

# 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



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# 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



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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

Rule: ED Frequent Filers

Patient Name	Birth Date
Ackling,Ricky	8/25/1929
Acuna,Virgil	9/26/2005
Alcaraz,Howard	4/14/2004
Allen,Catherine	5/11/1928
Andretus,Edwina	3/15/1967
Aranda,Jennie	8/3/1970
Athans,Linda	10/6/1999
Ayala,Leslie	10/4/1986
Barber,Ramona	3/28/1982
Barnes,Tessibel	7/23/1975
Barnett,Stephen	8/8/1940
Benevento,Michael	12/16/1981
Bennett,Susana	3/27/1958
Bernal,Porsha	4/24/2006
Bevers,Pamela	6/13/1976
Bloom,Brett	1/12/1972
Bloom,Roy	4/7/1969
Boede,Helen	3/19/1939
Boschian,Tommy	12/23/1997
Branson,Anna	4/30/1959
Bruce,Maria	5/17/2001
Buglewicz,Anissa	10/5/1926
Caid,Lois	9/5/1981
Carbo,Frank	1/31/1981
Carr,Eva	11/4/1932
Carroll,Arlene	2/6/1971
Chavez,Florence	11/18/1959
Coats,Ben	7/12/2005
Coker,Marie	2/6/1979
Colvin,Patricia	11/29/1984
Cooley,Harold	1/2/1913
Crawford,Barbara	4/15/1915
Cunningham,Emily	2/12/1965
Dalley,Linda	7/14/1924
Dawson,Bryan	4/28/1951
Dorame,Nick	7/28/1950
DuBos,Trinidad	9/4/1931
Duong,John	9/19/1970
Figueroa,David	5/13/1946
Flores,Patricia	12/6/1941
Foley,Thomas	6/24/1923
Garcia,Kristopher	3/9/1917
Garcia,Mary	12/27/1917
Garcia,Michael	2/25/2007
Gillette,Robert	1/31/1954
Gomez,Elizabeth	12/18/1977
Gonzales,Rocky	12/29/1944
Granados,Marjorie	9/21/1978
Green,Velma	8/6/1964
Griggs,Alfredo	3/5/1932
Haalk,Alejandro	5/10/2000
Haberman,Aileen	8/31/1937
Harper,Jolene	1/21/1981
Helmick,George	12/20/2003
Helmick,Ricardo	1/16/1945
Hernandez,Carolyn	2/27/2005
Hernandez,Ruth	4/7/1962
Jackson,George	2/9/1969
Jacobs,Gerald	6/16/1921
Johnson,Jadyn	10/16/1913
Keller,Martha	9/22/1980
Lange,Roland	10/28/2003

Home Page    Worklist/Rule Definition    **Modify Patient Tracking**

Description: ED Frequent Filers    Code: 1868

Copy From:

General

Monitor: Encounter

Condition Logic

AND    OR    Custom

If:

- ENCOUNTER:Encounter Type:Type  
Has Value: EMERGENCY
- And
- ENCOUNTER:Previous ER Encounter:Encounter Type  
Has Value: Emergency
- And
- ENCOUNTER:Days Since Previous ER Encounter  
Has Value: <31
- And
- ENCOUNTER:Days Until Next ER Encounter  
Has Value: <31
- And
- ENCOUNTER:Next Encounter:Encounter Type  
Has Value: Emergency
- And
- <Add New Condition>

If

Module:Field: ENCOUNTER:Encounter Type:Type

Has Value    Does Not Have Value    Is Not Entered

OF EMERGENCY

Reference Date: ENCOUNTER:Start Date    Sample Rate: 100

Active:



# Build a Worklist Rule to Notify ED Case Management of the Arrival of a “Frequent Flier”

**Description:** ED Frequent Flier Alert **Code:** 1869

**Copy From:**  **Title:** Frequent Flier Alert

**General** | **Assignment**

**Monitor:** Encounter

Condition Logic

AND  OR  Custom

If:

- PATIENT TRACKING:PATIENT TRACKING LIST  
Has Value: ED Frequent Fliers
- And
- ENCOUNTER:Encounter Type:Type  
Has Value: EMERGENCY
- And
- <Add New Condition>

If

Module:Field: ENCOUNTER:Encounter Type:Type

Has Value  Does Not Have Value  Is Not Entered

► Of EMERGENCY

\* Or

Reference Date: ENCOUNTER:Start Date **Sample Rate:** 100

Days Attribute

Follow-up Date:

Active:



# 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**      < E +

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:      Social Factors:

Diabetes	Homeless
History of substance/ETOH abuse	Indigent
Psychiatric Conditions	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.

Name: **Borgus,Michael** DOB/Sex: **11/27/1948 65Y / M** MRN: **6765-556** Enc. Type: **Emergency**

General Payers Referral InterQual Comments Episode UserFields Series UserFields

Review Date: 2/16/2014 Review Time: 1:36 PM Care Date: 2/16/2014

Review By: Clark,Barb Level of Care: Acute

Review Location: **Emergency Department** Review Category: **Pre-Admission**

Severity \* Intensity \*

Series Fields Common Across Reviews

Admission Review Reason: Criteria for Admission Prioritize:

Diagnostic Category: Heart Failure Reason for Priority \*

HCM Diagnosis: HCM Procedure: DRG: Length of Stay Arithmetic: Geometric: Current: 1 Outlier:

Name: **Borgus,Michael** DOB/Sex: **11/27/1948 65Y / M** MRN: **6765-556** Enc. T

General Payers Referral **InterQual** Comments Episode UserFields Series UserFields

Criteria Subset: Heart Failure Criteria Status: Criteria Not Met

InterQual Version: InterQual® 2013  
Review date: 04-07-2014  
Review Status: In Primary  
Product: LOC:Acute Adult  
Criteria subset: Heart Failure  
Criteria status: Criteria Not Met  
(Symptom or finding within 24h)  
(Excludes PO medications unless noted)

Select Day, One:  
Episode Day 1, One:  
ACUTE, Both:  
Finding, >= One:  
Right heart failure, One:  
Dyspnea at rest or on exertion and not returned to baseline after 2h treatment, >= One:  
Edema of extremities  
Intervention, One:  
Left or right heart failure, All:  
Oximetry or blood gas

Edit Review  
InterQual Book View

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# Adding an HCM Review for patients who will not be admitted

Name: **Borgus, Michael**    DOB/Sec: **11/27/1948 65Y / M**    MRN: **6765-556**    Enc. Type: **Emergency**

**General**   Payers   Referral   InterQual   Comments   Episode UserFields   Series UserFields

Review Date: 2/16/2014    Review Time: 1:36 PM    Care Date: 2/16/2014

Review By: Clark, Barb    Level of Care: Acute

Review Location: Emergency Department    Review Category: Pre-Admission

Severity: \*    Intensity: \*

Series Fields Common Across Reviews

Admission Review Reason: Criteria for Admission    Prioritize:

Diagnostic Category: Heart Failure    Reason for Priority: \*

HCM Diagnosis:

HCM Procedure:

DRG:

Length of Stay  
Arithmetic:     Geometric:     Current: 1    Outlier:

Status: Complete    Next Review:     Help



# Adding an HCM Review for Patients who will be admitted

Name: **Borgus,Michael**    DOB/Sex: **11/27/1948 65Y / M**    MRN: **6765-556**    Enc. Type: **Emergency**

General   Payers   Referral   InterQual   Comments   Episode UserFields   Series UserFields

Review Date: 2/16/2014    Review Time: 1:36 PM    Care Date: 2/16/2014

Review By: Clark,Barb    Level of Care: Acute

Review Location: Emergency Department    Review Category: Pre-Admission

Severity: \*    Intensity: \*

Series Fields Common Across Reviews

Admission Review Reason: Criteria for Admission    Prioritize:

Diagnostic Category: Heart Failure    Reason for Priority: \*

HCM Diagnosis:

HCM Procedure:

DRG:

Length of Stay

Arithmetic:     Geometric:     Current: 1    Outlier:

Status: Complete    Next Review:

Save    Save & Print    Documents    Save and Launch Web Query    Files    Cancel    Navigate    Help







# Using Screening Criteria - Milliman

## Guideline Overview

Select Content Edition:  [Benchmarks and Data Website](#)

### Search

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

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

#### Search

<b>Search by Diagnosis or Procedure Codes</b> <i>(recommended method)</i> If you know the code or part of the code, use this search method. Enter the code, including any leading zeros.	Enter <b>diagnosis</b> code	ICD-10	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>	
		ICD-9	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>	
		DSM-IV	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>	
	-OR-	Enter <b>procedure</b> code	ICD-10	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>
			ICD-9	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>
			CPT®/HCPCS	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>

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<b>Search Code Descriptions</b> If you know a word or words in the code description, use this search method.	Enter <b>word(s)</b> contained in code description: Include words found in index to expand search: <input type="checkbox"/> -OR- Browse all codes: <a href="#">ICD10-D</a> <a href="#">ICD10-P</a> <a href="#">ICD9-D</a> <a href="#">ICD9-P</a> <a href="#">CPT®/HCPCS</a> <a href="#">DSM-IV</a>	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>
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<b>Search Content</b> Use words contained in Care Guidelines content	Enter <b>word(s)</b> contained in guideline content: Match similar words: <input type="checkbox"/>	<input type="text"/>	<input type="button" value="Go"/>	<input type="button" value="Clear"/>
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# 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 mechanical ventilation without the need for weaning, see a specific Optimal Recovery Guideline for a severe condition associated with respiratory failure or involves only short-term mechanical ventilation

### Alternatives to Admission

[Return to top of Respiratory Failure GRG - GRG](#)

#### Clinical Indications for Admission to Inpatient Care

[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 with diuresis
  - Severe respiratory distress as indicated by 1 of the following:
    - Severe tachypnea (respiratory rate greater than 30 breaths per minute)
    - Severe hypoxemia (partial pressure of oxygen less than 55 mmHg)
    - Mental status deterioration from respiratory acidosis
  - Severe ventilation deficit as indicated by 1 or more of the following:
    - Respiratory acidosis (pH less than 7.32)
    - Partial pressure of carbon dioxide greater than 50 mmHg
    - Airflow measurements less than 25% of predicted
    - Forced vital capacity less than 15 mL/kg
  - Airway obstruction or inadequate protection of airway (9)(10)

