Team Communication to Reduce Hospital Readmissions
Marin General Hospital and CareInSync
COAST@Marin

Executive Summary

This paper describes the implementation and preliminary results of a program designed to reduce avoidable hospital readmissions while improving care transitions, quality of care, and the overall patient experience. COAST@Marin (Collaboration for Older Adult Safe Transitions) was introduced at Marin General Hospital (MGH) at the end of 2012, and includes elements of Project RED and the Care Transitions Intervention integrated with existing best practices at MGH. Carebook™, a mobile care collaboration platform from CareInSync (www.careinsync.com), was chosen as the technology to support the implementation of these interventions, making care team communication more effective and efficient.

While the COAST@Marin program has been in operation for only two quarters as of this evaluation, the effort is already yielding results that suggest it is heading for success. Although it is too soon to expect statistical significance in the primary measures, there has been a trend toward lower 30-day readmission rates of patients over 64 years of age (down from 11.6% to 9.9%), shorter lengths of stay (down from 5.8 days on average to 5.2 days), and improvement in patient satisfaction, as shown in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

Process measures associated with Project RED are also showing a trend toward improvement. More patients are getting their dates of discharge and dispositions set within 24 hours of admission, and there has been progress in reconciling medications and increasing patient understanding of their diagnoses, follow-up care needs, and symptoms that may indicate a need for additional care. MGH is currently working to engage all direct patient care staff in the project while reviewing task lists and processes. More universal engagement of the new care transitions processes should lead to more improvement.

Communication around discharge processes is becoming more efficient. MGH front-line staff is reporting more team communication around care transitions, with less time spent on activities associated with communication. They report that it is now easier to identify and contact members of the care team, quickly communicate changes in discharge plans, and track the progress of each patient's preparation for discharge, all while reducing the amount of time spent on communication. Non-MDs report that they now spend 15 minutes less per shift on communication; MDs report a reduction of 36 percent in time spent on pages and phone calls; and the proportion of staff who report that it is not a problem to share timely information with team members rose from 18 to 60 percent. Hospitalists involved in the program estimated a 65 percent reduction in their page volume.

The COAST@Marin project includes community partners as well. Carebook is used to carry communication connecting hospital staff with a network of community-based health coaches and a safety-net clinic system. Hospital staff use Carebook to notify the clinic about patients who require follow-up care, and the clinic then contacts the patient for follow-up appointments *before discharge*. This is associated with a 40 percent increase in follow-up appointments. Coach coordinators also use

Carebook to identify patients eligible for coaching, and then use home visits and phone calls to continue patient empowerment efforts begun in the hospital.

COAST@Marin was funded through the Gordon and Betty Moore Foundation. The Marin Unity Foundation provided support for the community coaching elements of the project and the California HealthCare Foundation provided funding for this study and has invested in CareInSync.

Marin General Hospital, located in Greenbrae, California, has 235 beds, eight units, and 1,600 staff members. COAST@Marin has been deployed to six of the units, including the emergency department.

Problem Addressed by COAST@Marin

Susan Cumming, MD, SFHM, and Medical Director of MGH, was concerned about patients being readmitted following discharge from the hospital. Relative to national averages, the readmission rate at MGH was good, with 2012 data showing that 11.6 percent of discharged patients over the age of 64 were being readmitted within 30 days after discharge (compared to approximately 20 percent of all patients nationally). However, continuous improvement would be needed to stay ahead of standards that would tighten as hospitals continue to improve their care transitions.

More importantly, Dr. Cumming recognized that discharge from inpatient care is a vulnerable time for patients. Patients are not just medically vulnerable and under unusual stress during this transition, but many also face new medical conditions, a need to integrate new prescriptions, and follow-up care and testing. Some patients have family or caregivers to help them through this transition, while others traditionally cope on their own. Ensuring that patients and their families have the support and information they need plays a large role in empowering patients to complete the recovery process without adverse effects.

Stated briefly, the quality of care, and patient and staff satisfaction, could all be improved with increased attention to patient care transitions, so MGH began the work of planning a comprehensive care transitions improvement project. Ultimately, better management of these transitions should be reflected in decreasing readmission rates.

