CARE TRANSITIONS NEWS
at a glance

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Volume I No. 1

In the News...

- Adults with Medicaid and Medicare (dual-eligible) have higher re-hospitalization rates than Medicare-only adults and other patients. The Agency for Healthcare Research and Quality (AHRQ) has developed a **Hospital Guide to Reduce Medicaid Readmissions Toolbox** to address this issue. The Toolbox, provides resources that can be used and adapted for any healthcare provider setting, and is available free of charge at www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-focus.html.
- **The Centers for Medicare & Medicaid Services (CMS) is 50 years old this year!** On July 30, 1965, then President Lyndon Johnson signed legislation that created the Medicare and Medicaid Program to provide healthcare benefits to Americans who did not have health insurance. At that time, roughly 50% of seniors had no health insurance. Today, Medicare and Medicaid cover nearly one of every three Americans and have become key drivers for increased access to quality and affordable healthcare.
- A new publicly reported measure on Hospital Compare, **"Medicare Spending per Beneficiary (MSPB),"** includes the average spending level per episode for each hospital, compared to state and national averages. The measure is risk adjusted to account for geographic and patient (age and illness severity) differences. The episode period includes Medicare Parts A & B claims paid from three days prior to a hospital admission through 30 days after discharge. The New York State average MSPB is $18,941; the National MSPB is $19,578. For more information visit Hospital Compare at www.Medicare.gov.

2015 IPRO Quality Award Winners Announced

IPRO's Anne Myrka, RPh, MAT led a cross-setting Medication Reconciliation Collaborative from January through June 2015. Although each organization in the Collaborative demonstrated improvements in care coordination, three had dramatic improvements and were presented with Quality Awards:

- **Albany Memorial Hospital** (Albany, NY) demonstrated a 34% improvement in communicating critical anticoagulation-related discharge information to downstream providers.
- **HealthAlliance of the Hudson Valley** (Kingston, NY), achieved 90% adherence to medication reconciliation protocols, the highest level of of all hospitals working with IPRO on this topic.
- **Evergreen Commons Nursing Home** (East Greenbush, NY) achieved an 89% improvement in medication reconciliation at admission and a 48% improvement in anticoagulation discharge communication from baseline measurement.

"By focusing on improving communication across settings and insisting on medication reconciliation as a means of preventing dangerous drug interactions, Albany Memorial, HealthAlliance, and Evergreen Commons demonstrated that they're quality improvement champions," according to Clare B. Bradley, MD, MPH, IPRO's Senior Vice President and Chief Medical Officer. "We salute their achievements and their commitment to patient safety."

Care Transition Coalition Highlighted

The accomplishments of the Albany Care Transitions Coalition (ACTC), the recipient of a 2014 IPRO Quality Award, were highlighted in the May/June issue of *Patient Safety and Quality Healthcare*. "New York State Coalition Improves Communication for Care Transitions." ACTC, an innovative community partnership includes **Albany Medical Center** and 35 skilled nursing facility, home health and hospice organizations covering a seven-county region in upstate New York. The Coalition has worked to advance the quality of care coordination for clinically complex, high-risk patients to ensure that healthcare is as seamless and as safe as possible, and that the necessary supports and information are available to help patients to participate fully in their health management. For the article and details about intervention strategies, visit http://psqh.com/may-june-2015/new-york-state-coalition-improves-communication-for-care-transitions.

Delivery System Redesign Incentive Program (DSRIP) Updates

DSRIP's purpose is to restructure the New York State health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by

Continued on next page

This material was prepared by the Atlantic Quality Innovation Network (AQIN), the Medicare Quality Innovation Network-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-Tskc3-15-26

IPRO
Serving New York State

Atlantic Quality Innovation Network
NY • DC • SC

25% over five years. A key component of this strategy is improving care transitions (CT), and DSRIP's Domain 2 provides nine CT/transitional care projects to meet program goals. Strategies include ED triage for high-risk patients, CT interventions to reduce 30-day readmissions for chronic health conditions, and use of the INTERACT for Skilled Nursing Facilities (SNFs). Currently 96% of DSRIP communities have chosen Domain 2 CT projects. The leading chosen CT project is the Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions. There are three main objectives of this project: 1) pre-discharge patient education, 2) transition of care records to the receiving practitioner, and 3) community-based support for a 30-day transition period post-hospitalization. For more information: visit www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP.

Preventing and Reducing Adverse Drug Events (PARADE)

IPRO is establishing collaborative cross-setting relationships between provider settings to facilitate adoption of evidence-based tools that improve care for patients who are prescribed high-risk medications; specifically anticoagulants, hypoglycemics, and opioids. The objectives of the PARADE initiative are to identify patients at risk of experiencing an ADE, identify hospital readmissions and emergency room visits associated with high risk drug exposure, evaluate the post-discharge medication use system across settings to identify opportunities for system improvement, and implement evidence-based intervention strategies. Cycle 1 of the PARADE initiative took place January–July 2015. Each participating organization assessed its medication reconciliation process upon admission and its discharge communication related to anticoagulant therapy. Interventions tailored to address individual organizations' results were implemented. Thirty-three facilities participated—12 hospitals; 15 SNFs; and four home care agencies. Results showed 15.39% improvement from baseline to re-measurement for anticoagulant discharge communication and 27.23% improvement in medication reconciliation process. Hospital teams also participated in an ADE surveillance process that identifies readmitted patients taking one of the high-risk drugs. Cycle 2 begins September 2015. For more information, visit http://qio.ipro.org/care-transitions/healthcare-professionals/tools-resources.

Patient/Beneficiary Engagement

United Hospital Fund's "Next Step in Care" website (www.nextstepincare.org) features easy-to-use guides to help family caregivers and healthcare providers work closely together to plan and implement safe and smooth transitions for chronically or seriously ill patients. The materials—available in English, Spanish, Chinese and Russian—highlight careful planning, clear communication, and ongoing care coordination.

For additional information, tools and resources please visit http://qio.ipro.org/care-transitions/overview.

For additional information, tools and resources related to care transitions please visit the IPRO Coordination of Care Web page: http://qio.ipro.org/care-transitions/overview.

Contact Us

CARE TRANSITIONS TEAM

Sara Butterfield, RN, BSN, CPHQ, CCM
Direct Dial: 518-320-3504
Fax: 518-426-3418
E-mail: Sara.butterfield@area-l.hcqis.org

Christine Stegel RN, MS, CPHQ
Direct Dial: 518-320-3513
Fax: 518-426-3418
E-mail: Christine.stegel@area-l.hcqis.org

Fred Ratto Jr., BA
Direct Dial: 320-3506
Fax: 518-426-3418
E-mail: fred.ratto@area-l.hcqis.org

DRUG SAFETY TEAM

Darren M. Triller, PharmD
Direct Dial: 518-320-3525
darren.triller@area-l.hcqis.org

Anne Myrka, RPh, MAT, BCPS
Direct Dial: : 518-320-3591
anne.myrka@area-l.hcqis.org

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Atlantic Quality Innovation Network
NY • DC • SC

IPRO
Serving New York State