CPCPracticeSpotlight29

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Care Compacts Can Work with Various Health Partners

Springfield Health Care Center, Springfield, Ohio — Independent; 3 physicians; 3,600 patients

Nov. 14, 2014

This strategy addresses CPC Milestone 6.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In April 2013, as **Care Manager Kim Blackburn, LPN,** completed hospitalization/discharge follow-up calls with patients from **Springfield Health Care Center** (SHCC)**,** she spotted multiple readmissions risks that were preventable by way of bi-directional communication among the providers and with SHCC.

Strategy: With support of the practice physicians, Kim set up group face-to-face meetings with leadership from local hospitals, home health agencies (HHAs) and extended care facilities (ECFs) to jump start conversations about collaborative agreements. Her intent was to engage providers as they cared for patients at critical points of transitions in care, emphasizing the process was two-way and would focus on identifying urgent patient care needs among newly discharged patients.

Care Manager Kim Blackburn, LPN, pictured here with Vipul K. Patel, MD.

At these meetings, Kim shared examples of how her discharge follow-up calls revealed significant risk for readmission and preventable harm, such as issues in post-acute care for "Betty" (name changed to protect patient privacy), a SHCC patient who had been recently hospitalized. Betty went without her medications for a week after discharged from the hospital. Betty was hospitalized on an acute-care floor, and then transferred to the hospital's rehab unit prior to being discharged home, all without notification of her primary care provider at SHCC. Betty complained to Kim that she could not find her medications. As Kim unraveled the story, she found that the patient gave her medications to the hospital upon admission; however, she left the rehab unit without them. Despite an interim visit from a home health nurse, the medications had not been located, reconciled or filled, including a new prescription for a blood thinner. As the clinic's care manager, Kim's established relationships with the PCP, lab and pharmacy enabled her to resolve these issues quickly before Betty experienced any complications.

This patient story clearly demonstrated how establishing collaborative agreements could meet the objective of reducing harm and cost by bridging seams of care for patients as they transition between settings and providers. Over time, the group created a robust list of needs and expectations while also managing to help each other create solutions for recurring problems. For example, Kim designed a one-page admissions notification for discharge planners at ECFs. It alerts them that a SHCC patient has been admitted to their facility, identifies the patient's PCP and requests a discharge medication list and other instructions be faxed to SHCC *before* the patient goes home.

To prevent a situation like Betty's, SHCC emphasizes medication issues in its agreements. Its agreement with an ECF specifies that patients go home with at least a seven-day supply of medications; in turn, SHCC agrees to see the patient within seven days of discharge. In the agreement with an HHA, the agency commits to initiate start of care within 24 hours of hospital discharge and to call SHCC during the first home visit to reconcile medications. SHCC has specific time periods for medication reconciliation phone calls to eliminate phone tag.

By fall 2014, the community partners agreed to terms in writing, which were signed in September 2014.

Springfield-area providers acknowledge these agreements have effectively streamlined two-way communication in patients' post-acute care. One hospital is now approaching other physician practices and facilities about forming collaboration agreements using the template developed with SHCC. Other providers have contacted SHCC for guidance on how to get started with collaborative agreements.

SHCC is tracking all ER and inpatient encounters, noting discharge dates and when SHCC makes follow-up contact. Last quarter, 59 of 60 patients were contacted and provided with transitional care within 48 hours. This success rate is largely attributable to the bi-directional communication agreement in the care compacts, which facilitates timely outreach.

TMF Health Quality Institute

This material was prepared by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Any statements expressed by the individual and resources cited in this publication are not an opinion of, nor endorsement by, TMF or CMS.