Whole Person Care Collaborative

December 3, 2018
Announcements
Announcements

Change Plans
• Open for Editing
• 2019 Change Plan due December 21st

Reporting
• January 10th

Learning Activities
• Empanelment Spring
  • Starts on Friday, December 7th, See Portal for Details
• CVD
• QI Workshop
Population and Race

Age

Poverty and Uninsured rate

<table>
<thead>
<tr>
<th>Education over 25</th>
<th>Douglas</th>
<th>Okanogan</th>
<th>Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Graduates</td>
<td>81%</td>
<td>82%</td>
<td>75%</td>
</tr>
<tr>
<td>Bachelors degree or higher</td>
<td>18%</td>
<td>18%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Needs Assessment

Social Determinants of Health

Respondents:
Douglas: 5
Okanogan: 29
Grant: 9
Needs Assessment

Hard to Meet Services

Respondents:
Douglas: 5
Okanogan: 29
Grant: 9
Needs Assessment

Preventive Services Gaps

Respondents:
Douglas: 5
Okanogan: 29
Grant: 9
Needs Assessment - Regional

Structural recommendations:

- Develop **cooperative agreements with local healthcare providers** to augment existing services and avoid competing with existing providers.
- Develop **EMR and IT capacity** to integrate with local providers and coordinate referrals for clinic follow up and specialty referral.
- Develop **telehealth capacity** and resources to expand specialty access to rural communities.
- Partner with **local community organizations**, particularly school districts, to ensure awareness and utilization of clinic services.
- Collaboration with WSU Extension offices can help **connect mobile medicine services to community need** and identify other programs to improve regional health.
- Given concerns about access/cost the mobile clinic should **provide care with no cost to the patient**.
- To ensure sustainability the mobile medicine program should **develop agreements with local providers and payors** to bill insurance and/or develop service contracts for care provided.
**Needs Assessment - Regional**

**Service recommendations:**

- **Dental services and referral networks** will need to be addressed as this is a top concern across the region. There is a spectrum of engagement from dental screening and referral to development of a combo medical/dental unit or a separate dental unit.

- Mobile clinics should be equipped to do: **Well Child Check-ups, family planning, immunizations, urgent care, STI screening, mental health, and substance abuse screening and diabetic eye exams.**

- Interprofessional teams should be engaged to provide **capacity to provide Pharmacy PT/OT, Nutrition, mental health, healthcare navigation, and social work.**

- **Interpreter services** should be available on the mobile units.

- The ability to provide **home visits** should be incorporated into mobile units.
Needs Assessment - Okanogan

Recommendations

- Use mobile medicine to **increase access to a temporary primary care** that could allow for an introduction to a permanent primary care solution, particularly for more remote communities or hard to reach populations.
  - Partner with DSHS. They have a mobile unit that has been very well received around Okanogan County. Providing health services while they offer SNAP benefit applications, temporary assistance for needy families, etc. would be a very effective partnership.
  - Partner with Okanogan Community Action for their ‘day of service’ with social service providers for the homeless. The event is put on every January and adding a medical unit would be a welcome addition.
  - Partner with school districts to coordinate well child checks and immunization campaigns.
Needs Assessment - Okanogan

Recommendations Cont.

- Partner with mental/behavioral health providers to **identify and address gaps to mental and behavioral health services**.
  - Currently the syringe exchange program is only available in Okanogan City and only a couple of days a week. It was suggested that a mobile unit could help further the reach of syringe exchange and harm reduction programming in the county.
- There is “tremendous interest” in alternative medicine in Okanogan County so **providing nutrition and self-care education** as part of mobile unit outreach efforts would likely be well received by much of the population. Community Action Council is an interested partner for nutrition related initiatives.
- **Dental and vision services**, particularly for communities lacking service providers, or providers that accept Medicaid.
Recommendations

- **Focus on rural areas with large migrant populations** as this population tends to experience numerous barriers to accessing health care. Mattawa, Quincy, and Royal City were all mentioned by interview respondents. Consider partnering with DSHS and timing visits to coincide with their mobile unit, which reportedly has “lines around the corner” in when visiting these communities.
  - In order to successfully reach out to these communities, interview respondents advised ensuring provision of bilingual information, planning clinic times outside of typical working hours, and providing reassurance before scheduled visits that immigration status will not be asked. One interviewee also indicated that a campaign-based approach (e.g. a vaccination campaign) may be a good initial approach in order to build relationships and trust in communities where concern over immigration status is a barrier to care seeking.
Needs Assessment - Grant

Recommendations cont.

