

Coaching Patients to Improve Care Transitions in Pennsylvania

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Objectives

❖ Attendees will be able to:

- Explain the goal of the CMS cross-setting Care Transitions Project
- Describe the unique transition coach model implemented in western Pennsylvania in collaboration with the Area Agency on Aging
- Explain how the coaches were trained

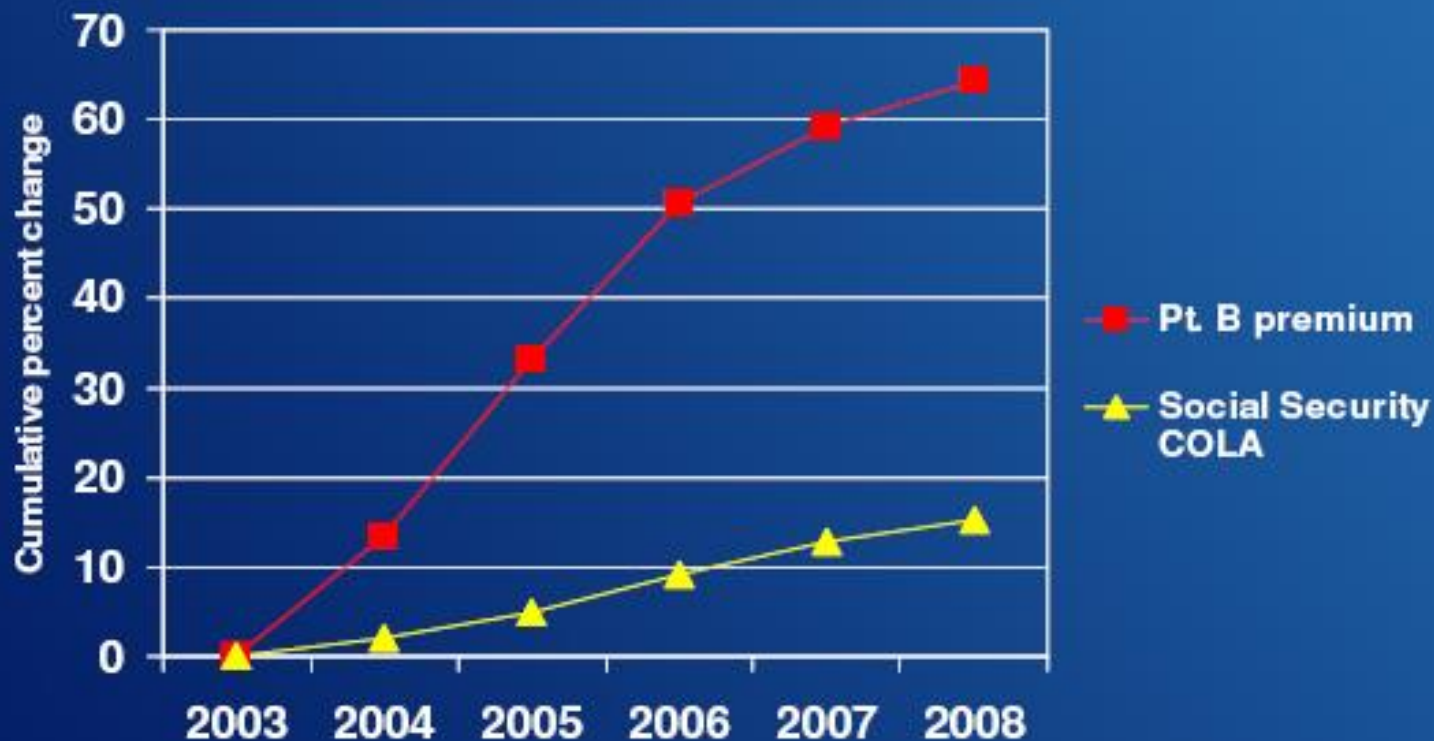


Across the Continuum

❖ Older patients with chronic illness often require care from varied practitioners in multiple settings. CMS reports, “This situation can be changed by approaching health care quality from a community-wide perspective and focusing on how all the members of the area health care team can better work together in the best interest of the shared patient population.”



Medicare beneficiaries are already facing growing financial liability



Note: COLA (cost-of-living adjustment).

Source: Social Security Administration and Medicare trustees' report.

Size of the Opportunity

- ❖ Nationally – 17.6% of Medicare beneficiaries discharged from the hospital are readmitted within 30 days
- ❖ More than 85% of these re-hospitalizations are unplanned
- ❖ The majority of Medicare beneficiaries who are hospitalized have been hospitalized within the last year



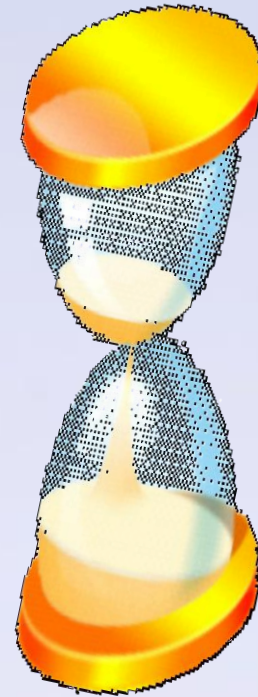
Size of the Opportunity...Continued

- ❖ 64 % of Medicare beneficiaries who are readmitted within 30 days do not receive any post-discharge care before readmission
- ❖ 20 – 40% of re-hospitalizations may be preventable

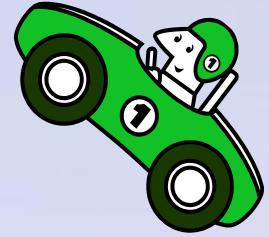


The Shift Continues

- ❖ Chronic illness management
- ❖ Self-care management
 - Empowerment
 - Responsibility
 - Accountability



Drivers of Readmissions



❖ The five most common medical conditions for which hospital readmissions occur are:

- heart failure
- pneumonia
- chronic obstructive pulmonary disease
- psychoses
- gastrointestinal problems



Introduction to the Project



Outcome Expectations

- ❖ Promote safe/effective transitions of care from
 - one provider setting to another
 - one caregiver to another



Project Measurement Timelines

❖ 18 months (January 31, 2010)

- Interim measurement
- CMS can end funding if progress not acceptable

❖ 28 months (November 30, 2010)

- Need to have reduced the “community”- “all-cause” 30-day readmission rate for Medicare beneficiaries by at least 2%



