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Welcome to the New England Safe Transitions QIN-QIO Webinar!

Thank you for joining. Our presentation will begin shortly.

If you haven't already, please dial in to the audio line by calling:

888-285-0307
Passcode: **4906624**

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Ensuring Every Transition is a Safe Transition ~ A Community Approach ~

Lynne Chase
Regional Safe Transitions Lead

Carol Dietz RN, MBA, CPHQ
Connecticut Safe Transitions – Hospital Lead

Kathleen Calandra, BSN, RN, CPHQ
Rhode Island Safe Transitions – Lead

April 17, 2015
11:00am – 12:00pm

This material was prepared by the New England Quality Innovation Network-Quality Improvement Organization (NE QIN-QIO), the Medicare Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy
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Lynne Chase

Massachusetts Program Director
New England QIN-QIO

Regional Safe Transitions Lead
New England QIN-QIO

Ms. Chase is the NE QIN-QIO Program in Massachusetts. In this role, she oversees a multi-disciplinary team, working on all aspects of the 11th SOW. Ms. Chase has directed the Healthcentric Advisors' Safe Transitions effort since 2009 and serves as the Regional Safe Transitions Lead for the NE QIO-QIN.

Prior to joining Healthcentric Advisors, she spent 17 years at CVS Health, as a Organizational Development and Training Program Manager. The positions she has held throughout her career have enabled Ms. Chase to develop skills in project management, people management, training and development, change management, quality improvement and community organizing.

What care settings and/or stakeholders are represented today?

- ❑ Community Support Services
- ❑ Hospital
- ❑ Home Health
- ❑ Hospice
- ❑ Member Organization
- ❑ Nursing Home
- ❑ Patient/Family Advocates
- ❑ Physician Office
- ❑ Other

What states are represented in this session?

- ❑ Connecticut
- ❑ Maine
- ❑ Massachusetts
- ❑ New Hampshire
- ❑ Rhode Island
- ❑ Vermont
- ❑ Other

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Goals for Today

- Outline the New England QIN-QIO focus areas;
- Identify opportunities to improve care transitions;
- Spotlight successful local communities; and
- Explore how you can help lead this effort in your organization, community, state and across New England

Chat In…

What you are hoping to gain from today's session?

We also welcome recommendations for future events.

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Carol Dietz, RN, MBA, CPHQ

Regional Hospital Lead
New England QIN-QIO

Connecticut Quality Improvement Consultant
New England QIN-QIO

Ms. Dietz has been with Qualidigm for 6 years and has directed their Connecticut hospital QI efforts since 2009. In her position as a Quality Improvement Consultant, she works with hospital providers to enhance quality, reduce cost, and improve health outcomes.

As the Regional Lead for the *NE Hospital-Associated Infection Reduction Collaborative*, she supports the project's overarching vision to reduce hospital associated infections, improve transitions of care and create a culture of safety.

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Your **New England Quality Innovation Network-Quality Improvement Organization** (NE QIN-QIO)

OVERVIEW OF THE QIN-QIO 11TH STATEMENT OF WORK

Background: 11th SOW Changes

- CMS modified the program - creating two types of QIOs:
  - Beneficiary Family Centered Care Quality Improvement Organizations (BFCC-QIOs) – **Medicare case review**
    - Five regions
    - Two contractors
    - Remote call centers

  - Quality Innovation Network Quality Improvement Organizations (QIN-QIOs) - **Quality improvement and technical assistance**

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BFCC- QIO for New England: Livanta

- **Contact Information:**
  - Toll-free telephone number: 1-866-815-5440
    - TTY number is 1-866-868-2289
  - Fax number for Appeals: 1-855-236-2423
  - Fax number for all Other Reviews: 1-844-420-6671
  - The address for mailing hard-copy medical records:
    - BFCC-QIO Program, Area 1
      9090 Junction Drive, Suite 10
      Annapolis Junction, MD 20701
  - Website: www.BFCCQIOAREA1.com

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QIN-QIOs

- CMS's Approach to Clinical Quality – Achieving the **Triple Aim**

- CMS contracted entities providing quality improvement assistance on CMS focus areas to providers within multi-state region
  - Contract run 5-years (7/2014- 7/2015)

The QIN-QIO for New England

The QIN-QIO is identified throughout six-state region as:

Providing a regional quality strategy with in-state support

Healthcentric Advisors awarded QIN-QIO contract for New England

- MA, ME, RI

Qualidigm, former Connecticut QIO, **partnering as subcontractor**

- CT, NH, VT

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Overview 11th SOW

- Assisting nursing homes in **improving clinical outcomes**
- Assisting hospitals in **reducing Hospital-Acquired Infections (HAIs)**
- Improving **chronic disease awareness & prevention** through the physician offices
- Assisting providers with **value-based payments and quality reporting**
- Working with providers and stakeholders across care continuum to **improve care transitions to reduce hospital readmissions**

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Focus Areas

- **Engaging Patients and Caregivers**
- **Reducing Healthcare Disparities**
- **Addressing Needs of Most Vulnerable Patients, including those with**
  - Multiple chronic conditions
  - Behavioral health conditions
  - Dementia / cognitive impairment
  - Socioeconomic factors

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MEET YOUR NE QIN-QIO SAFE TRANSITIONS TEAMS

NE QIN-QIO Safe Transitions Team

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Connecticut

Left – Right: Janine Hewitt, Deborah Quetti, Carol Dietz, Anne Elwell, Shelia Eckenrode, Florence Johnson (not pictured: Marghie Giuliano)

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Maine

Left – Right: Maureen Leary and Alejandro Enriquez Zamalloa

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Massachusetts

Left – Right: - front: Melissa Pollock & Ileizy Victor
back : Sheryl Leary & Lori Nerbonne

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New Hampshire

Left – Right: Joyce Johnson, Pamela Heckman, Margaret Crowley

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Rhode Island

Left – Right: Blake Morphis, Nelia Silva, Kathy Calandra, Maureen Marsella, Melissa Miranda, Pam Quinn

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Vermont

Left – Right: - front: Reggie Cooper & Gail Harbour
back : Gail Colgan & Liz Klepner

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Kathy Calandra, BSN, RN, CPHQ

Safe Transitions Lead - Rhode Island
New England QIN-QIO

In her role as the Safe Transitions Lead for Rhode Island, Ms. Calandra works with a multi-disciplinary team to improve transitions of care. Previously, Ms. Calandra managed the organization's Beneficiary Protection and Case Review Office.

Ms. Calandra's experience includes leadership roles in medical review, case management, development of evidence-based clinical medical policies, occupational health, hospital clinical areas, and quality improvement.

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IMPROVE CARE TRANSITIONS TO REDUCE HOSPITAL READMISSIONS

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The Care Transitions Landscape

Care transitions occur when a patient moves from one health care provider or setting to another. Nearly one in five **Medicare** patients discharged from a hospital - approximately 2.6 million seniors - are **readmitted** within 30 days, at a cost of over **$26** Billion every year.

http://www.cms.gov

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ACOs

Bundled Payment

Preferred Partners

Readmission Reduction

What's next??

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Hospital Readmission Reduction Program (HRRP)

- Based on 30 day readmission rates of Medicare patients
- Index hospitalization for
  - Heart failure
  - AMI
  - Pneumonia
  - COPD
  - Total Hip Replacement / Total Knee Replacement

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2015 HRRP Penalties

- 2,610 hospitals were assessed penalties ranging from 0.01% to 3% of Medicare revenue in FY 15
  - Readmission rates are assessed on three prior years of performance: July 2010 – June 2013
- Total penalties = $428 M vs. $280 M in FY 13
  - 75% of hospitals penalized

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2015 HRRP Impact to New England Hospitals

	% Hospitals Penalized	Penalty	# Hospitals Penalized
Connecticut	88 %	0.65%	28
Maine	41%	0.31%	15
Massachusetts	80%	0.78%	55
New Hampshire	35%	0.41%	9
Rhode Island	67%	0.67%	8
Vermont	27%	0.1%	4

Source: Kaiser Health News analysis of data from the Centers for Medicare & Medicaid Services.

