Coordinating Patient Care Across The Care Continuum: Integrating Care Delivery Effectively

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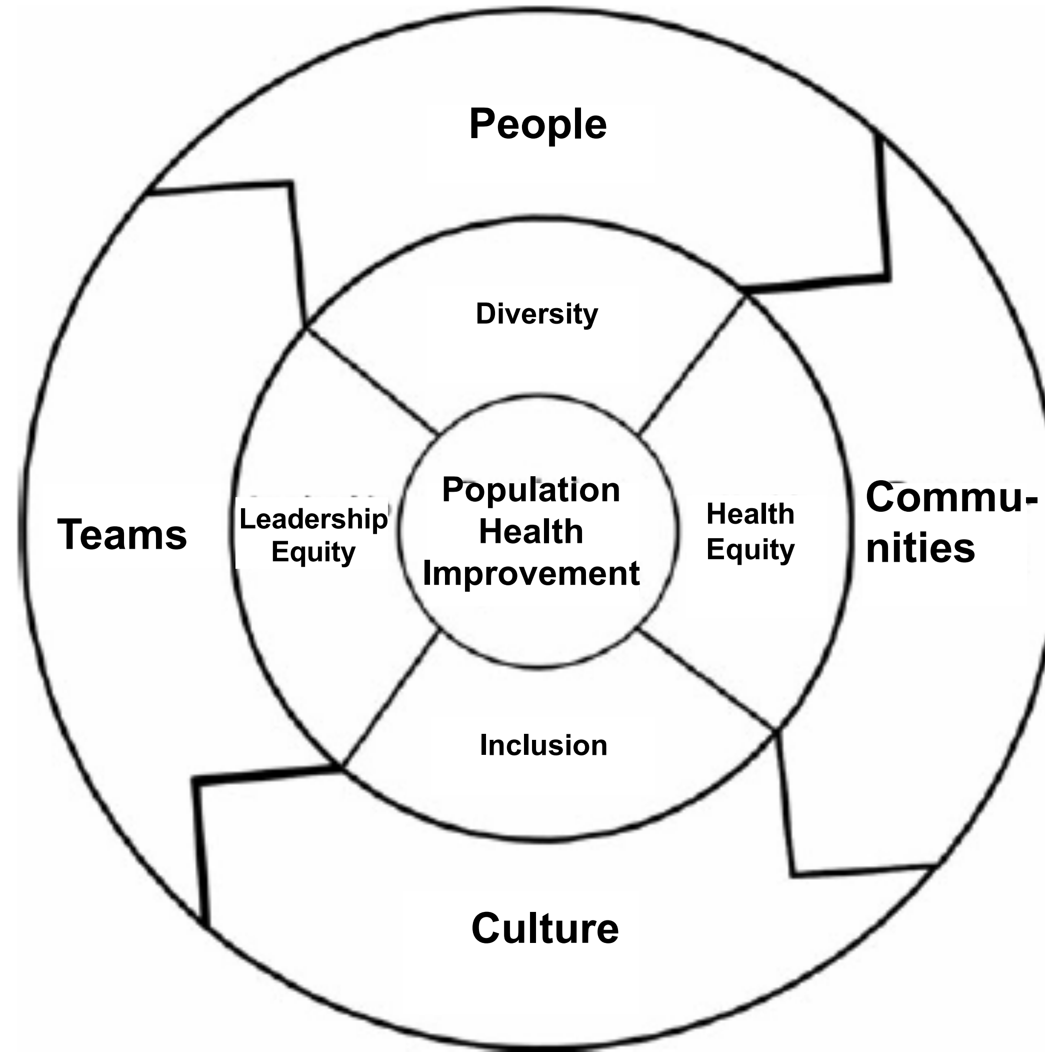
Objectives

- Describe the key aspects of care integration and its importance in today's environment
- Identify the key elements required for effective and efficient care coordination across the continuum
- Discuss the benefits of care coordination, as well as the challenges involved in managing transitions of care and preventing unnecessary acute care readmissions
- Pose questions which can help leaders think through improving population health and access to care delivery through care management across the continuum

Improving Population Health



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Source: Lemak CH, Paris NM, McDonagh K. Essential Values for Population Health Improvement. *Population Health Management*. 2017

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"Clinical integration is the extent to which patient care services are coordinated across people, functions, activities, and sites over time to maximize the value of services delivered to patients."

Stephen M. Shortell, Robin R. Gillies, David A. Anderson, Remaking Health Care in America. 2000

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Critical Components of Integration

Triple-aimed leadership and culture
Bifocal vision
Patient-centered focus
Diverse providers/interprofessional teams
Stratified, population-based care strategies
Communication and coordination across transitions of care
Streamlined purchasing and support processes

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Source: Mohler, M. Jane, Frontiers of Health Services Management, 2013.

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Medicare's Risk Goal Provides Clarity for Providers

Integrated Care Delivery the Way Forward for the Nation's Largest Payer

Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System

The Affordable Care Act offers many tools to improve the way providers are paid to reward quality and value instead of quantity, to strengthen care delivery by **better integrating and coordinating care for patients**, and to make information more readily available to consumers and providers. Doing so will improve the **coordination and integration of health care**, engage patients more deeply in decision-making and improve the health of patients – with a priority on prevention and wellness. It is our role and responsibility to lead this change, and we will lead.

Source: HHS, "Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value," January 26, 2015, available at: www.hhs.gov; Health Care Advisory Board interviews and analysis.