#### Alternatives include(11)(12)(13)(14):

- Home care
  - Home mechanical ventilation(15)
  - Palliative care, <sup>(9)</sup>including continuous care(13)(14)
- Recovery facility
  - Palliative care, including respite care

#### 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, <sup>(9)</sup>including continuous care(13)(14)
  - Recovery facility
    - Palliative care, including respite care



# Using Screening Criteria - CERME

File Edit View Function SmartMenu Tools Window Help

Name: **Ackling, Mae** DOB/Sec: **9/16/1963 49Y / F** MRN: **531937** Enc. Type: **Inpatient**

Facility: **Midas Medical Center** Account No.: **66787679** Start: **1/5/2013 11:35 AM**

Admitting Phvs.: Location/Room: **3300 East / 3341** End: **1/9/2013 1:40 PM**

Attending Phvs.: Principal Payer: **Aetna-PPO, HMO, or MC** LOS: **4**

General Payers Referral InterQual Comments Episode UserFields Series UserFields

Criteria Subset: **Cholecystitis** Criteria Status: **Acute Met**

InterQual Version: InterQual® 2013.2  
 Review date: 03-11-2014  
 Review Status: In Primary  
 Product: LOC:Acute Adult  
 Criteria subset: Cholecystitis  
 Criteria status: Acute Met  
 (Symptom or finding within 24h)  
 (Excludes PO medications unless noted)  
 Select Day, One:  
 Episode Day 1, One:  
 ACUTE, One:  
 Acute cholecystitis confirmed by imaging, Both:  
 Analgesic 3x/24h or continuous  
 Anti-infective

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CareEnhance Review Manager Enterprise

Patient Name/ID Ackling, Mae / 66787679  
 Review # 30528 Product LOC:Acute Adult Subset Cholecystitis Acute Met

LOC:Acute Adult Cholecystitis InterQual® 2013.2

Review Status	In Primary	Review Number	30528
Criteria Status	ACUTE MET	Location	All Locations
Requested Date/Time	03-11-2014 08:18 AM	Owned By	Admin, IQ Admin Admin
Last Edit By (Reviewer)	Admin, IQ Admin Admin	Last Edit Date/Time	03-11-2014 08:19 AM
Created by User	Admin, IQ Admin Admin	Review Created Date/Time	03-11-2014 08:19 AM

Primary Review Outcome

Outcome	Outcome Date/Time	Primary Reviewer
Product: LOC:Acute Adult Version: InterQual® 2013.2		
(Symptom or finding within 24h) (Excludes PO medications unless noted) ✓ Select Day, One: ✓ Episode Day 1, One: ✓ ACUTE, One: ✓ Acute cholecystitis confirmed by imaging, Both: ✓ Analgesic 3x/24h or continuous ✓ Anti-infective		
CRITICAL, ≥ One: Episode Day 2, One: Episode Day 3, One: Episode Day 4, One:		

Primary Review Outcome

Product: LOC:Acute Adult  
Version: InterQual® 2013.2

(Symptom or finding within 24h)  
(Excludes PO medications unless noted)  
✓ Select Day, One:  
✓ Episode Day 1, One:  
✓ ACUTE, One:  
✓ Acute cholecystitis confirmed by imaging, Both:  
✓ Analgesic 3x/24h or continuous  
✓ Anti-infective

CRITICAL, ≥ One:  
Episode Day 2, One:  
Episode Day 3, One:  
Episode Day 4, One:

Save Save & Print Documents Save and Launch Web Query Files Cancel

Status: Complete Next Review: Help



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

The screenshot displays the CareEnhance Review Manager Enterprise interface. The top navigation bar includes tabs for General, Payers, Referral, InterQual, Comments, Episode User Fields, and Series User Fields. The main window shows a review for a patient named Acling, Mae / 66787679, with a review number of 30528. The criteria subset is Cholecystitis, and the criteria status is Acute Met. The review is for a LOC:Acute Adult patient with an infection of the skin. The criteria are organized into a tree view, with the following items checked:

- Episode Day 1 (Selected Day)
- Episode Day 1, One: OBSERVATION, One: M
- Cellulitis, Both:
  - Finding, ≥ One:
    - Diabetes mellitus and BS ≥ 350 mg/dL (19.4 mmol/L) M
  - Intervention, All:
    - Anti-infective
    - Advancing diet as tolerated or IV fluid M
    - Cellulitis care and assessment M
- ACUTE, ≥ One: M
- Cellulitis, Both:
  - Finding, ≥ One:
    - Located over a prosthesis or implanted device
    - Animal or human bite of the face or hand
    - Purpura or Petechiae
    - Skin involvement, ≥ One:

The interface also includes a left sidebar with navigation options like Select Day, Episode Day 1-6, Primary Outcome, Review Results, Review Summary, Export, Clinical Evidence Summaries, Reference, and View Discharge Screens. A right sidebar contains buttons for Save, Save & Print, Documents, Save and Launch Web Query, Files, and Cancel. At the bottom, there is a Status dropdown set to Complete, a Next Review field, and a Help button.



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# Using Screening Criteria - CERME

The screenshot displays the CareEnhance Review Manager Enterprise interface. At the top, the patient information is shown: Patient Name/ID: Ackling, Mae / 66787679, Review # New Review, Product: LOC:Acute, and a status of 'In Progress'. The interface is divided into a left-hand navigation pane and a main content area. The navigation pane includes sections for 'Transition Plan', 'Risk factors for readmission', 'Expected Discharge Level of Care', and various care levels: HOME, HOME CARE, SKILLED NURSING FACILITY (SNF), SUBACUTE CARE (SAC), LONG-TERM ACUTE CARE (LTAC), and ACUTE REHABILITATION. The 'SUBACUTE CARE (SAC)' option is currently selected. The main content area displays a tree view of screening criteria under the heading 'SUBACUTE CARE (SAC)'. The criteria include: 'Lower level of care inappropriate' (with a sub-item 'Outpatient or home care services unavailable or inappropriate due to clinical complexity'), 'Patient or caregiver unable to manage care:', 'Skilled service required for assessment, treatment, monitoring, or education' (with sub-items 'Medical practitioner oversight at least 2 times per week' and 'Nursing 4h or more per day or skilled therapy 2-3h per day at least 5d per week'), 'SAC facility available' (with sub-items 'Provide information to patient or caregiver' and 'Review site information or visit site'), and 'Complete prior to facility transfer'. At the bottom of the interface, there is a status bar indicating 'No InterQual notes to display' and a button labeled 'Add Reviewer Comment'.



# 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

The screenshot displays two overlapping windows from the Midas+ Emergency Department Module. The top window shows patient information for Emby, John, including DOB, MRN, and admission details. The bottom window shows a detailed view of the patient's diagnosis, listing '493.90 Asthma NOS'.

**Top Window Data:**

Name:	Emby, John	DOB/Sex:	7/11/2001 11Y / M	MRN:		Enc. Type:	Emergency
Facility:	Midas General Hospital	Account No.:	250118980	Start:	1/29/2013 8:45 PM		
Admitting Phys.:		Location/Room:	Emergency Department / 5	End:	1/29/2013 11:54 PM		
Attending Phys.:	Hogan, Sean	Principal Payer:	Champus	LOS:	1		

**Bottom Window Data:**

Name:	Emby, John	DOB/Sex:	7/11/2001 11Y / M	MRN:		Enc. Type:	Emergency
Facility:	Midas General Hospital	Account No.:	250118980	Start:	1/29/2013 8:45 PM		
Admitting Phys.:		Location/Room:	Emergency Department / 5	End:	1/29/2013 11:54 PM		
Attending Phys.:	Hogan, Sean	Principal Payer:	Champus	LOS:	1		

**Diagnosis List:**

- 493.90 Asthma NOS



# Create User Fields for the ED Module

Name:	<b>Borgus,Michael</b>	DOB/Sex:	<b>11/27/1948 65Y / M</b>	MRN:	<b>6765-556</b>	Enc. Type:	<b>Emergency</b>	<input type="button" value="E"/>	<input type="button" value="+"/>
Facility:	<b>Midas Medical Center</b>	Account No.:	<b>7856757575</b>	Start:	<b>2/16/2014 3:20 PM</b>				
Admitting Phvs.:		Location/Room:	<b>Emergency Department / 4</b>	End:	<b>2/16/2014 10:45 PM</b>				
Attending Phvs.:		Principal Payer:		LOS:	<b>1</b>				

General DischargeDiagnoses **UserFields**

Mode of Arrival:

ED Times Disposition

Follow Up Medical Care:

- ▶ Referred to St. Martin's Free Clinic
- Prescriptions fulfilled in ED

Date and Time of Appointment for with Follow Up Provider:

Follow Up Social Care:

- Referred to Community Food Bank
- Transportation provided

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 Lasix doses for the next 14 d.



# 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
<b>What's ahead?</b>	
<input type="checkbox"/> 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.	
<input type="checkbox"/> If a caregiver will be helping you after discharge, write down their name and phone number.	
<b>Your health</b>	
<input type="checkbox"/> Ask the staff about your health condition and what you can do to help yourself get better.	
<input type="checkbox"/> 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.	



