OPTIMIZING THE TRANSITION “OUT”

IMPROVING COMMUNICATION ACROSS SETTINGS

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Lexington, Massachusetts
Objectives

1. Examine your hospital’s standard discharge process to identify gaps in best practice.

2. Identify 3 specific ways the discharge process can be improved immediately.

3. Identify 1 specific feasible test of change to take back to your readmissions improvement team.

4. Understand the value of the cross-continuum team in improving the transition out of the hospital.
FIRST, THIS IS ABOUT PEOPLE

The stories of my recently readmitted patients
Caught in a cycle.....

- 77F recently hospitalized for an infected dialysis catheter returns to the hospital 8 days following discharge with shortness of breath.

- 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.

- 86M with cancer hospitalized for constipation and abdominal pain returns to the hospital 1 day after discharge with abdominal pain.
77F recently hospitalized with sepsis returns 8 days later with shortness of breath

- **1st hospitalization**
  - Tunneled catheter placed to initiate dialysis
  - Acquired blood stream infection (sepsis)
  - All anti-hypertensives and diuretic held
  - Stabilized in ICU; transferred to floor; 14 day hospitalization

- **At discharge**
  - BP stable x 24 hours “off pressors”
  - Felt fine; eager to go home

- **Readmission**
  - Progressively short of breath days 3-7
  - Volume overloaded
  - Never resumed diuretics after d/c
  - Patient demoralized to be back in hospital
61M with 8 hospitalizations this year for SOB returns to hospital 10 days post d/c with SOB

- 1st hospitalization
  - Isn’t really “first” hospitalization is it?
  - Intern H&P covers issues as if first presentation of HF
  - Recognized marginal housing issues
  - Recognized personality issues (inappropriate with staff)
  - Refuses to work with PT

- At discharge
  - Patient can not be placed in SNF due to criminal history

- Readmission
  - Gained 30 lbs in 8 days
  - “oh honey, it always takes them about a week to tune me up”
  - Grabs remote, turns on TV and orders dinner
86M with metastatic cancer presents with abd pain and constipation, returns 1 day later with abd pain

- **1st hospitalization**
  - Constipation x 8 days with abdominal pain
  - Resolved in ED; ED concerned pain was due to cancer
  - Observed, felt fine, started on bowel regimen
- **At discharge**
  - Family eager to take him home
- **Readmission**
  - Recurrent abdominal pain
  - Family concerned it was due to cancer
  - Family eager to “do everything” to have dad comfortable
  - Patient clearly did not want to be there; didn’t argue with family
QUICK REMINDER OF THE DATA
### 2009 State Scorecard Summary of Health System Performance

#### State Rank
- ☐ Top Quartile
- ☐ Second Quartile
- ☐ Third Quartile
- ☐ Bottom Quartile

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**SOURCE:** Commonwealth Fund State Scorecard on Health System Performance, 2009
NOW, THE EVIDENCE

Why improve the discharge process? How?
Evidence v. Failure mode analysis

• Evidence – formal trials of specific components of discharge planning tasks – is mixed

• Failure mode analysis – what tasks that seem relevant and appropriate are done – is what guides most best practice recommendations

➢ Your team should understand no isolated practice in and of itself drives reduced readmissions; improving d/c process is a multi-faceted intervention
Failure: Post-discharge MD follow-up

National Medicare analysis:
• 50% of readmitted patients did not have a MD follow-up
• …but that means 50% did

Cross-continuum team meeting yesterday:
• Post-discharge follow up phone calls to 109 medicine pts
• 100% had an appointment scheduled, and 100% WENT to the appt
Failure: Hospital – PCP Communication

- 3-20%: Direct communication between hospital physicians and PCP
- 12-34%: Discharge summary available at the first post-d/c visit
- 51-77%: Discharge summary available at 4 weeks!

Failure: Discharge Summary Content

- Discharge summaries often lack important information
  - treatment or hospital course (7%-22%)
  - discharge medications (2%-40%)
  - follow-up plans (2%-43%)
  - diagnostic test results (missing from 33%-63%)
  - test results pending at discharge (65%)
  - patient or family counseling (90%-92%)

Failure: Post-discharge support

- 81% of patients requiring assistance with basic functional needs *failed* to have a home-care referral

- 64% said *no one* at the hospital talked to them about managing their care at home
Failure: Engaging the Caregiver

- 42 million family caregivers
- 46% perform nursing tasks
- 75% of them manage medicines
- 33% of them do wound care
- 66% of the patients had no VNA

Available at: http://www.uhfny.org/publications/880853.
“Despite frequent encounters with the acute care system, family caregivers were not prepared for the medical and nursing tasks they were expected to provide at home…

“We asked family caregivers how they learned to manage their family members’ medications and 61 percent said, ‘I learned on my own.’ Clearly, professionals need to do a better job of training family caregivers.”