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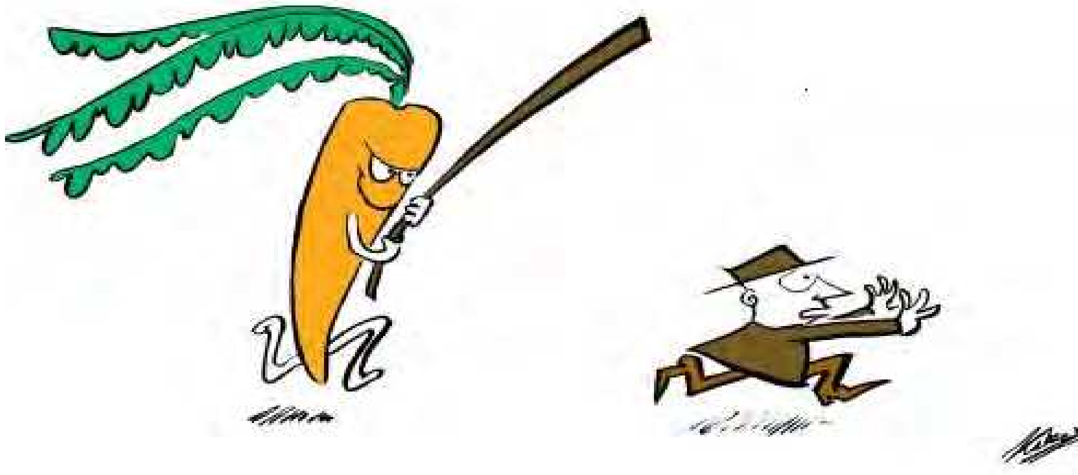
Payment Reform- It's here! And it's NOT going away!!



Value Based Payment (VPB) will impact SNFs soon…

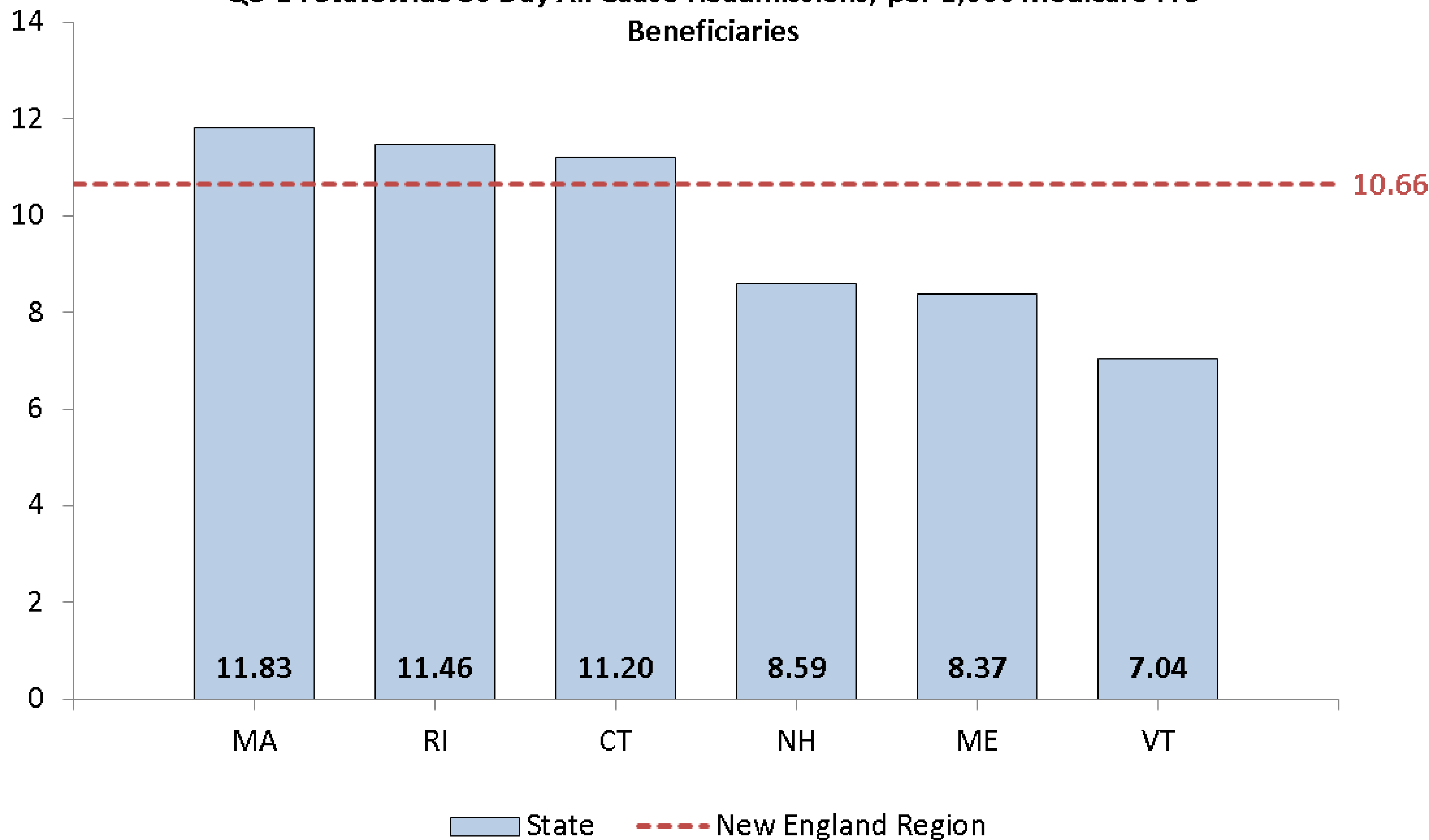
2018 SNF Value Based Payment Program

Plan

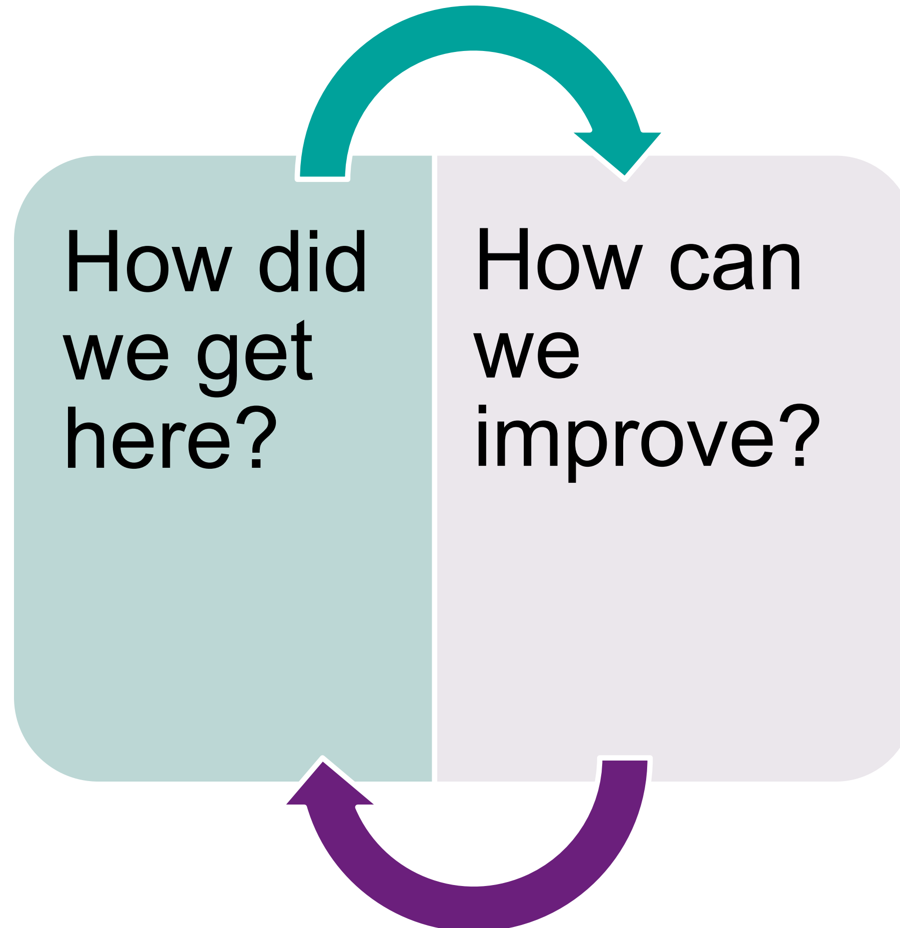
- CMS will withhold 2% of SNF payments for incentive pool
- 50-70% of the pool distributed to SNF's with incentive return
  - Highest ranking - highest return
  - Lowest ranking - lowest return

