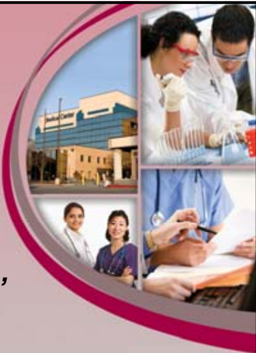
Improving the Discharge Process



Jerome A. Dixon, D.O., MNS, CCD, FACOFP

June 10, 2010

Objectives

- Identify problems with current hospital discharges
- Discuss the impact of unanticipated readmissions on the healthcare system & patient
- Identify common errors which occur during the discharge process
- Discuss new HFAP standards
- Discuss key steps/strategies to improving the discharge process

A Failure to Communicate

At discharge:

- 37% of patients able to state the purpose of all their medications
- 14% knew their medication's common side effects
- 42% able to state their diagnosis

Makaryus, Amgad N., et al. (2005). Mayo Clinic Proceedings. Patients' Understanding of Their Treatment Plans & Diagnosis At Discharge. Aug., 80 (8):991-994

A Failure to Communicate

Discharge Summaries:

- Not readily available
  - 12% to 34% available at first post-discharge appointment
  - 51% to 77% available at 4 weeks
- Lacking key components
  - Hospital course & tx. missing up to 22%
  - Discharge medications missing up to 40%
  - Completed test results missing 33% - 63%
  - Pending test results missing 65%
  - Follow-up plans missing 43%

Kripalani B., et al. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA. 297(8): 831-41.

Impact of Readmissions

- **CMS**
  - **Save Money**
  - **Improve Quality of Care**
  - **Improve Patient Outcomes**
- **Identified Target: Readmissions**

Impact of Readmissions

- Nearly 20% of Medicare fee-for-service patients discharged from hospital were readmitted within 30 days
- 34% were readmitted within 90 days
- Estimated cost to Medicare program: $17.4 Billion

Jencks, M.V. et al. (2009) Re-hospitalizations among patients in the Medicare fee-for-service program. New England Journal of Medicine. 360:1418-28

Impact of Readmissions

Unplanned re-hospitalizations often signal a failure of the transition process from the hospital to another source/level of care.

Errors in Continuity

- Variability in 30-day readmission rate
  - Dependent upon patient's diagnosis
  - "Part of the problem stems from continuity of care issues." – Dr. Michael Rapp, Director of the Quality Measurement and Health Assessment Group at CMS

Errors Medication & Testing

- Study looked at 366 patient discharges with a follow-up primary care appointment scheduled within 2 months
  - 42% of those patients had a medication continuity error
  - 12% had a 'work-up' error
  - 8% had a test follow-up error

Moore, Carlton, et al. (2003). Medical errors related to discontinuity of care from an inpatient to an outpatient setting. Journal of General Internal Medicine. 18 (8):646-51.

Errors & Adverse Events

- 19% of patients had post-discharge adverse events due to errors
- 33% were preventable
- 33% were ameliorable

Forster, Alan J, et al. (2003). The Incidence and Severity of Adverse Events Affecting Patients After Discharge from the Hospital. Annals of Internal Medicine. 138:161-167.

Errors & Adverse Events

- 23% of patients had post-discharge adverse events
- 28% were preventable
- 22% were ameliorable

Forster, Alan J et al. (2004). Adverse Events Among Medical Patients After Discharge from Hospital. CMAJ. 170(3): 345-349.

The Consequences

- Hospital admissions are a source of revenue for hospitals
  - New incentives for reducing readmissions are needed – *Dr. Rapp, CMS*
  - Positive and Negative
    - Quality Reporting
      - **Publishing hospital readmission rates**
    - Reductions in Payment

Improving the Discharge Procedure & Reducing Hospital Readmissions

- **CMS: Lessons Learned**
  - Community recruitment & engagement can take longer than anticipated
  - Community meetings are a catalytic point in the process
  - Increased time & resources are required to engage outpatient physicians & specialists
  - Each patient should be assigned a coach or team member before discharge

Re-Engineered Discharge (RED)

