Driving The Ultimate Patient Experience – Patient Discharge

Date: January 12th, 2012

Hendricks Regional Health
BOH-HFAP Joint Webcast
Agenda for today’s discussion:

- About Hendricks Regional Health
- HFAP 15.06.16-15.06.18 – Lessons learned from new discharge standard
  - Connection to HRH Quality Program
  - Project Components
  - Identified Interventions
  - Process Oversight
  - Wins and Lessons Learned
  - Preliminary Results
  - Q&A
- Wrap Up
About Hendricks Regional Health

• Indianapolis, MSA
  – Five locations

• Key Metrics:
  – 1.100 Annual Births
  – 31.000 + ER Visits
  – 7.000 Discharges

• HRHMG

• Recognitions:
  – MAGNET
  – Accredited Chest Pain Center
  – Breast Imaging Center of Excellence
Overview: Project @ HRH

- March, 2010: Buy-in from Administration: It’s a HRH opportunity to give our patients the best discharge process possible.
- HFAP 15 Focus: Inpatient Discharge process
  - Move from decentralized to centralized discharge
- Additional focus for HRH:
  - 1) Improving Patient Education
  - 2) Improving the kinds of patient information given at time of discharge
  - 3) Reduction of readmissions to hospital
  - 4) Streamlining and improving documentation for physicians
- Pilot: CHF Re-admission team
HRH’s HFAP 15 Journey

- Standard Released
  - 4Q2009
  - 4/2010

- HRH KickOff

- Standard effective
  - 9/2010

- Process Reworking

- HFAP Site Survey
  - 2/2011

- New PDI/PDRX/PDIP
  - 4/1/2011

- Meditech 6.0
  - 3/2012
Components - How do we get there?

- Initial Quality Forum Group charted April, 2010
  - Developed team goals:
    - Reduce re-admissions and call back from patients
    - Reduce medication and follow-up errors by patients post discharge
    - Increase customer satisfaction with communications related to discharge and continuity of care
    - Meet the current HFAP discharge systems standards
    - Develop standardized systems for data collection and validation of discharge process completion
    - Improve patient comprehension of discharge education and instruction
    - Improve efficiency and effectiveness of staff teaching for inpatient discharge
    - Integrate pertinent changes from current patient safety initiatives to synchronize efforts
Components - How do we get there?

- Initial Quality Forum Group charted April, 2010
  - Developed initial Fishbone Diagram:
Components - How do we get there?

- Initial Quality Forum Group charted April, 2010
  - Reviewed ‘Gaps’ to success:

<table>
<thead>
<tr>
<th>HFAP Mandated Standards</th>
<th>Meets current standard?</th>
<th>Discharge to Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Unit</td>
<td>ICU</td>
</tr>
<tr>
<td>1</td>
<td>Reason for hospitalization &amp; condition at time of discharge</td>
<td>Yes(a)</td>
</tr>
<tr>
<td>2</td>
<td>Education of patients &amp; families about their diagnosis throughout the hospital stay</td>
<td>No (b)</td>
</tr>
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<td>3</td>
<td>Medications</td>
<td>Yes</td>
</tr>
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<td>4</td>
<td>Types of complications which may occur &amp; actions to take should they happen post discharge</td>
<td>No (b)</td>
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<td>5</td>
<td>List of follow-up appointments for tests &amp; clinical visits, with dates, times, and locations</td>
<td>No (b)</td>
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<td>6</td>
<td>Organized services to be initiated following discharge</td>
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<td>Advising the patient and family of any tests compiled in the hospital with results pending at time of discharge and identifying the clinician responsible for the results</td>
<td>No (b)</td>
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<td>8</td>
<td>List of relevant contact information</td>
<td>No (b)</td>
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<td>9</td>
<td>Any special instructions (e.g., activity level, diet, restrictions, etc.)</td>
<td>Yes**</td>
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<td>10</td>
<td>Assessing the patients’ understanding of the discharge plan in their own words</td>
<td>No**</td>
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<td>11</td>
<td>Providing telephone follow-up two to three days after discharge for those patients assessed to be at risk for adverse event post discharge</td>
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Interventions - How do we get there?

• Identify Process Improvements (June, July 2010)
  – Patient Discharge Instructions Format: PDIP (Patient Discharge Instructions Printout)
  – Management of patient symptoms post discharge: Red/Yellow/Green “Zone” Sheets
  – Identification of patient’s condition: Risk Stratification, concurrent coding activities
  – Patient Understanding of Discharge Plan/Diagnosis: Teaching Checklists using TEACHBACK Methodology
  – Develop standardized systems for data collection and validation of discharge process completion: PDI/PDRX 3.0
New Format: Patient Discharge Instructions

- Patient Friendly Tools:
  - Magnetic Zone Forms
  - Discharge Instructions (PDIP)
  - Medications
  - Business card sleeve
  - Discharge Follow up
  - Patient Education
  - Other Concerns
  - Admission Packet
  - Health History
  - Pocket Sleeves for additional information
HRH has prepared “Zone” Sheets on our top 20 most commonly occurring discharging diagnoses.

