How to Prepare for Your Post-Acute Partnership: A Fresh Look at Reducing Avoidable Re-Hospitalization

Presented by:
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Objectives

- Clarify Forces Driving Post-Acute Care
- Apply Evidence-Based Strategies
- Describe Impact of Reducing Re-hospitalization
## Then and Now

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• 31.1% of acute care hospital discharges were re-admitted within 30 days of discharge</td>
<td>• 19% of acute care hospital discharges were re-admitted within 30 days of discharge</td>
</tr>
<tr>
<td>• Costs for unplanned hospital re-admissions within 30 days of discharge $17.4 billion</td>
<td>• Costs for unplanned hospital re-admissions within 30 days of discharge $15 billion</td>
</tr>
<tr>
<td>• Medicare fee-for-service 1 of every 5 acute care hospital discharges were re-admitted within 30 days of discharge</td>
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[National Quality Forum]

## The Past

CMS reviewed 15 months of data to determine rates of unplanned re-hospitalizations among some 12 million Medicare beneficiaries.

- Hospitalizations account for approx. 33% of total Medicare expenditures
- 2/3 patients were re-hospitalized or died within 1 year of D/C
- ½ of those re-hospitalized within 30 days no evidence of seeing a doctor
- 1/5 are readmitted to hospital within 30 days
- 1/3 are readmitted within 90 days
- Estimated $12 billion a year on preventable admissions

The Future

- By 2030 ALL baby boomers 65 & older
- By 2030 > 20% population over 65 years old
- Americans are living longer with increase chronic disease

The Journey Begins

**Medicare Value Purchasing Act 2005**

or

**Pay for Performance**: A budget neutral approach to enhance healthcare quality & efficiency by giving providers financial incentives for improved clinical outcomes, cost containment, and patient satisfaction.

*Porter Research & Solutions, 2003*
The Affordable Care Act (ACA) requires numerous disclosures accompanied by specific measures for transparency. For example 33 measures for ACOs and, 17 value-based purchasing measures.

<table>
<thead>
<tr>
<th>Section</th>
<th>Provision</th>
<th>Importance To Transparency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1003</td>
<td>Effective Rate Review Program</td>
<td>Health insurance plans must adjust premium rates increases above 10% to reflect higher cost growth. The premium change, which includes a justification for the rate increase and the number of plan participants involved.</td>
</tr>
<tr>
<td>3402</td>
<td>ACOs</td>
<td>Payments linked to performance and cost-containment. CMS defined 33 value-based measures based on 1) defining the processes of care, 2) coordinating care, 3) promoting health outcomes, and 4) reducing health care costs. ACOs must report performance on these measures.</td>
</tr>
<tr>
<td>8101</td>
<td>Nursing home transparency and accountability</td>
<td>Nursing homes are required to report ownership information, which will be made public by March 2018.</td>
</tr>
<tr>
<td>1004</td>
<td>Summary of coverage benefits</td>
<td>Health plans must provide a summary of coverage benefits in plain language to plan participants.</td>
</tr>
<tr>
<td>3002</td>
<td>Physician payment transparency program</td>
<td>Requires manufacturers of drugs, devices, and certain medical supplies to report payments to physicians or teaching hospitals. Requires manufacturers and group purchasing organizations (GPOs) to disclose physician ownership or investment interests in GPOs and the selection of ACOs and accountable entities to disclose and disclaim ownership or investment interests.</td>
</tr>
<tr>
<td>3003/3300/ 33001/3301/3302</td>
<td>Hospital value-based purchasing program, value-based purchasing program for skilled nursing facilities, Value-based purchasing program for ambulatory surgical centers (VAPORs), value-based payment modifier under the physician fee schedule</td>
<td>Value-based incentive payments are made to hospitals based on 12 measures (e.g., patient experience and care, percent of heart failure patients receiving discharge instructions, etc). Value-based incentive payments are also made to ambulatory surgical centers, accountable entities, and ACOs that meet defined performance standards. These provisions require increased transparency surrounding delivery of care and reporting.</td>
</tr>
<tr>
<td>10056</td>
<td>Pay for performance for certain Medicare providers</td>
<td>Providers are rewarded for meeting certain revenue objectives, such as increased quality of care and safety.</td>
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<tr>
<td>5402</td>
<td>Health Care Fraud and Abuse (HCFAC)</td>
<td>Increases funding for HCFAC—$15 million annually (FY 2011-FY 2020).</td>
</tr>
</tbody>
</table>

