The Home Health Therapist's Role in Care Transitions and Preventing Rehospitalizations

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Objectives

- Demonstrate how home health therapists are an integral part of minimizing re-hospitalizations and safely transitioning the patient from hospital to home

- Describe the importance of the home health therapists receiving the "hand-off" from their colleagues in acute care, SNF's and inpatient rehab at time of discharge home

- Discuss how the home health therapist's role overall is to leave a lasting impact on the independence and well-being of the patient, keeping them safe in the comfort of their own home
How objectives will be met:

- History of re-hospitalizations and government involvement
- Current challenges for transition to homecare
- How therapy involvement decrease re-hospitalizations

A Brief History on Re-hospitalizations
$6,609,600,000

Why Such A Focus?

- Nearly 1 in 5 Medicare patients discharged from the hospital are readmitted within 30 days
- 3.4 million Medicare recipients were under the care of 11,000 home health agencies in the country in 2011
- 918,000 patient re-hospitalized yearly

Delta study 2012
National readmission Rates

- 2007 - 2011 = 19%
- 2012 = 18.5%
- 2013 = <18%
  ✓ Approx. 130,000 fewer hospital readmissions

(CMS Blog 2013)

Top Reasons Patients may return to Emergency Room

- Medication mismanagement
- Lack of follow up with PCP
- Fear
- Lack of support/caregiver
- Lack of patient education
Medical Reasons for Receiving Home Health Care (Percent of All Patients)

- Injuries and Poisoning, 17%
- Cancer and Tumors, 8%
- Endocrine, Nutritional, Metabolic and Immunity, 12%
- Nervous System and Sensory, 2%
- Cardiovascular Disease, 34%
- Musculoskeletal and Connective Tissue, 16%
- Respiratory Disease, 12%

http://www.longtermcarelink.net/eldercare

Common Re-hospitalization Diagnoses

- CHF (24.7%)
- Renal insufficiency (21.7%)
- COPD (20.9%)
- DM (20.3%)
- Septicemia (21%)

Financial Costs

- Medicare spends $15 billion a year on re-hospitalization
- $6.6 billion is the annual cost for homecare patients hospitalized
- $7200 is the cost to Medicare on just one preventable hospital readmission

(delta study 2012)

$6,609,600,000
The Government Steps In...

Hospital Readmissions Reduction Program (HRRP)

- Requires CMS to reduce payments to inpatient hospitals with higher than expected readmissions starting in fiscal year 2013
  - “Readmission defined as an admission to hospital within 30 days of a discharge from the same or another hospital” (CMS.gov)
- Started with acute MI, CHF and pneumonia
- 2015 final rule expands to includes acute COPD exacerbation and TKR/THR
What is Care Transitions

- American Geriatric Society
  “care transition is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.”

Care Transition Programs

- RED (“Re-engineered Discharge”)
- CTI (“Care Transition Program”)
- BOOST (“Better Outcomes for Older Adults through Safe Transitions”)
- TCM (“Transition Care Model”)
- CCTP (Community based Care Transitions Program)
- STAAR (“State Action on Avoidable Rehospitalizations”)
- H2H – (“Hospital to Home”)
Discharge

- A period of transition from hospital to home that involves a transfer in responsibility from the inpatient provider or hospitalist to the primary care physician (PCP), outpatient provider, HCA (if involved), as well as the patient, family and or other support system.

 Hospitals role in discharge

- Provides education to the patient on what to expect with discharge
- Use a team approach to coordinate services/needs for patient upon discharge
- Provide patient/family/caregiver education towards discharge process/plan
- Hand off procedure initiated to community health care providers
- Order home health services when indicated
Challenges hospitals face with Discharge

- Economic pressures on our health care system causing patients to be released from the hospital “quicker and sicker”
- Discontinuity between hospitalists and primary care providers
- Complex discharge instructions with shorter time frames and frequently no caregivers to teach

http://caretransitions.org

Patient Role in Discharge

- Follow instructions provided by Hospital

- Participate in education provided by Home Health Agency
Challenges Patients Face with Discharge

