

# Increasing medication safety for older adults

Helping people age more independently at home







# Knute Nelson at Home

Knute Nelson Foundation Alexandria, MN

Knute Nelson created a medication safety program for older adults with chronic diseases that combines transition education and medication reconciliation with continuous real-time monitoring of health conditions.

# **Overview of organization**

Knute Nelson, an independent, nonprofit organization, provides services to older adults in 29 counties in West Central Minnesota, working in close collaboration with area hospitals to provide continuity of care. Its staff offers a range of post-acute programs and services including home care, outpatient therapy, senior apartments, assisted living, sub acute care, nursing home care and hospice.

"This program has allowed us to provide a higher quality of life for our clients, and lets them live independently and safely at home. It's helped us to focus on seniors' immediate needs, and, at the same time, has allowed us to increase efficiencies."

**Cadi Merten,** LPN and Clinical Technology Manager



# **Project summary**

Knute Nelson at Home was designed for patients with chronic diseases discharging from acute care to home or community-based living. Intended to improve both medication safety and increase seniors' connections to their care providers, the program focused on a formal check-in process and medication safety and reconciliation.

It includes both low-tech and high-tech solutions: Staff completes and documents medication reconciliation upon all admissions, discharges, readmissions and transfers to or from post-acute agencies. Providers follow careful "re-hospitalization prevention" scripts that help them to identify barriers and to ensure that follow-up appointments have been scheduled. Staff review plans for transitions with each patient, and send patients home with detailed and easy to read medication instructions.

The program incorporates new technology through GrandCARE Systems, smart-home technology that allows vital sign monitoring and socialization functions. (Clients' homes are equipped with a touch-based, in-home appliance that connects to an online dashboard accessed by caregivers.) Through GrandCARE, Knute Nelson can provide continuous real-time monitoring of health conditions for hundreds of clients spread across a large geographic area.

Knute Nelson at Home has reduced hospitalizations and improved care transitions between acute and post acute settings.



# **Project objectives**

- Reduce hospital readmissions from 25 percent to 15 percent
- · Decreased number of prescriptions per person in long-term care
- Increase seniors' quality of life and allow them to stay at home longer

Results (for 2,048 participants, 809 of them with chronic disease)

Reduced 30-day readmissions from 25% to 19% in the organization's home care agency

Reduced 30-day hospital readmissions in sub-acute center from

16.5% to 8.2%

Decreased number of prescriptions per person in long-term care from

(a savings of more than \$108 per person per month)

Estimated readmissions saved:

49

Hospital days saved:

655

Dollars saved:

\$392,000

Providers follow careful "re-hospitalization prevention" scripts with their patients.

# **Project continuation**

Today, Knute Nelson has implemented its medication reconciliation process and transition education program throughout the organization, and continues to use smart-home technology for chronic disease management for seniors at home.

In 2014, the Minnesota Department of Human Services awarded Knute Nelson with a \$350,613 performance-based incentive payment grant for home- and community-based services. Since receiving the grant, Knute Nelson at Home has increased the number of people it serves by 23 percent, has reduced hospitalizations further—and has led to an increased overall rating of care to 93 percent, according to Home Health Care CAHPS Survey results.

Early in 2016, the program earned Knute Nelson the Quality Award from LeadingAge Minnesota, a large association of organizations serving Minnesota's seniors. Knute Nelson was recognized for using technology to transform how care is delivered, thus improving health outcomes and allowing people to age more independently in their homes.

# Knute Nelson Foundation leadership

### **Konnie Evans**

Vice President of Home Care

### Jani Helm

Home Care Director of Clinical Care

## **Angie Urman**

Chief Operating
Officer/Administrator
of the Care Center

### Cadi Merten

LPN and Clinical Technology Manager



# **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.

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