INTEGRATING CARE FOR POPULATIONS AND COMMUNITIES AIM (ICPCA)

PART OF THE QUALITY IMPROVEMENT ORGANIZATIONS 10TH SOW

Traci Archibald, OTR/L, MBA
Technical Advisor
Centers for Medicare and Medicaid Services
Quality Improvement Group

QUESTIONS TO RUN ON

- Why is it important to include the community in quality improvement efforts to improve care transitions?
- How can my QIO assist my community with improving care transitions?
- What resources can I or my organization bring to my community to help improve the quality of care for the people we serve?
- What types of measures is my organization collecting to show the impact of interventions and are there other measures to collect?

STRATEGY

Aims

Foundational Principles:

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

Goals

Make care safer

Strengthen person and family engagement

Promote effective communication and coordination of care

Promote effective prevention and treatment

Promote best practices for healthy living

Make care affordable

CMS QUALITY STRATEGY

CMS is accepting public comments and responses to the following questions through Friday, January 10th, 2014. Please send your feedback and responses to Quality_Strategy@cms.hhs.gov.

•What are the top three quality topics that you think CMS should focus on?
•Do you see your organization reflected in this strategy? If so, how will your organization help execute the CMS quality strategy?
•Please select the goal most applicable to your organization and provide your thoughts on how your organization can contribute to CMS' effort to achieve this goal.

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

Search CMS.gov – CMS Quality Strategy 2013-Beyond

ICPCA GOALS

- Improve the quality of care for Medicare beneficiaries as they transition between providers

- Reduce 30 day hospital re-admissions by 20% over 3 years for the nation

WHAT WE LEARNED THROUGH STUDYING READMISSIONS

ORIGINAL CONTRIBUTION

Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries

Jane Brock, MD, MSPH
Jason Mitchell, MS
Kimberly Irby, MPH
Beth Stevens, MS
Traci Archibald, OTR/L, MBA
Alicia Goroski, MPH
Joanne Lynn, MD, MA, MS
for the Care Transitions Project Team

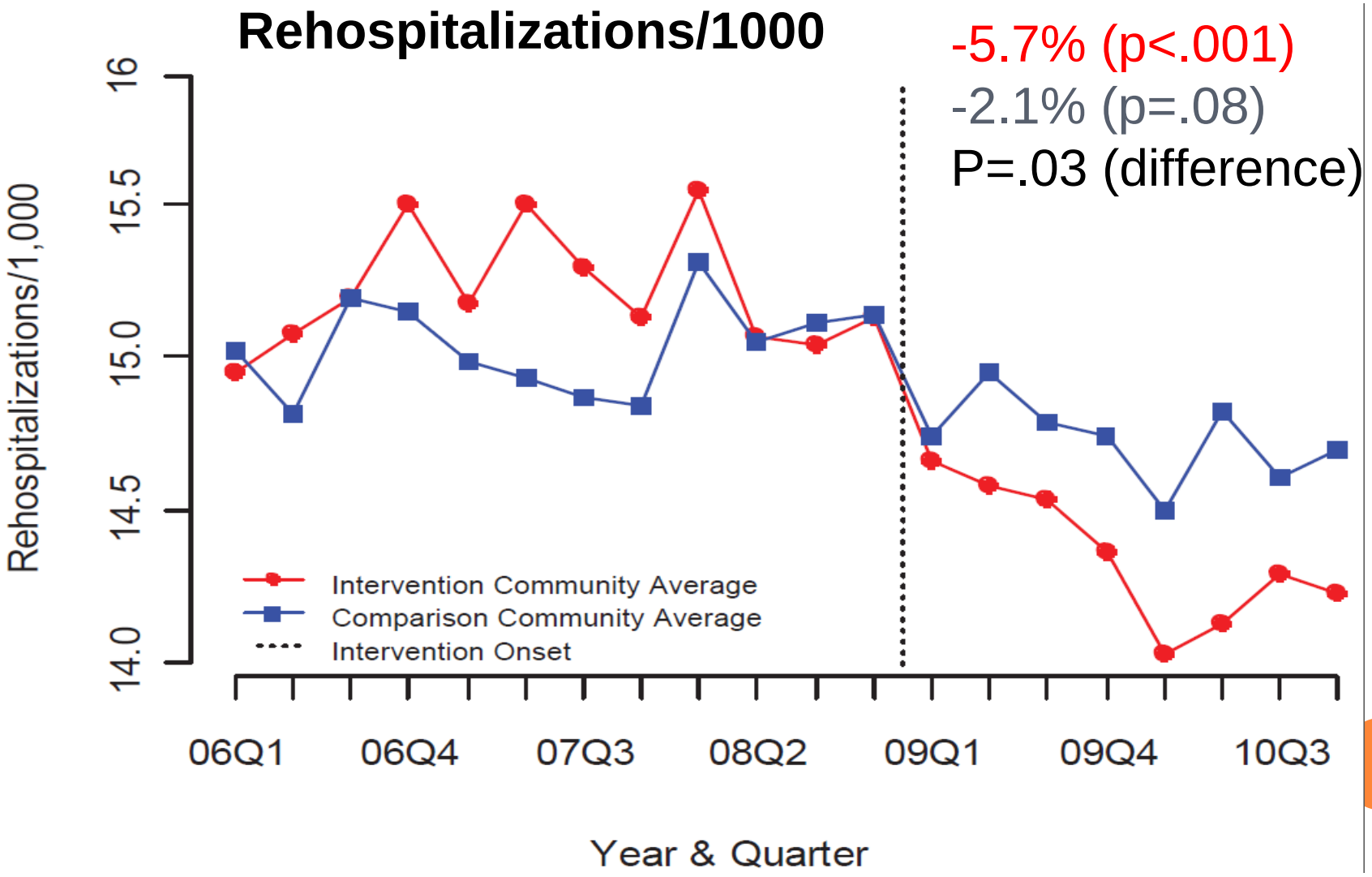
Importance Medicare beneficiaries experience errors during transitions among care settings, yielding harms that include unnecessary rehospitalizations.

