Comprehensive Healthcare for the Community

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Introduction

• Scope of the Problem: 88% of adults in the U.S. visit the Emergency Room due to lack of access to other providers (CDC, 2012).
  • Common reasons for ED visits: only a hospital could help (54.5%), the provider’s office was not open (48.0%), there was no other place to go (46.3% of all patients, 61% of uninsured patients). (CDC, 2012)
  • 2.3 million ED visits in the U.S. (2.0% of total) were made by patients who had been discharged in the previous 7 days.
    • Uninsured patients were 3 times as likely to make a hospital visit following discharge than insured patients. (Burg, Craig & Simon, 2008)
  • The percentage of uninsured patients utilizing local Maricopa County EDs has increased from 20% in 2009 to 32% in 2013 (Arizona DHS, 2013)

• National Care Management Movement:
  • Care Management: a set of activities in a healthcare setting designed to 1) improve patients’ functional health status 2) enhance coordination of care 3) eliminate duplication of services 4) reduce the need for expensive medical services (Bodenheimer & Berry-Millet, 2009).
  • Transition to Care: a transition from one healthcare provider or healthcare setting to another
Deficiencies in health literacy, patient education, appropriate medical follow-up, and communication among health care providers are associated with adverse event risk following ED discharge:

- In a recent study of patient and caregiver understanding of discharge instructions:
  - 78% of patients demonstrated deficiencies in one of 4 domains: 1) diagnosis and cause, 2) ED care, 3) post-ED care, and 4) return instructions.
  - Greater than one-third of the deficiencies involved understanding of post-ED care. (Engel KG et al, 2009)
- Patients enrolled in a medical home in Orange County for longer periods were less likely to have ER visits or multiple ER visits (Roby et al, 2009).
  - Switching medical homes three or more times was associated with enrollees being more likely to have any ER visits or multiple ER visits.
Transition of Care from ED to Primary Care Setting

Transition of Care Principles:
- Care team process (e.g. discharge planning, medication reconciliation)
- Information transfer and communication between providers
- Patient education and engagement (e.g. interpreter services, assessment of health literacy)

Outcomes
- Patient Experience – patient and family/caregiver
- Provider Experience – individual practitioners/facilities
- Patient Safety – medications
- Health care utilization- decreased return to ED, hospital
- Health outcomes-clinical and functional status, therapeutic endpoints (NTOCC, 2009)
Dignity Health Grant

- **Enrollment:** 200 uninsured and underinsured, non-duplicated patients *many with recent ER use*
  - Pts with Obesity (BMI >30), HTN (BP >140/90), Diabetes (A1C>9), Asthma (daily inhaler use), high depression score
- **Partners:** St. Joseph’s Hospital, Valle del Sol, Hope Lives- Vive la Esperanza
- **Goals:**
  - Patient self management and disease control
  - Decreasing incidence of complications associated with asthma, HTN, diabetes, obesity
  - Decreased hospitalizations over 2 years
My Project: Methodology

- Dignity Grant implementation of Comprehensive Healthcare for the Community has 2 phases:
  - **Planning/implementation of process**
  - Planning/implementation of clinical outcomes

- Objectives for this project:
  - Develop Patient Information Brochure and Intake forms
  - Finalize Individualized Action Plan form
  - Translate forms into Spanish
  - Pilot forms with Wesley Health Center patients who quality for Comprehensive Healthcare for the Community
  - Schedule meeting with St. Joseph’s Discharge Planner to develop system for effective transitions to care
  - Support the Care Coordinator in rolling out this program
Results

• Forms developed:
  • Patient Orientation Packet:
    • Patient Information Form
    • Participating Organizations Information
    • Reminder Postcard
  • Patient Needs Assessment
  • Individualized Action Plan
  • Recent ER or Hospitalization Questionnaire
  • Transitions to care meeting at St. Joseph’s hopefully early next week
**Sample Form**

**COMPREHENSIVE HEALTHCARE FOR THE COMMUNITY**
Part of the Community of Care Program through Dignity Health

### PATIENT INFORMATION

**Patient Name:**
_____________________________  
_____________________________  
DOB: _______________  
Zip Code: _____  

**Today’s Date:** ________________

### NEEDS ASSESSMENT

#### MEDICATIONS

Do you have any allergies to any medications?  
Y  
N

Which medications: ____________________________________________________________

Do you have your medications with you today?  
Y  
N

Do you have any trouble taking your medications?  
Y  
N

Do you have trouble keeping track of your medications at home?  
Y  
N

How do you keep track of your meds (e.g. Medi-Sets?): _____________________________________________

If yes, does anyone help you with your medications?  
Y  
N

Name/Relationship: ____________________________________________________________

Do you ever miss doses or go without your medications?  
Y  
N

How often: ____________________________________________________________

Do you get any side effects from your medications?  
Y  
N

Do you have any trouble paying for your medications?  
Y  
N

What pharmacy do you use? ____________________________________________________

Do you ever have problems getting your medications from the pharmacy?  
Y  
N

#### TRANSPORTATION

What type of transportation do you use? ____________________________________________

Do you have difficulty getting the transportation you need?  
Y  
N

#### MEDICAL CARE

Are you being seen by any other doctors or in any other clinics or agencies? List below:
Discussion

• Hospital-to-home care management has been shown to decrease hospitalizations and reduce costs for complex patients
  • MD, RN, care coordinator and health educator teams most effective
  • Coaching paradigm for teaching self-management
  • Targeting patients who could benefit from medical-psychosocial intervention (Bodenheimer & Berry-Millet, 2009).

• Feasibility of care coordination implementation at Wesley
  • Time constraints
  • Influx of 200 new patients
  • Structure for providing ongoing support

• Research about effective care management and transition of care programs
  • Nurse-managed programs are most effective
  • Home visits
  • Medication reconciliation
Recommendations

• Data Collection: define realistic, measurable outcomes for program success
  • e.g. How will progress in defined health indicators be measured? For instance, by how much will HgA1C or use of inhalers need to change from baseline patient information to determine success?

• Establish communication between Wesley and St. Joseph’s to ensure buy-in, sustainability and partnership:
  • Wesley primary care provider could present at St. Joseph’s with Donna Gomez regarding program objectives
  • Develop a relationship with ED staff who are responsible for the disposition of patients upon ED discharge
    • e.g. Weekly meeting or phone call with discharge planner, case managers
  • Noon conference for St. Joseph’s internal medicine residents

• 30 minute intake appointment with Care Coordinator or Health Educator following new patient appointment with the physician
  • For new Wesley patients recently in the ER or hospital
  • Patient intake by Medical Assistants: include questions about recent ER visit or hospitalization
  • Consider home visits as part of grant renewal
Conclusion

• Wesley Health Center is uniquely equipped as a Patient-Centered Medical Home to implement a care management program through the Dignity Health Grant. This program will help patients transition from the St. Joseph’s Emergency Room to a primary care setting and receive the other comprehensive healthcare services provided by Wesley, Valle del Sol and Hope Lives.

• In our current healthcare system, there are many barriers to effective partnership between healthcare providers in the hospital setting and the community. In order to provide patient-centered care for our most vulnerable patients, we must establish effective communication and collaboration between the hospital and community to best serve the underserved population in Phoenix and Maricopa County.
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References


