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Healthcare Transitions and Coordination:
Early Readmission, Effectiveness, Economics
Part 2: Coordination in Care
The project was supported by Award Number RC2NR011946 from the National Institute of Nursing Research. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute Of Nursing Research or the National Institutes of Health.
This seminar series is supported in part by a grant from the Dean's Scholarly Project Award Program: Scholarship of Teaching Award from the University of Texas Health Science Center San Antonio School of Nursing.
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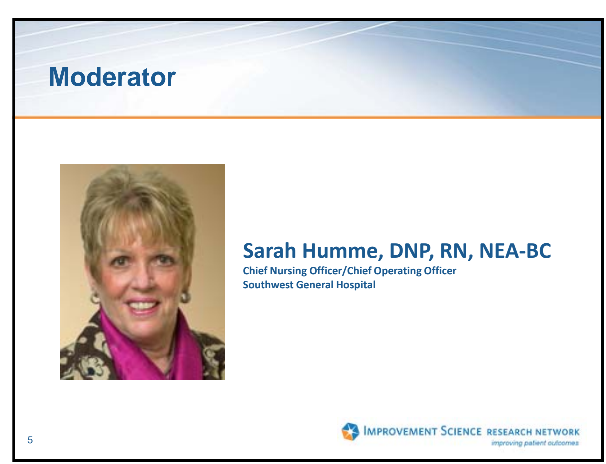
Moderator
Sarah Humme, DNP, RN, NEA-BC
Chief Nursing Officer/Chief Operating Officer
Southwest General Hospital
5
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ISRN Research Priorities

A. Coordination and Transitions of Care
B. High-Performing Clinical Systems and Microsystems Approaches to Improvement
C. Evidence-Based Quality Improvement and Best Practice
D. Learning Organizations and Culture of Quality and Safety

7 Improvement Science Research Network (ISRN). (2010). Research priorities. Retrieved from http://www.isrn.net/research.

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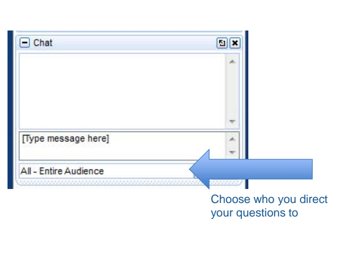

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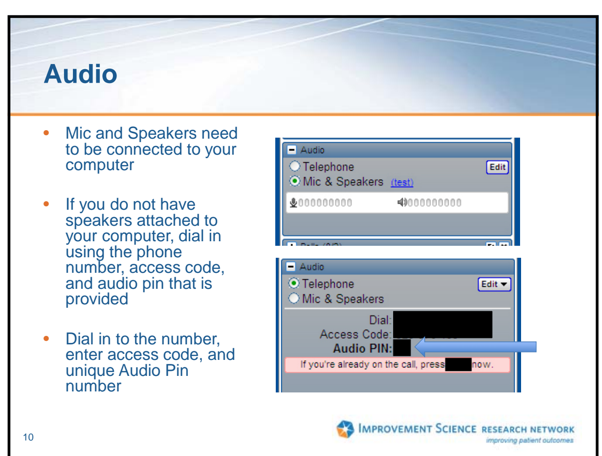
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10
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12
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Care Coordination

- Definitions
- Significance and Urgency for Action
  - Health care system
  - Patients and families
- Best Practices
- Gaps
- Opportunities

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What is care coordination?

Care coordination is the **deliberate organization of patient care activities** between two or more participants (including the patient) involved in a patient's care **to facilitate the appropriate delivery of health services. Organizing care** includes marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the **exchange of information** among participants responsible for different aspects of care."

McDonald et al, 2010, p. 4

This definition was developed from more than 40 definitions of care coordination and guided the review and selection of measures for the AHRQ Care Coordination Measures Atlas.

