Reducing Hospital Readmissions: The Role of Home Care

Steven Landers MD, MPH
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landers@ccf.org / dr.standers@gmail.com

Introduction / Outline
1. My Role(s) & Disclosures
2. Home Care’s “Secret Weapons”
3. Hospital Readmissions and the Chronic Illness Care Imperative
4. Evidence and Examples
5. Real World Opportunities

Ancient Concept in Medicine

“Into whatever houses I enter, I will go into them for the benefit of the sick...”

The First Aphorism of Hippocrates

But....
Physician Understanding and Training is Limited

“...wow, you're really going to do that? Is it safe?”

“...ok, you're like Marcus Welby? I didn't think anyone did that anymore.”

“...we're just starting to figure out best practices after patient is extubated, what happens outside the hospital is really foreign...”

“...this stuff is like Lewis and Clark for us...”

What I’m Learning “Secret Weapons of Home Care”

Enhanced View of Patient and Caregivers

Breaks Down Barriers to Care

Strengthened Relationships

Can Avoid Hazards

Can Cost less

Who I’m Meeting
Who’s the Dinosaur?

- Information & Communication Technology
- Mobile Diagnostics
- Remote Patient Monitoring
- Virtual Encounters

Context of Care: Medicare and Medicaid Spending

Percentage of GDP:

- Annual
- Projected

creator/source: CBO (Elmendorf 11/09)

Where Does the Money Go?

Percentage of Medicare Expenditures:

- 0 Chronic conditions: 1%
- 1 Chronic condition: 3%
- 2 Chronic conditions: 6%
- 3 Chronic conditions: 10%
- 4 Chronic conditions: 9%
- 5+ Chronic conditions: 79%

creator / source: Johns Hopkins/ RWJ 2010 (G Anderson)
Where Does the Money Go?

- No limitations: $2,662, $3,988, $4,497, $4,986, $5,838, $7,380, $9,764
- With limitations: $5,365, $7,879, $10,679

Number of Chronic Conditions

Where Does the Money Go? Where Does the Money Go? Where Does the Money Go?

Creator / Source: Johns Hopkins/RWJ 2010 (G Anderson)

Who's Being Hospitalized?

- Hospitalizations for Ambulatory Sensitive Conditions Per 1,000 Medicare Beneficiaries

Who's Being Hospitalized?

Creator / Source: Johns Hopkins/RWJ 2010 (G Anderson)

Medicare Readmissions We're Being Watched....

- Unplanned Readmits Cost ~$17 Billion
- Approximately 20% Readmitted by 30 Days
- Half Don’t See Physician Before 30 Day Readmission
- Readmission is Most Often Due to Another Condition or Complication

Current State of Post-Acute
Fragmentation, Unaligned Incentives, Limited Knowledge, and Practice Variation are Barriers to Quality and Efficiency

Relevant Health Reform Changes:
“Encouraging New Care Models”
CBO Est $13.5 Billion Savings 2011-19
Sec 3021-3027.
• CMS “Innovations Center”
• Accountable Care Organizations
• National Bundling Pilot
• Independence at Home Act
• Care Transitions Program Pilot
• Readmissions Reduction Prog (2012)

Relevant Health Reform Changes:
Hospital, SNF, Home Health Value Based Purchasing
Sec 3001/3006
• Hospital Incentive Payments
• Includes efficiency measures (spending per beneficiary)
• 1 to 2% of base DRG rate in 2013-2017
• For SNFs and HHAs Secretary Shall “Develop a Plan”
Is Home Care an “Escape Fire”?

- Accessibility?
- Healing Relationships?
- Science / Evidence?


Do Home Care Interventions Reduce Readmissions?

Reference:

Description:
Pooled analysis of 18 randomized controlled clinical trials

Relevance to Home Care:
11 of 18 trials included home visitation

Results:
After mean follow-up of 8 months intervention had lower readmission rates 35% vs. 43%
Subgroup of trials with home visit performed better

Limitations:
Includes international studies, variable follow-up / intervention

What if We Only do Good Discharge Planning?

