AF4Q 3.0 Collaborative Efforts Regarding Hospital Readmissions for CHF and COPD

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OREGON HEALTH CARE QUALITY CORPORATION
A nonprofit partnership for quality improvement

BACKGROUND

The Oregon Health Care Quality Corporation has received funding from the Robert Wood Johnson Foundation for the next phase of *Aligning Forces for Quality* (AF4Q 3.0). Over the last few months staff have engaged Quality Corp Board, Program Committee and Measurement and Reporting Committee members and a wide variety of additional stakeholders (Oregon Association of Hospitals and Health Systems, Oregon Health Care Leadership Council, State of Oregon Department of Human Services and other community groups working to improve care for Oregonians with CHF and/or COPD and reduce hospital readmissions). Quality Corp and all of these stakeholders view this as a unique opportunity to leverage different CHF, COPD and readmission planning efforts and coordinate communications, pilot projects and sharing best practices and outcomes of these ambitious efforts. The following information is a draft outline of current activities and implementation planning (subject to review and approval before finalization).

DESCRIPTION OF CURRENT ACTIVITIES IN OREGON (to be expanded following additional outreach)

- The **Transitional Care Collaborative**, sponsored by the Department of Human Services, Seniors & People with Disabilities, is an action-oriented effort throughout 2010-2011 to learn about and test best practices for improving care transitions. Teams composed of staff from hospitals, skilled nursing facilities, home health agencies, physician practices, community-based long-term care settings and Area Agencies on Aging are working together to improve care transitions in their community. Five community teams across six counties are collaborating and sharing their changes, experiences and data through Learning Sessions, conference calls and e-newsletters.

- **Hospital to Home** is a project based on Eric Coleman's Care Transition Intervention focused on reducing unplanned re-hospitalizations by using coaches to help individuals increase their ability to take a more active role in managing their health care. Samaritan Health Services and Oregon Cascades West Council of Governments/Senior & Disability Services have undertaken a one-year demonstration project beginning in November, 2010 to reduce 30-day unplanned readmission for the same diagnosis targeting people discharged from Lebanon Community Hospital with CHF, COPD and/or pneumonia. The 30-day intervention includes one or more home visits and follow-up phone calls with specially trained coaches who focus on medication discrepancies, signs and symptoms to monitor, follow-up appointments with PCP and/or specialist and a personal health record. Coaches

take a holistic approach to each patient, working with him/her on other health issues in addition to the focus conditions.

Next Steps for Hospital to Home include in-depth staff training on the complete Eric Coleman model sponsored by DHS – Seniors & People with Disabilities and expansion to additional demonstration projects between other Area Agencies on Aging and local health care partners in Jackson, Lane, Marion and Multnomah counties.

- The **Hospital Quality Network: Reducing Readmissions** is a project of the Oregon Health Care Quality Corporation, the Oregon Association of Hospitals and Health Systems and the Robert Wood Johnson Foundation's *Aligning Forces for Quality* (AF4Q) to reduce 30-day all-cause readmission rates following hospitalization for heart failure and 30-day readmission rates for heart failure following hospitalization for heart failure, and to increase the number of patients who receive all of the care they were eligible to receive – taken from the heart failure core measure set (called "Measure of Ideal Care"). The virtual collaborative, which began in August, 2010, runs for 18 months providing technical assistance from nationally recognized experts; successful interventions, strategies, approaches, tools and actions from previous RWJF initiatives; analysis of data and tailored "coaching" to improve performance and identify/reduce disparities.

- **Performance Health Technology** (PHTech) provides administrative and operational support to regional health plans throughout Oregon. It is one of six approaches to payment reform that are involved in the AF4Q 3.0 proposal. PHTech will test a payment reform model beginning with CHF and COPD to incentivize medical practices to reduce admissions and readmissions using a physician-designed, program-oriented claim payment engine that pays all of a patient's care team members based on their collective ability to achieve a specific clinical goal for each patient. The increased payment opportunity is adjudicated in real time, based on historical data. By May 2011, two health plans and 100 providers representing 20% of the delivery system in Salem will be ready to execute this new payment model for the COPD and CHF programs. PHTech expects to reduce costs by $0.94 per member per month. Quality Corp will assist and align support materials, including best practice guidelines that help providers meet the patient goals.

- **State of Oregon** – The Oregon Health Policy Board is charged with creating a comprehensive health reform plan for Oregon, and to that end, has released *Oregon's Action Plan for Health.* Part of that plan directs the state to "Identify and develop 10 sets of Oregon-based best practice guidelines." Quality Corp is working with the State and the OHSU Center for Evidence-based Policy on the development of guidelines for CHF and COPD.

