California Health Improvement Project (CHIP)
Reducing Readmissions with Improved Transitions of Care

David Sperling, MD, SFHM
Monarch HealthCare, Irvine

Problem Statement and Underlying Causes

Transitions of care after hospitalization remains a difficult situation with many pitfalls that lead to patients being readmitted to the hospital costing millions of unnecessary healthcare expenditures. Reasons for failed transitions include:

- Improper or incomplete medication reconciliation
- Lack of follow-up
- Poor communication and flow of information.

Current State:
High Readmissions
$$$$

Desired State:
Reduced Readmissions
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Project Description

Improve the process for successful transitions of care for all Monarch Healthcare's senior patients admitted to the hospital including the hiring of on-site coordinators, training, process improvement and communication tools.

Goal and Objectives

Goal: Reduce overall cost of care by reducing hospital readmissions while improving healthcare outcomes.

Output-oriented Objective: Ensure every patient discharged from the acute care setting has accurate medication list, a scheduled follow-up appointment with the PCP and/or specialist, and all hospital documents are transmitted to the PCP including a telephonic hand-off by December 31, 2014. This will be measured by monthly audits of discharged patients.

Outcome-oriented Objective: Decrease all cause 30 day readmissions for seniors at core staffed hospitals to less than 11% by December 31, 2014 thus reducing overall healthcare related costs.

