



RUSH UNIVERSITY
MEDICAL CENTER

IT'S HOW MEDICINE
SHOULD BE

Readmissions Tools: *An Enhanced Discharge Planning Program and Project BOOST*

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“The hospital of the future will be a health center, not just a medical center...the hospital will offer valuable resources to the community on matters of health and well-being, and will be held increasingly accountable for the community’s health status.”

--Shi & Singh, 2004

Objectives

- Present the process by which Rush developed a transitional care program
- Present how Rush provides transitional care to older adults and other at-risk populations
 - Enhanced Discharge Planning Program
 - Project BOOST
 - Other projects
- Present the future of transitional care at Rush and in Illinois



... in the heart of Chicago

Rush is located minutes from downtown Chicago in the West Side Medical District

- 676 staffed beds (72 rehab)
- 27 patient care units
- 495 ADC
- 2,276 births
- 30,012 admissions
- 5.3 ALOS
- 169,547 patient days
- 19,929 surgeries
- 49,773 emergency department visits

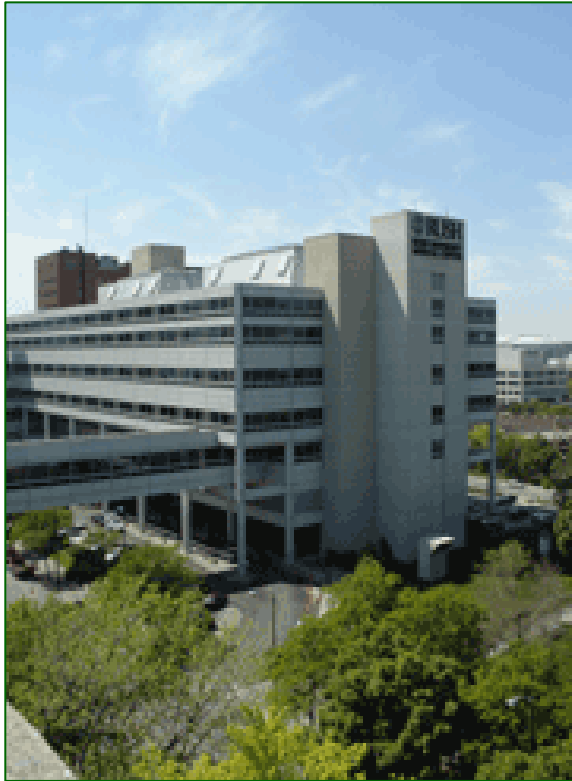


- Commitment to improving patient outcomes through the adoption of best practices
 - Data driven and evidence based
 - In consideration of regulatory and publicly reported measures
 - Sensitive to human and financial resources
 - With patient and family involvement
- Accountability and communication across disciplines
 - Maximize each disciplines' role in care coordination
 - Spirit of openness and willingness to look at things differently and change



- Short-term telephonic care coordination
- Provided by Master's-prepared social workers
- For older adults at risk for adverse events after an inpatient hospitalization

Rush EDPP: History



- Collaboration between Rush Older Adult Programs and Case Management Department
 - Performed between March 2007 and May 2009
 - Piloted on 4 units at RUMC
- Created to address a need seen by hospital staff

Rush EDPP: Goals

- Promote patient safety and quality of life
- Improve health outcomes and the patient experience
- Reduce unnecessary healthcare costs for older adults
 - Target major causes of preventable readmissions
- Create a bridge between the hospital and the community
 - Ensure the direction provided by the medical team is not lost
 - Provide referrals to important community services for older adults

Rush EDPP: Vision

- Develop discharge standards of care
 - Identify gaps in service for policy and systems change
 - Encourage community involvement and support for older adults at risk for rehospitalization
 - Determine issues requiring the most assistance after discharge

