The Stepping Stones Project

Community Engagement to Reduce Unnecessary Rehospitalizations

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About Qualis Health . . .

- Private, non-profit healthcare consulting and quality improvement organization
- Nationally recognized for leadership in improving health of individuals and populations through:
  - Promoting efficiency and reliability in care delivery
  - Supporting care coordination and improving care transitions
  - Leveraging health information technology to improve care
- Offices in six states across the nation
- Nearly 4.7 million covered lives

Our Staff and Consultants

More than 240 experienced professionals

- Case managers
- Medical directors
- Clinical reviewers
- Information technology / management professionals

More than 350 physician / practitioner consultants

- Physicians representing all medical specialties
- Dentists
- Mid-level practitioners
- Complementary / alternative medicine practitioners

Washington and Idaho's Medicare Quality Improvement Organization (QIO)

- Protecting the rights of Medicare beneficiaries
  - Reviewing concerns about quality and coverage,
  - Using results for improvement activities that benefit all patients
- Improving quality of care
  - Conducting patient safety projects in hospitals and nursing homes
  - Promoting prevention and chronic disease care in physician offices through meaningful use of HIT
  - Assuring safety and effectiveness of patient transitions between settings of care, such as hospital to nursing home (WA only)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Today's presentation

- Showcase a Medicare QIO Care Transitions demonstration project
- Focus on aspects of community engagement
  - Across the healthcare delivery continuum, the hospital and beyond

Introducing…

Care Transitions Project of Whatcom County

STEPPING STONES

Bridging Healthcare Gaps

Videos: http://www.SteppingStonesWhatcom.org/learn/videos.cfm

Reducing Hospital Readmissions: A Medicare Priority

- 1 in 5 of Medicare beneficiaries re□hospitalized w/in 30 days
  - Unplanned re□hospitalizations cost Medicare over $17 billion dollars
- Demonstration projects awarded to 14 QIOs, 2008-2011
  - Goal: to improve care transitions
  - Three years, 2008-2011
  - Seeking sustainable changes
  - QIOs aligned with community partners, healthcare providers and consumers

14 QIO Care Transitions Communities

CMS Care Transitions Goals

- Reduce 30 day all-cause readmission rate by 3%
  - Also reduce readmissions for AMI, heart failure, pneumonia
- Improve HCAHPS scores for medication management and discharge planning
- Increase patients seen by a physician post-discharge

Additional interim measures address implementation of interventions

Whatcom County, Washington

Population: 180,000+

- 28,000 Medicare beneficiaries
- Lummi and Nooksack reservations

Metro center: Bellingham, WA

Healthcare providers:

- St. Joseph Hospital/PeaceHealth (253 beds)
- 9 nursing homes
- 2 home health agencies
- 1 hospice
- 400 physicians

Why Whatcom County?

- Geographically well defined, stable population
- Well prepared to do the work
  - "Wired Community" -- HInet, Shared Care Plan
  - RWJ "Pursuing Perfection" site
  - Evidence of an organized community
- Already low hospital readmission rate (<12%)
  - Benchmarking project – what readmission rate reduction is possible?

Project Partners

- Medicare beneficiaries *(patient representatives)*
- St. Joseph Hospital/ PeaceHealth
- Northwest Regional Council *(Area Agency on Aging)*
- Critical Junctures Institute *(Western Washington University affiliate)*
- PeaceHealth Medical Group, Center for Senior Health, Family Care Network *(primary care physician networks)*
- HI-net *(local health information exchange)*
- Qualis Health *(Medicare QIO)*

St. Joseph Hospital
PeaceHealth

NWRC
NORTHWEST REGIONAL COUNCIL

HInet
Whatcom Health Information Network

CJI
CRITICAL JUNCTURES INSTITUTE

Project Goals

- Connect providers throughout the healthcare system in Whatcom County to enable safe and effective transition of patients
- Eliminate unnecessary hospital readmissions to St. Joseph Hospital
- Enable Whatcom County patients and their families to participate fully in their health and healthcare, particularly when leaving the hospital

