Hospital-to-Home model manages social determinants of health for high-risk patients

By **KERIN ZUGER**

Lexington Medical Foundation and a Right at Home office based in South Carolina built a strategic partnership based on a community-based, patient-centered program to provide social determinants of health support for high-risk patients once they transition home.

When healthcare providers focus on coordination of care, health outcomes are improved. Hospitals across the nation continue to seek out ways to reduce avoidable readmissions and overutilization of ED's. Implementation of community-based and patient-centered programs that provide social support for high-risk patients during their transition home has become a new emphasis in the post-acute industry. The healthcare industry is beginning to recognize that partnering with non-medical, community providers and improving communication during patient transfers allows patients to receive an additional level of care following a hospitalization, enabling them to remain in the least costly, yet most desired setting, their home.

Hospital-to-Home Programs are most effective when there is a collaboration between a hospital, home health agencies, and a non-medical home care company to provide additional support to patients when they transition home. Utilizing a care team approach led by a transitional care coordinator, the program provides eligible patients with appropriate non-medical assistance in their home. The interdisciplinary care team consisting of the hospital, home health agencies, and the in-home care company hold weekly face-to-face meetings to improve communication and coordinate patient care.

A non-medical care model provides the necessary services for patients to safely transition to their home environment. The focus on the psychosocial needs is critical to a safe, viable transition home. Services are customized based on the needs of the patient, but may include: meal preparation, assistance with activities of daily living (ADLs), chronic disease management education, medication reconciliation, and transportation to physician appointments.

TRANSITIONS PROGRAMS

Transitions programs have been around for years, dating back to 2010 when one of the very first transitions programs was launched by Right at Home in Winston-Salem, North Carolina. At that time, the goal of the program was simple. Ensure patients had the support they needed to stay safely in their home and reduce the risk of readmission.

The results of that early pilot illustrated the need and urgency to develop these types of programs, even before readmission penalties were enforced. The pilot saw a 65% reduction in readmissions and over a million dollars in hospital savings. Right at Home owners Greg and Jackie Brewer were lucky enough to have funding through a Duke endowment, but unfortunately when grant funding ended, participation in the program also tapered off.

Since that time, a variety of transitions

models have entered the landscape. All different types of companies have found ways to support and augment transitions from acute care settings to home, from DME and software companies to home healthcare and non-medical in-home care. There are all sorts of methodologies and tools to get a patient home safely and keep them there. The ultimate goal of these programs has stayed consistent over the years: bending the cost curve through reduction of hospital readmissions.

There have been numerous case studies illustrating huge hospital savings and improved patient satisfaction, however, reimbursement for these types of programs continues to be a struggle. Finding the right partners and the right approach are critical to hospital buy-in and funding.

This article will explore a success story in Columbia, South Carolina, where Right at Home VP of Operations Mike Brown and his colleague, Kathrine Watts, Director of Case Management for Lexington Medical Foundation, were able to work together to illustrate how transitions programs can benefit providers, payers and, most importantly, the client.

I recently caught up with Brown about the success of their collaborative care transitions program, and there was one thing he wanted to make clear: "It's not easy. This takes work and the clients we help aren't always typical private pay clients, with long hours. But, it's worth it."

Brown and Watts sought to develop a care transitions program that was patient-centered. Recognizing the impact social determinants have on hospitalizations and overall cost, they wanted to build in processes to address vulnerable patients with complex needs that would allow them to stay in their homes. They felt strongly that to improve care transitions and reduce hospital readmissions, there must be focus on the patient's physical comfort and emotional well-being.

"… Creating a transition program through partnership with non-medical, community providers improves communication during patient transfers and allows patients to receive an additional level of care, enabling them to remain at home following a hospitalization."

– KERIN ZUGER IS SENIOR VICE PRESIDENT OF BUSINESS DEVELOPMENT & STRATEGIC PARTNERSHIPS FOR RIGHT AT HOME

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in which people are born, grow, live, work and age and include factors like physical environment, social support, and access to healthcare. Vulnerable patients with complex needs who have recently been discharged from the hospital may need community support and social services in addition to post-acute medical care to safely stay in their home. Transitions models that use a patient-centered approach can lead to improved health outcomes and reduced expense throughout the care continuum (NEJM Catalyst).

