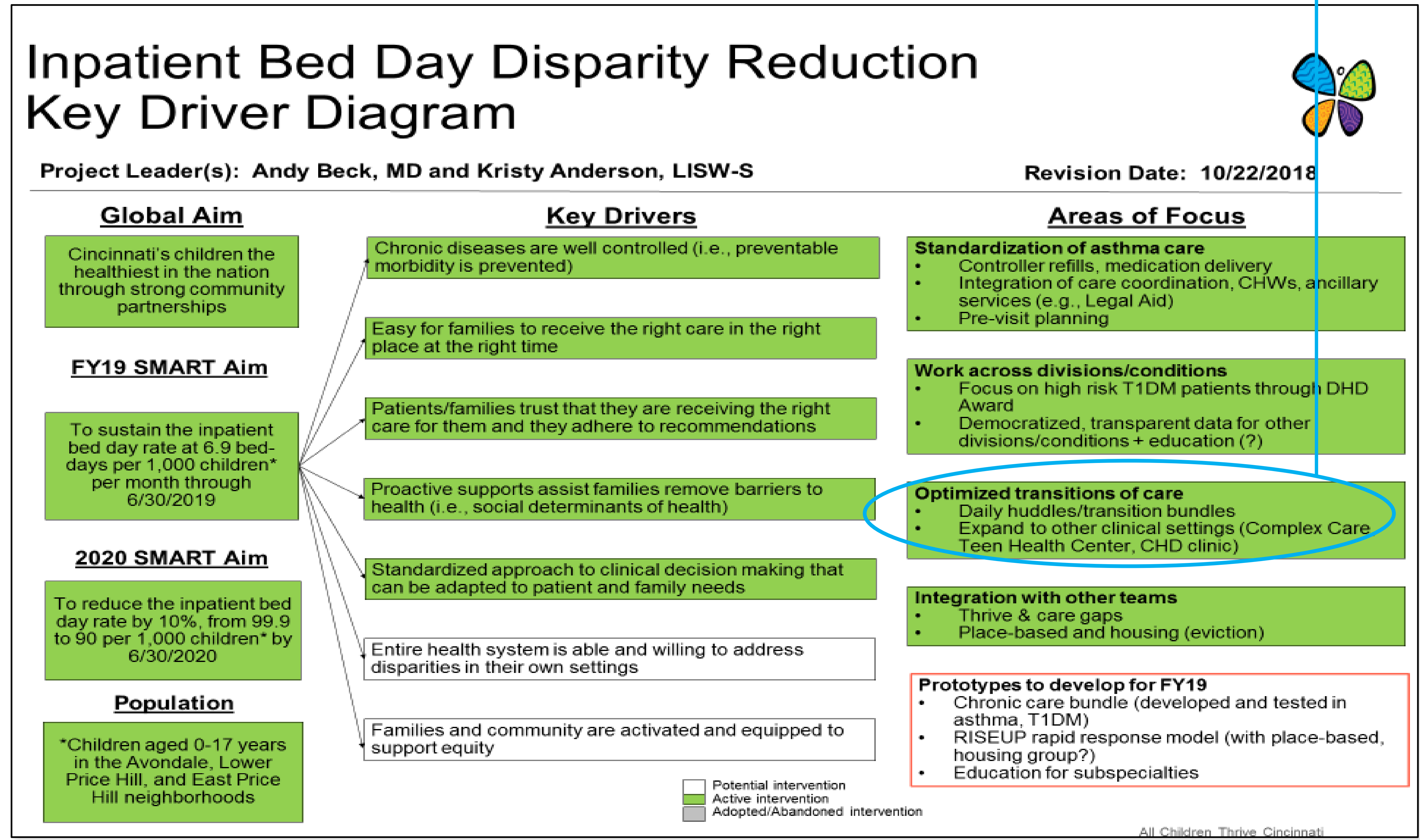
Transitions of Care: From Hospital to Home

December 2018
Learning Session

Background…

The **Transitions of Care** Team is part of the overall Inpatient Bed Day Disparity Reduction project team



