Common-Pool Resource Management

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Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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ICPC
Integrating Care for Populations & Communities

The Tragedy of the Commons

"The… problem has no technical solution; it requires a fundamental extension of morality." Garret Hardin

Science, New Series, Vol. 162 (3859): 1243-8, 1968.

Principles of Enduring CPR Arrangements
1. Clearly defined boundaries
2. Congruence between rules governing the taking (appropriation) and providing of resources and local conditions
3. Collective-choice arrangements allowing for the participation of most of the appropriators in the decision making process
4. Effective monitoring by monitors who are part of or accountable to the appropriators
5. Graduated sanctions for appropriators who do not respect community rules
6. Conflict-resolution mechanisms which are cheap and easily available

"Polycentric Local Management"

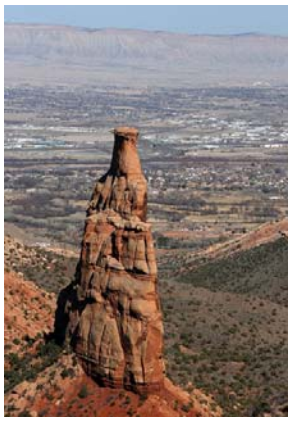
What does this have to do with healthcare?

Medicare spending

7

Bundled services/payments

Who lives here and what do they need?



TRACKING COMMUNITY TRENDS

By Marsha Thorson, Jane Brock, Jason Mitchell, and Joanne Lynn

Grand Junction, Colorado: How A Community Drew On Its Values To Shape A Superior Health System

ABSTRACT For the past decade, the high-quality, relatively low-cost health care delivered in Grand Junction, Colorado, has led that community to outperform most others in the United States. Medicare patients in Grand Junction have fewer hospitalizations, shorter hospitalizations, and lower mortality rates after hospitalization than do Medicare patients in comparison hospitals. Effective, efficient care is delivered in Grand Junction through separate, self-governing organizations that perceive health care as a community resource. This article describes how the various stakeholders in Grand Junction have addressed problems and set standards for the system. The lessons could apply to broader health reform efforts in communities around the country.

http://content.healthaffairs.org/content/29/9/1678.full.html

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A Managed Care Success?
A Medical Home Success?
A Palliative Care/Hospice Success?
A Community Services Success?

A collective action 'platform'

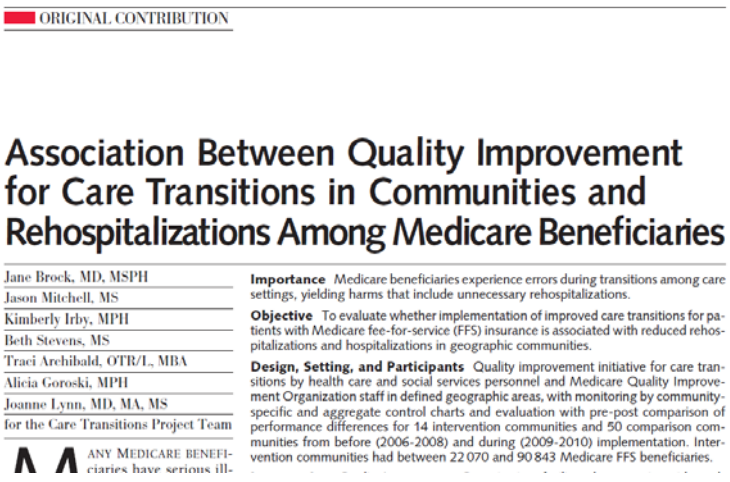
Very, Very Local

Common-Pool Resource Management

CPR Management	
Clearly defined borders	Geographic isolation
Local adaptation of access 'rules'	Local payer serving community needs
Participation of 'appropriators' in decision-making process	Longstanding culture of collective action
Effective monitoring by appropriators	Physician utilization comparison ranking
Graduated sanctions for those not respecting community rules	Payment incentives, pride in ranking
Conflict resolution mechanisms that are cheap and accessible	IPA culture, payment incentives, social networks – 'the grocery store factor'

http://en.wikipedia.org/wiki/Common-pool_resource

What we've learned through studying readmissions



ORIGINAL CONTRIBUTION

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

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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.

