

IS HOSPITAL DISCHARGE DAY OF THE WEEK ASSOCIATED WITH MEASURES OF CARE CONTINUITY FOR STROKE PATIENTS?

Janet Bettger, Duke University

Stacy Lender, Diane Nutter, Ohio Dept. of Health

On behalf of the Ohio Coverdell Stroke Program



Funding and Disclosures

- **CDC:** The Ohio Coverdell Stroke Program and this abstract are funded in part by Cooperative Agreement Number 5U58DP003965-02 and -03 from the U.S. Centers for Disease Control and Prevention. The contents of this abstract are solely the responsibility of the authors and do not necessarily represent the official views of CDC or the U.S. Department of Health and Human Services.
- **ODH:** Ohio Department of Health provides state general revenue funding to the Coverdell Stroke Program, including funding to Duke University.

Janet Bettger is a consultant to the Ohio Dept. of Health

Background

- Average length of acute hospital stay = 4 days
- 50% of patients are discharged home
- Stroke patients are at a significant risk of discontinuous care and consequently adverse events
- Follow-up with primary or specialty care after an acute hospitalization reduces readmission
- **National stroke registries do not include data to support QI for care coordination, continuity and transitions**

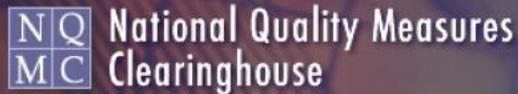
Ohio Coverdell Stroke Program

- Funded primarily by CDC as part of the Paul Coverdell National Acute Stroke Registry (PCNASR) to improve the quality of acute stroke care
- ODH is **one of three state health departments** funded by CDC from 2012-2015 to expand PCNASR **to improve the quality of stroke patients' care transitions** from acute to post-acute care settings
- Data driven QI using “Ohio Special Initiatives Tab” and “Coverdell” overlays (added modules) to GWTG-Stroke
- 48 hospitals participating in Ohio



Learning from our HF peers

- For other disease states, follow-up with primary or specialty care is known to facilitate care continuity and reduce hospital readmissions
 - part of discharge planning bundle



Measure Summary NQMC-7233

Title

Heart failure: percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented including location, date and time for a follow-up office visit, or home health visit (as specified).

Source(s)

American College of Cardiology Foundation, American Heart Association, Physician Consortium for Performance Improvement®. Heart failure performance measurement set. Chicago (IL): American Medical Association; 2011 Jan. 85 p. [51 references]

Designed Performance Measures for Stroke Patient Follow-up

Measure Name:	Follow-up with Neurology or Neurosurgery (specialty care) for patients discharged home
Description:	Percent of patients with an ischemic stroke or TIA or intracerebral hemorrhage or subarachnoid hemorrhage who have documentation at the time of hospital discharge of a scheduled appointment with specialty care for patients discharged home
Numerator:	Patients had a referral for a follow-up appointment after hospital discharge with neurology or neurosurgery ordered or recommended AND Patients had an appointment scheduled with neurology or neurosurgery
Denominator Inclusion:	Patients with a diagnosis of Ischemic Stroke or TIA or Intracerebral Hemorrhage or Subarachnoid Hemorrhage who were discharged home
Denominator Exclusions:	<ul style="list-style-type: none"> • Age < 18 years • Comfort Measures Only documented • Discharge Disposition of hospice at home or in a health care facility, another acute care facility, other health care facility, left AMA, expired, not documented or unable to determine • Not admitted

Measure Name:	Follow-up with PCP for patients discharged home
Description:	Percent of patients with an ischemic stroke or TIA or intracerebral hemorrhage or subarachnoid hemorrhage who have documentation at the time of hospital discharge of a scheduled appointment with primary care provider for patients discharged home
Numerator:	Patients who had a PCP appointment scheduled OR Patients who did not have a PCP prior to hospitalization and had a PCP assigned and had an appointment made with the new PCP
Denominator Inclusion:	Patients with a diagnosis of Ischemic Stroke or TIA or Intracerebral Hemorrhage or Subarachnoid Hemorrhage who were discharged home
Denominator Exclusions:	<ul style="list-style-type: none"> • Age < 18 years • Comfort Measures Only documented • Discharge Disposition of hospice at home or in a health care facility, another acute care facility, other health care facility, left AMA, expired, not documented or unable to determine • Not admitted

For more about this project, visit Poster 291 (Lender et al.) on Thursday

Strategy for Improvement

- Adapted version of the Institute for Healthcare Improvement's (IHI) Breakthrough Collaborative Model
 - hospitals identify, plan and implement organizational processes to *schedule recommended follow-up specialty care appointments for stroke patients prior to hospital discharge*
- 3 full-day meetings with participating hospitals to plan, share best practices, peer-support to strategize around barriers, celebrate little wins
- 6 webinars
- Customized quarterly data feedback reports to each hospital

