USC Center for Health Financing, Policy and Management
Sol Price School of Public Policy

"Solutions-Oriented Approaches to Improving Healthcare for Older Adults"

Effectiveness. Efficiency. Engagement.

CONFERENCE PRESENTATION SUMMARIES
June 20, 2013—RAND Corporation

Early Identification + Reduction of Patient Risk: The Cedars-Sinai Medical Center Frail Elders Program

- **Harriet Aronow, Ph.D., Research Scientist, Nursing, Cedars-Sinai**
- **Jeff Borenstein, M.D., Medical Director Applied Health Services Research, Cedars-Sinai Medical Center**

As the population ages and more people survive life-threatening illness/injury, the burden of chronic illness and/or disability is growing. There is a strong association between chronic illness and activity limitation, which increases patients' risk when hospitalized and can lead to adverse medical events and longer hospital stays. At Cedars-Sinai Medical Center, where more than 40% of medical-surgical patients are over 65 years of age, the issue of proactively addressing frailty in elders has come to the forefront. As part of CSMC's quality improvement efforts, an inter-professional team began working to improve patient outcomes by identifying at-risk older adults and proactively implementing preventive care plans. Methodologically, frailty risk factors were derived from the literature and a rigorous team consensus process, supplemented with patient interviews and chart reviews of 200+ elderly patients. A set of patient characteristics likely to place patients at risk were identified and clustered around adverse outcomes; e.g., hospital-inquired infections or pressure ulcers, falls, procedure complications, and readmission. Results suggested there is no "uniform theory" of frailty. Outcomes clustered and different risk factors were associated with different clusters of outcomes. However, initial work pointed to the importance of multi-dimensional assessment and prompt response. Assessment within 24 hours of admission was of the essence. The goal then became focusing and improving the process to target individual risk factors that placed patients at high risk for adverse medical events and 30-day readmissions. The work group intervention design included: early identification, inter-professional assessment, huddle, care plan communication, and follow-up/hand over. Patients initially are assessed by nurses, the primary caregivers and a focal point for interdisciplinary care, using the Fulmer SPICES criteria and further assessed by a geriatric nurse, a social worker, a pharmacist, and a physician. The care team members then huddle to create a care plan that is communicated to attending physicians, as well as any continuing care providers. Patients who underwent this intervention experienced an average of 1.7 fewer days in their lengths of stay compared with a control group. The team at Cedars-Sinai is interested in further testing the approach, as well as determining ways to further engage internal stakeholders, streamlining processes, and implementing post-acute frailty plans.

Improving Care Transitions: Readmission Root Cause Analysis (RRCA) Approach, Insights + Lessons Learned

- **Mari Zag, Administrative Director, Managed Care, Facey Medical Foundation**

Readmission Root Cause Analysis (RRCA) was a major focus of activity within Facey Medical Foundation's recent Care Transitions project. During the period October 2011 – January 31, 2013, Facey Medical Foundation and Facey Medical Group designed and launched in-person interviews of 266 patients readmitted within 30 days or less post-hospital discharge to Providence Holy Cross Medical Center (PHCMC), a primary network hospital with the group's highest daily census. Readmission interviews with patients/caregivers were administered by a nurse practitioner. A readmit chart record review was conducted by the nurse case manager and a PCP/hospitalist/hospital case manager completed a readmission interview tool. All results were entered into a web-based secure data base designed by Facey. An interdisciplinary RRCA Committee met biweekly to review cases and data, and then shared the feedback with the patient's provider and associated care team. Subjective evidence from patients, caregivers and the medical team, coupled with demographic and utilization data in Facey's HMO population, led to identification of opportunities to close care gaps, improve transitions communication, and develop safe and effective care alternatives to the ER and hospital. The RRCA stimulated multiple Care Transitions interventions, including: increased referrals for home visits and post-discharge Annual Wellness home visits for seniors; increased use of discharge checklists; patient alerts implemented in EHR for hospice diagnoses, advance directives and POLST; and implementation of multiple training activities (e.g., teach back) for the care management team.

