RED, BOOST, and You: Improving the Discharge Transition of Care

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Massachusetts General Hospital - Clinician Educator Service
Co-Investigator Project RED & Project BOOST
The John D. Stoeckle Center Seminar
March 26, 2010
Objectives

- Be familiar with the seminal literature in discharge transitions of care.
- Introduce participants to Projects RED and BOOST.
- Be able to identify first steps for yourself and for your institution to begin to improve discharge transitions.

I hate lectures! Please interrupt with questions/comments!
It’s not a happy story!
Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

<table>
<thead>
<tr>
<th>Interval after Discharge</th>
<th>Patients at Risk at Beginning of Period</th>
<th>Cumulative Rehospitalizations by End of Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number (percent)</td>
<td></td>
</tr>
<tr>
<td>All discharges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–30 days</td>
<td>2,961,460 (100.0)</td>
<td>579,903 (19.6)</td>
</tr>
<tr>
<td>31–60 days</td>
<td>2,277,816 (76.9)</td>
<td>834,369 (28.2)</td>
</tr>
<tr>
<td>Discharges after hospitalization for medical condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–30 days</td>
<td>2,154,926 (100.0)</td>
<td>453,993 (21.1)</td>
</tr>
<tr>
<td>31–60 days</td>
<td>1,613,197 (74.9)</td>
<td>653,998 (30.3)</td>
</tr>
<tr>
<td>Discharges after hospitalization for surgical procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–30 days</td>
<td>806,534 (100.0)</td>
<td>125,910 (15.6)</td>
</tr>
<tr>
<td>31–60 days</td>
<td>664,619 (82.4)</td>
<td>180,371 (22.4)</td>
</tr>
</tbody>
</table>

*NEJM 2009;360:1418-28*
Discharges are dangerous!

The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

- 19% of patients had a post discharge AE
  - 1/3 preventable and 1/3 ameliorable

- 23% of patients had a post discharge AE
  - 28% preventable and 22% ameliorable
Dangers of Discharge

Tying Up Loose Ends

Discharging Patients With Unresolved Medical Issues

Carlton Moore, MD; Thomas McGinn, MD, MPH; Ethan Halm, MD, MPH

• ¼ of discharged patients require additional outpatient work-ups
• > 1/3 not completed
• Increased time to post-discharge follow-up associated with lack of work-up completion
• Availability of discharge summary increased likelihood of work-up being done

Arch Intern Med. 2007;167:1305-1311
Tests/Data Lost to Follow-up

Patient Safety Concerns Arising from Test Results That Return after Hospital Discharge

Christopher L. Roy, MD; Eric G. Poon, MD, MPH; Andrew S. Karson, MD, MPH; Zahra Ladak-Merchant, BDS, MPH; Robin E. Johnson, BA; Saverio M. Maviglia, MD, MSc; and Tejal K. Gandhi, MD, MPH

• 1095 of 2644 (41%) inpatients discharged with test result pending
  – 191 (9.4%) potentially required action
  – Survey of MDs involved: almost 2/3 unaware of results
  – Of these: 37% actionable and 13% urgent

Inpatient to Outpatient Communications

• Info transfer and communication deficits at hospital discharge are *common*
  – Direct communication 3-20%
  – Discharge summary availability at 1*st* post-discharge appt 12-34%; 51-77% at 4 weeks
  – Discharge summaries often lack info
    • Dx test results (33-63%), hospital course (7-22%), discharge meds (2-40%), pending test results (65%)
    • Follow-up plans (2-43%), Counseling (90-92%)

Communications with Patients

Patients’ Understanding of Their Treatment Plans and Diagnosis at Discharge

Amoad N. Makaryus, MD, and Eli A. Friedman, MD

• At discharge:
  – 37.2% able to state purpose all their medications
  – 14% knew their medication’s common side effects
  – 41.9% able to state their diagnosis

Mayo Clinic Proceedings
2005; 80(8):991-994
Systems Approaches to Reducing Adverse Events
Discharge Planning

