Easing Hospital Transitions into Primary Care

April 29th, 2015
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Center for Excellence in Primary Care

Webinar sponsored by:
The Center for Excellence in Primary Care and the Center for Care Innovations
Facilitating Care Integration

Nearly half of adults with health issues report problems with the coordination of their care in the United States. As Community Health Centers (CHCs) and other safety net settings transform into Patient-Centered Medical Homes, their role in the larger medical neighborhood will become pronounced. However, challenges with care coordination are magnified in the safety net setting and continue to be increasingly complex.

In 2014, the UCSF Center for Excellence in Primary Care, with funding from the Blue Shield of California Foundation, completed a comprehensive literature review outlining strategies CHCs use to integrate into the medical neighborhood in the domains of primary care-specialty care, primary care-diagnostic imaging, primary care-pharmacy, primary care-oral health and primary care-hospital care. A conceptual model which was used to classify innovations and strategies for integration can be found in the full report here.

The UCSF Center for Excellence in Primary Care has partnered with the Center for Care Innovations to develop this online resource center. The purpose of this Care Integration site is to disseminate
Better transitions, Safer care

Susan Cumming, MD
Terry Winter, RN, MPH

Our home. Our health. Our hospital.
Root Cause Analysis

Key areas for Improvement at MGH

- Preparation of patient for discharge
- Communication
  - Within the inpatient care team
  - With outpatient care team
- Medication Reconciliation
Gathering Baseline Data
Listening to Our Patients
Gathering Baseline Data

Preparation of Patient For Discharge

- 75% were unable to verbalize important information about
  - Their diagnoses
  - Their medications
  - The plan of care
  - Ways to prevent exacerbations of their conditions

- Nearly 2/3 were unclear about their follow-up appointments

- No routine measurement of patient comprehension

- Low scores on HCAHPS
Handwritten Discharge Instructions
Gathering Baseline Data

Team Communication

“I can easily determine the names of all of the care team members for my patients”

Only 32% of staff agreed

2012 staff survey on communication, n=125
“I can easily reach my care team members when I need to communicate with them”

Only 33% of staff agreed

- Strongly Agree: 10%
- Agree: 23%
- Neutral: 21%
- Disagree: 31%
- Strongly Disagree: 15%

n=124
Gathering Baseline Data

Team Communication

“I am notified in a timely fashion of changes to my patient’s discharge plan”

Only 21% of nurses, case managers and ancillary staff agreed
• Historically the responsibility of the admitting nurse

• Admission Med Rec
  • averaged 30-40% complete*

• Discharge Med Rec
  • accurate in <20% of those readmitted within 30 days*

*Chart Audits May, 2011
Care Transitions Program at MGH

Project RED

- Multidisciplinary Collaboration
- Teamwork
- Reduces Unnecessary Readmissions

CareBook

- Easier, more effective communication

CTI

- Care Transitions Intervention
- Patient and Caregiver Engagement
Key elements of project RED

• Start planning for safe discharge upon admission
• Educate throughout the hospital stay, measuring comprehension through teach-back
• Reconcile medications upon admission and at d/c
• Assure that patient and caregivers
  • Understand their diagnosis and med regimen
  • Know what to expect
  • Know what to do if a problem arises
• Have outpatient follow up arranged before d/c
• Have the ability to obtain meds upon d/c
• Facilitate smooth handoff to primary care
• Create thorough, easy to understand d/c instructions
• Follow up on all patients after d/c
Project RED

Safer Handoffs to Primary Care

- Schedule f/u appts **before** leaving hospital
- Incorporate those appts in the discharge instructions
- Clear plan around tests/treatments to be done
- Plan around tests still pending
What are we implementing at MGH?

 Medication Reconciliation

– The Med Rec Tech
  » 16hrs/day, 7 days/wk.

– Accurate Med Lists on Admit/Discharge

– Education by Pharmacy on Hi-Risk Meds
  » Start with anticoagulants
### Staff Perception

#### Medication Reconciliation

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>“My patients' home meds are reconciled with admission medication orders.”</td>
<td>44%</td>
<td>72%</td>
</tr>
<tr>
<td>“My patient’s discharge medication list is reconciled with home meds.”</td>
<td>46%</td>
<td>74%</td>
</tr>
</tbody>
</table>

% of staff who stated “always” or most of the time
Project RED
What are we implementing at MGH?

- Improve Patient Preparation for Discharge
  - Teach effectively, Teach often
  - Teach-back
    - (Minimum 5 min/patient/shift)
### Noting Patient or Caregiver Comprehension

#### Primary Diagnosis
McMorris, Craig
on 6/4 1:45 PM

- **Not Ready**

#### Discharge Medications
RT, Test
on 5/12 3:50 PM

- **Not Ready**

#### Follow-up Plan
Edmondson, Nancy
on 5/17 10:35 AM

- **Ready**

#### Red Flags & Action Plan
Silva, Thania
on 5/20 8:13 PM

- **Ready**
Improved Patient Preparation for Discharge

New Patient Discharge Instructions
- Multidisciplinary team input
- Working to incorporate more health-literate components

Appts for Community Clinic Patients before D/C
- Working to implement in private practice
“Did you get information in writing about what symptoms or health problems to look for after you left the hospital?”

HCAHPS #20

% strongly agree  Percentile Ranking
“When I left the hospital, I had a good understanding of the things I was responsible for in managing my health”
"When I left the hospital, I clearly understood the purpose for taking each of my medications"
What are we implementing at MGH?

