

An Evidence-based Strategy for Transitioning Patients from the Hospital to the Community

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Improving transitional care from hospital to home requires comprehensive and highly coordinated intervention during the immediate days following discharge. The Hospital to Home Program addresses both medical and social needs, prevents unnecessary readmissions, promotes improvements in patient perceptions of physical and mental health, and results in excellent patient satisfaction.

Reducing unnecessary readmissions is high on the list of concerns for hospitals as a measure of quality care. The Patient Protection and Affordable Care Act will change aspects of reimbursement and will penalize hospitals for having unnecessary readmissions. Hospital providers and staff can become very frustrated when they see many repeat admissions from patients who seemed ready for discharge. All these reasons make it important for hospitals to assess processes and community resources in order to find ways to decrease readmissions. Many issues have been identified as to why patients do not make a successful transition to home including, lack of understanding by the patient and/or caregiver of the patient's disease, lack of reliable transportation to medical appointments or even to pick up prescriptions and groceries, lack of understanding of medical and medication management, lack of financial resources to purchase medications or pay for adequate housing and nutrition, reduced functional capacity for activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and inadequate social supports for independence in the home. Successful transitional care programs must be comprehensive, coordinated, and individualized to each person. The Hospital to Home Program at Forsyth Medical Center resulted from the passion and vision of the director of case management and a nursing director to create a transitional care safety-net for at-risk patients. While the community is rich in support services, most have a waiting list extending 2 or more months, the critical time for vulnerable patients to be readmitted to the hospital. The Heart Failure Society of America 2010 Comprehensive Heart Failure Practice Guideline recommends that patients with heart failure see a medical provider within 7-10 days after discharge [1]. Most transitional care models are designed to provide the first contact with the patient within 24-72 hours after discharge either by telephone or in person [2, 3, 4]. There is

limited research on how quickly community services should begin but any delay could put a newly discharged patient at increased risk of readmission due to poor nutrition, lack of medications, lack of transportation to medical appointments, or inadequate hygiene and safety in the home.

The Hospital to Home Program is designed to identify hospitalized patients at high risk for readmission, provide coordinated social and medical services for up to 4 months, and reinforce education provided in the hospital. Eligible patients are 65 years and older, reside in Forsyth County, enrolled in Medicare or Medicaid, and meet at least 2 of the following criteria: 2 or more chronic health conditions; physical disability, functional decline, or needing assistance with ADLs; history of falls requiring medical evaluation or treatment in past year; polypharmacy with greater than 8 medications at admission; cognitive decline or depression; 3 or more physician visits in the past 6 months; 3 or more emergency department visits in the past 6 months; 3 or more hospitalizations in the past year; nutritional impairment; history of or current hospitalization for hip fracture in the past year; limited social support; and lives alone. A computerized list is generated daily of patients who meet criteria from admission information gathered by nursing. Case managers, nurses, and physicians also may request consults. In the first 3 quarters of 2011, there were over 1,100 referrals from the computer list and other sources. Some patients may have been referred more than once (on both the computer list and through case managers). The referrals from physicians and case managers are given priority over the computer list referrals.

The referrals are received by the Hospital to Home Program navigator who performs a chart review and interviews patients during their hospital stay to verify that they meet program criteria. Not all people who are referred through the computerized list are seen in person, but all referrals from physicians and case managers are seen. The program is explained to patients and their consent to

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receive services is obtained before further steps are taken. Of the patients seen, over 15% did not meet criteria. About 30% declined although they met criteria. The navigator assesses patients' medical and social histories and identifies caregiver/s or sources of support. If the patient is determined to have non-skilled needs in the home at discharge, such as transportation, light housekeeping, or light meal preparation, a state-licensed home care agency is contacted to provide services within 24 hours of discharge at no cost to patients. The home care assistance staff is trained to watch for symptoms of health decline or safety concerns. A detailed visit note is made by the agency for every encounter with the participant. The manager notifies the navigator immediately if any concerns arise about the participant. The navigator also communicates by fax with the primary care physician to verify that the patient is enrolled in this program and to provide contact information.

The navigator makes an initial home visit within 24-72 hours of discharge. While in the home, the navigator does an assessment of the home environment for safety and reassesses the capabilities of the patient to be independent with medical and medication management. The discharge medication list is compared to medications available in the home, and physicians, pharmacists, or home health nurses are contacted if any discrepancies are discovered. In cooperation with the patient, caregiver, or family, further support services are arranged as needed. Teaching reinforcement is provided on discharge instructions, the importance of physician visits, and recognizing and addressing signs and symptoms of worsening health. Planning for long-term patient independence in the home with community supports in place continues and is modified as needed.

The navigator provides continuing follow-up by telephone or in-home visits for up to 4 months. Participants often call the navigator between contacts; however, a goal of the program is to empower them to be their own advocates with medical providers and to independently address their own medical and social issues by the time of discharge. In addition to the in-home care described, participants often utilize referrals for durable medical equipment, Meals on Wheels and other volunteer support, personal care services, and their local Department of Social Services. Some services have not been available through community agencies, such as appliance repair, pest extermination services, lymphedema sleeve purchases, and occasionally funds for medication co-payments. Philanthropic funds have been accessed to cover these needs.

