Quality Insights Quality Innovation Network
August Care Coordination Open Office Hours Call
August 27, 2015

Laurie Fink: Well, good afternoon everyone, and thanks so much for joining us. I would like to welcome you to today's Open Office Hours call being brought to you by the Care Coordination and Medication Safety Team at Quality Insights Quality Innovation Network.

Today's topic is Selecting Interventions to Drive Improvement. My name is [Laurie Fink 00:21], and I am the Communications Specialist for the Care Coordination Initiative.

To get things started, I would like to remind you that all of the phone lines have been muted, and will remain in a listen-only mode for the first part of the call. When we reach Q and A session, all lines will then be unmuted to allow for questions, and open discussion. When participant lines are unmuted, we ask that you mute your own phone line if you are not actively participating in our call, or asking a question. We ask that you do not place the call on hold, as then we will all hear your on hold music.

[Please note 00:56] this call is being recorded, and the recording will be posted on the Quality Insights website, at www.qualityinsights-qin.org. It is posted under the "events" tab as an archived event.

Now I will hand things over to the moderator of today's call. That is [Nicole Skyer-Brandwene 01:19]. Nicole is the Quality Insights Adverse Drug Events Network Task Lead. Nicole?

Nicole Skyer-Br: Thanks Laurie, and thank you all for tuning in today. Quality Insights Quality Innovation Network is comprised of five States: West Virginia, Pennsylvania, Delaware, New Jersey, and Louisiana. Each State is engaged in the same Medicare Quality Improvement activities we have done in the past, but now we are all part of the Quality Insights family.

We [decided 04:50] to share information on care coordination and medication safety interventions, and [learn 01:55] how to use the Quality Insights tools to guide intervention selection.

In the email invite for this call, we provided a link to sample reports. These reports are developed as part of a root-cause analysis process that we discussed on last month's call. The process involves preforming root-cause analysis in your practice setting to identify areas where care coordination improvements can be made. Interventions are then selected to address a specific problem area.

I will give a brief overview of the summary reports, and then we have a couple of speakers that will discuss specific interventions they worked on.

So if we could just go a little bit ahead in the slides, to the remission root-cause analysis report slide, number three. This is not the entire report. The link in the email gave you the entire thirteen-page report. This is just a few screen shots of some of the key parts of it.

This first slide that we are looking at now is an excerpt of the actual root-cause analysis tool that we discussed more in depth on last month's call, which is about a twenty-eight, thirty question item [inaudible 03:08] and on the report. And then-

And so what you would do is you would use this tool to do chart abstraction, and complete a setting-specific root-cause analysis in your practice setting.

Now, on this fictional example, it is a hospital report, and a hospital tool that we have listed. But if you were on last month's call, or if you have looked at the resources which are available on our website, you will recall that we do have tools for the skilled nursing setting, and the home health setting, as well. And those can be found on our website under "Care Coordination Resources".

What the tool does is it identifies best practices, and the drivers they are linked to. So for example, if we go to the next slide, this gives you a summary- After the chart abstraction process is done, it gives you a summary of the results of all the different question items, and they are listed in order of the areas that were the most non-compliant, or those areas that were most problematic, going down to the areas that were the least problematic. And also, on the left side, identifying the different driver areas that those different activities or items are linked to, such as patient activation, or transfer of information, or medication safety.

Then, if we go to the next slide, which is a bar graph, you will see- It is just another way of representing the information that we just saw in a more visually easy to interpret manner. And you can see that the very first item is from the most non-compliant to the least, just as it was on the previous slide. And you can see that item number eleven is the area where there was the least clients with that particular activity, or best practice. And it was eighty percent.

So then if we go to the next slide, number six, on the bottom is- The chart on the bottom summarizes the top five non-compliant areas. And then just to illustrate, on the first slide, best practice number eleven has to do with instructing the patient on how to contact their primary care physician, and ensuring that the patient has that kind of information on how to contact their physician after-hours.

So by identifying that as the number one area of need, then you could then select an intervention designed to address that particular area.

That will bring us to the next slide, and the next report, which was also included in a link in your invite, in your email invite. And this is intervention by driver of readmission. So this is a tool that we developed just to summarize. It is not all-inclusive, by any stretch of the imagination. But it tries to summarize a lot of different types of interventions, and which drivers they address.

