Sharp HospiceCare’s Transitions Program

A New Model for Late-Stage Disease Management

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Organization Snapshot

• Headquartered in San Diego, California
• Facilities located throughout San Diego and surrounding area
• 14,000 employees and 4,900 nurses

Ownership of the Care Continuum

• Seven acute-care hospitals
• Two medical groups with 370 physician clinics
• Three skilled nursing facilities
• Four long-term care facilities
• Home care and hospice services
• Health plan covering 120,000 members

• 2007 Malcolm Baldrige National Quality Award
• Planetree Patient-Centered Hospital designations at two hospitals
• ANCC Magnet recognition at two hospitals
• American Hospital Association’s “Circle of Life” Award 2012
Principles of *Transitions*

- Proactive In-home Disease Management
- Proactive Psychosocial Management
- Accurate description of what the health care industry can provide
Expanding the Care Continuum

- Home setting
- Focus on high-risk, late-stage chronic illnesses
- Skilled clinicians
- Flexible models
- Cost-efficient
Four Pillars of Transitions

Extending the evidence based benefits of hospice care to patients at an earlier point in their health care.

1. Comprehensive in-home patient and family education about their disease process; proactive medical management
2. Evidence-based prognostication
3. Professional proactive management of the caregiver
4. Advance health care planning
Pillar One: In-home Proactive Disease Management

Registered Nurse
Medical Social Worker
Spiritual Care
Primary Care MD
Palliative Care MD
Pillar Two: Evidenced-Based Medical Prognostication

1. 343 doctors
2. Estimates on 468 terminally ill patients
3. Mean patient survival: 24 days
4. Considered accurate if estimate within 33% for any given patient
5. 20% of the time accurate
   a) 80% of the time inaccurate
   b) 63% over-optimistic

British Medical Journal; Extent and Determinants of Error in Doctors Prognoses in Terminally Ill patients; Prospective Cohort Study; Vol 320(7233), 19 Feb 2000 pp.469-473.
The Clinical Consequences of Institutionalized Over-optimism
(Pillar Two continued)

6. The average over-optimistic estimate was off by 530%
   a. Increases the risk that treatment decisions by patients, families and health care providers are NOT consistent with reality
   b. Leaves patients and families emotionally unready for inevitable outcomes
   c. Increase risk that providers will lose credibility

*British Medical Journal; Extent and Determinants of Error in Doctors Prognoses in Terminally Ill patients; Prospective Cohort Study; Vol 320(7233), 19 Feb 2000 pp.469-473.*
Pillar Three: Professional Evidence-Based Care for the Caregiver

Evidence-based medicine: Hospice care is associated with an absolute reduction in death rates in the caregiver at 18 months post death of the patient of 0.5% (1 in 200)

Pillar Four: Advance Health Care Planning

Evidence-based medicine shows that AHCDs (which would include POLST) do not consistently match the health care desired by the patient with the care received by the patient.
Problems with Advance Health Care Directives

- They are not disease specific
- They are too vague or contradictory to be interpreted in the context of the care that is being provided

Resolve Morale Conflict Proactively
Issues Important in the Management of a Pre-terminal Aging Population

- Mobility Deficit
- Transportation Deficit
- Financial Restraint
- Social Support/Family Deficit
- Cognitive Deficit
- Compliance Deficit
- Change in Goals of Care
What *Transitions* does not do ...

- We do not prevent or discourage the patient from seeing their cardiologists or PCPs
- We do not prevent or discourage state-of-the-art cardiology therapies or interventions
- We do not discourage hospitalizations
- We do not "take over" the medical management of the patient
Key Performance Indicators

- Reduction of hospitalizations/ED visits
- Completion of advance health care plan
- Timely referral to hospice
- System cost savings
- Patient/family satisfaction
Transitions – Interventions

• To educate patient/family
  – Disease process
  – Early symptom recognition
  – Medication management
  – Dietary considerations
• To facilitate the development of a long term care plan that aligns with patient goals of care
• To improve care coordination between PCP/Specialist and patient/family
• To improve the end-of-life care by creating the option for the hospice pathway
Transitions – Staffing Components

- Referral and Intake
- Registered Nurse
- Medical Social Worker
- Physician
  - Attending
  - Palliative Care
Transitions – Staffing Model

- **RN Case Manager**
  - 1 FTE per 50-60 patients
    - 8-10 active; remainder in maintenance

- **Medical Social Worker**
  - 0.5 FTE per 100-120 patients

- **Palliative Care Physician**
  - Ongoing oversight and consultation
  - Participates in monthly IDT’s

- **Referral and Intake (LVN)**
  - 0.8 FTE
Transitions – Case Management Design

- Active Phase
- Maintenance Phase
- Role of Hospice
  - 24-hour call availability
  - Full integration and hand offs between programs
Transitions –
Active Phase

RN Case Manager
- 4-6 visits in 6-week time frame

MSW
- 1-2 visits for goals of care discussion; completion of POLST
Transitions – Maintenance Phase

RN Case Manager

- Telephonic case management – every 2-4 weeks until transferred to hospice
- Home visits as needed for assessment
- Coordinate care with MD ongoing
- Transfer to hospice when appropriate
Hospitalization ER Utilization

57% reduction

54% reduction

ED visits
Admissions
Total count for discharge HF patients (n=155) 2009-2010
Cost of Care

Average total cost of care

- Pre-Transitions: $50,000
- During Transitions: $25,000

43% reduction
## Transition patient demographics

(patients with primary diagnosis of heart failure, discharged from Transitions between 2008-2010)

<table>
<thead>
<tr>
<th>Total N</th>
<th>155</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age on enrollment</td>
<td>84</td>
</tr>
<tr>
<td>Average LOS in Transitions</td>
<td>165 days</td>
</tr>
</tbody>
</table>

**Reasons for Discharge**

<table>
<thead>
<tr>
<th>Reason</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer to Hospice</td>
<td>116</td>
<td>74.8%</td>
</tr>
<tr>
<td>Death at Home</td>
<td>8</td>
<td>5.2%</td>
</tr>
<tr>
<td>Death in a Facility</td>
<td>9</td>
<td>5.8%</td>
</tr>
<tr>
<td>No Further Care Needed</td>
<td>3</td>
<td>1.9%</td>
</tr>
<tr>
<td>Moved From Service Area</td>
<td>1</td>
<td>0.65%</td>
</tr>
<tr>
<td>Discharged: Other</td>
<td>18</td>
<td>11.6%</td>
</tr>
<tr>
<td>Percent VERY satisfied</td>
<td>CHF</td>
<td>COPD</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>1. The extent to which you were taught to manage your medications and symptoms related to your diagnosis</td>
<td>76%</td>
<td>75%</td>
</tr>
<tr>
<td>2. The education you received regarding contacting the Transitions team at any time for assistance in managing your symptoms</td>
<td>75%</td>
<td>88%</td>
</tr>
<tr>
<td>3. The assistance you received with long term care planning and advanced directives</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>4. Improvement in your quality of life</td>
<td>69%</td>
<td>57%</td>
</tr>
<tr>
<td>5. Assistance received from the nurse or medical social worker when problems occurred</td>
<td>69%</td>
<td>75%</td>
</tr>
<tr>
<td>6. Likelihood of recommending the Sharp Transitions Program to others for managing advanced chronic illness</td>
<td>78%</td>
<td>100%</td>
</tr>
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