Hospital to Home: A Care Transitions Project

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Readmissions

- 1 in 5 elderly patients
- Results in 2.3 million re-hospitalizations
- Annual cost to Medicare - $17 billion +

Jencks SF, Williams MV, Coleman EA. Rehospitalizations Among Patients in the Medicare Fee-For-Service Program. NEJM 2009;360(14):1418-1428.
CMS Initiatives

- PPACA – cut hospital pay by 1% if exceeding rate of readmission yet to be determined
- October 2012 – CHF – AMI – pneumonia
- 2013 – 1%
- 2014 – 2%
- 2015 & Beyond – 3%
  - Add COPD, CABG, vascular surgeries
- Estimated savings $7.1 - $8.2 billion over 10 years
- July 1, 2011 – beginning of initial performance period used to measure quality improvement
Incentive Established!

- Collaborative Effort
  - Hospitals
  - Physicians
  - Clinics
  - Home Health
  - Research
  - Hospice
Action Plan

- Coordinate weekly meetings
- Research other programs
- Establish goals
- Develop protocols
- Establish pathways
- Get buy-in

Due Diligence

- Began studying other models
  - St. Luke’s Hospital, Cedar Rapids, IA
  - HealthEast, St. Paul, MN
  - Baylor Health Care System, Dallas, TX

- IHI 5-part webinar series “Preventing Heart Failure Readmissions”
  - 50% of patients leave physician’s office not understanding what they were told
Common Themes

- Medication management & education
- Disease-specific education
- “Teach Back” at multiple levels of care
- Post-discharge appointment
- Interaction with health care professional for 30 days post-discharge

Goals

- Primary goal: Reduce readmissions
- Hospital Compare – primary CHF
  - Avera McKennan: 21%
  - Avera Heart Hospital of SD: 23.5%
- Chart Audit – primary and secondary CHF
  - Avera McKennan: 19.2%
  - Avera Heart Hospital of SD: 6.4%
Board Discussion

- Readmission rate not only measure of success
  - Medication Reconciliation
  - Days to follow up appointment
  - Assess understanding of CHF (teach-back methodology)
  - Satisfaction
- Interdisciplinary, multi-service level intervention to improve continuity of care, provide patients consistent tools and support to promote knowledge and self management of their disease

Strategies

- Standardized patient education materials
- Implementation of teach-back protocols
- Establish follow-up appointment standards
- Educate clinic staff and physicians
- Complimentary home visit
- Follow-up with patient for 30 days post-discharge
Management Tools

- Teach-Back Methodology
  - Assess understanding of discharge instructions
  - Training Video

CONGESTIVE HEART FAILURE: WHAT YOU NEED TO KNOW

- What amount of weight gain should be reported to your doctor?
- Can you name at least 2 examples of symptoms to report to your doctor?
- Can you name at least 3 examples of high-salt foods you should avoid?
- Can you name the medications you’re taking for your heart?
Good Questions for Your Good Health

Ask Me3™

Every time you talk with your doctor, nurse, or pharmacist, ask these questions

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

HEART FAILURE ZONES

GREEN ZONE
ALL CLEAR – This zone is your goal. You experience no sudden changes or symptoms. Take care:
- No edema or swelling
- No weight gain of 2 pounds in a week
- No shortness of breath
- No increase of 1 or more of the following
- No cough

YELLOW ZONE
CAUTION – This zone is a caution. You have one or more of the following:
- Weight gain of 2 pounds in one day
- Shortness of breath
- Speaking not fluent
- Sudden increase in shortness of breath
- Sudden increase in cough
- Sudden trouble breathing
- Nausea
- Enter emergency room or call 911 if you have any of the following:
- Struggling to breathe
- Confusion
- Consolability

RED ZONE
EMERGENCY
Enter the emergency room or call 911 if you have any of the following:
- Struggling to breathe
- Confusion
- Consolability
- Call 911 or go to the emergency room immediately.