It Takes a Village

- Pay For Performance
- Transitions In Care
- Extended Care Facility
- Private Duty
- Community Based Care Manager
- Palliative Care
- Evidence Based Care
- Urgent Care
- Home Care
- Accountable Care Organization
- Hospice
- Preferred Provider Network
Accountable Care Organization (ACO)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors (CMS.GOV 4/2012)

Accountable Care organization (ACO)

Four key areas with 33 measures:

• Patient/Caregiver Experience

• Care Coordination/Patient safety

• Preventive Health Measures

• At Risk Populations
Medical Home

- Team-based healthcare delivery model led by a physician that provides comprehensive and continuous medical care to patients.

- The provision of medical homes may allow:
  - better access to healthcare
  - increased satisfaction with care
  - improved health outcomes

- Care Coordination

- Payment models compensate for coordination activities that fall outside the face-to-face patient encounter.

Transitions of Care Community

**Definition** - A range of time-limited services that compliment primary care and are designed to ensure healthcare continuity and avoid preventable poor outcomes among at risk populations as they move from one level of care to another, among multiple providers and across settings.
Community-Based Care Transitions Program
The Home Care Journey Begins

Mandated by Section 3026 of the Affordable Care Act

GOALS:
• CMS 9th Scope of Work
• New Jersey HQSI one of 14 QIO’s selected by CMS to participate in pilot
• Improve transitions of beneficiaries from the inpatient hospital setting to other care settings with primary focus on disease process at the highest risk for hospitalization
## Transitional Care Model
### University of Pennsylvania
#### School of Nursing

Mary Naylor, PhD, RN

**Transitional Care Model (TCM)**
- TCM is a nurse-led multidisciplinary model
- Use of evidence-based protocols with a unique focus on increasing the patients/caregivers ability to manage care
- Provides comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults
- Emphasis on coordination/continuity of care and prevention/avoidance of complications

## Transitional Care Program
### Naylor Model

In-hospital screening for program participation (initially, now done by Manager/Admission Nurse)

- Comprehensive assessment using tools
- Enrollment in program by TCN
- Active engagement of patients & family
- Development of evidence-based plan of care-care paths

### Key Elements:
- Regular home visits by the TCN
- Emphasis on early identification & response to healthcare risks & symptoms
- Collaboration/partnership
- Communication between patient, family/caregivers & healthcare
The Care Transitions Program
Eric Coleman

The Program:
During a 4-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home.

Key Elements:
• Medication Management
• Red Flags
• Follow-up with Primary Care Physician
• Personal Health record

Virtua Home Care Model
Transitions of Care Program (TCP)

Target Population:
• Medicare and Managed care patients who meet the screening criteria
• Chronic illnesses known to be at high risk for re-admission
  – Heart Failure
  – COPD
  – Pneumonia
• Patients must be able and willing to participate in managing their chronic illness
• Focused on specific geographic location and community identified as high risk population for chronic illness
Virtua Home Care Model

Transitions of Care Program (TCP)

Challenges:

• Agency Acute Care Hospitalization Program initiated in 2006

• Telehealth Program (40 units) focused on management of heart failure patients

• Pilot focused on Medicare Fee-for-Service - Patients in pilot had to be eligible for Medicare home care benefit

• Naylor Model utilizes APN as transition nurse

• No additional funding for project

Virtua Home Care Model

Present Transitions of Care Program

Enrollment in TCP:

• Schedulers/Team Managers vs. Admission Nurse

Comprehensive Assessment:

• Mini –Mental Status
• Geriatric Depression Scale
• Quality of Life Assessment

Primary Interventions:

• Interventions from home care ACH and Telehealth Programs
• Primary care physician visit within 7-14 days
• Use of personal health record
• Monthly patient case conferences
# Virtua Home Care

## Strategies to Reduce Re-Hospitalization

<table>
<thead>
<tr>
<th>Acute Care Hospitalization (ACH)</th>
<th>Telehealth</th>
<th>Transitions in Care Program (TCP)</th>
<th>Nutrition</th>
<th>Access</th>
</tr>
</thead>
</table>

