Inpatient to Outpatient Transitions: Admissions, Discharges & Transfers

Care Coordination Matters
15th Annual Case Management Conference
November 10, 2015

Christopher Kim, MD, MBA, SFHM
Associate Medical Director, Quality and Safety
Medical Director, Center for Clinical Excellence
University of Washington Medical Center
1979

- Rosenthal, JM and Miller, DB
  "Providers have failed to work for continuity."
  Hospitals 53(10): 79-83.

Abstract: “Continuity of patient care between different health care settings has been advocated for nearly 20 years, but little has been done to affect it. The study described here emphasizes the current lack of effort by health care providers in hospitals and nursing homes to find a workable solution.”
June 2007 MedPAC Report

• Medicare pays for ALL admissions regardless
  – Initial stay or readmission for same condition
• 17.6% of admissions result in re-admissions within 30 days (6% in 7 days)
  – = $15 billion in spending
• Future
  – Public Disclosure of readmission rates
  – Lower case payments for readmissions
How Many Have Read...?

One Hundred Eleventh Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.
Are you as confused as I am?
“Random events connected to highly variable actions with only a remote possibility of meeting implied expectations.”

Roger Resar, MD
Agent of Tremendous Change and Global Innovation Seeker
Luther Midelfort – Mayo Health System
Senior Fellow, IHI

“To relieve oneself of a load, or a burden”

Merriam-Webster Dictionary
Airing medical mistakes
Brigham and Women’s reports errors to staff in drive for improvement

The patient, dying of metastatic cancer, had arrived at the hospital several weeks earlier in agony. But doctors at Brigham and Women’s Hospital fashioned a medication regimen that at last eased her suffering, and on the
Hospital Perspective

• Readmissions Reduction Programs have primarily targeted hospitals on penalties
• Overall Medicare readmission rates on the decline
• But: 75% of eligible hospitals will receive reduced payments
  – Hospitals in all states except Maryland
  – 433 without penalties for FY 2014
• Average penalty for 2015 is 0.63%, up from 0.38% for 2014
  – 39 hospitals to receive maximum 3% penalty
• Total reduction in hospital payments greater than $400 million for FY 2015

accessed 10/15/14
Ambulatory Care Perspective

• Medical Home
• Population Health Initiatives/Accountable Care Organizations Models of Care
Post-Acute Care Perspective

• External Pressures on Post-Acute Care Facilities
• Home Health Compare, Nursing Home Compare
• Department of Health and Human Services focus has turned to include skilled nursing Facilities: SNF VBP (Hospital Readmission Reduction Program for SNF)
• Starting in 2018, readmission penalties will begin for Skilled Nursing Facilities
  – Essentially, the government would withhold 2% of SNFs' Medicare payments starting in Oct 2018, and about 70% of those dollars would then by distributed to high-performing providers with reduced hospital readmissions
  – Report in Nursing Home Compare beginning Oct 2017
Growing Spotlight on Post-Acute Care

Ackerly, D. C., et al. NEJM, 2014
Colla, C.H., et al. HSR, 2010
Feder, J. NEJM, 2013
Mechanic, R. NEJM, 2014
Mor, V., et al. Health Affairs, 2010
In Michigan…

**MiPCT Demonstration Project**
We can do this together. We can make care better!

**Washtenaw County-wide CHF Collaborative**

**Community-based Care Transitions Program**

**CMS Innovation Center**
On Admission:
• Readmission risk factor screen
• Discharge needs analysis
• General assessment of preparedness
• Medication reconciliation
• Readmit root cause analysis (if needed)

During Hospitalization:
• Interprofessional rounds to develop safe transition plan
• Initiate readmission risk reduction interventions
• Develop a patient-centered transitional care plan
• Educate patient & caregiver using Teach Back
• Engage patient/caregiver and aftercare providers

At Discharge:
• Schedule post-discharge appointment
• Patient friendly discharge instructions
• Handoffs (hospital to aftercare)
• Medication reconciliation
• Reinforce education

