
Kaiser Permanente Colorado Improves Follow-up Care for Discharged Patients*Kaiser Permanente, Colorado*

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A telephonic care coordination program at Kaiser Permanente Colorado has improved follow-up care for patients discharged from a hospital or skilled nursing facility or who are at risk of hospitalization due to multiple chronic conditions. Care coordinators contact patients within 24 hours of discharge to assess needed services and to make referrals to community resources they may need, which has been documented in their electronic medical record.

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Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology

By Douglas McCarthy, Kimberly Mueller, and Jennifer Wrenn, Issues Research, Inc.

http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Jun/1278_McCarthy_Kaiser_case_study_624_update.pdf

“Improving Transitional Care. The Colorado region offers a telephonic care coordination program to improve follow-up care for patients discharged from a hospital or skilled nursing facility. The program also services patients who frequently visit the emergency department (ED) or are at risk of hospitalization because of multiple chronic conditions.

Care coordinators (specially trained nurses or social workers) contact discharged patients within 24 hours to assess needs and stratify them to receive short- or longer-term services that may include verifying medications, developing self-care skills, coordinating services, and making referrals to community resources. Information on each patient contact is documented in the EHR for communication to the care team.

The plan credited the program with annual cost savings of \$4 million from decreased readmissions (2.4% of intervention patients vs. 14% of usual-care patients at 12 months) and ED visits (7% vs. 16%, respectively). Satisfaction with the program exceeds 90 percent of physicians and 95 percent of patients.²¹

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