COACHING TO REDUCE INPATIENT HEALTH CARE UTILIZATION IN THE PACE SETTING

October 2016, National PACE Association Annual Meeting

Ann Dupree, Data Specialist, STAR Advocate
Peter DeGolia, M.D., Medical Director
McGregor PACE Organization, Cuyahoga County, Ohio
Learning Objectives

• Review the care transitions initiative of Dr. Coleman and others to reduce 30-day hospital readmissions.

• Describe the STAR program and motivational interviewing as employed by a patient advocate in the McGregor PACE organization.

• Cite inpatient health care utilization data collected over the past year.
Key Principle of Caring for Older Adults: Early Identification of a Change in Condition

- Recognition of a change in condition
- Early evaluation
- Early intervention
Care Transitions: Important in Senior Care

- Common place
- Sources for error and complications

CASE study: Mrs. S – admitted for cellulitis
- 1 week history of skin tear with increasing pain and redness
- PMH significant for depression with psychosis, secondary parkinsonism, HTN, OA with impaired mobility
- Multiple antidepressant and antipsychotic medications
- Notified of admission to hospital on HD2
- Inpatient service did not have accurate medications or history
- Shared up-to-date information
- Discharged home with incorrect medication regimen
Coleman - Care Transitions Intervention

- Patient centered coaching intervention designed to increase medical self-management and improve patient/provider communication quality and frequency

- 4 weeks, 4 or 5 contacts
  - One hospital visit pending discharge - optional
  - One home visit
  - Three phone calls

- Four Pillars
  - Medication self-management
  - Dynamic, patient-centered record - PHR
  - Red Flags
  - Follow-up

Quality Partners of Rhode Island in partnership with Centers for Medicare and Medicaid Services

- Took outline of the Care Transitions Intervention (CTI) into a nonintegrated health care system of 6 disparate urban hospitals

- Used non health professionals as coaches, required high school diploma

- 4 weeks, 4 contacts
  - One hospital visit pending discharge
  - One home visit within 3 days of discharge
  - Two phone calls   One within 7 to 10 days of home visit   Second within 30 days of first hospital visit

- Uses Four Pillars concept
  - Patient written Personal Health Record
  - Medication self-management
  - Knowledge of disease red flags
  - Scheduling and attending follow-up appointments with health care providers

Lessons from Care Transitions

- 20% of Medicare FFS patients were readmitted within 30 days

- The 3 most common causes of readmission:
  - CHF, Pneumonia, AMI

- 1 in 3 readmissions are avoidable with better self-management

- The Care Transitions Intervention by Eric Coleman, M.D. showed a 30% reduction in readmissions

- Replication of this initiative was effective.
Intervention Opportunities for PACE

• Experts in care coordination and communication
• Frequent Care Transitions
• Participant attendance at PACE Centers
SO,

S.T.A.R. POWER

was envisioned
The Goals

- Improve health outcomes
- Reduce emergency room visits and hospitalizations
- Increase participant’s PACE usage
- Increase participant’s health self-management and self-advocacy
The Strategy

S — Say signs associated with symptoms
T — Take medications properly
A — Ask for advise when symptoms worsen
R — Record information in Personal Health Record
Scenarios

1. Medications and side effects
2. Disease awareness and red flag symptoms
3. Communicating with your provider
4. Social conversation
Medications and side effects

• Begin by understanding the participants’ current medication knowledge and management system

• How are medication changes integrated into the participants’ system? Both knowledge of the change, what changed and why; and how the change will be incorporated into medication daily management
Disease awareness and Red Flag symptoms

- What about your health concerns you the most?
  - Drill down to details that are concerning
  - Brainstorm on whiteboard untilppt formulates question for provider

What does it feel like when health starts to go downhill?

