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The Power of a Community: Reducing Readmissions and Maximizing Patient Goals

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**Program Manager, Patient Safety and Care
Transitions**


www.ccmemedicare.org

Objectives

- Present an overview of CMS Care Transitions work.
- Describe the impact of community engagement on reducing avoidable readmissions.
- Effecting change through patient engagement.



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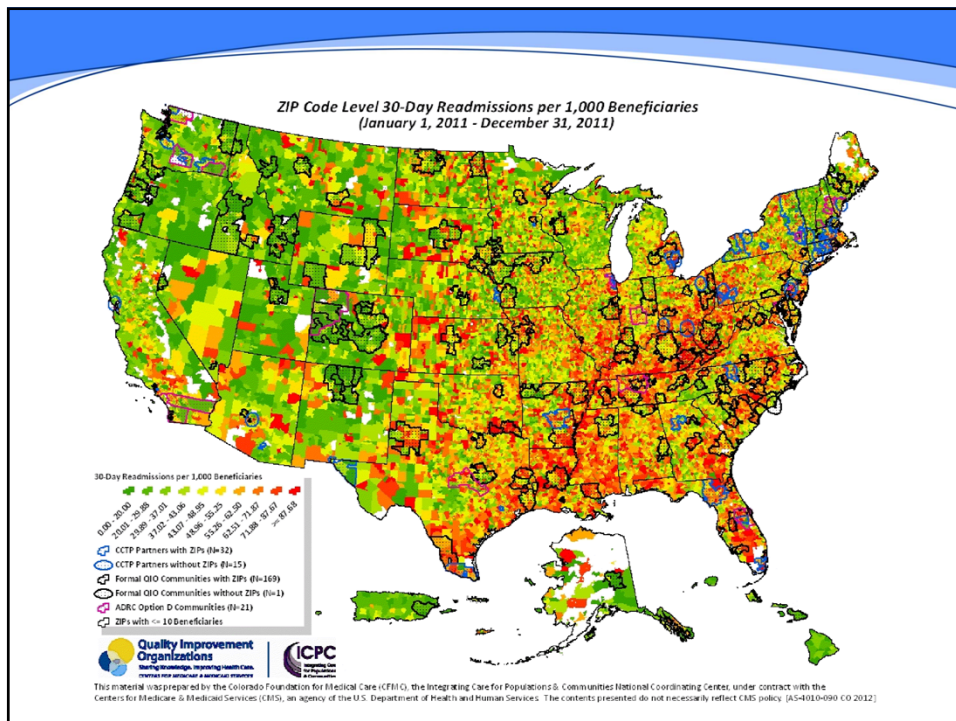
For the Nation

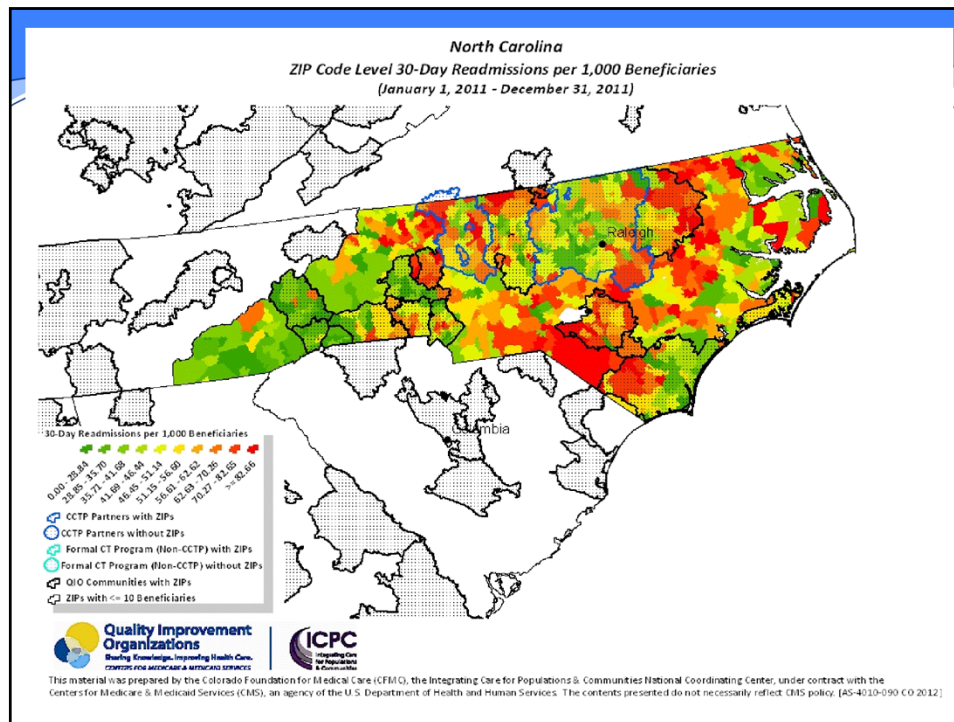
Partnership for Patients – Care Transitions

“Safe, effective, and efficient care transitions require thoughtful collaboration among health care providers, hospitals, nursing homes and other facilities, social service providers, patient caregivers, and patients themselves.”

