Reducing Avoidable Hospitalizations

Johns Hopkins Home Care Group
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Background

Why Reduce Avoidable Hospitalizations?

One in four patients receiving Home Health Services is hospitalized during their episode of care.

27% of Home Care patients hospitalized annually which costs the US Healthcare system $6,400,000,000

Acute Care hospitalization Rate (ACH)

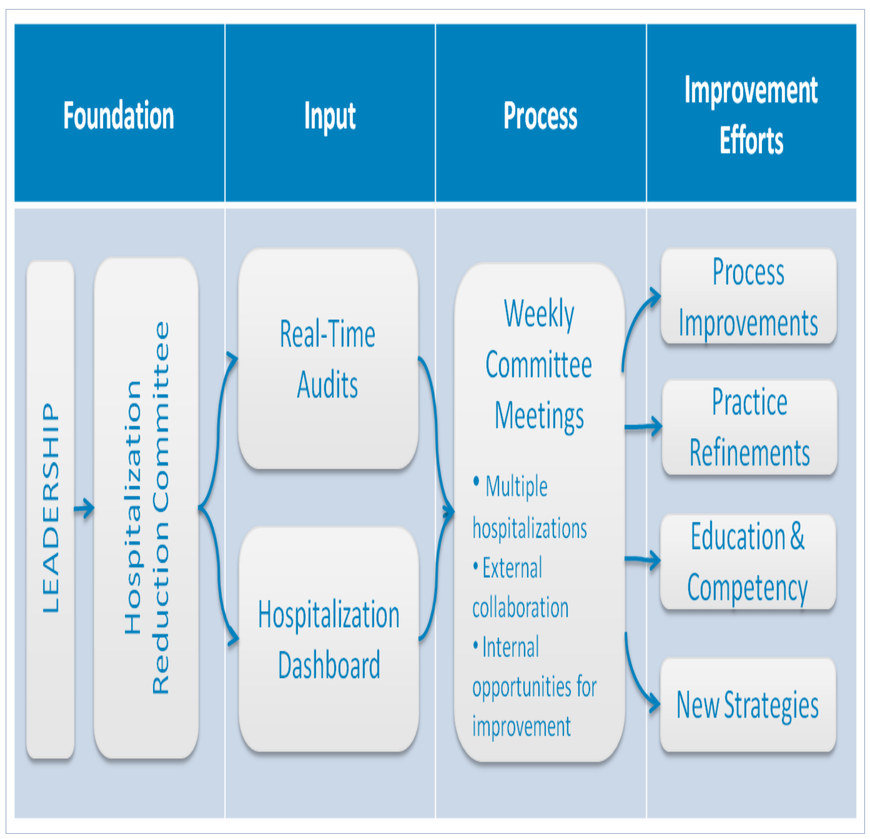
-Home Health Outcome Measure
-Home Health episode is 60 days

$$\frac{\text{Total \# of Hospitalizations}}{\text{Total \# of HHS Discharges and Transfers}}$$

*excluding deaths and planned hospitalizations

Methods

Our Approach: Leadership, Accountability, Data-Driven Decisions



Results

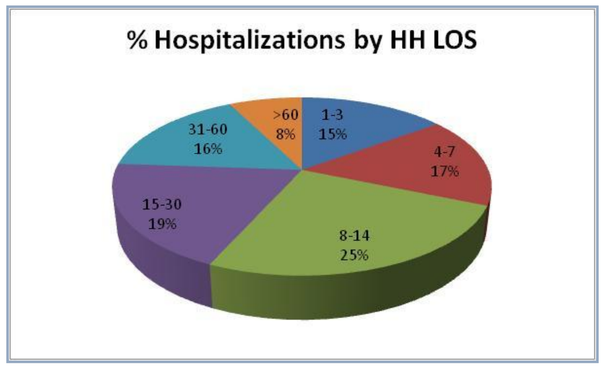
Contributing Factors to Re-hospitalization

