Central and Heart of Texas Community Meetings 1Q 2016

There were 4 Central Texas Community Meetings in 1Q 2016. At each meeting, Mary Healy presented TMF data (please refer to data emailed to you – if you did not receive data and would like it sent to you, please contact nanci.newberry@area-b.hcqis.org). Please see attached power point for details.

Here is an overview of data shared for 2Q 2015:

- National Scorecard Data showed both hospital admissions and readmissions trending downward.
- The QIN/State Data shows "Rate of 30-Day Readmits" decreasing from a high of 17.9% at the time of the community kick-off in Q4 2014, but is remaining stable for the past three quarters at around 16% - currently at 16.1%.
- The Community Data indicates a "Rate of 30-Day Readmits" at 16.7%.
  Community Home Health Agency (HHA) data for Q2 2015 is 23.0% which is 7% higher than the State HHA rate of 16.2%. This may indicate that the patients being referred to HHA may not be appropriate (higher acuity), or home health agencies could improve their education processes. Mary recommended doing an RCA to determine who are the patients being readmitted from home health and why they are being readmitted. 36.2% of patients discharged to HHA are readmitted within 0-7 days after discharge, compared with a state average of 30.1%.
- The top DRGs for Central Texas are Heart Failure at 49.3%, Renal Failure 30.6%, Septicemia 17.1%, Esophagitis/gastroenteritis/digestive disorders 17.1%
- Frequency of Readmits: 1 Beneficiary was readmitted 9 times in Q2 2015. 538 Beneficiaries were readmitted 1 time. Mary recommended that it was important to try to risk-stratify to identify the 538 Beneficiaries admitted once to potentially prevent their readmissions.

Hamilton: 02/02/16

Melissa DeLaGarza, Director of Quality Improvement at Hamilton General Hospital, opened meeting with recent statistics on the importance of medication safety. There was good representation from the hospital including Nursing, Case Management, Transitional Care, and Diabetes Education.

Mary Healy, TMF, presented a power point, "Coordination of Care and Medication Safety Project" which included:

- An overview of the TMF QIN (Quality Innovation Network)
- Major changes in the Medicare QIO (Quality Improvement Organization Program
  - Readmissions Network
  - Medication Safety Network
  - Nursing Home Quality Improvement Network (NHQI)
  - Behavioral Health Network
- Q2 2015 Data
- Best practice improvement strategies

Grace Bolanos, TMF, presented details about the Behavioral Health Network which includes working with Primary Care Providers to improve screening for depression and alcohol abuse for which there is now reimbursement for. Her team also works with Inpatient Psychiatric Facilities to improve coordination of care and reduce potentially preventable readmissions. She may be contacted at 512-334-1715 or Grace.Bolanos@area-b.hcqis.org

The participants formed breakout groups and discussed current processes for patient handoffs and medication reconciliation and then shared observations and opportunities for improvement. Nanci and Ruby will follow-up with participants to further discuss interventions and best practices to achieve desired outcomes.

Next meeting: Wednesday, August 3rd – Time and location TBD

Waco: 02/04/16

Gary Luft, Heart of Texas Area Agency on Aging, gave the welcome message and introduced Dr. Roland Goetz from the Family Health Center who spoke about healthcare reform and services the FQHC provides to over 50,000 indigent patients. They also have 11 dentists and 12 behavioral health counselors.

Donnis Cowan discussed the Care at Hand software that they will be using and introduced their coaches, Debbie and JoAnna. They will follow-up with discharged patients and ask questions to determine how they are doing. Based on the data (medical and psychosocial) entered, the software uses predictive analytics to risk-stratify patients who may be at increased risk for readmission and triggers an alert to a nurse/care coordinator who can intervene and potentially explore other options to re-hospitalization.

Howard Grueztner, M.Ed, LPC, gave a presentation on "Caregiver Support" and discussed common challenges and stressors that caregivers face and risks that suggest need for caregiver support in the home setting. There are multiple types of services available including assessment, counseling, resources, and support groups, as well as education and training.

