Transitional Care and the Hospital: Making it Work as a Community-Based Agency

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Agency Culture Transformation

- **40 different pilots in Health Care Reform for new payment and system delivery restructuring.**
- **All place the payment, bonus and accountability in a physician, hospital, or PHO organization.**
- **Get it? Home Care is not the center of the world.**
- **"Systemness" is the key**

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Starting Where They Are

- Hospitals are seeing the future, will become short term acute care centers
- In 2007 MedPAC gave warning about not paying for unnecessary care
  - First, “never events”
  - Now avoidable re-admissions, “failures”
- Medicare Advantage plans and commercial payors are now demanding the same
- The solution – improve the transition from the hospital to the community or “home”

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Common Hospital Transition Programs

Primary Hospital Programs to Re-Admissions

- RED Program – *Boston University School of Medicine 2007- present*
  - funded by AHRQ,
- BOOST – *Society of Hospital Medicine Hospitalists Organization 2008 to present*
- H2H – Hospital to Home *- Medicare QIO Transitions Project; 14 areas, 14 QIOS 2009-present*

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RED: Re-Engineered Discharge

Designated Nurses in Hospital:

- **Educate the patients about diagnosis**
- **Make appointments for clinician follow-up**
  - **Patient advises best time, date,**
  - **Confirm patient has a way to get there**
- **Discuss results of in-hospital tests and who is responsible for follow up regarding results**
- **Organizes post-discharge services**
- **Reviews with patient what to do if a problem arises, how to contact the PCP; eves and weekends**

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RED: Re-Engineered Discharge (cont'd)

- **Reconcile discharge medication with meds taken before admission**
  - **Pharmacist calls 2-4 days > discharge – does pt know what medications to take, purpose, side effects, what to watch for, how to take it; were scrips filled?**
- **Expedite Discharge Summary to MD and post-acute providers**
- **Give patient written discharge plan-**
  - **Reason hospitalized**
  - **Discharge medications, what tests results not ready at time of discharge and what follow up is needed**

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BOOST: Better Outcomes for Older adults through Safe Transitions

- Hospitalists by definition introduce discontinuity
- Goals:
  - Reduce 30 day readmission rates - emphasis on older adults
  - Improve facility HCAPHS score related to discharge
  - Use standardized discharge pathways/checklist: new medications; symptom management; follow-up community MD in 7 days; pending test follow-up
  - Identify high risk patients: cognition; dementia; confusion; alcohol abuse
  - Follow-up phone call 72 hrs if hi-risk: any above condition; >5 meds; poor health literacy; prior hospitalization < 6mos

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H2H: Hospital to Home (Read :Community)

- QIO Medicare FFS Transitions Project
  - 19.6% re-admitted in 30 days, cost $17 B (2004)
  - >50% re-admitted or dead within a year
  - 24% were re-admitted <30 days to other hospital
- Causes:
  - Medication Problems-non adherence due to poor understanding.
  - No reliable follow-up care, providers lack info
  - No patient engagement-symptoms worsening

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H2H – Patient Centered Emerges Again

Solutions:

- **Patient and family supported across settings.**
- **Information is transferred to :**
  - **Patient/family through "teach back" communication inpatient**
  - **Post acute providers**
- **"handovers" or "transitions" are managed events using known, reliable processes**
- **Hospitals have been working on internal processes**

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HHS Message from AHRQ

- **1 in 5 Medicare patients return to the hospital within 30 days of discharge**
- **> 33% of patients discharged don't get follow up care needed such as lab tests or see a MD**
  - **AHRQ June 2010, podcast for consumers**
- **Issue: patients and caregivers don't know what to do after a hospital stay – believe if pt/family have more active role can reduce re-admissions**
- **Release: *Taking Care of Myself: A Guide for When I Leave the Hospital* *Pub.10-0059 April 2010***

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Introducing the PHR – Personal Health Record

Many versions, common elements:

- **It goes home with patient and to be taken to the MD and back to hospital, ER, etc.**
- **Maintained by the patient/family caregivers**
- **What is my medical problem(s); why hospitalized**
- **Medication allergies, pharmacy name and number**
- **What medicines I take; why; when; how much and how to take each**
- **When is my next appointment and questions for MD**
- **What tests need follow-up, with whom**

Some are 1 pg, AHRQ 13 pages, some electronic – do they work?

