Implementation Outcomes to Reduce Readmissions in a Home Health Agency

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Background

- Advocate Health Care has a large ACO managing patients at risk in population health
- Home Care is a key post-acute service used to prevent hospital readmissions
- Evidence based interventions to prevent readmissions have not been widely studied
- Advocate Home Health Services (AHHS) developed the Readmission High Risk Protocol (HRP) in 2010
- The HRP has not been formally evaluated to determine its sustainability

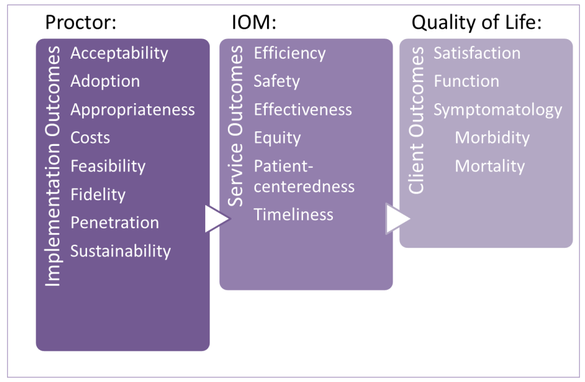
Purpose

- Determine the implementation outcomes of the HRP
- Assess the impact of evidence based interventions on 30-day readmissions in high risk home care patients
- Identify an exemplar for program evaluation in the post-acute setting.

Methods

- Proctor Framework for evaluation of outcomes
- Mixed method evaluation
- Team Member Survey
- Medical Record Review of High Risk Patients
- Administrative Review: Readmissions and Claims Data

Framework

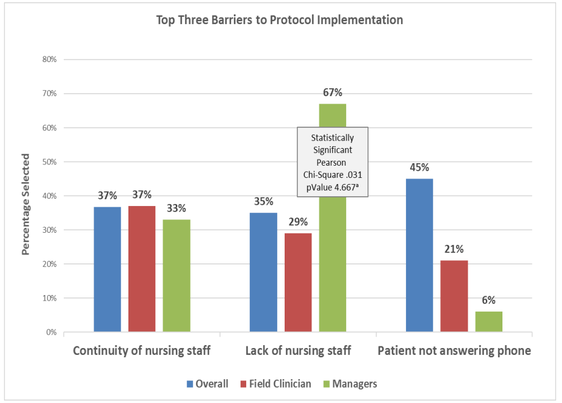


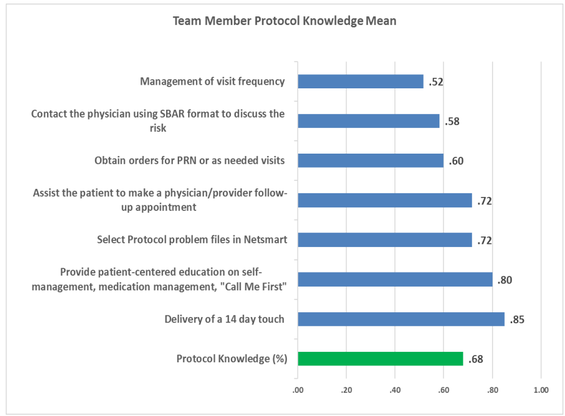
Proctor Taxonomy

Implementation Outcome	Defined in Literature
Acceptability	Satisfaction with innovation
Adoption	Uptake and utilization
Appropriateness	Perceived fit; relevance
Feasibility	Actual fit; utility; practicability
Fidelity	Delivered as intended; integrity
Cost	Cost effectiveness; cost benefit
Penetration	Level of institutionalization; spread
Sustainability	Maintenance; continuation; durability, integration; sustained use

Findings

- 42% of team members found the HRP to be acceptable/appropriate
- 63% of clinicians found the HRP easy to use
- 33% of team members recognized all components of the protocol
- Patients were recognized as high risk 47% of the time in population studied
- Patients received 7/14 HRP interventions on average
- 10% of patients who received tele-management received a quality encounter
- Claims were slightly higher in high risk patients compared to average reimbursement





30-Day Hospital Readmissions

Sample Group	N	D	Observed	Expected*
Overall	9	52	17.30%	13.55%
From Advocate Hospital	6	37	16.21%	19.47%
From Non-Advocate Hospital	3	14	21.42%	-------
SNF Stay after Hospital	3	16	18.75%	7.18%
Medicare	4	32	12.5%	13.55%
Medicare Advantage	5	20	25%	13.55%
*Premier Data Base (excludes cancer patients)				

Conclusions

- Identification of high risk patients is unclear to team members.
- Knowledge of the HRP was low resulting in poor implementation.
- The HRP as designed has many components.
- Team members fail to see the important of using all parts of the protocol or consider them optional.
- Most tele-management visits lacked quality.
- Unable to determine HRP effectiveness
- True cost benefit not established
- HRP not sustainable in current state.

Implications for Practice

- Staff and management have different perceptions of barriers to clinical practice-implementation requires collaboration
- Reduce complexity of protocol, consider bundle approach of vital interventions for ease of use
- Incorporate social determinants of health in risk modeling
- Measuring implementation outcomes is important for clinical programming

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