Quality Transitions of Care Learning Cohort
Session #1

January 19, 2023

12:00 – 1:00 PM CT

Objectives:

- Review transitions of care / safe discharge models and the benefits
- Discuss tracking of readmission and high-utilizers
- Look at current statistics
- Define TCM and CCM
- Connect Age-Friendly and safe transitions
- Review HQIC Goals and Return on Investment
- Complete Polling Questions
- Discuss Aim Statements
- PDSA Rapid Cycle Testing

Transitions of Care and Safe Discharge

- Process of transferring care from one setting/level of care to another. Transitions are particularly vulnerable points in the healthcare continuum.
- $26 Billion spent on poor transitions of acute care Medicare patients/year.
- Guiding Principles:

1. Create framework to support seamless transitions between settings across continuum.
2. Provide coordinated, efficient, cost effective, collaborative care transitions, aligned with safety and quality measures.
3. Implement standard practices to guide transitions between settings of care.
4. Include patient and family engagement in planning and execution of all transitions.
5. Promote the concept of a care managers, specifically for high-risk patients.
6. Identify and partner with community and other available resources.
7. Expand access to relevant information and maximize the use of available technology.
8. Track, trend, and review TOC fallouts.

30-day All Cause Readmissions

- Rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.
- Why does it matter?
  - A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination.
  - Unplanned readmissions are associated with increased mortality and higher health care costs.
  - Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management

Defining Readmissions

- Measure ID: Tell_SR_NERead
- Measure: All Cause Readmission Rate– Nebraska Self-Reported
  – Numerator: Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge to same facility
  – Denominator: All acute inpatients discharged from the hospital (excluding discharges due to death)
- Calculation Method: (N/D)*100

Defining Readmissions

- Measure ID: Tell_Core_Read1
  - Numerator: Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions
  - Denominator: All Medicare patients discharge from the hospital
  - Calculation Method: (N/D)*100

Defining Readmissions

- Measure ID: Tell_Core_Read2
- Measure: Unplanned All-Cause 30-Day Readmission Rate
  - Numerator: Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions
  - Denominator: Patients, age 65+, discharged alive from the hospital, with continuous Medicare FFS Coverage. Excludes psych, cancer and rehab admissions, as well as patients discharged AMA
- Calculation Method: (N/D)*100

ED Utilization-- Overuse

- ED visits are a high-intensity service and a cost burden on the health care system and patients.
- Some ED events may be attributed to preventable or treatable conditions.
- A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented.
- Imperative that patients receive appropriate, coordinated primary care to address preventable ED visit

ED Utilization Metrics

- Rate of patients that access the Emergency Department more than once in 30-days
- Rate of patients that return to the ED with 72 hours of discharge or previous ED visit
- Rate of patients that attend a follow-up visit with a PCP within 48 hours of an ED visit
- Rate of patients that can identify a PCP during and ED visit.

Transitional Care Management

- A program designed to improve the coordination of care for patients between the acute care setting and community setting
  - CMS has 2 billing codes:
    - CPT code 99495 – moderate medical complexity requiring a face-to-face visit within 14 days of discharge
    - CPT code 99496 – high medical complexity requiring a face-to-face visit within seven days of discharge
  - Goal: a provider will oversee management and coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support.
- Benefits:
  - Improved Outcomes
    - For members, receiving transitional care management means improved outcomes. There are significantly fewer readmissions when transitional care is properly managed.
  - Increased Satisfaction
    - Members feel safer when receiving transitional care. Knowing their care team is working to accurately address their care needs and keep them at home leaves members feeling satisfied with the overall care.
  - Savings
    - By reducing readmissions, both members and providers can save. Fewer hospital or clinic visits saves money in the long-term for both parties as well

