Care Coordination: Improving Value Through Re-engineered Care Transitions

NYeC, NYSDOH OHITT Health-Home Webinar Presentation by IPRO and the Visiting Nurse Service of Schenectady and Saratoga Counties
April 11, 2012
Session Elements

• Webinar series & context
• Hospital care transitions: scope of the problem & external forces
• Case study of community-based partnerships and approaches
• Moving to health-home coordination
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ohitt_ehr_webinars.htm
Context- New York State Medicaid Health Homes

976,000+ high cost/high need Medicaid enrollees

(1) Chronic conditions at risk for a 2nd chronic condition
(2) Chronic conditions
(1) Serious & Persistent Mental Health Condition

*Medically and Behaviorally Complex
Non-Compliant with Treatment
Health Literacy Issues
ADL Status
Inability to Navigate Health Care System
Social Barriers to Care
Homelessness
Temporary Housing
Lack of Family or Support System
Food, Income
Need assistance applying for Entitlement Programs

*NYSDOH Medicaid Health Homes
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Draft Patient Flow

1. Developmental Disability
2. Behavioral Health
3. Long-Term Care
4. Chronic Medical

NYSDOH
Medicaid
Health Home
State Plan
Amendment
and Provider
Application*

Level I Health Home Services – Moderate Need
Level II Health Home Services – Multiple Complex Needs
Level III Health Home Services – Intensive Complex Needs

Primary Care Practitioner Manages

Primary Care Practitioner Manages
Patient visits PCP or specialist and establishes trusted relationship and consents for release of data; consents and provider routing preferences are sent to HIE service.

Provider refers patient to a specialist, hospital or other provider for consultation or service.

HIE service submits referral authorization request to payer for approval and referral #.

HIE service routes visit summary to PCP, specialist or other interested and trusted party (e.g., health insurance case manager). HIE log can store summary or link to allow for tracking and later lookup.

HIE service checks participant directory for routing instructions and sends referral request with pertinent patient information / history, diagnosis and service requested to consulting provider; business rules can be stored in HIE service for elements of real-time decision support.

Participant Directory / Consents / Disclosure Log

HIE Service

Standard format visit summary with consultation notes transmitted to HIE network.

Patient visits consulting provider, receives services, and details are noted in patient chart, electronic medical record or other result is created (e.g., at lab).
Hospital Re-admissions
Scope of the Problem

National Priority to Reduce Avoidable Re-Hospitalizations:

- Hospitalizations consume one-third of the $2 trillion in health care expenditures in the U.S.
  - 1 in 5 (20%) of all hospitalizations occur within 30 days of acute care discharge
  - 64% receive no post acute care between discharge and readmission
  - 1 in 4 (28%) of hospitalizations are avoidable

Covering Health Issues 2006-2007. Alliance for Health Care Reform
### New York State 30-Day Hospital Readmission Rates

**Medicare FFS Beneficiaries Age 65 or Older**

<table>
<thead>
<tr>
<th>Condition</th>
<th>CY 2009</th>
<th>CY 2010</th>
<th>CY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cause</td>
<td>20.5%</td>
<td>20.9%</td>
<td>19.8%</td>
</tr>
<tr>
<td>Acute Myocardial Infarction</td>
<td>25.2%</td>
<td>23.8%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>28.8%</td>
<td>28.6%</td>
<td>27.4%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>21.3%</td>
<td>21.1%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>26.2%</td>
<td>26.4%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>24.3%</td>
<td>22.3%</td>
<td>22.6%</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>37.1%</td>
<td>35.4%</td>
<td>34.8%</td>
</tr>
</tbody>
</table>

