The Role of Case Managers in Improving Care Coordination

Improving Transitions in Care Services

What Is “Transition of Care”?

- **The movement of patients** from one health care practitioner or setting to another as their condition and care needs change
- **Occurs at multiple levels**
  - **Within Settings**
    - Primary Care ↔ Specialty Care
    - ICU ↔ Ward
  - **Between Settings**
    - Hospital ↔ Sub-acute facility
    - Ambulatory clinic ↔ Senior center
    - Hospital ↔ Skilled nursing ↔ Home Care ↔ Hospital
  - **Across Health States**
    - Curative care ↔ Palliative care/Hospice
    - Personal residence ↔ Assisted living

Transition Issues Dramatically Impact Patients & Their Caregivers

Transition Issues Dramatically Impact Patients & Their Caregivers & Providers
To Date We Have Not Had Consistent and Accepted Transition Tools

- Medication Reconciliation Elements
- Comprehensive Care Plan
- Health or Clinical Status
- Transition Summary
- Patient & Caregiver Tools & Resources
- Consistent Performance Measures That Apply to All Health Care Settings
- Accountability for Sending & Receiving Information

Rehospitalization – Medicare Fee-For-Service

- Analysis of Medicare Claims data from 2003-2004
- 11,855,702 Medicare beneficiaries DC from the hospital
  - 19.6% nearly 1/5 were rehospitalized within 30 days
  - 34% were rehospitalized within 90 days
  - 50.2% of those rehospitalized within 30 days after a medical discharge there was no bill for a visit to a physician office

Rehospitalization among Patients in the Medicare Fee-For-Service Program, Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.
Hospital Readmissions

Figure 1. Rates of Rehospitalization within 30 Days after Hospital Discharge. The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.


Collaborative Models of Care & Resources to Improve Transitions of Care

NTOCC®
NATIONAL TRANSITIONS OF CARE COALITION

www.NTOCC.org
NTOCC is a 501c4 non-profit Coalition

32 Advisory Council Members, 3276 Subscribers, 503 Associate Members, 83 Countries
The Care Transitions Intervention

Does encouraging older patients and their caregivers to assert a more active role in their care transition reduce rates of rehospitalization?


Transition Models

- Dr. Eric Coleman – Transition Coaching - [http://www.caretransitions.org](http://www.caretransitions.org)
- Dr. Mary Naylor – Advanced Nurse Practitioners - [http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx](http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx)
- Guided Care - Dr. Chad Boult - Guided Care Nurse -[http://www.guidedcare.org](http://www.guidedcare.org)
- Boston University Medical Center - Project RED – Re-engineering Discharges – [http://www.bu.edu/fammed/projectred/](http://www.bu.edu/fammed/projectred/)
- Society of Hospital Medicine – Project BOOST-[http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransition/CT_Home.cfm](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransition/CT_Home.cfm)
Emerging Models

• **Transition of Care Clinic** - Tallahassee Memorial Hospital – Dr. Dean Watson, Chief Medical Officer
  
  [Image 176x471 to 389x573]
  
  [Image 389x705]

  **http://www.tmh.org/TMHTransitionCenter**

• **Rush Enhanced Discharge Planning Program** – Rush University Medical Center - Robyn Golden, MA, Director of Older Adult Programs. robyn_golden@rush.edu

Tangible Savings

• **Transition Coaching (CTI)** - The anticipated cost savings of one “Transitions Coach” (responsible for 350 chronically ill adults), after an initial hospitalization, over a period of twelve months, is $330,000. The total annual intervention costs averages $196 per patient.
  
  Eric Coleman. “Person-Centered Models for Assuring Quality and Safety Transitions Across Care Settings.” Written Testimony to the US Senate Special Committee on Aging

• **Transitional Care Model (TCM)** - TCM’s impact on total healthcare costs within the University of Pennsylvania healthcare system at 24 weeks, per patient was $3,630, and at 52 weeks was $7,636, compared to $6,661 and $12,481 respectively for those not using the tools provided with the program.
  

• **Guided Care Model** - Guided Care patients experienced, on average, 24% fewer days in hospital, 37% fewer skilled nursing facility days, 15% fewer emergency department visits, and 29% fewer home health care episodes, as well as 9% more specialist visits. This translated into an **annual savings** annual savings of **$75,000 or $1,364 per patient**.
  