- Delineation of roles & responsibilities
- Patient education throughout hospital stay
- Seamless information flow
- Written discharge plan
- All info organized & communicated to PCP
- Patient access to discharge info in their language
- Reinforcement of discharge plan for at-risk patients
- Discharge process is: benchmarked, measured & subject to continuous quality improvement programs

RED Checklist

1. Medication reconciliation
2. Reconciled discharge plan with National Guidelines
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary to PCP
11. Telephone reinforcement

Adopted by National Quality Forum as one of 2009's 34 U.S. Safe Practices - Safe Practice # 15

Why Use HFAP RED Standards

- Improves community image
- Meets safety standards
  - Endorsed by NQF, IHI, Leapfrog & Others
- Improve clinical outcomes
  - Decrease readmissions from 20% to 15%
  - Decrease ED use from 24% to 16%
  - Improves PCP follow-up

Why Use HFAP RED Standards

- Saves money
  - Saved $412 per Medicare enrollee,
    - (in one pilot study)
  - Reduces diversion & creates greater capacity for higher revenue patients
  - Improves market share as ‘preferred provider’
  - Improves relationships with PCP
  - Prepares for change in CMS rules regarding readmission reimbursement

MULTIDISCIPLINARY PATIENT ASSESSMENTS AND PLANS OF CARE

STANDARD / ELEMENT	EXPLANATION	SCORING PROCEDURE	SCORE
16.06.16 Discharge Systems Facilities must have a discharge system in place to ensure the continuity of care of the patient post-discharge. Discharge instructions must be prepared for each patient, and communicated to the clinical caregiver accepting responsibility for post-discharge care at the time of hospital discharge. Organizations must ensure that there is confirmation of receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge. (NQF, #18, 2009)	The medical record must reflect that the information has been faxed, mailed or delivered in some fashion to the independent licensed practitioner assuming care of the patient after discharge. A fax transmittal sheet placed in the medical record is also acceptable.	OBSERVATION & CHART REVIEW Review the medical record of recently discharged patients to ensure the existence of discharge instructions & confirmation of communication of the discharge instructions to the accepting provider / facility. Ensure that documentation supports that discharge information has been delivered to the accepting independent licensed practitioner. Observe the discharge process for compliance with standard.	1= Full Compliance 0= Non-Compliant
16.06.17 Discharge Instructions & Checklist The hospital must provide written discharge instructions (separate from the traditional discharge summary, and written in lay terminology) with the inclusion of the following elements: 1. Reason for hospitalization & condition at the time of discharge; 2. Education of patients & families about their diagnosis throughout	Inconsistent practices in the discharge process may result in unsafe outcomes. The discharge process is intended to provide patients with adequate information and necessary resources to improve or maintain their health during the post-hospital period and to prevent adverse events and unnecessary re-hospitalization. The facility is responsible for making	OBSERVATION & CHART REVIEW Review the medical record of recently discharged patients to ensure written discharge instructions contain the eleven (11) elements required. Observe the discharge process for compliance with standard.	1= Full Compliance 0= Non-Compliant

2009 Healthcare Facilities Accreditation Program (HFAP)
Accreditation Requirements for Healthcare Facilities

STANDARD / ELEMENT	EXPLANATION	SCORING PROCEDURE	SCORE
the hospital stay (see Patient Education Regarding the Plan 15.06.13); 3. Medications (see Medication Reconciliation 25.02.07 & Medication and Biologicals – Drug Orders, Verbal Orders 15.00.03) 4. Types of complications which may occur & actions to take should these happen post discharge; 5. List of follow-up appointments for tests & clinical visits, with dates, times & locations; 6. Organized services to be initiated following discharge; 7. Advising the patient and family of any tests completed in the hospital with results pending at time of discharge and identifying the clinician responsible for the results; 8. List of relevant contact information (e.g., primary care providers, specialists, the pharmacy, and home health agencies, etc.) 9. Any special instructions (e.g., activity level, diet, restrictions, etc.)	appointments with the appropriate provider for follow-up clinical visits and tests after hospitalization. These appointments must be communicated, in writing, to the patient / caregiver at the time of discharge. Patient / caregiver understanding of the discharge instructions must be assessed and documented in the patient record. National guidelines and critical pathways, regarding evidence-based practice for patient diagnosis and presentation should be used, when appropriate. The facility must reconcile the discharge plan with national guidelines and critical pathways when relevant. It is not mandatory that the bedside RN make the follow-up patient phone calls. However, this individual should be an RN with experience, knowledge and training to recognize potentially emergent situations when speaking with the patient. Research has shown that the use of a checklist for discharge activities has decreased adverse events post discharge and reduced the number of readmissions with 30 days after discharge. (Jack, Brian, et al. (2009). A	Interview patients / family re: education & understanding of the discharge plan, their diagnosis, medications & complications. Review facility's data related to 30-day readmissions; review sample of readmitted patients for adequacy of the discharge plan and instructions. Review the medical record to ensure that attempts have been made to contact the patient 2 – 3 days post-discharge. It is appropriate to leave a generic message asking patient to return call when able. There should be documentation supporting this activity.	

