Jeff Critchfield:

Good morning, I'm Jeff Critchfield. I'm coming from San Francisco General Hospital. I'm having a little bit of fun. It feels like we're at a national convention. I'm following on the heels of my colleagues from the great state of Texas. So this is great. And I'm looking at Mark and going to tease him about coming from the city of broad shoulders, from Chicago. I'm coming from San Francisco, where I guess we can say, only in San Francisco.

What I'm going to talk you guys about today is our readmission project called Support from Hospital to Home for Elders based at the San Francisco General Hospital. A couple of key objectives to be clear right from the outset… One, I really feel a distinct privilege and a responsibility to able to share with you as a member of a Safety Net Hospital some of the challenges that we face with our patient population.

I'll address specifically how in our SHHE project, Support from Hospital to Home for Elders, we attempted to address some of those challenges. And I think we collectively – and, everyone, listening on the line, we have just a real treat today in the sense that there are a number of evidence-based models out here. And what I want to share with you today is how we drew from the evidence base and made decisions based on local needs to make our own hybrid.

And I just want to acknowledge them. We have today in the audience Eric Coleman who has done work on this. Mary Naylor's going to be talking later. Mark Williams has done work with BOOST. So we really have a real privilege today to some of the innovators who've done the work with this.

And I'll be real clear about how we went along and made decisions about them. From the outset, it's essential. I really have to acknowledge our funder. The Gordon and Betty Moore Foundation gave us a three-year very generous grant to design the intervention with a very clear point... they wanted us also to evaluate it. They knew we were going to make some changes and they wanted us to be able to add to the evidence base. And in particular, they put a lot of money into the Bay Area

thinking to actually change the whole region with regard to readmissions.

And I want to acknowledge Mary Beth Sharp and her real vision about that work. We're also collaborating with Brian Jack's group, specifically Michael Paasche-Orlow with the Project RED. And they've been noted, the group before us. And I want to introduce quickly San Francisco General Hospital. We're a large hospital, over 500 licensed beds. We're the only county hospital in San Francisco. We're the only trauma center in San Francisco. We're a level 1 trauma center. And all of our faculty and all of our house staff and fellows are University of California, San Francisco trainees and faculty.

I did want to just lay the groundwork, a lot of work at our hospital has been done around health literacy and we estimate two-thirds to three-quarters of our patients have limited health literacy. And I'll talk a little bit more about that later.

So, there we go. The key questions that we wanted to do with SHHE were to fill holes that we saw in the literature. We wanted to really look at readmissions among low income elders using key components of prior clinical trials. We wanted to look at how feasible is telephone follow-up. And I told you we're going to make some decisions. We were initially very excited about doing home visits. I think Eric and probably Dr. Naylor will talk more about that. And we really felt there was a great need in our patient population.

But as we made a clear decision with our funding issues, that we didn't think we could afford to do that. And so we really wanted to make the cognizant of creating a sustainable program and so we placed an investment on telephone follow-up, which I'll talk more about. And we really felt like we could help inform what are the factors that go into low socioeconomic patients that contribute to their readmissions so we could help design improvements going forward for patients who are being cared for in those kinds of systems.

From the outset, our study design – I'm going to share with you some results from a pilot study. The literature really excludes people who don't speak English. So, we

specifically said we're going to enroll and we're going to set up a program that looks at Spanish-speaking patients, Mandarin-speaking patients, Cantonese-speaking patients, and focus on patients over the age of 60, which is a growing patient population. We from the outset, said we're going to do it throughout the house, particularly on the services that disproportionally have readmissions so that's medicine, family medicine, cardiology, and neurology.

And for us, we said we're going to do it only for patients who are transitioning to home. Major issues with transitioning to long term care facilities acknowledged. We wanted to focus on home. And really make a special point. Home for us means also patients that go to shelters, home for us also means patients that are in so-called SROs who, those of you know, in San Francisco who live in the tenderloin or the south of market in single residency occupancy hotels where there's 40 of 50 people in a hotel, a single bathroom for a floor, no cooking facilities in the rooms, you know, pay from week to week, those kinds of things. And if people have a telephone, they could be in our study.

We enrolled people in the SROs even when there was only one hospital, there was only one telephone in that hotel. There would be one telephone at the front desk and people would stand in line to make phone calls. So we'll talk more about that also.

What's the nature of our intervention? The nature of intervention RED has introduced already. From the outset, we had dedicated nurses as part of our project who started interacting with patients essentially within the first 24 hours, worked with them throughout the hospitalization, were with them on the day of transition.

I mentioned the language piece, language is an important determinant of culture. It's not synonymous with culture. So we made also the investment and we're going to have culturally concordant nurses so we had a Hispanic nurse, we have a mainland China nurse and we have an African-American nurse, who interestingly was born in San Francisco General Hospital and commutes an hour and a half because she really feels strongly about the mission there. Now, in the Bay Area

community, and hour and a half means she lives 10 miles away, but she still comes back every day. So, it's not that bad.

Also, in our work in the pilot, we started out thinking we're going to do some great teaching and what we realized very quickly was we were doing talking at. We were doing talking at patients and we love to talk at patients. We love to help them and fix things for them, it feels so great. And we realized that wasn't working. And I really want to acknowledge Eric Coleman. I anticipate he'll talk more about this. He was influential for us of this kind of concept of coaching.

We have a lot of substance abuse at our hospital and there's a big movement around motivational interviewing. And so we took a coaching model based on motivational interviewing, which essentially was a lot of curiosity, a lot of questions, a lot of helping things percolate to the surface. And as you'll learn from Eric and what we learned, that's where things get very, very interesting. We were teaching about heart failure and they were like, you know, "I just need a ride to dialysis. You know, could you help me figure out how to get a ride to dialysis?" Well, what? But your left ventricular, what happens….