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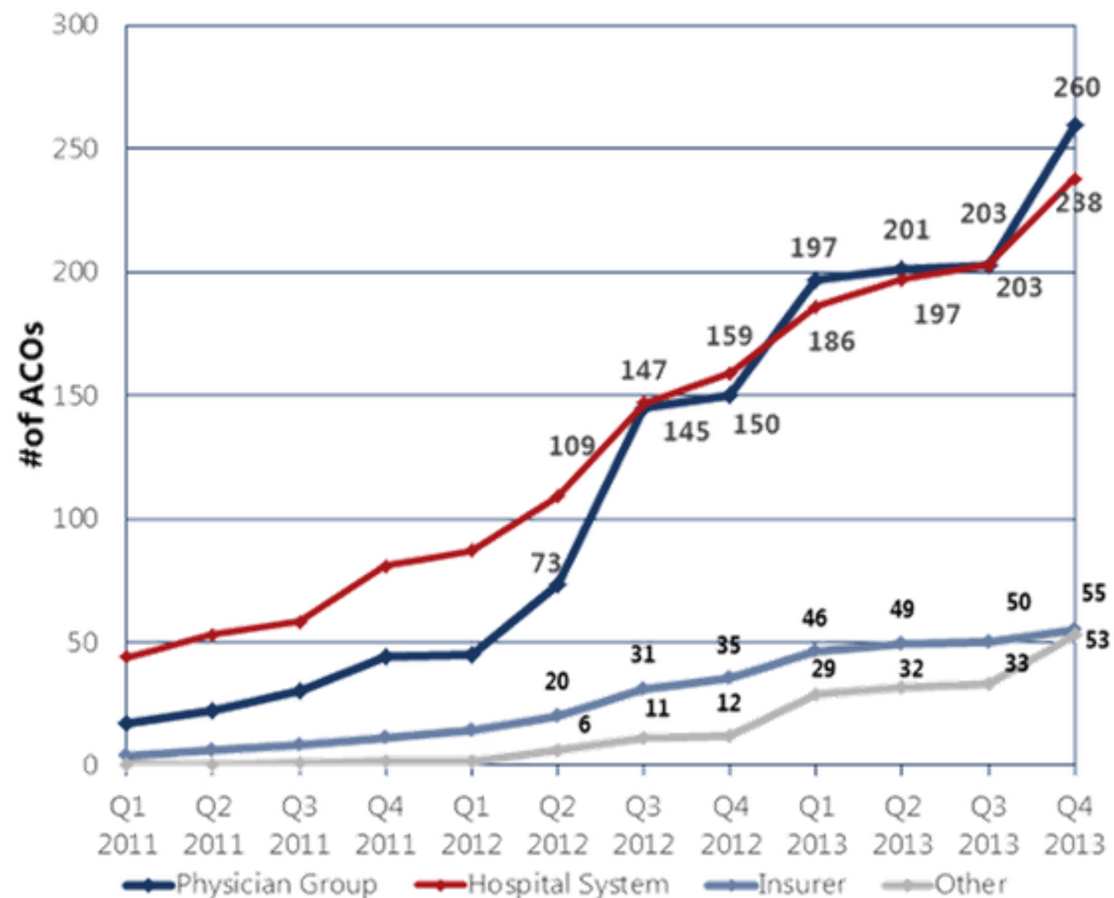
Growth in New Healthcare Delivery Models Focusing on Care Integration

Healthcare providers have been on a steady journey of ***integrating*** with one another.

- Accountable Care Organizations
- Integrated Delivery Systems
- Primary Care Homes and Neighborhoods



Health Affairs – February, 2014

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Reasons Health Systems Should Pursue Clinical Integration

1. Prepare for Additional Value-Based Payment Structures
2. Maintain and Expand the Hospital Referral Base
3. **BUILD TRUST WITH THE MEDICAL STAFF**
4. **SECURE THE HEALTH OF THE COMMUNITY**

Reference: http://info.healthdirections.com/blog/bid/31125/4-solid-reasons-hospitals-must-pursue-clin. Accessed 1/8/2014.

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Clinical Integration Drivers

- **Patient Longitudinal/Community Health Record:** The IT platform should be based on longitudinal patient record (i.e., no matter where the patient is being treated, there is one overarching longitudinal record)
- **Active Care Management:** Utilizes (evidence-based) care protocols or pathways across care settings to notify all the participants involved in care delivery, including the patient, of their roles and responsibilities and required interventions
- **Hierarchal Data Security:** Controls that allow for a multi-layered, configurable role-based security model to ensure compliance with privacy and confidentiality regulations

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Source: Health Directions, Launching a Clinical Integration Program, May 2013.

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The Benefits of Clinical Integration)

- **Foster Collaboration to Improve Quality of Care.** Collaboration is particularly important in health care. Gaps in quality can more effectively be addressed by better coordination among providers.
- **Improve Quality and Efficiency for Independent Providers.** Independent providers who wish to continue to work in solo or small group practices, yet access the infrastructure, staff, economies of scale and scope, and "best practices" that clinically-integrated arrangements can provide, can enable them to significantly improve the quality and efficiency of their practices.

Source: Lovells, H for The American Hospital Assn. Guidance for Clinical Integration. Sept. 2010.

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The Benefits of Clinical Integration
(continued)

- **Enable providers to perform well in Pay-for-Performance and other public reporting initiatives.** There is an increasing emphasis on linking payment to performance on various quality and efficiency measures, and to use public reporting mechanisms to indentify for patients, employers and health plans those providers who achieve high achievement scores.
- **Gain experience in forming provider organizations responsible for an entire episode of care or population of patients.** There is growing interest in both the public and private sectors to structure reimbursement systems based on provider organizations taking responsibility for the care of a population of patients, or for an episode of care. Such provider organizations would need to span both hospitals and physicians practicing in a broad range of specialties. Clinically-integrated physician-hospital organizations can provide experience with, and form the basis of, such entities.

