Transitional Care at Trinitas Regional Medical Center

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Agenda

- Background
  - Transitional Care Models
  - Four Pillars
  - Transition Coach
  - Key drivers for readmissions
- Transitional Care Program at TRMC
  - APN
  - Grotta Program
  - Central NJ Care Transitions Program
  - Mobile Integrated Health Services
- Transitional Care and the Renal Patient

Trinitas Regional Medical Center

- Established in January, 2000
- Full-service healthcare facility serving those who live and work in Eastern and Central Union County.
- Operating on two major campuses, Trinitas Regional Medical Center has 531 beds, including a 120-bed long-term care center.
- We treat over 17,000 inpatients annually, 70,000 emergency patients, and several hundred thousand outpatients.
- Three dialysis facilities with over 30,000 treatments annually.

TRINITAS
Regional Medical Center

Transitional Care at Trinitas Regional Medical Center

Elizabeth Demographics

	Percentage
Ethnicity	
Hispanic or Latino (of any race)	58.5%
Black or African American	20.0%
Foreign born	46.5%
Spanish language spoken at home	55.1%
Employment Status	
Employed	62.2%
Unemployed	7.6%
Not in labor force	30.1%
Income	
Past 12 months below the poverty level - all people	17.7%

U.S. Census Bureau, 2010

Opportunity

- ***"Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154)." (CMS, 2013)***

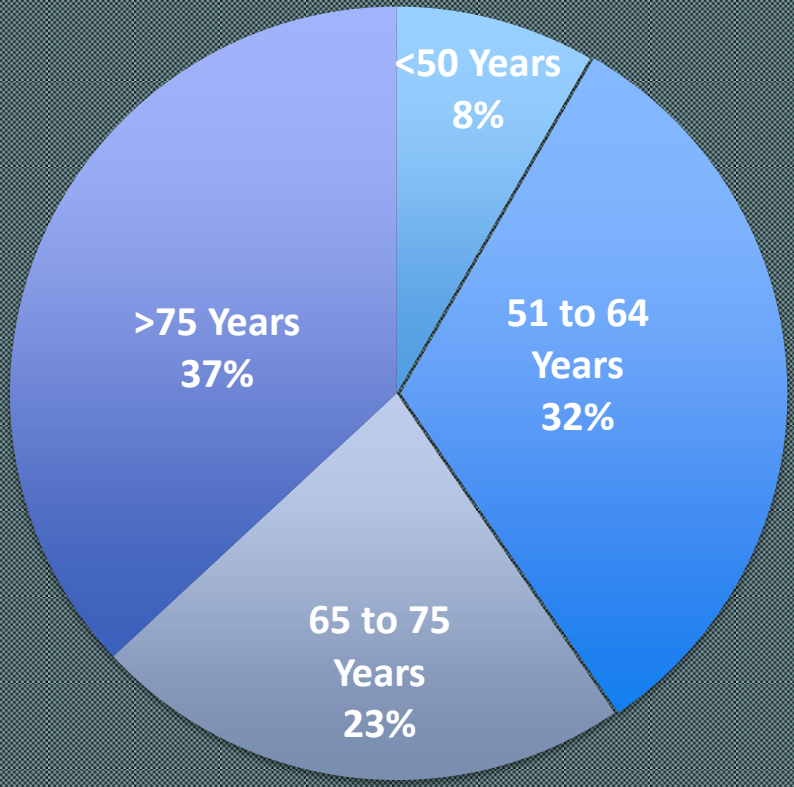
- **Hospital Readmissions Reduction Program**
  - Defined readmission as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital;
  - Adopted readmission measures for the applicable conditions of Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN). (CMS, 2013)

