Transitions in Care
Testing Discharge Decision Support
March 2010
Background Information

• Patients 65 and over account for over 38% of all hospital stays (2004) and utilize 44% of all days of care in hospitals; this represents an increase of 24% from 1970 to 2004
• From 1970 to 2005 ALOS decreased by 56%, from 12.6 to 5.5 days
• Shorter LOS makes adequate discharge planning and decision-making extremely important to avoid the “no care zone”
• The needs of this growing population must be met with shorter lengths of stay
Discharge Planning

• Care process done for more than 13 million Medicare beneficiaries each year
• Hospitals lack the resources and discharge planners lack the time to accurately identify patients in need of post-acute care
  – Result is increased risk of developing costly, poor outcomes
  – Without proper and timely identification they will have little chance to receive potentially beneficial services
• The proposed study aims to address this need
Testing Discharge Planning Support

• Three studies demonstrated a lack of congruence between experts and clinician’s decisions to refer to post-acute care (PAC) services
• Most recent study with a high risk sample, experts were nearly 18 times more likely to refer patients for PAC than hospital clinicians

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Prescott, Soeken and Griggs

- Found decision not to refer to home care was appropriate 74% of the time
- Clinicians failed to refer 26% of the patients for whom home care was needed
National Reviews

• Two national reviews of discharge planning found no large scale studies of how PAC assessments are conducted in hospitals and no studies describing how assessments are translated into decisions regarding need for referral for post-acute services.
Controlling for Severity of Illness

• For patients who use early home care, regardless of severity:
  – The post-hospital period of care costs less
  – The odds of hospital readmission are statistically significantly lower

Avalere study
Early Use of Home Care

• Associated with an 24,000 fewer hospital readmissions than other post-acute care sites
  – Resulted in a $216 million reduction in Medicare spending from 2005 to 2006
Right Care, Right Time for Older Adults

- 19% of Medicare beneficiaries are re-hospitalized within 30 days of discharge
  - 76% of these readmissions were preventable (MEDPAC)
  - Of the patients that are readmitted within 30 days, 64% received no post-acute services
  - Eliminating just 5.2% of these readmissions would save $5 billion annually
Right Time, Right Care for Older Adults

- Interventions suggested to prevent these readmissions include:
  - Identification of high risk patients upon admission
  - Devising new approaches to follow-up during the post-acute period of care
Discharge Planning: Two Critical Points

- Prioritization of patients that need an evaluation by discharge planner to assess present and future needs
- The decision to refer to post-acute care such as home care
Evidence Based Practice

• There are no nationally recognized, empirically derived, decision support tools to assist discharge planners in making important decisions

• Assessment criteria used by hospitals are often gathered and applied inconsistently
Results

• Improve the quality and consistency of discharge planning decisions
• Reduce the time for discharge planning decisions to occur
• Decrease the costs and patient suffering associated with poor outcomes related to unmet post-discharge needs
Discharge Support Study

- Proposes to fulfill a critical step in the continuum of care
- Will identify those older adults who need high quality complex discharge planning and referral for post-acute services
  - But are being missed completely or
  - Who need care but, due to policy barriers such as homebound requirements, will be denied services
- Such findings are essential to improve clinical practice and advance needed policy changes
Specific Aims of the Study

• Examine how two decision support tools impact discharge planning and patient outcomes

• Allow investigators to demonstrate feasibility and calculate intra-class correlation for a larger study
Study Groups

• Group one—tests the ESDP tool
• Group two—tests D2S2
• Group three—tests usual care
• Group four—combines the tools
Where?

- The sample will be accrued from patients receiving care at New York Presbyterian Cornell and Columbia Medical Centers
Risk Screening

- Risk for Rehospitalization Screening - Rosati Tool
- Bowles-Screen for Homecare
- Holland- screen for the need for complex discharge planning upon admission
Risk for Rehospitalization

- CRITERIA-New problems or issues
- New diagnosis or problem
- New social issues
- New onset of moderate to severe functional deficits
- New high risk medications or dosage change
Risk for rehospitalization (cont.)

- Active chronic conditions
- HIV/AIDS
- Heart Failure
- Diabetes Mellitus
- End Stage Renal Disease
- Active Neoplastic disease
- COPD
- Transplant Patients
Risk screening - rehospitalization

- Prior pattern: Use of acute care/homecare
  - Hospitalization or ER visits in the past 6 months
- Hospitalization within last 30 days
- Past homecare utilization within 6 months
Risk Screening-rehospitalization

- General Considerations
- 5 or more prescribed medications-help needed to manage
- Age 80 yrs or older
- Depression
- Fair or poor self health rating
- Recent falls
- Infectious process
- Lives alone
Bowles Screening tool

- Fair or poor health rating
- Use of homecare or acute care in last six months
- Use of assistive devices - functional deficit
- Depression
- Lives alone
- Number of co-morbidities
Holland Tool

- Predicts the need for complex discharge planning
- No available help at home
- Major walking restrictions
- Fair or poor health rating
- Depression
- Long length of stay
- 2 or more co morbidities
Screening Workflows

- Mayo Rochester - imbedded in EMR at admission - Holland
- University of Pennsylvania - embedded in EMR - Bowles
Bibliography

Questions?

• Next Steps