Objective To evaluate whether implementation of improved care transitions for patients with Medicare fee-for-service (FFS) insurance is associated with reduced rehospitalizations and hospitalizations in geographic communities.

Design, Setting, and Participants Quality improvement initiative for care transitions by health care and social services personnel and Medicare Quality Improvement Organization staff in defined geographic areas, with monitoring by community-specific and aggregate control charts and evaluation with pre-post comparison of performance differences for 14 intervention communities and 50 comparison communities from before (2006-2008) and during (2009-2010) implementation. Intervention communities had between 22 070 and 90 843 Medicare FFS beneficiaries.

MANY MEDICARE BENEFICIARIES have serious ill-

14 Community Pilot



AUGUST 1, 2011-JULY 31, 2014

- QIO 10th SOW ICPCA
  - Expanded community care transitions improvement efforts across the country to all states and territories

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

QIO TECHNICAL ASSISTANCE

- Community Coalition Formation
- Community-specific Root Cause Analysis
- Intervention Selection, Implementation and Measurement Strategies
- Assist with an Application for a Care Transitions Program

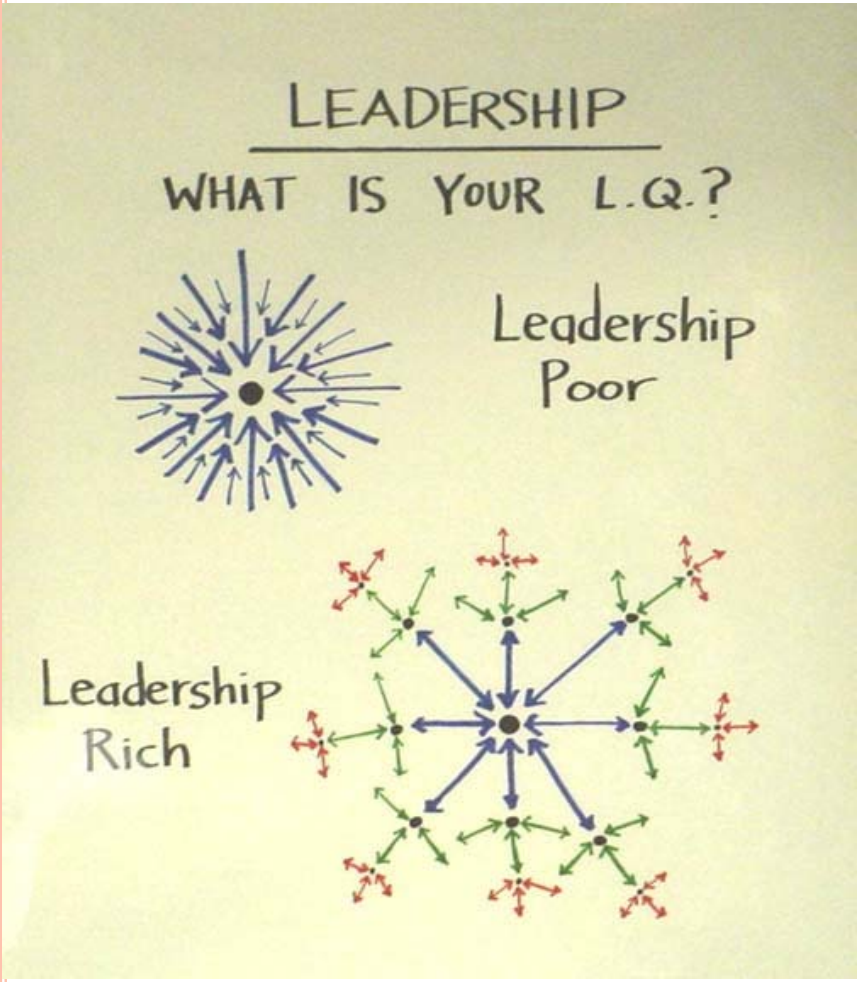
COLLECTIVE IMPACT

- Common agenda
- Standard measurement system
- Mutually reinforcing activities
