UnityPoint Health
Methodist

2015 ANCC Magnet Conference

C825: Care Coordination: from Hospital to Home and Everything In Between

Thursday, October 8, 2015, 11:15 am-12:15 pm

Jasmine Holloway, MSN, RN

Unity Point Health Methodist

Peoria, IL

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Objectives

Share care coordination initiatives

Share outcomes

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UnityPoint-Health Methodist overview

- Founded in 1900 by 3 Deaconesses
- Non-profit, non-denominational
- Annual revenues of $362 million and Charity Care $25M
- AA_3 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

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Peoria

UnityPoint Health
Methodist | Proctor

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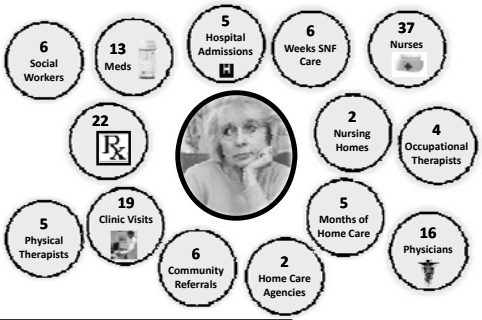
UnityPoint Health

- 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

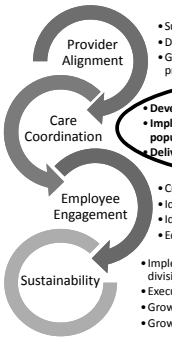
A Year in the Life of a Patient



Source: John Hopkins RWJ 2010 (G Anderson)

UnityPoint Health Aligned Planning

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**

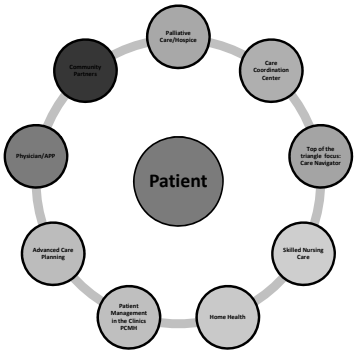
- Create an environment that makes UPH the employer of choice
- Identify future talent needs and proactively develop those resources
- Identify, develop, challenge and retain high-performing talent
- Educate and engage our employees in fulfilling our brand promise

- Implement a structured innovation process that breaks down regional and divisional silos to prepare for risk-based reimbursement
- Execute on sustainability initiatives
- Grow strategically in contiguous regions
- Grow consumer base through enhanced access strategy

7

Building the Infrastructure for Population Health

Medical Neighborhood



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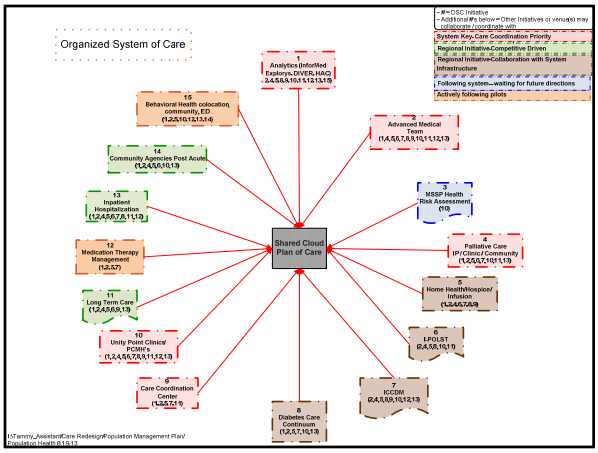

Accountable Care Organizations

- "Accountable" for what?
  - Access
  - Quality
  - Cost
  - Scope of "Healthcare" ("Continuum of Care")
    - Wholeness (disease…whole body…whole person…health & wellbeing…)
    - All locations (in-pt, out-pt, MD-offices, 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)

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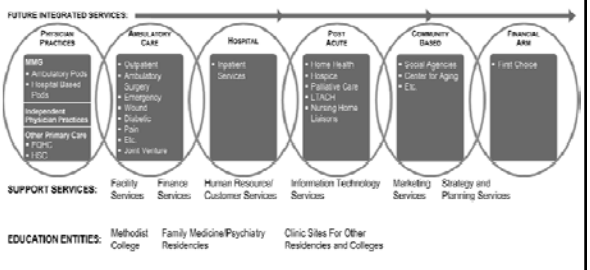
MAGNET RECOGNIZED