# Patient Handout

Action items	Notes
<input type="checkbox"/> Use "My drug list" on page 5 to write down your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.	
<input type="checkbox"/> Review the list with the staff.	
<input type="checkbox"/> Tell the staff what drugs, vitamins, or supplements you took before you were admitted. Ask if you should still take these after you leave.	
<input type="checkbox"/> Write down a name and phone number of a person to call if you have questions.	
<b>Recovery &amp; support</b>	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Ask if you're ready to do the activities below. Circle the ones you need help with, and tell the staff:	
<ul style="list-style-type: none"> <li>Bathing, dressing, using the bathroom, climbing stairs</li> <li>Cooking, food shopping, house cleaning, paying bills</li> <li>Getting to doctors' appointments, picking up prescription drugs</li> </ul>	
<input type="checkbox"/> Make sure you have support (like a caregiver) in place that can help you. See "Resources" on page 6 for more information.	
<input type="checkbox"/> 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.	
<input type="checkbox"/> 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.	
<input type="checkbox"/> 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
<input type="checkbox"/> 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.	
<input type="checkbox"/> Use "My appointments" on page 5 to write down any appointments and tests you'll need in the next several weeks.	
<b>For the caregiver</b>	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Can you give the patient the help he or she needs?	
<input type="checkbox"/> What tasks do you need help with?	
<input type="checkbox"/> Do you need any education or training?	
<input type="checkbox"/> Talk to the staff about getting the help you need before discharge.	
<input type="checkbox"/> Write down a name and phone number of a person you can call if you have questions.	
<input type="checkbox"/> Get prescriptions and any special diet instructions early, so you won't have to make extra trips after discharge.	
<b>More information for people with Medicare</b>	
<b>If you need help choosing a home health agency or nursing home:</b> <ul style="list-style-type: none"> <li>Talk to the staff.</li> <li>Visit <a href="http://Medicare.gov">Medicare.gov</a> to compare the quality of home health agencies, nursing homes, dialysis facilities, and hospitals in your area.</li> <li>Call <b>1-800-MEDICARE</b> (1-800-633-4227). TTY users should call 1-877-486-2048.</li> </ul>	
<b>If you think you're being asked to leave a hospital or other health care setting (discharged) too soon:</b> <p>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 <a href="http://Medicare.gov/contacts">Medicare.gov/contacts</a>, or call <b>1-800-MEDICARE</b>. 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.</p> <p>For more information on your right to appeal, visit <a href="http://Medicare.gov/appeals">Medicare.gov/appeals</a>, or visit <a href="http://Medicare.gov/publications">Medicare.gov/publications</a> to view the booklet "Medicare Appeals."</p>	

4



# Universal Patient Discharge Checklist



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

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



## 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



Midas+ Annual Symposium  
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# 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)

		<b>Patient PASS: A Transition Record</b> Patient Preparation to Address Situations (after discharge) Successfully	
<b>I was in the hospital because</b>			
<b>If I have the following problems ...</b>		<b>I should ...</b>	
1. _____		1. _____	
2. _____		2. _____	
3. _____		3. _____	
4. _____		4. _____	
5. _____		5. _____	
<b>My appointments:</b>		<b>Tests and issues I need to talk with my doctor(s) about at my clinic visit:</b>	
1. _____		1. _____	
On: ___/___/___ at ___:___ am/pm		2. _____	
For: _____		3. _____	
2. _____		4. _____	
On: ___/___/___ at ___:___ am/pm		5. _____	
For: _____			
3. _____			
On: ___/___/___ at ___:___ am/pm			
For: _____			
4. _____			
On: ___/___/___ at ___:___ am/pm			
For: _____			
<b>Important contact information:</b>			
1. My primary doctor:			
_____			
2. My hospital doctor:			
_____			
3. My visiting nurse:			
_____			
4. My pharmacy: _____			
_____			
5. Other: _____			
_____			
<b>Other instructions:</b>			
1. _____			
2. _____			
3. _____			
<b>I understand my treatment plan. I feel able and willing to participate actively in my care:</b>			
_____ <b>Patient/Caregiver Signature</b>			
_____ <b>Provider Signature</b>			
___/___/___ <b>Date</b>			



# BOOST Patient Pass

Teach-Back Patient Pass

**If I have the following problems**

1.

2.

3.

4.

5.

**Then I should**

1.

2.

3.

4.

5.

**Important contact informat**

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:

# 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:	Important Contact Information
I get short of breath	Rest, and call my primary care doctor if it gets worse	My primary care doctor: Johnathan Perez (520)444-4444
I get fluid in my legs	Keep my feet elevated.	My hospital doctor: Margaret Maloney (520)333-3333
I get fluid build up in my lungs	Weigh myself daily. If my weight is up 2 lbs, call my PCP	My visiting nurse: None My pharmacy: Walgreens (520)555-5555
<b>My appointments</b>		Other: Paul Chang, Cardiologist (520)777-7777
Dr. Perez, Marana Clinic 01/20/2014 at 2:00pm		
Dr. Chang, 1500 N. Broadway 02/03/2014 at 9:00am		
<b>Tests and Issues I need to talk with my doctor about at my next clinic visit</b>		
My current medications (bring with you to all appointments)		
A list of my blood pressures taken everyday		
A list of my daily weights		
<b>Other Instructions</b>		
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



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# Referrals to TCC: Concurrent Review

## Use Concurrent Review to Identify Targeted Readmission Diagnoses

The screenshot displays a software interface for concurrent review with the following fields and values:

- General** | Payers | Referral | InterQual | Comments | Episode User Fields | Series User Fields
- Review Date:** 3/20/2014 | **Review Time:** 10:43 AM | **Care Date:** 3/12/2014
- Review By:** Clark, Barb | **Level of Care:** Acute
- Review Location:** 3300 East | **Review Category:** Discharge
- Severity:** \* [dropdown menu]
- Intensity:** \* [dropdown menu]
- Series Fields Common Across Reviews**
- Admission Review Reason:** Targeted Readmission Prevention (highlighted in red circle)
- Diagnostic Category:** Heart Failure (highlighted in red circle)
- Prioritize:**
- Reason for Priority:** High-Risk Diagnosis (dropdown menu)
- HCM Diagnosis:** [text field]
- HCM Procedure:** [text field]
- DRG:** [text field]
- Length of Stay:** Arithmetic: [text field] | Geometric: [text field] | Current: 1 | Outlier: [text field]



# Using Support Services to Generate Follow-up

General Comments Episode User Fields Series User Fields

Date Entered: 4/8/2014

Type: Transitional Care Coaching

Service: Education & Counseling - Other

Payer: Self-Pay

Region:

Case Worker: Clark, Barb

Case Hrs: Worklist Date: 4/8/2014

Frequency: protocol Time: 12:43 PM

Referral Status:

Completed:

General Comments Episode User Fields Series User Fields

--- 4/8/2014 12:44 PM by Barbara Craig ---  
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

Assessment Patient Care Discharge Info Comments **User Fields**

Referral Source: Family

Emotional/Cognitive Assessment: Apprehensive  
Angry

Existing Support System: Family

Psychosocial Concerns: Financial  
Unrealistic expectations

Advance Directives: None

Identified Needs/Problem List: Transitional Care Coach

Proposed Discharge Plan:

# Observation Module

File Edit View Function SmartMenu Tools Window Help

Name: **Erickson,Raymond** DOB/Sex: **11/29/1969 43Y / M** MRN: **575137** Enc. Type: **Observation** [E] [+]

General Discharge DX/Procedures Comments User Fields

Start Date: 1/17/2013 Start Time: 11:30 AM Elapsed Time: 49:54

End Date: 1/19/2013 End Time: 1:24 PM

Attending Phys.: Jones,Hilary Kathleen Principal Payer: Partners Health Plans

Admitting Phys.: Atkins,Susan Alene Secondary Payer:

Disposition: Discharge

Location: 2200 East Room: 2234

Complaint: Chest Pain

File Edit View Function SmartMenu Tools Window Help

Name: **Erickson,Raymond** DOB/Sex: **11/29/1969 43Y / M** MRN: **575137** Enc. Type: **Observation** [E] [+]

UserFields

Patient does not meet Inpatient Criteria:  Patient was originally admitted to Inpatient Status:

Observation Criteria Met: [List Box] Medicare Condition requiring Extended Observation 24-48 hours: [Text Box]

Case Manager: [Text Box]

Patient Referral to CCM:  Yes  No



# Medical History

File Edit View Function SmartMenu Tools Window Help

Name: **Borgus,Michael**    DOB/Sex: **11/27/1948 65Y / M**    MRN: **6765-556**

General Medications/Diagnostic Tests

<b>Allergy</b>	Date	Reaction
Demerol	1/1/1999	Restlessness
Iodine	1/2/1988	Anaphyl
*		

<b>Immunization</b>	Date
Flu Vaccine	11/1/2013
Diphtheria, Tetanus, Petussis	2/14/2012
*	

File Edit View Function SmartMenu Tools Window Help

Name: **Borgus,Michael**    DOB/Sex: **11/27/1948 65Y / M**    MRN: **6765-556**

General Medications/Diagnostic Tests

<b>Medication</b>	Dose	Frequency	Route	Start Date	End Date	Physician
Digoxin	125 MCG	BID	PO	7/2/2013		Jones,Hilary Kathleen
Furosemide	40MG	BID	PO	5/25/2013		Jones,Hilary Kathleen
*						

<b>Diagnostic Test</b>	Date	Result
Serum Creatine	1/29/2014	1.7
*		



# Medical History Problem List

File Edit View Function SmartMenu Tools Window Help

Name: **Borgus, Michael**      DOB/Sex: **11/27/1948 65Y / M**      MRN: **6765-556**      > E +

Existing Diagnoses/Procedures

Enc. Date	Facility	Diagnosis/Procedure	
3/7/2014	Midas Medical Center	459.3 Chr Venous Hypertension	▲
3/7/2014	Midas Medical Center	N39.0 Urinary tract infection, site not specified	▼
3/7/2014	Midas Medical Center	87.49 Chest x-ray NEC	▼
1/14/2014	Midas Medical Center	401.0 Hypertensive NOS	▼

Add to Problem List

Problem List

Diagnosis	Date	Status	
428.21 Ac systolic hrt failure	3/7/2014	Chronic	▼
428.20 Systolic hrt failure NOS	2/16/2014	Major	▼
428.2 Systolic Heart Failure	1/14/2014		▼

Procedure	Date	Status	
96.05 Resp tract intubat NEC	3/7/2014	Resolved	▼

Patient-Identified Illness	Date	Status	
Heart Failure	5/11/2013	Chronic	▼



# Medical History User Fields


File Edit View Function SmartMenu Tools Window Help

Name: **Borgus,Michael**      DOB/Sex: **11/27/1948 65Y / M**      MRN: **6765-556**      > E +

General Medications/Diagnostic Tests **User Fields**

Patent needs chronic care manager for:

CHF
Psychiatric Conditions
<input type="text"/>

Date referred to chronic care manager:  

# Coordination with Post- discharge Providers



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)



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# Four Launch Points from Midas+

## Concurrent Review

The screenshot shows the 'Concurrent Review' form in Midas+. The form is divided into several sections: 'General' (Review Date, Review Time, Care Date), 'Review By' (Level of Care), 'Review Location' (Severity, Intensity), and 'Series Fields Common Across Reviews' (Admission Review Reason, Diagnostic Category, HCM Diagnosis, HCM Procedure, DRG, Length of Stay). A red box highlights the 'Save and Launch Web Query' button in the right-hand navigation pane. Other buttons include 'Save', 'Save & Print', 'Documents', 'Files', 'Midas+ Live', and 'Cancel'. The status is 'Status: [dropdown]' and the next review is 'Next Review: 4/23/2013'.

