Quality Insights Open Office Hours Session: Understanding the Transitions Community Readmission Report

February 25, 2016

Laurie Fink: Good afternoon everyone and thanks so much for joining us. I'd like to welcome you today's open office session, being brought to you by the Care Coordination and Medication Safety team at Quality Insights Quality Innovation Network. Today's topic is Understanding the Care Transitions Community Readmission Report. My name is Laurie Fink and I am the communications specialist for the Care Coordination Initiative. Before we get things started, I would like to remind you that all phone lines have been muted and will remain in a listen only mode for this first part of this call. When we reach the question and answer session, all lines will be unmuted to allow for questions and open discussion. Once the participant lines are unmuted, we do ask that you mute your own phone line if you're not actively participating in the discussion or asking a question.

We also ask that you don't place the call on hold as then everyone will hear your on hold music. If you'd prefer, please feel free to submit any questions you may have via chat or the Q&A features in WebEx. Please note that this call is being recorded and the recording, along with the presentation slide deck will be posted on the MyQualityInsights online learning platform. At this time, I will hand things over to Nicole Skyer-Brandwene, the Quality Insights Adverse Drug Events Network Task Lead. Nicole?

Nicole: Thanks, Laurie. Hello, to everyone that's here today. The Quality Insights Quality Innovation network is comprised of five states, West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana. Each state has local Medicare quality improvement staff working with providers and partners on reducing hospital readmission and medication safety as well as many other activities. As Laurie said, we're here today to share information on valuable data reports that Quality Insights has developed to help support the care coordination and medication safety activities in your communities. Today, we will be reviewing a newer addition to our arsenal of data, the care transitions community report. There was a link to a sample report in the reminder invite that went out yesterday. We're also going to try to get a link up to that in the chat in a few minutes.

If you don't have that invite handy, or you can't find it, you didn't catch it, hopefully we'll be able to get a link out so that you can open up your own and print out your own. However, later on in this discussion, I will be sharing my desktop and I will be sharing a full size screen of the sample report. If you didn't get it, never fear. Now, if you're not sure whether or not you have access to this report or a report for your area of your state, please reach out to your state's care coordination contact. State contact info will be posted towards the end of the call. The community report provides geographically relevant information that could be useful to many different health care settings within a community. I'm advancing my own slides for the first time.

I'm going to give a quick overview of where to find the report, what's in it, and then we're going to take a look at a sample version of the actual report and we'll be hearing from some of my trusty team members, who will give some insights and commentary into how this report is being used in their community amongst their participants and partners. Then we'll have open discussion amongst everyone on the call. First off, where can we find this community report? I don't believe it's visible

on this screenshot but I personally typed it into everyone in the chat myself a few moments ago. If you go to our main quality insights website, www.qualityinsights-qin.org, on the upper right hand corner of that screen there is a little button that says, log in. All the participants, it should be most people that are on the call that have working with us, have gotten an email somewhere along the way given you access to the quality insights web portal and information.

If you've completed your registration for that then you know your login and you should be able to just type it in and bring you to the screenshot that you see on the current slide. If anybody is not sure whether or not they have this or had it and lost it or don't know if they have access to it because they're not sure if they're working with us or not, again, you can reach out to your state contacts after this call or I suppose you could even chat in and if you identify yourself we can try and track you down, but it would probably be easier to reach out to your state contact. Assuming that you know your login information and you have logged in, this is the screen that you would then see. You notice an arrow pointing to the center circle that says, report data. Not everybody will see all these icons when you log in. You might only see reports or you might only see my quality insights.

Not everybody has access to all reports. It depends on what your level of participation is within the project that you're working with us on. It also depends on your individual title and responsibilities within your organization. Again, if you're unsure about what your access level is or you think you should have access to reports but you don't see that, you can always reach out to your state contacts and we can help walk you through that. If you click on the report data that brings you to a screen that looks something like this. It might not look exactly like it. I'm not sure, if everybody sees the select state or if your state is automatically input for you, depending on where you're located and what your level of access is. It should look something like this. Then you would select your provider type if you're an hospital PPS.

Then you would click the drop down to select the name of your hospital. Then you would get something like this that looks something like what you see below the red arrow on the bottom. Just to point out that there are two tabs, one on the left that says provider specific reports and the one just to the right of it above where it says, central Jersey [inaudible 00:07:22] that says community reports. Just be sure that when you're on the screen you've clicked on the right tab. The report that we're talking about today is going to appear on the community report tab and not the provider specific tab. The reason for that is this report does not contain provider specific information. It's community based admission and readmission information and that sort of thing. One of the nice things about it is that it is share-able because it does not contain any proprietary or confidential information. This is just a brief summary of some of the information contained in the report.