Timing

- Oct 2018 (2016 performance)– first adjustment

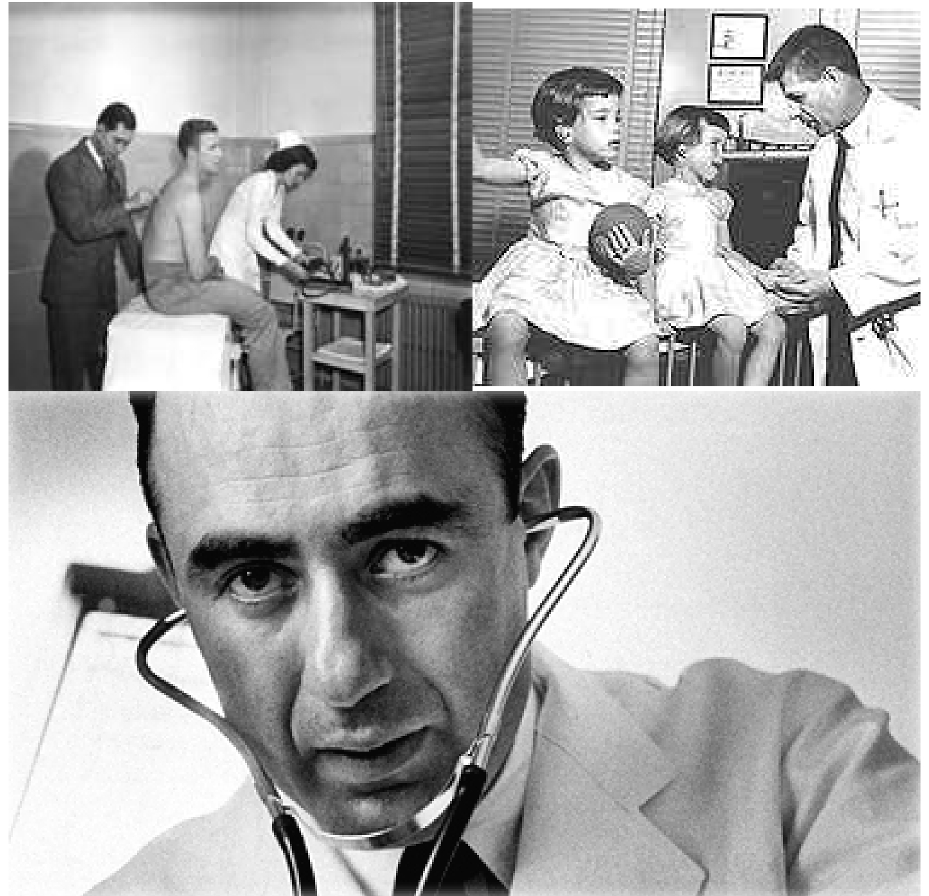

Q3-14 Statewide 30 Day All Cause Readmissions, per 1,000 Medicare FFS Beneficiaries
14
12
10
8
6
4
2
0
10.66
11.83
11.46
11.20
8.59
8.37
7.04
MA
RI
CT
NH
ME
VT
State
New England Region

Care Transitions and Readmissions



Health Care in the 1950s

In the 1950s people went to the hospital, then they went home.



The Patient has Changed

- Multiple co-morbid conditions
- Many medications
- Living longer
- More available services/treatments
- Socioeconomic factors impact health

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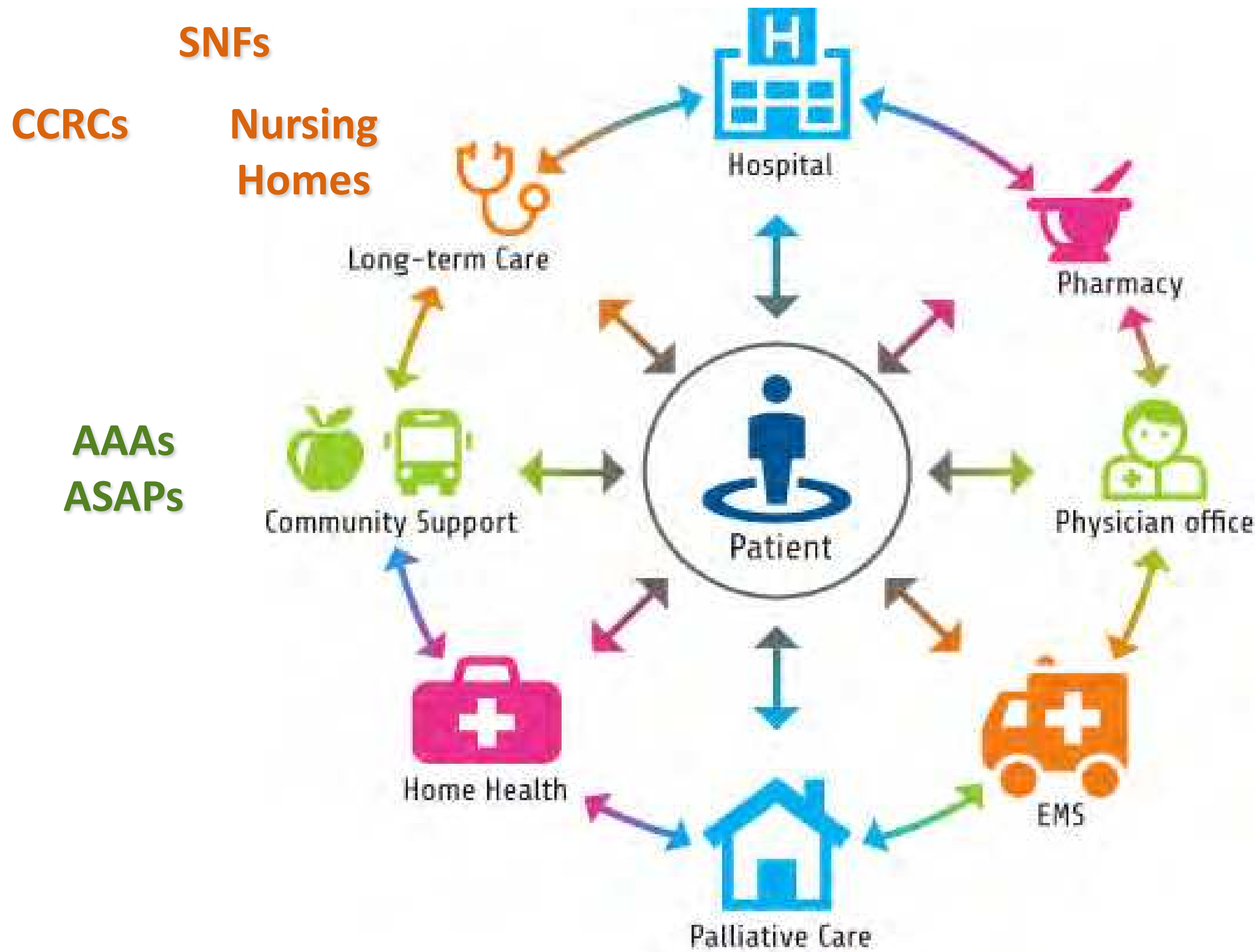
The System is More Complex

SNFs

CCRCs

Nursing Homes

AAAs
ASAPs



How do we fix this?

Address Opportunities *(within facility & community)*

Communication…information transfer

Patient / Caregiver Activation

Standardized Clinical Processes

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Evidence-Based & Best Practice

Programs

- BOOST
- Project RED
- CTI
- Grace
- Transitional Care
- HHQI - BPIPs
- INTERACT

Interventions

- Information transfer
- Patient/Caregiver Activation
- Risk Stratification
- Target Populations (CHF, COPD)
- End of Life Care

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Chat In…

What programs, interventions, and efforts have you implemented?