Planning Process

MGH planning for an intervention to address patient care transitions began in 2011. As a member of the Avoid Readmissions through Collaboration (ARC) effort, a networking community comprised of organizations working to reduce readmissions also funded by the Gordon and Betty Moore Foundation, MGH applied for and was granted a planning grant to assist them in their work. Using the framework established in the Readmission Reduction Strategies guide developed by ARC, MGH performed a route cause analysis of the factors contributing to their readmissions. An early step was to assess existing communication around patient discharge, to determine the extent to which patients and their caregivers may have had confusion about medications, follow-up care needs, and any indicators that the patient should seek additional medical care after discharge.

At a high level, patient evaluation of hospital communication is captured through HCAHPS scores. Two HCAHPS questions have historically been used to measure patient perception of communication around the transition processes associated with discharge, and MGH began the planning process in the bottom 20 percent nationally on both questions.

> Question 19. "Did the hospital staff talk with you about whether you would have the help you needed when you left the hospital?"
>
> Question 20. "Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?"

In order to get a deeper understanding of the effectiveness of existing communication with high-risk elderly patients, MGH staff conducted a focus group with residents of a local assisted living facility. Each of the residents participating in the focus group had been hospitalized at MGH at least once in the months prior to the focus group, and so was able to speak directly to the care transition experience.

Two points relevant to the effort to reduce readmissions emerged from this focus group:

- There was general agreement that patients were passive when it came to communication, relying on relatives to ask questions when available, but otherwise not initiating communication with staff about their care. "I am a passive recipient; it never occurred to me not to be," sums up a common theme.
- There was also strong agreement that communication around discharge and patient teaching was not accomplishing its goals. Having family members present to help with communication was important when possible. In general, patients felt they did not understand messages, citing lack of memory, instructions in a non-preferred form (written or oral), and, frequently, their own unwillingness to ask questions as impediments.

Staff input on transitions communication was also seen as important in developing plans for the new intervention. MGH conducted a survey of 125 doctors, nurses, specialists, and other staff involved in patient care in order to obtain baseline perceptions of discharge communications from the perspective of care team personnel. The responses from this pre-program survey suggested that staff felt at least half of their patients understood pre-discharge communications.

> Patient's understanding of their primary diagnosis. Nearly two-thirds (65%) of staff reported that they were confident their patients understood their primary diagnosis at least most of the time, with only 6% reporting they were rarely or never confident that patients understood their diagnoses.
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> Patient's understanding of when and where they needed to go for follow-up appointments and tests. More than half of staff (59%) reported they were confident their patients understood when and where to go for follow-up care at least most of the time, while only 3% reported being rarely or never confident.
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> Patient's understanding of their discharge medications. Again, more than half (58%) reported being confident their patients understood their discharge medications at least most of the time, with only 3% reporting being rarely or never confident.

Patient's understanding of symptoms to look for and when to seek help. Just over half (54%) reported being confident their patients understood the symptoms to watch and when to seek help at least most of the time, while 6% reported being rarely or never confident.

The difference between staff and patient perceptions of communication effectiveness suggests Marin General Hospital staff believed they had been more effective in transmitting information than they really were, and they likely overestimated their patient's health literacy. MGH identified a need to work on developing better means of communicating with patients, especially around discharge planning. When discharge instructions are delivered at the end of the patient stay amid the flurry of discharge activities, patients are eager to leave and go home, and staff may accept a lack of questions as an indication of understanding. This lesson informed the development of Project RED; discharge planning is more effective when it begins early in the hospitalization. Furthermore, it would not be sufficient to simply make information available to patients; it would also be necessary to make sure patients clearly understood the information they received and would be able to act on it after discharge.

Communication among members of the care team is also critical. Checklists of tasks can be customized to the individual patient's condition and disposition and shared among members of the care team. Early setting of discharge plans provides a better opportunity for care team members to complete all tasks prior to discharge, but strong team communication is necessary to coordinate the efforts of multiple team members. Clearly, any intervention to improve care transitions would require a robust and efficient communication system as its foundation.

Readmission Reduction Interventions

Several evidence-based interventions are available to hospitals looking to reduce their readmission rates. Strategies to reduce readmissions are receiving increasing national attention, partially driven by the requirement in 2010's Affordable Care Act's Hospital Readmissions Reduction Program that the Centers for Medicare & Medicaid Services (CMS) reduce payments to hospitals with excess readmissions. These interventions all strengthen care transitions by addressing factors that contribute to patient vulnerability before, during, and after discharge.

