QIO Care Transitions Activity: the *Good News* so far…

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This material was prepared by CFMC (PM-4010-046 CO 2012), the Medicare Quality Improvement Organization for Colorado 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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Objectives

- Share successes and key learnings of the QIO 9th SOW pilot project
- Describe the need for better transitions
- Discuss leading interventions in this work
- Outline future work and implications

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August 2008-July 2011: 14 QIOs working in 14 Communities

- AL: Tuscaloosa
- CO: Northwest Denver
- FL: Miami
- GA: Metro Atlanta East
- IN: Evansville
- LA: Baton Rouge
- MI: Greater Lansing area
- NE: Omaha
- NJ: Southwestern NJ
- NY: Upper capital
- PA: Western PA
- RI: Providence
- TX: Harlingen HRR
- WA: Whatcom county

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Totals among Communities

- 70 Hospitals
- 277 Skilled Nursing Facilities
- 316 Home Health Agencies
- 89 Other types of Providers (Dialysis, Hospice, etc.)

- 666 ZIP Codes
- 1,125,649 Fee-for-Service Medicare Beneficiaries

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The Strategy

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

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Why are people readmitted?

Provider-Patient interface

Unmanaged condition worsening;
Use of suboptimal medication regimens;
Return to an emergency department

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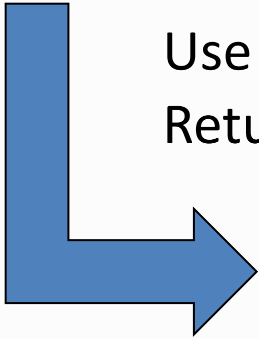

Unreliable system support

Lack of standard and known processes;
Unreliable information transfer;
Unsupported patient activation during transfers

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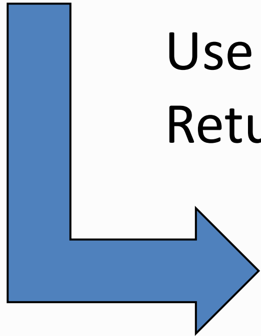

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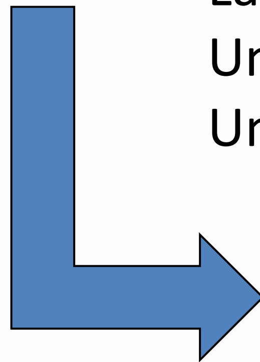

Lack of standard and known processes;
Unreliable information transfer;
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals

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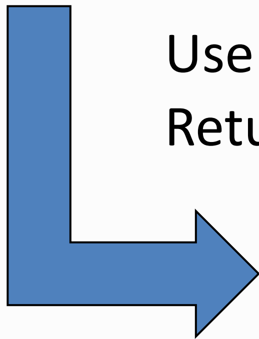

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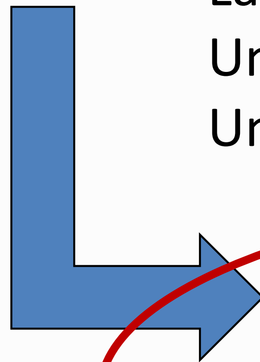

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Why Engage a Community?

- Every readmission begins with hospital discharge
  - Every transition has 2 sides
- Isolated information is not safe medical management
  - Inevitably need to share
- The problem of home
  - Patients are people too
- **Visibility to drive improvement and mission**
  - Providers are people too

Ways to Convene a Community

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Interventions to Improve Care Transitions

- Care Transitions Intervention℠
- Transitional Care Model
- INTERACT II
- HHQI Best Practice Intervention Packages
- Project BOOST
- Bridge model
- Project RED
- GRACE Model
- STAAR Initiative

