 Cleveland Clinic


Reducing Hospital Readmissions: The Role of Home Care

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Introduction / Outline

1. My Role(s) & Disclosures
2. Home Care's "Secret Weapons"
3. Hospital Readmissions and the Chronic Illness Care Imperative
4. Evidence and Examples
5. Real World Opportunities



Ancient Concept in Medicine

"Into whatever houses I enter, I will go into them for the benefit of the sick..."



The First Aphorism of Hippocrates

But....

Physician Understanding and Training is Limited

"...wow, you're really going to do *that*? Is it safe?"

"...ok, you're like Marcus Welby? I didn't think anyone did that anymore."

"...we're just starting to figure out best practices after patient is extubated, what happens outside the hospital is really foreign..."

"...this stuff is like Lewis and Clark for us..."

What I'm Learning "Secret Weapons of Home Care"

Enhanced View of Patient and Caregivers

Breaks Down Barriers to Care

Strengthened Relationships

Can Avoid Hazards

Can Cost less



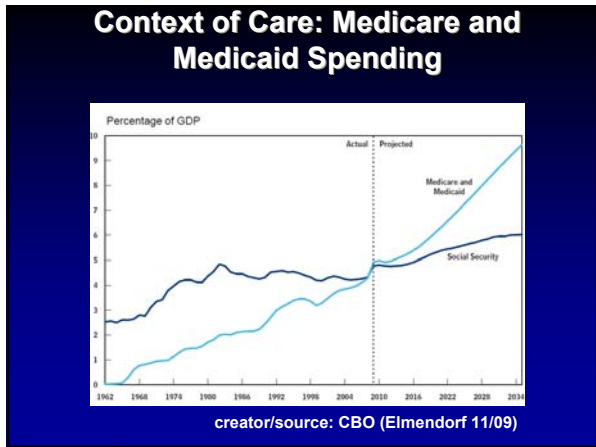
Who I'm Meeting

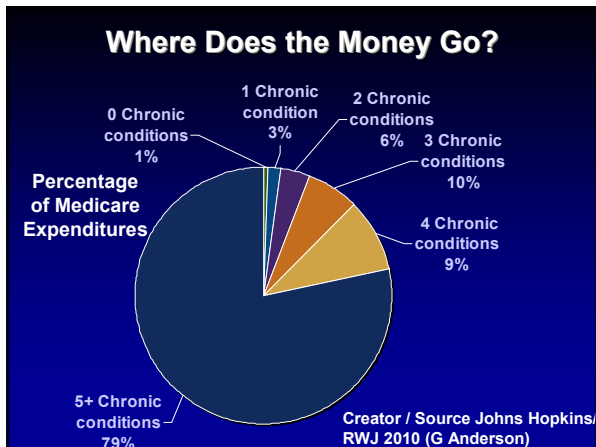


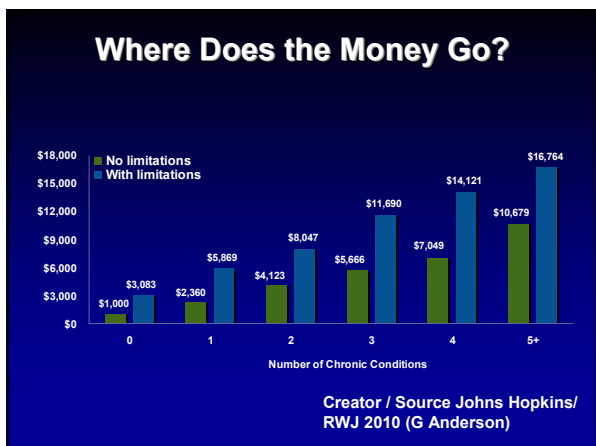
Who's the Dinosaur?

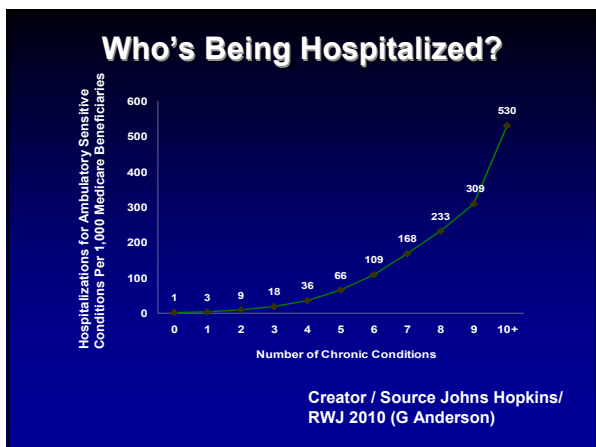
- Information & Communication Technology
- Mobile Diagnostics
- Remote Patient Monitoring
- Virtual Encounters







