Improving Care Transitions: Creating Your Evidence-Based Approach

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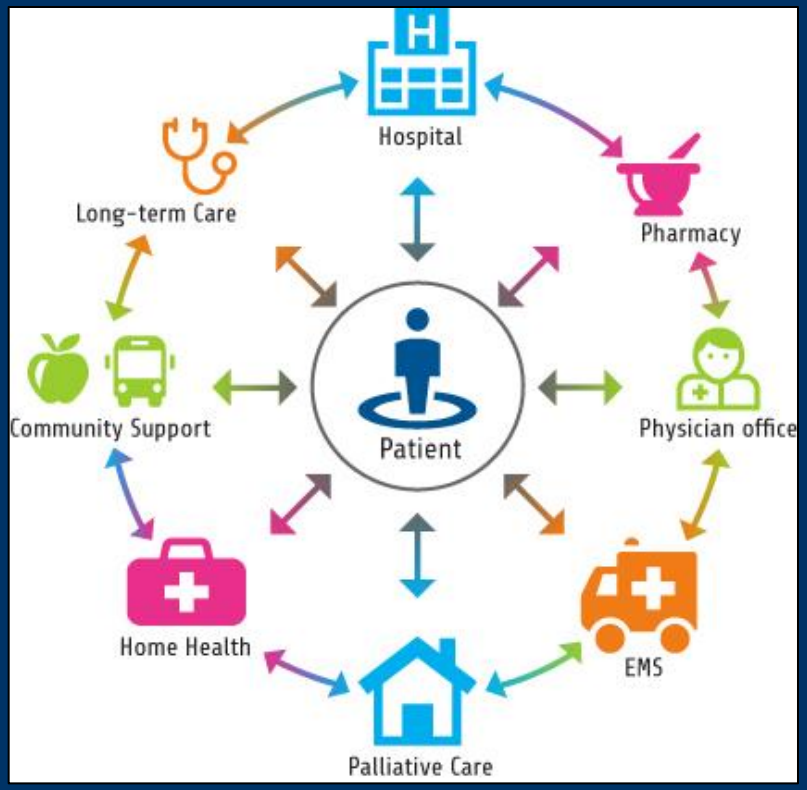
Outline

- Readmissions vs Care Transitions
- Quality Improvement Drivers
- Connecting the Best Case Models
- Our Work in Progress
- Current Understanding and Vision



Readmission Basics

- In 2011: 3.3 million 30 day readmissions among adults in US

Medicare national average	18%
COPD	17-25%
Myocardial Infarction	20%
Pneumonia	18%
Heart Failure	25%

- Medicare cost: $15 to $17 billion per year

- SFGH all cause readmission rate 2013-2014: 12.6%

Readmissions: A Complicated Metric

- Definition: is 30 days an appropriate timeframe?
- Data: no comprehensive source, easier to get subgroup data
- Universal access leads to increased utilization (esp. among lower SES)
- Risk adjustment: similar %'s between systems if control for patient characteristics
- Preventable? 23-30% readmissions appear to be avoidable
- No national consensus on preventability or approach

Can readmissions be prevented?

Goals:

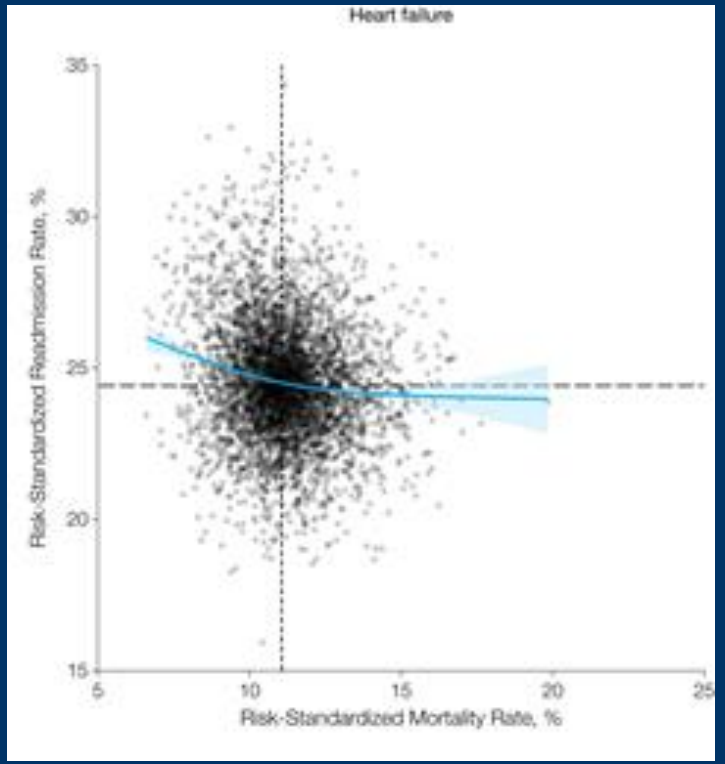
- Identify patients at high risk of re-hospitalization and target specific interventions to mitigate potential adverse events
- Reduce 30 day readmission rates
- Improve patient satisfaction scores and H-CAHPS scores related to discharge
- Improve flow of information between hospital and outpatient physicians and providers
- Improve communication between providers and patients
- Optimize discharge processes

Funding: >$2 million, via institutional, grant, federal and insurance-based funding

Results to date: Decreased readmissions by 13% (Absolute reduction = 2%: 14.7% to 12.7%)

Should readmissions be a focus?

- ? Effect on morbidity & mortality
  - Eg. COPD readmission = independent mortality predictor (OR 1.85)
  - Other studies (eg. Krumholz, *JAMA* 2013) have found little to no correlation
- Lost income & time in community
  - Likely a negative psychosocial impact
- Hospital acquired risk
  - ~10% risk of HAC/unnecessary inpatient day



Krumholz *JAMA* 2013

But wait…Hot off the presses!!!

J Gen Intern Med. 2015 Jul;30(7):907-15. doi: 10.1007/s11606-015-3185-x. Epub 2015 Jan 24.

A Patient Navigator Intervention to Reduce Hospital Readmissions among High-Risk Safety-Net Patients: A Randomized Controlled Trial.

CONCLUSIONS: A patient navigator intervention among high risk, safety-net patients decreased readmission among older patients while increasing readmissions among younger patients. Care transition strategies should be evaluated among diverse populations, and younger high risk patients may require novel strategies.

Ann Fam Med. 2015 Mar;13(2):115-22. doi: 10.1370/afm.1753.

Timeliness of outpatient follow-up: an evidence-based approach for planning after hospital discharge.

Jackson C[1], Shahsahebi M[2], Wedlake T[1], DuBard CA[3].

RESULTS: The final study sample included 44,473 Medicaid recipients with 65,085 qualifying discharges. The benefit of early follow-up varied according to baseline readmission risk. For example, follow-up within 14 days after discharge was associated with 1.5%-point reduction in readmissions in the lowest risk strata (P <.001) and a 19.1%-point reduction in the highest risk strata (P <.001). Follow-up within 7 days was associated with meaningful reductions in readmission risk for patients with multiple chronic conditions and a greater than 20% baseline risk of readmission, a group that represented 24% of discharged patients.

Readmissions as an ***accountability measure***:

Patient and health system-centered benefit can be achieved through improved transitions of care.

