The Impact of Discharge Decision Support on Reducing Readmissions

Dr. Kathy Bowles, University of Pennsylvania School of Nursing
Agenda
Evidence-based Solutions for Transitional and Post-Acute Care

1. Acknowledgements
2. Objectives
3. Developing a Care Transition Plan
4. Acute Care Strategies & Solutions
5. Post-Acute Care Strategies & Solutions
6. Take Home Messages
7. Questions & Answers
Acknowledgements

• Factors to Support Effective Discharge Decision Making
  – Funded by NINR
  – PI: Bowles, Co-I’s: Holmes, Liberator, Naylor, Ratcliffe

• Decision Support: Optimizing Post Acute Referrals & Impact on Pt Outcomes
  – Funded by NINR
  – PI: Bowles, Co-I’s: Hanlon, Holmes, Naylor, Ratcliffe, Shaha, Stabler

• Hospital to Home: Cognitively Impaired Elders/Family Caregivers
  – Funded by NIA
  – PI: Naylor, Co-I’s: Hirschman, Bowles, McCuailey, Bradway, Pauly, Hanlon

• Promoting Self Care Through Tele-homecare: Impact on Outcomes
  – Funded by NINR
  – PI: Bowles, Co-I’s: Dansky, Naylor, Riegel, Goldberg, Glick, Weiner

Disclaimer: Scientific co-founder of RightCare Solutions, Inc. and has equity ownership in the company.
Today’s Objectives

Challenges to Effective Discharge Planning

1. State the challenges to effective discharge planning and transitional care

2. Understand the barriers to effective discharge planning

3. Discuss the significance and consistency of with the challenges

Evidence-based Strategies & Solutions

1. Articulate a framework for developing a successful Care Transitions strategy & plan

2. Review key strategies for acute & post acute facilities

3. Highlight examples of evidence-based solutions to effective discharge planning, information transfer, transitional care, and post-discharge monitoring
Barriers to Effective Discharge Planning

1. Discovered Lack of Post Acute Referrals
   - 64% of patients readmitted within 30-days received NO post-acute care

2. No National Guidelines for Discharge Decisions
   - Over 40 million discharges in US annually with various discharge models

3. Lack of protocols
   - Inconsistent assessments, Varying levels of expertise & risk tolerance, No benchmarks

Short stays decrease the time for discharge planning and teaching time, potentially decreasing patient and family knowledge concerning care.

Discharge Planning is COMPLEX and has multiple steps requiring planning, education, communication, and coordination.

Patients often leave the hospital with more medications and poorer function than before admission.
Challenges to Effective Discharge Planning and Transitional Care

- Increasing Complexity of Patients
- Multiple clinical providers per patient
- Inconsistent decision making
- Inconsistent Patient Involvement
- Payor requirements
- Churn across care settings
Evidence-based Strategies & Solutions

• Establishing an evidence-based care transitions strategy & plan
• Review examples of evidence-based strategies and solutions
In 2011, Penn Medicine established “local leadership” on each hospital unit.

Three-Way Partnership Manages Quality on the Hospital Units

**Physician Leader** and **Nurse Leader** are paired at the hospital unit level — with a **Project Manager for Quality** who brings data and project management skills.

**We call these trios “UBCLs,”** for “Unit Based Clinical Leadership.”
# Released Blueprint for Quality & Patient Safety - The 5 Imperatives

<table>
<thead>
<tr>
<th>Imperatives</th>
<th>Priority Actions</th>
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| Accountability For Perfect Care | • “Always” events - strive to provide perfect care  
                                      • Implement clear lines of accountability that span inpatient and ambulatory environments |
| Patient And Family Centered Care | • Provide consistent and thorough communication with families & patient regarding plan of care  
                                      • Increase patient and family involvement in UPHS forums that address issues relevant to quality, safety and service excellence  
                                      • Enhance patient-provider partnership through better exchange of information |
| Transitions In Care/Coordination Of Care | • Ensure all UBCLs implement redesign care processes related to:  
                                      - Risk stratification  
                                      - Interdisciplinary rounding  
                                      - Discharge hand-off to outpatient care |
| Reducing Unnecessary Variations In Care | • Eliminate variations in care processes where evidence exists  
                                      • Balance conformity in practice with needs for personalized care  
                                      • Set goals that are positive and proactive |
| Provider Engagement, Leadership, And Advocacy | • Strengthen organizational capacity and capability for continuous improvement  
                                      • Increase involvement of house staff in quality, safety and service excellence efforts |

Source: Myers, Quality Colloquium, 2011
Analytics and Decision Support is at the Heart of the UPHS Transitions Model