- Improved Communication
  - Amongst the Members of the Hospital Care Team
CareBook

- Collaborate on Discharge Plan & Risk Checklists
- Coordinate discharge readiness by completing To-Dos
- Communicate with 1 or more team members instantly
“I can easily determine the names of all the care team members for my patients”

32% Agree/Strongly Agree

Before Project RED + CareBook (Mid 2012) n=125

- Strongly Agree: 10%
- Agree: 22%
- Somewhat Agree: 31%
- Disagree: 8%
- Somewhat Disagree: 10%
- Strongly Disagree: 10%

69% Agree/Strongly Agree

After Project RED + CareBook (Mid 2013) N=127

- Strongly Agree: 31%
- Agree: 38%
- Somewhat Agree: 13%
- Disagree: 4%
- Somewhat Disagree: 6%
- Strongly Disagree: 27%
“I can easily reach my care team members when I need to communicate with them.”

Before Project RED + Carebook

- Strongly Agree: 10%
- Agree: 31%
- Somewhat Agree: 23%
- Disagree: 0%
- Somewhat Disagree: 15%
- Strongly Disagree: 15%

n=125

After Project RED + Carebook

- Strongly Agree: 17%
- Agree: 28%
- Somewhat Agree: 28%
- Disagree: 8%
- Somewhat Disagree: 13%
- Strongly Disagree: 5%

N=127

33% Agree

45% Agree

MARIN GENERAL HOSPITAL
### Team Communication

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>“I can easily or efficiently contact all members of my patient’s care Team to notify them about changes to the discharge plans” (MDs)</td>
<td>8%</td>
<td>72%</td>
</tr>
</tbody>
</table>

% of staff who chose “agree” or “strongly agree”
I am notified in a timely fashion of changes to my patient’s discharge plan (non-MDs)

Always | Most of the time | Sometimes | Rarely | Never
--- | --- | --- | --- | ---
8% | 44% | 43% | 3% | 10%
8% | 24% | 38% | 7% | 7%

Before Project RED & Carebook | After Project RED and Carebook
N=86
Communication with Outpt Care Team

CareBook

- Alert of Admission or ED visit
- Bring care managers or PCP into the discussion in real time
- Sort patients for post-discharge follow up
- Touch screen documentation of post-hospital interventions
  - Coaching
  - Phone calls
Linking with Outpatient Care

- Meritage Medical Network
  - Notified electronically in real time upon entry to ED or Hospital
  - Teams linked in CareBook
    - Nurse Care Manager to MGH
      - Eval for Care Transitions Coaching

- Marin Community Clinics
  - Cardiologist involved while hospitalized
  - Contacted to arrange follow up
    - Linked in CareBook
      - Follow up arranged
        - Eval for Coaching by County

- Heart Failure
  - Home with Anticoagulants
  - Electronic Notification of Cardiovascular Center
    - Linked in CareBook
      - Follow up phone call and specialty care plan reinforced
Improved handoff to Community Clinics

# Follow-up Appointments Set up

<table>
<thead>
<tr>
<th>Month</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>60</td>
<td>103</td>
</tr>
<tr>
<td>April</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td>May</td>
<td>86</td>
<td>97</td>
</tr>
</tbody>
</table>

MARIN GENERAL HOSPITAL
Project RED
Design for follow up After Hospitalization

Discharge from Hospital

Assign a Coach
- Hospital Visit
- Home Visit
- Phone f/u

To:
- SNF
- Rehab
- Acute Care
- Home Hospice
- Prison

Phone call 2-3 days After Discharge

Meritage ACO

County Aging And Adult Services

MGH Phone follow-up Nurse

Cardiovascular Center of Marin
Care Transitions Coaching

- Work with clients for 30 days after discharge
  - Hospital visit
  - Home visit
  - 3 phone calls

- Encourages patient activation and self-management

- Referral made by CareBook
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
### Gathering data after hospitalization (phone follow up)

<table>
<thead>
<tr>
<th>How are you feeling since leaving the hospital?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Improved</td>
<td>80% 60</td>
</tr>
<tr>
<td>b. No change</td>
<td>15% 11</td>
</tr>
<tr>
<td>c. Worse</td>
<td>5% 4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When is your follow-up</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Aware of time of appointment</td>
<td>68% 51</td>
</tr>
<tr>
<td>b. Able to articulate basics</td>
<td>35% 25</td>
</tr>
<tr>
<td>c. In depth understanding</td>
<td>4% 3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>72</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can you tell me what changes in your health might indicate a worsening condition, needing urgent attention?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Null</td>
<td>11% 8</td>
</tr>
<tr>
<td>a. Limited understanding</td>
<td>54% 38</td>
</tr>
<tr>
<td>b. Able to articulate basics</td>
<td>31% 22</td>
</tr>
<tr>
<td>c. In depth understanding</td>
<td>3% 2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who would you call if you developed problems that would deserve urgent attention? Do you have their phone number?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Null</td>
<td>10% 7</td>
</tr>
<tr>
<td>a. Limited understanding</td>
<td>45% 31</td>
</tr>
<tr>
<td>b. Able to articulate basics</td>
<td>42% 29</td>
</tr>
<tr>
<td>c. In depth understanding</td>
<td>3% 2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>69</td>
</tr>
</tbody>
</table>
Readmissions trend

30 Day All-Cause Readmission Rate, Age 65+, MGH
Strengths of our efforts

• Extensive multidisciplinary planning effort
• Communication with staff
• Medication Reconciliation
• Coaching and Follow-up Calls
• Partnership and communication
  – Meritage ACO
  – Marin Community Clinics
  – Cardiology Center of Marin
Need for Improvement

• Standardizing our Practice
  – Holding all team members accountable
• Outpatient follow-up appts for all
• Need for integration of CareBook with other IT systems
• Patient Discharge Instructions
  – Need better health literacy
  – Need better instructions in other languages
You are welcome to contact us

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Questions

Care Integration Resource Center