Business Case*
  - Wednesday, February 23, 2:00-3:30 pm EST
  - Watch your email for registration information

Questions/Comments/Suggestions for Future Webinar Topics?

Send them to:

AffordableCareAct@aoa.hhs.gov