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

Wednesday May 19, 2010
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This material was prepared by CFMC, the Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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

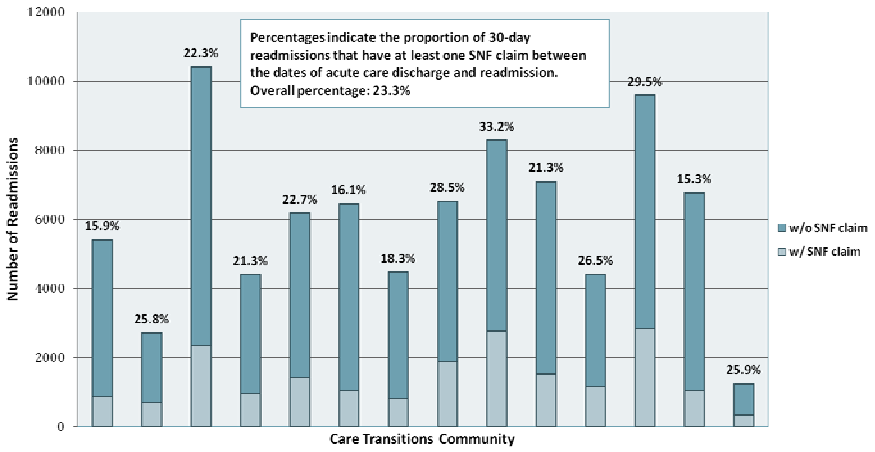
- Creation of SNF-ED liaison

Colorado

- Community action teams
- Sustainability

Part II: Analyses

Patient trajectory



Mortality after acute care discharge

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

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.