# Easing Hospital Transitions into Primary Care

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Susan Cumming, MD

Terry Winter, RN, MPH

**Marin General Hospital**

J. Nwando Olayiwola, MD, MPH, FAAFP

Ashley Rubin, MS

**Center for Excellence in Primary Care**

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

# Care Integration Resource Center

CCI
CENTER FOR CARE INNOVATIONS

*Creative Thinking, Smart Resources, Healthy Communities*

SEARCH

WHO WE ARE | PROGRAMS & GRANTS | INNOVATION SPOTLIGHT | KNOWLEDGE CENTER | NEWS & EVENTS

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## 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.

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

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**

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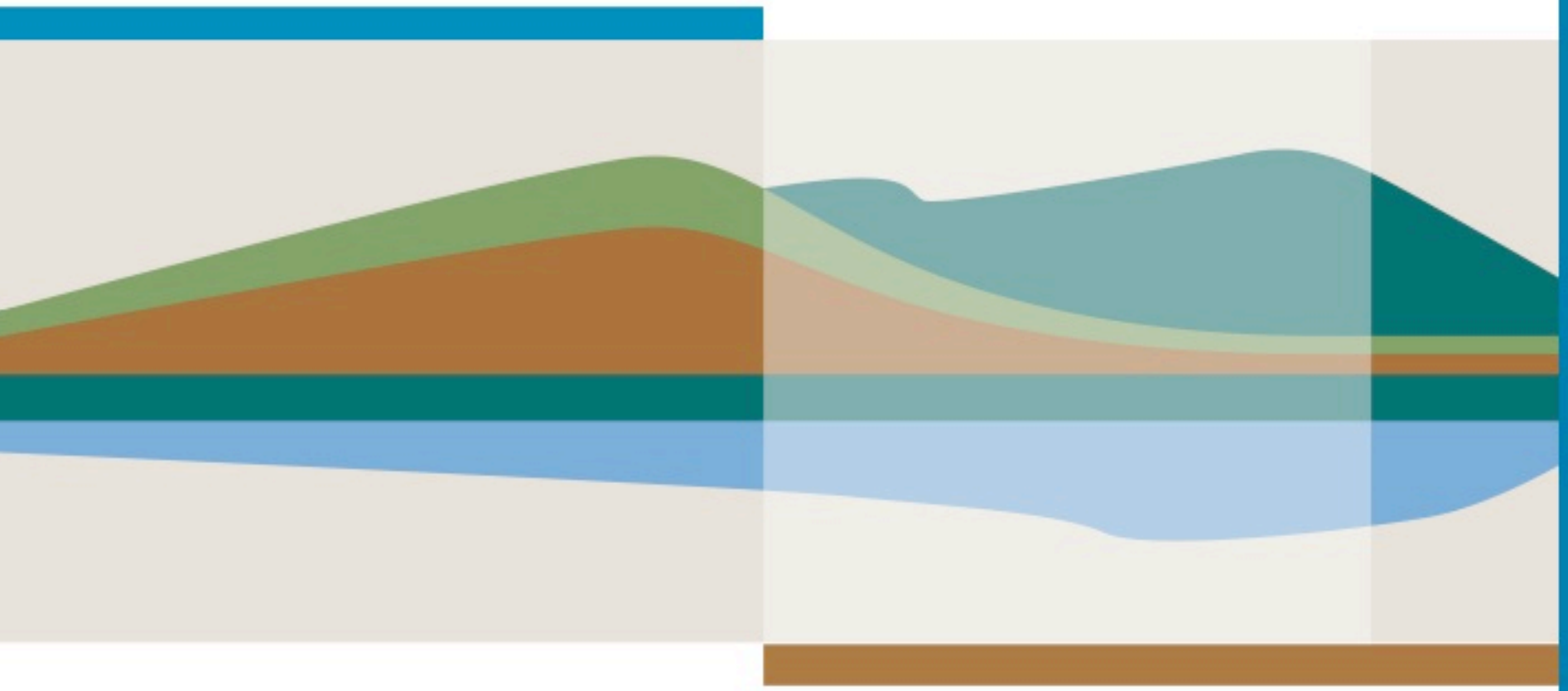
# Better transitions, Safer care



**Susan Cumming, MD**
**Terry Winter, RN, MPH**

Our home. Our health. Our hospital.

# Key areas for Improvement at MGH

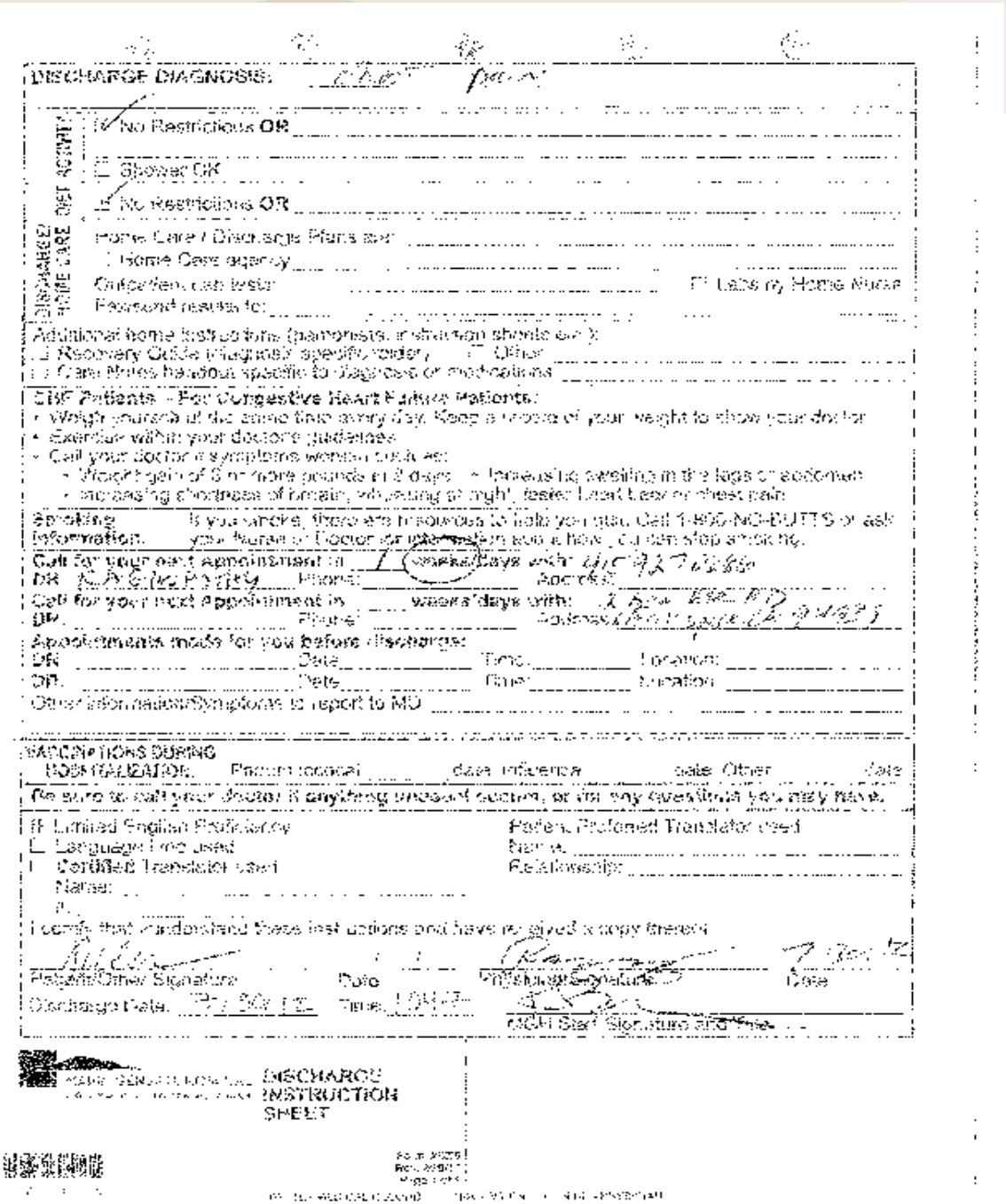
- Preparation of patient for discharge
- Communication
  - Within the inpatient care team
  - With outpatient care team
- Medication Reconciliation

# Listening to Our Patients

# 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**



DISCHARGE DIAGNOSIS:

DISCHARGED FROM CARE OF ACUITY UNIT

☑ No Restrictions OR

☐ Showers OK

☑ No Restrictions OR

Home Care / Discharge Plans set:

☐ Home Care agency

Outpatient lab tests: ☐ Labs by Home Nurse

Personal results to:

Additional home instructions (paramedic instruction sheets etc.):

☐ Recovery Guide (Hospital specific order) ☐ Other

☐ Care Notes handout specific to diagnosis or medications

CHF Patients – For Congestive Heart Failure Patients:

- Weigh yourself at the same time every day. Keep a record of your weight to show your doctor
- Exercise within your doctors guidelines
- Call your doctor if symptoms worsen such as:
  - Weight gain of 3 or more pounds in 2 days
  - Increasing swelling in the legs or abdomen
  - Increasing shortness of breath, wheezing at night, faster heart beat or chest pain

Smoking Information: If you smoke, there are resources to help you stop. Call 1-800-NO-BUTTS or ask your Nurse or Doctor on how you can stop smoking.