14 QIOs with 14 Target Communities



Emerging Definitions

❖ Transitional Care Coordination

- 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

(Coleman and Berenson, 2004)



Handoffs/Handovers



❖ Care transitions = **Handovers** in care

- Significant patient safety issue
- Information often acquired and transmitted without determining comprehension
- Includes transfer of patient information as well as professional responsibility to both deliver the information and assure it is understood



Transitional Care Coordination Goes Both Ways

Sending

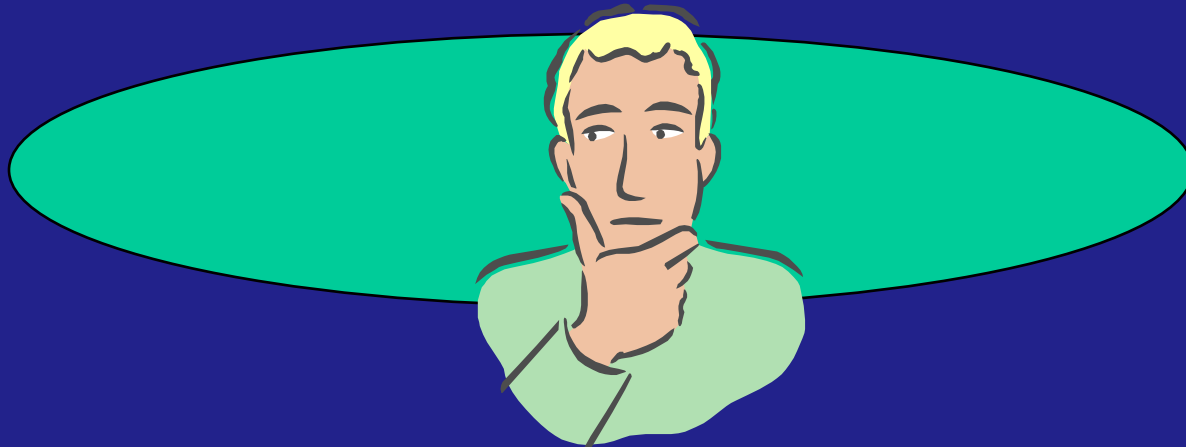


Receiving



Paradigm Shift

**Think Transitions, Not
Discharges!**



The Selection Recruitment Process



QIO RFP Expectations

❖ Select “community”

❖ 53 zip codes in the catchment area

- Westmoreland, Allegheny, Washington and Fayette counties
- Targeted community with higher incidence of Medicare FFS 30-day readmissions



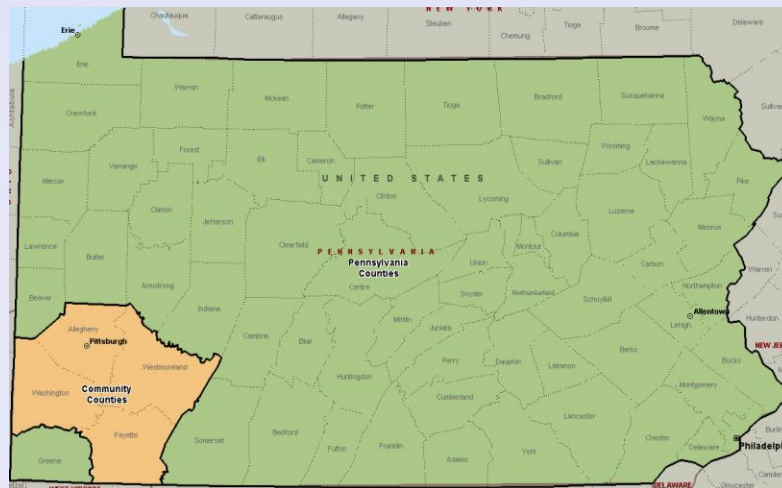
Community Selection

- ❖ Selected based on results from a thorough analysis of readmission rates from 2000 – 2007
 - Analyzed by region, county, ZIP code, and hospital
- ❖ Comprised of 53 contiguous ZIP codes where the largest number of Medicare FFS beneficiaries reside who receive care from the five targeted hospitals that have substantially higher readmission rates than the statewide average and other communities of similar characteristics
 - Medicare FFS population in community needed to be large enough to statistically demonstrate a 2% reduction in readmission rate

