Care Transitions for Patients Experiencing Homelessness
Wednesday, October 24, 2012
We will begin promptly at 3 PM EST

Event Host: Sabrina Edgington
National Health Care for the Homeless Council

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Initiatives to improve care transitions:

- The Community-based Care Transition Program (CCTP)
- The Hospital Readmissions Reduction Program (HRRP)
- Physician Quality Reporting Initiative
- Federal Coordinated Health Care Office
- State Option to Provide Health Homes for Enrollees with Chronic Conditions
- Medicare Shared Savings Program
Hospital to Home Transitions: Lessons from the Care Transitions Innovation (C-TraIn)

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Yes, American health care is an appallingly patched-together ship, with rotting timbers, water leaking in, mercenaries on board, and fifteen per cent of the passengers thrown over the rails just to keep it afloat. But hundreds of millions of people depend on it...There is no dry-docking health care for a few months, or even for an afternoon, while we rebuild it...If we get things wrong, people will die. This doesn’t mean that ambitious reform is beyond us. But we have to start with what we have.

Gawande A, The New Yorker, 2009
A bridge without a destination is just a plank.
Transitional Care

“A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care”

Coleman EA, Ann Int Med, 2004
Objectives

• Understand transitional care importance and current gaps

• Provide brief overview of interventions
  – Highlight limitations for patients facing homelessness

• Describe local needs assessment and program development

• Suggest strategies for improvement
Medicare rehospitalization within 30 Days after Hospital Discharge

Readmissions Are Common and Costly

Jencks, NEJM 2009
Readmissions: It’s Complicated

- Comorbidities
- Social support
  - Literacy
  - Housing
- Inpatient care quality
- Post discharge care
- Bed supply
Why Are Transitions Hard for Patients?

• Abrupt shift from provider centered care to patient self-management
• Patients are often ill-prepared
  – Patient education is often hurried
  – Pts are ill, social supports may not be present
  – Regimens are complex, little teach-back
• Silos of care
“So all of a sudden I [went] from this controlled setting here with people watching out for me and taking care of me... to, I’m out there in the real world bounding around... and no real place to live as of yet. You know, it’s just like, it’s like a big roll of the dice.”

-Hospitalized Patient
-England, Kansagara; JHM 2012
“We don’t have a community contract where everybody acknowledges their role... ‘my role as the sender is to do these things’, ‘my role as the recipient is to do these things’...the ‘who will’ and ‘how’ of the handoff. We never get close to that sort of formality, which is really what any smart handoff or transition would require.”

Transitions Are Risky

- Adverse drug events
- Delays in diagnosis and treatment
- Poor patient satisfaction
- Potentially preventable readmission
- Bad patient outcomes
Intervention Literature
Large Scale Quality Improvement Initiatives

- Set of tools to optimize discharge planning and cross site communication
- Incorporates best practice insights
- Is smart about implementation
- Not yet rigorously tested
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<tr>
<th>Coleman</th>
<th>Naylor</th>
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<tr>
<td>Older adults at high-risk for readmission</td>
<td>Older adults at high-risk for readmission</td>
<td>Socioeconomically disadvantaged adults</td>
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<td>HMO, single hospital</td>
<td>Two urban academic hospitals</td>
<td>Single urban hospital, MA</td>
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<td>“Health coaching” and home visits</td>
<td>Pt centered d/c planning and home visits</td>
<td>Pt centered d/c planning and phone f/u</td>
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<td>RN</td>
<td>APRN</td>
<td>RN and pharmacist</td>
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<td>ARR 3.6% (30 day), 5.8% (90 day)</td>
<td>ARR 16.8% (6 month)</td>
<td>ARR 5.3% (30 day)</td>
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But...Many Programs Fail

Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries
15 Randomized Trials

Deborah Peikes, PhD
Arnold Chen, MD, MSc
Jennifer Schore, MS, MSW
Randall Brown, PhD

Context  Medicare expenditures of patients with chronic illnesses might be reduced through improvements in care, patient adherence, and communication.
Objective  To determine whether care coordination programs reduced hospitalizations and Medicare expenditures and improved quality of care for chronically ill Medicare beneficiaries.
Lessons from Medicare Demonstration

The successful programs:
1) Had higher rates of in-person contact
2) Targeted high-risk patients
3) Provided better patient education
4) Had excellent cross site communication
National and Local Innovations Are Necessary

- Key issues: communication, patient education, and access
- Interventions thatconcertedly “bridge” the inpatient to outpatient divide may be most promising
- The literature suggests transitions of care are a useful target to improve care and lower costs,
  
  BUT
  
  – The WHAT, HOW, and WHO of the intervention matter
C-TraIN

Uninsured, low-income publicly insured adults at high-risk for readmission

Single urban academic hospital, OR CCO

Transitional care nurse (bridge)
Pharmacy consultation and 30d medications
Medical home linkages
Cross-site system integration

Multidisciplinary complex Health intervention;
includes RN, pharmacist

Outcomes: 30d readmissions, ED use, mortality, CTM-3
Steve’s Story

• 48-year-old uninsured man with untreated sleep apnea who was brought to ED by his father for increasing fatigue, shortness of breath
• Lost job as trucker – couldn’t stay awake
• Subsequently lost housing
Hospital Course

