Department of Health & Human Services

ACL Administration for Community Living

For seniors and people with disabilities

ADRC Care Transitions Workgroup Call

June 11, 2012

www.hhs.gov/acl

Agenda

- **Welcome and Introductions**
- **Quality Improvement Organization (QIO) Program & the Integrating Care for Populations & Communities (ICPC) Aim**
  - Jane Brock from the Colorado Foundation for Medical Care (CFMC)
- **Upcoming Events/Resources**

Department of Health & Human Services

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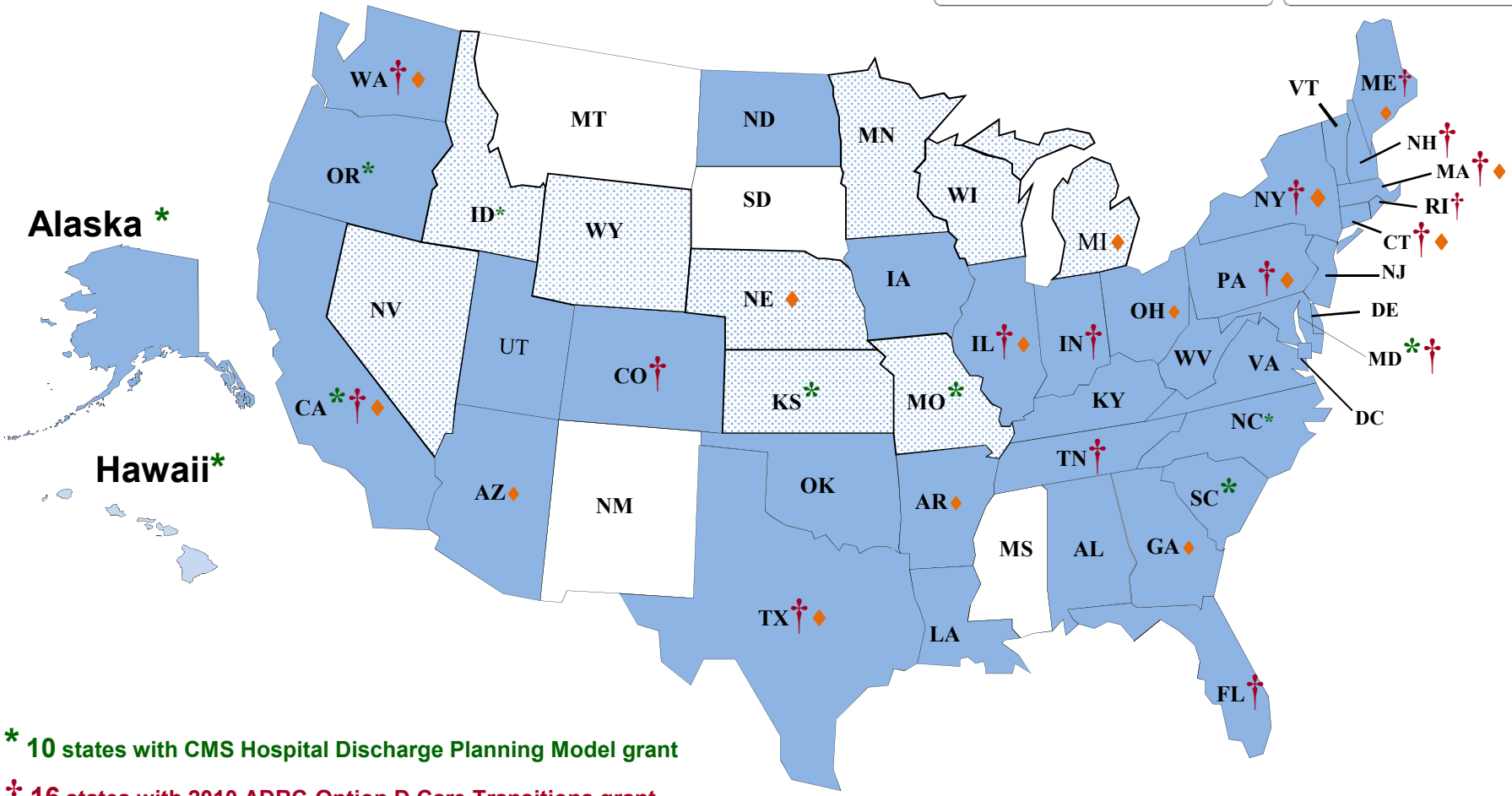
38 States currently conducting care transitions activities