## Certification Entry

The screenshot shows the 'Certification Entry' form in Midas+. The form includes a 'Payer' dropdown, 'Details for' section, and a 'Basic: Payer Detail' section with fields for Payer Status, Process Date, Authorization No., Service Start, Insurance No., Service End, and Total Cert. Days. A table titled 'Certifications' is visible with columns: Start Date, End Date, # Days, Type, Status, Auth. No., Ref. No., and More... A red box highlights the 'Save and Launch Web Query' button in the right-hand navigation pane. Other buttons include 'Save', 'Save & Print', 'Documents', 'Files', 'Payer Info', and 'Close'. The status is 'Status: [dropdown]' and the next review is 'Next Review: 4/23/2013'.

## Discharge Planning

The screenshot shows the 'Discharge Planning' form in Midas+. The form includes sections for 'Case Worker', 'ADL Limit', 'Living Status', 'Setting', and 'Current Agencies'. A red box highlights the 'Save and Launch Web Query' button in the right-hand navigation pane. Other buttons include 'Save', 'Save & Print', 'Documents', 'Close', and 'Navigate'. The status is 'Status: [dropdown]' and the next review is 'Next Review: 4/23/2013'.

## Support Services

The screenshot shows the 'Support Services' form in Midas+. The form includes sections for 'Date Entered', 'Case Worker', 'Type', 'Case Hrs', 'Worklet Date', 'Frequency', 'Time', 'Payer', 'Referral Status', 'Region', 'Completed', 'Agency', 'Special Lookup', 'Change Parameters', 'Agency Status', 'Anticipated Start Date', 'Assigned Level of Care', 'Actual Start Date', and 'Assigned Bed Type'. A red box highlights the 'Save and Launch Web Query' button in the right-hand navigation pane. Other buttons include 'Save', 'Save & Print', 'Save & Add', 'Documents', 'Agency Details', 'Files', and 'Close'. The status is 'Status: [dropdown]' and the next review is 'Next Review: 4/23/2013'.



# Curaspan



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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

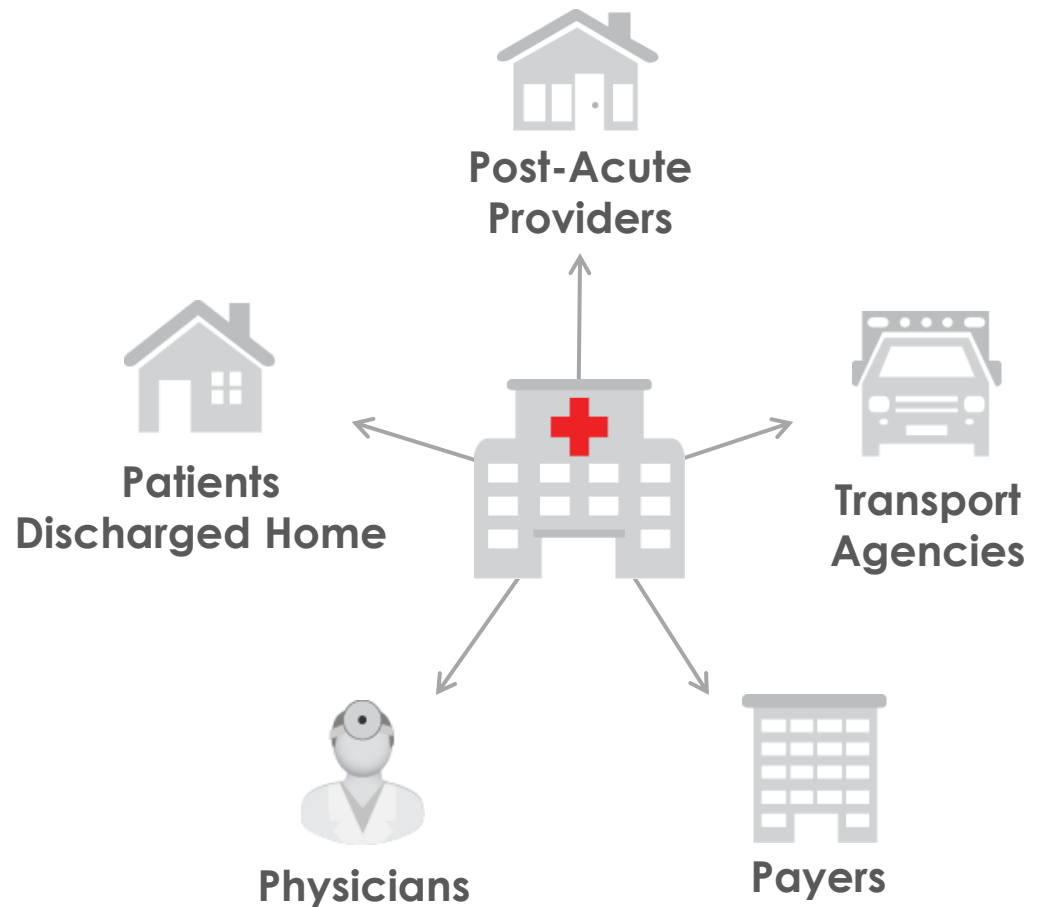
# Curaspan Powers Care Transitions

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

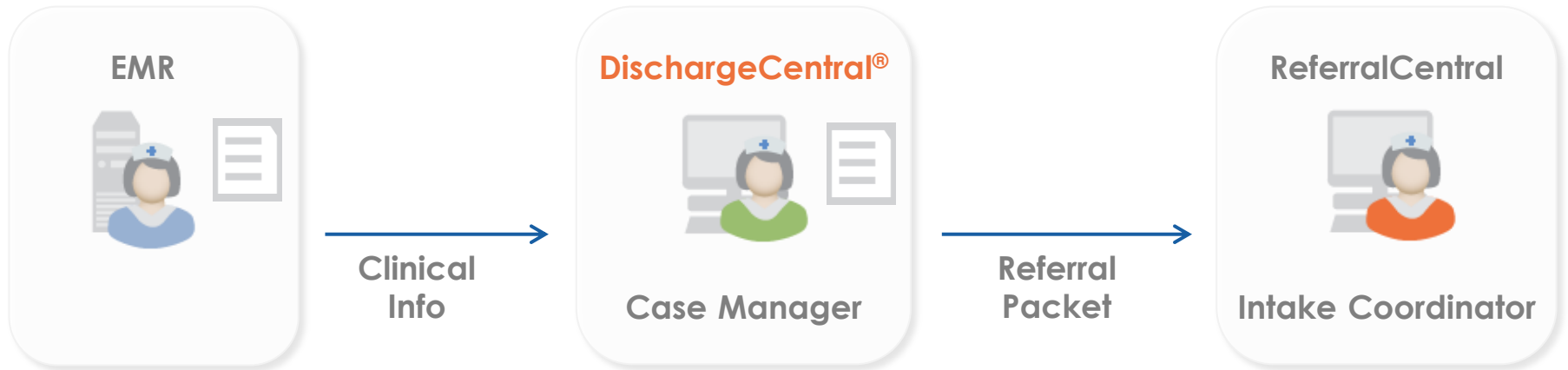
**15** years leading the industry

**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



**Boston Garden Hospital**

Discharge Doc Mgr Review Reports

0 Alerts

Logged in for: 0 hr. 10 min. 53 sec.

Return to Workbook
Help My Account Home Log Out

**Gold, Monica**

?
✍
📄
🔄
🖨

Estimated Discharge: 04-18-2014

Save Patient Record

Intake
Assessment
Matching
Implementation

👤 Discharge

📧 Create Inbound Fax Cover Sheet

Forms

Documents


**Forms** (Attached forms are viewable by post-acute providers)

Attach	Form Name	Last Edit Date	Form Complete	Complete Date
<input checked="" type="checkbox"/>	📄 Patient Information Form (rev.7/2012)	04-02-14 17:13 PM	<input type="checkbox"/>	
<input type="checkbox"/>	📄 Clinical Update Form (9/2008)		<input type="checkbox"/>	
<input type="checkbox"/>	📄 Discharge Transfer Form (10/2008)		<input type="checkbox"/>	
<input type="checkbox"/>	📄 DME - Durable Medical Equipment Form (2/2010)		<input type="checkbox"/>	
<input type="checkbox"/>	📄 Home Care Intake Form (11/2007)		<input type="checkbox"/>	
<input type="checkbox"/>	📄 Important Message - Notification of Discharge Rights (OMB 0938-0692) (rev.7/2010)		<input type="checkbox"/>	
<input type="checkbox"/>	📄 Important Message - Notification of Discharge Rights (OMB 0938-0692)-Spanish Version (rev.7/2010)		<input type="checkbox"/>	
<input type="checkbox"/>	📄 MI Preadmission Screening (PAS) / Annual Resident Review		<input type="checkbox"/>	

**Documents**

Attach	Action	Document Name	Receipt Date	Shared
<input checked="" type="checkbox"/>	<span style="border: 1px solid #ccc; padding: 2px 5px;">Rename</span>	📄 MD Order 040214	04-02-14 16:00 PM	
<input checked="" type="checkbox"/>	<span style="border: 1px solid #ccc; padding: 2px 5px;">Rename</span>	📄 MARs 040114	04-02-14 15:59 PM	

# Search for Available and Qualified Providers



**Boston Garden Hospital**

Discharge Doc Mgr Review Reports

**0 Alerts** ▾

Logged in for: 0 hr. 20 min. 14 sec.