Once I actually share the screen and we look at the actual report you'll see what I mean even better. For example, there's information on healthcare utilization rates. Here's something new that may be new to some people. We all know that we're supposed to be reducing readmission and looking at thirty day readmission rates. I see a typo on the screen. It should be all cause thirty day readmission rates per one thousand beneficiaries. Everything should be one thousand on this slide. I apologize for that. Which is a standard way that the admission rates are usually represented. I apologize for that. Something new is the first bullet is all cause hospital admission rates. That might be something new. That's something that Medicare is starting to take a look at as well is keeping people healthy in the home so that they're not only not readmitted but how about never admitted in the first place.

Of course it does impact the whole system, because if there were less admission then there can be less readmissions. It's interesting that that's something that's starting to be looked at as well. Then there is information on adverse drug events. Expressed as pro one thousand inpatient discharges among high risk beneficiaries. I'm going to go into a little bit more detail about exactly what that means and how that's defined once we get the actual report up. I think that warrants clarification but if you can hold tight we'll get into that in a moment more. Then something called community tenure which also may be a newer concept. That's the days per year beneficiaries spend in their home setting and if anybody wants more specifics on exactly how that's defined and what that means, then I'll call upon one of my colleagues later on in the call to chime in on that.

I don't have the specifics of that memorized. I have an idea of what that means but I don't recall the specifics. Then there's some community goals for readmission reduction, and things like that, represented in a graphical format just so that you can get a visual on where one is at and where one might want to go. Remember, this is at the community level, not at an individual hospital or individual nursing home level. Then there's also a lot of useful utilization data for selected demographics, such as race and certain diagnoses and health conditions that also can be very useful as well to look at as an community comes together to work on things like readmissions as a group. This is just a little screenshot of page one, title page of the report. I'm going to bring the actual report up in a moment. This is a sample report. It has no one in particular's information on it. Even so, as I said, it's not provider specific. It really isn't anything confidential.

That's one of the things that's nice about it. It really is useful to be shared with partners within your community such as post acute providers and hospitals taking a look at it together. There used to be a saying, it takes a village to raise a child. I think it takes a village to reduce readmissions and reduce adverse drug events because I don't think it's a burden that any one healthcare setting such as a hospital or a nursing home or a physician or other direct care provider could take on on their own. It has to be a group effort. Just this morning I had a meeting out with some folks at a hospital in the community and we were talking about running the readmission numbers, based on the total number of hospitalizations and the total number of readmissions. If you really wanted to reduce that readmission rate by one percent even, if you run the numbers it's potentially hundreds or even thousands of individuals that would have to receive one or more effect interventions to actually change those numbers.

That's not a task that any one organization or institution could really do on their own. It really does have to be a group effort. Now comes the fun part where I get to test out my desktop sharing. This is a new thing we're trying out. Hopefully somebody on my end will tell me what they see, tell me if it looks good.

Laurie Fink: Hi, Nicole. We're seeing your desktop. The sample report is, there you go. That looks good.

Nicole: I did put it on full screen for participants. I don't know if everyone's seeing what I'm seeing, but I'm going to take this time to qualify that as the quality improvement network we have to remain impartial and we do not advertise or promote any one particular product or service, but we couldn't figure out how to make my personal task bar on the left top go away. If anybody recognizes the task bar it's not an advertisement for any particular computer company. This is the actual report and I'm going to scroll through. Is everybody seeing the movement on the report, there?

Laurie Fink: Yep. It looks good.

Nicole: Great. It's about ten pages. No, It is ten pages, about fifteen charts and tables. Just to take a look, I'm not going to go through every table one by one. I am going to focus in on a few things to illustrate the kinds of information that's in there. If it's getting a little boring don't worry. I'm not going through every single one. We will start at figure one, key performance measure results for sample community. The community title would be up on the top. To clarify what the definition of community is, a community is defined as a geographic area, a grouping of zip codes, and there are various algorithms and things that are looked at as far as healthcare utilization [inaudible 00:15:55] to transitions, which means among the major hospitals in that community, what is the movement of the beneficiaries that live there between the hospitals to the nursing homes to home to other settings within that community and back and forth.