Adapted from Health Policy blog of Ashish Jha MD, Harvard School of Public Health

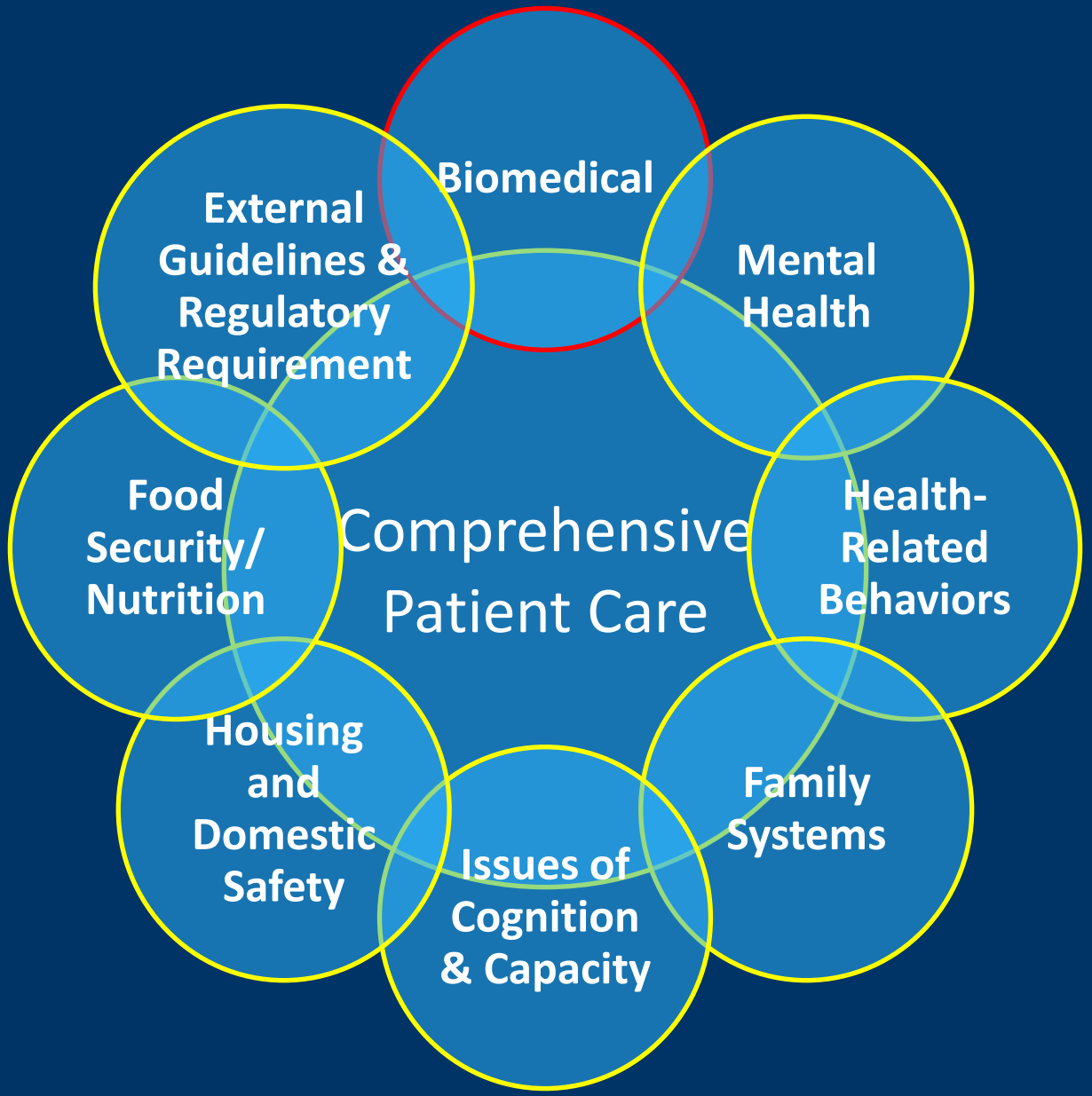
Drivers of Care Transitions QI

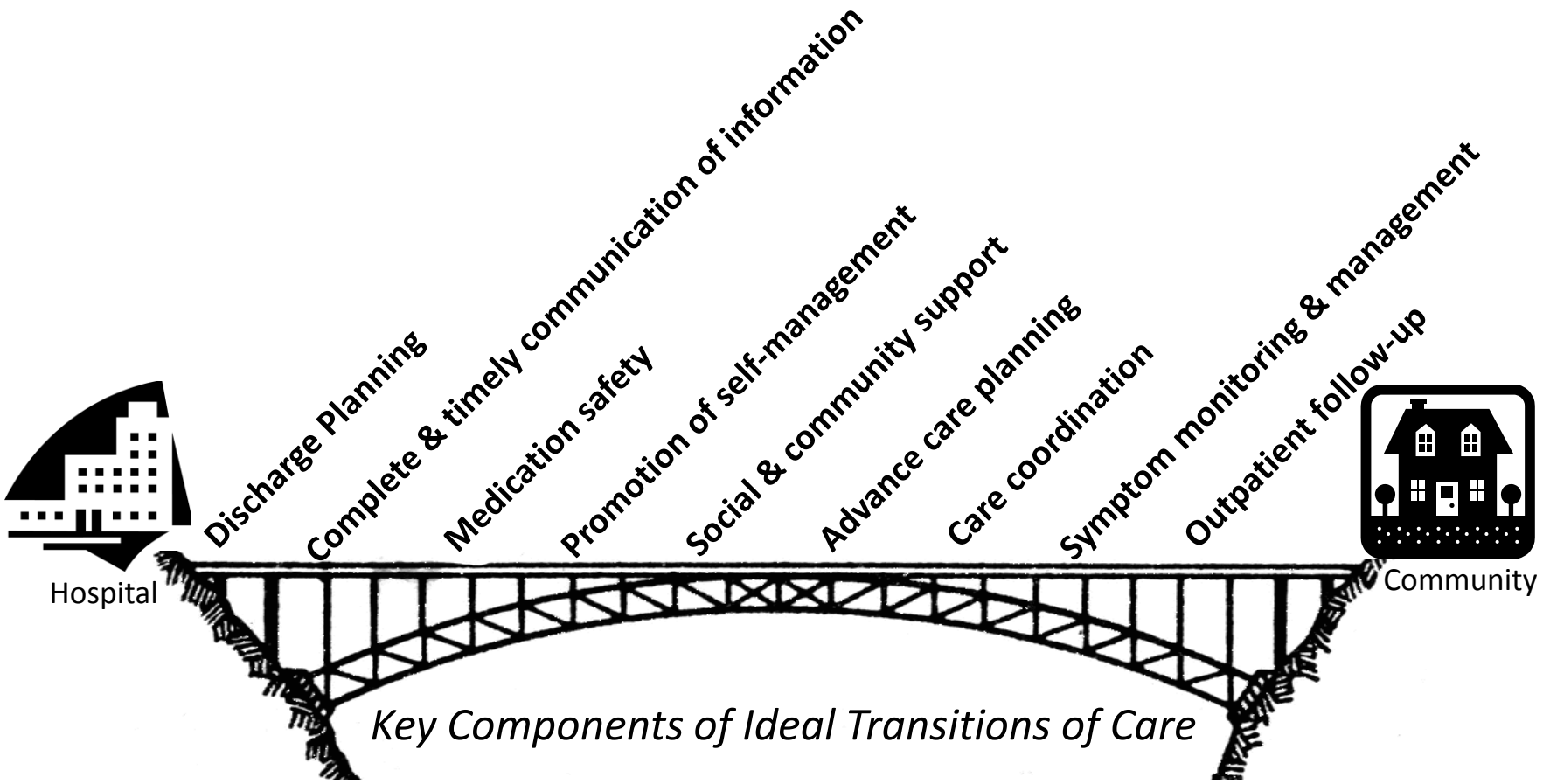
- National
  - CMS penalty up to 3% of yearly hospital reimbursement
  - HCAHPS Patient Satisfaction
- Community
  - SFHP P4P bonus to PCMH's
- Hospital/Individual
  - Optimal, patient-centered care

Models for Improving Care Transitions

- Care Transitions Intervention
- Transitional Care Model
- Project RED (Re-Engineered Discharge)
- Project BOOST (Better Outcomes for Older Adults through Safe Transitions)
- Transforming Care at the Bedside (TCAB)
- STAAR (State-Action on Avoidable Rehospitalizations)
- INTERACT II (Interventions to Reduce Acute Care Transfers) – SNF based

