ENHANCED TRANSITIONAL CARE MODEL:

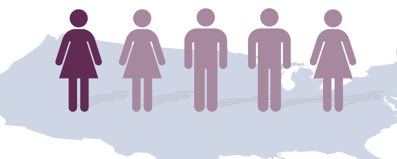
A HOSPITAL TO HOME 30 DAY PILOT PROGRAM

BROUGHT TO YOU BY

One in five Medicare recipients discharged from the hospital today is reportedly readmitted within 30 days -often unnecessarily.[1] Eighteen percent of Medicare patients who are readmitted back into the hospital within 30 days of their discharge account for over $15 billion in annual spending.[2] Medical breakthroughs and other advancements have allowed individuals with chronic illnesses to live longer, but not without exacting a huge toll on the healthcare system in the form of potentially avoidable hospital readmissions. It is not enough to educate patients for success. The time is here to move the healthcare model from patient education to patient engagement.

A care transition refers to the shift of a patient from one care setting or professional, to another. These transitions are often triggered by exacerbations of chronic illnesses. Unfortunately, frequent care transitions across multiple settings or professionals are far too common in the Medicare population. Vulnerable seniors must navigate through healthcare systems while often times receiving uncoordinated information which, in turn, often causes difficulty in finding the services they need. The coordination of a transition from hospital to home frequently falls on family caregivers who are typically insufficiently prepared to address the needs of the chronically ill patient. Both the patient and family caregiver often find themselves sorting through a myriad of information overload. Research shows that patients typically remember and understand less than half of what clinicians explain to them.[3]

Creating strategies to help maximize the patient's quality of life are critical to helping a senior manage the difficult stages of a chronic illness. There are often gaps in the medical system to assist patients in helping themselves. While Medicare and other insurers generally pay for

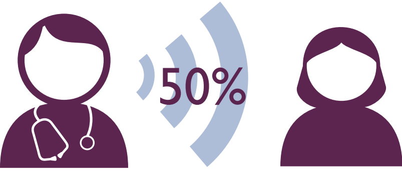


1 OUT OF EVERY 5

SENIORS

IS READMITTED TO THE HOSPITAL WITHIN 30 DAYS OF INITIALLY BEING DISCHARGED --

A SITUATION THAT ANNUALLY COSTS THE NATIONAL HEALTHCARE SYSTEM SOME[1]



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medically necessary care, there remains a huge void for support of non-medical in-home care services. Therefore, patients must become their own advocate of care in order to help manage their chronic illnesses. Otherwise, the effects of these chronic illnesses could have a dramatic impact on seniors by reducing their quality of life and their ability to remain independent in their home.

While some patients are able to navigate the healthcare system with success, many are not. Variables like cognitive level, financial status and family support are just some of the factors that contribute to a successful transition to home. Traditional transitional care models appear to lack the elevated support needed for more complex patients with higher psychosocial needs. This problem is indicated by the reported unnecessary high readmission rates currently experienced by the healthcare system.

This transitional care pilot program was designed to determine whether patient compliance with hospital discharge instructions, and monitoring of key indicators that drive quality outcomes in the home, would correlate to reducing unnecessary hospital readmissions of high risk patients within the first 30 days of discharge.

Additionally, vital information about factors in the home that could contribute to unnecessary readmissions would be tracked. Participation in the pilot program was offered at no cost to the patient or participating hospital. All patients admitted into the pilot program would receive non-medical in-home care throughout their 30 days post hospital discharge. The overriding objective was to help improve patient outcomes while enabling seniors to attain their personal healthcare goals.

PILOT OVERVIEW

The Enhanced Transitional Care pilot program was faciliated by a local Home Instead Senior Care® franchise office, as a unique in-home care program for seniors transitioning from hospital to home. The pilot program was designed to provide support during the critical first four weeks at home. While the pilot program outlined general guidelines for scheduled visits, individual care plans provided the flexibility needed for this high risk patient population. Participation in the pilot program could be terminated early depending upon the circumstances of care, as well as the needs and wishes of the patient and family. In two instances, participants chose to extend their services from the local Home Instead Senior Care franchise office when their 30 day participation in the pilot program had ended.