Patterns tend to emerge. Logical grouping of zip codes emerge based on the healthcare utilization patterns and the patterns of where beneficiaries reside within that area. It's not a decision that I make but I know that those that create those geographic groupings use very robust information to develop that. Taking a look at figure one, a couple of things I'm going to point out, that some of these key measures that I mentioned before, I brought the report up that were on one of the slides, it looks at a baseline year, which may or may not be a calendar year, as you can see and then compares that to the current year. What do we actually mean by the current year? It says, July 14 to June 2015. that's not the current year. What that really means is, because all of this analysis is based on Medicare fee for service claims data it really means the most recent year for which mature Medicare fee for service claims data is available.

That's the most recent full year for which mature claims are available. As time goes on, and these reports are updated quarterly and they were just updated recently, the current year time frame will change and then eventually it will continue to change quarterly but it will also be further and further away from the baseline time period. Then of course on the far right column is the relative improvement. If it's a negative and it's in red that's not an improvement. That's the opposite of improvement. It can be a little bit confusing. It was a little bit confusing to me at first because it says improvement in the title, but because it has the negative sign and it's in read the message is it's not the desired direction. As you can see, at this point, because it's very early on in this analysis, the numbers are very small. There's plenty of time to see further movement and further change.

The other thing I want to point out just looking at figure two, is there are multiple communities on here. This template was just taken from state of New Jersey, sample reports that you're seeing New Jersey one, New Jersey two, New Jersey xx which is the pretend sample community that we're looking at now. There are five altogether. There are multiple geographic areas within a state represented on this one report. However, later on in the report, in subsequent pages, there are detailed charts specific just for the [inaudible 00:19:27] community, the one community in question. In this case it would be community xx. Why do we have other communities throughout the state on here? Are we trying to compare one to another and say one's doing better than another? Not really. It's really very difficult to make a comparison between different geographic areas because there could be so many factors that differ across a geography, whether it's rural or more urban.

Socioeconomic factors, but in the interest of saving paper and lots of analytic time, making five

times the number of reports that we already have times the five states that the QIN covers, it makes sense to have things be a little bit condensed. In some situations where there might be a reason to take a look and compare you certainly can do that but that's not the intent of this information necessarily, is to make anyone feel like they're being compared to somebody else. Then of course you see the red dotted line represents the state average. It's more comparison to the state which is possibly something that communities would be more concerned with and more interested in. Just going back up again, I promised I would elaborate a hint more on the ADE definition. The average drug events, this is something that was calculated based on Medicare part d and Medicare fee for service part a claims data. It's something that, we looked at people that Medicare sees as high risk.

People on certain high risk medications and those are indicated in the little footnotes there. People that are on three or more medications chronically and one of those medications falls into what Medicare considers high risk. Anti-coagulant medications, insulin, or other diabetic drugs, and opiates or narcotics. Then, looking at specific ICV nine, soon to be ICV ten codes, that are highly likely or probably correlated with events related to the medication. In some cases the ICV nine codes are very specific, like adverse event to insulin or other diabetic drug. Or toxicity or poisoning due to insulin or other diabetic drug. Some things are more intuitive like bleeding, GI bleed or blood in the stool for a person on a anti-coagulant. We cannot say because ICV nine codes aren't designed to do that, for absolute certainty that every single situation it was definitely caused or the medication contributed to it.

We can say that there's a likelihood that that's the case. Wanted to clarify that point. Now we're going to move on. Here's hospital readmissions for all the communities. Looking for where there's a goal, there we go. Here we would have just the community for which the report has been prepared compared to the state. You have a table of information and then the same information represented graphically with the chart. There is a state goal and a community goal. This goal is based on a fixed percentage of relative improvement that is defined as a rate of improvement that Medicare would like to see. I don't recall off the top of my head exactly what that percentage is or how to express that. If somebody on my team would mind chiming in at this moment or later on, and want to comment on what goal is percentage wise, that would be great.

Andy: Nicole, this is Andy, if you can hear me. The goal is twenty percent reduction for admissions and readmissions and a thirty-five percent reduction for ADE's.

Nicole: That's all relative, correct?

Andy: Yes.

