PART: Preventing Avoidable Readmissions Together
Care Transitions Collaborative

Mapping Your Transition Record and Patient Education

R. Neal Axon, MD, MSCR
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Goals for the Next 90 Minutes

• Understand the difference between process mapping and needs assessment, and appreciate the value of both
• Define key elements of a “high-quality” discharge Transition Record
• Consider opportunities and challenges to implementing process improvement for patient education and preparation for discharge
• Begin to map discharge processes at your facility
Needs Assessment vs. Process Mapping
PART: Preventing Avoidable Readmissions Together

Thinking another way…

SWOT ANALYSIS

<table>
<thead>
<tr>
<th>Internal origin (attributes of the organization)</th>
<th>Helpful to achieving the objective</th>
<th>Harmful to achieving the objective</th>
</tr>
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<tbody>
<tr>
<td>Strengths</td>
<td></td>
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| External origin (attributes of the environment) | Opportunities | Threats |

A ROADMAP

VS.
Global Discharge Processes

Pre-Discharge

- PCP Alerted
- Case Manager Assessment
- Social Work Assessment
- Diabetes Educator Alerted, Teaching
- Pharmacy Alerted D/C Teaching

Active Discharge

- Nurse Alerted
- Nurse writes Discharge order
- Clerk receives order
- Patient Transport Alerted
- Nurse and other processes completed
- Patient Alerted
- Patient Leaves Hospital
- Care Services (HH, PT, OT)
- PCP Follow Up
- PCP Alerted

Teach-Back (MD, Nurse, Others)
- Patient Needs Assessment
- Readmission Risk Assessment

DC Summary
- Communicate/Coordinate with PCP
- F/U telephone calls to patients
Global Discharge Processes

Pre-Discharge

- PCP Alerted
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Readmission Risk Assessment
Patient Needs Assessment
Teach-Back (MD, Nurse, Others)
F/U telephone calls to patients
Communicate/Coordinate with PCP
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Drilling Down…

MD dictates D/C summary (Day of discharge)

D/C Summary gets transcribed (<12 hour turnaround on routine)

D/C Summary gets edited/signed by resident MD?

D/C Summary gets edited/signed by attending MD

D/C Summary faxed/mailed to PCP and other providers specified

D/C summary available for viewing in vOacis (MUSC providers have access)

D/C summary available to Non-MUSC providers
Putting It All Back Together...
10 Elements of a High Quality Transition Record

1. Reason for inpatient admission
2. Major procedures and tests performed during inpatient stay and summary of results
3. Principal diagnosis at discharge
4. Current medication list
5. Studies pending at discharge (e.g., laboratory, radiological)
6. 24-hour/7-day contact information including physician for emergencies
7. Contact information for obtaining results of studies pending at discharge
8. Plans for follow-up care
9. Primary physician or other responsible for follow-up care
10. Advance directives or surrogate decision maker
EVIDENCE FOR TRANSITION RECORDS

- Almost **ALL** programs that successfully reduce hospital readmissions include some form of transitional record as an intervention component.

- Single center study of:
  - Medication counseling/reconciliation
  - Condition-specific education, Enhanced discharge
  - Post-discharge telephone calls
  - 10% vs. 38% ED/Readmission rate at 30 days
Question 1

Which Elements are on your current discharge instructions?

- Where does this information come from in the chart?
- Who completes this information?
- How reliably does your current process work?
Question 2
Which Elements are not on your current transition record?

- Where on the chart might these elements of information come from?
- Who is best positioned to enter them into the transition document?
Question 3

Who teaches patients at your hospital?

- When do they teach?
- What materials, if any, do they use to teach?
- Specifically, which materials does your hospital use to teach patients with HF, Pneumonia, AMI, or COPD?
- How do they document what they’ve taught?
Question 4

How is all this valuable information communicated to the patients next provider or to the patients primary care provider?

- Does this process actually work?
- What improvements could be made in this process?
PROCESS MAPPING 101

Spend the next 15 minutes mapping the discharge process for your hospital.

• Focus on general processes initially…
• Then, zero in on patient education, preparation for discharge
REVIEW: TIPS FOR PROCESS MAPPING

• Define process and focus
  o Main goal to enhance reliability, reduce wait times, reduce costs or increase patient satisfaction?

• Right people at the table

• High Level first, defined input and output

• Depict as is (but don’t get bogged down)

• Blame process, not people

• Re-visit with more input and clarification

• Annotate / Measure
**PART: Preventing Avoidable Readmissions Together**

**Target Conditions (CHF, AMI, Pneumonia, COPD)**

- **Phase 1**
  - (0-6 months)
  - Focus on Implementing Transitional Records and Patient Education

- **Phase 2**
  - (7-12 months)
  - Focus on Discharge Summary Timeliness and Quality

- **Phase 3**
  - (13-18 months)
  - Focus on Timely Follow Up Appointments and Post-Discharge Contact

- **Phase 4**
  - (19-24 months)
  - Continued Implementation and Maintenance (Sustainability and Spread)

**Community Engagement**
HOMEWORK

• Complete the general process map you started today

• At “home”, engage key front-line personnel to generate a more detailed process map of your discharge process

• Complete failure modes effects analysis and prioritize opportunities to improve