

Health coaches help reduce rehospitalization rates at New York's Northeast Health



Northeast Health implemented a care transitions coaching program in February for patients at two of its hospitals in Upstate New York.

A grant from the system allows two full-time nurses to coach patients with chronic diseases, according to Michelle Mazzacco, director of the Eddy Visiting Nursing Association, which is based in Troy, N.Y., and employs the coaches.

At the same time, the hospital's largest payer also bought into the program and covers the cost for its members to receive counseling and education for three diagnoses, including congestive heart failure, chronic obstructive pulmonary disease, and coronary artery disease. The hospital targets those same three conditions for traditional Medicare and Medicaid patients, along with diabetes, pneumonia and end-stage renal disease.

The coaching program allows for two patient in-person encounters, one at the hospital and one in the home within 24 to 48 hours of discharge, with the goal of keeping the patient out of the hospital for the next 30 days, she said. For patients to qualify, they must be being discharged from one of the system's two hospitals, and they must be going home, said Mazzacco.

The coaches don't wait for patients to be referred to them. Instead, each morning they run a report that sorts patients by diagnosis and payer. Then they screen out the patients who are in the intensive care unit or who have been referred to inpatient rehabilitation or hospice. They follow up to find out which of the remaining patients are in need of coaching. Then they introduce themselves and offer their services.

In the hospital, the coach completes a brief assessment to try to identify risk areas that can result in rehospitalization. For example, the coach looks at whether the patient can get to doctors' appointments and afford medications. The coach also helps the patient, or the family, to schedule a follow-up appointment with the physician within seven days of discharge.

In the afternoons, coaches visit patients in the home. The coach's main priority is to compare the medications on the hospital discharge orders with those found in the home and to clarify any discrepancies with the patient's physician.

The coaches complete an in-home assessment to identify rehospitalization risk factors and work with the patient and their family to teach them about their chronic illnesses, especially what to do if their symptoms warrant action. After the assessment, the nurse coaches the patient about disease self-management. The nurse also provides a toolkit that includes the items a patient needs to stay healthy, such as a scale, a spirometer, a medication box, and even a cookbook with low-salt recipes, among other items. After that, the nurse makes weekly phone calls to the patient.

Then the coaches fax the reconciled medication list to the physician, so it will be on hand for the patient's appointment. They also fax the medication list and the completed assessment tools to the payers, so case managers can follow up on issues which may result in a rehospitalization. The coaching program is not a substitute for home health, said Mazzacco. Payers understand that some patients will need both and are willing to pay for coaching in addition to home health visits.

To chart the program's progress, Director of Clinical Specialties Patrick Archambeault keeps a detailed spreadsheet to track a multitude of factors. Since the inception of the coaching program, both hospitals have seen a reduction in rehospitalization rates. The current hospitalization rate of 15.3% percent is impressive and demonstrates the value of the program, Mazzacco said.

What's more, a second payer signed on for the program in July, and the largest payer is so pleased with the results that it wants to introduce it in its other hospitals.

"We were asked to train four other home care agencies," she said, "so the payer could replicate the program at its other hospitals."

As to coaching's future, Mazzacco said she envisions the cost being shared by payers, the hospital and home care, because all three see the value in positive outcomes for patients and decreased health care costs.



Care Transitions Coach Program Eddy VNA - In-Hospital Assessment Checklist

Patient Name: _____ DOB: _____ Hospital: _____ Room # _____

Patient Address: _____

Patient Contact Info (phone(s): _____

Date of Hospital Admission: _____ Payers: _____

Observation Stay: Y ____ N ____ (check with inpatient care coordinator)

Date of Initial Contact with Patient in the Hospital _____

Introduce Coach model. Explain Coach role in calling patient, visiting patient upon return home, possibly going to first MD appointment, etc. Obtain agreement.

If patient refused coach, why? _____

If refused, call referral to PHP 641-3466 or 866-629-9387

Admitting Diagnosis: _____

Presenting Symptoms: _____

Check all that Apply: CHF COPD CAD

Comments: _____

Was a caregiver present when you met with patient at the hospital (yes ____ no ____)

Ask if this person will be the primary caregiver at home and if not, who will be:

Caregiver Name: _____

Caregiver Contact Information/Phone number: _____

Do you have someone to help you when you are home?

Bathing/dressing	<input type="checkbox"/> Independent	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No
Shopping for food	<input type="checkbox"/> Independent	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No
Preparing meals	<input type="checkbox"/> Independent	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No
Picking up medications	<input type="checkbox"/> Independent	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No

How will you obtain **transportation** to doctor appointments/tests? _____

If issues with transportation refer to PHP 641-3466 or 866-629-9387

Have the patient/caregiver state in his/her own words a general understanding of patient's health conditions?

Complete Partial Unable at this time

Explain: _____

List name of primary MD: (PCP) _____

List name of Specialist(s): _____

Where will you have prescriptions filled?: Pharmacy Name: _____

Phone number: _____

Do you have the money or financial resources to pay for these meds? Yes No

Do you understand the cost for these copays? Yes No

If no, call PHP CM 641-3466 or 866-629-9387

If no, review Rensselaer Care Prescription Program application with patient and contact coordinator to review prior to discharge. Also alert Eddy VNA and MD regarding this so other means of paying for meds are reviewed (i.e. Buffaline Fund).