Existing evidence-based interventions share many common elements, including the following:

Care Transitions Intervention. Developed by Eric Coleman of the University of Colorado, this intervention emphasizes patient involvement in medication self-management, follow-up care scheduling, and knowledge of red flags. In recent trials, it has shown to reduce 30-day readmissions from 20% down to 13%.

Transitional Care Model. Developed by Mary Naylor of the University of Pennsylvania, this intervention focuses on high-risk older adults through in-hospital planning and home follow-up. It emphasizes coordination and continuity of care, and prevention of complications.

Project RED. Developed by Boston University Medical Center, Project RED re-engineers the hospital discharge process and uses the "teach-back" method to gauge patient understanding. Project RED has 11 elements that address patient education, coordination of care, and

communication to aftercare providers. In trials, it has shown to reduce 30-day readmissions by 32%, while improving rates of kept appointments for follow-up care.

In addition to these national-level interventions, MGH has integrated its own set of best practices surrounding care transitions and preparing patients for discharge into COAST@Marin.

The Intervention

With this background, MGH launched the COAST@Marin intervention in December 2012. The Collaboration for Older Adult Safe Transitions (COAST) intervention brought together MGH, Marin Community Clinics (MCC), and a network of five community-based organizations offering coaching for vulnerable populations linked through the Carebook application. This Mobile Care Transitions Network is a first-of-its-kind collaboration bringing together patient-centered teams across disparate organizations in real time to support patient care transitions.

Elements of evidence-based readmissions reduction interventions were selected to re-engineer the process surrounding patient discharge. This included elements of Care Transitions Intervention, Project RED, and MGH's own best practices. As patients are admitted, multidisciplinary care teams are formed, and discharge planning begins within 24 hours. Evidence-based checklists are used to guide the process of preparing patients for discharge. Team members are notified when checklist tasks are completed, and are able to check for any tasks that remain to be completed before discharge. Communication with patients about their diagnoses, follow-up care needs, and symptoms of concern is not accepted as complete until tested through teach-back methods, in which the care team member providing information tests comprehension by asking the patient to repeat the information.

COAST@Marin targets the vulnerable, including elderly, medically frail, and socially isolated patients, and so has been designed to continue support out into the community using Coleman's Care Transitions Intervention (CTI) model. Patients identified as being at high risk are selected for community coaching after discharge. Coaches from Sutter Care at Home, Marin County Health and Human Services, Meritage ACO, West Marin Social Services, and Jewish Family Services work with these vulnerable patients to empower them to manage their medications, make and keep recommended follow-up appointments, and recognize signs that they need additional care.

The intervention also works with Marin Community Clinics (MCC), a network of four safety-net clinics. Early in the discharge process, patients are identified for referral to MCC if they are eligible for public insurance *and* do not have a regular health care provider, or if they are already a patient of MCC. An MCC representative then visits patients *while they are in the hospital* to set necessary appointments for follow-up care and any necessary tests.

This new and continuously improving process relies heavily on efficient communication between members of the care team, and with coaches and providers in the community. MGH selected CareInSync's Carebook platform to facilitate this communication. Carebook is accessible on mobile devices, and is compliant with the Health Insurance Portability and Accountability Act (HIPAA.) It supports care team communications around discharge planning, allowing team members to be quickly

and efficiently notified of changes in discharge plans, progress in completing checklists of pre-discharge tasks, and communicating across organizational boundaries. COAST uses it as a tool to facilitate the communication around the handoff between hospital and coach and to arrange for a MCC scheduler to visit the patients *while they are still in the hospital*.

Early Measures of COAST@Marin Impacts

Health care organizations are constantly undergoing organizational and technical changes, and MGH is no exception. The launch of the COAST@Marin intervention in December 2012 meant the implementation of this project coincided with the launch of a new Computerized Physician Order Entry (CPOE) system in late spring and early summer of 2013. MGH was implementing new technology for two projects while attempting to re-engineer discharge practices, reshaping communication and teamwork, generating culture change within the hospital, and developing new and stronger relationships with external organizations.

