Care Coordination: Improving Value Through Re-engineered Care T*ransitions*

NYeC, NYSDOH OHITT Health-Home Webinar
Presentation by IPRO and the Visiting Nurse Service of Schenectady and Saratoga Counties
April 11, 2012

Visiting Nurse Service of Schenectady and Saratoga Counties

Quality Improvement Organizations
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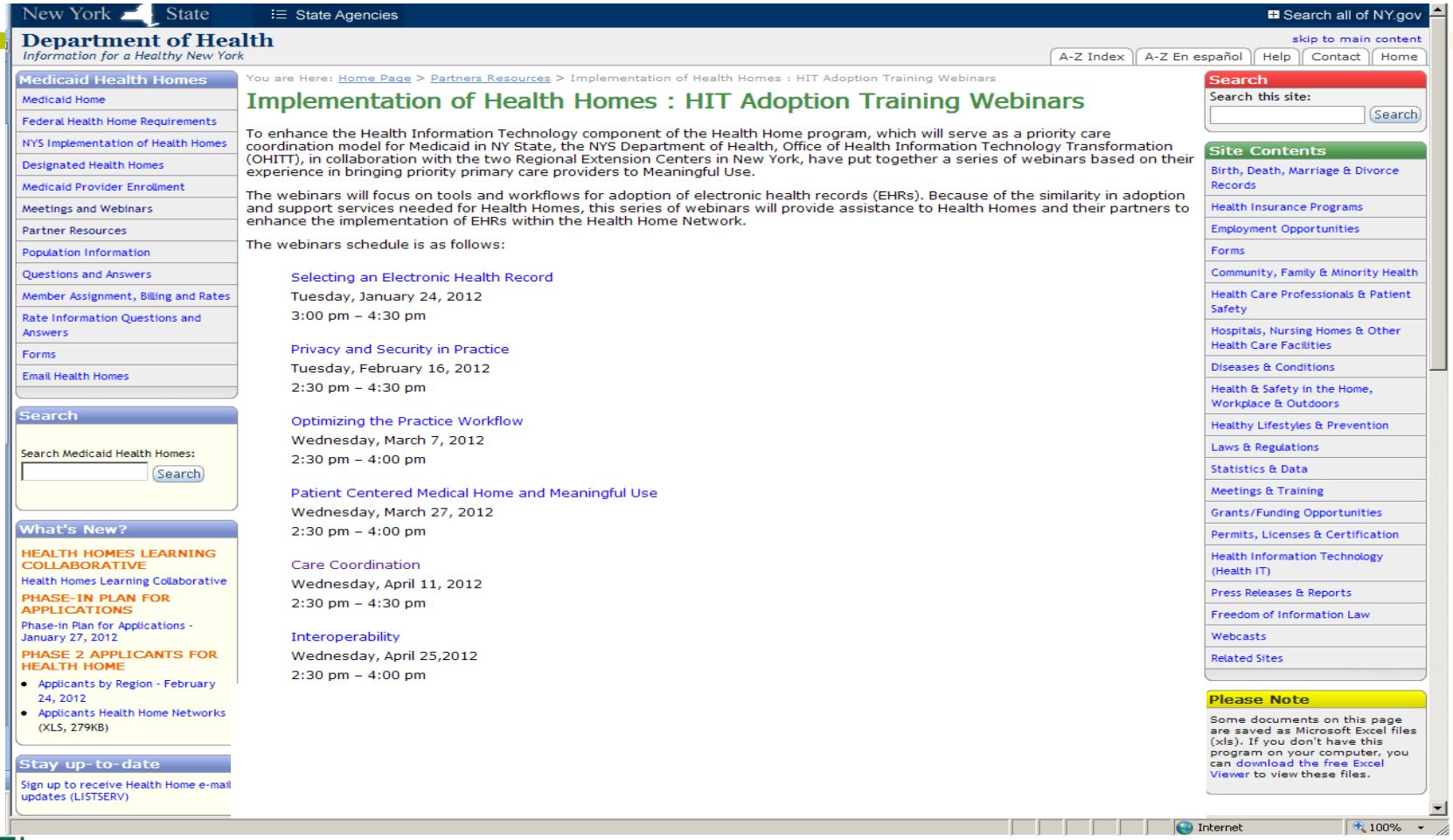
Session Elements

- Webinar series & context
- Hospital care transitions: scope of the problem & external forces
- Case study of community-based partnerships and approaches
- Moving to health-home coordination

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ohitt_ehr_webinars.htm



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Department of Health
Information for a Healthy New York

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Medicaid Health Homes

- Medicaid Home
- Federal Health Home Requirements
- NYS Implementation of Health Homes
- Designated Health Homes
- Medicaid Provider Enrollment
- Meetings and Webinars
- Partner Resources
- Population Information
- Questions and Answers
- Member Assignment, Billing and Rates
- Rate Information Questions and Answers
- Forms
- Email Health Homes

Search

Search Medicaid Health Homes: Search

What's New?

HEALTH HOMES LEARNING COLLABORATIVE
Health Homes Learning Collaborative

PHASE-IN PLAN FOR APPLICATIONS
Phase-in Plan for Applications - January 27, 2012

PHASE 2 APPLICANTS FOR HEALTH HOME
- Applicants by Region - February 24, 2012
- Applicants Health Home Networks (XLS, 279KB)

Stay up-to-date

Sign up to receive Health Home e-mail updates (LISTSERV)

You are Here: Home Page > Partners Resources > Implementation of Health Homes : HIT Adoption Training Webinars

Implementation of Health Homes : HIT Adoption Training Webinars

To enhance the Health Information Technology component of the Health Home program, which will serve as a priority care coordination model for Medicaid in NY State, the NYS Department of Health, Office of Health Information Technology Transformation (OHITT), in collaboration with the two Regional Extension Centers in New York, have put together a series of webinars based on their experience in bringing priority primary care providers to Meaningful Use.

The webinars will focus on tools and workflows for adoption of electronic health records (EHRs). Because of the similarity in adoption and support services needed for Health Homes, this series of webinars will provide assistance to Health Homes and their partners to enhance the implementation of EHRs within the Health Home Network.

The webinars schedule is as follows:

Selecting an Electronic Health Record
Tuesday, January 24, 2012
3:00 pm – 4:30 pm

Privacy and Security in Practice
Tuesday, February 16, 2012
2:30 pm – 4:30 pm

Optimizing the Practice Workflow
Wednesday, March 7, 2012
2:30 pm – 4:00 pm

Patient Centered Medical Home and Meaningful Use
Wednesday, March 27, 2012
2:30 pm – 4:00 pm

Care Coordination
Wednesday, April 11, 2012
2:30 pm – 4:30 pm

Interoperability
Wednesday, April 25,2012
2:30 pm – 4:00 pm

Search

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Site Contents

- Birth, Death, Marriage & Divorce Records
- Health Insurance Programs
- Employment Opportunities
- Forms
- Community, Family & Minority Health
- Health Care Professionals & Patient Safety
- Hospitals, Nursing Homes & Other Health Care Facilities
- Diseases & Conditions
- Health & Safety in the Home, Workplace & Outdoors
- Healthy Lifestyles & Prevention
- Laws & Regulations
- Statistics & Data
- Meetings & Training
- Grants/Funding Opportunities
- Permits, Licenses & Certification
- Health Information Technology (Health IT)
- Press Releases & Reports
- Freedom of Information Law
- Webcasts
- Related Sites

Please Note

Some documents on this page are saved as Microsoft Excel files (xls). If you don't have this program on your computer, you can download the free Excel Viewer to view these files.

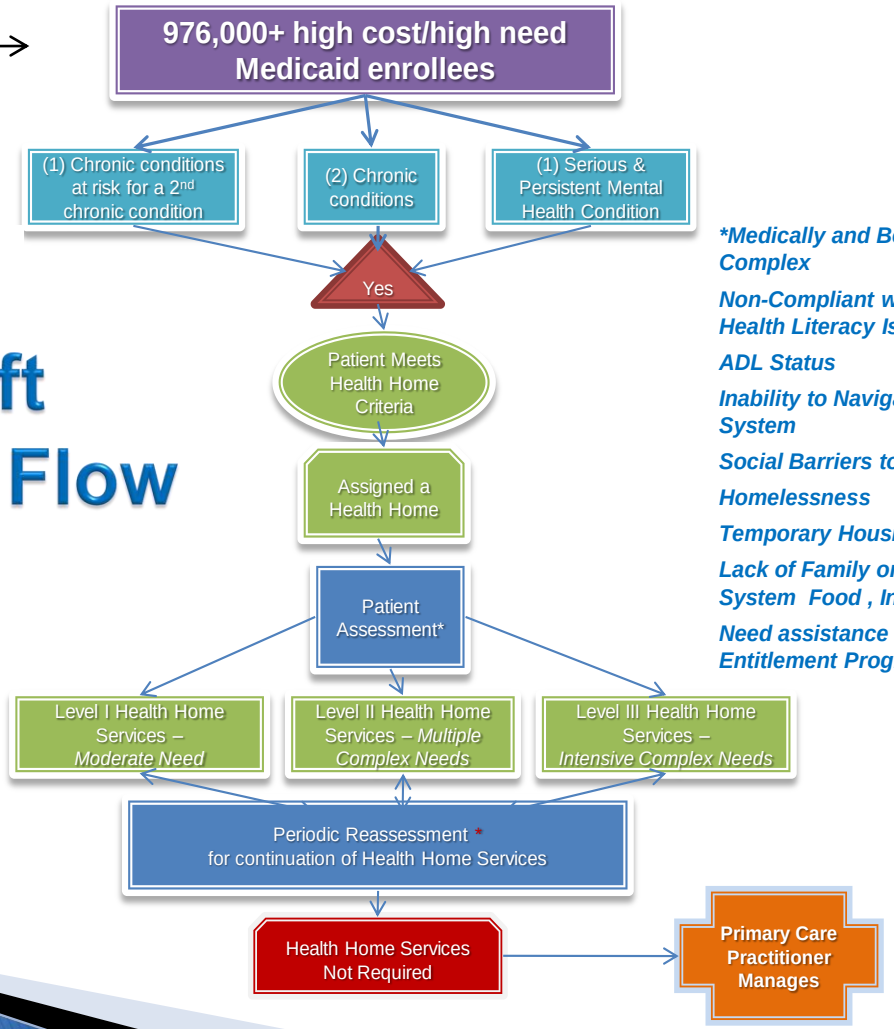
Internet | 100%

Context- New York State Medicaid Health Homes

1. Developmental Disability
2. Behavioral Health
3. Long-Term Care
4. Chronic Medical

NYSDOH Medicaid Health Home State Plan Amendment and Provider Application*

Draft Patient Flow



Medically and Behaviorally Complex

Non-Compliant with Treatment Health Literacy Issues

ADL Status

Inability to Navigate Health Care System

Social Barriers to Care

Homelessness

Temporary Housing

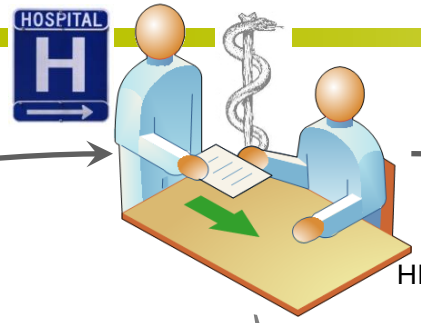
Lack of Family or Support System Food , Income