Chronic Care Management

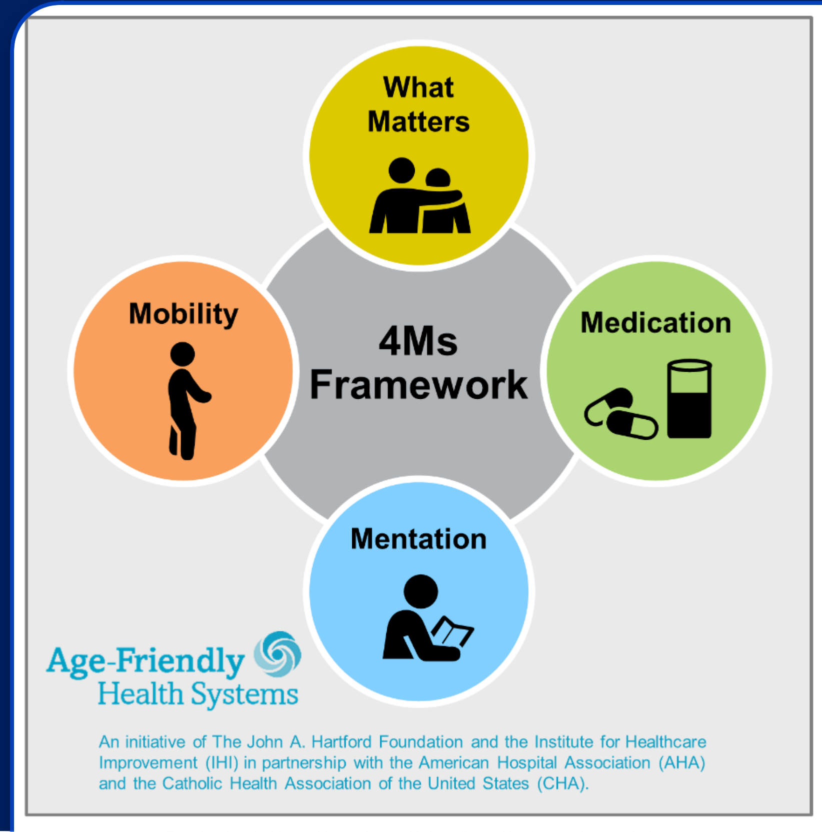
- A program for patients with 2 or more chronic conditions to create an ongoing, 24/7 relationship with their care team.
  - Enables clinicians to make more frequent contact with CCM patients
  - Provides additional touchpoints in between traditional in-office visits
  - Implements a comprehensive care plan that is agreed upon by both the clinician and the patient that must offer remote communication, medication management, and care coordination between primary care providers and specialists.
- Benefits:
  - Improve quality of life for participants
    - Reduced Stress
    - Improved Mobility
    - Better Sleep
  - Improve patient health outcomes and chronic disease needs
  - Decrease unplanned readmissions
- The main CPT Codes that are used for CCM are **99490,99439,99487, 99489, 99491**.

Age-Friendly Health System Aim

- Build a movement so all care with older adults is equitable age-friendly care:
  - Guided by an essential set of evidence-based practices (4Ms)
  - Causes no harms
  - Is consistent with What Matters to the older adult and their family

Why the 4Ms?