Data analyzed during the first 2.5 years of the program document that these coordinated transitional care services have improved patient outcomes and quality of life among participants at high risk for readmission. The population served by the Hospital to Home Program is the older Medicare population, with an average age of 80. Among enrollees, 14% were covered by Medicaid, 45% met the 2008 federal poverty guidelines, 69% were not married,

and 28% required an emergency department visit after discharge from the hospital. The average length of participant enrollment is 63 days. On average, participants received 2.7 navigator visits, 3.5 telephone calls, and 16 hours of home care assistance.

Improvements in patient perceptions of physical and mental health are validated by changes in SF-36 scores. The SF-36, a widely accepted standardized survey tool, is given to patients at the first and last home visits. The physical and mental health scales and all subscales showed statistically significant improvement to at least the $P < .002$ level. Overall, there was a high degree of patient and family satisfaction among participants, with 99% rating services as very good or excellent.

Based on the reductions in readmissions, cost savings are estimated to be more than 1.5 million dollars for 2.5 years of operation. During a 6-month period in 2010, enrollees were compared to those who met criteria but declined the service, demonstrating a 29% reduction in 30-day inpatient readmissions. In addition, average direct costs of readmissions were decreased 26% among the enrollees compared to their index admissions, whereas those who met criteria but declined enrollment had a 152% increase in average direct costs of readmissions.

Currently, this program serves only the county in which the hospital is located with 1 navigator. However, 1 navigator is not enough to meet the full needs of the hospital. Based on past volume, 5 navigators would be required to cover the immediate 6-county area from which the hospital draws patients. There are plans to expand the staff and geographic reach of this program in 2012.

Some of the most important lessons learned from this program include the value of case management, education, medication reconciliation, assessment, and plan of care revisions extending beyond the hospital stay. Home visits uncover many needs and risk factors that patients and their caregivers did not realize or did not describe during the hospitalization. Moreover, many patients and caregivers are unaware of their need for community-based support and do not know how to access available services.

For all services after discharge, a consistent point of contact is an important element. Having one coordinator for all questions and concerns relieves a lot of confusion and stress for caregivers and participants. The Hospital to Home Program navigator fulfills this function.

The stress of hospitalization and the transition home make patients and caregivers less able to retain education provided while in the hospital. Many patients and families believe they will be fine once they get home or they may have unrealistic expectations of what home health or hospice services will provide for them. Once home, they do not know who to contact for help. Having the initial navigator consult during the hospital stay is essential in establishing a highly coordinated effort. The close working relationship with the home care agency provides a presence in the home

to observe the participant and to notify the navigator of any concerns. Approximately half of all participants (51%) use the free home care agency services. The navigator's visits and telephone calls also provide access to a knowledgeable provider who can answer questions or listen to concerns.

Transportation issues often cause noncompliance with medical appointments. Many participants believe friends or family will take them to appointments but work schedules limit flexibility of transportation and often times appointments are missed or canceled. County transportation services require a multiple day notice and do not provide door-to-door assistance. Local volunteer agencies providing transportation will only transport one time a week and require a 5-day notice. With quickly arranged health care appointments to address medical changes these services may not meet patient needs. Providing a door-to-door transport service is often essential to promoting medical care compliance. Of those who use in-home support services, 38% also use transportation services. Transportation was most often used for physician office or other medical care visits until a more permanent solution could be worked out or the patient was strong enough to use other transportation options.

In some instances, essential home health services arranged by hospital case management prior to discharge may not be implemented without follow up. The navigator ensures that all necessary services and social support are initiated in a timely fashion.

Patients with mental illnesses pose additional challenges. Patients are screened for depression at admission to the hospital and when entering the Hospital to Home program. Sometimes symptoms worsen when a patient returns home and realizes he/she has less functional capacity. In-home care services assist in meeting these needs by providing the patient with a person to speak with on a regular basis. Additionally, a local nonprofit offers a volunteer companion program to provide visits. Other agencies offer a telephonic companion service. Forsyth Medical Center has a mobile crisis unit that responds to the homes of people in behavioral health crisis. At-risk patients are informed of this service and appropriate referrals are made to community treatment programs. The Hospital to Home Program utilizes effective navigation strategies to help patients and their families with a personalized plan for continued recovery.

Improving transitional care from hospital to home requires comprehensive intervention to address both medical and social needs. Care must be patient-centered and empowering to help patients direct their own medical care. For long-term independent living and safety, patients need ready access to community resources for social needs. In the short term, care must support the patient in the home with a single point of contact to help overcome barriers to health and address any unexpected issues as they arise. Quick medication reconciliation and disease process education are essential, as is reinforcing the need for continued medical follow-up with the primary physician. Since patients may not recognize their own needs, they may not be able to articulate their needs clearly to community agencies. The navigator is an advocate on their behalf. The Hospital to Home Program demonstrates that comprehensive and coordinated transitional care addresses the needs of patients with complex health issues, prevents hospital readmissions, improves patient perceptions of physical and mental health, and results in excellent patient satisfaction. **NCMJ**

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