Developing Community-Based, Standardized Hospital-Discharge Summaries

A physician-based task force aims to reduce hospital readmission rates and emergency room visits by increasing collaboration to improve patient care.

Executive Overview

High rates of readmissions to hospitals put the health of patients at risk and, under new U.S. regulations, increasingly hurt the bottom line of hospitals. Nationally, it’s been estimated that one in five Medicare patients are readmitted within 30 days of being discharged from a hospital. Many of these readmissions are believed to be preventable with more coordinated care, which the government estimates would save USD 17 billion annually.1 And beginning in 2012, the Readmissions Reduction Program of the Affordable Healthcare Act withholds a portion of Medicare reimbursements to hospitals that have 30-day readmissions rates considered too high.

Accountable care organizations (ACOs) are forming across the nation and experimenting on ways to reduce the so-called “revolving door” of readmissions. In Oregon, where provider groups are joining ACO-like models called coordinated care organizations (CCOs), there is an interesting project to reduce hospital readmissions as part of a larger healthcare transformation effort (see the “Oregon Experiment” sidebar).

The Tri-County Health Commons Project (“The Commons”) has brought together colleagues and competitors among healthcare providers serving Portland’s metropolitan area, as well as a project facilitation team from Intel Corporation, the largest private employer in Oregon.

The Commons seeks to re-engineer and standardize elements of the hospital-discharge process and the discharge-summary document. The project offers lessons for the national ACO movement to improve patient outcomes and prevent unnecessary costs such as excessive readmission rates.

“Physician buy-in and a neutral, third-party project adviser are keys to the successful implementation of a standardized discharge summary and improved patient outcomes.”

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The Revolving Door of Healthcare
For those in healthcare, the following scenario is all too familiar: "Sue" is a 42-year-old patient with multiple health issues, including heart disease and diabetes, and a history of substance abuse. She receives health coverage through a state-supported healthcare program. While she has an assigned primary care provider (PCP) at a nearby county health clinic, she is not actively engaged with her healthcare team. When in need of attention, she visits one of three emergency departments (EDs) in the metropolitan area in which she lives.

All three hospitals use a different EHR system, a different discharge summary format, and have variances in risk-identification and discharge workflow. Because the EHR systems don’t “talk” to one another, coordination of follow-up care at the time of discharge is difficult.

The hospital-discharge summary is forwarded to Sue’s PCP at the county clinic, which doesn’t receive it until two weeks later. Meanwhile, Sue does not get the follow-up care she needs, prompting a return to an ED, which might have been prevented.

Stepping up to the Challenge: The Tri-County Health Commons Project
In November 2011, a group of medical professionals from three counties located in the Portland metropolitan area came together to apply for a federal grant that would lay the groundwork for a CCO serving the region’s Medicaid patients. The participants were CareOregon, Providence Health and Services-Oregon, Clackamas County, the Coalition of Community Health Clinics, Kaiser Permanente Northwest, Legacy Health, Multnomah County, Oregon Health and Science University (OHSU), and Washington County. This joint effort, known as the Tri-County Health Commons Project (“The Commons”), set the following goals:

• Reduce admissions by 17%
• Decrease ED visits by 20%
• Reduce overall cost growth per Medicaid patient
• Improve Medicaid patient outcomes

Of the factors identified by The Commons as contributing to readmission rates, two were the hospital-discharge summary and patient follow-up workflow.
Pilot Program Puts Standardized Hospital-Discharge Summary to the Test

STAG defined a pilot program to track the three-year grant timeline (see Table 1). Two healthcare members of The Commons were selected to test the new summary in 2013. The design seeks to track the standardized discharge summary from hospital to follow-up care in clinics.

The target population included Medicaid and dual-eligible (Medicare and Medicaid) patients who experienced an inpatient hospital visit. A workflow is triggered upon notification of the patient’s discharge, including a five-question follow-up call to the patient (see Figure 1). If the patient answers questions about medications incorrectly or doubtfully, this triggers a medication review. The evaluation plan includes four key metrics:

1. Count of eligible patients who received standardized hospital-discharge summary
2. Count of eligible patients who received five-question follow-up call
3. Count of eligible patients who received medication review
4. Patient and provider satisfaction with new workflow process and standardized hospital-discharge summary

At the end of year one, lessons learned about the standardized hospital-discharge form and discharge notification process (Transitions of Care Workflow) will be shared with partner organizations. Year three will complete the standardized discharge process across all project sites, including a large university hospital. It is estimated the potential savings over three years will be USD 3 million.

Standardizing Patient Follow-up

Hand-in-hand with the standardized hospital-discharge summary is patient follow-up. As part of the pilot program, The Commons established a Transitions of Care Workflow that is triggered by the hospital-discharge summary and includes post-discharge contact, medication reconciliation (if needed), and appointment with the PCP, as shown in Figure 1.

