PART: Preventing Avoidable Readmissions Together

Improving the Quality of Post Discharge Contacts

R. Neal Axon, MD, MSCR
PART Lead Physician
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Target Conditions (CHF, AMI, Pneumonia, COPD)

Planning
(0-3 months)
Process Mapping and Root Cause Analysis

Phase 1
(4-9 months)
Focus on Implementing Transitional Records and Patient Education

Phase 2
(10-15 months)
Focus on Discharge Summary Timeliness and Quality

Phase 3
(16-18 months)
Focus on Timely Follow Up Appointments and Post-Discharge Contact

Maintenance
(21-24 months)
Continued Implementation and Maintenance (Sustainability and Spread)

Community Engagement
Today’s Agenda

• Post Discharge Telephone Contact

• Home Visits

• Discharge Follow Up Appointments
How Do Patients Feel After Discharge?

"It says your signal is important to us."

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Post-Discharge Telephone Contact

Key element of multiple successful care transitions interventions:

• Improved patient satisfaction
  ○ 86% vs. 61%, P = 0.007

• Decreased ED visits
  ○ 10% vs. 24% P = 0.005

Dudas V. et al. The impact of follow-up telephone calls to patients after hospitalization. Am. J. Med. 2001;111:26S.
Post-Discharge Calls and Follow Up

- RCT of 906 older hospitalized patients randomized to enhanced DC planning intervention vs. usual care
  - Intervention patients more likely to make and keep a follow up appointment
    - Appt Made: 92.5% vs. 81.4% (p < 0.001)
    - Appt Kept: 74.9% vs. 57.4% (p < 0.001)
    - No differences between groups in patient/caregiver stress or readmissions or mortality

Planning Your Program...

• Who will make post-discharge calls?
• From where will calls be made?
• When and how many calls should be made?
• Which questions should callers pose to patients?
Who Should Make the Calls?

- Inpatient MDs
- Outpatient MDs
- Inpatient Nurses
- Outpatient Nurses
- Pharmacists
- Case Managers/Social Work
- Call Centers
Who Should Make the Calls?

- RCT of 137 HF patients in New York
  - Weekly post-discharge telephone calls from undergraduate students
- Reduced 30-day readmissions
  - 7% vs. 19%, p < 0.05
- Decreased composite of 30-day readmission, worsening NYHA functional class, and death
  - 24% vs 49%, p=0.05

From Where Will Calls Be Made?

Hospital

Vs.

Clinic
Primary Care Calls?

Systematic Review of 3 clinical trials

- 3 of 3 reported improved primary care follow up
- 1 of 3 reported improved rates of completed “works ups”
- No effect on ED visits or readmissions

Common Evolution of Discharge Telephone Call Programs

- **No Program**
- **Patient Satisfaction Focus**
- **Patient Assessment/Coaching Focus**
- **Well-Defined:**
  - Assessment/Coaching
  - Closed-Loop Communication
  - Metrics/Reporting
Moving Forward in QI

No Structure
Structure in Place
Process in Place
Outcomes in Place
Post-Discharge Telephone Calls and Patient Satisfaction?

1 year retrospective Press-Ganey data for 30,000 patients in 2 large hospitals

- Patients receiving f/u calls indicated they were most likely to recommend ED (i.e. “top box”)
  - 70.6% vs. 51.1% (p <0.001)

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Closing the Loop...

- Patient
- Chart
- Other Providers
- Caller
Sample Reporting

Here are some suggestions:

• Proportion of calls attempted and completed over the total number indicated
• Descriptive information on issues arising in calls
• Categorical data (Types of patient problems)
• Qualitative data (Free text comments)
• Validated surveys
  o CTM-3
  o Patient knowledge of heart failure
**Sample Report Table...**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Call Attempt 1 (...2, 3)</th>
<th>Reached?</th>
<th>Question 1 (...2, 3, 4)</th>
<th>Problems?</th>
<th>Action Taken?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
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<td>Patient 2</td>
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<td>Patient 5</td>
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</tbody>
</table>
Call Tracking

- % Attempted
- % Reached
- % Concerns
Top 10 Lists

Patient Concerns
1. Unable to fill prescriptions
2. New Symptoms
3. Not sure who to call
4. No appointment
5. Etc.

