# POST DISCHARGE CARE CONTINUITY

#### How a Tertiary Care Hospital in Karachi, Pakistan Dealt With Readmissions

### Saba Akbar

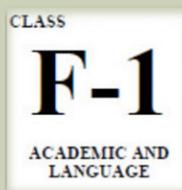
BScN|MBA|CPHQ Graduate Candidate Biomedical & Health Informatics University of North Carolina at Chapel Hill



### Why Did I Choose To Talk About This?

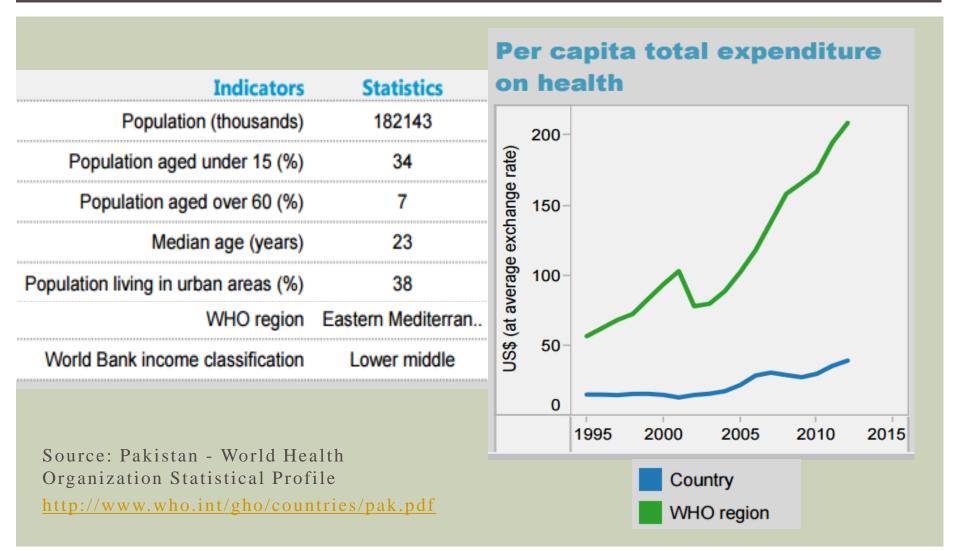








# PAKISTAN



# The Aga Khan University Hospital (AKUH)





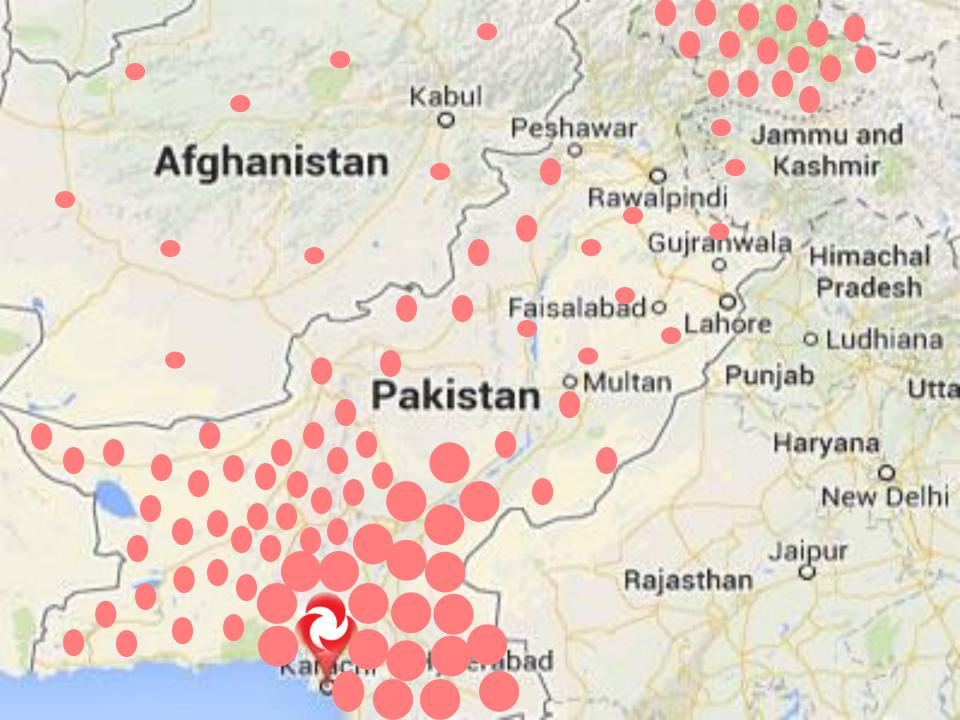




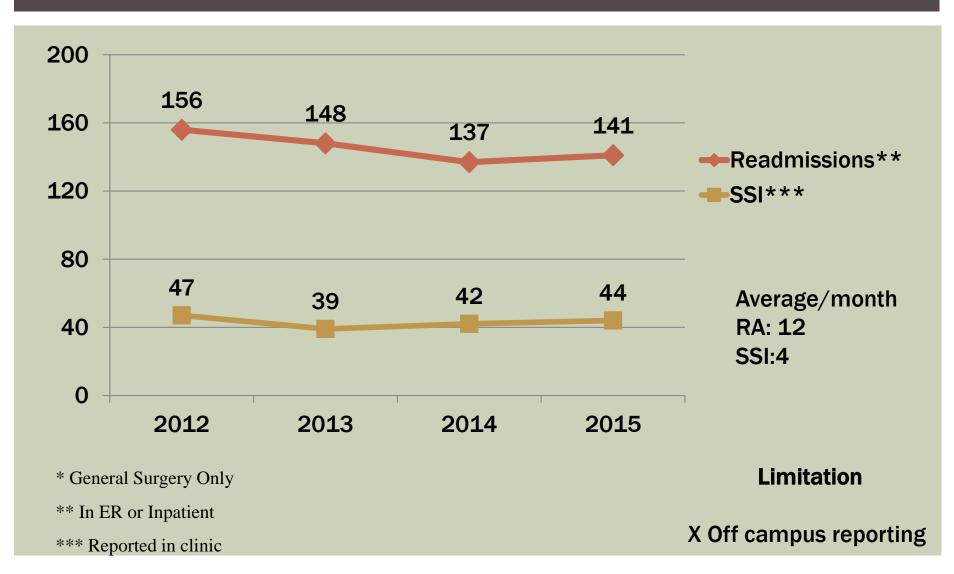
# THE AGA KHAN UNIVERSITY HOSPITAL (AKUH)

