Improving the Discharge Process

Management of the Hospitalized Patient
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Who are you and why are you here?
The case of D.C.

- 78 yr-old woman presents with SOB and LE edema
- Not taking meds since her husband died recently
- Admitted and treated for CHF exacerbation
- Discharged home with increased dose of furosemide
- Instructed to follow up with PCP
- Three weeks later: AMS, dehydration, creatinine 3.2
- Review of medications reveals patient taking both lasix and furosemide
Do you know this patient?

- Was she at high risk of readmission?
- Are you surprised by the medication error?
- Do you think her PCP could have helped?
- Is your hospital willing to support fixing the problems?
Workshop Overview

- Literature and best practices
- Small group cases
- Large group discussion
- Resources and tools
Why improve the discharge process?

- Reduce readmissions
- Improve patient satisfaction
- Improve flow of information to PCPs
- Reduce medical liability risk

Save lives!

Hospital Discharge: The Realities

- Prone to errors
  - 1 in 5 patients suffer an adverse event

- Incomplete hospital work-ups
  - 40% pending tests, PCPs unaware 60% of the time

- Poor handoff of information

Readmissions

- 19.6% of Medicare patients readmitted to the hospital within 30 days
- Half of these patients did not see an outpatient provider after first hospitalization
- Estimated $17.4 billion dollars for unplanned readmissions in 2004

MedPAC Recommendations to Congress

- Public disclosure of readmission rates
- Reduction in payments to hospitals with high readmission rates
- Pilot ‘bundled’ payment system around each hospitalization

Website: www.medpac.gov
Readmissions by State

Small Group Cases

- Divide into four small groups
- Discuss the case provided to you using your flipchart to collect your ideas: 20 minutes
- Designate one spokesperson to report out your ideas to the large group: 5 minutes
Case 1

You’re a hospitalist and receive a phone call from a disgruntled local health care plan agent who has just been notified that D.C. was yet again readmitted to your hospital. “What’s going on? This is the third admission for the patient this month! We can’t keep authorizing her hospital stay for the same problem.” You wonder, “Who are these patients who keep coming back?”

1. What do you know about risk factors for readmission?
2. Can you name some patient-specific factors that increase risk for readmission?
3. What does your hospital do to identify ‘at-risk’ patients?
Diagnosis-specific risk factors

- CHF
- PNA
- COPD exacerbation
- DM
- Stroke
- Cancer

*Project BOOST Annotated Literature Resource page: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/03BestPrac/03_Literature.cfm*
Medication-specific risk factors

- Beers criteria
- Injectable meds (including insulin)
- Anticoagulants
- Dual antiplatelet agents
- Digoxin
- Polypharmacy

Additional risk factors

- Age > 65
- Depression
- Poor health literacy
- Poor social support
- Prior hospitalization

*Project BOOST Annotated Literature Resource page:
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/03BestPrac/03_Literature.cfm
Best Practices: High-risk Patients

- Build an interdisciplinary team: RNs/ case managers/ pharmacists crucial to this process
- Analyze readmission predictors at your organization
- Target high-risk patients
# Tool for Addressing Risk: A Geriatric Evaluation for Transitions

<table>
<thead>
<tr>
<th>Risk Assessment: 7P Screening Tool (Check all that apply)</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insure intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem medications</strong> (anticoagulants, insulin, aspirin &amp; clopidogrel dual therapy, digoxin, narcotics)</td>
<td>□ Medication specific education using Teach Back provided to patient and caregiver &lt;br&gt; □ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) &lt;br&gt; □ Specific strategies for managing adverse drug events reviewed with patient/caregiver &lt;br&gt; □ Follow-up phone call at 72 hours to assess adherence and complications</td>
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<td><strong>Punk (depression)</strong> (screen positive or diagnosis)</td>
<td>□ Assessment of need for psychiatric aftercare if not in place &lt;br&gt; □ Communication with aftercare providers, highlighting this issue if new &lt;br&gt; □ Involvement/awareness of support network insured</td>
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<td><strong>Principal diagnosis</strong> (cancer, stroke, DM, COPD, heart failure)</td>
<td>□ Review of national discharge guidelines, where available (e.g. CHF) &lt;br&gt; □ Disease specific education using Teach-Back with patient/caregiver &lt;br&gt; □ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms &lt;br&gt; □ Discuss goals of care and chronic illness model discussed with patient/caregiver</td>
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<td><strong>Polypharmacy</strong> (&gt;5 more routine meds)</td>
<td>□ Elimination of unnecessary medications &lt;br&gt; □ Simplification of medication scheduling to improve adherence &lt;br&gt; □ Follow-up phone call at 72 hours to assess adherence and complications</td>
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<tr>
<td><strong>Poor health literacy</strong> (inability to do Teach Back)</td>
<td>□ Committed caregiver involved in planning/administration of all general and risk specific interventions &lt;br&gt; □ Aftercare plan education using Teach-Back provided to patient and caregiver &lt;br&gt; □ Link to community resources for additional patient/caregiver support &lt;br&gt; □ Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td><strong>Patient support</strong> (absence of care giver to assist with discharge and home care)</td>
<td>□ Follow-up phone call at 72 hours to assess condition, adherence and complications &lt;br&gt; □ Follow-up appointment with aftercare medical provider within 7 days &lt;br&gt; □ Involvement of home care providers of services with clear communications of discharge plan to those providers</td>
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<tr>
<td><strong>Prior hospitalization</strong> (non-elective; in last 6 months)</td>
<td>□ Review reasons for re-hospitalization in context of prior hospitalization &lt;br&gt; □ Follow-up phone call at 72 hours to assess condition, adherence and complications &lt;br&gt; □ Follow-up appointment with aftercare medical provider within 7 days</td>
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Complete TARGET by insuring the Universal Patient Discharge Checklist is completed for all patients.
Case 2