HEART FAILURE AT TRMC

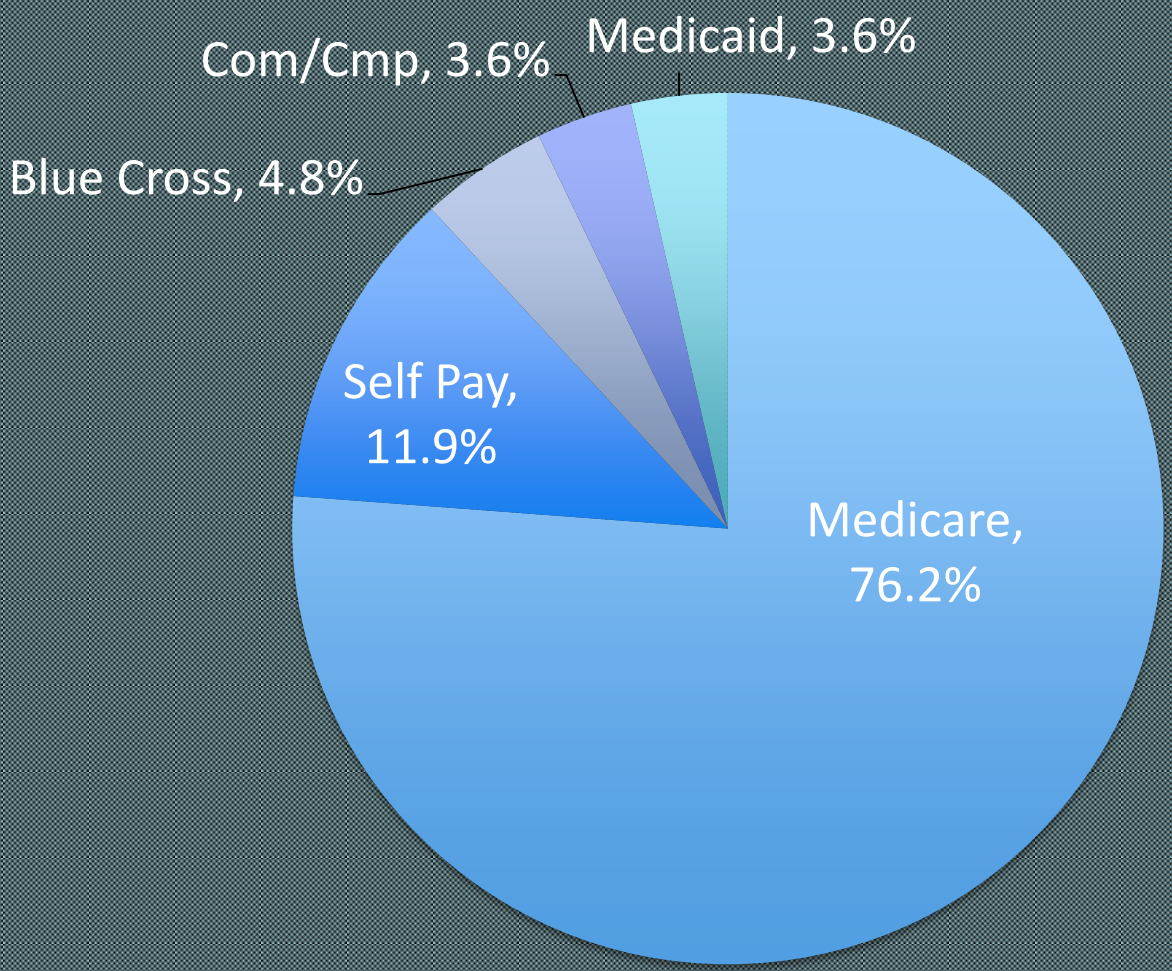
Age and Sex Breakdown of HF Readmission Patients at TRMC - 2012