Our Objective:
50% of Gen Peds primary care patients discharged from Hospital Medicine service have an **effective transition of care*

***Effective Transition of Care** defined as:

- ❑ 48 hour contact after discharge (patient directed contact approach)
- ❑ Follow up appointment scheduled
- ❑ Medication Reconciliation reviewed
- ❑ After Visit Summary (AVS) reviewed

Transitions of Care Key Driver Diagram

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Global Aim

Cincinnati's children the healthiest in the nation through strong community partnerships

FY19 AIMS

(1) Increase percent of Gen Peds primary care patients discharged from the Hospital Medicine service having an effective* transition of care from 40% to 50% by 06/30/19.

(2) Engage at least two out of three additional populations in ToC work by 06/30/19.

FY20 AIM

Inpatient Bed Days:
To reduce the inpatient bed day by 10%, from 99.9 to 90 per 1,000 children by 6/30/2020

Population

General Pediatrics patients, aged 0 -17 years living in Avondale, East & Lower Price Hill

*Effective: 48 hour contact (patient directed contact approach): physical apt, medicine reconciliation, AVS in discharge, single call if problem, prediction

System Drivers

Family

- I want to and am able to bring my child to care

Community

- I can help reach those who are yet to be engaged
- Address contextual factors related to the social and structural influences of health

Health System

- When I come, the Clinic/Care works well
- Address disparities in inpatient utilization related to admission decision, length of stay, and readmissions
- Prevent occurrence and/or severity of acute disease & chronic disease morbidity

Transition of Care Drivers

- Hospital & Care teams develop, strengthen & constantly work on trust with Communities of Avondale & Price Hill
- Care system designed around class and cultural differences and responds to meet those needs (medical & social)
- Setting and getting to appointments is easy for families
- Effective inpatient discharge
- Families engaged in discharge summary
- Value add for the family
- Reliable method of patient/family contact

