Partnership for Patients-National Priorities Partnership
Patient Safety Webinar Series
Webinar #2: Reducing Readmissions through Care Transitions
July 6, 2011

Today’s Hosts and Speakers
Moderator
- Helen Darling, MA, President, National Business Group on Health, NPP Co-Chair

Featured speakers
- Mary Naylor, PhD, RN, Professor of Gerontology, University of Pennsylvania School of Nursing, Director, NewCourtland Center for Transitions and Health
- Eric Coleman, MD, MPH, Professor of Medicine, Director, Care Transitions Program, University of Colorado at Denver

Today’s Reactor Panel
- Robyn Golden, LCSW, Director of Older Adult Programs, Rush University Medical Center
- Traci Cornelius, MSW, Care Transitions Coach, Riverside County Regional Medical Center
Welcome to the Patient Safety Webinar Series

The objectives of the series are to:

- Share strategies for “getting started” to accelerate improvements in patient safety nationally
- Highlight the role of public-private partnership in achieving Partnership for Patients goals
- Describe the role of the NPP in catalyzing action and enabling change

Objectives for Today’s Webinar

- Provide an opportunity for thought leaders in the field of care transitions to share best practices, success stories, and strategies for getting started
- Generate action in organizations and communities nationwide
- Provide examples of public-private partnerships working collaboratively to achieve results

About the Audience

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Healthcare provider (non-hospital)</td>
<td>19%</td>
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<tr>
<td>Hospital (administrative, clinical, etc.)</td>
<td>28%</td>
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<tr>
<td>Consumer organization or patient advocate</td>
<td>1%</td>
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<tr>
<td>Citizen (non-hospital)</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>35%</td>
</tr>
</tbody>
</table>
Polling Question

Which demographic best describes your organization or community?

Developing a National Quality Strategy

Health reform legislation, the Affordable Care Act (ACA), requires the Secretary of Health and Human Services to “establish a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health.”

HR 3590 §3011, amending the Public Health Service Act (PHSA) by adding §399HH (a)(1)
HHS' Domains and Principles for the National Quality Strategy

- Patient-centeredness and family engagement
- Quality care for patients of all ages, populations, service locations, and sources of coverage
- Elimination of disparities
- Alignment of public and private sectors

HHS 2011 National Quality Strategy: Six National Priorities

1. **Making care safer by reducing harm caused in the delivery of care.**
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

NPP’s Ongoing Role in Consultation to HHS on the National Quality Strategy

NPP has been specifically asked to provide input to HHS on identified priorities as well as at least:

- three goals per priority area
- two strategic opportunities per goal
- two measures per goal
Partnership for Patients Goals

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.

- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.

How Will Change Actually Happen?

And how will it happen at scale?

- There is no “silver bullet,” but we know we must:
  - work together
  - provide thoughtful incentives
  - engage patients and families, authentically
  - engage leadership
  - assist in the painstaking work of improvement
Community-based Care Transition Program (CCTP)

- The CCTP, created by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries
- Part of larger Partnership for Patients initiative through the U.S. Department of Health & Human Services
- $500 million is available for qualifying acute care hospitals and community based organizations

CCTP Section 3026 Program Goals

- Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
- Improve quality of care
- Reduce readmissions for high risk beneficiaries
- Document measurable savings to the Medicare program

For more information, visit: http://www.cms.gov/DemoProjectsEvaluations/MD/ItemDetail.asp?itemID=CMS1239313

Standout Stories: Transitional Care Model

Mary Naylor, PhD, RN
Professor in Gerontology
University of Pennsylvania School of Nursing
Transitional Care

A Promising Path to Person- and Family-Centered, High Quality, Affordable, Health Care

Mary D. Naylor, PhD, RN, FAAN
Marian S. Ware Professor in Gerontology
Director, NewCourtland Center for Transitions and Health
University of Pennsylvania School of Nursing

Context: Acute Care Episode

Adapted from the National Quality Forum (NQF) steering committee on Measurement Framework: Evaluating Efficiency Across Patient Focused Episodes of Care. The committee's report presents the NQF-endorsed measurement framework for assessing efficiency, and ultimately value, associated with the care over the course of an episode of illness and sets forth a vision to guide ongoing and future efforts.