- 21 RCTs:
  - N = 7234 (4509 medical, 2225 med-surg; 500 other)
  - LOS: mean decrease 0.91 days (-1.55 to -0.27)
  - Readmission: RR 0.85 (0.74 to 0.97)
  - Elderly medical pts: mortality OR 1.04 (0.74 – 1.48)
  - Elderly pts discharge to home: RR 1.03 (0.93 to 1.14)
  - Improved patient satisfaction

Sheppard, S et al. Cochrane Database of Systematic Reviews 2010
• Randomized 363 patients age > 65
• “Comprehensive discharge planning” and home follow-up with Advance Practice Nurses
• ~70% completion rate
• Readmissions at 24 weeks 20% vs 37%
  – Reduced multiple readmissions 6.2% vs 14.5%
  – Prolonged time to first readmission
  – Medicare reimbursements cut in half
Low-cost Intervention

Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study

Richard B. Balaban, MD¹,², Joel S. Weissman, PhD³,⁴,⁵, Peter A. Samuel, BS², and Stephanie Woolhandler, MD¹,²

- “user-friendly” Patient Discharge Form
- Telephone outreach from the primary care office nurse post-discharge
- Improved outpatient follow-up
- Reduced ER visits and rehospitalizations from historical controls

JGIM 2008
The Care Transitions Intervention

Results of a Randomized Controlled Trial

Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW;
Sandra Chalmers, MPH; Sung-joon Min, PhD

• Elderly patients transitioning to SNF/home
• Randomized: Intervention group paired with “Transition Coach” vs. standard care
• Empowerment and education: 4 pillars
  – Facilitate self management/adherence
  – Maintain a personal health record
  – Timely follow-up
  – Knowledge and management of complications
• Education during hospitalization
  – including meds and med reconciliation
• Phone calls and personal visits by TC post D/C
• N=750

Arch Intern Med 2006;166:1822-1828
The Care Transitions Intervention

Results of a Randomized Controlled Trial

Arch Intern Med 2006;166:1822-1828
Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW; Sandra Chalmers, MPH; Sung-joon Min, PhD

<table>
<thead>
<tr>
<th>Results</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehospitalization</td>
<td>Interv</td>
<td>Cont</td>
<td>P(adj)</td>
<td>OR (95%CI)</td>
</tr>
<tr>
<td>Within 30d</td>
<td>8.3</td>
<td>11.9</td>
<td>0.048</td>
<td>0.59 (0.35-1.00)</td>
</tr>
<tr>
<td>Within 90d*</td>
<td>16.7</td>
<td>22.5</td>
<td>0.04</td>
<td>0.64 (0.42-0.99)</td>
</tr>
<tr>
<td>Within 180d*</td>
<td>25.6</td>
<td>30.7</td>
<td>0.28</td>
<td>0.80 (0.54-1.19)</td>
</tr>
</tbody>
</table>

*Also significantly improved for “Rehospitalization for same diagnosis as index admission.”

<table>
<thead>
<tr>
<th>Costs($)</th>
<th>Interv</th>
<th>Cont</th>
<th>Unadj</th>
<th>Log Transformed</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 30d</td>
<td>784</td>
<td>918</td>
<td>0.048</td>
<td>0.06</td>
</tr>
<tr>
<td>At 90d</td>
<td>1519</td>
<td>2016</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>At 180d</td>
<td>2058</td>
<td>2546</td>
<td>0.04</td>
<td>0.049</td>
</tr>
</tbody>
</table>
The Care Transitions Intervention

Results of a Randomized Controlled Trial
Arch Intern Med 2006;166:1822-1828
Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW;
Sandra Chalmers, MPH; Sung-joon Min, PhD

To better understand which of the different components of the model were regarded as most helpful by the intervention patients, an adjunctive qualitative descriptive study was conducted. The primary findings of that study suggest that the intervention led to improved self-management knowledge and skills for many patients, primarily in the areas of medication management, condition management, and patient confidence about what was required of them during the transition and beyond. The findings suggest that the continuity of the coaching relationship fostered a sense of caring, safety, and predictability about the transition, which contributed to greater patient investment in the program.
N = 178 medical patients randomized