UPH Methodist Care Coordination Initiatives

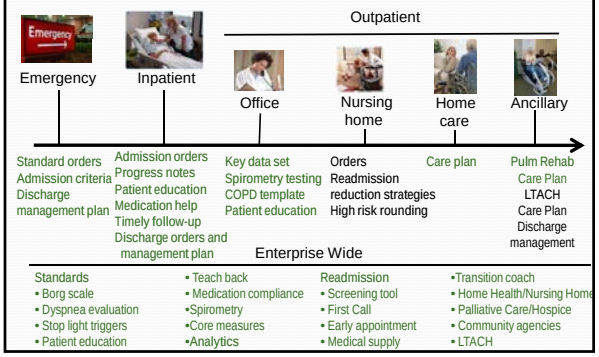
1. Enterprise model of care coordination
2. Care Coordination Center

METHODIST HEALTH SERVICES CORPORATION
METHODIST MEDICAL CENTER OF ILLINOIS

Integrated Delivery System
Organized Systems of Care



Multidisciplinary Enterprise Approach



Why COPD

Improving COPD in Strategic Plan

Mortality	Cost	LOS	Readmission
1.20	**1.05**	**1.03**	**1.28**

- ~~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 Eitenmiller
- Angie Schierer
- Anne Padwojski
- Anthony Howard
- Ben Hunsley
- Brian Cohen
- Denise Koetter
- Gregory Sowards
- Jaimie Underwood
- Jamie Lafollet
- Joan Golemon
- Jody Reynolds
- John Howerton
- Kathie Finch
- Kathy Kujawa
- Keith Knepp
- Kristin Fahey
- Lori Krieter
- Lori Mores
- Melissa Waldschmidt
- Merry Bassi
- Nancy Neal
- Patricia Smith
- Shams Ilahi
- Solivian Furness
- Toni Fields-Orozco

Team Facilitators – **Jasmine Holloway & David Trachtenbarg**

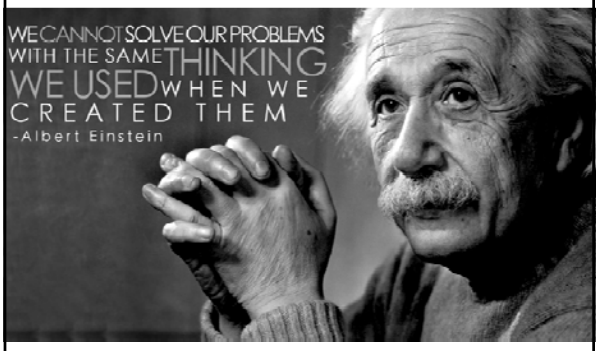
Center for Evidence Based Medicine

David Trachtenbarg
Jasmine Holloway

Program Grid

Design Phase → Implementation Phase → Monitoring Phase

	Plan Design	Do Implementation	Check Monitoring
1. Emergency			
a. Emergency Department Orders			
b. Standard criteria for admission			
c. Smooth transition when admitted			
d. Discharge from ED			
e. Prevention of repeat ED visits			
2. Inpatient			
a. Admission orders			
b. Admission documentation			
c. Physician progress note			
d. Inpatient physician billing			
e. Inpatient Patient education for COPD			
f. Palliative care			
g. Home medication planning			
h. Discharge Orders			
i. Readmission/Follow-up Process			
i. Follow-up appointment			
ii. Call center follow-up			
iii. Home health follow-up			
iv. Transition coach follow-up			
v. Pulmonary rehab follow-up			
vi. Home equipment follow-up			
3. Home care			
a. Home care documentation			
b. Home Care Patient Education			
4. Nursing Home			
a. Nursing home orders			
b. Nursing home readmission program			
7. Office Care			
a. Standardized COPD data fields			
b. Prototype COPD visit template			
c. Spirometry in offices			
d. Office COPD education			
e. Office readmission program			
8. Analytics			
a. Outcome measure ments			
b. Plan for monitoring			



