Improving care transitions among Medicare-Medicaid enrollees

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Objectives

• Describe a Medicare SIP to reduce 30-day readmissions for Medicare-Medicaid enrollees
• Discuss the benefits of community organizing and coalition formation
• Outline the root cause analysis process for the SIP
• Summarize the SIP interventions used to reduce 30-day readmission rates: a home health communication toolkit and a community resource guide
Introduction to AFMC’s CT SIP team
AFMC CT SIP team

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From Left: Jamey Mantz, Amy Witherow, Faye Nipps, Jerry Wicker, Dr. Christi Quarles Smith, Ashley Gibson, Dr. Kristy Bondurant, Tonyia Haynes

Above: Dr. Nichole Sanders

Above: Judy Johnston
Medicare 30-day readmission data
Arkansas readmissions per 1,000 Medicare beneficiaries

Readmissions per 1,000 Beneficiaries

- Observed
- Seasonally Adjusted

Start of 10th SOW
Arkansas diagnosis-specific readmissions per 1,000 Medicare beneficiaries

Quarterly Readmissions per 1,000 Beneficiaries

Readmissions per 1,000

Q1 2009, Q2 2009, Q3 2009, Q4 2009, Q1 2010, Q2 2010, Q3 2010, Q4 2010, Q1 2011, Q2 2011, Q3 2011, Q4 2011, Q1 2012, Q2 2012, Q3 2012, Q4 2012, Q1 2013, Q2 2013, Q3 2013

- AMI
- Congestive heart failure
- Chronic kidney disease
- Diabetes mellitus
- COPD
- Pneumonia
Arkansas Medicare post-acute care setting readmissions (CY 2012)
Improving care transitions among Medicare-Medicaid enrollees

A Medicare SIP
Purpose

Improve care transitions and reduce 30-day readmissions in the Medicare-Medicaid (dual eligible) population by:

- Performing a root cause analysis (RCA) of care transitions for the dual eligible (DE) enrollee population within the selected community
- Based on the RCA, develop and/or modify care transitions interventions for the DE population
Target population: Medicare-Medicaid beneficiaries

• In 2008, Arkansas had 118,000 DEs

• Most are chronically ill, potentially living with both functional and cognitive impairments

• Utilize the health care system at higher rates compared to individuals solely covered by Medicare (26 percent for DEs and 18 percent for Medicare-only)

• More likely to have two or more hospitalizations compared to Medicare-only patients (11 percent versus 6 percent)
Arkansas Care Transitions (ACT) DELTA

The CT SIP community coalition
Community selection
ACT DELTA community

- Located in Arkansas’ lower Mississippi Delta region
- Seven counties
- Approx. 7,000 DE beneficiaries¹
- Nearly one in five DE beneficiaries are readmitted within 30 days²

¹. Arkansas Department of Human Services, Division of Medical Services, Medicaid Data Analytics Department, 2012.
Community characteristics

- High rates of poverty
- Poor educational attainment
- Low literacy
- Low life expectancy rates
- High rates of chronic conditions (heart disease, diabetes, obesity, etc.)
- Poor access to health care/resources
ReThink Health training

• Personal narrative
• Mapping of actors
• 1:1 meetings
• Coalition formation – the Snowflake Model
• Defining your “ask”

Community organizing and coalition formation
ACT DELTA partners

- Eight hospitals (Greater Delta Alliance for Health, Inc.)
- Nine home health agencies (HHAs)
- 13 skilled nursing facilities (SNFs)
- Community health workers
- Civic leaders
- Clinics
- Area Agencies on Aging
- Hospice organizations
- Other health care providers/stakeholders
Piecing together the health care continuum.....
ACT DELTA coalition kick-off meeting

- April 23, 2013
- 53 attendees
- 32 coalition charters signed
What does care transitions mean to you?
“We are from the ARKANSAS DELTA and this is what great health care means to us…..”
Arkansas Care Transitions (ACT) DELTA

