CalvertHealth

New Provider Orientation

Calvert Health System
Provider Orientation

Module 4:
Clinical Preparedness
Section 4:
Patient Experience

Section 4 – Patient Experience

- Patient Rights and Responsibilities
- Services for Non-English Speaking and Hearing Impaired Patients
- Services for Visually Impaired
- Cognitive Challenges
- Using Patient Companions to Interpret
- SBAR and AIDET
- Patient Satisfaction Surveys
- Abuse/Neglect/Exploitation
- CDI Program
- Calvert CARES
- Patient Advocate

Patient Rights and Responsibilities

Patient Rights

- It is your responsibility to inform patients of their rights and responsibilities AND to involve the patient in his or her care
  - See Policy GA-80 for more details
- At CHMC the patient has the right to:

  - ✓ Receive considerate, respectful and compassionate care.
  - ✓ Have respect shown for personal values, beliefs and wishes.
  - ✓ An environment that preserves dignity and personal privacy.
  - ✓ Receive information, without charge, in a manner the patient understands, which may include:
    - sign and foreign language interpreters;
    - alternative formats, including large print, braille, audio recordings, and computer files;
    - vision, speech, hearing and other temporary aids as needed.
  - ✓ Be treated without discrimination or denied visitation privileges based on race, color, national origin, ethnicity, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, language, ability to pay or socioeconomic status.
  - ✓ Be provided care in a safe environment free from all forms of abuse, neglect and exploitation, including: verbal, mental, physical and sexual abuse; harassment and corporal punishment.
  - ✓ Freedom from restraint and seclusion unless needed for safety.
  - ✓ Be told the names and jobs of the health care team members involved in care if staff safety is not a concern.

Patient Rights and Responsibilities (con't)

- ✓ Receive efficient and courteous attention from hospital team members when requesting help, with the understanding that other patients may have similar or more urgent needs.
- ✓ Receive visitors and phone calls for emotional support during the hospital stay in accordance with hospital policy.
- ✓ Withdraw or deny visitor rights at any time.
- ✓ Have a family member or representative of the patient's choice and the patient's own physician notified of admission to the hospital.
- ✓ A medical screening exam.
- ✓ Stabilizing treatment for emergency medical conditions.
- ✓ Be screened, assessed, and treated for pain.
- ✓ Be informed of diagnosis and possible prognosis, the benefits and risks of treatment and the expected and/or unanticipated outcomes of treatment.
- ✓ Give informed consent before nonemergency care is provided, including the benefits and risks of care, alternatives to the care, and the benefits and risks of the alternatives to the care.

- ✓ Be actively involved in the plan of care.
- ✓ Refuse care and be informed of possible medical consequences of refusal of care.
- ✓ Be provided a list of protective and advocacy services when needed.
- ✓ Appoint an individual to make health decisions, if unable to do so.
- ✓ Make or change an advance directive and have these decisions honored.
- ✓ Be told in advance about the plan for discharge or transfer to another level of care.
- ✓ Agree or refuse to take part in medical research studies, without the agreement or refusal affecting care.
- ✓ Allow or refuse to allow pictures for purposes other than your care.
- ✓ Expect privacy and confidentiality in care discussions and treatments and records.
- ✓ Be provided a copy of the HIPAA Notice of Privacy Practices.
- ✓ File a complaint about care and have a complaint reviewed without the complaint affecting the patient's care.
- ✓ Participate in the consideration of ethical issues that arise during the hospital stay.
- ✓ Access medical records and to have the information explained or interpreted as necessary, in accordance with HIPAA Notice of Privacy Practices.
- ✓ Receive information about hospital and provider charges and ask for an estimate of hospital charges before care is provided as long as care is not impeded.
- ✓ Be notified of the existence of any business relationship among the hospital, educational institutions, other health care providers, and/or payers that may influence treatment and care.
- ✓ A written copy of the hospital's bill of rights.

Services for Impaired Patients

Non-English Speaking and Hearing/ Visually/Cognitively Impaired

- Calvert Health System (CHS) makes communication services available to all individuals in accordance with:
  - Patient's Bill of Rights
  - Civil Rights Act of 1964
  - Section 504 of the 1973 Rehabilitation Act and the Americans with Disabilities Act (ADA)
- All patients are assessed upon presentation to Calvert Health System for a communication barrier
  - If identified, hospital personnel will implement a mechanism to provide effective communication to obtain clinical information

Non-English Speaking, Deaf, Hard of Hearing

- For immediate assistance use available assistive devices:
  - Cyracom or SLUSA carts (remote interpretive services)
  - Telephonic interpreter by calling x5900
  - Written communication
  - Sound and/or telephone amplifier
- Certified interpreters may be requested 24/7- not on site 24/7
  - May take several hours to arrive; be sure to advise patient of expected wait using assistive devices
  - All live interpreters scheduled through
    - Case Management x4858 M-F, 8:00 a.m. – 4:00 p.m.
    - Clinical Coordinator x4878 - evenings and weekends
- Care should not be delayed if an emergent condition is assessed by the clinical staff
  - Use electronic assistive devices until the live interpreter arrives.