Project Organization

Hospital Board

Quality and Safety

COPD Project

Strategy #1
Stick to an Evidence Based Guideline

Standardization of Dyspnea

Figure 8.1-2: Modified Medical Research Council Questionnaire for Assessing the Severity of Breathlessness[1]

PLEASE TICK IN THE BOX THAT APPLIES TO YOU (ONE BOX ONLY)

I only get breathless with strenuous exercise.	☐
I get short of breath when hurrying on the level or walking up a slight hill	☐
I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level.	☐
I stop for breath after walking about 100 meters or after a few minutes on the level.	☐
I am too breathless to leave the house or I am breathless when dressing or undressing.	☐

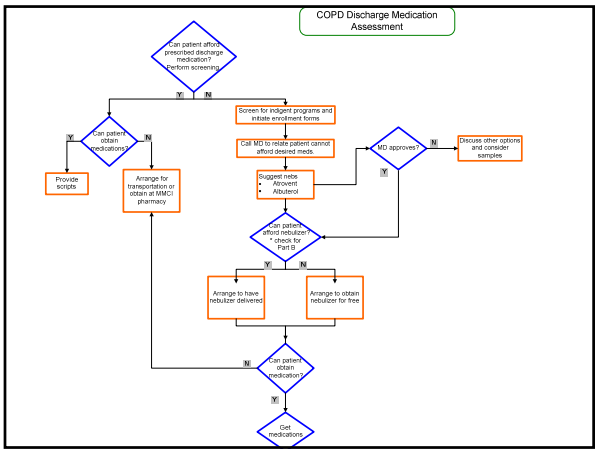
Strategy #2: Maximize What's There

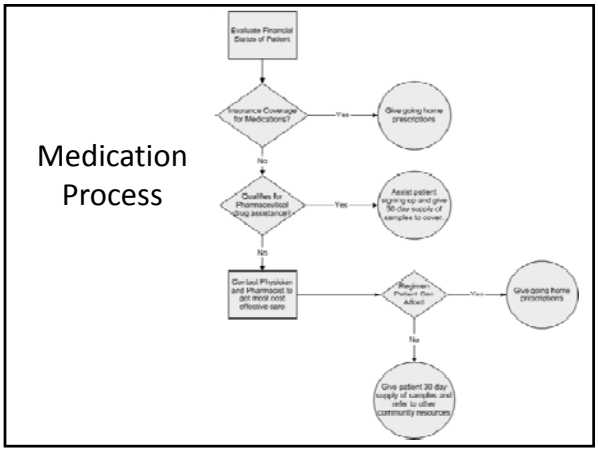
- Pulmonary service
- Respiratory care
- Pulmonary rehab
- Palliative care/Hospice
- Transition coach
- Office spirometry
- Hospitalists

- **1. Emergency**
- a. Emergency Department Orders
- b. Standard criteria for admission
- c. Smooth transition when admitted
- d. Discharge from ED
- e. Prevention of repeat ED visits
- **2. Inpatient**
- a. Admission orders
- b. Admission documentation
- c. Physician progress note
- d. Inpatient physician billing
- e. Inpatient Patient education for COPD
- f. Palliative care
- g. Home medication planning
- h. Discharge Orders
- i. Readmission/Follow-up Process
  - i. Follow-up appointment
  - ii. Call center follow-up
  - iii. Home health follow-up
  - iv. Transition coach follow-up
  - v. Pulmonary rehab follow-up
  - vi. Home equipment follow-up
- **3. Home care**
- a. Home care documentation
- b. Home Care Patient Education
- 4. **Nursing Home**
- a. Nursing home orders
- b. Nursing home readmission program
- **7. Office Care**
- a. Standardized COPD data fields
- b. Prototype COPD visit template
- c. Spirometry in offices
- d. Office COPD education
- e. Office readmission program
- **8. Analytics**
- a. Outcome measure ments
- b. Plan for monitoring

