Beyond Hospital Walls: Strategies for Reducing Readmissions

Wednesday, April 24, 2013

Oakland Airport Hilton Hotel

Breakout Session Key Discussion Points

A. Disease Specific Dissemination:

The Heart Failure Continuum of Care Tool kit was discussed by Celeste Chavez. Celeste shared how the tool kit was developed and used to spread the HF work throughout another system facility. The tool kit includes many valuable templates including staff education modules and ideas on how to develop a business case to sustain your program. The tool kit will be posted on the ARC web site shortly.

Additionally participants discussed several challenging issues including how to identify HF patients and how to inform PCPs about the hospitalizations of their patients. Not easy solutions were identified. For HF patient identification the following ideas were offered:

· Develop a list of admitting diagnoses used by your ED docs that often result in a HF DRG at the end of the stay and use this list to screen newly admitted patients
· Look at pharmacy reports for Lasix and lab reports for BNP
· Ask you concurrent documentation specialists to flag cases, if you have them.

For connecting with the PCP the following suggestions were made:

· Identify your process for obtaining updated PCP information
· Limit the number of people who can change this information in your system
· Talk to your HIM department to understand the system they use to send information to PCPs

Participants also heard from Maia White about the newly developed multidisciplinary program for their COPD patients. Once a week there is an opportunity for COPD patients to see a variety of healthcare professionals as well as fellow COPD patients. The benefits to the patient are clear. One stop coordinated care and peer support. Seeing patients with more advanced disease has also been helpful to underscore the need for smoking sensation.

B. Best Practices in Ambulatory Care:

Steve Escamilla, Samantha Valcourt, and Lance Lang presented on critical post-discharge care improvement and interaction. Some statistics included in the power point are the following:

- Up to 66 % of patients experience adverse drug related events post-discharge[1]
- Nearly 50% of hospital-related medication errors and 20% of adverse drug events attributed to poor communication at transitions of care[2]
- Up to 88% of adverse drug events related to hospitalizations in the elderly are preventable[3]

What are the goals to help guarantee post-discharge safety and who plays an active role in ensuring this safety? Information is collected from TAACT learning, Stanford Coordinated Care, and the Coleman Model.

Presenters also facilitated a group discussion drawing on stories from the individual hospitals and organizations represented in the audience. Among the discussion topics were outpatient cross-institutional partnerships, understanding the need for hospitals' continued involvement following discharge, and team dynamics. Often post-discharge teams need a "quarterback" to coordinate with a wide range of "players", including pharmacy students, primary care practitioners, elder care assistants for home visits, etc. The discussion also identified the importance that every team member is present at meetings to discuss high-risk clients.

There was further discussion on how mental health is being addressed. Building MH facilities into community clinics is a rapidly growing practice and may be a good way to assertively approach mental health. For some patients, social issues are more pressing than health issues. One attendee described how her facility's fall prevention center is a point of contact for referred patients who have fallen or are at-risk of falling, providing them with health education, medication management, and more.

C. Pharmacy Leaders Tool Sharing and Discussion:

Participants received copies of several key resources regarding the optimization of Medication Reconciliation, post discharge interventions, and the importance of community liaison programs. The session included discussion on issues that prevent effective medication reconciliation from happening and potential areas/activities to address these problems. The conversations highlighted recurring themes such as lack of standardization and accountability. Next steps include a future meeting to hear about successful models, closing the loop on accountability and the "who to call" issue after leaving the hospital, and the creation of a customizable med rec tool for ARC hospitals.

D. Implementation Strategies: Project RED, CTI, and mixed models:

There were four tables, each assigned with a topic and subcategories to discuss for 35 minutes. The discussion topics were one of the following:

Are you seeing enough patients to get the results you desire?

Subcategories:

- Do you have a goal for the number of patients you wish to see each month?
- If so, what is it and how did you establish it?
- How do you know that you are seeing a sufficient number of patients to move your overall readmission rate?
- How do you track your patient interventions?
- What ideas can you share about making enough high quality interventions?
- What ideas did you hear today that you would like to try?

Are you measuring performance data and reviewing it with your team?

Subcategories:

- How are you measuring the performance of your readmission reduction effort?
- How are you collecting performance measurement data?
- How are you aggregating and displaying these data?

- How are you distributing these data?
- What is the frequency at which you gather and share data?

Are you actively engaging with your community partners?

Subcategories:

- Describe your approach to community engagement?
- Do you meet separately with community partners? IF so, describe who, how often, etc.
- What specific work are you doing with your community partners?
- How did you determine which partners to work with?

Do you have a patient and or family member on your team?

Subcategories:

- Describe your approach to patient engagement?
- Do you meet separately with patients? If so, describe who, how often, etc.
- Do you have patients on your team? IF so, who and how did you recruit them?
- What specific work are you doing with your patients?
- How did you determine which patients to work with?

There are many discussion topics and we encourage you to think through your answers to these questions.

During the breakout, Bruce Spurlock facilitated discussion on roughly four areas of interest throughout all four tables. The first discussion focused on how effectively to inform hospital members of palliative care. The major question is which is the better solution: having a specialized team learn the ins and outs of Palliative care, or informing many people at a hospital on a little information in order to identify the problem. Someone also suggested that changing the name could bring a positive connotation. A suggested name change that has worked for other hospitals is from *Palliative Care* to *Advanced Illness Care*.

The second discussion focused on warm handoffs versus standard handoffs. Which is more effective and which can cut down the risk factor for readmissions. Readmissions affect everyone and many people suggested including social services (i.e. social workers) in this process since it is “everyone’s deal.”

A third topic was CHF sustainability. Many hospitals have found a successful way to enforce sustainability is by teaching doctors and nurses the way to identify CHF; often this is accomplished through lab results. However, there are some risks factors to this method. The first is detecting CHF can be time consuming and may take away from the nurses ability to treat more people. The second is depending on the test results, if a test is negative than the time spent determining CHF was inefficient time spent. The third is often this result identifies too many patients with CHF.

The final discussion was on patient engagement. A major issue for hospitals across the board is the inability to accommodate patients in need of transportation. It was suggested that the transportation issue might decrease if a volunteer opportunity is implemented allowing the community to participate with hospital needs.