GE-NMF PRIMARY CARE LEADERSHIP PROGRAM

PCLP

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

Background

- 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

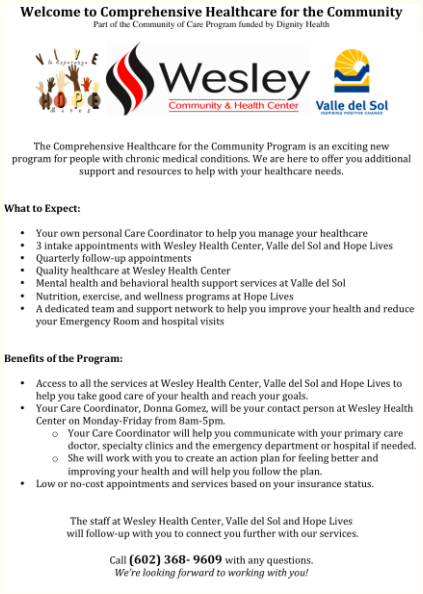
- Enrollment: 200 uninsured and underinsured, non-duplicated patients *many with recent ER use
  - Pts with Obesity (BMI >30), HTN (BP >140/90), Diabetes (A1C>9), Asthma (daily inhaler use), high depression score
- Partners: St. Joseph's Hospital, Valle del Sol, Hope Lives- Vive la Esperanza
- Goals:
  - 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**



Welcome to Comprehensive Healthcare for the Community

Part of the Community of Care Program funded by Dignity Health

Wesley Community & Health Center — Valle del Sol

The Comprehensive Healthcare for the Community Program is an exciting new program for people with chronic medical conditions. We are here to offer you additional support and resources to help with your healthcare needs.

What to Expect:

- Your own personal Care Coordinator to help you manage your healthcare
- 3 intake appointments with Wesley Health Center, Valle del Sol and Hope Lives
- Quarterly follow-up appointments
- Quality healthcare at Wesley Health Center
- Mental health and behavioral health support services at Valle del Sol
- Nutrition, exercise, and wellness programs at Hope Lives
- A dedicated team and support network to help you improve your health and reduce your Emergency Room and hospital visits

Benefits of the Program:

- Access to all the services at Wesley Health Center, Valle del Sol and Hope Lives to help you take good care of your health and reach your goals.
- Your Care Coordinator, Donna Gomez, will be your contact person at Wesley Health Center on Monday-Friday from 8am-5pm.
  - Your Care Coordinator will help you communicate with your primary care doctor, specialty clinics and the emergency department or hospital if needed.
  - She will work with you to create an action plan for feeling better and improving your health and will help you follow the plan.
- Low or no-cost appointments and services based on your insurance status.

The staff at Wesley Health Center, Valle del Sol and Hope Lives will follow-up with you to connect you further with our services.

Call **(602) 368- 9609** with any questions.

We're looking forward to working with you!

Programa de Salud Integral para la Comunidad

Organizaciones Afiliadas

	Misión:	Servicios:
Wesley Community & Health Center	La misión de "Wesley Community and Health Center" es: Juntos facilitamos cambios positivos. Esta organización proporciona servicios de atención médica primaria de salud y clases de prevención y manejo de enfermedades a personas sin o con poca cobertura de seguro médico.	Exámenes médicos, planificación familiar, Servicios de diagnóstico y laboratorio, manejo de enfermedades crónicas, cuidado prenatal, vacunas para niños y adultos, educación y coordinación del cuidado de la salud, urgencias, exámenes de detección del cáncer, salud mental.
Valle del Sol	Misión: Valle del Sol es una organización para la gente, con el propósito de ayudarles a lograr una mejor vida. Su mision es: "Inspirar un cambio positivo mediante la inversión en los servicios humanos y de salud para fortalecer familias con las herramientas y habilidades de autosuficiencia y para la construcción de la próxima generación de latinos y líderes diversos."	Servicios: Terapia de salud mental, servicios de apoyo para los jóvenes y adultos, manejo de crisis, servicio para prevención de abuso de sustancias, salud mental y servicios de cuidado de salud del comportamiento, evaluación y tratamiento psiquiátrico, servicio de consulta externa del abuso de alcohol y droga.
La Esperanza Es Hope Lives	Misión: "Hope Lives" Viva La Esperanza es una organización que se esfuerza en aumentar el acceso a servicios a los pacientes de las diferentes comunidades culturales y étnicas en el Condado de Maricopa, Arizona. Su compromiso es promover la recuperación y bienestar de la salud mental. Su mensaje es simple "Buena salud mental es fundamental para el bienestar de todos en el Condado de Maricopa.	Servicios: - Servicios de grupos de apoyo de colegas y amigos - Talleres,por ejemplo:" Pre-Vocational, Whole Health, HeartMath" - Servicios de apoyo como: ASH Line, G.E.D., Servicios de Estudio y Exámenes, Primeros Auxilios de Salud Mental, Administración de Beneficios del Seguro Social, Restauración de los derechos civiles, Beneficios del Departamento de Seguridad Económica "SSI MAO" con sus siglas en inglés.

Direccion de las Organizaciones:

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-Set?): _____

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 HgAIC 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

Bodenheimer, T. & Berry-Millet, R. (2009). Care management of patients with complex medical needs.

Burt, C.W., McCaig, L.F., & Simon, A.E. (2008). Emergency department visits by persons recently discharged from U.S. hospitals. *Natl Health Stat Report , 24*,1-9

Center for Disease Control. (2012). Emergency Room Use Among Adults Aged 18–64: Early Release of Estimates From the National Health Interview Survey, January-June 2011.

Engel KG, Heisler M, Smith DM, Robinson CH, Forman JH, Ubel PA. (2009). Patient comprehension of emergency department care and instructions: Are patients aware of when they do not understand? *Annals of Emergency Medicine,* 53(4): 454-61.

National Transitions of Care Coalition. (2009). *Improving transitions of care: Emergency department to home.* Retrieved from http://www.ntocc.org/Portals/0/PDF/Resources/ImplementationPlan_EDToHome.pdf

Rich E, Lipson D, Libersky J, Peikes D, Parchman ML. (2012). Organizing care for complex patients in the patient-centered medical home. *Annals of Family Medicine*, 10(1): 60-62.

Roby DH, Pourat N, Pirritano MJ, Vrungos SM, Dajee H, Castillo D & Kominski G. (2010). Impact of a patient-centered medical home assignment on emergency room visits among uninsured patients in a county health system. *Medical Care Research Review,* 67: 412-30.