

Integrating Care for Populations and Communities:
Coalition Building to Improve Care Transitions

**Preventing Avoidable Readmissions
and Improving Transitions of Care:**

The Time is Right!

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HealthInsight New Mexico

- Formerly New Mexico Medical Review Association (NMMRA)
- Medicare Quality Improvement Organization for New Mexico for more than 30 years
 - Current contract with the Centers for Medicare & Medicaid Services (CMS) 2011-2014
 - Beneficiary protection
 - Patient safety in hospitals and nursing homes, including drug safety
 - Using electronic health records to improve preventive services and care management
 - Reducing avoidable hospital readmissions; improving transitions of care

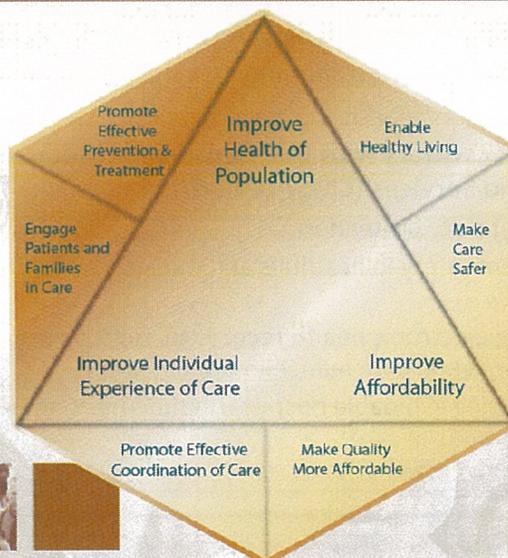


HealthInsight New Mexico

- Other Activities:
 - Medicaid External Quality Review
 - Health Information Technology Regional Extension Center (HITREC)
 - Aligning Forces for Quality (AF4Q)
 - Department of Health contracts
 - Rural/critical access hospitals
 - Healthcare-associated infection community effort (San Juan County)



The Triple Aim and National Quality Strategy



Preventing Avoidable Readmissions, Improving Transitions of Care

- One in five Medicare beneficiaries (2.6 million seniors) rehospitalized within 30 days of discharge
 - Cost to Medicare of over \$20 billion every year
- Discharge process ranked as area of significant dissatisfaction by respondents on Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey



Preventing Avoidable Readmissions, Improving Transitions of Care

- Hospital and home health readmission/admission rates publicly reported on www.medicare.gov
- Geographic variability in readmission rates
 - New Mexico in top 10 for lowest admission/readmission rates per 100,000 Medicare beneficiaries
- Nationally, 28 percent of home health agency patients hospitalized; 24 percent in New Mexico



Transitions of Care: What are they? Why do they matter?

- Movement of **people** and their **relevant health information** across health care settings
- Critical players include hospitals, nursing homes, home health/hospice agencies, community providers, senior services and consumers of health care
- Great human and cost burden
- Area of concern and frustration for providers
- Focus of attention of payers, evaluators, consumers



Who is most at risk for poor transitions of care?

- Members of our communities who :
 - Do not have a consistent site of care
 - Have not been engaged in management of their own health
 - Have serious, complex illness(es)
 - Seniors with heart and/or lung disease; children with asthma
 - Have behavioral health and/or substance abuse-related issues
 - Are dual eligible; have cognitive impairment
 - Take multiple medications
 - Are nursing home residents
 - Are at the end of life



Focus of National and State Attention

- **Hospital Readmission Reduction Program**
- **CMS QIO Project: Integrating Care for Populations and Communities**
- Accountable Care Organizations
- Value-Based Purchasing
- Hospital to Home Demonstrations
- **Patient-Centered Medical Home**
- Primary Care Discharge Follow Up Initiative
- Home Health Quality Initiative
- Advancing Excellence in American Nursing Homes
- APEX: Quality Leadership For Long Term Care
- Partnership for Patients (CMS Innovation Center)
 - **Hospital Engagement Network (HEN)**
 - Community-Based Care Transitions Program (CCTP)
 - innovation Challenge grants
- HITREC (ONC)
- **Aligning Forces for Quality – TCAB**



Hospital Readmission Reduction Program

- Section 3025 of the Affordable Care Act
 - Administered by CMS
- Beginning October 1, 2012, payments to a hospital will be reduced based on the percentage of preventable Medicare readmissions for heart failure, pneumonia, acute myocardial infarction (AMI); others to be added
 - Public reporting on HHS website
- “All cause, all site” readmissions in defined time period
- Some New Mexico hospitals will see reductions



CMS QIO Care Transitions Aim

- *HealthInsight* New Mexico is working with communities to reduce avoidable admissions and 30-day readmissions
- Funded by contract with CMS August 2011-July 2014
- Goal: reduce readmissions to improve health and reduce time in the hospital
- Focus on communities, coalition development
- Technical assistance
 - Root cause analysis, review of data, tailored interventions
- Local and national training, resources and tools



Preventing Avoidable Readmissions, Improving Transitions of Care

**What is happening in these
communities?**

Stories of Progress



Hospital Engagement Networks (HEN)

- Funded by CMS Partnership for Patients
- 10 national target topics including readmissions
- Goal: Reduce readmissions by 20 percent and other healthcare-associated conditions by 40 percent by December 2013
- Among four HENs nearly all NM hospitals involved
- Local and national training and support



New Mexico Hospital Engagement Network: A New Mexico Partnership

- Coordinated by New Mexico Hospital Association and *HealthInsight* New Mexico
- 23 participating hospitals statewide
- 11 hospitals now working on readmissions
- Interventions

