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

Barbara Craig, Midas+ SaaS Advisor
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 for 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
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.
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.

<table>
<thead>
<tr>
<th>Focus:</th>
<th>ED FREQUENT USER PLAN OF CARE</th>
<th>Date:</th>
<th>4/8/2014</th>
<th>Focus ID:</th>
<th>14-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Plan of Care Initiated:</td>
<td>4/8/2014</td>
<td>Number of ED visits in this past 6 months:</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Conditions:</td>
<td>Diabetes</td>
<td>Social Factors:</td>
<td>Homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of substance/ETOH abuse</td>
<td></td>
<td>Indigent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatric Conditions</td>
<td></td>
<td>No Primary Care Provider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Interventions

<table>
<thead>
<tr>
<th>ED Visit Date</th>
<th>Type of Intervention</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/8/2014</td>
<td>Referred to St. Martin's Free Clinic</td>
<td>Appointment scheduled for 4/10/2013 at 12noon</td>
</tr>
<tr>
<td>4/8/2014</td>
<td>Referred to homeless shelter</td>
<td>Spoke with Mr. Greene, intake counselor. They will accept and assist this patient with securing ...</td>
</tr>
<tr>
<td>4/8/2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
Using Screening Criteria - Milliman

![Screening Criteria Interface](image)

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**Midas+ Annual Symposium**
Clinical & Application Effectiveness

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**xerox**
Using Screening Criteria - Milliman

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**Guideline Overview**

- **Select Content Edition:** 17th Edition, Benchmarks and Data Website

### Search

#### 17th Edition

<table>
<thead>
<tr>
<th>Search by Diagnosis or Procedure Codes (recommended method)</th>
<th>ICD-10</th>
<th>Go</th>
<th>Clear</th>
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</thead>
<tbody>
<tr>
<td>Use this search method. Enter the code, including any leading zeros:</td>
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</tr>
<tr>
<td><strong>OR:</strong></td>
<td>DSM-IV</td>
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<td>Clear</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter procedure code</th>
<th>ICD-10</th>
<th>Go</th>
<th>Clear</th>
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<tr>
<td><strong>OR:</strong></td>
<td>ICD-9</td>
<td>Go</td>
<td>Clear</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
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<td>Clear</td>
<td></td>
</tr>
</tbody>
</table>

### Search Code Descriptions

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Include words found in index to expand search:</td>
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<td>Go</td>
<td>Clear</td>
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<tr>
<td><strong>OR:</strong></td>
<td>ICD9-D</td>
<td>Go</td>
<td>Clear</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>Go</td>
<td>Clear</td>
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</tbody>
</table>

### Search Content

<table>
<thead>
<tr>
<th>Use words contained in guideline content:</th>
<th>ICD10-D</th>
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<tbody>
<tr>
<td>Match similar words:</td>
<td>ICD10-P</td>
<td>Go</td>
<td>Clear</td>
</tr>
<tr>
<td><strong>OR:</strong></td>
<td>ICD9-D</td>
<td>Go</td>
<td>Clear</td>
</tr>
<tr>
<td>CPT/HCPCS</td>
<td>Go</td>
<td>Clear</td>
<td></td>
</tr>
</tbody>
</table>
Using Screening Criteria - Milliman

Respiratory Failure GRG

- 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 ILOS via Search functions
  - Discharge Criteria
  - Case Management
  - Discharge Destination
  - Usual
  - Alternate
  - References
  - Footnotes

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Admission

- Admission is indicated for acute respiratory failure.
  - Mechanical ventilation needed (acute invasive)
  - Noncardiac pulmonary edema not resolving with therapy
  - Severe respiratory distress as indicated by 1 or more of:
    - Severe hypoxemia (partial pressure of oxygen ≥ 30 mm Hg)
    - Severe hypercapnia (partial pressure of carbon dioxide ≥ 45 mm Hg)
    - Mental status deterioration from respiratory failure
    - Severe ventilation defect as indicated by 1 or more of:
      - Respiratory acidosis (pH less than 7.32)
      - Partial pressure of carbon dioxide greater than 60 mm Hg
      - Airflow measurements less than 25% of predicted
      - Forced vital capacity less than 15 mL/kg
    - Airway obstruction in inadequate patients

Alternatives to Admission

- Alternatives include
  - Home care
    - Home mechanical ventilation
  - Palliative care, including continuous care
  - Recovery facility
  - Palliative care, including respite care