Source: Lovells, H for The American Hospital Assn. Guidance for Clinical Integration. Sept. 2010.

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The Benefits of Clinical Integration
(continued)

- **Provide a vehicle for a hospital to work more closely with members of its medical staff.** This can provide a focal point around which hospitals can more closely associate with their physicians to build an integrated system of care.

- **Provide the means whereby providers can obtain greater reimbursement to cover the added costs of their efforts and which recognize the increased value of the services that they offer.** A properly established and implemented program can justify joint negotiations by competing providers.

Source: Lovells, H for The American Hospital Assn. Guidance for Clinical Integration. Sept. 2010.

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Questions that Guide Clinical Integration

- What is the value of Clinical Integration to the community and population?
- What is the best model for the physicians and the hospital?
- What are the key cultural changes that will need to be addressed?
- How can Clinical Integration be coordinated with other health system priorities?
- How can the governance structure (hospital vs. physicians) be best organized to successfully lead the process?
- What technology is required to build Clinical Integration?

Source: Health Directions, Launching a Clinical Integration Program, May 2013.

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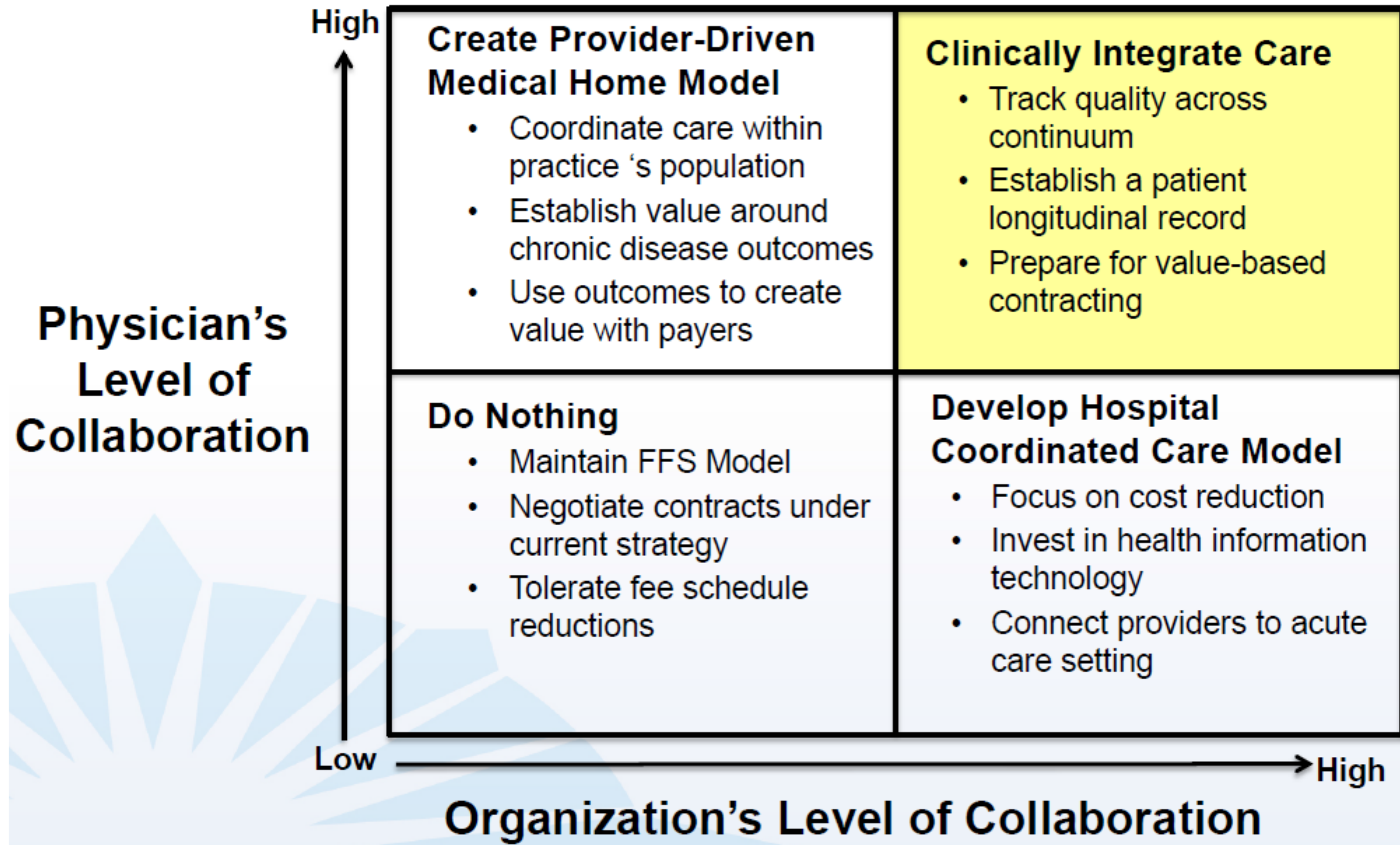
Options for Physicians & Organizations



Source: Health Directions, Launching a Clinical Integration Program, May 2013.

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A Key Challenge:
Transitions Across Settings

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What are Transitions of Care (TOC)?

- The movement of patients among health care practitioners, settings and home as their condition and care needs change
- Effective care transitions must be engineered into the structure of the health care system at each point of exchange – ideally becoming part of the workflow – instead of the current system which relies on the behavior of individuals
- A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or between different levels of care in the same location

-Mansur J. Transitions in Care: What are you doing to improve the process? [powerpoint] Oak Brook Terrace, IL: Joint Commission Resources. 2013. 1-38
-National Transitions of Care Coalition. Improving transitions of care. 2008 May. 1-44
-Cibulskis CC, Giardino AP, Moyer VA. Care transitions form inpatient to outpatient settings: ongoing challenges and emerging best practices. Hospital Practice. 2011 Aug. 39 (3): 128-139.