Call for your next appointment in 1 weeks/days with:

DR Phone: Address:

Call for your next appointment in weeks/days with:

DR Phone: Address:

Appointments made for you before discharge:

DR Date: Time: Location:

DR Date: Time: Location:

Other information/Symptoms to report to MD

VACCINATIONS DURING HOSPITALIZATION: Pneumococcal date influenza date Other date

Be sure to call your doctor if anything unusual occurs, or for any questions you may have.

☐ Limited English Proficiency
☐ Language Line used
☐ Certified Translator used
Name:

Patient Preferred Translator used
Name:
Relationship:

I certify that I understand these instructions and have received a copy thereof.

Patient/Other Signature Date

Discharge Date: Time:

Discharge Date: Time:

MGH Staff Signature and Title

DISCHARGE INSTRUCTION SHEET

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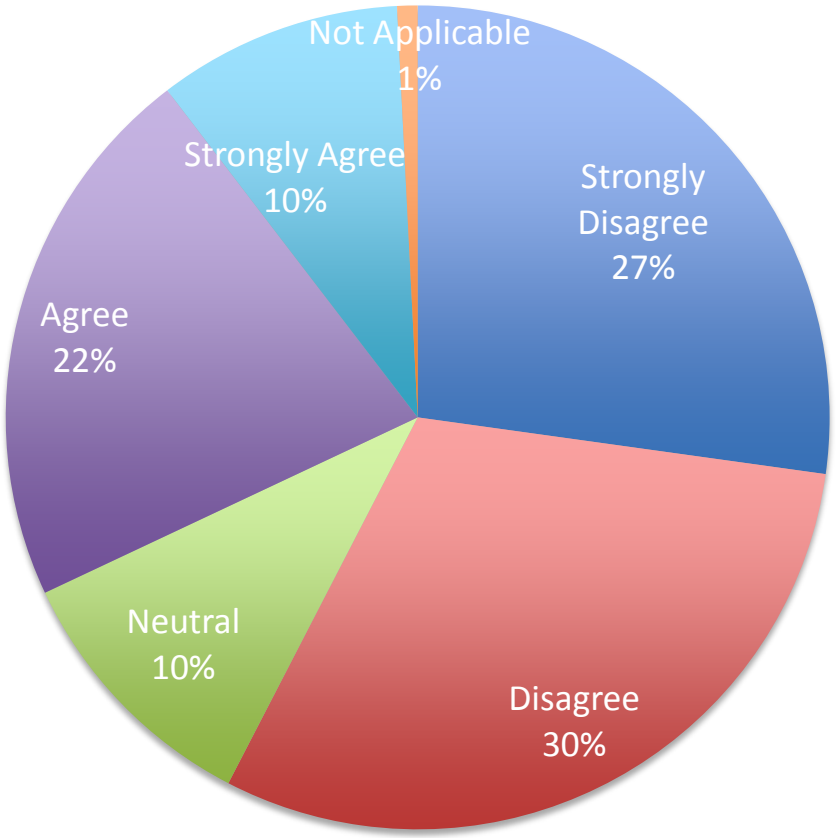
# Team Communication

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

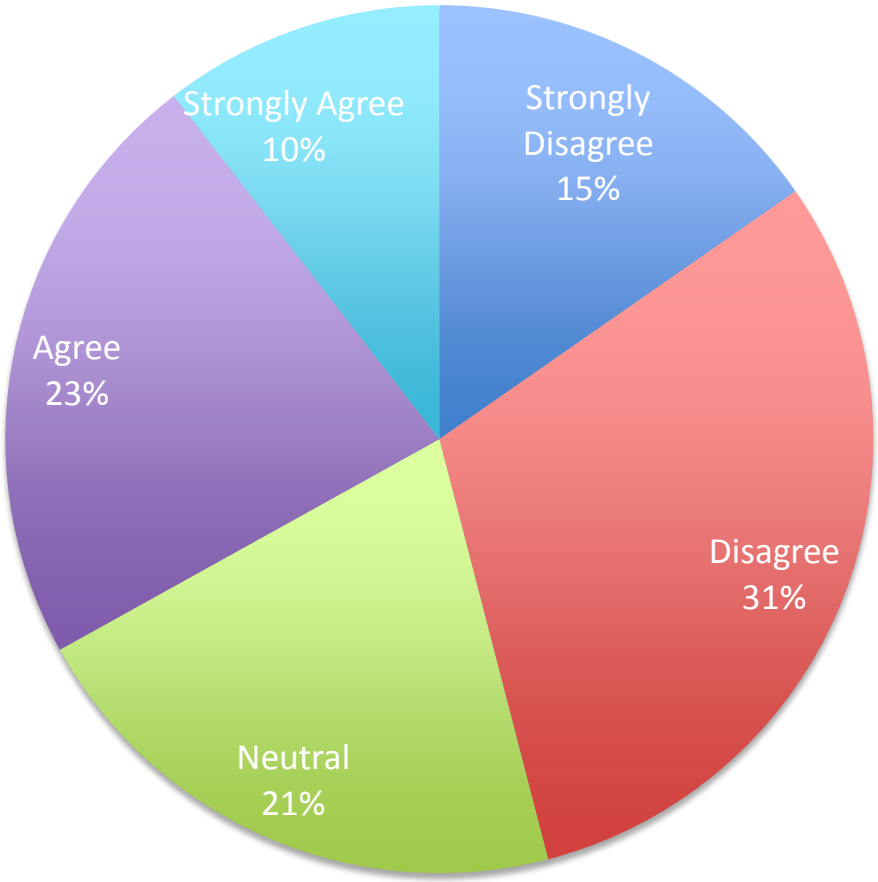



**Only 32% of staff agreed**

2012 staff survey on communication, n=125

# Team Communication

"I can easily reach my care team members when I need to communicate with them"




**Only 33% of staff agreed**

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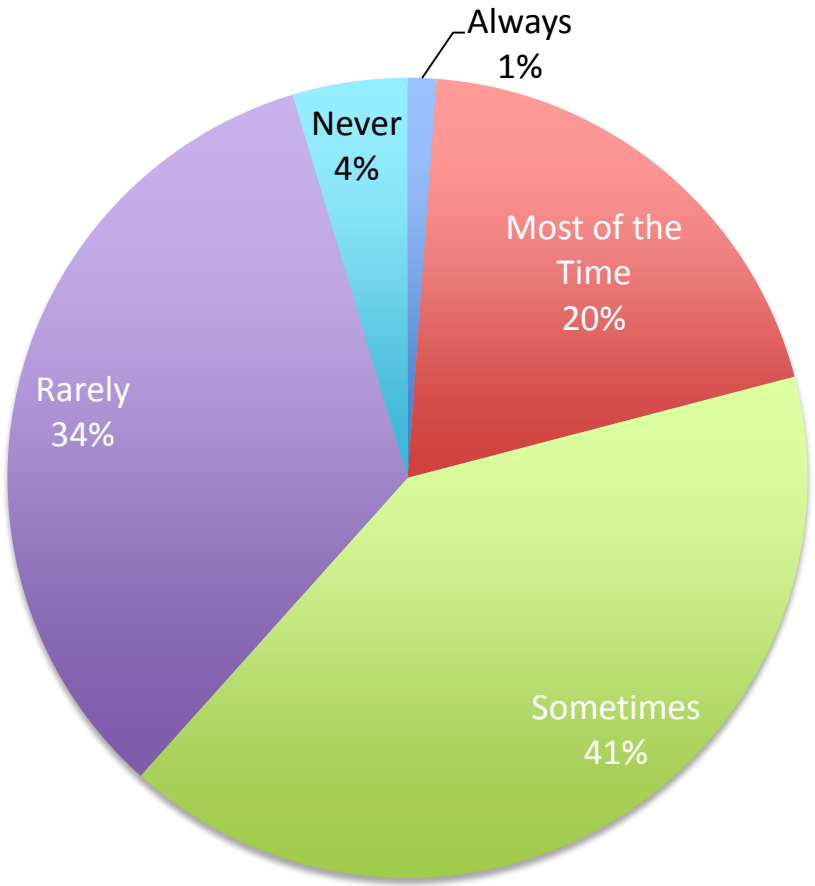
**n=124**

