CY 2014 Medicare- QIP Annual Update Submission

**DO Section-**

**I6- Barriers Encountered**

1. Barriers Encountered. Select- **Yes.**
2. If YES- What Barriers- *(2,500 characters)*

**Program data**: Intervention/program data is difficult to capture in the existing case management software. The case management team currently documents in free text forms rather than reportable fields. **Pharmacy data:** Transition of Care (TOC) staff has difficulty accessing pharmacy data. Consequently, they are not able to provide this information to the member’s PCP to be reviewed and discussed during the follow-up visit. **Unable to contact:** Members are unable to be reached post-discharge for various reasons including members are not home or the available phone numbers are incorrect, the member fails to respond, there is not the ability to leave a message and/or the number is disconnected. When a member is unable to be contacted, L.A. Care is not able to outreach to members to participate in the TOC program. **Members decline**: Despite L.A. Care’s offer to participate in the TOC program, some members decline. **Discharge summary** **unavailable**: L.A. Care continues to not always receive hospital information for admitted and/or discharged patients in a timely manner. Attending physicians dictate one or two weeks after a patient has been discharged, thus resulting in delays. Additionally, on occasion, discharge summaries are not legible; thus resulting in delays **Delay in program development**: There were delays in developing the program due to continued organizational and staff (including directors) changes within the key departments involved in the program. New staff that were essential to the intervention was learning the many details of L.A. Care’s organizational processes, therefore, did not clearly understand the various aspects of the intervention workflow and how their role was integral to the success of the intervention.

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

**Program data**: L.A. Care’s readmissions team met monthly to develop and finalize a Transition of Care (TOC) form. The form captures important program data, which will be useful in evaluating the various components of the program. The form is currently being built into the case management documenting system (software). **Pharmacy data**: L.A. Care’s TOC staff has been trained on accessing pharmacy data. They are able to provide this information to the member’s PCP as well as discuss with the member. **Unable to contac**t: In an effort to increase the ability to contact members, L.A. Care staff continued to attempt making phone calls at different times of the day to increase the member contact. Additionally, if a member could not be reached by phone, the TOC staff mailed a letter to them detailing how to contact the TOC team should they desire to. **Members decline**: L.A. Care’s readmission team continued to explore ideas to encourage members to participate. When a member declines to participate in any part of the intervention, TOC coordinators stress the importance of post-discharge care with greater emphasis to the member. In addition, if a member refuses, the coordinators continued to stress the importance of following up with his/her primary care physician (PCP) and the importance of discussing all medications with the PCP. While it is difficult to prevent member refusals, it is anticipated that the coordinator’s cue to action will lead the members to realize the importance of medication adherence, PCP follo up and other program components. **Discharge summary**: In an attempt to obtain discharge summaries in a timely manner, L.A. Care case managers continued to make attempts to retrieve the summaries by calling the hospital staff. In some instances, this was effective. **Delay in program development**: To prevent additional delays or gaps in the intervention, L.A. Care began having readmission meetings, at least quarterly and oftentimes more frequently, to discuss the program and new hires were trained promptly on the components of the program, and the importance of the program was emphasized. Despite organizational changes, our commitment to reducing readmissions remained a priority.

**STUDY Section-**

**J- Results and Findings**

**Notes in red are just an FYI to future QI staff**

J1- Total Population (members in contract) (number)- 6,814 source- Member Services Intranet report FY 2014 month of Dec.

J2- Numerator (# received project interventions) (number)- 37 Members who were in the TOC program from Dec 1-Dec 31, 2013.

J3- Denominator (# eligible to receive project interventions) (number)- 2396 Member eligible for readmissions measure according to HEDIS DST provided by Polo.

J4- Results and/or Percentage- *(4,000 characters)- Plan All Cause Readmissions B (ages 65+) rate- 14% (CMS Case Mix Adjusted Rate)*