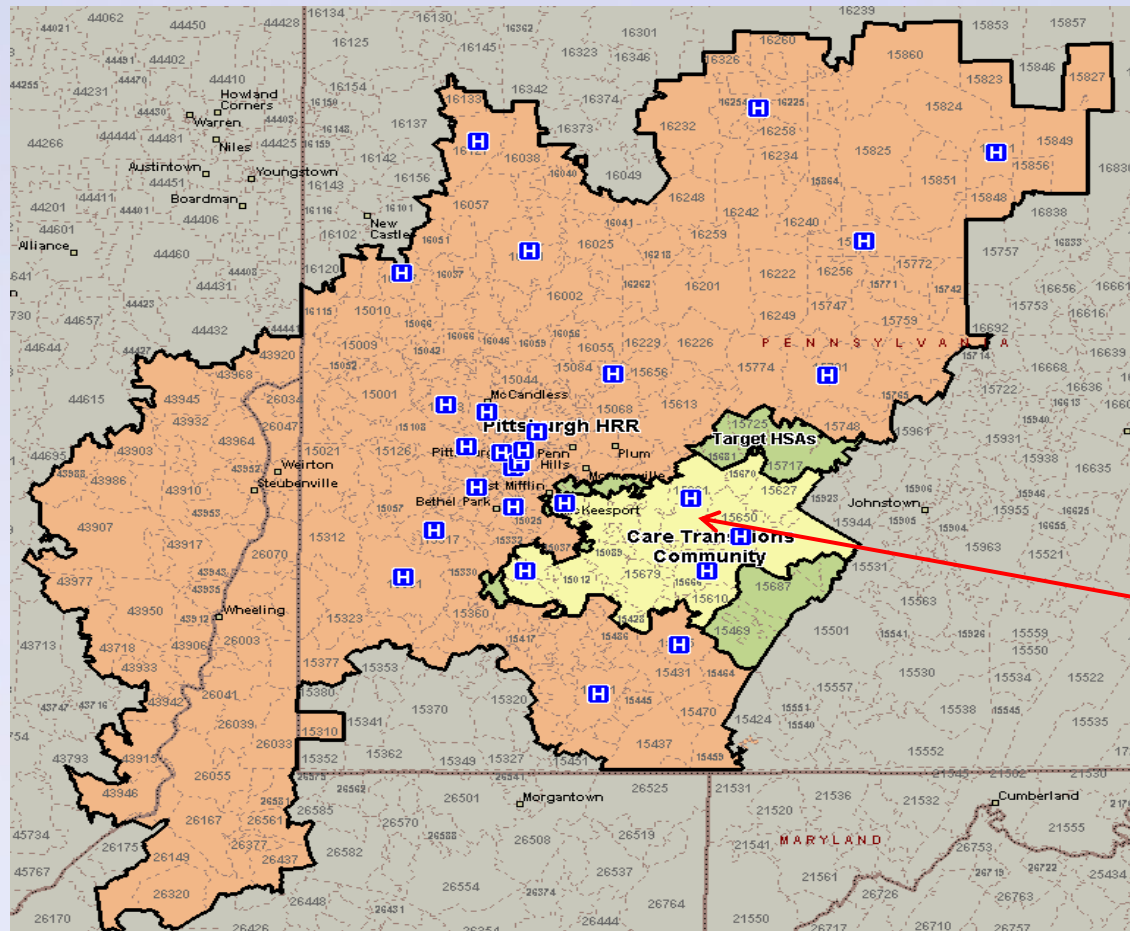


Targeted Community

- ✦ Located in southwestern PA, in a community surrounding the southern Pittsburgh metropolitan area.
- ✦ Community spans most of Westmoreland County and small portions of Allegheny, Washington, and Fayette counties.



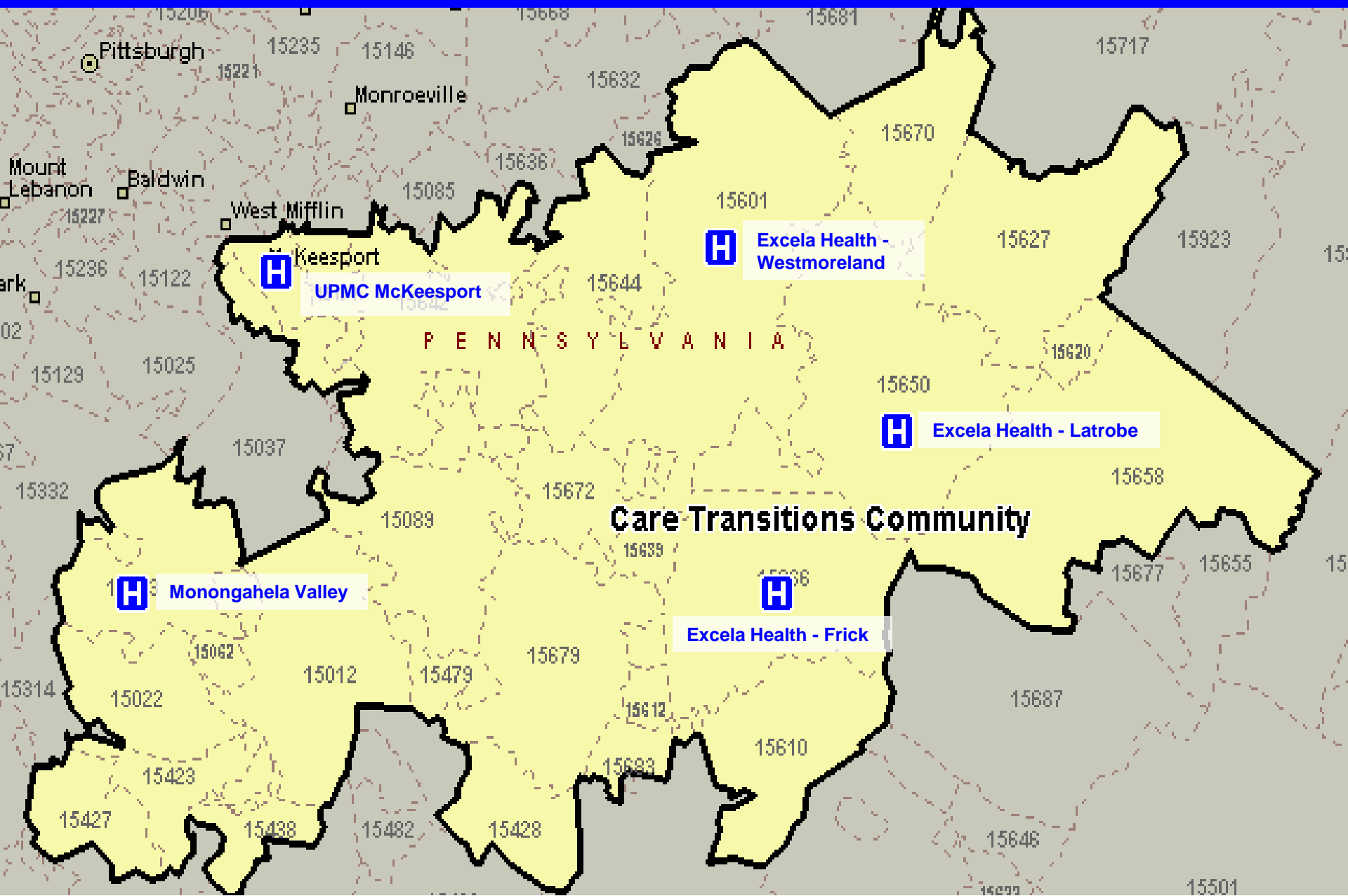
Targeted Community



- According to the Dartmouth Atlas:
 - 623 ZIP codes comprise the Pittsburgh Hospital Referral Region (HRR).
 - 108 of those ZIP codes comprise the Hospital Service Areas (HSAs) associated with the 5 target hospitals.
 - 53 of those ZIP codes comprise Pennsylvania's Care Transition Community.
- **27 short term acute care hospitals are located within the Pittsburgh HRR, 5 of which are the target hospitals that are located within the Care Transition Community.**

