Objectives

Share care coordination initiatives
Share outcomes

UnityPoint-Health Methodist overview
- Founded in 1900 by 3 Deaconesses
- Non-profit, non-denominational
- Annual revenues of $362 million and Charity Care $25M
- AA3 bond rating
- 3,000 employees
- Primary Service Area of 4 Counties, Secondary Service Area of 14 Counties - > 1M in population
- Full Service Tertiary hospital including open heart surgery, bone marrow transplant
- Level II Trauma Center
- Level II Nursery
- Physician Network – UnityPoint Clinic – 150 Providers, 35 Clinic Sites
- Methodist College
- 2 Residency Programs with U of I – Family Practice & Psychiatry
UnityPoint Health
Peoria

UnityPoint Health
Methodist | Proctor

- Formed in 1994
- Non-profit, non-denominational
- 17 non-profit hospitals
- Greater than 900 employed ambulatory clinic providers
  - >2.6 million clinic visits per year
- 25,000 employees
- 10 regional affiliates
- Annual revenues of $3.3 billion

**A Year in the Life of a Patient**

Source: John Hopkins RWJ 2010 (G Anderson)
UnityPoint Health Three-Year Roadmap – Proposed 2015

- Support the maturation of our patient-centric, physician driven culture
- Develop a high-performing employed medical group
- Grow a high-performing contracted network of employed and independent providers
- Develop a patient and family engagement strategy
- Implement a standardized approach for managing risk-segmented populations
- Deliver high value, team-based care in support of the Triple Aim
- Create an environment that makes UPH the employer of choice
- Identify future talent needs and proactively develop those resources
- Identify, develop, challenge and retain high-performing talent
- Educate and engage our employees in fulfilling our brand promise
- Implement a structured innovation process that breaks down regional and divisional silos to prepare for risk-based reimbursement
- Focus on sustainability initiatives
- Grow strategically in contiguous regions
- Grow consumer base through enhanced access strategy

Building the Infrastructure for Population Health

Medical Neighborhood

Patient

Organized System of Care

Advanced Care Planning

PCMH Patient Management

Skilled Nursing Care

Participant Top of the triangle focus:
Care Navigator

Coordination Center

Community Partners
Accountable Care Organizations

• “Accountable” for what?
  — Access
  — Quality
  — Cost
  — Scope of “Healthcare” ("Continuum of Care")
    • Wholeness (disease...whole body...whole person...health & wellbeing...)
    • All locations (in-patient, out-patient, MD-office, NH...pt’s home)
    • All persons (babies...elderly; rich...poor; ...everyone)
    • Healthy individuals... Healthy organizations
• “Sustainability” (Economic sustainability)
  • Individuals (patients, citizens)
  • Institutions (private and public)

UnityPoint Health

UPH Methodist Care Coordination Initiatives

1. Enterprise model of care coordination
2. Care Coordination Center
Why COPD
Improving COPD in Strategic Plan

<table>
<thead>
<tr>
<th>Mortality</th>
<th>Cost</th>
<th>LOS</th>
<th>Readmission</th>
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<tbody>
<tr>
<td>1.20</td>
<td>1.05</td>
<td>1.03</td>
<td>1.28</td>
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</tbody>
</table>

- Other teams frustrated by slow progress
  - Care not linked to evidence
  - Wide variation in care
  - No continuity between settings of care (i.e. inpatient and office)

Rapid Implementation Plan Developed to Correct

- COPD patient experience before our project
Our COPD Story

Implementation Goals
• Evidence based care using one standard
• Maximize elements that cross continuum of care and multiple diseases
• Extend current programs across continuum of care
• Minimize meeting times
• Rapid implementation

Only 5 months from initial planning to initial implementation on Feb 7, 2012

Population Analytics
• Patients with COPD on problem list – 4,997
• Current Smokers – 14,852
• Former Smokers – 12,309
• Estimate was 15% have COPD – 4,074 patients
• Epidemiologic evidence – 8% of approximately 150,000 adults have COPD or 12,000. Many of these will have stage 1 disease and be asymptomatic

The Initial Team: August 11, 2011: met to share goals, mission and expectations

Team Sponsors – Rick Anderson & Tammy Duvendack
Physician Champion - Kishore Karamchandani

• Andrea Eitemiller
• Angie Schner
• Anne Pabewaji
• Anthony Rossard
• Ben Runsey
• Brian Cohen
• Denise Koetler
• Gregory Sowards
• Jamie Underwood

