Bayada Home Health Care as a Transition Partner to Reduce Acute Care Readmissions.

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Readmission Rates and Costs

- A 2009 study by the *New England Journal of Medicine** found that 19.6% of patients over the age of 65 who were discharged from the hospital with a medical condition were readmitted within 30 days, 34% of patients were readmitted within 90 days.
- 50% of the patients that were readmitted within 30 days had not seen a physician between the time of discharge and readmission.
- The cost of unplanned hospital readmissions in 2004 was $17.4 billion.
- The most frequent conditions to be readmitted were heart failure and COPD.

**New England Journal of Medicine- Re-hospitalizations among Patients in the Medicare Fee-for-Service Program, Jenks, Williams, Coleman; April 2009*

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The Bayada Way

- Bayada Home Health Care is a home health care agency with over 35 years of experience helping people have a safe home life with comfort, independence and dignity.
- Our clients come first and we care for them with excellence, compassion and reliability.
- Our goal is to reduce unnecessary acute care readmissions and have clients remain safe and independent in the comfort of their own homes.

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Skilled home care interventions can reduce readmissions within 30 days of discharge

- Working with Bayada Home Health Care as a transition partner can address the three National Quality Initiative areas:
  - Is the client familiar and competent with their medication? Do they have access to their medications?
  - Does the client have a follow-up physician visit scheduled within a week of discharge? Are they able to get there?
  - Does the client fully comprehend the signs and symptoms that require medical attention? Do they know who to contact if they occur?

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Bayada Home Health Care Acute Care Readmission Reduction Program provides:

- Identification of an acute care readmission risk
- Personalized client emergency plan
- Evidence based fall risk assessment and a personalized fall prevention plans
- Medication management and reconciliation education
- Environmental and social assessments
- Identified high risk client visit protocols

Bayada Home Health Care Risk Assessment Tool

ACUTE CARE HOSPITALIZATION (ACH) RISK ASSESSMENT TOOL

Client Name: _____ Client # _____

Date: _____ ☐ SOC ☐ ROC ☐ Recert Office # _____

PRIOR PATTERN: Check all that apply	
☐ 2 or more Hospitalizations or ER visits in the past 12 months	☐ History of falls * *(Complete Falls Risk Assessment)*
CHRONIC CONDITIONS: Check all that apply (M1020/M1022)	
☐ HF	☐ Chronic skin ulcers *(Wound consult if indicated for any wounds)*
☐ Diabetes	
☐ COPD	☐ HIV/AIDS ☐ Cancer
RISK FACTORS: Check all that apply	
☐ Discharged from hospital or skilled nursing facility (M1000)	☐ Help with managing medications needed (M2020) + ★
☐ More than 2 secondary diagnoses (M1022)	☐ Non-compliance with medication regimen + ★
☐ Low socioeconomic status or financial concerns +	☐ Confusion (M1710) + ★
☐ Lives alone (M1100) ➤+	☐ Pressure ulcer (M1306) ★
☐ Inadequate support network +	☐ Stasis ulcer (M1330) ★
☐ ADL assistance needed ➤	☐ Daily pain (M1242) ★
☐ Fall risk (M1910) ➤	☐ Caregiver anxiety +
☐ Dyspnea (M1400) ➤ ★	☐ Low literacy level +
➤ Consider Therapy referral (PT, OT, ST)	+ Consider MSW referral ★ Consider RN referral, if not ordered
Total # of checked boxes:	HIGH RISK (7 or more)
****** Measures to be implemented to reduce risk for hospitalization ******	
Required for ALL clients: (Check when completed) ☐ **Considered referrals for other disciplines (see above)** ☐ PT (➤) ☐ OT (➤) ☐ ST (➤) ☐ MSW (+) ☐ RN (★)	**Required, if client has a Risk Score of 7 or higher:** (Check when completed) ☐ **Called Clinical Manager same day as SOC visit**

