Partnership for Patients Initiative: Relationships and Collaborations

National Organization of State Offices of Rural Health
May 31, 2012
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Presentation Outline

- NOSORH PfP Work
  - Current/Past Work
  - Upcoming Meetings
- Quality Improvement Organization
- Hospital Engagement Network
- Rural Health Clinic
- Questions and Comments
### NOSORH PfP Work

#### What’s we’ve done

1. SORH Calls assessing interest
2. Webinar Introduction to PfP
3. PfP Toolkit Edition 1
4. Learning Community Calls (2 series)
5. Member of Rural Affinity Group

#### What we’re planning

1. PfP Toolkit Edition 2
2. Learning Community Calls
3. PfP Updates at Regional Meetings
4. Post Conference Session-NOSORH Annual Mtg
5. Participate in HEN meeting content development
Integrating Care for Populations and Communities Aim

TRACI ARCHIBALD, OTR/L, MBA
QUALITY IMPROVEMENT GROUP
OFFICE OF CLINICAL STANDARDS AND QUALITY
CENTERS FOR MEDICARE AND MEDICAID SERVICES
ICPCA Goals

- Improve the quality of care for Medicare beneficiaries as they transition between providers

- Reduce 30 day hospital re-admissions by 20% over 3 years for the nation
Care Transitions

A definition...

- Movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change.

- Specifically, they can occur:
  - Within settings
  - Between settings
  - Across health states
  - Between providers

National Transitions of Care Coalition
http://www.ntocc.org/Portals/0/TransitionsOfCare_Measures.pdf
QIOs and Community Engagement

- Identify potential communities- defined by the Medicare beneficiaries that live in contiguous set of zip codes
- Recruit and convene community providers and stakeholders to collaborate to improve care transitions and reduce 30-day hospital readmissions for the beneficiaries they serve
QIO Technical Assistance

- Community Coalition Formation
- Community-specific Root Cause Analysis
- Intervention Selection, Implementation and Measurement Strategies
- Assist with an Application for a Care Transitions Program
Community Organizing Techniques

- Tie participation to values
- Include personal narratives
- Intentionally develop other leaders
- Intentionally develop relationships
- Develop flexible tactics
Strategic Plan

- Include broad range of community leaders
  - Provider groups
  - Community based organizations (CBO’s)
  - AAAs and ADRC’s
  - Regional Health Initiatives
  - State and local government
  - Advocacy and Service Organizations
  - Other payers
Why are people readmitted?

Provider-Patient interface
Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

Unreliable system support
Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals
Community Specific Root Cause Analysis

- Data Analysis
  - Proportion of Transitions Table
    - Coalition Readmission rates
    - Coalition Admission rates
    - Hospital Admission rates
    - Hospital Readmission rates
    - ED visit Rates
    - Observation Stay Rates
    - Mortality Rates
    - Post acute care setting Readmission rates
    - Disease specific readmission rates
- Process Mapping
- Chart Reviews
- Patient/Stakeholder feedback
ZIP Code Level Readmissions per 1000 Beneficiaries
(January 1, 2010 – December 31, 2010)
Intervention Selection & Implementation Plan

- Results from the community specific root cause analysis
- Existing local programs and resources
- Funding resources
  - Cost estimates associated with intervention implementation
  - Estimates for intervention penetration
- Sustainability
- Community preferences
Intervention Models

- Care Transitions Intervention (CTI)®
- THE BRIDGE MODEL
- GRACE
- BPIP
- GUIDED CARE
- Transitional Care Model
Intervention Measurement Strategies

- Involves a series of Reach, Intervention Effectiveness and Utilization Measures
- Providers and CBO’s will need to collect most of the Reach and Intervention Effectiveness Measure data
- QIOs can help facilitate linking Medicare claims-based Utilization Measures to interventions
- QIOs are working with communities to prepare run charts showing the impact of interventions over time
Application for participation in a formal Care Transitions Program

- Data analyses and trending reports
- Interventions selection rationale
- Cost estimates for interventions
- Other application requirements
Additional Assistance for Communities

- Provide quarterly community readmission metrics
- Host a State-wide Learning and Action Network
- Participate in Care Transitions Learning Sessions
- Use QIO developed tools and resources
QIO Activity
(August 1, 2011-March 31, 2012)

- 149 Communities Recruited
- 121 Community Coalition Charters Signed
- Assisted with 68 Communities Submitting Applications to Care Transitions Funded Programs
- Contributed to 22 Accepted Care Transitions Program Applications
Hospital Engagement Network

JEFF SPADE, EXECUTIVE DIRECTOR,
NC CENTER FOR RURAL HEALTH INNOVATION AND PERFORMANCE
Objectives

- Describe the Partnership for Patients (PFP) initiative
- Understand the key elements of the Hospital Engagement Network
- NoCVA as HEN example
- Engagement ideas for SORHs
National Alignment

