LEARNING COLLABORATIVE

RHP 10

"The DISCHARGE ALTERNATIVE: A STEP in the Right Direction"

Care Transitions Collaborative Webinar
August 21, 2014

Agenda

Welcome and Introduction	**Aubrie Augustus, RN, BSN, MHA**
Roll Call	**Heather Beal, MHA**
"The DISCHARGE ALTERNATIVE: **A STEP** in the Right Direction"	**Janice A. Knebl, DO, MBA**
Measure Reporting	**Vincent Do, BSIE, LSSMBB, LBC**
Questions and Answers	**Participants**
Upcoming Events and Next Steps	**Aubrie Augustus**

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"The DISCHARGE ALTERNATIVE: A STEP in the Right Direction"

Janice A. Knebl, DO, MBA

August 21, 2014

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Transitional Care - AGS

- A set of actions designed to **ensure** the **coordination** and **continuity** of health care as patients transfer **between different locations** **or** **different levels of care** within the same location.
- Based on a **comprehensive plan of care** & the availability of health care practitioners who are well-trained in chronic care & have current information about the **patient's goals, preferences, and clinical status**
- I**ncludes** **logistical arrangements**, **education** of the patient and family, and **coordination** among the health professionals involved in the transition
- Transitional care, which **encompasses both the sending** **and the** **receiving aspects** of the transfer, is essential for persons with complex care needs

Source: Coleman EA, Boult CE on behalf of the American Geriatrics Society Health Care Systems Committee. Improving the Quality of Transitional Care for Persons with Complex Care Needs. Journal of the American Geriatrics Society. 2003;51(4):556-557.

Re-hospitalizations Among Medicare Recipients

- Within 30d of discharge
  - 20% readmitted
    - Variable 13-23%
    - Texas 19.4%
  - Post op discharge readmitted with medical diagnoses
  - 50% readmitted unable to follow up with PCP
- At risk diagnoses: CHF, Pneumonia, COPD, Stroke, Hip Fracture
- Subsequent hospital stay slightly longer
- Re-hospitalization risk persists over time

Jencks SF, NEJM 2009/ Kane RL, HSR 2002

Interventions to Reduce Readmissions

Pre-discharge Programs
- ACE Units
- Delirium Prevention
- Consultation Services
- Hospitalist Programs
- Discharge Planning
- Appointment before D/C

Transitions Programs
- Care Transitions Intervention
- Chronic Care Coordination
- Collaborative Care Management
- D/C Planning & Home F/Up
- Home Healthcare Telemedicine
- Hospital to NH Transitions
- Medication Reconciliation Programs

Post-discharge Programs
- Timely communication and appointments
- F/Up phone calls
- Home Visits

Payment Incentives
- Value-based Purchasing
- ACOs Shared Savings
- Bundled Payments
- Capitation

Overview of High Quality Transitional Care Programs

"BOOST"
Better Outcomes for Older Adults Through Safe Transitions
http://www.hospitalmedicine.org

"Project RED"
Re-Engineered Discharge: Enhanced hospital D/C Plan
https://www.bu.edu/fammed/projectred

"Care Transition Program"
Transition Coach
Trained Volunteers
Empowered patients & caregivers
http://www.caretransitions.org

"POLST" (or "MOLST")
Physician (or Medical) Orders for Life Sustaining Treatment
Advanced Care Planning
http://www.ohsu.edu/polst

High Quality Care Transitions for

Older Adults & Caregivers

"Bridge Model"
SW coordinating Aging Resource Center Services @ Hospital D/C
http://www.transitionalcare.org/the-bridge-model

"Transitional Care Model"
APN coordinates care during/after D/C
http://www.transitionalcare.info/index.html

"INTERACT"
(***Interventions to Reduce Acute Care Transfers***)
Communication tools, Care Paths, Advance Care Planning Tools and QI
http://interact2.net

The Discharge Alternative

Mission Statement

To provide high-quality transition of care services for discharged Medicaid- eligible elders of Tarrant County.

The STEP Team

STEP Goals

Reduce *all-cause* 30 day hospital readmissions	Decrease falls	Improve Quality of Life

- Medical Director/Physicians
- Nurse Practitioners
- Social Workers
- Physical Therapists
- Medical Assistant
- Pharmacist
- Administrative Assistant
- Data Analyst
- Program Manager

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STEP's History

The STEP Timeline

2012

1115 Waiver for Discharge Planning and Care Transition Services Plan Submitted by UNTHSC for CMS Approval

2013

1115 Waiver for Discharge Planning and Care Transition Services Approved by CMS

October 2013-January 2014

Discharge Planning and Care Transition 1115 Waiver given name STEP-"Safe Transitions for the Elderly Patient"

Bulk of STEP Team Hired:
Medical Director
Nurse Practitioners
Social Workers
Physical Therapists
Medical Assistant
Pharmacist
Administrative Assistant
Data Analyst
Program Manager

January 2014-May 2014

Evidence Based Care Transition and Discharge Planning Protocols Developed and Tested by STEP Team

June 2, 2014

STEP Began Providing Services

Key Points:

-Nearly two years in the planning of STEP

-STEP is the classic definition of a "start-up"

-Many changes along the way that continue…"building the plane" while still in flight!

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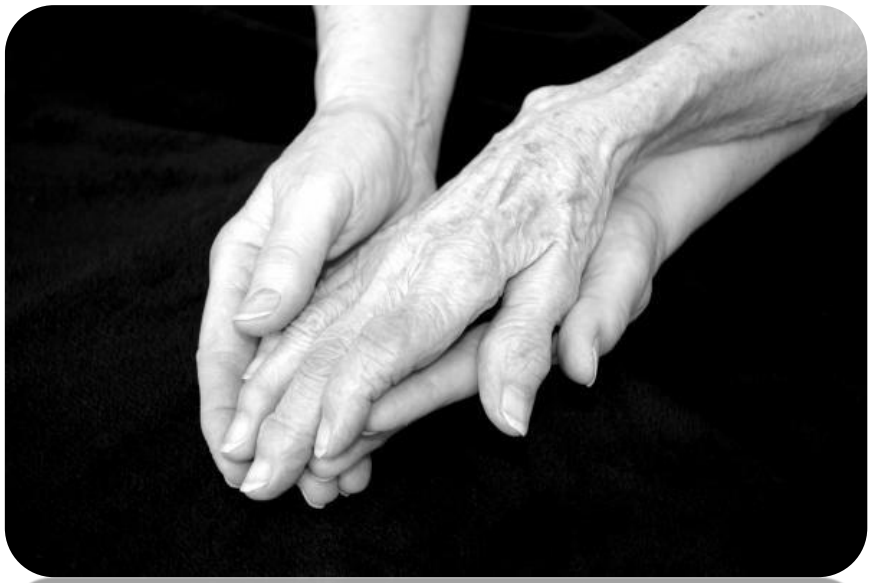
Eligibility

- Medicaid +/or eligible
- 50 years and older
- Tarrant County Resident
- Not disease specific--any diagnosis
- Discharged from inpatient or observation



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STEP Services

Holistic Care: meeting the patient's social, financial, spiritual, physical, and medical needs

- ✓ Provide in-home interdisciplinary evaluation and treatment for up to **90 days** post hospital discharge
- ✓ Re-establish patients with primary care providers for continued outpatient management
- ✓ Connect with community partners and resources
- ✓ Extensive physical therapy services