*Source: CMS FFS Medicare Claims Data*
# New York State Perspective - SNF

## New York State Skilled Nursing Facility Readmission Rates

### Medicare FFS Beneficiaries Age 65 or Older

<table>
<thead>
<tr>
<th></th>
<th>CY 2009</th>
<th>CY 2010</th>
<th>CY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYS Medicare FFS Acute Care Discharges</td>
<td>651,794</td>
<td>643,968</td>
<td>630,766</td>
</tr>
<tr>
<td>Percent NYS Direct SNF Placements</td>
<td>24%</td>
<td>24%</td>
<td>24%</td>
</tr>
<tr>
<td>Percent NYS Readmitted with 7 Days</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Percent NYS Readmitted with 14 Days</td>
<td>16%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Percent NYS Readmitted with 21 Days</td>
<td>21%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Percent NYS Readmitted with 30 Days</td>
<td>25%</td>
<td>25%</td>
<td>24%</td>
</tr>
</tbody>
</table>

*Source: CMS FFS Medicare Claims Data (In hospital deaths and transfers to another acute facility were not counted)*
Home Health

- Nationally, 28% of home care patients are hospitalized unexpectedly
- Nearly 58% of acute care hospitalizations (ACH) occur within the first three weeks of home health admission
- 25% of ACH occur within seven days of home health admission
- 68% of ACH patients had been hospitalized within the two weeks prior to home health admission
- 40% of hospitalizations are avoidable
- *NYS Home Health Compare ACH rate posted 01/2012 for 10/2010-09/2011 is 31% (national rate is 27%)*

Source: OASIS Data
NYS All Cause 30-Day Readmission Source

Percent of NYS All Cause 30 Day Readmissions by Source

<table>
<thead>
<tr>
<th>Source</th>
<th>CY 2010</th>
<th>CY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>25.20%</td>
<td>24.30%</td>
</tr>
<tr>
<td>Home Health</td>
<td>23.90%</td>
<td>23.70%</td>
</tr>
<tr>
<td>Home</td>
<td>17.50%</td>
<td>17.50%</td>
</tr>
</tbody>
</table>

Source: CMS Medicare FFS Paid Claims Data
Dilemmas

- Focus is on discharge versus transition
- No ownership of transition
- Burden of coordination is placed on patient
- Caregiver may not be available/involved at discharge
- Absence of common medical record
- Absence of cross-setting medication reconciliation
- Lack of advance directives & screening for palliative care
- No reassessment of patient and goals at each transition
- Communication gaps exist between disciplines and health care settings
External Drivers Motivating Cross-Setting Partnerships
The Driving Forces....

CMS Hospital Value Based Purchasing

- Value-based incentive payments to hospitals that meet certain performance standards during that fiscal year
- Discharges occurring on or after October 1, 2012
  - Acute myocardial infarction;
  - Heart failure;
  - Pneumonia;
  - Surgeries, as measured by the Surgical Care Improvement Project;
  - Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections

- Hospitals will be scored based on their performance on each measure relative to other hospitals and on how their performance on each measure has improved over time. The higher of these scores on each measure will be used in determining incentive payments.

Source: ACA 2010: Title III, Section 3001
The Driving Forces....

**CMS Value-Based Purchasing Nursing Home Demonstration Project**

Financial incentives to nursing homes that meet certain conditions for providing high quality care

- **Four Domains**
  - Nurse Staffing
  - Rates of potentially avoidable hospitalizations
  - Outcome on selected MDS-based quality measures
  - Results from State Survey Inspections

**NYS DOH Reserved Bed Day Reimbursement for Medicaid**

Quality Indicator Survey (QIS)–addresses hospitalization of nursing facility admissions

- Trigger of Stage II investigation if threshold of 15% is exceeded
  - Numerator - # of residents in readmitted within 30 days
  - Denominator - total # of residents in randomly selected sample
The Driving Forces....

CMS Home Health Value Based Purchasing

- Recruitment for participation in the demonstration began in October 2007, with implementation in January 2008, continued through December 2009
  - Connecticut and Massachusetts in the Northeast; Illinois in the Midwest; Alabama, Georgia, and Tennessee in the South; and California in the West

- Demonstration HHAs eligible to receive incentive payments if their quality improvement efforts result in the highest performance levels or significant quality improvements as determined by Outcome-Based Quality Improvement measures.

