It Takes a Village: Engagement Across the Health Care Continuum to Improve Care Transitions & Reduce Readmissions

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This material was prepared by CFMC (PM-4010-164 CO 2013), the Medicare Quality Improvement Organization for Colorado 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.

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

ICPC
Integrating Care for Populations & Communities

- Every readmission begins with a hospital discharge and every transition has two sides. All providers in the
- community have a role in achieving the high quality, coordinated, and patient-centered care that prevents
- avoidable readmissions. Learn from Dr. Brock how community collective action can make a difference.

The hottest topic in healthcare reform

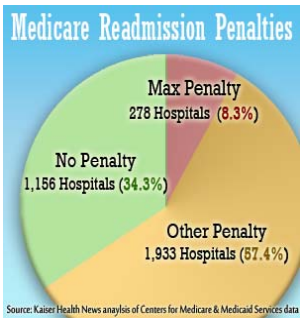
The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

- 19.6% readmitted in 30d
- $17.4 Billion (2004)

Medicare To Penalize 2,211 Hospitals For Excess Readmissions

http://www.kaiserhealthnews.org/Stories/2012/August/13/medicare-hospitals-readmissions-penalties.aspx



Care in the US is too hospital-centric	1949
Medical services alone won't be adequate	1954
We should integrate medical and social support	1956
Care patterns are local, and reflect capacity to deliver care	1973
Hospital costs are unsustainable	1980
Hospital readmissions are prevalent	1984
The Health Care Financing Administration could direct appropriate subcontractors to do things that would prevent readmissions	1984

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How we got here

"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided…"

The ACA and Integrating Care

- CMMI: to test innovative payment and service delivery models
  - to reduce program expenditures
  - while preserving or enhancing the quality of care
- The Secretary shall select models with evidence
  - address a defined population
  - for which there are deficits in care
    - poor clinical outcomes and/or
    - potentially avoidable expenditures

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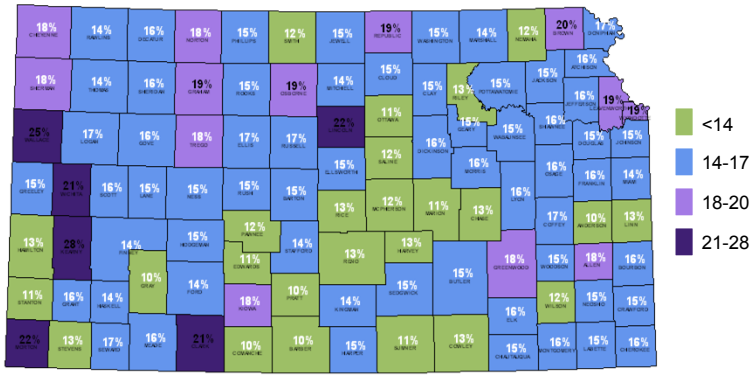
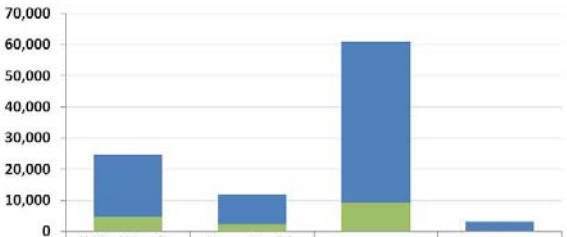
30-Day All-Cause Medicare Readmission Rates by Kansas County



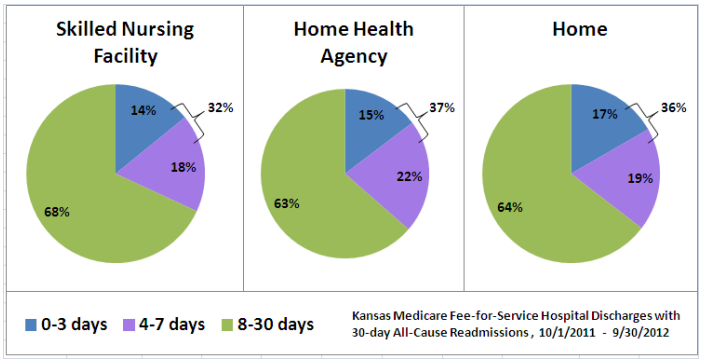
- Medicare Fee-for-Service data from 10/1/2011 to 9/30/2012.
- White labels indicate rates below the national rate and black are above (national rate 18.13%; state rate 16.03%).
- County rates are based on Medicare beneficiary residence and not hospital location.
- Critical Access Hospitals were included in this analysis.

