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IT'S HOW MEDICINE SHOULD BE

Who Can Really Drive Successful Transitions?

Discharge Planning Approaches

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"The hospital of the future will be a health center, not just a medical center…the hospital will offer valuable resources to the community on matters of health and well-being, and will be held increasingly accountable for the community's health status."

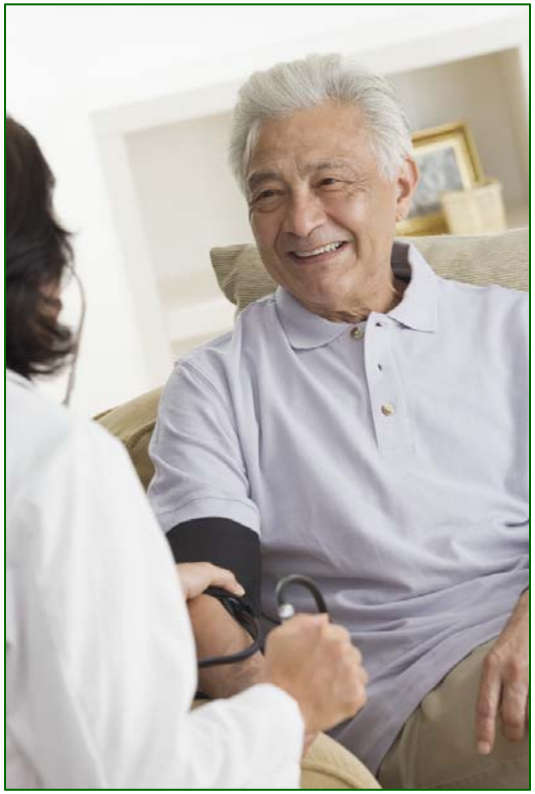
--Shi & Singh, 2004

Key Questions

- What are transitions of care?
- Why are transitions of care important?
- What are transitional care interventions?
- Who is interested in transitional care?
- Who drives successful transitional care?
- How does Rush University Medical Center provide transitional care?
- What is the future of transitional care?

What are transitions of care?

- Movement from one care setting to another
- Transitions of care can be complicated
  - Brief stays forcing abrupt, quick decision-making while in pain, acutely ill, or experiencing difficulty concentrating
  - Sudden self-management role with minimal preparation
  - Culture clash between institution-based medical model and community-based service model
    - Medical needs must be balanced with psychosocial needs
  - Need for coordination and communication between numerous care providers

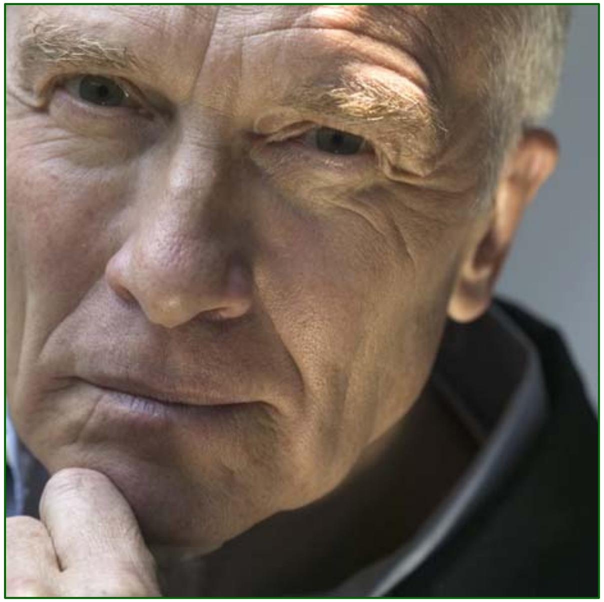


Older Adults and Transitions of Care

- Older adults are particularly vulnerable to poor transition outcomes
  - Multiple medical conditions, medications, and care providers
  - Physical and cognitive limitations
  - Psychosocial issues
    - Social isolation
    - Depression
    - Difficulty coping with change
    - Financial stressors

Older Adults and Transitions of Care

- Poor outcomes for older adults can be dangerous and costly
  - Preventable hospital admissions
  - Preventable emergency department visits
  - Preventable skilled nursing facility placements
  - Caregiver burden or burnout
  - Medication errors
  - Mortality



Systemic Barriers to Successful Transitions

- Complicated U.S. healthcare system
  - Difficult for patients and families to navigate
  - Patients and families confused and overwhelmed by responsibilities after discharge
- Structure reinforced "silos of care"
  - Key players separated and fragmented
    - Service delivery systems
    - Payment systems
    - Information management systems
- Current fee for service system lacks appropriate incentives
  - Systems not motivated to communicate effectively
- Systems are inherently resistant to change

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Why are transitions of care important?