- Continuous communication
- **Backbone to support organizations**

Collective Impact. Stanford Social Innovation Review, Winter 2011.
http://www.ssireview.org/pdf/2011_WI_Feature_Kania.pdf

Channeling change: Making collective impact work
http://www.fsg.org/Portals/0/Uploads/Documents/PDF/Channeling_Change_SSIR.pdf?cp

COMMUNITY ORGANIZING TECHNIQUES



- Tie participation to values
- Include personal narratives
- Intentionally develop other leaders
- Intentionally develop relationships
- Develop flexible tactics

STRATEGIC PLAN

- Include broad range of community leaders
  - Provider groups
  - Community based organizations (CBO's)
  - AAAs and ADRC's
  - Regional Health Initiatives
  - State and local government
  - Advocacy and Service Organizations
  - Other payers

COMMUNITY ROOT CAUSE ANALYSIS:WHY ARE PEOPLE READMITTED?

Provider-Patient interface

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

Unreliable system support

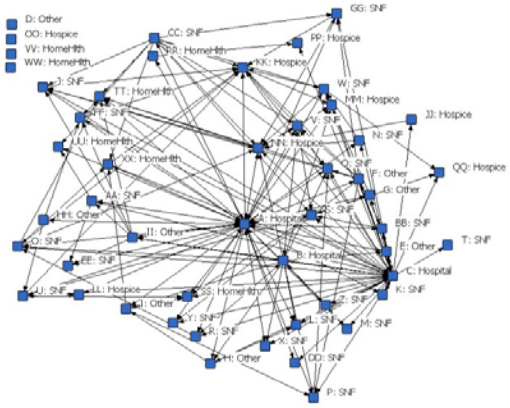
Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

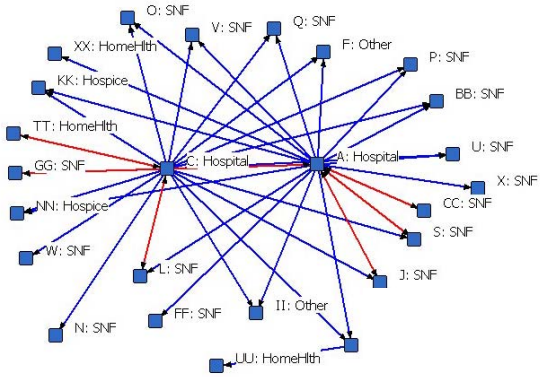
No Community infrastructure for achieving common goals

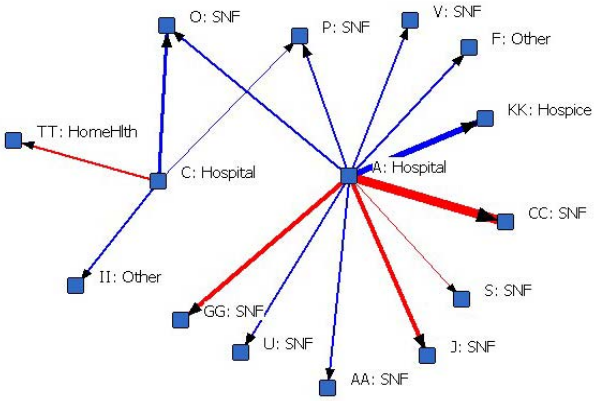
COMMUNITY SPECIFIC ROOT CAUSE ANALYSIS

- Data Analysis
  - Proportion of Transitions Table
  - Coalition Readmission rates
  - Coalition Admission rates
  - Hospital Admission rates
  - Hospital Readmission rates
  - 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

