



Community Care Coordination Planning: Workshop for Care Management and Quality Improvement

DRCHSD 2018 Summit

Wednesday, September 19th, 2018

Little Rock, Arkansas

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What is Care Transitions?

- Transitional care is defined as: *A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different settings or different levels of care within the same setting¹*
 - For example: Patients may receive care from an outpatient specialist then transition to a rehab provider or an inpatient admission to a skilled nursing facility
 - Often focus is on transition of care for patients with chronic conditions i.e. heart failure, pneumonia, COPD, diabetes



¹World Health Organization [Transitions of Care 2016](#)

What is Care Transitions? Continued

Root causes of ineffective transitions of care

The Joint Commission defines three main areas of breakdowns that are the root causes of ineffective transitions of care



Accountability Breakdowns

A survey at 101 Hospitals revealed that 9% of physicians have admitted to "Turking" patients.

Communications Breakdowns

Discharge summaries reach PCPs by the first follow-up visit only 12% to 34% of such visits, and then often lack key information

Patient Education Breakdowns

In a study of understanding of discharge instructions in patients > 65 years 54% did not accurately recall instructions about their follow-up appointment

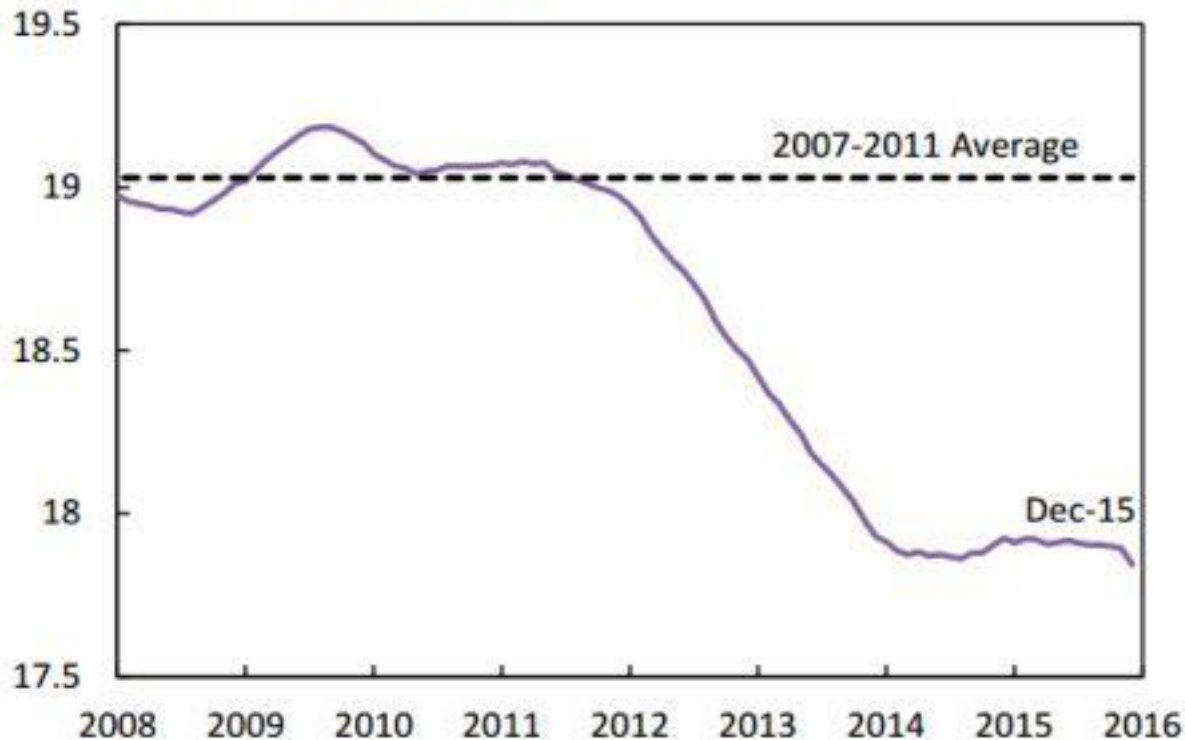
Why Care Transition Matters

- Lower readmissions rates
 - Penalty for high readmission rate within 30-days of discharge
 - Lower cost associated with readmission
- Reduction in adverse events, medication errors, complications from procedures, infection, falls
- Incentives for coordinated care i.e. participating in an ACO, bundled payment
- Improved patient outcomes
- Triple Aim: improving quality care, improving health of population and reducing per capita cost of healthcare