The complimentary program was offered to two area hospitals from May 2012 through November 2012. Referrals were made based on diagnosis, age and eligibility. A total of 30 patients were admitted from the hospitals during the pilot program's seven month period. Ten patients were discharged from the hospitals with the admitting diagnosis of congestive heart failure (CHF). Twenty patients were discharged with the admitting diagnosis of chronic obstructive pulmonary disease (COPD). In many instances, comorbidity was also present. All 30 patients had a history of one or more recent hospitalizations in the past year.

The pilot program was supervised by a registered nurse who opened all cases. Two Home Instead Senior Care CAREGivers℠ were dedicated to the pilot program. They received training with the nurse emphasizing the recording of key vital signs to include electronic blood pressure readings, weight, temperature and blood sugar readings (performed by patient). They were also trained to use a coaching model with the patients utilizing teach-back techniques. Patients were encouraged to take control of their health care needs and develop problem solving skills by monitoring their own red flag identifiers for their specific health care condition.

PILOT PROGRAM ADMISSION CRITERIA:

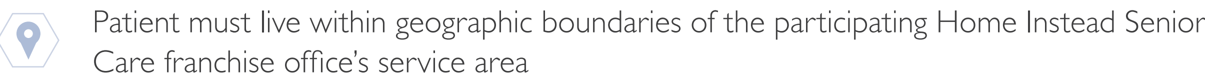
- Patient lives alone or is home alone for four or more hours daily
- Assistance needed with one or more activity of daily living (ADL)
- Visited emergency department in previous six months or is identified as a high risk for readmission by the referring hospital
- Four or more medications upon discharge, or new medication with discharge
- 60 years of age or older

ELIGIBILITY DIAGNOSES:

- COPD/pneumonia
- CHF
- Urinary tract infection

QUALIFYING CRITERIA:

Patient must satisfy one admission criterion and have one eligible diagnosis



Patient must live within geographic boundaries of the participating Home Instead Senior Care franchise office's service area

Care consultation must be done preferably in the hospital prior to discharge, or within 3 days of discharge

Patient must agree to see primary care physician within 5-7 days of discharge

Copies of all discharge plans and medication regimen provided to the pilot program's participants

Signed permission of the patient/family for the participating Home Instead Senior Care franchise office to provide non-medical care in the home for 30 days

ESTABLISHED GUIDELINES FOR COMMUNICATION INVOLVED:

Daily tracking in a journal performed by CAREGiver

Medication list and fluid tracking worksheets completed by patient

Excel spreadsheets for all data tracking monitored by RN

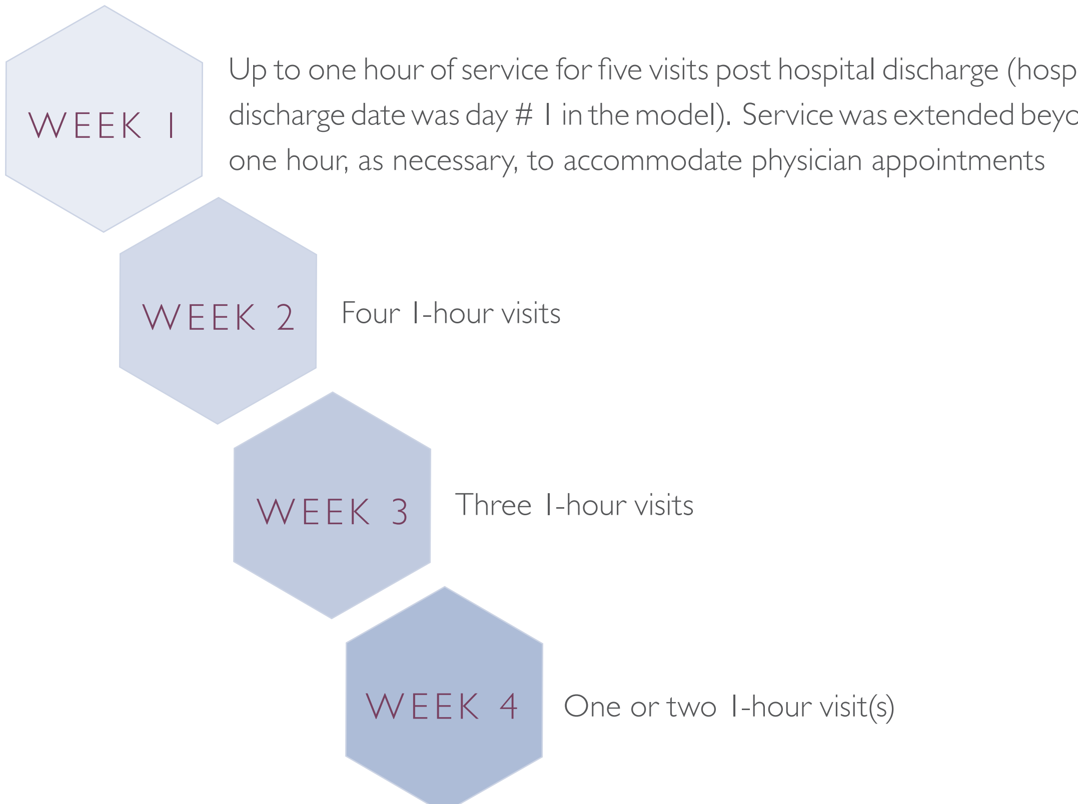
Calls made by CAREGiver to Home Instead Senior Care franchise office to report any adverse changes or events