Targeted Population & Projected Outcomes

Prior to Implementation (2016):
33% readmission rate for targeted population

Goals:

- Providing in-home support for approximately 20 patients per month (up to 20 hours of non-medical home care within 30 days of hospital discharge) for those with chronic, complex, co-morbid conditions.
- Reducing unnecessary 30-day discharge readmissions by 40% or more for program-enrolled patients with a diagnosis including, but not limited to, CHF, COPD, pneumonia, AMI, CVA, total joint replacement and CABG.
- Increasing the ability for patients to manage their healthcare needs by providing transportation, arranging meals, obtaining medications, scheduling MD appointments, and supporting daily living activities.

Projected Outcomes:

- ✓ Improve publicly reported quality data (readmissions rated on CMS Hospital Compare)
- ✓ Reduce unnecessary consumption of healthcare resources
- ✓ Reduce unnecessary cost to the health system

Non-Medical Social Determinants of Health

The "social determinants" of health (SDOH) are a subset of the non-medical determinants.

Non-medical factors account for 80 to 90 percent of a person's health, and the contribution of medical care remains 10 to 20 percent.

The leading causes of death in the United States – cancer, heart disease, and chronic respiratory disease – demonstrate the importance of the non-medical determinants to health, as all three chronic diseases are tied to unhealthy behaviors such as smoking and poor diet.

As we consider the role of non-medical in-home care, there is a recognition of the caregiver as being the "eyes and ears" in the home, which puts them in a position to capture and collect valuable data and insights to support the work of home health providers and acute care facilities.

Leveraging a home care provider's ability to report psychosocial needs early on feeds into a new emphasis on implementing community-based, patient-centered programs that provide social support for high-risk patients once they transition home.

Creating a transition program through partnership with non-medical, community providers improves communication during patient transfers and allows patients to receive an additional level of care, enabling them to remain at home following a hospitalization. The key is improving coordination of care in all healthcare settings, which leads to improved health outcomes.

During the early stages of the program, people did not understand the benefit and therefore were not interested in enrolling. In response, the nurse navigators changed their script and started using language like, "the doctor feels you would benefit from the program" or including that it "is a part of the transition process." As a result of the script changes, patients were more responsive to the program and more enrolled.

Study of the Interventions, Measures and Analysis

Not unlike other transitions programs, the goal of this project is to reduce preventable 30-day readmissions for high-risk patients. However, they focused on a population diagnosed with the Medicare Hospital Readmission Reduction Program's selected conditions – heart attacks, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), hip/knee replacement, and coronary artery bypass graft surgery. Data from the hospital and the home health agencies (HHAs) are used in the analysis of this program, while the hospital monitors the following measures:

- Total referrals to the program. Total number of enrolled participants.
- Enrolled patients with a previous 30-day readmission.
- Enrolled patients with a previous ED or in-patient stay prior to admission, 30, 60, and 90-day all cause readmissions for enrolled patients.
- In the early stages of the program, the hospital also tracked refusals. (Due to low enrollment, the hospital changed their approach when introducing the program to potential participants.)

INTERDISCIPLINARY APPROACH

Brown and Watts designed a team approach led by a transitional care coordinator, who assisted in determining which patients were eligible for non-medical assistance in their home. The interdisciplinary care team consists of the hospital, home health agencies, and the in-home care company. This care team held weekly face-to-face meetings to improve communication and coordinate patient care.

There was a focus on the psychosocial needs of the patients to ensure they have the proper supports in place to transition safely back to their home. Services provided typically include meal preparation, assistance with activities of daily living (ADLs), chronic disease management education, medication reconciliation, and transportation to physician appointments, but are tailored to meet the needs of the patient.

