Transitional Care and Quality Improvement

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Topics

- In-home Transitional Care Models
- Quality Measurement
- The Model for Improvement
Transitional Care: Components

- These programs:
  - Engage patients with chronic illnesses while hospitalized
  - Follow patients intensively post-discharge.
  - Teach/coach patients about medications, self-care, and symptom recognition and management.
  - Remind and encourage patients to keep follow-up physician appointments.

- Approaches to achieving these goals differ across programs.
Transitional Care: Promising Models

- Care Transitions Intervention (Coleman)
  - Patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across care settings

- Transitional Care Intervention (Naylor)
  - Patient-centered intervention designed to improve quality of life, patient satisfaction, and reduce hospital readmissions and cost for elderly patients hospitalized with congestive heart failure
Transitional Care: Target Populations

- Care Transitions Intervention (Coleman)
  - Included:
    - Patients discharged from hospital with certain diagnoses
    - 30-day Medicare readmissions for HF, MI, PNE
    - Additional risk algorithm for readmission drawn from administrative data
  - Excluded:
    - Dementia with no caregiver
    - Primary psychiatric diagnosis, with psychotic elements
    - Active drug or alcohol use
Transitional Care: Target Populations (cont’d)

- Transitional Care Intervention (Naylor)
  - Included:
    - 65+ CHF patient admitted to certain hospitals and residing within 60 miles of designated hospital
  - Excluded:
    - ESRD
    - Non-English speaking
Transitional Care: Staffing

- Care Transitions Intervention (Coleman)
  - APN, RN, social worker, or occupational therapist
  - One care coordinator per 40 patients
  - Duration: 30 days following hospitalization

- Transitional Care Intervention (Naylor)
  - Advanced Practice Nurses (3)
  - One care coordinator per 39 patients
  - Duration: three months following index hospitalization
Transitional Care: Intervention

- Care Transitions Intervention (Coleman)
  - Home visit post discharge, three follow-up calls
  - Based on four pillars:
    1. Medication management
    2. Patient-centered record
    3. Primary care and specialist follow-up
    4. Knowledge of red flags
Transitional Care: Intervention (cont’d)

- Transitional Care Intervention (Naylor)
  - Hospital visit and home visits of varying frequency
  - Comprehensive assessment in hospital, defining priority needs and services
  - Ongoing advocacy, education, and communication to ensure plan of care
Transitional Care: Evidence

- Care Transitions Intervention (Coleman)
  - Intervention patients had:
    - Lower re-hospitalization rates at 90 days:
      - For any reason (17% vs. 23%)
      - For initial condition (5% vs. 10%)
    - Lowered hospital costs: 19% over 180 days ($2,058 vs. $2,546)
Transitional Care Intervention (Naylor)

- Intervention patients had:
  - 54% fewer re-hospitalizations per patient after 12 months (1.18 vs. 1.79).
  - 10.5% decrease in re-hospitalization rate (44.9% vs. 55.4%).
  - 39% lower mean total costs ($7,636 vs. $12,481).
Quality Measurement

- **Process Measures**
  - The number of times the process occurs vs. number of patients in the sample set

- **Outcome Measures**
  - How have the process measures improved the outcome over time?
Testing Change

- The Model for Improvement
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in an improvement?

- PDSA
  - Plan, Do, Study, Act

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PDSA SToC

Cycle #1
Cycle #2
Cycle #3
Cycle #4

Changes that Result in Improvement

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Accessing Community Resources: Helping Hands
Thank You!

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This material was prepared by Health Services Advisory Group of California, Inc., the Medicare Quality Improvement Organization for California, 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. Publication No.