

HOSPITAL CHARACTERISTICS

RUSH UNIVERSITY MEDICAL CENTER

- ▶ Chicago, IL
- ▶ 671 staffed beds (plus 61 beds at Bowman Health Center)
- ▶ www.rush.edu

S.T.E.E.E.P.



EQUITABLE

EDPP provides services to adults age 65 or older, most of whom are Medicare beneficiaries.



EFFICIENT

The program aims to reduce readmissions, ED visits and nursing home placements for patients.



PATIENT-CENTERED

Telephonic post-discharge assessments and interventions by social workers improve patients' recovery and quality of life.

SOCIAL WORKERS ENHANCE POST-DISCHARGE CARE FOR SENIORS

The Problem

Almost 20 percent of Medicare beneficiaries are readmitted to the hospital within 30 days of discharge. Each older adult readmission costs the hospital an average of \$7,400. In addition, patients may have unmet biological, psychological and social factors that impede their

ability to follow up with discharge instructions.

The Solution

Staff from Rush University Medical Center's Older Adult Programs and Case Management Department teamed up to create the Enhanced Discharge Planning Program (EDPP). The program calls for social workers to phone patients and caregivers after discharge to ensure they are receiving the services detailed in their discharge plan and to investigate any unanticipated needs. If necessary, social workers intervene to help patients resolve problems and connect patients and caregivers to health care providers and community-based services.

Results

EDPP was piloted on four units at Rush between March 2007 and April 2009. Social worker interventions have proved successful in addressing patients' medical and social needs and potentially preventing readmissions. During the pilot period, study findings show a total of 1,248 referrals and 4,350 phone calls; social workers connected with over 1,400 older adults and/or their caregivers. The findings also show that 67 percent of pilot participants were not receiving necessary community services, following through on discharge recommendations or coping with care demands. Sixty-one (61) percent of patients required more than one call to resolve their identified issues and the average number of calls per person was

3.49. Average age of the patient was 74 years, with the oldest patient being 105 years.

Since June 2009, Rush has engaged in a hospital-wide randomized control trial to determine the program's impact in reducing hospital readmissions, improving patient satisfaction and reducing caregiver burden.

Background

Within 48 hours of discharge, an older adult patient deemed at risk for adverse events after inpatient hospitalization receives a call from a Rush social worker. The social workers making the calls specialize in health and aging issues and hold a master's degree. The social worker utilizes a biopsychosocial framework for assessing the patient's post-discharge adherence to the treatment plan, including medication compliance, physician visits, strategies for coping with care demands and other issues that influence health and quality of life. Appropriate patients are identified through the hospital's electronic medical record, based upon documentation completed by nurses and case managers during an inpatient stay, which includes factors such as living alone, being at high risk for falls, lacking social support, or having difficulty coping.

Madeleine Rooney, social worker and medical center liaison for Older Adult Programs,

TEAM MEMBERS

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believes that social workers are particularly well suited for this work because they “are trained in care coordination, possess extensive knowledge of community resources, and understand strategies for navigating complex systems.” Rooney explains, “[Social workers] are ideally situated to intervene around an array of issues that impact health outcomes like available social support, transportation, financial resources, health literacy, and mental health. EDPP’s social workers create a bridge between the hospital and the community. They ensure that the direction provided by the medical team is not lost.”

Anthony Perry, MD, a geriatric specialist and director of the Johnston R. Bowman Health Center at Rush, directs EDPP. The Bowman Health Center provides post-hospital inpatient recovery and short-term rehabilitation services and includes a special unit for geriatric psychiatry patients.

Principles of Performance Excellence

Perfect the Patient Experience

Patient satisfaction with EDPP has been very high. “Patients love having someone call them,” says Gayle Shier, project coordinator, Older Adult Programs. “They feel cared about, like they have someone to look out for them. They feel respected.”

“The literature says that telephonic intervention does not work. But I think it is different with social workers making the calls,” says Robyn L. Golden, Licensed Clinical Social Worker, director of Older Adult Programs. “A social worker engages the person and makes that person feel he or she is part of the continuum of care,” she adds. Rooney concurs: “Patients and

caregivers will often talk to us about life circumstances and issues impacting their care—information they may not share with other medical providers. We use a person-in-environment perspective to help us focus on asking questions that identify cultural and systemic factors that influence health and quality of life outcomes.” After a case is closed, some patients and caregivers call back at a later date asking for further assistance.

Manage Organizational Variability

Rush uses an electronic referral system to identify patients for EDPP. The hospital has established baseline criteria for which patients are at risk—such as being age 65 or older and taking seven or more medications—and other patient information—such as being at risk for falls or having no support for care at home.

EDPP has a manual with protocols and decision-making algorithms, explains Golden. Once they receive a referral, social workers make a phone call and make an assessment, guided by a basic set of equations. They ask questions about potential problems identified in the chart, find out what was not identified in the hospital, and follow up until issues are resolved. Typically the social worker follows the patient with three calls over four days. Social workers might follow up with some patients for a month; in other cases, if everything is going well for the patient, it requires about a week of work.

Training social workers and facilitating communication among clinicians are integral to EDPP, emphasizes Shier. “We sat down with social workers in planning the randomized control trial. We asked, ‘What issues do you commonly see? What

would you do in that situation?’ ” She observes that the Rush social workers do a lot of work among themselves to discuss what to do if certain situations arise. Rooney adds, “EDPP social workers talk on a daily basis. Once a week, we do a case review. Because we have been able to ‘template’ the program, specific interventions can be tied to outcomes. We actively consult with members of other disciplines, with Dr. Perry and Dr. Shannon Sims, nurses, and physical therapists.” Shier says that assessment scales are integral to the program and entire process. “Social workers must have the ability to assess a situation thoroughly over the phone. They have to know what questions to ask.”

The focus at Rush is on improving process. According to Rooney, “Part of the problem is creating solutions that involve adding more people to solve the problem. We already have the people and structures in place to provide care to our patients. We need to focus on improving the way we provide services through collaborative partnerships around common goals and interests.”

Create a High-Reliability Culture

Rooney says their work took hold and gained a high level of interest at the hospital in part because of Rush University Medical Center’s emphasis on patient-centered care. “Our work has become part of a larger initiative at Rush to improve the internal effectiveness of the discharge process and the overall patient experience,” she says.

As for barriers they have encountered, Golden observes, “When you are in the headlights with patients, things happen you cannot anticipate.” Rooney agrees that providing a clinical intervention while partnering with research can be challenging. “Our team met for many weeks discussing, ‘How do we structure the program in a way that meets requirements of research but does not lose the integrity of the intervention, which is around quality improvement?’ ” says Rooney. According to Shannon Sims, MD, director of clinical informatics, performance improvement department, “Quality improvement is always going to have surprises. It is hard to measure. We see positive trending.”

Continual Improvement

In May 2009, Rush joined a group of 30 hospitals in the pilot mentoring program of Project Boost (Better Outcomes for Older Adults through Safe Transitions). Sponsored by the Society of Hospital Medicine, Project Boost is a national project to redesign the hospital discharge process and reduce hospital readmissions. In January 2010 Rush began implementing the Project Boost toolkit. Though most of the toolkit is paper-based, Rush is working to integrate it into their electronic health record.

Sims sees using IT as an opportunity for additional savings in effective case management. Expanding and getting better communication tools and support, such as prompts about referrals that can be made, would be beneficial, she says. “I think we are scratching the surface of what is possible.” Sims adds, “We see Project Boost and post-discharge planning as very synergistic. The best tool we can add for social workers is an organized plan for discharge.”