Medical Home

Transition Post Hospital Discharge
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Independent Clinic Experience
Who is Multicare

- Privately owned
- Primary Care Focused
- Fridley, Blaine, Roseville
- 13 FP, 3 Peds, 4 OB, 2 IM, OH, Endo, Cards
- 12 PA’s, Peds NP, OB NP, FP/Wt loss NP
Agenda

- Introductions
- Independent clinic challenges in post hospital care
- High Risk patients
- COPD
- LTC
- Focused care management
- Future/ongoing plans
Introductions

- Meg Pluth, RN, MPA Director Clinic Operations, Medical Home Project Manager
- Nicole Lyden, HCC
- Kari Coddington, HCC
- Stacey Allen, HCC
- Rachel Burda HCC
Hospital Discharge List

• Purpose
• Who is called
• Numbers
• Miscellaneous
Readmission Committee

Invited to the readmission committee meetings at Unity hospital

Discuss ways to work together to prevent hospital readmissions
High Risk Admission Follow up

- Started with high risk medical home
- Now all high risk
- Recent addition to moderate and medium risk, all patients
- Goal is to capture more patients for follow up/reduce readmission
COPD

- Meeting with since 2013
- Meet every 2 weeks
- Home visits/AVS/discharge summary
- Paramedic visits
- Lung power program
- Added PA and PharmD to represent MCA
- 3 day education plan, pilot
- Multicare introducing COPD education plan
Community Partnership

- Nystrom and Associates
- Phone number direct for provider to provider
- Phone number for referrals outside of regular pathway
- Geriatric Services of Minnesota
Geriatric Services Minnesota

- Relationship between GSM and TCU’s
- GSM and Heartland home
- Care upon discharge
- Struggle with communication
Home Care

- Heartland home care relationship
- Providers not completing face to face sheets
- Cheat sheet to help providers
- 2 month pilot/providers
- Plans for template development in EMR
- 2015 new Medicare guidelines
- HCC invite to quarterly meetings
Changes : Community Partners

- Invited to Unity Readmission Committee Meetings
- Invited to patient care conference at Unity Hospital
- Invited to care conferences Nursing Home
- Meet with all new home care agencies
- New hospice director sit down
- HCC on Heartland advisory board
- Online list of community resources tab
Focused Management

- Pain Management
- Depression patients
- Medication Therapy Management
Focus Pain Management

- Committee, 3 physicians, 2 PA’s
- Contract developed
- Policy developed
- Post Discharge, pain discussion
Depression focus

- Hospital patients discharge
- Survey to providers
- Flow chart
Provider Survey on Depression

- If a representative from Nystrom and Associates came to speak as a “refresher”. What questions would you have for them/what information would you like them to cover?
- When to refer vs. trial of many different medications.
- What are considered 1st and 2nd line of therapies (when to increase dose, or when to change)
- How to improve resistant depression (no improvement after multiple meds)
- Medication combination therapy
- Bipolar, insomnia, ADHD
The healthcare coaches recently put together a survey for the providers regarding how we can help them better manage their depression patients. We had a total of 16 providers return the survey. The results were as follows:

- **Do you feel comfortable managing depression?**
  
  - Yes - 12
  - “Kind of” - 4

- **Do you feel comfortable managing 2 or more depression medications at a time?**
  
  - Yes - 6
  - Sometimes - 7
  - No - 3

- **Do you feel comfortable managing a patient that is being referred to psychiatry for a minimum of 3 months until they can get in for their psychiatry appointment?**
  
  - Yes - 8
  - Depends - 3
  - No - 5
Survey Cont.

- We learned from the survey that many providers are okay with managing their patients, but sometimes need some guidance in doing so.
- Direct phone number for providers to use for guidance.
- Work flow for focused depression patient.
New depression patient

Referring to psychiatry

Send task to HCC to refer to focused medical home.

F/u call 2 weeks after appt to see if pt has side effects

Yes

Phone message to provider

Follow up every (1) month with provider/ follow up call every 2 weeks after appt. with HCC until patient is able to get into psychiatry.

No

Send task to tickle file for follow up call.

F/u call 2 weeks after appt to see if pt has side effects

Yes

Phone message to provider

Schedule f/u appt for 2-4 weeks from f/u call while patient is on the phone

No

Schedule f/u appt for 2-4 weeks from f/u call while patient is on the phone

Pt seen every 3 months until PHQ9 is stable (9 or below). IF patient fails 2 meds send a task to HCC to refer to focused medical home.
Medication Management

In the beginning:

- Was a service we provided for our Medical Home patients that were discharged from the hospital
- Med lists did not match
- A third of hospital admissions are due to medication mismanagement

- Was a successful service!
- Reduced number of admissions
- We made it a clinic wide service offered to all patients who take 5 or more medications daily.
Medication Management (cont.)

- Not as many patients signed up for MTM
- Message for Medication Management was put on Patient Plans and given to patients during clinic visit to encourage scheduling with the pharmacist.
- Pharmacist’s schedules soon became busy!
- Now is a success and we are getting good feedback from patients and providers
Patient Advisory Committee

- Patient Advisory committee: 1 physician, 1 PA, quality director, clinical supervisor, 5 patients (3 new this year)
- Meet monthly
- Very engaged patient group
- Patients have input into agenda
Patient Advisory Committee

Things we have done:

- Patient portal
- Advise on new patient intake form/patient forms
- Review new reminder program
- Colonoscopy process
- HCC survey
- Provided recommendations our phone options for incoming calls
- Provided input into recall letters
Patient Advisory Outcomes

- Turn disgruntled patient into patient advocate
- New intake forms increased self referrals to Medication Therapy Management (MTM) program
Future plans

- Relationship with Nystrom
- Pain management enroll in Medical Home
- Better tracking ER visits
- Growing our community partners
- Reduce health care costs, i.e. reviewing health plan usage data