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Using Screening Criteria - CERME
Use Criteria to assist with determining Observation vs. Acute Care Admissions
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
Create User Fields for the ED Module

<table>
<thead>
<tr>
<th>User Fields</th>
<th>ED Times</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mode of Arrival:</td>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>Follow Up Medical Care:</td>
<td>Referred to St. Martin's Free...</td>
<td>Prescriptions fulfilled in ED</td>
</tr>
<tr>
<td>Date and Time of Appointment for follow-up appointment:</td>
<td>4/28/2014, 11:30 PM</td>
<td></td>
</tr>
<tr>
<td>Follow Up Social Care:</td>
<td>Referred to Community Food Bank</td>
<td>Transportation provided</td>
</tr>
</tbody>
</table>

Comments and Plans:

This is the third ED visit for this patient this month with the same/similar complaint. Patient does not have a PCP. An appointment has been made for him at the St. Martin Free Clinic. We have provided his last doses for the next 14 d.
Pre-Discharge Interventions

Use of Midas+ Hospital Case Management
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
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.

<table>
<thead>
<tr>
<th>Action items</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What’s ahead?</td>
<td></td>
</tr>
<tr>
<td>- Ask where you’ll get care after you leave (after you’ve discharged). Do you have options (like home health care)? Be sure you tell the staff what you prefer.</td>
<td></td>
</tr>
<tr>
<td>- If a caregiver will be helping you after discharge, write down their name and phone number.</td>
<td></td>
</tr>
<tr>
<td>Your health</td>
<td></td>
</tr>
<tr>
<td>- Ask the staff about your health condition and what you can do to help yourself get better.</td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
</tr>
</tbody>
</table>
Patient Handout

Action items

☐ 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.

Notes

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 how 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.

Notes

Action items

☐ 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.”
### Universal Patient Discharge Checklist

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

<table>
<thead>
<tr>
<th>Risk Assessment: 8P Screening Tool (Check all that apply.)</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems with medications</strong>&lt;br&gt;(polypharmacy – i.e. ≥10 routine meds – or high risk medication including: anticoagulants, insulin, oral hypoglycemic agents, aspirin &amp; clopidogrel dual therapy, digoxin, norepinephrine)</td>
<td>- Medication specific education using Teach Back provided to patient and caregiver&lt;br&gt;- Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)&lt;br&gt;- Specific strategies for managing adverse drug events reviewed with patient/caregiver&lt;br&gt;- Elimination of unnecessary medications&lt;br&gt;- Simplification of medication scheduling to improve adherence&lt;br&gt;- Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological</strong>&lt;br&gt;(depression screen positive or history of depression diagnosis)</td>
<td>- Assessment of need for psychiatric care if not in place&lt;br&gt;- Communication with primary care provider, highlighting this issue if new&lt;br&gt;- Involvement/awareness of support network insured</td>
<td></td>
</tr>
<tr>
<td><strong>Principal diagnosis</strong>&lt;br&gt;(cancer, stroke, DM, COPD, heart failure)</td>
<td>- Review of national discharge guidelines, where available&lt;br&gt;- Disease specific education using Teach Back with patient/caregiver&lt;br&gt;- Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms&lt;br&gt;- Discuss goals of care and chronic illness model discussed with patient/caregiver</td>
<td></td>
</tr>
<tr>
<td><strong>Physical limitations</strong>&lt;br&gt;(patients with deconditioning, frailty, or other physical limitations that impair their ability to participate in their own care)</td>
<td>- Engage family/caregivers to ensure ability to assist with post-discharge care assistance&lt;br&gt;- Assessment of home services to address limitations and care needs&lt;br&gt;- Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place.</td>
<td></td>
</tr>
<tr>
<td><strong>Poor health literacy</strong>&lt;br&gt;(inability to do Teach Back)</td>
<td>- Committed caregiver involved in planning/administration of all discharge planning and general and risk specific interventions&lt;br&gt;- Post-hospital care plan education using Teach Back provided to patient and caregiver&lt;br&gt;- Link to community resources for additional patient/caregiver support&lt;br&gt;- Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
<tr>
<td><strong>Patient support</strong>&lt;br&gt;(social isolation, absence of support to assist with care, as well as insufficient or absent connection with primary care)</td>
<td>- Follow-up phone call at 72 hours to assess condition, adherence and complications&lt;br&gt;- Follow-up appointment with appropriate medical provider within 7 days after hospitalization&lt;br&gt;- Involvement of home care providers of services with clear communications of discharge plan to those providers&lt;br&gt;- Engage a transition coach</td>
<td></td>
</tr>
<tr>
<td><strong>Prior hospitalization</strong>&lt;br&gt;(non-elective; in last 6 months)</td>
<td>- Review reasons for re-hospitalization in context of prior hospitalization&lt;br&gt;- Follow-up phone call at 72 hours to assess condition, adherence and complications&lt;br&gt;- Follow-up appointment with medical provider within 7 days of hospital discharge&lt;br&gt;- Engage a transition coach</td>
<td></td>
</tr>
<tr>
<td><strong>Palliative care</strong>&lt;br&gt;(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)</td>
<td>- Assess need for palliative care services&lt;br&gt;- Identify goals of care and therapeutic options&lt;br&gt;- Communicate prognosis with patient/family/caregiver&lt;br&gt;- Assess and address concerning symptoms&lt;br&gt;- Identify services or benefits available to patients based on advanced disease status&lt;br&gt;- Discuss with patient/caregiver role of palliative care services and the benefits and services available to the patient</td>
<td></td>
</tr>
</tbody>
</table>
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

