**QVIC - Transitions of Care Group - Executive Summary Draft**

**Introduction:** Heart failure readmissions incur significant costs on patients, payors and hospitals. As the US reimbursement system continues evolves from volume- to value-based payment, hospitals need to develop innovative, cost-effective solutions for delivering care. The QVIC is a novel, community-based initiative to collaboratively develop these novel approaches to care. Researchers throughout the region have a number of potential strategies that could be adopted by hospital partners to improve the efficiency of care (Figure). These include risk stratification strategies in the ED, improved medication reconciliation and adherence strategies, collaboration on the use of regional resources to address social determinants of health, tele-medicine, exercise/rehab, payer communication on med refills, caregiver support, and group appointments in the outpatient setting.

**Goal and Objective:** Our long-term goal is to collaborate with hospitals to build cost-effective quality improvement initiatives aimed at reducing 30-day heart failure readmissions. Researchers will work with hospitals to identify optimal strategies, develop and support an implementation plan and build measurement methods to quantify the impact of the interventions.

**Methods:** We anticipate using a series of interdisciplinary research teams using formal QI tools and methods involving direct observation, focus groups and interviews to identify the highest risk workflows across the continuum of care that likely cause readmissions. A series of interviews, for example, may involve investigating workflow failures involving medication reconciliation during transitions between home and the emergency department. Each hospital may select different interventions, based on their needs and opportunities.

**Expectations and Deliverables:** We expect to generate detailed maps of high-priority workflows within each participating hospital, from which key interventions will be designed and implemented. Continual performance improvement will customize and optimize the intervention within each setting. Based upon our team member’s research experience, we anticipate PDSA interventions could range from improved provider communication to health IT infrastructure changes. Tools may include but not be limited to medication discrepancy registries, redesigning workflow within the EHR, improving access to payor formularies, or delivering educational workshops for high-risk patients. Involving hospitals in the research process along the way will facilitate identifying these solutions once we identify the gaps. At the conclusion of a 1-year project, we anticipate a 20% reduction in readmissions, improved patient experiences with care and insights into future opportunities to improve care.