Care Coordination is more than a Care Coordinator: Translating Research to Practice in Rural

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I have no financial relationships to disclose.

Objectives

As a result of this session, participants will:

- Be familiar with the evidence-based strategies for improving care transitions and coordination
- Understand the barriers and opportunities in translating research to practice in care coordination in the rural environment

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Who is Stratis Health?

- Independent, nonprofit, community-based Minnesota organization founded in 1971
  - Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Funded by federal and state contracts, corporate and foundation grants
- Working at the intersection of research, policy, and practice
- Rural Health is longstanding priority focus

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What is care coordination and why should you care about it?

Care Coordination Definitions

- Function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites that are met over time (NQF)
- Deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care (AHRQ)

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Care Coordinator Definition

- A person in charge of coordinating client care in a clinical or health care setting, typically responsible for developing care plans, arranging and tracking appointments, educating clients/patients, and coordinating other aspects of clients' wellbeing

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A Comparison

Care coordination

- A function
- Based on a population and their needs
- A deliberate, systematic organization of patient care
- Infrastructure, policies, and resources

Care coordinator

- A person
- Individualized action and support for a patient
- Could involve case management, coaching, advocacy
- May be clinical or non-clinical

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Confusion abounds

- A 2007 AHRQ systematic review found 40 different definitions for “care coordination” in the literature
- A growing number of terms are used today – care coordination, care coordinator, care navigator, case manager, health coach, disease management, care guide…and more.

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The “burning platform” of care coordination

- Incentives, penalties, and new payment models are driving a shift to accountable care and population health which value (and pay for) well coordinated patient care
- New models and approaches are emerging and being tested that can inform how care is delivered and coordinated
- Need and opportunity to address medical *and* psycho-social needs of patients

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Unique considerations in rural health care

There are challenges:

- Rural providers serve fewer people, but a greater proportion of elderly and poor, as well as more advanced and chronic conditions.
- Rural communities face shortages in medical personnel, staff often have multiple roles, and resources and capital are limited.
- Transportation and access are often significant issues for patients.
- Quality improvement projects and measures designed for large urban providers generally don't fit rural providers.

But also opportunities:

- Changes can be made faster.
- Patient patterns are more easily identified.
- Care teams know their patients as their neighbors and community.
- Policies and payments recognize and accommodate some rural needs.

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What are the evidence-based best practices, and how do you know if you are effectively coordinating care?

Evidence-based Practices

- 5 focus areas known to impact care coordination as measured by hospital readmission
  - Comprehensive discharge planning
  - Transitions care support
  - Transitions communication
  - Patient and family engagement
  - Medication management

See Resources section for more details.

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Key Ingredients of Rural Care Coordination

According to the RUPRI (Rural Policy Research Institute) Health Panel:

- Effective information exchange
- Trained, available workforce
- Evaluation and improvement of care coordination programs

Measuring Care Coordination

In 2012, NQF endorsed 12 care coordination measures

- Medication reconciliation (4 versions)
- Acute care hospitalization
- ED use w/out hospitalization
- Advance care plan
- Timely initiation of care
- Medical home system survey
- Transition record with specified elements received by discharged patients (2 versions)
- Timely transmission of transition record

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NQF Rural Health Project

Performance Measurement for Rural Low-Volume Providers report was issued in September 2015.

- 14 recommendations, funding the development of rural-relevant measures. Many of the recommended measurement areas are directly or indirectly about care coordination:
    - patient hand-offs and transitions
    - alcohol/drug treatment
    - telehealth/telemedicine
    - access to care and timeliness of care
    - cost
    - population health at the geographic level
    - advance directives/end-of-life

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What are the lessons learned in care coordination in rural communities?

