CHAMP
The Ideal Hospital Discharge

Catherine E. DuBeau, MD
University of Chicago
Objectives

• Appreciate the impact of discharge quality and outcome on older patients, their caregivers, and all of the physicians who care for them
• Identify the components of an Ideal Discharge
• Implement effective discharge planning throughout the course of a hospital stay, including:
  – Lead team in multidisciplinary collaboration
  – Communicate early with older pts and their families
Exercise

- You admit an 80 yr old woman in transfer from a neighborhood hospital. There is no hospital summary, only loose papers and a cover sheet listing hospital admission date and meds (unclear if admission or transfer meds). Her family is unavailable.
- She is delirious, hypertensive, and severely impacted.
- The last labs sent with her are from 3 days previous; Hgb was 7.8 and creat 2.2.
- You call the hospital and the floor RN says the pt was discharged on the previous shift and she knows nothing about the patient.
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*This is a routine skilled nursing facility admission*
Scope of the Problem

• Hospital admission = first of multiple care transitions for older patients
  – At least 25% of hospitalized pts aged ≥ 65 are discharged to another institution (eg, skilled nursing facility, nursing home)
  – 12% are discharged with home care services
  – Of those transferred from hospital to rehab/skilled nursing, nearly 50% have four or more additional care transitions in the next 12 months

• Multiple opportunities for miscommunication and insufficient care
Discharge from Hospital to Other Institutions Increases with Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percent of Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-44</td>
<td>0</td>
</tr>
<tr>
<td>45-64</td>
<td>To short term hospital</td>
</tr>
<tr>
<td>65-84</td>
<td>To Nursing Home (rehab +/- long term)</td>
</tr>
<tr>
<td>85+</td>
<td>40</td>
</tr>
</tbody>
</table>

AHRQ HCUPnet http://www.ahrg.gov/data/hcup/factbk1/10shel.htm
“Falling Through the Cracks”

“It is becoming increasingly uncommon for any one clinician to provide continuous care to a patient transferring from one facility to another.”

Coleman EA. JAGS 2003;51:549

Given this reality, can proactive discharge planning improve quality of care and patient safety?
Evidence for the Impact of Discharge Interventions

• NHS Systematic review of 54 RCTs of discharge interventions
  - ↓ Hosp re-admission: RR 0.85 (95% CI .76-.95)
  - Lower costs with “geriatric” interventions
  - No impact on mortality or length of stay (LOS)

• Systematic review of 9 RCTs
  - ↑ Proportion at home at 6-12 mos: OR 1.4 (95% CI 1.1-2)

• Cochrane review of 11 RCTs
  - No difference regarding LOS, mortality (elderly pts), readmission, or discharge to home, yet power limited

NHS, Database of Abstracts of Reviews of Effectiveness, 2004;3.
Cochrane Database Syst Rev 2005 Issue 3
Quality of Transitional Care: American Geriatrics Society Position Statement

• Preparation and active involvement of pts and their caregivers necessary
• Bi-directional communication between hospital and Skilled Nursing Facilities
• Accessible record containing:
  – Current problem list
  – Medications
  – Advance directives
  – Baseline physical and cognitive function
  – Family and healthcare professionals contact info

Coleman EA and Boult C, JAGS 2003;51:556-7
“Isn’t this a systems issue?”

• Not entirely….
  – Still depends on individual acts
  – Still depends on a specific knowledge base
  – Still depends on transfer of specific knowledge from attending to care team

• It is, and…
  – Can become an opportunity for teaching Practice-Based Learning and Improvement and Systems-Based Practice
Where should the patient go at Discharge?

Admitted to Hospital From:

- Home
  - Home
  - Home with Services
  - Acute Rehab
- Nursing Home
  - Nursing Home
Where should the patient go at Discharge?

- Home
  - Recovering ADL independence or stable baseline
  - Sufficient and willing caregiver(s)
    - Safety/supervision
    - Meals
    - Med supervision
    - ADLs and IADLs
  - No skilled nursing or PT/OT needs

Why admitting Social Hx is important
Where should the patient go at Discharge?

