Improving Transitions of Care – Project BOOST and more

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University of California, San Diego

CMO, Society of Hospital Medicine

NSW Ministry of Health Master Class – Thursday, November 14th, 2013
Transforming the Health Care System, Why?

Every system is perfectly designed to get the results it gets.

- Dr. Paul Batalden
Why Patients Get Readmitted: A DESIGN RCA

On Admission:
- Poor communication with prior providers
- Redundant testing
- Inadequate medication information
- Limited efforts to identify risks and barriers to successful transition

During Hospitalization:
- Poor communication among members of care team, including outpatient
- Delays in initiating interventions to improve transitions
- Insufficient involvement of patient/caregiver in discharge education/plan
- Failures to clarify goals of care

At Discharge:
- Appointments made when patient/caregiver cannot attend
- Discharge instructions cumbersome
- Inadequate information handoffs
- Error prone med rec
- Rushed education

Post-Discharge:
- Little/Late/No contact with patient post-discharge (hospital/PCP or other caregiver)
- Patients/caregivers unaware of how to manage acute problems
- LIFE HAPPENS (social, financial, logistical, clinical barriers)

Adapted from Chris Kim, MD
Discharge Care Transitions

- ER visits
- Information loss
- Patient dissatisfaction
- Clinical deterioration
- Insufficient services
- Adverse drug events
- Inability to access care
- Inappropriate site of care
- Lack of engagement
- Readmissions
Traditional Care Transitions

Poorest communication
System failures
Nonstandardized care
Patient issues

Hard work
Good intentions
Smart caregivers
Invested patients

Adverse events

Modified from Reason, J. BMJ 2000
A Brief Primer on BOOST

• 2006 to SHM from the John A. Hartford Foundation.
• **Better Outcomes for Older Adults Through Safe Transitions**
• Identifies risk factors for failed discharge care transitions, standardizes interventions, improves patient preparation for discharge, and ensures access to appropriate and timely aftercare.
• Mentored implementation
• Initial 6 sites enrolled 2008
• Now over 200 sites
• Partnerships with Beacon, BC/BS, QIOs
• **Better Outcomes by Optimizing Safe Transitions**
Key Components of BOOST Toolkit

• **Standardized Risk Assessment:** Tool for Identification of High Risk Patients (8Ps)

• **Patient-centered Preparation for Discharge**
  – Checklists - GAP, Universal Patient Checklist
  – Use of Teachback Technique
  – Medication Reconciliation
  – Patient-friendly discharge forms
    • Principal Care Provider identification
    • Who to contact with questions/concerns
    • Warning signs/symptoms and how to respond
    • Outpatient appointments
    • Pending tests

• **Standardized PCP communication**

• **72 hour follow-up call for high risk patients**

• **Mentored Implementation**
What It Means to Be BOOST!

Official BOOST Sites get:

- Kickoff training (2-day)
- Access to free and “firewalled” resources
- 12-18 months of mentorship
  - Longitudinal 1:1 coaching, e-mail access
- Group webinars
- Robust community
- Data and Reporting Center
- A site visit
Tools
• Risk assessment tool
• Discharge preparedness assessment
• Patient-centered discharge education tools
• Teach Back

Resources
• Workbook
• Data collection tools
• Webinars
• Listserv access
• Online community
• Web-based resources
• ROI calculator
• Newsletters
• Teach Back Curriculum
• Mentors
8P Risk Assessment

- Prior hospitalization
- Problem medications
- Psychological
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Palliative Care

