Cleveland Clinic

Connected Care: Nursing's Role in Care Coordination

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Objectives

- Provide overview of Care Coordination
- Discuss goals of Care Coordination as relates to Value-based Care
- Discuss how the community hospital-based, Chronic Care Clinics incorporate care coordination into daily operations

What is Care Coordination?

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." (AHRQ)

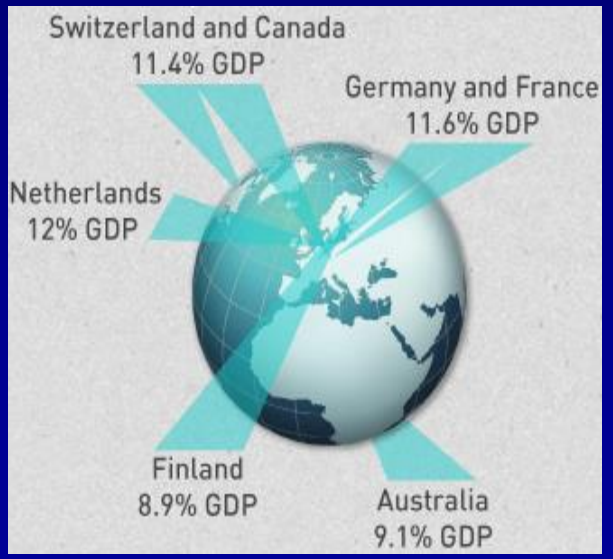
Value-Based Care

- Payments based outcomes and value of service on a patient population over the continuum of care
  - Transparency
  - Accountability
- Pressure on healthcare spending

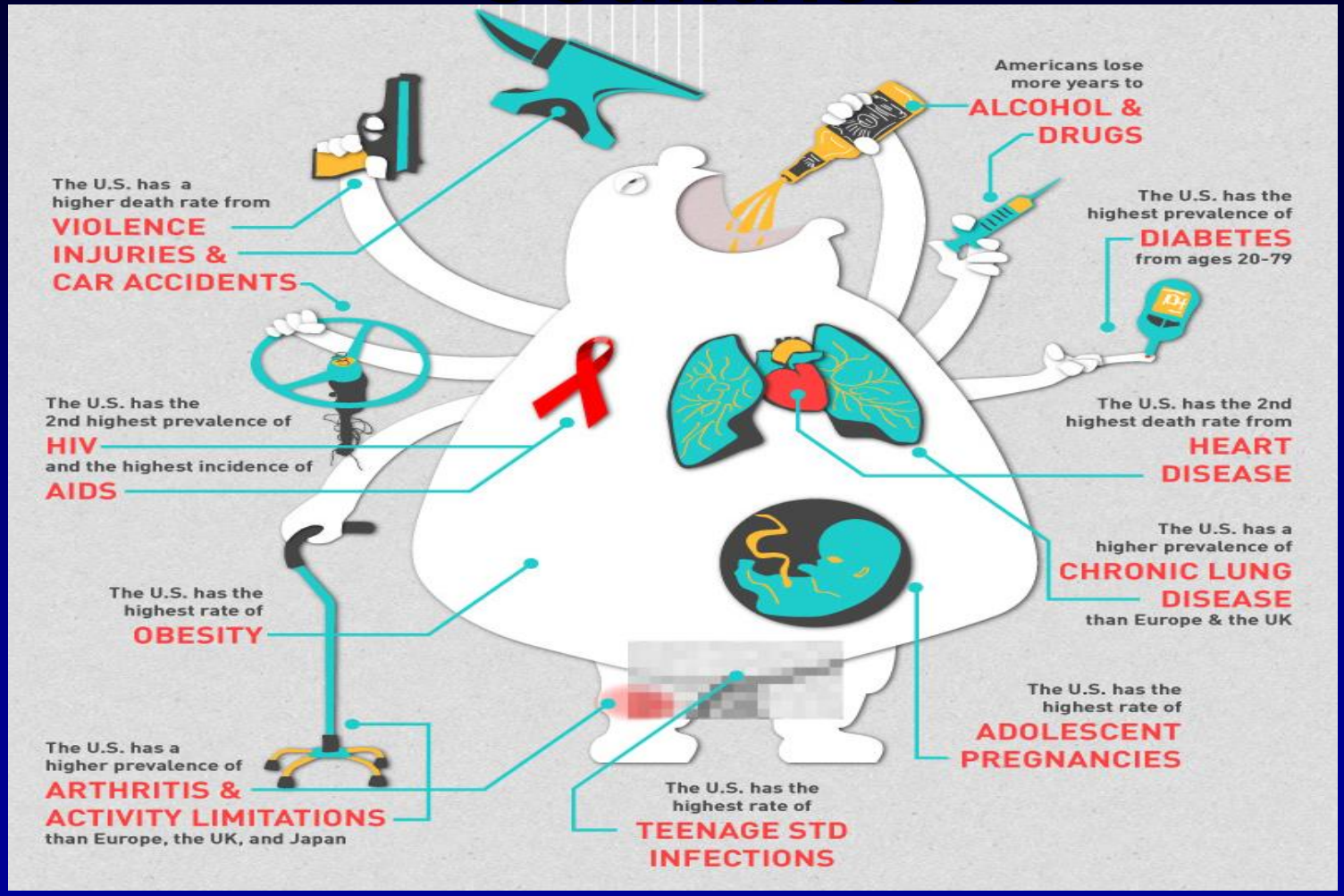
- Value= Outcomes/Cost

Statistics

- Americans spent $12 trillion on healthcare in 2010
- 17.6% of GDP or $8,233 per person
- Americans rank last in 57 different health indicators in every age group



America Compared to Other Countries



http://www.bestmasterofscienceinnursing.com/health/

Key Changes-VBC

- Accountability
  - PCP with primary care coordinator
  - Tracking of referrals and pt care
- Provision of pt support
  - Team based care across continuum
  - Foster patient engagement, involvement in care
  - Address barriers to care

Key Changes-VBC

- Build relationships and agreements
  - Identify, develop and maintain relationships with outside physicians, hospitals, community agencies
  - Develop agreements with these agencies
- Develop connectivity thru EMR
  - Integrate information needs across continuum– team members, plan of care

Key Changes Post Discharge

- Follow hospitalized patients during stay
- Review discharge summary
- Clarify outstanding questions with patient, provider
- Coordinate care with home care, caregivers
- Medication review** (unintended discrepancy)
- Follow up on test results performed during hospitalization

Why the Need for Care Coordination?

- Care fragmented; in silos
- Less than optimal hand offs and miscommunication leading to errors
- Enormous waste due to unnecessary referrals, duplication of tests, etc.

Care Coordination at Cleveland Clinic

- Provided by network of nurses working as integral leaders within and collaboratively with others across the continuum of care
- Ensure communication and planning between care providers across continuum

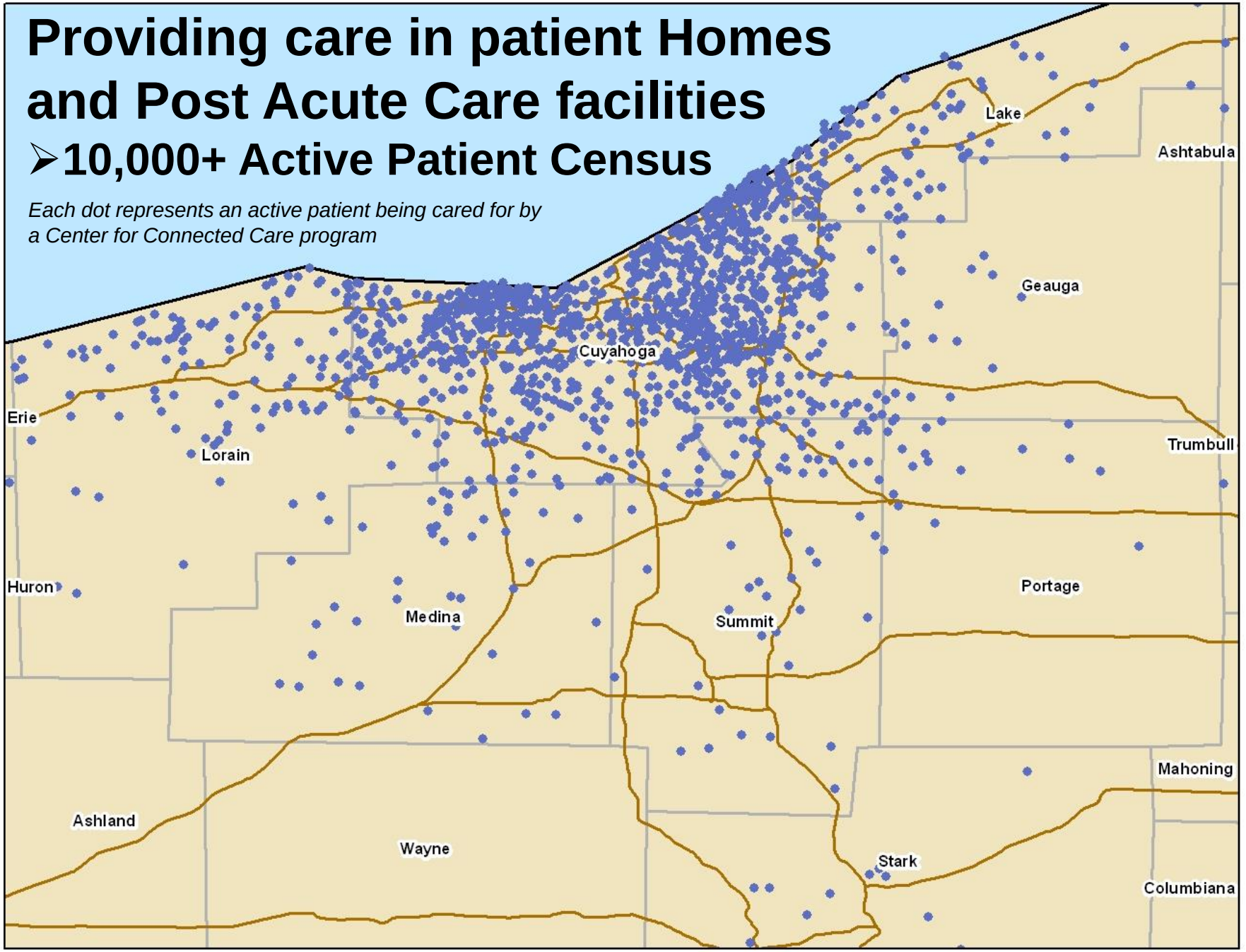
Care Coordination at Cleveland Clinic

- Facilitate transitions across continuum (including community)
  - Primary care
  - Specialty care
  - Transitional Care
  - ECFs, Home Care, Community Resources
- Includes preferences for care– including end of life