Patient Age	Years
Average	69.5
Minimum	37
Max	94

Sex	Percentage
Female	42.9%
Male	57.1%



Payer Mix
TRMC HF Readmission 2012

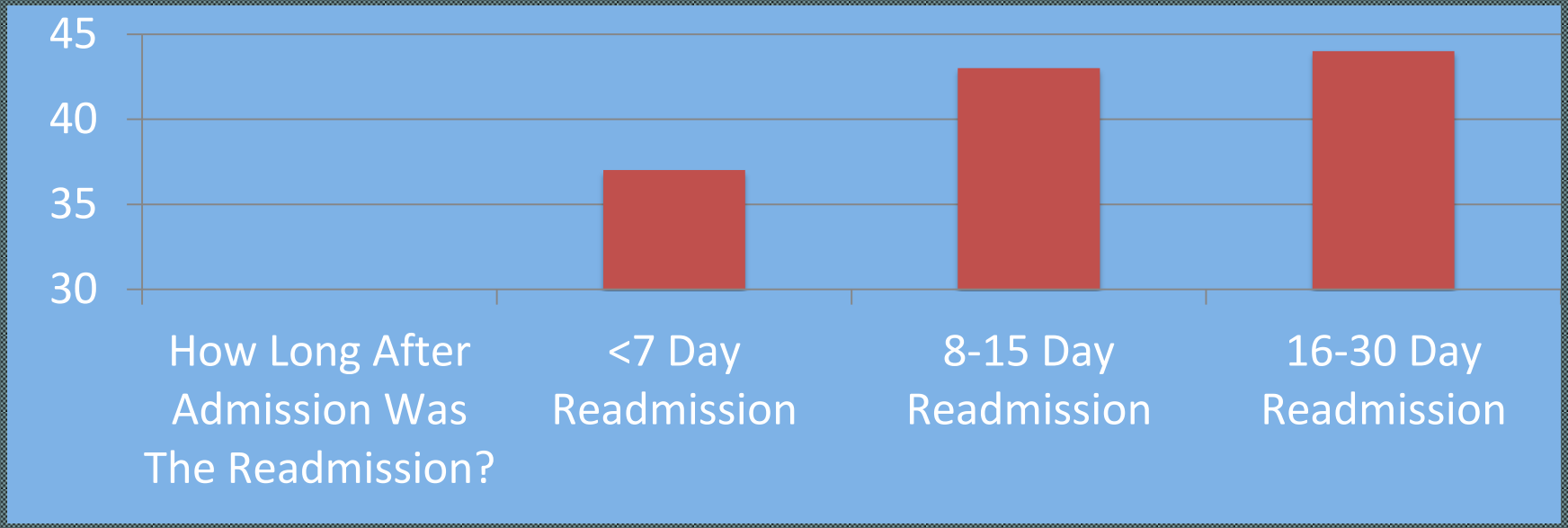


Inpatient TRMC Utilization HF Readmission2012

- 9 physicians accounted for 46% of HF readmissions
- Average IP admissions for HF readmission Patient - 4.08
  - Min 2
  - Max 17
- 50% of Patients had at least one admission prior to the initial HF admission in 2012.
- 27.4% of Patients had Multiple CHF <30 Day Readmissions
- Two patients had 11% of total HF readmissions (one 10, one 14)

Inpatient LOS and Time to Readmit TRMC HF Readmission2012

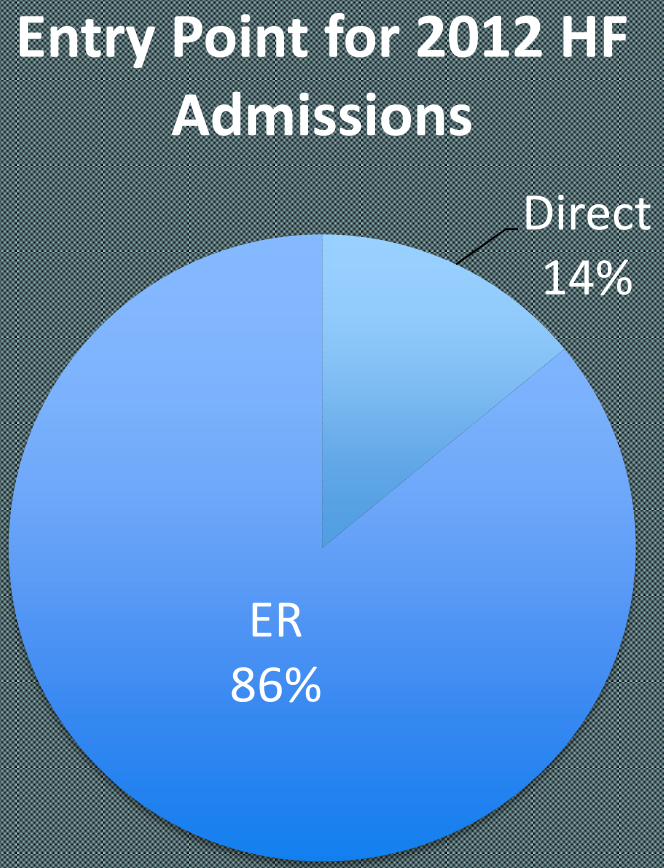
Initial CHF Admission	Days	Readmission	Days
ALOS on Admission	5.79	ALOS on Readmission	6.15



Reason for Readmission
TRMC HF Readmission2012

Reasons for Readmission	Percentage
Heart Failure	***54.3%***
Cardiac	14.3%
Respiratory	7.6%
Other	6.7%
Diabetes	5.7%
Infection	5.7%
Neurology	5.7%