IT CAN BE DONE

SHOWCASING COMMUNITY SUCCESS

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Connecticut Story

Concurrent QIO Supported Approaches to Reduce Readmissions

Hospital Approach

- 25 hospitals
- RCA, PDSA, Evidence-based Interventions

Community Approach

- 15 hospitals, 83 NHs, 40 HHAs
- Interactive workshops, individual training and support

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Statewide Success (CT 2010-2012)

Readmissions

- 21.6% Relative Improvement Rate

Admissions

- 15.3% Relative Improvement Rate

Washington County, Rhode Island Story

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- 20 Member Organizations
- Open Forum for sharing
  - Coalition meetings ~ every 8 weeks
  - Data sharing
  - Sharing portal- with key contacts/ tools & resources
- Key areas of focus
  - Formal Shadow Program ~ *"Walk A Day in My Shoes"*
  - ED / SNF Communication
  - Nurse to Nurse Report
  - Enhanced Medication Management

Learn more – see the video: https://www.youtube.com/watch?v=iCrFAneRWqA

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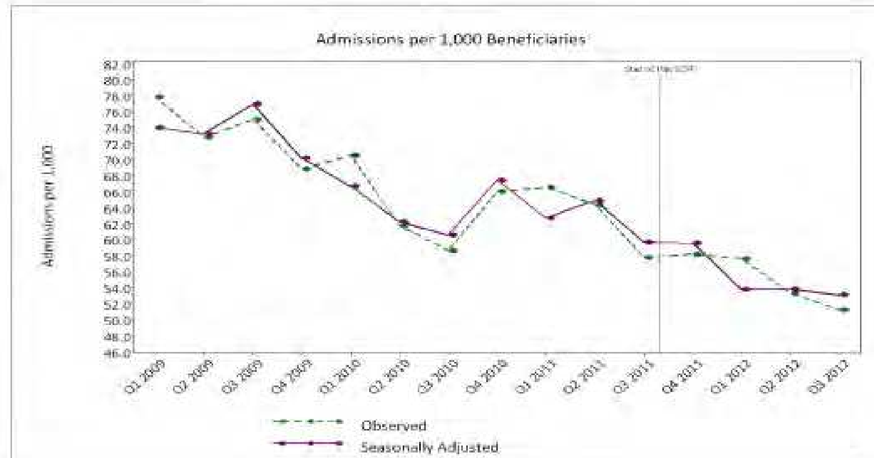
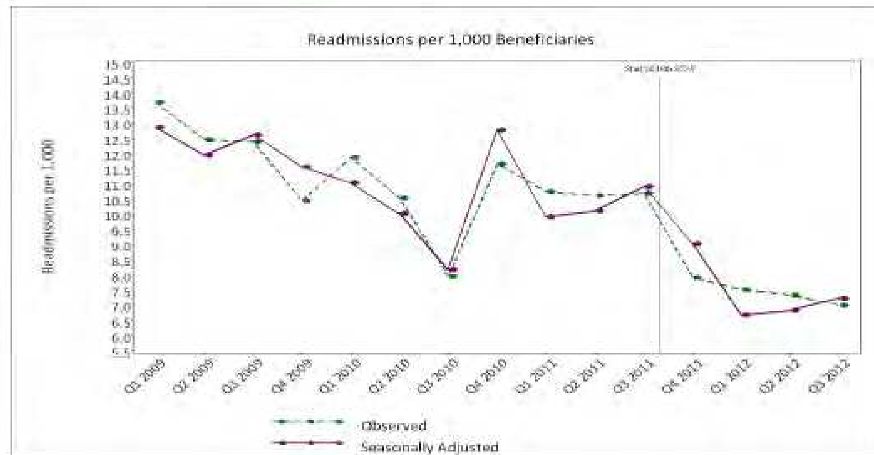
Community Success (2010-2012)

Washington County, Rhode Island



12.7%*



31.1%*

*10.1.10-3.31.11 compared to 10.1.11-3.31.12

***Population Based Measure for Medicare FFS Beneficiaries who live in these zip code areas:** 02804: 02808; 02812; 02813; 02822 ; 02832 ; 02833 ; 02873 ; 02874; 02875; 02879 ; 02880; 02881; 02882 ; 02883; 02891; 02892; 02894; 02898 . Relative Improvement Rate

Chat In…

Tell us what you've accomplished…and how you did it

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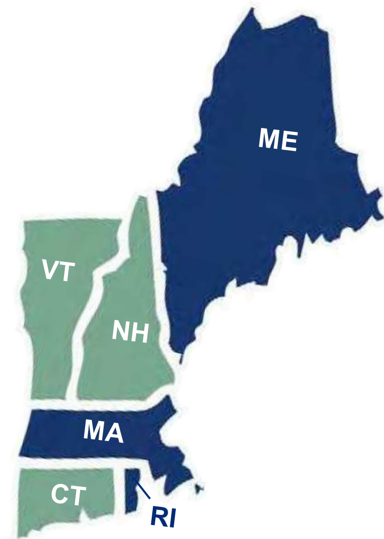
NE QIN-QIO COMMUNITY-BASED APPROACH TO IMPROVING CARE TRANSITIONS



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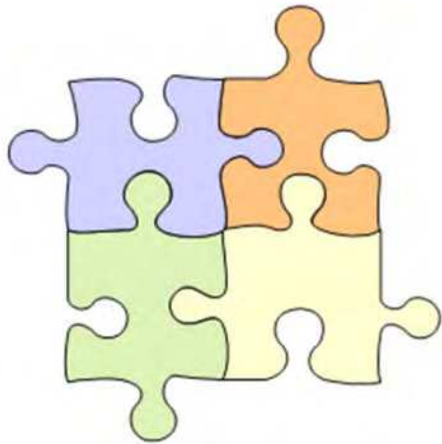
The QIN-QIO Plan



1. Align related efforts to minimize the burden on providers and maximize the benefit for NE patients
2. Provide participating providers education and support with intervention selection and measurement
3. Support Community Coalition Building
4. Facilitate a Regional Learning and Action Network

What other care transition efforts are you involved in?

- ❑ Internal efforts only
- ❑ ACO
- ❑ Bundled payment
- ❑ CCTP
- ❑ Community partnership
- ❑ I'm not sure
- ❑ None
- ❑ Other

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Support Community Building

- Build on existing efforts
- Bring the right partners to table
- Help understand the "root of the problem"
- Identify interventions
- Define feasible/meaningful measurement strategies

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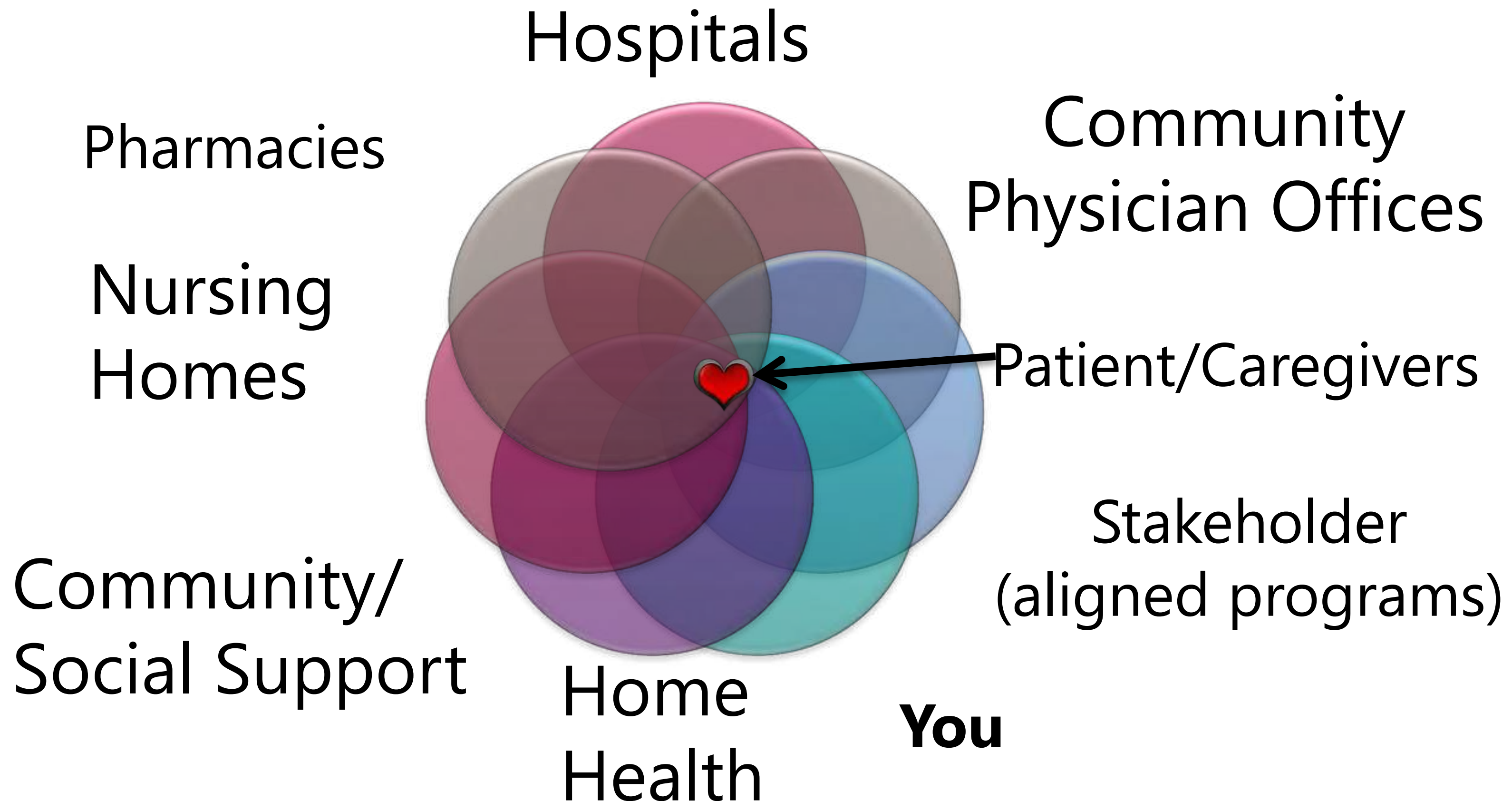
The Right Composition



Chat In…

Who are the critical players for your community solution?