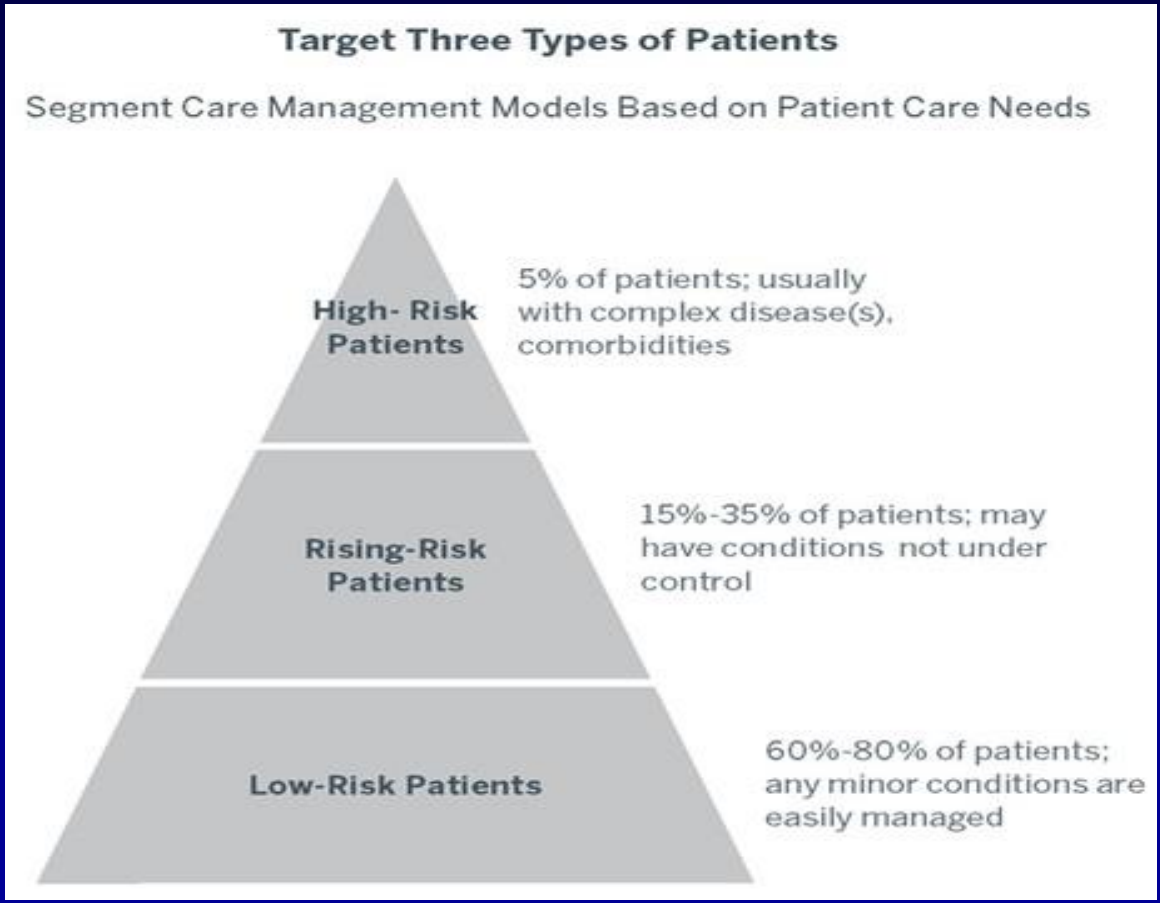
Providing care in patient Homes and Post Acute Care facilities

➢10,000+ Active Patient Census

Each dot represents an active patient being cared for by a Center for Connected Care program



Management of High Risk Patients

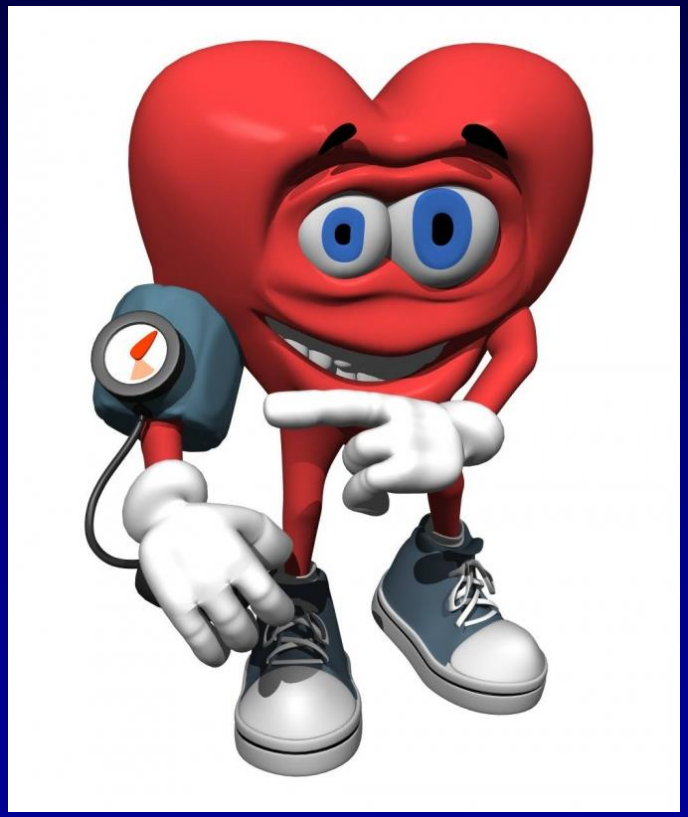


Assessing High Risk Patients

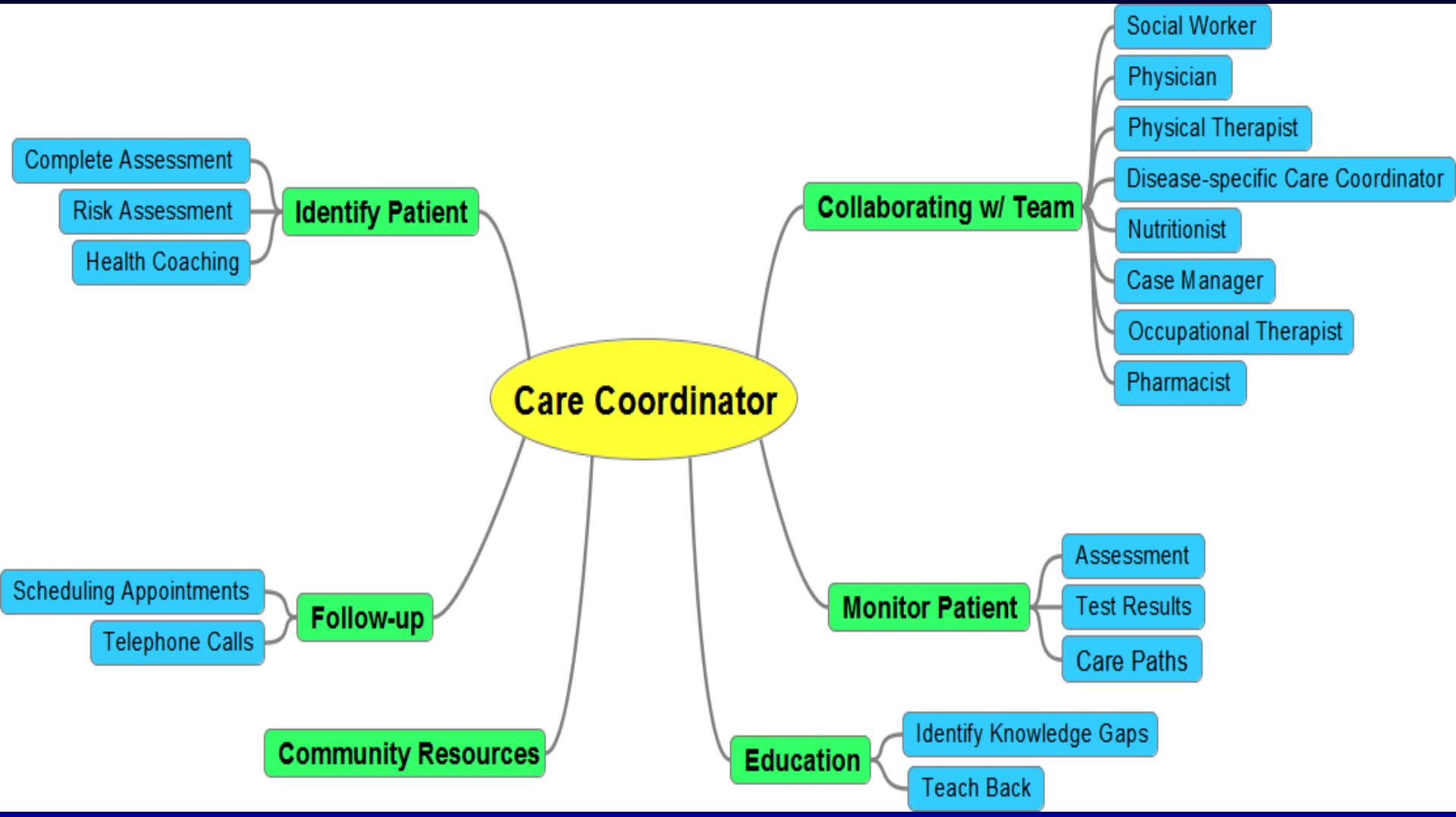
- Multiple co-morbidities
- Poly-pharmacy
- Increased age, Frailty
- Limited social support
- Mental health/ substance abuse
- Frequent hospitalizations, ED visits
- High cost
- “Gut” reaction