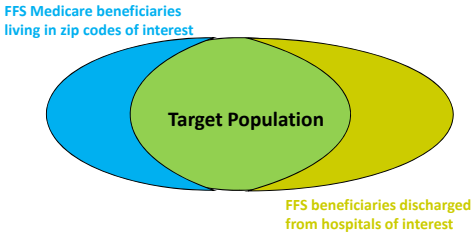
Design, Setting, and Participants Quality improvement initiative for care transitions by health care and social services personnel and Medicare Quality Improvement Organization staff in defined geographic areas, with monitoring by community-specific and aggregate control charts and evaluation with pre-post 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 BENEFI-
ciaries have serious ill-

12

The Care Transitions Theme, 2008

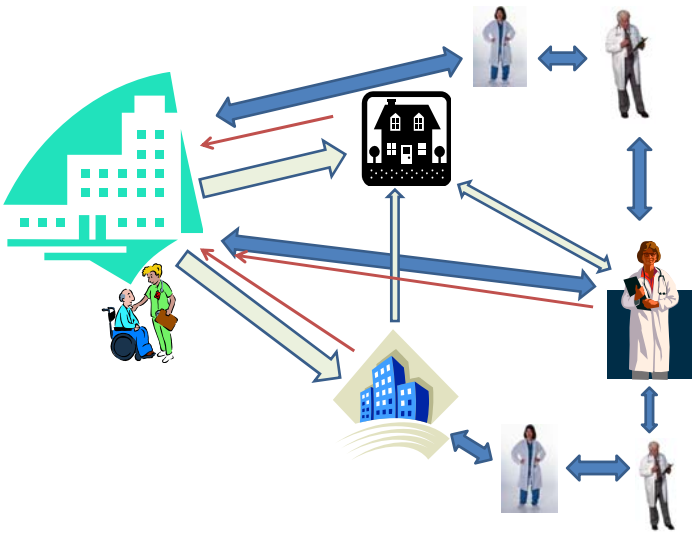
795,157



2% absolute reduction in readmissions

13

We started with hospitals..



Why are people readmitted?

Provider-Patient interface

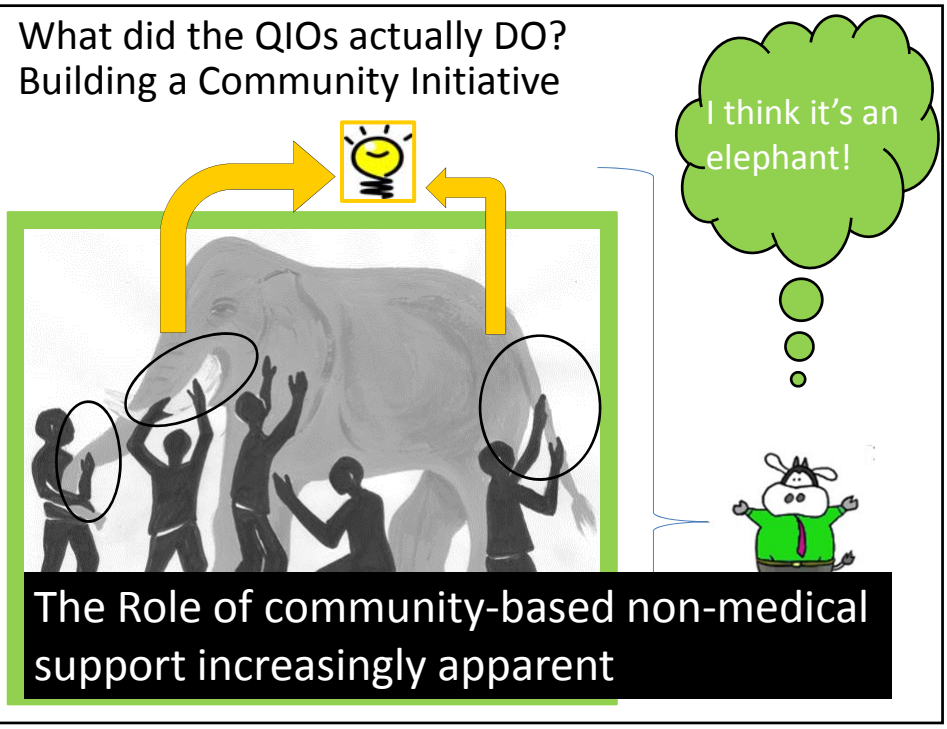
Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