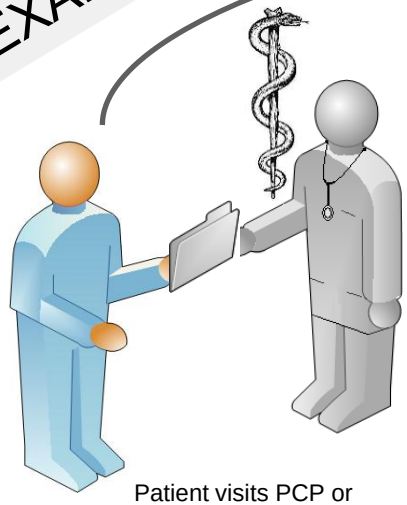
Need assistance applying for Entitlement Programs

Care Transitions & Health Information Exchange

EXAMPLE

Provider refers patient to a specialist, hospital or other provider for consultation or service



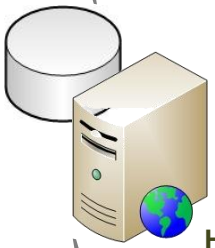


Patient visits PCP or specialist and establishes trusted relationship and consents for release of data; consents and provider routing preferences are sent to HIE service

Participant Directory / Consents / Disclosure Log

HIE service submits referral authorization request to payer for approval and referral #

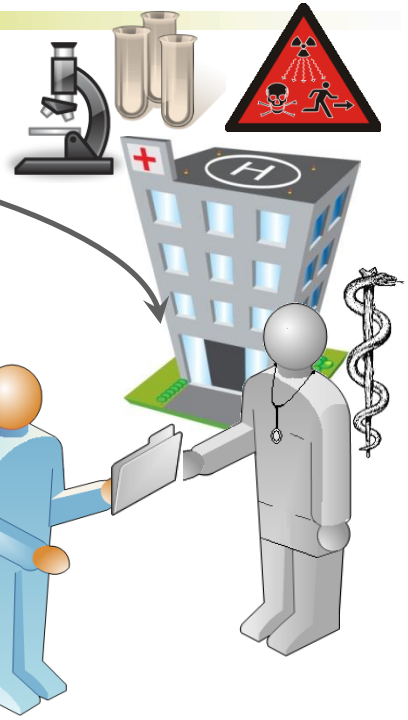
HIE service routes visit summary to PCP, specialist or other interested and trusted party (e.g., health insurance case manager). HIE log can store summary or link to allow for tracking and later lookup.



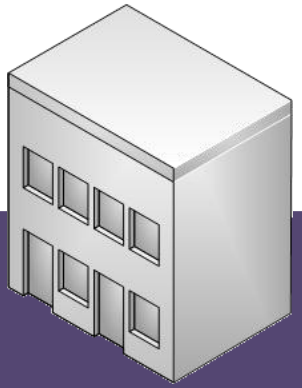
HIE Service

HIE service checks participant directory for routing instructions and sends referral request with pertinent patient information / history, diagnosis and service requested to consulting provider; business rules can be stored in HIE service for elements of real-time decision support

Standard format visit summary with consultation notes transmitted to HIE network.



Patient visits consulting provider, receives services, and details are noted in patient chart , electronic medical record or other result is created (e.g., at lab)



Health Plan, etc.

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Hospital Re-admissions

Scope of the Problem

National Priority to Reduce Avoidable Re-Hospitalizations:

- Hospitalizations consume one-third of the $2 trillion in health care expenditures in the U.S.
  - 1 in 5 (20%) of all hospitalizations occur within 30 days of acute care discharge
  - 64% receive no post acute care between discharge and readmission
  - 1 in 4 (28%) of hospitalizations are avoidable

Covering Health Issues 2006-2007. Alliance for Health Care Reform

New York State Perspective - Hospital

New York State 30-Day Hospital Readmission Rates Medicare FFS Beneficiaries Age 65 or Older			
	CY 2009	CY 2010	CY 2011
All Cause	20.5%	20.9%	19.8%
Acute Myocardial Infarction	25.2%	23.8%	23.3%
Heart Failure	28.8%	28.6%	27.4%
Pneumonia	21.3%	21.1%	20.3%
Chronic Obstructive Pulmonary Disease	26.2%	26.4%	25.3%
Diabetes	24.3%	22.3%	22.6%
End Stage Renal Disease	37.1%	35.4%	34.8%
Source: CMS FFS Medicare Claims Data			

New York State Perspective - SNF

New York State Skilled Nursing Facility Readmission Rates Medicare FFS Beneficiaries Age 65 or Older	CY 2009	CY 2010	CY 2011
NYS Medicare FFS Acute Care Discharges	651,794	*643,968*	630,766
Percent NYS Direct SNF Placements	24%	24%	24%
Percent NYS Readmitted with 7 Days	9%	9%	9%
Percent NYS Readmitted with 14 Days	16%	15%	15%
Percent NYS Readmitted with 21 Days	21%	20%	20%
Percent NYS Readmitted with 30 Days	25%	25%	24%

Source: CMS FFS Medicare Claims Data
(In hospital deaths and transfers to another acute facility were not counted)

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Home Health

- Nationally, 28% of home care patients are hospitalized unexpectedly
- Nearly 58% of acute care hospitalizations (ACH) occur within the first three weeks of home health admission
- 25% of ACH occur within seven days of home health admission
- 68% of ACH patients had been hospitalized within the two weeks prior to home health admission
- 40% of hospitalizations are avoidable
- ***NYS Home Health Compare ACH rate posted 01/2012 for 10/2010-09/2011 is 31% (national rate is 27%)***

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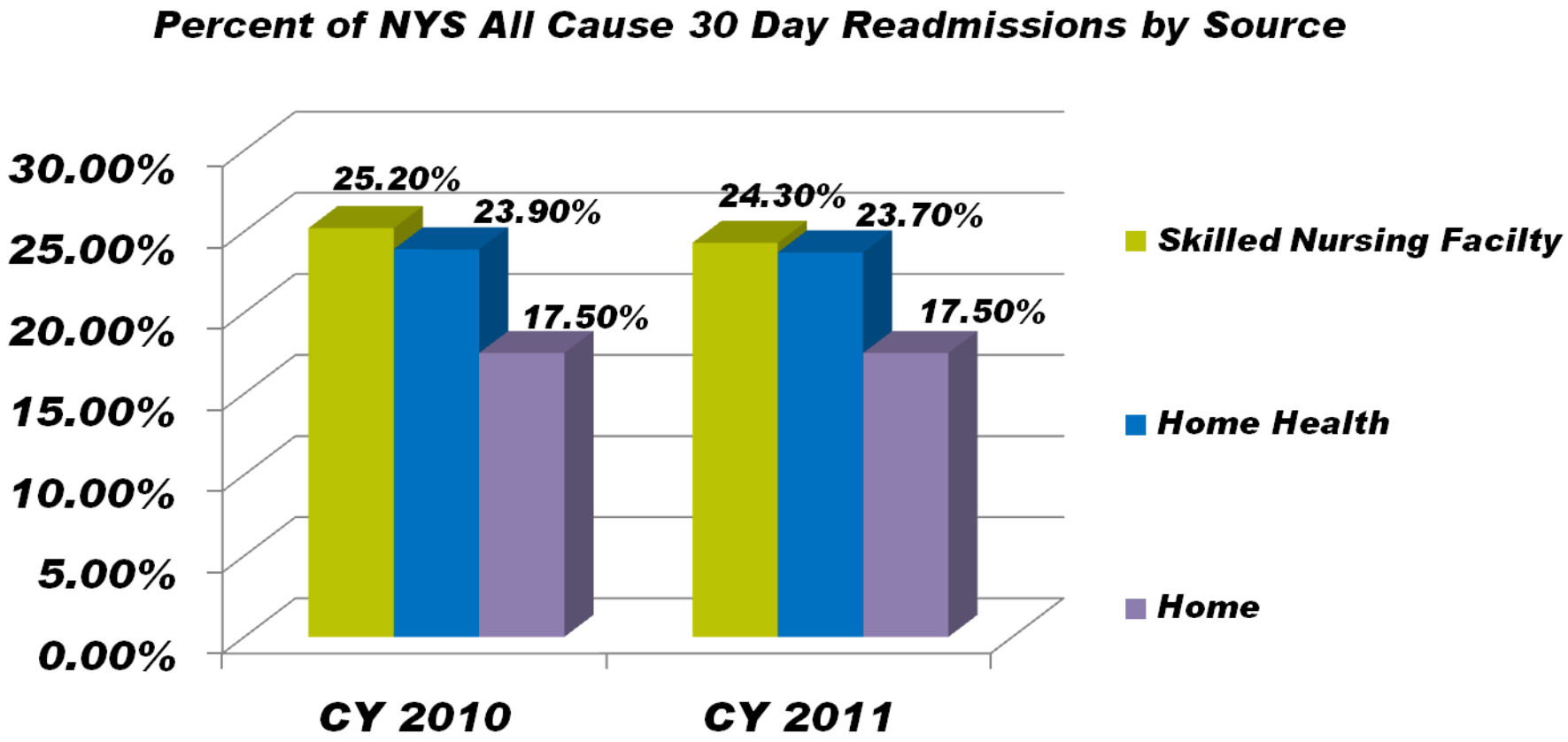
Source: OASIS Data

NYS All Cause 30-Day Readmission Source



Source: CMS Medicare FFS Paid Claims Data

Dilemmas

- Focus is on discharge versus transition
- No ownership of transition
- Burden of coordination is placed on patient
- Caregiver may not be available / involved at discharge
- Absence of common medical record
- Absence of cross setting medication reconciliation
- Lack of advance directives & screening for palliative care
- No reassessment of patient and goals at each transition
- Communication gaps exist between disciplines and health care settings

External Drivers Motivating Cross-Setting Partnerships

The Driving Forces….

CMS Hospital Value Based Purchasing

- Value-based incentive payments to hospitals that meet certain performance standards during that fiscal year
- Discharges occurring on or after October 1, 2012
  - Acute myocardial infarction;
  - Heart failure;
  - Pneumonia;
  - Surgeries, as measured by the Surgical Care Improvement Project;
  - Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections
- Hospitals will be scored based on their performance on each measure relative to other hospitals and on how their performance on each measure has improved over time. The higher of these scores on each measure will be used in determining incentive payments.

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Source: ACA 2010: Title III, Section 3001

The Driving Forces….

CMS Value-Based Purchasing Nursing Home Demonstration Project

Financial incentives to nursing homes that meet certain conditions for providing high quality care

- **Four Domains**
  - Nurse Staffing
  - Rates of potentially avoidable hospitalizations
  - Outcome on selected MDS-based quality measures
  - Results from State Survey Inspections

NYS DOH Reserved Bed Day Reimbursement for Medicaid

Quality Indicator Survey (QIS)–addresses hospitalization of nursing facility admissions

- Trigger of Stage II investigation if threshold of 15% is exceeded
  - Numerator - # of residents in readmitted within 30 days
  - Denominator - total # of residents in randomly selected sample

The Driving Forces….

