Inceptary 9
Patient Discharge and Eventual Outcomes

This discussion usually starts and ends with the challenge of hospital readmissions. We took the approach to look at it from the broader perspective of starting with the situation prior to hospital admission, for scheduled in- and out-patient procedures, and acute situations: from the time just prior to discharge and ending with the final outcome for the patient.

Most of our discussion focused on the discharge process, the information sharing failures (despite care plans) with primary care and rehab facilities, and required follow-ups.

Hospital discharge
We discussed four challenges surrounding the Care Plan.

1. The Care Plan is difficult to digest. It is printed, multiple pages long, and usually consists of added boilerplate information packets. Perhaps the plan is a victim of liability, geared to reduce risk of law suits, rather than guide the patient back to health.
2. The Care Plan may not reflect the post-acute living situation into which the patient is being discharged. This is especially true for the increasing number of patients that are discharged home – without enough knowledge of the lifestyle, living and support situation.
3. The Care Plan is provided at a time of great stress, perhaps even under lingering anesthetic effect in an outpatient environment. Comprehending (or finding the essence of) the Care Plan can be difficult even for family support who may be simultaneously searching for post-acute care, dealing with transportation, or planning the home to support the discharged patient from food and meds to laundry and cleaning.
4. A Care Plan should be dynamic. The patient's situation changes, rapidly at first, followed by increased mobility and self-care. The Care Plan and Health Record sometimes do not get shared with the primary care doctor, who is disconnected from the discharge, and at times not with the post care facility either.

Finding Post-Acute Care
In the Bay Area a patient needing post-acute care is given a long list of rehab facilities. The list has every facility on it, with name address and phone number. It is up to the patient or family member to determine which rehab facility to utilize. In theory, a hospital would already know which rehab has the services that match the patients need, but not so. Without easy access to ratings (which, if they can find, may have been gamed – see California AG indictment of Brookdale https://www.nytimes.com/2021/03/15/business/california-lawsuit-brookdale-senior-living-nursing-homes.html) For patients and families these decisions may be made without facts during an unusually stressful time for the patient – and their family as well.

Our thoughts on who we could assist among discharge planner, post-acute facility, or patient—we decided on the patient. Hospitals and post-acute facilities seem to be locked in a difficult relationship. Hospital planners are not equipped to partner with, nor hear value propositions from multiple post-acute facilities, and may be prohibited from making recommendations; while post-acute facilities are selling the prospect of lower readmissions to hospitals with internally developed and measured metrics. No one seems to be helping the patient.

- Ideas that come to mind: simple checklists; curated information resources that people can use to help make decisions – and get that to them in advance; curated/rated post-acute resource lists; interim 3rd party care plan management, sharing, meds reconciliation, and updates until patient is recovering with stability; one source resource for home care planning
- Thoughts for our Reimagining Rural Health: test a standard of requiring MD to speak with both the patient and care giver (or rehab coach?) present prior to discharge approval. The patient care giver dyad remains navigating the dynamics of changing and recovery needs until stable patient recovery is achieved. Need to define metrics for patient outcomes over time – as its not the 30-day readmission metric. Of course, will require assessing the self-managing capability, lifestyle and living situation to determine if a dyad is required or recommended. Other factors such as age, and health conditions matter as well.

Post-Acute Care

Focusing on discharges to the home, there are challenges with professional homecare – especially when there is no family support. Many do not have access to transportation, there are zip codes in the US with a shortage of providers that can provide post-acute care at home. Homecare businesses struggle financially with low Medicare reimbursement rates and high administrative costs for processing billing. While commercial insurance rates are higher, home health aide rates are still quite low. Administration of billing is what can make or break a home health business. Smaller operators find it difficult to work with five Medicare Advantage programs plus multiple insurance firms.

- Ideas that come to mind: low cost, accurate 3rd party billing node for small and independent home and rehab operators.
- Thoughts for our Reimagining Rural Health: it may be easier in rural areas due to reduced number of post-acute options, where all the businesses tend know each other well, and while possibly more scarce, it may be easier to arrange transportation within the community.

Critically we need to get out in the market to get first-hand information on needs, especially in the target rural counties for our Reimaging Rural Health initiative. In the meantime, there are opportunities in our local urban area to explore – such as The Villages in SF.

