IMPROVING TRANSITIONS: FROM HOME TO HOSPITAL TO NURSING FACILITY CARE MANAGEMENT

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Learning Objectives:

- Discuss the role of community based intensive case management in the reduction of hospital readmissions.

- Explain the collaborative relationship between the frail elderly patient & the caregiver, their provider, the managed care company, and a multi-disciplinary team that can reduce hospital readmissions.

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Care Coordination

Jayme Ambrose DNP RN
Beech Group

BEECH

• Family owned and operated business.
• Started in England in 2000 and moved to Arizona in 2009.
• Corporate Offices are in Mesa, Arizona
• Provide community based health care
  • Home care, home health, case management, telehealth, medical software
• Non Emergency Medical Transport Division

ADOBE

Adobe Case Management provides telephonic management, transitional care services, and intensive case management programs. We are assessing and responding to the diverse needs of an at-risk population to reduce hospital admissions.

• Utilizing evidence based care pathways
• Optimizing an individualized three tiered approach.
• Personalizing the coordination of healthcare needs
Care Coordination

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Population Health

Rand Health report...

More... Medicare patients were discharged from hospitals in unstable condition after PPS was implemented by 22%

• Post Hospital Syndrome
  o Patients are deprived of sleep, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that alter their thinking, and become deconditioned by bed rest or inactivity.
  
  o Each of these issues can adversely affect health and contribute to substantial impairments during the early recovery period, an inability to fend off disease, and susceptibility to mental error.
  
  o Krumholz (2013) NJM

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Population Health

• The at-risk population are misrepresented
• Lack of communication between caregivers
• Mistakes in medication reconciliation
• Missed follow-up physician appointments,
• Unnecessary readmissions
• Multiple healthcare workers providing complex instructions
• Missing components of the plan of care

(Coleman, 2004)

What Needs to Change?

• Create a prevention focused relationship
• Provide personalized skilled services for people in their homes
• Ensure adequate supports are implemented
• Provide education to reduce in-home risks & unneeded hospitalization
• Work towards the goal of highest quality of health and independence

How We Provide Services

• Safe Hand-off
• Web-based software program
• Telehealth monitoring
• 24 hour/7 day week call center
• Personal safety assessment
• Personalized Care Plan
• Predictive Modeling
• Collaboration with all team members
Assessment

- Diagnosis
- Hospitalizations
- Medication reconciliation/ adherence
- Fall Risk
- Home Safety
- Criminal/Safe Behavior
- Assistance with Shopping Housekeeping Laundry
- Transportation Food/Meal Prep
- Bio stats:
  - BP P Glucose

Assessment Tools

- Mini Mental Status
- PHQ 9
- Medication Reconciliation
- Katz ADL Scale
- Lawton-Brody IADL Scale
- Ottawa Assessment
- Nutritional Assessment
- Caregiver Burden Assessment
- Health Literacy – REALM- SF

Care Giver Burden

- Care Givers are:
  - Stressed and Exhausted
  - May be unable to identify best resources
  - May be unable to identify risk factors
  - May not be the best person to help patient engage in their care
  - May not be the best person to communicate with a care team
  - 53% increase in care giver mortality after the death of the patient they care for.
Health Literacy

- Limited health literacy skills are associated with an increase in preventable hospital visits and admissions.
- Studies have demonstrated a higher rate of hospitalization and use of emergency services among patients with limited literacy skills.
- Persons with limited health literacy skills make greater use of services designed to treat complications of disease and less use of services designed to prevent complications.
- This higher use is associated with higher healthcare costs.

http://www.health.gov/communication/literacy/quickguide/literacy.htm

Technology Interface

- Electronic Medical Record
  - open to Providers, Managed care
- Wireless Biostat Monitoring
  - Text abnormalities to Case Manager
  - Uploads into EMR
- Realtime Documentation
  - Web-based
- The value is predictability – we can see problems much early and intervene to ensure the health and well-being of the client.

Community Care Coordination

- Transitional Care
  - Hospital to Home
  - SNF to Home
  - Home to SNF
- Telephonic Support
  - Medication Reminders
  - Nutrition/ Fluid Intake
  - Biostats
- In-Home Care Coordination
  - Tier Based
  - Social Support
  - Medical Care Coordination
90-day Evaluation Statistics

- In reviewing the information related to the Adobe clients, the data has shown improvement at our 90-day re-assessments:
  - SPMSQ score: 25% Improvement
  - PHQ-9: 63.6% Improvement
  - Nutritional Assessment: 75% Improvement
  - Medications: 26% Decreased Number of Meds

90-day Evaluation Statistics

- The data has shown a 75% improvement in Nutritional Scores at 90-day re-assessment.
- This can be attributed to the increase awareness of social supports, nutritional supplements, and nutritionist visits.

Medications

*The population of hospitalizations was found to have an average a higher number of medications prescribed.*
The patients who were hospitalized scored on average significantly higher on the PHQ-9.

**PHQ-9**

![Bar chart showing PHQ-9 scores](chart.png)

Those patients that were hospitalized scored higher on the nutritional risk at initial intake.

**Nutritional Score**

![Bar chart showing Nutritional Score](chart.png)

**SPSMQ**

![Bar chart showing SPSMQ scores](chart.png)
What we have learned:

• Durable Equipment Needs
  - Walker
  - Shower Chairs
  - Bedside Commodes
  - Electric Wheelchair

• Home Safety Equipment
  - Grab bars

• Medical Monitoring
  - O2 stats
  - Glucose levels
  - Pain Management
  - Patient Education

• Social Issues versus Medical Issues
  - Nutritional Support
  - Financial Support
  - Caregiver Support
  - Home Safety Issues

• PCP Involvement
  - Lack of Medication Oversight

Medical Monitoring
  - O2 stats
  - Glucose levels
  - Pain Management
  - Patient Education

What We Learned...

- Whatever it takes.
- It takes a village...
- Substance abuse is prevalent
- Largest need
  - Nutritional
  - Availability
  - Caregiver support

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