

ALL IN
FOR
GOOD

Improving transitions to home for post-acute seniors

Three regional organizations implement transitions-to-home programs for high-risk seniors



E3 GRANT CASE STUDY

Hospital readmissions are difficult and costly for all populations, but they are particularly disruptive to the elderly, with high potential for negative physical, emotional and psychological impact.

According to a story in the August 3, 2015 edition of *Kaiser Health News*, one in five Medicare patients were readmitted to the hospital within 30 days.

With funding support from the Cardinal Health Foundation's E3 Grant Program, three regional organizations have created transitions-to-home programs for high-risk seniors with chronic diseases. Through pre-discharge education, plans for coordinated post-discharge care and medication reconciliation, these programs are dramatically decreasing readmission rates and improving the quality of life of hundreds of seniors.



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Home to Stay

Senior Independence
Toledo, OH

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Registered nurses serve as transition coaches, providing immediate and close follow up after hospitalization.

Overview of organization

Senior Independence provides home health, home care, adult day care and hospice care under the umbrella of Ohio Presbyterian Retirement Services. Its comprehensive programs are designed to provide seniors with the help and confidence they need to stay safely at home.

“Our Home to Stay program was outrageously successful. We have recently expanded the program, and have doubled the number of patients we can serve.”

Wendy Price Kiser,
Executive Director



Project summary

Senior Independence coordinates with the Northwest Ohio Accountable Care Organization (ACO) in the Toledo area in order to provide coordinated post-acute care for high-risk seniors.

Through its Home to Stay program, Senior Independence provides transitional care for Medicare patients who leave any of the eight hospitals served by the ACO, but who do not qualify for Medicare billable home health episodes.

In the Home to Stay program, Senior Independence employees introduce themselves to seniors while they're still in the hospital, and connect those who want to participate in the program to registered nurses who serve as their transition coaches. The RNs monitor patients' progress for 30 days post-discharge.

Each transition coach contacts his or her patients within 48 hours of hospital discharge, makes two home visits and an additional three coaching phone calls. In each contact with a senior, the RN provides supporting instructions on self-care, disease management and health and wellness coaching. The RNs evaluate the home setting,

reconcile medications, help patients prepare to ask questions at their doctor appointments and establish a personal health record and an emergency plan for each patient.

Transition coaches also educate seniors and their families to identify potential health issues early. As a result, they are more likely to call their transition coaches for support and avoid costly trips to the emergency room.

The program has dramatically improved medication compliance, reduced adverse drug events and has significantly reduced the 30-day readmission rate.

During its first pilot year (June 1, 2014 to May 31, 2015), Home to Stay worked with 436 ACO beneficiaries; all 436 seniors completed the 30-day program. Only 19 of the participants were re-admitted to the hospital, reflecting a 4.3 percent hospital re-admission rate, compared to a Toledo area average of 14 percent. According to the ACO, those eligible patients who chose not to participate in Home to Stay had a re-hospitalization rate exceeding 50 percent during the same period.

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Project objectives

- Provide high-risk seniors with chronic illness follow up, coaching and motivational information about self-care for 30 days post hospital discharge
- Increase medicine compliance and reduce adverse drug events
- Reduce hospital readmissions from 14 percent to 9.5 percent

Results (for 436 participants)

Reduced 30-day
readmission rate to
4.3%
(compared to an area
average of 14%)

Post-discharge, seniors are
more involved in self care and
more likely to call transition
coaches at early signs of
health issues, avoiding
emergency room visits

Estimated
readmissions
saved:
42

Hospital days
saved:
202

Dollars saved:
\$409,858

The summary results are estimates that have been separately prepared and provided by each individual grantee and were based on one year periods unless otherwise noted.

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Project continuation

Senior Independence continues to expand its Home to Stay program. Some of the costs of providing the service for those seniors who can't pay are offset by increased referrals from area hospitals. In 2015, Senior Independence acquired additional funding to supplement the cost of the Home to Stay program. ●



At every contact, transition coaches provide instructions on self-care and disease management, as well as health and wellness coaching.

Senior Independence leadership

Wendy Price Kiser
Executive Director

Sue Trumbull
Director of Wellness
and New Initiatives



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Hampton Roads Care Transitions Program

Senior Services of Southeastern Virginia
Norfolk, VA

This program surrounds high-risk seniors with a care team that includes a certified transition coach, the hospital care coordination team and a pharmacist, ensuring coordinated transition of care and medication reconciliation.

