

Improving Care Transitions for Rhode Island Patients

Nelia Odom, RN, BSN, MBA, MHA

Senior Program Coordinator, Quality Partners of Rhode Island

Deborah Correia Morales , MSW

Senior Program Coordinator, Quality Partners of Rhode Island



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

Care Transitions Project

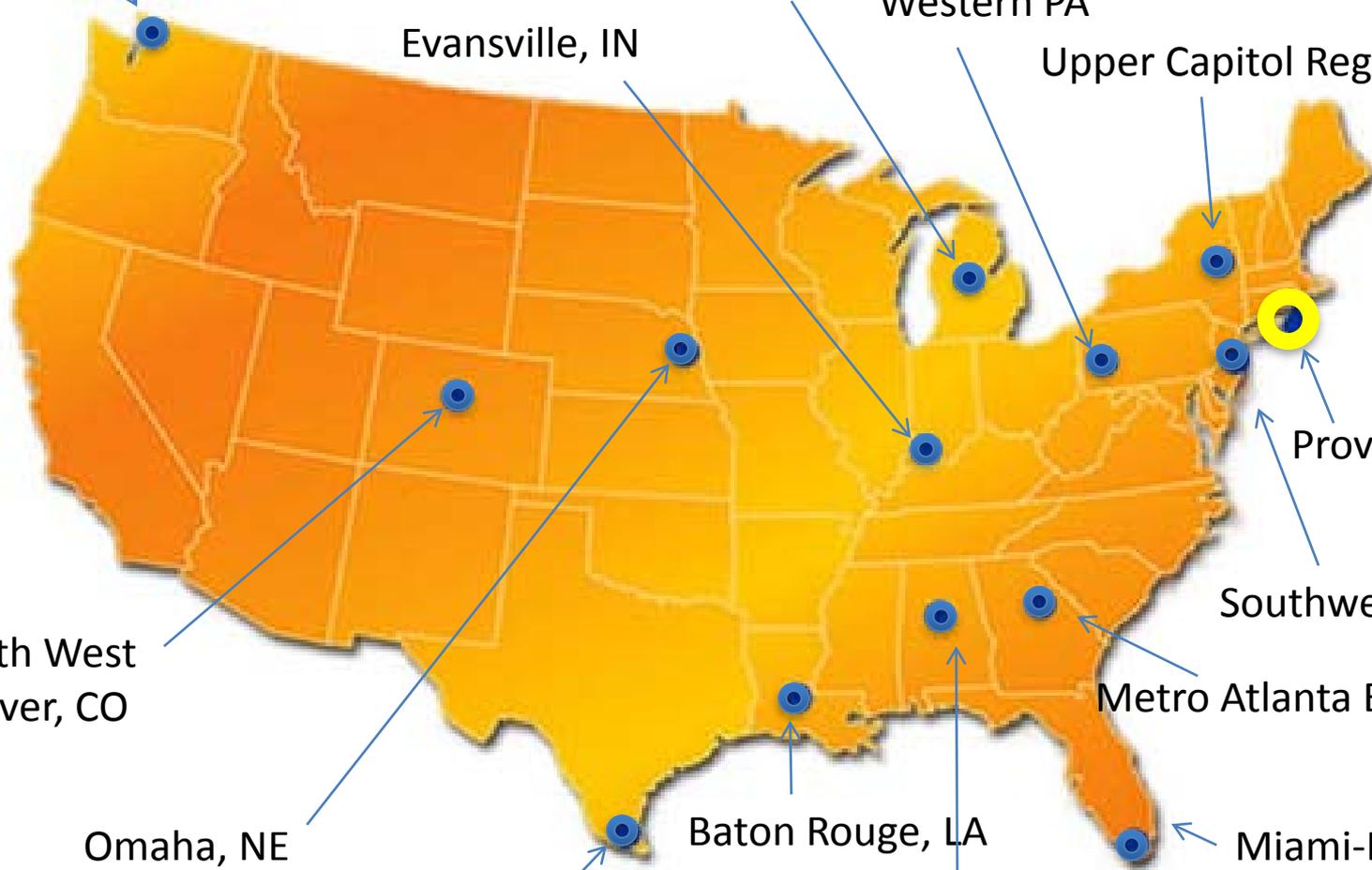
Whatcom
County, WA

Greater Lansing Area, MI

Western PA

Upper Capitol Region, NY

Evansville, IN



North West
Denver, CO

Providence, RI

Southwestern NJ

Metro Atlanta East, GA

Omaha, NE

Baton Rouge, LA

Miami-Dade, FL