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Why focus on care transitions and reducing hospital readmissions?

- Patient well-being can be improved with integrated and comprehensive care transitions
- Shifting of resources to outpatient and home care settings
- Significant variation in care delivery for similar patients based upon health care provider

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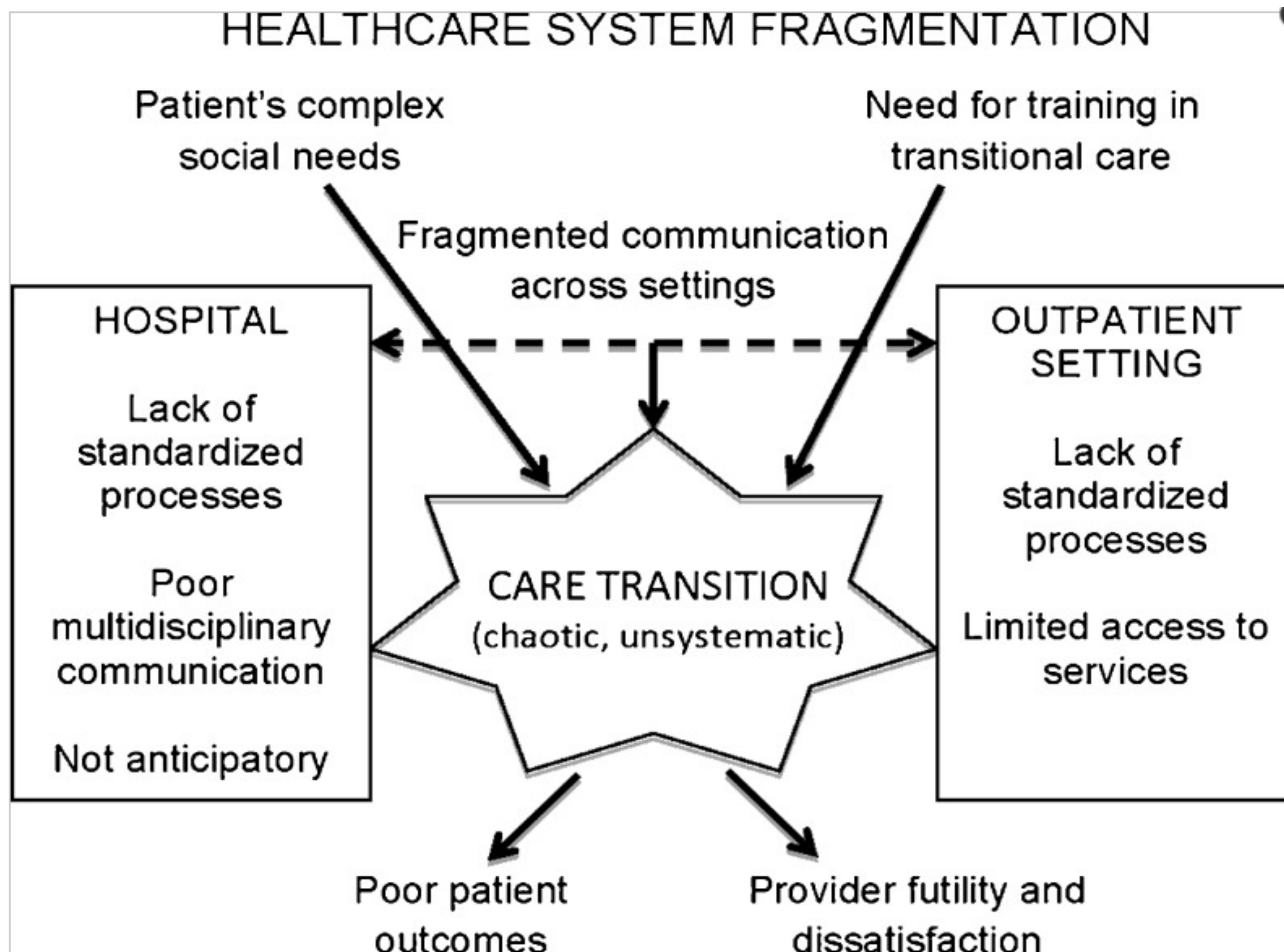
Healthcare Professional Views of Transition From the Hospital



Davis MM, Devoe M, Kansagara D, Nicolaidis C, Englander H. "Did I do as best as the system would allow me?" Healthcare professional views on hospital to home care transitions. J Gen Intern Med. 2012 Jul. 27 (12): 1649-1656.

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Ambulatory Practices: Principles for High Quality TOC

Responsibilities	Principles
Assessment - Conduct baseline assessment prior-to and post-discharge	**Person-centered** – focus on patients and caregivers
Goal Setting – Document patient's goals and care decisions	**Collaborative** – Take advantage of complementary skill sets of team members
Supporting Self-Management – Provide information and facilitate access to resources that can assist the patient/caregivers with safe management of their condition	**Structured** – Use clear and carefully planned protocols, forms and processes
Medication Management – Communicate with the patient, pharmacy and other members of the care team to promote effective and safe medication use	**Iterative** – Recognize the evolving nature of care and make adjustments as appropriate
Care Coordination – Synchronize the efforts of all members of the care team	**Flexible** – Pursue creative solutions to novel problems based on unique patient needs

Sokol PE, Wynia MK. AMA Expert Panel on Care Transitions. Chicago, IL: American Medical Association; February 2013.