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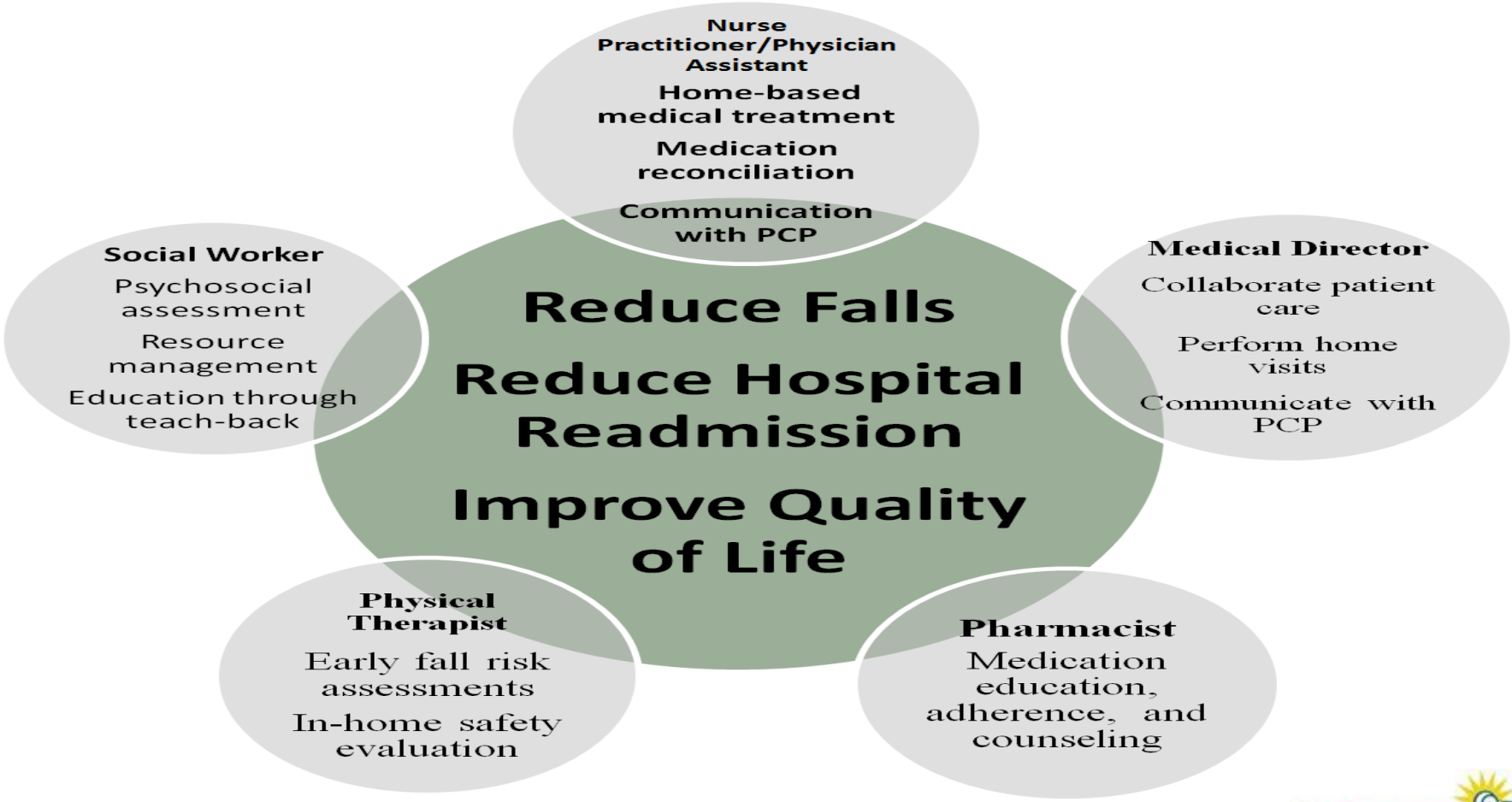
Team Approach to Care



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Factors That Makes STEP Unique

- Medical Director makes an in-home visit with EVERY STEP patient
- Re-connects patients with their PCP or finds a PCP
- Not restricted by Medicaid, Medicare, or other managed care rules
- Collaborative effort to improve quality of care and access to care and community services.

- One-stop shopping—All providers are from the same team: UNT Health Science Center!
- No competing interests
- **The patient is the center of our services!**

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Data, Metrics, and Milestones, Oh My!

- Key STEP data after two months:
  - 32 patients enrolled and counting
  - Lowered age eligibility for STEP from 65 years old to 50 years old in July 2014
  - Accepting referrals from observation and inpatient discharges

Partner Hospitals and Referral Counts

BAYLOR All Saints Medical Center

(14)

JPS HEALTH NETWORK

(0)

Texas Health Harris Methodist Hospital FORT WORTH

(9)

Methodist Mansfield Medical Center

(18)

PLAZA Medical Center of Fort Worth

(12)

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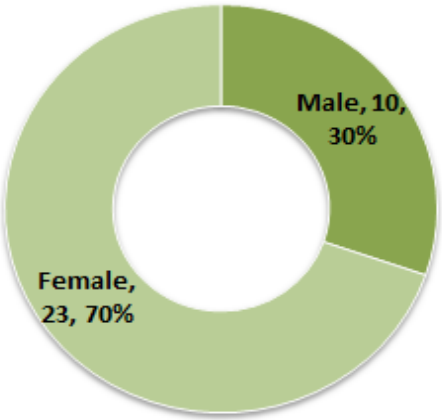
Data, Metrics, and Milestones, Oh My!

Reasons for declined referrals:

	Hospital						
Reasons for not being accepted into STEP	THR FW	Baylor	JPS	Plaza	Methodist	THR SW	Total
Patient did not give consent	0	2	0	3	0	1	6
Patient was sent to rehab or nursing home after d/c	4	2	0	1	0	0	7
Patient does not live in Tarrant County	1	1	0	1	2	0	5
Patient's income was too high	0	2	0	0	5	0	7
Unable to locate patient (transient)	1	1	0	4	0	0	6
Total	6	7	0	3	7	1	31

