IHQI IMPROVEMENT SCHOLARS PROGRAM

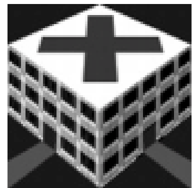
Geriatrics (MDA) Readmission Reduction Project

UNC INSTITUTE FOR HEALTHCARE QUALITY IMPROVEMENT

Maureen Dale, Project Lead

- **Core Team:** **Faculty** Laura Hanson | **Co-Lead** Ben Blomberg | **Project Manager** Sabrina Vereen |
- **Fellows** Adam Moskowitz, Sheri Mouw, Joy Norris, Bianca Yoo
- **Clinical Team and Advisors:** Jan Busby-Whitehead (Sponsor), Ronald Davis, John Downs, Margaret Drickamer,
- John Gotelli, Marvin McBride, Fabienne McClellan, Shana Ratner (IHQI Faculty Advisor), Stephanie Stout, Mark Toles

Risk Factors for Readmission =Multifactorial



Motor and Cognitive Functional Status Are Associated with 30-day Unplanned Rehospitalization Following Post-Acute Care in Medicare Fee-for-Service Beneficiaries

Addie Middleton, PhD, DPT[1], James E. Graham, PhD, DC[1], Yu-Li Lin, MS[2], James S. Goodwin, MD[3], Janet Prvu Bettger, ScD[4], Anne Deutsch, RN, PhD, CRRN[5], and Kenneth J. Ottenbacher, PhD, OTR[1]

Functional Impairment and Hospital Readmission in Medicare Seniors

S. Ryan Greysen, MD, MHS, MA[1], Irena Stijacic Cenzer, MA[2,3], Andrew D. Auerbach, MD, MPH[1], and Kenneth E. Covinsky, MD, MPH[2,3]

Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

Risk Factors for Potentially Avoidable Readmissions due to End-of-life Care Issues

Jacques Donzé, MD, MSC[1,2*], Stuart Lipsitz, SCD[1,2], Jeffrey L. Schnipper, MD, MPH[1,2,3]

Therefore Multimodal Approaches Work Best

September 2017

Effects of an Intervention to Reduce Hospitalizations From Nursing Homes
A Randomized Implementation Trial of the INTERACT Program

Robert L. Kane, MD[1]; Peter Huckfeldt, PhD[1]; Ruth Tappen, EdD, RN[2]; et al

Reduction of 30-Day Postdischarge Hospital Readmission or Emergency Department (ED) Visit Rates in High-Risk Elderly Medical Patients Through Delivery of a Targeted Care Bundle

Bruce E. Koehler, MPH[1]
Kathleen M. Richter, MS, MFA, ELS[1]
Liz Youngblood, RN, MBA[2]
Brian A. Cohen, PHARMD, MS[3]
Irving D. Prengler, MD, MBA[4]
Dunlei Cheng, PHD[1]
Andrew L. Masica, MD, MSCI[1]

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[2] Department of Patient Services, Baylor Health Care System, Dallas, Texas.
[3] Department of Pharmacy Services, Baylor Health Care System, Dallas, Texas.
[4] Department of Medical Staff Affairs, Baylor Health Care System, Dallas, Texas.

Project ReEngineered Discharge (RED) Lowers Hospital Readmissions of Patients Discharged From a Skilled Nursing Facility

Randi E. Berkowitz, MD, Zachary Fang, BS, Benjamin K.I. Helfand, MSc, Richard N. Jones, ScD, Robert Schreiber, MD, Michael K. Paasche-Orlow, MD, MA, MPH

Project Alignment with UNCMC FY18 Org Goal

Aim Statement: Reduce 30-day readmissions of vulnerable elders from the MDA service by **5%**[1] using evidence-based strategies that address key components of transitions in care delivery by 6/30/18

Project Baseline

30-Day Readmissions for MDA = 19.67%

Source: August 2017 transitions dashboard, all Transitions patients (low, mod, high)
Publisher: Performance Improvement and Patient Safety (PIPS)

Target patient population – Our target patient population is patients ≥65 years old discharged from MDA with particular focus on a high risk subset of patients who are either a) discharged to a skilled nursing facility (SNFs) or b) identified as a Transitions patient.