Key learnings drawn from three rural care coordination improvement projects

- RARE Campaign (statewide hospital campaign that included 38 critical access hospitals)
- Community Care Coordination Project (three rural communities)
- Rural Palliative Care Initiative (24 rural communities)

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RARE Campaign: A Care Coordination Example

- 82 hospitals participating, accounting for more than 85% of the annual Minnesota statewide hospital readmissions
  - 38 Critical Access Hospitals participating
  - Enthusiastic and engaged participation
- Prevented 5,441 readmissions between 2011 and 1st quarter of 2013

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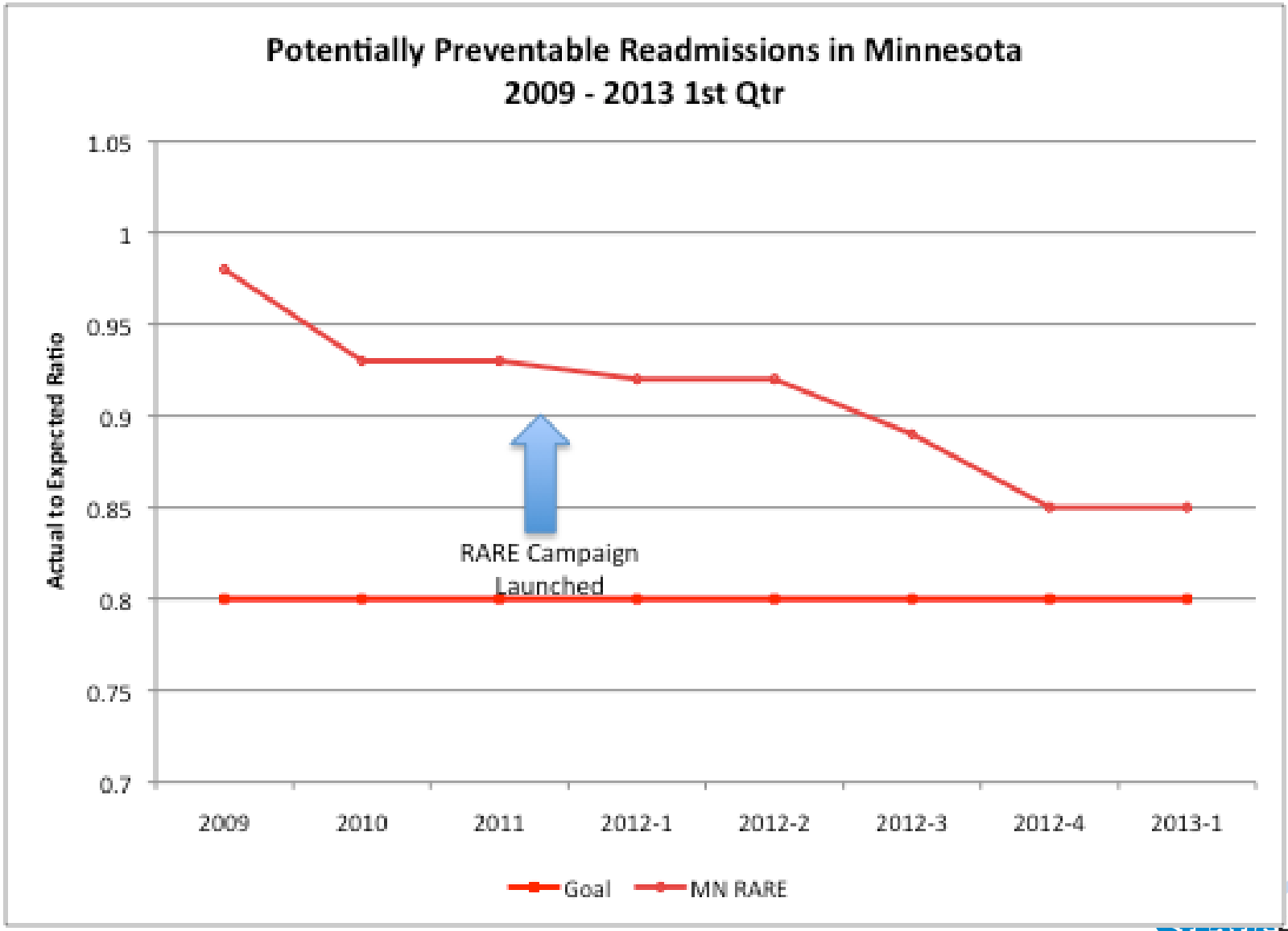

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RARE Campaign: 5,441 Readmissions Prevented to Date

Each person represents 250 prevented readmissions, and 1,000 more nights of sleep in their own beds for Minnesotans