CMS Home Health Value Based Purchasing

- Recruitment for participation in the demonstration began in October 2007, with implementation in January 2008, continued through December 2009
  - Connecticut and Massachusetts in the Northeast; Illinois in the Midwest; Alabama, Georgia, and Tennessee in the South; and California in the West
- Demonstration HHAs eligible to receive incentive payments if their quality improvement efforts result in the highest performance levels or significant quality improvements as determined by Outcome-Based Quality Improvement measures.
- Measures of the incidence of acute care hospitalization and emergency care, improvement in select activities of daily living, and improvement in the status of wounds and management of oral medications

American Medical Directors Association (AMDA) Perspective

IMPROVING CARE TRANSITIONS BETWEEN THE NURSING FACILITY AND THE ACUTE-CARE HOSPITAL SETTINGS *(White Paper H10, Became Policy March 2010)*

- **"*Avoidance* of unnecessary transfers should be a primary goal, but when transfers *are* necessary, we support implementation of processes that optimize efficient and well-orchestrated patient transitions. We also encourage improved competencies of the entire interdisciplinary team in the SNF/NF setting, both as individuals and as a team, and more effective processes to ensure appropriate assessments are performed before the decision to transfer a patient to the hospital is made."**

AMDA Acute Change of Condition Clinical Practice Guideline – www.amda.com/tools/cpg/acoc.cfm.

AMDA Transitions of Care in the Long-Term Care Continuum Guideline http://www.amda.com/tools/clinical/TOCCPG/index.html

The Driving Forces….

American Geriatrics Society Health Care Systems Committee Position

- Clinical professionals must prepare patients/caregivers to receive care in the next setting & actively involve them in decisions related to the formulation & execution of the transitional care plan
- Bi-directional communication between clinical professionals is essential to ensuring high quality transitional care
- The opportunity to collaborate with a coordinating health professional functioning across health care settings to reduce care fragmentation may enhance the care that these professionals deliver

Source: J Am Geriatric Soc 51:556-557, 2003

Health Care Reform: Implications for Providers & Relationship to Care Transitions

Medicare Commission — develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries

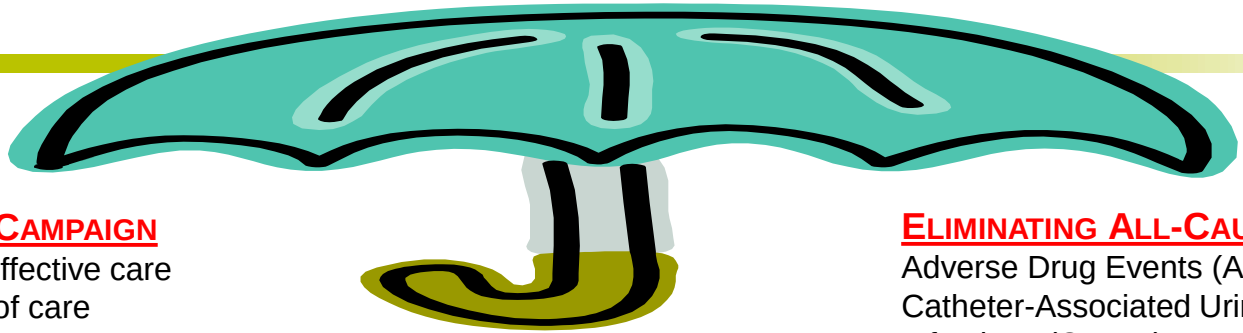
- ***Bundled payments*** - pay a fixed amount for an entire episode of care rather than piecemeal for each individual treatment or procedure to improve patient care by encouraging better and more coordinated care than under a fee-for-service system. Bills in both the Senate and the House would develop, test, and evaluate bundled payment methods through a national, voluntary pilot program.

- ***Penalties for high readmissions*** - Under the proposals being considered, Medicare would collect data on readmission rates by hospital and would assess penalties on those hospitals with high, preventable readmission rates.

Source: The White House. Gov Web Site at http://www.whitehouse.gov/blog/2009/10/13/bending-curve-more-ways-one

CMS Partnership for Patients: Better Care, Lower Costs

http://www.healthcare.gov/center/programs/partnership/index.html



Million Hearts Campaign

Improve access to effective care
Improve the quality of care
Focus more clinical attention on heart attack and stroke prevention
Increase public awareness of how to lead a heart-healthy lifestyle
Increase consistent use of high blood pressure and cholesterol medications

(http://www.hhs.gov/news/press/2011pres/09/20110913a.html)

Improving Care Transitions

Reduce hospital readmissions
Test sustainable funding streams for care transition services Maintain or improve quality of care
Document measureable savings to the Medicare program.

Community Based Care Transitions Initiative

(http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313)

Eliminating All-Cause Harm

Adverse Drug Events (ADE)
Catheter-Associated Urinary Tract Infections (CAUTI)
Central Line Associated Blood Stream Infections (CLABSI)
Injuries from Falls and Immobility
Obstetrical Adverse Events
Pressure Ulcers
Surgical Site Infections
Venous Thromboembolism (VTE)
Ventilator-Associated Pneumonia
Other Hospital-Acquired Conditions

Education -Technical Support - Tools - Resources

CMS Medicare Quality Improvement Organization (QIO) 10th Scope of Work (IPRO)

CMS Hospital Engagement Network (HEN) (HANYS & GNYHA)

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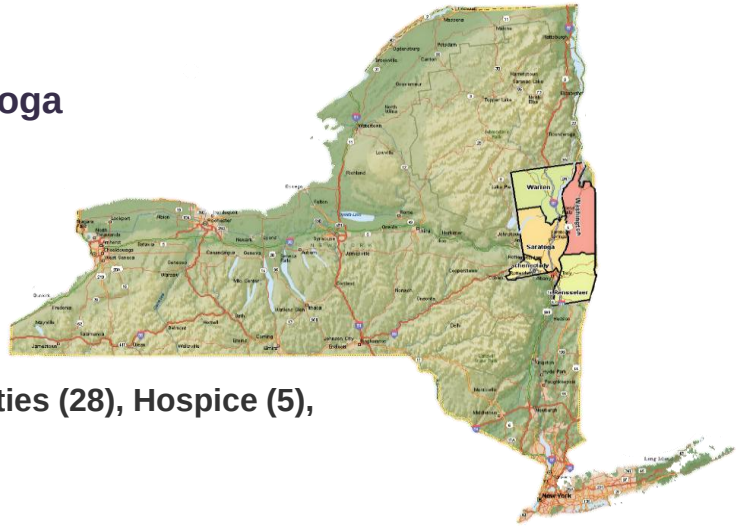
Case Study of Partnerships and Innovative Strategies

CMS QIO New York Care Transitions Initiative (08/2008-07/2011)

- **Five county** region in Upper Capital Region of New York State with integrated referral patterns incorporating urban, suburban and rural communities within **84 zip codes**
  - Warren, Washington, Saratoga, Rensselaer & Saratoga



- **Fifty providers**
  - Hospitals (6), Home Health (6), Skilled Nursing Facilities (28), Hospice (5), Dialysis Centers (5), Multiple Physician Practices

- Impacting **68,206 Medicare Fee for Service (FFS) beneficiaries**

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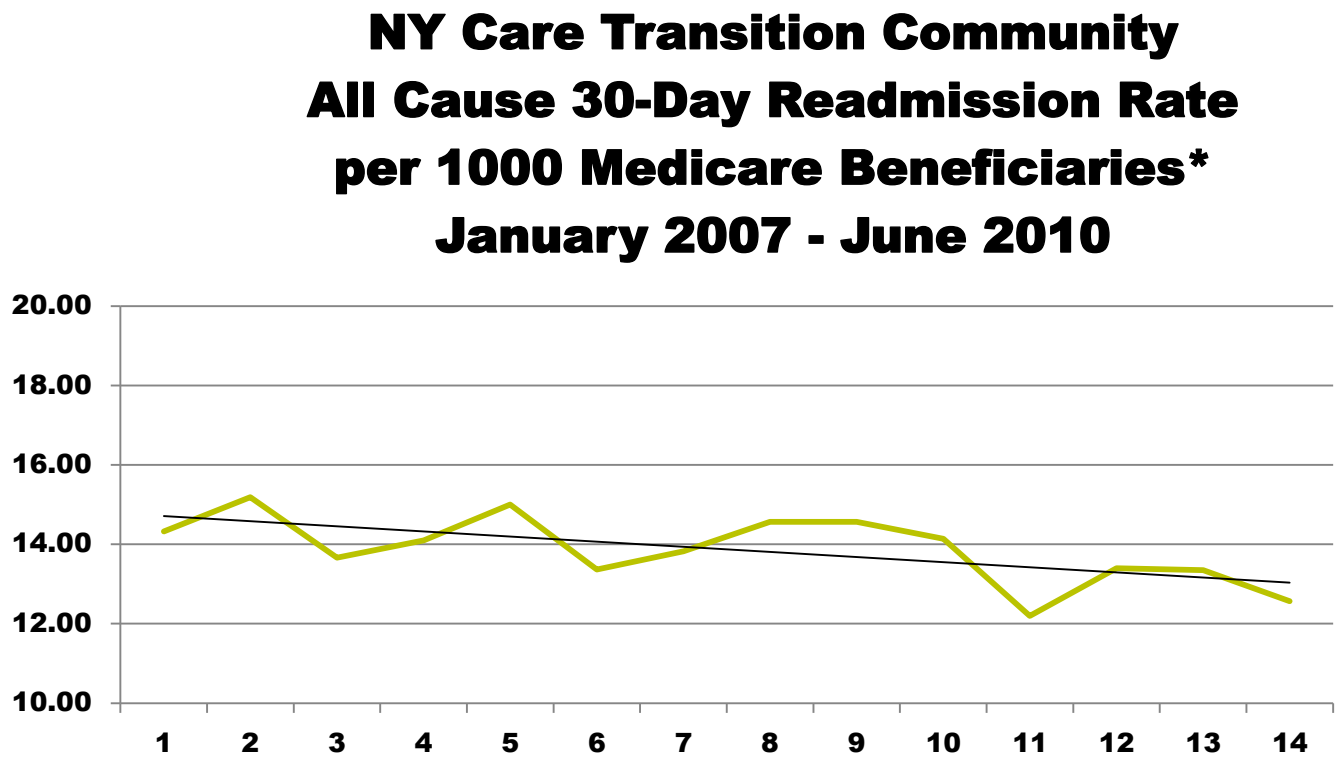
NY Care Transition Target Community All Cause 30-Day Readmission Trend



