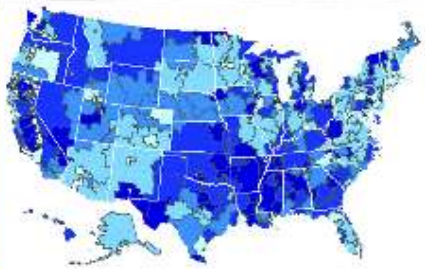
MAINE MEDICAL PARTNERS



Maine Medical Partners Care Transition Program

Debra McGill, RN

Population Health Manager

CARE TRANSITIONS DEFINED

- Refers to the movement of patients from one health care setting or provider to another
- Can be a time of great risk for error

WHY IS THIS IMPORTANT

"A common result of a failed discharge is a subsequent hospital readmission"

JUST THE FACTS

- Nearly one in five Medicare patients are readmitted within 30 days*
- Translates to approximately 2.6 million seniors at a cost of over $26 billion every year*

* Roadmap to Fewer Readmissions. available at www.healthcare.gov

WHY CARE TRANSITIONS

Medicare payment penalties for hospitals with high R/A rates for:

- Congestive Heart Failure
- Community Acquired Pneumonia
- Acute Myocardial Infarction

WHY CARE TRANSITIONS

It’s the right thing to do

Components of a Safe Transition: Effective & Efficient Communication

BARRIERS TO A SAFE TRANSITION

- Fragmented communication
- Lack of collaboration across settings
- Limited resources
- Sicker patients
- Aging population

PATIENT ROLE IN SAFE TRANSITIONS

- Patients and their caregivers are the most constant element in transitions
- Their contribution is essential to safe and effective transitions
- Post discharge care must be patient centered

PATIENT CONSIDERATIONS

The patient & caregiver need:

Sufficient information

- What just happened to me?
- What medications am I supposed to take?
- Who do I need to see and when?
- How will I get the results of my pending tests?
- Do I need any additional outpatient testing?
- Does my doctor even know I was sick?

PCP ROLE IN SAFE TRANSITIONS

- To reach out to patients who are experiencing transitions
- To provide prompt follow-up
  - over 50% of patients R/A within 30 days had not yet had a PCP follow up visit,
  - 70% of those were admitted within 2 weeks [1]

[1] *URMC – Reducing Hospital Readmissions, You-Tube Video

PCP CONSIDERATIONS

The Primary Care Provider needs:

Sufficient information

- Timely notification of hospital admission/discharge
- Summary of the key components of the patient's hospitalization
- Timely follow-up with the patient to ensure a smooth transition

WHAT PRIMARY CARE CAN DO

- General solutions are based on common sense*:
  - Target high risk patients early
  - Improve communication within care team (including patient & caregiver)
  - Discharge instructions
  - Make/Maintain contact after discharge

Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

MMP CARE TRANSITION PROGRAM

Objective:

To promote effective transitions for MMP patients when being discharged from an acute inpatient setting to home.

PROGRAM DEVELOPMENT

PROGRAM SCOPE

Patients:

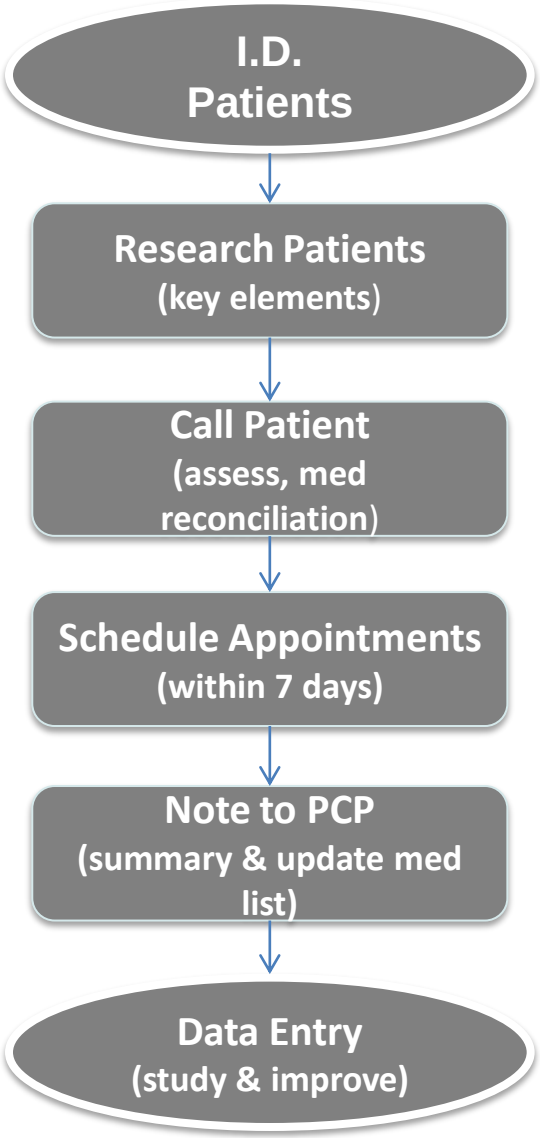
- Adult Internal Medicine
- Family Practice MMP
- MH MMP Cardiology

Discharge:

- Maine Medical Center

Service:

- Medical
- Surgical
- Cardiology



PROGRAM FOCUS

- Improve patient transition from hospital to home
- Decrease known risks for patients:
  - Medication discrepancies
  - Lack of communication with PCP
  - Lack of resources (knowledge, money, assistance)

PROGRAM GOALS

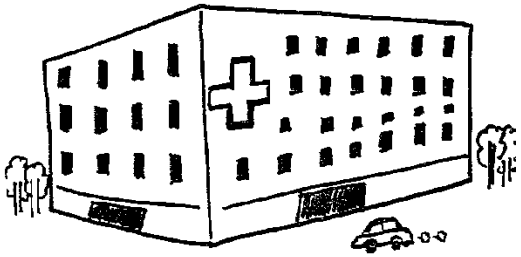
Help patient/caregiver to

- be knowledgeable about medication regimen
- complete early F/U care with PCP and/or specialists
- have basic understanding of his/her medical condition
- be knowledgeable about red flags and how to respond

