Innovation at Hospital Discharge

with

Nic Granum and Rachel Solotaroff

Ending Homelessness – Achieving Self-Sufficiency

Objectives:

1. What is Central City Concern?
2. What happens post-hospital for patients facing homelessness: Recuperative Care
3. What happens post-hospital for patients without a medical home: C-TraIn

Audience introductions:

1. Name
2. One hospital in your city
3. One thing your clinic is really good at

About Central City Concern

- **Who we serve –** yearly, more than 13,000 individuals

- **Who we are –** 46% of staff self-identify as in recovery; 25% have experienced Central City Concern's programs first hand.

- **What we believe –** every person we serve has unique skills & talents that can enrich the health, security, sustainability, and quality of life for us all.

Changing Lives

Building Communities

Creating Opportunities

~13,000 people impacted yearly

21 buildings/nearly 1,600 homes

600+ employees

Transitions Hypothesis: Timing matters

As a clinical intervention, “just in time” housing and primary care can be critical to finding cost savings and improved population health.

Hospital Provider to patient:

"Go home,
take care of yourself,
get lots of sleep,
take your medications,
make sure to stay dry
GO SEE YOUR DOCTOR
and come back and see me
in a couple weeks…"

Patient to discharge planner:

"I don't have a home,
I'd love to take care of myself,
but I can't sleep all night where I camp,
my medications were just stolen,
my sleeping bag is soaked and lost
I DON'T HAVE A DOCTOR
and I don't have a phone
or a way to get back up to
the hospital…"

Hospital interventions in the community:

1. **Recuperative Care**

2. **C-TraIn: Care Transitions Innovation**

Recuperative Care

- **OHSU:** Oregon Health and Science University Hospital
- **CareOregon**
- **Providence** Health System
  - Portland Medical Center
  - St. Vincent's Medical Center
  - Milwaukie Hospital
  - Willamette Falls Hospital
- **Providence** Health Plan
- **Legacy** Health System
  - Emanuel Hospital
  - Good Samaritan Hospital
  - Mt. Hood Medical Center
  - Salmon Creek Hospital
  - Meridian Park Hospital
- **Kaiser Permanente**
  - Kaiser Sunnyside Medical Center
- **City of Portland**: Housing Bureau
- **Portland Adventist** Medical Center
- **Portland Veteran's Administration** Medical Center