High Risk Populations

- Diabetes
- Hypertension
- Chronic Kidney Disease
- Congestive Heart Failure
- Malignancies
- CAD
- COPD/ Asthma



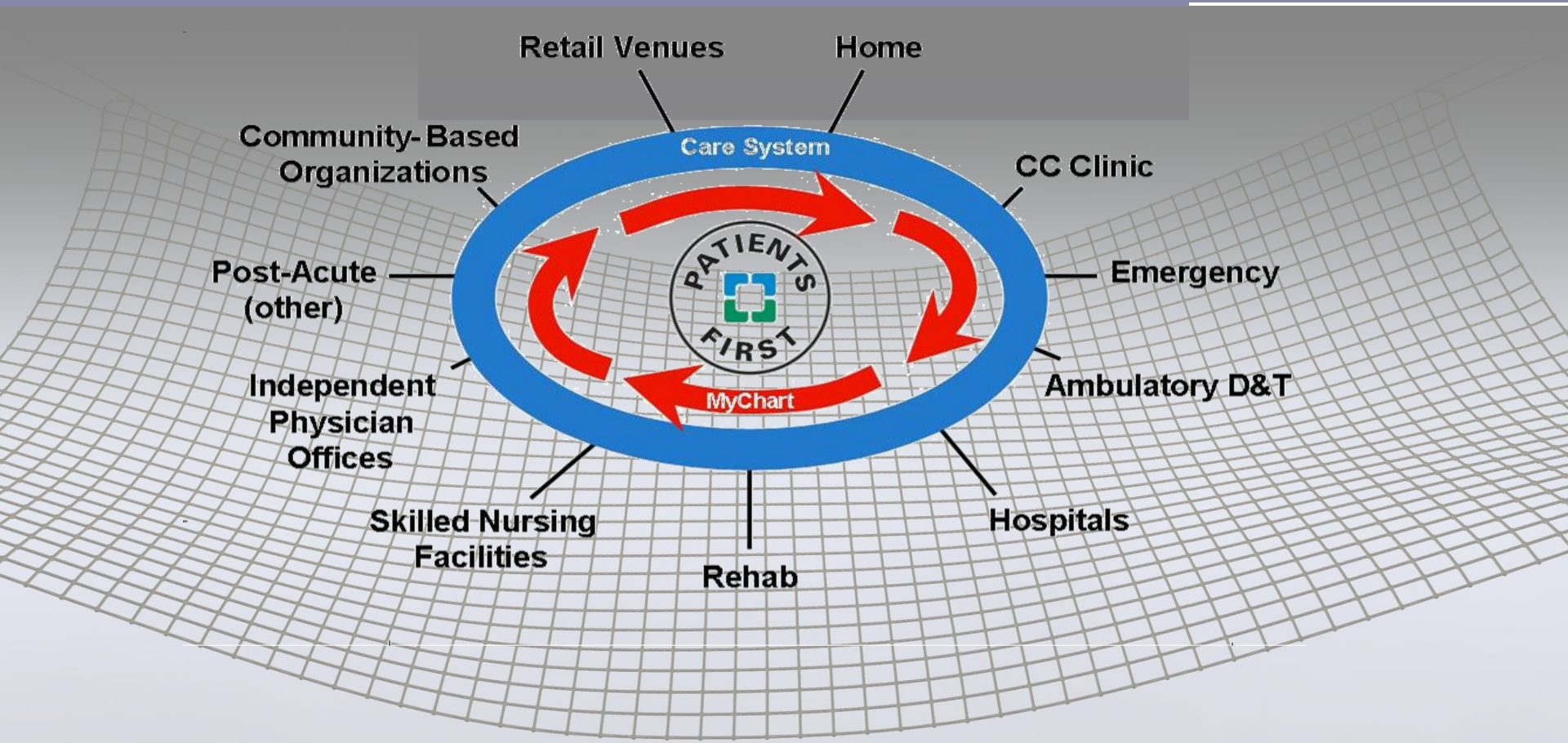
Role of the Care Coordinator



Coordinators - Definitive Roles

Primary Care	Specialty Care	Transitional Care
• Facilitate seamless cross continuum care for high risk patients • Targeted outreach • Ongoing assessment & monitoring • Partner with patients to achieve health management goals • Main point of contact for patient, family and providers thru the care process	• Collaborate with primary care coordinators in management of high risk patients within their specialty practice • Follow recommended care paths; facilitating transitions of care; transition back to primary care • Post-discharge phone calls, follow up appts, post-discharge clinic visit, transition planning, patient self management support, medication updates	• Includes specialty care advocates, care managers, home care nurses • Work in acute, post-acute, surgical & procedural settings • Facilitate transitions for high risk patients • Episode focused • Collaborate with primary care coordinators & specialty care coordinators to manage care • Assure follow up appts, transition planning, patient self management support, medication updates

Critical Role of Care Coordination
The "Net"



Care Coordinator

Job Summary:

Works collaboratively with multidisciplinary care team staff across the continuum of care to provide care and disease management to high risk patients identified in the ambulatory setting,

focusing efforts on patient outreach and coordination of care for a panel of patients to achieve:

- **optimal outcomes and**
- **promote wellness,**
- **decreasing preventable ED visits and**
- **readmissions while**
- **improving patient satisfaction.**

Job Responsibilites

- Assessment
- Coordination
- Education/Advocacy
- Quality Improvement

Job Responsibilites

Assessment:

- Conducts comprehensive clinical assessments that include disease-specific, age-specific, medical, behavioral, pharmacy, social and end of life needs of each patient.
- Actively involves the patient and family regarding coordination of their care. Shares this information with the healthcare team, patient, and family. Works collaboratively with interdisciplinary team to develop goals and plan interventions to maximize patient outcomes.
- Monitors patient compliance with plan of care. Performs reassessments regarding patient progress toward goals and updates plan of care as appropriate.
- Ensures care gaps are closed around specialty disease/chronic disease.

Job Responsibilites

Coordination:

- Often serves as primary patient contact for team related to condition; facilitates access to services.
- Links members of the patient care team. Organizes tasks and responsibilities around the patient and family needs.
- Serves as the liaison with patients and families to physicians, clinical staff.
- Assists in managing transitions of care across care settings, ensuring optimal communication and planning between care providers across different settings.
- Identifies barriers to receiving care and facilitates solutions.
- Connects patient back to primary care physician and primary care coordinator team as applicable.
- Liaison with other partner care coordinator teams across settings (e.g. transitional care). Partners with other care coordinator teams (e.g. primary and transitional care). Team includes Social Work, Rehabilitation, Pharmacy, Palliative Care and others.
- Defines and ensures compliance with disease-specific care paths for specialty care or chronic disease.

Job Responsibilites

Education/Advocacy:

- Advocates for patient and families, responds to and facilitates resolution of patient/family questions and concerns.
- Works with the patient and family to assess current knowledge, health literacy, and readiness to change, utilizing teach back to assess level of knowledge.
- Coaches patient and family on self management support including setting long and short term goals (including acute exacerbation management).
- Education about managing a specialty condition, including prevention and health maintenance tasks.
- Education and connection to other care providers and community resources to enhance care.

Job Responsibilites

Quality Improvement:

- **Works with practices on quality and process improvement initiatives. Assists in education, auditing quality, data analysis, and workflow processes.**
- **Outcome metrics include (but are not limited to) patient satisfaction, readmissions, cost per case, and compliance with care paths or evidence-based**
- **guidelines.**

Chronic Care Services

- **First clinic was Congestive Heart Failure which began in 1999**
- **Ensuring patient safety and quality**
- **Physician directed, nurse managed clinics using evidence based practices**
- **Fostering a healing environment that is patient and family centered.**

Purpose of the Chronic Care Clinics

- **To provide consistent, high level care to the patient who is in need of on-going follow-up**
- **To provide an intermediary care site between the physician office and the hospital**
- **To assist in the improved quality of life of this population**
- **To improve patient satisfaction**

Purpose of the Chronic Care Clinics

- To decrease cost of care by reducing readmission rates and ED visits
- Ongoing Education and Self-Management skills for the patient and their family
- Ongoing communication and plan of care with physician and other disciplines across the continuum

Chronic Care Services

- Leveraging technology to support nursing practice.
  - Documenting in My Practice since 2008
  - Paperless since 2009.
- Maintaining regulatory and practice compliance.
- Supporting life long learning and teaching.
- Scope and complexity of patient services to be provided by each department will be determined at the initial outpatient assessment

Chronic Care Clinics

- CHF/CKD which includes services for CHF, CKD, Anemia and Blood Management, Osteoporosis,
- Anticoagulation Support
- Diabetes Education and Self-Management which includes Dietitian support-MNT for Diabetes and other chronic diseases
- Wound Clinic
- Other Services – Dialysis and Health Heart Screening

Services Offered Through Heart Failure Center (CHF/CKD)

- Participate in education and discharge planning of CHF inpatients
- Initial Assessment and Educational / Adherence needs
- Patient and Family Education
- Symptom Management
- Cardiac Monitoring
- Fluid Management
- Lab Assessment
- BP Monitoring
- IV Medication
- Follow-up Assessment
- Goal Setting
- Anemia Management
- CKD Management
- Blood Management
- Osteoporosis

Anticoagulation Clinic Services Offered

- Comprehensive education regarding anticoagulation therapy
- Point of Care monitoring and review of the PT/INR
- Patient assessment
- Dosage adjustment of anticoagulation
- Follow-up
- Goal setting
- Home Monitoring Program
- Medication adherence

Diabetes Services Offered Through Comprehensive DSME/T

- Initial assessment/Knowledge-Learning needs assessment
- Lab assessment
- Single and Group Sessions: Patient/family education
- Behavioral Goal Setting
- Follow-up /DSMS (diabetes self management support)
- Community Support programs held several times a year with Guest speakers.
- Support Groups for patient after completing program.