System-Level Drivers of Readmissions

Provider-Patient interface

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Use of suboptimal medication regimens;
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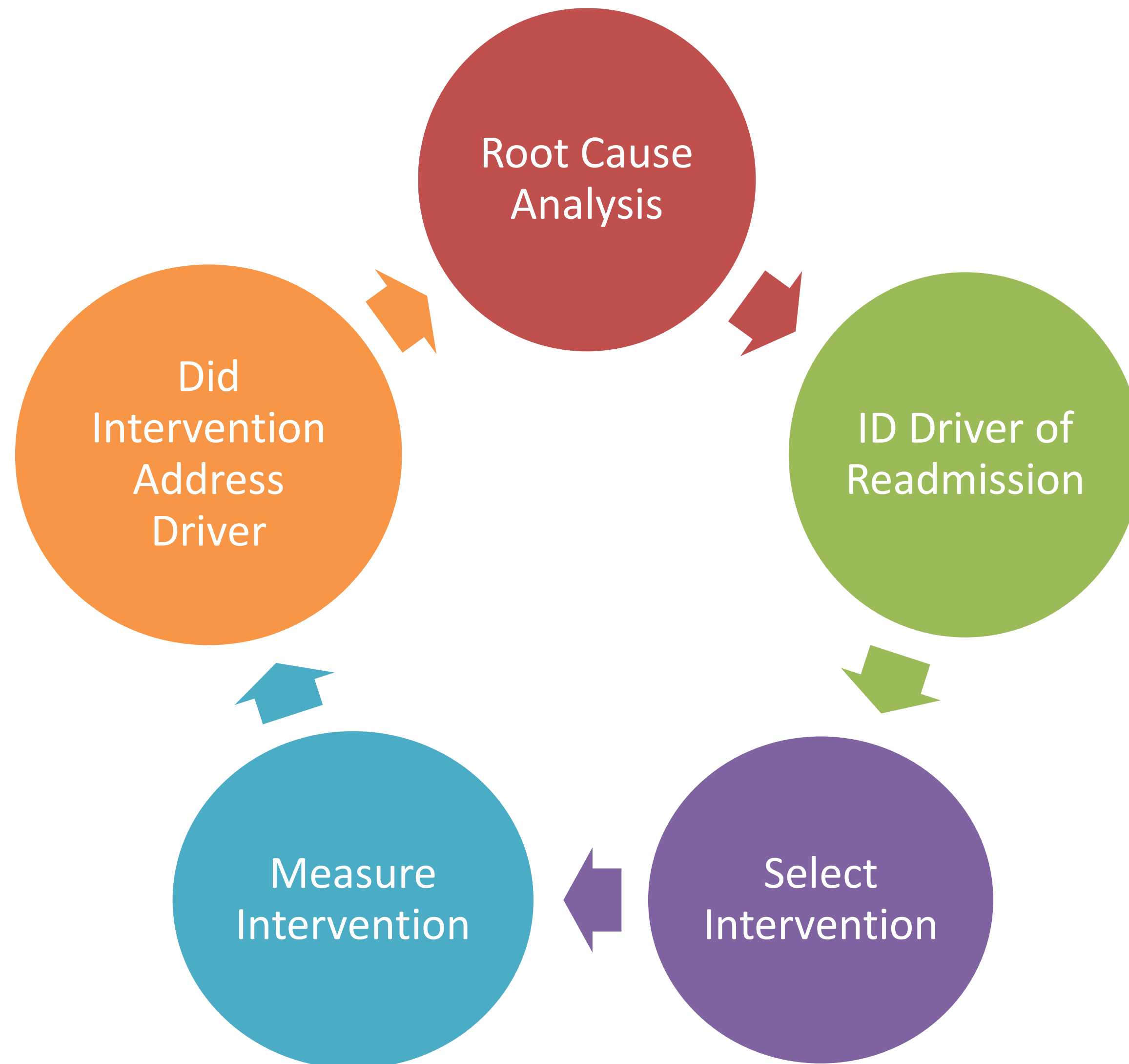
Building a Community-based Program



Interventions and Drivers

Intervention	Patient Activation	Standard Process	Information Transfer
Care Transitions Intervention℠	●●●●●●		●
Transitional Care Model	●	●●●	●●●●●
INTERACT II		●●	●●
HHQI Best Practices	●●	●●	●●
Project BOOST		●●●●●●	●●●
Bridge model	●●●		●●●
Project RED		●●●●●●	●●●
GRACE Model		●●●	●●●
STAAR Initiative	●●	●●	●●