① Reducing Patient Harm:
Deleterious Effects of Hospitalizations on Older Adult Patients

Hazards of Hospitalization of the Elderly

Morton C. Creditor, MD

Loss of Independence in Activities of Daily Living in Older Adults Hospitalized with Medical Illnesses: Increased Vulnerability with Age

Kenneth E. Covinsky, MD, MPH,‡ Robert M. Palmer, MD, MPH,§ Richard H. Fortinsky, PhD,‖ Steven R. Counsell, MD,‖ Anita L. Stewart, PhD,† Denise Kresevic, RN, PhD,# Christopher J. Burant, MA,** and C. Seth Landefeld, MD*‡*

The Illness Is Bad Enough. The Hospital May Be Even Worse.

Older patients are particularly vulnerable to "post-hospital syndrome," some experts believe, and that may be why so many patients return.

By PAULA SPAN

The New York Times

2 Train Next Cohort of Geriatric Fellows

Leadership Development in Patient Safety, Quality Improvement, and Care Innovations

STATE OF THE GERIATRICIAN WORKFORCE

Geriatricians are physician experts in pioneering advanced illness care for older people, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons.

As we live longer, access to a geriatrics-trained workforce will be key to ensuring we can contribute to our communities for as long as possible. **According to the Health Resources & Services Administration, which tracks data on the workforce we need as we age, the supply of geriatricians is projected to increase modestly between 2013 and 2025 but demand will grow more steeply.**

FAST FACTS

Older Adult Population (2018)
49.2M

Certified Geriatricians (2017)▲
6,910

Full-Time Practicing Geriatricians (2013)★
3,590

Research shows that 30% of people 65-years-old and older need care from a geriatrician, and that each geriatrician can care for up to 700 patients. This translates to a larger demand for geriatricians—both nationally and region by region across the U.S.

Source: www.americangeriatrics.org

Developing QI Interventions

1. How do we reduce readmissions in medically complex older adults?

2. What were the primary reasons patients were being readmitted?

3. What were the contributing factors?

PDSAs on Root-Cause Analysis

Geriatrics MDA Reasons for Readmission Form (Pilot) 37

Patient Identifier (MRN):
Readmission Date:
Reviewer: MCD
PCP:
Discharging MD:
Readmitting MD:

Readmitted From: home w HH

Was the readmission due to (Choose one):
- ☐ New Problem
- ☐ Same problem (nonresolution from index admission)
- ☒ Complication of the same problem as index admission or complication of therapy
- ☒ Disease recurrence or progression

Factors Leading to Readmission (Select all that apply, and indicate if actionable)

#	☐	*Inpatient*	Actionable
1	☐	Ultimate **Diagnosis not apparent** on index admission	☐
2	☐	Prior admission **did not fully treat** medical condition	☐
3	☐	Prior admission did not fully address **needs in regards to functional impairments**	☐
4	☐	Prior admission did not fully address **needs in regards to cognitive impairments**	☐
5	☐	Prior admission did not adequately address **advance care planning and goals of care. (true but didn't lead to readmission?)**	☐
6	☐	Prior admission did not provide **accurate medication list at discharge**. (missing, unclear, or conflicting)	☐
7	☒	Prior admission did not provide **adequate discharge instructions** to the patient or caregiver (missing, unclear, or conflicting). no weight gain instructions	☒
8	☐	Prior admission did not provide **adequate follow-up information for the post-acute care team** (Including contact info for inpatient team.)	☐
9	☐	Prior admission did not include caregiver training in the discharge process.	☐
10	☐	**Follow-up appointment** not timely or not scheduled.	☐
		Outpatient	
11	☐	Did not address outlined follow-up issues in discharge summary	☐
12	☐	Did not receive/review discharge summary.	☐
13	☒	Escalation of care by outpatient provider.	☐
14	☒	Ineffective / Flaws in outpatient management strategies held lasix	☐