CORE NON-MEDICAL SERVICE FOCUSED ON PATIENT-CENTERED GOALS WITH ACTION STEPS DURING EACH ONE HOUR VISIT:

- Promoting medication self-management (dosage and purpose of each medication)
- Organizing patient medical records in the home
- Following up with physician appointments and scheduling tests in a timely manner
- Observing and recording vitals (weight, blood pressure, blood sugar)
- Ensuring patient knowledge and ability to monitor red flags specific to the patient's chronic illness (e.g., weight gain, elevated blood pressure, difficulty breathing)
- Review of "zone sheets" (i.e., The zone sheets are tools specific for certain diagnoses such as chronic obstructive pulmonary disease and heart failure and are color coded green, yellow and red. If the patient's symptoms are in the green zone, they are "all clear"; in the yellow zone, they indicate "caution"; in the red zone, they are a "medical alert".) for patient's diagnoses
- Reviewing patient-centered goals

MODEL

- All patient-participation in the pilot program ended at 30 days post hospital discharge
- Flexibility in the pilot program allowed the addition or subtraction of visits within the 30 day period based on the individual patient's needs



MEASUREMENT OF SUCCESS

METRICS MEASURED:

- readmissions within 30 days post hospital discharge
- quality outcomes
- achievement of patient's personal goals
- quality of communication between patient, physicians and family members
- identification of key contributing factors or barriers that contributed to repeat hospital readmissions

PATIENT M

Patient M is an 80 year old female with CHF, atrial fibrillation and COPD. She had two previous hospitalizations with these diagnoses in the same calendar year prior to participating in the pilot program. Patient M is alert, oriented and lives alone. She uses a walker and cane for ambulation. Upon hospital discharge, she had swelling of both lower extremities and was short of breath with any exertion. She had very little family or social support. Prior to her last hospitalization, she was still driving and was also the main caregiving support and transportation for her widowed friend.

During her initial interview, she reported that her overall personal goal was to be able to drive again. Her health care goals were to be able to better manage her health care and diet. She willingly agreed to track her diet, fluid intake and weight. She stated, "I weigh myself every day!" When she was asked to demonstrate weighing herself, it was determined that she could not read the scale where it was placed in the home, thus, resulting in inaccurate readings of the scale by eight pounds.

The CAREGiver worked with Patient M for a total of 17 visits, totaling 12 hours over the 30 day period. During each visit, discussions centered around Patient M's goals, understanding her red flag zones, and when she should call her doctor in an effort to help avoid a hospitalization.

During week 2, Patient M's weight went up by more than three pounds, and with a prompt from her CAREGiver, she called her primary care physician who immediately increased her diuretics. She was also fitted by her doctor for compression stockings. The CAREGiver transported Patient M to her doctors' appointments, picked up her prescriptions, helped her with bathing in the first two weeks, and did some light housekeeping so that Patient M could conserve energy.

By the end of the 30 day period, Patient M had lost 18 pounds and was regaining her strength. She was still unable to drive but was determined to continue following her plan in an attempt to achieve her health care goals.

A second follow-up call was placed to Patient M at 60 days post discharge, and she was thrilled to report that she was down a total of 42 pounds and able to drive again. She completed the post care survey with a written comment stating, "I just could not have done it without your help. Thank you all for your help."

PATIENT B

Patient B is a 90 year old female with end stage CHF. She is on continuous oxygen. She uses a walker to assist with ambulation which frequently gets hung up in the oxygen tubing. She is short of breath with exertion. She had two hospitalizations within three months. Patient B lives alone with occasional help from her son. She had refused to allow any more help in her home as a result of trust issues. With additional prompting from the hospital case manager, Patient B hesitantly agreed to participate in the pilot program.