Partnership for Patients

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Goals of Care Transitions

- Improve transitions of beneficiaries from inpatient setting to other care settings.
- Improve the quality of care.
- Reduce readmissions for high risk beneficiaries.
- Document measurable savings to the Medicare program.

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TRACKING COMMUNITY TRENDS

By Marsha Thorson, Jane Brock, Jason Mitchell, and Joanne Lynn

Grand Junction, Colorado: How A Community Drew On Its Values To Shape A Superior Health System

ABSTRACT For the past decade, the high-quality, relatively low-cost health care delivered in Grand Junction, Colorado, has led that community to outperform most others in the United States. Medicare patients in Grand Junction have fewer hospitalizations, shorter hospitalizations, and lower mortality rates after hospitalization than do Medicare patients in comparison hospitals. Effective, efficient care is delivered in Grand Junction through separate, self-governing organizations that perceive health care as a community resource. This article describes how the various stakeholders in Grand Junction have addressed problems and set standards for the system. The lessons could apply to broader health reform efforts in communities around the country.

<http://content.healthaffairs.org/content/29/9/1678.full.html>

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Can it be replicated? Lessons from the Care Transitions Theme

The real world as opposed to 'clearly defined borders'

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14 QIOs with 14 Target Communities

- AL: Tuscaloosa
- CO: Northwest Denver
- FL: Miami
- GA: Metro Atlanta East
- IN: Evansville
- LA: Baton Rouge
- MI: Greater Lansing Area
- NE: Omaha
- NJ: Southwestern NJ
- NY: Upper Capital
- PA: Western PA
- RI: Providence
- TX: Harlingen HRR
- WA: Whatcom County

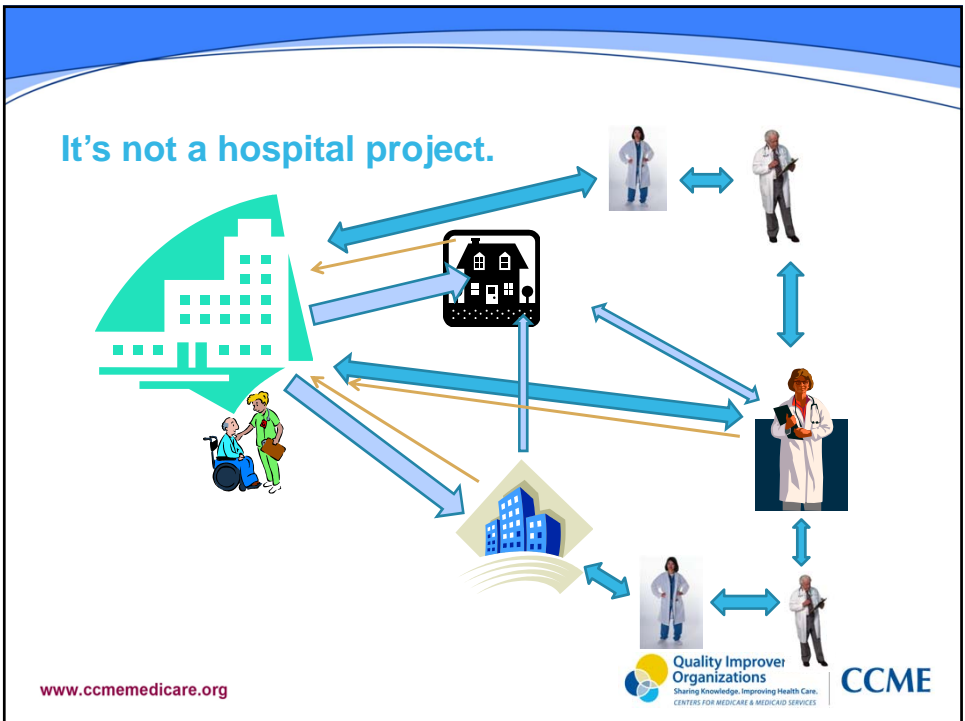
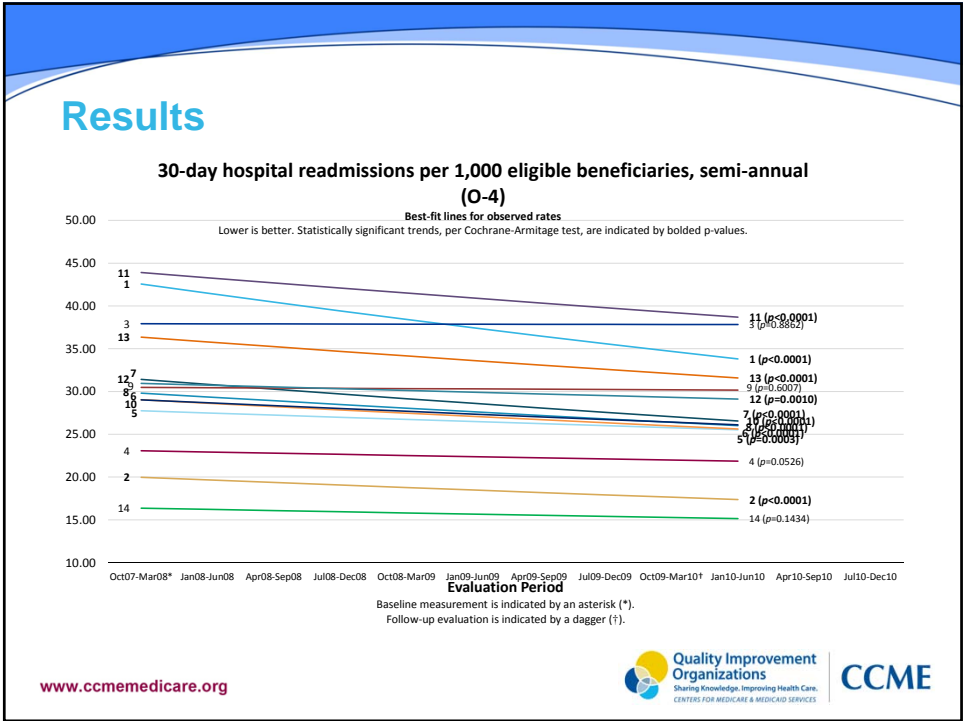