Tangible Savings

- **Project Re-engineered Discharge (RED)** - In 2008, a randomized controlled trial study found that patients who utilized Project RED experienced a 30% lower rate of hospital utilization 30 days post discharge and that readmission or emergency department visit was prevented for every 7.3 subjects receiving the intervention. Additionally, patients who received intervention had a 33.9% lower cost than those who did not receive intervention, translating into a savings of $412 per person. Boston University School of Medicine. “The Re-Engineered Hospital Discharge Program to Decrease Rehospitalization.” [http://www.bu.edu/fammed/projectred/publications/RED%20Fact%20Sheet%20v2.pdf](http://www.bu.edu/fammed/projectred/publications/RED%20Fact%20Sheet%20v2.pdf)

- **Rush University Medical Center’s Enhanced Discharge Planning Program (EDPP)** - In 2010, a randomized controlled trial at Rush University Medical Center showed readmission decreases at 30, 60, 90, 120, 150 and 180 days. Additionally, mortality rates in the intervention group were 2.2% vs. 5.3% in the control group. Cost analysis within Rush’s fee-for-service environment showed a $1,293 savings per patient. Rush University Medical Center, Older Adult Programs, Enhance Discharge Planning Programs: Early Findings, 2011

Patient and Family Caregiver Tool Development
Provider Tools & Resources

NTOCC Provides Tool and Resource Development for Patient and Family Caregivers

www.ntocc.org

Guidelines for a Hospital Stay with Helpful Definitions -- For Patient, Family, & Caregiver

Taking Care of MY Health Care – français & español

My Medicine List -- español, français
Considerations for Change

• Improve communication during transitions with providers, patients and caregivers
• Support the implementation of electronic medical records that include standardized data elements
• Establish points of accountability for sending & receiving
• Increase the use of case management and professional care coordination
• Expand the role of the pharmacist in transitions of care
• Implement a payment system that align incentives
• Development performance measures to encourage better transitions of care
TOC Compendium

The TOC Compendium is a collection of resources such as white papers, journal articles, and websites that a "Transitions of Care" professional or interested consumer might find useful in their practice or medical situation.

Explore the TOC Compendium at:
www.NTOCC.org/Compendium

Seven Essential Intervention Categories

1. Medications Management
2. Transition Planning
3. Patient and Family Engagement / Education
4. Information Transfer
5. Follow-Up Care
6. Healthcare Providers Engagement
7. Shared Accountability across Providers and Organizations

Source:
http://www.NTOCC.org/compendium (2011)

http://www.ntocc.org/Toolbox/browse/
Transition of Care Evaluation Software Tool

Introduction

Health care professionals and government leaders increasingly understand that improving care coordination among the various care settings can improve patient safety, quality of care, and health outcomes while avoiding significant costs.

This web evaluation tool is an open resource, available for free of charge, for any institution or facility undertaking a Transition of Care improvement and quality improvement project. The tool is designed to allow users to track data and report findings of projects developed using the TOC Evaluation Plan process.

TOC Evaluation Software Tool
Tracking & Monitoring the Intervention

Reporting on the Outcomes
Trend the Change

What Causes Hospital Readmissions?
Case Study

Mrs. Johnston is an 87 year old woman in good health. She has GERD, minor urinary incontinence, and severe arthritis in her right knee. She has prescription medication to treat these ailments. She is relying more on pain medications for her knee. Her leg is beginning to turn outwards and has given way on several occasions. She is a widow and lives by herself in her own home in a Midwest suburb. She swims five days a week, eats healthy balanced meals, volunteers at her church, plays bridge, quilts, and keeps up with current events and politics. She has four adult children, three who live in the city and one in a neighboring state. Mrs. Johnston is scheduled for a right knee replacement.

Case Study – Making A Difference?

• PCP sent medical information to the Surgeon for 1st visit
• Patient had a Medicine List and FAQ for 1st visit
• Surgeon provided written instructions or office health coaching
• Admission medication reconciliation & transition medication reconciliation were completed with patient and family caregiver health coaching
• Health coaching about urinary incontinence issues and care plan options
• Timely transition summary, care plan, and transition medication reconciliation were available to the PCP, home health agency and Physical therapist on transition from hospital
• Follow transition call with patient & family scheduled 24-48 hours after transition with possible home visit at day 4 or 5
• Scheduled follow up transition set prior to transition home
Promoting Effective Communication and Care Coordination: 
Building the Team and Improving the Handovers

Care Coordination Is A National Priority!

