Support from Hospital to Home for Elders

The SHHE Project at San Francisco General Hospital

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Objectives

• Communicate readmission challenges faced in the Safety Net Hospitals

• Share specific efforts by SHHE to address challenges

• Discuss adapting interventions for low-income, multi-ethnic setting
Clinical Scenario

Mr. B is a 68 year old, Spanish-speaking man who noticed shortness of breath during his morning routine, then suddenly collapsed at home.

Paramedics resuscitated him from a pulseless state and brought him to SFGH.
Clinical Scenario continued

Mr. B has DM II, HTN, ESRD, CHF.

He goes regularly to his medical home where he is prescribed 13 medications.

He lives with his wife; multiple family members and friends are involved in his care.
San Francisco General Hospital

- Only Trauma Center in San Francisco
- Care for over 100,000 patients per year
- Provides 20% of all inpatient care in SF
- Only Psychiatric Emergency & Rehabilitation Services
- Referral Center for Healthy San Francisco, the county’s healthcare access program
- 66-75% patients have limited health literacy
SFGH Payor Sources
FY 2009-2010

Inpatient Days
Includes SFBHC and 4A SNF
- Medicare: 19%
- Medi-Cal: 39%
- Others: 6%
- Commercial: 3%
- Uninsured: 33%

Outpatient Encounters
Emergency and Clinic
- Medicare: 16%
- Medi-Cal: 29%
- Others: 19%
- Commercial: 1%
- Uninsured: 35%
Support from Hospital to Home for Elders

• The Gordon and Betty Moore Foundation, in 2008, awarded a grant to implement and evaluate a readmission initiative
Support from Hospital to Home for Elders

• Collaborate with Boston University to adapt Project RED for patients at San Francisco General Hospital
Study Design and Population

- English, Spanish, Mandarin or Cantonese - speaking patients, age 55 or older
- Admitted to medicine, family medicine, cardiology, and neurology
- Transitioning to home (Hotel, shelter)
Study Design and Population

- 200-person pilot (all received intervention) is completed
- 700-person randomized controlled trial comparing usual care to intervention is ongoing
Intervention Elements: In-Hospital

• Dedicated SHHE nurse
  – Cultural/language concordance
  – Focus on coaching and patient goal-setting (Motivational Interviewing)

• Computer-assisted transition packet
  – After-Hospital Care Plan (AHCP) from Engineered Care
Intervention Elements: Post-Hospital

• Follow-up telephone calls
  – Nurse Practitioner or Physician Assistant (prescribing ability)
  – Days 1-2 and 6-7 post-hospitalization
Mr. B is admitted to the Cardiology Service. Hospital evaluation reveals 3 vessel epicardial disease, with significant left ventricular dysfunction. A coronary artery bypass procedure is recommended as an outpatient, while he is stabilized with acute dialysis for acute renal failure.
Usual Care vs. SHHE Intervention

• Usual Care
  – Patient assigned a bedside RN
  – Care is focused on diagnosis, from which creates plan
  – “one size fits all”

• SHHE Project
  – Patient assigned a culturally and/or language-concordant transitional care RN
SHHE Nurses

- Dedicated transition nurse
- Dedicated bedside coaching
- Cultural and language concordance
Devising a Care Plan

1. Intake – completed by the SHHE RN

3. Setting goals by assessing and engaging the patient

3. Coaching - AHCP
Intake/Transition Risk Assessment

• Getting the detailed picture
• Recognizing barriers to:
  – Understanding diagnosis
  – Red flag symptoms
  – Medications
  – Navigating the system
• Creating an individual strategy for each patient
Setting Goals

• Assessment of patient “meeting them where they are” with a holistic approach
• Open-ended conversation to encourage patient to speak of concerns/fears
• Eliciting change through motivational techniques
Coaching

• Frequent bedside visits
• Focus on patients’ empowerment, not doing for them
• Encouraging self-advocacy
• Acquiring skills to navigate the system
Prioritization Criteria

- Length of patient stay
- Complexity of illness/diagnosis
- Patient’s readiness
Educational Modalities

- Approved patient-resource health-sheets
- Education through verbal reinforcement
- After-Hospital Care Plan (AHCP)
AHCP

- Teaching tool to engage patient and assess his or her readiness
  - Red flags
  - Allergies
  - Goals
- Resource booklet for patients and their families in their preferred language.
- Medication regimen with indications, description and easy-to-understand icons.
- Appointment calendar
**Bring this Plan to ALL Appointments**

After Hospital Care Plan for:

Jane Patient

Discharge Date: MARCH 13, 2010

Questions or problems with this booklet? Call 206-4901 to talk to your SHHE nurse Tip Tam.

Serious health problem? Call TBA: (415) 206-8492
** traiga este plan a todas sus citas **

Plan de cuidado para:

Jane Patient

Dia de alta: 13 DE MARZO DE 2010

Preguntas o problemas sobre este paquete?
Llame al 206-4901 para hablar con su enfermera SHHE Tip Tam.

Problemas serios de salud? Llame TBA: (415) 206-8492
出院計劃書 爲了

Jane Patient

出院日期: MARCH 13, 2010

如對這計劃書有任何疑問或問題，
致電206-4901給你的SHHE 護士Tip Tam。

嚴重的健康問題? 打電話給 TBA: (415) 206-8492

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Bring all of your medicines (in their bottles) to your doctors' appointments.
Carry a list of medicines with you.

<table>
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<tr>
<th>Medicines</th>
<th>Medication Name</th>
<th>Why am I taking this medicine?</th>
<th>How do I take this medicine?</th>
<th>How much do I take?</th>
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Hand offs

• Formal discussion between RN’s and NP/PAs
• Discuss cases assigned to intervention
  – Admission diagnosis, old dx
  – Admission medications, new medications
  – Diagnostic tests
  – Psychosocial issues
  – Functional capacity
• Goals of in-patient education
First Call

• **Before making call:** review electronic and paper chart, review meds, review appts, review AHCP

• **Start a form on electronic database**

• **Make the call:** patient or support

• **Set the tone:** professional yet familiar

• **Reconcile meds, confirm future appts**

  » Red flags, transportation, problem solve, coach, DMEs, encourage patient to be involved in self care.
Second Call

• Goal is 6-7 days after discharge
• Review symptoms, reconcile meds, future appointments
• Problem solve:
  – if medication issue, will Rx one time refill until patient sees PCP
  – If patient needs follow up, will help patient navigate system
Pilot Results

Characteristics of Patients

• 81% are non-white
• 46% have less than a HS education
• 53% born outside the United States
• 72% are single, divorced, widowed
• 92% earn less than $20,000 per year
Pilot Results
High access to care

• 93% had PCP visit in prior 6 months

• 41% ED visit in 6 months prior

• 32% Hospitalization in 6 months prior
Successes in the pilot

• Remarkably successful connecting with patients
  – 80% completed at least one post-hospitalization phone call (clinical)
  – 98% completed 30-day follow-up interviews (evaluation)
Pilot Outcomes

• 23% of patients were re-hospitalized within 30 days

• 26% of re-admissions/ ED visits were at outside hospitals

• 5.5% 30-day mortality
Randomized Controlled Trial

Enrolling Now

- Comparing usual care to usual care with SHHE
- 700 person RCT
- Primary endpoint – 30, 90, 180 day readmission
- Build database – psychosocial, functional (readmission factors)
- Current enrollment – 300 subjects
Key Lessons

• Core of intervention is relationships
  – Coaching – patients feel heard
  – Teach back methods
  – Cultural concordance

• Morbidity is high among this patient population
  – Case management?!
  – Palliative Care
SHHE Team

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