Post-Discharge:
• Post-discharge follow-up phone call
• Post-discharge follow-up appointment
• Transmit discharge summary to PCP
TRANSITIONS ACROSS THE CONTINUUM
It Takes A Village for Successful Care Transitions
The denominators used to calculate the percentage of 30-day readmissions on each day after hospitalization were 329,308 30-day readmissions following heart failure hospitalization, 108,992 30-day readmissions following acute myocardial infarction hospitalization, and 214,239 30-day readmissions following pneumonia hospitalization.
Interventions to Reduce 30-Day Rehospitalization: A Systematic Review

Luke O. Hansen, MD, MHS; Robert S. Young, MD, MS; Kelki Hinani, MD, MS; Alicia Leung, MD; and Mark V. Williams, MD

Background: About 1 in 5 Medicare fee-for-service patients discharged from the hospital is rehospitalized within 30 days. Beginning in 2013, hospitals with high risk-standardized readmission rates will be subject to a Medicare reimbursement penalty.

Purpose: To describe interventions evaluated in studies aimed at reducing rehospitalization within 30 days of discharge.

Data Sources: MEDLINE, EMBASE, Web of Science, and the Cochrane Library were searched for reports published between January 1975 and January 2011.

Study Selection: English-language randomized, controlled trials; cohort studies; or noncontrolled before-after studies of interventions to reduce rehospitalization that reported rehospitalization rates within 30 days.

Data Extraction: 2 reviewers independently identified candidate articles from the results of the initial search on the basis of title and abstract. Two 2-physician reviewer teams reviewed the full text of candidate articles to identify interventions and assess study quality.

Data Synthesis: 43 articles were identified, and a taxonomy was developed to categorize interventions into 3 domains that encompassed 12 distinct activities. PredischARGE interventions included patient education, medication reconciliation, discharge planning, and scheduling of a follow-up appointment before discharge. Predischarge interventions included follow-up telephone calls, patient-activated hotlines, timely communication with ambulatory providers, timely ambulatory provider follow-up, and postdischarge home visits. Bridging interventions included transition coaches, physician continuity across the inpatient and outpatient setting, and patient-centered discharge instruction.

Limitations: Inadequate description of individual studies’ interventions precluded meta-analysis of effects. Many studies identified in the review were single-institution assessments of quality improvement activities rather than those with experimental designs. Several common interventions have not been studied outside of multicenter “discharge bundles.”

Conclusion: No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.

Primary Funding Source: None.

References: [ Insert references here.]

For author affiliations, see end of text.

<table>
<thead>
<tr>
<th>PredischARGE Intervention</th>
<th>Predischarge Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient education</td>
<td>Timely follow-up</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>Timely PCP communication</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Follow-up telephone call</td>
</tr>
<tr>
<td>Appointment scheduled before discharge</td>
<td>Patient hotline</td>
</tr>
<tr>
<td></td>
<td>Home visit</td>
</tr>
</tbody>
</table>

Intervention Bridging the Transition

Transition coach

Patient-centered discharge instructions

Provider continuity

• 4,013 studies identified, reviewed 386 for full text review, 43 included in systematic review
• No single intervention alone was regularly associated with risk for 30 day re-hospitalization
Recent study found that a “virtual ward” with intensive interventions for discharged patients did not reduce readmissions or mortality (at 30d, 90d, 6m, 1y)

Intervention: care coordination + direct care from inter-professional team (phone calls, home visits, or clinic visits) vs. usual care (typed, structured discharge summary, Rx for new meds, discharge counseling, home care as needed, and follow up arranged or recommended with PCP as needed)
Lessons Learned from Care Transitions Collaborative

• Change is hard... Changing care transitions is REALLY hard (...and slow)
  – Corollary: Mentors can help

• There’s leadership support and then there’s LEADERSHIP SUPPORT
  – “We support the Transitions of Care team...” vs.
  – “We support the Transitions of Care team and commit to provide the following resources to ensure their success...”

• Teamwork is critical. Break those silos!
  – Corollary: Don’t be hospital-centric
Lessons Learned from Care Transitions Collaborative

• Respect workflow...but EMRs are not *the* solution
  – Health Information Exchange would be nice, but...it’s only a part of the solution

• The prepared and educated patient and caregiver are your best allies
  – Need both basic and novel ways to be more patient-centered
Preparing Patients & Caregivers

• *Initially*: Patient and caregiver preparation is important for having a successful care transition.