SOCIAL NETWORK ANALYTIC TECHNIQUES FOR DISPLAYING THE PROVIDER NETWORK







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

Program / Toolkit	Supporting Evidence	Performance Indicators*
Interventions to Reduce Acute Care Transfers (INTERACT) **Description:** Toolkit for SNF personnel to reduce avoidable hospital admission. Three types of tools: 1) communication, 2) clinical care paths, and 3) advance care planning. Utilization specified for selected members of the care team. **Aim:** Reduce transfers to acute care setting. **Resource:** http://interact.geriu.org	**CMS Nursing Home Special Study** •*Ouslander (2008)*: Higher hospitalization rates associated with larger facilities, more Medicaid and Medicare skilled care residents, lower percentage of Caucasian residents and higher percentage of residents with impaired decision making; 68% of hospitalizations were avoidable, per expert panel record review. **Systematic Review** •Enderlin et al. (2013): Each model described can provide a framework for managing health conditions across settings of care in collaboration with the older client and his/her family. Benefits in utilizing the models during transitions include early recognition and resolution of changes in an older adult's health status. **Other support** •Ouslander et al. (2011): There was a 17% reduction in self-reported hospital admissions in these nursing homes from the same 6-month period in the previous year.	**Processes:** % nursing staff who agree to use INTERACT; % nursing staff using INTERACT; # patients or % eligible patient population whose care included INTERACT. **Outcomes:** ***Detection.*** Improved detection of acute change in condition of using early warning and/or communication tools (re: "Stop and Watch" and care paths) among SNF patients; lower percentage of acute changes in condition among SNF patients transferred to acute care (re: Acute Care Transfer Log). ***Clinical outcomes.*** Indicators of successful care path utilization (*e.g.*, lower incidence of dehydration, fever, mental status change, CHF, lower respiratory infection, and UTI) or other clinically relevant and measurable outcomes (*e.g.*, Quality Measures per Nursing Home Compare). ***Satisfaction.*** Higher provider-reported satisfaction with internal communication and completeness of information transfer. ***System changes.*** Implementation and results of structured quality improvement efforts based on INTERACT quality improvement review.

Ventura T, Gass B, Goroski A, et al. Approach To Improving Care Transitions and Reducing Hospital Readmissions: Updating The Evidence *Remington Report* 2013 Sept/Oct:25-41.

