Stroke Patients: Transition From Hospital to Home

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Presenter Disclosure Information

Lauren Pond RN CCM
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Discharge Planning and Transition of Stroke Patients

FINANCIAL DISCLOSURE:
No relevant financial relationship exists
Triad Model

- Separate UR functions from Care Coordination Functions
- Ensure synergy between the teams
- Focus on the intersections between social, financial and clinical outcomes
- Support for patient/family after discharge
- Transitions
Guiding Principles:

- Patient centric
- Standardization
- Shared Expectations/Accountability
- Right Person, Right Job
- Physician Relationship
- Interdisciplinary Partnerships
The team…

Utilization Manager

Care Manager

Clinical Social Worker

Health Advocate

Rhode Island Hospital
A Lifespan Partner

Care Manager

• CM Assessment on all patients who meet high risk screen

• Develop initial discharge plan with patient/family and care team

• Reassess discharge plan *daily* during collaborative care rounds

• Notification to transitions team of high risk patients

• Community Collaboration- safe handovers
Social Worker

- Collaborate closely with Care Manager to assess for psychosocial needs and assist with complex discharge plans
- Monitor psychosocial barriers to discharge and intervene as needed to avoid delays at discharge
- Manage the psychosocial crisis of admission and adjustment to illness
High Risk Screen for DC needs Readmission Risk

- > 75
- Hx recent falls
- Homeless
- Polypharmacy, > 7 meds
- No PCP
- Medication or dietary non-compliance
- Primary caregiver for another family member impacting discharge
- Requires support with ADLs
- Skilled or DME needs at discharge
- End-stage condition (CHF, HIV, COPD, CVA)
- Multiple co-morbid conditions
- Cognitive impairment
- From SNF, AL, rehab or group home
Screen in: One “yes”-

- In person - patient/family case management assessment
  - Determine needs, assess wants and discuss available options

- Discussed/updated at daily collaborative care rounds
Case management Assessment

• Living arrangements

• Support systems

• Current services

• Anticipated discharge plan

• Transportation

• Anticipated DC needs based on CMA -
  • Equipment, PT, OT, ST, MSW, medication management, wound care, IV medications, labs, other

• Anticipated Discharge Plan
  • Home, home care, DEA, DME, home infusion, skilled nursing facility, hospice, LTACH Preferences
Rhode Island Hospital – Stroke Length of Stay

Rhode Island Hospital
Q4 2014 (October - December 2014)
Length of Stay according to Stroke MS-DRG

<table>
<thead>
<tr>
<th>Stroke MS-DRG</th>
<th>Cases</th>
<th>LOS Obs</th>
<th>LOS Exp</th>
<th>O:E</th>
</tr>
</thead>
<tbody>
<tr>
<td>061 acute ischemic stroke w use of thrombolytic agent w mcc</td>
<td>7</td>
<td>7.43</td>
<td>8.53</td>
<td>0.87</td>
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<td>5.09</td>
<td>5.01</td>
<td>1.02</td>
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<tr>
<td>063 acute Ischemic stroke w use of thrombolytic agent w/o cc/mcc</td>
<td>6</td>
<td>2.67</td>
<td>4.46</td>
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<tr>
<td>064 intracranial hemorrhage or cerebral infarction w mcc</td>
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<td>6.41</td>
<td>6.99</td>
<td>0.92</td>
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<tr>
<td>065 intracranial hemorrhage or cerebral infarction w cc</td>
<td>62</td>
<td>3.71</td>
<td>5.25</td>
<td>0.71 **</td>
</tr>
<tr>
<td>066 intracranial hemorrhage or cerebral infarction w/o cc/mcc</td>
<td>31</td>
<td>2.61</td>
<td>4.54</td>
<td>0.58 **</td>
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<tr>
<td>067 nonspecific cva &amp; precerebral occlusion w/o infarct w mcc</td>
<td>1</td>
<td>8.00</td>
<td>2.55</td>
<td>3.13</td>
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<tr>
<td>068 nonspecific cva &amp; precerebral occlusion w/o infarct w/o mcc</td>
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<td>2.33</td>
<td>2.83</td>
<td>0.82</td>
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<tr>
<td>069 transient ischemia</td>
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<td>2.13</td>
<td>2.62</td>
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LOS Obs: Length of stay observed
LOS Exp: Length of stay expected according to UHC 2014 AMC Risk Adjustment Model
O:E= LOS observed / LOS expected according to UHC 2014 AMC Risk Adjustment Model
* Indicates a significant difference between observed and expected LOS with ≤ .05 level of significance
** Indicates a significant difference between observed and expected LOS with ≤ .01 level of significance
Significance testing not available for service lines with < 10 discharges
Transition from Hospital

- Care Transition Department
- Care Coordinator Call Team
- RN and Social Work Health Advocates
Patient Care Coordinators

- 48 hour post discharge call
- How are you feeling?
- Were you able to fill your prescriptions?
- Confirm PCP appt and transportation
- Do you have questions about your discharge instructions?
- Provide duplicate copies of discharge instructions.
Health Advocate

- Referrals from CM’s, SW, MDs,
- Triage from Patient Care Coordinators
- Complex care Rounds
- Unit specific rounds
Rhode Island Hospital – Stroke 30-Day All Cause Readmission Rate

Rhode Island Hospital
30-Day All Cause Readmission Rate according to Stroke MS-DRGs

% Patients Readmitted

Readmissions
Readmission Rate
Linear (Readmission Rate)

Q1 2013 (n=198) Q2 2013 (n=184) Q3 2013 (n=213) Q4 2013 (n=182) Q1 2014 (n=207) Q2 2014 (n=201) Q3 2014 (n=216) Q4 2014 (n=214)

Readmission Rate

Below Threshold
Threshold
Target
Maximum

Lower is better

*UHC standard restrictions applied
Numerator: Number of stroke patients readmitted within 30 days of discharge
Denominator: Number of stroke patients discharged
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<td>31</td>
<td>6.45</td>
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*UHC standard restrictions applied
Numerator: Number of stroke patients readmitted within 30 days of discharge
Denominator: Number of stroke patients discharged
Stroke Family/Caregiver Assessment
To be completed by the primary caregiver(s) within 24 hours of discharge

Primary Caregiver(s): ____________________________________________________________

1. Are you able to care for and provide assistance to the patient after discharge?
□ Yes □ No If no, please check boxes you need help with.
□ Mobility/Out of Bed □ Dressing □ Feeding
□ Bathing/Toileting □ Giving Medications

2. Would you like to speak to someone about any of the following?
If yes, please check boxes of skills you would like to discuss with the staff.
□ Mobility/Out of Bed □ Dressing □ Feeding
□ Giving Medications □ Bathing Toileting

3. Do you feel you have had enough education to care for the stroke survivor?
□ Yes □ No If no, please explain

4. Do you have support to assist with the care of the stroke survivor?
□ Yes □ No If no, please check areas that would best support you.
□ Home Health Aid □ Meals on Wheels □ Transportation
□ Visiting Nurse □ Stroke Support Groups □ Caregiver support resources

5. Are there any additional education, skills, or resources that you need to provide post-hospital care?
□ Yes □ No If yes, please describe______________________________________________
Starfish

- Stroke survivor group
- Pt experiencing dysphasia; weakness triaged to ER admitted with stroke
- Assistance in transitioning from home to SNF if condition warrants
- Home care scheduling mishaps
- Palliative care and hospice referrals
- Family adjustment to illness and advanced care planning.