Defining Communities: Care Transitions Partnerships between QIOs and the Aging Network

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Agenda

- Housekeeping/Introductions
- Integrating Care for Populations and Communities Aim
  - Looking toward the Quality Improvement Organization (QIO) 10th Scope of Work (SOW)
  - Lessons learned from the 9th SOW
- Partnerships between Quality Improvement Organizations (QIO) and the Aging Network: the Pennsylvania (PA) Story
- Resources/Next training
- Questions/Comments

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Presenters

- Traci Archibald, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, Division of Chronic and Post Acute Care, Centers for Medicare & Medicaid Services
- Naomi Hauser, Director - Care Transitions Project, Quality Insights of Pennsylvania
- Tim Landrin, Director - Home and Community-Based Long Term Care Division, Southwestern Pennsylvania Area Agency on Aging
- Ray DuCoeur, Administrator, Westmoreland County Area Agency on Aging

Integrate Care for Populations and Communities Aim (ICPCA)

SPARKING INNOVATION
IGNITING ACTION
BETTER CARE, BETTER HEALTH, REDUCED COSTS

Traci Archibald, OTR/L, MBA
Centers for Medicare and Medicaid Services
Office of Clinical Standards and Quality
Quality Measurement and Health Assessment Group
Division of Chronic and Post Acute Care

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Objectives

- Overview of the Integrate Care for Populations and Communities Aim (ICPCA) of the QIO 10th SOW
- The importance of community recruitment, engagement, and collaboration in reducing hospital readmissions
- Key successes and challenges from the QIO 9th SOW sub-national Care Transitions Theme in 14 communities

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ICPCA Goals

- Improve the quality of care for Medicare beneficiaries as they transition between providers
- Reduce 30-day hospital readmissions by 20% over 3 years for the nation

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QIOs and Community Engagement

- Identify potential communities- defined by the Medicare beneficiaries that live in contiguous set of zip codes
- Recruit and convene community providers and stakeholders to collaborate to improve care transitions and reduce 30-day hospital readmissions for the beneficiaries they serve

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QIO Technical Assistance

- Community coalition formation
- Community-specific root cause analysis
- Intervention selection and implementation
- Assist with an application for a formal care transitions program

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Community Coalition Building Support

- Education on models
- Social Network Analysis
- Strategic plan
- Develop and sign a coalition charter

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Building Community-ness: Four Models of Community Engagement

1. Multi-representative steering committee
2. Aggregate providers vertically in clusters, then merge
3. Aggregate providers by setting then vertically integrate
4. Individual improvement projects, with information and data-broker