From *Reducing Readmissions*, produced by US DHHS, Partnership for Patients

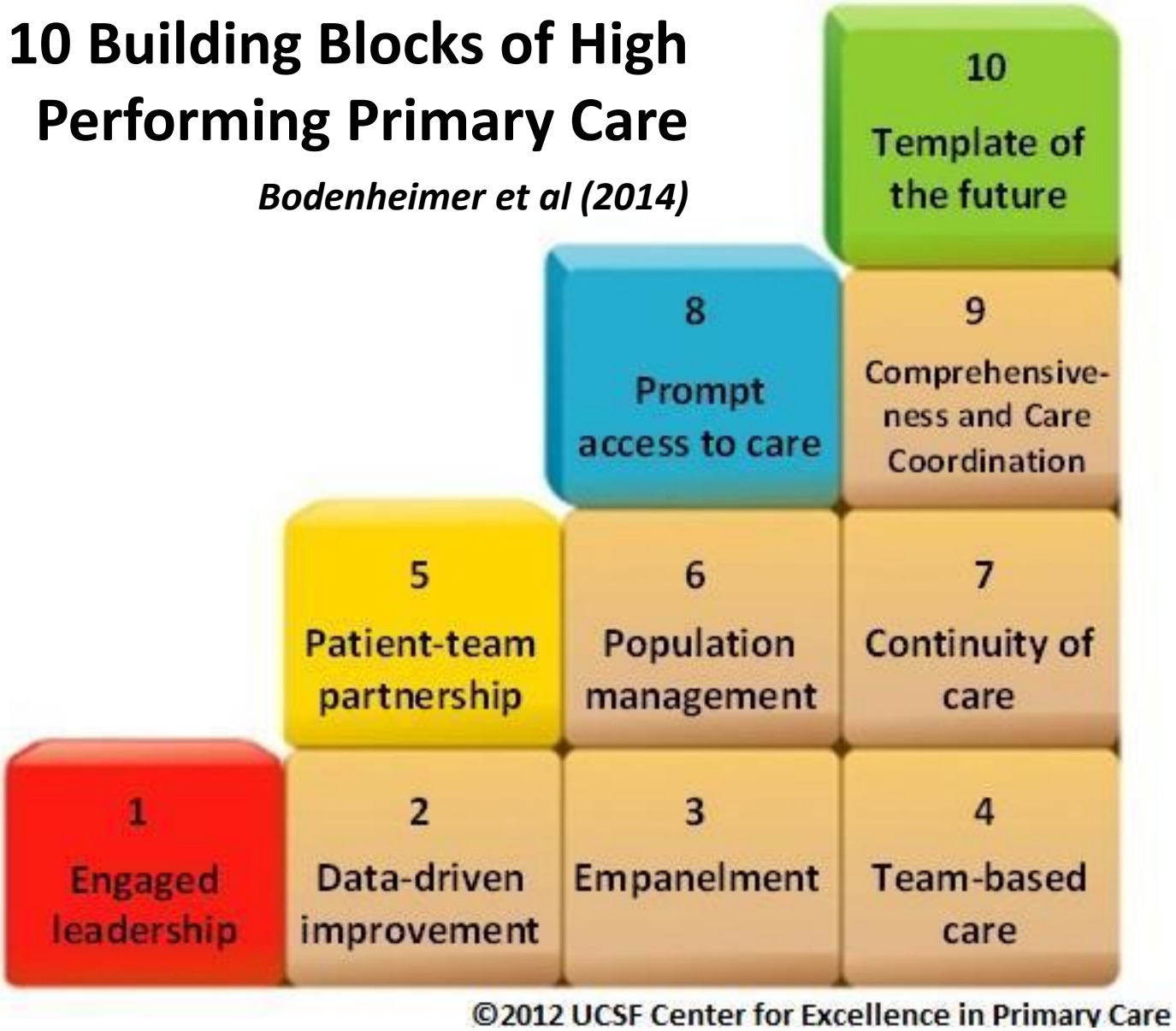

Biomedical
External Guidelines & Regulatory Requirement
Mental Health
Food Security/ Nutrition
Comprehensive Patient Care
Health-Related Behaviors
Housing and Domestic Safety
Issues of Cognition & Capacity
Family Systems

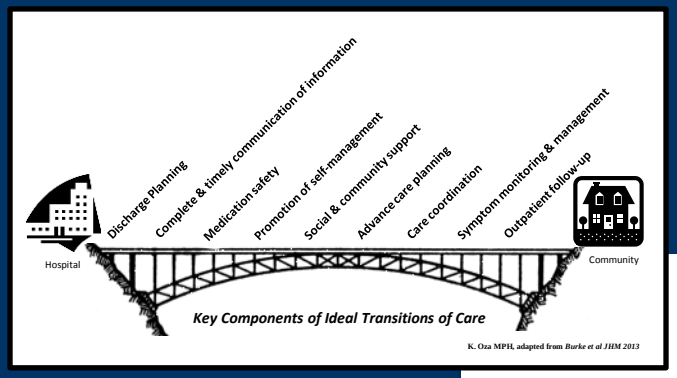


K. Oza MPH, adapted from *Burke et al JHM 2013*

10 Building Blocks of High Performing Primary Care

Bodenheimer et al (2014)





Outpatient follow-up

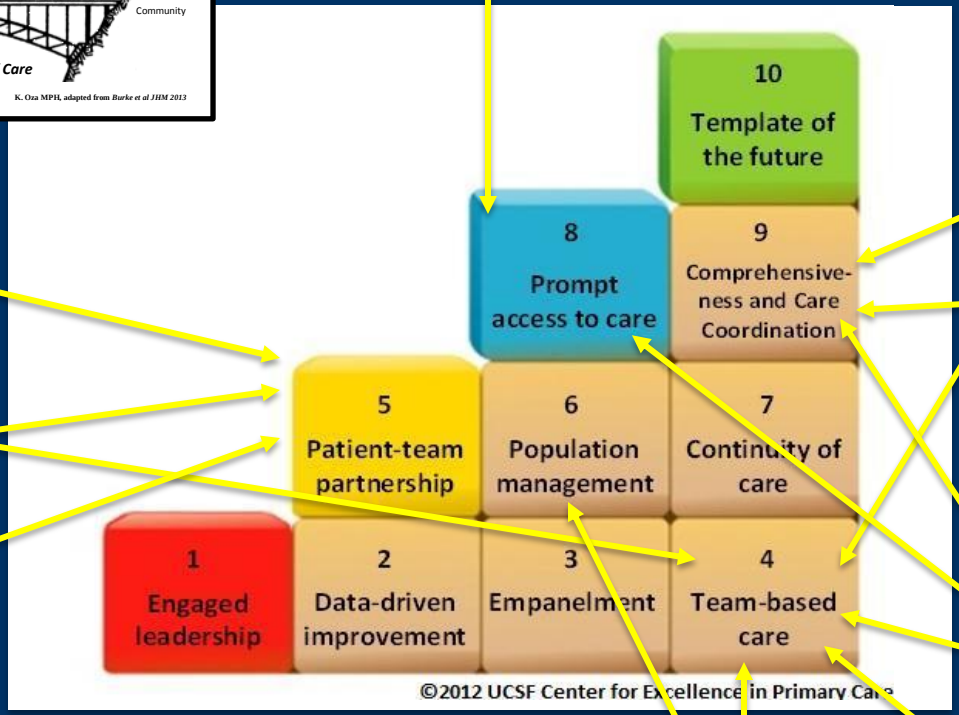
Care coordination

Promotion of self-management

Advance care planning

Medication safety

Symptom monitoring & management



Discharge Planning

Social & community support

Complete & timely communication of information

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San Francisco Health Network

- San Francisco's only complete care system
  - Primary care for all ages
  - Dentistry
  - Emergency & trauma treatment
  - Medical & surgical specialties
  - Diagnostic testing
  - Skilled nursing & rehabilitation
  - Behavioral health

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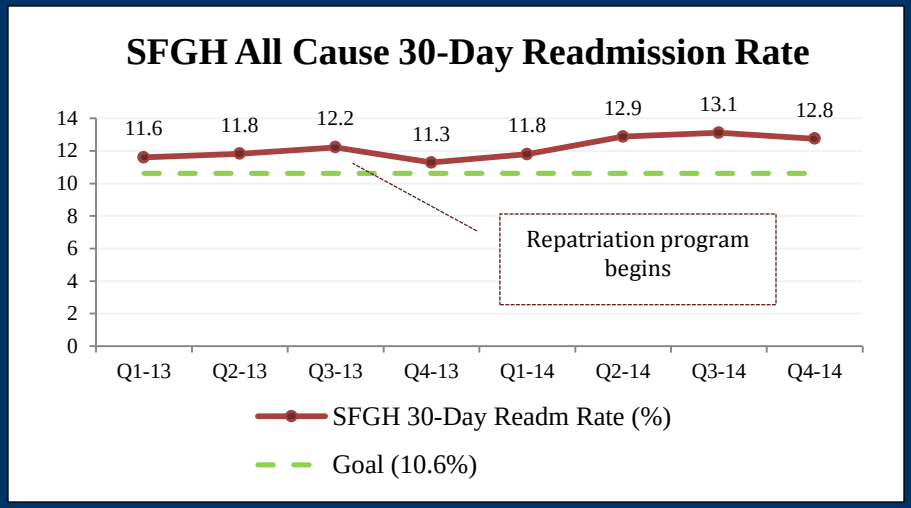
San Francisco General Hospital and Trauma Center

- San Francisco's public hospital
  - Devoted to care of the city's most vulnerable residents
  - Sole provider of trauma and psychiatric emergency services in SF
- Serves over 100,000 patients per year
- 16,000+ admissions/year
  - 20% of the city's inpatient care
- Average LOS adult inpatients is 5 days

Readmissions at SFGH



Top 5 Discharge APR-DRG	SFGH 30-Day Readmit Rate (%, *n*)	AEH Public Hospitals 30-Day Readmit Rate
COPD*	**25.8%** (78)	20.8%
Heart Failure*	**24.8%** (103)	20.0%
Renal Failure	**24.7%** (44)	19.1%
Sepsis	**13.6%** (67)	16.6%
Cellulitis	11.3% (55)	10.2%

- 64% of readmitted patients have **Medi-Cal coverage**.
- 60% of readmitted patients have **mental illness**.
- 28% of readmitted patients have a **substance use** diagnosis.
- 16% of readmitted patients are **homeless**.
- 28% of readmitted patients are **not empaneled with a PCP**.
- 33% of readmissions occur **within 7 days of discharge**.
- **326 individuals** accounted for 1734 hospitalizations & 764 readmissions (**47% of all readmits**).

