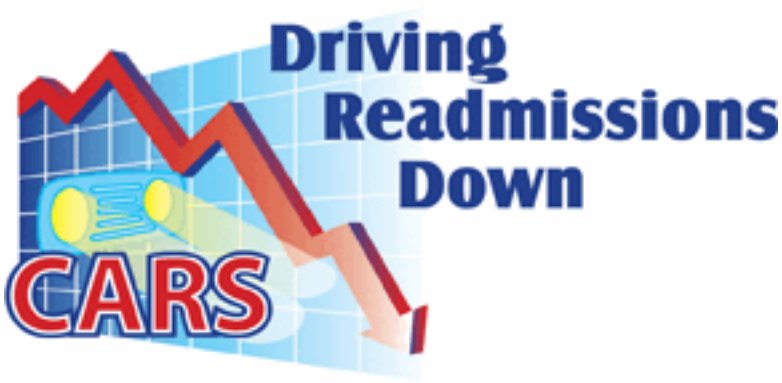


"Catching Discharged Patients in the Outpatient Setting"

Track: *Mapping the Route with Your Community Partners*

Ricki Stajer, RN Administrator of Care Management,
Sarah Delgado, RN MSN ACNP, Chronic Care
PIH Health, Whittier, California

PIH Presbyterian Intercommunity Hospital

Community non profit

Established 1959

541 beds

Payer Mix:

- **26% Medicare**
- **11% Medi-Cal**
- **35% HMO**
- **10% PPO**
- **12% uninsured**
- **5% other**

PIH Presbyterian Intercommunity Hospital

Who?

PIH Health: Integrated Delivery System

- 541 bed hospital, physician group, IPA
- Home Health, Hospice
- Skilled Nursing Unit, Inpatient Rehab Unit

PIH Health Physician Patients

- Commercial & Medicare Advantage
- 6000 senior members
- our patients are our neighbors

Our Team

- Dr. Kathleen Barry, Sr. VP Medical Management
- Dr. Bharat Patel, Medical Director
- Ricki Stajer, RN Administrator of Care Management
- Sarah Delgado, Nurse Practitioner
- Barbara Slingluff, RN Ambulatory Case Management
- Patricia Bray, RN VP of Continuum of Care Services
- Gilbert Dorado, LCSW Interim Director of Care Management
- Dr. Virag Shah, Director of Family Practice Residency
- Dr. Jimmy Liao, Hospitalist
- Anna Adamian, Pharm. D, BC-ACP Clinical Pharmacist
- Judy Crog, Manager, Community Clinics
- Dena Gehrig, Project Manager

Team Process

- Chart review
- Weekly meetings with project manager
- Flow chart of current practice
  - identify duplication
  - specify areas for improvement (scoring)
- Define roles in relation to scheduling
  - Training in scheduling system
  - Assessment scores
  - Education to patients about the program
- Establish criteria for home visits and clarify how this is different from home health

What?

- A **P**ost **H**ospital **D**ischarge **C**linic with Discharge appointments made within 72 hours of discharge had been established in 2010
- Partnership between the hospital and the medical group to improve transitions for patients at high risk for readmission
- Hour long appointments with an advance practice nurses who provide transitional care
- Key step was identifying an interdisciplinary team comprised of both inpatient and outpatient members
- committed to making this work

PHDC Intervention Visits with RNPs

1. Review hospital record and patient's current status
2. Assess for factors that contribute to risk of readmission:
    - Lack of knowledge, poor adherence,
    - Poly-pharmacy, inadequate medication reconciliation
    - Social factors
3. Intervene to address the identified risk factors
4. Reconcile med lists: discharge, and actual medications
    - Patient education about disease management
    - Assist patients in identifying strategies to improve adherence
    - Review medication list
    - Refer patients with social issues to social worker.
5. Collaborate with social worker on advance care planning
6. Collaborate with Home Health to monitor for "red flags"
7. Follow up phone calls
8. Timely communication with primary care physician

How?