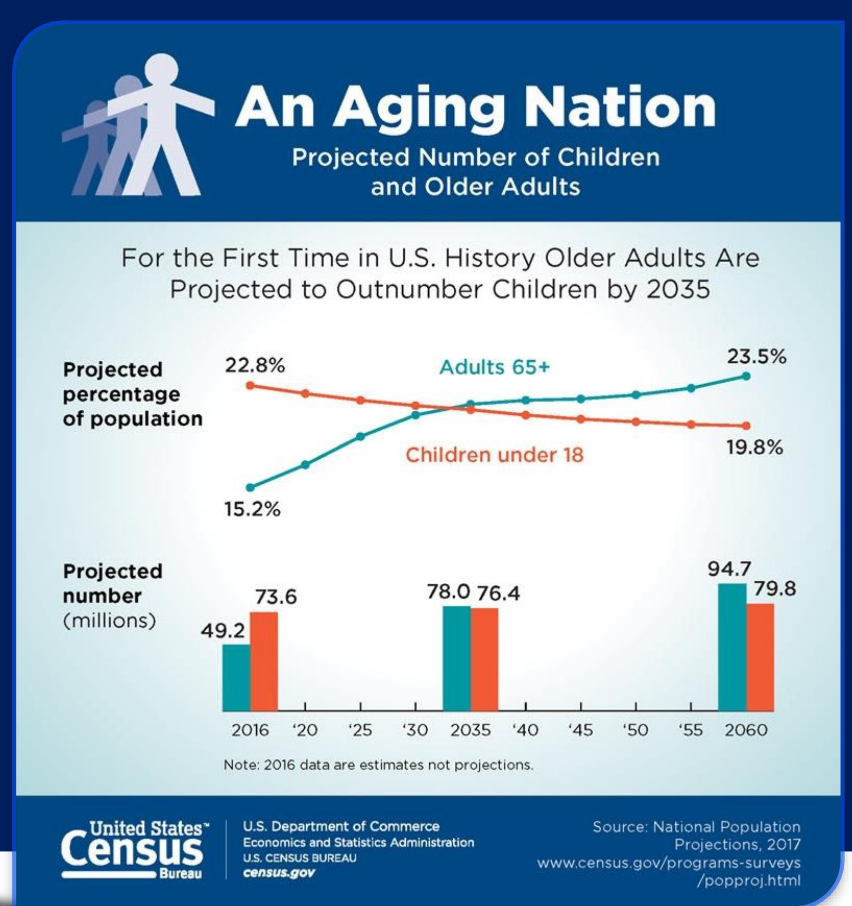
- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies and reduces implementation and measurement burden on systems while increasing effect
- Components are synergistic and reinforce one another



Why Age-Friendly Health Systems?

Committed to building a social movement so all care with older adults is age-friendly care

<u>Quality Goals:</u>
- Reduce Readmissions and ED Utilization
- Identify and Treat Delirium Timely
- Reduce Falls | Increase Mobility
- Improve Quality of Life
- Reduce Costs
- Provide Equitable Healthcare to all older adults



Evidence-based

What Matters:

- Asking what matters and developing an integrated systems to address it lowers inpatient utilization (54% dec), ICU stays (80% dec), while increasing hospice use (47.2%) and pt satisfaction (AHRQ 2013)

Medications:

- Older adults suffering an adverse drug event have higher rates of morbidity, hospital admission and costs (Field 2005)
- 1500 hospitals in HEN 2.0 reduced 15,611 adverse drug events saving $78m across 34 states (HRET 2017)

Mentation:

- Depression in ambulatory care doubles cost of care across the board (Unutzer 2009)
- 16:1 ROI on delirium detection and treatment programs (Rubin 2013)

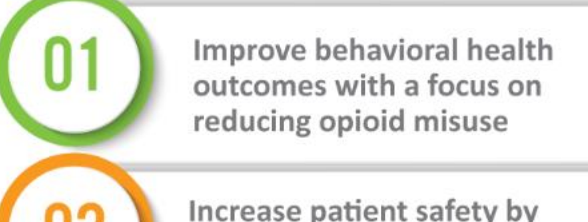
Mobility:

- Older adults who sustain a serious fall-related injury required an additional $13,316 in hospital operating cost and had an increased LOS of 6.3 days compared to controls (Wong 2011)
- 30+% reduction in direct, indirect, and total hospital costs among patients who receive care to improve mobility (Klein 2015)

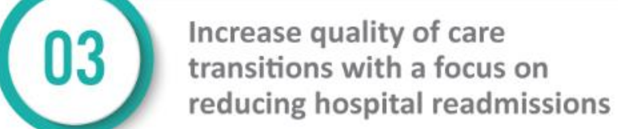
HQIC Goals

IMPROVE PATIENT SAFETY

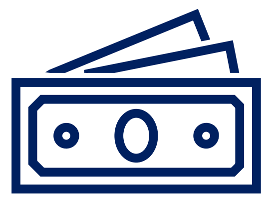
- Target: Reduce all-cause harm in hospitals by 9% or more in recruited hospitals to include reducing Adverse Drug Events (ADEs) by 2024.
  - Sub-Goal: Reduce all-cause harm in hospitals by 9% or more by 2024.
  - Sub-Goal: Reduce readmissions by 5% for the recruited population by 2024.
  - Sub-Goal: Reduce ADEs in hospitals by 13%
  - Sub-Goal: Reduce Clostridioides Difficile (C. difficile, formerly known as Clostridium Difficile) in hospitals