Admission Points for 2012 HF Readmissions

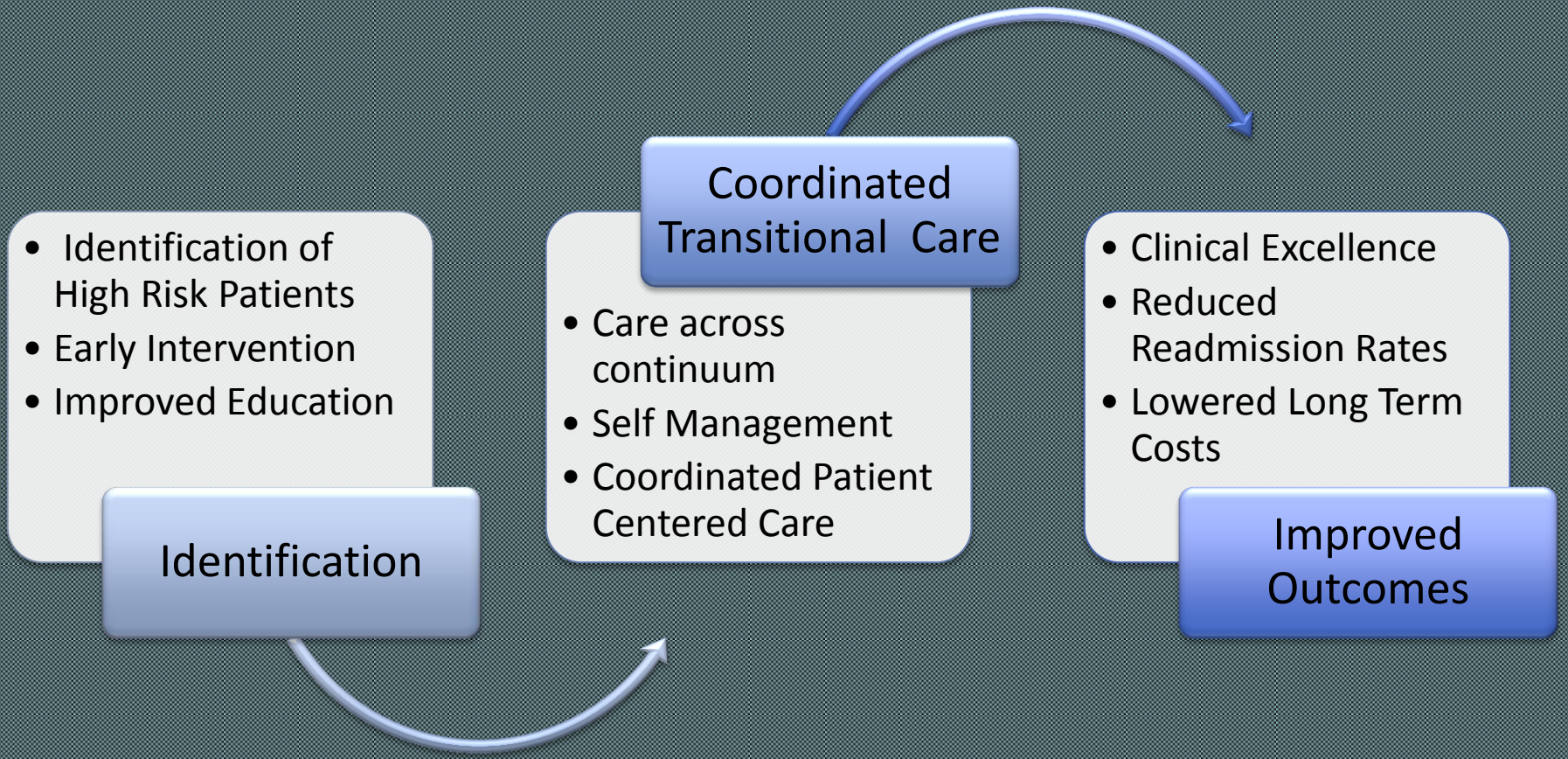


Discharge Disposition
HF Readmission 2012

Primary Admission - Discharge to	Percentage
Discharged to home	39.0%
D/C to skilled nursing ctr.	32.9%
D/C to home health service	25.6%
D/C to short term hospital	2.4%

Readmission - Discharge to	Percentage
Discharged to home	40.7%
D/C to skilled nursing ctr.	31.4%
D/C to home health service	18.6%
D/C to short term hospital	3.5%
Expired	3.5%
D/C to intermediate care ctr.	1.2%
Left against medical advice	1.2%

Logic Model


Identification of High Risk Patients
Early Intervention
Improved Education
Identification
Coordinated Transitional Care
Care across continuum
Self Management
Coordinated Patient Centered Care
Clinical Excellence
Reduced Readmission Rates
Lowered Long Term Costs
Improved Outcomes

Care Transitions

"Care Transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

"The Naylor Model"

- Qualifications: Transitional Care Nurses are advanced practice nurses (BA-prepared nurses under study)
- Length of intervention: 1 to 3 months
- Average cost: $982 per patient

- Steps:
  - Visit patient in hospital, home visit w/24 hours, accompany patient to 1st doctor visit, facilitate clinician collaboration and communications with patient/family, on call 7 days a week

Coleman Care Transitions Model

- Qualitative Studies
  - Patients inadequately prepared for next setting
  - Receive conflicting advice for illness management
  - Inability to reach the right practitioner
  - Repeatedly completing tasks left undone

The "Silent" Care Coordinators

- By default, older patients and family caregivers function as their own care coordinators
- First line of defense for transition related errors
- Model explicitly recognizes their role as integral members of the interdisciplinary team

