Home Health and Care Transitions

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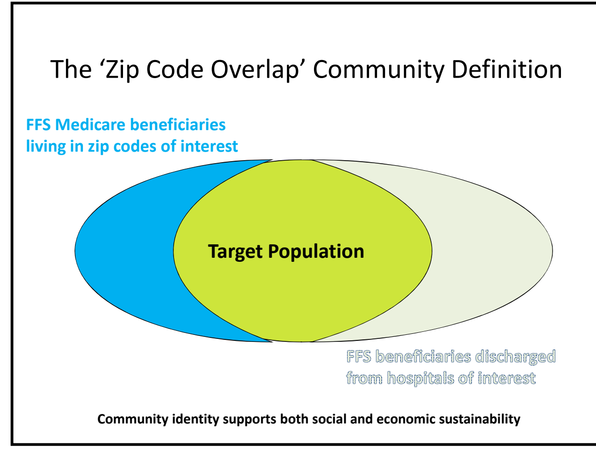
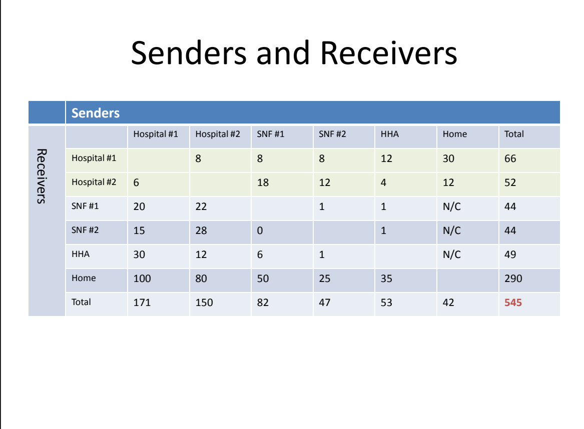
Objectives

- Overview of the QIO Care Transitions Theme
- Community as a key lesson learned
- The role of Home Health in the Theme

The Care Transitions Theme:

- Define a community
- Identify service patterns associated with readmission
- Recruit and convene providers/whoever
- To reduce unplanned 30d hospital readmissions for the *community*
- Using evidence based interventions and tools





Senders and Receivers

Senders (columns) / Receivers (rows)

	Hospital #1	Hospital #2	SNF #1	SNF #2	HHA	Home	Total
Hospital #1		8	8	8	12	30	66
Hospital #2	6		18	12	4	12	52
SNF #1	20	22		1	1	N/C	44
SNF #2	15	28	0		1	N/C	44
HHA	30	12	6	1		N/C	49
Home	100	80	50	25	35		290
Total	171	150	82	47	53	42	545

Interventions – Whatever it takes..

- Care Transitions Intervention
- CMS Discharge Checklist
- Interact
- Transitional Care Nursing
- RED
- BOOST
- Best Practices Intervention Package (BPIP)
- Transforming Care at the Bedside (TCAB)

14 QIOs with 14 Target Communities

Totals among 14 communities

- 70 Hospitals
- 277 Skilled Nursing Facilities
- **316 Home Health Agencies**
- 89 Other types of Providers (Dialysis, Hospice, etc.)

- 666 Zip Codes
- 1,125,649 Medicare Beneficiaries

- 2,712 avoided 30-day Readmissions

What we are learning

Why do hospitals have unwanted readmissions?

Poor Provider-Patient interface
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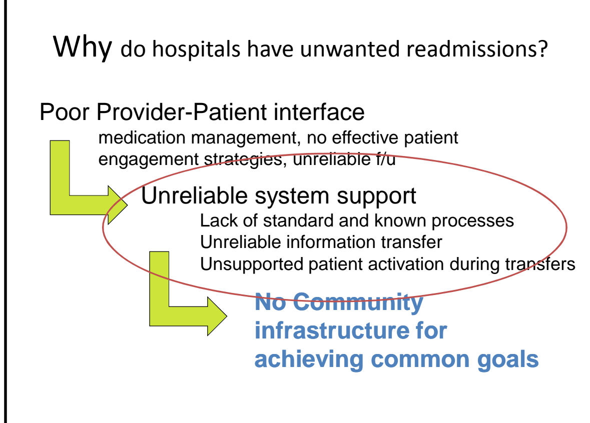
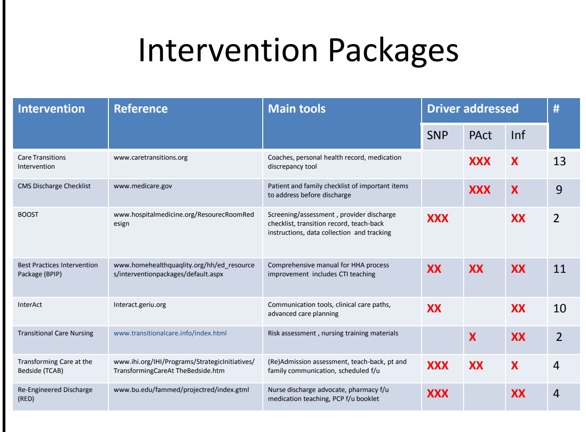
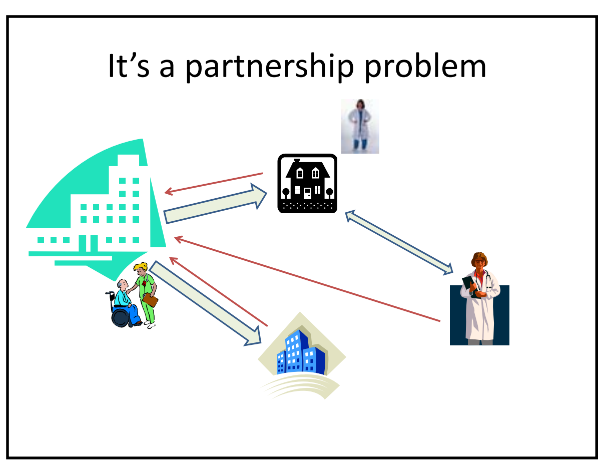
No Community infrastructure for achieving common goals



