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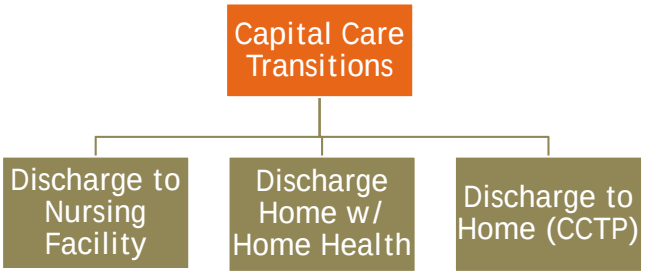
Kansas Health Quality Forum

June 5, 2014

Capital Care Formation

- Why we formed
- How- KFMC guidance and assistance



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Root Cause Analysis

- Based on a Root Cause Analysis of 2010 CMS data we developed a budget goal of 199 Care Transitions completed per month.
- Key Findings
  - Concerns with follow up appointments
  - Medication accessibility
  - Difficult transition from hospital back to home- lack of self-management skills

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Application Criteria

- Our original patient criteria
- Medicare A & B primary insurance
- Age 65 and older
- 6 Chronic Diagnoses:

CHF	CAP
COPD	CABG
DM	AMI

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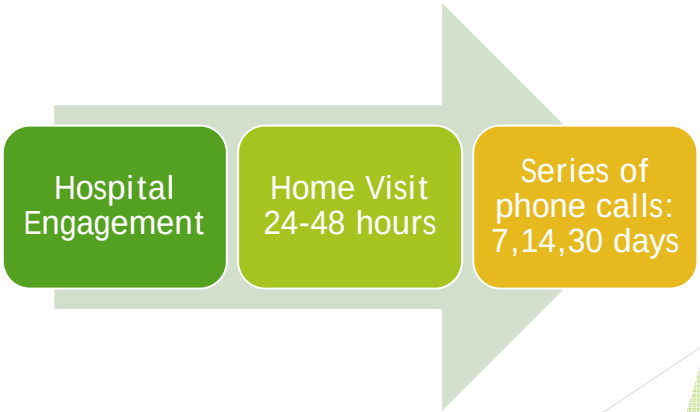
Coleman Model

Coleman Care Transition Intervention

Four Pillars

- Med Reconciliation,
- follow-up appointments,
- signs and symptoms,
- connection to community resources

Coleman Transition Timeline



Innovations

- Additional services provided:
  - Be-Close
  - Transportation
  - TeleHealth
  - Partnership with Washburn University for data collection and analysis

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Timeline

- Application Submitted- August 2012
- Notified of Acceptance- March 2013
- Saint Francis- August 12, 2013
- Stormont-Vail – September 2, 2013

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Operationalizing Program

- Development of Consents
- Develop Marketing Materials
- Train Hospital Staff
- Communicate program to physicians
- Create process with EMR to identify patients based on application criteria
- Hire and Train Coaches
- Create database to capture patient data to ensure fidelity to Coleman model

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Developments

- Volume of appropriate eligible patients to be approached for the program was below budget.
  - Went to an all cause diagnosis patient base Dec 2013.
- During our first six months September 2013-February 2014 we have seen a gradual increase in completed 30 day billable transitions.
- In 2014 our numbers significantly increased:
  - January 102 patients completed the program, February 94, March 100, and April 117.