CMS' Table of Interventions

Available at:
www.cfmc.org/integratingcare

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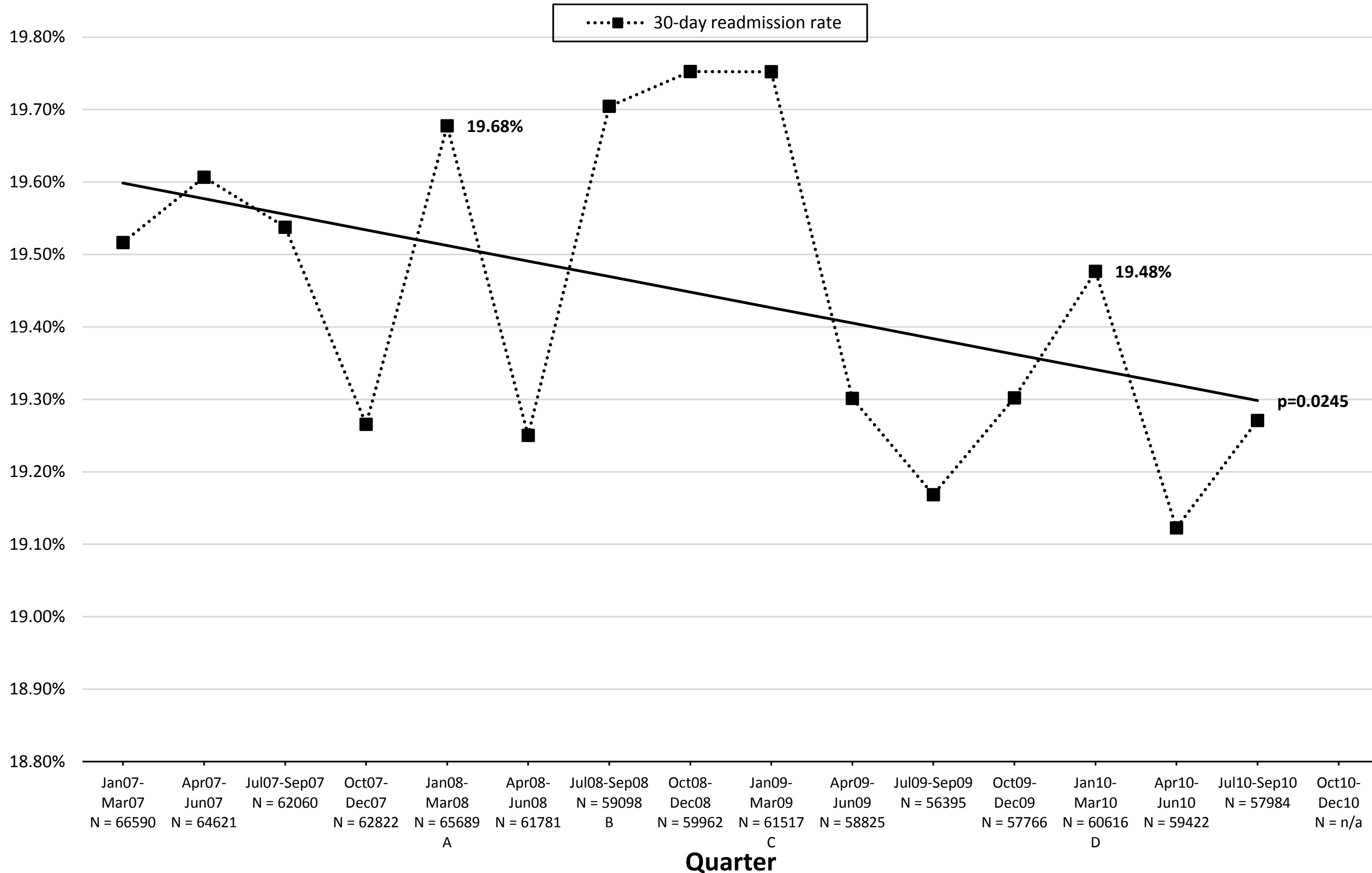
Lessons Learned

1. **Importance of community collaboration**
   – Providers talking, visiting each other, sharing
2. **Tailor solutions to fit community priorities**
   – Community needs determine change
3. **Include patients and families**
   – Incorporate beneficiaries when they are sick and healthy
4. **Public outreach activities**
   – Storytelling to support data
5. **Community Organizing tactics helpful**
   – Every QIO used some organizing tactics in their community
6. **Population-based Measures are critical**
   – Readmission reduction work reduces admissions too

30-day readmission rates, quarterly: all QIOs

Observed rates (dotted) and best-fit lines (solid)

Statistically significant trends per Cochrane-Armitage test are indicated by p-values, where applicable.



The unit N represents admissions among target community eligible beneficiaries.
MIlestones: A) baseline quarter; B) Care Transitions theme initiation (Aug 2008);
C) intervention implementation (Jan 2009); and D) 28-month follow up quarter.

*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.

Events per 1,000 eligible beneficiaries, quarterly: all QIOs

Observed rates (dotted) and best-fit lines (solid)

