

The Way Forward

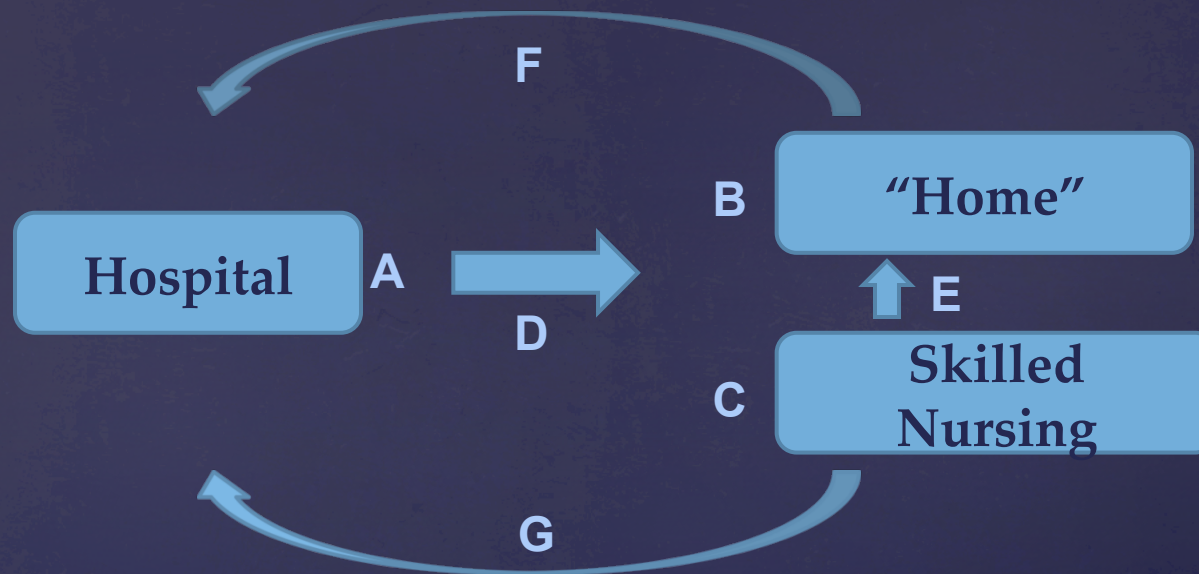
{ Lessons From Current Collaborative Efforts

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Landscape of complementary efforts

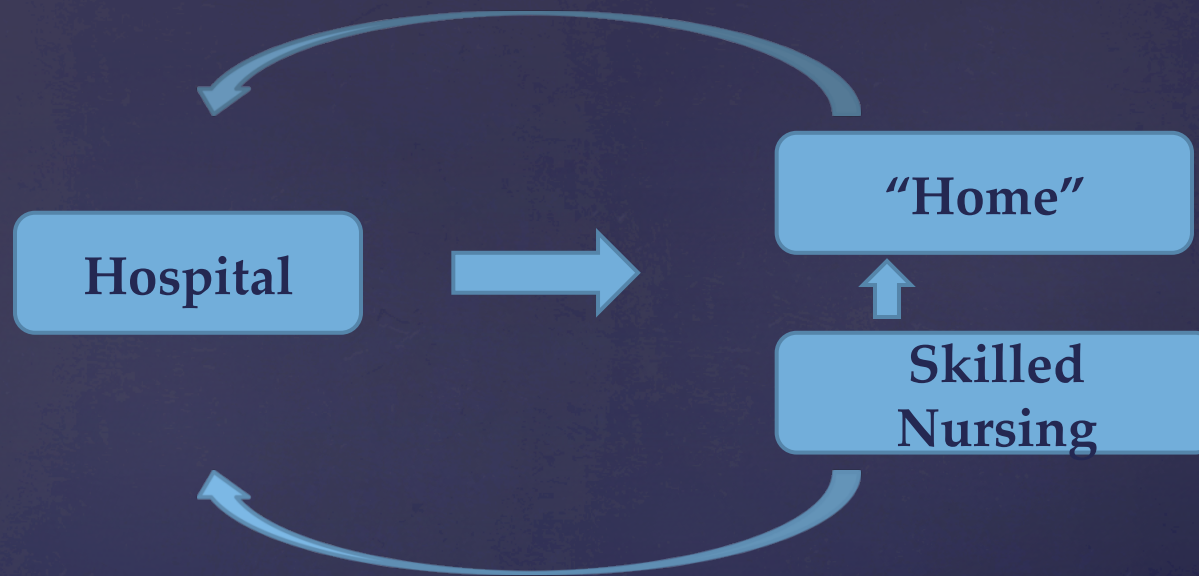
- Hospital based efforts
- Provider based efforts
- Payer-led efforts
- Technology enabled or enhanced efforts
- Patient engagement efforts
- Community, regional, and state-based efforts