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Common Transition Themes

- **Get to the patient's physician most often <10 days; address any barriers to MD follow up**
- **Know discharge medications; reconcile with current medications at home; compliance/adherence**
- **Involve family caregivers**
- **Patient/family has information about in-hospital treatment and any need for follow up**
- **Know what are S&S of emergency, what to do**
- **Need to teach self-management, system navigation**

Weakness: Only One Way Transition

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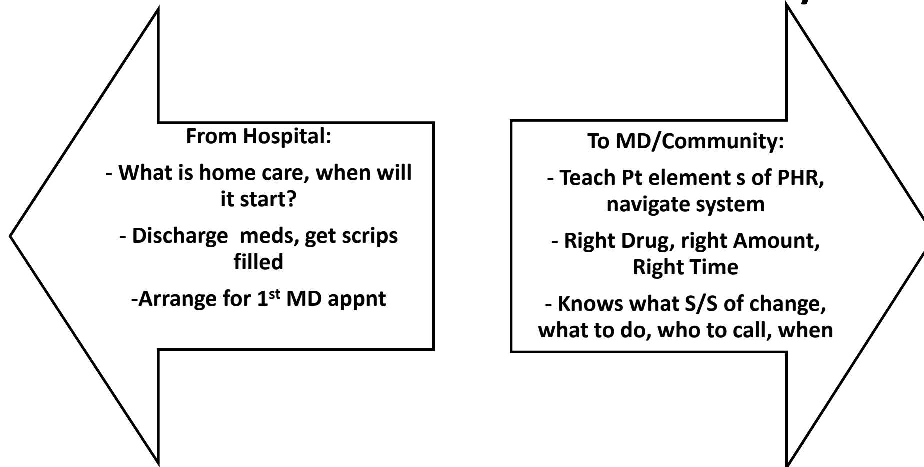
Basics of Care Transitions for HHAs



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Why Now? Hospitals and Home Care "Share" 30 Days

- **Health reform holds hospitals financially responsible for avoidable re-admissions within 30 days post discharge, return to any hospital FY 2012**
- **HHS Secretary will select 3 diseases, add each year**
- **Home Health facing P4P or value based purchasing 2012 or 2013, re-admissions heavily weighted element**
- **2013 Bundling demonstration begins**
- **2013 post acute payment reform**
- **Hospital and HHA share risk 30 days > discharge**

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Transitions to the Home Care: Two Populations

- **Note: Transitions *__after__* referral to home care**
- **Remember, hospitals responsible for *all* transitions**
- **Transitions to home care *now* focus on *__two__* populations that are particularly a challenge for effective transitions**
  - **Chronically ill (HF, DM, COPD, CAD),**

OR

  - **Acute episode – needing immediate in-home intervention to sustain progress (e.g. joint replacement)**

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Transitions Aren't Enough – Reducing Readmissions Requires Also Focusing on Chronic Illness

- **Diseases associated with re-admissions in 30 days:**
  - **Heart Failure (HF)**
  - **Pneumonia (studies indicates as many as 50% also have COPD)**
  - **CAD, associated events, procedures (AMI, angioplasty, etc.)**
  - **COPD**
- **5% of discharged HF patients, no co-morbidities, readmitted to hospital for CHF within 30 days**
- **10%+ of HF patients with four co-morbidities, readmitted to hospital for HF < 30 days**

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Care Transitions: What You Need to Start

What are you offering?

- ✓ **How does what you do for care transitions differ from what a liaison does? …Hint, it does!**
- ✓ **Who will do the transition coordination? How many hours a day are they available?**
- ✓ **How will you manage medication reconciliation from hospital to home?**
- ✓ **How will you approach follow-up with community physician?**
- ✓ **How will you offer patient-centered transitions?**

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Care Transitions: Can You Meet the Promise of Reducing Readmissions?

- ✓ **What is your re-admission rate? If good, know why?**
- ✓ **Do you have chronic care management programs that meet the "Four Pillars" of transition?**
  - ✓ **Standardized education-team teaches from same source?**
  - ✓ **Is your team familiar with "teach-back" or "coaching"?**
  - ✓ **Does your team teach self-management ,or stabilization?**
  - ✓ **Do they teach S/S condition change, what to do, who to call, when?**
  - ✓ **Do they teach medication management and adherence?**
  - ✓ **Do they teach navigating the system – what information the patient maintains, who to share it with, how, when?**

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Where Hospitals Are Now

- Care transition s or chronic care access limited to 2-5 HHAs, even if the hospital owns home care – Key is performance, not ownership
- Expectation of participation in numerous meetings as hospital revises their processes, need to talk-the-talk
- Minimum achievement: in-hospital follow-up of your own patients when re-hospitalized
- 6-9 months on average til hospital opens up, most often based on data – ability to offer disease specific data

