PCMH Regional Forum

Improving Patients’ Quality of Life through Improved Communications During Care Transitions

Fall 2014
Purpose

- Convene primary care practice, oncology, pulmonology, and cardiology care teams to identify action steps towards improving care transitions and quality of life for patients.
  - Beginning focus on people living with cancer, COPD and/or heart failure: top three conditions for placing patients at highest risk of readmissions.
Learning Objectives

• Identify challenges in care transitions that people living with cancer, COPD and heart failure experience

• Identify how care teams can improve communication and coordination of care between care settings to promote safe and effective transitions of care and improve patient/family quality of life

• Learn from others ideas for promoting better communications between care settings and patients for purposes of improving the transition experience

• Brainstorm potential solutions for improving coordination of care and decreasing potentially avoidable admissions or re-admissions for these patients

* 6 to MUTE, *7 to UNMUTE
Agenda

• Welcome/Introductions
  o Who is here?
  o Improving transitions for high risk patients: a case study
• Connecting the Dots: Round Table Discussions
• Debrief & Action Planning

* 6 to MUTE, *7 to UNMUTE
Who is Here?

- Specialists
- Practice assistants
- Patients
- Managers
- Educators
- Providers
- Specialty workers
- Medical staff
- Home care
- Health workers
- Social workers
- Care teams
- Navigators
- representing
- System
- care
- Social administrators
Mr. K. was a stoic 70-year-old with a few minor medical problems. His care was fairly straightforward — I was the only doctor he saw regularly — until the day he came into my office with flank pain and fever. A CT scan of his abdomen revealed a kidney stone — and a 5-cm mass in his liver, which a subsequent MRI indicated was probably a cholangio-carcinoma. Over the 80 days between when I informed Mr. K. about the MRI result and when his tumor was resected, 11 other clinicians became involved in his care, and he had 5 procedures and 11 office visits (none of them with me). As the complexity of his care increased, the tasks involved in coordinating it multiplied. I kept a running list and, at the end, created an “instant replay” of Mr. K.'s care.

In total...

- I communicated with the other clinicians 40 times (32 e-mails and 8 phone calls) and with Mr. K. or his wife 12 times. At least 1 communication occurred on 26 of the 80 days, and on the busiest day (day 32), 6 communications occurred.
Insert a video short of patient voice

- http://www.youtube.com/watch?v=cRAouvIlSQY
And Maine Patients are No Different: Results of Earlier Maine PCMH Pilot Pre Work: Knowledge of 11 High Risk Patients

<table>
<thead>
<tr>
<th>Patients</th>
<th>Diagnoses</th>
<th>Hospitalization Patterns</th>
<th>Reason for Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 yo male</td>
<td>Severe Crohns</td>
<td>4 in 3 months Jan-Mar ‘11</td>
<td>Pain control</td>
</tr>
<tr>
<td>67 yo Female</td>
<td>COPD, CHF, Depression, DM, HTN, HypoThyroid</td>
<td>5 Last 4 years</td>
<td></td>
</tr>
<tr>
<td>73 yo Female</td>
<td>DM, HTN, Afib, RF, CAD, hyperlipidemia,</td>
<td>9 in 12 months 2010</td>
<td>Does not know who to call and when , early symptoms to watch for</td>
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<tr>
<td></td>
<td>admitted with acute infection</td>
<td>2 hosp&gt; 2 wk LOS</td>
<td></td>
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<tr>
<td>56 yo Male</td>
<td>Multiple chronic illness – admitted with acute infection</td>
<td>Readmission within 7 days post hospital d/c</td>
<td>Stopped taking med due to financial issues</td>
</tr>
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<tr>
<td>79 yo Female</td>
<td>Multiple Chronic Illness</td>
<td>4 in 4 months (Jan-April 2011)</td>
<td>Patient not able to follow med instructions. In addition to discharge discrepancies.</td>
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<tr>
<td>84 yo Female</td>
<td>DM, Hyperlipid, Dementia, CVA</td>
<td>2</td>
<td>No caregiver support for adherence to meds, diet, ADLs</td>
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<tr>
<td>40 yo Male</td>
<td>CHF, EF 15% Cardiomyopathy, Crohns, Bowel Res</td>
<td>5 in 3 months since end March</td>
<td>Cannot stay within fluid restriction – feels needs it. Poor absorption oral Lasix.</td>
</tr>
<tr>
<td>40’s yo Male</td>
<td>Pancreatitis, ETOH, chronic pain, Whipple, DM, anxiety, depression, suicidal ideation, gastritis, AFib</td>
<td>17 in 12 months May 2010-May 11 Plus 5 ED evals</td>
<td>Barriers care management by phone calls, PCP appts. CM - 23 phone calls attempt – 5 successful contacts. 8 of 23 appts kept. Substance abuse and mental health care management gaps.</td>
</tr>
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<tr>
<td>48 yo Female</td>
<td>Factor V Leiden deficiency, DVT, DM, COPD, CHF, Depression</td>
<td>4 in 3 months March – May 2011 DVT, COPD 5 Specialists</td>
<td>Cannot stay within fluid restriction – feels needs it. Poor absorption oral Lasix.</td>
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<tr>
<td>59 yo Male</td>
<td>CAD, CHF, CVA, HTN, Venous Ulcer, GERD, OSA, Peripheral Neuropathy, Obesity, Afib, Diverticulosis, Hyperlipid, DM, COPD, Valve Replacement</td>
<td>2 in 4 months Feb – May 2011 2 hospitals</td>
<td></td>
</tr>
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</table>
Themes and Considerations