Landscape of complementary efforts



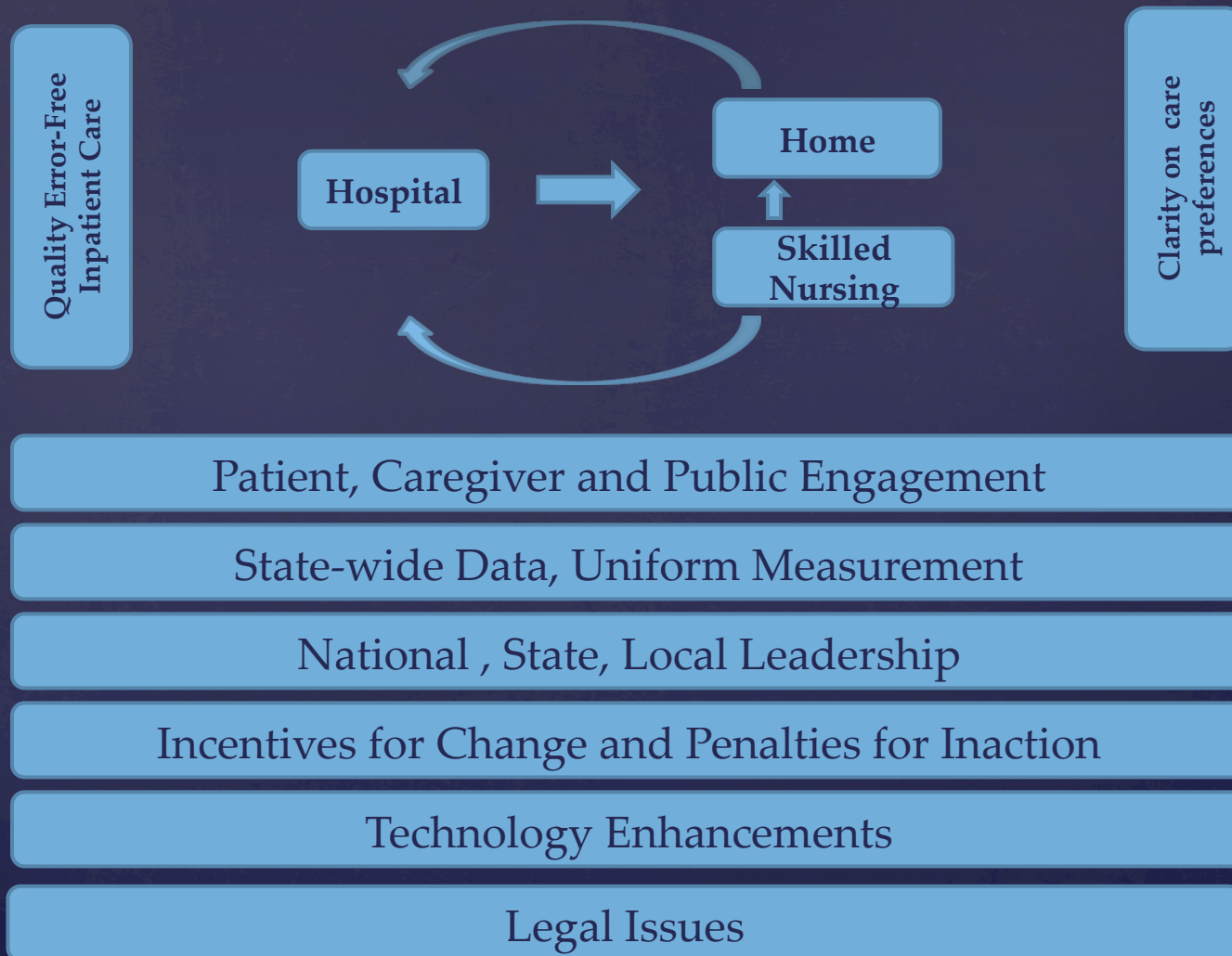
- A: Improve *transition out* of the hospital
- B: Improve *reception into* the community-based home environment
- C: Improve the *reception into* the skilled nursing facility/rehab/VNA care
- D: Provide *supplemental transitional care services* for high-risk patients
- E: Improve the *transition out* of the SNF to community-based home environment
- F: Improve the *communication of key elements* when sent from home to ED
- G: Improve the *communication of key elements* when sent from nursing care to ED