Established Primary Health Care

Primary Care

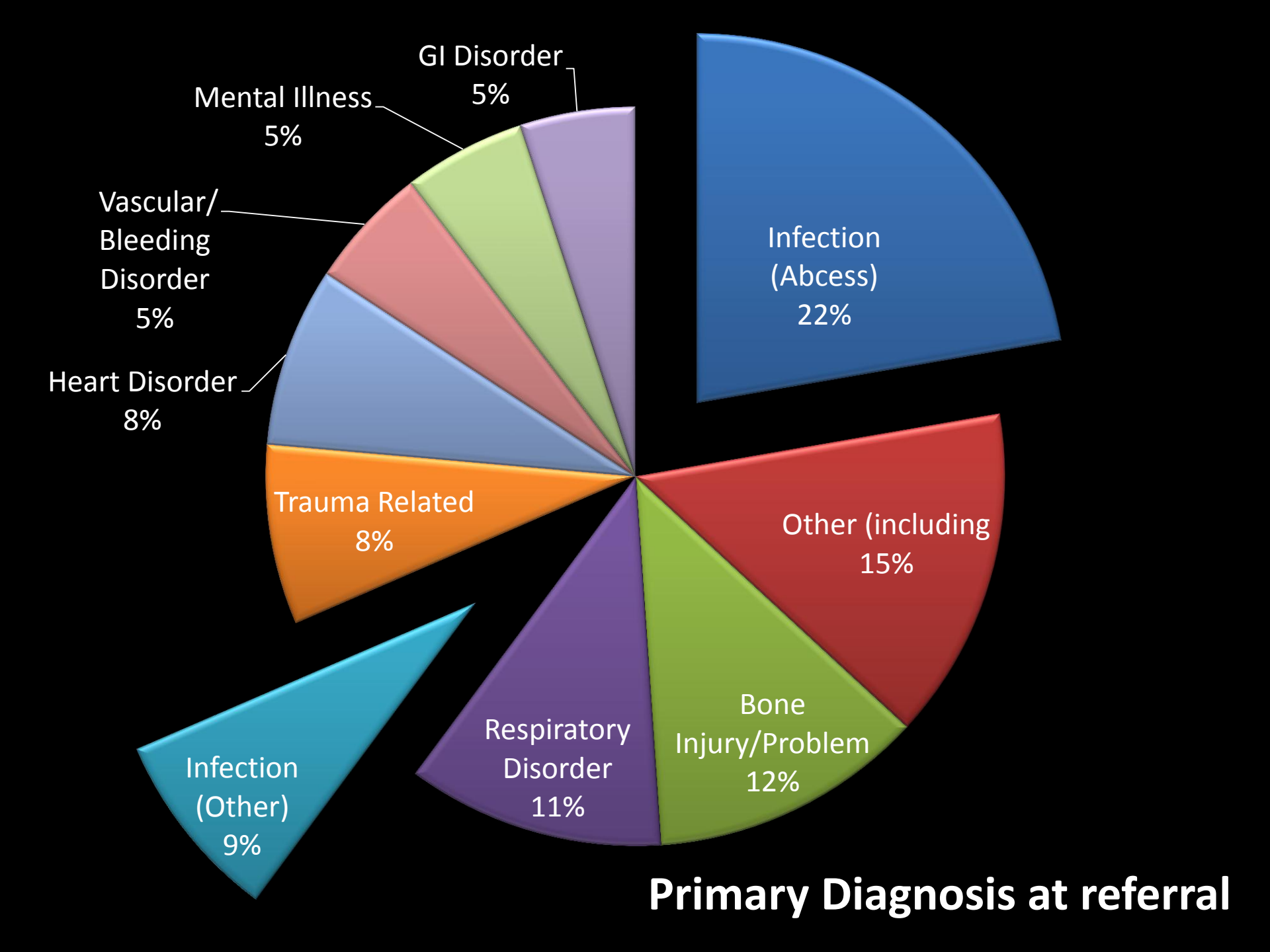
Old Town Clinic

- 3,300 patients per year
- Primary & mental health
- Acupuncture
- Pharmacy
- Medical education program