9 States currently planning to conduct care transitions activities

4 States not reporting current or planned care transition activities

116 active sites, partnering with 225 hospitals

94 planning sites, partnering with 69 hospitals



* 10 states with CMS Hospital Discharge Planning Model grant

† 16 states with 2010 ADRC Option D Care Transitions grant

♦ 15 states participating in CCTP

The Quality Improvement Organization (QIO) Program & the Integrating Care for Populations & Communities (ICPC) Aim

June 11, 2012

Jane Brock
Colorado Foundation for Medical Care

This material was prepared by the Colorado Foundation for Medical Care (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-4010-156 CO 2012)

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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Lessons Learned from the 9th SOW

- Importance of community collaboration
  - Providers talking, visiting each other, sharing
- Tailor solutions to fit community priorities
  - Community needs and leaders determine change
- Include patients and families
  - Incorporate beneficiaries when they are sick and healthy
- Public outreach activities
  - Storytelling to support data

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

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)

August 2011 – July 2014

Integrating Care for Populations & Communities Aim:

- Form effective care transitions coalitions
- Improve the quality of care for Medicare beneficiaries as they transition between providers
- Reduce 30 day hospital re-admissions (nationally) by 20% within 3 years
- Build capacity to qualify for funding through Section 3026 of the Affordable Care Act

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

Why are Readmissions a Community Problem?

Poor Provider-Patient interface

medication management, no effective patient engagement strategies, unreliable f/u

Unreliable system support

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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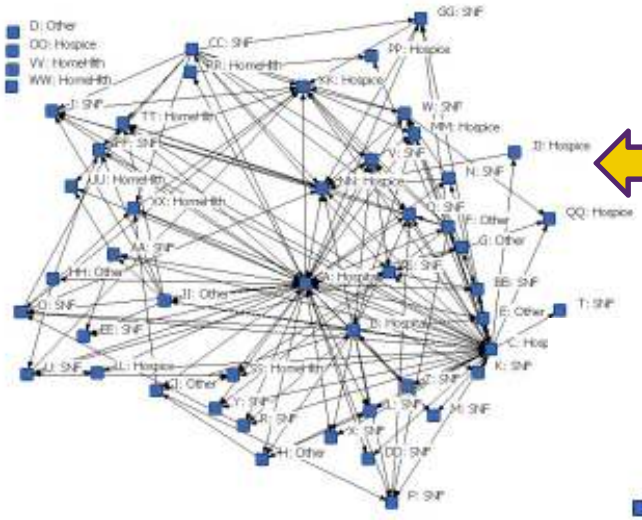
Why Engage a Community?

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

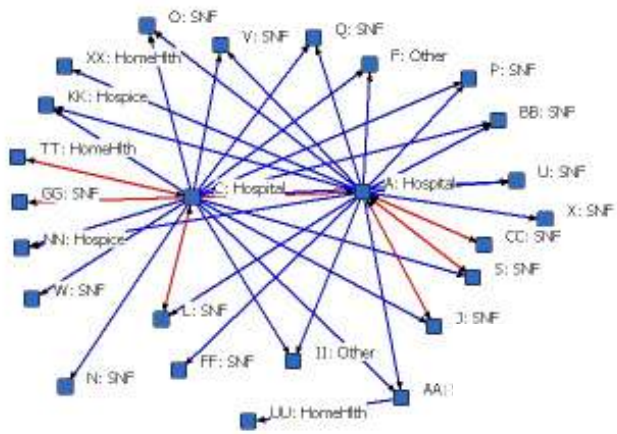
Why would communities want to engage?