Overview of organization

Senior Services of Southeastern Virginia is the Area Agency on Aging that serves residents of eight cities/counties in the region. Senior Services develops and operates coordinated programs that assist seniors 60 and older, their families and caregivers and serves as a resource center for adults with disabilities.

“Our agency’s mission is to help seniors to live with choice and dignity in their communities. When we help them avoid preventable re-hospitalizations—which are incredibly disruptive for the seniors and their families—we go a long way toward achieving this mission.”

Brad Lazernick,
Director of The Center for
Aging, Senior Services of
Southeastern Virginia



Project summary

Hampton Roads Care Transitions Project focuses on reducing preventable hospital readmissions and medication issues of high-risk patients age 60 and older. The target population includes patients with diagnoses of congestive heart failure, acute myocardial infarction, acute renal failure, atrial fibrillation, stroke, pneumonia, diabetes, chronic obstructive pulmonary disease and sepsis.

Senior Services of Southeastern Virginia works in collaboration with Sentara Healthcare and Hampton University School of Pharmacy in the program and uses the evidence-based programs of Care Transitions Intervention and HomeMeds.

Transition teams provide in-hospital and post-discharge follow-up for each senior. Each team includes a certified transition coach from Senior Services of Southeastern Virginia, the care coordination team from Sentara Healthcare, and a pharmacy student supervised by a licensed pharmacist from the pharmacy school.

In addition to providing care transition services under the Coleman Care Transitions model, transition coaches use HomeMeds software as the home medication management system, conducting a comprehensive in-home

assessment with the patient that is reviewed by a pharmacy student and their supervising/consulting pharmacist on the transition team. Transition coaches support patients in making calls to their pharmacist or physician with medication or other medical questions.

The pilot program served 114 seniors, and showed a significant reduction in hospital readmissions. For the period from May 2014 through June 2015, the readmission rate was 6 percent for program participants, compared to the baseline rate of 19.6 percent for patients with targeted diagnoses at Sentara Norfolk General Hospital. Overall, this translated into 94.16 hospital days saved. Of the 114 patients who completed the program, only seven were readmitted to hospital.

In early 2015, the Hampton Roads project was named one of six national Hartford Change AGENTS Action Award winners for achieving meaningful change in practice to improve the health and wellbeing of older adults. The award came with a \$10,000 grant to support the continuation of the program.

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Objectives

- Engage 50 percent of the senior patients being discharged from Sentara Healthcare in the transition-to-home program
- Facilitate reconciliation of patient medication regimen across settings and prescribers to ensure that 100 percent of those participating in the project have had their medical records thoroughly reviewed
- Reduce 30-day readmission rate by 50 percent for patients with targeted diagnoses

Results (for 114 participants)

Engaged 40% of eligible referrals	Provided thorough reviews of medication regimens with 100% of participants	Reduced 30-day readmission rate to 6% from baseline of 19.6%
Estimated readmissions saved: 15	Hospital days saved: 94	Estimated dollars saved: \$120,000

The summary results are estimates that have been separately prepared and provided by each individual grantee and were based on one year periods unless otherwise noted.

E3 GRANT CASE STUDY

Project continuation

Senior Services of Southeastern Virginia is continuing its Hampton Roads Care Transitions Program, supporting it through a variety of grants. The organization is also working with Sentara Healthcare to explore the potential of direct reimbursement through the healthcare system. ●



When seniors have questions about their medications or other medical issues, transition coaches support them in making calls to their pharmacist or physician.

Senior Services of Southeastern Virginia leadership

John N. Skirven
Chief Executive Officer,
Senior Services of
Southeastern Virginia

Brad Lazernick
Director of The
Center for Aging,
Senior Services of
Southeastern Virginia

April Russell
Care Transitions
Program Manager,
Senior Services of
Southeastern Virginia

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SWIRCA & More Care Transitions Program

Southwestern Indiana Regional Council on Aging, Inc
Evansville, IN

In this rural region of Indiana, a transition-to-home program pairs transition coaches with high-risk seniors living with chronic diseases.

Overview of organization

Southwestern Indiana Regional Council on Aging (SWIRCA & More) is a private, not-for-profit agency that helps seniors and people with disabilities remain safely at home, through education, advocacy and support services. The organization serves people in a largely rural six-county area in southwest Indiana. SWIRCA & More's comprehensive services are designed to help seniors continue to live safely at home.