Unreliable system support

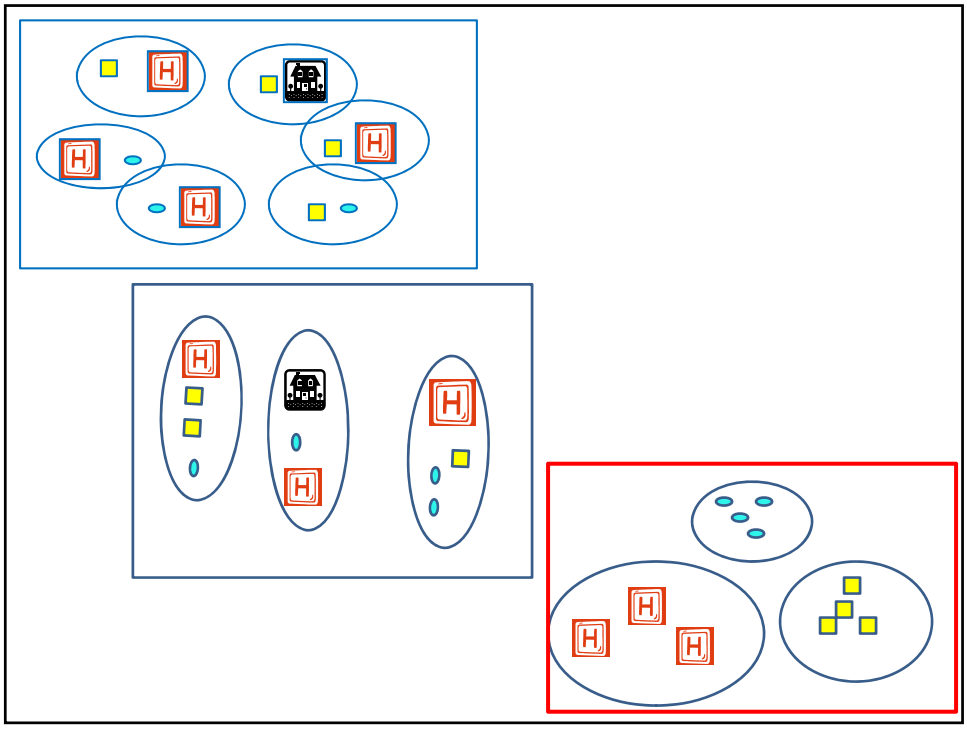
Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals

What did the QIOs actually DO? Building a Community Initiative



The Role of community-based non-medical support increasingly apparent

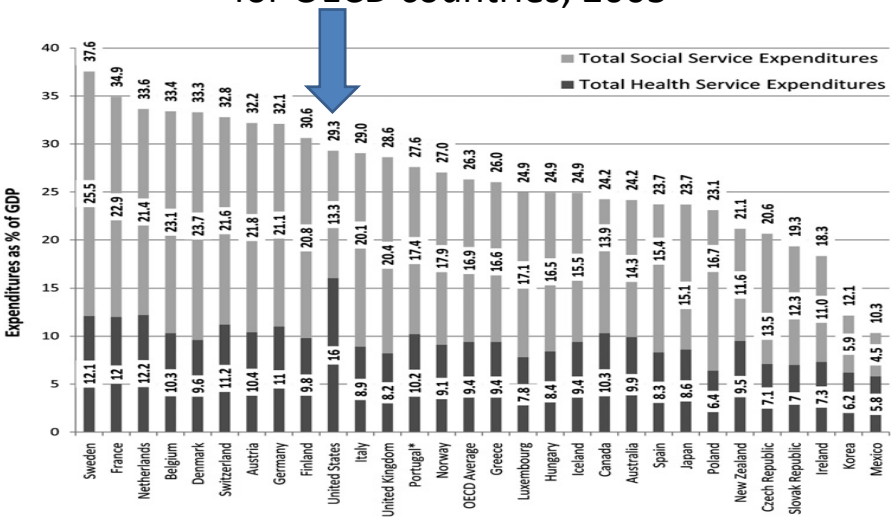


Interventions

18

www.eldercare.gov

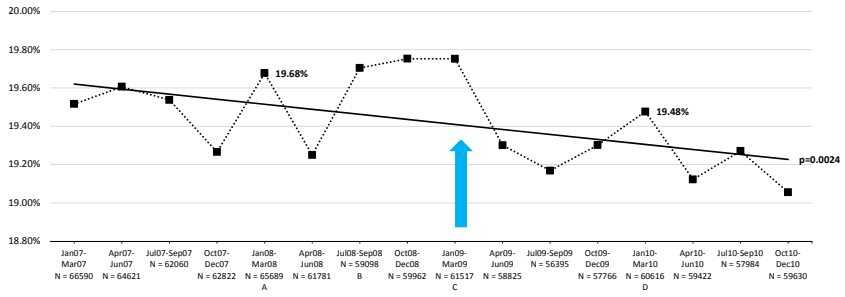
Health-service and social-services expenditures for OECD countries, 2005



BMJ Qual Saf 2011;20:826e831.

Interim Quarterly Results

Baseline Quarter Readmissions = 12,926
First quarter after intervention readmissions = 12,151



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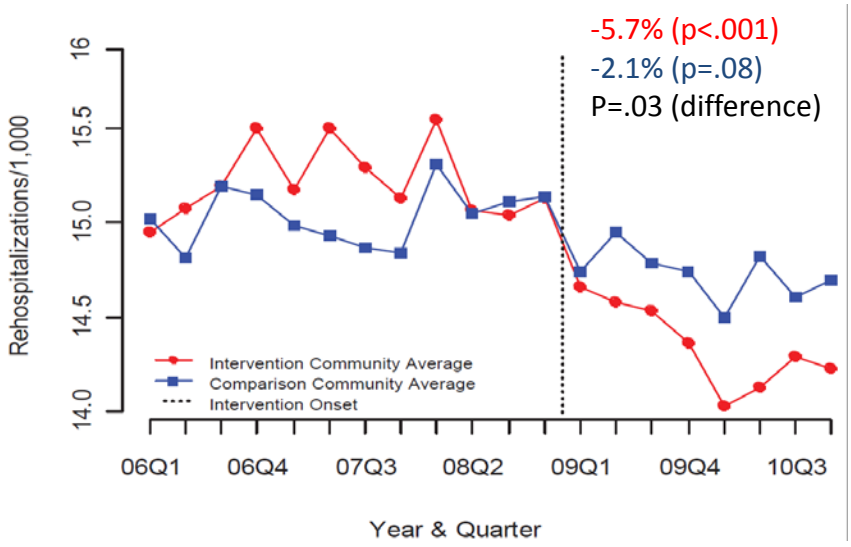
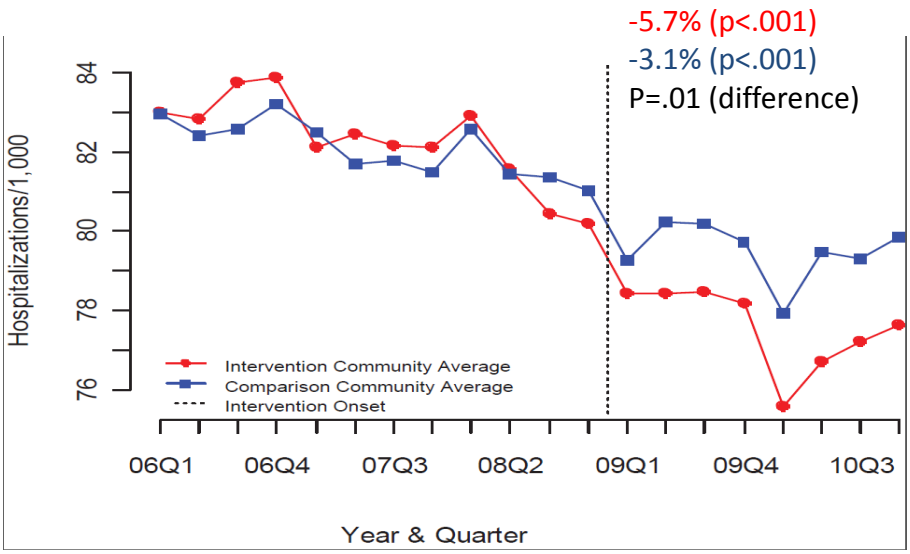