- Measures of the incidence of acute care hospitalization and emergency care, improvement in select activities of daily living, and improvement in the status of wounds and management of oral medications
American Medical Directors Association (AMDA) Perspective


“Avoidance of unnecessary transfers should be a primary goal, but when transfers are necessary, we support implementation of processes that optimize efficient and well-orchestrated patient transitions. We also encourage improved competencies of the entire interdisciplinary team in the SNF/NF setting, both as individuals and as a team, and more effective processes to ensure appropriate assessments are performed before the decision to transfer a patient to the hospital is made.”


AMDA Transitions of Care in the Long-Term Care Continuum Guideline http://www.amda.com/tools/clinical/TOCCPG/index.html
Clinical professionals must prepare patients/caregivers to receive care in the next setting & actively involve them in decisions related to the formulation & execution of the transitional care plan.

Bi-directional communication between clinical professionals is essential to ensuring high quality transitional care.

The opportunity to collaborate with a coordinating health professional functioning across health care settings to reduce care fragmentation may enhance the care that these professionals deliver.

Health Care Reform: Implications for Providers & Relationship to Care Transitions

Medicare Commission — develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries

- **Bundled payments** - pay a fixed amount for an entire episode of care rather than piecemeal for each individual treatment or procedure to improve patient care by encouraging better and more coordinated care than under a fee-for-service system. Bills in both the Senate and the House would develop, test, and evaluate bundled payment methods through a national, voluntary pilot program.

- **Penalties for high readmissions** - Under the proposals being considered, Medicare would collect data on readmission rates by hospital and would assess penalties on those hospitals with high, preventable readmission rates.

CMS Partnership for Patients: Better Care, Lower Costs

MILLION HEARTS CAMPAIGN
Improve access to effective care
Improve the quality of care
Focus more clinical attention on heart attack and stroke prevention
Increase public awareness of how to lead a heart-healthy lifestyle
Increase consistent use of high blood pressure and cholesterol medications

IMPROVING CARE TRANSITIONS
Reduce hospital readmissions
Test sustainable funding streams for care transition services
Maintain or improve quality of care
Document measureable savings to the Medicare program.

ELIMINATING ALL-CAUSE HARM
Adverse Drug Events (ADE)
Catheter-Associated Urinary Tract Infections (CAUTI)
Central Line Associated Blood Stream Infections (CLABSI)
Injuries from Falls and Immobility
Obstetrical Adverse Events
Pressure Ulcers
Surgical Site Infections
Venous Thromboembolism (VTE)
Ventilator-Associated Pneumonia
Other Hospital-Acquired Conditions

Community Based Care Transitions Initiative

Education -Technical Support - Tools - Resources

CMS Medicare Quality Improvement Organization (QIO) 10th Scope of Work (IPRO)
CMS Hospital Engagement Network (HEN) (HANYS & GNYHA)
Case Study of Partnerships and Innovative Strategies
CMS QIO New York Care Transitions Initiative (08/2008-07/2011)

- **Five county** region in Upper Capital Region of New York State with integrated referral patterns incorporating urban, suburban and rural communities within **84 zip codes**
  - Warren, Washington, Saratoga, Rensselaer & Saratoga

- **Fifty providers**
  - Hospitals (6), Home Health (6), Skilled Nursing Facilities (28), Hospice (5), Dialysis Centers (5), Multiple Physician Practices

- **Impacting 68,206 Medicare Fee for Service (FFS) beneficiaries**
NY Care Transition Community All Cause 30-Day Readmission Rate per 1000 Medicare Beneficiaries*
January 2007 - June 2010

*Population-Based Measurement

Source: Paid Medicare Fee For Service Claims
NY Care Transition Community Post Acute Care Discharge Physician Follow-up Rate January 2007 - June 2010

Source: Paid Medicare Fee For Service Claims
Targeted Opportunities for Improvement

- Assessment of patient / caregiver understanding of discharge medications & instructions using Teach-Back Method
- Identification and referral of high-risk readmission patients for follow-up care
- Inclusion of 7-day follow-up physician visit appointment in discharge instructions with follow-up phone call
- Cross setting medication reconciliation & education
- Support of patient / caregiver learning for self-management (signs / symptoms / red flags / action)
- Improved cross setting partnerships and communication for care coordination and management
- Streamlined and standardized cross setting information transfer
Systems Improvement

