Improving the Transition From the Hospital to the Clinic: What Works, What’s Recommended, and How to Improve Your Systems

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Why Should We Care

► Extensive national focus
► Multiple reports of transition programs and systems
► No clear and definitive data on what individual interventions work
► Good data showing the effectiveness of groups of interventions
   — Led to consensus guidelines

• Costs the health system a lot of money
• Costs the patient even more than money in harm and poor outcomes
Risk of Transitions

► 1 out of 5 patients have an adverse event after hospital discharge
► One third are related to medications
► Most are caused by poor communication between the inpatient team and the PCP

Medicare Data

► 19.6% of admitted patients readmitted within 30 days
► 34% within 90 days
► 50.2% of rehospitalized patients had no bill for follow up clinic appointment
► Estimated cost $17.4 billion
  ▶ Jenks SF, Williams MV, Coleman EA. NEJM 2009;360:1418

Areas of Error – Pending Tests

► 40% of patients leaving the hospital have at least one pending test
► 10% of these tests require some action or response
► PCP’s frequently not aware of these tests
Areas of Error – DC Communication

► Direct communication - 3% - 20% of the time
► DC Summaries
  – Available at first visit – 12% - 33% of the time
  – Missing information
    ► Hospital course 14%
    ► Responsible inpatient provider 17%
    ► Discharge medication 21%
    ► Test results 38%
    ► Pending tests 65%
    ► Patient instructions 91%

Quick Discussion

• What is everyone doing at their systems?
  – Nothing?
  – Risk assessment in the hospital?
  – Some intervention regarding post DC communication?
  – HFU Clinics?
    ▪ In primary care?
    ▪ Hospitalist run?

What’s Proven

► No studies of individual interventions
► Multiple studies demonstrating the effectiveness of groups of interventions or programs
► Common elements of most studies
  – Patient centered instruction sheet given at discharge
  – Transition record
  – Post discharge follow up call

Kripalani S, et al. JAMA 2007;297:831
Current Guideline

► Transition of Care Consensus Conference (TOCCC)
  – SHM, SGIM, ACP, American Geriatric Society,
    Amer. College of Emergency Physicians
► Reviewed literature and outlined principles of good transitions
  ► Snow V, et al. Jointly published in JGIM and Journal of
    Hospital Medicine 2009

Guideline Key Principles

► Accountability
► Clear direct communication
► Timely feedback and communication
► Patient involvement
► National standards
► Standard metrics

Recommendations – Prior to DC

► Prior to discharge
  – Risk assessment
  – Patient education
  – Interdisciplinary discharge team
    ► Discharge advocates
► Post discharge
Recommendations – At DC

• Appropriate DC summary content
  – Principle diagnosis and problem list
  – Medication list, medication reconciliation
  – ID transferring physician and receiving physician and their contact info
  – Patient’s cognitive status
  – Test results including pending tests

• Timely availability

Recommendations – Post DC

• Early PCP follow up within 1 – 2 weeks
• Post discharge call within 48 hours

Resources – SHM BOOST Project

• Goal to ID at risk patients for rehospitalization, improve readmission rates and patient satisfaction, improve communication and DC processes
• Comprehensive program
• Implementation guide
• Tools and metrics to track performance
Risk Assessment

What I Am Doing

• Limited to the areas I have control over
  – Resident teaching service
  – Resident clinic
  – Only our own patients when they are on our service
DC Summary Content

– Day of Admission
– Day of Discharge
– Discharge Diagnoses
– A brief summary of the hospital course
– A list of completed diagnostic tests and their results (summarize the results, do not copy or read the official report into the summary)

DC Summary Content

– A list of pending diagnostic and laboratory tests
– A complete list of all discharge medications including dose and frequency (it is not acceptable to put “see medication reconciliation”)
– A list of all follow up appointments including specialty follow up
DC Summary Content

– A list of all home health and equipment orders made for the patient prior to discharge
– A brief summary of key issues for follow up after discharge

Post DC Call

– Review of how the patient is doing and what if any issues/concerns they have since discharge
– Review of scheduled follow up appointments
– Review of discharge medications and verification that the patient has obtained all meds especially newly prescribed medications
– Review of ordered equipment and home health services and verification that these have been initiated

HFU Clinic Visit

• Nurse rooms patient, performs vitals, follows up on any issues noted in phone call
• Pharm D, Pharmacy resident complete medication reconciliation and perform medication education (ideally IM resident observes if available)
• IM resident completes interview, examination
HFU Clinic Visit

• Social work meets with patient to assist with any identified needs
• Case reviewed with attending MD
• Patient education completed by whichever team member is best suited to identified educational needs of the patient

What Our Institution is Doing

• Risk assessment – not standardized process
• Working to standardize DC summary content and timeliness
  – Workgroup met 7/28/16 – not currently implemented
• Post DC follow up call program for ED and hospital patients
• ACCESS Clinic and Hospitalist run follow up clinic

Implementation How Not to Do It?

• Blame the PCP’s
• Blame the Hospitalists
• Blame the system, the government, administration
• Hire a bunch of extra staff
• Start a HFU clinic
Implementation How to Do It?

• Need buy in
• Need leadership
• Need all stakeholders involved
• Need data
• Take it step by step

Benefits

• Better outcomes for patients
• Increased patient satisfaction
• Avoid losses on unremitting readmission charges
• Transition charges for the PCP’s

Transition Codes - 99495

Transitional Care Management Services with the following required elements:
• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
• Medical decision making of at least moderate complexity during the service period
• Face to face visit within 14 calendar days of discharge
Transition Codes - 99496

Transitional Care Management Services with the following requirements:

• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
• Medical decision making of high complexity during the service period
• Face to face visit within 7 calendar days of discharge

Transition Codes - Reimbursement

2013 Medicare Allowable
• 99495 – $156.16
• 99214 – $101.97
  – (53% increase over E&M alone)
• 99496 – $220.46
• 99215 – $136.60
  – (61.4% increase over E&M alone)