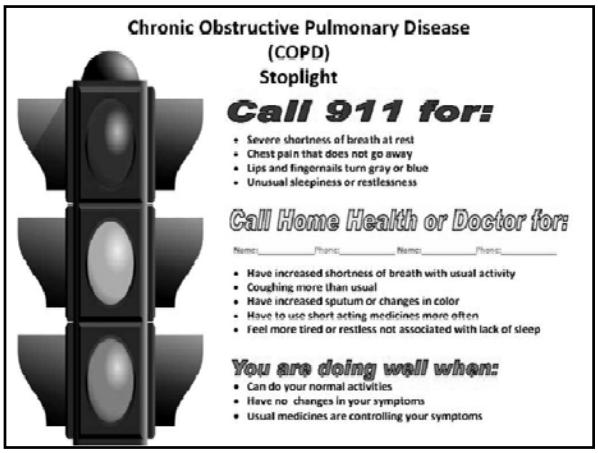
Strategy #3
Inclusive Group

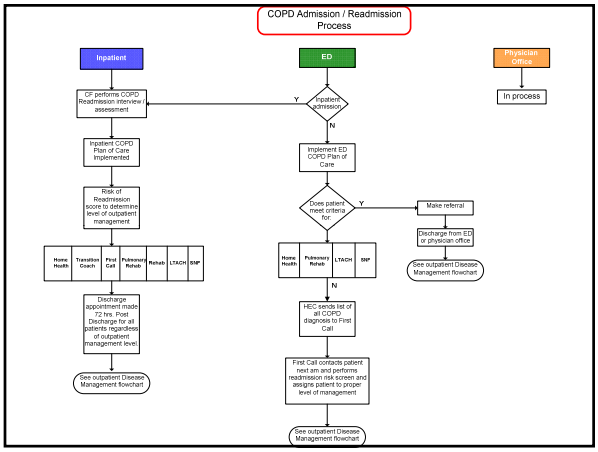
- Care requires collaboration across a social network

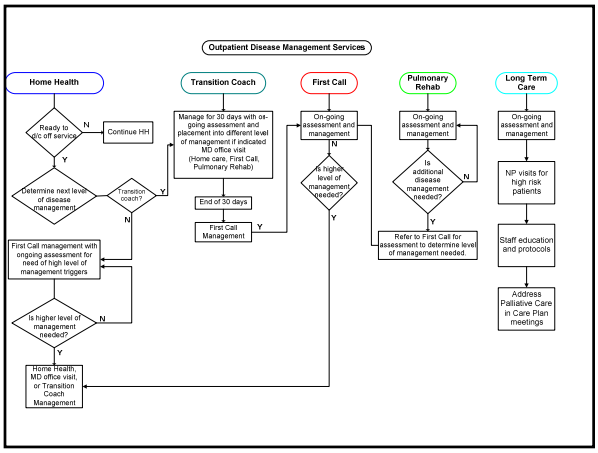




Strategy #4
Develop new processes, coordinate and communicate


Chronic Obstructive Pulmonary Disease
(COPD)
Stoplight
Call 911 for:
Severe shortness of breath at rest
Chest pain that does not go away
Lips and fingernails turn gray or blue
Unusual sleepiness or restlessness
Call Home Health or Doctor for:
Name:_____Phone:_____ Name:_____Phone:_____
Have increased shortness of breath with usual activity
Coughing more than usual
Have increased sputum or changes in color
Have to use short acting medicines more often
Feel more tired or restless not associated with lack of sleep
You are doing well when:
Can do your normal activities
Have no changes in your symptoms
Usual medicines are controlling your symptoms


COPD Admission / Readmission Process
Inpatient
ED
Physician Office
In process
Inpatient admission
Implement ED COPD Plan of Care
Does patient meet criteria for
Make referral
Discharge from ED or physician office
See outpatient Disease Management flowchart
HEC sends list of all COPD diagnosis to First Call
First Call contacts patient next am and performs readmission risk screen and assigns patient to proper level of management
See outpatient Disease Management flowchart
CF performs COPD Readmission interview / assessment
Inpatient COPD Plan of Care Implemented
Risk of Readmission score to determine level of outpatient management
Home Health
Transition Coach
First Call
Pulmonary Rehab
Rehab
LTACH
SNF
Discharge appointment made 72 hrs Post Discharge for all patients regardless of outpatient management level
See outpatient Disease Management flowchart