Root Cause Analysis

Readmission Drivers

Interventions
Principles & Application of Community-Wide Root Cause Analysis of Readmission Drivers

“We can’t solve problems by using the same kind of thinking we used when we created them.”
-Albert Einstein
Root Cause Analysis

Definition

- A Root Cause Analysis (RCA) is a process for identifying the basic or causal factors that underlie variations in outcomes
- Allows you to identify the “root” of the problem in a process, including how, where, and why a problem, adverse event, or trend exists
- This analysis should focus on a process that has potential for redesign to reduce risk
Root Cause Analysis

- An RCA focuses primarily on systems and processes, not individual performance.
- To begin, identify the underlying functions leading to poor outcomes. Then, determine the primary cause(s) and contributing factors.
- An RCA is generally broken down into the following steps:
  - Collect data
  - Analyze data
  - Develop and evaluate corrective actions, using PDSA cycle
  - Implement successful corrective actions
Root Cause Analysis Purpose

- Identify causes of hospital 30-day readmissions within the community
  - Health care provider perspective (hospital, nursing home, home health agency, hospice, etc)
  - Community perspective (Office for Aging and other community service providers)
  - Patient/caregiver perspective

- Identify patterns of readmissions for the community
Root Cause Analysis Methods

- Retrospective review
- Analysis of admission and discharge data
- Process assessment (discharge process, communication, coordination, referral, etc)
  - Interviews
  - Direct observation
- Focus groups
Who Will Perform?

**Healthcare Provider(s)**
- Interdisciplinary team (physicians, nurses, discharge planner, social worker, pharmacist, therapist, IS, etc)
- Identify a day-to-day leader and a senior leader (decision-maker)

**Community Organizations/Stakeholders**
- Focus group at senior centers
- Interview seniors during visits post hospital discharge
- Gather scenarios and identify senior volunteers who are willing to participate in improvement efforts
Root Cause Analysis

- Identify high volume 30-day readmission population to focus efforts
  - Diagnosis specific – HF, COPD, diabetes, ESRD
  - Unit specific – HF unit, respiratory unit, post-acute rehab
  - Criteria specific – all patients with a readmission within 30 days post discharge

- Start small and spread efforts to next population

- Communicate efforts to physicians and leadership within organization
Root Cause Analysis

- Overall 30 day all cause readmission rate and defined project population
- Source of readmissions by provider setting
- Record review to determine if potentially preventable
- Identify patterns and trends
  - Example: Nursing Home concurrent tracking of readmissions by unit, shift, sending physician, reason for transfer (event & family), diagnosis, patient assessment 72 hours up to event
- Medication discrepancy measurement trends
- Hospital HCAHPS Data
  - Composite 5 (Questions 16 & 17) – Communication About Medications
  - Composite 6 (questions 19 & 20) – Discharge Information
Root Cause Analysis Findings

Readmission Drivers usually fall into 3 categories:

- Lack of engagement or activation of patients and families into effective post-acute self management

- Lack of standard and known processes among providers for transferring patients and medical responsibility

- Ineffective or unreliable sharing of relevant clinical information
Root Cause Analysis Target Populations

- Heart Failure
- Chronic Obstructive Pulmonary Disease
- Pneumonia
- End Stage Renal Disease
- Acute Myocardial Infarction / Coronary Artery Disease
- Diabetes
Root Cause Analysis Resources - A Care Transitions Toolkit

http://www.cfmc.org/caretransitions/toolkit.htm
Priority Cross-Setting Intervention Strategies

- Naylor Transitional Care Nurse Model
- Coleman Care Transitions Intervention (CTI) Model / Coaches
- 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
- Cross-setting partnerships
- Patient / Caregiver self-management
- Telehealth
- Global Access to Critical Patient Information
- Standardized Transfer of Information (Admission & Discharge Summary)
- Palliative Care
Care Transition Coach