- Intervention:
  - Med reconciliation done at d/c by Pharmacist
  - Pharmacist counseling at d/c and 3d follow-up call
  - At d/c, pharmacist recommended med changes in 60%
  - At 3d call, unexplainable discrepancies between d/c meds and reported home meds in 29%

- At 30d
  - Fewer preventable ADEs: 1% vs. 11% (p=0.01)
  - Fewer preventable med related ED visits: 1% vs. 8% (p=0.03)
  - 49% had med discrepancies!
  - No difference in total ADEs, health care utilization, patient satisfaction, or med adherence
Root Causes of Failed Transitions
Introducing Project **RED**: A Randomized Controlled Trial

**Enrollment Criteria:**
- English speaking
- Have telephone
- Able to independently consent
- Not admitted from institutionalized setting
- Adult medical patients admitted to Boston Medical Center (urban academic safety-net hospital)

**Notes:**
- Enrollment N=750
- Randomization
- RED Intervention N=375
- Usual Care N=375
- 30-day Outcome Data
  - Telephone Call
  - EMR Review
Components of RED Intervention

• In Hospital – Nurse Discharge Advocate (DA)
  – Interacts with care team: medication reconciliation and national guidelines
  – Assists with follow-up appointments
  – Prepare and teach After Hospital Care Plan (AHCP)

• After Discharge – Clinical Pharmacist
  – Follow-up call @ 2-4 days
  – Reinforce dc plan and review medications
After Hospital Care Plan

My Medical Problem:

Pulmonary Embolism
A pulmonary embolism is a blood clot in your lungs.

Please remember it is best to:
- Take walks; get exercise.
- Eat healthy food.
- Watch for signs of swelling in your legs.
- Take your medications as prescribed and carry them with you.
- See your doctor and ask questions.
Analysis

Primary outcome:
• Total hospital utilization (readmissions plus ED visits)

Secondary outcomes:
• PCP follow-up rate, identified dc diagnosis, identified PCP name, self-reported preparedness for discharge
## Baseline Study Population

<table>
<thead>
<tr>
<th>Sociodemographic Variables</th>
<th>All Subjects (n=749)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, M</td>
<td>50%</td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>49.9 (15.2) yrs</td>
</tr>
<tr>
<td>Race, Black NH</td>
<td>52%</td>
</tr>
<tr>
<td>Insurance, Medicaid</td>
<td>48%</td>
</tr>
<tr>
<td>Have PCP</td>
<td>80%</td>
</tr>
<tr>
<td>Education, HS or less</td>
<td>63%</td>
</tr>
<tr>
<td>Employment, Full time</td>
<td>24%</td>
</tr>
<tr>
<td>LOS, mean (SD)</td>
<td>2.7 (3.2) days</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>32%</td>
</tr>
</tbody>
</table>

No significant differences found between study groups
Primary Outcome: Hospital Utilization within 30d after Discharge

<table>
<thead>
<tr>
<th></th>
<th>Usual Care (n=368)</th>
<th>Intervention (n=370)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Utilizations</strong> *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # of visits</td>
<td>166</td>
<td>116</td>
<td>0.009</td>
</tr>
<tr>
<td>Rate (visits/patient/month)</td>
<td>0.451</td>
<td>0.314</td>
<td></td>
</tr>
<tr>
<td><strong>ED Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # of visits</td>
<td>90</td>
<td>61</td>
<td>0.014</td>
</tr>
<tr>
<td>Rate (visits/patient/month)</td>
<td>0.245</td>
<td>0.165</td>
<td></td>
</tr>
<tr>
<td><strong>Readmissions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # of visits</td>
<td>76</td>
<td>55</td>
<td>0.090</td>
</tr>
<tr>
<td>Rate (visits/patient/month)</td>
<td>0.207</td>
<td>0.149</td>
<td></td>
</tr>
</tbody>
</table>

* Hospital utilization refers to ED + Readmissions
Cumulative Hazard Rate of Patients Experiencing Hospital Utilization
30 Days After Index Discharge

Usual care
Intervention
\( p = 0.004 \)
Risk of Hospital Re-utilization by Health Literacy Category

