OREGON HEALTH CARE QUALITY CORPORATION
A nonprofit partnership for quality improvement

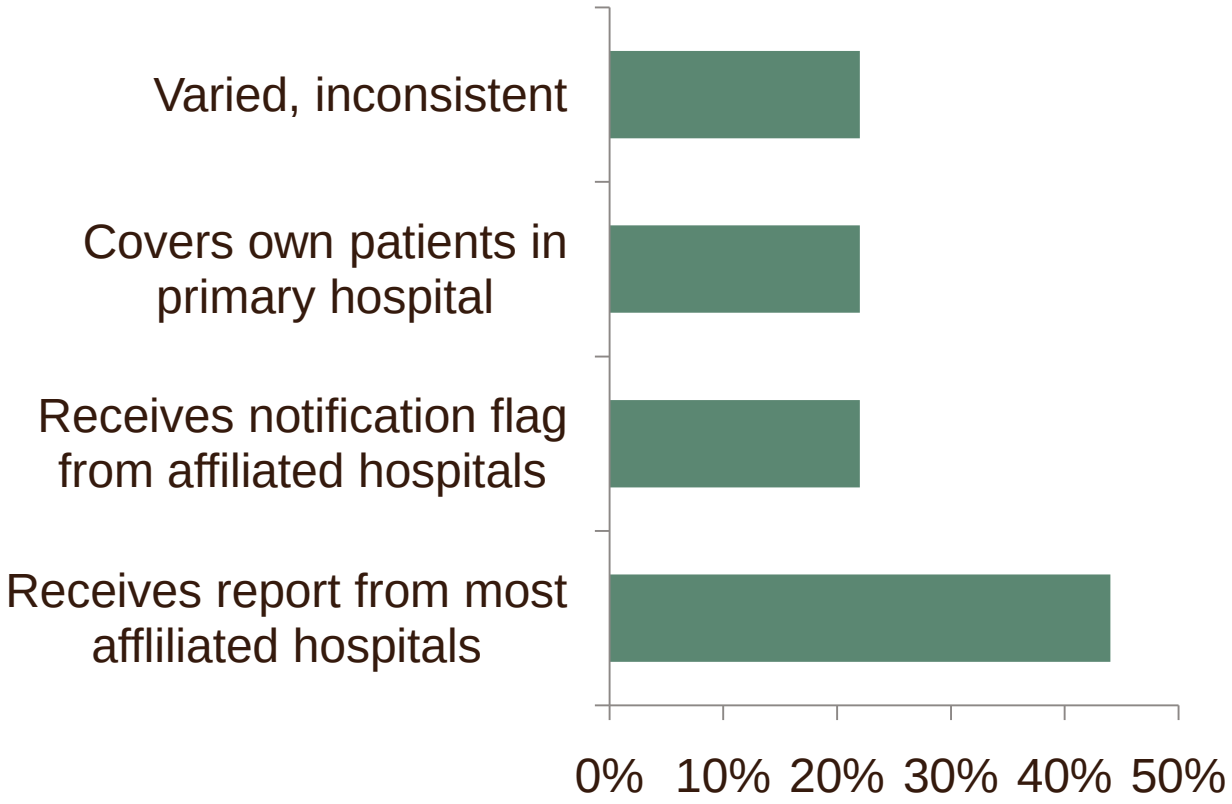
Transitions in Care
Medical Group Survey

