ADAPTING A TRANSITIONAL CARE INTERVENTION IN A SAFETY NET SETTING

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SF GH
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OBJECTIVES

- Review TOC – definition, extent of problem, approaches to improve TC
- Gaps in literature
- Review LEP and health literacy
- How SFGH approached a transitional care model
- Lessons learned in evaluating & implementing
TRANSITIONS OF CARE

- Movement of patients from one health care practitioner or setting to another as their condition and care needs change
- Occurs within settings, between settings, across health states
TRANSITIONAL CARE

- Set of actions designed to ensure the *coordination* & *continuity* of health care as patients transfer between different locations or different levels of care within the same location.

- Based on a *comprehensive care plan* & availability of well trained providers that have *current information* about the patient’s goals, preferences, and clinical status.
WHAT LEADS TO PROBLEM TRANSITIONS?

- Poor discharge processes
- Ineffective communication between sending and receiving providers
- Lack of timely follow-up
- Uncertainty regarding self-management tasks
- Confusion about medications
REHOSPITALIZATION IS SYMPTOM OF POOR TRANSITION

- Rehospitalization rates have become a focus of attention for payers & policy makers as discrete symptom of the deficiencies in our system.
- In general, the process of d/c from the hospital is intended to establish the patient, stably, in a new setting of care.
- Early rehospitalization **signals a failure** in this process.
WHAT CONTRIBUTES TO REHOSPITALIZATION?

- Lack of valued central role for PC
- Silo’d care with fragmented providers and poor information sharing across providers
- Volume based fee for service payment systems
- Variable efforts in engaging patients in shared decisions making, including at the end of life
WHO IS AFFECTED?

- Almost 1/5 Medicare patients is readmitted to the hospital within 30 days of discharge (Jenks, 2009).

- High rates of avoidable rehospitalization are especially likely among patients with
  - chronic illnesses, particularly heart failure CHF and COPD
  - frail elderly
  - patients residing in nursing homes or who receive home health care services;
  - patients nearing the end of life
  - >5 chronic conditions: most complex medical requirements & highest rates of readmission

OTHER FACTORS THAT PREDICT REHOSPITALIZATION

- poor social support
- depression and other psychiatric illness
- substance abuse
- complex social challenges, including poverty
Improving Care Transitions: ACA Begins to Re-align Payments

- **Carrot and Stick approach**
  - **Carrot** - increases to their Medicare payments if they achieve/exceed quality performance targets
    - Telling patients about problems to look out for post discharge
    - Asking patients if they have the help they need at home
    - Providing heart failure patients discharge instructions
  - **Stick** - CMS has begun to reduce payments by up to 1% to hospitals whose readmission rates for patients with CHF, AMI, PNA exceed a particular target.
    - The rate will likely increase to 3% based on this year’s data and the list of targeted diagnoses is also set to increase.
IMPROVING CARE TRANSITIONS: ACA BEGINS TO RE-ALIGN PAYMENTS

Payments to primary care practices that operate as medical homes and provide care transition services

- Medicare Multi-Payer Advanced PC Practice Demo
- FQHC Advanced PC Practice Demo
- State Medicaid agencies offering enhanced reimbursement
IMPROVING CARE TRANSITIONS: ACA BEGINS TO RE-ALIGN PAYMENTS

- New Payment Models:
  - ACO’s
    - Incentive to coordinate care more closely to keep patients healthy and out of the hospital because they’ll be eligible to share in the savings generated.
  - Bundled Payments
    - Pilots underway to test whether making 1 payment to 1 entity for services provided by several providers for 1 episode of care (Ex. Hip replacement) will incentivize providers to work together efficiently & effectively
Projects to improve transitions in care have shown that as much as one-third of hospital utilization in the month after discharge can be avoided (Jack, 2009; Naylor, 2004; Coleman, 2004)
PROJECT RED (RE-ENGINEERED DISCHARGE)

- Discharge checklist (11 components)
- RN in-hospital education
- After Hospital Care Plan
- Follow-up pharmacist telephone call
CARE TRANSITIONS INTERVENTION (CTI™)

- **Intervention**
  - 4-week program consists of
    - Patient-centered record
    - A structured discharge checklist of critical activities
    - In-hospital session with a Transitions Coach™
    - Transitions Coach™ follow-up visits and accompanying phone calls

- **Focuses on 4 conceptual areas**
  - Medication self-management
  - Patient-centered record
  - Primary Care and Specialist Follow-Up
  - Knowledge of Red Flags
The Transitional Care APN as care coordinator

Patients are visited:

- In the hospital within 24 hours of enrollment
- Daily throughout the hospitalization
- In the home within 24-48 hours of discharge
- At least weekly during the first month
- At least semi-monthly throughout the intervention
COMMON THREADS FOR SUCCESSFUL MODELS

- Comprehensive Discharge Planning with Timely Communication with PCP
- Post-discharge support
- Patient Education and Self-Management Support
GAPS IN KNOWLEDGE STILL EXIST