This seems to be working. Just six months after the initial launch of the COAST@Marin intervention, MGH began to see evidence that the new transitions process was improving care and affecting readmission rates. Although the impacts are not statistically significant this early in the implementation, nearly every measure is showing change in the direction of improvement. Furthermore, to the extent that a trend can be discerned this early, the improvements appear to be becoming stronger as Project RED and use of Carebook become mandated at MGH.

The 30-day readmission rate for patients over the age of 64 has fallen from an average of 11.6 percent in 2012 to 9.9 percent over the first five months of the project. While it is too early to determine if this will be sustained, this is a substantial improvement. This improvement would be equivalent to avoiding readmissions for 31 patients over those first five months.

Patient satisfaction with the improved transition process is showing up in HCAHPS scores traditionally associated with care transitions:

- There was positive change on Question 19, "Did the hospital staff talk with you about whether you would have the help you needed when you left the hospital?" Compared to the MGH average for the previous 10 quarters, the proportion of patients who responded yes to this question was 5% higher in the first quarter of the COAST@Marin intervention and 12% higher in the second quarter. Relative to national standards, this improvement moved MGH from the bottom 20% nationally into the top 30%.

- There was similar positive change on Question 20, "Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?" Compared to the MGH average for the previous 10 quarters, the proportion who responded yes was 9.5% higher in the first quarter of the project and 10% higher in the second quarter. This improvement still leaves MGH below national averages for this question.

HCAHPS has added three new questions relating to care transitions within the last year. These new questions get at the heart of the transition process, but have shown mixed results for the COAST@Marin project during its first two quarters:

There was a small decline in the proportion who gave a positive response when asked for agreement with the statement, "When I left the hospital I had a good understanding of what I was responsible for in managing my health." Prior to the launch of the transitions project, 53% answered yes, while this fell to 49% in the first quarter of the project.

There was no change in patient agreement with the statement, "When I left the hospital I had a clear understanding of the purpose for taking each of my medications." Positive responses were received from 56% of patients both before and after the launch.

Dramatic, and positive, change was seen in responses to the question, "How would you rate the discharge process at the hospital?" In the quarter before launch, 42% rated the MGH discharge process as excellent. On a percentile basis, this was poor; MGH ranked in the bottom 7% of hospitals nationally. During the first quarter of the COAST@Marin project, this proportion fell to below the third percentile, but rose to just over the fiftieth percentile by the second quarter.

We also can see improvements when we look at the elements of the intervention itself. MGH staff were surveyed six months into the implementation to assess their sense of changes in care transitions early in the process, with 128 staff members involved in patient care responding. Their responses suggest most staff believe the process is moving in the right direction after the first six months.

Setting the discharge date within 24 hours of admission is critical to avoiding the last-minute discharge rush, and staff responses show clear improvement (as shown in the following table). More staff believe patients receive their discharge dates within 24 hours, and fewer are reporting that this never happens. As participation is mandated, these numbers should continue to improve. Even after only six months, there is substantial movement in the right direction.

	Always		**Most of the time**		**Never**	
	Before	**After**	**Before**	**After**	**Before**	**After**
Discharge date and disposition set within 24 hours of admission	0%	5%	15%	37%	48%	19%
Patients understand primary diagnosis prior to discharge	7%	9%	30%	36%	4%	3%
Patients understand when and where follow-up appointments and tests will happen	11%	16%	36%	41%	3%	1%
Patients understand symptoms to look for and when to seek help	8%	10%	34%	44%	2%	1%

MGH is also seeing slow improvement in patient understanding of pre-discharge communications (as shown in the table above). The COAST@Marin intervention is using teach-back techniques to make certain patients understand the information being provided to them around discharge. MGH staff do not take it for granted that communication is complete, but instead ask patients to demonstrate understanding by teaching it back.

To some extent, these staff opinions may understate progress. Effective communication with patients is important enough that it is targeted not just through pre-discharge communications and teach-back, but also after discharge through a network of community health coaches.

Crossing Organizational Boundaries

A major component of COAST@Marin is that at-risk patients are supported throughout the transition from hospital to follow-up care. Marin General Hospital is engaging two primary strategies for improving this continuity of care after discharge. In the first, MGH initiates a process to arrange necessary follow-up primary care appointments prior to the patient's discharge. At present, this has been implemented with a single clinic system (Marin Community Clinics, or MCC), but with the expectation that more physician practices will be added as the COAST@Marin implementation continues.