**Goal:** Reduce re-hospitalization within the 60 day home care episode

**Assessment:** At SOC, every new admission is screened for risk of hospitalization

**Interventions:**
- Care paths for chronic diseases
- Develop problems/interventions for populations identified as “high risk hospitalization”
- Front load visits
- Telephone monitoring
- My Emergency Plan
- Medication management
- Community resources
- Monthly ACH focus review

**Dashboard**

**Acute Care Hospitalization**

<table>
<thead>
<tr>
<th>ACH Rate</th>
<th>2005</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
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</table>

- 2004: Implement EMR
- 2006: Implement EVB ACH Program
- 2009: Pilot Transitions Program
ACH Risk Assessment Tool

Patients scoring 5 or > are considered at high risk for unplanned hospitalization

| ACH Hospitalization Risk Tool |  
|-------------------------------|------------------|
| **Total Score**               | **Total Score 0** |

**Hospitalization Risk Screening**
- Box all that apply
- > 1 Hospitalizations or ER visits in the past 12 months
- History of falls
- None

**Chronic Conditions**
- Check all that apply
- High blood pressure
- Diabetes
- COPD
- Chronic kidney disease
- None

**Risk Factors**
- Box all that apply
- Discharged from hospital or skilled nursing facility
- Low socioeconomic status or financial concerns
- Inadequate support network
- Home safety issues
- Help with medications needed
- Confusion
- Stabilizer use
- Poor prognosis
- None

**Comments**

(Chisholm, 2003)

My Emergency Plan

**Heart Failure Guidelines**

**Call the Virtua Home Care if you experience:**
- Increase shortness of breath, especially when lying flat
- Weight gain of 2 lbs in 2 days
- Coughing at night
- Dizziness
- Increased tiredness
- Feet, ankles, or stomach swell more than usual; shoes may be tight

Call 800-858-5172, press 0 and ask for a nurse

**Call 911 if you experience:**
- Sudden or severe chest pain pressure tightness or palpitations
- Severe shortness of breath
- Fainting
- Change in color of lips, fingernails or skin to blue/gray
- Cold sweaty skin

Please call 911!!!!

If you stay in the hospital for more than 24 hours, please notify us at 800-858-5172, press 0 and ask for a nurse.
Medication Management

- Medication Management versus Medication Reconciliation
- Medication reconciliation starts at the first visit
- Reconciliation process for nursing versus therapy
- Coach patient / caregiver to develop a working medication list
- Medication list should be in a format acceptable and easily understood by the patient / caregiver
- Assess patient’s ability to manage their medications

Medication Assessment

**Morisky Scale**

- Validated medication assessment tool
- Answers classify the patient’s knowledge- motivation level for recommended adherence improvement
- Useful for nurses to assess need for intervention
- Allows patients to be categorized as either high or low on knowledge
Morisky 8-Item Medication Adherence Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient Answer (Yes/No)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you sometimes forget to take your medicine?</td>
<td></td>
<td></td>
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<tr>
<td>People sometimes miss their medicines for reasons other than forgetting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking over the past 2 weeks, were there any days when you did not take your medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever cut back or stopped taking your medicine without telling your doctor because you felt worse when you took it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you travel or leave home, do you sometimes forget to bring along your medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you take all your medicines yesterday?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you feel like your symptoms are under control, do you sometimes stop taking your medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking medicine every day is a real inconvenience for some people. Do you ever feel bothered about sticking to your treatment plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you have difficulty remembering to take all your medicine?</td>
<td>A: Never; rarely</td>
<td></td>
</tr>
<tr>
<td>B: Once in a while</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C: Sometimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D: Usually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E: All the time</td>
<td></td>
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</tbody>
</table>

Total score

Score Interpretation:
- 0-2: Poor adherence
- 3-4: Moderate adherence
- 5-6: High adherence

*High adherence more common with daily use of medications.*

Medication Management Requirements

1st & 2nd Visit
- Visualize ALL Medications
- *Compare to D/C List &/or meds in home*
- *Coach/encourage pt to have a 'working' Med List by 2nd visit*
- *Clinician to add intervention/Goal w/response*