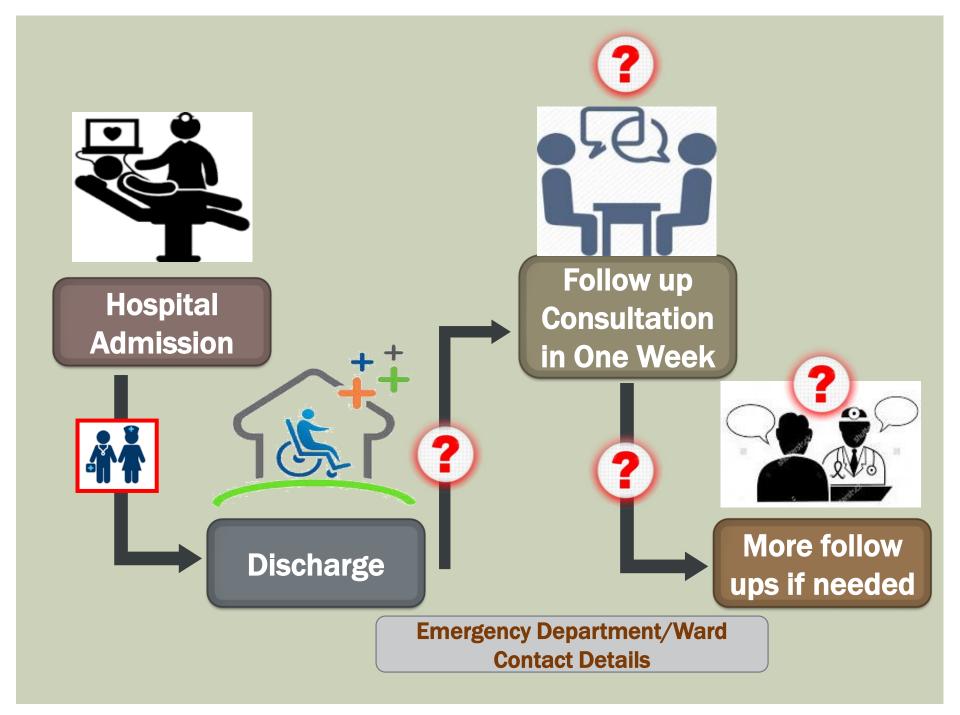




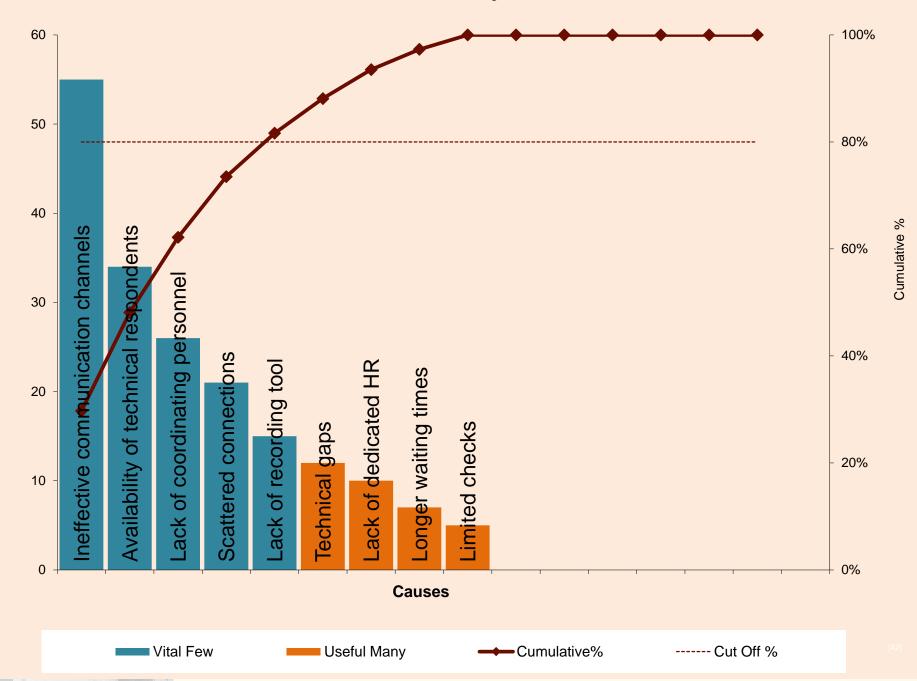


# PROBLEM: POST-OP READMISSIONS & SSI\*





#### **Pareto Analysis**



# **EVIDENCE BASED PRACTICE**

"Unsafe transitions of care from the hospital to the community are common and are frequently associated with post-discharge adverse events, including hospital readmission" "In the vulnerable post discharge period, communication between patients and the healthcare system is one of the few modifiable factors that may reduce preventable readmissions."

"Post-discharge communication is a common component of bundled discharge interventions."

"Increased coordination after discharge was necessary to continue active management of the entire care episode to optimize outcomes and improve quality" "Post-discharge care should focus attention not only on the primary index admission diagnosis, but also on the comorbidities."

# 1. POST-DISCHARGE FOLLOW UP CALLS (PROACTIVE APPROACH)

Within 48 hours of discharge, our clinical nurse coordinators (CNCs) call each patient to see if they are complying with discharge teachings.

Call details are recorded.