- Most evaluations of transitional care models have not included sufficient samples of minorities, recent immigrants, or limited English proficiency (LEP) seniors to determine effectiveness in these groups.
- Only one study to date has evaluated a program specifically targeting African American and Spanish-speaking seniors with heart failure.
  - showed modest reductions in rehospitalizations and improved function (Sisk, 2006)
- Why do we care about these gaps?
LIMITED ENGLISH PROFICIENCY: LEP

- **DEFINITION:** the limited ability or inability to speak, read, write or understand the English language

- Over 20 million people (8.6% of US population) are LEP status.
- LEP status has been associated with communication problems.
- Without appropriate language assistance for LEP patients, hospitals cannot teach patients and caregivers self-management skills
HEALTH LITERACY

- **DEFINITION:** a patient’s ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions

- 77 million US adults have limited health literacy

- Health literacy barriers are more common among minority adults and those who did not speak English before going to school.

- Low health literacy is a predictor for readmission.

- Assessing health literacy in a cross-cultural context can be complex
HIGH RISK POPULATION

- A recent survey of National Association of Public Hospital members (NAPH Data Brief, 2011) identified immigration status, language barriers, and low health literacy as major contributing factors to readmission.

- Recent studies have demonstrated
  - Seniors who are recent immigrants and/or ethnic minorities are especially vulnerable during health care transitions (Graham 2009).
  - Ethnic minorities have slower rates of recovery after hospitalization and increased incidence of potentially preventable rehospitalizations compared with the general population, (Davis, 2003; Jiang, 2005; Lafata, 2004; Sands, 2005).
DEMOGRAPHICS ARE CHANGING

- The number of minority group elderly is on the rise
- Cultural factors, socioeconomic factors, as well as language and literacy, will be increasingly important to consider in designing transitional care models to meet the needs of a changing population.
The gap in the care transitions literature is significant.

The CEO of SFGH saw this gap as an opportunity to bring new knowledge to the health care community.
SFGH

- Only Trauma Center in San Francisco
- Care for over 100,000 patients per year
- Provides 20% of all inpatient care in SF
- Only Psychiatric Emergency & Rehabilitation Services
- Referral Center for Healthy San Francisco, the county’s healthcare access program
- 66-75% patients have limited health literacy
- Teaching hospital
SFGH

- Disproportionately admits higher numbers of patients with major predictors of readmissions
- Top 5 diagnoses associated with readmission are CHF, EtOH/drug abuse, COPD, Diabetes, Renal Failure
- Close to 10,000 discharges/year
SELECTING AN INTERVENTION

» Team reviewed existing evidence-based innovations

» Goals were to
  » identify an existing model that would most readily lend itself to adoption & dissemination in the safety net
  » test whether the model demonstrated benefit by doing a randomized controlled trial
SELECTING AN INTERVENTION

- Initially wanted to pursue an intervention with a home visit component
  - Concern about financial sustainability.
- Had to take staffing into account
  - What was readily available
- Examined what we thought our patients needed
  - High burdens of disease and polypharmacy led us to choose intervention that emphasized med reconciliation and medication management.
SELECTING AN INTERVENTION

- After we secured funding from the Moore Foundation, the team from Project RED approached us for collaboration
- Support from Hospital to Home for Elders (SHHE) study
- Goals:
  - Test the efficacy of reengineered discharge in elderly non-English-speaking patients
  - Figure out if telephone follow-up feasible
  - Modify tools to fit our patient population
  - Understand why this population is readmitted
SHHE PILOT

- Collaborate with BUMC researchers to adapt their intervention to patients at SFGH
- English, Spanish, or Chinese (Mandarin or Cantonese)-speaking patients, age 60 or older
- Admitted to medicine, family medicine, cardiology, and neurology
- Discharged to home
- 200-patient pilot (all received intervention)
SHHE PILOT INTERVENTION

- RN Discharge Advocate met with patient while admitted and provided
  - Teaching about diagnosis, medications, follow-up
  - Help with medication reconciliation
  - Patient education materials
  - Low literacy “After-Hospital Care Plan” (AHCP) in the patient’s language

- Post Discharge Phone Call 4-5 days after transition
  - Made by NP
  - Check on knowledge of diagnosis, medications, symptoms, follow-up.
    Intervene when necessary.
CREATIVITY AROUND TEACHING

- 74 year old Chinese speaking woman with type 2 diabetes, hypertension, hyperlipidemia, hypothyroidism, and hyponatremia

- Monolingual Chinese speaker, can’t read in any language, low health literacy.

- SHHE RN found
  - patient did not know which medication served what purpose
  - though she was illiterate, she recognized numbers and symbols
CREATIVITY AROUND TEACHING

- RN color coded the bottles and marked the number of pills to take on each bottle cap and then combined symbols with images that were familiar to her in order to increase her interest and the efficiency of coaching.
**Bring this Plan to ALL Appointments**

After Hospital Care Plan for:

Jane Patient

Discharge Date: MARCH 13, 2010

Questions or problems with this booklet? Call 206-4901 to talk to your SHHE nurse Tip Tam.