STEP
Patient Demographics

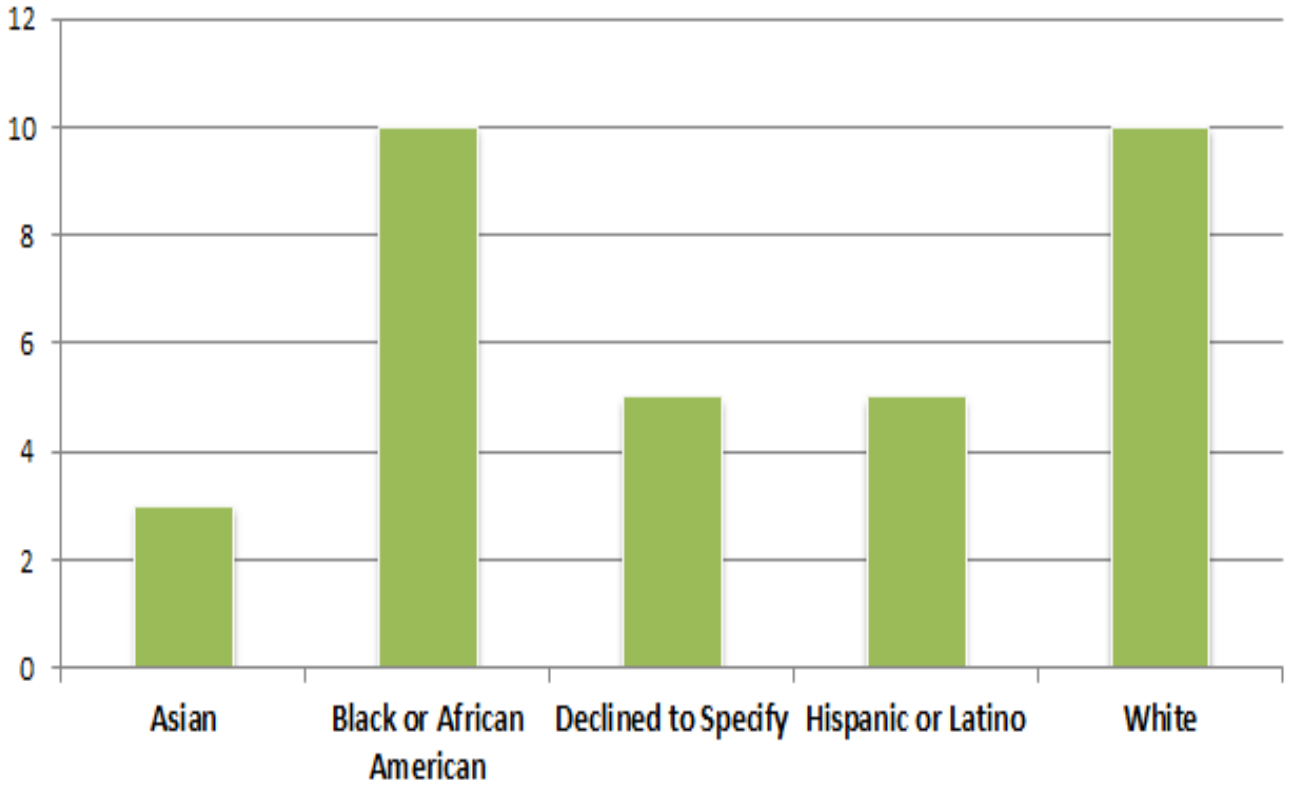
Gender



Mean Age: 72

Median Age: 70

Race/Ethnicity



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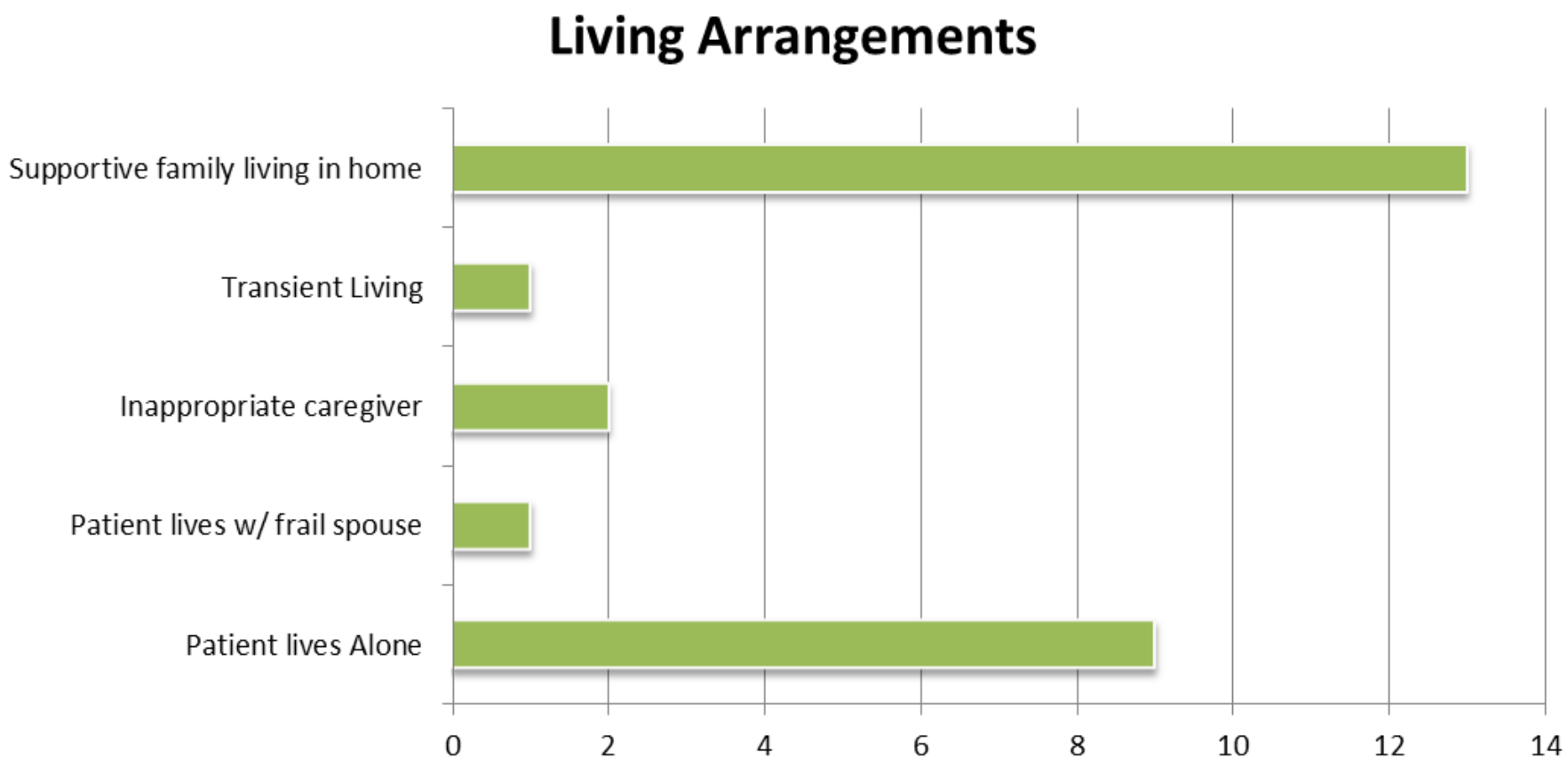
STEP
Patient Demographics



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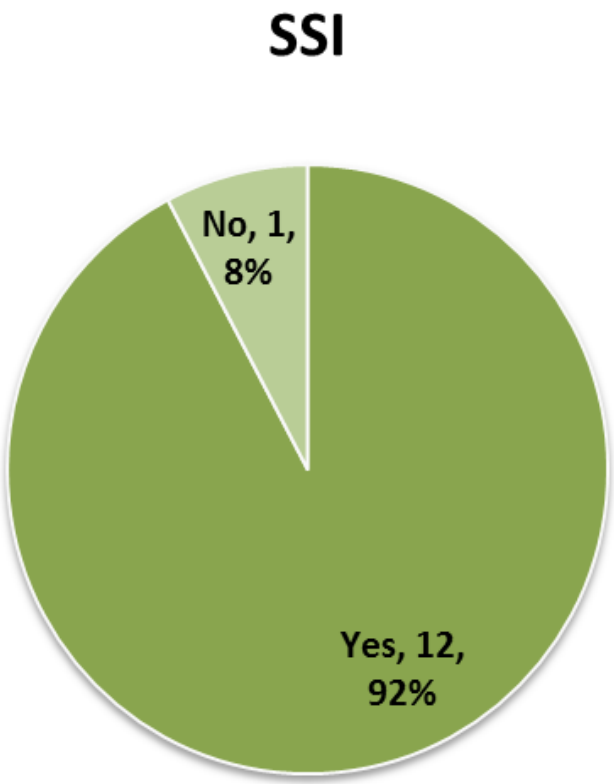
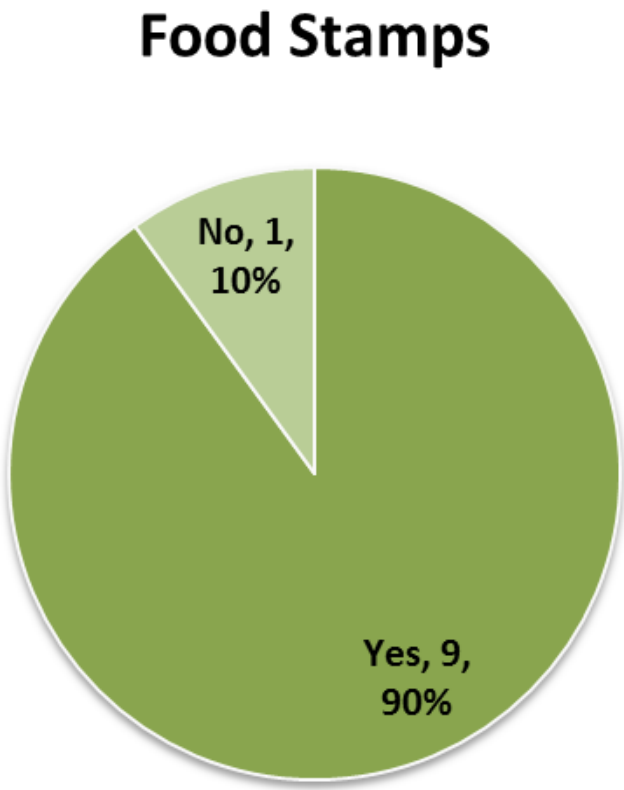
STEP
Patient Demographics