# 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**

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**N=86**

# Medication Reconciliation

- 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**

**Reduce Unnecessary Readmissions**

**Teamwork**

**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

| Staff Surveys | Before Project **RED** (2012) | With Project **RED** (2013) |
|---|---|---|
| "My patients' home meds are reconciled with admission medication orders." | 44% | 72% |
| "My patient's discharge medication list is reconciled with home meds." | 46% | 74% |

% of staff who stated "always" or most of the time"

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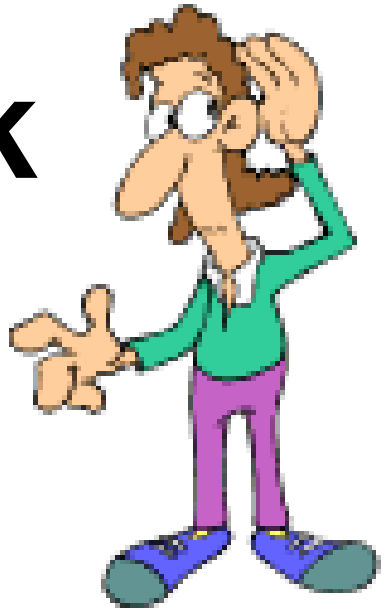
- Improve Patient Preparation for Discharge

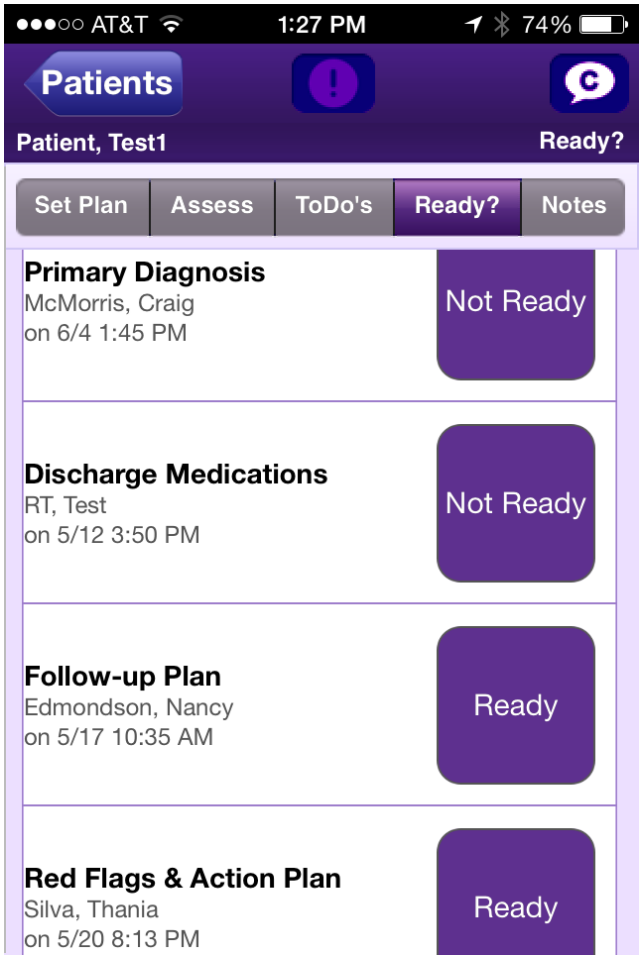
  -Teach effectively, Teach often

  **Teach-back**

  - (Minimum 5 min/patient/shift)



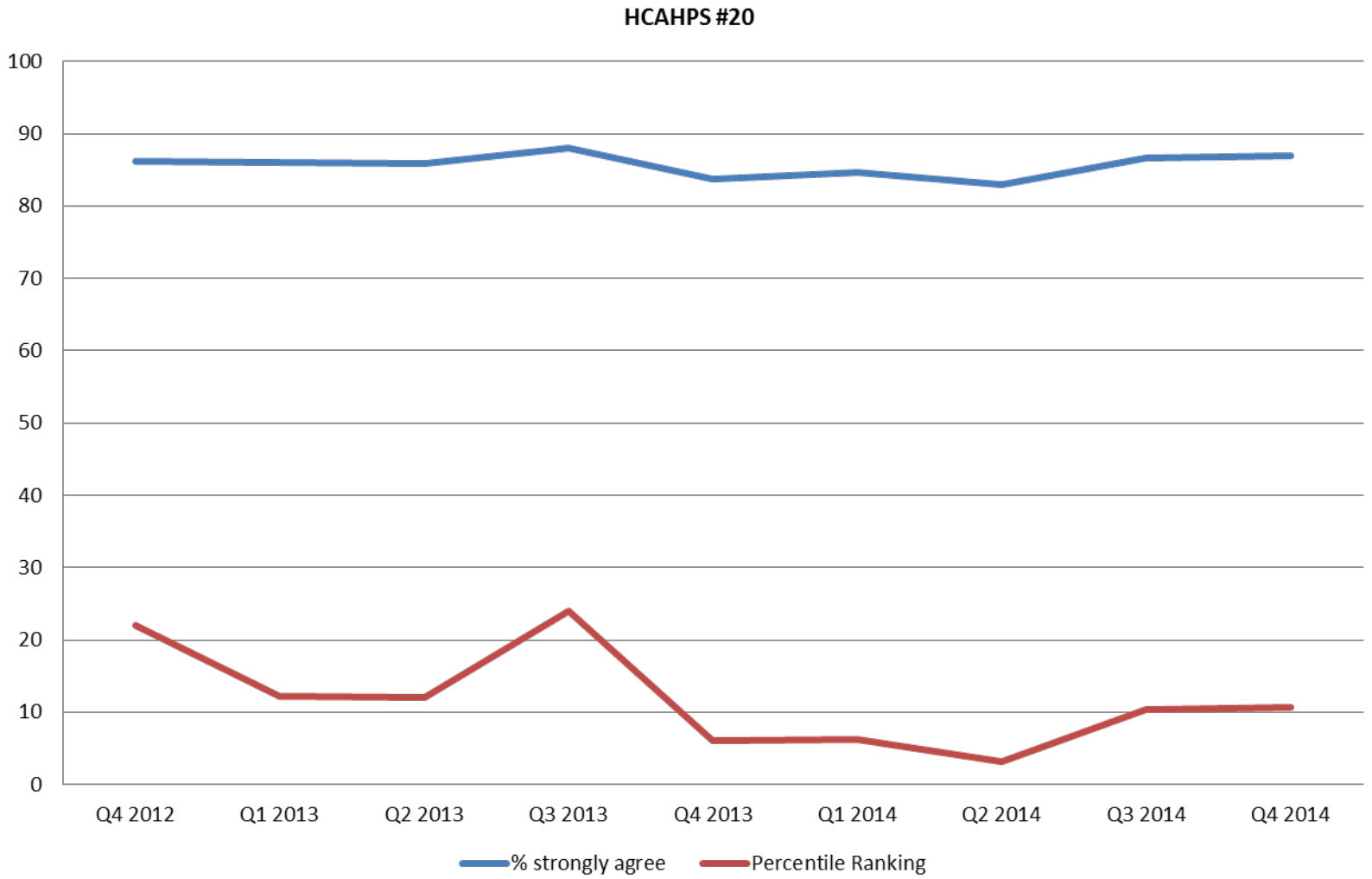
# Noting Patient or Caregiver Comprehension