HOW IT WORKS

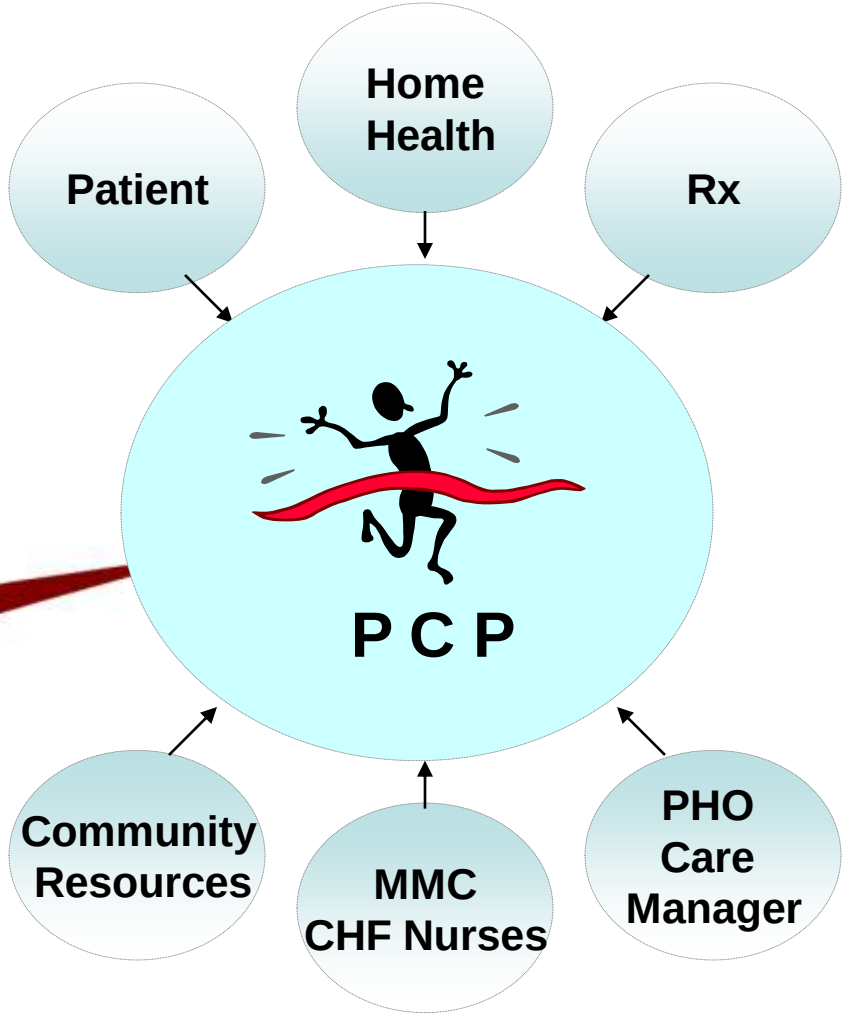
Put old technology to new use:

HOW IT WORKS



Hospital Discharge

MMP Care Transition Nurse



PROCESS

- Patient receives an intense telephone intervention
- Can be brief, but can be powerful; patient centered

INTENSIVE TELEPHONE INTERVENTION

Medication Reconciliation

- Review hospital discharge instructions & discharge summary
- Review PCP EMR
- Ask the patient “what are you ACTUALLY taking?”

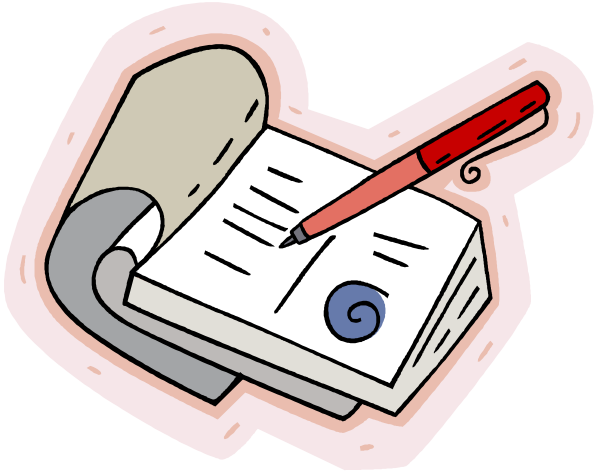
INTENSIVE TELEPHONE INTERVENTION

Ensure Early Follow-Up

- Schedule if no appointment made
- Change what was scheduled
- Confirm what was scheduled

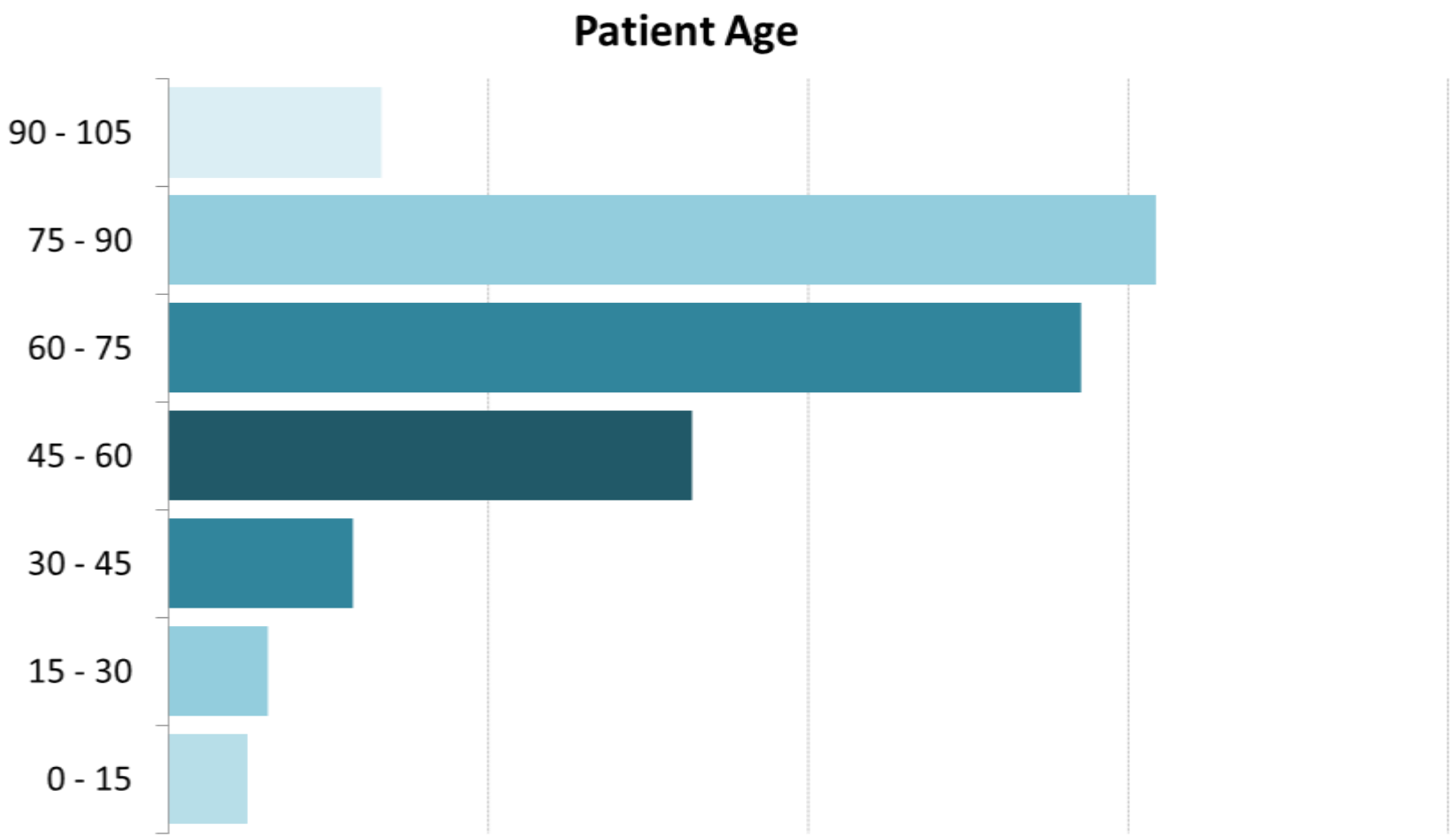
INTENSIVE TELEPHONE INTERVENTION

- Confirm ordered services have been initiated
- Identify lack of resources
- Make referrals as necessary
  - Home Health Care
  - Community Services
  - Med Access