September 2011

Survey Parameters

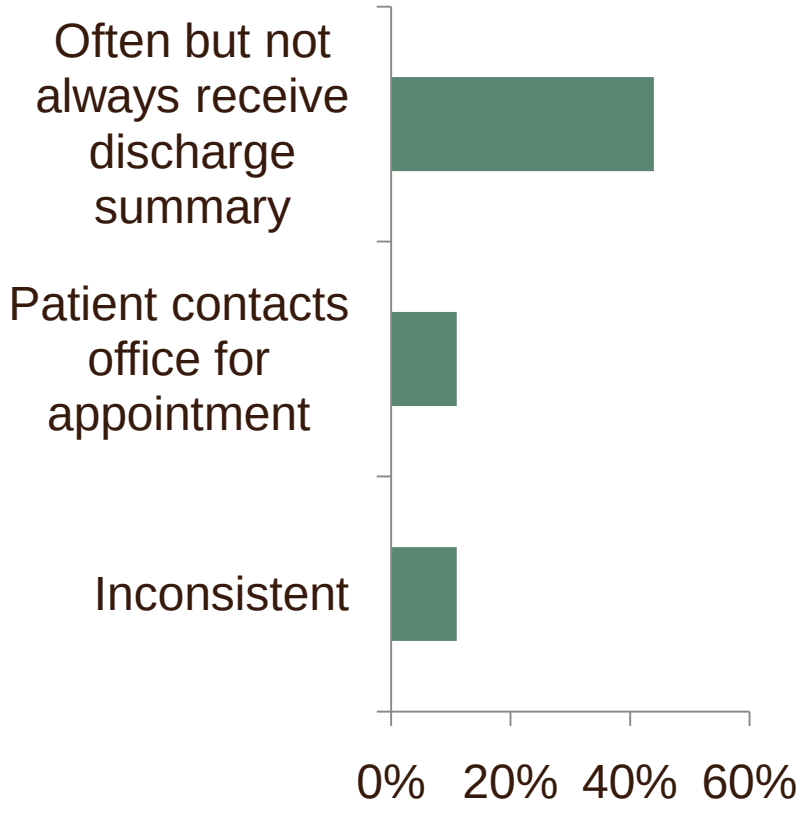
- 13 questions created by provider team
- N=9 unique clinic responses (clinics are participating in the Oregon Health Leadership Council's High Value Patient Centered Primary Care Initiative)

How do you find out when one of your patient's is admitted to the hospital?

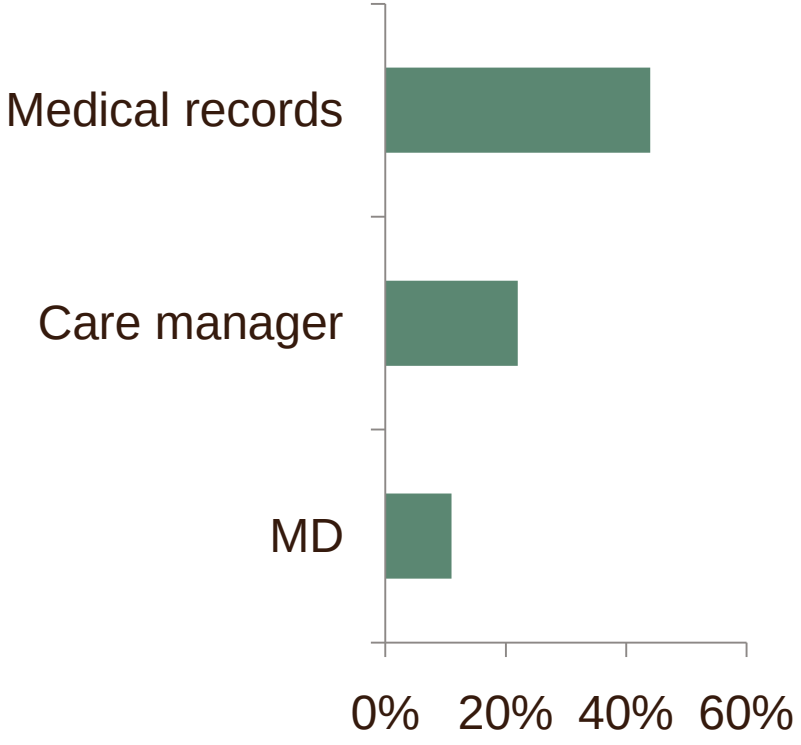


How do you find out when your patient is discharged?