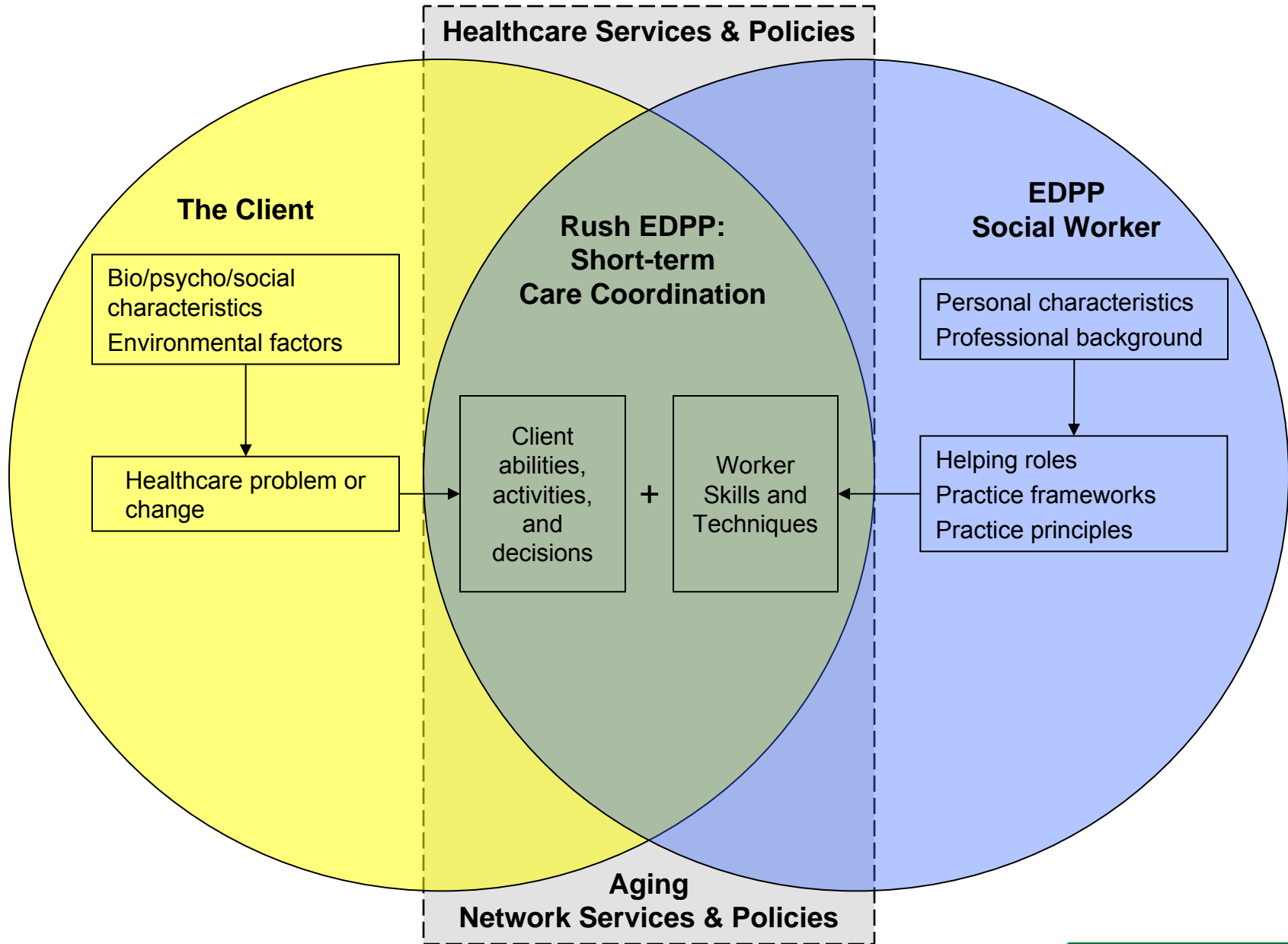


Rush EDPP: Key Components



- Follows a basic protocol
 - Biopsychosocial and environmental framework to determine patient needs
 - Evaluation of patients' expectations and ability to follow the discharge plan of care
 - Intervention around issues arising as a result of a complicated transition
 - Collaboration with existing providers to promote better health outcomes and quality of life