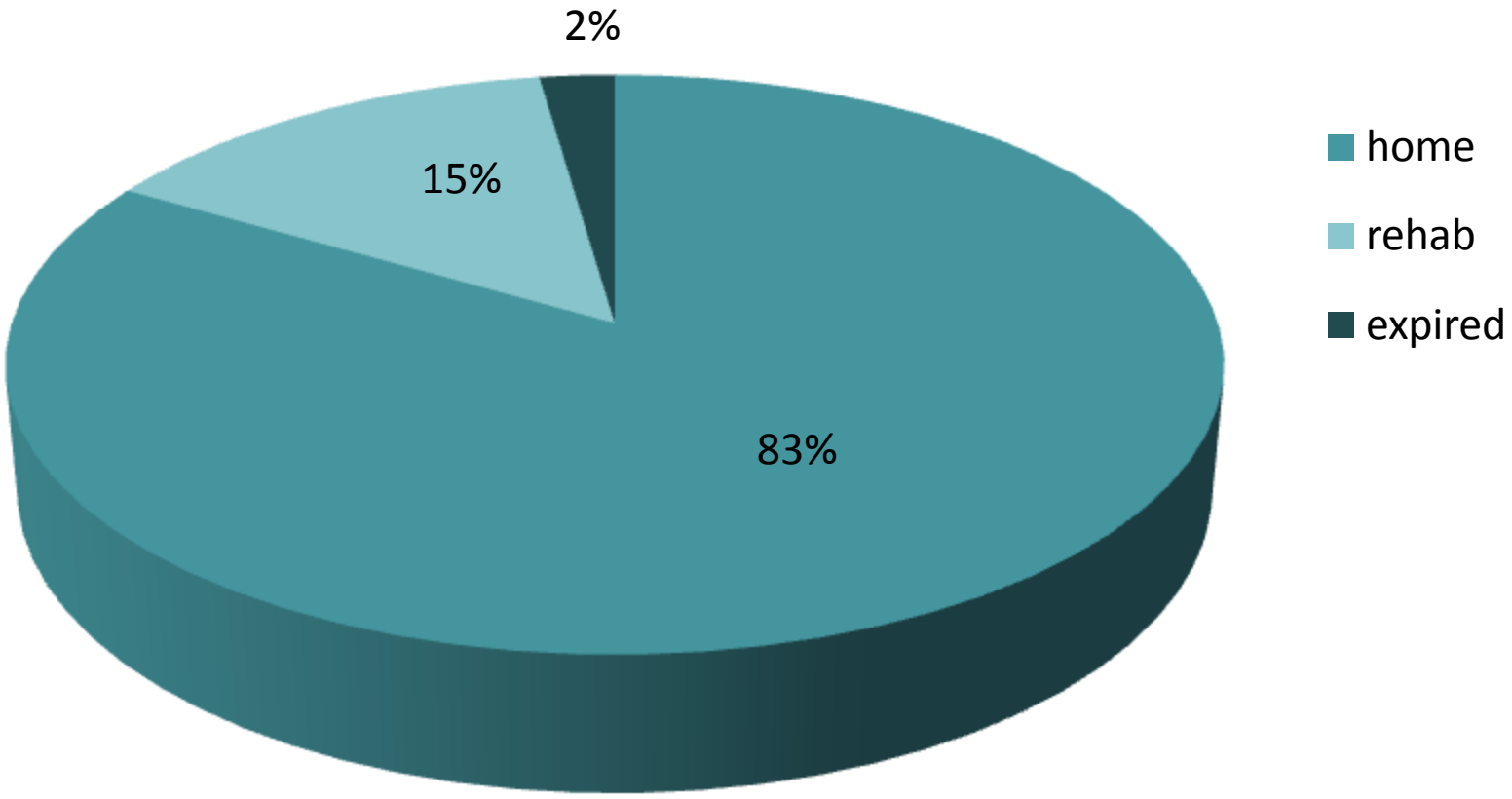


Who Are Our Patients?

