



Promoting Safe and Effective Transitions of Care: The Critical Role of Primary Care Practices

PRIMARY CARE ROADMAP FOR CHANGE

Introduction: *In Maine, approximately 1 in 6 Medicare patients are rehospitalized within 30 days of discharge.¹ The Robert Wood Johnson Foundation has termed this the “revolving door syndrome”, and is working to promote a new approach to care. While many hospitals are working to improve their discharge process with initial promising results, we recognize that **primary care practices play a critical role** in addressing this problem and improving care. This “Roadmap” summarizes key roles for primary care practices to promote safe and effective care transitions and reduce avoidable readmission, and emphasizes the need for rapid and complete flow of information from all involved.*

Key Changes:

- 1. Reduce readmissions by preventing avoidable admissions:** Identify patients at high risk for hospital admission/readmission and use evidence-based strategies to reduce avoidable admissions.
 - Prospectively identify and track patients with diagnoses that put them at high risk for admission – e.g. heart failure, COPD, dementia, polypharmacy, co-occurring mental health/substance abuse
 - Use protocol-driven care management strategies to improve self-management, home monitoring
 - Provide after-hours options for care (e.g. telephonic support, evening & weekend hours)
 - Use provider knowledge, primary care management, and all available data to identify practice patients who are at high risk for admission, or have been recently and/or frequently hospitalized (e.g. HealthInfoNet, MAPCP RTI Portal, MaineCare HH Utilization Reports). Review admission data monthly.
- 2. Develop reliable systems for timely, two-way communications about patients admitted or discharged from hospital, Skilled Nursing /Rehab facilities:** Ensure that systems are in place to regularly provide patient information to Emergency Department and hospital-based physicians, and to reliably receive information on patients discharged from hospitals, Skilled Nursing Facilities (SNF), and/or rehab facilities.
 - Establish reliable systems with local hospital, SNF, and rehab facilities to ensure that your practice is routinely notified regarding patients from your practice at time of admission and discharge (e.g. EMR, fax, or other secure messaging notice)
 - Enroll your practice with HealthInfoNet (HIN), and use HIN notification function to receive automated alerts when your patients are admitted/discharged from any HIN-participating facility statewide (soon to include all Maine hospitals!)
 - Whenever possible, establish system for facilities to provide telephonic report (“warm hand-off”) to practice staff on admitted and discharged patients
 - Establish systems to ensure that your practice receives clear discharge information on all patients, including list of patient medications at time of facility discharge
- 3. Conduct telephonic outreach to all patients within 24-48 hrs. of discharge, including medication reconciliation:** Many patients following hospital discharge are unclear about their medications, symptom self-monitoring, and/or plans for home care or follow-up care; providing timely phone follow up to high-risk patients can identify problems early and provide needed education and support.
 - Develop reliable systems for conducting telephone outreach to patients within 24-48 hours of discharge
 - Use standard phone protocols or scripts for staff to assess readmission risk and post-discharge needs

¹ Robert Wood Johnson Foundation; The Revolving Door: A Report on U.S. Hospital Readmission, February 2013, page 11

- Use call to conduct medication reconciliation using standard protocols, and to schedule post-discharge follow up visit with primary care provider
 - Utilize Medicare reimbursement available for non-visit based services through CMS “Transitional Care Management” codes²
- 4. Provide patient-centered, timely access to follow-up care (i.e. office visit within 3-7 days)**
- Educate front-office practice staff on the need to be receptive to the needs of recently discharged patients and families, and ensure that practice scheduling systems provide adequate access to accommodate timely post-discharge follow up visits
 - Conduct follow-up office visit with patient and family member, ideally within 3-7 days of discharge (adjusted for risk level); note that CMS “Transitional Care Management” codes² require in-person post-discharge visit within 14 days
 - Encourage patients to bring in medications (“brown bag”) to the visit to confirm accurate medication list
 - Assess patient understanding and needs and establish (or update) care plan, including plans for self-management goals, warning signs, and follow up care
 - Use plain language and teach-back methods to assure that patient and family have a clear understanding of the care plan
 - Consider use of patient navigators or advocates to support patients through high-risk time periods
 - Facilitate coordination of care with other members of care team (e.g. specialists, home care)
- 5. Connect with community resources to optimize patient & family/caregiver supports:** Many patients require enhanced home-based services after discharge to support basic needs and assure safety. Practices can take an active role to identify those needs and connect patients to community-based resources that are appropriate to patient preferences and educational and cultural needs.
- Routinely assess social service needs for patients following discharge; use community resources (e.g. Area Agencies on Aging) to conduct in-home assessment of service needs for high-risk patients
 - Establish links with community partners such as home care providers, Area Agencies on Aging, Emergency Medical Services, and parish nursing programs to arrange and provide needed home-based services
 - For patients with history of frequent ED or hospital use, consider referral to local Community Care Team
- 6. Facilitate patient and family-centered discussions regarding end of life care:** Primary care providers are best situated to identify patients who are facing end of life decisions, and can best support compassionate discussions with patients and families about patient preferences.
- Encourage advance care planning for patients with dementia and others not able to self-advocate
 - Encourage compassionate discussions about end of life decisions with patients and families
 - Promote use of advance directives with all patients; encourage use of Physician Orders for Life-Sustaining Therapies (POLST)³
- 7. Build personal relationships across your medical neighborhood!** Collaborative relationships are fundamental to safe and effective transitions. Relationships can help break down “silos” of care and bring perspectives and solutions of colleagues working in other areas of the health care system.
- Work to build multi-disciplinary care transition teams within your community that include primary care, patients and families, Skilled Nursing and Rehab facility staff, Area Agencies on Aging, and others
 - Find ways to re-build relationships and ongoing communication between hospital and community-based providers – e.g. medical neighborhood “block parties”, medical staff meetings, breakfast meetings

² See info on CMS Transitional Care Codes: <http://www.aafp.org/news-now/practice-professional-issues/20130305tcmttools.html>

³ See info on POLST: <http://mainehospicecouncil.org/polst/>