#	☐	*Patient*	Actionable
15	☒	Declined recommended services or disposition (SNF, HH), or left AMA.	☐
16	☐	Did not pick up or take medications prescribed at discharge.	☐
17	☐	Did not follow medication changes or medical recommendations made at discharge. ☐Did not adhere (note reason if possible) ☐Could not adhere due to health literacy or access	☐
18	☐	Inappropriate use of Emergency Department resources	☐
19	☐	Inappropriate use of Emergency Department resources	☐
		Intrinsic Factors	
20	☒	Patient with serious illness with frequent unavoidable decompensations.	☐
21	☒	Patient with barriers to outpatient social support.	☐
22	☒	Barriers to outpatient medical support.	☐
		System Issues	
23	☐	**Inadequate transition communication** at index discharge (could be addressed in interview).	☐
24	☐	Post-acute care **did not receive/review** DC summary in time.	☐
25	☐	Patient needing a higher level of care at discharge (would also indicate if they did not meet criteria in index admission.)	☐
26	☐	Patient exhausted available resources in their current level of care.	☐

Comments on Actionable Items (By whom?):

Disposition of (this) readmission hospitalization:
- ☐ Home
- ☐ Home with HH
- ☐ Home with hospice
- ☐ Inpatient hospice
- ☒ SNF
- ☐ Deceased
- ☐ Other

ACO patient (based on presence of Value Care Banner in Epic)?: ☐ Yes ☐ No

One Item That Contributed Most to Readmission: 20

OPEN COMMENTS (optional):

Want a closer look? Please refer to your handout

Building On Last Year's Progress

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

Handing Off the Older Patient: Improved Documentation of Geriatric Assessment in Transitions of Care

Ben A. Blomberg, MD, Rebekah C. Mulligan, MD, Stephen J. Staub, MD, Laura C. Hanson, MD, MPH, Margaret A. Drickamer, MD, and Maureen C. Dale, MD

Journal of the
American Geriatrics Society

By the Numbers

Intervention Quality Assurance, Training, and Stakeholder Feedback

Documentation Quality | Oct 17 – Apr 18	Readmissions Case Reviews| Nov 17 – Mar 18
309 chart audits	**45 RCA reviews**
Readmissions RCA Team	**Readmissions Monthly RCA Review Sessions**
Avg of 7-person team – geriatrics attendings, fellows, and QI project manager	**Avg Session Time = 60 – 90 min**
PCP Interviews| Jan 18 – Apr 18	**Documentation Training Sessions| Nov 17 – Apr 18**
10+ PCP Interviews	**Over 30+ MDA Housestaff Trained Monthly**

Geriatric Comprehensive Assessment

HPI:

is a 79 y.o. woman with past medical history of atrial fibrillation, T2DM, HTN, and pulmonary hypertension who presents with diffuse abdominal pain, intermittent nausea, and lethargy. She was diagnosed with pulmonary hypertension by echocardiography and diuresed to a suspected dry weight of 138 lbs in her recent admission. She was discharged with lasix 40 mg bid in weight based dosing, but has not required this due to her weight being persistently 138 pounds. Yesterday, it dropped suddenly at home to 132 pounds. She has also had several days of worsening oral intake, with one episode of vomiting after eating prepared tuna on a cracker. She has become less interactive with her caregivers and is not walking or participating in activities. She has also begun to complain of abdominal pain. She persistently has tarry-appearing stools.

In the emergency department, she was given basic labs, 500 mL NS bolus, levofloxacin/metronidazole, and CT a/p with contrast.

Want a closer look? Please refer to your handout

Cognitive Assessment

Delirium Assessment:	CAM (Confusion Assessment Method):
On discharge, the patient did not show evidence of delirium. The patient did have symptoms of chronic severe dementia on discharge.	*A Positive CAM is define by the presence of:* Acute Onset or Fluctuating Course + Inattention + Disorganized Thinking *OR* Altered Consciousness

Other cognitive assessment: The patient scored 6/30 Saint Louis University Mental Status Exam (SLUMS). This is consistent with the diagnosis of dementia.