Performance Improvement

PHENOMENAL SUCCESS

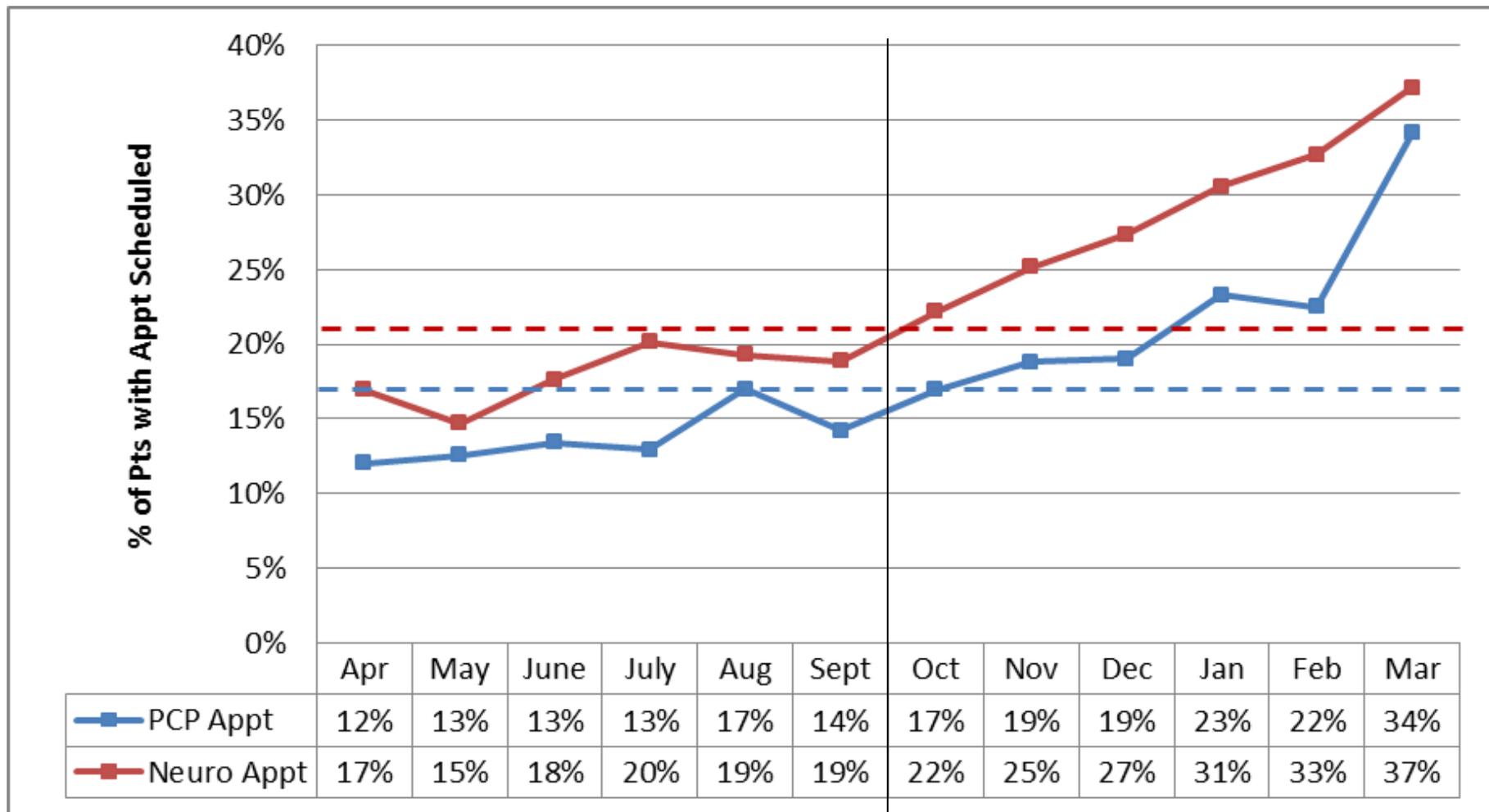
from quarter 1 to quarter 4



- ❖ Neurology follow-up appointments scheduled for patients discharged home and other healthcare facilities increased **75%**
- ❖ Primary Care Provider follow-up appointments scheduled for patients discharged home increased **92%**



April 2013-March 2014 (N=5,302 patients)



- - - 12 mo. Median

Collaborative
Launch

Still Room to Improve...

What was the most commonly reported system barrier?

→ Most primary care and specialty offices are closed on weekends.