• Partner with the Grant County Housing Authority for their annual “Homeless Connect” program which typically occurs in January and provides health and social services in the local homeless camps.

• **Reproductive health services** in communities outside of Moses Lake, particularly family planning and STI screening.

• **Work with local hospitals/clinics to “shore up” primary care access** in the areas surrounding Grand Coulee and Ephrata where the Emergency Departments are being overly utilized for non-emergent concerns.
Recommendations cont.

- Work with mental health providers to help **address gaps in screening and treatment for mental health conditions**.
- Work with behavioral health providers to help **address gaps in screening and treatment for substance use**.
- **Partner with existing dental providers to fill gaps in coverage** (most likely Medicaid patients).
Needs Assessment - Douglas

Recommendations

- Offer education, through social workers or local social service providers, on what resources are available, including housing services, and how to access services.
- Partner with existing services to augment and expand dental services to adults utilizing Medicaid.
- Partner with school counselors and local mental health providers to support the mental health care of pediatric populations, with a focus on children of migrant/immigrant families.
- Increase the availability of bilingual with special considerations for providing culturally competent care.
- Increase access to reproductive health services, particularly family planning, and STI/ HIV screening.
- Work with local behavioral and mental health providers to expand access to substance use treatment and counseling.
MTP Performance Data Update
North Central ACH Pay for Performance (P4P) Measure Dashboard

Measurement Period: Baseline Year 1 (Calendar Year 2017) Metric Results

<table>
<thead>
<tr>
<th>Measures active in 2019</th>
<th>ACH Performance</th>
<th>Statewide Performance</th>
<th>Relative to State</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause ED Visits, per 1000 MM - ages 0-17</td>
<td>28.4</td>
<td>35.5</td>
<td></td>
</tr>
<tr>
<td>All-Cause ED Visits, per 1000 MM - ages 18 – 64</td>
<td>50.4</td>
<td>66.1</td>
<td></td>
</tr>
<tr>
<td>All-Cause ED Visits, per 1000 MM - ages 65+</td>
<td>57.3</td>
<td>54.3</td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication management – Acute (12 weeks)</td>
<td>46.1</td>
<td>51.2</td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication management - Continuation (6 months)</td>
<td>32.2</td>
<td>35.8</td>
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<tr>
<td>Children’s and Adolescents’ Access to Primary Care Practitioners - ages 12-24 months</td>
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<td>Children’s and Adolescents’ Access to Primary Care Practitioners - ages 25 months - 6 years</td>
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<tr>
<td>Medication Management for People with Asthma: Medication Compliance 75%</td>
<td>27.6</td>
<td>33.2</td>
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<tr>
<td>Mental Health Treatment Penetration (Broad Version) - 6-17 years</td>
<td>60.8</td>
<td>63.5</td>
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<td>Mental Health Treatment Penetration (Broad Version) - 18-64 years</td>
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<td>Mental Health Treatment Penetration (Broad Version) - 65+ years</td>
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Legend

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- Lowest ACH performer in the State

Number of Medicaid enrollees for measurement year: 92,539

Lower rate indicates better performance

Data sources used include: Healthier Washington Data Dashboard

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<td>All-Cause ED Visits, per 1000 MM - ages 65+</td>
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<td>N/A</td>
<td>77</td>
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<td>48</td>
<td>48</td>
<td>41</td>
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</tr>
<tr>
<td>Mental Health Treatment Penetration (Broad Version) - 65+ years</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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Lower rate indicates better performance
N/A Indicates that county level metric reporting were suppressed due to small and/or unstable numbers