- Readmissions are common and expensive
  - 19% of patients experience an adverse event within 3 weeks of hospital discharge[1]
  - 18% of Medicare beneficiaries are readmitted in 30 days[2]
    - $15 billion total cost for Medicare in 2005
    - According to CBO, 43% of Medicare costs can be attributed to 5% of Medicare's most costly beneficiaries
  - Each older adult readmission costs hospital an average of $7,400[3]

[1] Forster, A.J., Murff, H.J., Peterson, J.F., Gandhi, T.K., and Bates, D.W. (2003). The incidence and severity of adverse events affecting patients after discharge from the hospital. *Annals of Internal Medicine, 138*(3):161–167.
[2] Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008; Friedman, B., & Basu, J. (2004). The rate and cost of hospital readmissions for preventable conditions. Medical Care Research and Review, 61(2), 225.
[3] Friedman, B., & Basu, J. (2004). The rate and cost of hospital readmissions for preventable conditions. Medical Care Research and Review, 61(2), 225.

Why are transitions of care important?

- MedPac and AHRQ found that 75% of readmissions were preventable
  - Medicare could save $12 billion annually
  - 250 bed hospital will lose $2 million a year if rehospitalizations are not prevented
- Major reasons for preventable rehospitalizations
  - Lack of coordination during transition between care settings
  - Some researchers have estimated that 40-50% of hospital readmissions are linked to social problems and lack of community resources[1]

[1] Proctor, E.K, Morrow-Howell, N., Li, H., and Dore, P. (2000). Adequacy of home care and hospital readmission for elderly congestive heart failure patients. *Health & Social Work, 25*(2).

Why are transitions of care important?

- Known deficits that impair a patient's ability to follow through on a discharge plan[1]
  - Cognitive (ex. memory)
  - Mental (ex. depression)
  - Physical (ex. seeing, hearing)
  - Language (ex. non-English speaking, illiterate)
  - Economics
  - Social supports
  - Transportation

- Most common factors that keep a patient from complying with medication regimes are:
  - Cost of the medication
  - Lack of transportation to fill prescriptions
  - Depression

1 Coye, M.J., & Harvath, B. (2008). 30-day readmissions: Understanding the problems. HealthTech. Presentation.

What are transitional care interventions?

- Programs to assist patients as they move from one system of care to another
  - Ensure needs are met in the new care setting
  - Ensure vital information handed off successfully
  - Ensure patient is aware of rights and responsibilities
  - Ensure care providers communicate effectively in the interest of patient's well-being

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Who is interested in transitional care?

- The Joint Commission (TJC, formerly JCAHO)
- Centers for Medicare and Medicaid Services (CMS)
- National Quality Forum (NQF)

Complies to three JCAHO Accreditation Standards and four National Patient Safety Goals for 2009

JCAHO Standard or Goal	Elements of Performance
Post-discharge needs *(PC.04.01.01)*	Addresses post-discharge needs in conjunction with family and caregivers; performed by social worker/qualified staff; reassesses care plan for continuing care needs and appropriateness of initial plan
Discharge plan reassessment *(PC.04.01.03)*	Ensures discharge plans meet the needs of patient; reassesses change in patient needs after initial discharge assessment
Discharge education *(PC.04.01.05)*	Reinforces and follows up on information, resources, and instruction given by inpatient discharge planners
Hand-off communication *(NPSG.02.05.01)*	Improves accuracy of hand-off to home health care or other post-acute services; encourages questions and feedback from patient; verifies information received by patient and post-acute service providers
Anticoagulation therapy *(NPSG.03.05.01)*	Individualizes care provided to patient receiving anticoagulation therapy; ensures patients and families receive education regarding anticoagulation therapy; monitors compliance with therapy regime
Medication reconciliation *(NPSG.08.01.01)*	Verifies patient received and understands medication list; triggers further intervention for medication discrepancies, noncompliance, or management issues
Patient involvement in care *(NPSG.13.01.01)*	Allows and encourages patients and families to report concerns related to care, treatment, and services