Data analysis by K. Oza MPH (SFGH Care Transitions Taskforce)

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Team-Based Complex Care Planning

FMIS MULTIDISCIPLINARY ROUNDS FORMAT
Monday – Friday 8:30AM – 3B Conference Room

Goal 1-2 minutes/patient

Begin with:

Name, age & hospital unit
Primary diagnosis & inpatient treatment needs
Expected dc date and location – try to anticipate DC 1-2 days in advance

eg. *"Mr. John Jones is a 65 year old man on 5C with community acquired pneumonia. He is receiving IV antibiotics and we expect d/c home in 3 days."*

Then note the following as needed:

For *SW*

1) ***Housing instability?***
2) ***Non-home discharge location?*** (SNF, respite, board & care)
3) ***Home care needs?*** (RN, skilled therapy – PT/OT, social work)
4) ***Substance use disorder?***
5) ***Family systems issues?*** (neglect, abandonment, violence)
6) ***Other general social concerns?***

For *UM*

1) ***Need for placement?***
2) ***Referral to Care Transitions Nursing?***
   - Admit for HF, COPD, DM w complications, PNA, or ACS/MI *AND* ≥55yo or readmit in past 30 days

For *skilled therapists* (PT/OT/ST)

1) ***Current mobility?*** (eg. bedrest, NWB, assistive devices)
2) ***Baseline mobility?*** (eg. fully independent, ADL dependent in community, long term SNF due to mobility impairment)
3) ***Cognitive deficit from baseline?***
4) ***ADL deficit from baseline?***
5) ***Speech and/or swallowing deficits from baseline?***

Morning multidisciplinary rounds on the UCSF Family Medicine Inpatient Service.

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	Resource	Who qualifies	What it is	Limitations
Homeless	**Medical Respite**	Homeless with time-limited active medical problem or chronic problem needing stabilization.	"Home health for people who don't have a home"-shared room for women, dorm for men, RNs, NPs and SW's on site, meals, transportation. Can come and go, can stay during the day.	Similar in feel to shelter. No place to store belongings. Patients free to come and go. Patients must be independent in ADL's & continent. Not appropriate for patients whose primary problem is substance use
	Shelter	Anyone	Shared room with cots and/or bunk beds, some meals.	Must wait for bed, must leave during the day unless letter given, no medical services.
	Residential Substance Rehab	Active substance addiction.	Shared room, meals, medication supervision, substance treatment.	SW must call on day of discharge to assess bed availability. Usually must be willing to participate in chores.
	Medical Detox (eg. Joe Healy)	Actively receiving medication for alcohol withdrawal, stable enough to be outpatient.	Medically supervised detoxification program (with substance treatment services.)	Usually outside of eligibility window by the time patient is stable.
	Acute Diversion Unit	Patients with active psychiatric disorder-referred by psych consult.	Short term intensive psych treatment program in supervised environment.	Usually limited to subset of high-risk psychiatric patients. Typically not staffed for medical complexity.
Housed	**SRO (Single-Room Occupancy)**	Anyone who can pay $500-800/month	One room efficiency, +/- bathroom, may be temporary or permanent., often 28 day limit	No on-site services, may lack easy bathroom access, usually cannot arrange on hospital discharge unless self-pay.
	DAH (Direct Access to Housing) Supportive Housing	Homeless, those with active mental health or substance use, medical problems prioritized.	DPH-run SROs that have wraparound services on site, may include nursing, SW, CM. Permanent housing.	Long wait list (currently closed), usually not available on d/c from hospital. No 24 hour support. Uses 30% of income
	Home Health	Homebound or limited mobility patients (exact criteria vary by insurance and company).	Home nursing (labs, med rec, wound care, BP checks), PT, OT, or social work.	Must have responsible provider (usually PCP), very functional patients may not qualify, need stable housing.
	In-home Support Services (IHSS)	>65, disabled, or blind and must have Medi-Cal. Many patients with mental health/substance dx qualify (hours vary).	Lay person (selected by patient or by agency) who provides assistance with ADLs & IADL's (cooking, cleaning, shopping, laundry, etc.) or "protective supervision."	No skilled medical care, usually maxes out at 7h/day, may have share of cost.

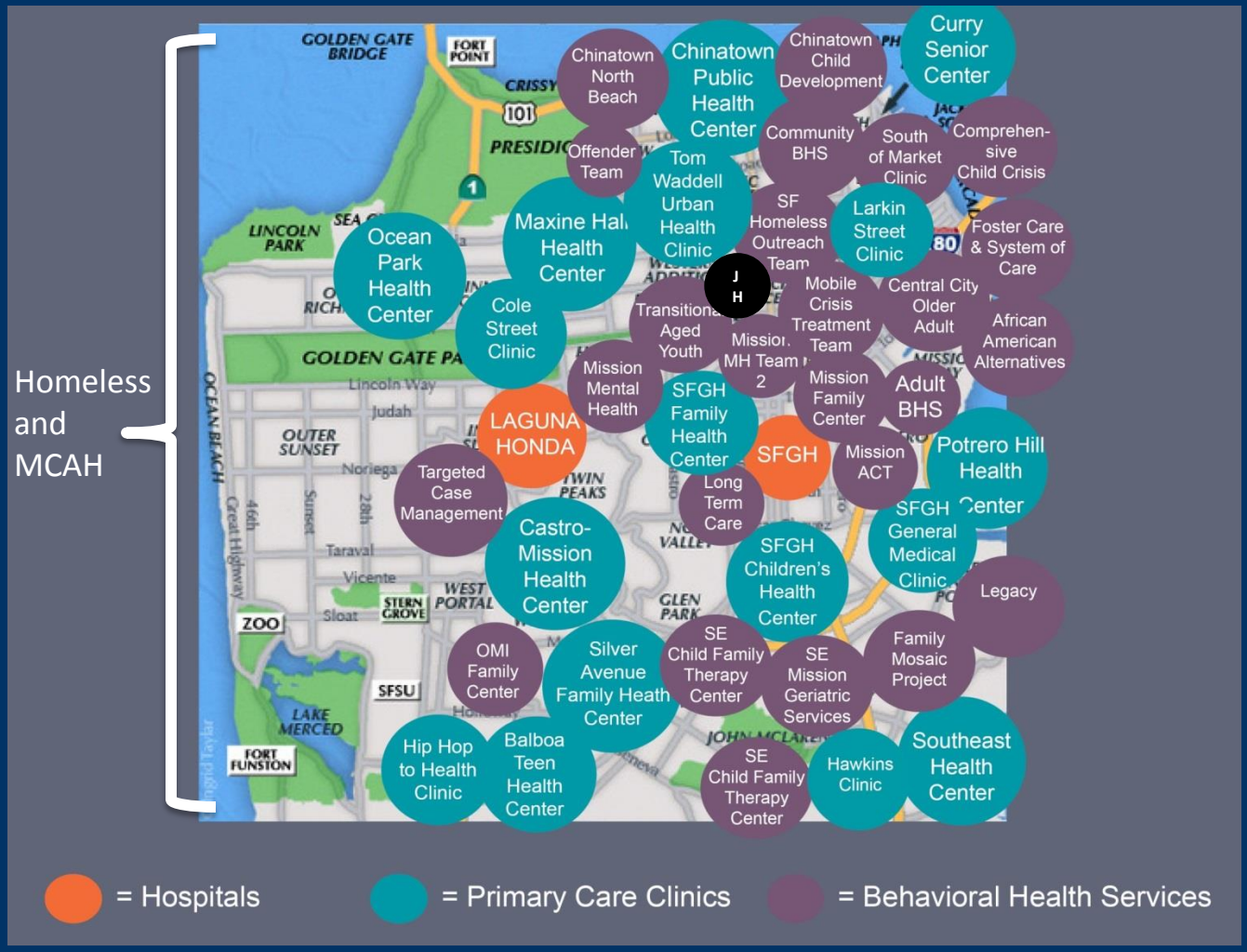
Core (Provider/RN) Interdisciplinary Round Questions
1) Plan for the day.
2) Estimated Discharge Date
3) Anticipated Disposition.
4) Needs for Discharge

Core (Provider/Patient) Interdisciplinary Round Questions
1) You are here for ____.
2) We are doing _____ to treat your diagnosis.
3) We expect that you will be able to get out of the hospital_____.
4) What can we do for you today?