• Follows patient for a 30-day period
• Hospital visit
• Home visit within 24-48 hours post-acute discharge
• Three follow-up telephone contacts
• Teach-back method

Four Pillars

• Medication reconciliation
• Identification of “Red Flags”
• Post acute physician follow-up visit within 7 days post discharge (can be scheduled prior to hospital discharge)
• Personal Health Record

Dr. Coleman’s Web site: http://www.caretransitions.org/
Naylor TCM Workflow*

- **PATIENT** admitted to a hospital within the past 24 - 48 hrs

  - Patient is evaluated based on the TCM screening and risk assessment.

  - **YES**
    - **Patient eligible?**
    - **TCM Nurse visits patient in hospital within 24 hrs of enrollment.**
    - TCM Nurse conducts comprehensive assessment of patient’s and family caregiver’s goals and needs, and initiates collaboration with patient’s physicians.

  - **NO**
    - Standard Discharge Plan

  - **NO**
    - **Patient consent obtained**

  - **YES**
    - **TCM Nurse visits patient in hospital within 24 hrs of enrollment.**
    - TCM Nurse collaborates with members of the health care team to design and coordinate evidence-based transitional care plan.

  - **TCM Nurse visits the patient daily during hospitalization.**

  - **TCM Nurse visits patient transitioned from hospital to home within 24 hrs.**

  - **TCM Nurse implements care plan, continually reassessing patient’s status and the plan with the patient, family caregiver and primary care clinicians.**

  - Average length of care is 2 months

  - **Seven days per week availability** (includes at least weekly home visits during first month, and at least weekly telephone outreach throughout intervention).

  - Accompanies patient to at least initial primary care clinician visits.

  - Makes referrals for health care or community support as needed.

  - Promotes transition to primary care clinicians.

  - PATIENT transitioned from TCM program:
    - a summary of patient’s goals, progress and continuing needs is sent to patient, family caregivers and primary care clinicians within 48 hrs.

*http://www.transitionalcare.org*
Project RED
Re-Engineered Hospital Discharge

Purpose
- Standardize the hospital discharge process using a Nurse Discharge Advocate

Focus
- Create for the patient an After Hospital Discharge Plan that prepares them for the days between hospital discharge and first post-acute physician follow-up appointment
** Bring this Plan to ALL Appointments **

After Hospital Care Plan for:

John Doe

Discharge Date: October 20, 2006

Question or Problem about this Packet? Call your Discharge Advocate: (617) 444-2222
Serious health problem? Call Dr. Brian Jack: (617) 444-2222

** Bring this Plan to ALL Appointments **

What is my main medical problem?
Chest Pain

When are my appointments?

<table>
<thead>
<tr>
<th>Tuesday, October 24th at 11:30 am</th>
<th>Thursday, October 26th at 3:20 pm</th>
<th>Wednesday November 1st at 9:00 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Brian Jack Primary Care Physician (Doctor)</td>
<td>Dr. Jones Rheumatologist</td>
<td>Dr. Smith Cardiologist</td>
</tr>
<tr>
<td>at Boston Medical Center ACC – 2nd floor</td>
<td>at Boston Medical Center Doctor’s Office Building 4th floor</td>
<td>at Boston Medical Center Doctor’s Office Building 4th floor</td>
</tr>
<tr>
<td>For a Follow-up appointment</td>
<td>For your arthritis</td>
<td>to check your heart</td>
</tr>
</tbody>
</table>

Office Phone #: (617) 444-2222

Office Phone #: (617) 444-7777

Office Phone #: (617) 555-1234

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Questions for Dr. Jack
For my appointment on
Tuesday, October 24th at 11:30 am

Check the box and write notes to remember what to talk about with Dr. Jack

I have questions about:

☐ my medicines
☐ my pain
☐ feeling stressed

What other questions do you have?