IDENTIFY
MITIGATE
COMMUNICATE
<table>
<thead>
<tr>
<th>Score Possible/Earned</th>
<th>Risk Description</th>
<th>Need Complete</th>
<th>Risk Specific Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 points (30d), 2 points (60d), 1 point (em)</td>
<td>Prior Hospitalization (non-elective in the last 6 months)</td>
<td></td>
<td>Identify reasons for re-hospitalization in the context of prior hospitalization in interdisciplinary rounds</td>
</tr>
<tr>
<td></td>
<td># Hospitalizations ______</td>
<td></td>
<td>Referral to Case Management</td>
</tr>
<tr>
<td></td>
<td>Last Discharged ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 point or automatic high risk for CHF</td>
<td>Principal Diagnosis [Stroke, Diabetes, Heart Failure, COPD, Cancer, CAP Pneumonia, Acute MI]</td>
<td></td>
<td>Stroke Education with Teach Back</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diabetes Education with Teach Back</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Heart Failure Education with Teach Back</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COPD Education with Teach Back</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cancer Education with Teach Back</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pneumonia Education with Teach Back</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaccination Not Needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaccination Declined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Acute MI Education with Teach Back</td>
</tr>
<tr>
<td>1 point</td>
<td>Problem Medications (Insulin, oral hypoglycemics, anticoagulation, high dose narcotics)</td>
<td></td>
<td>Pharmacy Consult</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pain Consult</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prophylaxis for Narcotic Side Effect ordered at Discharge</td>
</tr>
<tr>
<td>1 point</td>
<td>Polypharmacy (&gt;8 routine medications)</td>
<td></td>
<td>Pharmacy Consult</td>
</tr>
<tr>
<td>1 point</td>
<td>Psychiatric Complications (acute psychiatric issues, history of psychiatric disease that hinders self-care abilities, history alcohol/drug abuse)</td>
<td></td>
<td>Prior to Admission Psychiatric Medications Reconciled</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychiatric Consult for Acute Psychiatric Needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community Resources Provided for Psychiatric Follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Work Consult for Alcohol/Drug Abuse Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Accepts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Declines</td>
</tr>
<tr>
<td>1 point</td>
<td>Poor Health Literacy (literacy screening tool) How often do you need to have someone help you when you read instructions or other written material from your doctor or pharmacist? 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always. If more than 2. (sometimes or greater, 1 point is earned)</td>
<td></td>
<td>Identify Barriers to Learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identify Key Learner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identify Co-Learner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aftercare 1:1 Teach Back Coaching at discharge</td>
</tr>
<tr>
<td>2 points</td>
<td>Patient Support (absence of a caregiver to assist with discharge and home care)</td>
<td></td>
<td>Patient Meeting (MD/interdisciplinary team @bedside to collaborate)</td>
</tr>
<tr>
<td>1 point</td>
<td>Palliative Care</td>
<td></td>
<td>Howell Service Consult</td>
</tr>
</tbody>
</table>

**High Risk for Readmission Universal Interventions**

- [ ] PCP Verification
- [ ] PCP Confirmed
- [ ] PCP Documented in AVS
- [ ] PCP Incomplete
- [ ] Correct PCP Updated (≥6331)
- [ ] No PCP
- [ ] Care Coordination Provides PCP List
- [ ] New PCP Selected
- [ ] Follow-up Appointment Scheduled
- [ ] Within 7 Days Post Discharge and Documented in AVS
- [ ] Within 14 Days Post Discharge and Documented in AVS
- [ ] Med reconciliation verified
- [ ] Pharmacist Verification
- [ ] BNI Verification No Duplicates
- [ ] Day of Discharge Checklist
- [ ] Day of Discharge Checklist Complete
- [ ] 1:1 Teach Back Coaching at Discharge
- [ ] 72 hour post discharge call back
- [ ] Referred to Care Coordination
- [ ] Discharge Summary Sent to PCP
- [ ] Valid Fax # in EPIC
- [ ] No Valid Fax # in EPIC
- [ ] MD Notified to Send Discharge Summary
- [ ] Authorization for Release of PHI Fax to x37128

UC San Diego Health System
Interventions to mitigate risk

• GENERAL
  • Early follow up, making appointment in conjunction with patient
  • Follow up phone call within 24 hours
  • Teach back

• RISK-SPECIFIC
  • Pharmacy / medication management consultation for polypharmacy of problem medications
  • Triggering pre-existing protocols
    • (eg, make sure CHF discharge module is utilized)
NEW CONCEPT: Health information, advice, instructions, or change in management

The Teach Back Method

1. Explain new concept / Demonstrate new skill
2. Patient recalls and comprehends / Demonstrates skill mastery
3. Assess patient comprehension / Ask patient to demonstrate
4. Clarify and tailor explanation
5. Re-assess recall and comprehension / Ask patient to demonstrate
6. Adherence / Error reduction

The General Assessment of Preparedness: The GAP

On Admission

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

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

- 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
Patient-friendly Discharge Document

• Form, plus a patient-centered med list, goes home with the patient
• Use as guide for discharge teaching

• Includes several key components:
  • Hospital Diagnosis
  • Warning signs
  • F/u information
  • Who to contact with issues
# Patient PASS

