Ensure Timely Post-Hospital Care Follow-Up

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These presenters have nothing to disclose.

Session Objectives

Participants will be able to:

- Provide an overview of this key change.
- Discuss strategies for testing and implementing this key change.
- Provide an introduction to action planning for this key change, including designing reliable processes as well as testing and using process measures.

Ensure Post-Hospital Care Follow-Up

- Recommend that patients that are high-risk for a readmission be seen within 48 hours (either in an office visit or a home care visit); there is not consensus about how soon patients need to be seen after discharge form the hospital.
- In general, it is a challenge to schedule appointments with office practices, as needed.
- Follow-up phone calls give caregivers the opportunity to reinforce education and assess self-care knowledge through the use of Teach Back; often patients are receiving multiple calls.
- Need a much deeper understanding of how best to meet the needs of high-risk patients – front-loaded home care visits, office practice appointments within 48 hours, supplemental transitional care by APNs or RNs or intensive care management through primary care or health plans?

Ensure Timely Post-Hospital Follow-Up

Typical Failures:

- Medication errors;
- Discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy;
- Lack of scheduled follow-up appointment with appropriate care providers, including specialists;
- Follow-up visit too long after hospitalization;
- Follow-up visit made the sole responsibility of the patient;

Ensure Timely Post-Hospital Follow-Up

Typical Failures (cont):

- Inability of patient to keep follow-up appointments because of illness or transportation issues;
- Lack of an emergency plan with number the patient should call first;
- Multiple care providers, resulting in patient confusion about which provider is in charge;
- Lack of patient social support; and
- Patient lack of adherence to self-care activities (e.g., medications, therapies, daily weighing, or wound care) because of confusion about needed care, availability of transportation, method for scheduling appointments, or how to access or pay for medications.

Evidence Is Mixed

- Hernandez et al reported that patients with HF who were discharged from hospitals with lower rates of follow-up visits had a higher 30-day readmissions
- Mayo clinic study no difference in 30-day readmissions between those with and without a follow-up visits

Controlled Trials

- Clinic visit only is not enough
- Nursing support alone is equivalent to telemonitoring
- Early follow up appointment important, but not clear if it is 3-5-7 days, some data shows 7 is too long
- Multidisciplinary Team most effective
- Single home visit can make a difference

Phillips et al, JAMA 2004: 29(11) 1358-67

Timely Post-Hospital Follow-Up

Changes:

A. Identify each patient's medical and social risks for readmission

B. Prior to discharge:

- Schedule timely follow-up care and
- Initiate clinical and social services based upon the risk assessment

Timely Post-Hospital Follow-Up

High risk patients:

- Patient has been admitted two or more times in the past year
- Patient unable to "Teach Back' or the patient or family caregiver has low degree of confidence to carry out self-care at home

Recommended Action:

- ✓ Patient and family caregiver have the phone number for questions and concerns
- ✓ Before discharge schedule a face-to-face visit with home care or physician's office within 48 hours
- ✓ Consider home care or discharge coach

Timely Post-Hospital Follow-Up

Moderate risk patients:

- Patient has been admitted once in the past year
- Patient or family caregiver has moderate degree of confidence to carry out self-care at home

Recommended action prior to discharge schedule:

- ✓ Patient and family caregiver have the phone number for questions and concerns
- ✓ Follow-up phone call within 48 hours
- ✓ Physician office visit within 5 days

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Timely Post-Hospital Follow-Up

Low risk patients:

- Patient has had no readmissions in the past year
- Patient or family caregiver has high confidence and can Teach Back how to carry out self-care at home

Recommended action prior to discharge:

- ✓ Patient and family caregiver have the phone number for questions and concerns
- ✓ Schedule a physician office visit as ordered by the attending physician

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Evidence Based Models for Reducing Hospital Readmission

Advanced Practice Nurse-Driven Transitional Care

- APNs use an evidence-based protocol for care, based on national heart failure guidelines and designed especially for this patient care group and their caregivers.
  - Naylor MD, et al. Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial. *J Am Geriatr Soc.* 2004 May;52(5):675-684.