Interventions

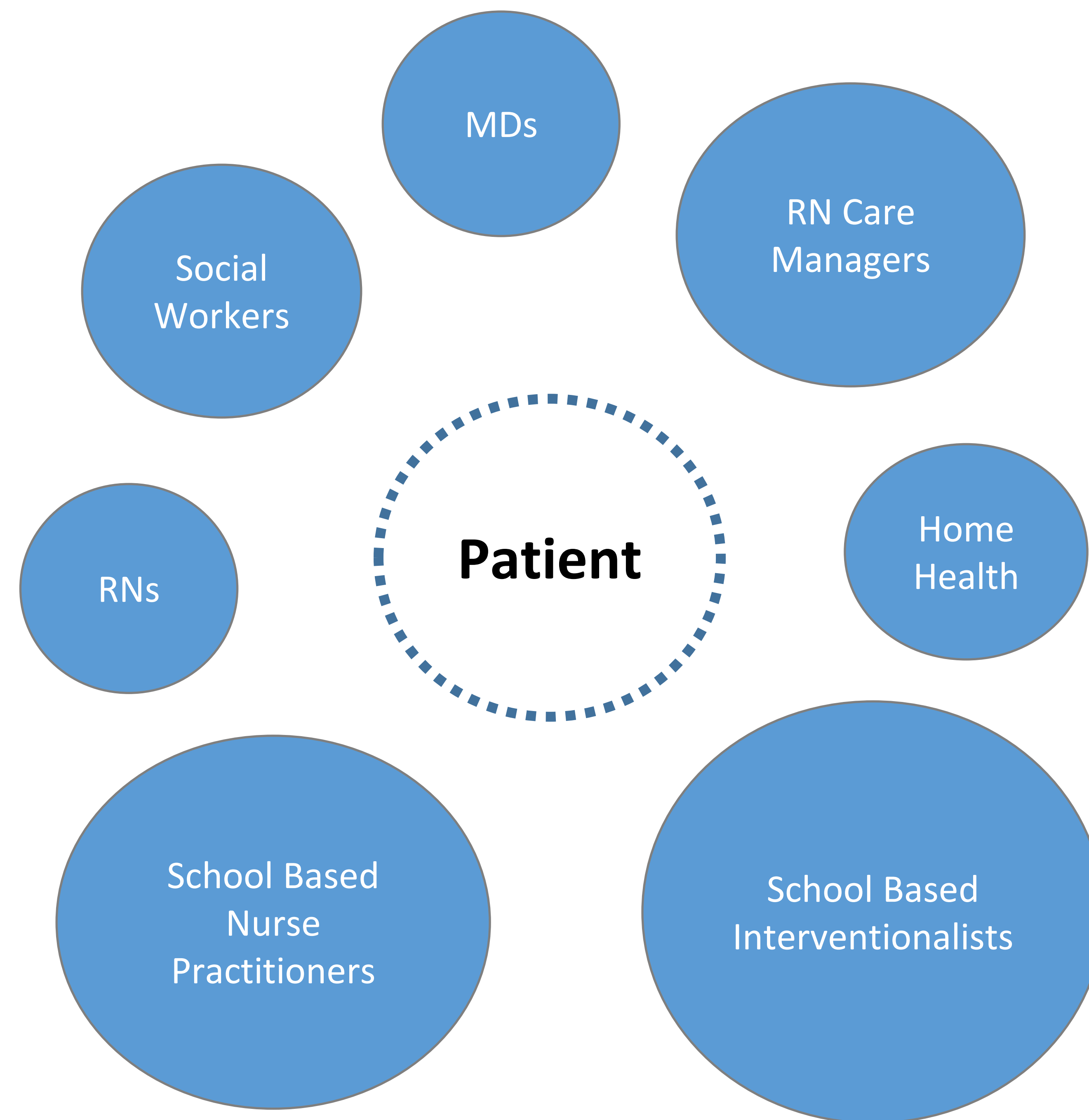
- Spread ToC process to additional areas with focus on different aspects of care:
  *Clinical diagnosis (Complex Care, subspecialty)
  *Age (Adolescent Medicine)
  *Site of Care (external Health Dept, Crossroads)
- Outreach to patients based on risk within 48 hours
- Care Management Support – CHW help find someone who not able to respond to traditional outreach
- Discharges (target population) are communicated to associated school nurse
- One number for families to call if family have problems to receive help navigating
- Daily huddle call (Adopted)
- Physician predict risk of readmission to understand risk stratification (Abandoned)
- Families predict risk of readmission (Abandoned)

Legend

- Potential intervention
- Active intervention
- Adopted/Abandoned intervention

How does this work?

It starts with a daily morning **HUDDLE CALL**



- Discuss patient’s admitting diagnosis, preventive services status, discharge needs, social determinants, need for subspecialty referrals

- If concern for prolonged admission or particular social or medical complexity, will plan for follow up discussion on the next huddle call

- ✓ Monitor daily for discharge and once discharged, patient receives **effective transition bundle**