"Our primary focus is improving the patient's overall care and well-being, post discharge. Achieving this increased quality of life for our patients means reducing preventable hospital readmissions and saving dollars."

Carolyn Conners
Business Development Director



Project summary

The Care Transitions Program was designed to help patients with a diagnosis of heart failure, COPD, renal failure or pneumonia transition from acute care back to their homes, with the goal of improving continuity of care and decreasing hospital readmissions. Patients are referred to the program from three acute-care hospitals in the region.

SWIRCA & More established the program in 2012 with two transition coaches serving patients from area acute-care hospitals. In 2013, an E3 Grant from the Cardinal Health Foundation allowed SWIRCA & More to hire a third coach and expand services to more seniors. Certified social workers serve as the transition coaches.

Care Transitions interventions begin with a visit with patients while they're still in the hospital. Two home visits follow, the first within 48 hours of discharge and the second, one week later. The transition coach then makes three follow-up phone calls: The first in week three after discharge, the second at 30 days post discharge and the third at 60 days post discharge.

Transition coaches work with seniors on medication reconciliation, encouraging the patients to call their physician or pharmacist if there's any discrepancy. Coaches reinforce discharge instructions and help plan for follow-up medical appointments. They work with patients to develop and use personal health records, and assist patients in gaining access to other available community resources.

The program has significantly decreased readmission rates among the seniors it serves. From July 2013 to July 2014, the 30-day readmission rate for those who completed the Care Transitions intervention was 14.14 percent, compared to 20 percent for those patients who did not participate. The 60-day readmission rates for individuals who received the Care Transitions intervention was 18.18 percent, compared to 28.89 percent for those who didn't participate in the program.

In 2014, the program's efficacy in improving quality of care, quality of health and reducing healthcare costs among Medicare patients was recognized with an Award of Excellence from Health Care Excel and the Medicare Quality Improvement Organization.

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Objectives

- Provide seniors with follow up and coaching for 60 days post hospital discharge
- Encourage the use of personal health records, medication self-management, and encourage patients to follow up with their primary physician
- Assist patients with access to community resources
- Reduce hospital readmissions and improve patients' overall care and quality of life

Results (for 198 participants)

**Reduced 30-day
readmission
rate to 14%**

Compared to 20% for those seniors who did not participate.

**Reduced 60-day
readmission
rate to 18%**

Compared to 28.89% for those who did not participate in the Care Transitions program.

Estimated
readmissions
saved:
21

Hospital
days saved:
32

Estimated
dollars saved:
\$134,848

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Project continuation

The SWIRCA & More team continues to provide a fee-for-service Care Transitions Program to support seniors who live with chronic diseases in avoiding preventable hospital readmissions, with registered nurses as transition coaches. (SWIRCA & More is currently marketing the program to area hospitals.) ●



Coaches work with high-risk seniors to reinforce discharge instructions, and help them gain access to multiple community resources.

**Southwestern Indiana
Regional Council on
Aging, Inc. leadership**

Rhonda Zuber
President

Carolyn Conners
Business Development
Director

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About the E3 Grant Program

Since 2008, through its E3 Grant Program, the Cardinal Health Foundation has invested in hundreds of healthcare organizations across the country.

We support a wide array of patient safety work with a focus on accelerating the rate of change with two goals:

- Improved patient outcomes
- Reduced healthcare costs

Because of the complexities in healthcare and healthcare systems, it takes an average of 17 years for evidence-based practices to be fully implemented into healthcare practices, according to *The National Institutes of Health*. Within a year or two, some of our grantees are affecting change, eliminating errors and creating lasting improvement. They are reducing readmissions to hospitals, reducing lengths-of-stay and, most importantly, saving lives. For more information, visit cardinalhealth.com/patientsafetygrants.

About the Cardinal Health Foundation

The Cardinal Health Foundation supports local, national and international programs that improve healthcare efficiency, effectiveness and excellence and the overall wellness of the communities where the Cardinal Health (NYSE:CAH) nearly 37,000 employees live and work.

The Cardinal Health Foundation also offers grants to encourage community service among its employees and works through international agencies to donate much-needed medical supplies and funding to those who need them in times of disaster. Cardinal Health is #AllInForGood.



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