Case Overview

Readmission Reduction Simulation:
Interprofessional Home Visit after Hospital Discharge

Part of the JHUSON Interprofessional Education and Online Simulation Program

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Brief Summary for Instructors

Learning Objectives

By the end of this simulation, the learner will be able to:

1. Assess the home environment for risk factors that may cause adverse effects and/or re-admission to the hospital for the patient.
2. Identify the indication and potential adverse effects of prescribed medications for patients with diabetes.
3. Develop an awareness of factors that may make it difficult for a patient to adhere to a prescribed therapy.
4. Provide relevant patient/family education and teaching for a patient with diabetes being discharged from the hospital.
5. Collaborate to create a trusting relationship between the patient, family, and interprofessional team.
6. Develop an appreciation for the knowledge and skills various healthcare professionals bring to the team when helping a patient understand and manage a diabetes treatment plan.
7. Discuss the following **Core Competencies for Interprofessional Collaborative Practice (2016)**

Core Competencies for Interprofessional Collaborative Practice (2016)

A. Values/Ethics sub-competencies

VE1. Place interests of patients and populations at center of interprofessional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span.
VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health team.
VE6. Develop a trusting relationship with patients, families and other team members.
VE9. Act with honesty and integrity in relationships with patients, families, communities, and other team members.
VE10. Maintain competence in one's own profession appropriate to scope of practice.

B. Roles and Responsibilities sub-competencies

RR1. Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals.
RR2. Recognize one's limitations in skills, knowledge, and abilities.
RR3. Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations.
RR4. Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease.
RR5. Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable.
RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
RR9. Use unique and complementary abilities of all members of the team to optimize health and patient care.

C. Interprofessional Communication sub-competencies

CC2. Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.
CC3. Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies
CC4. Listen actively and encourage ideas and options of other team members.
CC8. Communicate the importance of teamwork in patient-centered care and population health programs and policies.

D. Teams and Teamwork sub-competencies

TT3. Engage health and other professionals in shared patient-centered and population-focused problem-solving.
TT4. Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting patient and community values and priorities/preferences for care.
TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.
TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.
TT10. Use available evidence to inform effective teamwork and team-based practices.
TT11. Perform effectively on teams and in different team roles in a variety of settings.

Key teaching/debriefing points

In addition to interprofessional communication, teamwork, roles and responsibilities, and values/ethics included on the debriefing tool, important discussions points include:

1. Review the purpose of home visits
2. What impact will the home visit have on patient understanding?
3. What impact will the home visit have on hospital readmission?
4. Did a member of the team use medical jargon? How was that handled?

Scenario overview

Lester Washington, date of birth 05/05/1940, is a male with a history of type 2 diabetes and hypertension was discharged from the hospital one week ago. His admitting diagnosis was uncontrolled diabetes with extreme hyperglycemia (850mg/dl). He now requires several new medications and diet changes. An interprofessional team (nurse, pharmacist and physician) will make a home visit to assess his adherence with the prescribed treatment regimen and his current health status. The simulation begins with an interprofessional team arriving at the home.

Indication for home visit: Discharge from hospital one week ago for uncontrolled type 2 diabetes.

Curricular information

Educational Rationale and Need

The risk for adverse events, especially from medications, increases when a patient transitions from the hospital to the home setting. Older adults are frequently hospitalized for exacerbations of uncontrolled chronic illnesses, such as diabetes mellitus and congestive heart failure, and are vulnerable to complications when discharged. Approximately 1 in 5 older adults incur an adverse event within 4 weeks of hospital discharge and up to half of these adverse events are considered preventable (Kanaan AO, et al 2013; Forster, et al, 2004). According to the Joint Commission, there are three main root causes of ineffective transitions of care: Communication breakdown, patient education breakdown, and accountability breakdown (Clark et al, 2012). Communication breakdown is due to ineffective or incomplete communication among providers as well as between providers and patients. Standardized handoff procedures, such as SBAR, have helped with communication problems. Patient education breakdowns can result from confusing medication regimens and unclear instructions about follow-up care. Thorough discharge counseling and patient education about the treatment plan at appropriate literacy levels for patients is key in improving adherence.

Although discharge instructions are designed to improve patient education, it has been estimated that 50% of patients' discharge medication lists contain at least one discrepancy (Moore et al, 2003; Belda-Rustarazo et al, 2015). Despite discharge counseling, approximately 40-50% of patients fail to adhere to the prescribed medication regimen when they return to their homes after a hospitalization (Faridi K et al, 2016; Lindquist LA, et al 2012; Moore, et al, 2003). Lastly, accountability breakdowns occur when no clinical provider takes responsibility for coordination of the care, particularly arranging follow-up appointments, and ensuring that resources will be available when patients transition across settings upon discharge (Clark et al, 2012).

The 2010 Patient Protection and Affordable Care Act specifies that hospitals will not be reimbursed for patient re-admission charges occurring within 30 days of discharge. In 2013, approximately two-thirds of U.S. hospitals received penalties from the Centers for Medicare and Medicaid Services because of high 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia (Rau, 2013). It was estimated that approximately 1 in 5 Medicare patients discharged to home would be readmitted to the hospital for a chronic condition within 30 days of discharge (Raval AD et al, 2015; Jencks, et al, 2009). Pre-licensure students must be prepared to deliver care and provide education within health care systems to patients with common chronic illnesses, such as type 2 diabetes, in order to reduce both readmissions to hospitals and adverse events.

Reference Materials

Belda-Rustarazo S, Cantero-Hinojosa J, Salmeron-Garcia A et al. (2015) Medication reconciliation at admission and discharge: an analysis of prevalence and associated risk factors. *International Journal of Clinical Practice* 69(11),1268-74.

Clark K, Doyle J, Duco S, Lattimer C and The Joint Commission. (2012) Transitions of Care: The need for more effective approach to continuing patient care. Hot Topics in Health Care. Available at https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

Faridi KF, Peterson ED, McCoy LA. (2016) timing of first postdischarge follow-up and medication adherence after acute myocardial infarction. *JAMA Cardiology,* 1(2),147-55.

Forester AJ, Clark Hd, Menard A, et al. (2004) Adverse events among medical patients after discharge from hospital. *Canadian Medical Association Journal,* 170(3), 345-9.

Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine, 360*(14), 1418-1428. 19339721.

Kanaan AO, Donovan JL, Duchin NP, et al. (2013) Adverse drug events after hospital discharge in older adults: types, severity, and involvement of Beers Criteria Medications. *Journal of the American Geriatric Society, 61*(11), 1894-9.

Linquist LA, Go L, Fleisher J, et al. (2012). Relationship of health literacy to intentional and unintentional non-adherence of hospital discharge medications. *Journal of General Internal Medicine*, 27(2),173-8.

Moore, C., Wisnivesky, J., Williams, S., & McGinn, T. (2003). Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *Journal of General Internal Medicine, 18*(8), 646-651. DOI 10.1046/j.1525- 1497.2003.20722.x

Rau J. Nearly 1,500 hospitals penalized under Medicare program rating quality. *Kaiser Health News* 2013 Nov 14.

Raval AD, Zhou S, Bhattacharjee S, et al. (2015). 30-day readmission among elderly medicare beneficiaries with type 2 diabetes. *Population Health Management*, 18(4), 256-64.