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<td>21.3</td>
<td>23.0</td>
<td>🟢</td>
</tr>
<tr>
<td>Patients Prescribed High-dose Chronic Opioid Therapy: &gt;50 mg MED in a calendar quarter</td>
<td>32.4</td>
<td>34.4</td>
<td>🟢</td>
</tr>
<tr>
<td>Patients Prescribed High-dose Chronic Opioid Therapy: &gt;90 mg MED in a calendar quarter</td>
<td>15.2</td>
<td>17.2</td>
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</tr>
<tr>
<td>Percent Homeless (Narrow Definition) - 0-17 years</td>
<td>0.2</td>
<td>0.7</td>
<td>🟢</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition) - 18-64 years</td>
<td>2.6</td>
<td>5.1</td>
<td>🟢</td>
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<tr>
<td>Percent Homeless (Narrow Definition) - 65+ years</td>
<td>0.9</td>
<td>1.5</td>
<td>🟢</td>
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<tr>
<td>Plan All-Cause Hospital Readmissions (30 Days)</td>
<td>10.3</td>
<td>13.8</td>
<td>🟢</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration - 12-17 years</td>
<td>28.3</td>
<td>32.5</td>
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<td>29.9</td>
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<tr>
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<td>16.7</td>
<td>8.0</td>
<td>🟢</td>
</tr>
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<tbody>
<tr>
<td>Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions ↓</td>
<td>21</td>
<td>21</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Patients Prescribed High-dose Chronic Opioid Therapy: &gt;50 mg MED in a calendar quarter ↓</td>
<td>30</td>
<td>36</td>
<td>16</td>
<td>20</td>
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<tr>
<td>Patients Prescribed High-dose Chronic Opioid Therapy: &gt;90 mg MED in a calendar quarter ↓</td>
<td>16</td>
<td>15</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition) - 0-17 years ↓</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition) - 18-64 years ↓</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Percent Homeless (Narrow Definition) - 65+ years ↓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Plan All-Cause Hospital Readmissions (30 Days) ↓</td>
<td>10</td>
<td>10</td>
<td>12</td>
<td>7</td>
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<tr>
<td>Substance Use Disorder Treatment Penetration - 12-17 years</td>
<td>38</td>
<td>34</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration - 18-64 years</td>
<td>25</td>
<td>23</td>
<td>17</td>
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</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration – 65+ years</td>
<td>N/A</td>
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<thead>
<tr>
<th>County</th>
<th>Number of Medicaid Enrollees</th>
<th>% of County Population on Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelan</td>
<td>25,355</td>
<td>33</td>
</tr>
<tr>
<td>Douglas</td>
<td>13,243</td>
<td>32</td>
</tr>
<tr>
<td>Grant</td>
<td>36,943</td>
<td>39</td>
</tr>
<tr>
<td>Okanogan</td>
<td>16,998</td>
<td>40</td>
</tr>
</tbody>
</table>
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<table>
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</thead>
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<tr>
<td>Acute Hospital Utilization</td>
<td>50</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) Performed</td>
<td>56</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 7 days</td>
<td>23</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 30 days</td>
<td>34</td>
<td>34</td>
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</tr>
<tr>
<td>Follow-up After Emergency Department Visit for Mental Illness: 7 days</td>
<td>85</td>
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<tr>
<td>Follow-up After Emergency Department Visit for Mental Illness: 30 days</td>
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<td>Follow-up After Hospitalization for Mental Illness: 7 days</td>
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<tr>
<td>Follow-up After Hospitalization for Mental Illness: 30 days</td>
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<tr>
<td>Percent Arrested</td>
<td>7</td>
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<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease (Prescribed)</td>
<td>81</td>
<td>78</td>
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<tr>
<td>Substance Use Disorder Treatment Penetration (Opioid) - 18- 64 years</td>
<td>N/A</td>
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<tr>
<td>Substance Use Disorder Treatment Penetration (Opioid) – 65+ years</td>
<td>N/A</td>
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**North Central Medicaid population**
Number of Medicaid enrollees for measurement year: 92,539