Chronic Conditions in Older Adults: Interventions for Physical Activity and Self-management

- **Huong Nguyen, RN, Ph.D., Research Scientist, Kaiser Permanente Southern California**

The Chronic Care Model encompasses a variety of structures to improve outcomes for patients with chronic conditions. One of these structures, self-management support, can be a cost-effective way to help patients gain the skills and confidence to manage their chronic condition outside of the traditional healthcare system. Dr. Huong Nguyen, a research scientist at Kaiser Permanente, recently studied how patients with chronic obstructive pulmonary disease (COPD) can use self-management techniques to increase exercise and to desensitize their reaction to dyspnea, or shortness of breath. COPD patients often experience anxiety upon moderate exertion, which can lead to decreasing exercise and result in further physical deconditioning, social isolation and depression. The study included three treatment arms: 1) electronic dyspnea self-management, 2) face-to-face dyspnea self-management, and 3) general health education. The electronic treatment arm included a variety of components such as use of mobile technology, collaborative monitoring, educational modules, and text chatting. After 12 months, the study showed no difference in the experience of dyspnea with activities, but there were improvements in self-efficacy and the duration of participants' exercise. In the case of increasing exercise duration, both self-management treatments resulted in significantly better outcomes, compared to the general health education treatment. Ultimately, however, more than half (52%) of all patients surveyed reported that being "too busy" was the primary reason they did not exercise, suggesting the importance of continuing to explore self-management strategies to assist COPD patients in managing this chronic condition.

Patient Activation + Engagement: Implementing Diabetes Group Appointments

- **Janelle Howe, Director, Disease Management, HealthCare Partners Medical Group**
- **Aurora Galindo-Simental, Health Educator, HealthCare Partners**

HealthCare Partners Medical Group (HCP) serves a significant diabetic patient population, one that increased by 11% from 2010-11. In an effort to support those whose diabetes was not under control, HCP implemented diabetes group appointments (DGAs) and tested a P4P4P (pay for performance for patients) incentive, alongside a non-incentive DGA option, to determine how the use of financial incentives could compare with non-incentives in improving patients' glycemic control. A study sample of HCP's diabetic population, excluding those with type 1 diabetes, gestational diabetes, or dementia, was randomized to receive one of three treatments: DGA with incentives, DGA with no incentives, or a control group receiving usual care (i.e., health enhancement classes, one-on-one interaction with a nurse or diabetes educator, and consultation with an endocrinologist as needed). Patients in the DGA groups were invited by mail, called and registered to participate in the nine-session DGA series, and reminded several days prior. The DGAs were held monthly for 2.5 hours with 10-14 participants, in English or Spanish depending on the population. Caregivers/family members were also invited to participate. At the first and every third appointment, blood was drawn to check the Hemoglobin A1c and LDL levels. Patients received a podiatry exam, repeated every six months. Weight, blood pressure, and fasting blood glucose were measured and a depression inventory was administered monthly. At every appointment, patients received a healthy breakfast demonstration, and participated in a "conversation map" curriculum. They engaged in one-on-one conversation with a nurse or diabetes educator, received comments from a doctor, developed a patient action plan, shared their experiences with other DGA participants. Patient satisfaction and patient engagement surveys were administered each time to determine how to improve the sessions, as well as their degree of self-mastery with the disease. Incentives were offered for attending the first session, and for every 0.5 reduction in HbA1c level. There was also a lottery at each session, and patients received a gift basket when they their HbA1c levels achieved goal: below 7% (or below 8% if over 65). Preliminary results of the 18-DGAs study in locations across Southern California suggest that both types of DGAs are leading to reductions in patient LDL and HbA1c levels, but are inconclusive as to whether either the non-incentive or incentive DGAs has a greater effect. The study continues until December 31, 2013. The presenters shared information regarding DGA costs and challenges confronted in implementing diabetes group appointments that are instructive for organizations considering DGAs as a diabetes intervention.

The USC Center for Health Financing, Policy and Management gratefully acknowledges the generous support of the **SCAN Health Plan® Community Giving Program** in underwriting this conference as part of the "Improving Healthcare for Older Adults" project. Special thanks to our project collaborator, the **HealthCare Partners Institute for Applied Research and Education.**