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Another influential definition

"Care coordination is a function that helps ensure that the **patient's needs and preferences** for **health services and information sharing across people, functions, and sites** are met **over time.**"

Five Domains of Care Coordination: healthcare home, proactive plan of care and follow-up, communication, information systems, transitions or hand-offs

NQF Framework for Defining and Measuring Care Coordination, 2006

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You're doing Care Coordination when you:

- Communicate with patients, families and other team members about the plan of care and keeping it on track.
- Get the needed people involved at the right time and right place to assure that appropriate services are provided.
- Work with patients and families to identify their goals and preferences and incorporate them in the plan of care.
- Monitor that the needed services have been identified, arranged, and are delivered when needed.

17

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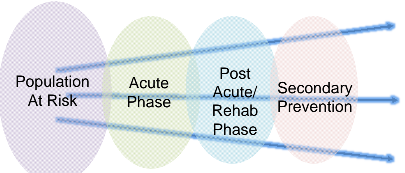
Within and across providers, functions and settings



Adapted from the National Quality Forum (NQF) steering committee on Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care. The committee's report presents the NQF-endorsed measurement framework for assessing efficiency, and ultimately value, associated with the care over the course of an episode of illness and sets forth a vision to guide ongoing and future efforts.

18 www.transitionalcare.info

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Transitional Care

Transitional care – range of *time limited* services and environments that *complement primary care* and are designed to ensure health care continuity and avoid preventable poor outcomes among *at risk* populations as they move from one level of care to another, among multiple providers and across settings.

Naylor, ISRN Webinar
June 2012

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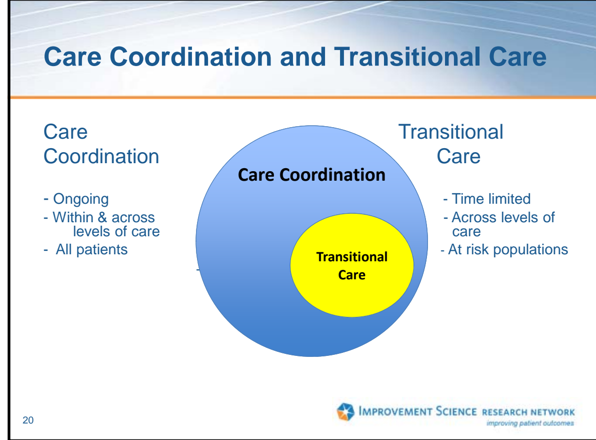
Care Coordination and Transitional Care

Care Coordination

- Ongoing
- Within & across levels of care
- All patients



Transitional Care

- Time limited
- Across levels of care
- At risk populations

20

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Care Coordination may be done by

- Specialized staff
- Direct care providers

21

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Significance of Care Coordination

- **Part of every current proposal and model to improve health care outcomes and reduce costs.**
- **Viewed as the missing link to connect patients and families to appropriate services at appropriate cost**

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The Case for Care Coordination

- Overuse, underuse
- Medical Errors
- Hospital Readmission
- Duplication or Gaps in services
- Patient and family satisfaction

23

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Medicare to penalize over 2,000 hospitals

- **Medicare To Penalize 2,211 Hospitals For Excess Readmissions**
- By Jordan Rau
- KHN Staff Writer
- Aug 13, 2012
- **More than 2,000 hospitals** including some nationally recognized ones — will be penalized by the government starting in October because many of their patients are readmitted soon after discharge, new records show.
- Together, these hospitals **will forfeit about $280 million in Medicare funds over the next year** as the government begins a wide-ranging push to start paying health care providers based on the quality of care they provide.
- With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers **readmissions a prime symptom of an overly expensive and uncoordinated health system.** Hospitals have had little financial incentive to ensure patients get the care they need once they leave, and in fact they benefit financially when patients don't recover and return for more treatment.
- Kaiser Health News 8-13-12

24

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For Patients and Families

"Care coordination is the weathervane – the canary in the mine – of how well health care works for patients." Lamb, 2012

The quality of care coordination signals: continuity, communication among providers, caring about patient preferences and goals

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Each profession has a stake in assuring effective care coordination

"Care coordination is one of the traditional strengths of the nursing profession whether in the community or the acute care setting."