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Centers for Medicare and Medicaid Services

- Transitional care interventions adhere to CMS's Post-Acute Care Reform Plan (2006)
  - Increase consumer choice and control
  - Provide a seamless continuum of care through improved coordination, including better management of transitions between settings
- Outcomes of transitional care reflected in quality standards reported to CMS and accessible by the public
  - Capable of improving patients' discharge experience
  - Satisfaction with discharge experience reported in HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)
  - Published on hospitalcompare.hhs.gov

Centers for Medicare and Medicaid Services Policy Council (2006). *Post-acute Care Reform Plan.* Policy Council document.

National Quality Forum

- Transitions of care are a top goal of the National Priorities Partnership convened by the National Quality Forum
  - National Priorities and Goals, November 2008
    - “Engage patients and families in managing their health and making decisions about their care”
      - Feedback mechanism for improving quality of care
      - Assistance navigating care system
      - Access to information and assistance in making informed decisions about care
    - “Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care”
      - Guidance to prevent 30-day readmissions
      - Encouragement to promote communication among patients and caregivers

Who drives successful transitional care?

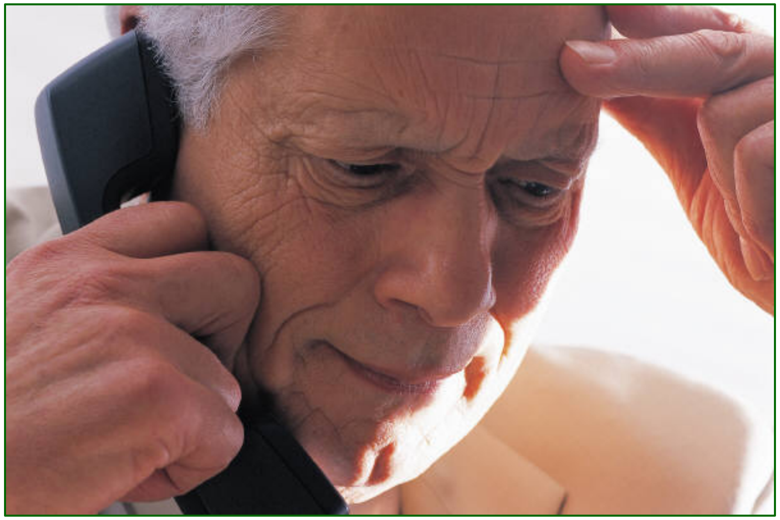
- Social work's potential and possibilities
  - Master's prepared social workers with community, healthcare, and gerontology experience
    - Advanced psychosocial assessment skills
    - Able to perform sophisticated assessments and interventions
- Focusing on psychosocial factors that contribute to readmission and adverse events
  - Through assessment, linkage to community resources, and effective partnerships
  - Assessment and intervention focusing on patients, their caregivers, and their families

Social Workers and Transitional Care

- Advantages of a social work model of care, according to Brown[1]
  - Training in assessment of patients' psychosocial needs and family dynamics
  - Experience addressing patients' financial needs
  - Greater availability and reduced costs compared to nurse care coordinators makes social work models efficient and cost-effective
  - Bridge health care and community based care model, not deficit model
- Successful social work transitional care models take a holistic view of the patient [1]
  - Social aspects
  - Medical aspects
  - Communications
  - Behavioral aspects

[1] Brown, R. (in print). The Promise and challenges of improving care for Medicare beneficiaries with chronic illnesses.

How does Rush provide transitional care?



- Rush Enhanced Discharge Planning Program
  - Short-term telephonic social work care coordination
  - For older adults at risk for adverse events after an inpatient hospitalization