Monthly income range: $721 - $1200





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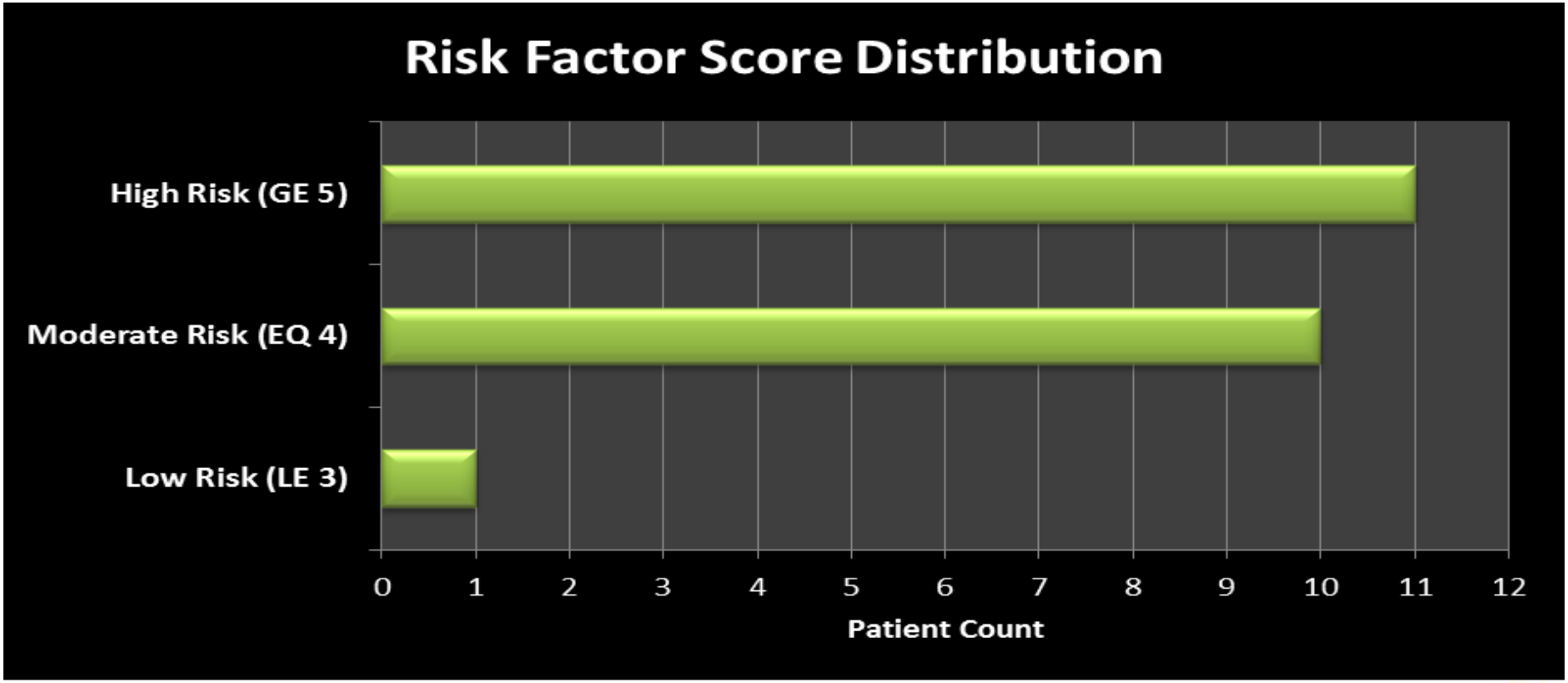
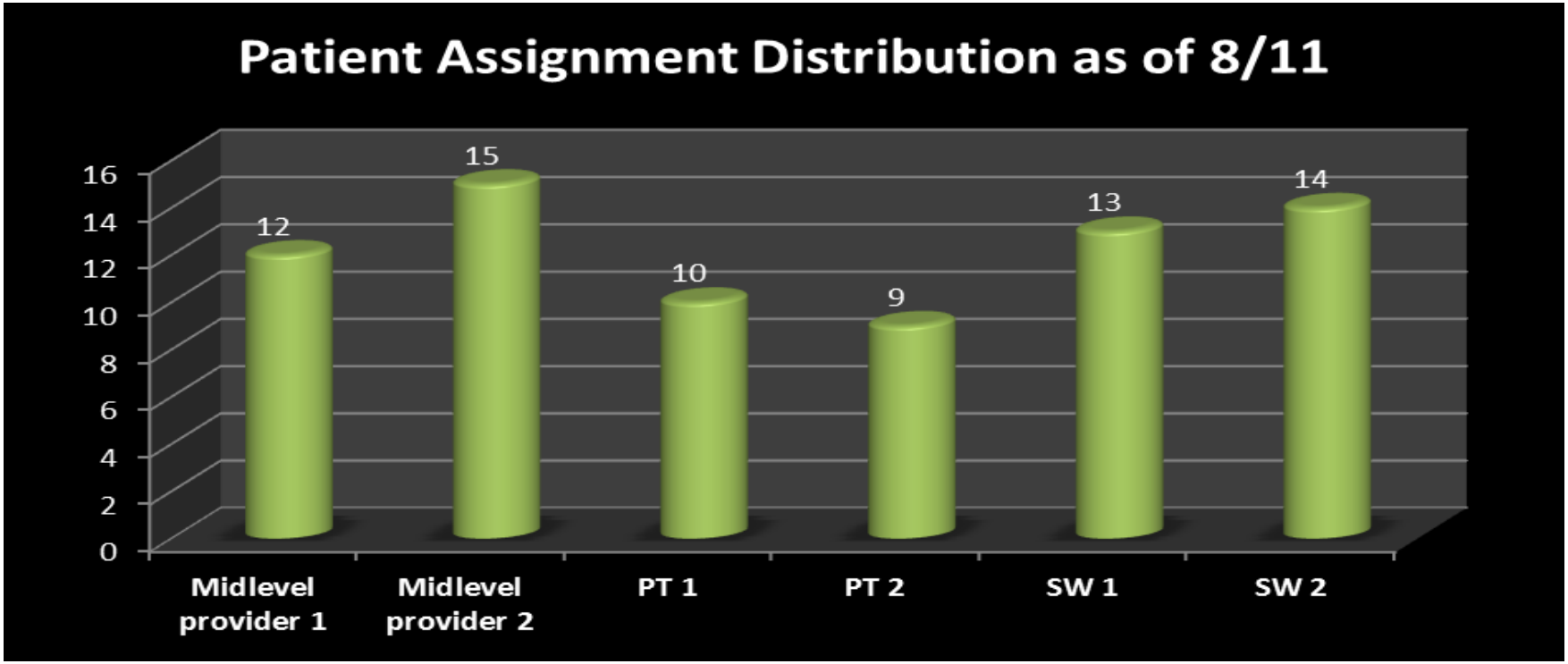
Data, Metrics, and Milestones, Oh My!

Baseline Scores for Risk Assessment Tool:



Data, Metrics, and Milestones, Oh My!