Brief, structured format for MD:nursing huddle and provider:patient discussion.

Cross-System Communication and Care Coordination

San Francisco Health Network



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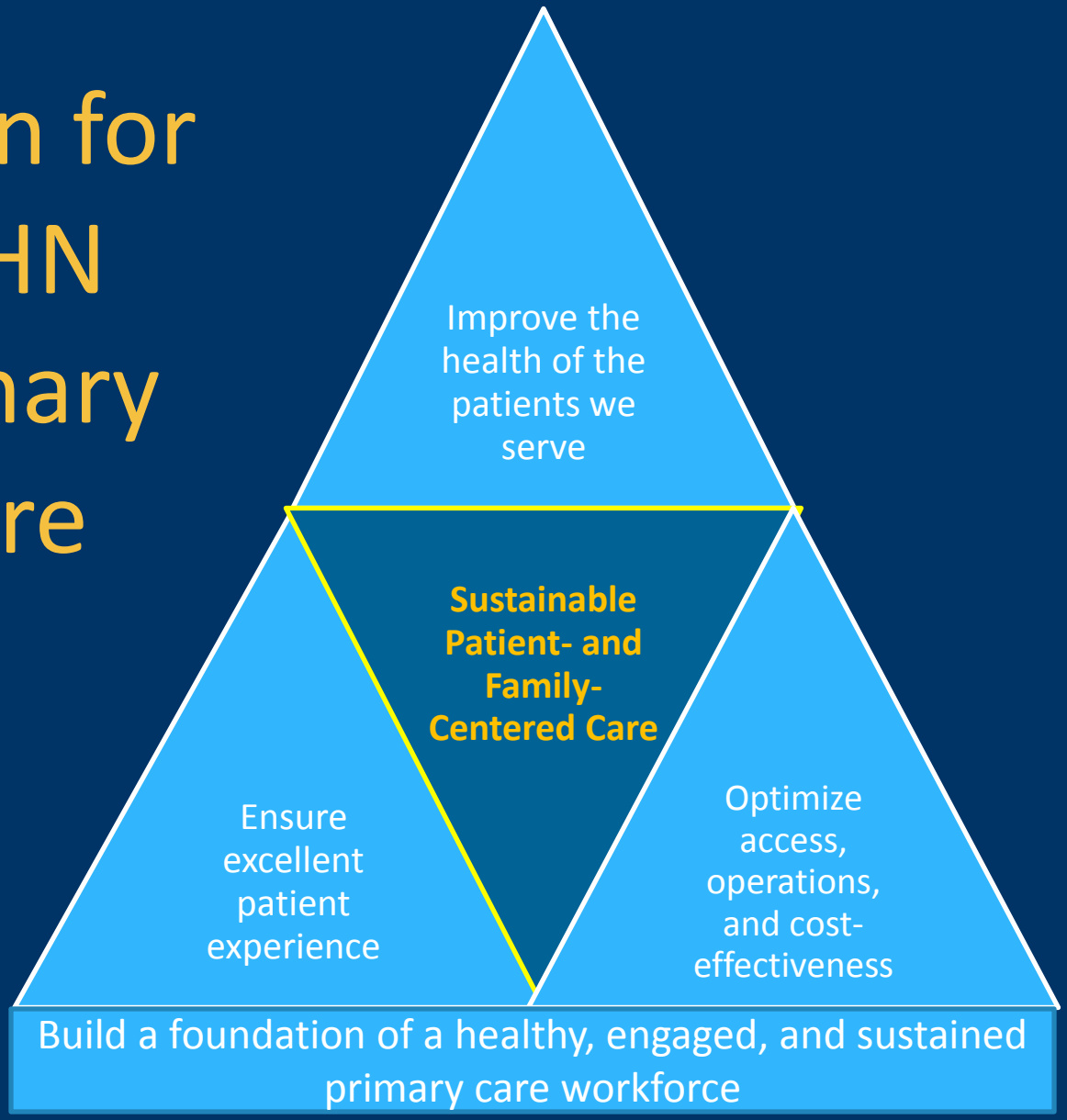
Pharmacy Interventions and Medication Reconciliation

Vision for SFHN Primary Care



Improving Post-discharge care

- Standardization of post-discharge visits
  - Timing
  - Team based care
- Metrics for each health center
  - Monthly rates of follow up within 7 days of d/c
  - Readmission rates
- Services for high risk patients, such as case management, home health services, supportive housing, Bridge clinic, Respite, caregiver support

UCSF Family Medicine Inpatient Service

San Francisco General Hospital
Building 5 (Main Hospital) Office 4F53
Office Phone 415-206-8651 / Fax 415-206-6135

HOSPITAL ADMISSION NOTICE

Dear **Dr. Chase**,

Your patient **Jane Smith MRN 01234567** was admitted for **COPD exacerbation.**

At admission, we found that **she had run out of her inhalers and did not have any refills. She has been smoking cocaine every 2-3 days. She had hypercapnic respiratory failure in the SFGH ED and required urgent BiPAP.** We plan to **treat with steroids, bronchodilators, evaluate for pneumonia and provide cocaine cessation resources.**

We estimate that the patient will be discharged on: ***5/1/2015***

Primary care follow-up –please reply with date and time for a visit within **7 days** after the expected discharge date. Primary care clinic pharmacist/medication reconciliation visit should be scheduled for **medication literacy teaching.**

Specialty clinic follow-up –- please schedule appointment after the expected discharge date and reply with date and time:

1. **Better breathing class** Indication for referral: **COPD**
2. **COPD NP Clinic** Indication for referral: **COPD**

To communicate with us, please (1) reply to this email ***and/or*** (2) page (before 7:30AM or after noon) using the table below.

Sincerely,
The FMIS team

Bundled, email-based care transitions communication.

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Post-discharge phone calls

- Call within 72 hrs of discharge
- HW, MA, or RN
- Scripted
  - Appts
  - Meds
  - Red flags
  - Primary care access

Complex Care Management

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Patient Education and Supported Self-Management

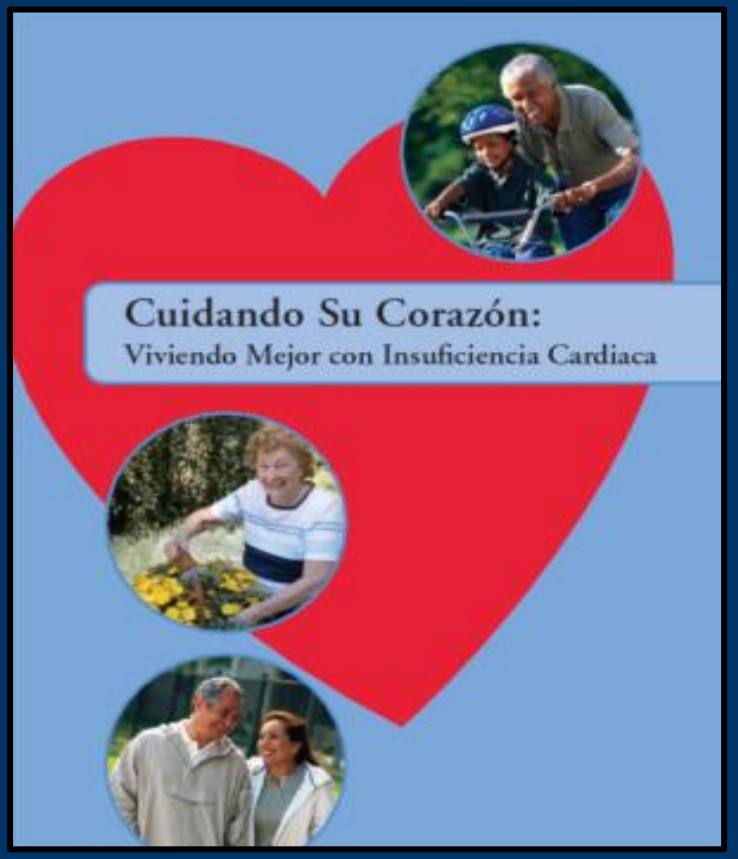
SFGH Transitional Care Nursing Program

Catheryn Williams
RN

Tip Tam
RN

Richard Santana
RN

Tami Lenhoff
PharmD



Spanish language self-management guide produced by the UCSF Center for Vulnerable Populations, 2007