Visually Challenged

- All forms requiring signature will be read to the patient prior to their signing
- All patients will be offered the opportunity to listen to the relevant documents via a CD/CD player
  - Patient Handbook (inpatient admissions)
  - Outpatient Guide (outpatient services, including ED and observation stays)

Cognitive Challenges

- Patient Access Service Center (PASC) will notify the staff who will be caring / providing services for the patient of noted challenges

Using Patient Companions to Interpret

- Companions should not be utilized as interpreters unless the effected patient insists.
  - If a patient insists that a companion be used as their interpreter, a certified interpreter must be present to validate the accuracy of the interpretative communication.
- Companion members and staff are not to translate in the following situations:
  - Obtaining medical history or other types of assessment, informed consent or permission for treatment
  - Diagnoses of ailment of injury, explanations of medical procedures to be used

Using Patient Companions (con't)

- Companion members and staff are not to translate in the following situations (con't):
  - Treatment or surgery if the patient is conscious or to determine if the patient is conscious
  - Patients in Intensive Care or Recovery Room
  - Emergency situations that arise
  - Explanations of the medications prescribed, how and when they are to be taken, and possible side effects
  - Assisting at the request of the physician or other hospital staff.
  - Discharge of the patient
- Translator services are not to be used for general conversation / non-medical purposes
  - Companion members and staff may be utilized in this capacity.

Communications – SBAR and AIDET

Communications – SBAR and AIDET

- Communications failure is the leading cause of adverse events in healthcare
- SBAR and AIDET are our chosen tools
  - They provide a framework for consistent communications among and between practitioners, nurses and staff
  - They ease patient anxiety by ensuring they know what is happening to and around them

SBAR

- SBAR is part of the CalvertHealth effort to ensure clear, appropriate communications among healthcare teams and with patients
- SBAR is intended to present information in a brief, organized manner and avoid irrelevant information that may slow reactions and decision making
- Within the healthcare team, SBAR is used
  - Nurse to physician/physician to nurse
  - Nurse to nurse
  - Physician to physician
  - Nurse/physician to STAT team members

SBAR Process

- **S**ituation: briefly describe the situation
  - Identify patient and unit
  - Briefly state problem, when it happened/started, how severe
- **B**ackground: provide background information specifically related the current situation
  - Admitting diagnosis and admission date
  - Current list of meds, allergies, IV fluids
  - Most recent vital signs
  - Key diagnostic results
  - Code status
  - Other pertinent clinical information

SBAR Process (con't)

- **A**ssessment: describe what is thought to be the problem or healthcare provider's assessment
  - i.e. "the problem seems to be cardiac"
- **R**ecommendation: Describe what you think needs to be done
  - i.e. labwork, new medication or change in medication, assessment by another physician or specialist, etc.

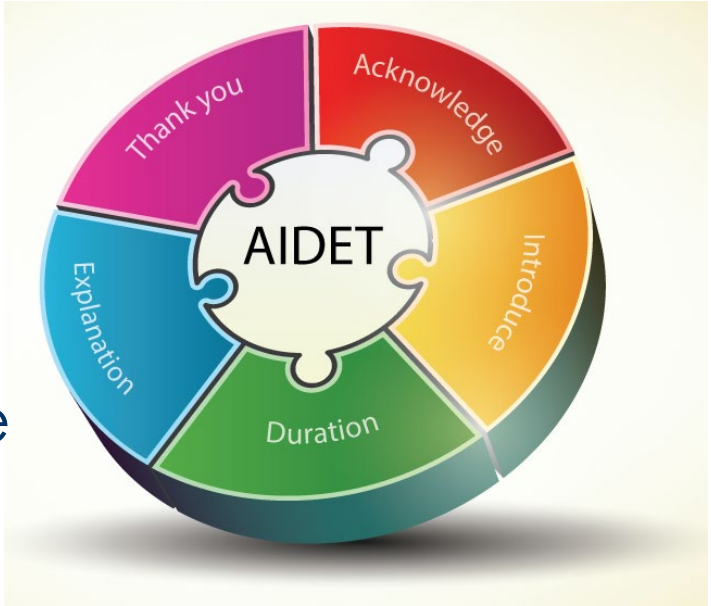
When is SBAR Used

- By clinical staff during shift changes, prior to transfer of care to another floor/unit/facility/ care provider
- By nursing staff prior to calling a physician
- Between physicians to facilitate concise, complete communications in order to provide appropriate continuity of care

