IMPROVING TRANSITIONS OF CARE IN POPULATION HEALTH
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THE TRANSITIONS CHALLENGE

Adults 75 and older are in a health care setting 17 days a year, on average.

Approximately half of all hospital-related medication errors and 20% of all Adverse Drug Events have been attributed to poor communication at the transitions and interfaces of care.

40 percent of patients 85 years and older are discharged to a skilled nursing facility (SNF).

The chronically ill will see on average up to 16 physicians in one year.

42 percent of providers report things fall between the cracks when transferring patients from one facility to another.

40 percent of patients 85 years and older are discharged to a skilled nursing facility (SNF).
Impact to provider’s outcomes

CMS estimates that it would penalize 2,588 hospitals, constituting more than half the nation’s hospitals for excessive admission rates in fiscal year 2017.

A component for success in all value-based care programs

- BPCI
- MSSP
- CPC+
- DSRIP
- Penalty programs
- Payment modifiers
- All cause quality measures

Care transformation

100% applicable to all who seek to reduce variations in care and implement consistent best practices.
PATIENT INSIGHTS FROM PROJECT BOOST

PRIOR STATE

• COMPLEX

• UNCOORDINATED/FRAGMENTED

• LOOSE ENDS

• COMMUNICATION

• POOR QUALITY INFORMATION

• POOR PREPARATION: DO THE PATIENTS KNOW THE PLAN?

AT DISCHARGE

• ONLY 42% WERE ABLE TO STATE THEIR DIAGNOSIS

• ONLY 37% WERE ABLE TO STATE THE PURPOSE OF ALL THEIR MEDICATIONS

• ONLY 4% KNEW THEIR MEDICATIONS’ COMMON SIDE EFFECTS

• 40-80% OF MEDICATION INFORMATION IS IMMEDIATELY FORGOTTEN

POST DISCHARGE EVALUATION AND SUPPORT IS KEY TO EFFECTIVE DISCHARGE FOLLOW-UP TO REDUCE AVOIDABLE READMISSIONS.
IMPROVING THE PATIENT EXPERIENCE

WHY IT’S IMPORTANT
Navigating the healthcare system can be confusing and overwhelming for patients. This is especially true for co-morbid patients due to the higher degree of complexity of their care and greater number of clinicians and transitions between care settings. In order to establish a relationship of trust and activate patients in their own care, it’s critical to deliver a coordinated patient experience during transitions so that patients receive consistent guidance through a complex process.

AREA OF FOCUS
Map out your care pathways for proactive support at vulnerable points of transition. Begin building a relationship with patients while they are in an inpatient setting by discussing the care team and roles. Specify how the team will be interacting with the patient moving forward. Implement improvement areas such as better information sharing among clinicians or additional support to remove identified barriers for patients (e.g. access to transportation, 24 hour call line, attending follow-up care appointments with patients).

HOW WE CAN HELP
Caradigm can help you improve the patient experience by aggregating and sharing all the information needed and by helping coordinate care amongst a diverse team. Best practice work flows time interventions and outreach to proactively support the crucial first 30 days after discharge.

PEOPLE
• Include patients and their caregivers as critical members of the care team.
• Give patients a primary point of contact who has overall responsibility to ensure that care is coordinated across settings and providers.

PROCESS
• Include patients and caregivers early in transition planning.
• Enhance transitions processes with barriers identification and mitigation or knowledge gaps.
• Survey patients to gauge patient satisfaction and effectiveness of transitions.

TECHNOLOGY
• Create a longitudinal patient view and a team-based shared care plan.
• Provide tools and resources such as a self-management action plan (SMAP) with clear instruction for self-care, medication management and who to call when problems arise.
IDENTIFYING PATIENTS

WHY IT’S IMPORTANT
The first two to three days post-discharge are critical, so timely patient identification is crucial. Early evaluation and assessment of medication changes and compliance, support needs assessment as well as post discharge follow up care are essential for transitions program success.

AREA OF FOCUS
Establish your protocols for patient identification (e.g. all covered lives, prioritizing specific patient segments), then explore how technology solutions can help streamline workflows by replacing manual processes.

HOW WE CAN HELP
Caradigm can help automate manual patient identification processes by enabling ADT-based or similar alerts that can be sent to care managers to initiate best practice workflows.

PEOPLE
• Engage the right care team to support patient behavioral, social and clinical needs.
• Consider community resources.

PROCESS
• Assess TOC enrollment trends to maximize population supported.
• Track and trend key success measures such as timeliness of referral, assessment and medication review to support continuous process improvement.
• Emphasize TOC best practice and show how automated work flows support it.

TECHNOLOGY
• Send real-time alerts directly to care team members so they can initiate transitions of care workflows faster.
• Integrate clinical decision support into your care management work flow.
REducing Variations In Care

Why It’s Important
Standardizing care pathways utilizing industry validated best practices can reduce variation and raise the overall standard of care. Initiating a project to standardize care pathways helps transitions of care become recognized as an organizational priority.

Area of Focus
Gain organizational agreement on protocols and best practices (discharge planning, assessments, timely follow-up, enhanced support and tools) that constitute a successful transition. Establish accountability and goals for all points of care including partner organizations and the ability of the patient to participate in self-care.

How We Can Help
Caradigm Care Management is an enterprise care coordination application that provides evidence-based guidelines and automated work flows to enhance effectiveness of transitions of care programs.

People

- Leverage a cross-functional team of clinician leaders to optimize transitions of care across and between organizations.
- Delineate clear goals, roles and responsibilities for all other points of care.

Process

- Establish key organizational and performance metrics specific to transitions of care and care coordination (e.g. time to follow-up, readmission rates, length of stay) in order to monitor performance.
- Provide timely performance feedback to help clinicians adapt to new protocols.

