Using Facets of Midas+ Hospital Case Management to Support Transitions of Care

Barbara Craig, Midas+ SaaS Advisor

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What does Transitional Care Include?

Transitional Care is the smooth conversion of a patient from one care setting to another setting or to home. It involves patients moving from:

- Emergency Room to Hospital Observation
- Emergency Room to Hospital Inpatient
- Hospital Observation to Inpatient
- Inpatient to Skilled Care
- Inpatient to Sub-Acute Care
- Inpatient to Home Health
- Inpatient to Home
- Skilled Care to Acute Care Hospital
- Sub-Acute Care to Acute Care
- Sub-Acute Care to Home
- Skilled Care to Home

What is the impetus to do this right?

- Improved patient outcomes
- Appropriate patient placement
- Reduced length of stay
- Improved patient satisfaction
- Improved information flow between providers
- Financial dis-incentives
- Incomplete hand-offs of care are a patient safety issue

What needs to be done?

- Assure patients are in an appropriate level of care
- Identify high-risk patients on admission and target risk-specific interventions
- Assess patients ability to provide self-care post discharge
- Educate patients and families on post-acute care
- Coordinate post-discharge care
- Follow up on at-risk patients
- Communicate with post-discharge providers

Current Models

- **BOOST - Better Outcomes for Older Adults through Safe Transitions**
  - Care Transitions Model
  - Society for Hospital Medicine
- **Care Transitions**
  - 4 Pillars
  - Coleman Method
- **STAAR - State Action on Avoidable Rehospitalizations**
  - IHI
  - AHRQ
- **Care Coordination Model** - IHI
- **CGH2H** -Common Ground Hospital to Home
- **SMART –** Signs, Medications, Appointments, Results, Talk
- **Transitional Care Model (TCM) -** Mary Naylor University of Pennsylvania
- **GRACE –** Geriatric Resources f**o**r Assessment and Care of Elders – Indiana University for Aging Research
- **Guided Care** – Johns Hopkins University
- **Bridge Program –** Illinois Transitional Care Consortium
- **COMPASS –** Organized Medicine Provided Across a Seamless System

Midas+ Facets

- Preadmission Interventions
- Pre-discharge Interventions
- Post-discharge Interventions
- Outcome metrics

Pre-Admission Interventions

Use of Midas+ Care Management in the Emergency Department

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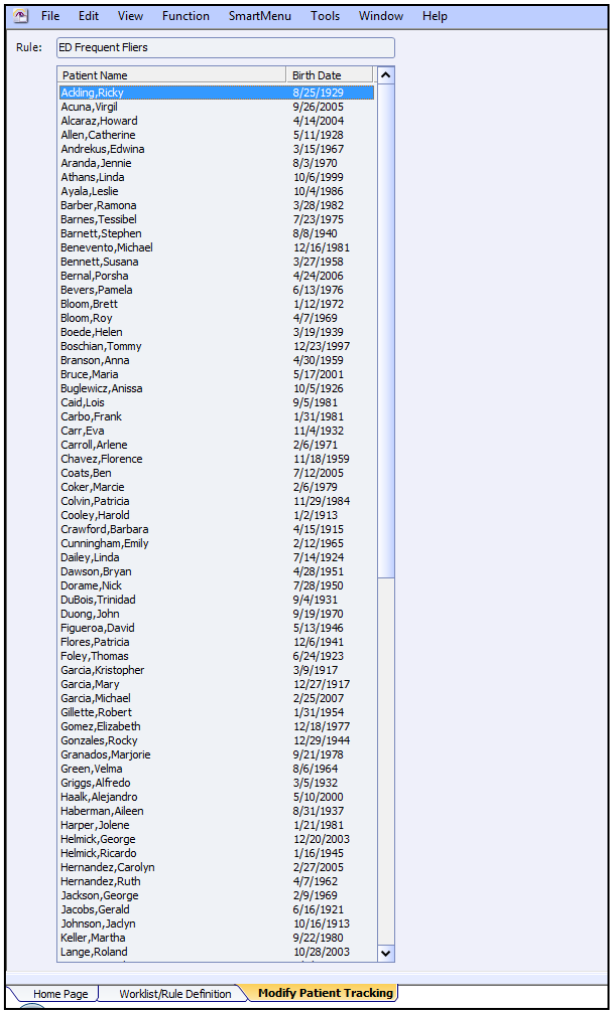
Reason for ED Case Management

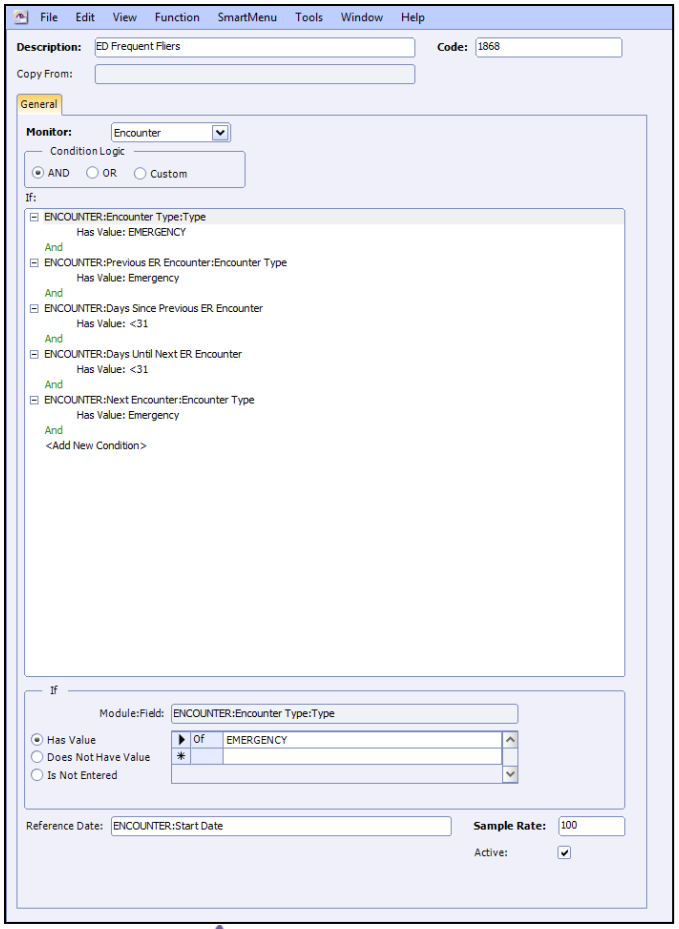
- Emergency Department as primary care source
- Appropriate patient placement
- Identification of social issues that lead to overuse of the ED
- Lack of coordination with outpatient providers
- Providing alternatives to hospitalization

Identifying Frequent Users of Emergency Department Services

- Use Patient Explorer
- Patients with no identified PCP
- Patients with chronic Illness
- Patients with chronic pain
- Patients with drug-seeking behavior
- Patients with no insurance
- Patients with poor social support networks

Use a Midas+ Tracking File to track and plan for frequent ED users





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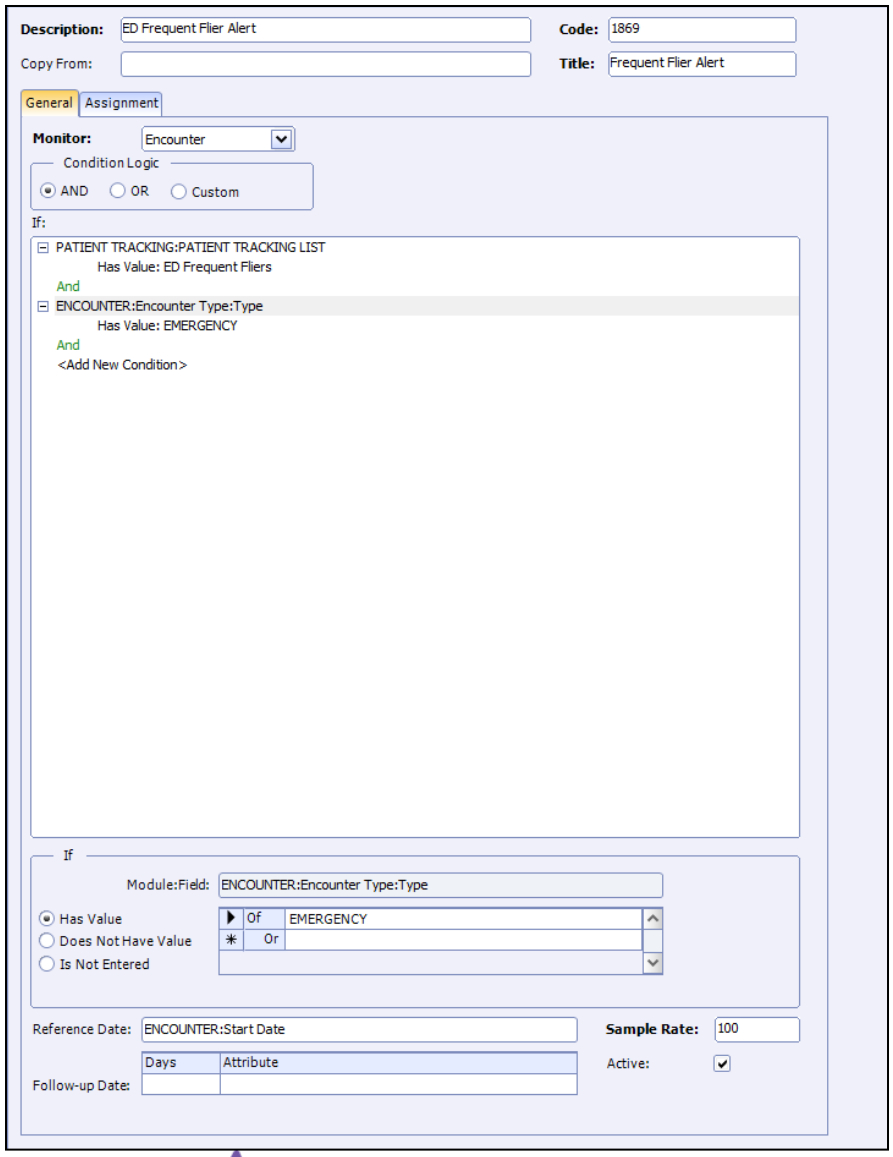
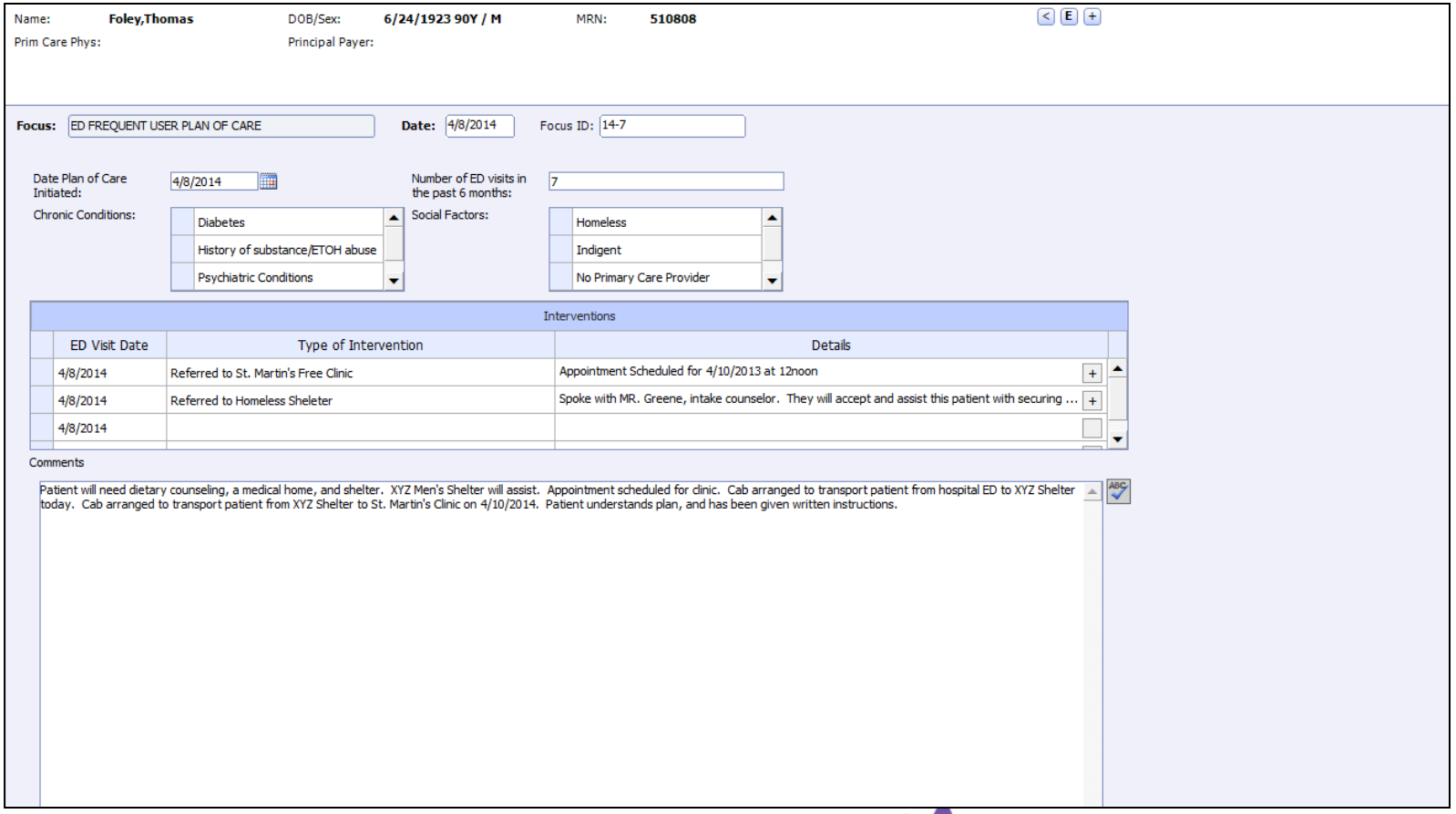
Build a Worklist Rule to Notify ED Case Management of the Arrival of a "Frequent Flier"



Use a Midas+ Patient-level Focus Study to create a plan track for these frequent fliers.



Name: **Foley,Thomas** DOB/Sex: **6/24/1923 90Y / M** MRN: **510808**

Prim Care Phys: Principal Payer:

Focus: ED FREQUENT USER PLAN OF CARE **Date:** 4/8/2014 Focus ID: 14-7

Date Plan of Care Initiated: 4/8/2014

Number of ED visits in the past 6 months: 7

Chronic Conditions:
- Diabetes
- History of substance/ETOH abuse
- Psychiatric Conditions

Social Factors:
- Homeless
- Indigent
- No Primary Care Provider

Interventions

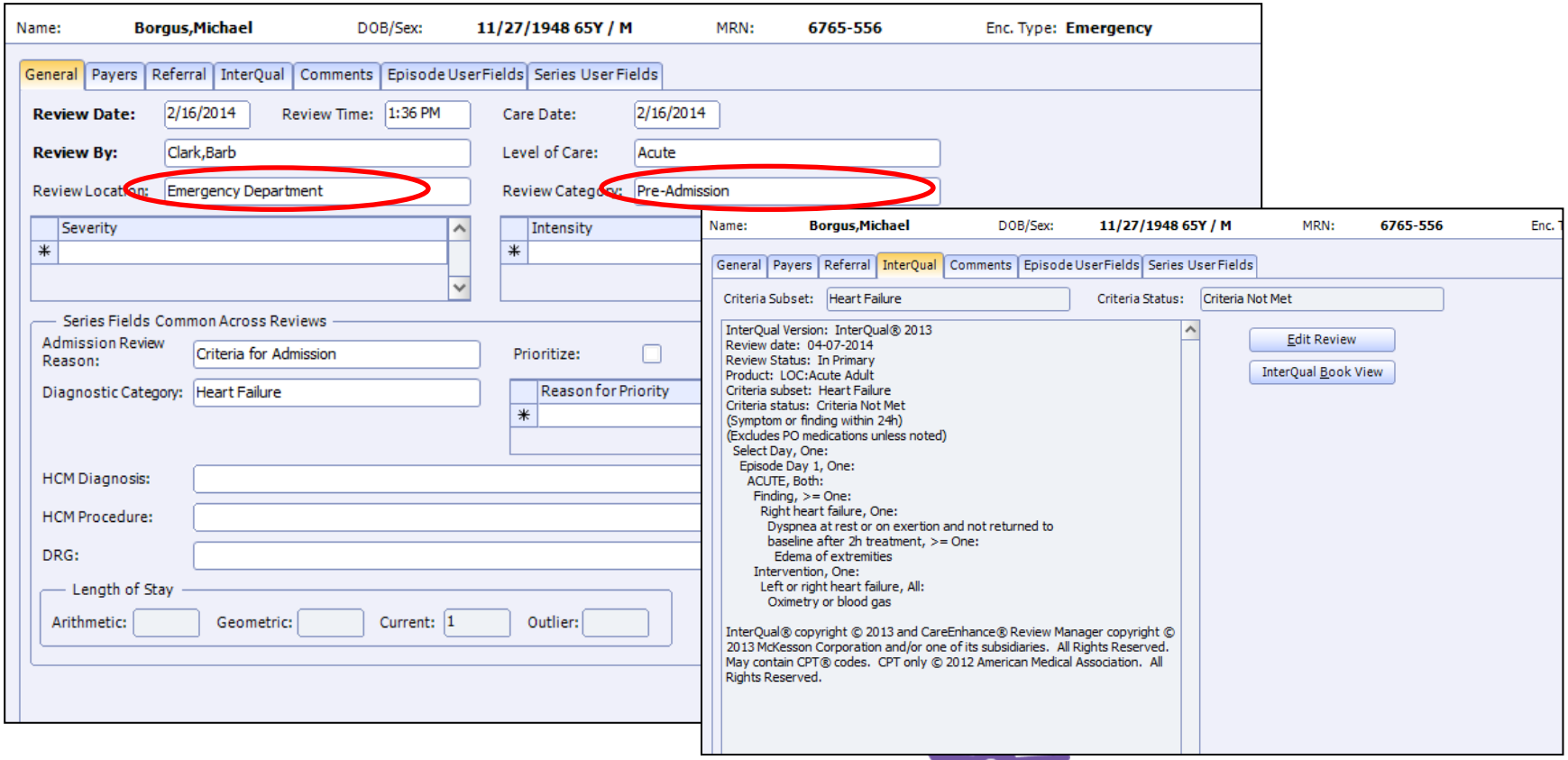
ED Visit Date	Type of Intervention	Details
4/8/2014	Referred to St. Martin's Free Clinic	Appointment Scheduled for 4/10/2013 at 12noon
4/8/2014	Referred to Homeless Sheleter	Spoke with MR. Greene, intake counselor. They will accept and assist this patient with securing ...
4/8/2014		

Comments

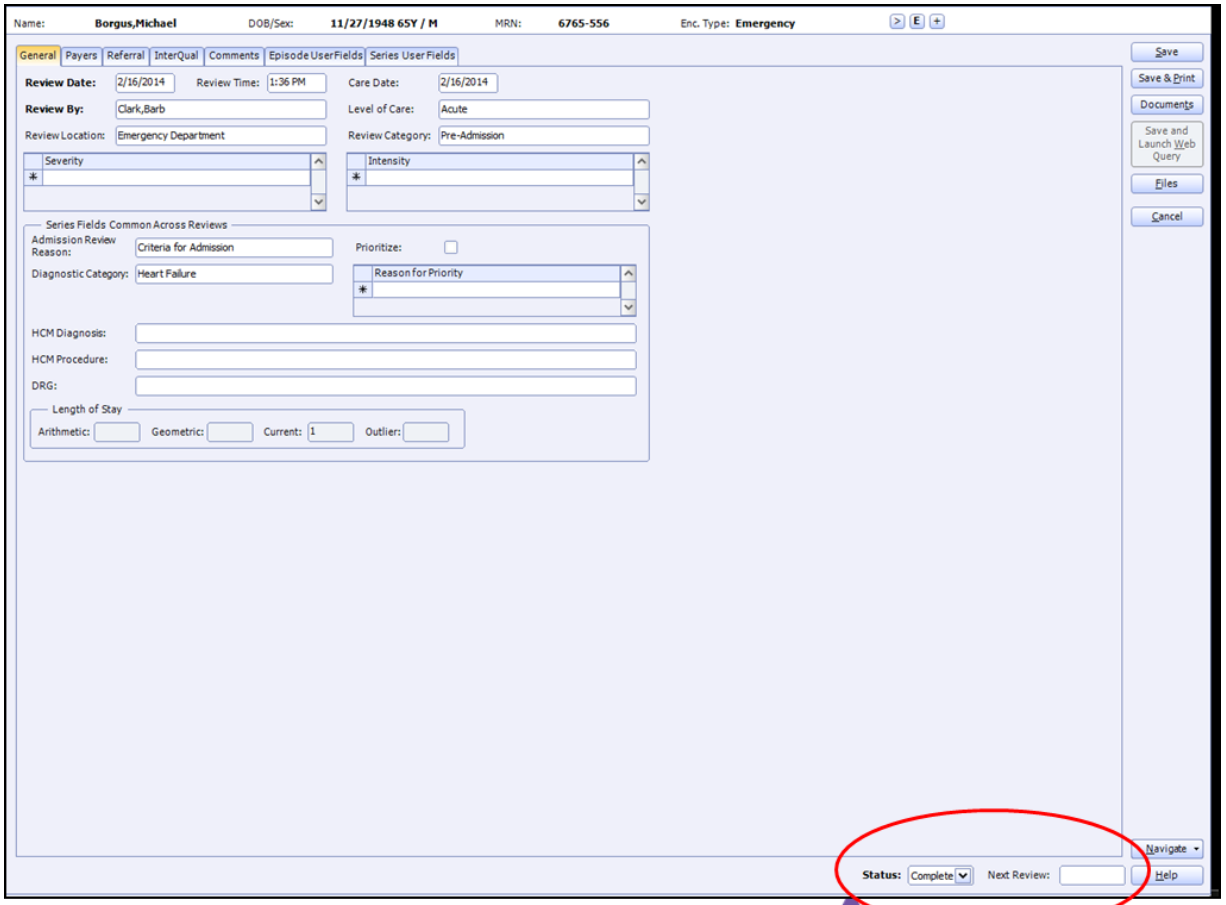
Patient will need dietary counseling, a medical home, and shelter. XYZ Men's Shelter will assist. Appointment scheduled for clinic. Cab arranged to transport patient from hospital ED to XYZ Shelter today. Cab arranged to transport patient from XYZ Shelter to St. Martin's Clinic on 4/10/2014. Patient understands plan, and has been given written instructions.

Using Concurrent Review

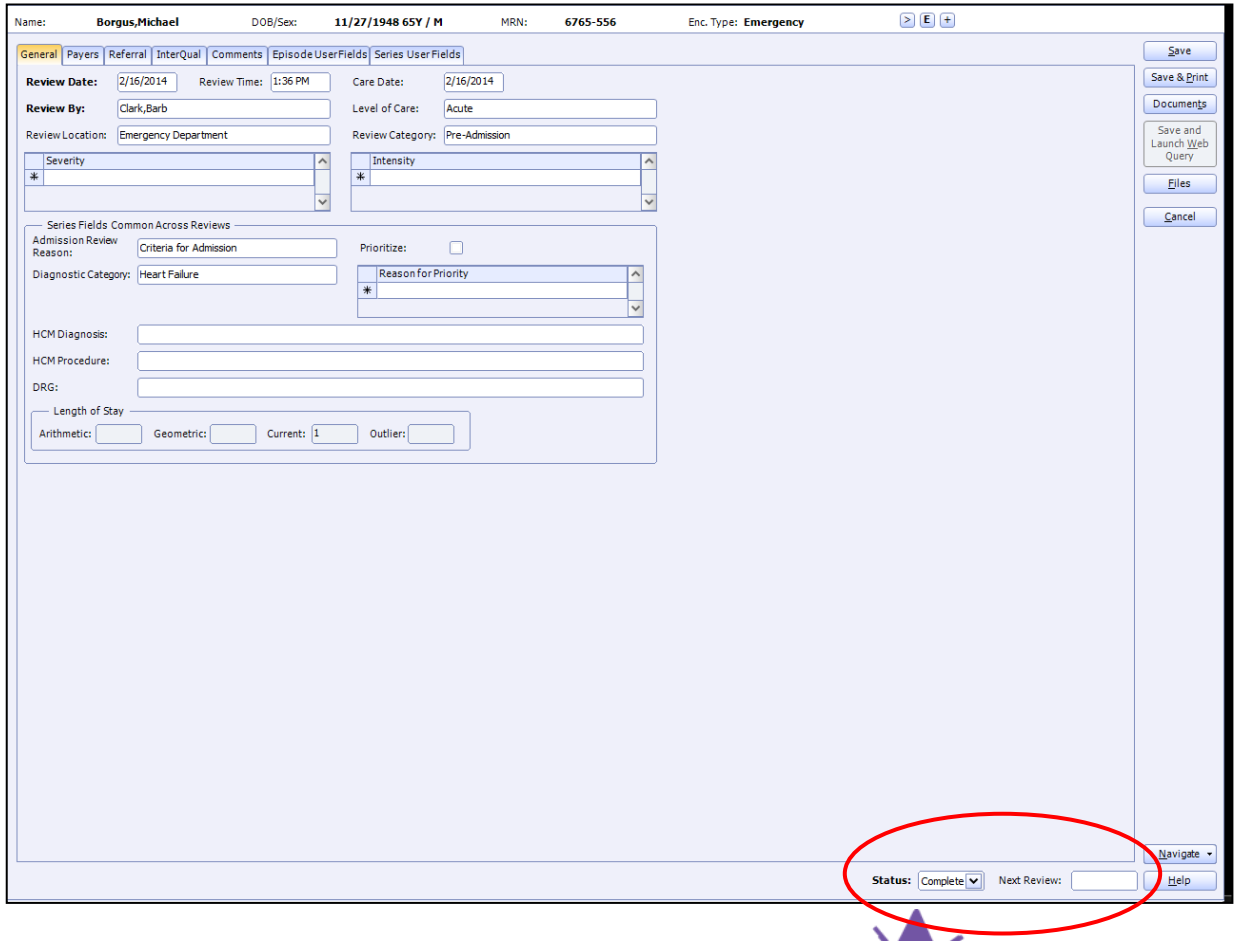
Concurrent Reviews can be done for ED patients for whom admission/observation is being considered.