10.8% Relative Improvement/1000 Beneficiaries

**Population-Based Measurement*

Source: Paid Medicare Fee For Service Claims

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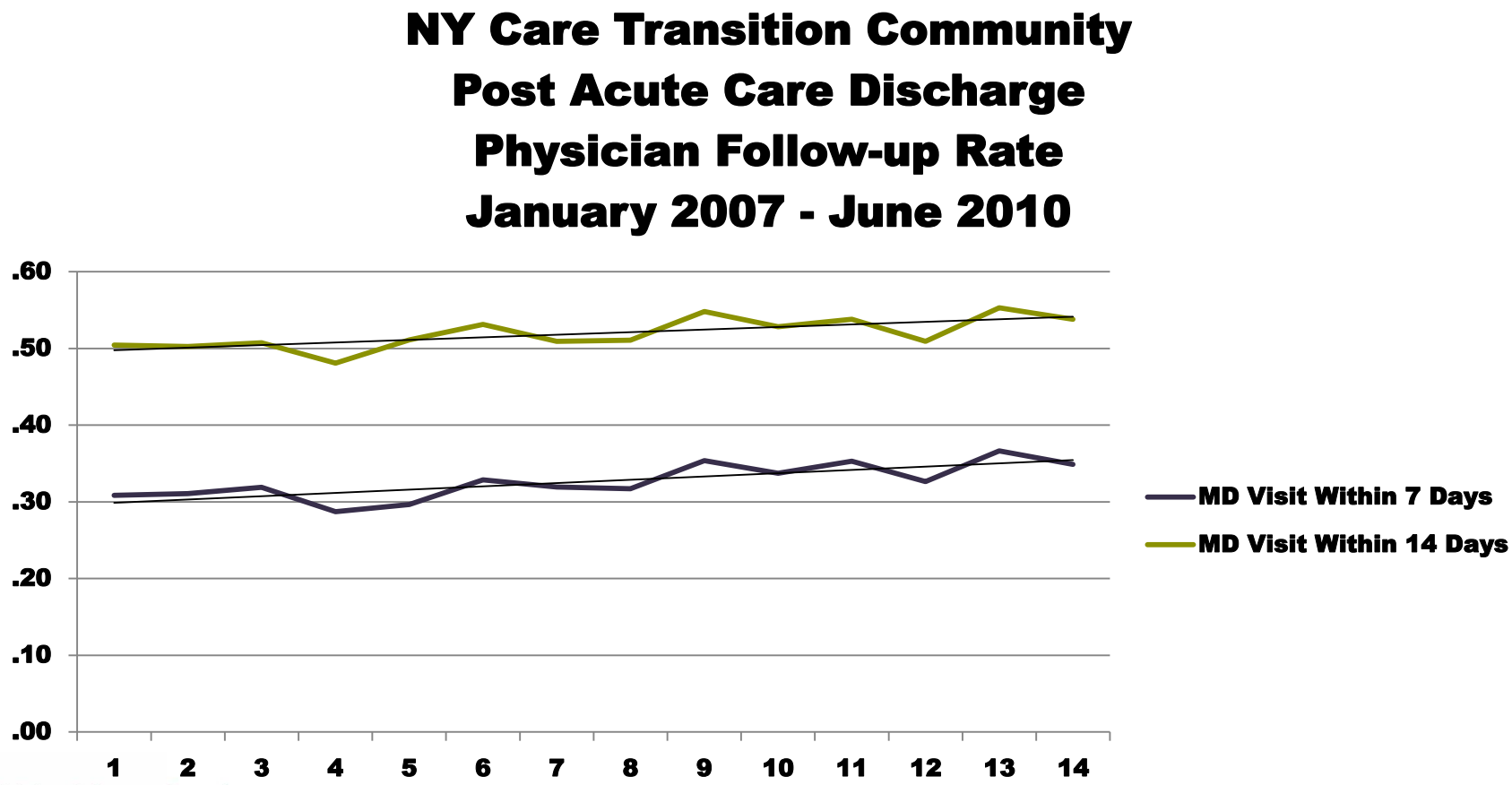
NY Care Transition Target Community Post Acute Care Physician Follow-up



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Source: Paid Medicare Fee For Service Claims

Targeted Opportunities for Improvement

- Assessment of patient / caregiver understanding of discharge medications & instructions using Teach-Back Method
- Identification and referral of high-risk readmission patients for follow-up care
- Inclusion of 7-day follow-up physician visit appointment in discharge instructions with follow-up phone call
- Cross setting medication reconciliation & education
- Support of patient / caregiver learning for self-management (signs / symptoms / red flags / action)
- Improved cross setting partnerships and communication for care coordination and management
- Streamlined and standardized cross setting information transfer

Systems Improvement

Root Cause Analysis

Readmission Drivers

Interventions

Principles & Application of Community-Wide Root Cause Analysis of Readmission Drivers

“We can’t solve problems by using the same kind of thinking we used when we created them.”
-Albert Einstein

Root Cause Analysis

Definition

- A Root Cause Analysis (RCA) is a process for identifying the basic or causal factors that underlie variations in outcomes
- Allows you to identify the “root” of the problem in a process, including how, where, and why a problem, adverse event, or trend exists
- This analysis should focus on a process that has potential for redesign to reduce risk

Root Cause Analysis

- An RCA focuses primarily on systems and processes, not individual performance
- To begin, identify the underlying functions leading to poor outcomes. Then, determine the primary cause(s) and contributing factors
- An RCA is generally broken down into the following steps:
  - Collect data
  - Analyze data
  - Develop and evaluate corrective actions, using PDSA cycle
  - Implement successful corrective actions

Root Cause Analysis Purpose

- Identify causes of hospital 30-day readmissions within the community
  - Health care provider perspective (hospital, nursing home, home health agency, hospice, etc)
  - Community perspective (Office for Aging and other community service providers)
  - Patient/caregiver perspective
- Identify patterns of readmissions for the community

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Root Cause Analysis Methods

- **Retrospective review**
- **Analysis of admission and discharge data**
- **Process assessment (discharge process, communication, coordination, referral, etc)**
  - Interviews
  - Direct observation
- **Focus groups**

Who Will Perform?

- **Healthcare Provider(s)**
  - Interdisciplinary team (physicians, nurses, discharge planner, social worker, pharmacist, therapist, IS, etc)
  - Identify a day-to-day leader and a senior leader (decision-maker)

- **Community Organizations/Stakeholders**
  - Focus group at senior centers
  - Interview seniors during visits post hospital discharge
  - Gather scenarios and identify senior volunteers who are willing to participate in improvement efforts

Root Cause Analysis

- **Identify high volume 30-day readmission population to focus efforts**
  - Diagnosis specific – HF, COPD, diabetes, ESRD
  - Unit specific – HF unit, respiratory unit, post-acute rehab
  - Criteria specific – all patients with a readmission within 30 days post discharge
- **Start small and spread efforts to next population**
- **Communicate efforts to physicians and leadership within organization**

Root Cause Analysis

- Overall 30 day all cause readmission rate and defined project population
- Source of readmissions by provider setting
- Record review to determine if potentially preventable
- Identify patterns and trends
  - Example: Nursing Home concurrent tracking of readmissions by unit, shift, sending physician, reason for transfer (event & family), diagnosis, patient assessment 72 hours up to event
- Medication discrepancy measurement trends
- Hospital HCAHPS Data
  - Composite 5 (Questions 16 & 17) – Communication About Medications
  - Composite 6 (questions 19 & 20) – Discharge Information

Root Cause Analysis Findings

Readmission Drivers usually fall into 3 categories:

- Lack of engagement or activation of patients and families into effective post-acute self management
- Lack of standard and known processes among providers for transferring patients and medical responsibility
- Ineffective or unreliable sharing of relevant clinical information

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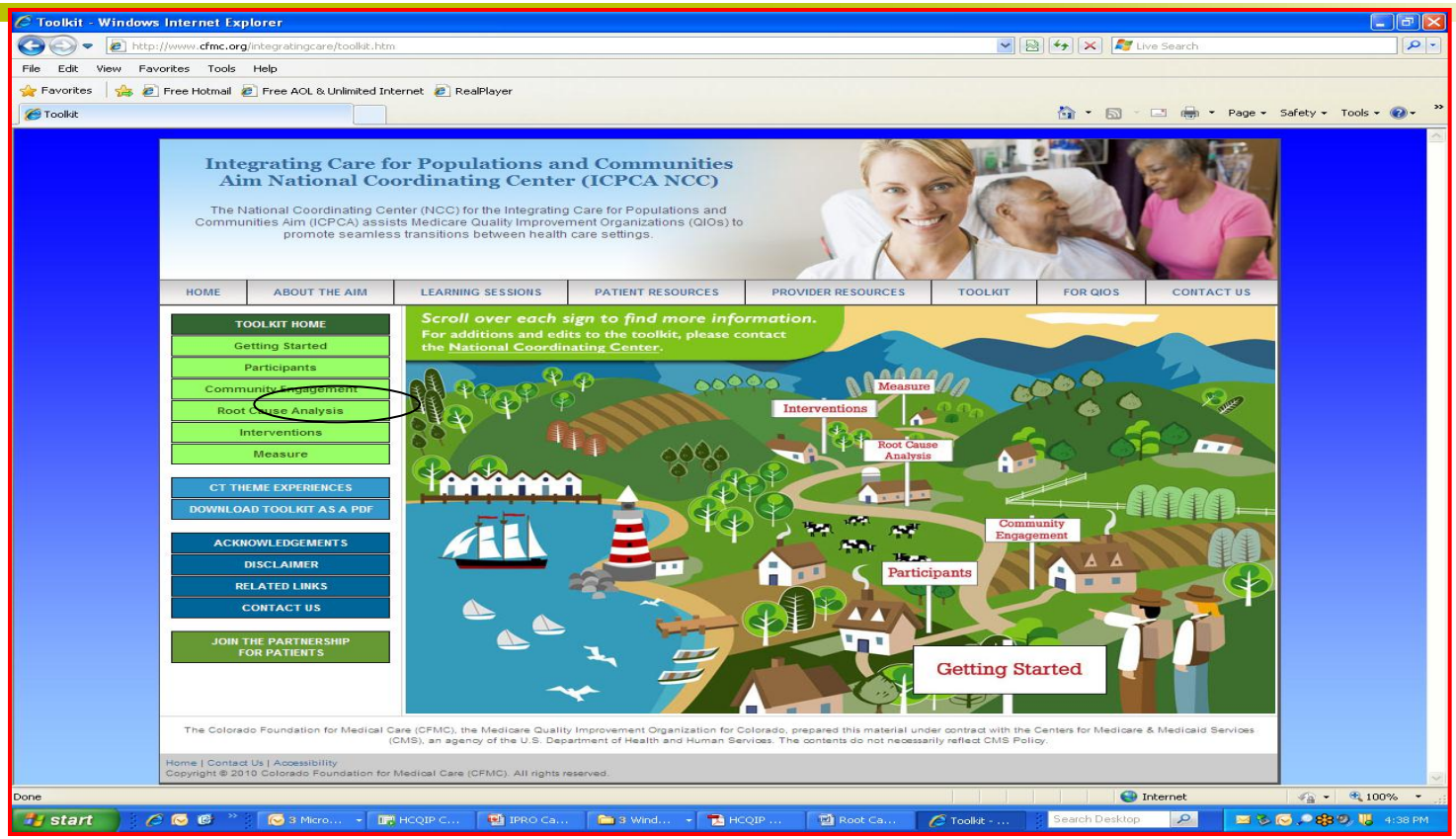
Root Cause Analysis Target Populations

- Heart Failure
- Chronic Obstructive Pulmonary Disease
- Pneumonia
- End Stage Renal Disease
- Acute Myocardial Infarction / Coronary Artery Disease
- Diabetes

Root Cause Analysis Resources- A Care Transitions Toolkit



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

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Priority Cross-Setting Intervention Strategies

- *Naylor Transitional Care Nurse Model*
- *Coleman Care Transitions Intervention (CTI) Model / Coaches*
- *Cross-setting Medication Reconciliation*
- *Medication Discrepancy Monitoring & Communication*
- *Physician Visit 7-days post acute discharge*
- *Follow-up phone call post discharge*
- *Patient / Caregiver "Teach Back" Education*
- *Cross-setting partnerships*
- *Patient / Caregiver self-management*
- *Telehealth*
- *Global Access to Critical Patient Information*
- *Standardized Transfer of Information (Admission & Discharge Summary)*
- *Palliative Care*

