Bridging the Gap: Discharge Clinics Providing Safe Transitions for High Risk Patients

Northwest Patient Safety Conference
May 15, 2012

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Thanks to Dr. Lauren Doctoroff and Dr. Tyler Jung, who also presented this workshop at Society for Hospital Medicine National Meeting, April 2012.
Learning Objectives

• Recognize that the post-hospitalization transition is a period of great risk for patients

• Identify roles that hospitalists can play in post-discharge patient care

• Discuss strategies to consider when implementing a discharge clinic at your institution
DANGER

DON'T RUN

BEWARE!

DON'T WALK BACKWARDS

DEEP SHAFTS

UNMARKED HOLES
Transitions = Danger Zone

• Patients at time of discharge:
  – 49% experience at least one medical error
  – 60% with test results pending
    • 37% requiring follow up, unbeknownst to patient and provider

J Gen Intern Med. 2003;8:646-51
Attention to transitions increasingly important because of…

- Increased use of hospitalist system for inpatient care
- Patients being discharged “quicker and sicker” than ever before
- Increasing complexity of medicine
- Changing reimbursements for complications and readmissions
Barriers to safe transitions

• Systems issues:
  • Different EMR systems
  • Lack of timely appointments available at PCP offices
  • No established primary care provider

• Provider Barriers:
  • Lack of direct inpatient <-> outpatient provider communication
  • Discharge summary available at first f/u appointment only 25% of time

• Patient Barriers
  • Low health literacy
  • Lack of clear communication

JAMA. 2007; 297(8): 831-841
Coll Gen Pract. 1987; 494-495
Is timely follow up a solution for dangers at discharges?

Though there is mixed data, some evidence supporting post-discharge follow up:

- Increased PCP follow up independently associated with decreased risk of hospital readmission

- Pts with PCP follow up within one month of discharge up to 10x less likely to be readmitted with index condition

- Timely follow up may reduce admissions in key populations (CHF, COPD)

J Hosp Med. 2010:392-397
JAMA 2010:1716-1722
Timely Follow-up

However,

- On average, <50% of patients will see their PCP within 14 days after discharge
- What about patients without established primary care?

Can hospitalists play a role?

Hospitalists and Post Discharge Care: Advantages

What are possible benefits of hospitalist involvement in post discharge care?
Hospitalists and Post Discharge Care: Advantages

- Familiarity with complex patients
- Familiarity with new antibiotics, new anticoagulants
- Close connection with inpatient care teams and inpatient medical record
- Possible improvement in transitions for patients without PCPs
- Practice changing for hospitalists
- Opportunity for closer interactions with PCPs
Hospitalists and Post Discharge Care: Disadvantages

What are possible disadvantages of hospitalist involvement in post discharge care?
Hospitalists and Post Discharge Care: Disadvantages

- Lack of interest among hospitalists
- Poor familiarity with outpatient medicine, including clinical issues and processes
- Difficult business model
- Complex intersection with clinical schedule for hospitalists
- Turf issues with PCPs
Breakout Session: The Case of Mr. G
Questions to consider

• Who is responsible for patients unaffiliated with primary care after their hospital discharge?
• How could a discharge clinic have been helpful for Mr. G?
• What kinds of services should a discharge clinic for patients without a primary care provider provide?
The Aftercare Clinic
Harborview Medical Center
Seattle, Washington
Harborview Medical Center

- 413-bed public “safety net” hospital
- >$200 million in charity care
- ~50% patients indigent
- Low health literacy
- 95-105% occupancy rates
- 5 primary care clinics
The Aftercare Clinic: A safety net for the safety net

- Established in October 2007

- Transitional care for patients without primary care:
  - Seen at HMC ED or discharged from HMC wards (any service)
  - In need of urgent follow up with provider
Clinic goals

• Providing safe transitions for patients without established primary care
  – F/u within 2 weeks
  – Med reconciliation, symptom management

• Community partnering with FQHC clinics and dissemination of primary care
  – Referrals to primary care in community
  – Improved communication between academic center and community clinics
Clinic goals

• Targeting vulnerable patients with high risk of readmission/ ED recidivism
  – CHF patients seen within 72 hours of discharge
  – Returning wound care
  – Visiting immigrants
  – Health care for the homeless
  – Patients recently released from jail
Daily clinic life

- Staffed by hospitalists, ARNPs
- Open 5 days per week, 1-2 providers in clinic each session
- 20 minute visit slots
- Average 270 visits monthly
- ~30% no show rate
- Main diagnoses: HTN, DM, SSTI
- >50% patients unsponsored
- >25% limited English-speaking
Success with referrals

- Total referrals: 115
- Appts made by ACC: 94
- Total show rate for CHC appts: 59.1% (68/115)
- Show rate if we made appts for patient: 72.3% (68/94)
Lessons Learned

• Brings reality to the discharge process/ planning from inpatient and ED
• Multiple “safety catches” for unaffiliated patients
• Improved communication between academic center and community clinics
• Different skill set for hospitalists can be challenging
• Metrics for objectively measuring “success” challenging to create in this setting
Breakout Session

Consider a post-discharge clinic at your institution
Bridging the Gap: Conclusions

• Transitions in care are vulnerable periods for patients
• Post discharge care is an important part of ensuring safe transitions
• Hospitalists may have a role in post discharge care in the new health care system
• How your hospitalist group will rise to this challenge is up to you!