Make it visibly a community effort

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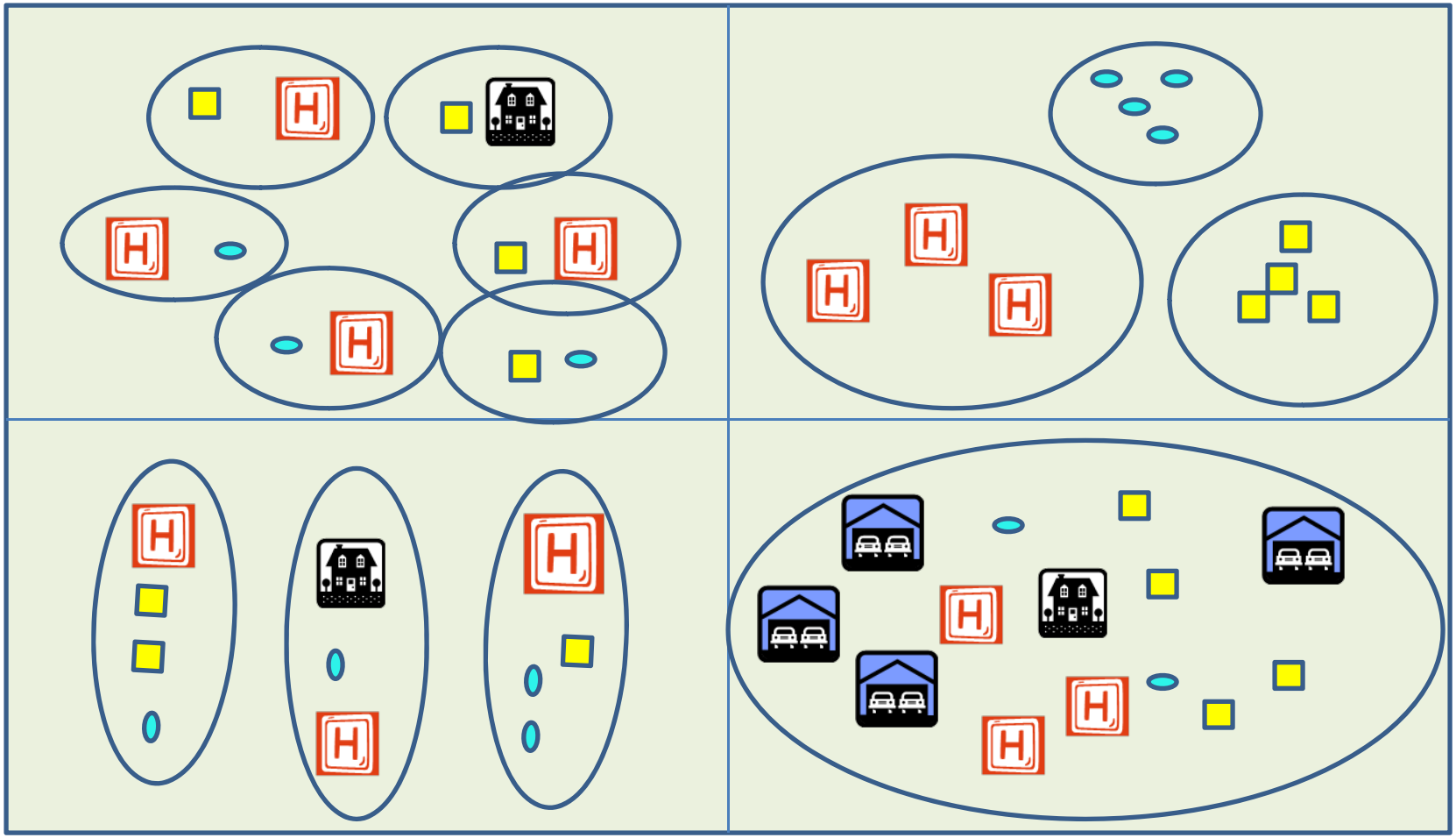
Ways of organizing a community effort



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Social Network Analysis (SNA)

- **Tool Description**

  SNA maps are a visual depiction of the number of transitions that are shared between providers in the community

- **Tool Uses**
  - Used by several QIOs midway through the 9th SOW Care Transitions Theme.
  - Can be used for provider recruitment & engagement and targeting interventions to highly problematic pairs.
  - Can be recalculated over time to show improvement in transitions between sender/receiver pairs.

