Using Patient Activation to Transition Patients from Hospital to Home

Cleveland Clinic

Mary McLaughlin Davis DNP MSN APRN ACNS-BC CCM

Lakewood Hospital Cleveland Clinic

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).

- 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	New
Information Asymmetry	Information Symmetry
Passive Recipient	Active Partner
Paternalism	Participation
Patient Physician	Consumer Health Care Team

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**

Methods

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)

Levels of the Patient Activation

Level 1	Level 2	Level 3	Level 4
Disengaged & Overwhelmed	**Becoming aware, but still struggling**	**Taking action**	**Maintaining behaviors and pushing further**
Passive and lack confidence	Some knowledge	Have the key facts	Adopted new behaviors, but may struggle with stress or change
Low knowledge	Health is largely out of their control	Building self-management skills	Maintaining a healthy lifestyle is a key focus
Weak goal orientation	Able to set simple goals	Strive for best practice behavior	"I'm my own advocate"
Poor adherence	"I could be doing more"	Goal oriented	
"my doctor is in charge of my health"		"I'm part of my health care team"	

Hibbard, Greene, & Overton (2013)

Increasing Levels of Activation

Results

Cost Benefit Analysis

2013 Lost CMS Reimbursement due to readmissions $12,500

	Social Workers & Administrative Assistant	Education Nurse	Total
Productive Hours	48	260	308

Salary Social Workers & Secretary	$2,296
Salary Education Nurse	$0
Overhead and Supplies	$1,000
Total	$3,296
Payment Loss 2012	$12,500
Return on Project Investment	$9,304

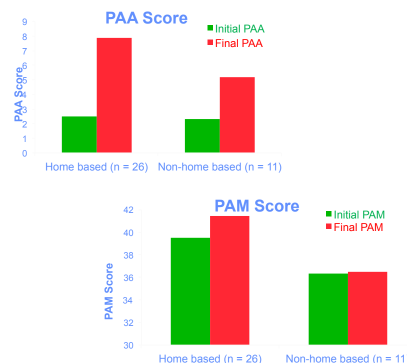
Results

Project Findings
Demographics: Complete Data Set June – Sept 2013

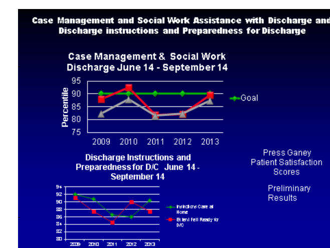
- Complete data set was available for 37 (55%) out of 67 patients
- Age:
  - 71 years (mean)
  - 74 years (median)
  - 32 – 94 years (range)
- 18 females and 19 males
- Length of Stay:
  - 18 days (mean)
  - 16 days (median)

Readmission Rates decreased by 10% for Project Stroke Patients compared to the previous two years June-Sept

Initial and Final PAA and PAM Scores per discharge disposition
PAA scores pre-teaching compared to scores post-teaching improved significantly $p<0.005$ (paired t test)
Patients with a PAA score above 7 and a PAM score above 40 were discharged home vs. an extended care facility



Results



Analysis of Project Outcomes

Trending toward positive outcomes in

- **Readmission Rates**
- **Patient Satisfaction Scores**

PAM and PAA useful tools in evaluating

- **Patients safe discharge home**
- **Risk for readmission**