Laurie Robinson: My name is Laurie Robinson and I'm from Baton Rouge, Louisiana. And we're going to tell you a little bit about what we're doing. OK, great. I've listened today and this whole week about our projects and transitioning care and not calling this discharge planning anymore and all these wonderful things. And I've heard a lot of things today that I've written down that I want to be able to touch base with everyone on because I think they're critical pieces. The first being skill transfer with this coaching process. That's pretty critical. We're trying to transfer the skill to the patient and the caregivers. Modeling behavior, that's how people learn by doing and empowering them to do. So that's pretty critical with coaching. Selecting the coach, this is one of the most important aspects of implementing this intervention. You got to like people and you got to be patient and you got to be a listener and you have to be able to sit on hands.

The coach is a safety net when all the other interventions don't work. We can rearrange discharge and we can change all these processes, but on occasion, processes aren't 100 percent. The coach kind of is that little safety net for the patient in the event the process is broken. I heard the compliance and patient adherence, and I'll talk a little bit about that, but we don't even say those terms in that process anymore.

And motivational interviewing, that's pretty interesting stuff as well, but we use some of that when we first get to know the patient but don't use it really beyond there. So let's talk a little bit about us and we're going to start kind of with our objectives. I'd like for you to be able to identify barriers to smooth transitions by the time I get done here today. Maybe just a couple that resonate with you. Also, to understand the role of the coach and the role of the patient in the coaching relationship, I think that's critical, before you embark on something like this in your own environment.

I'm going to start with a story because I think it's real important. Some of you may have heard this story. It's not the same story from yesterday or the day before. But I have a couple of real live patient experiences that as a nurse and a case manager and a caregiver and a patient in the past that has struck me as one of those Aha! moments. I may have been doing this wrong for 25 years, but anyway.

So we start coaching in a smaller hospital. This was like the third hospital to come onboard with this intervention. The coaches in our project are employed by the QIO, so we go in and we do this kick-off rally. And the first thing that we are there to do is to be the solution to the revolving door patient. We're going to, you know those frequent flyers that have lost their name and identity because they're the frequent flyer, which is not always what we're there to do but it's part of the what we got to get over to get the project started in a hospital. So we go in and the first patient they select for us to take is an intensive care, which is not a great place to learn or coach a patient. But we say you know, maybe we ought to wait until she moves to telemetry and, oh, no, no, she's just there because we don't have a

bed. And the other side of me, the utilization nurse, says, oh god, please don't tell me this. But, anyway, so we say, OK, we'll go in. And they give us the down and dirty on the patient. And she's a 45-year-old Medicare patient who basically, dual eligible, who they basically said, you know, if she would just quit drinking all that Diet Coke and eating all that salt, she wouldn't be back in the hospital. She has congestive heart failure and she just really is non-compliant. She doesn't manage her disease.

So, OK, well, we'll go meet with her. Well we go in to the ICU and Ms. Kaye is in the bed, a lovely lady. She's 45 years old. She's disabled. She has CHF, COPD, hypertension, diabetes – I mean I would be in the fetal position under the bed if I had to manage all those things myself, and I'm a nurse, OK – insulin independent. She is raising two of her grandchildren because her daughter as she put to me "loves crack more than she loves her children."

Her husband has died two years ago with COPD and was in hospice at home when he passed away while she was raising two children; and has a daughter who is in her mid 20s who has a closed head injury, so she's a walking wounded. OK, she might need to drink a Diet Coke every once in a while. So, anyway, so I walked out of that ICU cubicle thinking what have we all missed here?

So she transfers to tele and we continue to follow her in the house and it becomes very apparent to me that the coach is really struggling to get this whole warning signal across to her. And, you know, I'm just observing this and thinking, gosh, this lady, why are we missing this? So I just start to quiz her a little bit about her heart failure to see what she knows – absolutely nothing. She's an end-stage heart failure patient that doesn't know that her heart pump is not going to get better. We have missed the boat, OK? Nobody has established the "why‖ for all of this treatment we're giving her and all these things we're demanding that she do, OK? So, we start to work a little bit more with her in that respect. She transfers to skilled care to beef up her walking and all the other things because she's got to care for herself and all these other people so they transfer her to skilled care.

And we go in on a Monday after a weekend. And she is leaning over the bedside table in visible respiratory distress. The coach comes running out and she says, "Oh, my god, Laurie, something is really wrong." Like what is going on? She said, "She can't breathe. She can't breathe." And I said, "Wait a minute. We are on skilled and we are fixing to get ready to go home. We should be doing our coaching discharge session. What's the deal?" So, I go in there.

She visibly is having some struggles. She tells me her weight is 9 pounds over what it was on Friday. And they keep turning the oxygen up but it's really not helping. Well, anyway, so, I turn my nurse hat on at that moment and I go out and speak with the charge nurse. And one critical piece the patient tells me. "You know that water pill you all are teaching me about? They haven't been giving it to me. No, they have not been giving me that. I've been watching my medicines every day like you told me to. And they're not giving me

that water pill. And that's why I think I've gained this weight and I can't breathe."

