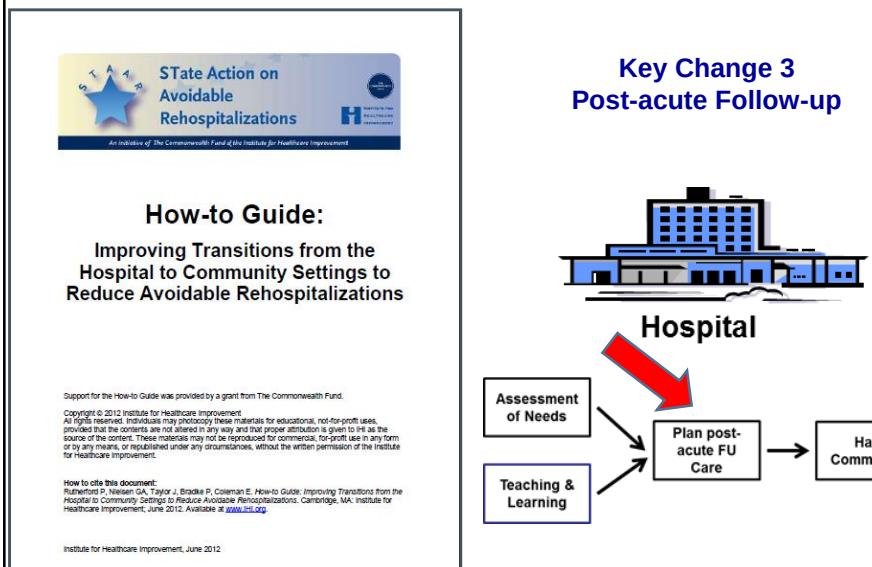
Institute for Healthcare Improvement

These presenters have nothing to disclose

Key Change 3: Create and Activate Post-Hospital Care Follow-Up

Maureen Carroll

April 23, 2013



Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

What do we know?

3

- Phillips meta-analysis found **comprehensive discharge planning** reduced rehospitalizations by 25%
- In 15 of 18 trials evaluating cost, multidisciplinary strategy was identified as key intervention –
- Collaboration and communication are needed between care providers

How Might We…

"….develop a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers?"

Create and Activate Post-Hospital Care Follow-Up

Typical Failures:

- Medication errors and complexity
- Confusing discharge instructions- contradictory to other instructions, or not tailored to a patients level of health literacy
- Lack of scheduled follow-up appointment
- Follow-up visit too long after hospitalization
- Follow-up visit made the sole responsibility of the patient

Create and Activate Post-Hospital Care Follow-Up

Typical Failures continued:

- Inability of patient to keep follow-up appointments
- Multiple care providers resulting in patient confusion about which provider is in charge
- Lack of patient social support and community-based services for patients
- Patients inability to carry out self-care activities

Assess Risk for Readmission

- Risk assessments are needed to help teams to appropriate transitional care resources
- Number of risk-assessment tools are reported in the literature (BOOST, LACE, Transitional Care Model (TCM), etc.)
- Inconsistencies regarding which characteristics and/or variables are most predictive of patients who are at risk for readmissions

Eric Coleman, MD: Identification of Patients at High-Risk for Admission

- Ideally a risk tool would not only identify those at high-risk for readmission but more precisely those who have modifiable risk.
  - In other words, risk tools should be aligned with what we understand about how our interventions work and for which patients our interventions work best
- In the case of heart failure, we should be careful to not assume that the primary readmission for heart failure is after all…the heart
  - Low health literacy, cognitive impairment, change in health status for a family caregiver, and more may be greater contributors than left ventricular ejection fraction

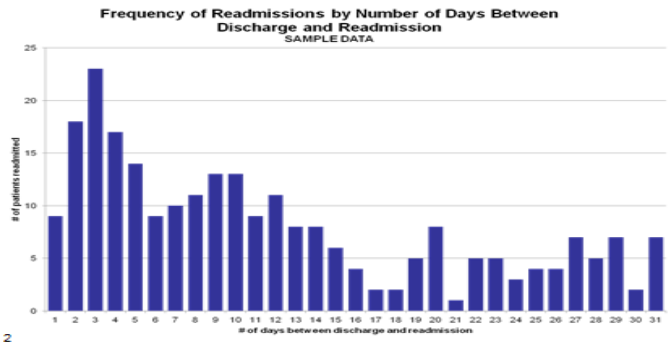
Eric Coleman, MD: Identification of Patients at High-Risk for Admission (cont.)