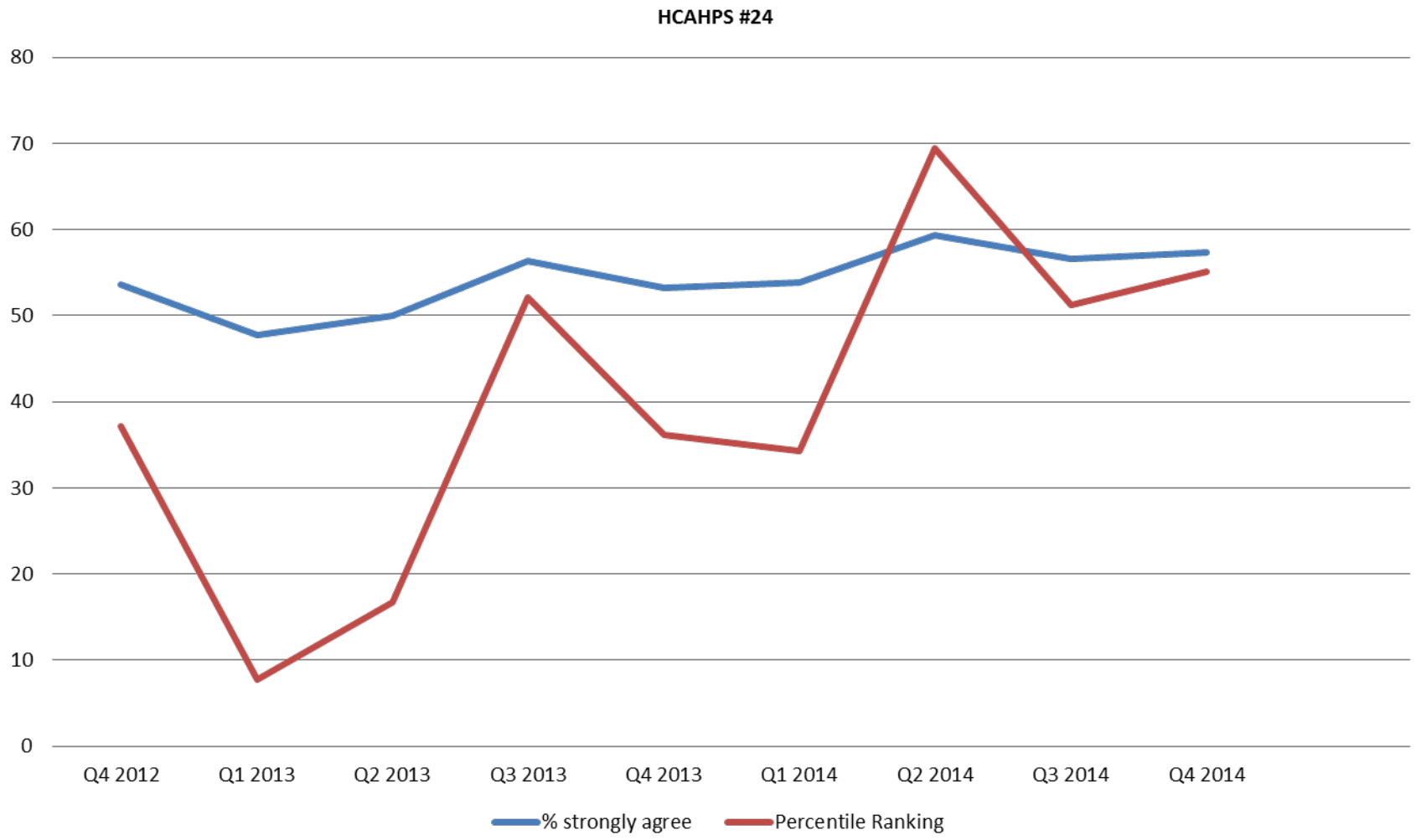
# Project RED
## What are we implementing at MGH?

- 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

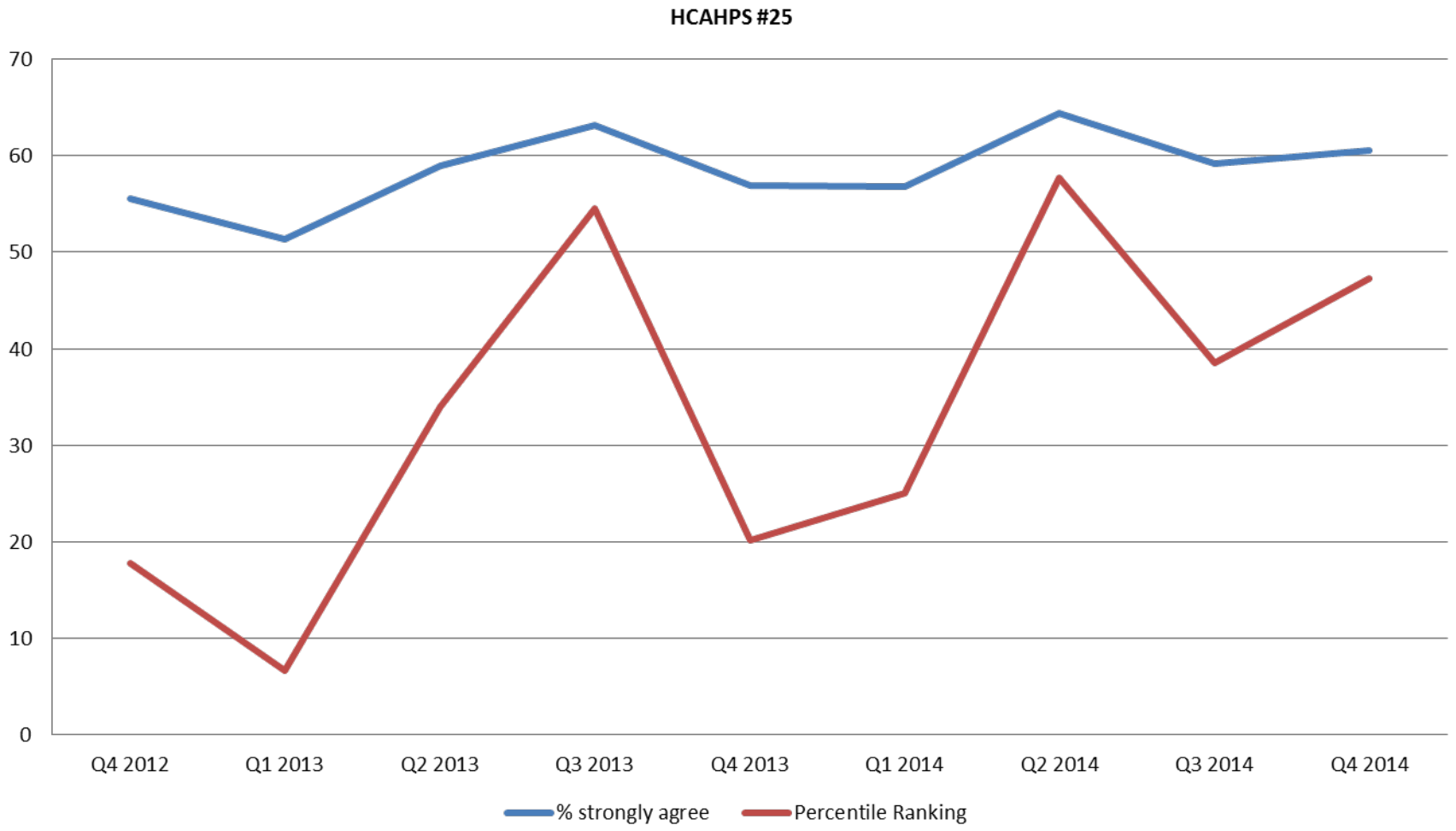
# “Did you get information in writing about what symptoms or health problems to look for after you left the hospital?”