Sue Gleason, Director of Comprehensive Care Management at Baylor Scott & White Hillcrest, gave a presentation on the MOST form. Group discussion included having Debbie Ussery, a mid-level provider with their Palliative Care Program do a webinar for the group.

Matt Boetcher, VP of Comprehensive Care Management at Baylor Scott & White Health, gave an update which included:

- IMPACT Act and proposed changes in Conditions of Participation requiring case managers to provide information regarding post-acute providers to help patient selection and the creation of a BSW Quality Alliance.
- Closure of the Herring Campus with IRF beds moving to the I-35 campus and SNF beds closing. Home Care and Hospice will also relocate.

- CJR program starts April 1, 2016 and will affect 2 BSW Central Texas hospitals: Temple and Round Rock.
- Hospital quality initiatives for each BSW hospital include:
    - Advance Care Planning
    - Medication Reconciliation
    - Follow-up Appointments – PCP, specialists, lab/x-ray
    - Discharge Education

Matthew Malinack, Assistant Administrator, Kindred Healthcare, shared that CMS has implemented a new payment policy for long-term acute-care (LTAC) providers – they will be reimbursed at the full prospective payment system rate if patients have spent at least 3 days in ICU or at least 96 hours on a ventilator. All other stays will receive a per diem "site-neutral" payment rate. SNFs will be getting sicker patients sooner which will result in a need for SNF staff to improve their ability to care for higher acuity patients. Kindred is currently increasing education for their post-acute staff, specifically wound care. Also, there have been recent acquisitions by Kindred at Home (Girling, Gentiva and Integracare) and there is a referral line for all Kindred organizations: 866-KINDRED.

Grace Bolanos, Quality Improvement Consultant TMF Behavioral Health, gave an overview of this initiative to work with Primary Care Providers to improve screening for depression and alcohol abuse for which there is now reimbursement for. Her team also works with Inpatient Psychiatric Facilities to improve coordination of care and reduce potentially preventable readmissions. She may be contacted at 512-334-1715 or Grace.Bolanos@area-b.hcqis.org

Next meeting: Thursday, April 28th – 2:00-4:00 PM – Heart of Texas Area Agency on Aging

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Hillsboro: 02/17/16

Introductions – half of attendees were there for the first time.

Mary presented data and then asked for examples of a de-identified recent readmission or examples how a readmission was prevented.

Lynette Rhea, DON at Homestead Nursing and Rehabilitation of Hillsboro, shared an example of a resident with repeated admissions/readmissions and the group discussed possible options.

Shanna Girsh, Hill Regional Hospital Director of Medical/Surgical/CCU gave an update on the discharge call back process which addresses follow-up appointments and medications. This process has been in place for several years. The goal is to call patients discharged home with or without home health within 3 days. A report is generated to the CEO if calls are not made in a timely manner. The hospital is also scheduling follow-up physician visits.

Susan Schaetti, Market CEO with Kindred, shared that their LTAC is making calls within 3 working days of discharge. The IRFs also make calls at 60-90 days to follow functional improvement.

Mary added that some providers are utilizing a "Discharge Readiness Survey" that can be given to patients/families prior to discharge. TMF Teach-back Cards will be available soon.

Debbie Hancock, CNO at Hill Regional Hospital, shared the process they have implemented called "M in the Box." For patients on new medications, the nurse draws a box with the letter M in it on the patient's white board. Subsequent nurses will see the "M in the box" and ask the patient questions about the new medication including purpose, side effects, etc. Once the patient is able to do accurate teach-back, the M is erased – or if another new medication is ordered, another M is place in the box.

Mary added that the community needs assessment identified a problem with patients getting affordable medications. Some providers have put in outpatient pharmacies to be able to supply discharge medications and have increased the use of pharmacist involvement in providing discharge education.

