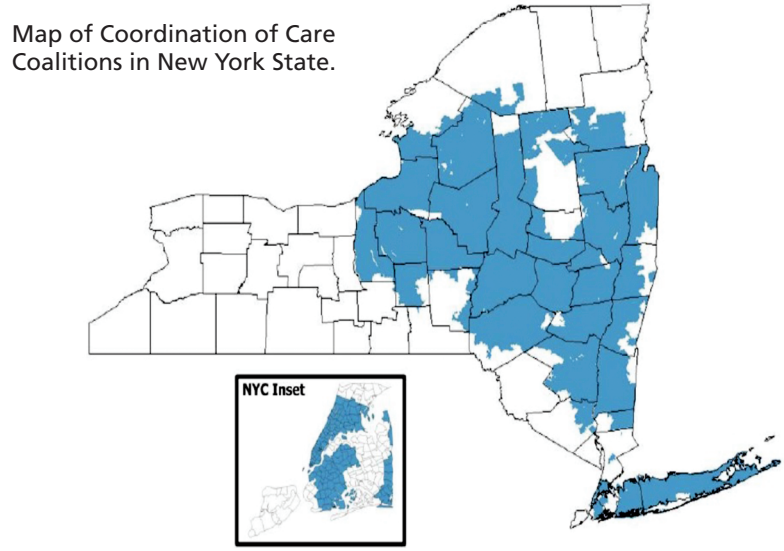
Improving Coordination of Healthcare, Communication and Patient/Caregiver Knowledge by Fostering Community-based Coalitions, Teamwork and Patient-centered Care



Map of Coordination of Care Coalitions in New York State.

The Challenge

Avoidable hospital readmissions, poor patient satisfaction scores and a lack of comprehensive discharge planning are growing problems nationwide. Research shows that 17.5 percent of Medicare beneficiaries are rehospitalized within 30 days of a hospital discharge. Of those patients who are readmitted, the Medicare Payment Advisory Committee estimates that 64 percent received no post-acute care between discharge and readmission and projects that 76 percent of readmissions may be preventable. Furthermore, the Centers for Medicare & Medicaid Services (CMS) demonstrate that beneficiaries report greater dissatisfaction regarding discharge-related service delivery than any other aspect of care.[1]

The Approach

The Atlantic Quality Innovation Network (AQIN) QIN-QIO, under contract with CMS in the 11th Scope of Work, established and facilitates 35 Care Transition Coalitions at the community level. Community-based providers are invited to be active Coalition members and are drawn from hospitals, skilled nursing facilities, home health agencies, hospice, assisted living facilities, physician practices, payers, patients, caregivers, community service agencies and other key stakeholder organizations.

AQIN supports well coordinated care transitions among institutions, practitioners and community service organizations, with the patient and caregiver at the center of care. AQIN is committed to building and sustaining cross-setting interdisciplinary coalitions with a focus on improving transitions of care, providing a vehicle for the patient and family voice, encouraging person-centered and person-directed models of care, and encouraging collaborative efforts across organizations with a shared vision.

AQIN's comprehensive approach offers technical assistance and education addressing cross-setting communication, coordination of care, information transfer, medication reconciliation, patient and family engagement, and standardized care management to the community coalitions responsible for the care of 1,735,451 Medicare beneficiaries across NY, SC and DC. Together, issues are identified and solutions are developed to improve care transitions across all settings, from hospital discharge to rehabilitation, home health care and supported community-based care.