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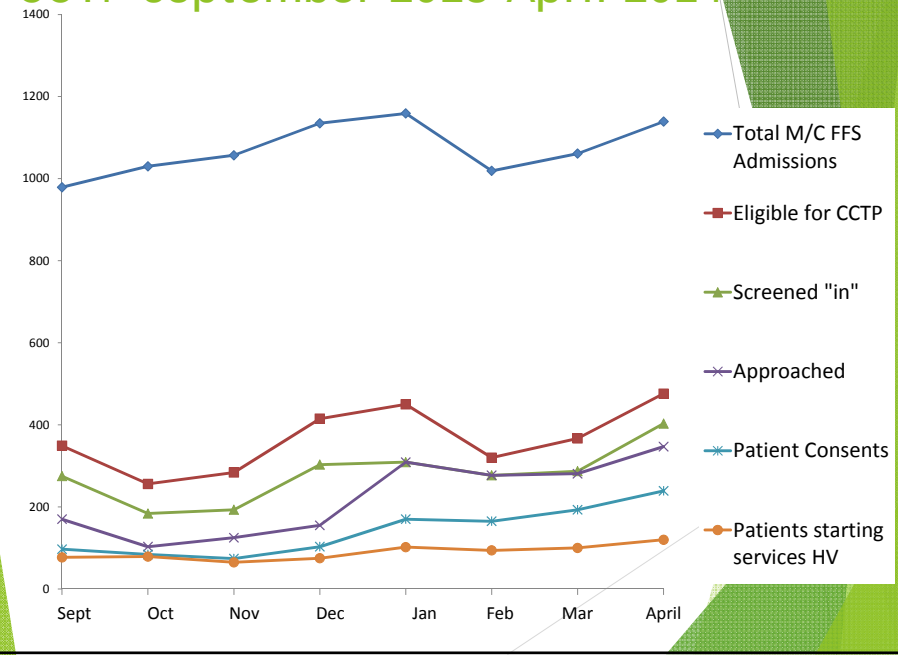
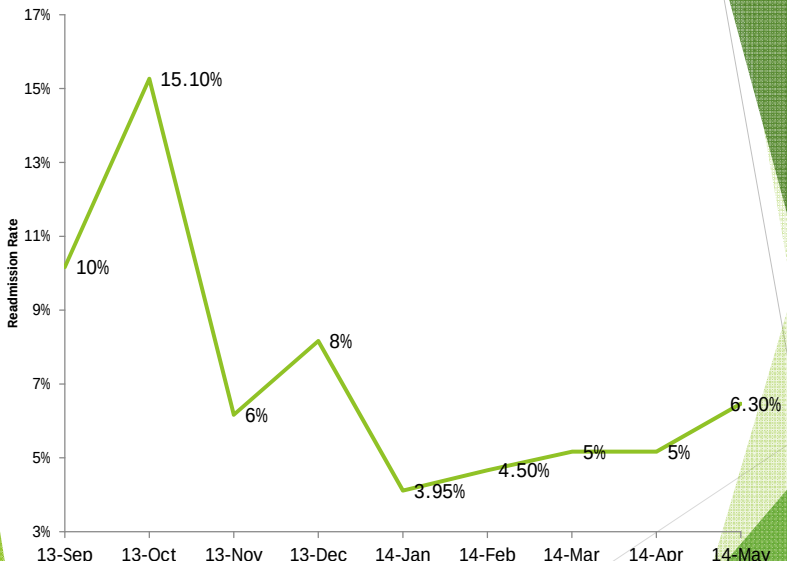
CCTP September 2013-April 2014



Readmission Rate



Monthly Data

Description	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May
Total M/C FFS Admissions	979	1030	1057	1135	1159	1019	1061	1139	
Eligible for CCTP	349	256	284	415	450	320	367	476	
Screened "in"	275	184	193	303	309	277	287	403	
Approached	170	103	125	155	309	277	**281**	**347**	
Patient Consents	97	84	74	103	170	165	193	239	
Patients starting services HV	77	79	65	75	102	94	100	120	127
Readmit	8	12	4	6	4	4	5	6	8
Readmit %	10%	15.10%	6%	8.00%	3.95%	4.50%	5%	5%	6.3%

Patient Case Studies

Quality Outcomes and Satisfaction

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Learning Sessions

- Quarterly improvement sessions hosted by CMS
- Entire coalition participates
- Opportunities for improvement identified and action plans created

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Action Items

1. Analyze KFMC data to determine if root cause analysis correlates with anticipated number in budget
2. Engage Clinical Nurse Leaders (CNL) to provide education to hospital nursing staff, hospitalists, PCP offices regarding program

3. Engage CNL's to provide education/feedback to coaches related to process improvement
4. Provide re-education to SVHC clinical secretaries about process in Loopback to streamline workflow for CCTP process
5. Provide tent cards for patient rooms if patient not available at time of coach visit

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Action Items continued

6. Discuss marketing article hospital's community newsletters.
7. Provide refresher for coaches regarding frequently used community resources such as Meals on Wheels, JAAA, Health Wise, Health Connections.
8. Engage initial coalition partners such as SCHD, JAAA, and VNA to attend regular coalition meetings.
9. Develop process to analyze readmission data and opportunities to have readmission reviews.
10. Revisit consent opportunities—rearrange consent to move opt in option to top of form and opt out option to bottom of form.
11. Investigate models of successful projects in regards to staffing

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Hospital Liaison Model

Coach Liaison – full-time M-F 8am-4:30pm;
part-time Liaison Sat & Sun.

Liaison accesses EMR (read only file.)

Uses access to view Medicare FFS patients, Face sheet, H&P, Medication List, Diagnosis, scanned Insurance Card, social work and discharge planning notes.

Liaison introduces Care Transitions Program, receives patient consent, follows patient to DC, schedules home visit, provides coach info for patient and family.

Liaison will be able to better identify needs or barriers the patient and family may have concerns about. Gives report to home visit coach prior to home visit.
Liaison is the face of the program at the hospitals.

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Expected Outcomes

Using the strengths of the current coaches

Liaison coach model will double the current program volume with in 60 - 90 days

The Liaison coach is chosen based on current conversion rates of 80% or higher in getting consent.

They will be able to filter out inappropriate patients sooner and preschedule appointments with access to Epic read only files.

Prescheduling field coach home visits will allow us to serve up to 252 visits per month with our current staff.

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Moving Forward

1. Liaison Model Implemented 5/4/2014
2. Evaluate model in 30, 60, 90 days

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One Year Program Perspective

Acute Care Partners-

Saint Francis

Stormont-Vail

Community Based Organization – CBO Perspective

Brewster

Questions? Comments?

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