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I. Overview of QIO Care Transitions
    I. Background
    II. Drivers of poor transitions
    III. Interventions
    IV. Stories
II. Analyses: patient trajectory
III. Palliative and end-of-life care

An overview

Care Transitions

- Medicare Quality Improvement Organization (QIO) program
- Competitively awarded ‘subnational’ theme
  - 14 QIOs
  - 14 respective target communities
- 3-year scope of work (starting August 1, 2008)
- Evaluation measure
  - Reduced 30-day hospital re-admissions among FFS Medicare beneficiaries

Target communities

- AL: Tuscaloosa
- CO: Northwest Denver
- FL: Miami
- GA: Metro Atlanta East
- IN: Evansville
- LA: Baton Rouge
- MI: Greater Lansing area
- NE: Omaha
- NJ: Southwestern NJ
- NY: Upper capital
- PA: Western PA
- RI: Providence
- TX: Harlingen HRR
- WA: Whatcom county

QIO general strategy

1. ***Define the community.***
   - FFS Medicare beneficiaries
   - “ZIP code overlap”
     a) Living in the **ZIP codes** of interest
     b) Discharged from the **hospitals** of interest
2. ***Engage providers.***
   - Hospitals, SNFs
   - HHAs, outpatient rehabilitation, etc…
3. ***Identify and target problematic utilization patterns.***
   - FFS Medicare claims
   - Provider observation, insight
   - Root cause analyses
4. ***Implement effective interventions, tools.***
5. ***Measure outcomes per CMS Scope of Work.***
   - 30-day readmissions

Drivers of poor transitions

Low patient activation

- Health literacy
- Self-management skills, tools
- Motivation; locus of control

Lack of standardized, known process

- Patient discharge, handover
- Internal workflow

Inadequate cross-setting information transfer

- Delays
- Inaccuracies
- Missing information

Other potential drivers

- Unavailable, inaccessible resources
- Lack of community identity; low cohesiveness

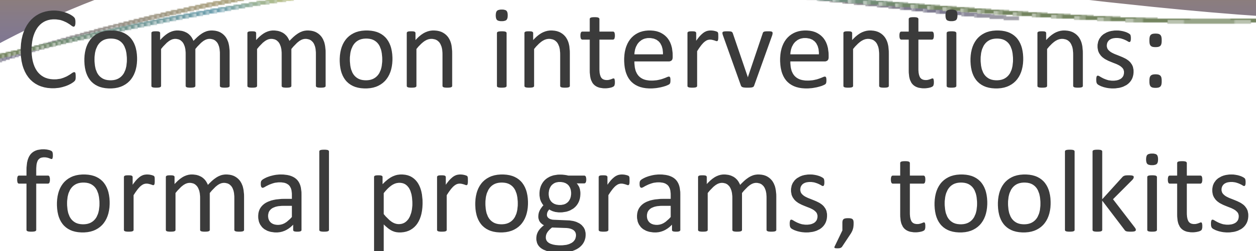
Interventions

Selection and implementation

- Community/QIO-specific
- Variation among interventions selected, scope of implementation, targeted problems/drivers

Taxonomy

- Origin
  - Formal program, toolkit
  - Homegrown, standalone intervention
  - Systemic process enhancement
- Targeted driver(s)
  - Patient activation
  - Standardized, known process
  - Information transfer



Common interventions: formal programs, toolkits

- **BOOST:** *Better Outcomes for Older Adults through Safe Transitions*
- **BPIPs:** *Best Practice Intervention Packages*
- **CTI:** *Care Transitions Intervention*
- **INTERACT II:** *Interventions to Reduce Acute Care Transfers*
- **RED:** *Re-engineered Discharge*
- **TCAB:** *Transforming Care at the Bedside*
- **TCM:** *Transitional Care Model*

Common interventions: patient activation

- Self-management tools
  - Questions to ask providers
  - Discharge planning
  - Medications
  - Red flags
  - Personal health record
- Teach-back method
- Patient/family education
- Transitions coaching

Common interventions: standardized, known process

- Assessment tools
  - Readmission risk
- Audit, review or tracking systems
- Communication re-designs (internal)
- Document standardization
- Enhanced referrals
- Provider education, support and outreach
- Scheduling of follow-up appointments at discharge
- Staffing re-design; transition-specific FTEs
- Telemedicine; telephone follow-up

Common interventions: information transfer

- Care coordination
- Communication re-designs (external; cross-setting)
- Cross-setting collaborative groups
- Discharge process notification
- HIT; data sharing and transfer
- Provider education, support and outreach (cross-setting)
- SBAR: *Situation-Background-Assessment-Recommendation*

Some success stories

Nebraska

- Process mapping, SBAR (1 hospital, 4 SNFs)
- Readmission rate reduced from 19% to 10%