The Care Transitions Intervention:[SM] Transitions Coach

- A "Transitions Coach" empowers patients with skills, tools and confidence tod ensures their needs are met during the transition from hospital to home.
  - http://www.caretransitions.org/.

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Post-Hospital Follow-up Visit

Coleman EA. “The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmissions”. California Health Care Foundation Issue Brief, October 2010. www.chcf.org

Institute for Healthcare Improvement

Laying the Groundwork

- Meet with hospitalists to redesign summary
  - Action oriented
  - If/Then statements
  - Mode and timeliness of communication
- Create access for hospital follow-up visits

Prior to the Visit

- Review discharge summary
- Clarify outstanding questions
- Reminder call to patient or family caregiver
- Stress importance of visit & address barriers
- Remind to bring medication lists and all meds
- Provide instructions for after-hours care

During the Visit

- Ask the patient to reflect on the factors that may have contributed to hospital admission
- Perform medication reconciliation
- Instruct patient in self-management
- Explain warning signs and how to respond
- Provide instructions for seeking after-hours care

At the Conclusion of the Visit

- Print reconciled, dated, medication list and provide a copy to the patient, family caregiver, home health nurse
- Communicate revisions to the care plan to family caregivers, home health nurses
- Ensure that the next appointment is made

St. Luke's Heart Failure Continuum

- Written discharge instruction sent home with patient and available immediately on line in clinic or home care agency.
- Home Care complimentary visit 24 to 48 hours post discharge – use Teach Back again
- Physician office visit within three to five days
- Advance Practice Nurse follow-up phone call on seventh day post discharge – Teach Back repeated
- Outpatient Heart Failure class – seeing increased participation
- Collaboration with cardiology office Heart Failure Clinic

Home Care Visit
24-48 Hours Post Discharge

- Small test of change October 2006
- Education to all Home Care staff
- Visit 48 hours after discharge
- Visit outline
  - Medication Reconciliation
  - Review of diet and foods in-house
  - Teach back on water pill, diet and weight
  - Vital signs
  - Hardwired process in January 2007

St Luke's Hospital, Cedar Rapids, Iowa

Cost for Heart Failure Program

- Home Care visit: $110.00
  - St. Luke's covers $58.00; the remainder of $52.00 is absorbed
  - Follow-up phone calls: $10,000 (annual)
  - Education material
    - Magnet: $1.00
    - Total with handouts: $1,200

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Follow-Up Phone Call

- Advance Practice Nurse makes follow-up phone call at seven days post-discharge
- Standardized questions
- Results monitored and changes made as needed based on feedback
- Results monitored globally and per individual unit