Kansas Medicare FFS Hospital Discharges and 30-Day All-Cause Readmissions by Disposition, 10/1/2011 – 9/30/2012



	Skilled Nursing Facility	Home Health Agency	Home	Hospice
Discharges	24,779	12,022	60,910	3,081
30-Day Readmissions	4,729	2,431	9,324	70
Percent Readmitted	19.08%	20.22%	15.31%	2.27%

Length of Time to Readmission, by Disposition



This material was prepared by the Kansas Foundation for Medical Care, Inc. (KFMC), the Medicare Quality Improvement Organization for Kansas, 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. 10SOW-KS-CareT_13_100

About Readmissions..

Provider-Patient interface

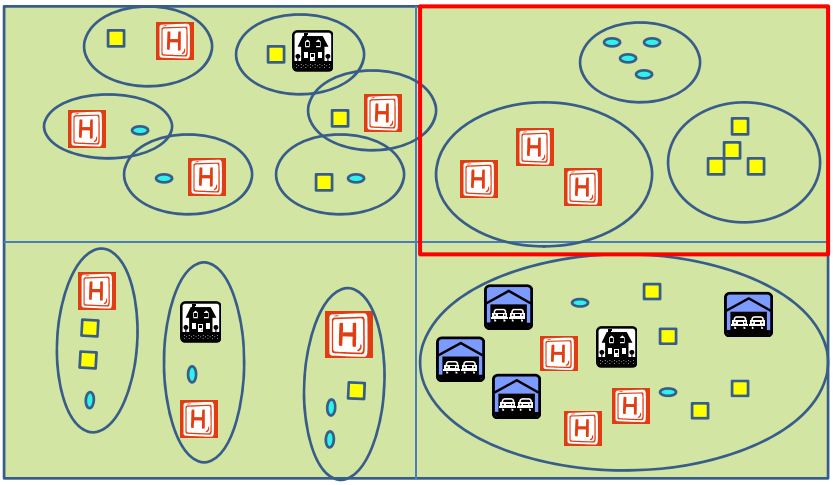
Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