Summary of results

Rehospitalizations

5.7% ↓ (1 hospitalization for every 1000 Medicare beneficiaries)

2.7x that experienced by comparison communities

Hospitalizations

5.74% ↓ (5 hospitalization for every 1000 beneficiaries)

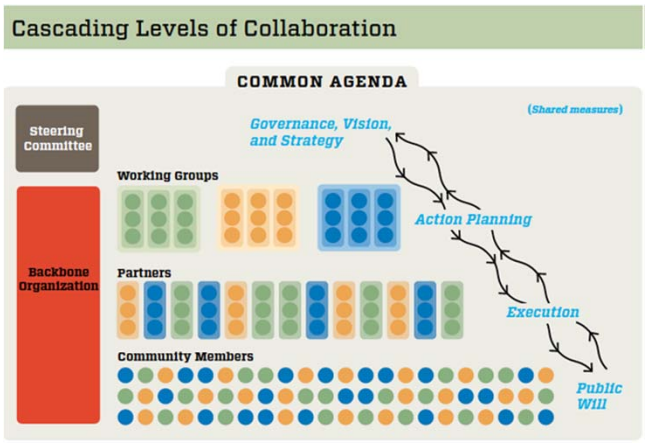
1.8x that experienced by comparison communities

vs.

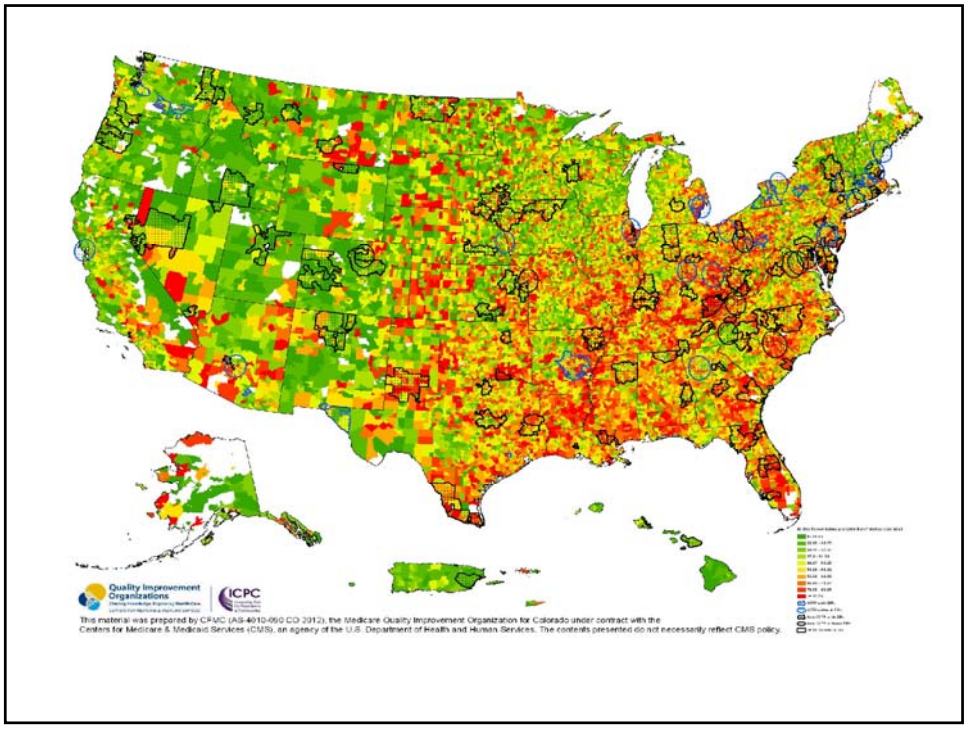
Where we are now

- Many CMS initiatives to reduce readmissions
  - CCTP, HENs, penalties
- QIOs
  - 222 formally recruited communities (≈7 Million)
  - Work based on Collective Impact
    - Population readmission rates
    - Coordinating role
  - Using community organizing techniques

Collective Impact



Kania and Kramer: Embracing Emergence.
http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity


