Conversations Across the Discharge Divide
Home Health Quality Improvement National Campaign

January 20, 2011

Luke Hansen, MD, MHS - Instructor, Feinberg School of Medicine
Robert Young, MD – Post-doctoral Fellow, Feinberg School of Medicine
Jessica Soos Pawlowski, LCSW - Manager, Dept. of Case Management at Northwestern Memorial Hospital

Outline for presentation

- To review the evidence on risks at the time of transition from hospital to home and interventions tested to address these risks
- To review the evidence on risks at the time of transition from hospital to skilled nursing facility
- To describe the role the care facilitators can play in reducing fragmentation of an individualized care plan at the time of care transition

Health Expenditures as a Percentage of Gross Domestic Product, 1960–2020

Data: Centers for Medicare and Medicaid Services, The Lewin Group.
Health reform legislation and Incentivizing better transitions of care

“Beginning 2013, [Affordable Care Act(ACA)] imposes penalties on hospitals for so-called ‘excess’ readmissions based on ‘expected’ 30-day readmission rates for heart attack, heart failure, and pneumonia.”

PPACA, 2010, Section 3025

Starts in FY ’13 based on FY ’12 (starts Oct ’11). Payments for all Medicare patients will be reduced by up to 1% and increase to 3% by 2015, at which time COPD, CABG, PCI and others will be added.

The Dangers of Discharge

The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

Alan J. Forster, Heather B. Clark, Alex Mecred, Natalie Dupuis, Robert Charland, Natasha Chomick, patch Kirt, Carl van Walraven.

- 23% of patients had a post discharge AE
- 1/3 preventable and 1/3 ameliorable
- 28% preventable and 22% ameliorable
- 72% were medication related
Communication deficits at hospital discharge are common:
- Direct communication 3-20%
- Discharge summary availability at 1st post-discharge appointment 12-34%; 51-77% at 4 weeks
- Discharge summaries often lack information
  - Dx test results (33-63%), hospital course (7-22%), discharge meds (2-40%), pending test results (85%)
  - Follow-up plans (2-43%), counseling (90-92%)


Types of interventions:

Before discharge:
- Patient education
- Discharge Planning
- Med Reconciliation

After discharge:
- Follow-up call
- Timely PCP eval
- Home visit

Interventions connecting the inpatient and outpatient setting:
- Patient-centered discharge instructions (e.g. Project RED)
- Transition Coaches and Nurse Discharge Advocates (e.g. CTI)
### Home Visits


- **Coleman EA, Parry C, Chalmers S, Min SJ.** The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. Sep 25 2006;166(17):1822-1828. 3.6 (S)


### Nurse Discharge Advocates


- **Parry C, Min SJ, Chugh A, Chalmers S, Coleman EA.** Further application of the care transitions intervention: results of a randomized controlled trial conducted in a fee-for-service setting. Home Health Care Serv Q. Apr 2009;28(2):84-99. 9.9 (NS)

- **Coleman EA, Parry C, Chalmers S, Min SJ.** The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. Sep 25 2006;166(17):1822-1828. 3.6 (S)


### Project BOOST: Better Outcomes for Older Adults through Safe Transitions
BOOST Tools

Technical Support
- Mentors
- Teleconferences
- Education (webinars, newsletters)
- Enduring Materials (Teachback DVD)

Peer Support
- Listserv
- Document sharing
- Moral support

Boost Toolkit
- freely available pdf

BOOST toolkit: Principal components

Tool for Identification of High-Risk Patients
- 7 P's: Principal dx (CA, DM, COPD, CHF, CVA), problem meds, polypharmacy, poor health literacy, patient support lacking, psych, prior hospitalizations

Tools for identifying barriers to safe discharge follow up and proactive management
- GAP assessment, Discharge checklist

Patient and Family/Caregiver Preparation, teachback, patient friendly summary
- Multidisciplinary, requires work flow and culture change

Discharge Summary Communication
Accountable Care Organization (ACO) Model

Conversations Across the Discharge Divide

QUESTION AND ANSWER
Conversations Across the Discharge Divide

Jessica Soos Pawlowski, LCSW
Manager, Department of Case Management Northwestern Memorial Hospital

Objectives

- Assess current Case Management practice in context of Healthcare Reform
- Contrast current state practice with future state practice
- Discuss role of Home Health Agencies in future state practice

Case Management Models

- Various names and titles
- Integrated vs Collaborative
- Focus is on inpatient discharge planning/moving patients to the next level of care
Current Process Flow for Inpatient Discharge Planning