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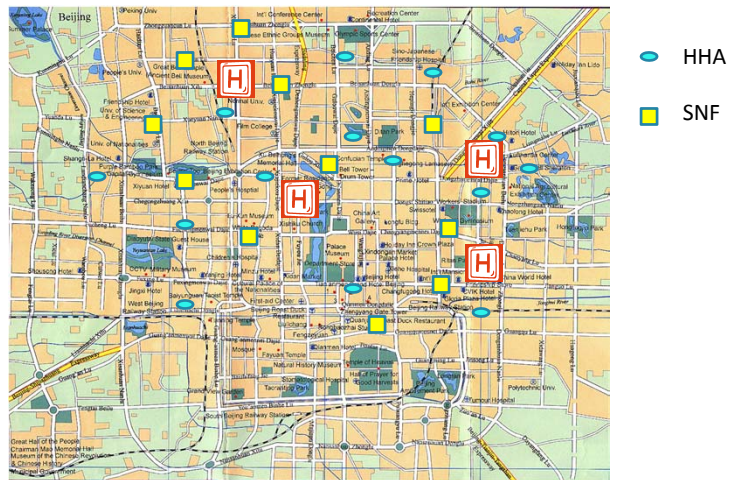
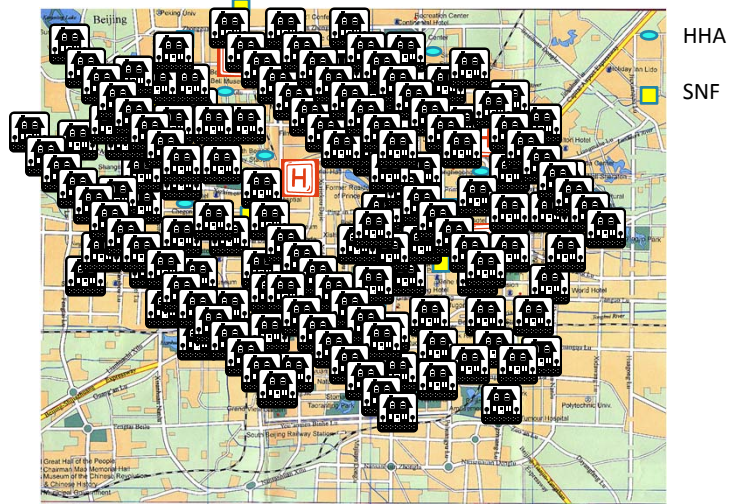