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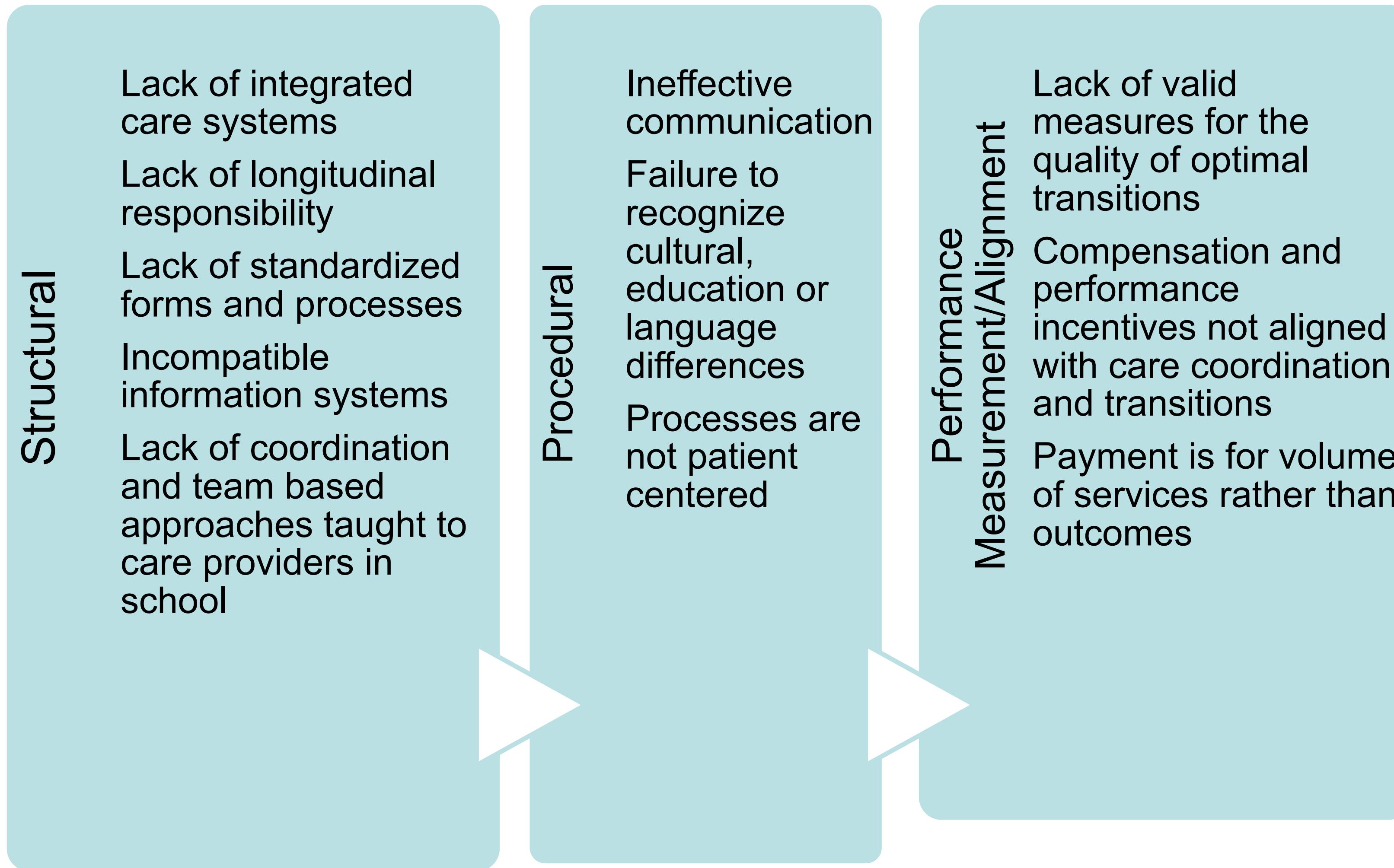
Barriers to Effective Care Transitions



Cibulskis CC, Giardino AP, Moyer VA. Care transitions from inpatient to outpatient settings: ongoing challenges and emerging best practices. Hospital Practice. 2011 Aug. 39 (3): 128-139.

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Transitions of Care (TOC) Portal

A valuable resource of information from The Joint Commission enterprise, related to the topic of transitions of care (the movement of patients between various health care settings) .

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Home > Transitions of Care (TOC) Portal

Thursday 9:07 CST, July 19, 2012

Transitions of Care (TOC) Portal

Welcome to the new Transitions of Care (ToC) Portal. This website is a valuable resource of information from The Joint Commission enterprise, related to the topic of transitions of care (the movement of patients between various health care settings). We hope you find this website helpful!

New!
- Hot Topics in Health Care - Transitions of Care: The need for a more effective approach to continuing patient care

Joint Commission Information

Examples of Programs with TOC
- Requirements for Advanced Certification in Heart Failure

Patient Information
- Speak Up: Planning Your Follow-up Care
- Speak Up: Understanding Your Doctors and Other Caregivers
- Speak Up: Help Avoid Mistakes With Your Medicines

Performance Measures and TOC
- Substance Use
- Tobacco Treatment
- Venous Thromboembolism
- Advanced Certification in Heart Failure Measures
- Osteoporosis Initiative
- Children's Asthma Care
- Heart Failure
- Hospital-Based Inpatient Psychiatric Services
- Stroke
- Hospital Outpatient Department

Center for Transforming Healthcare Information
- Hand-off Communications
- TST for Hand-off Communications Video
- Targeted Solutions Tool
- Preventing Avoidable Heart Failure Hospitalizations

IHI: Improving Transitions Guides
- Community Settings
- Skilled Nursing Facilities
- Home Health Care
- Clinical Office Practice