Early in the patient's stay at the hospital, MGH staff identify the patient's eligible for this strategy. Existing MCC patients are eligible, as are patients without a medical home. If a patient agrees, Carebook is used to communicate the patient's anticipated date of discharge and related information to MCC. A representative of MCC visits MGH three times per week to meet with these patients and arrange any necessary follow-up appointments, and may also arrange transportation if necessary. By catching the patient before he or she leaves the hospital, the likelihood that patient does not receive follow-up care is reduced. Compared to the previous year, the number of follow-up appointments at MCC has increased by more than 30 percent. All follow-up appointments set in 2013 were set before discharge.

In the Coleman CTI strategy, patients identified as being at high risk (over the age of 65 with specific set of conditions and/or medications) are referred to a Transitions Coach Coordinator (TCC) who evaluates patients using the Patient Activation Measure. During April, May, and June of 2013, there were 383 patients referred to the TCC for this evaluation, representing 40 percent of all medical surgical discharges for patients over the age of 65. This proportion has been increasing each month as the implementation continues.

Eligible patients who consent to coaching are then referred to one of 12 coaches. Prior to the adoption of Carebook, the TCC manually searched patient records to identify patients that were eligible for coaching, and then might need to access the records during a home visit to confirm discharge instructions or medications. With Carebook, however, this process has been streamlined. While not all eligible patients are referred in Carebook yet, TCC estimates 30 percent of time spent on administration has been saved due to these efficiencies.

Community coaches are nurses or social workers, but for coaching, they are asked to do no health education or assessments. Instead, they promote patient activation in their health care decisions and interventions. They ask patients to identify their health priorities and confirm patient and/or caregiver knowledge on diagnoses, medications, and follow-up activities. As issues are identified, coaches help the patient drive them to resolution. The coaching program includes a hospital visit, a home visit, and three follow-up phone calls within a period of one month after discharge. If a patient is readmitted, the coach is able to provide information to hospital staff about observations at the patient's home that may have contributed to the readmission.

In addition, this program element is working to address communication issues that might otherwise have been missed. During 2013, coaches caught medication discrepancies in 39 percent of patients with whom they worked. When testing patient understanding through teach-back techniques, they found 94 percent were able to at least articulate the basics of their conditions, with 45 percent showing in-depth understanding. Similar results were found with patient knowledge of whom to call if problems arose, with 94 percent able to articulate basics and 63 percent demonstrating in-depth understanding.

Carebook as Communication Support

Efficient communication is crucial to COAST, as recognized by the inclusion of Carebook as a tool to facilitate team communication. Adding new communication demands through existing channels can result in an increase in staff workload at a time when staff are already dealing with increased demands on their time. To ease implementation, MGH arranged to include a new communications modality designed to make team communication more efficient while supporting the transitions intervention.

CareBook training modules require less than one hour to complete, and many users have learned to use the tool in less than 15 minutes. The major aspect of training at MGH was the use of Carebook *within* Project RED. As the intervention was being designed, CareInSync worked with MGH leadership to understand previously existing care transition processes and areas for improvement, and participated in the design of Project RED as implemented at MGH. They then tailored Carebook to support communication around provider workflows within Project RED. The tailoring process is ongoing, as Carebook's real-time tracking features allow the MGH Quality Improvement (QI) team to identify elements of Project RED needing additional refinement, and to further customize transitions processes and Carebook communication support for continuous improvement.

The addition of Carebook was expected to ease the implementation of the transitions intervention, and early evidence suggests this is already happening, even before the tool has been universally adopted. Based on the July survey of MGH staff, the amount of time spent on communication by non-MDs has fallen by more than 70 percent, freeing up an estimated 15 minutes per shift per staff member for other activities. In addition, Carebook has been replacing other forms of communication: the time spent on pages and phone calls by the average MD during a typical shift has fallen by 36 percent, and hospitalists involved with the project estimated their volume of pages has decreased by 65 percent.

COAST is benefiting from improved communications through Carebook. The first step in implementing a team approach to transitions management is to set the teams, and Carebook has proven to be quite effective in facilitating team construction and communication. There have been substantial increases in the proportion of MGH staff who agreed they could easily identify and contact all care team members, while proportions who reported they could not declined substantially.