Nicole: I feel like I'm on Jeopardy. I'll have, that's all relative, for two hundred dollars or something like that. Thanks a lot. I appreciate that. Moving on, now. That's where these goal lines come from. Wanted to move on. I wanted to make a clarification here as well. You know how it doesn't matter how much you look at something while you're preparing it, the better you get to know it the more things you see and the better you understand it? I was just looking at the title for this chart. Actually I'm not sure that's the right model. Looking for the ADE. Here we go. That's what I meant. [inaudible 00:25:59] relative, hospital ADE's per one thousand Medicare inpatient discharges. I wanted to clarify or expand upon what I had discussed earlier about how the ADE calculation is made, because it says hospital here, I would even consider taking that word hospital off. I think it

might be a little bit redundant.

The implication is not that the ADE occurred in the hospital or that the hospital was responsible in any way. It means that we looked at people that had hospital events and had ICV nine codes associated with that event that as I explained earlier were likely or probable could have been related to an ADE. The origination of where that event occurred. Did it happen in the community and then the person presented to the hospital? It's possible. It cannot be determined from a claims analysis where the event began or originated. I wanted to clarify that. The ICD-9 code was identified as part of a hospital claim but in no way implies that the event originated or took place in the hospital. It very well may not have and it could have. There's not a way to know. We tried. We tried to look. There is a field in claims, present on admission, where if it's used, can be attached to an ICV code which would say that this event, this health condition was present on admission.

Unfortunately that code is so rarely used that it was not informative in any way. One or two more comments and then we're going to open it up for comments from the team and questions from the group. Figure ten and beyond. That's the utilization information that I talked about, by demographics, which is something I know that we also provide in hospital specific reports but in terms of looking at something from a community perspective or a coalition of different providers within a community coming together, this can be very useful to look at that from the community level. Then the same thing with the different diagnosis codes. That can be really interesting and useful to look at from the community perspective as well. Just one more quick thing I wanted to point out on Figure thirteen. This is some interesting way of looking at the readmission rates by index hospitalization factors, by length of stay. If the length of stay was one to three days, what is the readmission rate for that group, as to be expected, at least in this sample case.

I would guess that this probably is something that is seen elsewhere as well, is the longer the index hospitalization is the greater chance of the readmission happening, in a lot of cases. Also the discharge disposition. This can be very useful when a community group is coming together but what percentage of our discharges go to SNF (skilled nursing facility) or receive home health service or go to rehab or hospice. In terms of planning and coordinating as a community perspective, that can be really useful. At this time I know a couple of my team members wanted to comment about how they have used this report with their community groups or how they planned to use it with their community groups. I'm going to let them speak right now and then we'll go into question and answer and discussion. I don't know who wanted to talk first. Mary Ellen, where you going to say something?

Mary Ellen: Sure. I'm right here. Thanks Nicole. I appreciate it. I have been utilizing the community reports when working on establishing communities and bringing different providers together to talk about decreasing readmissions and preventing ADEs. I find it very helpful for exactly those reasons you mentioned, some providers are a little hesitant to share their own internal data. That they have the data laid out like this in a comprehensive manner is great for the whole community to see where they are in terms of their readmission rate and talk about those things that affect them directly and the breakdown of the discharge disposition is very helpful. Especially when you're working across the writers and also the diagnosis as so many people are now focusing their transitions of care program and hospital reduction programs on those high risk patients. Or the patients at higher risk for readmission, broken down by ICV nine codes.

Nicole: Thank you. Did anybody else? I know there are couple that have used this report in community

meetings. If they wanted to comment.

Biddy: Hi, Nicole. This is Biddy. I haven't used it yet but next month I plan on utilizing it in all four of my communities to help develop the plans for our coming year, what goal we may want to focus on and hopefully these reports will drive us to a definitive goal of what to focus on over the next year.

Nicole: Great. Anybody else?

Andy: Nicole, this is Andy. Can you take this off of full screen so that we'll be able to see if questions are coming in through the chat or the question and answers?

Nicole: Yes. As a matter of fact, I was just going to comment on that that while I have my screen sharing on I can't see any chat or anything but I didn't realize that others could not either. Here we are. We should be back to the regular screen now. Are we seeing the presentation again?

Andy: Yes. We are. Thanks.

Nicole: Great. At this time, we will take your questions and comments as Doctor Miller said. Feel free to type into the chat if you would like. We are going to open the phone lines. If you would like to ask a question over the phone we will be opening the lines. As this is an informal office hours, please be cautioned that once the lines are opened you will not be muted. Any noise you make will be heard by everyone. It is up to you to mute yourself on your individual phone if you are not speaking and only unmute if you plan to say something. Please, I ask that everyone mute themselves now on their end if you are not speaking at this time. Please do not put us on hold because we may hear some very lovely music if you do so. Mute yourself and only unmute if you plan to ask a question. Laurie you can go ahead and open the lines up now.