Four Pillars

Medication Self-Management

Patient Centered Health Record (PHR)

Primary Care Provider/Specialist Follow-Up

Knowledge of Red Flags

Pillar #1:
Medication Self-Management

- *Focus*: reinforcing the importance of knowing each medication
  - when, why, and how to take what is prescribed
  - developing an effective medication management system

Rates of Medication Errors

- 14 Percent Experienced 1+ Med Discrepancies
- 62 percent experienced one
- 25 percent experienced two
- 8 percent experienced three
- 5 percent experienced four or more

Pillar #2:
Personal Health Record (PHR)

- *Focus:* providing a health care management guide for patients; the PHR is introduced during the hospital visit and used throughout the program.

  - Record of patient's medical history
  - Red flags, or warning signs
  - Medication list and allergies
  - Advance Directives
  - Structured Checklist of critical activities (instructions, f/u appointments)
  - Space for patient questions and concerns

Pillar #3:
Primary Care Provider/Specialist Follow-Up

- *Focus*: enlist patient's involvement in scheduling appointment(s) with the primary care provider or specialist as soon as possible after discharge

Pillar #4:
Knowledge of Red Flags

- *Focus*: patient is knowledgeable about indicators that suggest that his or her condition is worsening and how to respond

Key Elements of Intervention

- "Transition Coach"
  - Prepares patient for what to expect and to speak up
  - Provides tools (Personal Health Record)

- Follows patient to nursing facility or to the home
  - Reconciles pre- and post-hospital medications
  - Practices or "role-plays" next encounter or visit

Key Attributes for the Transition Coach

- Ability to shift from a "doing" role to a coaching role
- Skill and knowledge to manage and reconcile medications
- A strong enough sense of empowerment to empower a patient and/or caregiver
- Ability to engage in critical thinking within the framework of a care plan

Goal Attainment

"What is one personal goal that is important for you to achieve one month after you get home?"

Response Categories

1. I have not worked on it
2. I have not met that goal, but am working on it
3. I have met the goal as well as I expected
4. I have met the goal better than I expected

Patients who worked with the Transition Coach were more likely to achieve their goals around symptom control and functional status

Patient's Story

- 53y/o Hispanic female who was admitted c/o shortness of breath with 3 pillow orthopnea, has 3+ pedal edema b/l LE with anasarca extending to abdominal wall. No CP or palpitation however she had occasional cough with sputum production.
- MHX: Asthma, DM, Hyperlipidemia, HTN, COPD, CAD
- SHX: s/p cardiac cath/PCI with stent, Cholecystectomy
- Social HX: current smoker, no ETOH or drug use, lives alone in a one bedroom apartment, has no children

Labs/Test

- BUN 41, Creatinine 1.63, GFR 9, Hemoglobin 9.1, Potassium 4.2, BNP 402, EF 45 – 50%
- Chest X-ray – Bilateral pleural effusion
- ASS: 1. 9cm JVD with hepatojugular distension with 3/6 systolic murmur and mitral regurgitation. 2. lungs with b/l crackles heard on all lung field

Hospital Course

- Found to have CHF exacerbation with underlying COPD
- Acute kidney injury
- Respiratory failure s/p Intubated
- Started on Hemodialysis
- Discharged with plans to continue HD MWF

Admissions/LOS

Admission Date	Discharge Date	LOS	Days spent at home
March 18	March 27	10 days	13 days
April 9	May 12	33 days	5 months by May 12
Patient enrolled in the program May 10	First Home visit May 13 at 12noon		