Grade 3 and below
Grade 4-6
Grade 7-8
Grade 9+

REALM category

P for trend = 0.009
Grade 3 and below
Grade 4-6
Grade 7-8
Grade 9+

Usual Care
Intervention

p=0.06
p=0.59
p=0.38
p=0.04

Risk of re-utilization

REALM category
## Medication Errors

Interim Analysis of PharmD Telephone Calls
2-4 days after discharge (n=197)

<table>
<thead>
<tr>
<th>Medical Errors Due to Failure to Take Meds</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient did not think s/he needs med</td>
<td>19</td>
</tr>
<tr>
<td>Patient did not fill due to cost</td>
<td>21</td>
</tr>
<tr>
<td>Patient did not pick up from pharmacy</td>
<td>14</td>
</tr>
<tr>
<td>Patient did not get prescription on discharge</td>
<td>15</td>
</tr>
<tr>
<td>Patient self-discontinued due to side effects</td>
<td>14</td>
</tr>
<tr>
<td>Patient did not fill because of insurance</td>
<td>10</td>
</tr>
<tr>
<td>Medication not on discharge summary</td>
<td>83</td>
</tr>
<tr>
<td>Wrong frequency/interval</td>
<td>39</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>33</td>
</tr>
<tr>
<td>Patient not given prescription for most current regimen</td>
<td>5</td>
</tr>
<tr>
<td>Conflicting information</td>
<td>4</td>
</tr>
<tr>
<td>Duplication on EMR medication list (same drug, same class, same indication)</td>
<td>3</td>
</tr>
</tbody>
</table>
Median Clinical Time Required

DA: 90 minutes/subject *
• Collect information from patient, teach AHCP
• Communicate with medical team, enter data into AHCP

*Some information collection redundant with existing hospital staff

PharmD: 30 minutes/subject
• Prepare for call
• Call patients
• Conduct interventions post-call
# Outcome Cost Analysis

<table>
<thead>
<tr>
<th>Cost (dollars)</th>
<th>Usual Care (n=368)</th>
<th>Intervention (n=370)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital visits</td>
<td>412,544</td>
<td>268,942</td>
<td>+143,602</td>
</tr>
<tr>
<td>ED visits</td>
<td>21,389</td>
<td>11,285</td>
<td>+10,104</td>
</tr>
<tr>
<td>PCP visits</td>
<td>8,906</td>
<td>12,617</td>
<td>-3,711</td>
</tr>
<tr>
<td>Total cost/group</td>
<td>442,839</td>
<td>292,844</td>
<td>+149,995</td>
</tr>
<tr>
<td>Total cost/subject</td>
<td>1,203</td>
<td>791</td>
<td>+412</td>
</tr>
</tbody>
</table>

We saved $412 in outcome costs for each patient given RED, including DA and PharmD time!
Introducing Project BOOST

- Funded by the John A Hartford Foundation
- Grant to the Society of Hospital Medicine
- Principle Investigator = Mark Williams, MD
- Implementation project
Project BOOST

• Developed a project team and national advisory board
• Developed a toolkit and implementation guide with web resources
• Rolled out via mentored implementation initially to 6 pilot sites across USA
• Now completing phase 2: full roll out to 24 more sites
Overview

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions resource room provides a wealth of materials to help you optimize the discharge process at your institution. We developed this through support from the John A. Hartford Foundation (Read more about Project BOOST). We based the approach and tools on principles of quality improvement, evidence-based medicine as well as personal and institutional experiences. Of note, we are piloting the contents at multiple hospitals and will be constantly revising the resource room based on this invaluable experience.