It starts off on the first page with a lot of interventions that are formal programs that address multiple drivers. Things you have heard of, like [Boost 06:34] and [Interact 05:35]. And obviously, they address multiple areas of care coordination, so they would address multiple drivers. But then also, if you go further down on the sheet, or onto the next slide, slide number eight, the last- For example, the last line in the top blue section is "patient [teach back 06:55]". So that is something that can be done individually, and not- Does not necessarily have to be part of a formal program.

And we have identified that this driver linked to patient activation, but with this one- As I am sure you could see with some of the others, as well, is if you are teaching somebody about patients and they are demonstrating back to you that they have a better understanding of how to take their medications, then that could also address medication safety.

So, you know, it is just a guide, but there is definitely overlap in these- Some of the areas. And definetly amongst the [different 07:32] drivers.

And at this time, we do have a couple of guest speakers lined up. One of them is a little bit late coming on to the call, so I am not sure if she is on. Actually, she- I do see that she is on, so we are going to try and go now to [Angela Lucente-Prokop 07:49], from the Western Pennsylvania Community-Based Care Transitions Program. She will give you a little bit, just a quick overview. A nice example of how they use this process, and some interventions that they implement as a result of it.

Angela, are you on?

Angela Lucente-: Yes, I am. Thank you very much. It is a pleasure to join the group this afternoon. My name is Angela Lucente-Prokop, and I am the Regional Director for the Western Pennsylvania Care Transitions Community. That community represents an area Agency on Aging, the Southwest Pennsylvania Area Agency on Aging, and six hospital partners. The partners are [Monongahela 08:28] Valley Hospital, Canonsburg Hospital, the Washington Hospital, and the [Excela 08:35] Health System's [Frick 08:36], [Latrobe 08:37] and [WestMoreland 08:38] Hospitals.

And I am really kind of pleased to share that this community really went though this very process. So at the beginning of the [QIQINIO 08:49] tenth scope of work, our community did use this very root-cause analysis process, the very same tool, and basically did ten chart reviews per hospital. And then were able to, as a result, after doing the chart reviews, the QIQINIO statistician did a

[inaudible 09:14] summary reports, and it really kind of informed us on what our root-cause drivers of readmissions were.

And then we were able to use the tool, that is actually on the [web-x 09:23] event center, now, which- It is the "intervention by driver of readmission" chart. And we were able to use that tool to match it up to an intervention. And in the end, the community chose the Care-Transitions Intervention, that is the [Coleman 09:38] Intervention. We found that it really addressed our root-cause drivers, but it was also an economical model for us to be able to implement. And we did go on and do that work. And in fact, we are in our forth year of the [CMS 09:55] Care-Transitions or [CCTP 09:58] scope of work.

And we continue our partnership with the QIQINIO. It is extremely value-added for us. And we look forward to refreshing our root-cause analysis. We anticipate that this will be our last year under the Medicare Demonstration Project. So we anticipate going into another round of root-cause analysis, which will give us a fresh perspective on what is driving the readmissions after four years of implementation, how that has changed, how we should further stratify our intervention. And maybe this will suggest to us that we should further stratify, and perhaps not just use the Coleman Intervention, but perhaps use some other interventions for populations that we are really not moving the needle on.

So we appreciate the opportunity and the value of this partnership, and all of the expertise that comes out of it.

Nicole Skyer-Br: Thank you so much, Angela, for that great description and explanation, and also for your kind words about the services that we have been able to provide to you over the years.

And now, we will hear from one of our own team members, Biddy Smith, which- She will talk about a West Virginia intervention.

Biddy Smith: [Thank you 11:08] Nicole. Good afternoon, everybody. In the last [scope 11:11] of work, hospitals participating in our community utilized the [RCA 11:15] tool [inaudible 11:16] information on what where key drivers for readmission.

One particular hospital found the following: Of [the 11:25] best practices on the tool, [four of 11:26] the best practices were noted for non-compliance. And this is associated with one or more of the three drivers of readmission.

The four practices based on the non-compliance were: [inaudible 11:38] and complete a test or state the importance of follow-up for future tests. [Take 11:44] family education about the diagnosis throughout the impatient stay. Education for patient's family on medication regimen. Include the medication purpose, [dosage 11:55], side effects, and wanted effects. And we [need to 11:58] discuss with healthcare providers, [complete an 12:01] assessment of degree of understanding of discharge plan by the patient's family, by asking

patient's family to explain, in their own words, the details of the plan. Teach back on [plan of 12:12] care.