Other Sites to Visit
- Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse
- Alliance of Community Health Plans
- The American Geriatrics Society

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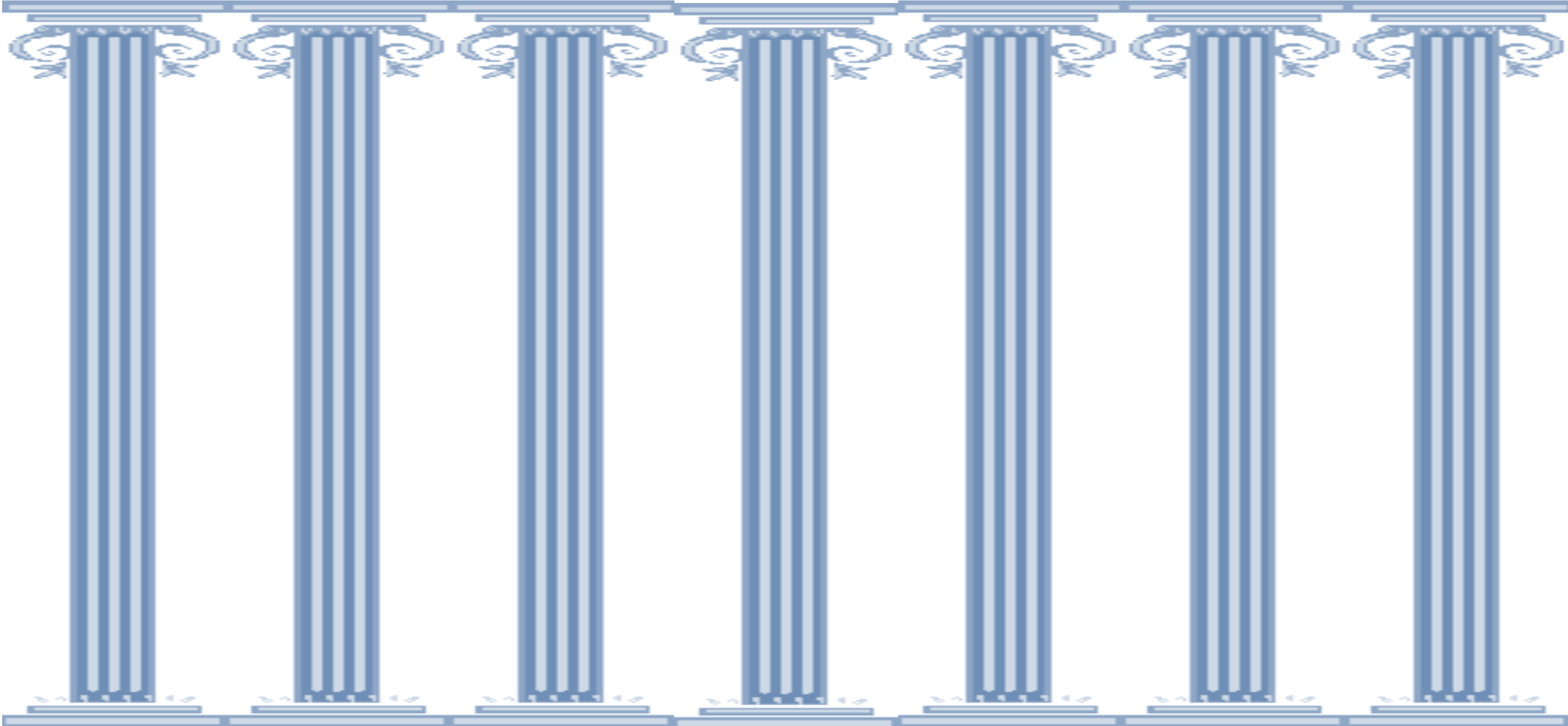
7 Foundations of Safe Transitions



LEADERSHIP SUPPORT	MULTIDISCIPLINARY COLLABORATION	PATIENTS AT RISK	MEDICATION MANAGEMENT	TRANSITIONAL PLANNING	PATIENT/FAMILY ACTION	TRANSFER OF INFORMATION

These foundations are based on the literature, our learning visits and calls with the customer, and leading practices.

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Critical Components of Care Integration

- **Handovers (receipt of information)**
- Sequencing (timing of tasks and decisions)
- Interdependency (awareness of what others are thinking and doing)
- Storage and retrieval (of information)

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Hand-off Communications: Improving Outcomes

- Meta-analyses reveal that standardized handoff protocols improve information shared among team members, between settings and shifts (transitions of care) resulting in better patient, provider, and organizational outcomes

Sources: Keebler, Joseph R., et al. "Meta-analyses of the effects of standardized handoff protocols on patient, provider, and organizational outcomes." *Human factors* 58.8 (2016): 1187-1205 and Blouin, A.S., 2011. Improving hand-off communications: new solutions for nurses. *Journal of Nursing Care Quality*, *26*(2), pp.97-100.