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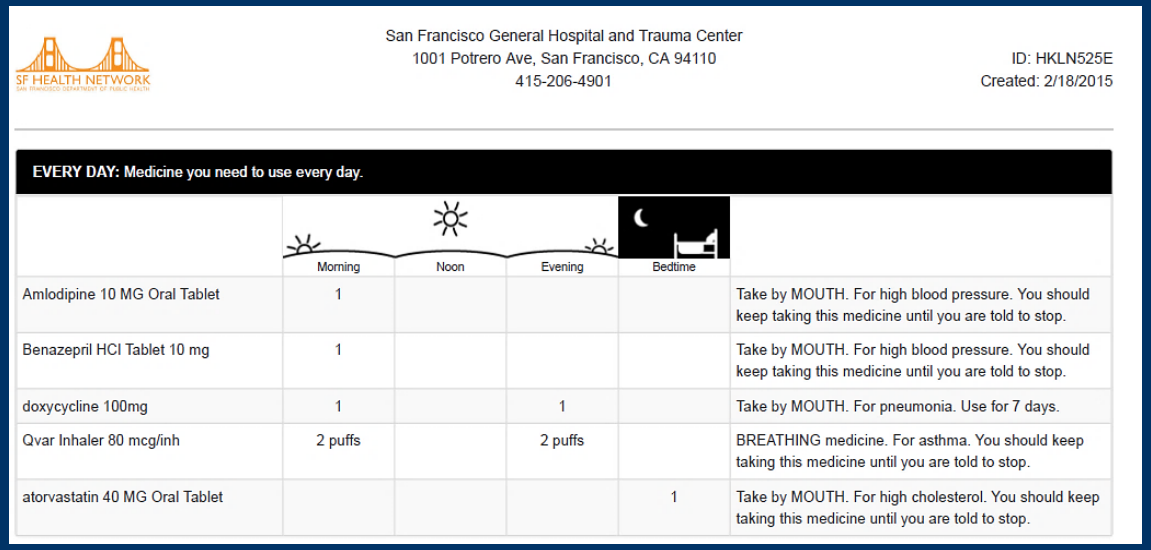
Medication Instructions with *Polyglot's Meducation™*



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1001 Potrero Ave, San Francisco, CA 94110
415-206-4901

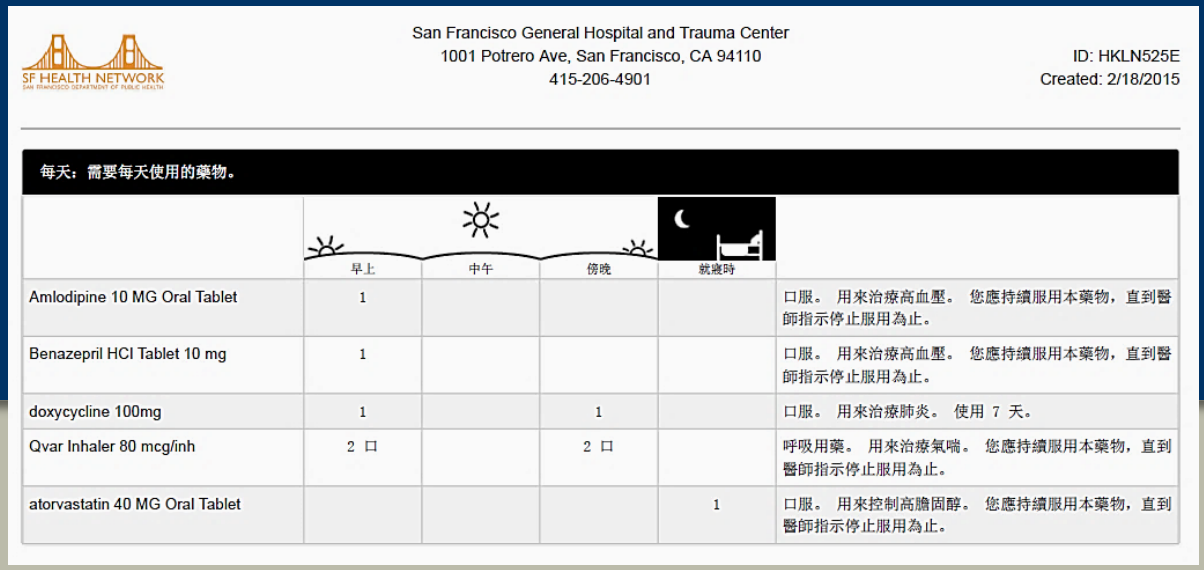
ID: HKLN525E
Created: 2/18/2015

EVERY DAY: Medicine you need to use every day.

	Morning	Noon	Evening	Bedtime	
Amlodipine 10 MG Oral Tablet	1				Take by MOUTH. For high blood pressure. You should keep taking this medicine until you are told to stop.
Benazepril HCl Tablet 10 mg	1				Take by MOUTH. For high blood pressure. You should keep taking this medicine until you are told to stop.
doxycycline 100mg	1		1		Take by MOUTH. For pneumonia. Use for 7 days.
Qvar Inhaler 80 mcg/inh	2 puffs		2 puffs		BREATHING medicine. For asthma. You should keep taking this medicine until you are told to stop.
atorvastatin 40 MG Oral Tablet				1	Take by MOUTH. For high cholesterol. You should keep taking this medicine until you are told to stop.

- 5th to 8th grade reading level
- Uses universal medication scheduling language & pictograms

Can be translated into 18 different languages



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415-206-4901

ID: HKLN525E
Created: 2/18/2015

每天：需要每天使用的藥物。

	早上	中午	傍晚	就寢時	
Amlodipine 10 MG Oral Tablet	1				口服。 用來治療高血壓。 您應持續服用本藥物，直到醫師指示停止服用為止。
Benazepril HCl Tablet 10 mg	1				口服。 用來治療高血壓。 您應持續服用本藥物，直到醫師指示停止服用為止。
doxycycline 100mg	1		1		口服。 用來治療肺炎。 使用 7 天。
Qvar Inhaler 80 mcg/inh	2 口		2 口		呼吸用藥。 用來治療氣喘。 您應持續服用本藥物，直到醫師指示停止服用為止。
atorvastatin 40 MG Oral Tablet				1	口服。 用來控制高膽固醇。 您應持續服用本藥物，直到醫師指示停止服用為止。