The more you know about your health, the better
Pilot Project
Research Focus

- All CHF Patients Evaluated and Categorized
  - Enrolled in the H2H program
  - Eligible but not enrolled
    - Patient refuses and decides not to continue
    - Possible palliative care or hospice eligible but patient refuses
  - Excluded
  - Control group: chart audit

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Research Focus

- Inclusions:
  - Hospitalized at Avera McKennan or Avera Heart Hospital of SD between June 2010 - June 2011
  - Primary or secondary diagnosis of heart failure
  - Age 18 years or older
  - Must be able to participate in the Informed Consent process
  - Geographic area (greater Sioux Falls area)
    - Limited initially - expand to 40 mile radius
Research Focus

- Exclusions:
  - ESRD
  - Patients going to long-term care, skilled nursing facility, rehabilitation
  - Experiencing suicidal ideation within past 6 months
  - Blind or deaf
  - Unable to speak English
  - Without a phone
  - Planned hospital readmission scheduled within 30 days

Enrollment

- Process for Enrollment
  - Identify heart failure patients. Evaluate for inclusions and exclusions. Patients do not have to be homebound
  - Heart Failure patients are given the “red folder” and staff educate using the “teach-back” method.
  - Caregivers educated as appropriate
  - Case Manager visits with the patient and gets order. If home health is ordered, patients are given a choice of agencies
  - Case Manager calls Interim Home Health
  - Cardiac nurse from Interim is the Transitional Care Coordinator
H2H Program Process

- Transitional Care Coordinator visits with the patient in the hospital within 48 hours of admission
- Transitional Care Coordinator makes complimentary home visit
  - Medication reconciliation
  - Heart Failure Patient Education is reinforced
  - Verifies follow up appointment is made
  - Patient is assessed for home health needs
- Weekly follow up phone calls are made.

Statistics & Findings
Patients Evaluated

- Enrolled – 100
- Non-Enrolled – 159
- Exclusions - 829

Readmissions – All Cause

- Enrolled – 17%
- Non-Enrolled – 28%
Readmissions for Heart Failure

- Enrolled – 5%
- Non-Enrolled – 11%

Medication Reconciliation

- Discrepancies Found – 22% of the time
  - Discharge Discrepancy – 10%
  - Non-Filled Rx – 5%
  - Undisclosed Rx at Home – 3%
  - Noncompliance – 3%
  - Financial Burden – 1%
Follow Up Appointment

- Prior to study
  - Up to 4-6 weeks
- June – March
  - 9.1 days

Teach Back Evaluation

- Initial Score – 62%
- Final Score – 99%

  - What weight gain should be reported to your doctor?
  - Can you give me at least 2 examples of symptoms to report to your doctor?
  - Can you give me at least 3 examples of high salt foods you should avoid?
  - Can you tell me the names of the medications you are taking for your heart?
Patient Caregiver Knowledge/Satisfaction

- How well do you understand your heart condition?
  - Initial 3.81
  - Final 4.30

- Do you feel anxious, sad or lonely at home?
  - Initial 3.72
  - Final 3.98

- Can you give me examples of food you should avoid eating?
  - Initial 3.28
  - Final 3.92

- How often do you weigh yourself & record your weight?
  - Initial 3.59
  - Final 4.86
- How well do you understand when/why to take prescribed medication?
  - Initial 4.13
  - Final 4.45

- How well do you understand problems to watch for/when to call the doctor or seek emergent care?
  - Initial 3.96
  - Final 4.30

- How many minutes do you walk in a day?
  - Initial 2.30
  - Final 3.06

- How do you feel about the pilot program?
  - Initial 3.43
  - Final 3.76
Lessons Learned

- Readmission Rates can be significantly improved with a coordinated hospital to home program
- Change mindset from “discharge” to “transition of care to another setting”
  - Challenges
    - Some difficulties identifying patients early
    - Variation with inclusion of secondary diagnosis heart failure
    - Variation with expanded time frame and expanded geographic area
    - What can be done with excluded cases?
    - Patient education/knowledge does not always end in compliance
    - Factors include motivation, financial issues, support, etc

Expanding H2H

- Expansion:
  - System-wide
  - Including current exclusions
  - COPD
  - Other
From This - 40 mile Radius

To This: 300 Locations, 97 Communities, 5 States
Objectives

- Maintain integrity of program while recognizing differences in communities
  - Key participants
  - Who is the transitional care coordinator
  - 24/7 calls
- Establish baseline for measurement
- H2H Champion

Tool Kit

- Program materials
  - Required vs. optional
- Educational materials
- Teaching methods
- Discharge Orders
- Communication
  - Scripting
  - Power Point presentations
  - Email
  - Newsletter articles
Identifying patients
- EHR – physician orders “referral to H2H”
- Data Collection/Aggregation
  - Baseline audit
  - Capturing data points – who/how

Keys to Success
- Uniformity among hospitals
- Physician involvement
- Community involvement
- Generic design – applicable to other chronic diseases