

# UPMC McKeesport

## Annual Progress Report: 2009 Formula Grant

### Reporting Period

January 1, 2010 – June 30, 2010

### Formula Grant Overview

The UPMC McKeesport received \$48,585 in formula funds for the grant award period January 1, 2010 through December 31, 2011. Accomplishments for the reporting period are described below.

### Research Project 1: Project Title and Purpose

*Transitional Care Coaching Intervention in Medicare Patients in a Medically Underserved Community* - This project will assess the effectiveness of a transitional care coach focused on Medicare patients. The goal of the transitional care coach is to reduce hospital re-admissions in this population. While previous studies elsewhere have demonstrated effectiveness in reducing re-admissions in general populations, it is unknown if there are differences in re-admission rates relative to underserved individuals. UPMC McKeesport serves areas in the county region that have higher than state and county averages for elderly populations as well as for minorities and those of low socio-economic status. Should the data reveal a positive outcome relative to re-admission rates, it will assist in determining decisions to implement a transitional care coach program for the broader population to improve health outcomes and reduce the financial burden of patients as well as for hospital administration.

### Anticipated Duration of Project

1/1/2010 - 12/31/2011

### Project Overview

UPMC McKeesport is a community hospital in Western Pennsylvania serving a diverse population with higher than state and county averages of elderly, minorities and those of low socio-economic status. Early in 2010 we will pilot the use of a transition care coach in partnership with Quality Insights of Pennsylvania (QIP) in an effort to reduce the hospital re-admission rates in elderly patients. While the QIP initiative has been demonstrated to effect reduction in re-admissions, there is little data on the success of this program relative to elderly populations in a small community setting. We plan to measure rates of re-admission pre and post implementation of the program as well as measure effectiveness of the transition coach with regard to minority and low socio-economic status participants in the QIP program compared to a control group of non-participants.

## **Principal Investigator**

Doris Gaudy, RN MS NEA-BC  
Principal Investigator  
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## **Other Participating Researchers**

Barbara Klewien, BS; Hilary Spell – employed by UPMC McKeesport

## **Expected Research Outcomes and Benefits**

We expect a reduction in the hospital re-admission rates in pre and post program implementation as well as a reduction of re-admission rates in minorities and persons of low socio-economic status within the program relative to a control group. The benefits of having access to a transition care coach will provide a higher degree of personalized patient care after a patient is discharged compared to those who do not receive the coaching. Coaching will provide transition to care communication with the patient or patient support cadres as well as with destination health professionals such as nursing homes, that will address post discharge issues related to patient status, medication management and follow up care. Those individuals who do not receive such ongoing support and communication are more likely to struggle with post discharge instructions and indications resulting in deteriorating health conditions which may result in re-admission to the hospital. Reduction of re-admission rates will benefit the patients' health outcomes, care providers in-hospital and external care providers as well as result in decreasing costs to the patient and the Medicare payment system.

## **Summary of Research Completed**

Work on the project commenced in January with the principal investigator initiating steps to establish data collection forms and methods along with a tracking mechanism for reporting purposes. We have developed a referral document to be implemented by social work staff for initiating appropriate referrals to the Transition Care Coach. This form, Care Transitions Coach Referral form, details inclusion criteria based on insurance type (to determine low socioeconomic status i.e. Medicaid), zip code, discharge destination, diagnosis and patient demeanor (i.e. alert and oriented). Data will be entered into a Microsoft Excel spread sheet that was drafted early in June.

Patients will be accrued to the program with the goal of decreasing readmissions. There are no reports available indicating this particular approach is successful in the community setting, and it is the goal of this project to analyze the effect of a transition coach intervention as it relates to hospital readmissions.

The Care Transition Coach was hired June 1 and immediately began orientation and training. We originally anticipated an earlier hire date for the coach, however, after review of the proposed

timeline indicated in the original proposal, it has been determined that this later hire will not impact the planned milestones.

Since this project will focus on intervention analysis, the scheduled implementation of the clinical program of note will provide pre and post intervention data. Patients will begin to be referred, interviewed and accrued around mid-July.