Redesign the discharge process for enhancing coordination at care transitions and reducing readmission

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1. The revolving door syndrome

30 days hospital readmissions is considered an indicator of suboptimal health care quality and existing studies assessed that up to 59\% of readmissions are preventable.

Among patients admitted in Tuscany in 2012 for treatment of AMI, heart failure and pneumonia the cause of readmission is the same as that of the index admission for only 48\%, 65\%, and 81\%, respectively (Forni, 2012). Single condition study are unable to provide insight on how to prevent readmissions. Quality improvement studies which triangulated medical records review with patient and family caregivers interviews and primary care provider interviews indicated quality improvement focus area. Factors related to discharge process, transition planning, care coordination, medication management and clinical care occurred in potentially preventable readmissions (Feigenbaum, 2012).

1.1 Redesign the discharge process

A quality improvement intervention bundle aiming at standardizing the discharge process and at improving care coordination will be introduced in the internal medicine of a tertiary referral hospital (Careggi Teaching Hospital, Florence, IT) and in 4 primary care urban districts where patients are more frequently discharged.

The intervention is composed of an educational intervention to patient and family caregiver on home medications management, the redesign of the discharge summary, a patient agenda for medication administration, for follow up appointments and pending diagnostics tests, a direct phone contact for discharged patients and family caregivers, GPs access to the hospital EMR, allowing GPs to read and comment patients EMR before discharge, notification of patient discharge to GPs 2 days ahead.

A telephone structured interviews to 600 patients and family caregiver and a questionnaire to hospital staff and GPs (50 health care workers) before and after the intervention will be used to assess the comprehensive discharge process experience. The 30 days after discharge readmission rate to the internal medicine ward and to ED will be monitored before and after the intervention

1.1.1 The bundle intervention introduced with CARED study protocol

The intervention aimed at removing barriers related to organizational process regarding GPs partaking, lack of personalised communication to patients as well as characteristics, layout and wording of patient medical documentation. The improvements introduced by study protocol are:

1) Medical visits and Follow up: provide patients with usable and accessible schedules including planned medical appointments and to empty spaces for additional follow up visits;
2) Drug Therapy:
   a. clearly identify each single drug prescribed, with particular look out to those ones modified with respect to the home/previous therapy
   b. a simple matrix supporting and facilitating patients and caregivers in therapy management
3) Contacting hospital after discharge: Provide contact names and direct phone number of medical team including time windows and emergency contact numbers
4) Provide GPs with a consultation view of inpatient EMR and instant messaging and notification of patient discharge planning ahead of discharge.
5) Discharge Letter: provide an accessible and easy to read discharge letter with a clearly reported reason for hospitalization. Understandable medication list and recent medication history, instructions on how to assume drug therapy.

2 Expected results

Reducing all causes readmission addressing factors regarding care coordination issues and patient and family caregiver empowerment is a promising intervention area that we aim to investigate through a before and after study focusing on the impact of a quality improvement intervention bundle on the comprehensive discharge process.

The impact of factors related to suboptimal care coordination, poor coordination between inpatient and outpatient providers (Hesselink, 2012) is supposed to account for many of the all-causes 30 days readmissions diverging from index admission. A quality improvement intervention bundle focused on the care coordination improvement may provide elements for enhancing the quality and safety of the healthcare system.

References

