Home care role in reducing re-hospitalization for patients with CHF and pneumonia within 30 days of discharge

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Recommended Citation
Hodorff, Janelle (Nelli), "Home care role in reducing re-hospitalization for patients with CHF and pneumonia within 30 days of discharge" (2014). Celebrating Scholarship & Creativity Day. 37. https://digitalcommons.csbsju.edu/elce_cscday/37
Home Care Role in Reducing Re-hospitalization for Patients with CHF and Pneumonia within 30 Days of Discharge.

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Oct 1, 2012- Hospitals start to have a reduction in reimbursement from Medicare

Nearly 1 in 5 Medicare patients being re-admitted within 30 days of discharge.
  ◦ Costing Medicare $17.5 billion in additional hospital bills
  ◦ Prime examples of an “overly expensive and uncoordinated health care system”

Maximum amount penalized is 1%
  ◦ $280 million hospitals will forfeit nationwide
  ◦ Government rewards hospitals for quality of care
Record Review Data

- Conducted a complete chart review. Patients were admitted and discharged Jan 1- Jan 31st.

- 10 patients with primary diagnoses of CHF and/or Pneumonia.
  - 3 patients were re-admitted into the hospital within 30 days of discharge
  - 7 patients were not readmitted

- Medicare Patients
  - Purpose was to find similarities and differences among patients
- Found in physician and nursing notes

- Non-compliances with medication
  - Patient doesn’t want to take medications, what can homecare do?

- Not informed or not educated
  - Patient stated “they didn’t know”
  - Edu happen at discharge, statics show, “Patients only retain 50% of discharge information after they hear they are going home”
• Lack of Home Care Services within 2 days of discharge
  ◦ Patients scheduled to be seen 5-7 after discharged, were already readmitted.
  ◦ Patient’s that refuse Home Care- education.

• Re-admitted within 3 to 5 days of being discharged.
  ◦ Discharged to early
• Started Home Care Service within 1-2 days of being discharged home.
  ◦ Patients that were discharged to outpatient facility, re-admitted back to hospital.

• Front loading visits by therapy (PT and OT) and nursing
  ◦ Nursing 1-2 days a week, Therapy 3-4 days a week

• Seen by a Transition Coach

**Commonalities of Non Re-Admitted**
• Project RED (ReEngineered Discharge)

• Interventions
  ◦ 1. A discharge advocate
  ◦ 2. A after- hospital care plan (AHCP)
  ◦ 3. Use of a clinical Pharmacist

• Results
  ◦ Showed a decrease in re-hospitalizations in high risk patients
  ◦ Increase patient compliance and patient satisfaction
Institute for Healthcare Improvement

Effective interventions include:
- Communication tools
- Patient activation
- Nurse-led coaching
- One-hour education sessions
- Telephone outreach
- Comprehensive discharge planning
- And at home follow up visits
• Founded by Dr. Erik Coleman out of the University of Denver

• His research formed nurses and social workers, trained by him, to give patients and care givers the critical knowledge and skills in enable self-care.
- Mary Eisenchenk, RN

- Sees patient, once in the hospital, one home visit, and makes three weekly phone calls.

- Uses the teach-back method of teaching, putting patient in control of their health care.

- NO COST TO PATIENT

Transition Coaches at SCH
Today’s Recommendations

- Hospital staff encourage patients to use Home Care Services 1-2 days post discharge
  - Initial appointment made day after discharge

- Nursing and PT/OT work a team
  - Communication tools

- Front loading visits
  - Decreases readmission rates by 30%

- Transition Coach involvement
Future Recommendations

• Change in nursing role for Home Care Nurses.
  ◦ Home care nursing taking on the transition coach role
  ◦ Require additional appointment with patient

• Hiring more Transition Coaches
  ◦ Encouraging nursing to be trained by a transition coach
Future Recommendations

- Providing more information about Transition Coaches to patients and medical staff
  - More involved with patient care plans

- Help decrease re-admission rates each year.
Thank you for your time and are there any questions?