• Jamie Lafollet
• Joan Golsten
• Josie Reynolds
• John Howerton
• Kathy Finch
• Kathy Kujawa
• Keith Knepp
• Kristi Falehy

• Lori Krierter
• Lori Menes
• Melissa Wallichmuller
• Merry Bassi
• Nancy Neal
• Patricia Smith
• Shams Fahi
• Solivan Fumess
• Tore Field-Orozco

Team Facilitators – Jasmine Holloway & David Trachtenbarg
Program Grid

**Design Phase**
- Phase 1: Needs assessment
- Phase 2: Program development
- Phase 3: Program implementation

**Implementation Phase**
- Phase 4: Program delivery
- Phase 5: Program evaluation

**Monitoring Phase**
- Phase 6: Continuous improvement
- Phase 7: Program sustainability

**Program Grid**

1. **Emergency**
   - Emergency Department Orders
   - Standard criteria for admission
   - Smooth transition when admitted
   - Discharge from ED
   - Prevention of repeat ED visits

2. **Inpatient**
   - Admission orders
   - Admission documentation
   - Physician progress note
   - Inpatient physician billing
   - Inpatient Patient education for COPD
   - Palliative care
   - Home medication planning
   - Discharge Orders

3. **Home care**
   - Home care documentation
   - Home Care Patient Education

4. **Nursing Home**
   - Nursing home orders
   - Nursing home readmission program

7. **Office Care**
   - Standardized COPD data fields
   - Prototype COPD visit template
   - Spirometry in offices
   - Office COPD education
   - Office readmission program

8. **Analytics**
   - Outcome measurements
   - Plan for monitoring

---

"We cannot solve our problems with the same thinking we used when we created them." - Albert Einstein
Project Organization

Hospital Board
Quality and Safety
COPD Project

Strategy #1
Stick to an Evidence Based Guideline

Standardization of Dyspnea

![Image](https://via.placeholder.com/150)

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I get short of breath when cooking or walking up stairs</td>
<td>2</td>
</tr>
<tr>
<td>I get short of breath when eating, or dressing or undressing</td>
<td>2</td>
</tr>
<tr>
<td>I have to slow down on level ground</td>
<td>2</td>
</tr>
<tr>
<td>I get short of breath after walking 2 to 3 blocks</td>
<td>1</td>
</tr>
<tr>
<td>I have to use a wheelchair in shopping</td>
<td>1</td>
</tr>
<tr>
<td>I get short of breath while doing housework</td>
<td>1</td>
</tr>
<tr>
<td>I get short of breath on flat streets if riding in a car</td>
<td>1</td>
</tr>
<tr>
<td>I get short of breath when walking up steps</td>
<td>0</td>
</tr>
<tr>
<td>I get short of breath after walking about 100 yards or after 2 to 3 minutes on the level</td>
<td>0</td>
</tr>
<tr>
<td>I get short of breath after walking about 3 to 5 minutes on the level</td>
<td>0</td>
</tr>
</tbody>
</table>
Strategy #2: Maximize What’s There

- Pulmonary service
- Respiratory care
- Pulmonary rehab
- Palliative care/Hospice
- Transition coach
- Office spirometry
- Hospitalists

Strategy #3

Inclusive Group

- Care requires collaboration across a social network
Strategy #4
Develop new processes, coordinate and communicate
Strategy #5
Minimize Meetings

- Entire Group Only Met 3 Times Before Initial Go-live
- Initial meeting
  - Brief overview of COPD & Treatment
- Meetings 2 & 3
  - Multiple brief presentations done by individuals or small groups for approval
- Don’t start with a blank sheet of paper
- Changes reviewed by e-mail
- Presentation to Quality Council for Approval
- Presentation to hospital leadership
- Final Celebration

Initial Timeline: COPD project

- Initial meeting explaining project: August 11, 2011
- Numerous specific department team meetings to develop processes
- Two other COPD project team meetings: Sept 25 and Dec 15, 2011 (updates and get teams together to collaborate and put down silos)
- Presentation and approval of COPD project elements to Quality and Safety Council on October 26, 2011
- Jan 23, 2012: Ready for implementation team meeting
- Feb 7, 2012- Phase 1 implementation, COPD Project (took only 5 months of planning, yeah!)