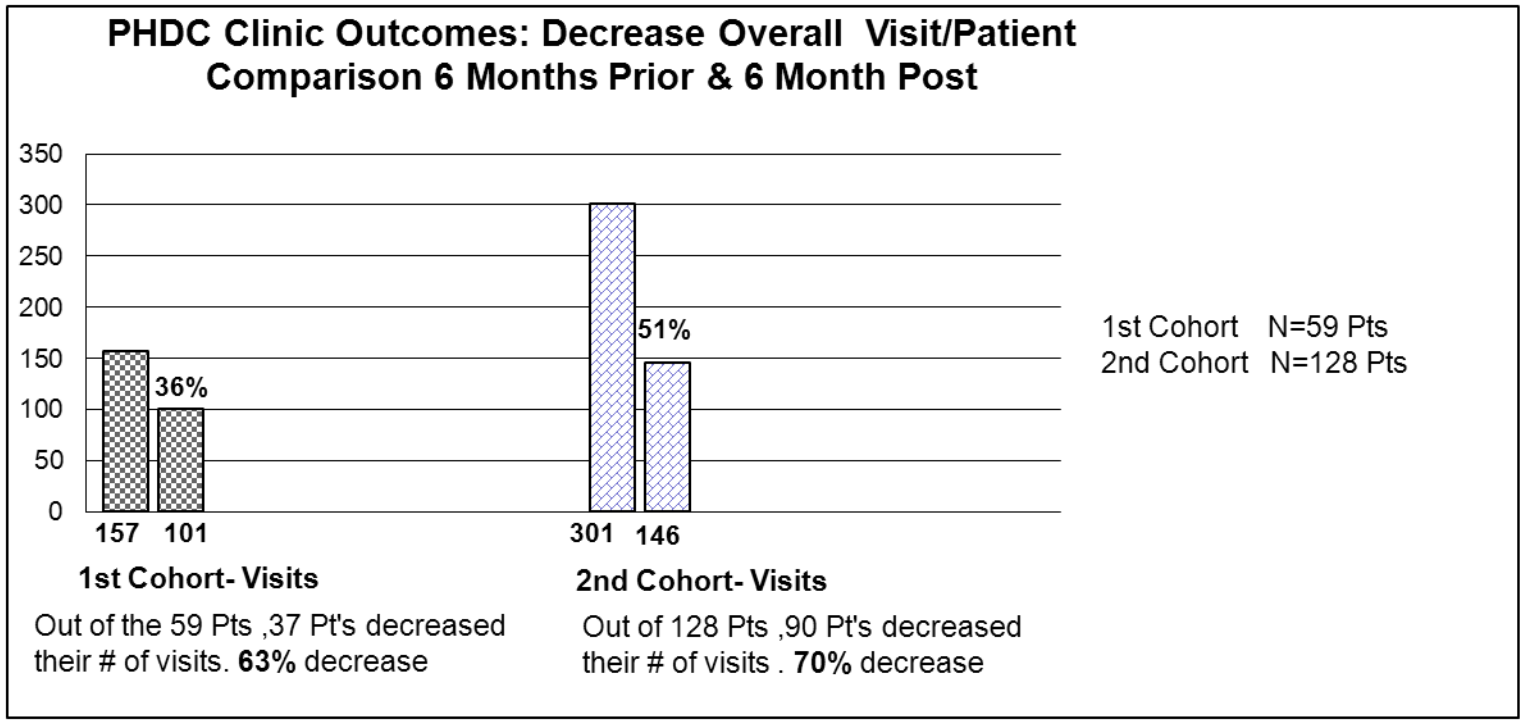
- 100% of patients with readmission risk assessment scores of 4 and above are scheduled prior to discharge, into a PHDC visit either at home or in the clinic setting to occur within 72 hours of discharge
- Case Management staff schedule appointments while patient is still in the hospital

- Educational flyers are given to patients and families
- Physicians, nurses and case managers all emphasize the importance of going to the PHDC

- Phone call reminders about appointments
- Criteria clarified the difference of a home PHDC vs clinic visit