Michigan

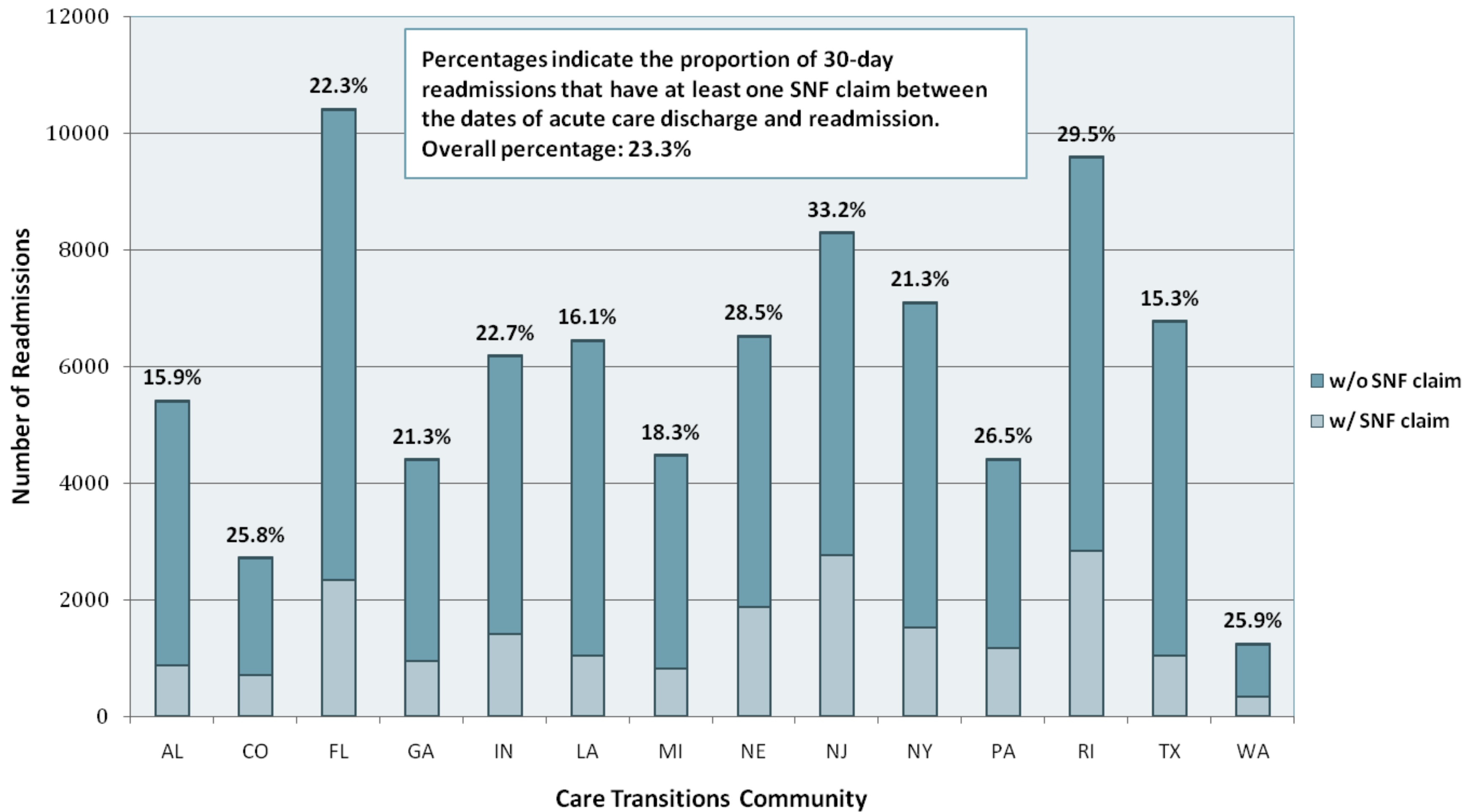
- Creation of SNF-ED liaison

Colorado

- Community action teams
- Sustainability

Patient trajectory

Intervening SNF claims among 30-day readmissions (Oct 2007 - Jun 2009)



Among the 30-day readmissions with intervening SNF stay…

- 28% died within 30 days
- 49% died within 180 days

Quality improvement and implications for utilization

Care Transitions work in palliative and end-of-life care

What's being done out there?

- INTERACT II and other tools for advanced care planning
- Provider palliative care education
  - Learning sessions
  - Speakers
- Improved information transfer to downstream provider (re: palliative care consult)
- POLST, MOLST and analogues

Colorado: Palliative care community action team

NW Denver palliative care community

- Hospital-based palliative care services
- Hospices
- Other providers
- Palliative care educators
- QIO staff

Priorities

- Resource compendium
- Provider education campaign
  - Plant seeds for improving referral to palliative care, hospice
  - Pilot with case managers

Challenges

- Scope; target population
- Partner engagement, attrition
- Outcome measurement

Findings

- Role ambiguity
- Difficulty initiating the conversation
- Desire for training, resources
- Cross-organization trainings
  - Legitimate community priority (vs. commands from *on high*)

Next steps

- Roll out provider education campaign
- Engage physician groups, other partners
- Patient education
- Contribute to policymaking discourse
- Ensure sustainability

Stories: Successful hospital-based palliative care services

Texas

Highlights

- Roll-out preceded by inservices
  - Given by clinician from within the service (re: buy-in)
- Utilizes CAPC resources
- Continual involvement with units, staff
  - Monthly grand rounds
  - Incidental trainings; hallway conversations

Lessons

- Educate physicians.
  - Purpose: to assist with goals of care, not take patients away from doctors
- Select the right leader.
  - Not everyone is supposed to be good at this.

Georgia

Evolution

1. Document development, standardization
2. POLST language; CMEs for PC education
3. Care communication protocol
4. Screening tools
5. Joined committees, increased visibility, engaged physicians

Lessons

- Educate the public to demand information from providers.
- Start with a consultation service.
  - Build referral base before launching a dedicated unit
- Leverage with data.
- Emphasize cost savings.

Care Transitions Palliative Care Interest Group

Challenges

- Variability among programs
  - Implementation
  - Definition
- Physician engagement
  - PC, hospice seen as "giving up"
  - Disease not seen as terminal
    - Nephrology
    - Pulmonology
- Incongruent personal values
  - Staff vs. patient
  - Chaotic family dynamic

Culture change

- No instant gratification
  - 30d readmissions, latency of effect
  - Requires engagement, enthusiasm from physicians
- Long-term effectiveness and sustainability

Lessons

- Ask the 'surprise' question.
- Use opportunities to 'plant the seed.'
- Effective resources already exist.