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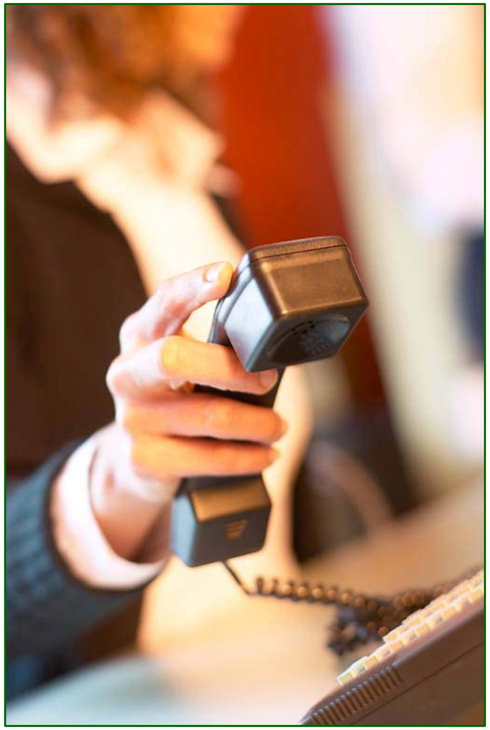
How does Rush provide transitional care?



- Follows a basic protocol
  - Biopsychosocial framework to determine patient needs
  - Evaluation of patients' expectations and ability to follow the discharge plan
  - Intervention around issues arising as a result of a complicated transition
- Created in response to a need seen by hospital staff

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What are the goals of Rush EDPP?

- Promote patient safety and quality of life
- Improve health outcomes and the patient experience
- Reduce unnecessary healthcare costs for older adults
  - Target major causes of preventable readmissions
- Create a bridge between the hospital and the community
  - Ensure the direction provided by the medical team is not lost
  - Provide referrals to important community services for older adults

What is the vision of Rush EDPP?

- Develop discharge standards of care
  - Identify gaps in service for policy and systems change
  - Encourage community involvement and support for older adults at risk for rehospitalization
  - Determine issues requiring the most assistance after discharge

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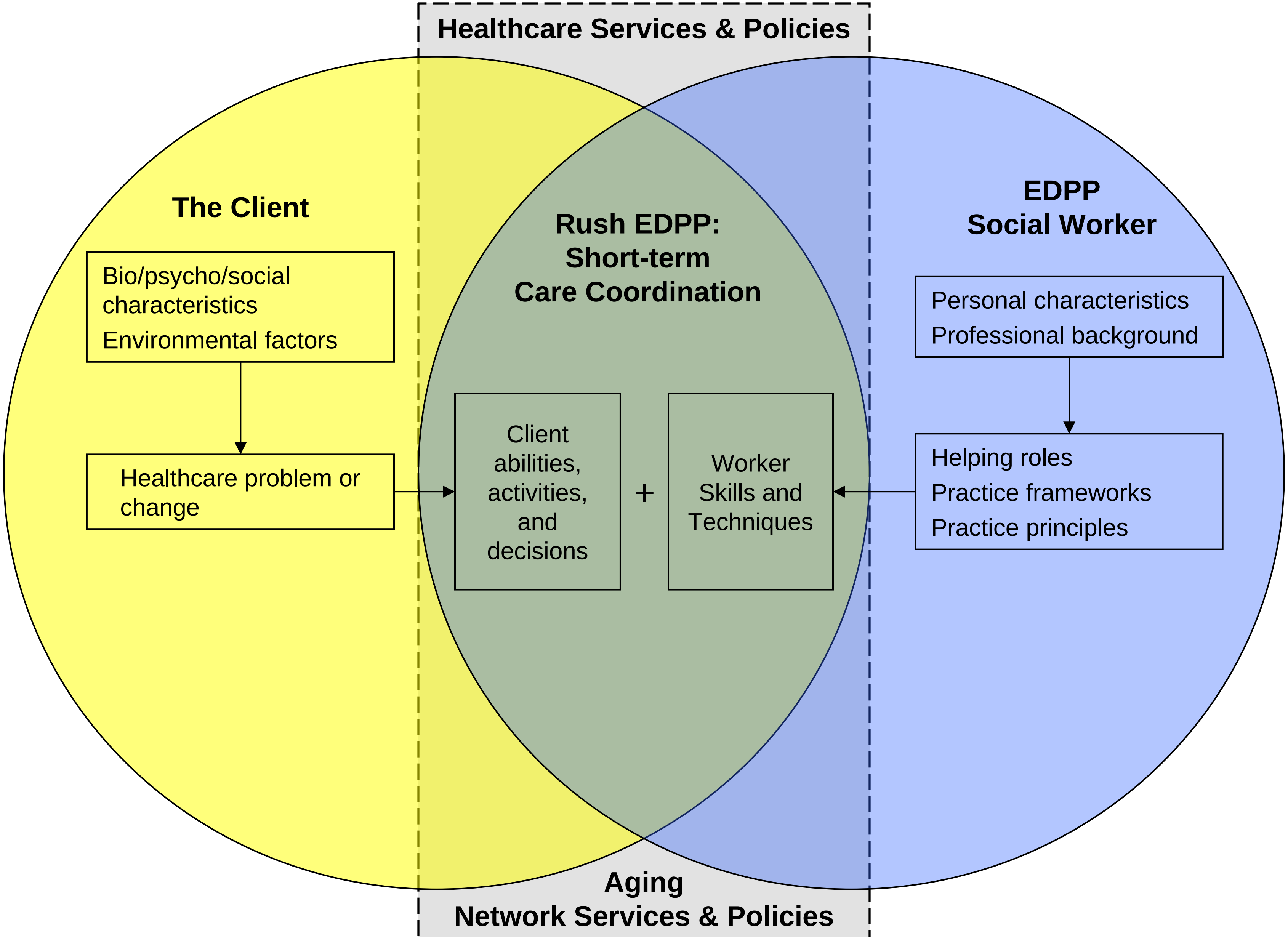
Rush EDPP Systems Framework



