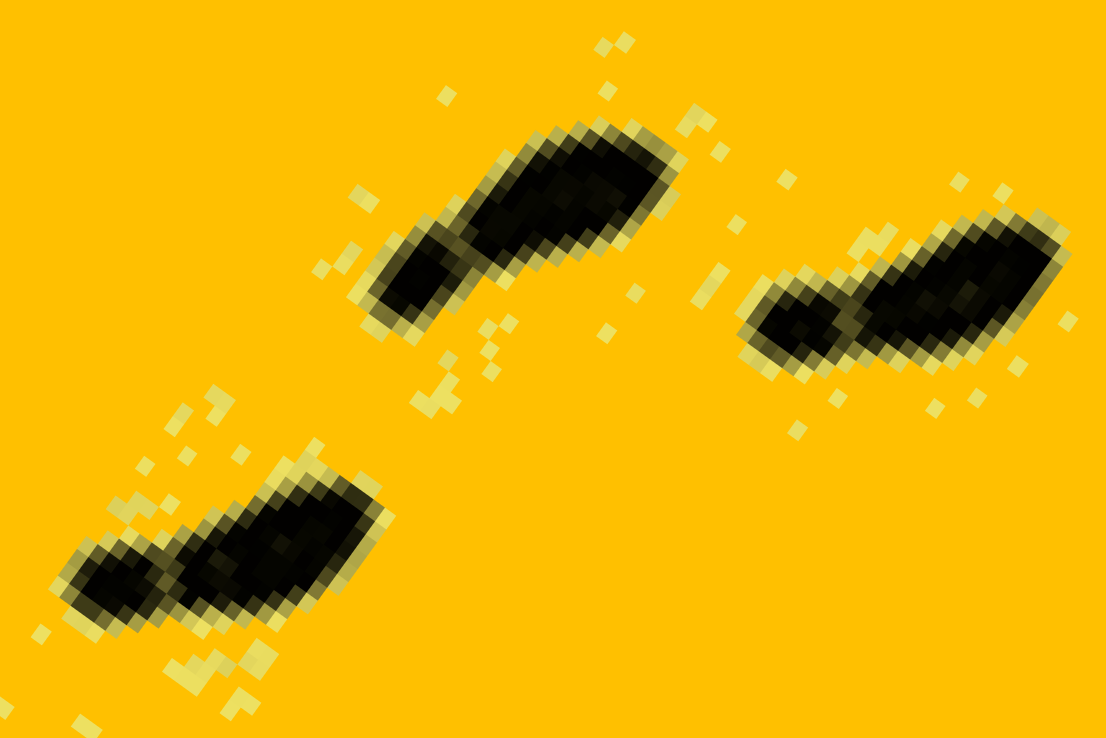


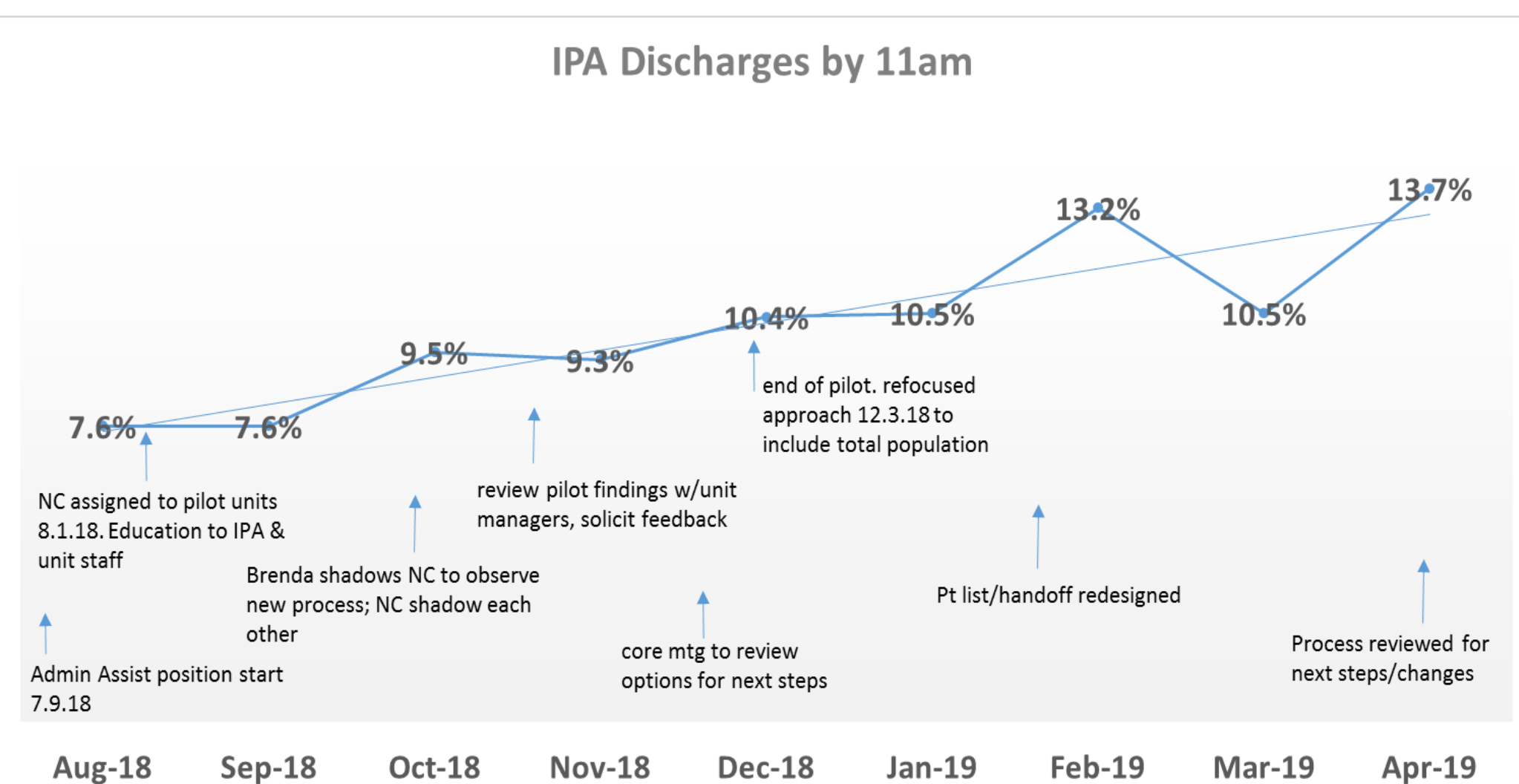
# Trek to Transformation

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## Patient discharge coordination

- ❖ Healthcare outcomes and recidivism are influenced by patient & family engagement with plan of care
- ❖ Includes organizing patient's plan of care in anticipation for handoff to next level of care



### Actions

- ❖ NC role modified to enhance patient care coordination
- ❖ Pilot study for selected units to evaluate intervention effectiveness

### Sustainability Plan

- ❖ Internal and external coordination of care development; data review
- ❖ Co-management agreements with practice groups

### Lessons Learned

- ❖ Established culture and priorities vary per hospital unit
- ❖ Administrative burdens for facility placement are time-consuming

*Early steps on this journey align with TCPI goals.....*

**Improve health outcomes for patients**  
**Transform processes to prepare for participation in APMs**

Paths we chose.....

