The Hospital + Healthsystem Association of Pennsylvania

HAP Achievement Awards
Delivering a Healthy Pennsylvania

2024 HAP Achievement Award

Community Champions—Small/Medium Division

Independence Health System Clarion Hospital

Care Coordination Implementation

The Goal

Within the rural community, needs were identified with individuals who had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or Pneumonia (PN) or were High Risk/High Utilization. The program goals were to address and decrease specific Social Determinants of Health (SDoH) barriers as well as lower Potentially Avoidable Utilization (PAU) of admitted patients.

Intervention

Through development and collaboration with the Rural Health Initiatives, a Care Coordination Program, supported by Executive Leadership, was developed.

A Transition Plan was created that would take the organization from "Illness Care" to "Wellness Care" with a focus on prevention, education, and addressing Care Coordination needs affecting the community's rural population. The quality methodology—Plan Do Study Act (PDSA) was deployed to develop this plan.

All admitted patients that had a diagnosis of COPD, PN, and High Risk/High Needs were contacted within the first seven days of discharge. At that time, questions are asked concerning their Health-Related Screening Needs (HRSN). The focus was on the development of a registry within their electronic medical record (EMR) to be able to track and manage patients.

Interdisciplinary teams, reviewing discharge information during daily case conferences and assessing the ongoing active patient needs, determined there was a greater need for support for those who have additional diagnoses of Diabetes (DM), Congestive Heart Failure (CHF), and other respiratory needs. Individuals are followed continuously through 90 days post-discharge and monitored if they were readmitted within that timeframe.

Results

A Community Health Needs Assessment (CHNA) was completed in 2021 and the Care Coordination Program was rolled out in July 2022 by hiring a Care Transitions Navigator that assisted in managing patient needs and supports.

By October 2022, the Care Transition Navigator assisted 60 patients with a diagnosis of COPD and PN.

With the help of a sophisticated registry embedded in the organization's EMR, patients with needs at discharge were captured and followed, as well as the ability to add patients with diagnoses of DM, CHF, and Respiratory Distress.

As of November 2023, our Care Coordination program assisted 428 patients in total.

The Care 1 Coordination program tracked admissions and noted a reduction for COPD, PN, COPD/CHF/DM, and all 30-day readmissions as well as a reduction in total cost of care.