Adding an HCM Review for patients who will not be admitted



Adding an HCM Review for Patients who will be admitted



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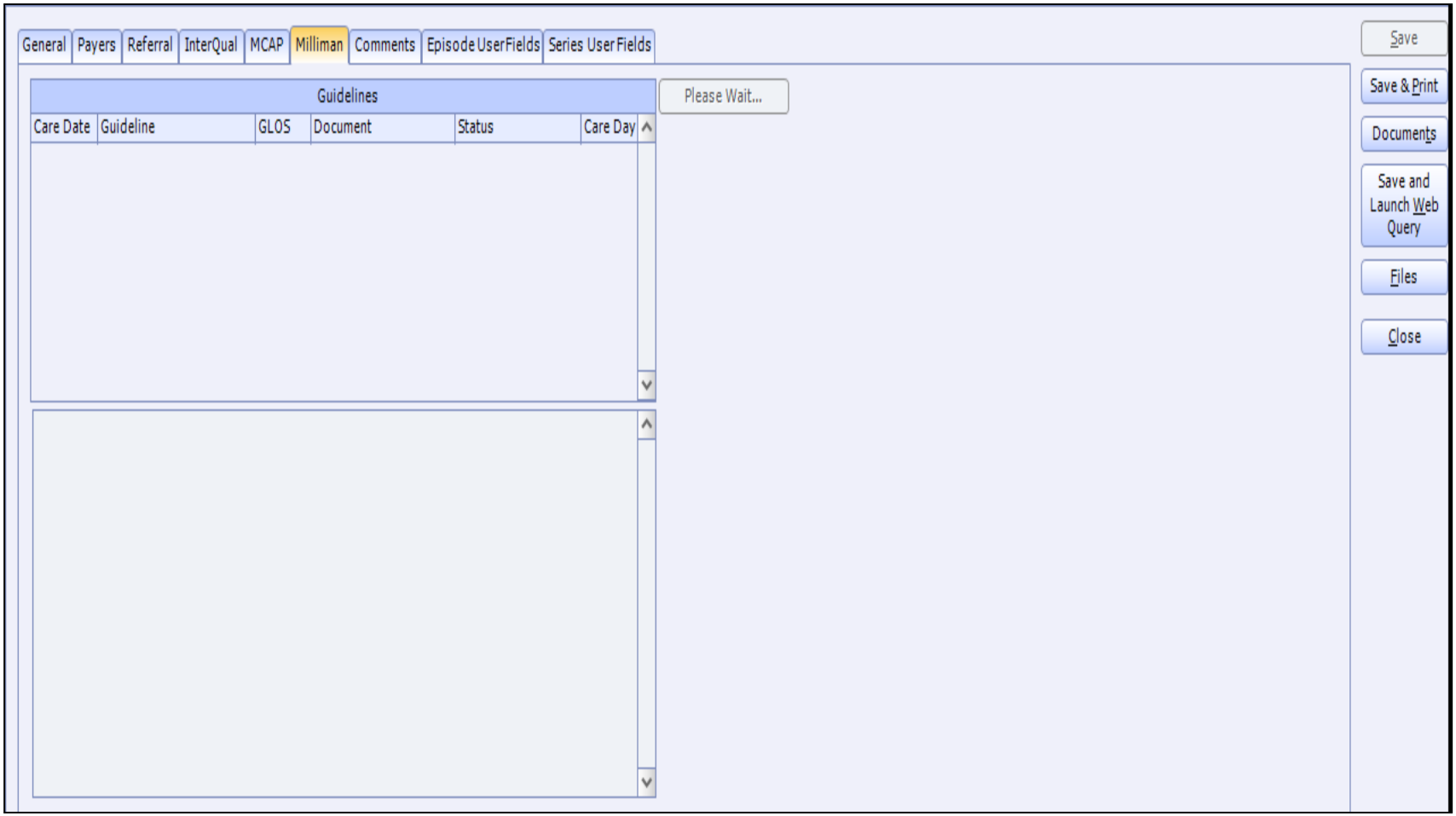
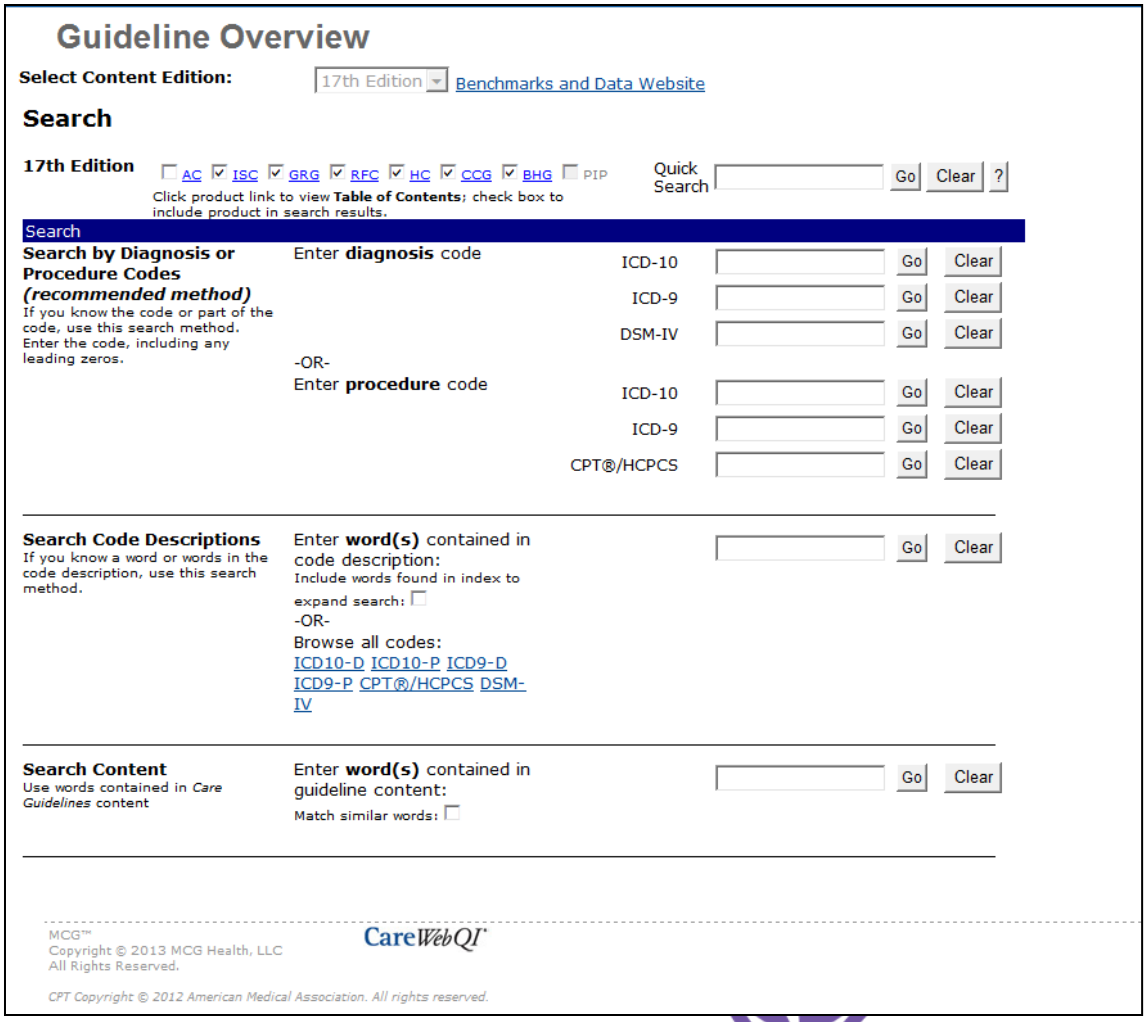
Using Screening Criteria - Milliman



Using Screening Criteria - Milliman



Guideline Overview

Select Content Edition: 17th Edition Benchmarks and Data Website

Search

17th Edition AC ISC GRG RFC HC CCG BHG PIP Quick Search Go Clear ?

Click product link to view **Table of Contents**; check box to include product in search results.

Search

Search by Diagnosis or Procedure Codes ***(recommended method)***
If you know the code or part of the code, use this search method. Enter the code, including any leading zeros.

Enter **diagnosis** code
ICD-10 Go Clear
ICD-9 Go Clear
DSM-IV Go Clear

-OR-

Enter **procedure** code
ICD-10 Go Clear
ICD-9 Go Clear
CPT®/HCPCS Go Clear

Search Code Descriptions
If you know a word or words in the code description, use this search method.

Enter **word(s)** contained in code description: Go Clear
Include words found in index to expand search:

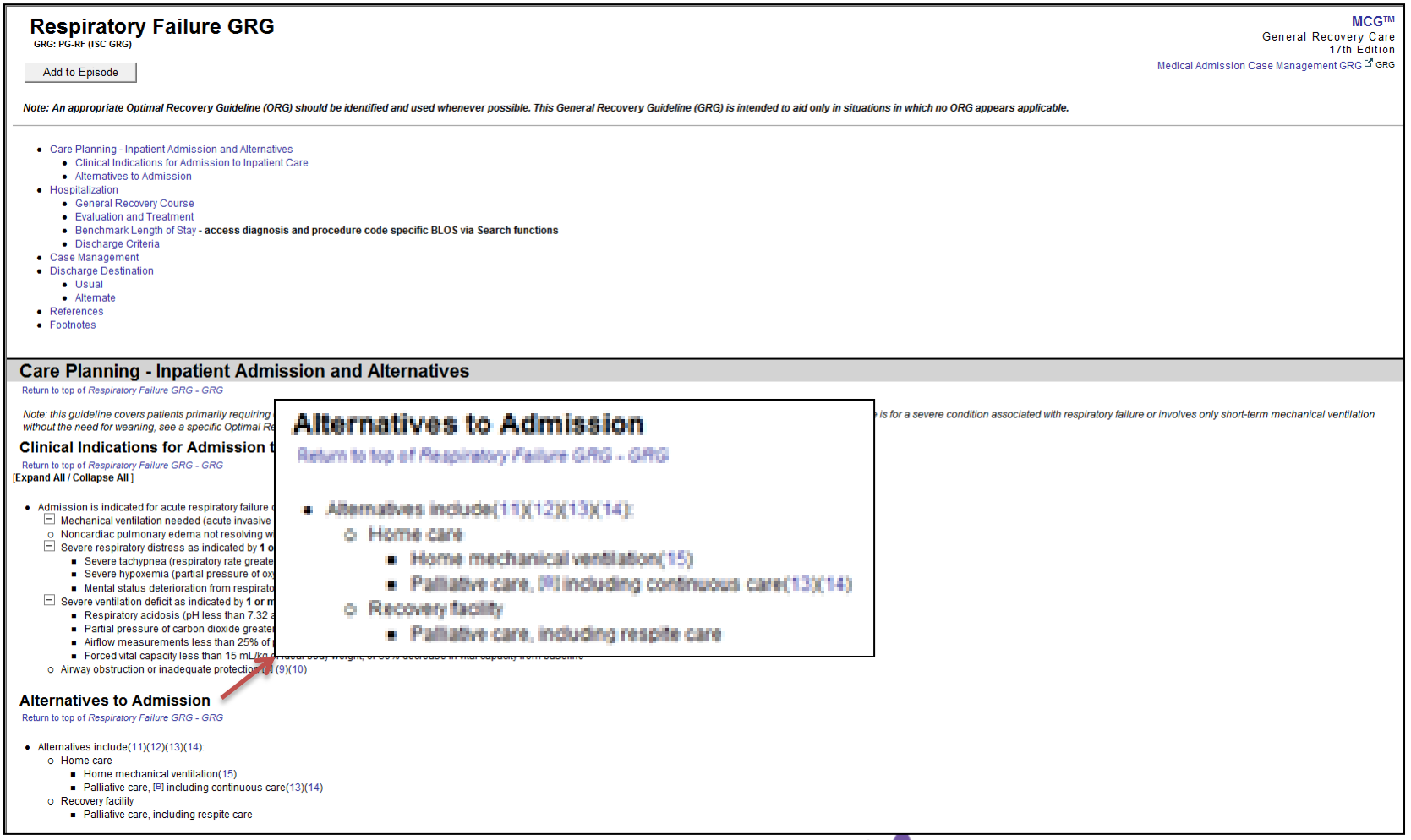
-OR-

Browse all codes:
ICD10-D ICD10-P ICD9-D ICD9-P CPT®/HCPCS DSM-IV

Search Content
Use words contained in *Care Guidelines* content

Enter **word(s)** contained in guideline content: Go Clear
Match similar words:

Using Screening Criteria - Milliman



Respiratory Failure GRG

GRG: PG-RF (ISC GRG)

Add to Episode

MCG™
General Recovery Care
17th Edition
Medical Admission Case Management GRG GRG

Note: An appropriate Optimal Recovery Guideline (ORG) should be identified and used whenever possible. This General Recovery Guideline (GRG) is intended to aid only in situations in which no ORG appears applicable.

- Care Planning - Inpatient Admission and Alternatives
  - Clinical Indications for Admission to Inpatient Care
  - Alternatives to Admission
- Hospitalization
  - General Recovery Course
  - Evaluation and Treatment
  - Benchmark Length of Stay - **access diagnosis and procedure code specific BLOS via Search functions**
  - Discharge Criteria
- Case Management
- Discharge Destination
  - Usual
  - Alternate
- References
- Footnotes

Care Planning - Inpatient Admission and Alternatives

Return to top of *Respiratory Failure GRG - GRG*

Note: this guideline covers patients primarily requiring … is for a severe condition associated with respiratory failure or involves only short-term mechanical ventilation without the need for weaning; see a specific Optimal Re…

Clinical Indications for Admission t…

Return to top of *Respiratory Failure GRG - GRG*

[Expand All / Collapse All]

- Admission is indicated for acute respiratory failure …
  - Mechanical ventilation needed (acute invasive …
  - Noncardiac pulmonary edema not resolving w…
  - Severe respiratory distress as indicated by **1 o…**
    - Severe tachypnea (respiratory rate greate…
    - Severe hypoxemia (partial pressure of ox…
    - Mental status deterioration from respirato…
  - Severe ventilation deficit as indicated by **1 or m…**
    - Respiratory acidosis (pH less than 7.32 a…
    - Partial pressure of carbon dioxide greate…
    - Airflow measurements less than 25% of …
    - Forced vital capacity less than 15 mL/kg …
  - Airway obstruction or inadequate protection … (9)(10)

Alternatives to Admission

Return to top of *Respiratory Failure GRG - GRG*

- Alternatives include(11)(12)(13)(14):
  - Home care
    - Home mechanical ventilation(15)
    - Palliative care, [B] including continuous care(13)(14)
  - Recovery facility
    - Palliative care, including respite care

Alternatives to Admission

Return to top of *Respiratory Failure GRG - GRG*

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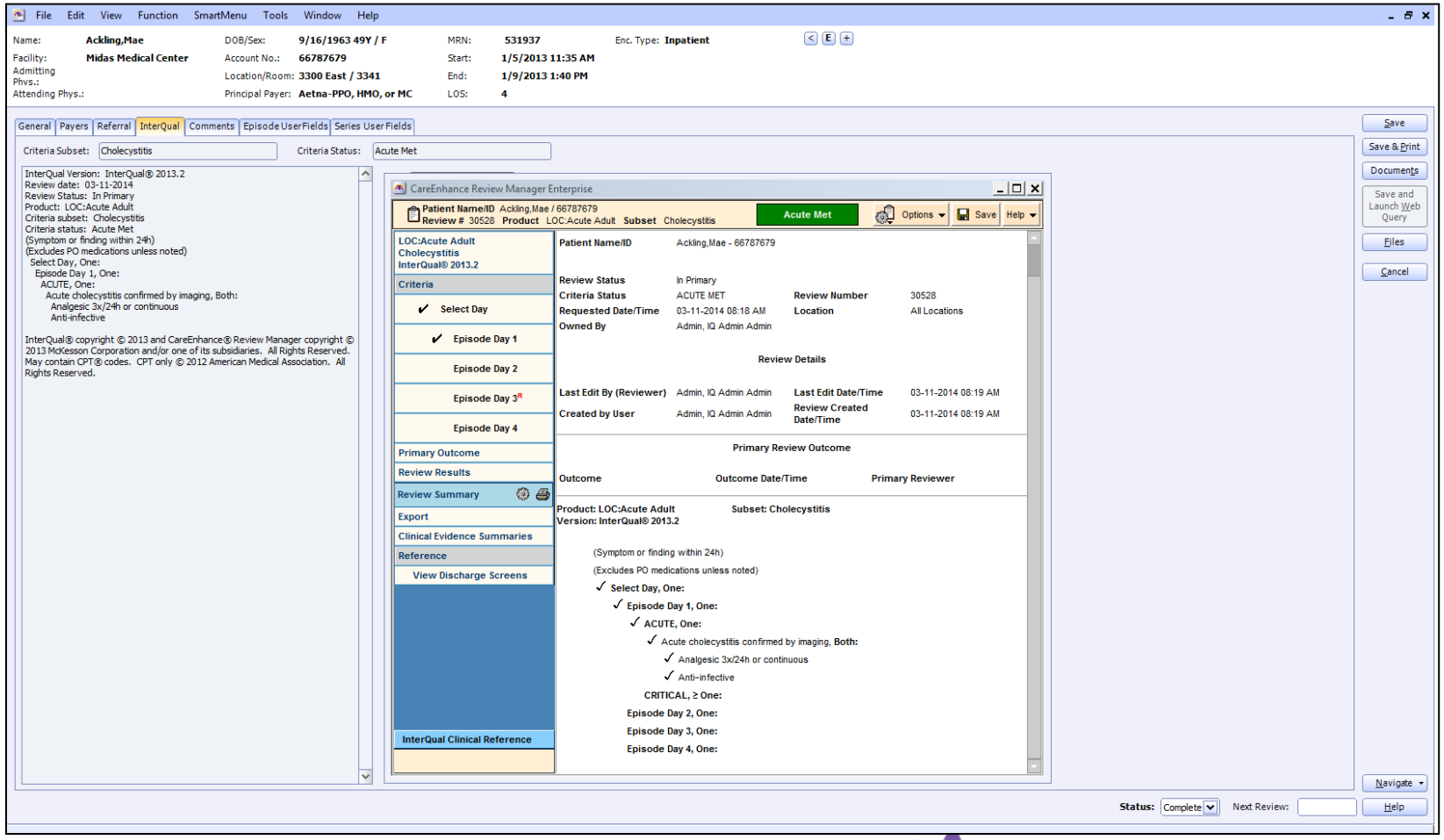
Using Screening Criteria - CERME



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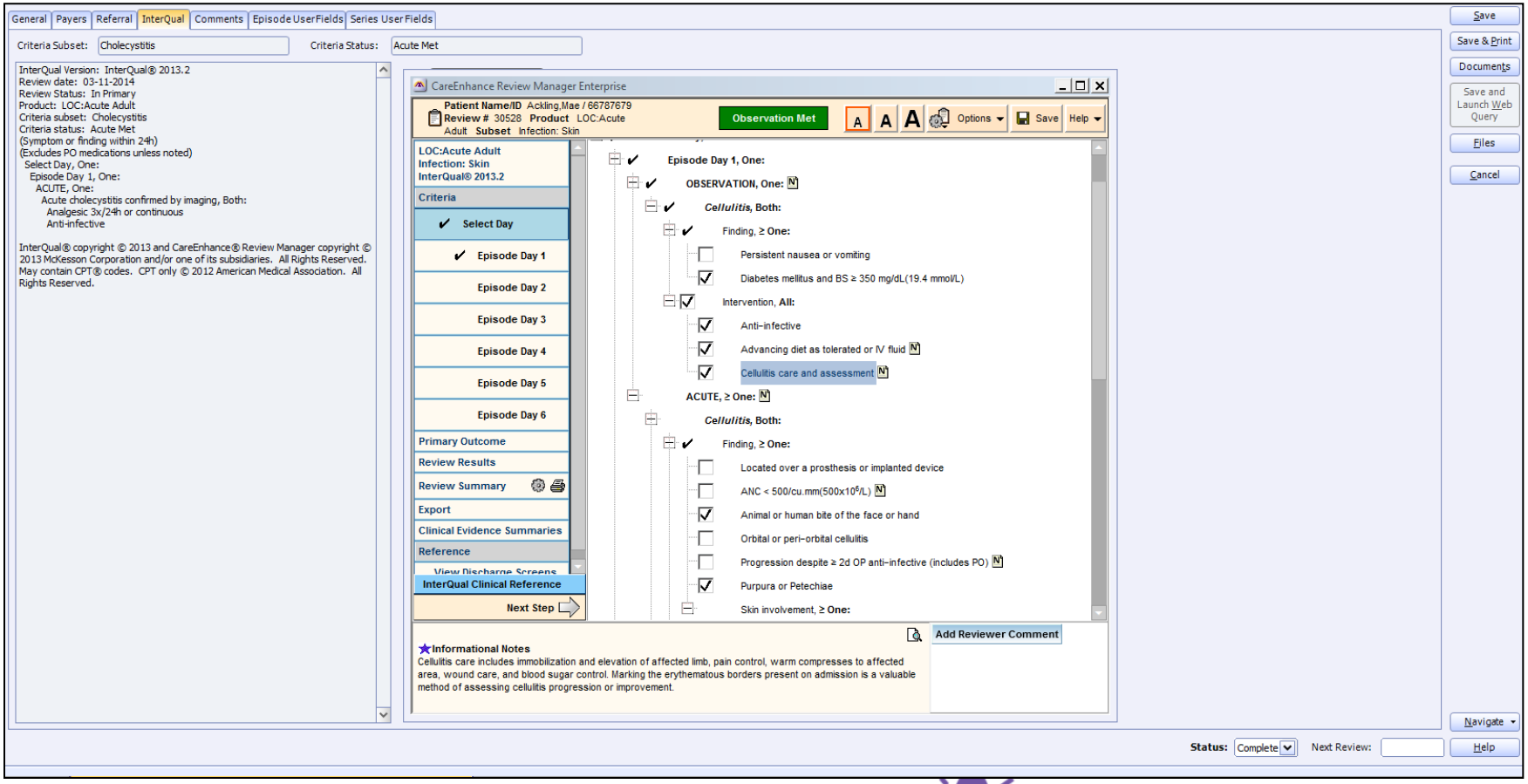
Use Criteria to assist with determining Observation vs. Acute Care Admissions



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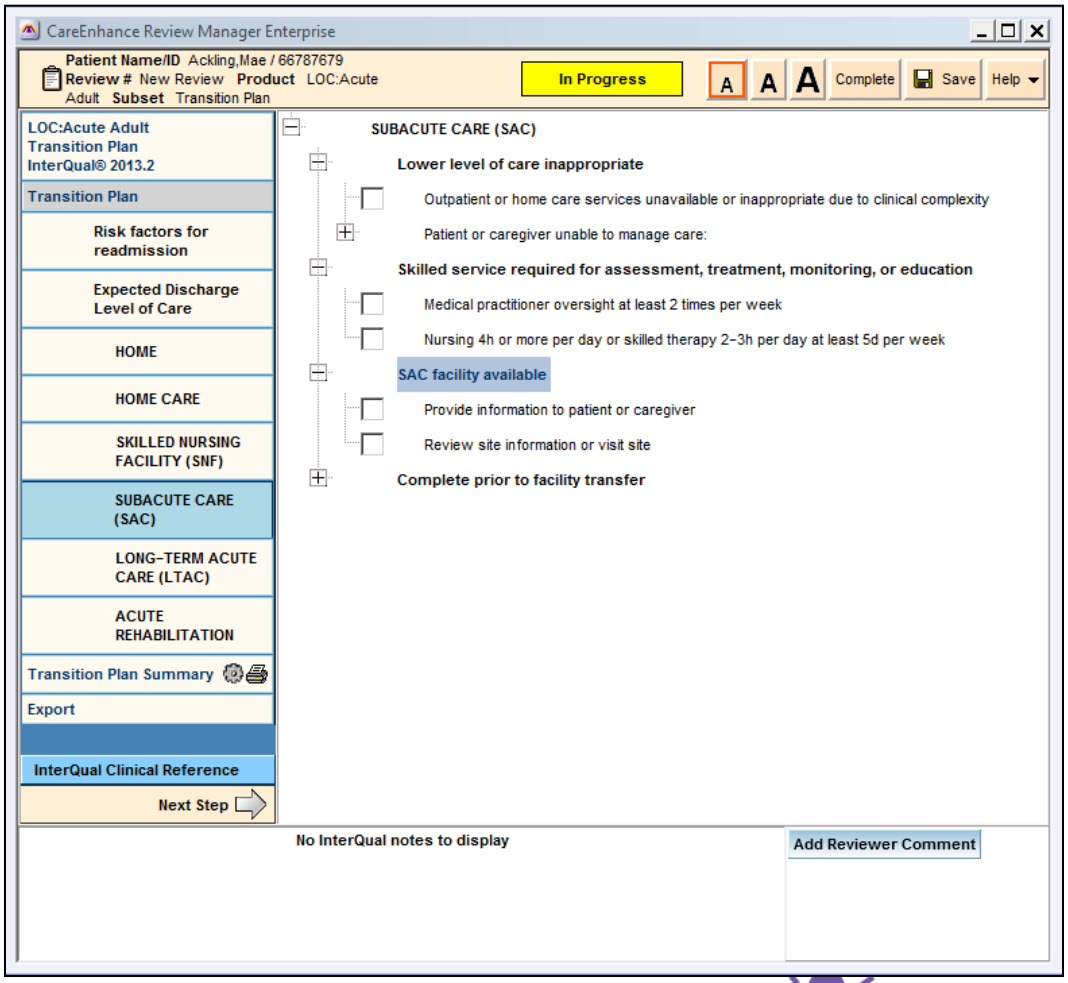
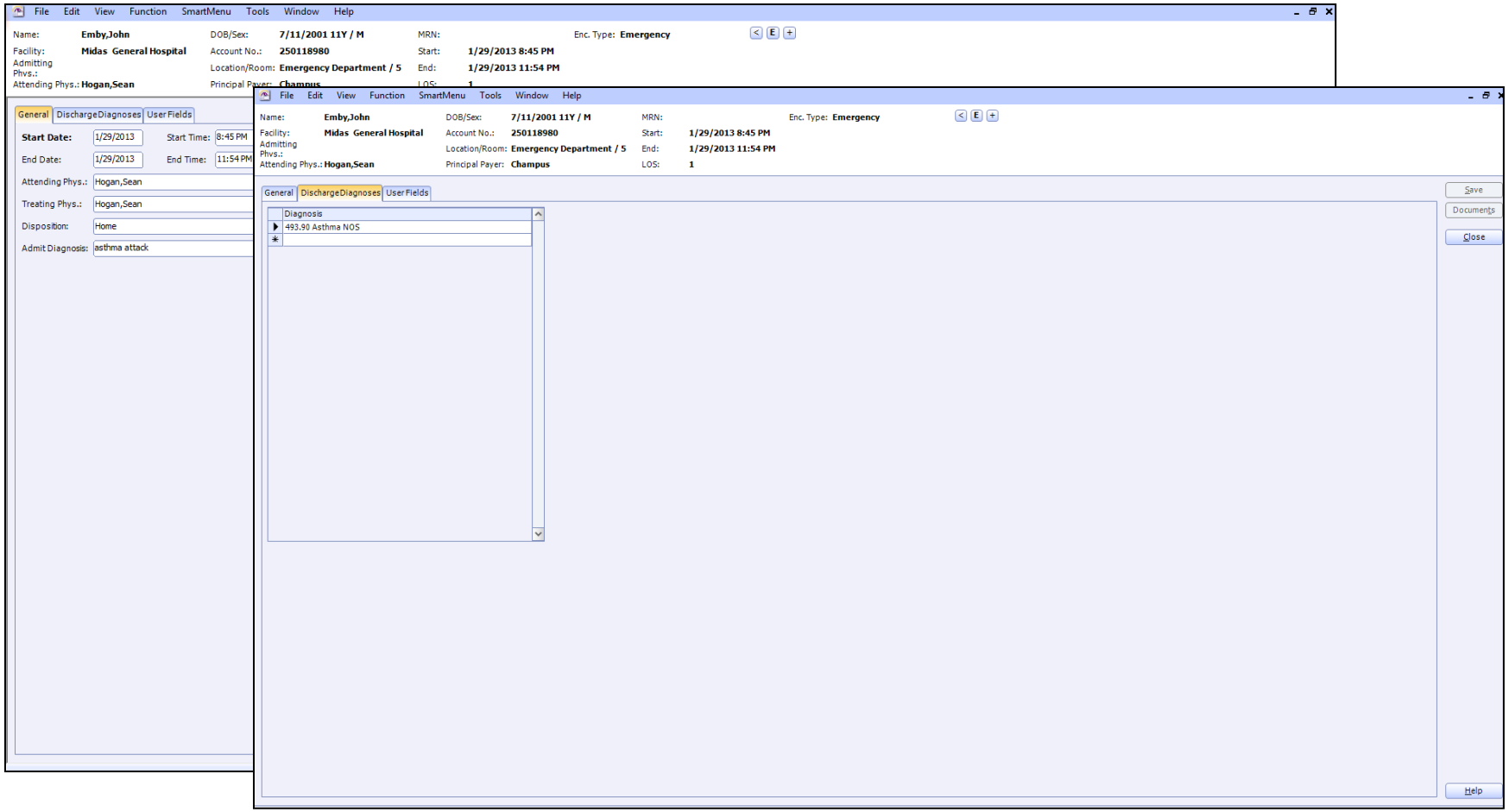
Using Screening Criteria - CERME



Tracking Actions and Alternatives to Hospital Admission

- Referral to Chronic Care Manager
- Referral to Primary Care Source
  - Internal Clinics
  - Community Clinics
- Homeless Shelters
- Prescriptions
- Transportation
- Home Health