- Self-care responsibilities increase in number and importance for patients and their families as they return home.
- Changes to the medication regimen
- Increased need for safe and independent mobility
- Lack of carryover from education provided in hospital
  - Due to depth or lack of education provided.
- Lack of finances/resources
  - Ability to afford medications
  - No homecare coverage on insurance plan
- Decreased mobility/Limited transportation

Homecare Role in Discharge

- Provide smooth transition to the home setting
- Continue to provide and reinforce education initiated inpatient
- Use multidisciplinary teams to provide quality care to prevent re-hospitalization
- Care coordination with community healthcare providers
Challenges for Homecare

- Incomplete or delayed receipt of patient discharge summaries
  - Incomplete medication lists
- Limited patient access to primary care physician
- Financial constraints
  - Minimal (or lack of) health insurance coverage
- Limited or absent caregiver to reinforce teaching and education provided to ensure safety in the home

Hand off Communication

- The process of passing patient specific information from one caregiver to another for the purpose of ensuring the continuity, safety, and transition of patient care
- Transfer and acceptance of patient care responsibility achieved through effective two way communication
  - face to face
  - written
  - electronic
  - Telecommunication/verbal
Why is hand-off so important?

- Promote patient safety
  - Avoid errors that could adversely affect the patient
- Ensure key information is shared among caregivers
- Improve patient satisfaction
- Reduce hospital re-admissions
  - Experts believe 76% of readmissions may be preventable (MedPac)

Results of defective handoff

- Potential to cause patient’s harm with increased risk for re-hospitalization
- Increased length of stay in hospital
- Delay in initiation of treatment in community
- Inappropriate treatment
- Omission of care
  - Missed referrals to all necessary disciplines
- Increased costs in overall care
Results of effective handoff

- Improves communication between inpatient health providers and community health providers
- Allows effective reconciliation of prescribed medication regimens
- Adequate education to patients about discharge instructions
- Closer medical follow-up
  - greater clarity in physician–patient communication
- Appropriate referrals to community resources

• https://www.youtube.com/watch?v=RY25RSLYCFY
What Services for The Elderly Are Provided by Home Health Agencies? (Percent of All Visits)

- Nursing Services: 84%
- Physical Therapy: 38%
- Social Services: 17%
- Homemaker Services: 15%
- Medication Management: 11%
- Occupational Therapy: 10%
- Physician Services: 5%
- Counseling: 4%
- Nutrition Services: 4%
- Speech Therapy: 2%

http://www.longtermcarelink.net/eldercare/personal_care_home_care.htm

Key strategies......
What is the role of Rehab services in Homecare?

PHYSICAL THERAPY

Assess, Evaluate, and Educate

- Functional mobility
- Balance
- Strength and ROM
- Pain management
- Fall risk/prevention

- Med management
- Equipment needs
- Safety
- Environmental safety
- Proprioception
**OCCUPATIONAL THERAPY**

Assess, Evaluate, and Educate

- Self care
- activities of daily living,
- home management
- safety
- energy conservation training/techniques,
- Strength and ROM
- Vision and need for adaptation
- Environmental adaptations
- Equipment needs
- Proprioception

**SPEECH THERAPY**

Assess, Evaluate, and Educate

- Receptive/Expressive language
- Cognition
- Swallowing
- speech intelligibility
- Functional communicative
- cognitive tasks
- diet modification
- oral motor deficits
What does “Hand off” Mean to the therapist?

- Knowledge of accurate functional status obtained from inpatient therapy notes
- Allows the therapists to have the overall picture of the patient
- Helps to Increase efficiency, effectiveness, and continuity of care

How is Hand-Off information helpful?

- Was there a medical conditions
- DME
- Compliance and motivation
- On-going goals discussed
- Results of standardized Assessment tests
Added Benefits to Rehab services in decreasing re-hospitalization

- Multidisciplinary communication for prevention of Re-hospitalization
- Front loading visits (89.0%)
- Accurate fall risk assessment and timely initiation of fall prevention (94.9%)
- Added support for medication reconciliation (78.8%)

Front loading

- A strategy whereby the agency increases the visit frequency or services at the beginning of care in order to reduce the potential for unplanned hospitalizations (briggs)
- 3rd most frequently used strategy in preventing re-hospitalization (Delta Study)
- 2-3 week window in the beginning of care is the most crucial
Why Front Loading in therapy is so important?