INTERVENTION MODELS

Care Transitions Intervention (CTI)®
Health Care Services

project BOOST®
Better Outcomes for Older adults through Safe Transitions

PROJECT RED
Re-Engineered Discharge

itcc
ILLINOIS TRANSITIONAL CARE CONSORTIUM
THE BRIDGE MODEL

GRACE

INTERACT™

BPIP

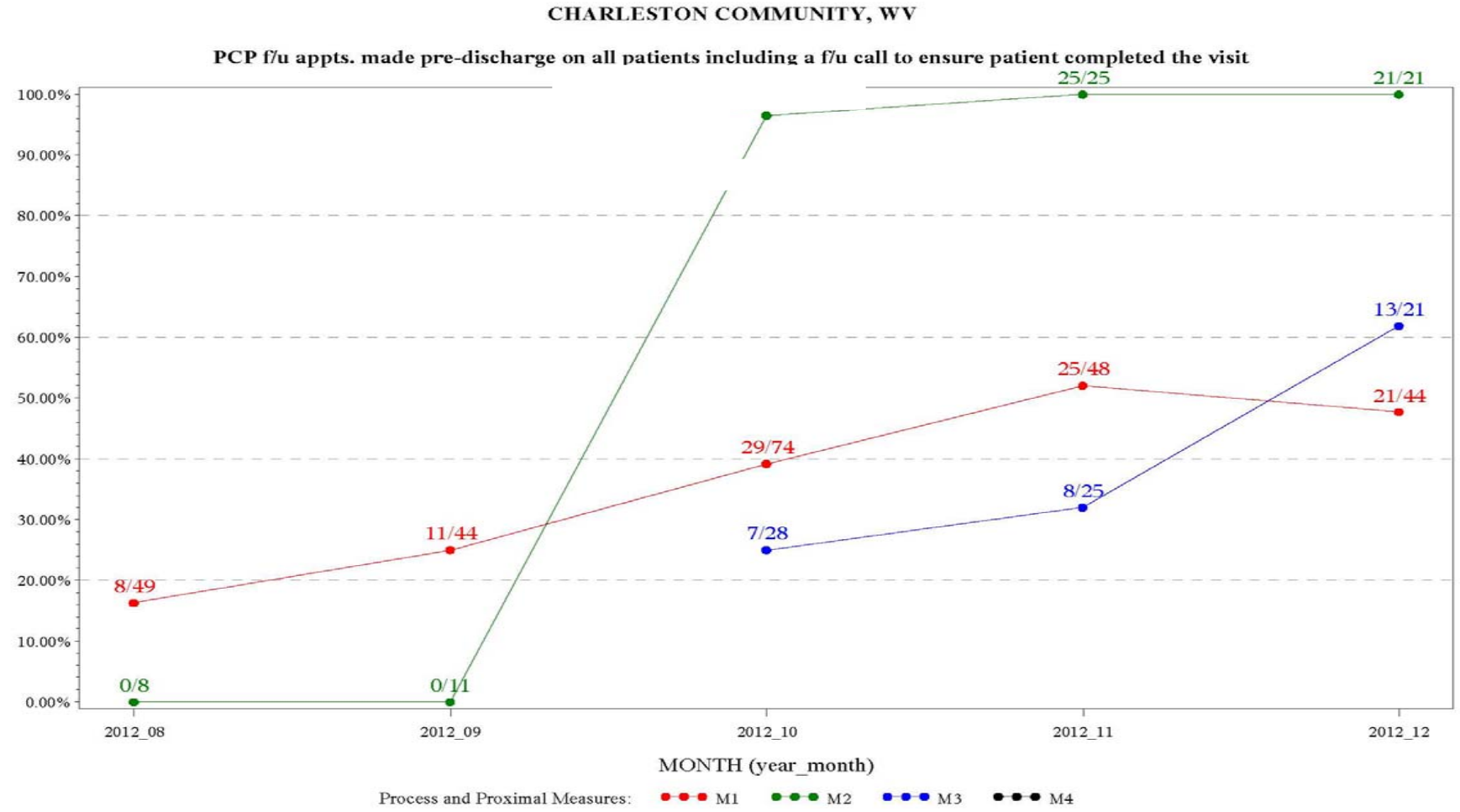
Transitional Care Model

GUIDED CARE

INTERVENTION MEASUREMENT STRATEGIES

- **Involves a series of Reach, Intervention Effectiveness and Utilization Measures**
- **Providers and CBO's will need to collect most of the Reach and Intervention Effectiveness Measure data**
- **QIOs can help facilitate linking Medicare claims-based Utilization Measures to interventions**
- **QIOs are working with communities to prepare run charts showing the impact of interventions over time**

EXAMPLE SUBMISSION



M1: [PROCESS] % of AMI/CHF/PNE discharges that had a PCP appointment scheduled prior to discharge, or within 48 hours of discharge
M2: [PROCESS] % of AMI/CHF/PNE discharges that had a PCP appointment scheduled prior to discharge, or within 48 hours of discharge and completed a f/u phone call assessment
M3: [PROXIMAL] % of AMI/CHF/PNE discharges that had a PCP appointment scheduled prior to discharge, or within 48 hours of discharge and completed a f/u phone call assessment, and were actually seen by their physician as scheduled
M4: N/A