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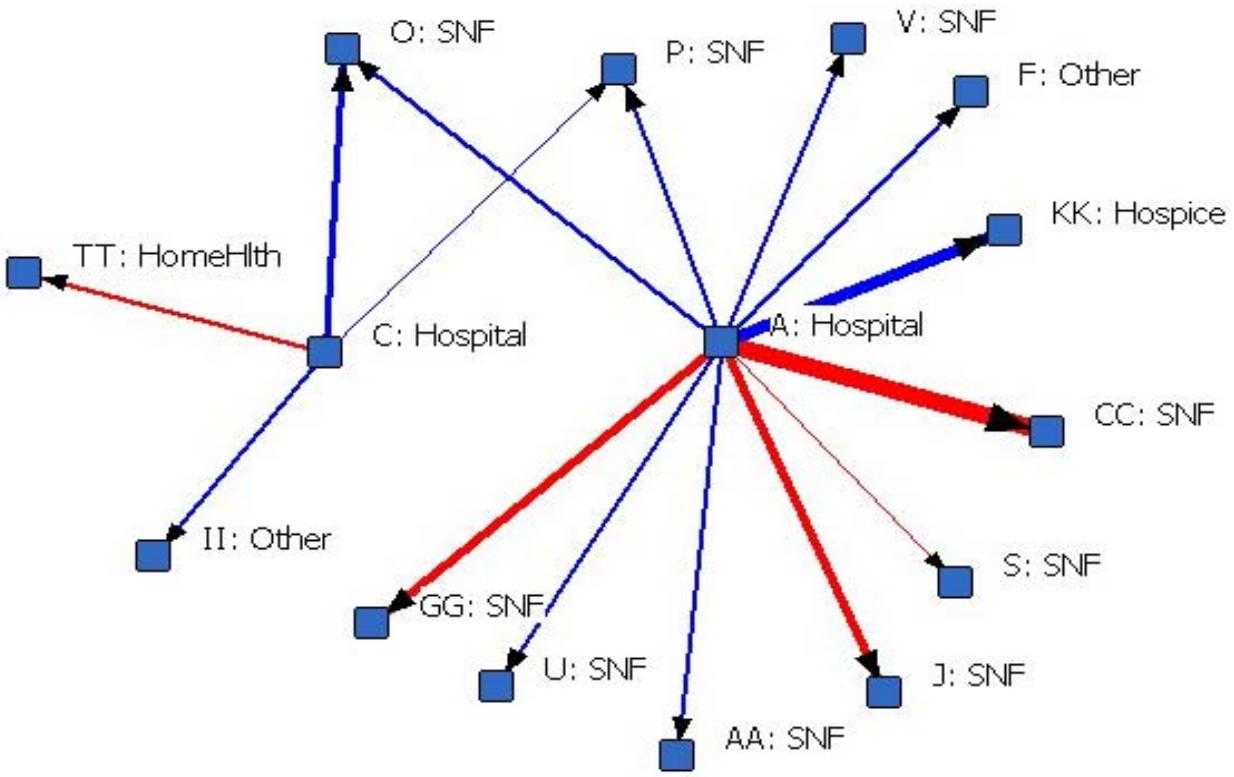
Social Network Analysis



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Strategic Plan

- Include broad range of community leaders
  - Provider groups
  - Community based organizations (CBOs)
  - Area Agencies on Aging (AAAs) and Aging and Disability Resource Centers (ADRCs)
  - Regional Health Initiatives
  - State and local government
  - Advocacy and service organizations
  - Other payers

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Drivers of Poor Transitions and Readmissions

- Poor information transfer between providers
- Decreased patient and/or family activation
- A lack of a standard and known process for sharing patients among providers

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Community Specific Root Cause Analysis

- Data Analysis
  - Proportion of Transitions Table
  - Coalition Readmission rates
  - Coalition Admission rates
  - Hospital Admission rates
  - Hospital Readmission rates
  - Emergency Department (ED) visit Rates
  - Observation Stay Rates
  - Mortality Rates
  - Post acute care setting readmission rates
  - Disease specific readmission rates
- Process Mapping
- Chart Reviews
- Patient/Stakeholder feedback

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Intervention Selection & Implementation Plan

- Results from the community specific root cause analysis
- Existing local programs and resources
- Funding resources
  - Cost estimates associated with intervention implementation
  - Estimates for intervention penetration
- Sustainability
- Community preferences

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CMS's Table of Interventions

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

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Intervention Measurement Strategies

- Involves a series of Process and Outcome Measures
- Providers and CBOs will need to collect most of the Process Measure data
- QIOs can help facilitate linking Medicare claims-based Outcome Measures to interventions
- QIOs are creating time series graphs to show intervention progress and improvements on related outcome measures using data provided by their community partners