STANDARD / ELEMENT	EXPLANATION	SCORING PROCEDURE	SCORE
10. Assessing the patients' under-standing of the discharge plan in their own words; 11. Providing telephone follow-up two to three days after discharge for those patients assessed to be at risk for adverse event post discharge.	Reengineered hospital discharge program to decrease re-hospitalization. *Annals of Internal Medicine*, 150(3): 178.) The discharge process must include the following activities: 1. Education of patients & families about their diagnosis throughout the hospital stay; 2. Assessing the patients' under-standing of the discharge plan in their own words; 3. Advising the patient and family of any tests completed in the hospital with results pending at time of discharge and identifying the clinician responsible for results; 4. Scheduling follow-up appointments and tests to be done following discharge; 5. Organizing services to be initiated following discharge; 6. Confirming the medication plan; 7. Reconciling the discharge plan with national guidelines and critical pathways when relevant; 8. Reviewing with the patient what to do if a problem occurs; 9. Communication of the discharge summary to the healthcare providers who are accepting responsibility for the patient's care; 10. Giving the patient written discharge instructions; and		

STANDARD / ELEMENT	EXPLANATION	SCORING PROCEDURE	SCORE
	11. Providing telephone follow-up two to three days after discharge.		
15.00.18 <u>Discharge Summary</u> A concise discharge summary must be completed on each patient within 7 days of patient discharge.	In order to facilitate the transition of care between providers, it is essential that the discharge summary document is available to the next provider, at a minimum, by the time of the patient's next appointment. Future care of the patient may depend upon findings / events incurred during the inpatient stay. All tests / diagnostics pending at the time of discharge may be noted as such in the discharge summary. As new results are obtained, relating to the inpatient stay, the document may be amended by the discharging practitioner.	<u>OBSERVATION, INTERVIEW & CHART REVIEW</u> Observe the discharge process for compliance with standard. Review the patient record for inclusion and completion of the discharge summary within the designated time frame.	1= Full Compliance 0= Non-Compliant

Improving the Discharge Procedure & Reducing Hospital Readmissions

- Measures suggested by Dr. Rapp (CMS):
  - Exchanging quality data routinely
  - Creating a collaborative forum that includes patients and families
  - Identifying the sickest patients & reviewing the way they get care, and
  - Implementing personal health records

Improving the Discharge Procedure & Reducing Hospital Readmissions

- Keep the process simple by developing a hospital-wide process using:
  - Discharge checklist for outpatient discharges
  - Discharge medication reconciliation forms or print-outs
  - Discharge/Transfer order forms for long-term care and Rehab transfers
  - Transfer order forms for hospital-to-hospital transfers

Barriers to Implementation

- Unclear responsibilities for all elements of discharge
- Process receives low priority
- Medication plan regularly changed
- Financial pressure to fill beds ASAP

Barriers to Implementation

- Discharge responsibility delegated to least experienced team members
- Less than optimal staffing when most discharges occur
  - Late afternoon & evening

Key Steps

- Develop a policy to improve the discharge process
- Recruit and engage key stake holders
- Educate hospital staff & physicians
- Identify the sickest patients & review ways they get care & improve on the process
- Track your result with an ongoing Quality Assessment Performance Improvement (QAPI) program

Questions?

For any questions regarding the interpretation / application of the new HFAP discharge standards, please submit to:

info@hfap.org