Health Quality Transformation 2013
Qualité de la santé

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Hugh MacLeod (moderator)

Moderator

Hugh MacLeod

Chief Executive Officer

Canadian Patient Safety Institute

Session Objectives

1. Develop an understanding of patient care coordination and the importance of medication reconciliation

2. Hear the experiences of organizations that are successfully ensuring care coordination and discover how you can apply the lessons they have learned in your own work environment

Presenter Disclosure

- **Session Name:** Care Coordination through the Eyes of the Patient: A Health Links Opportunity

- **Presenters:** Hugh MacLeod (moderator), Angela Morin, Dr. Jocelyn Charles, Kimindra Tiwana, Eleanor Rivoire, Dr. Karen Hall Barber, Sherri Elms

- **Relationships with commercial interests:**
  - Not Applicable

Disclosure of Commercial Support

- This session has received no commercial support

Mitigating Potential Bias

- Not applicable

Speakers

Angela Morin

Patient and Family Experience Advisor

Kingston General Hospital, Kingston Ontario

Speakers

Dr. Jocelyn Charles

Medical Director, Veteran's Centre

Sunnybrook Health Sciences Centre, Toronto, Ontario

Sunnybrook
HEALTH SCIENCES CENTRE

Speakers

Kimindra Tiwana

Project Leader

Institute for Safe Medication Practices, Canada

Speakers

Eleanor Rivoire

Vice President

Kingston General Hospital,

Kingston, Ontario

Speakers

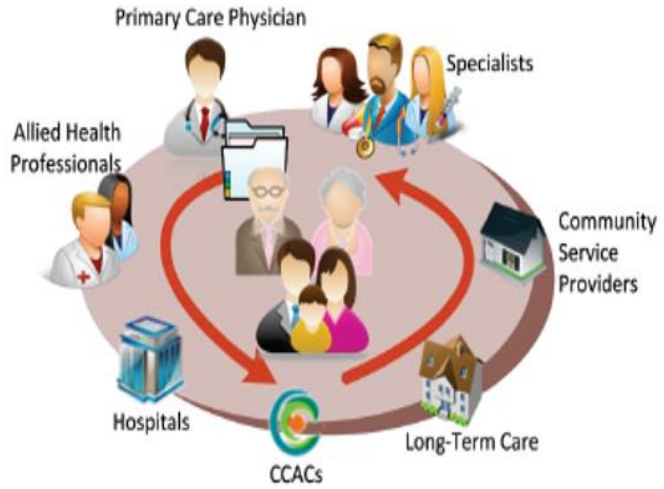
Dr. Karen Hall Barber

Sherri Elms

Queen's Family Health Team
Kingston, Ontario

Health Links: Partnering Around Patients

- Coordinating care at the patient level
- Priorities for year 1:
  - Access to a primary care provider
  - Enhanced health system experience
  - All persons with complex chronic illness will have a coordinated plan of care



Ministry of Health and Long Term Care, June 25, 2013

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Bonnie's Story

Angela Morin

We were a team!


L
A
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M
E
R

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Fundamental Concepts in Care Coordination

Dr. Jocelyn Charles

Care Coordination: Theory

Why has care coordination become so challenging?

- What has changed?
- Why has it changed?
- What has resulted?

What do we need to do to make it better for patients?

What has Changed?

- ↑ number of providers per patient
  - ↑ specialization of care
  - E.g. hospitalists, sub-specialists

- Providers no longer know each other
  - provider referral networks now depersonalized

- Gap between inpatient and outpatient care has widened
  - often providers unfamiliar with each other's work

(Wagner, 2012; Carrier et al, 2011)

More Doctors is Not Necessarily Better!

- 4 or more physicians:
  - Doubles self-report of poor care coordination
- Reported errors double as the number of physicians involved in a patient's care doubles

(2008 Commonwealth Fund International Health Policy Survey of Sicker Adults)

Why Don't We Talk to Each Other?

- FP unable to reach the treating MD in ED
  - Too busy or shift change so FPs stop trying
- Specialist unable to reach the FP
  - Phone line busy, no direct access
  - Providers have different preferences: fax, email, mail – no directory
  - Too busy to keep trying

→ Absence of ***two-way communication***

  - Patients report receiving providers don't know why patient referred or what is expected

(Carrier et al. 2011; Wagner, 2012)

Why Have Changes Occurred?

- ↑ population with multiple chronic diseases
- Care more complex with shorter time frames:
  - Limited human and financial resources
- Multiple specialists directing care for single diseases
- Evidence-based care for one disease often conflicts with evidence for another disease
- Single provider, serial consultation model of care
  - Office visits scheduled on fee-for-service remuneration

(Wagner, 2012)

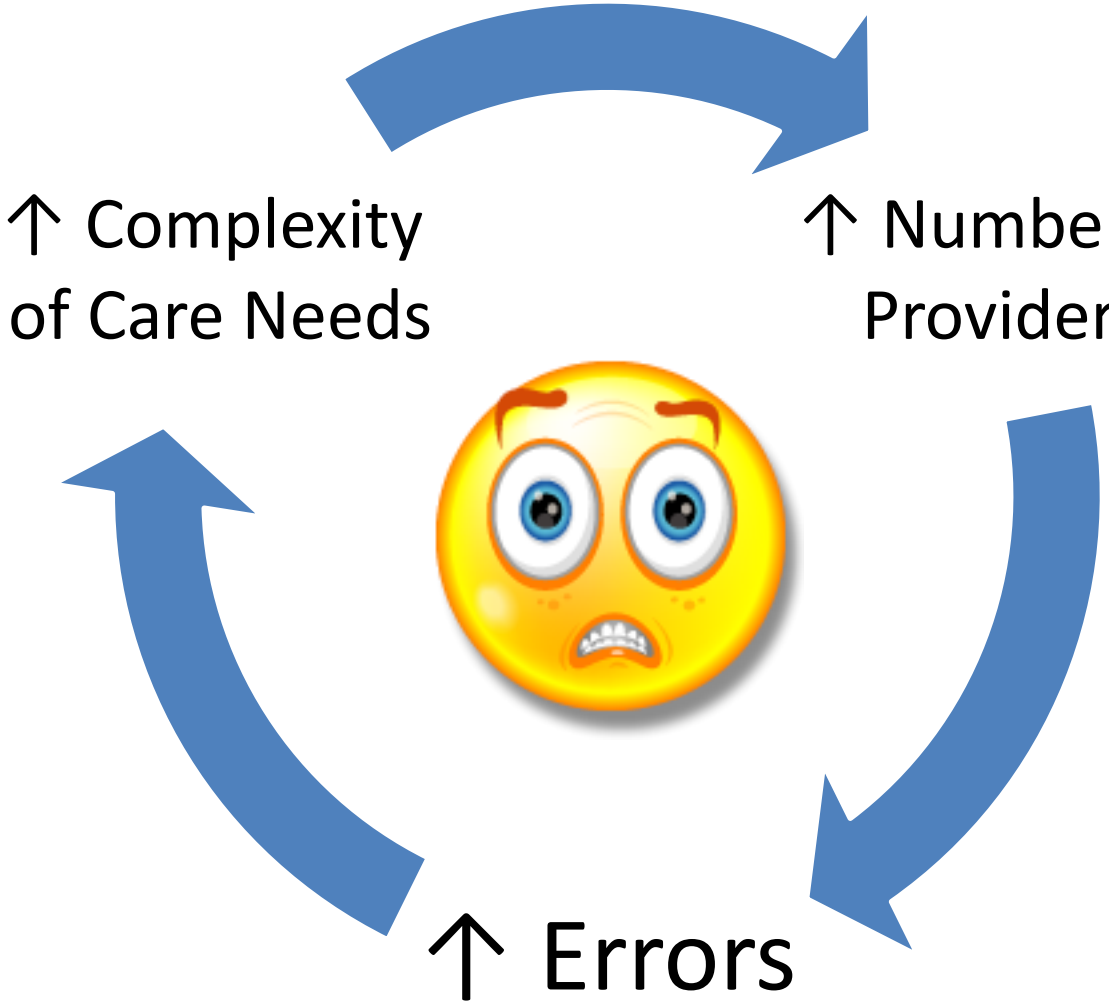
Why Have Changes Occurred?