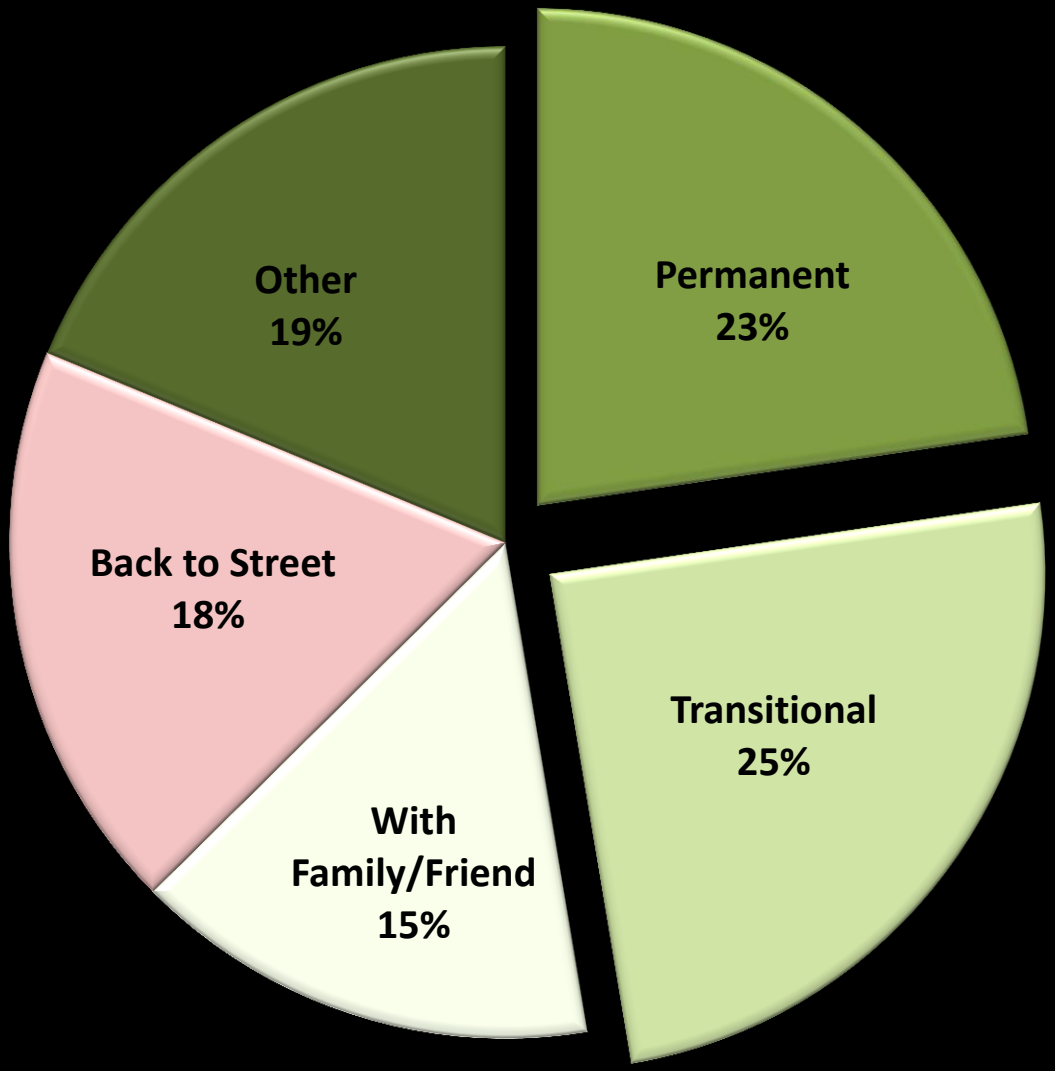
Intensive Case Management Team

Immediate Supportive Housing

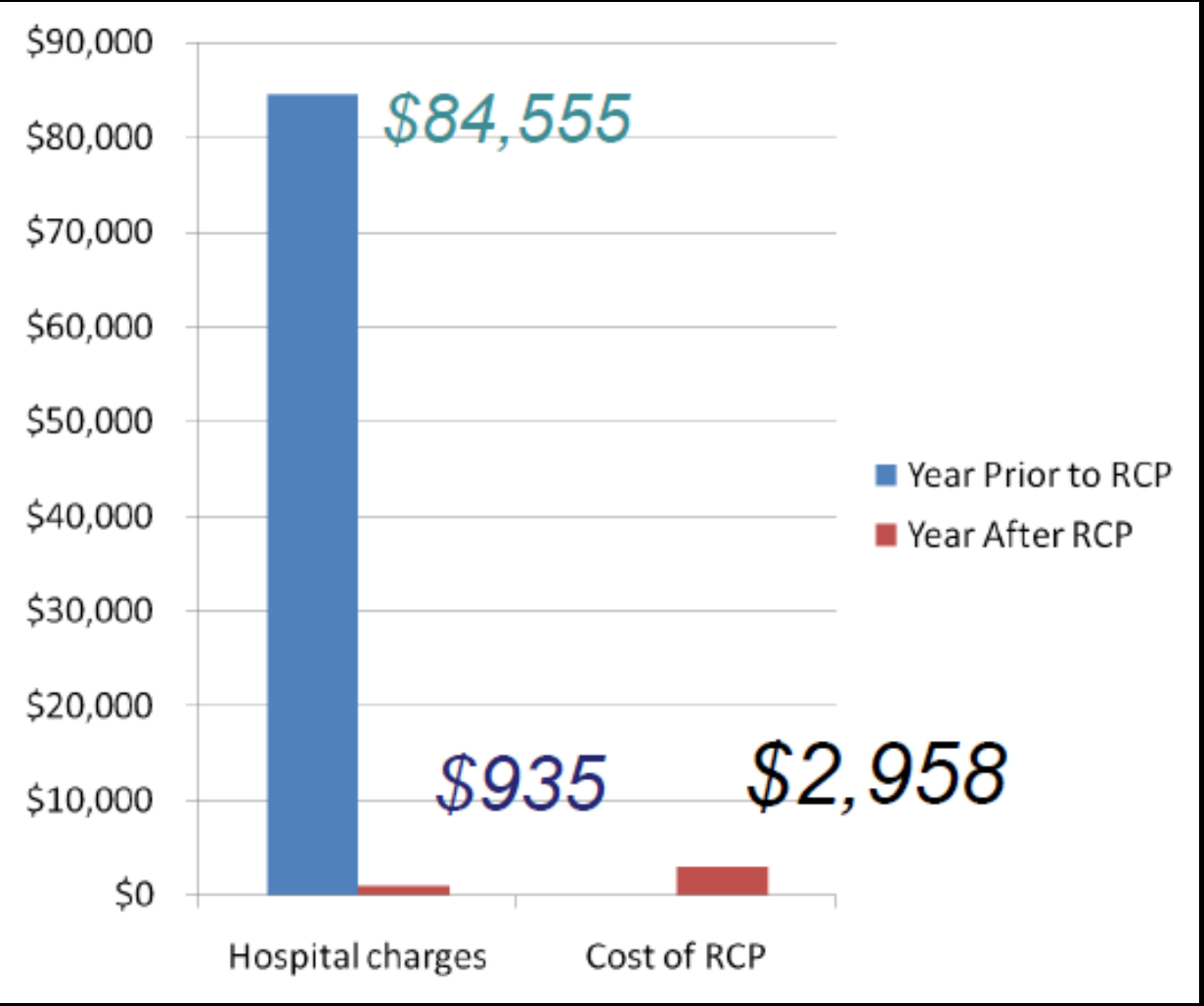
Results?