Hospitals teach patients to manage post-discharge care

Role-playing, teach-back methods can reduce readmissions, experts say

Topics: Outcomes, Quality, Performance Improvement, Readmissions, Safety, Patient Satisfaction, Service

February 11, 2013
# Teach-back Techniques

## Symptoms
- Patient verbalizes signs of worsening condition:
- Patient verbalizes when to call MD or go ED:
- Did CM need to repeat/re-teach about signs and symptoms?
- Comments regarding Teach-Back of Signs and Symptoms:

## Medication Self-management
- Patient verbalizes correct medication dosages and schedule:
- Patient verbalizes possible side effects of medication:
- Patient verbalizes food and drug interactions with medications:
- Did CM need to repeat/re-teach about self-medications:
- Comments regarding Teach-Back of Medications:

## Self-Care Understanding
- Patient verbalizes self care regarding:

## Follow-Up Appointments
- Patient verbalizes the dates and locations of all follow-up appointments:
# Patient Pass (BOOST)

**Patient PASS: A Transition Record**

**Patient Preparation to Address Situations (after discharge) Successfully**

<table>
<thead>
<tr>
<th>I was in the hospital because</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>2. My hospital doctor:</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>3. My visiting nurse:</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>4. My pharmacy:</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>5. Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My appointments:</th>
<th>Tests and issues I need to talk with my doctor(s) about at my clinic visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On: <em><strong>/</strong></em> at <em><strong>:</strong></em> am/pm For:</td>
<td>1. ___</td>
</tr>
<tr>
<td>2. On: <em><strong>/</strong></em> at <em><strong>:</strong></em> am/pm For:</td>
<td>2. ___</td>
</tr>
<tr>
<td>3. On: <em><strong>/</strong></em> at <em><strong>:</strong></em> am/pm For:</td>
<td>3. ___</td>
</tr>
<tr>
<td>4. On: <em><strong>/</strong></em> at <em><strong>:</strong></em> am/pm For:</td>
<td>4. ___</td>
</tr>
<tr>
<td>5. On: <em><strong>/</strong></em> at <em><strong>:</strong></em> am/pm For:</td>
<td>5. ___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other instructions:</th>
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<tbody>
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<td>1.</td>
<td>___</td>
</tr>
<tr>
<td>2.</td>
<td>___</td>
</tr>
<tr>
<td>3.</td>
<td>___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Important contact information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My primary doctor:</td>
<td>____</td>
</tr>
<tr>
<td>2. My hospital doctor:</td>
<td>____</td>
</tr>
<tr>
<td>3. My visiting nurse:</td>
<td>____</td>
</tr>
<tr>
<td>4. My pharmacy:</td>
<td>____</td>
</tr>
<tr>
<td>5. Other:</td>
<td>____</td>
</tr>
</tbody>
</table>

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

- Patient/Caregiver Signature
- Provider Signature
- Date
BOOST Patient Pass

If I have the following problems

1. [ ]
2. [ ]
3. [ ]
4. [ ]
5. [ ]

Then I should

1. [ ]
2. [ ]
3. [ ]
4. [ ]
5. [ ]

Important contact information

My primary doctor: [ ] Phone: [ ]
My hospital doctor: [ ] Phone: [ ]
My visiting nurse: [ ] Phone: [ ]
My pharmacy: [ ] Phone: [ ]
Other: [ ] Phone: [ ]