- Asking the patient to describe, in her or his own words, the factors that led to the hospitalization and where they need our support may provide greater insight into risk for return-
- What is the real story from patients perspective?
- There are inconsistencies regarding which characteristics are most predictive
  - One possible explanation is that non-patient factors may have a larger role in readmission rates, such as the health care system and access

Identifying Opportunities

10

- Observe patient assessment and care plan processes
- Visually display the patterns of return to hospital within 30 days; what questions arise?



2

IHI's Approach: Assess the Patients Medical and Social Risk for Readmission

High-Risk	Moderate-Risk	Low-Risk
• Admitted two or more times in the past year • Patient or family caregiver is unable to Teach Back, or has a low confidence to carry out self-care at home	• Admitted once in the past year • Patient or family caregiver is able to Teach Back most of discharge information and has moderate confidence to carry out self-care at home	• No other hospital stays in the past year • Patient or family caregiver has high confidence and can Teach Back how to carry out self-care at home

Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Expand the Focus of Daily Multidisciplinary Patient Care Rounds

Suggestions for developing a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers:

- Develop one comprehensive assessment of patients post-acute care needs that integrates input from all members of the care team
  - Make sure each member of the care team is clear about what information they must bring to rounds each day
- Change the focus on daily patient care rounds to include a dual focus :
  - decreasing the length of stay while simultaneously
  - planning to meet the post-discharge care needs of patients and to prevent readmissions

Proposed Agenda for Patient Care Rounds

- Reasons for this admission? Are health care teams' and patient's and family caregiver's goals in sync?
- What needs to happen during this hospitalization?
- What post-acute care plan will meet the patients' (or family caregivers') level of activation and comprehension of the discharge plans? (using teach-back)
- Routinely ask: "what is the likelihood that this patient will be readmitted in the next 30 days?"
  - If the likelihood is high, why?
  - What services can be put in place to mitigate potential problems?
  - ***Ask patient and families " What are your concerns or worries about going home or to the next care setting?"***

Physician Follow-Up Care

National Medicare analysis found 50% of patients who were rehospitalized within 30 days did not have an intervening physician visit between the date of discharge and readmission to the hospital.

MedPAC Report to Congress, Promoting Greater Efficiency in Medicare. June 2007

Recommended Changes

15

Institute for Healthcare Improvement
How-to Guide: Improving Transitions from the Hospital to Community Care Settings to Reduce Avoidable Rehospitalizations

3. Create and Activate Post-Hospital Care Follow-up

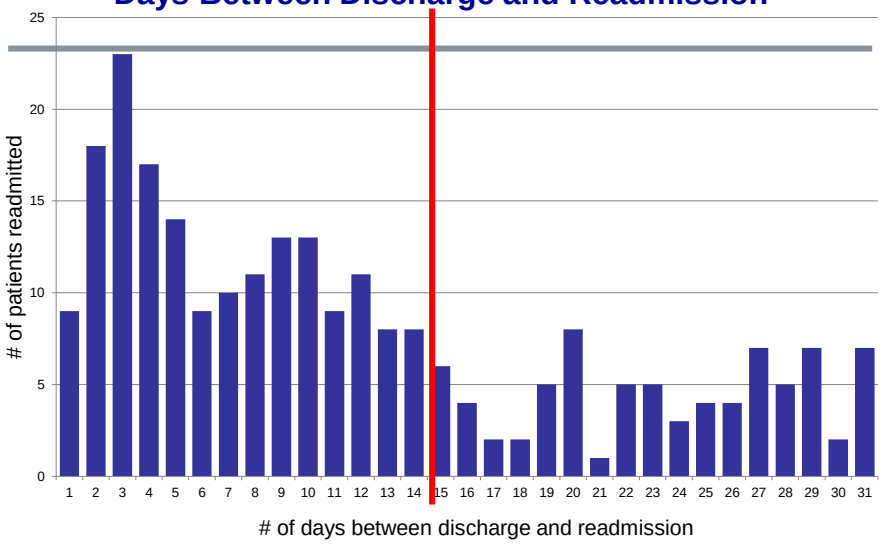
Recommended Changes:

3A. Review daily the patient's medical and social risk for readmission and finalize the customized post-hospital follow-up plan.

