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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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**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

Record Review Data

- 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"

Commonalities of Re-Admitted

- 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.

- 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

Literature Review

- 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

Literature Review Cont.

- 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

- 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

Today's 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.

Future Recommendations

Thank you for your
time and are there
any questions?

QUESTIONS

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