• *Reality bites*: VERY True...and working to improve this also:
  – Helps to improve patient satisfaction scores
  – Is low hanging fruit for early team success
    • Teach Back
    • Patient-Centric Discharge Document
  – Is very satisfying for staff
Lessons Learned from Care Transitions Collaborative

• Pilots sites not pilot services
  – Select locations of care to implement and disseminate
  – A lot of what happens during care transitions is culture of that area
  – Starts in the hospital, and continues throughout post-acute care settings
  – Focusing on a disease state doesn’t get at all the issues a patient may face (“post-hospital syndrome”)

• Small organizations are more nimble
  – More flexibility, more tolerant of rapid cycle improvements, less committees to clear, less constituents who need to “bless” → More rapid success
MICHIGAN TRANSITIONS OF CARE COLLABORATIVE (M-TC²)

- BCBSM Professional CQI on Care Transitions
- Provider Organizations eligible to participate
  - Required to have a “partner” hospital
- M-TC² mentor assigned to work with both PO and hospital
- Focused on implementing “best practices” in Care Transitions from hospital to next setting of care
- 3-4 meetings/year
- Site visits by mentors
- Data used to help drive improvement locally
Recap of Target Goals for M-TC$^2$ for 2014

- 50% Increase in discharges impacted

- 80% of Discharge summaries received within 72 Hours of discharge

- 50% of Patients seen within 7 days of discharge
Overall M-TC²:
Most targeted metrics went up
## Penalties from CMS

<table>
<thead>
<tr>
<th>State</th>
<th>% of all hospitals penalized</th>
<th>Average hospital penalty</th>
<th>Number of hospitals penalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>52</td>
<td>0.64</td>
<td>71</td>
</tr>
<tr>
<td>M-TC2 Sites</td>
<td>70</td>
<td>0.21</td>
<td>12/17</td>
</tr>
<tr>
<td>Ohio</td>
<td>63</td>
<td>0.73</td>
<td>107</td>
</tr>
<tr>
<td>Illinois</td>
<td>65</td>
<td>0.78</td>
<td>118</td>
</tr>
<tr>
<td>Indiana</td>
<td>53</td>
<td>0.62</td>
<td>68</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>37</td>
<td>0.43</td>
<td>47</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services & Kaiser Health News
Transitions Collaborative

Regional Sites

Coordination of Best Practices

Data Support to Drive Change

Patient Experience to Guide the Change

Goal to Reduce Post-Acute Adverse Events (e.g. Hospital Readmissions)
## Location of Readmissions

### BCBSM

<table>
<thead>
<tr>
<th>Condition</th>
<th>% readmissions to index hospital</th>
<th>Median distance (miles) between index and readmission hospital (when discordant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>69.8</td>
<td>13 (0 – 203)</td>
</tr>
<tr>
<td>CHF</td>
<td>69.8</td>
<td>13 (0 – 299)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>74.7</td>
<td>21 (0 – 287)</td>
</tr>
<tr>
<td>THR</td>
<td>84.9</td>
<td>9 (0 – 193)</td>
</tr>
</tbody>
</table>
## Location of Readmissions

### Medicare

<table>
<thead>
<tr>
<th>Condition</th>
<th>% readmissions to index hospital</th>
<th>Median distance (miles) between index and readmission hospital (when discordant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>58.7</td>
<td>18 (0 – 2066)</td>
</tr>
<tr>
<td>THR</td>
<td>75.8</td>
<td>12 (0 – 1980)</td>
</tr>
</tbody>
</table>
## Geography of Readmissions