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

Social Network Analysis



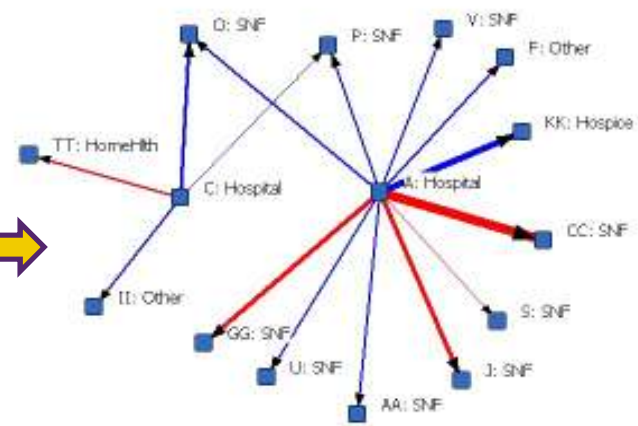
Represents all transitions in community



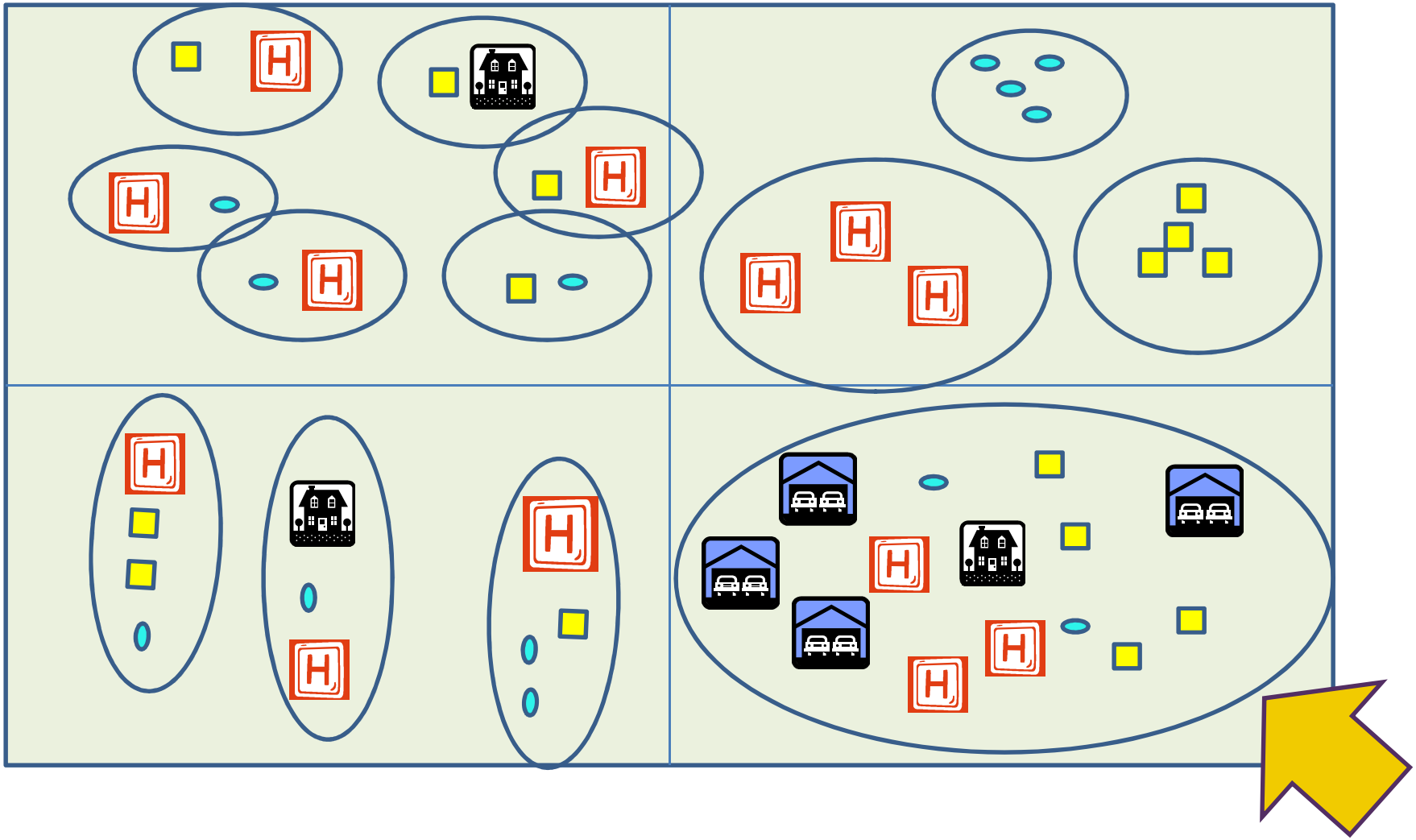
Represents providers who share 10 or more transitions