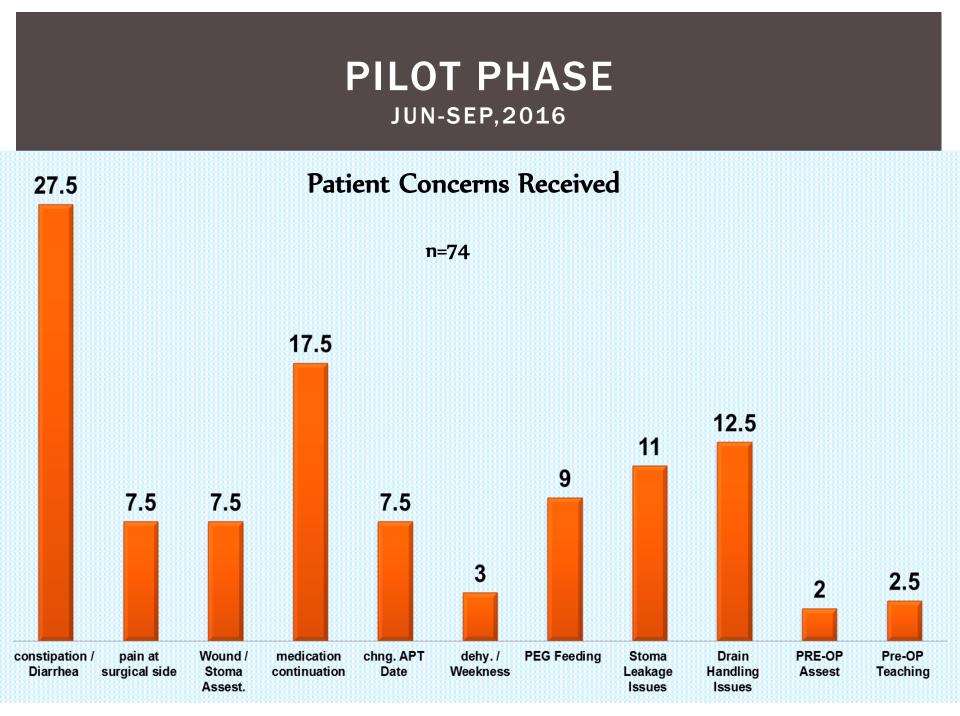
When clinical problems encountered, another call is generated in next 24-48 hours



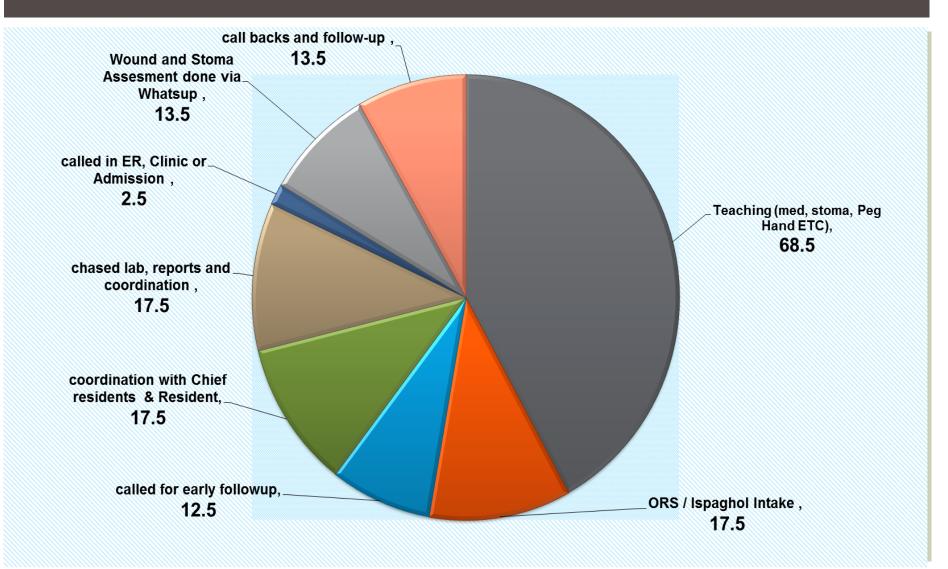
# 2. PATIENT HOTLINE SERVICE (REACTIVE APPROACH)