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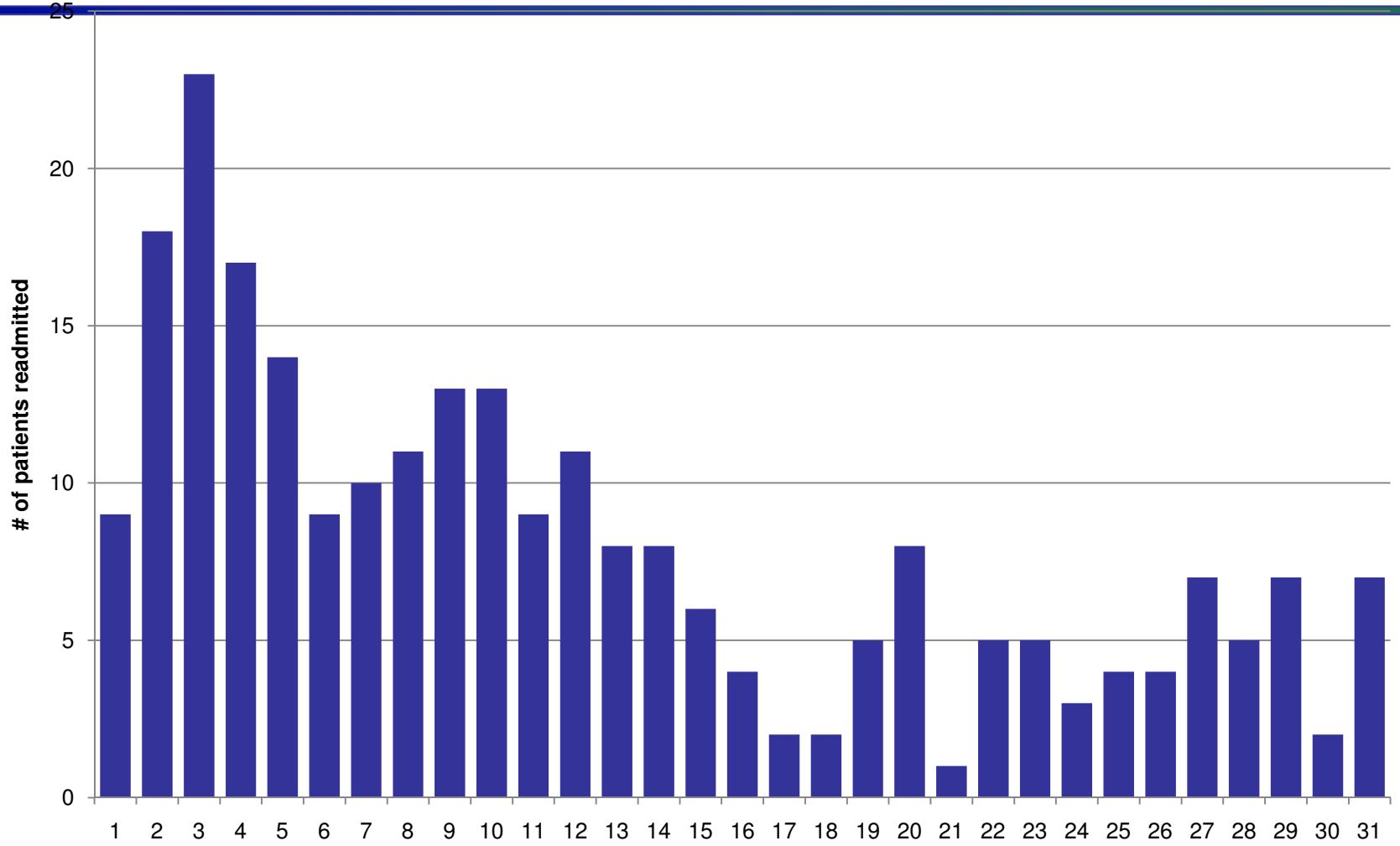
Frequency of Readmissions by Number of Days Between Discharge and Readmission