Outpatient Disease Management Services
Home Health
Transition Coach
First Call
Pulmonary Rehab
Long Term Care
Ready to D/C off service
Continue HH
Determine next level of disease management
Transition coach?
First Call management with ongoing assessment for need of high level of management triggers
Is higher level of management needed?
Home Health, MD office visit, or Transition Coach Management
Manage for 30 days with on-going assessment and placement into different level of management if indicated MD office visit (Home care, First Call, Pulmonary Rehab)
End of 30 days
First Call Management
On-going assessment and management
Is higher level of management needed?
On-going assessment and management
Is additional disease management needed?
Refer to First Call for assessment to determine level of management needed.
On-going assessment and management
NP visits for high risk patients
Staff education and protocols
Address Palliative Care in Care Plan meetings

Strategy #5
Minimize Meetings

- Entire Group Only Met 3 Times Before Initial Go-live
- Initial meeting
  - Strategy
  - 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

ED – 4
Inpatient - 15
Respiratory Care – 2
Pulmonary Rehab - 1
Hospital Medical Group - 7
Coding/Billing - 3
Information Services - 3
Home Health - 5
Transition Care - 1
Medication Process - 5
Long Term Extended Care - 5
Nursing Home - 5
Marketing – 3
Nurse Call Center – 6
Physician representatives – 4
IM, FP, Hosp, ED
Palliative Care - 1
Physicians Champion- 1
Compliance – 2
Analytics - 2
Pharmacy - 3
Patient - 1
Community - 2
Executive sponsors – 2
CMO, VP Nursing
Secretarial support- 2
Project Management - 2

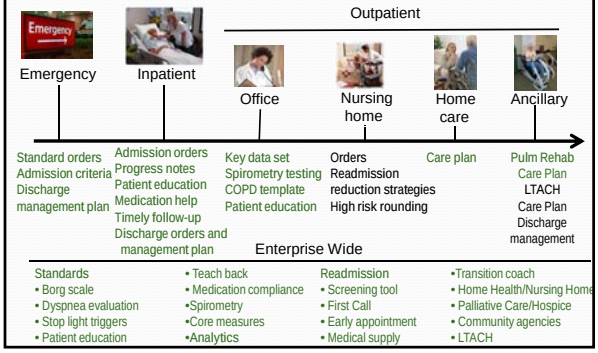
Strategy #6
Unwavering executive/physician support

&

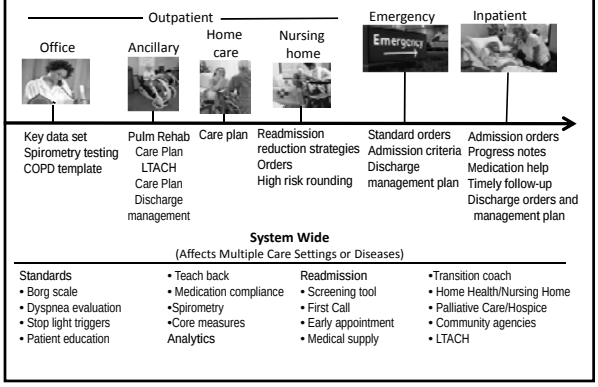
Physician Champion

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!

Before

After

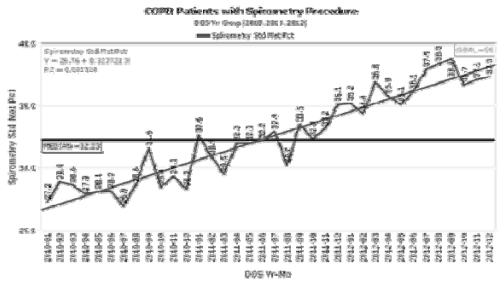
COPD Patients - Spirometry, Pneumovax, Smoking Status & Counseling

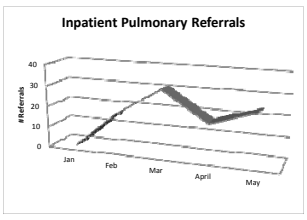
Note: Last visit of the month per provider
Updates @ Monday at 7a.m.

