Clinical Safety & Effectiveness
Cohort # 10

Improve CSRH ACE Unit Discharge Process

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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
- Robert Parker, MD, Dr S Liliana Oakes, MD
- TK Efeovbokhan, Ughanmwan T,NP
- Andrew Hanna MS3
- Facilitator
- Amruta Parekh, MD, MPH

Sponsor Department

- M.D. – SOT/Chair/Professor

Department of Family & Community Medicine, Division of Geriatrics

Sandra Liliana Oakes, MD

Carlos Jaen, MD

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 1st 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

- Forster, AJ et al. Ann Intern Med 2003;138:161-167.)

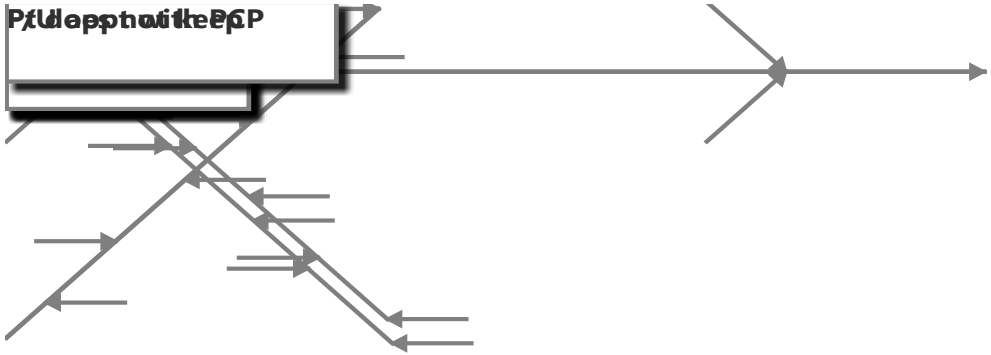
Lack of Follow-up

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%

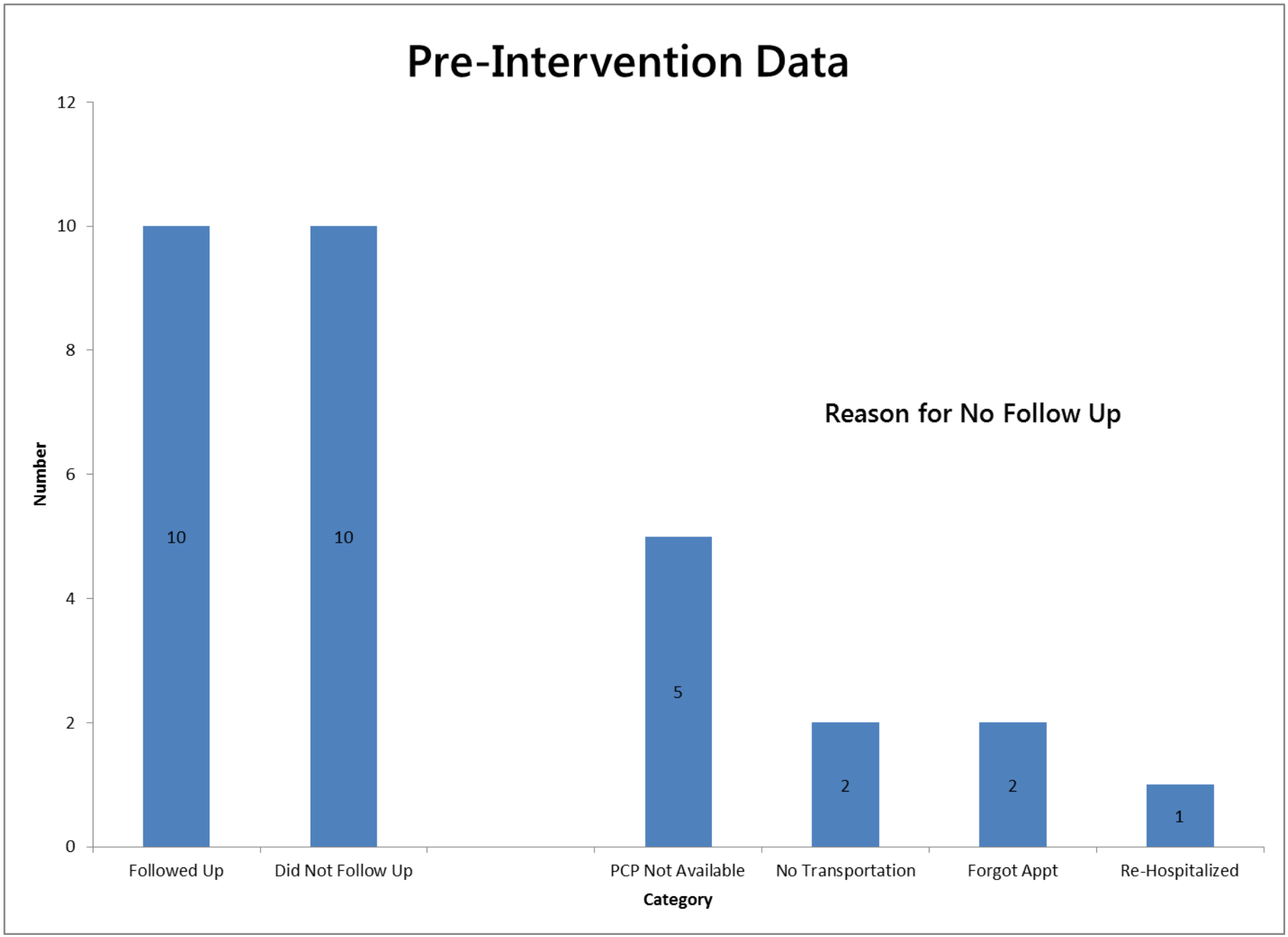
(Kripilani, S et al. JAMA. 2007;297:831-841.)