Wound Clinic

- To provide wound treatment/support
- Physical assessment
- Disease management strategies
- Nutritional Needs
- Education for all aspects of wound management
- Goal Setting
- Ostomy Care

Patient and Family Involvement

- Involve pt and caregivers in planning & assessment
- Safe, timely, efficient patient-centered care
- Health Coaching to promote patient engagement, determine self care goals

Patient /Family Education Program

Behavioral Goals Towards Self Management

- **Nutritional Management**
- **Physical Activity**
- **Medications**
- **Monitoring**
- **Symptom Management**
- **Preventing, Detecting, Treating acute complications**
- **Risk Reduction**
- **Psychosocial Adjustment**
- **Goal Setting**

The Chronic Care Model

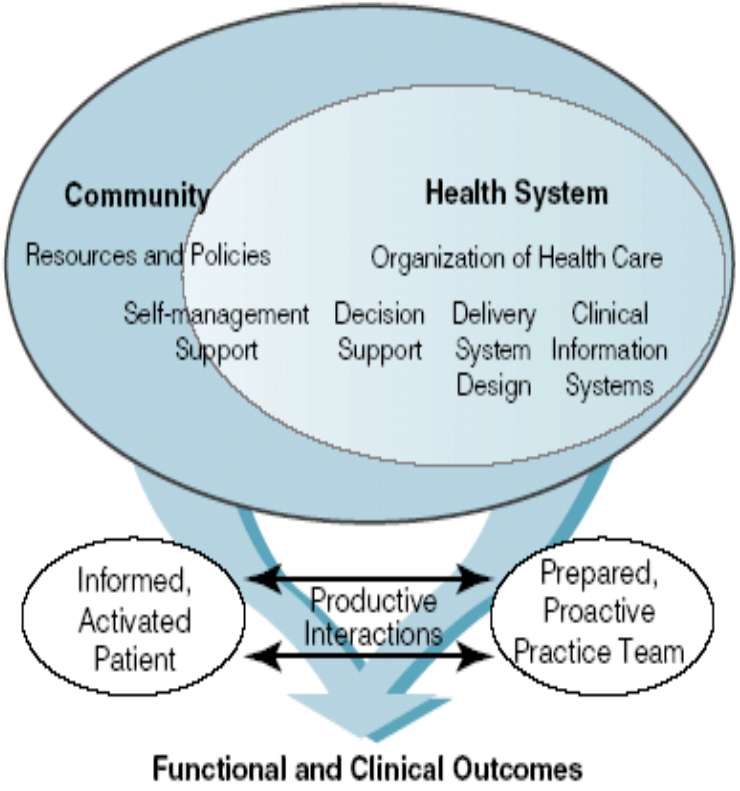


FIGURE 1. Model for improvement of chronic illness care.

http://www.acponline.org/journals/ecp/augsep98/cdm.pdf

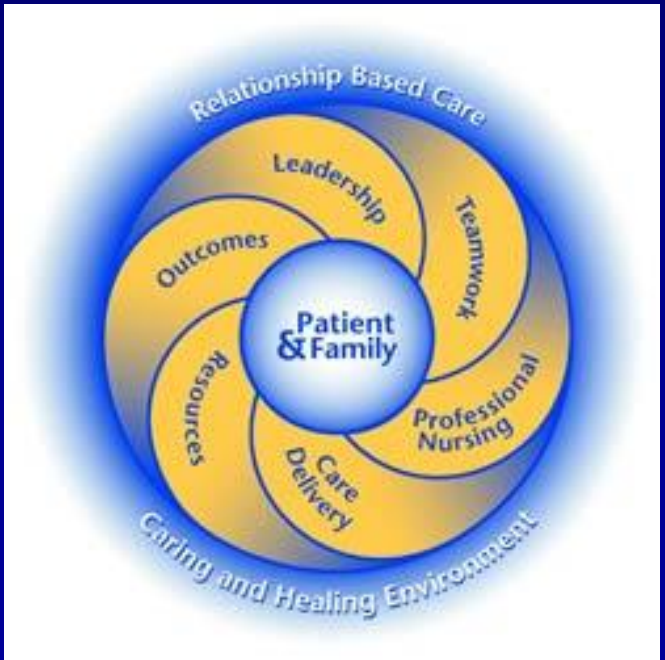
Effective Clinical Practice August/September 1998 Volume 1 Number 1

- **Health System** - Create a culture, organization and mechanisms that promote safe, high quality care
- **Delivery System Design-** Assure the delivery of effective, efficient clinical care and self-management support
- **Decision Support** -Promote clinical care that is consistent with scientific evidence and patient preferences
- **Clinical Information Systems-** Organize patient and population data to facilitate efficient and effective care
- **Self-Management Support** - Empower and prepare patients to manage their health and health care
- **The Community** - Mobilize community resources to meet needs of patients

Relationship-Based Care

- The RBC model provides a conceptual framework with a vision for care and underlying values and principles, a practical infrastructure for putting it into action, the education and leadership necessary to make it happen and ways to measure evidence of success.
- Care takes place in a Caring and Healing Environment with the Patient and Family at the center.
- Six dimensions are critical for successful transformation:
  - Leadership
  - Teamwork
  - Professional Nursing Practice
  - Patient Care Delivery System
  - Resource Driven Practice
  - Outcomes Measurement

http://www.chcm.com/services/RBC/rbc.asp



Cleveland Clinic Zielony Nursing Institute Professional Practice Model

- Colleagues in Care Professional Practice Model recognizes the Nursing Institute's "Patients First" focus and our shared vision.

- Our model is based on theories which enlighten the model. These theories are:
  - Shared Vision,
  - Relationship Based Care
  - Thinking in Action
  - Serving Leader

- Colleagues in Care Professional Practice Model has 4 components which are the observable manifestation of the model in practice. They are:
  - Quality and Patient Safety
  - Healing Environment
  - Research and Evidence Based Practice
  - Professional Development and Education

Professional Practice Model

Shared Vision-Peter Senge, PhD

Relationship-based Care-Marie Manthey

Thinking in Action-Patricia Benner, PhD, RN, FAAN

Serving Leader-Ken Jennings, PhD

QUALITY & PATIENT SAFETY

- National quality indicators
- Performance improvement
- Safe clinical care supported by appropriate staffing
- Competent workforce
- Skilled communications and handoff across the continuum of care
- Change management
- Safe staffing
- Fiscally responsible
- Ongoing Measures

HEALING ENVIRONMENT

- Empathetic, respectful, compassionate and holistic care
- Effective communication and relationship management
- Patient and family centered care
- Shared effective decision-making
- Interdisciplinary collaboration
- Embrace diversity
- Leverage technology to support practice
- Culturally sensitive
- Patient experience

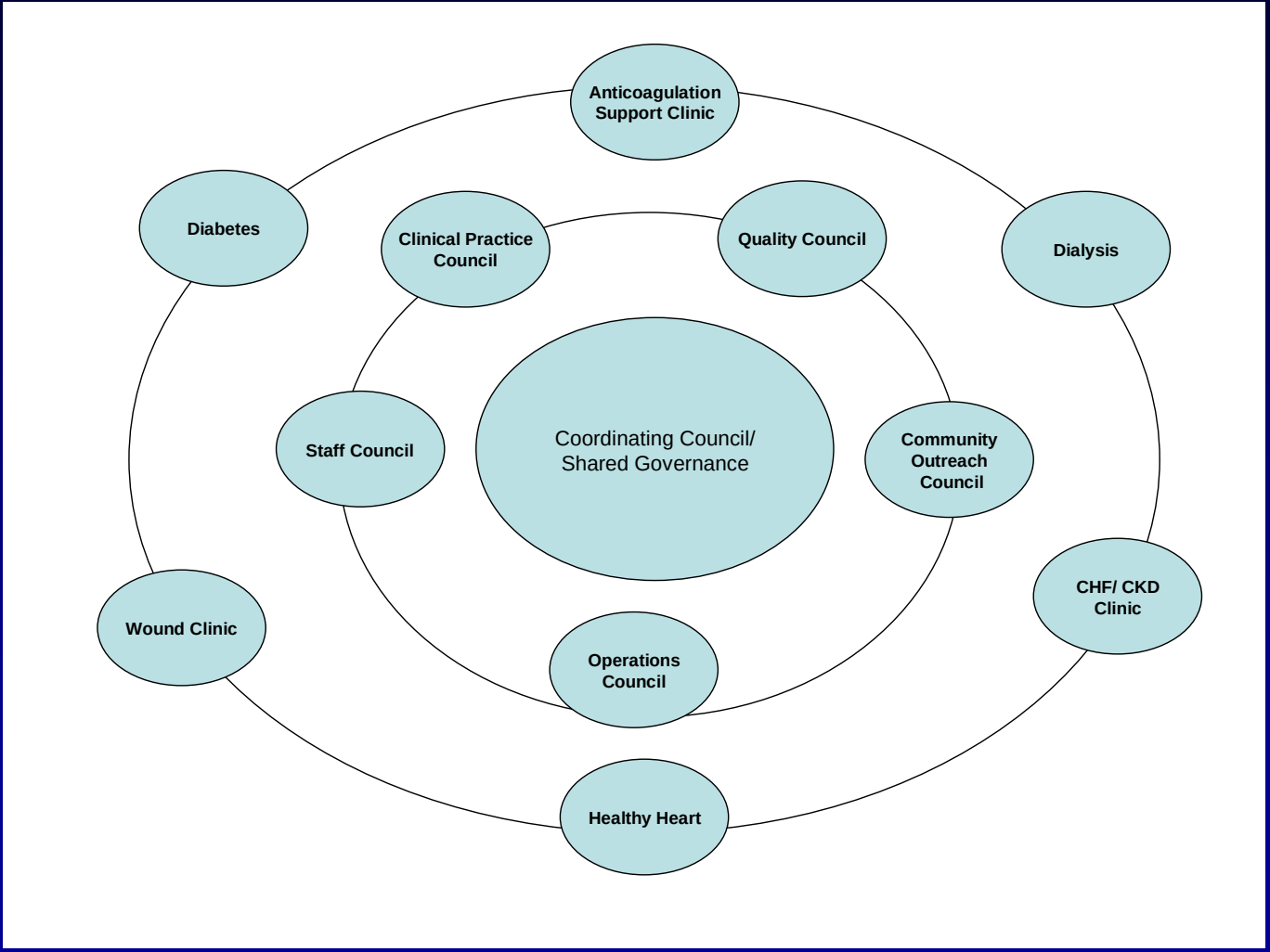
RESEARCH & EVIDENCE-BASED PRACTICE

- Evidence-based clinical practice and management
- Nursing Knowledge
  - Generation
  - Translation
  - Dissemination
- Innovation
- Clinical inquiry
- Standardization
- Integrate technology
- Care delivery using the nursing process