Using the Emergency Department Module



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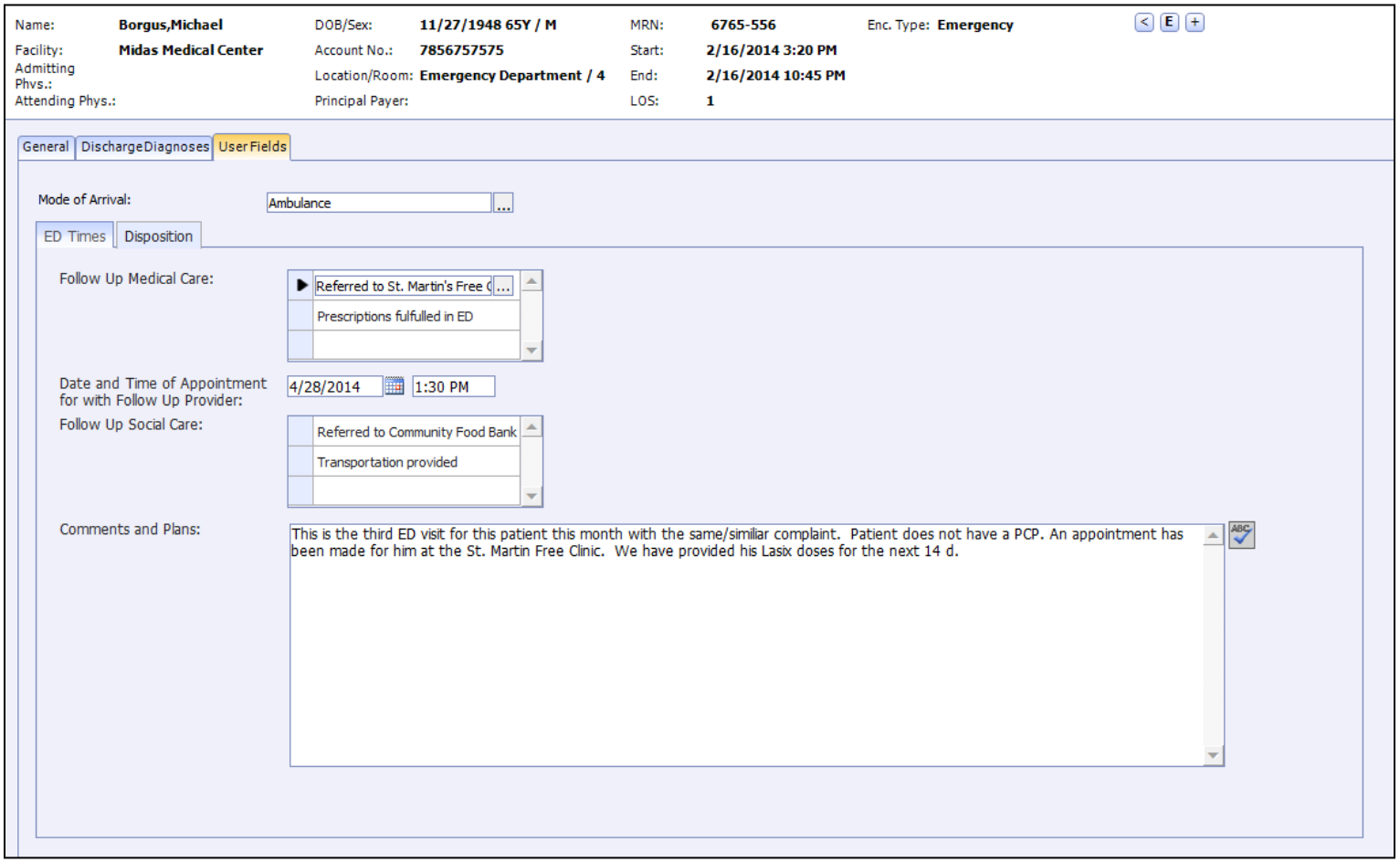
Create User Fields for the ED Module



Pre-Discharge Interventions

Use of Midas+ Hospital Case Management

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General Goals for Hospital Case Management

- Reduction in LOS
- Reduction in readmissions
- Prevention of additional complications
- Patient transfer to an appropriate level of post-discharge care
- Increased patient satisfaction
- Increased patient/caregiver understanding and competence managing disease
- Prevention of post-discharge adverse outcomes
- Improvement in patient safety
- Improved communication between hospital and post-discharge providers

Specific Pre-discharge Strategies

- Assessment of patient for discharge risk
- Patient/family involvement care during stay
- Creation of an individualized discharge plan
- Teach-back Techniques
- Medication Reconciliation
- Discharge Case Manager/Planner
- Communication with post-discharge providers

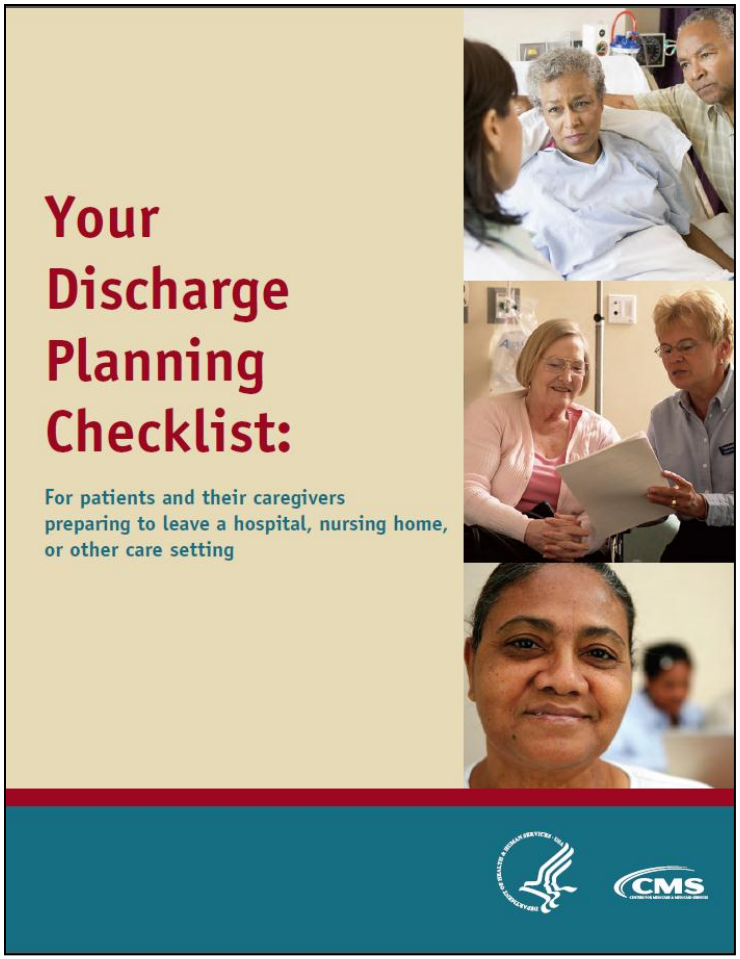
Focus on Patients

- With chronic illnesses (physical and mental)
- With no PCP or Medical Home
- With no primary caregivers/complex social needs
- With limited cognitive abilities
- With targeted/high-risk conditions
  - Acute Myocardial Infarction
  - Pneumonia
  - Congestive Heart Failure
  - COPD
  - Total Hip Replacement
  - Total Knee Replacement

Midas+ Modules to Assist with Pre-discharge Assessments

- Hospital Case Management
  - Concurrent Review
  - Support Services
  - Discharge Planning
- Encounter Subsystem
  - Observation Module
- Registration Subsystem
  - Medical History
  - Medical History Problem List

Patient Handout



Your Discharge Planning Checklist:

For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting

Name: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (a family member or friend who may be helping you) are important members of the planning team. You and your caregiver can use this checklist to prepare for discharge.

Instructions:

- Use this checklist early and often during your stay.
- Talk to your doctor and the staff (like a discharge planner, social worker, or nurse) about the items on this checklist.
- Check the box next to each item when you and your caregiver complete it. ☑
- Use the notes column to write down important information (like names and phone numbers).
- Skip any items that don't apply to you.

Action items	Notes
What's ahead?	
☐ Ask where you'll get care after you leave (after you're discharged). Do you have options (like home health care)? Be sure you tell the staff what you prefer.	
☐ If a caregiver will be helping you after discharge, write down their name and phone number.	
Your health	
☐ Ask the staff about your health condition and what you can do to help yourself get better.	
☐ Ask about problems to watch for and what to do about them. Write down a name and phone number of a person to call if you have problems.	

2

Patient Handout

Action items	Notes
☐ Use "My drug list"on page 5 to write down your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.	
☐ Review the list with the staff.	
☐ Tell the staff what drugs, vitamins, or supplements you took before you were admitted. Ask if you should still take these after you leave.	
☐ Write down a name and phone number of a person to call if you have questions.	
Recovery & support	
☐ Ask if you'll need medical equipment (like a walker). Who will arrange for this? Write down a name and phone number of a person you can call if you have questions about equipment.	
☐ Ask if you're ready to do the activities below. Circle the ones you need help with, and tell the staff:	
• Bathing, dressing, using the bathroom, climbing stairs	
• Cooking, food shopping, house cleaning, paying bills	
• Getting to doctors' appointments, picking up prescription drugs	
☐ Make sure you have support (like a caregiver) in place that can help you. See "Resources" on page 6 for more information.	
☐ Ask the staff to show you and your caregiver any other tasks that require special skills (like changing a bandage or giving a shot). Then, show them you can do these tasks. Write down a name and phone number of a person you can call if you need help.	
☐ Ask to speak to a social worker if you're concerned about how you and your family are coping with your illness. Write down information about support groups and other resources.	
☐ Talk to a social worker or your health plan if you have questions about what your insurance will cover, and how much you'll have to pay. Ask about possible ways to get help with your costs.	

3

Action items	Notes
☐ Ask for written discharge instructions (that you can read and understand) and a summary of your current health status. Bring this information and your completed "My drug list" to your follow-up appointments.	
☐ Use "My appointments" on page 5 to write down any appointments and tests you'll need in the next several weeks.	
For the caregiver	
☐ Do you have any questions about the items on this checklist or on the discharge instructions? Write them down, and discuss them with the staff.	
☐ Can you give the patient the help he or she needs?	
☐ What tasks do you need help with?	
☐ Do you need any education or training?	
☐ Talk to the staff about getting the help you need before discharge.	
☐ Write down a name and phone number of a person you can call if you have questions.	
☐ Get prescriptions and any special diet instructions early, so you won't have to make extra trips after discharge.	

More information for people with Medicare

If you need help choosing a home health agency or nursing home:

- Talk to the staff.
- Visit **Medicare.gov** to compare the quality of home health agencies, nursing homes, dialysis facilities, and hospitals in your area.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

If you think you're being asked to leave a hospital or other health care setting (discharged) too soon:
You may have the right to ask for a review of the discharge decision by an independent reviewer called a Quality Improvement Organization (QIO) before you leave. To get the phone number for the QIO in your state, visit **Medicare.gov/contacts**, or call **1-800-MEDICARE**. You can also ask the staff for this information. If you're in a hospital, the staff should give you a notice called "Important Message from Medicare," which contains information on your state QIO. If you don't get this notice, ask for it.

For more information on your right to appeal, visit **Medicare.gov/appeals**, or visit **Medicare.gov/publications** to view the booklet "Medicare Appeals."

4

Universal Patient Discharge Checklist

project BOOST
Better Outcomes by Optimizing Safe Transitions

The 8Ps:
Assessing Your Patient's Risk For Adverse Events After Discharge

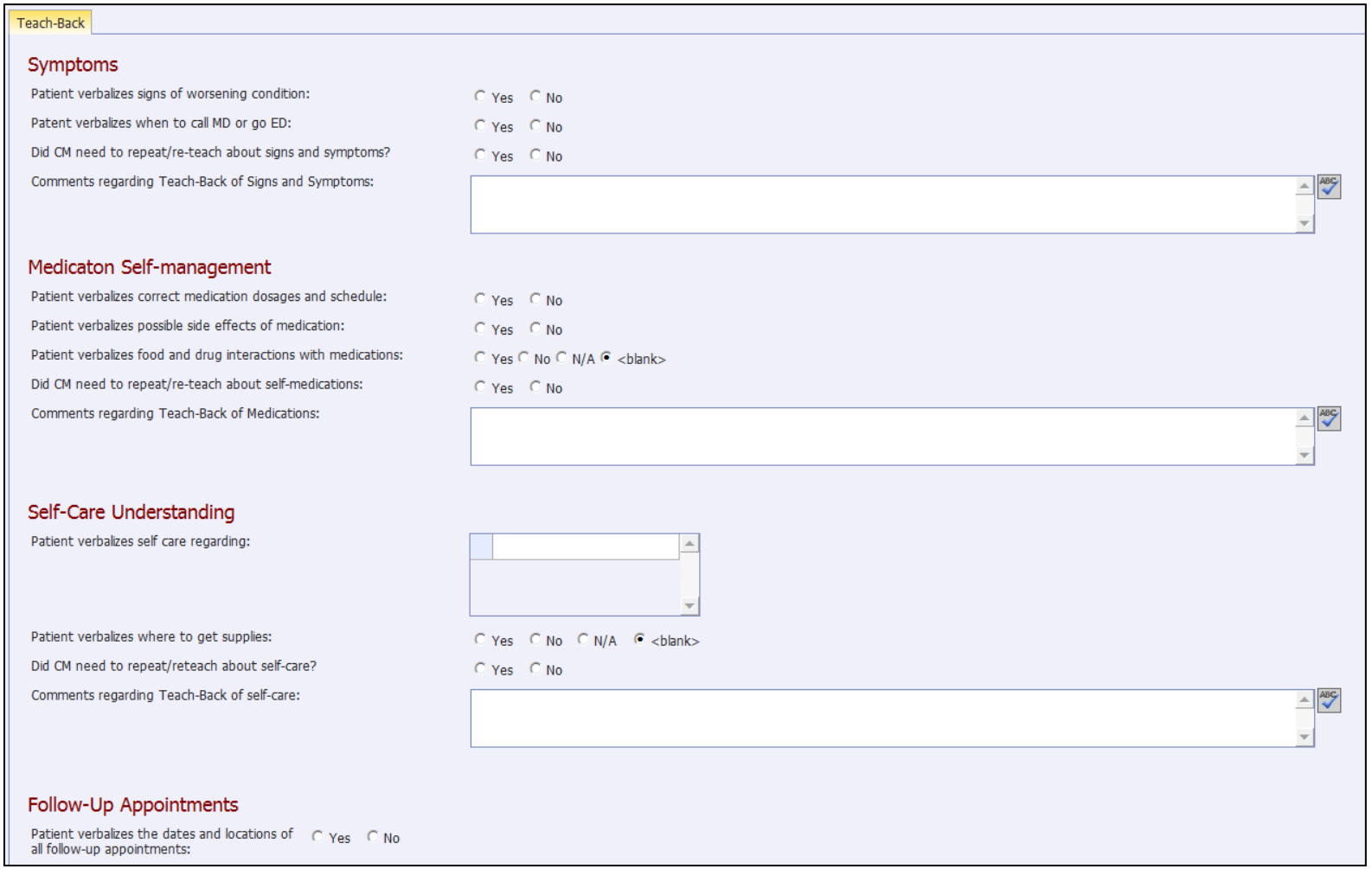
Risk Assessment: 8P Screening Tool (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problems with medications (polypharmacy – i.e. ≥10 routine meds – or high risk medication including: anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or history of depression diagnosis) ☐	☐ Assessment of need for psychiatric care if not in place ☐ Communication with primary care provider, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Physical limitations (patients with deconditioning, frailty, or other physical limitations that impair their ability to participate in their own care) ☐	☐ Engage family/caregivers to ensure ability to assist with post-discharge care assistance ☐ Assessment of home services to address limitations and care needs ☐ Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place.	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions ☐ Post-hospital care plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with appropriate medical provider within 7 days after hospitalization ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers ☐ Engage a transition coach	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with medical provider within 7 days of hospital discharge ☐ Engage a transition coach	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness? "No" to 1st or "Yes" to 2nd = positive screen) ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address concerning symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient	

Coleman Model Four Pillars

1. Medication Self-management
2. Patient uses a Personal Health Record to facilitate communication and ensure continuity across providers and setting
3. Follow Up: Patient schedules and completes follow-up visit with PCP
4. Patient recognizes “red flags” about worsening conditions and understands how to respond

Proven Successes:
Teach-back Technique

Teach-back Techniques



Teach-Back

Symptoms

Patient verbalizes signs of worsening condition: ○ Yes ○ No

Patent verbalizes when to call MD or go ED: ○ Yes ○ No

Did CM need to repeat/re-teach about signs and symptoms? ○ Yes ○ No

Comments regarding Teach-Back of Signs and Symptoms:

Medicaton Self-management

Patient verbalizes correct medication dosages and schedule: ○ Yes ○ No

Patient verbalizes possible side effects of medication: ○ Yes ○ No

Patient verbalizes food and drug interactions with medications: ○ Yes ○ No ○ N/A ◉ <blank>

Did CM need to repeat/re-teach about self-medications: ○ Yes ○ No

Comments regarding Teach-Back of Medications:

Self-Care Understanding

Patient verbalizes self care regarding:

Patient verbalizes where to get supplies: ○ Yes ○ No ○ N/A ◉ <blank>

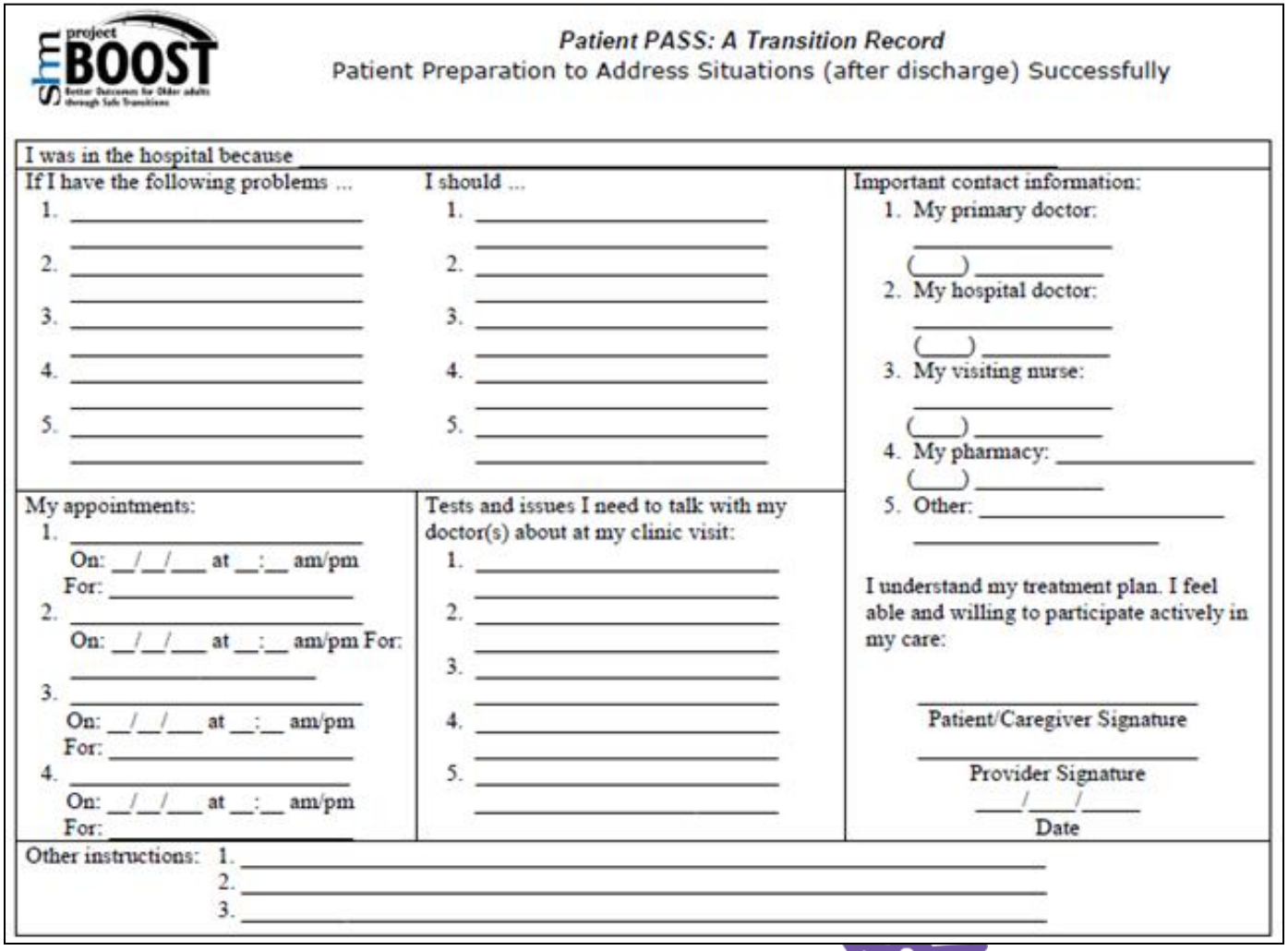
Did CM need to repeat/reteach about self-care? ○ Yes ○ No

Comments regarding Teach-Back of self-care:

Follow-Up Appointments

Patient verbalizes the dates and locations of all follow-up appointments: ○ Yes ○ No

Patient Pass (BOOST)



project BOOST

Patient PASS: A Transition Record

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because _____

If I have the following problems ...

1. _____
2. _____
3. _____
4. _____
5. _____

I should ...

1. _____
2. _____
3. _____
4. _____
5. _____

Important contact information:

1. My primary doctor:
   _____
   (___) _____
2. My hospital doctor:
   _____
   (___) _____
3. My visiting nurse:
   _____
   (___) _____
4. My pharmacy: _____
   (___) _____
5. Other: _____
   _____

My appointments:

1. _____
   On: __/__/___ at __:__ am/pm
   For: _____
2. _____
   On: __/__/___ at __:__ am/pm For:
   _____
3. _____
   On: __/__/___ at __:__ am/pm
   For: _____
4. _____
   On: __/__/___ at __:__ am/pm
   For: _____

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand my treatment plan. I feel able and willing to participate actively in my care:

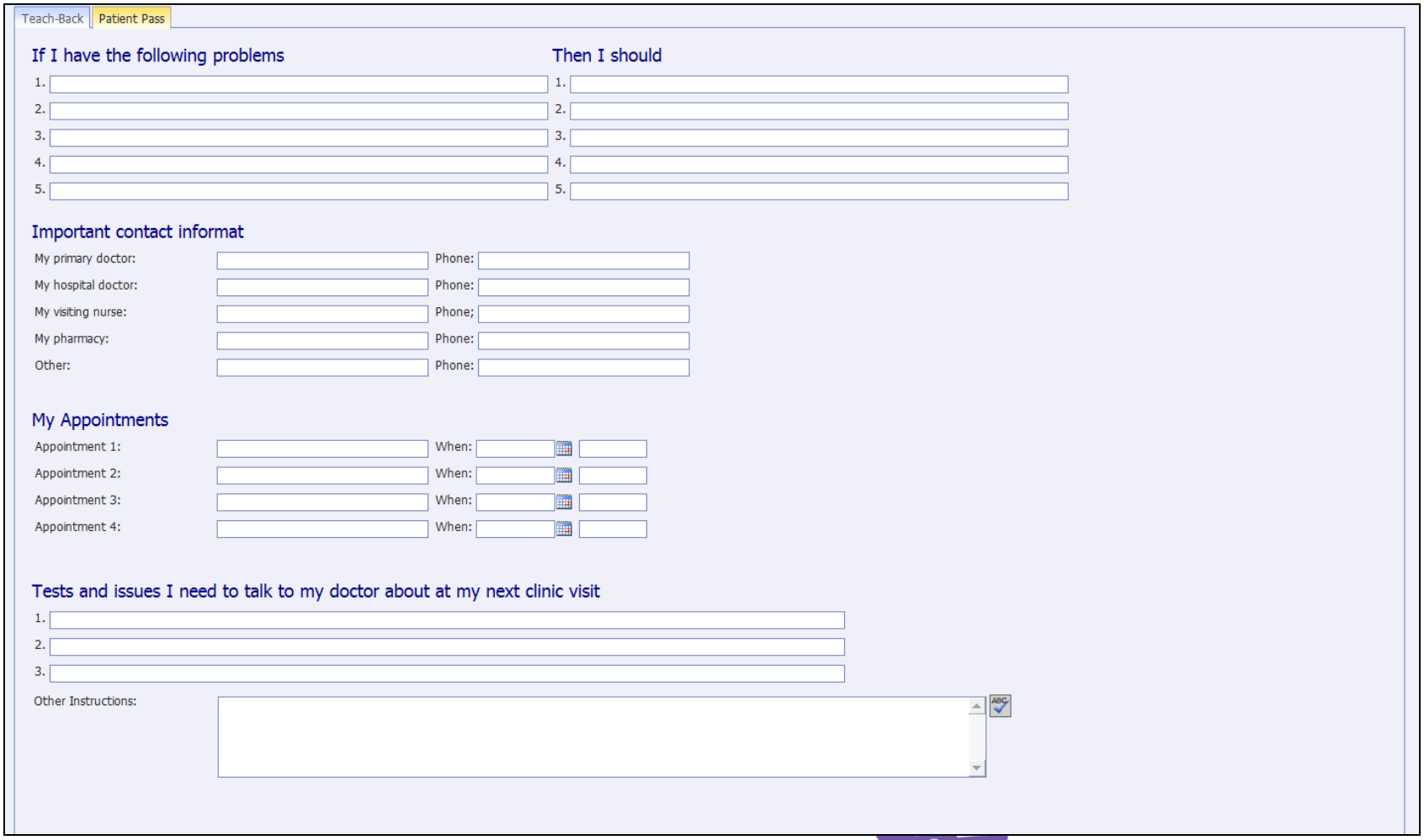
_____
Patient/Caregiver Signature

_____
Provider Signature

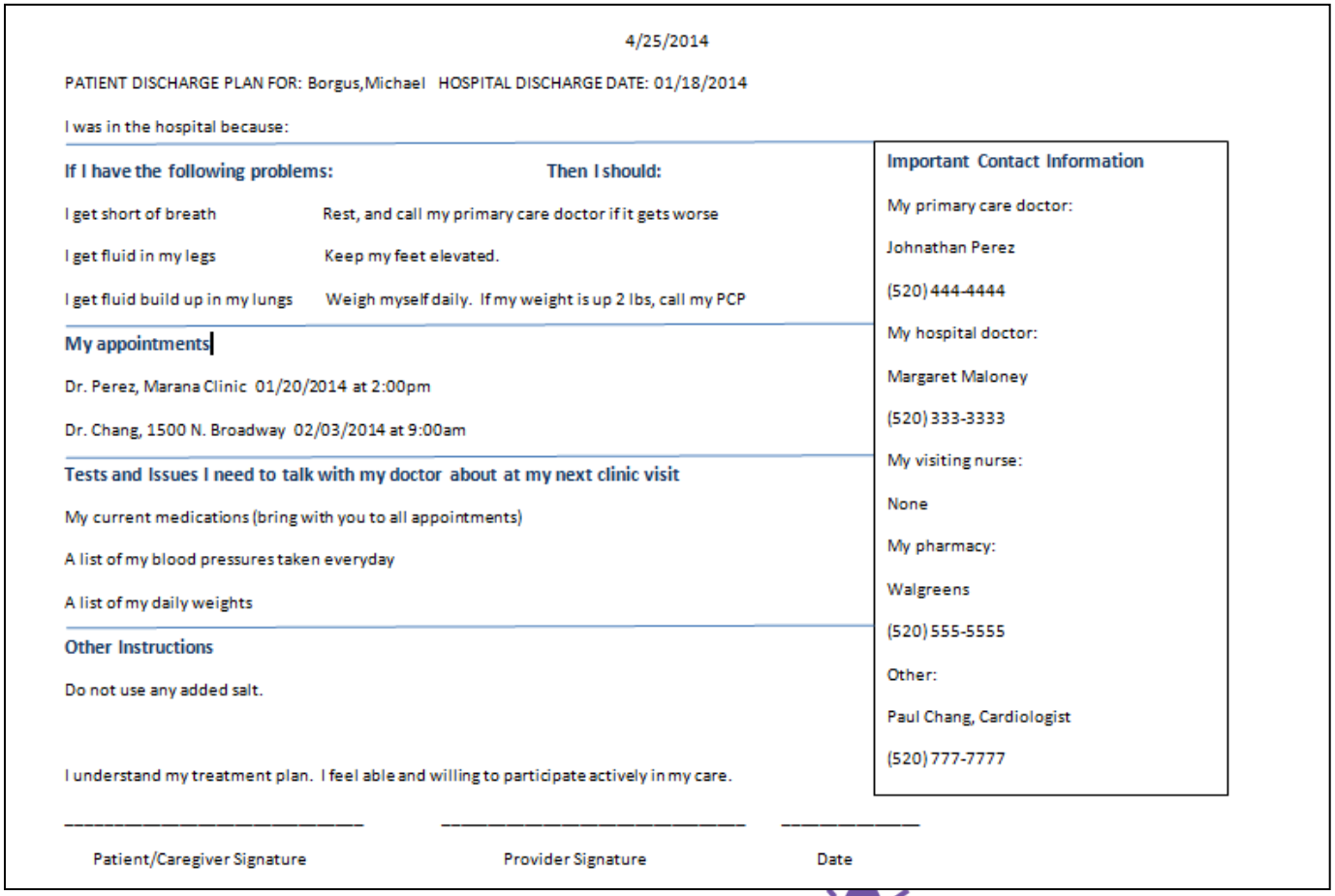
____/____/_____
Date

Other instructions: 1. _____
2. _____
3. _____

BOOST Patient Pass



BOOST Patient Pass as ReporTrack Document



4/25/2014

PATIENT DISCHARGE PLAN FOR: Borgus,Michael HOSPITAL DISCHARGE DATE: 01/18/2014

I was in the hospital because:

If I have the following problems:	Then I should:
I get short of breath	Rest, and call my primary care doctor if it gets worse
I get fluid in my legs	Keep my feet elevated.
I get fluid build up in my lungs	Weigh myself daily. If my weight is up 2 lbs, call my PCP

My appointments

Dr. Perez, Marana Clinic 01/20/2014 at 2:00pm

Dr. Chang, 1500 N. Broadway 02/03/2014 at 9:00am

Tests and Issues I need to talk with my doctor about at my next clinic visit

My current medications (bring with you to all appointments)

A list of my blood pressures taken everyday

A list of my daily weights

Other Instructions

Do not use any added salt.