Return to Workbook Help My Account Home Log Out

**Gold, Monica**

Intake Assessment **Matching** Implementation

Estimated Discharge:\* 04-18-2014

**Search for Matching Providers**

POS\* **NEEDS A BED** ▾

Level\* **Skilled Nursing Facility (SNF)** ▾

Key Services

- Joint Commission
- Isolation
- Ventilator Weaning

Match all selected key services

Provider

State **ZZ** ▾

County **Curaspan** ▾

City **All** ▾

Or  Search Entire State

ZIP **No ZIP Selected** ▾

Distance **No Range Selected** ▾

In Hospital Network

More Options **Search**

**80 Match Results 0 Selected | Select All | Clear**

Create Provider Matching List
Add to My Scratch Pad
Send Booking Request
 View My Scratch Pad

	Provider Name	Distance	Info	Avail	Notification
<input type="checkbox"/>	Thunder Test Nursing and Rehab	--		yes	Notified
<input type="checkbox"/>	ReferralCentral Critical Care Provider	--		yes	Notified
<input type="checkbox"/>	ReferralCentral Skilled Nursing Facility	--		n/a	Notified
<input type="checkbox"/>	Sunnyside Test Nursing Home	--		n/a	Connected
<input type="checkbox"/>	ACME Demo Nursing Care Center	--		n/a	Connected
<input type="checkbox"/>	Test Darragh SNF	--		n/a	Connected
<input type="checkbox"/>	Test Chronic Care Provider	--		n/a	Connected
<input type="checkbox"/>	NDM Test Healthcare Center	--		n/a	Connected
<input type="checkbox"/>	Test Demo Rehab Center	--		n/a	Connected
<input type="checkbox"/>	Test Cayer Nursing Home	--		n/a	Connected
<input type="checkbox"/>	Test Assisted Living	--		n/a	Connected
<input type="checkbox"/>	Demo Clinic One	--		n/a	Connected
<input type="checkbox"/>	Curaspan Happy Days Nursing Home	--		n/a	Connected
<input type="checkbox"/>	Rocky Mountain SNF Demo	--		n/a	Connected

# Share Detailed Provider Profiles

Print
Close

### Thunder Test Nursing and Rehab

Address **28282 Cloudburst Drive  
CURASPAN CITY, ZZ 99999**

Phone **(617) 395-0125**

Fax **(617) 849-7694**

Contact

Visiting Hours **Please contact provider**

Availability Last Updated **Wednesday Apr 02, 2014**

#### Level of Care

	Male Beds	Female Beds
<input type="radio"/> SNF / Chronic		
<input type="radio"/> Skilled Nursing Facility (SNF)		
<input type="radio"/> SNF / Rehab		

#### Payer Information

Payer Name	Contract Expires	Comments
AETNA	07-15-2011	Hospital employee provider
Medicare HMO	04-30-2011	Cert line 800-435-3344

#### Available Key Services

#### Clinical Services

- Speech Therapy
- Adolescent Services
- Locked Unit
- Wound Vac
- Infusion Therapy
- Pharmacy Services
- Vocational Services

#### Non-Clinical Services

- Clinical Diets
- Internet Access (for patients/residents)
- Dining Hall
- Semi-Private Room
- Full Dietary Services
- Barber/Beauty Services
- Exercise Room
- Private Room
- Kosher Style
- Kosher
- Private Room Phone

# Send Referral Packets to Multiple Providers Simultaneously

**Curaspan HEALTH GROUP** Boston Garden Hospital 0 Alerts  
 Get Connected.® Discharge Doc Mgr Review Reports Logged in for: 0 hr. 20 min. 14 sec.

[Return to Workbook](#) Help My Account Home Log Out

**Gold, Monica** Estimated Discharge:\* 04-18-2014

**Intake** **Assessment** **Matching** **Implementation** Discharge

### Search for Matching Providers

POS\* **NEEDS A BED**

Level\* **Skilled Nursing Facility (SNF)**

Key Services  
 Joint Commission  
 Isolation  
 Ventilator Weaning  
 Match all selected key services

Provider

State **ZZ**

County **Curaspan**

City **All**

Or  Search Entire State

ZIP **No ZIP Selected**

Distance **No Range Selected**

In Hospital Network

[More Options](#) Search

80 Match Results 0 Selected | [Select All](#) | [Clear](#)

[Create Provider Matching List](#) [Add to My Scratch Pad](#) [Send Booking Request](#) [View My Scratch Pad](#)

	Provider Name	Distance	Info	Avail	Notification
<input type="checkbox"/>	Thunder Test Nursing and Rehab	--	<a href="#">i</a>	yes	Notified
<input type="checkbox"/>	ReferralCentral Critical Care Provider	--	<a href="#">i</a>	yes	Notified
<input type="checkbox"/>	ReferralCentral Skilled Nursing Facility	--	<a href="#">i</a>	n/a	Notified
<input type="checkbox"/>	Sunnyside Test Nursing Home	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	ACME Demo Nursing Care Center	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Test Darragh SNF	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Test Chronic Care Provider	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	NDM Test Healthcare Center	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Test Demo Rehab Center	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Test Cayer Nursing Home	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Test Assisted Living	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Demo Clinic One	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Curaspan Happy Days Nursing Home	--	<a href="#">i</a>	n/a	Connected
<input type="checkbox"/>	Rocky Mountain SNF Demo	--	<a href="#">i</a>	n/a	Connected



# View All Referral Activity in One Place

**Curaspan**  
HEALTH GROUP  
Get Connected.®

**Boston Garden Hospital**

**0 Alerts** ▼

Discharge Doc Mgr Review Reports

Logged in for: 0 hr. 24 min. 25 sec.

Return to Workbook Help | My Account | Home | Log Out

**Gold, Monica**

Estimated Discharge:\* 04-18-2014

Intake Assessment Matching **Implementation** Discharge

Discharge

Provider Status: Select One

**Connected Provider(s)**

Book Referral Send Message

Connected Providers	Status	Provider Status	Msg	Action
Thunder Test Nursing and Rehab	Booked on 04-02-14 21:13	Accept on 04-02-14 21:03		<span style="border: 1px solid #ccc; padding: 2px 5px;">Message &amp; Actions</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notification Log</span>
ReferralCentral Critical Care Provider	Notified on 04-02-14 20:49	No Response Submitted		<span style="border: 1px solid #ccc; padding: 2px 5px;">Message &amp; Actions</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notification Log</span>
ReferralCentral Skilled Nursing Facility	Notified on 04-02-14 20:49	No Response Submitted		<span style="border: 1px solid #ccc; padding: 2px 5px;">Message &amp; Actions</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notification Log</span>

**Unconnected Provider(s)**

Send Fax

Providers	Phone Number	Provider Status	Action
Appletree Test Care Center	(617) 395-0125	QuickCase Accepted on 04-02-14 21:08	<span style="border: 1px solid #ccc; padding: 2px 5px;">Send Fax</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notes and Status</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Fax History</span>
Business Central Provider	(617) 395-0125	QuickCase Pending on 04-02-14 20:49	<span style="border: 1px solid #ccc; padding: 2px 5px;">Send Fax</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notes and Status</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Fax History</span>

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

Address Book

\* Attachments

\* Organization Type Select One

\* Organization Name

Document Name	Receipt Date	Last Update Date

# Communicate with Providers Securely

**Submit a Response**

Gold, Monica booking request with Thunder Test Nursing and Rehab

Notes:

Update Message Status

Message Only

- Select a Status
- Message Only
- Booked
- Cancel
- Suspend
- Delayed EDD
- Clinical Update
- Re-open Referral

Thunder Test Nursing and Rehab  ReferralCentral Critical Care Provider

Thunder Test Nursing

Select All | Clear All

Send Cancel


**Communication history with this booking request**

<i>Status changed from Notified to Booked</i>	04-02-14 21:13 PM By Cheri Bankston
Ambulance is picking patient up at noon. Thanks	04-02-14 21:13 PM By Cheri Bankston
Bed Ready- let us know when patient is leaving.	04-02-14 21:03 PM By Cheri Bankston
<i>Status changed from Received to Accept</i>	04-02-14 21:03 PM By Cheri Bankston
We have a bed today. Please let us know if patient would arrive before noon.	04-02-14 21:02 PM By Cheri Bankston
<i>Status changed from No Response to Received</i>	04-02-14 21:01 PM By Cheri Bankston

Print

Send Cancel

# Notify All Providers When Referral is Booked



**Boston Garden Hospital**

Discharge Doc Mgr Review Reports

0 Alerts

Logged in for: 0 hr. 24 min. 25 sec.

Return to Workbook
Help My Account Home Log Out

**Gold, Monica**

Intake
Assessment
Matching
Implementation
Discharge

Estimated Discharge:\* 04-18-2014

Provider Status: Select One

**Connected Provider(s)**

Book Referral
Send Message

Connected Providers	Status	Provider Status	Msg	Action
Thunder Test Nursing and Rehab	Booked on 04-02-14 21:13	Accept on 04-02-14 21:03	✉	<span style="border: 1px solid #ccc; padding: 2px 5px;">Message &amp; Actions</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notification Log</span>
ReferralCentral Critical Care Provider	Notified on 04-02-14 20:49	No Response Submitted	✉	<span style="border: 1px solid #ccc; padding: 2px 5px;">Message &amp; Actions</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notification Log</span>
ReferralCentral Skilled Nursing Facility	Notified on 04-02-14 20:49	No Response Submitted	✉	<span style="border: 1px solid #ccc; padding: 2px 5px;">Message &amp; Actions</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notification Log</span>

**Unconnected Provider(s)**

Send Fax

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Appletree Test Care Center	(617) 395-0125	QuickCase Accepted on 04-02-14 21:08	<span style="border: 1px solid #ccc; padding: 2px 5px;">Send Fax</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notes and Status</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Fax History</span>
Business Central Provider	(617) 395-0125	QuickCase Pending on 04-02-14 20:49	<span style="border: 1px solid #ccc; padding: 2px 5px;">Send Fax</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Notes and Status</span> <span style="border: 1px solid #ccc; padding: 2px 5px;">Fax History</span>

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

Address Book

\* Organization Type Select One

\* Organization Name

\* Attachments

Document Name	Receipt Date	Last Update Date
...	...	...

# Involve Other Members of the Care Continuum

**Curaspan HEALTH GROUP** Boston Garden Hospital 0 Alerts  
Get Connected.® Discharge Doc Mgr Review Reports Annie Hetzel Busch Logged in for: 0 hr, 47 min, 37 sec.