<table>
<thead>
<tr>
<th>Condition</th>
<th>AMI</th>
<th>CHF</th>
<th>Pneumonia</th>
<th>THR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marquette</td>
<td>100</td>
<td>100</td>
<td>92.3</td>
<td>100</td>
</tr>
<tr>
<td>Petoskey</td>
<td>95.2</td>
<td>100</td>
<td>85.7</td>
<td>100</td>
</tr>
<tr>
<td>Traverse City</td>
<td>85.7</td>
<td>100</td>
<td>81.8</td>
<td>100</td>
</tr>
<tr>
<td>Muskegon</td>
<td>50.0</td>
<td>100</td>
<td>77.8</td>
<td>100</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>100</td>
<td>96.0</td>
<td>91.8</td>
<td>100</td>
</tr>
<tr>
<td>Lansing</td>
<td>90.2</td>
<td>80.0</td>
<td>86.5</td>
<td>100</td>
</tr>
<tr>
<td>Saginaw</td>
<td>88.2</td>
<td>92.1</td>
<td>90.0</td>
<td>95.2</td>
</tr>
<tr>
<td>Flint</td>
<td>77.5</td>
<td>84.0</td>
<td>90.6</td>
<td>100</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>100</td>
<td>75.0</td>
<td>69.2</td>
<td>100</td>
</tr>
<tr>
<td>Kalamazoo</td>
<td>93.0</td>
<td>96.9</td>
<td>97.9</td>
<td>100</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>82.4</td>
<td>85.0</td>
<td>85.7</td>
<td>89.7</td>
</tr>
<tr>
<td>Pontiac</td>
<td>96.2</td>
<td>72.2</td>
<td>96.1</td>
<td>54.6</td>
</tr>
<tr>
<td>Royal Oak</td>
<td>82.4</td>
<td>81.3</td>
<td>91.5</td>
<td>93.3</td>
</tr>
<tr>
<td>Dearborn</td>
<td>83.7</td>
<td>73.7</td>
<td>82.7</td>
<td>100</td>
</tr>
<tr>
<td>Detroit</td>
<td>88.1</td>
<td>77.0</td>
<td>81.1</td>
<td>100</td>
</tr>
</tbody>
</table>

BCBSM
Care Transitions Improvement Program Partners

Percentage of Hospitals that Involve each Organization Type in their Care Transitions Improvement Program

- Home Health: 90%
- SNF: 80%
- Community Orgs: 50%
- Provider Orgs: 40%
- Health Plans: 30%
- Other: 20%
- Assisted Living: 10%
- Other Hospitals: 10%
Key Factors to Success

- Post-discharge follow up calls: 80%
- Scheduling of post-discharge appts: 80%
- Home visit program: 60%
- Leadership support of care transitions: 50%
- Coordination of community and social support resources: 40%
- Dedicated resources for transitions of care program: 30%
- Advanced care planning: 20%
- Other: 10%
Key Barriers to Success

- Difficulties scheduling post-discharge appts: 45%
- Lack of dedicated resources for transitions of care program: 38%
- Advanced care planning: 25%
- Low rates of post-discharge follow up calls: 20%
- Other: 15%
- Patient non-compliance: 15%
- Home visit program: 10%
- Ability to coordinate with community and social support resources: 5%
- Lack of leadership support in care transitions: 5%
ADT Notifications

Percentage of Hospitals that Transmit ADT Notifications

- Yes: 84%
- No: 11%
- Unknown: 5%
Risk Assessment

- 54% of hospitals currently utilize a risk assessment prediction tool or score to identify targeted interventions.

Percentage of Hospitals Utilizing each Risk Assessment Prediction Tool

<table>
<thead>
<tr>
<th>Tool Description</th>
<th>Percentage of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>LACE Internally developed</td>
<td>45%</td>
</tr>
<tr>
<td>PRISM</td>
<td>15%</td>
</tr>
<tr>
<td>8P's</td>
<td>10%</td>
</tr>
<tr>
<td>Modified BOOST tool</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
<tr>
<td>EPIC</td>
<td>0%</td>
</tr>
</tbody>
</table>
Care Managers

Percentage of Hospitals that Employ Trained Care Managers

- Yes: 84%
- No: 13%
- Unknown: 3%
Innovative Ideas

• Auto-notify of ADT, with access to parts of medical record every time a patient transitions settings

• Automated phone call service, that can help streamline the call back RN’s work flow

• CarePartner Program for Improving Quality of Transitions
Innovate and Create New Practices

• Patients and their family members are the one constant point of information across the care continuum
• Enhance established practices
• Understand better patients’ reasons for poor care transitions and readmissions
• Patient care advisory and participation in improvement initiatives
• Innovate in how to better engage patients during care transitions across the continuum of care
  – What motivates them? What discourages them? How can active case-management support their needs?
Thank you for your attention!  
I would be happy to answer any questions

Christopher Kim
seoungk@uw.edu