Rush EDPP: Systems Framework



Rush EDPP: Research

- Created to test EDPP's impact
- In response to national imperative
 - 30-day readmissions
 - Health care reform
- Required standardization of EDPP model
 - Referral procedure
 - Assessment
 - Intervention



EDPP Step 1: Referral

Rush EDPP Referral Criteria

Must meet all the following criteria:

Aged 65+
Speak English
Discharged to home or home with assistance
7+ medications prescribed
Without a primary diagnosis of transplant

Must also meet one additional criterion:

Lives alone
Without a source of emotional support
Without a support system for care in place
Discharged with a service referral
High falls risk
Inpatient hospitalization in past 12 months
Identified in-depth psychosocial need
High risk medication prescribed

- Eligible patients referred through electronic report
- Eligibility criteria based upon:
 - Review of literature
 - Trends observed during program's pilot
 - Feedback from Rush case managers

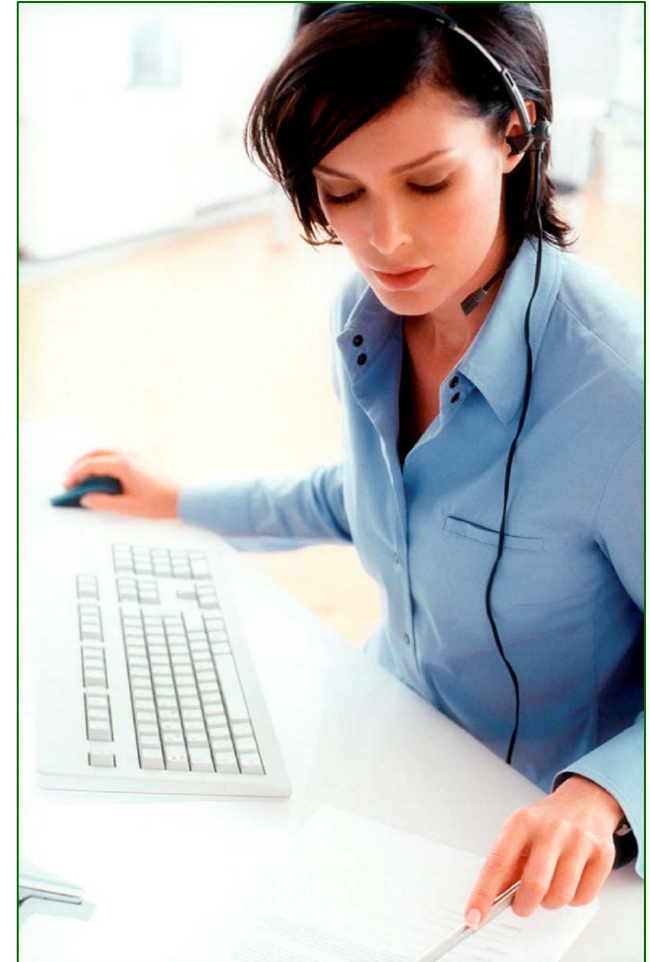
EDPP Step 2: Pre-assessment

- Upon receiving an electronic referral, the EDPP Social Worker:
 - Reviews the patient record and case management notes for relevant medical and psychosocial information
 - Investigates previous hospitalizations as required
 - Identifies potential problem areas requiring in-depth assessment
 - Generates a list of questions addressing potential problem areas
 - Seeks information about and clarification of patient situation from inpatient case manager as necessary



EDPP Step 3: Telephonic Assessment

- The EDPP Social Worker calls the patient or caregiver within 2 working days of discharge
 - Performs a basic biopsychosocial assessment
- Goals of the initial post-discharge assessment
 - Stabilize existing post-discharge situation
 - Ensure the patient and family follow up with medical providers and are receiving appropriate health care and community services



- Next, the EDPP Social Worker asks targeted questions
 - Questions regarding potential problem areas suspected during the pre-assessment
 - Questions regarding issues identified during the assessment

For example, if a patient is identified as having potential transportation difficulties:

How do you get around outside your home?

