St. Jude Heritage Healthcare:

Bridging Care from the Hospital Back to the PCP

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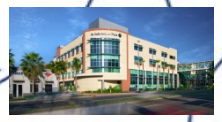
St. Joseph Health
St. Jude Heritage Healthcare

St. Jude Heritage Medical Group: Who we Are

- Integrated Delivery Network
- 72,000 patients

St. Jude Heritage Medical Group
Who we Are



Why Care Transitions are Important to Us

- Improve quality of care
- Improve patient experience
- Decrease ED costs/readmissions/ALOS
- Strategic focus on Population Health Management in preparation for upcoming renewal of contracts that will be full risk
- A top priority for the Integrated Delivery Network

Aim Statement

To create a post discharge clinic model that allows our complex, high risk patients a smooth transition from the hospital to home, as well as to reduce unnecessary ER visits, readmissions and unnecessary Observation holds.

Post Discharge Clinic Model

- Initial part-time efforts May 2012
- Full-time, M-F 8a-5p starting November 2013
- St. Jude Heritage Medical Group & Affiliated Network patients, all payors
- Patients seen 48-72 hours post discharge
- 1 hour joint visit with MD, Pharmacist and RN Care Manager (40 minute MD slots)
- Short-term (1, maybe 2 visits), high intensity
  - Available procedures: IM Rocephin, nebulizers, IM Toradol & Phenergan, IM Dexamethasone, IV fluids for hydration, simple wound care (dry dressing)

Some more details

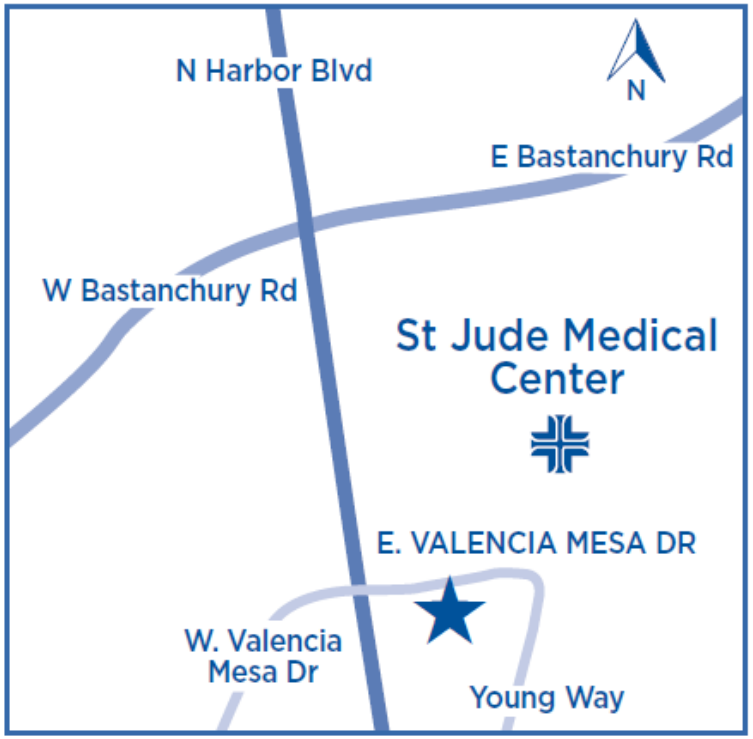
- Initial weekly workgroup (facilities, operations, clinical, care management, pharmacy) with a project manager
- Every 2 weeks, then transitioned to manager; now monthly (just care team)
- ROI conducted to leverage hospital resources (executives)

Target Patient Population

Patients are identified/stratified by:

- Automatically scheduled if LACE score 10 or greater (all payors, any disease category)
  - Length of Stay
  - Acuity of admission
  - Co-morbidities
  - ED visits in previous 6 months
  - Scores range from 1-19 and predicts rate of readmission within 30 days
  - Report automatically generated daily
- Also accept referrals (ED, SNF, home health, etc.)
  - Any readmission, any diagnosis
  - 2 emergency department visits in 1 month
  - All patients with diagnoses of CHF or COPD exacerbations
  - Complex medical diagnoses with high risk medications
  - Patient discharge directly from Step Down or ICU/CCU

Transitional Medical Clinic
Bridging Your Care from the Hospital Back to Your Doctor



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Valet or self-parking available.

St. Joseph Health
St. Jude Heritage Medical Group

www.sjhmg.com

YOUR NEXT APPOINTMENT

Patient Name: _____

Appointment Date: _____ Appointment Time: _____
(please arrive 15 minutes prior)

Name of Doctor: _____

Please bring the following to your appointment:

- All hospital or nursing home discharge information, including your medication list.
- All prescription and non-prescription medication bottles you have at home including:
  - Medicines prescribed by any health care provider
  - Vitamins
  - Herbal drugs
  - Over-the-counter medications
- All unfilled written prescriptions given to you by a doctor or when discharged from the hospital.
- A family member or other person who is actively involved in your health care.