Functional Assessment

ADLs:	IADLs:
Feeding: Independent	**Using the phone**: Requires Assistance
Dressing: Requires Assistance	**Shopping**: Dependent
Ambulation: Requires Assistance	**Meal preparation**: Dependent
Toileting: Requires Assistance	**Medication mgmt**: Dependent
Bathing: Dependent	**Managing finances**: Dependent
	Housework: Dependent
	Transportation (driving or navigating public transit): Dependent

Living situation: Patient lives in her niece-in-law's home with niece-in-law, and nephew.

Changes in ADLs during hospitalization: The patient had episodes of delirium that interfered with her ADLs. She is at baseline per her family

Assistive devices: Walker

Additional services recommended at discharge: SNF

Pre-Discharge Medication Reconciliation by Pharmacist

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Pharmacy Discharge Medication Reconciliation Note

Discharge medication reconciliation has been completed for by a pharmacist on 04/09/18.

Noteworthy Medication Changes:

Stopping apixiban due to bleeding.
Stopping metoprolol due to lower HR.
Decreasing furosemide to once a day.

Starting acetaminophen for pain.
Starting sucralfate for melena.

Medication related barriers:

None. Being discharged to SNF.

Suggested monitoring for outpatient follow-up:

Heart rate. H&H.

D/C Summary: Geriatric Comprehensive Assessment

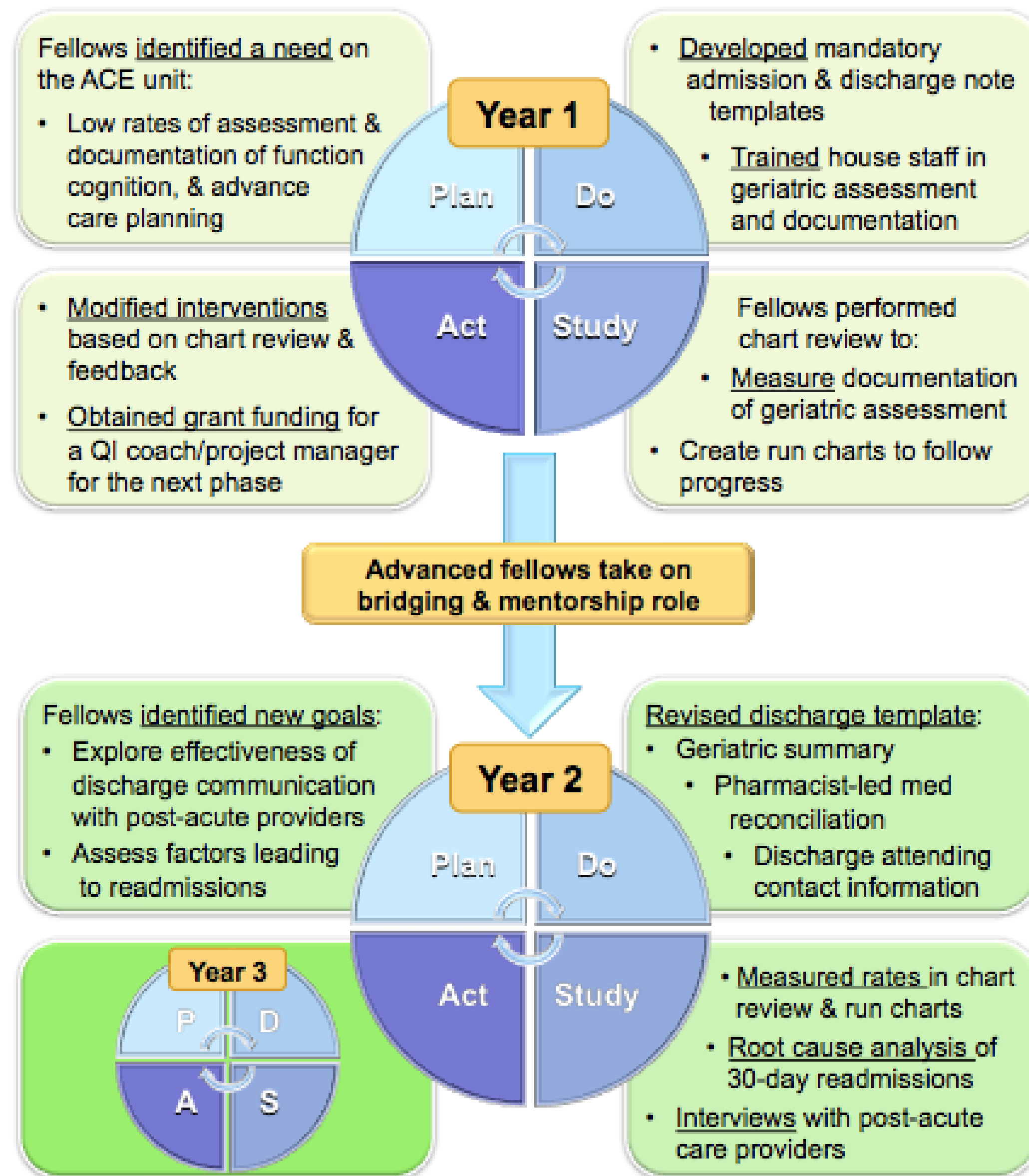
****GERIATRIC ASSESSMENT**: is a 79 y.o. woman with past medical history of atrial fibrillation, T2DM, HTN, PVD, and pulmonary hypertension who presented with diffuse abdominal pain, intermittent nausea, and lethargy. The patient has significant dementia, pulmonary hypertension and broadly distributed vascular disease. Chronic bowel ischemia and dementia likely contribute to reduced food intake. Continued GI bleeding after cessation of anticoagulation concerning, but the patient is neither a surgical candidate nor a candidate for scope to further evaluate given danger of hypoxia and hypercarbia in setting of pulmonary hypertension. The patient would benefit from assistance with ADL/IADLs and rehab to maintain or perhaps improve function. She has been delirious sporadically throughout her stay and will continue to be at risk of this. Regular volume assessment and appropriate titration of Lasix dosing will be key to avoid additional hospitalizations.

