We CAN Keep Our Patients at Home!  
*The Home Health Therapist's Role in*  
*Care Transitions and Preventing Rehospitalizations*

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Beyond Home Health Care Services, CEO/Owner

**Objectives**

- Demonstrate how home health therapists are an integral part of minimizing rehospitalizations and safely transitioning the patient from hospital to home

- Describe the importance of the home health therapists receiving the "hand-off" from their colleagues in acute care, SNU and inpatient rehab at time of discharge home

- Discuss how the home health therapist's role overall is to leave a lasting impact on the independence and well-being of the patient, keeping them safe in the comfort of their own home
Readmission Rate

30-Day, All-Cause, Hospital Readmission Rates, January 2007–December 2012

- NO statistical difference 2004-2011
- Statistically significant decrease 2011 to 2012


Change in Readmission Rates by Hospital Referral Region, 2011–2012.

SOURCE: Chronic Conditions Data Warehouse 2011, Dartmouth Hospital Referral Regions.
Hospital Readmission Reduction Program (HRRP)

2012-2013
► 67% of Hospitals had a penalty
► $126,525 per hospital

FY 2014
► increase to 2% max penalty

FY 2015
► Third phase of HRRP
► Increase in max penalty 3%
► Expand number of conditions for readmission penalty to Chronic Lung Disease and Elective TKA/THA

What is going on the first two weeks the patient is home?

Dharmarajan, et al., Diagnosis and Timing of 30-day Readmissions after Hospitalization For Heart Failure, Acute Myocardial Infarction, or Pneumonia. JAMA, 2013, January(23). 306(4)
Risk for Readmission

- Not only comprises clinical risk, but of *non-clinical factors* such as:
  - patient access to an available primary care physician,
  - patient mobility and access to transportation,
  - patient financial constraints, such as lack of health insurance, that may limit access to medications,
  - the lack of a support system to assist the patient with self-care and management.

Rehospitalization Risk Tool

- Meaningful – for your patients and for your multidisciplinary team
- Incorporates functional assessment data
- “Non-clinical” risks
- Review/post your data from the tool regularly to staff (*let them know you are constantly looking at this tool as an intervention itself!*)

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Risk Stratification Groups

- Stratify patients into risk groups
- Determine interventions associated with each readmission risk group

Example:

**Low Risk:**
- Normal discharge process

**Moderate Risk:**
- Enhanced care-coordination and discharge transfer process

**High Risk:**
- Enhanced care-coordination and discharge transfer process, plus immediate community resource interventions

*Therapy should be adapting their plan of care based on patient’s risk group!*

Top Reasons for Readmissions

1. Patients may not fully understanding what’s wrong with them
2. Patients may be confused over which medications to take and when
3. Hospitals don’t provide patients or doctors with important information or test results
4. Patients do not schedule a follow up appointment with their doctor
5. Family members lack proper knowledge to provide adequate care

*Care About Your Care: Tips for Patients When They Leave the Hospital. The Dartmouth Atlas Project, 2011.*
Decreased Knowledge/Understanding of Disease/Medical Condition

- Nearly half of adults have trouble understanding simple health information (procedure consent, prescriptions, oral instructions)
  
  Vastag, B. Low health literacy called a major problem. JAMA. May 12 2010;291(18):2181-82

- Less than half of patients discharged from the hospital know their diagnoses, treatment plan or side effects of prescribed medications
  
  Powell, CK. Resident recognition of low literacy as a risk factor in hospital readmission. JGIM 20(11):1042-4, 2005 Nov

- Post-hospitalization patients typically identified multiple concerns including understanding their progress, activity, insurance, medications, and pain control
  

Rehab Therapy Interventions– Increase Patient’s Knowledge and Level of Understanding

**Occupational Therapy:**

- Collaborate with nursing to assess the patient/caregiver’s cognitive ability to retain new or on-going education.
- What MODE of learning is best? Written, verbal, video-recorded?

