Identifying Critical Factors in Determining Readiness for Discharge from Skilled Home Health Services

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Background

• 3.4 million Medicare beneficiaries received skilled home health in 2012 consisting of 6.7 million home health episodes costing $18 billion (MedPAC, 2014)

• Medicare relies upon home health clinicians and physicians to evaluate beneficiary needs and to decide to discharge from skilled home health or recertify patients for an additional 60-day episode of care
Background

• There are no empirically derived, evidence-based decision support tools available to assist in making these important and often daily decisions.

• A lack of readiness for discharge from home health could result in poor outcomes such as hospitalization, emergency department use, increased physician visits, shorter time to death, and a decline in functional status.
Study Aim

To explore factors the interprofessional home health team (nurses, physicians, physical therapists, occupational therapists, speech-language pathologists, medical social workers) perceive as critical when determining older adult patient readiness for discharge from skilled home health services
Prior Research....Since HH PPS

- HH patients are 2.9 times more likely to be discharged within the first 60 days of admission (Han & Remsburg, 2005)

- HH patients are discharged with unresolved issues related to wounds, cognition, behavioral and continence status and show less improvement overall (Schlenker, Powell & Goodrich, 2005)

- HH length of stay of 22 days or more reduced the need for hospitalization compared to a HH length of stay of 21 days or less (O’Connor, Hanlon, Naylor & Bowles, 2015)
Methods

• Qualitative methods

• Focus Groups (4)
  • Held at VNSNY offices
  • VNSNY interprofessional clinicians (2 groups)
  • VNSNY interprofessional clinician supervisors (2 groups)
Study Sample

• Interprofessional VNSNY employees (32)
  • Home Health Clinicians
    • Physicians (2); Nurses (8); Physical Therapists (5); Occupational Therapists (4); Speech-Language Pathologists (3); Medical Social Workers (3)
  • Home Health Clinician Supervisors
    • Nursing (3); Social Work (2); Rehab (2)
Findings

• Each participant contributed to the discussion at least once

• Themes
  • Patient Safety
  • Long-term Plan is in Place
  • Independence
  • Caregivers
  • Patient attributes
Patient Safety

• Adequate support
• Overall safety & safe home environment
• Presence of a caregiver & advocate
• Appropriate equipment in place
• Living alone (often presents a challenge)
Long-term Plan is in Place

• Connected to community resources
• Long-term plan is in place
• Patient agrees to discharge
• Physician involvement/knowledge of patient
• Other disciplines are aware of plan
• Transportation
• Financial concerns (often present a challenge)
Independence

- Overall independence
- Patient able to manage care & medications
- Attend follow-up appointments
- Maximum potential reached
- Able to communicate wants and preferences
- Patient confidence
Caregivers

- Having a willing caregiver to care for the patient once skilled home health is discharged
- Caregiver’s ability to manage the patient and meet their needs
Patient Attributes

- Non-compliant/Not able to make progress
- Stable condition with goals met
- Achieved previous level of function
- Understands their chronic condition & medications
- Shortness of breath
- Advanced age
- Oxygen
Next Steps...

• Future research will explore factors patients and caregivers perceive as critical when determining older adult patient readiness for discharge from skilled home health services.

• Future research will identify the clinical, functional, service and socio-demographic factors associated with hospitalization among older adults within 30 days of completing at least one skilled home health episode.
Conclusions

This study is the first step in generating evidenced-based knowledge to build a standardized decision support tool associated with interprofessional home health experts’ recommendations for discharge from skilled home health

Thank you

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