4-24-2014

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

Janelle (Nelli) Hodorff
*College of Saint Benedict/Saint John's University*

# Home Care Role in Reducing Re-hospitalization for Patients with CHF and Pneumonia within 30 Days of Discharge.

Nelli Hodorff, SN
College of Saint Benedict/ Saint John's University

# Hospital Re-Admission Penalties

- 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 nation wide
  - 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

# Commonalities of Re-Admitted

- 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

# Commonalities Cont.

# Commonalities of Non Re-Admitted

- 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

# Literature Review

- 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

# Literature Review Cont.

- 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.

# Transition Coach

- 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?

# QUESTIONS

# References


Rau J. (2012). Medicare to Penalize 2,217 Hospitals For Excess Readmissions. *Kaiser Health News.* Retrieved from http://www.kaiserhealthnews.org/stories/2012/august/13/medicare-hospitals-readmissions-penalties.aspx

Greenwald J, L. (2009) Preventing the Preventable: Reducing Rehospitalizations Through Coordinated, Patient-Centered Discharge Process. *Professional Case Management.* 14(3), 135-140.

Boutwell, A., Hwu, S. (2009). Effective Interventions to Reduce Rehospitalizations: A survay of the Published Evidence. *Institute for Healthcare Improvement.*

Coleman, E. (2012). *Macarther Fellow/ Meet the Class of 2012.* Denver, CO.