Laurie Fink: We did have two questions submitted through the Q&A. I thought I'd read those first before we opened the phone lines.

Nicole: Great.

Laurie Fink: The first question asks, if the code has POA it is present on admission. Do you have access to that information?

Nicole: I'm going to start to answer that question and by all means, my analytic colleagues feel free to chime in at any time. My understanding is that we do have access to that field and we can do claims analysis on it. The data analysis experience I would be speaking to Sue and Andrew. Their experience in doing analysis is that that field is not often completed. It's not a reliable tool for us, at least at this time.

Andy: Nicole, they're nodding their heads, that you gave the accurate answer.

Nicole: Thank you Andy. One day we're going to have video where we're all going to be on video and I'll be able to see that.

Laurie Fink: The next question asks, has this report been published for hospitals to view yet?

Nicole: Yes. Let me qualify. There aren't community reports for every single geographic area in all of our five states. We have community reports prepared for those geographic areas that we're already actively working with throughout our state. As we expand our work and engage new communities where we'll have the ability to then prepare reports down the line for those communities as well. That's the first thing. For those communities for which the reports haven't already been prepared, yes, they are available on the quality insights portal that I showed in the beginning of the presentation for anybody that is in our system and has been granted access to the quality insights data reporting portal as somebody that we've recognized as working with us, should already have that community report tab is there in a participating community and have access to it.

It wouldn't just be hospitals. It could be a nursing home or a home health. If you're working as part of that community and you're working with us and you've got access to the data portal you should be able to see that there. If you're not sure if you have access or you know you have access but you don't remember how to log on or whatnot, we can definitely reach out to your state contacts and we can help you get access to that if you are eligible. I just put the state lead contact information up on the screen so everybody can reach out to the appropriate person if they need to.

Laurie Fink: The next question asks if you would please define community.

Nicole: I alluded to it a little bit in the beginning and I would lean on my analytic folks to chime in if I leave anything out or if I don't explain it fully or correctly, is through claims data analysis and other data sources, we look patterns of where Medicare fee for service beneficiaries reside in a geographic area and also healthcare utilization patterns in a geographic area. Based on that, natural groupings of zip codes are identified. There's certain patterns we look for. To define something as a care transitions community there needs to be some cohesiveness in terms of x percentage are above a certain percentage, whether it's sixty percent, or seventy percent, or eighty percent, a certain amount of overlap utilization of the healthcare resources in that geographic area.

There could sometimes be situations where that natural overlap isn't so obvious, where people are going to hospitals outside of the geographic where they live, if they live close to another state or something. Using those methods, I called it parties to transitions, analysis and things like that, there is some natural patterns that developed and based on that these care transitions, geographic community can be identified. Did anybody want to expand on that? I feel like maybe I didn't explain that as simply as it could've been. Am I still on?

Andy: Yeah, Nicole, I'm sorry. You're still on.

Nicole: I did get a call waiting, which was the one technical thing that I wasn't anticipating. I'm using a land line but I guess you can get call waiting on a cell phone too. I got call waiting from, it said, Jaguar. I think that means I might have won a car or something. I don't know. Maybe I should've picked up. Laurie if you want to read the next question, I think that'll help. It's similar in terms of how we choose the communities. We can answer that one too.

Laurie Fink: Sure. The next question is, is information provided in the readmission areas compiled of just information provided by other county hospitals? Or is compiled of all Medicare claims? For example, our closet other hospital is in another county.

Nicole: Can I defer to an analytic person on that one?

Andy: Nicole, I can take that one.

Nicole: Thanks.

Andy: The answer there is that it's all the claims of the beneficiaries who live in the zip codes in the defined community. It doesn't matter what hospitals patients go. It's based on the individuals who live within the community. If somebody is hospitalized in the next community, or re-hospitalized, that gets counted. If it's somebody from outside the community who gets hospitalized in one of the hospitals within a county, they would not get counted because they are not from the community.

Laurie Fink: That's all the questions that have been submitted so far in the q&a or the chat. I'll go ahead and we'll try and unmute the lines. If anyone has any questions please speak up and we'll address any questions you may have.