- No standard requirements for:
  - Content & timing of discharge summaries and consultation letters
  - Communication at transitions of care
  - Electronic medical records → many different EMRs that don't communicate

Common Culture

Once discharged
from provider's care:

- "No longer my patient"
- "Not my problem"
- "Send another referral"



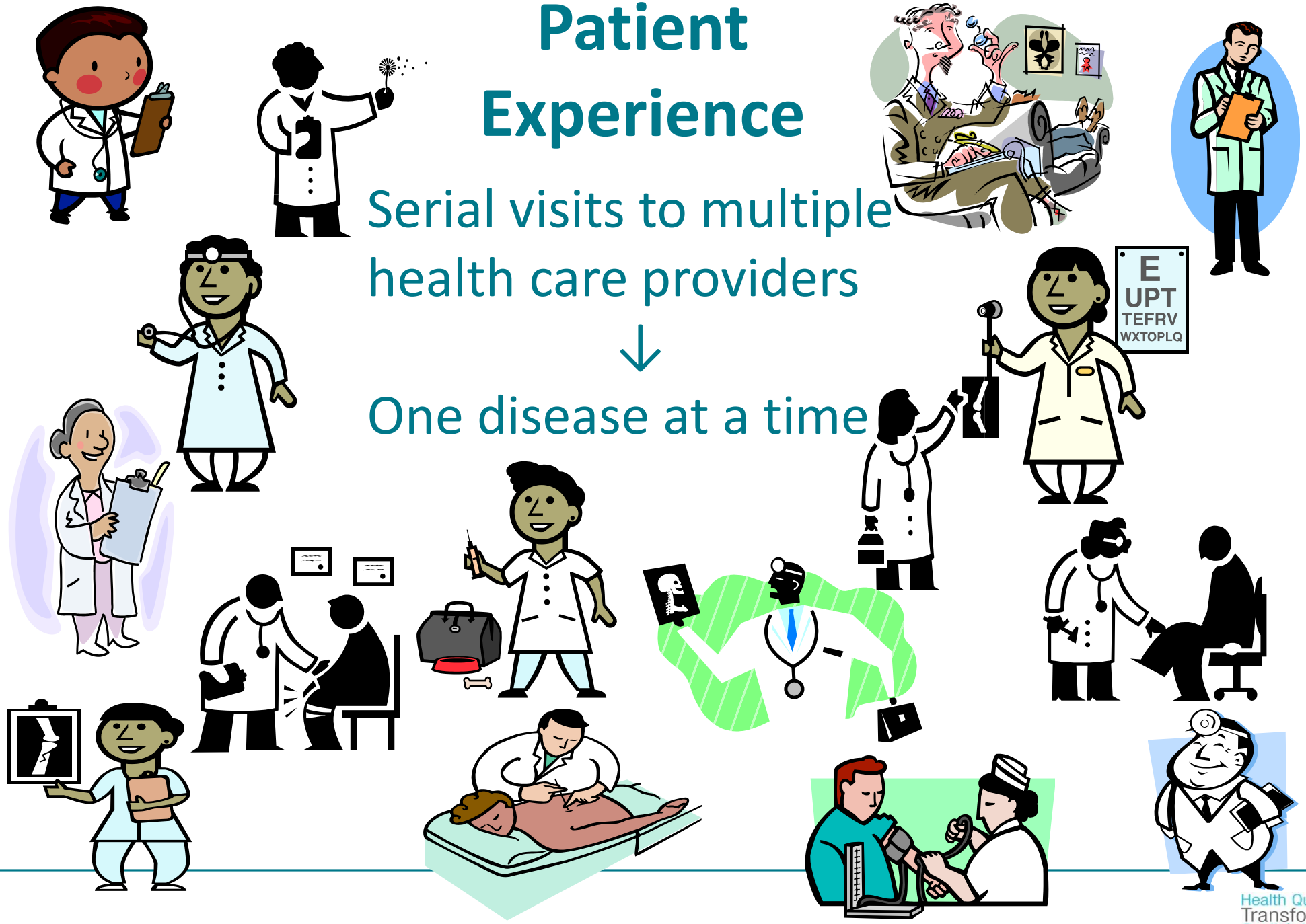
…no one is accountable for coordinating care!

Patient Experience

Serial visits to multiple health care providers

↓

One disease at a time



What Changes Mean for Patients

- Transition errors that can lead to significant patient harm
    - Medication errors
    - Preventable hospital re-admissions & ED visits
    - Unnecessary pain & procedures for patients
    - Premature institutionalization
    - Premature death
- Lost opportunities for patients to achieve better health outcomes

(Institute for Health Improvement)

What Do We Need for Safe, Effective Patient Transitions?

- ***Patient-centred*** focus
  - Individual patient choices & goals
- Involvement of ***whole*** multi-professional ***team***
  - With clearly defined roles
  - Effective 2-way communication between team members
- ***Health information technology*** that is:
  - Accessible, integrated across sites
- Available patient ***self-management*** tools

How Do We Make it Better?

- Move from ***multi-disciplinary care:***
  - Each team member is responsible only for the activities related to own discipline (O'Daniel, Rosenstein 2008)

- To → ***Interprofessional care:***
  - Team members responsible for combining their knowledge & skills to meet the patient's goals within and across settings (Oandasan, Closson 2007)
  - Requires a common platform of communication:
    - Need to talk to each other

Care Coordination System Requirements

- ***Real time communication*** between primary care, specialists and community providers at ***all points of care***

- ***Shared accountability*** for anticipating patient needs, planning care & educating each other

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Medication Reconciliation: A Key Part of Care Coordination

