

Coaching patients to keep them from returning to the hospital

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By **Arielle Levin Becker**

NEW BRITAIN--If you end up in The Hospital of Central Connecticut, you might meet Joyce Kolpa and Tamara Johnson. They'll visit you after you go home, make a couple follow up calls, even role play if it will help you be a better patient--all with the goal of keeping you from coming back.

Patients leaving hospitals routinely get instructions on how to take care of themselves. But increasingly, health care providers are realizing that a few minutes of guidance aren't enough.



Care Transition Coaches Tamara Johnson (left) and Joyce Kolpa

That's where Kolpa and Johnson come in. They're "care transition coaches," charged with identifying the underlying issues that keep patients from effectively managing their health, and helping patients address them. Kolpa is a registered nurse and Johnson is a social worker, but they're also experts in the gaps that bedevil the health care system.

The potential glitches are seemingly endless. A patient might not understand the hurried instructions she gets just before leaving the hospital. Maybe the handwriting on the discharge instruction form is illegible. Or the patient is afraid to call the doctor, doesn't know what medications he should be taking, or can't afford the drugs. Maybe the patient was supposed to go back to the doctor within days of discharge but could only get an appointment several weeks later. Or the patient has the right appointment date, but no ride to get there.

For patients wary of calling the doctor, Kolpa and Johnson--who work for Bristol-based Connecticut Community Care, Inc., and whose work is funded through a federal grant--will try role playing to make them more comfortable. They have patients write out a list of their medications and make sure they know how and when to take them. They have patients set goals--walk further, take a trip to Florida--that can motivate them to manage their conditions.

"What we're doing now is really recognizing that we need to do a better job of teaching patients how to manage their own chronic care," said Shelley Dietz, director of care coordination at The Hospital of Central Connecticut.

The stakes are not inconsequential. Patients who don't have a handle on their medications after leaving the hospital, or who don't see a doctor soon after discharge, are at risk of ending up back in the hospital. Potentially preventable readmissions account for about **\$12 billion** in annual Medicare spending, according to the Medicare Payment Advisory Commission, which advises Congress on Medicare policy, and they're a major target of federal efforts to improve the health care system. Beginning next fall, Medicare will **penalize** hospitals with higher-than-expected readmission rates.

Connecting the dots

There are many discrete parts of the health care system that function reasonably well on their own. But the links between them are often problematic, and for patients, moving from one setting to another can be perilous.

Many of the coming changes in health care are focused on reducing fragmentation, addressing the gaps that patients can easily fall into. The increasing use of electronic medical records, and the developing infrastructure that will allow them to be shared by all the providers who see a patient, is expected to help. Other models of care also emphasize coordination, including the patient-centered medical home, which the state is piloting for employees and is expected to expand widely for Medicaid patients beginning next year.

The focus on reducing readmissions has led hospitals to step up their **coordination** with other types of care, such as visiting nurses, home care agencies and nursing facilities/rehab facilities.

Typically, patients leaving hospitals have received about 7 to 8 minutes of discharge instructions just before leaving, Dietz said.

"That's just not the way," she said. "Because things are busier, hospitals have gotten busier, patients are sicker, and a lot more of the care that's given in terms of education occurs within the community."

Dietz likened patients getting a quick battery of discharge instructions to someone like herself sitting in a work meeting where colleagues use technology jargon. If someone asks if she understands, Dietz said, she might say "oh sure," even if she doesn't, because she doesn't want to look dumb.

A better way to give patients information, she said, is through a method called "teach back," talking to patients in terms they understand and breaking information down into easily understandable pieces. Then patients have to teach the material back to the person who told it, making clear how much the patient understood.

"It's really the right way to go when you're teaching patients," she said.

Understanding the barriers

Kolpa and Johnson use a model called Care Transitions Intervention, developed by Dr. Eric Coleman, a professor of medicine at the University of Colorado Denver, to ensure continuity of care between settings.

They work with patients who have congestive heart failure, diabetes or bacterial pneumonia, meeting them in the hospital, visiting them at home and following up with phone calls.

The program aims to get patients to take more responsibility for their health and give them the tools to do it. As coaches, part of Kolpa and Johnson's job is to make sure that patients know how to manage their medications, have access to a personal health record, follow up with their primary care doctors and specialists, and know the red flags that signal their conditions are getting worse.

They can also provide feedback to the hospital, as they did when one of Kolpa's patients went home with a medication reconciliation that was so illegible the patient's pharmacist couldn't tell what drugs were being prescribed. Kolpa brought it back to the hospital. The hospital is now redesigning the forms.

Kolpa and Johnson began in July 2010. One challenge: Getting people to accept the service. Some scam-wary patients were suspicious of people offering a free service that included home visits. Others said they had other in-home services, didn't have the time, or--particularly among younger patients, Kolpa said--didn't need any help.

Since July 2010, more than 500 patients have been screened for the program, and just over 100 have participated.

The success is measured in 30-day readmission rates, and so far, it has exceeded its goal of reducing readmission rates by 2 percentage points, although since the program is voluntary, comparing those who choose to participate with all patients in the hospital is an uneven measure. Among patients with congestive heart failure, 2.6 percent have been readmitted within 30 days; before the program started, the hospital's rate was 26.7 percent. One of the six patients with diabetes has been readmitted, while none of the 20 patients with bacterial pneumonia were.

They also keep data on the barriers patients face so they can report to the state and federal government about systemic problems. Those include cognitive issues, financial problems, a lack of transportation, and difficulty accessing the supports that make it possible to live in the community, like getting meals or finding home health aides.

"There's a huge workforce issue in regards to home care, and we are finding that that does impact as well," said Dan Flynn, the project lead.

In addition, he said, some patients aren't actively playing a role in taking care of their health.

"The system doesn't engage them. It just tells them what to do," Flynn said. "Either you do it or you don't, and if they don't, there's really limited consequences for them." One consequence might be returning to the hospital, but Flynn said many patients who return frequently are used to getting treated and discharged again.

Having patients set goals is one way Johnson and Kolpa try to get them engaged. Some choose health-related targets--to quit smoking, lose weight, or be able to walk further than they can now.

Others are less directly related to health, but require it nonetheless. Johnson worked with a woman with heart failure who wanted to take a trip to Florida that she'd been planning for a decade. To be able to go, she had to begin weighing herself to monitor for fluid retention--a sign of problems for heart failure patients--recording the weight, and calling the doctor if she gained too much. She stayed out of the hospital, and made it to Florida.

Another man who spent time in a nursing home before he got home wanted to return to the nursing home at Christmastime, wearing his Santa hat, to pass out candies. Johnson said she can use that to motivate him, telling him, "You want to visit that nursing home, you've got to stay with the diet, keep on weighing yourself."

"How much more motivating is that for an individual than us to say, 'Your goal is that you're going to lose five pounds and you're not going to eat that ham steak?'" Flynn said.

(Not that all the goals are realistic. Kolpa recalled one man who told her his goal was to play on a professional hockey team: "I said to him, 'Well, you'll need to learn to skate first.'")

The federal grant goes through the end of next September. Connecticut Community Care and Qualidigm, which works with hospitals to reduce readmissions, are seeking federal funding to expand similar services statewide.

"It's just a good feeling that you know that you helped somebody," Kolpa said, "And that hopefully they're not going to be back."