AIDET

- Used to communicate with patients and family to reduce anxiety, increase trust and improve outcomes

- Used among staff to communicate expectations and ensure compassionate and safe care
- Requirement for everyone who works at CalvertHealth



AIDET

A **ACKNOWLEDGE**
- Greet the patient by name (if an adult, use Mr. or Mrs. Or Ms., not first name)

I **INTRODUCE**
- Always tell patient and family your name
- Tell them what your role is
- Talk up the team

D **DURATION**
- Give a specific time expectation
- How long will a procedure/test take?
- When can I expect results?

E **EXPLANATION**
- Enlist patient and family in care plan
- Describe what will take place, what they can expect
- Use terms the patient and family can understand

T **THANK YOU**
- For choosing us
- For trusting us

Patient Satisfaction Surveys

Patient Satisfaction Surveys

- CHMC has engaged Press Ganey to perform patient satisfaction surveys
  - Use HCAHPS Survey protocols
    - Includes questions on nursing care, physician care, confidence in treatment protocols used, intention to recommend provider and hospital
  - Scores reported based on 'Top Box'
    - Percentage of patients who award the highest score
  - All patients receiving services in every department will be surveyed

Suspected Abuse, Neglect or Exploitation

Suspected Abuse, Neglect or Exploitation

- As a healthcare provider you have a responsibility to report suspected abuse, neglect or exploitation to the appropriate authorities
- Suspicion of abuse, neglect or adult exploitation ***does not require proof*** that abuse, neglect or exploitation has occurred
- Make verbal report to the Department of Social Services as soon as possible if abuse/neglect/exploitation is suspected
  - After contact, examination, treatment or other circumstances

Who is Vulnerable?

- Vulnerable individuals exist in every patient population
  - Children, Teens, Adults, Elderly – ALL AGES!
  - White, African American, Asian – ALL RACES!
  - Christian, Jewish, Muslim, Buddhist – ALL RELIGIONS!
  - Single, married, divorced, partnered, parent, child, grandchild, step child, spouse – ALL RELATIONSHIPS!
  - Heterosexual, homosexual, transgender – ALL SEXUAL ORIENTATIONS!
- Abuse, neglect and exploitation exist in every population demographic
- It is YOUR JOB to put your own biases aside and identify vulnerable patients

What to Look For: Physical Indicators Physical Abuse

- Unexplained bruises and welts
- Unexplained burns
- Unexplained or previously undocumented suspicious or multiple fractures/dislocations
- Unexplained lacerations or abrasions
  - To mouth, lips, gums, eyes or other areas of the body to external Genitalia
- In various stages of healing
- Head injuries
  - Subdural hematomas (due to hitting or shaking)
  - Retinal hemorrhage or detachments (due to shaking)
- Internal injuries
- Duodenal or jejunal hematomas
- Rupture of the inferior vena cava

What to Look For: Behaviors Associated With Physical Abuse

- Hyperactivity, impulsivity
- Extreme behaviors, either aggressiveness or withdrawal
- Nervous habits or movements
- Excessive requests for food and tokens of affection
- Distrust of adults
- Display of adult responsibilities
- Frequent school absences or lateness
- Guarded responses when questioned regarding an injury or home life

What to Look For: Signs of Physical Neglect

- Failure to thrive (non-organic)
  - Chronic malnutrition, wasting of subcutaneous tissue, poor growth
- Consistent lack of supervision especially in dangerous activities or for Long periods (child age 0-12)
- Unattended serious physical problems or medical needs
- Abandonment
- Repeated ingestions of noxious substances
- Poor hygiene resulting in serious infections, disease
- Improper clothing resulting in hypothermia or heat exhaustion
- Living in a home without minimal health, nutrition and fire standards

What to Look For: Behaviors Associated With Neglect

- Flat affect and/or depression
- Extreme behaviors, either aggressiveness or withdrawal
- Nervous habits or movements
- Excessive requests for food and tokens of affection
- Distrust of adults and display of adult responsibilities
- Frequent school absences or lateness
- Guarded responses when questioned regarding an injury or home life

What to Look For: Physical Signs of Sexual Abuse

- Difficulty in walking or sitting
- Torn, stained or bloody underclothing
- Pain, swelling, or itching in genital area
- Pain on urination
- Bruises, bleeding or lacerations in external genitalia, vaginal or anal areas
- Vaginal/penile discharge
- Venereal disease, especially in pre-teens
- Poor sphincter tone
- Pregnancy
- Swollen or red cervix, vulva, perineum
- Internal scarring of genitalia
- Recurrent urinary tract infections