Dr. Jack:
When I left the hospital, results from some tests were not available. Please check for results of these tests.
Project RED
Re-Engineered Hospital Discharge

Tools

- Use of Teach-back
- Schedule post-acute physician follow-up appointment prior to hospital discharge
- Confirm discharge medication regimen
- Review what to do if problems occur once home
- Discharge Plan handbook sent home with patient

Website: http://www.ahrq.gov/qual/projectred/
Project BOOST: Better Outcomes for Older Adults Through Safe Transitions

Focus
- Provide resources for hospitalists to improve the hospital discharge process

Purpose
- To improve the hospital discharge process using a team approach to plan and implement interventions to manage high risk patients identified on admission

Visiting Nurse Service of Schenectady and Saratoga Counties

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

Discharge Planning Toolkit:

- Training materials in performance improvement principles
- Patient risk assessment tools
- Teach-back and discharge education strategy
- Guidance for follow-up communication with receiving MDs, patients and families

Website:
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm
Transforming Care At the Bedside

Focus

- To improve the transition from hospital to home for Heart Failure patients on medical and surgical units

Purpose

- To engage front line staff and unit managers to develop new care models to improve patient care and to engage and improve patients and families experience of care
Transforming Care At the Bedside

“Creating an Ideal Transition Home” Toolkit

- Enhanced admission assessment for post discharge needs
- Enhanced teaching and learning utilizing teach-back
- Patient and family centered hand-off communication
- Post-acute care follow-up

Website:
http://www.ihi.org/IHI/Programs/Collaboratives/TransformingCareattheBedside.htm
INTERACT II : Interventions To Reduce Acute Care Transfers

Interventions are designed to improve the identification, evaluation, and communication about changes in resident status.

Include clinical and educational tools and strategies for use in every day practice in long-term care facilities.

Website: http://interact2.net/
Using the INTERACT II Tools in Every Day Work in the Nursing Home

- ADVANCED CARE PLANNING TOOLS
  - New Resident Admission
  - Resident Re-assessment
  - Change in Resident Status Noted

- CNA Alerts LPN/RN
  - EARLY WARNING “Stop and Watch Tool”

- LPN/RN Evaluation

- CARE PATHS
  - ACUTE CHANGE IN CONDITION File Cards

- MD/NP/PA Notified?
  - SBAR Form and Progress Notes
  - TRANSFER CHECKLIST Envelope
  - RESIDENT TRANSFER FORM

- Acute Care Transfer
  - QUALITY IMPROVEMENT TOOL FOR REVIEW OF ACUTE CARE TRANSFERS

- Quality Improvement Meetings

http://interact2.net/
Improving Care Transitions And Reducing Hospital Readmissions:
Establishing The Evidence For Community-Based Implementation Strategies
Through The Care Transitions Theme

By: Thomas Vestuto, MD, MHP (Colorado Foundation for Medical Care), Douglas Brown, MHS (Centers for Medicare & Medicaid Services), Traci Archbold, CTML, MBA (Centers for Medicare & Medicaid Services), Adisa Gakoski, MPH (Colorado Foundation for Medical Care), Jane Brock, MD, MSPH (Colorado Foundation for Medical Care)

Background
The problem of hospital readmissions has become the cornerstone of discussion in seemingly any forum addressing health care improvement or reform. Reformers are targeting hospital readmissions as a quality problem, a safety problem and the most immediately-actionable driver of excessive costs. The Centers for Medicare & Medicaid Services (CMS) is an early leader in the push to understand and modify current care patterns that appear to be dependent on hospital services. And rightfully so — although there is notable regional variation in readmission rates, nationally nearly one in five discharges paid for through Fee for Service Medicare is followed by another admission to a hospital within 30 days. Additionally, CMS is ideally positioned to lead change towards reducing re-admissions both through being the largest payer of hospital services, and through having the nationally coordinated resources to understand the impact of substantially geographic variation.

What Is The Care Transitions Theme?
The Care Transitions Theme is a CMS-funded initiative for Medicare Quality Improvement Organizations (QIOs) to measurably improve the quality of care for Medicare beneficiaries who transition across care settings through a comprehensive community effort. Fourteen QIOs began working with target communities within their respective States on August 1st, 2010, and the project will be completed by August 2011.