Kimindra Tiwana

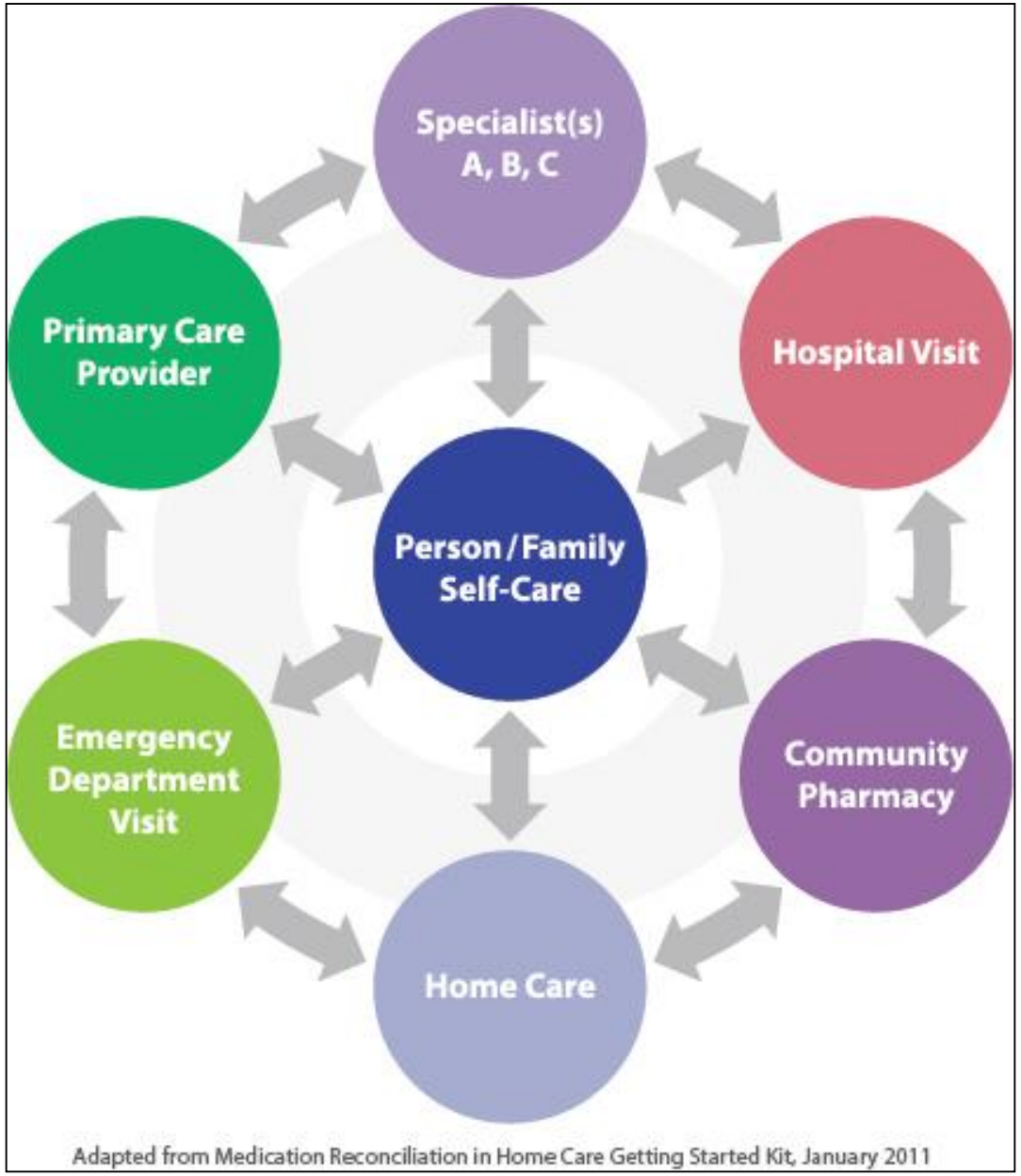
Medication Reconciliation

- Medication reconciliation (MedRec) is a **formal** process in which health care professionals **partner with patients** to ensure **accurate and complete** medication information is **communicated** consistently at **transitions of care**

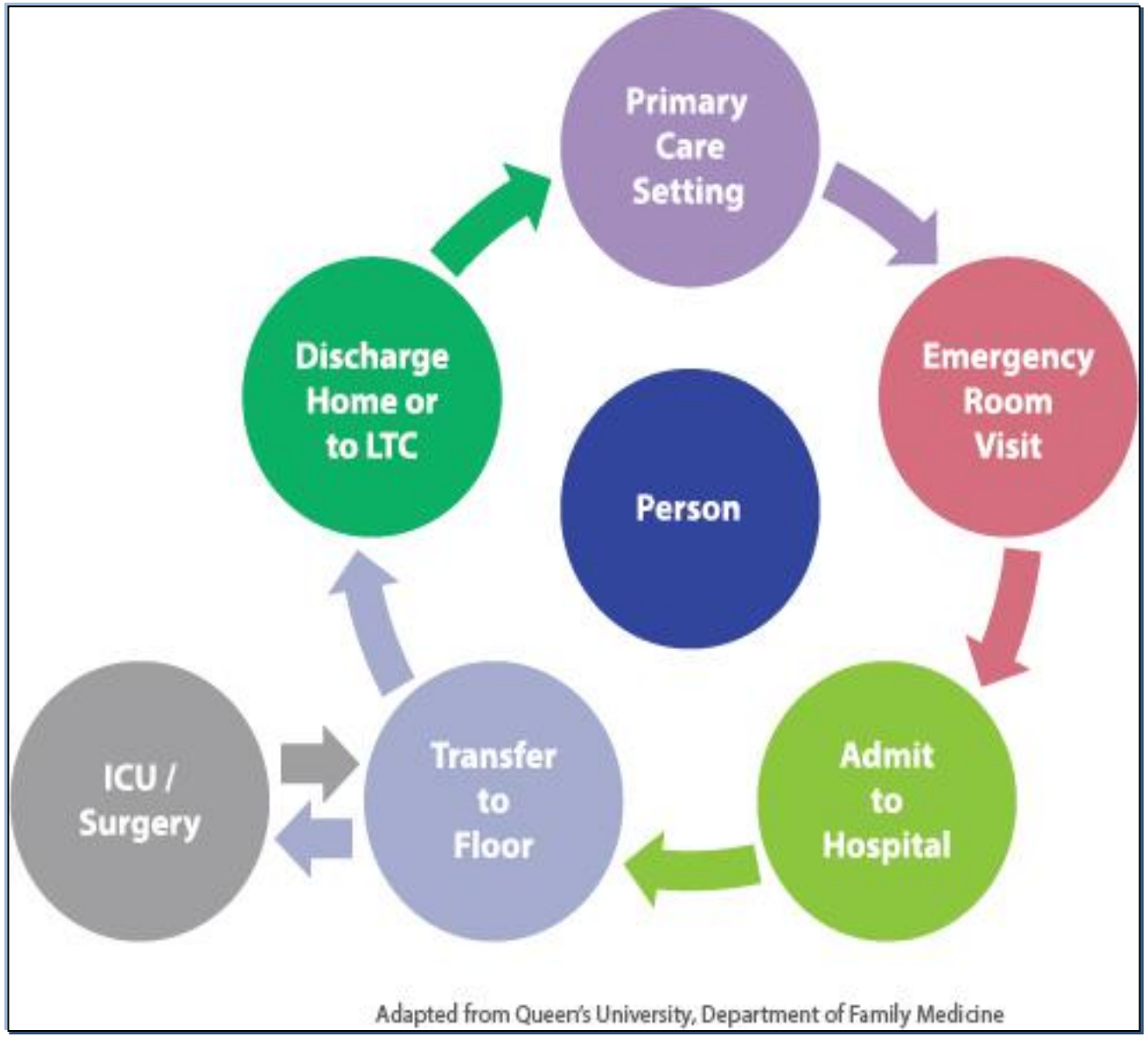
- It requires a **systematic and comprehensive review of all the medications** a patient is taking, known as a **best possible medication history** (**BPMH**), to ensure that medications being added, changed or discontinued are carefully evaluated

In Other Words

….making sure the right information is communicated about a patient's medications each time the patient moves throughout the health care system



Adapted from Medication Reconciliation in Home Care Getting Started Kit, January 2011


Primary Care Setting
Emergency Room Visit
Admit to Hospital
Transfer to Floor
ICU / Surgery
Discharge Home or to LTC
Person
Adapted from Queen's University, Department of Family Medicine

Why Do We Need MedRec?

