Improving Care Transitions Between Hospital and Home Health

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Facilitated by Dr. Amy Boutwell, President, Collaborative Healthcare Strategies and Consultant, Transitions: Handle with Care
Welcome &
Opening Remarks

Amy Boutwell MD MPP
President, Collaborative Healthcare Strategies
Consultant, Transitions: Handle with Care
About the Alliance

• 501(c)(3) non-profit research and education foundation

• Mission: To lead and support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

• www.ahhqi.org
About the Alliance’s Transitions of Care Technical Advisory Panel

- Convened a national group of clinical experts and leaders in home health.
- Thorough review of existing care transitions literature across providers and settings.
- Identified best practices and tools starting from patient referral to home healthcare during inpatient stay through discharge from homecare provider to the community.
Work of the Alliance TOC Panel

- Defined a home health model for care transitions from hospital to home health care to support better health, better care, lower cost.
- Ensured the care transitions practices and tools clearly support patient, family, and care giver engagement across all transitions.
- Currently disseminating care transition best practice interventions and tools for use by home health providers and hospital partners.
- Future: Test and evaluate home care’s impact on quality outcomes with TOC model and tools.
Alliance Model and Tools
Literature Review of Care Transitions Best Practices Across Providers & Settings

Hospital Programs
Ambulatory Care Programs
Home/Community Programs
Accrediting Organization Programs
# AHHQI Home Health Model Compared to Other TOC Models

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>Coleman CTI</th>
<th>Naylor TCM</th>
<th>Project BOOST</th>
<th>Re-engineered Dis-Charge RED</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>“Red Flags” &amp; Follow-up</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>24/7 on call response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Hospital Visit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Physician F/U</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Home Visit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Remote Monitoring</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Active engagement of pts</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>PHR</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*Note: ✓ indicates the presence of the intervention.*
## AHHQI Home Health Unique TOC Interventions

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<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Literacy Screen</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Depression Screen</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Personal concerns/goals</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Med Management</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Pt friendly med list</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Health Literate stoplights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Case conf High Risk pts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Family Caregiver Assessment</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Examples of OASIS Assessments

**Health History**

(M1032) Risk for Hospitalization; Which of the following signs or symptoms characterize this patient as a risk for hospitalization?

(M1036) Risk Factors, Present or Past

**Depression Screening (M1730)**

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

- 0 - No
- 1 - Yes, patient was screened using the PHQ-2® scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?")

<table>
<thead>
<tr>
<th>PHQ-2®*</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half of the days</th>
<th>Nearly every day</th>
<th>N/A Unable to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>na</td>
</tr>
<tr>
<td>b) Feeling down, depressed, or hopeless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>na</td>
</tr>
</tbody>
</table>

- 2 - Yes, with a different standardized assessment and the patient meets criteria for further evaluation for depression.
- 3 - Yes, patient was screened with a different standardized assessment and the patient does not meet criteria for further evaluation for depression.

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**Fall Risk Standardized Testing**

Missouri Alliance Fall Risk Assessment:
- Visual Impairments;
- Polypharmacy;
- Cognitive Impairments;
- Incontinence
## Example of HH OASIS Hospitalization Risk Factors

### Hospitalization Risk Factors (M1032)

<table>
<thead>
<tr>
<th>Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)</th>
<th>You</th>
<th>SHP State Database</th>
<th>SHP National Database</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicated at SOC/ROC</td>
<td>Indicated at SOC/ROC &amp; Hospitalized</td>
<td>% of All Patients Indicated</td>
</tr>
<tr>
<td>Recent decline in mental, emotional, or behavior</td>
<td>2,540</td>
<td>586</td>
<td>10.6%</td>
</tr>
<tr>
<td>Multiple hospitalizations (2 or more - past year)</td>
<td>8,709</td>
<td>2,435</td>
<td>36.2%</td>
</tr>
<tr>
<td>History of falls (2 or more w/ injury - past year)</td>
<td>7,091</td>
<td>1,284</td>
<td>29.5%</td>
</tr>
<tr>
<td>Taking five or more medications</td>
<td>19,972</td>
<td>3,893</td>
<td>83.1%</td>
</tr>
<tr>
<td>Frailty indicators, e.g., weight loss, exhaustion</td>
<td>8,858</td>
<td>2,194</td>
<td>36.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1,704</td>
<td>343</td>
<td>7.1%</td>
</tr>
<tr>
<td>None of the above</td>
<td>1,514</td>
<td>101</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
Home Health Model of Care Transitions Work Flow

Hospital Admission

Hospital case management does early risk screening to identify patients with a high risk of hospital readmission.

High or Moderate Risk?

Hospital case management team (or physician) and patient determine post-acute care plans.

In-Hospital Transitional Care
After the referral to home health, a home health care transition coordinator (or coach) ("HHCC") (who works for the home health provider) sees the patient while still in the hospital.

Referral to SNF, IRF, or home (without home health)

Referral to Home Health Provider

Home Health Start of Care
For high risk patients, home health begins within 24 hours of discharge. The home health (HH) nurse or physical therapist (PT) can start care. For moderate risk patients, the HH nurse or PT begins the Start of Care within 48 hours of discharge.

