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Transitions House Calls Significantly Reduces Readmissions

A Texas Health Physicians Group white paper

Reducing hospital readmissions has become a national priority and has most hospital administrators scurrying for solutions before the Centers for Medicare & Medicaid Services (CMS) 2012 penalties are defined and implemented. The New England Journal of Medicine study estimated that unplanned readmissions cost Medicare $17.4 billion in 2004. Roughly 20% of Medicare patients are readmitted to the hospital within 30 days of discharge (1). There are several effective initiatives (i.e. Project RED, Community-based Care Transitions Programs) and numerous pilot studies throughout the country to help demonstrate improved outcomes and reduce readmissions, but few have been widely adopted. In one study, researchers in Rhode Island recruited 1,042 patients over an 18-month period (January 2009 through June 2010) and concluded a 12.8% readmission rate for the control group consisting of a "coach" who completed a hospital visit, a home visit and two-follow-up telephone calls with the patient. A widely quoted article by Brett D. Stauffer, MD, MHS, of the Institute for Health Care Research and Improvement at Baylor Health Care System in Dallas, conducted a study to determine the effectiveness of transitional care program for patients 65 years or older with heart failure. The use and intervention, offered by an advanced nurse practitioner, reduced 30-day readmission rates to Baylor Medical Center Garland by 48% (2). Such affirmation of a Transitional Care Model, developed by Mary Naylor, PhD, RN, FAAN, supports the growing needs of elders at a vulnerable point in their care; when care is transferred from hospital to home.

Pillars of Effective Transitional Care

While each program has unique results, there is overwhelming evidence from which to glean the following best practices:

- Medication Issues are at the crux of many readmissions
- Timely PCP Follow Up appointments is a close second reason for readmissions
- Coordination of Care and sharing of information is paramount

How Transitions House Calls Measures Up

Transitions House Calls opened in May 2010 with the intent of using advanced nurse practitioners to help manage high-risk, high-cost patients enrolled in a Medicare Advantage Plan. By including a house call visit and continuing the extensive care coordination offered by a social worker, the savings for 2010 was substantial; while perhaps anecdotal, for a single patient, the savings exceeded 600%. The program was later expanded in order to determine what the impact on recidivism rates for Texas Health Resources would be. From June through November 2011, 433 patients were seen by a Transitions House Calls nurse practitioner for a post-hospital discharge home visit shortly after leaving the hospital (usually within 48 hours). All patients had a diagnosis of heart failure and were identified as high-risk based on more than one hospital admission for the same calendar year. As reported in the Rhode Island study, participation or the conversion of "referral to visit" was 53.9%; slightly half of those referred elected to participate in the program. For the study, 24% or 139 referred to Transitions House Calls refused services. Of the 433 seen, as total of 49 patients were readmitted (Note: one was for CVA and six were status-post fall). The "all cause" readmission rate was

11.3%. The group who chose not to participate in the program had twice the readmission rate (23.7%) and a over a third of the patients in this group had more than one readmission post 30-days. The data presented was validated by North Texas Specialty Physicians in Fort Worth in December 2011 using SandlotConnect HIE Solution. It is worth mentioning, the 433 were selected due to the presence of issues that caused the hospital physician to be concerned the patient would have a high likelihood of readmitting in the immediate post discharge period. Therefore, the savings might even be greater than what was demonstrated in this study.

Well known for her research and contributions to Transitional Care Model, Mary Naylor, PhD, from the University of Pennsylvania School Of Nursing concludes, the advanced practice nurse model of following patients post-hospitalization reduced readmissions and thereby reduced the costs of providing care (3). While Naylor, et al report the effectiveness, it is unknown whether they were pilot studies or were long-term programs. Transitions House Calls is a sustainable program that continues to demonstrate an ongoing consistency in the community and has the potential to rapidly become an industry leader.

Comprehensive transitional care interventions that emphasize coordination between healthcare providers, patient education, and self-care management will invariably address some of the issues and reduce rates of rehospitalizations (Daley, 2010; Naylor et al., 2004). Moreover, medication issues and timely follow-up with a primary care physician (PCP) are significant contributing factors for readmissions among the elderly. Our experience has shown that, sending a nurse practitioner to the home is resulting in lower than expected 30 day readmission rate and should become a tenant of discharge planning immediately; for all patients where there are concerns for readmission soon after discharge. The nurse practitioner has the prescriptive authority to change and/or order the solution for issues that might cause an unnecessary hospital readmission without delay, thus "bridging the gap in patient care." The frequency is open-ended or is best defined by the moment the patient follows up with their PCP. The upside to Transitions House Calls is that our involvement can remain more long-term if warranted if the PCP is in agreement.

What The Future Holds

While Transitions House Calls is not a profit center; under the current fee-for-service (FFS) model and is not currently subsidized by the health care system (e.g. hospital), the return on investment is found in the a cost-savings associated with each individual reduction from an unnecessary hospital readmissions as reported by Naylor in 2004 (4).For the health care system, reduction in recidivisms can avoid substantial penalties from CMS related to high 30-day readmission rates for patients discharged with CHF, Pneumonia and Acute MI. While transitional care type programs remain dependent on FFS; creating incentives that demand quality outcomes should become the payment platform or a shared cost-savings model should be adopted. Transitions House Calls treat high-risk patients until they are seen by their PCP or when they get in trouble until they are stable. However, a closer look at the acute care climate, with respect to length of stay, Transitions House Calls may be well positioned to reduce the more costly type patients because of multiple comorbidities. According to The Hospital in the Home Association, caring for patients in their homes instead of the hospital can cut costs by almost a third while achieving the same health outcomes (September 2011). While the study was conducted in Australia, it suggests the potential for similar savings in the US and deserves further review.

For more information about Transitions House Calls, contact: brettparish@texashealth.org

1 Jencks, S.F., M.V. Williams, and EA Coleman, Rehospitalizations among patients in the Medicare fee-for-service program, New England Journal of Medicine 360:14, April 2, 2009.
2 Stauffer, BD. Arch Intern Med. 2011; 171: 1238-1243.
3 Naylor, MD, et al. Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders. JAMA 2011; 281(7): 613-620.
4 Naylor MD, Aiken, LH, Kurtzman, ET, Olds, DM, Hirschman, KB. The Importance of transitional care in achieving health reform. Health Affairs 2011; 30(4): 746-754.