Eliminating the Pitfalls and Barriers to Reducing Rehospitalizations

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Barriers to Care Coordination

• System level barriers
• Practitioner level barriers
• Patient level barriers

Pitfalls

• Medication reconciliation and management
• Communication
• Multiple rehospitalizations without an intervention plan
• Lack of shared medical information between providers of care
• Poor care coordination within and across organizations
• Inadequate transition planning

Medication Errors

The results of studies reveal:
• On hospital admission, more than 50% of patients had at least one medication discrepancy. Of these, approximately 40% have potential to cause harm. (1)
  — Errors between admission medication orders and patient interview of medication history.
• On discharge from the hospital, 30% of patients had at least one medication discrepancy with the potential to cause harm. (2)
  — Most common discrepancy is omission of pre-admit medication.
• Adverse drug events attributable to medication changes occurred in 20% of transfers between hospitals and SNFs (3)
  — 50% were caused by discontinuation of medications during hospital stay.

Little to No Communication with PCP

• One study revealed direct communication between hospital physicians and primary care physicians occurred infrequently

  • Discharge summary
    - Availability at first post discharge visit low (12%-34%)
    - Remained poor at 4 weeks (52%-77%)
    - Affected quality of care in ~25% of follow-up visits
    - Often lacked important information (e.g., lab results, discharge medications, treatment, follow-up plan)

Ineffective Transitions Lead to Poor Outcomes

• Wrong treatment
• Delay in diagnosis
• Patient/family complaints
• Severe adverse events
• Increased length of hospital stay
• Increased healthcare costs


How can we Improve?

- Setting clear expectations for the sending and receiving teams
- Standardized objectives related to care coordination
- Care transition programing using evidence based models of care
- Medicare and Hospital Readmission Reduction Program
- Specialized Home Care and community programs

Expectations for Both Sending and Receiving Teams

- Shift from “discharge” to “transfer with continuous management”
- Begin transfer planning upon or before admission
- Incorporate patient and caregivers’ values, goals and preferences into the care plan
- Identify and engage patient’s social support network
- Collaborate with practitioners across settings to formulate and execute a common care plan

Effective Care Coordination Program

Includes:
1) Logistical arrangements for appropriate supports
2) Motivational coaching and education of patients and their caregivers
3) Coordination among professionals involved in transitions, both in sending and receiving information
4) Change the culture of “doing everything” for the patient verses empowering the patient to do for themselves

Care Transitions Defined

- The coordination of care related to the movement of patients between health care practitioners or settings as their condition and care needs change during the course of a chronic or acute illness.
- Transitions occur at many levels:
  - Within Settings
    - Primary care → Specialty care
    - TCU → LTC
  - Between Settings
    - Hospital → Skilled Nursing Facility
    - Skilled Nursing Facility → Home
    - Home → Assisted Living
  - Across health states
    - Curative care → Palliative care/Hospice

Communication

Pt./Family Caregiver → Center Staff
PCP → Home Health
Case Mng./Healthcare Provider
Communication
Get everyone’s attention!!

Start with the patient
What are their goals?
What do they know?
What stops them from achieving their goals?
Listen!!

Patient and Family/Caregiver
- Discuss Goals of Care from their perspective
- Ask them what they know.....
- Listen and work form there

Primary Care Physician

PCP Communication
- Written
  - Medication Profile
  - Transfer plan
  - What transpired from Hospital to SNF
  - Physician Summary of patient’s stay in the SNF
  - Appointment within 7 days post discharge

Home Health Services
Communication Continued

**Written**
- Risk assessment
- Discharge summary
- Discharge plan
- Medication plan/prescriptions

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Case Management/Healthcare Plan

- Direct Communication
- Challenging High Risk Patients
- Cost Savings
- Return to Center when needed

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Value Added from Enhanced Coordination

- Improved continuity and quality of patient care
- Supports the provision of Transitional Care Management services by community providers
- Improves PCP understanding of Center capabilities
- Enhances referral patterns from the community
- Best practice for participation in future Accountable Care Organizations

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Transitional Care Program
Discharge to Home

1. Reconnect Patient with Primary Care Physician within 7 days
   - Pt/CG can schedule a PCP appointment.
   - Pt/CG lists issues for discussion with PCP.
2. Support Creation/Use of Personal Health Record
   - Pt/CG creates and takes PHR to all provider visits.
   - Pt/CG updates PHR
3. Ensure Adherence to Appropriate Medication Regimen
   - Pt has in place and can follow a home medication management system
   - Pt/CG can describe steps to take when medication is missed
4. Establish Chronic Disease Self-Management Program
   - Pt/CG can identify “flags” that require PCP attention and emergency care
   - Pt/CG can name three key self-care behaviors to manage chronic disease
   - Pt/CG follows a physical activity plan

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Genesis Care Transitions Mission

- Provide our patients with the capabilities and confidence to manage their own care in their own community.
- Reduce health system costs and risks to patient well-being through the elimination of unnecessary rehospitalizations.
Delivery Model

- Combination of in-person visit in SNF, home evaluation, post discharge home visit + weekly telephone calls for 30 days post facility discharge
- Care Management Team
  - 1-2 RN Care Managers, supported by
  - 1 Licensed Social Worker
  - Call Center
- Each short-stay patient will be assessed for risk for rehospitalization upon admission to SNF, and assigned to a care manager for coaching, navigating, and coordination of resources.

Number of Patients Enrolled in GCT
Jan-Oct 2013: 175 Patients

Number of Patients Rehospitalized 30 Days Post Discharge

Eliminating the Barriers

1. Require home health partners to provide rehospitalization data and partner with those who have lowest rehospitalization rate.
2. Enhance your centers capabilities by training staff to recognize early onset of symptoms and provide skilled treatment alternatives to reduce hospital admissions.
3. Critically look at your discharge planning process and make improvements, does it begin at admission?
4. Staff training related to motivating patients to manage their healthcare.
5. Provide a formalized program for care transitions
6. Medication reconciliation at every transition.
7. Formalize communication between settings and require it from your referral sources, hospitals, physicians, Home Health, Assisted living

Working together; We can Move Forward to Improve Patient Outcomes