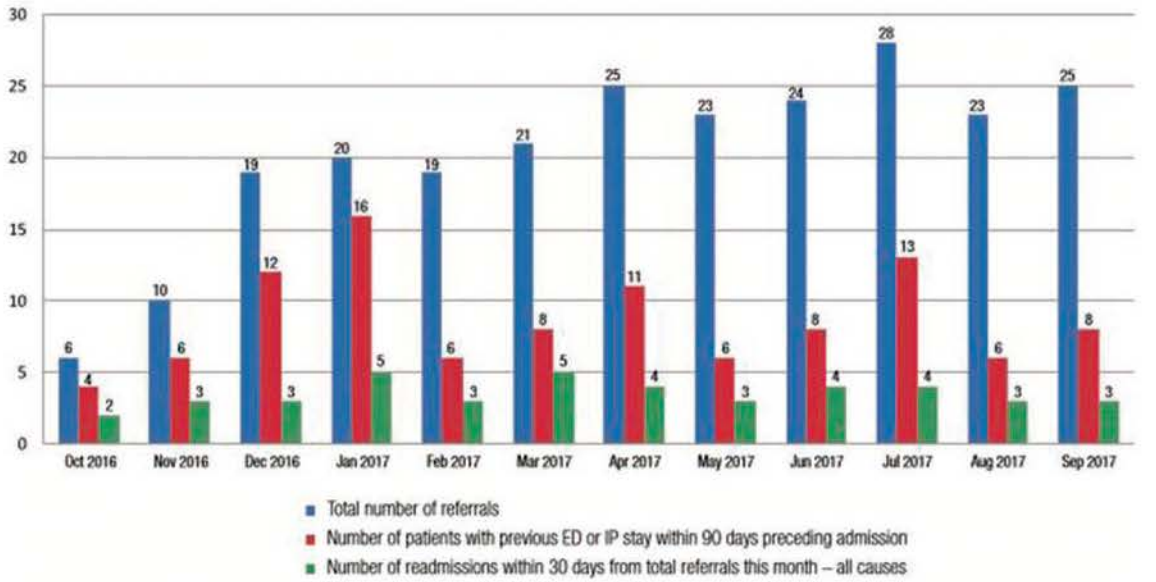
Measured Outcomes:

Progress – October of 2016 through March of 2019

- Providing Hospital to Home ("HTH") for approximately 20 patients per month. Since Oct 2016, we have provided HTH services to 484 patients, which is an average of 20 patients per month.
- Reducing unnecessary 30-day post-discharge readmissions by 40% or more for program-enrolled patients. Our readmission rate for this program prior to Duke Endowment involvement was 24%. We are happy to report that as of September 2018 our readmission rate for the program is 17%, a total reduction of 30%.
- Increasing the ability for patients to manage their healthcare needs. We work