Technology

- Embed best practice guidelines into workflow tools as much as possible to reduce practice variation.
- Include tools to conduct readmission root cause analysis to support improvements at a patient and population level.
- Use analytics to measure how the care team is performing in regards to case load and tracking of overall transitions of care program effectiveness.
SHARING PATIENT INFORMATION

WHY IT’S IMPORTANT
A complete and shared patient view of information from multiple patient records and data sources is essential for effective handoffs. This includes lab and test results, medications prescribed and filled, care team members, a plan of care, patient goals, recommended interventions etc. Without this view, care can become disjointed, which leads to breakdowns.

AREA OF FOCUS
Identify the different types of data and systems you have available (e.g. EMRs, lab, pharmacy, claims) and how that data will be used in care transitions. If multiple EMRs are utilized among the care team, you will need to develop a strategy for aggregating and sharing data.

HOW WE CAN HELP
The Caradigm Intelligence Platform has a proven ability to aggregate and structure healthcare data from any information system into a longitudinal patient view. Patient information is materialized in care management providing a 360° view of aggregated data at a patient level, assuring transparency and coordination of information from multiple care delivery systems.

PEOPLE
- Include a data governance team to ensure accountability and information security.
- Identify partner organizations and clinicians that will need access to shared patient data.

PROCESS
- Train partner organizations and clinicians on how they will access shared patient data.
- Incorporate data into clinician workflows to increase adoption (e.g. performing medication review, follow-ups with patients, closing gaps in care).
- Support coordination and documentation of interdisciplinary team meetings for complex patients.

TECHNOLOGY
- Automate ingestion of data.
- Leverage a healthcare specific data model that can automatically structure data and terminology from different data sources.
- Grant secure web-based access for all care team members.
- Enable a variety of interoperability mechanisms to support data sharing use cases.
TEAM-BASED CARE

WHY IT’S IMPORTANT
Coordinated care is central to success in value-based programs. In addition, the shift of financial risk to providers working in these programs creates greater urgency to coordinate care across the continuum of care.

AREA OF FOCUS
Beginning with a few specific patient populations, map out how a multi-disciplinary care team (primary care, social workers, pharmacists, home health, psychiatrists) can work together better and make patients more confident in a team-based delivery model.

HOW WE CAN HELP
Caradigm Care Management provides the transparency and workflow efficiency that a multi-disciplinary care team needs to scale and support high-risk patients in value-based programs.

PEOPLE
- Establish a culture of teamwork with clear accountability across the continuum so each care team member understands their individual responsibilities.
- Assign one clinician with overall responsibility to ensure that care is coordinated across settings and providers for a patient.
- Consider enhancing primary care by embedding shared care coordinators, mental health and social workers into practices.

PROCESS
- Meet regularly with partner stakeholders to align on goals, consider ideas for improvement and celebrate successes.
- When readmissions occur, determine cause and share learnings among all clinicians.
- Consider offering financial bonuses and or volume incentives to partner organizations for performance.

TECHNOLOGY
- Equip the entire care team with the info necessary to ensure a successful transfer to the next setting regardless of what EMR they may be using.
- Leverage Intelligent plans of care with role-based tasking that can help assure that steps aren’t missed.
- Utilize alerts that can let the appropriate care team member know when a patient has a change in status.
IMPROVING MEDICATION REVIEW

WHY IT’S IMPORTANT
Adverse drug events (ADEs) account for an estimated 1 million emergency department visits and over 3.5 million physician office visits annually. Organizations that improve medication review and patient adherence at all transitions of care can lower patient complications and readmissions.

AREA OF FOCUS
Give all clinicians full medication context on a patient so that they are better equipped to evaluate and direct additional care as they move between settings.

HOW WE CAN HELP
Caradigm Care Management improves medication review by giving clinicians accurate and up to date medication context as part of the longitudinal patient view so all clinicians are to be able to see what was prescribed, filled and taken.

PEOPLE
• Create a team responsible for standardizing the medication reconciliation process and data elements required.
• Consider adding a pharmacist to the care team to help manage dosing regimens and timing of medications.

PROCESS
• Train all care givers responsible for medication review to ensure consistency.
• Measure baseline and improvement (e.g. errors caught).
• Increase access to services (e.g. transportation) and create patient education tools to help promote adherence.

TECHNOLOGY
• Automate the capture of data elements (e.g. pharmacy claims data) so clinicians don’t have to log into multiple systems.
• Share notes with all clinicians on medication regimens or barriers to medication compliance.
• Give the ability to auto-assign tasks related to medication review or compliance (e.g. have pharmacist call patient).
86% of patients were very satisfied with medication care instructions in the intervention group compared to 61% in the control.

46% relative reduction in the 30-day all-cause heart failure readmission rate, from 24% to 13%

Decrease of $439 per member per month at 3 months and annual per member savings of $2170

Average CMS readmission penalty assessed in 2016: $203,312.
IT-ENABLED TRANSITIONS OF CARE

REAL-TIME DATA ACQUISITION

CARADIGM INTELLIGENCE PLATFORM

- Identify patients
- Improve the patient experience
- Standardize care pathways
- Share patient information
- Coordinate care among an interdisciplinary team
- Improve medication review

EMBED BEST PRACTICE IN WORKFLOWS

CARADIGM CARE MANAGEMENT

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Caradigm is an award-winning population health company dedicated to improving patient care, advancing the health of populations and reducing healthcare costs. Its enterprise software portfolio encompasses all capabilities critical to delivering effective population health management, including data control, healthcare analytics, and care coordination and engagement.
SOURCES

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http://www.ntocc.org/Portals/0/pdf/resources/ntoccissuebriefs.pdf
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https://health.gov/hcq/ade.asp

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Project BOOST
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