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<td>86</td>
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<tr>
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N/A Indicates that the metric has not yet been reported by HCA/WA State

###North Central ACH Pay for Performance (P4P) Measure Dashboard
Measurement Period: Baseline Year 1 (Calendar Year 2017) Metric Results

<table>
<thead>
<tr>
<th>Legend</th>
<th>Performance is at or above statewide</th>
<th>Performance is below statewide</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Medicaid Enrollees</th>
<th>% of County Population on Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelan</td>
<td>25,355</td>
<td>33</td>
</tr>
<tr>
<td>Douglas</td>
<td>13,243</td>
<td>32</td>
</tr>
<tr>
<td>Grant</td>
<td>36,943</td>
<td>39</td>
</tr>
<tr>
<td>Okanogan</td>
<td>16,998</td>
<td>40</td>
</tr>
</tbody>
</table>
Leadership Series
December 2018 WPCC Meeting

Change

Asthma

Follow-up to Discharge
Today’s Leadership Learning Topic:  Change

• Individual change

• Group change

• System change
Two basic types of Motivation

**Extrinsic Motivation**
- Fear
  - Punishment
  - Public humiliation
- Incentives
  - Incentive pay
  - Pay for performance
  - Negative incentives
- Campaigns-Slogans/Appeal to Authority

**Intrinsic Motivation**
- Variety of stimuli
- Ability to control the variables; influence outcome
- Sense of meaning, making a difference
- Feedback
- Recognition

Concept: Hygiene vs. Motivating Factors
Prochaska and DiClemente’s Stages of Individual Change

- Pre-contemplation-Not considering
- Contemplation-Ambivalent
- Preparation-Testing the waters
- Action-Practicing new behavior
- Maintenance-Sustained commitment
- Relapse-Fall from Grace
Tuckman Model on Group Development

- **Forming**: in which the group is just coming together. It is often characterized by shyness, uncertainty and diffidence among the members, although extravert members may rapidly assume some kind of leadership. Maintenance concerns predominate.

- **Storming**: in which, having been established, there is a period of jockeying for position, authority and influence among the members. In classes, this is the period of "testing-out" the teacher. Disagreements appear or are manufactured and roles are eventually allocated. The initial leaders may not survive this period: it is the most uncomfortable phase of the group's life—a sort of group adolescence.

- **Norming**: having sorted out its internal structure, there is then the issue of what the group stands for. What kind of behaviour and contribution is acceptable and what isn't? Members explore behind the power processes of storming and begin to form some idea of the group's identity: the "group in the mind". This is rarely done explicitly, of course, and it can readily slip back into Storming.

- **Performing**: after all that, the group can begin to get some work done, on the basis of a relatively stable structure.

Everett Rogers Diffusion of Innovation

- Innovators
- Early Adopters
- Early Majority
- Late Majority
- Laggards
Popular Change Models

The Process of Change
Lewin’s Model

Unfreezing
Disproving current beliefs
Creating a tension for change

New Learning
Need new tools and methods

Refreezing
Reinforcement
Recognition

Jeffrey Hiatt Change Model

Kouzes & Posner

- Inspire a shared vision
- Challenge the process
- Model the way
- Enable others to act
- Encourage the heart

Kotter

- Create Urgency
- Form a Powerful Coalition
- Create a vision for change
- Communicate the vision
- Remove obstacles
- Create Short term wins
- Build on the change
- Anchor the changes in the Culture

IHI Leadership Framework

1. Set Direction: Mission, Vision and Strategy
   - Make the status quo uncomfortable
   - Make the future attractive

2. Establish the Foundation
   - Reframe Operating Values
   - Build Improvement Capability

3. Build Will
   - Plan for Transformation
   - Set Aims/Allocate Resources
   - Measure System Performance
   - Provide Encouragement
   - Make Financial Links
   - Learn Subject Matter
   - Work on the Larger System

4. Generate Ideas
   - Radiate and Scan Widely
   - Relate to other industries/disciplines
   - Benchmark to Find Ideas
   - Listen to Customers
   - Invest in Research
   - Development
   - Knowledge management
   - Understand Organization as a System

5. Execute Change
   - Use Model for Improvement
   - Design and Redesign
   - Use Change Leadership Models
   - Review and Guide Key Initiatives
   - Spread Ideas
   - Communicate Results
   - Sustain improved levels of performance

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Asthma Data
Asthma Data

• At the last meeting we agreed to go back and gather data on our populations of people with Asthma.