Who assists you in getting to appointments?

EDPP Step 4: Intervention

- EDPP Social Worker intervenes around identified issues

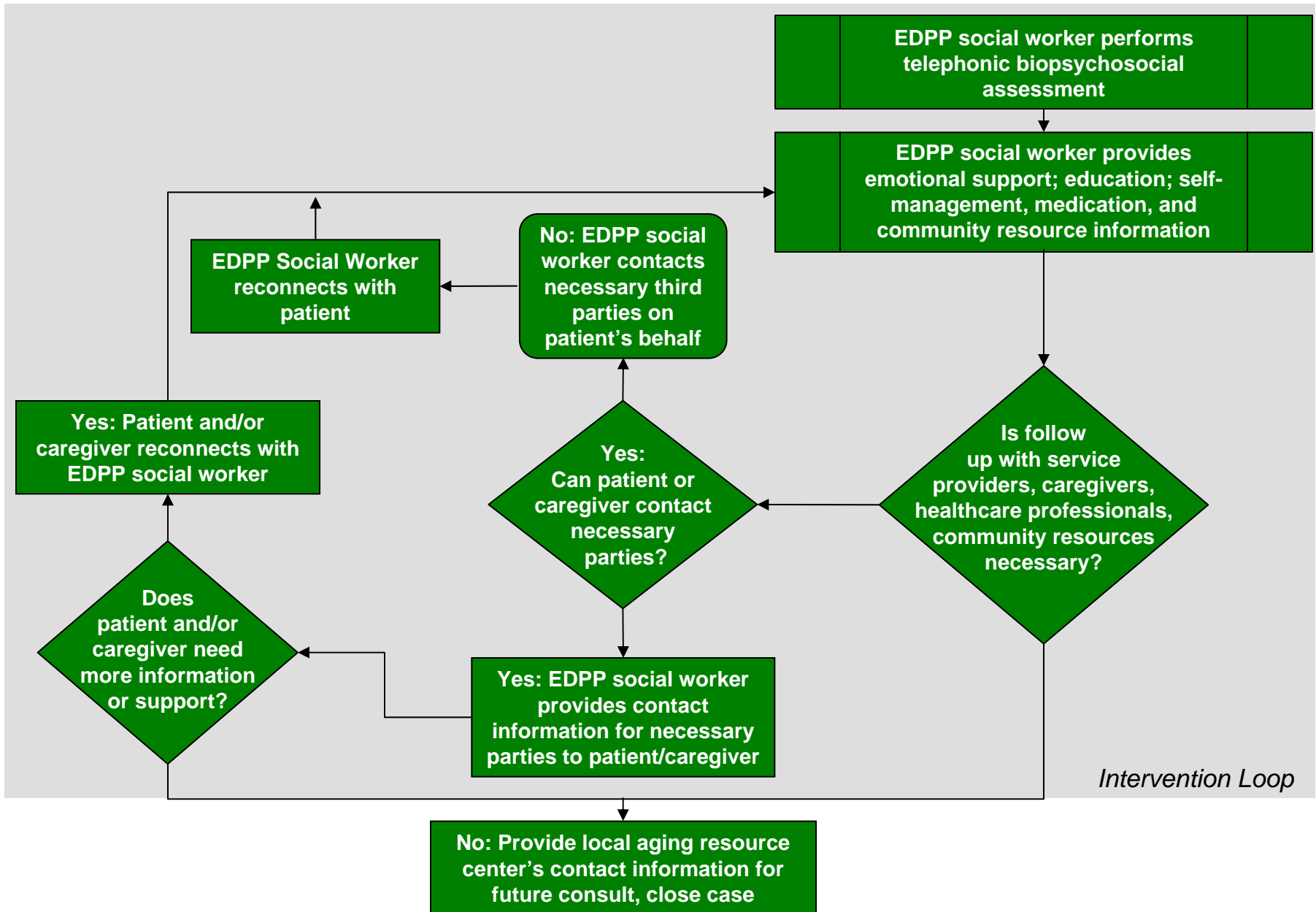
For example, if a patient has transportation difficulties:

Provide information, literature, and/or resources related to transportation programs

Refer to community-based, faith-based, and/or aging network resources that can provide the service

- EDPP Social Worker completes the intervention loop until issues resolved

EDPP Step 4: Intervention





- Randomized controlled trial between June 2009 and February 2010
- 720 participants
 - 360 intervention group
 - Receiving full EDPP intervention upon discharge
 - 360 control group
 - Receiving usual care upon discharge

- 82.8% of intervention group patients had issues identified by an EDPP clinician upon discharge
 - For 73.5% of these individuals, problems did not emerge until post-discharge
- On average, resolving issues identified during the initial assessment required:
 - 7.57 days
 - 5.36 calls



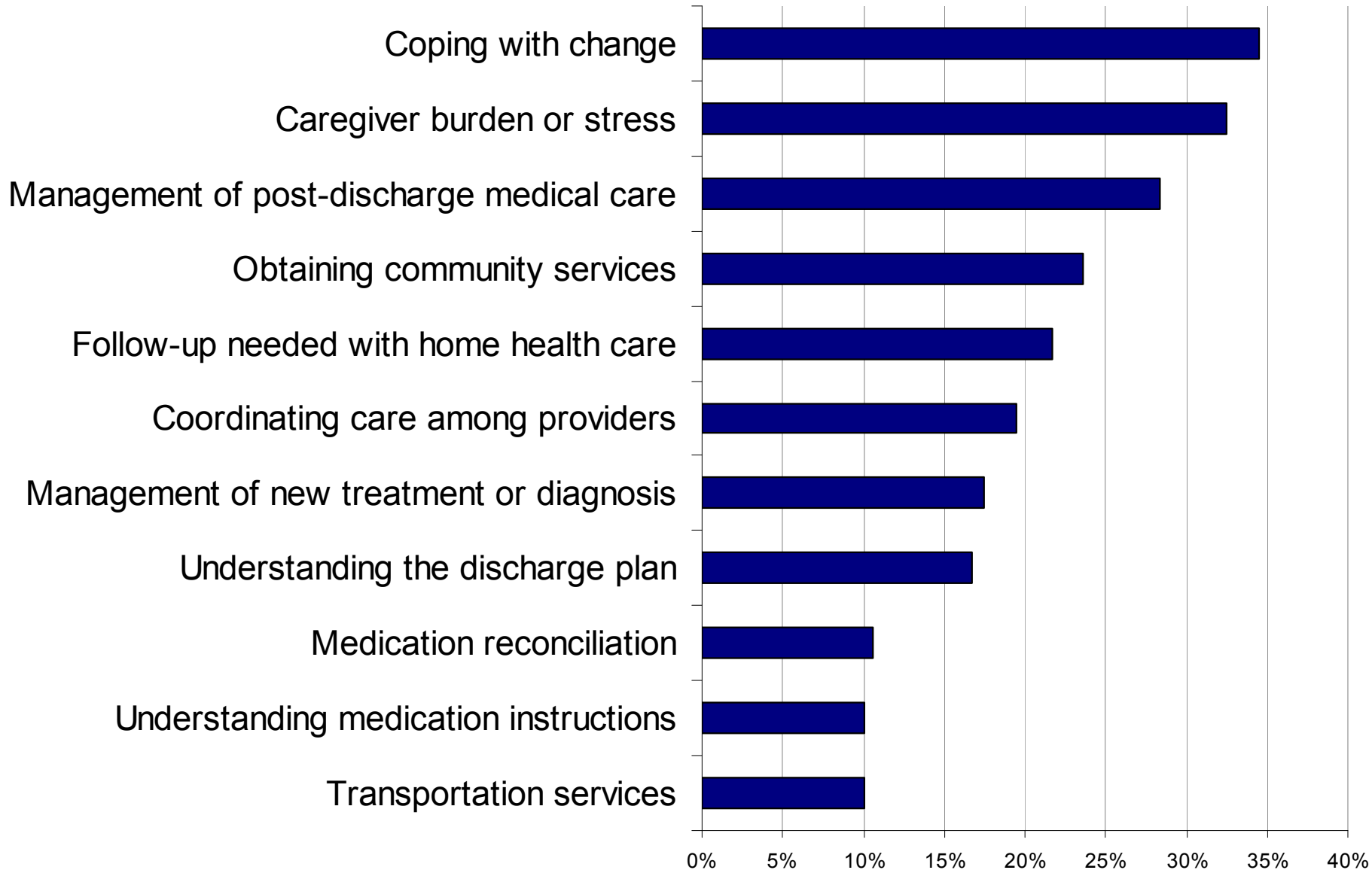
EDPP RCT: Utilization

Physician Follow-Up		
	<i>Intervention</i>	<i>Usual Care</i>
No	27	34
Yes	239	205
Rate	89.8%	85.6%

$\chi^2=9.88, p=.001$

- Intervention Group participants are more likely to make and keep follow-up appointments
- Readmission, emergency department usage, and nursing home placement currently under analysis

EDPP: Most Common Problem Areas



- Link patient to Rush services, 95.0%
- Provide emotional support, 85.3%
- Coach on patient advocacy, rights, and responsibilities, 71.4%
- Provide information, literature, and/or resources around identified issue, 58.7%
