

Home Health and Care Transitions

Jane Brock, MD, MSPH
Colorado Foundation for Medical Care

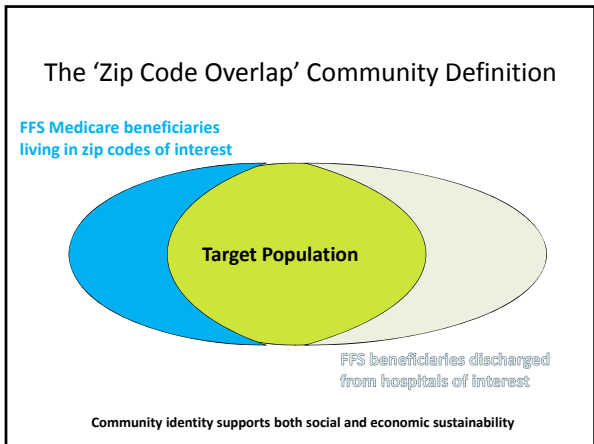
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Objectives

- Overview of the QIO Care Transitions Theme
- Community as a key lesson learned
- The role of Home Health in the Theme

The Care Transitions Theme:

- Define a community
- Identify service patterns associated with readmission
- Recruit and convene providers/whoever
- To reduce unplanned 30d hospital readmissions for the *community*
- Using evidence based interventions and tools



Senders and Receivers

		Senders						
		Hospital #1	Hospital #2	SNF #1	SNF #2	HHA	Home	Total
Receivers	Hospital #1		8	8	8	12	30	66
	Hospital #2	6		18	12	4	12	52
	SNF #1	20	22		1	1	N/C	44
	SNF #2	15	28	0		1	N/C	44
	HHA	30	12	6	1		N/C	49
	Home	100	80	50	25	35		290
	Total	171	150	82	47	53	42	545

- ### Interventions – Whatever it takes..
- Care Transitions Intervention
 - CMS Discharge Checklist
 - Interact
 - Transitional Care Nursing
 - RED
 - BOOST
 - Best Practices Intervention Package (BPIP)
 - Transforming Care at the Bedside (TCAB)

14 QIOs with 14 Target Communities



Totals among 14 communities

- 70 Hospitals
 - 277 Skilled Nursing Facilities
 - **316 Home Health Agencies**
 - 89 Other types of Providers (Dialysis, Hospice, etc.)
-
- 666 Zip Codes
 - 1,125,649 Medicare Beneficiaries
-
- 2,712 avoided 30-day Readmissions


What we are learning

Why do hospitals have unwanted readmissions?

Poor Provider-Patient interface
medication management, no effective patient engagement strategies, unreliable f/u


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 Unreliable system support
Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

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 **No Community infrastructure for achieving common goals**

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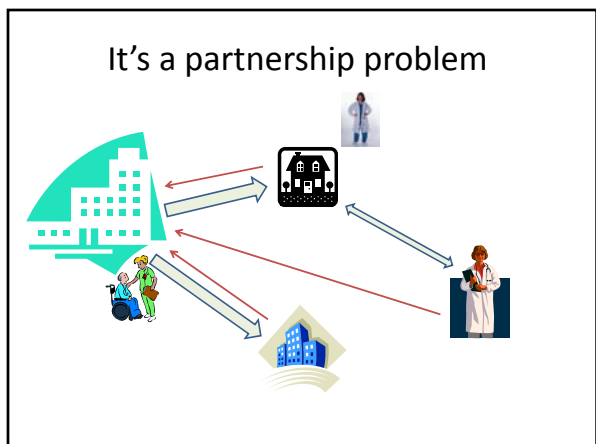
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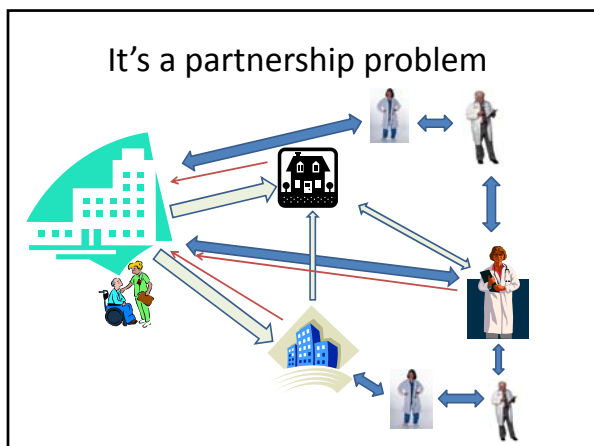
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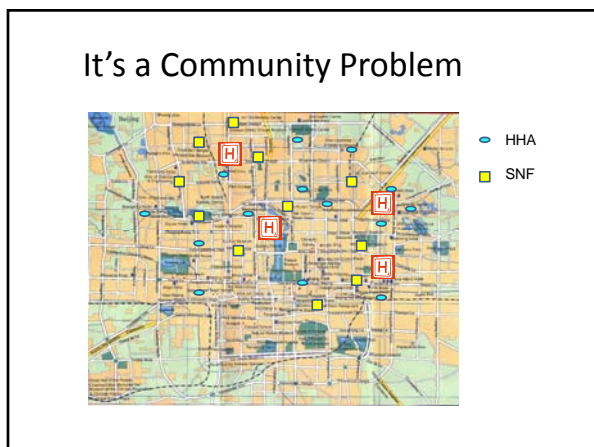
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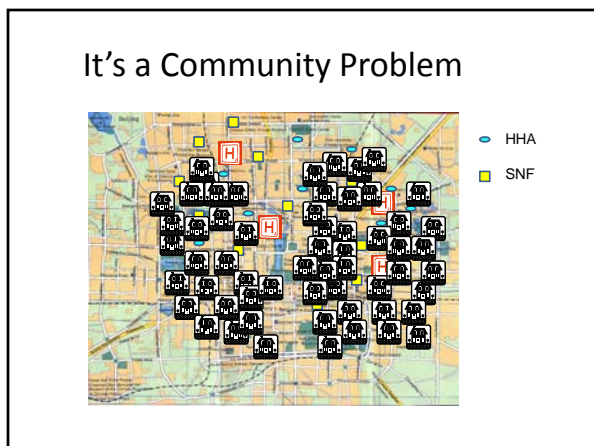
Intervention Packages