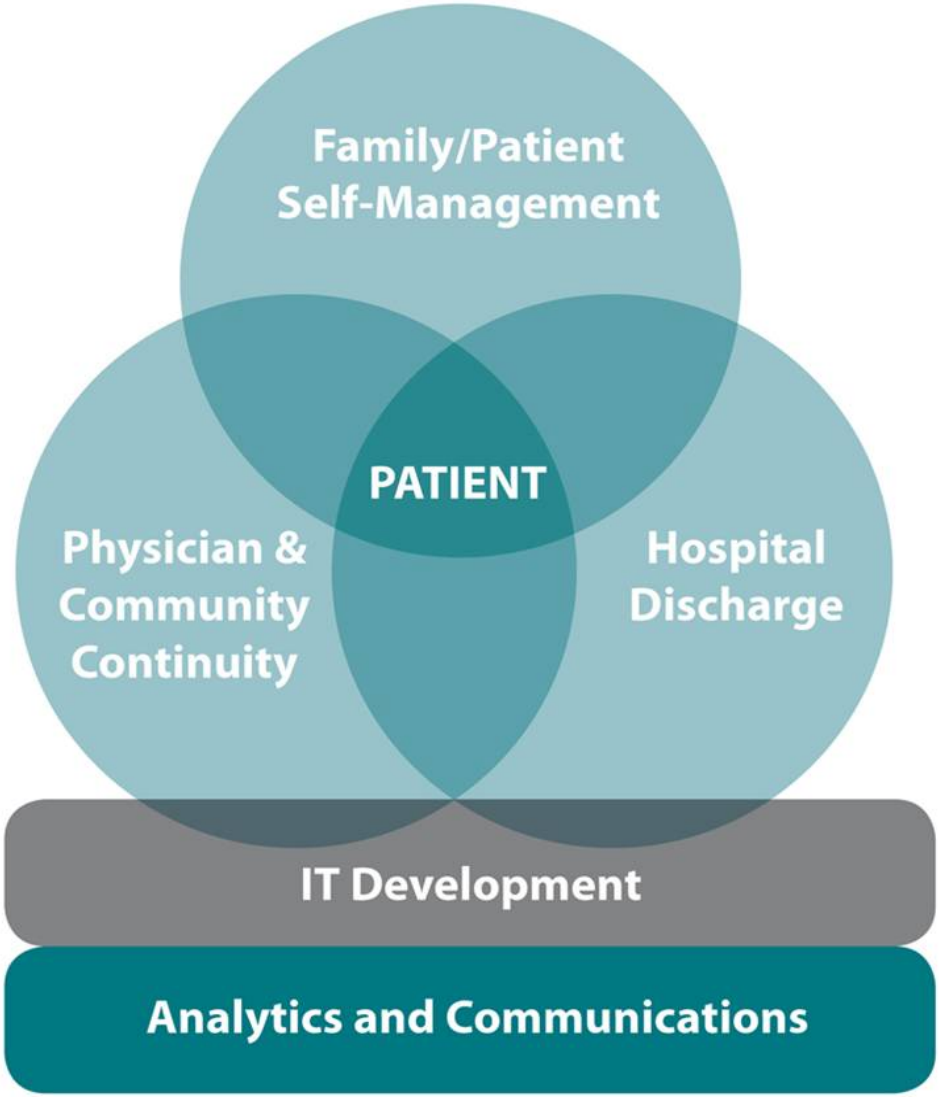
Project Strategies

- Engage healthcare providers to ensure ***optimal coordination, communication and information exchange*** around the needs of each patient and family, particularly when patients are leaving the hospital
- Implement use of ***care transition coaches*** and coaching protocols to help patients self-manage their care (Eric Coleman's Care Transitions Intervention^{SM})
- Expand use of Shared Care Plan ***personal health record*** among Whatcom County residents
- Activate ***strategic partnerships*** that engage key healthcare, business, nonprofit, and government entities within the community in the Care Transitions Project

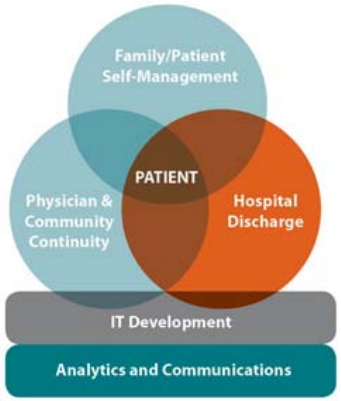
Interventions selected

- Evidence-based interventions across settings
  - Identified through CMS literature review (now published)
  - Multi-layered and multi-setting -- not focusing on just the hospital.
- Driven by data
  - Analysis of hospital readmission data, chart audits across settings
  - Determine areas of greatest potential, both by need and opportunity for improvement
- Driven by needs of the community
  - Dialogue with providers and stakeholders
  - Qualitative evaluation (patient interviews, physician focus group)

