Better Communication, Collaboration and Care Coordination

Supporting Care Transitions with Communication Technology
ABSTRACT

REDUCING UNNECESSARY READMISSIONS HAS BECOME AN URGENT CONCERN OF PROVIDERS AND PAYERS AS REGULATORY OVERHAUL AND PERFORMANCE-BASED PAYMENT MODELS TRANSFORM THE AMERICAN HEALTHCARE SYSTEM.

ONE IN FIVE MEDICARE PATIENTS IS READMITTED TO THE HOSPITAL WITHIN 30 DAYS OF DISCHARGE. CONVINCED THAT POOR POST-DISCHARGE CARE COORDINATION IS AT THE ROOT OF THE PROBLEM, MEDICARE IS EXPECTED TO LEVY OVER $300 MILLION IN PENALTIES DURING 2013 AGAINST HOSPITALS THAT TOO FREQUENTLY READMIT PNEUMONIA, HEART FAILURE AND HEART ATTACK PATIENTS. THE BASIS FOR THOSE PENALTIES WILL TRIPLE BY LATE 2014.

HOSPITALS ARE RESPONDING BY TRANSFORMING THEIR DISCHARGE, POST-DISCHARGE AND OUTPATIENT TREATMENT PROCESSES. BUT THE EXPANSION OF THE CARE CONTINUUM OUTSIDE HOSPITAL WALLS HAS ADDED NEW COMPLEXITY TO THESE INITIATIVES.

THE CARE TEAM FOR A DISCHARGED PATIENT HAS MANY PLAYERS: THE HOSPITAL AND ITS STAFF, PRIMARY CARE PHYSICIANS, NURSING AND REHAB FACILITIES, HOME HEALTH WORKERS, PHARMACIES, AND FAMILY MEMBERS. IT IS IMPERATIVE THAT EACH TEAM MEMBER HAS THE RIGHT INFORMATION AND THE ABILITY TO COMMUNICATE EFFECTIVELY – BOTH AMONG THE TEAM AND WITH THE PATIENT.

OPTIMIZED DATA MANAGEMENT AND COMMUNICATION MANAGEMENT ARE CRITICAL TO ENHANCING COLLABORATION TO BETTER COORDINATE CARE TRANSITIONS – REDUCING UNNECESSARY READMISSIONS AND DELIVERING BETTER OUTCOMES.

THIS WHITE PAPER EXAMINES FOUR PROCESSES THAT SUPPORT THAT OPTIMIZATION.
The Mandate: Reinvent Care Transitions, Reduce Readmissions

The Center for Medicare and Medicaid Service's Hospital Readmission Reduction Program (HRRP) became a reality on the first day of October 2012.

Backed by data that projects that $26 billion in annual Medicare spending is the result of hospital readmissions – and that $17 billion of that (65 percent) may be unnecessary or prevented by better post-discharge care – the agency took decisive action to contain costs. It calculated “expected” readmission rates for pneumonia, acute myocardial infarction, and congestive heart failure over a three-year period from 2008-11, and then adjusted that data for factors such as patient age and co-existing medical conditions.

It then identified hospitals with high readmission numbers for those ailments and instituted penalties based on reduced Medicare reimbursements – one percent in 2012-13, two percent in 2013-14 and three percent beginning October 1, 2014. During the HRRP’s first year, about $300 million in penalties from over 2,000 hospitals, was expected to be collected.

The hospital is the most directly impacted organization in this scenario, but it’s not the only one responsible for post-discharge care. The healthcare continuum includes primary care physicians, nursing and rehab centers, home health services, physical therapists, pharmacists – and family members – and necessitates transitions in care between those stakeholders along many touchpoints.

As The New England Journal of Medicine has noted, some hospitals have questioned whether they are “the appropriate entity to be held accountable for readmissions, given that the events and circumstances that predict readmissions largely take place outside the hospital’s walls.”

In response, healthcare providers are reviewing and reinventing their discharge and care transition policies. Entities like Accountable Care Organizations, Patient-Centered Medical Homes and vertically integrated providers have been created to coordinate patient care to cut readmissions, eliminate redundant or unnecessary services, and provide better outcomes.
Better Communication, Collaboration and Care Coordination
Supporting Care Transitions with Communication Technology

**Keys to the Solution: Better Coordination and Communication**

Other projects from academic institutions and medical schools are recommending sweeping changes in a process that mandates intervention and proactive engagement with patients to ensure that they follow discharge protocols, take appropriate medications, and schedule and attend follow-up appointments with medical professionals.

Many of these projects – including the University of Colorado-Denver’s Care Transitions Program, Boston University’s Project RED (Re-Engineered Discharge), the University of Pennsylvania’s Transitional Care Model, and the Society of Hospital Medicine’s Project BOOST – emphasize the critical importance of improving coordination and communications among care givers and with patients in improving care transitions and reducing readmissions.

