An Overview of Care Transitions Efforts in Arkansas

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Objectives

- Describe Medicare initiatives to reduce 30-day readmission rates
- Define a community coalition
- Outline the root cause analysis process
- Summarize evidence-based interventions aimed at reducing 30-day readmission rates
- Describe how home health providers can get involved in efforts to reduce readmission rates
The actions of health care providers designed to ensure the coordination and continuity of health care during a patient’s movement between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

Background

- In 2009, more than 7 million Medicare beneficiaries experienced more than 12.4 million inpatient hospitalizations
- Medicare spent an estimated $26 billion in 2009 on hospital readmissions
- Up to 76% of readmissions may be preventable

1. MedPAC: June 2007

Background

- Within 30 days of discharge, 19.6% of Medicare beneficiaries are re-hospitalized
- Patients who understand discharge instructions are 30% less likely to be readmitted within 30 days

Results of Improved Care Transitions

- Improved health care and patient outcomes
- Reduced health care costs for the patient, family, health care system, and public and private payers
- Reduced chaos and stress for the patient and family
- Improved patient safety
- Fewer errors or harm associated with health care
Arkansas Readmissions per 1,000 Medicare Beneficiaries

[Graph showing readmission rates over time]
Medicare Initiatives to Reduce 30-Day Readmission Rates

Patient Protection & Affordable Care Act

- **Hospital Readmissions Reduction Program**
  - Subjects Inpatient Prospective Payment System (IPPS) hospitals with readmission rates over a certain threshold to Medicare reimbursement penalties
  - Currently applies to readmissions related to heart failure, heart attack and pneumonia
    - CMS may expand the list of conditions to include chronic obstructive pulmonary disease (COPD), additional cardiac procedures, vascular conditions, etc., during subsequent years of the program
  - Began October 2012

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

- **Hospital-Wide All-Cause Unplanned Readmission (HWR) Measure**
  - Estimates a risk-standardized readmission rate (RSRR) based on unplanned readmissions to any acute care hospital for any cause within 30 days of discharge
  - Similar to the readmission measures for acute myocardial infarction, heart failure and pneumonia
  - Calculated for all non-federal short-stay acute care hospitals and critical access hospitals
  - Publically reported (starting July 2013)

http://www.qualitynet.org
Partnership for Patients

• Improve Care Transitions:
  By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

  http://partnershipforpatients.cms.gov/

Medicare 10th Scope of Work (SOW)

• 10th SOW: Integrate Care for Populations & Communities
  • Improve the quality of care for Medicare beneficiaries who transition among care settings through a comprehensive community effort
  • Reduce statewide 30-day readmission rates by 2% over three years
  • Reduce recruited community 30-day readmission rates by 7% over three years

  http://qio.afmc.org/HealthCareProfessionals/CareTransitions.aspx
Coalition Formation

Coalition Definition

A temporary **alliance** of distinct parties, persons or states for **joint action**

Coalition Formation

- Utilize existing relationships
- Build new relationships
- Educate community providers
Coalition Benefits

- Networking, relationship building
- Additional information/resources
- Sharing of best practices and barriers
- Different vantage points
- Widespread change

Root Cause Analysis (RCA)

RCA Definition

A process for identifying the basic or causal factors that underlie variations in outcomes
RCA

- Analysis should focus on a process that has potential for redesign to reduce risk
- Should be comprehensive, community-based and include other providers
- Results of the RCA should drive the selection of the population of focus and the proposed interventions

RCA Process

- Identify the root cause of readmissions at your home health agency
- Identify patterns of readmissions specific to your community and its providers
- Use RCA results to guide targeting criteria and intervention selection

RCA Methods

- Patient/family interviews
- Care coordinator interviews
- Medical chart reviews
- Process mapping
- Cause-and-effect diagrams
- "5 Whys"
Patient/Family Interviews

- Semi-structured telephone or face-to-face interviews with patients who were readmitted
- Helps to identify opportunities for improvement from the patient’s perspective

Patient/Family Interviews

- **Readmission Diagnostic Tool**
  - Patient/Family Interview Worksheet

  1. STAAR Initiative; Institute for Healthcare Improvement; 2009

Medical Chart Reviews

- Review randomly sampled hospital discharges and 30-day readmissions
- **Common finding:**
  - Patient education is completed and documented, but patients need more in-depth understanding to be compliant
Medical Chart Reviews

- **Readmission Diagnostic Tool**
  - Chart Review Worksheet

1. STAAR Initiative; Institute for Healthcare Improvement, 2009

Using RCA to Drive Intervention Selection

- RCA Technique: Patient interview for all patients during one month who are currently in hospital for a 30-day readmission
- Key Findings: Patient did not understand how to correctly take medication
- Intervention:教育 patients to understand correct medication regimen
- Intervention improves patient adherence and reduction of hospital readmissions
- Red flag: notification management, follow-up

Selection of Intervention
Interventions

- Select evidence-based interventions
  - Results from the community-specific RCA
  - Existing local programs and resources
  - Funding resources
  - Sustainability
  - Community preferences