**Physical Therapy:**

- “Mobility Coach” - establish *daily mobility program* from day one post DC (walking, rolling, sit to stand, standing for ___ minutes,) -[consider adding the instructions to sign-in log in home]
- Incorporate patient/caregiver education regarding the disease process or medical condition into the patient’s daily mobility program
  - Diabetic - proper nutrition before activity, proper footwear before activity
Incorporating Disease Process Teaching in Therapy Interventions and Goals

Rehab Therapy Interventions

- *All* interventions should have patient self-management as a goal

- When the patient is neither the primary caregiver nor the primary learner, identify who is the caregiver(s) for the patient and target care management skills towards them
Medication Mis-management

- Medication mismanagement accounts for 30% of all hospitalizations and 45% of readmissions among the elderly

- 62% of patients could recall having been told about potential medication side effects at time of discharge.
  The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital. Farster AJ. Ann Intern Med. 2003;138:161-167

Medication Mis-management

- 2/3 of older adult hospitalizations were related to unintentional overdoses
- 2/3 of implicated drugs belonged to 4 common classes [warfarin, insulin, oral anti-platelets, and oral hypoglycemics]
- Only 1.2% of implicated drugs were in designated “high risk” classes [BZDs, Narcs, Chemo]

Rehab Therapy Interventions – Medication Management

- Every clinician is responsible for medication reconciliation
  - Knowing when to consult with nursing/physician is the key
- Therapist needs to understand functional side effects of medications
  - Narcotics (dizziness, balance)
  - Sinemet (initiation of movement)
  - Baclofen (lethargy, balance)
- Interdisciplinary approach to medication reconciliation/management
  - Standardized tool all disciplines use
  - Medication List is visible to all staff in home
  - Medication list is reviewed EVERY visit, by EVERY clinician
  - Medication changes are communicated to team (dosage, side affects, functional side affects)
  - IDT conference include Patient’s medication management status and every clinician’s input

Multidisciplinary Role in Medication Management

<table>
<thead>
<tr>
<th>Potential Non-Adherence Issue</th>
<th>Assessment Strategies</th>
<th>Referral Triggers</th>
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<tbody>
<tr>
<td>Knowledge Deficit</td>
<td></td>
<td>RN</td>
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<td></td>
<td>Is there evidence to support/suggest that patient/ caregivers does not understand medication regimen?</td>
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<td>- &quot;I’m not having symptoms anymore, so I’m not sure whether to keep taking this.&quot;</td>
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<td>- &quot;That makes my stomach upset, so I try not to take it.&quot;</td>
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<td>Dissolution</td>
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<td>RN, SLP, OT</td>
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<td>Is there evidence to support/suggest that patient’s caregiver’s inability to read is affecting medication compliance?</td>
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<td>- Unable to read medication name, frequency, dose, other instructions</td>
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<td>Financial Concerns</td>
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<td>RN, MSW</td>
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<td>Is there evidence to support/suggest that patient is limiting medication use to save drug (i.e. to over-count)?</td>
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<td>- &quot;I take it when I really need it.&quot;</td>
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<td>- &quot;I sometimes only take half the ordered amount.&quot;</td>
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<td>Fear of Addiction</td>
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<td>RN, MSW</td>
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<td>Is there evidence to support/suggest that patient is limiting medication use due to concern he or she will become addicted?</td>
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<td></td>
<td>- &quot;I want to get off that stuff.&quot;</td>
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<td>- &quot;I really take it when I can’t stand it anymore.&quot;</td>
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<tr>
<td>Drug Diversion or Over-Medicating</td>
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<td>RN, MSW</td>
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<td>Is there evidence to support/suggest that patient is taking too much medication?</td>
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<td>- &quot;I’m not really getting the benefits.&quot;</td>
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<td>- &quot;Even doubling the prescribed amount doesn’t help the pain.&quot;</td>
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Potential Non-Adherence Issue | Assessment Strategies | Referral Triggers |
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<td>Health Belief Expectations</td>
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<td>RN, MSW</td>
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<td>Is there evidence to support/suggest that the patient is forgetting to take medications, or forgetting that medications have already been taken – resulting in non-compliance?</td>
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<td>- &quot;I usually take one each lunch, but my daughter told me I can’t remember if I took it.&quot;</td>
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<td>- pills found in chair, on table by bed, etc.</td>
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<td>- some medicines left on floor</td>
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Memory Deficit
- Is there evidence to support/suggest that the patient is not keeping track of medications? |
- "I usually take one each lunch, but my daughter told me I can’t remember if I took it."
- Pills found in chair, on table by bed, etc.
- Incorrect pill counts
- Some medicines left on floor

Functional Deficit
- Is there evidence to support/suggest that the patient is not keeping track of medications? |
- "I usually take one each lunch, but my daughter told me I can’t remember if I took it."
- Pills found in chair, on table by bed, etc.
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- Some medicines left on floor