The following initiatives are not specifically focused on reducing readmissions for CHF and/or COPD, however each will benefit transition of care for all patients regardless of condition.

- **CareOregon Releasing Time to Care (RT2C)** is a nurse-led innovation designed to improve patient care. RT2C was developed by the NHS Institute for Innovation and Improvement and rolled out to

almost all hospitals throughout the UK. This methodology is designed to help front-line hospital nursing staff increase the time available for bedside nursing by improving the safety and delivery of care. Hospitals participating in the RT2C Collaborative include OHSU, Providence Portland Medical Center, St. Charles in Bend and Tuality Healthcare. In addition to CareOregon, the Oregon Nurses Association and the Oregon Association of Hospitals and Health Systems are also partners in this initiative.

- **Transforming Care at the Bedside** (TCAB) engages nurses and other frontline hospital workers in testing improvements that can lead to processes that are more consistent and safe, a more patient-centered approach to providing care and a more fulfilled workforce. The goals of TCAB are to improve the quality and safety of patient care and reduce disparities in care; increase the vitality and retention of nurses and frontline staff; engage and improve the patient and family members' experience of care; and improve the effectiveness of the entire care team. The Oregon Health Care Quality Corporation and the Oregon Association of Hospitals and Health Systems are partnering with RWJF through *Aligning Forces for Quality* to launch TCAB in Oregon in June, 2011.

- **The Oregon Health Leadership Council (OHLC) Evidence based Best Practices group** is also evaluating opportunities to reduce unnecessary hospitalizations. The group is currently reviewing best practices and national model programs as part of the early evaluation and decision making.

GOALS

The following high-level goals have been developed by Quality Corp and community stakeholders for this work with additional milestones and process goals to be articulated by a multi-stakeholder committee convened in early summer of 2011 to provide oversight to these projects.

- Achieve national average for complete instructions given at discharge for heart failure patients by April 2013 in hospitals participating in the Hospital Quality Network and targeted communities.

- Reduce preventable admission rates and 30 day readmission rates following hospitalization for heart failure or COPD by 10% in targeted communities by April 2013.

- Reduce 30 day readmission rates following heart failure hospitalization by 20% for hospitals participating in the Hospital Quality Network by March 2012.

DELIVERABLES

The following deliverables have been drafted by Quality Corp staff with input from stakeholders and will be reviewed by steering committee members in early summer 2011.

Produce an environmental scan of current regional and national best practices for CHF/COPD readmission reduction areas (STAR, BOOST, etc.).	April 2011

Convene multi-stakeholder committee – including the Oregon Transitional Care Collaborative, Oregon Association of Hospitals and Health Systems, hospitalists, consumers with CHF and/or COPD and the Oregon Health Leadership Council – to develop consensus about possible approaches and pilot sites.	May 2011
Quality Corp hires additional project management staff to support program	May/June 2011
Produce baseline data to demonstrate where key opportunities for improvement are in Oregon. Data may include: • 30-day all cause readmission rate following CHF/COPD hospitalization • 30-day readmission rate following CHF hospitalization (CHF readmit are Hospital Compare measure) • Total cost of care • Utilization • Discharge instructions given (Hospital Compare measure) • Avoidable admissions • Guideline utilization	June 2011
Conduct assessment of best practices nationally and in Oregon to evaluate different models, evidence and results to date.	June /July 2011
Select pilot sites and intervention for reducing hospital readmission.	June /July 2011
Analyze data from pilot sites to validate issues and develop focus.	August 2011
Provide technical assistance to pilot sites to implement interventions.	September 2011 – December 2012
Collect and analyze data from pilots at regular intervals to create actionable reports.	September 2011 – December 2012
Facilitate consistent discharge planning tools, including consumer-developed collateral materials for patients.	September 2011 – December 2012
Support incorporation of standard processes for the flow of discharge information through the REC and HIE implementation, and through IPA driven community-based HIE nodes.	September 2011 – December 2012
Foster payment reform that creates a business case across all payers, health plans and providers to reduce readmissions with OHLC (plans), Oregon Health Authority (State government), OCHCP (purchasers), OAHHS (hospitals) and physician groups.	September 2011 – December 2012
Develop summary of efforts to reduce CHF/COPD readmission, including clinical summary information, to share with Oregon providers and stakeholders.	January – April 2013