CY 2015 Medicare- QIP Annual Update Submission

**DO Section-**

**I6- Barriers Encountered**

1. Barriers Encountered. Select- **Yes.**
2. If YES- What Barriers- *(2,500 characters) –* (notes in red)1488 characters

**Change in Delegation Model**: With the ending of the D-SNP plan and starting of the Medicare-Medicaid plan, Cal-Medi-Connect (CMC), discharge planning and management of care transitions were delegated to L.A. Care (LAC) participating provider groups (PPGs). **Evaluating Care Transition functions:** Due to the variable nature of how each PPG decided to approach managing care transitions, it was difficult to characterize, monitor, and evaluate which intervention components were driving changes in outcomes. Also, with CMC being a new plan and claims/encounter lag, there was limited HEDIS 2015 (MY 2014) data to establish baselines specific to the duals population. **Variable PPG CMC membership size:** The three PPGs with the majority of our CMC membership (Top 3 PPGs) represent 70% of CMC membership and were most engaged with L.A. Care (LAC) regarding the QIP. The remaining PPGs represent 30% of CMC membership but each have less than 5% of total CMC membership (some with only single digit membership)- with such small numbers, it is difficult to engage and assess individual PPG performance. **Discharge summary** **unavailable to PPGs**: PPGs do not always receive hospital information for admitted and/or discharged patients in a timely and complete manner. **PPG Unable to Contact Member**: Members are unable to be reached post-discharge (phone number not valid, no response to outreach, etc.) so PPGs cannot engage the member in care transition activities and coordination of follow-up care.

1. If YES- Mitigation- How did you address the barrier(s) encountered- *(2,500 characters) -* **1486 characters**

**Change in Delegation Model:** LAC outlines PPG responsibilities for management of transitions of care (TOC) in the provider manual including seven minimum requirements. LAC began requiring PPGs to report data on the sharing of transition records within 24 hours of discharge and members getting follow-up care within 30 days. **Evaluating Care Transition functions:** The provider manual outlined PPG TOC requirements are rooted in the care transition evidence-base like the Coleman Model. Using both PPG reported metrics and LAC claims/encounter data, LAC is able to track and trend certain shared outcomes despite variability in PPGs’ TOC programs. **Variable PPG CMC membership size:** Although all PPGs are monitored for compliance,directintervention by LAC’s QIP team was limited to those PPGs with at least 30 index admissions in the past year. **Discharge summary unavailable to PPGs:** PPGs reported streamlining this process by identifying key points of contact at hospitals and outpatient facilities to retrieve and share discharge information. LAC is exploring potential health information exchange (HIE) initiatives to share more real-time admission/discharge/transfer data. **PPG Unable to Contact Member:** Each PPG has a protocol that involves multiple attempts to reach members- some require multiple numbers be shared so there can be alternative means of contact, some PPGs meet members in-person at the hospital so that they are more likely to engage in TOC processes post-discharge.

**STUDY Section-**

**J- Results and Findings** (notes in red)

J1- Total Population (members in contract) (number)- 14516 Member Services Intranet report FY 2015 month of Sept.

J2- Denominator (# eligible for readmissions measure, all CMC) (number)- 1007 Members eligible for readmissions measure according to HEDIS PCR index discharges Q3 of 2014 through Q2 of 2015.

J3- Numerator (# readmitted within 30 days per PCR HEDIS specs, all CMC) – 162 (For all of CMC there was a 16.09% PCR rate (not risk adjusted), Q3 of 2014 through Q2 of 2015. )

\*\*\*- Top 3 PPGs population (# members in top 3 PPGs) (number)- 10093

Top 3 PPGs Denominator (# eligible for readmissions measure, **combined** Top 3 PPGs) (number)- 583 Members eligible for readmissions measure according to HEDIS PCR index discharges Q3 of 2014 through Q2 of 2015.

Top 3 PPGs Numerator (# readmitted within 30 days per PCR HEDIS specs, **combined** Top 3 PPGs) – 80 (Among our Top 3 PPGs (representing 70% of total CMC membership) there was a 13.72% PCR rate (not risk adjusted), Q3 of 2014 through Q2 of 2015)

\*\*\*- Grouping of Remainder PPGs with CMC membership (# members) (number) - 4404

Grouping of Remainder PPGs Denominator (# eligible for readmissions measure, **combined** Grouping of Remainder PPGs) (number)- 424 Members eligible for readmissions measure according to HEDIS PCR index discharges Q3 of 2014 through Q2 of 2015.