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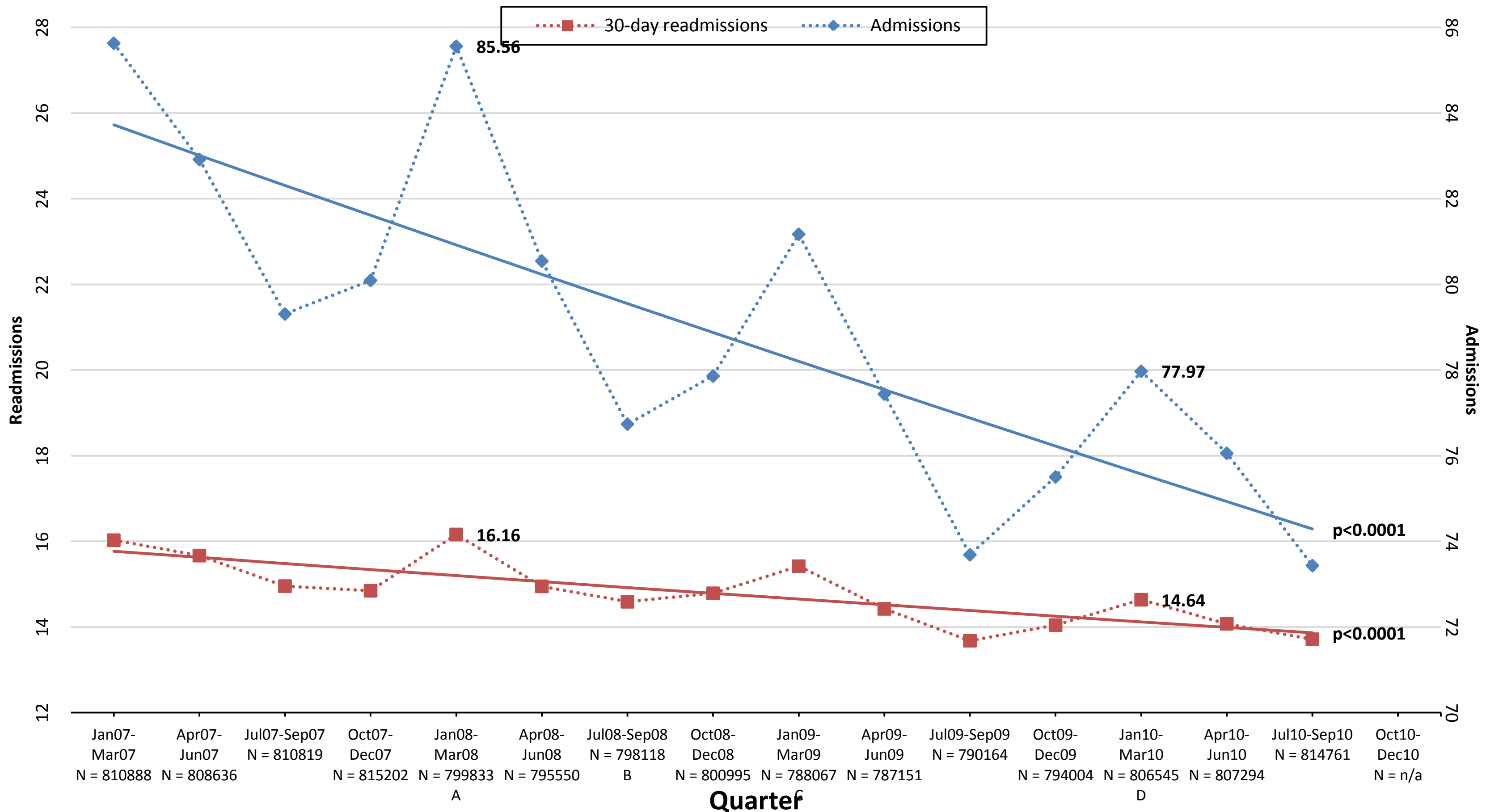

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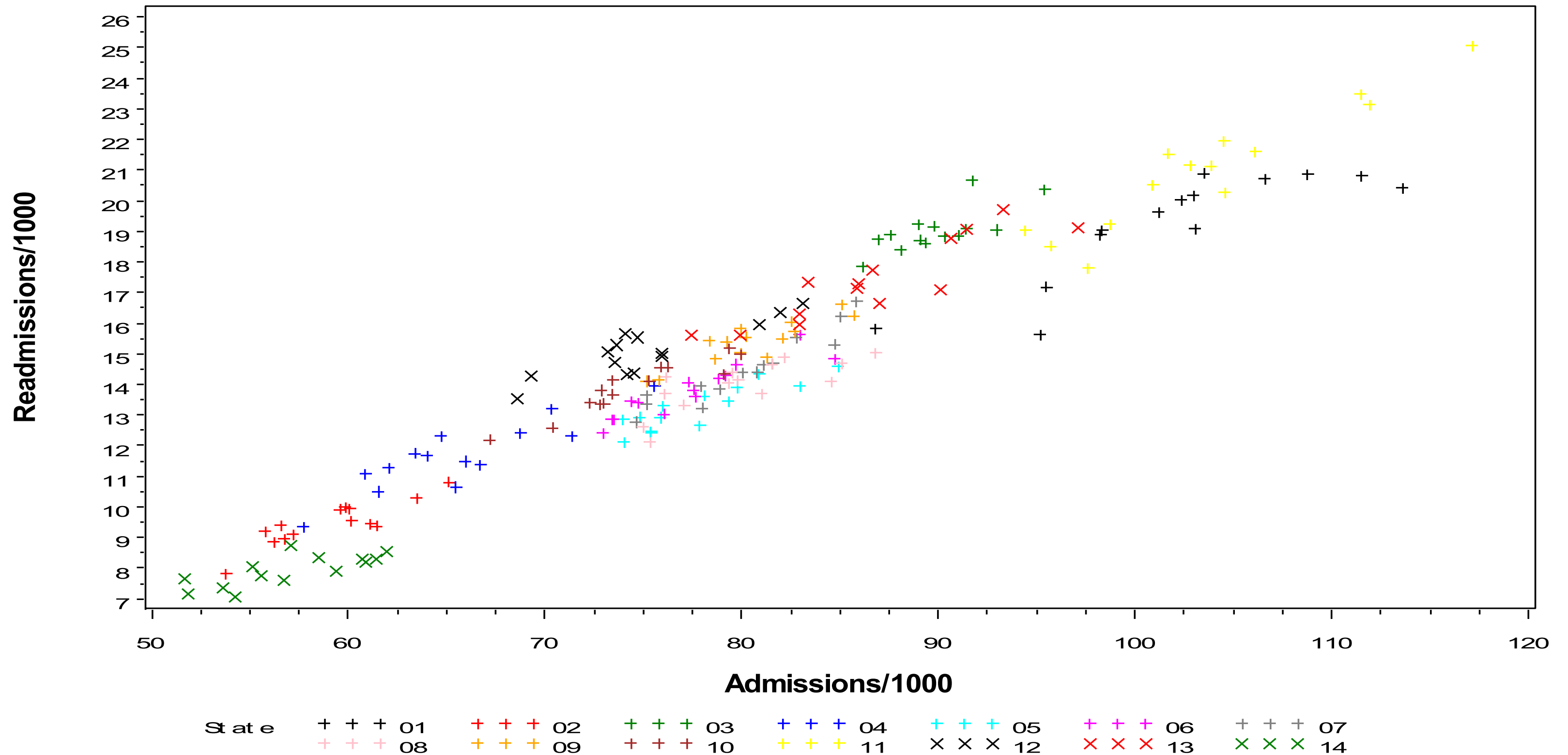
Correlation of Readmissions per 1000 Beneficiaries with Admissions per 1000 Beneficiaries