~ Carol Levine
Director of Families and Health Care Project
United Hospital Fund
Failure: Core Measure “Compliance”

- Association of providing “written discharge instructions” for heart failure (core measure) and patient-reported experience of discharge planning and rates of RA

- Weak correlation in performance between 2 measures

- No association between provision of written discharge instructions and HF readmissions

To the Editor:

• Jha and colleagues (Dec. 31 issue) report no association between hospital performance on one of two measures of discharge planning and rates of hospital readmissions within 30 days for patients with heart failure. However, there is little reason to suspect that the measure they studied — the adequacy of documentation in the chart that discharge instructions were provided to patients with heart failure — would result in improved care at times of transition out of the hospital.

• Key approaches to improving the discharge process that are promising include engaging patients or their families or caregivers as partners in care, using anticipatory guidance for self-care needs, appropriately mobilizing support and follow-up, and communicating directly and promptly with the receiving clinicians. Performance on the measure studied by Jha et al. bears little resemblance to performing such services reliably or effectively.

• Opportunities abound to improve transitions out of the hospital. Better discharge practices are necessary but not sufficient: linking to and enhancing community-based care are essential to facilitating improved coordination of care over time and across settings.

Amy E. Boutwell, M.D., M.P.P.
Failure: Looking for One Failure Mode…..

• KP team reviewed 523 readmissions across ~14 hospitals:
  • 250 (47%) deemed potentially preventable
  • Found an average of 9 factors contributed to each readmission

• Assessed factors relating to 3 phases of care:
  • 57% readmissions involved an issue of care during 1\textsuperscript{st} hospitalization
  • 67% involved an issue during the discharge process
  • 79% involved an issue relating to follow up care

• Assessed factors related to 5 domains of quality improvement:
  • 73% - care transitions planning & care coordination
  • 80% - clinical care
  • 49% - logistics of follow up care
  • 41% - advanced care planning & end of life
  • 28% - medications

• 250 readmissions identified 1,867 factors!
SO WHAT IS THE EVIDENCE DISCHARGE PLANNING HELPS?
• Meta-analysis; 18 RCTs from 8 countries
• Interventions generally began in hospital with post-discharge support
• Follow-up ranged from single home visit to extensive visiting and phone support
• Results: **25% reduction in readmissions**; 13% reduction (p=0.06) in all-cause mortality; Net savings $359-536 per month of intervention
Discharge Planning from Hospital to Home

- Review of 21 RCTs (>7,000 patients) in 2010
  - 14 focused on specific medical condition; 1 focused on falls
  - 4 with mix of med-surg conditions
  - 2 psychiatric populations

- LOS and readmissions significantly reduced for those with *structured discharge planning process tailored to individual needs*
  - LOS reduced by 0.9 days (-1.55d to -0.27d)
  - Readmission risk reduction 0.85 (0.74 to 0.97)
  - Increased patient satisfaction in 3 trials

Project RED

• Discharge Advocate; assigned role to ensure all components of a 11-point d/c checklist are complete

• Use of 2 technologies to facilitate better teaching (Louise, the avatar) and auto-customized “After Hospital Care Plan”

• Post-discharge pharmacist-performed phone call to review meds

• These interventions significantly reduced the combined endpoints of ED use and hospitalization within 30 days by 30%

• Intervention required approximately 1 hour for implementation

OPTIMIZING THE TRANSITION OUT

Who’s done it? What can we learn?
1. Know your data

2. Form a cross-continuum team

3. Review transitions across settings
STAAR/IHI Recommendations
Recommendations based on addressing common failure modes

1. **Enhanced Assessment of Patients**: Identifying high-risk criteria and meeting needs; engaging pt/family/outpt to identify needs

2. **Enhanced Teaching and Learning**: change focus from what providers tell patients to what patients/caregivers *learn*

3. **Real-time Communication**: timely, clinically meaning information exchange with opportunity for clarification

4. **Timely Post Acute Care Follow-Up**: clinical contact (call, home health visit, office visit) within 48h or 5 days depending on risk
Project BOOST
Recommendations based on addressing common failure modes

- Direct communication with provider *before* discharge
- Telephone contact with patient within *72 hours* post-discharge to assess condition, discharge plan comprehension and adherence, and to reinforce follow-up
- Follow-up appointment with provider *within 7 days*
- *Contact information* for hospital personnel familiar with patient’s course provided to patient/caregiver to raise questions/concerns if unable to reach principal care provider prior to first follow-up
EXAMPLES FROM THE FIELD
Baystate Medical Center, MA