**UPHS Transitions Model — Seven “Levers”**

<table>
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<tr>
<th>Screen for patients at greatest risk</th>
<th>Real-time readmissions feedback to actively manage patients</th>
<th>Interdisciplinary care planning</th>
<th>Links to post-acute follow-up services</th>
<th>Primary care follow up</th>
<th>Med mgmt. across the continuum</th>
<th>Education &amp; red flag mgmt.</th>
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Source: Victoria Rich, CNO UPHS, 2011
10+ years of NIH-funded Research led to Risk Stratification Tools At Admission For All Patients

A patient's true individual risk and need is NOT found in the EMR. Multiple community, socio-economic, demographic factors are critically important in understanding a patient's ability to take care of themselves once they leave the hospital.
D2S2 (now “RightCare Risk Assessment”) was developed over 10+ years by interdisciplinary team

Assesses all patients at admission and assigns a risk score which includes:

1. Seven questions added to or modified in current nurse intake form that takes into consideration the following:
   - Socio-economic factors
   - Demographic factors
   - Psychological factors
   - Environmental factors
   - Clinical factors
   - Utilization factors

2. Plus, RightCare big data analytics platform where the software learns over time

* D2S2 has been exclusively licensed to RightCare by University of Pennsylvania
RightCare Risk Assessment showed a 34% reduction in 30-day all-cause readmission.

**Intervention Units - 30-day All-Cause Readmissions**

3 Hospitals, 6 Units, n=404

- **High-Risk - Control (n=54)**: [VALUE]
- **High-Risk - Experimental (n=64)**: 22.2% decrease
- **Low Risk - Control (n=121)**: [VALUE]
- **Low Risk - Experimental (n=165)**: [VALUE]
- **All Patients - Control (n=175)**: [VALUE]
- **All Patients - Experimental (n=229)**: 34% decrease

Provided by RightCare
RightCare Leverages Big Data for Advanced Discharge Planning Decision Support

Who?

What Level(s)?

Which Agency(s)?

Patient 1

Home Alone

Agency 1

Patient 2

Tele Health (IVR)

Agency 2

Patient 3

Home Health

Agency 3

Patient 4

Skilled Nursing Facility

Agency 4
Getting the Right Level of PAC Matters

Key Takeaways:
Patients receiving at or above the recommended level of care were ~24% less likely to be readmitted.
Referral Patterns Matter

Key Takeaways:

Through the use of the RightCare software, fewer high-risk patients were discharged to home with no post-acute care. This resulted in a 15% increase in home health referrals, and a 6.5% decrease in SNF utilization.

Date: Q2 – Q4 2013
n = 3,630 patients
Analytics is at the heart of the Transitions Model

**UPHS Transitions Model — Seven “Levers”**

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Source: Victoria Rich, CNO UPHS, 2011
Enabling Links to Post Acute Care Services with Technology

**ACUTE CARE**

- ED/Admit
- Inpatient Care Coordination

**POST-ACUTE**

- Integrated Care Partners (SNFs, Home Health, Rehab, Nursing Home, etc)
- Dedicated Patient Navigators

**Care Coordination by RightCare**

- Readmission Risk Assessment & Focused Interventions
- ED Care Coordination Optimization
- Alternative Site of Care Transitions
- Focused Interventions
- Prioritization of Resources
- Standardized Care Processes
- Acute to Post Acute Transitions
**Transitional Care Model with Patient Navigators**

**GENERAL SERVICES PROVIDED BY PATIENT NAVIGATOR**

- Facilitating communication among patients, family members, survivors and healthcare providers
- Coordinating care among providers
- Arranging financial support and assisting with paperwork.
- Arranging transportation and childcare.
- Ensuring that appropriate medical records are available at medical appointments.
- Facilitating follow-up appointments.
- Community outreach and building partnership with local agencies and groups.
- Ensuring access to clinical trials.

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**Improve Identification of Patients in Need of Post Acute Care**

**Need for Consistency Across Care Settings**

**Establish Patient Navigators in Acute Setting**
Effective telehealth in patients’ home is to teach self care and monitor chronic illness management.

Not all patients benefit from telehealth.
# Take Home Messages

1. The lack of time and resources available to hospital discharge planners calls for improved methods and rethinking the current workflow.

2. Need to efficiently and accurately identify patients in need of discharge planning and post acute care. Is this your core expertise or should you engage experts with already proven methodology?

3. The quality of your discharge planning process determines whether patients receive the health and social services they need.

4. Decision support tools can help improve important decisions on who needs post acute care, what type of post acute care, and the combination of follow-up services to best maximize the patient outcome.

5. RightCare is a highly effective scalable technology to bridge the gap between acute and post-acute care partners to ensure a seamless transition to the right type of post-acute care services.

6. The Transitional Care Model is a highly effective advanced practice nurse led model to support the transition from hospital to home.

7. Telehealth monitoring is an increasingly used strategy to teach self care and monitor for changes in health status BUT not all patients benefit from this technology. Needs to be used for only patients that will respond.
Thank you!

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