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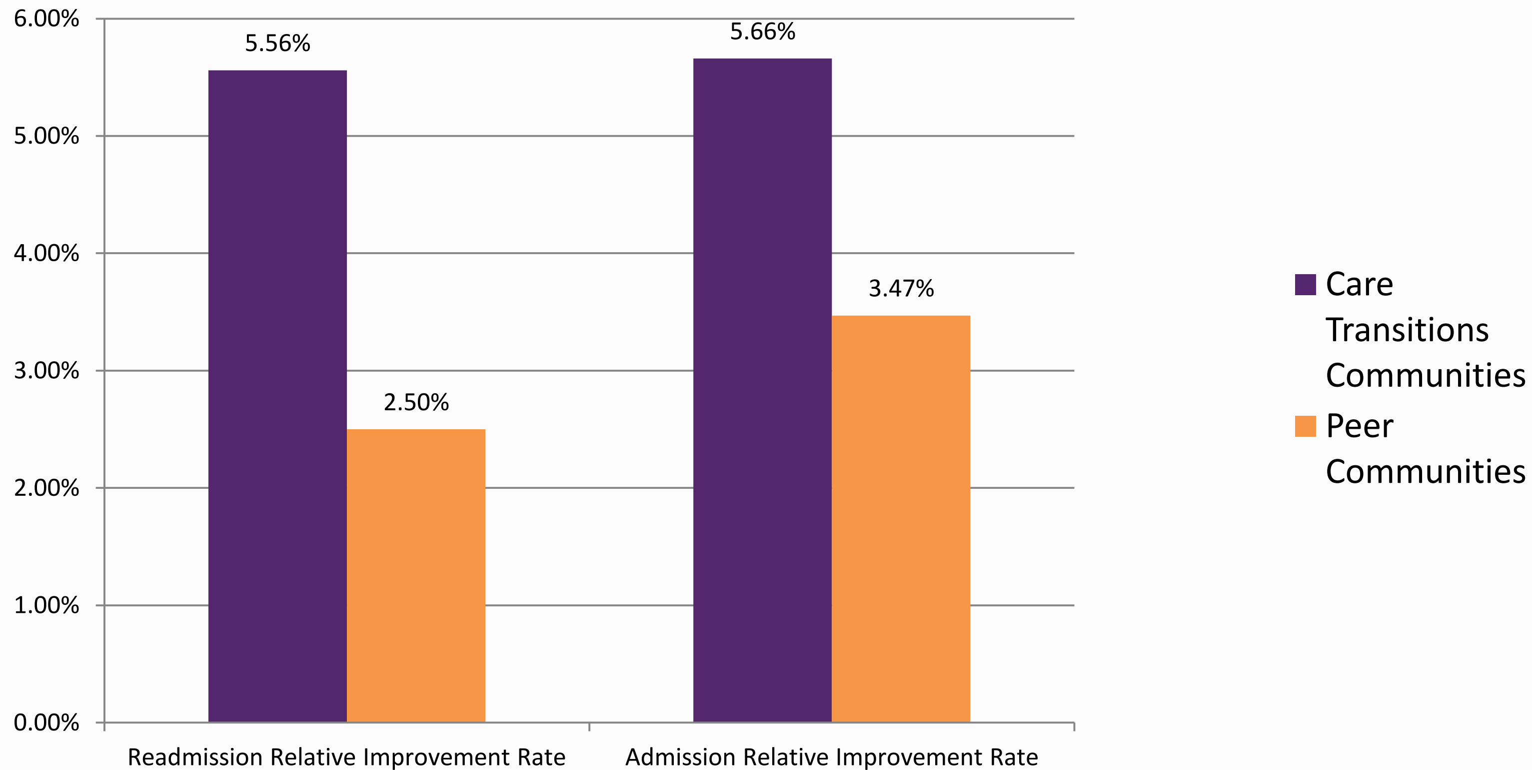
Preliminary Results*: Relative Improvement
July 2007-June 2008 compared to July 2009-June 2010