Outcome Improvements

30-Day All-Cause Pilot Unit Readmissions

Springfield 4: 34 bed acute care unit specializing in caring for heart failure and short stay cardiac patients

Launch of MA STAAR Collaborative

Percent Readmissions

- UCL
- LCL
- % Readmission
- Baseline Mean

COLLABORATIVE HEALTHCARE STRATEGIES
Baystate Medical Center, MA

Outcome Improvements

30-Day All-Cause Pilot Unit Readmissions

Springfield 3M: 34 bed acute care nursing unit specializing in caring for general medical populations

- Launch of MA STAAR Collaborative
- Increased VNA referrals, instituted RN call-backs
- ID Learner on admission fully implemented
- Ask Me 3/Teach-Back fully implemented
- MDR fully implemented
- In white board goals for the day fully implemented

Percent Readmissions

Sep-08 Nov-08 Jan-09 Mar-09 May-09 Jul-09 Sep-09 Nov-09 Jan-10 Mar-10 May-10 Jul-10 Sep-10

UCL  LCL  % Readmission  Baseline Mean
Hennepin County Medical Center

- 2007, medication events, patient complaints re: d/c process
- Evaluated medication orders
- Found that only 8% of their patients had NO errors

  Medication reconciliation was complete >90% of the time!

- Common medication errors:
  - Formulation errors
  - Duplicates
  - Incorrect dose
  - Missing medications
  - Insulin dosing errors

Bruce Thompson, AHRQ Innovations Exchange
Hennepin County Medical Center - experience

• New Process: Enhanced medication review
  MD orders → Pharm D and CC → SNF
• Identify patients being d/c to SNF
• When bed available, MD, Pharm D and CC paged
• MD has 4 h to enter d/c orders
• CC scans orders hourly; paged Pharm D when entered
• Pharm D & CC have 2 hours to review; clarify with MD
• When errors are noted, resident AND attending are paged
• Outcomes: intervention group had 5.7% readmissions v. 10.2%
• High patient satisfaction, high physician satisfaction

Bruce Thompson, AHRQ Innovations Exchange
Carolinas HealthCare “SNF Circle Back”

- Multi-hospital system in North Carolina
- Pilot in one hospital; commitment to spread system-wide if effective
- Problem: early readmissions from SNF
- Test:
  - warm handoffs to SNF
  - Call back to SNF 3-24 hours after transfer to answer questions
- Details:
  - RCA revealed SNF-readmission patterns
  - Hospital readmission champion met with SNFs to discuss shared goals
  - Hospital (with some leadership effort) asked SNF to participate in this communication
  - RN calls nurse at SNF
  - SW or care coordinator calls for follow up clarification 3-24 hours after transfer
  - Daily workflow (with some modifications for weekends, done next business day)
  - Follow up calls are scripted and documented in Allscripts system
  - Pilot on paper with 1 RN and 1 SW
  - Pilot expanded to RN call report to SNF
  - Pilot expanded to add follow up calls
  - Pilot expanded to build questions into Allscripts
  - Expand to all; new standard of practice

Source: Emily Skinner, Carolinas Healthcare System
SNF Circle Back Questions
1. Did the patient arrive safely?
2. Did you find admission packet in order?
3. Were the medication orders correct?
4. Does the patient’s presentation reflect the information you received?
5. Is patient and/or family satisfied with the transition from the hospital to your facility?
6. Have we provided you everything you need to provide excellent care to the patient?

Insights
- Transitions are a PROCESS (forms are useful, but only a tool to achieve intent)
- Best done ITERATIVELY with COMMUNICATION

Source: Emily Skinner, Carolinas Healthcare System
INTERACT
Information Transfer From the Hospital

- Designed to serve the receiver
- Don’t need to use form per se
- Provide the information
Transition Out and HCAHPS

1. How often did nurses/ doctors treat you with courtesy and respect?
2. How often did nurses / doctors listen carefully to you?
3. How often did nurses / doctors explain things in a way that you could understand?
4. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
5. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
6. Did the doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
7. Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
8. Staff took my preferences and those of my family/caregiver into account in deciding what my healthcare needs would be when I left the hospital
9. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
10. When I left the hospital, I clearly understood the purpose for taking each of my medications.
Improving the Transition “Out”

- Facilitate *transitions* in care
- Focus on patient and caregiver *learning*
- Embrace a comprehensive perspective of *needs over time*
- Recognize *patients and families* provide the majority of care
- *Co-design* handoff processes between senders and receivers
- *Facilitate effective collaboration* between clinical and community based support services
Thank you!

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