AGE GROUPS

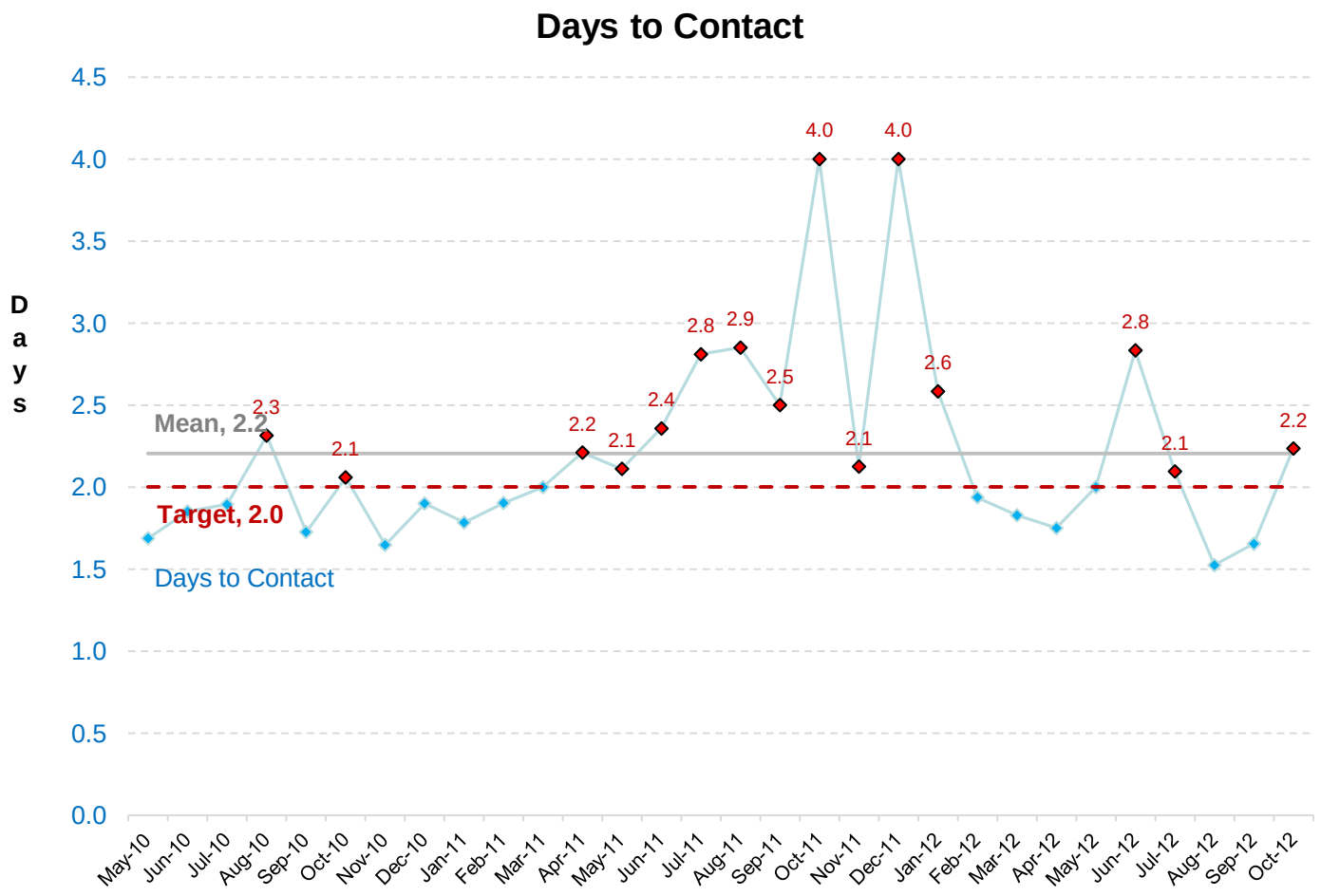


DISCHARGE TO LOCATION

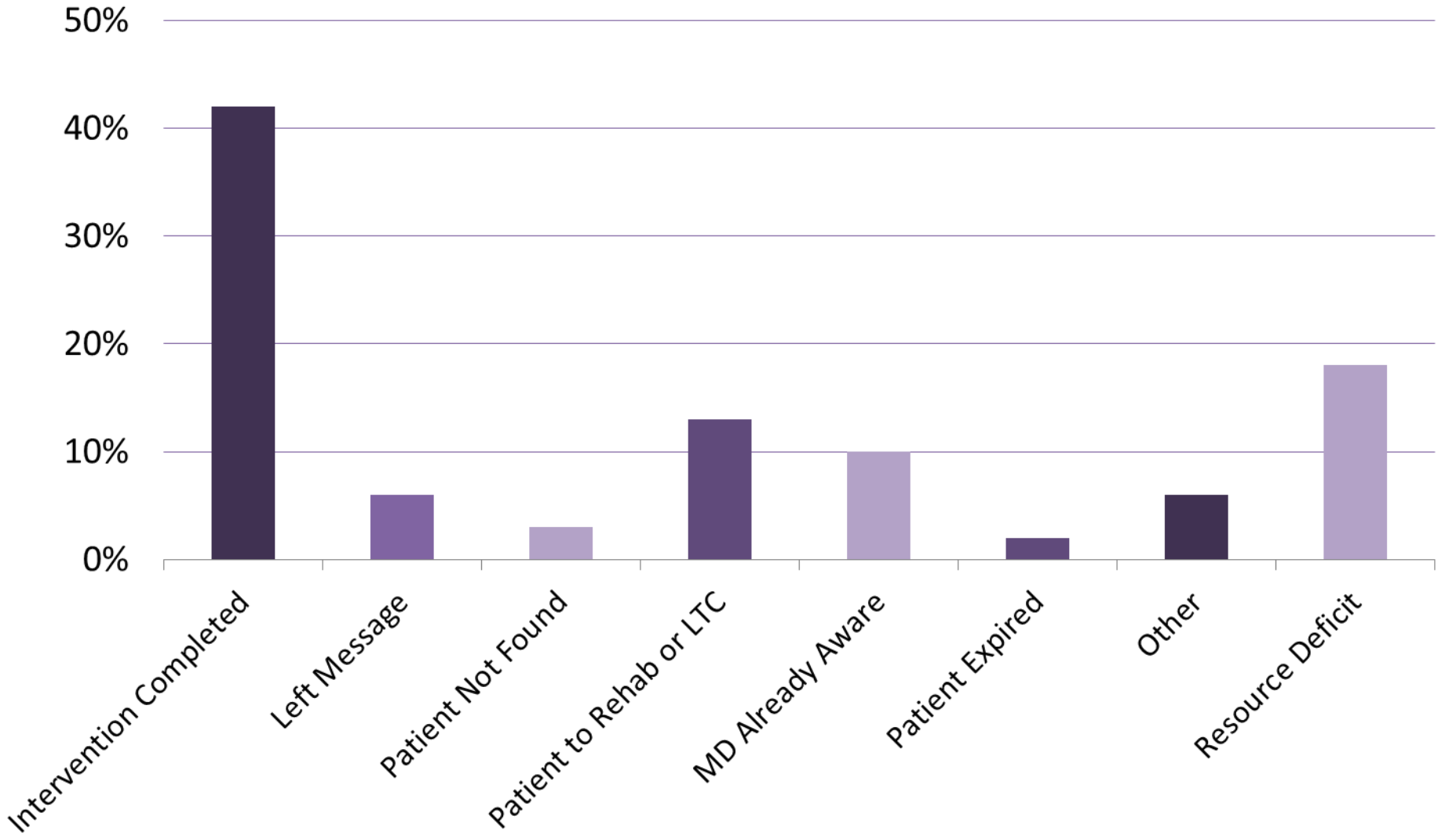


Discoveries

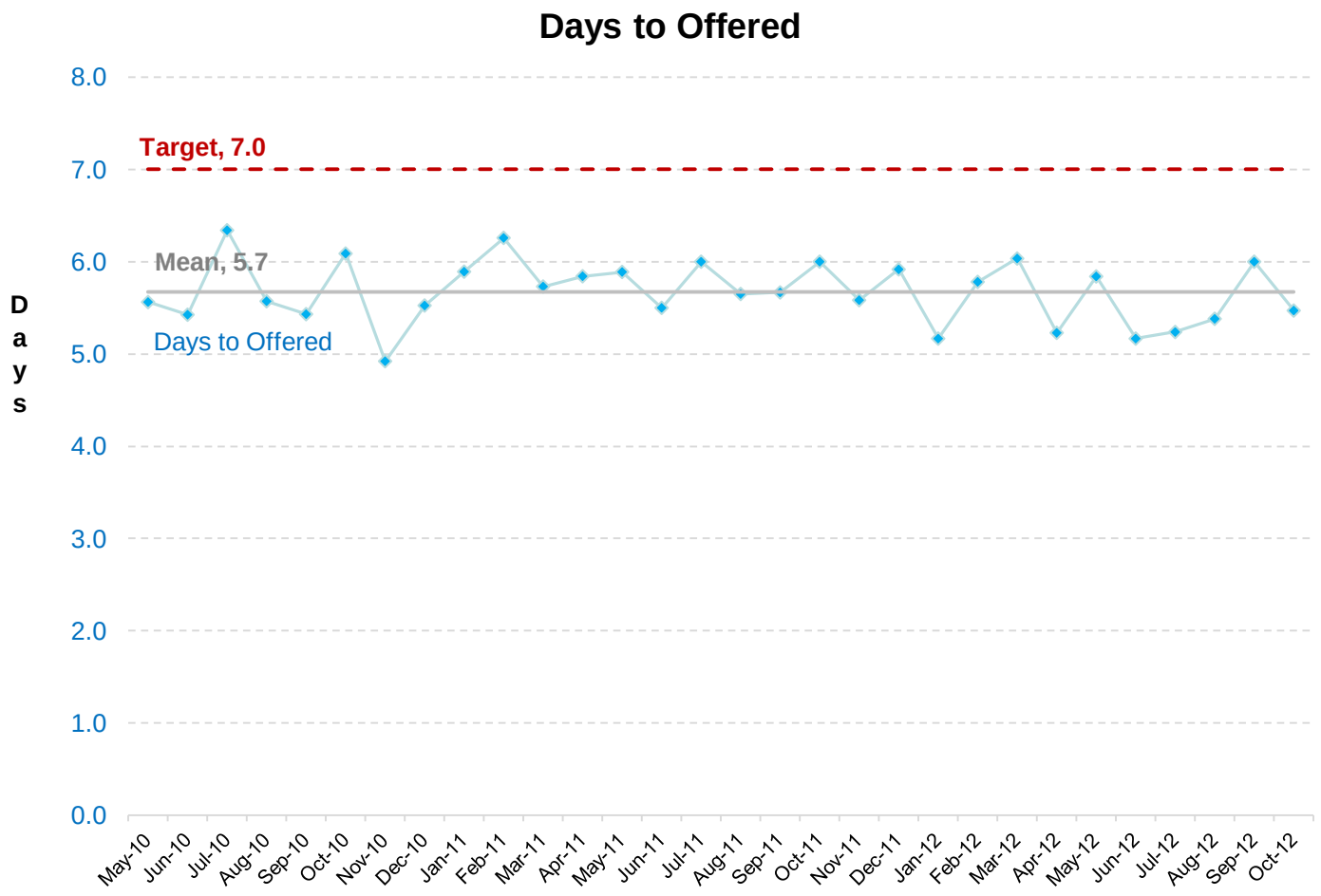
DAYS TO FIRST CONTACT