We love that stuff. So, the other piece that we felt, because of the health literacy, we really wanted to put an investment into what do people go home with. And a part of our collaboration with Project RED also is we set up collaborations with engineered care who licensed the software that was published in the annals paper around Project RED. And I'll show you some examples of that. We ended up translating that into multiple languages. Here's what it looks like if you haven't seen it. It's got pretty colors. It's very clear around health literacy. Chris Corio, he's actually the CEO, he's here today, we're kind of teasing him by putting his name on the after hospital care plan.

It's got, anything you want, it's in there… All your appointments, phone numbers. Here it is in Spanish. Here it is in Chinese. It's configured through Chinese. We've heard a representative from the pharmacy already talking about it today, med reconciliation is an enormous, enormous challenge when you bring in multiple-

languages, cultural understandings about how to take medications. Here's an example of the after-hospital care plan that shows each of the medications, how to take them, why to take them. Let’s see if I can get my pointer to work.

On the end, you’ll see little figures, we were trying to also use figures instead of like BID or TID. We're trying to say things like take it in the morning when you get out of bed – so there's a little image for there, take it in the evening, take it at night. We're trying to use literacy work that's been done. And I hope Mark and others may talk to you with BOOST, they’ve done a lot with teach-backs. We're going to teach back also, but just really focusing on patient-centeredness becomes really crucial.

What about the post-hospitalization? I told you that Dr. Naylor and Dr. Coleman have done a lot of work with people going in to the home. And I think we would think that that would be great. We decided we couldn’t afford that. And so we ultimately made the decision that we're going to have folks make phone calls who have prescribing ability, also not a cheap decision, quite honestly. So... And we're studying that, but we had nurse practitioners and physician assistants calling at day one and three and then days seven and nine, going through the after-hospital care plan that the patients have or their caregiver have in front of them. And that's really important.

And we're finding significant challenges when patients have socioeconomic challenges, they make decisions about which medicines they're going to buy and it isn’t always based on whether they have a seizure, it may be what they can afford. And so really understanding that, and we also know from our other experience when you go in to the home and actually see what they have in the home, it becomes very challenging to find out what they're taking as well.

What we learned. Here's some of the issues around safety nets. So, 80 percent of our patients, non-whites. About half have less than a high school education. About 50 percent were born outside the United States, the residents. But we also are taking care of non-doc, undocumented residents who are contributing to our

economy, who are contributing to our society and we feel it’s important to take care of them as well.

A striking number, three quarters are single, divorced, or widowed. So, issues around social isolation, enormous. We know depression will contribute to readmissions. And ninety-two percent earn less than $20,000 per year.

Success is remarkably, we were able to contact over 80 percent of our patients by phone within the first 10 days. And I think this really speaks to the relationships that we developed in the hospital. There were amazing stories of patients who are in these downtown hotels we’ll call, as we said, we make an appointment to call and someone will pick up the phone and he’s like, you know, he just want to go to the bathroom, he had to go upstairs, please don't hang up, he’s coming back, he’s been waiting for you to call. There's like one phone in the building and this person’s like waiting for us to call because they feel like they're being heard, their needs will be met. And it's very powerful.

For the research study, 98 percent were able to reach 30 days. Strikingly, these folks are really very ill and their very connected. Ninety-three percent had seen a primary care provider in the prior six months. Forty percent had been in the emergency department and a third had already been hospitalized in the last six months. These people are in the system. They're just very, very ill. Twenty-three percent were readmitted within the first 30 days.

An important point, those of you who are using primarily administrative data, we learned a quarter of our readmissions were happening at outside hospitals. So, if you're really going to follow your readmission rates, you also really have to kind of think what's happening in your region to be very clear about that. And, strikingly, about one in 18 of the patients readmitted to their trial were dead in 30 days. Yes, 5.5 percent dead in 30 days. Very dramatic.

We’ve got a randomized controlled trial we’re doing now to actually see with the intervention we've done, what impact is it having compared to the usual care. And I’ll leave you with a couple of core lessons, and I think

again, I hope I've really made the point. Really, this is about relationships. Dr. Berwick talked about the team. The patient being an important part of that team. Coaching is essential. And it's not easy. We are wired to teach and do and save the people. And when they go home, we're not there. So that's powerful, the teach-back, the cultural concordance we think is very important. It's a very powerful thing to see patients when someone walks in to the room that speaks their language and looks like them, using material that's there that's in their own language.

And I want to also acknowledge the morbidity is very high. These interventions will probably have a sweet spot. Some of these patients probably don't need this much. A lot of patients probably need more, and so how do you find the right level for the right patient? And, quite honestly, I think it's important to start talking about palliative care. You know, identifying, and you know, I think we can be more sophisticated. Palliative care is not hospice care. It's identifying who could really benefit from conversations earlier on about their needs.

I'll leave you with preventability of readmissions. And the question of how do you factor in socioeconomic issues of preventability? So, if a person had a house would this be a preventable readmission? If they lived in a neighborhood where in home health support felt safe to go see them, would this be a readmission? I'll leave you with that. And then really, finally, what an exciting day to have the chance to talk about balancing the different evidence-based approaches to like local needs, local realities.

I'll end there. We have a wonderful team. I've talked a lot about a number of them. Here's the group. And if you've got any questions, my information is in there. Email is the best way to get a hold of me. And I'll be here the rest of the day. Thanks very much for your attention.