Conversations Across the Discharge Divide

Home Health Quality Improvement National Campaign

January 20, 2011

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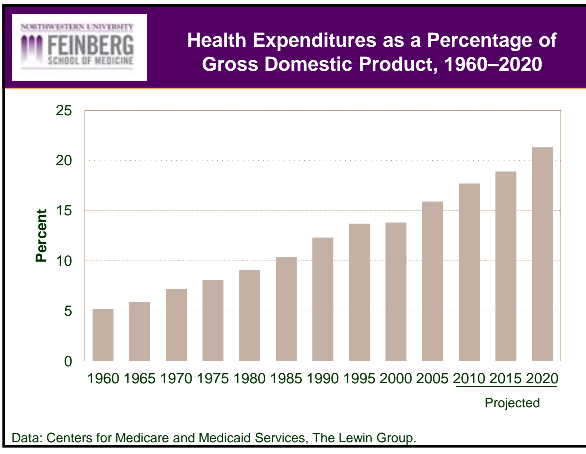
Outline for presentation

- 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.

SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.
N ENGL J MED 360;14 NEJM.ORG APRIL 2, 2009

- 1 in 5 patients rehospitalized in 30 days
- Half never see an outpatient doctor prior to rehospitalization
- 70% of surgical readmissions are for chronic medical conditions
- Costs $17.4 billion annually

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

Annals of Internal Medicine | ARTICLE

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

Alan J. Forster, MD, FRCPC, MSc; Harvey J. Murff, MD; Josh F. Peterson, MD; Tejal K. Gandhi, MD, MPH; and David W. Bates, MD, MSc

- 19% of patients had a post discharge AE
  - 1/3 preventable and 1/3 ameliorable

Adverse events among medical patients after discharge from hospital

Alan J. Forster, Heather D. Clark, Alex Menard, Natalie Dupuis, Robert Chernish, Natasha Chandok, Asmat Khan, Carl van Walraven

- 23% of patients had a post discharge AE
  - -28% preventable and 22% ameliorable
  - -72% were medication related

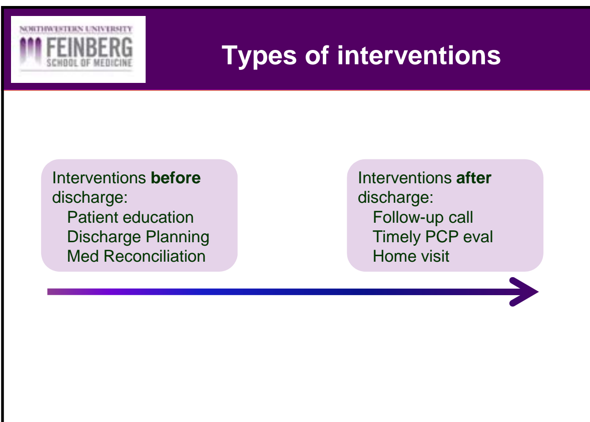
The Dangers of Discharge

Communication deficits at hospital discharge are ***common***

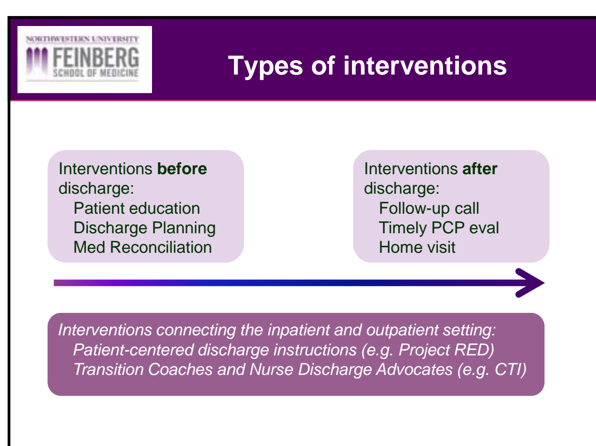
- Direct communication 3-20%
- Discharge summary availability at 1st post-discharge appt 12-34%; 51-77% at 4 weeks
- Discharge summaries often lack info
  - Dx test results (33-63%), hospital course (7-22%), discharge meds (2-40%), pending test results (65%)
  - Follow-up plans (2-43%), Counseling (90-92%)

Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. JAMA 2007;297:831-41.