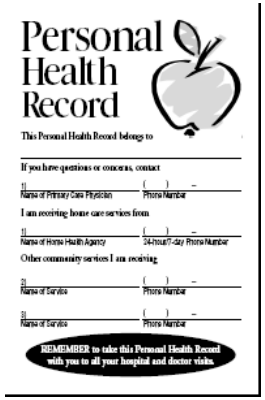
Dr. Eric Coleman's Care Transitions Intervention Model (CTI)

Care Transition Coach

- Follows patient for a 30-day period
- Hospital visit
- Home visit within 24-48 hours post-acute discharge
- Three follow-up telephone contacts
- Teach-back method

Four Pillars

- Medication reconciliation
- Identification of "Red Flags"
- Post acute physician follow-up visit within 7 days post discharge (can be scheduled prior to hospital discharge)
- Personal Health Record


Personal Health Record

This Personal Health Record belongs to

If you have questions or concerns, contact

1) Name of Primary Care Physician ( ) – Phone Number

I am receiving home care services from

1) Name of Home Health Agency ( ) – 24-hour/7-day Phone Number

Other community services I am receiving

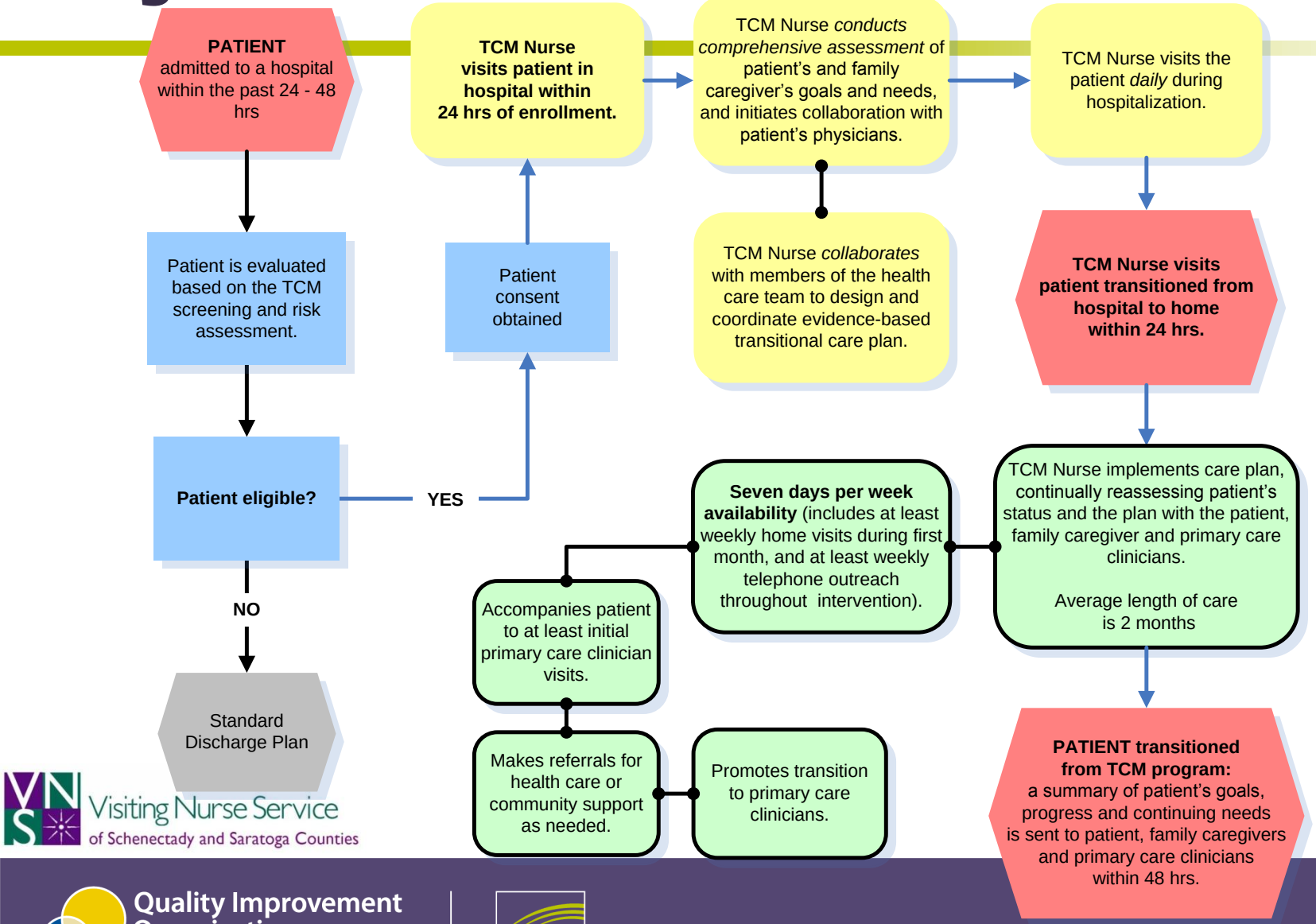
2) Name of Service ( ) – Phone Number

3) Name of Service ( ) – Phone Number

REMEMBER to take this Personal Health Record with you to all your hospital and doctor visits.

Dr. Coleman's Web site: http://www.caretransitions.org/

Naylor TCM Workflow*



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*http://www.transitionalcare.org

Project RED
Re-Engineered Hospital Discharge

Purpose

- Standardize the hospital discharge process using a Nurse Discharge Advocate

Focus

- Create for the patient an After Hospital Discharge Plan that prepares them for the days between hospital discharge and first post-acute physician follow-up appointment

** Bring this Plan to ALL Appointments**

BOSTON MEDICAL CENTER

PROJECT RED Re-Engineered Discharge

After Hospital Care Plan for:

John Doe

Discharge Date: October 20, 2006

Question or Problem about this Packet? Call your Discharge Advocate: (617) 444-1111

Serious health problem? Call Dr. Brian Jack: (617) 444-2222

** Bring this Plan to ALL Appointments**

John Doe

What is my main medical problem?

Chest Pain

When are my appointments?

Tuesday, October 24th at 11:30 am	Thursday, October 26th at 3:20 pm	Wednesday November 1st at 9:00 am
Dr. Brian Jack Primary Care Physician (Doctor)	Dr. Jones Rheumatologist	Dr. Smith Cardiologist
at Boston Medical Center ACC – 2nd floor	at Boston Medical Center Doctor's Office Building 4th floor	at Boston Medical Center Doctor's Office Building 4th floor
For a Follow-up appointment	For your arthritis	to check your heart
Office Phone #: (617) 444-2222	Office Phone #: (617) 444-7777	Office Phone #: (617) 555-1234

Morning	heart	ASPIRIN EC 325 mg	1 pill	By mouth
	To stop smoking	NICOTINE 14 mg/24 hr	1 patch	On skin
	Then, after 4 weeks use →	NICOTINE 7 mg/24 hr	1 patch	On skin
	Blood pressure	COZAAR LOSARTAN POTASSIUM 50 mg	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5 % soln	1 drop	In your left eye
Noon	Blood pressure	ATENOLOL 75 mg	1 pill	By mouth
	Blood pressure	LISINOPRIL 40 mg	1 pill	By mouth
	Infection in eye	VIGAMOX MOXIFLOXACIN HCl 0.5 % soln	1 drop	In your left eye

Questions for
Dr. Jack
For my appointment on
Tuesday, October 24th at 11:30 am

Check the box and write notes to remember what to talk about with Dr. Jack

I have questions about:

- ☐ my medicines _____
- ☐ my pain _____
- ☐ feeling stressed _____

What other questions do you have? _____

Dr Jack:
When I left the hospital, results from some tests were not available. Please check for results of these tests.

Project RED
Re-Engineered Hospital Discharge

Tools

- Use of Teach-back
- Schedule post-acute physician follow-up appointment prior to hospital discharge
- Confirm discharge medication regimen
- Review what to do if problems occur once home
- Discharge Plan handbook sent home with patient

Website: http://www.ahrq.gov/qual/projectred/

Project BOOST: Better Outcomes for Older Adults Through Safe Transitions

Focus

- Provide resources for hospitalists to improve the hospital discharge process

Purpose

- To improve the hospital discharge process using a team approach to plan and implement interventions to manage high risk patients identified on admission

Project BOOST

Discharge Planning Toolkit:

- Training materials in performance improvement principles
- Patient risk assessment tools
- Teach-back and discharge education strategy
- Guidance for follow-up communication with receiving MDs, patients and families

Website:
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm

Transforming Care At the Bedside

Focus

- To improve the transition from hospital to home for Heart Failure patients on medical and surgical units

Purpose

- To engage front line staff and unit managers to develop new care models to improve patient care and to engage and improve patients and families experience of care

Transforming Care At the Bedside

"Creating an Ideal Transition Home" Toolkit

- Enhanced admission assessment for post discharge needs
- Enhanced teaching and learning utilizing teach-back
- Patient and family centered hand-off communication
- Post-acute care follow-up

Website:
http://www.ihi.org/IHI/Programs/Collaboratives/TransformingCareattheBedside.htm

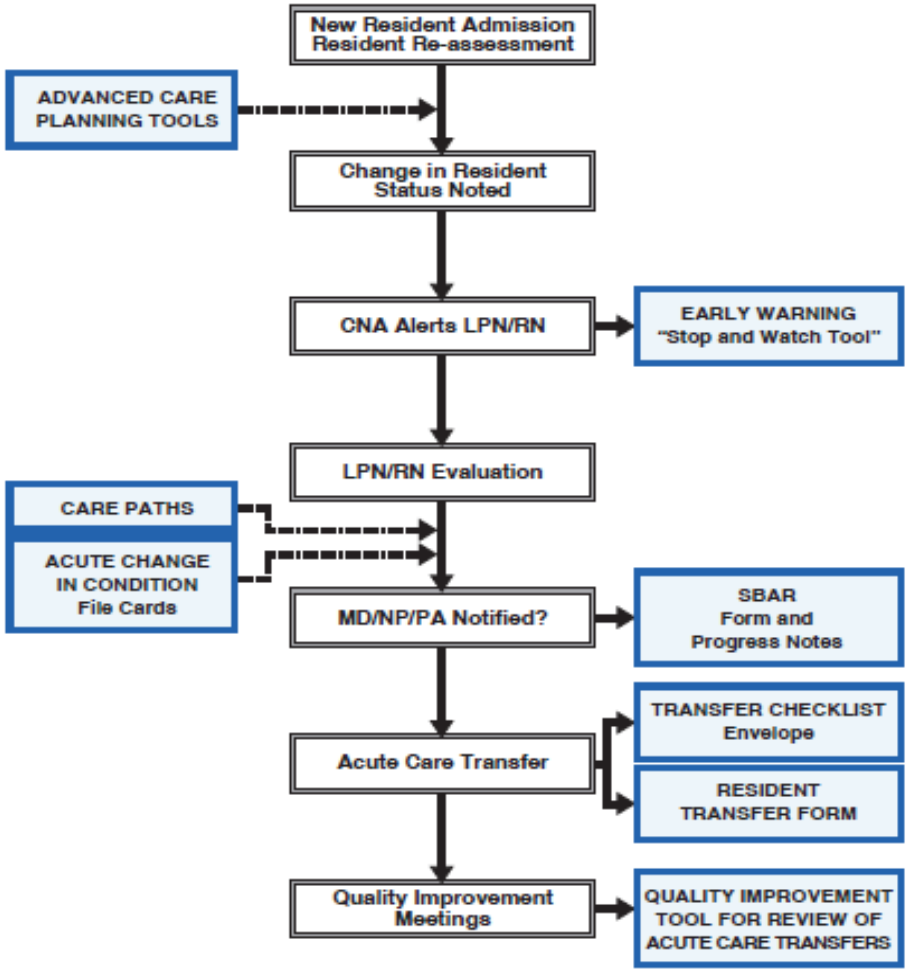
INTERACT II : Interventions To Reduce Acute Care Transfers