You’re at the end of a busy shift. A nurse on the floor approaches you about the discharge plan for patient D.C., who is scheduled to be discharged this afternoon. You admit to yourself that the last thing you want to do is spend time beyond your shift discharging a patient from the hospital. Besides, you figure what you say and how you do it won’t make a difference anyway. You give the patient her med list, ask, “Any questions?” and then go home. The next day, the patient is re-admitted and you find out that she has been taking the wrong dose of beta-blocker.

1. How common are medication errors after discharge?
2. Which medications increase risk for complications after discharge?
3. What are some best education practices to improve patients’ understanding of diagnoses and medications after discharge?
4. What are your patient education practices at your hospital?
Medication errors are common

- Medication discrepancy rate reported as high as 30-50% after discharge
- 20% report non-adherence due to pharmacy-related issues
- Adverse drug events occur ~11% of the time and can be dramatically reduced by reinforced medication education and reconciliation

High risk medications

- Beers criteria
- Injectable meds (including insulin)
- Anticoagulants
- Dual antiplatelet agents
- Digoxin
- Polypharmacy

Best Practices: Patient Education

- Teach-back
- Med reconciliation
- Involve pharmacists/ RNs on your team
- Patient-centered forms
- Phone number to call for questions
- Follow-up phone calls

Discharge improvement interventions

☐ Project RED

☐ The Care Transitions Intervention
Follow this schedule of medications EACH DAY.
Bring this form to all of your medical appointments.

Allergies: ___________________________________________________

<table>
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<tr>
<th>Medication</th>
<th>Why am I taking this medicine?</th>
<th>Dose</th>
<th>AM</th>
<th>Noon</th>
<th>PM</th>
<th>Bed-Time</th>
<th>Other Instructions ex. As needed for pain</th>
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IMPORTANT! STOP these medications
1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________
**UCSF Patient-Centered Discharge Plan**

*Adopted from Project BOOST Patient PASS form: [http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/PASS.pdf](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/PASS.pdf)*

**I was in the hospital because:**

<table>
<thead>
<tr>
<th>If I have the following problems ...</th>
<th>I should...</th>
</tr>
</thead>
</table>
| 1. ___________________________________ | 1. ___________________________
| _______________________________________ | _____________________________ |
| 2. ___________________________________ | 2. ___________________________
| _______________________________________ | _____________________________ |
| 3. ___________________________________ | 3. ___________________________
| _______________________________________ | _____________________________ |

**My appointments:**

| 1. ___________________________________ | On: ___/___/___ at ________ |
| _______________________________________ | ____________________________ |
| 2. ___________________________________ | On: ___/___/___ at ________ |
| _______________________________________ | ____________________________ |
| 3. ___________________________________ | On: ___/___/___ at ________ |
| _______________________________________ | ____________________________ |
| 4. ___________________________________ | On: ___/___/___ at ________ |

**Important Contact information:**

1. My Primary Doctor:
   - _______________________________ ( ) __________________

2. My Hospital Doctor:
   - _______________________________ ( ) __________________

3. My Pharmacy:
   - _______________________________ ( ) __________________

4. My Home Health Nurse:
   - _______________________________ ( ) __________________

**Tests and issues I need to talk with my doctor(s) about on my next visit:**

| 1. _____________________________________________________________________________ |
| 2. _____________________________________________________________________________ |
| 3. _____________________________________________________________________________ |

**With questions about my hospital stay I should call:**

______________________________

**Other Instructions:**

( ) __________________________

______________________________

______________________________

**I understand my treatment plan. I feel able and willing to participate actively in my care:**

______________________________

______________________________

______________________________

Patient/Caregiver __________________ Provider __________________ Date ____________
Case 3

You direct a local hospitalist group and get a phone call from a primary care provider. “I just got a call from patient D.C.’s son who told me she was readmitted after a recent hospitalization three weeks ago. I had no idea she was even admitted in the first place. Why wasn’t I informed about this? What kind of place are you running?”