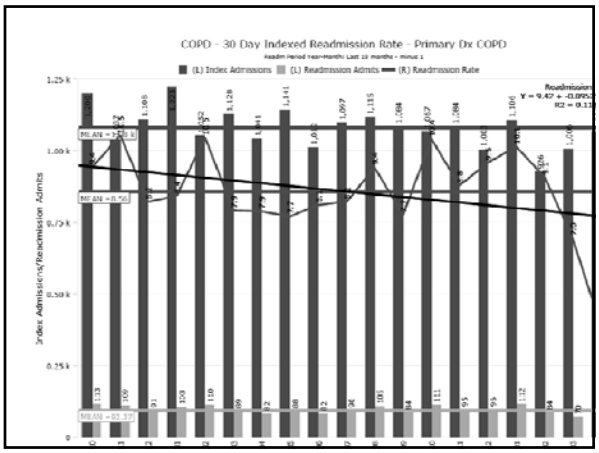
Sunday, June 3, 2012

DOS Yr: 2012

	Patient Visit	Spiro-metry	Pneumo-vax	Non-smoker*	Tobacco Status	Smoking Cessation Counseling
	Target-->	>=50%	>=50%	>=90%	>=90%	>=80%
Family Medical Center						
FAMILY MEDICAL CENTER	477	44.0%	10.9%	89.7%	97.7%	82.5%
Family Medical Center Total	477	44.0%	10.9%	89.7%	97.7%	82.5%







Why COPD

Improving COPD in Strategic Plan (2011)

Mortality	Cost	LOS	Readmission
1.20	**1.05**	**1.03**	**1.28**

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

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MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

The Care Coordination Center

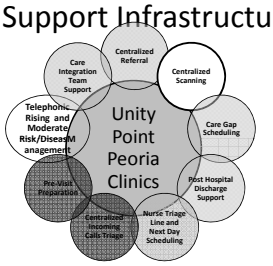
Some of the new enhancements Support the Unity Point Clinic Support Infrastructure

= Live

= pilot August 2014

= Workflow teams designing pilot

= Function **not** performed in Care Coordination Center



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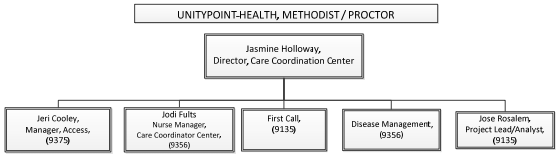
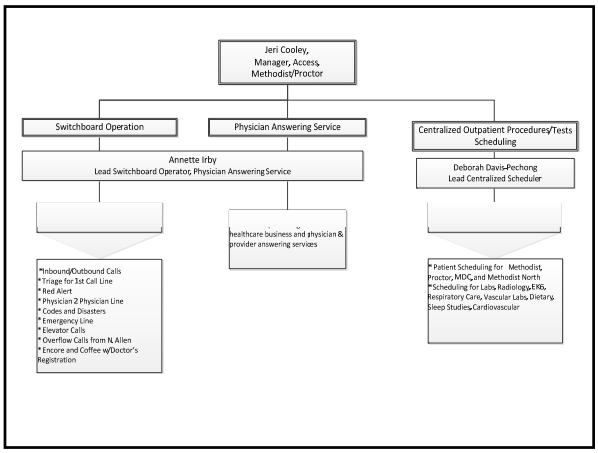
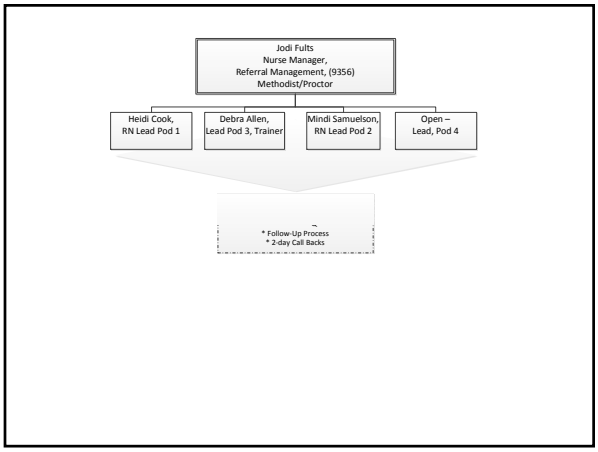
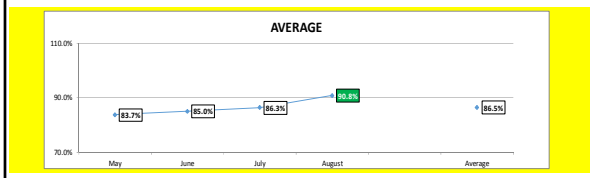
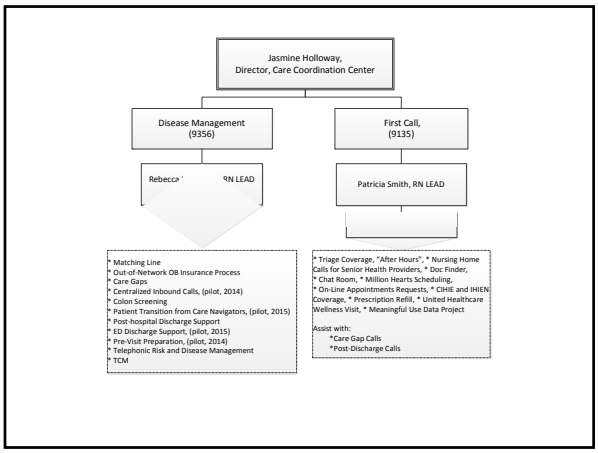