Grouping of Remainder PPGs Numerator (# readmitted within 30 days per PCR HEDIS specs, combined Grouping of Remainder PPGs) – 82 (Among our remainder PPGs (representing 30% of total CMC membership) there was a 19.34% PCR rate (not risk adjusted), Q3 of 2014 through Q2 of 2015)

J4- Results and/or Percentage- *(1500 characters) - 951 characters*

Being a new plan and given the continuous enrollment criteria (12-month pre-discharge) based on PCR HEDIS specs, the denominators (index admissions) are smaller in HEDIS 2015 (service dates 2014) so the readmission rates may not be stable. Thus, we opted to make the measurement year from July 1, 2014 through June 30, 2015 (Q3 2014 through Q2 2015) for our baseline measurements. The PCR rate (**not risk adjusted**) baseline analysis of the CMC population from July 1, 2014 through June 30, 2015 (Q3 2014 through Q2 2015) includes (a) the overall PCR HEDIS rate for all of CMC and then segmented analysis of the HEDIS PCR rate by (b) those members within one of the three top PPGs (representing 70% of the CMC population) and (c) those members in the remaining PPGs (each PPG with membership no greater than 5% of total CMC population but combined representing 30% of CMC population): these PCR rates are as follows: **(a) 16.09%, (b) 13.72%, (c) 19.34%.**

J5- Other Data or Results- *(1,500 characters)- 1490 characters*

LAC is tracking two additional TOC metrics-sharing of transition records between settings within 24 hours of discharge and ambulatory follow-up after discharge. The PPG reported rates of transition record shared within 24 hours of discharge was 79.7% for all of CMC in Q1 of 2015. Of note, the rate was greater than 98% for two of the Top 3 PPGs, though more variable among the PPGs with less CMC membership. Among those PPGs not in the Top 3 PPGs with greater than 30 instances of reported shared transition records, the rate dropped to an average of 56.4%. Using claims and encounter data, analysis of the days from discharge to receipt of ambulatory care follow-up occurred (ambulatory health services based on state report criteria). From Q3 2014 through Q2 2015, the percent of CMC members who received follow-up care within 30-days of discharge was 44.17% for all of CMC. Of those who received follow-up care after discharge, the median days to follow-up was 11 days with an average of 25.87 days, standard deviation of 38.55. In CY 2015, LAC conducted extensive inquiry meetings with each of our three top PPGs to better understand the details of how they conduct discharge planning and manage TOC. Qualitative summaries of each meeting were documented and component commonalities identified among their various programs and initiatives. Inquiry meetings are planned for the remaining PPGs with at least 30 index admissions in the past year (Q3 2014 – Q2 2015) (n of 7 PPGs).

J6- Analysis of Results or Findings- *(2,500 characters) 1453 characters*

On a quarterly basis the primary TOC metrics- PCR rates, sharing of transition record, and days to ambulatory care follow-up- are tracked and trended to share with our PPGs and frame discussions during inquiry meetings. Of note, there is approximately a 90 day delay for claims data so review of quarterly data for tracking and trending reflect this lag time. The Top 3 PPGs are excelling in preventing readmissions compared to the PPGs with less CMC membership (each with less than 5% of total membership) by developing evidence-based TOC programs (mainly rooted in the Coleman Model, Project RED, and Boost), streamlining communications, and more fully integrating components from LAC’s TOC and reporting requirements . At baseline, the Top 3 PPGs have an average PCR rate of 13.72% which is 2.37 percentage points lower than the overall CMC and 5.62 percentage points lower than the PCR rates for the grouping of PPGs representing 30% of CMC membership. PPG level analysis identified 3 low performing PPGs with at least 30 index admissions that are targeted for LAC intervention/support given that the average PCR rate among these three PPGs is 26.8% and thus pulling down LAC’s overall CMC PCR rate significantly. Among all the PPGs, the median days to follow-up were similar at10 to 11 days, however the Top 3 PPGs have significantly better rates of sharing transition records within 24 hours which may be contributing to lower PCR rates in this grouping.

**ACTION Section-**

K1- Action Plan- Check all that apply. Revise Intervention-**yes**, Revise Methodology-**yes**, Change Goal-**yes**, Other-**no**.