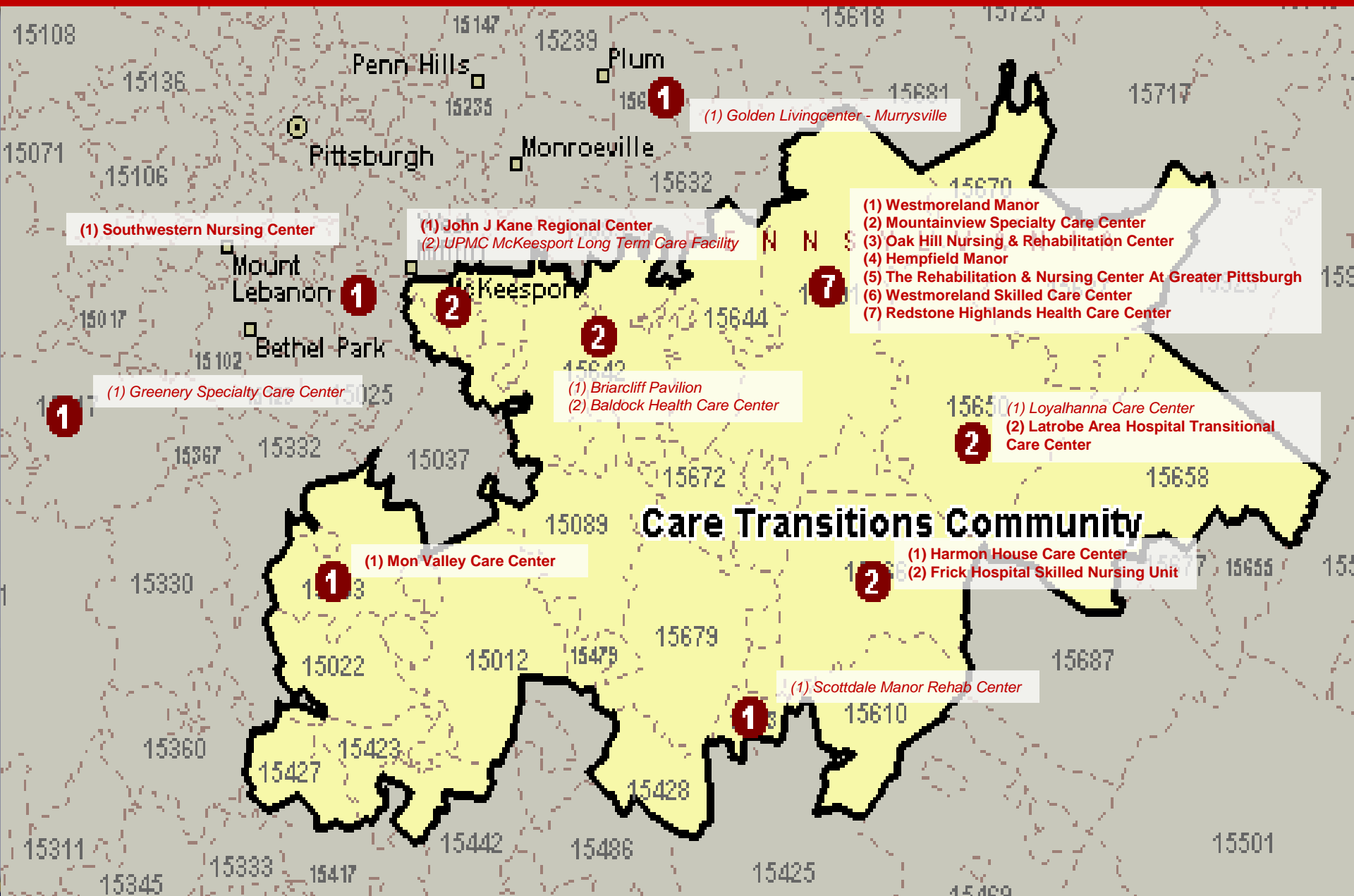


Targeted Hospitals



Each symbol represents one hospital.

Targeted Nursing Homes



Care Transitions Community

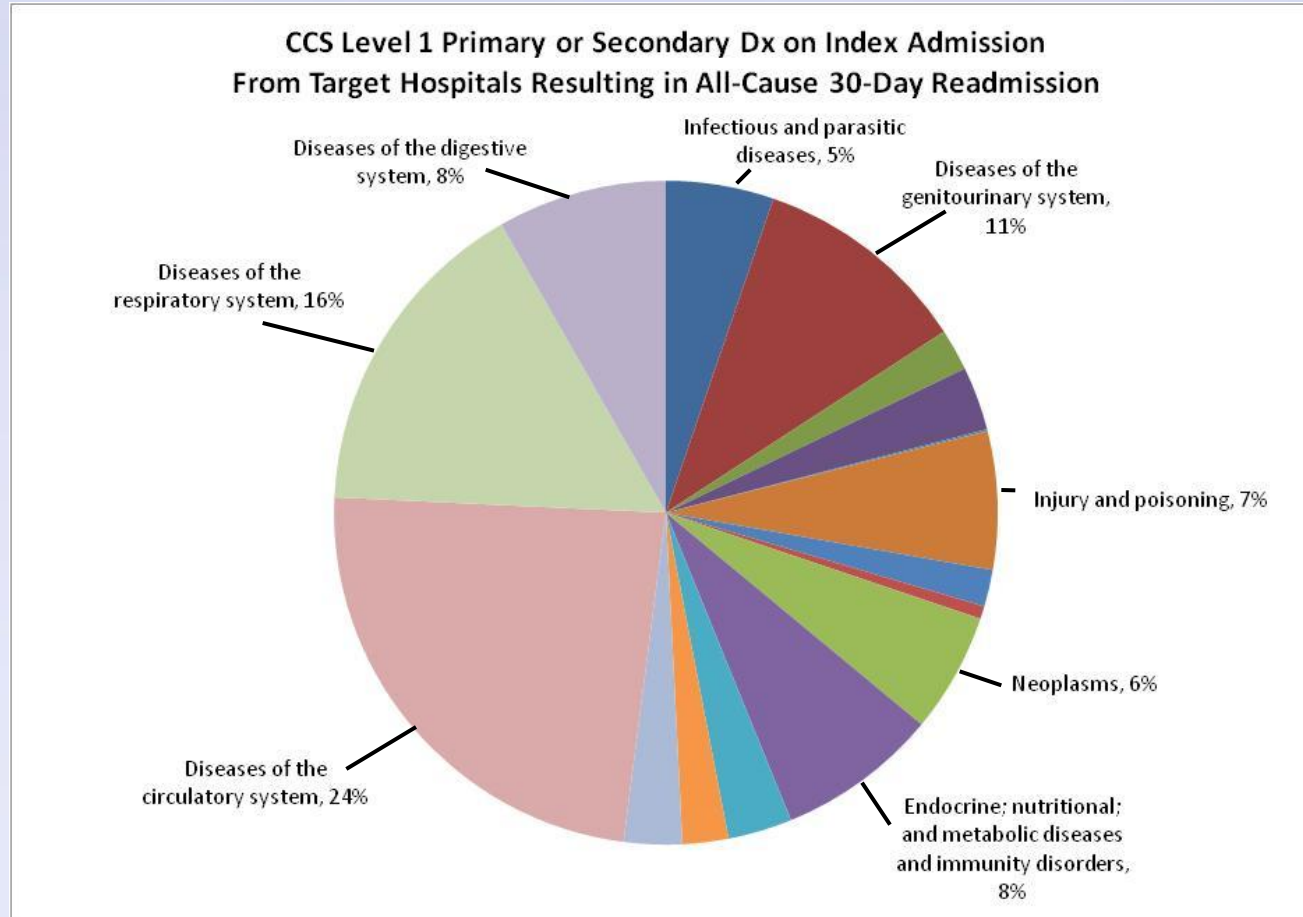
Number within circle represents the number of nursing homes located in ZIP code. Italicized providers are not participating.