Adapted from Sheafer, B.W., Harejsi, C.R., and Horejsi, G.A. (2000). *Techniques and Guidelines for Social Work Practice.* Fifth ed. New Jersey: Allyn and Bacon.

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Rush EDPP Process

1. Eligible patients electronically referred through Rush's electronic medical record
2. EDPP social worker reviews clinical notes and discharge plan
3. EDPP social worker calls the patient or caregiver within two working days of discharge for assessment
4. EDPP social worker responds to needs identified in assessment
5. EDPP social worker documents interaction and contacts service providers and/or provides telephone counseling for needs identified
6. EDPP social worker follows up with the patient or caregiver until the issues are resolved

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Rush EDPP Referral Criteria

Must meet all the following criteria:
Aged 65+ Speak English Discharged to home or home with assistance Multiple medications prescribed (polypharmacy of 7+ medications) Without a primary diagnosis of transplant
Must also meet one additional criteria:
Lives alone Without a source of emotional support Without a support system for care in place Discharged with a service referral (ex. home health care, durable medical equipment, transportation, Department on Aging, etc.) High falls risk Inpatient hospitalization in past 12 months Identified in-depth psychosocial need High risk medication prescribed (ex. anticoagulation, antidepressant, etc.)

Rush EDPP Preliminary Findings

- Collaboration between Rush Older Adult Programs and Case Management Department
- Performed between March 2007 and May 2009
- Data collected and analyzed for trends
  - 1248 patients in the program’s first two years
    - 4350 intervention phone calls
    - 3.49 average calls per case
    - 4.5 day average duration of intervention

