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Reducing Hospital Readmissions by Engaging Physicians

CPIN Webinair

September 7, 2011

What is broken?

- Quality/Patient Safety
  - Transition related complications
    - High risk medication (Anticoagulants, hypoglycemics)
    - High risk conditions (HF instructions- weight, diet)
- Cost
  - Unnecessary readmissions, returns to ED
  - Duplication of studies, procedures
- Patient Satisfaction
  - Lack of coordination
  - “The morass of healthcare”

Why is that?

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- Fragmentation of care
  - (The Delivery “non-system”)
- Lack of access to patient information
- A payment system that neither rewards nor promotes coordination
- Lack of crucial “end of life” conversations

All create barriers for patients, families and communities

And it leads to…

- Outpatient to Inpatient-
  - Poor transitions
  - Lack of information
- Inpatient
  - Failure to inform, share and coordinate with patient and family throughout the hospitalization
- Inpatient to outpatient
  - Failure to prepare patient and family
  - Medication reconciliation
  - Lack of coordination with outpatient community at discharge

There is background

- The past: Inpatient management/coordination by PCP
- Transitions were less of an issue
- Increased readmissions with Hospitalist model
- But the "ists" developed out of necessity
  - PCP productivity demands
  - Requirement of inpatient expertise
  - Duplication of effort

This is what created the need for transition coordination.

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What would an ideal system look like?

- Someone to coordinate through the continuum of care
- Information systems accessible to all caregivers, patient, and family
- Standardized "best practice" care, including handoffs
- Payment reform that rewards health, not illness; coordinated not fragmented care

Hmmm…perhaps Integrated Delivery Systems

(ACO's- but no one is sure about the "O" part)

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How are we addressing this in the world as it is in Everett?

- Risk stratification on admission (stolen shamelessly from Group Health)
- Discharge planning on admission
  - Estimated Date of Discharge
  - Standard “White Board” information
  - Patient and family part of daily rounds (with MD-RN rounding together)
- PCP notification on admission and discharge- frequently voice mail but hopefully a conversation
- Access to ambulatory EHR

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How are we addressing this in the world as it is in Everett?

- Four Pillars as universal patient education across community
- Structured discharge summaries within 2 hours of discharge orders
- Daily multi-disciplinary “huddles” (with MDs) as part of team-based care

All greatly influenced by our Patient, Family Advisory Committee and hospitalization redesign work co-sponsored with TEC

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Questions To Ask My Care Team:

Date/Time	Question	Answered?
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Ask Me 3™

Before you go we want you to know!

Before you go home we want to be sure you and your family know the answers to these three important questions...

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Please keep asking us questions until you can say "I know...

- ☐ ...how to take care of myself at home."
- ☐ ...what my medicines are for and how to take them."
- ☐ ...the warning signs I should call my doctor about."
- ☐ ...when and where to go for follow-up visits or tests."

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Care Checklist

We want your hospital stay and discharge to go well. You and your chosen "key person" are a vital part of making sure that happens. It is important you both take part in learning about your care. Please check off boxes as you complete them. It helps if you write down questions you have.

My Key Person is: ______________________

Phone number: ____________ **Alternate number:** ____________

I expect to leave the hospital on: ______________________

The reason I am here: ______________________

As I am admitted

- ☐ My doctor knows all medicines/doses I take (even over-the-counter medicines).

While I am here

- ☐ We know the team who is taking care of me here and how to contact them.
- ☐ We understand my treatment.
- ☐ We understand my tests.
- ☐ My pain is controlled.

Before I leave

- ☐ We know which medicines I need to take when I go home and why. We know how and where to get them.
- ☐ We know warning signs to watch out for.
- ☐ We have received information specific to my condition.
- ☐ We know my diet instructions.
- ☐ We know what movement and activity is safe for me.

To be ready to go

- ☐ We have a plan to get equipment I may need at home.
- ☐ My ride home is arranged.
- ☐ We know which doctor(s) to call and have phone numbers.
- ☐ My follow up appointments are made.
- ☐ We are comfortable with my care needs after I leave.
- ☐ Ask Me 3 on the back cover is complete.

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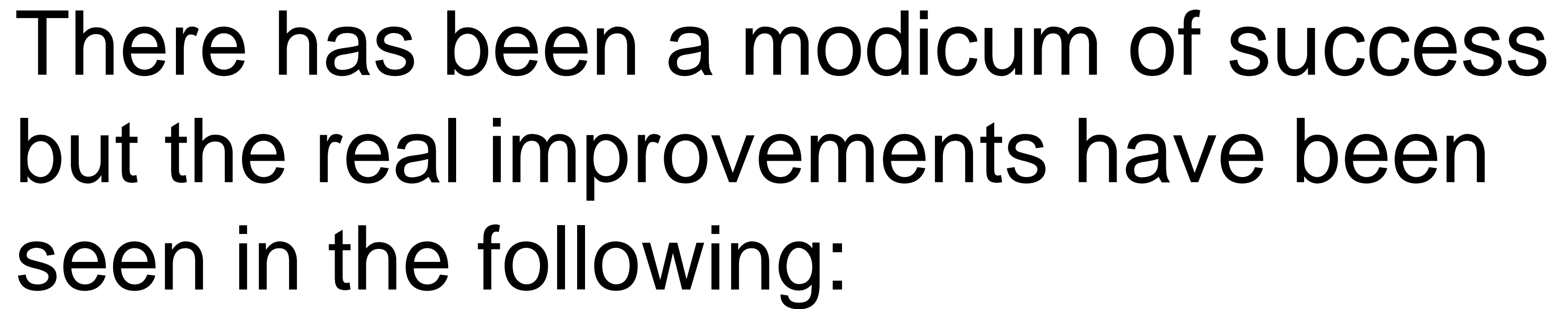

There has been a modicum of success but the real improvements have been seen in the following:

Does it work?

- The Everett Clinic
  - Transition Coach
    - Inpatient Visits of Medicare Advantage patients
    - Coordination of post-acute care (ACC, SNF, etc)
    - PCP office calls patient post-discharge for first visit (visit expected within 5 days)
    - Facilitation of early home care
    - Partners in Palliative Care Program facilitates palliative and hospice care

And others…

- Group Health Cooperative
  - Stratification on admission
  - Dedicated Discharge planner/care coordinator paired with MDs
  - Medical Hospitalist coordination
- Molina
  - Much of the same, plus
  - Extensive education for patient and family regarding their accountability for post discharge PCP appointment (a la Dr. Eric Coleman)

There is a common theme…..these are all "risk" contracts
There is some financial reward for such coordination that makes it sustainable.

Conclusions

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- Coordination of care across continuum drives the results we are seeking
- Current payment system is a barrier
- Consolidated community-wide health information systems are a critical tool
- Requires a cultural transformation of providers, patients, families and communities.