Project Structure



The Hospital Discharge Process

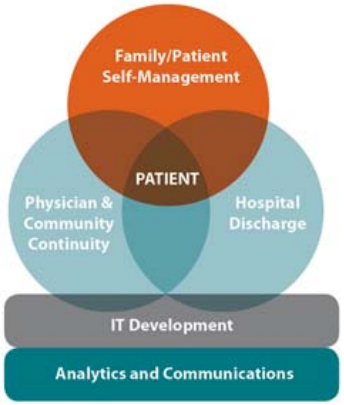


- Chart audits, root cause analysis
- Engagement of hospital leadership
  - Executives, unit managers, hospitalist program director
- Standardized hospital discharge processes
  - Pilot on one unit → spread house-wide
  - Process mapping
  - Robust set of interventions based on Project RED elements

The hospital's pilot test: multiple evidence-based interventions

- Teach-back technique used in patient interactions
- Standardized discharge documentation:
  - Discharge orders; patient instructions; discharge dictation template; advise primary care physician via fax
- Follow-up physician visit appointments made by hospital staff
- Discharge education class for families and patients (moving to video format)
- Follow-up phone calls by hospital staff after discharge
- *Planned:* Assessment of patient activation level, associated with referral to coaching

Family/Patient Self-Management



- Care Transitions Intervention^{SM} (coaching)
- Assessment of Patient Activation (PAM)
- “Going Home from the Hospital” class
- Teach-back technique
- Personal health record, Family & Patient Responsibilities booklet (“1-2-3 Plan”)

Care Transitions Intervention℠ (CTI)

- Evidence basis, linked to reduced readmission rates
- Goal: impart self-management skills
- Coaching paradigm, not education or direct care/treatment
- Free of cost to patient
- Comprises 5 interactions over 4 weeks:
  - Visit to patient in the hospital/skilled nursing facility
  - Home visit
  - Three follow-up phone calls

Our CTI approach

- Community-based coaches supported by Qualis Health coordinator
  - Potential for sustainable coaching program to continue after the 3-year CMS-funded contract ends
- Pilot implementation focused on Medicare beneficiaries
  - *Goal:* community-wide coaching program for all patient and payer types
- Patient Activation Measure (PAM)
- Personal Health Record (Shared Care Plan) supported by regional health information exchange

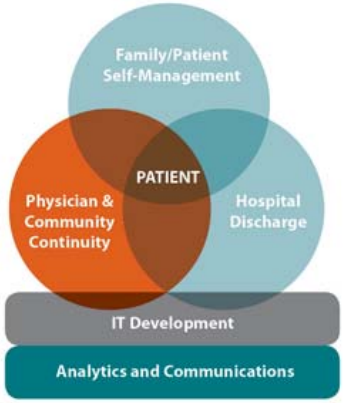
Family/Patient Self-Management

Training Community-Based Coaches

- Parish Nurses
- Tribal clinic staff
- AAA case managers

- University students
- Hospital discharge planner
- Nurses from HHAs, SNF, assisted living/adult homes
- Medicare Advantage case managers
- Elder law case manager
- Retired RN volunteer
- Primary care clinic RN

Physician/Community Continuity



- Follow-up phone calls (one pilot clinic)
- Chart audits/root cause analysis at nursing homes, home health agencies and clinics
- Field testing and feedback to refine the hospitals' new discharge documentation
- Home health national campaign interventions (readmission risk assessment, visit front-loading)
- Teach-back technique

Receivers' Workgroup Participants

Providers/care mgrs who "receive" patients post-discharge:

- Primary care physicians (network Medical Directors)
- Community Safety Net Clinic
- Community-based pharmacy
- Skilled Nursing Facilities
- Home Health Agencies
- Hospice and Palliative Care Team
- Area Agency on Aging Case Management Program
- Qualis Health (facilitator)

So where are we?

- A learning lab for testing strategies to reduce unnecessary rehospitalizations
- Clear engagement of community providers/partners who are actively implementing change strategies
- Successful implementation of evidence-based interventions across multiple settings
- Making progress
  - Process/Outcome measures trending in the right direction: hospital readmission, post-hospital physician office visits
  - Interim results from specific interventions

Some interim results

- Coaching:
  - Medication discrepancies among coached pts = 2.23 (mean)
  - 55/74 (74.3%) increased Patient Activation Measure score after coaching
  - Increasing numbers of patients being coached
- Follow-up phone calls from hospital pilot unit
  - 18.4 % of pts with follow-up calls had acute issue requiring RN action
    - *"still weak and head spinning, will call MD"*
    - *"not taking antiarrhythmia med, had spell where could not think straight"*
    - *"fell at home getting out of bed, arm in sling"*
- Follow-up phone calls from pilot primary care clinic
  - 20/30 (67%) of higher-risk post-hospital patients called had some adverse finding (medication discrepancies, missed follow-up

Thank you!

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This material was prepared by Qualis Health, the Medicare Quality Improvement Organization for Idaho and Washington, 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.