Hospital Readmissions and Shared Responsibility

Dr Sean Blaine

Family Physician, Stratford

Clinical Lead, STAR FHT

President, AFHTO

Faculty/Presenter Disclosure

- **Faculty:** Dr. Sean Blaine
  - Assistant Professor DFCM Univeristy of Toronto

- **Relationships with commercial interests:**
  - None

Disclosure of Commercial Support

- **This program has not received financial or in-kind support from any organization**
- **Potential for conflict(s) of interest:**
  - Not applicable

Mitigating Potential Bias

- **President, AFHTO**

Association of Family Health Teams of Ontario

Cost

- Readmissions to acute care cost estimate is $1.8 billion (excluding physician fees) - CIHI
- During 11-month study period, accounted for more than 1 in 10 dollars (11.0%) spent on inpatient care in Canada
- 9 - 59% of readmissions may be preventable
- Using low end of this range – represents potential reallocation of $162 million to other aspects of care

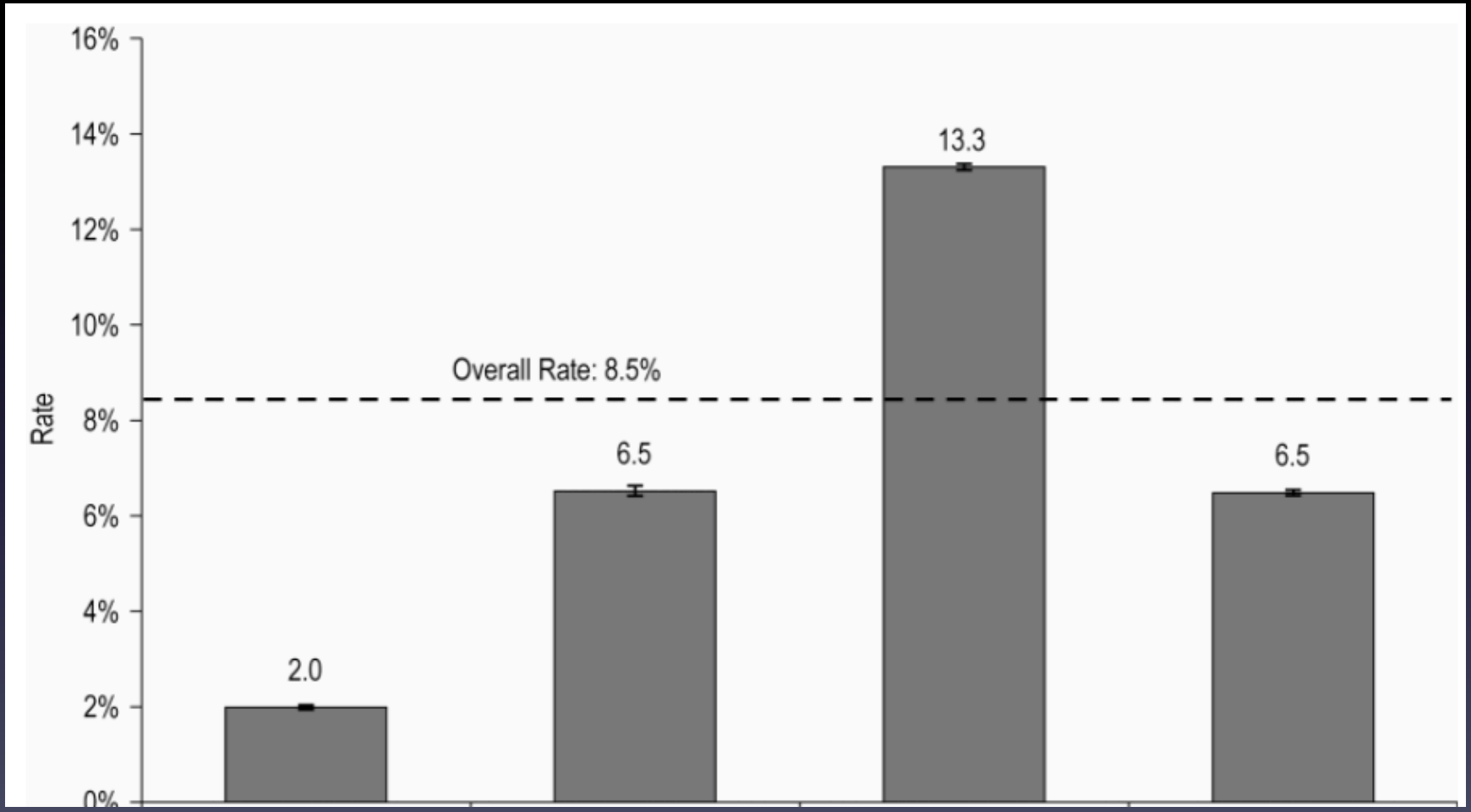
Incidence

- 8.5% of acute care patients were readmitted to an acute care hospital within 30 days of their initial discharge, CIHI
- > 180,000 Canadians were readmitted to acute care in 2010
- nearly 1 in 10 acute care patients returned to the ED within 7 days of hospital discharge.