02
Increase patient safety by reducing all-cause harm by preventing ADEs and *C. difficile*



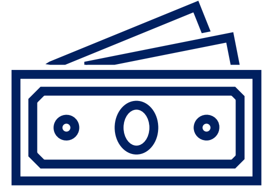
Return on Investment TCM



$176.50	x	10	=	$1,765	or	$21,180
CPT Code 99495 monthly reimbursement rate per patient		10 patients receive moderate-complexity TCM services per month		Monthly Reimbursement		Annual Reimbursement

Billing Transitional Care Management CPT Codes: Understanding TCM's Reimbursement Potential (thoroughcare.net)

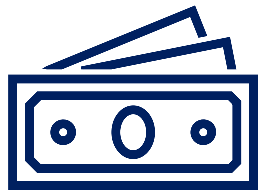
Return on Investment CCM



$62	x	50	=	$3,100	or	$37,200
CPT Code 99490 monthly reimbursement rate per patient		Clinic staff provide non-complex services to 50 patients per month		Monthly Reimbursement		Annual Reimbursement

What is the ROI of a Chronic Care Management Program? (thoroughcare.net)

Return on Investment
Readmissions



$7,300	x	24	=	$175,200
Average cost of an inpatient readmission		Average of 2 readmissions/month for a CAH		Annual Cost of Hospital Readmissions

Making the business case for quality-monetizing quality (PLJ) 3 of 4 Sep-Oct 2022 (1).pdf

Building your Case for Quality

Baseline				**Target**		
January 1- December 31, 2022				By December 31, 2023		
Readmission Cases	Cost per Case	Rate	Total Cost of Waste	Readmission Cases	Rate	Cost Savings
47	$7,300	8.79%	$343,100	40	7.5%	**$51,100**

Understanding your Current State

- Pull individual data from CDS
- What does your current data show?
- Where would you like it to be?

NE Current State

Nebraska Readmission Rate (SR)

8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00

Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22

Nebraska Goal:

4.76

NE Current State

Nebraska Readmission Rate (Read_1)

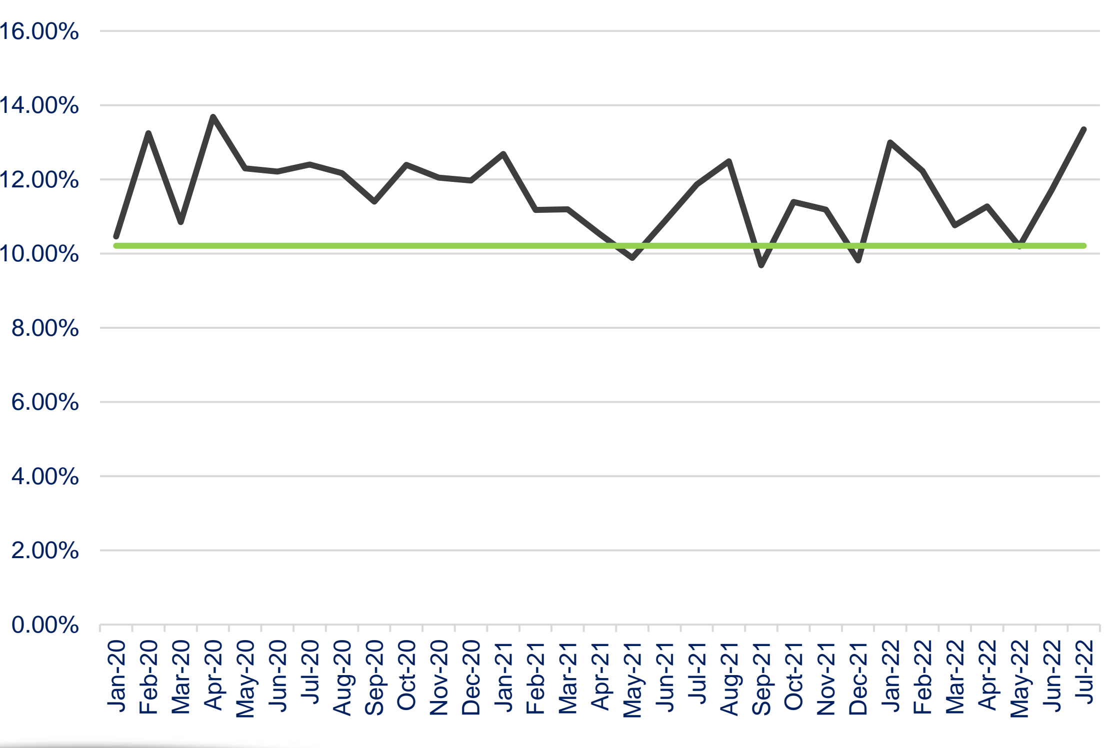
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%

Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22

Nebraska Goal:

10.46

NE Current State



Nebraska Goal:

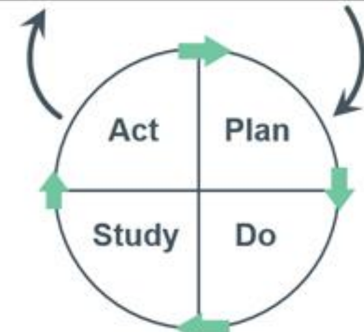
10.21

PDSA Rapid Cycle Testing

Plan-Do-Study-Act (PDSA) is:
- A structured cycle to test ideas/interventions to improve practices
- A guide to test a change idea/interventions to confirm it is an improvement before implementing facility wide
- The next step after completing a Root Cause Analysis (RCA)

Thinking Part: Driven by the following questions:
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?

Doing Part: Testing change ideas by running cycles.
Plan how the test will be done
Do the test as planned
Study collected data from doing the plan
Act on results after studying data collected from doing the plan



Build your Team

Creating an AIM Statement

Tool Template: Aim Statement Worksheet

What? What's the problem or opportunity?

How much? By how much will you improve, or "how good" do you want to get?

By when? What is the date by which you will achieve the level of improvement you've set out to accomplish?

For whom? Who is the customer or population who will benefit from the improvement?

Where? What are the boundaries of the process or system you're trying to improve? Where does it begin and end?

Completed aim statement:

Ask a colleague to check your work and recommend improvements:

- [ ] Is the problem or opportunity clearly stated?
- [ ] Do you know what the team is going to do about the problem?
- [ ] Has the team set a numerical goal to quantify the amount of improvement they'd like to make?
- [ ] Do you know the calendar date by which the team plans to achieve the goal?
- [ ] Is it clear who will benefit from the improvement?
- [ ] Is the scope of the project clear?
- [ ] Do you know why this improvement effort is important?

SMART Goals

SPECIFIC

Be clear and specific so your goals are easier to achieve. This also helps you know how and where to get started.

M

MEASURABLE

Measurable goals can be tracked, allowing you to see your progress. They also tell you when a goal is complete.

A

ACTIONABLE

Are you able to take action to achieve the goal? Actionable

R

REALISTIC

Avoid overwhelm and unnecessary stress and frustration by making the goal realistic.

TIMEBOUND

A date helps us stay focused and motivated, inspiring us and providing something to work towards.

Process vs. Outcome

Process Measures	Outcome Measures
Follow-up phone calls Follow-up PCP visit coordination Improved discharge planning Screening for SDoH Needs HCAHPS Analysis Education Coding Documentation	↓ Readmissions ED Utilization Cost Adverse Events ↑ Patient Satisfaction Patient Overall Health and Engagement Outcomes Revenue Clinical Efficiency

POLL Questions

Next Steps

- Build your team
- Create your goal / AIM Statement
- Set up a 1:1 call with Dana or Amber

Wrap-Up

- Questions

- Next Meeting:
  - Chronic Care Management
  - January 25th, 2023, 12:00-1:00 PM CT

Thank You!

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