Quality Improvement Organizations
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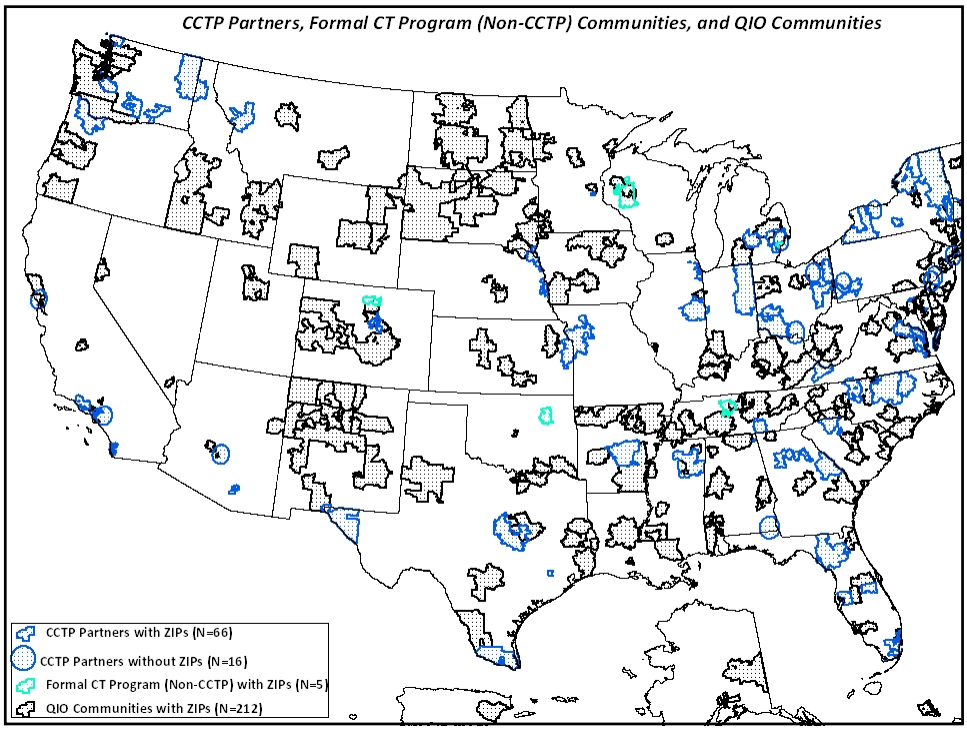