Types of interventions



Types of interventions



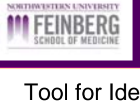
Home Visits

Author(s), title, journal	Absolute risk reduction
Dunn RB, et al. Health visitor intervention to reduce days of unplanned hospital re-admission in patients recently discharged from geriatric wards: The results of a randomised controlled study. Archives of Gerontology and Geriatrics. 1994;18(1):15-23.	-2(NS)
Kwok T, et al A randomized, controlled trial of an intensive community nurse-supported discharge program in preventing hospital readmissions of older patients with chronic lung disease. J Am Geriatr Soc. Aug 2004;52(8):1240-1246.	-10(NS)
Jaarsma, T., R. Halfens, et al. Effects of education and support on self-care and resource utilization in patients with heart failure. 1999 Eur Heart J 20(9): 673-682.	2 (NS)
Parry C, Coleman EA, et al. 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)
Wong FK, Chow S, Chung L, et al. Can home visits help reduce hospital readmissions? Randomized controlled trial. J Adv Nurs. Jun 2008;62(5):585-595.	2.4 (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)

Nurse Discharge Advocates

Author(s), title, journal	Absolute risk reduction
Brown A, Caplan G. A post-acute respiratory outreach service. Aust J Adv Nurs. Jun-Aug 1997;14(4):5-11.	7.7 (ns-not stated)
Jaarsma, T., R. Halfens, et al. (1999). Effects of education and support on self-care and resource utilization in patients with heart failure. 1999 Eur Heart J 20(9): 673-682.	2 (NS)
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)
Coleman EA, Smith JD, Frank JC, Min SJ, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriatr Soc. Nov 2004;52(11):1817-1825.	4.9(S)

Project BOOST: Better Outcomes for Older Adults through Safe Transitions



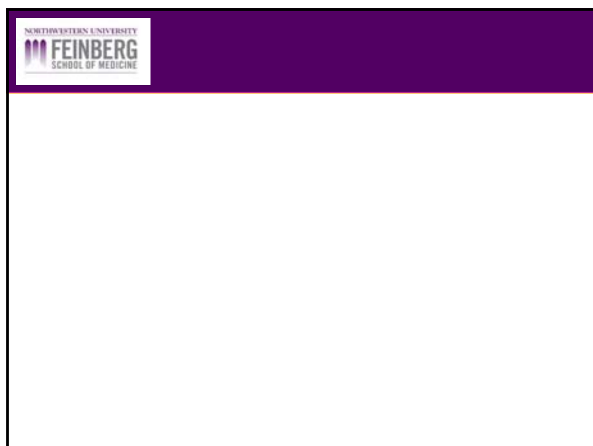
BOOST toolkit: Principal components

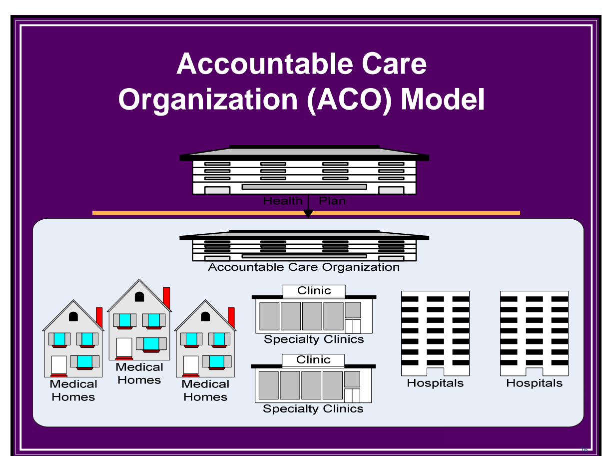
Tool for Identification of High-Risk Patients
- 7 P's: Principal dx (CA, DM, COPD, CHF, CVA), problem meds, polypharmacy, poor health literacy, patient support lacking, psych, prior hospitalizations