- Transfers from one health care setting to another can lead to errors in patient's medication regimens

- These errors can potentially lead to:
  - adverse events
  - prolonged hospitals stays
  - re-admissions back to hospital

Medication Communication Failures Impact EVERYONE!

PATIENT & FAMILY

- loss of life
- prolonged disability
- temporary harm
- complicated recovery
- loss of income
- confusion about treatment plan

HEALTHCARE SYSTEM

- prolonged recovery time
- increased cost and staff time due to rework
- avoidable readmissions and Emergency department visits
- reduced access to health services

SOCIETY

- loss of productivity
- workplace absenteeism
- increased cost
- loss of public confidence in the healthcare system

Medication Safety: We all have a role to play.

Safe patient care depends on accurate information. Patients benefit when clinicians work with patients, families, and their colleagues to collect and share current and comprehensive medication information. Medication reconciliation is a formal process to do this at care transitions, such as when patients enter the hospital, are transferred or go home. We all have a role to play.

Accreditation Canada, Canada Health Infoway, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, Patients for Patient Safety Canada, the Royal College of Physicians and Surgeons of Canada, The College of Family Physicians of Canada, Canadian Patient Safety Institute and the Institute for Safe Medication Practices Canada **actively support strategies to improve medication safety and call on all healthcare professionals to contribute to effective communication about medications at all transitions of care to improve the quality and safety of our Canadian healthcare system.**

ACCREDITATION CANADA / AGRÉMENT CANADA — Driving Quality Health Services / Force motrice de la qualité des services de santé

Canada Health Infoway / Inforoute Santé du Canada

Association médicale canadienne / Canadian Medical Association

Canadian Nurses Association / Association des infirmières et infirmiers du Canada

cpsi icsp — Canadian Patient Safety Institute / Institut canadien pour la sécurité des patients

Canadian Pharmacists Association / Association des pharmaciens du Canada

Canadian Society of Hospital Pharmacists / Société canadienne des pharmaciens d'hôpitaux

ismp Canada

Patients for Patient Safety Canada / Patients pour la sécurité des patients Canada

Royal College of Physicians and Surgeons of Canada / Collège royal des médecins et chirurgiens du Canada

The College of Family Physicians of Canada / Le Collège des médecins de famille du Canada

PATIENT & FAMILY

- loss of life
- prolonged disability
- temporary harm
- complicated recovery
- loss of income
- confusion about treatment plan

MedRec

Defined as 3 step process of:

- Create a complete and accurate best possible medication history (BPMH)
- Reconcile medications
- Document and **communicate**

TABLE 1.
Medication reconciliation in varying levels of intensity, as seen in published studies

Level	Key Components	Published Examples
Bronze	BPMH with admission reconciliation	Cornish et al. 2005; Kwan et al. 2007
Silver	Bronze level + reconciliation at discharge by prescriber only ± electronically generated discharge prescription	Schnipper et al. 2009; Wong et al. 2008
Gold	Silver level + discharge reconciliation is inter-professional (e.g., prescribing physician and pharmacist collaboration) + electronically generated discharge prescription	Cesta et al. 2006; Dedhia et al. 2009; Schnipper et al. 2009
Platinum	Gold level + attention to broader medication management issues (e.g., appropriateness of agents, safety and effectiveness assessment) + medication counselling prior to discharge (including discussion of medication changes) + provision of patient-friendly reconciled medication schedules upon discharge	Al-Rashed et al. 2002; Dedhia et al. 2009; Makowsky et al. 2009; Murphy et al. 2009; Nazareth et al. 2001
Diamond	Platinum level + additional elements, such as • post-discharge follow-up phone call to patient by hospital clinician (e.g., nurse or pharmacist) • communication of medication changes with rationale directly to community pharmacy and primary care physician	Gillespie et al. 2009; Jack et al. 2009; Karapinar-Çarkit et al. 2009; Schnipper et al. 2006; Walker et al. 2009)

BPMH = best possible medication history.

What Information Does the Patient Receive?

- Discharge summary
- Discharge prescriptions for:
  - all medications
  - only new medications
  - medications that were changed
- Medication calendar
- List of medications on the pharmacy receipt

Can We Do Better?

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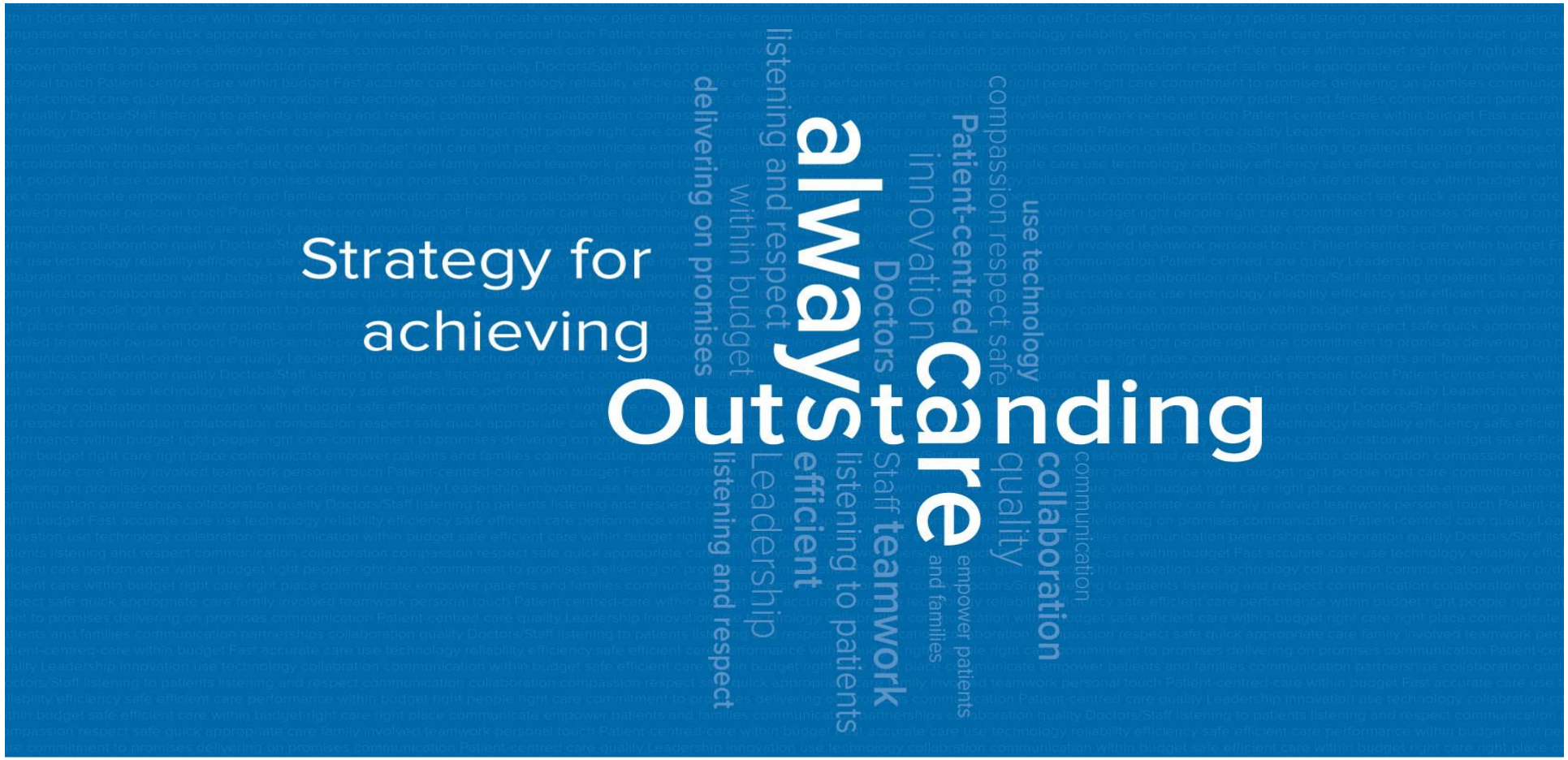
Medication Reconciliation: Patient Co-Design

