

VALUE Project Final Results Part 2 of 2 CO and NM Experience

This material was prepared by CFMC, the Medicare quality Improvement Organization for Colorado, 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. PM-418-039 CO 2008

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Background

Pilot to implement the Care Transitions
Intervention*

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Pilot to reduce geographic variation in resource
utilization

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Need to develop methods of creating
'communities' to develop common processes

*Coleman, et al. JAGS 52:1817-1825, 2004.

www.caretransitions.org

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Thank You

A big thanks to CMS for allowing these two special projects to work together

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CFMC's multi-provider approach

- At least one hospital, one HHA, one SNF/LCT and one physician office
- Hospital first
- They identify their partners

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Our Recipe

1. Understand the current state
2. Facilitate site exchange visits
3. Train direct providers in the CTI
4. Brainstorm a new model
5. Measure and feedback important results

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Community-based Care Coordination

- NM community attended CTI training in CO

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The VALUE Project: The New Mexico Experience

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QI Manager: Sheila Conneen, MSN, PhD, MPH *

QI Manager: Carlene Brown, MPH, CPHQ *

Chief Operating Officer: Boyd Kleefisch, FACHE

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* Presenters

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Initial Target: Higher Utilizer(s) of Acute Care Services in New Mexico

Measure*	New Mexico	ABQ HRR	Hospital A
Hospital days/decedent, last six months of life	11.1	10.7	12.9
Inpatient reimbursement/decedent, last six months of life	\$11,327	\$11,598	\$15,308
Percent of decedents enrolled in hospice, last six months of life	30.8	30.8	16.0
Intensive care unit (ICU) days per decedent, last six months of life	2.9	2.7	1.9

* Dartmouth Atlas of Health Care, 1999-2003 data

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Comparing Colorado to New Mexico

Measure	Colorado HSA / County	N.M. Hospital HSA / County
Hospital days per decedent, last six months of life*	5.4 (HSA)	8.4 (HSA)
Population estimate (2006)**	134,189	126,473
Median household income (2004)**	\$40,045	\$36,821
Percent 65 years+ old (2004)**	15%	9%
Percent White, including Hispanic (2004)**	96%	57%
Percent American Indian and Alaska Native (2004)**	1%	40%

* Dartmouth Atlas of Health Care, 1999-2003 data

** U.S. Census Bureau, State and County QuickFacts

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Comparing Colorado to New Mexico

Measure	Colorado Community Hospital	N.M. Community Hospital
Hospital days/decedent, last six months of life	8.7	12.9
Inpatient reimbursement/ decedent, last six months of life	\$10,531	\$15,308
Percent of decedents enrolled in hospice, last six months of life	41%	16.0%
Intensive care unit (ICU) days per decedent, last six months of life	1.6	1.9

* Dartmouth Atlas of Health Care, 1999-2003 data

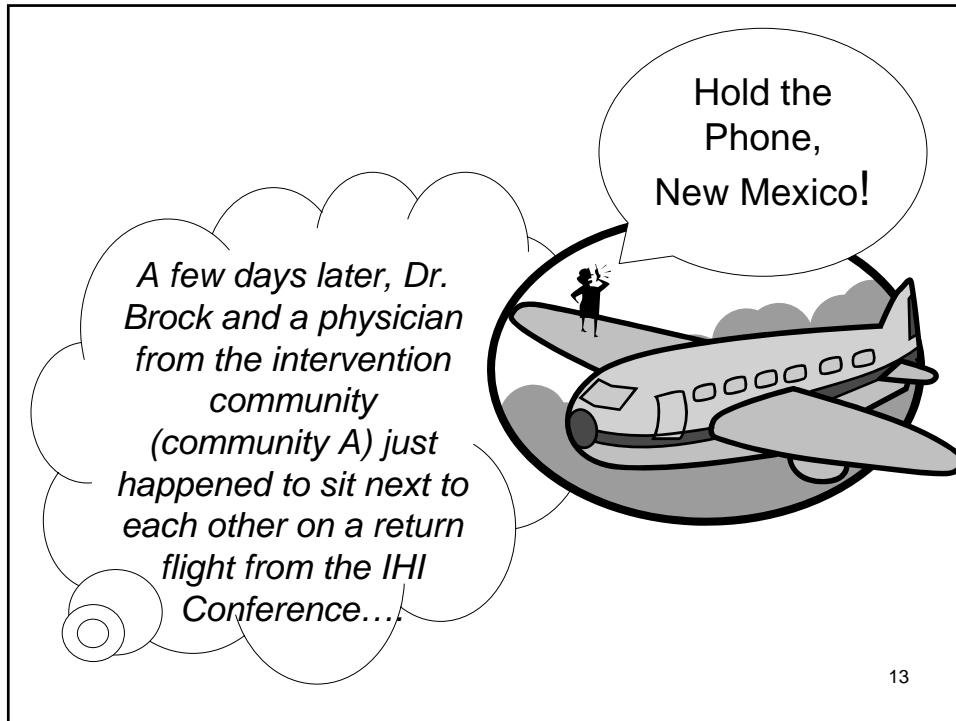
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Recruitment Attempt #1