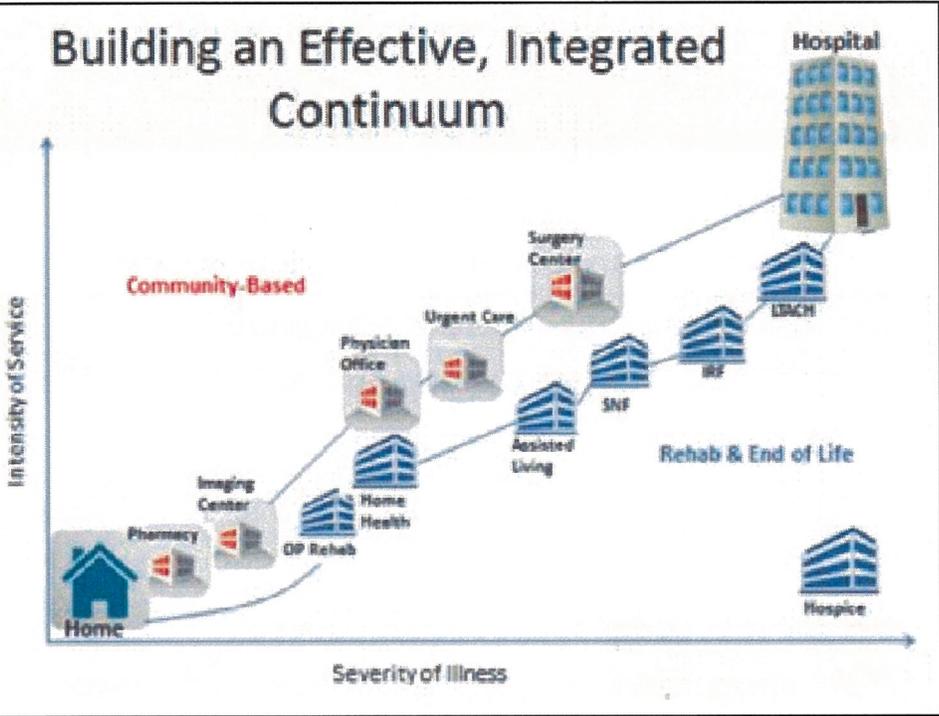


The Moving Parts Fit Together

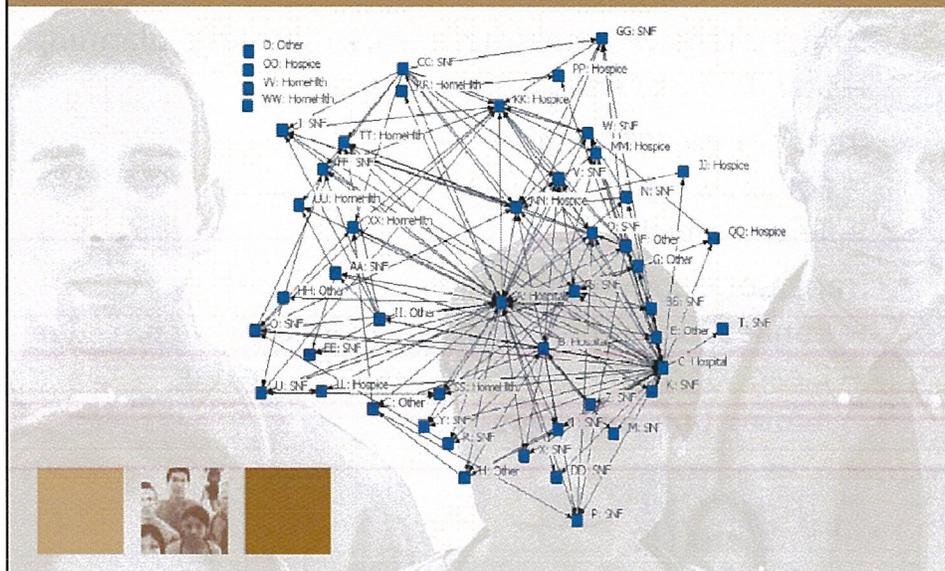
What do we need to know and do to reduce avoidable readmissions?



Building an Effective, Integrated Continuum



A Typical Care Transitions Network



Why are people readmitted?

- **Lack of communication: provider-patient**
 - Condition getting worse
 - Confusion about medications
 - Return to emergency department
- **Uncoordinated systems**
 - Lack of standard and known processes
 - Unreliable information transfer
 - Patient not involved in decision-making process
- **No community infrastructure for achieving common goals**

What helps to improve care transitions?

- Comprehensive assessment, care discharge planning
 - Standard and known processes
- Transitions care support
 - Follow-up appointments
 - Telemonitoring
- Transitions communication
 - Connection/reconnection with primary care provider
 - Clear, consistent process for reliably sharing information, e.g. electronic



What helps to improve care transitions?

- Patient and family engagement
 - Self-management /patient activation supported during/after transfers
 - Personal health records
- Medication management/reconciliation
 - The “brown bag”
- Targeting patients/populations at risk
 - “Hot spotting”
- Enhance ongoing work or mandates rather than adding to the burden



Keys to Successful Interventions

- Common agenda
- Standard measurement system
- Mutually reinforcing activities
- Continuous communication
- Backbone support organizations



How We Will Help

- Convene Learning and Action Networks
- Provide technical assistance
- Help to bring together community partners
- Assist hospitals and other providers to improve processes that affect readmissions
- Provide access to tools and interventions
- Support data collection and submission



Thank You

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