- Patient Admitted
- Interdisciplinary Team develops discharge plan
- Discharge plan presented to patient
- Barriers identified
- Discharge plan revised, presented to patient (repeat as necessary)
- Discharge plan secured, patient discharged
- Patient presents to Emergency Department 5 days later (repeat cycle)

Current Process Flow for Home Health Referrals

- Care Facilitator makes referral to home health agency
- Home Health liaison accepts case
- Liaison gives report to Home RN
- Care Facilitator follows assumption that Home Health agency will communicate with Primary MD
- Care Facilitator task complete; no follow-up with patient or Home Health agency

Healthcare Reform driving focus on Readmissions

- Home Health providers will become integral to bridging the gap between inpatient hospitalization and outpatient follow-up care
- “Transitions to Home” Programs available but currently under utilized
- “Transitions to Home” Programs address the Medical Home Model
- Quality care and outcomes to be affected: rates of readmission, emergent care rates, patient compliance, and medication management
<table>
<thead>
<tr>
<th>Common Features and Benefits of “Transition to Home” Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Dedicated case manager for Primary MD practices = ensures effective communication/strong relationships</td>
</tr>
<tr>
<td>▪ Medication reconciliation provided to Primary MD prior to initiation of home health services = real time information to MD regarding hospitalizations and ED visits</td>
</tr>
<tr>
<td>▪ Outpatient follow-up appointments made for patients = ensures compliance and addresses obstacles/barriers in attending the appointments</td>
</tr>
<tr>
<td>▪ Ongoing condition/disease management/education provided to patients in their home = promotes self care and empowerment of managing condition/disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialized “Transition to Home” Programs Emerging</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Examples: high risk falls, heart failure</td>
</tr>
<tr>
<td>▪ Heart Failure Program features:</td>
</tr>
<tr>
<td>▪ Use of Cardiac RNs in the home</td>
</tr>
<tr>
<td>▪ Completion of Assessment and development of home care plan with Primary MD within 24 hours of home arrival</td>
</tr>
<tr>
<td>▪ Use of “Telehealth” Monitoring systems - track weight, oxygen saturation, heart rate, blood pressure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Process Flow for Home Health Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Facilitator makes referral to home health agency</td>
</tr>
<tr>
<td>↓ Home Health liaison accepts case</td>
</tr>
<tr>
<td>↓ Liaison facilitates home progress report including outpatient appointment compliance with Primary MD</td>
</tr>
<tr>
<td>↓ Liaison provides follow-up report to Care Facilitator 3-5 days after patient discharge from hospital</td>
</tr>
<tr>
<td>↓ Care Facilitator performs “Discharge Call-back” to patient 3-5 days after discharge to ensure/confirm care plan with patient</td>
</tr>
</tbody>
</table>
Acute Care – Skilled Nursing Facility (SNF) Readmissions

Robert Young, MD
Post-Doctoral Health Services Research Fellow, Institute for Healthcare Studies
Clinical Instructor, Division of Hospital Medicine
Feinberg School of Medicine Northwestern University

• 40% of Medicare patients are discharged to Post Acute Care
• About half of these are discharged to SNF (~26% of hospitalized Medicare enrollees)

They found:
• ~25% of SNF patients are readmitted in 30 days
• SNF readmissions are rising from 2000-2006 data (18.2% to 23.5%)
• 2006 readmissions cost $4.34 Billion
Facility Related Factors

- Higher nursing staff levels associated with lower numbers of readmissions (Feuerberg, 2001)

- Lack of availability of resources at SNFs such as access to primary care clinicians, laboratory tests, and certain IV treatments (Ouslander, 2010)

Medicaid Policy

- State Medicaid bed hold policies have been found to be related to increased rehospitalization (Grabowski, 2010)

- Since SNFs often times share the same physical building as nursing homes, the level of funding for nursing homes (much through medicaid) likely effects the shared SNF-NH resources and readmissions. (Grabowski, 2007)
Patient Level Factors

- Functional Status
- Number of Emergency Room Visits Prior to Hospitalization
- Comorbid Health Conditions  
  [Chandra, in press]

Other potential factors

- Nursing home litigation risk
- Lack of available records
- Issues with patient stability
- Omitting palliative care, end-of-life discussions
- Communication

Current Interventions

- BOOST, Transforming Care at the Bedside (IHI), Care Transitions Program, National Transitions of Care Coalition Projects.
- The American Medical Directors Association: Interventions to Reduce Acute Care Transfers
  INTERACT II ([http://interact2.net](http://interact2.net))
  - Communication
  - Care paths/Clinical Tools
  - Advanced Care Planning
“Under this provision, no later than January 1, 2013, the Secretary is required to establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program.”

(Congressional research office, 2010)