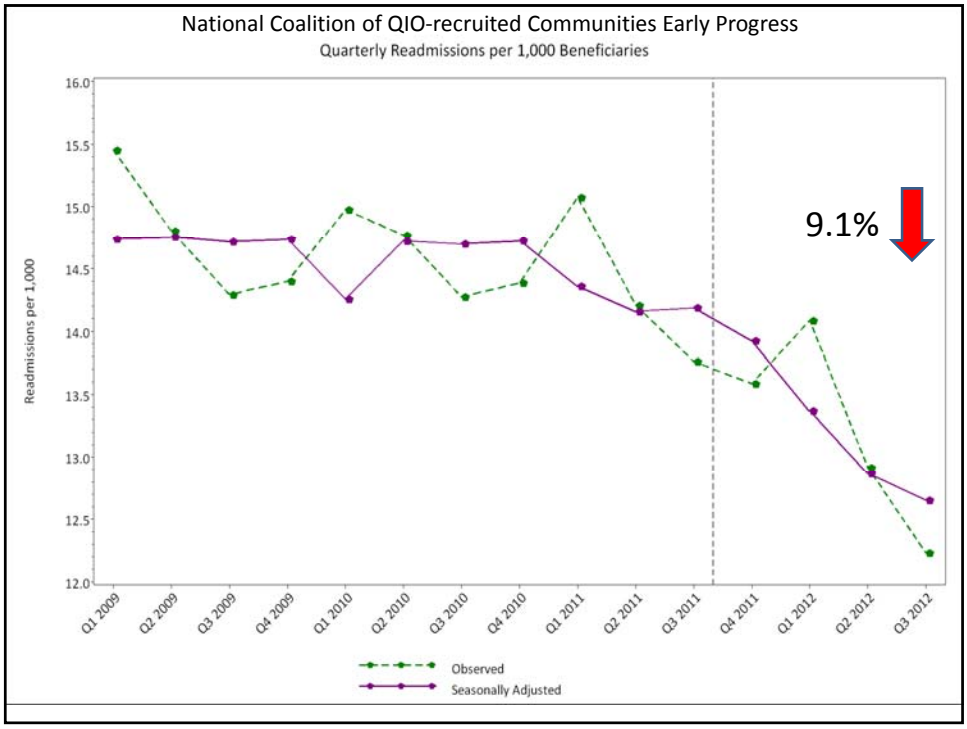
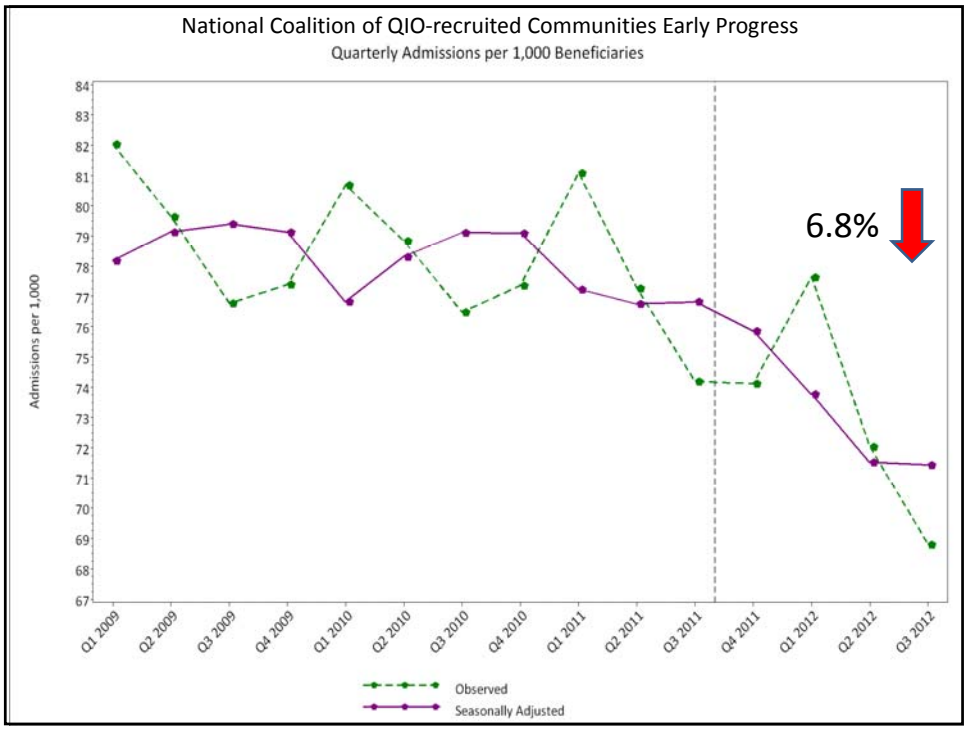
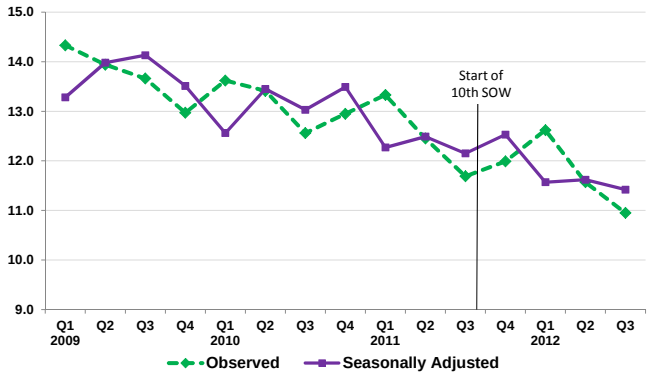