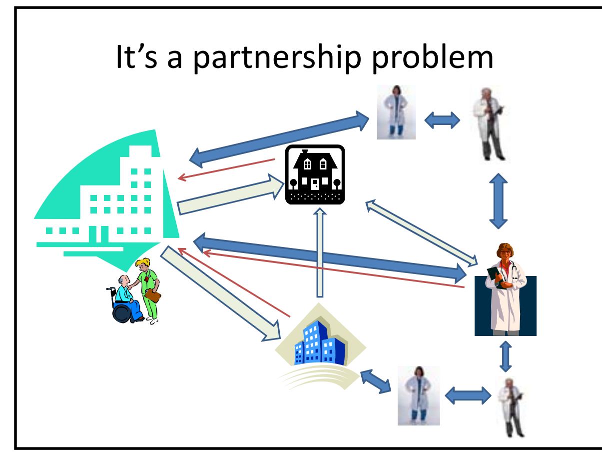


Intervention Packages

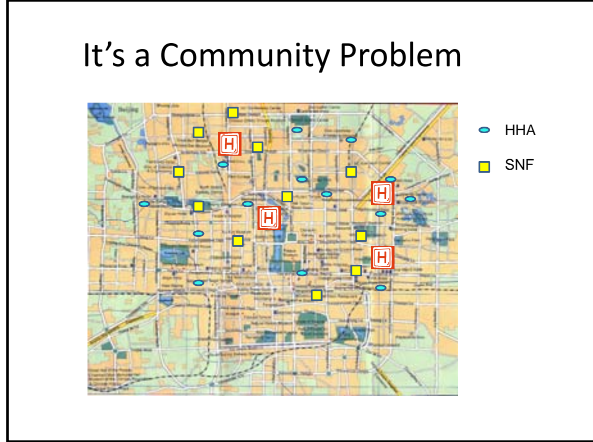
Intervention	Reference	Main tools	Driver addressed			#
			SNP	PAct	Inf	
Care Transitions Intervention	www.caretransitions.org	Coaches, personal health record, medication discrepancy tool		XXX	X	13
CMS Discharge Checklist	www.medicare.gov	Patient and family checklist of important items to address before discharge		XXX	X	9
BOOST	www.hospitalmedicine.org/ResourecRoomRedesign	Screening/assessment , provider discharge checklist, transition record, teach-back instructions, data collection and tracking	XXX		XX	2
Best Practices Intervention Package (BPIP)	www.homehealthquaqlity.org/hh/ed_resources/interventionpackages/default.aspx	Comprehensive manual for HHA process improvement includes CTI teaching	XX	XX	XX	11
InterAct	Interact.geriu.org	Communication tools, clinical care paths, advanced care planning	XX		XX	10
Transitional Care Nursing	www.transitionalcare.info/index.html	Risk assessment , nursing training materials		X	XX	2
Transforming Care at the Bedside (TCAB)	www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAt TheBedside.htm	(Re)Admission assessment, teach-back, pt and family communication, scheduled f/u	XXX	XX	X	4
Re-Engineered Discharge (RED)	www.bu.edu/fammed/projectred/index.gtml	Nurse discharge advocate, pharmacy f/u medication teaching, PCP f/u booklet	XXX		XX	4



