Improving Care Transitions for Rhode Island Patients

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Objectives

• Understand Care Transitions issue
• Consider the three readmission drivers
• Hear about the Rhode Island Safe Transitions Experience
• Learn about evidence-based interventions
Background

• Estimated $17 Billion in Medicare readmission
  – 30-day FFS hospital readmission of 15-30%
• Several RCTs suggest that this can be reduced by 20-40% using various strategies
  – Patient Activation
    • Coleman: In-home coaching and phone f/u
    • Jack: In-hospital computerized ed. and phone f/u
  – Care management
    • Naylor: Patient supported by transitional care nurse as primary care coordinator
Care Transitions Project

• Medicare-funded pilot
  – 3 year pilot (09/08-08/11)

• Competitively funded
  – 14 contracts nationwide
  – Each based on various evidence-based research projects (independent approach)

• Cross-setting project
  – Hospitals, home health, nursing homes, community physicians
The project targets 3 counties and patients (initially) with:
- Acute myocardial infarction (AMI)
- Congestive heart failure (CHF)
- Pulmonary processes (PNE+)

Altogether, 41 ZIP codes with:
- 7 hospitals
- 60 nursing homes
- 20 home health agencies
- ~375 physicians

*Included in Target Community*
As a community, we defined our vision

A healthcare system where discharged patients:

– understand their conditions and medications,
– know who to contact with questions (and when), and
– are supported by healthcare professionals who have access to the right information, at the right time.

Over the past 2 ½ years, our transitions community and grown and RI has become a front runner in this journey...
Project Goals

• Increase patient self-management
• Improve coordination of care
  – Evidence-based practice
  – Improved communication between providers
• Ultimately:
  – Reduce 30-day re-hospitalization rates
  – Improve post-discharge physician follow-up
  – Enhance discharge-related outcomes (patient satisfaction)
    1. Communication of information about medicines
    2. Discharge information

*Our project’s long-term goal: sustainability of proven interventions through cross-setting collaboration*
Project Team’s Initial Considerations

• How do we translate research to real-world conditions?
• What will work in our community?
• How can we affect outcomes quickly?
• How can we sustain change in the long-run?
HATCH Safe Transitions Model™

Advisory Board
• Best practices (e.g., hospital discharge)
• Economic models
• Business case
(Long-term impact)

Patient interventions
• Coaching
• RED Education
(Short term impact)

Systems interventions
• Tailored QI (each facility)
• Communities of practice:
  Within setting
  Across settings
(Medium-term impact)

Patient/caregiver
Three Drivers

1. Low Patient (caregiver) activation

2. Lack of implemented standard and known processes

3. Inadequate communication
Team Considered the Existing Transitions Programs/Models

• Bridging Nursing Support / Transitional Care Model
  Transitional Care Nurses follow patients from the hospital into the home to provide services.

• Better Outcomes for Older Adults through Safe Transitions (BOOST)
  Toolkit for improving hospital discharge, including screening/assessment tools, discharge checklist, transition record, teach-back process, risk-specific interventions and written discharge instructions.

• Best Practices Intervention Package (BPIP) Transitional Care Coordination
  Comprehensive manual for home health agency leadership and staff to identify tools and processes to improve patient transitions.

• Care Transitions Intervention
  Care transitions coaches support patients by providing specific tools and teaching self-management skills to ensure their needs are met during the transition from the acute care setting to home.

• Hospital to Home (H2H) National Quality Initiative
  Co-sponsored by the American College of Cardiology (http://www.acc.org/) and the Institute for Healthcare Improvement (http://www.ihi.org/ihi). H2H is an effort to improve the transition from inpatient to outpatient status for individuals hospitalized with cardiovascular disease.

• Interventions to Reduce Acute Care Transfers (INTERACT)
  Toolkit for SNF personnel to reduce avoidable hospital admission. Three types of tools: 1) communication; 2) clinical care paths; and 3) advance care planning.

• Re-Engineered Discharge (RED)
  Standardized discharge intervention; includes patient education, comprehensive discharge planning, post-discharge telephone reinforcement.