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Application for Participation in a Formal Care Transitions Program

- Data analyses and trending reports
- Interventions selection rationale
- Cost estimates for interventions
- Other application requirements

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Additional Assistance for Communities not in a formal Care Transitions Program

- Provide quarterly community readmission metrics
- Host a statewide Learning and Action Network
- Participate in care transitions learning sessions
- Use QIO developed tools and resources

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Lessons Learned: 9th SOW Care Transitions Theme

- Importance of community collaboration
  - Providers talking, visiting each other, sharing
- Tailor solutions to fit community priorities
  - Community needs determine change
- Include patients and families
  - Incorporate beneficiaries when they are sick and healthy
- Public outreach activities
  - Storytelling to support data

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Results

- Hospital readmissions work reduces hospital "admissions"
- Population-based measures of readmission going down
- Population-based measures of admission also going down
- Preliminary cost-savings are very promising

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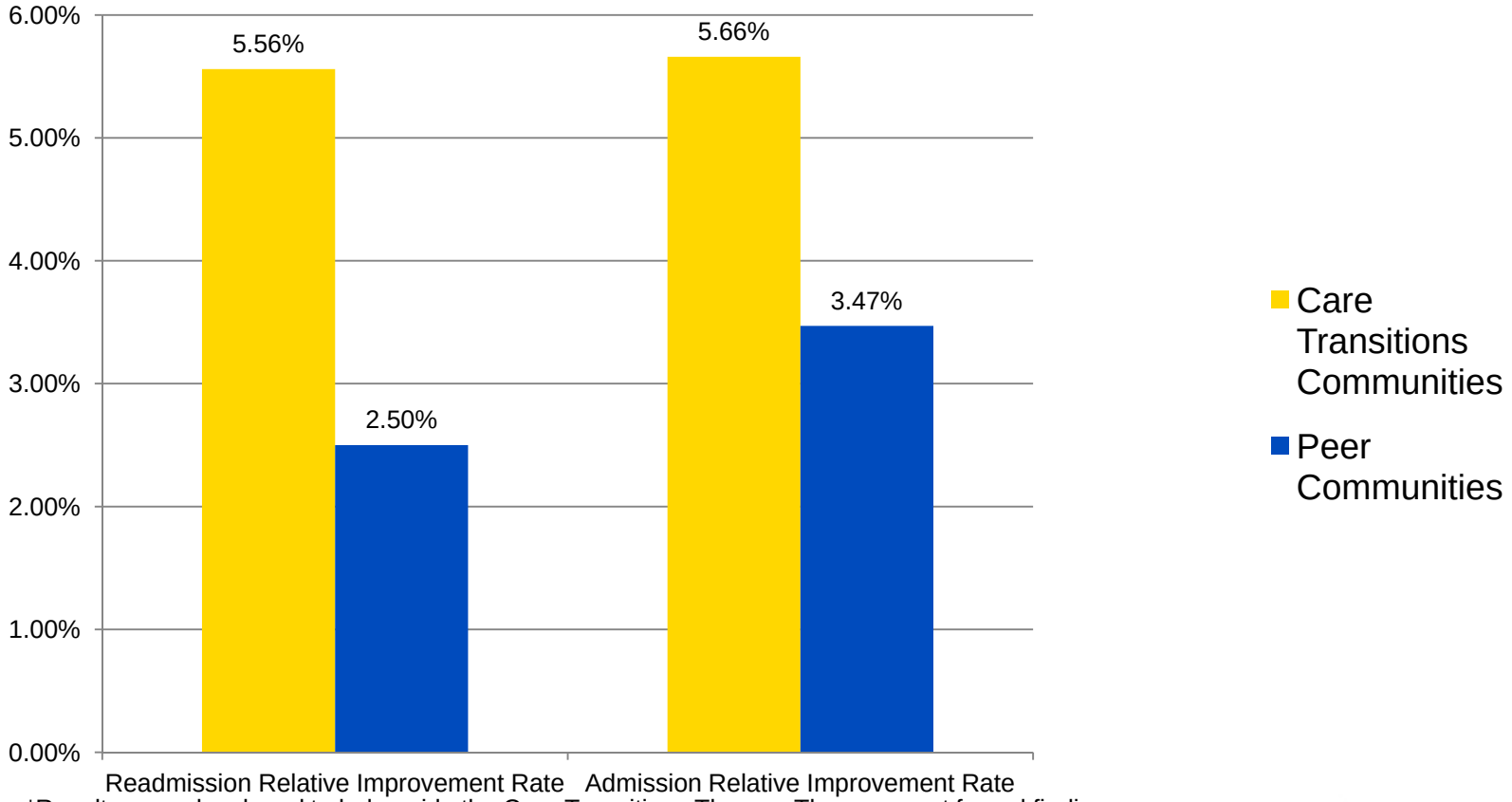
Preliminary Results*: Relative Improvement