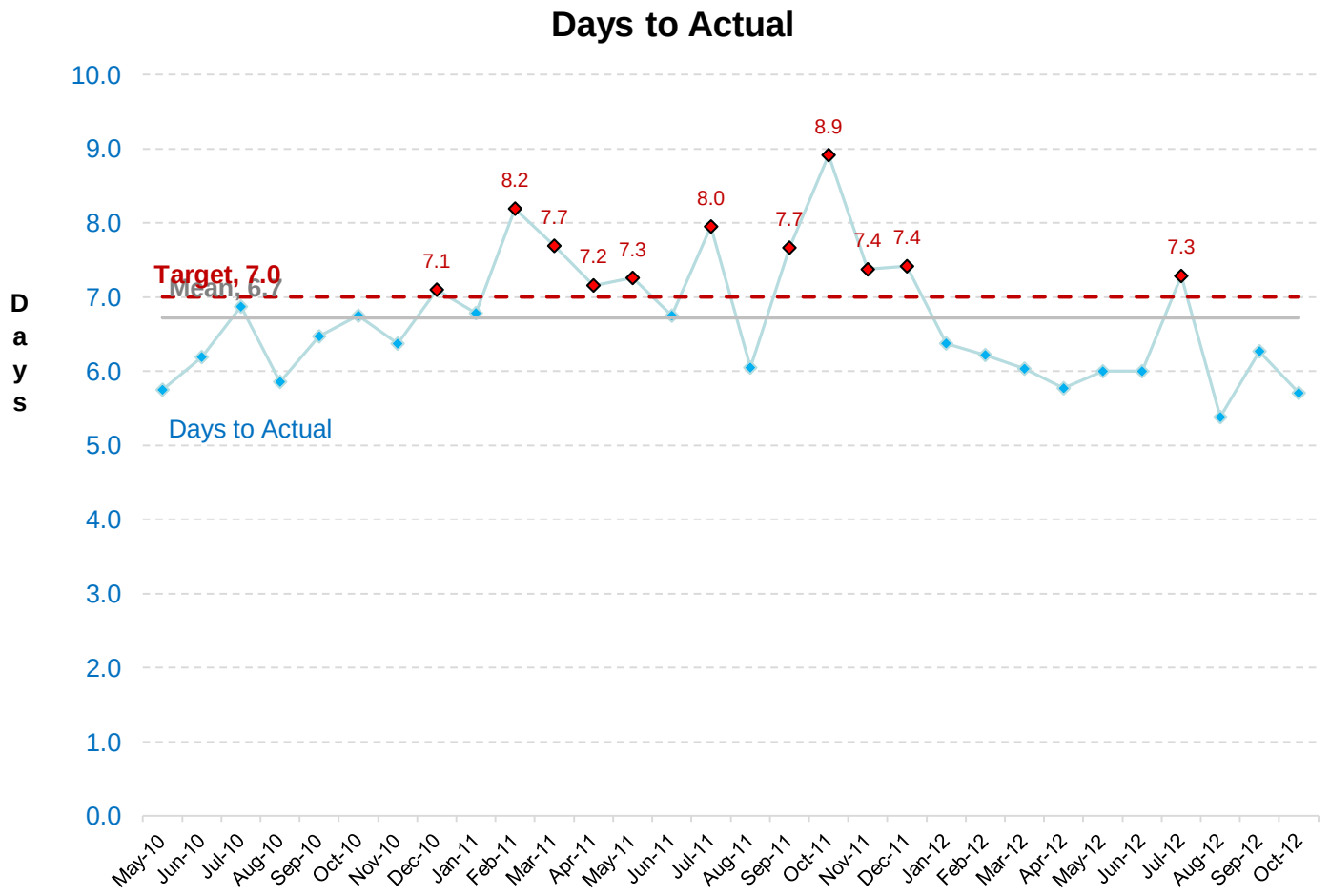
COMPLETE CONTACTS



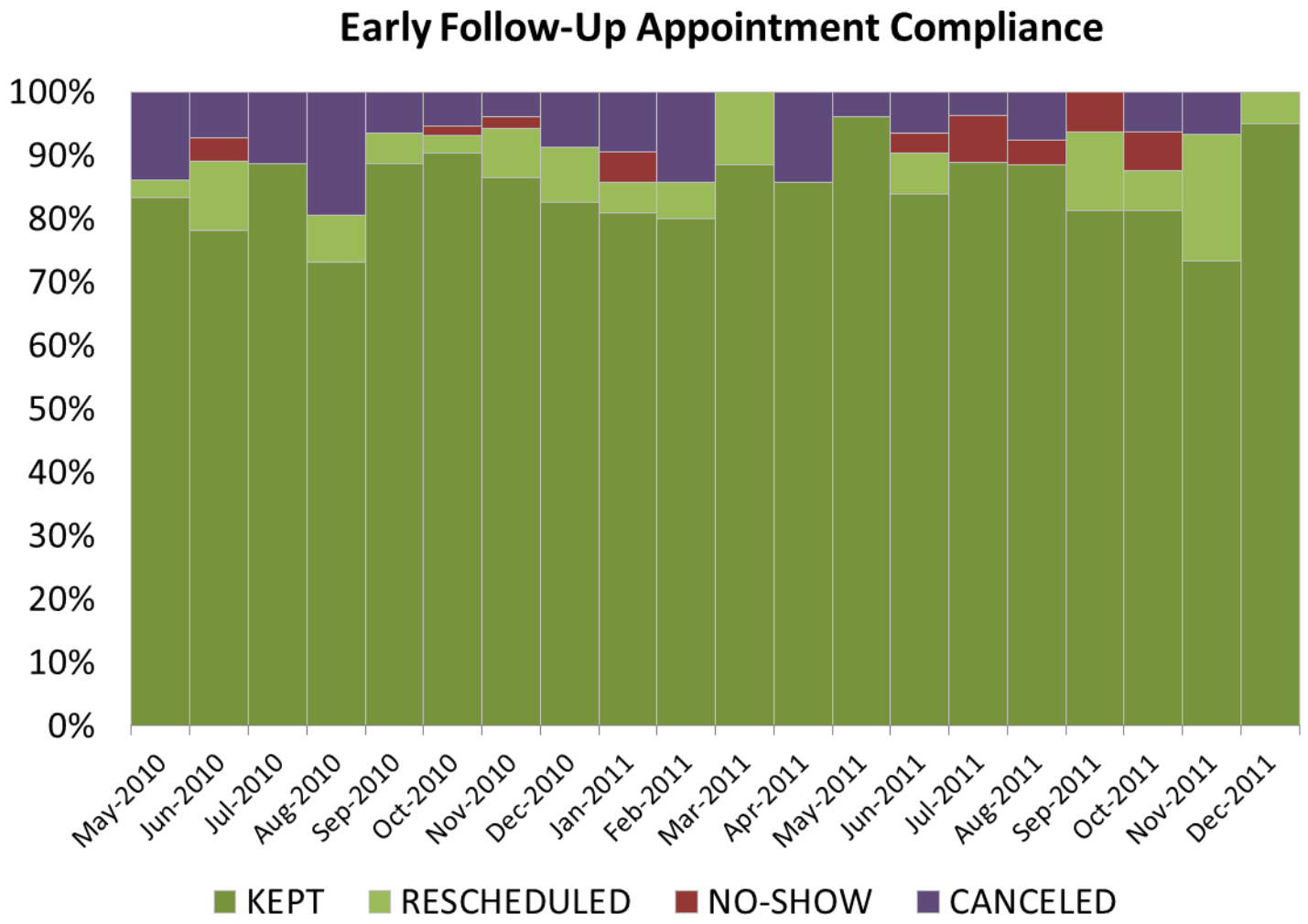
DAYS TO FIRST OFFERED



DAYS TO FIRST ACCEPTED



APPOINTMENT COMPLIANCE



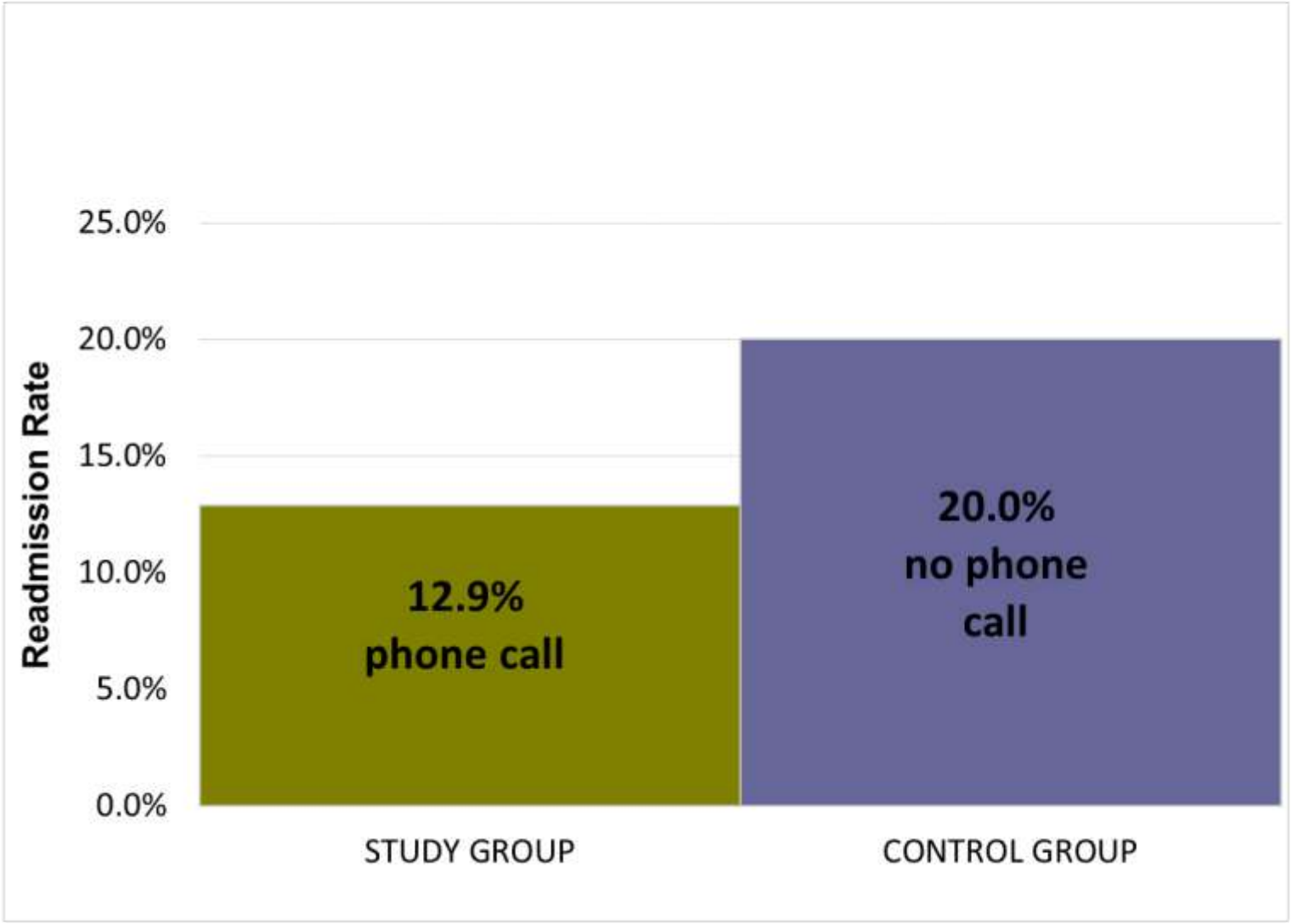