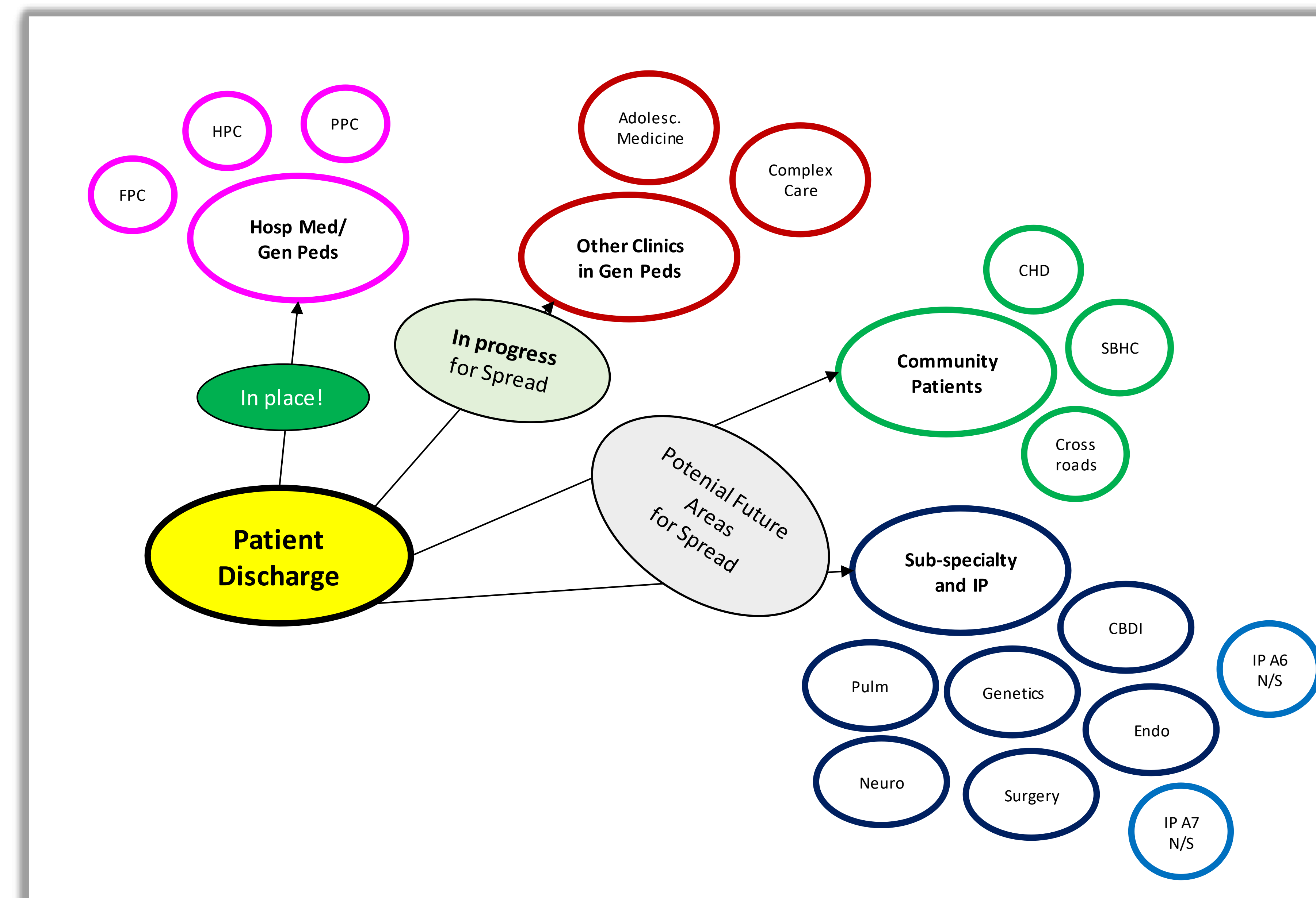
- ✓ Escalation process established if patient unable to be reached and concerns remain high

Current Focus

- ✓ Taking the **well established** Gen Peds process and collaborating with our Complex Care and Adolescent Medicine colleagues.
- ✓ We **share continuity** in process, elements reviewed at time of call, and documentation.
- ✓ We share **similar struggles** in reaching some patients.
- ✓ We plan to review shared data monthly (who do they capture, how are we all doing, **what can we learn together…**)

Future Strategies for Spread

- ✓ ***Possible*** future plans include spreading to other chronic conditions managed by CCHMC specialists and community patients/partners



Measures and Results

% Patients of patients completing bundle
October 2017 to November 2018

100%
80%
60%
40%
20%
0%

% Patients of patients completing bundle

10/08 10/25 11/11 12/12 12/18 12/27 01/04 01/16 01/30 02/14 03/08 03/11 03/14 03/31 04/12 04/21 05/14 06/12 07/06 07/26 08/23 08/28 09/14 10/16 11/16

Date of discharge for 5th patient

Median Goal % Patients

- We also track data on the individual bundle components
- Review of process reveals that most failures due to inability to contact patients

Contacts

Thank you!

We welcome any questions or further discussion…

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