• Emergently intubated
  – 19 day hospitalization in ICU and medicine ward

• Prior OHSU hospitalization:
  – Hypothyroid (TSH 130)
  – Sleep apnea
  – No primary care: given list of low-cost clinics
    • Difficult to navigate complex system, limited safety net capacity
Moving toward Broad System Change

• Health Systems M&M:
  – Social factors play a large role in quality of transitions
  – Early stakeholder engagement

• Needs assessment
  – Local, data driven strategies
  – Continued engagement of broad stakeholder base
Stakeholders

- Clinical staff
  - Physicians (inpatient, outpatient, emergency medicine)
  - Pharmacy (Inpatient, Outpatient, Medication assistance programs)
  - Care Management/ Social Work

- Health System Leadership
  - Hospital administrative leadership
  - Primary Care / safety net clinic leadership
  - Specialty clinic leadership

- Other
  - Medicaid plans
  - Patients
  - Health Systems Researchers
  - Clinical Informatics
  - Hospital Financials – billing, financial screening, admitting

Englander, Kansagara, JGIM 2012
Understanding Patient Needs

- Survey of inpatients (n= 116)
  - Adults (18-64 yo) medicine or cardiology
  - Uninsured, Medicaid, Medicaid-Medicare
- 40 semi-structured interviews
- Cost analysis

Englander, Kansagara, JGIM 2012
Population Needs

• 1/3 of all patients were marginally housed
• >40% had low health literacy
• >50% with co-morbid depression
• 1/3 uninsured patients reported cost as a leading barrier to taking medications as prescribed
  – Patients self-ration medications due to cost
Population Needs

- High cost hospital utilization common
  - >50% reported previous hospitalizations within prior 6 months

- Many lacked usual source of care:
  - 1/3 uninsured and 1/10 Medicaid patients lacked a usual source of care

- Many described that self-management demands were overwhelming
Understanding Provider Views

• 13 focus groups and 2 interviews
• Diverse perspectives including in- and out-patient physicians, nurses, pharmacists, social workers, case managers, administrators, Medicaid managed care organization
• Thematic analysis

Davis, Devoe et al, JGIM 2012
Transitional Care Gaps Reflect Broader System Fragmentation

I felt ridiculous that [while] we could provide intensive care [in the hospital]...[we] couldn't provide any of the outpatient care....We couldn't keep him in the hospital because he didn't have any indication at that point, but I felt like I was not treating the patient correctly.

-Resident physician,
  Davis, Devoe et al, JGIM 2012
Psychosocial Needs and Limited Access to Outpatient Resources
Present Barriers

“We just assume everybody can pay for their meds, or everybody has insurance. And if they don't...there's nobody following up on the other side.”

-Inpatient pharmacist,
Davis, Devoe et al, JGIM 2012
Communication across Settings Is Fragmented

“The package that leaves the hospital now...more often than historically, includes a PICC line, Foley catheter, oxygen--without a plan for when those are to be stopped and without communication to anyone about who's in charge next. Sometimes we end up with [the patients] coming back to see us months after they've been discharged. They've been wearing a Foley catheter all that time! It's amazing the way those balls can get dropped.”

-Primary care provider
Davis, Devoe et al, JGIM 2012
HEALTHCARE SYSTEM FRAGMENTATION

Patient’s complex social needs
Need for training in transitional care

Fragmented communication across settings

HOSPITAL
Lack of standardized processes
Poor multidisciplinary communication
Not anticipatory

OUTPATIENT SETTING
Lack of standardized processes
Limited access to services

CARE TRANSITION
(chaotic, unsystematic)

Poor patient outcomes
Provider futility and dissatisfaction

Figure 1. Healthcare professional views of hospital to home care transitions.
Supporting the Business Case

Estimated >$10,000 savings per avoided readmission among uninsured
Local Needs Assessment + National Transitions Experience

Health System Leadership Support
Local Needs Map to C-Train Components

- **Trouble accessing care; poor social support**
  - Transition care nurse

- **Rx complexity and costs as barriers**
  - Value Based Formulary
  - Pharmacy Consult

- **Many lack usual care**
  - OHSU links with medical homes; coordinates specialty access

- **Social, Geographic Needs**
  - Select strategic clinic partners

- **Health System fragmented**
  - Cross-site Multidisc. meetings
Reflecting Back to Steve’s Story

What would his experience have looked like if C-Train existed in 2008?
C-TraIn Patient Experience

• Care plan that identifies unmet needs
• Targeted education: personal health record
• Home visit (or phonecall) after discharge
• Access to necessary medications
• Close follow-up with a provider who knows what happened in the hospital
• Post-hospital specialty care (30d after discharge)
• Ongoing primary care access
Scaling up through Health Reform

• CCO Expansion beyond OHSU internal medicine to include
  – Surgical patients
  – 3 area hospitals

• Continued efforts on sustainable quality improvement and systems integration
Suggestions for Developing Local Improvements

• Consider broad stakeholder engagement
• Identify local needs and opportunities
• Partner across settings
• Consider local and regional context
• Appeal to leadership!
Questions, Comments?

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Questions & Answers

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