INTERVENTION REQUIRED

9.7 % of our patients require an intervention beyond what is standardly expected

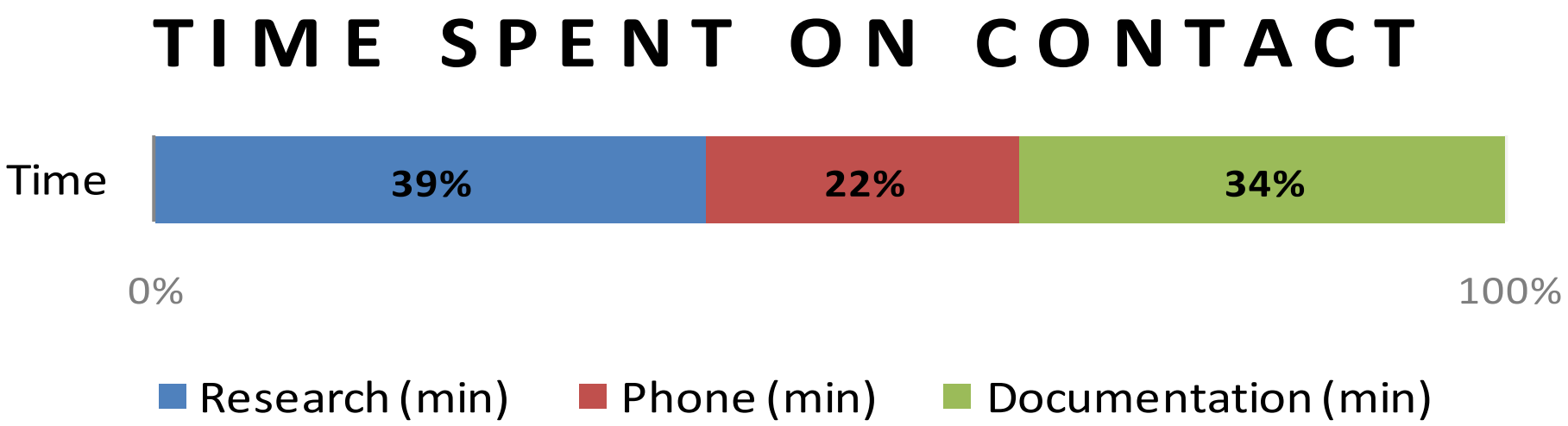
- F/U home care
- F/U provider
- F/U community resource