[To resolve 12:15] these non-compliance areas, the hospital decided to focus [on 12:17] interventions for Medicare fee-for-service patients with the diagnosis of CHF, pneumonia, or [COPD 12:25].

[inaudible 12:26] Was for the pharmacy staff to perform and document medication reconciliation at admission and discharge. Then the [nursing 12:34] staff standardized their patient education process by using teach back methods [inaudible 12:39] Within [the 12:40] patient understanding at admission and discharge.

Overall, the success rate for this intervention was ninety-six percent [inaudible 12:47] That have demonstrated a positive [change 12:49] from admission to discharge. And as a result of the intervention implementation, there was a downward trend in all-cause readmission rates in the community.

Nicole Skyer-Br: [Thanks 13:04] Biddy. That was really wonderful. And we do want to have question and answers soon, but I am just going to take a moment to talk about a New Jersey-based intervention that is [inaudible 13:17] intervention that is still underway. So we do not have results for it, yet. But it is- We will take some of the things we have talked about to the next step.

A home-care organization in New Jersey called Holy Redeemer received a grant, and they wanted to do some enhanced medication management with individuals. So what they decided to to was to partner with a hospital- A large hospital system in their area, in central New Jersey, [Trinitas 13:48] Regional Medical Center. And what they decided to do was develop a pharmacist-led intervention, where a pharmacist would visit the patient before they left the hospital. But then, to educate them about medications, and new medication reconciliation, but then they would also follow up with the individual- Those high-risk individuals, with a home visit in their home, to continue home medication reconciliation, and do more patient education.

It is a one-year [project 14:21], so- And it is in the middle of it right now, so we do not have any results yet. But unfortunately, the pharmacist was unable to be on the call today. But she did send me an example of one type- Just an example of the kind of intervention that she has been able to do, as a result of going to the home for a home visit. And this is somebody- These are patients that are also having other home supports, as well. It is not just the pharmacist. So what the pharmacist is doing is being coordinated with nursing home visits, and other activities as well.

One example that she wanted me to share was an individual that she had seen on the floor, while they were still in the hospital. And then told the patient that she would follow-up with them, once the patient went home. She called the

patient at home to try to schedule a home visit, and the patient was initially a little resistant, because the patient said, "Well, I am already- The nurse is already coming."

But the pharmacist persisted, and was able to successfully schedule a home pharmacy visit. Once the pharmacist arrived at the home, the patient realized that it was the same pharmacist that had seen her in the hospital, and the patient was much more receptive, at that point, presumably because the pharmacist was more familiar. They had met her already.

[One morning 15:45]- And in this particular instance, that the pharmacist found- And this had happened to be a CHF individual that had recently been hospitalized for CHF exacerbation. When the pharmacist looked at all her medications, and was trying to- Looking at all the medication bottles, trying to assess [compliance 16:06], the pharmacist found that one of her medication bottles was filled all the way to the top. And it was supposed to be a diabetes- Oral diabetes medication, but when the pharmacist opened the bottle, the pharmacist was able to [discern 16:21] that actually what was in the bottle was two different medications, mixed together. It was a diabetes medication and the persons' heart medication, mixed together.

The pharmacist believed what happened is that when the patient got a new refilled prescription, they wanted to consolidate the new bottle and the old bottle. But they accidentally mixed two different medications together. So clearly, had the pharmacist not had the opportunity to intervene in this case, there could have been an adverse outcome, if the person was not taking those two medications correctly. So obviously the pharmacist educated the patient about- Not to do that. And that is the- Because this is how those kind of errors can occur, especially when medications look similar.

And that is where the story ends. I am just going to add my little editorial comment on the end of it, is- You know, this might be a situation where the patient could benefit from some kind of [safety 17:28] packaging, or a medication organizer, or [compliance packaging 17:31], or something like that. Or maybe it is just a matter of educating the individual, and teaching them about the different medications, and how to read the prescription labels, so that they would know what was what, and when things are different, and when things are the same.

That is the [last 17:48] example that we have today. So now, it is time for questions and comments. Once again, before we open the phone lines, I must ask everyone to personally mute your phone on, your end, if you are not speaking, to avoid noise on the line. Because once we open the lines, then everyone's line will be open, unless you personally mute yourself, on your end. Please do not put yourself on hold.