CCTP Partners, Formal CT Program (Non-CCTP) Communities, and QIO Communities
CCTP Partners with ZIPs (N=66)
CCTP Partners without ZIPs (N=16)
Formal CT Program (Non-CCTP) with ZIPs (N=5)
QIO Communities with ZIPs (N=212)


National Coalition of QIO-recruited Communities Early Progress
Quarterly Readmissions per 1,000 Beneficiaries
Readmissions per 1,000
16.0
15.5
15.0
14.5
14.0
13.5
13.0
12.5
12.0
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
9.1%
Observed
Seasonally Adjusted

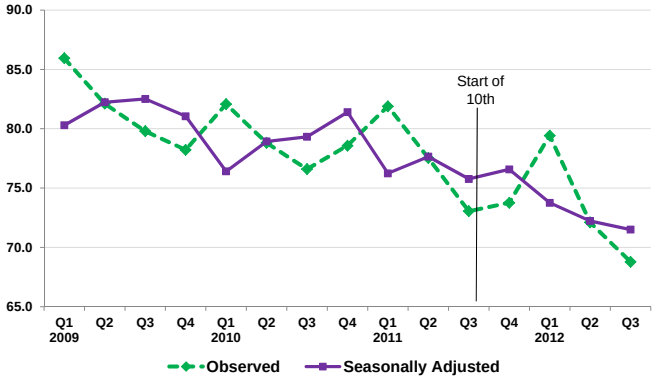

National Coalition of QIO-recruited Communities Early Progress
Quarterly Admissions per 1,000 Beneficiaries
Admissions per 1,000
84
83
82
81
80
79
78
77
76
75
74
73
72
71
70
69
68
67
Q1 2009
Q2 2009
Q3 2009
Q4 2009
Q1 2010
Q2 2010
Q3 2010
Q4 2010
Q1 2011
Q2 2011
Q3 2011
Q4 2011
Q1 2012
Q2 2012
Q3 2012
6.8%
Observed
Seasonally Adjusted

Kansas Quarterly Readmission Rates per 1,000 Medicare FFS Beneficiaries



Data: 30-day, all cause readmission rates; 1/1/2009 – 9/30/2012.
Seasonally Adjusted: Calculations done by the National Coordinating Center to adjust for variety of issues including more hospitalizations in winter months, number of days in the quarter, and major holidays in the quarter.

Kansas Quarterly Admission Rates per 1,000 Medicare FFS Beneficiaries



Seasonally Adjusted: Calculations done by the National Coordinating Center to adjust for variety of issues including more hospitalizations in winter months, number of days in the quarter, and major holidays in the quarter.

"Somebody has to do something, and it's just incredibly pathetic that it has to be us."

- Jerry Garcia