SAMPLE DATA



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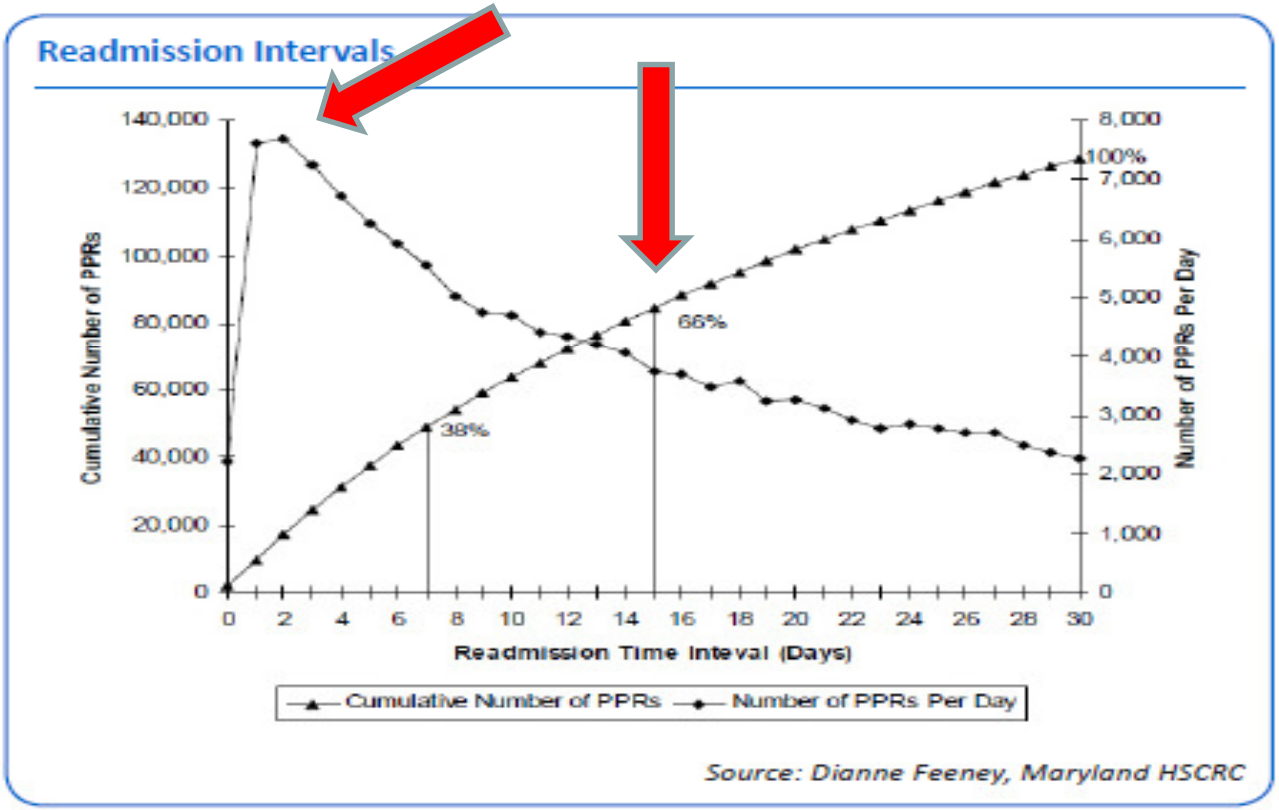
When are patients being readmitted?

- Initial readmissions spike within 48 hours of discharge
- 66% of readmissions occur within 15 days



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Primary Care
Follow-Up Appointment

- Worked with Primary Care to assure follow-up visits scheduled 3 to 5 days post discharge

