Comparison of Discharge Care Coordination Process at TMDU and MGH

	TMDU		MGH
General Structure & Function	• Centralized case mgmt: MSW and nurses clustered at TMDU CMWS • CMWS staff attend pt rounds for select specialties (i.e. neurosurgery, endocrinology, geriatrics, pulmonology) • No formal care coordination oversight for non-referred pts	• Similar roles and responsibilities of care coordinators, clinical team, other staff • Case mgmt attends physician-led rounds • Physician determines date of discharge	• Decentralized case mgmt: case mgers assigned to hospital floors • Multidisciplinary case mgmt rounds for all applicable specialties • Attending nurse oversees care coordination for all assigned floor pts
High-Risk Screen	• High-risk screen mainly implemented for select specialties (as above) • No formal case mgmt monitoring for pts deemed not high-risk upon admission	• Pts undergo high-risk screen on admission by case mgmt and/or clinical nurses • High-risk defined by age as well as social support, △functional/cognitive status, insurance, terminal illness, homelessness	• All adult inpts screened by case mgmt. • All adult inpts monitored by attending nurse and discussed during multidisciplinary rounds
Reimbursement	• Requires hardcopy of discharge screen and discharge plan <7d of admission • Provider meetings for home discharge pts are also eligible	• Care coordination reimbursement available	• Attending nurse calls home discharge pts <2 days for TCM reimbursement

Discharge Care Coordination at TMDU and MGH: Comparison of Strengths and Weaknesses

	TMDU	MGH
Key Strengths	• Detail-oriented consideration of patient preferences with ***high overall patient satisfaction*** • ***Successful integration of CMWS discharge coordination services on select specialty floors*** with established relationships (i.e. neurosurgery, endocrinology, geriatrics, pulmonology) • CMWS staff ***fill patient-perceived communication gaps*** with physicians/clinical team • ***Rigorous data collection and analysis*** of CMWS referral volume and pt demographics	• ***Strong culture of inter-provider collaboration*** in discharge coordination with formalized multidisciplinary rounds • ***Attending nurse role*** allows for broad oversight of care coordination and serves as patient-provider liaison with continuity during hospitalization • ***Innovative initiatives in high-risk patient care coordination*** and population mgmt ***(i.e. iCMP)*** • ***Established modes of communication between inpatient and outpatient providers*** within Partners system
Key Weaknesses	• Need for ***greater institutional awareness of care coordination services*** offered by CMWS, particularly for high-risk geriatric pts • ***Additional staffing resources needed*** for any anticipated increases in patient referral volume • Difficult to streamline dynamic completion, storage, and submission of ***hardcopy discharge screening and planning documents*** required for reimbursement • ***No primary care infrastructure*** for post-discharge mgmt of high-risk pts	• Decentralized case mgmt model with many providers – ***challenge to establish leadership role*** • ***Need for greater institutional awareness of care coordination process*** and roles/responsibilities – no formal educational curriculum exists • ***Challenges of over documentation in EMR*** and ensuring efficient, accurate communication of discharge summaries to relevant providers • ***No centralized data/difficult to access data*** related to case management activities, pt demographics