3rd Quarter Data Showed:

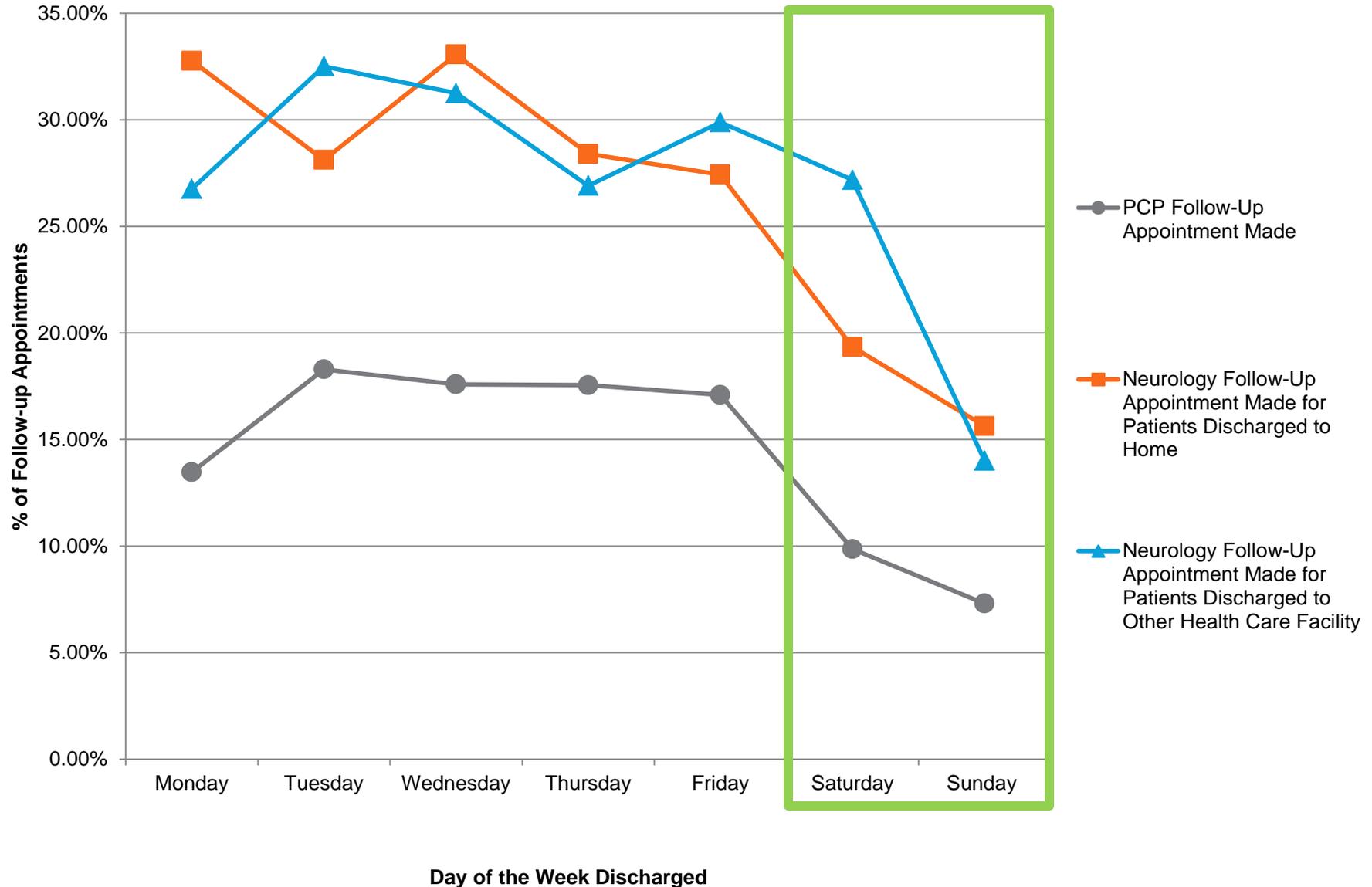
Appointment to be Scheduled	Weekday discharge	Weekend discharge
Primary care	16.4%	8.5%
Specialty care	29.6%	17.5%

p<0.001

Ohio Coverdell Stroke Program

Percentage of Follow-up Appointments Made by Day of the Week Discharged

Discharge Dates from April 1, 2013- December 31, 2013



Group Reported Barriers

- Lack of/limited availability of dedicated weekend scheduling staff
- No primary or specialty care staff available for scheduling
- Limited/no access to online or electronic appointment scheduling
- Limited access to neurologists
- Support for more immediate post-stroke follow-up varies



Limitations in this Study and Work

- No verification of the % of appointments made that were kept
- Registry does not collect post-discharge care outcomes

Conclusions

- Significant gap in stroke care continuity
- Patients discharged on weekends at a disadvantage for having a scheduled follow-up appointment at discharge
- Discharge planning earlier in the hospital stay may promote improve care continuity
- Research is needed to delineate timing of follow-up, method of follow-up (phone, home, clinic, office), provider for follow-up
- **Studies of efficiency and effectiveness coupled with best practices for promoting a safe transition could lead to meaningful improvements in stroke care delivery and patient outcomes**



Improving Stroke Care Continuity: It is going to take a village

与隋菲菲一起2008
没有不可能 IMPOSSIBLE IS NOTHING

THANK YOU TO THE COMMITTED PARTNERS IN OHIO