Research deck for Inceptary 9 follows

Hospital Discharge

For Inceptary 9

The Inceptary
a healthcare "thinking social network"
a public benefit corporation

opportunities in hospital discharge and the life after

- Over 35 million discharges annually in the U.S. (CDC, 2016)
- Medicare spending on post-acute care (after hospital discharge care), both facility-based and in-home, doubled from $29 billion to $59 billion per year between 2001-2013. (Agency for Healthcare Research and Quality (AHRQ), 2016)

most post acute care occurs at home

Home: approx. 70-75% of patients are discharged to their home

1. *with a static care plan: n pages on why you may die, and*
2. *a follow-up appointment*
3. *personalization and engagement stops at the hospital door*

Acute care hospitals

Exempt hospitals (a variety of requirements and limitations)

- IRFs (Inpatient rehabilitation facilities) *1,177 in 2014*
- LTCHs (Long-term acute care hospitals) *422 in 2014*
- SNFs (Skilled Nursing facilities) *15,173 in 2014*
- HHA (Medicare-certified Home Health Agencies) *12,461 in 2014*

lack, or difficulty of cross-business silo cooperation and synchronization of up-to-date information

In Theory:

- Discharge planning (an accreditation required process) determines appropriate level of patient services and matches patient to appropriate post acute care site (PAC).

In Practice:

- No clear clinical guidance exists to determine the type of PAC setting to which a patient with a specific condition should be discharged.
- Discharges to PAC often are driven by the availability of specific types of settings and by financial incentives that are not always aligned with clinical needs. (Agency for Healthcare Research and Quality (AHRQ), 2016)

let's flip preventable readmissions to preventable recovery delays and health deterioration

Preventable readmission stats

- Median preventable readmissions of 27%; range 5%-79%.
  (Zuckerman et al.(2016))
- In 12 academic medical centers, preventable general medicine patients readmission rate of 27% within 30 days of discharge.
  (Auerbach et al. (2016))

an Inceptary gold mine: factors affecting readmission

- Premature discharge
- Inadequate post-discharge support
- Insufficient follow-up
- Therapeutic errors
- Medication issues (20%)
  adverse effects follow-up
  sent home w/o script
  duplicate script with different name
- Failed handoffs (40%)
  pending tests not reported to aftercare providers
  direct communication hospital to post acute care - rare
- Complications following procedures
- Nosocomial incidents
  infections, pressure ulcers, falls
- Absent or delayed follow-up
- Discharge against medical advice
- High risk patients
  > 6 chronic conditions
  polypharmacy
- ER decision-making regarding readmission
- Lack of care goals discussions with patients with serious conditions
- Interventions that could have been provided during initial hospitalization
- Rural and micropolitan region with <100 beds have lower readmission rates
  distances barriers?
  better hospital community resource relations?
- Only 12-34% of primary care providers receive discharge summary before 1st follow-up visit

patient experience of transitioning from hospital to home

- Patients recall receiving discharge instruction, but not details on what to do if problems arise
- Lacking important information despite instruction
- Patients can find it challenging to translate knowledge into contextually appropriate action at home
- Same-day discharge teaching can be ineffective because patients are anxious to leave the hospital or staff members feel rushed.
- The desire to return to normal life, coupled with uncertainty about who to call for clarification, can lead patients to simply do the best they can with whatever information they recall

Source: Cain, et al. (2012)

patient experience of transitioning from hospital to home

- Patients may have needs that fall outside traditional discharge activities but significantly impact patient experiences such as transportation
- Teaching is a relatively low priority for hospital staff, unless there is a hands-on care task
- Even when a primary caregiver is present, hospital staff frequently direct teaching exclusively toward the patient
- Patients may need explanation of medications in a patient-friendly terms and might need aligning medication lists with physical aids (such as weekly pill boxes)

Source: Cain, et al. (2012)

references

Auerbach AD, Kripalani S, Vasilevskis EE (2016). Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients. *JAMA, Intern Med.,176*:484.

Alper, E., O'Malley, T., Greenwald, J. (2012). Hospital discharge and readmission. UpToDate.

Cain, C., Neuwirth, E., Bellows, J., Zuber, C., Green, J. (2012). Patient experiences of transitioning from hospital to home: An ethnographic quality improvement project. *Journal of Hospital Medicine,* 7(5).

Tian, W. (2016). An all-payer view of hospital discharge to postacute care, 2013. Statistical Brief #205, *Healthcare Cost and Utilization Project*.

Werner, R., Coe, N., Qi, M., Konetzka, T. (2019). Patient Outcomes After Hospital Discharge to Home With Home Health Care vs to a Skilled Nursing Facility. *JAMA, Intern Med, 179(5)*, 617-623

Zuckerman RB, Sheingold SH, Orav EJ (2016). Readmissions, Observation, and the Hospital Readmissions Reduction Program. *New England Journal of Medicine, 374*:1543.