Norman Community Providers Join Forces to Improve Care Transitions

In just three months, nearly 30 organizations in the Norman, Oklahoma area have come together to create the first community coalition to improve patient care transitions. Inspired by a conference hosted by OFMQ, Norman Area Care Transitions (N-ACT) was formed and quickly took on a life of its own.

Members of this community have enthusiastically embraced the idea of working together to improve care coordination and reduce hospital admissions. But it’s more than just the coalition that’s helping this community. Key new roles within the hospital have been instrumental in improving care coordination, and the use of electronic health information exchange among a pilot group of providers has made communication more effective and efficient.

Susan Swann is a social worker stationed in the emergency department (ED) at Norman Regional Hospital (NRH). She plays an integral role in keeping patients from being admitted or readmitted to the hospital. Using a tracker system, she is able to identify patients who come into the ED and who have been admitted within the last 30 days, their particular diagnoses, chronic conditions, and Medicare status. She consults with each patient who may be at risk for readmission, or whose condition might be addressed by a lower level of care, and she works with case management on a patient-centered safe discharge plan.

“We were finding a lot of patients were being admitted and they didn’t necessarily need to be,” Swann told OFMQ. For example, patients may be discharged with home health and they begin having problems. They aren’t sure what their options are, so they end up back in the ED. Swann says she’s able to intervene and help them find community placements, such as skilled facilities or other therapy. Susan connects with the patient’s primary care and other providers to help ensure appropriate transitional or follow up care is in place, and information about the patient is communicated.

One patient with chronic issues came to the hospital with shortness of breath and weakness. She had been admitted just over 30 days prior and then spent about two weeks in a skilled nursing facility. With a lack of acute diagnosis, the ED physician requested Susan’s help to determine options to readmission. Susan worked with the patient and her family and learned that she needed help at home, but her family was not able to care for her there. After fully understanding the situation and their options, the patient chose a skilled nursing facility. This facility evaluated the patient in the ED and transferred her to the facility within an hour. The patient and family were relieved.

Internally, Susan works closely with the ED physicians, hospital case management and a nurse navigator who works for NRH hospitalists. Externally, she’s connected to providers in the community as well as numerous community resources to help develop the best care plans for her patients.

She told OFMQ the N-ACT coalition has helped these organizations get to know each other, so they know what’s available and who to call. The coalition includes nursing homes, home health, rehab,
hospice, senior services, dialysis, physician groups and more. “Those providers are already contacting me, because they know me now, and we’re trying to improve our communication and make sure everyone is on board with this,” she said.

Technology is playing a big role in this community as well. A health information exchange program, Direct, interfaces with the hospital’s electronic medical records system and a Care Tracker system used by group of nursing homes participating in a pilot project initially funded through a grant. This interface enables the nursing home to efficiently send comprehensive information about a patient being transferred to the hospital. With good information in an easy-to-use format, the physician and nurse in the ED can be more prepared to streamline the patient’s care.

Additionally, within the nursing home, the Care Tracker system is used by nurses and aides to document activities of daily living, vitals and trends with a patient throughout each day. The system helps identify problems early so that the physician at the nursing home can address the issue before it worsens or necessitates a hospitalization.

“The benefit has been multi-faceted,” said Randy Voigtschild, administrator at Cedar Creek Living Center, a long term care home in Norman. Cedar Creek is one of the homes connected to NRH via the Direct program, and a participant in the N-ACT coalition. Some of the benefits Randy has seen with the new health information exchange include improved clinical documentation, buy-in from nurses, the ability to track and monitor care provided with real time data, and better communication among staff to make sure things get done in a timely fashion. For the future, Randy sees more effective and more efficient care for his residents that will ultimately result in fewer hospital readmissions.

Members of the N-ACT coalition have a shared vision for improving care transitions and a passion and doing the right thing for patients. We look forward to watching this community keep the energy alive and create sustainable improvements for the long term.