Nicole: [inaudible 00:42:18]. I'm hearing a lot of background noise already. Remember to mute yourself people. Are we opened or closed right now, Laurie?

Laurie Fink: The lines are still unmuted.

Nicole: They are unmuted? Maybe we just need to give people a moment or two to mute themselves. Remember, as I said before, it's your responsibility to mute yourself on your phone at this point so we don't hear your noise. If you have a question and would like to speak to all of us, we would love to hear from you. At that point feel free to unmute yourself and ask your question. Anybody have a question or comment? I'll read a comment. There was a comment in the chat from someone in Alexandria, Louisiana. I'm still learning to read the reports. I appreciate this opportunity to learn how to access and use the website. I'm a patient care coordinator with a home health agency.

Thank you very much for that comment. That was from Laura. I appreciate that. While we're seeing if there are any questions coming in, there's something else that I wanted to share that came up in my meeting this morning that I had at a hospital. In addition to the data reports, web portal has the my quality insights learning platform component. That's something that we've shared on other calls is about the educational information that's available on there and that we have eLearn or web based learning programs for which you can get certified nursing education credit for. In addition to that, there's a lot of resources based on your area of interest such as care coordination in this case.

Within that there's also news where we post up relevant news items and links and tools and not only our own webinars and things that are coming up but if it's webinars, something that somebody else is holding that we think is relevant and supportive we post that as well. One of the areas that we're trying to really get off the ground and we really encourage people to use is the forum. There's a community forum space where there's an opportunity to have group discussion in there. Somebody can post a comment and then somebody else, anybody that's affiliated with care coordination and medication safety throughout our entire QIN region can see that and has the opportunity to respond. I had a question at my meeting this morning is, one of the biggest challenges that hospitals have is getting real time readmission data so that they can do more cause analysis and drill down in more real time as to what the cause of a readmission was so that they can then take action on it.

The question was asked, what are other sites doing? How have other sites dealt with that and what are they doing to get more timely information? I said, that's a great question. Why don't we put that up in the forum? Those kinds of things. We're here to help and we'll do everything that we can to help you but the opportunity to speak to one another and benefit from one another's experience from those that are on the front lines is so much more valuable than what I as an individual can bring to the table. I highly encourage everyone to take a look at that. Everybody that's a participant with the QIN in this work, gets a weekly email that says what new information has been posted in the community. Not only the forum but news and other things. Please be on the lookout for that. I know it takes a little bit of a login because you've got to type your user name and your password.

It's not an open site. It's only for QIN participants that are working with and one another. It is password protected for your protection but we encourage you to take the time to take that step and login and use the resources and use the forum because we think that it can be really helpful.

Laurie Fink: Nicole, there have been a few other questions submitted. The first one asks, how often are the community reports updated and when was the last time they were updated?

Nicole: I think I tried to squeeze that in while I was talking. They are updated quarterly and they were updated recently, the end of January actually is the last time they were updated. That is something that will be ongoing as I said and will reflect the most recent claims data, that mature claims data that we have access to.

Laurie Fink: Do you have reports for the entire state?

Nicole: No. That's something else that I already said is we don't have reports for every geographic area in the state. Only the ones in which we are currently and actively working, but as time goes on and we broaden our scope of the areas that we're working in we will develop reports for those areas as well. Not quite the whole state but probably getting close to it by the end of 2016, 2017.

Andy: Nicole, this is Andy Miller again. For the state of Delaware it is the entire state. The entire state has been now designated as the community. For people who are on from Delaware it is a state wide report.

Nicole: Thank you very much. I apologize for always forgetting that. Delaware, as most know, is not my home state. I'm New Jersey which right next door to Delaware and I should remember that. I apologize for that. Any other questions or comments at this time? Think we had a lot of phone shy people this month.

Laurie Fink: We still have a couple extra minutes. I actually went ahead and muted everyone's line again as there was no questions coming through. If you would like to submit a question via the q&a or the chat, please feel free to do that now. Here’s another question. It says, I'm very new to this. If a patient falls into our community zip code but always goes to another hospital, do they count as ours?

Nicole: Andy, I think you had commented on that before as well. Do you want to reiterate?

Andy: The answer is yes. It's ours if you're defining ours as within our community. If it's for a particular hospital or other provider in that community, no it's not counted against that individual facility, but

for the purposes of this report, yes, that individual would be included as part of the community.

Nicole: Right, but if it were a hospital specific report then than that would be reflecting fee for service beneficiaries that go to that hospital.