And as I have [done 18:15] in the past, I will start out by addressing one State at a time. And then once each State has had the opportunity to ask one question, after that, then, everyone is free to speak up, in no particular order.

So usually we start with Pennsylvania, so why don't we go ahead and start with Pennsylvania. Do we have any questions from the wonderful State of PA?

Okay. I am starting to hear a little background noise, so hopefully everyone is in the process of muting their phone.

While we are waiting for questions to come in, I just want to point out the slide that is on the screen, right now. This is your individual State contact, in your State. I just want to take a moment to give a shout-out to each one of the States in our Quality Insights family, and let you know that if you have any questions, concerns, interested in getting involved, following up, please make sure that you know who the contact person is in your State. And it is on the screen, [right now 19:29], and it is also on our website, as well. If you go to your individual State, you can find it there, as well, of course.

So any questions from Pennsylvania, yet? [inaudible 19:47] Back to you. Yes.

How about Delaware? Any questions? It is very organized, and orderly today. Nobody wants to speak.

So Louisiana? West [Virginia 20:07]? [New 20:14] Jersey? [inaudible 20:19] Usual. Usually, we have some people speaking up, right away. But I think that there might be a couple of questions coming through the [chat 20:25]. Do we have a couple of questions coming from the chat that we can read [off 20:30]?

Laurie Fink: Nicole, this is Laurie. We did have a couple of questions entered. The first question is actually for Angela. It asks, how did you get the six hospitals and other providers to agree to implement the same intervention?

Angela Lucente-: This is Angela. [I would 20:49] be happy to answer that question. I guess I do not recall that it was really a struggle. Folks seem to understand that there some real funding constraints that were, you know, driving the need to be very lean in our approach. But it might also be that the community had, in the ninth scope of work, done some unfunded work together. And that was the intervention that was used, then. So that probably helped, too.

Now, not all of the hospitals- Not all of those six hospitals were involved in that. In fact, I believe that only four of them were involved in the ninth scope of work, and then we had six of them in the tenth scope of work.

So it probably really helped to have done some of that work together, even though it was an unfunded effort. And then having the root-cause analysis with some really solid statistical evidence or credibility, that is kind of suggesting,

yes, these are your root-cause drivers. And then being able to see that matched, and well fitted to the Coleman Intervention, with having some experience just seemed like a bit of a no-brainer. Folks were really so supportive of that.

But I can picture that, you know, being very different in a different community, depending on what everybody's interests are. In fact, [there was 22:15] another community that I did some work with. We were working with some hospital partners that had some experience with a different intervention, and, you know, they really wanted to use that intervention. So it was some work where we had different partners wanting to use the different intervention. And I can appreciate that that would be a little challenging.

And perhaps the QIQINO has some advice, or experience, in that regard.

Laurie Fink: Okay, thanks. There was another question submitted online. It said, "Does [the 22:48] New Jersey grant include long-term care residents, [just launched 22:53] on the long-term care facilities, or Holy Redeemer Home Care?

Nicole Skyer-Br: That is a good question. And in that particular case- And I can certainly verify this with the team that we are working with, and get back to the group. I believe that it does not. They are working with patients that are going directly to the home. However, there are a couple of similar project and grants underway in other New Jersey communities. And I do know that one of them actually is following patients from the hospital, to nursing home, and then the home. Or basically regardless of whatever setting they go to after the hospital, they follow them all the way through.

This particular one that I just described is not. But some of the others are, actually. So that is a really great question.

Laurie Fink: [inaudible 23:42] Question. [inaudible 23:45] able to use one of the official interventions, [with 23:47] the abbreviation for it's name?

Nicole Skyer-Br: I will take that. This is Nicole. Obviously not. I mean, some of the more formal, comprehensive interventions have been adopted by [large institutions and 24:03] organizations, but, you know, you certainly do not have to use one of those large interventions. Very often, sites like to start small, pick one process, or one aspect of a process that they want to improve, and then they take it from there. [inaudible 24:29] their own [interventions 24:31].

[inaudible 24:36] Any other questions? I see that- I see on the webinar screen that [Mary Kathryn Spins 24:41] from Water's Edge has a [inaudible 24:44]. [Either 24:44] raise your hand, or use the question feature on the webinar. Mary Kathryn, if you are on the line, go ahead and ask your question.

Mary Kathryn: I [read 24:58] to you about the New Jersey [grant 25:00]]

Nicole Skyer-Br: Okay.

