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

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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 nation wide
  ◦ Government rewards hospitals for quality of care

Hospital Re-Admission Penalties
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
- 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 caregivers 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
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
- 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
• 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?