Root cause analysis (RCA)
• **Data analysis**
  • Medicare Part A claims data
  • Hospital chart reviews
  • Home health chart reviews

• **Qualitative**
  • 1:1 meetings
  • Focus groups at coalition meetings
RCA findings

- Highest readmission rates for DEs were for those discharged home with home health services\(^1\)
- Poor provider-to-provider communication
- Underutilization of community resources

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>MEDICARE ONLY</th>
<th>DUAL ELIGIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility</td>
<td>22.04%</td>
<td>21.82%</td>
</tr>
<tr>
<td>Home</td>
<td>16.32%</td>
<td>16.36%</td>
</tr>
<tr>
<td>Home health agency</td>
<td>22.44%</td>
<td>28.14%</td>
</tr>
<tr>
<td>Swing bed</td>
<td>27.42%</td>
<td>22.22%</td>
</tr>
<tr>
<td>Intermediate care facility</td>
<td>23.61%</td>
<td>20.44%</td>
</tr>
<tr>
<td>Other</td>
<td>18.62%</td>
<td>16.92%</td>
</tr>
</tbody>
</table>

Intervention to Reduce Acute Care Transfers (INTERACT) for Home Health Agencies¹
Quality improvement program designed to:

• Reduce the frequency of acute care hospitalizations

• Improve early identification and evaluation of a patient’s change in condition

• Improve communication between HHA staff and other providers (hospitals, physician offices, etc.)

1. http://interact2.net/
Types of tools:
• Communication
• Decision support
• Advanced care planning
• Quality improvement

1. http://interact2.net/
INTERACT for HHAs

• Toolkit implemented by nine HHAs in the coalition area

• Eight hospitals in the area are implementing the “Hospital-to-HHA Transfer Form”

• INTERACT training included:
  • Two webinar training sessions
  • Onsite trainings at each HHA by AFMC quality specialists
  • Development and distribution of an INTERACT Tools Usage Form
  • Virtual technical assistance as needed

1. http://interact2.net/
INTERACT for HHAs – HHA Capabilities Checklist

- Displays the capabilities of all recruited HHAs
- Distributed >60 lists to providers to-date
SBAR tool:

- Situation, background, assessment, request
- Communication form and progress note
- Enhance evaluation and communication of information to primary care providers
Stop and Watch tool:

- Early warning tool
- Aids in identification of a change in condition
- Can be used by any HHA staff member and/or the patient’s family/caregivers

1. http://interact2.net/
INTERACT for HHAs – Examples of successes

- Using the *Stop and Watch* tool
- Using the *SBAR* tool
- Using the *Medication Reconciliation* tool
Community resource guides and events
Community resource guides

- Worked with coalition to develop a community resource guide
- Categorized by county and type of resource
- Separate guides for providers and beneficiaries
Community resource guides

• **Provider guide:**
  • Three-ring hardcover binder
  • > 50 guides distributed to 30 different providers

• **Beneficiary guide:**
  • 8.5 in. x 5.5 in. softcover booklet
  • Recently began distribution at resource guide events

• **Online guide**
Community resource events

- One event per county
- Providers and community resources exhibit for beneficiaries

**ACT Delta is coming to a health fair near you!**

Enjoy free health screenings such as cholesterol, blood pressure and blood sugar checks, and free nutritional information!¹

Visit our booth to learn about local organizations and resources to help you manage your health care.

*ACT Delta is coming to a health fair near you!*

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**Wed., March 19 • 10 A.M.—1 P.M.**
Monticello (Drew County) • UAM Health Fair
University of Arkansas at Monticello,
University Center Green Room • 346 University Court

**Tues., April 1 • 3:30—6:30 P.M.**
Dumas (Desha County) • Family Night
Dumas High School • 709 Dan Gill Road

**Sat., April 5 • 8 A.M.—12:30 P.M.**
Warren (Bradley County) • Bradley County Health Fair
Bradley County Medical Center
Brunson Complex • 204 Bragg St.