Community Demographics

- ⚡ Nearly 4,000 beneficiaries from the community were hospitalized at least once during the baseline period October 1, 2007 – March 31, 2008
- ⚡ Nearly 800 of those beneficiaries were re-admitted at least once within 30-days of their initial hospitalization
- ⚡ Roughly half of the beneficiaries who were hospitalized were discharged from the five targeted hospitals
- ⚡ Approximately 30,000 Medicare FFS beneficiaries reside in the community
- ⚡ Median age is 73 years
- ⚡ 96% are white
- ⚡ About 14% live at or below the Federal Poverty Level
 - National Medicare population in 2004, 18%
 - Pennsylvania general population in 2005, 11%



Drivers of Readmissions



Based on discharges from 2007. Clinical Classification Software (CCS) 2008 downloadable from <http://www.ahrq.gov/data/hosp/>.



30-Day Readmissions

- ❖ Of discharges of CT residents from the five targeted hospitals that result in a 30-day readmission to any acute care hospital
 - 36% are discharges to home or self care
 - 29% are discharges to a SNF
 - 27% are discharges to home under the care of a HHA
 - Most readmissions occur within **seven days** of discharge from the hospital to these care settings
 - 28% readmitted in last six months of life
 - 88% of all readmissions are to the same hospital



End of Life

- ❖ Of discharges of CT residents from the five targeted hospitals that result in a 30-day readmission to any acute care hospital during the last six months of life
 - 35% are discharges to a SNF
 - 33% are discharges to home under the care of a HHA
 - 23% are discharges to home or self care
 - 1.5% have hospice referrals
 - 28% of all readmissions occur during the last six months of life



Participant Expectations



Community Responsibility

- ❖ The responsibility for addressing these concerns lies across provider settings within the community
- ❖ Requires community resources to analyze the root causes and develop shared interventions to minimize existing gaps that contribute to the fragmentation of health care delivery