PROFESSIONAL DEVELOPMENT & EDUCATION

- Successful on-boarding
- Competency
- Clinical Ladder
- Certification
- Leadership skills
- Shared Governance
- Academic partnership
- Elevate the professional image of nursing
- Involvement in professional organizations and communities
- Life-long learning

Chronic Care Shared Governance



Councils/Teams

- SG Coordinating Council
- Clinical Practice Council
  - Informatics
  - P&P
  - Research
- Quality Council
  - Safety
  - PI
  - Medical Record Review
- Operations Council
- Staff Council
  - Onboarding
  - Recognition
- Community Council

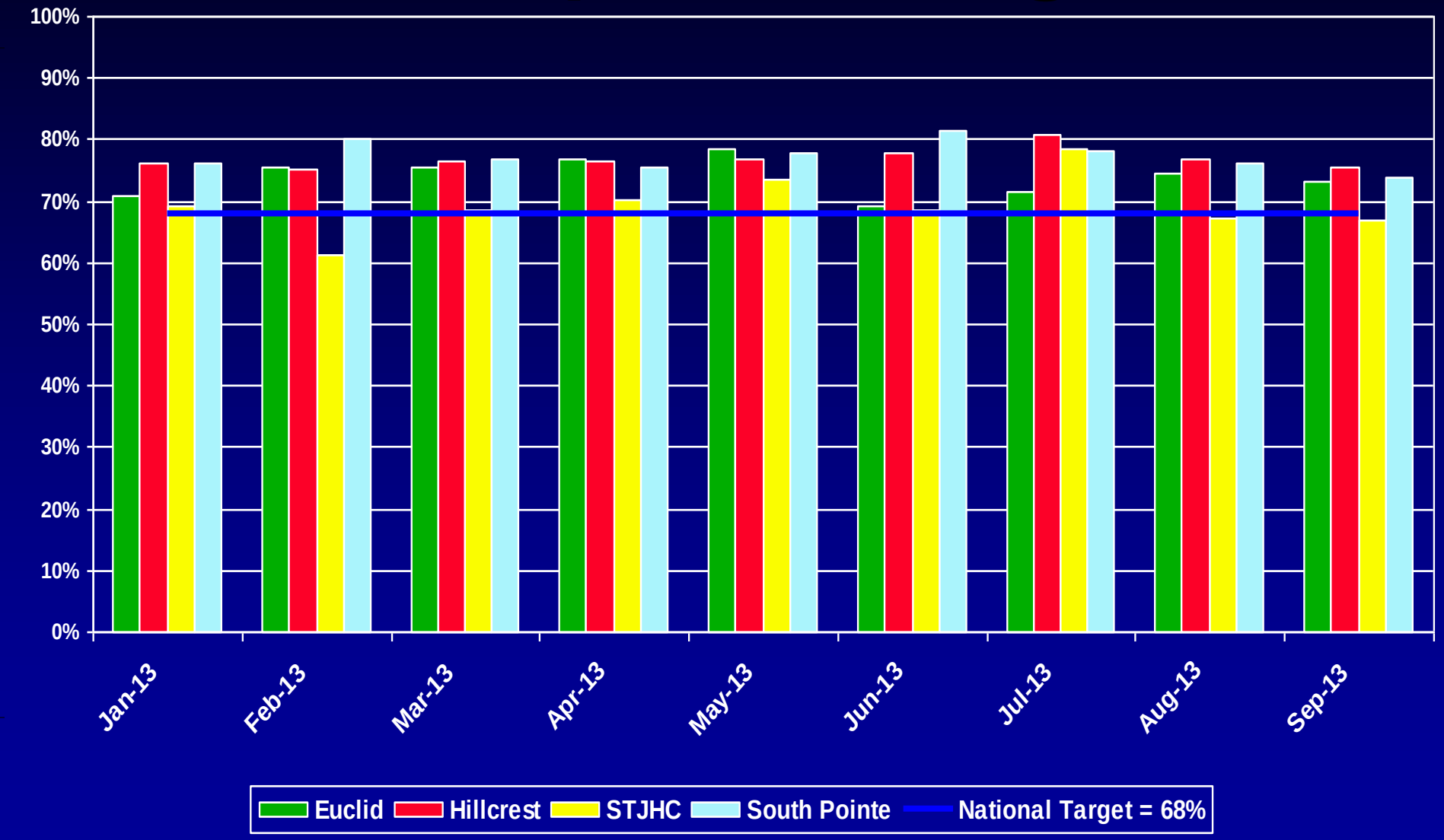
The Importance of Data

- Each Clinic has multiple Performance Improvement Measures (PIM) that are reported monthly.
- Each PI measure has target and goals set yearly based on national benchmarks and historical data.
-
- Data is gathered from variety of sources including – SQL reports, EPSI, and EPIC.
- Database Development Evolution from manual collection to MS Access Database to Web-based Data Entry to Epic Reporting.

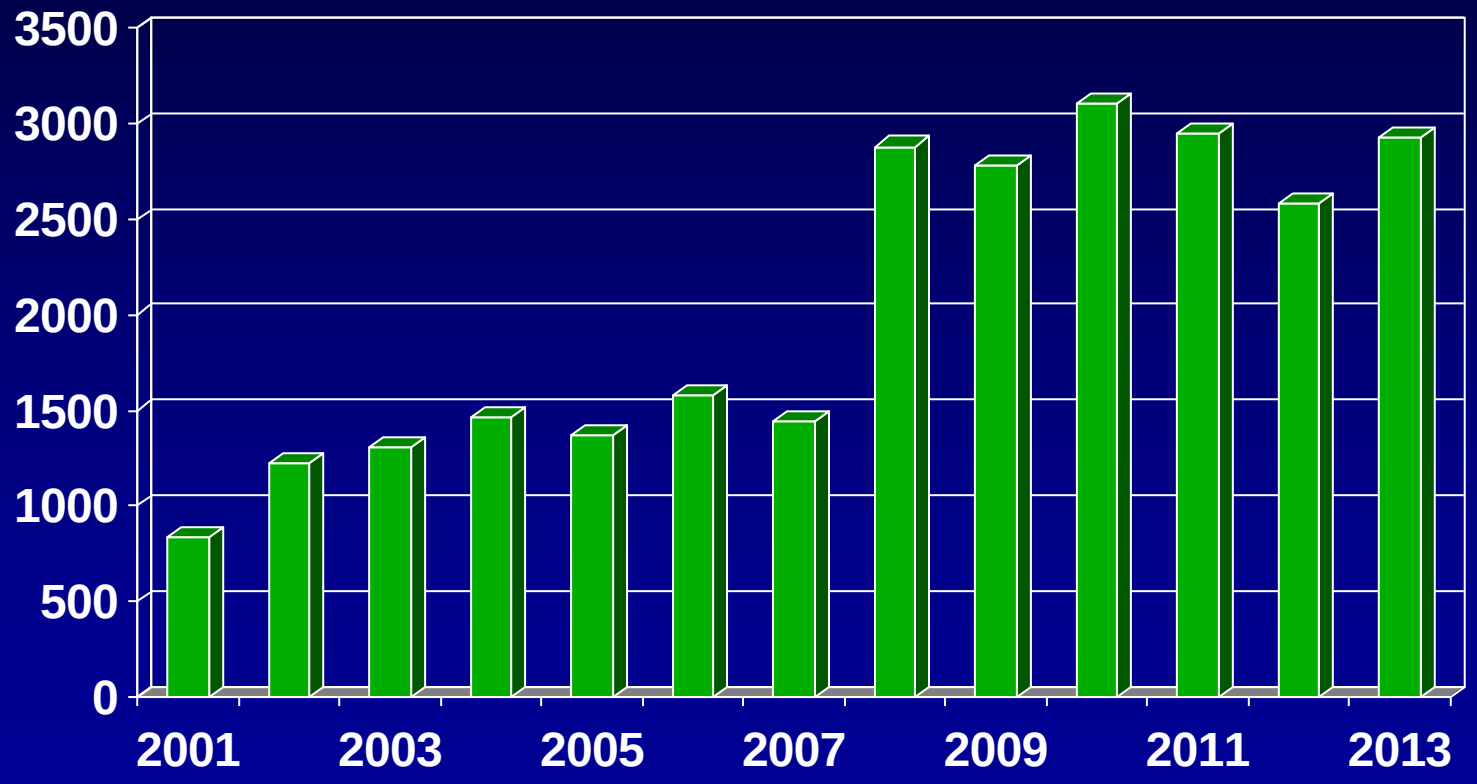
Performance Improvement Monitoring

- Rate of complications
- Hospital admissions
- Reduction in 30-day admissions
- Patient and caregiver satisfaction
- Frequency of preventive services
- Cost of care
- ED visits
- Improved outcomes