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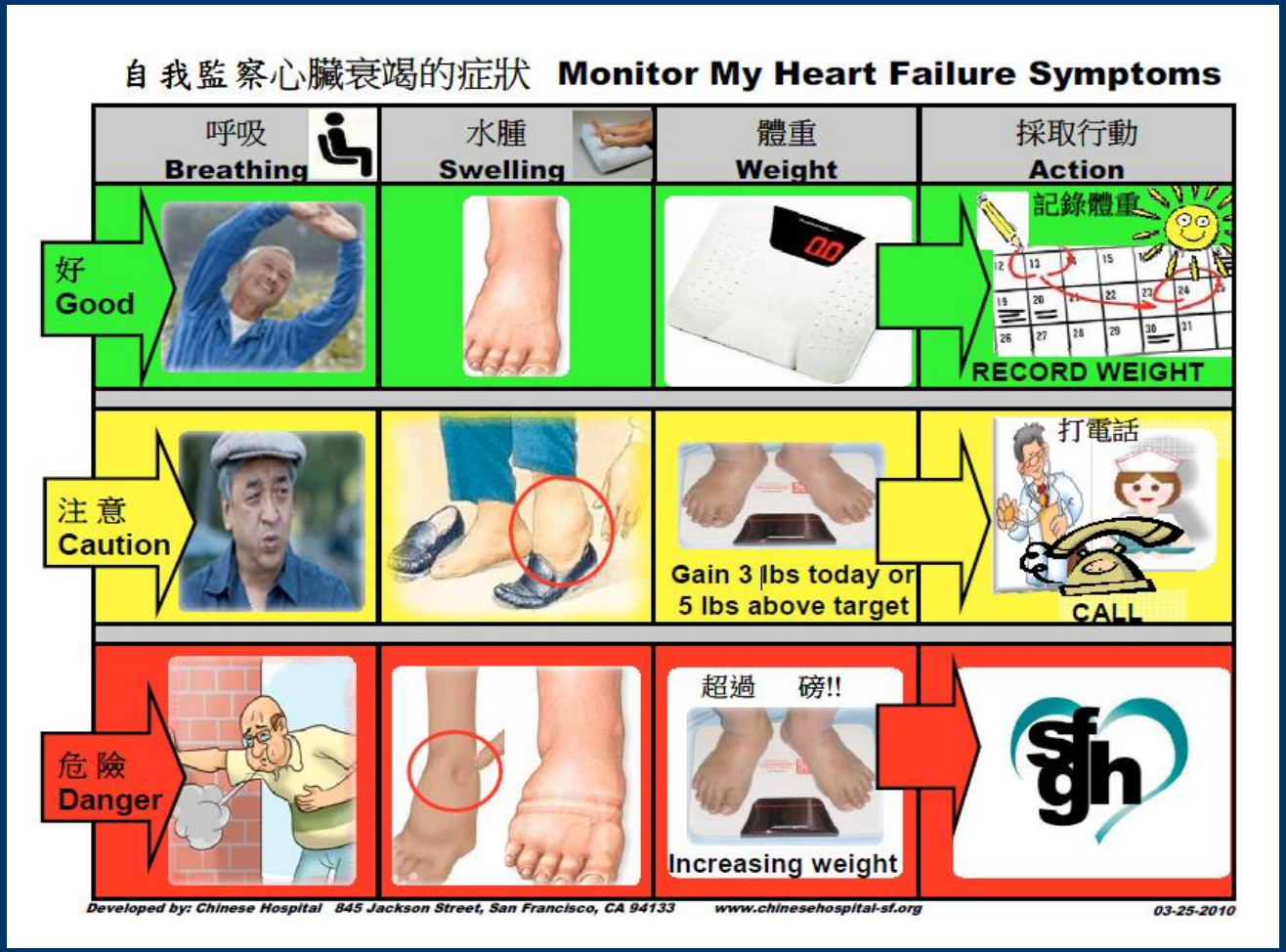
Multilingual Heart Failure Education



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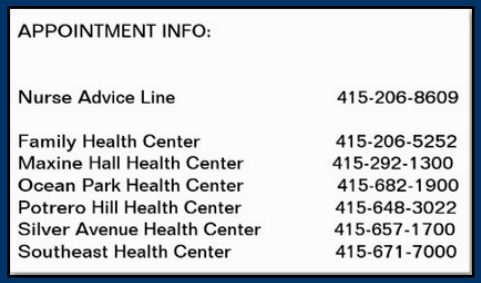
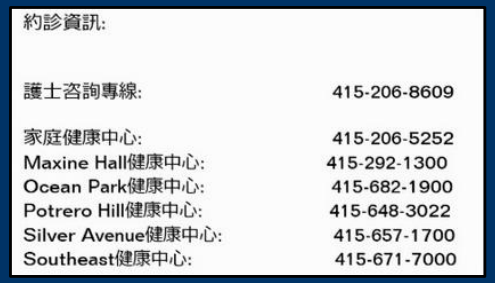
Business Cards and Warmline





Building a Community of Support

Data Capture, Analysis and Metrics

Bridging Silos: San Francisco General Hospital's Care Transitions Taskforce

Karishma Oza, MPH*[1]; Larissa Thomas, MD, MPH*[1]; Elizabeth Davis, MD[1,2]; Anna Robert, RN, DrPH[2]; Jack Chase, MD[3]; Jeanette Cavano, PharmD[2,4]; Anne Rosenthal, MD[2]; David Smith, PharmD[4]; Jeff Critchfield, MD[1]; Michelle Schneidermann, MD[1]

[1]UCSF Department of Medicine at San Francisco General Hospital (SFGH); [2]San Francisco Health Network, [3]UCSF Department of Family and Community Medicine at SFGH; [4]Department of Pharmacy, SF Department of Public Health

*co-first author

Needs and Objectives

Challenges:

Numerous factors make care transitions challenging for the vulnerable patients at San Francisco General Hospital (SFGH) and within the San Francisco Health Network (SFHN):

Goals:

- Create a comprehensive, systems-based care transitions program to provide patients with the proper care and the tools to stay out of the hospital.
- Reduce readmissions by 15 percent
- Standardize and improve processes of care

Setting and Participants

SF Health Network:

- Serves city's most vulnerable populations
- Array of services across healthcare continuum:
  - Primary care, specialty care, acute care, home care, long-term care, emergency care

San Francisco General Hospital:

- Only public safety net hospital in San Francisco
- Primary acute care hospital in the system
- Provides 20% of San Francisco's inpatient care
- Diverse patient population; high risk for readmission
  - All-cause, 30-day readmission rate to SFGH: 13.5% (FY12-13)
  - 30-day readmission rate among Heart Failure patients: 27% (FY12-13)

SFGH Patient Characteristics	Proportion
Marginally housed or homeless	8-10%
Uninsured	30%
Medicaid	40%
Medicare	20%

Description of Program/Intervention

The SFGH Care Transitions Taskforce

- Chartered in Fall 2012
- Multidisciplinary working group of inpatient and outpatient providers
- Central organizing platform
- Supports pilots of new, evidence-based care transitions initiatives
- Disseminates projects and data throughout network of providers
- Partners with local initiatives
- Inpatient, pharmacy, and outpatient subgroups

Care Transitions Taskforce Interventions

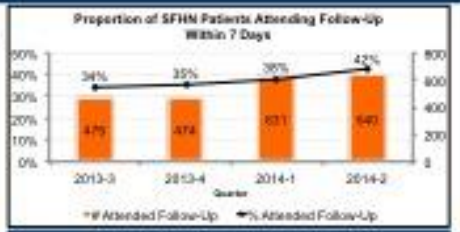
Evaluation – Measures of Success

Successes:

- Reduced duplication of services
- Increased effectiveness of provider communication
- Streamlined access to medical information
- Rapid expansion of pilot projects with stakeholder input
- Care Transitions improvements in SFHN

Data:

Variable	2013	2014
All cause, 30-day readmission rate to SFGH	13.5%	12.8%
30-day readmission rate among Transitional Care Nursing patients (>65 years, core measure dx)	16%	11%
30-day readmission rate among patients attending follow-up within 7 days of discharge from SFGH	N/A	5%



Discussion/Reflection/Lessons Learned

Discussion

- Overall hospital readmission rate has not yet decreased by goal of 15%; however, notable improvement in readmission rates among higher risk patients (e.g. Transitional Care Nursing Program patients & CHF Medicare beneficiaries).
- After less than a year of pilot & implementation, 23% increase in rates of attended follow-up within 7 days of discharge.

Reflection

- Building a multidisciplinary, cross-continuum working group of key stakeholders is complex and time-consuming, but is essential to successfully sustaining care transitions and quality improvement initiatives.
- We have developed a unique model for strategically building a collaborative working group of key stakeholders that can innovate, disseminate care transitions improvements, and optimize efficiency and quality.

Next steps

- Refining assessment of readmission risk
- Deploying tiered interventions across care continuum
- Disseminating our work and lessons learned with healthcare teams in the safety net

Acknowledgements

The Gordon & Betty Moore Foundation for their generous support

Department of Medicine | University of California, San Francisco

SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

SFGH Care Transitions Taskforce: a multidisciplinary QI workgroup aligning initiatives across continuum of care within and outside of SFGH and SFHN.