My Appointments

Appointment 1: [ ] When: [ ]
Appointment 2: [ ] When: [ ]
Appointment 3: [ ] When: [ ]
Appointment 4: [ ] When: [ ]

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

1. [ ]
2. [ ]
3. [ ]

Other instructions: [ ]
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

Important Contact Information

<table>
<thead>
<tr>
<th>My primary care doctor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnathan Perez</td>
</tr>
<tr>
<td>(520)441-4414</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My hospital doctor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margaret Maloney</td>
</tr>
<tr>
<td>(520)333-3333</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My visiting nurse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My pharmacy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walgreens</td>
</tr>
<tr>
<td>(520)555-5555</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Chang, Cardiologist</td>
</tr>
<tr>
<td>(520)777-7777</td>
</tr>
</tbody>
</table>

**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
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

Image of a form with fields filled in:
- **Admission Review Reason:** Targeted Readmission Prevention
- **Diagnostic Category:** Heart Failure
Using Support Services to Generate Follow-up

Patient has been inpatient for 5 days. He has been non-compliant with follow-up appointments, medications, and smoking cessation. Please provide follow-up assessments and reports to PCP.
Using Discharge Planning to Generate Follow-up with Transitional Care Manager
Medical History

**Allergy**
- Demerol: 1/1/1999, Restlessness
- Iodina: 1/2/1988, Anaphylaxis

**Immunization**
- Flu Vaccine: 11/13/2013
- Diptheria, Tetanus, Pertussis: 2/4/2012

**Medications/Diagnostic Tests**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Start Date</th>
<th>End Date</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digoxin</td>
<td>125 MCG</td>
<td>BID</td>
<td>PO</td>
<td>7/2/2013</td>
<td></td>
<td>Jones, Hillary Kathleen</td>
</tr>
<tr>
<td>Furosemide</td>
<td>40MG</td>
<td>BID</td>
<td>PO</td>
<td>5/25/2013</td>
<td></td>
<td>Jones, Hillary Kathleen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Test</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum Creatinine</td>
<td>1/29/2014</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Medical History Problem List

Existing Diagnoses/Procedures

<table>
<thead>
<tr>
<th>Enc. Date</th>
<th>Facility</th>
<th>Diagnosis/Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/7/2014</td>
<td>Midas Medical Center</td>
<td>459.3 Chr Venous Hypertension</td>
</tr>
<tr>
<td>3/7/2014</td>
<td>Midas Medical Center</td>
<td>N39.0 Urinary tract infection, site not specified</td>
</tr>
<tr>
<td>3/7/2014</td>
<td>Midas Medical Center</td>
<td>87.49 Chest x-ray NEC</td>
</tr>
<tr>
<td>1/14/2014</td>
<td>Midas Medical Center</td>
<td>401.6 Hypertensive NEC</td>
</tr>
</tbody>
</table>

Problem List

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>428.21 Ac systolic hrt failure</td>
<td>3/7/2014</td>
<td>Chronic</td>
</tr>
<tr>
<td>428.20 Systolic hrt failure NOS</td>
<td>2/16/2014</td>
<td>Major</td>
</tr>
<tr>
<td>333.3 Systolic-Heart Failure</td>
<td>1/14/2014</td>
<td></td>
</tr>
<tr>
<td>96.05 Resp tract Intubat NEC</td>
<td>3/7/2014</td>
<td>Resolved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>5/11/2013</td>
<td>Chronic</td>
</tr>
</tbody>
</table>

Midas+ Annual Symposium
Clinical & Application Effectiveness

xerox
Medical History User Fields

<table>
<thead>
<tr>
<th>Patent needs chronic care manager for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
</tr>
<tr>
<td>Psychiatric Conditions</td>
</tr>
<tr>
<td>Date referred to chronic care manager:</td>
</tr>
<tr>
<td>3/1/2014</td>
</tr>
</tbody>
</table>
Coordination with Post-discharge Providers

3/26/2014

Dear Dr. Jones,

I have been following your patient, Michael Borgua, 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
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