[Return to Workbook](#) Help My Account Home Log Out

**Gold, Monica** Estimated Discharge: 04-18-2014

Intake Assessment Matching Implementation Discharge

Provider Status: Select One

Connected Provider(s)

Connected Providers	Status	Provider Status	Msg	Action
Thunder Test Nursing and Rehab	Booked on 04-02-14 21:13	Accept on 04-02-14 21:03		Message & Actions Notification Log
ReferralCentral Critical Care Provider	Notified on 04-02-14 20:49	No Response Submitted	✉	Message & Actions Notification Log
ReferralCentral Skilled Nursing Facility	Notified on 04-02-14 20:49	No Response Submitted	✉	Message & Actions Notification Log

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

Address Book

\* Organization Type Select One

\* Organization Name Dr. Michael Sanders

\* Fax Number (601) 255-4274

Attention Sarah - Scheduling

Comment Patient know to Dr. Sanders -- recently in hospital - follow-up in 2 weeks for recheck of HbgA1C

Add Organization to My Address Book

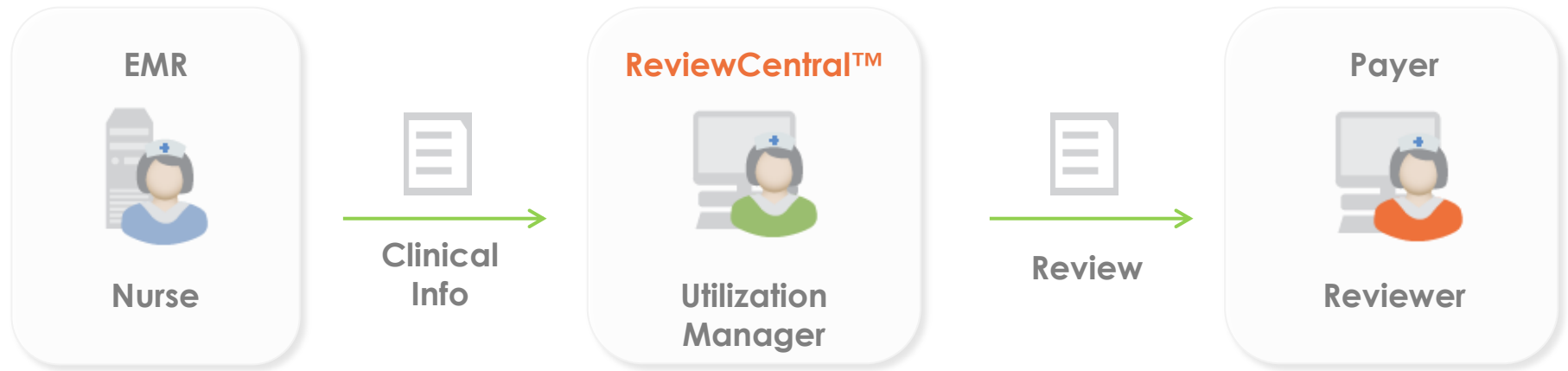
### \* Attachments

	Document Name	Receipt Date	Last Update Date
[1] <input type="checkbox"/>	Patient Information Form		04-02-14 17:13
[1] <input type="checkbox"/>	Consult Note	04-02-14 15:59	04-02-14 15:59
[5] <input type="checkbox"/>	History and Physical	04-02-14 15:57	04-02-14 15:57
...	...	...	...

Send Clear


Show Fax History


# 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

Get Connected.®0 AlertsAcceptanceDischargeDoc MgrReviewReportsProfileSetupCheri Bankston Logged in for: 0 hr. 7 min. 12 sec.Admin | Help | My Account | Home | Log Out

**Monica Gold** 

Date of Birth:	02-17-1952	Account #:	1130042	Admitted Date:	11-03-2013
Attending Physician:	Lisa Brown	Member ID:	AGC22336-9	Estimated Discharge:	04-18-2014
		Medical Record #:	101462	Actual Discharge:	
		Status:	M	Admit Type:	Other

Diagnosis	Code	Local Payer	Fax	Assign Payer
		ACME INSURANCE		<input type="button" value="Assign Payer"/>

**Payer Authorization**  Approved: 0 Denied: 0

Next Action Due:

**Messages / Notes To Payer**


# Create and Submit All Forms and Documents Electronically

The screenshot shows the Curaspan Health Group interface for an Insurance Review. The main window is titled "Insurance Review" and contains the following sections:


- Header:** Curaspan HEALTH GROUP logo, navigation tabs (Acceptance, Discharge, Doc Mgr, Review, Reports, Profile, Setup), user info (Cheri Bankston, Logged in for: 1 hr. 2 min. 22 sec.), and a "0 Alerts" dropdown.
- Case Manager:** Search bar with "Bankston, Cheri" and a "Close Case" button.
- Encounter Information:** Fields for Diagnosis (ICD): Periapical Abscess, CPT Code: 522.5, Service Type: Select, Length of Stay: 3 Days, Request Type: Select, Admit Date: 11-03-2013, Start: 11-03-2013, End: 11-05-2013, Status: Inpatient, Level: Med/Surg.
- Forms and Documents:** A list of forms including "Patient Information Form (rev.7/2012)", "Utilization Review Communication Form - Payer (12/2012)", "VA Uniform Assessment Instrument - (rev.12/2010) Adobe Version", "WI PASARR Level I Screen F-22191 (rev. 8/2008)", and "WI Preadmission Screening and Resident Review (PASARR) Level I Screen (DDE-2191, Rev 06/2005)".
- Documents Table:**

Documents	Status	Share
<input checked="" type="checkbox"/> Consult Note	New 04-02-14 02:59 PM	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> History and Physical	New 04-02-14 02:57 PM	<input checked="" type="checkbox"/>
- Notes:** A text area containing "Please review and call me with any questions."
- Contact:** Fields for "Contact: Mary" and "(555) 555-5555", with an "Address Book" button.
- Buttons:** "Submit" and "Cancel" buttons at the bottom right.

# Monitor Submission Status

Get Connected.®0 AlertsAcceptanceDischargeDoc MgrReviewReportsProfileSetupCheri Bankston Logged in for: 1 hr. 2 min. 22 sec.Admin | Help | My Account | Home | Log Out

[Return to Workbook](#) |  | Case Manager: **Bankston, Cheri** | [Close Case](#) | [Print](#) | [Add Note](#) | Authorization Number:

**Monica Gold** 

Date of Birth: 02-17-1952 | Account #: 1130042 | Admitted Date: 11-03-2013  
Attending Physician: Lisa Brown | Member ID: AGC22336-9 | Estimated Discharge: 04-18-2014  
Medical Record #: 101462 | Status: M | Actual Discharge:   
Admit Type: Other

Diagnosis	Code	Local Payer	Fax	Assign Payer
		ACME INSURANCE		<a href="#">Assign Payer</a>

### Payer Authorization

[New Payer Review](#) | ✔ Approved: 0 | ✘ Denied: 0

Next Action Due:  | [View Detailed History](#) | [Create Inbound Fax Cover Sheet](#)

			<a href="#">View Submission</a>	<a href="#">Status</a>
11-03-2013-	Inpatient	Submitted		
11-05-2013	Med/Surg	04-03-2014 04:20:07		

**Note:**

### Messages / Notes To Payer

Please review and call me with any questions. Cheri Bankston  
[Mark as Unread](#) | 04-03-14 04:20 PM



# Document and Track Approvals and Denials

0 Alerts

Cheri Bankston Logged in for: 1 hr, 2 min, 22 sec

Admin | Help | My Account | Home | Log Out

Print | Add Note | Authorization Number: \_\_\_\_\_

Setup

Case

**Last Status Received**

Enter approvals for : All Days

Date	Approved	Denied	Pending	Reason
<b>All Dates</b>	✓	✗	⌚	Evaluating Patient Information
(11-03-2013 - 11-05-2013)				

Authorization Number: 8675309

Next Review Date: 11-05-2013

Authorized By: Mary

Contact Number: 555-555-5555

**Last Status Received**

Enter approvals for : All Days

Date	Approved	Denied	Pending	Reason
<b>All Dates</b>	✓	✗	⌚	Does not meet criteria
(11-03-2013 - 11-05-2013)				

Authorization Number \* 8675309

Next Review Date: 11-05-2013

Authorized By: Mary

Contact Number: 555-555-5555

**Last Status Received**

Enter approvals for : All Days

Date	Approved	Denied	Pending	Reason
<b>All Dates</b>	✓	✗	⌚	
(11-03-2013 - 11-05-2013)				

Authorization Number \* 8675309

Next Review Date: 11-05-2013

Authorized By: Mary

Contact Number: 555-555-5555

Notes: Spoke with Mary; send updated lab results


Submit

11-03-2013- Inpatient  
11-05-2013 Med/Surg

**Note:**

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# Track Approved Days



Get Connected.®

Acceptance Discharge Doc Mgr Review Reports Profile Setup

Cheri Bankston Logged in for: 1 hr. 2 min. 22 sec.

0 Alerts

Return to Workbook Admin Help My Account Home Log Out

Search Name, MRN, SSN, ID Case Manager: Bankston, Cheri Close Case Print Add Note Authorization Number:

**Monica Gold**

Account #: 1130042 Admitted Date: 11-03-2013  
Member ID: AGC22336-9 Estimated Discharge: 04-18-2014  
Date of Birth: 02-17-1952 Medical Record #: 101462 Actual Discharge:  
Attending Physician: Lisa Brown Status: M Admit Type: Other

Diagnosis Code Local Payer Fax Assign Payer  
ACME INSURANCE

**Payer Authorization** ?

New Payer Review ✔ Approved: 1 ✘ Denied: 0

Next Action Due:  [View Detailed History](#) [Create Inbound Fax Cover Sheet](#)

	<a href="#">View Submission</a>	<a href="#">Status</a>
11-03-2013- Inpatient	<span>✔</span>	
11-05-2013 Med/Surg		

**Note:** Spoke with Mary; send updated lab results

**Messages / Notes To Payer**

Please review and call me with any questions. Cheri Bankston  
[Mark as Unread](#) 04-03-14 04:20 PM

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# Access Robust Transaction Audit Trail

Case History		
Case History <a href="#">Expand All</a>   <a href="#">Collapse All</a>		
Activity	Date	User
<a href="#">▼ Authorization Approved - 1 day</a>  <b>AUTHORIZED</b> Authorization Number: 8675309 # Days Authorized: 1 Dates Authorized: 11-03-2013 - 11-03-2013 Status: M	04-03-2014 15:30	Bankston, Cheri
	Next Action Due: 11-05-2013 Contact #: (555) 555-5555 Authorized By: Mary Notes: Spoke with Mary; send updated lab results	
<a href="#">▼ Submit</a>  Notes: Please review and call me with any questions. Payer: Mary Fax: (555) 555-5555	04-03-2014 15:20	Bankston, Cheri
	<a href="#">Note to Payer 04-03-14 03:20 PM</a> <a href="#">Consult Note</a> <a href="#">History and Physical</a>	
<a href="#">▶ Change Case Owner</a>	04-02-2014 15:37	Bankston, Cheri
<a href="#">Create</a>	04-02-2014 15:37	Bankston, Cheri

# Store and Access Documentation of Successful Communication

The screenshot displays the Curaspan Health Group web application interface. At the top left is the Curaspan logo with the tagline "Get Connected®". A navigation bar contains buttons for "Acceptance", "Discharge", "Doc Mgr", "Review", "Reports", "Profile", and "Setup". The user "Cheri Bankston" is logged in for 1 hr, 38 min, 1 sec. A secondary navigation bar includes "Return to Workbook", "Admin", "Help", "My Account", "Home", and "Log Out". A search bar is present with "Case Manager: Bankston, Cheri" and a "Close Case" button. A red "0 Alerts" notification is in the top right.