Care Transitions Discharge Worklist

Advanced search | Export results | Print this page | Print all pages

search

Details found: **2637** Page **1** of **132**

MRN	Pt Id	DOB	Vst Start Dtime	Vst End Dtime	Pt Name	PCC	PCP	Pt Phone No	Race Cd	Race Cd Name	Gender Cd	Lang	Last Dsch Order	Last Dsch Order Entry Dtime	Dsch Disp	Dsch Disp Desc	Tot Len Of Stay	Hosp Svc	Prov Cd
			5/29/2015 8:39:00 PM	6/5/2015 12:15:00 PM		SILVER AVENUE FAMILY H C	BARASH ,JONATHAN		6	AMERICAN INDIAN/ALASKA NATIVE	M	ENG	MEDS PRESCRIBED TO DC PHARM	6/5/2015 8:25:00 AM	ATC	Transferred to a critical access hospital (CAH)	7	FPR	FMISB
			4/13/2015 5:05:00 PM	6/5/2015 12:25:00 PM			KHAYAM-BASHI ,SHIEVA C.		1	WHITE	M	ENG			ATC	Transferred to a critical access hospital (CAH)	53	SNF	
			6/2/2015 10:20:00 PM	6/5/2015 12:25:00 PM		CHINATOWN PUBLIC H C	LI ,SHIRLEY		5	ASIAN	F	ENG	NO DSCHARGE PRESCRIPTIONS SENT	6/5/2015 9:44:00 AM	AHR	Routine discharge	3	MED	MED1B
			5/26/2015 5:10:00 PM	6/5/2015 12:30:00 PM		CASTRO-MISSION H C	GRENIER ,ELISE		1	WHITE	M	ENG	DISCHARGE TO:	6/5/2015 10:02:00 AM	ATE	Transferred to a skilled nursing facility	10	ORT	NOTEAM
			5/18/2015 9:24:00 AM	6/5/2015 12:50:00 PM		TOM WADDELL URBAN HLTH CENTER	LIN ,ROYCE		3	OTHER RACE	M	SPA	MEDS PRESCRIBED TO DC PHARM	6/5/2015 9:29:00 AM	AHR	Routine discharge	18	PSU	PSU
			6/1/2015 1:55:00 PM	6/5/2015 1:00:00 PM		TOM WADDELL URBAN HLTH CENTER	BORNE ,DEBORAH E.		1	WHITE	M	ENG			ATF	Transferred to cancer center or childrens hospital	4	PSY	

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UCSF/SFGH Family Medicine Inpatient Service Dashboard – Apr-Jun, 2015

SAFE TRANSITIONS OF CARE USING PRIMARY CARE, TEAMWORK, PATIENT EDUCATION AND COMMUNITY SUPPORT ARE THE HIGHEST PRIORITY.

Challenge #1: Improve Care Transitions & Reduce Readmissions

What we are doing well:

Morning Multidisciplinary Rounds (MD, Pharmacy, SW, UM, PT) focusing on successful transition to community

Email-based Care Transition Communication on Admission & Discharge

Work with patient & PCP during admission on goals of care and long term planning

% Patients with Scheduled Follow-Up at Discharge *(Nov 2014-Jun 2015)*	
Appt in ≤ 7 days	82%
Appt in ≤ 14 days	96%
Any follow-up appt	97%

Universal EHR access to all documentation on date of service

What we are working on:

FMIS Patient Navigator - hire ***new position*** for discharge planning and phone follow-up

Call community pharmacies to give pager number for discharge prescription questions

Consistent distribution of FMIS Business Card with Warmline Instructions

Plans in development:

Identify highest needs patients and collaborate with PCPs and ambulatory care for complex care planning across SFHN

Create SFGH discharge prescription warmline for community pharmacies

FMIS pharmacist-Primary care pharmacist collaboration

Goal outcome measure: reduce readmission rate	
FMIS 30 day Readmission Rate (3 month average)	16.4%
Our Goal: *Medicare Readmission Rate*	15.6%
To reach our goal, we need 5 fewer readmissions/month	

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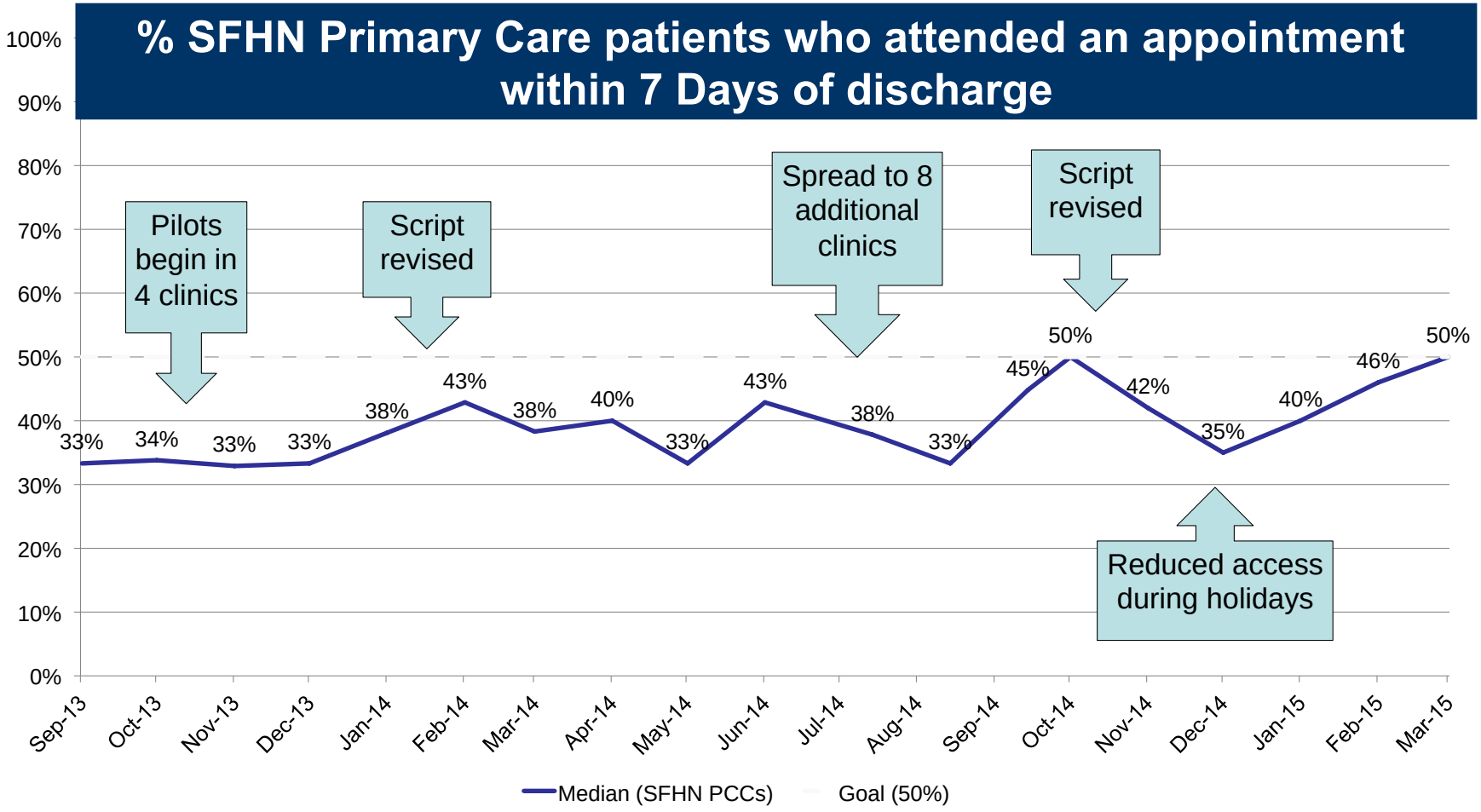
% SFHN Primary Care patients who attended an appointment within 7 Days of discharge



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Current Understanding

- Readmissions are complex & costly for patients and health systems
- Outcomes involve a diverse set of contributing factors, variable by patient, health system and community
- No consensus on exact definition of readmission or prevention
  - Bigger win is to improve transitions of care
- Engage stakeholders, create high functioning teams, connect through efficient EBM processes, track & distribute data

Big Picture Goals

1. Team-oriented, standard-work approach for care transitions from hospital to community – ***critical to align hospital and primary care.***

2. Reduce total readmissions by 15-20% (the preventable component)

With thanks to the Moore Foundation, the SF General Hospital Foundation, the SFGH Care Transitions Taskforce, & our partners from SFGH and SFHN.

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- 364 Hospitals Have High Rates Of Overall Readmissions, New Medicare Data Show: www.kaiserhealthnews.org

Web Resources

Institute for Healthcare Improvement
www.ihi.org

America's Essential Hospitals
www.essentialhopitals.org

Society for Hospital Medicine BOOST
www.hospitalmedicine.org/boost

ProjectRED (Re-Engineered Discharge)
www.bu.edu/fammed/projectred

More Web Resources

US Dept of Health and Human Services
Partnership for Patients
www.healthcare.gov

Hospital Consumer Assessment of Healthcare Providers and Systems
www.hcahpsonline.org

Agency for Healthcare Research and Quality www.ahrq.gov

San Francisco Health Network
http://www.sfhealthnetwork.org/