- Home
  - Recovering ADL independence or stable baseline
  - Sufficient and willing caregiver(s)
    - Safety/supervision
    - Meals
    - Med supervision
    - ADLs and IADLs
  - Skilled nursing or PT/OT needs
  - Skilled nursing care and PT can be covered by Medicare or insurance

- Home with Services
Where should the patient go at Discharge?

Medically unstable for SNF

- Needs frequent MD evaluation (> q2-4 wk)
- Rising Cr, dropping Hgb
- Meds will need adjustment in < 24-48 hr (eg, BP meds)
- Needs and can tolerate intensive PT/OT
- Needs telemetry, daily/STAT labs

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Home

Acute Rehab
Where should the patient go at Discharge?

- Newly impaired ADL
- No need or unable to tolerate acute rehab
- Lack of sufficient and willing caregiver(s)
- Skilled nursing needs (eg, wounds, IVs)
- 3-night stay for Medicare SNF coverage
## Discharge Disposition Fact Sheet

<table>
<thead>
<tr>
<th>Disposition site</th>
<th>Patient Characteristic</th>
<th>Usual Source of Payment</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home with formal support services</td>
<td>Recovering ADL independence or stable baseline; needs skilled nursing care and PT and caregiver at home</td>
<td>Medicare, third party payor</td>
<td>Post-COPD exacerbation, CHF monitoring, pressure ulcer</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Dependence in ADL/ambulation preventing home d/c; too impaired for inpt rehab</td>
<td>Medicare with 3 night stay, third party payor</td>
<td>Impaired ambulation, delirium, deconditioning</td>
</tr>
</tbody>
</table>

Society for Hospital Medicine
Components of the Ideal Discharge

- **Active advanced planning**
  - Anticipation from first hospital day
  - Admission social history: with whom does the pt live? What are the ADL and IADL capabilities?
  - Hospital course: any delirium, deconditioning? Special medical needs? Rehab and PT consults?

- **Communication**
  - In hospital and at D/C: case managers, family, PCP
  - Inter-facility: paperwork; direct phone call

- **Core information elements**
4 Core Elements of Discharge Information and Communication

- Medical needs
- Functional support (ADL, IADL)
- Nursing needs
- Rehabilitative needs
4 Core Elements of D/C Information and Communication

• Medical needs
  – Summary of admitting problems and course
  – Active Problem list
  – Recent and important pending labs
  – Reconciled Medication List (incl admit meds and all changes) and allergies
  – Advance directives: DPOA-HC, preferences, goals

• Functional support (ADL, IADL)
  – Disposition: where from and where next
  – Functional status: baseline and present
  – Social support and contact info

• Nursing needs: monitoring, wounds

• Rehabilitative needs: PT, OT
“Getting Ready to Go Home”
Checklist for Patients & Families

• Components
  – Transportation
  – Medication List
  – Medical supplies (e.g., O2, dressings)
  – Treatments
  – Moving about the home
  – Groceries and meal planning
  – Financial concerns
  – Follow-up appointments
5 Steps to Constructing the Reconciled Medication List

1. Stop prophylaxis and prn meds if no longer indicated (eg, PPI, “sleepers,” SQ heparin)
2. If drug was changed to another in its class because of hospital formulary (and not specific medical indication), change back to previous outpatient drug
3. Indicate all new, stopped or changed drugs
4. Provide prescriptions for all new or changed drugs
5. For SNF/rehab discharge: all IV meds and unusual antibiotics need to be called to facility the day before discharge; otherwise there could be substantial delay in the pt getting them upon transfer
Reconciled Medication List