More likely to readmit

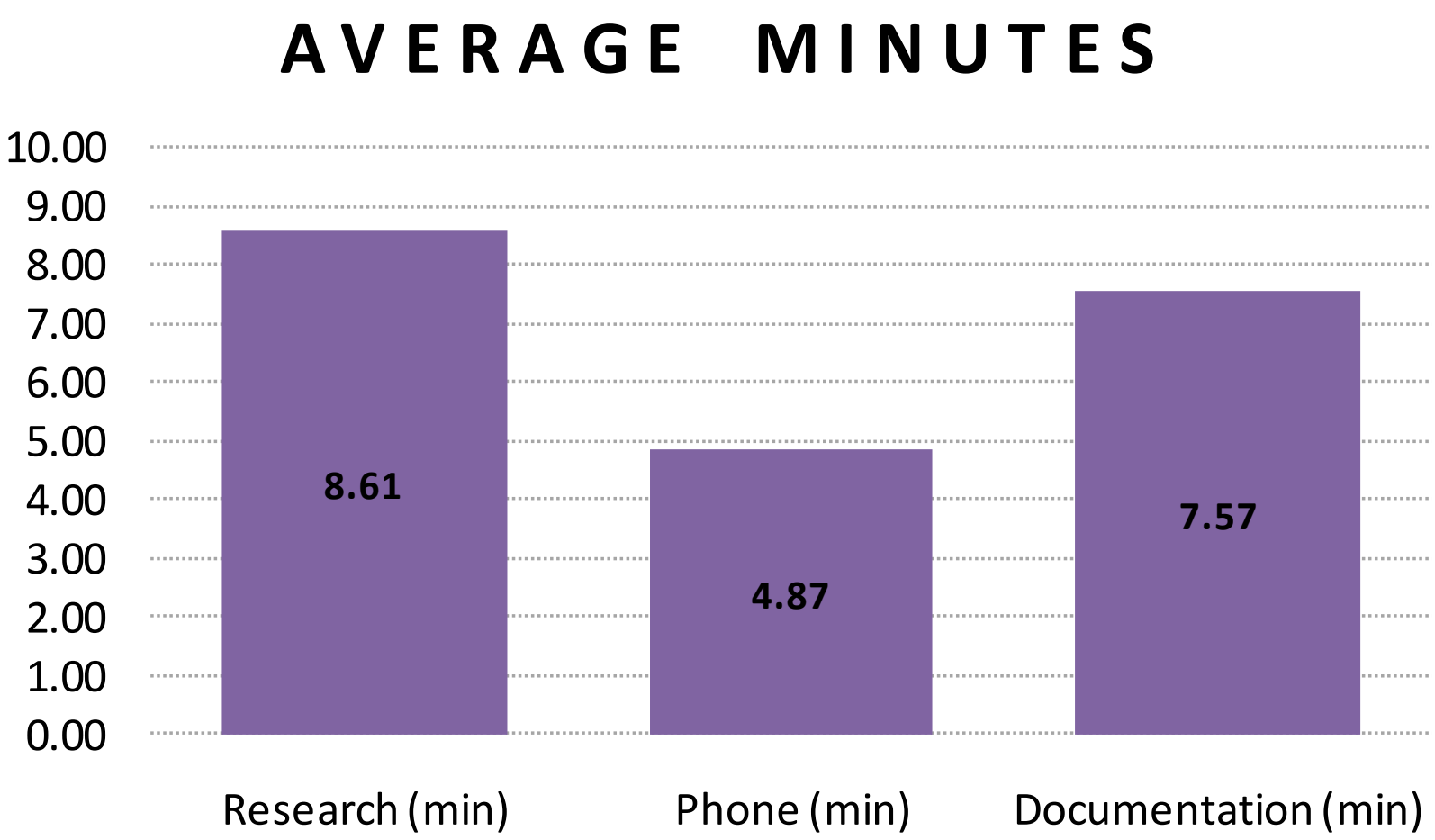
READMISSION RATES



RESOURCES


TIME SPENT ON CONTACT
Time
39%
22%
34%
0%
100%
Research (min)
Phone (min)
Documentation (min)