What's your plan when that happens?
- Creating questions for providers to amend plans on both ends of the spectrum
  - Call 911
  - Go to bed
Participant/Provider communication

• Conversation revealing frustration, outstanding questions, questionable medical facts and assumptions, some avoidance
• Took a guess at a conclusion
• The Bad News and The Good News
• The foot in the mouth
• The apology
• The relationship
• The ongoing issues
Social conversation

- Coaching relationship enhances participant’s PACE experience
- Completely outside of any STAR exercise
  - PACE wants to listen
  - Addresses loneliness, isolation issues
  - Adds to appeal of day center attendance
  - Someone appreciates their experience and stories
  - Have a better day than without coach interaction
The Plan

• Eight week initial interaction schedule
  • Week 1 – Introduce program, introduce PHR, guide PHR completion
  • Week 2 – PHR review
    • Has all information been completed
    • Answer questions
    • Reinforce ppt’s confidence in using and maintaining PHR
  • Week 4 - Repetition of STAR conversations
    • Deepen STAR conversations, added detail, develop questions for IDT
  • Week 8 - Maintenance conversations
The Techniques

• Motivational Interviewing
  • Basics
    • Listen
    • Elicit commitment to ‘change’ using reflections, open ended questions in conversation
    • Facilitate conversation that has participant explore option and commit to change through intrinsic motivation
  • Historically most successful in addiction counseling
• In PACE
  • “Don’t sass me.”
  • Most PACE participants, most seniors, have made difficult choices and persisted through to their goal.
  • “If I decide to do something, I’ll get it done.”
The Goals

• Improve health outcomes
• Reduce emergency room visits and hospitalizations
• Increase participant’s PACE usage
• Increase participant’s health self-management and self-advocacy
## The Numbers

Pilot Data: Coaching in a PACE organization using a non-health professional

Annual number of days of care (SD) by setting among 71 PACE participants

<table>
<thead>
<tr>
<th></th>
<th>Before STAR</th>
<th>After STAR</th>
<th>Percent Δ</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>11 (87.84)</td>
<td>0.37 (0.79)</td>
<td>-97%</td>
<td>0.159</td>
</tr>
<tr>
<td>Observation</td>
<td>0 (0)</td>
<td>0.06 (0.52)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>20.33 (112.66)</td>
<td>2.39 (8.15)</td>
<td>-88%</td>
<td>0.092</td>
</tr>
<tr>
<td>SNF/ICF</td>
<td>6.91 (32.69)</td>
<td>4.63 (10.81)</td>
<td>-65%</td>
<td>0.292</td>
</tr>
<tr>
<td>Total</td>
<td>38.57 (201.41)</td>
<td>7.45 (14.68)</td>
<td>-81%</td>
<td>0.102</td>
</tr>
</tbody>
</table>
Major Lesson

• Amazing participants!
• Amazing providers!
• Amazing program!
Epic Failures

• Using a Personal Health Record
  One of 102 participants has embraced keeping a PHR
  Illiteracy
  Physical barriers
  Mental capacity
  Anxiety producing

• Coach communication with IDT
  What coach hears that IDT doesn’t hear

• Participant resignation and defeatism
• Underestimating PACE participants
• Overestimating PACE participants
BIG WINS

Connecting with our participants

• Listening – connecting and creating trust
• Brainstorming
• Learning to adapt to our participants
• Participants desire to increase elements of self-management
• Pilot study data shows trends
  • Reduction in inpatient admissions (ED/Hospitalizations)
  • Increase in direct skilled admissions
  • Increase in PACE-centered use
    • On-call contact
    • Acute clinic visits
    • Psych and Social Work
    • Directed Skilled admits
Great Next Steps

- Don’t be silent campaign
- Empowering PAC
- SA/ALOC prep
  - Preparing participants and/or care givers to participate
- Training staff to be effective more communicators
- MI
- Staffing to connect and stay connected
  - Restorative aides in ALFs
  - Care Transitions Coordinator
Opportunities for PACE-wide Collaborative

• Pilot Study with statistically encouraging trends
• Application to the broader PACE community
• Identification of interested PACE programs in pursuing further application of Coaching within PACE
References


http://caretransitions.org