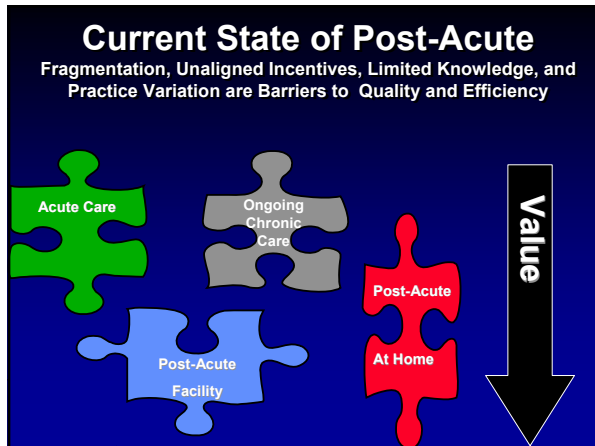




Medicare Readmissions We're Being Watched....

- **Unplanned Readmits Cost ~\$17 Billion**
- **Approximately 20% Readmitted by 30 Days**
- **Half Don't See Physician Before 30 Day Readmission**
- **Readmission is Most Often Due to Another Condition or Complication**

Source: Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009 Apr 2;360(14):1418-28.



Relevant Health Reform Changes: "Encouraging New Care Models"

CBO Est \$13.5 Billion Savings 2011-19
Sec 3021-3027.

- CMS "Innovations Center"
- Accountable Care Organizations
- National Bundling Pilot
- Independence at Home Act
- Care Transitions Program Pilot
- **Readmissions Reduction Prog (2012)**

Relevant Health Reform Changes: Hospital, SNF, Home Health Value Based Purchasing

Sec 3001/ 3006

- Hospital Incentive Payments
- Includes efficiency measures (spending per beneficiary)
- 1 to 2% of base DRG rate in 2013-2017
- For SNFs and HHAs Secretary Shall "Develop a Plan"

Is Home Care an "Escape Fire"?

- Accessibility?
- Healing Relationships?
- Science / Evidence?

Berwick, DM. Escape Fire: Lessons for the Future of Health Care. The Commonwealth Fund. 2002



Do Home Care Interventions Reduce Readmissions?

Reference:

Phillips CO, et al. "Comprehensive discharge planning with postdischarge support for older patients with congestive heart failure: a meta-analysis." JAMA. 2004 Mar 17;291(11):1358-67.

Description:

Pooled analysis of 18 randomized controlled clinical trials

Relevance to Home Care:

11 of 18 trials included home visitation

Results:

After mean follow-up of 8 months intervention had lower readmission rates 35% vs. 43%
Subgroup of trials with home visit performed better

Limitations:

Includes international studies, variable follow-up / intervention

What if We Only do Good Discharge Planning?

References:

- 1) Jha AK, et al. Public reporting of discharge planning and rates of readmissions. N Engl J Med. 2009 Dec 31;361(27):2637-45. Jack BW, et al.
- 2) A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med. 2009 Feb 3;150(3):178-87.

Description:

- 1) Analysis of CMS Hospital Compare Measures
- 2) Robust Discharge Planning and Preparation

Results:

Very modest association between HCAHPS discharge planning measure and hospital compare readmission rates

Reengineered discharge planning associated with 30% decrease in readmissions (~37% vs ~27%) intervention vs control

Do Home Care Interventions Reduce Readmissions? (Care Transitions Intervention)

References:
Coleman EA, et al. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriatr Soc. 2004 Nov;52(11):1817-25.
Coleman EA, et al. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006 Sep 25;166(17):1822-8.

Description:
Health Coaching Model Based on "4 pillars"

Relevance to Home Care:
In-home coaching visit is key element of model.

"...existing healthcare practitioners may assume some of the specific roles of the transition coach. For example, discharge planners or home health nurses are [well] positioned ..."

