Partner with Health Services Advisory Group

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Presentation Outline

• About HSAG
• The Quality Improvement Organization (QIO) Program
• Quality Innovation Network (QIN)-QIOs
  – Healthy People, Healthy Communities
  – Better Healthcare for Communities
  – Better Care at a Lower Cost
• Champions for patient-centered care
• Engaging beneficiaries in their health and care
• Encouraging statewide and community-wide conversations on healthcare delivery
QIN-QIOs
The Centers for Medicare & Medicaid Services (CMS) separated medical case review from quality improvement work, creating two separate structures:

**Medical Case Review**
Beneficiary Family Centered Care-QIOs (BFCC-QIOs)

**Quality Improvement**
Quality Innovation Network-QIOs (QIN-QIOs)
Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare QIN-QIO for California, Ohio, Arizona, Florida, and the U.S. Virgin Islands.
1. Make care safer.
2. Strengthen person and family engagement.
3. Promote effective communication and coordination of care.
5. Work with communities to promote best practices of healthy living.
QIN-QIOs

• QIN-QIO Aims
  – Healthy People, Healthy Communities
    • Improving the health status of communities
  – Better Healthcare for Communities
    • Beneficiary-centered, reliable, accessible, and safe care
  – Better Care at a Lower Cost
Healthy People,
Healthy Communities
Better Healthcare for Communities: Cardiac Health

• Improve Cardiac Health and Reduce Cardiac Healthcare Disparities
  – Place health informatics specialists in physician offices to examine care delivery and business practices and recommend evidence-based changes for better clinical outcomes
  – Support Million Hearts® Initiative
  – Promote the use of **Aspirin**, **Blood pressure control**, **Cholesterol management**, and **Smoking assessment and cessation** (ABCS)
  – Work with racial and ethnic minority beneficiaries/dual-eligible, and providers to improve ABCS
Healthy People, Healthy Communities in Ohio

• Boost interest in diabetes self-management education (DSME) classes with physicians and community organizations.

• Introduce beneficiaries to Million Hearts®.

• Invite beneficiaries to join a network that designs forums to create heart- and diabetes-related education programs/tools.

• Host educational events for medical providers on heart-related best practices and help them use health information technology (HIT) for improved care to patients.

• Encourage beneficiaries to use online patient portals.
Healthy People, Healthy Communities: Diabetes Care

- Reduce Disparities in Diabetes Care:
  - Everyone with Diabetes Counts
  - Improve HbA1c, lipids, blood pressure, and weight control.
  - Decrease number of beneficiaries requiring lower-extremity amputations.
  - Provide and facilitate DSME training classes.
  - Increase adherence for appropriate use of utilization measures (HbA1c, lipids, eye exams).
Healthy People, Healthy Communities: EDC Goals

• Graduate 3,786 beneficiaries in DSME by 2019.
  – Focus on Medicare beneficiaries, dual-eligible, minority and/or rural populations.

• Work with care teams who have low rates of care in diabetes and/or cardiac measures.
  – Workflow redesign
  – Reminders
Healthy People, Healthy Communities: EDC Goals (cont.)

- Train-the-Trainer program
  - Develop and implement a Train-the-Trainer program to increase the number of lay leaders/peer educators
  - Facilitate the development of statewide DSME training sites
  - Assist entities to become AADE/ADA-certified
    - American Association of Diabetes Educators (AADE)
    - American Diabetes Association (ADA)
- Provide DSME education
CMS-Approved Educational Programs

• Diabetes Empowerment Education Program™ (DEEP)
• Stanford’s Diabetes Self-Management Program (DSMP)
• Project Dulce—Not yet in Ohio
• Others subject to CMS approval
Comparison

• **DSMP***
  – Two leaders
  – Minimum of eight participants to start
  – Six-week length
  – 2.5-hours long
  – Adult learning principles
  – Participatory

• **DEEP**
  – One leader
  – No minimum number of participants
  – Six-week length
  – 2-hours long
  – Adult learning principles
  – Demonstration
  – Participatory

*DSMP= diabetes self-management program
Topics Covered in All Models

• Healthy eating/meal planning
• Understanding the body
• Monitoring
• Risk factors
• Diabetes and physical activity
• Complications of diabetes
• Living with diabetes
  – Weekly action planning
  – Problem solving
  – Goal setting
We Couldn’t Do It Without Partners