• Requirement of The Joint Commission
• Quality of Care Performance Measure
  – AMA / ABIM : Personal Performance Improvement
  – CMS: Pay-for-performance
<table>
<thead>
<tr>
<th>Destination</th>
<th>Home</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical needs</strong></td>
<td>• F/u appointment(s)</td>
<td>• F/u appointment(s)</td>
</tr>
<tr>
<td></td>
<td>• Warning sx/signs, who/how to contact*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reconciled med list *</td>
<td></td>
</tr>
<tr>
<td><strong>Functional support</strong></td>
<td>• Family/caregive/home care providers</td>
<td>• Type of institution, care goals, anticipated length of stay*</td>
</tr>
<tr>
<td></td>
<td>• Walkers, canes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Meals, groceries</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing needs</strong></td>
<td>• Home care providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• O2, dressings</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitative needs</strong></td>
<td>• Home PT/OT</td>
<td></td>
</tr>
<tr>
<td>Medical needs</td>
<td>Medical needs</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• F/u appointment(s)</td>
<td>• F/u appointment(s)</td>
<td></td>
</tr>
<tr>
<td>• Reconciled med list</td>
<td>• Hospital provider and PCP contact name and number</td>
<td></td>
</tr>
<tr>
<td>• Discharge diagnoses</td>
<td>• Reconciled med list</td>
<td></td>
</tr>
<tr>
<td>• Pending study results*</td>
<td>• Problem list (not just discharge dx)</td>
<td></td>
</tr>
<tr>
<td>• Advanced directives (if changed)</td>
<td>• Pending study results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Goals of care (if comfort, palliation, limited testing and/or re-hospitalization)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• F/u labs needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Advanced directives</td>
<td></td>
</tr>
<tr>
<td>Functional support</td>
<td>Functional support</td>
<td></td>
</tr>
<tr>
<td>• Issues with caregivers</td>
<td>• Plans/concerns regarding return home</td>
<td></td>
</tr>
<tr>
<td>Nursing needs</td>
<td>Nursing needs</td>
<td></td>
</tr>
<tr>
<td>• Home care providers</td>
<td>• Monitoring, wound care, oxygen</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative needs</td>
<td>Rehabilitative needs</td>
<td></td>
</tr>
<tr>
<td>• Home care providers</td>
<td>• PT, OT, speech</td>
<td></td>
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</tbody>
</table>
Teaching Triggers
Teaching Trigger 1: Person over age 65 admitted

Discharge is a *medical* team responsibility

Active Physician role

Begin discharge planning at admission – Importance of SHx!
Trigger 2: Can this patient go home?

Assess:

- Recovering ADL independence or stable baseline
- Sufficient and willing caregiver(s)
  - Safety/supervision
  - Meals
  - Med supervision
  - ADLs and IADLs
- Skilled nursing care and PT can be covered by Medicare or insurance

If All Yes → HOME with home care nursing, home PT/OT
Trigger 2: Can this patient go home?

Assess:

- Recovering ADL independence or stable baseline
- Sufficient and willing caregiver(s)
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  - Meals
  - Med supervision
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If NO’s → discharge to Rehab/SNF
Trigger 2: Can this patient go home?

Assess:

- Recovering ADL independence or stable baseline
- Sufficient and willing caregiver(s)
  - Safety/supervision
  - Meals
  - Med supervision
  - ADLs and IADLs
- Skilled nursing care and PT can be covered by Medicare or insurance

If NO’s → discharge to Rehab/SNF

Needs 3 night stay for Medicare benefit
Trigger 3: Pt has ≥ 1 skilled nursing need (e.g., wounds, injectables), dementia, falls, and/or safety issues?

Is patient medically stable for subacute care?
Is patient medically stable for subacute care?

- Needs daily MD evaluation?
- Needs MD visit more than q2-4 weeks?
- Hemodynamically unstable, rising Cr, dropping Hgb?
- Meds will need adjustment in < 24 hr (eg, BP meds, diuretics)?
- Can’t tolerate 12-24 hr lapse in meds?
- Needs telemetry, daily/STAT labs?

If YES to any, consider acute rehab hospital
Trigger 4: Anticipate D/C in AM

Discharge Check lists

Pt/family

Medical team:
1. Discharge early in day
2. Medication reconciliation
3. Communication materials ready and complete, including contact info
4. Remove IVs, Foleys, etc
Multidisciplinary Team Inputs

• Physicians: Delirium abatement, ongoing management

• PT/OT: determine level of rehab (home, SNF, acute rehab); consider re-consulting if status changes or disagree with conclusion

• PCP: notification and discussion

• Case manager: arrange transfer and/or home services

• Family notification and discussion

• Nursing staff: notification and discussion
Summary

• Discharge planning and quality affects patients and all who care for them (family, MDs)
• Effective discharge planning must occur throughout the hospital stay, starting at admission
• Ideal Discharge components
  – Active, anticipatory advanced planning
  – Communication
  – 4 Core elements
    • Medical needs
    • Functional support
    • Nursing needs
    • Rehabilitative needs