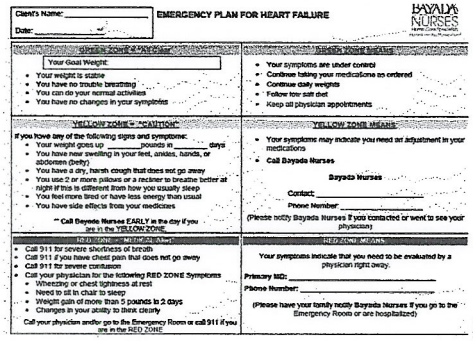
National Quality Initiative #1:

- **Does the client fully comprehend the signs and symptoms of disease exacerbation that require medical attention, and who to contact if they occur?**
- **Bayada Home Heath Care provides:**
  - Validated Risk Assessment
  - Individualized zone plan
  - Education and confirmation that the client/caregiver can identify early signs of illness exacerbation through a teach-back methodology
  - High touch visit protocol
  - Teletriage calls
  - Fall risk assessment and interventions

The Bayada Zone Tool: "What's your zone today?"

- **"Green Zone"**
- **"Yellow Zone"**
  - Possible early symptoms of an exacerbation
  - Bayada would be called into action to prevent a readmission
- **"Red Zone"**
  - Direct intervention by Bayada and Physician
  - Acute care readmission is possible

Bayada Zone Tool for Heart Failure™



Client's Name: _____
Date: _____

EMERGENCY PLAN FOR HEART FAILURE

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GREEN ZONE = "OKAY"

Your Goal Weight: _____

- Your weight is stable
- You have no trouble breathing
- You can do your normal activities
- You have no changes in your symptoms

GREEN ZONE MEANS:

- Your symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow low salt diet
- Keep all physician appointments

YELLOW ZONE = "CAUTION"

If you have any of the following signs and symptoms:

- Your weight goes up _____ pounds in _____ days
- You have new swelling in your feet, ankles, hands, or abdomen (belly)
- You have a dry, harsh cough that does not go away
- You use 2 or more pillows or a recliner to breathe better at night if this is different from how you usually sleep
- You feel more tired or have less energy than usual
- You have side effects from your medicines

** Call Bayada Nurses EARLY in the day if you are in the YELLOW ZONE

YELLOW ZONE MEANS:

- Your symptoms may indicate you need an adjustment in your medications
- Call Bayada Nurses

Bayada Nurses

Contact: _____

Phone Number: _____

(Please notify Bayada Nurses if you contacted or went to see your physician)

RED ZONE = "MEDICAL EMERGENCY"

- Call 911 for severe shortness of breath
- Call 911 if you have chest pain that does not go away
- Call 911 for severe confusion
- Call your physician for the following RED ZONE Symptoms
  - Wheezing or chest tightness at rest
  - Need to sit in chair to sleep
  - Weight gain of more than 5 pounds in 2 days
  - Changes in your ability to think clearly

Call your physician and/or go to the Emergency Room or call 911 if you are in the RED ZONE

RED ZONE MEANS:

Your symptoms indicate that you need to be evaluated by a physician right away.

Primary MD: _____

Phone Number: _____

(Please have your family notify Bayada Nurses if you go to the Emergency Room or are hospitalized)

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National Qualify Initiative #3:

- **Does the client have a follow-up physician visit scheduled within a week of discharge and are they able to get there?**
- **Bayada Home Health Care provides**
  - Confirmation that a physician's visit is scheduled upon home care admission
  - Confirmation of ability to get to the physician
  - Client/caregiver education on need for physician follow-up

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National Quality Initiative #2:

- **Is the client familiar and competent with their medication and do they have access to medications?**
- **Bayada Home Health Care provides**
  - Medication reconciliation in the home
  - Resources to get medication (MSW)
  - In home visit or phone calls to foster medication adherence
  - In home client/caregiver medication education
  - Follow up to monitor the effectiveness of medication

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Full Circle Communication

- Bayada Home Health Care communicates our findings with the physician and co-develops a personalized plan of care.
- Bayada reinforces the importance of scheduling and keeping a follow up physicians visit.
- Result: Reduced unnecessary acute care readmissions within 30 days of discharge.

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