National Quality Strategy Priorities

- Making care safer
- Ensuring person- and family-centered care
- Promoting effective communication/coordination of care
- Promoting the most effective prevention and treatment of leading causes of mortality
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable

A full summary of the National Quality Strategy is available at www.ahrq.gov/workingforquality
Development of Care Coordination Measures

- AHRQ – Comparative Effectiveness Research for Case Management
- NQF – Performance Measures for Care Coordination
- CMS – 10th SOW for QIOs supports Care Transitions
- TJC – Patient Safety Standard #8 Medication Reconciliation
- URAC – Incorporated Transition of Care in revised CM Standards
- NCQA – Complex Case Management Standards
- AMA – PCPI Transitions of Care

Current Focus in The New Health Care Landscape

Better Health

Value for Money

Best Care
What Will Get Us There

It’s All About Promoting an Interprofessional Model of Care

http://www.rwjf.org/humancapital

Moving Towards Collaborative Care

Table 1

<table>
<thead>
<tr>
<th>Conventional vs. Collaborative Care</th>
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<tbody>
<tr>
<td>Conventional</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Authoritarian</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Autonomous practice culture</td>
<td>Team culture</td>
</tr>
<tr>
<td>Physician driven, with physicians accountable for care outcomes</td>
<td>Patient centered, with team members sharing responsibility for care outcomes</td>
</tr>
<tr>
<td>Episodic, fragmented</td>
<td>Continuous, coordinated</td>
</tr>
<tr>
<td>Primary care delivered in one-size-fits-all, 15-minute visits</td>
<td>Primary care delivered via individualized visits, phone calls, and online communication</td>
</tr>
<tr>
<td>Payment based on quantity (fee for service)</td>
<td>Payment based on value (considers both quality and cost)</td>
</tr>
<tr>
<td>Reactive, focused on illness</td>
<td>Preventive, focused on health</td>
</tr>
<tr>
<td>Communication is inconsistent</td>
<td>Communication is imperative</td>
</tr>
</tbody>
</table>


Core Competencies for Interprofessional Collaborative Practice

Values/Ethics for Interprofessional Practice

- Work with individuals of other professions to maintain a climate of mutual respect and shared values.

Roles/Responsibilities for Collaborative Practice

- Use the knowledge of one’s own role and those of other professions to appropriately assess and address the health care needs of the patients and populations served.

Interprofessional Communication

- Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

Interprofessional Teamwork and Team-Based Care

- Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.

The Integrated Team

- Patient
- Physicians
- Wellness or Health Coaches
- Lab and Radiology Professionals
- Rehab
- Allied Health Professional
- Case Managers
- Care Partners
- Pharmacists
- Specialists
- Hospitalists
- Nurses
- Therapists
- Social Worker

Transition Connector

**Collaborative Team**
- Patient/Care Partner
- Physician
- Pharmacist
- Nurse
- Social Worker
- Case Manager
- Lab Technician
- Allied Health
  - Respiratory Therapist
  - Dietitian
  - Physical Therapist
  - Educator

**Community Team**
- Patient/Care Partner
- PCP
- Specialist
- Skilled Nursing Facility
- LTC Services
- Pharmacy
- Community Clinic
- Home Care
- GCM/CM
- Rehabilitation
- Hospice
- Community Resources
- Health Plan
- Medical Home
- DME
Interdisciplinary Team Concepts

“Care transitions is a team sport and yet all too often we don’t know who our teammates are, or how they can help.”

— Eric A. Coleman, MD, MPH

1) Remember your team members come from diverse training and backgrounds

2) Teams should focus on a defined goal with parameters, such as a specific unaddressed care need, improvement on a quality measure or a particular setting or patient population

3) So together team members will determine team’s mission and common goals

4) Teams must develop respect, competence, accountability and trust for each other and work interdependently to define and treat not only patient problems but those affecting process and workflow

5) It is key to develop a communication process that defines how the team will solve differences and build collaboration

6) The outcomes of the team’s work must be deemed superior to individually based outcomes
Promoting Collaboration

Requires functional interprofessional care teams

Requires a culture of trust, respect, and professional interdependence

Case managers are key component of this new culture

Results in creating and delivering value

“The biggest problem with communication is the illusion that it has been accomplished.”