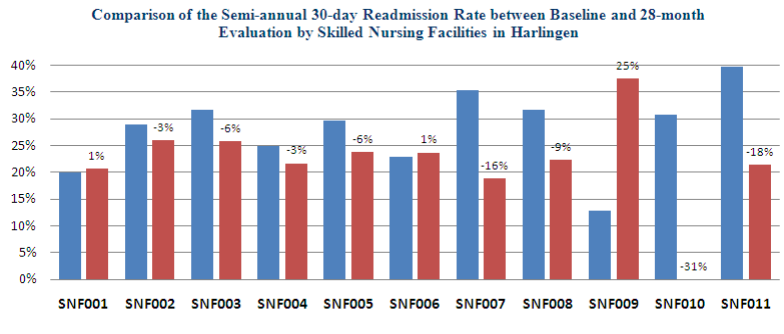
Unreliable system support

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

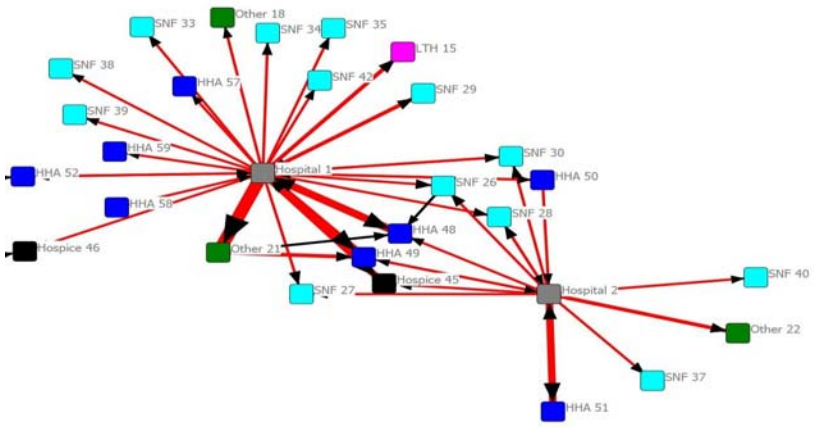
No Community infrastructure for achieving common goals

About Building a Community..





Social Network Maps (≥ 30 patients)



Which Interventions?

Most used 'evidence-based' interventions

- Hospital discharge standardization protocols
  - RED/BOOST
  - Insufficient by themselves
- The Care Transitions Intervention
  - Activated patients cover a multitude of mistakes
- The Transitional Care Nursing Model
  - Proven in HF patients with high co-morbidity
  - An alternative medical care model
- Interact
  - Standardize communication and expectations between hospitals and nursing facilities; 68% transfers avoidable

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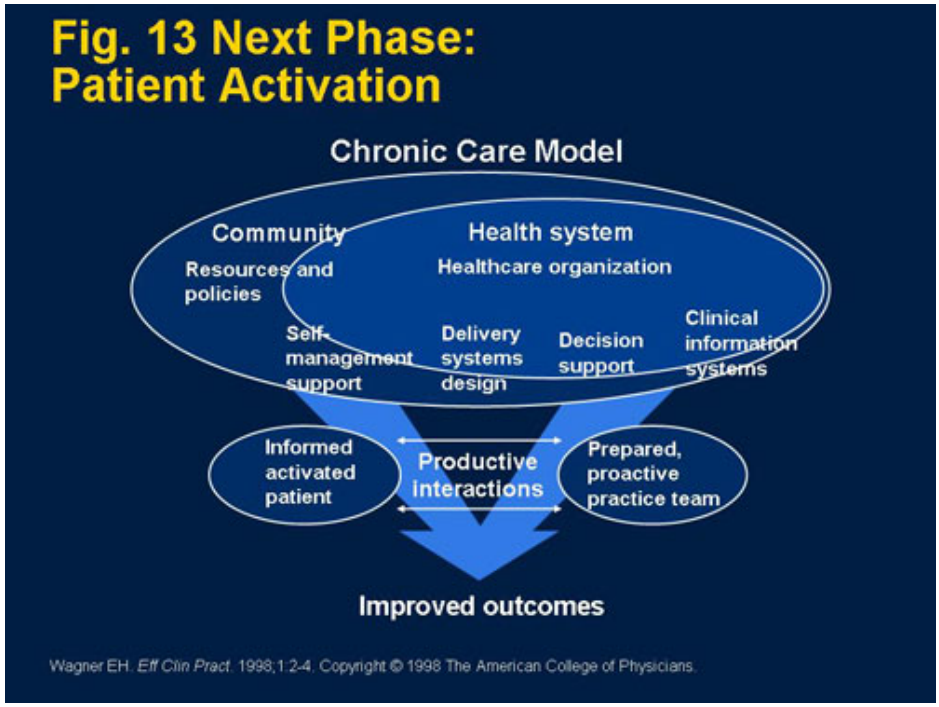
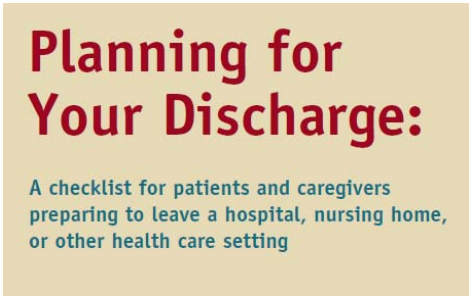
1. Patient activation trumps all