- Facilitate communication between patient/caregiver and service provider, 55.8%
- Facilitate transfer of information, 53.3%
- Communicate with and support identified caregiver, 50.6%
- Assist in decision-making, 50.0%

“I may need more resources, but now I know where to call. There’s so much out there I didn’t know, but I’m now aware thanks to the social worker...I’m so happy with the quick attention I received after I left the hospital.”



Other Programs at Rush

- Other programs are happening simultaneously at Rush to improve transitional care for patients
 - Project BOOST
 - Collaborative Care Model
 - Conjestive Heart Failure Program
 - Anticoagulation Program



- Project BOOST: Better Outcomes for Older Adults through Safe Transitions
 - Society of Hospital Medicine initiative to create and implement transitional care best practices
 - Improves the transition process by improving care across the continuum through the following elements:
 - Team communication
 - Content of the discharge summary
 - Patient education through teach back
 - Medication safety and polypharmacy
 - Symptom management
 - Discharge and follow-up care



- TARGET: Tool for Adjusting Risk: A Geriatric Evaluation for Transitions
 - 7P Risk Scale
 - Prior hospitalization
 - Problem medication
 - Punk (Depression)
 - Principal Diagnosis
 - Polypharmacy
 - Poor health literacy
 - Patient support
 - Risk specific checklist
 - GAP: General Assessment of Preparedness

