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
Care Coordination Principles at Rush

• 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

The Client
- Bio/psycho/social characteristics
- Environmental factors
- Healthcare problem or change

Rush EDPP: Short-term Care Coordination
- Client abilities, activities, and decisions
- Worker Skills and Techniques

EDPP Social Worker
- Personal characteristics
- Professional background
- Helping roles
- Practice frameworks
- Practice principles

Healthcare Services & Policies

Aging Network Services & Policies

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
• 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

EDPP Step 3: Telephonic Assessment

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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

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EDPP Step 4: Intervention

EDPP social worker performs telephonic biopsychosocial assessment

EDPP social worker provides emotional support; education; self-management, medication, and community resource information

EDPP Social Worker reconnects with patient

Yes: Patient and/or caregiver reconnects with EDPP social worker

Does patient and/or caregiver need more information or support?

Yes: EDPP social worker provides contact information for necessary parties to patient/caregiver

No: Provide local aging resource center’s contact information for future consult, close case

No: EDPP social worker contacts necessary third parties on patient’s behalf

Yes: Can patient or caregiver contact necessary parties?

Is follow up with service providers, caregivers, healthcare professionals, community resources necessary?

Intervention Loop
• 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
Prevalence of Unmet Needs

- 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

<table>
<thead>
<tr>
<th>Physician Follow-Up</th>
<th>Intervention</th>
<th>Usual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td>27</td>
<td>34</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td>239</td>
<td>205</td>
</tr>
<tr>
<td><strong>Rate</strong></td>
<td>89.8%</td>
<td>85.6%</td>
</tr>
</tbody>
</table>

\( \chi^2 = 9.88, p = .001 \)

- Intervention Group participants are more likely to make and keep follow-up appointments
- Readmission, emergency department usage, and nursing home placement currently under analysis
<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping with change</td>
<td>35%</td>
</tr>
<tr>
<td>Caregiver burden or stress</td>
<td>32%</td>
</tr>
<tr>
<td>Management of post-discharge medical care</td>
<td>29%</td>
</tr>
<tr>
<td>Obtaining community services</td>
<td>28%</td>
</tr>
<tr>
<td>Follow-up needed with home health care</td>
<td>22%</td>
</tr>
<tr>
<td>Coordinating care among providers</td>
<td>20%</td>
</tr>
<tr>
<td>Management of new treatment or diagnosis</td>
<td>19%</td>
</tr>
<tr>
<td>Understanding the discharge plan</td>
<td>17%</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>15%</td>
</tr>
<tr>
<td>Understanding medication instructions</td>
<td>14%</td>
</tr>
<tr>
<td>Transportation services</td>
<td>10%</td>
</tr>
</tbody>
</table>

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EDPP: Most Common Interventions

- 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

- 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

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Project BOOST: Principal Tool

- 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
New Concept: Health Information, Advice, Instructions, or Change in Management

Clinician Explains/ Demonstrates New Concept

Patient Recalls and Comprehends/ Demonstrates Mastery

Clinician Assesses Patient Recall & Comprehension/ Asks Patient to Demonstrate

Clinician Clarifies & Tailors Explanation

Clinician Re-assesses Recall & Comprehension/ Asks Patient to Demonstrate

Adherence/ Error Reduction

### Project BOOST: Patient Pass

**Patient PASS: A Transition Record**

Patient Preparation to Address Situations (after discharge) Successfully

<table>
<thead>
<tr>
<th>I was in the hospital because</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I have the following problems ...</td>
<td>1. ________________</td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>1. ________________</td>
<td>2. ________________</td>
<td>(____) __________________</td>
</tr>
<tr>
<td>2. ________________</td>
<td>3. ________________</td>
<td>2. My hospital doctor:</td>
</tr>
<tr>
<td>3. ________________</td>
<td>4. ________________</td>
<td>(____) __________________</td>
</tr>
<tr>
<td>4. ________________</td>
<td>5. ________________</td>
<td>3. My visiting nurse:</td>
</tr>
<tr>
<td>5. ________________</td>
<td></td>
<td>(____) __________________</td>
</tr>
</tbody>
</table>

**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. ________________

**Other instructions:**

1. ________________
2. ________________
3. ________________

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I understand my treatment plan. I feel able and willing to participate actively in my care:

__________________________
Patient/Caregiver Signature

__________________________
Provider Signature

/ / / 
Date
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
Care Coordination Key Components

- 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

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Care Model Interdisciplinary Rounds

- **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

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Other Care Coordination at Rush

• 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
Illinois Transitional Care Consortium

- 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
ITCC Members

• 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
Thanks to…

• Our funders and supporters:
  – Community Memorial Foundation
  – Sanofi Aventis
  – New York Academy of Medicine
  – Harry and Jeanette Weinberg Foundation
“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