Eleanor Rivoire



Kingston General Hospital

Outstanding care, always™

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

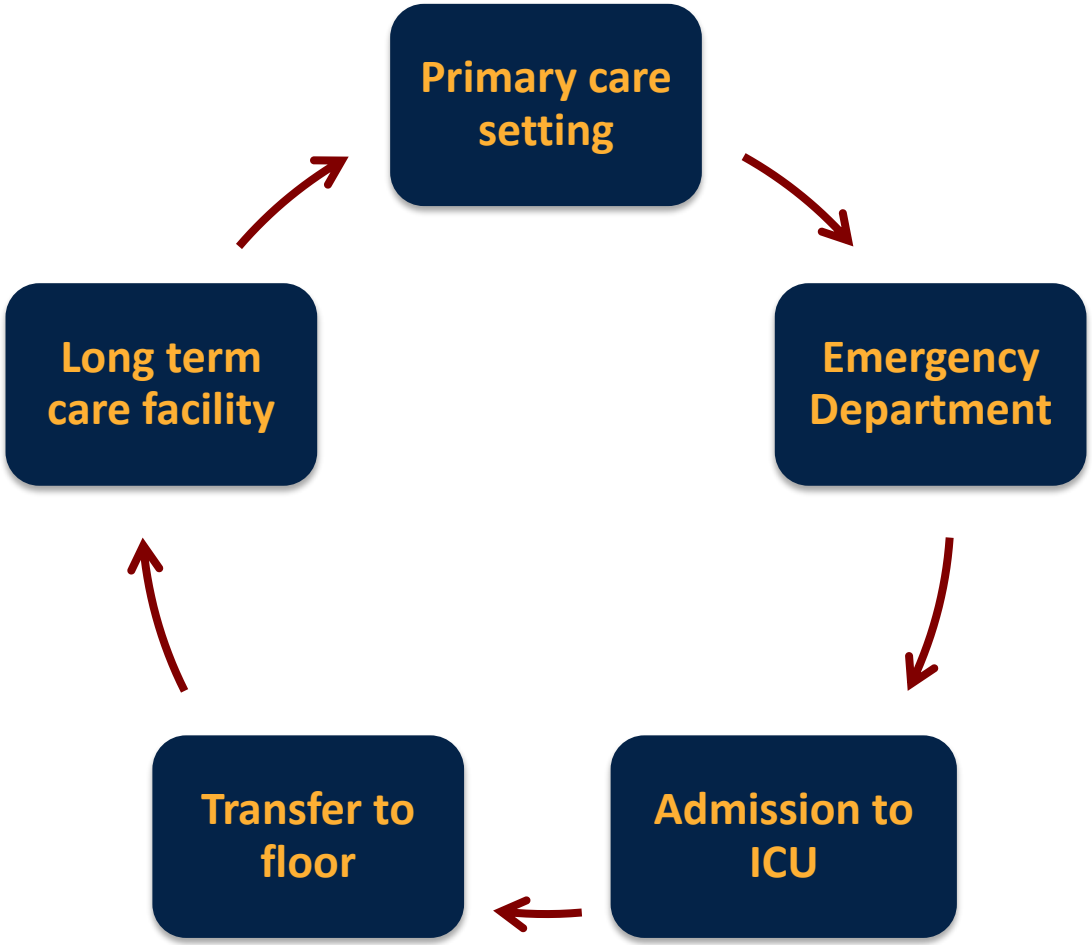
Medication Reconciliation: A Primary Care Success Story