Percent of Patients in Therapeutic Range



Chronic Care Clinics
Active Patient Volume by Year

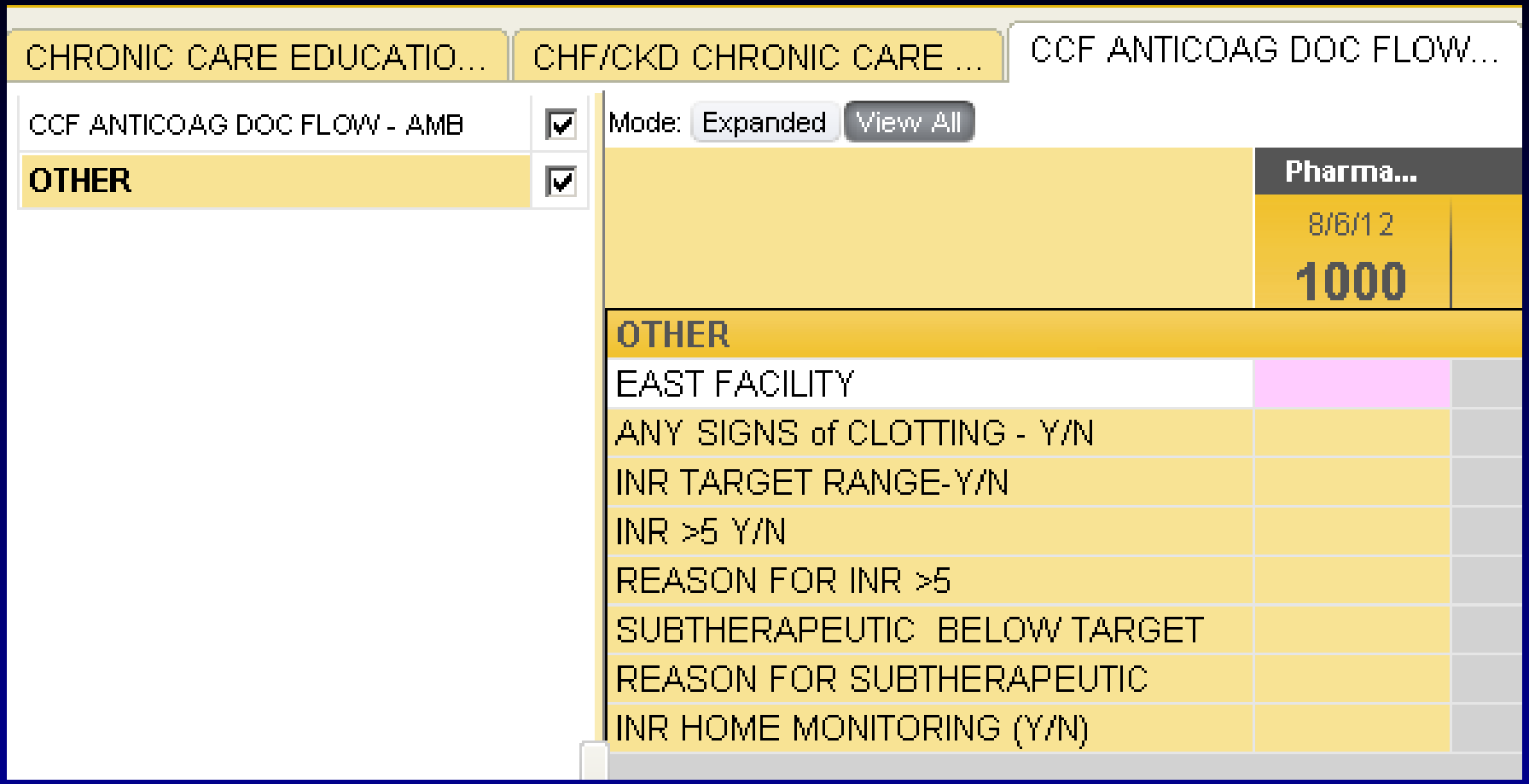


**Data includes Euclid, Hillcrest, South Pointe, and Stephanie Tubs Jones Health Center

Documentation

Flowsheets

- Flowsheets are design to allow us to collect data that can be abstracted from chart for reporting easily.
- There are two type of Flowsheets
  - Doc Flowsheet – Where enter the data during the visit with the patient.
  - Review Flowsheets - allows to review the data over time and also add other key information like labs, weight,…
- The Chronic Care Education Flowsheet is used by everyone and collect key information about teaching method, safe scores, and Advance Directives.
- Each Clinic has a specific Flowsheet that design to details for specific condition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CHF/CKD CHRONIC CARE ...
CCF ANTICOAG DOC FLOW...
CCF ANTICOAG DOC FLOW - AMB
OTHER
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Pharma...
8/6/12
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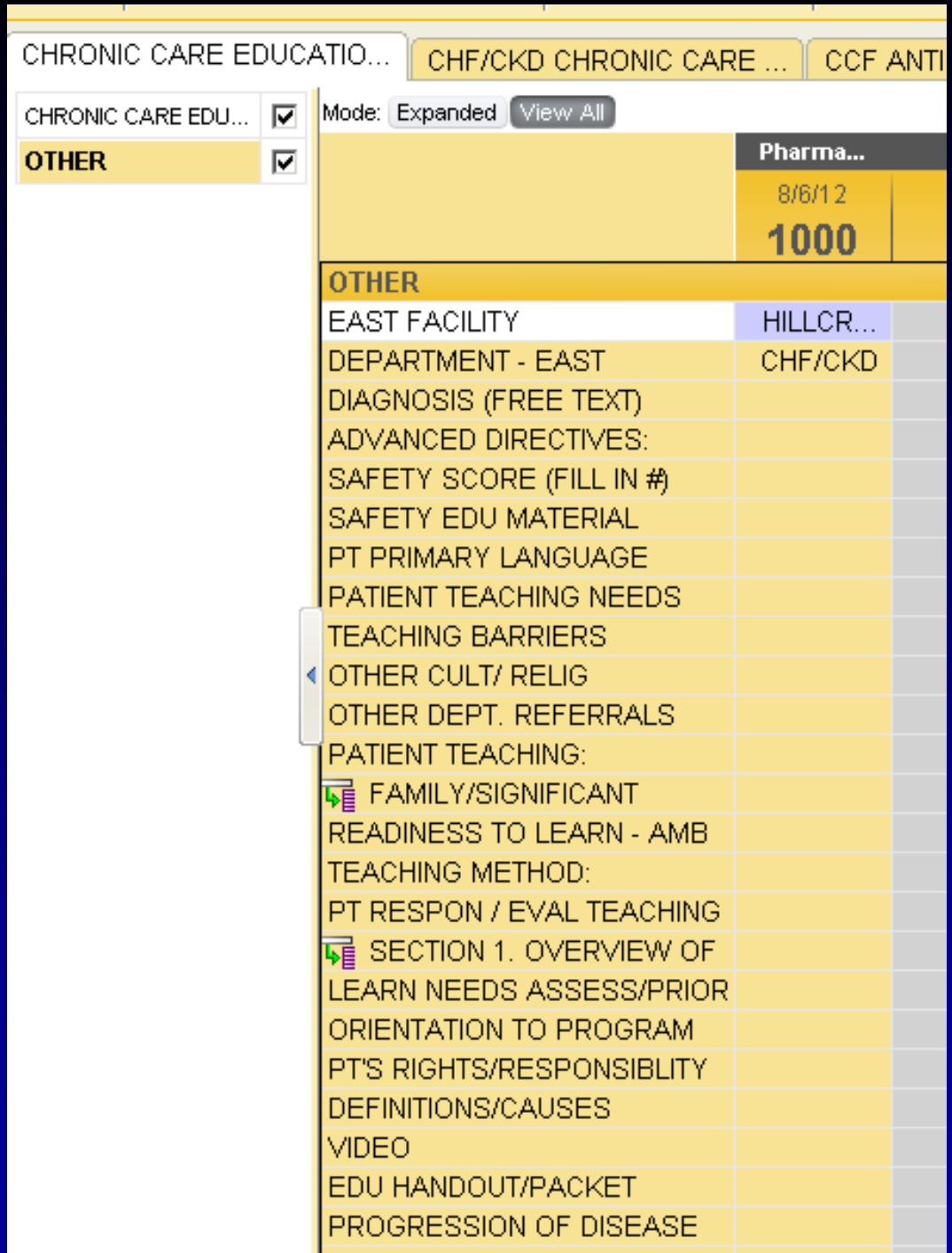
OTHER
EAST FACILITY
ANY SIGNS of CLOTTING - Y/N
INR TARGET RANGE-Y/N
INR >5 Y/N
REASON FOR INR >5
SUBTHERAPEUTIC BELOW TARGET
REASON FOR SUBTHERAPEUTIC
INR HOME MONITORING (Y/N)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8/6/12
1000
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EAST FACILITY
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DEPARTMENT - EAST
CHF/CKD
DIAGNOSIS (FREE TEXT)
ADVANCED DIRECTIVES:
SAFETY SCORE (FILL IN #)
SAFETY EDU MATERIAL
PT PRIMARY LANGUAGE
PATIENT TEACHING NEEDS
TEACHING BARRIERS
OTHER CULT/ RELIG
OTHER DEPT. REFERRALS
PATIENT TEACHING:
FAMILY/SIGNIFICANT
READINESS TO LEARN - AMB
TEACHING METHOD:
PT RESPON / EVAL TEACHING
SECTION 1. OVERVIEW OF
LEARN NEEDS ASSESS/PRIOR
ORIENTATION TO PROGRAM
PT'S RIGHTS/RESPONSIBLITY
DEFINITIONS/CAUSES
VIDEO
EDU HANDOUT/PACKET
PROGRESSION OF DISEASE