What to Look For: Behaviors Associated With Sexual Abuse

- Clinging to adults or wary of adult contact
- Expressing affection inappropriately
- Unusual knowledge of sexual matters and sophisticated sexual play
- Refusing to undress in physical education class
- Passivity during a pelvic examination
- Isolation/poor peer relationships and/or withdrawal
- Difficulty concentrating/poor academic progress
- Regressive or aggressive behaviors
- Poor self-concept
- Flat affect
- Recurrent nightmares, disturbed sleep patterns, fear of the dark
- Use of drugs and delinquent acts e.g. running away

Violence in Intimate Relationships

- Also known as partner abuse, spouse abuse, or battery
  - Refers to violence occurring in intimate relationships, regardless of marriage or whether it is a current relationship
- Screen patients' ages 18 years and older and emancipated minors
- Be aware of high risk indicators

What to Look For: **Physical Injuries**

- Explanation of injury does not seem plausible
- Delay in seeking medical care
- Present vague complaints
- Injuries to the head, neck chest, breast, abdomen, or genitals
- Contusions, abrasions, sprains, lacerations, as well as fractures
- Numerous injuries at multiple sites unless another explanation is obvious
  - e.g. auto accident or other catastrophe
- Repeated or chronic injuries

What to Look For: Clinical Clues

- Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence
- Physical symptoms related to stress
  - Suicide attempts or gestures, alcohol and drug abuse, depression, anxiety, sleep disturbances, panic attacks, heart palpitations, atypical chest pain, chronic headaches
- Gynecological problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- Frequent use of prescribed minor tranquilizers or pain medications
- Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality

What to Look For: Behavioral Signs

- Partner accompanies patient, insists on staying close, and answers all questions directed to patient
- Reluctance of a patient to speak or disagree in front of partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- Denial or minimization of violence by partner or by patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame for partner's violence

What to Do

- Record information on standardized intimate partner violence screening tool in patient database.
  - Attempt to screen patient in private
  - Notify patient's primary nurse/physician of self-reported or suspected intimate partner violence.
- Further assess and treat physical injuries when indicated.
  - Notify patient's physician or (if outpatient) Emergency Department if physical injuries require treatment.
- **Do not document name or telephone number of referrals on discharge form**

Resources Available to Provider

- Security – notify to be on standby in immediate area if patient indicates s/he feels unsafe or if alleged abuser displays threatening behavior
- Police – if appropriate of if patient requests it
  - Recognize that police involvement may increase risk and intensity of battering
- Police notification not mandatory UNLESS
  - Patients Request
  - Assaults involving a deadly weapon (inform patient and report to police).
  - Suspected abuse and/or neglect is of a child
- SAFE Nurse
  - RN specially trained to collect forensic evidence in suspected cases of physical and/or sexual abuse

Resources Available to Patients

- Refer patient to the following resources if he/she requests:
  - Calvert Memorial Hospital Case Management Department, ext. 4858
  - Calvert County Crisis Intervention Center (24 hours daily) 410-535-1121
- If patient request follow-up after discharged refer to:
  - Calvert County Crisis Intervention Center, 410-535-1121
  - Walden Counseling Center, St. Mary's County, 301-863-6661
  - Center for Abused Persons, Charles County, 301-645-3336

CDI Program 2017 Introduction

Documentation Improvement & Revenue Recovery Team

Meet the "DIRRT" Team

- ✓ *Dr. Tom Annulis*
  Physician Advisor
- ✓ *Teri Rice, RN*
  DIRRT Manager
- ✓ *Karen Nega, RN, CCDS*
- ✓ *Crystal Gray, RN, CCDS*
- ✓ *Angela Roeder, RHIA, CCSP*
- ✓ *Shelley Bingham, RN*

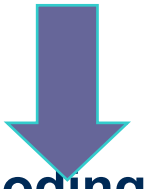
Who We Are & What We Do

- We are nurses that perform daily *concurrent* reviews on in-patient medical records
- We support the providers by *bridging the gap* between 'clinical' language & 'coding' requirements
- Concurrent reviews help to ensure the documentation supports:
  - ✓ Medical Necessity
  - ✓ Severity of Illness
  - ✓ Length of Stay
  - ✓ Intensity of Services
  - ✓ Treatment Complexity
  - ✓ Hospital Acquired Conditions

Why is Documentation so Important?

