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CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

CMS Care Transitions Event: National Engagement
Compendium: Effective Care Transition Interventions

Intervention Type	Intervention	Description	Aim	Targeted Drivers of Readmission
Health Information Technology	Revising electronic records	Revising electronic records to reflect nursing home transfers.	Create access to up-to-date and accurate health information for providers.	Poor information transfer
	Created community online resource	Webpage for community resources from multiple health care partners including links to organizations' sites.	Allow patients and providers to easily pick and click resources.	Insufficient support for patient and family self-management
	Chart review	Reviewing charts for patients with multiple readmits with the coalition.	Identify trends/causes for re-admits for targeting coordinated efforts according to re-admit reasons.	Lack of sharing and understanding of patient utilization information between community providers
	Created a resource for behavioral health services	Created a real-time, online resource for behavioral health services and programs in the region.	Allow patients and providers to easily find appropriate resources.	Insufficient resources and support for providers, patients and family
Pharmacy and Medication Safety	RIOSORD (Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression) scoring system intervention at a FQHC to assess patient risk of an opioid adverse event	The RIOSORD retrospectively risk assess all patients who filled an opioid prescription during 2016, via Electronic Medical Record (EMR). Analyze 2017 claims for death, unintentional overdoes, respiratory depression, fall, respiratory exacerbation, hospital admission or ER visit.	Use the RIOSORD to predict risk and inform interventions to reduce risk through targeting modifiable risk factors that contribute to the RIOSORD score.	Adverse drug events such as overdose or opioid-induced respiratory depression.

	Intensive Pharmacy Transitions of Care (TOC) Project	A hospital pharmacy department lead the medication history and reconciliation process during admission and discharge. They added 2.4 full time pharmacy technicians to assist with prior to admission (PTA) medication histories, complete admission histories, preform admission and discharge medication reconciliation and provide discharge counseling.	Improve disease management, decreasing polypharmacy, as well as reducing medication errors and adverse events. Therefore, reduce readmission and healthcare utilization.	Ineffective medication history and reconciliation on hospital admission and discharge. As well as poor communication between healthcare professionals during transitions of care.
	ER Anti-Microbial Stewardship (AMS) Project	Match Medicare Part A and B encounter data to the Part D prescription fill for ER patients. Analyze data for antibiotic prescribing rates.	Compare practices to each other, compare providers within practices and to the state average. Impact measures related to UTIs, community acquired pneumonia (CAP) and uncomplicated skin and soft tissue infections (SSTI).	Inappropriate antibiotic use due to lack of prescribing data and provider support. And limited ability to measure impact of interventions given the lack of baseline data.
	Meds to Beds Program	Before hospital discharge, pharmacists bring discharge medications to patient, review medications with the patient and perform medication reconciliation.	Patients adhere to prescribed mediation regimes.	Lack of medication adherence
	Medication adherence support	Gave patients medication blue tote bags with pill minders and lists at hospital discharge.	Patients adhere to prescribed mediation regimes.	Lack of medication adherence

Patient/Family Education and Engagement (zone stoplight tools)	Diabetes Empowerment Education Program (DEEP) A1c Testing	Collaborated with the college of pharmacy to provide point of care: glucose, A1c, lipids and blood pressure tests after DEEP classes. The testing is after one of the classes and we invited graduates back in the three-to-nine-month window after graduation for post class results.	Promote patient diabetes self-management.	Inadequate patient or caregiver education Insufficient resources and support for providers, patients and family
	Standardized patient education	Implemented standard patient education for congestive heart failure (CHF) for hospital, skilled nursing facility (SNF), home health agency (HHA) and durable medical equipment (DME) providers.	Promote patient education for self-management of CHF.	Inadequate patient or caregiver education
	Dietary/nutritional consultations	Provided diabetes, cardiac and renal patient consults with dietician or nutritionist before they discharge.	Promote patient education for self-management of common chronic diseases.	Inadequate patient or caregiver education
	Patient Activation Measure (PAM)	Implemented patient education on self-management, including Patient Activation Measure (PAM) trainings for providers and patients.	Promote patient education for self-management of common chronic diseases.	Inadequate patient or caregiver education
	Care plan conferences	A care conference allows everyone to openly communicate and develop a plan that everyone understands. These meetings allow the family and patient to comprehend the situation and feel	Improve communication between care team and patient/family to best support them in their care plan.	Insufficient support for patient and family self-management.

		empowered to ask questions to all members of their health care team.		
Provider Education	Project Extension of Community Healthcare Outcomes (ECHO)	Online meetings include a case presentation and a didactic presentation on a specific topic. Communities present cases and discuss them among the network to generate evidence-based recommendations from local and national experts.	This ECHO Network contributes significantly to providers' sense of connection with other providers in the state. The experience has a significant impact on knowledge of care transitions and intent to improve practice. Assist frontier/ rural providers with limited area resources by providing tools and resources to help keep their patients from being admitted or readmitted to acute care facilities.	Frontier/ rural providers with limited area resources have fewer opportunities and access to tools and resources to help keep their patients from being admitted or readmitted to acute care facilities.
	Chronic Care Management (CCM) / MIPS Quality Reporting	An intensive training platform, site assessments, on-site implementations, complete all-inclusive program and an ongoing consultation and support network. Work with clinics to align the CCM program with the Quality Payment Program and contribute to successful MIPS reporting.	Chronic care management (CCM) is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients and providers.	Cross task education for quality improvement needs and reporting
	Chronic Care Management (CCM)	CCM has been implemented to deliver the coordinated care the	Conduct a workflow assessment. Evaluate	Lack of Primary Care Providers managing patients with chronic

