Community-Based Transitional Care Improvement

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Some Emerging Definitions

- **Transitional Care**
  - A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location.

- **Care Coordination**
  - Managing and coordinating services supplied by different providers.

- **Continuity of Care**
  - Seeing the same provider
  - Relational Continuity

Hospital Readmission rates are one proxy measure for the quality of transitional care.
Why Engage a Community?

Every readmission begins with hospital discharge
  Every transition has 2 sides
The problem of home
  Patients are people too
Isolated information is not safe medical management
  Inevitably need to share
Visibility to drive improvement and mission
  Providers are people too
Visibility to Drive Improvement
The ‘Zip Code Overlap’ Community Definition

FFS Medicare beneficiaries living in zip codes of interest
FFS beneficiaries discharged from hospitals of interest

Target Population

Community identity supports both social and economic sustainability
Where can we target interventions?

Return to hospital (readmissions)
Return to ED
Un-necessary labs/procedures

**WHY?**

- Medication Errors
- Patients not getting adequate follow-up care
- Home Care not utilized adequately
- Advanced directives not followed

**WHY?**

- Physicians (PCPs) not aware of hospitalization
- Receiving provider (PCP, HHA or other) not getting adequate information
- Patients poorly engaged in care process
Patient-Level Causes of Readmissions

- Medication problems
  - Improperly managed by the HC team
  - Actual mistakes
  - No agreement between settings
  - Inadequate communication to patients
  - Patient non-adherence through poor understanding

- Lack of reliable follow-up care
  - Receiving providers unaware
  - Patients unable to access follow-up provider

- Poor patient engagement
  - Symptom worsening
  - Need for timely follow-up
CMS’s Table of Interventions
“Intervenable” Drivers

Standard and known process for sharing patients among medical service providers
Home-based support/patient and family activation
Information transfer/sharing
“Intervenable” Drivers

Standard and known process for sharing patients among medical service providers
Home-based support/patient and family activation
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Not Directly Intervenable:
Payment incentives
# Intervention Packages

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Reference</th>
<th>Main tools</th>
<th>Driver addressed</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Intervention</td>
<td><a href="http://www.caretransitions.org">www.caretransitions.org</a></td>
<td>Coaches, personal health record, medication discrepancy tool</td>
<td>? XXX X</td>
<td>13</td>
</tr>
<tr>
<td>Transitional Care Nursing</td>
<td><a href="http://www.transitionalcare.info/index.html">www.transitionalcare.info/index.html</a></td>
<td>Risk assessment, nursing training materials</td>
<td>? XXX XX</td>
<td>2</td>
</tr>
<tr>
<td>CMS Discharge Checklist</td>
<td><a href="http://www.medicare.gov">www.medicare.gov</a></td>
<td>Patient and family checklist of important items to address before discharge</td>
<td>? XXX X</td>
<td>9</td>
</tr>
<tr>
<td>BOOST</td>
<td><a href="http://www.hospitalmedicine.org/ResourceRoom">www.hospitalmedicine.org/ResourceRoom</a> Redesign</td>
<td>Screening/assessment, provider discharge checklist, transition record, teach-back instructions, data collection and tracking</td>
<td>XXX XX</td>
<td>2</td>
</tr>
<tr>
<td>Best Practices Intervention Package (BPIP)</td>
<td><a href="http://www.homehealthquality.org/hh/ed_resources/interventionpackages/default.aspx">www.homehealthquality.org/hh/ed_resources/interventionpackages/default.aspx</a></td>
<td>Comprehensive manual for HHA process improvement includes CTI teaching</td>
<td>XX XX XX</td>
<td>11</td>
</tr>
<tr>
<td>InterAct</td>
<td>Interact.geriu.org</td>
<td>Communication tools, clinical care paths, advanced care planning</td>
<td>XX XX</td>
<td>10</td>
</tr>
<tr>
<td>Transforming Care at the Bedside (TCAB)</td>
<td><a href="http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm">www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm</a></td>
<td>(Re)Admission assessment, teach-back, pt and family communication, scheduled f/u</td>
<td>XXX XX X</td>
<td>4</td>
</tr>
<tr>
<td>Re-Engineered Discharge (RED)</td>
<td><a href="http://www.bu.edu/fammed/projectred/index.html">www.bu.edu/fammed/projectred/index.html</a></td>
<td>Nurse discharge advocate, pharmacy f/u, medication teaching, PCP f/u booklet</td>
<td>XXX XX</td>
<td>4</td>
</tr>
</tbody>
</table>
Care Transitions Intervention\textsuperscript{SM} (CTI)

**Description:** Care transitions coaches support patients by providing specific tools and teaching self-management skills to ensure their needs are met during the transition from the acute care setting to home.

**Resource:** [http://www.caretransitions.org](http://www.caretransitions.org)

**Evidence:** Coleman et al. (2006): Lower 30-day readmission; lower readmission at 90 days and 180 days.

Coleman et al. (2004): Lower readmission for same diagnosis at 90 days
Bridging Nursing Support / Transitional Care Model

**Description:** Multidisciplinary, comprehensive in-hospital planning and home follow-up. Transitional Care Nurses follow patients from the hospital into the home to provide services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use and prevent health status decline.

**Resource:** [http://www.transitionalcare.info/index.html](http://www.transitionalcare.info/index.html)

**Evidence:** *Naylor et al. (1999):* 45% reduction in readmission rate.

*Naylor et al. (2004):* Increased time to readmission/death; reduced readmission rate.
The CMS Discharge Checklist

**Description**: CMS developed checklist for patients and families to prepare for care capability after transition

Attributing change to interventions

3 levels of measurement:

- Degree of dissemination
- Effect of disseminated intervention on targeted driver
- Effect of intervention on utilization (readmission/ED use)
Example:
Quarterly Community 30-day Readmission Rate
Baseline Rate (01.01.08-03.31.08) as compared to Most Recent Quarter (04.01.09-06.30.09)
What Factors are Associated with Success?

Transitions coaching!
Community engagement
Cooperative relationships between hospitals and between hospitals and other service providers
The role of information transfer among providers is unclear
A further word on the Role of Community Cohesion: A Case Report

- Grand Junction, Colorado
- Total Mcare Spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending($)</th>
<th>Rank</th>
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<tbody>
<tr>
<td>1992</td>
<td>3209</td>
<td>304</td>
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<tr>
<td>2006</td>
<td>5873</td>
<td>301</td>
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Sustainable CPRs

1. Clearly defined boundaries
2. Congruence between appropriation and provision rules and local conditions
3. Collective-choice arrangements allowing for the participation of most of the appropriators in the decision making process
4. Effective monitoring by monitors who are part of or accountable to the appropriators
5. Graduated sanctions for appropriators who do not respect community rules
6. Conflict-resolution mechanisms which are cheap and easy of access
7. Minimal recognition of rights to organize (e.g., by the government)
10 Things a Motivated Community Could Do

• Identify your population – who/where do you mostly serve?
• Identify your provider community - Include home based service providers
• Create a collaborative forum to find an easier way.. ie have a meeting
• Create a collaborative forum that includes patients and families
• Exchange quality data routinely
• Create a standard communication process
• Institute an expectation of visiting each other
• Identify the sickest people and review their care pattern
• Think about integrating coaching
• Implement a community-standard PHR and expect (measure) it
• Capture the CTM instead of the typical PAC fu/ call