DISCHARGE PLANNING ENHANCED

SANFORD WORTHINGTON MEDICAL CENTER

SANFORD
Worthington

INTRODUCTIONS

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OBJECTIVES

- Examine impetus for change at SWMC and apply principles to your organization
- Explore multifaceted and multidisciplinary approaches used at SWMC to improving discharge planning and how these might benefit other organizations
- Identify challenge areas and a future direction for more successful discharge planning outcomes

IMPETUS FOR CHANGE

- Patient Protection and Affordable Care Act (2010, Amended 2015) – Linking payment to quality outcomes including readmissions
- Evidenced-based literature suggesting comprehensive discharge planning and follow up care to help prevent readmissions (Naylor, et al., 2011)
- Quarter 3 (July-Oct) 2013 – Readmission rate 8.3%

ANALYSIS CURRENT PRACTICE

- Began by utilizing Centers for Medicare & Medicaid Services "survey worksheet toolkit"

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf

- Surveyor Worksheet Discharge Planning.pdf

CMS WORKSHEET RESULTS (BRIEF SUMMARY)

- Couldn't answer "yes" for all questions, i.e.
  -  DC planning documented in EMR (not consistently done)
  -  Eval included post-DC care needs met in pre-hospital environment (not consistently done)
  -  Eval completed timely to allow for arrangements of post-hospital services as needed

ACTION PLAN

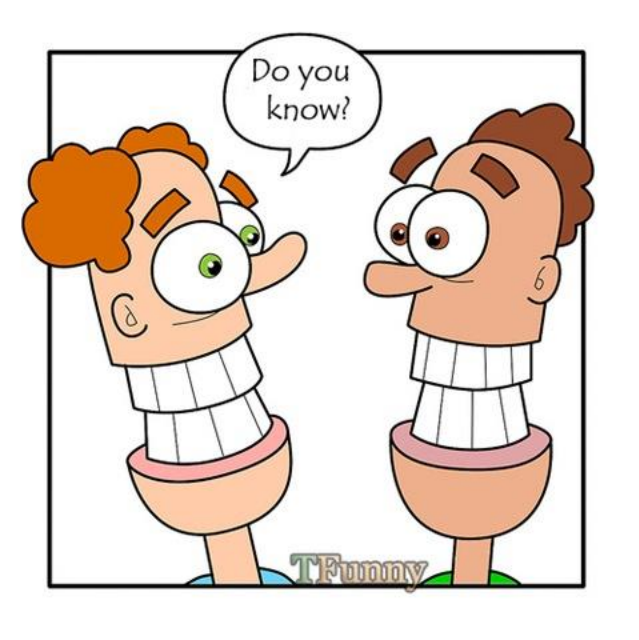
- Patient rounding – RN, pharmacist, physician
- Know needed more support for RN = social worker
- Interdisciplinary team involvement
- Post-hospital contact – care transition team and follow up phone call

PATIENT ROUNDING

- Care coordinator – RN focused primarily on discharge planning
  - Meets with patients to assess patient DC goals
  - Recognize resources patient has and will need to meet DC goals
- Hospitalist
  - Assessments and plan of care discussion
  - Answers questions, elicits family involvement
- Pharmacist
  - Began with ½ days on unit
  - Focus in on high-risk medications, patient education

TOOLS FOR DC PLANNING

- Patients don't know what they don't know!!
- AHRQ Are You Ready To Go Home brochure.pdf



INTERDISCIPLINARY TEAMWORK

- IDT team meets daily – current practice focused on DC plan
- Realized need to enhance
- IDT team breakout sessions – discuss contributions of each discipline and set expectations for participation
- Later focus = DC plan, Length of stay, and plan of care

DOCUMENTATION TOOL

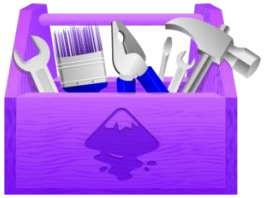
- Created template to document daily IDT conferences
- Serves as communication tool for others viewing chart
- Meets COP requirement for CMS

TEMPLATE EXAMPLE

- The patient was discussed with the interdisciplinary team today. Members of the care team include:

  Charge Nurse, Occupational Therapist, Pharmacist, Physical Therapist, Provider, Respiratory Therapist, Social Worker, Unit Manager, UR, Supervisor, Home Health, WOCN, CNO.
- **Insurance:** Medicare
- **Status:** Inpatient
- **Working Diagnoses:** COPD CHF/Pneumonia
- **Length of Stay:** Day 1 of 6
- **Family Involvement/Support:** Spouse
- **Community Services (prior to admission)**: Home Health: Sanford
- **Baseline Self-Care Capacity (prior to admission):** Minimal
- **Current Self-Care Capacity:** TBD
- **Hospital Referrals:** Physical Therapy
- **Community Service Referrals:** Home Health: Sanford
- **Transportation**: Family/Friends
- **LACE Score:** 9

READMISSION PREDICTOR TOOL



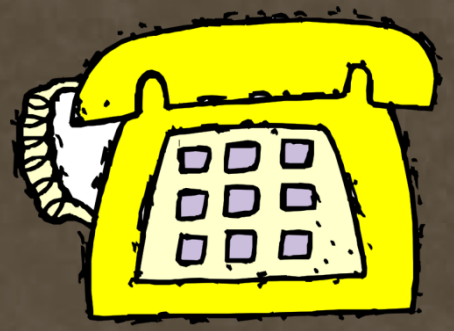
- LACE tool – readmission predictor
  - L = length of stay (# days in the hospital)
  - A = acuity level (observation vs inpatient)
  - C = comorbidities
  - E = emergency room visits in last 6 months
- Incorporate in IDT daily care conferences
- Gives RN and team common language to work from – LACE $\geq$ 10 = high risk for readmission