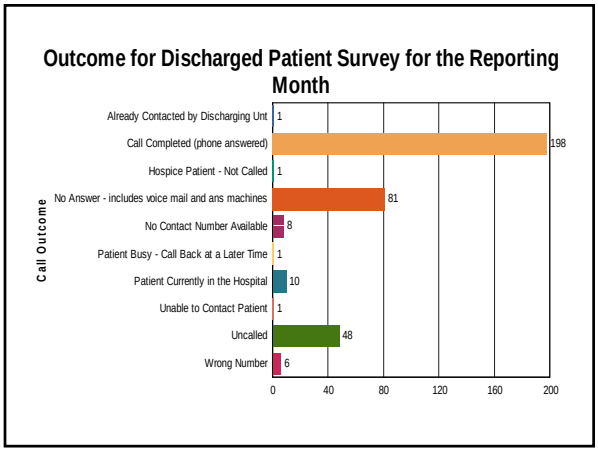


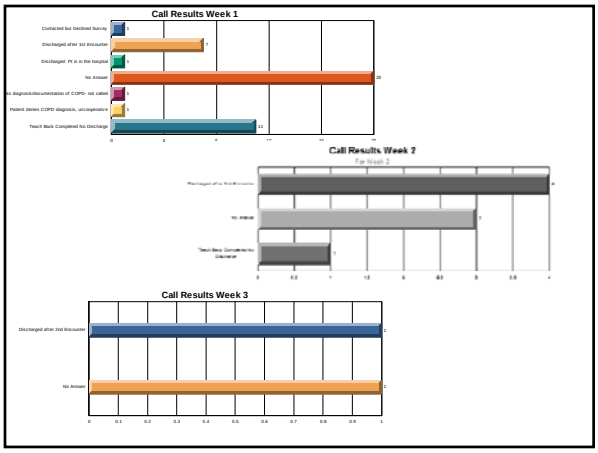


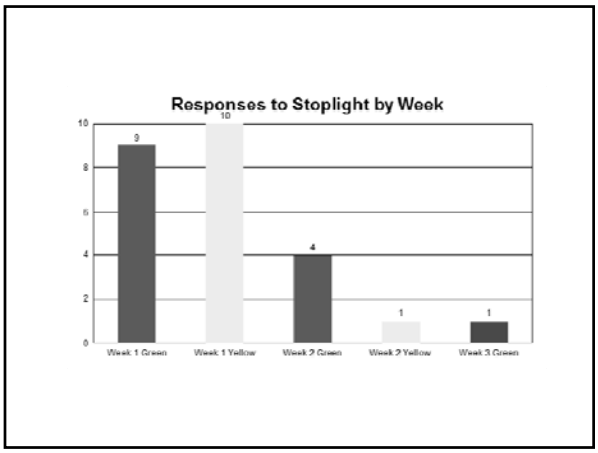
Care Coordination Center Referral Management