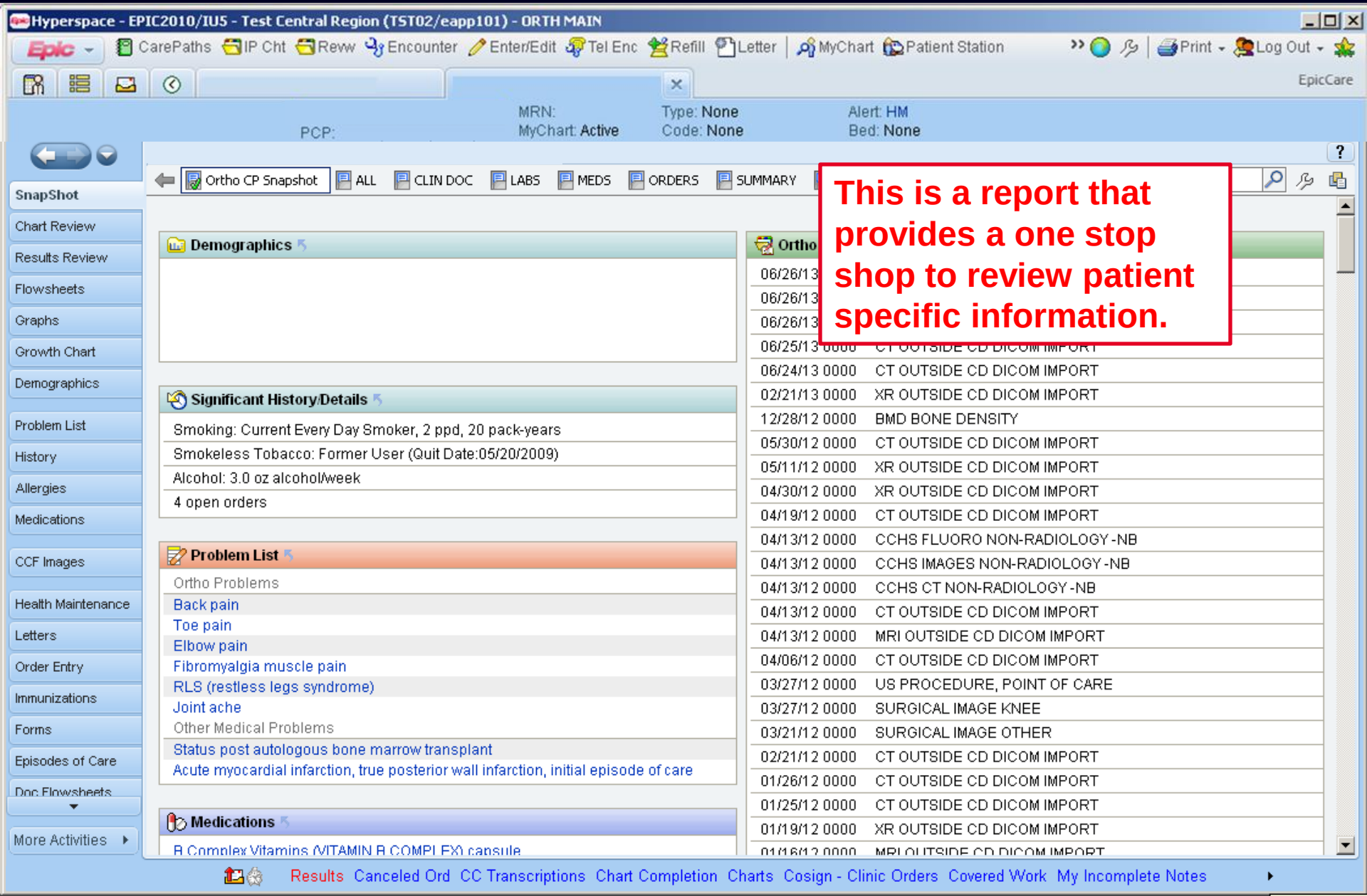
Select Flowsheets to View
CHF DATA DOC FLOWSHEET/RESULTS [667]
VITALS [23]

CHF DATA DOC FLOWSHEET/RESULTS	Latest Ref Rng		5/30/2012		3/30/2
CHF/CKD FAILURE TYPE			DIASTOLIC		
CKD STAGE			I I I		
PT INR					
PT INR					
Last INR					
Date					
INR Goal					
Pt. Deviated from dose					No
Weekly dose					
Dose Range					
Vitals		7/27/2012		5/21/2012	
SYSTOLIC					
DIASTOLIC					
PULSE				90	
TEMPERATURE					
RESPIRATIONS				14	
WEIGHT in POUNDS					
WEIGHT in KILOGRAMS					
HEIGHT					
BLOOD PRESSURE					
PULSE OX		96		100	
BODY MASS INDEX					

EPIC Tools for Care Coordination

- Snapshot
- Identification of Patient Care Team Members
- Patient Lists
- Care Coordination Note

Snapshot”


Hyperspace - EPIC2010/IU5 - Test Central Region (TST02/eapp101) - ORTH MAIN
CarePaths
IP Cht
Reww
Encounter
Enter/Edit
Tel Enc
Refill
Letter
MyChart
Patient Station
Print
Log Out
EpicCare
PCP:
MRN:
MyChart: Active
Type: None
Code: None
Alert: HM
Bed: None
Ortho CP Snapshot
ALL
CLIN DOC
LABS
MEDS
ORDERS
SUMMARY
SnapShot
Chart Review
Results Review
Flowsheets
Graphs
Growth Chart
Demographics
Problem List
History
Allergies
Medications
CCF Images
Health Maintenance
Letters
Order Entry
Immunizations
Forms
Episodes of Care
Doc Flowsheets
More Activities
Demographics
Significant History/Details
Smoking: Current Every Day Smoker, 2 ppd, 20 pack-years
Smokeless Tobacco: Former User (Quit Date:05/20/2009)
Alcohol: 3.0 oz alcohol/week
4 open orders
Problem List
Ortho Problems
Back pain
Toe pain
Elbow pain
Fibromyalgia muscle pain
RLS (restless legs syndrome)
Joint ache
Other Medical Problems
Status post autologous bone marrow transplant
Acute myocardial infarction, true posterior wall infarction, initial episode of care
Medications
B Complex Vitamins (VITAMIN B COMPLEX) capsule
Ortho
06/26/13
06/26/13
06/26/13
06/25/13 0000
06/24/13 0000 CT OUTSIDE CD DICOM IMPORT
02/21/13 0000 XR OUTSIDE CD DICOM IMPORT
12/28/12 0000 BMD BONE DENSITY
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04/30/12 0000 XR OUTSIDE CD DICOM IMPORT
04/19/12 0000 CT OUTSIDE CD DICOM IMPORT
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04/13/12 0000 CCHS IMAGES NON-RADIOLOGY -NB
04/13/12 0000 CCHS CT NON-RADIOLOGY -NB
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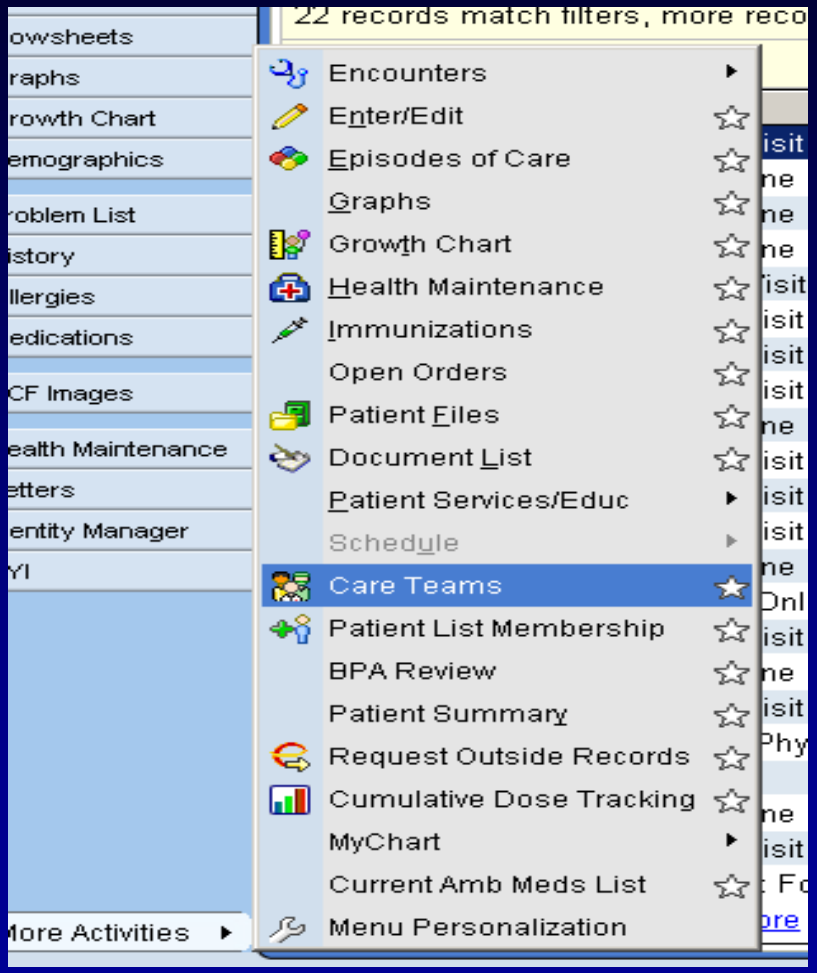
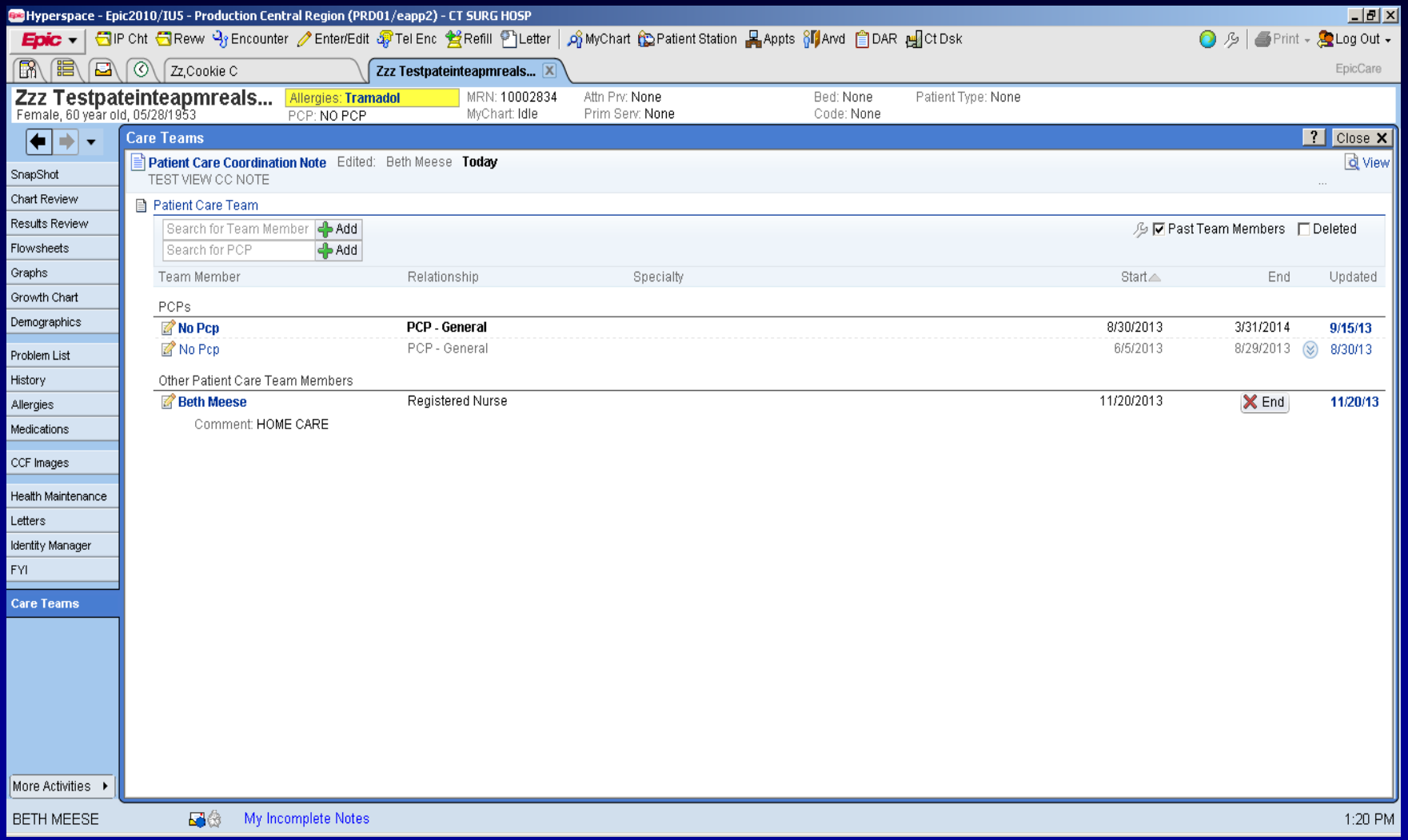
04/13/12 0000 MRI OUTSIDE CD DICOM IMPORT
04/06/12 0000 CT OUTSIDE CD DICOM IMPORT
03/27/12 0000 US PROCEDURE, POINT OF CARE
03/27/12 0000 SURGICAL IMAGE KNEE
03/21/12 0000 SURGICAL IMAGE OTHER
02/21/12 0000 CT OUTSIDE CD DICOM IMPORT
01/26/12 0000 CT OUTSIDE CD DICOM IMPORT
01/25/12 0000 CT OUTSIDE CD DICOM IMPORT
01/19/12 0000 XR OUTSIDE CD DICOM IMPORT
This is a report that provides a one stop shop to review patient specific information.
Results
Canceled Ord
CC Transcriptions
Chart Completion
Charts
Cosign - Clinic Orders
Covered Work
My Incomplete Notes