Documentation Drives the Process

Documentation



Coding

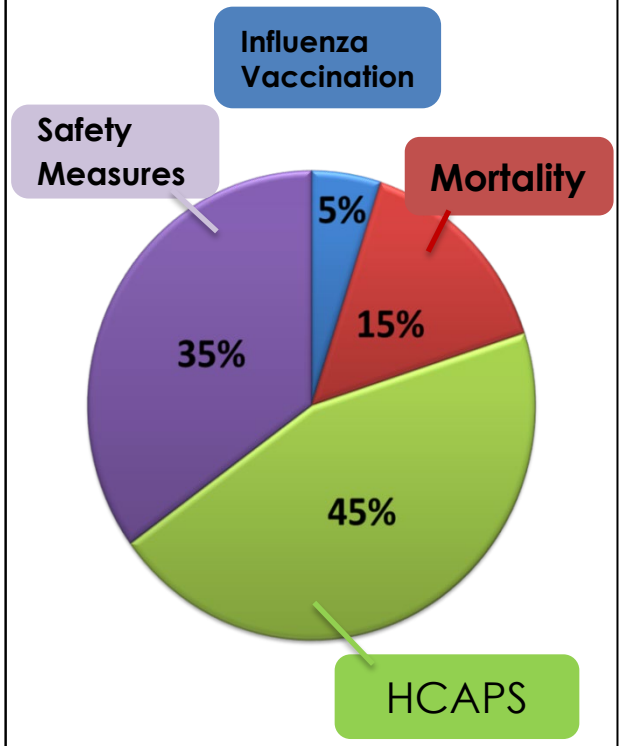
Quality Based Reimbursement (QBR)

Did You Know?

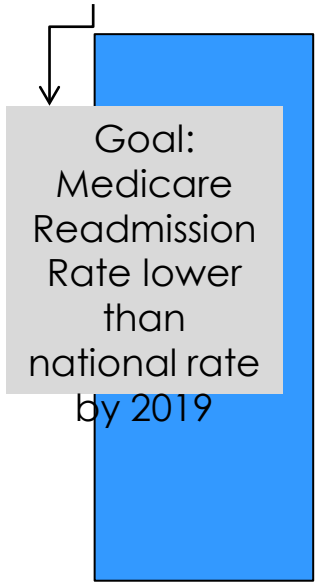
- Maryland's reimbursement is different than the rest of the country
- Maryland Hospitals are exempt or "waived" from The Centers of Medicare and Medicaid (CMS) hospital based quality programs under a 5 year waiver that began in 2014

Maryland's Pay for Performance Program

Quality Based Reimbursement

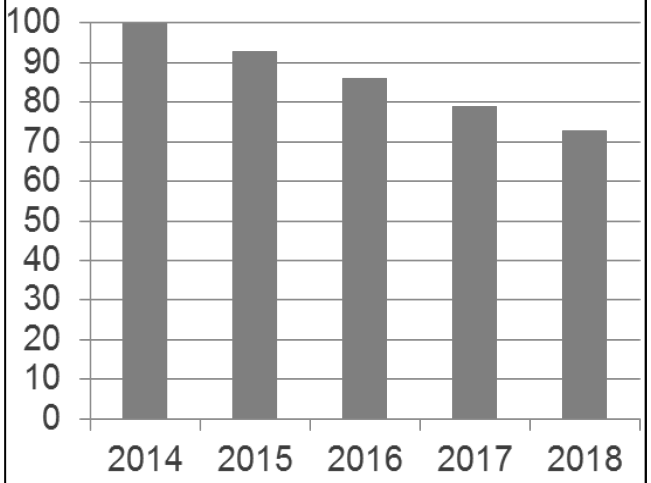


Readmissions



Maryland Hospital Acquired Conditions (PPC)

Goal:30% Reduction in PPC's by 2019



What does this mean?

- Our hospital performance is ***directly*** linked to our reimbursement rates
- Each fiscal year we are either penalized or rewarded for our performance
- At Risk: $$ (Total Inpatient Revenue)
  - ✓ ***Up to 2% can be penalized***
  - ✓ **Up to 1% can be rewarded**

Provider Impact

- Incomplete/unclear documentation may result in poor performance scores and may not reflect real clinical quality
- Documentation Opportunities:
  - ✓ Presence on admission
  - ✓ Clinical indicators support all diagnoses
  - ✓ Specificity & acuity of all diagnoses

Present on Admission (POA)

- Federally defined as present ***at the time the order for inpatient admission occurs***
- Include all conditions that develop during an ***outpatient encounter***
  - Emergency Room
  - In Observation Status
  - Outpatient Surgery
- Providers are expected to identify the POA status for ***every diagnosis*** by time of discharge
- Coders must indicate the POA status for every diagnosis billed to Medicare (***Y or N or Unable to clinically determine***). This status is audited regularly by the state's regulatory agency & if deemed incorrect may result in financial penalties.