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 discharge 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
Number
Category
0
2
4
6
8
10
12
10
10
5
2
2
1
Followed Up
Did Not Follow Up
PCP Not Available
No Transportation
Forgot Appt
Re-Hospitalized

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 **Date:**
Discharge Orders (r7) **Time:**

Admit Date: ___/___/_____
D/C Date: ___/___/_____

PRIMARY DISCHARGE DIAGNOSES (short statement):

Condition on Discharge: PATIENT TO BE DISCHARGED TODAY ☐

Pending Labs, Reports: _____

Procedures / Surgeries performed:

Allergy: ☐NKDA ☐PCN ☐SULFA

Abnormal Labs/imaging for F/u

Unresolved issues for F/u:

Other Diagnosis

☐DNR (copy attached) ☐ FULL CODE

Discharge Instructions:

Discharge Medication: (ONLY TAKE THESE MEDS)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

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 _____

Patient label:

SIGNATURE_____ RESIDENT'S NAME: _____
ESPINO OAKES PARKER PATEL SUH YE
_____ 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

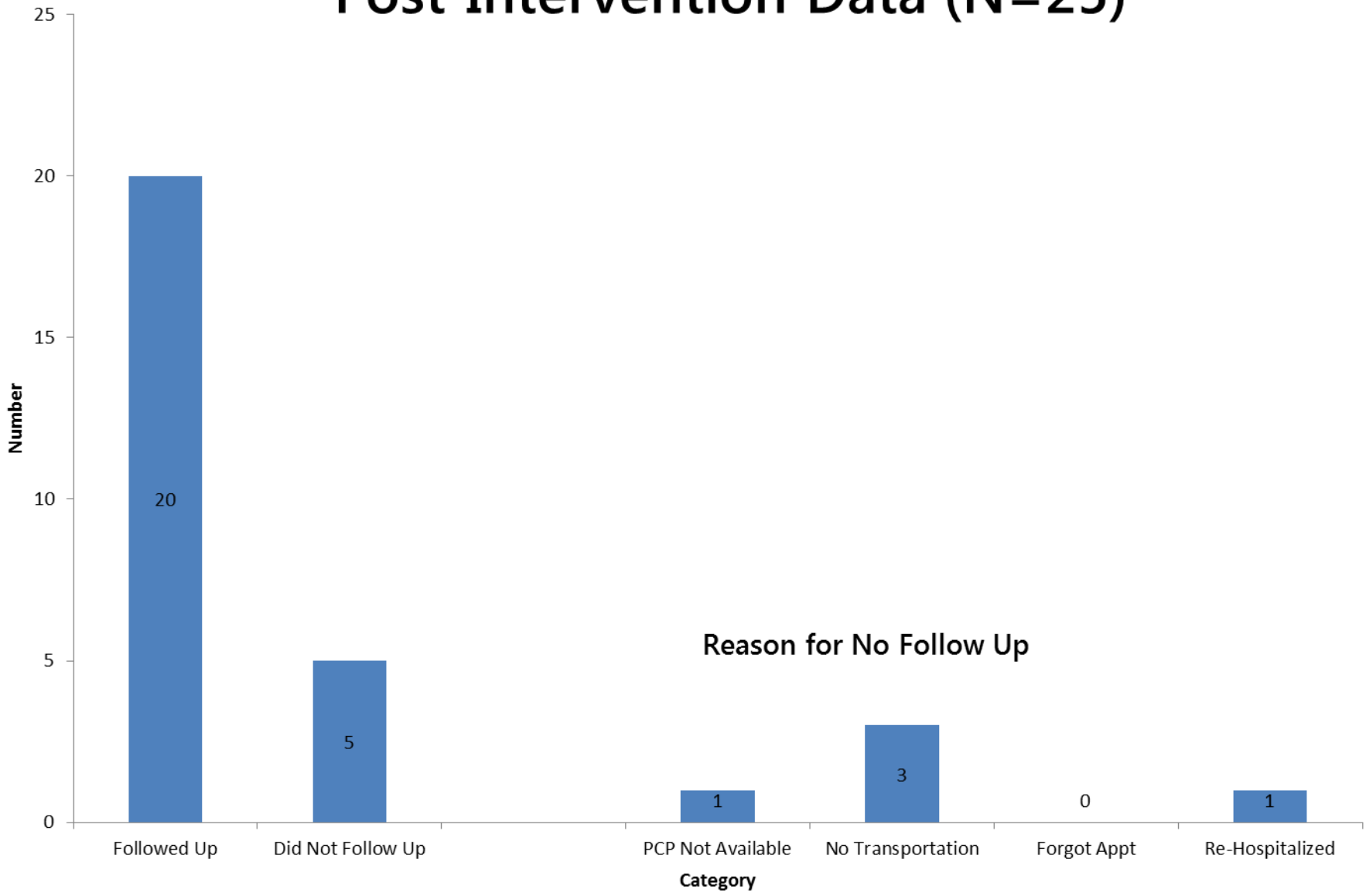
Did patient bring their information, discharge summary and med list to your follow-up appointment.

- 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

Post-Intervention Data (N=25)



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!

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