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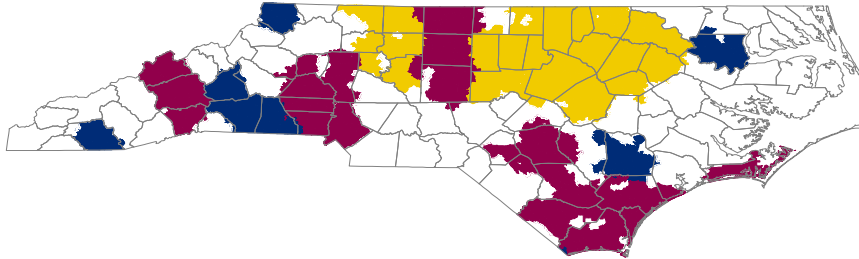


It's a Community Problem



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Care Transitions Communities in NC



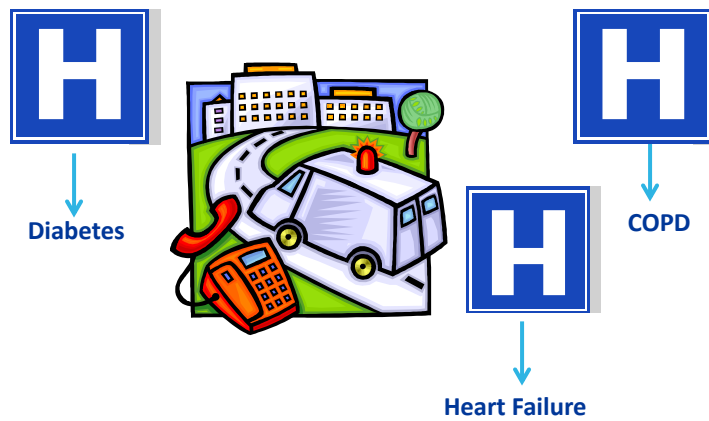
■ CCTP Awardee ■ Engaged Community ■ Recruited Community

CCME provides 3 levels of support to our community partners:
Engaged communities receive one-on-one support from CCME consultants in community building and technical assistance.
Recruited communities are further along in their community development and receive more intensive service.
CCTP communities are recruited communities awarded the CMS Community Care Transitions program grant.

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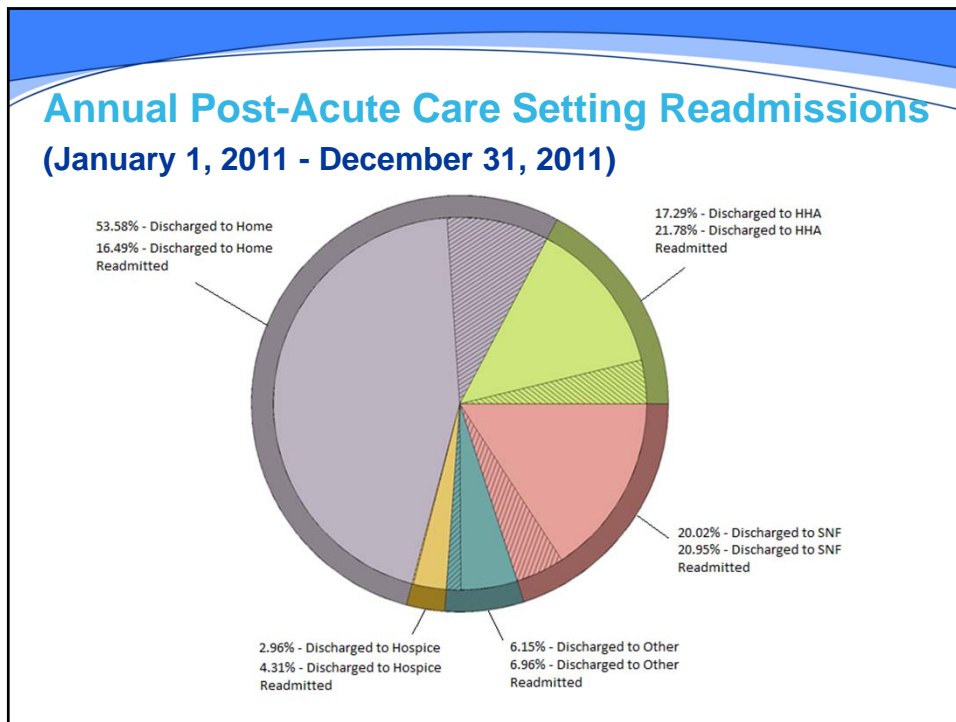