Do you have Durable Medical Equipment (DME) at home? Yes No

If yes, please list: _____

If patient needs DME ordered, this should be completed prior to discharge.

Is patient being referred to homecare? Yes No Unknown N/A

If so, agency name: _____

Did patient refuse homecare and why: _____

Personal Health Coach

Date



Care Transitions Coach Program Eddy VNA Home Assessment Form

Hospital D/C Date: _____

Home Visit Date: _____

Patient's First Name: _____		Middle Initial or Name: _____		Patient's Last Name: _____	
Date of Birth: _____			Sex: _____	Education: <input type="checkbox"/> 8th Grade <input type="checkbox"/> HS <input type="checkbox"/> Coll <input type="checkbox"/> Other _____	
Caregiver Present: <input type="checkbox"/> Yes <input type="checkbox"/> No		Caregiver Name: _____		Relationship: _____	
Caregiver Telephone No: _____					
Type of assistance available for picking up meds/medical appointments/tests: (If no, clinician should arrange or provide assistance or report issue to CDPHP case manager) 641-3466 or 866-629-9387					
Primary language(s)? _____		Does the patient want or need an interpreter at time of visit (oral or sign language)? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Race/Ethnicity <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown			Immunizations: <input type="checkbox"/> Flu (Month: _____ Year: _____) <input type="checkbox"/> Pneumococcal (Month: _____ Year: _____)		
			DME Equipment Needs (list) _____ <input type="checkbox"/> Has <input type="checkbox"/> Needs _____ <input type="checkbox"/> Has <input type="checkbox"/> Needs _____ <input type="checkbox"/> Has <input type="checkbox"/> Needs _____ <input type="checkbox"/> Has <input type="checkbox"/> Needs		
Allergies: _____					
# of Discharge Medications ordered on hospital d/c: _____			# of Medications actually taken in home: _____		
Does patient have: <input type="checkbox"/> DNR <input type="checkbox"/> MOLST <input type="checkbox"/> Advance Directive <input type="checkbox"/> HCP					
In the last 12 months, what other medical services has the patient received? <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Home health agency (HHA) <input type="checkbox"/> Short-stay acute hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Long-term care hospital <input type="checkbox"/> Outpatient services <input type="checkbox"/> Inpatient rehabilitation hospital or unit <input type="checkbox"/> None <input type="checkbox"/> Psychiatric hospital or unit					
Hospitalization/ER in prior 12 months and reasons/causes: Date: _____ Cause: _____ Date: _____ Cause: _____ Date: _____ Cause: _____ Date: _____ Cause: _____					

When was your last PCP visit before hospital stay: _____	
When was your last Specialist visit:	
Type: _____	Date: _____
Type: _____	Date: _____
Type: _____	Date: _____
	If the patient lived in the community prior to this illness, who did the patient live with? <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with paid helper <input type="checkbox"/> Lives with other(s) <input type="checkbox"/> Unknown

Was patient referred to Palliative Care? Yes No

Was Telehomecare referred upon discharge from hospital? Yes No

Did patient refuse? Yes No If yes, why: _____

If the patient was not referred to home care from the hospital, did the Coach refer to home care Yes No

If so, why? _____

Health Literacy:

[Use a Ice Cream Label example]

- High likelihood of limited literacy Possibility of limited literacy Adequate literacy

Grocery Shopping:

Who does the grocery shopping for patient? _____

Is this person aware of any dietary needs? _____

Discharge Instructions and Obtaining Medications

Discharge Instructions and Obtaining Medications

Does patient have discharge instructions and they have been reviewed with patient? YES NO

Did the patient have a problem obtaining their medications when they went home? YES NO

Comments: _____

Have all new prescriptions been filled? YES NO

Does the patient need any scripts? YES NO IF NO, OBTAIN

How long was it before the patient was able to obtain new prescriptions? _____(Hours/Days)

Comments: _____

Are there money/financial barriers or cultural barriers? YES NO

Comments: _____

Patient states he/she does not need the medications or will not take YES NO

Comments: _____

Medication Reconciliation

1. EVNA coach contacted primary provider and clarified medication regimen and any discrepancies. Yes No N/A

2. EVNA coach discussed potential benefits and harm that may result from non-adherence with patient/caregiver. Yes No N/A

3. EVNA coach provided resources and information to facilitate adherence with patient/caregiver. Yes No N/A

4. EVNA coach addressed performance/knowledge deficit with patient/caregiver. Yes No N/A

5. EVNA coach scheduled an appointment with primary provider to discuss problem at next provider visit. Yes No N/A

6. Other (please explain) _____

Home Safety Assessment

Ability to do stairs? YES NO

Lives alone? YES NO

Excessive clutter which may cause falls? YES NO Plan: _____

Multiple scatter rugs? YES NO Plan: _____

Phone in easy access environment? YES NO Plan: _____

Has an emergency contact/caregiver? YES NO Plan: _____

Lifeline? YES NO Plan: _____

List any home safety recommendations given: _____