Getting to the Root – Data Driven Improvement

What readmission data is your organization reviewing?

- ❑ Internal – all cause readmissions
- ❑ Internal – diagnoses specific
- ❑ Intervention data
- ❑ Pepper reports
- ❑ ACO reports
- ❑ Trade Organization data
- ❑ Community partner data
- ❑ I'm not sure
- ❑ All and any data
- ❑ None
- ❑ Other

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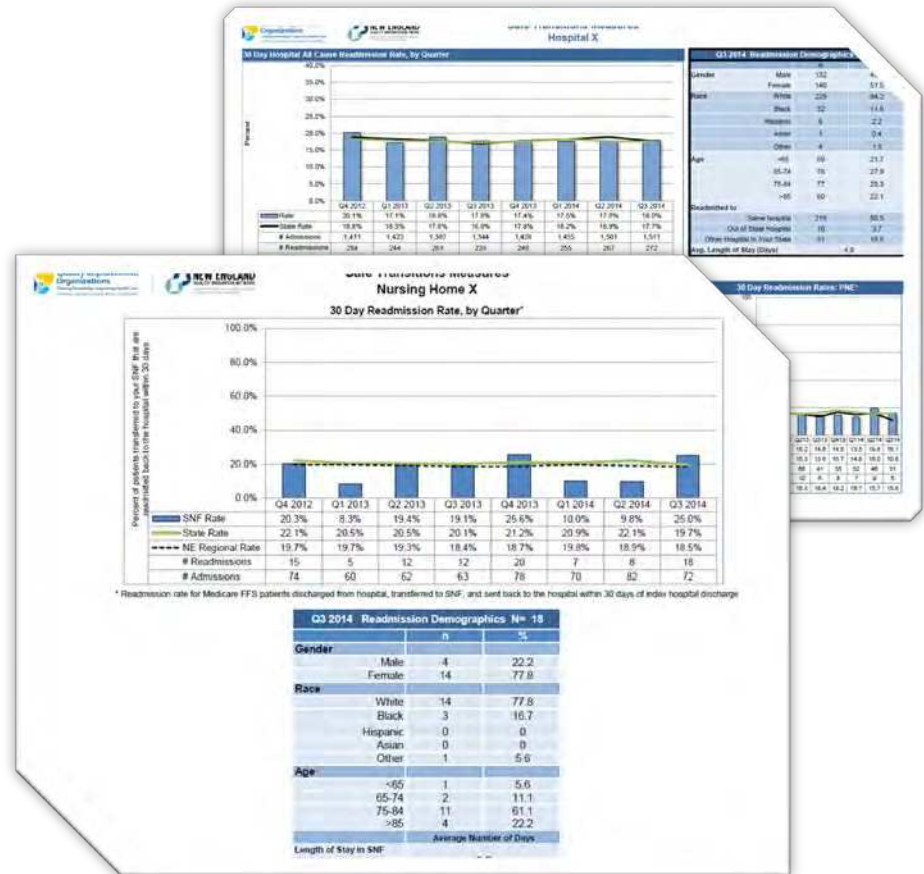
Provider (Hospital & NH) Readmissions Report

- Trending - 30 Day All Cause Readmissions Rate (Raw Claims)
- Quarterly Reports includes:
  - Medicare FFS beneficiaries only
  - State and Regional Benchmarks
  - Demographics
  - Diagnosis information



HHQI – provides Home Health readmission data

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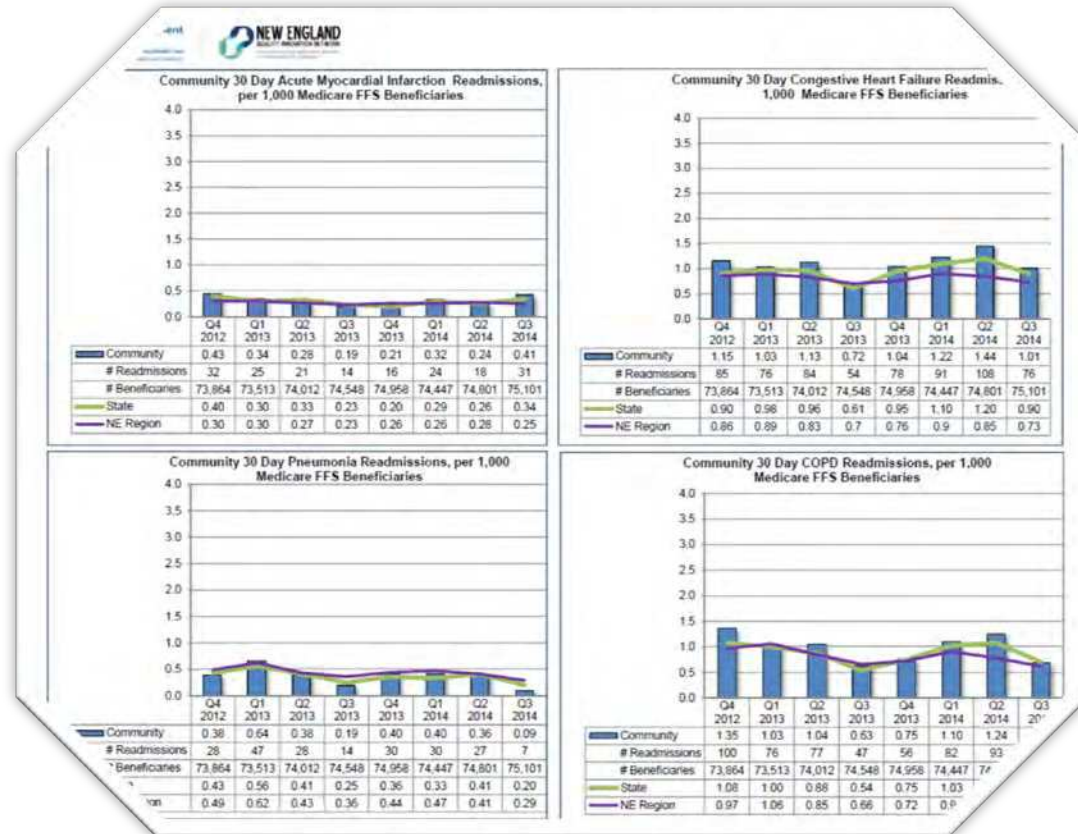
Community & Statewide Readmissions Reports



Community 30 Day Acute Myocardial Infarction Readmissions, per 1,000 Medicare FFS Beneficiaries

	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014
Community	0.43	0.34	0.28	0.19	0.21	0.32	0.24	0.41
# Readmissions	32	25	21	14	16	24	18	31
# Beneficiaries	73,864	73,513	74,012	74,548	74,958	74,447	74,801	75,101
State	0.40	0.30	0.33	0.23	0.20	0.29	0.26	0.34
NE Region	0.30	0.30	0.27	0.23	0.26	0.26	0.28	0.25

Community 30 Day Congestive Heart Failure Readmis. 1,000 Medicare FFS Beneficiaries

	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014
Community	1.15	1.03	1.13	0.72	1.04	1.22	1.44	1.01
# Readmissions	85	76	84	54	78	91	108	76
# Beneficiaries	73,864	73,513	74,012	74,548	74,958	74,447	74,801	75,101
State	0.90	0.98	0.96	0.61	0.95	1.10	1.20	0.90
NE Region	0.86	0.89	0.83	0.7	0.76	0.9	0.85	0.73

Community 30 Day Pneumonia Readmissions, per 1,000 Medicare FFS Beneficiaries

	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014
Community	0.38	0.64	0.38	0.19	0.40	0.40	0.36	0.09
# Readmissions	28	47	28	14	30	30	27	7
Beneficiaries	73,864	73,513	74,012	74,548	74,958	74,447	74,801	75,101
	0.43	0.56	0.41	0.25	0.36	0.33	0.41	0.20
ion	0.49	0.62	0.43	0.36	0.44	0.47	0.41	0.29

Community 30 Day COPD Readmissions, per 1,000 Medicare FFS Beneficiaries

	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 20
Community	1.35	1.03	1.04	0.63	0.75	1.10	1.24	
# Readmissions	100	76	77	47	56	82	93	
# Beneficiaries	73,864	73,513	74,012	74,548	74,958	74,447	7[illegible]	
State	1.08	1.00	0.88	0.54	0.75	1.03		
NE Region	0.97	1.06	0.85	0.66	0.72	0.[illegible]		

Understand Data What it Is, What it's Not, and What else you need…

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Keep in mind

- Medicare FFS population only

So….