GI Disorder
5%
Mental Illness
5%
Vascular/
Bleeding
Disorder
5%
Heart Disorder
8%
Infection
(Abcess)
22%
Trauma Related
8%
Other (including
15%
Infection
(Other)
9%
Respiratory
Disorder
11%
Bone
Injury/Problem
12%
Primary Diagnosis at referral

Placement in stable housing



Cost savings for individual patients



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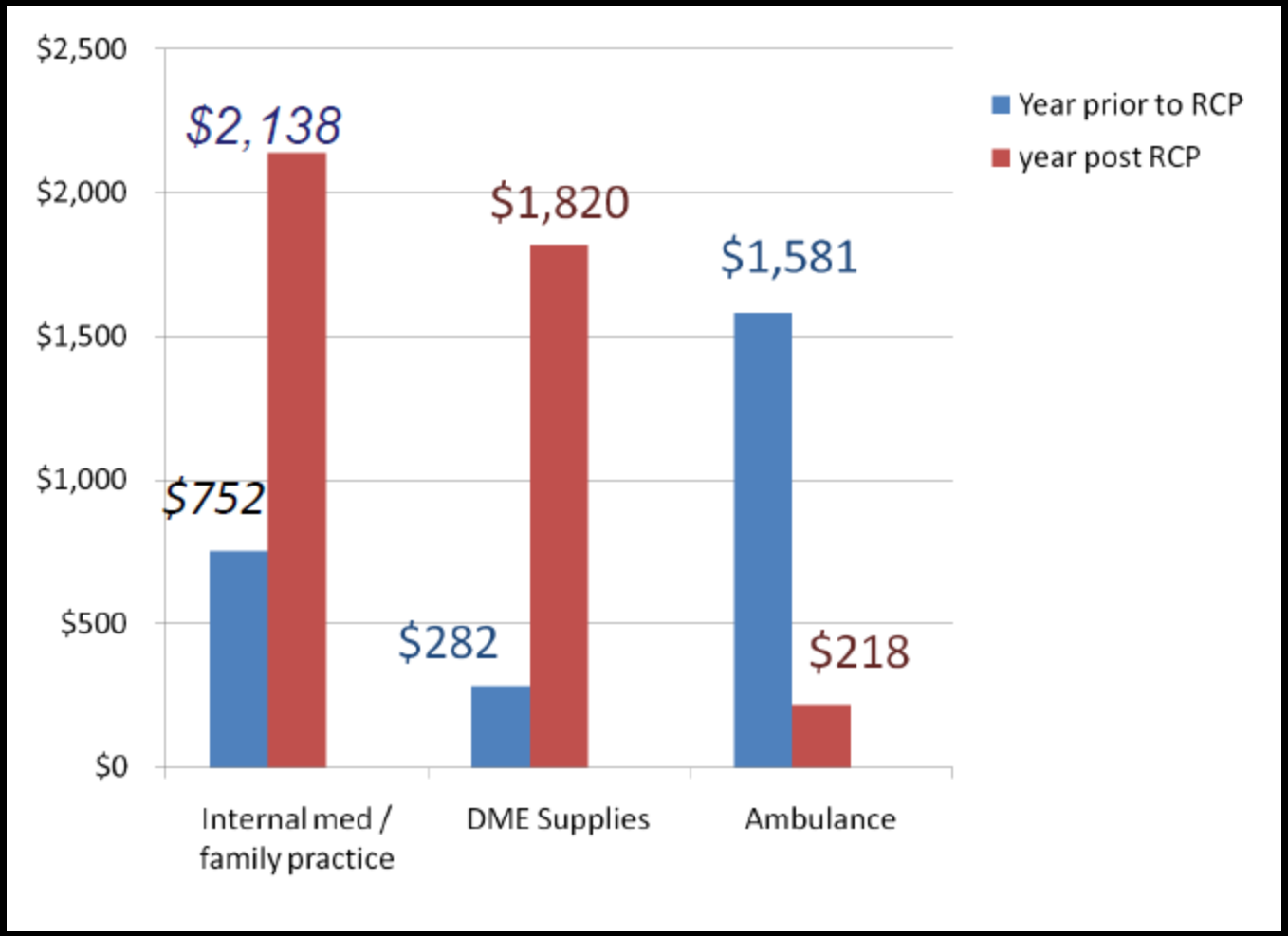

