Sharp HospiceCare's *Transitions Program*

A New Model for Late-Stage Disease Management

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Organization Snapshot

- Headquartered in San Diego, California
- Facilites 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

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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

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Four Pillars of *Transitions*

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

- Comprehensive in-home patient and family education about their disease process; proactive medical management
- Evidence-based prognostication
- Professional proactive management of the caregiver
- Advance health care planning

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Pillar One:
In-home Proactive Disease Management

Registered Nurse

Medical Social Worker

Spiritual Care

Primary Care MD

Palliative Care MD

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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 give 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.

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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)

Nicholas Christakis, et al, *The Health Impact of Health Care on Families: A Matched Cohort Study of Hospice Use by Decedents and Mortality Outcomes in Surviving, Widowed Spouses,* Social Science and Medicine 2003, vol57 pp.465-475.

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

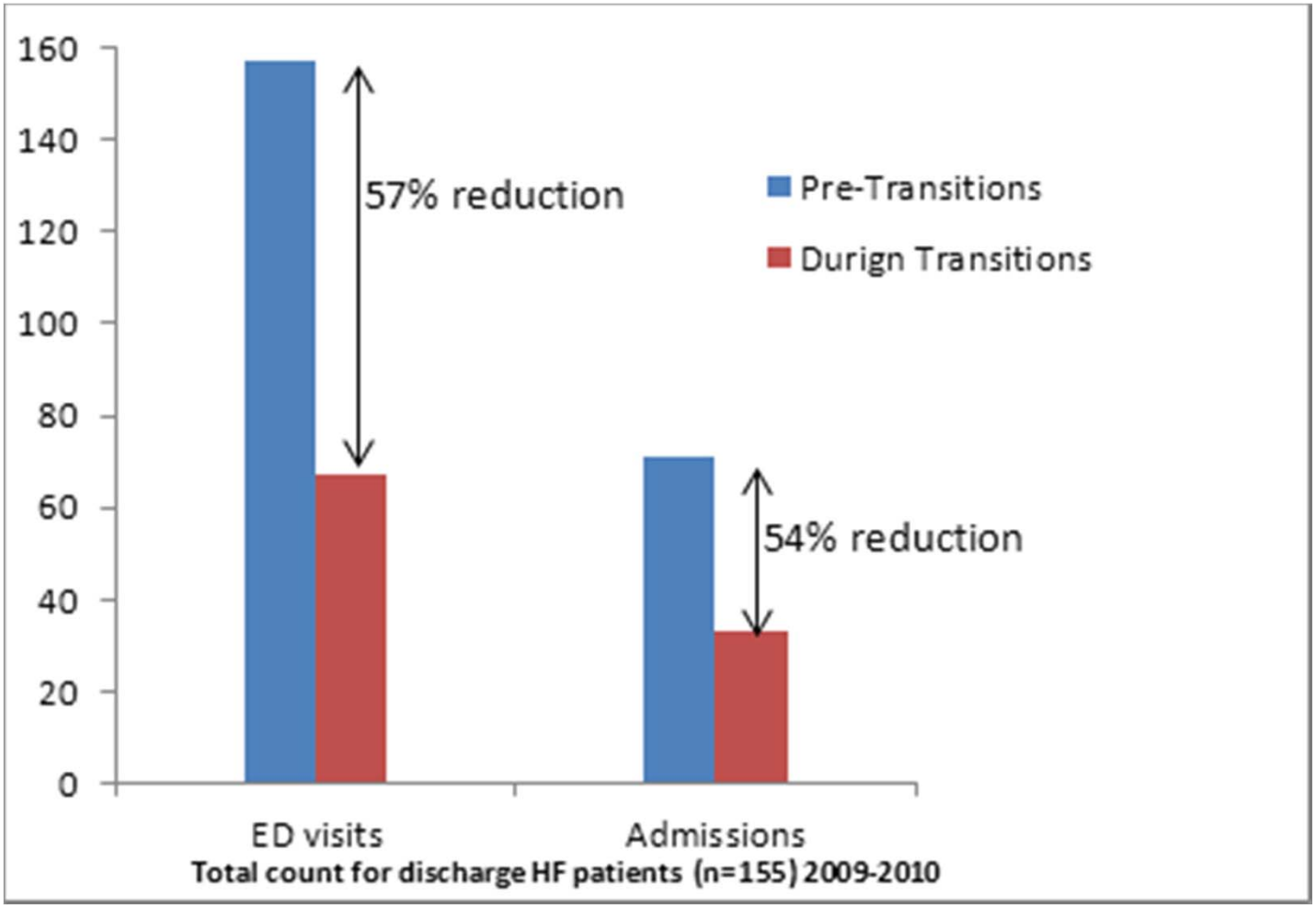
- 1-2 visits for goals of care discussion; completion of POLST