PATIENT ACTIVATION

The CMS Discharge Planning Checklist

- http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf



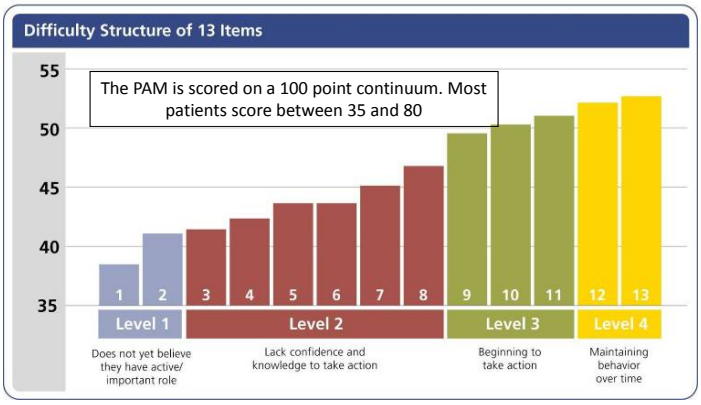
The Patient Activation Measure

www.insigniahealth.com

Sample Questions:

#1: "When all is said and done, I am the person who is responsible for taking care of my health."

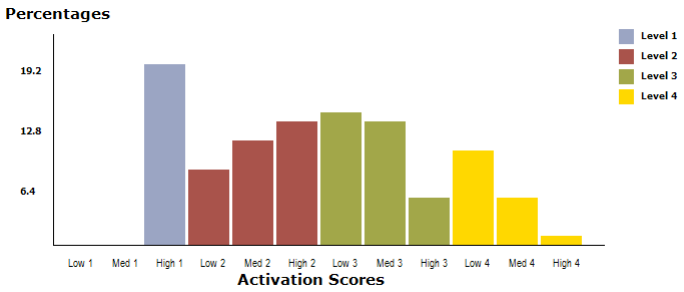
#12: "I am confident I can figure out solutions when new problems arise with my health"

