SO YOU WANT TO IMPROVE THE DISCHARGE PROCESS?

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Who are we? Why are we here?

Oh Betty...

Why Betty?

- What makes her at risk for readmission?
- Why didn't she listen to her doctors about her salt intake?
- Did she see her PCP after discharge?
- Is your hospital willing to support fixing the problems?
Workshop goals and overview

- What's the hype about readmissions?
- Cases: How do we think about preventing readmissions?
  - Risk Factors
  - Patient Education
  - PCP communication & follow up
  - Stakeholders
- Literature and best practices
- Resources and tools

Why improve the discharge process?

- Improve Patient Experience
  - Increase care coordination
  - Increase patient’s ability to self-manage
  - Improve patient satisfaction
- Raise Quality of Care Provided
  - Promote safe discharge process
  - Improve chronic disease management
  - Decrease adverse events
- Reduce Unnecessary Cost/Spending
  - Increase capacity
  - Improve margin
  - Decrease cost

Hospital Discharge: The Realities

- Prone to errors
  - 1 in 5 patients suffer an adverse event after discharge
- Incomplete hospital work-ups
  - 40% pending tests, PCPs unaware 60% of the time
- Poor handoff of information

Readmissions: Frequent, Preventable Costly

- Alarmingly frequent
  - Percentage of Medicare Patients Readmitted Within 36 Days
  - Highly preventable
  - Percentage of Readmissions Among Medicare Patients Considered Preventable
  - Excessively costly
  - Cost of Preventable Readmissions to the Medicare Program, 2003

Half of these patients did not see an outpatient provider after first hospitalization
Case 1. Identifying Risk Factors

You're a hospitalist and receive a phone call from a disgruntled local health care plan agent who has just been notified that Betty 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. Can you name some patient-specific factors that increase risk for readmission?
2. Are there certain meds that you think of as high risk?
3. Does your hospital currently identify ‘at-risk’ patients?

### Diagnosis-specific risk factors

<table>
<thead>
<tr>
<th>Condition at Discharge</th>
<th>30-Day Hospitalization Rate (%)</th>
<th>Proportion of All Hospitalizations (%)</th>
<th>Most Frequent</th>
<th>2nd Most Frequent</th>
<th>3rd Most Frequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>All medical</td>
<td>21.0</td>
<td>77.6</td>
<td>Heart failure</td>
<td>Pneumonia</td>
<td>Psychoses</td>
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<tr>
<td>Heart failure</td>
<td>28.9</td>
<td>7.6</td>
<td>Heart failure</td>
<td>Pneumonia</td>
<td>Heart failure</td>
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<td>Pneumonia</td>
<td>20.1</td>
<td>6.3</td>
<td>Pneumonia</td>
<td>COPD</td>
<td>Pneumonia</td>
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<tr>
<td>COPD</td>
<td>22.6</td>
<td>4.0</td>
<td>COPD</td>
<td>Psychoses</td>
<td>Drug toxicity</td>
</tr>
<tr>
<td>Psychoses</td>
<td>24.6</td>
<td>3.5</td>
<td>Psychoses</td>
<td>Drug toxicity</td>
<td>Drug of alcohol</td>
</tr>
</tbody>
</table>

These are your high impact diagnoses!!
Meds are a common culprit

- 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


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

Ways to improve...

*Project BOOST Annotated Literature Resource page:
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/03BestPrac/03_Literature.cfm
Best Practices: Start with your team

- Build an interdisciplinary team: RNs/case managers/pharmacists crucial to this process
- Analyze readmission predictors at your organization
- Target high-risk patients

Case 2. Patient Ed, Any questions?

You’re at the end of a busy shift. A nurse on the floor approaches you about the discharge plan for Betty 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. Rushed, you give the patient her med list, ask, “Any questions?” and then go home. She is readmitted a week later and you find out that she has been taking both her “Furosemide” and “Lasix.”

1. What are some best practices to educate patients about diagnoses and medications after discharge?
2. Who does discharge teaching at your hospital? What do you think is the ideal system?
3. Do you think patients understand your forms/med lists?

Learning from Others

- Care Transitions Intervention: Use of transition coach, home visit, phone call all promote patient involvement in discharge process.
  - Reduced 30, 90, 180 day rehospitalization rates
- Project BOOST: (Better Outcomes for Older Adults through Safe Transitions). Toolkit of interventions to perform best practice risk stratification, PCP communication, patient education & follow up.
- Project RED: (Re-engineered Discharge) Founded on 11 discrete, mutually reinforcing components: patient education, clear post discharge appointments, services and medications, discharge summary...