APPLICATION/COLLABORATION FOR PARTICIPATION IN A FORMAL CARE TRANSITIONS PROGRAM

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

ADDITIONAL ASSISTANCE FOR COMMUNITIES

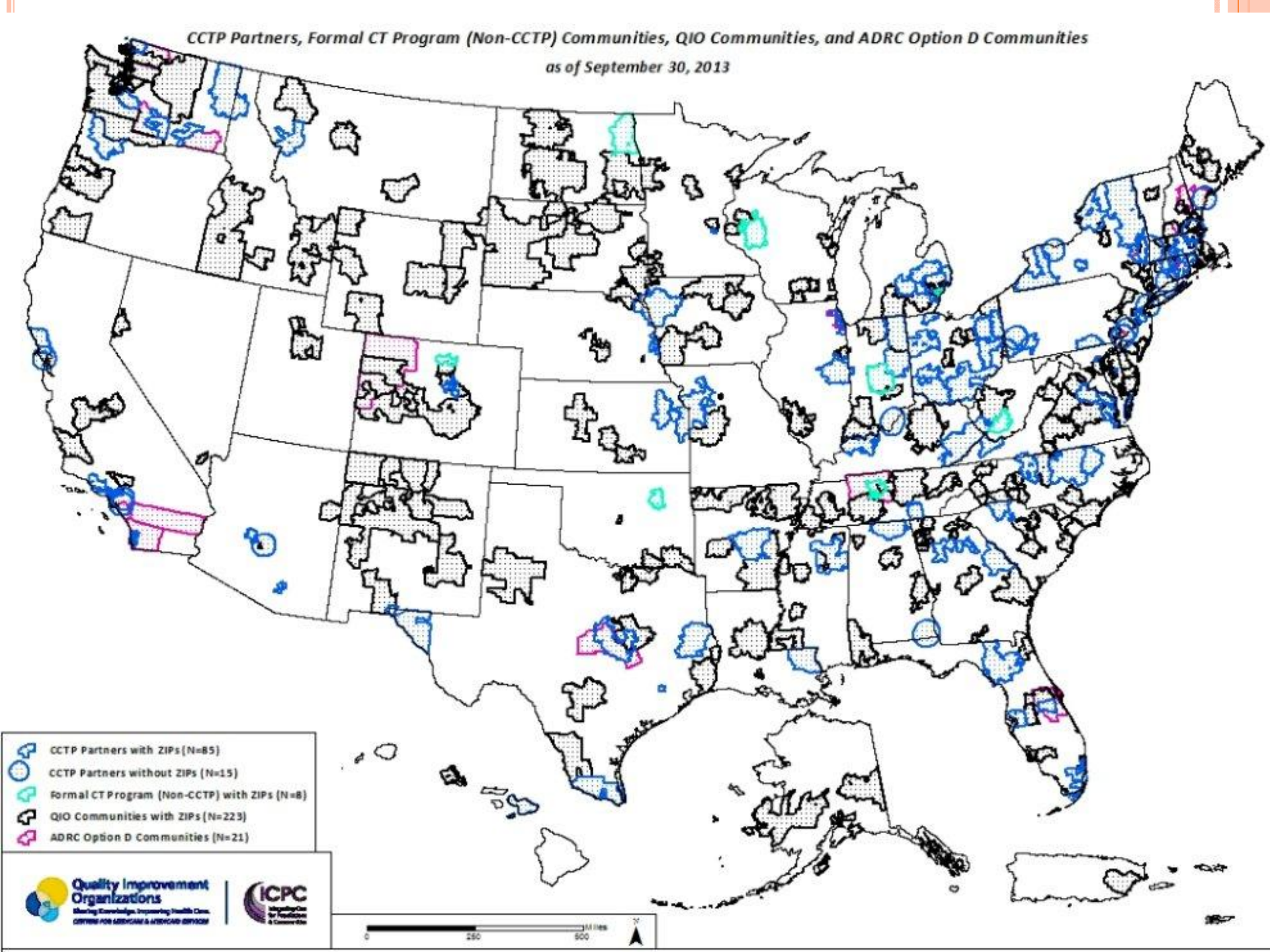
- Provide quarterly community readmission metrics
- Host a State-wide Learning and Action Network
- Participate in Care Transitions Learning Sessions
- Use QIO developed tools and resources

