# 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

## Why Should We Care

- 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
  - Roy CL, et al. Ann Intern Med. 2005;143(2):121

## 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%

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

## 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

## 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

http://www.hospitalmedicine.org/BOOST/

Project BOOST® Mentored Implementation Program

What is Project BOOST®?

BOOST® Objectives

Program Offerings and Resources:

C-Suite Buy-In: Need Help Building the Case?

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## Risk Assessment

The 8P Screening Tool
Identifying Your Patient's Risk for Adverse Events After Discharge

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## 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

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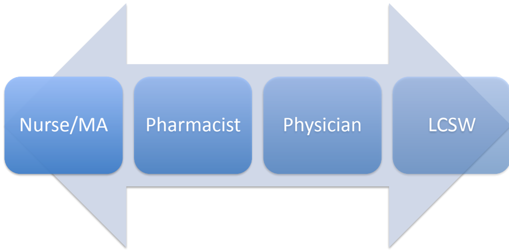
## HFU Clinic



## 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 unremitted 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)