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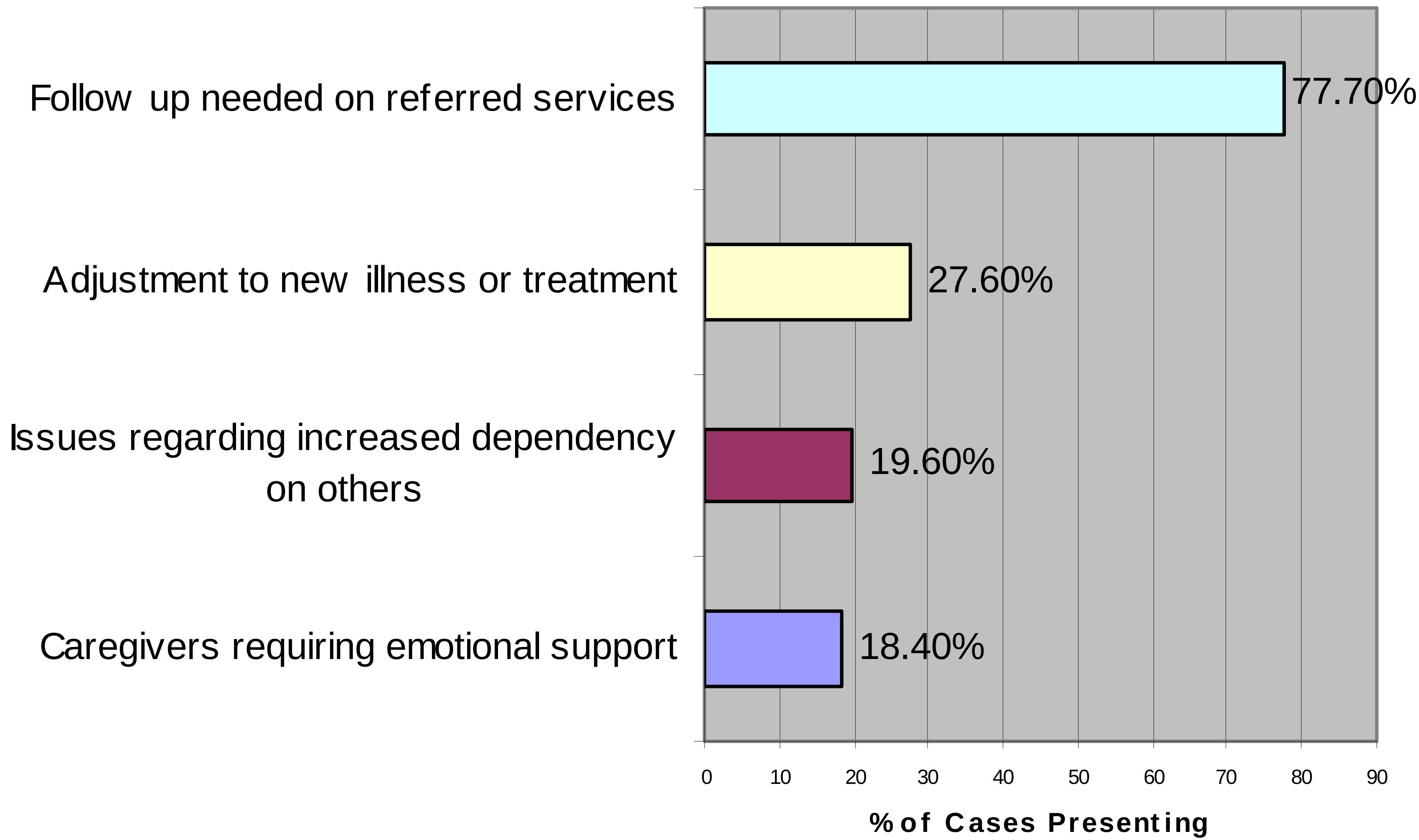
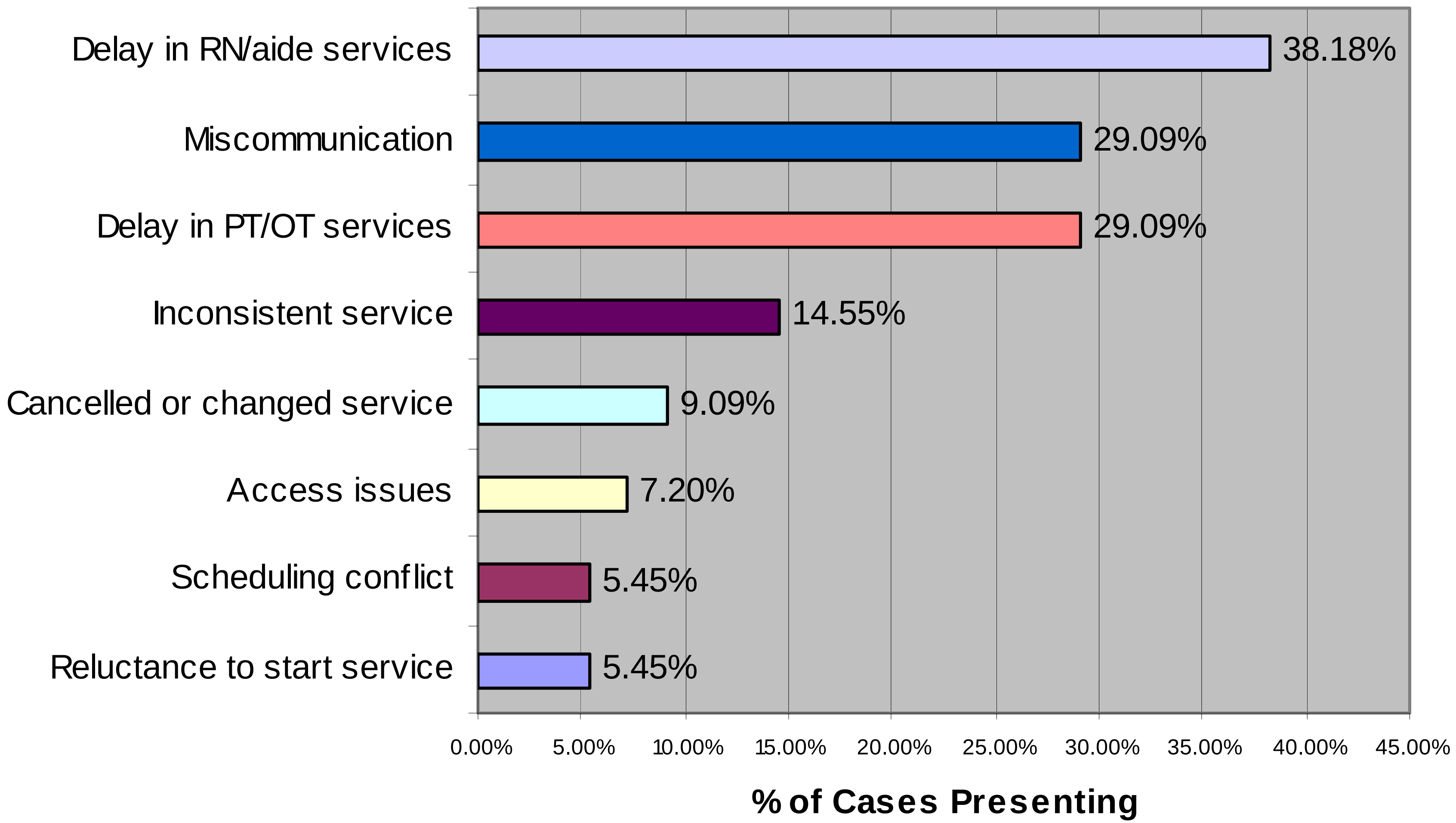
Most Common Problem Areas