AMAZING PROGRESS

- **Look how far we've come**
- *5 years ago….*
- *Today…*

9TH SOW-14 COMMUNITIES

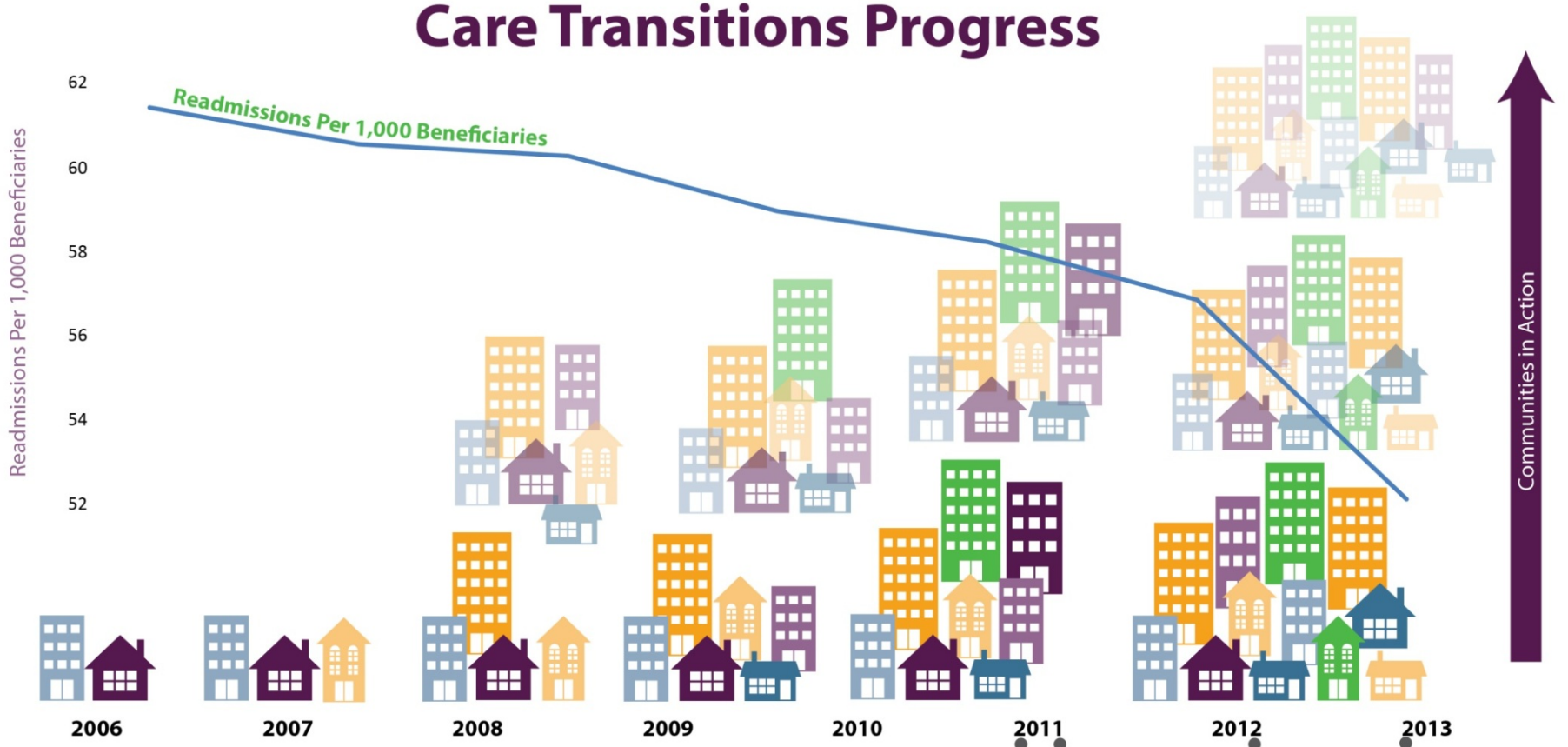
- AL: Tuscaloosa
- CO: Northwest Denver
- FL: Miami
- GA: Metro Atlanta East
- IN: Evansville
- LA: Baton Rouge
- MI: Greater Lansing area
- NE: Omaha
- NJ: Southwestern NJ
- NY: Upper capital
- PA: Western PA
- RI: Providence
- TX: Harlingen HRR
- WA: Whatcom county


CCTP Partners, Formal CT Program (Non-CCTP) Communities, QIO Communities, and ADRC Option D Communities
as of September 30, 2013
CCTP Partners with ZIPs (N=85)
CCTP Partners without ZIPs (N=15)
Formal CT Program (Non-CCTP) with ZIPs (N=8)
QIO Communities with ZIPs (N=223)
ADRC Option D Communities (N=21)
Quality Improvement Organizations
ICPC
0
250
500
Miles

QIO ACCOMPLISHMENTS AS OF SEPTEMBER 30, 2013

# of Engaged Communities	410
# of Beneficiaries Living there	14,607,292
# Communities with Signed Coalition Charter	230
# Communities Receiving Formal Funding	83
# Recruited Hospitals	884
# Recruited Nursing Homes	1,619
# Recruited Home Health Agencies	965
# Recruited Hospice Facilities	367
# Recruited Dialysis Facilities	92
# Recruited Outpatient Physicians	> 1,975

Care Transitions Progress



11/2006 - 07/2008: CMS Variation Analysis by Location-Understanding Efficiency QIO Special Study (3 states)

11/2006 - 03/2008: CMS Transitions of Care QIO Special Study (3 communities)

07/2006 - 01/2008: CMS Nursing Home Care Transitions QIO Special Study (INTERACT developed)

09/2009 - 09/2015: Multiple ACL/CMS ADRC Care Transitions Grants (173 communities)

08/2010 - 08/2013: ONC Beacon Community Program (17 communities)

08/2008 - 07/2011: CMS QIO Care Transitions Theme (14 communities)

08/2011 - 07/2014: CMS QIO ICPC Aim (397 communities)

Partnership for Patients launched—04/2011

11/2011 - The end and continuing: CMMI Community-based Care Transitions Program (100 communities)

Section 3025 Hospital Readmission Reduction Program Final Rule Published – 08/2011

12/2011 - 12/2013: CMMI Hospital Engagement Network Program (26 HENs working with 3700 hospitals)