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Care Coordination Advice and Considerations for Rural Communities

- *One Size Does not Fit All*
- *Build for Sustainability*
- *Understand your Build-or-Partner Options*
- *Engage in Data-Driven Decision Making*
- *Leverage Shared Goals and Challenges*

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One Size Does not Fit All

- Use a comprehensive needs assessment to understand your community's current care coordination processes, gaps, and needs; then establish your goals and build a program to meet those goals – there is no universal or off-the-shelf solution (although there are many useful tools and resources to draw upon once you know what you need and want)

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Build for Sustainability

- Care coordination is a function which is by necessity led and managed at the local rural site – you need to build your capacity through consistent leadership and a strong interdisciplinary team, and you have unique opportunities to connect and implement in meaningful ways within and beyond the health care system in your community

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Understand your Build-or-Partner Options

- The temptation may be to build rather than partner to gain the comprehensive medical and psycho-social services needed for effective care coordination – instead, explore and engage expert, trusted community-based partners who already deliver cost-effective services

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Engage in Data-driven Decision Making

- Data, accompanied by thoughtful analysis and interpretation, is essential to good decision making – optimize electronic health records and health information exchange; use data and analytics to make well informed, strategic, and patient-/community-centered decisions; and then measure your progress, even if you have small numbers

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Leverage Shared Goals and Challenges

- While there are differences across the rural communities, there also are many common challenges and needs – find peers and colleagues who can support you, teach you, share with you

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The Bottom Line…

- Significant momentum behind the transformation from volume to value, which is driving care delivery redesign
- Effective care coordination is essential for success, both for patient care and for new payment models
- Opportunities abound for robust research specific to rural health care

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Care Coordination Resources

Rural Policy Resource

RUPRI paper, “Care Coordination in Rural Communities: Supporting the High Performance Rural Health System”, June 2015

- Framework and recommendations

http://www.rupri.org/wp-content/uploads/2014/09/Care-Coordination-in-Rural-Communities-Supporting-the-High-Performance-Rural-Health-System.-RUPRI-Health-Panel.-June-2015.pdf

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Rural Innovation Resource

- *Rural Health Value* project (RUPRI, Stratis Health) has gathered and developed a comprehensive set of tools to support the transformation from volume to value, including care coordination
  - Tools and resources
  - Profiles in innovation
  - Innovation table

http://cph.uiowa.edu/ruralhealthvalue/

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Rural Technical Assistance Resource

- Stratis Health Community-based Care Coordination – A Comprehensive Development Toolkit
  - Tools for use at different stages in the development of a CCC program,
  - Focus on people, functions, policy, and processes

https://www.stratishealth.org/expertise/healthit/carecoord/

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Brief descriptions of the five evidence-based approaches to care coordination

Additional information available at:
http://www.rarereadmissions.org/areas/index.html

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Comprehensive Discharge Planning

- Ensuring that all of a patient's needs are considered and included in a comprehensive discharge plan with input from the patient and family. Interventions may consist of written, visual or recorded discharge plans that include and consider follow-up appointments, medications, nutritional needs, family support, transportation, health literacy, knowing whom to call, social problems, and red flags.

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Transition Care Support

- Ensuring that transition plans are in place and followed so that the patient's care is coordinated between one caregiver and another, including across settings, hospitals, post-acute facilities, home care agencies, clinicians, and community-based organizations. Interventions may include the care coach, transition coordinator, and post-transition follow-up care.

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Transition Communication

- Ensuring that effective communication occurs between sending and receiving caregivers working with the hospital. Interventions may include processes for transferring information, providing discharge summaries in a timely manner, defining accountability for care, communication of the plan of care, methods for talking directly with sending or receiving caregivers, and developing common definitions of key information.

Patient and Family Engagement

- Ensuring that processes are in place to engage patients and family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. Interventions may include such methodologies as teach back, collaborative conversations and communication, and simulations with the patient and family member.

Medication Management

- Improving the use of medications for the patient's condition and ensuring that the patient understands the purpose of the medications and is taking them in the correct manner at the correct time. Interventions may include medication reconciliation, patient/family education on medications, medication therapy management, and medication set-up simulations for the patient/family.

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