Chronic Care Improvement Program (CCIP)

Decreasing Cardiovascular Disease

Quality Improvement Program (QIP)

Reducing All Cause Readmission

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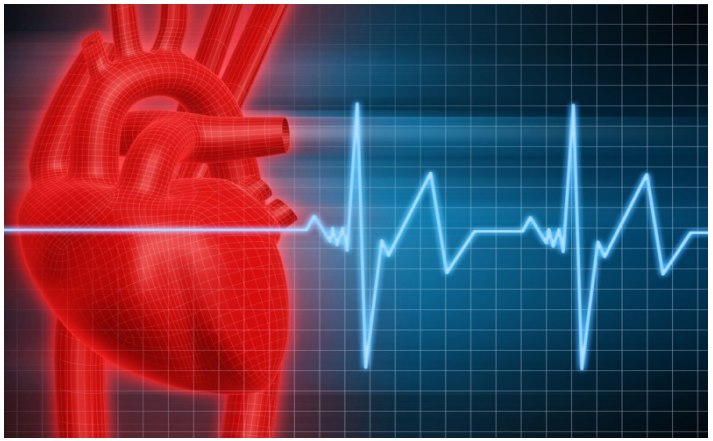
Decreasing Cardiovascular Disease



Quality Improvement Program (QIP)

Reducing All Cause Readmission

Reasons for required CCIP

The required CCIP mandatory topic starting CY 2012 by Centers for Medicare and Medicaid (CMS) is

Decreasing Cardiovascular Disease - (5 yrs. Project)

- **Diabetes also remains a top condition among co-morbidities in plan members.**
- **Diabetes is the fourth most common chronic condition, just behind:**
  - **Heart disease (3,700 members/20%)**
  - **Hypertension (4,100 members/22%)**
  - **Hyper lipidemia (4,300 members/23%)**

- **This topic is the focus of the national Million Hearts Campaign**

CCIP/QIP Reporting process

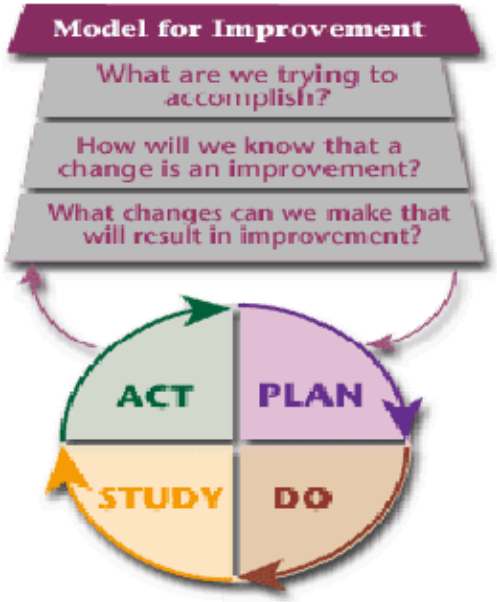
- **Plan-Do-Study-Act (PDSA) Quality Model**
- **Plan**

  Identify disease state, plan the program and implement policy to improve quality
- **Do**

  Implementation of the program, put plan into action
- **Study**

  Data collection and analysis, check if the plan has worked
- **Act**

  Next steps, stabilize improvement or determine why plan did not work



MEASUREMENTS	TARGET OUTCOMES
Aspirin Use	People at increased risk of cardiovascular disease who are taking aspirin
Blood pressure control	People with hypertension who have adequately controlled blood pressure
Cholesterol control	People with high cholesterol who have adequately controlled hyperlipidemia
Smoking cessation	People trying to quit smoking who get help

Providers Actions can include the following:

Focus on the "ABCS":

Aspirin use, Blood pressure control, Cholesterol control and Smoking cessation.

- **Prescribe: aspirin, ACE/ARB's, statin-unless contraindicated.**

- **Ask your patients: about their smoking habits and provide smoking cessation counseling and tools for smokers. (1-800-NO-BUTTS).**

- **Prioritize control: of high blood pressure, cholesterol management, aspirin use and smoking cessation. Help your patients follow treatment instructions and improve adherence.**

- **Use of Clinical Practice Guidelines and algorithms:** to promote best practices.

- **Support team-based approaches:** Referral to specialist, CHF/Diabetes education programs, Cholesterol Management classes, Smoking Cessation programs, Exercise and Weight management classes.

- **Connect at-risk patients with community resources:** Referral to social worker or other community resources to address barriers to adherence. Use culturally appropriate education materials, to address barriers to care.

REASONS FOR QIP

The required QIP mandatory topic starting CY 2012 by Centers for Medicare and Medicaid (CMS) is:

Reducing Plan All Cause Readmissions –

(3 yrs. Project)

- **Current HEDIS® measure**
- **One of the goals of the national**

CMS Partnership for Patients

- **Plan data also shows that *readmissions have a higher length of stay* (All admission = 3.9, Re-Admissions =4.5). We seek to reduce readmissions to relieve the burden of high morbidity caused by complications that could be prevented with improved post-discharge planning and follow-up.**

Disease Management: Six Required Elements

- **Population identification**
- **Evidence based guidelines**
- **Collaborative care** – dedicated Hospitalists Program, Inpatient CM and Discharge Coordinators, After Hours Support and Physician Champion
- **Patient self-management** – Self Management classes, programs
- **Process and outcome measures**
- **Routine reporting/feedback loop**

The success of our CCIP and QIP Project depends on clinical and utilization processes of both Provider Groups and Plan:

- **<u>Comprehensive discharge planning</u> with timely communication between <u>patients, Hospitalist, SNF MD, CM/DC planners, and PCP.</u> Having a strong transition plan, prompt post-discharge communication, and follow-up care within 1-2 wks after discharge can significantly reduce re-hospitalizations.**

- **Ancillary support such as home health evaluation and a post-acute telephonic follow-up call by coordinators or nurses are also proven beneficial.**

- **Post-discharge support**. The strongest evidence is in the use of more stringent follow-up after discharge.
  - **Telephonic outreach** calls post-discharge by CM/cord.
  - **Setting appointment** to PCP/Specialist within 1-2 wks
  - **Home visit** evaluation/programs, Tele-monitoring
  - **Report findings** to PCP/specialist
  - **Referral to SW** – community resources, AD/POLST
- **Patient education and self-management support**.
  - **Referral to CM/DM programs**, chronic self management classes and promotion of preventive health measures

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