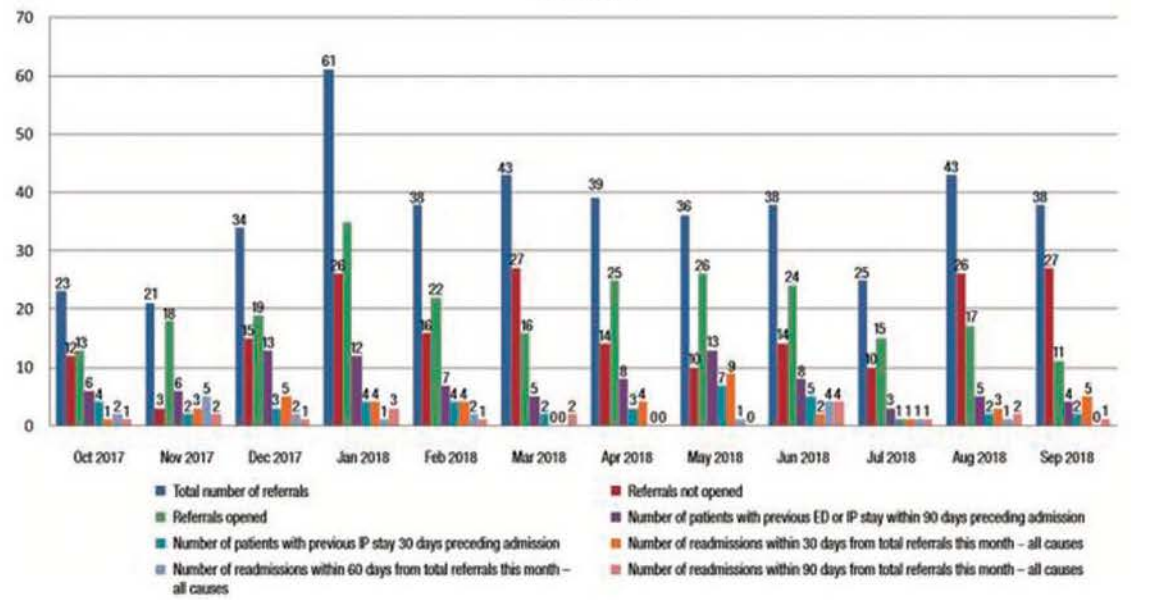
Hospital to Home Data FY 2017

Hospital to Home Transitions Program
Referrals for Patients with CHF, COPD, TKA,THA, CABG, TAVR, CVA and Pneumonia
FY 2017



Hospital to Home Data FY 2018

Hospital to Home Transitions Program
Referrals for Patients with CHF, COPD, TKA,THA, CABG, TAVR, CVA and Pneumonia
FY 2018



About Right at Home

Right at Home, based in Omaha, Nebraska, was founded by Allen Hager in 1995. The company began franchising in 2000, when Brian Petranick was hired as CEO and President. Franchisees work with clients and their families to develop a custom care plan and match them with caregivers to provide in-home care services. Right at Home has approximately 500 locations in the United States and over 100 locations in 7 other countries, serving tens of thousands of clients annually.

with Right at Home to address any barriers to transitioning home successfully. We have even addressed pest control issues, transportation barriers, language barriers, access to care concerns and many other psychosocial needs.

Initiatives:

- ✓ Hospital-wide team addressing CHF readmissions
- ✓ Focus on HTH program with Total Joints to improve transitions of care
- ✓ COPD Navigator program
- ✓ CVA/Pneumonia program
- ✓ EPIC Readmission Risk tool

Addressing care transitions through a patient-centered approach focused on the specific non-medical needs of high risk, medically complex patients has demonstrated success through a decrease in avoidable readmissions for the target population. Patients receive an additional level of support to help them successfully transition to their home environment and stay there.

Brown and Watts believe the transitions care coordinator is critical to the success of the program, as this role manages the patient and the communication process among healthcare providers. The non-medical Right at Home team becomes the eyes and ears for the hospital to avoid readmissions, if at all possible.

Improving communication among the care team members through weekly meetings also contributes to the success of the program by providing a more coordinated approach and allowing the patients to have more points of contact to support their transition home.