July 2007-June 2008 compared to July 2009-June 2010

14 Care Transitions Communities vs. 52 Peer Communities



*Results were developed to help guide the Care Transitions Theme. These are not formal findings about the success of the QIO Program (individual QIOs or collectively) in relation to QIOs' obligations under their CMS contracts.

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Common Winning Themes

- Community cohesiveness
- Provider activation/will
- Strategic partners
- Cross-setting work
- Coaching as an intervention
- Strong community leadership (e.g., physician champions)

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Partnership Through Collaboration: Coaching Through Collaboration:

The Pennsylvania Model

QUALITY Insights of Pennsylvania
Westmoreland County Area Agency on Aging
Southwestern Pennsylvania Area Agency on Aging

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Size of the Opportunity

- About one in five Medicare patients is re-hospitalized within 30 days of discharge
- More than 85% of these re-hospitalizations are unplanned
- The majority of Medicare beneficiaries who are hospitalized have been hospitalized before within the last year

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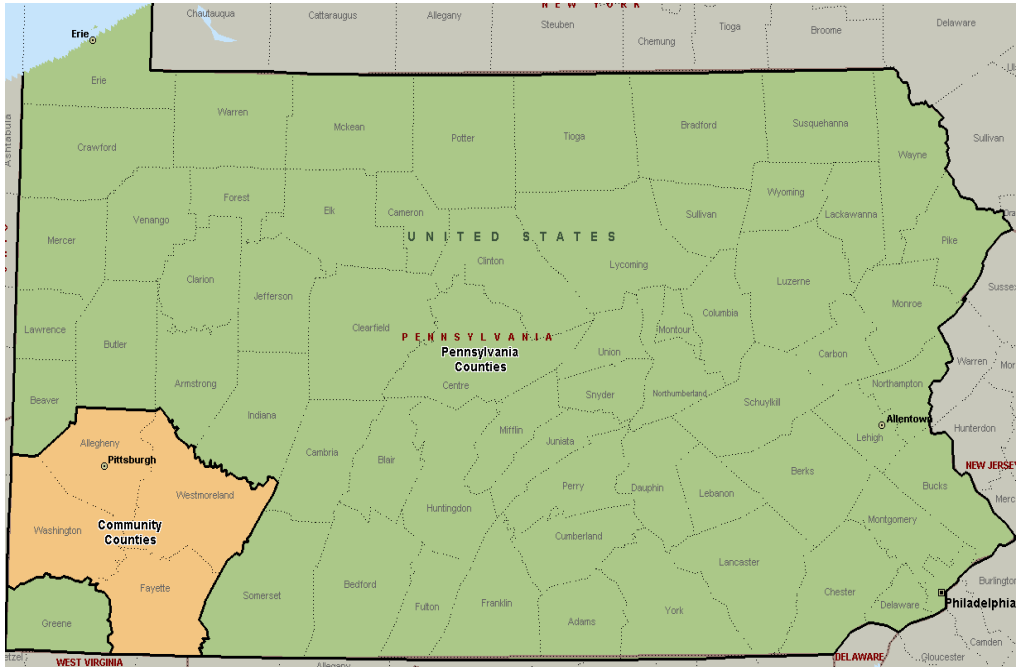
Targeted Community