Top Conditions for Admission & Readmission



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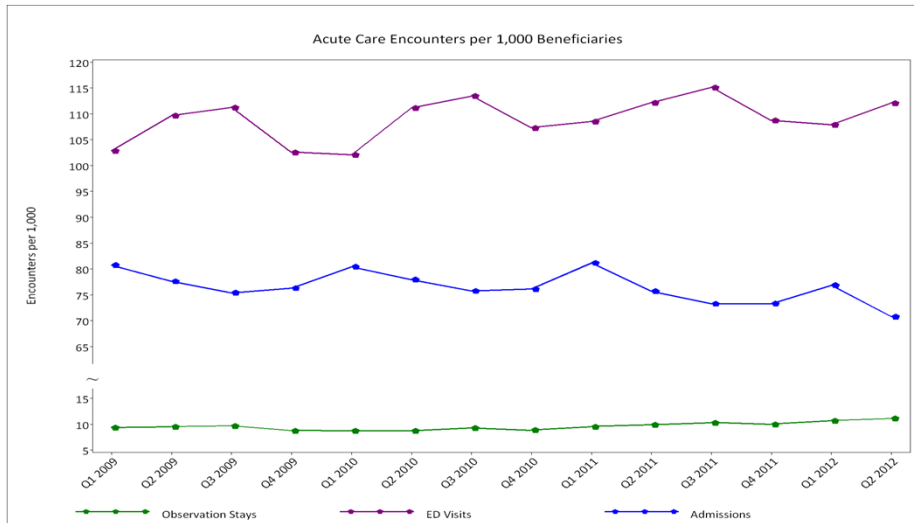


North Carolina

Drivers of Readmission

- Lack of coordinated care among providers
- Lack of integrated electronic medical records
- Lack of medication management
- Lack of patient engagement
- Lack of advanced care planning
- Social isolation
- Poverty

Quarterly ED Visits/Observation Stays



It Takes a Community



But it Begins with a leader.

To engage and motivate the patient and family to make goals for care.

To assess, treat, and follow up with the patient.

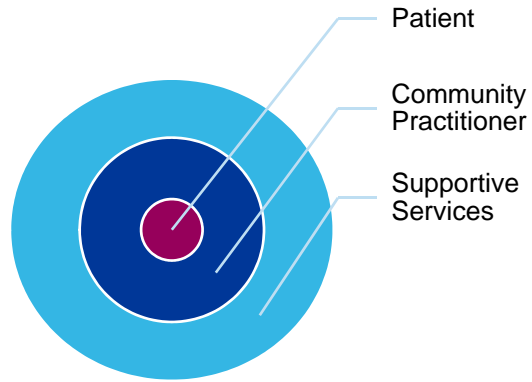
Coordinate effective services to enhance the quality of the patient's care.

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Interventions at Work

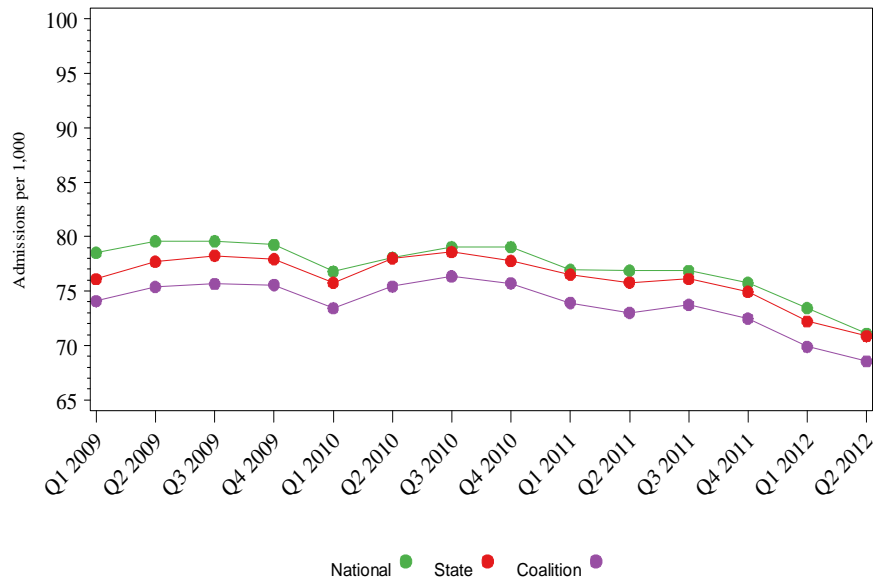
- Utilizing EMS to provide transition follow up
- Clinical pharmacy in the hospital and community
- Schedule appt and follow-up phone calls post-discharge to physician and patient
- Expanding EHR reach to community partners
- Area on Aging working with Care Transitions teams in some hospitals