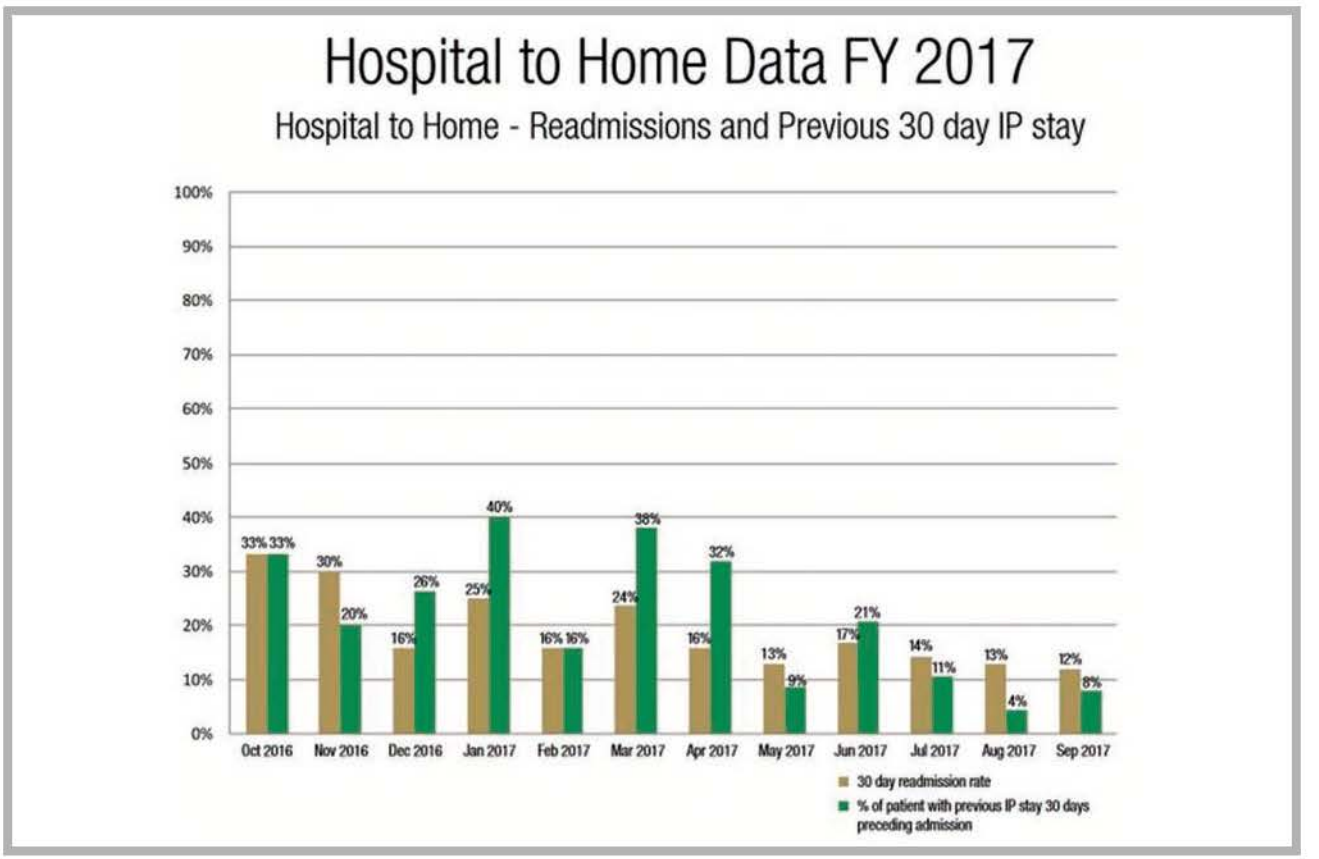
The Duke Foundation will continue funding this program for the next year, at which point Lexington Medical Center will take over the program expense, recognizing the return is well worth their investment.