- Higher than state average readmission rate
- Located in southwestern PA, in a community surrounding the southern Pittsburgh metropolitan area
- Community spans most of Westmoreland County and small portions of Allegheny, Washington, and Fayette counties



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Developing Partnership

- Approach AAA/hospitals
- Engage leadership
- QIO set culture for collaboration
  - Transparency
  - Equal playing field
  - Non-blame

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Developing Partnership (continued)

- Why the AAA?
  - Congruent mission
  - Shared vision
  - Sustainable model
  - Leadership and staff commitment
  - Do home visit
  - Observe for additional service needs

Referral Process

- Implementation July 2009
- Selection criteria/risk assessment
  - Medicare Fee-for-Service (MFFS) beneficiaries
  - Alert and oriented, or with a caregiver
  - Diagnose Congestive Heart Failure (CHF)/Chronic Obstructive Pulmonary Disease (COPD) and other diagnoses
  - Within Care Transitions Intervention zip codes

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Challenges

- Resources
- 8% of discharged patients coached
- MFFS volume

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Outcomes June 2009-May 2011

- 950 (65%) accepted coaching
- 11% overall readmission rate
- 497 (52%) completed the 30-day program
- 74% demonstrate Patient Activation Assessment (PAA) improvement scores

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Patient Outcomes June 2009-May 2011 (continued)

- 96% stated they understood the purpose of their medications
- 96% stated they understood the red flags of their condition
- 97% are more comfortable talking with their physician
- 88% stated they continue to use and update their Personal Health Record (PHR)
- 96% stated they had not been re-hospitalized since the last call from their coach

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Success

- Relationship building
- Workflow /referral process
- Decreased refusal rate
- Expansion of community services
- Increased patient activation
- Lower readmission rate

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Lessons Learned

- Engage all levels of leadership for support
- Develop a workflow process collaboratively
- Train involved staff and leadership together
- Have consistent AAA coach on site three to five days per week
- Collect data weekly, and document progress
- Ongoing monitoring and support to define success
- Complete post-coach follow-up call

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Lessons Learned (continued)

- Obtain funding resources early!
- Bring all players to table
- Support face-to-face, open communication between partners
- Discuss opportunities/barriers openly
- Robust facilitation from QIO to even playing field
- Assist with data management
- Complete post coach follow up call

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QIO Story

- Benefit of Collaboration
- Lessons Learned
  - QIO role
  - Enhanced relationship with hospital staff
  - Administrative support
  - Value of on-site hospital visitations
  - Value of home visit
  - Value of AAA involvement
  - Patient empowerment
- Barriers
  - Resources
- Next steps
  - 10th SOW

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Southwestern PA AAA Story

- Benefit of collaboration
- Barriers
- Effect on service base
- Lessons learned
- Next steps
- Story

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AAA Opportunities for Collaboration

- AAA mission
  - "We hereby adopt the mission to be responsible to the maximum degree of our resources, to assist and enable older and/or disabled persons to live their lives as independently as their circumstances will allow and in the best possible and desired manner."
- Services provided: Preventative care, nutrition services, transportation, caregiver services, support services

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Coaching Partnerships

- Westmoreland Area Agency on Aging
- Excela Westmoreland Hospital

- Southwestern Pennsylvania Area Agency on Aging
- Monongahela Valley Hospital

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Improved Relationship

- Questionnaire
  - Improved communication
  - Cross-setting goals achieved
  - Increase in service referrals/services