3B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the identified post-hospital needs and the capabilities of patients and family.

Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

High-Risk	Moderate-Risk	Low-Risk
Post-acute Follow-up Care: Prior to Discharge		
• Schedule a face-to-face follow-up visit within 48 hours of discharge. Assess whether an office or home health care is the best option for the patient. • If a home care visit in 48 hours, also schedule a physician office within 5 days. • Initiate intensive care management as indicated (if not provided in primary care or in outpatient specialty clinics • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and a physician office visit within 5 to 7 days. • Initiate home health care services (e.g. transition coaches) as needed. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule follow-up phone call within 48 hours of discharge and a physician office visit as ordered by the attending physician. • Provide 24/7 phone number for advice about questions and concerns. • Initiate referral to social services and community resources as needed.



Post-hospital Follow-Up Phone Calls

- Have been frequently cited as a cost-effective method to enhance communication with patients and families in the critical period following discharge
- Give patients and caregivers the opportunity to reinforce education and assess self-care knowledge through the use of Teach Back
- There is little standardization or consensus on the timing and frequency of post-discharge follow-up calls

Johnson M, Laderman M, Coleman E. *STAAR Issue Brief: Enhancing the Effectiveness of Follow-up Phone Calls to Improve Transitions in Care*. Cambridge, MA: Institute for Healthcare Improvement; 2012.

Evidence-based Transitional Care Models

19

- The Care Transitions Intervention™ (Coleman Model) Transitions Coaches encourage patients to take an active role in their care and empower them with skills, tools, and confidence to ensure their needs are met during hospital to home transitions.
- Advanced Practice Nurse-Driven Transitional Care (Naylor Model). APNs design and coordinate care with patients and providers and attend the first post-acute physician office visit.

Medication Reconciliation

20

- Medication reconciliation on admission and discharge
- List of medications should:
  - Name each medication clearly and reason for taking
  - “Red stop sign” for discontinued medications
  - Highlight changes compared to pre-hospital medications
  - Clear instructions for medications that should NOT be taken
  - Reconcile medications with formulary of skilled nursing facility

Recommended Changes:

21

- Give patient and family members a patent-friendly, post-hospital care plan with a clear medication list
  - Use Teach Back to ensure understanding
- Provide customized, real-time critical information to the next clinical care provider
- Written handover communication for high-risk patients is inadequate
- Direct verbal communication, in addition to handwritten, allows for inquiry and clarification

Post-hospital Follow-up Care

22

- Ensure patient family caregivers are present for discharge instructions- Use Teach back to discover understanding
- Provide written instructions for follow-up care, list of reasons to call for help and phone numbers for emergent- and non-emergent questions
- Provide Information on follow-up appointments in writing and verify with Teach Back

Provide Information to Next Clinical Care Provider

- Plan ahead for a safe and comfortable trip home - Does the patient need medications filled prior to discharge?
- Ideally, information precedes or is sent at time of discharge
- Comprehensive overview is needed so that critical information is not overlooked and services are not duplicated

Using Process Measures to Guide Your Learning

Percent of patients discharged who had a follow-up visit scheduled before being discharged in accordance with their level of assessed risk

Definition details on page 72 of the How-to Guide

Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Table Exercise

25

- In your work what area of focus needs attention?
- Pick a focus and discuss what your next test or steps will be.
  - Medication Reconciliation
  - Timely follow up appointments at time of discharge
  - Follow up phone calls
  - Comprehensive discharge plan
  - Communication with community provides
  - Tracking of readmissions to identify trends