Leveraging Advances in Technology: Getting it Right for the Providers and the Patients

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Our Priorities

**UCLA Nursing Vision:** through the Art of Nursing, we strive to heal humankind, one patient at a time, by delivering care that is grounded on the Relationship-based Care Model.

**FY19 Priorities include:**

- Reducing readmissions
- Increasing patient discharge preparedness
- Promoting patient-centered care through improved patient experience
Identifying the Gaps

**Challenges**
- Unresolved Issues Post-Discharge
- Larger Risk Burden for Value-Based Care

**Gaps**
- Lack of Standardized Follow-Up
- Limited Focus on Specific Populations

**Solution**
- Post-Discharge Outreach Tool
Evidence Based Practice

1. Post discharge phone calls allow providers to reinforce key elements of the discharge instructions, medication changes, and follow-up plans for patients who are doing well.

2. Most of the successful transitional care programs employ calls after discharge as part of a multimodal intervention.
How Our Outreach Solution Works

**System Integration**
Integrate with EMR to auto-enroll outreach eligible patients

**Patient Engagement**
Enrolled patients receive relevant outreach post-discharge

**Care Team Intervention**
If a patient indicates an issue, appropriate staff member or team are automatically alerted to resolve the issue

**Data Collection**
Aggregated information utilized to drive actionable improvements
Building for Sustained Success

People
- Senior leadership support
- Local leadership buy-in
- Identifying internal collaborations

Process
- Mapping the new workflow
- Outline key priorities

Technology
- Curate an engaging script
- Build focused alerting system
- Design Issue Resolution Tracking Panels
Building for Sustained Success

Initial Implementation Needs
- Collaboration with IT to build post-discharge call algorithm
- Technical and Operational Testing
- Branded promotional materials
- Adding Program Information to Discharge Instructions

Core Components for Implementation & Expansion
- Educating Patients and Staff
- Continuous Improvement
- Accountability through Data
Expansion in Scope & Complexity

General Inpatient Program (3 Units)  
Feb 2015 (Initial Roll Out)

Obstetrics Program
Breastfeeding Program

Stroke Program  
Sept 2017

Inpatient Program Expansion (All SM Units)  
Feb 2018

Joint Replacement Program  
Apr 2018

Emergency Department Program  
Jul 2018
The Results…

Pilot HCAHPS Data: Not Engaged with Program vs. Engaged with Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Not Engaged</th>
<th>Engaged</th>
<th>Change</th>
</tr>
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<tbody>
<tr>
<td>Recommend</td>
<td></td>
<td></td>
<td>+4.3%</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td></td>
<td></td>
<td>+4.5%</td>
</tr>
<tr>
<td>Staff Responsiveness</td>
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<td></td>
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<tr>
<td>Care Transitions</td>
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<td>+12.8%</td>
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Units: SM-OB, SM-GERI, SM-Ortho, GOU, RR-OB
95% CI
Meeting Current Initiatives: Readmissions

Readmissions Data: Not Engaged with Program vs Engaged with Inpatient Program

Patients who engaged with the post-discharge program showed a 36% lower readmission rate than those who did not.
Connecting Post-discharge Call Program to Relationship-based Care

Post-discharge call program is an opportunity for providers to connect with patients, listen to patients’ feedback, provide clinical advice, and improve patient outcomes & experience.
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