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

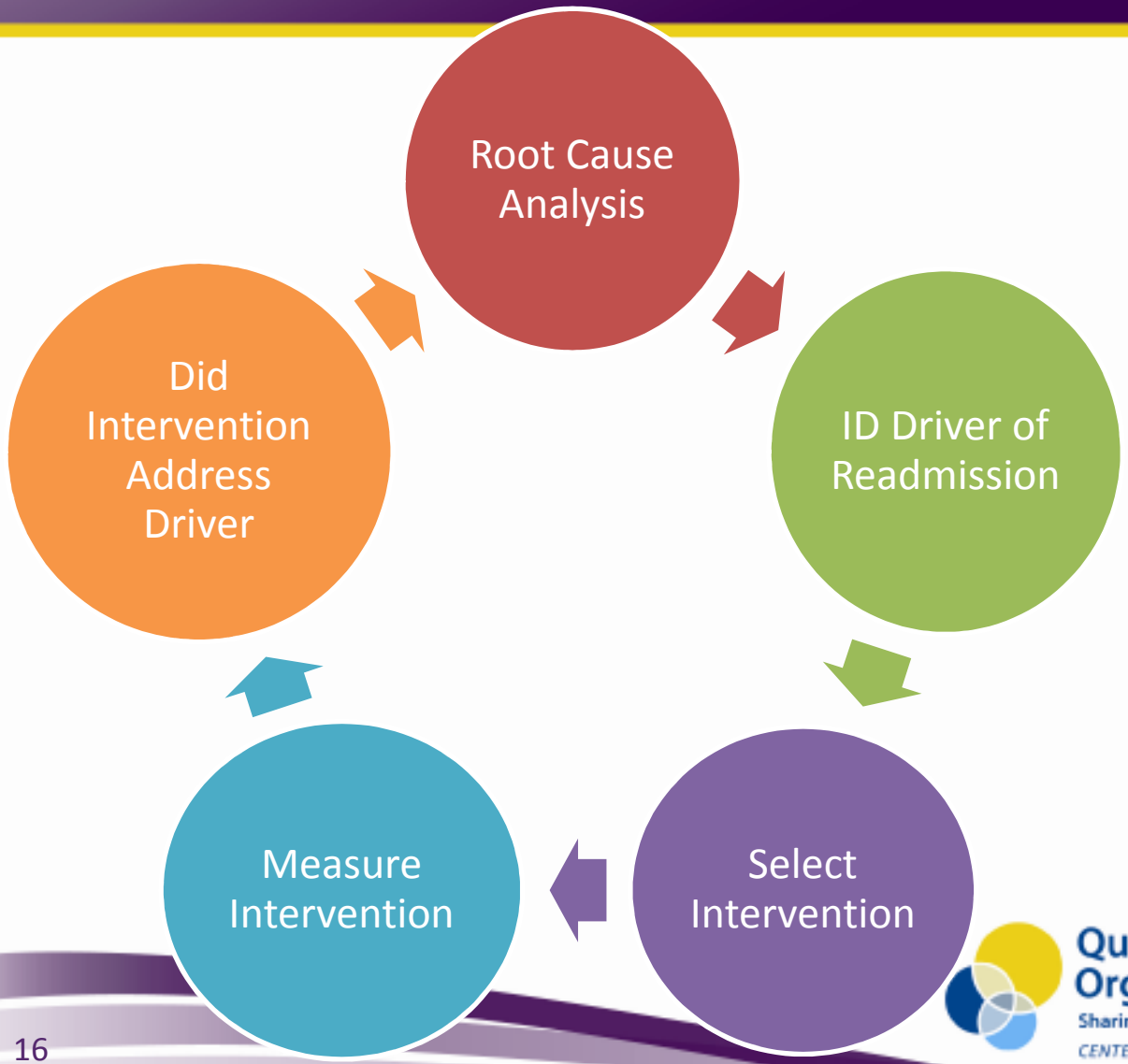
Represents providers who share 30 or more transitions



