



Foundation for  
Healthy Communities

June 2016

## **Patient Transitions & Care Coordination Project Summary**

### **Issue**

Supporting individuals with an illness or disability to enable them to receive health care services and live safely in the most supportive and least restrictive environment is a desirable goal for enhancing quality of life and well-being. Collectively working towards this goal, within and across organizations, can minimize the use of medical resources in the long term. There are an increasing number of new positions in the health care sector designed to coordinate the right care at the right time, with the goal of avoiding unnecessary emergency or in-patient acute care. The specific titles and responsibilities of staff and their roles in different organizations can overwhelm and confuse patients and their families about who is doing what for whom. How do 'coordinators' within the health care sector coordinate with one another, with the patient, and with the patient's family or caregiver? How is the value of new coordination efforts being evaluated? These are major questions that must be addressed in order to optimize patient well-being and care while efficiently using health care resources.

### **Project Objective/Method**

The objective was to understand services available to support at risk patients who need care coordination to prevent avoidable emergency or acute care. We interviewed staff in health care organizations in four New Hampshire communities (Concord, Dover, Littleton and Peterborough).

Interviews were conducted in the fall of 2015 and early winter 2016. Information was examined in relation to care coordination models to identify 'best' or promising practices and identify opportunities for improvement that support patients in transition within their community. Interested stakeholders met to learn about new approaches to more effectively support patients in transition and care coordination initiatives in June 2016.

### **Observations/Findings**

There were common observations that were noted in interviews with staff in different organizations across all four communities. These included:

- All organizations value care coordination and offer some care coordination service or program.
- Avoiding preventable hospital re-admissions and emergency room visits are key factors underlying care coordination efforts.
- Organizations vary significantly in whether they have any risk assessment strategy related to care coordination for their patient/clients. Risk assessment criteria most often cited by organizations were patient age, select diagnoses with COPD and CHF prominent; length of stay; polypharmacy; insurance or ACO criteria; and housing status.

- A patient often has many case managers/navigators/care coordinators depending on where they have received health services, insurance coverage, and where they may need to receive future health services.
- Insurance coverage and requirements (e.g., prior authorizations, length of stay for post-acute rehabilitation services; observation status rules, etc.) or the lack of coverage and/or financial resources significantly influences the availability of services for a person requiring non-acute care.
- People with behavioral health issues (e.g., dementia, anxiety/depression, substance use disorder, etc.) create additional challenges for care coordination related to different service eligibility categories, lack of services, different interpretations of behavioral health diagnoses, and the stigma of mental illness.
- Periodic meetings (usually daily) are held in many hospital systems and other organizations regarding patient care coordination issues. An in-person, inter-organizational community meeting with acute and subacute care providers and their designated care coordinators is held monthly or bi-monthly in some communities.
- Care coordination efforts provided directly by insurance companies are seldom linked with efforts in the community.
- Communication among care coordination programs is challenging. Information is exchanged via phone calls, faxes, e-mail, electronic records, and face-to-face meetings. Use of information technology is limited.
- Staff that perform care coordination functions represent a broad range of disciplines (nursing, social work, community health worker, etc.) and wide range of experience levels.
- Staff who have a working relationship and personally know a care coordinator or peer in a potential referral organization indicate a better ability to support patients in transition.
- Care coordination services are primarily available Monday through Friday during the workday. Weekend access to engage with family members is not readily available.

We found that the most ***challenging issues*** for quality care coordination in the community were:

- Lack of appropriate ***mental health care services*** for people with a behavioral health diagnosis, including people with dementia.
- No community had a clear ***framework or risk criteria for prioritizing coordination of care*** among patients in transition although many organizations had their own criteria or an informal “target population”.
- Timely written ***communication of information*** about a patient’s clinical care and social support issues is difficult to exchange among staff engaged in care coordination from different organizations.
- Patient and caregiver understanding of ***medications*** (e.g.; name and purpose, getting the medicine, when to take, etc.) and their overall health literacy, require the attention of staff from all points of care.

- Connecting staff from **emergency department(s)** with established or developing community care coordination strategies is very limited.
- There are very limited **transportation** resources for many people once they leave a facility (e.g., acute care, rehabilitation care, etc.).

Our observations indicate that social determinants of health such as transportation can be a factor in coordinating health care services. Also, social determinants link to the concept of total population health for a geographic community compared to population health management for a group of people registered for clinical care with a provider and/or insurance plan.

The issues identified in this summary report will inform the work of the NH Partnership for Patients in the coming year. Avoiding preventable re-admissions, preventing adverse drug events and falls, and promoting patient and family engagement are a few of the Partnership priorities linked with the issues identified in this report.

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The Foundation for Healthy Communities appreciates the information for this report from people with the following organizations:

**Concord** – Concord Hospital (In-Patient and Out-Patient Programs), Concord Regional Visiting Nurse Association, Health South Rehabilitation Hospital, Riverbend Community Mental Health Center, Merrimack County Nursing Home, Granite Ledges (Genesis) Assisted Living Center, and Service Link Program in Concord

**Dover** – Wentworth-Douglass Hospital (In-Patient and Out-Patient Programs), Goodwin Community Health, Community Partners, and Minuteman

**Littleton** – Ammonoosuc Community Health, Littleton Regional Hospital, Grafton County Nursing Home, North Country Home Health and Hospice, and Riverglen House

**Peterborough** – Good Shepherd Nursing Home, Monadnock Community Hospital, Rivermead Assisted Living, Pheasant Wood (Genesis) Nursing Home, NH QIN, Peterborough Fire & Rescue; Home Health Care, Hospice and Community Services

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