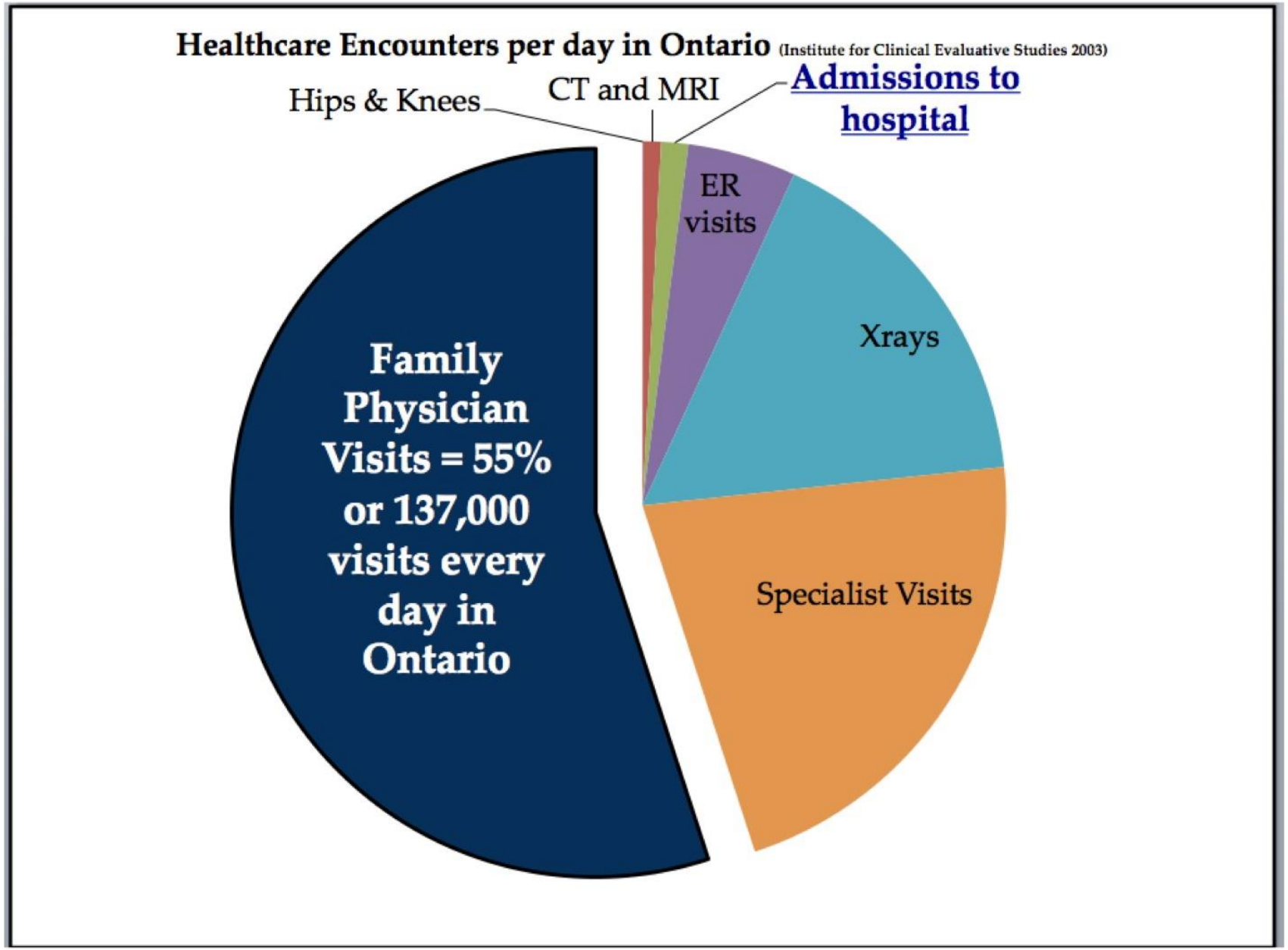
Dr. Karen Hall Barber & Sherri Elms

Let's Start with a Case:

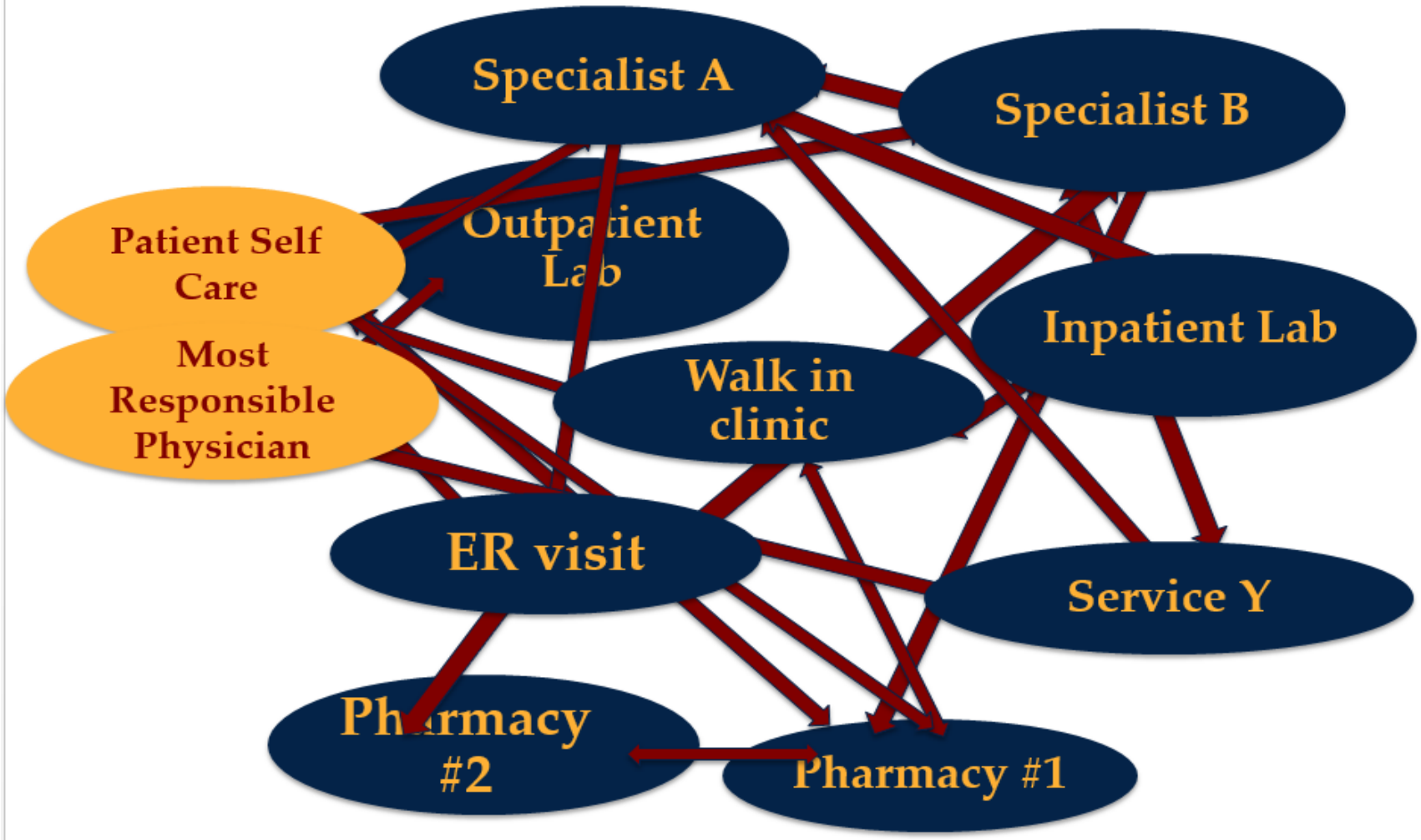
- 80 year old Jane Smith was admitted for lower GI bleed with an international rationalized ratio **(INR) of 10.2**
- Four days earlier she attended the After Hours Clinic in her family doctor's office and was prescribed **azithromycin** for pneumonia.
- The emergency room physician states Jane should have had her INR measured 2 days ago and wonders why this was not done.
- Warfarin was not on Jane's medication list
- Jane's daughter wonders how this could happen

Patients' Health Care Paths are Often Described Like This




Healthcare Encounters per day in Ontario (Institute for Clinical Evaluative Studies 2003)
Hips & Knees
CT and MRI
Admissions to hospital
ER visits
Xrays
Specialist Visits
Family Physician Visits = 55% or 137,000 visits every day in Ontario

More Often Than Not it Looks Like This




Transfer of patient care,
including medication reconciliation,
seems largely unmonitored

Literature

Where do medications errors occur?

- 39% prescribing
- 12% transcription
- 11% dispensing
- 38% administration

Koppel 1995 JAMA

Do Accurate Medication Lists Reduce Adverse Events?

RCT: pharmacist lead medication reconciliation reduced preventable adverse events

Schnipper J, AIM2006

- 10% absolute risk reduction in preventable AEs 30-days post hospital discharge

Patient Related Risk Factors for Self-reported Medication Errors in Community versus Hospital

Sears, CPJ, March 2012

	Community	Hospital In-Patient
Self-reported Medication Errors	79%	21%

Literature Shows that Community-Based Medication Lists are *WORSE* than Institutional Lists

Errors in *Community* Causing Adverse Events

- Primary care med lists are inaccurate 92% of the time

  Balon (2011)

- 66% of physicians did not record medications prescribed by external providers in patients' EMRs

  Spina (2011)

Why are there more Medication Inaccuracies in Community Patient Records?