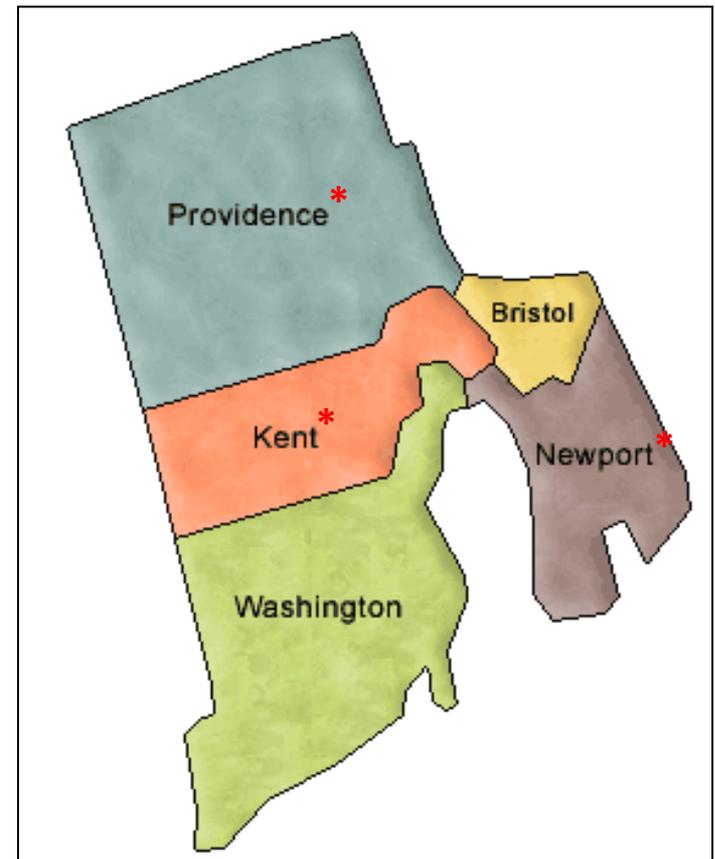
QUALITY PARTNERS
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Harlingen, TX

Tuscaloosa, AL

RI -Target Patients/Community

- 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

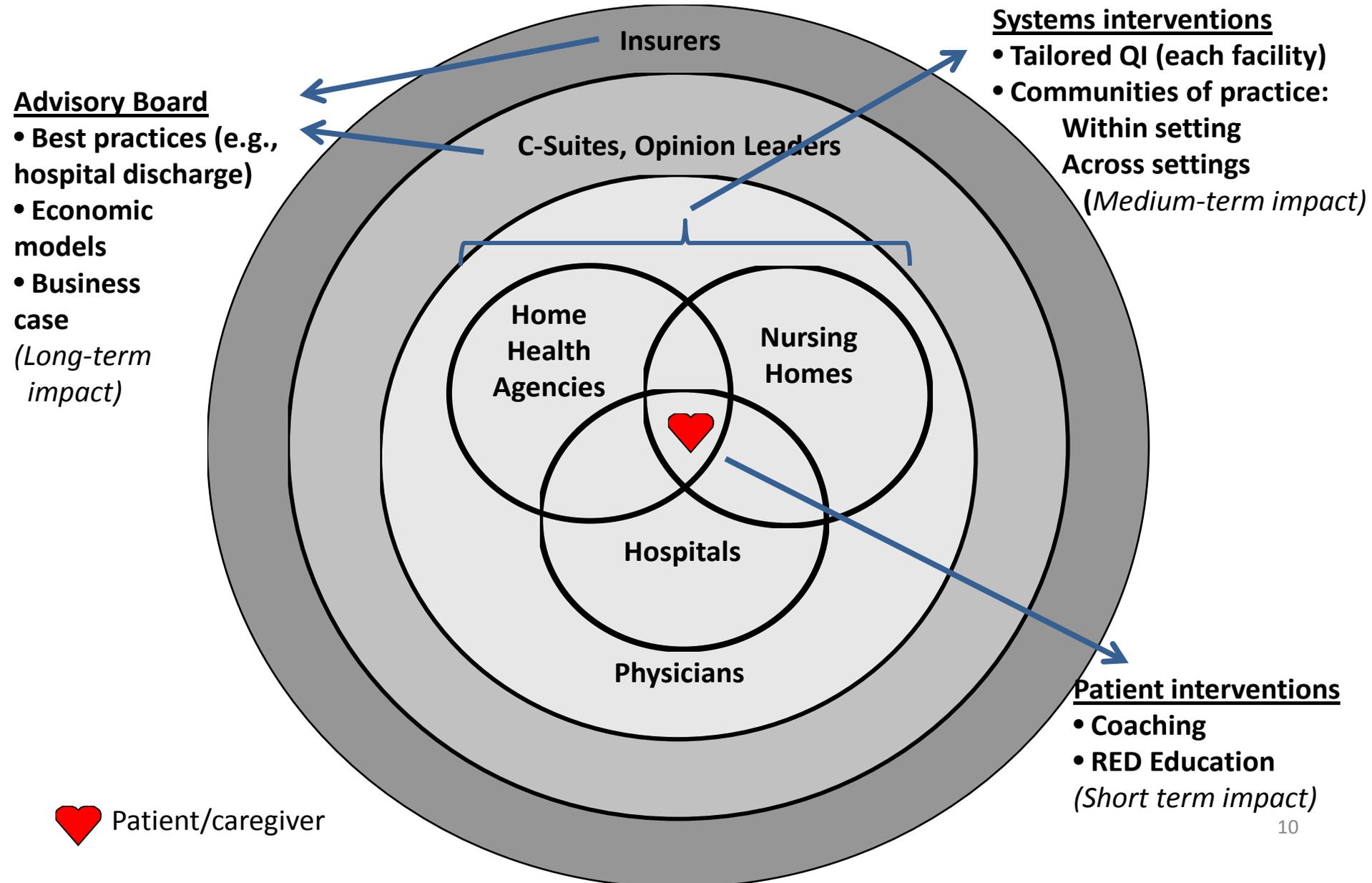
- Increase patient self-management
- Improve coordination of care
 - Evidence-based practice
 - Improved communication between providers
- Ultimately:
 - Reduce 30-day re-hospitalization rates
 - Improve post-discharge physician follow-up
 - Enhance discharge-related outcomes (patient satisfaction)
 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™