Patient Preparation to Address Situations (after discharge) Successfully

## I was in the hospital because

<table>
<thead>
<tr>
<th>If I have the following problems ...</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>(_____ )</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td>(_____ )</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td>(_____ )</td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
<td>(_____ )</td>
</tr>
</tbody>
</table>

## My appointments:

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>On: _/<strong>/</strong> at <strong>:</strong> am/pm</td>
<td>On: _/<strong>/</strong> at <strong>:</strong> am/pm</td>
<td>On: _/<strong>/</strong> at <strong>:</strong> am/pm</td>
<td>On: _/<strong>/</strong> at <strong>:</strong> am/pm</td>
</tr>
<tr>
<td>For: ____________________</td>
<td>For: ____________________</td>
<td>For: ____________________</td>
<td>For: ____________________</td>
</tr>
</tbody>
</table>

## Tests and issues I need to talk with my doctor(s) about at my clinic visit:

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td>____________________</td>
<td>____________________</td>
<td>____________________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

## I understand my treatment plan. I feel able and willing to participate actively in my care:

______________________________
Patient/Caregiver Signature

______________________________
Provider Signature

______/____/____
Date
BOOST tools are not intended to be worn right “off the rack.”

They are to be tailored to your own institutional needs and resources.
Does it work?

- Volunteer sample of 11 out of 30 hospitals
  - Vary in geography, size and academic affiliation
- Pre-post changes in same hospital readmission rates – BOOST vs Control Units
- BOOST unit readmission rate: 14.7% to 12.7% in 12 months
  - Relative reduction of 13.6%
- No change in control units (14.0 vs 14.1%)

Hansen et al, JHM 2013
The 7th hospital’s control unit had less than 10 monthly discharges and not included in the analysis. All units included in analysis had 60 or more monthly discharges.
Readmission Rate (Illinois Cohort)

Average Readmission Rate in BOOST Units (6 Hospitals)*

* 7th hospital’s control unit had less than 10 monthly discharges and not included in the analysis. All units included in analysis had 60 or more monthly discharges.

Preliminary
Who We Are

- UC San Diego Health System
  - The only academic health system in San Diego
  - 2 campuses, totaling 600 beds
- Level I Trauma Center
- Certified Stroke Center
- Magnet Hospital
- Named one of the nation’s “Most Wired” for the sixth consecutive year in 2011

- Employees
  - 850 physicians
  - 2500 nurses

- Fiscal 2011 year key statistics
  - 61,446 ED visits
  - 25,742 discharges
  - 54,013 total outpatient visits

- Project BOOST
UC San Diego Transitions of Care Efforts

• BOOST Framework PLUS

• CTI (Care Transitions Intervention)
• CCTP (Community Based Care Transitions Program)
• Medication Management
Building a BOOST Team

Advisory Board

Core BOOST Team

Ad Hoc Members

Subgroup

Subgroup

Subgroup

Subgroup

C-suite, PO/PHO, ambulatory care leadership, hospital/board QI committee

Project Leader & Mgr, QI/PI, RN, CM, SW, PharmD, IT/data, Doctor (inpt & outpt), Advanced Practice Provider

Schedulers, pt education, unit secretary, VNA, financial, patient and caregiver, hospice, SNF
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” (TC) 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 discharge
- N=750
### 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

### Table 3. Utilization Outcomes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Intervention Group (n = 379)</th>
<th>Control Group (n = 371)</th>
<th>2-Sided <em>P</em> Value†</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 30 d</td>
<td>8.3</td>
<td>11.9</td>
<td>.11</td>
<td>0.59 (0.35-1.00)</td>
</tr>
<tr>
<td>Within 90 d</td>
<td>16.7</td>
<td>22.5</td>
<td>.05</td>
<td>0.64 (0.42-0.99)</td>
</tr>
<tr>
<td>Within 180 d</td>
<td>25.6</td>
<td>30.7</td>
<td>.15</td>
<td>0.80 (0.54-1.19)</td>
</tr>
<tr>
<td>Rehospitalization for same diagnosis as index hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 30 d</td>
<td>2.8</td>
<td>4.6</td>
<td>.21</td>
<td>0.56 (0.24-1.31)</td>
</tr>
<tr>
<td>Within 90 d</td>
<td>5.3</td>
<td>9.8</td>
<td>.03</td>
<td>0.50 (0.26-0.96)</td>
</tr>
<tr>
<td>Within 180 d</td>
<td>8.6</td>
<td>13.9</td>
<td>.045</td>
<td>0.55 (0.30-0.99)</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; OR, odds ratio.
*Data are given as percentages unless otherwise indicated.
†To test statistical significance between the intervention and control groups, χ² test was used for unadjusted utilization outcomes, and logistic regression analysis was used for adjusted use outcomes.
‡Adjusted for age, sex, education, race/ethnicity, self-reported health status, chronic disease score, prior hospitalization and emergency department utilization, and discharge diagnosis.