Her personal and health care goals were the same: "I just want to feel better and be able to stay in my home." Upon review of her discharge medication regimen it was discovered that two important medications were missing in the home. She was not confident in calling her physician herself as she feared he would be upset with her not complying with his orders. She had been prescribed both medications during both previous admissions, yet the medications could not be located in the home. According to the pharmacy, one prescription had not been filled for six months. After reconciling with both the physician and pharmacy, Patient B received both of her needed prescriptions.

The CAREGiver worked with Patient B for 11 visits, totaling 9 hours. She assisted Patient B with bathing, light housekeeping and transportation. During each visit, meal plans and potential red flags were reviewed. Safety awareness related to the oxygen tubing and potential for falling was also reiterated. Patient B appeared to understand that placement and awareness of the tubing location was very important. At the end of the 30 day period, Patient B stated that she felt better as a result of participating in the pilot program and had a more complete personal health record to share with her physician.

PATIENT P

Patient P is a 70 year old male with COPD, non-insulin dependent diabetes and hypertension. He is obese, and uses a walker and motorized chair for mobility. He is short of breath with exertion. Patient P lives alone and is socially isolated. He does not drive and, therefore, uses public transportation to grocery shop or go to appointments. He had three previous hospital admissions for exacerbation of his COPD in five months.

During the initial assessment, Patient P stated, "I know everything that I need to know about what is wrong with me!" Patient P was discharged on a low sodium, low fat, diabetic diet; however, his daily intake consisted of deliverable take-out food and frozen microwaveable dinners. Prior to his participation in the pilot program, Patient P had never tracked his blood sugar levels and did not use a pill box for medication tracking.

Patient P agreed to start tracking his daily blood sugar and weight. The CAREGiver and Patient P worked on creating a more healthy diet plan. This plan required trips to the grocery store. It was identified that part of his exertion problems was related to carrying groceries and transportation. The bus would not allow him to bring a cart onto the bus in order to carry his groceries. He would become very short of breath if he carried them without a cart. Together, a strategy was developed where Patient P could bring down his cart and leave it in the foyer of the building. Then, when he used the public transportation, even though he could not bring the cart on the bus, he could have the driver retrieve it so that he didn't need to carry the bags. Simple as it seems, this discussion fostered greater sense of independence for Patient P.

Transportation for doctor appointments was also an issue as the "free" transportation available to him frequently needed to be scheduled two weeks in advance. This type of schedule would not accommodate urgent visits to the doctor. During the first week of service, Patient P developed increased swelling in his arm and hand. He stated, "I just was feeling crappy." He said he thought about calling EMS to go to the emergency department (ED) but then decided to call his physician. The CAREGiver was able to transport Patient P to the doctor and help him to avoid a potentially unnecessary ED visit.

The CAREGiver worked with Patient P for a total of 18 visits, totaling 20 hours. Patient P received transportation to multiple physician appointments, light housekeeping, prescription pick up and trips to the grocery store. During each visit, discussions focused on understanding his red flag zones and

steps he could take to help avoid an unnecessary hospitalization. Patient P successfully completed the 30 day pilot program, resulting in a loss of 11 pounds. He had a more complete home medical record that included his daily weights and blood sugar readings. During the final visit, Patient P stood up out of his chair and said, "Can I just have a hug?" Patient P remained out of the hospital greater than 90 days. He was re-hospitalized in his fourth month post-discharge. The complimentary pilot study had been completed at the time of this last discharge. Patient P was disappointed to learn that most of these non-medical in-home care services are not covered under his current Medicare benefits.

PATIENT S

Multiple barriers for patient success were identified throughout the pilot program; some simple, some more complex. Patient S was a COPD patient who was referred to the pilot program because she had six hospital admissions and one ED visit in the past five months. It was identified that her barrier to a successful transition home was the need for cleaning assistance. She would come home from the hospital each time to a dust and cat dander ridden home. She did not have the strength to do anything about it. It was a vicious circle for the patient. Light housekeeping to reduce the dust and dander also are believed to have helped her reduce her hospitalizations. A simple skill set transfer that provided the patient knowledge of her red flags and the cause behind the exacerbations of her illness has enabled her to remain out of the hospital for five months and counting.