Duplication/Discrepancy/ Missing Meds/ Polypharmacy
- Follow – up w/ MD, Pharmacy, Pt as necessary
- Update Med Profile w/ Verbal Order; Save & Check for 'Major' drug interactions; Notify MD if yes & Document

If any Medications a Plan of Care is required
- Instruct pt/ptc to take Med List to MD appts, update med list & carry at all times in case of emergency.
- Document ALL med issues/problems w/ resolution

Follow up w/ MD, Pharmacy, Pt as necessary
**Telehealth for Heart Failure Patients**

**Goal:** Use of innovative technology to improve clinical outcomes

**Assessment:** 65 Units/web–based
- Blood pressure
- Heart rate
- Pulse Ox
- Weight

**Interventions:**
- Physician and patient education
- Telehealth screening criteria
- Physician standing orders
- Monitoring station staffed 7 days/week
- Patient visits coordinated with when patient needs to be seen

**Dashboard**

**Re-hospitalization Rate Telehealth Patients with Primary / Secondary Diagnosis Heart Failure**

**Barriers:**
- Reimbursement
- Management of Information

**Transitions in Care**

**Goals:** Reduce re-admission of patients discharged from acute care within 30 days of discharge and improve self-management of chronic disease process

**Assessment:** Quality of Life, Geriatric Depression Scale, Mini-Mental Status

**Interventions:**
- Transition RNs
- Follow-up physician visit within 7 – 14 days discharge
- Case conference
- Medication management
- Personal health record

**Dashboard**
How is Transition of Care Different from Regular Case Management?

- Data collection tools are used as part of the assessment: Quality of Life Scale, Geriatric Depression Scale, and Mini-Mental Scale
- Patient population
- Patient in agreement in behavior change/engagement/self management
- Case conferencing completed monthly with TCN, TM
- TCP/nutrition problems
- Care paths
- Personal Health Record (PHR)
- Nutrition support - Abbott
- Utilization of Motivational Interviewing
- MD appointment within 7-14 days
- Keep patient open to service for entire certification period

Transition in Care Nurse

- Role of TCN in home care
- Education to role of Transition In Care Nurse
  - SBAR
  - Teachback
  - Motivational Interviewing
## TCN Tools

<table>
<thead>
<tr>
<th>SBAR</th>
<th>Teachback</th>
</tr>
</thead>
<tbody>
<tr>
<td>A structured communication technique designed to convey a great deal of information in a succinct and brief manner.</td>
<td>A way to make sure you, the healthcare care provider, explained information clearly. It is not a test or quiz of patients.</td>
</tr>
<tr>
<td><strong>Situation:</strong> A concise statement of the problem</td>
<td>• Asking a patient (or family member) to explain in their own words what they need to know or do, in a caring way.</td>
</tr>
<tr>
<td><strong>Background:</strong> Pertinent and brief information related to the situation</td>
<td>• A way to check for understanding and, if needed, re-explain and check again.</td>
</tr>
<tr>
<td><strong>Assessment:</strong> Analysis and consideration of options</td>
<td>• A research-based health literacy intervention that improves patient/provider communication and patient health outcomes</td>
</tr>
<tr>
<td><strong>Recommendation:</strong> Request/recommend action</td>
<td></td>
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</tbody>
</table>

## Motivational Interviewing

- A method to change the direction of a conversation to stimulate the patient’s desire to change and give them the confidence to do so.
- Tool to express empathy and understanding
- **Principles**
  - Express Empathy
  - Develop Discrepancy
  - Roll with Resistance
  - Avoid Argumentation
  - Support Self-efficacy

(Brobeck, Bergh, Odencrants, & Hildingh, 2011).
Motivational Methods

- Confirmation
- Open-ended questions
- Reflective Listening
- Summarizing

(Brobeck et al., 2011)

Nutrition

Goal: Improving patient outcomes through nutrition

Interventions:

Find: Identify patients at risk for loss of body mass and malnutrition

Feed: Recommend nutrition supplements to fill the gaps and educate in the benefits of nutrition

Follow: Provide patients with the nutrition tools to create self-management of nutrition and remain healthy at home
Access

- Community Resources
- Community-Based Care Managers
- Health Information Exchange

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### Virtua Home Care Model to Reduce Re-Hospitalization