- 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

<table>
<thead>
<tr>
<th>Attach</th>
<th>Form Name</th>
<th>Last Edit Date</th>
<th>Form Complete</th>
<th>Complete Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Patient Information Form (rev 7/2012)</td>
<td>04-02-14 17:13 PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Update Form (9/2008)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharge Transfer Form (10/2008)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DME - Durable Medical Equipment Form (2/2010)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Care Intake Form (11/2007)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Important Message - Notification of Discharge Rights (OMB 0938-0552) (rev.7/2010)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Important Message - Notification of Discharge Rights (OMB 0938-0552) - Spanish Version (rev.7/2010)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MI Preadmission Screening (PAS) / Annual Resident Review</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attach</th>
<th>Action</th>
<th>Document Name</th>
<th>Receipt Date</th>
<th>Shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Rename</td>
<td>MD Order 040214</td>
<td>04-02-14 16:00 PM</td>
<td></td>
</tr>
<tr>
<td>✔️</td>
<td>Rename</td>
<td>MARs 040114</td>
<td>04-02-14 15:59 PM</td>
<td></td>
</tr>
</tbody>
</table>
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

![Image of a hospital referral system interface]

**Boston Garden Hospital**

**Gold, Monica**

**Return to Workbook**

<table>
<thead>
<tr>
<th>Intake</th>
<th>Assessment</th>
<th>Matching</th>
<th>Implementation</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider Status:**

- Select One

**Connected Provider(s)**

<table>
<thead>
<tr>
<th>Connected Providers</th>
<th>Status</th>
<th>Provider Status</th>
<th>Msg</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thunder Test Nursing and Rehab</td>
<td>Booked on 04-02-14 21:13</td>
<td>Accept on 04-02-14 21:03</td>
<td></td>
<td>Notification Log</td>
</tr>
<tr>
<td>ReferralCentral Critical Care Provider</td>
<td>Notified on 04-02-14 20:49</td>
<td>No Response Submitted</td>
<td></td>
<td>Notification Log</td>
</tr>
<tr>
<td>ReferralCentral Skilled Nursing Facility</td>
<td>Notified on 04-02-14 20:49</td>
<td>No Response Submitted</td>
<td></td>
<td>Notification Log</td>
</tr>
</tbody>
</table>

**Unconnected Provider(s)**

<table>
<thead>
<tr>
<th>Providers</th>
<th>Phone Number</th>
<th>Provider Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appletree Test Care Center</td>
<td>(617) 395-0125</td>
<td>QuickCase Accepted on 04-02-14 21:08</td>
<td>Send Fax, Notes and Status, Fax History</td>
</tr>
<tr>
<td>Business Central Provider</td>
<td>(617) 395-0125</td>
<td>QuickCase Pending on 04-02-14 20:49</td>
<td>Send Fax, Notes and Status, Fax History</td>
</tr>
</tbody>
</table>

**Outbound Faxes (off-line providers, payers, doctors and agencies)**

<table>
<thead>
<tr>
<th>Address Book</th>
<th>Attachments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Document Name</td>
</tr>
</tbody>
</table>

---

*Organization Type:* Select One

*Organization Name:*
Involve Other Members of the Care Continuum

- 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

**Monica Gold**

- **Account #:** 1130042
- **Member ID:** AGC22336-9
- **Medical Record #:** 101462
- **Status:** M

**Diagnosis Code**

- **Local Payer:** ACME INSURANCE

**Payer Authorization**

- **New Payer Review**
- **Next Action Due:**
  - 11-03-2013 Inpatient Submitted

**Messages / Notes To Payer**

- Please review and call me with any questions.
- **Cheri Bankston**
  - 04-03-14 04:20 PM

**Messages / Notes To Payer**

- **Mark as Unread**
Document and Track Approvals and Denials
Track Approved Days
### Case History

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Approved - 1 day</td>
<td>04-03-2014 15:30</td>
<td>Bankston, Cheri</td>
</tr>
<tr>
<td><strong>AUTHORIZED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization Number: 8675309</td>
<td></td>
<td></td>
</tr>
<tr>
<td># Days Authorized: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dates Authorized: 11-03-2013 - 11-03-2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status: M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next Action Due: 11-05-2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact #: (555) 555-5555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorized By: Mary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes: Spoke with Mary; send updated lab results</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit</td>
<td>04-03-2014 15:20</td>
<td>Bankston, Cheri</td>
</tr>
<tr>
<td>Notes: Please review and call me with any questions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payer: Mary</td>
<td>Note to Payer 04-03-14 03:20 PM</td>
<td></td>
</tr>
<tr>
<td>Fax: (555) 555-5555</td>
<td>Consult Note History and Physical</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Case Owner</td>
<td>04-02-2014 15:37</td>
<td>Bankston, Cheri</td>
</tr>
<tr>
<td>Create</td>
<td>04-02-2014 15:37</td>
<td>Bankston, Cheri</td>
</tr>
</tbody>
</table>
Store and Access Documentation of Successful Communication