- Met with target hospital and IPA group
- Showed them Dartmouth data
- Proposed project matching Colorado hospital to this N.M. hospital
 - Geographically proximate: two hours apart
 - Learn from high performer
 - Similar demographics except for age/ethnicity

But...they weren't buying it!

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Comparing Two New Mexico Communities and Community Hospitals

	Hospital A Intervention Community	Hospital B Reference Community
Population of county (2006)*	126.5 K	71.8 K
Percent White (incl. Hispanic Wt./ Percent Native American (2006)*	58% / 38%	22% / 74%
Median Household Income (2004)*	\$36,821	\$27,301
Hospital days/decendent, last six months of life**	12.9	10.9
Inpatient reimbursement/ decendent, last six months of life**	\$15,308	\$11,289
Percent decedents enrolled in hospice, last six months of life**	16.0%	21.4%

* U.S. Census Bureau, State and County QuickFacts

** Dartmouth Atlas of Health Care, 1999-2003 data

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Comparing Two New Mexico Community Hospitals

- Both are community-owned
- Both are co-located near Indian Health Service (IHS) hospitals
- Hospital B has its own home health agency
- Hospital A does not

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Comparing Two Similar New Mexico Communities

Measure	Intervention Community		Reference Community	
	Community Hospital	IHS Hospital	Community Hospital	IHS Hospital
Hospital days/decendent, last six months of life*	12.9	19.0	10.9	15.5
Inpatient reimbursement/decendent, last six months of life*	\$15,308	\$19,980	\$11,289	\$16,835
Percent decedents enrolled in hospice, last six months of life*	16.0	2.8	21.4	2.9
ICU days per decendent, last six months of life*	1.9	NA	2.7	NA

* Dartmouth Atlas of Health Care, 1999-2003 data

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Care Subsequent to Pneumonia, Heart Failure, or Acute Myocardial Infarction Index Admissions

	New Mexico	Intervention Community Hospital	Reference Community Hospital
Percent patients with readmit to same hospital within 30 days post discharge*	25%	21%	5%

* Part A Medicare claims 2005-2006 – VALUE Measures

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Home Health Agency (HHA) Hospitalizations

Agency	% of Patients Hospitalized from Home Health 2005Q4-2006Q3
Statewide / National	26% / 28%
Community A:	20%
Five HHAs	38%
	45%
	48% (2)
Community B:	
Two HHAs	25% (2)

Reference: Home Health Compare

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Revised VALUE Project Goals

Focus efforts on Intervention Community

- Reduce # Hospital Days in Last 6 months of life
- Reduce 30 day readmissions
- Reduce Home Health hospitalization rates

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Bringing Reference Community Together

- Met with both hospital leaders together
- Obtained data sharing agreements
- Included HHA
- IHS Palliative Care expert: Tim Domer, MD
- Project Lead: Jane Brock, MD

Goals Established

- Work together to improve access to nursing homes, home health and hospice for IHS patients
- Work with palliative care expert to incorporate culturally sensitive patient management team approach across settings

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Bringing Intervention Community Together