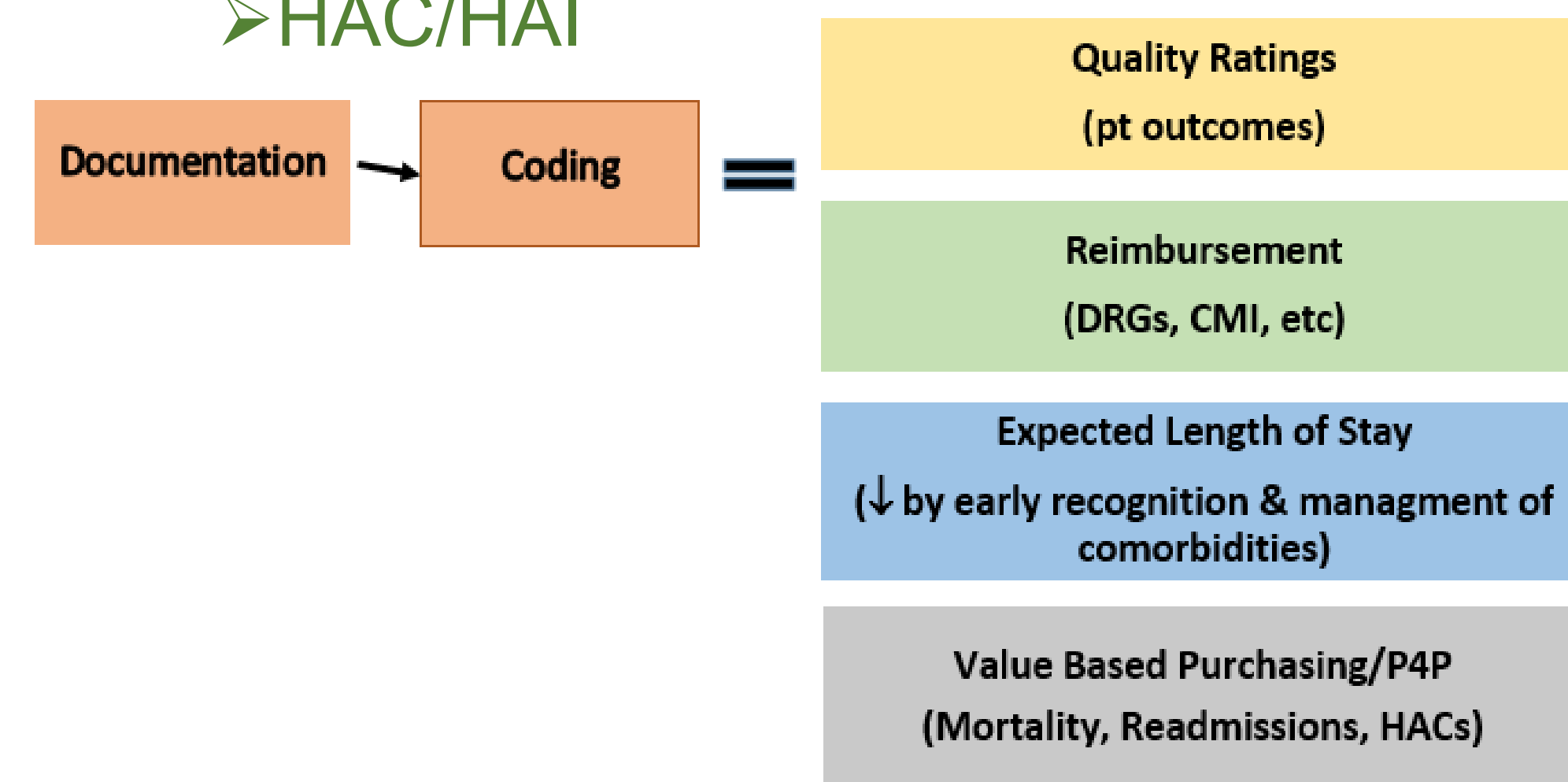
**Patient discharge coordination**

**Accurate & complete provider documentation**

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## Accurate & complete documentation

- ❖ Levels the playing field for risk-adjusted analysis of patient outcomes
  - Mortality
  - Readmissions
  - HAC/HAI



### Actions

- ❖ Education on why/how (patient case reviews, poster presentations, weekly tips, outreach to CDI staff/ resources)
- ❖ Initial goal: Increase CMI rates 10% above baseline

### Sustainability Plan

- ❖ Ongoing education refreshers via multiple modalities; data review
- ❖ Regular collaboration with clinical documentation staff

### Lessons Learned

- ❖ Knowledge base for specificity with documentation varies widely
- ❖ Small steps & reinforcement are most effective to scale success