SQAC Quality Priority Proposal

Proposed Priority Area: Appropriateness of Facility-Based Care

Description of the priority area: This priority area has three components that address improving quality in inpatient and institutional care use through reducing:

- unplanned readmissions to hospitals within 30 days of hospital discharge;
- preventable hospitalizations from the community,
- preventable admissions from Skilled Nursing Facilities.

When considering preventable hospitalizations there are two areas that stand out -- those admissions that that could potentially be avoided by better primary and preventive care in an ambulatory setting, and those admissions that could potentially be avoided through better care in a skilled nursing facility.

Reasons priority area is being highlighted: While many stakeholders in the Commonwealth have focused on reducing readmissions and preventable hospitalizations, there is still opportunity for improvement. Reducing readmissions and preventable hospitalizations can improve care and lower health care costs.[1] Doing so requires a coordinated and collaborative effort from actors in the health care system and in the community, and that lowering readmissions remains a priority for stakeholders. Admissions and readmissions can be expensive and disruptive and disorientating, particularly for the frail elderly population and persons with disabilities. CMS recently published a report on an initiative to reduce such admissions among residents in nursing facilities and noted that 15% of residents experienced a preventable hospitalization.[2]

Ways that quality may be improved: There are several paths for reducing readmissions and preventable hospitalizations. For reducing readmissions, hospitals and primary care providers can work on improved discharge planning and follow-up care once an individual leaves the hospital, including focusing on patients at-risk for readmissions, coordinating with care givers in the next setting, whether that be in a skilled nursing facility or with home health or other providers and family members in a community-based setting.

Patients and providers can work to improve patient activation so that patients and their care givers can make better choices about self-care in the community. For example, patient activation can help patients with chronic diseases to adhere to self-care plans aimed at

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[1] http://healthaffairs.org/blog/2013/08/16/reducing-hospital-readmissions-its-about-improving-patient-care/
[2] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html

maintaining health status and reducing preventable hospitalizations. Patient activation can also help patients take a more active role in care coordination and thereby help reduce readmissions.

Ways that quality could be measured: There are a number of current SQMS measures that address these topics:

Measures of Readmissions and Care Coordination

- Plan All-Cause Readmission (NCQA)[3]
- Hospital-Wide All-Cause Unplanned Readmission Measure (Yale/CMS)[4]

Preventable Hospitalizations

- Asthma in younger adults (PQI 15)
- Chronic obstructive pulmonary disease (PQI 5)
- Congestive Heart Failure Admission Rate (PQI 8)
- Diabetes Short-Term Complications Admission Rate (PQI 1)

In addition to the measures already in the SQMS there are additional measures that could be considered including: the AHRQ's PQI measures not included in the SMQS and a Skilled Nursing Facility Readmission Measure (SNFRM) NQF #2510: All-Cause Risk-Standardized Readmission Measure which is currently used for Medicare FFS.[5]

Other related measures included in the SQMS that address issues that can impact hospitalizations and readmissions, such as care coordination and end of life care, are included in the Appendix.

Cross Cutting Dimensions

The SQAC believes that it is important to consider the appropriateness of facility and institutional care across a number of different dimensions including disparities, transparency, care coordination and patient experience/activation.

*Ways that disparities could be measured and improved***:** There is evidence that risk of preventable admissions and readmissions is increased for individuals living in high poverty neighborhoods. [6],[7] In addition, there is also evidence that lack of social support can also increase the risk of

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[3] This could be compared across payer type (Medicare, Medicaid, commercial)
[4] http://www.chiamass.gov/assets/docs/r/pubs/15/CHIA-Readmissions-Report-June-2015.pdf
[5] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNFRM-Technical-Report-3252015.pdf
[6] http://www.mass.gov/anf/docs/hpc/cost-trends-july-2014-section-c.pdf
[7] http://content.healthaffairs.org/content/33/5/778.abstract

readmissions.   Measures, for both preventable admissions and readmissions could be stratified by race/ethnicity, income, geography, commercial insurance vs MassHealth and by hospital.

Improving transparency: CMS reports 30 day hospital readmissions rates on Hospital Compare.[8] CHIA has also done extensive analysis in this area including a recently published report on readmissions rates for all payers and an analysis of the characteristics of readmitted patients.[9] Increased reporting of the results of hospitals readmissions rates, may help patients make more informed choices in where to seek care. Increased transparency on measures that impact preventable hospitalizations may identify areas where access to ambulatory care needs to be improved or where more investment in patient outreach and activation needs to be done.

Link to care coordination: Improved care coordination may lead to reduced avoidable readmissions and prevention of more hospitalizations. Coordination between hospital staff and patient and family members, as well as between SNF staff could have an impact on readmissions and preventable hospitalizations. As care coordination is an important link in both preventing readmissions and hospitalizations, care coordination measures have been included in the identified measures listed above. An integrated health care system would provide linkages between hospitals, specialists, primary care providers, behavioral health and the community. For complex cases there may be dedicated care managers involved, but it can also be viewed as a system-wide responsibility.

Patient experience/patient activation: Improving discharge planning including educating the patient and the patient's family about care after leaving the hospital is one area that can impact readmissions and preventable hospitalizations. There is also research showing that 1) patients level of activation can be changed and 2) that patients with higher levels of patient activation are better able to self-manage their chronic conditions potentially reducing preventable hospitalizations.[10] It should be noted that one of the more wide-spread measures of patient activation, the Patient Activation Measure (PAM) survey, is a proprietary tool and must be licensed from Insignia Health.

State Actors Who Are Working in this Area: CHIA, the Health Policy Commission (Community Hospital Acceleration, Revitalization, & Transformation (CHART) Investment Program), MassHealth, the Care Transitions Steering Committee (see: www.patientcarelink.org) and the New England Quality Innovation Network (NEQIN-QIO) which is administered by Healthcentric Advisors in partnership with Qualidigm.

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[8] See www.medicare.gov/hospitalcompare
[9] This report may be accessed at http://www.chiamass.gov/hospital-wide-adult-all-payer-readmissions-in-massachusetts-2011-2013/
[10] Hubband J, and Greene J. What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. Health Affairs. February 2013, vol 32, no 2. P 207-214. http://content.healthaffairs.org/content/32/2/207.short

Appendix

Related measures in the SQMS

Elder Care or End of Life Care

The measures listed below relate to elder care or end of life care. These measures are indirectly related to reducing admissions and readmissions as appropriate care to patients in the end of life may reduce preventable hospitalizations and readmissions.

- Proportion admitted to hospice for less than 3 days (NQF 216)
- Advance Care Plan (NQF 326)
- Palliative and End of Life Care: Dyspnea Screening & Management
- Potentially harmful drug-disease interactions in the elderly
- Care for older adults - medication review

SNF Specific Measure

This measure looks at a falls in SNFs. Falls are a preventable source of injury and hospitalizations particularity among the frail elderly.

- Fall Risk Management

Measures of Care Coordination

These measures address care coordination for persons discharged from the hospital. Care coordination can help in preventing readmissions.

- Home Management Plan of Care Document Given to Patient/Caregiver (CAC 3)
- Timely transmission of transition record (CCM 3)
- Detailed Discharge Instructions (HF 1)
- Post discharge continuing care plan transmitted to next level of care provider upon discharge (HBIPS 7)
- Post discharge continuing care plan created (HBIPS 6)