SMOG™ (http://www.readabilityformulas.com/smog-readability-formula.php) for readability.

Printed on tear-off pads for accessibility for now, future enhancement magnetized.
The PDIP are instructions the patient/family are to perform or follow after discharge.

Example:
- NOT: Keep your oxygen on continuously
- YES: Wear your oxygen all the time
- NOT: Keep your oxygen at 2L
- YES: Make sure the number on your oxygen tank is at 2
Re-engineering the discharge process allows for an opportunity to improve patient education delivery model: TEACHBACK methodology.

Teachback methodology is applied to Teaching Checklists, which are downloaded from hospital intranet and placed in Discharge Notebook under the Education Tab.

This will help subsequent caregivers know what has been done and what may need to be reinforced.
The canned text function has been updated to be more specific and follow the HFAP requirements. The same fields are also used in any department specific documentation screen.

Staff are reminded to document when they are unable to teach the patient/family and why or if the patient is unable to understand or perform the instructions.
How do we get there?

- Identify new Processes and Oversight (June, July 2010)
Oversight: Care Coordination

- New/Re-engineered responsibilities:
  - Risk Stratification upon admission
  - Multidisciplinary Care Conference;
    - Used to review the patient’s diagnosis, risk, what education has been done, what zone sheets are being used, the patient/so understanding at that point, what still needs done and taught, reminder to enter any patient instructions, etc.
  - Oversee the completion of the discharge checklist:
    - C/C handles during business hours; nursing after hours
Identification – Patient Diagnosis

- Confirmation of the patient’s diagnosis completed by Coding staff in Health Information Management (HIM)
- When changed, the updated Visit Reason and date of the change will show up on the Meditech Administrative Data screen at the Visit Reason item. The length of stay (LOS) may also be there (based on type of patient). This information is to help the caregiver begin and complete education on the correct diagnosis prior to the patient’s discharge
Summing it up:

- Patient discharge begins at admission:
  - Coders in HIM work to finalize patient diagnosis <24hrs
  - Care Coordination works on Risk Stratification of patient
  - Care Coordination begins review of Discharge Process Checklist during Care Conferences

- During Patient Stay:
  - Patient Education is documented, Zone Sheets are compiled
  - PDIP discharge instructions are authored
  - Physician discharge instructions compiled
    - Appointments are scheduled/Follow up care scheduled/Special services scheduled

- After Discharge:
  - Care Coordination makes follow up call
  - Physician discharge summary faxed by HIM to follow up provider (<7days)
Tying Interventions to Goals:

- Patient Discharge Instructions Format: PDIP
- Management of patient symptoms post discharge: Red/Yellow/Green “Zone” Sheets
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- Reduce re-admissions and call back from patients
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Lessons Learned so far:

• Wins:
  – Unified physician discharge system
  – TEACHBACK methodology
  – PDIP – Simplified Patient Education
  – Multi-disciplinary approach to patient care
  – Formal Discharge Policy & Established follow up call policy in place
  – Structure in place to accommodate new change

• Lessons Learned:
  – Timing of IS systems to help with rollout (PDIWEB)
  – Can not remove 100% of redundancy in the system (Patient Education + PDIP)
  – Not enough floor support during rollout
  – Too large of a focus on diagnosis in start leads to large volumes
  – Improved discharge requires more time...
  – Re-education of staff
Re-Engineered Discharge Process V2.0:

• What's still coming:
  – Uniform EHR (Meditech 6.0)
  – CPOE (12/2012)
  – Potential staffing enhancements:
    • Discharge Coaches
    • Enhanced Use of Pharmacy Staff (Med recon at Discharge/after Discharge)
  – Better integration with non-acute patient services
  – Further collaboration based on CMS’s Partnerships for Patient’s Initiative
Did it reduce readmissions?
**Current Process is Standardized:**

**Discharge Instructions Audit Tool**

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*Process Identified*
It's early to make predictions, but things seem to be heading the right way...

**Readmission Rate, HRH**

Q2, 2010
Q3, 2010
Q4, 2010
Q1, 2011
Q2, 2011

**Q2, 2011 Benchmarks**

Indiana
Staffed Beds: 100-249
VHA Select Peer Group

Source: IHA Comparative Outcome Profile, 2Q2011
Questions?
Thank you for your time today!

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