Ways to Convene a Community



Building a Community-based Program



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Community-Specific Root Cause Analysis

- Data Analysis
- Process Mapping
- Chart Reviews
- Patient/Partner/Provider focus groups

System-Level Drivers of Readmission

Poor Provider-Patient interface

medication management, no effective patient engagement strategies, unreliable f/u

Unreliable system support

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

No Community infrastructure for achieving common goals

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

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

Measures

Population-Based Readmission Measure

- The rate of rehospitalizations within 30 days of discharge from a hospital per 1,000 eligible FFS beneficiaries from the specified geographic area

Population-Based Admission Measure

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

Cost Savings Measure: 9th SoW

Definition:

- Estimated Savings per Beneficiary in 2009
- Estimated Savings per Community in 2009

General Information

Time Periods:

- CY 2007: 01/01/2007 – 12/31/2007
- CY 2009: 01/01/2009 – 12/31/2009

Method:

- Estimate cost of admissions / community / year
- Calculate cost per eligible beneficiary
- Adjust cost to account for inflation
- Estimate savings per beneficiary
- Estimate savings per community

General Information

Example Computation for 2007:

- Admissions = 28,285
- Median Payment for Admission = $7068.46
- Est Total Expenditures = 28,285*$7068.46 = $199,931,391
- Total Beneficiaries = 76,883
- Cost per Bene= $ 199,931,391 /46,883 = $2600.46

General Information

Adjustment Computation:

- Adjustment needed to account for changes in health care costs, payments, and inflation from 2007 to 2009.
- Estimated by taking median payment of all inpatient FFS claims that for 2007 and 2009 and calculating the percentage increase. Median(2009) / Median(2007)
- Adjustment factor = 1.111977
- ~11.2% inflation from 2007 to 2009

General Information

Example Computation:

- Cost per Bene 2007 = $2600.46
- Adj Cost per Bene = $2600.46*1.111977=$2891.65
- Cost per Bene 2009 = $2694.78
- Savings per Bene = $2694.78 - $2891.65 = -$196.87
- Estimated Savings = Savings * # of Benes in 2009
  - -$196.87 * 78601 = -$15,474,178.87
  - Communities with a negative estimated savings reduced cost from 2007 to 2009

Considerations for 10th SOW Measure

- All Part A claims vs. Readmissions only
- Interventions effect on methodology
- Inflation
  - Calculated using claims
  - Standard consumer price index (CPI)
- Outliers
- Specific Part A issues
  - Zero and Negative dollar claims
  - Transfers and Continuing Stays

Other considerations

- Gold Standard – Control Groups
- Modeling/Estimating Payments
- Average cost per payment
- Time-based vs. episode-based
- Per capita
- Diagnosis-specific aspect
- Utilization as a proxy
- Emphasize resource cost

QIO Contacts & Website

- To see Care Transitions Efforts by State (with maps):

http://www.cfmc.org/integratingcare/ct-efforts-map.htm

- ICPC Aim Contact by State:

http://www.cfmc.org/integratingcare/files/ICPC%20Aim%20Lead%20Contacts_022712.pdf

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Upcoming Events and Resources

- **ADRC Funding Information Teleconference**
  - **June 12, 2012** at 1:00 p.m. Eastern
  - Dial in: (800) 369-3160
  - Code: 1683139

- **Integrating Care for Populations & Communities / Colorado Foundation for Medical Care Learning Session Series: Cultivating Partnerships**
  - **June 14, 2012** from 3-4:00 p.m. Eastern
  - Topic: Engaging Partners 101

Upcoming Events and Resources

- **Next ADRC Care Transitions Work Group Call**
  - **September 10, 2012** from 1:00-2:30 p.m. Eastern

- ***Health Affairs* article:** How Kaiser Permanente Uses Video Ethnography Of Patients For Quality Improvement, Such As In Shaping Better Care Transitions

- **All slides and resources from today's webinar will be posted on the TAE website: www.adrc-tae.org.**

Contact Information

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