Problems with Home Health Care: An Example

- Based on a sample of 55 EDPP patients requiring assistance with home health care services:



Rush EDPP Testimonials

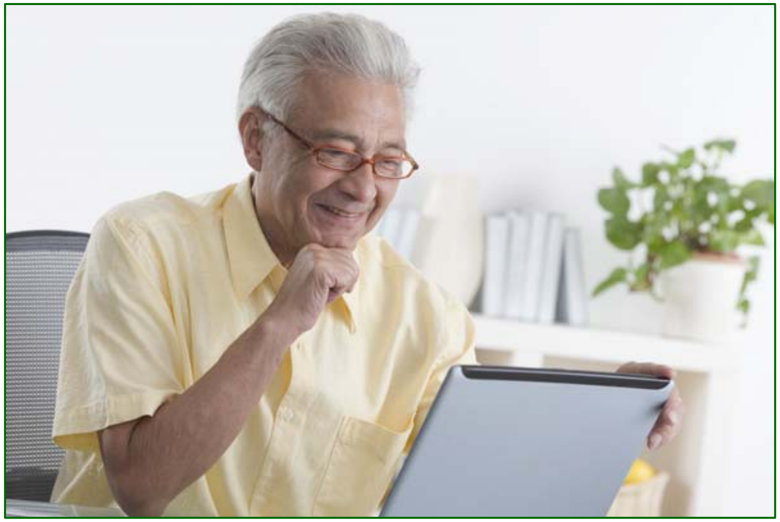
"I had a wonderful experience with EDPP. I was impressed by the calls from the social worker, and in such a short time since I returned home."

"The social worker's perseverance in locating transportation resources was invaluable. I appreciate that we're able to continue collaborating to meet my needs."

"I may need more resources, but now I know where to call. There's so much out there I didn't know, but I'm now aware thanks to the social worker…I'm so happy with the quick attention I received after I left the hospital."

What is the future of transitional care?

- Improved information hand-off with MyChart
  - Improved access to information and ability to manage personal healthcare
  - Secure web-based tool connecting patients to their personal health information
- Medicare reimbursement for transitional care services
  - A transitional benefit
  - Bundling payment
- Current legislative efforts
  - Community-Based Transitional Care Suppliers (CTSC)



Thanks to…

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Conclusion

"Nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicines as the only approach to health care."

--George Engel, 1977