Table 1. Three-Year Pilot Program

<table>
<thead>
<tr>
<th>Year One (2013)</th>
<th>Participant Organization</th>
<th>Target Population</th>
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</thead>
<tbody>
<tr>
<td>2 sites</td>
<td>400 patients</td>
<td></td>
</tr>
<tr>
<td>3 sites</td>
<td>1,500 patients</td>
<td></td>
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<tr>
<td>All sites</td>
<td>1,600 patients</td>
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THE COMMONS STANDARDIZED HOSPITAL-DISCHARGE SUMMARY TASK FORCE

The goal of the Standardized Transitions Advisory Group (STAG) is to transform care by streamlining a patient’s transition from acute care to home care with a standard community process of enhanced electronic communication, integrated workflows, and role-based accountability.

STAG consists of clinical leaders, including 20 physicians, 7 healthcare administrators, and a neutral third-party healthcare IT architect from Intel Corporation.

The task force established a STAG charter, outlining responsibilities and goals:

- Provide input on content and process development.
- Develop a standardized transition process and discharge summary template.
- Abide by principles for decision making, with consensus preferred or super-majority vote.
- Establish accountability through the creation, review, and iteration of the document and process.

Figure 1. This Transitions of Care workflow is currently undergoing a three-year pilot program. Conducted by clinic staff at primary care facilities, it is targeted at Medicaid and dual-eligible (Medicare and Medicaid) patients following a hospital discharge. This process is intended to increase the likelihood that a patient will attend a follow-up visit. Results so far indicate a strong likelihood of achieving goals of improving patient outcomes.
“Every healthcare organization knows they have to adopt ACO or CCO efficiencies.”

— Dr. Muller

Initial Field Report

Although the pilot program is now only in early stages, initial anecdotal reports show positive interventions. Dr. Muller recounts a typical field report in which a nurse at a primary care facility reported a call to a patient who was confused about how to take a blood-thinning medication used to prevent clots. After explaining the dosage to the patient, the nurse was satisfied that the communication had been successful. Another phone call to the patient confirmed that the patient was now taking the medication correctly and that the initial call had likely enhanced the patient’s understanding of how to take the drug. Without the call, the patient may have taken the medication incorrectly and ended up in the ED with dangerous bleeding.

For Sue, the fictional 42-year-old, high-risk patient described earlier, a coordinated care experience with standardized hospital-discharge summary, transition workflow, and follow-up outreach will help improve her outcome and reduce risk of readmission (Figure 2). This patient experience model extends beyond the standardized hospital-discharge summary and follow-up workflow to include the broader goals set forth by The Commons CCO model.

Lessons for Healthcare Collaboration

“Every healthcare organization knows they have to adopt ACO or CCO efficiencies,” said Dr. Muller, who led the initiative and brought community healthcare professionals together to discuss options. “It’s just a matter of how to go about doing it.”

Figure 2. When admitted to the hospital, Sue is assigned a transitional care nurse (TCN). Upon discharge, the hospitalist, pharmacist, and discharge planner communicate with the TCN, who in turn communicates with Sue’s health center and transmits the discharge summary. A follow-up appointment is made for Sue, and her care management team at the health center assigns her to an outreach worker.
During the STAG experience to develop a standardized workflow and discharge summary, several interactions proved successful to the outcome and may provide lessons or tactics for others:

- Enlist clinical physicians and hospitalists. Clinicians are integral to the collaborative work groups. While they may not be the final decision makers, they are the ones most intimately involved with the discharge and workflow process, and can make the greatest difference to a successful outcome.

- Ask a neutral third party to act as the project advisor to keep a collaborative group on task and provide guidance. In the case of The Commons, two Intel project experts provided analysis and project assistance.

- Start with basic collaborative principles and identify key commonalities in processes and documents.

- Align the new discharge document as much as possible with documents previously used to encourage adoption. Because there are varying types of EHR systems and clinical records practices used within a community, it is important to develop documents and workflows that can be easily implemented and understood.

- Work with IT organizations that understand the operations of a healthcare organization, as well as the depth of information required to both share and protect private patient information.

- Share findings and recommendations to help other communities develop standardized practices, such as the Transitions of Care Workflow shown in Figure 1.

Healthcare providers that want to make an impact in a community, especially with a publicly supported program like Medicaid or Medicare, must look beyond the walls of a single hospital or clinic. The plan is for workflow improvements achieved through Medicaid-initiated activities such as a standardization of hospital-discharge process will be used for all patients in the community. The community outreach model that a CCO supports includes several healthcare organizations interconnected through technology and cooperation, including primary care, recovery-based care, emergency services, specialty care, behavioral health, and home care.

Dr. Muller emphasizes that physician buy-in and a neutral, third-party project adviser are keys to the successful implementation of a standardized hospital-discharge summary, follow-up care, and improved patient outcomes.