Hospital

Nursing Home

PCP

Payor

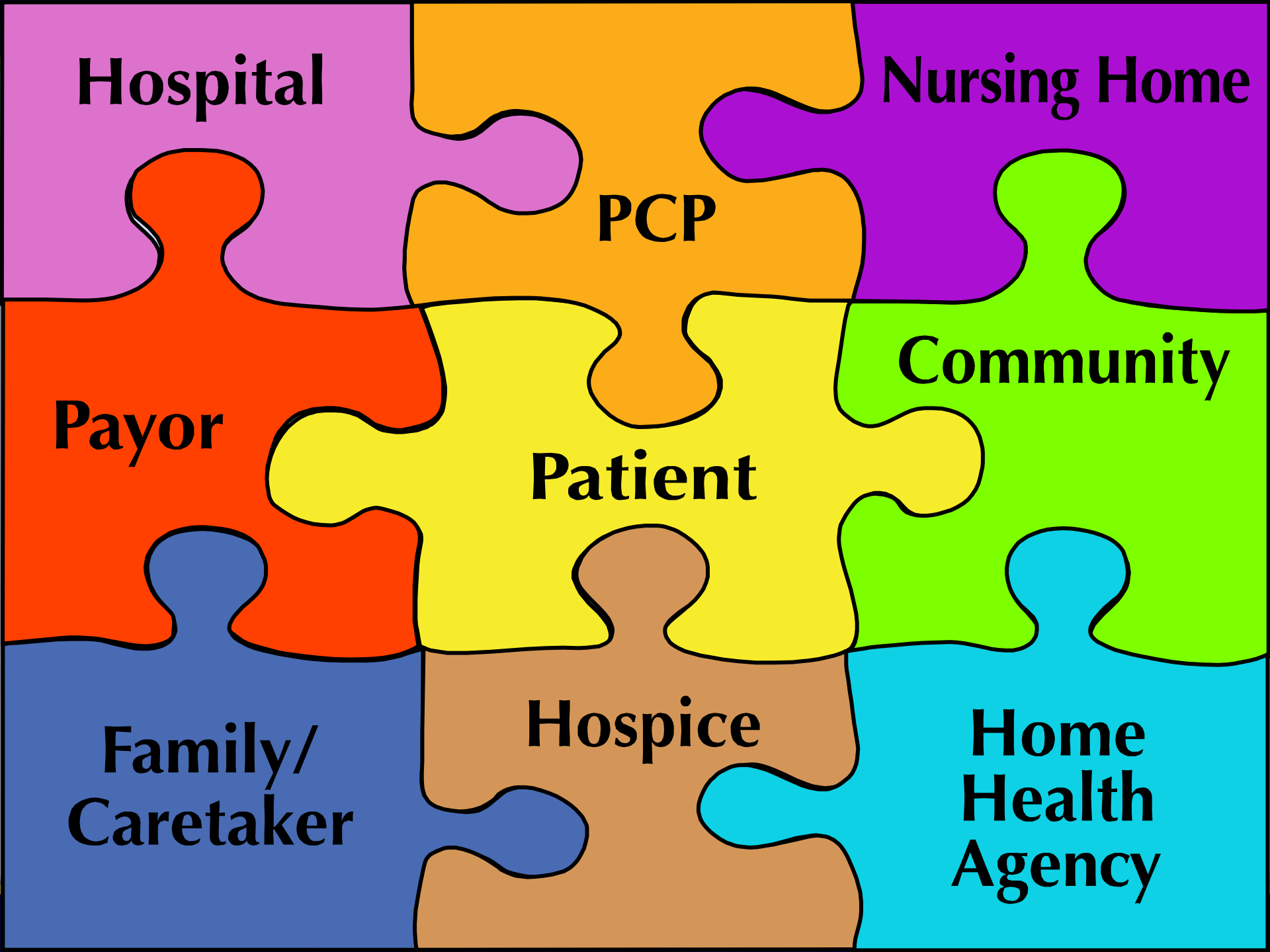
Community

Patient

**Family/
Caretaker**

Hospice

**Home
Health
Agency**



Partners and Stakeholders

- ⚡ Highmark
- ⚡ PRHI
- ⚡ ESRD
- ⚡ Vitas Hospice
- ⚡ Westmoreland AAA
- ⚡ Southwestern AAA
- ⚡ AHA
- ⚡ PAHNA



QIO Activities

- ❖ Provider selection and recruitment
- ❖ Support intervention selection
- ❖ Support intervention implementation
- ❖ Facilitate monitoring and metrics tracking



Cluster Groups — The “Engine”



Provider Expectations

- ❖ Implement interventions/process improvements to address issues in
 - Post-discharge follow-up
 - Medication management
 - Cross-setting patient care planning across the continuum

- ❖ Receive
 - Coaching, training, and consultation by Quality Insights of Pennsylvania

- ❖ Collaborate with community hospitals, nursing homes, home health agencies, physician offices, and providers to
 - Share ideas
 - Improve communication across settings
 - Analyze care processes that affect readmission

- ❖ Improve care transitions with the goal of decreasing readmission rates



***Interventions:
Development/Implementation***



Readmission Intervention Categories

⚡ System-wide

- System level readmission prevention process improvements

⚡ Specific diseases

- AMI
- Heart failure
- Pneumonia

⚡ All-cause

- Any reason beyond the targeted diseases
- End of life/palliative care



Intervention Selection Process

- ❖ Select care transitions team
- ❖ Complete process of investigation related to readmissions to determine root cause
- ❖ Chose interventions based on those findings.
- ❖ Defined Intervention – define whether it is a “system” “diagnosis specific,” or “all cause” intervention.
- ❖ Developed implementation plans of action (pilot, etc.)
- ❖ Determined metrics, etc. (PDSA-PDCA)



56 Intervention Implementation

- ⚡ Cross setting information sharing form
- ⚡ SBAR communication
- ⚡ Follow up post transition
- ⚡ Unplanned transition chart review
- ⚡ CTI
- ⚡ Front loading visits
- ⚡ Staff education/cross training
- ⚡ POLST education



Care Transition Intervention

CTI™



Eric Coleman, MD, MPH

☞ University of Colorado

☞ Empowers older adults and their caregivers to take a more active role during care transitions

☞ www.caretransitions.org



Coleman Research Findings

❖ Suggests effective care transition interventions lead to improved self-management knowledge and skills for many patients primarily in the areas of:

- Medication management
- Condition management
- Patient confidence during transition and beyond

1. ASSESS
2. ACCESS
3. ADMINISTERed



Primary role

- ❖ The primary role of the Care Transition CoachSM is to empower the patient/caregiver to
 - Assert a more active role during care transitions and
 - Develop lasting self-management skills



AARP

More Involved

Less Involved

Readmitted in 30 days	12.8%	28.0%
Experience medical error	19.2%	35.8%
Poor care coordination	19.2%	42.8%
Poor communication consequence	13.2%	48.6%
Less confidence health system	15.1%	50.8%



AARP July-August 2009



Coach Training

- ❖ Dr. Coleman and team trained coaches and QIO staff at a 1 1/2 day training session in Pennsylvania
- ❖ May 28 and 29, 2009

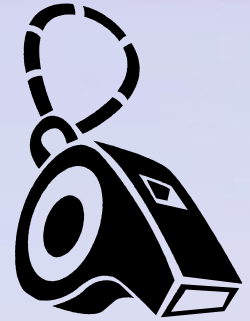


Structure of the Training

- ❖ QIO training
- ❖ Preparation
- ❖ Materials
- ❖ Who attends
- ❖ Training site
- ❖ Timeline
- ❖ Next step
- ❖ Ongoing support



Coleman Model (CTI) Transition Coach



- ❖ Assigned to every high-risk hospital discharge
- ❖ Assures continuity of care
- ❖ Educates by coaching patient/family/caregiver
- ❖ Troubleshoots system glitches
- ❖ Provides a contact in case of problems