# “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"

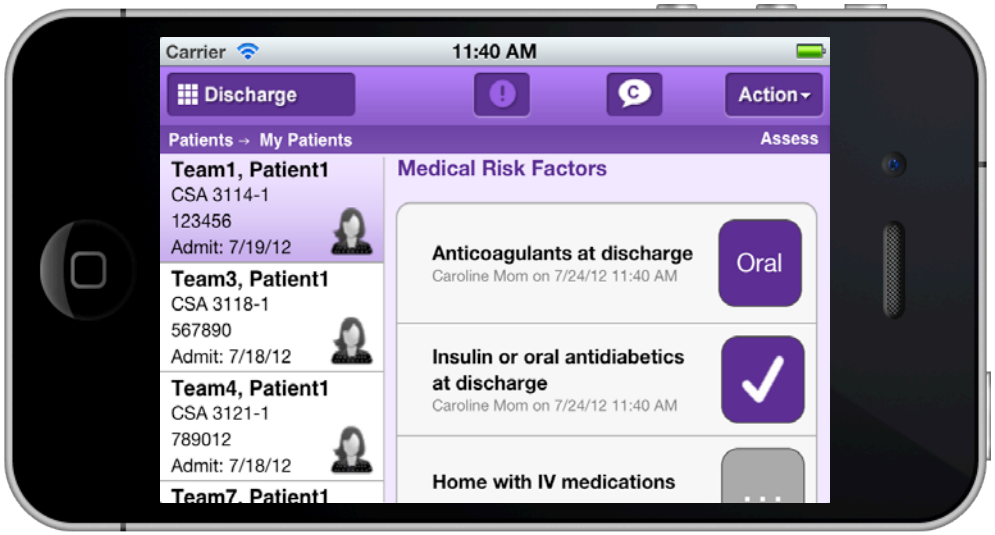


# Project RED
## What are we implementing at MGH?

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

# Team Communication

## CareBook




- **Collaborate**

  on Discharge Plan & Risk Checklists

- **Coordinate**

  discharge readiness by completing To-Dos

- **Communicate**

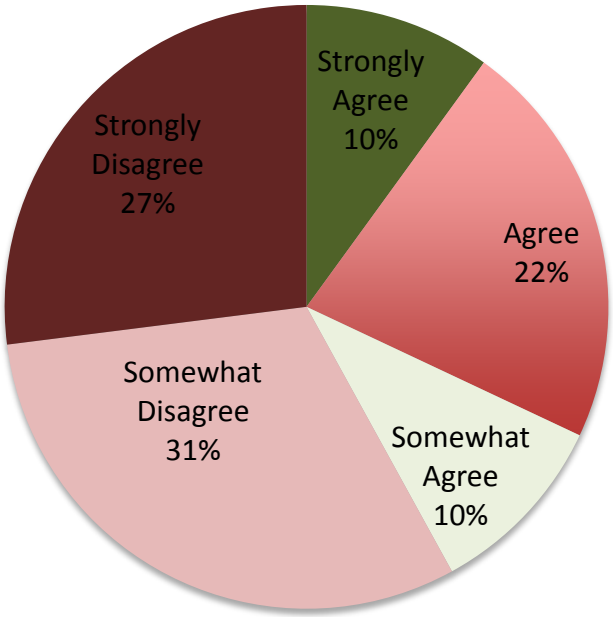
  with 1 or more team members instantly

## Team Communication

# Measuring the Impact

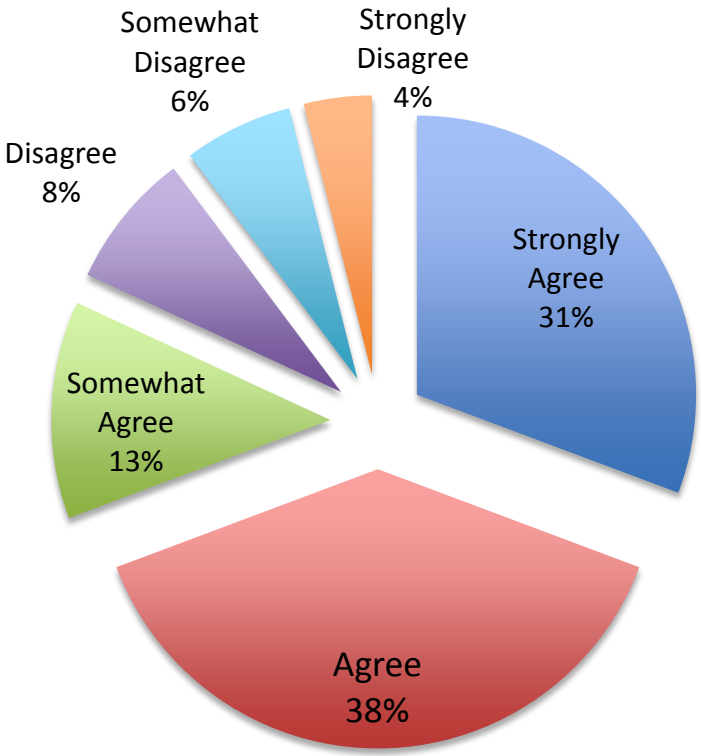
"I can easily determine the names of all the care team members for my patients"