IOM, Future of Nursing, 2011, p. 65.

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Position Statements

- **American Nurses' Association: Care Coordination and Nursing's Essential Role, 2012**

  www.nursingworld.org/position/care-coordination

- **American Academy of Nursing: The Imperative for Patient, Family, and Population Centered Interprofessional Approaches to Care Coordination and Transitional Care, 2012**

  www.aannet.org/assets/docs/policyresources/aan_care%20coordination_3.7.12_email.pdf

27

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Observations on care coordination

- Complex and skilled work
- Purposeful – doesn't happen by chance
- Time-consuming

Patients and Families do far more of it than health care professionals

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Care Coordination consumes 20% of medical surgical nurses' practice time

Staff Nurse Practice Time

Hendrich, Chow, Skiercynski, Lu 2008

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The Evidence

- Elements of the models we're currently using are not new.
- We're expanding knowledge built across several decades of research and demonstrations

Channeling Social HMOs PACE
Community Nursing Organizations
Coordinated Care Demonstration

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Best Practices

- Transitional Care
- Primary Care
- Community

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Care Transition Models

Slide credit to INTERACT program, Florida Atlantic University

High Quality Care Transitions for Older Adults & Caregivers

"BOOST"
(*Better Outcomes for Older Adults Through Safe Transitions*)
http://www.hospitalmedicine.org

"Project RED"
(Re-Engineered Discharge)
https://www.bu.edu/fammed/projectred

- Enhanced hospital discharge planning

"Care Transition Program"
http://www.caretransitions.org

- Transition coach
- Trained volunteers
- Empowered patients and caregivers

"POLST" (or "MOLST")
(*Physician (or Medical) Orders For life Sustaining Treatment*)
http://www.ohsu.edu/polst

- Advance care planning

"Bridge Model"
http://www.transitionalcare.org/the-bridge-model

- Social Worker coordinating Aging Resource Center Services at hospital discharge

"Transitional Care Model"
http://www.transitionalcare.info/index.html

- APN coordinates care during and after discharge
- Home, SNF, and clinic visits

"INTERACT"
(*Interventions to Reduce Acute Care Transfers*)
http://interact2.net

- Communication Tools, Care Paths, Advance Care Planning Tools, and QI tools for nursing homes and SNFs

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Common Elements - Transitional Care

- Risk stratify population with different types and levels of intervention based on need and risk level
- One designated person who serves as hub or switchboard for designated period of time (time-limited)
- Standardized intervention guidelines
- Standardized data collection within QI approach

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Evidence – please see Dr. Naylor's slides

- > 20 randomized control trials of hospital-home models; about half showed reduction in hospitalization
- Nursing home – hospital models – small comparative studies; RCT of INTERACT underway

34

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INTERACT – Reducing hospital transfers

Pilot Study Results
CMS & Commonwealth Fund Projects

1. Significant reductions in hospitalization
2. More engaged facilities had greater reductions in hospitalizations
3. Substantial savings for Medicare and NHs

Ouslander et al: J Amer Med Dir Assoc 9: 644-652, 2009
Ouslander et al: J Am Geriatr Soc 59: 745-753, 2011

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Primary Care and Community-based Models

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Common features

- Risk stratify population with different types and levels of intervention based on need and risk level
  - usually programs focus on high-risk, high-cost populations
- One or more designated people who serve as hub
- May have standardized intervention guidelines
- Standardized data collection within QI approach

37

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Preferred Practices NQF, 2010

25 Preferred Practices

- Patient choice, documentation of experience
- Role of health care home/primary care
- Content of plan of care
- Systems, policies for monitoring care coordination, plan of care, referrals
- Transitional Care Programs

38

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Evidence – Primary Care and Community-based Models

- Most studies focus on care coordination interventions for populations with multiple chronic illnesses – at risk for hospitalization and rehospitalization
- Many different programs evaluated - inconsistent results
- Common issues
  - Too many low risk individuals in the mix
  - Lack of standardization of interventions
  - Key stakeholders don't embrace model

39

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Lessons from the Medicare Coordinated Care Demonstrations

