CARE TRANSITIONS:
Connecting Care Across the Care Continuum

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June 7, 2018

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Atlantic Quality Innovation Network (AQIN)

The federally funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New York State

Under contract with the Centers for Medicare & Medicaid Services (CMS)

- 11th Scope of Work (August 1, 2014 – July 31, 2019)

Leading the Atlantic Quality Innovation Network (AQIN)

- IPRO – New York
- Delmarva Foundation for Medical Care – District of Columbia
- The Carolinas Center for Medical Excellence (CCME) – South Carolina

Healthcare Quality Improvement Program

- Non-regulatory

Coordination of Care (Care Transitions)

Care Transition or Transitional Care Definition

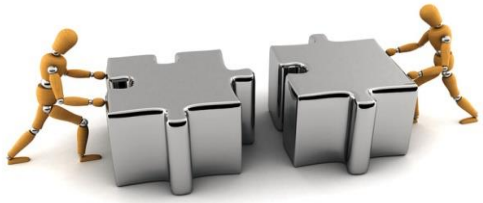
A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location

Coordination of Care Task Goals

- Improve the quality of care for patients who transition among health care settings through a comprehensive community effort.
- Facilitate engagement and activation of patients to be more involved in their health care, especially as they transition from one health care setting to another during care transitions.
- Assist health care professionals in working together across settings to achieve effective communication, patient information transfer and care coordination to ensure person-centered care.
- Reduce 30-day readmissions for Fee for Service Medicare Beneficiaries

Approach

- **Regional cross-setting community coalitions**
  - **Hospitals, Home Health, Nursing Homes, Assisted Living Facilities, Physician Practices, Hospice, RHIO, Office for Aging, County-based services, community service providers, EMS, Community Pharmacies, Key Stakeholders**
- **Community Based Root Cause Analysis**
- **Adoption of Evidence Based Interventions**
- **Assistance in monitoring & measuring impact**
- **Building collaborative partnerships to support sustainability**



Medication Safety Task

- ***Work within C.3 Coordination of Care Task*** to establish relationships and collaborations in the community to coordinate provider communication and medication management across care settings with a patient centered focus
- ***Reduce the prevalence of adverse drug events (ADEs) due to anticoagulants, antihyperglycemics, and opioids (and other facility/community specific drugs/drug categories)*** that contribute to significant patient harm, emergency department visits, observation stays, or readmissions occurring as a result of the care transitions process
- ***Help providers utilize new or existing evidence-based tools*** and practices to improve medication management and the care of those prescribed high risk medications
- ***Use health information technology to screen for and prevent ADEs in Medicare beneficiaries***

All NYS MFFS Hospital Readmissions by Discharge Disposition Trends CY 2017

Observations Drawn From The Numbers In The Re-admission Table			Numbers Used In Computation: Numerator		Denominator
Your Facility's Overall 14 Day Re-admission Rate	12.0%		60,888		507,595
Your Facility's Overall 30 Day Re-admission Rate	19.7%		99,881		507,595
Your Facility's Percent Of Discharges With No After Care	42.7%		216,965		507,595
14 Day Re-admission Rate For These Patients		10.7%	23,256		216,965
30 Day Re-admission Rate For These Patients		17.7%	38,380		216,965
Your Facility's Percent Of Discharges To SNF	23.7%		120,366		507,595
14 Day Re-admission Rate For These Patients		12.5%	14,992		120,366
30 Day Re-admission Rate For These Patients		21.0%	25,272		120,366
Your Facility's Percent Of Discharges To HHC	24.0%		121,760		507,595
14 Day Re-admission Rate For These Patients		13.4%	16,316		121,760
30 Day Re-admission Rate For These Patients		22.0%	26,786		121,760

Most Common Primary Diagnosis For Less Than 30 Day Re-admissions

Disease Category*		Number
Septicemia (except in labor)		12,320
Hypertension with complications and secondary hypertension		7,771
Chronic obstructive pulmonary disease and bronchiectasis		3,665
Complications of surgical procedures or medical care		3,410
Complication of device; implant or graft		2,768
Acute and unspecified renal failure		2,742
Respiratory failure; insufficiency; arrest (adult)		2,545
Cardiac dysrhythmias		2,521
Diabetes mellitus with complications		2,515
Pneumonia except that caused by tuberculosis or sexually transmitted		2,504

Source: CMS FFS Medicare Claims Data
(In hospital deaths and transfers to anothe facility were not counted)

Driving Forces

Dilemmas

Health Care System

- No Common Medical Record
- Gaps in Communication and Care Coordination between health care and community service providers
- Advance Directives and Palliative Care screening

Community driven

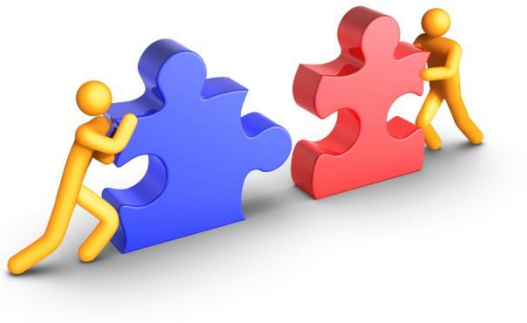
- Availability of community services
- Money, food, housing insecurity

Patient driven

- Lack of understanding of medical plan of care

Priority Cross Setting Interventions

- **Coleman Care Transitions Intervention (CTI) Model / Coaches**
- **Naylor Transitional Care Nurse Model** (TCN)
- Cross-setting Medication Reconciliation
- Medication Discrepancy Monitoring & Communication
- Physician Visit 7-days post acute discharge
- Follow-up phone call post discharge
- Patient / Caregiver “Teach Back” Education
- Patient / Caregiver self-management
- **Telehealth**
- **Project BOOST** (Better Outcomes by Optimizing Safe Transitions)
- **Project RED** (Re-engineering Discharge)
- **INTERACT** (Interventions to Reduce Acute Care Transfers)
- Standardized Transfer of Information
- **Palliative Care** (MOLST / eMOLST)
- Bridge Model
- Guided Care Nurse (Physician office)
- **Patient Activation Measure** (PAM)
- Warm Hand-offs



How Can Community Service Providers Assist?

When an individual in your facility/home is hospitalized:

- Communicate with the individual's family/caregiver
- Communicate with the hospital's Case Management Department to make them aware of services provided at home/facility
- Communicate with the individual's primary care physician to make them aware or person's hospitalization
- Visit the person in the hospital
- Communicate with the community service providers caring for the individual, if applicable

For more information

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