- Ohio Department of Aging
  - Area Agencies on Aging
- Ohio Department of Medicaid
  - MyCare Ohio Health Plans
- Medicare Advantage Plans
- Physician offices
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Centers (RHCs)
- Community organizations
  - Senior housing
  - Senior centers
  - Faith-based communities
Data Collection and Sharing

• Demographics
• Pre- and post-surveys to evaluate learning/behavior change
  – Great results to date
• Pre- and post data on clinical outcomes
  – A1c
  – Lipids
  – Blood Pressure
  – Weight
  – Eye and Foot Exam
Coping Questions

Asking for support: 72% Pre-PAS, 91% Post-PAS
Asking doctor questions about treatment plan: 92% Pre-PAS, 96% Post-PAS
Ability to make a plan to control diabetes: 73% Pre-PAS, 89% Post-PAS
Empowerment Questions

In the last week, average number of days doing self-care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Pre-PAS</th>
<th>Post-PAS</th>
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<tbody>
<tr>
<td>Eating Fruits and Vegetables</td>
<td>3.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Exercising 30 Minutes</td>
<td>3.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Testing Blood Sugar</td>
<td>4.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Taking Medications</td>
<td>6.6</td>
<td>6.8</td>
</tr>
<tr>
<td>Checking Feet</td>
<td>5.0</td>
<td>5.6</td>
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Better Healthcare for Communities
Better Healthcare for Communities: Making Hospitals and Hospital Stays Safer

• Reduce healthcare-acquired conditions in hospitals (HACs)
  – Work to reduce the number of the most common infections.

• Reduce hospital-acquired conditions (HAIs)
  – Help prevent infections by teaching and coaching hospitals to follow best practices in caring for beneficiaries.
Better Healthcare for Communities: Making Hospitals and Hospital Stays Safer in Ohio

• Work to decrease the number of infections that beneficiaries may get when they are hospitalized.

• Engage beneficiaries to be good stewards in their own prevention of healthcare associated infections.
Better Healthcare for Communities: Reducing HACs in Nursing Homes (NHs)

• Reduce Healthcare-Acquired Conditions (HACs)
  – Work to improve the care that beneficiaries receive in nursing homes (e.g. reducing the occurrence of high pressure ulcers).
  – Improve rates of mobility among long-stay nursing home residents.
  – Reduce use of unnecessary medications in dementia residents.
Better Healthcare for Communities: Reducing HACs in NHs in Ohio

• Work to improve quality of care for NH residents.
• Assist NHs with implementing Quality Assurance Performance Improvement (QAPI) practices.
• Train NH staff and resident or family member peer coaches to help spread success stories, best practices, and quality improvement strategies.
Better Healthcare for Communities: Coordination of Care

- Coordination of Care
  - Work to reduce the number of hospitalizations, readmissions, and emergency room visits of beneficiaries.
  - Work to reduce adverse drug events (ADEs) that contribute to patient harm, hospital admissions, or readmissions.
  - Collaborate with community providers on strategies to help medical professionals work better together.
Better Healthcare for Communities: Coordination of Care in Ohio

We are working with beneficiaries and families:
• to improve self-management of chronic disease and prevent hospital admission, re-hospitalizations, and emergency room use.

We are working with communities and healthcare providers:
• to improve the care coordination for beneficiaries and their family members across provider settings
• to improve medication adherence and safety and prevent ADEs.
Re-hospitalizations Among Patients in the Medicare Fee-For-Service Program

• New England Journal of Medicine
Stephen F. Jencks, MD, MPH, Mark Williams, MD, and Eric A Coleman, MD, MPH

Abstract
• 1 in 5 Medicare beneficiaries are readmitted within 30 days
  – Equates to 2.3 million patients
• National cost of over $17 billion
• Half of patients readmitted had no physician contact
• 70 percent of surgical readmits were for chronic medical conditions
• Potentially, 40 percent of all readmissions are preventable
# Changing Paradigms

<table>
<thead>
<tr>
<th>Traditional focus</th>
<th>Transformational Focus</th>
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<tbody>
<tr>
<td>Immediate clinical needs</td>
<td>Comprehensive needs of the whole person</td>
</tr>
<tr>
<td>Patients are the recipients of care and the focus of the care team</td>
<td>Patients and family members are essential and active members of the care team</td>
</tr>
<tr>
<td>Variety of different teams</td>
<td>Cross continuum team with a focus on the patients experience over time</td>
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Source: [www.ihi.org/knowledge/pages/audio and video/ihi approach to reducing avoidable rehospitalizations.aspx](http://www.ihi.org/knowledge/pages/audio and video/ihi approach to reducing avoidable rehospitalizations.aspx)
2015 All-Cause Readmission Rates in Ohio by Region

Source: Calendar Year 2015 Medicare FFS claims data.
What Is the Community Coalition?