It's a partnership problem



It's a Community Problem



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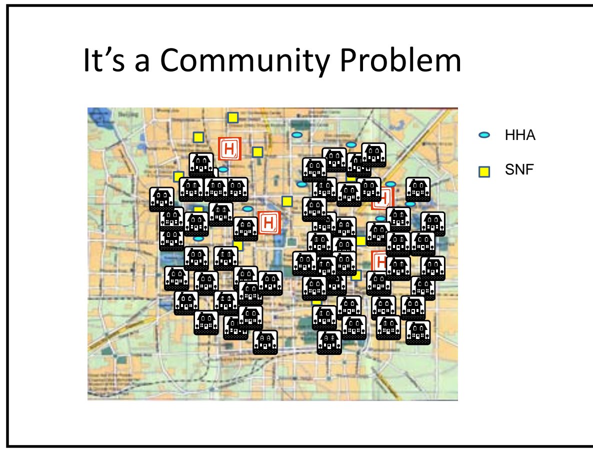
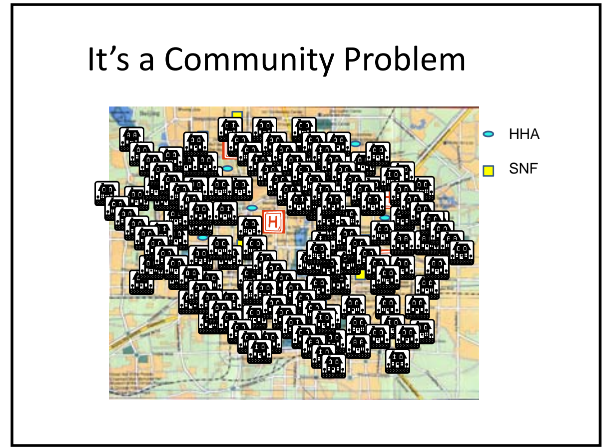
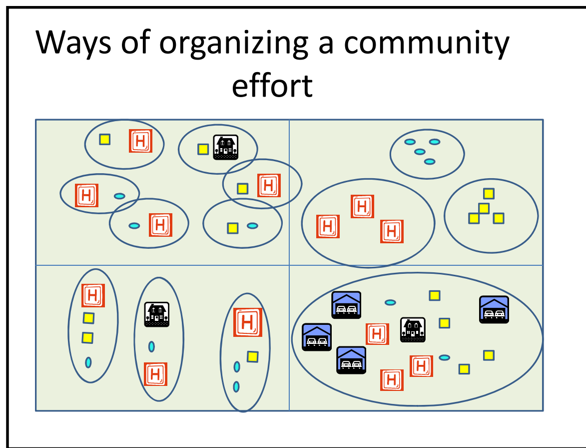
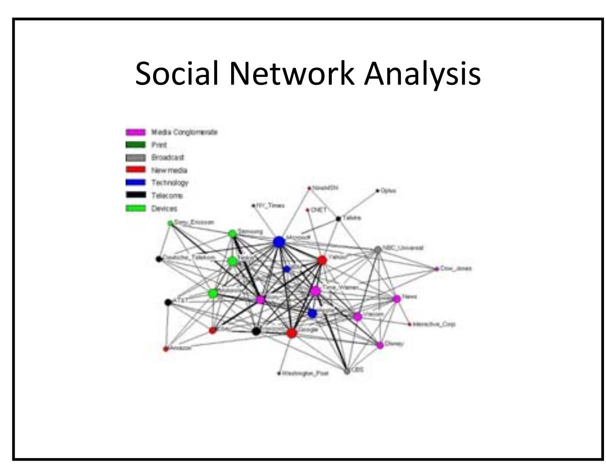



It's a Community Problem
HHA
SNF


Ways of organizing a community effort


Social Network Analysis
Media Conglomerate
Print
Broadcast
New media
Technology
Telecoms
Devices

Results

- Hospital readmissions work reduces hospital 'admissions'
- Population-based measures of readmission going down

Results*
CY 2007 compared to CY 2009

Measure	CT Theme (Comparisons) absolute change		CT Theme (Comparisons) relative change	
% readmitted	**-0.08%**	(+0.30%)	**-0.39%**	(+1.91%)
Readmissions/1000	**-2.96/1000**	(-0.36/1000)	**-4.75%**	(+0.15%)
Admissions/1000	**-15.23/1000**	(-7.62/1000)	**-4.59%**	(-2.11%)

*Results are not intended to reflect formal evaluation of the success of any individual QIO nor the QIO program in relation to QIO contractual obligations.

The Role of HH in the Theme

Senders and Receivers

	Senders							
Receivers		Hospital #1	Hospital #2	SNF #1	SNF #2	HHA	Home	Total
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HH as a receiver = 49 (9%)
HH as a sender = 53 (10%)
HH is a party in 19% of transitions

HH Transitions

- 25215 (7%)
- 1037 transitions affected by interventions that are demonstrating improvement

What a Motivated HHA Could Do..

- Become a community of practice/build relationships
  - Agree on best practices
  - Compete on execution
  - Understand your role in your local system
- Review a(some) readmission case(s) with the hospital (RCA)
- Review/develop common processes with partners in the referral chain
- Hire a/some coach(es)