- Population same as VBP programs

Keep in mind

- Raw claims - not risk adjusted

So….

- Does not match publically reported data

Keep in mind

- Data lag

So….

- Great for trending – and in combination with facility collected data

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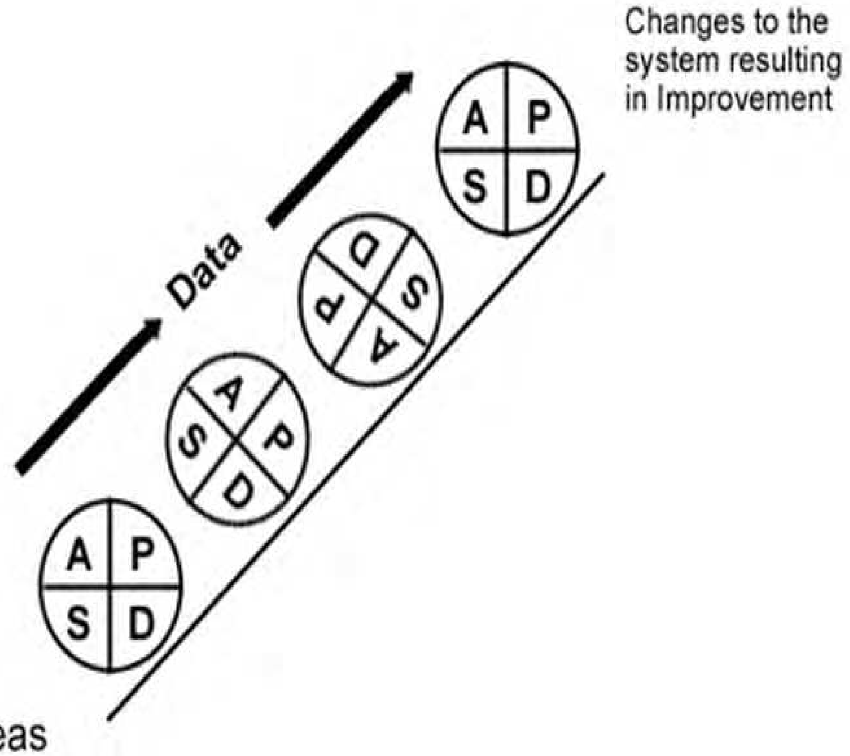
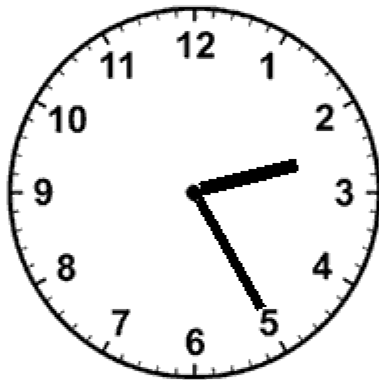
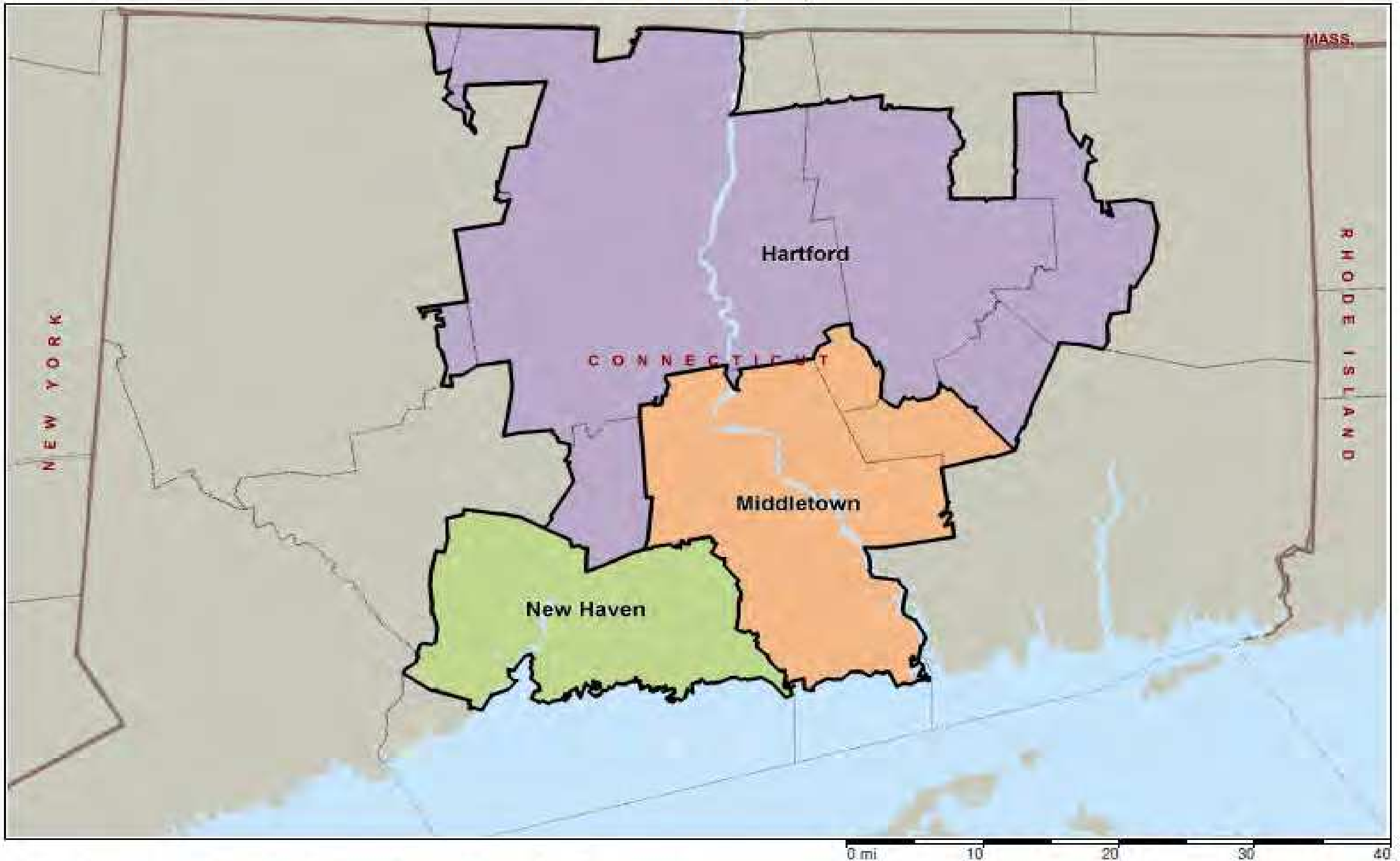
The Best Data … Yours!



A Phased Approach



Building Communities Over Time


CT Community Map
MASS.
NEW YORK
RHODE ISLAND
CONNECTICUT
Hartford
Middletown
New Haven
0 mi
10
20
30
40