Interventions are designed to improve the identification, evaluation, and communication about changes in resident status

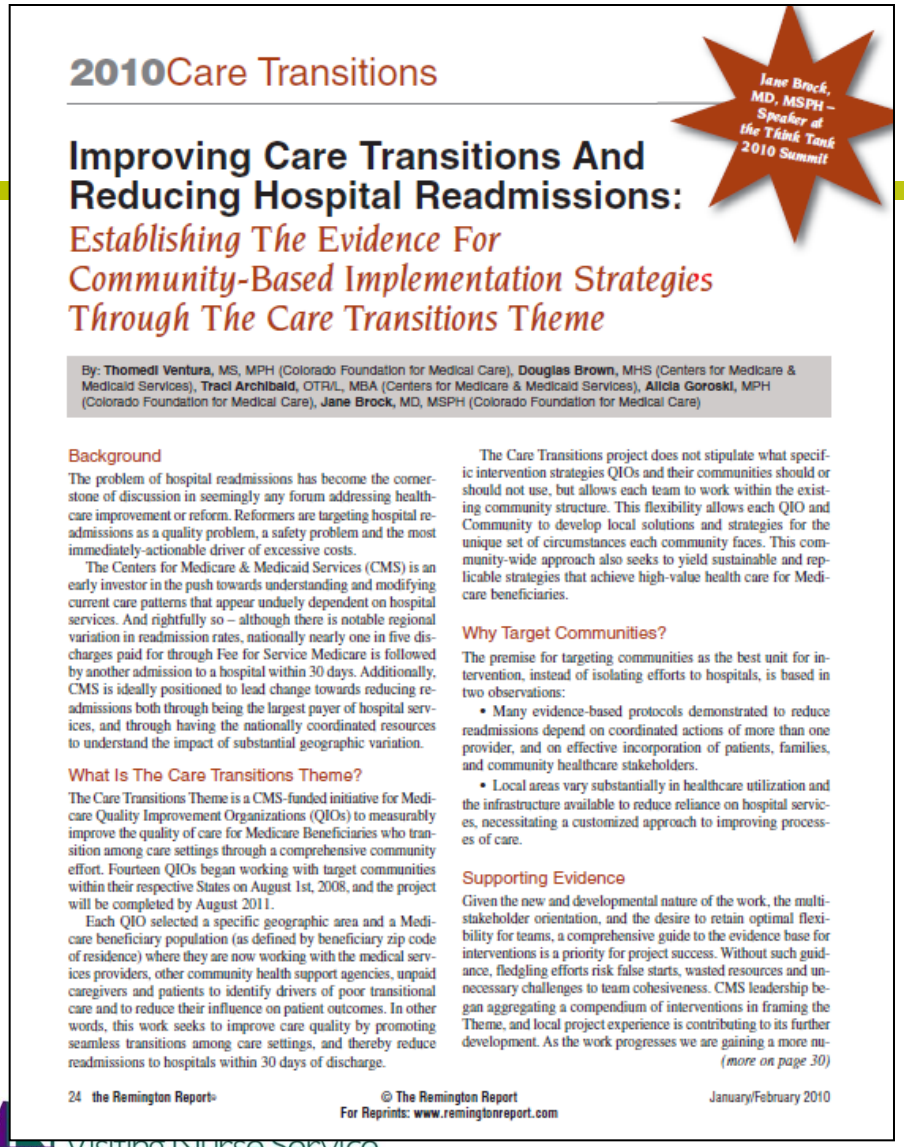
Include clinical and educational tools and strategies for use in every day practice in long-term care facilities

Website: http://interact2.net/

Using the INTERACT II Tools
in Every Day Work in the Nursing Home



http://interact2.net/



2010Care Transitions

Jane Brock, MD, MSPH – Speaker at the Think Tank 2010 Summit

Improving Care Transitions And Reducing Hospital Readmissions:

Establishing The Evidence For Community-Based Implementation Strategies Through The Care Transitions Theme

By: **Thomedi Ventura,** MS, MPH (Colorado Foundation for Medical Care), **Douglas Brown,** MHS (Centers for Medicare & Medicaid Services), **Traci Archibald,** OTR/L, MBA (Centers for Medicare & Medicaid Services), **Alicia Goroski,** MPH (Colorado Foundation for Medical Care), **Jane Brock,** MD, MSPH (Colorado Foundation for Medical Care)

Background

The problem of hospital readmissions has become the cornerstone of discussion in seemingly any forum addressing healthcare improvement or reform. Reformers are targeting hospital readmissions as a quality problem, a safety problem and the most immediately-actionable driver of excessive costs.

The Centers for Medicare & Medicaid Services (CMS) is an early investor in the push towards understanding and modifying current care patterns that appear unduely dependent on hospital services. And rightfully so – although there is notable regional variation in readmission rates, nationally nearly one in five discharges paid for through Fee for Service Medicare is followed by another admission to a hospital within 30 days. Additionally, CMS is ideally positioned to lead change towards reducing readmissions both through being the largest payer of hospital services, and through having the nationally coordinated resources to understand the impact of substantial geographic variation.

What Is The Care Transitions Theme?

The Care Transitions Theme is a CMS-funded initiative for Medicare Quality Improvement Organizations (QIOs) to measurably improve the quality of care for Medicare Beneficiaries who transition among care settings through a comprehensive community effort. Fourteen QIOs began working with target communities within their respective States on August 1st, 2008, and the project will be completed by August 2011.

Each QIO selected a specific geographic area and a Medicare beneficiary population (as defined by beneficiary zip code of residence) where they are now working with the medical services providers, other community health support agencies, unpaid caregivers and patients to identify drivers of poor transitional care and to reduce their influence on patient outcomes. In other words, this work seeks to improve care quality by promoting seamless transitions among care settings, and thereby reduce readmissions to hospitals within 30 days of discharge.

The Care Transitions project does not stipulate what specific intervention strategies QIOs and their communities should or should not use, but allows each team to work within the existing community structure. This flexibility allows each QIO and Community to develop local solutions and strategies for the unique set of circumstances each community faces. This community-wide approach also seeks to yield sustainable and replicable strategies that achieve high-value health care for Medicare beneficiaries.

Why Target Communities?

The premise for targeting communities as the best unit for intervention, instead of isolating efforts to hospitals, is based in two observations:

- Many evidence-based protocols demonstrated to reduce readmissions depend on coordinated actions of more than one provider, and on effective incorporation of patients, families, and community healthcare stakeholders.
- Local areas vary substantially in healthcare utilization and the infrastructure available to reduce reliance on hospital services, necessitating a customized approach to improving processes of care.

Supporting Evidence

Given the new and developmental nature of the work, the multi-stakeholder orientation, and the desire to retain optimal flexibility for teams, a comprehensive guide to the evidence base for interventions is a priority for project success. Without such guidance, fledgling efforts risk false starts, wasted resources and unnecessary challenges to team cohesiveness. CMS leadership began aggregating a compendium of interventions in framing the Theme, and local project experience is contributing to its further development. As the work progresses we are gaining a more nu-

(more on page 30)

http://www.cfmc.org/integratingcare

Visiting Nurse Service of Schenectady and Saratoga Counties

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Innovative Strategies

- Improve **cross -setting partnerships and communication** for care coordination and management
- **Cross-setting** medication reconciliation
- **Cross-setting** staff education
- **Cross -setting** support of resident / caregiver learning for self-management (signs/symptoms/red flags/action)
- Streamlined and standardized **cross -setting** information transfer

Visiting Nurse Service of Schenectady and Saratoga Counties

PROVIDER LOGO

Addressograph

PROVIDER NAME

CONTINUUM OF CARE COMMUNICATION FORM

Transfer Date: _____ Time: _____

Transferred to: _____

ADVANCED DIRECTIVES

☐ DNR ☐ DNI ☐ MOLST ☐ Living Will

☐ Health Care Proxy (HCP)

Name & Contact Information of HCP:

CONTACT INFORMATION *(Relative/Guardian/POA)*

Name: _____

Relationship: _____

Phone: _____

Notified of Transfer: ☐ Yes ☐ No

VITAL SIGNS: BP____ P____ R____ T____ O2 SAT____

HEIGHT: _____ **WEIGHT:** _____

PAIN Level (1-10)_____ Site _____

Pain Treatment: _____

Date/Time last dose pain med administered: _____

ALLERGIES: ☐ None ☐ Yes, *List* _____

LANGUAGE: ☐ English ☐ Other, Specify _____

Has the patient/resident/primary contact been informed who to contact with questions regarding their transfer?

☐ Yes *Name of Contact Provided:* _____ ☐ No, *reason* _____

REASON FOR TRANSFER:

ACTIVE INFECTIONS & SITE: ☐ None ☐MRSA ☐VRE ☐C.Diff

ISOLATION PRECAUTIONS – SPECIFY _____

MENTAL STATUS (CHECK ALL THAT APPLY)

☐ Alert ☐ Forgetful ☐ Other, *describe* _____

☐ Oriented ☐ Unresponsive ☐ Recent Change, *describe* _____

☐ Disoriented ☐ Depressed

AT RISK ALERTS (CHECK ALL THAT APPLY):

☐ None ☐ Seizure ☐ Other, describe_____

☐ Falls ☐ Elopement _____

☐ Aspiration ☐ Restraints, type_____

☐ Pressure Ulcers ☐ Harm to: ☐ Self ☐ Others

☐ Wanders ☐ Limited / Non-weight Bearing: ☐ Left ☐ Right

SENSORY STATUS (CHECK ALL THAT APPLY):

Vision: ☐ Good ☐ Poor ☐ Blind ☐ Glasses

Hearing: ☐ Good ☐ Poor ☐ Deaf ☐ Hearing Aid ☐ Left Ear ☐ Right Ear ☐ Bilateral

Speech: ☐ Clear ☐ Difficult ☐ Aphasia

ACTIVITIES OF DAILY LIVING STATUS

Ambulation	☐ Self	☐ Assist	☐ Not able	☐ Continent	☐ Bowel	☐ Bladder
Transfer	☐ Self	☐ Assist	☐ Not able	☐ Incontinent	☐ Bowel	☐ Bladder
Toileting	☐ Self	☐ Assist	☐ Not able	☐ Foley Catheter	Date Inserted/Changed: _____	
Meals	☐ Self	☐ Assist	☐ Not able	☐ Ostomy		
				☐ Date/Time of Last Bowel Movement: _____		

SKIN INTEGRITY

☐ No open wounds or pressure ulcers

☐ Yes, Wound Type : ☐ Pressure Ulcer ☐ Surgical Wound ☐ Vascular Wound ☐ Other, specify

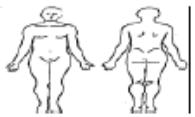
☐ Braden Score _____

Description of Wound(s) or Pressure Ulcer(s) Site/Size/Appearance/Current Treatment

_____

_____

_____



1 of 2

PROVIDER LOGO

Addressograph

PROVIDER NAME

CONTINUUM OF CARE COMMUNICATION FORM

IMMUNIZATIONS

Influenza Vaccine: Did the patient receive the influenza vaccine from your facility for this year's influenza season during this admission? (Influenza Season = October 1 through March 31)

☐ Yes Date Administered: _____

☐ Not applicable, the entire admission is outside this influenza season (October 1-March 31)

☐ No, Reason Influenza Vaccine not received:

- ☐ Received from another health care provider prior to admission during current flu season(e.g., physician)
- ☐ Received from your facility prior to this admission during current flu season Date Received: _____
- ☐ Offered and declined
- ☐ Assessed and determined patient has allergy/sensitivity to influenza vaccine OR has medical contraindication(s)
- ☐ Not applicable; patient does not meet age/condition guidelines for influenza vaccine
- ☐ Inability to obtain vaccine due to declared shortage
- ☐ Other (specify): _____

Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your facility during this admission?

