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# Too Many Cooks in the Kitchen? Interdisciplinary Team Discharge Clinic Prevents Hospital Readmissions

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# Too Many Cooks in the Kitchen? Interdisciplinary Team Discharge Clinic Prevents Hospital Readmissions

## **Abstract**

Establishment of Interdisciplinary healthcare teams have shown to improve health outcomes and lower readmission rates in medically complex patients during hospitalization. Exploration of interventions has happened largely during the pre-discharge phase rather than post-discharge. To extend the team based approach, we implemented a pilot study of an interdisciplinary discharge clinic to determine what impact a biopsychosocial approach to care can have on hospital readmission rates. This work was conducted at a large family medicine residency-based practice, and facilitated by a physician, behavioral health clinicians, a clinical pharmacist, nurse care managers, and medical assistant. Patients were seen in the discharge clinic within 7 days of hospital discharge. In addition to patient demographics, data collected prior to visits included the calculation of a LACE score to identify risk of readmission, utilizing the BOOST (Better Outcomes for Older Adults Through Safe Transitions) risk assessment tool to identify high-risk medications. Additional data collected during the team visit included a CESD (Center for Epidemiologic Studies Depression Scale) score and MOCA (Montreal Cognitive Assessment) score to determine any psychosocial barriers to optimizing patient care; these standardized measures were conducted as part of a larger clinical interview. The total number of medications pre- and post-visit were collected along with the number of medication related problems identified following a comprehensive medication review. The primary outcome is the number of patients readmitted in 30 days. Secondary outcomes include average length of visits, total number of medications pre and post visit, number of medication related problems identified, existence of social support systems, and degree of patient satisfaction with the team visit. Future considerations include developing a sustainable, reproducible model for interdisciplinary discharge care that includes a component of inter-professional education. "

## **Keywords**

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## **Disciplines**

Pharmacy and Pharmaceutical Sciences

## **Comments**

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### Objectives

- To provide collaborative, well-coordinated comprehensive care to complicated patients that are at high risk for hospital readmissions through implementation of an interdisciplinary discharge clinic in an academic family medicine practice
- Determine the impact a biopsychosocial approach can have on hospital readmission rates

### Methods

**The Team:** Physicians, Behavioral Health Clinician, Nurse Care Managers, Clinical Pharmacist, and Medical Assistant

#### The Intervention:

Interdisciplinary office visit at PCP office within 7 days with "The Team". (Fig. 1)

**The Outcomes:** The 30 and 90 day hospital readmission rates. Prevalence of psychological conditions, cognitive assessment results, and polypharmacy pre- and post- visit. (Figs. 2 through 6)