A Portfolio of Complementary Approaches



1. Hospital: RED, BOOST, STAAR, H2H
2. INTERACT
3. Medical home demonstrations and community supports (AoA, ADRC)
4. Enhanced services, such as coaching, transitional care
5. Improved communications, clarity on care preferences (MOLST)

Beyond Setting-Specific Approaches



Where are we, and where have we been?

Program	2007	2009	2011
RED	pilot	dozens	>300
BOOST	pilot	25	82
STAAR	pilot	62, >250	148, >500
H2H	n/a	launch	1141
QIO Theme	n/a	14 communities	53 QIOs
Florida	n/a	80	>100
Illinois	n/a	n/a	~200
New Jersey	n/a	n/a	46
N. California	n/a	n/a	40

Where are we now?

Complementary Efforts	Programs
Hospitals	BOOST, RED, STAAR, H2H
Community Teams	QIO Care Transitions, STAAR, CCTP
Skilled Nursing Facilities	INTERACT
Medical Homes	Local collaboratives
Aging Services	Aging and Disability Resource Centers
Care Transitions Intervention	CCTP, ADRC, QIO, others
Health Information Exchange	ONC Beacon Communities
Public Engagement	AARP, Aligning Forces for Quality
Multi-Sector Engagement	AHRQ Chartered Value Exchange, P4P

Where are these programs active?

Program	State/Setting
BOOST	26 states; 82 hospitals
RED	>300 hospitals
H2H	50 states; 1141 hospitals
Care Transitions Intervention	>36 states, >450 organizations
STAAR	4 states; 148 H; >500 xc partners
QIO Care Transitions	14 communities; 682 xc partners
Aligning Forces for Quality	16 regions
ONC Beacon Communities	17 communities
AHRQ Chartered Value Exchanges	24 communities
Aging and Disability Resource Centers (AoA)	50 states
CMS CCTP and QIO 10 th SOW	50 states

xc=cross-continuum

Coordinating and Aligning in MA

STAAR Initiative (STate Action on Avoidable Rehospitalizations)

- Grant-funded initiative of the Commonwealth Fund
- 4-year effort (2009-2013)
- Program Office: Institute for Healthcare Improvement
- Led by voluntary state leadership organizations in Massachusetts, Michigan, Washington, and Ohio
- The state, not the specific setting of care, is the unit of interest

State-Action Model

Two- approach to mobilize a state-wide effort to reduce rehospitalizations:

- Provide quality improvement assistance to *front-line cross-setting teams* to improve care transitions

AND

- Create *a state-wide, multi-stakeholder initiative* to galvanize attention, align efforts, address common barriers and change the standard of care