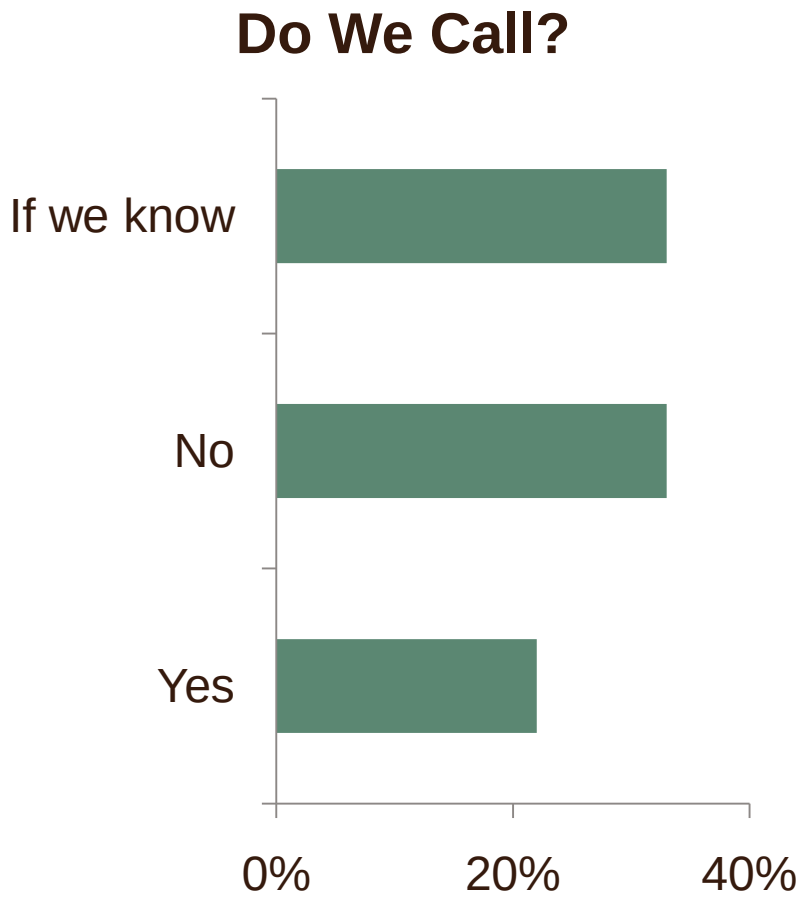
How we find out

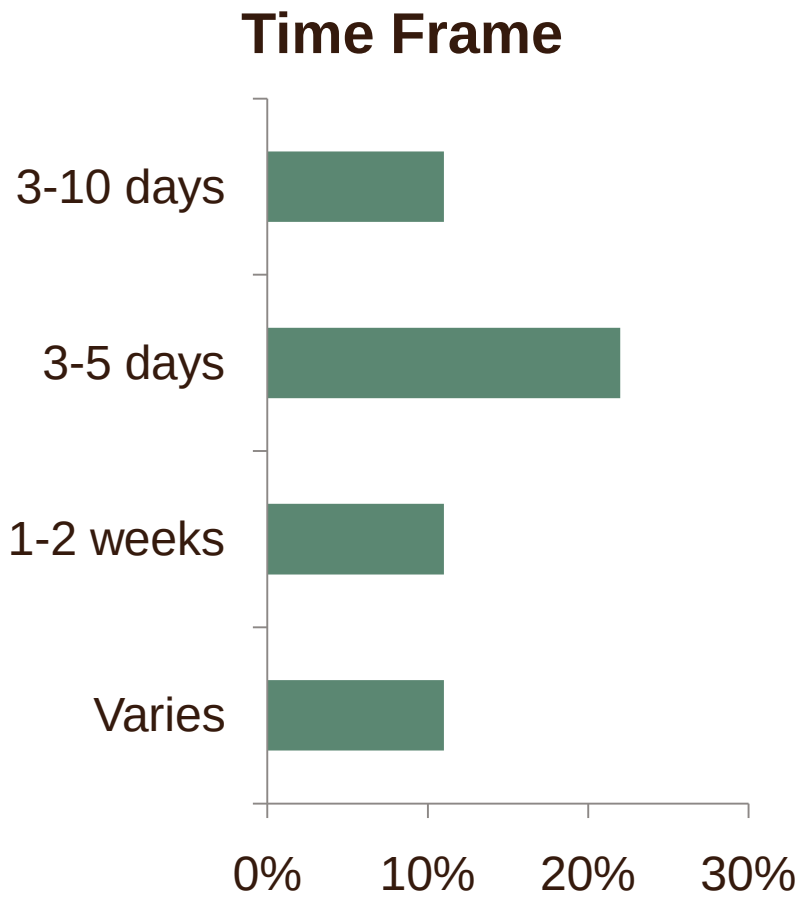


Who receives the information?