- Held health care community meeting for hospitals, nursing homes, home health and IPA to identify issues:
 - Perceived cultural barriers to hospice and access issues to palliative care for Native Americans
 - Payment issues and barriers between hospitals
 - Lack of coordination across settings
- Case managers from both hospitals and one HHA attended transitions of care (ToC) training with QIO team in Colorado with Eric Coleman

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Intervention Community Planning

- Held First Collaborative Planning Meeting
 - Community hospital CEO, senior leaders
 - IHS hospital QI Director and Utilization Manager
 - Five HHAs
 - Two nursing homes
 - Physician, Medical Director (nursing homes)
 - COO from IPA
- VALUE project staff presented on ToC tools, communications, community building, and using the Model for Improvement

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Intervention Community Goals

- Review re-admission data (one HHA and IHS hospital)
- Develop a collaborative approach to improve communication and reduce readmissions to both hospitals
- Test and implement ToC tools
- Implement personal health record (PHR) for patients
- Address medication management and pharmacy access issues for Native Americans
- Test the addition of hospice beds in community hospital

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Intervention Activity

- IHS hospital has developed a culturally appropriate PHR being tested by discharge planners
- IHS and community hospitals have begun to collect data on their readmissions
- Nursing homes and HHAs have begun to implement SBAR
- HHA is tracking all readmissions by physician
- Geriatrician, the medical director for most of the nursing homes in the area, is a project champion

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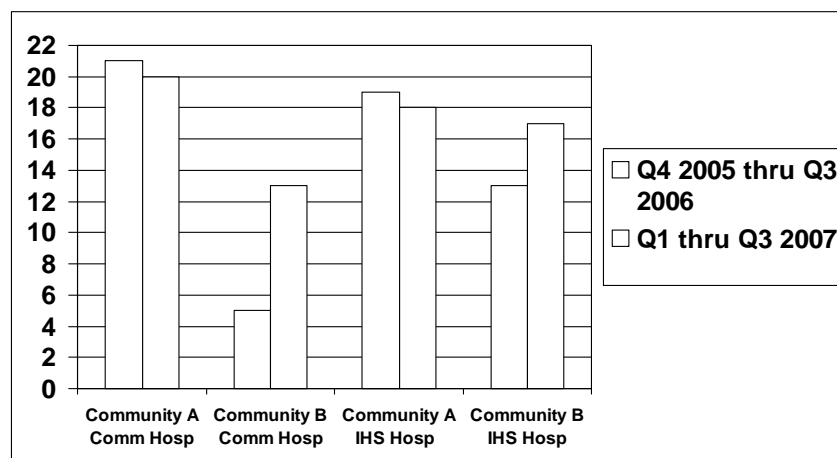
Keeping a Community Together

- Give them data, but not excessive
- DON'T say overutilization
- People, relationships, and history affect the "acceptability" of data
- Maintain communication with individuals in collaborative group
- Attend collaborative meetings to provide direction and technical assistance
- Involve hospital leadership as opinion leaders
- Provide training opportunities for staff to come together across settings

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Interim Remeasurement: 30 day Re-admissions

(initial AMI, PNE, and HF admissions, rate/100 for same hospital 30 day readmission)

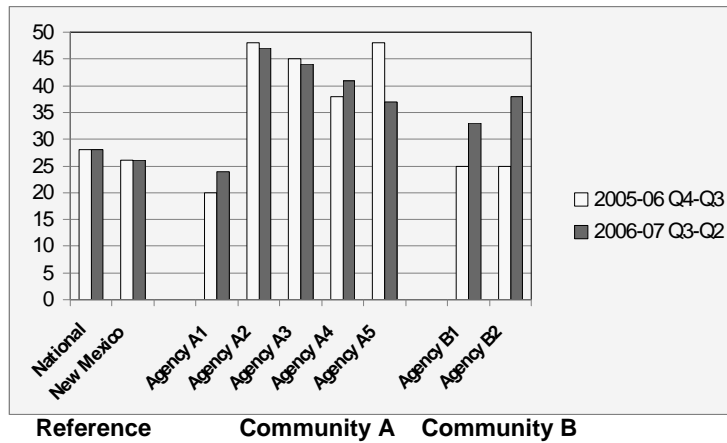


Source: ISAT Part A Claims Abstract

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Remeasurement: Home Health Agency (HHA) Hospitalizations