Figure 1: Interdisciplinary Interventions and Assessments

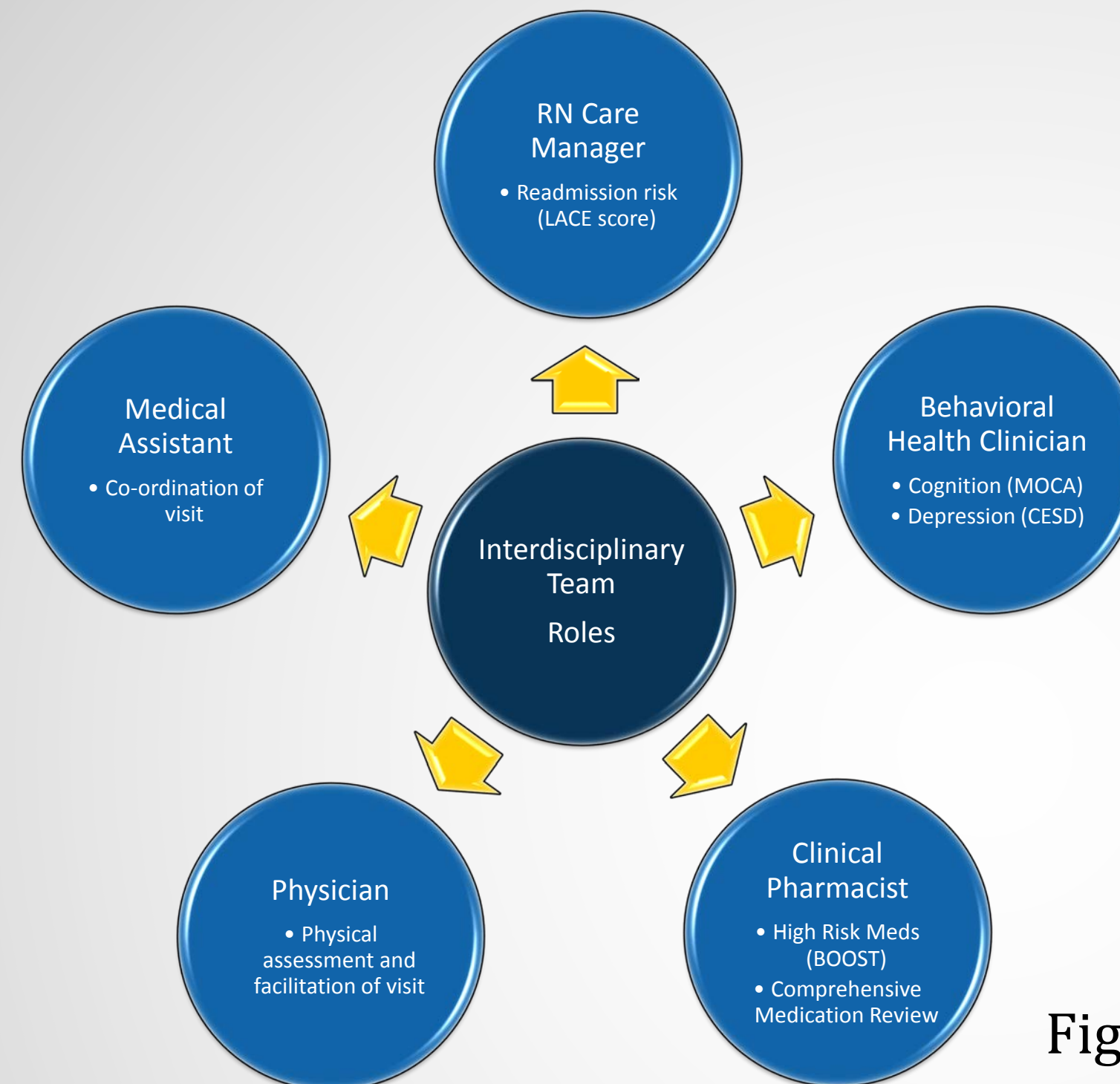


Figure 2: LACE Score Frequency

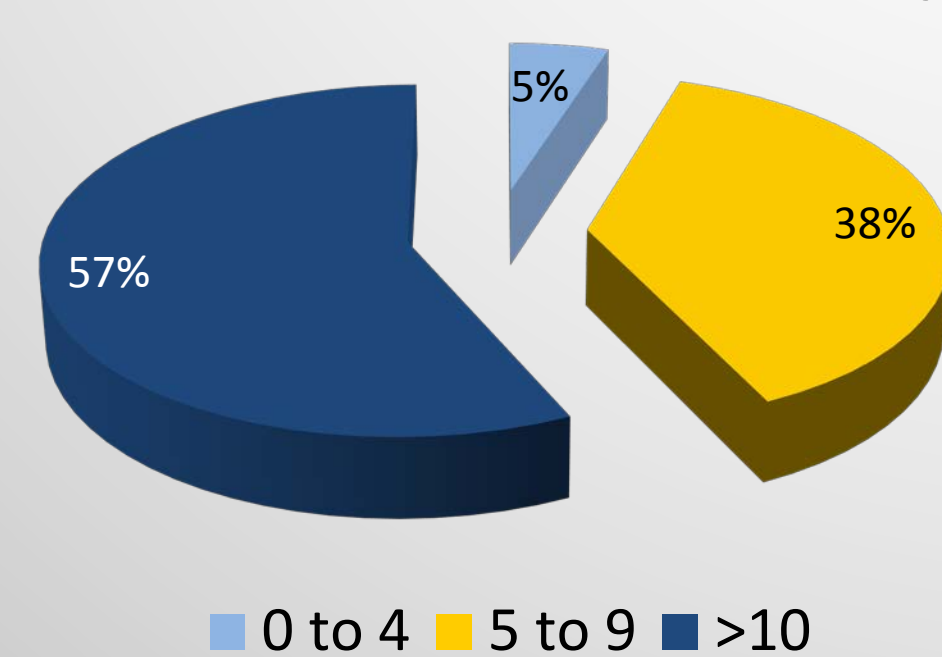


Figure 5: Clinical Pharmacy Outcomes

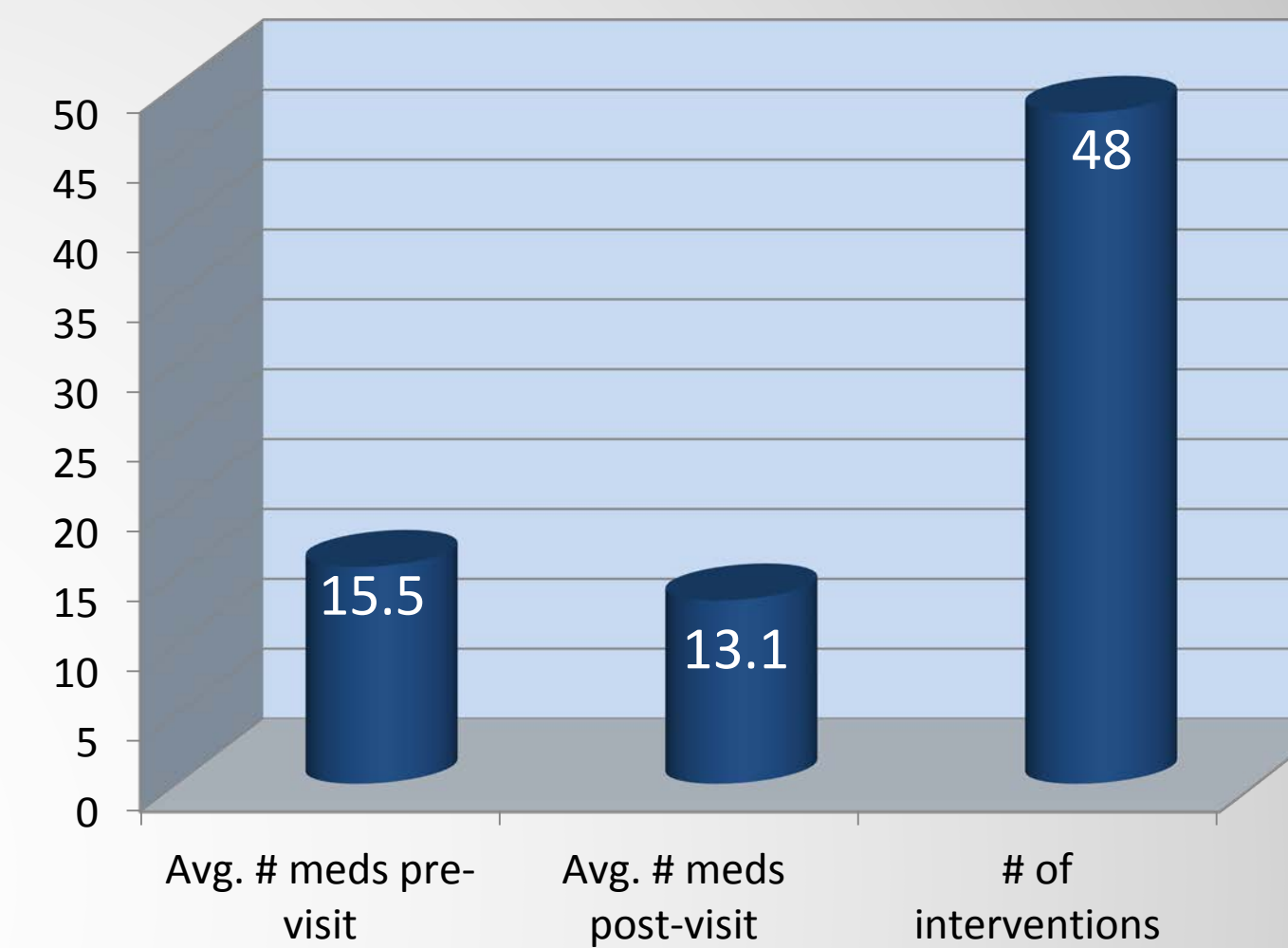


Figure 6: Behavioral Health Outcomes