Home assessment

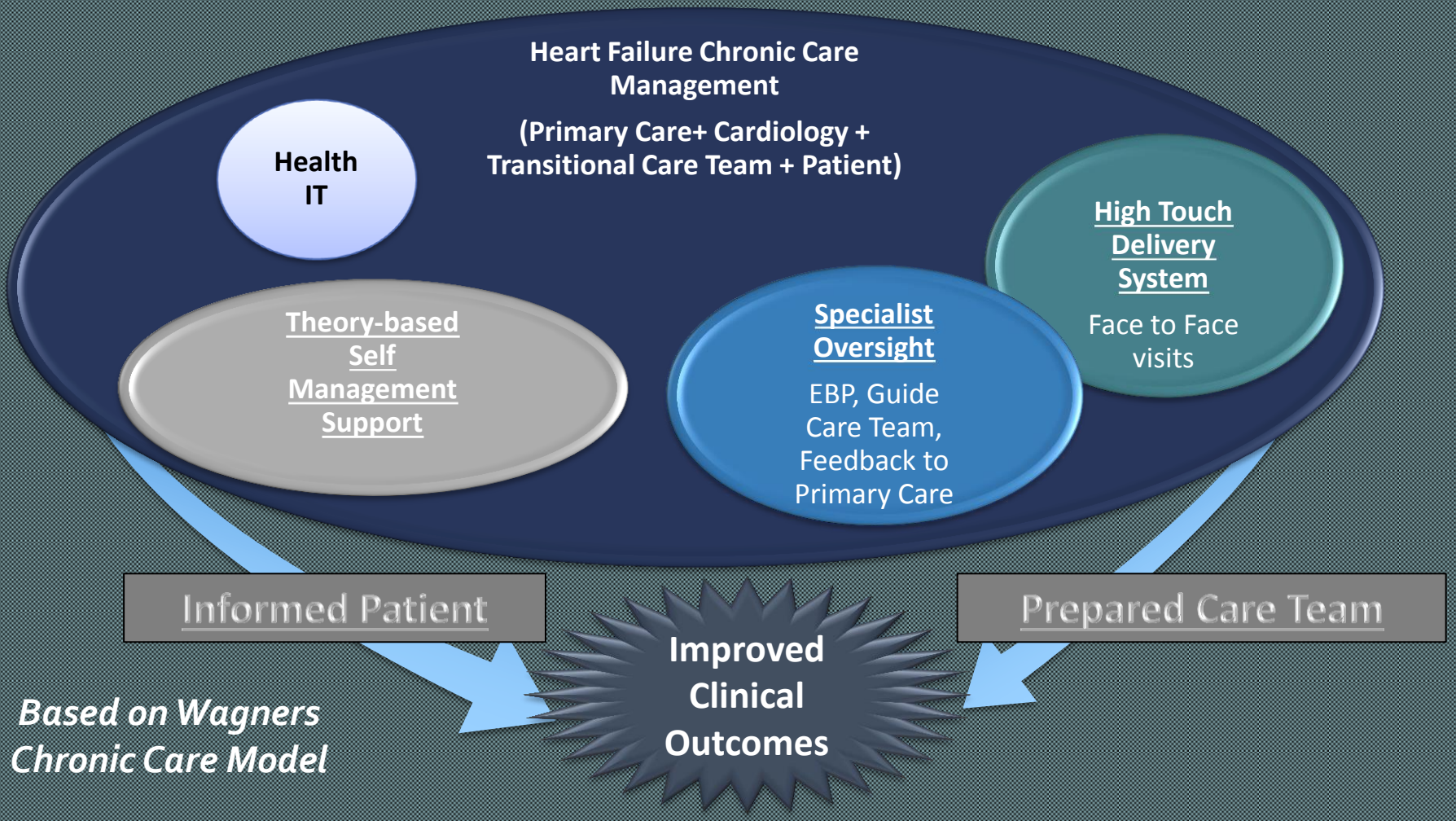
- BP 190/90, P 112, Pulse Oxymetry 90%, afebrile
- Alert and oriented, very weak and has not eaten since morning because she is waiting for her friend to get off work and bring her food
- # of discharge Medications = 18
- # medications at home = 4
- Primary care provider has no privileges at our hospital
- Patient does not know the cardiology to follow post discharge.

Intervention

- 1. coordination with primary physician and cardiology for Medication management
- 2. PHR
- 3. primary care provider/ cardiology follow up
- 4. Knowledge of red flag
- 5. provided 10 frozen meals for patient
- 6. called pharmacy to deliver medication
- 7. making sure patient takes first dose of medication