• What did we learn?
The psychological characteristics of asthmatic patients and the presence of mental problems, have been shown to be linked to both asthma severity and level of disease control. Difficulties in achieving the objectives of asthma therapy suggested by current guidelines may depend also on psychological factors such as symptoms’ perception, alexithymia, coping strategies, mood disorders.

Despite numerous data support this association, a causal relationship between asthma and mental health is not clear. The hypothesis of a bidirectional influence seems to be more acceptable.

Independently of the nature of this association, when a psychological problem or difficulty is present, it interferes with an optimal disease management, especially in patients with severe asthma and poor control. At the same time, the psychological characteristics of asthmatic patients have an influence on symptoms’ recognitions, daily management and disease outcomes.

A screening of mental symptoms and psychological aspects that are known as associated to asthma, could lead to plan appropriate intervention to better control asthma and to improve the patient’s well-being.
Follow-up to Discharge
Transitional Care and Diversion Workgroup

• **TCDI Workgroup:**
  • Ensures that the region implements effective evidence based practices that align with the Medicaid Transformation Project.
  • Current focus areas are: Transitional Care Management, ED Diversion
  • Partners are acute care providers (e.g. Hospitals and EMS Agencies)
  • Workgroup wants to ensure projects align with other work occurring in the North Central Region

• **Workgroup Implementation Partners:**
  • All Hospital/EMS partners are completing similar projects as their counterparts focused on transitional care and diversion intervention.
  • There is an expectation that partners will share resources and best practices (Not set up as a learning collaborative)
  • Work is project focused and partners are dedicated to complete work in 2019 only (2020 TBD)
## Transitional Care and Diversion Hospital Partners

<table>
<thead>
<tr>
<th>Hospital Partner</th>
<th>Transitional Care Management</th>
<th>ED Diversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia Basin Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Confluence Health *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Coulee Medical Center</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lake Chelan Community Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mid Valley Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>North Valley Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Samaritan Healthcare</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Three Rivers Hospital</td>
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</tbody>
</table>

*Confluence Health is acting as the regional training for Transitional Care Management*
What is Transitional Care Management?

- Transitional Care Management provides telephone discharge follow-up calls 24 – 48 hours post discharge from the hospital to patients.
- Follow up phone calls are completed by a transitional care nurse (RN).
- A brief review of symptoms, medication changes, and follow-up care is discussed during this telephone call.
- The RN making the TCM call then enters a telephone note into patient’s record.
- If a patient meets criteria for TCM, the provider who provides the hospital follow-up appointment with the patient may bill a TCM code.
Partnership Opportunities with WPCC

• TCM Model:
  • Collecting and reporting on data
  • Aligning how follow up calls are made between agencies in the region to reduce duplicity of work
  • Training both Outpatient and Inpatient staff the model
  • Incorporate TCM codes/workflows into follow up visits to ensure proper billing and reimbursement

• Additional Opportunities:
  • Social Determinant of Health Screening
  • Discharge Planning

Note: A number of partners are working directly with WPCC members to partner on completing the TCM follow up calls.
The "Why"

Annals of Internal Medicine
The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

• 19% of patients had a post discharge adverse event
  - 1/3 preventable and 1/3 ameliorable

Adverse events among medical patients after discharge from hospital

• 23% of patients had a post discharge adverse event
  - 28% preventable and 22% ameliorable