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



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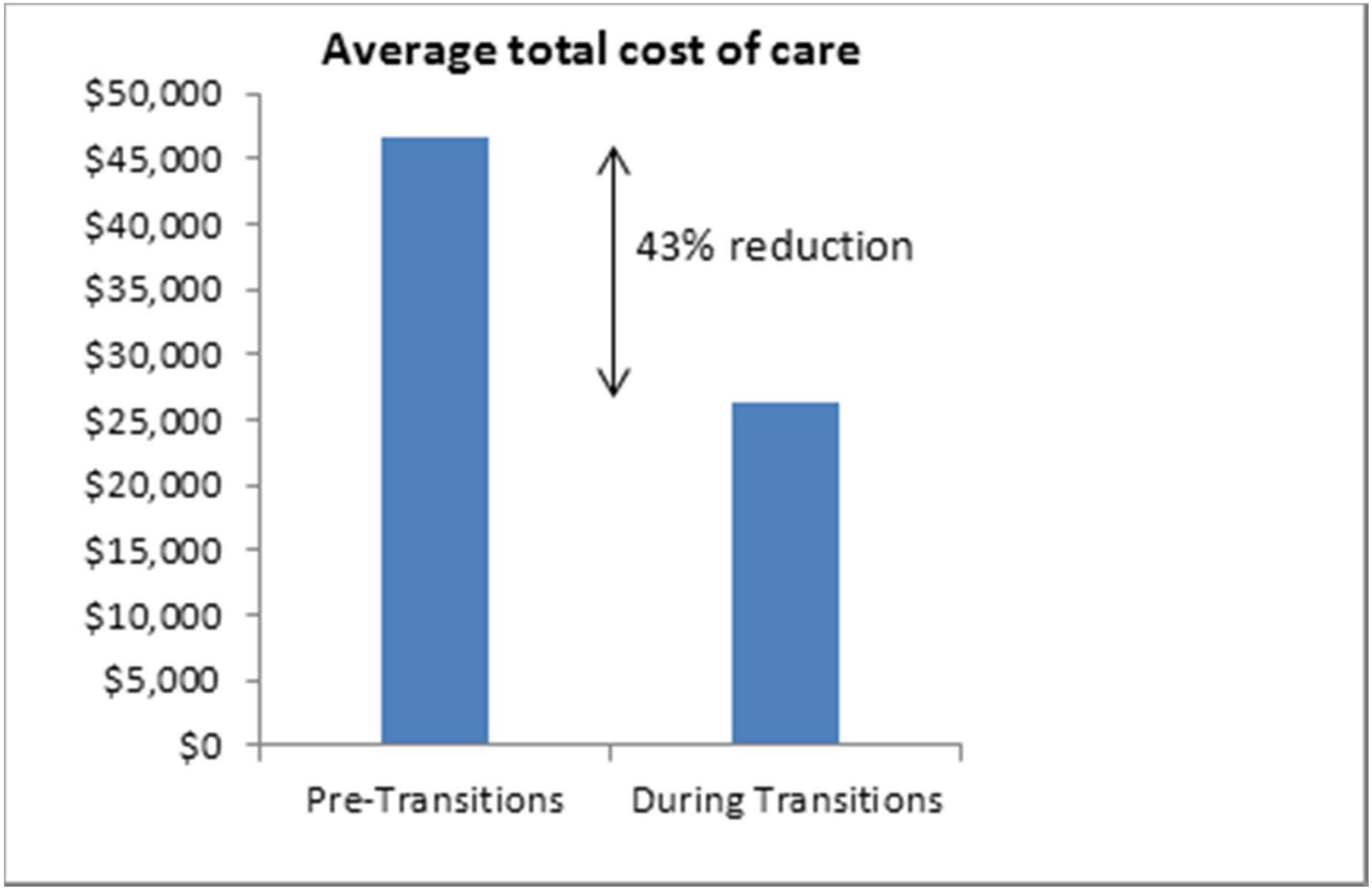
Cost of Care



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Transition patient demographics (patients with primary diagnosis of heart failure, discharged from Transitions between 2008-2010)		
Total N	155	
Age on enrollment	84	Range: 45 – 102
Average LOS in Transitions	165 days	Range: 2 – 726
Reasons for Discharge		
Transfer to Hospice	116	74.8%
Death at Home	8	5.2%
Death in a Facility	9	5.8%
No Further Care Needed	3	1.9%
Moved From Service Area	1	0.65%
Discharged: Other	18	11.6%

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Patient Family Satisfaction *Transitions* FY2011

Percent VERY satisfied	CHF	COPD	Dementia	Overall
1. The extent to which you were taught to manage your medications and symptoms related to your diagnosis	76%	75%	88%	79%
2. The education you received regarding contacting the *Transitions* team at any time for assistance in managing your symptoms	75%	88%	90%	82%
3. The assistance you received with long term care planning and advanced directives	81%	86%	88%	84%
4. Improvement in your quality of life	69%	57%	89%	72%
5. Assistance received from the nurse or medical social worker when problems occurred	69%	75%	82%	74%
6. Likelihood of recommending the Sharp *Transitions* Program to others for managing advanced chronic illness	78%	100%	91%	86%

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