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Relationship Success

- Hospital
  - 67% believe they have more contact with AAA than before project
  - 66% know more about services AAA can provide patient
  - 63% feel more confident that they understand the services the patient needs now
  - 46% are more satisfied with contact with AAA
- AAA
  - 74% feel more satisfied with hospital contacts
  - 67% believe there have been more services provided to patients by the AAA today than a year ago, due to the improved relationship with the hospital.
  - 60% feel that referrals are more appropriate
  - 60% feel more confident that patients' needs met
  - 60% feel more confident that hospital staff understands the services AAA offers to patients
  - 53% have more contact about referrals

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Westmoreland County AAA Story

- Coaching model
- Barriers
- Lessons Learned
- Next steps
- Story

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Coleman Model: The Four Pillars

- Medication management
- Patient health record
- Follow-up with Primary Care Physician (PCP) and/or specialist
- Knowledge of “Red Flags” -- warning signs and/or symptoms -- and how to respond

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Transition Coach

- The use of a “transition coach” is yet another intervention being implemented in some hospitals. The transition coach is a trained professional that will help patients become more empowered with their health care
- Multiple models

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Primary Role

- The primary role of the Care Transition Coach[SM] is to empower the patient/caregiver to
  - Assert a more active role during care transitions and
  - Develop lasting self-management skills

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The Structure of the Intervention

- Five Steps
  - Hospital the day of discharge
  - Home visit within 48 hours/PAA
  - Three follow-up phone calls
- Completed within one month

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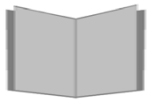
Patient Activation Assessment (PAA)

Name: _____

Patient Activation Assessment				
Level of Performance (Please rate: 1 point each)				
				
Medication Management	**Red Flags**	**Medical Care Follow Up**	**Personal Health Record (PHR)**	**Comments**
__ Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.) __ For each medication, understands the purpose, when and how to take, and possible side effects __ Demonstrates ability to accurately update medication list __ Agrees to confirm medication list with PCP and/or Specialist	__ Demonstrates understanding of Red Flags, or warning signs that condition may be worsening __ Reacts appropriately to Red Flags per education given (or understands how to react appropriately)	__ Can schedule and follow through on appointment(s). __ Writes a list of questions for PCP and/or specialist and brings to appointment	__ Understands the purpose of PHR and the importance of updating PHR __ Agrees to bring PHR to every health encounter	
Sum: /4	**Sum: /2**	**Sum**: /2	**Sum: /2**	
Total Score: /10				

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Challenges

- The shift to…
  - Chronic illness management
  - Self-care management
    - Empowerment
    - Responsibility
    - Accountability
    - Patient activation

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Success Stories

- Readmission rates for coached individuals within 30 days of discharge has been 10% vs. prior rate over 20%
- Avoiding unnecessary readmissions by getting to the physician follow-up visits
  - Shared-ride reduced transportation costs to the physician from $56 to $1.50
- Avoiding unnecessary readmissions by making prescribed medication more affordable
  - LIHEAP and PACE eligibility
- Avoiding unnecessary readmissions by hooking up with various preventive services
  - Services for the visually impaired and transportation
- Avoiding medication errors

Lessons Learned

- Congruent mission
- Leadership/staff buy-in
- Dedicated coach required
- Improved relationship
- Collaboration is essential

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Questions

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Resources: QIOs and care transitions

- http://www.cfmc.org/caretransitions
  - QIO ICPCA website: Care Transitions
  - Patient and Provider Resources
  - Learning Sessions
  - Toolkit
- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)

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Resources: Care Transitions

- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform page – where archived webinars are stored)
- http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx (AoA's The Aging Network and Care Transitions: Preparing your Organization Toolkit)
- http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/index.aspx (AoA's Aging and Disability Resource Centers Care Transitions page)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers Technical Assistance Exchange care transitions page)
- http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf (Innovative Communities report from the Long-Term Quality Alliance)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page – where webinar recordings, transcripts and slides are stored)
- 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

- *Medication Management Tools and Resources*
  - Watch your email in October for registration information

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