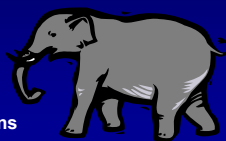
Results:
Intervention patients had lower 30-d readmissions (8.3% vs 11.9%)

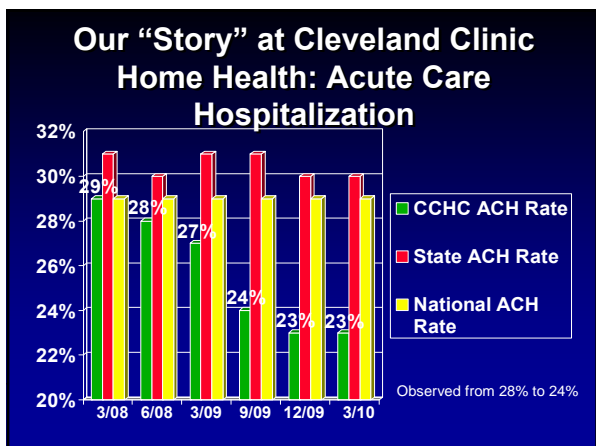
Other Concepts With Reported Success in Literature

- Telehealth Monitoring
- Telephonic Monitoring
- Medication Reconciliation
- Early Physician Follow-up
- Home Based Primary Care Teams
- Front Loading of Home Health Visits

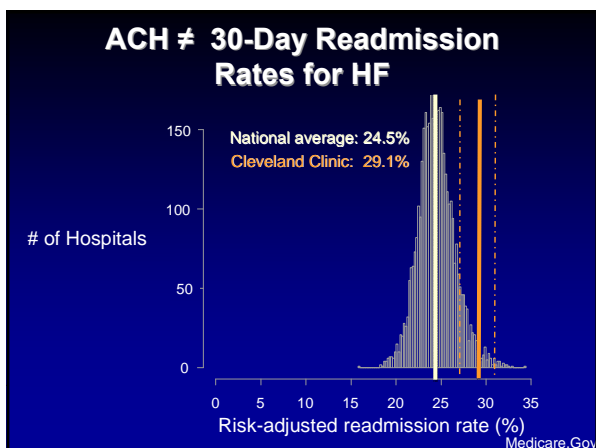
Elephant(s) in the Room (experience / opinion)

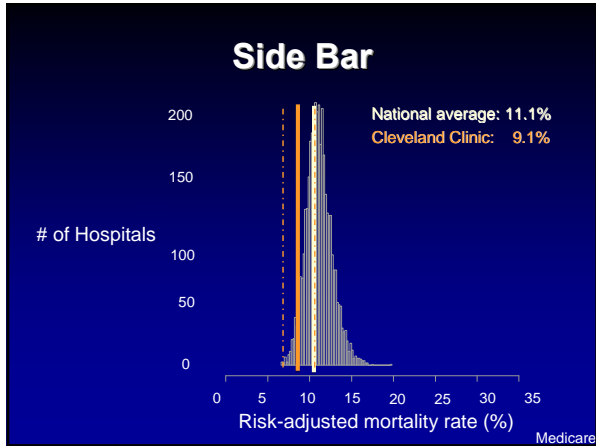
- End of Life Care / Goals of Care
 - HH to Hospice Transitions
 - Home Palliative Care
- Custodial Care Issues
 - AAA Partnerships
 - Elder Protection
 - Counseling About Options
 - Home to Residential Transitions





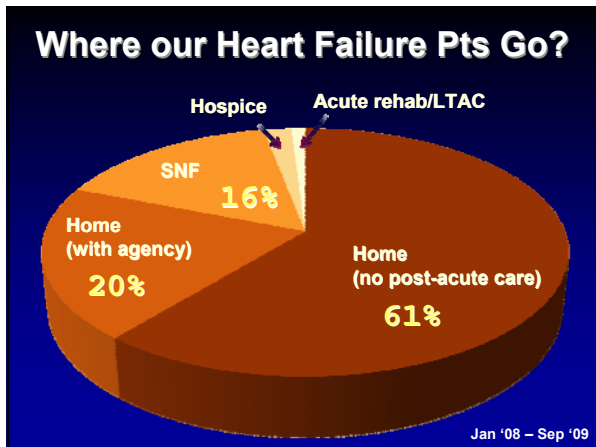
- ### Kitchen Sink Approach? (strategy vs implementation issues?)
- Raise Awareness / Prioritize
 - Point of Care Electronic Documentation
 - Telehealth for Heart Failure
 - Front Loading
 - Hospice Transitions Pilot
 - Medical Director / Physician Home Care
 - Medical Record Integration



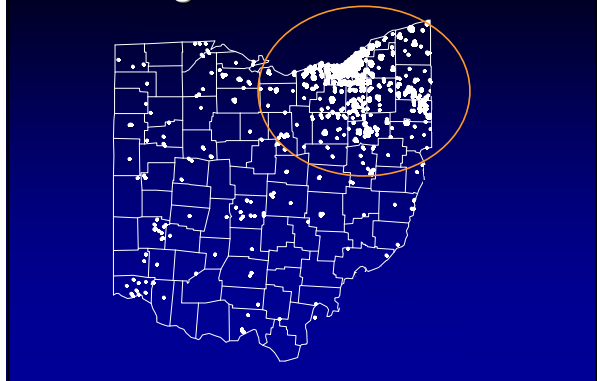


Building Home Health / Hospital Partnership Around Reducing Readmissions

“Heart Care at Home” Example



Geocoding HF and AMI admissions



Vision: Delivering Value and Reducing Readmissions With Multi-Component Home Care Management