Patient distribution:



The CQI Imperative

- Use PDSA/rapid cycle improvement, gap analysis, and other methods to evaluate and improve services. Examples of CQI efforts include:
  - Internal audits for quality assurance and continuous improvement of data collection methods
  - Conducted gap analysis to re-design consenting process and establish measures of success
  - Performed PDSA to improve efficiency and focus of Interdisciplinary Group (IDG) meetings

STEP Outreach & Marketing Activities

- Over 77 STEP Promotional Events Since January 2014
- STEP Community Outreach Events in February, April, June, and July With a Combined 200+ attendees
- Presented STEP to:
  - ❑ 7 home health agencies
  - ❑ 4 hospitalist groups
  - ❑ 7 Tarrant County hospitals
  - ❑ 15 charity and community organizations
  - ❑ Multiple local public and private healthcare partners with 1115 Waiver projects

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STEP Success Story

- **65 year old female** admitted for infection and wound dehiscence of an arteriovenous fistula

Challenges included:

-ESRD, multiple comorbidities

-Social challenges: no family support or transportation, infestation, fragmented care

-Patient was not properly insured-Medicaid application incomplete

STEP Success Story

STEP Program Interventions:

Coordination of care with PCP/specialists/social needs/and therapy/NP Prevented rehospitalization

Establish home health services (HHS) and reconnect patient with PCP

Pharmacist completed medication reconciliation & coordinated pharmacy benefits (free, ensuring continuous access to medications)

Arranged reliable transportation to dialysis appointments

Arranged home disinfection of bed-bugs through UNTHSC School of Public Health and charity and community resources

Provided assistance with acquisition of Medicaid

Provided comprehensive physical therapy services: evaluation and fall risk identification, provided therapeutic exercises and performed and home safety assessment to de-clutter home and improve home safety

Questions and Feedback

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Measures Progress Update

July 2014 Data Reporting

Vincent Do

Care Transition - Inpatient

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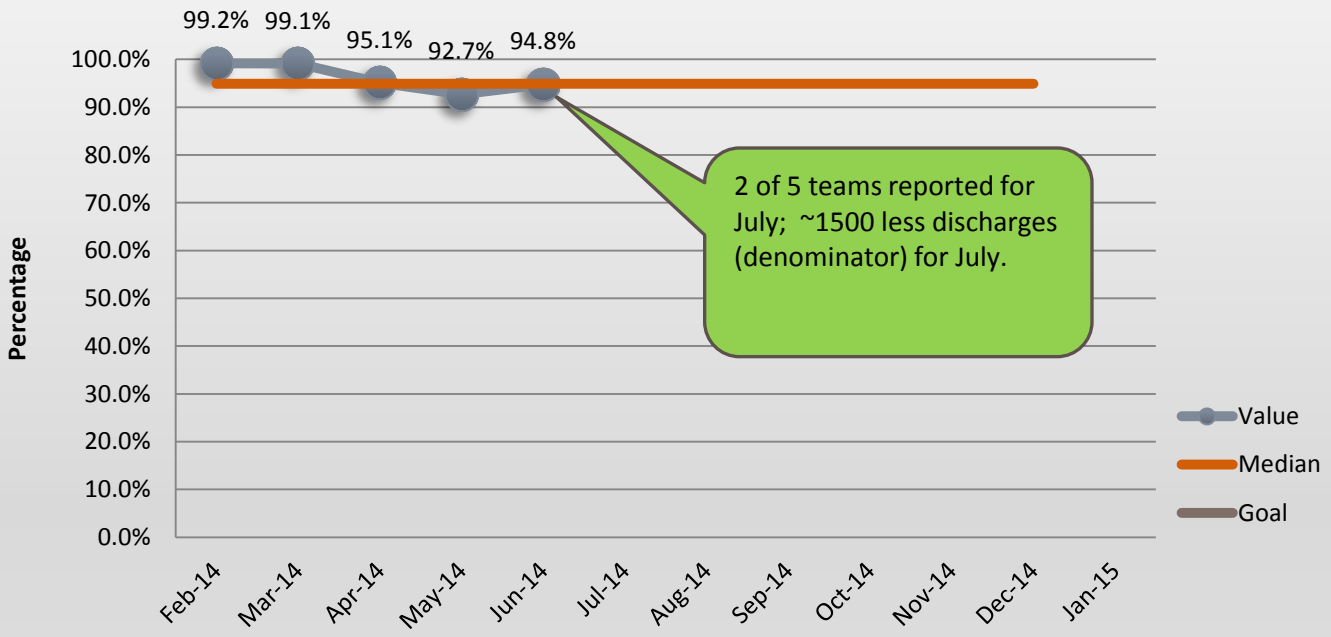
Collaborative (2 of 5 Teams): Percentage discharged patients who received written discharge summary

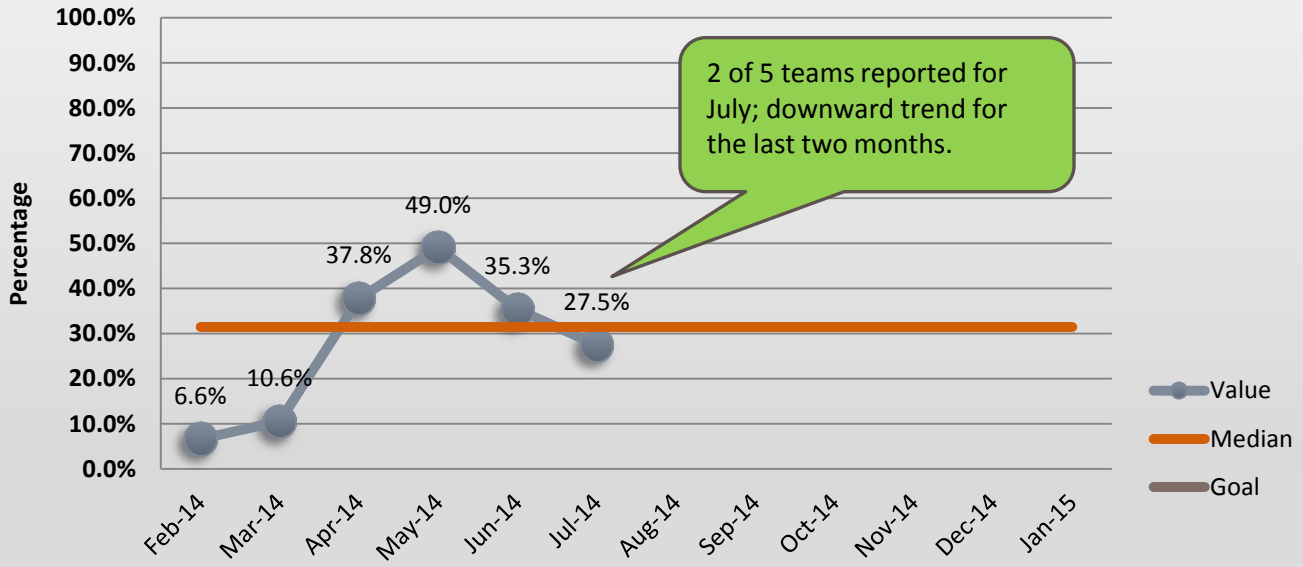


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	99.2%	99.1%	95.1%	92.7%	94.8%							
Median	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
Goal												
Numerator:	1722	6461	6333	6706	6681	5152						
Denominator:	1736	6520	6660	7236	7049	5482						

Care Transition - Inpatient

LEARNING COLLABORATIVE RHP 10

Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days

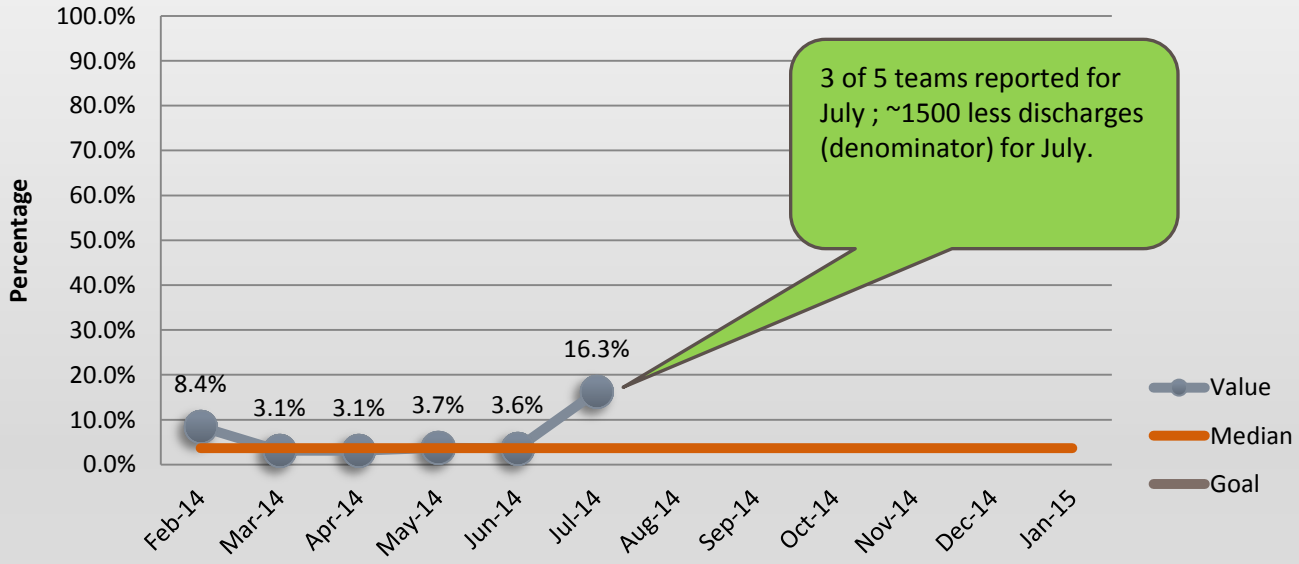


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	6.6%	10.6%	37.8%	49.0%	35.3%	27.5%						
Median	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%
Goal												
Numerator:	26	52	182	251	135	110						
Denominator:	391	492	482	512	382	400						

