Improving Transitions of Care
A Strategy to Defer Decline

How the Foundation Got Started with Care Transitions

- First Quality Improvement Collaborative 2005-2006
  - Teams chose palliative care or transitions
  - By the end, almost all teams included some aspects of care transitions with uniform transfer forms, medication reconciliation and other system changes.
  - Learned about Dr. Eric Coleman and his recently published Care Transitions Intervention
Collaboratives and Learning Community

• 2007-2008 Collaborative
  – Fourteen teams, almost all worked to implement Care Transitions Intervention

• 2009-2010 Collaborative
  – Fourteen teams implemented Care Transitions Intervention and the Next Steps in Care, family caregiver bundle

• 2011 Care Transitions Learning Community
  – Components of the ACA and 4 evidence-based best practice models

The NEW ENGLAND JOURNAL OF MEDICINE

SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program
Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

ABSTRACT

1. 1 in 5 Medicare Beneficiaries are readmitted in 30 days
2. National cost of over USD $17 Billion
3. Half of patients readmitted had no physician contact
4. 70% of surgical readmits were for chronic medical conditions

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Care Transitions Intervention

Developed by Dr. Eric Coleman of the University of Colorado

*Care Transitions Intervention™* is:
designed to encourage older patients and their caregivers to assert a more active role during care transitions

Patients and Families as Care Coordinators

- Most transition plans assume the patient and family will play a significant role for success
- Patients and families
  - May be willing and able, BUT they...
  - Don’t know what to expect
  - Aren’t prepared – lacking tools, knowledge and confidence
Dr. Coleman Began Listening to Voice of the Patient

- Inadequately prepared for next setting
- Conflicting advice for illness management
- Inability to reach the right practitioner
- Repeatedly completing tasks left undone

The Care Transitions Intervention: A Patient Self-Management Model

Foster skill transfer
Build confidence
Promote use of tools

Patient / Family

Successful Patient Self-Management
- Medication Self-Management
- Use of Dynamic Patient Centered Record
- Primary Care Follow-Up
- Knowledge of Red Flags

Current Policies, Resources

Health Care Organization
Adoption of Care Transitions Intervention

Care Transitions Coaching to:

OUTCOMES
- Sustained reduction in hospital readmissions
- Accompanying net annual cost savings
- Activation leading to achievement of patient health goals

The CTI was developed with the support of The John A. Hartford Foundation
Key Elements
Care Transitions Intervention

- Low-cost, low-intensity, adapt to different settings
- One home visit, three phone calls over 30 days
- “Transition Coach” is the vehicle to build skills, confidence and provide tools to support self-care
  - Model behavior for how to handle common problems
  - Practice or role-play next encounter or visit
  - Elicit patient’s health related goal
  - Create a “gold standard” medication list

Coach Focus on Four Pillars

- Medication self-management
- Follow-up with PCP/Specialist
- Knowledge of “red flags” or warning signs/symptoms and how to respond
- Patient-centered record
Home Visit

Patient identifies a 30-day health related goal

Patient asked: “Show me what medications you take and how you take them”

Transition Coach models the behavior for how to resolve discrepancies, respond to red flags, and obtain a timely follow up appointment

Patient and Transition Coach practice or role play next encounter(s)

Patient identifies 2-3 questions for next encounter

Follow-up Phone Calls (Three)

- Follow-up on active coaching issues
- Review the Four Pillars
- Estimate progress made in activation
- Ensure that patients needs are being met
Care Transitions Intervention
Summary of National Key Findings

- Significant reduction in 30-day hospital readmits (time period in which Transition Coach involved)
- Significant reduction in 90-day and 180-day readmits (sustained effect of coaching)
- Net cost savings of $300,000 for 350 pts/12 mo
- Adopted by over 375 leading health care organizations in 34 states nationwide

“Real World” Results

John Muir Physician Network (CA) reduced 30 day readmissions from 11.7% to 6.1% and 180 day readmissions from 32.8% to 18.9%.

Health East (MN) demonstrated reduced 30-day readmission rate from 11.7% vs 7.2%
Model Fidelity- Important for Results

- Dedicated Transition Coach role
- Coach focuses on skill transfer, identification and pursuit of patient self-identified goal and modeling of behavior
- Home visit is essential
- Coach receives training offered by the Care Transitions Program

Who is the Best Transitions Coach?

