Discharge Protocol Cuts Readmissions

BY HEIDI SPLETE
Senior Writer

RIO GRANDE, P.R. — A comprehensive discharge program aimed at educating patients about their diagnoses and their medications, and nailing down appointments for follow-up tests and primary care physician visits, reduced hospital readmission rates and emergency department visits together by 30%, according to the results of a randomized trial of more than 700 adult patients. “This isn’t rocket science,” said family physician Brian Jack of Boston Medical Center. Dr. Jack designed the protocol dubbed the reengineered discharge (RED) intervention.

As hospital lengths of stay shrink, patients are being sent home earlier and in more serious condition. “We have a responsibility to prepare them to go home and do the things necessary to take care of themselves until they can see their family physicians,” he said in an interview. The protocol’s 11 steps are aimed at helping them do that. Research has shown that existing discharge practices are often fragmented, and few patients understand their diagnoses and medications when they are discharged, said Dr. Chris Manasseh, director of hospital medicine at Boston Medical Center. To determine the impact of an improved discharge program, Dr. Jack and his colleagues compared hospital use among 370 patients who received the RED protocol with 368 who received the standard discharge protocol. The average age of the patients in both groups was 50 years; 50% were men and 52% were black. The majority (80%) had primary care providers, and 48% had insurance or Medicaid coverage. The RED intervention was designed by 30% more adult patients. The results of a randomized trial of more than 700 adult patients.

“These national trends in infection rates of chlamydia, gonorrhea, and syphilis are ‘not new, but the fact that they are continuing at such a dramatic level is really the major area of concern,” said Dr. John M. Douglas Jr., director of the division of STD prevention at the CDC. All three STDs have long-standing federally funded control programs. The report is compiled from 2007 surveillance data obtained from case reports from state and local STD programs and national surveys implemented by federal and private organizations.

Chlamydia
Since 1994, Chlamydia trachomatis infections have comprised the greatest percentage of all STDs reported to the CDC. This trend continued in 2007, with more than 1.1 million sexually transmitted cases of chlamydia reported. The rates of three major sexually transmitted diseases continued to follow a nearly decade-long climb that has disproportionately affected minorities and women, according to a report issued by the Centers for Disease Control and Prevention.

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Software that simulates a discharge nurse who provides patient-specific guidance is being tested, says Dr. Brian Jack.

Persistent STD Rates Are a ‘Major Area of Concern’

BY JEFF EVANS
Senior Writer

THE LEADER IN NEWS AND MEETING COVERAGE

Out-of-Network Care Costs To Patients to Be Rectified

BY MARY ELLEN SCHNEIDER
New York Bureau

As part of an agreement with New York Attorney General Andrew Cuomo, UnitedHealth Group has agreed to shut down a national billing database used by health plans to determine reimbursements to members who use out-of-network physician services. The billing database, which is operated by the UnitedHealth Group (UHG) subsidiary Ingenix Inc., will be replaced with a new, independent database run by a qualified nonprofit organization. Under the terms of the agreement, UHG will pay $50 million to help establish the new database. In addition, the nonprofit organization will develop a public Web site where consumers can research—before seeking services—how much they may be reimbursed for common out-of-network medical services in their area.

Aetna, the nation’s third largest insurer, also has entered into an agreement with the New York attorney general to abandon its use of the Ingenix database with the new, independent database run by a qualified nonprofit organization. Under the terms of the agreement, UHG will pay $50 million to help establish the new database. In addition, the nonprofit organization will develop a public Web site where consumers can research—before seeking services—how much they may be reimbursed for common out-of-network medical services in their area.

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prescribing information and reinforce the follow-up care plan.
Overall, during the first 30 days after discharge the rate of rehospitalization among patients in the RED group was significantly lower compared with the usual-care group (21% vs. 15%). The control group also had significantly fewer emergency department visits compared with controls (24% vs. 16%).

Patients in the RED group were more likely than those in the usual-care group to be discharged with a primary care provider appointment (94% vs. 35%). In addition, self-reports at 30 days after hospital discharge indicated that 113 patients in the RED group and 108 patients in the control group showed that significantly more patients in the RED group identified their primary care providers by name (95% vs. 89%), followed up with their primary care providers (62% vs. 44%), and knew their discharge diagnosis (79% vs. 70%).

“Self-reported readiness for discharge was higher” in the intervention group, compared with the control group, when patients were interviewed 30 days after discharge. Dr. Manasseh added. Patients in the RED group were more likely than control group participants to remember their diagnoses, drugs, and appointments, and to have had their questions answered.

The results were limited by the use of patient self-reports, but the findings suggest that the plan should be used for all patients, Dr. Manasseh noted.

In terms of what the RED discharge plan required approximately 90 minutes per patient, including 14 minutes with a pharmacist. But the hospital saved approximately $400 in outcome costs per patient, Dr. Manasseh said.

Dr. Jack added that a computerized version of the RED protocol has been well received by patients in separate preliminary tests. Software developed by Timothy Bickmore, Ph.D., of the College of Computer and Information Science at Northeastern University, Boston, allows patients entering the RED program to complete an electronic dis- charge nurse named Louise. The software operates on a touch-screen kiosk and reviews patient-specific information regarding the individual’s after-hospital care plan. Louise can also test competence, “which is something none of us take the time to do now,” Dr. Jack said.

If a nurse were to spend 30 minutes going over a patient’s discharge plan, there would never be enough time to repeat it when the patient’s son or daughter arrived at the hospital later. The benefit is that “I can do it all over again,” he added.

The research was granted by a fund from the Agency for Healthcare Research and Quality.

For more information about the protocol, visit www.bu.edu/fammed/projected.html.

RED’s 11 Steps
1. Educate patient about relevant diagnoses throughout hospital stay.
2. Make appointments for clinician follow-up and postdischarge testing.
3. Discuss with patient any in-hos- pital tests or studies completed and who will follow up with results.
4. Organize postdischarge services.
5. Confirm medication plan; explain what to take and why.
6. Reconcile discharge plan with national guidelines and critical pathways.
7. Review appropriate steps for what to do if a problem arises.
8. Transmit discharge summary to physicians and services accepting responsibility of patient’s care.
9. Assess degree of understanding by asking patient to explain in his or her own words the details of the plan.
10. Give the patient a written discharge plan at the time of discharge.
11. Pharmacist telephones patient to remind them of discharge plan, review medications, and problem solve.

Dr. Jack