Transitions of Care in a FQHC: Addressing unique needs with a post-hospitalization clinic

Reza Talebi Dolouei, MD[2], Amy Di Sano, MSG[2], Connie McGuire, PhD[1], Lisa Gibbs, MD[1]

[1] School of Medicine, University of California, Irvine

[2] Department of Family Medicine, Division of Geriatrics, University of California, Irvine

UC Irvine | GWEP C3OA CULTIVATING A CULTURE OF CARING FOR OLDER ADULTS

Background:

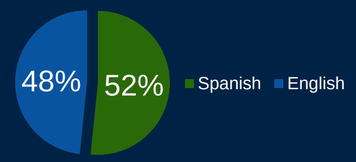
"Transitions of care" is the care involved when a patient leaves one care setting (i.e. hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moves to another (1,2,3). The Joint Commission (9) recognizes that ineffective transitions play a role in a majority of serious medical error and as such, implementing evidence-based strategies to facilitate effective transitions in care. Poor transitions will compromise patient safety and quality of care, place a significant burden on patients and their families and caregivers through inefficiencies and increase costs to patients, providers, payers. (3)

Methods:

This study was designed to identify the factors that impact transitions of care from Hospital to the post-hospitalization clinic at Federally Qualified Health Center (FQHC) in Southern California from November 2016 to March 2017 in order to develop an intervention to improve transitions of care and decrease possible re-hospitalization and/or Emergency department visit. Since the rate of no-show inputs hospitalization clinic was around 50%, we have developed 2 different surveys, one for an In-person visit and the other one for no-shows via phone call. Total 62 patients and/or their caregiver were surveyed, 31 surgery were in-person at FQHC and 31 surveys were conducted via phone since Patient missed their appointments.

Results:

31 In -person surveys were conducted in Spanish(16) and English(15).

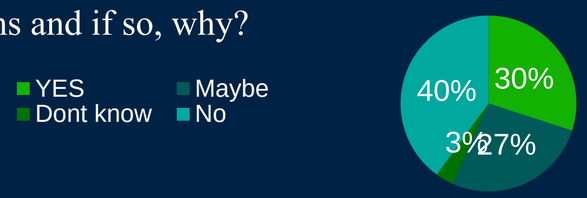


In-person group results were significant for 6 (19%) readmissions since discharge and prior to post hospital follow-up within 7 days. 50% of these readmissions were related to medical problem and were unavoidable, and 50% were considered preventable, caused by lack of coordination.

Of the 31phone-surveys, 12 readmissions (39%) were noted. The reason for readmission was not captured in phone survey.

In the phone Interview participants were asked 2 additional questions:

1- Do you think you will be admitted to the hospital in the next 6 months and if so, why?



Patients cited potential readmissions would be caused by an uncontrolled medical condition like pain, diabetes and blood clot.

2- “Do you have anything to share regarding the transition from hospital to home?”

28 respondents replied “no” and 3 patients responded “yes”, noting concerns about coordination of care.

Conclusions:

Risk of re-hospitalization and/or ER visit was significantly higher in the phone survey. Most of the patients were not able to get to their post-hospital visit because either transportation issues or lack of communication before discharge from the hospital. In both groups surveyed, memory and understanding medication were the main areas of concern. Developing a program to address and improve transitions of care between settings, understanding the plan of care, medications, and discussing the barriers with the patient, and caregiver or family members will decrease the risk of rehospitalization or Emergency room visit.

Intervention:

We had several transitions of care with the family medicine and internal medicine teams, and residents were educated to focus on discharge instruction. 3 main questions were added to be asked and addressed at the time of discharge:

1) Do you know when is your appointment with your Primary care physician?
2) Can you tell me what medications you are supposed to take after discharge home?
3) Do you have any transportation to get to your Primary care physician?

Currently, we are gathering further data.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under 1 U1QHP28724-01-00, *Cultivating a Culture of Caring for Older Adults, for $2.5 million. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.*

UC Irvine Health School of Medicine
Division of Geriatric Medicine and Gerontology