![Image of a software interface showing patient documentation and communication history]

### Documents

<table>
<thead>
<tr>
<th>Note to Payer</th>
<th>Date/Time</th>
<th>Submitted</th>
<th>Shared Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-11-13 01:54 PM</td>
<td>07-11-13 12:54 PM</td>
<td>Not Shared</td>
<td></td>
</tr>
<tr>
<td>DME - Durable Medical Equipment Form (2/2010)</td>
<td>07-11-13 01:54 PM</td>
<td>Not Shared</td>
<td></td>
</tr>
</tbody>
</table>

### Fax History

<table>
<thead>
<tr>
<th>Sender</th>
<th>Request Time</th>
<th>Document Recipient</th>
<th>Latest Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheri Bankston</td>
<td>07-11-2013 01:54 PM</td>
<td>Hospital Review Submit Fax sent to payer@(601) 255-4274</td>
<td>Attempt 1 : 07-11-2013 01:54 PM SENT OK</td>
</tr>
<tr>
<td>Cheri Bankston</td>
<td>07-11-2013 01:54 PM</td>
<td>Note to Payer 07-11-13 01:54 PM sent to payer@(601) 255-4274</td>
<td>Attempt 1 : 07-11-2013 01:54 PM SENT OK</td>
</tr>
<tr>
<td>Cheri Bankston</td>
<td>07-11-2013 01:54 PM</td>
<td>DME - Durable Medical Equipment Form (2/2010) 07-11-13 01:54 pm sent to payer@(601) 255-4274</td>
<td>Attempt 1 : 07-11-2013 01:54 PM SENT OK</td>
</tr>
</tbody>
</table>

### Notes to Payer

- **Notes**
  - This is where I would type note

- **Added By**
  - Cheri Bankston 07-11-13 01:54 PM
Organize and Prioritize Cases

<table>
<thead>
<tr>
<th>Patient</th>
<th>M/F</th>
<th>Location Status</th>
<th>Auth. Days Rem.</th>
<th>Next Action Due</th>
<th>Current Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>NurseUser5, Training</td>
<td>F</td>
<td>In Patient</td>
<td>N/A</td>
<td>04-03-14</td>
<td>H: Pending</td>
</tr>
<tr>
<td>Gold, Monica</td>
<td>F</td>
<td>3180 - East - 001 M</td>
<td>0 Authorized Days Remaining</td>
<td>11-05-13</td>
<td>H: Authorized</td>
</tr>
<tr>
<td>ZOUTTE, MADONNA</td>
<td>F</td>
<td>Out Patient</td>
<td>N/A</td>
<td>08-20-13</td>
<td>H: Submitted</td>
</tr>
<tr>
<td>LynneChiger, Training</td>
<td>F</td>
<td>Training - 35 - A</td>
<td>N/A</td>
<td>10-24-13</td>
<td>H: New</td>
</tr>
</tbody>
</table>
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

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
# Reporting

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

## 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

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

## 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

*NEW* Readmissions

Reports

Back to Report List

Provider

Age

Previous Attending

Previous Booked Provider

Previous Diagnosis

Previous Payer

Period

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

Generate Report

Diagnosis

Physician

Date Range

Payer

Date Range

Patient Age

Diagnosis

Payer

Physician

Provider

Insurance

Highest readmission rates by diagnosis

01/01/2009 thru 12/31/2009

Bar chart showing the highest readmission rates by diagnosis.
## Provider Placements and Return Summary Report

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

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Enabled</th>
<th>Total</th>
<th>Accept</th>
<th>Received</th>
<th>Declines</th>
<th>Bookings</th>
<th>Placements</th>
<th>Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Necessities, LLC - MD</td>
<td>yes</td>
<td>37</td>
<td>25</td>
<td>37</td>
<td>1</td>
<td>28</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>SUMCARE HOME HEALTH ID</td>
<td>yes</td>
<td>33</td>
<td>27</td>
<td>33</td>
<td>7</td>
<td>25</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Community at Desert</td>
<td>yes</td>
<td>33</td>
<td>21</td>
<td>33</td>
<td>5</td>
<td>23</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>HOME HEALTH CARE OF MT</td>
<td>yes</td>
<td>29</td>
<td>19</td>
<td>29</td>
<td>2</td>
<td>23</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>DREXEL HEALTH AND IT</td>
<td>yes</td>
<td>26</td>
<td>5</td>
<td>26</td>
<td>2</td>
<td>11</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>