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Results

- Hospital readmissions work also reduces hospital admissions
- Population-based measures of readmission going down
- Population-based measures of admission also going down
- Nursing Home and Home Health utilization has increased slightly; while 30-day readmission rates from Nursing Home and Home Health have decreased
- Promising measures of cost-savings

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Recurring Themes in Successful Communities

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

QIO Care Transitions: Good News for the Next 3 years

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Aims:

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

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I think it's an elephant!

Every component is necessary…

1. Expertise in an individual area,
2. Experts from different areas coming together to address a specific problem, but
3. Backbone Organization/Group is critical:
    - Common agenda
    - Common measures
    - Structured collaboration

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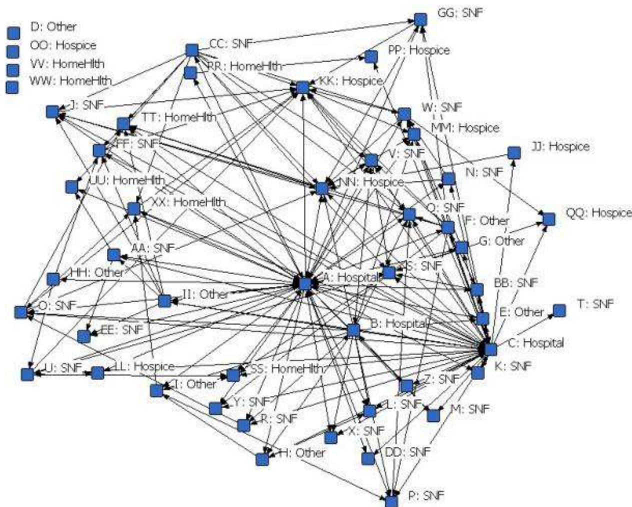
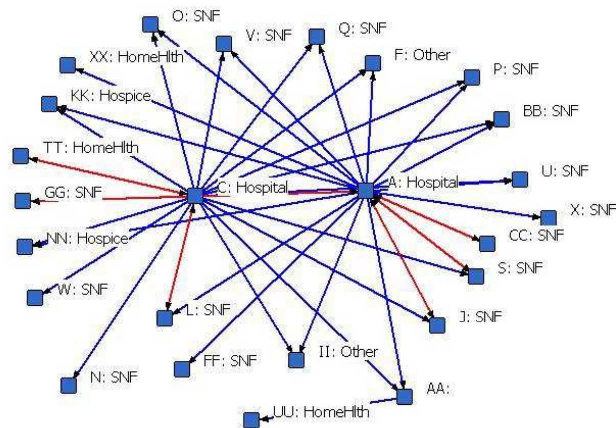
Community Coalition Building

- Information about Intervention Models
- Social Network Analysis
- Strategic Plan
- Develop and Formalize a Charter

Social Network Analysis



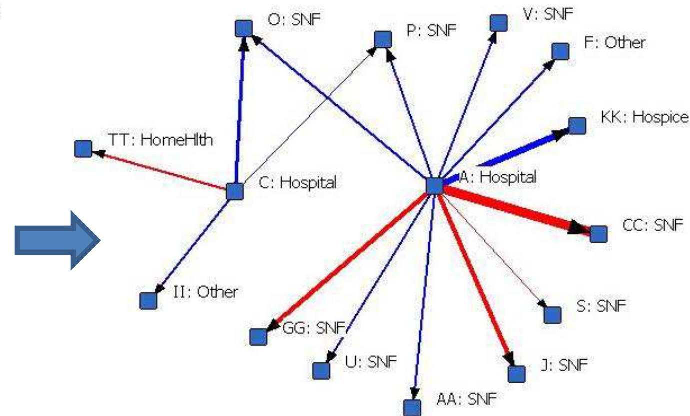
Represents all transitions in community



Represents providers who share 10 or more transitions

Red connectors represent provider pairs with high numbers of readmissions. The wider the connectors the greater the number of shared transitions.

