

# *The Stepping Stones Project*

## **Care Transitions and the Coaching Model**

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## About Qualis Health . . .

- Private, non-profit healthcare consulting and quality improvement organization
- Nationally recognized for leadership in improving health of individuals and populations through:
  - Promoting efficiency and reliability in care delivery
  - Supporting care coordination and improving care transitions
  - Leveraging health information technology to improve care
- Offices in six states across the nation
- Nearly 4.7 million covered lives



# Washington and Idaho's Medicare Quality Improvement Organization (QIO)

- Protecting the rights of Medicare beneficiaries
  - Reviewing concerns about quality and coverage,
  - Using results for improvement activities that benefit all patients
- Improving quality of care
  - Conducting patient safety projects in hospitals and nursing homes
  - Promoting prevention and chronic disease care in physician offices through meaningful use of HIT
  - Assuring safety and effectiveness of patient transitions between settings of care, such as hospital to nursing home (WA only)



## Today's presentation

- Showcase a Medicare QIO Care Transitions demonstration project
- Focus on the Care Transitions Intervention (coaching) model
  - Coaching applicability to various settings
  - AAA applicability and partnerships

# Reducing Hospital Readmissions: A Medicare Priority

- 1 in 5 of Medicare beneficiaries rehospitalized w/in 30 days
  - Unplanned rehospitalizations cost Medicare over \$17 billion dollars
  - Unnecessary hospital admissions are a patient safety issue
- Demonstration projects awarded to 14 QIOs, 2008-2011
  - Goal: to improve care transitions
  - Three years, 2008-2011
  - Seeking sustainable changes
  - QIOs aligned with community partners, healthcare providers and consumers

# 14 QIO Care Transitions Communities



# CMS Care Transitions Goals

- Reduce 30 day all-cause readmission rate by 2%
  - Also reduce readmissions for AMI, heart failure, pneumonia
- Improve HCAHPS scores for medication management and discharge planning
- Increase patients seen by a physician post-discharge

*Additional interim measures address implementation of interventions*

# Whatcom County, Washington



*Population:* 180,000+

- 28,000 Medicare beneficiaries
- Lummi and Nooksack reservations

*Metro center:* Bellingham, WA

*Healthcare providers:*

- St. Joseph Hospital/PeaceHealth (253 beds)
- 9 nursing homes
- 2 home health agencies
- 1 hospice
- 400 physicians

# Why Whatcom County?

- Geographically well defined, stable population
- Well prepared to do the work
  - “Wired Community” – HInet, Shared Care Plan
  - RWJ “Pursuing Perfection” site
  - Evidence of an organized community
- Already low Medicare hospital readmission rate (<14%)
  - Benchmarking project – what readmission rate reduction is possible?

# Project Partners

- Medicare beneficiaries  
*(patient representatives)*
- St. Joseph Hospital/  
PeaceHealth
- Northwest Regional Council  
*(Area Agency on Aging)*
- Critical Junctures Institute  
*(Western Washington  
University affiliate)*
- PeaceHealth Medical  
Group, Center for Senior  
Health, Family Care  
Network *(primary care  
physician networks)*
- HI-net *(local health  
information exchange)*
- Qualis Health *(Medicare  
QIO)*