  —Particularly on high-risk patient for readmission

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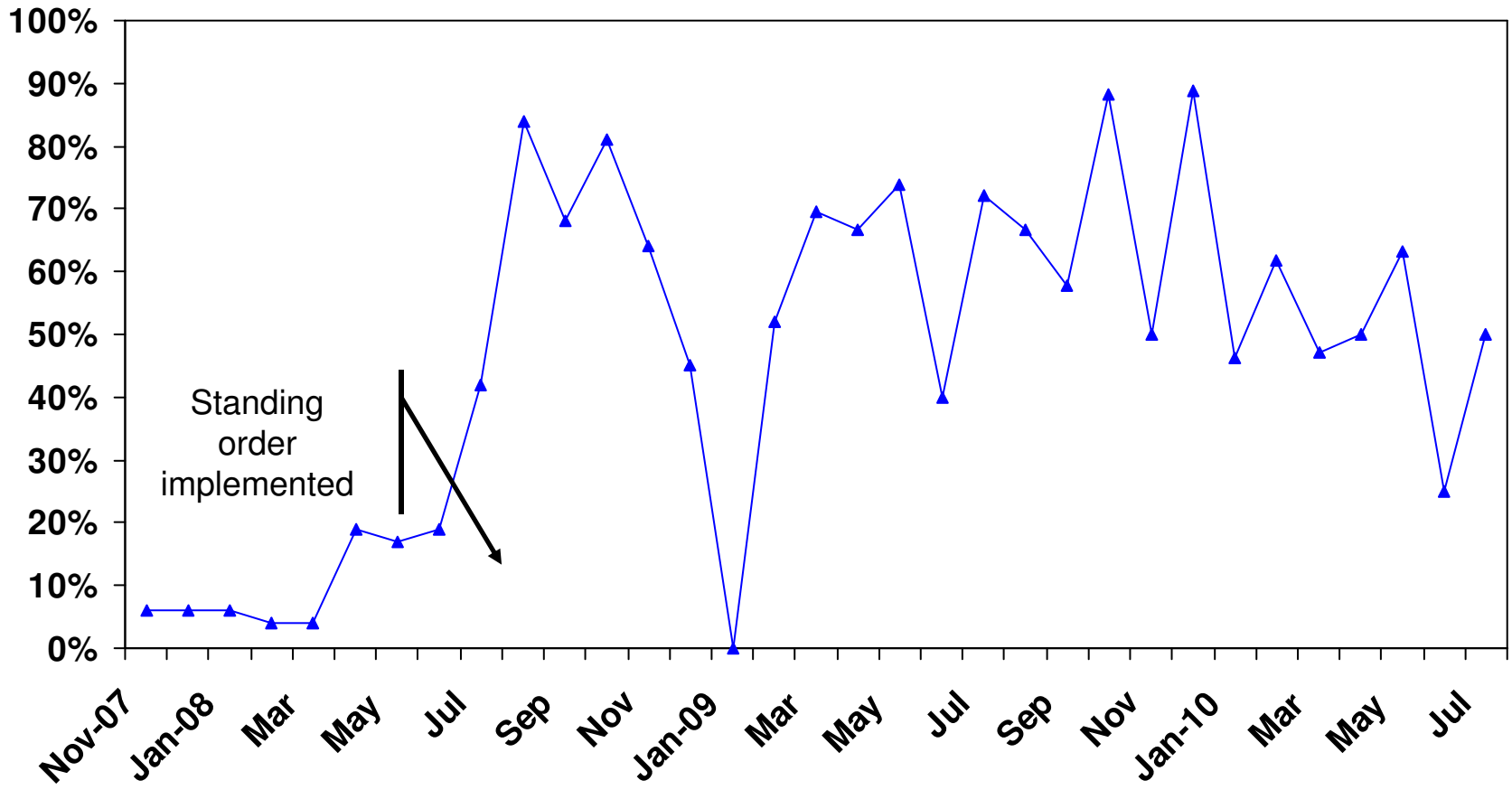
% Patients with Follow-up Appointment Scheduled for Three to Five days after Discharge

Nov 07 – Jul 10



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Identify Opportunities

- Review your readmission rates by # of days between discharge and readmission
- Review role of palliative care in your process
- Check usefulness of discharge summary with your providers
- Does your discharge information arrive in time for the patient visit?

Process Measures

Timely Post-Hospital Follow-Up:

- Percent of patients discharged who had a follow-up visit scheduled before being discharged in accordance with their risk assessment

What we are learning about timely follow-up care?

- There is not consensus about how soon high risk patients need to be seen after discharge form the hospital.
- In general, it is a challenge to schedule appointments with office practices as needed.
- Hospitals need to create processes for assigning patients to a primary care provider if they don't have one.
- Follow-up phone calls give caregivers the opportunity to reinforce education and assess self-care knowledge through the use of teach-back.
- We need a much deeper understanding of how best to meet the needs of high risk patients – front-loaded home care visits, office practice appointments within 48 hours, supplemental transitional care by APNs or RNs or intensive care management through primary care or health plans?