- 15 programs funded; RCTs
- A few (< 50%) reduced hospitalizations by 8-33%

Common to successful programs
- frequent in person meetings with patients
- occasional in person meetings with providers
- communication hub
- evidence-based education for patients
- medication management
- transitional care after hospitalization

Peikes et al, 2009
Brown et al, 2012

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Gaps

- Research on care coordination functions and outcomes
- Measurement of care coordination
- Contributions of different professionals to care coordination processes and outcomes
- Cost effective ways to deliver care coordination – especially for high risk populations

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Staff Nurse Care Coordination

- Within the hospital, nurses spend significant time coordinating care
- Numerous care coordination activities
- Believe that care coordination work is invisible to patients and team members

Lamb, Schmitt, Edwards, Duva
Manuscript under review

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Care Coordination Performance Measures

- AHRQ CC Atlas - > 60 measures
- NQF Performance Measures for Measuring and Reporting Care Coordination
  - In 2010, only 10 (13%) of 77 submitted measures were recommended for approval .
  - Of the 10 endorsed measures, 5 were condition, treatment or setting specific; 5 specific to hospital or ER transfer to home
  - The10 measures addressed only 2 of 5 NQF domains

In 2012, No new measures for care coordination were submitted

Endorsed Practices & Measures 2010

	Preferred Practices Endorsed 25	Measures Submitted 77	Measures Endorsed 10
Healthcare Home	5		0
Plan of Care	5		5
Communication	4		0
Info Systems	3		0
Transitions	8		5

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Care Coordination Performance Measures

- Most are **process measures** that capture a small part of care coordination activities
- Most are **provider centric and condition specific** (Naylor & Kurtzman, 2010)
- Most work on **transitional care** measures

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Examples of NQF Endorsed Measures 2010

- Cardiac rehab patient referral from an inpatient setting
- Patients with transient ischemic event ER visit who had a follow up office visit
- Reconciled medication list received by discharged patient
- Transition record with specified elements received by discharged patients
- Timely transmission of transition record (inpatient discharge to home/self care or any other site of care)
- 3-item Care Transitions Measure

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Significant Gaps in Measures

- **Patient and family experience of care coordination** – no measures of patient and family expectations and experience of sequencing and integration of care
- **Essential structures to support care coordination** – staffing and resource requirements not defined
- **Outcomes of care coordination** – no standard definition of preventable hospitalization; few outcomes measures
- **Nursing's and team contribution**

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Many Opportunities to improve care coordination

- Contribute to development and testing process and outcome measures
- Test and refine care coordination models in primary care and community settings
- Identify your care coordination activities, document them, include them in QI initiatives
- Encourage local and state initiatives to disseminate information about best practices and share tools and resources

48

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Next ISRN Web Seminar
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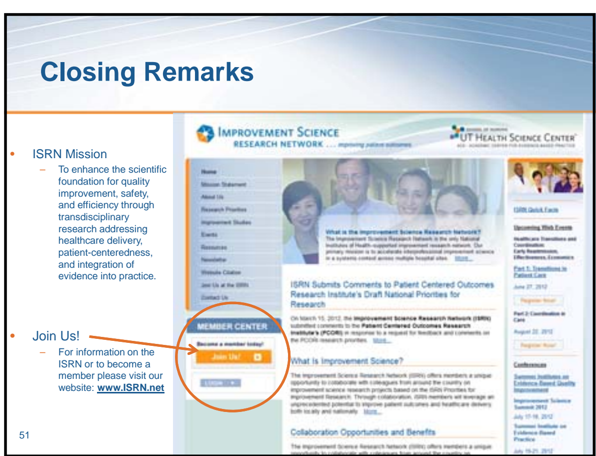
Closing Remarks
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Citations

- Brown, R.S., Peikes, D., Peterson, G., Shore, J., & Razafindrakoto, C.M. (2012). Six features of Medicare Coordinated Care Demonstration programs that cut hospital admissions of high risk patients. *Health Affairs*, 31(3) 1156-1167.
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53