- Nurses, social workers, others
- Demonstrated patient-centered focus, without the need to set the agenda or complete tasks
- Experienced, empowered, professional comfortable with home visits
- Excellent communication skills
Community Health Foundation of W&C NY Supported Regional Results

- Jones Memorial Hospital in Wellsville
- United Memorial Hospital in Batavia
- Crouse Hospital in Syracuse
- Lakeshore Hospital and Community Concern in Irving

Jones Memorial Hospital

- Focused on CHF patients
- 39% decline in CHF admissions for patients who had been coached
- Discovered a 20% medication error rate during coaching with mostly system errors
  - Discharge instructions inaccurate or incomplete
  - Led to hospital QI effort to improve medication reconciliation
Medication Discrepancies

<table>
<thead>
<tr>
<th>System Level Errors</th>
<th>Patient Level Errors</th>
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<tbody>
<tr>
<td>Discharge Instructions Inaccurate</td>
<td>38</td>
</tr>
<tr>
<td>Discharge Instructions Incomplete</td>
<td>30</td>
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<tr>
<td>Discharge Instructions Illegible</td>
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<tr>
<td>Incorrect Label</td>
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<tr>
<td>Confusion Between Brand &amp; Generic</td>
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</tr>
<tr>
<td>Non-Intentional Non-Adherence</td>
<td>11</td>
</tr>
<tr>
<td>Intentional Non-Adherence</td>
<td>1</td>
</tr>
<tr>
<td>Script Not Filled</td>
<td>2</td>
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</tbody>
</table>

United Memorial Hospital

- Focus on CHF patients
- 10% readmission rate during time of Collaborative
- When CHF patients were readmitted over LOS dropped from 7.6 days to 4.2 days
- Cost to hospital for CHF patients dropped from $5,717 per admission to $4,870
- With 65 CHF admissions this was a savings of over $55,000 in the last year of project
Crouse Hospital (Syracuse)

- Reduced 30-day readmission rate for heart failure to 9.7%
- Patient and Physician Satisfaction High (3.5/4.0)
- Functional goals met
- Improvements in discharge process
- Currently expanding number of coaches to cover all older patients with multiple chronic conditions or admissions

Average Days Out - CHF Patients

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td># patients</td>
</tr>
<tr>
<td>Patients with no other admission</td>
<td>122</td>
</tr>
</tbody>
</table>
| Patients with subsequent admissions | 172 | Before 105
                                           |       | After 279 |
From 2007 Collaborative Lakeshore Hospital with a Transition Coach from Community Concern (a CBO)

- Faye Contino - Discharge Planner
- Beth Nowak - Social Worker
- Jerry Bartone MA MBA Executive Director
- Jennifer Anselmo - Team Leader
- Dawn Abramowski - Transition Coach

**Hospital Readmissions**

Transition Coaching reduced hospital readmissions by 50%.

Patients who agreed to coaching (n=47) had a hospital readmission rate of 13% vs. 26% for patients (n=70) who declined transition coaching.
Hospital Readmissions

<table>
<thead>
<tr>
<th>Days Between Hospitalizations</th>
<th>% of Patients by Admitting Dx. - Accepted vs. Declined Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted Coaching</td>
<td>69.2 Days</td>
</tr>
<tr>
<td>Declined Coaching</td>
<td>38.7 Days</td>
</tr>
</tbody>
</table>

Admitting Diagnosis

- angina
- respiratory
- syncope
- cellulitis
- chest pain
- anemia
- dehydration
- COPD
- pneumonia
- CHF

% of Sample

Care Transitions Coaches

- 103 trained since 2007
- Surveyed 87 in June 2011; ~ 50% response
  - 80% use what they learned in their work
  - 48% combine coaching with other roles
  - 42% use what was learned in patient care
  - 74% report increased coaching since they began
Next Step in Care

Focus:

- Seriously and chronically ill patients whose family caregivers are significantly involved in their care
- Transitions to and from hospitals, nursing homes, and certified home health agencies

Goals:

- **Change provider practice** so that family caregivers are routinely included in transition care planning, implementation, and follow-up. Transform the abrupt admission/discharge processes into transitions in care
- **Provide information and tools to family caregivers** to enable them to manage transitions in cooperation with health care professionals

For more information

Community Health Foundation of Western and Central New York
www.chfwcny.org

Care Transitions Intervention
www.caretransitions.org

Next Step in Care
www.nextstepincare.org