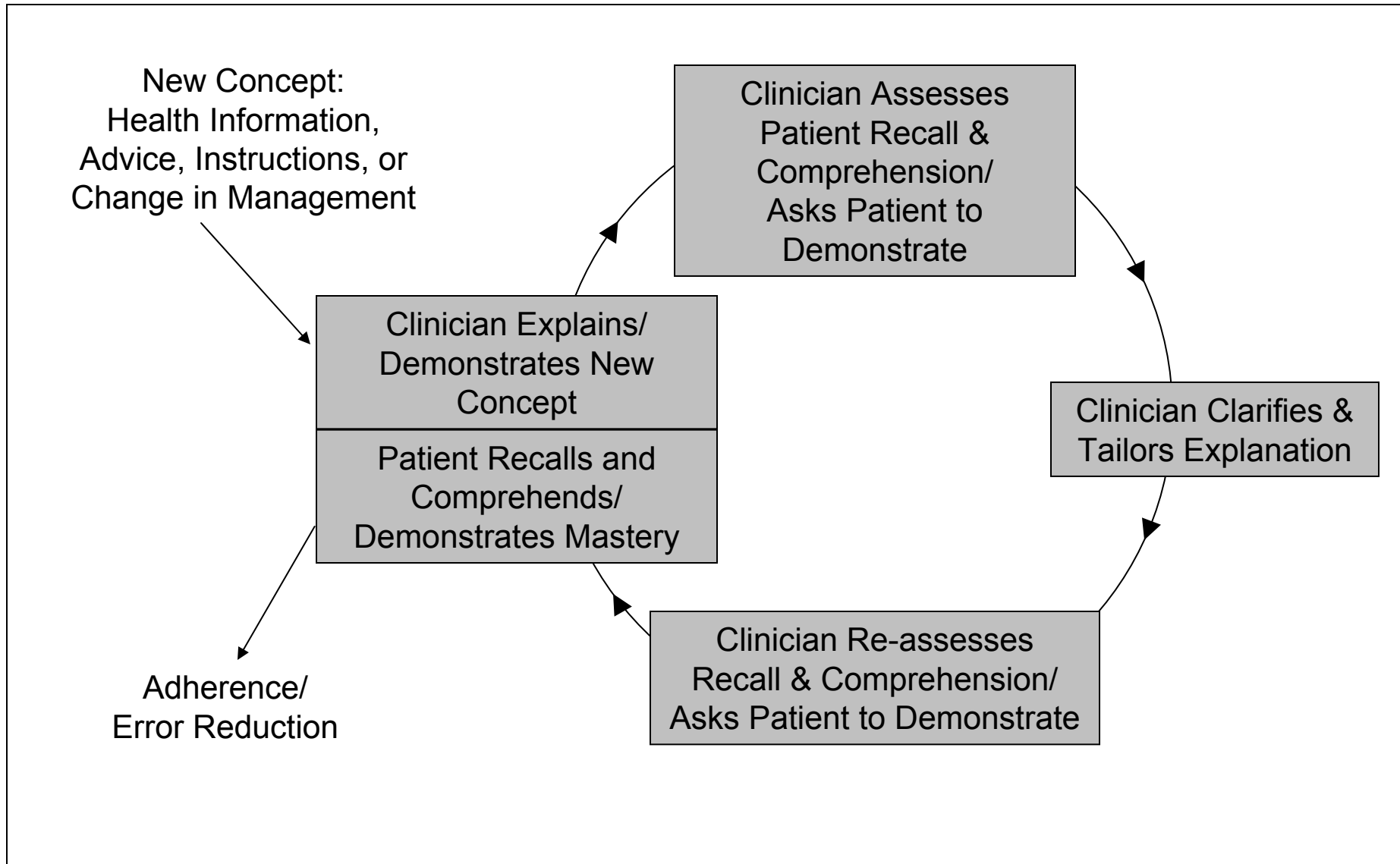


- At admission:
 - Caregivers and social support circle for patient identified
 - Functional status evaluation completed
 - Cognitive status assessed
 - Abuse/neglect presence assessed
 - Substance abuse/dependence evaluated
 - Advanced Care Planning documented

- Prior to discharge:
 - Functional status evaluation completed
 - Cognitive status assessed
 - Ability to obtain medications confirmed
 - Responsible party for ensuring medication adherence identified and prepared (if not patient)
 - Home preparation for patient's arrival (eg, medical equipment, safety evaluation, food)
 - Financial resources for care needs assessed
 - Transportation home arranged
 - Access (eg, keys) to home ensured
 - Support circle for patient identified