I understand my treatment plan. I feel able and willing to participate actively in my care.

_____ _____ _____

Patient/Caregiver Signature Provider Signature Date

Important Contact Information

My primary care doctor:

Johnathan Perez

(520) 444-4444

My hospital doctor:

Margaret Maloney

(520) 333-3333

My visiting nurse:

None

My pharmacy:

Walgreens

(520) 555-5555

Other:

Paul Chang, Cardiologist

(520) 777-7777

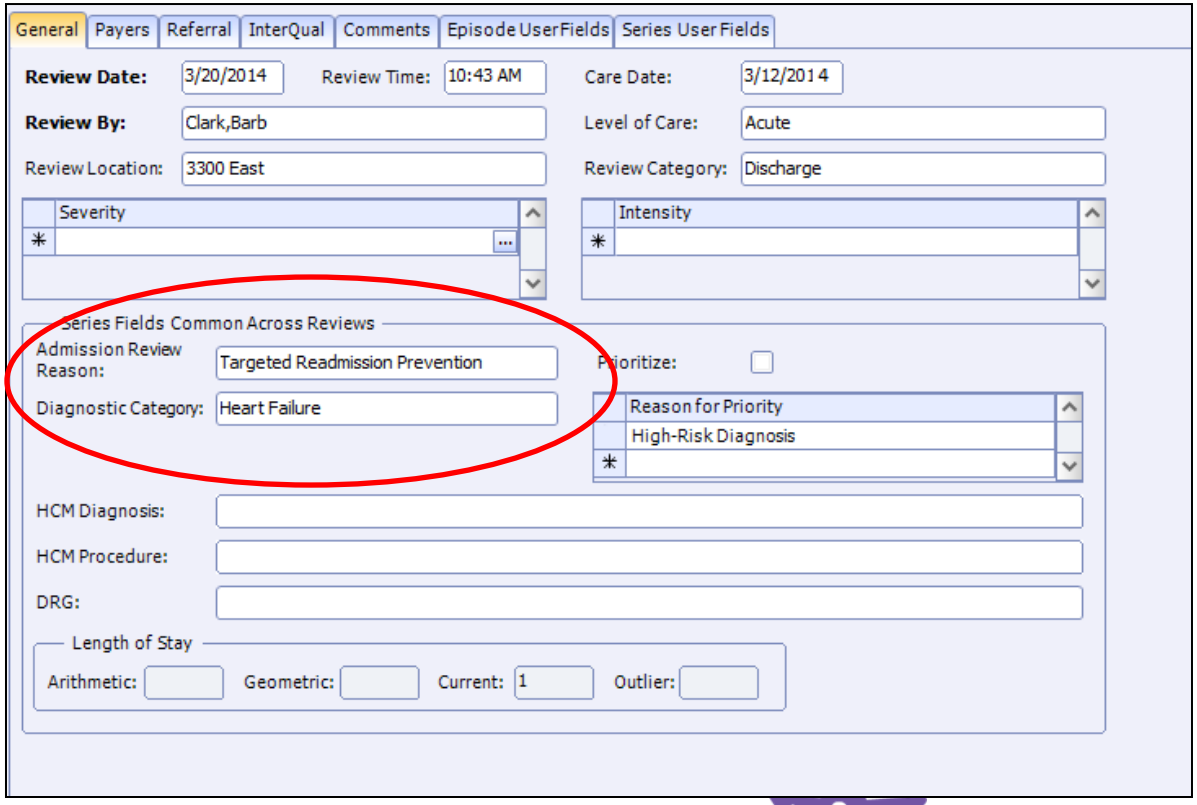
Referrals HCM to a Transitional Care Coach

FROM:

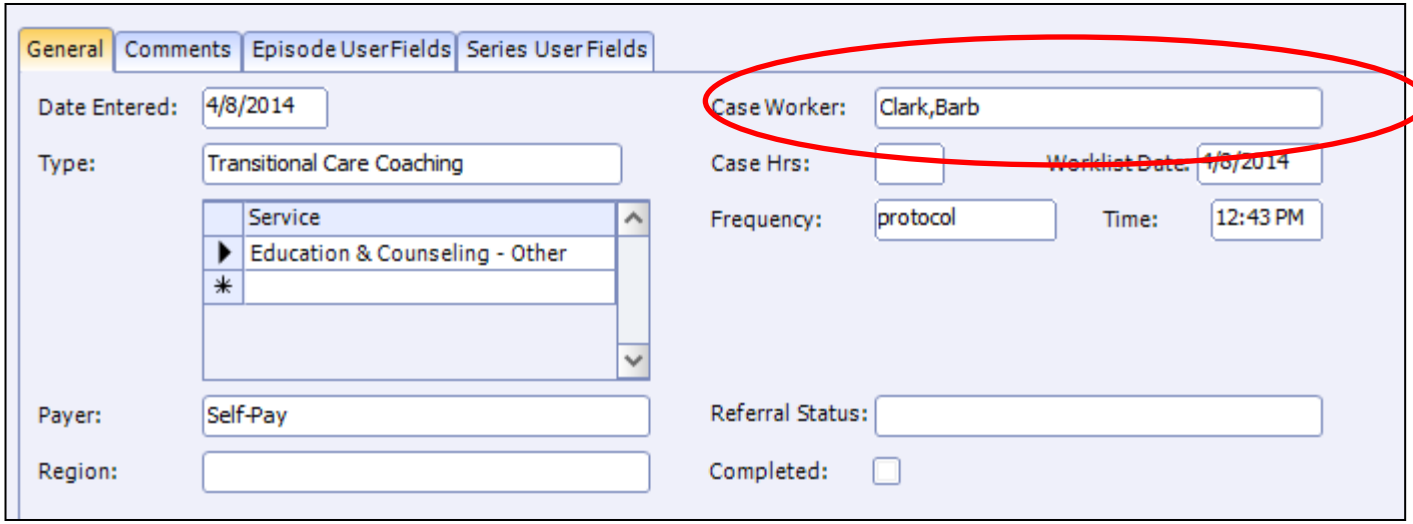
- Concurrent Review
- Support Services
- Discharge Planning
- Medical History

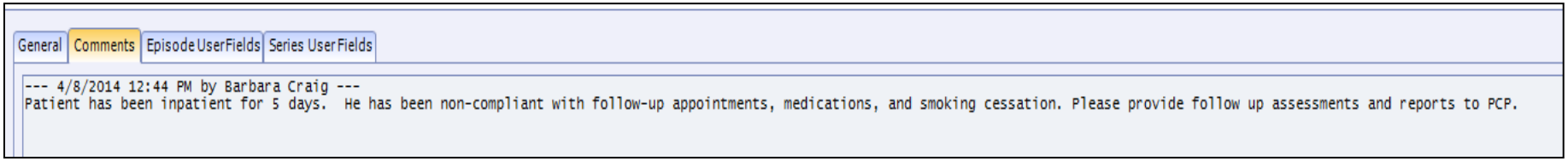
Referrals to TCC: Concurrent Review

Use Concurrent Review to Identify Targeted Readmission Diagnoses

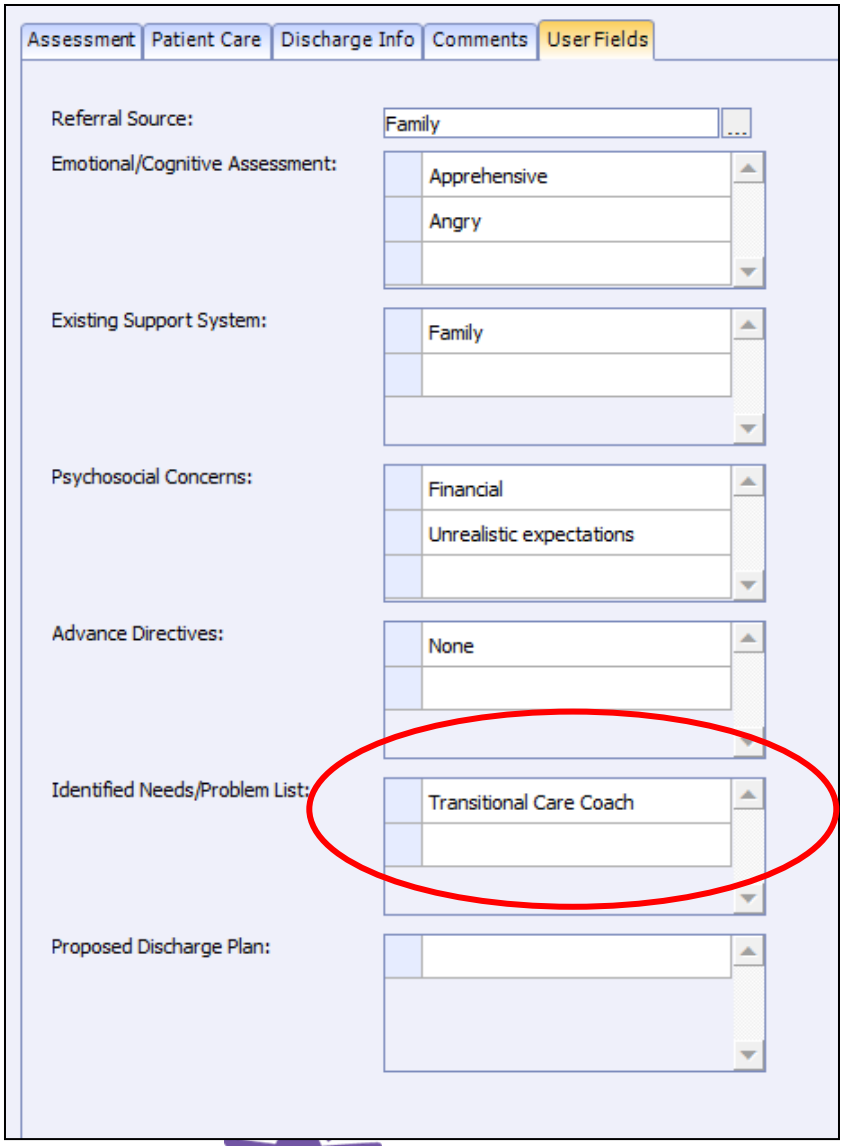


Using Support Services to Generate Follow-up

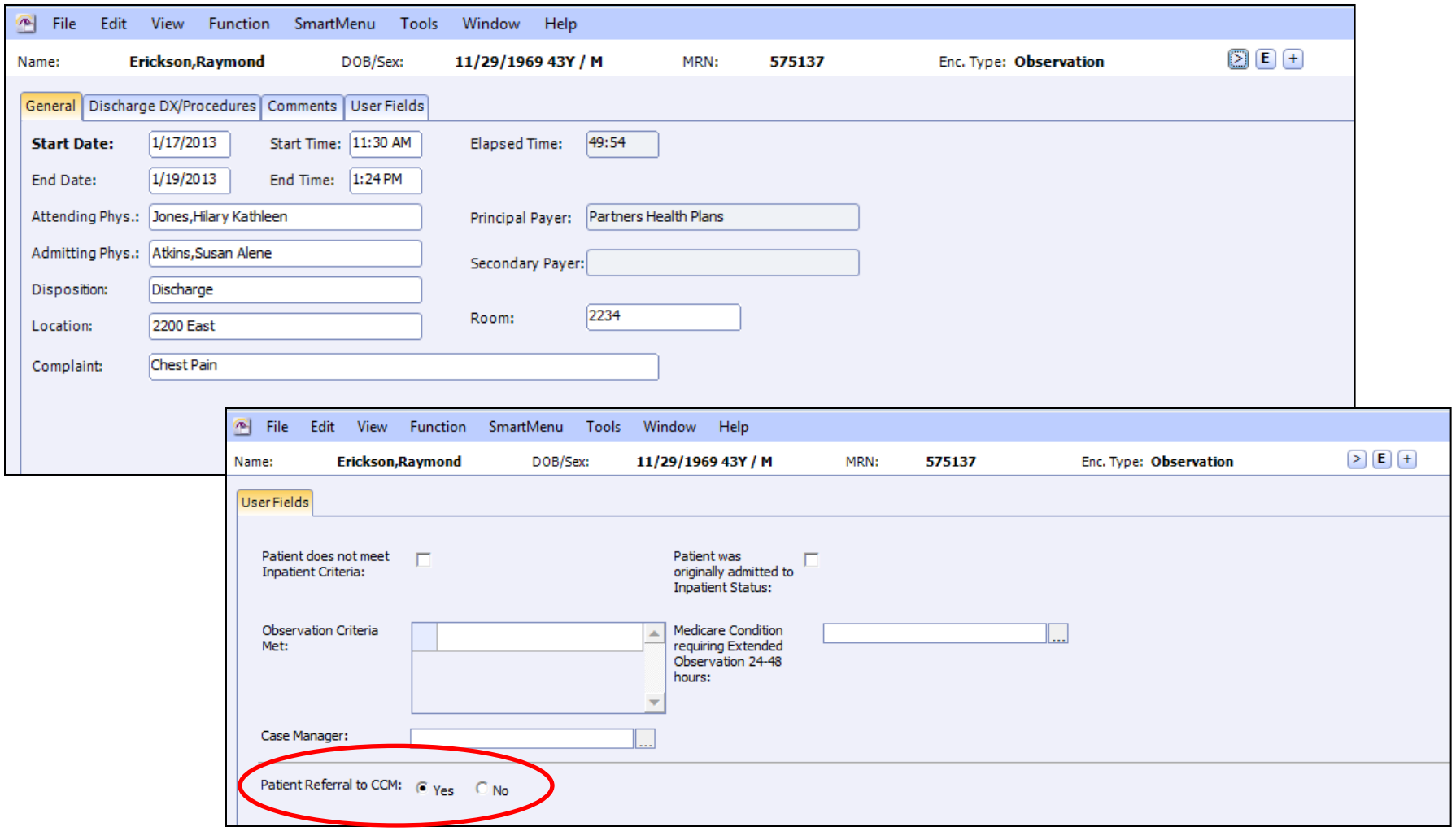




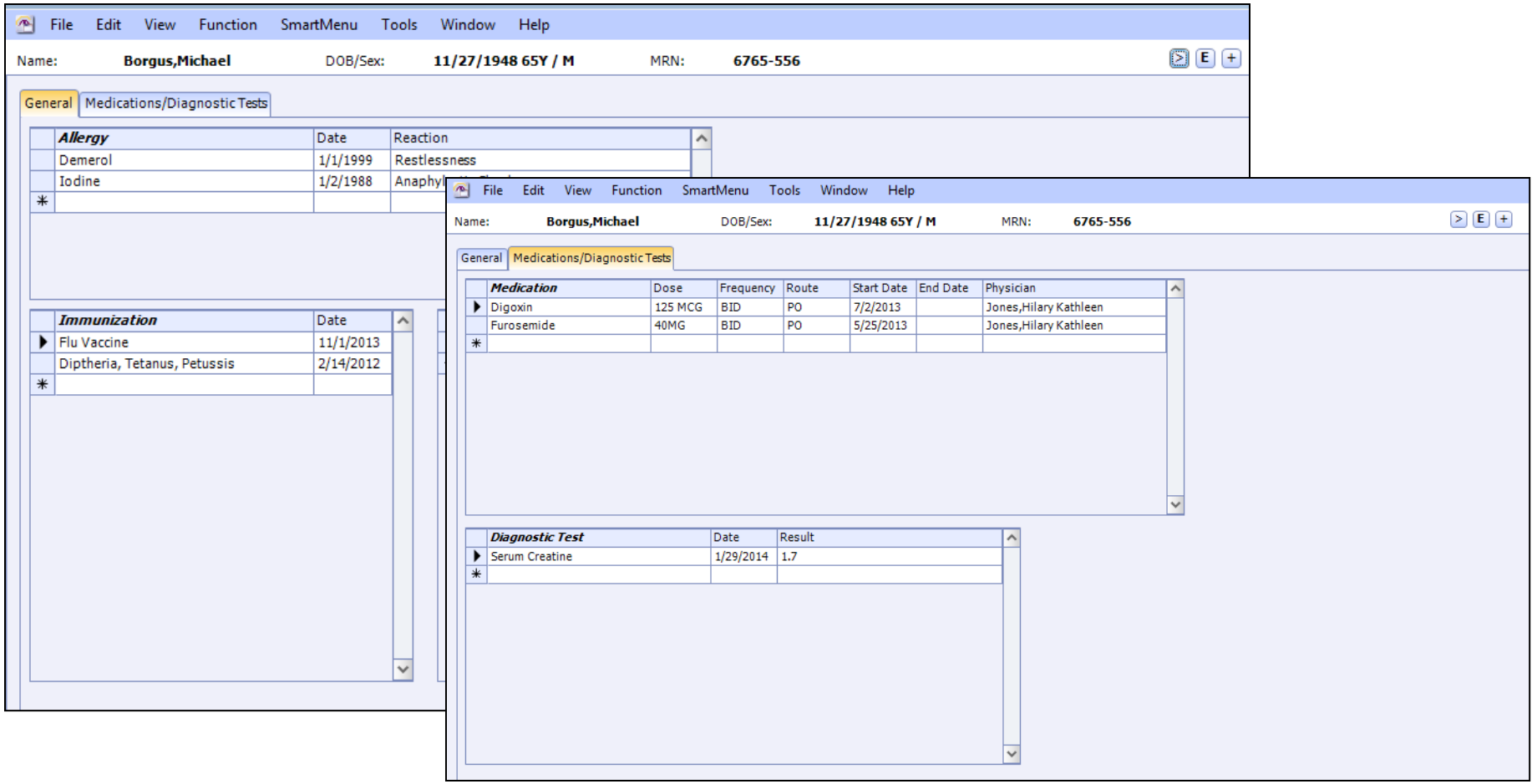
Using Discharge Planning to Generate Follow-up with Transitional Care Manager



Observation Module



Medical History

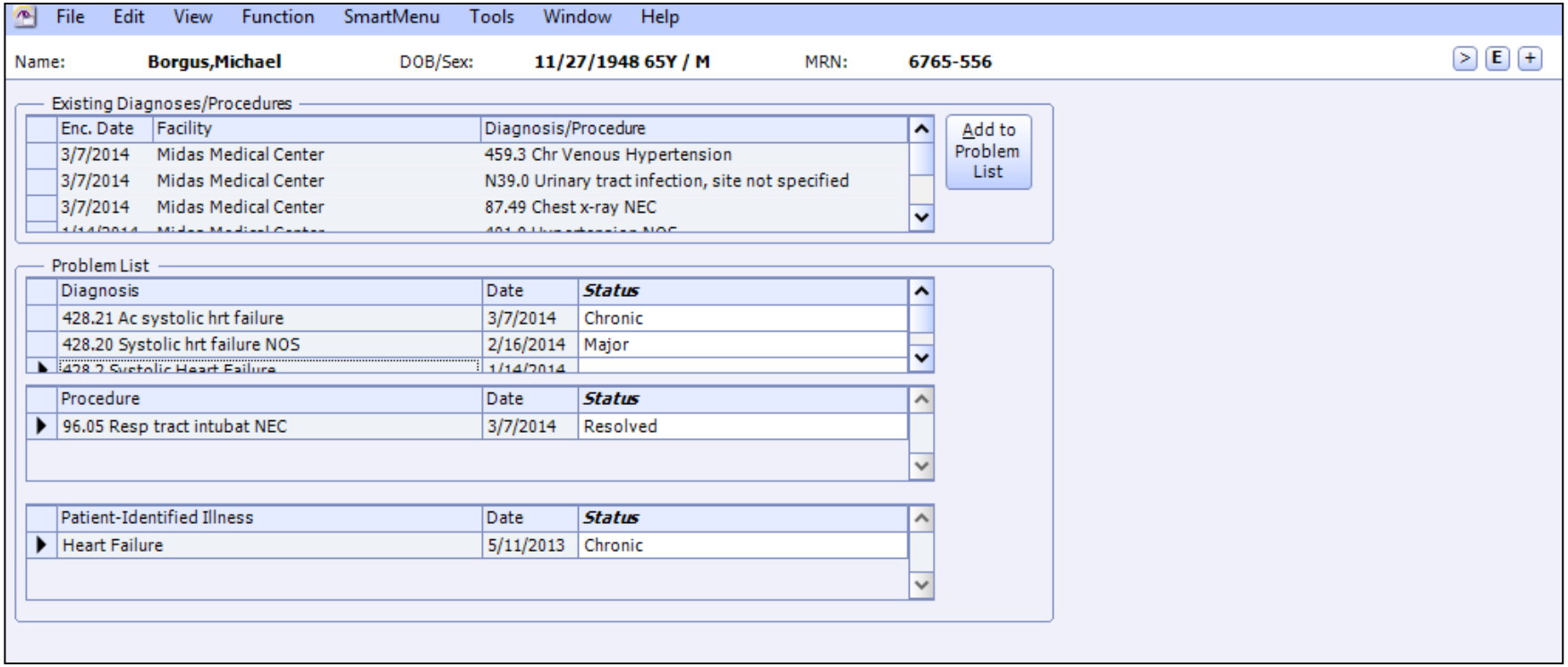


Midas+

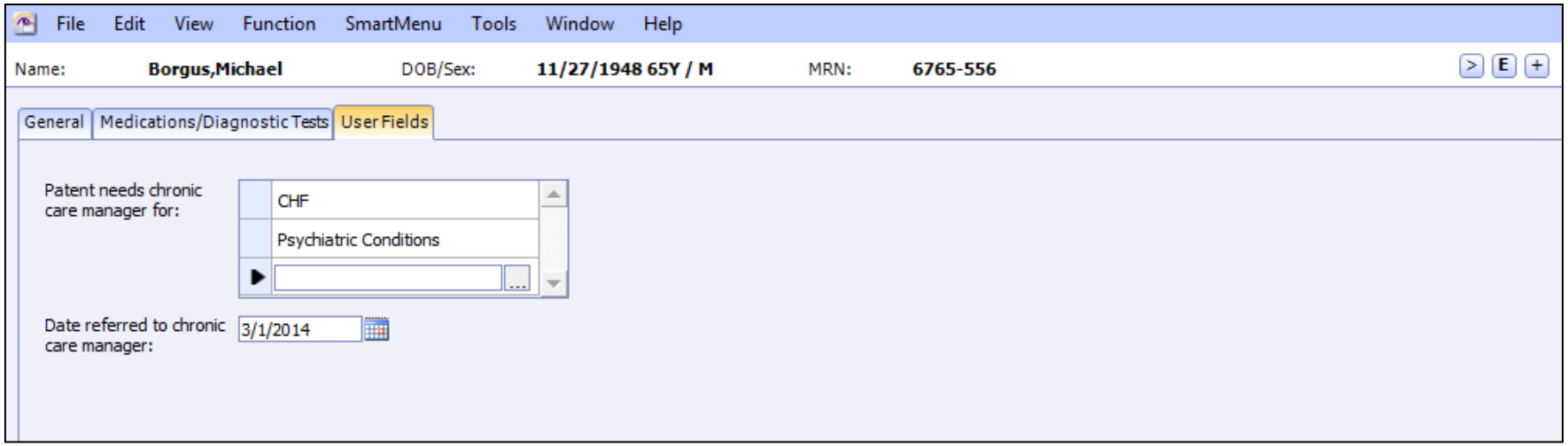
Midas+ Annual Symposium
Clinical & Application Effectiveness

xerox

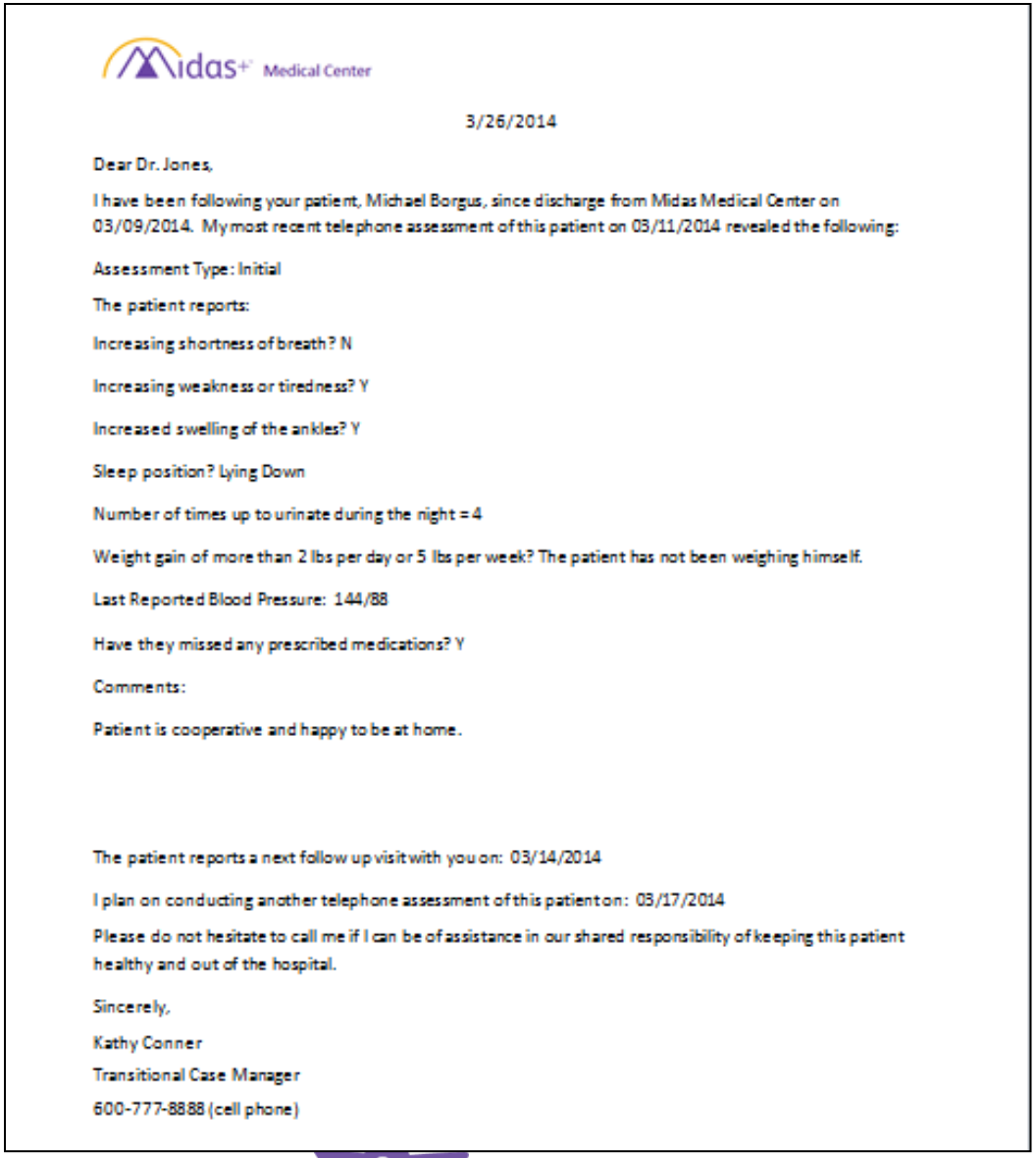
Medical History Problem List



Medical History User Fields



Coordination with Post-discharge Providers



Midas+ Medical Center

3/26/2014

Dear Dr. Jones,

I have been following your patient, Michael Borgus, since discharge from Midas Medical Center on 03/09/2014. My most recent telephone assessment of this patient on 03/11/2014 revealed the following:

Assessment Type: Initial

The patient reports:

Increasing shortness of breath? N

Increasing weakness or tiredness? Y

Increased swelling of the ankles? Y

Sleep position? Lying Down

Number of times up to urinate during the night = 4

Weight gain of more than 2 lbs per day or 5 lbs per week? The patient has not been weighing himself.