Reasons

- Medical
  - COPD and CHF, most costly, Often for same condition as originial Dx
  - accounted for about 2/3 (65%) of the unplanned readmissions
- Pediatrics
  - pneumonia, respiratory infection
  - Chemo / radiotherapy
- Surgical
  - mostly unplanned
  - 9% post infections, ¼ C sections

30 day all-cause unplanned readmission rates to inpatient acute care



Medical conditions / reasons causing largest # readmissions

Table 2: Conditions Representing the Largest Number of Readmissions and Their Reasons for Return, for Medical Patients

Most Frequent Conditions at Index (CMG)	Readmission Rate	Readmission Volume	Two Most Frequent Conditions Upon Readmission (CMG, Percentage)	
COPD	18.8	10,517	COPD (56.3)	Heart Failure Without Coronary Angiogram (5.2)
Heart Failure Without Coronary Angiogram	21.0	7,855	Heart Failure Without Coronary Angiogram (42.2)	COPD (5.2)
Pneumonia (Viral/Unspecified)	12.5	4,386	Pneumonia (Viral/Unspecified) (18.8)	Heart Failure Without Coronary Angiogram (7.6)
Symptom/Sign of Digestive System	15.6	3,953	Symptom/Sign of Digestive System (25.7)	Gastrointestinal Obstruction (3.3)
Arrhythmia Without Coronary Angiogram	12.6	3,548	Arrhythmia Without Coronary Angiogram (31.6)	Heart Failure Without Coronary Angiogram (12.2)

patient, hospital, community predictors

- Deviation from expected length of stay
  - Short length of stay
  - Long length of stay (? sicker patients)
- Lower income neighbourhood or rural settings
- Age, comorbidity, male

Returning to ED after inpatient care

- 31% of patients who returned to the ED within 7 days were admitted to hospital
- clinical reasons for returning were very often the same as or related to the index hospitalization
- Almost ¾ patients returning to ED within seven days triaged as urgent or emergent - strong indication they were in need of additional immediate care and not seeking simple reassurance

Conditions causing largest # ED returns

Table 8: Conditions Representing the Largest Number of ED Returns and Their Reasons for Return, for Medical Patients

Most Frequent Conditions at Index (CMG)	Return to ED Rate	Return to ED Volume	Two Most Frequent Conditions at Return (CACS, Percentage)	
Chronic Obstructive Pulmonary Disease	10.1	2,536	Respiratory Condition With Acute Admission/ Transfer (27.0)	Disease or Disorder, Respiratory System (15.3)
Heart Failure Without Coronary Angiogram	11.4	2,072	Dead on Arrival (25.9)	Other Condition With Acute Admission/ Transfer (11.0)
Symptom/Sign of Digestive System	13.9	1,646	Disease or Disorder, Digestive System (26.4)	Digestive System Condition With Acute Admission/Transfer (21.5)
Arrhythmia Without Coronary Angiogram	12.3	1,550	Other Disease or Disorder, Cardiac System (22.3)	Dead on Arrival (19.4)
Viral/Unspecified Pneumonia	9.9	1,498	Respiratory Condition With Acute Admission/Transfer (15.6)	Disease or Disorder, Respiratory System (15.2)

Current state - Complex transitions of care

- Individuals with comorbidity
  - diabetes, CHF, CAD, stroke, COPD have complex care needs
- involves primary care, home care, hospitals, and specialists – operating in silos, with incompatible EHRs and irrational funding

Holy Grail – Continuum of care

- bring together providers and organizations from across the care continuum
- ensure complimentary and coordinated services
- share information between providers with greater accuracy – EHR connectivity
- Break down the silos and funding obstacles
- better equipped to manage patients with chronic disease and multiple illnesses.

Reasons for Readmissions in the first 30 days

- Unclear or delayed discharge plan and instructions
- Conflicting plans and instructions from different providers
- Medication errors, including dangerous drug interactions and duplications

Simple task ?

- Getting the discharge summary to the family physician in a timely manner

AFHTO

- 185 Family Health Teams (FHTs) and Nurse Practitioner Led Clinics (NPLCs) in Ontario
- AFHTO members provide comprehensive primary health care to over 3 million patients
- Nearly a quarter of the population of Ontario

D2D

- Data to Decisions
- Grassroots member-wide summary of performance data on indicators that are:
  - Measureable
  - Manageable
  - Meaningful

7 day follow up from discharge

- Easy, right ?

Workarounds

for timely, comprehensive discharge notification

- Targeted patient populations by hospital
  - The hospital creates a daily list of patients being discharged with a primary diagnosis of COPD and faxes it to our FHT. Our administrators transfer the patient list into our shared computer drive which is then checked by a member of our respiratory team who calls the patient within 48 hours of discharge.
  - NP and registered nurse receive discharge notifications from 4 floors at local hospital
  - Local hospital is sending bi-weekly reports with discharge information. This is a pilot project with information from one unit only, not whole hospital

Workarounds

for timely, comprehensive discharge notification

- Patient provides the notification
  - Notification is done by means of a verbal notification sometimes given by patient or patient's family member.
  - Seven day post hospital follow-up is mostly done by patient self-reporting.
  - We asked on our patient experience survey: Were you seen by your health care provider within 7 days of being discharged from hospital?
  - Practitioners provide a card with their contact information and educate patients on how to use it at hospital admitting [to increase chance of receiving discharge notification].