Now, she was getting warnings signals whether we knew it or not, and so sure enough I go out and look at the medical record and the lasix had not been continued over. So we talk to the charge nurse. She assures me she's going to call the doctor, and so I figure that is settled. We go back to the patient. I said, wow, what a great opportunity for this patient to talk to this doctor in this controlled setting and we can maybe get a good, you know, success out of this. So we role played with her in the house what she was going to say when the doctor made rounds. I said, "Can you do that for me? Can you talk with him about this lasix situation?" "Sure I can." Knowing that he was going to know when he walked in the door because the charge nurse was going to handle that. The charge nurse did not handle that.

The doctor walked into the room and the patient handled it with the doctor. And the doctor challenged the patient and the patient challenged the doctor back. And the doctor went to the medical record and the doctor came back and said you are right. That patient – that experience for that patient of the treatment team telling the patient "you are right‖ was incredible. I just can't tell you how she felt the next day when we got there other than she was really angry that she spent all night in the bathroom. But she was nine pounds down and she could breathe. She totally in a controlled setting saw the relationship between her warning signs, how she felt, how to interact with the treatment team was successful. And what a great story. Now, that wasn't good for her heart or her physical condition, but patients do not activate in the hospital.

For those of you who treat patients or have been in the hospital, you know they become very submissive to us as the treatment team, our secret society that we don't let them into. So for her to do this and have the confidence to do this was incredible. And I attribute that to coaching and the relationship that a coach establishes with the patient which is trust. The end of the story, she was discharged. We did follow her outpatient. She did readmit, but not in the 30 days. But when she readmitted, she did talk with the social worker about other options. And she said, "You know, you told me about this hospice stuff and my heart was not going to get better and I cannot take care of what I need to care of in this hospital." And she opted hospice and hasn't been back in the hospital.

And from what I appreciate, is improving. So our CMS project is in the Baton Rouge community. We collaborate with hospitals on process redesign as well as partnering with patients and caregivers and we provide patient tools and hospital tools and we track our success. So here's what we've identified are the drivers of rehospitalization in our community. And as we've work with the other 14 QIOs, and we all talked together about these things, they're pretty much not unique to us, OK?

So fragmented patient information. So we've already talked about data going back and forth, right, between provider care settings.

Inappropriate end-of-life care, recognizing that, talking to patients about their options and getting them plugged into appropriate end-of-life care resources. Medication issues, we don't have to go any further on that one. At risk patients are not being properly identified at discharge. We're not doing our due diligence in the hospital to say these patients have risk factors that we need to talk to somebody else about.

Lack of post discharge follow-up, only 50 percent of our patients were hitting the mark. And getting that doctor visit, you know, you can make the appointment, but if the claim doesn't hit the system, it didn't happen. Lack of disease specific protocols. In hospitals, care maps have kind of gone away in some hospitals. I was amazed because I was in the hospital 25 years ago when we had to write all those things. And I got back to the same hospital and said, “Where are the maps?” “What maps?”

OK, that was a lot of work for nothing. And then there's no protocol in the downstream provider, so there's no seamless care map. Patient adherence to the care plan, sometimes they choose to do that and that’s an A-OK thing. Patient knowledge deficit, what I just talked about with Ms. Kay, her not really knowing what was wrong with her. And that impacts them being able to make decisions. And then certainly lack of community awareness that we had a problem.

What does the coaching intervention drive to do? How does it address some of those drivers of readmission? Certainly, patient fragmented information. The single common thing in this whole thing is that you have to have a patient to have an admission, right, or discharge or readmission or doctor's visit. And if they have a portable record in their hand that's relatively updated with their medicines and what their diet is and how much fluid restriction they're on and what their – when they were supposed to stop their antibiotics and what their weights have been, wouldn't that be wonderful if they showed up to us what those things?

Medication issues, medication reconciliation form is critical. The patient writes it in their own handwriting. You know, it's not something that the treatment team prints and hands them, right? It’s the patient taking that at the moment of discharge, we take the discharge instructions and they write it in their handwriting however they want. If they want to write water pill for lasix, they can write water pill, but they write it in their own handwriting so that they can have a document that's theirs, that they own.

Lack of post discharge follow-up, you know, a lot of folks are stepping out there and making those appointments for patients, but what we’re finding is that that doesn't secure the – that doesn't guarantee the patient is going to go to the appointment and so it's critical that the coach help to drive for that patient why it's important. What we've also noticed if the patient has to invest in making the appointment and the coach helps them to do that that they go to the appointment. You know, getting through the gatekeeper is difficult. I have terminology as a clinician that I know how to get through the gatekeeper. I just insist on the nurse and if I don't her than I insist on

the doctor calling me that afternoon. The patient is quite comfortable with that, so we help them with that.