- Hospitalization leads to loss of functional independence in 25% to 50% of all older persons
  - Only a third resume pre-hospital levels of functioning by three months
- Restorative care, such as physical, occupational and speech therapy and social service consultations, enhance the health outcomes and day-to-day lives of older persons. (Briggs)

Why Front Loading in therapy is so important?

- Assists in restoring physical health and enhancing comfort, rather than simply treating individual disease.
- Close monitoring of a patient's needs and ensure timely care
  - increase both the patient's comfort level and function
- Patients receiving intensive services after hospitalization have shorter home care episodes and a generally lower use of services in other areas than those receiving traditional care.
Fall Prevention

• #1 strategy used by home care agencies to prevent hospitalization

• The home is the PRIMARY location for non-fatal unintentional falls

National Fall Facts

• Falls occur more frequently within the first 2 weeks after discharge from a hospital.

• 60% of falls occur in the home

• 23% falls occur outside but near the house

• In 2009 22 million nonfatal fall injuries among older adults were treated in ED

• By 2020 the cost of fall injuries is projected to reach $43.5 billion
Patient specific risk factors

- Orthostatic hypotension
- Polypharmacy
- Visual Impairments
- Pain affecting function
- Incontinence
- Cognitive Impairments
- Impaired Functional Mobility
- Improper Use of an assistive device
- 3-4 coexisting diagnoses
- Prior history of falls/fear of falls
- Environmental Hazards present in the home
- Patients with oxygen tubing

Fall Prevention Program

- Fall Risk Assessment
- Proactive Fall Intervention
- Patient/caregiver education
- Evaluation of the Effectiveness of Fall Prevention Program
Rehab specific Fall Prevention Interventions

- Balance/Gait/Muscular Weakness issues
  - Institute activity program that is enjoyable and individualized to the patient to increase compliance
  - Provide transfer instruction to individual before transfers
- Assistive devices
  - Assess if device is in good repair
  - Educate patient on keeping device within reach
  - Perform home modifications if needed

Rehab specific Fall Prevention Interventions

- Mobility Issues
  - Assess need for assistance
- Visual Impairment: known or suspected
  - Clearly mark edges of steps
  - Keep walkways free of clutter
  - Place bells on pet collars
- Continence issues
  - Institute regular toileting times
  - Review timing and amount of caffeine intake
  - Review timing of diuretics and/or laxatives
Medication Reconciliation

Medication Management

- “30% of all hospitalizations and 45% of all readmissions among the elderly are associated with medication mismanagement”

- Medication changes often lead to an increased risk for falls.
Medication Reconciliation:

• Must be performed and documented at EVERY visit.

• Needs to be an interdisciplinary approach:
  - Review med list each visit (each team member)
  - Any changes need to be reported/communicated to the team
  - Case conference

• Medication list visible in the home to all staff

Role of Therapy in Medication Reconciliation

• Therapist needs to understand functional side affects of medications

• Knowing when to consult with nursing/physician is key

• Medication changes are communicated to team (dosage, side affects, functional side affects)
Interdisciplinary Communication

- Joint effort on behalf of the patient with a common goal from all disciplines
- Improves patient confidence and trust
  - therefore patient safety
- Relays important/critical info
  - Decrease risk for error
- Enhances team work and team building
  - Increases our own knowledge and skills

Patient Safety and Quality: An Evidence-Based Handbook for Nurses

Think Rehab...

- Rehab therapists serve an important role in patient safety and patient care transitions.
- They provide comprehensive assessments
- Advocate and communicate their expertise and critical-decision making providing recommendations for the most appropriate level of care to help in reducing hospital readmissions.
Why Home...

- Thrive and do better at home
- Ultimately what patients want
- Goal inpatient is to get them home, goal at home is to keep them home
- Happier, more independent (at times)

Last thoughts.....

- 5 major causes driving health care into homes:
  - The aging of the U.S. population
  - Epidemics of chronic diseases
  - Technological advances
  - health care consumerism
  - Rapidly escalating health care costs
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Discussion and Questions
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