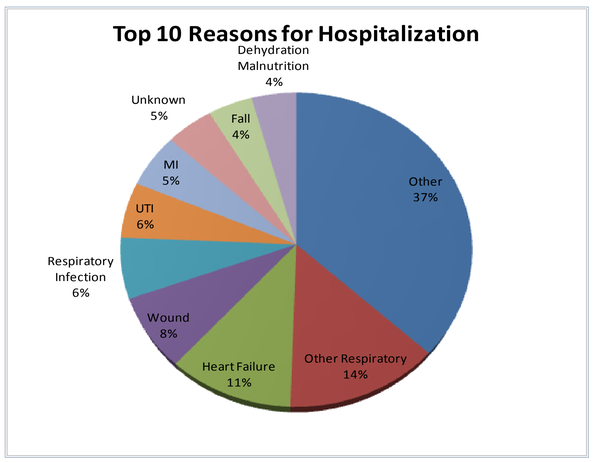
- **Patient's Anxiety 31%**
- **Non Adherence 25%**
- **Candidate for Hospice 16%**
- **Inconsistent Caregiver 16%**
- **Home Environment 6%**
- **Financial Hardship 3%**

HOSPITALIZATION AUDIT RESULTS

		Aug	Sept	Oct	Nov	Dec	Jan	Feb
	Completed Audits	60	72	64	76	66	64	54
	Total Hospitalizations	60	90	67	85	66	73	57
	Audit %	100%	80%	96%	89%	100%	88%	95%
Prior to HHS	Appropriate for Home Care	82%	72%	92%	94%	94%	87%	75%
	Effective Discharge Plan	97%	97%	100%	96%	93%	89%	93%
	Hospital Re-Admission Pilot Patient	38%	44%	36%	45%	43%	40%	37%
1st 48 hrs	% of hospitalized cases initiated > 2days post hosp DC	12%	13%	13%	11%	10%	10%	12%
	Identified as High Risk for ACH	98%	97%	96%	99%	98%	95%	100%
	Interventions for ACH Risks Identified	98%	100%	100%	100%	100%	100%	100%
	Critical information was communicated during transition	96%	97%	98%	100%	98%	100%	100%
Throughout Episode	Interventions Implemented for ACH Risks	96%	100%	100%	97%	98%	100%	100%
	Teach Back	98%	98%	98%	97%	95%	98%	94%
	Patient Prescribed High Risk Meds	80%	77%	89%	83%	76%	75%	76%
	Evidence Patient Can Manage High Risk Meds	91%	98%	98%	97%	96%	97%	97%
	Med Teaching included Teach Back	98%	91%	98%	100%	97%	96%	91%
	Treatments match provided PoC / Orders	100%	98%	98%	100%	100%	100%	100%
	Appropriate agency or community referrals made timely	98%	94%	94%	92%	88%	90%	93%
	Appropriate care communication provided to all team members with every change in patient condition	88%	81%	87%	98%	98%	83%	88%
	Patient status changes reported to MD same day as findings	96%	100%	98%	91%	98%	100%	100%
	Appropriate visit frequency / pattern	90%	86%	93%	89%	93%	88%	87%
Preventable	Unavoidable / Unpreventable	80%	91%	98%	83%	81%	89%	88%
	Preventable - External Collaboration	15%	7%	2%	7%	13%	6%	6%
	Preventable - Internal Opportunity	2%	1%	0%	11%	4%	5%	6%
	Clinically Unnecessary	3%	0%	0%	0%	1%	0%	0%

Conclusions





Reducing hospitalizations require the collaboration of the entire interdisciplinary team, as well as providing education, and self-management of the patient and family

Data shows that Home Care patients are most likely to be re-admitted within one week of hospital discharge.

Emphasis is placed on front loading and identifying, prioritizing and addressing re-hospitalization risk factors, as well as assessing patient understanding through teach back, and engaging patient's in their own self care and disease management.

JHHCG has identified the importance of cooperation with members of the interdisciplinary team including medical doctors, nurses, social work staff, and occupational and physical therapists to generate a clear plan of care upon acute care discharge.

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