Dysfunction
- Is there evidence to support/suggest that the patient is not keeping track of medications? |
- "I usually take one each lunch, but my daughter told me I can’t remember if I took it."
- Pills found in chair, on table by bed, etc.
- Incorrect pill counts
- Some medicines left on floor

Incomplete Discharge Information and Test Results

- Communication between hospital MD and PCP occurred infrequently (3%-20%)
- DC Summary availability - 12%-34
- Discharge summaries lacking:
  - diagnostic test results - 33%-63%
  - treatment or hospital course (7%-22%)
  - discharge medications (2%-40%)
  - test results pending at discharge (65%)
  - patient or family counseling (90%-92%)
  - and follow-up plans (2%-43)

- Patients discharged with test results still pending - 41%
  - Up to 10% of these results can change the medical management
  - Physicians are often (61%) unaware of test results returning after discharge that may change management


Are your patients really following up with their PCP?
Any Correlation between PCP follow up and the reductions of rehospitalizations?

Rehab Therapist’s Role in the “Clinical Hand-Off”

- Increase efficiency, increase effectiveness and continuity of care
- Start with ensuring Marketing/Nurse Liaison obtains last inpatient therapy note(s) with hospital DC records

PT/OT/SLP “Hand-Offs:”

- Medical conditions that limited therapy progress
- DME recommended/ordered/trained
- Compliance and motivation during inpatient therapy
- On-going goals discussed with patient
- Family training initiated/completed
- Standardized Assessment tests completed (Allen Cog, Tinetti, EAT-10, Boston Aphasia, Modified Barium Swallow Study)
Rehab Therapist’s Role in the “Clinical Hand-Off”

- What is your therapist’s current communication/relationship with inpatient or referring rehab team?
- HH Clinical Manager/Director facilitate transitional “hand-off” with inpatient/referring rehab manager
  - Reasonable expectation of therapists for information exchange
  - How can we do this most efficiently? (electronic via secure email? Phone?)
  - Once process is mutually agreed upon, HH Clinical manager rolls out process to HH rehab staff
  - May have to “hand hold” process in the beginning
  - Use a “case study” (that resulted in a positive outcome) as an example in next rehab or clinical staff meeting to demonstrate the need for the hand off communication

Readmissions Risks

1. Patients may not fully understanding what’s wrong with them
2. Patients may be confused over which medications to take and when
3. Hospitals don’t provide patients or doctors with important information or test results
4. Patients do not schedule a follow up appointment with their doctor
5. Family members lack proper knowledge to provide adequate care

1. Knowledge deficit
2. Medication Non-adherence
3. Incomplete information/data
4. Fragmented care
5. Family/Caregiver disconnect
What can bridge these gaps?

Care Transitions!
Bridging the Gap with Care Transitions

- Patient Safety
- Good Quality Clinical Care
- Improves Trust (with patients and providers)
- Financial [penalty]
- It is *REALLY* why we provide home care!

Do you practice *Transitional Care* **within** your own agency?

- Does information flow down AND upstream?
- What is the *depth* of information exchange when there is a change in medication? Includes possible systemic and functional affects?
- Is information exchange meaningful to the patient’s plan of care?
- How does the team communicate their progress with the patient’s stated goal?

*How do you measure the success of your agency’s “care management?”*
## Evidence-Based Care Transition Interventions

- **BOOST** ("Better Outcomes for Older adults through Safe Transitions") toolkit
- **BPIP** (Best Practices Intervention Package - Transitional Care Coordination) toolkit
- **CTI** (Care Transitions Intervention)
- **INTERACT** ("Interventions to Reduce Acute Care Transfers" of nursing home residents)
- **POLST** ("Physician Orders for Life-sustaining Treatment") or analogue (MOLST, POST, MOST)
- **RED** ("Re-engineered Discharge")
- **TCAB** ("Transforming Care at the Bedside") and "Creating an Ideal Transition Home"
- **TCM** ("Transitional Care Model")

## Care Transitions Resources

- **Project RED**
  

- **BOOST**
  

- **Eric Coleman**
  

- **STAAR**
  

- **Mary Naylor**
  

- **INTERACT**
  
Prevalence of Falls

**Falls**

- Leading cause of injury-related visits to emergency departments in US
- Primary etiology of accidental deaths in persons over the age of 65 years
- Account for 70 percent of accidental deaths in persons 75 years of age and older
- More than 90 percent of hip fractures occur as a result of falls, with most of these fractures occurring in persons over 70 years of age.
- One third of community-dwelling elderly persons and 60 percent of nursing home residents fall each year.