Care Transition - Inpatient

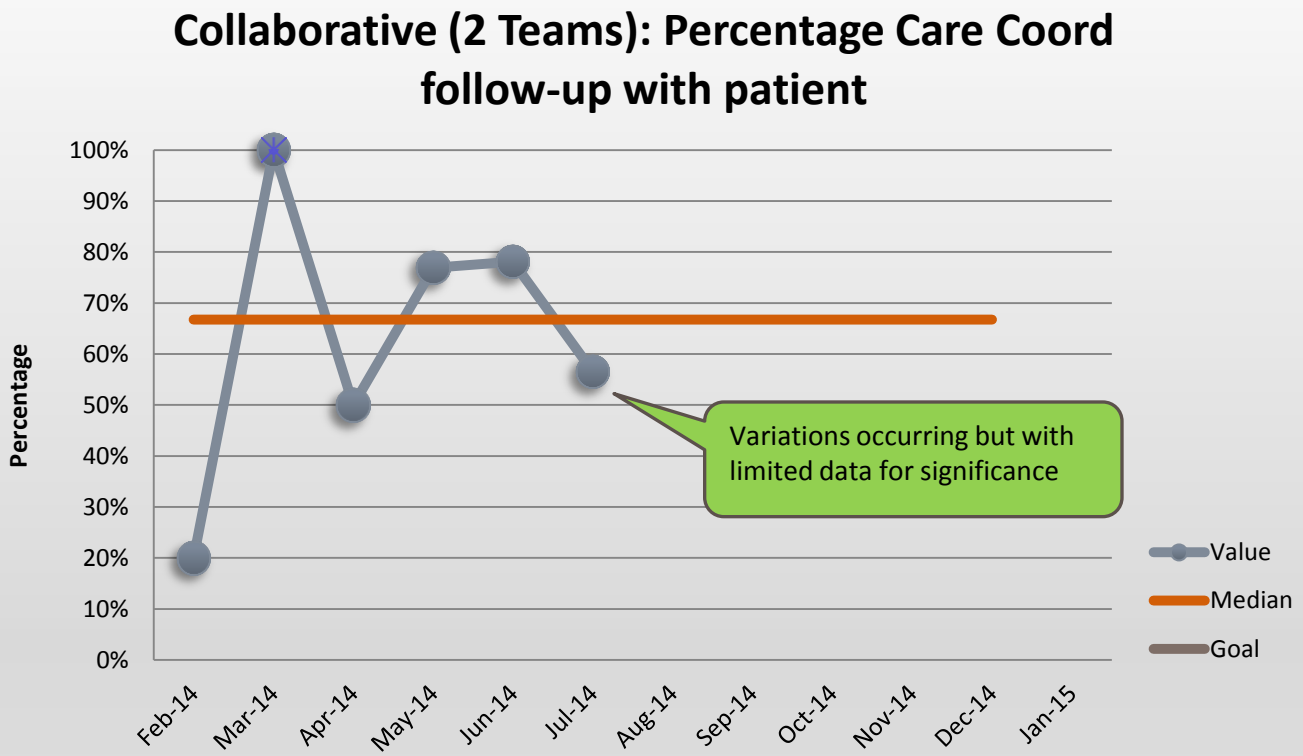
LEARNING COLLABORATIVE RHP 10

Collaborative (3 of 5 Teams): Percentage discharged patients with community provider contact within 7 days



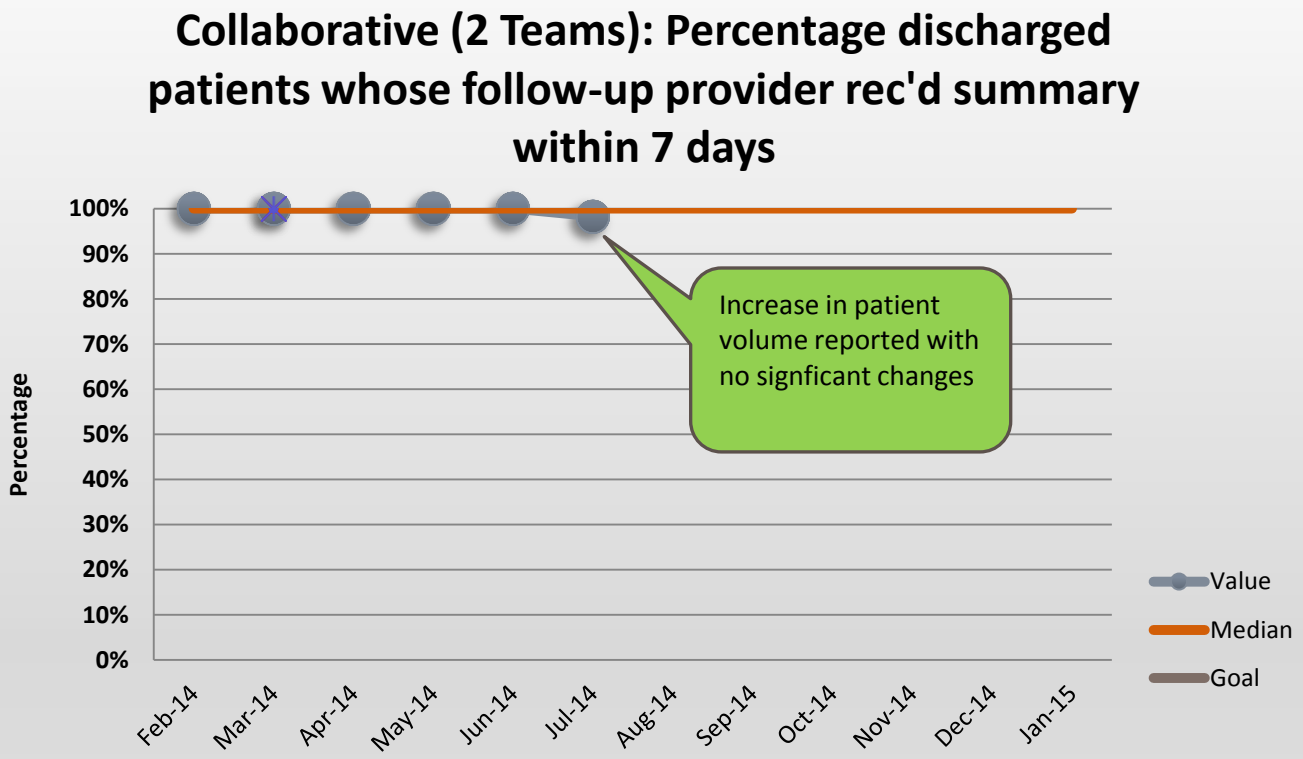
	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	8.4%	3.1%	3.1%	3.7%	3.6%	16.3%						
Median	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Goal												
Numerator:	150	218	206	268	258	898						
Denominator:	1778	7011	6694	7257	7074	5514						

Care Transition - Outpatient



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	20%	100%	50%	77%	78%	57%						
Median	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	
Goal												
Numerator	1	1	1	10	25	13						
Denominator	5	1	2	13	32	23						