**32% Agree/Strongly Agree**




**Before Project RED + CareBook (Mid 2012)**

n=125



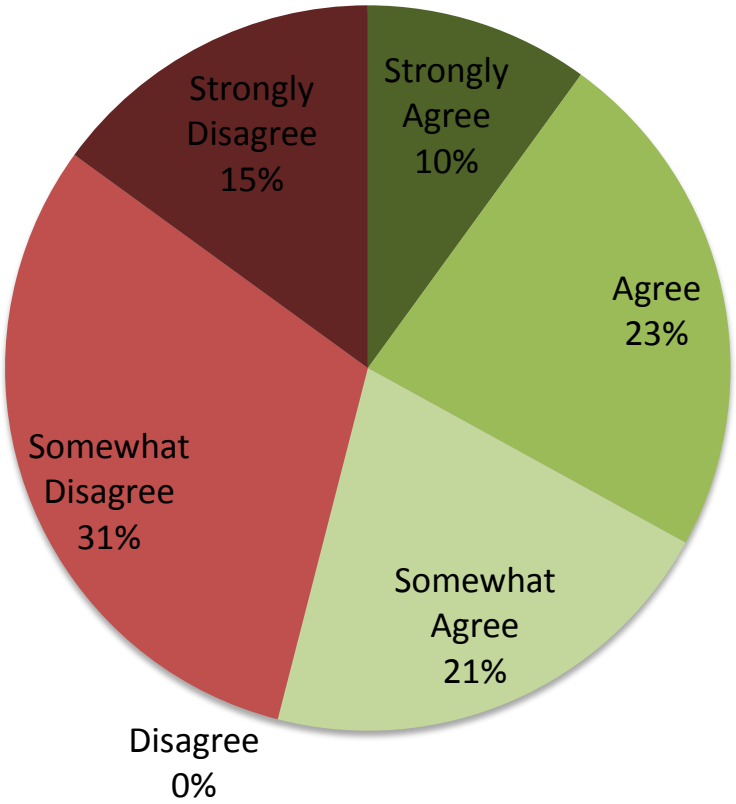

**69% Agree/Strongly Agree**

**After Project RED + CareBook (Mid 2013)**

N=127

# “I can easily reach my care team members when I need to communicate with them.”

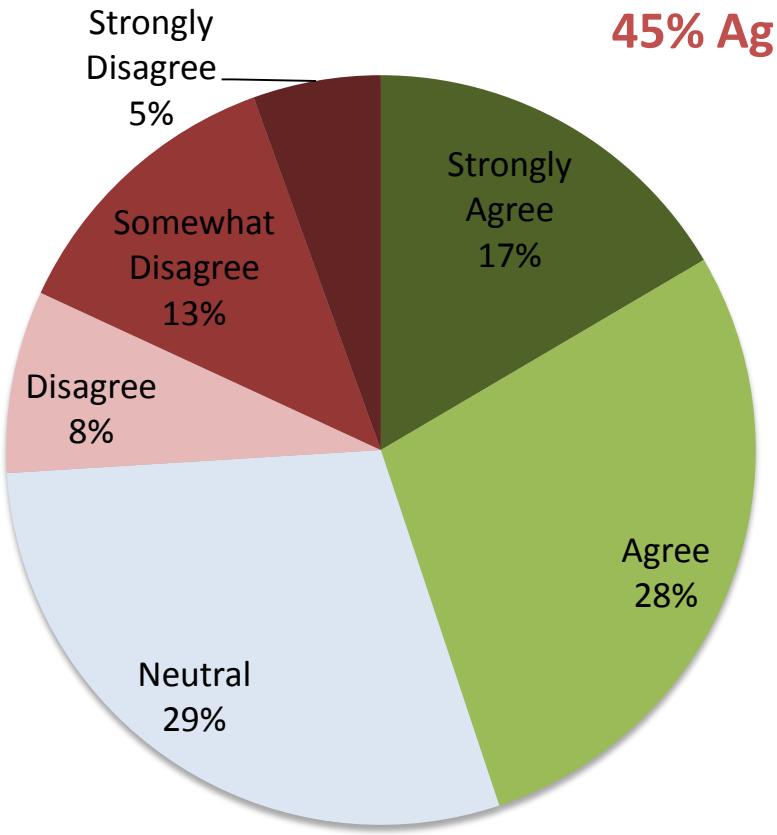
**33% Agree**




n=125

**Before Project RED + Carebook**

**45% Agree**




N=127

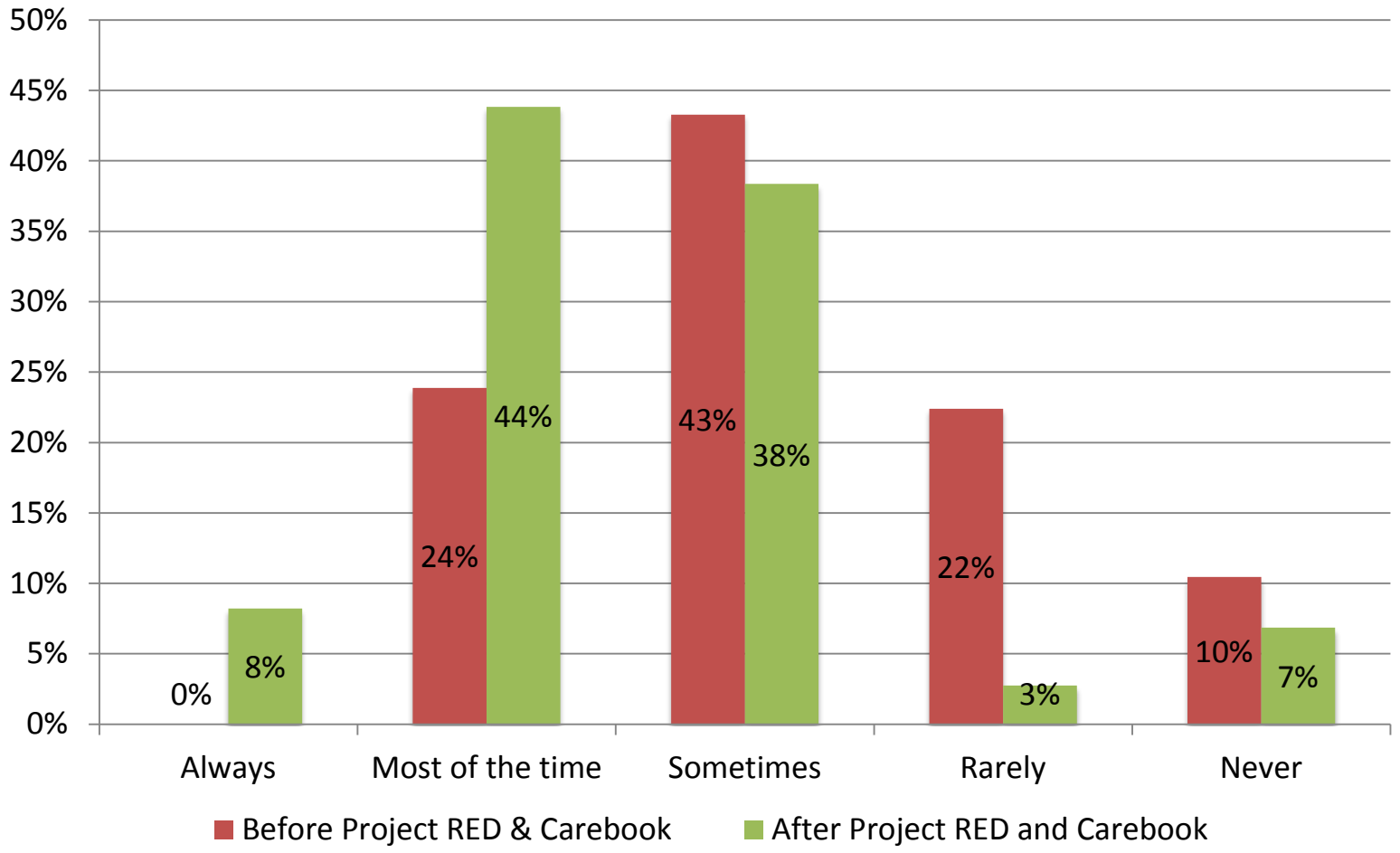
**After Project RED + Carebook**

# Team Communication

| Staff Surveys | Before Project **RED** (2012) | With Project **RED** (2013) |
|---|---|---|
| “I can easily or efficiently contact all members of my patient’s care Team to notify them about changes to the discharge plans” (MDs) | 8% | 72% |

% 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)




N=86

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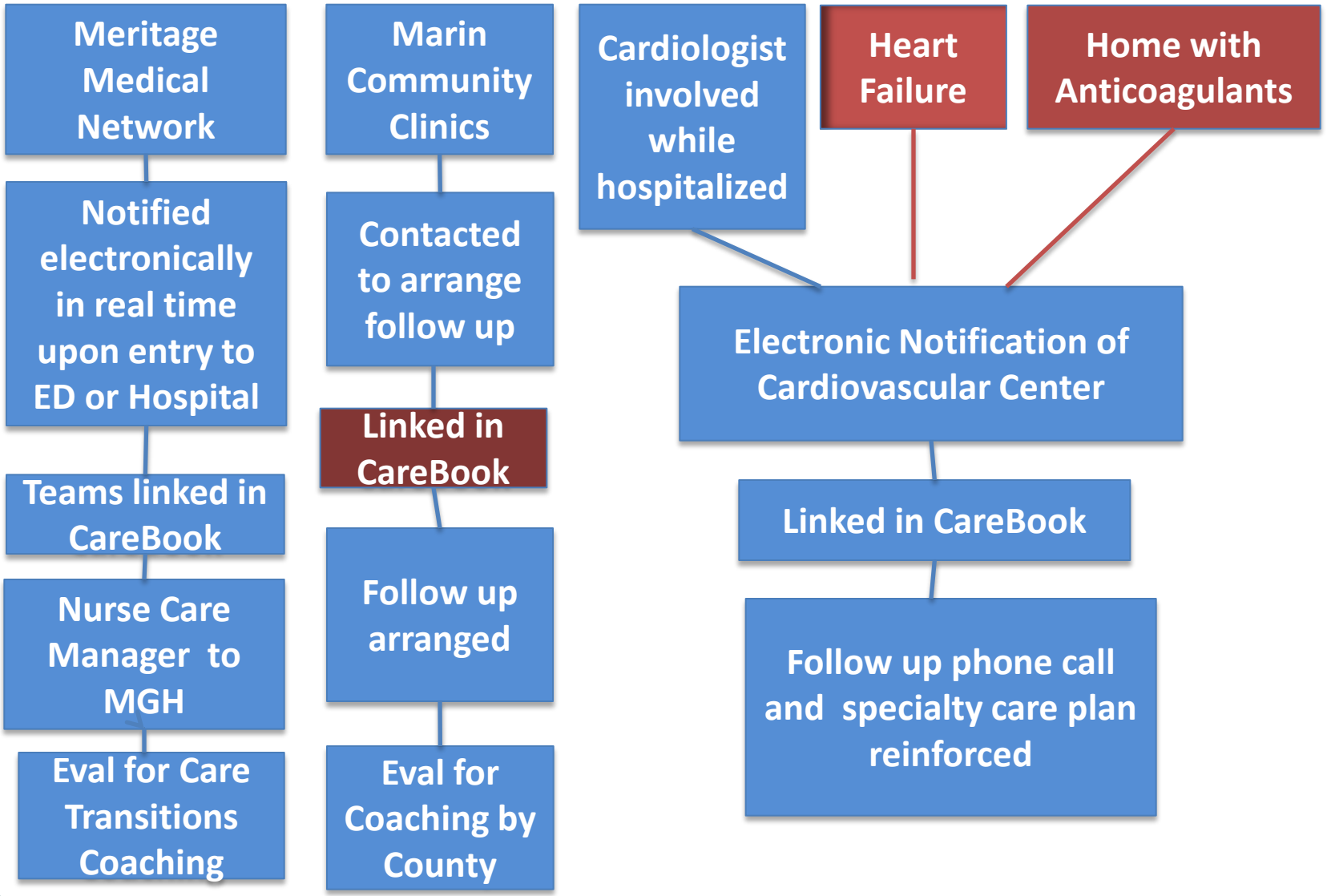
# Communication with Outpt Care Team

