Primary Care’s Role in Transitions of Care
Oxford Hills Family Practice

Cardinal Grant 2010
Stephens Memorial Hospital joined efforts with Maine Health to improve patient transitions

Stephens Team Members
September 1, 2010
Senior Leadership: Kathy Bonney
• Shelley Shibles, Quality and Safety Specialist
• Robin Green, Social Services
• Steve Charles, Pharmacy
• Kyle Phillips, Practice Manager
• Jane Frost, RN, Care Transitions Coach
• Sue Rosenberg, RN, Med/Surg, Home Health Agency Nurse
• Anita Day, RN, Manager Med/Surg
• Gayle Castonguay, RN Home Health
• Melanie Corbett, RN
• Alison Danforth, RN, Long Term Care
• Jodi Wilson, Physical Therapy
• Jen Bennet, Occupational Therapy
• Suneela Nayak, RN, Maine Health CQS
Project BOOST

Adoption of risk assessment tools
Information flow from Meditech to the ambulatory EPIC EMR
Phone call within 48 hours to all patients discharged to pilot practice, Oxford Hills Family Practice
Addition of Patient Care Facilitators (PCF’s) at SMH

Project RED

Process Improvements

Adoption of risk assessment tools
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Addition of Patient Care Facilitators (PCF’s) at SMH
Provider Strategies

- Timely follow-up visit within one week
- Follow-up phone calls to review medications, scheduled appointments
- Targeted interventions, referral to Care Transitions RN when indicated
- Include local nursing homes, to improve communication between hospital and nursing homes

Cross Continuum Team Today:

Increased:
- Comfort
- Trust
- Teamwork attributes
- Engagement
- Patient and family involvement in care decisions
- Communication between hospital, PCP practice, nursing homes, care managers and home health services

No single magic bullet

Corner stones:

1. Cross continuum teams
2. Transitions of Care Bundle
Cross-Continuum Team Collaboration

- Transformational hallmark
- Common goal of keeping patients safe during transitions between care settings and to coordinate care
- Meet regularly to facilitate communications, assess progress, remove barriers and support improvement efforts

MaineHealth Transitions of Care Bundle

1. Risk stratification for readmission
2. Transition Checklist
3. Medication reconciliation
4. Patient/family health education
5. Timely communication among hospital and post-hospital providers
6. Timely follow-up of patients

Risk Assessment Tool: The 9P Risk Scale

Done on admission but revised throughout stay if risks change.

- Prior hospitalization: in last 6 months
- Problem medications: anticoagulants, insulin, aspirin & clopidogrel, digoxin, narcotics
- Polypharmacy: > 5 routine medications
- Principal diagnosis: cancer, stroke, DM, COPD, heart failure
- Punk (depression): screen positive or diagnosis
- Poor health literacy: unable to do Teach Back
- Patient support: absence of caregiver to assist with discharge & home care
- Falls
Successful Hand-offs…

Involve:

• Improved transitions out of the hospital

• An activated and reliable reception into the next setting of care.

So…

How has all this improved outcomes for our patients?
Lessons Learned:
What makes for success?

- Regular participation in Work Group Meetings
- Having key players at the table such as case managers, families, community supports
- Empowering staff through education to be pro-active decision makers
- Collaborative Communication
- Supportive Physicians & Medical Staff

Summary

- Readmission is a quality of care issue
  - Impacts patient safety, satisfaction
- Health care cost impact considerable
  - Hard to quantify as “optimal” rate of readmissions undefined
  - Progressive financial penalties for hospitals
- Best practices defined
- Challenge is in coordinating our efforts, both locally and system-wide
- Stephen’s Hospital initiatives most promising
- Board knowledge and oversight paramount