- Affordable Care Act – *the law*
- National Quality Strategy – *the vision*
  - To set the priorities for increased access to high quality, affordable care
  - National aims and priorities
- Partnership for Patients – *the campaign*
- Hospital Engagement Network – *resources and support*
Partnership Goals

Reduce harm caused to patients in hospitals

*By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010*

Approximately 1.8 million fewer injuries to patients, more than *60,000 lives saved* over three years!
Hospital-acquired Conditions

- Central line associated blood stream infection
- Catheter associated urinary tract infection
- Surgical site infection
- Pressure ulcers
- Injuries from falls and immobility
- Adverse drug events
- Obstetrical adverse events
- Venous thromboembolism
- Ventilator-associated pneumonia
Partnership Goals

Improve care transitions

By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be reduced by 20% compared to 2010.

Approximately 1.6 million patients would recover from illness without suffering a preventable complication requiring re-admission within 30 days of discharge!
Partnership Programs

**The Hospital Engagement Network (HEN)**

- Essential network of resources to support hospitals in achieving PFP goals.
- 26 HENs
- Conduct training programs in all core events
- Provide technical assistance
- Measure and track improvements/outcomes
- Funding for 2 years, optional third year
- Hospitals pledge to join only one HEN
Hospital Engagement Networks

- American Hospital Association
- Ascension Health
- Carolinas HealthCare System
- Catholic Healthcare West
- Dallas-Fort Worth Hospital Council Foundation
- Georgia Hospital Association Research and Education Foundation
- Healthcare Association of New York State
- Hospital & Healthsystem Association of Pennsylvania
- Intermountain Healthcare
- Iowa Healthcare Collaborative
- Joint Commission Resources, Inc.
- Lifepoint Hospitals, Inc.
- Michigan Health & Hospital Association

- Minnesota Hospital Association
- National Public Health and Hospital Institute
- New Jersey Hospital Association
- Nevada Hospital Association
- North Carolina Hospital Association
- Ohio Children’s Hospital Solutions for Patient Safety
- Ohio Hospital Association
- Premier Tennessee Hospital Association
- Texas Center for Quality & Patient Safety
- United Healthcare Veteran’s Health Administration
- Washington State Hospital Association
PFP Internet Resources

CMS.gov
- http://www.healthcare.gov/compare/partnership-for-patients/

CMS Innovation Center
- http://innovations.cms.gov/initiatives/Partnership-for-Patients/index.html

AHA & HRET
- http://www.hret-hen.org/

Institute for Healthcare Improvement (IHI)
- http://www.ihi.org/explore/CMSPartnershipForPatients/Pages/default.aspx

Healthcare Communities (PFP)
Partnership for Patients Hospital Engagement Network

ABOUT

Last year, the Department of Health and Human Services (HHS) launched the national Partnership for Patients initiative to make healthcare safer and less costly by targeting and reducing the millions of preventable injuries and complications from healthcare acquired conditions. The Partnership for Patients set two crisp aims:

- Reduce hospital acquired conditions by 40%, and
- Reduce preventable hospital readmissions by 20% by 2013

Iowa’s hospitals rallied behind this call to action, with 100% of hospitals pledging their commitment to the Partnership.

Shortly after the launch of the campaign, the Center for Medicare and Medicaid Services (CMS) Innovation Center launched a nationwide public-private collaboration termed the Hospital Engagement Networks (HEN) to identify and create innovative solutions designed to reduce patient harm and improve care coordination. CMS awarded 26 organizations a two-year contract to help identify the key improvements and spread initiatives across their defined population.

The Iowa Healthcare Collaborative has been awarded the sole Iowa-based contract to serve Iowa hospitals in this campaign. IHC will work with the Iowa Hospital Association (IHA) and Tlligen, Iowa’s Medicare quality improvement organization, to implement the program and serve as subcontractors.

The Impact of the HEN on Iowa’s Healthcare System

Hospitals and the healthcare community will continue to receive the proven and dedicated efforts IHC has provided in the past. Over the next two years, the HEN will focus on 10 key areas that will seek to improve hospital performance on the following quality markers: adverse drug events, catheter-associated urinary tract infections, central line-associated blood stream infections, injuries from falls, adverse obstetrical events, pressure ulcers, surgical site infections, ventilator-associated pneumonia, venous thromboembolism, and preventable hospital readmissions.