Care Coordination and Continuity of Care Interventions		patients need between appointments and assist many of the Medicare and dual-eligible (Medicare and Medicaid) patients with chronic disease to stay on track with their treatments and health plans.	existing tools and identify supplemental resources. Provide initial orientation of primary care coordinators as well as staff who will function in support roles. Provide a continuing education network for care coordinators and support staff to share best practices, keep up to date on the regulation changes, enhance care coordination skills and provide a supportive environment for continued learning.	diseases between appointments and acute care stays.
	Referral education	Provided education on appropriate referrals to area public health nurses, including criteria for follow-up and post-discharge care for hospital, HHA and SNF partners.	Continue post-discharge care continuity of care and longitudinal care management, if needed.	Lack of community support and awareness of area services.
	Transitional Care Program/Transition Teams	Created a transitional care program with care navigators and care transition coaches who refer high-risk patients to transitional care. Transition Teams meet the patient in the hospital and ensure PCP follow-up.	Continue post-discharge care continuity of care and longitudinal care management, if needed.	Lack of community support and awareness of area services.
	Discharge Planning	High-risk patients see their PCP within three to five days of hospital discharge. Handoff from	Standardize processes for continuity of care post-discharge.	Insufficient support and resources for providers and

		inpatient case management to post-acute transitional case management for high-risk patients. Help patient with follow-up post-discharge, transportation, recognition of signs and symptoms, appointments and medications. Workflow for transitional care follow-up calls within 48 hours of discharge.		patients discharging from the hospital.
	PCP communication	PCP notification of ED visit, admission and discharge within 24 hours.	Consistent communication among the care team.	Lack of timely and clinically relevant communications
	Collaboration to coordinate care for the homeless population	A HHA collaborated with a hospital to prevent discharging homeless patients back to the street after hospitalization. The organizations continue care until the patient is safe for discharge. Staff transitions patients to an appropriate independent group home or other options.	Reduce hospital readmission and unnecessary utilization of urgent care facilities for these high-risk patients and provide better outcomes for the patient, including their social determinants of health.	Lack of community support and awareness of area services.
	Community stakeholder collaboration	Community stakeholders working with state agencies on an ongoing discussion between organizations and providers integral to the care of older adults to promote understanding of programs and challenges, and to develop	Improve collaboration among health care partners to better coordinate patient care.	Lack of community support and awareness of area services.

		systems that join hospitals, physicians, health information technology, community-based programs and aging networks to align efforts improve access to care for older adults.		
	Zone/Stop Light Tools	Concise, succinct, clinically developed information on patient self-management of common chronic diseases and behavioral health for providers to distribute to their patients.	Improve patient knowledge and support for self-management of chronic diseases.	Insufficient resources and support for providers, patients and family.
	Development and continuation of the community partner coalition groups	Improved working relationships as a result of the coalition activities and that now have better understanding of the challenges all partners face. The initial intervention that helped strengthened relationships and built trust.	Enhanced provider communications re: available healthcare services and resources in the community from team-building and trusted relationships.	Lack of community support and awareness of area services. Lack of communication regarding patient continuum of care.

Intervention Outcomes

- **RIOSORD (Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression)**
  - Educated providers on the RIOSORD score and modifiable risk factors that contribute to the patient score. We will compare the effect of the education or patient population RIOSORD scores and look at the same outcomes from Phase II again to see if the intervention improved outcomes.
- **Intensive Pharmacy Transitions of Care (TOC) Project:**
  - Eighty-six percent of the admission histories done after the nursing admission history had at least one error and the average number of errors on the PTA medication list in the EMR was six incorrect medications.

- Of the 86 percent of patients with errors, 73 percent of them were ordered as inpatient medications then corrected by the pharmacist.
- On discharge, pharmacists corrected discharge prescriptions in the EMR and outgoing e-prescriptions to external pharmacies, discontinued prescriptions when indicated with outpatient pharmacies and provided discharge counseling and education.
- Thirty-day readmissions decreased by 23% for COPD patients.
- No statistically significant reduction in readmissions were observed in the high risk for readmission (LACE+ score and known high utilizers) or patients on anticoagulants.

- **The Project Extension of Community Healthcare Outcomes (ECHO):**
  - The relative improvement rate percentage (RIR %) on readmissions/1000 Medicare beneficiaries from an established baseline = 9.11 percent;
  - RIR percentage on admissions/1000 Medicare beneficiaries = 10.38 percent;
  - RIR percentage on emergency department encounters/1000 Medicare beneficiaries = 0.01 percent.
  - Eighty-three percent of participants felt they learned new information from didactic presentations.
  - Sixty percent reported learning something new from case presentations.
  - Eighty-four-point five percent of participants felt an increased sense of connection with providers across the two-state region.
  - Eighty-four percent reported an intent to change their practice by providing better care to patients, improving communication between provider and patient/caregiver, improving education of patients and educating other providers.