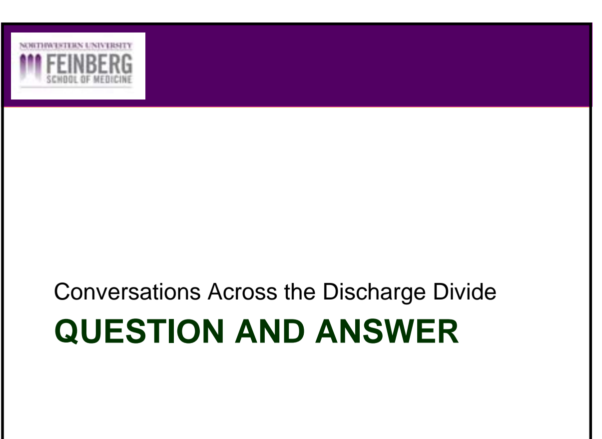
Tools for identifying barriers to safe discharge follow up and proactive management
- GAP assessment, Discharge checklist

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

Discharge Summary Communication




Accountable Care
Organization (ACO) Model
Health Plan
Accountable Care Organization
Clinic
Specialty Clinics
Clinic
Specialty Clinics
Medical Homes
Medical Homes
Medical Homes
Hospitals
Hospitals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QUESTION AND ANSWER

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

Common Features and Benefits of "Transition to Home" Programs

- Dedicated case manager for Primary MD practices= ensures effective communication/strong relationships
- Medication reconciliation provided to Primary MD prior to initiation of home health services= real time information to MD regarding hospitalizations and ED visits
- Outpatient follow-up appointments made for patients= ensures compliance and addresses obstacles/barriers in attending the appointments
- Ongoing condition/disease management/education provided to patients in their home= promotes self care and empowerment of managing condition/disease

Specialized "Transition to Home" Programs Emerging

- Examples: high risk falls, heart failure
- Heart Failure Program features:
  - Use of Cardiac RNs in the home
  - Completion of Assessment and development of home care plan with Primary MD within 24 hours of home arrival
  - Use of "Telehealth" Monitoring systems- track weight, oxygen saturation, heart rate, blood pressure

Future Process Flow for Home Health Referrals

Care Facilitator makes referral to home health agency

↓

Home Health liaison accepts case

↓

Liaison facilitates home progress report including outpatient appointment compliance with Primary MD

↓

Liaison provides follow-up report to Care Facilitator 3-5 days after patient discharge from hospital

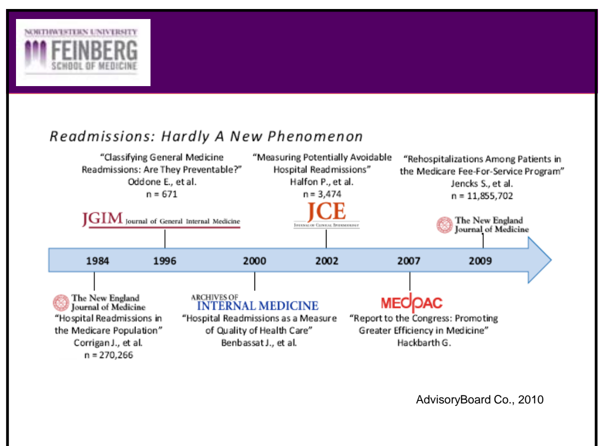
↓

Care Facilitator performs "Discharge Call-back" to patient 3-5 days after discharge to ensure/confirm care plan with patient

