

The Trek

CIMRO of Nebraska's Care Transitions Project newsletter

Issue 2
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Defining the role of CareTrek

by Audrey Paulman, MD, MMM

CIMRO of Nebraska is pleased to report CareTrek is on time, on track and on target. CareTrek has evolved from the preliminary education stage to the intervention period.

Participating hospitals have mapped their internal processes and common themes have been identified. Hospital systems reported similar issues. Discussions have occurred about internal gaps as well as community wide gaps in transitions of care.

Medication reconciliation remains a priority. Medication management is a big factor for readmissions, a big commitment for providers and a big worry for patients and their family. At this time, the CareTrek team is exploring electronic capabilities for communication, storage and access to the patient-centered medication list. There are many resources already available in the community. The CareTrek team will be working with providers to increase use of these tools.

A community learning group is looking at the processes of care during the transfer between skilled nursing facilities and one hospital. This will include exchange visits between the providers, as well as a series of group action and problem-solving sessions. The initiative is scheduled to begin this month and conclude in December 2010. We thank those who volunteered to partner with us in this process and are certain the entire metropolitan area will benefit from the hard work being done.

The Care Transitions Intervention (CTI), a formal coaching model developed by Dr. Eric Coleman, is being adopted by some CareTrek participants. A Coleman CTI training will be held in September in Omaha; the pre-work and planning has already begun. While the actual coaches need to be recruited and prepare for the training, the community will receive information about the coaching process overall.

There are remarkable things going on in the CareTrek community. Project RED (Re-Engineered Discharge) is being adopted and best practices are being identified. There is strong work in the areas of advance directives to ensure patient's wishes are met, enhanced practices, such as APRNs in nursing homes and disease specific pathway development, especially in the areas of heart failure and pneumonia. Work continues to improve electronic connectivity through individual and community-wide initiatives.

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The Trek . . .

Welcome to the second issue of *The Trek*. The purpose of this newsletter is to keep you informed of the progress of CareTrek and topics relating to improving transitions of care. Visit www.cimronebraska.org/caretrek.aspx for additional information, including resources, tools and links.

If you wish to be added to the distribution list, visit www.cimronebraska.org and click on "Join our E-mail List." Select "CareTrek Mailing List" on the CIMRO of Nebraska Mailing List Sign-up Form.

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The next three CareTrek initiatives will focus on follow-up care:

1. The CIMRO of Nebraska CareTrek team will be meeting with several physician groups about post-acute care access.
2. There will be a focus on post-acute care provider information, looking at both access and use of available information.
3. Gaining an understanding of how the diagnosis of end stage renal disease impacts readmission.

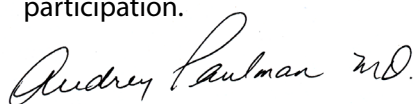
Data analysis continues as providers try to understand their own patterns of care. CIMRO of Nebraska is also analyzing data to identify transition patterns in the community. For example:

- ❖ The largest number of readmissions occur two days after discharge for AMI (acute myocardial infarction)
- ❖ Most readmissions for heart failure and pneumonia patients occur within one week
- ❖ As many as one in four patients are readmitted for AMI

Hospital-specific readmission data will be part of the Medicare public reporting project in June. If providers have a question or theory about what the data shows, please feel free to contact us.

As time progresses, the CareTrek team will continue to look for opportunities for CareTrek partners to implement interventions to improve care. In addition, best practices and communications from national initiatives will be shared.

Stay in touch; let us know how we can be of help in your care improvement initiatives. Thanks for your continued interest and participation.



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Useful resources

Web page	Web Address
CIMRO of Nebraska's CareTrek page	www.cimronebraska.org/CareTrek.aspx
National Transitions of Care Coalition	www.ntocc.org
Transforming Care at the Beside	www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm
AHRQ Patient Safety Tools: Improving Safety at the Point of Care	www.ahrq.gov/qual/pips/issues.htm
Seamless Care: Safe Patient Transitions from Hospital to Home	www.ahrq.gov/downloads/pub/advances/vol1/Spedar.pdf
Care Transition Intervention Model by Dr. Eric Coleman	www.caretransitions.org
Re-Engineered Discharge (Project RED)	www.bu.edu/fammed/projectred/

Improving care transitions through the CTI model

During an episode of illness, patients may receive care in many healthcare settings, putting them at risk for fragmented care and poorly-executed care transitions. During a specific episode of care, a patient may experience multiple transitions of care and interact with multiple disciplines and providers. Duplication of services, inappropriate care, medication errors, patient and caregiver distress, higher cost of care due to rehospitalization and inappropriate use of emergency services are each potential effects of fragmented care.

A care transition occurs anytime a patient moves from one healthcare setting to another or from one healthcare provider to another. Improved care transitions will improve patient and caregiver satisfaction, reduce errors and decrease rehospitalization of patients with chronic disease.

There are several models of care developed to improve the care transition process. Dr. Eric Coleman and his team at the University of Colorado have developed the Care Transition Intervention (CTI) model. During a four-week program, patients with chronic disease and/or complex care needs and their family/caregivers work with a transition coach to learn self-management skills. These self-management skills will empower patients and caregivers to remain out of the hospital for longer periods of time and encourage them to participate during future transitions of care.

The CTI focuses on four conceptual areas, referred to as pillars. During the four weeks post-hospitalization, the transition coach works with the patient and caregiver utilizing the four pillars, which include:

- ❖ **Medication self-management:** Patient is knowledgeable about medications and has a medication management system.
- ❖ **Use of a patient-centered record:** Patient understands and utilizes the personal health record (PHR) to facilitate communication and ensure continuity of the care plan across providers and settings. The PHR is managed by the patient or the informal caregiver.
- ❖ **Primary care and specialist follow-up:** Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is prepared to be an active participant in these interactions.
- ❖ **Knowledge of 'red flags':** Patient is knowledgeable about indicators that suggest his/her condition is worsening and how to respond.

Most patients will experience many transitions of care. Using the four pillars of care, the transition coach empowers patients and caregivers to become more comfortable and competent during care transitions. The transition coach is not an educator and does not provide "hands-on" care. Rather, the coach encourages the patient to be able to self-manage their own healthcare and assert a more central role in their care.

For additional information about the Care Transition Intervention, visit www.caretransitions.org.



Resources for better healthcare

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Patients with certain diagnoses are at increased risk for rehospitalization.

These diagnoses include:

- ❖ congestive heart failure
- ❖ chronic obstructive pulmonary disease
- ❖ coronary artery disease
- ❖ diabetes
- ❖ stroke
- ❖ medical and surgical back conditions
- ❖ hip fracture
- ❖ peripheral vascular disease
- ❖ cardiac arrhythmias
- ❖ deep venous thrombosis
- ❖ pulmonary embolism