Redesign of the Hospital Discharge: Patient-Centered Care to Improve Safety, Cost and Outcomes

Moderator:
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Speaker:
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Transitions and Patient Centered Care:

Patient-Centered Care to Improve Safety, Cost and Outcomes
Clearwater Valley Hospital & Clinics
CVHC

- 23 Bed Critical Access Hospital with 3 associated rural health clinics in Clearwater and Idaho Counties
- Patient-Centered Medical Home
- 8 Family Medicine Physicians, 3 Physician Assistants, 1 General Surgeon and 4 ED physicians
- CVHC serves 15,000 Patients in an area greater than the state of Delaware
- Population density is 4 people / square mile (rural designation is 100 / square mile)
- Only Emergency Department along 240 miles of Highway 12
Population Challenges

Compared with the rest of Idaho, this population is:

- Older
- Significantly lower per capita income
- Lower levels of education
Perfect Laboratory For Health Care:

![Chemical Lab Equipment](CoolClips.com)

CLEARWATER VALLEY HOSPITAL & CLINICS
Patient Centered Medical Home
Three-Part Aim:

- Improve the health of the population
- Enhance the patient experience of care (quality, access & reliability)
- Reduce or control cost of care
Why Focus on Hospital Discharge?:

- Care transition = high risk to patients
- AHRQ “top ten” safety step for hospitals
- Critical events & patient safety
- Highest risk/cost population
- Opportunity to leverage PCMH advantages to improve high risk population health
Healthcare Cost Inequality

1% US Population

22% US Health Care Costs
Safer Transitions:
The Journey
Project Team

CORE TEAM

Kelly McGrath MD  
CMO

Sharon Moriarty  RN  
CNO

Donna Hoopes,  
Discharge Planning

Medical Records

UR

Admin. CFO/CEO

Clinic / Medical Home

QI / Patient Safety

Nursing

Grants

Medical Staff

IT

Visiting Nurse Service

CLEARWATER VALLEY HOSPITAL & CLINICS
Project Goals

- Improve Safety / outcomes around Hospital Discharge
- Reduce 30, 60 & 90 day Hospital Readmission Rates
- Reduce 30 Day ED Utilization
- Reduce Net Healthcare Costs in Our Patient Population
- Improve Patient Experience through PCMH & VNS
- Quantitatively Measure Project Outcomes to Assess Effectiveness
Strategy / Methods

- Reduce Errors in Discharge Process
- Educate patient to recognize problems / understand plan of care
- Frequent contact with patient post discharge to correct errors and alter treatment plan as needed
5 Degree Error

New York

304 miles
Manchester

London
20 Degree Error

New York -> London

Trondheim, Norway

1,263 miles
20 Degree Error with Corrections
Shorten the distance
PROJECT BASELINE DATA
CVH Readmission Rates

Days Post Discharge

% Readmissions

- 0 to 30: 20.0%
- 31 to 60: 10.0%
- 61 to 90: 5.0%
Risk of ED Visit After Discharge

% Discharges w/ ED Visit

Days Post Discharge

0 to 30: 34.50%
31 to 60: 22.70%
61 to 90: 20%
Discharge Redesign Methods
Status Quo at Project Start

Discharge Planner assessment / management of barriers to safe discharge care transition

Medication Reconciliation
Typically completed by Discharge Planner

Post Discharge Care
Inpatient Team Follow-up Phone Call to Patient
Hospital Admission

- Admit
- Hospital Stay
- Discharge

Post Discharge Care

Clearwater Valley Hospital & Clinics
Medication Reconciliation

Discharge Planner assessment / management of barriers to safe discharge care transition

Medication Reconciliation
Starts in ED – must be complete within 24 hours of admit

Medication Reconciliation
Typically completed by Discharge Planner

Post Discharge Care

Inpatient Team Follow-up Phone Call to Patient
Teach Back / MD Orders

ADMIT

Care Transition Risk Assessment

Discharge Planner assessment / management of barriers to safe discharge care transition

“Teach Back” Technique for RN discharge teaching

HOSPITAL STAY

Physician Standardized “Best Practice” Discharge Order Sets

Post Discharge Care

DISCHARGE

Inpatient Team Follow-up Phone Call to Patient

Medication Reconciliation
Starts in ED – must be complete within 24 hours of admit
Improve Follow up Calls

ADMIT

- Care Transition Risk Assessment
- Discharge Planner assessment / management of barriers to safe discharge care transition

HOSPITAL STAY

- Medication Reconciliation: Starts in ED – must be complete within 24 hours of admit
- Physician Standardized “Best Practice” Discharge Order Sets

DISCHARGE

- “Teach Back” Technique for RN discharge teaching
- Post Discharge Care
- Inpatient RN Follow-up Phone Call to Patient < 48-72 hours post DC & Action Plan / Communication with PCP if problems

Inpatient Team Follow-up Phone Call to Patient
Improved Transcription Times

**HOSPITAL STAY**

- **ADMIT**
  - Care Transition Risk Assessment
  - Discharge Planner assessment / management of barriers to safe discharge care transition
- **DISCHARGE**
  - “Teach Back” Technique for RN discharge teaching
  - Post Discharge Care
  - Discharge Summary Transcribed <24 hr
  - Physician Standardized “Best Practice” Discharge Order Sets
  - Inpatient RN Follow-up Phone Call to Patient < 48-72 hours post DC & Action Plan / Communication with PCP if problems