And then help them with adherence to the care plan. If they can't do the fluid restriction, OK, tell the doctor. He needs to be able to know that that's what you've chosen to do, so that he can help to maybe make some modifications that make this all better. And then address the patient knowledge deficit with tools.

If I can drive nothing home to you, the different track is the person that is, you know, hired to do just this job. We know what happens when case managers that are utilization review nurses and also have to do discharge planning and also have to do what happens. That this gets diluted and then it's not effective. So the coach needs to be the coach.

The coach empowers and encourages the patient to self care. The patient and the caregivers in this relationship are the doers, not the coach, right? If the patient says, can you call the doctor and tell him that because you said it so well. No, actually, you know, if they have questions for you, I can’t answer those. So let's go through it one more time and then I know you can do this for me. You can do this.

The coach reinforces the discharge plan. The coach doesn't determine what the plan is. The treatment team does. The coach is just a complement to the treatment team. And we do this through a series of hospital visits and telephonic follow-up. We get our patients from hospital management teams and from case management teams. And we go on the units and we work with those guys to get these referrals. I'll go through this quickly.

We have Fee-For-Service Medicare beneficiaries. These are the diagnosis, AMI, COPD, CHF, and pneumonia that we cover. We added COPD because our hospital said you're really missing the boat if you don't add it. And we do it disease-specific because we have a tool that we give patients that are warning signals, right, when to call on yellow rather than red.

So if you’re CHF, that means a 2-pound weight gain and then we realize that the hospitals weren't telling the patients what they weighed when they left. So when we said, OK so what's your target weight to call the doctor on? Well, I don't know. I don't know what I weighed when I left the hospital, so the intervention had to change again. But the key there is that there are specifics to each diagnosis that are critical for the patient to be watching. So we created tools that were specific for those.

And we want to be able to engage with caregivers as well. You know, the patient has a network that we've talked a whole lot about this week. And if you can engage the network as well as the patient, so the patient's network, you're going to be more successful in coaching. Just a little bit about our process, our hospitals push back on us really hard, you know, we agree with it. We're drinking the Kool-Aid, but we are not going to fund this. So figure out a way and we'll be happy to work with you. So the QIO say we'll resource the coaches.

For sustainability purposes, because I'm going to tell you I truly, truly

believe in my heart that a home visit is the way to go to see patients in their environment. The hospitals told us we cannot sustain that, not with the 600 beds in this house and 75 percent of those being Medicare. So we said, OK, what's something you could do? If we leave here in three years what can you continue to do because we want to be able to keep going? They said we'll consider telephonic. So that's why we went to a hospital and telephonic model, to look at sustainability.

I can tell there are home care agencies in our community that want to do this as well. They've trained in the model, but have not been able to pull the trigger for whatever reason. I think part of the difficulties, you got to see it on two tracks. You do have to see that coach separate from their home care nurse. We do our telephonic follow-up, 2, 7, 14, 21 and 30-day. Two-day because home visit would have occurred in that time. But two day because the patient that didn't fill their prescriptions, you're going to catch them at that time. Too much time had not lapsed for them to have a boo boo if they've interrupted their antibiotics.

Seven-day because you're either fixing to have that doctor visit or – fixing to have – don't you love the Louisiana phrase? Or the patient is getting, has just come from that hospital visit and you need to reinforce those changes that need to occur on that plan of care, if medication changed or diet has changed or something has changed. Fourteen days just makes me feel better. I just think that if you go seven days without talking to folks, they're going to say I'm done. I'm, you know, throwing in the towel.

Twenty-one days, most people who have changed, their diet is slipping and they're starting to see, make some changes in their plan of care that they're not really confiding in you about, they start to have some physical changes. And 30-day because that's when we do our follow-up to say how did you like this program. You made it, you know, would you recommend this to other folks?

We are doing a 45-day call because after 30 days people started in it, well, what this is about. The minute we stop calling, they start going back to the hospital. At each interaction, we focus on those things I talked about. The plan of care, post discharge plan of care, medications, discharge follow-up and any other follow-ups that need to occur with specialists, warning signals, the portable health record or personal health record and the patient-centered goal.

The patient-centered goal is the why. And when they understand what's wrong with them and you tell them connect treatment and adherence to treatment, to go into that soccer game to be able to watch it from the field rather than the car, going to church, going to the mailbox, going dancing, then it all seems to fall into place.

These are some of our results. We have one, two, three, four, five hospitals – hospital D had a huge C-suite overhaul in the very beginning of their coaching. And it was very labor intensive for them to keep up that intervention in their hospital. They agreed to some of the other interventions we had put into place, but you'll see their referrals were low and relatively, you know, when you have 10

coached and 4 readmitted, your readmission rate is not going to look so good.

And hospital E just came onboard, but you can see that hospital A came onboard first, we've had the most referrals from that hospital, and they actually have hired a coach and have reaped the benefits and see the benefit and their patient satisfaction scores with regards to discharge, satisfaction with discharge and medications have also soared. Good stuff about coaching, can't say enough about it, can't say enough about how the patient is the solution to this problem. Thank you.