Trajectory 1 (T1)
Relatively healthy adult with onset of new chronic illness

Trajectory 2 (T2)
Adult with multiple chronic conditions

Trajectory 3 (T3)
Adults at end of life

Population At Risk
Acute Phase
Post Acute Phase
Rehab Phase
Secondary Prevention

Transitional Care

Range of time limited services and environments that complement primary care and are designed to ensure health care continuity and avoid preventable poor outcomes among at risk populations as they move from one level of care to another, among multiple providers and across settings.
Transitional Care Model (TCM)

**Unique Features**

- Care is delivered and coordinated
  - ...by same advanced practice nurse
  - ...in hospitals, SNFs, and homes
  - ...seven days per week
  - ...using evidence-based protocol
  - ...with focus on interrupting chronic illness trajectory/achieving long term impact

**Core Components**

- Holistic, person/family-centered
- Nurse-coordinated, team model
- Single “point person” across episode of care
- Protocol guided but customized to match individuals’ priority transitional and follow-up needs (e.g., primary care, behavioral health, palliative, and community services)
**Core Components (con’t)**

- Capitalizes on evidence-based tools
  - risk screen
  - web-based orientation modules
  - information system (standardized assessment, intervention protocol, documentation system)
  - “root cause” quality monitoring and improvement system guided by meaningful measures

**Across NIH funded trials and in “real world” applications, the TCM has…**

- Increased time to first readmission
- Improved physical function and quality of life
- Resulted in better experiences with care
- Decreased total all-cause readmissions
- Decreased total health care costs

**Lessons Learned**

- Solving complex problems will require multidimensional, adaptive solutions, matched to individuals’ and communities’ needs
- Evidence provides a foundation for immediate change in care processes and in health professionals’ roles and relationships to each other and people they serve
Getting started…

- Identify strong champions
- Make case for change
- Establish community/partnerships/commitment
- Capitalize on what we know works and invest in preparation of teams
- Clearly define actionable, measurable, aligned and stretch performance goals and path forward
- Promote shared accountability for higher value
- Maintain unwavering focus on people we serve

Getting Patients Back on Their Feet Faster
Study Says Care Before and After Discharge From the Hospital Saves Money, Spurs Recovery

THANK YOU

www.transitionalcare.info
Polling Question

Do you have a system in place for identifying vulnerable populations at risk of readmission after discharge?

Polling Question

Do you use an evidence-based model, such as the Transitional Care Model or Care Transitions Intervention, to improve care transitions?

Standout Stories: Care Transitions Intervention (SM)

Eric Coleman, MD, MPH
Director, Care Transitions Program
University of Colorado at Denver
The Care Transitions Intervention℠

Eric A. Coleman, MD, MPH, AGSF, FACP
Professor of Medicine
Director, Care Transitions Program
University of Colorado at Denver
www.caretransitions.org

Self-Care Support for the “Silent” Care Coordinators

- By default, patients/family caregivers perform a significant amount of their own care coordination
- They do this without skills, tools and confidence to be effective

Key Elements of The 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

(c) Eric A. Coleman, MD, MPH
Key Findings of
The Care Transitions Intervention℠

- 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 465 leading health care organizations in 36 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%.
- Crouse Hospital (NY) reduced 30-day readmission rate for heart failure to 9.7%, and average number of days to readmission increased from 86 to 175.

Getting Started:
Factors That Promote Success

1. Complete Readiness Assessment Tool (RAT)
2. Select Transitions Coaches
3. Promote Model Fidelity through Training
4. Design Workflows
5. Prepare to Sustain/Expand the Model
Key Questions for the Audience

1. What has been your experience using the Transitional Care Model or the Care Transitions Intervention?
2. In your experience, what were the barriers to implementation and keys to success?

To provide comments, please type into the Q&A box at the bottom left of your screen or dial 1-866-575-6536 (confirmation code 5314337).