- **Medication Reconciliation**
  - Starts in ED – must be complete within 24 hours of admit
VNS “opt out” Referral

ADMIT

HOSPITAL STAY

DISCHARGE

Care Transition Risk Assessment

Discharge Planner assessment / management of barriers to safe discharge care transition

Post Discharge Care

Medication Reconciliation
Starts in ED – must be complete within 24 hours of admit

“Teach Back” Technique for RN discharge teaching

“Best Practice” Discharge Order Sets

Physician Standardized

Discharge Summary Transcribed <24 hr

Visiting Nurse Referral < 48 -72 hr post DC

Inpatient RN Follow-up
Phone Call to Patient < 48-72 hours post DC & Action Plan / Communication with PCP if problems
Patient Centered Medical Home

**ADMIT**

- Care Transition Risk Assessment
- Discharge Planner & Inpatient Care Team Ongoing assessment / management of barriers to safe discharge care transition

**HOSPITAL STAY**

- "Teach Back" Technique for RN discharge teaching
- "Teach Back" Technique for RN discharge teaching
- Post Discharge Care
- Discharge Summary Transcribed <24 hr
- Physician Standardized "Best Practice" Discharge Order Sets

**DISCHARGE**

- Inpatient RN Follow-up Phone Call to Patient < 48-72 hours post DC & Action Plan / Communication with PCP if problems

**Visit during hospital stay**
- Medical Home MA/RN Visiting Nurse Referral < 48-72 hr post DC
- Follow up Visit < 7 days post discharge with PCP / Medical Home Team as "opt out" in scheduling

**Medication Reconciliation**
- Starts in ED – must be complete within 24 hours of admit
High Risk Case Review

**ADMIT**

- Care Transition Risk Assessment
- Physician QI Team Case Review for ≥ 2 admits / 90 days
- Discharge Planner & Inpatient Care Team Ongoing assessment / management of barriers to safe discharge care transition
- Teach Back” Technique for RN discharge teaching

**HOSPITAL STAY**

- Discharge Summary Transcribed <24 hr
- Post Discharge Care
- Physician Standardized “Best Practice” Discharge Order Sets

**DISCHARGE**

- Visiting Nurse Referral < 48-72 hr post DC
- Inpatient RN Follow-up Phone Call to Patient < 48-72 hours post DC & Action Plan / Communication with PCP if problems

**Follow up Visit < 7 days post discharge with PCP / Medical Home Team as “opt out” in scheduling**

**Medication Reconciliation**
- Starts in ED – must be complete within 24 hours of admit

**Medical Home MA/RN**
- Outpatient Care Team Visit during hospital stay

**Inpatient Care Team**
- Ongoing assessment / management of barriers to safe discharge care transition

**Post Discharge Care**
- Follow up Visit < 7 days post discharge with PCP / Medical Home Team as “opt out” in scheduling
Outcome Data
Medication Reconciliation

Pre and Post Discharge Process Redesign

% Admissions with Med Reconciliation

- 2010 Baseline
- 2011 Discharge Redesign
High Risk Patients with VNS Referral

High Risk Inpatients Referred to VNS for Post-Discharge Care

% High Risk Inpatients Referred to VNS

Months After Risk Stratification Trigger For VNS Referral
Patients with PCMH Follow up within 7 days

% High-Risk Patients with Follow-Up visit scheduled for within 7 days of Discharge

- Goal
- % of Patients
- % of patients with adjusted definitions*

Time Period:
- Oct-11
- Nov-11
- Dec-11
- Jan-12
- Feb-12
- Mar-12
- Apr-12
- May-12
- Jun-12

Graph shows the percentage of high-risk patients with follow-up visits scheduled within 7 days of discharge, comparing the goal to the actual percentage of patients meeting this criterion from October 2011 to June 2012.
30 day Readmission Rates
60 Day Readmission Rates

60 Day Readmission Rate vs Time

% Readmission Rate

Month

Jan-10  Mar-10  May-10  Jul-10  Sep-10  Nov-10  Jan-11  Mar-11  May-11  Jul-11  Sep-11  Nov-11  Jan-12  Mar-12

Pre-intervention Average

Post-intervention Ave
% Discharge With ED Visit Within 30 Days

30 Day ED Visit vs Time

% of Discharge with ED Visit within 30 day

MONTH

Jan-10  Mar-10  May-10  Jul-10  Sep-10  Nov-10  Jan-11  Mar-11  May-11  Jul-11  Sep-11  Nov-11  Jan-12  Mar-12  May-12

Pre-intervention Average

Post-intervention Average
Visiting Nurse Visits and Readmission

CVHC - % Patients Readmitted after having VNS

Goal

% of patients readmitted after VNS visit within 2 days

% of patients readmitted after VNS visit some time after DC

% Patients

Oct-11 Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12

Time Period
Risk of ED Visit Within 30 Days of Hospital Discharge

PCMH Visit within 7 days of Hospital Discharge?
Estimated Savings

$146,000 Program Cost

$660,000 Estimated Prevented Admissions/ED Visits
Next Steps

✓ Use similar techniques for discharged patients with subsequent ED visit
✓ Continue to improve current processes
✓ Optimize health literacy / patient education techniques to improve patient role in self management
✓ Extend elements of process to our patient panels when they are hospitalized at other facilities outside our system
✓ Engage in discussions regarding reimbursement
Take Our “Experiment”...
...and climb your “mountains”
Patient Centered Medical Home – the time has come!!!
Questions / Discussion?