- **30** patients were admitted into the pilot program.
- **96%** stayed out of the hospital greater than 30 days post discharge
- **93%** stayed out of the hospital greater than 60 days post discharge
- **90%** stayed out of the hospital greater than 90 days post discharge
- **93%** remained in their own homes
- **7%** transferred to a skilled nursing facility due to limited family support, but stayed out of the hospital. They did not receive care in the pilot program once transferred.

A total of 289 CAREGiver hours were provided, averaging 9.625 hours and 11 visits per patient during the 30 day period.

- **37%** of the patients needed transportation to their primary care physician appointments
- **30%** of the patients needed prescriptions to be picked up
- **43%** of the patients needed some sort of physical assistance with activities of daily living, such as bathing or dressing
- **100%** of the patients were assisted in organizing their medical records which included all discharge instructions, medications and pertinent health information to share with their physician.

An exit survey was completed by 94% of the patients to identify patient and family satisfaction with the care transition interventions and overall pilot program experience.

- **100%** of the survey respondents "Strongly Agreed" in response to the question: I feel better as a result of participating in this Home Instead Senior Care transitional care program.
- **89%** of the survey respondents "Strongly Agreed" in response to the question: I felt more confident having a Home Instead CAREGiver visit.

BARRIERS IDENTIFIED

- language barriers
- cognitive disabilities
- physical disabilities
- poor diet
- medication reconciliation/ management
- transportation
- social isolation
- confusion with discharge instructions
- issues related to obtaining durable medical supplies
- health status of family caregivers providing care to the patient

SUMMARY

Easing the transition from hospital to home by empowerment of patients in the management of their care is essential for their future success. As patients traverse from one health care setting to another, the only common denominator between settings is the patient. The patient must become the focal point of all communication and coordination of care. Streamlined care plans and proper hospital discharge preparation of patients and family members are crucial for the prevention of multiple hospitalizations. Millions of older adults are suffering from chronic illnesses causing a rapid rise in healthcare costs. According to a study conducted by the Alliance for Aging, Americans who lose their ability to live independently increase the overall national healthcare cost by over $26 billion nationally. Both patients and their healthcare partners have a vested interest in the collaboration of care across settings for the purposes of achieving positive patient outcomes while reducing costs. It is not enough to educate patients. The time is here for active patient engagement for the purpose of meeting their goals. This pilot program using patient involvement in monitoring and managing their health care needs demonstrated significantly improved outcomes and reduced hospital readmissions for high risk, cognitively intact older adults when compared to their own previous hospital readmission rates.

RESOURCES:

1. Alliance for Aging Research. Independence for Older Americans: An Investment for Our Nation's Future. 1999. http://www.agingresearch.org/content/article/detail/695
2. Centers for Disease Control and Prevention. Healthy Aging: Effect of an Aging Population. April 2004. http://www.cdc.gov/aging/han/index.htm.
3. Coleman, Eric A. The Care Transitions Intervention: Results of a Randomized Controlled Trial, Archives of Internal Medicine, 2006: vol. 166, no. 17, pp. 1822-1828.
4. National Hartford Center of Gerontological Nursing Excellence. http://www.geriatricnursing.org/

ABOUT HOME INSTEAD SENIOR CARE

Founded in 1994 in Omaha, Nebraska, by Lori and Paul Hogan, the Home Instead Senior Care® network is the world's leading provider of non-medical in-home care services for seniors, with more than 1,000 independently owned and operated franchises providing more than 50 million hours annually of care throughout the United States, Canada, Japan, Portugal, Australia, New Zealand, Ireland, the United Kingdom, Taiwan, Switzerland, Germany, South Korea, Finland, Austria, Italy, the Netherlands, Mexico and China. Local Home Instead Senior Care offices employ more than 65,000 CAREGivers℠ worldwide who provide basic support services – assistance with activities of daily living (ADLs), personal care, medication reminders, meal preparation, light housekeeping, errands, incidental transportation and shopping – which enable seniors to live safely and comfortably in their own homes for as long as possible. In addition, CAREGivers are trained in the network's groundbreaking Alzheimer's Disease or Other Dementias CARE: Changing Aging Through Research and Education® Program to work with seniors who live with these conditions. This world class curriculum is also available free to family caregivers online or through local Home Instead Senior Care offices. At Home Instead Senior Care, it's relationship before task, while continuing to provide superior quality service that enhances the lives of aging adults and their families.

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