Maine Community Map

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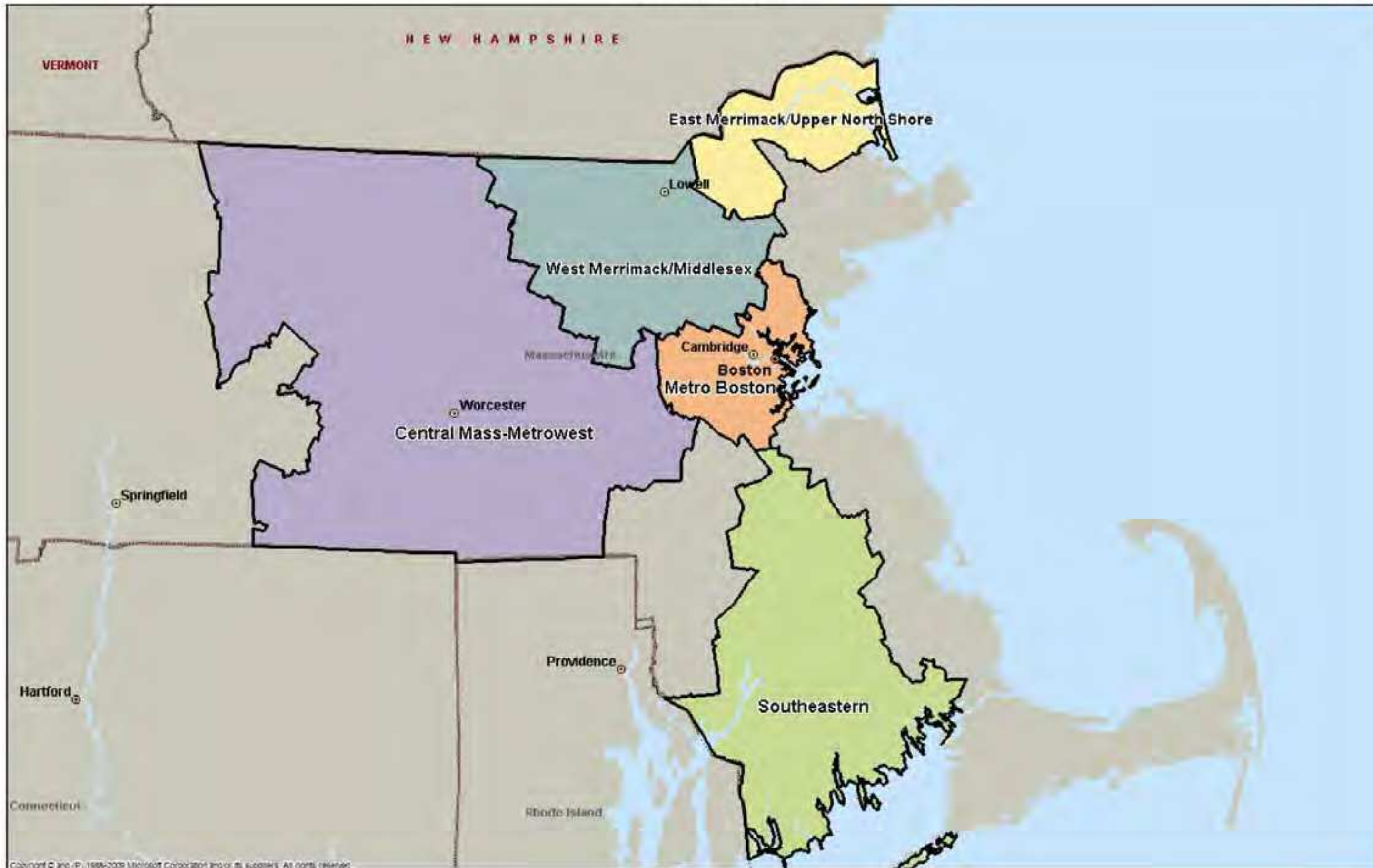

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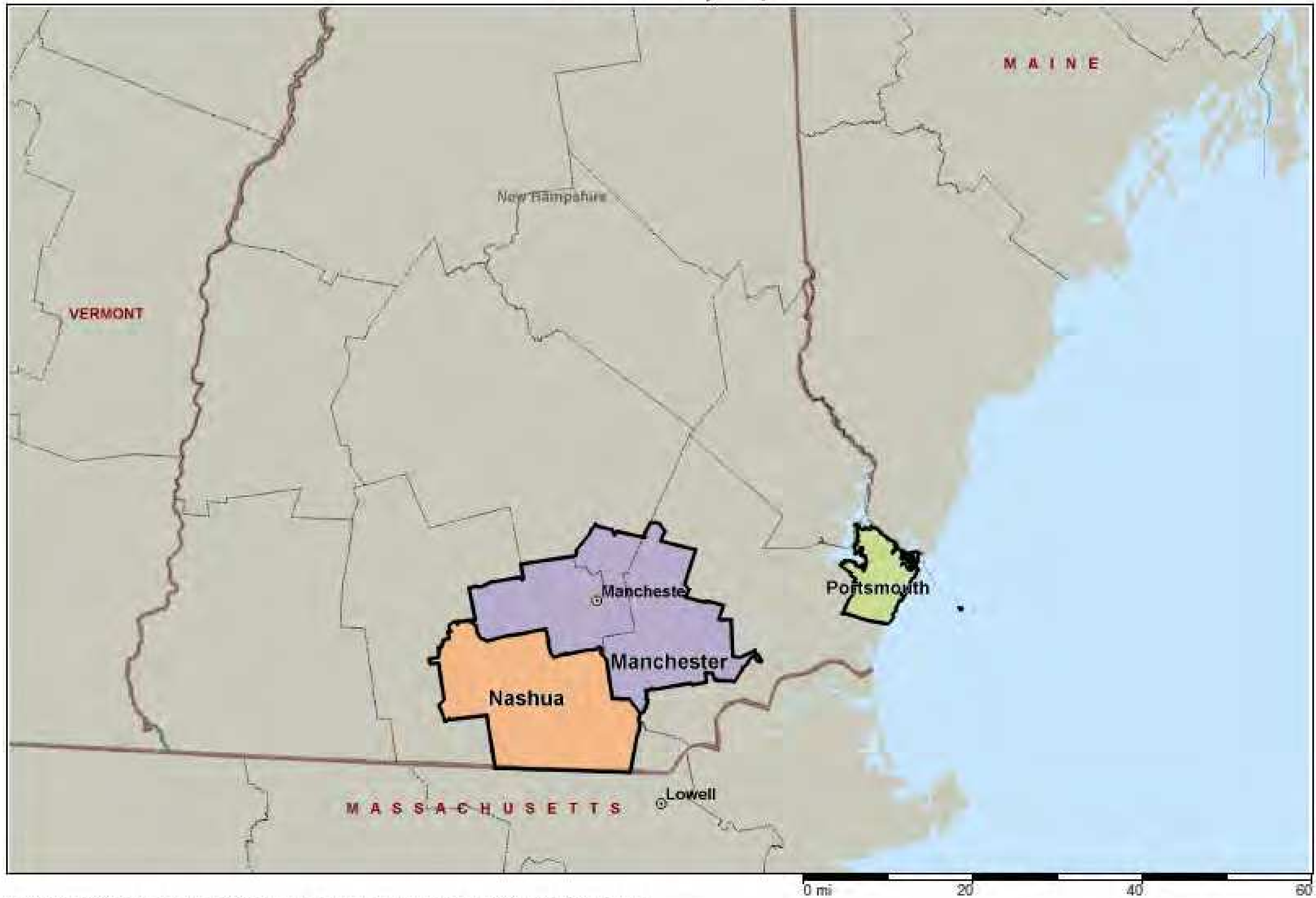
NH Community Map



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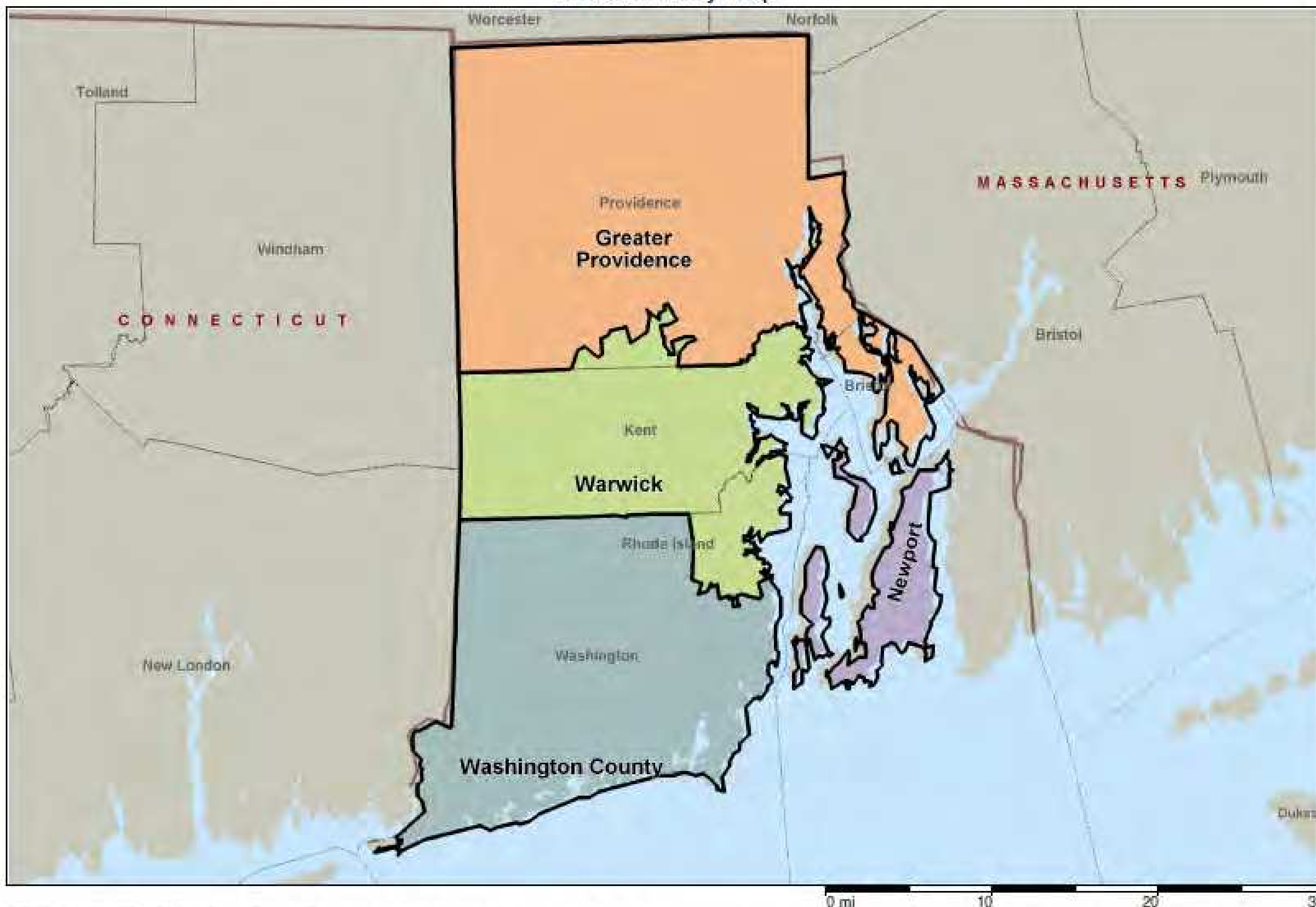
RI Community Map