Each QIO selected a specific geographic area and a Medicare beneficiary population (as defined by beneficiary zip code of residence) where they are now working with the medical services providers, other community health support agencies, unpaid caregivers and patients to identify drivers of poor transitional care and to reduce their influence on patient outcomes. In other words, this work seeks to improve care quality by promoting seamless transitions among care settings, and thereby reduce readmissions to hospitals within 30 days of discharge.

http://www.cfmc.org/integratingcare
Innovative Strategies

- Improve **cross-setting partnerships and communication** for care coordination and management

- **Cross-setting** medication reconciliation

- **Cross-setting** staff education

- **Cross-setting** support of resident / caregiver learning for self-management (signs/symptoms/red flags/action)

- Streamlined and standardized **cross-setting** information transfer
How To Get There.....

- Cross-setting partnerships are key
  - Hospital, Home Health & SNF meet monthly to review readmissions
  - Hospital assisting SNF in training RNs in physical assessment
  - SNF Medical Directors conferencing with Hospitalists on high-risk residents
  - Coaches partnered with Community Nurse Navigators

- Focus on the process, not the setting
  - Process map of referral process
  - Standardizing materials transferred with patients/residents at discharge
  - Standardizing patient educational materials at cross-setting level

- Include all levels and disciplines of staff
- “Blame Game” not allowed
- Place the patient/resident at the center of the process
  - Patient / Caregiver focus groups
Resources

- IPRO Care Transitions Web site: http://caretransitions.ipro.org
- Next Step In Care: http://www.nextstepincare.org
- Project BOOST: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
- Project RED: http://www.bu.edu/fammed/projectred/index.html
- IHI Initiatives: http://www.ihi.org/IHI/Programs/StrategicInitiatives
- National Transitions of Care Coalition: http://www.ntocc.org
- Transitional Care Model:
  http://www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm
- Care Transitions Intervention: http://www.caretransitions.org
Care Transitions / Health Home

NYeC-NYSDOH OHITT Health Home Webinar
April 11, 2012

Joseph Twardy
President and CEO
twardyj@vnshomecare.org
Structure

Many Initiatives – One Chassis
### Medical Home

**Meet:** Quarterly  
**Purpose:** Overarching community health/ direction  
**Participants:** Multiple & Various  

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### Care Central (Health Home / Care Transitions)

#### Care Central Workgroup

**Meet:** Bi-weekly (Call / Meeting)  
**Purpose:** Overview and Direction of Health Home  
**Participants:** AIDS Council of NENY, Belvedere Health Services LLC, Bethesda House, Capital District Psychiatric Center, Carver Counseling Center, Catholic Charities AIDS Services, Catholic Charities Senior Services in Schenectady, Clearview Center, Conifer Park, County of Schenectady Department of Social Services, Ellis Medicine, Family and Children’s Service of the Capital Region, Inc., Hometown Health Center, Hope House, Inc., Mohawk Addiction Treatment Center, Mohawk Opportunities, Inc., New Choices Recovery Center, Northeast Parent and Child Society, Parsons Children and Family Services, Rehabilitation Support Services, Saratoga County Mental Health Center, Schenectady City Mission, Schenectady County Action Program, Schenectady County Chapter ARC, Schenectady County Community Action Program, Schenectady County Homeless Services, Visiting Nurse Service of Schenectady and Saratoga Counties, Inc., Volunteer Physicians Project of Schenectady, Inc., Whitney M. Young Jr. Health Center, YWCA of Schenectady

#### Care Management Taskforce

**Meet:** Frequently (at least bi-weekly)  
**Purpose:** Execution of Health Home rollout and deliverables with engaged “Downstream” partners and key stakeholders  
**Participants:** AIDS Council of NENY, Belvedere Health Services LLC, Catholic Charities AIDS Services, CDPHP, Conifer Park, Ellis Medicine, Fidbix, Hometown Health Center, Mohawk Opportunities, Inc., Parsons Children and Family Services, Rehabilitation Support Services, Schenectady County (Community Services), Visiting Nurse Service of Schenectady and Saratoga Counties, Inc., Volunteer Physicians Project of Schenectady, Inc.