Talking Points

1. **The TMC is a one time visit to bridge care from the hospital to your primary doctor.**

2. **The physician works with your primary doctor to answer all of your medical questions and keep you home.**

3. **The TMC physician lead team will spend 30-60 minutes with you at your appointment. This team includes the doctor, pharmacist , nurse care manager and clinical social worker.**

4. **All of your medications will be reviewed and coordinated to meet your ultimate goal of feeling better.**

5. **The team will assist in coordinating your appointment with your primary doctor and ensure that he/she receives a report of your visit.**

Post Discharge Team and Roles

- ✓ Rotating hospitalists (additional stipend)
- ✓ Pharmacist
- ✓ RN Care Manager Supervisor
- ✓ 1 Front Office/Medical Assistant Combo
- ✓ 1 Medical Assistant
- ✓ 1 Office manager (shared with other offices)

Communicating with the Hospital

- Order not needed
- Patient Care Coordinators schedule appointments at bedside upon discharge
- Appointment date/time appears on Discharge Plan
- Hospital discharge summary sent to PCP and available in EMR for any doc to see.

Working with PCP Offices

- Post discharge clinic staff make follow-up PCP appointments
- Task sent through EMR to PCP office notifying of ED visit or hospital discharge and date of post discharge appointment
- PCP offices given list of patients with post discharge appointment to call and encourage keeping their post discharge appointment before coming back to PCP
- Post discharge progress note sent to PCP (EMR for medical group; fax for affiliates)
- Medication reconciliation happens real-time by pharmacist so patient returns to PCP with accurate medication list

Care Management Documentation

TMC Phone Contact: [date]
Contact was with [patient] [spouse] [caregiver]
TMC Appt [date]

PCP Appt [date]
Specialist referral to [TypeTextHere] [appointment date] [coumadin clinic]

Discharge from [hospital] [SNF] [out of network]**:** [date]
Discharge Dx: [TypeTextHere]
Acute care facility [St. Jude][CHOC] [Placentia Linda] [St. Joseph] [UCI] [UCLA] [USC] [TypeTextHere]
Consulting Physician(s): [TypeTextHere]
Discharged [home] [to Greenfield] [to Park Vista] [to St. Elizabeth] [to Fullerton Post Acute] [to Emeritus] [to Mirade Hills] [to Terrace View] [to Kindred] [Windsore Gardens] [Mission]

[No interventions]
Medication reconciliation [discontinue:] [counseling for new Rx of:]
Patient education [ ]
Health education referral to [ ]
Support group referral to [ ]
Behavioral health referral to [ ] [scheduled with] [on-going treatment with] [psychiatrist] [psychologist] [social worker]

Transportation resources provided [patient has] [following up on order for] [nursing] [PT] [OT] [ST] [Home Health Aid] [ ]

[Discussed end of life planning]
[Patient given information on][advanced directives] [POLST] [five wishes]
[Patient has][advanced directives] [POLST] [five wishes]
Agent [ ] Contact Phone# [ ]

DME [W/C,] [FWW,] [BSC,] [ ]

Pharmacist Documentation

[No medication discrepancies] [Medication discrepancies identified:]
[No adverse events/intolerance's] [Adverse event/intolerance identified:]
[No drug-drug interactions] [Drug-drug interaction identified:]
Pharmacist present with MD in exam room during [date] **TMC encounter.**
Education/counseling [none needed] [provided:]

Signature: [Pharmacist] **, PharmD**

Other Components

End of life discussions

Referrals as needed:

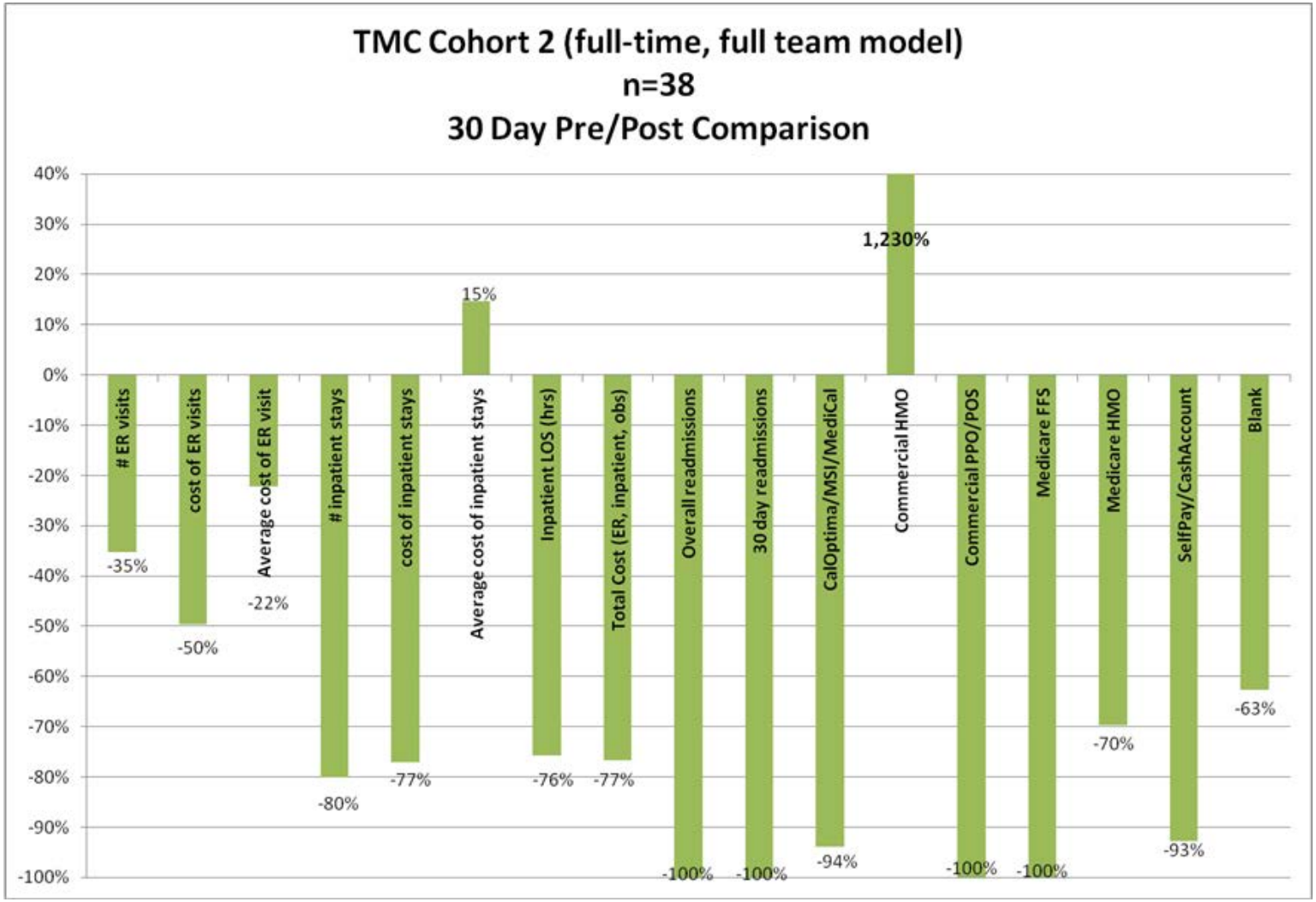
- Coumadin Clinic
- Health education
- Social work
- Palliative Care
- Home Health
- Hospice
- Rehab

Arrive/ No Show/ Cancellation rate

Arrive	No Show	Cancellation
552	169	77
	31%	14%

End of life addressed (83%) Information given or Discussion

Outcomes to Date



Successes

Mr. G. was seen post discharge from a skilled nursing facility. He came in, accompanied by his wife, short of breath because he did not bring his oxygen with him. The physician and pharmacist reviewed his medications and put him on a long acting inhaler. He was given a breathing treatment and his oxygen saturation went from 86% to 97%. The physician discussed his disease process and the need to keep his oxygen on at all times. The patient stated “no one really talked to me and explained like this before”. He said he understood how important his oxygen is and that “we saved his life today”. He was set up for Home Health while at SNF. We called and left a message for home health and asked that a nurse check on him during the weekend. While he was still at the post discharge clinic, he got a call to set up that visit time. He left feeling better and happy.

Challenges / Lessons Learned

- *Treating the post discharge appointment as part of regular discharge care.*
- *"Selling" the importance of showing up to patients.*
- *"Selling" the importance of referring to ED physicians, hospitalists, PCPs and nursing units at the hospital.*
- *Avoiding creation of another community clinic.*
- *Appropriate referrals rather than "workups" or trying to get around other constraints.*
- *Creating shared documentation templates and training users in two systems (hospital and ambulatory).*
- *Knew medication reconciliation would be challenging, but underestimated how much so.*
- *Setbacks with dedicated location- issues with licensing a clinic in a hospital owned space.*
- *LACE score only calculated upon hospital admission for those who are in our system.*
- *Recruitment process including re-writing and grading of job descriptions is a very untimely process.*
    - ***Physician**- not a lot of physicians willing to see complex patients all day with no ownership of patient*
    - ***Patient Care Coordinator**- person who makes appointments must be available after hours and weekends is hard to recruit*
    - ***Ambulatory Pharmacist**- this must be a shared resource with other programs to justify cost until clinic is up and running full time*

Spread Plan & Next Steps

plan for spread

- St. Joseph Affiliated Network created post discharge clinic 1/15/2014 but did not include pharmacist
- Combine St. Joseph Hospital Affiliated Network and St. Joseph Medical Group to serve all of St. Joseph Hospital patients

next steps

- More weekend and evening coverage
- Better ED coordination (scheduling at time of visit; limitation is M-F 8-5 schedule of post discharge clinic)

QUESTIONS & DISCUSSION