CARE TRANSITIONS NEWS
at a glance

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

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In the News...

- The Office of the HHS Assistant Secretary for Health has created new training materials for health care professionals on caring for people living with multiple chronic conditions. These conditions encompass physical illnesses as well as mental/emotional disorders. The resource includes a conceptual model that outlines core domains and competencies for interdisciplinary health care teams. The course is Web-based and consists of six (6) modules. The training is accessed here: www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html
- Beginning January 2, 2016, the Home Health Quality Improvement (HHQI) Campaign is sponsoring a free QAPI series in its University. The series and tools have been created from the *draft Conditions of Participation (CoP)*. The program covers the five (5) Standards of Home Health QAPI and offers 1.5 Nursing CE's. (www.homehealthquality.org/Home.aspx)
- The newly created CMS Medicare-Medicaid Coordination Office (MMCO) is dedicated to supporting providers in their efforts to deliver more coordinated care to Medicare-Medicaid enrollees. These enrollees, sometimes referred to as "dual-eligibles," have multifaceted chronic care needs, with two-thirds of enrollees defined as elderly and poor, and one-third disabled and under 65. Heavy utilization of services across all settings result in disproportionately higher costs to Medicare and Medicaid programs, with estimates that 45% of dual-eligibles' hospitalizations are avoidable. To meet the care needs of this population and their providers, MMCO offers technical assistance and tools based on successful innovations and care models. The resources are available via www.resourcesforintegratedcare.com. MMCO has contracted with The Lewin Group and Institute for Healthcare Improvement (IHI) to assist these efforts.

CMS Releases Proposed Discharge Planning Rules For Hospitals (including, Critical Access and Long Term Care Hospitals) And Home Health Agencies

On October 29, 2015 CMS released a proposed rule that will revise the discharge planning requirements for hospitals, including long term care and critical access hospitals (CAHs), inpatient rehabilitation facilities, and home health agencies. The rule updates the CMS discharge planning requirements to better align with current practices. Under the proposed rule, hospitals and CAHs will be required to develop discharge plans within 24 hours of admission and complete them prior to discharges or transfers to other facilities. In addition, the new rule extends the discharge planning process to specific outpatient populations. These include patients under observation; patients undergoing outpatient surgery or other same day procedures if receiving anesthesia or moderate sedation; and patients in the emergency department who have been identified by practitioners as needing discharge plans. The rule stipulates that hospitals and CAHs must implement discharge planning processes that adhere to the following:

- Give consideration to the availability of caregivers and community based services,
- Address the patients' goals for care and treatment preferences,
- Assist the patient and family/caregiver in selecting a post-acute care service provider via access to information on quality measures and data on resource use
- Provide discharge instructions to patients who are discharged home, which is defined to include discharge to the care of a primary care physician, home care program, or hospice. A copy of the discharge instructions must be provided to the primary care physician, home care, or hospice.
- Implement a medication reconciliation process that includes all prescribed and over the counter medications that will be taken after hospital discharge.
- Send pertinent medical information when a patient is transferred to another facility.
- Establish a post discharge follow-up process that includes follow-up care appointments, pending or planned diagnostic tests and telephone numbers of practitioners involved in the follow-up care.
- Assure that a copy of discharge instructions, the discharge summary and a summary of pending tests are forwarded to the follow-up care service provider within 24 hours of availability.

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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-Tskc3-16-04

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Continued from page 1

For Home Health Agencies, the discharge planning process must focus on preparing the patient/caregiver to actively participate in post-discharge care and assure that patient goals, preferences and needs are identified and incorporated into the discharge plan. In addition, the physician must be involved in the discharge planning process. The rule describes the requirements for home health agency discharge/transfer summary documentation.

IPRO awarded two CMS Special Innovation Projects

IPRO has received two (2) CMS Special Innovation Project (SIP) Awards focused on Sepsis and Medical Orders for Life Sustaining Treatment (MOLST/eMOLST) implementation. The Sepsis SIP will be directed at providers and Medicare beneficiaries in the Albany and Syracuse regions. The objective is to reduce sepsis-related mortality and complications through the implementation of protocols that ensure alignment with the sepsis regulations and best practices of care. IPRO plans to expand upon existing evidence-based guidelines and protocols for the identification and treatment of sepsis into pre-hospital and hospital settings, as well as the community. Currently, sepsis is the leading diagnosis for 30-day hospital readmissions in New York State.

The MOLST SIP is a cross-setting initiative targeting Long Island r due to the region's low MOLST and eMOLST adoption rates. The project will educate New York's Medicare beneficiaries and their families/caregivers on the importance of "advance care planning" and how to communicate with healthcare professionals about end of life wishes. The project will also focus on preparing documentation such as MOLST forms or completion of an electronic eMOLST, in order to assure that end-of-life wishes are carried out. IPRO will provide technical support to hospitals, skilled nursing facilities, home health agencies, hospices, emergency medical services and physician practices for adoption, training and implementation regarding MOLST/eMOLST completion.

Both the MOLST and Sepsis SIP projects align with the National Quality Strategy and CMS Quality Strategy triple aim to improve health, improve care and lower costs using innovative techniques.

Preventing and Reducing Adverse Drug Events (PARADE)

PARADE Cycle 2 is well underway with participating providers submitting data for the r second measurement period in November 2015. In Cycle 2, a Diabetes Management Discharge Communication Audit has been offered for providers who wish to focus their medication improvement efforts on anti-hyperglycemic medications. Also, new tools developed for Cycle 2 include *Guidelines for Identifying and Resolving Discharge Medication Accessibility Problems, Manufacturers' Patient Assistance Plans for High Cost Prescription Medications and a Discharge Medications: Nurse to Nurse Warm Hand-off Guidance* tool. PARADE Cycle 2 is due to end in March 2016, but providers interested in participating can contact Anne Myrka,

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

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IPRO Pharmacist, at anne.myrka@area-l.hcqis.org. Recruitment for PARADE Cycle 2 is ongoing.

Patient/Beneficiary Engagement

The *Next Step In Care* website (www.nextstepincare.org) has recently released a new Family and Caregiver Guide named "A Family Caregiver's Guide to Electronic Organizers, Monitors, Sensors, and Apps." The guide offers questions to consider when deciding whether to buy an electronic product or service. The guide includes information on coordinating health care, organizing health information, communicating with family and friends, and home monitoring systems. The guide is available in English, Spanish, Chinese, and Russian.

The *Next Step In Care* website has easy-to-use guides for family care givers and health care providers in order to coordinate safe care transitions for acute and chronically-ill individuals.