- Piloted in June, 2016
- Specific mobile lines
- Managed by CNCs
- Data maintained and audited
- Use of smart phone communication apps
  - Whatsapp
  - Viber

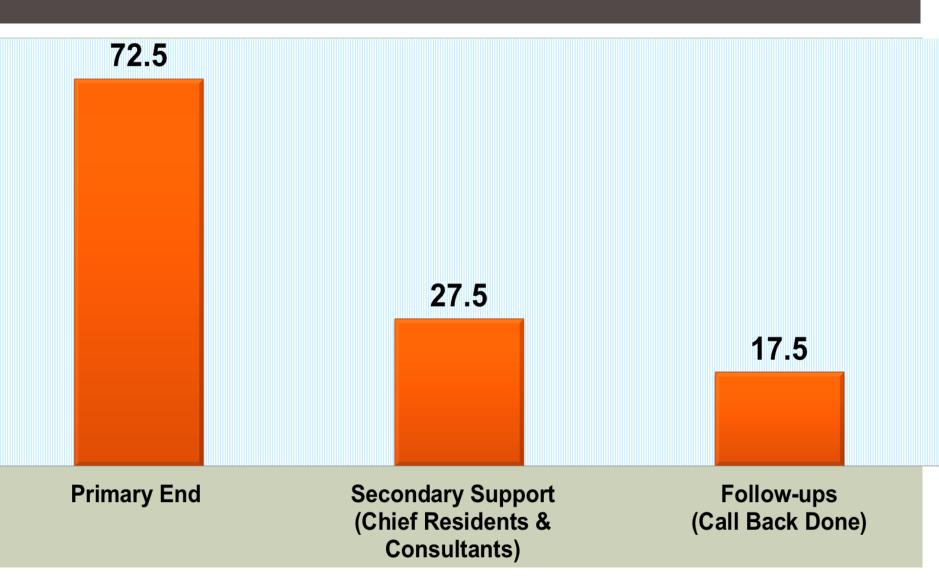




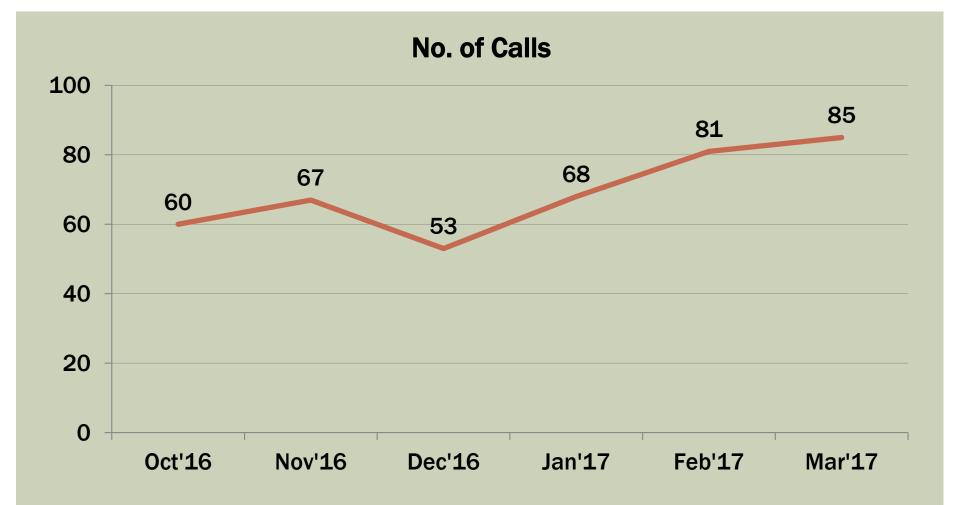
# **OUR RESPONSES**



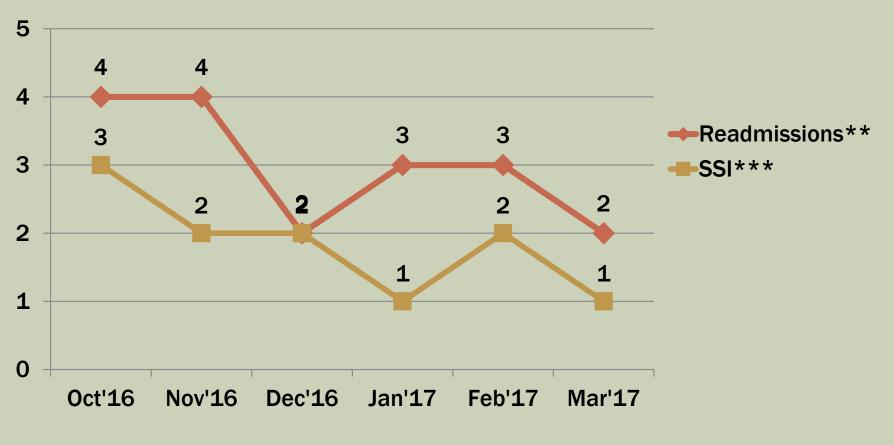
# PROBLEMS IDENTIFIED AND SOLVED



# CALL RECORD (OCT'16-MAR'17)



### **POST-OP READMISSIONS & SSI\***



\* General Surgery Only

\*\* In ER or Inpatient

\*\*\* Reported in clinic

# IMPACT

🔕 A Telephone Call That Sa 🗙

https://hospitals.aku.edu/pakistan/success-stories/Pages/a-telephone-call-that-saved-my-life.aspx

#### A Telephone Call That Saved My Life

Usman, in his early 20's, was engaged and counting days to his wedding, when suddenly he started to experience bouts of uncontrollable vomiting. Dismissing it as an infection at first, Usman and his family got worried when the vomiting continued for the next 3 weeks. Apart from the continuous episodes of throwing up, Usman also had a recent history of weight loss without an identifiable cause.

Usman lives in Abbottabad and sought help in his hometown; but the local doctors were unsuccessful in diagnosing the cause of the repeated vomiting. His parents then decided to reach out to The Aga Khan University Hospital for medical assistance.

Usman's family called The Aga Khan University Hospital, Main Campus, Karachi, on the highly responsive General Surgery (GS) Hotline. The Gastrointestinal (GI) and Surgery Service Line provides this phone number to patients on their discharge summary. The discharge summary is a