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Best Practices in Care Coordination & Transitions of Care Communications

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Best Practices in Care Coordination & Transitions of Care Communications

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Overview/Agenda

- Care Coordination - Defined
- Essential Elements of Care Coordination
- Transitions of Care - Defined
- Transitions of Care & Communications
- Considerations to Improve Communication Across Providers
- Best Practices in Action

Care Coordination - Defined

“The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors”

*Centers for Medicare and Medicaid Services

Care Coordination - Defined

“Care coordination occurs when care plans are implemented by a variety of service providers and programs in an organized fashion.”

*AAP Council on Children with Disabilities

Care Coordination - Defined

“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 care services. Organizing care involves the 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.”

*Agency for Healthcare Research and Quality, 2007

Essential Elements of Care Coordination

- Comprehensive
 - All services, regardless of health system, are coordinated
- Patient-centered
 - Meets the needs of the patient and family

*CMS – Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children and Adolescents.

Essential Elements of Care Coordination

- Access & Follow-up
 - Connects patients to services
 - Services are delivered appropriately
 - Information shared among and across providers, and always back to the PCP
 - *Successful transitions of care*

*CMS – Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children and Adolescents.

Transitions of Care - Defined

“...patients...experience transitions in their care, meaning that they leave one care setting (i.e. hospital, nursing facility, assisted living facility, primary care physician care, home health care, or specialist care), and move to another”

*National Transitions of Care Coalition. Improving Transitions of Care – Findings and Considerations of the “Vision of the National Transitions of Care Coalitions.” September 2010

Transitions of Care & Communication

- Communication is integral to successful transitions of care
 - Across care settings
 - Across providers

*National Transitions of Care Coalition. Improving Transitions of Care – Findings and Considerations of the “Vision of the National Transitions of Care Coalitions.” September 2010

Impact of Poor Communication

- Confusion about the patient's condition
- Duplicative Tests
- Inconsistent Patient Monitoring
- Medication Errors
- Delays in Diagnosis
- Lack of referral follow-up

*National Transitions of Care Coalition. Improving Transitions of Care – Findings and Considerations of the “Vision of the National Transitions of Care Coalitions.” September 2010

Considerations to Improve Communication Across Providers

- Implement EHR
 - Increase the flow of data across providers
 - Support access to accurate and complete clinical data

*National Transitions of Care Coalition. Improving Transitions of Care – Findings and Considerations of the “Vision of the National Transitions of Care Coalitions.” September 2010

Considerations to Improve Communication Across Providers

- Health Information Exchange (HIE)
 - Standardization of data
 - Integration of data across providers into EHR
 - Timely sharing of patient information



*www.healthit.gov

Considerations to Improve Communication Across Providers

- Medication Reconciliation
- Establish points of accountability
- Increase use of case managers and care coordinators

*National Transitions of Care Coalition. Improving Transitions of Care – Findings and Considerations of the “Vision of the National Transitions of Care Coalitions.” September 2010

Considerations to Improve Communication Across Providers

- Align incentives
- Develop performance measures
- Empower patients and family caregivers

*National Transitions of Care Coalition. Improving Transitions of Care – Findings and Considerations of the “Vision of the National Transitions of Care Coalitions.” September 2010

Best Practices in Action

- Coordination of long-term services (LTSS) and supports for Medically Complex Members
 - Medicaid Example

LTSS Care Coordination

- Authorization and coordination of Medicaid LTSS
 - Continuous skilled nursing, durable medical equipment, home health and therapy services, respiratory equipment and supplies, orthotics and prosthetics
- Nurse Case Manager - Single point of entry for patient and provider(s) related to Medicaid LTSS

LTSS Care Coordination

- Integration of Nurse Case Manager into facility-based discharge planning
 - Onsite assessment in facility
- Supports successful transitions of care to home settings through authorization of appropriate LTSS
- Facilitates communication with community-based and medical providers

LTSS Care Coordination

- Integration of pharmacist into multi-disciplinary team
- Provide medication management services
 - Antiepileptic therapy
 - Pain management
 - Mitochondrial disease
 - Ketogenic diet

Questions/Discussion