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A Successful Hand-off is Critical

S H A R E

Standardize Critical Content
- Provide details of patient's history and status when speaking with receiver
- Identify and stress key information and critical elements about patient when talking with the receiver
- Synthesize patient information from disparate sources prior to passing it on to the receiver
- Develop and use key phrases to help standardized communications

Hardwire Within Your System
- Develop and use standardized forms, and tools and methods, e.g. checklists, SBAR tool
- Establish a workspace or setting that is conducive for sharing information about a patient, e.g. zone of silence
- Have patient present during hand-off discussion between sender and receiver
- State expectations about how to conduct a successful hand-off
- Focus on the system, not just the people
- Identify new and existing technologies to assist in making the hand-off successful and complete, e.g. electronic medical records, PDAs
- Ensure access to electronic medical record is available to all staff caring for patient
- Integrate process into electronic medical record application
- Provide post acute staff with access to hospital information systems (if part of the same health care system)
- Examine the work flow of health care workers to ensure a successful hand-off

Allow Opportunity to Ask Questions
- Use critical thinking skills when discussing a patient's case
- Share and receive information--as an interdisciplinary team--about the patient at the same time, e.g. "pit crew"
- Expect to receive all key information and critical elements about the patient from the sender
- Collect sender's contact information in the event there are follow-up questions
- Scrutinize and question the data

Reinforce Quality and Measurement
- Demonstrate leadership's commitment to implement successful hand-offs
- Utilize a sound measurement system to determine the real score in real time
- Hold staff managing patient's care responsible
- Monitor compliance of standardized form, tools and methods for hand-off between sender and receiver
- Measure the specific, high-impact causes of a poor hand-off and target solutions to those causes
- Use data as the basis for a systematic approach for improvement

Educate and Coach
- Teach staff on what constitutes a successful hand-off
- Standardize training on how-to conduct a hand-off
- Engage staff--real time performance feedback; just-in-time training
- Make successful hand-offs an organizational priority and performance expectation

Joint Commission Center for Transforming Healthcare

Developed by the participating hospitals, this is a compilation of solutions that are linked to specific root causes.

Update: December 22, 2014

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Care Coordination

Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

- Examples of specific care coordination activities include:
  - Establishing accountability and agreeing on responsibility
  - Communicating/sharing knowledge
  - Helping with transitions of care
  - Assessing patient needs and goals
  - Creating a proactive care plan
  - Monitoring and follow-up, including responding to changes in patients' needs
  - Supporting patients' self-management goals
  - Linking to community resources
  - Working to align resources with patient and population needs

Source: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. Accessed August 3, 2015.

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Care Coordination

(continued)

- Redesigning a health care system in order to better coordinate patients' care is important for the following reasons:
  - Current health care systems are often disjointed, and processes vary among and between primary care sites and specialty sites.
  - Patients are often unclear about whey they are being referred from primary care to a specialist, how to make appointments, and what to do after seeing a specialist.
  - Specialists do not consistently receive clear reasons for the referral or adequate information on tests that have already been done. Primary care physicians do not often receive information about what happened in a referral visit.
  - Referral staff deal with many different processes and lost information, which means that care is less efficient.

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Source: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. Accessed August 3, 2015.

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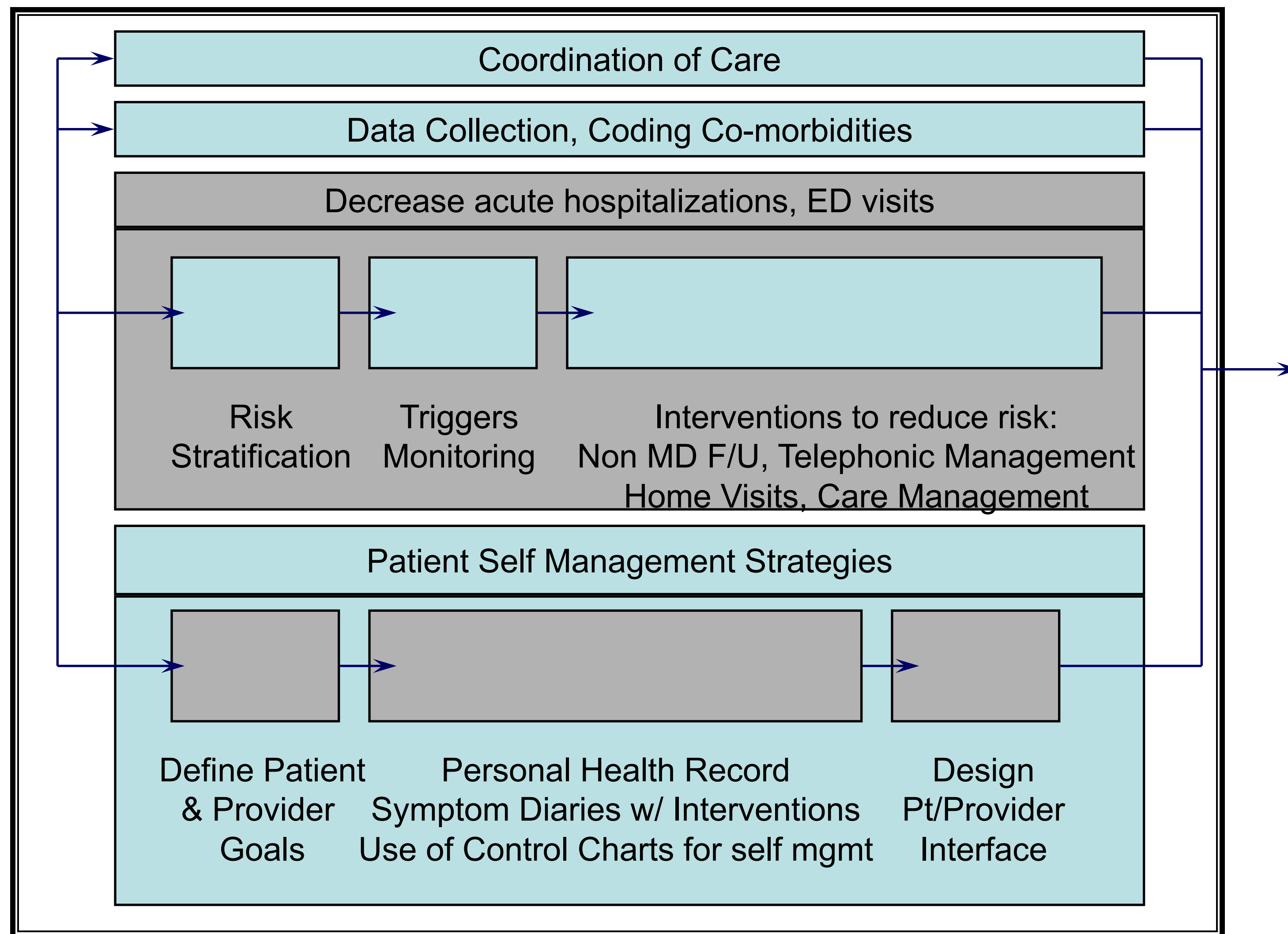
What are the processes of care for patients with chronic illnesses? How do we change care delivery toward improved outcomes?