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<tr>
<td>Goal: Reduce re-hospitalization within 60 day episode</td>
<td>Goal: Provide a service that offers the use of innovative technology to improve clinical outcomes while keeping patients safe at home. Equipment: 65 Units Assessment Monitor Blood pressure Heart rate Pulse Ox Weight Video conferencing</td>
<td>Goal: Reduce re-admission of patients discharge from acute care within 30 days of discharge Improve self management of chronic disease process Assessment: Quality of Life, Geriatric Depression Scale Mini-Mental Status Interventions: Transition RNs •Follow-up physician visit within 7 – 14 days discharge •Case conference •Medication management •Personal health record Control: Telehealth dashboard</td>
<td>Goal: Improving patient outcomes through nutrition Interventions: Find: Identify patients at risk for loss of body mass and malnutrition Feed: Recommend nutrition supplements to fill the gaps and educate in the benefits of nutrition Find: Provide patient’s with the nutrition tools to create self management of nutrition and remain healthy at home</td>
<td>Goal: Provide patients / caregivers with a convenient method to access healthcare Interventions: • Home Care discharge case management referral to access center • Community Based Case Managers • Connect to Community Resources MYVIRTUA.org</td>
</tr>
</tbody>
</table>
Challenges & Opportunities to Consider for Your Program

Our Patient Population

• Patients with:
  – multiple physicians
  – multiple medications
• Patients not adhering to recommended treatment
• Patients with poorly controlled disease management
• Lack of end-of-life care discussions
MORE THAN HALF OF PEOPLE WITH SERIOUS CHRONIC CONDITIONS HAVE THREE OR MORE PHYSICIANS

Source: Gallup Serious Chronic Illness Survey

HOME CARE CHALLENGE

- Develop innovative, workable approaches to reduce avoidable re-hospitalization
- Use of evidence-based protocols
- Improve care coordination
- Engage patients to become accountable for their healthcare
Strategies to Consider

- Assessments
  - Verify provider in charge of care
  - Clarify with patient reason for hospitalization
  - Risk assessment
  - Evaluate unauthorized admission “triggers” (hospice)
  - Critical conversations (palliative care)
  - Patient Activation Measure
    http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361231/
  - Utilize home visiting providers/EMTs

Strategies to Consider

- Implementation
  - Front load visits
  - Providing ongoing support (“tuck-in”, telehealth, telephonic)
  - “Flag” patient as high risk so all, including on-call, are aware
  - Contact by on-call service (hospice)
  - Symptom awareness on aide care plan
  - Case conference within two weeks of admission
  - Establish “transitions in care” program including transportation (private duty)
  - Root cause analysis for each readmission (team huddle)
Strategies to Consider

- Organizational Capacity
  - Education & competency of staff
    - Heart and lung sound auscultation
    - Suggested treatment (SBAR)
    - Assertiveness training
    - Teach-back
    - Motivational interviewing
      http://www.youtube.com/watch?v=dm-rJPCuTE

Strategies to Consider

- Organizational Capacity
  - Consider patient & caregiver advisory committee
    - Clarify “triggers”
    - Educational materials
    - Medication reconciliation
  - Relationship with discharge planning
  - Getting a seat at the table
  - Develop dashboard
## Metrics

### Implementation
- Timeliness of initial assessments
- Patients accurately identified as “at risk”
- Percentage of “at risk” patients who received front-loaded visits
- Number of after hours visits made
- Staff utilization of motivational interviewing
- Staff utilization of teach back
- Accuracy of medication profiles

### Physician collaboration
- Was there a change in condition, if yes, was MD contacted
- If MD contacted, what was result
  - Treatment change or ED
- Identify MD
Metrics

- Hospitalization
  - Number of days prior to hospital stay last visit made
  - Avoidable hospitalization rate – including time of day and week

Impact of Success

- Reduce avoidable re-hospitalization
- Cost avoidance
- Preferred provider: deemed worthy collaborator
- Patient/family satisfaction
- Staff satisfaction
- Regulatory compliance
Lessons Learned

- It's not about the tools but rather implementation
- Importance of relationships
- Include measurements
- Constant vigilance needed

“Home healthcare is the component of the healthcare industry best positioned to bridge gaps in care between hospitals and home, especially for high-risk groups such as older adults coping with multiple health problems.”

Healthcare Quality Strategies, Inc.
Questions

Thank you

Reference


Reference