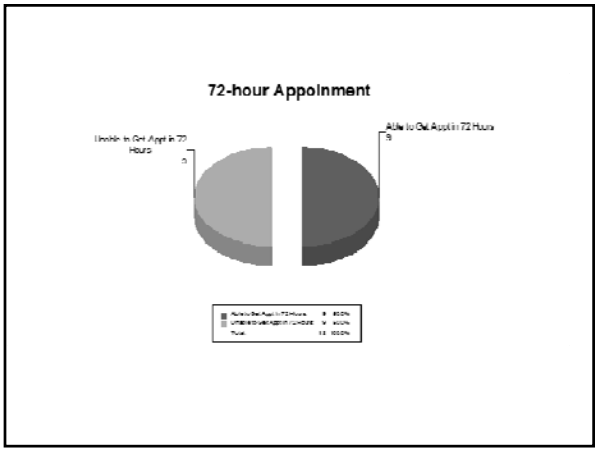


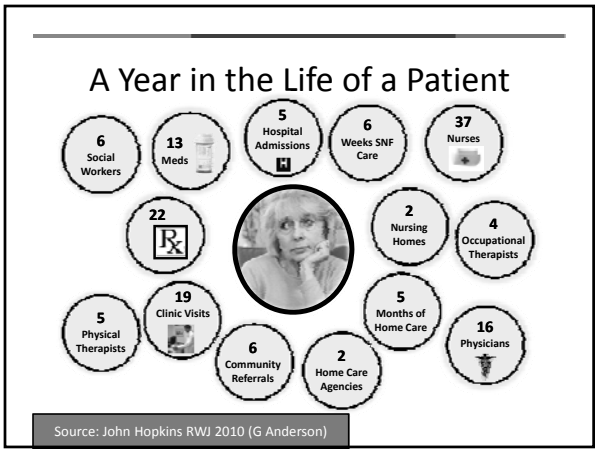

Jasmine Holloway,
Director, Care Coordination Center
Disease Management
(9356)
First Call,
(9135)
RN LEAD
Patricia Smith, RN LEAD
* Matching Line
* Out-of-Network OB Insurance Process
* Care Gaps
* Centralized Inbound Calls, (pilot, 2014)
* Colon Screening
* Patient Transition from Care Navigators, (pilot, 2015)
* Post-hospital Discharge Support
* ED Discharge Support, (pilot, 2015)
* Pre-Visit Preparation, (pilot, 2014)
* Telephonic Risk and Disease Management
* TCM
* Triage Coverage, "After Hours", * Nursing Home Calls for Senior Health Providers, * Doc Finder, * Chat Room, * Million Hearts Scheduling, * On-Line Appointments Requests, * CHIE and IHIEN Coverage, * Prescription Refill, * United Healthcare Wellness Visit, * Meaningful Use Data Project
Assist with:
*Care Gap Calls
*Post-Discharge Calls


Outcome for Discharged Patient Survey for the Reporting Month
Call Outcome
Already Contacted by Discharging Unt
Call Completed (phone answered)
Hospice Patient - Not Called
No Answer - includes voice mail and ans machines
No Contact Number Available
Patient Busy - Call Back at a Later Time
Patient Currently in the Hospital
Unable to Contact Patient
Uncalled
Wrong Number
1
198
1
81
8
1
10
1
48
6
0
40
80
120
160
200


Call Results Week 1
Call Results Week 2
Call Results Week 3


Responses to Stoplight by Week
10
8
6
4
2
0
9
10
4
1
1
Week 1 Green
Week 1 Yellow
Week 2 Green
Week 2 Yellow
Week 3 Green


72-hour Appointment
Unable to Get Appt in 72 Hours
5
Able to Get Appt in 72 Hours
9


A Year in the Life of a Patient
6
Social Workers
13
Meds
5
Hospital Admissions
6
Weeks SNF Care
37
Nurses
22
2
Nursing Homes
4
Occupational Therapists
5
Physical Therapists
19
Clinic Visits
5
Months of Home Care
16
Physicians
6
Community Referrals
2
Home Care Agencies
Source: John Hopkins RWJ 2010 (G Anderson)

Healthcare wrapped around the patient
[connected, information shared, smooth hand-offs]

Result: Higher Quality, Higher Service, Lower Costs

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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