Hospital Readmissions Drop in 49 States

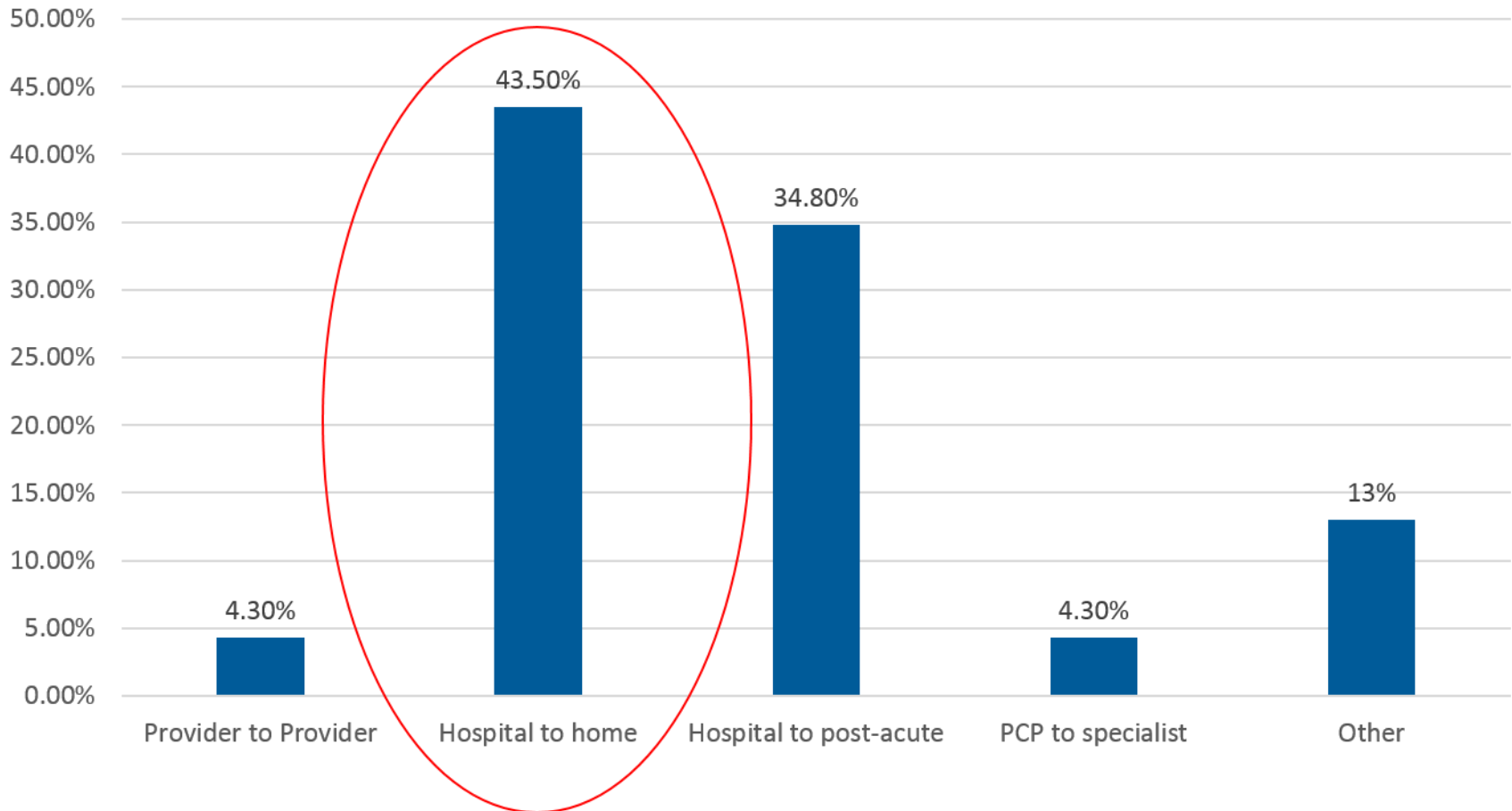
Medicare 30-Day, All-Condition Hospital Readmission Rate

Percent, 12-month moving average



Since the Hospital Readmission Reduction Program (HRRP) began in 2012, readmissions have declined

Which Care Transition Is Most Critical?



Study of 116 organizations- 35% identified as hospitals

Source: HIN Care Transitions Management in 2015
Survey, February 2015

Care Transition and Discharge Planning

A 68-year old man is readmitted for heart failure only one week after being discharged following treatment for the same condition. He brought all of his pill bottles in a bag; all of the bottles were full, not one was opened. When questioned why he had not taken his medication, he began to cry, explaining he had never learned to read and couldn't read the instructions on the bottles.