“We have to learn to collaborate while at the same time competing for market share,” says Dr. Muller. “Our efforts are working because we keep our focus on improving patient outcomes, which also reduces risk to organizational finances. And that benefits us all.”

**Conclusion**

New federal reimbursement strategies are forcing clinicians to adopt new models of care for large patient populations. Projects such as Oregon’s Tri-County Health Commons suggest that improving the patient discharge experience will not only reduce readmission rates, but also increase the likelihood of patient attendance at follow-up appointments.

The Commons project provides an example of collaborative approaches that work among competing and supportive healthcare organizations. Third-party facilitation by Intel helped address issues and concerns about standardized EHR documents. This type of collaborative healthcare initiative will be of utmost importance in the challenges of improving patient outcomes while reducing healthcare costs.

Still in its first year, The Commons has already gained insights that are helping to form a model that other healthcare organizations across the country can look to as they, too, seek to lower readmission rates, improve patient care, and reduce financial risk. Getting the project started successfully, this Oregon team has found, requires reaching out to others within and beyond institutional walls.

**For More Information**

- Oregon’s Tri-County Health Commons Project
- Intel Healthcare IT Solutions
- Top IT Considerations for Coordinated Care
- Global Imperative to Redesign the Nucleus of Care
- Reducing Readmissions at Presbyterian Healthcare Services

For more information on Why the Oregon Experiment Matters, visit [www.intel.com/aco-white-paper](http://www.intel.com/aco-white-paper)
Appendix 1: Sample Standardized Hospital-Discharge Summary

Patient Name: Patient Sue
DOB: 12/20/1956
MRN: 55500020431
PCP: Muller, Melinda J

FACILITY NAME: Legacy Health
Legacy Emanuel Medical Specialties
2801 N Gantenbein Ave
Portland, OR 97227-1623
503-413-2200

DISCHARGE SUMMARY:
Date of Admission: 05/07/2013
Date of Discharge: 05/09/2013
Length of Stay: 2 days

Providers:
Attending provider: Dr. A
Consulting provider: Dr. B
Consulting provider: Dr. C
Consulting provider: Dr. D
Admitting provider: Dr. E

Principal Final Diagnosis:
Acute exacerbation of chronic obstructive pulmonary disease (COPD)

Secondary Diagnoses:
Active hospital problems: Acute exacerbation of chronic obstructive pulmonary disease (COPD)
Dates noted: 05/07/2013
Resolved Hospital Problems: No resolved problems to display

Procedures:
None

Imaging:
None

Pending Studies:
None

Reason for Hospital Admission:
Shortness of breath

Hospital Course by Problem:
Acute exacerbation of chronic obstructive pulmonary disease (COPD) (5/7/2013)

Core Measure Checklist:
Does the patient have a diagnosis of heart failure? (ANY type: Acute, chronic, systolic or diastolic) NO
Was the patient diagnosed with Acute Coronary Syndrome/Acute Myocardial Infarction? NO
Was the patient diagnosed with Pneumonia at any time during the hospitalization? NO

Discharge Exam:
BP 190/110 | Pulse 60 | Temp 36.8 °C (98.3 °F) (Ora l) | Resp 20 | Ht 160 cm (5' 2.99") | Wt 63.504 kg (140 lb) | BMI 24.81 kg/m2 | Sp02 98%

Notable Labs:
CBC – Hgb 11.1
MEDICATIONS:

Allergies:
Review of patient’s allergies indicates not on file.

START Taking These Medications:
acetylsalicylic acid (aspirin) 81 mg EC tablet
Take 1 tablet by mouth Daily. Qty: 1 tablet, Refills: 5
oxycodone (ROXICODONE) 5 mg immediate release tablet
Take 1-2 tablets by mouth Every 3 Hours As Needed (moderate pain). Qty: 1 tablet, Refills: 2
zolpidem (AMBIEN) 5 mg tablet
Take 1 tablet by mouth At Bedtime As Needed for Sleep. Qty: 1 tablet, Refills: 2
omeprazole (PRILOSEC) 20 mg capsule
Take 1 capsule by mouth Every Morning. Qty: 1 capsule, Refills: 5

Prescriptions Printed:
Yes, paper copies were printed and handed to patient

Preferred Pharmacy:
RITE AID, 16401 SE DIVISION ST. PORTLAND OR 97236-1931
Phone: 503-752-1491  Fax: 503-762-0456

DISCHARGE INSTRUCTIONS:

Disposition:
Home

Close Outpatient Follow Up Recommended:
Yes

Condition at Discharge:
Good

Diet:
Regular diet

Activity:
As tolerated

The Patient’s Code Status at Discharge:
Attempt Resuscitation (FULL CODE)
30 minutes was spent on discharge and coordination of post hospital care.
The AVS has been given to the Patient/Family/Caregiver.

Medicine Testipprova, MD

ROUTING HISTORY:

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