- At discharge:
 - Understanding of diagnosis, treatment, prognosis, follow-up, and post-discharge warning signs and symptoms confirmed with teach-back
 - Transportation to initial follow-up arranged
 - Contact information for home caregivers obtained and provided to patient

Project BOOST: Teach Back



Project BOOST: Patient Pass



Patient PASS: A Transition Record

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because _____		
If I have the following problems ... 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	I should ... 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Important contact information: 1. My primary doctor: () _____ 2. My hospital doctor: () _____ 3. My visiting nurse: () _____ 4. My pharmacy: _____ () _____ 5. Other: _____
My appointments: 1. _____ On: __/__/__ at __:__ am/pm For: _____ 2. _____ On: __/__/__ at __:__ am/pm For: _____ 3. _____ On: __/__/__ at __:__ am/pm For: _____ 4. _____ On: __/__/__ at __:__ am/pm For: _____	Tests and issues I need to talk with my doctor(s) about at my clinic visit: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	I understand my treatment plan. I feel able and willing to participate actively in my care: _____ Patient/Caregiver Signature _____ Provider Signature ____/____/____ Date
Other instructions: 1. _____ 2. _____ 3. _____		

Rush Collaborative Care Model

- Pilot to identify best practices for improving patient outcomes from the point of admission through post-discharge
 - Interdisciplinary team holds daily rounds to identify and intervene around high-risk patients
 - Provides EDPP transitional care coordination to high-risk patients upon discharge
- Collaboration of multiple initiatives at Rush, including EDPP and Project BOOST

Care Coordination Requirements

- Processes, tools and technology developed for consistent care across all shifts and weekends
- Applicable to changing trends, payer mixes, and patient populations
- Replicable
- Preserve the strengths of being a Magnet Hospital
- Leverage existing resources
 - Personnel
 - Expertise
 - Technology

- Patient risk screening on admission
- Daily interdisciplinary rounds
- Written interdisciplinary plan of care
- Patient and family involvement in care planning
- Interdisciplinary patient teaching
- At-risk patient post-discharge follow-up
- Outcome metrics

- Participants
 - Case manager
 - Direct care nurse
 - Physician
 - Pharmacist
 - EDPP Social Worker



- Information Shared
 - Plan of care
 - Goal for day/stay
 - Treatment decisions
 - Patient status
 - Concerns/issues
 - Discharge plans
 - Risk factors and interventions
 - Reasons for potential readmissions

- Congestive heart failure program
 - Patients discharged with a history of congestive heart failure
 - Reinforces need for and identifies barriers to appropriate medical follow-up
 - Interdisciplinary team identifies systemic issues contributing to poor patient outcomes and rehospitalizations
- Anticoagulation program
 - Patients discharged new on anticoagulants
 - Reinforces patient education
 - Ensures patients understand medications and medical treatment

- Central issues of ITCC collaboration:
 - Lack of coordination between medical services and long-term care systems
 - Illinois' Community Care Program (CCP) lacks direct link to the medical care system
 - Poor coordination of care consistently leads to problematic health outcomes and increased health care costs
- Goal to establish a state-wide Transitional Care Model



- Rush University Medical Center
- Health and Medicine Policy Research Group
- Aging Care Connections
 - Adventist LaGrange Memorial Hospital
- Solutions for Care (formerly Berwyn-Cicero)
 - MacNeal Hospital
- Shawnee Alliance for Seniors
 - Carbondale Memorial and Herrin hospitals
- UIC School of Public Health

- Received funding from the Harry and Jeanette Weinberg Foundation
- Implementing the Bridge Program, a state-wide social worker driven transitional care model with built-in geographic flexibility
 - Utilizes universal transitional care principles to bridge silos of care
 - Will be applied and evaluated in urban, suburban and rural hospitals
 - Will incorporate a health IT component coordinated by a social work Care Manager

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Conclusion



“Nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicines as the only approach to health care.”

--George Engel, 1977