George Bernard Shaw
Improving Communication

Responsibilities of Health Professionals for Patients in Transition

**Sending health care team**
- Stable for transfer
- Patient/caregiver understand and are prepared
- Transfer information is complete
- Contact person’s name and number

**Receiving health care team**
- Review transfer information promptly and clarify
- Incorporate patient’s goals/preferences in care plan
- Document contact information

(c) Eric A. Coleman, MD, MPH
Promoting Good Communication and Meaningful Conversations

Open and honest conversations among health care professionals are critical to promote an interprofessional approach to patient care.

Practice effective communication—bring active listening skills into everyday conversations.

Clear communication helps ensure safer care and better health outcomes.

Need to be fully in the moment for meaningful communication to occur.

Connect on a personal level to build trusting relationships.

Improving Transitions

Requires Change:
- Systems
- Process
- Workflow
- Culture & Behavior

“Becoming A Change Agent Team”
Building High-Performance Teams

• Becoming the Change Agent
• Community-Based Transitions Teams
• Networking between the Acute & the Post Acute & The Continuum of care

Characteristics for High-Performing Healthcare Teams

• Team Culture
• Team Participation
• Communication
• Patient/Family Engagement
• Accountability
• Support of High Quality Care in the Organization
• Leadership
Seek Out and Fully Embrace Leadership Opportunities

1. Act as full partner in health care delivery redesign efforts
2. Educate and mentor professional colleagues
3. Model a collaborative approach
4. Work with leaders from other professions

What Will It Take to Ensure High Quality Transitional Care?

1. Foster Greater Engagement of Patients and Family Caregivers
2. Elevate the Status of Family Caregivers as Essential Members of the Care Team
3. Implement Performance Measurement
4. Define Accountability During Transitions
5. Build Professional Competency in Care Coordination
6. Explore Technological Solutions to Improve Cross Setting Communication
7. Align Financial Incentives to Promote Cross Setting Collaboration

Eric Coleman, MD [http://www.caretransitions.org/What_will_it_take.asp](http://www.caretransitions.org/What_will_it_take.asp)
Elements of Best Practice Defined

Medication Management
Transition Planning Tools
Patient and Family Engagement/Education
Tools For Information Transfer
Follow-up Visit – PCP/Specialist
Post-Transition Call or Visit
Accountability For Sending & Receiving

Safe, effective, efficient transitions of care

Evidence Based Care Transitions Models

Common Themes Across Models Include:

- Identification of a specific staff person to provide transitional care support
- Interdisciplinary communication/coordination
- Patient engagement/activation
- Enhanced post-discharge follow up
YOU Can Promote Safe, Effective Care Transitions

- Patient-centered care — patient's goals and preferences
- Patient (or caregiver) education to increase activation and self-care skills
- Accurate communication and information exchange during handovers
- Medication reconciliation and safe medication practices
- Procurement and timely delivery of DME
- Ensuring “sender” maintains responsibility for patient until “receiver” confirms assumes responsibility
- Follow-up with patient/caregiver within 48 hours after discharge from a setting or service

Transitioning the Continuum of Care with Bi-Directional Communication
Improving Communication Will Improve Transition Issues

Additional Resources for TOC

- **NFCA** - National Family Caregiver Association - Family Caregiving Resources – [www.thefamilycaregiver.org](http://www.thefamilycaregiver.org)
- **CAPS** - Consumers Advancing Patient Safety – Toolkits [www.patientsafety.org](http://www.patientsafety.org)
- **NTOCC** - National Transitions of Care Coalition – Provider & Consumer Tools [www.ntocc.org](http://www.ntocc.org)
- **CMSA** - Case Management Society of America – CM Medication Adherence Guidelines & Disease Specific Adherence Guidelines - [www.cmsa.org](http://www.cmsa.org)
- **AMDA’s** (Dedicated to Long Term Care Medicine™) Transitions of Care in the Long Term Care Continuum practice guideline - [http://www.amda.com/tools/clinical/TOCCPG/index.html](http://www.amda.com/tools/clinical/TOCCPG/index.html)
- **AHRQ** – Questions Are The Answers – [www.ahrq.org](http://www.ahrq.org)
Thank You

Questions

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