Represents providers who share 30 or more transitions



Community-Specific Root Cause Analysis

- Patient/family interviews
- Care coordinator interviews
- Medical record reviews
- Data Analysis
- Process mapping
- Cause-and-effect diagrams
- "5 Whys"

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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 of intervention implementation
  - Estimates for intervention penetration
- Sustainability
- Community preferences

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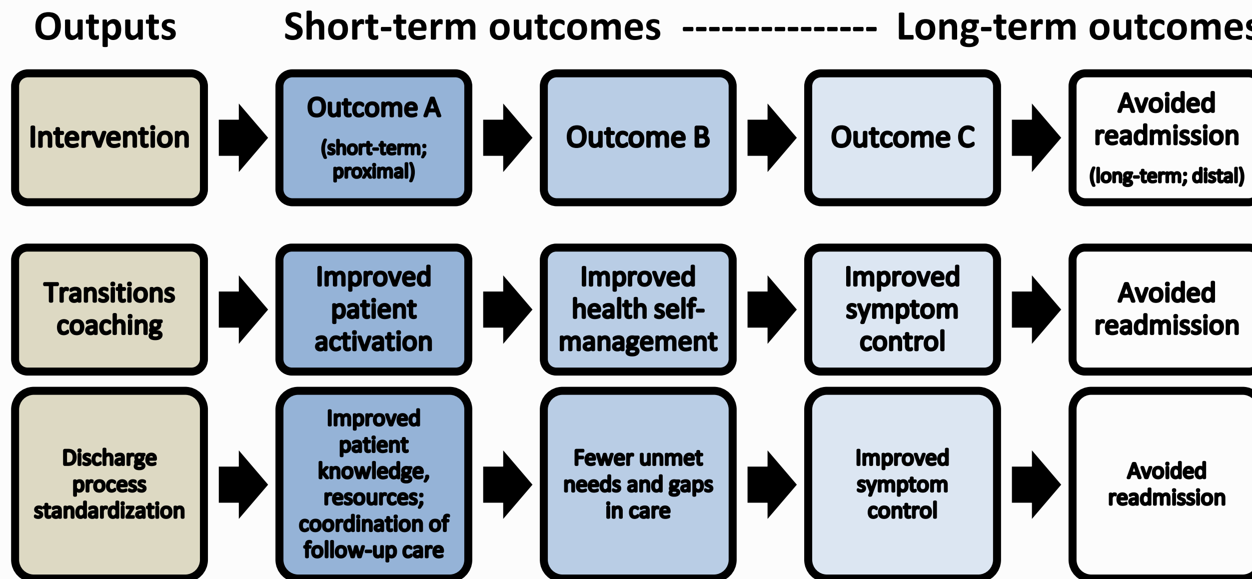
Intervention Measurement Strategies

- Involves both *process* and *outcome* Measures
- Providers and CBOs collect most **Process** data
- QIOs can help link **Outcome** Measures from Medicare claims to interventions
- QIOs can create time series control charts to show intervention progress and to monitor potential effects

Logic Models to guide measurement strategies

Short-term outcomes are more likely to show movement…



…but consider downstream (medium-term) outcomes if short-term outcomes are not feasibly measured.

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Coalition Charter Example

Community Coalition Charter

(Template – please adjust as needed for your community)

(10th SOW Section C.8.1.C.2.b)

Article I – Name

The name of this Coalition shall be [name].

Article II – Mission & Vision

The mission of the [Coalition Name] is...

The coalition will...
[Include commitment to reduce 30 day readmission rates by 20% over three years & consider adding a statement about whether the community intends to apply for a formal care transitions program]

Article III – Purpose

Examples:

1. To build and sustain a community coalition with a focus on improving transitions of care for Medicare beneficiaries
2. To be a vehicle for the patient and family voice
3. To encourage person-centered and person-directed models of care
4. To collaborate and encourage efforts of organizations with shared visions
5. To advance public policies that further the vision

Article IV – Participation

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Additional Assistance

For communities not getting this support from another program

- Host a statewide **Learning and Action Network**
- Participate in **Care Transitions Learning Sessions**
- Freely use QIO-developed tools, analytic programs, and other resources
- Provide **quarterly readmission** metrics

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Community Metrics

Population-Based Readmission Measure

- The rate of rehospitalizations within 30 days of discharge from an “acute care” hospital per 1,000 eligible FFS beneficiaries from the specified geographic area

Population-Based Admission Measure

- The rate of “acute care” hospitalizations per 1,000 eligible FFS beneficiaries from the specified geographic area