Intervention	Reference	Main tools	Driver addressed			#
			SNP	PAct	Inf	
Care Transitions Intervention	www.caretransitions.org	Coaches, personal health record, medication discrepancy tool		XXX	X	13
CMS Discharge Checklist	www.medicare.gov	Patient and family checklist of important items to address before discharge		XXX	X	9
BODOT	www.hospitalmedicine.org/Resources/Roomed-edge	Screening/assessment, provider discharge checklist, transition record, teach-back instructions, data collection and tracking	XXX		XX	2
Best Practices Intervention Package (BIP)	www.homehealthquality.org/files/resources/interventionpackages/default.aspx	Comprehensive manual for HHA process improvement includes CTI teaching	XX	XX	XX	11
InterAct	interact.geniu.org	Communication tools, clinical care paths, advanced care planning	XX		XX	10
Transitional Care Nursing	www.transitionalcare.info/index.html	Risk assessment, nursing training materials		X	XX	2
Transforming Care at the Bedside (TCAB)	www.ih.org/files/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm	(Re)Admission assessment, teach-back, pt and family communication, scheduled t/u	XXX	XX	X	4
Re-Engineered Discharge (RED)	www.bu.edu/rammed/projectred/index.gtml	Nurse discharge advocates, pharmacy t/u medication teaching, PCP t/u booklet	XXX		XX	4

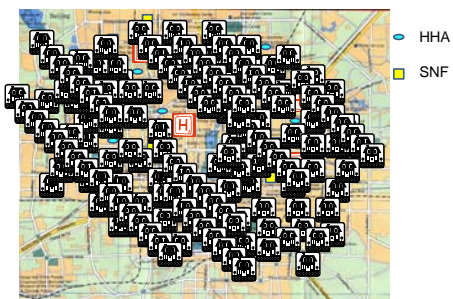




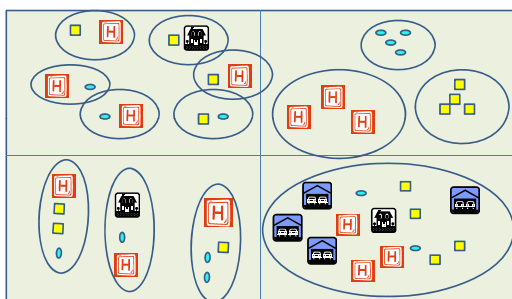




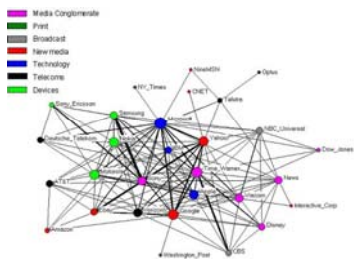
It's a Community Problem



Ways of organizing a community effort



Social Network Analysis



Results

- Hospital readmissions work reduces hospital 'admissions'
- Population-based measures of readmission going down

Results*

CY 2007 compared to CY 2009

Measure	CT Theme (Comparisons)		CT Theme (Comparisons)	
	absolute change		relative change	
% readmitted	-0.08%	(+0.30%)	-0.39%	(+1.91%)
Readmissions/1000	-2.96/1000	(-0.36/1000)	-4.75%	(+0.15%)
Admissions/1000	-15.23/1000	(-7.62/1000)	-4.59%	(-2.11%)

*Results are not intended to reflect formal evaluation of the success of any individual OIO nor the OIO program in relation to OIO contractual obligations.

The Role of HH in the Theme

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HH as a receiver = 49 (9%)
 HH as a sender = 53 (10%)
 HH is a party in 19% of transitions

HH Transitions

- 25215 (7%)
- 1037 transitions affected by interventions that are demonstrating improvement

What a Motivated HHA Could Do..

- Become a community of practice/build relationships
 - Agree on best practices
 - Compete on execution
 - Understand your role in your local system
- Review a(some) readmission case(s) with the hospital (RCA)
- Review/develop common processes with partners in the referral chain
- Hire a/some coach(es)