RESOURCES

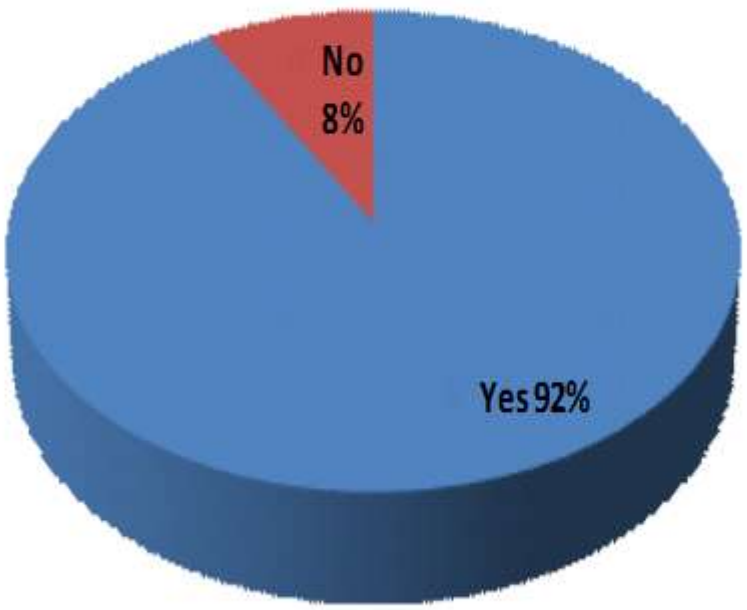

AVERAGE MINUTES
10.00
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
8.61
4.87
7.57
Research (min)
Phone (min)
Documentation (min)

Next Steps

PROVIDER FEEDBACK

MEDICATION RECONCILIATION

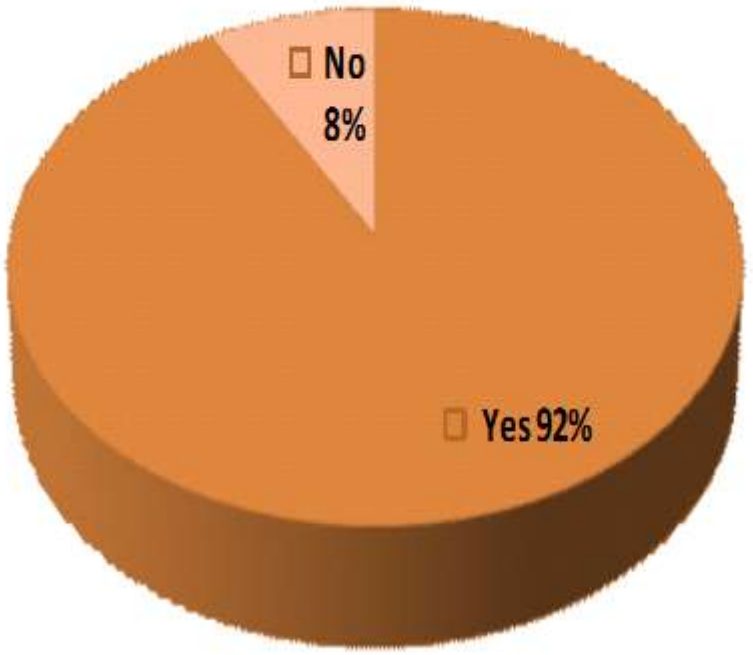
Do you find the process of performing medication reconciliation with patient during the Care Transition phone call is helpful in reducing the number of medication discrepancies you find at the patient's hospital f/u visit?



PROVIDER FEEDBACK

VOLUME OF POST-HOSPITAL FOLLOW-UP CARE QUESTIONS

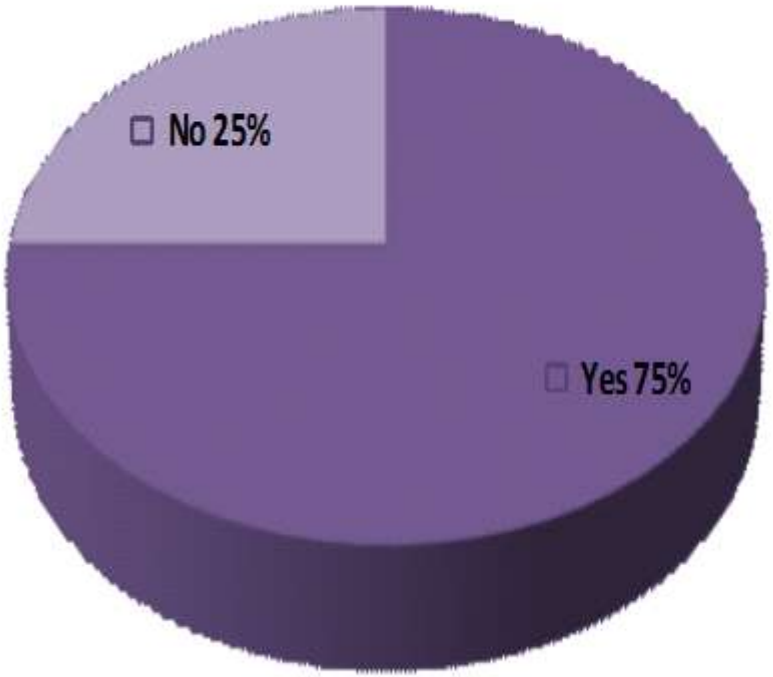
Do you find that the process of providing Care Transition telephone calls to your patients reduces the number of questions they have regarding their post-hospital follow-up care?



PROVIDER FEEDBACK

NOTIFICATION OF PCP FOR LONG TERM CARE PATIENTS

Do you want to be notified when your patient, who resides in a long term care facility, is admitted and/or discharged from the hospital?



NEXT STEPS

- Program redesign
  - risk-based
- Expand scope to include
  - ED Discharges
  - Rehab Discharges
  - Specialty Practices

FINAL THOUGHTS

- System is is moving away from pay for volume
- Important to consider more than just financial savings
- Reducing readmissions reduces patient pain & discomfort
- Ultimate goal is to reduce the burden of people's illness

Q & A