This resource room will help you to:

- Analyze current workflow processes
- Select effective interventions
- Redesign work flow and implement interventions
- Educate your team on best practices
- Promote a team approach to safe and effective discharges
- Evaluate your progress and modify your interventions accordingly

Each section of this resource is described below.
Introducing…

The BOOST Tool
## TARGET - Tool for Addressing Risk: A Geriatric Evaluation for Transitions

### Tool for Addressing Risk: A Geriatric Evaluation for Transitions

<table>
<thead>
<tr>
<th>Risk Assessment: 7P Screening Tool (Check all that apply)</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
</tr>
</thead>
</table>
| **Problem medications**  
- antimicrobial(s)  
- analgesic(s)  
- sedative(s)  
- hypnotic(s)  
- diuretic(s)  
- antiplatelet(s)  
- anticoagulant(s)  
- ACE inhibitors  
- beta blockers  
- dihydropyridine calcium channel blockers  
- angiotensin receptor blockers  
| - Medication specific education using Teach Back provided to patient and caregiver  
- Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g., warfarin, digoxin and insulin)  
- Specific strategies for managing adverse drug events reviewed with patient/caregiver  
- Follow-up phone call at 72 hours to assess adherence and complications | | |
| **Pain (depression)**  
- assessed positive or diagnosis  | - Assessment of need for psychiatric aftercare if not in place  
- Communication with aftercare providers, highlighting this issue if new  
- Involvement of support network insured | | |
| **Principal diagnosis**  
- cancer, stroke, DTA, COPD, heart failure  | - Review of national discharge guidelines, where available (e.g., CHF)  
- Disease specific education using Teach Back with patient/caregiver  
- Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms  
- Discuss goals of care and chronic illness model discussed with patient/caregiver | | |
| **Polypharmacy**  
- ≥ 4 more routine meds  | - Elimination of unnecessary medications  
- Simplification of medication scheduling to improve adherence  
- Follow-up phone call at 72 hours to assess adherence and complications | | |
| **Poor health literacy**  
- inability to do Teach Back  | - Committed caregiver involved in planning administration of all general and risk specific interventions  
- Aftercare plan education using Teach Back provided to patient and caregiver  
- Link to community resources for additional patient/caregiver support  
- Follow-up phone call at 72 hours to assess adherence and complications | | |
| **Patient support**  
- absence of caregiver to assist with discharge and home care  | - Follow-up phone call at 72 hours to assess condition, adherence and complications  
- Follow-up appointment with aftercare medical provider within 7 days  
- Involvement of home care providers of services with clear communications of discharge plan to those providers | | |
| **Prior hospitalization**  
- non-adhesive, last 6 months  | - Review reasons for re-hospitalization in context of prior hospitalization  
- Follow-up phone call at 72 hours to assess condition, adherence and complications  
- Follow-up appointment with aftercare medical provider within 7 days | | |

Complete TARGET by insuring the Universal Patient Discharge Checklist is completed for all patients.
Principal BOOST Intervention Tools

• TARGET: Tool for Adjusting Risk: A Geriatric Evaluation for Transitions
  – 7P Risk Scale
  – The Universal Patient Discharge Checklist
  – The General Assessment of Preparedness

• The Patient PASS

• Teach Back training
The 7P Risk Scale

- Prior hospitalization
- Problem medications
- Punk (depression)
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support

Each associated with risk specific interventions
Universal Patient Discharge Checklist

- GAP assessment
- Medications reconciliation
- Medication use and side effects reviewed*
- Confirm understanding of prognosis, self-care, and symptoms requiring immediate medical attention*
- Best Practice guidelines assessment
- Discharge plan completed, taught, and provided to patient/caregiver
- Discharge communication provided to post-hospitalization care provider
- Documented receipt of discharge information from principal care providers

*Using Teach Back with patient/caregiver
The General Assessment of Preparedness: The GAP

- Caregivers and social support circle for patient
- Functional status evaluation completed
- Cognitive status assessed
- Abuse/neglect
- Substance abuse
- Advanced care planning addressed and documented

On Admission

- Functional status
- Cognitive status
- Access to meds
- Responsible party for ensuring med adherence prepared
- Home preparation for patient’s arrival
- Financial resources for care needs
- Transportation home
- Access (e.g. keys) to home

Nearing Discharge

- Understanding of dx, treatment, prognosis, follow-up and post-discharge warning S/S (using Teach Back)
- Transportation to initial follow-up