- Identify a common understanding of the readmission and ADE issues in the community.
- Establish a collaborative partnership with local providers to improve coordination of care.
- Share best practices and evidence-based interventions with community partners.
• Interventions to Reduce Acute Care Transfers
  – Designed to improve care of nursing home (NH) residents by identifying and managing situations that commonly result in transfers to the hospital

• Results of CMS pilot
  – 50 percent reduction of hospitalizations in three NHs with high baseline rates
  – 36 percent reduction in hospitalizations rated as potentially avoidable
Areas for Change in Potentially Preventable Readmissions: Education

Improve quality of inpatient care

1. Implement education
   - Choose a champion.
   - Customize patient education.
   - Use teach back regularly.
     • Especially with regard to understanding discharge instructions
   - Teach patient self-managed care.
   - Involve different disciplines to teach.
     • For example, registered respiratory therapist (RRT) is required to teach respiratory methods.
   - We do not get reimbursed on education.

Currently, an average of 8 minutes is spent on education of our patients in the hospital!

Areas for Change in Potentially Preventable Readmissions: Rounds, Facilities, Follow-Up

2. **Set up multidisciplinary rounds**
   - Schedule communication times to discuss patient as a team.
   - Set up a discharge plan that is looked at and signed off on by all disciplines.
     » Respiratory Therapy should always be involved with chronic lung patient discharge plan

3. **Use pulmonary rehabilitation facilities**
   - Within three days of discharge
   - Teach and explain medications and lifestyle changes, exercises, etc.
     » It is shown that when patients go to a long-term acute care facility before they go home there are three times fewer readmission bounce backs.

4. **Establish a follow-up plan before discharge**
   - Provide patient medications at discharge.
   - Have a dedicated advocate/coach for patient at discharge and beyond.
Areas for Change in Potentially Preventable Readmissions: Post-Discharge, Meds, Proactive

5. Perform early post-discharge follow up
   - Remote monitoring/telehealth
     • It was shown that an RN or RRT giving patient education over the phone reduced hospital admissions by 40 percent and emergency department visits by 41 percent for COPD patients.¹

6. Conduct reconciliation of medication

7. Be proactive rather than reactive
   - There is a lack of preventative healthcare.
   - Symptoms treated, not the root cause²

COPD= chronic obstructive pulmonary disease

Adverse Drug Events (ADEs) and Readmissions

ADEs prolong hospital length of stay by approximately 1.7 to 4.6 days.

Cost up to $5.6 million per hospital.

Identified as the most common causes of post-discharge complications. Occurring within three weeks of hospital discharge.

Depending on the type of ADE, overall costs range from $677 to more than $9,000 per patient.

ADEs have been defined by the Institute of Medicine as “an injury resulting from medical intervention related to a drug.”
Champions for Patient-Centered Care Systems
Champions for Patient-Centered Care Systems Goals

• Close health literacy gaps to help beneficiaries make informed health decisions.
• Engage beneficiaries for shared medical decision-making.
• Coach empowered self-care among beneficiaries.
Engage Medicare Beneficiaries in Their Health and Care: Our Goals

• Partner with beneficiaries to:
  – Improve their quality of life.
  – Increase preventive health knowledge.
  – Increase health resource knowledge.
  – Help them partner with their doctors.
Encourage Conversations on Healthcare Delivery

• Fortify Learning and Action Networks (LANs) by including these unique voices:
  – Medicare beneficiaries, families, caregivers, and support providers
  – Practitioners, doctors, and other healthcare professionals
  – People from the medical and business communities representing those groups
Food for Thought

“If you want to go quickly, go alone. If you want to go far, go together.”
— African proverb
Thank you!

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HSAG is a centralized, no-cost resource for knowledge and tools that help partner organizations improve health quality, efficiency, and value for their constituents.

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