Serious health problem? Call TBA: (415) 206-8492

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** traiga este plan a todas sus citas **

Plan de cuidado para:

Jane Patient

Dia de alta: 13 DE MARZO DE 2010

Preguntas o problemas sobre este paquete?
Llame al 206-4901 para hablar con su enfermera SHHE Tip Tam.

Problemas serios de salud? Llame TBA: (415) 206-8492

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與醫生見面時請攜帶此計劃書

出院計劃書 爲了

Jane Patient

出院日期: MARCH 13, 2010

如對這計劃書有任何疑問或問題，
致電206-4901給你的SHHE 護士Tip Tam。

嚴重的健康問題？ 打電話給 TBA : (415) 206-8492

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Bring all of your medicines (in their bottles) to your doctors' appointments. Carry a list of medicines with you.

### MEDICINES

<table>
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<th>Medication Name</th>
<th>Why am I taking this medicine?</th>
<th>How do I take this medicine?</th>
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<th>noon</th>
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**Bring this Plan to ALL Appointments**

Jane Doe

What is my main medical problem?

A. Fib

When are my appointments?

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<td>To follow-up with your doctor</td>
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## PILOT RESULTS: PATIENT CHARACTERISTICS

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## PILOT RESULTS: PATIENT CHARACTERISTICS

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<td>(70)</td>
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PILOT RESULTS: HIGH ACCESS TO CARE

- Virtually all had active primary care
  - (93%) PCP visit in prior 6 months

- Frequent utilization of acute care
  - 41% ED visit in 6 months prior
  - 32% Hospitalization in 6 months prior

- Very different from prior transition intervention populations – access not a major issue
PILOT RESULTS: HIGH MORBIDITY

- 5.5% 30-day mortality (11/200)
- Early onset of geriatric syndromes
- 17% of patients were re-hospitalized or re-presented to the ED within 30 days
- 26% of re-admissions/ ED visits were at outside hospitals
PILOT RESULTS: PATIENTS RECEPTIVE

- Significant engagement by patients with enrollment rates of approximately 60% (15% refusal)
- Remarkably successful reaching patients by phone once transitioned home
  - 80% of discharged patients or caregivers completed at least one post-hospitalization phone call.
  - Over 98% of discharged patients completed 30-day follow-up interviews.
LESSONS LEARNED FROM PILOT

- Tech start-up issues are non-trivial
  - Proprietary/Licensing issues
  - Software solutions are not plug and play
    - System compatibility needs to be established
    - Software must adapt to needs of institution
    - Re-design the medication instructions
  - Translation time/costs

- Translation and health literacy is key
LESSONS LEARNED FROM PILOT

- Core of intervention is relationships
  - Coaching/Motivational Interviewing
  - Teach-Back
  - Cultural & language concordance
  - Follow-up post discharge

- Ambulatory providers need to be engaged early and often
MODIFICATIONS BASED ON PILOT EXPERIENCE

Several Modification Made:

- Changed focus to from teaching to coaching and motivational interviewing to achieve patient activation in self-management.
- Increased the number of follow up phone calls to two per patient, and moved them closer to the time when patients returned home.
- Adopted a “warm-line” whereby patients could call in with questions when they were unable to reach their own clinics or PCP’s.
- Changed the AHCP to create a more compact & user-friendly medication schedule.
- Increased outreach efforts to primary care providers, at admission and discharge.
WHERE ARE WE NOW?

- The SHHE team just finished enrolling 700 patients.
- The results will be analyzed and published sometime in the next year.
- Intervention has been widely accepted by hospital leadership and front-line staff and is being embedded in the routine transitional care processes offered to all patients over the age of 55.
- As CMS begins to fund more options for transitional care such as the CCTP, the hope is that the SHHE Project will become part of a menu of culturally and language appropriate interventions.
TAKE HOME MESSAGES FOR LEP AND LOW HEALTH LITERACY PATIENTS

- Use a “universal precautions” approach for discharge education, assuming that all patients have some limitation in health literacy.
- Remember that just like English-proficient patients, not all LEP patients can read in their preferred language.
- Get creative with symbols & pictures and use teach-back systematically.
- Provide discharge materials in English as well the patient’s preferred language whenever possible, for the benefit of health care providers and care takers who read English.
TAKE HOME MESSAGES ABOUT ADAPTING A CARE TRANSITIONS INTERVENTION

- Very few programs are “turn-key”
- To be effective, programs should meet the unique needs of the community served by each hospital/health system and capitalize on existing resources
- Program fidelity is important but not sufficient. Be ready to evaluate processes and outcomes as you implement. Tweak your processes as needed to improve your outcomes.
- Hospitals cannot achieve success in isolation and must begin to reach out to community partners to share the burdens and successes of a comprehensive transitional care program.
QUESTIONS?