(Home Health Acute Care Hospitalization Rates/100)



Reference: Home Health Compare

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Recommendations for Future Projects

- Understand the community before going in
- Stay flexible on assumptions about community issues
- The drivers of acute care services utilization are not always as straight-forward as would appear
- Access to home health, hospice and nursing homes may be limited
- Utilization of these services may be affected by cultural preferences

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Recommendations for Future Projects

- The IHS and Medicare systems have different payment and utilization structures that need to be considered for transitioning patients
- Bringing and keeping cross-setting providers together is labor-intensive, but developing a patient-focused approach requires eliminating silos of care
- This should be at least a two-year project in order to grow a community of care and see results of system changes

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The VALUE Project: The Colorado Experience

The VALUE Team:

Jane Brock, Medical Officer
Alicia Goroski, VALUE Project Manager
Jason Mitchell, Health Data Analyst
Jennifer Regensberger, Biostatistician
Maureen O'Brien, Senior Scientist

The Transitions of Care Team:

Jane Brock, Medical Officer
Marsha Thorson, TOC Project Manager
Risa Hayes, Quality Improvement Coach
Jason Mitchell, Health Data Analyst
Christina Underwood, Project Assistant

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Results – Community 1

- Outpatient physician office took the lead
- Tested modified model of CTI – found to be very difficult
- Dedicated a half-time coach position in January 2008
- Have coached 10 patients
- Continuing to do this work beyond this project
- Expanding to patients discharged from SNF

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Results – Community 2

- Hired two dedicated coaches (one coached Medicare FFS patients, the other coached Medicare MCO patients)
- Implemented CTI in August 2007 and concluded in February 2008

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Results – Community 2

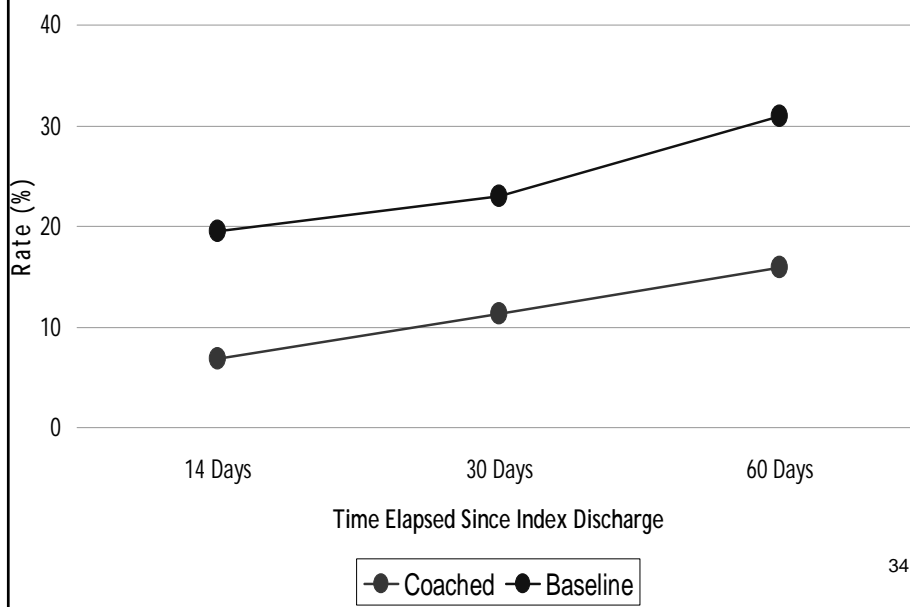
FFS Patients Only
(N=157)

	14-day readmits	30-day readmits	60-day readmits
Coached Patients	6.82	11.36	30.97
Non-Coached Patients	19.47	23.01	15.91
P value*	.0554	.1207	.0707