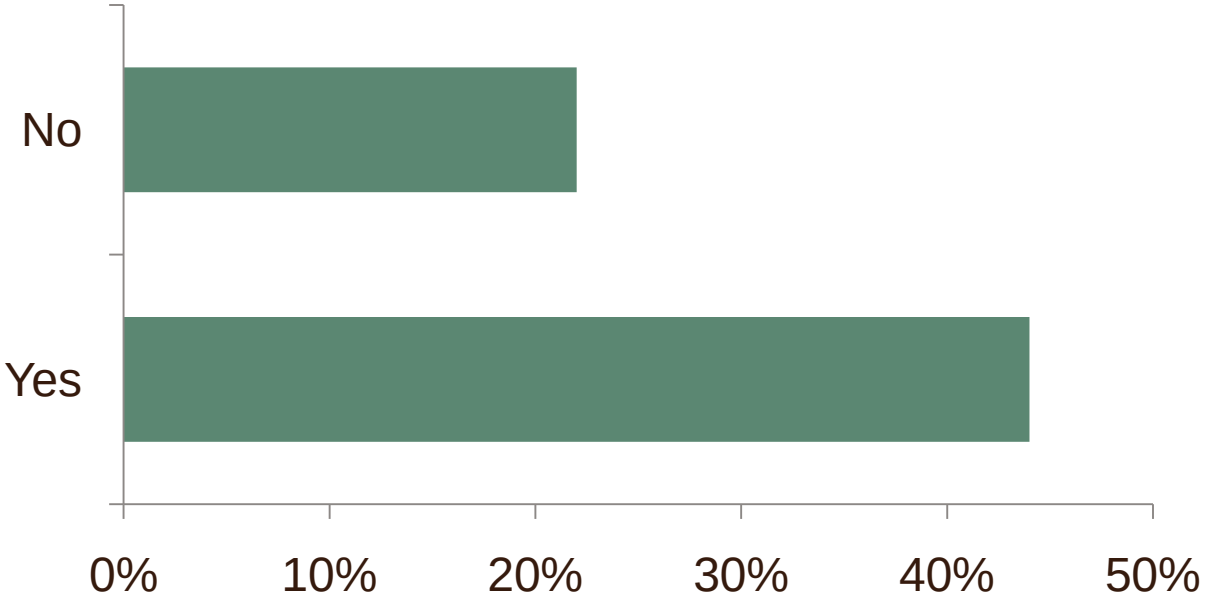


Do you call the patient within a certain timeframe?