St. Joseph Hospital  
*PeaceHealth*



# *Introducing...*

Care Transitions Project of Whatcom County



# STEPPING STONES

Bridging Healthcare Gaps

Videos: <http://www.SteppingStonesWhatcom.org/learn/videos.cfm>

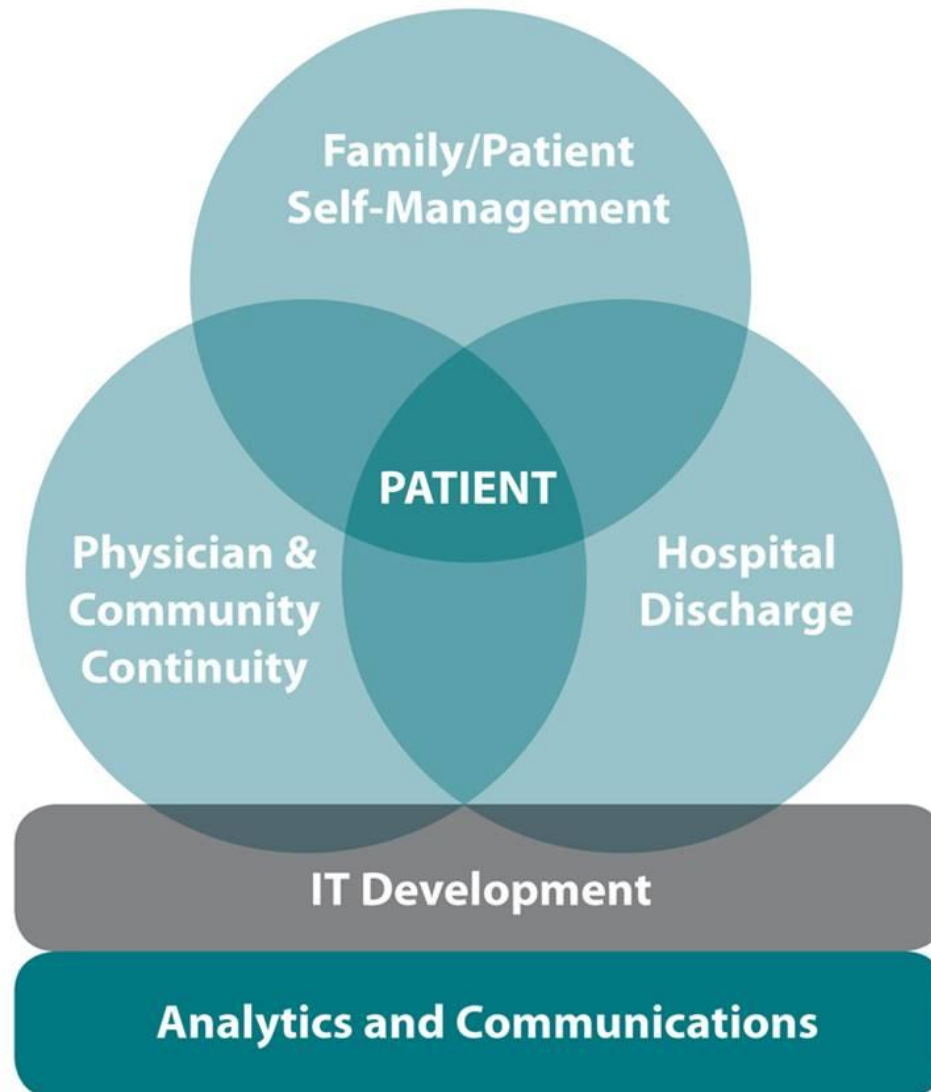
# Project Goals

- Connect providers throughout the healthcare system in Whatcom County to enable safe and effective transition of patients
- Eliminate unnecessary hospital readmissions to St. Joseph Hospital
- Enable Whatcom County patients and their families to participate fully in their health and healthcare, particularly when leaving the hospital

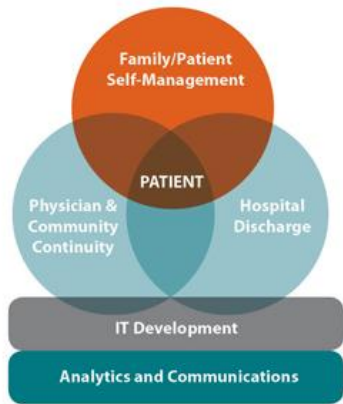
# Interventions Selected

- Evidence-based interventions across settings
  - Identified through CMS literature review (now published)
  - Multi-layered and multi-setting -- not focusing on just the hospital.
- Driven by data
  - Analysis of hospital readmission data, chart audits across settings
  - Determine areas of greatest potential, both by need and opportunity for improvement
- Driven by needs of the community
  - Dialogue with providers and stakeholders
  - Qualitative evaluation (patient interviews, physician focus group)

# Project Structure



# Family/Patient Self-Management



- Care Transitions Intervention<sup>SM</sup> (coaching)
- Assessment of Patient Activation (PAM)
- “Going Home from the Hospital” class
- Teach-back technique
- Personal health record, Family & Patient Responsibilities booklet (“1-2-3 Plan”)
- Community Education
- Strong NWRC collaboration