☐Yes Date Administered: _____

☐ No, Reason pneumococcal vaccine not received:

- ☐Patient has received PPV in the past
- ☐Offered and declined
- ☐ Assessed and patient determined to have allergy/sensitivity to pneumococcal vaccine OR has medical contraindication(s)
- ☐Not indicated; patient does not meet age/condition guidelines for PPV
- ☐Other (specify): _____

PPD/TUBERCULIN STATUS : Was patient tested during this admission?

☐ Yes, Date tested: _____ / Site: _____ Result: ☐ Negative ☐ Positive ☐ Unknown

NUTRITION

Diet: _____

Tube Feeds: _____

Nothing By Mouth (NPO) _____

PERSONAL ITEMS SENT WITH PATIENT/RESIDENT:

☐ None ☐ Dentures ☐ Upper/partial ☐ Lower/partial ☐ Wheelchair

☐ Glasses ☐ Walker ☐ Other: specify _____

☐ Hearing Aid(s) ☐ Cane

Name of person completing transfer form: _____

Contact information of person completing transfer form: *Phone:* _____ *Pager:* _____

Signature of Person completing transfer form: _____

CURRENT MEDICATIONS – PLEASE REFER TO ATTACHED LIST/MEDICATION ADMINISTRATION RECORD

MOST RECENT LAB, X-RAY AND EKG REPORTS – PLEASE REFER TO ATTACHED REPORTS

☐ NO RECENT ECG ☐NO RECENT LABS

CURRENT PROBLEM LIST-PLEASE REFER TO ATTACHED LIST

10/14/10

2 of 2

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 9SOW-NY-THM7.2-10-23

How To Get There.....

- Cross-setting partnerships are key
  - Hospital, Home Health & SNF meet monthly to review readmissions
  - Hospital assisting SNF in training RNs in physical assessment
  - SNF Medical Directors conferencing with Hospitalists on high-risk residents
  - Coaches partnered with Community Nurse Navigators
- Focus on the process, not the setting
  - Process map of referral process
  - Standardizing materials transferred with patients/residents at discharge
  - Standardizing patient educational materials at cross-setting level
- Include all levels and disciplines of staff
- "Blame Game" not allowed
- Place the patient/resident at the center of the process
  - Patient / Caregiver focus groups

Resources

- **IPRO Care Transitions Web site:** http://caretransitions.ipro.org
- **Next Step In Care:** http://www.nextstepincare.org
- **Project BOOST:** http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
- **Project RED:** http://www.bu.edu/fammed/projectred/index.html
- **IHI Initiatives:** http://www.ihi.org/IHI/Programs/StrategicInitiatives
- **National Transitions of Care Coalition:** http://www.ntocc.org
- **Transitional Care Model:**
- http://www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm
- **Care Transitions Intervention:** http://www.caretransitions.org

Care Transitions / Health Home

NYeC-NYSDOH OHITT Health Home Webinar
April 11, 2012

Joseph Twardy
President and CEO
twardyj@vnshomecare.org

Structure

Many Initiatives – One Chassis

2

Visiting Nurse Service
of Schenectady and Saratoga Counties

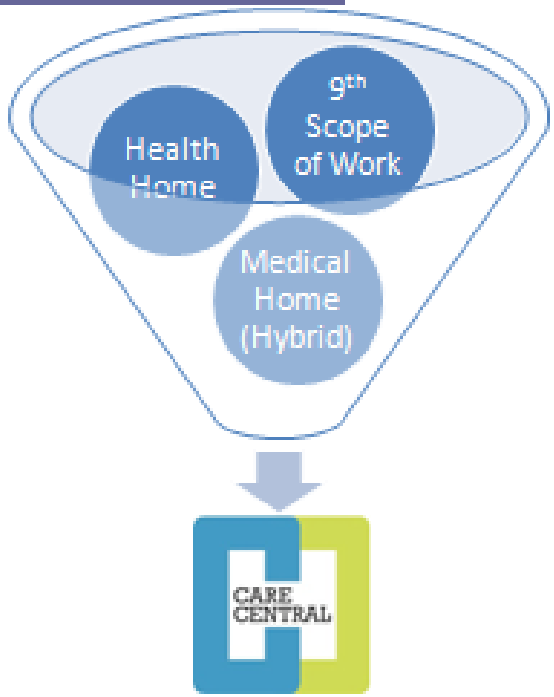
Visiting Nurse Service of Schenectady and Saratoga Counties

Ellis MEDICINE

Hometown Health Center at State Street

IPRO Improving Healthcare for the Common Good®

40+ Other Medical and Social Care Providers



Community Collaboration

3

Visiting Nurse Service of Schenectady and Saratoga Counties

Structure & Frequency: Group / Committee / Taskforce

Medical Home

Meets: Quarterly

Purpose: Overarching community health/ direction

Participants:

Multiple & Various

Care Central (Health Home / Care Transitions)

Care Central Workgroup

Meets: Bi-weekly (Call / Meeting) **Purpose:** Overview and Direction of Health Home

Participants: AIDS Council of NENY, Belvedere Health Services LLC, Bethesda House, Capital District Psychiatric Center, Carver Counseling Center, Catholic Charities AIDS Services, Catholic Charities Senior Services in Schenectady, Clearview Center, Conifer Park, County of Schenectady Department of Social Services, Ellis Medicine, Family and Children's Service of the Capital Region, Inc., Hometown Health Center, Hope House, Inc., McPike Addiction Treatment Center, Mohawk Opportunities, Inc., New Choices Recovery Center, Northeast Parent and Child Society, Parsons Children and Family Services, Rehabilitation Support Services, Saratoga County Mental Health Center, Schenectady City Mission, Schenectady Community Action Program, Schenectady County Chapter ARC, Schenectady Municipal Housing Authority, Transitional Services Association, Inc., Visiting Nurse Service of Schenectady and Saratoga Counties, Inc., Volunteer Physicians Project of Schenectady, Inc., Whitney M. Young Jr. Health Center, YWCA of Schenectady

Care Management Taskforce

Meets: Frequently (at least bi-weekly) **Purpose:** Execution of Health Home rollout and deliverables with engaged "Downstream" partners and key stakeholders

Participants: AIDS Council of NENY, Belvedere Health Services LLC, Catholic Charities AIDS Services, CDPHP, Conifer Park, Ellis Medicine, Fidelis, Hometown Health Center, Mohawk Opportunities, Inc., Parsons Children and Family Services, Rehabilitation Support Services, Schenectady County (Community Services), Visiting Nurse Service of Schenectady and Saratoga Counties, Inc., Volunteer Physicians Project of Schenectady, Inc.

Care Central Steering Committee

Meets: Monthly **Purpose:** Overview all CC (Health Home, CMS Care Transitions etc)

Participants: VNS, Ellis Medicine, Hometown Health

CMS Care Transitions Steering

Meets: Adhoc (was weekly) **Purpose:** Implement CMS Program Once Approved

Participants: Adirondack Health Institute, Adirondack Medical Center, Alice Hyde Medical Center, Champlain Valley Physicians Hospital, Community Health Center, Ellis Medicine, Glens Falls Hospital, High Peaks Hospice, IPRO, Nathan Littauer Hospital, Saratoga County Office for the Aging, Saratoga Hospital, St. Mary's Hospital, Visiting Nurse Service, Washington County Office for the Aging

Visiting Nurse Service of Schenectady and Saratoga Counties

Health Home
Approved Phase One

Visiting Nurse Service
of Schenectady and Saratoga Counties

HEALTH HOME

PATIENT

HOSPITAL

ED

TRANSITION TEAM/DISCHARGE PLANNERS

Health Home: Acute and Chronic

Care Coordinators/Navigators

- ROLE: Air traffic controllers getting the pt where they need to go with support

Acute Care Interventional Team

- ROLE: Facilitation and emergency intervention
- MD, RN, RPH, Case Mgmt, Social Services

Community Health Workers

- ROLE: "Boots on the ground" to make sure support is there and to confirm the pt status
- RN, NA, Coaches, Drivers, Home Aides, Volunteers

Case Management

- ROLE: Manages the provision of specialized services for a specific pt population (AIDS, Mental Health, Disabilities)
- Social Worker, RN, or other dedicated program professional

Interventional Team: Chronic

Chronic Care Interventional Team

- ROLE: Supplements PCP by providing enhanced support through direct pt relationships focused on changing unhealthy behaviors and lifestyles
- Multispecialty MD's, Nurse Practitioners, Case Managers/Social Workers – integrated with the rest of the Health Home Team

Transition: neighbor-hood home

100% Social

100% Clinical

Social and Community Services Ex: SCAP, City Mission, VNS, etc.