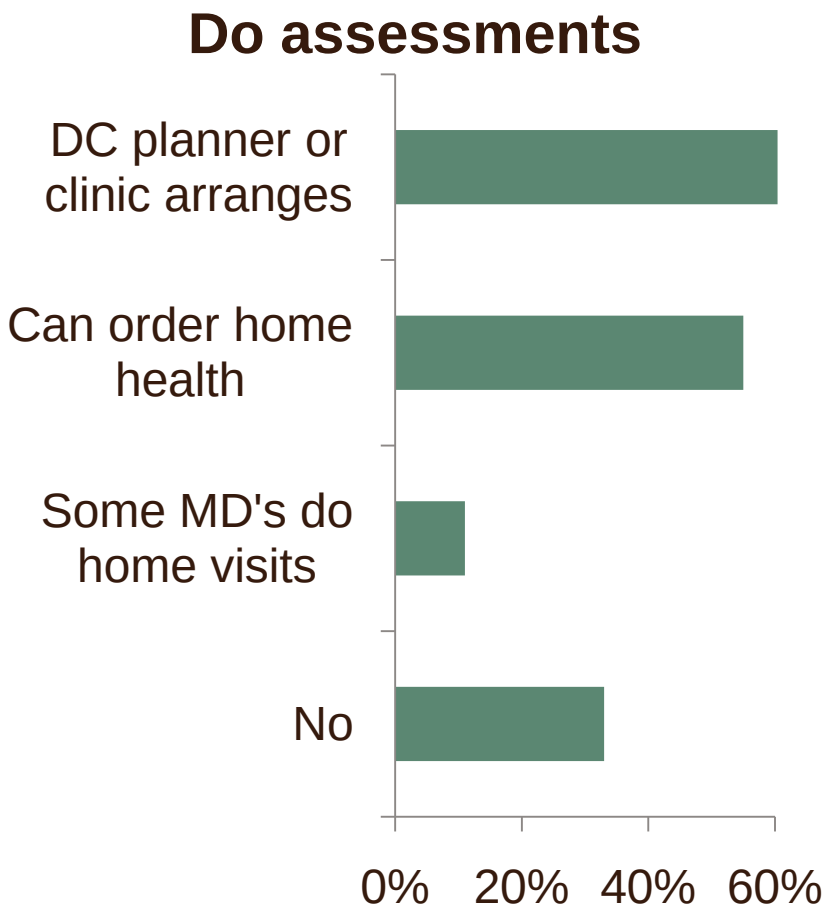


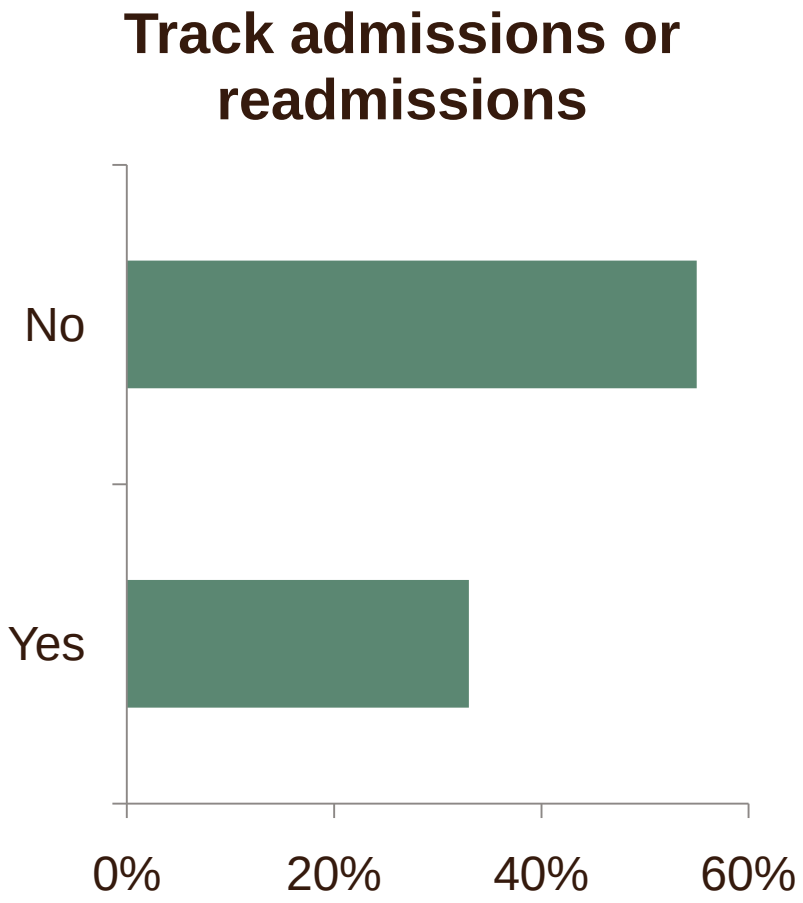
Do you have a standard process for medication reconciliation?



No standard process described; “Usually done at patient visit”

Can you accommodate the need for home visits to assess patient's ability to manage?





What is most frustrating for you when your patients are in the hospital?

- Family expectations
- Lack of coordination
- Lack of available information/communication with hospitalists
- Not having discharge summary at visit
- Nursing home discharges; lack of info on patient
- Not knowing of admission or discharge
- Lack of medication reconciliation
- Stopping/starting meds without talking to PCP

What is the most difficult or frustrating issue you face when your patient is discharged?

- Patient does not qualify for SNF but needs it
- Missing info, d/c summaries, plan of care
- Patients not sure what to do when discharged
- Communication with d/c planners
- Making sure pending issues are followed up
- Unavailability of d/c summaries
- Specialists not getting post d/c info to PCP
- Patient d/c on meds not covered by insurance
- Lack of knowledge of what PCP should follow up