EPIC Tools

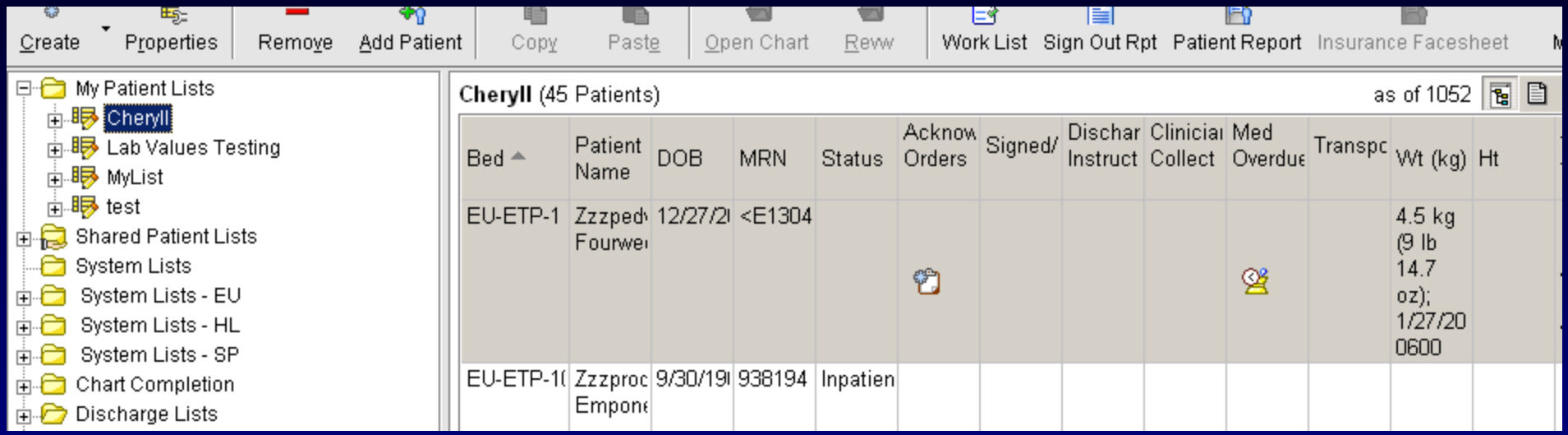
- Select patient
- Select more activities
- Select Care Teams



Care Coordination Notes

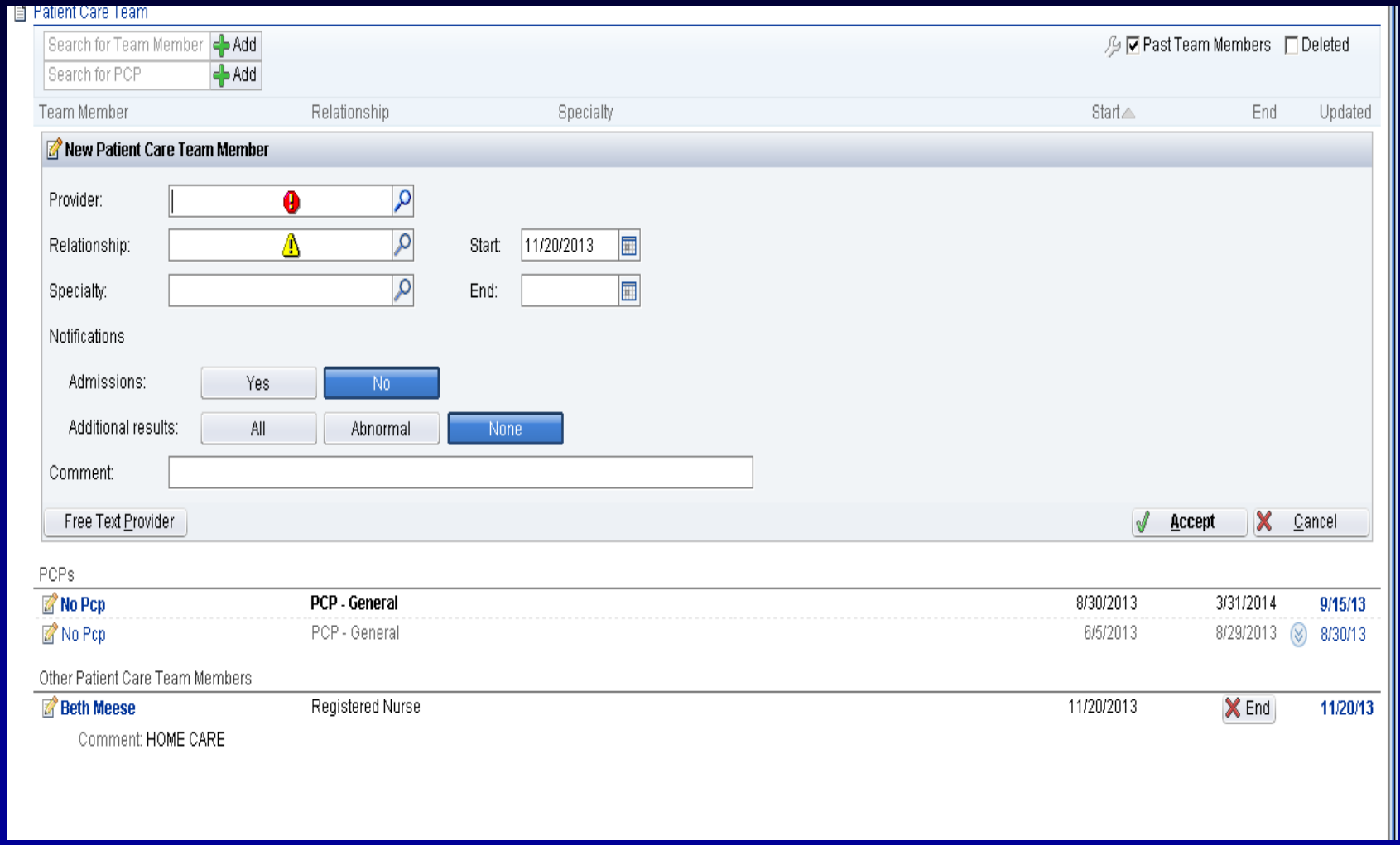


“Patient Lists”



Patient Lists provide a grouping of specific patients who meet selected criteria. Patient lists can be created by the system, created to be shared, and each end user can create their own.

Adding Care Team Members



Make a Referral…..

- Enter an order in EPIC: Go To Order Entry and select the “Consult to Cleveland Clinic at Home”
- Call the Home Care office at 216-444-HOME (4663)
- Enter an order in ECIN (inpatient)

Care Coordination Resources

- Center for Connected Care
- EPIC
- Community Resources

Community Resources

- Knowledge Center—Community Resources

http://portals.clevelandclinic.org/knowledgecenter/ResourcesEducationForms/CommunityResources/tabid/6750/Default.aspx

- Community Outreach 445-2009
- Ohio Area Agency on Aging
- United Way 211
- Professional Organizations
  - American Cancer Society

Center for Connected Care

Providing Care in Patient's Homes

- Home Care
- Hospice
- Home Infusion Pharmacy
- Home Respiratory Therapy
- Physician services
  - Medical Care at Home: house calls practice
  - Home Palliative Medicine practice

Providing Care in Post Acute Care facilities

- Skilled Nursing Facility (SNF) Connected Care program

Challenges of Care Coordination

- Communication among caregivers
- Ensuring clinical competency
- Paradigm shift: Focusing on chronic diseases and not the acute medical problems
- Accountability
- Patient's lack of knowledge of self care

Newer Concepts Learned

- Motivational Interviewing
- Change Theory
- Shared Visits
- Team/Scribing
- Value-based Care
- Patient-Centered Home
- Accountable Care Organizations
- My Chart Utilization

Conclusion

- Care Coordination provides the patients and familes with safe, quality care with access to resources needed to improved patient outcomes.

- Cleveland Clinic will have improved patient outcomes, savings per patient and increase in patient and caregiver satisfaction.

Cleveland Clinic

Every life deserves world class care.