Last Reported Blood Pressure: 144/88

Have they missed any prescribed medications? Y

Comments:

Patient is cooperative and happy to be at home.

The patient reports a next follow up visit with you on: 03/14/2014

I plan on conducting another telephone assessment of this patient on: 03/17/2014

Please do not hesitate to call me if I can be of assistance in our shared responsibility of keeping this patient healthy and out of the hospital.

Sincerely,

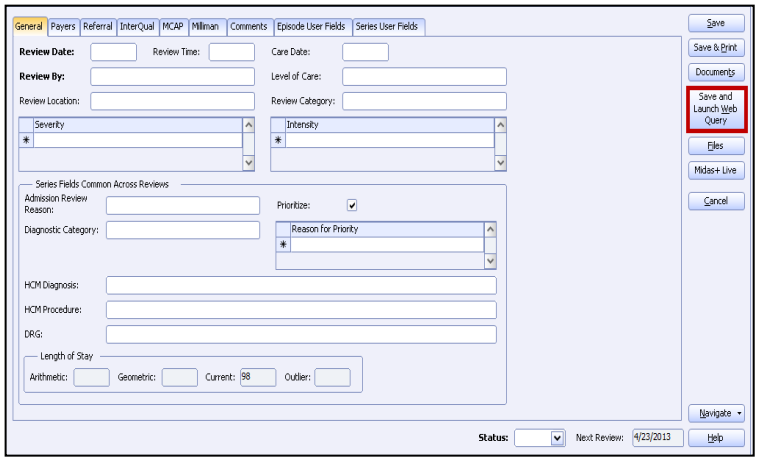
Kathy Conner

Transitional Case Manager

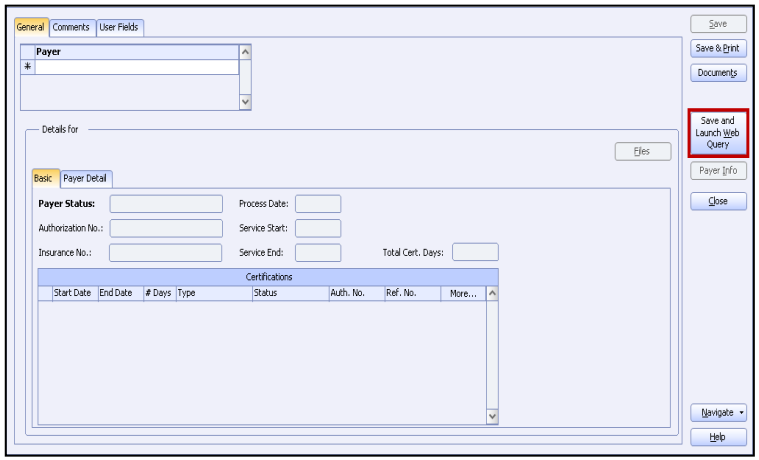
600-777-8888 (cell phone)

Four Launch Points from Midas+

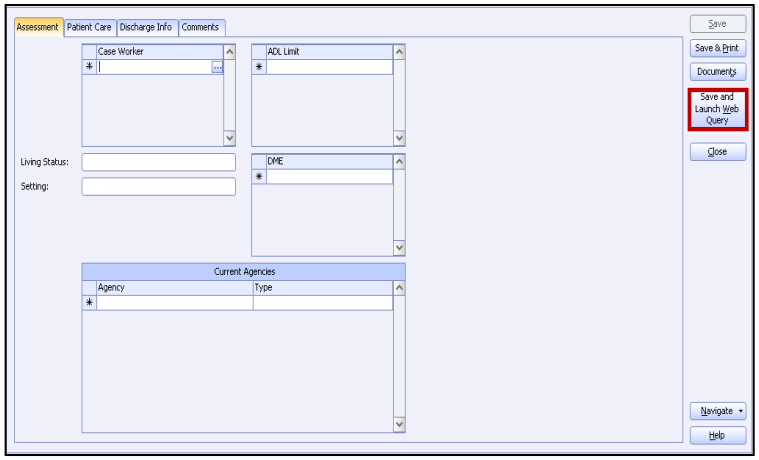
Concurrent Review



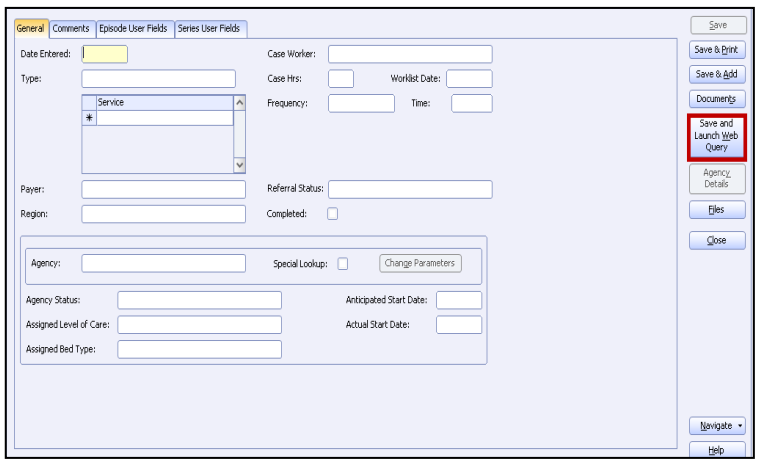
Certification Entry



Discharge Planning



Support Services



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Curaspan and Midas+

Leading provider of
patient transition solutions

Leading provider of
care performance software

10+ year partnership

Nearly **350** shared customers

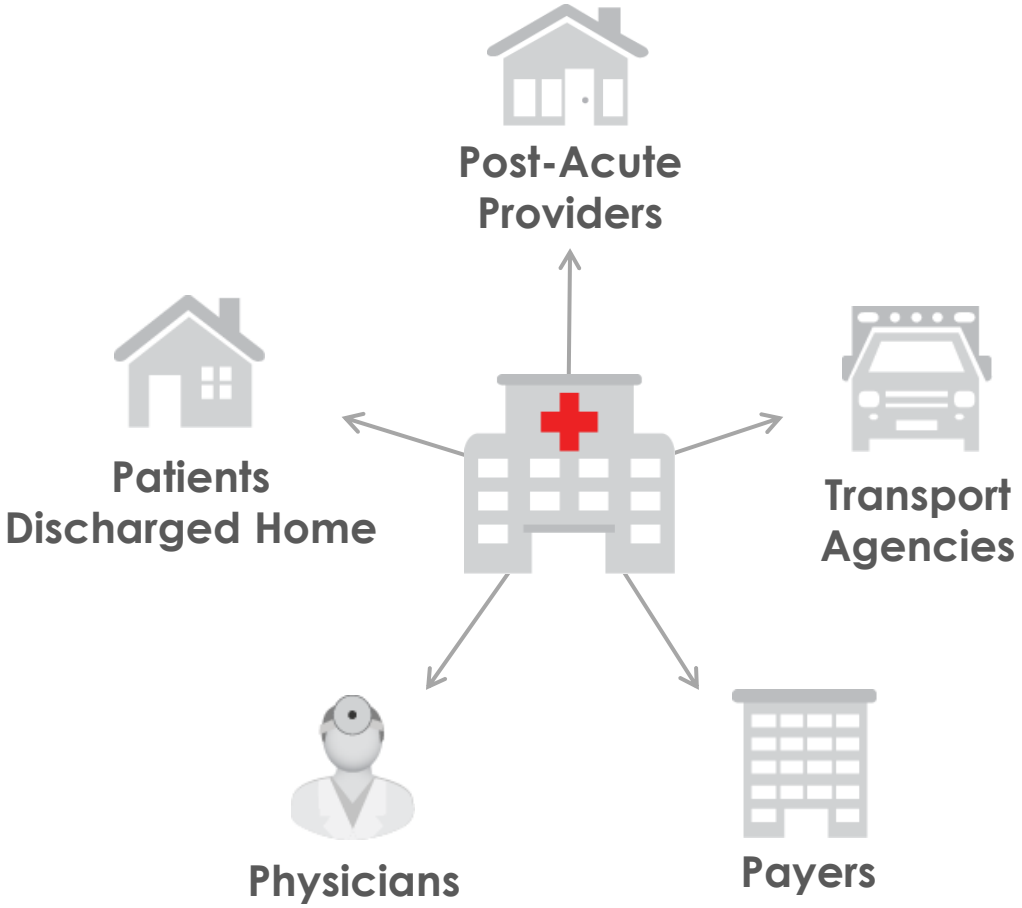
Curaspan Powers Care Transitions

Care Transition: **"The movement of a patient from one setting of care to another."**

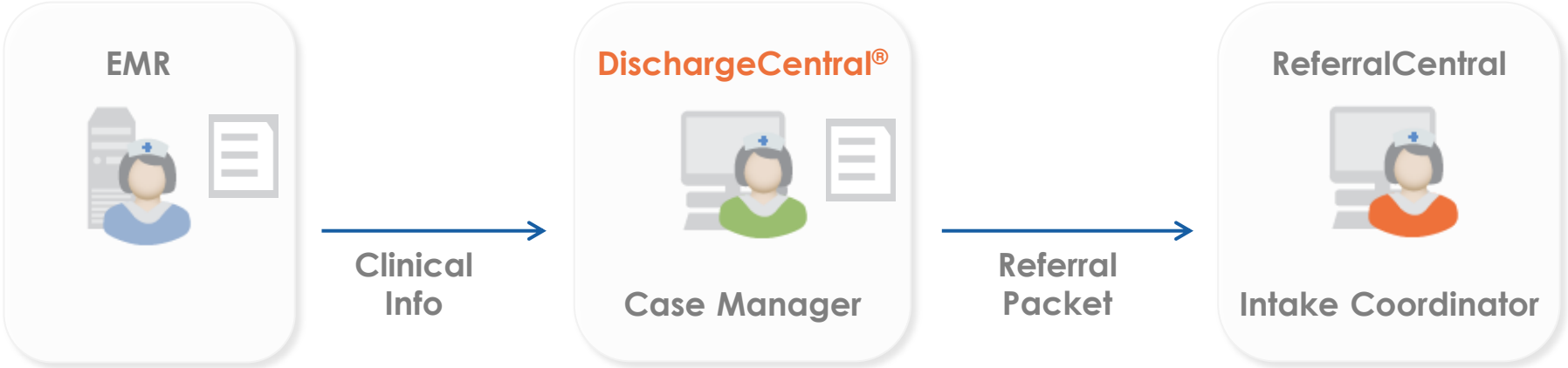
15 years leading the industry

15% of all acute discharge in the US move across our network

6 million discharges per year

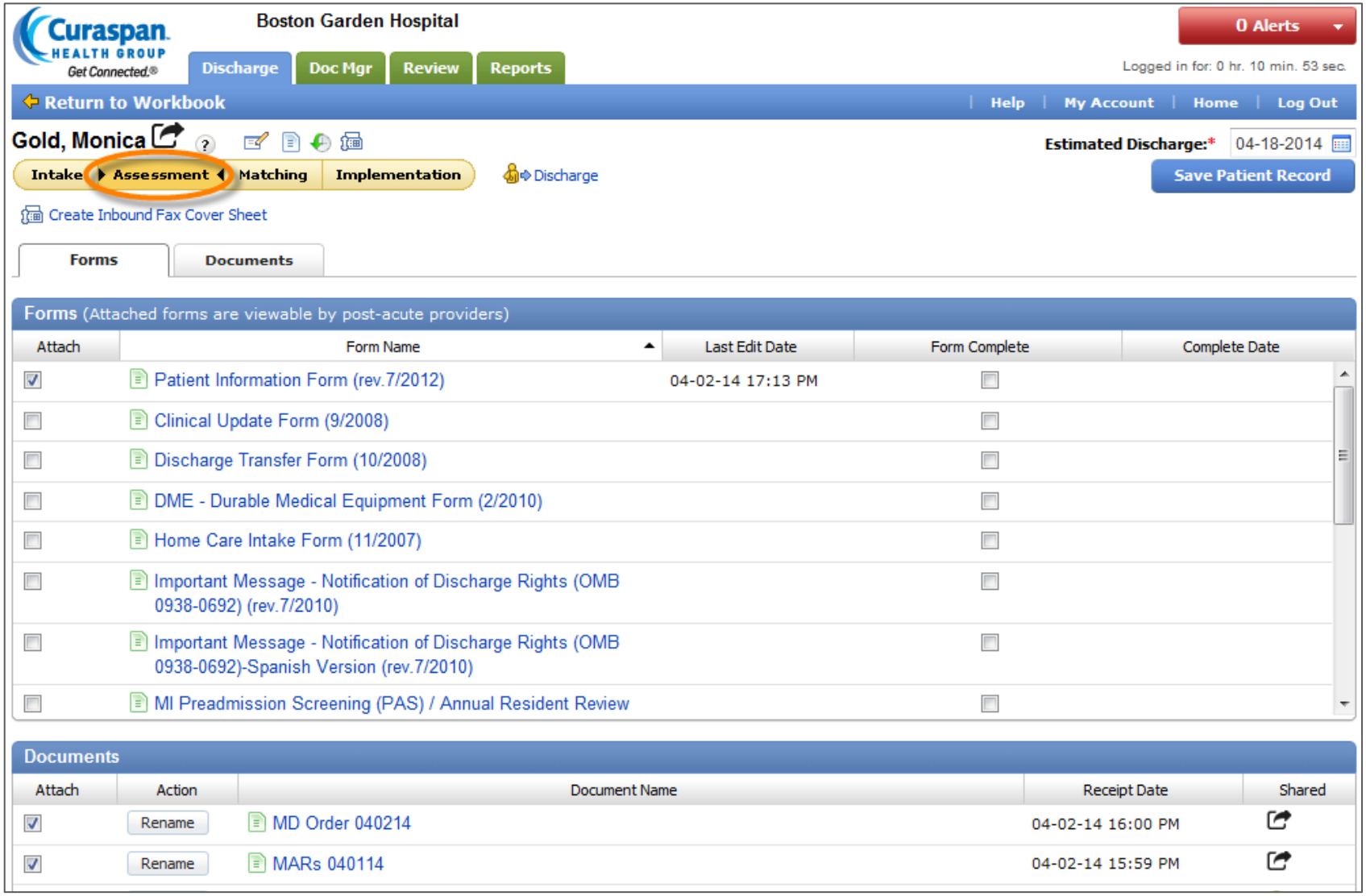


Automate. Collaborate. Optimize.

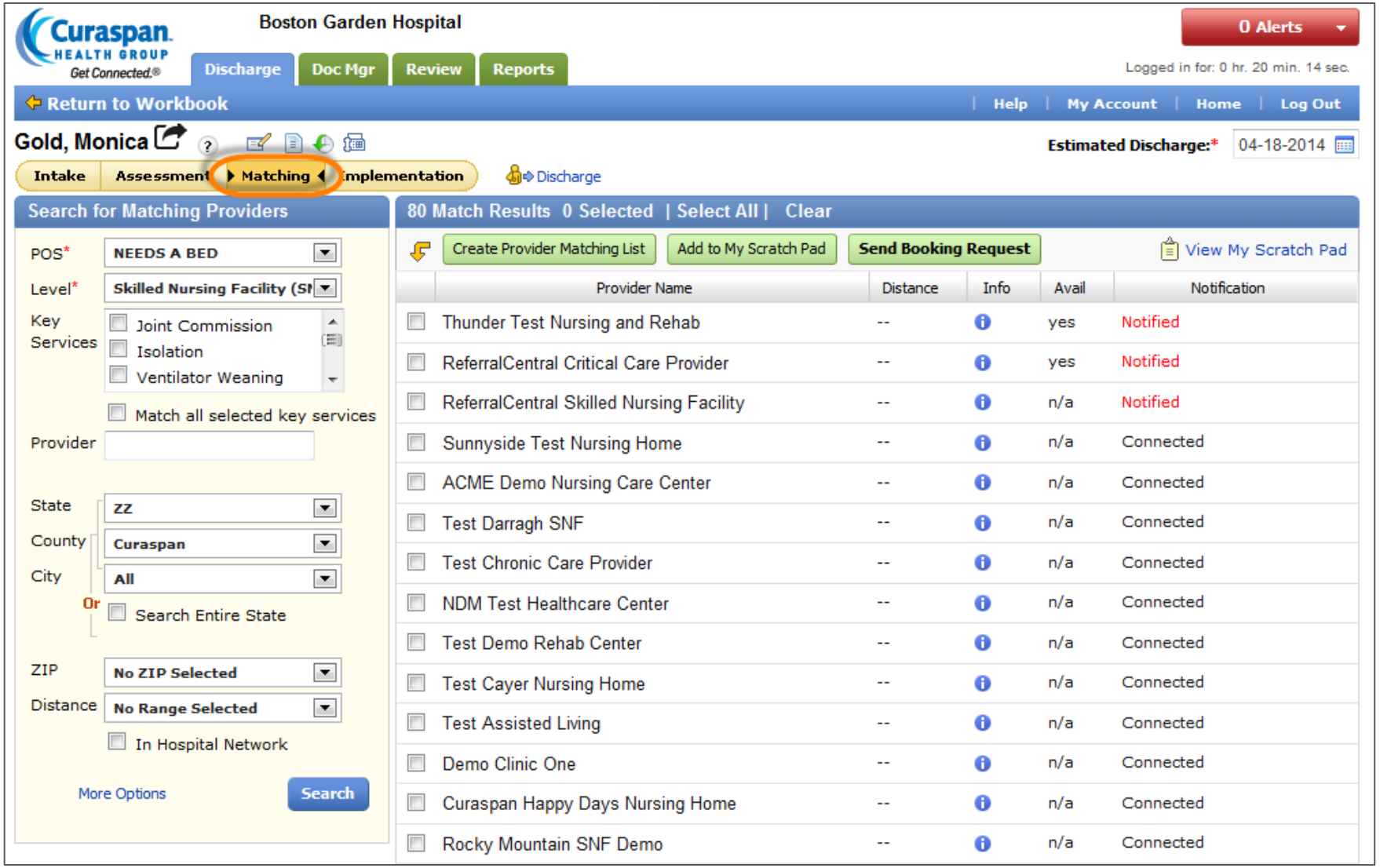


- Streamline and automate manual, administrative tasks
- Easily identify qualified post-acute care providers
- Securely share clinical information in real-time
- Gather key metrics on internal hospital processes and external provider performances

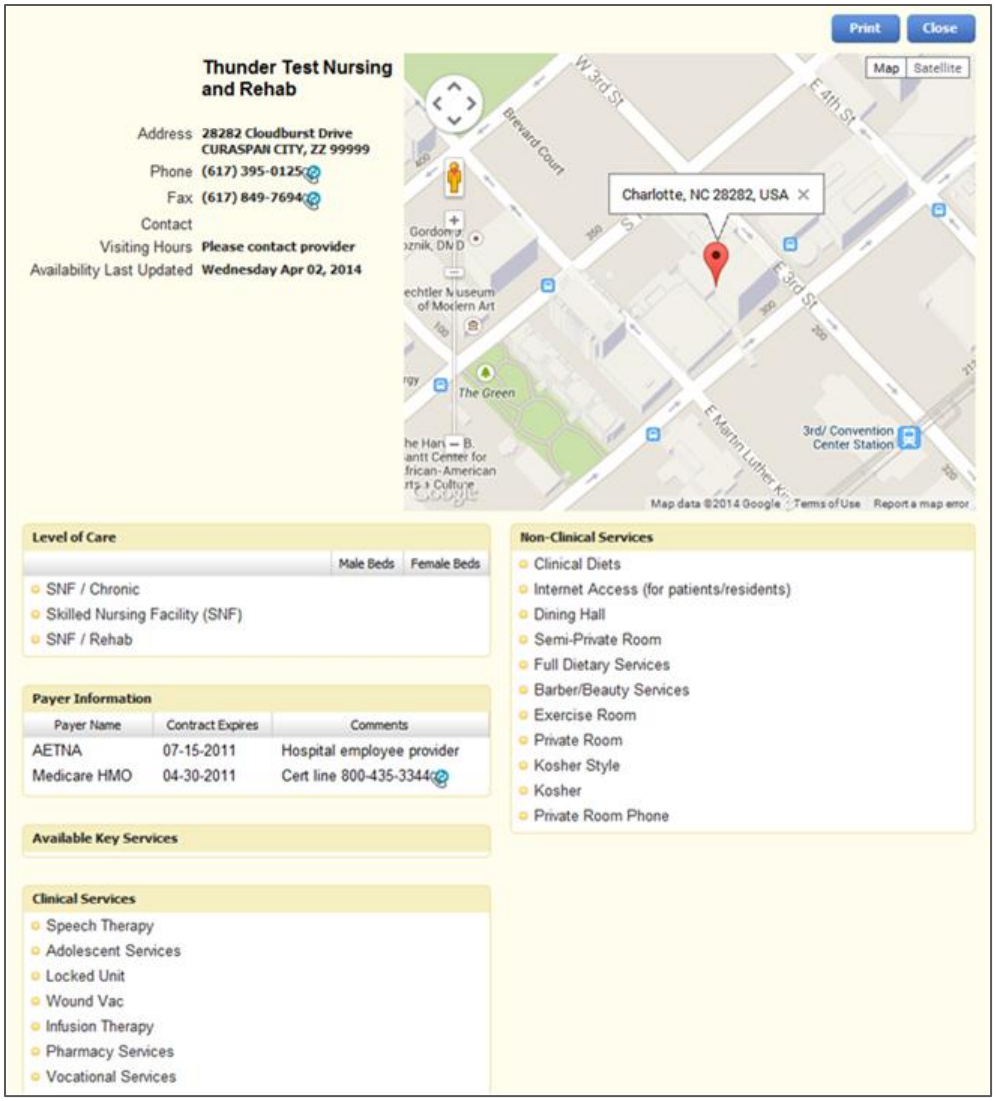
Save Time with Pre-populated Forms



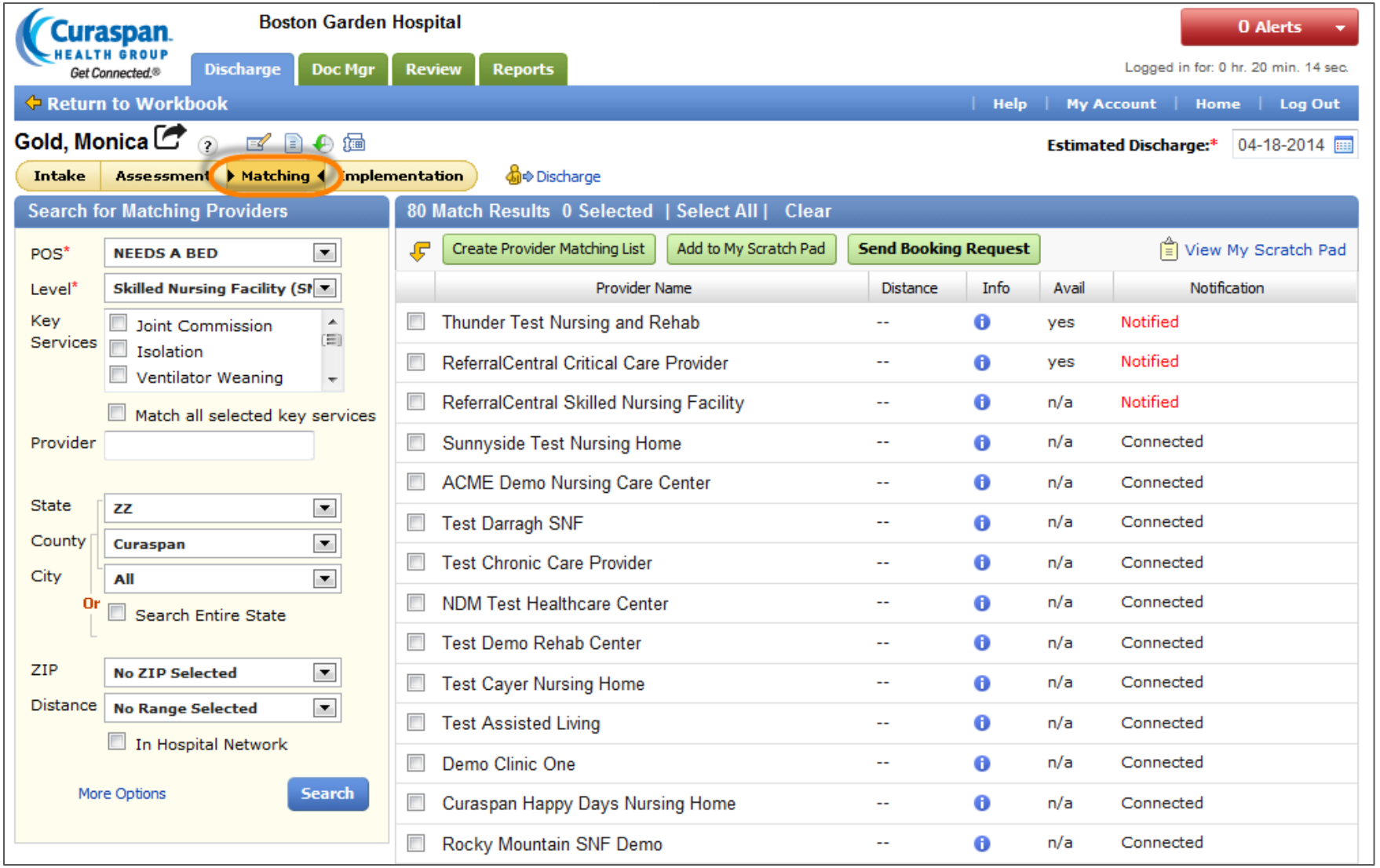
Search for Available and Qualified Providers