Matt Malinak, Assistant Administrator at Kindred, discussed some upcoming changes affecting the LTAC setting in September, 2016.

Home Health Agencies Bridgeway, Encompass, Lee) discussed care coordination opportunities, especially regarding medication reconciliation, during handoffs at admissions and discharges.

SNF providers were encouraged to work with the TMF NHQI (Nursing Home Quality Improvement) Team, if they are not already.

Next meeting: TBD

Belton/Temple/Killeen: 02/18/16

Nanci welcomed group and explained agenda.

Donna Parker, Central Texas Area Agency on Aging, gave update on CTI/Bridge Program and Care at Hand software. This technology is currently being used at Baylor Scott & White Memorial and allows hospital social workers to trigger referrals to CTI/Bridge coaches who schedule follow-up visits and/or phone calls with discharged patients. Based on data (medical and psychosocial) documented by coaches, the software uses predictive analytics to risk-stratify patients who may be at increased risk for readmission and triggers an alert to a nurse/care coordinator who can intervene and potentially explore other options to re-hospitalization. Plans are to add this intervention at Metroplex Hospital in the near future.

Mary Healy, TMF, presented a data update (see above).

Teach-back cards have been updated and will be available soon. All post-acute providers should consider implementing these and use it as intervention. There is potential for positive impact on HCAHPS scores as well as readmission rates.

Nanci gave an update from the last MSAG (Medication Safety Advisory Group) call in 12/15 and encouraged all facilities with pharmacists to participate – and anyone involved with medication education.

Grace Bolanos, Quality Improvement Consultant with TMF, gave an introduction to the TMF Behavioral Health initiative which encourages PCP's to screen MCR FFS patients for depression and alcohol usage. She is available to work with physician practices to learn billing codes for these screenings. She is also available to IPFs to help with care coordination and readmission prevention. She may be contacted at 512-334-1715 or Grace.Bolanos@area-b.hcqis.org

Jessica Laskoskie, Discharge Call Nurse at Seton Medical Center Harker Heights, gave the group an overview of her discharge call-back program and presented data showing a significant decrease in readmissions since implementation of this program in 3Q 2015.

Susan Burchfield, Central Texas Area Agency on Aging, shared that she will be teaching Evidence Based Programs including the Stanford "Diabetes Self-Management Program" and "Chronic Disease Self-Management Program" and also "A Matter of Balance" in the 7 counties that they service. For more information, please contact her at 254-770-2356.

Matt Boetcher, VP of Comprehensive Case Management with Baylor Scott & White Health, gave an update on the CJR (Comprehensive Care for Joint Replacements) which is a type of bundled payment initiative that will affect providers in the Killeen, Temple, Round Rock areas starting April 1, 2016. He also gave an update on the IMPACT Act which will impact post-acute providers (LTAC, IRF, SNF and HHA) with readmission penalties in the next few years. It also directs hospitals to provide their inpatient population with information to make an informed decision when selecting a post-acute provider. BSW is also in the process of developing a Quality Alliance of preferred post-acute providers based on quality metrics. Since January, 2016, BSW is referring 100% of discharged CHF patients (and other diagnoses) to the CTI/Bridge Program.

Marcia Lowe, Executive Director of Girling Health Care in Temple, explained that the community PHC patients they care for are under Girling and their certified patients are now under Kindred at Home. The phone number to the Temple office is 254-778-6334.

Gloria Cruz, ADCS at Meridian Brookdale, shared that they are hosting monthly educational programs that offer CEUs for nurses and social workers with lunch provided.

Debby Smith, Case Manager at Rollins Brook Community Hospital, shared an innovative idea: The volunteers at the hospital have donated money to help needy patients obtain certain medications they would not otherwise be able to obtain. This effort will potentially prevent a readmission. The program has been so successful, they have increased the amount they donate.

Next meeting: Wednesday, May 18 – 2:00-4:00 PM – Metroplex Hospital