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What Happens When Patients Are Discharged?

- **18% of Medicare beneficiaries are re-hospitalized within 30 days of discharge**
  - 70% of surgical patients were readmitted within 30 days for a medical (not surgical) diagnosis
  - 90% of readmissions deemed unplanned
  - 81% of patients requiring home assistance did not receive a referral
  - 65% of patients said no one talked to them about managing their care at home
  - 50% of readmissions had no intervening physician visit
  - These readmissions are estimated at $15 billion for one year (2007) of which $12 billion is potentially preventable
- **80% of serious medical errors involve miscommunications during the hand-off between medical providers**
  - Expectations differ between senders and receivers of patients in transition
  - Culture does not promote successful hand-offs
  - Inadequate amount of time provided for successful hand-offs
  - Lack of standardized procedures in conducting successful hand-off

The Joint Commission Enterprise. Transitions of care: the need for a more effective approach to continuing patient care. 2012 Jun. 1-8.
Discern, LLC. A re-engineered delivery model for transitions of care: addressing evolving market trends. 1-50.

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What Happens When Patients Are Discharged?

- Half of discharged patients experience a medication error
- Outstanding diagnostic tests are often lost to follow-up post discharge
- Inadequate communication between inpatient and outpatient providers can lead to delayed or incomplete clinical workups

Academic Medical Centers

- Residents who participated in surveys around patients' post- discharge visits reported medication reconciliation (31%) and adherence issues (26%), and would change the way they discharge patients
- Patients did not mind seeing an interim physician to expedite post-discharge care (82%)

Lee JI, Ganz-Lord F, Tung J, Bishop T, DeJesus C, Ocampo C, et al. Bridging Care Transitions: Findings from a resident-staffed early post discharge program. Academic Medicine. 2013 Nov. 88 (11): 1685-1688.

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Undertaking Root Cause Analysis on Readmissions

Key Findings Vary Based Upon Hospital

- Handoffs and communication; issues to next care setting
- Lack of support system at next setting
- Social limitations
- Economic situations
- Psychological challenges
- Differing incentives – financial, occupancy, resources
- Ongoing goals of life discussions
- Community resource limitations
- Support for activities of daily living
- Patient clinical management
- Digression in clinical or functional status

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Studies on Re-Admissions and Improved Patient Health

- Patients with CHF in Lebanon (Deek et al) – contributing factors: lack of adherence to evidence-based guidelines; lack of documentation on discharge instructions.
- MCH and mental health in Pakistan (Rahman) – contributing factors: lack of integration of mental health assessment and interventions in MCH program; lack of coordination between public health efforts and provider efforts.
- Continuity of care in patients with MS in Iran (Masondi et al) – contributing factors to better continuity were human-oriented (patient centered) attention; purposeful care planning; clear responsibility; and caring with empathetic sensing.
- Patients with CHF in Egypt (El Badawy, El Hefnawy) – contributing factors to less re-admissions: inpatient and outpatient "face-to-face" education; monthly phone calls; written discharge instructions.

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Studies on Re-Admissions and Improved Patient Health

(continued)

- Patients with diabetes in Saudi Arabia (Mochter et al) – contributing factors to fewer re-admissions within 28 days: adherence to ADA guidelines for (1) admission work-up and (2) patient met readiness for discharge criteria.
- Primary care patients with Type 2 diabetes in Saudi Arabia (Al Asmary et al) – contributing factors to lower HbA1c and LDL cholesterol: intensive, multi-disciplinary care team.
- Patients undergoing CABG surgery in Iran (Varaei et al) – contributing factors to reduced readmissions and improved self-care: peer education.
- Patients with colorectal cancer in Saudi Arabia (Rafferty et al) – contributing factors to improved outcomes: consistent with studies cited next.

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Benefits of Colorectal Cancer Care Coordination

Benefits for Patients	Benefits for Healthcare Staff	Benefits for Organization
Better access; reduced time to first visit	Improved flow of communication between departments	Improved staff satisfaction, increased retention of staff
Improved flow through the system	Reduced Admissions	Reduced average length of staff
Personalized care	Reduced wait times	Better clinic utilization
Education, information, empowerment	Improved patient satisfaction	Reduced patient flow within facility
Psychological support	Better clinic utilization	Elevate reputation and branding for the organization
Key contact person, advocate: “my person”	Enhanced communication between patient & physician	Increased cost savings and revenue
Better experience, improved satisfaction		

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Source: Gorman et al, 2000; Bairati et al, 2006; S22 Health Intelligence Agency, 2006; Victorian Government Dept. of Human Services, 2007; Slade, 2013; Young et al, 2013

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Summary: Considering Care Providers for the Continuum of Care

- Assessing quality of hand-offs
- Capabilities and resources of receiving party
- Follow-up support for receiving provider
- Engagement of clinical oversight
- Implementation of Rapid Response Notification System (when transition of care problem)
- Ongoing monitoring and tracking
- Importance of activities of daily living

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