*calculated using Two-sided Fisher's Exact Test

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Readmission Rate as a Function of Index Hospitalization Discharge for FFS Patients



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Results – Community 2

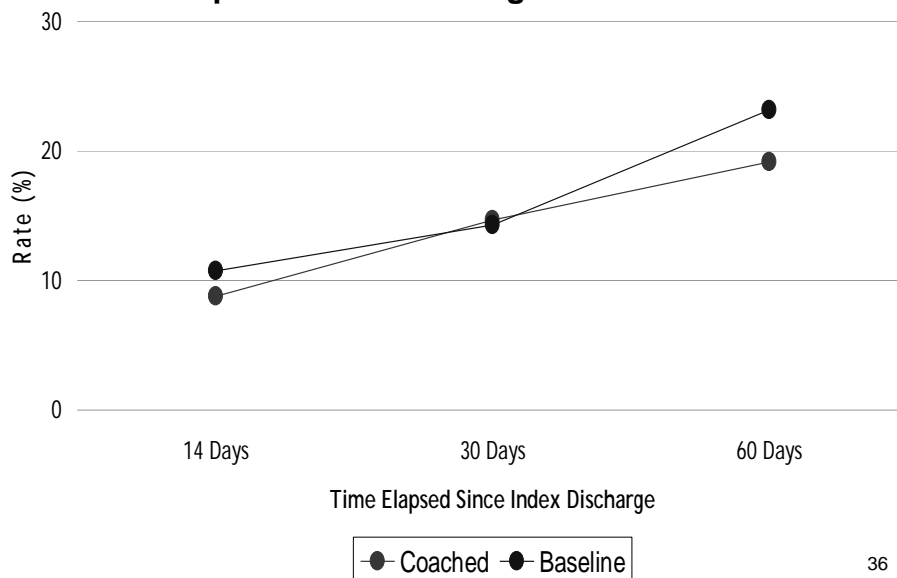
MC Patients Only
(N=124)

	14-day readmits	30-day readmits	60-day readmits
Coached Patients	8.82	14.71	19.12
Non-Coached Patients	10.71	14.29	23.21
P value*	.7675	1.0	.6596

*calculated using Two-sided Fisher's Exact Test

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Readmission Rate as a Function of Index Hospitalization Discharge for MC Patients



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Results – Community 2

All Patients (FFS & MCO)

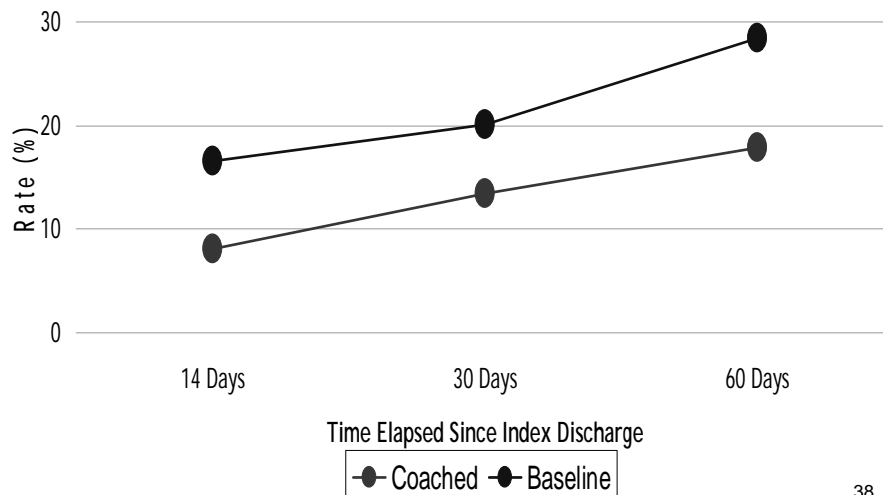
(N=281)

	14-day readmits	30-day readmits	60-day readmits
Coached Patients	8.04	13.39	17.86
Non-Coached Patients	16.57	20.12	28.40
P value*	.0470	.1529	.0472

*calculated using Two-sided Fisher's Exact Test

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Readmission Rate as a Function of Index Hospitalization Discharge for All Eligible Patients



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