Note the authors of Project RED: “The hospital discharge is a complex process requiring integrated communications among the inpatient care team, primary care team, community services, the patient, and the patient’s caregivers.”

According to the Robert Wood Johnson Foundation’s February 2013 study that revealed that 80 percent of hospitals and primary care physicians lack direct post-discharge contact with patients – communications that could identify risks and offer a chance for intervention – there is significant room for improvement.

The communication challenges can be daunting.

Internally, within the care team, siloed patient information may reside in closed Electronic Health Records databases or disparate IT systems, making it difficult or impossible for the extended caregiving team to access it. Errors, redundancies and gaps may compromise data accuracy. Important notifications and escalations must be effectively triggered, transmitted and acted upon. Caregivers may need to communicate across channels – email, mobile, web-enabled, telephone – in order to coordinate services.

Meanwhile, in reaching out to patients and family members, care teams must regularly engage via telephone and IVR systems, face-to-face meetings, email contact, and other channels to motivate compliance with discharge instructions, and review appointments, medications and ongoing medical issues.
SUPPORTING CARE TRANSITIONS WITH COMMUNICATION TECHNOLOGY

Transcending Limitations, Enabling New Processes

For organizations committed to improving care transitions, reducing readmissions, and embracing accountable, collaborative care, there are three imperatives:

- Aggregate, integrate and manage critical patient data and communication history from disparate sources, organizations and IT platforms.
- Seamlessly communicate internally across all care team members, to optimize coordination of care during transitions.
- Improve patient communication – motivating them to take responsibility for their own care through adherence to prescribed treatments and discharge instructions, maintaining scheduled office visits, and participating in wellness and preventive programs.

Collecting, cleansing, and optimizing the quality of patient data in a collaborative care setting exceeds the capabilities of most inpatient care management systems. Despite Meaningful Use incentives, adoption of Electronic Health Records (EHRs) was slow prior to the 2009 HITECH Act, and it continued to flag until the 2010 Patient Protection and Affordable Care Act was upheld in 2012 by the U.S. Supreme Court’s June decision and the November presidential election.

Moreover, most EHR systems are designed as proprietary solutions and do not effectively interoperate with competing technologies. This can impede a 360-degree patient view and add complexity to communications with caregivers located outside the hospital’s walls. In addition, systems must support multiple channels and platforms – smartphones and tablet computers, as well as telephones, laptops and PCs – in order to enable team communications.

Finally, there has also been a dearth of infrastructure, analysis tools and technologies that leverage information to give providers deeper insights about their care delivery systems and processes.

However, emerging data management, communications and analysis tools support new collaborative workflows – streamlining processes, and improving effectiveness and outcomes in care transition. These solutions impact four key functions: (1) Connect; (2) Orchestrate; (3) Communicate; and (4) Analyze.
(1) Connect

AGGREGATING, INTEGRATING AND CLEANSING DATA ACROSS DIFFERENT EHR, MEDICAL AND CLAIMS PLATFORMS, TO OFFER CAREGIVERS A HOLISTIC VIEW OF INTERACTIONS WITH EACH PATIENT

The foundation for any information management initiative is quality data – enabling analysis and action based on the most accurate, most complete, and most universal “version of the truth.” The data that first comes to mind is clinical data, typically housed within EHR systems.

But clinical data provides only a portion of the story required for effective care transition management. Other valuable information includes communication history, claims or disease risk scores, and extended demographic information that provide context for understanding the potential need for intervention during transitions. The nature of collaborative care necessitates a holistic, 360-degree patient view from multiple systems and sources.

Despite the impetus created by the HITECH Act in 2009 – and the resulting investment in Electronic Health Record systems and establishment of Health Information Exchanges – gaining this aggregated view is often difficult to achieve. Necessary privacy and security concerns are compounded by a significant incidental problem: a lack of interoperability.

EHR systems have become more powerful and sophisticated, and offer clinicians within their network access to critical patient data. But as “closed,” end-to-end environments, they lack connectivity with the other systems that may be prevalent in a distributed, collaborative environment – and create a data silo.

Organizations like the openEHR Foundation are in the process of developing specifications, tools, and clinical models to create a standard, sharable EHR and greater interoperability across systems. But providers endeavoring to meet mandates to improve care transitions and reduce readmissions by October 1, 2014, may demand more immediate solutions.
The challenge has multiple dimensions and is bi-directional.

Within the team, there are different caregivers and organizations, different levels of access to information, and multiple types of platform and channel options to transmit and receive information. Those accountable for the patient’s care must receive accurate information and precise instructions beginning with the discharge notification in the most effective way – via existing care management applications, emails, phone conversations, mobile devices, and other channels.

At the individual patient level, caregivers must identify patients at risk for readmission – and connect them with the right caregiving resource for swift intervention and treatment. Automated communication and escalation can identify gaps in care and triage people who need immediate clinical support.