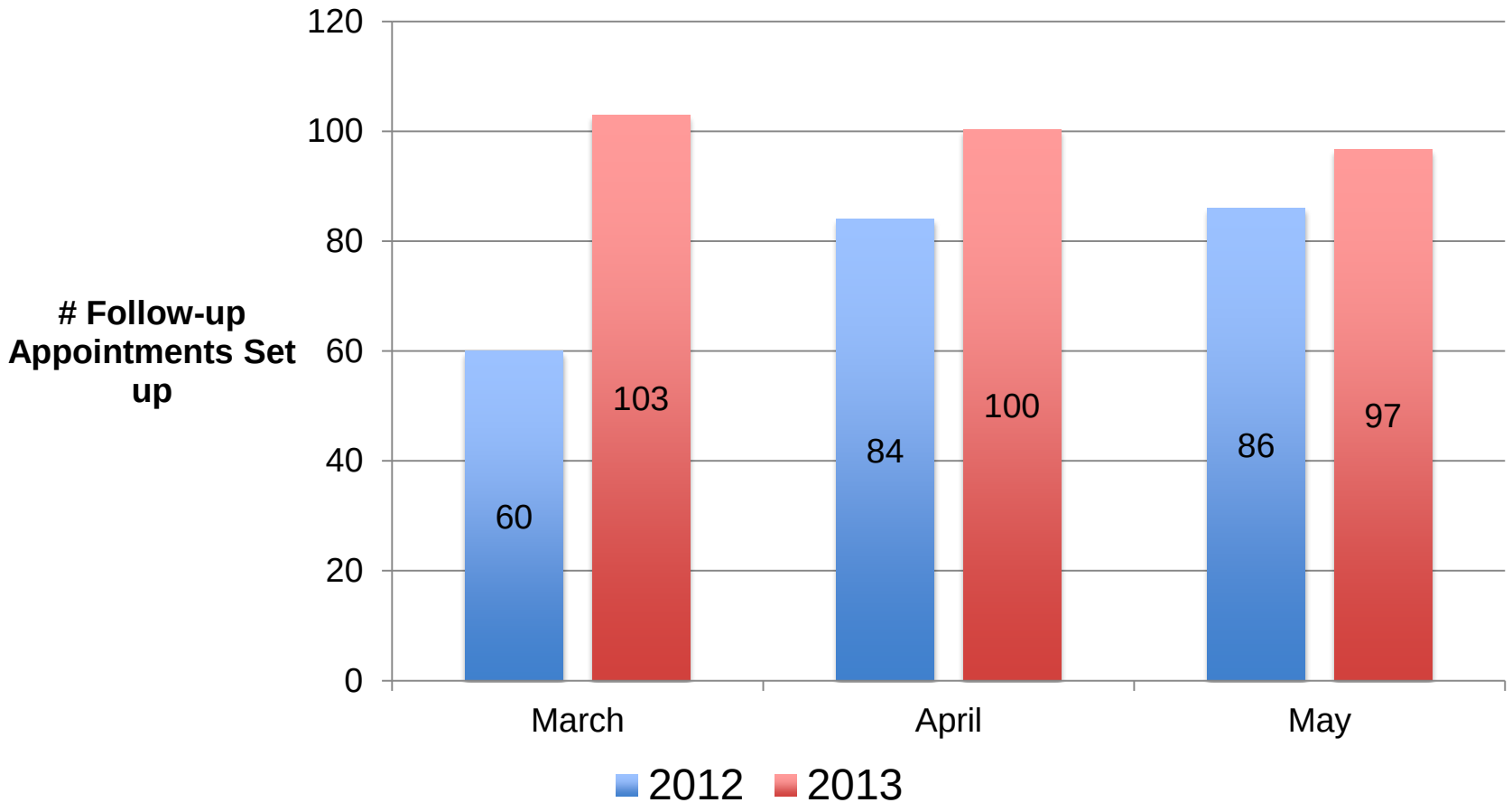
## CareBook


- 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

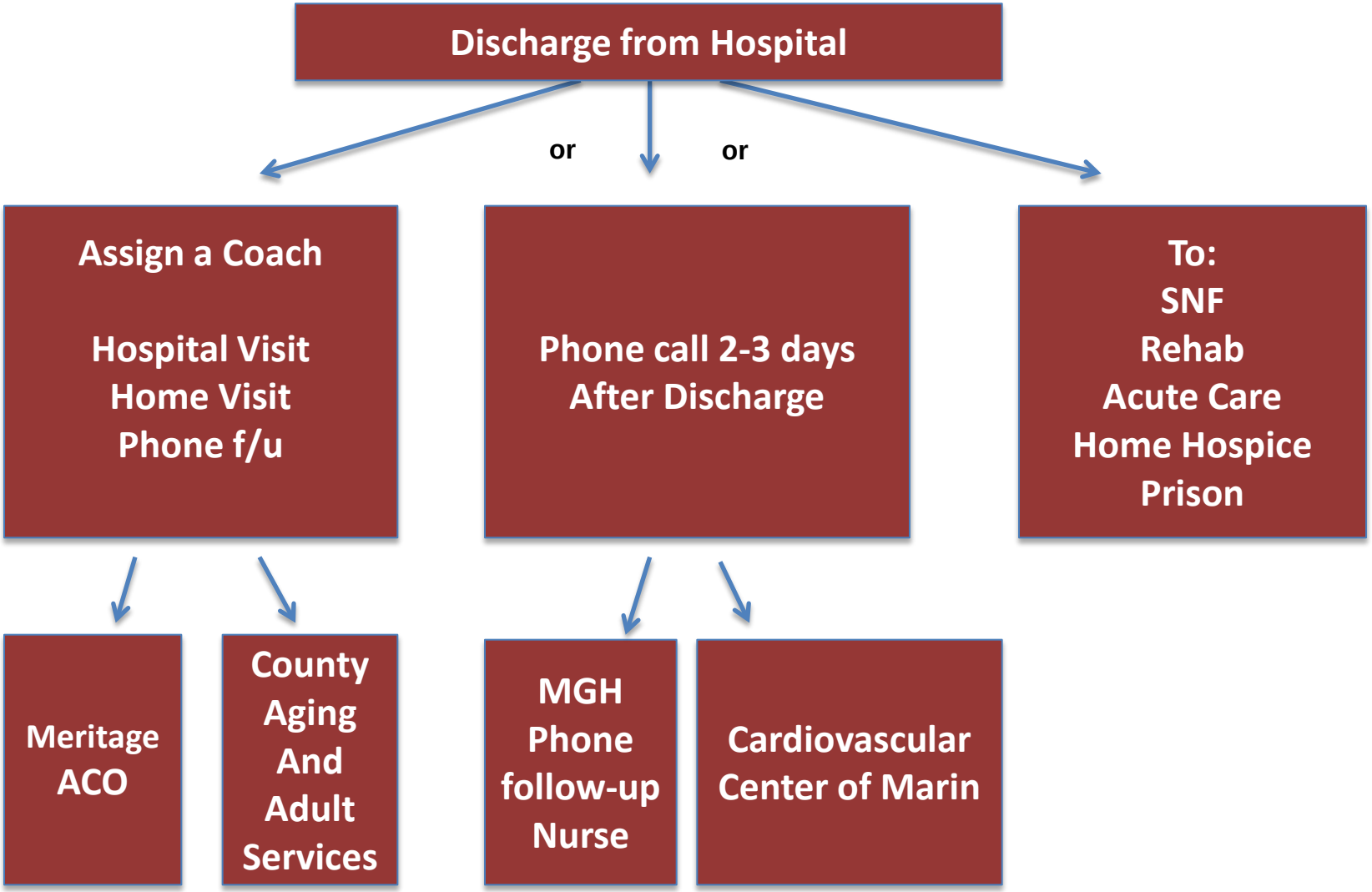


# Improved handoff to Community Clinics



Project RED

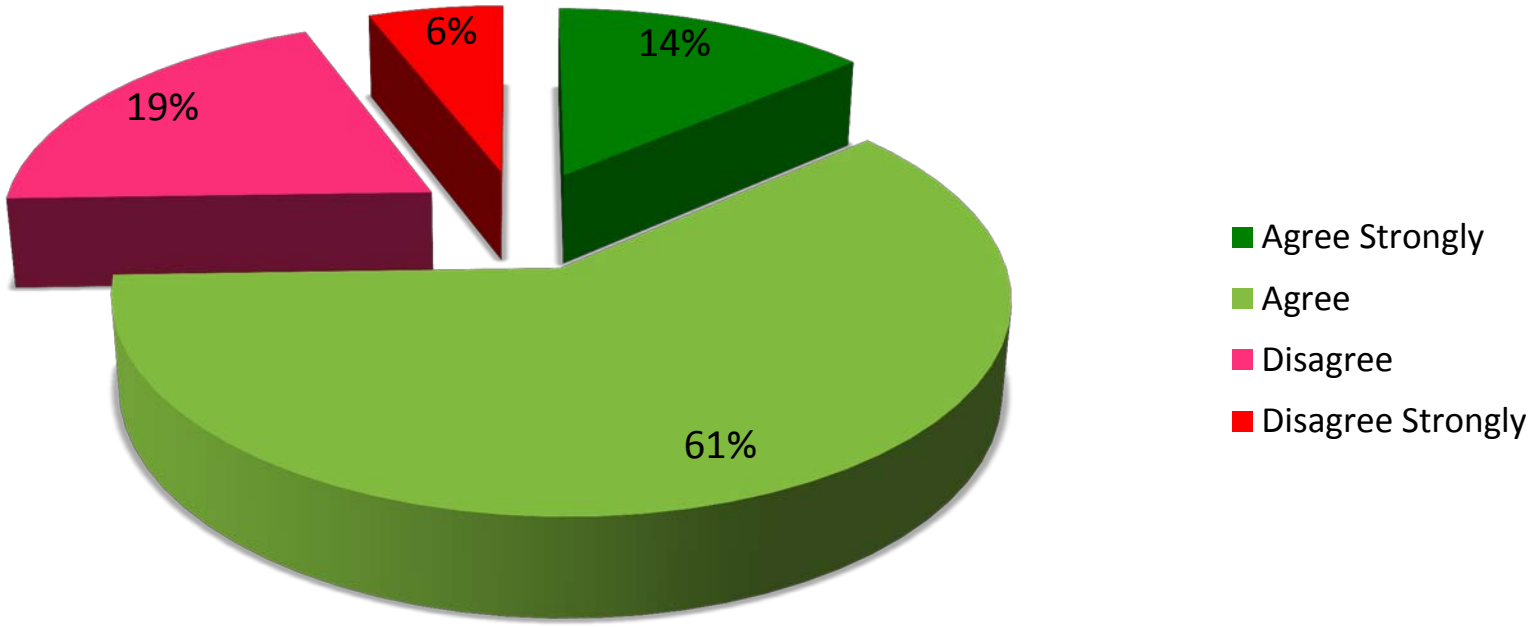
# Design for follow up After Hospitalization



# 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

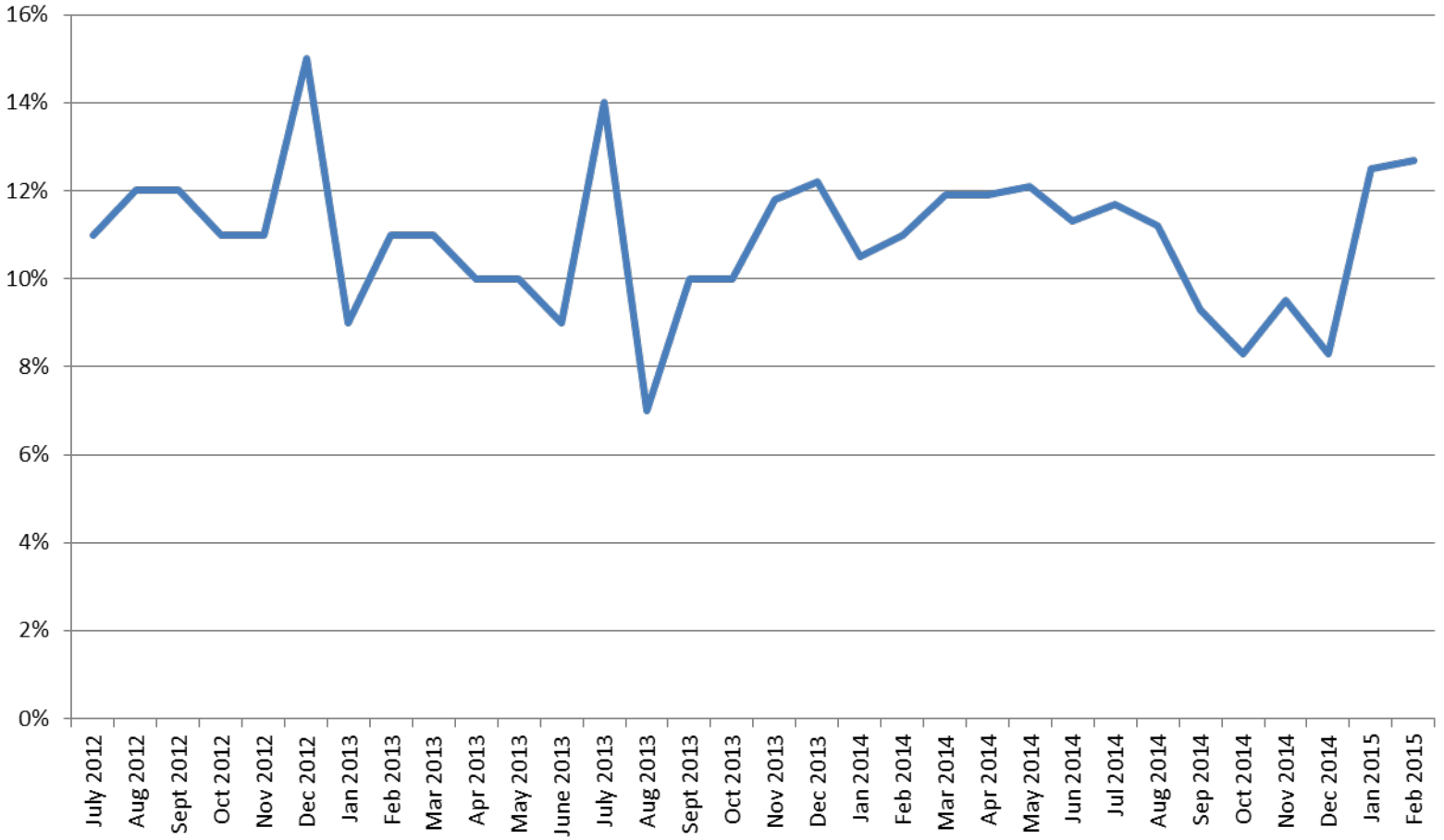
# When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.



# Gathering data after hospitalization (phone follow up)

| | | | |
|---|---|---|---|
| How are you feeling since leaving the hospital? | a. Improved | 80% | 60 |
| | b. No change | 15% | 11 |
| | c. Worse | 5% | 4 |
| | **Total** | | 75 |
| When is your follow-up | a. Aware of time of apogint | 68% | 51 |
| | b. Able to articulate basics | 35% | 25 |
| | c. In depth understanding | 4% | 3 |
| | **Total** | | 72 |
| Can you tell me what changes in your health might indicate a worsening condition, needing urgent attention? | Null | 11% | 8 |
| | a. Limited understanding | 54% | 38 |
| | b. Able to articulate basics | 31% | 22 |
| | c. In depth understanding | 3% | 2 |
| | **Total** | | 70 |
| Who would you call if you developed problems that would deserve urgent attention? Do you have their phone number? | Null | 10% | 7 |
| | a. Limited understanding | 45% | 31 |
| | b. Able to articulate basics | 42% | 29 |
| | c. In depth understanding | 3% | 2 |
| | **Total** | | 69 |

# 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

Susan Cumming, MD

Medical Director for Quality, Marin General Hospital

cumminss@maringeneral.org

Terry Winter, RN, MPH

Director, Care Transitions Program

Marin General Hospital

wintert@maringeneral.org

# Questions

Care Integration Resource Center
http://www.careinnovations.org/knowledge-center/facilitating-care-integration/