**Title**: Post-Acute Home Care Initiative: New Directions in Transitional Care for High Utilizers

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**Objectives of the Program**: Decrease 30-day readmissions, long-term utilization of emergency department (ED), and hospitalizations of "High Utilizers" within the Southern Arizona VA Health Care System (SAVAHCS).

**Planning/research methods**: The Agency for Healthcare Research and Quality (AHRQ) reports that, in 2012, the top 10% of the health care-utilizing population accounted for 66% of overall health care expenditures in the United States (Yang, Delcher, Shenkman, & Ranka, 2018). Despite these data, very few transitional programs target high utilizers as a population requiring specific interventions. This can be complicated by the complexity of high utilizers. High utilizers are more likely to have multiple chronic medical conditions, mental health diagnoses, and social detriments of health that require multidisciplinary interventions (Bell, Turbow, George, & Ali, 2017). Additionally, many short-term (30-day programs) have generally been ineffective at changing the long-term rate of ED utilization or hospitalization of high utilizers. The most effective interventions, research shows, focus on improving patients' capacity for self-care (Leppin, et al., 2014), which requires a longer-term intervention.

**Implementation methods**: Based on an evidence-based review, it was determined that a 60-to-120-day multidisciplinary, home-based intervention would be most effective at breaking the cycle of frequent ED visits and hospitalizations. High utilizer patients are identified using a data-driven approach during their hospitalization. They are then invited to participate in a facilitated transition home after discharge. The intervention team is made up of a physician, a nurse, a social worker, a registered dietician, and an occupational therapist who will all do home visits - based on patient need - in order to improve self-care skills and medical stabilization in the home.

**Results**: The team was able to admit an average of 1-2 patients a week, with an average length of stay in program of 108 days. The patients required an average of 14 total visits while in the program, as well as case management. As of January 2022, 15 patients have been discharged from the program for more than one year, only 2 (13%) were readmitted within 30 days. Additionally, these patients showed a 36% decrease in ED utilization and a 73% decrease in hospitalization one year later. These results show that a multidisciplinary home care team that focuses on developing self-care skills can make a long-term impact.

**References:**

Bell, J., Turbow, S., George, M., & Ali, M. K. (2017). Factors associated with high-utilization in a safety net setting. *BMC health services research, 17*(1), 1-9.

Leppin, A., Gionfriddo, M., Kessler, M., Brito, J., Mair, F., Gallacher, K., . . . Erwin, P. (2014). Preventing 30-Day Hospital Readmissions A Systematic Review and Meta-analysis of Randomized Trials. *JAMA interanl medicine*, 174 (7); 1095-1107.

Yang, C., Delcher, C., Shenkman, E., & Ranka, S. (2018). Identifying High Health Care Utilizers Using Post-Regression Residual Analysis of Health Expenditures from a State Medicaid Program. *AMIA Annual Sumposium Proceddings Archive*, Yang C, Delcher C, Shenkman E, Ranka S. Identifying High Health Care Utilizers Using Post-Regression Residual Analysis of Health Expenditures from a State Medicaid Program. AMIA Annu Symp Proc. 2018;2017:1848-1857. Published 2018 Apr 16.