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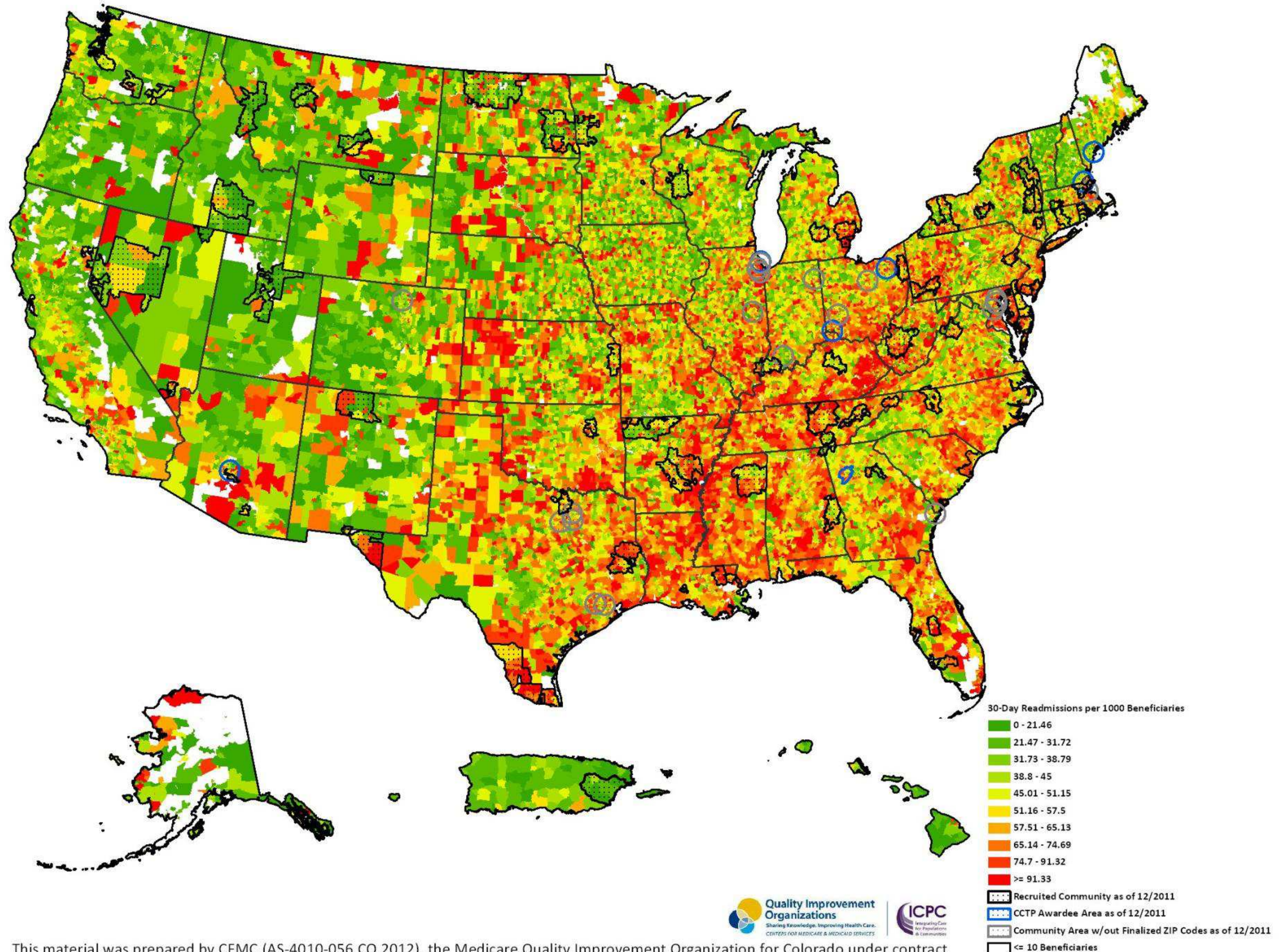
ZIP Code Level Readmissions per 1,000 Beneficiaries



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Other Helpful Metrics

- Hospital Readmission Rates
- Other Setting (SNF, HHA, Hospice) Readmission Rates
- Diagnosis-specific Readmission Rates
- Mortality Rates
- ED/Observation Stay Rates

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How to Get Started

- Contact your QIO

http://www.cfmc.org/integratingcare/files/ICPC_contacts.pdf

- Join (and listen to archived) Care Transitions Learning Sessions

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

- Browse our Toolkit

http://www.cfmc.org/integratingcare/toolkit.htm

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Additional Resources

- Medicaring – an independent website for improving care transitions www.medicaring.org
- Partnership for Patients

www.healthcare.gov/compare/partnership-for-patients/

- Community-based Care Transitions Program http://go.cms.gov/caretransitions
- The AoA Toolkit

www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_caretransitions/Toolkit/index.aspx

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Thank You & Questions

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