

# Clinic Perspective on Reducing Readmissions

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Have you ever walked in an exam room  
and had no idea the patient had been in  
the hospital?

How does this make patients feel about us?

What opportunities for care have we already missed?

# Ideal Discharge Scenario

- 2-way sharing of info between hospital/ER and clinic
- Medical home knows when all patients are admitted
- Discharge summary standardization
  - Includes the primary diagnosis, labs, procedures, results, reconciled med list, unfinished labs that need follow-up
  - Should be to the clinic within 48 hours
- Follow up appointments made before discharge and clinic contacts if not kept
- Phone call to patient within 48 hours of discharge by someone with medical knowledge who is familiar with patient's hospitalization

# Current State

- Some institutions notify some providers of admissions – often by fax, often only in-system providers
- Clinics often only know of admissions if notified by patients
- Follow up appointments not made
- Discharge summaries incomplete and come too late
- Unnecessary complications and readmissions occur

# Example: Canyon Park

- Part of Evergreen Medical Center in Kirkland
  - Evergreen Medical Group has 6 primary care clinics, a Senior Health clinic, 2 urgent care clinics

Our patients go to 23 different hospitals and independent ERs!

# Canyon Park's discharge coordination

- Majority of our patients use Evergreen
  - Clinic EMR (Practice Partner) doesn't have true data exchange with hospital EMR (Cerner)
  - Primary provider always identified on admission
  - Signed note automatically dropped into PCP folder in Cerner
  - Note then manually plinked into Practice Partner
  - Hospitalists sometimes call PCP on discharge
  - Clinics have Cerner access, can look up inpatient info

# Canyon Park Workflow

- Evergreen HIM sends provider email notification of admission and discharge
- Provider forwards email to MA
  - MA calls pt: “We saw that you were in the hospital – how are you doing? Can we schedule an appointment?”
  - 30 minute visits for hospitalization follow up

# Problems with Canyon Park

- Relies on manual plinking
- Depends on hospitalist timeliness
- Outside hospitals often send no notification or info
- Info sent often incomplete – no procedures, lab, radiology
- Some info overload – ER reports include unnecessary nurse's notes, patient handouts

# A better way: Evergreen Senior Health Clinic

- 9 providers, 2 RN case managers, a social worker and a PharmD
- More resources –clinic is subsidized and has hospital based billing
- Simpler because most of patients go to Evergreen Medical Center

# Senior Health

- Get a daily list of their inpatients at Evergreen
  - Case manager contacts family and sometimes even visits pt in hospital
  - Pt added to case management data base
  - Data base updated when discharged
  - PharmD updates med list and looks for problems
  - RN calls to arrange for a 1 hour f/u appointment
  - RN fills out hospitalization summary form

# Senior Health

- Patient remains active on case management database until stable
- At follow up appointment
  - Case manager and pharmacist see patient before seen by provider
  - Hospital summary form filled out and on front of chart for provider

Most of us don't have those kind of resources – what can we do?

# First steps

1. Decide how you would like to get info - email, fax, phone?
2. Identify all the facilities your patients use
3. Designate someone to coordinate communication expectations with outside facilities
4. Monitor how the facilities are doing and give feedback
  - Have a coordinator that providers can notify if they didn't get discharge info – just takes a quick message
5. Standardize what you do when you receive notification of hospitalizations
  - who will contact pt
  - schedule appointment then rather than waiting for pt to schedule
  - how will you cross check med list before visit

Questions?