Reducing the Revolving Door Syndrome: Working together to reduce re-admissions

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Conflict of Interest Disclosure

• No conflicts of interest to disclose
Session Objectives

• Understand the benefits from hospital and primary care perspectives of working together to address hospital readmissions versus working in silos
• Explain how care transitions impact avoidable and unavoidable readmissions for populations at risk
• Understand why COPD /CHF populations were targeted
• Describe tests of change undertaken
• Discuss lessons learned so far
The Problem We are Trying to Solve

• Local data shows 42% of hospital readmissions that happen within 4 weeks will happen within 7 days of the last admission

• Lack of communication & collaboration between acute care & primary care = providers not having all of the information + uncoordinated patient care

• Patients feel confused and unsupported when their care team does not know what one another are doing
Understanding the Causes

**Physician**
- Lack of knowledge re patient admission & discharge
- Lack of access to specialist services
- Lack of follow-up between primary physician and hospital physician
- Inconsistency around what to do with patient during their disease
- Discomfort with the difficult patient conversation (time, insurance repercussions, etc.)

**Patient**
- Lack of knowledge of long-term impact of disease (or even that this is a chronic illness)
- Confusion about medication changes and what to take
- Frailty / palliative / end stage
- Caregiver burden
- Lack of clarity re who they can go to with questions
- Poor supports
- Anxiety

**Process**
- Lack of appropriate follow-up after GGH visit
- Lack of clear and concise messaging from GGH re when to see physician
- Lots of appointments / burnout for appointments (e.g., cardiologist)
- Lack of clear process re triggering follow-up appointment (e.g., getting pt to f/u)
- Lack of resource/process to follow-up with pt within 48 hours and that pt can contact to ask questions to if they have them between discharge and FP apt
- Slow documentation of discharge summary

**Policy**
- Poor handoff from hospital to community transitions
- Lack of use of best practices cross-system
- Lack of comprehensive medication reconciliation
- Lack of timely communication from CCAC re notes from seeing the patient
- Slow communication to regional services outside of city

**Patient readmission to hospital <30 days**
- Lack of adequate LTC beds & palliative supports
- Absence of convalescent care
- Funding - difficult for patient to pay for medications, O2, nebulizers and additional supports to help them stay stable in home
- Lack of resources available for weekend questions
- Shortened length of stay

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Guelph Family Health Team
Guelph General Hospital
HealthLink Guelph
Patient

Lack of knowledge of long-term impact of disease (or even that this is a chronic illness)

Confusion about medication changes and what to take

Frailty / palliative / end stage

Failure to cope at home

Caregiver burden

Poverty, housing, money, values/beliefs/culture

Knowledge – what is normal

Poor supports

Poor access to long-term care setting

Anxiety

Lack of clarity re who they can go to with questions

Lack of follow-up on post-hospital discharge visit
Physician

Lack of knowledge re patient admission & discharge

Lack of access to specialist services

Lack of follow-up between primary physician and hospital physician

Lack of consistent process booking follow-up appointment

Difficulty diagnosing between COPD and CHF

Inconsistency around what to do with patient during their disease

Discomfort with the difficult patient conversation (time, insurance repercussions, etc.)

Lack of timely visit post discharge (including patient books but misses appt)

Patients getting mixed messages
Lack of appropriate follow-up after GGH visit

Lack of clear and concise messaging from GGH re when to see physician
(Lots of appointments / burnout for appointments (e.g., cardiologist)
Lack of clear process re triggering follow-up appointment (e.g., getting pt to f/u)
Lack of resource/process to follow-up with pt within 48 hours and that pt can contact to ask questions to If they have them between discharge and FP appt

Process

Poor handoff from hospital to community transitions
Lack of use of best practices cross-system
Poor use of standardized care across the system
Lack of comprehensive medication reconciliation
Lack of timely communication from CCAC re notes from seeing the patient
Slow documentation of discharge summary
Readmission Days by Disposition

- 139 Chronic obstructive pulmonary disease
  - 0-5 days: 4, 2, 3
  - 15-30 days: 12, 17, 12

- 196 Heart failure without coronary angiogram
  - 0-5 days: 2, 3, 4
  - 15-30 days: 14, 16, 14

Legend:
- Blue: Numerator Count
- Red: Numerator Same Site
- Yellow: Index Same Site
Understanding the Client Experience with the Current System

- Individual diagnosed with COPD or CHF
  - I wasn’t worried, I felt fine
  - I was just sick for a while and then I felt fine
  - I felt scared because I didn’t understand what it meant
  - I felt angry because I didn’t know I had this disease

- Post exacerbation
  - I was cured and I feel fine now, they wouldn’t send me home if I wasn’t
  - I don’t understand why this keeps happening to me
  - I felt happy with the good care I received
  - I felt grateful that my doctor’s office followed up

- Condition declining
  - I felt worried because my doctor didn’t know I had been to hospital
  - I felt angry because I have lost so much
  - I am not sure what happens next
  - I felt like I was waiting for death
What We Are Trying to Achieve

• To decrease readmissions for COPD and CHF (from 33% CHF & 28% COPD) by 5% by April 2016.
Ground Ourselves in Value from the Client’s Perspective

Client Value Statement

As an individual with COPD/CHF, I need for me & my support network:
To be part of the decisions about my care
To understand the options and their outcomes
To be respected for my decisions
To have timely access to the best care and supports to improve my quality of life

Co-design session with system partners identified the improvement opportunities to test
Changes We Have Tested So Far

• Hospital providing discharge notes to primary care within 48-hours of discharge (I)

• Hospital fax to primary care requesting post-discharge appointment date and information about relevant tests and procedures as part of the QBP implementation (T)

• Primary care team visit with patient within 7 (14) days post discharge (in office or in home) (T)

• Primary care nurse participation in the hospital discharge rounds (A)

• Primary care pharmacist medication assessment and review post-hospital discharge (T)
• Hospital charge nurse call to primary care team prior to patient discharge to discuss concerns and ensure scheduled primary care visit (including in-home team visit if needed) (T)
• Primary care nurse call patient within 48-hours of discharge (A)
• Primary care office call to patient within 48-hours of discharge to discuss concerns, ensure patient appointment with physician and primary care nurse (T)
• Primary care nurse appointment (in conjunction with physician appointment) to provide self-management support and navigation support (T)
• Hospital calculating LACE score to identify patients at high risk of readmission and trigger increased wrap-around care (P)
Lessons Learned So Far

• Working on it together is important
  – Just ask – invite partners to work together
  – Pick a “good enough” measure and work on improving it together
  – Sharing order sets across the system to increase consistency

• Communication is key, key, key
  – It’s about the conversations and working and learning together
  – There is a lot going on in isolation – “Lots of committees working on this but it is not translated into practice”

• Perception that human to human contact is a burden
  – Hospital staff need to feel okay about just calling the doctor’s office
  – Primary care staff need to know the call may be coming & to shape what is expected
• Involving the whole practice team is critical
  – Each practice needs to decide who they want their ‘go-to person’ to be

• Admission and readmission numbers are small and want to build consistent clinical competency

• Learn from PDSA cycles – there is as much to learn from changes we abandon as those we implement

• Spread to multiple hospital floors and multiple primary care clinics is challenging
  – It takes time

• Improvements are needed in the end of life care related to access and processes for non-cancer patients
Success

what people think it looks like

what it really looks like

Success