Home Visiting Programs: A Study in Return to Hospital Reduction.

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Objectives

- A: Address barriers within the post acute process
- B: Increase understanding of implementing TC / Home visit programs
- C: Analyze barriers to implementation and possible solutions.

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Current CMS Statistics

- 21% of all patients discharged from hospital return within 30 days.
- 32% of all patients discharged from hospital return within 90 days.
- Current CMS goals are to be below 12% irrelevant of SNF or home placement.
- Not specific to Florida / Central Florida

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RTH Data

- 28% of all RTH within 30 days have a sepsis associated dx.
- 47% of patients admitted within 7 days post D/C have a AMS associated Dx.
- 15% of all RTH patients admitted within 7 days can not clarify their initial admitting dx and / or their care provided at home.

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Post Acute Data

- Current Central Florida data shows to home vs to SNF discharge RTH rate:
  - RTH for to home d/c: 18.9% (irrelevant of hospital system)
  - RTH for to SNF d/c: 19.8% (irrelevant of hospital and SNF system)
  - Data shown is for 30 RTH rate.

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RTH s/p Post Acute

- So what is our data for patients discharged home, from a post acute setting.
  - 16% return within 7 days. All Dx.
  - 27% return within 30 days. All Dx driven

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- Case #1
  - 101 y/o male Pt discharged from SNF with initial Dx of pneumonia, AMS, and AFTT. Pt was on hospice prior to hospitalization. Family opted not to return on hospice. Pt completed a 14 day therapy of IV Abx. Discharged home with home health. No PCP, as Pt was on hospice prior.

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- Post acute discharge:
  - Pt seen within 48 hours.
  - ACP performed with family members present. No hospice yet. But Pt made DNR and DNH.
  - Home health for 30 days for med education, ROM and fall prevention.
  - Mobile radiology to monitor resolution of pneumonia, CBC and BMP ordered as well.
  - Pt developed 2 more episodes of pneumonia over next 6 month. Likely aspiration related. Home health initiated for IV Abx. Once a day. CBC BMP ordered QOD. CXR qWeekly.
  - IV Fluids were initiated at home via IV Infusion / Home Health with second case of pneumonia. ARF improved and returned to baseline. Pt was hypotensive for first three days of 2nd episode.
  - Third episode occurred 60 days later. Pt did not respond to IV Abx. Became lethargic. Hospice initiated. Crisis care put in place. Pt passed away peacefully with 5 generations of family at bedside.

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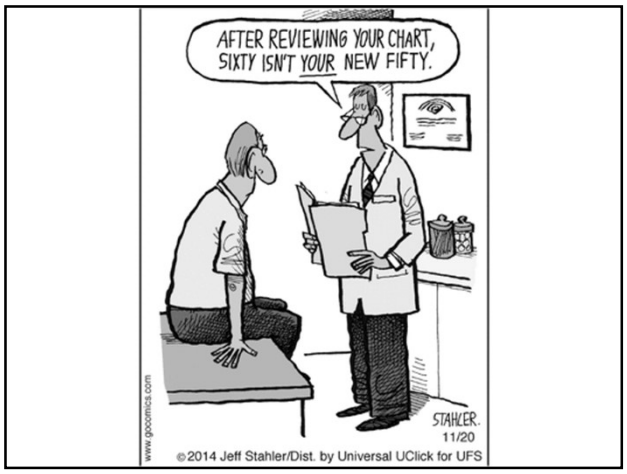

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- Case #2:
  - 78 y/o female with DM, HTN, CKD, CHF, Atrial Fibrillation. Admitted to SNF with dx of Resp Insufficiency. Pt had in house pulmonary and ID consults. PT/OT performed for 19 days. Upon discharge Pt could not be seen by PCP within 14 days. Transitional care initiated.

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- Measures initiated
  - Home health upon discharge, with RN, PT/OT.
  - Labs to be drawn. BMP, CBC, BNP.
  - Provider to see Pt within 48 hours at home. Pt seen weekly afterwards for three weeks.
  - Medication list reviewed from SNF and Home health. Compared and two errors found in Metoprolol dose and frequency of Lasix.
  - Med errors corrected. Pt visited the following week. Continuing to recover. Discharge note competed. PCP f/u arranged. Corrected med list and discharge summery provided.

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RTH Reduction Pilot

- Started 2 years ago.
- 482 patients seen in study.
- Measured against CMS data.
- Methods
  - Patient must be home bound or seen for transitional care
  - Patient is to be seen within 72 hours post discharge.
  - Medication reconciliation done at each visit
  - Pathways for labs, and communication placed with each HHC that saw patients.
  - Education for each patient and / or POA for contacting staff for any medical / social need
  - ACP performed upon admission for each patient.

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- **Outcomes**
  - 30 day all RTH was approximately 6.4%
  - 60 / 90 day RTH was at 11.3 and 14.1%
  - All time admission rate for home bound patients 4.8%.
- **Barriers**
  - Education of patient and caregiver / guardian
  - Anxiety and social stimuli
  - Inappropriate / Incomplete discharge from SNF / Hospital.
  - Accessible data related to recent medical event.

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General Barriers

- What are our barriers moving forward?
- * Geography / patient density *
- Scheduling
- Education of patient and / or POA Caregiver
- Partnership involvement.

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