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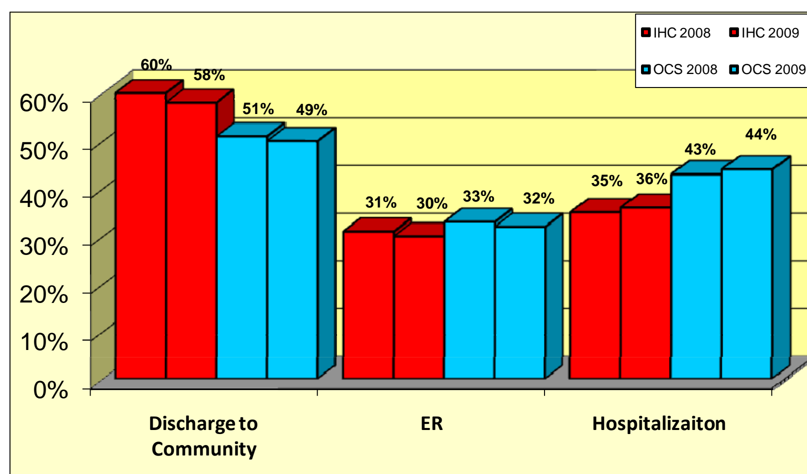
Heart Failure Outcomes: Accountability
IHC National vs. OCS National Benchmark 2008, 2009



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Focused Intervention: Depression

- Literature identifies as many as 59% of HF patients clinically depressed; diagnosis missed by 90% of MDs.
  - Depression screening is currently part of CMS physician reported data.
  - Be able to articulate importance of identifying signs and symptoms of depression and its role in chronic disease.
- Use of a standardized depression screen (PHQ 9) to identify *signs and symptoms* of depression
- If not currently treated, refer to confirmed diagnosis by community MD
- Finally, acknowledgment of role of depression screening and diagnosis

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Where the Physicians Are?

- Some considering medical home demonstrations – patient centered primary care
- Some physician group practices are ready to pursue Accountable Care Organizations (ACOs)
- Others are seeking to be bought by Physician Hospital Organizations (PHOs)
- Others will see what happens
- Few understand and appreciate the role of home care
- Do HHAs understand the "hand-off" to MD practices and opportunity for *pre-acute care?*

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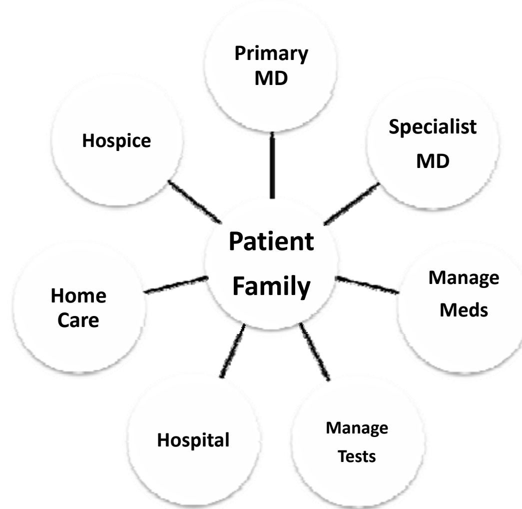
National Demonstrations: All Payor 6 States Medical Home, Patient Centered Primary Care



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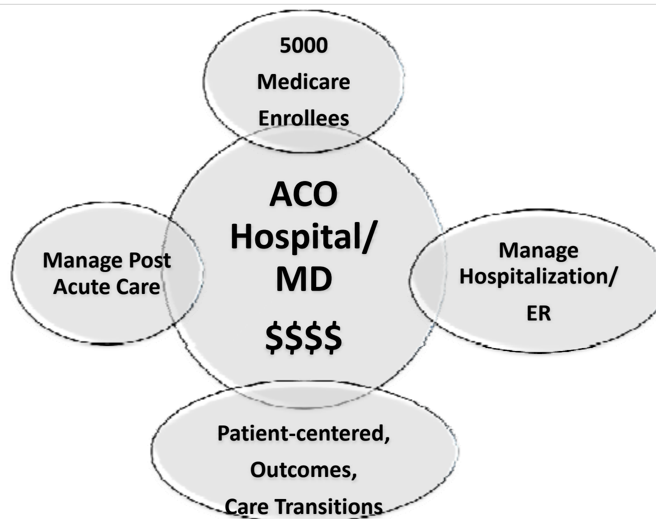
2012 ACO-Accountable Care Organizations Population Care Managed to Savings and Outcomes



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The Challenge: If We Don't Do It, <u>They</u> Will

- **Work of Dr. Eric Coleman, Dr. Mary Naylor and others introduce need for nurses to follow up patients in the home via visits and telephone.**
- ***<u>Research emphasizes the critical value of the home in effecting change for chronically ill elderly</u>***
- **Health reform funds:**
  - **Care transition programs for "troubled hospitals"**
  - **Independence-at-home, using home care as a pre-requisite for eligibility**
  - **"health home" under Medicaid**
  - **Otherwise, home care is not guaranteed in any option**

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Opportunity is There, No Guarantees

- **Necessity – home care asserts its role in the evolution of transitional care**
- **Strategic decision – Promote collaboration with other providers – "systemness"**

Home Care is uniquely positioned
to effectively address transitions and
outcomes in the community for
a growing population of older adults
with continuous, complex needs

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