Care Coordination Best Practices

Tim Saunders, MSW, LCSW-C
Greater Baltimore Medical Center

Care Coordination Best Practices

Hospital-based Case Management background

Hospital-centric mentality

New perspective on the healthcare system

Care Coordination Best Practices

I. Risk Assessment
II. Connection to Programs and Services
III. Coordination Across the Continuum

Risk Assessment

Why do Risk Assessments?

- Risk Stratification/Patient Segmentation
- Appropriate allocation of limited resources

Risk for what?

- Readmission
- Negative health outcome
- High utilization

Risk Assessment

Who should be assessed?

- Hospitalized patients
- Primary care/PCMH patients
- Covered patients (for insurance companies)

How?

- Past utilization
- Current risk factors (diagnosis, social factors, etc.)

project BOOST
Better Outcomes For Older Adults Through Safe Transitions

Tool for Addressing Risk: A Geriatric Evaluation for Transitions

Risk Assessment: 8P Screening Tool (Check all that apply.)	**Risk Specific Intervention**	**Signature of individual responsible for insuring intervention administered**
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

Connection to Programs & Services

Application of Risk Assessment

- Start with High Risk population

Connection to Programs & Services

All patients from Hospital:

- Follow-up appointment with PCP within 1 week

Some patients from hospital:

- Placement (LTAC, SNF, ALF, Psych, etc.)
- Home Care services
- Transition Guide
- Case Management (via PCMH, insurance company)

Connection to Programs & Services

From PCMH/PCP:

- Other outpatient services (wound care, tests/studies, referral to specialist, etc.)
- Education (diabetes education, disease management)
- Skilled Home Care Services
- Personal care home services
- Case Management
  - Through PCMH, insurance company, or privately
- Transportation Assistance
- Mental Health treatment/referrals
- SNF placement

Communication across the Continuum

- Coordination between care coordinators across the system
- Avoids duplication of work and services
- Allows sharing of information (ex. Patients being sent to ED, hospital admissions, Multi-Disciplinary Rounds, discharge summaries, follow-up appointments, services arranged)
- Sharing of resources

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Questions