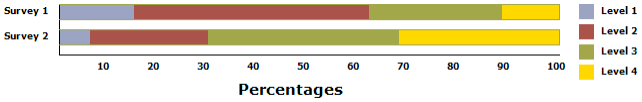


Knowledge, skills and confidence

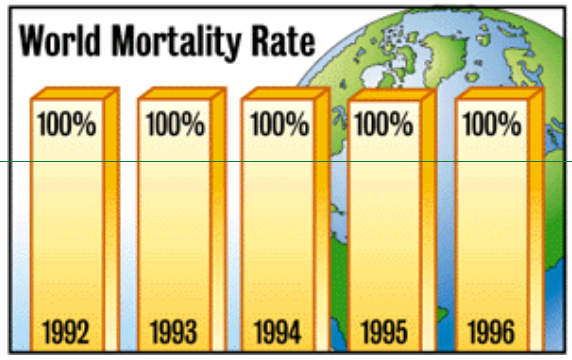
PATIENT ACTIVATION

The PAM is very helpful to guide interventions



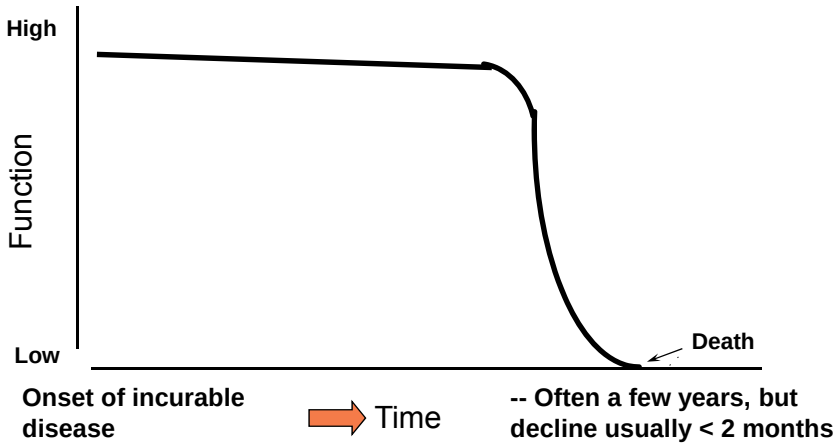


2. A 'population segmentation' perspective is essential

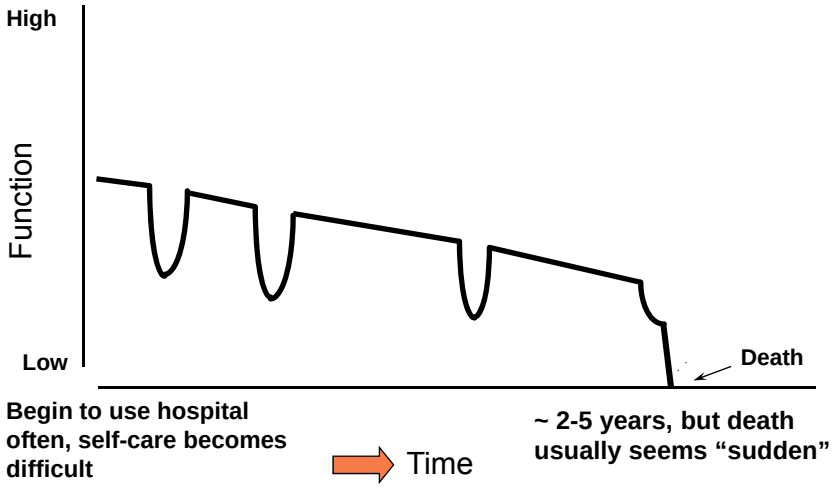


Lynn et al. The Bridges to Health Model. The Milbank Quarterly, Vol. 85, No. 2, 2007 (pp 185-208

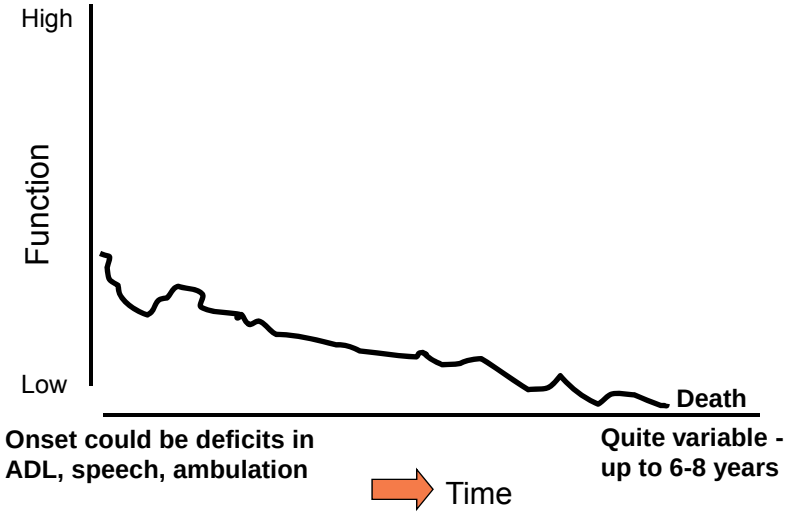
Single Terminal Disease



Organ System Failure (mostly heart and lung failure)