Section 3025 readmission penalties implemented—10/1/2012

Physician Follow-up CPT codes implemented—01/1/2013

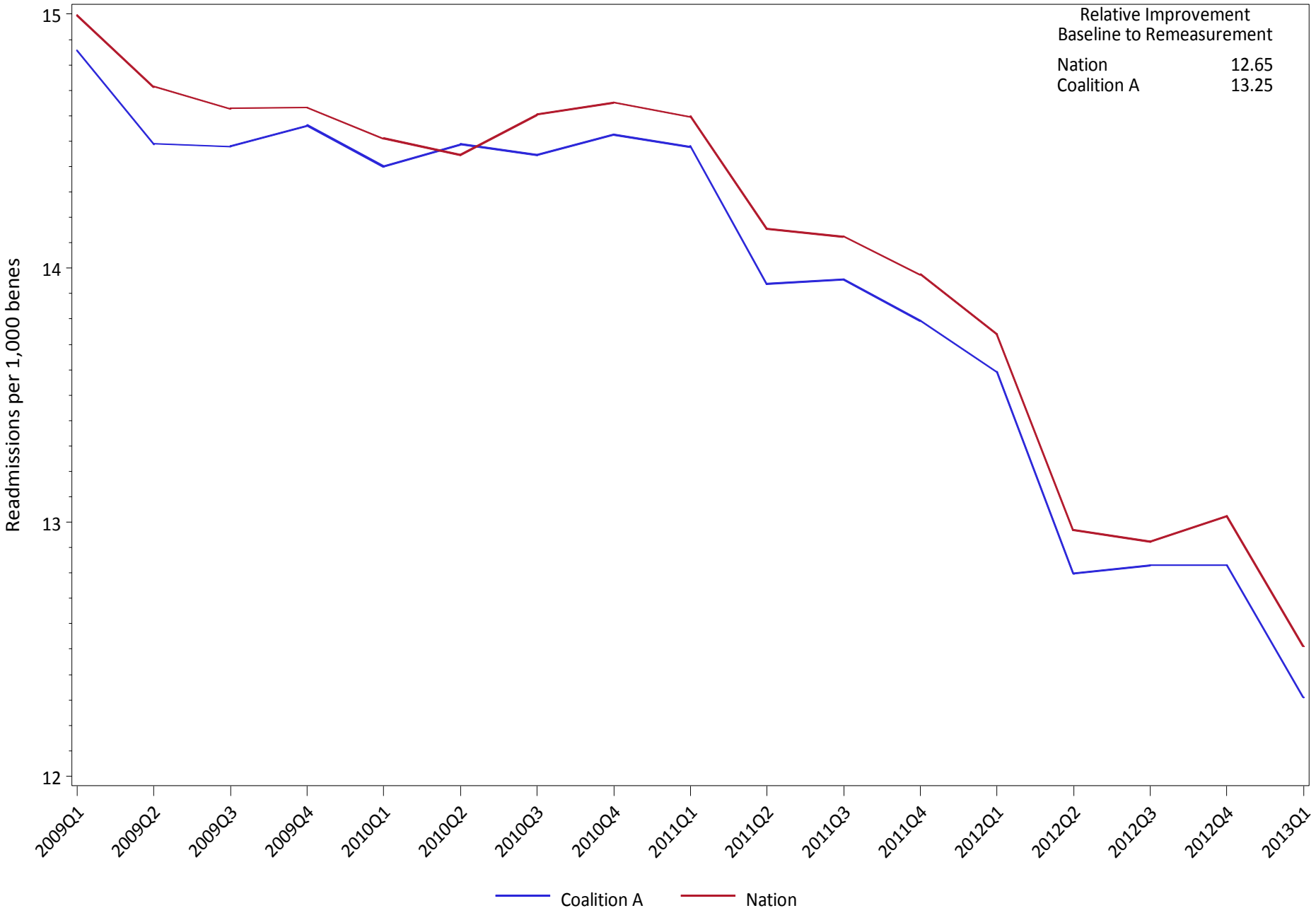
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ICPC
Integrating Care for Populations & Communities

This material was prepared by CFMC, the Integrating Care for Populations & Communities National Coordinating Center, 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. PM-4010-213 CO 2013

Seasonally-adjusted Admission Rates per 1,000 benes

Seasonally-adjusted Readmission Rates per 1,000 benes



RESOURCES: CARE TRANSITIONS

- http://www.cfmc.org/caretransitions/Default.htm (Care Transitions Quality Improvement Organization Support Center)
- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- AoA care transitions toolkit -- *The Aging Network and Care Transitions: Preparing your Organization* http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx
- http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/index.aspx (AoA's Aging and Disability Resource Centers 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)