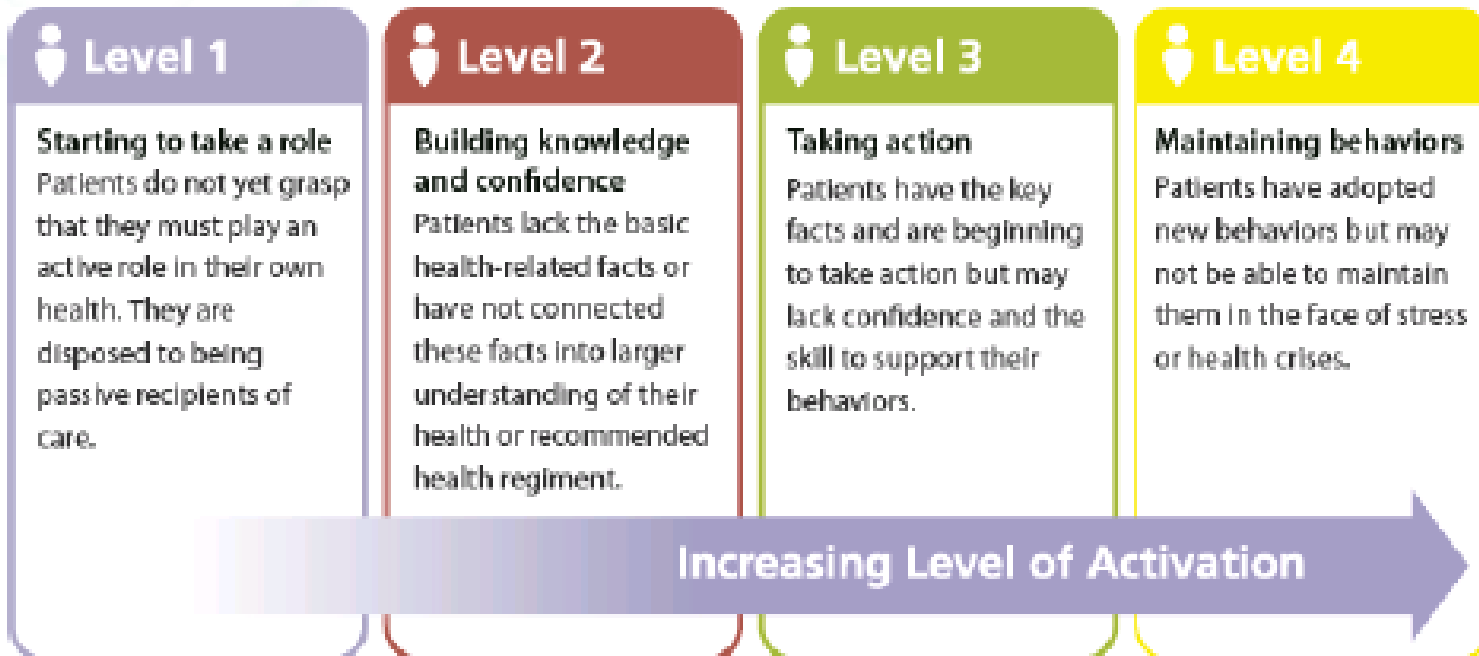


Paradigm Shift

Doing	Teaching & Advising	Coaching & MI
<p>Clinician “owns” the agenda</p> <p>Clinician “does to” the patient</p> <p>Patient receives skilled care</p>	<p>Educator still controls agenda</p> <p>Patient is receiving information and advice on specific issues, medications, diseases</p>	<ul style="list-style-type: none">•Patient is telling the coach what their goals are•Patient is telling the coach what they know about their health and meds•Patient is telling the coach what prevents them from reaching their goal•Patient outlines their plan to meet goals•Patient creates action items, agrees to tasks



Activation is developmental



Source: J. Hibbard, University of Oregon



Coleman Model: The Four Pillars

- ❖ Medication management
- ❖ Patient-centered record (PHR)
- ❖ Follow-up with PCP/Specialist
- ❖ Knowledge of “Red Flags” or warning signs/symptoms and how to respond



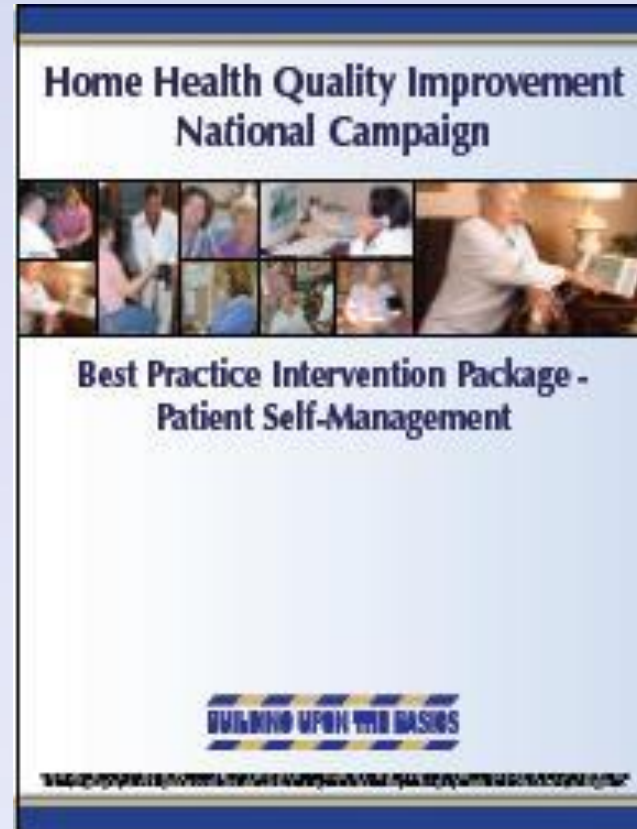
The Four Pillars

- ❖ Assures care continuity
- ❖ Educates patient, family and caregiver
- ❖ Trouble shoots system glitches
- ❖ Provides a contact in case of problems



Patient Self-Management

- ❖ Understands his/her illness
- ❖ Knows how to manage symptoms
- ❖ Knows how to obtain assistance
- ❖ Will be less likely to require ACH



Medication Reconciliation

- ❖ List on admission
- ❖ List on discharge
- ❖ List from the PCP
- ❖ Reality...



Personal Health Record

- ❖ Patient understands and uses the record to facilitate communication and ensure continuity across providers
- ❖ Only patient uses



Red Flags

- ⚡ Knowledge of signs and symptoms
- ⚡ Response understanding



Follow-Up Appointment



⚡ Method:

- Every patient leaves the hospital with an appointment for follow-up care
- Appointment in less than one week for high-risk patients

⚡ Evidence:

- Not controlled trials, but many patients are currently not seen before they are readmitted





Physicians Need to Know About Coaches

1. There is NO cost to you or your patients for coaching.
2. Coaches DO NOT interfere with your patient care.
3. Coaches DO NOT practice clinical medicine or direct patient care.
4. Coaches DO empower patients with their health care.
5. Coaches can assist you and your patients with their Medication Reconciliation.
6. Coaches will be trained professionals.
7. Selected patients will be visited in the hospital by the coach with one follow-up in their home (NOT to give direct care) and several phone contacts over a four week period.
8. Coaches assist patients with transitions across care settings.
9. Coaches will be assigned to patients with high risk for readmissions.
10. To learn more about coaches and their role visit: www.caretransitions.org.

Care Transition Coaching™ is a model designed to:

- Transfer skills
- Build patient/caregiver confidence
- Provide tools to support self management.

The goal is to coach patients/caregivers to actively engage in self-management skill development.

The primary role of the Care Transition CoachSM is to empower the patient/caregiver to:

- Assert a more active role during care transitions and
- Develop lasting self-management skills.