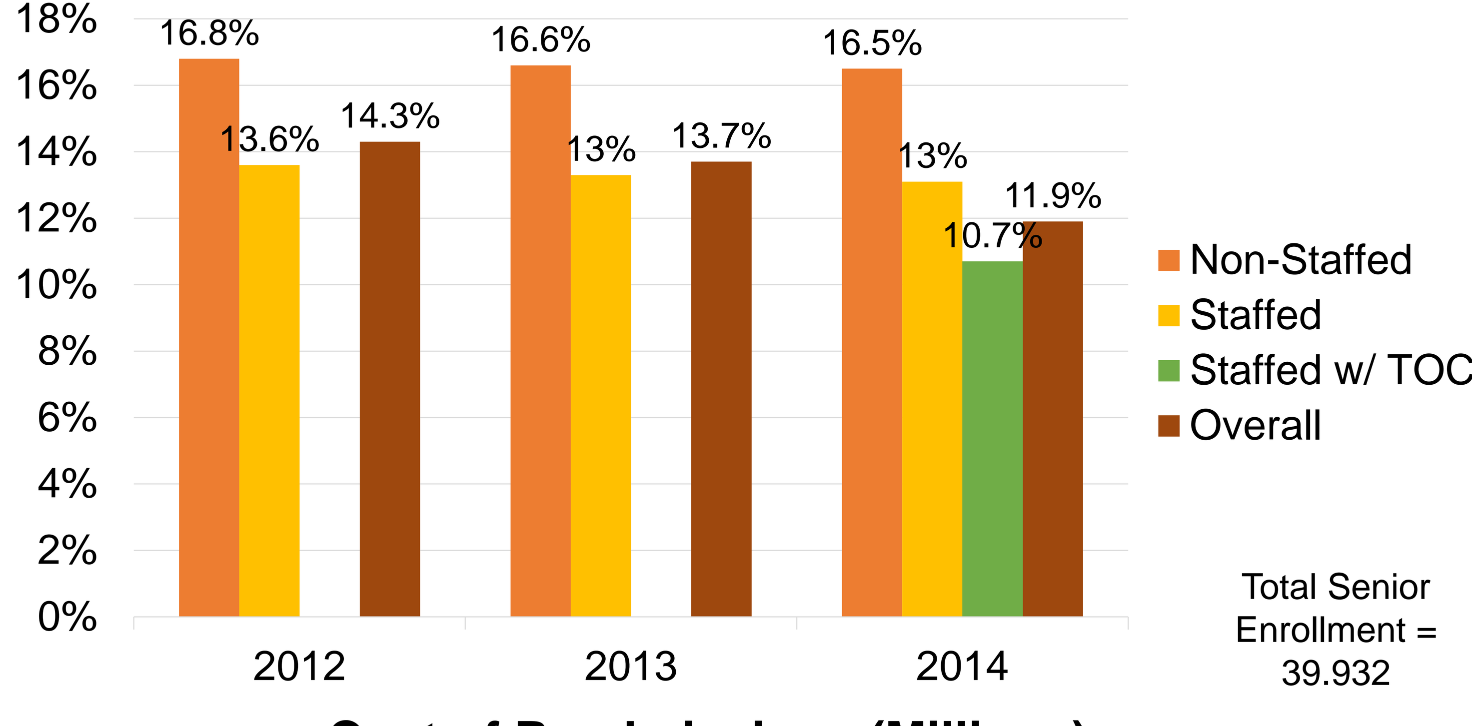
Outputs & Outcomes

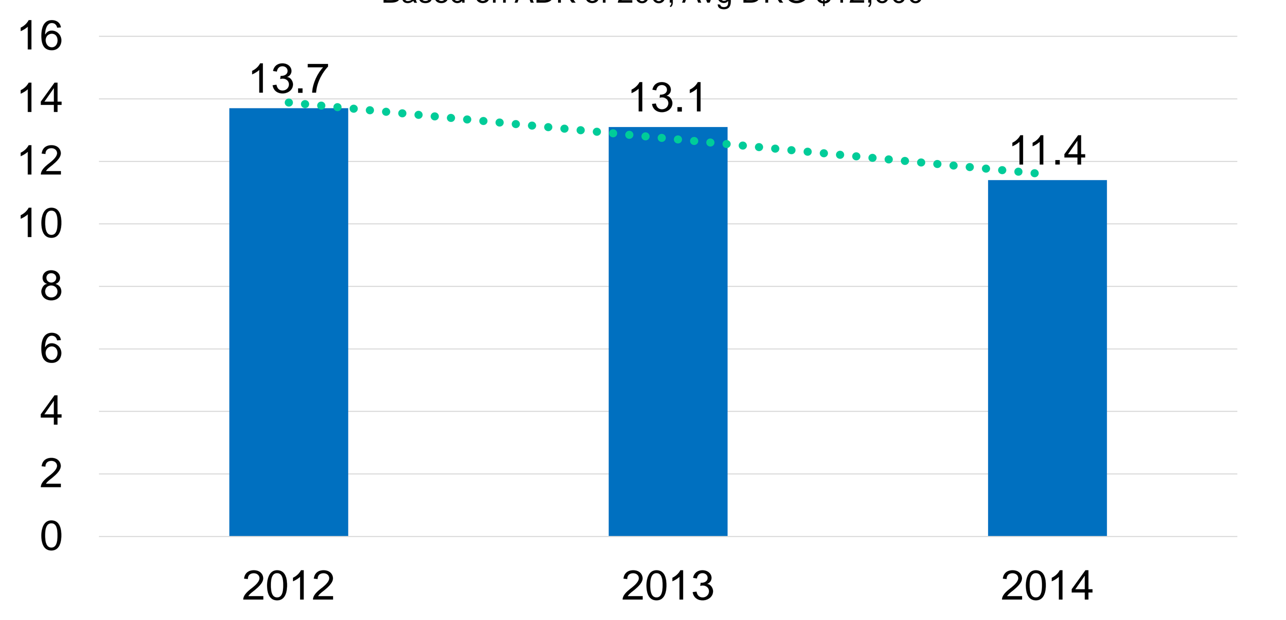
Outputs Achieved

Implemented the Transitions of Care Model:

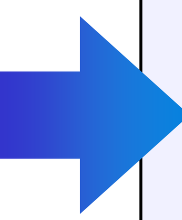
- Case Managers paired with discharge coordinators at each hospital.
- Case Managers identify potential issues to discharge and follow up on initial assessment and work with hospitalists to help overcome these barriers.
- Discharge Coordinators meet with patient prior to discharge.
- Appointments scheduled with Primary care provider prior to discharge. (All appointments within 7 days)
- Hospitalists ensure proper medication reconciliation, utilize teach back techniques, and reinforce need for early follow up.
- Discharge coordinator gives patient a packet with appointment time, date, and place, medication list, prescriptions, summary of hospitalization events, emergency contact instructions, and informs patients of future phone calls.
- Follow up phone calls made on day 3, 7, 14, 21, and 28.
- Clinical Pharmacist calls patient and does medication reconciliation within 1 week of discharge.

Outcomes Achieved

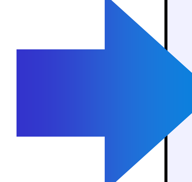




Lessons Learned

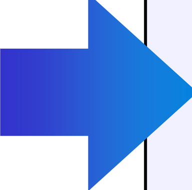


Bring in key stakeholders earlier in the process to ensure model is followed.



Ensure adequate resource allocation from finance team to implement program fully.

Need to adapt the process for different hospitals and staffing models.



Focus efforts on higher risk patients using LACE score to limit demand on resources.

About My Organization

With over 2,500 physician partners, Monarch HealthCare is the largest association of independent physicians in Orange County. Our physician partners and health plans work closely together to coordinate and improve your care. Over 196,000 Orange County residents have selected Monarch HealthCare.

MISSION STATEMENT
Helping Physician Partners Advance Medical Excellence in the Communities We Serve
CORE VALUES
Demonstrating integrity and trust in all relationships
Commitment to:
Innovation, Communication, Accountability, Respect, Excellence

Contact Me

David Sperling, MD, SFHM
david.sperling@caremore.com
Office: (562) 207-3629

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