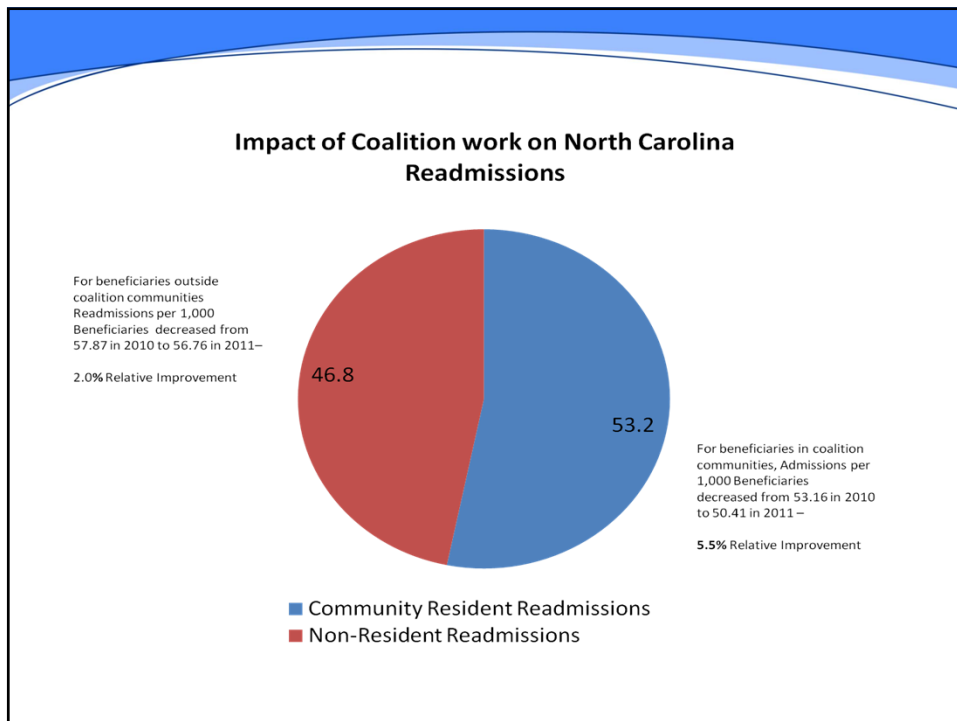
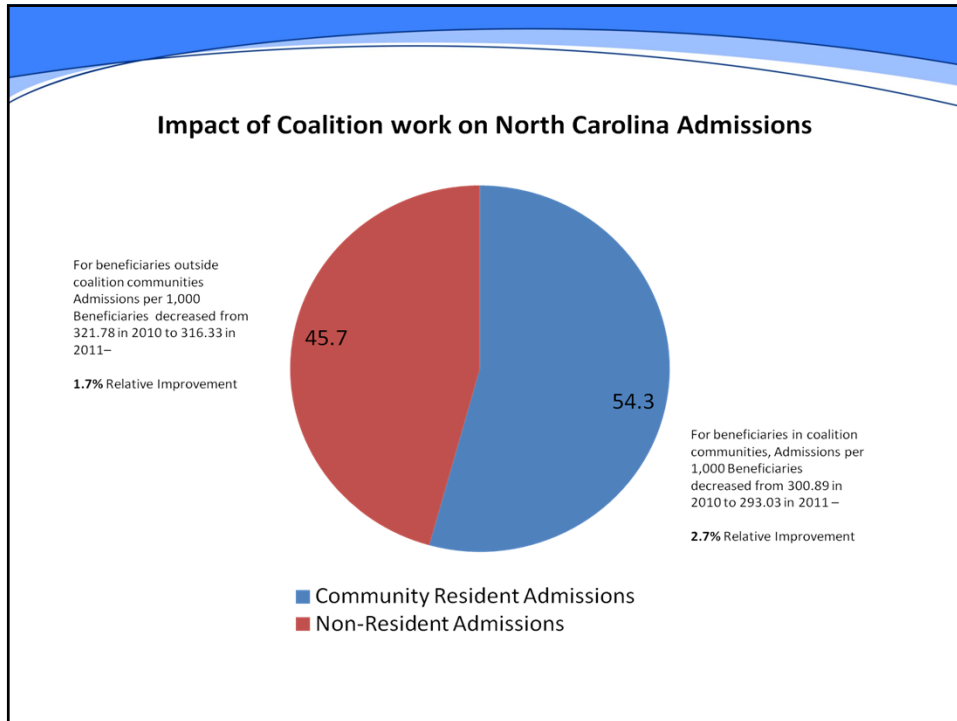


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Seasonally Adjusted Quarterly Admissions per 1,000





QIO Support to the Community Through Learning and Action Events

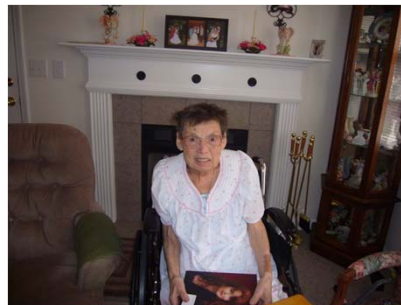


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Mend with Friends

In July 2011, Senior Services received a \$50,000 Wal-Mart Foundation /Meals-On-Wheels Association of America Grant to provide **rapid** nutrition and support services to patients being discharged from local hospitals.