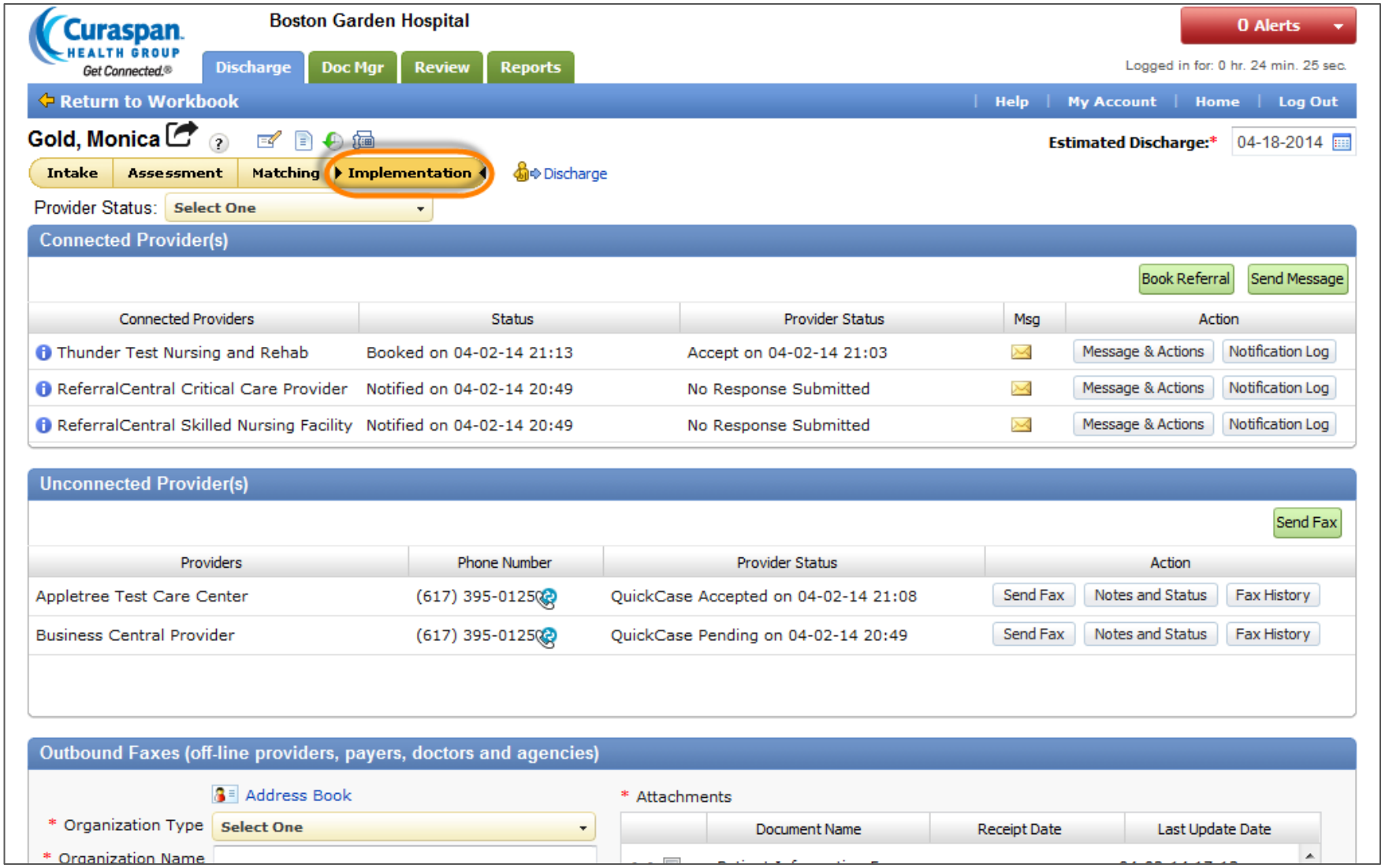
Share Detailed Provider Profiles



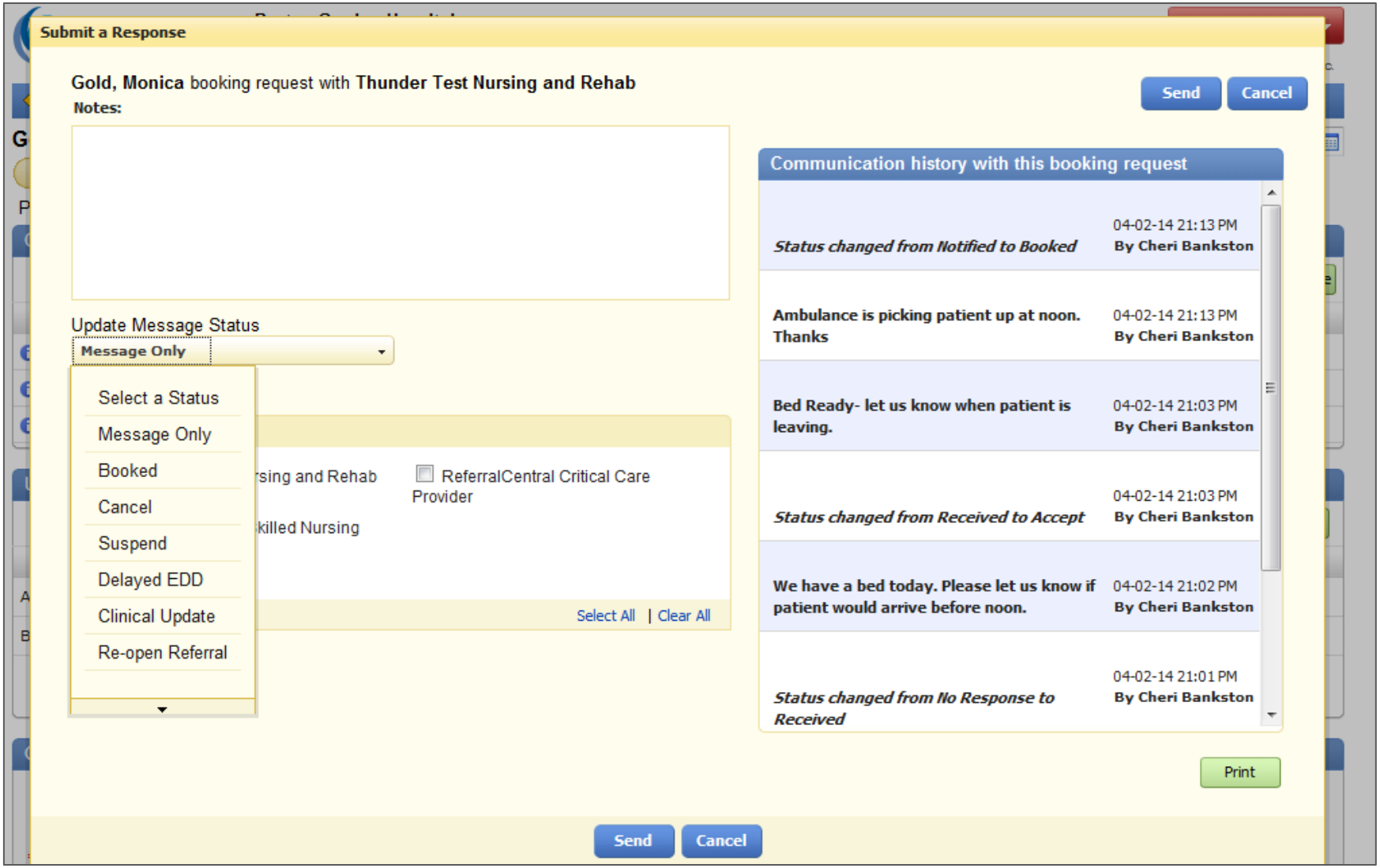
Send Referral Packets to Multiple Providers Simultaneously



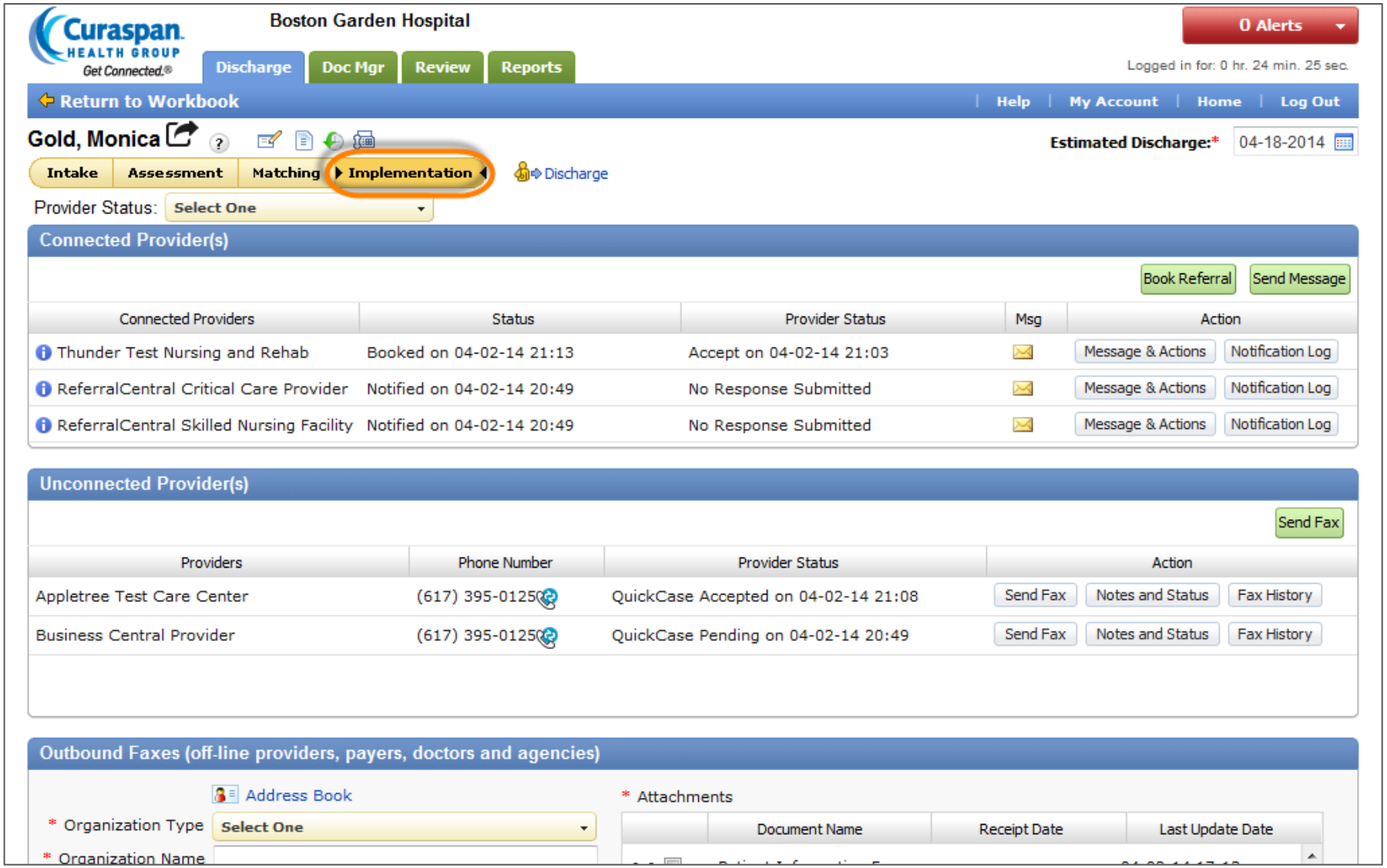
View All Referral Activity in One Place



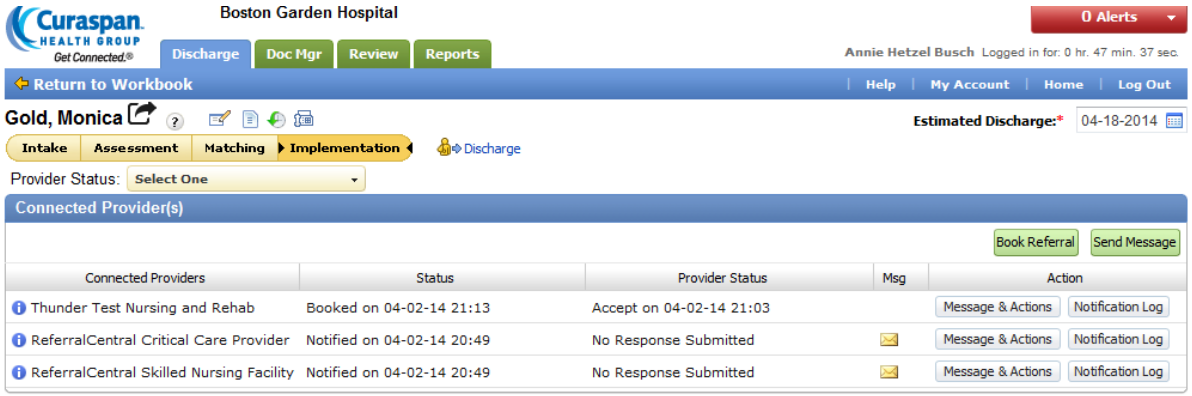
Communicate with Providers Securely

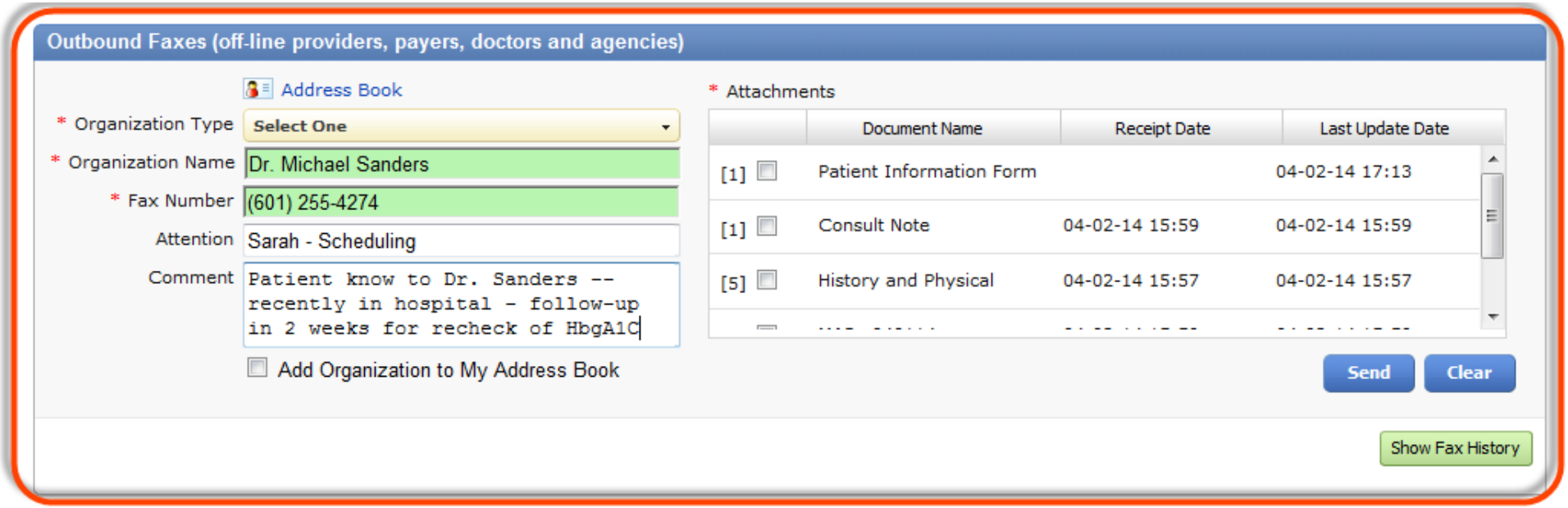


Notify All Providers When Referral is Booked



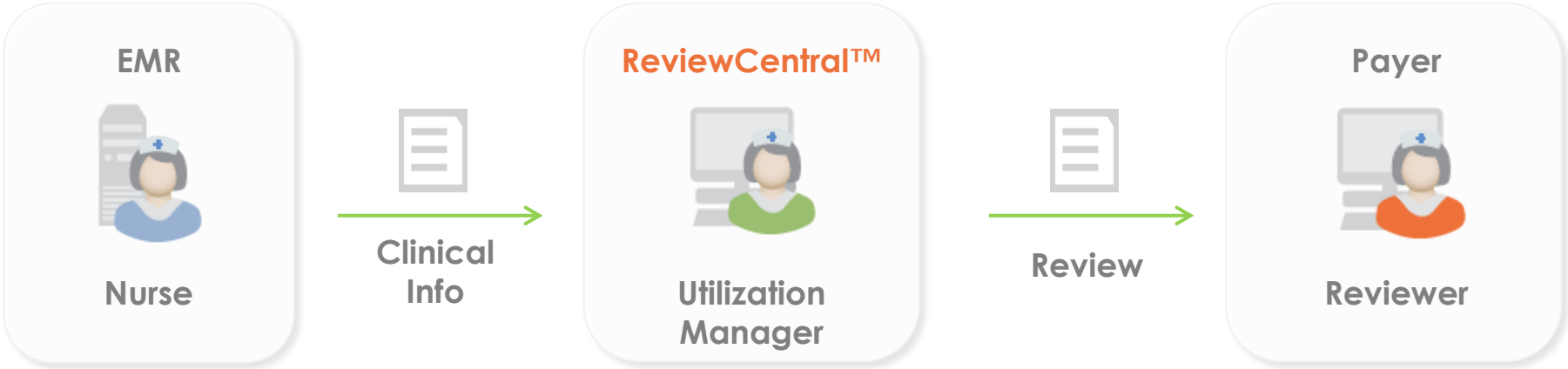
Involve Other Members of the Care Continuum





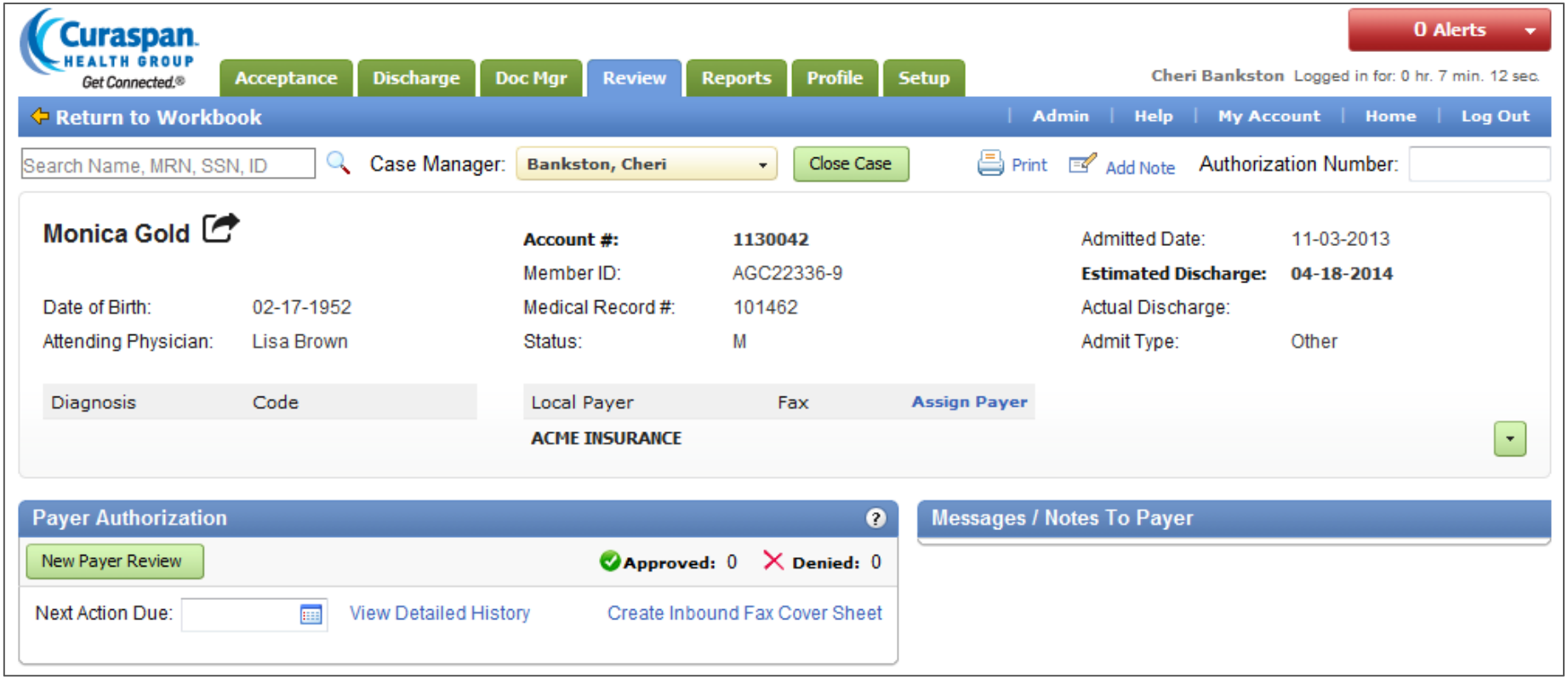
DischargeCentral® 12.6.3|2|prd

Automate. Collaborate. Optimize.

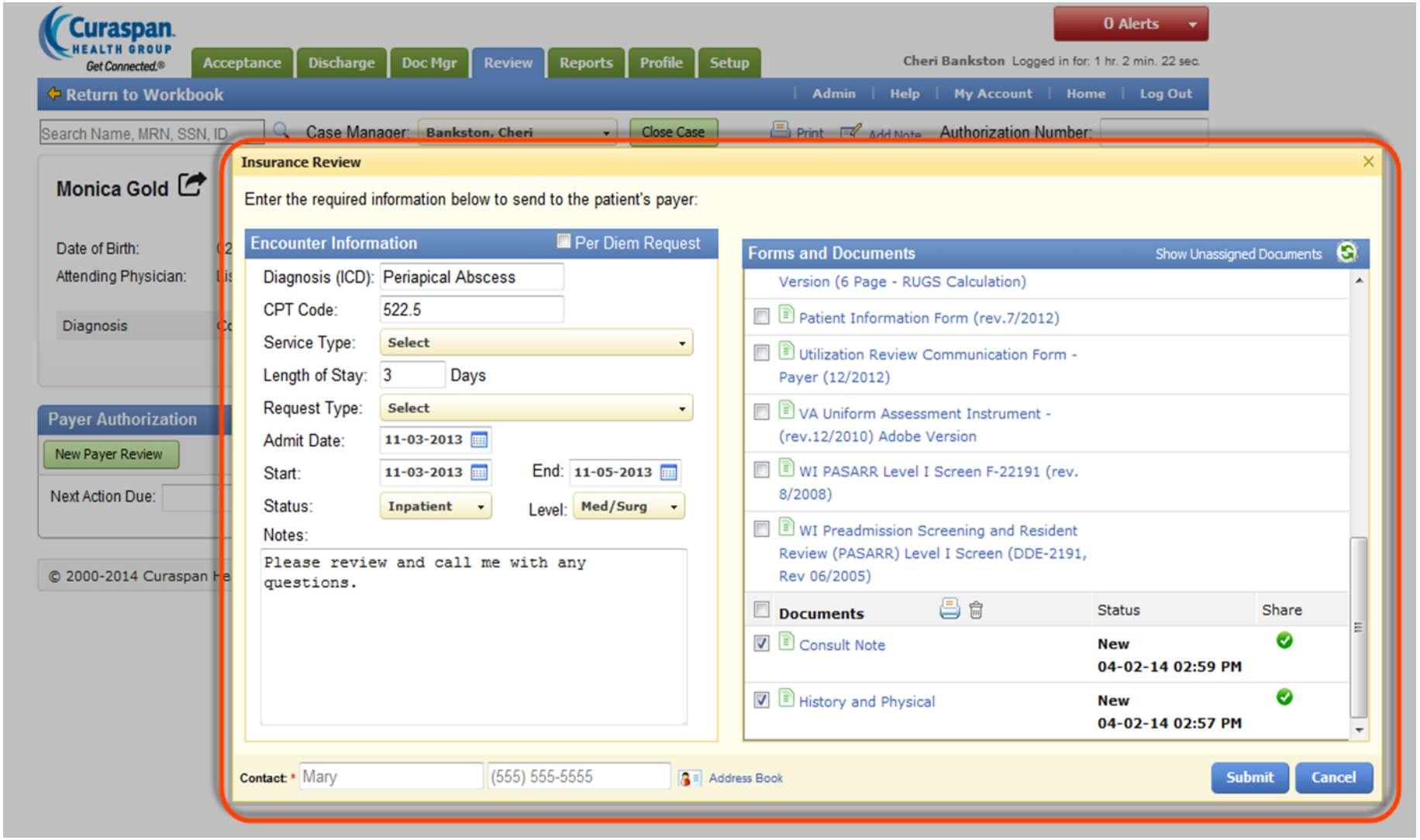


- Standardized workflow
- Secure, time-and-date-stamped communications
- Real-time workflow reminders
- Comprehensive reporting
- Improve internal communication with internal notebook and work lists

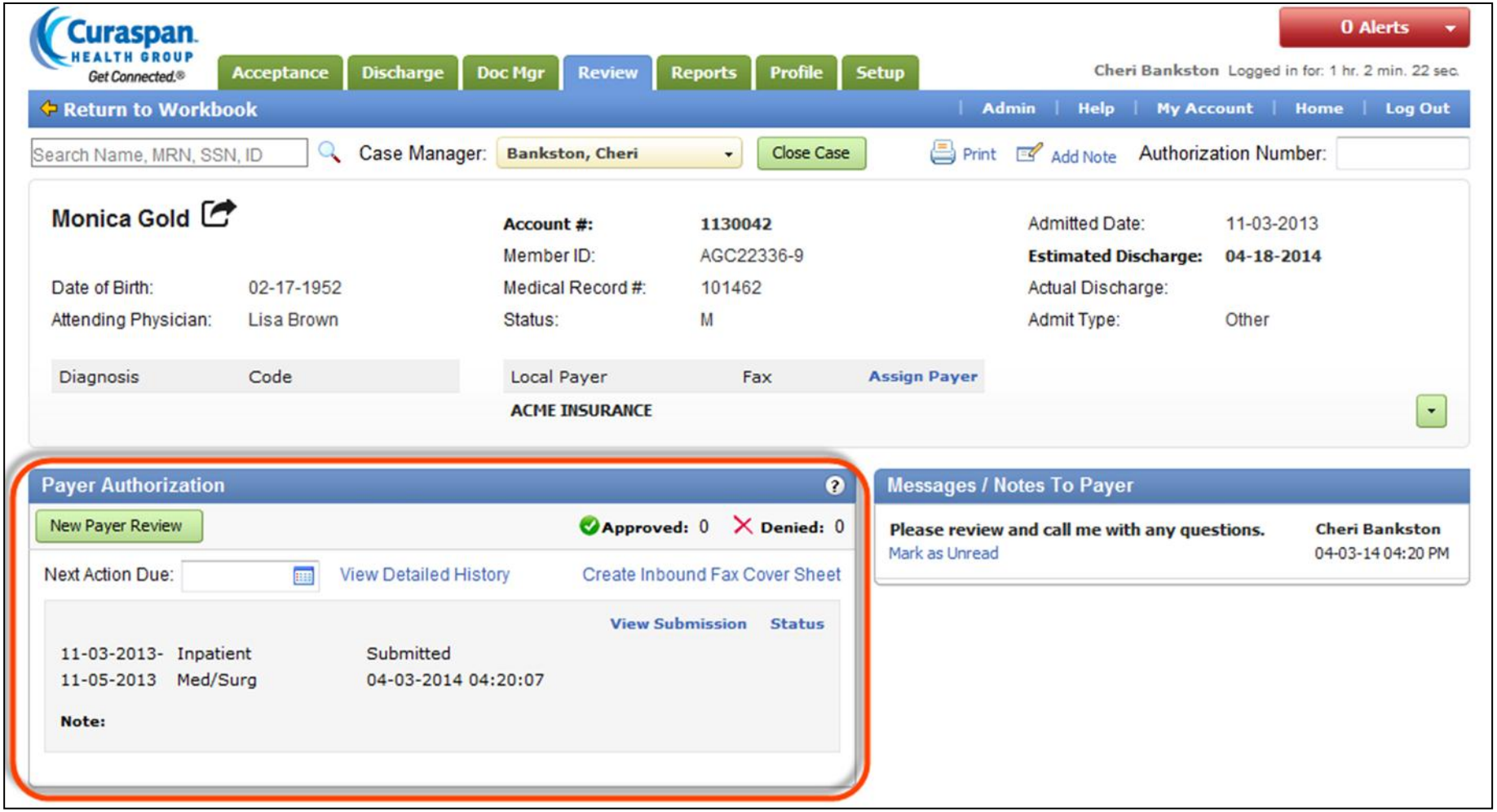
View All Relevant Patient Information in a Single Place