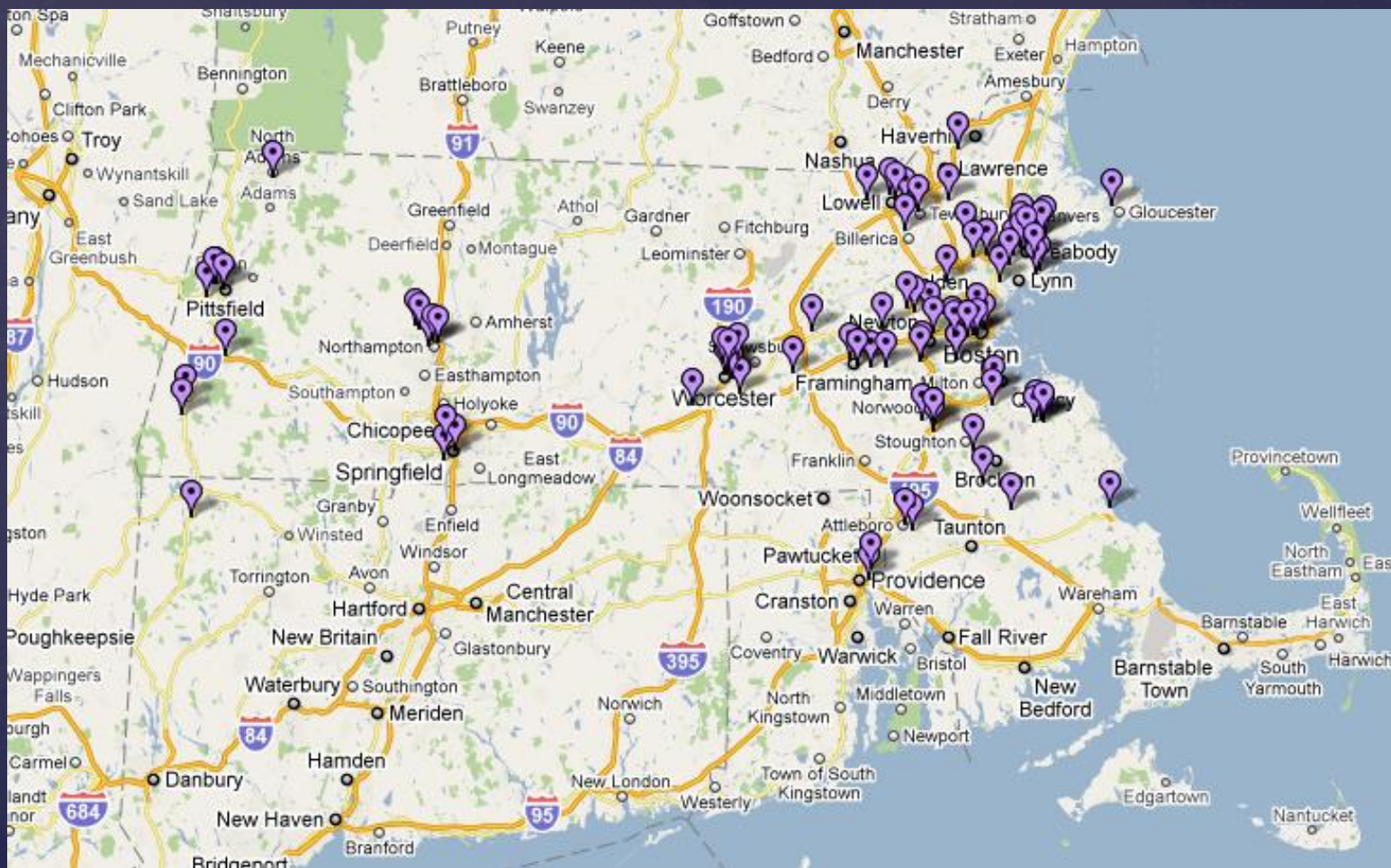
STAAR Hospitals



N=50

STAAR Cross Continuum Team Organizations

Home Health Agencies, Office Practices, Nursing Homes, SNFs, etc



N>250

Multi-Payer Medical Home Initiative



N=46

INTERACT Nursing Homes/SNFs (INTERventions to Reduce Acute Care Transfers)



N>100

Aging Service Access Points



N=116 trained care transition coaches

MOLST Pilot & IMPACT Pilot

(Medical Orders for Life Sustaining Treatment)

(Improving Post Acute Care Transitions)



Worcester “Galaxy” Meeting with STAAR, MOLST, IMPACT, INTERACT

Massachusetts Care Transitions Programs



N>300

Massachusetts CCTP Applications



Good News

- Language, framing, general principles across all these complementary approaches are synergistic
- Each of the programs have unique and compelling strengths
- Signals, incentives, threat of penalties, leadership are all contributing to serial waves of engagement
- Growing acceptance to work within and across settings by coordinating communities of providers

What still needs some attention

- Measurement
- Community –based data for improvement
- Physician engagement
- Public engagement
- Standards of care and regulations
- Attention to disparities, including population with mental health and substance abuse
- Coordinating and aligning resources and efforts in a community*

Lessons from 2011

- Work within and across settings
- Identify and analyze your community of providers
- Involve patients and caregivers
- Inventory the complementary initiatives in your region/state
- Form a coordinating body to ensure programs are complementing each other
- Design a strategy for your region to layer complementary initiatives, such as STAAR, INTERACT, medical home, ADRCs, and others; no one program needs to do it all!

Thank you for your attention, and

Thank you all for participating in the 3rd National
Medicare Readmissions Summit

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