J5- Other Data or Results- *(2,500 characters)-*

The Transition of Care (TOC) program began 12/1/13. From 12/1/13-12/31/13, 37 members were admitted into the hospital and participated in the TOC program. No members during that month refused the TOC program or were unable to be contacted. No members admitted from 12/1/13-12/31/13 readmitted to the hospital. As a result, the numerator listed in the results and findings section is only 37. During CY 2013, this relatively small amount of members was in the TOC program because, as mentioned, it did not begin until late in the 4th quarter. Due to significant difficulties in capturing complete extractable data, and an extended timeline to build a TOC form into the case management software, L.A. Care will only report on a subset of the population intervened on, based on available data. The data represents the TOC program for 132 participants between 12/1/13 and 8/31/14. 34.9% of members in this subset were deemed high risk for readmission as a result of the SCARF score derived at the beginning of the intervention. The majority, 90.2%, of hospital admissions were not planned. Of members in the subset who participated in the program, 34.8% of them did not readmit into the hospital. 15.9% of those who accepted program participation did readmit into the hospital within 30 days. Of members in the subset who declined program participation, 1.5% of them did not readmit into the hospital. 0.8% of those declined participating in the TOC program did readmit into the hospital within 30 days. Of the subset, 3.8% were referred to case management at the culmination of their program participation and 2.3% were referred to complex case management. Additionally, 0.8% were referred to social workers.

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

L.A. Care’s Transition of Care (TOC) intervention began in December of 2013 and as a result, the 2013 calendar year rate could not be greatly impacted by the program. It is unclear what affect the post-discharge calls had on that rate or if other interventions by hospitals or IPAs had an effect on the HEDIS rate. It is very possible that hospitals have been working to improve readmission rates due to penalties imposed by CMS. Only a rate decrease in the target group of those who participate in the TOC program would demonstrate a causal relationship. Tracking data and using the PDSA improvement strategy will help determine if the intervention had an impact on the rate.

* The CY 2012 (HEDIS 2013) CMS Case Mix Adjusted PCR Rate- 18%
* The CY 2013 (HEDIS 2014) CMS Case Mix Adjusted PCR Rate- 14%
* For PCR, lower rates are better, L.A. Care’s rate decreased from HEDIS 2013 (18%) to HEDIS 2014 (14%)
* The most current available fee-for-service Medicare national average rate for hospital readmissions in CY 2012 was 18.4% (http://www.cms.gov/mmrr/Briefs/B2013/mmrr-2013-003-02-b01.html). L.A. Care’s Case Mix Adjusted Rate of 14% was 4.4% less than the national average. L.A. Care’s rate was higher than the Medicare national average in CY 2012 and it was 1% lower than L.A. Care’s baseline rate of 15%. Demonstrating improvement in hospital readmissions.
* It is important to note that L.A. Care could not greatly impact the HEDIS 2014 rate with the TOC intervention, because it did not begin until December 2013.

**ACTION Section-**

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

K2- Action Plan Description- *(2,500 characters)(next steps)*

Revise intervention: L.A. Care’s Transition of Care (TOC) intervention began in December of 2013 and as a result, the 2013 calendar year rate could not be greatly impacted by the program. As an overview, the TOC team engages high and moderate risk members while they are at the hospital to receive high-touch interventions during the period following discharge for up to 30 days. As necessary, high and moderate risk members are transferred to case management and complex case management following the TOC program. Members at low risk for readmission receive assistance with care and transportation coordination from L.A. Care’s care coordinators. The TOC program focuses on medication reconciliation and adherence, enhanced patient education, PCP/specialist follow-up and connecting members with resources that enable stable health outcomes and lower use of acute emergency services for care. While the program is largely the same in 2014, there were some revisions. There is an addition of a member mailing for those members that cannot be reached by phone to participate in the TOC program. TOC staff has also been trained on using the pharmacy database so they can provide information to the member’s PCP for appropriate follow up discussions and care. Upcoming months will focus on improving data capture in order to evaluate the outcomes of the members that participate in the program and make data driven changes to the intervention. Lastly, L.A. Care is in exploring the option of delegating the TOC program, or certain levels of the TOC program to provider groups to enhance care coordination and have the most optimal outcomes for members.

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

A best practice is determining a members’ risk for readmission at the beginning of the intervention so staff and resources may be allocated most appropriately. L.A. Care utilized a unique risk assessment tool, developed specifically for L.A. Care’s population. Due to increasing membership volumes, staff and resources must be allocated appropriately in order to effectively implement an intervention.

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

The primary lesson learned is that the development of an evaluation plan is vital in the program planning stage. This includes developing a robust process evaluation and developing appropriate tracking systems. Additionally, L.A. Care has continued to learn that an interdisciplinary approach is critical. We are expanding the member intervention to integrate multiple stakeholders, such as provider groups. We have developed strategies to continuously enhance our intervention to reduce readmissions, for instance the addition of a form to track data adequately being added into the case management software and the development of an unable to contact member mailing. The value of our efforts will be demonstrated by a continued reduction in our PCR rate in CY 2014. L.A. Care is remaining committed to improving care and health outcomes for enrollees.