Home Health Second Visit Checklist
The HH nurse or PT makes a second visit within 72 hours of hospital discharge for patients with a high risk of hospital readmission. For moderate-risk patients, the HH nurse or PT should complete the second visit or contact (such as a telephone call) within 96 hours of discharge.

Subsequent Visits Per Plan of Care
### In-Hospital Checklist

**Patient Assessment**
- Risk Assessment
- Language interpretation needs
- Early Med risk error assessment

**Patient Education**
- Intro to home health
- Begin discussing patient’s goals
- Coach patient on understanding meds/new prescriptions

**Follow up Coordination**
- Identify Primary Care Physician
- Coordinate with hosp case mgmt

### Home Care Checklist

**Start of Care**
- High risk within 24 hours; moderate risk within 48 hours of hospital discharge
- Medication reconciliation
- Assess barriers, health literacy
- Assess need for other disciplines

**Patient Education**
- Advance Directives/My Health Wishes
- Personal Health Record
- Red Flags Teaching

**Follow up**
- Physician Appt post hosp D/C.
One Specific Application of Model: Partnership Between a Hospital and Home Health Care
Hospital & HH TOC Partnership
In Hospital Process

**Multidisciplinary Rounds**
- Attendees: MDs, Case Mgt, Nursing, Social Work, Pharmacists
- Risk Assessment

**Transitions Care Planned by Team**
- Appropriate for Homecare: MD writes order

**Hospital Secures Pt Choice**
- Hospital Case Manager meets with patient and secures Pt Choice
- Notify SCAH if selected to provide Home Care services

**HCC Accesses Patient Data**
- Chart Review
- Reviews with RN Case Manager
- Initiates Referral Intake (RI)Note

**HCC Initial Bedside Visit**
- Explains program and inquires about patient’s concerns
- Pt Assessments: Risk for readmission (IHI 2 question tool)
- Begins Stoplight teaching

**HCC Second Bedside Visit**
- Continues assessment and stoplight teaching
- Builds rapport
- Updates RI note

**Admission**

**Family/caregiver conference may be held to determine appropriate level of care: HH, AIM, Hospice**

**Discharge**

**HCC notifies branch of discharge**
Person-Centered Starting in Hospital

“I have four areas we need to focus on to help prepare you and your family for discharge, but before we start on my list can you tell me what you are the most concerned about when you leave here and go home?”

Then transitions of care focus areas.

1. Medication Management Post-Discharge
2. Early Follow-up
3. Symptom Management
4. Personal Health record
## Risk Stratification: Institute for Health Improvement

<table>
<thead>
<tr>
<th>High-Risk Pts</th>
<th>Moderate Risk Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong> Patient has been admitted two or more times in the past year</td>
<td><strong>a.</strong> Patient has been admitted once in the past year</td>
</tr>
<tr>
<td><strong>b.</strong> Patient failed teach back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home</td>
<td><strong>b.</strong> Patient or family caregiver has moderate degree of confidence to carry out self-care at home</td>
</tr>
</tbody>
</table>
Health literacy: A matter of quality, cost and satisfaction

Stoplight form *before* universal precaution approach

- Third person
- Zones drive navigation
- Graphic does not support text
- Font, layout, graphics not consistent with health literacy principles
Stoplight form with universal precaution approach applied

- First person
- Patient assessment drives navigation
- Font, layout, graphics consistent with health literacy and plain language principles
- Supports patient and caregiver engagement

<table>
<thead>
<tr>
<th>Controlling heart failure at home</th>
<th>How do I feel today?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Image of stoplight form]</td>
<td>[Image of form]</td>
</tr>
</tbody>
</table>

- **Green zone**
  - You are in control.
  - Take action today.
  - Call:
  - My weight is up:
    - 3 pounds overnight
    - 5 pounds since last week
  - My weight is up:
    - 5 pounds overnight

- **Yellow zone**
  - I do not have swelling.
  - I have swelling in my:
    - Foot, ankle, or shin
    - Knee or thigh
  - I have swelling in my:
    - Belly - feels bloated or pants are tighter
    - Hands or face

- **Red zone**
  - I do not feel short of breath:
    - Breathing is normal
    - Sleep is normal
  - I feel short of breath or cough while:
    - Walking or talking
    - Eating
    - Bathing or dressing
  - I feel:
    - Short of breath or wheeze at rest
    - Less alert
    - I need to sleep sitting up to breathe.
  - My energy level is normal.
  - I am too tired to do most of my normal activities.
  - I am so tired that I can hardly do any of my normal activities.

- **My other signs of heart failure**
  - Chest pain or pressure that does not go away.
Consistency across providers & settings

Current Stoplight Topics:
1. Heart failure
2. COPD
3. Diabetes
4. Depression
5. Pneumonia
6. Falls
7. Wounds
8. Pain
9. Constipation
10. Nausea
11. Anxiety
12. Stroke
13. Shortness of breath

Provider specific instruction determined here:
- Call your nurse
- Call your doctor
- Call HH/hospice
- Call Case Manager
Patient Engagement

“I didn’t know with heart failure I could feel so good. I’m in ‘the green zone’ and I’m controlling my heart failure instead of my heart failure controlling me.”