The main content area is titled "Print Patient Detail - Curaspan Health Group - Windows Internet Explorer". The browser address bar shows the URL: <https://network.curaspan.com/CuraspanApplicationSuite/index.cfm?event=reviewcentral%3Arvcntrl.private.print.patientSummary&id=71056992>. Below the browser window, there are sections for "Documents" and "Fax History".

**Documents**

Document Title	Request Time	Submitted Time	Status
Note to Payer 07-11-13 01:54 PM	07-11-13 12:54 PM	Submitted 07-11-13 01:54 PM	Not Shared
DME - Durable Medical Equipment Form (2/2010) 07-11-13 01:54 pm	07-11-13 12:54 PM	Submitted 07-11-13 01:54 PM	Not Shared

**Fax History**

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

**Notes to Payer**

Notes	Added By
This is where I would type note	Cheri Bankston 07-11-13 01:54 PM

# Organize and Prioritize Cases

**Curaspan** HEALTH GROUP  
Get Connected.®

Boston Garden Hospital

0 Alerts

Acceptance Discharge Doc Mgr Review Reports Profile Setup

Cheri Bankston Logged in for: 1 hr. 37 min. 25 sec.

Dashboard Patient Census Admin Help My Account Home Log Out

Search Name, MRN, SSN, ID

View: Bankston, Cheri

	New Updates			All Active					
			New	Due Today	Denied	Med Dir Review	Peer to Peer	No Response	All Cases
+ All	3		5	3				2	9

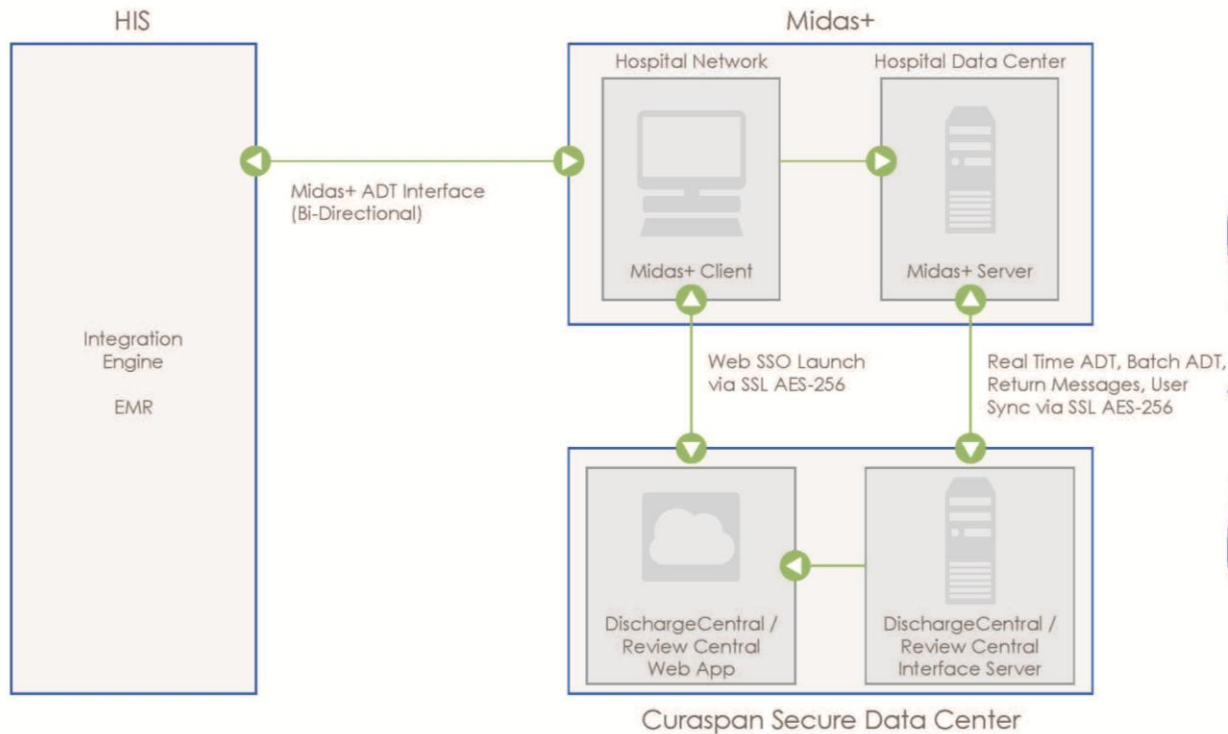
9 Patient(s) Print

Select All Mark as read (0) Close Cases (0)

	M/F	Patient	Payer Plan Name Member ID	Arrived Date EDD Discharged Date	New Msg	Location Status	Auth. Days Rem.	Next Action Due	Current Determination
<input type="checkbox"/>	M	<b>NurseUser5, Training</b> DOB: 11-07-74 MRN: 100010 Acct: 100000009	Local Payer: TRAINING PAYER 123456789	04-02-14 x x		TRAINING - 11 - A In Patient	N/A N/A	04-03-14	H: Pending 04-02-14
<input type="checkbox"/>	F	<b>Gold, Monica</b> DOB: 02-17-52 MRN: 101462 Acct: 1130042	Local Payer: ACME INSURANCE AGC22336-9	11-03-13 04-18-14 x		3180 - East - 001 M	0 Authorized Days Remaining 11-03-13 - 11-03-13	11-05-13	H: Authorized 04-03-14
<input type="checkbox"/>	F	<b>ZOUTTE, MADONNA</b> DOB: 11-09-13 MRN: 6486811 Acct: 5575693	Health Plan of America PPO 806252418	08-12-13 x 09-08-13		W4 - 112 - A Out Patient	N/A N/A	08-20-13	H: Submitted 11-21-13
<input type="checkbox"/>	M	<b>LynneChiger, Training</b> DOB: 11-07-74 MRN: 100034 Acct: 100000033	Health Plan of America Commercial - Small Business	04-02-14 x x		TRAINING - 35 - A	N/A N/A		H: New 10-24-13

n/CuraspanApplicationSuite/index.cfm/private.reports.reportmain/under 50

# 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

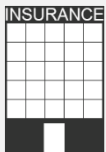
## Care Management Reports




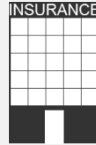

- Readmissions by:
  - Placement
  - Diagnosis
  - Provider
  - Physician
- New Placement vs. Returns
- Referral Process Timeline
- Barrier Days
- Case Manager Referrals
- Decline Reasons
- Delay Reasons
- Payer Bookings

## 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

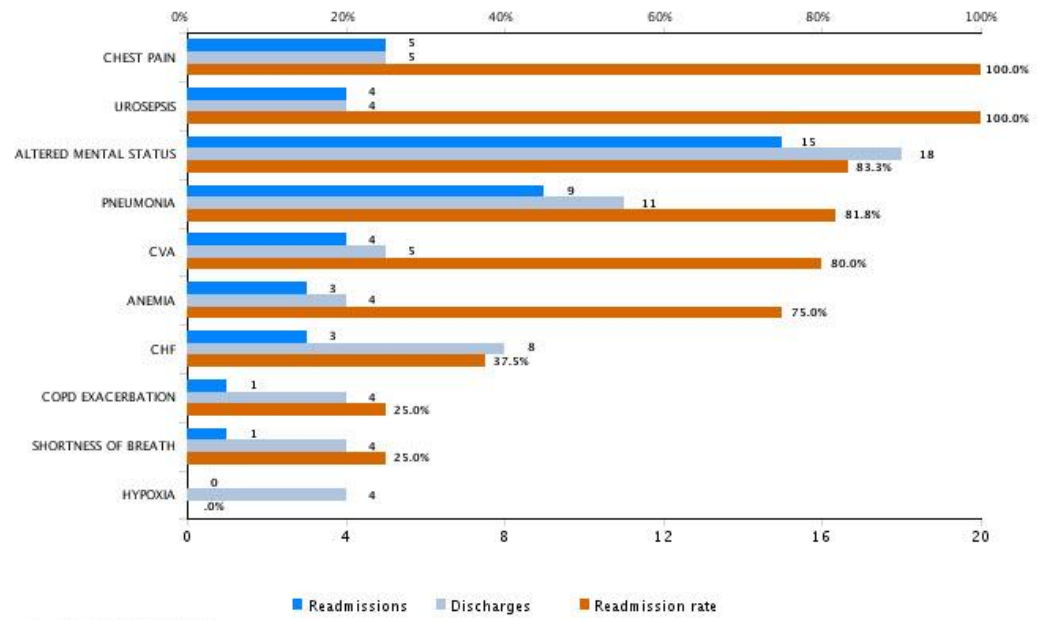
[Generate Report](#)

## \*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](#)

### Highest readmission rates by diagnosis 01/01/2009 thru 12/31/2009





# Insight Into Provider Performance



## Provider Placements and Return Summary Report

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

Hospital

Provider Name	Enabled	Total	Accept	Received	Declines	Bookings	Placements	Returns
Medical Resources, LLC - St	yes	37	25	37	1	28	28	0
SUNCREST HOME HEALTH S	yes	33	27	33	7	25	25	0
Continuum Ho - Nashville	yes	33	21	33	5	23	23	0
HOME HEALTH CARE OF MI	yes	29	19	29	2	23	23	0
GREENWELL'S HEALTH AND R	yes	26	5	26	2	11	11	0