- Lack of reporting from ER, specialists etc.
- Patients using different pharmacies
- Samples are used and not recorded
- Lack of emphasis/culture of med rec in primary care

Sears, Scobie, MacKinnon

Only

1 out of 86

medication lists

was accurate

Department of Family Medicine

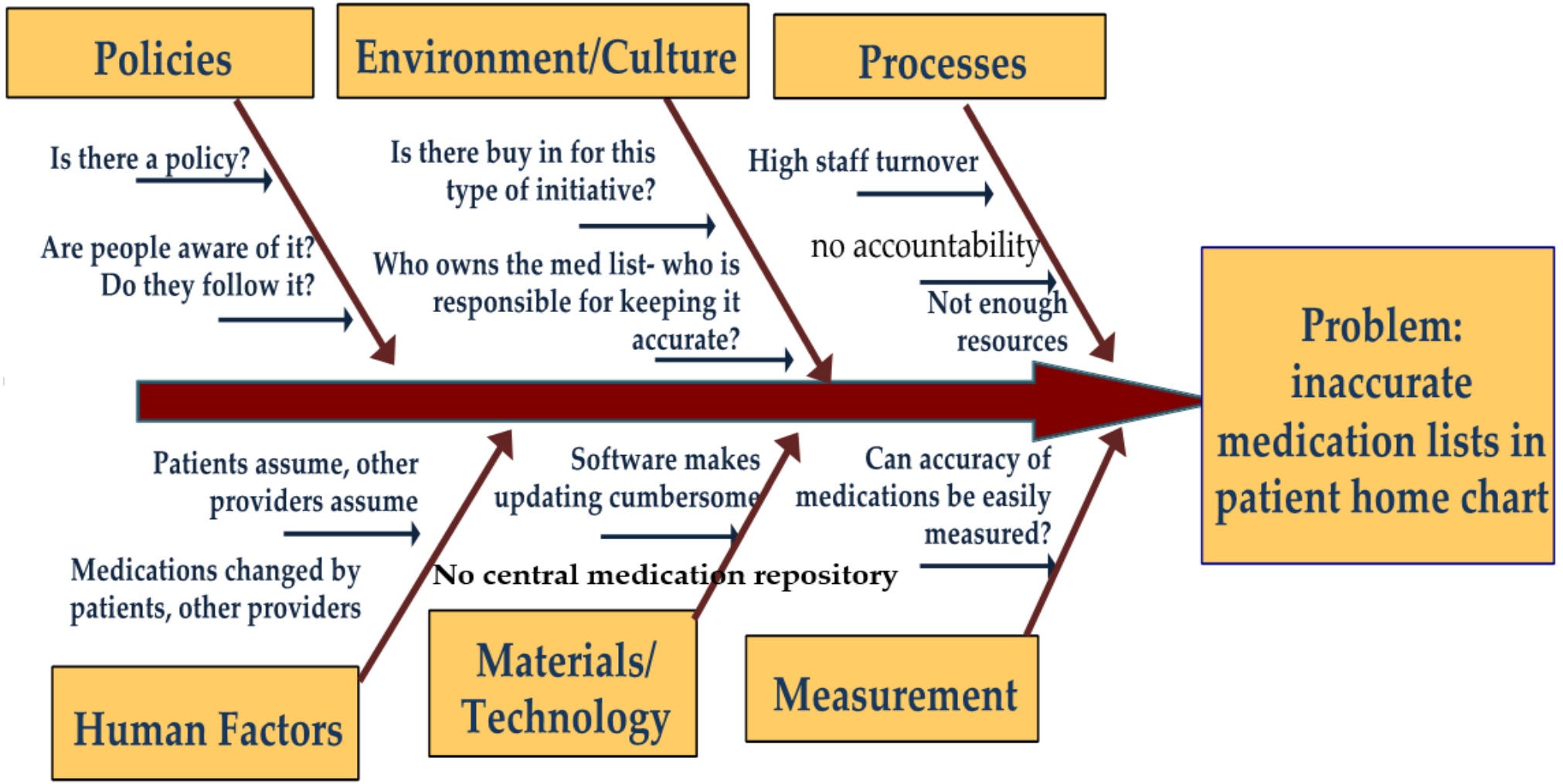
POLICY

SUBJECT:	***Queen's Family Health Team*** ***Medication Reconciliation and Allergy Verification***	**NUMBER:**	P-2012-005
ORIGINAL ISSUE:	June 18, 2009: Revised April 20, 2011, April 20, 2012	**SECTION:**	Vaccines/ Medications
APPROVED BY:	Department Head, QFHT Physician Lead	**EFFECTIVE DATE:**	JUL 2 7 2012

1. Objective	**1.1** To ensure the QFHT Electronic Medical Records include an accurate list of current medications and allergies. The QFHT recognizes that an accurate list of current medications and allergies is an important component of excellent patient care and necessary to ensure patient safety. Additionally, The Ontario College of Physicians and Surgeons requires that an accurate list of current medications and allergies be kept and maintained within the medical record. (Policy # 5-05 Medical Records)

2. Policy	**2.1 An accurate list of current medications and allergies will be included within the medical record. This list will be maintained collaboratively by the staff of the QFHT and with information provided by the patient.**

Factors Influencing Inaccuracy of Primary Care Medication Lists



Reconciliation…When?

