Using Patient Activation to Transition Patients from Hospital to Home

May 2014

Mary McLaughlin Davis DNP MSN APRN ACNS-BC CCM
Lakewood Hospital Cleveland Clinic
Background

• Stroke affects an estimated 795,000 people annually in the U.S.
  - It is one of the highest contributors to Medicare costs (Litchtman et al., 2012).

• Case Managers as Care Coordinators lead in health care innovation as government and commercial payers impose financial penalties on hospitals and health care providers for quality and patient satisfaction indicators (Coleman, et al., 2004).

• Case Management can influence avoidable costs and partnership with providers (Jack et al., 2009).
Background

• **Case Manager Key Roles**
  - Care coordinators
  - Med reconciliation
  - Arranging physician appointments
  - Assessing for home safety

• **Ohio Coverdell Stroke Program**
  - State wide Centers for Disease Control Funded
  - Improve the quality of stroke patients’ care transitions
  - Reduce preventable complications
  - Support the reduction of stroke patients’ preventable hospital readmissions
Changing the Healthcare Relationship

Old

- Information Asymmetry
- Passive Recipient
- Paternalism
- Patient Physician

New

- Information Symmetry
- Active Partner
- Participation
- Consumer Health Care Team
Significance to Nurses as Care Coordinators

• Nurses develop strong relationships with patients, and their families

• Joint Commission 2008 Consensus Stroke Performance measures mandates that nurses educate stroke patients on
  - Personal risk factors for stroke
  - Signs and symptoms of stroke, and how to access the Emergency Management System
  - Stroke prevention
  - Medication
  - Follow up care
Project Tools

• Judith Hibbard’s Patient Activation Measure (PAM)
  - 13 question measurement instrument

• Eric Coleman’s Patient Activation Assessment (PAA)
  - Four Columns
    • Medication Management
    • Red Flags
    • Medical Follow Up
    • Personal Health Record (PHR)
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disengaged &amp; Overwhelmed</strong>&lt;br&gt;Passive and lack confidence&lt;br&gt;Low knowledge&lt;br&gt;Weak goal orientation&lt;br&gt;Poor adherence “my doctor is in charge of my health”</td>
<td><strong>Becoming aware, but still struggling</strong>&lt;br&gt;Some knowledge&lt;br&gt;Health is largely out of their control&lt;br&gt;Able to set simple goals “I could be doing more”</td>
<td><strong>Taking action</strong>&lt;br&gt;Have the key facts&lt;br&gt;Building self-management skills&lt;br&gt;Strive for best practice behavior&lt;br&gt;Goal oriented “I’m part of my health care team”</td>
<td><strong>Maintaining behaviors and pushing further</strong>&lt;br&gt;Adopted new behaviors, but may struggle with stress or change&lt;br&gt;Maintaining a healthy lifestyle is a key focus “I’m my own advocate”</td>
</tr>
</tbody>
</table>

Hibbard, Greene, & Overton (2013)
Project Findings
Demographics: Complete Data Set June – Sept 2013

• Complete data set was available for 37 (55%) out of 67 patients

• Age:
  - 71 years (mean)
  - 74 years (median)
  - 32 – 94 years (range)

• 18 females and 19 males

• Length of Stay:
  - 18 days (mean)
  - 16 days (median)
Is there a relationship between patients discharge to acute care and nursing homes and their PAM and PAA scores?

Initial and Final PAM and PAA scores for various discharge dispositions

<table>
<thead>
<tr>
<th>Discharge Dispositions</th>
<th>Average of Initial PAA</th>
<th>Average of Final PAA</th>
<th>Average of Adm PAM</th>
<th>Average of Disch PAM</th>
<th>Count of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>2.8</td>
<td>5.0</td>
<td>34.4</td>
<td>36.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Acute Care</td>
<td>1.0</td>
<td>5.7</td>
<td>41.3</td>
<td>38.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Home Care</td>
<td>3.1</td>
<td>7.8</td>
<td>38.5</td>
<td>40.9</td>
<td>13.0</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>2.5</td>
<td>8.7</td>
<td>41.2</td>
<td>43.8</td>
<td>6.0</td>
</tr>
<tr>
<td>Home</td>
<td>1.3</td>
<td>7.3</td>
<td>40.0</td>
<td>40.1</td>
<td>7.0</td>
</tr>
<tr>
<td>Group Average</td>
<td>2.4</td>
<td>7.1</td>
<td>38.5</td>
<td>39.9</td>
<td>37.0</td>
</tr>
</tbody>
</table>

- PAA score (pre-teaching first visit compared to post-teaching final visit) improved significantly (P<0.005, paired t-test)
- Patients with PAA score of 7 and above were discharged to a home-based setting
- Similarly, patients with a PAM of 40 and above went to home-based setting
- There was no correlation between initial PAA and PAM scores;
- At discharge there was a 40% correlation
- Initial scores (both PAA and PAM) cannot be used to classify or predict discharge dispositions.
Case Management and Social Work Assistance with Discharge and Discharge instructions and Preparedness for Discharge

**Case Management & Social Work Discharge June 14 - September 14**

**Discharge Instructions and Preparedness for D/C June 14 - September 14**

- Press Ganey Patient Satisfaction Scores
- Preliminary Results
Readmission Rates less than 30 days June-Sept Stroke Patients discharge home

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent 2011</th>
<th>Percent 2012</th>
<th>Percent 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>
Cost Benefit Analysis
2013 Lost CMS Reimbursement due to readmissions $12,500

<table>
<thead>
<tr>
<th>Social Workers &amp; Administrative Assistant</th>
<th>Education Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productive Hours</td>
<td>48</td>
<td>260</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Salary Social Workers &amp; Administrative Assistant</th>
<th>$2,296</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary Education Nurse</td>
<td>$0</td>
</tr>
<tr>
<td>Overhead and Supplies</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total</td>
<td>$3,296</td>
</tr>
<tr>
<td>Payment Loss 2012</td>
<td>$12,500</td>
</tr>
<tr>
<td>Return on Project Investment</td>
<td>$9,304.00</td>
</tr>
</tbody>
</table>
Analysis of Project Outcomes

- Trending toward positive outcomes in
  - Readmission rate
  - Patient satisfaction scores

- PAM and PAA useful tools in evaluating
  - Patients’ safe discharge to home
  - Risk for Readmission
Project Sustainability
June 2013 through February 2014
full data set n = 102

Admission and Discharge PAM Scores for Home and Non-Home Discharge Disposition (June 2013 - Feb 2014)

- Admission PAM
- Discharge PAM

Home-based (N = 73):
- Admission PAM: 39.4
- Discharge PAM: 41.7

Non-home based (N = 29):
- Admission PAM: 36.3
- Discharge PAM: 37.2
Total patients n = 129

Readmission Rate for Stroke Patients Discharged from Acute Rehabilitation June 2013 through February 2014

- Total patients: 129
- Readmissions: 3
- Patients: 126
Care Coordination Team

- Janet Baker, DNP, APRN, CNS, ACNS-BC, CPHQ, CNE
- Mary Beth Zeni, ScD, RN
- Laura Olitsky, DPT
- Melissa Burkett, LISWs
- Tricia Marquard RN, BSN, CRRN

- Molly Getzlaff, RN, BSN
- Amy Lajack, LSW
- Sheila Matosky, CNP-BC
- Nicholas Molley, MBA, MIDS
- Vinoth K. Ranganathan MSE, MBA, CCRP