The HEN will include 116 of Iowa’s community hospitals, as well as five hospitals across the state lines affiliated with the University of Iowa Hospitals and Clinics.
NoCVA Hospital Engagement Network

The North Carolina-Virginia Hospital Engagement Network (NoCVA HEN) is a group of 117 hospitals in North Carolina and Virginia working to meet the goals of the Partnership for Patients, a national initiative which aims to reduce patient harm by 40% and reduce readmissions by 20%. Hospitals who participate in NoCVA identify strategies to reduce harmful patient events, share solutions, and have access to learning opportunities.
North Carolina Virginia HEN

- NCHA as the prime contractor
  - NC Quality Center is leading the initiative
- VHHA is a subcontractor and partner
- Other subcontractors
  - Carolinas Center for Medical Excellence (CCME)
  - Healthcare Team Training (HTT)
  - Virginia Health Quality Center (VHQC)
- Many partners
- 120 NC and VA hospitals
Who Has Pledged?

http://partnershippledge.healthcare.gov/

170 VA organizations
260 NC organizations
<table>
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<tr>
<th>Component</th>
<th>Collaborative</th>
<th>Learning Network</th>
<th>Campaign</th>
<th>Educational Program</th>
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<tr>
<td>Data collection</td>
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<tr>
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Small, Rural Hospitals Enrolled in NoCVA

- 17 Critical Access Hospitals
- 22 rural hospitals less than 30 average daily census
- 8 hospitals 30 to 50 average daily census
- 3 hospitals 50 to 60 average daily census
Small, Rural Focus Areas

Targeting six PfP activities that are the most relevant harm categories and improvement opportunities for small, rural hospitals:

- Eliminating CAUTI
- Falls prevention
- Improved pressure ulcer care
- Surgical site infection prevention
- Reducing adverse drug events
- Improving care transitions to prevent hospital readmissions
Major Activities for Rural Hospitals

- Complete the organizational assessment.
- The Center will help small, rural hospitals enroll in the collaboratives organized by NoCVA.
- Organizing face-to-face improvement workshops, two workshops in eastern NC and two workshops in western NC annually.
- Develop and post to the internet two webinars annually focused on the six PfP activities.
- Webinars and workshops are devoted to focused improvement concepts, evidence-based practices, rural hospital examples and shared learning.
Engagement and Partnership Ideas

- Sign the PFP Pledge as a state-level partner
- Actively seek a partnership role:
  - How can I (we) help achieve success?
  - Promotion
  - Enrollment
  - Engagement
- Encourage CAHs and small, rural hospitals to join the HEN
- Align MBQIP and FLEX with PFP
- Help organize improvement collaboratives
- Engage rural health partners
ACHS
Ammonoosuc Community Health Services

EDWARD D SHANSHALA II, MSHSA, MSED, CEO
Who are we? We are ACHS.

- **Scope**
  - ACHS is an NCQA Level 3 PCMH including medical, behavioral, dental, pharmacological and enabling services.

- **Priorities/Mission**
  - To provide a network of comprehensive Primary Health Care and Support Services to individuals and families throughout the 26 communities we serve. In support of this mission, ACHS provides evidence-based, outcome-specific, systematic care that is: patient-centered, prevention-focused, accessible and affordable for all.

- **Community**
  - ACHS Serves 26 towns in the White Mountain Region of Northern New Hampshire
  - Collaborating Partners cover the continuum of care

- **Statistics**
  - ACHS is the Patient Centered Medical Home of Choice for 1 in 3 of the 31,000 residents in our service area.
Quality & Patient Safety an Integrated Approach

- Rather than Quality & Patient Safety contrasted an integrated paradigm may prove most effective and efficient; a question to consider.
- Place the patient at the center and work one’s way outward to resolve differences.
- Not a zero sum endeavor rather a multi-win scenario
Examples of Projects for SORH Collaboration

- Health Resource Service Administration (HRSA)
  - Chronic Disease Collaborations
  - Patient Safety Pharmacy Collaborative (PSPC)
- Federally Qualified Health Center (FQHC), Critical Access Hospital (CAH), and Certified Home Health & Hospice Agency (CHHA) Collaborations
  - Health Information Exchange (HIE)
  - Accountable Care Organization (ACO)
  - Patient Safety Pharmacy Collaborative (PSPC)
- Regional Healthcare Consortium Collaborations
  - Oral Health
  - Accountable Care Organization (ACO)
- Statewide Healthcare Consortium Collaborations
  - New Hampshire (NH) Citizens Health Initiative (CHI) Patient Centered Medical Home (PCMH) Pilot Project
  - New Hampshire Citizens Health Initiative Accountable Care Organization Pilot Project
Health Resource Service Administration (HRSA) Chronic Disease Collaborations

BACKGROUND
• 1998 Depression, Diabetes, Asthma, Coronary Artery Disease.

GOALS
• Disease specific i.e., PHQ9 (Depression), HgA1c (Diabetes), etc.,
HRSA Patient Safety Pharmacy Collaborative (PSPC)

BACKGROUND

- 2009 ACHS joins PSPC with an initial population of focus of 62 diabetics who had 12 or more prescription medications on their active medication list.