Adapted from Project RED
The 2014 NRD contained 15,769,527 weighted index admissions for medical (1,825,405 weighted readmissions) and surgical (590,121 weighted readmissions) reasons (Table 1). The all-cause 30-day medical readmission rate was 23.1% for patients with SMI and 13.8% for patients without SMI. The all-cause 30-day surgical readmission rate was 19.3% for patients with SMI and 9.4% for patients without SMI. In the multivariate logistic regression models, even after controlling for clinical, demographic, and hospital characteristics, the odds of a patient with SMI being readmitted were greater than for patients without SMI (adjusted odds ratios, 1.80 [95% CI, 1.77-1.83] for medical and 1.95 [95% CI, 1.90-1.99] for surgical readmissions; P < .001) (Table 2).
Follow-up from Discharge: 7 days and 30 days

Transitions Care Manager

Emergency Room

Discharge Planners

Transitions Care Management

Patient Engagement Centers

50% +

Physician Office

Nursing Home

Emergency Department

Urgent Care Centers

Home Walk-in

EMR

Home/SNF

Behavioral Health Home

EDIS Emergency Department Information System

PCP Medical Home
Interventions

• SDOH Screening & referral
• TCM Model
• EDIE
• Home visits
• EMS/CHW/Extensivist
• Telehealth
• Coleman Care Transitions Intervention
AIM: Improve Follow-up 7 days and 30 days Post Discharge

<table>
<thead>
<tr>
<th>ROLE</th>
<th>Pre-Visit</th>
<th>In ER</th>
<th>In the Hospital</th>
<th>Post Discharge</th>
<th>In Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic staff</td>
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<tr>
<td>ER Staff</td>
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<tr>
<td>Intake Staff</td>
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<tr>
<td>Discharge Planners</td>
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<tr>
<td>Transition Care Manager</td>
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</tr>
<tr>
<td>Patient Contact Center</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Community Health Workers</td>
<td></td>
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</tr>
<tr>
<td>Telehealth</td>
<td></td>
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<tr>
<td>EDIE Notification System</td>
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<tr>
<td>EMS</td>
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<tr>
<td>PCP/Office staff</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Center</td>
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</tr>
</tbody>
</table>
For questions or to provide input contact Roger Chaufournier: rchaufournier@spreadinnovation.com
Reference Slides
Eleven mutually reinforcing components:

1. Patient education throughout hospital course
2. Schedule follow-up appointments – physician visits & tests
3. Follow up on outstanding test results
4. Organize post-discharge services
5. Confirm medication plan – reconcile discharge medications
6. Reconcile discharge plan with national guidelines
7. Review steps for what to do if problem arises
8. Transmission of discharge summary to primary care physician
9. Assess patient understanding of discharge plan
10. Give written discharge plan
11. Provide telephone reinforcement
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Lewin’s Model

Unfreezing

New Learning

Refreezing

Disproving current beliefs
Creating a tension for change

Need new tools and methods

Reinforcement
Recognition
Kotter

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• Communicate the vision
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Jeffrey Hiatt Change Model

<table>
<thead>
<tr>
<th>A</th>
<th>Awareness of the need for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Desire to support and participate in the change</td>
</tr>
<tr>
<td>K</td>
<td>Knowledge of how to change</td>
</tr>
<tr>
<td>A R</td>
<td>Ability to implement the change</td>
</tr>
<tr>
<td>R</td>
<td>Reinforcement to sustain the change</td>
</tr>
</tbody>
</table>

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   - Spread Ideas
   - Communicate results
   - Sustain improved levels of performance

2. Establish the Foundation
   - Reframe Operating Values
   - Build Improvement Capability
   - Personal Preparation
   - Choose and Align the Senior Team
   - Build Relationships
   - Develop Future Leaders
Mapping ADKAR® to change management tools

- Why are these channels critical for change management?
- What is the goal of each tool?
Mapping ADKAR® to change management tools

Change management tools

- Communications
- Sponsor roadmap
- Coaching
- Resistance management
- Training

Individual phases of change (ADKAR®)

- Awareness
- Desire
- Knowledge
- Ability
- Reinforcement™
Kouzes & Posner

• Inspire a shared vision
• Challenge the process
• Model the way
• Enable others to act
• Encourage the heart