Refer below for the patient's functional / cognitive assessments, and advance care planning

Want a closer look? Please refer to your handout

Lessons learned

Lesson #1: Sustainability
Build a Program of Continuous QI Curriculum

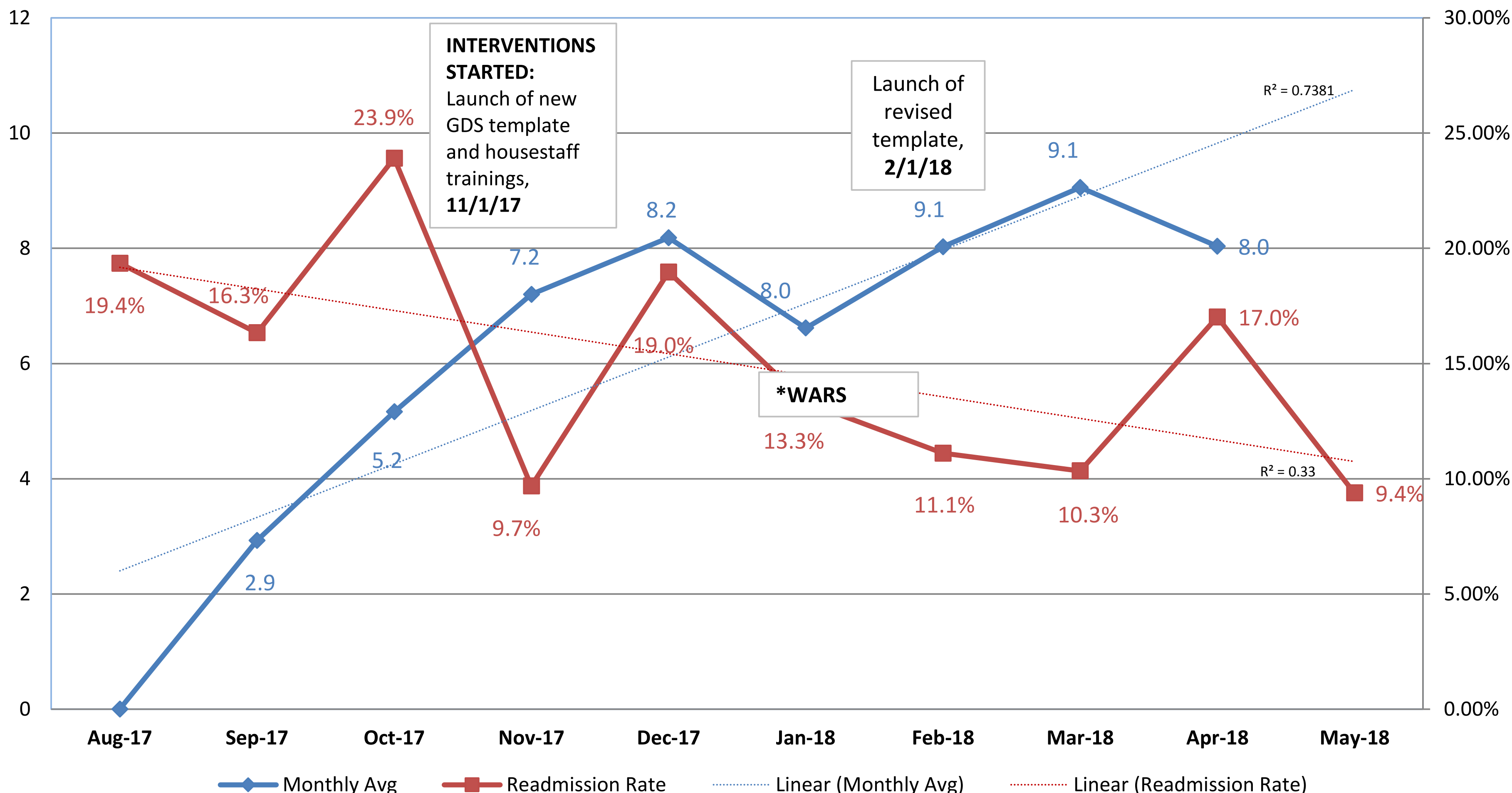


Lesson #2: Identify Impactable Readmissions
Most frequent = Unavoidable Decompensations

Ranking of *primary* factors in readmissions

Item	Contributing factor	Count
20	Serious illness with frequent unavoidable decompensations	22
1	Ultimate diagnosis not apparent on index admission	6
15	Patient declined recommended services or disposition (e.g., SNF, HH)	3
17a	Patient did not follow discharge medication changes or recommendations	3
13	Outpatient provider escalated care.	2
14	Ineffective outpatient management	2
7	**Team gave inadequate discharge instructions to patient or caregiver.**	2
18	Inappropriate use of emergency department	1
25	Patient needed higher level of care at discharge.	1
2	**Team did not fully treat medical condition.**	1
6	**Team did not provide accurate medication list at discharge.**	1
3	**Team did not fully address needs re: functional impairments.**	1
4	**Team did not fully address needs re: cognitive impairments.**	1
9	**Team did not include caregiver training in the discharge process.**	1
26	Patient had exhausted available resources in current level of care.	1

But we still were able to show improvement!



*Average Geriatric Discharge Summary (GDS) quality composite score max = 12 points
Assessed documentation for presence and level of completion of cognitive and function assessments, functional checklist, CAM, code, ACP.

KEY TAKEAWAYS + NEXT STEPS

Key Takeaways +Next Steps

1. **Continue to develop a multi-year CQI curriculum**
2. **Feedback is important!**
3. **Root Cause Analysis = greater insight regarding patient experience and care processes, which led to more targeted improvement efforts**

Thank You!

Core Team: ISP Scholar | Maureen Dale **Faculty** Laura Hanson | **Co-Lead** Ben Blomberg |

Project Manager |Sabrina Vereen

Fellows | Adam Moskowitz, Sheri Mouw, Joy Norris, Bianca Yoo

Clinical Team and Advisors | Jan Busby-Whitehead (Executive Sponsor)

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Partners | MDA/Hillsborough Care Teams | PIPS & IHQI Teams | PCPs and Post-Acute Partners|

&

All of our patients & their families!