**Tues., April 15 • 9 A.M.—6 P.M.**
DeWitt (Arkansas County) • Spring Fling
DeWitt Hospital • 1605 S. Madison St.

¹For more information, visit the ACT Delta website or contact your local ACT Delta office.
ACT DELTA

Results
Data collection

Process:
- Monthly HHA chart reviews by AFMC quality specialists

Timeframes:
- Baseline = (Oct. 16, 2012 – March 16, 2013)
- Remeasurement = (Oct. 16, 2013 – March 16, 2014)
Number of unique DE patients identified
Emergency department (ED) visits and admissions among HHA DE patients

![Graph showing inpatient admissions compared to emergency department only visits during HHA care.](image)
Percentage of DE charts with hospital discharge information present

Rate Discharge Information from GDAH Hospitals in Reviewed Charts

<table>
<thead>
<tr>
<th>Discharge Info/Charts Reviewed</th>
<th>Baseline</th>
<th>Remeasurement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66.67%</td>
<td>92.86%</td>
</tr>
</tbody>
</table>
Percentage of DE charts with community resource referrals

Community Resource Referrals from Reviewed Charts

- GDAH: Baseline 21.74%, Remeasurement 23.21%
- Non-GDAH: Baseline 24.00%, Remeasurement 18.52%
Responses of Selected Community Resources when asked if the Number of Referrals Has Increased

- Indicated "Yes": 78%
- Indicated "No": 22%
INTERACT tool utilization

INTERACT Tool Usage

Number of Tools Utilized

Oct-Nov  Nov-Dec  Dec-Jan  Jan-Feb  Feb-Mar

Stop and Watch  SBAR
INTERACT tool usage by HHAs

Percentage of HHAs Using INTERACT Tools

- Oct-Nov: 80% (Stop and Watch) 70% (SBAR)
- Nov-Dec: 60% (Stop and Watch) 60% (SBAR)
- Dec-Jan: 60% (Stop and Watch) 60% (SBAR)
- Jan-Feb: 60% (Stop and Watch) 60% (SBAR)
- Feb-Mar: 60% (Stop and Watch) 60% (SBAR)
Medication discrepancy rates

Percent of DE Beneficiary Charts with Medication Discrepancies

- Baseline: 8.33%
- Remeasurement: 13.58%
Admissions among DE patients

Number of Admissions Based on Time Period and Chart Selection Process

- Baseline (Claims Based): 95
- Remeasurement (Chart Review Based): 55
- Remeasurement (Estimate): 88
30-Day readmissions among DE patients *(from chart reviews)*

**Readmission Rates Based on Claims at Baseline and Based on Chart Reviews at Remeasurement: Oct-Mar of Respective Time Periods**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Remeasurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions/admissions</td>
<td>29.47%</td>
<td>7.27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Readmissions</th>
<th>GDAH only Admissions Identified by Respective Selection Processes</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (selection based on claims)</td>
<td>28</td>
<td>95</td>
<td>29.47%</td>
</tr>
<tr>
<td>Remeasurement (selection based on chart reviews)</td>
<td>4</td>
<td>55</td>
<td>7.27%</td>
</tr>
</tbody>
</table>

RIR 75.32%
p-value (z-test) 0.007
30-Day readmissions among DE patients (estimation)

![Bar chart showing claims based readmission rates at baseline and estimated readmission rates at remeasurement: Oct-Mar of respective time periods.]

<table>
<thead>
<tr>
<th></th>
<th>GDAH DE Inpatient Claims</th>
<th>GDAH only Admissions Identified by Respective Selection Processes</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>641</td>
<td>95</td>
<td>29.47%</td>
</tr>
<tr>
<td>Estimates of Remeasurement</td>
<td>590</td>
<td>88</td>
<td>15.91%</td>
</tr>
</tbody>
</table>

**Figure 3**

- **RIR**: 46.02%
- **p-value (z-test)**: 0.015
For more information:

www.afmc.org/ctsip

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