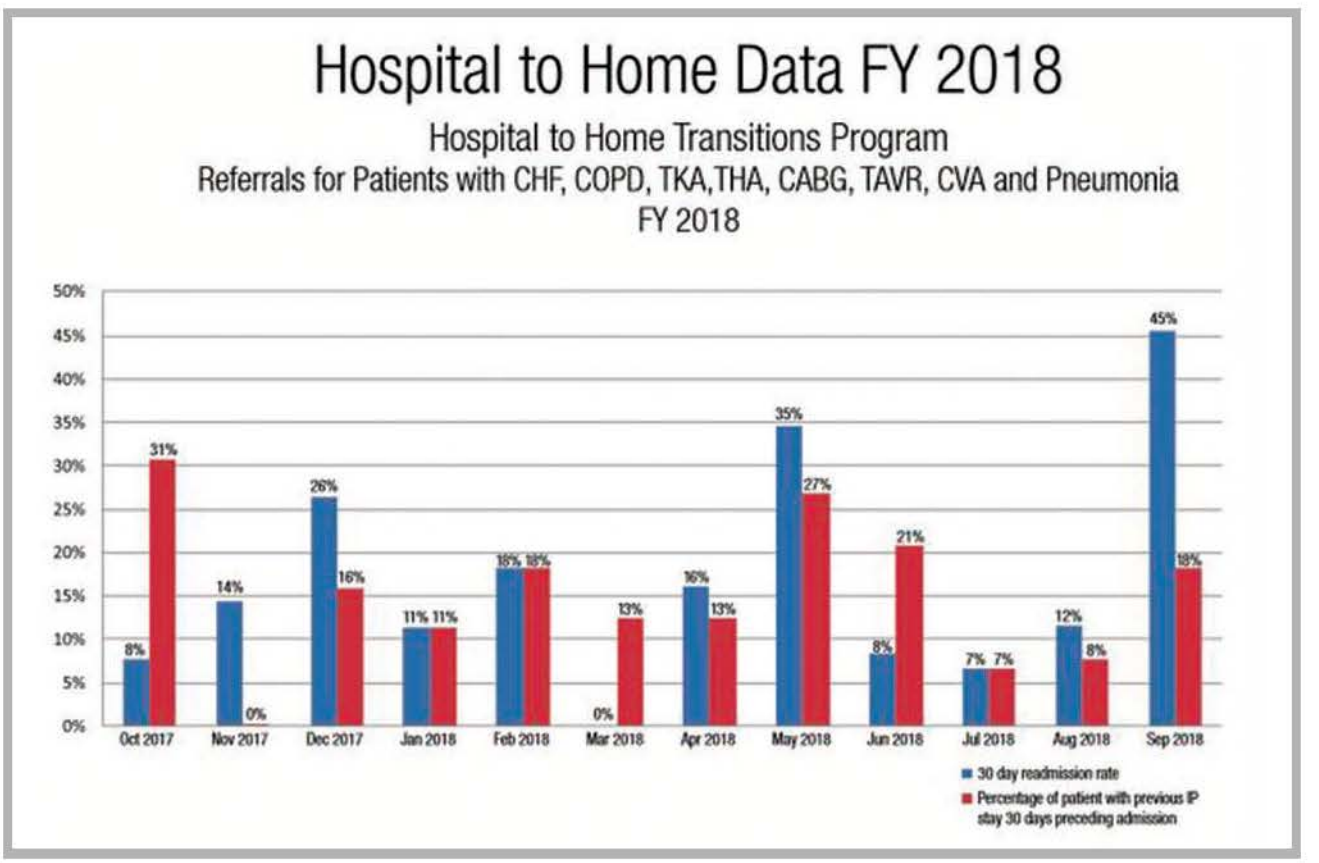
These types of programs are truly a breath of fresh air, as providers explore ways to broadly collaborate throughout the continuum. We all know the days of dropping off donuts and business cards are over. It's time for payers and providers to sit around the table and figure out how to work together to achieve a common goal: A common goal that has been in place well before transition programs were even a thing; a common goal that should encourage us all to build strategic partnerships and leverage each other's skillsets; a common goal of keeping patients out of the acute care settings and avoiding unnecessary spend.

As the dynamics of the industry change, so will the partnerships within.

Internal Hospital Data for Readmissions (Medicare)

	FY 2017	FY2018	National Benchmarks (06/2016)
Overall	12.7%	13.9%	15.3%
CHF	18.6%	19.7%	21.6%
Total Joints	4.0%	4.4%	4.4%
Heart Attacks	14.5%	9.9%	16.3%
COPD	16.1%	11.8%	19.8%
Pneumonia	15.2%	11.0%	16.9%
CVA	11.6%	8.0%	12.2%
CABG	14.2%	9.4%	13.8%


Hospital to Home Data FY 2017
Hospital to Home - Readmissions and Previous 30 day IP stay
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
33% 33%
30%
20%
16%
26%
25%
40%
16% 16%
24%
38%
16%
32%
13%
9%
17%
21%
14%
11%
13%
4%
12%
8%
Oct 2016
Nov 2016
Dec 2016
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
30 day readmission rate
% of patient with previous IP stay 30 days preceding admission


Hospital to Home Data FY 2018
Hospital to Home Transitions Program
Referrals for Patients with CHF, COPD, TKA,THA, CABG, TAVR, CVA and Pneumonia
FY 2018
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
31%
14%
0%
26%
16%
11% 11%
18% 18%
0%
13%
16%
13%
35%
27%
8%
21%
7% 7%
12%
8%
45%
18%
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
30 day readmission rate
Percentage of patient with previous IP stay 30 days preceding admission