continued

Care Transitions

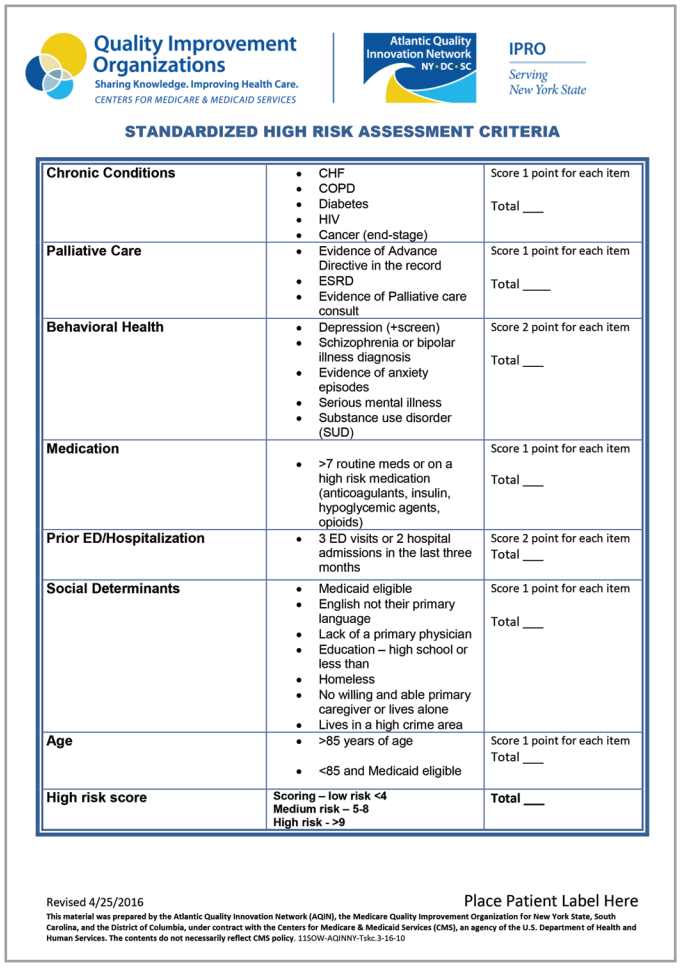
continued

Results

The AQIN QIN-QIO has developed and assisted healthcare providers in implementation of tools to support care transition efforts. These tools include **1)** Socioeconomic Risk Assessment Tool, **2)** Health Literacy Assessment Tool, **3)** High Risk Readmission Assessment Tool, **4)** County-based Community Resource Tool, **5)** Medication Reconciliation Brown Bag and Tracking Tool, **6)** Post-Acute Care Readmission Tracking Tool, **7)** Hospital/SNF Collaborative Change Package; and **8)** Data Collection Tools.

Results of AQIN Coordination of Care interventions and activities to date include the following:

- 35 care transition community coalitions engaged and facilitated, encompassing healthcare facilities and community organizations, to reduce avoidable hospital admissions and readmissions.
- 1,735,451 Medicare beneficiaries touched by Care Transition Coalition interventions.
  - 331,471 beneficiaries residing in rural regions were included in AQIN Coordination of Care interventions and activities.
- Approximately 23,765 hospitalizations avoided, yielding a cost savings of $274,000,000.
- An estimated 4,587 readmissions avoided, with a cost savings of $59,000,000.



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STANDARDIZED HIGH RISK ASSESSMENT CRITERIA

Chronic Conditions	• CHF • COPD • Diabetes • HIV • Cancer (end-stage)	Score 1 point for each item Total ___
Palliative Care	• Evidence of Advance Directive in the record • ESRD • Evidence of Palliative care consult	Score 1 point for each item Total ___
Behavioral Health	• Depression (+screen) • Schizophrenia or bipolar illness diagnosis • Evidence of anxiety episodes • Serious mental illness • Substance use disorder (SUD)	Score 2 point for each item Total ___
Medication	• >7 routine meds or on a high risk medication (anticoagulants, insulin, hypoglycemic agents, opioids)	Score 1 point for each item Total ___
Prior ED/Hospitalization	• 3 ED visits or 2 hospital admissions in the last three months	Score 2 point for each item Total ___
Social Determinants	• Medicaid eligible • English not their primary language • Lack of a primary physician • Education – high school or less than • Homeless • No willing and able primary caregiver or lives alone • Lives in a high crime area	Score 1 point for each item Total ___
Age	• >85 years of age • <85 and Medicaid eligible	Score 1 point for each item Total ___
High risk score	**Scoring – low risk <4** **Medium risk – 5-8** **High risk - >9**	**Total ___**

Revised 4/25/2016

Place Patient Label Here

This material was prepared by the Atlantic Quality Innovation Network (AQIN), the Medicare Quality Improvement Organization for New York State, South Carolina, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 11SOW-AQINNY-Tskc.3-16-10

High Risk Assessment Tool

1. MedPAC: June 2007 Report to the Congress: Promoting Greater Efficiency in Medicare

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