## Provider Scorecard

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

<table>
<thead>
<tr>
<th>Level of Care Totals</th>
<th>Patients Referred</th>
<th>Total Placements</th>
<th>Conversion Rate</th>
<th>Response Time (In Hours)</th>
<th>Acceptance Time (In Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Rehabilitation Facility (hospital or unit) (IRF)</td>
<td>10</td>
<td>5</td>
<td>50.00%</td>
<td>0.35</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td>66.67%</td>
<td>0.16</td>
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<td></td>
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<td>0.82</td>
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<td>0.05</td>
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<td>3</td>
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<td>0.00%</td>
<td>0.36</td>
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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**

### Monthly Average Length of Stay by Discharge Disposition Grouping

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>F</td>
<td>7.96</td>
<td>8.03</td>
<td>9.02</td>
<td>7.45</td>
<td>9.45</td>
<td>8.15</td>
<td>8.40</td>
<td>9.05</td>
<td>8.15</td>
<td>7.05</td>
<td>7.28</td>
<td>7.04</td>
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<tr>
<td>TX ADULT CARE FACILITY</td>
<td>4.50</td>
<td>3.94</td>
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<td>5.06</td>
<td>4.05</td>
<td>4.00</td>
<td>5.08</td>
<td>4.35</td>
<td>3.76</td>
<td>4.37</td>
<td>4.62</td>
<td>4.67</td>
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<tr>
<td>TX Hosp w/Swing Bed</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>TX HOSPICE FACILITY</td>
<td>8.33</td>
<td>4.20</td>
<td>5.00</td>
<td>13.33</td>
<td>6.75</td>
<td>9.88</td>
<td>9.50</td>
<td>6.00</td>
<td>12.75</td>
<td>5.50</td>
<td>13.25</td>
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### Referral Process Timeline

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

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

**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 notification date/time stamp and discharge date for all patients in the level of care selected.
Information At-a-Glance

Monthly Summary Report - Total Discharges
Discharge Date: 2/1/2014 to 2/28/2014

Total Discharges by Placement Type
- Home: 59%
- Transfer: 3%
- Other: 13%
- HC: 15%
- Others: 2%
- F: 8%
- Non-participating providers: 6.78%

Participating providers: 93.22%

eDischarge Utilization:
- F
- HC
- T
- Others

% of Total Visits
- Non-eDischarge Bookings
- Total Bookings
### 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
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.

### Diagram

**Reviewed By:** Clark, Barb  
**Date:** 4/8/2014  
**Assigned To:** Clark, Barb  
**Location:**

- **Select/Deselect Worklist Rules:**
  - HCM Discharge Planning
  - New Encounter for CCM pt
  - RRP Discharge DX
  - Referral from HCM - DX Category
  - CCM CHF F/U Appointment
  - Referral from Discharge Planner

- **Referral from Support Services**
- **Referral from Concurrent Review**
- **Referral from DCP User Fields**
Information Flow from Discharge Planning to CCM Episode

• Site Parameter
  – Transfers data from HCM Discharge Planning
    • Assessment Tab
    • DME Tab
    • Patient Care Tab
Using CCM to Continue Post-discharge Follow-up: Episode Entry
Using CCM to Continue Post-discharge Follow-up: Assessments
Using CCM to Continue Post-discharge Follow-up: Problem List

<table>
<thead>
<tr>
<th>Assessment Date</th>
<th>Issue</th>
<th>Problem</th>
<th>Start Date</th>
<th>Status</th>
<th>Files</th>
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<tbody>
<tr>
<td>4/9/2014</td>
<td>Chronically Ill</td>
<td>Chronic Condition</td>
<td>4/9/2014</td>
<td>Open</td>
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<td>4/9/2014</td>
<td>Frequent Admissions</td>
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<tr>
<td>4/9/2014</td>
<td>High Risk Diagnosis</td>
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</table>

**Details for Inadequate, Financial Resources**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Establish Primary Medical Care</td>
<td>Intervention Required</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