Intervention Examples

Project RED: A Re-Engineered Discharge Process

Brian Jack, MD

www.bu.edu/fammed/projectred/
• “The Hospital Discharge: A Review of a High Risk Care Transition with Highlights of a Re-Engineered Discharge Process”
  • New patient discharge process
  • Educate the patient
  • Improve continuity of patient information
  • Goals:
    • Reduce post-discharge adverse events
    • Decrease hospital readmissions
    • Lower overall health care costs

1. Educate the patient about their diagnoses throughout their hospital stay
2. Make appointments for clinician follow-up and post-discharge testing
3. Discuss with the patient any tests or studies that have been completed
4. Organize post-discharge services
5. Confirm the medication plan
6. Reconcile the discharge plan with national guidelines and critical pathways
7. Review the appropriate steps on what to do if a problem arises
8. Expedited transmission of the discharge summary to the physicians accepting responsibility for the patients care after discharge
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan
10. Develop/give the patient a written discharge plan
11. Telephone reinforcement of the discharge plan

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Care Transitions Intervention™

Eric A. Coleman, MD, MPH, AGSF, FACP
Director, Care Transitions Program
www.caretransitions.org

- A patient self-activation and management session with a Transitions Coach™: designed to help patients and their family caregivers build skills, confidence and use tools to assert their role in managing transitions
- Transitions Coach™ (caseload 24-28): visits patients in the home and via phone calls designed to reinforce and sustain behavioral change as well as provide continuity across the transition
- Four Pillars: Key Areas to Support Self-Care
  - Medication self-management
  - Follow-up with PCP/specialist
  - Knowledge of “red flags” or warning signs/symptoms and how to respond
  - Patient-centered record

- Hospital Visit
- Personal Health Record
- Home Visit after Discharge
- Three Follow-Up Phone Calls

Transitional Care Model

Mary D. Naylor, PhD, RN, FAAN
www.transitionalcare.info
The Transitional Care Nurse (TCN) as the primary coordinator of care to assure consistency of provider across the entire episode of care

In-hospital assessment, preparation and development of an evidenced-based plan of care

Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge

Continuity of medical care between hospital and primary care physicians facilitated by the TCN accompanying patients to first follow-up visits

Comprehensive, holistic focus on each patient's needs including the reason for the primary hospitalization as well as other complicating or coexisting events

Active engagement of patients and their family and informal caregivers including education and support

Emphasis on early identification and response to health care risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to readmissions
Multidisciplinary approach that includes the patient, family, informal and formal caregivers as part of a team
- Physician-nurse collaboration
- Communication to, between and among the patient, family and informal caregivers, and health care providers and professionals

GOAL:
- Improve nursing home care by reducing avoidable acute care transfers and hospitalizations
INTERACT II

- Aid in the early identification of a resident change of status
- Guide staff through a comprehensive resident assessment when a change has been identified
- Improve documentation around resident change in condition
- Enhance communication with other health care providers about a resident change of status

Coming Soon....
The INTERACT team is in the process of developing and pilot testing INTERACT Version 1.0 Tools for Home Health Care agencies with the support of a CMS Innovations grant in collaboration with Brookdale Senior Living.

 Interested in pilot testing INTERACT for Home Health?

• CMS National Quality Campaign
• Free resources and assistance for home health and cross-setting providers to reduce avoidable hospitalizations and improve care quality
  • Education
  • Data
  • Networking
  • Assistance
• http://www.homehealthquality.org

Education

• Best Practice Intervention Packages (BPIPs) that offer practical applications of quality improvement strategies in simple steps designed to be implemented at a self-set pace
• Pave Your Path webinar series in partnership with the Institute for Healthcare Improvement

Data

• HHQI Data Access is a secure online portal that allows home health agencies to view both risk-adjusted and non-risk adjusted OASIS data reports for select measures
• https://secure.homehealthquality.org
• HHQI Network is a grassroots and virtual community of campaign participants, stakeholders and partners united to improve the quality of care patients receive
  • Blog, discussion boards, live chat

• Assistance
  • Implementing quality improvement strategies
  • Data collection metrics
  • Troubleshooting the website

How Can Home Health Agencies Get Started?
Next Steps

- Join HHQI
- Develop or participate in a coalition near you
- Pilot test INTERACT for Home Health
- Utilize home health interventions aimed at improving care transitions and reducing readmissions
- Adopt an all-teach, all-learn philosophy
- Participate in AFMC’s Care Transitions Learning & Action Network sessions

Care Transitions Learning & Action Network

- What:
  - Educational sessions discussing various care transitions topics
  - Opportunities to share best practices, barriers and solutions, etc.
- When/Where:
  - Quarterly
  - One face-to-face per year
  - Three remote sessions (i.e. webinar, teleconference) per year
Health Literacy and Medication Use: 
*Improving Pharmacotherapy Literacy*

- **Tuesday, July 2**
- **Noon–1 p.m.**
- **Webinar**
- **Speakers:**
  - Donna West Strum, RPh, PhD
  - Sean King, MS, PhD
- **CE:**
  - Pharmacy – approved for one credit hour
  - Nursing/LNHA – CE pending

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For More Information

[http://qio.afmc.org](http://qio.afmc.org)

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