Care Transition - Outpatient

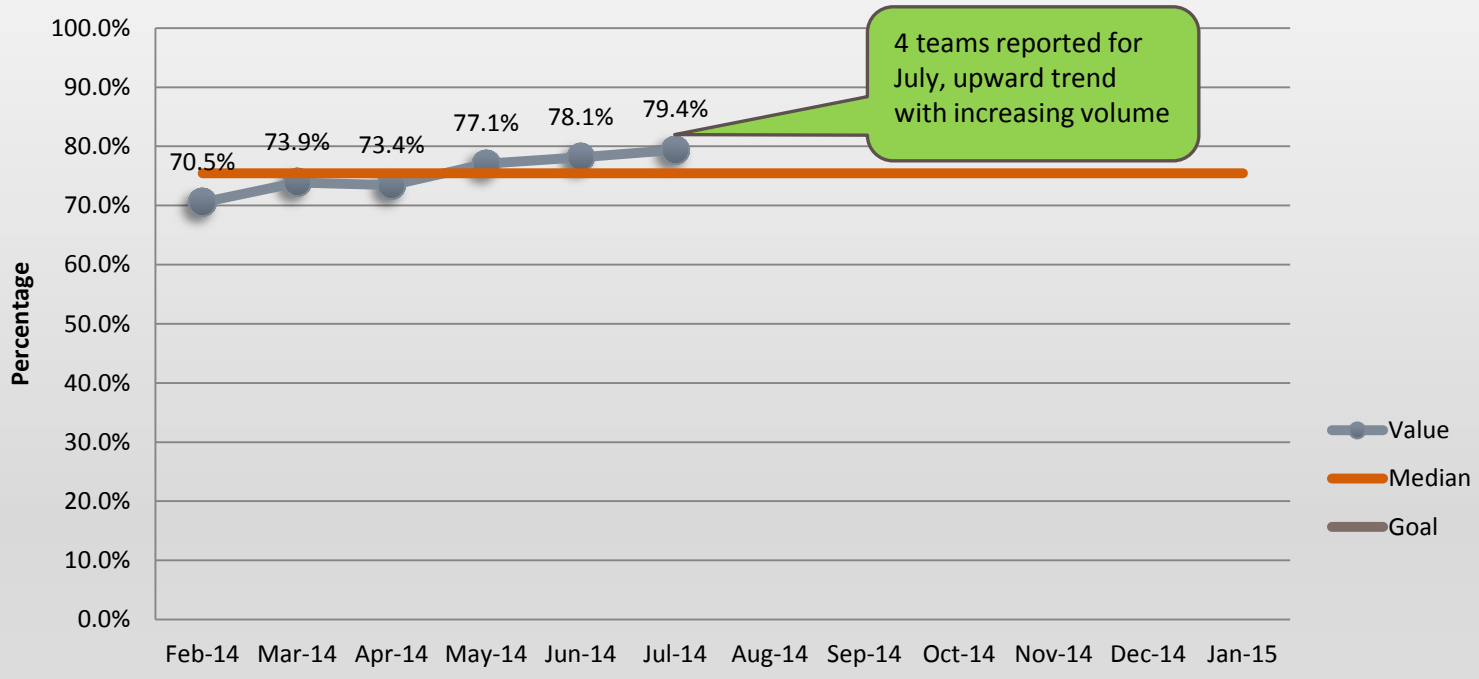


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	100%	100%	100%	100%	100%	98%						
Median	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Goal												
Numerator	5	1	13	22	24	60						
Denominator	5	1	13	22	24	61						

Behavioral Health

LEARNING COLLABORATIVE RHP 10

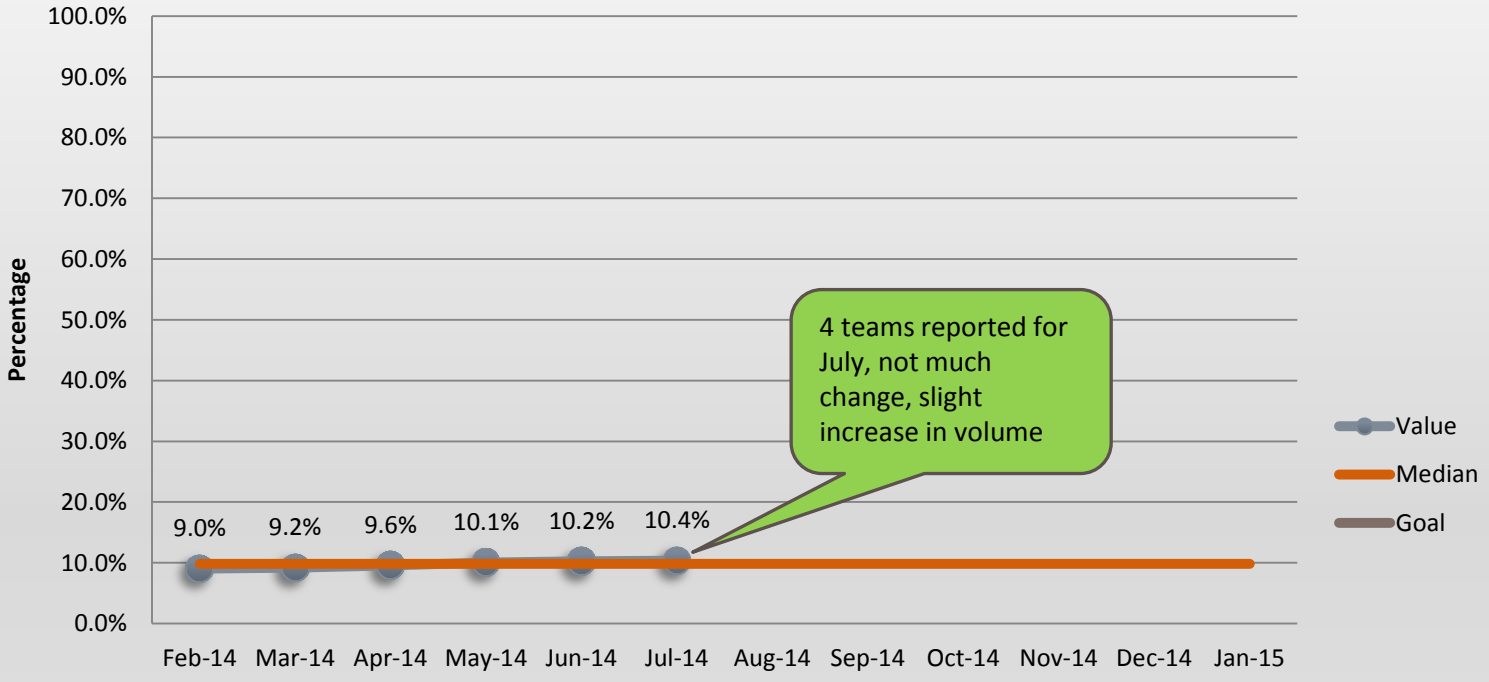
Collaborative (4 Teams): Percentage patients screened with cross-specialty tool



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	70.5%	73.9%	73.4%	77.1%	78.1%	79.4%						
Median	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%	75.5%
Goal												
Numerator	12764	14530	15433	16781	17957	19082						
Denominator	18099	19667	21016	21778	22979	24028						

Behavioral Health

Collaborative (4 Teams): Percentage patients received integrated care intervention