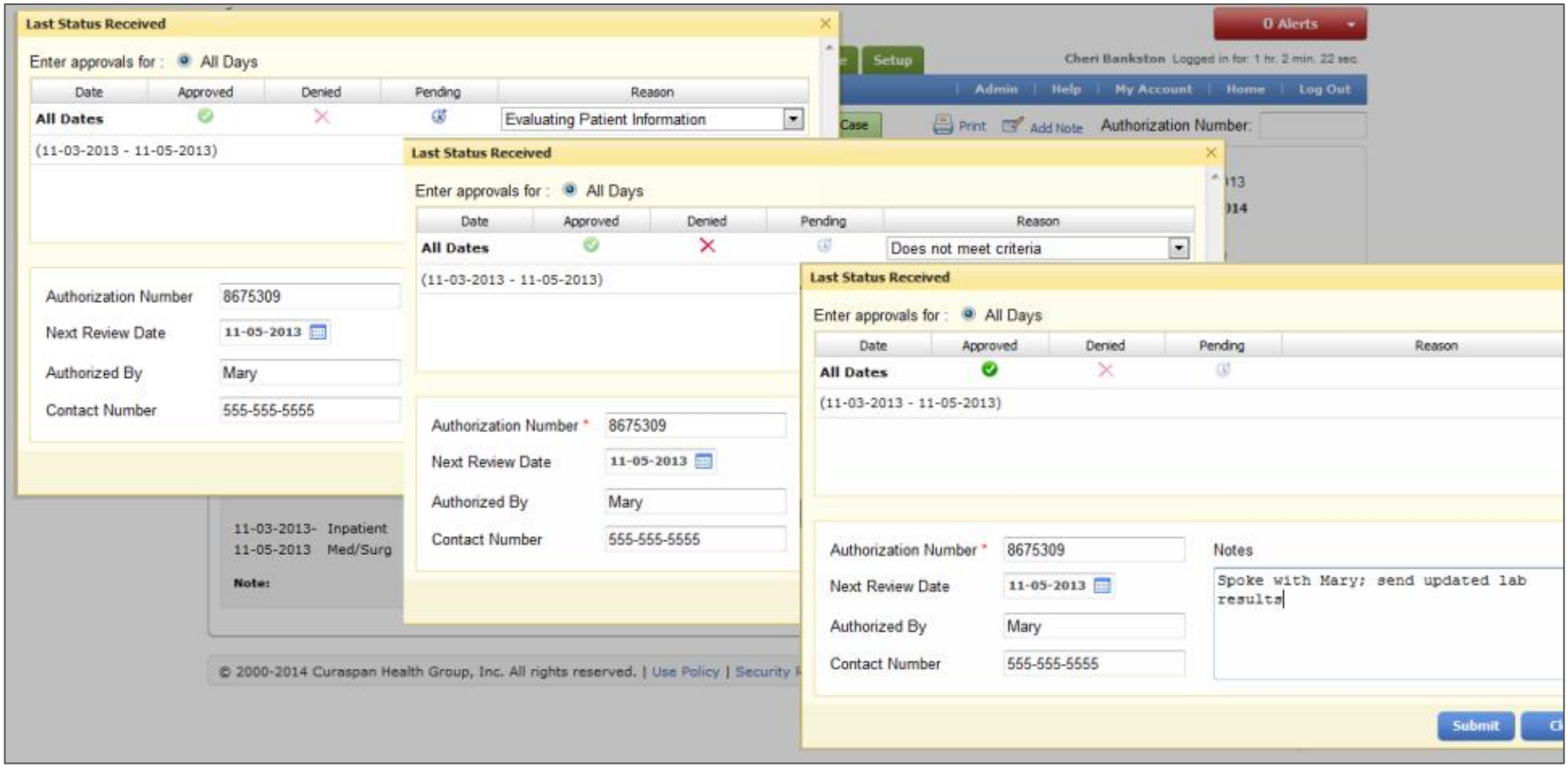
Create and Submit All Forms and Documents Electronically



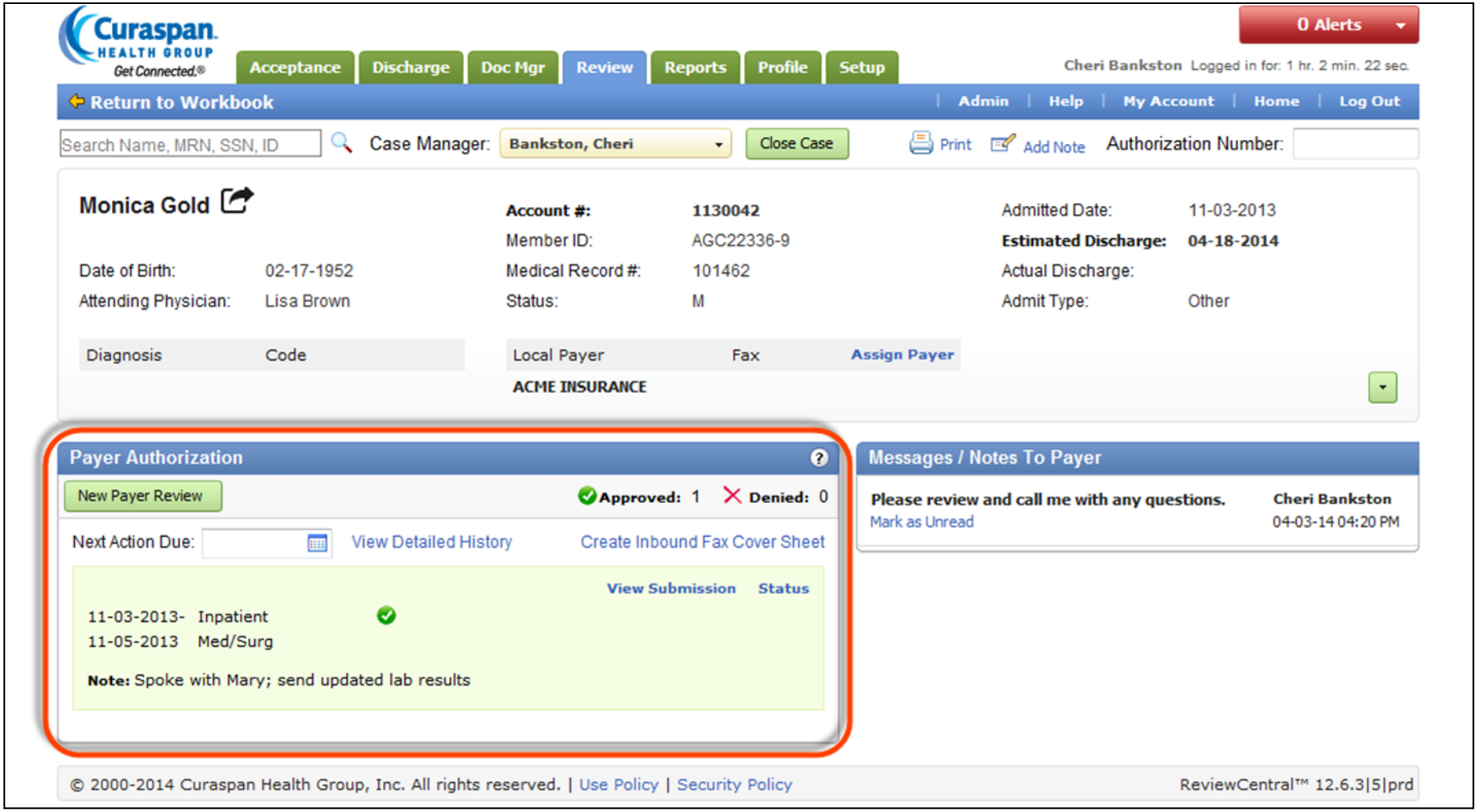
Monitor Submission Status



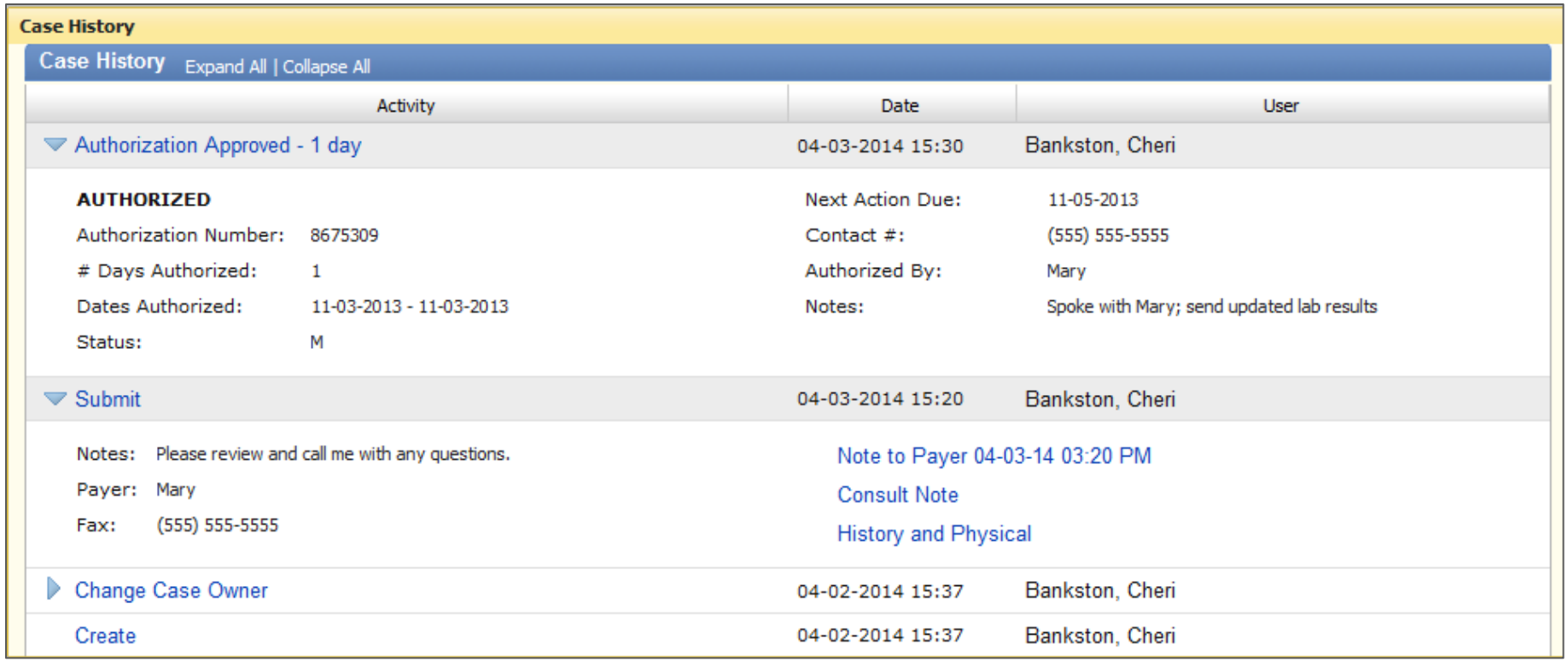
Document and Track Approvals and Denials



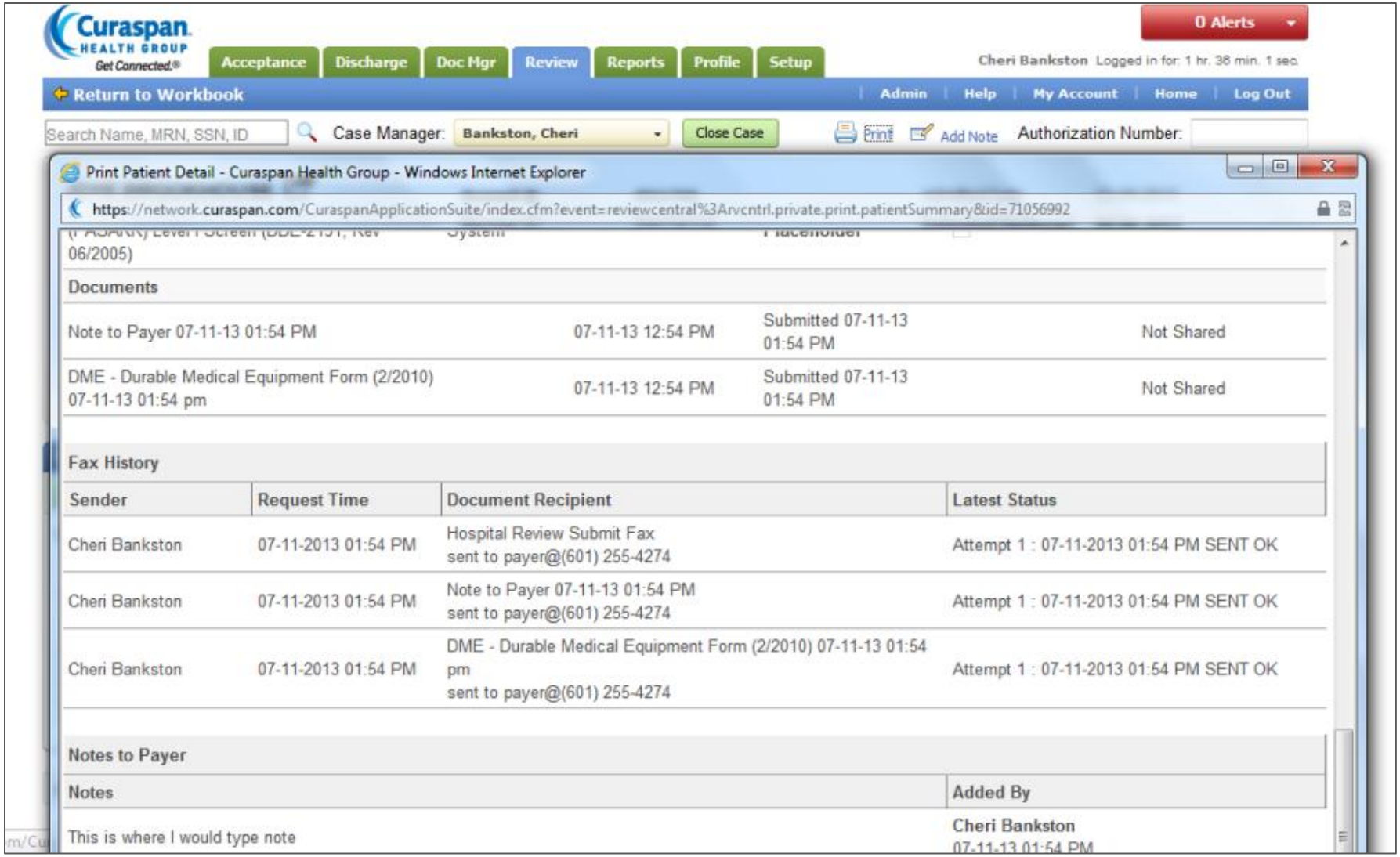
Track Approved Days



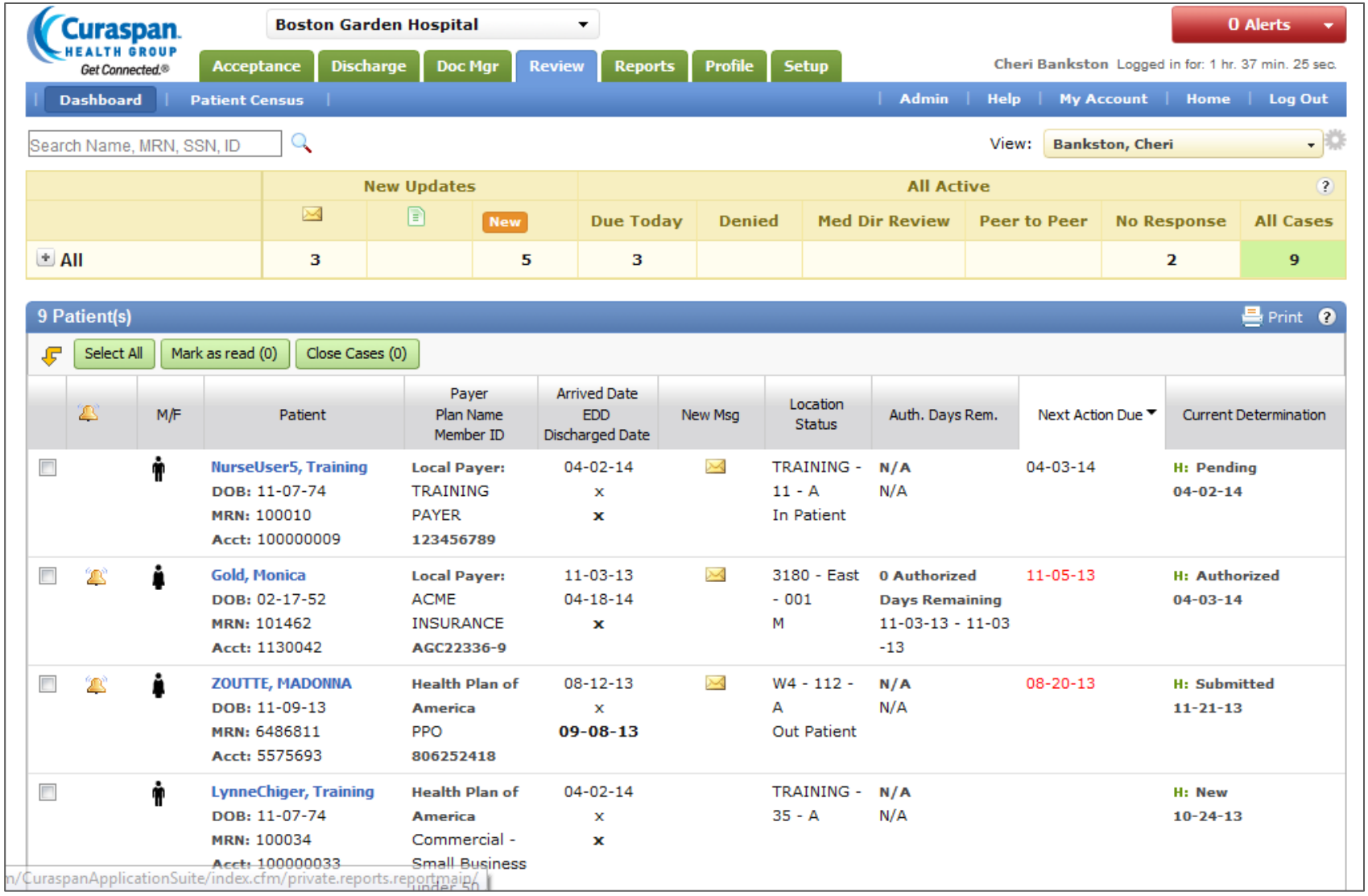
Access Robust Transaction Audit Trail



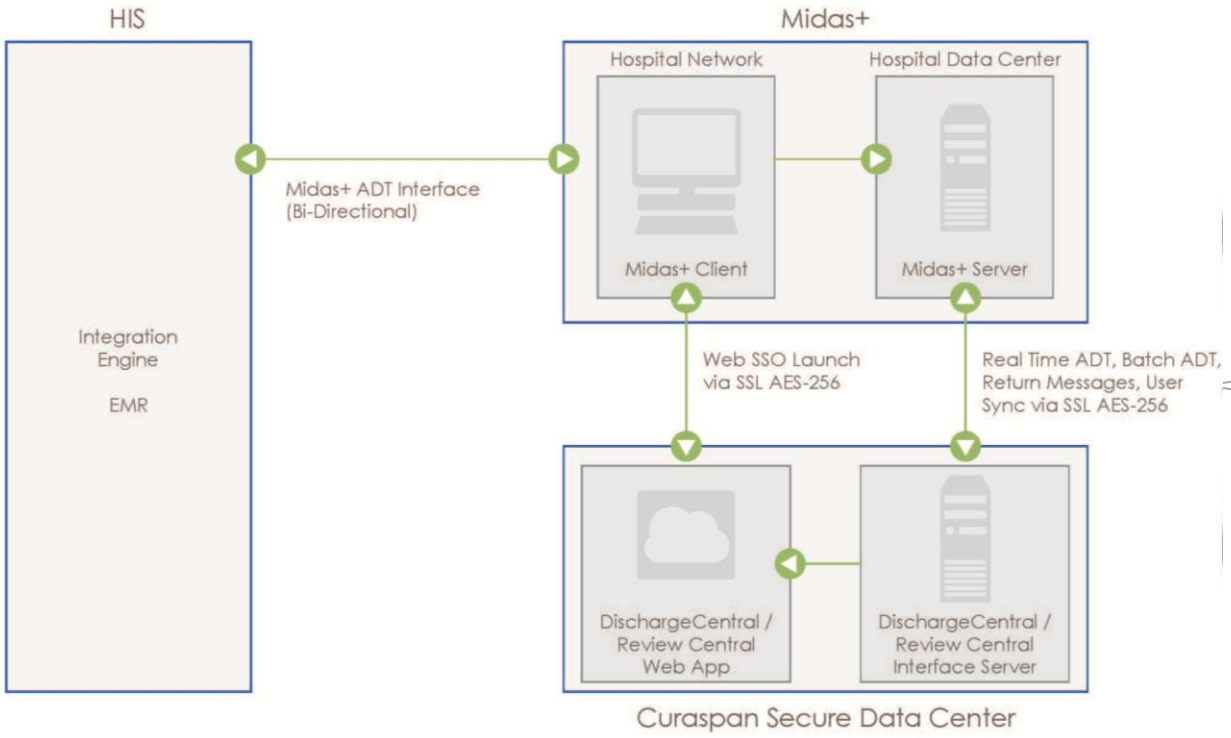
Store and Access Documentation of Successful Communication



Organize and Prioritize Cases



Integration Overview



The following data elements would be available for reporting:

- Referral Data & Time
- Provider(s) Referral
- Referral Type
- Referrer Case Worker
- Referral Status
- Provider Status
- Level of Care & Service Bed Type
- Anticipated Start Date
- Actual Start Date
- Discharge Status
- Booked provider
- Discharge Delay Reason
- Payer Authorization Numbers
- Number of Days Authorized

Share information with clinical and utilization review team members in real time

Reduce redundant tasks and eliminate duplicate documentation

Access shared data for more complete reporting

Reporting

Executive Leadership Reports

- LOS Savings
- LOS Comparison
- Days Saved for Facility Placements
- Provider Scorecard (summary)
- Referrals In/Out of Network (summary)

Compliance Reports

- Home Care – Start of Care
- Discharge Disposition Discrepancies
- Early Warning - Referral-Pattern Changes
- Post-Discharge Release of Information
- PASRR Completion

Care Management Reports

- Readmissions by:
  - Placement
  - Diagnosis
  - Provider
  - Physician
- New Placement vs. Returns
- Referral Process Timeline
- Barrier Days
- Case Manager Referrals
- Decline Reasons
- Delay Reasons
- Payer Bookings

Operations Reports

- Placement Cycle Times
- Referrals – In/Out Network (detail)
- Total Discharges
- LOS Variance
- LOS Quarterly Comparison
- Provider Scorecard (detailed)
- Unit Statistics
- Inpatient Length of Stay
- One-Day Stay

Readmission Dashboard

Provider

Patient Age

Physician

Diagnosis

Payer

Date Range

Date Range | Patient Age | Diagnosis | Payer | Physician | Provider

Reports

Back to Report List

Provider

Age: All

Previous Attending: All

Previous Booked Provider: All

Previous Diagnosis: All

Previous Payer: All

Period: Last Month

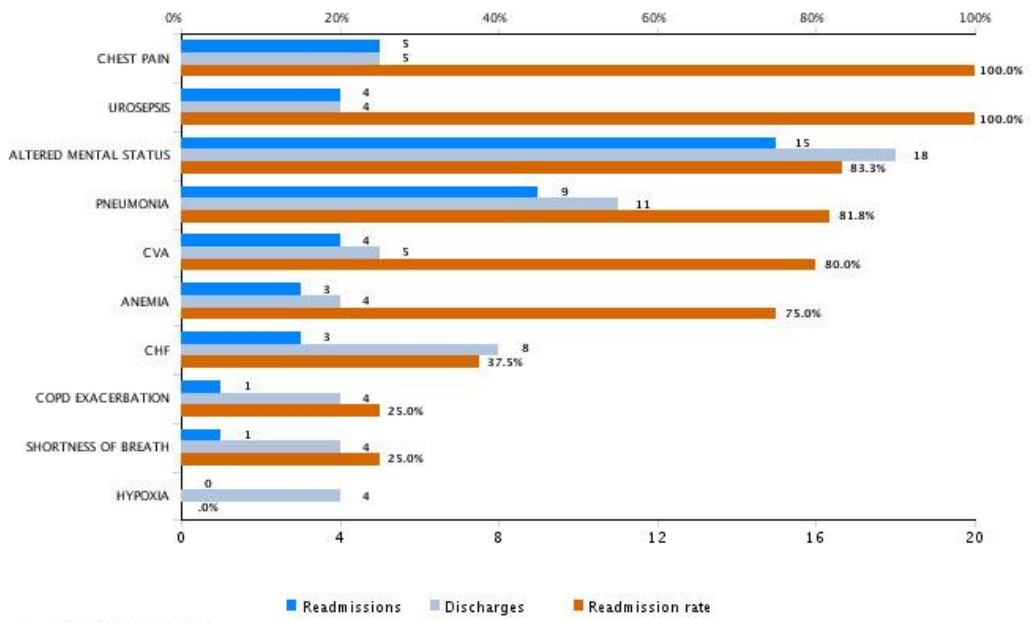
From 01-01-2009 To 12-31-2009

Generate Report

***NEW* Readmissions**

By Date | By Age | By Diagnosis | By Payer | By Physician | By Provider

Highest Rates Per Discharge | Lowest Rates Per Discharge | Export to Excel



Insight Into Provider Performance

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Provider Placements and Return Summary Report

Discharge Date: **2/1/2014 to 2/28/2014**

[redacted] Hospital

Provider Name	Enabled	Total	Accept	Received	Declines	Bookings	Placements	Returns
[redacted]	yes	37	25	37	1	28	28	0
[redacted]	yes	33	27	33	7	25	25	0
[redacted]	yes	33	21	33	5	23	23	0
[redacted]	yes	29	19	29	2	23	23	0
[redacted]	yes	26	5	26	2	11	11	0

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Provider Scorecard

Discharge Date: **2/1/14 to 2/28/14**

[redacted] Hospital

	Patients Referred	Total Placements	Conversion Rate	Response Time (In Hours)	Acceptance Time (In Hours)
Level of Care Totals: Acute Rehabilitation Facility (hospital or unit) (IRF)	10	5	50.00%	0.35	0.00
[redacted]	3	2	66.67%	0.16	0.00
[redacted]	2	1	50.00%	0.82	0.00
[redacted]	1	1	100.00%	0.20	0.00
[redacted]	1	1	100.00%	0.05	0.00
[redacted]	3	0	0.00%	0.36	0.00

The calculation for this report is looking at referrals made to Enabled Providers only, and measures their response times and other core measures.

Insight Into Internal Processes

curaspan™

Monthly Average Length of Stay by Discharge Disposition Grouping

Discharge Date: [redacted]

	1/2010	2/2010	3/2010	4/2010	5/2010	6/2010	7/2010	8/2010	9/2010	10/2010	11/2010	12/2010
F	**7.96**	**8.03**	**9.02**	**7.45**	**9.45**	**8.15**	**8.40**	**9.05**	**8.15**	**7.05**	**7.28**	**7.04**
TX ADULT CARE FACILITY	4.50	3.94	6.09	5.06	4.85	4.00	5.08	4.35	3.76	4.37	4.62	4.67
TX Hosp w/ Swing Bed	0.00	0.00	0.00	0.00	0.00	0.00	4.00	0.00	0.00	0.00	0.00	0.00
TX HOSPICE FACILITY	8.33	4.20	5.00	13.33	6.75	9.88	9.50	6.00	12.75	5.50	13.25	5.33

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[redacted] Referral Process Timeline

Discharge Date: 3/1/2014 to 3/31/2014

[redacted] Hospital

	# of Patients referred thru eDc	Average Days from Admit to 1st Referral	Average Days from 1st Referral to Discharge
Level of Care: Skilled Nursing Facility (SNF)	304	2.71	2.45
Level of Care: Acute Rehabilitation Facility (hospital or unit) (IRF)	38	6.27	5.33
Level of Care: Home Health Agency	481	2.16	1.74
Level of Care: Long Term Care Hospital (LTCH)	10	6.14	8.11
Level of Care: SNF / Rehab	2	2.75	3.60
Totals:	**679**		

*** Patients may be counted under more than one level of care if notifications are sent on more than one level of care.*

This report represents the referral process through eDischarge based on the Level of Care for the notifications. The average day the first referral is sent is captured based on referral date/time stamps for notifications. The average number of days from first referral to discharge is calculated using the captured first notication date/time stamp and discharge date for all patients in the level of care selected.