# Care Transitions Intervention<sup>SM</sup> (CTI)

- Evidence basis, linked to reduced readmission rates
- Goal: impart self-management skills
- Coaching paradigm, not education or direct care/treatment
- Free of cost to patient
- Comprises 5 interactions over 4 weeks:
  - Visit to patient in the hospital/skilled nursing facility
  - Home visit
  - Three follow-up phone calls

# Four Pillars

- Medication self-management and reconciliation
- Use of a patient-centered record
- Timely follow-up with primary care physician and/or specialist within a week post-discharge
- Red flags – signs of a worsening condition and what to do – reinforce hospital discharge instructions

# Referral Criteria

- Payer-specific – Medicare recipient
- Geographically specific – Whatcom County resident during four week intervention
- Patient specific – at risk for readmission, cognitively able to participate, English-speaking
- Discharging to – home, assisted living facility, adult family home (long term care facilities excluded)
- Targeted diagnoses – heart failure, heart attack, pneumonia (not limited to these diagnoses), lacking social support

# Data Collection

- Number of patients initiating / completing coaching
- Pre / Post Patient Activation Measure
- Pre / Post revised Activated Behaviors Assessments
- Medication Discrepancies
- Readmission rates & ED utilization

# Our CTI Approach

- Community-based coaches supported by Qualis Health coordinator
  - Potential for sustainable coaching program to continue after the 3-year CMS-funded contract ends
- Pilot implementation focused on Medicare beneficiaries
  - *Goal:* community-wide coaching program for all patient and payer types
- Patient Activation Measure (PAM™)
- Personal Health Record (Shared Care Plan) supported by regional health information exchange

# Training Community-Based Coaches

- Parish Nurses
- Tribal clinic staff
- AAA case managers
- University students
- Hospital discharge planner
- Nurses from HHAs, SNF, assisted living/adult homes
- Medicare Advantage case managers
- Elder law case manager
- Retired RN & lay volunteers
- Primary care clinic RN



# Patient Activation Measure

- Evidence based assessment of self management competency based on knowledge, skills and confidence essential to health activation
  - Judith Hibbard, Dr.P.H., University of Oregon
  - 13 item questionnaire to determine activation level
  - Coaching support is tailored to the individual's self management competency
  - Measures activation improvement pre and post coaching

# Patient Activation Levels

- Level 1 – Starting to take a role: patients do not yet believe they have active/important role & are disposed to being passive recipients of care
- Level 2 – Building knowledge and confidence: patients lack health-related facts to take action
- Level 3 – Taking action: Patients have key facts and are starting to take action but may lack confidence & skill
- Level 4 – Maintaining behaviors: patients are adopting new behaviors, maintaining may be difficult in times of stress or health crisis

# Coaching Vignette

- Referral
  - Patient with history of frequent re-admissions
  - PCP concerned about patient's understanding of care plan
- Home Visit
  - Medication Discrepancies
    - Two un-reconciled medications, one incorrect dose
    - One medication refill needed
    - Lack of understanding of complicated dosing and rescue medication
  - Red Flags – patient did not understand signs of worsening condition & when to call the PCP
  - Physician Follow up
    - Patient made follow up visit with coach prompting
    - Patient made transportation arrangements via community resource provided by coach
  - Personal Health Record
    - Patient wrote questions for the PCP with coach support
    - Confusing medications written out with clear instructions via coach assistance

# Coaching Vignette

- Phone Call Follow Up – patient shared with coach that:
  - Patient took PHR to PCP visit & reviewed
  - PCP wrote clarifications in PHR & answered questions
  - PCP taught Red Flags & when to call MD
  - PCP simplified complicated med regime & taught re: rescue medication
  - PCP ordered two missing medications
  - Patient had already scheduled next PCP appt and planned to independently arrange for medical transportation
- Coach & Physician Debriefing
  - Coach and PCP identified need for email communication re: patient referred for coaching, which prepares PCP for office visit in which patient brings PHR, updated medication list & questions
  - PCP identified need to educate all patients about Red Flags
  - PCP identified need to solicit patient questions & concerns early in follow up visit
  - PCP identified that a therapy-specific clinic was ordering unnecessarily complex medication regimes and PCP plans to address this organizationally

# Teach Back

- A method to ensure understanding of information being communicated by asking the receiver of the information to “teach back” what was said
- Factors limiting health literacy; medical jargon, illness, stress, too much info

# Teach Back

- “Recounting” or teaching back provides greater recall and comprehension
  - Increases patient retention
  - Provides a gauge of patient understanding of instructions
  - Actively involves patients in discussion
  - Improves safe transitions of care

# Teach Back

- Patients should be able to show they understand, and not just repeat back or nod - It is important to have the provider own the concern
  - “I want to be certain I explained this clearly”
  - “I want to be sure we have the same understanding”
  - “Can you tell me, in your own words...”