The Care Transition Coach

Key Attributes of a CTI Coach

- Model & Facilitate New Behaviors & Skills
- Promote Patient Self-Activation
- Competent in Medication Review & Reconciliation
- Bridge between Staff and the Patient and/or Family
Key Elements of the Care Transitions Intervention (CTI)

- Referral Process
- Hospital Visit
- Phone call to patient after discharge from hospital
- Home visit within 2 days after discharge
- Phone calls to patient 7 days and 14 days after the home visit
- Enhanced CTI will provide additional services to a subset of patients
Community-based Care Transitions Partnership (CCTP)

- Mandated from the Affordable Care Act
- Part of larger Partnerships for Patients initiative
- Goals-
  - improve patient care, reduce cost, reduce readmissions by 20%
- Target population - High Risk Medicare FFS inpatients
- $500 million in funding from 2011 – 2015
- Community Based Organizations (CBO) partner with hospitals and others in community
- Competitive process to obtain funding
- Currently 82 groups funded after four rounds
The CCTP Partners

Click anywhere on the map to view the interactive version

Source: Centers for Medicare & Medicaid Services
County AIS, Scripps, Sharp, Palomar, UCSD

- 11 hospitals targeting over 21,000 high risk patients
- UCSD interventions
  - Phone call, medication management, Transition Nurse Specialist
  - AIS Interventions
    - Care Transitions Intervention (CTI), Enhanced CTI

San Diego Care Transitions Partnership
Transforming Care Across the Continuum
Transitions Nurse Specialist (TNS)

- Blended role: nurse educator, case manager, community health nurse
- Bridge patients from inpatient to outpatient
- Available to patients for up to 30 days post discharge
- Manages high risk patient populations
- Average daily caseload of 8 patients
Transitions Nurse Specialist Daily Workflow

- Receives list of patients who are high risk
  - (captured in PADB and Epic report)
- Uses Project BOOST 8 P’s as a tool: In-depth patient/family interview, assessment
- Develops patient-centered discharge plan
- Uses teach back for patient/family education
- Communicates discharge plans and patient education needs with physician and multidisciplinary team
- Arranges post-discharge follow up appointment with primary care physician
- Communicates important updates with patient’s primary care provider
- Reviews discharge instructions with patients
- Requests additional interventions, as appropriate:
  - Pharmacy
  - CTI Coach
Patient Follow Up Post Discharge

- Completes follow up phone call within 72 hours on a subset of patients
- Reviews Discharge Summary with patients: Reason for admission, medications, follow up appointments, and red flags that would require follow up
- Provides number to call should patient have questions/concerns
- Refers any questions or concerns to patient’s primary care provider, as appropriate
Additional Interventions:
CTI Transition Coach (provided by community partner)

On identified subset of patients
- Hospital visit
- Personal Health Record
- Home visit
- Follow up phone calls

CTI Advanced intervention
- Homemaker, personal care attendants, transportation

✓ Communicates any concerns or problems to UC San Diego Transition Nurse Specialist (TNS)
Pharmacist Interventions

- Pharmacist-performed medication reconciliation and patient education in the inpatient setting:
  - Decreases errors
  - Improves patient drug knowledge
  - Reduces readmission rates

- Pharmacist interventions in the outpatient setting:
  - Reduce readmissions
  - Reduce mortality
  - Increase adherence
  - Increase medication knowledge

Transitional Care Pharmacist Model

**Admission/Inpatient**
- Medication reconciliation
- Interdisciplinary rounds
- Address adherence/compliance to medications

**Discharge**
- Medication reconciliation
- Medication education with patient friendly tools
- Coordination of medication acquisition