• Poor transfer of information to patient:
  ➢ Poor patient understanding of how to use medications after hospital discharge
  ➢ Patient doesn’t understand warning signs that warrant an emergency call to their physician or self care plan implementation
  ➢ Patients do not have a coordinated medical plan of care shared with others

• Poor handovers and communication within and between settings
  ➢ Among and between hospitals and EDs, primary care, specialists, care managers, nursing homes, patient/caregivers

• Lack of clarity on end of life care preferences – palliative and long term care planning gaps

• Gaps Mental Health Assessment |Management- Patient & Caregivers
Some Certainties

- You will not be able to help your patients during transitions without understanding factors leading to breakdowns
  - one patient at a time

- Improving transitions cannot be done within the walls of primary care—it takes a medical “neighborhood”
  - cross continuum case reviews and improvement meetings

- Must understand the big picture factors, while focusing on specific challenges and their solutions
  - workflows integrating best practices across settings
It’s Complex!!
Tonight’s Focus

- Connecting the Dots through Roundtables
  - Streamlining communication between care settings to improve transitions of care for patients, families and care givers
  - Streamlining communication between care settings and patients to improve transitions of care for patients, families and care givers
Connecting through Roundtables

- Look on the back of your name tag.
- Those representing specialty care practices will have a red dot and a number (the number represents the roundtable you will attend). Others will have two numbers.
- As we want a specialty presence in each group, we have split those from the specialty teams so that there is at least one at each table.

* 6 to MUTE, *7 to UNMUTE
Connecting through Roundtables

- The specialty care team member will not rotate and will serve as the continuity between round tables.
- Others have two numbers—the first is the first roundtable you will join and the second number the second roundtable.
- When you arrive at the table:
  - Select a table facilitator who, along with the specialty care practice team member, will also stay at the table. (Note: They can be the same person.)
  - Select a table recorder to record high level notes on flip chart paper.
CONNECTING THE DOTS: IMPROVING TRANSITIONS BY IMPROVING COMMUNICATIONS BETWEEN SETTINGS

Round Table 1
Conversation Starters

- Begin with introduction. “Hello, I am ______________. I think that our organization’s (state organization name) biggest strength related to communicating with other settings on behalf of better patient transitions of care is ___________.”
- Each describe his/her perspective and what it is important for others to know about communications with them to help improve patient care transitions.
- How consistent are the messages for family’s throughout the continuum of care?
- Group identify some (at least 3) improvement opportunities for better communication. Recorder, with help of group, gather information on flip chart paper.
CONNECTING THE DOTS: IMPROVING TRANSITIONS BY IMPROVING COMMUNICATIONS BETWEEN SETTINGS AND PATIENTS
Conversation Starters

- Begin with introduction. “Hello, I am _____________. I think that our organization’s (state organization) biggest strength related to communicating with patients and engaging them in their care transitions journey is __________.”
- How does your organization make choices easy for patients?
- How could you work together to make them easier?
- Group identifies some (at least 3) improvement opportunities for better communication with patients. Record, with help from group, gathers information on flip chart paper.
Round Table 3

FINISHING TOUCHES
Round Table 3

- Share with your team any insights you gained, ideas you can use, or new ways of promoting communication between sites and with patients to improve transitions.
- With your team, develop one thing that you can change/improve immediately.
- Complete the change worksheet. Leave one part of the two-part change form with faculty.
Closing

- Debrief
- Next Steps
- Adjourn