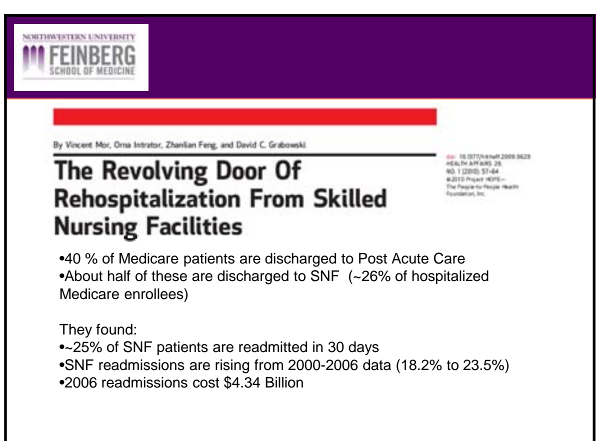
Acute Care –Skilled Nursing Facility (SNF) Readmissions

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



AdvisoryBoard Co., 2010



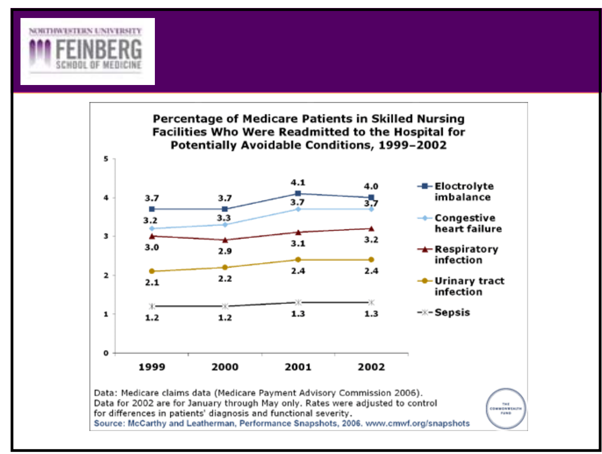
By Vincent Mor, Orna Intrator, Zhanlian Feng, and David C. Grabowski

The Revolving Door Of Rehospitalization From Skilled Nursing Facilities

- •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



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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

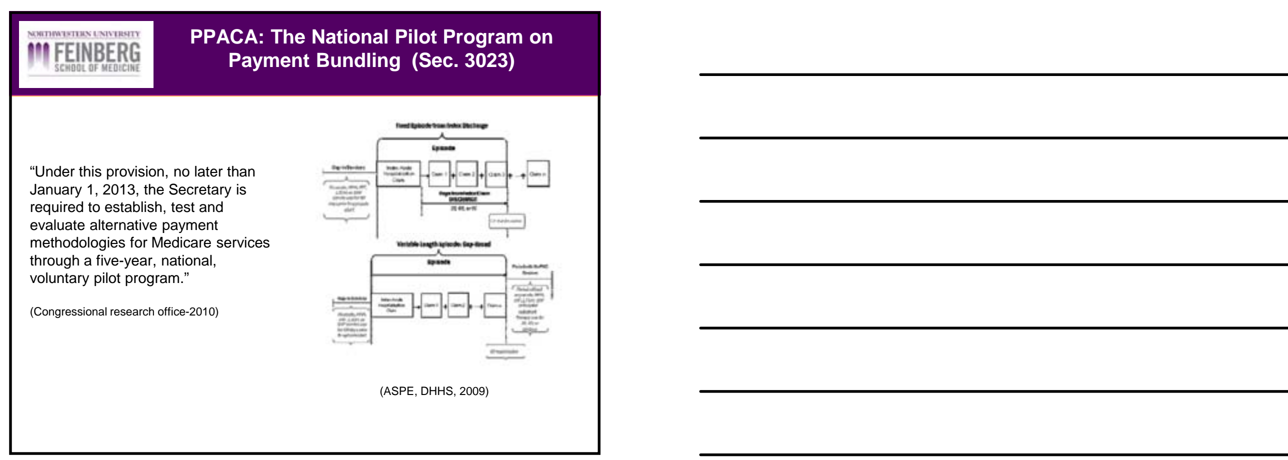
- Functional Status
- Number of Emergency Room Visits Prior to Hospitalization
- Comorbid Health Conditions (Chandra, in press)

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)*
  - Communication
  - Care paths/Clinical Tools
  - Advanced Care Planning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PPACA: The National Pilot Program on Payment Bundling (Sec. 3023)
"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)
(ASPE, DHHS, 2009)