document letter that summarizes a patient's health condition and treatment given during their stay at the hospital, as well as follow-up care information, which is explained to the patient at their time of leaving the hospital. The primary objective of this number is to facilitate the discharged patient in seeking assistance regarding post-operative care or any complications that may arise once they are at home.

Commenting on the idea behind the GS Hotline, Rozina Khimani, Nurse Manager for the GI and Surgery Service Line said,



☆

# **NEXT PHASE**

- Home Health Care (HHC) visit within 48 hours, for open surgeries.
  - Bundle (Packaged) charging
- Implementation of ERAS program

# REFERENCES

- Burke, R. E., Guo, R., Prochazka, A. V., & Misky, G. J. (2014). Identifying keys to success in reducing readmissions using the ideal transitions in care framework. *BMC Health Services Research*, 14(423). doi: 10.1186/1472-6963-14-423
- Donze J et al (2013) Causes and patterns of readmission in patients with common co-morbidities: retrospective cohort study. *BMJ*, 347, 7171.
- Horstman, M. J., Stewart, D., Naik, A. D. (2014). Improving patients' postdischarge communication. American Heart Association Journals, 130, 1091-1094. doi: 10.1161/CIRCULATIONAHA.114.010621
- Mcllvennan, C. K., Eapen, Z. J., Allen, L. A. (2015). Hospital readmission reduction program. *Circulation*, 131(20), 1796-1803. doi: 10.1161/CIRCULATIONAHA.114.010270.
- Slover, J. D. (2016). You want a successful bundle: What about postdischarge care? *The Journal of Arthroplasty*. 936-937. doi:10.1016/j.arth.2016.01.056