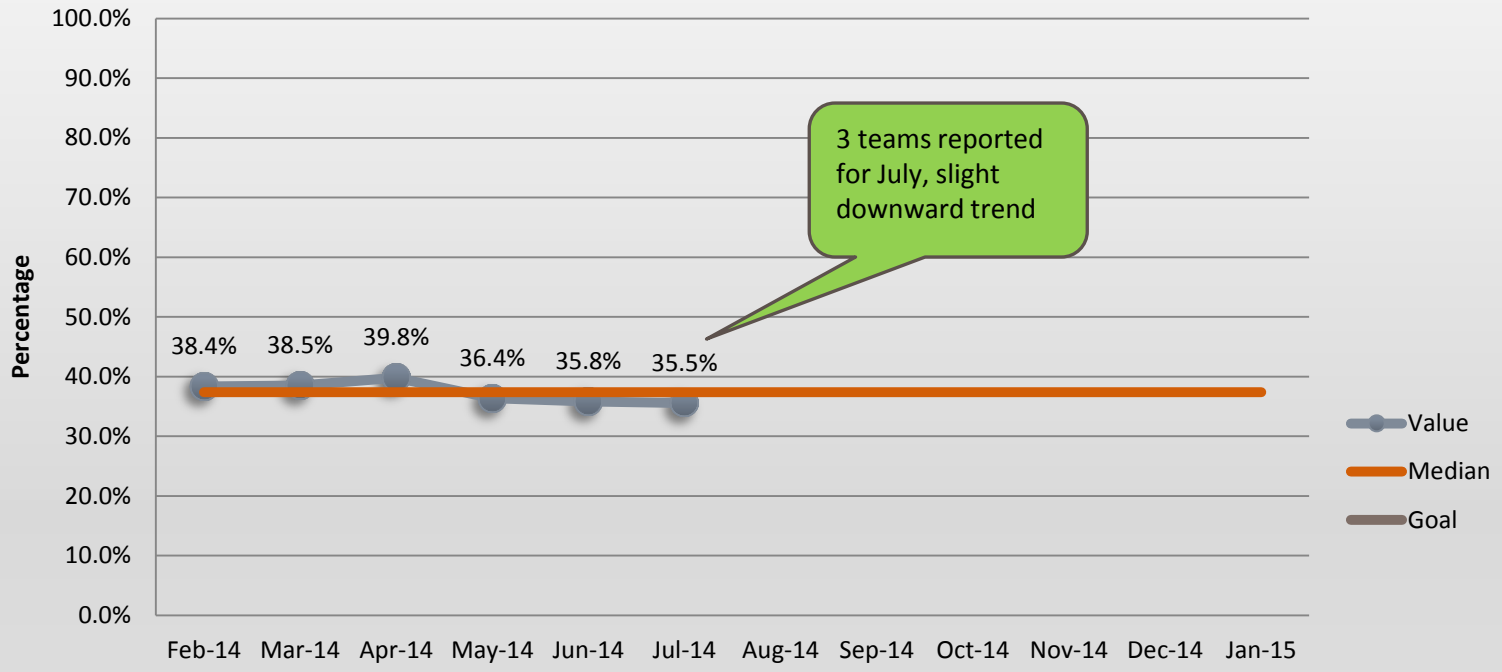


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	9.0%	9.2%	9.6%	10.1%	10.2%	10.4%						
Median	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%	9.8%
Goal												
Numerator	1629	1803	2004	2185	2347	2485						
Denominator	18028	19563	20932	21727	22940	23989						

Behavioral Health

LEARNING COLLABORATIVE RHP 10

Collaborative (3 Teams): Percentage patients whose condition improved with intervention



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	38.4%	38.5%	39.8%	36.4%	35.8%	35.5%						
Median	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%	37.4%
Goal												
Numerator	6512	6587	6587	6146	6095	6043						
Denominator	16970	17098	16550	16893	17020	16999						

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RHP 10

Upcoming Events and Next Steps

Aubrie Augustus

Upcoming Events

Behavioral Health Site Visit at MHMR Tarrant County
Date: Monday, August 25, 2014
Time: 9:00 - 11:00 am
Place: 3840 Hulen St, North Tower, Ft. Worth, TX 76107 (In the 4th floor Board Room)

Region 10 Learning Collaborative –Learning Session 2
Date: Thursday, September 25, 2014
Time: 8:00 am – 4:30 pm
Place: Hilton Hotel, Downtown Fort Worth: 815 Main Street, Fort Worth, TX 76102
Registration Link: Registration required, please register at:
http://rhp10txwaiver.com/informationresources/registration92514.html

The Clinical and Quality Committee Meeting
To begin the Learning Collaborative for DY 4
Date: Tentatively scheduled for **October 16, 2014**
Time: 10:00 am – 12:00 pm
Place: TBD

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Region 10 Learning Collaborative Learning Session 2-Speaker Information

Speaker	Tricia Nguyen, MD
Biography	Tricia Nguyen, M.D., joined Texas Health Resources in September 2013 as the system's executive vice president for population health and president of the Texas Health Population Health, Education & Innovation Center. Nguyen joined Texas Health from Banner Health Network in Arizona, where she served as chief medical officer. Nguyen has a broad range of experience working with providers, hospitals and payers, all focused on establishing the foundations for population health and outcomes-based reimbursement.
Topic	**Care Transitions**

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Region 10 Learning Collaborative Learning Session 2-Speaker Information

Speaker	Kevin W. O'Neil, MD, FACP, CMD
Biography	Dr. O'Neil is the CMO of Brookdale Senior Living. He practiced and taught geriatric medicine for over 30 years. He is the Co-Director for the CMS Health Innovations Challenge Grant awarded to UNTHSC in collaboration with Brookdale Senior Living. This grant provides funding to expand and test the Brookdale Transitions of Care Program, which incorporates INTERACT (Interventions to Reduce Acute Care Transfers), an evidenced-based quality improvement program developed by Dr. Joseph Ouslander and colleagues, to reduce hospitalizations and readmissions for residents living in skilled nursing, assisted living, and independent living communities.
Topic	**Innovation and Transformation in Transitional Care**

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Region 10 Learning Collaborative Learning Session 2-Speaker Information

Speaker	Benjamin Miller, Psy.D.
Biography	Dr. Miller is an Assistant Professor in the Department of Family Medicine at the University of Colorado Denver School of Medicine where he is the Director of the Office of Integrated Healthcare Research and Policy. He leads the Agency for Healthcare Research and Quality's Academy for Integrating Behavioral and Primary Care project as well as the highly touted Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) project in Colorado and Oregon. Dr. Miller's research interests include models of integrating mental health and primary care, health behavior interventions, primary care practice redesign, using practice-based research networks to advance whole person healthcare, and healthcare policy.
Topic	**Seamlessly Integrating Behavioral Health Across Healthcare**

Region 10 Learning Collaborative
Care Transitions Monthly Webinar
August 21, 2014

Provider	Participant
MCA	Kathleen Sweeney
Cook Children's	-
TCPH	-
MHMRTC	Mahie Ghoraishi, Elewechi Ndukwe, Erin Fogarty, Shelly Adkins, Christopher McMullen, Illayna Miller, Michael Parker, Edna Chism-Nicholas, Camille Patterson
NHH	Kathleen Sweeney
Lake Granbury Medical Center	-
PMC	Kathleen Sweeney
Huguley	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
THFW	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
THSW	Charisse Huey, Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
THS	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
Ennis Regional	Edwina Minor, Edwina Henry
Lakes Regional	Robert Johnson
JPS Hospital	Heather Beal, Alan Townsend, Susan Reed, Julie Idoine, Victor Henderson, Gillian Franklin, Annie Goodrich, Carol Johnson, Gwen Darby, Kathy Owens, Michelle Reed, Brenda Gomez, Christine Putz, Jo Hamilton, Aubrie Augustus, Vincent Do, Dr. Carter, Hunter Gatewood, Robert Hernandez, Salil Shilotri, Shelly Corporon, Lori Muhr, Erica Hilliard, Yvonne Kyle
UT Southwestern Moncrief Cancer Institute	Paula Anderson, Emily Berry
THAZ	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
Helen Farabee	-
Wise Regional	Margaret, Polly, Wanda Villard
THAM	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
Pecan Valley	-
THC	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
Baylor	Tonya Selman, Jennifer Anderson
THHEB	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan
Dallas Children's	Robert Hewson

Region 10 Learning Collaborative
Care Transitions Monthly Webinar
August 21, 2014

UNTHSC	Jeanie Foster, Andrew Harmon
JPS PG	-
Methodist Mansfield	Stacie Anderson
Wise PG	Margaret, Polly, Wanda Villard
Glen Rose	-
Texas Health Alliance	Vicki Galati, Chris Myers, David Salsberry, Jennifer Mayhan

Other Stakeholders

Provider	Participant
Kindred	Karen White