Workarounds

for timely, comprehensive discharge notification

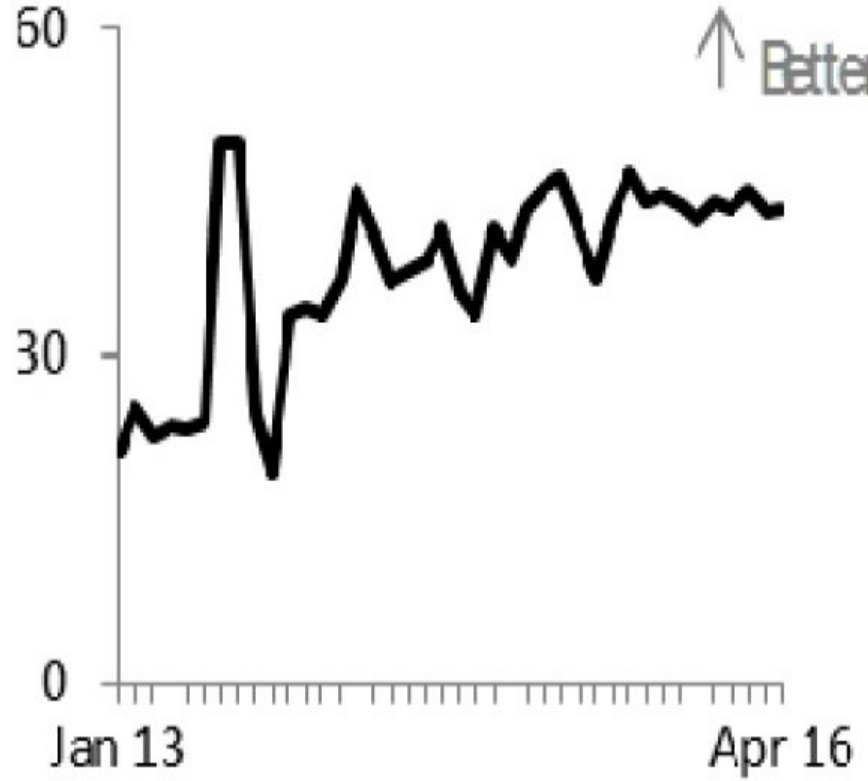
- Team "pulls" data, often manually and by individual patients
  - Each [primary care] site coordinator connects with the discharge planner at the hospital and then follows up manually with patients to get their appointment set up.
  - These data are accessed through logging into a Physician's Portal that reports daily admissions.

Workarounds

for timely, comprehensive discharge notification

- Primary care provider is discharging physician
  - Our physicians are part of a rotating on-call group that care for their own patients admitted to hospital under family medicine. Once a physician discharges a patient home, they notify appropriate clerical staff members at the FHT.
  - For a patient to be enrolled in this hospital discharge process, they must be discharged by a physician within the FHT.

3. Increase percent of discharge summaries sent from hospital to



Baseline:22.9

Current:43.1*

Target: 50.0

* HPHA data not available

http://www.southwestlhin.on.ca/goalsandachievements/Performance.aspx

AFHTO members - barriers to measuring and improving follow-up

- we want the discharge notifications but they usually don't make it to primary care in a timely fashion
- Difficult to implement without cooperation from hospitals.
- Only discharge notifications received via HRM are received in a timely manner.
- We do not have control over whether we receive d/c notifications within 48 hours.
- we pull discharge data from Clinical Connect weekly, as not every hospital sends DC notifications
- We continue to have tremendous difficulty accessing timely discharge notification

AFHTO members – D2D

- *Until a concrete mechanism is put into place that hospitals are required to provide discharge data to FHTs, 7 day follow up cannot be an accurate or feasible indicator*

HRM: Hospital Report Manager

- https://www.ontariomd.ca/portal/server.pt/community/hospital_report_manager/sending_facilities/
- Check out this site to see if your hospital is sending messages via HRM

Goal = reduce 30-day hospital readmissions

- improve the quality of care
- enhance patient safety
- optimize health resources
- improve patient and provider experience

How

- effectively planning care and discharge from hospital to appropriate hand-offs
- discharge summaries
- medication reconciliation
- smooth transitions between these areas of care.

Strategies to reduce readmission

Before discharge:

- improved patient education
- improved discharge planning
- scheduling follow-up appointments
- Patient-centred discharge instructions

After discharge:

- follow-up phone calls,
- patient hotlines
- same-provider continuity

Shared Responsibility

- Transitional care involves multiple health professionals within and between disciplines and settings, all sharing the responsibility of care for one individual

Suggestions for Action

1. Hospitals must ensure discharge plans and summaries are consistently developed and shared with patients, families and primary care in a timely manner.
2. Primary care must contact and engage patients early post-discharge for follow up and medication reconciliation
3. Patents First Act must ensure that care coordination moves from the LHIN to ultimately reside in primary care