Key Conditions to Document Using Clinical Indicators

Maryland Hospital Association (MHA) Workgroup Definitions:

- ✓Acute Respiratory Failure
- ✓Acute Renal Failure
- ✓Pneumonia
- ✓OB Hemorrhage

Need for Additional Specificity

Diagnosis	Documentation
Anemia	Specify type; especially acute blood loss anemia with GI Bleed
Acute Renal Failure	Meets Maryland Hospital Association (MHA) Workgroup Definition
BMI	Specify Morbid Obesity (BMI > 40)
CHF	Specify type & acuity
CKD	Specify stage
Diabetes	Specify with hyperglycemia or hypoglycemia (indicates uncontrolled)
POA status	Specify Y or N or Unable to determine
Respiratory Failure	Meets Maryland Hospital Association (MHA) Workgroup Definition (Remember O-2 dependence in COPD=chronic respiratory failure)
Sepsis	Specify if resolved or ruled out
UTI	LINK to device (i.e. foley catheter or suprapubic catheter)

Documentation Impact on Severity

Severity of Illness	Diagnosis
Minor	Uncomplicated Diabetes
Moderate Manifestation	Diabetes with Renal
Major	Diabetes with Ketoacidosis
Severe Coma	Diabetes with Hyperosmolar

Hospital Acquired Conditions (HAC's)

- Any condition that could have reasonably have been prevented through the use of evidence-based guidelines
- Assigned based on 65 Potentially Preventable Complications (PPC's) that are documented & coded as not present on admission (POA)

Charges associated with most common HAC's

HAC'S	$$ At Risk per HAC
Acute Respiratory Failure without Ventilation	$ 9, 256
UTI	$ 14, 549
Pneumonia	$ 19,788
Sepsis	$ 21, 766
Decubitus Ulcer	$ 45,528

Global Exclusions for HAC's

- Receiving **Palliative Care** (Meaning End of Life/Terminal Care)
- **6 or more PPC's** during hospital course
- Patient presents with one of these conditions as present on admission (POA):
  - **Shock (any type)**
  - Cardiac Arrest
  - HIV Disease
  - Transplant(s)
  - **Metastatic & Major Malignancies**
  - 3rd Degree Burns
  - Major Trauma

Palliative Care

- For palliative care to be coded/billed:
  - a patient must be a DNR;
  - have a diagnosis of a terminal illness;
  - and the cessation of care is directed at the terminal illness (can continue to receive care for other diagnoses like infections etc.)
- If the clinical documentation supports the treatment plan of palliative care than any HAC's that might have occurred during that patient encounter will be excluded by the state

Mortality

- Address **ALL** body systems impacted by the dying process.
- Remember you can use “suspected”, “possible”, “likely”, etc. to qualify your diagnoses until it can be confirmed or ruled out

Documenting the Death Summary

Key Body Systems:

- Cardiovascular:
  - ✓ Hypotensive = ? Shock
  - ✓ Bleeding = ? Acute blood loss anemia
  - ✓ Cardiac Rhythms = Ventricular fibrillation or Ventricular tachycardia
- Neuro status:
  - ✓ Altered level of consciousness (AMS) = ? Encephalopathy
  - ✓ Unresponsive = ? coma
- Respiratory status:
  - ✓ Respiratory distress = ? Acute respiratory failure

End of Life

- Document if patient is receiving hospice, palliative, comfort, or end of life care.

- Required to complete:
  - ✓ Death Pronouncement Note

    AND

  - ✓ Death/Discharge Summary

The Query Process

When do we query?

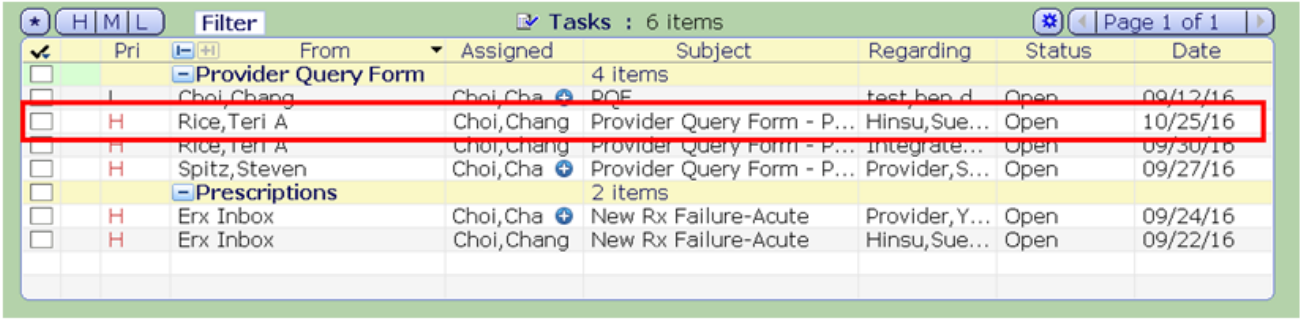
- ✓ Conflicting information
- ✓ Ambiguous information
- ✓ Incomplete information
- ✓ Clinically relevant information not addressed
- ✓ Significant reportable condition or procedure
- ✓ Unclear for assignment of POA indicator

