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

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%


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

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

Errors & Adverse Events

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


Errors & Adverse Events

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


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

- 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
<table>
<thead>
<tr>
<th>STANDARD</th>
<th>EDUCATION</th>
<th>SCORE SHEET</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Standard: Meet with the patient or legal guardian to explain the procedure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Standard: Assist the patient in completing the informed consent form.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Standard: Confirm the patient's understanding of the procedure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Standard: Ensure the patient's medical history is updated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Standard: Review the patient's laboratory results.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Notes:**
- Patient must be informed of all potential risks and benefits of the procedure.
- Ensure proper consent form completion.
- Follow up with patient post-procedure.
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 stakeholders
• Educate hospital staff & physicians
• Identify the sickest patients & review ways they get care & improve on the process
• Track your results 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