Final Team Members – 829

<table>
<thead>
<tr>
<th>Department</th>
<th>Members</th>
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<tbody>
<tr>
<td>ED</td>
<td>4</td>
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<tr>
<td>Inpatient</td>
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</tr>
<tr>
<td>Respiratory Care</td>
<td>2</td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
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</tr>
<tr>
<td>Hospital Medical Group</td>
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<tr>
<td>Coding/Billing</td>
<td>3</td>
</tr>
<tr>
<td>Information Services</td>
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<tr>
<td>Home Health</td>
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<tr>
<td>Transition Care</td>
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</tr>
<tr>
<td>Medication Process</td>
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</tr>
<tr>
<td>Long Term Extended Care</td>
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<tr>
<td>Nursing Home</td>
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</tr>
<tr>
<td>Marketing</td>
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<tr>
<td>Nurse Call Center</td>
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<tr>
<td>Physician representatives</td>
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<tr>
<td>IM, FP, Hosp, ED</td>
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</tr>
<tr>
<td>Palliative Care</td>
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</tr>
<tr>
<td>Physicians Champion</td>
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<tr>
<td>Compliance</td>
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<tr>
<td>Analytics</td>
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<tr>
<td>Pharmacy</td>
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<tr>
<td>Patient</td>
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<tr>
<td>Community</td>
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</tr>
<tr>
<td>Executive sponsors</td>
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<tr>
<td>CMO, VP Nursing</td>
<td></td>
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<tr>
<td>Secretarial support</td>
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</tr>
<tr>
<td>Project Management</td>
<td>2</td>
</tr>
</tbody>
</table>
Strategy #6
Unwavering executive/physician support

&

Physician Champion

Executive Sponsors

Multidisciplinary Enterprise Approach

Multidisciplinary IDS Approach
3 Month Outcomes

- 20 new care measures in place
- Measuring/monitoring systems in place
- Increased spirometry
- 16% increase in total home health referrals for COPD
- Transition coach only 3 of 35 patients readmitted
- Patients in pulmonary rehab have doubled!
COPD Patients - Spirometry, Pneumonectomy, Smoking Status, & Cessation

<table>
<thead>
<tr>
<th>Practice</th>
<th>Spirometry</th>
<th>Pneumonectomy</th>
<th>Smoking Status</th>
<th>Tobacco Status</th>
<th>Cessation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine Clinic 1</td>
<td>45%</td>
<td>12%</td>
<td>10%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Family Medicine Clinic 2</td>
<td>57%</td>
<td>18%</td>
<td>15%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Jan Feb Mar April May

Inpatient Pulmonary Referrals

09/10/15
**Why COPD**

Improving COPD in Strategic Plan (2011)

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Nov. 2013

1.20 1.01 .95 1.06

**Outcomes**

- In 2015 COPD was developed clinic as a result of this model
- Model is duplicated with diabetes
The Care Coordination Center

Some of the new enhancements Support the Unity Point Clinic Support Infrastructure

- Live
- pilot August 2014
- Workflow teams designing pilot
- Function not performed in Care Coordination Center

UnityPoint Peoria Clinics

Post Hospital Discharge Support Infrastructure

Nurse Triage Line and Next Day Scheduling

Centralized Incoming Calls Triage

Pre-Visit Preparation Risk/Disposition Management

Workflow teams designing pilot

Function not performed in Care Coordination Center
Jodi Fults, Nurse Manager, Referral Management, (9356) Methodist/Proctor
Debra Allen, Lead Pod 3, Trainer
Mindi Samuelson, RN Lead Pod 2
Heidi Cook, RN Lead Pod 1
Open – Lead, Pod 4

Referral management
Schedule Order Work Queue
Referral Work Queue
Follow-up Process
2-Day Call Backs

83.7% 85.0% 86.3% 90.8% 86.5% 90.0% 110.0%

AVERAGE Care Coordination Center Referral Management
May June July August Average
A Year in the Life of a Patient

- 6 Social Workers
- 13 Weeks
- 22 Clinic Visits
- 5 Hospital Admissions
- 6 Weeks Skilled Care
- 5 Months of Home Care
- 2 Home Care Agencies
- 4 Occupational Therapists
- 16 Physicians
- 37 Nurses

Source: John Hopkins RWJ 2010 (G Anderson)
“You can’t predict the future, but you can create it”

- Peter Drucker

Questions?

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UnityPoint Health- Methodist-Proctor
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(309) 672-5690
Jasmine.Holloway@unitypoint.org

Result: Higher Quality, Higher Service, Lower Costs
Source: John Hopkins RWJ 2010 (G Anderson)