• Transforming Care at the Bedside (TCAB)
  Hospital intervention that includes four core elements: 1) enhanced admission assessment for post-discharge needs; 2) enhanced teaching and learning; 3) patient and family-centered handoff communication; and 4) early post-acute care follow-up.
Safe Transitions Project Provider Interventions

- Patient/Caregiver Activation
  - CTI / RED Education
  - Health Literacy
  - Post Discharge Patient Call Back Programs
  - Patient tools
    - Zone tools
    - CMS Discharge Checklist
    - Pill boxes/ green bags

- Standard and Known Processes
  - Standing Orders - Referral to SNF/ HH
  - Follow-up Physician Appointments
  - Palliative Care Counseling/Referrals

- Communication (within/across settings)
  - CoC Form Audit/Feedback and Enhancements
  - Multi-Disciplinary Rounding
  - SBAR, Teach-back
A Closer Look at the Coleman: Patient Coaching
The “Care Transitions Intervention”

• Coaches work 1:1 with hospitalized patients, following them for 30 days after discharge
  – Two in-person visits (hospital and home/SNF)
  – Two phone calls

• RNs coach patients to (“Four Pillars”):
  1. Use a **personal health record (PHR)** to self-manage
  2. Perform **medication reconciliation**, or ask for help
  3. Visit a physician for **follow-up within seven days**
  4. Seek help for worsening ‘**red flags’** symptoms
CTI Key Lessons

• Patient activation appears to work among those who accept coaching
• This is not a clinical intervention – coaches do not need to be nurses
  – Our model also deployed social workers, a CNA, and a non-clinician
• The coach does not have to be “owned” by the hospital
  – It may be a more effective intervention when deployed by a receiving provider in a way that it helps connect post-hospitalization care to PCP
What Else Works –

• Preparing patients for Discharge - Day 1
  – Incorporating CTI’s 4 pillars
  – Educating using teach back method
• A Safe Discharge: Setting up for success
  – Re-connecting with community resources
    • Scheduling Follow-Up Visits
    • Assisting with non-medical needs -The POINT
  – Post discharge outreach
Incorporating Best Practices
Hospitals and Community Physician Offices to start...

now working with Home Health Agencies and Nursing Homes
### ED/Hospital Visit Timeline

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<tr>
<th>Timeline</th>
<th>Hospital</th>
<th>Community Physician</th>
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<tbody>
<tr>
<td>At intake</td>
<td>• Notify PCP about hospital utilization</td>
<td>• Provide clinical information when referring patients for ED evaluation</td>
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<tr>
<td>During visit</td>
<td>• Invite PCP to participate in EOL discussions</td>
<td>• Provide ED/hospital with phone access to outpatient staff who can answer clinical questions</td>
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<tr>
<td></td>
<td>• Provide patient with effective education</td>
<td>• Provide ED/hospital with access to outpatient clinical info</td>
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<td></td>
<td>• Provide patient with written discharge instructions</td>
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<tr>
<td></td>
<td>• Provide patient with follow-up phone #</td>
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<tr>
<td></td>
<td>• Perform medication reconciliation</td>
<td></td>
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<tr>
<td></td>
<td>• Schedule outpatient follow-up appointment</td>
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<tr>
<td>At discharge</td>
<td>• Provide PCP with hospital contact info</td>
<td>• Confirm receipt of hospital discharge info</td>
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<tr>
<td>After discharge</td>
<td>• Provide PCP with summary clinical info</td>
<td>• Follow-up with high-risk patients via phone</td>
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<tr>
<td></td>
<td></td>
<td>• Conduct outpatient follow-up</td>
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<td></td>
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<td>• Perform outpatient medication reconciliation</td>
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## Best Practice Development Process

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<th>Process</th>
<th>Hospital</th>
<th>Community Physician</th>
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<tr>
<td>Development</td>
<td>• Evidence base review</td>
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<td></td>
<td>• Health Plan CMO meetings</td>
<td>• Local input (e.g., survey, PCPAC, CSI-RI)</td>
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<td></td>
<td>• Local input (including PCPAC discussions)</td>
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<tr>
<td>Vetting</td>
<td>• Project’s Advisory Board meetings</td>
<td>• Project’s Advisory Board meetings</td>
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<td></td>
<td>• Hospital quality directors endorsement</td>
<td>• Discussion at October PCPAC meeting</td>
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<td></td>
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<td>• Select community physicians’ input</td>
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<tr>
<td>Implementation</td>
<td>• Hospital executive leadership opt-in*</td>
<td>• Physician opt-in*</td>
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<td>• (Confidential hospital/plan contracting)*</td>
<td>• (Confidential physician/plan contracting)*</td>
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Wrap Up
Q & A
Session
Interested in learning more...

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