Care Transitions: Perspectives on palliative and end-of-life care

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Outline

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
Part I: The QIO Care Transitions initiative

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
Part II: Analyses

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

Percentages indicate the proportion of 30-day readmissions that have at least one SNF claim between the dates of acute care discharge and readmission. Overall percentage: 23.3%
Among the 30-day readmissions with intervening SNF stay...

- 28% died within 30 days
- 49% died within 180 days
Part III: Palliative and end-of-life care

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

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<thead>
<tr>
<th>Highlights</th>
<th>Evolution</th>
<th>Lessons</th>
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<tr>
<td><strong>Texas</strong></td>
<td><strong>Georgia</strong></td>
<td><strong>Lessons</strong></td>
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<tr>
<td>• Roll-out preceded by inservices</td>
<td>1. Document development, standardization</td>
<td>• Educate the public to demand information from providers.</td>
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<td>• Given by clinician from within the service (re: buy-in)</td>
<td>2. POLST language; CMEs for PC education</td>
<td>• Start with a consultation service.</td>
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<td>• Utilizes CAPC resources</td>
<td>3. Care communication protocol</td>
<td>• Build referral base before launching a dedicated unit</td>
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<td>• Continual involvement with units, staff</td>
<td>4. Screening tools</td>
<td>• Leverage with data.</td>
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<td>• Monthly grand rounds</td>
<td>5. Joined committees, increased visibility, engaged physicians</td>
<td>• Emphasize cost savings.</td>
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<td>• Incidental trainings; hallway conversations</td>
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**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.
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.