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North Carolina

The Faces of Disparity

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Why are people readmitted?

Provider-Patient interface

- Unmanaged condition worsening
- Use of suboptimal medication regimens
- Return to an emergency department

↳ **Unreliable system support**

- Lack of standard and known processes
- Unreliable information transfer
- Unsupported patient activation during transfers

↳ **No Community infrastructure for achieving common goals.**

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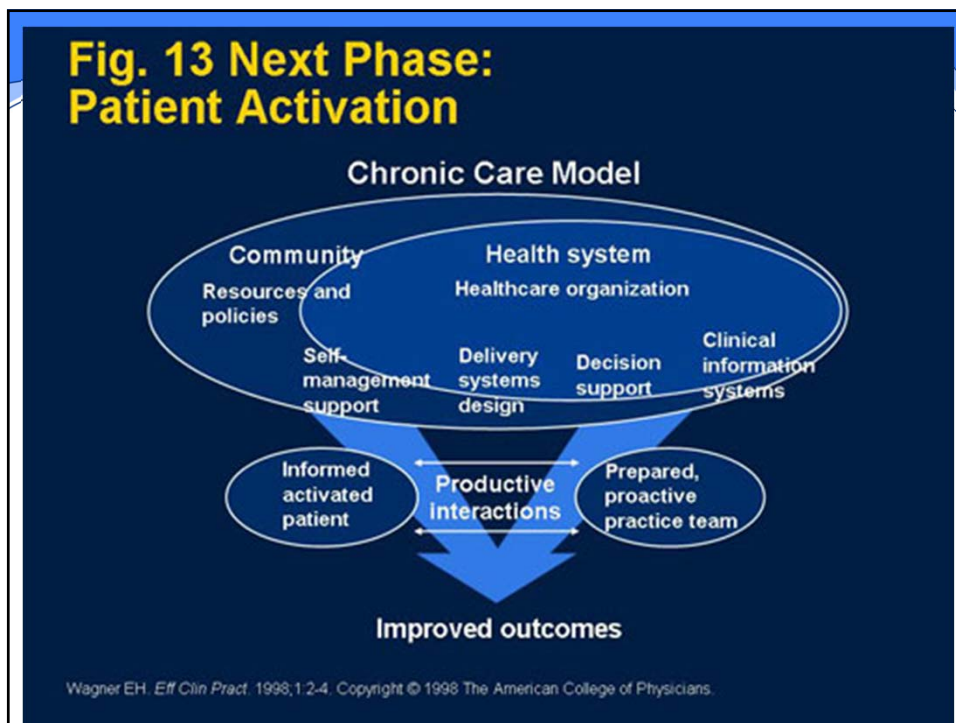
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What's he saying? I sure hope my wife is getting this..

No I'm good to go. Whatever you say is what we'll do Doctor

Blah blah blah, blah blah. Any questions?

1. Patient activation trumps all.





What is the Patient's Goal?

PATIENT ACTIVATION

The Patient Activation Measure

www.insigniahealth.com

Sample Questions:

#1: "When all is said and done, I am the person who is responsible for taking care of my health."

#12: "I am confident I can figure out solutions when new problems arise with my health"

Difficulty Structure of 13 Items

The PAM is scored on a 100 point continuum. Most patients score between 35 and 80

Item	Level	Score (approx.)
1	Level 1	38
2	Level 1	41
3	Level 2	42
4	Level 2	43
5	Level 2	44
6	Level 2	44
7	Level 2	45
8	Level 2	47
9	Level 3	50
10	Level 3	51
11	Level 3	52
12	Level 4	53
13	Level 4	54

Level 1: Does not yet believe they have active/important role
 Level 2: Lack confidence and knowledge to take action
 Level 3: Beginning to take action
 Level 4: Maintaining behavior over time