Primary Care AND Medical Homes

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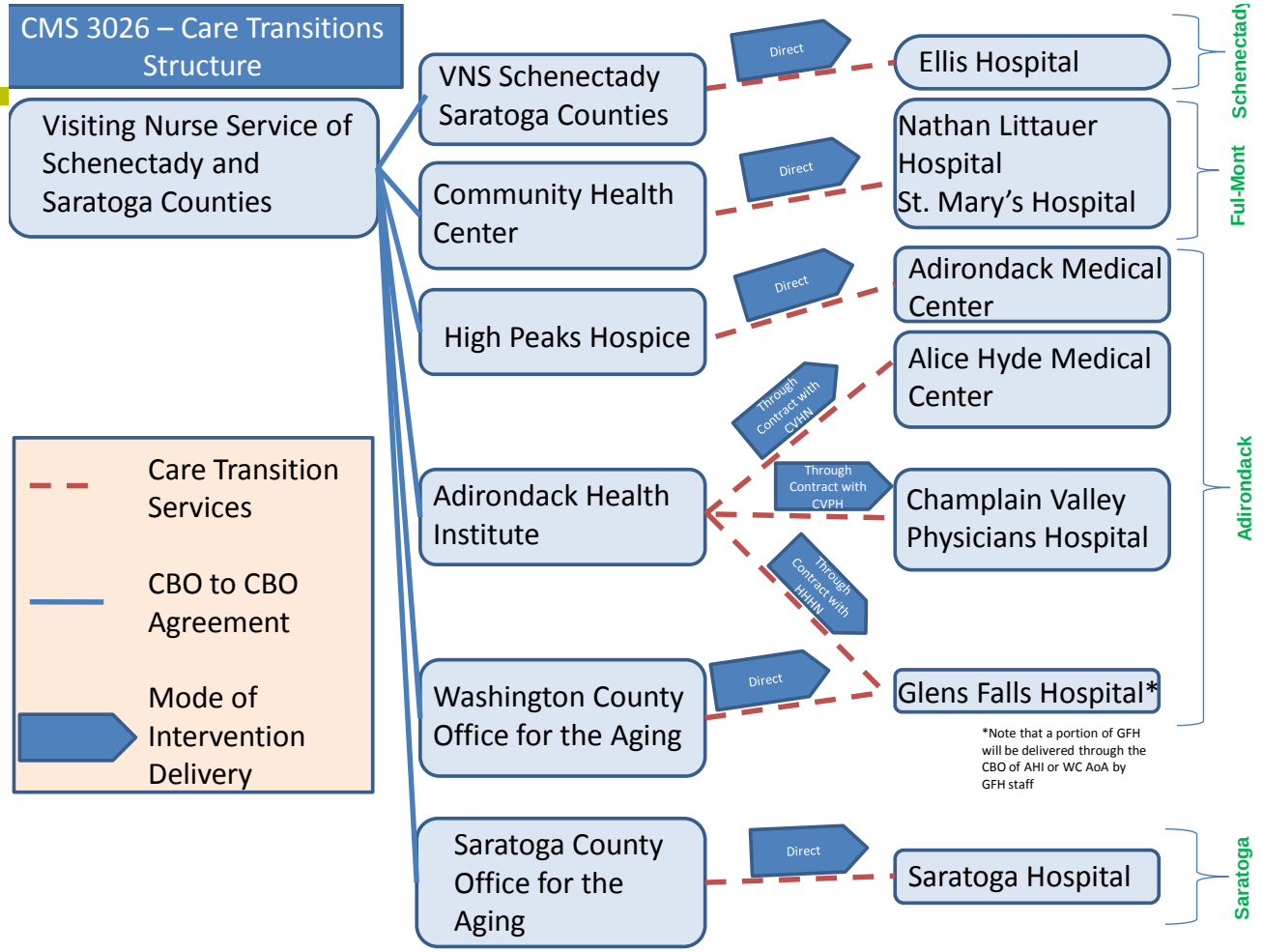
Loop of Readmissions

Care Transition Program - Medicare (CMS) 3026 Approved

Visiting Nurse Service
of Schenectady and Saratoga Counties

North Eastern New York Community-based Care Transitions Program:

- Program Structure:
  - Six community-based organizations (CBOs)
  - Ten community hospitals
  - All serving Medicare beneficiaries in a ten-county region of upstate New York
- All of the participants have worked together, and have successfully delivered care transitions services.
- Many of the participants are healthcare innovators, among them the only current Medicaid Health Homes in upstate New York, a Centers for Medicare and Medicaid Services (CMS) Multi-payor Advanced Primary Care Practice (MAPCP) Demonstration and a State Medical Home Pilot Project, and two communities which have recently experienced successful hospital consolidation.
- There are over 100,000 Medicare fee-for-service (FFS) beneficiaries living in the approved service area, with 80 percent of their inpatient admissions to the participating hospitals.
- The region comprises 21 percent of New York State's land area



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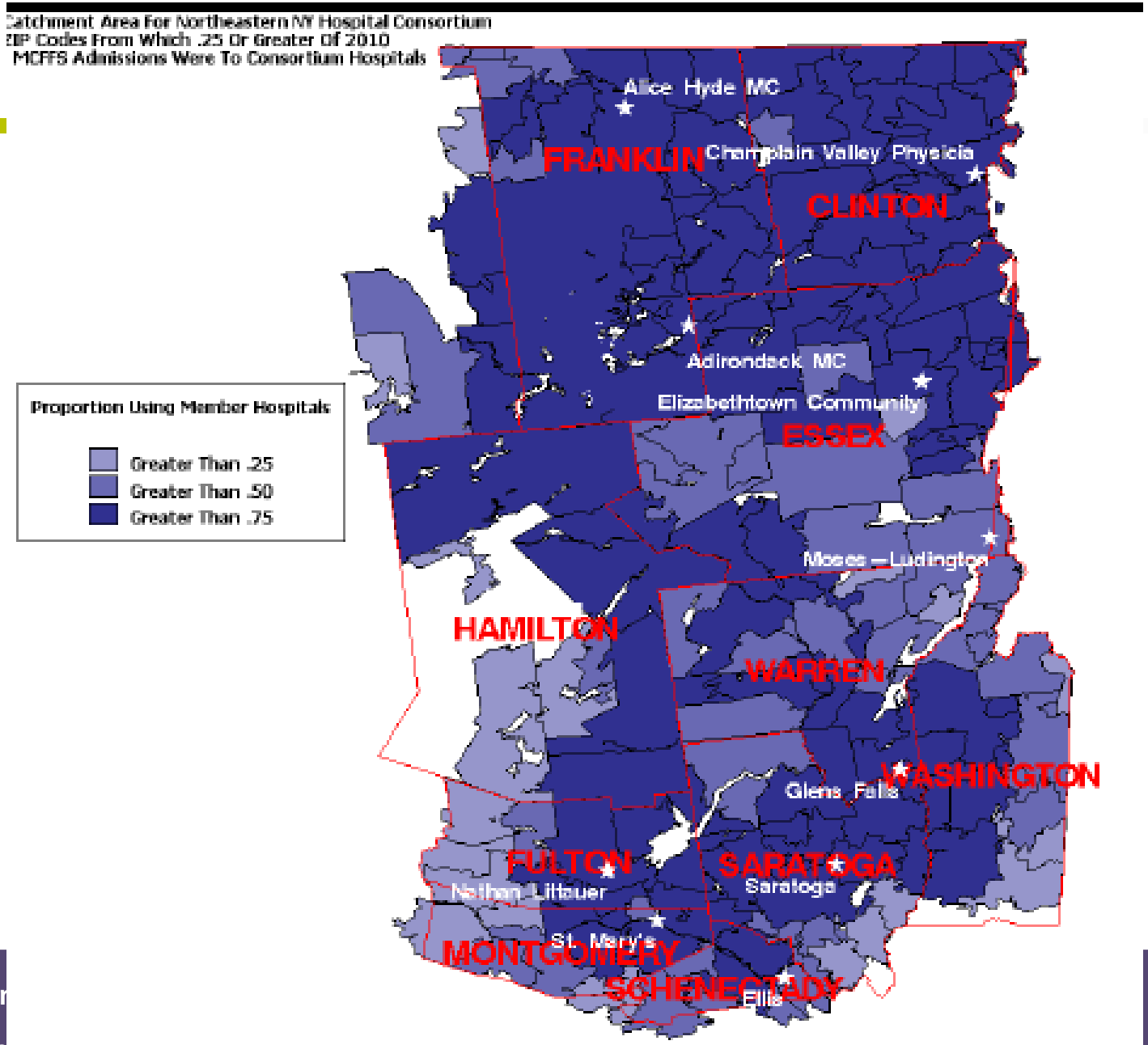

CARE CENTRAL

Visiting Nurse Service of Schenectady and Saratoga Counties

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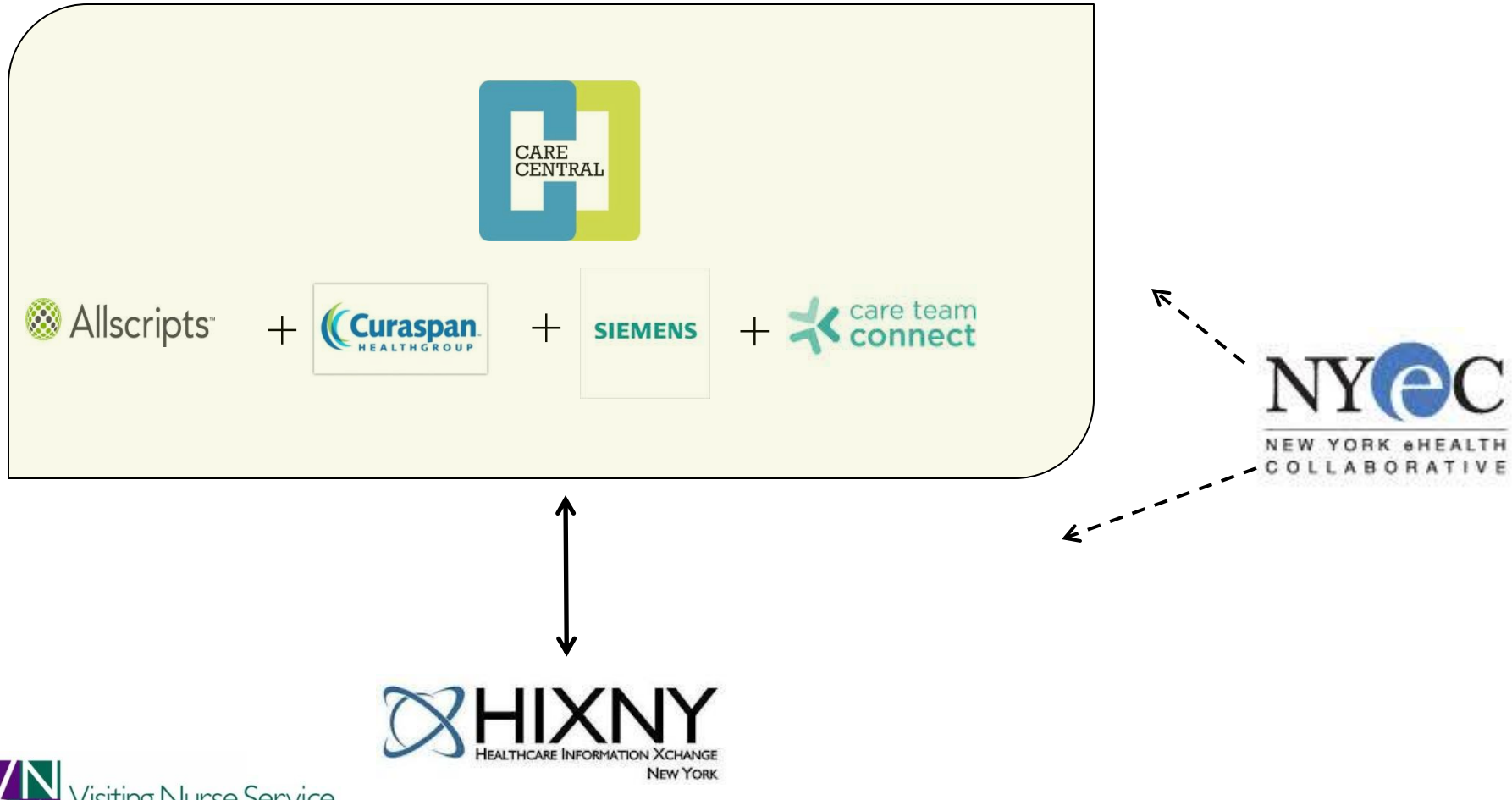
Navigating Health Information Technology Needs

Building Linkages to HIXNY and the NYeC Digital Health Accelerator Program



Session Elements

- Hospital care transitions: scope of the problem & external forces
- Case study of community-based partnerships and approaches
- Moving to health-home coordination

Questions?

For more information

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HH Implementation Session 6: EHR 101

Presenters: Denise Reilly,MBA
Executive Director of the eHealth Network of Long Island

Date & Time: Wednesday April 18,2012 2:30 pm eastern time

Registration Link: https://cc.readytalk.com/r/bcx7gjmbek2

All training sessions (recordings and registrations) will be made available on the Medicaid website.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ohitt_ehr_webinars.htm

STATE OF NEW YORK
DEPARTMENT OF HEALTH