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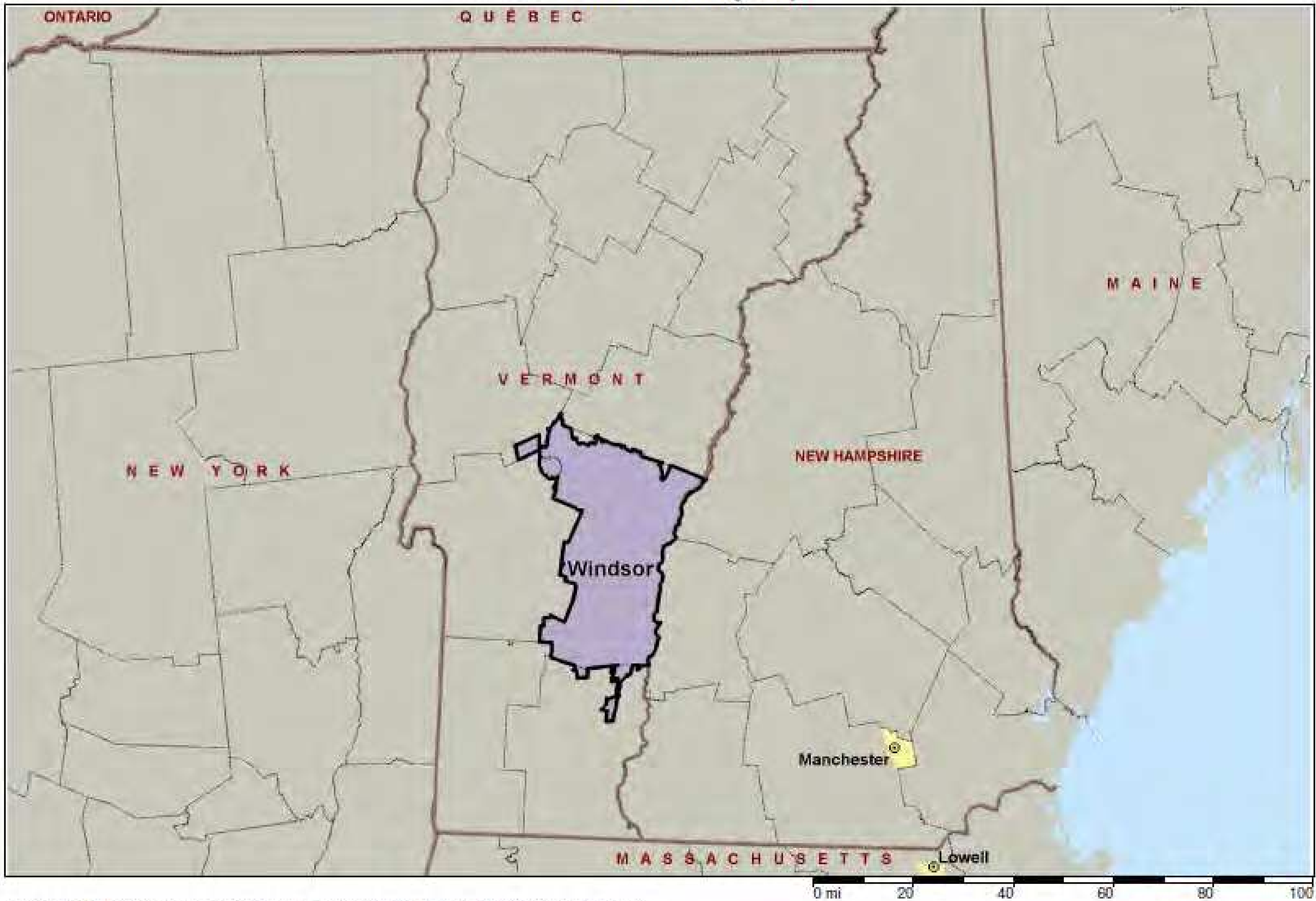

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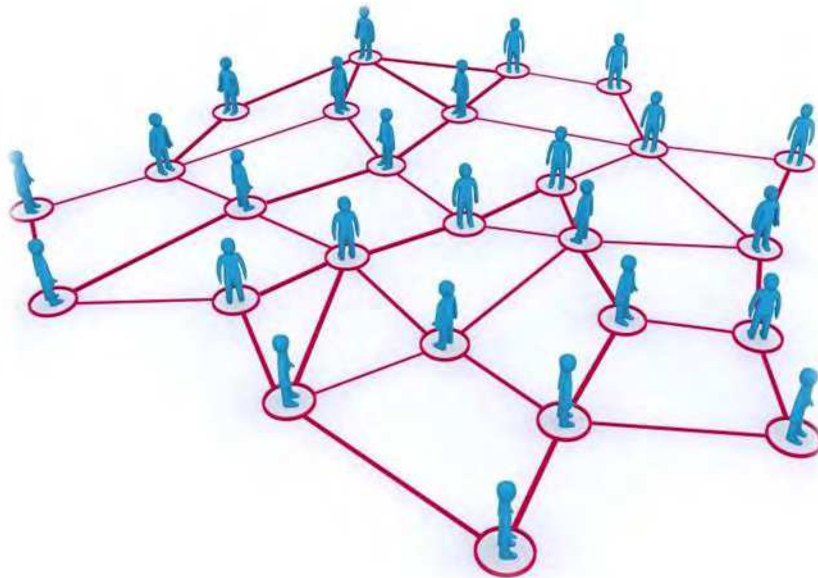

Ready to Join or Want to Learn More

Connect with your Safe Transitions State Lead

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Questions, Comments & Recommendations

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Special Focus: Adverse Drug Events (ADEs)

- ADEs account for 1/3 of hospital adverse events [1]
- ADEs cause ~ 280,000 hospital admissions annually [1]
- Hospital admissions related to ADEs in adults > 65 years was 24.9% [2]
- One-quarter of all ADEs are preventable [3]
- The CDC estimates that $3.5 billion is spent on extra medical costs associated with ADEs every year

[1]U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2014). National Action Plan for Adverse Drug Event Prevention. Washington, D.C.: Koh, H.
[2]Bourgeois FT, Shannon MW, Valim C, Mandl KD. Adverse drug events in the outpatient setting: an 11-year national analysis. *Pharmacoepidemiology and Drug Safety*. September 2010;19(9):901-910.
[3] Neumiller J, Corbett C. Prevention of Medication Errors in the Older Adult Patient. Postgraduate Healthcare Education, LLC. Power-Pak C.E. Mylan Pharmaceuticals, 2013.

Save the date

Improving Transitions of Care by Enhancing Medication Safety

June 25th
11am-12pm

Details will be shared in May and posted on our website:
http://www.healthcarefornewengland.org/

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