#### Care Central Steering Committee

**Meet:** Monthly  
**Purpose:** Overview all CC (Health Home, CMS Care Transitions etc)  
**Participants:** VNS, Ellis Medicine, Hometown Health

### CMS Care Transitions Steering

**Meet:** Ad hoc (was weekly)  
**Purpose:** Implement CMS Program Once Approved  
**Participants:** Adirondack Health Institute, Adirondack Medical Center, Alice Hyde Medical Center, Champlain Valley Physicians Hospital, Community Health Center, Ellis Medicine, Glens Falls Hospital, High Peaks Hospice, IPRO, Nathan Littauer Hospital, Saratoga County Office for the Aging, Saratoga Hospital, St. Mary’s Hospital, Visiting Nurse Service, Washington County Office for the Aging
Health Home
Approved Phase One
**Role:** Air traffic controllers getting the patient where they need to go with support

**Role:** Facilitation and emergency intervention
- MD, RN, RPH, Case Mgmt, Social Services

**Role:** “Boots on the ground” to make sure support is there and to confirm the patient status
- RN, NA, Coaches, Drivers, Home Aides, Volunteers

**Role:** Manages the provision of specialized services for a specific patient population (AIDS, Mental Health, Disabilities)
- Social Worker, RN, or other dedicated program professional

**Role:** Supplements PCP by providing enhanced support through direct patient relationships focused on changing unhealthy behaviors and lifestyles
- Multispecialty MD’s, Nurse Practitioners, Case Managers/Social Workers – integrated with the rest of the Health Home Team
Care Transition Program - Medicare (CMS) 3026
Approved
North Eastern New York Community-based Care Transitions Program:

- Program Structure:
  - Six community-based organizations (CBOs)
  - Ten community hospitals
  - All serving Medicare beneficiaries in a ten-county region of upstate New York
  - All of the participants have worked together, and have successfully delivered care transitions services.
  - Many of the participants are healthcare innovators, among them the only current Medicaid Health Homes in upstate New York, a Centers for Medicare and Medicaid Services (CMS) Multi-payor Advanced Primary Care Practice (MAPCP) Demonstration and a State Medical Home Pilot Project, and two communities which have recently experienced successful hospital consolidation.
  - There are over 100,000 Medicare fee-for-service (FFS) beneficiaries living in the approved service area, with 80 percent of their inpatient admissions to the participating hospitals.
  - The region comprises 21 percent of New York State’s land area
CMS 3026 – Care Transitions Structure

Visiting Nurse Service of Schenectady and Saratoga Counties

- Care Transition Services
- CBO to CBO Agreement
- Mode of Intervention Delivery

VNS Schenectady Saratoga Counties

Community Health Center

High Peaks Hospice

Adirondack Health Institute

Washington County Office for the Aging

Saratoga County Office for the Aging

Ellis Hospital

Nathan Littauer Hospital St. Mary’s Hospital

Adirondack Medical Center

Alice Hyde Medical Center

Champlain Valley Physicians Hospital

Glens Falls Hospital

*Note that a portion of GFH will be delivered through the CBO of AHI or WC AoA by GFH staff

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Navigating Health Information Technology Needs
Building Linkages to HIXNY and the NYeC Digital Health Accelerator Program
Session Elements

• Hospital care transitions: scope of the problem & external forces
• Case study of community-based partnerships and approaches
• Moving to health-home coordination
Questions?
For more information

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HH Implementation Session 6: EHR 101

**Presenters:** Denise Reilly, MBA
Executive Director of the eHealth Network of Long Island

**Date & Time:** Wednesday April 18, 2012  2:30 pm eastern time

**Registration Link:** [https://cc.readytalk.com/r/bcx7gjmbek2](https://cc.readytalk.com/r/bcx7gjmbek2)

All training sessions (recordings and registrations) will be made available on the Medicaid website.

[http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ohitt_ehr_webinars.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ohitt_ehr_webinars.htm)