At Discharge
<table>
<thead>
<tr>
<th>I was in the hospital because</th>
<th>If I have the following problems ...</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td>1.</td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td>2.</td>
<td>(____) ________</td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td>3.</td>
<td>(____) ________</td>
</tr>
<tr>
<td></td>
<td>4.</td>
<td>4.</td>
<td>(____) ________</td>
</tr>
<tr>
<td></td>
<td>5.</td>
<td>5.</td>
<td>(____) ________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My appointments:</th>
<th>Tests and issues I need to talk with my doctor(s) about at my clinic visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/ at <strong>:</strong> am/pm</td>
<td>2.</td>
</tr>
<tr>
<td>For: ________________________</td>
<td>3.</td>
</tr>
<tr>
<td>2.</td>
<td>4.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/ at <strong>:</strong> am/pm</td>
<td>5.</td>
</tr>
<tr>
<td>For: ________________________</td>
<td>Other:</td>
</tr>
<tr>
<td>3.</td>
<td>(____) ________</td>
</tr>
<tr>
<td>On: <strong>/</strong>/ at <strong>:</strong> am/pm</td>
<td>5.</td>
</tr>
<tr>
<td>For: ________________________</td>
<td>Other:</td>
</tr>
<tr>
<td>4.</td>
<td>(____) ________</td>
</tr>
<tr>
<td>On: <strong>/</strong>/ at <strong>:</strong> am/pm</td>
<td>5.</td>
</tr>
<tr>
<td>For: ________________________</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Other instructions: 1. 
2. 
3.
So What Can I Do?

Let's play a game!
Understanding Misunderstanding

vs.

[Image of a hand with two fingers raised, suggesting a gesture of making a deal or offering something.]

[Image of a cartoon character with a puzzled or confused expression, scratching his head.]
NEW CONCEPT: Health information, advice, instructions, or change in management

Assess patient comprehension / Ask patient to demonstrate

Clarify and tailor explanation

Re-assess recall and comprehension / Ask patient to demonstrate

Patient recalls and comprehends / Demonstrates skill mastery

Explain new concept / Demonstrate new skill

Adherence / Error reduction

The Teach Back Method

Lessons Learned

- Think: Does this past the “if this were your mother” test? (PATIENT CENTEREDNESS)
- Start by re-aligning roles and clarifying lines of communication and responsibility – clear and appropriate ownership is central. (ACCOUNTABILITY)
- It takes a village: a coordinated multidisciplinary approach is mandatory. (TEAMWORK)
- Empower the patient with disease and medication education – utilize nurses and clinical pharmacists as educators by freeing them from non-clinical tasks. (EMPOWERMENT)
- Be proactive and think prospectively about which patients are at risk and what you can do to intervene. (PREVENTION)
- Be an army of one, a great role model, and start today. (CHAMPION)
Thank You!

Questions??

Comments??

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Could Partners Help Us Identify High Risk Patients?

Posthospital Care Transitions: Patterns, Complications, and Risk Identification

Eric A. Coleman, Sung-joon Min, Alyssa Chomiak, and Andrew M. Kramer

• Utilized 1997-8 Medicare Current Beneficiary Survey results on 1404 pts >65 years old
• Created prediction model using available Medicare data +/- survey results
Administrative Data +/- Survey

80 yrs. of age or older
Medicaid recipient
Male
Heart disease
Cancer
Diabetes
No. of prior hospitalizations
Charlson comorbidity index
Age * Medicaid
Age * Prior Hosp
Age * Male
Diabetes * Comorbidity
Prior Hosp * Comorbidity
Heart Disease * Cancer

80 yrs. of age or older
Medicaid recipient
Heart disease
Prior stroke
Cancer
Diabetes
No. of prior hospitalizations
Self-rated general health
Visual impairment
Function score
Assistance with ADL score
Charlson comorbidity index
Age * Medicaid
Diabetes * Comorbidity
Function * Comorbidity
ADL * Comorbidity
Stroke * Self-Rated Health
Cancer * Self-Rated Health
Heart Disease * Vision
Heart Disease * Cancer
Figure 2: Receiver Operating Curves (ROC) for Predicting Poor Care Transitions