This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication No. 8320W-PA-CMIF-08-40 App-4/08



The Structure of the Intervention

❖ Five visits

- Hospital the day of discharge
- Home visit within 48 hrs
- Three follow-up phone calls

❖ Completed within one month



Coaching Model

- ❖ Why AAA
- ❖ Develop Collaboration
- ❖ Develop work flow process
- ❖ Action Plan
- ❖ Timeline



AAA Opportunities for Collaboration

⚡ AAA mission

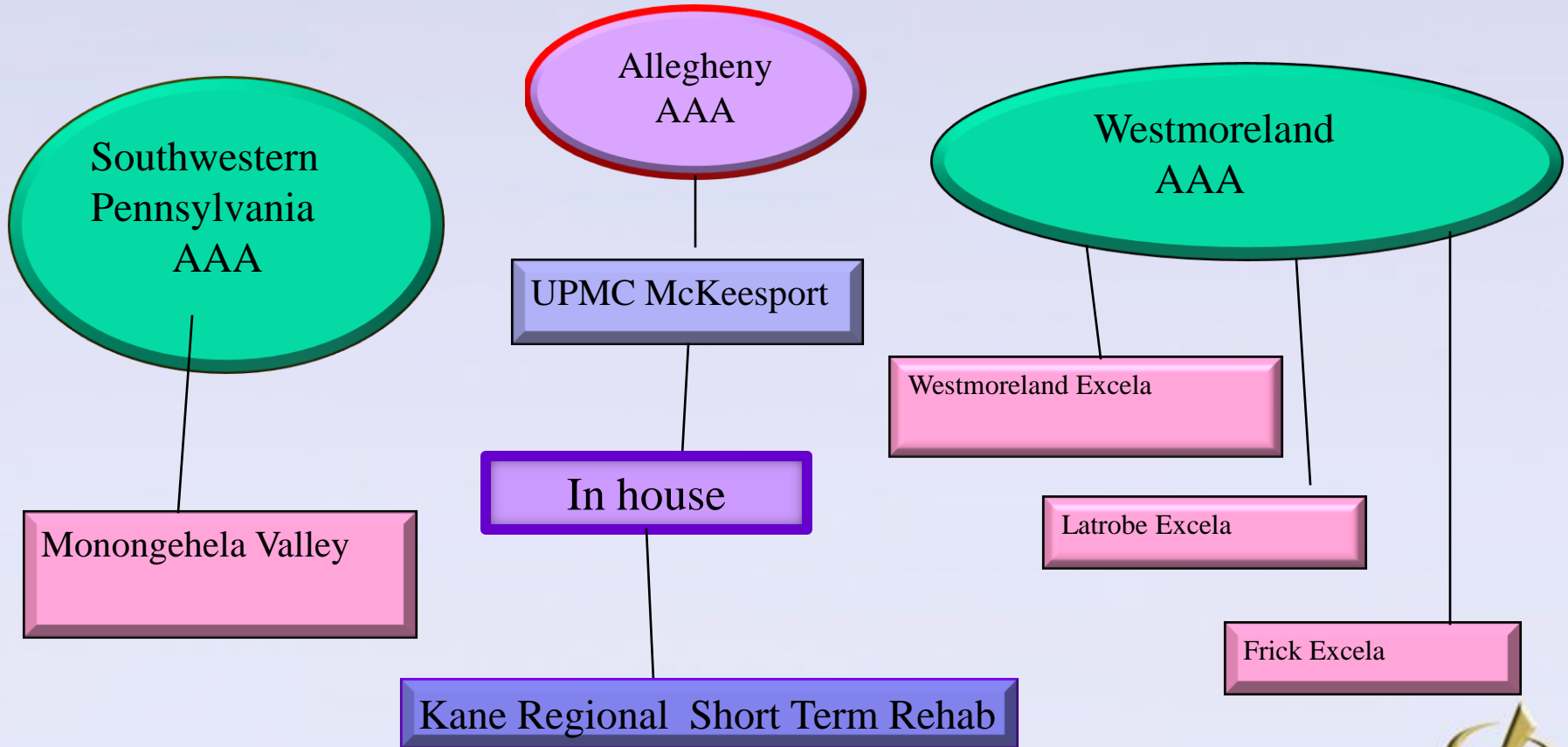
“We hereby adopt the mission to be responsible to the maximum degree of our resources, to assist and enable older and/or disabled persons to live their lives as independently as their circumstances will allow and in the best possible and desired manner.”

⚡ Services

- Preventative care
- Nutritional
- Transportation
- Caregiver service
- Support services



Coach Structure



Coaching vs. Caregiving

⚡ A Coach:

- Collaboratively assists the patient/caregiver with goal setting
- Assists the patient to anticipate barriers and plan for their resolution
- Collaboratively strategizes with the patient in how to take action to meet goals
- Does not do it for the patient
- Is not a caregiver
- Is not a teacher



Coaching Action Plan

- ⚡ Agreement/consensus
- ⚡ Leadership/buy-in
- ⚡ Educate AAA on project goals
- ⚡ Develop workflow process
- ⚡ Review model/requirements
- ⚡ Training
- ⚡ Implementation
- ⚡ Scripts
- ⚡ Flyers
- ⚡ PHR
- ⚡ Ongoing support
- ⚡ Track/trend information



Lessons Learned

⚡ Opportunities

- Silos/territoriality
- ID cultural differences
- Team development
- Role identification
- Ongoing monitoring/tweaking
- Maintain patient focus
- Educate, educate, educate

⚡ Barriers

- MFFS contract focus
- Zip code parameters



Success factors

- ❖ Sustainable
- ❖ Increase community resources across setting
- ❖ Patient familiar with AAA
- ❖ AAA coaches familiar with many patients
- ❖ Improved communication across settings
- ❖ Infection control inservice



Success Stories



Lasix

PHR

Coumadin

Transportation



Solutions to Ponder

- ❖ Re-engineer the discharge process
- ❖ Reliable and prompt follow-up care by primary care physicians
- ❖ Aggressive management of chronic illnesses
- ❖ Supportive palliative care and implementation of advance directives including the Physician Orders for Life Sustaining Treatment (POLST)



Resources

☞ www.qipa.org

– Quality Insights of Pennsylvania Toolkit

– www.caretransitions.org

☞ www.CFMC.org

☞ www.cms.hhs.gov/QualityImprovementOrgs





We did the best we could, with what we knew,
and when we knew better, we did better.

-Maya Angelou

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