Opportunities for Improvement
1. Patient number not recorded/confirmed
2. Medication reconciliation
3. Discharge teaching
4. 4th floor not scheduling appointments
5. Etc.
Scripting...Key Items

• New or Worsening Symptoms/Red Flags
• Medications
• Follow Up Appointments
• Additional Concerns/Questions
• Disease Specific Teaching
The Goal: Decreased Readmissions

- Increase Evidence-based Practices
- Decrease Hospital Readmissions
Timely Follow Up Appointments

• Patients without timely F/U (within 4 weeks) → 10 times more likely to be readmitted
  • (3% vs. 21%, p= 0.03)

• Heart failure patients discharged from hospitals offering more early follow up (within 7 days) had fewer 30-day readmissions
  • (HR 0.91 between top and bottom quartiles)
How to Increase Timely Follow Up?

• Discharge Phone Calls

• Appointment prior to discharge

• Anticipatory Guidance

• Transportation/Travel Pay?
Options for Home Visits...

• Home Health-Skilled Care
• Non-skilled care organizations
• Hospital-sponsored “bridging” interventions
• Bundled Care demonstrations
• Hospital at Home?
The Care Transitions Intervention

Results of a Randomized Controlled Trial

Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW; Sandra Chalmers, MPH; Sung-joon Min, PhD

Arch Intern Med 2006;166:1822-1828

• Elderly patients transitioning to SNF/home
• Randomized: Intervention group paired with “Transition Coach” vs. standard care
• Empowerment and education: 4 pillars
  o Facilitate self management/adherence
  o Maintain a personal health record
  o Timely follow-up
  o Knowledge and management of complications
• Education during hospitalization
  o Including meds and med reconciliation
• Phone calls and personal visits by TC post discharge
• N=750
Care Transitions Intervention: Bridging the Gap

**Hospital Visit:**
Discuss importance of knowing medications

**Home Visit:**
1. Reconcile pre- and post-hospitalization medication lists
2. Identify and correct any discrepancies

**Follow-up Calls:**
Answer any remaining medication questions

Medication Reconciliation
Roles of a Health Coach

• Providing self-management support
  ○ Providing information
  ○ Teaching disease-specific skills
  ○ Promoting healthy behaviors
  ○ Imparting problem-solving skills
  ○ Assisting with the emotional impact of chronic illness
  ○ Providing regular follow up
  ○ Encouraging people to be active participants in their care

• Bridging the gap between clinician and patient
• Helping patients navigate the health care system
• Offering emotional support
• Serving as a continuity figure

Hospital at Home
Prospective evaluation of Johns Hopkins “Hospital at Home” program across 3 clinical sites

• 455 community dwelling elders with pneumonia, COPD, HF, and cellulitis
• Overall, 60% patients chose HAH over routine hospital care
• LOS: 3.2 vs. 4.9 days, P 0.004
• Cost: $5081 vs. $7480, P < 0.001
• Favorable effects on patient satisfaction

Conclusion: “[The] model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care”

Hospital at Home

Systematic review (10 trials) and meta-analysis (5 trials, 887 patients)

• Lower 6 month Mortality
  o Adjusted HR 0.62, 95% CI 0.45–0.87, \( p = 0.005 \)

• Non-significant trend toward higher hospitalization rates
  o Adjusted HR 1.49, 95% CI 0.96–2.33, \( p = 0.08 \)

• Increased patient satisfaction

• Lower direct costs

Shepperd S. et al. CMAJ 2009;180(2):175
One Hospital’s Story: Pease St. Joseph’s

• 253 bed community hospital, Bellamy, WA

• Implemented 5 part discharge “bundle” as part of IHI-STAAR initiative
  o Teach back
  o F/U Calls
  o D/C orders
  o F/U Appointments
  o Discharge video

• 15.2% readmissions vs. 6.8% for patients receiving the bundle

Questions/Discussion?