Reactor Panel Discussion

Moderated by Helen Darling
NPP Co-Chair
The Bridge Model

- Based on Rush’s Enhanced Discharge Planning Program, which extends the hospital’s reach into the community
- Places equal importance on psychosocial and environmental factors impacting health outcomes in patients vulnerable to post-discharge adverse events
- Telephonic short-term care coordination provided by social workers
- Pre-discharge
  - Risk screen integrated into hospital’s Electronic Medical Record (EMR)
  - EMR review and facilitating interdisciplinary team (nurse, physician, discharge planner, pharmacist, community case managers)
- Post-discharge
  - Understanding plan of care
  - Understanding medications
  - Physician follow-up
  - Patient and caregiver stress and burden
  - Community resources

Rush RCT Outcomes

- Readmissions
  - 13.6% 30 day readmission rate
  - Positive impact at 30, 60, 90, 120, and 180 days
- Improved (p<.05):
  - Community physician follow-up
  - Understanding of discharge instructions
  - Understanding of medication regimen
  - Patient and caregiver stress
  - Connection to community services
- Mortality
  - Statistically significant impact on mortality confirmed with a second 6 month test

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Frontline Provider Perspective

Traci Cornelius, MSW
Care Transitions Coach
Riverside County Regional Medical Center

Riverside County Office on Aging/ADRC
Target Population:
- All adults (18+)
- One or more chronic health conditions such as congestive heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (COPD), or others who are at high risk for readmission and have community discharges

Readmission Data: Jan 2010 – Dec 2010
Out of 89 patients who completed CTI during our first year, 33 patients were re-admitted

<table>
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<tr>
<th>Readmit after</th>
<th>30days</th>
<th>60days</th>
<th>90days</th>
<th>120days</th>
<th>121+days</th>
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<tr>
<td>Same dx</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>3</td>
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<tr>
<td>Different dx</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>4</td>
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8 patients were readmitted more than once:
- 3 for the original admission dx;
- 2 for different dx; and
- 3 had multiple readmissions, both for the same and different dx.
Questions for the Panelists

1. From your perspective, what are the most important elements of an effective care transitions program?

2. Are there any high-impact opportunities for change?

Questions for the Panelists

3. What is your advice for webinar participants who want to replicate your results and approaches?

4. Looking back, what would you do differently if you were to implement the care transitions program again?

Discussion with the Audience

Please use the Q&A box at the bottom left of your screen to send a comment or question to the moderators, or dial 1-866-575-6536 (confirmation code 5314337).
Polling Question

Have you experienced success with reducing hospital readmissions through effective care transitions?

Polling Question

Is your organization in focused action to reduce preventable readmissions?

Audience Discussion Questions

1. What action might you take based on what you heard today?

2. What would you do more of, differently or better than the speakers and panelists to implement change in your community?
**Audience Discussion Questions**

3. What is the most significant barrier you are facing in your community?

4. What is the most significant tool that would help you accelerate change in your organization or community?

**Polling Question**

When do you plan to act on the information provided in this webinar?

**Polling Question**

Did you find tangible actions and practices you can put to use in your organization or community in this webinar?
Conclusion

Next Steps, Further Resources, and Concluding Remarks

Further Resources

- Partnership for Patients website:
  www.healthcare.gov/center/programs/partnership/index.html
- National Priorities Partnership website:
- National Quality Forum patient safety webpage:
  www.qualityforum.org/Topics/Safety_pages/Patient_Safety.aspx
- Care Transitions Roadmap:
  http://www.healthcare.gov/center/programs/partnership/safer/transitions.html

Patient Safety Webinar Series

Upcoming webinar topics:

- Adverse Drug Events
- Infections in Intensive Care Units
- Surgical Site Infections
- Pressure Ulcers and Injuries from Falls
- Obstetrical Adverse Events
- Venous Thromboembolism

To register: eo2.commpartners.com/users/pfp/
Concluding Remarks

Mary Naylor, Featured Speaker
Eric Coleman, Featured Speaker
Helen Darling, NPP Co-Chair

Thank You

A recording of this webinar will be available on the National Quality Forum website within 48 hours. When you exit, you will automatically be directed to an evaluation about this webinar.

For further questions, please contact priorities@qualityforum.org