Information At-a-Glance

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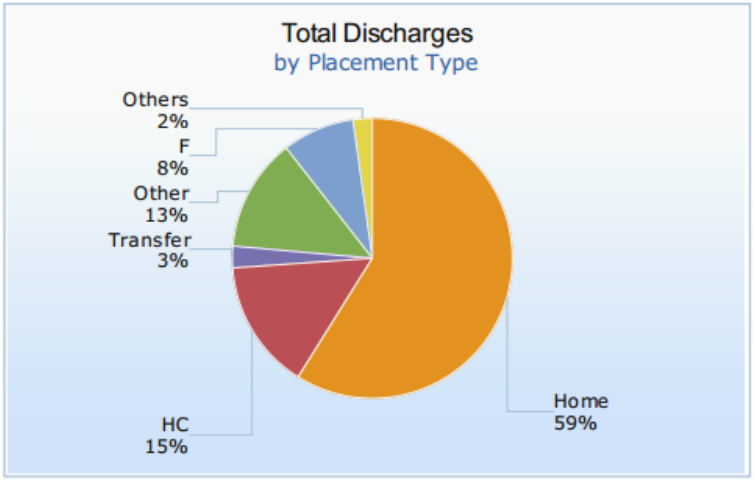
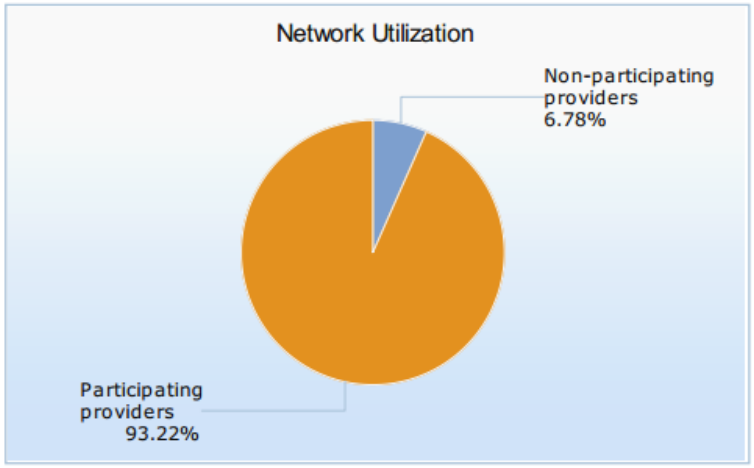
Get Connected.

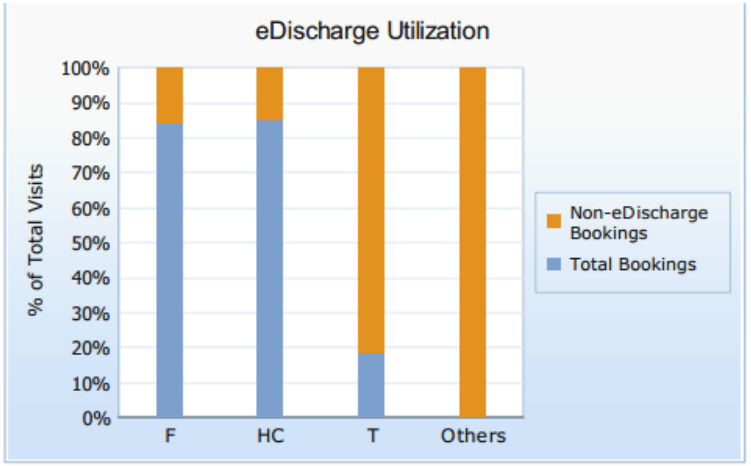
Monthly Summary Report - Total Discharges

Discharge Date: **2/1/2014 to 2/28/2014**

[redacted] Hospital







Services

Before Implementation

Consultative sales process

- Cross-departmental interviews
- Access to dedicated clinical, technical and security subject matter experts at Curaspan
- Sharing of best practices

During Implementation

- Clinical workflow analysis and redesign
- Project management
  - Manage implementation schedule
  - Identify and overcome roadblocks
  - Oversee technology
- On-site training
- Network Development
  - Identify top providers in community
  - Educate providers on new workflows
  - Update provider service profiles

After Implementation

- Regular account check-ins
  - Data analysis
  - Best practices
  - Utilization review
- Ongoing monitoring of provider utilization
- Training & Education
  - Computer-based training
  - Regularly scheduled webinars
  - Monthly product and regulatory updates
- Customer Support
  - Representatives available via phone & e-mail

Post-discharge Interventions

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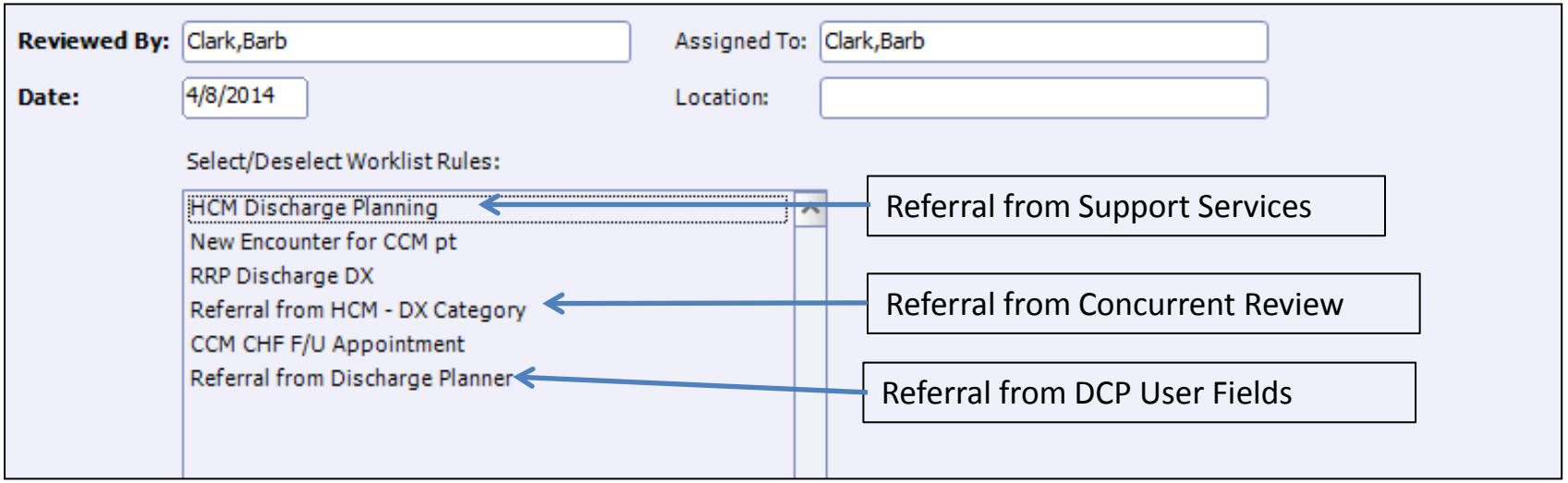
Referrals from Inpatient Discharges

Based on the Midas+ modules used from Hospital Case Management, worklist referral to any post-discharge Transitional Care Manager should be set up to be automatic.

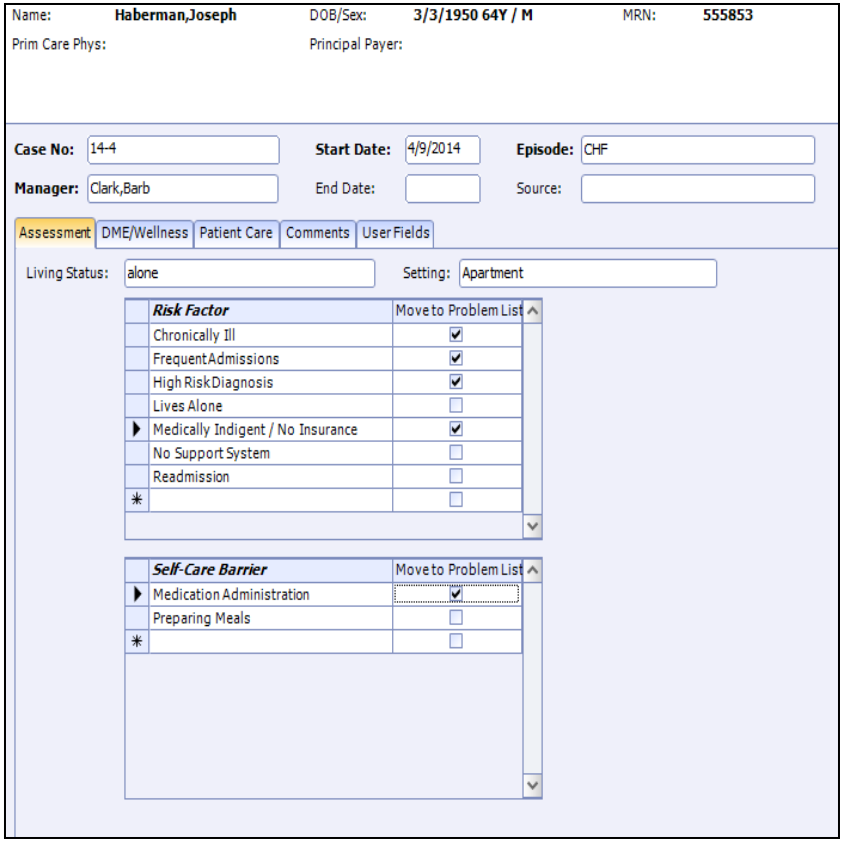


Information Flow from Discharge Planning to CCM Episode

- Site Parameter
  - Transfers data from HCM Discharge Planning
    - Assessment Tab
    - DME Tab
    - Patient Care Tab

CCM	**CMGE-LOAD UR DISCHARGE DATA**	Y or N	N		Choose Y to allow HCM Discharge Planning data from an Encounter to populate the CCM Episode Entry form.

Using CCM to Continue Post-discharge Follow-up: **Episode Entry**



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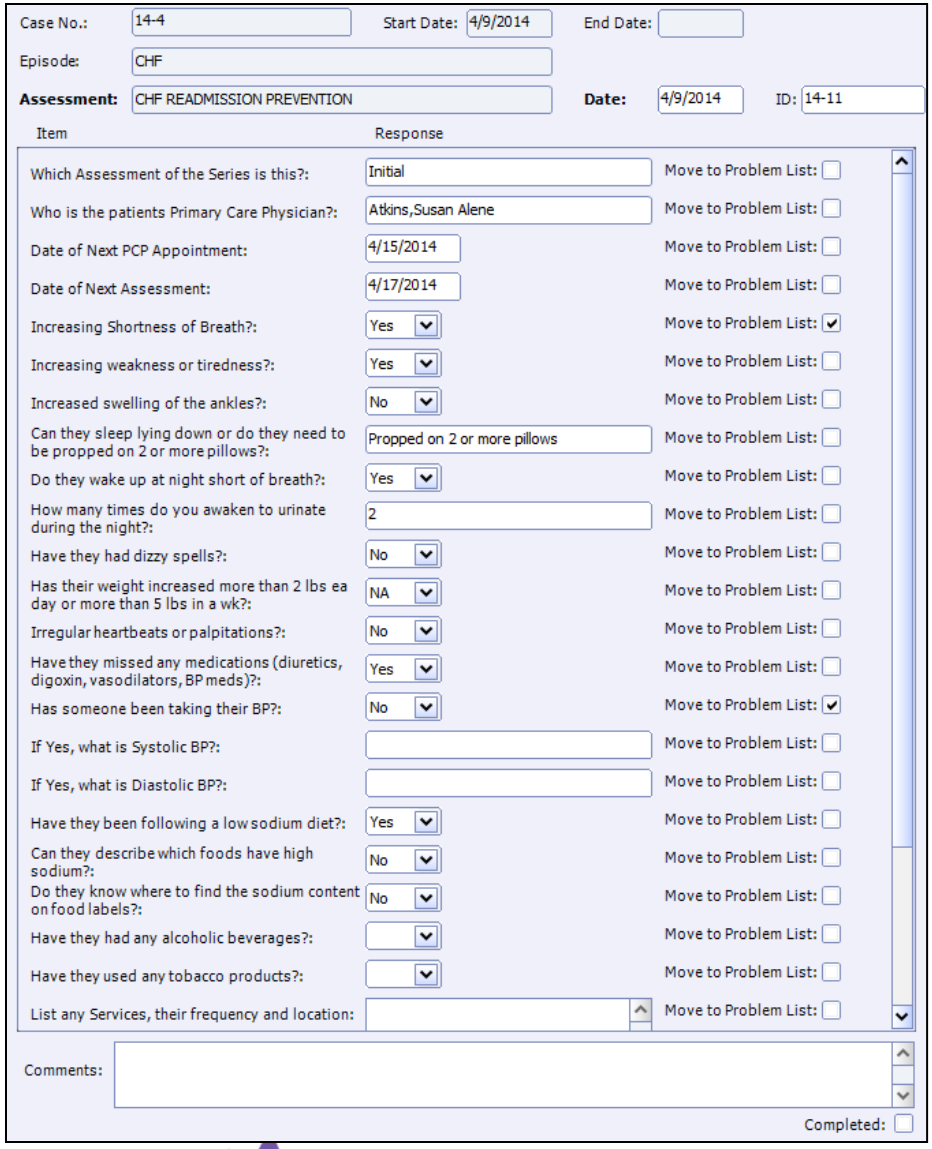
Using CCM to Continue Post-discharge Follow-up: **Assessments**



Case No.: 14-4 Start Date: 4/9/2014 End Date:

Episode: CHF

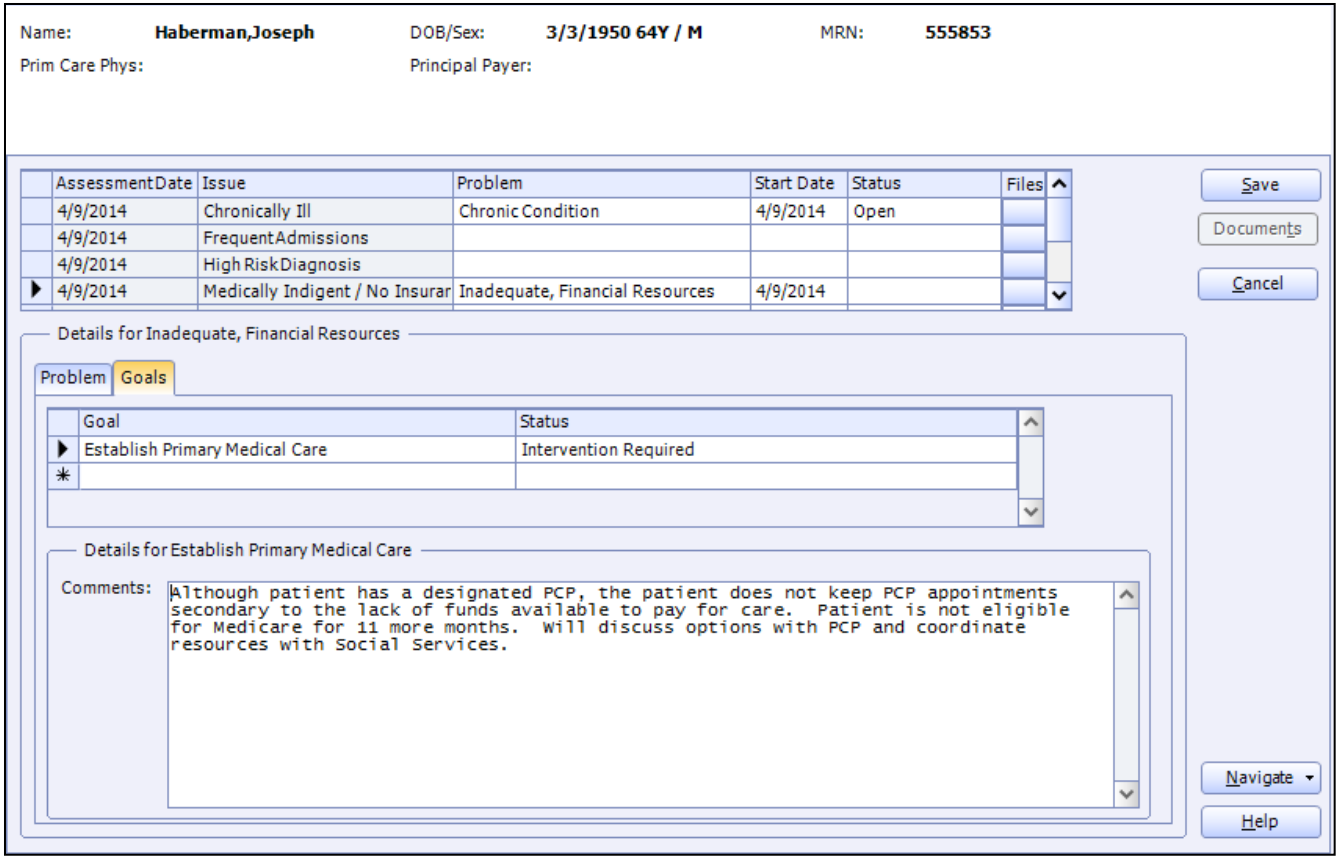
Assessment: CHF READMISSION PREVENTION **Date:** 4/9/2014 ID: 14-11

Item	Response	Move to Problem List:
Which Assessment of the Series is this?:	Initial	☐
Who is the patients Primary Care Physician?:	Atkins,Susan Alene	☐
Date of Next PCP Appointment:	4/15/2014	☐
Date of Next Assessment:	4/17/2014	☐
Increasing Shortness of Breath?:	Yes	☑
Increasing weakness or tiredness?:	Yes	☐
Increased swelling of the ankles?:	No	☐
Can they sleep lying down or do they need to be propped on 2 or more pillows?:	Propped on 2 or more pillows	☐
Do they wake up at night short of breath?:	Yes	☐
How many times do you awaken to urinate during the night?:	2	☐
Have they had dizzy spells?:	No	☐
Has their weight increased more than 2 lbs ea day or more than 5 lbs in a wk?:	NA	☐
Irregular heartbeats or palpitations?:	No	☐
Have they missed any medications (diuretics, digoxin, vasodilators, BP meds)?:	Yes	☐
Has someone been taking their BP?:	No	☑
If Yes, what is Systolic BP?:		☐
If Yes, what is Diastolic BP?:		☐
Have they been following a low sodium diet?:	Yes	☐
Can they describe which foods have high sodium?:	No	☐
Do they know where to find the sodium content on food labels?:	No	☐
Have they had any alcoholic beverages?:		☐
Have they used any tobacco products?:		☐
List any Services, their frequency and location:		☐

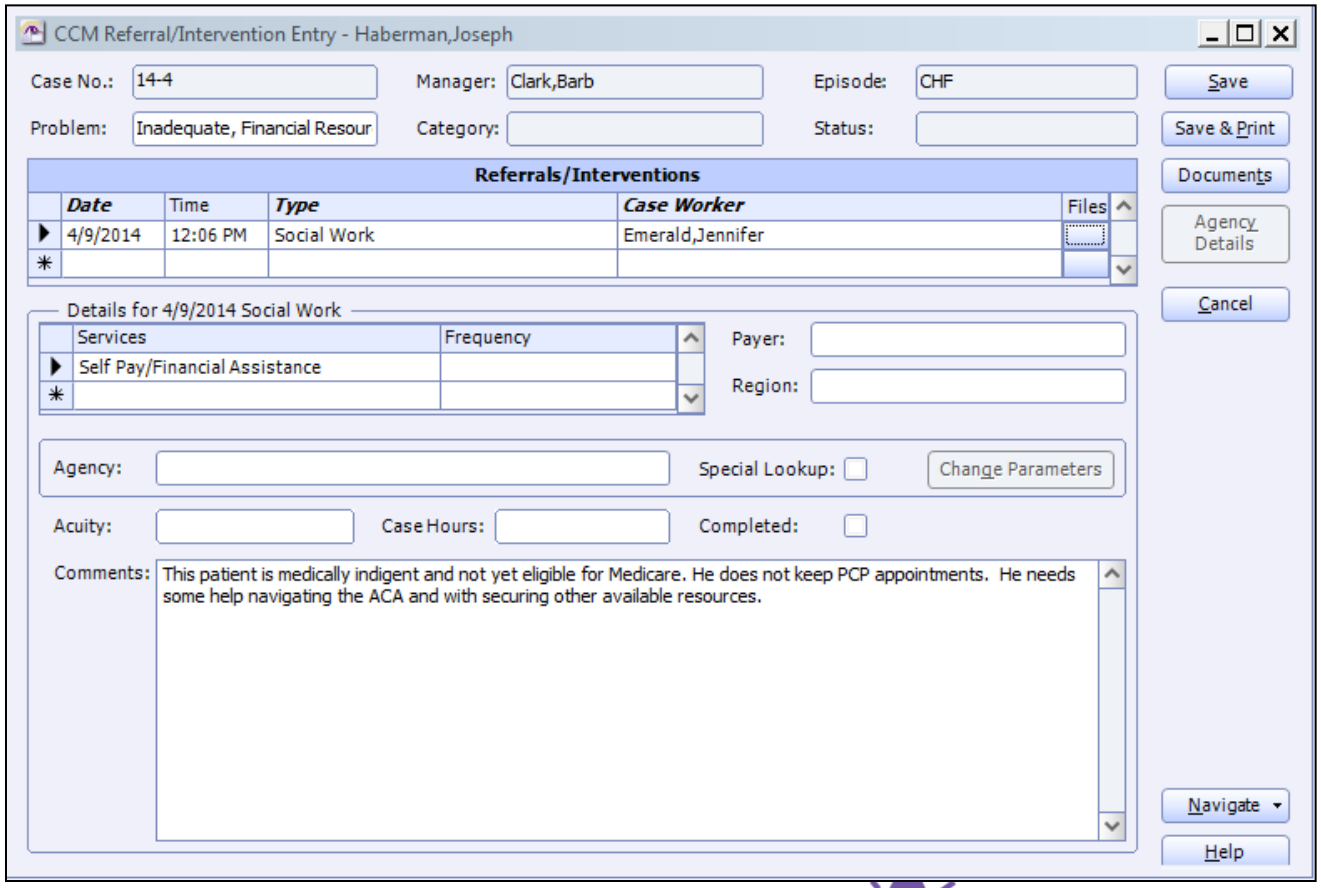
Comments:

Completed: ☐

Using CCM to Continue Post-discharge Follow-up: **Problem List**



Using CCM to Continue Post-discharge Follow-up: **Referrals and Interventions**



Evidence-based Models of Transitional Care

- Care Transitions Intervention (CTI)
- Transitional Care Model (TCM)
- Better Outcomes for Older Adults through Safe Transitions (BOOST)
- The Bridge Model
- Guided Care Geriatric Resources for Assessment and Care of Elders (GRACE)
- Project RED (Re-Engineered Discharge)

Joint Commission Hot Topics in Health Care: "Transitions of Care"
June 2012

Common Elements of Transitional Care Models

Multidisciplinary communication, collaboration, and coordination from admission through transition

- Must include patient and caregivers
- Care Team includes physician, nurse, pharmacist, social worker
- Includes active daily patient teaching
- Includes self-management of medications

Joint Commission Hot Topics in Health Care: "Transitions of Care"
June 2012

Common Elements of Transitional Care Models

Clinician involvement and shared accountability during all points of transition

- Includes both sending and receiving clinicians
- Care Coordinator is identified
- There is a written exchange of information as well as verbal

Joint Commission Hot Topics in Health Care: “Transitions of Care”
June 2012

Common Elements of Transitional Care Models

There is comprehensive planning and risk assessment throughout the hospital stay

- Discharge Planning begins at admission
- Patients are assessed during their stay for risk factors that limit self care including:
  - Low literacy
  - Multiple Chronic Conditions
  - Poly-pharmacy
  - Poor self-health ratings

Joint Commission Hot Topics in Health Care: "Transitions of Care"
June 2012

Common Elements of Transitional Care Models

Standardized transition plans, procedures, and forms

Written plans and Discharge Summaries include:

- Active Issues
- Diagnoses
- Medications
- Needed Services
- Warning signs of worsening condition
- Whom to contact 24/7 in case of emergency

Joint Commission Hot Topics in Health Care: "Transitions of Care"
June 2012

Common Elements of Transitional Care Models

Timely follow-up, support, and coordination

- Telephone or in-person follow-up, support, and coordination
- Performed by Case Manager, Social Worker, nurse, or other health care provider
- Provided within 48 hours after discharge
- Patients have a 24/7 number to call for information, reassurance, and advice

Joint Commission Hot Topics in Health Care: "Transitions of Care"
June 2012

Community Coordination

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Community Coordination

Center For Pathways Community Care Coordination
Rockville Institute for the Advancement of Social Science (transitioned from AHRQ)

- Community care coordination is the process of Identifying and engaging individuals within their community home setting
- Assessing their health and social needs
- Connecting them to the health and/or social services they need

https://www.rockvilleinstitute.org/CPCCC/mission.asp

Outcome Metrics

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Outcome Metrics

- LOS
- RSRRs
- HWRR
- Returns to ED
- % ED patients admitted
- % Total Inpatients admitted via ED
- Tracking Readmissions from sub-acute providers
- Assessing Quality of Interventions – outcomes
- Discharged pts. with ED visit within 10 days

Outcome Metrics Available in DataVision

- HCAPS – CDBR:1251
- HBIPS
- Readmission measures
- CMS Readmissions Reduction Program Indicators
- Facility Profile – Readmission Measures

Outcome Metrics

Indicator	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013
General Measures						
All Inpatient Encounters	1412	1504	1488	1563	1644	1670
Average Inpatient Length of Stay	3.69	3.62	3.34	3.61	3.58	3.80
Inpatient Readmissions within 30 Days	20.1 %	22.2 %	18.7 %	19.3 %	18.1 %	17.9 %
Emergency Department Case Management						
Total Emrgency Encounters by Discharge Disposition	232	452	373	376	309	219
Home	215	424	346	357	284	191
Transfer AC	7	10	17	10	14	10
AMA	3	8	8	5	4	13
Expired	0	3	1	0	2	0
Psych DC to AC	2	1	1	3	2	3
Rehab	0	1	0	0	0	1
SNF	2	4	0	1	3	1
Other	3	1	0	0	0	0
Returns to the ED within 10 days	12.9 %	16 %	14.3 %	15.5 %	13.2 %	12.9 %
Admissions to Acute Care from ED (of total ED visits)	19 %	8 %	7 %	6 %	9 %	14 %
Number of Reviews on ED Patients	5	6	14	22	28	47
Pre-Discharge Measures						
Inpatients Discharged Home with Documented Teachback Used	623	501	512	624	530	482
Inpatients Discharged Home with Documented Patient PASS	72.9 %	72.7 %	74.2 %	74 %	75.8 %	74.1 %
Post-Discharge Measures						
Inpatients Discharged Home Referred to CCM from HCM	6.2 %	8.1 %	7.7 %	7.4 %	8.3 %	9.1 %
Patients on CCM/TCM Program Readmitted within 30 Days	8.2 %	7.2 %	7.1 %	6.8 %	6.3 %	6.3 %
Inpatients Discharged with Visit to Ed within 10 Days	7.6 %	7.7 %	7.4 %	6.9 %	6.7 %	6.6 %
DataVision Measures						
CDB1251 - HCAHPS - Discharge Information - % Yes	81.86	81.22	86.33	80.31	81.53	80.9
CDB799 - HWR, Overall, CMS Readm Rdctn - % Readmit within 30 Days	13.841	12.308	10.954	11.932	13.721	12.775
HBIPS-6a - Post Discharge continuing care plan (Overall)						
CDB098 - Congestive Heart Failure - % Readmit within 30 Days	20.833	20.69	22.222	40	14.815	20.455
CDB1008 - COPD - % Readmit within 30 Days	20	13.793	6.897	11.111	8	22.449
CDB1083 - Pneumonia, Adult - % Readmit within 30 Days, Age over 64	13.636	26.667	26.087	19.355	22.222	12.195

References

- Joint Commission Hot Topics in Health Care: “Transitions of Care” June 2012
- Rockville Institute for the Advancement of Social Science Center for Pathways Community Care Coordination https://www.rockvilleinstitute.org/CPCCC/mission.asp
- **Decreasing Avoidable Hospital Admissions With the Implementation of an Emergency Department Case Management Program Ghazala Q. Sharieff, MD, MBA, et al;** American Journal of Medical Quality XX(X) 1–6 2013 by the American College of Medical Quality
- **Best Practices: Case Management in the Emergency Department;** Washington State Hospital Association; June 2012
- **Hospital-Initiated Transitional Care Interventions as a Patient Safety Strategy: A Systematic Review:** Stephanie Rennke, MD, et al *Ann Intern Med.* 2013;158(5_Part_2):433-440.
- BOOSTing Care Transitions; Society for hospital Medicine; http://www.hospitalmedicine.org/resourceroomredesign/rr_caretransitions/html_cc/project_boost_background.cfm

Thanks for attending.
Are there any questions?

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