Dementia/Frailty



3. Community, Coalitions and Cross-Continuum Teams

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Collective Impact

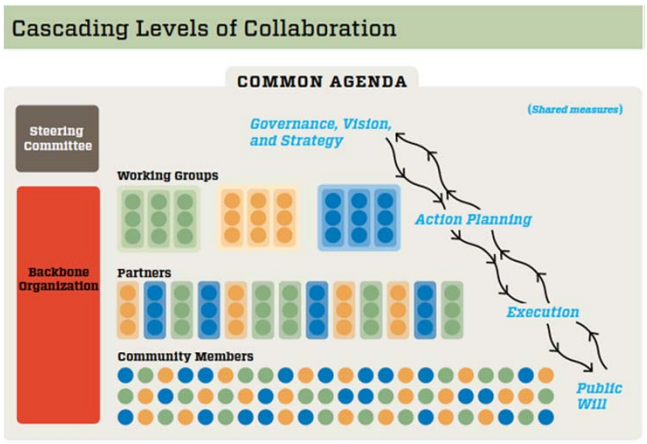
- Many organizations with similar work
- Aimed to improve the whole continuum
- No new funding
- Developed a common set of goals and metrics
- Structured the process and communication
- + trends in 34/53 indicators

5 conditions of collective success

- Common agenda
- Standard measurement system
- Mutually reinforcing activities
- Continuous communication
- **Backbone 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?cpgn=WP%20DL%20-%20Channeling%20Change



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

Washington County, Rhode Island

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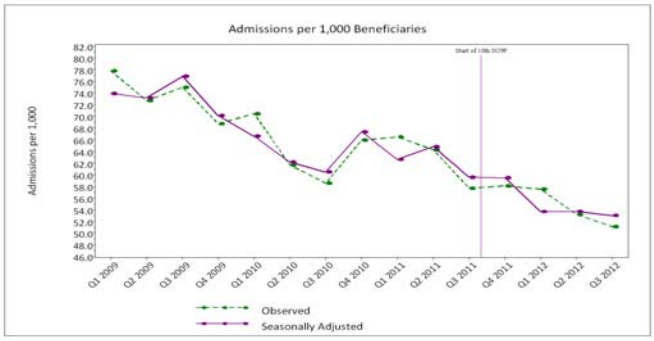
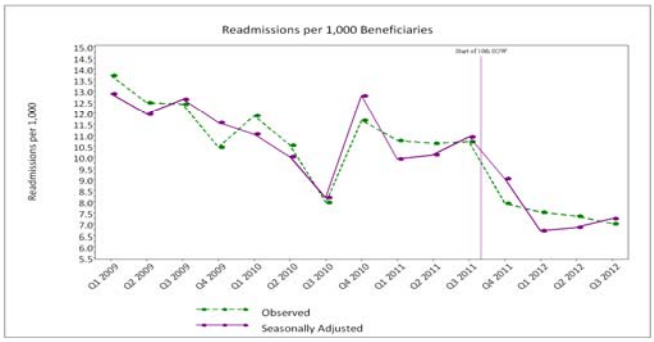
Washington County, Rhode Island

Intervention	# Beneficiaries Touched
Send a complete communication document at the time of patient transfer (Transfer information sheet with reason for ER visit, current medication list, face sheet-demographics, DOB,PCP, Insurance, Emergency Contact, IC, Advance Directives)	630
Schedule outpatient follow-up appointment prior to discharge	2600
Provide PCP with summary clinical information at discharge	2600