	Agree		Disagree	
	Before	**After**	**Before**	**After**
Can easily determine names of all care team members	32%	68%	58%	10%
Can easily contact all care team members	33%	45%	46%	18%

MGH staff were also asked to assess the extent of specific communication problems, and similar gains were reported. Once Carebook was put into use, there was a dramatic shift reflecting improved communication.

	Not a problem		Major problem	
	Before	After	Before	After
Sharing up-to-date information with care team members	18%	58%	26%	10%
Receiving communication too late to be effective	21%	46%	20%	9%

This tool was designed to make it easier for MDs to contact all team members, to notify them of any changes to discharge plans, and this is having dramatic impact. The proportion of MDs who agreed that this communication was easy rose from 8 percent before Carebook to 72 percent of MDs once Carebook was put into use, while the proportion who disagreed declined from 61 to 14 percent.

I can easily or efficiently contact all members of my patient's care team to notify them about changes to the discharge plans.	Agree		Disagree	
	Before	After	Before	After
	8%	72%	61%	14%

This is reflected on the other side of this communication, as other team members are seeing substantial gains in receiving these notifications.

I am notified in a timely fashion of changes to my patients' discharge plans.	Always or most of the time		Rarely or never	
	Before	After	Before	After
	26%	52%	32%	10%

Carebook also provides shared checklists of tasks that need to be completed prior to discharge and provides a forum for these tasks to be checked off as they are completed so team members can quickly tell which tasks remain to be completed before discharge.

I can quickly tell which tasks remain to be completed before discharge.	Always or most of the time		Rarely or never	
	Before	After	Before	After
	24%	52%	24%	11%

MGH staff also volunteered comments that shed additional light on Carebook's role in COAST@Marin. As might be expected this early in the program, these comments were mixed. In addition to comments about improved communication, there were a few reports of technical and time issues that may have been related to the simultaneous implementation of the CPOE system. However, half of all staff comments were a variation on the less-than-universal usage in the introduction period, with staff members noting this limited gains and/or required the use of legacy systems to communicate with some team members. This suggests the people using Carebook expect greater gains as the program is rolled

out to the night shift, is adopted by all specialties, and has more complete entries for checklist tasks completed, appointments, and assessments. MGH is making a priority of addressing these issues at this stage in the implementation.

In addition to supporting the COAST@Marin intervention, Marin General Hospital is finding Carebook is a flexible tool with applications across the hospital. One area that has received special attention is the transition from emergency department to inpatient admissions. A one-touch "Admit Patient" button added to Carebook has reduced the average time elapsed from the ED physician initiating the process to the admitting physician's writing orders by 18 minutes per patient. Communication between the ED physician, triage physician, and admitting physician is accomplished through the mobile Carebook modality, without the need for pages or phone calls.

What Remains to Be Done?

The implementation of COAST@Marin is ongoing, with just over six months of operation at the time this is being written. Marin General Hospital is in the process of making use of Carebook mandatory, recognizing that communication is much more efficient when all team members are using the same communications modality. The tool has already been expanded to cover the emergency department, but the night shift has not yet adopted it, and there are some individual staff or departments who do not fully participate.

As the implementation progresses, MGH staff are working with CareInSync staff to further customize Carebook while implementing more of the components of COAST@Marin. Attention is being turned to fully implementing the teach-back elements of the intervention and documenting both the process and results in Carebook.

At present, completion of tasks on the evidence-based checklists is not being documented in Carebook consistently, leading to some staff members feeling they have more than their share of the tasks to accomplish themselves. To address this issue, task checklists are being revised to make them more streamlined and to avoid duplication with the newly deployed electronic health records (EHR) MGH providers are meeting to reconsider elements of these checklists now that they have experience working with the original set. Carebook supports this type of customization.

Carebook also provides a reporting function that can monitor task completion as each patient progresses through the hospital stay, ensure staff compliance with the elements of the care transition process, and manage the coaching process, allowing shared accountability between the hospital and community partners. MGH is identifying middle management data needs that can be met through Carebook and will work with CareInSync staff to design appropriate reports customized to the needs of those managers.

MGH will also be working to extend the network of external providers participating in the transitions intervention, thus providing greater continuity of care for more patients. Building off the success with MCC, the program will be able to provide care transitions information to outpatient providers, from

alerting them when their patients are first admitted to whether or not the patient is eligible for coaching to facilitating follow-up care appointments.