Pt Goal: “Return to ROMEO Club”
Home Health “Touch-Points”
Within 2 weeks of Hospital Discharge

**Pre-discharge**
- Home Care Coordinator in-hospital pt visit
- Pt Assessments: Risk for readmission
- Pt Concerns & Stoplight teaching

**Home visits**
- 1st visit w/in 24 hrs of dc
- 2nd visit w/in 72hrs by same clinician
- 3rd visit same week
  - Focus on med rec, signs & symptoms, MD f/u, pt engagement

**Remote monitoring**
- Remote monitoring to detect signs of exacerbation

**Additional interventions**
- Case conference
- Pt-friendly med list
- Medication Management
- SBAR communication

**Week 1**
- 3 home visits
  - Focus on patient engagement, med management, barriers and confidence-building

**Week 2**
- Home visits continue based on need
  - Remote monitoring with focus on health coaching
Health Coach in the Home: Medication Management

- Emphasis on med reconciliation and adherence
- Med – “brown bag” – bring all meds out
- Include all meds taken before hospitalization
- Ask:
  - What concerns do you have about your medications?
  - Do you take any herbs and over the counter meds?
  - Teach back: Show me which meds you take
- NOTE: Ongoing Reconciliation: Any new or changed meds since my last visit?
Client Friendly Medication List

Jane Doe

<table>
<thead>
<tr>
<th>Medicine name and how to take</th>
<th>Strength of medicine</th>
<th>How much to take</th>
<th>When to take</th>
<th>Reason to take</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen Oral</td>
<td>325 mg</td>
<td>1-2 Tabs</td>
<td>Every 4 Hours - Take Only As Needed</td>
<td>Prn Pain, Increased Temp</td>
<td></td>
</tr>
<tr>
<td>Amlodipine Oral</td>
<td>10 mg</td>
<td>1 Tab</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baclofen Oral</td>
<td>10 mg</td>
<td>1/2 Tab</td>
<td>2 Times Daily</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A recent study found that four agents were responsible for 2/3 of all drug related hospitalizations:

1. Plavix
2. Coumadin
3. Insulin
4. Oral Hypoglycemics

One Tool for Meaningful Data Exchange: SBAR

- SBAR is a structured method for communicating critical information that requires immediate attention & action
- SBAR improves communication, assists with effective escalation and increased safety
- Its use is well established in many settings including the military, aviation, and healthcare settings
- SBAR: 1) Situation 2) Background 3) Assessment 4) Recommendation

Source: NHS Institute for Innovation and Improvement
SBAR Application

• Transitions of Care Notes
• EMR Documentation
• New or change order requests of MD
• Personal Health Record
• Case Conferences/ Huddles
• Eliciting information from patients/families/caregivers
How to give your doctor a quick, clear picture of your health problem

1. Say who you are: __________________________
   - Give your name
   - If you are not the patient, say how you know the patient

2. Say what you are being treated for at this time: __________________________

   Include:
   - Names of medical problems
   - Home health care services you have now
   - Medical supplies you use (medication, oxygen, walker)

3. Say why you are calling: __________________________

   For example:
   - To ask a question
   - To report a problem or a change from normal
   - Because you noticed new signs or symptoms

4. Say what you need: __________________________

   For example:
   - To make an appointment
   - Have a test
   - More information

5. End the call by asking how to reach the doctor if you need more help: ________
I’m a Berkley girl …

I have HF and Diabetes ….

Before SCAH my blood sugar would go up and I’d have to go to the ER ........

In one years time I went 36 times.

Since SCAH I absolutely am able to take care of myself ....
The stoplight forms make me feel empowered by helping me know what to do to take care of myself, what to do to bring my blood sugar down, AND I don’t have to go back to the ER .
Our care transitions partnership with Sutter Santa Rosa resulted in a 40% decrease in 30-day rehospitalization rates from Q2-2012 to Q3-2013.
From the hospital staff

I just wanted to take the opportunity to let you know how much we appreciate the Sutter Home Health hospital liaisons. We have had several cases lately that required an enormous amount of post discharge follow up and their follow through has been amazing. Just wanted you to know! Thank you.

Susan
Case Management
Sutter Medical Center, Santa Rosa
What patients should expect from their health care:

**Cooperation:** “Those who provide care will cooperate and coordinate their work fully with each other and with you. The walls between professionals and institutions will crumble, so that you experience becomes seamless. You will never feel lost.”

*Crossing the Quality Chasm: A new Health System for the 21st Century, (IOM, 2001)*
What questions do you have
We have time?
Faculty Contact Information

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Beth Hennessey, RN, MSN
Executive Director, Sutter Center for Integrated Care
Email: hennesb@sutterhealth.org
Save the Date:

“Addressing Disparities in Hospital Readmissions”
February 19 2014
2-3pm ET