Finding A Query

MEDITECH
The EHR for New Healthcare

Meditech 6.15 – Provider Query Forms

From the Msg/Task tab, click on the Provider Query Form that needs to be completed:



Click Update from the bottom tool bar:

Click on Shared Text to answer the query:

Answering A Query

MEDITECH
The EHR for New Healthcare

Meditech 6.15 – Provider Query Forms

Answer the query appropriately:

Shared Text

Hinsu,Sue Testing
M0001098
H030011506
09/01/16 06:51

PHYSICIAN'S DOCUMENTATION REQUEST - Permanent part of record

By submitting this query, we are merely seeking further clarification of documentation to accurately reflect all conditions that you are monitoring, evaluating, treating or that you extend the hospitalization or utilize additional resources of care. Please utilize your independent clinical judgment when addressing the questions(s) below.

Clinical Indicators:

Please clarify the type of atrial fibrillation:

(X) Paroxysmal	{ [ ] } Permanent (Chronic)
{ [ ] } Persistent	
{ [ ] } Unable to determine (Please specify why): [ ]	
{ [ ] } Other (please specify type): [ ]	

Please clarify the type of atrial flutter:

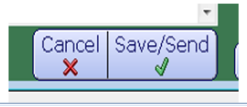
{ [ ] } Atypical (Type II)	{ [ ] } Typical (Type I)
{ [ ] } Unable to determine (Please specify why): [ ]	
{ [ ] } Other (please specify type): [ ]	

{ [ ] } I disagree with the above query (please explain why): [ ]

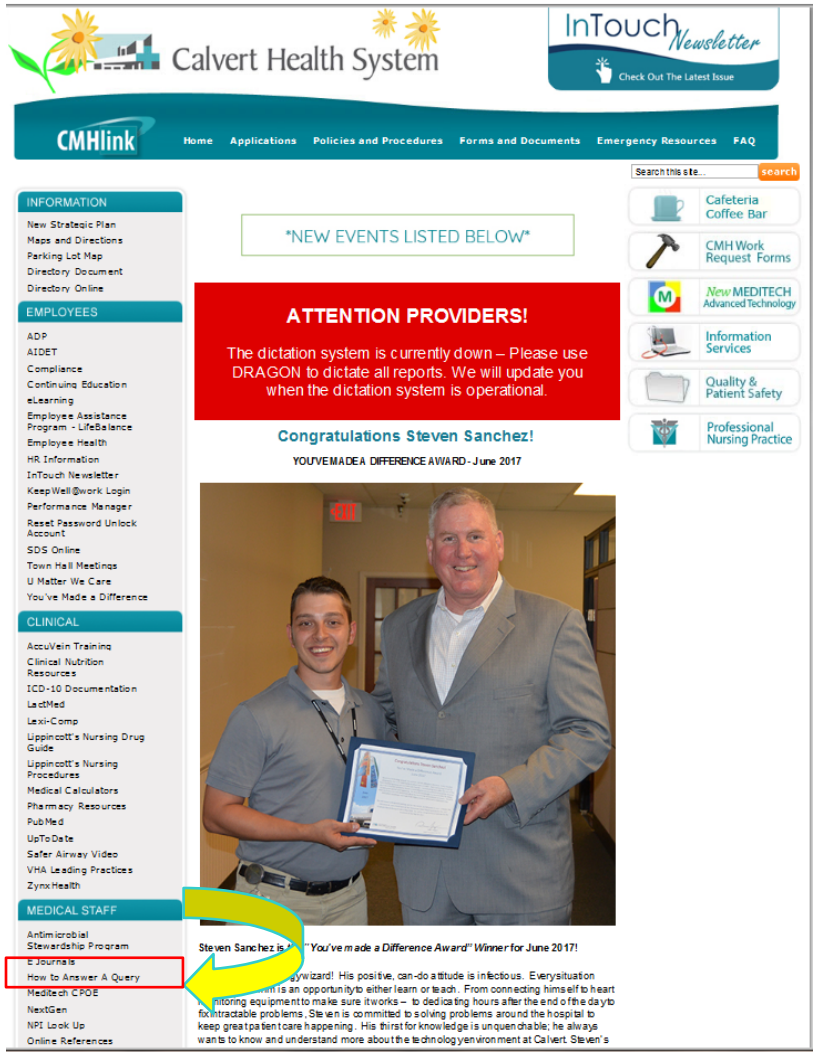
Comments: please see progress note dated 10/1/16 for more details.