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.ihl.org/ihl>). 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 –

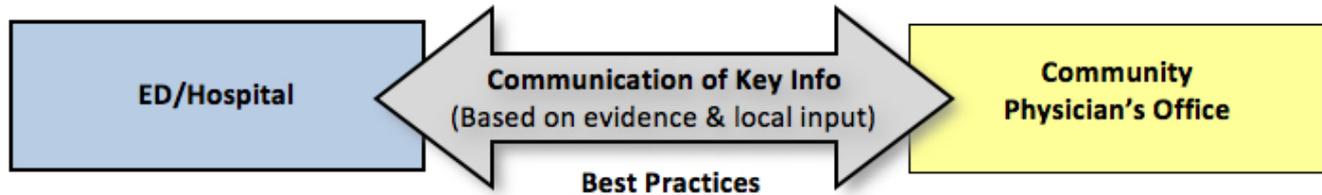
- Preparing patients for Discharge - Day 1
 - Incorporating CTI's 4 pillars
 - Educating using teach back method
- A Safe Discharge: Setting up for success
 - Re-connecting with community resources
 - Scheduling Follow-Up Visits
 - Assisting with non-medical needs -The POINT
 - Post discharge outreach

Incorporating Best Practices

Hospitals and Community
Physician Offices to start...

*now working with Home Health
Agencies and Nursing Homes*





ED/Hospital Visit Timeline	Hospital	Community Physician
At intake	<ul style="list-style-type: none"> Notify PCP about hospital utilization 	<ul style="list-style-type: none"> Provide clinical information when referring patients for ED evaluation
During visit	<ul style="list-style-type: none"> Invite PCP to participate in EOL discussions Provide patient with effective education Provide patient with written discharge instructions Provide patient with follow-up phone # Perform medication reconciliation Schedule outpatient follow-up appointment 	<ul style="list-style-type: none"> Provide ED/hospital with phone access to outpatient staff who can answer clinical questions Provide ED/hospital with access to outpatient clinical info
At discharge	<ul style="list-style-type: none"> Provide <u>PCP with</u> hospital contact info Provide PCP with summary clinical info 	<ul style="list-style-type: none"> Confirm receipt of hospital discharge info
After discharge		<ul style="list-style-type: none"> Follow-up with high-risk patients via phone Conduct outpatient follow-up Perform outpatient medication reconciliation

Best Practice Development Process

Process	Hospital	Community Physician
Development	<ul style="list-style-type: none"> Evidence base review Health Plan CMO meetings Local input (including PCPAC discussions) 	<ul style="list-style-type: none"> Evidence base review Local input (e.g., survey, PCPAC, CSI-RI)
Vetting	<ul style="list-style-type: none"> Project's Advisory Board meetings Hospital quality directors endorsement 	<ul style="list-style-type: none"> Project's Advisory Board meetings Discussion at October PCPAC meeting Select community physicians' input
Implementation	<ul style="list-style-type: none"> Hospital executive leadership opt-in* (Confidential hospital/plan contracting)* 	<ul style="list-style-type: none"> Physician opt-in* (Confidential physician/plan contracting)*

Wrap Up Q & A Session



Interested in learning more...



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Nodom@riqio.sdps.org

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Dmorales@riqio.sdps.org