You know this is not the first time you’re hearing the same complaint so you decide to do something about improving communication with PCPs.

1. What is known about the quality of communication between inpatient and outpatient providers?
2. How often are discharge summaries available and complete?
3. What kind of information do PCPs want to know?
4. What does your hospital do to improve communication and optimize handoffs in care?
Communication with PCPs

- Direct communication gap
  - Only 3-20% reported

- Discharge summary unavailable
  - Only 12-34% available at discharge

- Discharge summary lacks critical information
  - Test results, discharge meds, pending tests, follow-up plans

Best Practices: PCP Communication

☐ Ask your PCP’s how you’re doing
☐ Electronic discharge summary
☐ Standardized template
☐ Use patients as couriers
☐ Add PCPs to your team

PCPs want…

- To know meds and diagnosis
- To be informed at admission and discharge
- To receive information by fax or phone

Case 4

You have been charged by the head of your hospitalist group to “deal with this readmission thing that everyone is talking about”. You quickly realize that you will need resources to do this, and that you might need to convince your boss and their bosses to provide some resources.

1. Why should your hospital care to improve discharge?
2. What are the specific qualitative and quantitative elements that matter to the powers that be?
3. Who are the important stakeholders and how would you obtain their buy-in?
4. What are your experiences in “making a business case”? 
Ensure solution meets organizational goals.
Examples:
• Quality improvement & measurement
• Patient satisfaction
• Reputation
• Revenue generation

Proposed Solution

Organizational Goals

Costs

Quantitative

Personnel
• Partial FTE for creation of service specific discharge templates

IT Infrastructure
• Information Technology (IT) infrastructure for electronic discharge within existing platform
• IT infrastructure for tracking & dissemination of discharge summaries

Maintenance and Training
• Physician & Staff training on new platform
• IT maintenance

Qualitative

Initial staff efficiency
• Initial loss of efficiency in staff inexperience with new system

Redundancy in data
• Auto-populated fields lead to lengthy or extraneous discharge information

Benefits

Cost Avoidance
• Maintenance of the current transcription system
• Transcription costs
• Dissemination costs
• Notification/Tracking of Discharge Summaries Delinquencies

Cost Savings
• Reduction in billing delays
• Potential decrease in Readmissions
  • Increase in hospital efficiency: staffing, bed control, occupancy through decrease in unplanned admissions

Revenue Generation
• Potential decrease in readmissions
  • Increase percentage of favorable payer mix in the shift from unexpected admissions to higher revenue referrals

Staff Morale
• Staff sense of value over communication goals and readmission rates leading to higher staff retention.

Reputation
• Improved Reputation with referring physicians
• Improvements in publically reported patient satisfaction data

Documentation Quality
• Documentation used for quality reporting
• Documentation used for medical-legal issues
Summary

- High-risk patients can be identified and targeted appropriately.
- Focused, intensive patient education can improve health outcomes.
- Optimal communication of information to the outpatient setting is crucial and necessary.
- A viable business case can influence stakeholders to support discharge improvements.
Pearls to improve discharge process

- Build an interdisciplinary team
- Obtain stakeholder buy-in
- Learn from your experience
- Learn from others
Resources available to you

- **Project BOOST:**
  - [http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm)

- **Transitions of Care Consensus Policy:** ACP, SGIM, SHM

- **Our emails:**
  - Arpana Vidyarthi: arpana@medicine.ucsf.edu
  - Neil Gupta: ngupta@medicine.ucsf.edu
  - Maria Novelero: maria@medicine.ucsf.edu
Appendix
Care Transitions Intervention

- 750 patients randomized
- Use of transition coach, home visit, phone call
- Four pillars to promote involvement in discharge process:
  - Med self-management
  - Patient-centered record
  - PMD and specialist follow-up
  - Knowledge of red flag warning signs
- Reduced 30, 90, 180 day rehospitalization rates

Coleman, et al. The Care Transitions Intervention Results of a Randomized Controlled Trial. *Arch Intern Med.* 2006;166(17):1822-8
Project RED

- Randomized trial (~370 intervention group)
- Intervention:
  - (1) Nurse Discharge Advocate (education booklet, f/u appointment, med rec)
  - (2) After hospital care plan (AHCP) faxed to PMD
  - (3) Pharmacist phone call 2-4 days post discharge
- Reduced 30 day readmissions and ER visits
- Patients able to ID diagnosis, PCP name, self-preparedness, understanding of meds and diagnoses
- Increased PCP follow-up
- Cost analysis: 33.9% lower observed cost for hospitalization