READMISSION PROGRAMS AT TRMC

TRMC Heart Failure Model



Based on Wagners Chronic Care Model

TRINITAS Regional Medical Center

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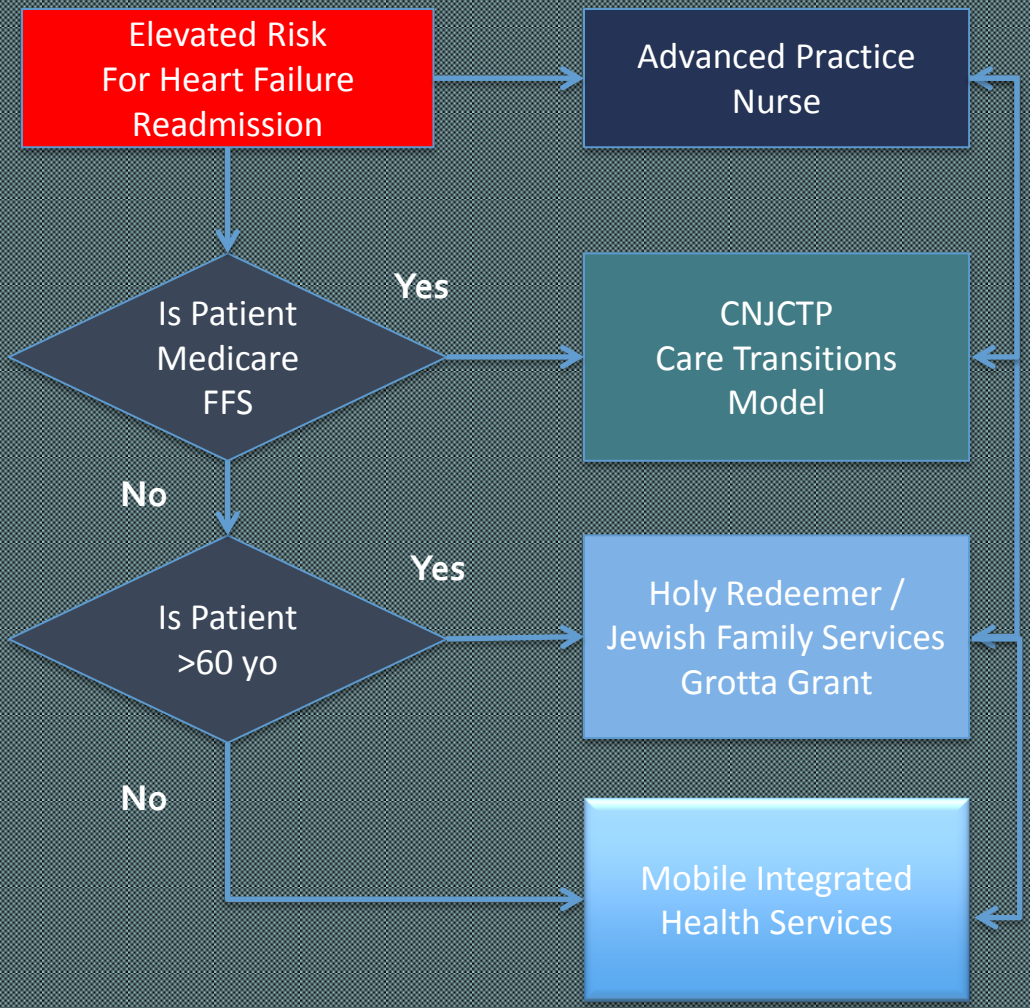
Current Initiatives to Reduce Readmissions at TRMC



READMISSIONS AND RENAL SERVICES

Comorbid Conditions for HF Readmit

Co-Morbid Condition	PERCENTAGE
HTN	83.1%
DIABETES	64.0%
HYPERLIPID	32.6%
RENAL	28.1%
COPD	23.6%
CAD	23.6%
AFIBB	20.2%
MI	18.0%
PACEMAKER	16.9%

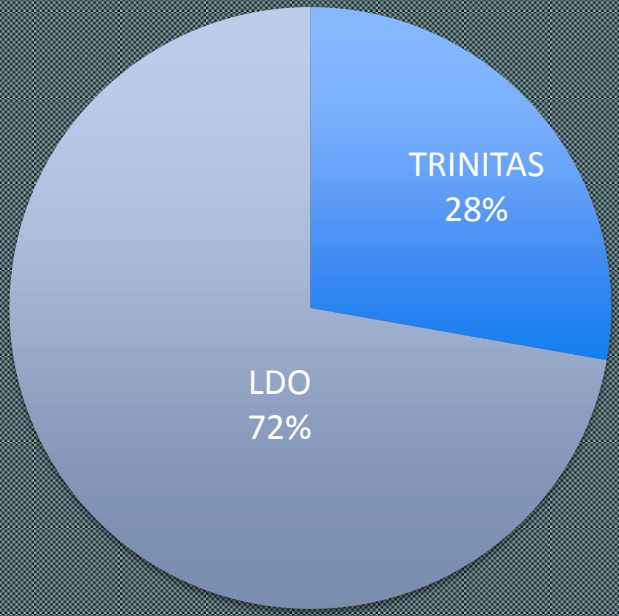
Kidney Disease and HF

CKD	%
No	38.2%
3B	15.7%
3A	10.1%
4	10.1%
5	25.8%
Has CKD 3A or Higher	61.8%

ESRD on Dialysis	%
No	78.6%
Yes	21.4%

Renal
TRMC HF Readmission 2012

Chronic Dialysis Patients - Home Facility



8 PATIENTS HAD A READMISSION AFTER THEIR 1ST DIALYSIS TREATMENT

Addressing Readmissions in the Renal Patient

- Building processes and program for everyday practice
  - Safe and Sound in the Hospital
    - Care Partner Concept
    - Use as tools in Care Planning
  - Behavioral Health
    - Screening for Depression and Substance Abuse
    - Follow up with appropriate services