## What's Different about Coaching

- Patient is the center of the visit
- Coach listens more than talks (25%)
- Coach does NOT write in PHR
- Emphasis on coach as “encourager” and “educator” not someone who “gives info”
- Coach asks “what do you want to be able to do in the next 30 days?”

# Other Coaching Strategies

- Open ended questions
  - “tell me what brought you to the hospital”
  - “show me your medicine and how you take each one”
- Active listening
- Paraphrasing, reframing, redirecting
- Coach is the “guide on the side” not the “sage on the stage”!

# Northwest Regional Council Coaching

- Staff trained in April 2008
- Incorporated 4 pillars into case management, Sr. I&A, Caregiver Support and other client interactions
- One CM used coaching in her caseload

# Northwest Regional Council Coaching

- Small contract with Qualis Health 8/2010
  - Train more staff in CTI model
  - Use coaching with dual-eligible clients
  - Track process and outcome measures
  - AAA CM advantages
    - Access to EHR– aware of hospitalized clients
    - Improved consenting – already has relationship with client
- Early results

## ADRC Evidence-Based Care Transitions Program

- Two year grant funded October 1, 2010
- ADSA, NWRC, SE ALTC & QH partners
- Expand CTI coaching model to non-Medicare FFS population in Whatcom Co.
- Expand model to Skagit Co. in 1st year
- Expand model to Yakima Co. in 2<sup>nd</sup> year

# So Where Are We?

- A learning lab for testing strategies to reduce unnecessary rehospitalizations
- Clear engagement of community providers/partners who are actively implementing change strategies
- Successful implementation of evidence-based interventions across multiple settings
- Making progress
  - Process/Outcome measures trending in the right direction
  - Interim results from specific interventions

# Coaching Successes & Challenges

- Successes
  - High volunteer coach loyalty and satisfaction
  - Volunteer Center, NWRC, Health Ministries & University partnerships
  - Coaching stories highlight improved self management and discharge failure learning opportunities
- Challenges
  - QIO coach not fully integrated into hospital processes
    - impacts referral & consenting
  - Volunteer coaches require extensive training & support (and take vacations!)

# Coaching Results

- 48+ coaches trained
- 150 volunteer hours monthly average
- 6 active volunteers & 2 university students
- 228+ patients initiated coaching
- 164+ patients completed coaching
- 7.8% readmit rate for patients who complete all 5 coaching encounters

# Coaching Results

- 2.23 medication discrepancies among coached patients
- 70+ % increase in Patient Activation Measure score after coaching
- Improved 4 pillars related activated behaviors assessments

## Next Steps


- Stepping Stones Steering Committee is in the process of analyzing business case for sustainability and evaluating best settings for coaching (hospital vs. MD office)
- Community organizations involved in coaching plan to explore partnership synergies

# Questions

- More information on Teach Back:  
<http://www.steppingstoneswhatcom.org/act/forproviders.cfm#teachback>
- More information on the Care Transitions Intervention:  
[www.caretransitions.org](http://www.caretransitions.org)

# www.SteppingStonesWhatcom.org

Care Transitions Project of Whatcom County



**STEPPING STONES**

*"When mom left the hospital, I realized the importance of sharing information and communicating with her caregivers."*



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### Bridging Healthcare Gaps

The Stepping Stones Project of Whatcom County is aimed at improving communication gaps between healthcare providers and patients to ensure safe transitions from one healthcare setting to another. The Stepping Stones Project seeks to engage providers, patients, and caregivers to take steps to ensure safer transitions. There are some key tools such as the Shared Care Plan Personal Health Record, Transitions Coaching, and Medication Self-Management that will help you manage your healthcare transitions as a patient, family member, or provider. We invite you to take a step in improving healthcare transitions by joining us in the Stepping Stones Project. Together we can ensure safer and more effective care transitions for patients living in Whatcom County.

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# Thank you!

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