Mary Kathryn: Including long term care as an [inaudible 25:02]. Yup. (affirmative)

Nicole Skyer-Br: Okay. I was not sure. Okay.

Mary Kathryn: [inaudible 25:06] to check. Yeah. (affirmative)

Laurie Fink: Next question. Can Quality Insights give us data that shows whether our intervention has been successful?

Nicole Skyer-Br: I can take that. And anyone else certainly chime in after me.

Yes, absolutely. I mean, obviously one of the parts of this process is, whatever the site is doing, is that you want to monitor them relative to what you are doing, to see if the intervention is having the intended effect. And we, you know, assist with that. We can help the site develop a simple spreadsheet, or simple data collection tool that they can use to gather data on the intervention itself, and then monitor that over time to look for improvement.

And that can be process data of, you know, how many patients in a given month received the intervention, whether it was education, or follow-up phone call. You know, whatever it is. But it can also- But that can also be done hand in hand with [using 26:14] claims data analysis, as well, to look for trends, and see if the facility is trending in the right direction on whatever you are measuring. Whether it be readmissions, or something like that.

There will be different ways of using data to measure the impact of an intervention. If anyone has anything to add, please feel free.

Biddy Smith: I just want to add in that those reports would be [accessible 26:40] though our [inaudible 26:43] [website 26:44] too, to get kind of easier [inaudible 26:45]. They can go on any time, and get those reports, so they [are 26:49] easily accessible to your [participants 26:52].

Laurie Fink: [Thank you 27:00] Biddy. If anyone else on the call has a question at this time, we do have a few more minutes, and we can stay on a little bit longer if we have not gotten to everyone.

Mary Kathryn: [I have 27:16] another question. If we choose an intervention, does it have to be used for all of our patients?

Biddy Smith: You can use a subset population, just like, to give you an example, I gave [inaudible 27:34] They focused on CHF, COPD and pneumonia. So you can choose a subset of your population that you want to focus on. And [all the 27:43] ones [that 27:44] are easier to start out that way, to start out small, it is just more manageable until you get your head around the [inaudible 27:51].

Nicole Skyer-Br: Yes. Absolutely. And in the case of looking at medication safety issues, as an example, here in New Jersey, I have a long-term care facility that is interested in doing some type of intervention looking at Warfarin safety. So in that case, they would be looking only at residents that are on that particular drug of interest.

Okay. Great. Any other questions at this time?

Then I think we will move forward, and once again, here is the contact information for your State person, if you have any additional questions. Thank you all for the great questions and discussions today. Oh, do we have a [question 28:42]?

Laurie Fink: Yes, actually.

Nicole Skyer-Br: Go ahead. Laurie Fink: It asks, how did the pharmacist get paid for her home visits?

Nicole Skyer-Br: As I had said in the New Jersey example, I talked about. As I had mentioned that is a grant-funded pilot project. It is a one-year project. It is funded by a private organization, nonprofit that does- Funds various healthcare projects. And the hope is- And that is always the issue, is the funding. And how do we going to cover the costs of that kind of intervention? And the hope is that the results that are shown, hopefully there will be some direct cost-savings, in terms of those individuals that were part of the pharmacist visit pilot program having a lower readmission rate, and being less likely to be readmitted.

And also, hopefully avoided costs from all the examples of the interventions that the pharmacist had, like correcting a medication error that could have led to the person having an adverse drug event, or something like that.

And, you know, it is an indirect measurement, but there are ways to measure the avoided costs of those kinds of interventions. So hopefully, putting the two things together, if enough cost savings can be demonstrated, then it would justify that the health system alone, or in partnership with other organizations, self-fund the intervention to continue after the grant is over.

Okay. So that was the [last 30:34] question. If there is anything else, then you can always reach out to us if something does pop up. And you [will 30:45] find the contact information on the slide that we [have 30:49] currently on the screen. But you can also go to our website, qualityinsights-qin.org, click on "get local", go to your individual State, and then click on "local assistance".

[Office hours 31:06] is scheduled for the fourth Thursday of each month. Please be sure to tune in to our next call on September twenty-forth, and 2:00pm Eastern, 1:00pm Central time.

Again, thanks to all our participants and our wonderful speakers for joining us today, and sharing all of the great things that you have done. And we will see you next month. Thank you all, and have a great afternoon.