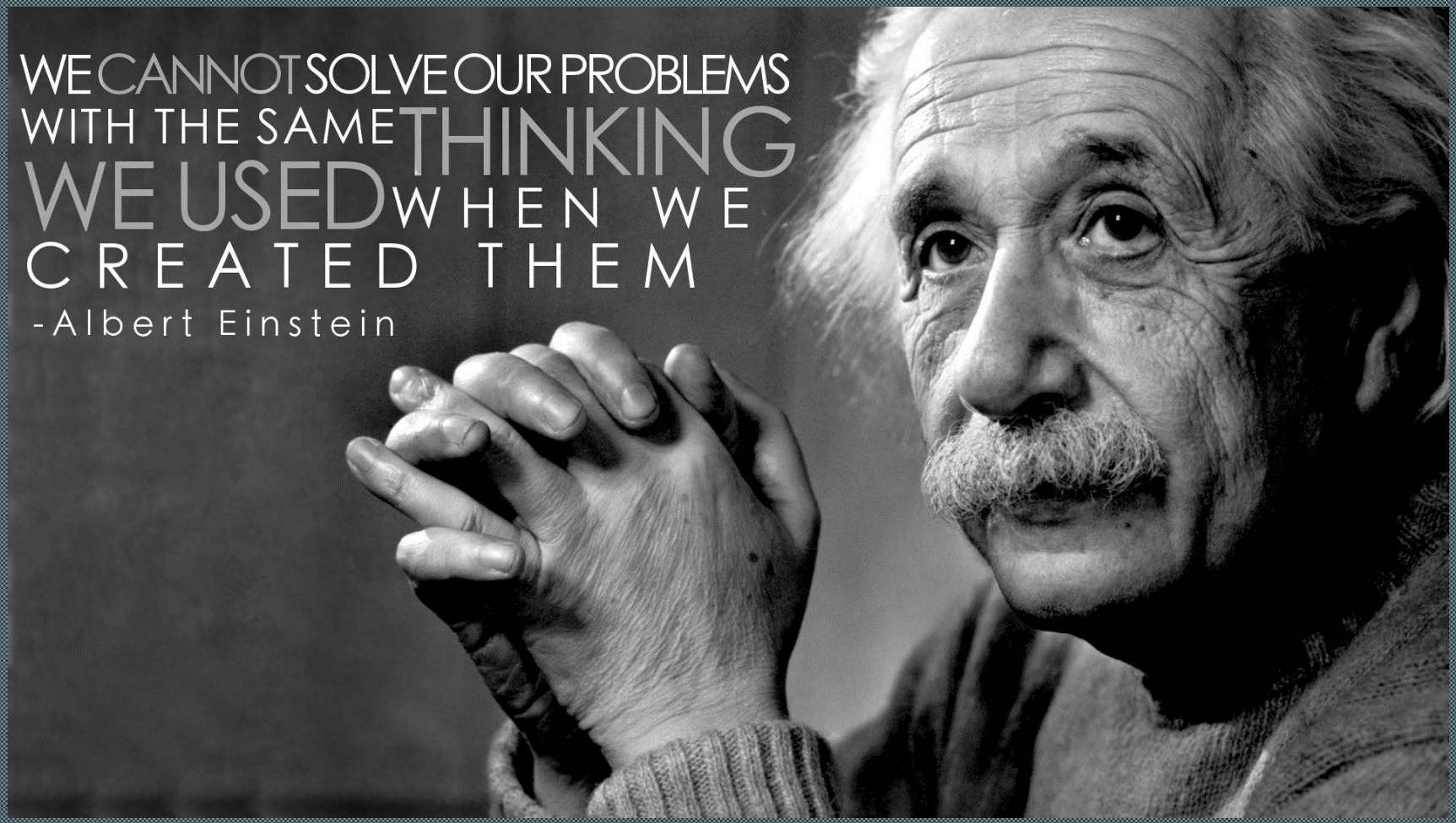
Addressing Readmissions in the Renal Patient

- Emergency Department Partnerships
  - Original Model
    - Patient would enter ED symptomatic, be admitted under PMD, consult Nephrologist, dialyze and discharged.
  - New Model
    - Patient would enter ED symptomatic, R/O Cardiac Issues, moved to observation status, contact Nephrologist, dialyze, and re-evaluate

Addressing Readmissions in the Renal Patient

- Fluid / Weight Management
  - Review of high weight gainers
- Challenge of working with non-TRMC Dialysis Partners

Thought….


WE CANNOT SOLVE OUR PROBLEMS
WITH THE SAME THINKING
WE USED WHEN WE
CREATED THEM
-Albert Einstein