Various “triggers” – like noncompliance with instructions, missed appointments, confusion about medication, warning signs, and simple feedback about whether the patient is feeling better or worse day-to-day – can escalate the case to the primary care physician, a nurse, or any other point in the continuum.
(3) Communicate

CREATING AND SUPPORTING BI-DIRECTIONAL DIALOGUES ACROSS ALL CHANNELS — ELECTRONIC AND PHYSICAL MAIL; INTERACTIVE VOICE RESPONSE (IVR) AND CONTACT CENTERS; WEB PORTALS, SOCIAL MEDIA AND MOBILE DEVICES — AMONG STAKEHOLDERS AND WITH PATIENTS.

Communication along the care continuum among care team members and with patients may demand the use of multiple channels: physical mail, email, face to face visits (in office and even home settings), social media, patient portals, mobile devices, contact centers, patient registries, and self-service telephone.

Accurate and comprehensive data, consistency of information across channels, and a comprehensive understanding of all interactions are all necessary to optimize all exchanges within the care team.

At the patient and family caregiver level, individualized communication – personal, understandable, based on information with the highest level of accuracy – is essential to creating and maintaining an effective dialogue. Message consistency across channels is imperative to make sure that patients receive, understand and comply with important reminders and instructions.

“Once discharged from the hospital, community caregivers including the patient and their family assume responsibility for the patient’s daily activities, diet, medications, etc.,” say the authors of HIMMS’ 2012 study Reducing Readmissions: Top Ways Technology Can Help.

“They must have the necessary information in order to seek appropriate, post-acute care, recognize early signs of a worsening condition, institute early interventions, and avoid unnecessary readmission.”

For inbound communication, swift response and escalation of queries and messages about changes in the patient’s condition are all critically important.
A 360-degree, holistic view of interactions among the care team and with patients offers insights into both readmission risks and ways of making patient dialogues more productive and effective.

For interactive channels, like call centers, online chats and interactive voice response, high quality data integrated from all patient and care team touchpoints, coupled with predictive analytics, enable sophisticated “Best Next Action” recommendation capability.

Best Next Action combines data from all patient interactions across channels with analytic models and organizations’ unique business rules. It creates an “arbitrated” message that can organically change the workflow and suggest a dialogue or course of action that meets the present need, or even anticipates future needs, of individual patients. This guidance can be used to determine the appropriate situations and times for triggered intervention or other communication.
Cornerstones of the Technology Foundation

There are five major technology solutions that support the four discrete activities and the overall process changes in post-discharge care.

Data Integration consists of processes and tools that aggregate data from disparate sources, standardize and store that data, and provide a unified view of it. Data integration includes such disciplines as data warehousing, data migration, enterprise application/information integration, and Master Data Management.

Triggered Automatic Escalation promptly identifies certain actions (or failures to act) and then spurs an intervention by the next-highest level of authority in a command chain – to enhance collaboration, affect behavior, and improve outcomes.

An Interaction Hub improves the effectiveness of patient dialogues across multiple channels, improving patients’ understanding and engagement, helping to guide team members through interactions, and performing analytics on the effectiveness of the encounter.

Multichannel Delivery and Response Monitoring enables care teams to communicate with each other and with patients over a range of channels, ensure messages are received, and follow-up effectively to reinforce key information.

Variable Document Composition creates persuasive electronic and physical patient communication with consistent messaging and look and feel.
A holistic view of patient conditions, interaction, and risk based on complete, accurate data from disparate caregiver systems, is crucial to better care transitions – and to fulfilling the promise of collaborative care.

“Each member of the [care] team tends to have specific, limited interactions with the patient and – depending on the team member’s area of expertise – a somewhat different view of the patient,” the U.S. Department of Health & Human Services has observed.

HealthPoint 360 Collaborate from Pitney Bowes Software creates a universal view of the patient. It uniquely combines best-in-class data integration and communications management technologies with workflow and analysis tools to support collaborative, accountable care.

It extends the value of current IT investments, empowering the information available in providers’ electronic health and medical records, ADT, patient registries, claims, and LIS systems with powerful communication automation to ensure that critical information reaches the right people at the right time through the right channels.

The care team receives a timely, appropriate, and comprehensive view of communication with each other and with patients, improving the effectiveness of the services they offer and reducing the risk of adverse events during transitions. Providers also realize better financial performance – sharing in cost savings, reducing readmission penalties, and maximizing Meaningful Use incentives of EHR technology.

Patients get better, more coordinated care – and can become more engaged in activities that improve both outcomes and their level of satisfaction.

Payers can lower claims costs and improve member satisfaction.

HealthPoint 360 Collaborate is a communication platform that complements existing investments in care management software and EHR technology and is available as a hosted, “Software as A Service” (SAAS) application – for faster implementation, scalability, and cost control.

It comes from Pitney Bowes Software – leaders in digital and physical customer communication management solutions. We work with over 1,000 organizations worldwide across the healthcare spectrum and can put our technical and industry experience to work for you. Let us help you create a forward-scaling, next-generation core system that meets the challenges of tomorrow.