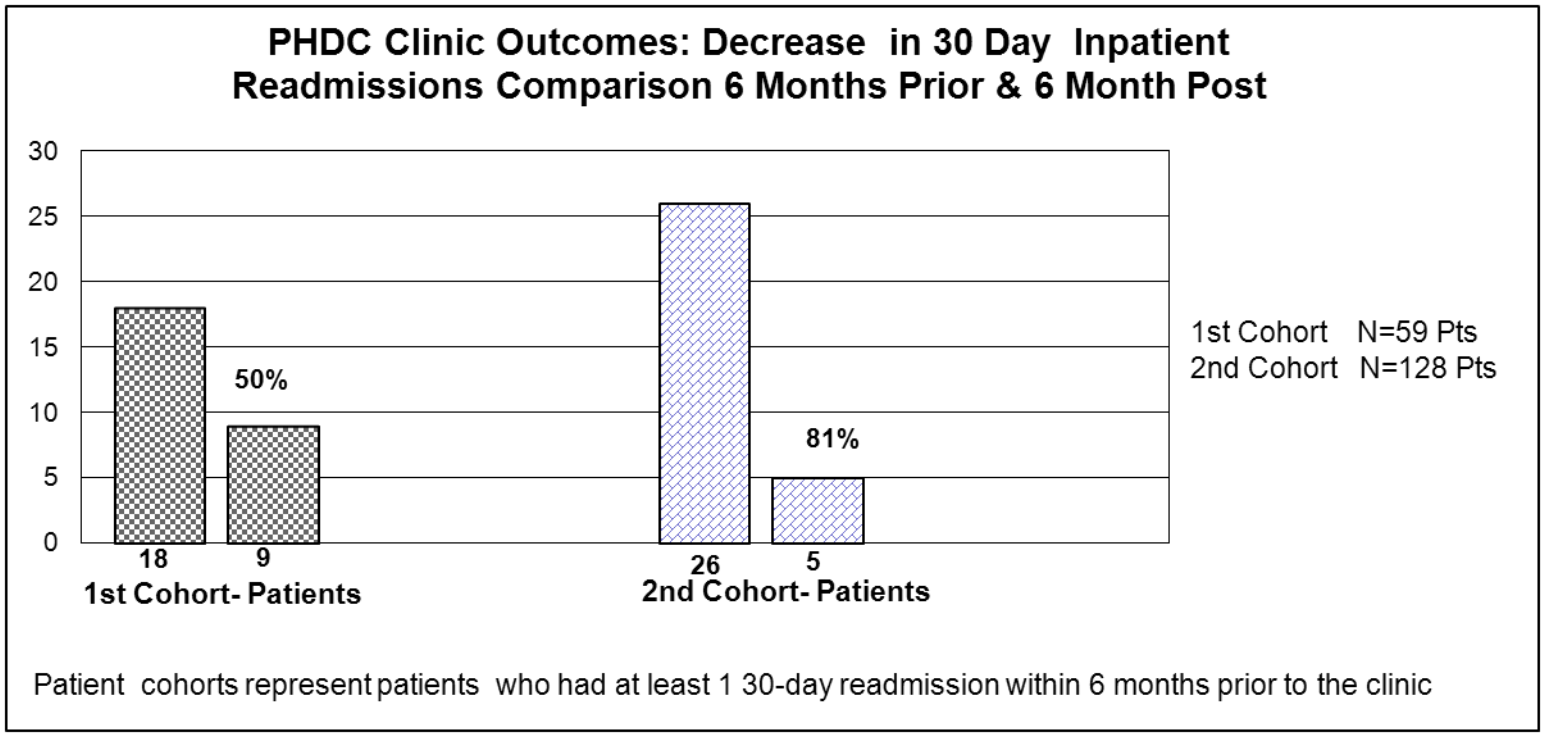
- Attracting patients: “the sell”, patient handout, emphasis on more time with the provider, no co-pay charge, guarantee follow-up communication & care planning with PCP

Post Hospital D/C Clinic Outcomes Related To Admission, ED & Observation Visits



Presbyterian Intercommunity Hospital

Post Hospital D/C Clinic Outcomes Related To 30 Day Readmissions



Presbyterian Intercommunity Hospital

Spread Planning

- Provide the intervention to a larger population.
  - IPA patients including all types of insurance
- Actively engage other ambulatory providers to support PHDC
- Introduce pharmacy services into the PHDC
- Increase social services support to manage issues that prevent patient participation
- Include PHDC as part of a larger Chronic Care program
- Pool existing resources into one comprehensive program to ensure a smooth transition across the continuum.

CQC California Quality Collaborative
Breakthroughs for Better Healthcare

TAACT TAKE ACCOUNTABILITY FOR AMBULATORY CARE TRANSITIONS

©CQC 2013

What's Next?

- *Rallying even more leadership and peer support*
- *Adding a permanent pharmacist into the clinic*
- *More education and training for everyone*
- *Sustaining the gains*
  - *Marketing*
  - *Data reporting and validation*
  - *Primary care physician engagement*
  - *Hospital-based physician and nurse engagement*
  - *Family member engagement*
- *Thinking Bigger!*
  - *Nutrition, palliative care, community education program,*

Take Home Points

1. *Have a clear and measurable goal*
    1. *Establish metrics and baselines*

2. *Have a formal project manager to track details and tasks*

1. *Break up the project into smaller targets by setting milestones along the way*

1. *Include providers and "frontline" people EARLY in the work.*

1. *Ensure representation from inpatient and outpatient settings and support services right from the start.*

1. *Engage physicians to be full team members – it's worth the effort!*