**Post Discharge**
- 48 hour telephone follow-up
- 7-day clinic visit
Transitions of Care: Medication Management Program

- Medication Reconciliation
  - Admission
  - Discharge
- Discharge counseling with MedAction Plan
- Post discharge follow up
  - 48-72 hour phone call +/-
  - 7 day clinic visit

http://medactionplan.com
Pilot results:
Point of Pharmacist Intervention

Admission: 38%
Discharge: 37%
Post Discharge: 25%

N=131
UCSD Hillcrest 6-East/6-West (BOOST Pilot Unit)
30-day Readmission Rates
Baseline Heart Failure Readmission Rate 36.1%  (May 2010 – April 2011)
Current Heart Failure Readmission Rate  17.9%
UCSD Hospital Medicine Services
7 day readmission rates

All Cause Hospital Readmissions - 7 Day
July 2011 - December 2011

July '11 | August '11 | September '11 | October '11 | November '11 | December '11
---|---|---|---|---|---
12.0% | 10.0% | 8.0% | 6.0% | 4.0% | 2.0% | 0.0%

- Medicine Hillcrest
- Medicine Thornton
- Combined
## DC Summaries – Hospital Medicine

**UC San Diego Hospital Medicine Service Lines**

### Discharge Summaries Signed within 48 hours of Discharge

*September 2012 - August 2013*

**DY9 (FY13-14) Target is 90%.**

**DY9 YTD – 93.1%**

<table>
<thead>
<tr>
<th>Hospital Medicine</th>
<th>September '12</th>
<th>October '12</th>
<th>November '12</th>
<th>December '12</th>
<th>January '13</th>
<th>February '13</th>
<th>March '13</th>
<th>April '13</th>
<th>May '13</th>
<th>June '13</th>
<th>July '13</th>
<th>August '13</th>
<th>FY YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total DC Summaries</td>
<td>551</td>
<td>573</td>
<td>529</td>
<td>508</td>
<td>583</td>
<td>532</td>
<td>580</td>
<td>566</td>
<td>605</td>
<td>584</td>
<td>587</td>
<td>460</td>
<td>1047</td>
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<td>Dc Summaries win 48 hrs</td>
<td>493</td>
<td>544</td>
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<td>537</td>
<td>563</td>
<td>555</td>
<td>556</td>
<td>419</td>
<td>975</td>
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<tr>
<td>Percent</td>
<td>89.5%</td>
<td>94.9%</td>
<td>93.4%</td>
<td>92.9%</td>
<td>96.7%</td>
<td>94.2%</td>
<td>94.0%</td>
<td>94.9%</td>
<td>93.1%</td>
<td>95.0%</td>
<td>94.7%</td>
<td>91.1%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

* Baseline data - 7/1/2011 - 6/30/2012
Lessons Learned

- Transitions in Care are not medical events
- Responsibility for the patient does not disappear when the patient disappears
- The entire continuum of care needs to be committed to improving transitions of care
- Focus on the patient not the disease
- Executive Support
Keep the patient at the center

• Vision – Provide best quality service to all patients, regardless of payer
• Go outside of boundaries to accommodate our patients
• CCTP / CTI give us payment mechanism and opportunities to collaborate
• If you aren’t part of the solution…..
• Identify, mitigate, communicate
**BOOST Future State**

Adapted from Chris Kim, MD

**On Admission:**
- Readmission risk factor screen
- Discharge needs analysis
- General assessment of preparedness
- Medication reconciliation
- Input from outpatient caregivers
- Readmit RCA (if needed)

**During Hospitalization:**
- Interprofessional rounds to develop patient-centered, safe transition plan
- Initiate readmission risk reduction interventions
- Educate patient & caregiver using Teach Back
- Clarify goals of care

**At Discharge:**
- Schedule post-discharge appointment
- Patient friendly discharge instructions
- Handoffs (hospital to aftercare)
- Medication reconciliation
- Reinforce education

**Post-Discharge:**
- Post-discharge call
- Follow-up appointment
- Transmit accurate discharge summary
- Family/caregiver support
- Appropriate services
- Transitional support
Improved Care Transitions

Effective communication

Standardized care

System support

Patient-centered care

Patients

Hard work

Good intentions

Smart caregivers

Invested patients

Adverse events

Modified from Reason, J. BMJ 2000;320
The Future is Coming
What questions do you have?

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Thank you ...