CARE TRANSITIONS

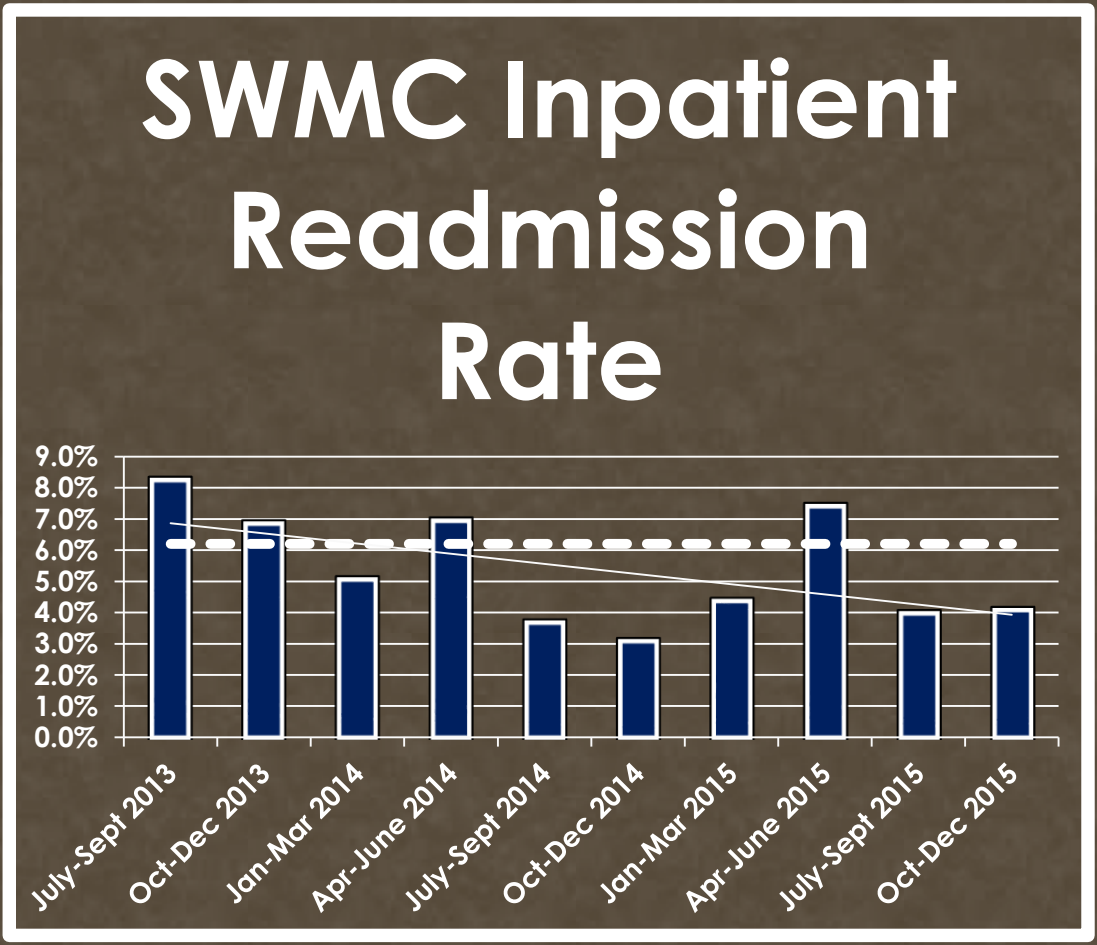
- Through chart review of readmitted patients – realized need for better post-hospital follow up
- How can we reach patients with high LACE score?
- Developed CT team
  - RN - Health coach at clinic provide 'touches' to patients each week for 4 weeks (LACE $\geq$ 10)
  - Offer health coach services free for 4 weeks
  - Way to see what PCPs are talking about with patient and measure compliance with f/up visits

FOLLOW UP PHONE CALLS

- All patient discharged to home & English speaking – get follow up call 24-72 hours after discharge
- Those with LACE score ≥ 10 get call within 24 hours
- Use standard template
  - Ability to get to follow up appointment
  - Questions regarding discharge instructions
  - Ability to get prescriptions filled
  - Questions about overall health or how to care for self



RESULTS



- Q3 2013 = 8.3%
- Goal = 6.2%
- Q4 2015 = 4.1%

FUTURE IN DISCHARGE PLANNING

- Better manage post-hospital follow up on patients from different health systems
- Post-hospital follow up for patients discharged to nursing homes/SNF
- Helping patients address mental health needs & substance abuse
- Need for palliative care

ZDOGGMD – IMPORTANCE OF DISCHARGE PLANNING

- ZDOGGMD You Tube Video Parody of Readmissions

REFERENCES

- https://www.youtube.com/watch?v=aS3xaXsh6vo
- Naylor, et al., 2011. The importance of transitional care in achieving health reform. *Health Affairs, 30*(4), 746-754.
- Statute (Patient Protection and Affordable Care Act of 2010, Amended 2015).

QUESTIONS??