

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Naomi Hauser: Good afternoon everybody, I'm Naomi Hauser from Quality Insights of Pennsylvania, the QIO from Pennsylvania, and it's certainly a pleasure to be able to talk about the program that we have instituted in western Pennsylvania.

Well, when we started the project, the Care Transitions Project as the same as all the other QIOs it was July 2008. And we were given the goal of reducing readmissions, but also to improve transitions of care as patients moved across the settings. That became the major focus of our work, and there were a lot of evidenced- based interventions that were offered up to us and obviously one that we wanted to definitely adopt was the Care Transitions Intervention. And the question that we came up with was where do you get a coach? It was not something we were familiar with. We didn't know where there would be a resource to get a coach. And so, we approached the hospitals, and the hospitals clearly told us that they really didn't have a resource to be able to provide such a position out of their staff. It was recommended to us that we approach the AAA. And that's exactly what we did. We did approach three AAAs. We presented the program, what our goal was and what our vision was to be able to move forward. And two of the AAAs said that they thought that they could actually do it at neutral budget, because they also were using their own already existing staff to be able to provide transition coaches.

So with that, we decided, OK, we're going to have to go to our next steps. And why did we go to the AAA? For obvious reasons as you

heard today, because the mission was very congruent to what the project was looking at. And it was a sustainable model which was very important, because we wanted to make sure that whatever we put all this effort into would be able to be sustained in the community, and then in fact, it would be from resources directly from the community.

We chose to adopt Dr. Coleman's model and we really tried to have strong fidelity to the model. There were times where we had to flex that, but for all intent purposes, we really did stay true to the model. We approached the hospitals and the AAAs, we started getting them together and in all collaborative efforts, the first step is getting everybody to the table and talking about how we can do this collaboratively. And once we did do that, it really became a pretty smooth process.

There were some, you know, problems along the way, but nothing that we couldn't work out. And the QIO really was a facilitator to this process in the beginning, kind of laid some ground rules down, tried to get the nobling environment so that we had trust across the providers to be able to talk and really identify what some of these barriers were and be able to talk honestly.

So the QIO in setting the culture of collaboration made sure to include transparency, which was critically important, and to equal the playing field. Nobody had any more voice than anybody else. Everybody was important. It was important to identify workflow processes. Make that very clear and make sure that people

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

understood what their roles were and to understand what coaching was really all about. And, certainly, we had training from Dr. Coleman's team. They came to Pennsylvania. They trained not only the coaches from AAA, but also the staff from all of our providers. We had health agencies there. We had some of our skilled providers there. We had the hospital there and the QIO. So everybody got trained at the same time and I think that was very important to be able to have everybody on the same page. So nobody was at the head of the class. We were all learning together.

I'd like to share some of our outcomes. We were successful. I'd like to announce that. And some of the success measures that we looked at certainly were looking as if our rates of discharge went down. And they did. I will share with you that out of 500 – or 5,531 discharges we coached 418 patients. That was an impact of 8 percent on all the discharges in our community; and we had 53 percent of those 418 patients completed the 30-day CTI.

The reason someone might not finish it was because they were readmitted, because they left the community. There could be a variety of reasons, but 53 percent did in fact complete the 30-day transition program.

And as Dr. Coleman and everyone has told you that really the measurement of successful coaching is are patients activated. What we mean by that is how involved are they in their care. If they're more involved in their care, then evidence base shows that they are going to probably lower the risk of readmission.

So we applied a tool called a patient activation assessment. And what we did is the coaches would actually go in on the home visit and apply this assessment; ask some questions related to the four pillars. And the patients would answer and they would get a score. And then on the third call done by the coach after 30 days, the assessment would be applied again, or those questions would be reasked.

And we had a success rate of 73 percent improvement of scores from the pre to the post patient activation assessment. And that was an average of a 2 point increase for patients. And the discharge rate for hospitals across our community was at patient's discharge from any hospital, not particularly our participating hospitals, but any hospital to any other hospital in the community readmitted was 20 percent. Our participating hospitals in our identified community that were readmitted to any hospital was 18 percent. Our coached patients in our community that were readmitted to any hospital was 14 percent. So that went from 20 to 14 percent.

Another measure of success, we decided that if the AAA staff and the hospital staff were working so closely and they really began working seamlessly with each other, we thought that that must have improved their relationship with working. So we decided to apply a questionnaire to both the AAA staff as well as the hospital staff. And these are the results that we obtained and the questions that we asked. We asked the hospital staff and their response was 60 percent of the hospital staff felt that they had more contact with the

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

AAA staff than they had before. And 66 percent said that they knew more about the services that AAA was providing. And 46 percent said they were more satisfied with the contact they in fact had with the AAA staff.

And from the AAA side, the answers that we got, 74 percent were more satisfied with the hospital contacts they had; 67 felt there were more AAA services that were actually provided; 60 percent said that the referrals were more appropriate; 53 percent said they had more contact with the referrals that were made; and 60 percent said they were more confident that the patients' needs were being met.

So we feel that that was a success, relationships were improved, services were increased, patients' needs were met. We couldn't ask for more than that, but to continue that and hopefully continue this process. So that's what I have to offer here today. And I thought what you really want to hear is what the AAA can talk about what they did, how they did it and what their outcomes were. So I'm going to turn this over to Tim Landrin from Southwest Pennsylvania AAA.