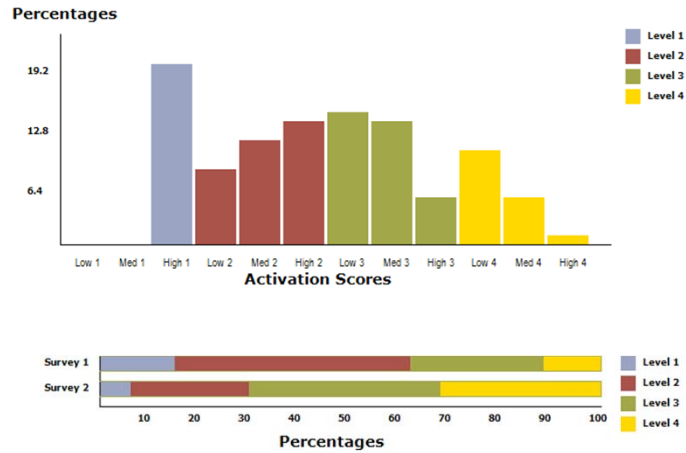
Knowledge, skills and confidence

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The PAM is Very Helpful to Guide Interventions



The CMS Discharge Planning Checklist


<http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf>

Planning for Your Discharge:

A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting



Ask the Community to Help

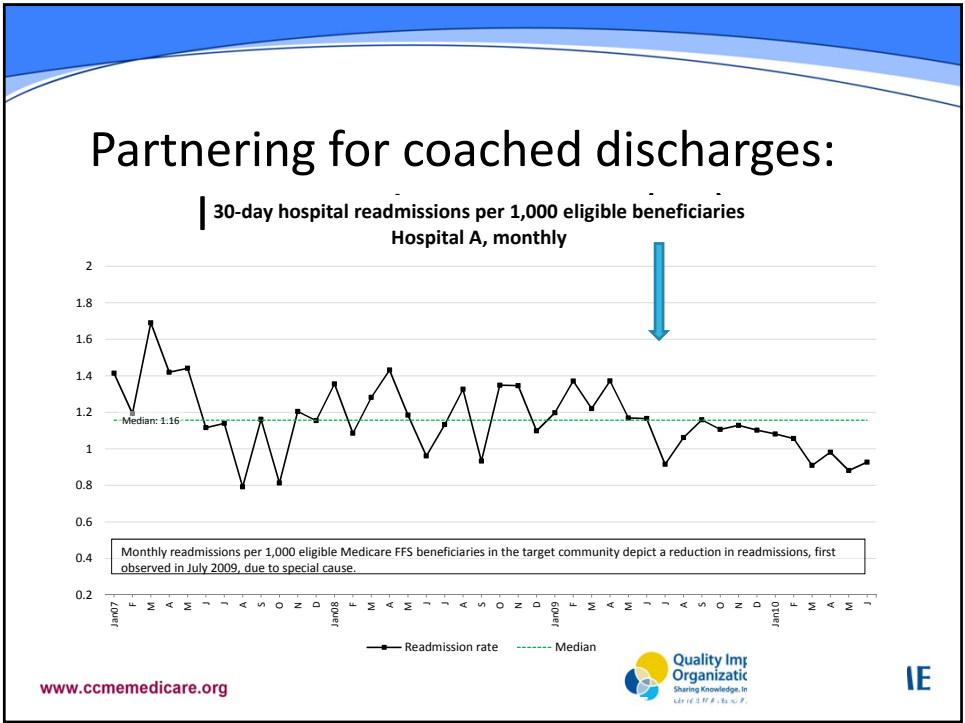
Personal Health Record for



Remember to take your
Personal Health Record
with you to all doctor visits.

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What Can You Do In a Week ?

<http://youtu.be/fW8amMCVAJQ>

Your Charge – Start a Movement

1. Share what you learned with 2-3 other individuals in your organization- seed your knowledge
2. Find out what is going on within your community regarding reducing readmissions – share the work

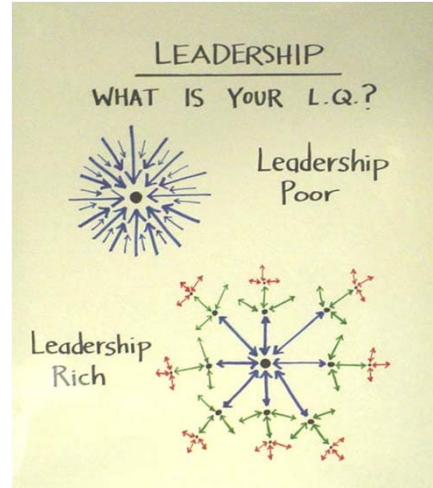
Join a Care
Transitions
Movement

Create the
Urgency, Fuel
the Vision

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Community Organizing Techniques

- Tie participation to values
- Include personal narratives
- Intentionally develop other leaders
- Intentionally develop relationships
- Develop flexible tactics



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This material was prepared by The Carolinas Center for Medical Excellence (CCME), the Medicare Quality Improvement Organization for North and South Carolina, 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. 10SOW-NC-C8-13-30