References:

Description:
1) Analysis of CMS Hospital Compare Measures
2) Robust Discharge Planning and Preparation

Results:
Very modest association between HCAHPS discharge planning measure and hospital compare readmission rates
Reengineered discharge planning associated with 30% decrease in readmissions (~37% vs ~27%) intervention vs control
Do Home Care Interventions Reduce Readmissions?
(Care Transitions Intervention)

References:

Description:
Health Coaching Model Based on “4 pillars”

Relevance to Home Care:
In-home coaching visit is key element of model.

“...existing healthcare practitioners may assume some of the specific roles of the transition coach. For example, discharge planners or home health nurses are [well] positioned...”

Results:
Intervention patients had lower 30-d readmissions (8.3% vs 11.9%)

Other Concepts With Reported Success in Literature

- Telehealth Monitoring
- Telephonic Monitoring
- Medication Reconciliation
- Early Physician Follow-up
- Home Based Primary Care Teams
- Front Loading of Home Health Visits

Elephant(s) in the Room
(experience / opinion)

- End of Life Care / Goals of Care
  - HH to Hospice Transitions
  - Home Palliative Care

- Custodial Care Issues
  - AAA Partnerships
  - Elder Protection
  - Counseling About Options
  - Home to Residential Transitions
Our “Story” at Cleveland Clinic
Home Health: Acute Care Hospitalization

Kitchen Sink Approach?
(strategy vs implementation issues?)

- Raise Awareness / Prioritize
- Point of Care Electronic Documentation
- Telehealth for Heart Failure
- Front Loading
- Hospice Transitions Pilot
- Medical Director / Physician Home Care
- Medical Record Integration

ACH ≠ 30-Day Readmission Rates for HF

Risk-adjusted readmission rate (%)

# of Hospitals

National average: 24.5%
Cleveland Clinic: 29.1%

Medicare.Gov
Building Home Health / Hospital Partnership Around Reducing Readmissions

“Heart Care at Home” Example

Where our Heart Failure Pts Go?

Home (no post-acute care) 61%
Home (with agency) 20%
SNF 16%
Acute rehab/LTAC
Hospice

National average: 11.1%
Cleveland Clinic: 9.1%
Vision: Delivering Value and Reducing Readmissions With Multi-Component Home Care Management

Example from Pilot: Mr. B

- 59 year-old man
  - Smoker
  - NICM
  - Morbid obesity
  - OSA
  - Diabetes

Lives 3.4 mi away from us
Mr. B: A Revolving Door of Readmissions

Multiple Admissions:
• 11/13, ED, 6 days, Home
• 11/29, ED, 4 days, Home
• 12/28, 9 days, Home
• 1/29, 3 days, Home
• 2/18, 5 days, Home
• 3/21, 5 days, Home, CRT
• Again in April…

Readmission Results to Date

Heart Care @ Home Health Status Outcomes
(Post-Acute Patients at Day 1 & Day 28; p < 0.05)
**Access Challenges**

![Graph showing access challenges over time]

**Away from “Squeaky Wheel”**

**Case Management / Discharge Planning Model?**

- Holistic Needs Assessment (CARE tools)
- Genetic and Condition Based Health Status Measures
- Longitudinal Outcomes Tracking
- Assessment of Transitions Care Models
- Coexisting Resource Self-Management Of Transition

**Who Are the High Risk Patients?**

- Role for predictive modeling and scoring tools
- Even among older patients admitted and discharged within 24hrs
  - ~2% mortality at 60d
  - ~11% 30d readmission rate

Leadership Role for Home Health Agencies
(strategy vs implementation issue?)

- Expertise and Workforce
  - > 9,000 Home Health Agencies
  - >100 million annual visits
  - 870K (employees) 250K FTEs
  - OBQI history
  - Technology and new models
  - Local expertise

- Many Functions Already Covered in Benefit
  - Teaching and Training
  - Observation and Assessment
  - Care Plan Evaluation and Management
  - Home Health Eligibility Approximates High Risk Population


Summary

- Home Care Especially Well Positioned to Impact Hospital Readmissions
- Multi-component, Cross-Venue Models Show Best Promise
- Universal and Holistic Discharge Process Likely Important Most Pts With Chronic Illness
- Implementation Issues Should Be Considered in Conjunction With Strategy

Thank You

“The future belongs to those who believe in the beauty of their dreams”
E. Roosevelt

landers@ccf.org / dr.slanders@gmail.com