Teach Back

- Assess Recall & Comprehension: Ask Patient to Demonstrate
- Clarify & Tailor the Instructions
- Reassess Recall & Comprehension: Ask patient to Demonstrate
- Explain discharge instructions to patient
Follow Up Phone Calls

- Assess understanding of discharge instructions and medication changes
- Reminders for follow up appointments
- Ensure that prescriptions have been filled
- Ensure patients received home care/supplies
- Make sure patients know who to call if things are getting worse at home

Common Flaws in Follow Up Phone Calls

- Non-clinical driven—focus on patient satisfaction
- Target all patients, not high-risk
- All patients receive same call regardless of risk level
- Call data not collected
- No metrics to measure success beyond percentage of patients called

Best Practices: Patient Education

- Implementing Teach-back
- Med reconciliation is for the patient too: Meds “stopped, started, continued”
- Involve pharmacists/RNs on your team
- Create patient-centered forms
- Follow-up phone calls/Patient Hotline

Case 3: PCP communication & f/u

You direct a local hospitalist group and get a phone call from Betty’s PCP. “I just got a call from Betty’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. How are PCPs notified of admissions, discharge? Do you have a system for this? Can you envision one?
2. Name 3 “best practice” guidelines for discharge summaries. Do they occur at your institution?
3. Name the top 3 things PCPs want to know on discharge.

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
- Involve PCP in discharge planning
- Get a follow up appointment before the patient leaves
- Move to an electronic discharge summary
  - Standardized template
  - Quick turn around


PCPs want...

- To know meds and diagnosis
- Know what the patient will need from them in terms of follow up plans and pending tests
- To be informed at admission and discharge
- To receive information by fax or phone

Giving PCPs what they want will allow you to get what you want... follow up appointments!


Early follow up appointment

- Recommended by IHI (Institute for Healthcare Improvement) in 2 weeks for high risk diagnoses (CHF, AMI, Pneumonia)

- Large study of CHF patients found decreased readmission with higher rates of early follow up

- Small study of medicine patients in JHM found patients without a f/u appointment in 4 weeks were 10x more likely to be readmitted.

Readmission Initiatives and Components

<table>
<thead>
<tr>
<th>Initiative</th>
<th>PCP Handoff</th>
<th>Follow-up Appointments</th>
<th>Phone Calls</th>
<th>Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Intervention (Eltman)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Project RED (SMC)</td>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Transitional Care Model (NwED)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Project REBOOT (pilot)</td>
<td>✔️</td>
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<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Quick ways to innovate

- Make PCP information easy for inpatient providers to find
- Talk to your admissions department about automating communication
- Involve PCPs early
- Consider setting the bar for the discharge summary within 24 hrs
- Make PCP communication at discharge a quality incentive

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. What are some financial and quality gains you would use to convince your hospital?
2. Who are the important stakeholders and how would you obtain their buy-in?
3. What are your experiences in “making a business case”?

Negotiating points

Key Data Points for Negotiation

<table>
<thead>
<tr>
<th>Finance</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of eligible patients</td>
<td>• Readmission rates</td>
</tr>
<tr>
<td>• Cost per case</td>
<td>• ED utilization</td>
</tr>
<tr>
<td>• Annual cost of readmissions to payer</td>
<td>• Avoidable episodes</td>
</tr>
<tr>
<td>• Total hospital investment, including staff salaries and equipment</td>
<td>• Avoidable days</td>
</tr>
<tr>
<td>• Foregone revenue to the hospital</td>
<td>• LOS for index admission</td>
</tr>
<tr>
<td>• LOS for readmission</td>
<td>• Patient satisfaction</td>
</tr>
</tbody>
</table>
Stakeholders & Your Team

- Critical to gather relevant stakeholders at the table
- Build an interdisciplinary team
- Obtain stakeholder buy-in
- Learn from your experience (fail early, fail often)
- Learn from others
- Find way to measure processes as well as outcomes

Framework for Understanding and Preventing readmissions

1. Be able to articulate why it's a problem
2. Identify high-risk patients and target them for an easier win.
3. Focus on educating patients in a way they understand
4. Engage and communicate with PCPs and get early follow up
5. Use a business case to recruit a team and influence stakeholders.

UCSF “Core Measures” of Discharge

- Patients leave with two-week follow up appointments
- Patients receive diagnosis specific education: CHF, DM, AMI, COPD
- Patients receive discharge teaching for high risk meds
- Patients have an e-discharge completed on day of discharge
- Patient receive a follow up phone call within 72 hrs of discharge
### Resources available to you

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

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

- **Our emails:**
  - Arpana Vidyarthi: arpana@medicine.ucsf.edu
  - Michelle Mourad: michelle.mourad@ucsf.edu
  - Maria Novelero: maria@medicine.ucsf.edu

### Recognition of Patient Centered Discharge

- **Project RED**

- **The Care Transitions Intervention**