GEORGE F. FULLER, COL, MC, USA, White House Medical Clinic, Washington, D.C.


What is your agency’s practice with these strategies? Does therapy have a specific role with each strategy?
A *Meaningful* Fall Reduction Program

- Does your agency track patient fall data?
- Does your therapy staff know # falls per month at your agency?
- What is the documented details of the fall?
  - Location?
  - Reason?
  - Systemic vs. musculoskeletal imbalance?
- Did therapy address the *reason* for the fall?
- Did therapy have patient perform same activity safely? (fall area)
- Revisit your agency KPI for falls every quarter and involve the therapy staff in setting this goal.

Agency Awareness and Support - The Therapist’s Intervention

- All clinicians document if Emergency Plan and “Call Us First” plan is posted on fridge or in designated place
- Incorporate this as an “assessment item” during case conference
  - Every clinician reports on the patient/caregiver’s ability
- Put it on the HHA Plan of Care (have them quiz the patient/caregiver)
It’s not just frontloading visits...

...it’s *HOW* you frontload visits!
Meaningful Frontloading

- It’s not enough to just “lay eyes on the patient”
  - EACH front-loaded visit has a “care coordination” component
  - Safely settling the patient in...one visit at a time.
    - Anxiety is another “risk” factor. Each visit starts with “Anything you are anxious about since you have been home?”
  - Divide and conquer! Each clinician should know exactly what the clinician before accomplished or reviewed or performed and move the care coordination forward
  - Utilize your HHA’s for frontloading visits.
    (Specific Frontloading HHA Care Plan)

Meaningful Frontloading

Document against the Risk Assessment Tool

- **> Six medications:** Therapy reviewed medication list with patient. Confirmed patient had taken all meds as prescribed this morning. Patient has a question about his new cardiac medication Coreg regarding time of day. PT contacted RN during visit and RN resolved patient’s question and stated she will make a visit tomorrow to discuss medication use further.

- **Inadequate Support System:** Therapist discussed options for caregiver support during the daytime for ADL activity that requires assistance for safety. Patient stated that with a couple days’ notice he can call his daughter to come over during PT visit for training. PT obtained permission to contact daughter to arrange CG training on shower transfers. Patient instructed to continue sponge bath seated at sink level until daughter has completed training. Patient verbalized good level understanding and agreed. Therapist reviewed HH 24 hour contact phone number located on HH folder and encouraged patient to call with any questions or concerns. Patient was able to read back phone number and demonstrated good understanding of when to call the HH agency for questions or help.

- **Low Health Literacy:** Patient was unable to return demonstrate or verbalize daily mobility program despite two attempts to verbally instruct patient on daily mobility program (walking around dining room table 5X per day for 2 minute bouts). Therapist provided patient with hand-written instructions and posted on refrigerator with daily check off system for completion. Patient demonstrated good understanding of following written program.
Setting the Bar...from day ONE!

- **Review Therapy Role Expectations (during the interview)**
  - Rehospitalization
  - Care Transitions Role
  - Record Review of Readmission patients (rotation among therapy staff)
  - Front-loading visit interventions
- **Therapy Job Description and Annual Performance Review**
  - Management of rehospitalization
  - Role in care transitions
- **Therapy Orientation and Training**
  - Rehospitalization initiatives
  - Care Transitions Role
  - Team communication expectations

Changing the Practice...Changing the Culture

Get the Therapist’s BUY-IN!

- Enlist a therapy leader as a champion to advocate for and promote the initiatives
- Solicit lead therapists to develop or re-develop your therapy “intervention guidelines” for risk stratification groups (High, Moderate, Low)
- Make it competitive – have weekly “postings” via email blast on teams that had no readmissions for the week
- Reward teams with lowest readmission rates
- Celebrate the small wins (“Because of Bob’s quick problem-solving and coordination with the inpatient therapist, he helped prevent a hospital readmission”)
Tools and Support

- Medication reconciliation resources, links to tools, apps
- Copies of nurses’ patient education tools to reference
  - CHF education on diet, edema, etc.
  - Diabetic insulin administration, diet
  - Pneumonia signs and symptoms
- State Practice Acts for each discipline
- Routinely have therapists share case studies
- Whenever possible, have all disciplines together to discuss agency’s readmission outcomes and launch improvement processes.

Care Transitions

- Driving safety first
- Providing a meaningful experience
- Instilling Trust
- Stewards of the community
Transitional care is about relationships.

Working together to make a lasting impact on the patient’s well being.

Thank You!

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