

Medical Home

Transition Post Hospital Discharge



 FRIDLEY MEDICAL CENTER

480

**Transition Post Hospital Discharge
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

Survey cont.

- 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?

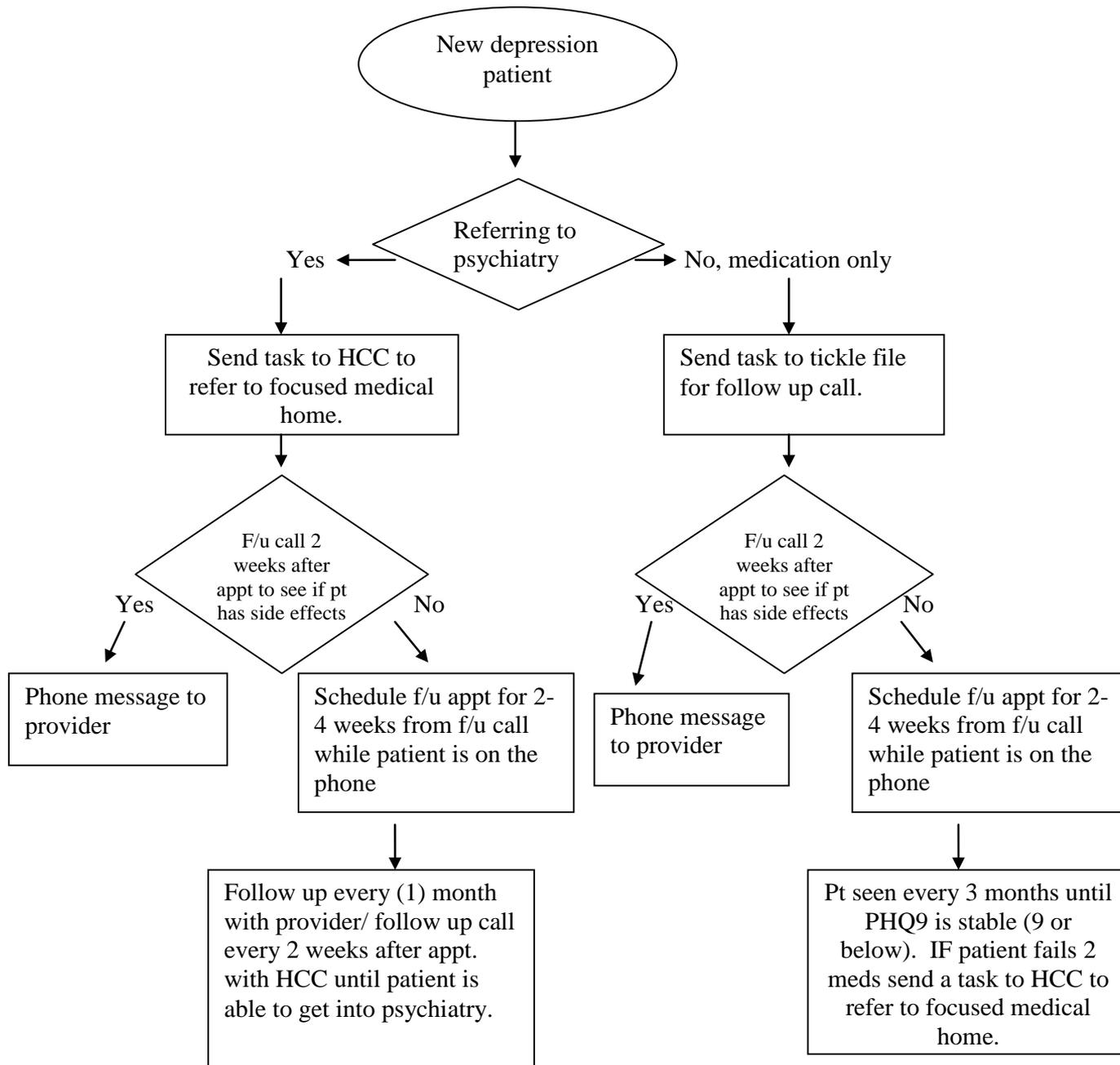
Yes- 6 Sometimes- 7 No- 3

- 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.



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