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

### Inpatient Bed Day Disparity Reduction Key Driver Diagram

**Project Leader(s):** Andy Beck, MD and Kristy Anderson, LISW-S  
**Revision Date:** 10/22/2018

#### Global Aim
- Cincinnati’s children the healthiest in the nation through strong community partnerships

#### Key Drivers
- Chronic diseases are well controlled (i.e., preventable morbidity is prevented)
- Easy for families to receive the right care in the right place at the right time
- Patients/families trust that they are receiving the right care for them and they adhere to recommendations
- Proactive supports assist families remove barriers to health (i.e., social determinants of health)
- Standardized approach to clinical decision making that can be adapted to patient and family needs
- Entire health system is able and willing to address disparities in their own settings
- Families and community are activated and equipped to support equity

#### Areas of Focus
- **Standardization of asthma care**
  - Controller refills, medication delivery
  - Integration of care coordination, CHWs, ancillary services (e.g., Legal Aid)
  - Pre-visit planning
- **Work across divisions/conditions**
  - Focus on high risk T1DM patients through DHD Award
  - Democratized, transparent data for other divisions/conditions, education?
- **Optimized transitions of care**
  - Daily huddles/transition bundles
  - Expand to other clinical settings (Complex Care, Teen Health Center, CHD clinic)
- **Integration with other teams**
  - Thrive & care gaps
  - Place-based and housing (eviction)

#### FY19 SMART Aim
- To sustain the inpatient bed day rate at 9.9 bed-days per 1,000 children* per month through 6/30/2019

#### 2020 SMART Aim
- To reduce the inpatient bed day rate by 10%, from 9.9 to 9.0 per 1,000 children* by 6/30/2020

#### Population
- *Children aged 0-17 years in the Avondale, Lower Price Hill, and East Price Hill neighborhoods

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### 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

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All Children Thrive Cincinnati
Transitions of Care Key Driver Diagram

Project Leader(s): Susan Wade-Murphy, John Morehous, Andy Beck
Revision Date: 11/27/2018

**Global Aim**
- Cincinnati's children the healthiest in the nation through strong community partnerships

**FY19 AIMS**
1. Increase percent of Gen Ped's primary care patients discharged from the Hospital Medicine service having an effective* transition of care from 40% to 50% by 06/30/2019.
2. Engage at least two out of three additional populations in TcO work by 06/30/19.

**FY20 AIM**
- Inpatient Bed Days: To reduce the inpatient bed day by 10%, from 99.9 to 50 per 1,000 children by 6/30/2020

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

**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 is 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)

*Effective: 48 hour contact (patient driven: contact approach); physical, apt, medicine reconciliation, AVIS in discharge, single call if problem, prediction
How does this work?

It starts with a daily morning 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

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
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**)…

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Future Strategies for Spread

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

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

We welcome any questions or further discussion...

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