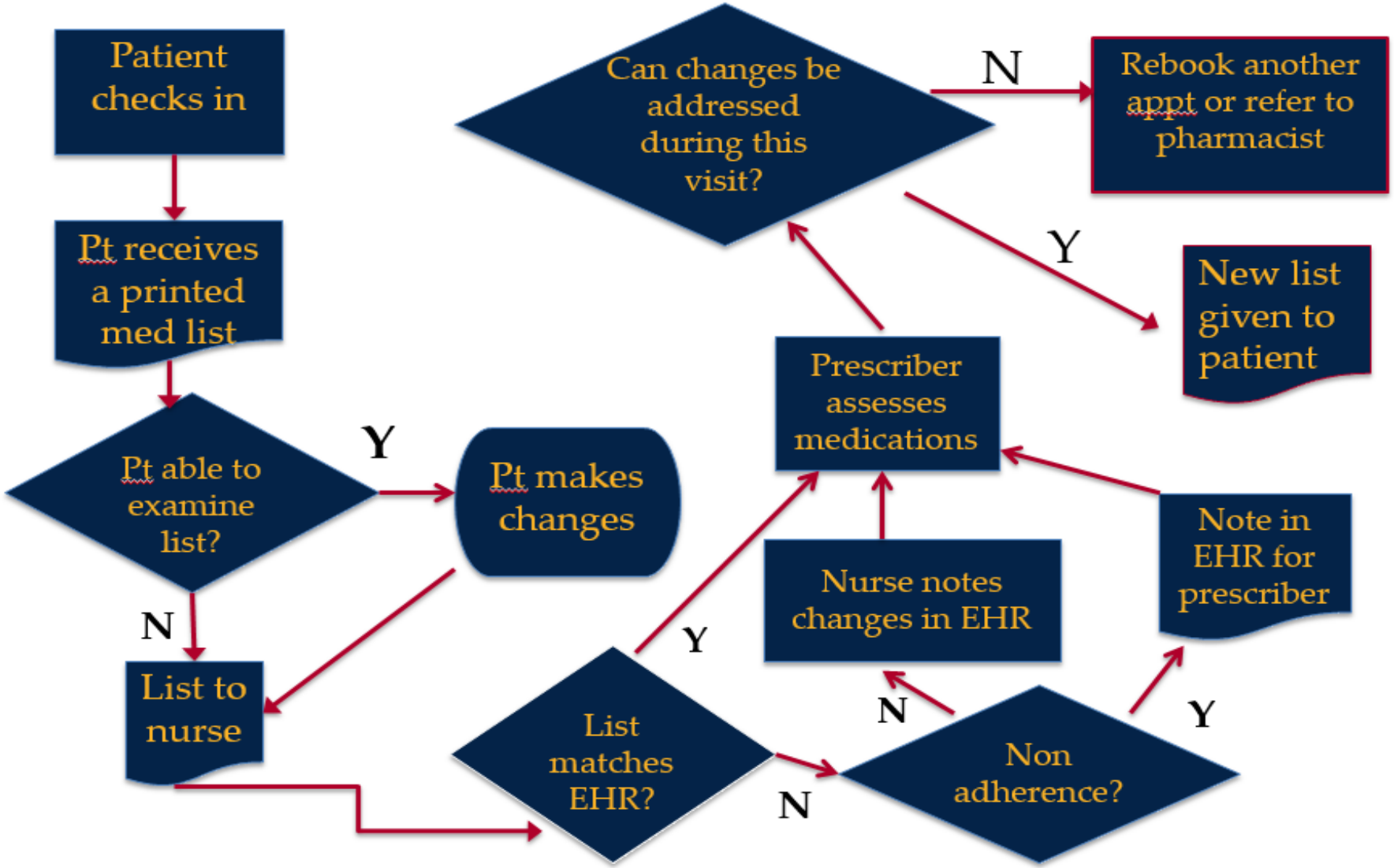
Medication reconciliation prevents errors at patient ***transition points***

We propose that key transitions points in primary care include:

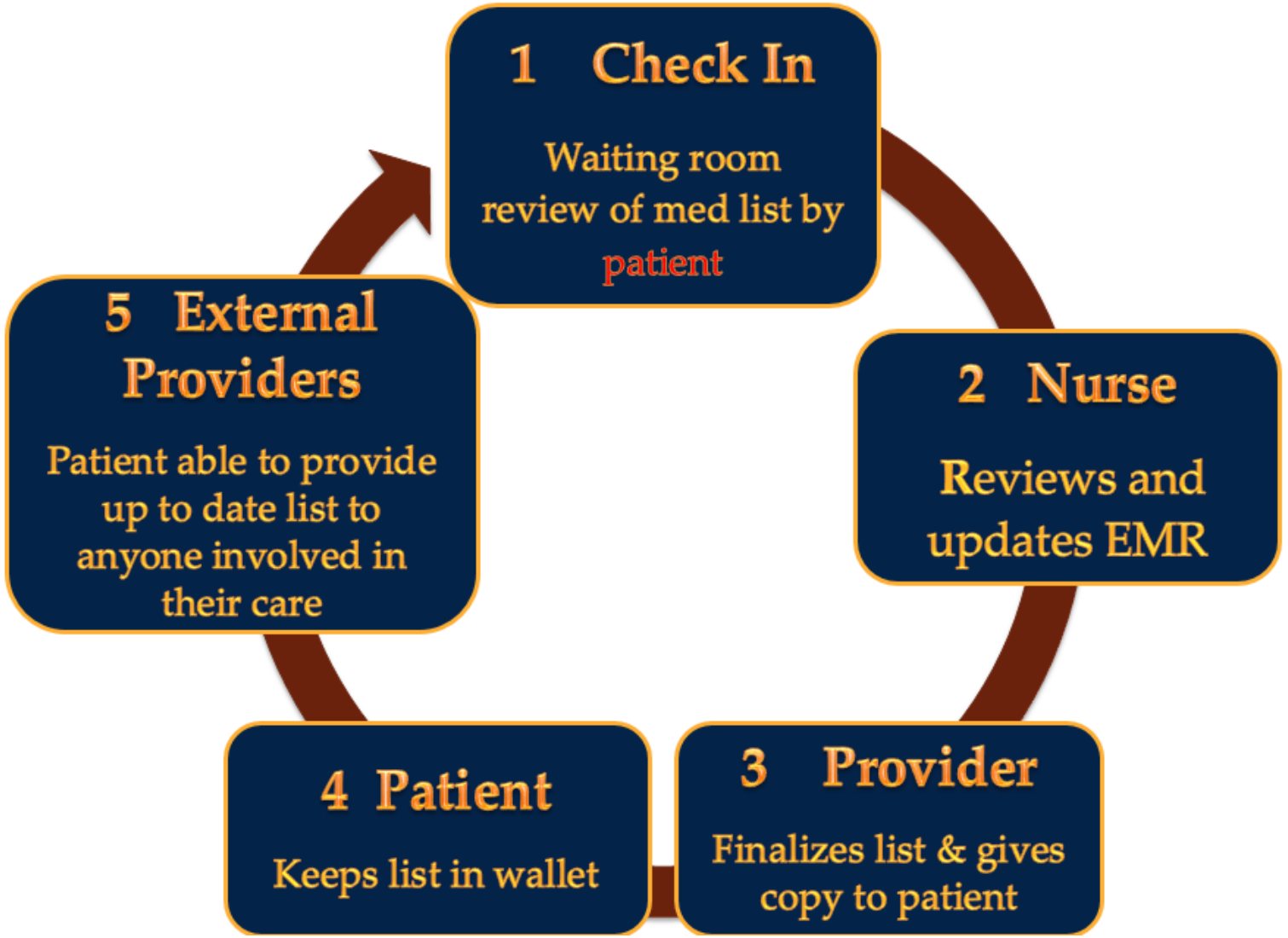
- face-to-face office visits
- incoming ER records, discharge reports and consultant letters
- fax refill requisitions or pharmacist phone calls

These are transition points **where two medication lists should be compared and reconciled**

Verifying Medication List in Home Clinic



Include Entire Circle of Care



Let's Reflect on the Case:

- 80 year old Jane Smith was admitted for lower GI bleed with an international rationalized ratio **(INR) of 10.2**
- Four days earlier she attended the After Hours Clinic in her family doctor's office and was prescribed **azithromycin** for pneumonia.
- The emergency room physician states Jane should have had her INR measured 2 days ago and wonders why this was not done.
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Take Home Points

1. Majority of health care transactions take place outside of an institution
2. Care coordination is tremendously complex
3. Medication lists become inaccurate…

Thus,

1. Promotion of medication reconciliation in primary care is the essential starting point
2. Centralized provincial medication list repository is the long term goal

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Bonnie's Story:

The Next Chapter

Angela Morin

Definition

- Respect me
- Hear me
- Work with me

A Day Without Laughter is a Day Wasted!

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Questions?

Care Coordination through the Eyes of the Patient: A Health Links Opportunity

Please complete the session evaluation!

Thank you