Clinical Safety & Effectiveness
Cohort # 10

Improve CSRH ACE Unit Discharge Process

CENTER FOR PATIENT SAFETY & HEALTH POLICY

UT Health Science Center
San Antonio

Educating for Quality Improvement & Patient Safety
Financial Disclosure

Jesus Roberto Ortiz Ter-Veen, MD has no relevant financial relationships with commercial interests to disclose.
The Team

Division

– CS&E Participant: J Roberto Ortiz, MD
– Team Members
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– Facilitator
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Sponsor Department

– M.D. – SOT/Chair/Professor
Department of Family & Community Medicine, Division of Geriatrics
Sandra Liliana Oakes, MD
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Project Milestones

• Team Created 11/11
• AIM statement created 11/11
• Weekly Team Meetings every month
• Background Data, Brainstorm Sessions, Date 02/02/12
  Workflow and Fishbone Analyses 03/12
• Interventions Implemented
• Data Analysis August 2012
• CS&E Presentation Sept 14, 2012
Aim Statement

• The aim of this project is to increase the number of patients who follow up within 7 days with their PCP after being discharged from the CSRH ACE unit by 10% by 1\textsuperscript{st} June 2012
Transitions of Care

Set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care.
Gaps in Care Transitions

PCP Specialists

• Poor documentation of clinical information or lack of access to that information.
• Patient’s impaired ability to communicate their symptoms to the physician.
• Lack of direct communication between PCP and other physicians participating in care.
• Discharge Home or SNF
• Often incomplete information for long-term care staff, PCP, or for the patient and caregiver to institute the follow up plan.
Impact of Poor Transitions

Adverse events in the pre-discharge period

• Increased rates of re-hospitalization
• Increased rates of return to the ED
• Lack of communication between care settings
• Reduced patient and provider satisfaction
• Increased costs of care
Adverse Events Following Discharge

Forster et al.

• Approximately one in five pts had an adverse event in the two weeks following D/C.
• Two-thirds were preventable or ameliorable
• Adverse drug events the most common

Lack of Follow-up

More than half of patients readmitted by 30 days had no record of a follow-up visit with PCP

Direct communication between
• Hospital and PCP 3-20%
• D/C Summary available
• At 1st follow-up appt: 12-34%
• At 4 weeks post D/C: 51-77%

(Kripilani, S et al. JAMA. 2007;297:831-841.)
Patient Problem with medication
Inadequate D/C orders
Economic impact secondary to readmission
Physician not willing to F/U a D/C'ed Pt

System
Social Workers not involved in D/C
Inadequate D/C Planning process
Multiple med lists generated
Poor provider to provider communication
Inadequate info from nursing
No D/C planning team
Long LOS

Resources
Medical Team
Communication
Pt does not keep F/U appt with PCP
Pre-Intervention Discharge Process from ACE Unit
Pre Intervention Data

• 20 patients checked by chart review and interviews.
• February 2011 to November 2011
• Of the 20, 10 patients didn’t f/u in the first 7 days after being discharged home for the following reasons:
  – PCP was not available in the first 7 days after hospital discharge (5)
  – Transportation issues (2)
  – Re- hospitalization / same diagnosis (1)
  – Forgot about the appointment (2)
Pre-Intervention Data

Reason for No Follow Up

- Followed Up: 10
- Did Not Follow Up: 10
- PCP Not Available: 5
- No Transportation: 2
- Forgot Appt: 2
- Re-Hospitalized: 1
Evidence-Based Interventions

Multidisciplinary care coordination

• RED (Re-engineered Discharge)

• Rapid Discharge Follow-up
Multi-Component Intervention

- Started in December 2011
- Discharge was coordinated by nurse and residents
- Discharge summary reduced to one page for the patients
- Medication reconciliation
- Arrange follow-up appointment within 7 days
- PCP’s provided with discharge instructions for F/U appointments and a medication list.
- Patient education: Discharge summaries (explained in English and Spanish) and Med list for appointment
UT Medicine-CHRISTUS Santa Rosa Geriatrics
Discharge Orders

PRIMARY DISCHARGE DIAGNOSES (short statement):

Condition on Discharge:
PATIENT TO BE DISCHARGED TODAY

Pending Labs, Reports:

Procedures / Surgeries performed:

Allergy: □ NKDA □ PCN □ SULFA

Discharge Medication: (ONLY TAKE THESE MEDS)
1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10. 
11. 
12. 
13. 
14. 
15.