Andy: Exactly.

Nicole: Not only those that live in a certain zip code and go to that hospital, unless we've made a special report just for that. That's the advantage of the community based report is it's really the activity of those that live there as opposed to the activity of one particular institution in a certain place.

Laurie Fink: I'm not seeing any more questions but we can hold for a minute or two and give people time to think about it. If any questions come to mind, go ahead and send it via the chat or the q&a and we'll hang on for a couple more minutes.

Nicole: Again, I would definitely encourage use of that community forum and looking at the reports in general. I know that people are very busy and they have so many things on their plate and whenever we show people, when we happen to do a presentation or a discussion such as this or in an in person meeting, show these kinds of reports they're always perceived as very useful but when we say you could've asked this yourself just by going onto the quality insights website and logging in, a lot of times people either weren't aware or they knew but they were very busy. Or they forgot what their login was and that sort of thing. Again, the state contacts are on the screen.

Do not hesitate to reach out and when you see those weekly emails saying, new content has been added to the care coordination community or some people are involved in multiple communities who might be working also on nursing homes, quality improvement collaborative and things like that. Or healthcare [inaudible 00:52:55], those sorts of things, please take the time to check in and take a look at what's there. We hope that you'll find it very useful.

Laurie Fink: Nicole, there has been another question submitted. Will CJR impacting care give any strategies for analyzing potential practice changes, with regards to anti-coag?

Nicole: Can you repeat the beginning of that question? With what impacting community care?

Laurie Fink: With CJR impacting community care.

Nicole: CJR?

Andy: Nicole, CMS has a demonstration project which it's not by choice. Certain regions of the country have been selected by CMS to participate in this and payment for joint replacement surgery is going to be made on a ...

Judy: Bundle

Andy: Bundle payment basis. Thank you Judy. There is incentive to cooperate among hospitals that are doing the surgery and the post-acute care providers that are going to be involved in the patient's care. I would bet that there's probably in all of our states at least one region which is included in this. I'm not sure about that. The question is, if you're going to have people who are needing, I

think the question is need anti-coagulation post-surgery. Do we have any suggestions for that? I'll throw that one back to you.

Nicole: Thank you. As you were starting to explain, the acronym clicked in and then I knew what they were talking about. It's hard to keep all the acronyms straight at all times. I think that the bottom line is, because I'm the pharmacist I get to speak on the medication safety part of it, is, going back to those events and ICV nine codes that we looked at, really the ICD-9 codes that we saw coming up most frequently are very much in line and very supportive of previous literature that has already been out there and already been published like the [inaudible 00:55:29] emergency hospitalizations, two thirds of them are [inaudible 00:55:39] for drug related events, two thirds have traced back to four groups of drugs, anti-coagulants, anti-platelets, insulin, and what's number four?

Other oral hypoglycemic agents. I do report a couple of years ago looking at adverse events in the inpatient setting. Very similar with the only slight difference of respiratory events to opioids showing up a little bit more on the impatient versus the outpatient. The bottom line is we really need to look at, if there's one event that we can focus on. If there's one adverse event or one problem we can focus on. Bleeding for anti-coagulants. Hypoglycemia for insulin. Respiratory compromise for opioids and if we can do education, best practice, intervention, working together across the community in different settings to have an impact on that, then that's the best thing that we can do. That's the smart thing that we can do.

I can't personally comment on whether one anti-coagulant is better than another because there's so many factors that come into play as far as cost of the drug itself but then cost of monitoring or lack of monitoring. Things like that. I would say, that's a special, specific topic and it would have to be a deep dive into what the literature says on that and if it were a particular pilot program to go in a certain direction or recommend a certain protocol in that regard. I couldn't speak to that directly but I would say that looking at what the research, or what the literature, what the evidence says is the safest route to go would probably be a good place to start in that kind of demonstration [inaudible 00:57:56] or that kind of environment.

Laurie Fink: Thanks so much Nicole. I'm not seeing any more questions coming through. I think we'll go ahead and wrap up this session today. I want to thank everyone who joined us this afternoon. As I mentioned earlier, the presentation slides and the recording of this session will be posted on the my quality insights online learning platform, probably within the next day or two. There will be a brief four question evaluation at the close of this session. Please take just a minute to complete it. Your feedback really does help us to plan for future events that will best fit your needs. Thank you and have a great rest of the day.

Nicole: Thanks everyone.