SUBMITTED (1497 characters) into “other section”:

**LAC is monitoring discharge planning and management of care transitions as part of PPGs’ delegated functions based on TOC requirements outlined in the provider manual. As part of LAC’s delegation oversight, all PPGs with at least 30 index admissions will be engaged in TOC inquiry meetings and completion of the TOC assessment tool. Initial inquiry meetings are structured to discuss variables within the California Quality Collaborative TAACT (Take Accountability for Ambulatory Care Transitions) Driver Diagram. We noted that annual review of PCR rates may not be sufficient for actionable use at the PPG level, thus LAC is tracking and trending three primary metrics (PCR rates, sharing of transition record within 24 hours, and days to ambulatory care follow-up) on a quarterly basis to share with PPGs. LAC will implement a TOC assessment tool to have a more prescriptive approach with the PPGs. Thus, though delegated functions, LAC is using a participatory approach to regularly interact with the PPGs, support PPGs in continuous quality improvement (CQI) processes around TOC, and identify best practices specific to L.A. County duals population which can then be shared with LAC’s network. The target goal will remain a reduction of 3 percentage points in the CMC PCR rate (not risk adjusted) by 2017, however the timeframe of analysis will occur from July (Q3) through the following June (Q2) (not the standard HEDIS calendar year) to be comparable to the full year baseline measurement.**

K2- Action Plan Description- *(1,500 characters) (next steps)-* **1267 characters**

Going forward, LAC will implement a TOC assessment tool that spans all PPGs in the network to verify that the TOC requirements outlined in the provider manual are in place and ask that the PPGs provide documentation of these processes. One-on-one inquiry meetings will continue to occur with the PPGs with at least 30 index admissions in the past year (Q3 214-Q2 2015) to gather details of each of their TOC programs and have a forum for discussing performance (PCR rates, sharing of transition records within 24 hours, and ambulatory care follow-up after discharge), barriers, and opportunities for improvement. From what we have learned so far, it will be important to be prescriptive in our interactions with the PPGs so we can fully understand often overlooked details of TOC program implementation. Using the assessment tool, we will more likely be able to pinpoint gaps and remediate as well as gather best practices that may work for PPGs with similar membership size and/or member demographics. The goal of these collaborative PPG TOC meetings and assessment/oversight is to improve patient care, decrease hospital readmission rates, close the gaps in PPG TOC programs/reporting, as well as increase accountability and transparency between the PPGs and LAC.

K3- Describe “Best Practices”- *(2,500 characters-ok not to have much for 1st year) 1415 characters*

With limited data for this new duals population, few best practices can be drawn from quantitative data at this time. We did learn that the efforts of our PPGs, though varying in approach, are structured to address key components that can impact transitions of care – and are now planning to assess these key components more fully with our TOC assessment tool and inquiry meetings. Several innovations being implemented by high volume PPGs are of interest for evaluation over the coming years as they may become “best practice”. For example, one PPG uses a video interface (iPads) to educate members on the discharge process, red flags, and how the CM nurses will be assisting the member post-discharge. Additionally, this decreases variation of information shared with members prior to hospital discharge. Other PPGs are initiating contact early on in admissions to establish expectations of the discharge process and follow-up by case managers. Through our inquiry meetings, LAC has partnered to implement some sub-pilot initiatives/collaborations, for example, one of the top 3 PPGs is mailing LAC Family Resource Center (FRC) calendars to a subset of specific members to educate on available resources (free health education, exercises classes, etc.) nearby. When best practices are identified within our collaborating PPGs, there will be opportunity to share these best practices across the CMC PPG network.

K4- Describe “Lessons Learned” *(2,500 characters-positive and negative) 1456 characters*

Several valuable lessons have been learned over the course of our initial phase of the CMC readmission QIP. During inquiry meetings with the Top 3 PPGs, there were many questions related to the role of LAC versus the PPG in the delegated functions of discharge planning and care transition management processes, which we had an opportunity to clarify and will continue to do so during future planned PPG TOC meetings. We learned that it is important to be prescriptive in our interactions with the PPGs so we can fully understand often overlooked details of TOC program implementation. PPGs have limitations related to analytic capabilities and LAC can provide valuable support to aggregate and provide data/tracking/trending of associated TOC metrics. These metrics are and will be useful for analysis over shorter quality improvement cycles which tempers the limited baseline data available. The value of our PPGs’ efforts will be demonstrated by a reduction in the PCR rate in the next 2 years, verified ability of the PPGs to implement key TOC program components, as well as consistent reporting and analysis/trending of TOC metrics. This collaborative approach to engaging our PPGs is proving positive in confirming implementation of evidence-based TOC program components, supporting data driven CQI, and identifying best practices which can be extrapolated to our greater network of CMC PPGs to improve the care and health outcomes of our members.