Abnormal Labs/imaging for F/u:

Unresolved issues for F/u:

Other Diagnosis:

Home Health Agency
Diet
PT □ OT □ Speech □
PCP Contacted:

DISPOSITION: □ Home □ AFVI □ AFVII □ PLW □ Buena Vida □ Grayson □ MSM □ Other:

Follow up appointments needed:
with Dr. _______ Date _______
with Dr. _______ Date _______

□ DNR (copy attached) □ FULL CODE

Discharge Instructions:

Signature ________________________

Resident’s name: ________________________

Patient label: ________________________

Resident’s Pager: ________________________

Office: 315 N San Saba. (210) 450-9881
Please Fax to 450-6088 if patient belongs to UT Geriatrics or to community PCP.
Types of Measures

• Types of measures: questionnaires
• Patient phone interviews with structured questions
• Questionnaires to primary care practices to confirm results
• How you will measure: Track number of patients who are not seen within 7 days and document reason.
Types of Measures: Questionnaire

- AGE
- Sex
- Ethnicity
- Telephone number/Name, and
- Admit DX
- Dementia yes/no
- PCP Name
- Day of appointment
- Discharge Dx
- Day that Patient Was Discharge
- Patient able to read discharge summary yes/no.
- D/C Home
- With caregiver or by it self
Patient Questions

• Written discharge instructions and a discharge summary of your current health status were given to you before discharge.
  – Yes
  – No
  – Do not remember

• Patient was scheduled for a PCP appointment during D/C process:
  – Yes
  – No
  – No because PCP was not available in the first 7 days
  – No because Hospitalist didn’t schedule an appointment before discharge
  – No because patient suppose to schedule an appointment
Phone Questionnaire

• Did Patient f/u with PCP within the first 7 days after discharge
  – Yes
  – No because:
    – Transportation issues
    – Home bound patient
    – Didn’t remember appointment date
    – PCP not available
PCP Questionnaire

Did pt f/u with you within 7 days of discharge from the hospital to home.

• Yes
• No

Did patient bring their information, discharge summary and med list to your follow-up appointment.

• Yes
• No
• Do not remember
Results

• We surveyed a total of 25 patients
• Only 5 of the 25 did not have a F/U visit with PCP within 7 days
• Reasons for no F/U visit were
  – Transportation: total: 3
  – PCP of preference was not available: 1
  – Re hospitalization: 1
Results

• Prior to intervention the Follow Up rate was 50% (10 out of 20 patients)

• After intervention the Follow Up rate increased to 80% (20 out of 25 patients)

• This is a 60% rate of improvement.
What We Were Trying to Accomplish

• Raise the standard of care delivered to patients that had been discharged home from the ACE unit.

• Identify main reasons for no follow up with PCP in the first 7 days after discharge

• Verify with PCP if patients did keep F/U appointment

• Verify if it was necessary to establish a Home Visit Team for ACE unit.
What We Accomplished

• Increased rate of compliance with Follow-Up Appointments after discharge

• Decreased admission rate from 8.5 per 100 patients within 30 days of D/C to 3.5 per 100 patients within 30 days of D/C.
  – Intervention is helping to reduce readmissions within 30 days of D/C and costs to the hospital.
Return on Investment

- Average hospital stay for a readmission is 3.5 days.
- Cost per day is $3,000.
- By decreasing readmission rate we are saving hospital a total of $10,500 per patient.
- At 5 patients/month = $52,500 dollar per month.
- $630,000 per year.
Thank you!