12.7%*



31.1%*

*10.1.10-3.31.11 compared to 10.1.11-3.31.12

Lufkin, Texas

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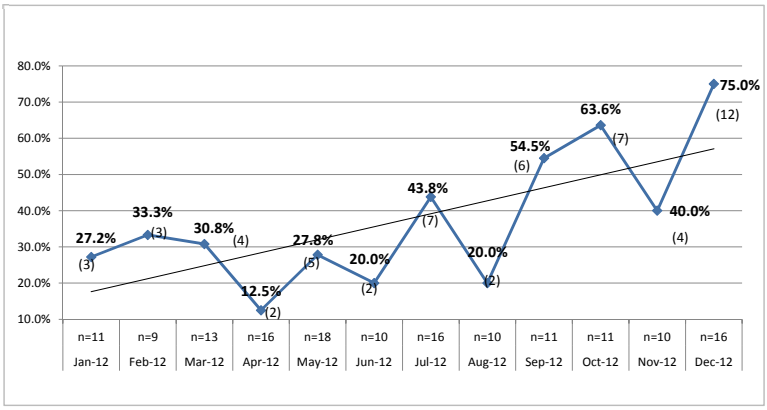
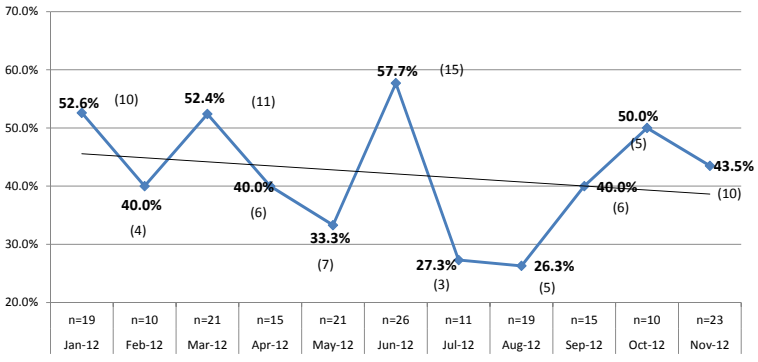
Lufkin, Texas

Intervention	# Beneficiaries Touched
Follow Up Appointment Scheduled for CHF Patients	151
Follow Up Appointments Scheduled for CHF, AMI, and PNE patients	190
Patient Education: Use of CHF Zone tool for CHF patients	50

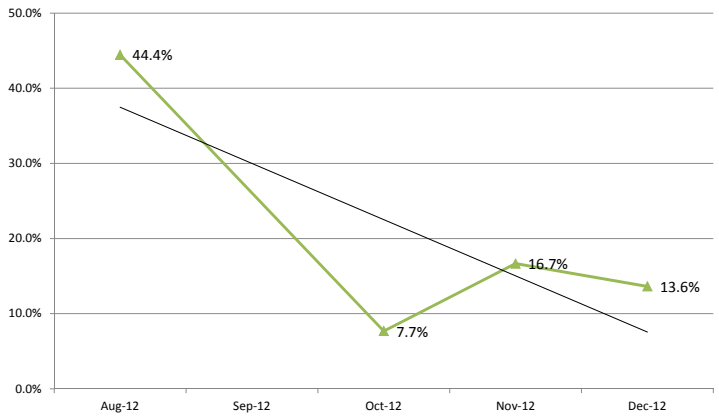
Follow-up Appointments Scheduled for CHF Patients



Follow-up Appointments for CHF, AMI, PNE Patients



30-day Readmission for HF Patients



ORGANIZING AS A THEORY OF CHANGE: Grounded in Collective Action

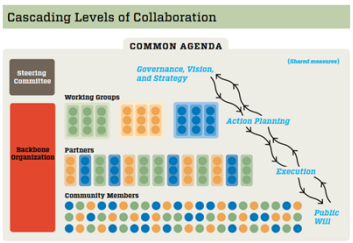
What is the vision that will motivate people to take action?
How do we move from vision to goal?

What is organizing?

'Organizing is identifying, recruiting and developing leaders; building community around that leadership; and building power out of that community.'

Organizing Theory of Change

Change = People + Power



To drive change as a social movement or 'campaign'

Me, Us and Now

- **Motivating vision**
  - What is the intolerable situation we need to solve?
- **Personal narratives** that reveal our values
  - What values bind us together?
- **Intentional relationship building** based on interest and resources
  - Relationships = resource
- Strategy - **Mapping actors**
  - Supporters, competitors, opponents

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Leadership in an organizing campaign

Leadership is **accepting responsibility** for **enabling others** to **achieve purpose** in the face of uncertainty.

Who are the actors stepping into leadership to address the intolerable condition?

Organizing for Health

- Part of the Fannie E. Rippel Foundation's ReThink Health initiative (http://rippelfoundation.org/rethink-health/action/)
- http://www.cfmc.org/integratingcare/learning_sessions.htm

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Who lives here and what do they want/need?

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[A lesson in leadership]

From Derek Sivers at: http://sivers.org/ff