Example from Pilot: Mr. B

- 59 year-old man
 - Smoker
 - NICM
 - Morbid obesity
 - OSA
 - Diabetes



Lives 3.4 mi away from us

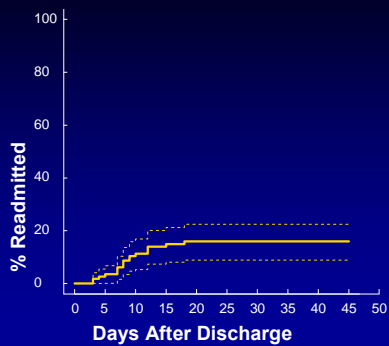
Mr. B: A Revolving Door of Readmissions

Multiple Admissions:

- 11/13, ED, 6 days, Home
- 11/29, ED, 4 days, Home
- 12/28, 9 days, Home
- 1/29, 3 days, Home
- 2/18, 5 days, Home
- 3/21, 5 days, Home, CRT
- Again in April...



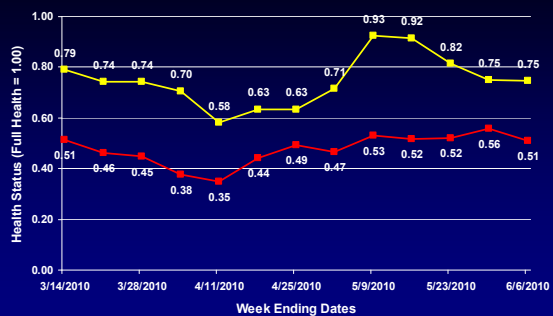
Readmission Results to Date



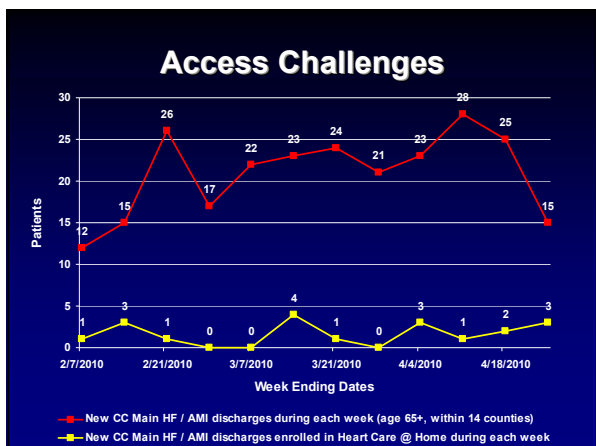
No. at risk 115 112 103 90 80 67 55 40 33 25

Heart Care @ Home Health Status Outcomes

(Post-Acute Patients at Day 1 & Day 28; p < 0.05)



— Rolling average health status at Day 1 during previous 4 weeks
 — Rolling average health status at Day 28 during previous 4 weeks





Who Are the High Risk Patients?

- Role for predictive modeling and scoring tools
- Even among older patients admitted and discharged within 24hrs
 - ~2% mortality at 60d
 - ~11% 30d readmission rate

Reference: Pines JM, et al. Ann Emerg Med. 2010 Feb 25. Postdischarge Adverse Events for 1-Day Hospital Admissions in Older Adults Admitted From the Emergency Department.

Leadership Role for Home Health Agencies (strategy vs implementation issue?)

- Expertise and Workforce
 - > 9,000 Home Health Agencies
 - >100 million annual visits
 - 870K (employees) 250K FTEs
 - OBQI history
 - Technology and new models
 - Local expertise
- Many Functions Already Covered in Benefit
 - Teaching and Training
 - Observation and Assessment
 - Care Plan Evaluation and Management
 - Home Health Eligibility Approximates High Risk Population

Reference: The National Association for Home Care & Hospice. Basic Statistics About Home Care. 2008. Accessed June, 2010 at http://www.nahc.org/facts/06HC_Stats.pdf

Summary

- Home Care Especially Well Positioned to Impact Hospital Readmissions
- Multi-component, Cross-Venue Models Show Best Promise
- Universal and Holistic Discharge Process Likely Important Most Pts With Chronic Illness
- Implementation Issues Should Be Considered in Conjunction With Strategy

Thank You

“The future belongs to those who believe in the beauty of their dreams”

E. Roosevelt

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