Atrial Fibrillation Definitions
Paroxysmal A. Fib: terminates within 7 days
Persistent A. Fib: sustained > 7 days and is subject to rhythm control (e.g. metoprolol, flecanide, amiodarone) to maintain NSR
Permanent (chronic) A. Fib: NSR cannot be sustained and physician/patient cease further attempts to maintain NSR

Click Save/Send:



Need Help Answering a Query



Go to Intranet for a quick Power Point Presentation or call the CDI Department at 410-414-4513 or 410-414-4866

The Problem with the "Problem List"

Problem lists are dynamic & need to be updated throughout the course of the stay especially at discharge.

Avoid Bad Habits

Strive to be a "Super" Documenter

- Typical Documentation

"75 y/o presents with fever, leukocytosis, SOB with hypoxia and altered mental status."

(Notice-these are all symptoms!)

- Best Practice Documentation

"75 y/o presents with acute exacerbation of COPD & chronic respiratory failure (home oxygen dependent); complicated by acute pneumonia with probable sepsis & acute septic encephalopathy."

Collaborate for Success

- Be specific as possible
- Give a "possible" diagnosis, not a symptom
- Document whether present on admission
- Earlier identification of palliative care status
- Include ALL diagnoses on DC/Transfer/Death Summaries
- And lastly…..

✓Please answer your queries!


THANK
YOU

Calvert CARES – An Overview

What is Calvert CARES?

- **C**ollaborative **A**ctivation of **R**esources and **E**mpowerment **S**ervices
  - County wide program that seeks to address county residents' challenges in accessing care
- Partners with other county resources to identify at risk population based on Community Health Risk Assessment
  - Access to care
    - Insurance, availability of providers, ED visits
  - Hospital readmission post discharge
  - Population living below poverty level
  - Unmanaged chronic diseases

Key Program Components

- Transition to Home (Nurse, Social Worker, Pharmacist
  - Health management coaching, medication management guidance
- Project Phoenix (Behavioral Health Social Work Case Manager)
  - Partnership between CMH, Health Dept
  - Case management coaching, medication management
- Partners in Accountable Care Collaboration and Transitions (PACCT)
  - 30 agency coalition focused on optimizing patient outcomes through care coordination, collaboration, communication
  - Manages transition between hospital and home
  - Increasing awareness of housing options for seniors

Key Programs

- Patient Portal
  - Improves pt access to medical records, results; opens communication with provider
- Medication Therapy Management (MTM)
  - Pharmacist consult to optimize drug therapy
    - Medication therapy review; personal medication record; medication-related action plan; intervention and/or referral; documentation and follow up
- Medication Assistance Program/Transportation Assistance Program
  - CHMC provided financial assistance to help pts pay for essential medications, supplies or transportation to medical appointments

Key Safetynet Program – Discharge Clinic

- Care management coaching, health status assessment, goals building, intervention, medication therapy management, psycho-social support, resource access
- Allows pts extended time with care team
- Facilitates communication, education between care provider and pt
- Pts assessed at each encounter to provide real time feedback and identify risks
- Clinic visits scheduled 3 – 7 days post-discharge
- Multiple visits scheduled together (e.g. with PCP, specialists)
- Clinic staff dedicates significant time for each patient
  - Up to 1 hour per staff for up to 4 staff members

Discharge Clinic Staff Options

- Transition of Care RN Case Manager
- Clinic Physician
- Transition of Care Pharmacist
- Transition of Care Social Worker
- Respiratory Therapist
- Diabetes Educator

Accessing Calvert CARES

- Referral process using dedicated CARES form
- Includes 'trigger criteria' to demonstrate need
  - Readmission rate, ED visits, need for intensive case management, transportation barrier, etc.
- Identifies special needs, challenges that may impact pt's ability to self care
  - Visual/language/hearing/cognitive impairment, literacy, physical/financial challenges, substance abuse, etc.
- Project Phoenix Referral form used for behavioral health concerns

Calvert CARES Works!

- FY 2016 Results
  - 732 Referrals
  - 725 qualified for service – 99% conversion rate
  - 96% Overall patient satisfaction
  - For those receiving care within 30 days of referral:
    - 4.6% came to ED or were referred by CARES team
    - 3.4% admitted as inpatient to CMH (new and readmits)
    - 2.3% held for outpatient observation
      - All vs all-cause readmission rate of 9.42%