## Provider Scorecard

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

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
	3	2	66.67%	0.16	0.00
	2	1	50.00%	0.82	0.00
	1	1	100.00%	0.20	0.00
	1	1	100.00%	0.05	0.00
	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



## Monthly Average Length of Stay by Discharge Disposition Grouping

Discharge Date: 1/1/2010 - 12/31/2010

Hospital: [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
<b>F</b>	<b>7.96</b>	<b>8.03</b>	<b>9.02</b>	<b>7.45</b>	<b>9.45</b>	<b>8.15</b>	<b>8.40</b>	<b>9.05</b>	<b>8.15</b>	<b>7.05</b>	<b>7.28</b>	<b>7.04</b>
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



## Referral Process Timeline

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

Hospital: [REDACTED]

	# 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
<b>Totals:</b>	<b>679</b>		

\*\* 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.**

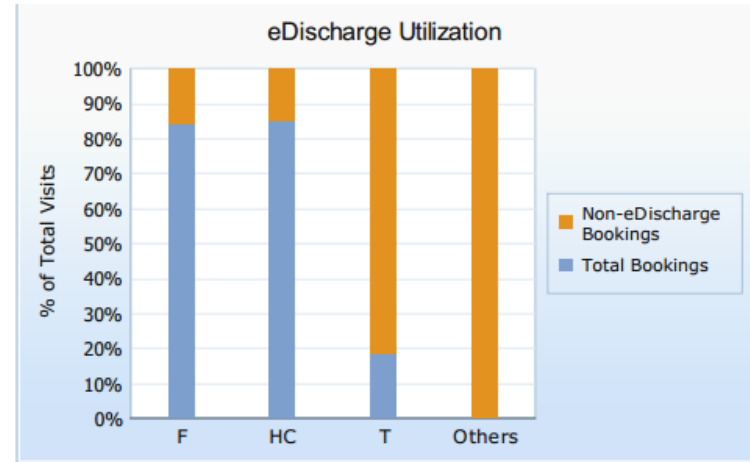
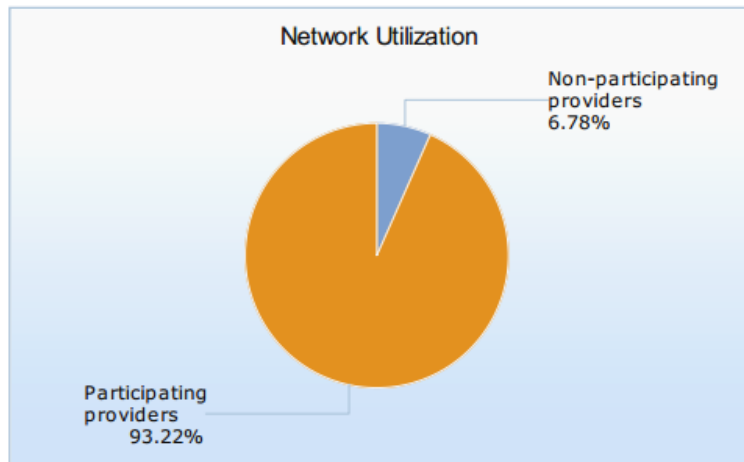
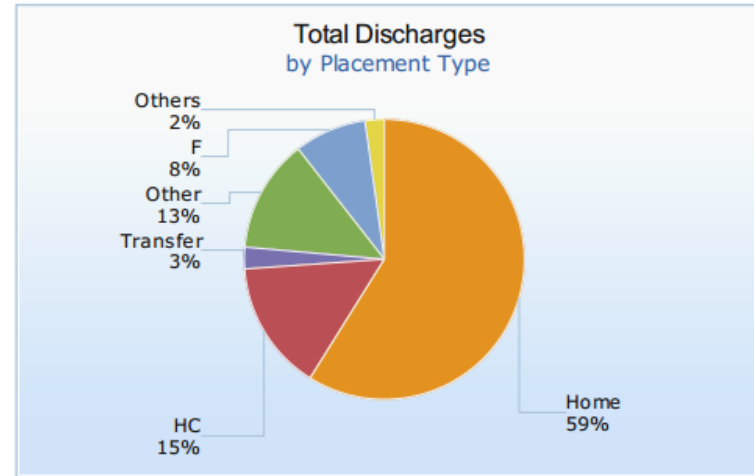
# Information At-a-Glance



## Monthly Summary Report - Total Discharges

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

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.

Reviewed By:  Assigned To:

Date:  Location:

Select/Deselect Worklist Rules:

<input checked="" type="checkbox"/> HCM Discharge Planning	← Referral from Support Services
<input type="checkbox"/> New Encounter for CCM pt	
<input type="checkbox"/> RRP Discharge DX	
<input type="checkbox"/> Referral from HCM - DX Category	← Referral from Concurrent Review
<input type="checkbox"/> CCM CHF F/U Appointment	
<input type="checkbox"/> Referral from Discharge Planner	← 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

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

Name: **Haberman, Joseph** DOB/Sex: **3/3/1950 64Y / M** MRN: **555853**  
Prim Care Phys: Principal Payer:

Case No:  Start Date:  Episode:   
Manager:  End Date:  Source:

Assessment **DME/Wellness** Patient Care Comments User Fields

Living Status:  Setting:

<b>Risk Factor</b>	Move to Problem List ^
Chronically Ill	<input checked="" type="checkbox"/>
Frequent Admissions	<input checked="" type="checkbox"/>
High Risk Diagnosis	<input checked="" type="checkbox"/>
Lives Alone	<input type="checkbox"/>
▶ Medically Indigent / No Insurance	<input checked="" type="checkbox"/>
No Support System	<input type="checkbox"/>
Readmission	<input type="checkbox"/>
*	<input type="checkbox"/>

<b>Self-Care Barrier</b>	Move to Problem List ^
▶ Medication Administration	<input checked="" type="checkbox"/>
Preparing Meals	<input type="checkbox"/>
*	<input type="checkbox"/>





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

Case No.:	14-4	Start Date:	4/9/2014	End Date:	
Episode:	CHF				
<b>Assessment:</b>	CHF READMISSION PREVENTION	<b>Date:</b>	4/9/2014	<b>ID:</b>	14-11
Item	Response				
Which Assessment of the Series is this?:	Initial			Move to Problem List:	<input type="checkbox"/>
Who is the patients Primary Care Physician?:	Atkins,Susan Alene			Move to Problem List:	<input type="checkbox"/>
Date of Next PCP Appointment:	4/15/2014			Move to Problem List:	<input type="checkbox"/>
Date of Next Assessment:	4/17/2014			Move to Problem List:	<input type="checkbox"/>
Increasing Shortness of Breath?:	Yes			Move to Problem List:	<input checked="" type="checkbox"/>
Increasing weakness or tiredness?:	Yes			Move to Problem List:	<input type="checkbox"/>
Increased swelling of the ankles?:	No			Move to Problem List:	<input type="checkbox"/>
Can they sleep lying down or do they need to be propped on 2 or more pillows?:	Propped on 2 or more pillows			Move to Problem List:	<input type="checkbox"/>
Do they wake up at night short of breath?:	Yes			Move to Problem List:	<input type="checkbox"/>
How many times do you awaken to urinate during the night?:	2			Move to Problem List:	<input type="checkbox"/>
Have they had dizzy spells?:	No			Move to Problem List:	<input type="checkbox"/>
Has their weight increased more than 2 lbs ea day or more than 5 lbs in a wk?:	NA			Move to Problem List:	<input type="checkbox"/>
Irregular heartbeats or palpitations?:	No			Move to Problem List:	<input type="checkbox"/>
Have they missed any medications (diuretics, digoxin, vasodilators, BP meds)?:	Yes			Move to Problem List:	<input type="checkbox"/>
Has someone been taking their BP?:	No			Move to Problem List:	<input checked="" type="checkbox"/>
If Yes, what is Systolic BP?:				Move to Problem List:	<input type="checkbox"/>
If Yes, what is Diastolic BP?:				Move to Problem List:	<input type="checkbox"/>
Have they been following a low sodium diet?:	Yes			Move to Problem List:	<input type="checkbox"/>
Can they describe which foods have high sodium?:	No			Move to Problem List:	<input type="checkbox"/>
Do they know where to find the sodium content on food labels?:	No			Move to Problem List:	<input type="checkbox"/>
Have they had any alcoholic beverages?:				Move to Problem List:	<input type="checkbox"/>
Have they used any tobacco products?:				Move to Problem List:	<input type="checkbox"/>
List any Services, their frequency and location:				Move to Problem List:	<input type="checkbox"/>
Comments:					
					Completed: <input type="checkbox"/>



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

Name: **Haberman, Joseph**      DOB/Sex: **3/3/1950 64Y / M**      MRN: **555853**  
Prim Care Phys:      Principal Payer:

AssessmentDate	Issue	Problem	Start Date	Status	Files
4/9/2014	Chronically Ill	Chronic Condition	4/9/2014	Open	
4/9/2014	FrequentAdmissions				
4/9/2014	High RiskDiagnosis				
▶ 4/9/2014	Medically Indigent / No Insur	Inadequate, Financial Resources	4/9/2014		

Save  
Documents  
Cancel

Details for Inadequate, Financial Resources

Problem Goals

Goal	Status
▶ Establish Primary Medical Care	Intervention Required
*	

Details for Establish Primary Medical Care

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.

Navigate  
Help



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

CCM Referral/Intervention Entry - Haberman, Joseph

Case No.: 14-4      Manager: Clark, Barb      Episode: CHF     

Problem: Inadequate, Financial Resour      Category:      Status:     

Referrals/Interventions				
Date	Time	Type	Case Worker	Files
▶ 4/9/2014	12:06 PM	Social Work	Emerald, Jennifer	<input type="button" value="..."/>
*				<input type="button" value="v"/>

Details for 4/9/2014 Social Work

Services	Frequency	Payer:
▶ Self Pay/Financial Assistance		<input type="text"/>
*		Region: <input type="text"/>

Agency:       Special Lookup:      

Acuity:       Case Hours:       Completed:

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 with 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



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# 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”  
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# 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

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# 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

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# 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

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# 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

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# 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
<b>General Measures</b>						
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 %
<b>Emergency Department Case Management</b>						
Total Emergency 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
<b>Pre-Discharge Measures</b>						
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 %
<b>Post-Discharge Measures</b>						
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 %
<b>DataVision Measures</b>						
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](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](mailto:barbara.craig@xerox.com)