Immediate cost savings

Direct savings (estimate):

Assuming an average of 5 inpatient days reduced per patient (assuming variable savings per patient @ $250/day) x 989
(INSERT LOCAL HOSPITAL PER DAY COSTS HERE)

= potential savings of $1.23 million

Opportunity costs (estimate):

Backfill opportunities at ~$5,500 per admission x 989
(INSERT LOCAL ADMISSION REVENUE HERE)

=potential additional revenue of $5.43 million

Hospital interventions in the community:

1. Recuperative Care

2. C-TraIn: Care Transitions Innovation

OHSU C-TraIn
Care Transitions Innovation

HOSPITAL (at discharge)

Pharmacy consult

Transitions Nurse visit

Personal Health Record

COMMUNITY (intake)

Pharmacy consult

Transitions Nurse visit

Primary Care Home

Low-cost medication formulary

Monthly meetings

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Care Transitions Innovation

Case study:

Middle aged uninsured patient admitted to the hospital with pneumonia and comorbid hypothyroidism, sleep apnea and depression. After discharge, he developed progressive edema and fatigue, eventually losing his job (then housing) because he couldn't stay awake.

Later readmitted to ICU for severe hypercarbic respiratory failure, volume overload and hypothyroidism—and stayed for 19 days, at a cost to the hospital of $130,000.

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Care Transitions Innovation

Monthly team meetings

Clinic champions

Payment structure and processes

Patient experiences

OHSU C-TraIn
Care Transitions Innovation

OHSU C-TraIn: Patient Tracking Metrics

Clinic Name: OLD TOWN CLINIC

	Patient name	MRN	PCP	Nurse Mgr	PHARM Y / N	Hospital D/C Date	Date of 1st clinic visit	Dates of follow up clinic visits attended	# of No-show Appts or canceled	Comments
1			Redwood	Teresa	N		11/19/10	11/24/10	0	-
2			_____	_____	_____		_____	_____	2	Pt CxI
3			_____	_____	_____		_____	_____	2	No shows
4			Devoe	Teresa	N		12/13/10	12/7, 1/3, 2/4, 2/9, 2/11	0	-
5			_____	_____	_____		_____	_____	1	No show
6			_____	_____	_____		_____	_____	3	No shows
7			O'Hara	Carol	N		2/3/11		1	Pt cxl
8			Jones	Teresa	N		12/23/10	1/4, 1/7, 2/4, 2/7	2	No shows
9			LeFaunce	Carol	Y		1/3/11	2/11	5	No Shows
10			Jones	Teresa	N		2/17	2/28	1	No show
11			Sobota	Teresa	N		2/11/11	2/14, 2/23	1	Pt cxl
12										
13										
14										
15										
16										
17										
18										
19										
20										
etc										

Notes (ongoing issues); **Feedback for OHSU C-TraIn team**

Internal Clinic issues identified

1. Need to schedule MTM at time of initial visit
2. Using the correct appointment type when scheduling CTrain for tracking purposes

Clinic tracking only. Please feel free to contact Honore Englander (englandh@ohsu.edu) with any questions. For specific clinic questions within IMC, please contact Lorri Aldridge; OTC: Carol Weber; VGMHC: Barb Fordyce.

Results?

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Care Transitions Innovation

"You feel like they have a safe place to go, like they have good connections on the outside," - Dr. Sustersic (OHSU Hospitalist and Primary Care Provider at Old Town Clinic)

Improved Patient experience

Decreased mortality

Strengthened connections

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Care Transitions Innovation

Lessons learned:

Pharmacy consult and formulary are critical

Standard care transitions program is not designed for patients with substance abuse and mental health issues

When you start something, study it!

OHSU C-TraIn
Care Transitions Innovation

Credits

- Honora Englander, MD, and Devan Kansagara, MD, FACP
- OHSU Hospital Administration
- Old Town Clinic, Virginia Garcia Clinic and OHSU Internal Medicine Clinic
- Stephanie Pena, RN
- C-Train Multi-disciplinary Team (including many members of OHSU and clinic staff)
- OHSU Research Team
- and many others...

Questions?

rcp@ccconcern.org

centralcityconcern.org

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