

UPMC McKeesport

Annual Progress Report: 2009 Formula Grant

Reporting Period

July 1, 2010 – June 30, 2011

Formula Grant Overview

The UPMC McKeesport received \$48,585 in formula funds for the grant award period January 1, 2010 through June 30, 2012. 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 – 6/30/2012

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

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Other Participating Researchers

Barbara Klewien, BS; Candace Aiken – 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

Unfortunately we have experienced a key staffing change that has heavily impacted our data collection. Our initial hire for the transition care coach position terminated her employment shortly after orientation and we did not succeed in hiring a replacement for three months - late Fall of 2010. Another orientation period ensued and data collection began in earnest early in 2011.

General activities for the transition care coach include working with a social worker to identify potential patients. She then speaks with patients to ascertain if they would like to accept the care coach. If so, she visits them in their home within a few days of discharge. She spends time with them reconciling medication orders, helping to ensure they have a timely physician follow up visit, helps them understand the warning signs of a worsening condition and helps them complete a personal health record. She also provides information regarding advance directives. This is followed by three follow up phone calls over the course of 1 month to reinforce the above. Ultimate goal is to prevent readmission. The coach usually works with 6-8 patients at a given time.

Data collection has begun using Microsoft Excel worksheets as proposed. Review of the sheets from month to month revealed some reporting inconsistencies that will be addressed immediately. The nature of these inconsistencies are minor at this early stage, i.e. spelling out “accepted” as opposed to using “A”. The project coordinator will work with the team to correct this to avoid future data cleaning efforts and this will enable efficient and seamless transition of all data to the analyst.

The principal investigator holds weekly update meetings to review data collection and monitor progress and trends emerging with the coach intervention. These meetings are valuable tools that provide important stabilizing effects on the team.