Industry Best Practices in Care Transitions



- Discharge Planning
 - Interdisciplinary discharge planning team
 - Provider, nurse, pharmacy, case management, social worker, etc.
 - Follow-up phone call to patients 24-48 hours post discharge
 - Patient rounding
 - Whiteboard utilization
- Complete and timely communication of information
 - Discharge summaries are sent 24-48 hours of discharge to outpatient providers
- Medication reconciliation/management

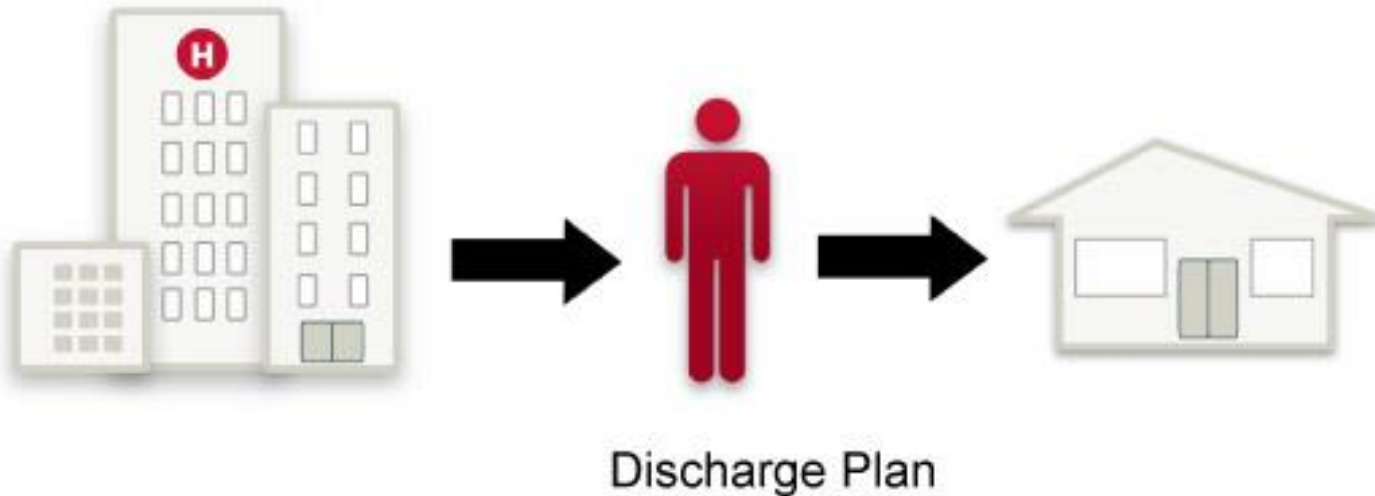
Industry Best Practices in Care Transitions Continued

- Patient/caregiver education and engagement
 - Teach-back methodology
- Follow-up visit with outpatient provider after discharge
- Utilization of technology
 - Communication between provider team
 - Admission/Discharge notifications
 - Telemedicine/telemonitoring



DRCHSD Hospital Best Practices in Care Transitions

- Discharge Planning on Admission
 - Use of discharge planning checklist
 - Readmission risk assessment i.e. LACE tool
 - Flag patients that may need additional support at discharge
 - Interdisciplinary Care Team Meetings
 - Medication management



DRCHSD Hospital Best Practices in Care Transitions Continued

- Admission/Discharge Folders
 - Discharge checklist for patient (Project Red Discharge Tool)
 - Stoplight forms for disease specific instructions
 - Audit during daily rounding



DRCHSD Hospital Best Practices in Care Transitions Once More

- Discharge Follow-up Phone Calls
 - Phone calls to all (IP and ED) discharged patients to home
 - Utilization of a script
 - Collection of data points/feedback to track and trend
- "Joint Health Partners"
- Patient Family Advisory Council



Community Care Coordination and Care Transitions



- Care coordination is: *The extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients*²
- Purpose of DRCHSD's Community Champion: enhance coordination of care and develop a community care coordination plan
- "Joint Health Partners" or **collaboration of community organizations**
 - Goal to improve quality, efficiency and coordination of healthcare and social services for at-risk populations
- Patient Family Advisory Council (PFAC)
 - PFAC partners patients and families with the healthcare team to provide guidance on how to improve patient and family experience³

²The Institute of Medicine [Priority Areas for National Action: Transforming Health Care Quality \(2003\)](#)

³BJC Healthcare [Patient and Family Advisory Council Tool Kit](#)