**Comments:** Although patient has a designated PCP, the patient does not keep PCP appointments secondary to the lack of funds available to pay for care. Patient is not eligible for Medicare for 11 more months. Will discuss options with PCP and coordinate resources with social services.
Using CCM to Continue Post-discharge Follow-up: Referrals and Interventions

Details for 4/9/2014 Social Work

- **Services**: Self Pay/Financial Assistance
- **Agency**: 
- **Frequency**: 
- **Payer**: 
- **Region**: 

**Comments:** This patient is medically indigent and not yet eligible for Medicare. He does not keep PCP appointments. He needs some help navigating the ACA and securing other available resources.
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
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
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

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<tr>
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<td><strong>General Measures</strong></td>
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<td>All Inpatient Encounters</td>
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<td>1504</td>
<td>1488</td>
<td>1563</td>
<td>1644</td>
<td>1670</td>
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<tr>
<td>Average Inpatient Length of Stay</td>
<td>3.69</td>
<td>3.62</td>
<td>3.34</td>
<td>3.61</td>
<td>3.58</td>
<td>3.80</td>
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<td>Inpatient Readmissions within 30 Days</td>
<td>20.1%</td>
<td>22.2%</td>
<td>18.7%</td>
<td>19.3%</td>
<td>18.1%</td>
<td>17.9%</td>
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<td>Total Emergency Encounters by Discharge Disposition</td>
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<td>Home</td>
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<td>452</td>
<td>373</td>
<td>376</td>
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<td>AMA</td>
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<td>2</td>
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<td>SNF</td>
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<td>Other</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td></td>
<td>Returns to the ED within 10 days</td>
<td>12.9%</td>
<td>16%</td>
<td>14.3%</td>
<td>15.5%</td>
<td>13.2%</td>
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<tr>
<td>Admissions to Acute Care from ED (of total ED visits)</td>
<td>19%</td>
<td>8%</td>
<td>7%</td>
<td>5%</td>
<td>9%</td>
<td>14%</td>
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<td>Number of Reviews on ED Patients</td>
<td>5</td>
<td>6</td>
<td>14</td>
<td>22</td>
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<td>Inpatients Discharged Home with Documented Teachback Used</td>
<td>623</td>
<td>501</td>
<td>512</td>
<td>624</td>
<td>530</td>
<td>482</td>
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<td>Inpatients Discharged Home with Documented Patient PASS</td>
<td>72.9%</td>
<td>72.7%</td>
<td>74.2%</td>
<td>74%</td>
<td>75.8%</td>
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<td>Inpatients Discharged Home Referred to CCM from HCM</td>
<td>6.2%</td>
<td>8.1%</td>
<td>7.7%</td>
<td>7.4%</td>
<td>8.3%</td>
<td>9.1%</td>
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<td>Patients on CCM/TCM Program Readmitted within 30 Days</td>
<td>6.2%</td>
<td>7.2%</td>
<td>7.1%</td>
<td>6.8%</td>
<td>6.3%</td>
<td>6.3%</td>
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<tr>
<td>Inpatients Discharged with Visit to Ed within 10 Days</td>
<td>7.6%</td>
<td>7.7%</td>
<td>7.4%</td>
<td>6.5%</td>
<td>6.7%</td>
<td>6.6%</td>
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<td>CDB1251 - HCAHPS - Discharge Information - % Yes</td>
<td>81.86</td>
<td>81.22</td>
<td>86.33</td>
<td>80.31</td>
<td>81.53</td>
<td>80.9</td>
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<td>CDB799 - HWR, Overall, CMS Readm Rdtm within 30 Days</td>
<td>13.34</td>
<td>12.30</td>
<td>10.95</td>
<td>11.93</td>
<td>13.72</td>
<td>12.77</td>
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<td>HBPS-6a - Post Discharge continuing care plan (Overall)</td>
<td>20.83</td>
<td>20.69</td>
<td>22.22</td>
<td>40</td>
<td>14.81</td>
<td>20.45</td>
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<td>CDB008 - Congestive Heart Failure - % Readmit within 30 Days</td>
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<td>13.79</td>
<td>6.89</td>
<td>11.11</td>
<td>8</td>
<td>22.44</td>
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<td>CDB1008 - COPD - % Readmit within 30 Days</td>
<td>13.53</td>
<td>26.57</td>
<td>26.08</td>
<td>19.35</td>
<td>22.22</td>
<td>12.19</td>
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</table>
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
- 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?

Barb Craig, Midas+ SaaS Advisor
barbara.craig@xerox.com