Reducing Unnecessary Utilization: Creating a Transition Care Model to Improve Care Coordination

Questions and Answers

*This document reflects discussion during the second Reducing Unnecessary Utilization learning module presented on July 28, 2016.

NRHI SAN Clinical and Quality Experts included on the Q&A panel:
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When it comes to care coordination, what is the most important element to reducing unnecessary utilization?

Communication. It is important to look at different aspects of communication, including whether or not the communication is paper or electronic, whether or not it is appropriate in its complexities, whether it is two-way communication, and whether the communication is one time or on-going. Most often coordination difficulties are the result of poor communication.

What advice do you have for primary care practitioners to better partner with different players and be leaders when it comes to reducing readmissions?

Discharge planning is a team sport. When we look at what is going on with a provider we often fail to widen the lens and talk about what is going on overall in the practice. There are so many members of the practice that have touch points with patients and families who can be wonderful ambassadors for good coordination of care- from the receptionist who gets a call and understands that a patient's request might be linked to an underlying issue, to the medical assistant who recognizes a patient's stress from rushing to appointments. It's important to be able to recognize when the care plan might not be working. When there are no shows in the practice, this is more than just a statistic- 20% no shows mean that 20% of the patients require an outreach to figure out why they didn't come in.

Another way providers can partner with different players to improve care coordination is by visiting the places they are referring patients to if they have not yet been there. This will help providers to feel confident in their referrals and forge better relationships with their partners.

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What are some concrete steps you would recommend for people working with practices on different levels?

It is important providers use the tools they have to better understand their patient populations, such as:

- Understanding their no show rates
- Knowing what percentage of their population has been hospitalized in the last year or the last six months
- Determining when patients with complex needs were last seen
- If possible, determining if patients are having their medications renewed

Teaching providers to mine their own data helps them better know their own practice and patients and allows them to see the gaps and begin to raise the important issues. Absence of that data can be missing clues that are right there in front of them.

When it comes to addressing the patient and family how can we expect families to cope with the reality of home care, with often limited time for teachings in hospitals and lack of information in primary care?

First, it's about understanding which patients need more help and which don't. If you set up a patient with a simple care plan who seems to understand it you can set that in motion and walk away, only having an early warning sign when something goes wrong. If you have a complicated case, for example a patient who lives alone or with a partner just as frail as they are, that's when you know some additional help is needed. Some questions to think about:

- Is there an additional potential care giver in the family or in the community?
- Can your practice develop a partnership with a nursing school or pharmacy school that can go into the home?
- Is there a television station in your community that will run community and patient education?
- Are there technology resources that can provide more education, for example a film or YouTube video to offer a visual for patients on their care?
- Is there a support group in the community, for example Alzheimer's organization? What resources are available in the community? Very often people don't ask social workers or community organizations such as the United Way for resources or help.

It will take the entire community to keep people safe and home in their community and we all have a vested interest in that. People have a desire to be at home receiving their care. We can achieve that if we all work together and think outside the box.

Additional Resources:

- **PRHI (Pittsburgh Regional Health Initiative)**
  - www.prhi.org
- **JHF Closure**
  - www.closure.org
- **CMS Penalties**
  - https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html
- **Explanation of CMS Penalties**
  - http://khn.org/news/a-guide-to-medicare-readmissions-penalties-and-data/

Links to PRHI Projects:

- **RAVEN**
  - https://www.jhf.org/whatwedo/whatwedo-2/projects-and-programs/raven
- **Patient Care Resource Center**
  - http://www.prhi.org/initiatives/primary-care-resource-center
- **Practice Transformation**
  - https://www.prhi.org/whatwedo/organizations-systems/practice-transformation

The Four Collaborative Care Models:

- **BOOST Model**
  - https://partnershipforpatients.cms.gov/p4p_resources/tsp-preventablereadmissions/toolpreventablereadmissions.html
- **RED Model**
  - https://www.bu.edu/fammed/projectred/
- **Transition Care Model**
  - http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf
- **Care Transition Intervention Model**
  - http://www.rosalynncarter.org/caregiver_intervention_database/miscellaneous/care_transitions/