GOALS

- (1) Diabetes in control, (2) decrease potential & adverse drug events (ADE), (3) decrease emergency department and acute care utilization for ADE’s
FQHC and CAH Collaborations
Health Information Exchange (HIE)

BACKGROUND

- 2006 ACHS initiates labs being performed by Littleton Regional Hospital and Cottage Hospital whereby the results are delivered through an HL7 interface into the ACHS General Electric Centricity Electronic Health Record/Practice Management Solution.

GOALS

- (1) Increase accuracy, timeliness, effectiveness, and efficiency of lab results. (2) Financial stabilization of all organizations through collaboration.
FQHC, CAH, CHAA Collaborations Accountable Care Organization (ACO)

BACKGROUND
• ACHS was the lead agency leveraging NCQA PCMH Level 3 recognition and existing collaboration with Littleton Regional Hospital, Cottage Hospital, and North Country Home Health and Hospice to become a pilot for the NH CHI ACO Pilot Project

GOALS
• (1) enhance patient flow through the continuum of care (2) improve quality of clinical outcomes (3) eliminate non-value added work and associated expense.
**FQHC and CAH Collaborations**

**Patient Safety Pharmacy Collaborative (PSPC)**

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**BACKGROUND**

- ACHS is the 340B Contract for Littleton Regional Hospital, is in conversations with Cottage Hospital for 340B and both of which are engaged in the PSC

**GOALS**

- (1) Implement and integrate clinical pharmacy services across the continuum of care, (2) decrease potential/adverse drug events, (3) decrease polypharmacy, (4) decrease pharmacy related emergency department and acute care use.
Regional Healthcare Consortium Collaborations
Oral Health: Molar Express

BACKGROUND
• The North Country Health Consortium (NCHC) is a rural health network, created in 1997, as a vehicle for addressing common issues through collaboration among health and human service providers serving Northern New Hampshire. The Molar Express is an example of a collaborative effort to meet the unmet oral health needs of a rural population

GOALS
• (1) Focus on School-Based Hygiene Program, Oral Health Education, Nursing Homes and efficient use of limited oral health resources. (2) Expand to a “Hub & Spoke” model with FQHC and CAH Collaboration. (3) Expand to teach facility with NH DHHS, Bi-State, PCA, HRSA, and University of New England
Regional Healthcare Consortium Collaborations
Accountable Care Organization (ACO)

BACKGROUND

- Lead by Mid State Health Center, the North Country Health Consortium as the parent organization created the North Country Accountable Care Organization as a non-profit subsidiary of NCHC comprised of Mid State Health Center, Ammonoosuc Community Health Services, Coös Family Health Services, and Indian Stream Health Center. NCACO is now a CMS Shared Savings Advanced Payment Model ACO Pilot Project.

GOALS

- (1) enhance patient flow through the continuum of care (2) improve quality of clinical outcomes (3) eliminate non-value added work and associated expense.
Statewide Healthcare Consortium Collaborations
NH CHI PCMH Pilot Project

BACKGROUND
• ACHS participated with 8 other organizations and commercial insurance organizations in a patient centered medical home three year demonstration project. The unpublished results of which demonstrate success both clinically and financially and enable ACHS to expand into two ACO pilot projects.

GOALS
• (1) Clinical outcomes consistent with Health People standards. (2) enhanced patient engagement as active participants in their own healthcare. (3) financially sustainable model of care.
Statewide Healthcare Consortium Collaborations
NH CHI ACO Pilot Project

BACKGROUND
• ACHS was the lead agency leveraging NCQA PCMH Level 3 recognition and existing collaboration with Littleton Regional Hospital, Cottage Hospital, and North Country Home Health and Hospice to become a pilot for the NH CHI ACO Pilot Project

GOALS
• (1) enhance patient flow through the continuum of care (2) improve quality of clinical outcomes (3) eliminate non-value added work and associated expense.
NEEDS-HIGHLIGHT SORH ROLE

- Facilitator of process.
- Connector to policy makers
- Provider of data and/or data analysis
- Access to funders
## Collaboration with SORHs

<table>
<thead>
<tr>
<th>What works</th>
<th>What doesn’t work</th>
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<tbody>
<tr>
<td>• Convene potential collaborators</td>
<td>• Taking sides</td>
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<tr>
<td>• Facilitate collaborative process</td>
<td>• Having all the answers</td>
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<tr>
<td>• Create connection to to policy makers</td>
<td>• Being Partisan</td>
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<td>• Provide data and / or data analysis</td>
<td>• Not maintaining a focus on the patient</td>
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<tr>
<td>• Provide access to funders</td>
<td>• Being prescriptive rather than descriptive</td>
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<tr>
<td>• Author the “story”.</td>
<td>• Using words such as why, can’t good, bad, better, worse, right, wrong, and but.</td>
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<tr>
<td>• Facilitate replication</td>
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<tr>
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Questions and Comments?

THANK YOU