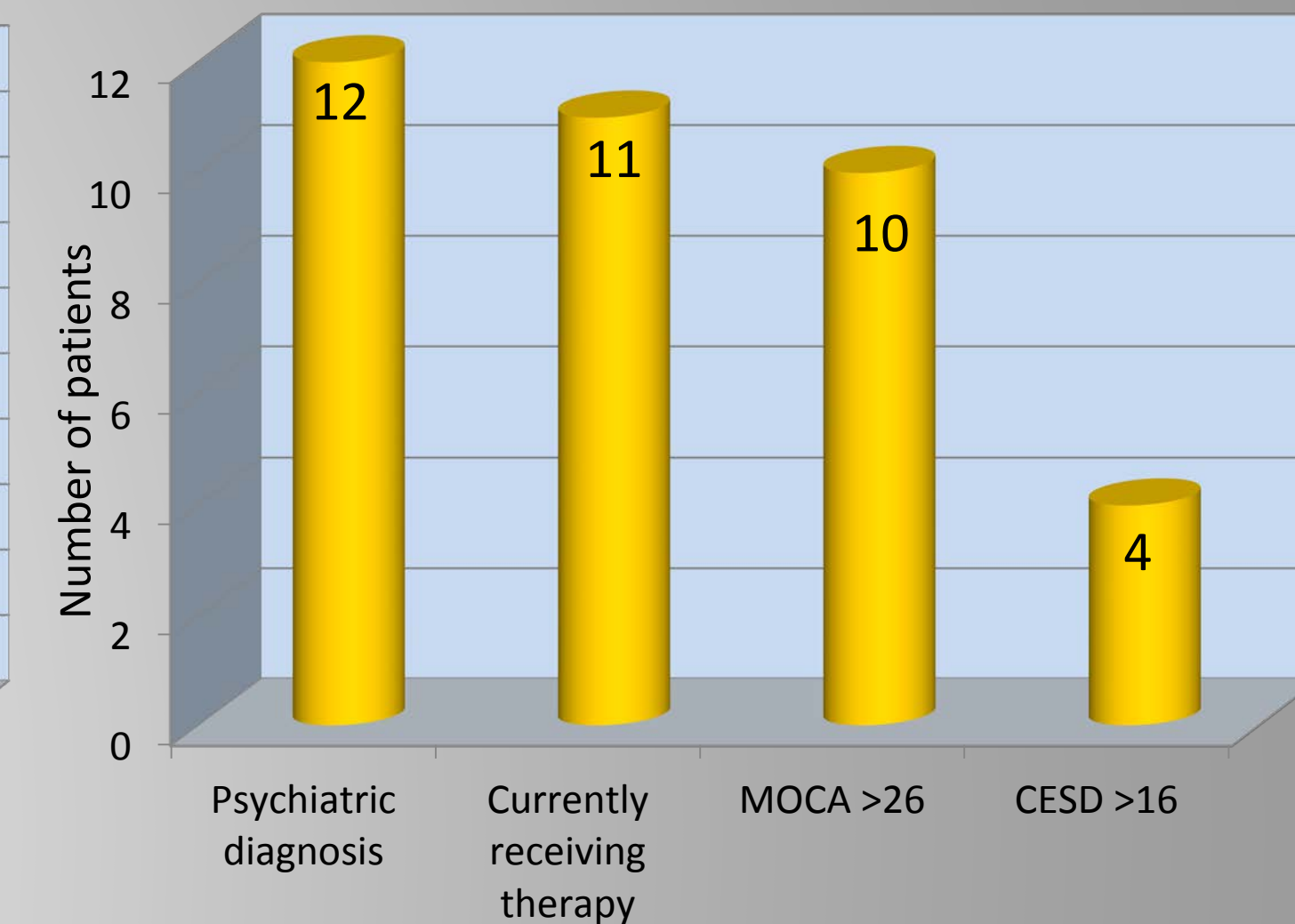
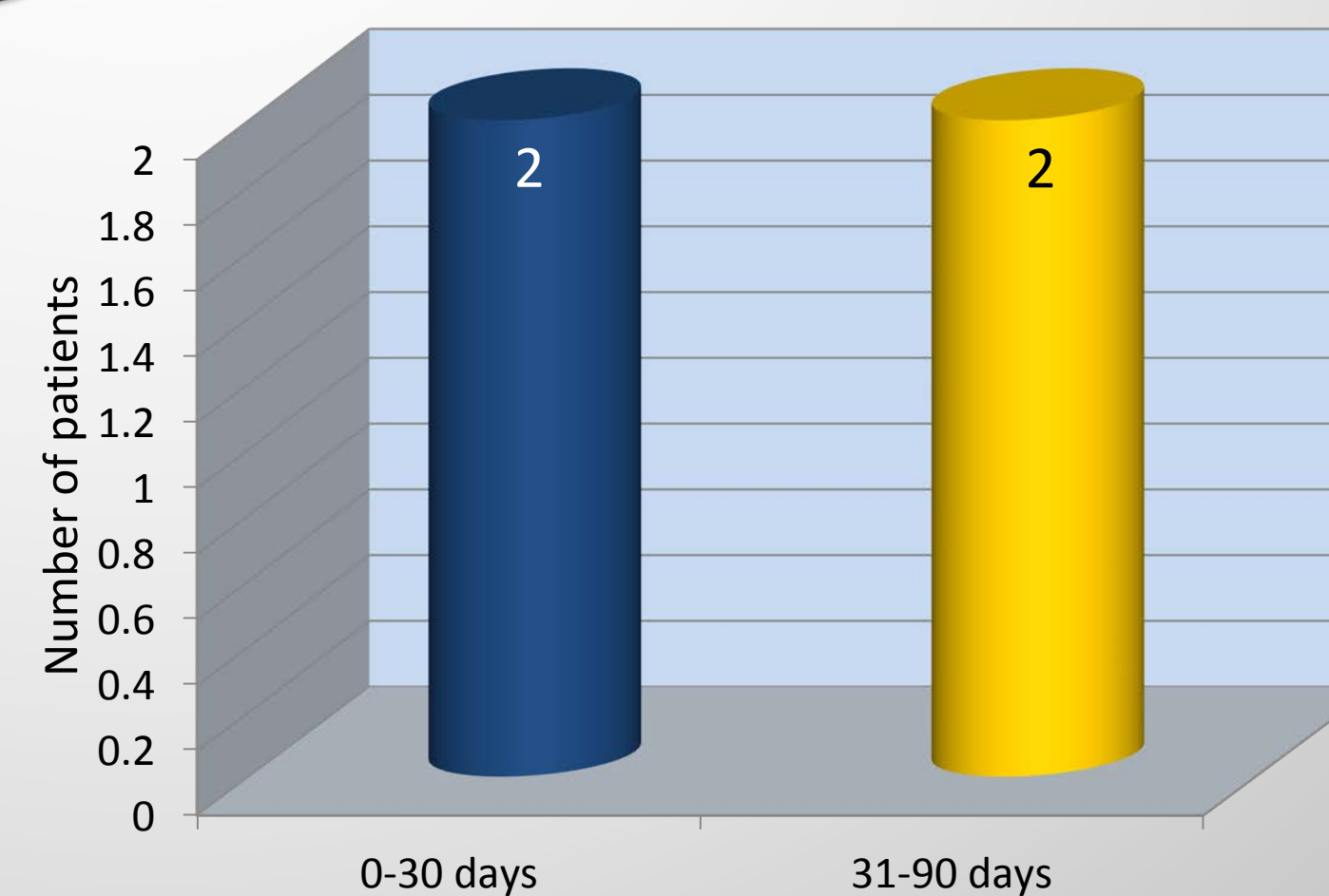


Figure 3: Hospital Readmissions



### Results

- Two of the twenty patients included were readmitted at 30 days. One of the two patients was again readmitted between days 31-90
- Approximately 60% of patient seen in the discharge clinic were at high risk for readmission
- The average number of total medications was reduced post visit
- Adjustments to medications regimens due to patient factors and/or drug interactions occurred at a rate of 2.4 interventions per patient
- Cognitive assessment and depression screening responses were limited by patient's willingness and ability to participate

### Conclusions

- Interdisciplinary team discharge clinics are associated with a reduction in readmissions
- Integration of non-physicians clinicians for post-discharge assessments aids in identification of barriers and optimizes patient care